Bradford Teaching Hospitals
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK: Quarter 1 2019/20

The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the organisation's strategic objectives. Assurance can be secured through a range of sources, but wherever possible, it should be systematic, consistent, independently verified and incorporated within a robust governance process. The Board achieves this primarily through the work of its assurance committees, through audit and other sorts of independent review, and by the systematic collection and analysis of performance data, to demonstrate the achievement of its strategic objectives. The Board Assurance Framework is a live document that will continue to be populated and amended as risks and assurances associated with the organisational objectives are identified

BOARD ASSURANCE FRAMEWORK												Q 1 2019/20
Assurance Overview						Date						
Strategic Objective		Current Assurance Level	Reason for Assurance Level	Executive Lead	Assuring Committee	Quarterly assurance ratings				Strategic Risk	
						18/19			19/20		
						Q2	Q3	Q4	Q1	Principal composite	Highest
1	To provide outstanding care for our patients		There is confidence that structures and processes to identify and support the mitigation of risk associated with the achievement of this strategic objective are established. The Quality Committee recognises that significant improvements have been made and sustained. The Committee undertook a formal review of achievements and performance during 2018/19 at the April meeting.	Chief Nurse/ Chief Medical Officer	Quality					12	16
2a	To deliver our financial plan		The Q1 planned deficit before PSF is £5.2m. This position was achieved for the period ending 30.6.19 and as such the RAG rating for the Quarter is '*green*'. The underlying run rate is the largest risk given there are minimal non recurrent measures available in 19/20. The current run rate will not secure the Q2 position which is a £2.4m improvement on the Q1 target (ie a planned deficit in the quarter of £2.8m). The Trust has agreed a fixed income contract with its main commissioners (Bradford and Airedale) which means that delivery of the financial plan inclusive of the liquidity position and capital programme is reliant on cost efficiencies and transformation. The Trust has limited opportunity to rely on growth to support the financial position.	Director of Finance	Finance and Performance					16	16
2b	To deliver our key performance targets		There has been significant improvement in performance against cancer 2 ww and 62 day standards and improvement is in line with trajectory. Both standards are predicted to be achieved by the end of Q1 2019/20. The revised breach allocation rules which came into effect in April will negatively impact on BTHFT due to late IPTs. There has been a month on month improvement in RTT performance and improvement is in line with trajectory. The total waiting list has reduced for eleven consecutive months. There have been zero 52 week breaches for 6 months. There is limited confidence in the Trust's ability to achieve the ECS 95% standard although there has been a recent improvement in performance and on track with the improvement trajectory. Demand and capacity analysis has shown that lack of physical capacity and insufficient clinical decision makers in ED is a major contributor to poor performance. Recruitment to the additional workforce is progressing well. The improvement programme is on track and there is measurable improvement in a number of KPIs. A number of new roles have been implemented and are showing a measurable impact on performance improvement. Time from arrival to assessment and average LOS in ED has reduced. Ambulance handover performance has improved. Green Zone with GPs and ED practitioners working together has commenced with performance maintained.	Chief Operating Officer	Finance and Performance					16	20
3	To be in the top 20% of employers in the NHS		The Committee was assured that significant progress is being made across a range of key workforce indicators. Evidence is being routinely presented to Committee demonstrating tangible assurance. Concerns re vacancies in key areas remain with performance below metric in some areas. The Committee have reviewed the risk appetite and composite risk rating for this strategic objective at the February meeting, and agreed at the march meeting to revise this to 'seeking'.The committee is intending to recommend to Board of Directors in July that its level of assurance is revised to green.	Director of Human Resources	Workforce					12	12
4	To be a continually learning organisation		Evidence continues to be presented to Committees and Board which demonstrates the significant progress made, recognising that there are further opportunities for change and improvement. The Quality Committee will undertake a full review of achievements and performance during 2018/19 in April 2019.	Chief Medical Officer	Quality					12	12
5	To collaborate effectively with local and regional partners		Partnership work for all acute collaboration and vertical integration is necessarily dependent on the work and cooperation of external organisations, which means elements of partnership work will always be beyond the direct influence and control of BTHFT, but within that context we believe our mitigations are effective	Director of Strategy and Integration	Partnerships					12	12

BOARD ASSURANCE FRAMEWORK	Strategic Objective	1	To provide outstanding care for our patients		2018/19			19/20
					Q2	Q3	Q4	Q1
Executive Lead	Karen Dawber/Bryan Gill		**Assuring Committee**	**Quality**	**Assurance Level**			

Positive Assurance (bold received to date in quarter)		
Date	Assurance	Source
Monthly	**Safe Staffing report** **Quality Committee Dashboard and trend analysis** **Information Governance report** **Quality oversight system**	Report
Quarterly	**Incident report** **Leadership walk around programme** ProGRESS **Learning from deaths** Learning **Patient experience report** **Freedom to speak up report**	Report
Annual	**Sub Committee reports** **Data Security Protection Toolkit**	Report
April/June	**Maternity report (Quarterly)** **Focus on: safer procedures, pressure ulcers, IPCC**	Reports
June	**IPCC report**	Reports

