Meeting Title	Council of Governors		
Date	18 April 2019	Agenda item	CGo.4.19.14

Understanding our progress towards achieving our Strategic Objectives:
The work of the Board Committees
A report to the Council of Governors

Presented by	Tanya Claridge, Director of Governance and Corporate Affairs	
Author	Tanya Claridge, Director of Governance and Corporate Affairs	
Lead Director	John Holden, Acting Chief Executive	
Purpose of the paper	This paper has been written to provide an overview of the work of the Board Committees in assuring that the risks to achieving our strategic objectives have been identified and are being managed appropriately	
Our strategic objectives and the roles of our Board Committees		
1	To provide outstanding care for patients	Oversight and assurance is provided by the **Quality Committee**
2	To deliver our financial plan and key performance targets	Oversight and assurance is provided by the **Finance and Performance Committee**
3	To be in the top 20% of employers	Oversight and assurance is provided by the **Workforce Committee**
4	To be a continually learning organisation	Oversight and assurance is provided by the **Quality Committee**
5	To collaborate effectively with local and regional partners	Oversight and assurance is provided by the **Partnerships Committee**

The **Integrated Governance and Risk Committee** reviews the strategic risks being managed across the organisation, those that could have a direct impact on the achievement of our strategic objectives if not managed appropriately, and makes sure that the controls we have in place and the actions we are taking are effective.
The **Major Projects Committee** receives the Board Assurance Framework and Strategic Risk Register and so acknowledges the progress the Trust is making towards achieving its strategic objectives and understands the risks that are being managed to support this achievement in the decisions that it makes.
The **Audit and Assurance Committee** now reviews and comments on the effectiveness of the assuring functions of the Board Committees above through a routine report, and reports on this to the Board of Directors.

Oversight and assurance

All Committees with an **Oversight and Assurance** role are chaired by a Non-Executive Director. They also have a nominated Executive Director lead.
In setting the Terms of Reference for its Committees, the Board of Directors identified the **key controls** we have in the Trust (which are designed to support the management and control of the risk we may experience in achieving our strategic objectives) for which it requires assurance in relation to their effectiveness. These key controls are reflected in the Committee work-plans, ensuring that their associated assurance is defined, considered at appropriate intervals and in the appropriate depth. These are also described on the **Board Assurance Framework**.
The **Board Assurance Framework** is a key tool for the Committees in their assuring role. They use it to proactively

1) Review the **Strategic Objective** and its associated **Key Performance** Indicators. They

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use the **Integrated Committee Dashboard** to review detailed metrics associated with key performance indicator performance.

2) Remind itself of the Board agreed '**risk appetite'**-(the amount of risk the Trust is prepared to take in order to achieve its strategic objective-both opportunistic and operational risk)
3) Review the **strategic risks** being managed relevant to the strategic objective, the committees look at this in two ways-an overarching **principal risk** and also the **component risks** (these are the risks on the strategic risk register) which relate to that principal risk
4) Review the **controls** and ensure there are **no gaps in controls** which require addressing
5) Review the **assurance** received, through the business of the Committee, and assess whether there are any **gaps in assurance** and whether the assurance received **is positive,** i.e. reinforces the effective achievement of the strategic objective, or may reflect **a risk**. The Committee, in that case will often require additional assurance.
6) Review the **overall assurance statement** relating to the achievement of the strategic objectives, which describes the **level of confidence**, based on the information they have reviewed and the assurance they have seen

The effectiveness of the oversight and assurance Committees

The Audit and Assurance Committee considers key elements of the Board Committee business cycle, such as quoracy, the management of work-plans, meeting governance, effective escalation of risk, management of gaps in controls and in assurance.

The assurance provided by the Board Committees in respect of the achievement of the Trust's Strategic Objectives

The Appendices of this paper are designed to reflect the work of the assuring Committees in relation to the achievement of the Trust's Strategic Objectives.

Appendix 1: The overall Board Assurance Framework
Appendix 2: Strategic Objectives 1 and 4: the Quality Committee
Annex 1: The Committee Overview Report (January and February 2019)
Annex 2: The Board Assurance Framework (Updated in March 2019)
Annex 3: Board Committee Oversight Report
Appendix 3: Strategic Objective 2: The Finance and Performance Committee
Annex 1: The Committee Overview Report (January and February 2019)
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Annex 1: The Committee Overview Report (January and February 2019)
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Appendix 5: Strategic Objective 5: the Partnerships Committee
Annex 1: The Committee Overview Report (January and February 2019)
Annex 2: The Board Assurance Framework (Updated in March 2019)
Appendix 6: The Audit and Assurance Committee Overview report

CoG.4.19.14 - Appendix 1 Board Assurance Framework Overview

Bradford Teaching Hospitals NHS Foundation Trust

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 18/19				Risk	
						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 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

Bradford Teaching Hospitals NHS Foundation Trust

Meeting Title	Board of Directors		
Date	7/3/2019	Agenda item	Bo.3.19.10

A report from the Chair of the Quality Committee

Presented by	Laura Stroud, Non-Executive Director
Author	Tanya Claridge, Director of Governance and Corporate Affairs
Lead Directors	Bryan Gill, Medical Director; Karen Dawber, Chief Nurse
Purpose of the paper	This paper is to provide the Board of Directors with an overview of the work of the Quality Committee in January and February 2019.
Key control	This paper is a key control for the strategic objectives to provide outstanding care for patients and to be a continually learning organisation
Action required	To note

Background

The purpose of the Quality Committee is to provide detailed scrutiny of the Foundation Trust's arrangements for the management and development of safety, effectiveness and patient experience in order to provide assurance and, if necessary, raise concerns or make recommendations to the Board of Directors.

