

BOARD ASSURANCE FRAMEWORK: Quarter 4 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										Q4 2018_19	
Assurance Overview						Date		27/3/2019			
Strategic Objective		Current Assurance Level	Reason for Assurance Level	Executive Lead	Assuring Committee	Quarterly assurance ratings				Risk	
						18/19					
						Q1	Q2	Q3	Q4	Principal composite	Highest
1	To provide outstanding care for our patients		There is confidence that structures and processes to identify and support the mitigation of risk associated with the achievement of this strategic objective are established. The Quality Committee recognises that significant improvements have been made and sustained. The Committee will undertake a formal review of achievements and performance during 2018/19 at the April meeting.	Chief Nurse/ Medical Director	Quality					12	16
2a	To deliver our financial plan		The Income & Expenditure (I&E) financial plan is being delivered as at month 11 (February 2019). This is against a planned year to date pre-PSF deficit of £7.7m. The annual control total pre-PSF deficit of £7.5m requires a £0.2m surplus to be delivered in Month 12. The Trust has introduced a range of recovery measures to improve the underlying run rate and subsequently forecast delivery of the annual control total, albeit a number of material risks remain. The level of risk to this forecast has increased in Month 11 and as a consequence year end control total delivery cannot be certain until the Month 12 position is finalised. To protect the cash and liquidity position, measures have been taken to safely reduce the capital expenditure plans in 2018/19.	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. Target for sustainability is 20-25. 2WW modelling has been undertaken and additional capacity now provided. Due to an increase in prostate 2ww referrals there is a need for increased capacity on a longer term basis. A locum has been appointed providing additional 2ww prostate capacity and a business case has been developed for a substantive consultant. There are a number of specialties showing a demand and capacity gap. RTT has improved month on month and recovery plans are on track to improve to 86-89% by March 19. The waiting list has reduced by 50% over the last 6 months. There is still a need to correct some ongoing DQ issues.	Chief Operating Officer	Finance and Performance					16	20
3	To be in the top 20% of employers in the NHS		The Committee was assured that significant progress is being made across a range of key workforce indicators. Evidence is being routinely presented to Committee demonstrating tangible assurance. Concerns re vacancies in key areas remain with performance below metric in some areas. The Committee have reviewed the risk appetite and composite risk rating for this strategic objective at the February meeting, and a proposal was agreed at the march meeting to revise the appetite to 'seeking'	Director of Human Resources	Workforce					12	12
4	To be a continually learning organisation		Evidence continues to be presented to Committees and Board which demonstrates the significant progress made, recognising that there are further opportunities for change and improvement. The Quality Committee will undertake a full review of achievements and performance during 2018/19 in April 2019.	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		2018/19				
											Q1	Q2	Q3	Q4	
Executive Lead		Karen Dawber/Bryan Gill			Assuring Committee		Quality								
Positive Assurance (bold received to date in quarter)					Negative Assurance (bold received in quarter)					Gaps in Assurance		Rationale for Assurance Level			
Date	Assurance			Source	Date	Assurance			Source	Any gaps identified have been managed within the business of the committee through the provision of enhanced assurance		There is confidence that structures and processes to identify and support the mitigation of risk associated with the achievement of this strategic objective are established. The Quality Committee recognises that significant improvements have been made and sustained. The Committee will undertake a formal review of achievements and performance during 2018/19 at the April meeting.			
Monthly	Safe Staffing report Quality Committee Dashboard and trend analysis Information Governance report Quality oversight system			Report	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 Patient experience report Freedom to speak up report			Report	Quarterly	Incident report Clinical Effectiveness report			Report to Quality Committee						
Annual	Sub Committee reports Data Security Protection Toolkit			Report	Annual				Report to Quality Committee						
January	Maternity report (Quarterly) Focus on: safer procedures, pressure ulcers, IPCC			Reports	January										
February	Cyber security assessment Sepsis progress report			Reports	February	National audit Care at end of life presentation			Report to Quality Committee						
March	IPCC report			Reports											

