Board Assurance Report

PRINCIPAL RISK2 – ESSENTIAL COMPONENTS OF ROUND THE CLOCK (24/7) URGENT/EMERGENCY CARE NOT IN PLACE/NOT EFFECTIVE		**Executive Lead: Medical Director**
Strategic Priorities		
SP2 – To eliminate the variability of access to and outcomes from our acute and community services.		
SP4 – To develop extended clinical networks that benefit the patients we serve		
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	**23rd 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 2		
The evidence required by committee should be: proportionate, Appropriately independent, Demonstrate controls have been robustly tested / audited		
Report compiled by: Medical Director ***Latest review July 2015***		

RISK 2.1 – FAILURE TO MEET NATIONAL STANDARD OF CARE/INAPPROPRIATE USE OF RESOURCES/POOR QUALITY JUNIOR TRAINING AND EDUCATION • Potential Effects: Poor quality care, failure to control costs and loss of training grade posts • Potential Impact: Loss of reputation, collapse of services and restriction of license		
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)		
Appraisal, revalidation and job planning for senior medical workforce		
Workforce Strategy		
Medical Director has regular meetings with Junior doctors – See Principal Risk 5.5		
Sources of Assurance: (The evidence that shows we are reasonably managing our risks and objectives are being delivered)		
Stafflo locum usage report		
Variable pay tracking		
Divisional Performance Reports		
Workforce, Finance and Quality/Safety Board reports		
Nurse Staffing report to Board		
Ad hoc 7 day services presentations to Board and TMB		
Medical Appraisal and Revalidation Report to Board		
Training and Education reports to OD and Workforce		
External Support in Radiology (Francis) reporting through Transformation Board		
DME quarterly reports to TMB and Board of Directors		
Assurance on Controls: (where we have tested/audited our controls/systems to ensure they are adequate and effective)		
Foundation and GP trainee Surveys		
Post induction and exit meetings with Junior Doctors		
Junior doctor forums		
GMC Surveys		
HEEM surveys and visits – elements of		
E Midlands Acute Chief Execs group and ATOS external gap analysis		
QUIPP for 7 day standard targets for 2015 onwards		

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)
C1.0 7 day services project status – national standard of care
C2.0 Increase visibility of trainee feedback to a wider audience – See detailed actions in Principal Risk 5.5
C3.0 Quality information to assess clinical productivity
C4.0 Continued high spending on locum staff
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.)
G1.0 Overnight Junior Doctor cover
G2.0 Urology Cover at weekends and ongoing T & O concerns

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)
C1.0	Ascertain status of 7 day services nationally	September2015	Medical Director	Clarity sought regarding national standards of care for 7 day services	N
C3.0	Implement software option to enhance quality information with regard to clinical productivity	October 2015	Chief Information Officer	HED to be implemented	N
C4.0	Locum staff costs to be reduced	September 2015	Turnaround Team	Workstream focussed on reducing agency and locum staff Working with Monitor intensive support team	N
G1.0	Additional F2 on H@N team	August 2015	Medical Director	HoN team and group formed to review working practices, Surgical Registrar.	N
G2.0	Enhance Urology cover at weekends	July 2015	Medical Director	2 extra middle grades appointed , on call arrangements with Chesterfield continue	Y
G2.0	Monthly meetings with T & O team to review progress	March 2015	Medical Director	CEO and Director of HR included in monthly meetings External visits due July 2015 – any actions identified from informal feedback will be addressed	Y

