Bradford Teaching Hospitals
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK: Quarter 2 2018/19

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												Q2 2018_19 Month 2	
Assurance Overview						Date	04/09/2018						
Strategic Objective		Current Assurance Level	Reason for Assurance Level	Executive Lead	Assuring Committee	Quarterly assurance ratings				Risk			
						2017/18		2018/19					
						Q3	Q4	Q1	Q2	Principal composite	Highest		
1	To provide outstanding care for our patients	Limited Confidence	Whilst there is confidence that structures and processes to identify and support the mitigation of risk associated with the achievement of this strategic objective are becoming established and despite evidence of significant improvement in key areas there remains some quality domains where latent and actual risks continue to emerge and result in compromised quality of care. Quality Committee 29th August	Chief Nurse/ Medical Director	Quality					12	16		
2a	To deliver our financial plan	Limited confidence	The financial plan is being delivered in month 4, noting that this is against a planned deficit of £5.9m, which accounts for 79% of the full year planned deficit. This is also set against a low CIP requirement for the first four months (ie 15% of the annual value). The requirement to deliver the annual CIP of £25m steps up in subsequent months and represents a material change in the underlying monthly run rates.	Director of Finance	Finance and Performance					16	16		
2b	To deliver our key performance targets	Limited confidence	Current performance against trajectories indicate that there is limited confidence in delivering the required standard in quarter: Recovery plans are in place for the contractual KPIs for RTT, ECS and Cancer. These are yet to deliver.	Chief Operating Officer	Finance and Performance					16	20		
3	To be in the top 20% of employers in the NHS	Limited confidence	Evidence presented to Committee shows significant progress and assurance in a number of areas. Concerns re vacancies in key areas remain with performance below KPI in some areas	Director of Human Resources	Workforce					12	12		
4	To be a continually learning organisation	Confidence	evidence presented to committees demonstrates the significant progress made, recognising that there are further opportunities for change and improvement	Medical Director	Quality					12	12		
5	To collaborate effectively with local and regional partners	Confidence	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. Partnerships Committee, 26 July	Director of Strategy	Partnerships					12	12		

BOARD ASSURANCE FRAMEWORK	Strategic Objective	1	To provide outstanding care for our patients		2017/18		2018/19	
				Assurance Level	Q3	Q4	Q1	Q2
Executive Lead	Karen Dawber/Bryan Gill	**Assuring Committee**	**Quality**					

Positive Assurance		
Date	Assurance	Source
Monthly	Safe Staffing Quality Committee Dashboard and trend analysis Information Governance report Quality oversight system	Report to Quality Committee
Quarterly	Risk Management Leadership walk around programme ProGRESS Learning from deaths Learning	Report to Quality Committee
Annual	FTSU annual report Patient experience report Safeguarding report (s) High priority audit plan Annual Clinical Audit report Quality Account Security Report Infection Control Maternity Report	Report to Quality Committee
July July July August August August August	Maternity Improvement Plan Stroke Improvement Plan Focus on falls Stroke SSNAP data Public health screening reports NHSR maternity safer care standards achieved Pathology assurance	Report to Quality Committee

Negative Assurance		
Date	Assurance	Source
Monthly	Safe Staffing report Quality Committee Dashboard and trend analysis Serious incident report	Report to Quality Committee
Quarterly	Clinical Effectiveness report Clinical Audit report	Report to Quality Committee
Annual	Patient Experience report (FFT response, overdue complaints) Maternity Report Care Quality Commission Inspection Report	Report to Quality Committee
August August	Puerperal Sepsis Outlier CQC CQC notification that maternity services are under review	

Gaps in Assurance

Rationale for Assurance Level

Whilst there is confidence that structures and processes to identify and support the mitigation of risk associated with the achievement of this strategic objective are becoming established and despite evidence of significant improvement in key areas there remains some quality domains where latent and actual risks continue to emerge and result in compromised quality of care.
Quality Committee 29th August

Key performance Indicator		Principal Risk (s)		Potential consequences	Composite risk rating					Component risks	
					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	↔	15	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.										