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

High Level Controls (From Quality Plan 2018/19)		Gaps in controls	Routine Sources of Assurance	Risk Appetite
Quality Strategy Risk management strategy Patient experience strategy Quality Oversight System Infection Prevention and Control Standards LocSSIPs programme Quality improvement collaboratives: harm free care Incident reporting benchmarking SAFER implementation programme NICE guidance implementation programme Delayed Transfers of Care benchmarking Policy and Procedure compliance benchmarking National Audit Programme Health and safety benchmarking Structured Judgement Review Programme	Friends and Family test National Inpatient survey Other National Patient Surveys Complaint benchmarking CQC compliance action plan Performance (RTT/ECS/Cancer) benchmarking PLACE assessments Freedom to Speak Up programme Bradford Accreditation Scheme Workforce: Safe staffing standards, appraisal, mandatory training, sickness absence benchmarking, Placement satisfaction benchmarking (medical students) Data Security Protection Toolkit Internal audit reports relevant to controls	Implementation of always events Real time quality data: sepsis indicators	Exception reports from Sub Committees (from February 2019) Patient experience report Risk management report Serious Incident report Effectiveness Report CQC compliance reporting Safeguarding report Learning report Learning from deaths report Quality Committee Dashboard Quality Oversight System report Infection Prevention and control report Safe staffing report Escalation of risks to quality from other Board Committees	Cautious. Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward

BOARD ASSURANCE FRAMEWORK	Strategic Objective	1	To provide outstanding care for our patients	Action Plan to address Gaps in Controls and Assurance
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				Date of update	27/3/2019
Accountability			Responsibility		
Lead	Oversight/governance structure		Lead	Work-stream/operational group	
Chief Nurse (CN)	Quality Committee		Deputy Medical Director (DMD)	Infection Prevention and Control Committee Patients First Committee Going Digital Programme Board	
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	June 2019	O		This is part of ongoing work to optimise the data available from EPR and its associated analytics. This is being tested in maternity services		
2	To ensure that the Trust has appropriate metrics and processes in place to monitor the quality of sepsis care and management	CNIP	June 2018	October 2018	C	September 2018	Presented to quality committee in September	Paper presented to Quality Committee	
3	To implement Always Events through the implementation of the Patient Experience Strategy	CN	Jan 2019	September 2019	O				

Objective	2	To address gaps in assurance related to achievement of this strategic objective							
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence	
1	To ensure that the national inpatient survey and a summary of recommendations is received by the Quality Committee in July 2018	CN	June 2018	July 2018	C		Presented to quality committee in August 2018		

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

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

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source		
March 2019	Financial recovery plan – February planned trajectory delivered.	Finance and Performance Oversight Committee Report	March 19	Cash position compromised by non-recurrent income and expenditure measures deployed in 2018/19	Finance report and FPOC report	Definitive plans to secure the full value of control total requirement on a recurrent and sustainable basis: Risk of data quality and activity delivery issues on contract negotiations; Newly mitigated	The Income & Expenditure (I&E) financial plan is being delivered as at month 11 (February 2019). This is against a planned year to date pre-PSF deficit of £7.7m. The annual control total pre-PSF deficit of £7.5m requires a £0.2m surplus to be delivered in Month 12. The Trust has introduced a range of recovery measures to improve the underlying run rate and subsequently forecast delivery of the annual control total, albeit a number of material risks remain. The level of risk to this forecast has increased in Month 11 and as a consequence year end control total delivery cannot be certain until the Month 12 position is finalised. To protect the cash and liquidity position, measures have been taken to safely reduce the capital expenditure plans in 2018/19.
Dec 18	Capital Programme Review to protect cash and liquidity	Finance Report					
Dec 18	Conclusion of negotiations with host Commission to agree a forecast income quantum for 2018/19	Finance Report					
Mar 19	EPR Pathway/Activity Data Significant Report	Internal Audit Report					

Key performance Indicator		Principal Risk(s)		Potential consequences	Composite risk rating (strategic risks)					Component risks >12	
					Initial	Residual	Target	Current	Direction of travel	Number	Highest Current
a	Deliver 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	20

