Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

**Trust Board**
**23 April 2015**

| | |
|---|---|
| **TITLE** | **Board Assurance Framework** |
| **EXECUTIVE SUMMARY** | The Board Assurance Framework (BAF) is a key assurance tool that ensures the Board has been properly informed about the risks to achieving the Trust's Strategic Objectives. The BAF is aligned to the four Strategic Objectives as detailed in the Corporate Business Plan 2014-15. |
| **ASSURANCE (Risk) / IMPLICATIONS** | The Board assurance process ensures that risks to achieving the Trust's strategic objectives are actively identified and managed. |
| **LINK TO STRATEGIC OBJECTIVE** | The Framework links to all Strategic Objectives. |
| **STAKEHOLDER / PATIENT IMPACT AND VIEWS** | The BAF incorporates risks and their impact to stakeholders, staff and patients. |
| **EQUALITY AND DIVERSITY ISSUES** | None known. |
| **LEGAL ISSUES** | The Board Assurance process supports the Chief Executive in signing the Annual Governance Statement which forms part of the Trust's statutory accounts. |
| **The Board is asked to:** | Review, discuss and approve the Board Assurance Framework. |
| **Submitted by:** | Liz Davies, Acting Company Secretary |
| **Date:** | 17 April 2015 |
| **Decision:** | For Approval |

# Board Assurance Framework (BAF)

## 1 Introduction

The BAF is an assurance tool to ensure that the Board is properly informed about the risks to achieving all of the Strategic Objectives as detailed in the Corporate Business Plan.

## 2 Strategic Context

The BAF is aligned to achieving the four Strategic Objectives as documented in the Corporate Business Plan 2014-15. The BAF also supports the Annual Governance Statement, and has been cross referenced to the Trust Risk Register.

As a Foundation Trust it is important that the Board Assurance Framework works as a tool to support the Board's assurances in terms of self certification on compliance with the Trust's License.

## 3 Review

In accordance with the new business plan for 2014/15 and the revised strategic objectives an in-depth review of the BAF was undertaken in March 2014. A briefer review is undertaken quarterly.

The entire BAF has been submitted to IGAC for review.
The risks under SO4 (Top Productivity) were reviewed at the Finance Committee on the 23rd April..

## 4 Commentary on Risks

### 4.1 Closure of risks

It Is proposed to close one risk.

Approval is requested to close risk:

1.1 If the quality governance and impact assessment processes fail during the design or CIPs, this could lead to a negative impact on quality;

- *The QSIA review panel met on the 19 March 2015 to review the high risk CIPs for 2015/16 from a quality perspective. The Director of Finance has specified some further actions in relation to sign-off of the high risk CIPS; these will be undertaken in Q1 2015/16. The QSIA CIP review process has been much strengthened this year as a result of embedding the process in the clinical divisions. Recommend that BAF risk 1.1 be closed.*

### 4.2 Additional risk

Approval is requested to add the following risk:

- **SO 1.5** If delivery of CQC inspection action plan slips this risks quality of service delivery, reputation and further regulatory action.

## 4.2 Extreme risks

At April there are nine extreme risks compared with ten at January (and seven at October).

| Risk | Rating (Jan '15) | Rating (Apr '15) |
|---|---|---|
| **1.2** If divergent and multiple organisational priorities compete with and undermine staff engagement leading to a distraction from the focus on high quality care. | 20 | 20 |
| **1.3** If there is poor capacity and flow in the emergency pathway this could result in a poor patient experience and quality of care outcomes. | 20 | 20 |
| **1.4** If the Trust workforce was not appropriately aligned to meet safer staffing levels, approved WTE establishments, agency usage and pay costs, resulting in poor patient outcomes. | 16 | 16 |
| **2.4** Administrative delays and cancellations to appointments leading to poor patient experience. | 15 | 15 |
| **3.1** If the Trust was unable to recruit and retain high calibre staff. | 16 | 16 |
| **3.2** If individuals and teams do not feel valued or motivated resulting in poor patient care and staff experience and ineffective team working. | 16 | 16 |
| **4.1** Poor alignment of the clinical workforce around the Trust's efficiency improvement programme could lead to insufficient productivity. | 16 | 16 |
| **4.2** A failure to deliver the clinical quality incentives (CQUINS), the performance standards or to respond to the admission thresholds/readmission caps/ambulance turnaround penalties within the 2014/15 contract leads to an under recovery of income and reduction in productivity. | 16 | 8 |
| **4.3** A failure to deliver 2014/15 CIPs to the level required and/or pay and non-pay expenditure exceed budget without a compensating increase in income may lead to a reduction in productivity. | 16 | 16 |
| **4.5** Excess demand could increase financial pressure due to emergency income on over-performance being received at marginal tariffs whilst additional staffing is paid at premium rates. | 16 | 16 |

**Risk 1.2** There are significant "divergent and multiple" priorities at present due to the operational pressures in the hospital which is not expected to reduce greatly, and despite the CQC visit having now taken place there are still significant operational pressure on the hospital.

**Risk 1.3** The Trust is still experiencing unprecedented demand and resultant capacity constraints. This risk remains extreme.

**Risk 1.4** Operational pressures persist with the resultant impact on staffing through the use of agency staff.

**Risk 2.4** The risk remains extreme. Following the outpatient workshop in November 2014 a plan has been developed, Project Manager appointed and a Programme Board has been set up. Booking team capacity to be assessed and

review of management structure is underway.

**Risk 3.1** It remains challenging to recruit and retain high calibre staff with a resultant reliance on temporary staff in some areas. Actions to mitigate are detailed within the appendix.

**Risk 3.2** Despite improvement in the Q2 14/15 staff friends and family score (both versus Q1 and peer organisations) this risk remains extreme until the national staff survey results are published later in Q4.

**Risk 4.1** Periods of severe operational pressure lead to poor alignment of the clinical workforce. This risk remains extreme.

**Risk 4.2** Current activity pressures still impact upon most CQUIN measures resulting in the raising of this risk to extreme however this risk now stands at high.

