Bradford Teaching Hospitals
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK: Quarter 3 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 2
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 (31st 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	Director of Finance	Finance and Performance					16	16	
2b	To deliver our key performance targets		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. 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.	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		17/18	2018/19		
					Q3	Q1	Q2	Q3
Executive Lead	Karen Dawber/Bryan Gill	**Assuring Committee**	**Quality**	**Assurance Level**				

Positive Assurance (bold received in quarter)		
Date	Assurance	Source
Monthly	**Safe Staffing** **Quality Committee Dashboard and trend analysis** **Information Governance report** **Quality oversight system**	Report to Quality Committee
Quarterly	**Incident report** **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
October	Medicines safety	Report to quality committee

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	Clinical Effectiveness report Clinical Audit report **Incident report**	Report to Quality Committee
Annual	Patient Experience report Maternity Report Care Quality Commission Inspection Report	Report to Quality Committee
October	JAG accreditation report	Report to F&P committee

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. The Quality Committee recognises the improvements that have been made, but determined that a longer period of scrutiny was required to ensure sustainability

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	↔	21	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	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
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	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	CNIPCC	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	
					Q4	Q1	Q2	Q3
Executive Lead	Matthew Horner		Assuring Committee	Finance and Performance				

Positive Assurance		
Date	**Assurance**	**Source**

Negative Assurance		
Date	**Assurance**	**Source**

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
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.

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
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	17/18	2018/19		
					Q4	Q1	Q2	Q3
Executive Lead	Sandra Shannon		Assuring Committee	Finance and Performance				

Positive Assurance		
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	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	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**
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.
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
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

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 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. 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.

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
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	15/11/18
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
COO? Deputy CEO	Cancer Improvement Programme	DM for Cancer Improvement	Cancer delivery group
COO/ Deputy CEO	Elective Care recovery Programme	Head of Performance / head of elective access	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 December . The IST has completed modelling of medical staffing against demand which demonstrated a significant shortfall in decision makers against demand. .	
2	Cancer- To implement a team restructure that provides a more integrated MDT	CSM	May 18	31/9/18	**C**	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. The number of patients over 40 weeks has reduced from over 500 to approx. 300.	
3	Cancer- To temporarily increase the number of staff within the 2ww booking team	CSM	May 18	318/18	**C**	October 18.	Additional staff appointed. Daily huddles taking place to review all patients past 62 days All patients reviewed daily.	
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 well– impact now monitored through performance turnaround board. A three tiered approach to training has commenced and additional support commissioned from Cymbio to develop super users. Validation of endoscopy waiting list continues. New SOPs have been developed with training to prevent further user errors.	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. Revised SOPs for	Validation SOP
2.	Cancer – To put in place a detailed recovery plan for prostate and dermatology 2ww and identify options for creating additional 2ww 1st 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. Monies have been provided through the cancer alliance to increase prostate 2ww diagnostic capcity. A locum is being sought. 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 have been agreed. Review of waiting times show that 2ww backlog is reducing .	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	**C**	October 18	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		
					Q4	Q1	Q2	Q3
Executive Lead	Pat Campbell	**Assuring Committee**	**Workforce**					

Positive Assurance

Date	Assurance	Source
Nov 2018	Workforce report Nurse staffing data publication report WRES/Equality and Diversity report/Closing the Gap WRES Action Plan Equality Update –overall workforce, leavers and promotions Appraisals on track to hit target Overall nurse vacancy position Staff engagement QA of postgraduate medical education Turnover stable Reduction in agency, increase in bank Flu campaign/uptake	Workforce Committee Education and Workforce Sub-Ctte

Negative Assurance

Date	Assurance	Source
March 2018	Staff engagement/experience scores for disabled staff	NHS Staff Survey
Nov 2018	vacancy position particularly in stroke and, theatres Service pressures /gaps in microbiology,dermatology and medical oncology Middle grade gaps in A&E and Paediatrics Increase in year to date sickness absence Q2 SFFT response rates/results Nurse staffing data publication report Equality Update 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	⟷	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

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 to be developed by end Q4

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	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		
Date	**Assurance**	**Source**
MONTHLY	Serious Incident Report	Quality Committee
QUARTERLY	Combined Learning Report	Quality Committee
	Leadership Walk round update	Quality Committee
	Learning from Deaths	Quality Committee
	Patient Experience	Quality Committee
	Guardian of Safe Working Hours	Workforce Committee
ANNUALLY	Safer Procedures	Quality Committee
	Patient Safety Sub- Committee Report	Quality Committee
	Research Translation & Innovation Report	
	Quality Account	Quality Committee
		Quality Committee
Oct 2018	Focus on Medication Safety	Quality Committee
Oct 2018	Patient Safety & Health & Safety Management Compliance	Quality Committee
Oct 2018	Treat as one update	Quality Committee
Oct 2018	Safeguarding Adults update	Quality Committee
Nov 2018	GIRFT Visits Paediatric Surgery & Dentistry	
Nov 2018	Quality Assurance of Postgraduate Medical Education GMC National Training Survey 2018	Quality Committee Data pack-GIRFT Workforce Committee
Nov 2018	Library Quality Assurance Framework [LQAF] Compliance result – 99%	Letter to Chief Executive from HEE 30/11/2018

Negative Assurance		
Date	**Assurance**	**Source**
MONTHLY	Serious Incident Report	Quality Committee
QUARTERLY		
ANNUALLY		
Sept 2018	Guardian of Safe Working Hours	Workforce Committee
Nov 2018	Safeguarding Children's Update	Quality Committee

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 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	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
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
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/ 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	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	2017/18		2018/19	
					Q3	Q4	Q1	Q2
Executive Lead	John Holden	Assuring Committee	Partnership Committee					

Positive Assurance		
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

Negative Assurance		
Date	**Assurance**	**Source**
05 Oct	Partnerships Committee noted the difficulties arising from potentially moving to new Partnership Operating Framework and Partnership Agreement (now known as Strategic Partnering Agreement) within the Bradford District and Craven place.	P.10.18.6

Gaps in Assurance

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

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	
					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

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 integrated care)
   - Integrated Management Board (IMB) of Bradford Provider Alliance
   - WYAAT Committee in Common
   - Design group for SPA

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
7. Papers for Integration and Change Board, and Health and Care Partnership Board
8. 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	7 December 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
4	Set up sub group for ED input into collaboration with AFT.	JH	7 Dec 2018	30 January 2018			Meeting set up with Director of strategy and MD to assess how to complete action	
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	30 November 2018		20 Nov 18	System introduced where feedback on progress of collaborative programmes I gained from EDs. This feedback is then assessed by S&I team against overall KPIs. This will be supplemented by assessing the externally produced metrics/reports that are created as part of vertical and horizontal workstreams and associated governance.	Email to EDs 20 November
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 18	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 18	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
	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	Seek written comments on SPA (key opportunity to influence its development) and this BAF.	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

Bradford Teaching Hospitals NHS
NHS Foundation Trust

Appendix 1 Corporate Risk Register

CORPORATE RISK REGISTER: PRINCIPAL RISKS

		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	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	
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