The Quality Committee uses the assurance presented throughout its meeting, which is aligned to key controls for identified risks associated with delivering the Trust's strategic objectives

- to provide outstanding care for patients and
- to be a continually learning organisation

in combination with a review of the relevant risks on the strategic risk register to review the Trust's Board Assurance Framework. At the end of each meeting consensus is achieved in relation to the assurance level and associated statement. This is presented in the Board Assurance Framework.

Key Matters Discussed

1. Are our Services safe?

1.1 Strategy: Quality Dashboard

The Quality Dashboard is reviewed at every meeting and specific areas of quality performance considered have been:

- There has been sustained improvement on the sepsis indicators following the improvement programme, noting the positive impact of the EPR and the appointment of the sepsis nurse.
- Strong performance has been maintained on a number indicators including VTE assessment, Clostridium difficile, HSMR and MRSA.

1.2 Governance: Quality Oversight System

The Committee was informed of the work of the Quality Oversight system and noted the quality summit programme which includes: Stroke, Maternity, Theatres, Haematology and Accident and Emergency services. It was assured that the appropriate level of scrutiny was in place and that the risks described corresponded with those that are currently being managed on the Strategic Risk Register or had been highlighted previously to the Committee.

The Committee were informed of a current CQC inspection into safeguarding and looked after children services across the health economy, which involved maternity, accident and emergency and paediatric services in the Trust. The Committee will receive formal feedback when the inspection process is concluded.

1.3 Key Control: Serious Incidents

The Committee receives a report detailing serious incidents declared and serious incident investigations completed at each meeting. The Committee was assured the governance associated with management of this type of incident, and explicitly the identification of recommendations and learning was proportionate and

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appropriate**.**

1.4 Key Control: Safe Staffing

The Committee receives a report relating to safe staffing every month, this report is also received by the Workforce Committee. The Committee was alerted to areas of potential risks and decided that it was assured that appropriate mitigation was in place to manage risk associated with staffing.

1.5 Key Control: Safer Procedures

The Committee received assurance in relation to the safer procedures collaborative, but also a specific piece of work being undertaken to assure the Trust's response to the implementation of National Safety Standards for Interventional Procedures (NatSSIPs). The Committee will receive further assurance during quarter 1 2019/20.

1.6 Risk: Sepsis

The Committee received a presentation in relation to the progress with the sepsis action plan and the implementation of NEWS2 (the revised national early warning score) and were assured that the actions currently in progress were effective.

1.7 Risk: VTE information for patients

The Committee received assurance in relation to the response made by the Trust in relation to a Regulation 28 notice from HM Coroner. The Committee was satisfied that the Trust had responded appropriately and proportionately.

2. Are our services effective?

2.1 Key Control: Information Governance

The Committee reviewed the content of the Information Governance report and the Senior Information Risk Owner's (SIRO) report and decided that it was assured that information governance was being effectively managed in the Trust and that actual and latent risks were being managed appropriately.

2.2 Key Control: Effectiveness Report (Quarter 2)

The Committee received the Quarter 3 Clinical Effectiveness report. It again acknowledged the concerns described about the participation of the Trust in the National Audit Programme, but decided that it was assured that risks were being identified and managed in a consistent way and mitigated appropriately. The Committee also decided that it was assured that the appropriate governance is in place to manage the clinical effectiveness programme of work in general, and to effectively escalate actual, emergent and latent risk. The Committee are keen that the Trust's approach to the High Priority Audit Plan for 2019/20 is reflective of both the mandated national audit programme but also of the quality improvement priorities of the organisation.

3. Are our services responsive?

3.1 Key Control: End of Life Care National Audit

The Committee received a presentation from the Palliative Care team, subsequent to the receipt of the national audit report. The Committee were again informed of capacity and demand issues within the service, and clear opportunities for change and improvement. The Committee requested that the issues raised were discussed at a meeting of the Executive Management Team.

1. Are our services caring?

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1.1 Key Control: Patient Experience Report (Quarter 2)
The Committee received the Quarter 3 patient experience report. The Committee noted positive achievements described in the report, but required further information and assurance at its next meeting associated with the maternity inpatient survey.

2. Are our services well led?

2.1 Governance: Quality Account
The Committee received an update in the progress with the actions described in the 2017/18 Quality Account relating to Pressure ulcers and safer interventional procedures (see 1.5). The Committee reviews the incidence and harm caused by pressure ulcers on a monthly basis and received detailed assurance in relation to the progress being made and the governance associated with the reporting, investigating and learning from pressure ulcers occurring where there have been identified omissions in care, but also in relation to the impact of the quality improvement initiatives which are being implemented across the Trust.

2.2 Key Control: Freedom to Speak Up Quarter 3 report
The Committee received this report and noted the governance associated with this initiative in relation to both workforce and governance issues.

2.3 Key Control: Bradford Accreditation Scheme
The Committee approved the Bradford Accreditation Scheme, which is designed to accredit care environments (wards/departments) based on a range of quantitative and qualitative measures of quality. The Committee was informed of the governance and escalation of concerns framework in relation to this scheme.

2.4 Risk: Maternity Services Report
The Committee noted this report and required further assurance in relation to the sustainability of the changes and improvements being made in the quarter 4 report.

2.5 Governance: Sub-Committee reports
The Committee received reports from the Patient Safety Sub-Committee and the Children and Young Peoples Board. It also received a report from the Research, Translation and Innovation Committee. The Committee was assured in respect of the work being undertaken by its sub-committees and other committees which support the assurance associated with the achievement of the strategic objectives.

Recommendation

The Board of Directors is requested to note the work of the Quality Committee in scrutinising the Foundation Trust's arrangements for the management and development of safety, effectiveness and patient experience. It is also asked to note the assurance level and statement agreed by the Committee which is provided on the Board Assurance Framework.

Strategic Objective 1: To provide outstanding care for patients
Limited Confidence: There is increasing 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 the improvements that have been made and will undertake a formal review of achievements and performance during 2018/19 at the April meeting.