**Risk 4.3** £2.5m CIP risk at month 1. Mitigation schemes to be developed to bridge gap. Risk remains extreme.

**Risk 4.5** Due to the likelihood and impact of increased demand this risk remains rated extreme.

**4.3 Top Five Risks**

The Board has previously agreed that the key risks should be highlighted. At April 2015 these are:

**1.2** If divergent and multiple organisational priorities compete with and undermine staff engagement leading to a distraction from the focus on high quality care.
**1.3** If there is poor capacity and flow in the emergency pathway this could result in a poor patient experience and quality of care outcomes.
**3.1** If the Trust was unable to recruit and retain high calibre staff leading to lack of skilled and motivated teams.
**3.2** If individuals and teams do not feel valued or motivated, resulting in poor patient care experience and ineffective team working.
**4.3** A failure to deliver 2014/15 CIPs to the level required and/or pay and non-pay expenditure exceed budget without a compensating increase in income may lead to a reduction in productivity.

Actions to mitigate these risks are detailed within the individual tabs in the Appendix.

**5 Recommendation**

The Board is asked to discuss and approve the Board Assurance Framework.

**Paper 5.7**

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

# Board Assurance Framework - Summary
## Version: April 2015

| | Lead | Nov 13 Risk Score | Mar 14 Risk Score | Jul 14 Risk Score | Oct 14 Risk Score | Jan 15 Risk Score | Apr15 Risk Score | In Quarter Risk Change |
|---|---|---|---|---|---|---|---|---|
| **Objective 1: Best Outcomes** | | | | | | | | |
| **Risks to Objective** | | | | | | | | |
| 1.1 If the quality governance and impact assessment processes fail during the design of CIPs this could lead to poor quality of care. | CN | 8 | 8 | 8 | 8 | 8 | 4 | ↔ |
| 1.2 If divergent and multiple organisational priorities compete with and undermine staff engagement leading to a distraction from the focus on high quality care. | CN | 12 | 12 | 12 | 20 | 20 | 20 | ↔ |
| 1.3 If there is poor capacity and flow in the emergency pathway and insufficient frequency in senior decision making this could result in poor outcomes and patient experience. | DCE | 16 | 16 | 16 | 16 | 20 | 20 | ↑ |
| 1.4 If the Trust workforce was not appropriately aligned to demand and acuity, agency usage and pay costs, resulting in poor patient outcomes. | DoW/CN/ MD | 12 | 12 | 12 | 12 | 16 | 16 | ↑ |
| 1.5 If delivery of CQC inspection action plan slips this risks quality of service delivery, reputation and further regulatory action | CN | n/a | n/a | n/a | n/a | n/a | 9 | |

**Paper 5.7**

| | Lead | Nov 13 Risk Score | Mar 14 Risk Score | Jul 14 Risk Score | Oct 14 Risk Score | Jan 15 Risk Score | Apr 15 Risk Score | In Quarter Risk Change |
|---|---|---|---|---|---|---|---|---|
| **Objective 2: Excellent Experience** | | | | | | | | |
| **Risks to Objective** | | | | | | | | |
| 2.1 The Friends and Family results are not used as a driver for improvement leading to persistently poor experience. | CN | 8 | 8 | 8 | 8 | **8** | **8** | ↔ |
| 2.2 Lack of awareness of key issues relating to vulnerable groups may lead to compassionless care and poor patient experience. | CN | n/a | 6 | 9 | 6 | **6** | **6** | ↔ |
| 2.3 If the Trust fails to adopt the culture of a listening, kind and compassionate organisation in dealing with complaints then our patients, within the course of their care and treatment, will have a poor experience. | CN | n/a | 12 | 12 | 12 | **12** | **12** | ↔ |
| 2.4 Administrative delays and cancellations to appointments leading to poor patient experience. | DCE | n/a | 9 | 9 | 15 | **15** | **15** | ↔ |

| | Lead | Nov 13 Risk Score | Mar 14 Risk Score | Jul 14 Risk Score | Oct 14 Risk Score | Jan 15 Risk Score | Apr 15 Risk Score | In Quarter Risk Change |
|---|---|---|---|---|---|---|---|---|
| **Objective 3: Skilled, motivated teams** | | | | | | | | |
| **Risks to Objective** | | | | | | | | |
| 3.1. The inability to recruit and retain high calibre staff would lead to lack of skilled and motivated teams. | DoW | 16 | 16 | 16 | 16 | 16 | **16** | ↔ |
| 3.2. If individuals and teams do not feel valued or motivated resulting in poor patient care and staff experience and ineffective team working. | DoW | 16 | 16 | 16 | 16 | 16 | **16** | ↔ |

**Paper 5.7**

| | Lead | Nov 13 Risk Score | Mar 14 Risk Score | Jul 14 Risk Score | Oct 14 Risk Score | Jan 15 Risk Score | Apr 15 Risk Score | In Quarter Risk Change |
|---|---|---|---|---|---|---|---|---|
| **Objective 4: Top Productivity** | | | | | | | | |
| **Risks to Objective** | | | | | | | | |
| 4.1 Poor alignment of the clinical workforce around the Trust's efficiency improvement programme could lead to insufficient productivity. | DoFI | 12 | 12 | 12 | 12 | **16** | **16** | ↔ |
| 4.2 A failure to deliver the clinical quality incentives (CQUINS), the performance standards or to respond to the admission thresholds/readmission caps/ambulance turnaround penalties within the 2014/15 contract leads to an under recovery of income and reduction in productivity. | DoFI | 16 | 12 | 12 | 12 | 16 | **8** | ↓ |
| 4.3 A failure to deliver 2014/15 CIPs to the level required and/or pay and non-pay expenditure exceed budget without a compensating increase in income may lead to a reduction productivity. | DoFI | 16 | 16 | 16 | 16 | 16 | **16** | ↔ |
| 4.4 Financial or service pressures on third party providers of health and social care or commissioners cause operational difficulties or to enforcement of contract levers more aggressively than expected leading to reduced income and inability to achieve top productivity. | DoFI | 12 | 9 | 9 | 9 | 9 | **9** | ↔ |
| 4.5 Excess demand could increase financial pressure due to emergency income on over-performance being received at marginal tariffs whilst additional staffing is paid at premium rates. | DoFI | n/a | n/a | n/a | 16 | 16 | **16** | ↔ |

