

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										Q3 2018_19 Month 1	
Assurance Overview						Date		04/09/2018			
Strategic Objective		Current Assurance Level	Reason for Assurance Level	Executive Lead	Assuring Committee	Quarterly assurance ratings				Risk	
						17/18	18/19				
						Q4	Q1	Q2	Q3	Principal composite	Highest
1	To provide outstanding care for our patients		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. The Quality Committee recognises the improvements that have been made, but determined that a longer period of scrutiny was required to ensure sustainability (31 st October)	Chief Nurse/ Medical Director	Quality					12	16
2a	To deliver our financial plan		The Income & Expenditure (I&E) financial plan is being delivered in month 6, noting that this is against a planned pre-PSF deficit of £8.4m with an annual control total of £7.5m deficit requiring a £0.9m surplus over Quarters 3 and 4. It is doubtful that run rates will improve quickly enough to deliver this improvement and a number of unmitigated variables cast further doubt on the Trust's ability to deliver its 2018/19 control total. The Trust's cash and liquidity forecasts are increasingly challenged by the I&E projections. Following discussion at Finance & Performance Committee, consideration will be given to increasing the risk rating and reducing the assurance level in November.	Director of Finance	Finance and Performance					16	16
2b	To deliver our key performance targets		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. Additional support being provided by ECIST including staffing modelling against demand and escalation tools. The 62 day backlog is reducing slightly but still a higher level than required to meet the 62 day standard. 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. Overall waiting list size has reduced for 4 months in succession. (31 st October)	Chief Operating Officer	Finance and Performance					16	20
3	To be in the top 20% of employers in the NHS		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.	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	Medical Director	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	Partnerships					12	12

BOARD ASSURANCE FRAMEWORK		Strategic Objective	1	To provide outstanding care for our patients			Assurance Level	17/18	2018/19		
								Q3	Q1	Q2	Q3
Executive Lead	Karen Dawber/Bryan Gill			Assuring Committee		Quality					

Positive Assurance (bold received in quarter)			Negative Assurance (bold received in quarter)			Gaps in Assurance	Rationale for Assurance Level			
Date	Assurance	Source	Date	Assurance	Source					
Monthly	Safe Staffing Quality Committee Dashboard and trend analysis Information Governance report Quality oversight system	Report to Quality Committee	Monthly	Safe Staffing report Quality Committee Dashboard and trend analysis Serious incident report	Report to Quality Committee					
Quarterly	Incident report Leadership walk around programme ProGRESS Learning from deaths Learning	Report to Quality Committee	Quarterly	Clinical Effectiveness report Clinical Audit report Incident report	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	Annual	Patient Experience report Maternity Report Care Quality Commission Inspection Report	Report to Quality Committee					
October	Medicines safety	Report to quality committee	October	JAG accreditation report	Report to F&P committee					

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.							
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.			Reduced reputation and risk to continuity of services	16	8	4	12	↔	21	16

High Level Controls	Gaps in controls	Routine Sources of Assurance	Risk Appetite
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	Lack of real time reporting of quality information Sepsis indicators	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:	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
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				Date of update	October 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 Patients First Committee Information Governance Committee	
Medical Director (MD)			Deputy Chief Nurse (DCN)		
			Nurse Consultant IPCC (NCIPCC)		
			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	31/03/2019	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 (October 2018)		
2	To ensure that the Trust has appropriate metrics and processes in place to monitor the quality of sepsis care and management	CNIP CC	June 2018	October 2018	C	September 2018	Presented to quality committee in September	Paper presented to Quality 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	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	C		Presented to quality committee in August 2018		

BOARD ASSURANCE FRAMEWORK		Strategic Objective	2a	To deliver our financial plan			Assurance Level	17/18		18/19	
Executive Lead		Matthew Horner		Assuring Committee		Finance and Performance		Q4	Q1	Q2	Q3

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source		
						<p>Definitive plans in place to secure full value of CIP requirement</p> <p>Definitive plans in place to secure contract income quantum and in particular elective activity and income</p> <p>Alignment of contract activity and income plan to capacity availability quantified from demand and capacity project</p> <p>Accurate alignment of delivered activity to appropriate specialty and point of delivery</p> <p>Definitive plans in place to secure both current planned values and full annual value of CIP requirement</p>	<p>The Income & Expenditure (I&E) financial plan is being delivered in month 6, noting that this is against a planned pre-PSF deficit of £8.4m with an annual control total of £7.5m deficit requiring a £0.9m surplus over Quarters 3 and 4. It is doubtful that run rates will improve quickly enough to deliver this improvement and a number of unmitigated variables cast further doubt on the Trust's ability to deliver its 2018/19 control total. The Trust's cash and liquidity forecasts are increasingly challenged by the I&E projections. Following discussion at Finance & Performance Committee, consideration will be given to increasing the risk rating and reducing the assurance level in November.</p>