Strategic Objective 4: to be a continually learning organisation
Confidence: Evidence continues to be presented to Committees and Board which demonstrates the significant progress made, recognising that there are further opportunities for change and improvement. The Quality Committee will undertake a full review of achievements and performance during 2018/19 in April 2019**.**

Bradford Teaching Hospitals
NHS Foundation Trust

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Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for patients		g				
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers			g			
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Risk Implications	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	▪	
Quality implications	▪	
Resource implications	▪	
Legal/regulatory implications	▪	
Diversity and Inclusion implications		▪

Regulation, Legislation and Compliance relevance
NHS Improvement: Risk assessment framework, quality governance framework, code of governance , annual reporting manual
Care Quality Commission Domain: *Safe, caring, effective, responsive, well led*
Care Quality Commission Fundamental Standard:
Other (please state):

Relevance to other Board of Director's Committee:					
Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)
▪	▪				

Bradford Teaching Hospitals NHS Foundation Trust

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

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

Negative Assurance (bold received in quarter)		
Date	Assurance	Source
Monthly	**Safe Staffing report** **Quality Committee Dashboard and trend analysis** **Serious incident report**	Report to Quality Committee
Quarterly	**Incident report** **Clinical Effectiveness report**	Report to Quality Committee
Annual		Report to Quality Committee
January		
February	National audit Care at end of life presentation	Report to Quality Committee

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

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

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

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

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

Routine Sources of Assurance
Exception reports from Sub Committees (from February 2019)
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

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

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

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

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

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

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

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

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

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		
Date	**Assurance**	**Source**
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
ANNUALLY	Safer Procedures Patient Safety Sub- Committee Report Research Translation & Innovation Report Quality Account	Quality Committee Quality Committee Quality Committee
Jan 2019 23/01/2019	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 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

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

Gaps in Assurance
Further work required to ensure that data can be extracted to evidence and assure compliance with Core and High priority training targets. Identification of risks associated with the delivery of the objectives.

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

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

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

Gaps in controls
Lack of a single dashboard to reflect this strategic objective.

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

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

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

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

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

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

Annex 1 Strategic Risk Register

STRATEGIC RISK REGISTER: PRINCIPAL RISKS (Overview)

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

Appendix 2: Board Assurance Framework Legend

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

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

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

CoG.4.19.14 - Appendix 2 Annex 3 - Board Committee Summary

Board Committee Process and Governance Oversight

Committee	**Quality**		**Chair**	Laura Stroud
Meeting Dates	27/2/2019	27/3/2019	**Executive Lead (s)**	Chief Nurse Chief Medical Officer
Confirmed minutes available	Yes	No		

Strategic Objective(s) Assured		**Level of Assurance**	**Comments (Updated BAF is attached at Appendix 2 of this paper)**
1	**To provide outstanding care for patients**	Confident (27/3/2019)	The Committee agreed to change the level of assurance associated with the achievement of this strategic objective considering the strategic risk profile and the assurances received in the course of its business.
4	**To be a continually learning organisation**	Confident (27/3/2019)	The Committee agreed to maintain the level of assurance associated with the achievement of this strategic objective considering the strategic risk profile and the assurances received in the course of its business

Work-plan (Consideration of key controls and assurance)	**Gaps in controls identified and action taken**
The work-plan for 2019/20 has been agreed for the Committee. The Committee is assured that the work-plan enables the consideration of assurance associated with all controls in a timely and proportionate way. The Committee has completed all required work-plan items at the meetings included in this report. In addition the Committee considers the agenda for the subsequent meeting at each meeting to assure themselves that work-plan items are included and any required additional information or assurance identified as being required is included.	1) Mandatory training: the committee requested that the monitoring of mandatory training was undertaken at the workforce committee 2) Governance elements of the integrated dashboard-the committee endorsed the request of the Board to review the metrics to enable a more accurate assessment of the performance of governance systems in the Trust 3) Risk management strategy and quality management system: Committee requested a formal update on the progress with implementing the Risk Management Strategy and sight of the assurances received by the Audit and Assurance Committee.

Gaps in assurance identified and action taken	**Committee Governance**		
1) Maternity Service-patient survey: the Committee requested additional assurance in relation to the actions being taken to address the results of the survey 2) Sepsis-the committee requested additional assurance in relation to the delivery of the Sepsis improvement Programme 3) Security standards-the committee requested additional assurance in relation to the progress being made with the compliance actions being taken	**Quoracy**		
	Conduct	Papers published as per terms of reference	
		Agenda items completed at meeting	
		Actions completed by deadlines	
		Received escalations from other Committees effectively	
		Reported to Board as per terms of reference	
	Report Date	29/3/2019	
	Report Author	Director of Governance and Corporate Affairs	

Bradford Teaching Hospitals NHS Foundation Trust

Meeting Title	Board of Directors		
Date	07/03/2019	Agenda item	Bo.3.19.14

A report from the Chair of the Finance and Performance Committee

Presented by	Trevor Higgins, Non-Executive Director
Author	Tanya Claridge, Director of Governance and Corporate Affairs
Lead Directors	Sandra Shannon, Chief Operating Officer; Matthew Horner, Director of Finance
Purpose of the paper	This paper is to provide the Board of Directors with an overview of the work of the Finance and Performance Committee in September and October 2018.
Key control	This paper is a key control for the strategic objective to deliver our financial plan and our key performance indicators
Action required	To note

Background

The purpose of the Finance and Performance Committee is

- to maintain a detailed overview of the Trust's assets and resources in relation to the achievement of financial targets, business objectives and the financial stability of the Trust
- to provide detailed scrutiny of performance matters

and if necessary, raise concerns or make recommendations to the Board of Directors.

