Board Assurance Report

PRINCIPAL RISK: 4 – FAILURE TO DELIVER AND MAINTAIN CLINICAL SUSTAINABILITY		**Executive Lead: Chief Operating Officer (Interim)**
Strategic Priorities		
SP3 – To reduce demand on hospital services and deliver care closer to home		
SP4 – To develop extended clinical networks that benefit the patients we serve		
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	17th September 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, 11 February, 11 March 2015,		
Trust Management Board 26th January, 23rd February 2015, 23rd March 2015		
Quality Committee, 22 January 2015, 19 March		
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 4		
The evidence required by committee should be: proportionate, Appropriately independent, Demonstrate controls have been robustly tested / audited		
Report compiled by: Chief Operating Officer (interim) ***Latest review August 2015***		

RISK 4.1 – WHOLE SYSTEM FAILS TO REDUCE DEMAND ON ACUTE SERVICES RESULTING IN INABILITY TO REDUCE FOOTPRINT & COST BASE		
RAG: Gross Impact	4	Gross RAG Score 16
Gross Likelihood	4	
Net Impact	3	Net RAG Score 9
Net Likelihood	3	
Key Controls in place: (what controls/systems are in place to assist in securing delivery of our objectives)		
Streaming to PC 24 on the Kings Mill Site		
Frail/elderly team at the front door of Kings Mill Site		
Complex Discharge Team and the Multidisciplinary Discharge hub – and the associated discharge to assess service		
Clinical decision unit at the Kings Mill Site – increase use of ambulatory pathways to prevent inpatient admission		
Flow Matron and Emergency Flow Coordinators		
Emergency Care Improvement Lead and supporting team		
Sources of Assurance: (The evidence that shows we are reasonably managing our risks and objectives are being delivered)		
Data in relation to number of patients streamed and 48% increase in number of patients using PC24 in last year		
Data regarding reduction in long length of stay patients >14 day reduced by 1000 beddays (12%) and >20 day more than 1100 beddays (15%)		
Correlation between increased attendance and admissions		
Commissioned Beds in Use (Ward 21, Ward 33 no longer in use at Kings Mill Hospital)		
Assurance on Controls: (where we have tested/audited our controls/systems to ensure they are adequate and effective)		
ECIST review in December 2013 and followed up again in May 2014 recommended the focus on long length of stay patients who do not require acute care		
System Resilience Group plan and bi-weekly monitoring of progress and planning assumptions		
Urgent Care Working Group and the reviews of planning assumptions		
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)		
Consistency in use of alternatives to admission and earlier discharge by high use of locum medical staff		
Usage of Discharge to Assess Service limitations by organisations other than SFHFT		
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	Reduced reliance on locum medical staff	Oct 15	Chief Operating Officer/EC&M Clinical Director	Commenced August Rotation with 5 out of 6 middle grade posts in ED not filled substantively. Partial success in 2014 for recruitment now left only 1 middle grade in post. Renew of international recruitment and extension of 4 ANPs 2015 will reduce dependency on middle grades.	N – further monitoring required
2	Improve control of Discharge to Assess service through greater oversight at Urgent Care Working Group and the Systems Resilience Group	Sept 15	Chief Operating Officer	Review of Discharge to Assess service now tabled for the Urgent Care Working Group. Request for SRG regular KPI and controls set sent August 2015. TBC	N- review Sept for completion

RISK 4.2 Failure to reduce Length of Stay year on year • **Failure to maintain emergency flow across the Trust and economy may lead to overcrowding** • **Failure to right size facilities and bed base to accommodate demand**			
RAG:	Gross Impact	4	Gross RAG Score 16
	Gross Likelihood	4	
	Net Impact	3	Net RAG Score 9
	Net Likelihood	3	
Key Controls in place: (what controls/systems are in place to assist in securing delivery of our objectives)			
Increased ambulatory care pathways via clinical decisions and medical day-case unit			
Co-location of discharge team with social services to streamline assessment processes			
All patients have an expected date of discharge EDD			
Daily review of long LOS >14 day patients at Discharge Meeting			
Emergency flow transformation programme			
Provision of an economy wide pull team to ensure patients are appropriately and safely transported to other facilities			