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	↑	5	16

High Level Controls	Gaps in controls	Routine Sources of Assurance	Risk Appetite
<p>Executive led Divisional Financial performance management meetings</p> <p>Bradford Improvement Plan Governance process and performance management of CIP delivery</p> <p>Budget setting and business planning</p> <p>Quality Impact Assessment and Financial Impact Assessment process – Improvement plan</p> <p>Chief Executive CIP confirm and challenge meetings with COO & FD</p> <p>Standing Financial Instructions and Scheme of Delegation</p>	<p>As at Month 1 – BIP management and governance processes not embedded across the organisation</p> <p>Detailed specialty and point of delivery activity and income plans not available to compare to month 1 actuals</p>	<p>Director of Finance report to Finance and Performance Committee and Board – including assessment of NHSI ‘Use of Resources’ framework</p> <p>Bradford Improvement Plan Report to Finance and Performance Committee and Board of Directors</p> <p>Internal Audit Committee Reports on controls assurance</p> <p>Audit Committee Report to Board</p> <p>Finance & Performance Committee Dashboard</p> <p>Board Integrated Dashboard</p>	<p>Cautious</p>

BOARD ASSURANCE FRAMEWORK	Strategic Objective	2a	To achieve our financial plan	Action Plan to address Gaps in Controls and Assurance
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			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	17/18	2018/19		
								Q4	Q1	Q2	Q3
Executive Lead	Sandra Shannon		Assuring Committee		Finance and Performance						

Positive Assurance			Negative Assurance			Gaps in Assurance		Rationale for Assurance Level	
Date	Assurance	Source	Date	Assurance	Source				
9/10/18	Implementation of the action plan to improve the ECS performance Daily performance reporting of ECS	ECS Action Plan EPR – Trust performance team	9/10/18	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.	Delays in validating 4 hour breach position There is a mismatch in 2ww 1 st OPD capacity to demand in dermatology which will significantly impact on overall 2ww performance Data quality issues in 18 week PTL DQ issues may provide an inaccurate position against 18 week RTT standard.		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. Additional support being provided by ECIST including staffing modelling against demand and escalation tools.	
9/10/18	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	9/10/18	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			The 62 day backlog is reducing slightly but still a higher level than required to meet the 62 day standard. 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.	
9/10/18	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	9/10/18	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			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. Overall waiting list size has reduced for 4 months in succession.	

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	↑	10	20
		6	Failure to maintain sustainable contracts with commissioners	Loss of market share, loss of public confidence, lack of service sustainability	12	6	6	15	↔	6	16

High Level Controls	Gaps in controls	Routine Sources of Assurance	Risk Appetite
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.	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	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	Cautious

BOARD ASSURANCE FRAMEWORK	Strategic Objective	2b	To deliver our key performance targets	Action Plan to address Gaps in Controls and Assurance
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			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	30/11/18	O		A draft business case is in development – to be tabled at EMT in November. Additional support given by IST to undertake modelling of staffing against demand.	
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; Daily huddles are taking place to review all long waiting patients. .	
3	Cancer- To temporarily increase the number of staff within the 2ww booking team	CSM	May 18	31/8/18	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	C	June 18	A new validation sop is in place.	Validation SOP
2.	Cancer – To put in place a detailed recovery plan for dermatology 2ww and identify options for creating additional 2ww 1 st OP capacity	COO	May 18	31/12/18	O		A Directorate Manager has been seconded to focus purely on cancer improvement. A detailed recovery plan has been put in place for all tumour sites. New dermatology pathways have been agreed to reduce demand and focus only on suspected cancer. 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. Additional activity being undertaken with some outsourcing of long waiters to ISP	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	17/18	18/19		
Executive Lead		Pat Campbell			Assuring Committee		Workforce		Q4	Q1	Q2	Q3