<table>
<tr><td colspan="3">RISK 2.2 FAILURE TO DELIVER APPROPRIATE FLOW AND REDUCE LoS/Failure to reduce gap in weekend and weekday mortality
Potential Effects: Poor quality patient experience, poor quality care, failure to meet performance targets and failure to meet financial milestones
Potential Impact: Loss of reputation and license to practice</td></tr>
<tr><td>RAG: Gross Impact</td><td>5</td><td rowspan="2">Gross RAG Score 20</td></tr>
<tr><td>Gross Likelihood</td><td>4</td></tr>
<tr><td>Net Impact</td><td>5</td><td rowspan="2">Net RAG Score 15</td></tr>
<tr><td>Net Likelihood</td><td>3</td></tr>
<tr><td colspan="3">Key Controls in place: (what controls/systems are in place to assist in securing delivery of our objectives)</td></tr>
<tr><td colspan="3">Workforce Strategy</td></tr>
<tr><td colspan="3">Divisional Performance Meetings</td></tr>
<tr><td colspan="3">Divisional Governance meetings</td></tr>
<tr><td colspan="3">Trusts Mortality Group chaired by Senior Clinician</td></tr>
<tr><td colspan="3">Capacity and flow meetings</td></tr>
<tr><td colspan="3">Better Together Urgent and Proactive Care Steering Group</td></tr>
<tr><td colspan="3">Transformation Board and Steering Group</td></tr>
<tr><td colspan="3">Restructure of Mortality group – action plan agreed with CCG</td></tr>
<tr><td colspan="3">Sources of Assurance: (The evidence that shows we are reasonably managing our risks and objectives are being delivered)</td></tr>
<tr><td colspan="3">Flow and 7 Day services programme reports – See principal risk 4.2</td></tr>
<tr><td colspan="3">Emergency flow and capacity report – See principal risk 4.2</td></tr>
<tr><td colspan="3">Monthly urgent and proactive care report</td></tr>
<tr><td colspan="3">Morbidity and mortality reviews with Mortality Group note reviews</td></tr>
<tr><td colspan="3">Incident reports</td></tr>
<tr><td colspan="3">HSMR alerts</td></tr>
<tr><td colspan="3">Flash reports to Patient Safety Group</td></tr>
<tr><td colspan="3">Performance, workforce, quality/Safety and TMB escalation reporting process to Board of Directors</td></tr>
<tr><td colspan="3">Report to Quality Committee and deep dives</td></tr>
<tr><td colspan="3">RUH reviewed Mortality reporting</td></tr>
<tr><td colspan="3">Assurance on Controls: (where we have tested/audited our controls/systems to ensure they are adequate and effective)</td></tr>
<tr><td colspan="3">ATOS Gap Analysis and E Mids Chief Execs Meeting</td></tr>
<tr><td colspan="3">Better Together Board</td></tr>
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System Resilience Group					
Dr Foster Reports					
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)					
C1.0 Mortality not identified as a separate risk on BAF document with regard to Sepsis concerns					
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)**
C1.0	Review weekend mortality rates	August 2015	Medical Director	CQGC and Quality Committee to review and re-score risk	N
C1.0	Mortality action plan includes focus on sepsis	August 2015	Medical Director	Delivery against plan to be monitored and scrutinised by CQGC & Quality Committee	N

RISK 2.3 INCREASED SERIOUS INCIDENTS, COMPROMISED PATIENT SAFETY Potential Effects: Poor patient experience, poor quality care, adverse publicity and poor staff morale Potential Impact: Loss of reputation and license to practice		
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)		
Executive/ Non Executive Ward visits and observation of care reviews		
Patient Feedback via complaints, claims, NHS Choice Comments and Family and Friend responses		
SI investigation 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
'Raising Concerns' Whistleblowing policy
M & M/Clinical Governance meetings at Service level
Quality Performance meetings between Trust and CCG executives leads for quality
Appraisal and revalidation
C Difficile, falls and Pressure Ulcer Reduction plans
Trust Board Committee Structure and process of escalation
Risk Management Strategy
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
• Quality and Safety Report
• Reports from Quality Committee to Trust Board
• Audit Committee Reports to Trust Board
Reported elsewhere
• Inpatient and staff surveys
• PROMs
• 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 the Board
• Quality & Safety, Quarterly Report, Quality and Safety Monthly Report & Patient Experience Quarterly Report
• Patient Story to Trust Board
Reported to Quality Committee
Ward Assurance Metrics and Early Warning Dashboard
Complaints Annual Report
Infection Control Annual Report
Safeguarding Annual Report
Deep dives via 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)
C1.0 Preparation for and learning from - Inquests
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.)
G1.0 Improved system and evidence of organisational learning

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)**
C1.0	Streamlined process for preparation for Inquests	August 2015	Legal Services Manager	Detailed Standard Operating procedure being developed	N
C1.0	Ensure learning from feedback from Inquests	September 2015	Head of GSU	Disseminate feedback from inquests to division in order to aid learning	
G1.0	Ensure organisational learning through improved opportunities to share learning	September 2015	Medical Director	Implementation of quality improvement plan which incorporates a number of actions related to organisational learning	N

RISK 2.4 ENSURE ED IS FIT FOR FUTURE PURPOSE			
RAG:	Gross Impact	5	Gross RAG Score 20
	Gross Likelihood	4	
	Net Impact	5	Net RAG Score 20
	Net Likelihood	4	
Key Controls in place: (what controls/systems are in place to assist in securing delivery of our objectives)			
Workforce Strategy			
International recruitment programme for Medical staff including Deanery			
External support for Radiology Transformation Programme			
Full recruitment to Cardiology consultant workforce			
Development of enhanced training programmes for ED junior doctors			