Establishment of Transfer to Assess bed aligned to PRISM model
Sources of Assurance: (The evidence that shows we are reasonably managing our risks and objectives are being delivered)
Data evidence of clinical decision unit utilisation
Emergency Flow Programme updates providing live status of the programme, as part of Transformation
Emergency flow dashboard
Daily list of patients > 14 days Length of Stay
Throughput of discharge lounge
Silver report analysis
Divisional Performance reviews
Weekly capacity meeting involving all Head of Service & Matrons to review KPIs and hold to account
Assurance on Controls: (where we have tested/audited our controls/systems to ensure they are adequate and effective)
Independent report by CCG in December 2014 and again in January 2015
Perfect week held with key impacts – improved relationships between providers and the start of integration of teams
System Resilience Group scrutiny
Urgent Care Work Group scrutiny
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.)

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)**

RISK 4.3 Failure to reduce avoidable admissions			
RAG:	Gross Impact	4	Gross RAG Score 16
	Gross Likelihood	4	
	Net Impact	3	Net RAG Score 9
	Net Likelihood	3	
Key Controls in place: (what controls/systems are in place to assist in securing delivery of our objectives)			
Streaming to PC24 on the Kings Mill Site			
Frail/elderly team at the front door of Kings Mill Site			
"Hot phones" advice line for GP referrals for high risk specialties, cardiology, respiratory, Acute Medicine & gastroenterology			
"Hot clinics" for high risk specialties, cardiology, Acute Medicine, respiratory & gastroenterology			
Clinical decisions unit at the Kings Mill Site – increase use of ambulatory pathways to prevent inpatient admission for some conditions			
Acute Physicians working in ED increasing discharge directly from ED and controlling readmissions			
Sources of Assurance: (The evidence that shows we are reasonably managing our risks and objectives are being delivered)			
Data in relation to number of patients streamed and 48% increase in number of patients using PC24 2014/15			
Data regarding avoided admissions from internal services in place			
Correlation between increased attendances and admissions			
Divisional Performance reviews			
Assurance on Controls: (where we have tested/audited our controls/systems to ensure they are adequate and effective)			
Independent report by CCG in January 2015			
System Resilience Group scrutiny			
Joint PMO with CCG on QIPP schemes (which include the review of readmissions)			
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)			
Consistency in use of alternatives to admission by high use of locum medical staff			
Utilisation of hot clinic/phone 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.)

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	Reduced reliance on locum medical staff	Oct 15	Chief Operating Officer/EC&M Clinical Director	Commenced August Rotation with 5 out of 6 middle grade posts in ED not filled substantively. Partial success in 2014 for recruitment now left only 1 middle grade in post. Renew of international recruitment and extension of 4 ANPs 2015 will reduce dependency on middle grades.	N – further monitoring required
1	Acute Physician permanently rostered to work in ED to relieve Medical take pressure and improve decision making (reduce readmissions)	Nov 15	DGM – EC & M	Acute Physicians working in ED as part of additional flow improvements. Business case for the permanent extension of this post into ED needs to be developed and signed off. Temporary funding for 15/16 is included in the Trusts block contract.	Y – see control
2	Increase oversight and monitor usage of hot phone and hot clinics	Oct 15	Chief Operating Officer	Introduce greater transparency on hot clinic and hot phone usage and the ability to avoid admissions and readmissions.	N – further monitoring required

RISK 4.4 Failure to produce productivity & efficiency gains			
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)
Outpatient Improvement Board (OPIB)
Elective transformation programme
Job planning processes
Emergency transformation programme and specifically Length of Stay >14 days project
Variable Pay Workstream
Turnaround Board / Turnaround Team
Sources of Assurance: (The evidence that shows we are reasonably managing our risks and objectives are being delivered)
OPIB dashboard – utilisation improvement, reconciliation, DNA etc. and Highlight reports through to RMC/Quality committees
Emergency Flow Dashboard and Programme Updates
Job planning documentation and the Allocate Planning System
Divisional Performance reviews
Workstream Reports to Turnaround Board
Assurance on Controls: (where we have tested/audited our controls/systems to ensure they are adequate and effective)
IMAS Reports on RTT and Emergency Care
OPIB feedback from Improvement Director and CCGs
System Resilience Group scrutiny
Turnaround Team Review of Schemes
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)
Pace of delivery of the programme against plans
Pace and engagement on enabling job plan changes and implementing the Allocate System
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.)
Variable Pay and the lack of delivery against flow (LOS) improvements (ward closures)