High Level Controls	Gaps in controls	Routine Sources of Assurance	Risk Appetite
Executive led Divisional Financial performance management Bradford Improvement Plan Governance Performance management of CIP delivery Budget setting and business planning Quality Impact Assessment and Financial Impact Assessment process Standing Financial Instructions and Scheme of Delegation CEO led Finance & Performance Oversight Committee (FPOC) Annual Accounts with a clean audit opinion	Delivery of the control total in full through BIP plans and additional recovery measures	Director of Finance report to Finance and Performance Committee and Board – including assessment of NHSI ‘Use of Resources’ framework Bradford Improvement Plan Report to Finance and Performance Committee and Board of Directors Internal Audit Committee Reports on controls assurance Audit Committee Report to Board Finance & Performance Committee Dashboard Board Integrated Dashboard Finance & Performance Oversight Committee Report to Finance and Performance Committee and Board of Directors	Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward

BOARD ASSURANCE FRAMEWORK	Strategic Objective	2a	To achieve our financial plan	Action Plan to address Gaps in Controls and Assurance
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				Date of update	27/3/2019
Accountability				Responsibility	
Lead	Oversight/governance structure			Lead	Work-stream/operational group
Director of Finance (DoF)	Finance and Performance Committee			Chief Executive	Finance and Performance Oversight Committee
Chief Operating Officer (COO)					

Objective	1	To address gaps in controls that compromise the assurance related to this strategic objective							
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence	
1	Delivery of the control total in full through BIP plans and additional recovery measures	DoF COO	30.11.18	31.3.19	OC		The recovery plan measures to be taken between December 18 and March 19 are performance managed through the Finance and Performance Oversight Committee (FPOC) that is chaired by the Chief Executive. The FPOC reports directly to the Finance and Performance Committee and Board of Directors	Minutes of meetings Achievement of control total	

Objective	2	To address gaps in assurance related to this strategic objective							
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence	
1	Definitive plans to secure the full value of CIP requirement on a recurrent and sustainable basis	DoF COO	30.11.18	31.3.19	OC		Plans are in place to deliver the control total in 2018/19 but not on a sustainable basis. The financial plan for 2019/20 will target delivery of sustainable measure to secure the new control total.	Issuance of the 2019/20 Control Total and production of the Operational and Financial Plan	
2	Risk of data quality and activity delivery issues on contract negotiations	DoF	30.9.19	31.12.2019	C	31.12.2019	Contract negotiations concluded	Finance Report Informatics Report Audit Reports	

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

BOARD ASSURANCE FRAMEWORK			Strategic Objective	2b	To deliver our key performance targets			Assurance Level	2018/19				
									Q1	Q2	Q3	Q4	
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							
Mar 2019	Implementation of the action plan to improve the ECS performance Daily performance reporting of ECS	ECS Action Plan EPR – Trust performance team		Mar 2019	Current performance in relation to ECS standard	Performance Report to Finance & Performance Committee Staffing rotas.		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.				
Mar 2019	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		Mar 2019	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. Target for sustainability is 20-25. 2WW modelling has been undertaken and additional capacity now provided. Due to an increase in prostate 2ww referrals there is a need for increased capacity on a longer term basis. A locum has been appointed providing additional 2ww prostate assessment clinic capacity and a business case has been developed for a substantive consultant.		
Mar 2019	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	Mar 2019	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 demand and capacity gap. RTT has improved month on month and recovery plans are on track to improve to 86-89% by March 19. The waiting list has reduced by 50% over the last 6 months. There is still a need to correct some ongoing DQ issues.							