Negative Assurance (bold received in quarter)		
Date	Assurance	Source
Monthly	**Safe Staffing report** **Quality Committee Dashboard and trend analysis** **Serious incident report**	Report to Quality Committee
Quarterly	**Incident report** **Clinical Effectiveness report**	Report to Quality Committee

Gaps in Assurance
Any gaps identified have been managed within the business of the committee through the provision of enhanced assurance

Rationale for Assurance Level
There is confidence that structures and processes to identify and support the mitigation of risk associated with the achievement of this strategic objective are established. The Quality Committee recognises that significant improvements have been made and sustained. The Committee undertook a formal review of achievements and performance during 2018/19 at the April meeting.

Key performance Indicator		Principal Risk (s)		Potential consequences	Composite risk rating (strategic risks)					Component risks>12	
					Initial	Residual	Target	Current	Direction of travel	Number	Highest Current
a	To achieve the NHS quality of care standards	1	Failure to maintain the quality of patient services	Poor quality of care to the population that we provide services for. Reduced reputation and risk to continuity of services	16	8	4	12	↔	10	16
b	To continuously improve in all services over the cycle of the clinical services strategy and have no services rated as requires improvement or inadequate.	8	Failure to meet regulatory expectations and comply with laws regulations and standards	Harm to patients, visitors and staff Incidents, complaints Regulatory/legal action	12	8	6	8	↔	0	12
		9	Failure to maintain a safe environment for staff patients and visitors	Harm to patients, visitors and staff Reduced reputation and risk to continuity of services Regulatory/legal action	12	6	4	12	↔	1	12

High Level Controls (From Quality Plan 2018/19)	
Quality Strategy	Friends and Family test
Risk management strategy	National Inpatient survey
Patient experience strategy	Other National Patient Surveys
Quality Oversight System	Complaint benchmarking
Infection Prevention and Control Standards	CQC compliance action plan
LocSSIPS programme	Performance (RTT/ECS/Cancer) benchmarking
Quality improvement collaboratives: harm free care	PLACE assessments
	Freedom to Speak Up programme
Incident reporting benchmarking	Bradford Accreditation Scheme
SAFER implementation programme	Workforce: Safe staffing standards, appraisal, mandatory training, sickness absence benchmarking, Placement satisfaction benchmarking (medical students)
NICE guidance implementation programme	
Delayed Transfers of Care benchmarking	
Policy and Procedure compliance benchmarking	
National Audit Programme	Data Security Protection Toolkit
Health and safety benchmarking	Internal audit reports relevant to controls
Structured Judgement Review Programme	

Gaps in controls
Implementation of always events Real time quality data: sepsis indicators

Routine Sources of Assurance	
Exception reports from Sub Committees (from February 2019)	Quality Oversight System report
Patient experience report	Infection Prevention and control report
Risk management report	Safe staffing report
Serious Incident report	Escalation of risks to quality from other Board Committees
Effectiveness Report	
CQC compliance reporting	Safe Staffing report
Safeguarding report	Quality Committee Dashboard and trend analysis
Learning report	
Learning from deaths report	Serious incident report
Quality Committee Dashboard	Incident report
Clinical Effectiveness report	
National audit Care at end of life presentation	

Risk Appetite
Cautious. Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward

BOARD ASSURANCE FRAMEWORK	Strategic Objective	1	To provide outstanding care for our patients	Action Plan to address Gaps in Controls and Assurance

			Date of update	27/3/2019
Accountability		**Responsibility**		
Lead	**Oversight/governance structure**	**Lead**	**Work-stream/operational group**	
Chief Nurse (CN)	Quality Committee	Deputy Medical Director (DMD)	Infection Prevention and Control Committee	
Medical Director (MD)		Deputy Chief Nurse (DCN)	Patients First Committee	
		Nurse Consultant IPCC (NCIPCC)	Going Digital Programme Board	
		Head of Business Intelligence (HBI)		

Objective	**1**	**To address gaps in controls that compromise the assurance related to this strategic objective**

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
1	To develop functionality to enable real time quality metric reporting	HBI	June 2018	June 2019	O		This is part of ongoing work to optimise the data available from EPR and its associated analytics. This is being tested in maternity services	
2	To ensure that the Trust has appropriate metrics and processes in place to monitor the quality of sepsis care and management	CNIP	June 2018	October 2018	C	September 2018	Presented to quality committee in September	Paper presented to Quality Committee
3	To implement Always Events through the implementation of the Patient Experience Strategy	CN	Jan 2019	September 2019	O			

Objective	**2**	**To address gaps in assurance related to achievement of this strategic objective**

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
1	To ensure that the national inpatient survey and a summary of recommendations is received by the Quality Committee in July 2018	CN	June 2018	July 2018	C		Presented to quality committee in August 2018	

BOARD ASSURANCE FRAMEWORK	Strategic Objective	2a	To deliver our financial plan	Assurance Level	18/19			19/20
					Q2	Q3	Q4	Q1
Executive Lead	Matthew Horner		Assuring Committee	Finance and Performance				