The Finance and Performance Committee uses the assurance presented throughout its meeting, which is aligned to key controls for identified risks associated with delivering the Trust's strategic objective

- To deliver our financial plan and our key performance indicators

in combination with a review of the relevant risks on the strategic risk register to review the Trust's Board Assurance Framework. It was agreed that for the Board Assurance Framework the strategic objective is split into two (2a: to deliver our financial plan and 2b: to deliver our key performance indicators. Following each meeting consensus is achieved in relation to the assurance level and associated statement. This is presented in the Board Assurance Framework.

Key Matters Discussed

1. Strategic Objective 2a: To deliver our financial plan

1.1 Risk: Strategic Risks relevant to the Committee

The Committee reviewed strategic risks related to the above strategic objective, for which it has an assuring role, at both meetings, and was assured that the mitigation described was proportionate and appropriate.

1.2 Strategy: Finance Dashboard

The Committee reviewed the Finance Dashboard in the context of the information contained in the report of the Finance and Performance Overview Committee

1.3 Report of the Finance and Performance Overview Committee

The report from the Finance and Performance Overview Committee was used by the Committee to contextualise the strategic risks related to delivery of the financial plan, the data presented in the Finance dashboard and the Finance Report, all received by the Committee at both meetings.

In relation to the delivery of the Financial plan the Committee noted that there remained a number of dependencies, including risk associated with the realisation of financial benefits of the establishment of the Wholly Owned Subsidiary and the MEAV, and that the most likely scenario was a year end deficit in line with control total. The Committee explored the associated risks of a failure to deliver the control total, and the steps that were being taken to mitigate these risks.

Meeting Title	Board of Directors		
Date	07/03/2019	Agenda item	Bo.3.19.14

1.4 Strategy: The Financial Plan 2019/20

The Committee received a summary of the draft Financial Plan, which had been developed with the independent scrutiny of two Non-Executive Directors. The Committee noted the principles within the plan and that it would be subject to routine negotiations prior to being agreed.

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2. Strategic Objective 2b: To deliver our key performance indicators

2.1 Risk: Strategic Risks relevant to the Committee

The Committee reviewed strategic risks related to the above strategic objective, for which it has an assuring role, at both meetings, and was assured that the mitigation described was proportionate and appropriate.

2.2 Strategy: Performance Dashboard

The Committee reviewed the Performance Dashboard in the context of the information contained in the report of the Finance and Performance Overview Committee.

2.3 Report of the Finance and Performance Overview Committee

The report from the Finance and Performance Overview Committee was used by the Committee to contextualise the strategic risks related to delivery of key performance targets, the data presented in the Performance dashboard and the Performance Report, all received by the Committee at both meetings. The Committee specifically considered risks and assurance in relation to:

- **Emergency Care Standard:** Whilst acknowledging the challenges to performance, the Committee highlighted concern about the variability in performance which is not always linked to increased demand. The Committee were assured that the Trust was obtaining the external support to ensure the identification of the root cause of this variability, and noted the planned receipt, by the Board of Directors, in March, of a proposal in relation to a new staffing and delivery model for the Accident and Emergency Department. The Committee also re-iterated their concern and frustration that attempts to manage demand through a different approach to the 'front door' of the department had not been successful or sustained. The Committee were informed that approaches to attendance avoidance are being considered at the Accident and Emergency Delivery Board.
- **Cancer standards:** The Committee was assured that the overall delivery of the cancer 2 week wait recovery plan is effective, with performance being delivered to trajectory. The Committee were impressed by the level of granularity in the reports provided to support assurance and noted the key areas where concern in relation to performance persisted. The Committee noted the overall delivery of the 62 day referral to specialist treatment target, again noting specific specialties which are below trajectory. The Committee were informed of the actions being taken to address concerns in these areas.
- **Referral to Treatment:** The Committee was informed that there was still risk associated with achieving the recovery plan trajectory by the end of 2018/19. Whilst acknowledging the continued issues faced by the Trust, the Committee noted that significant improvements and progress had been made.

Recommendation

The Board of Directors is requested to note the work of the Finance and Performance Committee in scrutinising the Foundation Trust's financial matters: maintaining a detailed overview of the Trust's assets and resources in relation to the achievement of financial targets, business objectives and the financial stability of the Trust and providing detailed scrutiny of performance matters.

It is also asked to note the assurance level and statement agreed by the Committee which is provided on the

Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Board of Directors		
Date	07/03/2019	Agenda item	Bo.3.19.14

Board Assurance Framework.

Strategic Objective 2a: To deliver our financial plan

Limited Confidence: *The Income & Expenditure (I&E) financial plan is being delivered as at month 10 (January 2019). This is against a planned year to date pre-PSF deficit of £7m. The annual control total pre-PSF deficit of £7.5m requires a £0.5m deficit to be delivered over Months 10 and 11. 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 Trust's cash and liquidity forecasts are increasingly challenged by the I&E projections. To protect the cash and liquidity position, measures have been taken to safely reduce the capital expenditure plans in 2018/19. Following discussion at Finance & Performance Committee, consideration will be given to amending the risk rating and assurance level in February.*

Strategic Objective 2b: To deliver our 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 capcity 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.

Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients			g			
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers			g			
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Risk Implications (see section 4 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	▪	
Quality implications	▪	
Resource implications	▪	
Legal/regulatory implications	▪	
Diversity and Inclusion implications		▪

Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Board of Directors		
Date	07/03/2019	Agenda item	Bo.3.19.14

Regulation, Legislation and Compliance relevance
NHS Improvement: Risk assessment framework, quality governance framework, code of governance , annual reporting manual
Care Quality Commission Domain: *Safe, caring, effective, responsive, well led*
Care Quality Commission Fundamental Standard:
Other (please state):

Relevance to other Board of Director's Committee:					
Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)
	▪				

CoG.4.19.14 - Appendix 3 Annex 2 SO 2 Board Assurance Framework - Quarter 4

Bradford Teaching Hospitals NHS Foundation Trust

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

Positive Assurance

Date	Assurance	Source
March 2019	Financial recovery plan – February planned trajectory delivered.	Finance and Performance Oversight Committee Report
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

Negative Assurance

Date	Assurance	Source
March 19	Cash position compromised by non-recurrent income and expenditure measures deployed in 2018/19	Finance report and FPOC report

Gaps in Assurance

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**

Rationale for Assurance Level

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.