High Level Controls

Clinical Service Strategy 2017-22
Various frameworks that underpin clinical strategy.
Quality dashboard
Sub-Committees of the Quality Committee
National Audit Programme
Quality Oversight System
Quality Improvement Strategy
Structured Judgement Review Process
Policy and procedure related to the management of precursor incidents (e.g. incidents/claims/complaints)
Risk management strategy
CQC steering group
CQC compliance action plan
Workforce Committee

Gaps in controls

Lack of real time reporting of quality information
Sepsis indicators

Routine Sources of Assurance

Ward to board reporting and the committee structures
Patient experience report
Risk management report
Effectiveness Report
CQC compliance reporting
Safeguarding report
Learning report
Friends and Family Test
Patient Survey
Dashboards
Quality Committee Dashboard
Board Integrated Dashboard
National reports:

Risk Appetite

Minimal. (as little as reasonably possible) preference for ultra- safe delivery options that have a low degree of inherent risk

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	June 2018
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)	Information Governance Committee
		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	TBC	**O**		This is part of ongoing work to optimise the data available from EPR and its associated analytics	
2	To ensure that the Trust has appropriate metrics and processes in place to monitor the quality of sepsis care and management	CNIPCC	June 2018	October 2018	**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	KD	June 2018	July 2018	**O**			

BOARD ASSURANCE FRAMEWORK	Strategic Objective	2a	To deliver our financial plan	Assurance Level	2017/18		2018/19	
					Q3	Q4	Q1	Q2
Executive Lead	Matthew Horner		Assuring Committee	Finance and Performance				

Positive Assurance		
Date	**Assurance**	**Source**
June 18	Financial Plan submitted	Bradford Improvement Plan to F&P Committee & Board of Directors
June 18	Expenditure Budget Re set (realigned to reflect 17/18 run rates)	Budget Setting Paper to F&P Committee
June 18	Introduction of key enablers to facilitate tracking and delivery of financial plan (eg weekly activity trackers)	Weekly activity trackers presented to F&P committee (May 18)
June 18	Bradford Improvement Programme (BIP) governance & performance management arrangements	Presented to F&P Committee and Board of Directors
Aug 18	Detailed Data Quality Improvement plan in place focussing on 5 key themes 1. EPR build issues 2. Staff input errors 3. Productivity challenges 4. Business as usual capacity gaps 5. Coding and casemix changes	Bradford Improvement Programme

Negative Assurance		
Date	**Assurance**	**Source**
Aug 18	Financial Plan broadly on line at end of month 4 albeit with contract income under trades and CIP shortfalls being offset by fortuitous run rate underspends	Month 4 F&P Finance Report
June 18		
Aug 18	Activity and Income under trade reported for month 4. Activity allocation to Specialty and Point of Delivery continues to be a challenge resulting from EPR data quality issues	Month 4 F&P Finance Report
Aug 18	Limited expectation in month 4 for CIP delivery (ie 15% of full annual value). BIP governance processes in place but CIP delivery remains a challenge	Month 4 F&P Finance Report

Gaps in Assurance
Definitive plans in place to secure full value of CIP requirement Definitive plans in place to secure contract income quantum and in particular elective activity and income
Alignment of contract activity and income plan to capacity availability quantified from demand and capacity project Accurate alignment of delivered activity to appropriate specialty and point of delivery
Definitive plans in place to secure both current planned values and full annual value of CIP requirement

Rationale for Assurance Level

Limited confidence: the financial plan is being delivered in month 4, noting that this is against a planned deficit of £5.9m, which accounts for 79% of the full year planned deficit. This is also set against a low CIP requirement for the first four months (ie 15% of the annual value). The requirement to deliver the annual CIP of £25m steps up in subsequent months and represents a material change in the underlying monthly run rates.