**Key:**

| | |
|---|---|
| **15-25** | Extreme |
| **8 –12** | High |
| **4 – 6** | Medium |
| **1-3** | low |

| | |
|---|---|
| ↔ | No change in risk score |
| ↓ | Risk score decreased |
| ↑ | Risk score increased |

| | |
|---|---|
| CN | Chief Nurse |
| DCE | Deputy Chief Executive |
| DoW | Director of Workforce Transformation |
| MD | Medical Director |
| DoFI | Director of Finance & Information |

## Principle Risk:

## 1.1 If the quality governance and impact assessment processes fail during the design of CIPs, this could lead to a negative impact on quality

**Chief Nurse**

| | Initial | Current | Target | Strategic Objective Affected |
|---|---|---|---|---|
| **Likelihood** | 3 | 2 | 1 | Objective 1: Best Outcomes |
| **Consequence** | 3 | 4 | 4 | |
| **Level** | 9 | 8 | 4 | |

**Opened:** 01-Apr-11
**Closed:**

### Controls

- Process control - procedural level - CIP threshold for QSIA is determined in line with the ratified policy.
- Pre-implementation - process control - procedural level - there is a policy in place to govern this process.
- ***Post implementation - system overview control*** - QEWS dash board measures impact on quality.
- ***Post implementation - system overview control*** - The QEWS dashboard evaluates Quality, Experience, Workforce and Safety metrics across the Trust. This early predictor tool will indicate if quality is being compromised (a proxy for the quality:cost balance becoming unfaraourable).
- QSIA reviews of CIPS are presented to panel consisting of Medical Director, Chief Nurse, Chief of Patient Safety and Deputy Chief Nurse.

### Assurance

- Monthly review at CIP performance meetings.
- "Quality and Safety Impact Assessment" (Section 2) submitted to Quality and Transformation Review Panel for approval. Panel comprises Executive Sponsor, Medical Director, and Chief Nurse. For 2013/14 a threshold is to be implemented for this process, so that minor value / low risk CIPS do not require panel approval.
- All Division Quality Leads have been trained in the QSIA process.

QEWS monitored monthly by Integrated Governance and Assurance Committee (IGAC).

- Complaints and Incident data trends- reported to Board and Integrated Governance Assurance Committee (IGAC).

### Gaps in Controls

- 

### Gaps in Assurance

- 

### Closure Request?

The QSIA review panel met on the 19 March 2015 to review the high risk CIPs for 2015/16 from a quality perspective. The Director of Finance has specified some further actions in relation to sign-off of the high risk CIPs; these will be undertaken in Q1 2014/15. The QSIA CIP review process has been much strengthened this year as a result of embedding the process in the clinical divisions. Recommend that BAF 1.1 be closed.

### Action Plan

| Due: | Action Description | Progress to Date | Date Completed |
|---|---|---|---|
| on-going | Familiarise business development managers with the quality governance and impact assessment processes. | Divisional quality leads leading on this familiarisation (completed in Q3 14/15).<br>Internal Audit to audit process in Q2 14/15 - in progress | 01-Apr-15 |

**Principle Risk:**

## 1.2 If divergent and multiple organisational priorities compete with and undermine staff engagement leading to a distraction from the focus on high quality care.

**Chief Nurse**

| | Initial | Current | Target |
|---|---|---|---|
| **Likelihood** | 3 | 5 | 2 |
| **Consequence** | 4 | 4 | 4 |
| **Level** | 12 | 20 | 8 |

**Strategic Objective Affected**
Objective 1: Best Outcomes

**Opened:** 01-Apr-11
**Closed:**

### Controls

- Clear vision of Quality of care as major driver for the trust
- Clear Strategic Objectives with two relating to quality
- PMO approach helps prioritise competing priorities
- Strong quality monitoring
- Strong clinical leadership at both Executive level , through Divisional Triumvirates.
- Achiement of full CQC Compliance. Compliance in Practice audits undertaken.
- PMO overview of change activity within the organization
- Merger PMO in place providing monitoring of merger budget and timescales

### Assurance

- Scorecards including Best Care dashboards
- Self certification process by Trust board based on a structured assurance process
- Staff and patient Survey results (Improvements in 2014 National Staff Survey & Q3 Friends & Family Test)
- Corporate Objectives are monitored quarterly
- Clinical sounding board chaired by Medical Director and Chief Nurse established.
- Merger: Steering Group and Strategic Oversight Group in place
- CQC: Compliance in practice audits in 2014 identified high level of CQC compliance

### Gaps in Controls

- None known

### Gaps in Assurance

- Junior doctor GMC Survey improved in 2014 but not at level required yet.
- Merger: CMA submission result unknown.

### Closure Request?

n/a

### Action Plan

| Due: | | Action Description | Progress to Date | Date Completed |
|---|---|---|---|---|
| Ongoing | | Test all new initiatives against two core SOs (Emergency pathway and financial balance) | On going | |
| On going | | Monitor staff comments on The Wall, other forum of communication | On going | |
| 1-Jan-15 | | Hold a Schwartz Round on related subject | Scheduled for February 2015 | |
| Q1 14/15 | | PMO to train Divisions to deliver change projects | On-going | |
| Q2 14/15 | | ASPH/RSCH Merger - backfill arrangements for workstream leads | Backfill for Director of Workforce Transformation and Medical Director in place. PMO set up. | Q2 14/15 |
| | | Strengthened business continuity prospective planning being commenced (to incorporate staffing levels, annual leave planning, safer staffing plan) | First draft to be complete by end of January 2015. | |

**Principle Risk:**

**1.3 If there is poor capacity and flow in the emergency pathway this could result in poor outcomes and patient experience.**

**Deputy Chief Executive**

| | Initial | Current | Target | Strategic Objective Affected | | |
|---|---|---|---|---|---|---|
| **Likelihood** | 4 | 5 | 2 | Objective 1: Best Outcomes | **Opened:** | 01-Apr-12 |
| **Consequence** | 4 | 4 | 4 | | **Closed:** | |
| **Level** | 16 | 20 | 8 | | | |

## Controls

- Weekly 4 hour performance meeting chaired by CEO
- Weekly NWS Capacity meeting with Partners (Urgent Care working group and Capacity and Resilience group)
- 4 hour recovery plan shared with CCG and Monitor (including forecast trajectory)
- Whole-system action plan in place and monitored through Unscheduled Care Partnership Board
- Implementation of robust Frail Elderly pathway (OPAL)
- Opening of Gynae assessment unit, SAU changes
- Development of 14/15 Winter Plan

## Assurance

- Trust signed off by ECIST November 2012. Positive feedback from visits in Jul 13 and Jan 14.
- Compliance with trustwide 4 Hour standard (Q3 14/15) monitored and multi-disciplinary, multi-divisional review of breaches.
- Quality indicators are reported at divisional and corporate levels
- Recruitment of additional A&E Consultants
- SIRI levels not increasing
- Discharge complaints decreasing

## Gaps in Controls

- Insufficient Consultant cover for 7 day working
- Urgent Care Strategy has a long term focus with less short term actions
- Securing Commissioner and Community engagement and desired results

## Gaps in Assurance

- RealTime - full potential of system yet to be realised
  7 day working
- Performance in December on the SPH site of 84.65%.