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

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

Gaps in controls

Delivery of the control total in full through BIP plans and additional recovery measures

Routine Sources of Assurance

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

Risk Appetite

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

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

			Date of update	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		
Date	**Assurance**	**Source**
Jan 2019	Implementation of the action plan to improve the ECS performance Daily performance reporting of ECS	ECS Action Plan EPR – Trust performance team
Jan 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
Jan 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

Negative Assurance		
Date	**Assurance**	**Source**
Jan 2019	Current performance in relation to ECS standard ECS- there is a significant gap in middle grade doctors resulting in insufficient clinical decision makers to meet demand. 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.
Jan 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
Jan 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

Gaps in Assurance
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. 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.
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

			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	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.	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.

Annex 1 Strategic Risk Register

STRATEGIC RISK REGISTER: PRINCIPAL RISKS (Overview)

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

Appendix 2: Board Assurance Framework Legend

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

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

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

CoG.4.19.14 - Appendix 3 Annex 3 - Board Committee Summary

Board Committee Process and Governance Oversight

Committee	**Finance and Performance**		**Chair**	Trevor Higgins	
Meeting Dates	27/2/2019	27/3/2019	**Executive Lead (s)**	Director of Finance Chief Operating Officer	
Confirmed minutes available	Yes	No			

Strategic Objective(s) Assured		**Level of Assurance**	**Comments (Updated BAF is attached at Appendix 2 of this paper)**
2a	**To deliver our financial plan**	Limited confidence (27/3/2019)	The Committee agreed to maintain the level of assurance associated with the achievement of this strategic objective considering the strategic risk profile and the assurances received in the course of its business.
2b	**To deliver our performance targets**	Limited Confidence (27/3/2019)	The Committee agreed to maintain the level of assurance associated with the achievement of this strategic objective considering the strategic risk profile and the assurances received in the course of its business

Work-plan (Consideration of key controls and assurance)	**Gaps in controls identified and action taken**
The work-plan for 2019/20 has been agreed for the Committee. The Committee is assured that the work-plan enables the consideration of assurance associated with all controls in a timely and proportionate way. The Committee has completed all required work-plan items at the meetings included in this report. In addition the Committee considers the agenda for the subsequent meeting at each meeting to assure themselves that work-plan items are included and any required additional information or assurance identified as being required is included.	1) Finance and Performance Oversight Committee: the committee requested that this committee continued to operate for a further month rather than ceasing in March 2019 to allow for the transition into the new organisational structure 2) Strategic risks: the Committee were concerned that the strategic risks were not as up to date as they should be and did not fully reflect the content of assurance presented to Committee. They requested that the IGRC considered the frequency at which risks are reviewed on an individual basis to ensure they were as contemporaneous as possible.

Gaps in assurance identified and action taken	**Committee Governance**		
1) ECS-patient survey: the Committee requested additional assurance in relation to the actions being taken to address the performance in relation to this constitutional standard 2) 2018/19 financial position. The Committee requested a closed meeting of the Board of Directors in April to conclude and assure this matter	**Quoracy**		
	Conduct	Papers published as per terms of reference	**2 late papers**
		Agenda items completed at meeting	
		Actions completed by deadlines	
		Received escalations from other Committees effectively	
		Reported to Board as per terms of reference	
	Report Date	29/3/2019	

CoG.4.19.14 - Appendix 4 Annex 1 Workforce Committee Overview Report

Bradford Teaching Hospitals NHS Foundation Trust

Meeting Title	Board of Directors		
Date	07/03/2019	Agenda item	Bo.3.19.21

A report from the Chair of the Workforce Committee

Presented by	Selina Ullah, Non-Executive Director
Author	Tanya Claridge, Director of Governance and Corporate Affairs
Lead Directors	Pat Campbell, Director of Human Resources
Purpose of the paper	This paper is to provide the Board of Directors with an overview of the work of the Workforce Committee in January and February 2019.
Key control	This paper is a key control for the strategic objective to deliver our financial plan and our key performance indicators
Action required	To note

Background

The purpose of the Workforce Committee is to provide the Foundation Trust Board with an objective and independent review (including relevant strategic risks and associated assurance) of the effectiveness of the workforce management arrangements for the Trust.

Key Matters Discussed

1. Strategic Objective 3: To be in the top 20% of NHS Employers

1.1 Risk: Strategic risks relevant to the Committee

The Committee reviewed strategic risks related to the strategic objective for which it has an assuring role at both meetings, and was assured that the mitigation described was proportionate and appropriate.

1.2 Workforce Dashboard

The Workforce Dashboard is reviewed at every meeting and the Committee considers specific areas of workforce performance and risk. The Committee noted that a review of the elements of the Integrated Dashboard are currently under review and a refreshed version will be in use from April 2019. The Committee are sighted on any changes related to the performance indicators which they review.

- The Committee noted the position of the Trust in relation to appraisal rates and the steps being taken to ensure a sustainable approach in the future. The Committee were sighted on a new appraisal/pay progression policy is being developed in line with the terms and conditions changes in Agenda for Change.
- The Committee were concerned to note that the Trust is performing below the average for staff recommending the Trust as a place to be treated and a place to work in Yorkshire and Humber. The Committee were informed that steps were being taken to identity ways to improve the Trust's response rate.
- The Committee noted that there had been no real difference in sickness absence trend up to the end of December, although there had been a slight decrease compared to October. The Committee were assured that this is an area under close review, particularly short-term sickness.
- The Committee noted that the nursing shift fill rate has stabilised.
- The Committee noted the reduction in use of agency staff across the Trust
- The Committee noted first the progress with (January) and more latterly the success of the flu vaccination campaign (February).