Key performance Indicator		Principal Risk(s)		Potential consequences	Composite risk rating					Component risks	
					Initial	Residual	Target	Current	Direction of travel	Number	Highest Current
a	Deliver a NHS Improvement Use of Resources rating of at least "2"	4	Failure to maintain financial stability	Damage to reputation, financial compromise, loss of market share, regulatory action	16	10	10	16	↔	8	16

High Level Controls

Executive led Divisional Financial performance management meetings
Bradford Improvement Plan Governance process and performance management of CIP delivery
Budget setting and business planning
Quality Impact Assessment and Financial Impact Assessment process – Improvement plan
Chief Executive CIP confirm and challenge meetings with COO & FD
Standing Financial Instructions and Scheme of Delegation

Gaps in controls

As at Month 1 – BIP management and governance processes not embedded across the organisation

Detailed specialty and point of delivery activity and income plans not available to compare to month 1 actuals

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

Risk Appetite

Cautious

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

			Date of update	June 2018
Accountability		**Responsibility**		
Lead	**Oversight/governance structure**	**Lead**	**Work-stream/operational group**	
Director of Finance (DoF)	Finance and Performance 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	As at Month 4 (July) – BIP management and governance processes continue to be embedded across the organisation. A range of KPI's for specific improvement programmes continue to be established to allow for appropriate performance management arrangements to function effectively	DoF COO	31.5.18	30.6.18	**OC**		Core BIP Documentation completed for all known schemes– Meeting Structure, Monitoring & Performance Management arrangements to be embedded throughout June/July and identification of all appropriate KPIs required	BIP documentation presented to BIP Programme Board and BIP report to Finance and Performance Committee
2	Accurate and detailed specialty and point of delivery activity and income required to evaluate the income position of the Trust	COO	30.5.18	Varied – based on timelines for resolution of individual issues in recovery plan	**OC**		Detailed activity reconciliation plans at specialty and point of delivery level to be created, shared and agreed with Divisions, with agreed timelines for resolution.	A number of key actions have been completed (eg A&E EPR build and activity capture/allocation) Continued development of the data quality action/recovery plan with operations, informatics and contracting contributing. Improvement plan in place. Individual specialty meetings commencing w/c 20.8.19 to review activity run rates and identify/address anomalies.

BOARD ASSURANCE FRAMEWORK	Strategic Objective	2b	To deliver our key performance targets	Assurance Level	2017/18		2018/19	
					Q3	Q4	Q1	Q2
Executive Lead	Sandra Shannon	Assuring Committee	Finance and Performance					

Positive Assurance		
Date	**Assurance**	**Source**
15/8/18	Implementation of the action plan to improve the ECS performance Daily performance reporting of ECS	ECS Action Plan EPR – Trust performance team
15/8/18	Implementation of the action plan to improve the Cancer 62 Day performance Cancer waiting time dashboard	Cancer 62 day performance Action Plan PPM – Cancer Manager
15/8/18	Implementation of the plan to reduce elective waiting times Weekly 18 week RTT performance against trajectories Demand and capacity modelling	ECR action plan Incomplete PTL Outputs of D&C modelling

Negative Assurance		
Date	**Assurance**	**Source**
15/8/18	Current performance in relation to ECS standard ECS- there is an over reliance on flexible staffing to provide adequate staffing levels to meet the needs of emergency demand	Performance Report to Finance & Performance Committee Staffing rotas.
15/8/18	Current performance in relation Cancer 62 day standard No reduction in 62 day backlog There has been a reduction in the number of patients on a cancer pathway treated each month Delays in tracking patients on a 62 day pathway	Performance Report to Finance & Performance Committee Cancer dashboard
15/8/18	Current performance in relation to RTT 18 week access standard Increase in over 18 week patients on waiting list Reduction in elective activity against activity plan	Performance Report to Finance & Performance Committee Access highlight report 18 week incomplete waiting list

Gaps in Assurance
Delays in validating 4 hour breach position There is a mismatch in 2ww 1st OPD capacity to demand in dermatology which will significantly impact on overall 2ww performance Data quality issues in 18 week PTL and lack of staff resources to undertake full validation. DQ issues may provide an inaccurate position against 18 week RTT standard.