Sources of Assurance: (The evidence that shows we are reasonably managing our risks and objectives are being delivered)
7 Day Services gap analysis identified key areas to progress
Transformation Board and Steering group reporting on Flow programme
System Resilience Group
Urgent and Proactive Care programme reports to Better Together Board
Assurance on Controls: (where we have tested/audited our controls/systems to ensure they are adequate and effective)
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)
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.)
G1.0 Retention of Consultants in current environment is difficult
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)
G1.0	Develop an ED workforce Strategy	September 2015	CD for EC & M	Dialogue initiated with Head of Service and Divisional Team	N
G1.0	Risk assessment and mitigation plan for loss of ED consultants shared with CCG and wider health economy partners	September 2015	CD & DGM for EC & M	Dialogue initiated with Head of Service, Divisional Team and Nottingham University Hospitals	N
G1.0	Overseas recruitment	November 2015	Deputy Director HR	See Principal Risk 5.4 for detailed actions	N
G1.0	Attract more trainees	November 2015	Deputy Director HR	See Principal Risk 5.4 for detailed actions	N

RISK 2.5 SINGLE HANDED SERVICES BECOME NON-VIABLE – Breast, Vascular, Max Fax

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)

- Memorandum of Understanding with other local health providers
- Orthodontic service terminated
- On going dialogue with other health providers about providing a comprehensive Breast service which would include enhanced medical cover
- Cancer Strategy

Sources of Assurance: (The evidence that shows we are reasonably managing our risks and objectives are being delivered)

- Cancer Management Board reports to TMB

Assurance on Controls: (where we have tested/audited our controls/systems to ensure they are adequate and effective)

- On going dialogue with Better Together and CCG re Mid Notts Cancer Strategy and enhance Nottinghamshire pathways

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)

C1.0 Service supported by more than 1 partner

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)
C1.0	Review of Clinical Services as part of clinical strategy development	October 2015	Medical Director	Breast - Dialogue with NUH to pursue one external partner option. Vascular – ongoing partnership with NUH through VLit board to improve service	N

				provision	

RISK 2.6 ON CALL ARRANGEMENT FOR RADIOLOGY, OPHTHALMOLOGY, MICROBILOGY, UROLOGY, VASCULAR AND STROKE BECOME NON TENABLE		
RAG: Gross Impact	5	Gross RAG Score 20
Gross Likelihood	4	
Net Impact	5	Net RAG Score 20
Net Likelihood	4	
Key Controls in place: (what controls/systems are in place to assist in securing delivery of our objectives)		
Enhanced outsourcing and locum cover in Radiology		
Stroke service option appraisal planned with NUH and CCG partners. Service monitored via Nottinghamshire Stroke Partnership Board		
Vascular service upgraded to include weekly publishing of cover rota for clinics, ward and on call. On-going issues with job planning and scope of services on-going via VLIT Board		
Microbiology arrangements under discussion via Western Alliance and Empath. Third consultant appointment planned		
Urology on call arrangements clarified with Division.		
External Recommendations Policy		
Sources of Assurance: (The evidence that shows we are reasonably managing our risks and objectives are being delivered)		
Planning and delivery of Radiology and 7 Day Services Programmes reported via Transformation Board		
Assurance on Controls: (where we have tested/audited our controls/systems to ensure they are adequate and effective)		
Feedback from external visits – HEEM, GMC, reported to OD and Workforce and Trust Board		
Vascular and Stroke Nottinghamshire partnership Board report to CCG		
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)		
C1.0 Monitoring of on call arrangements		
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.)		
G1.0 Clear lines for reporting for external reports		
Action and Time Scales to close Gaps in Control and Assurance		

Gap	**Action to close gap**	**Timescale**	**Lead Owner**	**Update**	**Closed**

Ref No.					(Y/N)
C1.0	Ensure services are monitored robustly with regard to on-call arrangements	September 2015	Medical Director	EMRAD (Radiology) to be implemented	N
		August 2015	Medical Director	Ophthalmology – ongoing arrangements with Chesterfield Stroke and Vascular monitored through partnership board Oncology – monitored through partnership board Urology – Stabilised through the recruitment of 2 extra middle grades Microbiology – 3rd microbiologist appointed and in post.	Y
G1.0	Implement External Recommendations Policy	September 2015	Deputy Director Corporate Services	Attendance at Clinical Governance Committees in Divisions to raise awareness of policy and process	N