1.3 Strategy: Workforce plan

The Committee reviewed the draft Workforce Plan, and noted how it had been developed through triangulation of risks on the strategic and divisional risk registers and in conjunction with development of the financial plan, particularly in relation to contracting activity and including projections in relation to the revised staffing model for urgent care, which is subject to a proposal to be received by the Board of Directors. The Committee approved the draft plan, noting subject to final review.

Meeting Title	Board of Directors		
Date	07/03/2019	Agenda item	Bo.3.19.21

1.4 Strategy: Strategic Nurse and Midwifery Staffing Review 2019

The Committee received the Nurse Strategic Staffing Review, and noted the assurance contained within the paper that the Trust plans safe nurse and midwifery staffing levels across all wards and other departments. The paper confirmed that there are appropriate systems in place to manage the demand for nursing and midwifery staff. The Committee acknowledged the limitations of this document (in its mandated format) in understanding the totality of staffing required to manage a ward optimally. The Committee intends to develop this focus during 2019/2020.

1.5 Risk: Nurse Staffing Data Publication Report

The Committee received updates relating to Nurse Staffing at each meeting, and received assurance in relation to how risk is being understood (through the use of the heat-map) and mitigated. The Committee was informed that any specific risk related to a ward or department which was not being effectively mitigated at a divisional level would be escalated to the Integrated Governance and Risk Committee.

1.6 Risk: Mandatory Training

The Committee received a specific report, at their request, following consideration of the workforce dashboard, focusing on the delivery of mandatory training in the Trust. The Committee considered the implications of the issues reported in the context of personal responsibility, and prioritising collaboration between health care organisations to facilitate staff transitioning between organisations.

1.7 Committee Business

The Committee reviewed its revised Terms of Reference, as agreed by the Board of Directors, and approved its work-plan to enable the delivery of its objectives. In addition the Committee considered

- the Board approved Risk Appetite statement in relation to the strategic objectives for which it has an assuring role. As a result will be considering a revised statement at their March meeting.
- the need to realign measures being used to monitor progress in relation to the achievement. As a result a revised suite of key performance metrics to support the assurance in relation to the Strategic Objective will be proposed to a future Committee meeting.

Recommendation

The Board of Directors is requested to note the work of the Workforce Committee in scrutinising the Trust's relevant strategic risks and associated assurance with respect to the effectiveness of the workforce management arrangements for the Trust.

It is also asked to note the assurance level and statement agreed by the Committee which is provided on the Board Assurance Framework.

Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients			g			
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers			g			
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated.	Low		Moderate	High	Significant	

Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Board of Directors		
Date	07/03/2019	Agenda item	Bo.3.19.21

Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Risk (*)
Explanation of variance from Board of Directors Agreed General risk appetite (G)	

Risk Implications (see section 4 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	▪	
Quality implications	▪	
Resource implications	▪	
Legal/regulatory implications	▪	
Diversity and Inclusion implications		▪

Regulation, Legislation and Compliance relevance
NHS Improvement: Risk assessment framework, quality governance framework, code of governance , annual reporting manual
Care Quality Commission Domain: *Safe, caring, effective, responsive, well led*
Care Quality Commission Fundamental Standard:
Other (please state):

Relevance to other Board of Director's Committee:					
Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)
	▪				

Bradford Teaching Hospitals NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK	Strategic Objective	3	To be in the top 20% of employers in the NHS		18/19			
				Assurance Level	Q1	Q2	Q3	Q4
Executive Lead	Pat Campbell	Assuring Committee	Workforce					

Positive Assurance		
Date	Assurance	Source
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

Negative Assurance		
Date	Assurance	Source
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

Gaps in Assurance

Routine access to comparator data in some areas

Rationale for Assurance Level

The Committee was assured that significant progress is being made across a range of key workforce indicators. Evidence is being routinely presented to Committee demonstrating tangible assurance. Concerns re vacancies in key areas remain with performance below metric in some areas. The Committee have reviewed the risk appetite and composite risk rating for this strategic objective at the February meeting, and 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

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

Gaps in controls

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

Routine Sources of Assurance

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

Risk Appetite

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

		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							

Annex 1 Strategic Risk Register

STRATEGIC RISK REGISTER: PRINCIPAL RISKS (Overview)

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

Appendix 2: Board Assurance Framework Legend

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

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

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

CoG.4.19.14 - Appendix 4 Annex 3 - Board Committee Summary

Board Committee Process and Governance Oversight

Committee	**Workforce**		**Chair**	Selina Ullah
Meeting Dates	27/2/2019	27/3/2019	**Executive Lead (s)**	Director of Human Resources
Confirmed minutes available	Yes	No		

Strategic Objective(s) Assured		**Level of Assurance**	**Comments (Updated BAF is attached at Appendix 2 of this paper)**
3	**To be in the top 20% of employers**	Limited confidence (27/3/2019)	The Committee agreed to advise Board of a proposed change of the risk appetite associated with this strategic objective, from cautious to seeking. It agreed to maintain its level of assurance associated with the achievement of this strategic objective considering the strategic risk profile and the assurances received in the course of its business

Work-plan (Consideration of key controls and assurance)	**Gaps in controls identified and action taken**
The work-plan for 2019/20 has been agreed for the Committee. The Committee is assured that the work-plan enables the consideration of assurance associated with all controls in a timely and proportionate way. The Committee has completed all required work-plan items at the meetings included in this report. In addition the Committee considers the agenda for the subsequent meeting at each meeting to assure themselves that work-plan items are included and any required additional information or assurance identified as being required is included.	1) The Committee noted the reflection of an identified gap in control relating to the microbiology service staffing on the strategic risk register and requested further updates

