Board Assurance Report

PRINCIPAL RISK: 1 – FAILURE TO MAINTAIN THE QUALITY OF PATIENT SERVICES DEMANDED	**Executive Lead: Executive Director of Nursing and Quality**
Strategic Priorities	
SP1 – To consistently deliver safe, effective high quality care achieving a positive staff and patient experience	
SP2 – To eliminate the variability of access to and outcomes from our acute and community services.	
SP5 – To provide efficient and cost effective services and deliver better value healthcare	
Purpose of Report:	
To provide assurance to the committee that the controls in place to manage/reduce risks identified in the Board Assurance Framework (BAF) Document have been tested. The outcome of testing the controls will result in either positive assurance being provided or where a negative result has been obtained an action plan will be provide with this report.	
Date Submitted to Audit and Assurance Committee	**23 July 2015**
Information contained within this report has been scrutinised and challenged by lead Committee(s) to assure themselves of the effective operation of each key control relating to the principle risk as detailed below: (Executive lead to insert names and dates of Committees who have reviewed this report	
Clinical Quality and Governance Committee, 14 January 2015, 11 February 2015, 11 March 2015, 15 April 2015, May 2015, June, 2015, July 2015	
Quality Committee, 22 January 2015, 19 March 2015, May 2015	
Declaration: As lead executive, having taken reasonable steps to test the effectiveness of controls to mitigate the risks of not achieving clinical sustainability, I recommend to the Audit and Assurance Committee that appropriate actions are being taken to close gaps in assurance and controls.	
Recommendation to A & A Committee: (To be completed by lead Executive)	
To note actions completed and on-going in relation to Principal Risk 1 and the escalated risk regarding the implementation of the Medway PAS	
The evidence required by committee should be: proportionate, Appropriately independent, Demonstrate controls have been robustly tested / audited	
Report compiled by: Director of Nursing/ Medical Director ***Latest review July 2015***	

RISK 1.1 – INABILITY TO MAINTAIN STAFFING LEVELS THAT REFLECT THE NEEDS OF PATIENTS AND ARE SUFFICIENTLY FLEXIBLE TO SUPPORT VARIABILITY IN DEMAND: • Failure to ensure that are sufficiently available Medical and Nursing staff to provide safe, timely care in the Emergency Department and Medical wards • Failure to ensure there are sufficient numbers of Radiologists to meet clinical demands • Heavy reliance on Bank, Agency and Locum staff to sustain staffing levels		
RAG: Gross Impact	4	Gross RAG Score 16
Gross Likelihood	4	
Net Impact	4	Net RAG Score 12
Net Likelihood	3	
Key Controls in place: (what controls/systems are in place to assist in securing delivery of our objectives)		
Nurse staffing agency and bank data submitted weekly to Executive Management Team		
Additional Night Registered Nurse on all inpatient wards since July 2013		
Recruitment campaigns to attract numbers and quality of staff		
International recruitment campaign to increase Registered Nurse Numbers		
Recruitment Strategy for newly qualified nurses		
Escalation flowchart for managing nursing numbers daily		
Monitoring of nursing number x 4 a day		
6 month acuity and dependency assessment		
Francis team working with the clinical team reviewing radiology provision to identify efficiencies and transformation change.		
Alternative recruitment strategy for 'Hard to Fill' medical posts		
Workforce Strategy		
Overseas Recruitment Strategy		
Nurse Recruitment Strategy		
Providing enhanced care shifts x 4 per shift		
Focus on reducing LoS >14 days to reduce demands on beds		
• Closed winter capacity ward		
• Closed 8 beds on Sconce Ward		
• Closed 8 beds on ward 33		
Consultant Radiology Strategy		
Sources of Assurance: (The evidence that shows we are reasonably managing our risks and objectives are being delivered)		
Reported to the Board:		
£4M case for investment in Registered Nurses – January 2014		