Rationale for Assurance Level
Limited confidence: current trajectories indicate that there is limited confidence in delivering the required standard in quarter. Although there has been a small increase in performance against standard there is still significant variation in performance on a day to day basis.
The 62 day backlog is still increasing at the same rate as patients are being removed. There are also 2ww demand and capacity gaps for dermatology and LGI. Both of these indicate limited confidence that cancer standard will be achieved in quarter.
There are a number of specialties showing a significant demand and capacity gap. Many have waiting lists that are over-sized and unless there is a reduction in waiting list sizes the trust will be unlikely to be able to achieve 18 weeks RTT.

Key performance Indicator		Principal Risk (s)		Potential consequences	Composite risk rating					Component risks	
					Initial	Residual	Target	Current	Direction of travel	Number	Highest Current
	To achieve organisational trajectories set for RTT, Cancer and ECS	3	Failure to maintain operational performance	Damage to reputation, financial compromise, loss of market share, regulatory action	20	6	6	16	↑	4	12
		6	Failure to maintain sustainable contracts with commissioners	Loss of market share, loss of public confidence, lack of service sustainability	12	6	6	15	↔	2	16

High Level Controls
Executive led Divisional performance management meetings (national/local and contractual KPI's/standards) ECS performance action Plan Cancer 62 day action plan 18 week RTT action plan Weekly Access Meetings 2 weekly ECS breach review meetings Urgent Care Programme board Trust Improvement Committee work programmes – Urgent Care and Cancer Additional management support in place.

Gaps in controls
ECS- the current staffing model is not sufficient to meet current emergency demand Cancer – due to vacancies there is insufficient tracking of patients on the cancer PTL. Cancer – due to vacancies there is a delay in booking patients for 2ww appointment ECR – due to the increase in WL size there are insufficient validation staff available to undertake the required amount of validation which will impact on performance

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

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

		Date of update	4/5/18
Accountability		**Responsibility**	
Lead	**Oversight/governance structure**	**Lead**	**Work-stream/operational group**
DCD Medicine	Urgent Care Improvement Programme	AED leadership	Emergency care Access and flow
DCD Medicine	Urgent Care Improvement Programme	Service Manager Patient flow	Hospital Flow and discharge
Deputy COO	Cancer Improvement Programme	Cancer Service manager	Cancer delivery group
Head of Planned Access	*Elective Care recovery Programme*	*Deputy COO*	*Elective access delivery group*

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 a substantive staffing model that matches staff resource with emergency demand	COO	May 18	31/9/18	**O**		A draft business case is in development – to be tabled at EMT in August	
2	Cancer- To implement a team restructure that provides a more integrated MDT	CSM	May 18	31/9/18	**O**	August 18	The restructure of the MDT teams is now complete tumour site specific teams which will provide greater oversight and operational grip of pathways management. Additional pathway trackers have been appointed, tracking is now 2 days behind standard – standard is every patient every day.	
3	Cancer- To temporarily increase the number of staff within the 2ww booking team	CSM	May 18	318/18	**O**		Additional staff appointed.	
4	ECR- To implement a data quality recovery plan and reduce waiting list errors at source	C S	May 18	31/12/18	**O**		Plan in place and progressing – impact monitored through Cymbio DQ dashboard . A three tiered approach to training has been agreed and additional support commissioned from Cymbio to develop super users	DQ recovery plan

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 put in place a process for early morning validation of all 4 hour breaches to ensure accurate reporting by 11 am.	AED CL	May 18	31/5/18	**O**			Validation SOP
2.	Cancer – To put in place a detailed recovery plan for dermatology 2ww and identify options for creating additional 2ww 1st OP capacity	COO	May 18	30/6/18	**O**		A detailed recovery plan has been put in place following a dermatology summit with options identified for creating 2ww capacity There is an agreed pathways change for high volume benign pathways to enable more patients to be seen in primary care. Options for transferring backlogs to AQP primary care providers being explored.	Dermatology 2 WW recovery plan Action plan following dermatology summit
4	ECR- To increase the central access team staffing and undertake a programme of detailed validation of the waiting list.	HPA	May 18	31/12/18	**O**		A programme of validation is in development. It is expected that a total waiting list validation will take place over the next 6 months. Additional validators appointed. Elective care recovery plan in place.	Elective care recovery plan Validation plan.