Positive Assurance		
Date	**Assurance**	**Source**
July 2019	Fixed Income Contract agreed with main commissioners (Bradford & Airedale). Improved baseline contract value compared to PbR contract	Finance Report
July 2019	Financial position on plan for Quarter ensuring PSF and FRF funding is recovered.	Finance Report
July 2019	Weekly CBU meetings focussing solely on CIP delivery	Finance Report
July 2019		

Negative Assurance		
Date	**Assurance**	**Source**
July 19	Identification and implementation of sufficient cash releasing measures to ensure annual CIP target is delivered. Underspends against budgets utilised to deliver Quarter 1 position. The current underlying run rate will not deliver the quarter 2 control total which requires a £2.4m improvement on Q1.	Finance report

Gaps in Assurance

Definitive plans to secure the full value of control total requirement on a recurrent and sustainable basis:

The new Care Group Structures continues to bed in with a number of staff in new roles both clinical and operational. The level of understanding/operational grip and skills/capabilities continues to evolve. The CBU development programme will help facilitate this process.

Rationale for Assurance Level

The Q1 planned deficit before PSF is £5.2m. This position was achieved for the period ending 30.6.19 and as such the RAG rating for the Quarter is '*green*'. The underlying run rate is the largest risk given there are minimal non recurrent measures available in 19/20. The current run rate will not secure the Q2 position which is a £2.4m improvement on the Q1 target (ie a planned deficit in the quarter of £2.8m). The Trust has agreed a fixed income contract with its main commissioners (Bradford and Airedale) which means that delivery of the financial plan inclusive of the liquidity position and capital programme is reliant on cost efficiencies and transformation. The Trust has limited opportunity to rely on growth to support the financial position.

Key performance Indicator		Principal Risk(s)		Potential consequences	Composite risk rating (strategic risks)					Component risks >12	
					Initial	Residual	Target	Current	Direction of travel	Number	Highest Current
a	Deliver the financial plan to secure PSF and FRF funding and deliver liquidity plan to ensure sufficient cash to protect the capital programme	4	Failure to maintain financial stability	Damage to reputation, financial and liquidity compromise, loss of market share, regulatory action	**16**	**10**	**10**	**16**	↔	**2**	**16**

High Level Controls

Executive led Divisional Financial performance management
Bradford Improvement Plan Governance
Performance management of CIP delivery (including weekly CIP delivery meetings for each CBU)
Budget setting and business planning
Quality Impact Assessment and Financial Impact Assessment process
Standing Financial Instructions and Scheme of Delegation
CEO led Finance & Performance Oversight Committee (FPOC)
Issuance of Budgetary Management Framework to support new Care Groups and Clinical Business Units (CBU's)

Gaps in controls

Routine Sources of Assurance

Director of Finance report to Finance and Performance Committee and Board – including assessment of NHSI 'Use of Resources' framework
Bradford Improvement Plan Report to Finance and Performance Committee and Board of Directors
Internal Audit Committee Reports on controls assurance
Audit Committee Report to Board
Finance & Performance Committee Dashboard
Board Integrated Dashboard
Finance & Performance Oversight Committee Report to Finance and Performance Committee and Board of Directors

Risk Appetite

Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward

BOARD ASSURANCE FRAMEWORK	Strategic Objective	2a	To achieve our financial plan	Action Plan to address Gaps in Controls and Assurance

		Date of update	15/7/2019
Accountability		**Responsibility**	
Lead	**Oversight/governance structure**	**Lead**	**Work-stream/operational group**
Director of Finance (DoF)	Finance and Performance Committee	Chief Executive	Finance and Performance Oversight Committee
Chief Operating Officer (COO)			

Objective	**1**	**To address gaps in controls that compromise the assurance related to this strategic objective**						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
1	Delivery of the control total in full through CIP plans and additional recovery measures	DoF COO	1.4.19	31.3.20	**OC**		The pre-PSF control total deficit for 2019/20 is £12.5m. There is currently a gap in securing the full value for the year.	Finance Report to Finance & Performance Committee Outputs from CBU weekly CIP meetings

Objective	**2**	**To address gaps in assurance related to this strategic objective**						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
1	Definitive plans to secure the full value of CIP requirement on a recurrent and sustainable basis	DoF COO	1.4.19	31.3.20	**OC**		The current plans identified do not secure full delivery of the CIP target for the year. Underspends reported across a number of expenditure lines are offsetting the gaps at the end of quarter one.	Finance Report to Finance & Performance Committee Outputs from CBU weekly CIP meetings
2								

Status:	
O	Open
O	Open and compromised
C	Closed
OD	Overdue

BOARD ASSURANCE FRAMEWORK	Strategic Objective	2b	To deliver our key performance targets	Assurance Level	2018/19			19/20
					Q2	Q3	Q4	Q1
Executive Lead	Sandra Shannon		Assuring Committee	Finance and Performance				