## Closure Request?

## Action Plan

| Due: | Action Description | Progress to Date | Date Completed |
|---|---|---|---|
| 01-Feb-13 | Widen the remit of RealTime | Q2 2015/16 Remaining elements of Inpatient Lists (IPL) transfer to RealTime (RT) for Adult inpatient wards.<br>Delayed Transfer of Care reporting will transfer to Radar, using data from RealTime and Patient Centre.<br>Rehab reporting - awaiting input from Supplier. | |
| Mar-15 | 14/15 funding to increase Consultant cover at the weekends | Added to 15/16 Business Plan. | |
| Mar-15 | Development of Therapies Improvement Programme | Therapies Lead now appointed. Programme in progress | |
| Jun-14 | Recruit further two A&E Consultants | New recruitment plan developed with Dir of Workforce & OD for implementation. | |
| Jan-15 | Development of the Urgent Care Programme ASPH/NWS CCG | Joint Urgent Care Recovery Programme in place | |
| Jan-15 | Strengthening support to the hospital at weekends, with more physicians working. This includes the Trust's 'Enhanced Care for Older People' team and an additional discharge consultant for the | OPAL team on site at weekends. Additional discharge Registrar for medical wards and Registrar to support AECU service in place. | |
| Jan-15 | Opening of the ambulatory care unit, moved to new location on the ramp. on our Medical Assessment Unit at weekends (making a positive difference to patient flow at weekends). | Complete. AECU moved to new location, gradual increase in numbers of patients seen. | Jan-15 |
| Jan-15 | Trialing a GP working in A&E during a time of intense pressure. GP's commissioned to work in Department over Easter weekend. | In progress. Commenced Jan '15. | |

**Principle Risk:**

**1.4 If the Trust workforce was not appropriately aligned to demand and acuity; particularly to meet reductions in WTE, agency usage and pay costs, resulting in poor patient outcomes.**

**Director of Workforce Transformation/Chief Nurse/Medical Director**

| | Initial | Current | Target |
|---|---|---|---|
| **Likelihood** | 3 | 4 | 2 |
| **Consequence** | 3 | 4 | 3 |
| **Level** | 9 | 16 | 6 |

**Strategic Objective Affected**
Objectives 1 & 3: Best Outcomes & Skilled Motivated Teams

**Opened:** 01-Apr-11
**Closed:**

**Controls**

- Annual Workforce Plan
- Business Planning process and targets set for 2015/16
- Weekly vacancy Control panel & weekly rostering meeting
- Centralised change programmes led by an Executive Director
- Safer Staffing Templates
- Compliance with CQC Outcome 13

**Assurance**

- Safer staffing Levels
- Divisional Performance Review Meetings to review appointment to establishment & forward plan
-
- Workforce reports supplied to Divisions weekly and monthly
- Agency usage monitored at ED Finance and Division Review meetings and actions agreed monthly
- Bimonthly monitoring of workforce metrics at Workforce and OD Sub Committees, weekly rostering meeting -
- attended by Exec Directors & Non Exec Directors
  Safer Staffing Levels report presented to Board monthly.
- Nursing Acuity Tools deployed . Safer staffing templates being used to validate staffing levels for other non nursing staff groups.

**Gaps in Controls**

- Agency suppliers not reported (see below)

**Gaps in Assurance**

- Number of escalation areas open in times of severe operational pressure.

**Closure Request?**

**Action Plan**

| Due: | | Action Description | | Progress to Date | Date Completed |
|---|---|---|---|---|---|
| Mar-14 | | Embed trust wide processes for financial governance, decision making and control of use and expenditure | | In progress | |
| 01-Mar-14 | | Validate authorisation, booking and invoice approval processes for temporary staff | | In progress | |
| 31-Jan-15 | | Safer Staffing plan being developed. | | Ongoing. | |

**Principle Risk:**

## 1.5 If delivery of CQC inspection action plan slips this risks quality of service delivery, reputation and further regulatory action

**Chief Nurse**

| | Initial | Current | Target | Strategic Objective Affected |
|---|---|---|---|---|
| **Likelihood** | 3 | 3 | 2 | Objective 1 Best Outcomes |
| **Consequence** | 3 | 3 | 3 | |
| **Level** | 9 | 9 | 6 | |

**Opened:** 17-Apr-15
**Closed:**

### Controls

- High level action plan for compliance actions with Senior Responsible Officer oversight
- Detailed action plan for improvement actions
- Devolved setting, implementing, and monitoring of the plans promotes local ownership
- Clear link between action owner, deliverable, and timescale

### Assurance

**Formalised governance structure for monitoring**

- High level action plan on compliance actions is being reviewed monthly via IGAC, with summary monthly update to Trust Board
- Detailed action plan on improvement actions to be formulated and reviewed at CQC Quality Review Group fortnightly
- External scrutiny by CQC (details to be agreed in meeting June 2015). Anticipate monthly written updates and quarterly face to face review.