BOARD ASSURANCE FRAMEWORK	Strategic Objective	3	To be in the top 20% of employers in the NHS	Assurance Level	Q3	Q4	Q1	Q2
Executive Lead	Pat Campbell	**Assuring Committee**	**Workforce**					

Positive Assurance		
Date	Assurance	Source
July 2018	Workforce report Nurse staffing data publication report Quarterly guardian of safe working hours report Annual report on medical appraisal and revalidation Development of Schwartz rounds WRES/Equality and Diversity report SFFT results Q1 improved response rates and improved scores Nurse recruitment and retention action plan Health and Well being – Schwartz round development	Workforce Committee

Negative Assurance		
Date	Assurance	Source
March 2018	Staff engagement/experience scores for disabled staff	NHS Staff Survey
July 2018	Workforce report re appraisal rates, vacancy position particularly in nursing, theatres Increase in year to date sickness absence Nurse staffing data publication report Guardian of Safe Working Hours report Nurse recruitment and retention action plan WRES/Equality and Diversity report – bands 8a+	Workforce Committee

Gaps in Assurance
Routine access to comparator data in some areas

Rationale for Assurance Level
Evidence presented to Committee shows significant progress and assurance in a number of areas. Concerns re vacancies in key areas remain with performance below metric in some key areas.

Key performance Indicator		Principal Risk (s)		Potential consequences	Composite risk rating					Component risks	
					Initial	Residual	Target	Current	Direction of travel	Number	Highest Current
A	Achieve a Friends and Family Test (Staff) result showing a target percentage of staff recommending the Trust as a place to work	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	↔	6	12
B	To be in the top 20% of places to work as measured by the NHS staff survey though a year on year improvement in staff engagement scores										
C	To deliver good performance on recruitment fill rates and turnover as benchmarked against other acute hospitals										
D	To employ a workforce representative of our local communities in line with our Equalities Objectives/WRES action plan										

High Level Controls
Divisional performance management Workforce dashboard Monitoring of safe staffing Monitoring of recruitment against budget Time to talk Our People Strategy 2017 and workplans Personal responsibility framework Guardian of Safe Working Hours reports Workforce planning Staff survey action plan 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 NHS QUEST Standards when developed

Gaps in controls
Contemporaneous staff experience data Urgent Care staffing model – does not meet demand – refer to action plan under 2b Workforce plan to match clinical services strategy

Routine Sources of Assurance
Workforce report Workforce Committee Dashboard Board Integrated Dashboard HEE workforce return 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 EWin/Model Hospital portal for benchmarking purposes Audit reports Leadership walkarounds

Risk Appetite
Cautious/open – Preference for safe delivery options that have a low degree of inherent risk to patient safety and may only have limited potential for reward, but beginning to be willing to consider all potential delivery options and choose while 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	
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	**0**		To be picked up through staff engagement actions and reported to E&W Committee	Proposal developed
2	To undertake a strategic workforce review	DDHR	06.2018	31.03.2019	**0**		Terms of reference being developed and consultancy support to be determined.	