Positive Assurance

Date	Assurance	Source
20/6/ 2019	Implementation of the action plan to improve the ECS performance Daily performance reporting of ECS Business case for revised staffing model approved. Recruitment in progress Improved performance for ambulance handover. Implementation of green zone External visit and review of programme by NHSEI Regional clinical leads for urgent care and GIRFT Recruitment to 4 clinical fellow posts Recruitment to 2 consultant posts in ED .	ECS improvement Plan 2019/20 EPR – Trust performance team Formal report from NSHEI
20/6/ 2019	Implementation of the action plan to improve the Cancer 62 Day performance There has been an increase in the number of patients seen within 2 weeks of referral There has been a month on month reduction in 62 day backlog 2ww tracker in place for all cancer specialties Revised escalation process in place Daily cancer huddle to review patient level information on waiting times/ delays. Cancer waiting time dashboard	Cancer 62 day performance Action Plan PPM – Cancer Manager
20/6/ 2019	Implementation of the plan to reduce elective waiting times Weekly 18 week RTT performance against trajectories Demand and capacity modelling RTT waiting list has reduced for 11 successive months. There have been no 52 week waiters for 6 months.	ECR action plan Incomplete PTL Outputs of D&C modelling

Negative Assurance

Date	Assurance	Source
20/6/ 2019 20/6/ 2019 20/6/ 2019	Current performance in relation to ECS standard Still relatively low numbers of patients being treated on same day emergency care/ ambulatory pathway. Consultant vacancies for acute medicine – recruitment in process	Performance Report to Finance & Performance Committee Staffing rotas.
Mar 2019	Current performance in relation Cancer 62 day standard – 2ww and 62 standards not yet achieved consistently	Performance Report to Finance & Performance Committee Cancer dashboard
Mar 2019		Performance Report to Finance & Performance Committee Access highlight report 18 week incomplete waiting list

Gaps in Assurance

Data quality issues in 18 week PTL which limits the Trust's ability to provide a weekly report

Rationale for Assurance Level

There has been significant improvement in performance against cancer 2 ww and 62 day standards and improvement is in line with trajectory. Both standards are predicted to be achieved by the end of Q1 2019/20. The revised breach allocation rules which came into effect in April will negatively impact on BTHFT due to late IPTs. There has been a month on month improvement in RTT performance and improvement is in line with trajectory. The total waiting list has reduced for eleven consecutive months. There have been zero 52 week breaches for 6 months. There is limited confidence in the Trust's ability to achieve the ECS 95% standard although there has been a recent improvement in performance and on track with the improvement trajectory. Demand and capacity analysis has shown that lack of physical capacity and insufficient clinical decision makers in ED is a major contributor to poor performance. Recruitment to the additional workforce is progressing well. The improvement programme is on track and there is measurable improvement in a number of KPIs. A number of new roles have been implemented and are showing a measurable impact on performance improvement. Time from arrival to assessment and average LOS in ED has reduced. Ambulance handover performance has improved. Green Zone with GPs and ED practitioners working together has commenced with performance maintained.

Key performance Indicator		Principal Risk (s)		Potential consequences	Composite risk rating (strategic risks)					Component risks>12	
					Initial	Residual	Target	Current	Direction of travel	Number	Highest Current
	To achieve organisational trajectories set ECS	3	Failure to maintain operational performance	Damage to reputation, regulatory action	20	6	6	16	↔	2	20
					12	6	6	12	↓	1	12

High Level Controls

New performance management and accountability framework
Development of care group and CBU dashboards including national/local and contractual KPI's/standards
ECS improvement plan
Cancer improvement plan
Elective care improvement plan
Weekly Access Meetings
2 weekly ECS breach review meetings
Urgent Care Programme board
Planned care programme board

Gaps in controls

ECS- the current staffing model is not sufficient to meet current emergency demand

Routine Sources of Assurance

Daily return to NHSI for ECS
National cancer submission of cancer waiting times by standard
Monthly national reporting of 18 weeks RTT through Unify
Director of Finance - Performance report to Finance and Performance Committee and Board
Audit Committee Report to the Board
Contract Management Board
Internal Audit Committee Reports on controls assurance
Audit
Finance & Performance Committee Dashboard
Board Integrated Dashboard

Risk Appetite

Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward

BOARD ASSURANCE FRAMEWORK	Strategic Objective	2b	To deliver our key performance targets	Action Plan to address Gaps in Controls and Assurance

		Date of update	20/6/2019
Accountability		**Responsibility**	
Lead	**Oversight/governance structure**	**Lead**	**Work-stream/operational group**
Deputy Director of Operations	Urgent Care Improvement Programme	AED leadership	Emergency care Access and flow
Deputy Director of Operations	Urgent Care Improvement Programme	Deputy Director of Operations	Hospital Flow and discharge

Objective	**1**	**To address gaps in controls that compromise the assurance related to this strategic objective**