**Process assurance**

- Test of effectiveness to ensure than an action has been effectively resolved

### Gaps in Controls

### Gaps in Assurance

### Closure Request?

### Action Plan

| Due: | | Action Description | | Progress to Date | Date Completed |
|---|---|---|---|---|---|
| 7 April 2015 | | High level plan for compliance actions approved by Chief Executive and submitted to Care Quality Commission 7 April 2015. | | Plan has been submitted | 7 April 2015 |
| April 2015 | | Implement monthly monitoring to IGAC and Trust Board | | First reports to be submitted for month of April 2015 | |
| June 2015 | | Agree arrangements for monitoring of progress with CQC in meeting of June 2015 | | Meeting scheduled for 2nd week in June 2015 | |
| TBC | | Formulate detailed improvement action plan for non compliance actions | | Commenced, will set timescale and progress via CQC Quality Review Group forums | |
| 30-Jun-15 | | Review risk in June 2015 - Associate Director of Quality | | | |

## Principle Risk:

### 2.1 The Friends and Family Test (FFT) results are not used as a driver for improvement leading to persistently poor experience

**Chief Nurse**

| | Initial | Current | Target | Strategic Objective Affected |
|---|---|---|---|---|
| **Likelihood** | 2 | 2 | 2 | Objective 2: Excellent Experience |
| **Consequence** | 4 | 3 | 3 | |
| **Level** | 8 | 6 | 6 | |

**Opened:** 01-Apr-13
**Closed:**

**Controls**

- New satisfaction targets to be set for 15/16 with new recommended % score replacing the NPS
- Monitor performance against similar trusts - agree target from Q2 15/16
- Monthly reporting - monitor response and satisfaction rates across all areas of hospital
- Improvement plans and initiatives, plus any concerns in feedback to be reviewed at PEMG on a quarterly basis

**Assurance**

- The Trust has achieved roll out of FFt to all areas of the hospital
  The Trust has achieved the set response rate targets for Inpatients and A&E
- NPS score for Inpatients and maternity is above the target level for 14/15
- A&E NPS response rate was elow set target of 55 for the year 14/15, however the NPS is replaced with new recommended scoring system which should provide a more stable and true score for A&E
- Review at speciality performance meetings, Quality Governance Committee and IGAC.
  QEWS dashboard in place highlighting F&F scores

**Gaps in Controls**

- None known

**Gaps in Assurance**

- It has been identified that response rates in maternity at touchpoint 1 and 4 in the community are insufficient to guide improvement actions at present
- Text service across A&E and outpatients but further roll out required to inpatients and maternity

**Closure Request?**

**Action Plan**

| Due: | | Action Description | | Progress to Date | Date Completed |
|---|---|---|---|---|---|
| 01-Dec-14 | | Plan for roll out of text services to all areas | | Outpatient Department and Day surgery roll out completed in Oct '14. Inpatients and maternity 2015/16. | |
| TBA | | Because the response rates in maternity FFT are insufficient to guide improvement actions at present, the response rate requires improvement. | | The complexity of capturing data at four points in maternity continues to be challenging due to different data system - this is being addressed by the Women's Health Division with support from the Head of Patient Experience. Plan to roll out the text service in maternity shortly. | |
| 01-Jan | | Interactive voice messaging service for F&F being put in place for A&E patients. | | Roll out commenced. | Jan-15 |

**Principle Risk:**

## 2.2 Lack of awareness of key issues relating to vulnerable groups may lead to compassionless care and poor patients experience

**Chief Nurse**

| | Initial | Current | Target |
|---|---|---|---|
| **Likelihood** | 3 | 2 | 1 |
| **Consequence** | 2 | 3 | 2 |
| **Level** | 6 | 6 | 2 |

**Strategic Objective Affected**
Objective 2: Excellent Experience

**Opened:** 31-Mar-14
**Closed:**

**Controls**

- Policies have been reviewed, updated and ratified pertaining to all Adult Safeguarding, being reviewed again to reflect Care Act 2015.
- Prevent (Management of radicalisation of public service) in place.
- Health & Safety Manager is facilitator and Adult Safeguarding lead Nurse is nominated lead for
- Prevent.
- All policies and process reviewed recently.
- HealthAssure has been updated - Outcome 7.
- Trust Intranet Safeguarding section has been updated.
  Clinical pathway has been created for safeguarding and adult alerts. Safeguarding domestic abuse has been developed. Partnership with MARC . Winterbourne strategy achieved, working in partnership with the adult social care team.
- Deputy Medical Director interim Lead Safeguarding Adults Physician
- Safeguarding Lead Nurse appointment.

**Assurance**

- CQC compliant - as per inspection 13th and 14th Jan 2015 (Outcome 7 - Safeguarding people for abuse, Outcome 14 Supporting workers, Outcome 16)
- New package has been introduced with projection to have 85% compliance with training within 3 years
- Quarterly assessments take place at Divisional level and organisational level, reported into the Integrated Governance and Assurance Committee (IGAC).
- Safeguarding Adults at Risk - Self Assessment tool (Surrey Safeguarding Board) completed in May 14.
- Increased DOLS referrals.
- Level 3 training commenced.
- Safeguarding team recruiting to a band 6 safeguarding adult nurse and administrative support.

**Gaps in Controls**

- Specialised audit pertaining to Safeguarding Adults focussing paticually in regards to capacity assessment and best interest decisions. The use of DoLs and application needs to be more robust.

**Gaps in Assurance**

- No evidence in-place to suggest Court of Protection to staff. No safeguarding competency framework in-place (however Trust will adopt Surrey Adult Board competencies and progress level 3 training for nominated individuals as part of strategic development when new safeguarding team is progressed). In regards to capacity assessments education and process in need of more robust management. Compliance:
- Adult safeguarding 80.3%, DOLS 95.5% and Child safeguarding 85.1%.
- CQC finding re vulnerable groups re help with meal times.