Nurse Staffing report and UNIFY return
Workforce monthly and quarterly reports
Quality Improvement plan
Staff Survey
Quality and staffing metrics in monthly divisional reports
Reported elsewhere
Ward Assurance Matrix to triangulate quality and safety metrics
Bank, Locum and agency usage
Bed closure plans
Division & Corporate Performance and Delivery Meetings
Weekly and Monthly quality dashboard to assess risks
Assurance on Controls: (where we have tested/audited our controls/systems to ensure they are adequate and effective)
Regular reports to Board:
• Nurse staffing and establishment review – 6 monthly
• Integrated Performance report
• Workforce Monthly and Quarterly Reports
Reported elsewhere
• Recruitment and workforce data considered by OD and Workforce Committee and Nursing Workforce Committee
• Reduction in Neonatal band capacity to manage staffing shortfalls
• Francis report and recommendations in relation to Radiology presented to the Executive Team November 2014
Early warning scorecard to CQGC & Quality Committee
Gaps in Control: (Where are we failing to put controls/systems in place? Where are we failing in making them effective? Please ensure that for each gap you provide additional information in the action and timescales section on how the gap will be closed)
1.0 The Trust is utilising a high number of bank and agency staff to sustain safe nurse staffing levels in Emergency Care & Medicine Division
2.0 Reliance on locum Medical Staff to meet Emergency Department activity
3.0 Struggling to fill all level 4 (Reducing harm) requests
Gaps in Assurance (Negative Evidence) (Where are we failing to test/audit that our controls/systems, on which we place reliance, are effective. Please ensure that for each gap you provide additional information in the action and timescales section on how the gap will be closed.)
Action and Time Scales to close Gaps in Control and Assurance

Gap Ref	Action to close gap	Timescale	Lead Owner	Update	Closed (Y/N)

No.					
1.0	Implement a nurse staffing investment strategy (3 Year Plan) to increase the numbers of nurses and change the skill mix to 70:30 (TN:HCA) in line with professional and evidence recommendations	June 2016	Executive Director of Nursing	Trust Board has agreed to £4 million investment in Nursing (January 2014). Additional Registered Nurse in place on all inpatient wards since July 13. All nursing staffing information collated into one spread sheet (includes investment, actual, planned and vacancies). Director of Nursing and Director of Operations have met with all ward sisters to communicate current establishments and expectations foe 2014/15. **05/01/15** – Surgical wards have moved to the second phase of the Keogh investment (60:40) sill mix and 3+1 on night duty). closure of a surgical ward has enabled permanent staff to be redeployed into medical nursing vacant posts (12 surgical nurses have moved to medicine)	N
1.0	Proactive overseas recruitment of Band 5 Nurses to help fill current vacancies	01.09.15	Deputy Director of Human Resources	24 Overseas RGN's in post. Practice Development Nurse appointed to lead on international recruitment and provide orientation support. Furthe overseas recruitment planned for Ireland and Greece in Oct/Nov **05/01/15** – Successful recruitment of overseas nurses >50 now working at SFH	N
1.0	Reduce number and spend on agency and bank staff	01.09.15	Deputy Director of Human Resources	Implement Bank and Agency Booking Policy Identify Project manager to sustain implementation Identify Master Vendor Monitor – Agency Support Team working	

				with SFH to reduce reliance on agency and locum staff	
2.0	Implement alternative models for recruiting and sustaining high calibre front door clinical decision making	29/09/2014 – and on going	Director of Operations	The Trust has had significant success from international recruitment, all acute physician posts and ED middle grade posts have been filled with candidates starting to commence	N
2.0	Implement alternative, attractive strategies to recruit into 'hard to fill' Medical posts	29/09/14 – and on going	Director of Operations	The Trust recognised that in the current climate, alternative recruitment strategies are required. A recruitment and retention package for middle grade doctors in hard to fill specialties has been implemented to improve recruitment and retention. To date there has been improved success particularly in ED and Acute Medicine Changed rota to match substantive workforce with activity Utilise regular Locums to ensure consistency and quality.	N