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
1	ECS- To implement the revised staffing model that matches staff resource with emergency demand	COO	May 19	30/10/18			Revised workforce model agreed. Business case approved at Trust Board and recruitment has commenced. Due to the education timetable the majority of medical posts will not be filled until September 18. Recruitment progressing well to nursing and ACP vacancies.	
2	ECS – to increase the number of patients who attend ED who are treated by same day emergency care and avoid overnight admission	COO	May 19	31/11/19			Plan for blue zone has been agreed. 4 ambulatory pathways have commenced and the number of patients transferred from ED to ACU and avoiding 4 hour breach has increased from 7-8 to 15-20 per day. There is a total opportunity of approximately 70 patients who could be transferred to same day emergency care (blue zone)	

Objective	**2**	**To address gaps in assurance related to achievement of this strategic objective**

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
1	18 weeks RTT- To implement a DQ improvement programme	COO	June 19	Dec 19			Programme commenced. Detailed action plan in place.	

BOARD ASSURANCE FRAMEWORK	Strategic Objective	3	To be in the top 20% of employers in the NHS	Assurance Level	18/19			19/20
					Q1	Q2	Q3	Q1
Executive Lead	Pat Campbell	Assuring Committee	Workforce					

Positive Assurance		
Date	Assurance	Source
May/ June 2019	Workforce report Nurse staffing data publication report 95% target met on appraisals and performance maintained at +90%. Risk to be managed at CBU level, not corporate. Overall nurse vacancy position Consultant recruitment Staff engagement – significant improvement demonstrated through staff survey results –feedback on staff survey action plan 2018/9 Turnover stable Reduction in agency, increase in bank, Mandatory training trajectories 2018 NHS Staff Survey results above average in 9 out of the 10 themes Progress on key equality metrics and plans in place where performance below target Medical appraisal and revalidation –annual report Guardian of Safe Working report	Workforce Committee NHS Staff Survey

Negative Assurance		
Date	Assurance	Source
/April/June 2019	Equality indicators from staff survey being analysed as only theme where we are below average WDES draft submission Escalation from Health and Safety Committee re stress at work vacancy position particularly in stroke and, theatres Service pressures /gaps in microbiology, y and medical oncology Infectious diseases/microbiology recruitment/service provision Middle grade gaps in A&E and Paediatrics Increase in year to date sickness absence Nurse staffing data publication report Industrial action – WoS -reputational	NHS Staff Survey Workforce Committee

Gaps in Assurance
Routine access to comparator data in some areas

Rationale for Assurance Level
The Committee was assured that significant progress is being made across a range of key workforce indicators. Evidence is being routinely presented to Committee demonstrating tangible assurance. Concerns re vacancies in key areas remain with performance below metric in some areas. The Committee have reviewed the risk appetite and composite risk rating for this strategic objective at the February meeting, and agreed at the march meeting to revise this to 'seeking'.The committee is intending to recommend to Board of Directors in July that its level of assurance is revised to green.

Key performance Indicator		Principal Risk (s)		Potential consequences	Composite risk rating (strategic risk register)					Component risks >12	
					Initial	Residual	Target	Current	Direction of travel	Number	Highest Current
A	Overall:Retain above average overall staff engagement indicator scores benchmarked against acute Trusts with a target of top 20% by 2021/22	2	Failure to recruit and retain an effective and engaged workforce to meet the needs of our Clinical Services Strategy	Disengaged staff – poor staff morale High staff turnover High vacancy rate/agency staff usage Poor quality and continuity of care Unanticipated bed closures		15	6	4	12	↔	1	12
B	Retain: Maintain a turnover rate between 10 -14% Develop:										
C	Ensure all eligible staff have an effective annual appraisal monitoring both completion rates [95%] and quality [through staff survey]										
D	Attract and Lead:To employ a workforce representative of our local communities in line with our Equalities Objectives/WRES action plan to include monitoring against our agreed equality objectives.										
E	Happy, healthy and here :achieve sickness absence rates of less than 4.50% in 2019/20										

High Level Controls	
Divisional performance management Workforce dashboard Monitoring of safe staffing Monitoring of recruitment against budget Time to talk/We are Bradford/OD Plan Our People Strategy 2017 and annual workplans Personal responsibility framework Guardian of Safe Working Hours reports Workforce planning	Staff survey action plan Bi -Annual review of nurse and midwife staffing establishments Mandatory training and appraisal performance management Education and workforce Committee Human Resources Policies and Procedures Equality objectives/ WRES Action plan/Equality plan GMC reports

Gaps in controls
Contemporaneous staff experience data – Workforce transformation support Workforce plan to match clinical services strategy in development

Routine Sources of Assurance	
Workforce report Workforce Committee Dashboard Board Integrated Dashboard HEE/NHSI workforce return/workforce plan Junior Doctor fill rates Update report on staff survey action plan Nurse recruitment and retention plan GMC survey Nurse staffing data publication report Bi-annual review report of nurse and midwife staffing Medical appraisal and revalidation report Quarterly 'freedom to speak up guardian' return	Workforce Race Equality Standard Report Guardian of safe working hours report Staff Friends and Family Test Model Hospital portal for benchmarking purposes Audit reports Staff Advocate service contacts and outcomes Leadership walkarounds