Key performance Indicator		Principal Risk (s)		Potential consequences	Composite risk rating (strategic risks)					Component risks>12	
					Initial	Residual	Target	Current	Direction of travel	Number	Highest Current
	To achieve organisational trajectories set 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	↔	2	20
		6	Failure to maintain sustainable contracts with commissioners	Loss of market share, loss of public confidence, lack of service sustainability	12	6	6	12	↓	1	12

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

BOARD ASSURANCE FRAMEWORK			Strategic Objective	2b	To deliver our key performance targets	Action Plan to address Gaps in Controls and Assurance
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				Date of update	27/3/2019
Accountability			Responsibility		
Lead	Oversight/governance structure	Lead	Work-stream/operational group		
Deputy Director of Operations	Urgent Care Improvement Programme	AED leadership	Emergency care Access and flow		
Deputy Director of Operations	Urgent Care Improvement Programme	Deputy Director of Operations	Hospital Flow and discharge		
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	OD		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	31/8/18	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.	Validation SOP	
2.	Cancer – To put in place a detailed recovery plan for prostate and 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. Monies have been provided through the cancer alliance to increase prostate 2ww diagnostic capacity. 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				18/19			
												Q1	Q2	Q3	Q4
Executive Lead		Pat Campbell			Assuring Committee		Workforce								
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			
Feb 2019		Workforce report Nurse staffing data publication report 95% target met on appraisals Overall nurse vacancy position Staff engagement QA of postgraduate medical education Turnover stable Reduction in agency, increase in bank,increase in staff in post Flu vaccination target achieved Mandatory training trajectories		Workforce Committee		March 2018		Staff engagement/experience scores for disabled staff		NHS Staff Survey					
						Feb 2019		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		The Committee was assured that significant progress is being made across a range of key workforce indicators. Evidence is being routinely presented to Committee demonstrating tangible assurance. Concerns re vacancies in key areas remain with performance below metric in some areas. The Committee have reviewed the risk appetite and composite risk rating for this strategic objective at the February meeting, and a proposal was agreed at the march meeting to revise the appetite to ‘seeking’			
Key performance Indicator		Principal Risk (s)		Potential consequences		Composite risk rating (strategic risk register)					Component risks >12				
						Initial	Residual	Target	Current	Direction of travel	Number	Highest Current			
A	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	↔	1	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 Bi -Annual review of nurse and midwife staffing establishments Mandatory training and appraisal performance management Education and workforce Committee Human Resources Policies and Procedures Equality objectives/ WRES Action plan/Equality plan NHS QUEST Standards when developed		Contemporaneous staff experience data Urgent Care staffing model – does not meet demand – refer to action plan under 2b –paper going to March Board of Directors Workforce plan to match clinical services strategy in development		Workforce report Workforce Committee Dashboard Board Integrated Dashboard HEE/NHSI workforce return/workforce plan Junior Doctor fill rates Update report on staff survey action plan Nurse recruitment and retention plan GMC survey Nurse staffing data publication report Bi-annual review report of nurse and midwife staffing Medical appraisal and revalidation report Quarterly ‘freedom to speak up guardian’ return Workforce Race Equality Standard Report Guardian of safe working hours report Staff Friends and Family Test EWin/Model Hospital portal for benchmarking purposes Audit reports Staff Advocate service contacts and outcomes Leadership walkarounds		Seeking: Eager to be innovative and to choose options offering potentially higher rewards									

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	27/3/2019
Accountability			Responsibility		
Lead	Oversight/governance structure		Lead	Work-stream/operational group	
Director of Human Resources (DHR)	Workforce Committee		DHR	Education and Workforce Sub Committee	
			Deputy Director of Human Resources (DDHR)		
			Assistant Director of Human Resources (ADHR)		