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	2017/18		2018/19	
					Q3	Q4	Q1	Q2
Executive Lead	Bryan Gill		Assuring Committee	Quality Committee				

Positive Assurance		
Date	**Assurance**	**Source**
July 18	Risk Management Report	Quality Committee
July 18	Serious Incident Report	Quality Committee
July 18	Leadership Walk round update	Quality Committee
July 18	Mortality Review Improvement	Quality Committee
July 18	Guardian of Safe working	Quality Committee
July 18	GIRFT Review Orthopaedics	GIRFT Visit
July 18	GOSPORT Enquiry Report	Quality Committee
July 18	Stroke Presentation	Quality Committee
July 18	Wolfson Build commenced	
July 18	Mandatory training figures	Workforce Committee
July 18	NHS LA safer maternity standards achieved	Quality Committee
July 18	New Physician Associate Workforce	Workforce Committee

Negative Assurance		
Date	**Assurance**	**Source**
July 2018	Mortality Review Improvement	Quality Committee
July 2018	Stroke Presentation Update	Quality Committee

Gaps in Assurance

Rationale for Assurance Level

Confidence: evidence presented to committees demonstrates the significant progress made, recognising that there are further opportunities for change and improvement

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							
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

Gaps in controls

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

QI update and reports to be reviewed to include more detailed data in terms of staff involvement in collaboratives and training.

Routine Sources of Assurance

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

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	June 2018
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	**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	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	**O**			

BOARD ASSURANCE FRAMEWORK	Strategic Objective	5	To collaborate effectively with local and regional partners	Assurance Level	2017/18		2018/19	
					Q3	Q4	Q1	Q2
Executive Lead	John Holden		Assuring Committee	Partnership Committee				

Positive Assurance		
Date	**Assurance**	**Source**
26 July	Partnerships Committee noted positive progress across "horizontal" integration and as well as Acute service collaboration with Airedale NHS FT.	P.7.18.6 P.7.18.7

Negative Assurance		
Date	**Assurance**	**Source**
26 July	Partnerships Committee noted the difficulties arising from potentially moving to new Partnership Operating Framework and Partnership Agreement within the Bradford District and Craven place	P.7.18.5

Gaps in Assurance

Subjective judgement of S&I directorate is the main way of assessing key performance in delivering strategic goals under this objective. Potential need to draw on wider expertise or formalise process to come to judgement(s).

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.
Partnerships Committee, 26 July.

Key performance Indicator		Principal Risk (s)		Potential consequences	Composite risk rating					Component risks	
					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 the benefits of 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	9	9	12	↔	4	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

1. Partnerships Committee meetings
2. EMT discussions (including time-out sessions)
3. Implementation of Clinical Services Strategy 2017-2022 through Divisional service planning and EMT updates
4. Participation in :-
   - STP System Leadership Exec Group
   - Bradford & Districts Health & Wellbeing Board
   - Bradford districts & Craven Integration & Change Board (ICB)
   - Bradford Health & Care Partnerships Board (programme board for accountable care)
   - Integrated Management Board (IMB) of Bradford Provider Alliance
   - WYAAT Committee in Common

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. Pathology JV Board of Directors meetings (receives regular reports from Managing Director and Clinical Director)
3. WYAAT Programme Director's Report (feeds in to Committee in Common, WYAAT CEOs and sub groups eg FDs, Med Directors, Strategy & Ops)
4. Papers for STP System Leadership Executive
5. Discussions and papers for Acute Collaboration Programme (with AFT)
6. Board Integrated Dashboard

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	18 July 2018
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**
3	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	November 2018			Options being considered to address this action	N/A
2	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	Following issue being raised at 20 June IRGC, Head of Policy has drafted risk on Datix (3260) awaiting approval at IRGC on 20 July	Datix reference 3260; 20 June IRGC minutes
1	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 2018	Head of Policy drafted risk which is on Datix and is scheduled for IGRC approval as required	Datix reference 3255; IGRC I.6.18.5

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

Appendix 1 Corporate Risk Register

CORPORATE RISK REGISTER: PRINCIPAL RISKS (assessed using significant risks >12)

September 2018

		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	15	↔	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	20	6	4	12	new	Minimal	
9	Failure to meet regulatory expectations and comply with laws, regulations and standards	16	6	4	12	new	Minimal	
10	Failure to continually learn and improve the quality of care for our patients					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