RISK 3.2 FAILURE TO EMBED AND SUSTAIN QUALITY IMPROVEMENT THROUGH: • Failure to meet the Trust's quality strategy goals • Failure to deliver the quality aspects of the contracts with commissioners • Patient experience show a decline in quality • Breach of CQC regulations – currently assessed as 'Requires Improvement' • CIP's impact on safety or unacceptably reduce service quality • The Trust is dependent upon a small group to provide reports, analysis and assurance • Staff to not receive appropriate and timely feedback from incidents and complaints so actions taken and lessons learnt are not always shared between teams		
RAG: Gross Impact	4	Gross RAG Score 16
Gross Likelihood	4	
Net Impact	4	Net RAG Score 12
Net Likelihood	3	
Key Controls in place: (what controls/systems are in place to assist in securing delivery of our objectives)		
Quality Metrics in Ward Assurance Metrics – Monthly meeting chaired by Director of Nursing		
Safety Thermometer Data		
Executive/Non Executive Ward visits and observation of care reviews		
Patient Feedback via complaints, claims, NHS Choices Comments and Family and Friend responses		
Incident reporting		
CQUIN and Contract Monitoring process		
Quality and Safety Strategy and Patient Experience and Involvement Strategy		
Transformation Strategy and programme of work		
Quality Improvement Plan overseen by the Trust Board		
Patient Safety Fellow to support and drive Patient Safety Strategy		
Whistle blowing policy		
M & M/ Clinical Governance meetings at service level		
Quality meetings between Executives and CCG Quality leads		
Appraisal and revalidation		
Specific committees to focus on key areas: HCAI Committee -C Difficile, Falls steering group - falls		
Trust Board Committee Structure to oversee the different components of reporting		
QIA process intrinsic within CIP		

Risk Management Strategy
Being Open Policy and Duty of Candor
Sources of Assurance: (The evidence that shows we are reasonably managing our risks and objectives are being delivered)
Reported to the Board
• Integrated Performance Report – Monthly
• Reports from Quality Committee to Trust Board
• Audit and Assurance Committee Report to Trust Board
• Annual Health & Safety Report
• 6 monthly nursing skill mix review
Reported elsewhere
• Inpatient and staff surveys
• PROM's
• GMC Trainee survey (Inpatient Survey)
• National Clinical Audits
• Risk Register
Assurance on Controls: (where we have tested/audited our controls/systems to ensure they are adequate and effective)
Reported to Trust Board
• Patient Story to Trust Board
• CQC Inspection Report and Quality Summit – July 2014 Highlighted areas of good practice
• QGF Internal Assessment – Monthly to Trust Board
Reported to Quality Committee
• Complaints Annual Report – September 2014
• Infection Control Annual Report – September 2014
• Safeguarding Annual Report – September 2014
• Deep Dive - Pressure Ulcers, Falls, ED Patient Experience
Practice Development Matrons recruited and working across the Trust to drive Quality Improvements
Gaps in Control: (Where are we failing to put controls/systems in place? Where are we failing in making them effective? Please ensure that for each gap you provide additional information in the action and timescales section on how the gap will be closed)