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	Focus Turnaround Board Oversight on Variable Pay and Extend Project/Programme resource working on it	Oct 2015	COO/ Turnaround Director	Lead for variable pay on nursing in place and exploring the gaps in assurance and controls. Lead for Medical variable pay now recruited and in place (August) and exploring gaps. Both will require approval of solutions and closure of gaps in September 2015	N – Further view in September
2	Written communication of job plan changes instead of verbal consultation to agree changes	September 2015	Medical Directors / Clinical Directors	A project team has been developed and is implementing the Allocate system. Formal written changes will be communicated once reviews have taken place.	N – reviewed again once Allocate is implemented.

RISK 4.5 FAILURE TO MANAGE AND CO ORDINATE OUTPATIENT SERVICES WITHIN CLINICAL AND NATIONAL STANDARDS			
RAG:	Gross Impact	4	Gross RAG Score 16
	Gross Likelihood	4	
	Net Impact	2	Net RAG Score 8
	Net Likelihood	4	
Key Controls in place: (what controls/systems are in place to assist in securing delivery of our objectives)			
Improved reporting systems (Weekly/daily/twice daily) to inform teams and subsequent management action to identify potential escalation and to deliver risk mitigation			
Weekly review of progress (RTT meetings) and actions			
Daily Outpatient and Administrate Services Capacity Review Meeting in place chaired by Deputy COO/DGMs			
Fortnightly review meetings with CCG in place			
Fortnightly outpatient Improvement Board			
Project Managers in place for three key workstream within the Outpatient Improvement Programme			
Sources of Assurance: (The evidence that shows we are reasonably managing our risks and objectives are being delivered)			
RTT reporting and progress against trajectory			
Outpatient Improvement Dashboard			

Daily Outpatient Capacity Dashboard and Action Lists
Business Case for increase in administration and informatics staffing levels
Use of IST – Modelling Demand and Capacity Tools
Monthly reports to Divisional Performance, RMC, CQ&G, then to Quality Committee
Assurance on Controls: (where we have tested/audited our controls/systems to ensure they are adequate and effective)
18 week Intensive Support Team IMAS support in developing sign off of improvement plan July 2015
Governor, Patient, CCG and staff representation on OPIB
Improvement Director Review of Improvement Plans
Weekly CCG Performance Management Meetings
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.)

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)
	N/A				

RISK 4.6 FAILURE TO ACHIEVE JAG ACCREDITATION			
RAG:	Gross Impact	3	Gross RAG Score 9
	Gross Likelihood	3	
	Net Impact	2	Net RAG Score 4
	Net Likelihood	2	
Key Controls in place: (what controls/systems are in place to assist in securing delivery of our objectives)			
Additional administration staff shortlisted to support booking and audit data collection			
Band 6 deputy department leader appointed – in post			

Tracking and tracing audit completed
Ventilation installation completed
Endobase system in use which will provide data required to comply with BSG KPI's
User group meetings established – forum for presentation and discussion of BSG KPI's
Staff Survey completed – action plan to follow
Acute Gastroenterologist of the day is now responsible for vetting referrals
Audit of Histopathology results review completed
Capacity flexed to address waiting times including urgent cancers, routine diagnostics and surveillance patients.
NHSI Capacity and demand model completed
Sources of Assurance: (The evidence that shows we are reasonably managing our risks and objectives are being delivered)
Achievement of regional training centre status
Weekly performance management of patient waiting times
Assurance on Controls: (where we have tested/audited our controls/systems to ensure they are adequate and effective)
Twice yearly GRS submission aligned with JAG
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. JAG Accreditation status currently: Assessed – Improvements required – deferred for 6 months
2. BSG KPI reporting system to be developed using Endobase and Medway data , including 30 day M&M
3. Staff to be signed off against the endoscopy competences – newly appointed deputy department leader to lead.
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	Action plan developed and tracked operationally	Aug 15	Tony Shonde	Plan submitted to JAG, being monitored.	Y – to become new control
2	Audit tool to be developed	Mar 15	Terri Munson	To check….	
3	Staff to be signed off against endoscopy competences	May 15	Karen Shacklock		