Risk Appetite
Seeking – Preference for safe delivery options particularly in relation to nurse staffing that have a low degree of inherent risk to patient safety and may only have limited potential for reward. Is now willing to consider all potential options including the introduction of new workforce models and new ways of working whilst also providing an acceptable level of reward

BOARD ASSURANCE FRAMEWORK	Strategic Objective	3	To be in the top 20% of Employers in the NHS	Action Plan to address Gaps in Controls and Assurance

		Date of update	27/2/2019
Accountability		**Responsibility**	
Lead	**Oversight/governance structure**	**Lead**	**Work-stream/operational group**
Director of Human Resources (DHR)	Workforce Committee	DHR	Education and Workforce Sub Committee
		Deputy Director of Human Resources (DDHR)	
		Assistant Director of Human Resources (ADHR)	

Objective	**1**	**To address gaps in controls that compromise the assurance related to this strategic objective**						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
1	To review methods for getting more contemporaneous staff experience data out with SF&F and NHS Staff Survey	DDHR	01.07.2018	30.09.2018	**C**		To be picked up through staff engagement actions and reported to E&W Committee. Limited outcome-to be reviewed at March meeting.	Proposal developed but not able to be pursued
2	To undertake a strategic workforce review	DDHR	06.2018	31.03.2019	**OC**	tbc	Terms of reference developed , awaiting start date of workforce transformation support. Appointment made . Meeting set up for 27 June 2019	

Objective	**2**	**To address gaps in assurance related to achievement of this strategic objective**						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
1	nil							

BOARD ASSURANCE FRAMEWORK	Strategic Objective	4	To be a continually learning organisation	Assurance Level	18/19			19/20
					Q2	Q3	Q4	Q4
Executive Lead	Bryan Gill		Assuring Committee	Quality Committee				

Positive Assurance		
Date	**Assurance**	**Source**
MONTHLY	Serious Incident Report	Quality Committee
QUARTERLY	Combined Learning Report	Quality Committee
	Leadership Walk round update	Quality Committee
	Learning from Deaths	
	Patient Experience	Quality Committee
	Guardian of Safe Working Hours	Quality Committee
		Workforce Committee
ANNUALLY	Safer Procedures	Quality Committee
	Patient Safety Sub- Committee Report	Quality Committee
	Research Translation & Innovation Report	
	Quality Account	Quality Committee
Mar 2019	Single Stroke Service Collaboration	Quality Committee
April 2019	Quality Improvement Programme -update	Quality Committee
	Safer Procedures Local Safety Standards	Quality Committee
April 2019	Medical Appraisal & Revalidation	Workforce Committee
	External GIRFT Visits	
05/04/2019	Endocrinology	
02/05/2019	Anaesthetics & Perioperative Medicine	

Negative Assurance		
Date	**Assurance**	**Source**
MONTHLY	Serious Incident Report	Quality Committee
QUARTERLY		
ANNUALLY		

Gaps in Assurance

Further work required to ensure that data can be extracted to evidence and assure compliance with Core and High priority training targets.

Identification of risks associated with the delivery of the objectives.

Rationale for Assurance Level

Confidence: Evidence continues to be presented to Committees and Board which demonstrates the significant progress made, recognising that there are further opportunities for change and improvement. The Quality Committee will undertake a full review of achievements and performance during 2018/19 in April 2019.

Key performance Indicator		Principal Risk (s)		Potential consequences	Composite risk rating					Component risks	
					Initial	Residual	Target	Current	Direction of travel	Number	Highest Current
1	To achieve 5% year on year training of clinical staff in Quality Improvement	8	Failure to demonstrate that the organisation is continually learning and improving the quality of care to our patients	Reputation, loss of HEE contracts, research funding, harm to patients, reduced recruitment and retention of staff	12	8	6	8	↔	0	-
2	To deliver upper quartile performance for recruitment to time and target for NIHR portfolio studies										
3	Achieving upper quartile performance on national education surveys										
4	Continuous learning: Ratio of near miss to SI reporting [Learning culture]										

High Level Controls

Research Committee
Organisational learning system
Trust's Improvement Programme
Quality oversight system
National Audit Programme (Improvement)
Patient safety/Clinical Effectiveness/workforce and education Sub-Committee
NHS QUEST
AHSN
Improvement Academy, BIHR
Centre for applied health research, HEE
HEI
CQC Compliance Action Plan
GMC National Training Survey 2018

Gaps in controls

Lack of a single dashboard to reflect this strategic objective.