**Closure Request?**

**Action Plan**

| Due: | | Action Description | | Progress to Date | Date Completed |
|---|---|---|---|---|---|
| 20-Mar-14 | | Head of Nursing & Midwifery CPD will progress level 3 training and review competences in the next quarter. | | Level 3 training progressed. | |
| Jan-15 | | Training re physical disability and comunciation needs with vulnerable groups. | | On-going. Communication study day being run, dementia study day introduced and running monthly. Physical and Learning disability training being planned for induction and mandatory update. | |

**Principle Risk:**

**2.3 If the Trust fails to adopt the culture of a listening, kind and compassionate organisation in dealing with complaints then our patients, within the course of their care and treatment, will have a poor experience.**

**Chief Nurse**

| | Initial | Current | Target | Strategic Objective Affected |
|---|---|---|---|---|
| **Likelihood** | 2 | 2 | 1 | Objective 2: Excellent Experience |
| **Consequence** | 3 | 4 | 2 | |
| **Level** | 6 | 8 | 2 | |

**Opened:** 31-Mar-14
**Closed:**

**Controls**

- Trust forums in place to monitor and scrutinise complaints and the actions undertaken to improve: Patient Experience Monitoring Group, Patient Experience Group (Governors), Patient Panel (Patients Representatives).
- Board oversight. Complaints data within monthly quality report.
- Complaints policy.
- Target set of 10% or less follow up complaints per month
- Chief Nurse review established
- Weekly Trust Complaints Panel - chaired by Chief Nurse.
- New datix web system for managing complaints from 20.4.15

**Assurance**

- Achievement of less than 10% in follow up complaints ongoing
- Timeliness of response between 96% and 100% for Jan - March 2015
- New datix web system to ensure better understanding of themes and trends and further breakdown of data

**Gaps in Controls**

**Gaps in Assurance**

**Closure Request?**

**Action Plan**

| Due: | | Action Description | | Progress to Date | Date Completed |
|---|---|---|---|---|---|
| 01-May-15 | | Substantive band 6 recruitment | | Not yet at full establishments | |
| 31-Mar-15 | | Systematic review of the behaviours, practices and processes around complaints handling | | To be carried out by the Chief Nurse Project Lead supported by the PMO. | |
| 31-Mar-15 | | Development of a complaints procedure guidance | | Commenced. Connected to Chief Nurse Project. | |
| Q2 14/15 | | Develop training and development programmes | | Training delivered, ongoing program in progress | 01-Dec-14 |
| Q2 14/15 | | Focus session on medical engagement | | In progress | |
| Jan-15 | | Complaint response improvement plan being developed | | Developed. Being implemented. | |

**Principle Risk:**

**2.4 Administrative delays and cancellations to appointments leading to poor patient experience.**

**Deputy Chief Executive**

| | Initial | Current | Target | Strategic Objective Affected |
|---|---|---|---|---|
| **Likelihood** | 3 | 5 | 1 | Objective 2: Excellent Experience |
| **Consequence** | 3 | 3 | 1 | |
| **Level** | 9 | 15 | 1 | |

**Opened:** 31-Mar-14
**Closed:**

**Controls**

- Patient Experience Monitoring Group
- Divisional level review
- Improving Outpatient Experience Programme (Customer Service strategy, Out-patient promise)
- Weekly Trust wide performance meetings (Cancer, A&E, RTT)

**Assurance**

- Complaints (marginal decrease year on year)
- Outpatient Friends & Family (live from October 2014)

**Gaps in Controls**

- Embedding Divisional review processes
- Pre-operative assessments

**Gaps in Assurance**

- Out-patient cancellation report reviewed in every Division

**Closure Request?**

**Action Plan**

| Due: | | Action Description | | Progress to Date | Date Completed |
|---|---|---|---|---|---|
| 2014/15 | | Improve pre-operative assessment process (recruit, expand facility, increase one stop shop clinics) | | Recruitment in progress, currently 3 WTEs vacancies. One stop clinics will commence on recruitment to at least 2 WTEs. Expanding the capacity currently in progress. | |
| 2014/15 | | Trust wide performance meetings | | Q2 - strengthen review of cancellation process (in and out-patients) | |
| 01-Sep-14 | | Review of booking pathway | | Review of Management structure & process underway | |
| 12-Nov-14 | | Outpatient workshop | | Took place on 12th November with over 50 attendees | 12/11/2014 |
| 2014/15 | | Reduction in cancellation of outpatient appointments with <6 weeks notice | | Work progressing with the Divisional teams | |
| End March 2015 | | Improving Outpatient Experience Programme (run by PMO) | | In progress - Programme has been redefined in Q2 14/15. Following outpatient workshop the output have been collated with a plan developed. Project manager appointed and Programme Board set up. | 31-Mar-16 |

**Principle Risk:**

**3.1 The inability to recruit and retain high calibre staff would lead to lack of skilled and motivated teams.**

**Director of Workforce Transformation**

| | Initial | Current | Target | Strategic Objective Affected | |
|---|---|---|---|---|---|
| **Likelihood** | 4 | 4 | 2 | Objective 3: Skilled, motivated teams | **Opened:** 01-Apr-13 |
| **Consequence** | 3 | 4 | 3 | | **Closed:** |
| **Level** | 12 | 16 | 6 | | |

**Controls**

- All employment policies, including appraisal, structured in accordance with the 4Ps
- Corporate and divisional LED plans
- Team ASPH continuing
- Compliance with CQC Outcome 14
- ADN bi-weekly Recruitment and Retention Group
- Weekly review of temporary staff spend
- Establishment of the Health Roster User Group for Nursing (Chaired by an ADN)

**Assurance**

- Staff turnover rates monitored at PMO at divisional and speciality level
- Employment policies available on Trustnet and reviewed with EPF & TEC
- Specific action plans in place to identify and address areas with retention difficulties
- Compliance with CQC Outcome 14 - monitored by WOD Committee
- Leadership Programme in conjunction with Hay in progress
- Establishment of Workforce and OD Committee from July 2013.
- Consultant Conference in June 2014.

**Gaps in Controls**

- Control of rostering and planning

**Gaps in Assurance**

- Continuing inability to retain key staff.