1.0 The Trust remains in significant breach for Governance with Monitor					
2.0 Staff feel they are not receiving appropriate and timely feedback					
Gaps in Assurance (Negative Evidence) (Where are we failing to test/audit that our controls/systems, on which we place reliance, are effective. Please ensure that for each gap you provide additional information in the action and timescales section on how the gap will be closed.)					
1.0 Most recent CQC assessment judged the Trust as 'Requires Improvement' Overall					
Action and Time Scales to close Gaps in Control and Assurance					
Gap Ref No.	**Action to close gap**	**Timescale**	**Lead Owner**	**Update**	**Closed (Y/N)**
1.0	Implementation of the Quality Improvement Plan (QIP) to support exit from Special Measures	June 2015	Executive Director of Nursing	The Quality Improvement Plan incorporates continuous improvement actions contained within the previously published Keogh and CQF improvement plans. All actions are either implement or on going with 6 actions RAG rated Red (these will be reduced to Amber before Dec' Trust Board)	N
2.0	Implement Quality Summit and Mock CQC visit to improve learning & sharing Implementation of Incident Module on DatixWeb Implementation of the Patient Experience module (Datix) to improve recording of complaints and learning opportunities Develop and implement a sharing and learning strategy with evidence of individual learning	June 2015	Executive Director of Nursing	DatixWeb in place across the whole Trust. This version increase the opportunity for incident reporters to receive feedback whilst also improving the depth and sensitivity of information to aid learning. Quality Summit shared best practice from Maternity, Critical Care and C & YP. Examples of 'what works well' from individual service lines discussed. Development of Medical Matters, use of iCare2 and safety bulletins. Strengthened SI process to support sharing and learning being implemented across the Trust.	

				Learning from incidents and complaints strategy being developed. **05/01/15** iCare2share & iCare2learn tools progressed. Ward and department learning board tested in ward areas 09/01/15. First nursing and AHP Grand Round planned for January 2015. First patient safety briefing held in December 2014. 23.04.15 CQC Communications plan implemented Organisational Learning framework established Listening events across all 3 sites carried out during April 2015	

RISK 3.3 IMPLEMENTATION OF MEDWAY PAS IMPACTING ON QUALITY OF CARE AND PATIENT EXPERIENCE			
RAG:	Gross Impact	5	Gross RAG Score 20
	Gross Likelihood	4	
	Net Impact	5	Net RAG Score 15
	Net Likelihood	3	
Key Controls in place: (what controls/systems are in place to assist in securing delivery of our objectives)			
PAS project board meet monthly – risks are reviewed, escalated where appropriate and mitigated where possible and reported if necessary to monthly Risk Committee meeting			
Information Team running regular report to check data accuracy:			
• Data Quality reports are run on patients with double stops and double starts			
• Daily reports that cover areas like un-reconciled Outpatient Appointments and Missing Outpatient Outcomes are circulated to operational teams and divisions – See Principal Risk 4.5 **FAILURE TO MANAGE AND CO ORDINATE OUTPATIENT SERVICES WITHIN CLINICAL AND NATIONAL STANDARDS**			
• CAS files are run daily			
Sources of Assurance: (The evidence that shows we are reasonably managing our risks and objectives are being delivered)			
Regular reports to Executive Team, Trust Management Board and Board of Directors			
Assurance on Controls: (where we have tested/audited our controls/systems to ensure they are adequate and effective)			
Internal audit report on PAS fitness for purpose highlighted that compliance with mandatory reporting requirements is satisfactory			
Gaps in Control: (Where are we failing to put controls/systems in place? Where are we failing in making them effective? Please ensure that for each gap you provide additional information in the action and timescales section on how the gap will be closed)			
1.0 Clinical with outpatient issues – addressed through Principal risk 4.5			
2.0 Financial with extra resources and no clear time limit			
Gaps in Assurance (Negative Evidence) (Where are we failing to test/audit that our controls/systems, on which we place reliance, are effective. Please ensure that for each gap you provide additional information in the action and timescales section on how the gap will be closed.)			

Action and Time Scales to close Gaps in Control and Assurance					
Gap Ref No.	**Action to close gap**	**Timescale**	**Lead Owner**	**Update**	**Closed (Y/N)**
1.0	Outpatient Programme Board	July 2016	Deputy COO	See principal risk 4.5	N
2.0	Review next PAS release and patch updates	March 2016	Chief Information Officer	Preparing report for executive team, detailing status of current risks and rationale for any reduction in score. Detailing the implication of known and unforeseen risks from implementation of patch updates and upgrade.	N