Routine Sources of Assurance

Quarterly learning report
National Education Surveys
ESR reports
Board Integrated Dashboard
National Audits
GIRFT Data Packs/ Visits

Risk Appetite

Open: There is a willingness to support staff to innovate in methods of delivering continuous learning and improvement

BOARD ASSURANCE FRAMEWORK	Strategic Objective	4	To be a continually learning organisation	Action Plan to address Gaps in Controls and Assurance

			Date of update	27/3/2019
Accountability			**Responsibility**	
Lead	**Oversight/governance structure**		**Lead**	**Work-stream/operational group**
Dr Bryan Gill	Quality Committee & Patient Safety Sub Committee		DMD	

Objective	**1**	**To address gaps in controls that compromise the assurance related to this strategic objective**						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
1	Work being completed to ensure that HSMR and SHMI data will be available for next quarter.	MD/D OI	June 2018	01/09/2018	**C**	September 2018	Reported to quality Committee	Paper to quality committee in September 2018

Objective	**2**	**To address gaps in assurance related to achievement of this strategic objective**						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
1	Further work required to ensure that data can be extracted to evidence and assure compliance with Core and High priority training targets.	GM	June 2018	31/12/2018	**C**	October2018		Paper presented at Quality Committee, October 2018 (within the dashboard)

BOARD ASSURANCE FRAMEWORK	Strategic Objective	5	To collaborate effectively with local and regional partners	Assurance Level	2018/19			19/20
					Q2	Q3	Q4	Q1
Executive Lead	John Holden	Assuring Committee	Partnership Committee					

Positive Assurance		
Date	**Assurance**	**Source**
May 2019	Positive progress across "horizontal" and "vertical" integration and as well as Acute service collaboration with Airedale NHS FT.	Report to partnerships Committee
May 2019	WYAAT Programme Directors report	Closed Board
May 2019	Partnerships dashboard	Dashboard

Negative Assurance		
Date	**Assurance**	**Source**
May 2019	Partnerships dashboard	**Dashboard**

Gaps in Assurance

Ensuring there is regular formal but also flexible oversight from EDs as partnership work with Airedale gathers pace.

Ensuring the trust monitors the programme from both a strategic and programme management perspective.

Rationale for Assurance Level

Confident: Partnership work for all acute collaboration and vertical integration is necessarily dependent on the work and cooperation of external organisations, which means elements of partnership work will always be beyond the direct influence and control of BTHFT, but within that context we believe our mitigations are effective.

Key performance Indicator		Principal Risk (s)		Potential consequences	Composite risk rating					Component risks >12	
					Initial	Residual	Target	Current	Direction of travel	Number	Highest Current
1	Local integrated care ("vertical" integration): assessment of strategy and integration directorate of progress towards BTHFT's strategic goals in this area.	7	Failure to deliver strategic partnerships	Missed opportunity to implement clinical strategy and improve patient care due to e.g. destabilised clinical services, loss of market share, reputational damage, financial loss, operational issues	12	8	8	10	↓	6	12
2	System-wide planning & decisions ("horizontal" integration): assessment of strategy and integration directorate of progress towards BTHFT's strategic goals in this area.										
3	Acute service collaboration with Airedale NHS FT: assessment of strategy and integration directorate of progress towards BTHFT's strategic goals in this area.										

High Level Controls

EMT Governance
Implementation of Clinical Services Strategy 2017-2022 through CBU service planning and EMT updates
Participation in :

- ICS System Leadership Exec Group, and System Oversight and Assurance Group
- Bradford & Districts Health & Wellbeing Board
- Bradford Districts & Craven Integration & Change Board (ICB)
- Bradford Health & Care Partnerships Board (programme board for integrated care)
- Integrated Management Board (IMB) of Bradford Provider Alliance
- WYAAT Programme exec (CEOs) and Committee in Common and Exec directors groups.

Gaps in controls

Need to better co-ordinate activity and information within the trust (exec and senior managers) related to vertical and horizontal integration.

Routine Sources of Assurance

1. Stakeholder engagement survey
2. WYAAT Programme Director's Report (feeds in to Committee in Common, WYAAT CEOs and sub groups eg FDs, Med Directors, Strategy & Ops)
3. Papers for ICS System Leadership Executive and System Oversight and Assurance Group (by exception)
4. Papers for Acute Provider Collaboration Programme (with ANHSFT)
5. Partnerships Dashboard
6. Papers for Integration and Change Board, and Health and Care Partnership Board (by exception)
7. Papers for Integrated Management Board of Bradford Provider Alliance (currently chaired by BTHFT).

Risk Appetite

Seek: Eager to be innovative and to choose options offering potentially higher business rewards

BOARD ASSURANCE FRAMEWORK	Strategic Objective	5	To collaborate effectively with local and regional partners	Action Plan to address Gaps in Controls and Assurance

			Date of update	27/3/2019
Accountability		**Responsibility**		
Lead	**Oversight/governance structure**	**Lead**	**Work-stream/operational group**	
Director of Strategy and Integration	Partnerships Committee of BTHFT Board	Head of Policy	Horizontal integration (WYAAT/STP); acute collaboration programme (ie AFT)	
		Head of Partnerships	Vertical integration (Bradford); stakeholder engagement	

Objective	**1**	**To address gaps in controls that compromise the assurance related to this strategic objective**