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source	Routine access to comparator data in some areas	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.
Sept 2018	Workforce report Nurse staffing data publication report Quarterly guardian of safe working hours report WRES/Equality and Diversity report/Closing the Gap WRES Action Plan SFFT results Q1 improved response rates and improved scores Nurse recruitment /vacancy report People Strategy workplan update Improving appraisal rates GMC Survey	Workforce Committee Education and Workforce Sub-Ctte	March 2018	Staff engagement/experience scores for disabled staff	NHS Staff Survey		
			Sept 2018	vacancy position particularly in nursing, theatres Service pressures /gaps in dermatology Increase in year to date sickness absence Q2 SFFT response rates/results Nurse staffing data publication report Guardian of Safe Working Hours report Nurse recruitment /vacancy report WRES/Equality and Diversity report – bands 8a+	Workforce Committee		

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		3	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	Gaps in controls	Routine Sources of Assurance	Risk Appetite
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	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 to be developed by end Q4	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	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
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				Date of update	September 2018
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	17/18	18/19		
								Q4	Q1	Q2	Q3
Executive Lead	Bryan Gill			Assuring Committee		Quality Committee					

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source	<p>At present unable to generate the Mortality dashboard report on HSMR & SHMI performance</p> <p>Further work required to ensure that data can be extracted to evidence and assure compliance with Core and High priority training targets.</p> <p>Identification of risks associated with the delivery of the objectives.</p>	<p>Confidence: evidence presented to committees demonstrates the significant progress made, recognising that there are further opportunities for change and improvement</p>
July 18	Risk Management Report	Quality Committee	July 2018	Mortality Review Improvement	Quality Committee		
July 18	Serious Incident Report	Quality Committee	July 2018	Stroke Presentation Update	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					

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	12	↔		
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	Gaps in controls	Routine Sources of Assurance	Risk Appetite
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	QI update and reports to be reviewed to include more detailed data in terms of staff involvement in collaboratives and training.	Quarterly learning report National Education Surveys ESR reports Board Integrated Dashboard National Audits GIRFT Data Packs	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
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				Date of update	October 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	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	17/18		2018/19		
								Q4	Q1	Q2	Q3	
Executive Lead		John Holden			Assuring Committee			Partnership Committee				

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source		
05 Oct	Partnerships Committee noted positive progress across “horizontal” integration and as well as Acute service collaboration with Airedale NHS FT.	P.10.18.7 P.10.18.8	05 Oct	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.10.18.6	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).	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	
					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	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	Gaps in controls	Routine Sources of Assurance	Risk Appetite
<ol style="list-style-type: none"> Partnerships Committee meetings EMT discussions (including time-out sessions) Implementation of Clinical Services Strategy 2017-2022 through Divisional service planning and EMT updates Participation in :- <ul style="list-style-type: none"> 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 	<p>Need to better co-ordinate activity and information within the trust (exec and senior managers) related to vertical and horizontal integration.</p>	<ol style="list-style-type: none"> Stakeholder engagement survey Pathology JV Board of Directors meetings (receives regular reports from Managing Director and Clinical Director) WYAAT Programme Director’s Report (feeds in to Committee in Common, WYAAT CEOs and sub groups eg FDs, Med Directors, Strategy & Ops) Papers for STP System Leadership Executive Discussions and papers for Acute Collaboration Programme (with AFT) Board Integrated Dashboard 	<p>Seek: Eager to be innovative and to choose options offering potentially higher business rewards</p>

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

	Principal Risk	Proposed Overall Risk Rating					Risk Appetite	
		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	12	8	6	12	new	cautious	
9	Failure to meet regulatory expectations and comply with laws, regulations and standards	12	8	6	12	new	minimal	
10	Failure to demonstrate that the organisation is continually learning and improving the quality of care to our patients					new	open	

Appendix 2: Board Assurance Framework Legend				
Descriptors		Defining risk appetite		
Principal Risk	What could prevent the Strategic Objective from being achieved?	0	Avoid	Avoidance of risk is a key organisational objective
High Level Controls	What controls/systems do we have in place to assist secure delivery of the objectives?	1	Minimal	(as little as reasonable possible) preference for ultra- safe delivery options that have a low degree of inherent risk
Gaps in Controls	Are there any gaps in the effectiveness of controls or systems?	2	Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
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?	3	Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward
Negative Assurance	What evidence have we of progress towards our strategic objectives being compromised?	4	Seek	Eager to be innovative and to choose options offering potentially higher business rewards
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?	5	Mature	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
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			
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