**Closure Request?**

**Action Plan**

| Due: | Action Description | Progress to Date | Date Completed |
|---|---|---|---|
| on-going | Complete roll out of team coaching to all speciality teams across the Trust | In progress - of 32 teams, 15 are complete, and 13 are on-going. | |
| 2014 | New Consultant Development Programme | Implemented - 3rd cohort of Consultants started programme in Jan '15 | 2015 |
| 31-Mar-14 | Medical Workforce Planning: Assessment of future Divisional workforce model. | In progress - on-going, part of 2015/16 business plan | |
| 2014/15 | Recruitment plan for nurses (UK and overseas) | In progress. Open days taken place with success. Recruitment for nurses in Portugal has also been successful (30 joined in Jan '15). Recruitment in the Philipines with offers to 60 nurses in Jan '15. | |
| 2014/15 | Nurse rotational programme for Band 5/6 to be developed | In progress | |
| Nov-14 | Development of Corproate Framework for hard to recruit to areas | In progress | |
| Nov-14 | Development of pay incentives for nurses in targeted areas. | Developed. | Nov-14 |
| | Refreshed approach to employer branding and recruitment with 4 key workstreams: | Ouline Project Plan drafted | |
| Mar-15 | Defining our corporate identity and our recruitment needs – why do people work here, what sets us apart from others. | Scoping USP with CEO Sounding Board and other forums, developing organisation story, developing benefits package, developing a *working in surrey* brochure. | |
| Mar-15 | Describing this through a re-branding exercise – Trust video, template job packs, *Join The Team* page on website. | Corporate branding and recruitment material drafted, toolkit being developed for recruiting managers, corporate video filming in progress, developing microsites for individual campaigns | |
| Mar-15 | Positioning ourselves in the jobs market – conferences, social media, developing an alumni. | Developing social media toolkit for recruitment to enhance organisational profile | |
| Mar-15 | Recruitment Tactics – Advertorials in professional press, job stands in local shopping centre, recruitment days, refer a friend scheme | Microsites for medical staffing campaigns to be launched in May onwards. Calendar of nursing events developed for 2015/16 | |

## Principle Risk:

**3.2 If individuals and teams do not feel valued or motivated resulting in poor patient care and staff experience and ineffective team working.**

**Director of Workforce Transformation** | **2**

| | Initial | Current | Target |
|---|---|---|---|
| **Likelihood** | 2 | 4 | 4 |
| **Consequence** | 4 | 4 | 2 |
| **Level** | 8 | 16 | 8 |

**Strategic Objective Affected**
Objective 3: Skilled, motivated teams

**Opened:** 01-Apr-12
**Closed:**

### Controls

- All employment policies, including appraisal, structured in accordance with the 4Ps
- Team ASPH continuing
- Chief Executive Sounding Board
- Development of Values Based Behaviours
- Junior doctor sounding board
- Development of new appraisal policy with inclusion of values based behaviours

### Assurance

- Employment policies on Trustnet and reviewed every three years
- Staff attitude survey and patient survey results reported to Trust Board, TEC (annually)
- Monitor improvements against KPIs
- Staff Social Committee
- Exit interviews
- Open Communication channels (ideas wall)
- WOD Committee meets bi-monthly
- Improved NSS staff survey results 2014
- 700 managers and staff trained on new appraisal policy.

### Gaps in Controls

- 

### Gaps in Assurance

- Appraisal rates now well below 90% target
- GMC survey results in 2014 identify improvements needed.

### Closure Request?

### Action Plan

| Due: | | Action Description | | Progress to Date | Date Completed |
|---|---|---|---|---|---|
| 2014 | | Improve career development and training and development opportunities | | In progress (aided through new Appraisal Policy) | |
| Sep-14 | | Culture diagnostic launched in September 2014 | | completed. | Q3 14/15 |
| Sep-14 | | CEO Chat Room launched | | Commenced - on-going | |
| Sep-14 | | CEO Consultant one on one meetings initiated | | Commenced - on-going | |
| Jan-15 | | Additional communciation forums being developed | | CEO weekly messages videoed once a month. Weekly operational update from Deputy CEO. | |
| Jan-15 | | Increased CEO/Executive visibility throughout the organisation. | | In progress. Increased visibility noted by staff governors. | |
| Mar-15 | | In Their Shoes career shadowing established | | 3rd cohort completed in Mar 2015 | |
| Apr-15 | | Annual staff appreciation & recognition awards | | Held on 16th April 2015 | |

**Principle Risk:**

**4.1 Poor alignment of the clinical workforce around the Trust's and Commissioner efficiency programmes could lead to insufficient productivity.**

**Director of Finance and Information**

| | Initial | Current | Target | Strategic Objective Affected |
|---|---|---|---|---|
| **Likelihood** | 3 | 4 | 3 | Objective 4: Top productivity |
| **Consequence** | 4 | 4 | 3 | |
| **Level** | 12 | 16 | 9 | |

**Opened:** 01-Apr-11
**Closed:**

**Controls**

- KPIs on LOS, admissions, discharges etc. weekly and monthly
- Clear demand and capacity plan
- Escalation Policy in place
- Monthly speciality performance reviews in place
- Daily Information Reporting and Intelligence systems
- Weekly Trust wide dashboards
- Theatre Utilisation Monitoring
- Realtime inpatient system
- Bed Management Radar

**Assurance**

- Balanced Scorecard
- Monthly Finance Committee
- Bi-monthly Workforce and OD Committee
- Joint Trust / CCG fortnightly CIP/QIIP delivery review board (starts May 15)

**Gaps in Controls**

**Gaps in Assurance**

- Evidence of delivery around business plans
- Evidence of delivery over planned care demand management programme
- Emergency Capacity Plan and crowding out of elective workload.

**Closure Request?**

N/A

**Action Plan**

| Due: | Action Description | Progress to Date | Date Completed |
|---|---|---|---|
| 01-Sep-15 | Theatre Utilisation action plan | In progress. 18 week capacity issues still requiring large weekend elective activity levels. | |
| 01-Dec-15 | Length of Stay action plan | In progress. Not yet seeing significant improvement. Hampered by capacity constraints in Q1-Q4 14/15. Escalation remain open. New 15/16 plan currently in sign off processes. | |
| 30-Jun-15 | Rehab reprovided across the community. Reduction in Trust provided rehab beds. | Demand for Trust rehab beds was reduced significantly in the run up to Easter but have since beenr eopened. New Trust owned plan under development. | |
| 31.4.15 | Trust delivered demand managmenet schemes for A&E, MSK, Cardiology, ENT, Urology, Dermatology, Opthalmology, Neurology and Diabetes under development | Still in design stage. | |
| 01-Sep-15 | Consultant recruitment plan | In progress. Various posts recruited to in hot-spot areas (i.e. Care of the Elderly, Acute physicians) but key posts remain unfilled. | |

**Principle Risk:**

**4.2 A failure to deliver the clinical quality incentives (CQUINS), the performance standards or to respond to the admission thresholds/readmission caps/ambulance turnaround penalties within the 2015/16 contract leads to an under recovery of income and reduction in productivity.**

**Director of Finance and Information**

| | Initial | Current | Target | Strategic Objective Affected |
|---|---|---|---|---|
| **Likelihood** | 4 | 3 | 2 | Objective 4: Top productivity |
| **Consequence** | 4 | 3 | 3 | |
| **Level** | 16 | 8 | 6 | |

**Opened:** 01-Apr-12
**Closed:**

**Controls**

- Service planning processes in place with clear targets
- Clear internal Performance Review Framework
- Clear articulation of internal programme of work.
- Monthly contract KPI monitoring
- CQUIN project managed through PMO with Executive Director leads

**Assurance**

- Balanced scorecard KPIs
- Divisional Performance Review Meetings (monthly)
- Monthly income reports to Finance Committee and Board
- CQUIN report to Strategic Delivery Committee
- 2015/16 CQUINs to be finalised.