Objective	1	To address gaps in controls that compromise the assurance related to this strategic objective							
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence	
1	To review methods for getting more contemporaneous staff experience data out with SF&F and NHS Staff Survey	DDHR	01.07.2018	30.09.2018	C		To be picked up through staff engagement actions and reported to E&W Committee. Limited outcome-to be reviewed at March meeting.	Proposal developed	
2	To undertake a strategic workforce review	DDHR	06.2018	31.03.2019	OC		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	18/19			
								Q1	Q2	Q3	Q4
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		
MONTHLY	Serious Incident Report	Quality Committee	MONTHLY	Serious Incident Report	Quality Committee		
QUARTERLY	Combined Learning Report Leadership Walk round update Learning from Deaths Patient Experience Guardian of Safe Working Hours	Quality Committee Quality Committee Quality Committee Quality Committee Workforce Committee	QUARTERLY				
ANNUALLY	Safer Procedures Patient Safety Sub- Committee Report Research Translation & Innovation Report Quality Account	Quality Committee Quality Committee Quality Committee	ANNUALLY				
Jan 2019	Focus on Safer procedures, pressure ulcers and IPCC Patient Safety & Health & Safety Management Compliance Library Quality Assurance Framework [LQAF] Compliance result – 99% Update on Safer Procedures Collaborative Education & Training Self –Assessment Update on 7 Day Working External GIRFT Visit – Renal [External Visit Report]	Quality Committee Quality Committee Quality Committee Quality Committee Letter to Chief Executive from HEE 30/11/2018 Quality Committee Workforce Committee Integrated Risk & Governance					
Feb 2019 19/02/2019	External GIRFT visit – Dermatology [External Visit Report]	Integrated Risk & Governance					

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

High Level Controls	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 CQC Compliance Action Plan GMC National Training Survey 2018	Lack of a single dashboard to reflect this strategic objective.	Quarterly learning report National Education Surveys ESR reports Board Integrated Dashboard National Audits GIRFT Data Packs/ Visits	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	27/3/2019
Accountability			Responsibility		
Lead	Oversight/governance structure		Lead	Work-stream/operational group	
Dr Bryan Gill	Quality Committee & Patient Safety Sub Committee		DMD		

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

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

BOARD ASSURANCE FRAMEWORK		Strategic Objective	5	To collaborate effectively with local and regional partners			Assurance Level	2018/19			
								Q1	Q2	Q3	Q4
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	Ensuring there is regular formal but also flexible oversight from EDs as partnership work with Airedale quickly gathers pace	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.
Jan 2019	Positive progress across “horizontal” integration and as well as Acute service collaboration with Airedale NHS FT.	Report to partnerships Committee	Jan 2019	Partnerships dashboard	Dashboard		
Jan 2019	WYAAT Programme Directors report	Closed Board					
Jan 2019	Partnerships dashboard	Dashboard					

Key performance Indicator		Principal Risk (s)		Potential consequences	Composite risk rating					Component risks >12	
					Initial	Residual	Target	Current	Direction of travel	Number	Highest Current
1	Local integrated care (“vertical” integration): assessment of strategy and integration directorate of progress towards BTHFT’s strategic goals in this area.	7	Failure to deliver strategic partnerships	Missed opportunity to implement clinical strategy and improve patient care due to e.g. destabilised clinical services, loss of market share, reputational damage, financial loss, operational issues	12	9	9	12	↔	1	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
EMT Governance 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 integrated care) Integrated Management Board (IMB) of Bradford Provider Alliance WYAAT Committee in Common Design group for SPA 	Need to better co-ordinate activity and information within the trust (exec and senior managers) related to vertical and horizontal integration.	1. Stakeholder engagement survey 2. WYAAT Programme Director’s Report (feeds in to Committee in Common, WYAAT CEOs and sub groups eg FDs, Med Directors, Strategy & Ops) 3. Papers for STP System Leadership Executive (by exception) 4. Discussions and papers for Acute Collaboration Programme (with AFT) 5. Partnerships Dashboard 6. Papers for Integration and Change Board, and Health and Care Partnership Board (by exception) 7. Papers for Integrated Management Board of Bradford Provider Alliance (currently chaired by BTHFT).	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
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				Date of update	27/3/2019
Accountability				Responsibility	
Lead	Oversight/governance structure			Lead	Work-stream/operational group
Director of Strategy and Integration	Partnerships Committee of BTHFT Board			Head of Policy	Horizontal integration (WYAAT/STP); acute collaboration programme (ie AFT)
				Head of Partnerships	Vertical integration (Bradford); stakeholder engagement

Objective	1	To address gaps in controls that compromise the assurance related to this strategic objective						
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
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

Annex 1 Strategic Risk Register

STRATEGIC RISK REGISTER: PRINCIPAL RISKS (Overview)

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

Appendix 2: Board Assurance Framework Legend					
Descriptors		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	