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
5	Ensuring there is regular formal but also flexible oversight from EDs as partnership work with Airedale quickly gathers pace Ensuring the trust monitors the programme from both a strategic and programme management perspective	JH	Jan 31 2019	30 July 2019			EDs are sitting on governance board for the Airedale collaboration and the work is a standing item at EMT. In initial months of the programme, the Trust will monitor to ensure this provides sufficient oversight. Work being completed to align programme and Trust approaches to risk management.	Airedale Programme Board ToR, EMT agenda.
4	Assess whether broader information or objective process can be fed into in directorate judgment as to whether KPIs are being attained	JH	17 Aug 2018	30 November 2018		20 Nov 18	System introduced where feedback on progress of collaborative programmes is gained from EDs. This feedback is then assessed by S&I team against overall KPIs. This will be supplemented by assessing the externally produced reports that created as part of the collaborative programmes.	Email to EDs 20 November
3	Create a risk regarding lack of understanding of our current level/depth of collaboration with AFT	JH	20 June 2018	20 July 2018		20 July 18	Following issue being raised at 20 June IRGC, Head of Policy drafted risk on Datix, approved at IRGC.	Datix reference 3260
2	Work with Governance Team to co-develop a risk for CRR in relation to proposals for future acute collab with Airedale FT	JH	1 March 2018	20 June 2018		20 June 18	Head of Policy drafted risk which is on Datix, approved by IGRC	Datix reference 3255; IGRC I.6.18.5
1	Following cancellation of Partnerships Board on 30 November 2018 circulate key papers for written comment.	JH	30 Nov 2018	7 December 2018		7 December 2018	Comments were sought on SPA (key opportunity to influence its development) and this BAF. NB SPA now finalised and signed	Email to Partnerships Committee

Objective	**2**	**To address gaps in assurance related to achievement of this strategic objective**

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
1	Appoint dedicated "Head of Partnerships" to oversee and co-ordinate vertical integration	JH	1 Feb 2018	6 June 2018		9 July	Appointee started 9 July.	Advert on NHS Jobs; HR paperwork

Annex 1 Strategic Risk Register

STRATEGIC RISK REGISTER: PRINCIPAL RISKS (Overview)

		Proposed Overall Risk Rating					Risk Appetite	
	Principal Risk	**Initial**	**Residual**	**Target**	**Current**	**Direction**	**Current**	**Profile**
1	Failure to maintain the quality of patient services	16	8	4	12	↔	Minimal	
2	Failure to recruit and retain an effective and engaged workforce	15	6	4	12	↔	Cautious/open	
3	Failure to maintain operational performance	20	6	6	16	↔	Cautious	
4	Failure to maintain financial sustainability	16	10	10	16	↔	Cautious	
5	Failure to deliver the required transformation of services	12	8	8	8	↔	Open	
6	Failure to achieve sustainable contracts with commissioners	12	6	6	12	↓	Cautious	
7	Failure to deliver the benefits of strategic partnerships	12	9	9	12	↔	Seek	
8	Failure to maintain a safe environment for staff patients and visitors	12	8	6	8	↔	cautious	
9	Failure to meet regulatory expectations and comply with laws, regulations and standards	12	6	4	12	↔	minimal	
10	Failure to demonstrate that the organisation is continually learning and improving the quality of care to our patients	12	8	6	8	new	open	

Appendix 2: Board Assurance Framework Legend

Descriptors	
Principal Risk	What could prevent the Strategic Objective from being achieved?
High Level Controls	What controls/systems do we have in place to assist secure delivery of the objectives?
Gaps in Controls	Are there any gaps in the effectiveness of controls or systems?
Sources of assurance	Where can we gain evidence in relation to the effectiveness of the controls/systems which we are relying on?
Positive Assurance	What evidence have we of progress towards or achievement of our strategic objective?
Negative Assurance	What evidence have we of progress towards our strategic objectives being compromised?
Gaps in Assurance	Where can we improve the evidence about the effectiveness of one or more of the key controls/systems which we are relying on?
Rationale for assurance level	(see Appendix 2) a description of the reason for the decision in relation to assurance level agreed by the assuring committee
Risk Appetite	The level of risk the organisation is prepared to tolerate in relation to the secure delivery of each individual strategic objective

Defining risk appetite		
0	Avoid	Avoidance of risk is a key organisational objective
1	Minimal	(as little as reasonable possible) preference for ultra- safe delivery options that have a low degree of inherent risk
2	Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
3	Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward
4	Seek	Eager to be innovative and to choose options offering potentially higher business rewards
5	Mature	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

Levels of assurance		
little or no confidence	Low. No evidence of necessary structure/processes supporting mitigation of risk associated with the achievement of strategic objective	Risk
limited confidence	Compromised. Limited evidence of necessary structure/processes mitigation of risk associated with the achievement of strategic objective	Risk
confidence	Confident. Range of structures and processes in place supporting mitigation of risk associated with the achievement of strategic objective available and used by the organisation	Opportunities for change and improvement
High Confidence	Trust. Comprehensive evidence of effective and sustainable mitigation of risk associated with achievement of the strategic objectives	Opportunities for learning