**Gaps in Controls**

**Gaps in Assurance**

- Current activity pressures now impacting upon most CQUIN measures.

**Closure Request?**

N/a

**Action Plan**

| Due: | | Action Description | | Progress to Date | Date Completed |
|---|---|---|---|---|---|
| 01-Jun-14 | | Implementation of re-admissions action plan (clinical change programmes) | | Contract requirements renegotiated, but change programmes continue. | |
| 01-Jun-15 | | Implementation of Emergency Care action plan | | In progress. Q1 remains extremely challenging in light of pressures experienced. | |
| 2015/16 | | CQUIN delivery plan | | Monitored monthly - in progress | |

## Principle Risk:

**4.3 A failure to deliver 2015/16 CIPs to the level required and/or pay and non-pay expenditure exceed budget without a compensating increase in income may lead to a reduction productivity.**

**Director of Finance and Information**

| | Initial | Current | Target | Strategic Objective Affected |
|---|---|---|---|---|
| **Likelihood** | 4 | 4 | 2 | Objective 4: Top productivity |
| **Consequence** | 4 | 4 | 4 | |
| **Level** | 16 | 16 | 8 | |

**Opened:** 01-Apr-11
**Closed:**

### Controls

- Monthly Directorate and Divisional performance reviews look at workforce, activity, finance and
- Trust's quality framework
- Planned programme of LOS reductions which is regularly reviewed with Directorates
- Other delivery metrics i.e. theatre utilisation, weekly bank and agency usage reports
- Major Productive schemes identify patients experience objectives as well as productivity objectives and monitor any adverse impacts during implementation.
- Monthly Divisional CIP meetings

### Assurance

- TEC review of business cases and quality impact reports
- Board performance and PMO delivery / impact reports
- Strategic Delivery Committee
- Performance Review meetings
- Internal and external audit reports
- £2.5m CIP risk at month 1. Mitiagtion schemes to be developed to bridge gap.

### Gaps in Controls

### Gaps in Assurance

- Delivery of recruitment plans to reduce agency spend.
- CIP mitigation schemes not delivering as required
- Complete Medicine and TASCC recovery plan.

### Closure Request?

N/a

### Action Plan

| Due: | Action Description | Progress to Date | Date Completed |
|---|---|---|---|
| 01-Sep-15 | Delivery of Divisional Recruitment plans | In progress | |
| 31-Mar-16 | Delivery of Cost Improvement Plans | In progress - £13.5m identified. Actions to underpin this are being pursued. | |
| 01-Jul-14 | Deliver Medicine recovery plan | In progress - challenging due to on-going demand, capacity and temporary staffing requirement. | |
| 31-Oct-14 | Deliver TASCC recovery plan | Plan complete. Being implemented. | |
| 31-Jul-15 | Finance Committee to undertake deep dive on Q1 performance | | |

**Principle Risk:**

**4.4 Financial or service pressures on third party providers of health and social care or commissioners cause operational difficulties or to enforcement of contract levers more aggressively than expected leading to reduced income and inability to achieve top productivity.**

**Director of Finance and Information**

| | Initial | Current | Target | Strategic Objective Affected |
|---|---|---|---|---|
| **Likelihood** | 3 | 3 | 2 | Objective 4: Top productivity |
| **Consequence** | 4 | 3 | 4 | |
| **Level** | 12 | 9 | 8 | |

**Opened:** 01-Apr-11
**Closed:**

**Controls**

- Focus on NW Surrey Locality and specialist commissioner relationships
- Regular Board-to-Board with the CCG.
- Activity profiled across year
- Demand management scheme monitoring.

**Assurance**

- Monthly contractual close down and agreement processes.
- Contractual escalation arrangements will be used as required.
- Activity reporting via Board and Finance Committee reports.
- CCG notification of issues or performance concerns are reported to the Board as required.

**Gaps in Controls**

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**Gaps in Assurance**

- Confidence in CCG QIIP programmes to deliver fully the expected activity reductions
  Confidence in the impact of the Better Care Fund

**Closure Request?**

N/A

**Action Plan**

| Due: | | Action Description | | Progress to Date | Date Completed |
|---|---|---|---|---|---|
| 15/16 | | Joint strateegic work to allign future financial and activity plans | | | |
| 15/16 | | Better Care Fund / QIIP impacts in 2015/16 to be activily monitored. | | | |

**Principle Risk:**

**4.5 Excess demand could increase financial pressure due to emergency income on over-performance being received at marginal tariffs whilst additional staffing is paid at premium rates.**

**Director of Finance and Information**

| | Initial | Current | Target | Strategic Objective Affected |
|---|---|---|---|---|
| **Likelihood** | 4 | 4 | 3 | Objective 4: Top productivity |
| **Consequence** | 4 | 4 | 3 | |
| **Level** | 16 | 16 | 9 | |

**Opened:** 30-Oct-14
**Closed:**

**Controls**

- Monthly monitoring on contract activity, QIIP
- Planned programme of LOS reduction
- Funidng of escalation beds from April 15.
- Health economy winter plan
- Rehab action plan to transfer Trust beded proviion to the community

**Assurance**

- Limited impact from health system on reducing demand

**Gaps in Controls**

**Gaps in Assurance**

- Lack of confidence in existing whole system plan.
- Crowding out of elective activity

**Closure Request?**

N/A

**Action Plan**

| Due: | | Action Description | | Progress to Date | Date Completed |
|---|---|---|---|---|---|
| 15/16 | | System wide provider response discussions being co-ordinated by Trust and CCG CEOs and the Local Area Team. | | Plan developed to achieve four hour compliance by Q1 2015. | |