Gaps in assurance identified and action taken	**Committee Governance**		
1) Stress- the Committee received an escalation from the Health and Safety Committee and required further assurance in the form of the Health and well-being plan in response to the outcome of the National Staff Survey	**Quoracy**		
	Conduct	Papers published as per terms of reference	
		Agenda items completed at meeting	
		Actions completed by deadlines	
		Received escalations from other Committees effectively	
		Reported to Board as per terms of reference	
	Report Date	29/3/2019	
	Report Author	Director of Governance and Corporate Affairs	

CoG.4.19.14 - Appendix 5 Annex 1 Partnerships Committee Overview Report

Bradford Teaching Hospitals NHS Foundation Trust

Meeting Title	Board of Directors		
Date	7.3.19	Agenda item	Bo.3.19.25

Report from the Partnerships Committee

Presented by	Trevor Higgins, Interim Chairman	
Author	Edward Cornick, Head of Policy	
Lead Director	John Holden, Director of Strategy and Integration	
Purpose of the paper	Update from the Chairman on the discussions held at the Partnerships Committee	
Key control	Strategic Objective - To collaborate effectively with local and regional partners	
Action required	To note	
Previously discussed at/ informed by	Partnerships Committee held on 25 January 2019	
Previously approved at:	**Committee/Group N/A**	**Date**

Key matters discussed

The following key matters were discussed at the meeting held on 25 January 2019.

Horizontal integration - the committee noted the Trust is working with WYAAT to ensure that the award of BTHFT as an arterial centre gains NHSE approval, as a part of this process, approval will be needed from the West Yorkshire Health Overview and Scrutiny Committee. It was noted that WYAAT/BTHFT was not successful in securing national capital funding for the hybrid theatre required for the arterial centre, and the committee requested the trust should take actions to ensure capital funding for this is still prioritised within the STP for any future funding rounds.

Airedale collaboration - the committee noted the programme governance for the collaboration with Airedale has been agreed. Following discussions between BTHFT, AFT and the CCGs, it has been agreed that the funding for the programme management office and executive lead will be split equally between the three parties regarding in planning submissions. The committee was informed that a joint clinical summit is planned to launch the programme with clinicians will take place in April.

Vertical Integration – the committee noted the Trust is actively involved in the drafting of a Strategic Partnering Agreement, which will set out how collaboration and decision making will work in Bradford District and Craven. It is planned that this document will be signed and agreed by the partners by the end of March, and as such it will go to the March BTHFT board for approval. The committee did not note any significant risks in approving the document, and also noted that not approving potentially carries risk regarding our relationships with local partners.

Links between the Trust and Bradford's economy – the committee considered an item outlining the contribution the Trust makes to the local Bradford economy. The contribution and links includes the Trust's role as a large local employer, its involvement in innovation and research and the concept of NHS Trust's as "anchor institutions" which add social value to local communities. It was agreed this topic should be added to a future board development session.

Recommendation

The Board of Directors is requested to note the work of the Partnerships Committee in scrutinising the Foundation Trust's partnership arrangements and providing assurance on its relevant strategic objective.

Risk assessment	
Strategic Objective	**Appetite (G)**

Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Board of Directors		
Date	7.3.19	Agenda item	Bo.3.19.25

	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients		g				
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers			g			
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)	**No variation**					

Risk Implications (see section 4 for details)	**Yes**	**No**
Corporate Risk register and/or Board Assurance Framework Amendments		X
Quality implications		X
Resource implications		X
Legal/regulatory implications		X
Diversity and Inclusion implications		X

Regulation, Legislation and Compliance relevance
NHS Improvement: Code of governance
Care Quality Commission Domain: *Well led*
Care Quality Commission Fundamental Standard:
Other (please state):

Relevance to other Board of Director's Committee:					
Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)
			X		

Bradford Teaching Hospitals NHS Foundation Trust

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

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

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 >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

EMT Governance
Implementation of Clinical Services Strategy 2017-2022 through Divisional service planning and EMT updates
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. 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).

Risk Appetite

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

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

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

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

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
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

STRATEGIC RISK REGISTER: PRINCIPAL RISKS (Overview)

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

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

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

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

CoG.4.19.14 - Appendix 6 Audit & Assurance Committee Overiew Report

Bradford Teaching Hospitals NHS Foundation Trust

Meeting Title	Board of Directors		
Date	7.3.19	Agenda item	Bo.3.19.27

REPORT FROM THE AUDIT & ASSURANCE COMMITTEE MEETING 5 FEBRUARY 2019

Presented by	Barrie Senior – Non-Executive Director and Audit Committee Chairman	
Author	Barrie Senior – Non-Executive Director and Audit Committee Chairman	
Lead Director	Matthew Horner, Director of Finance	
Purpose of the paper	To provide an update regarding key matters covered in the Audit & Assurance Committee meeting on 5 February 2019	
Key control	Identify if the paper is a key control for the Board Assurance Framework	
Action required	To note	
Previously discussed at/ informed by		
Previously approved at:	**Committee/Group**	**Date**
Recommendation		
The Board is asked to note and derive assurance from this report.		

Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for patients		g				
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers			g			
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Risk Implications (see section 4 for details)	**Yes**	**No**
Corporate Risk register and/or Board Assurance Framework Amendments	☒	☐
Quality implications	☒	☐
Resource implications	☒	☐
Legal/regulatory implications	☒	☐
Diversity and Inclusion implications	☒	☐

Regulation, Legislation and Compliance relevance

Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Board of Directors		
Date	7.3.19	Agenda item	Bo.3.19.27

NHS Improvement: (please select those that are relevant)	
☐Risk Assessment Framework	☐Quality Governance Framework
☐Code of Governance	☐Annual Reporting Manual
Care Quality Commission Domain:	
Care Quality Commission Fundamental Standard:	
Other (please state):	

Relevance to other Board of Director's Committee: (please select all that apply)					
Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)
☒	☒	☒	☒	☒	☐

Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Board of Directors		
Date	7.3.19	Agenda item	Bo.3.19.27

1 PURPOSE/ AIM

To provide an update regarding key matters covered in the Audit & Assurance Committee meeting on 5 February 2019

2 BACKGROUND/CONTEXT

The agenda of the meeting held on 5 February was driven by the 2018/19 Audit and Assurance Committee Annual Workplan.
The key matters considered, discussed and from which, where appropriate, assurance was gained were:

- Quality Report Audit Guidance 2018/19
- Internal Audit Progress Report
- Counter Fraud Progress Report
- 2018/19 Annual Accounts Update
- Assurance regarding third party providers to the Trust
- Internal Audit Report Process
- Audit & Assurance Committee revised terms of reference
- CQC Inspection Report and Compliance Actions
- Update on Provider to Provider Limited Assurance Internal Audit Report
- Data Quality
- Self-Certification of the NHS Provider Licence
- Board Assurance Framework

3 PROPOSAL

4 RISK ASSESSMENT

5 RECOMMENDATIONS

The Board is asked to note and derive assurance from this report.

6 Appendices

Report included overleaf

Meeting Title	Board of Directors		
Date	7.3.19	Agenda item	Bo.3.19.27

Audit and Assurance Committee meeting – 5 February 2019

1. Introduction

The purpose of this paper is to inform the Board of Directors of the key matters discussed during the Audit and Assurance Committee meeting held on 5 February 2019.

2. Key Matters discussed

The key matters discussed during the course of the meeting were as follows:

2.1 Quality Report Audit Guidance 2018/19

The Committee noted the update provided by External Audit regarding NHSI's requirements for 2018/19 Quality Reports.

The mandated indicators for audit scrutiny were confirmed as:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

It was noted that NHSI "strongly recommend" that the Summary Hospital-level Mortality Indicator (SHMI) should be selected as the local indicator for 2018/19. The Trust has adopted this recommendation.

2.2 Internal Audit Progress Report

Internal Audit presented their report of progress since the Committee meeting in December.

The Committee considered the justifications for the deferral or cancellation of seven Internal Audit reviews in the 2018/19 plan. All were accepted and approved.

The Committee noted continued 100% compliance with Internal Audit Key Performance Indicators relating to Internal Audit reporting and agreement with management.

The Committee sought and received reassurance that completion of the 2018/19 Internal Audit Plan was on track and that sufficient resources are available so as to achieve completion within timescale.

In accordance with the risk-based Internal Audit Plan 2017/18, since the December Committee meeting Internal Audit had produced six further audit reports agreed with management with:

- One 'High Assurance' rating
- Three 'Significant Assurance' ratings

- One 'Limited Assurance' rating

and one report, providing an update on follow up of Internal Audit recommendations, not requiring a rating.

Audit Report Summaries: The Committee considered, discussed and derived assurance from each of the six audit reports that had been agreed with management since the December Audit Committee meeting:

BH/26/2019 - Safer Staffing; Safe Care (Acuity Scoring) – High Assurance

The objective of the review was to provide assurance that the Health Roster Safe Care module is being effectively utilised in recording and reporting accurate staffing mix data.

The review confirmed that Safe Staffing is a key focus for the Trust and is supported by a sound system of recording, monitoring and assessment of acuity of care based upon the levels of staff available and the health needs of patients on each ward.

One minor audit recommendation was made and accepted, for completion by 28 February.

BH/27/2019 – Risk Management Framework and Strategy – Significant Assurance

The objective of the review was to provide assurance that the Trust has effective and embedded risk management processes in place.

The review confirmed that the Trust has appropriate and effective controls in place to ensure that divisional risks are raised, reviewed, updated and reported on, with escalation where appropriate.

Internal Audit noted that the Trust has made significant advances in risk management since the last Internal Audit review in April 2017. Internal Audit observed that divisional personnel are now fully aware of the required risk management processes and procedures.

The review generated three moderate and five minor recommendations. The Committee was satisfied with the agreed deadlines.

BH/28/2019 – Short Stay Ward; Follow Up of Limited Assurance Report – Limited Assurance

The objective of the review was to provide assurance that the recommendations made in the previous Internal Audit report (BH/25/2018) had been implemented.

The Committee expressed concern that the follow up had resulted in yet a further Limited Assurance opinion.

The Chief Operating Officer attended the meeting to reassure the Committee that the matter was receiving urgent attention and that the four outstanding recommendations (two major, two moderate) would all be fully implemented by 31 March 2019.

BH/29/2019 – Recruitment – Significant Assurance

The objective of the audit was to provide assurance that there is a rigorous and equitable recruitment process to select appointees and to verify their suitability to work for the Trust.

The audit identified a sound system of internal control to protect against unsuitable individuals being employed by the Trust. The review confirmed that there are policies and procedures in place to enable a rigorous and fair recruitment process.

The review generated three recommendations, all minor.

BH/30/2019 – IT Asset Management/Maintenance – IT Portfolio Management and Maintenance – Significant Assurance

The objective of the audit was to provide assurance that effective systems and processes are in place and being adhered to in order appropriately to manage the Trust's owned IT assets.

The review provided significant assurance regarding the arrangements and controls in place regarding hardware and software asset management and maintenance.

The review generated four moderate and one minor recommendation, four of which are due for completion by 31 March and one by 31 May.

BH/31/2019 – Follow Up of Internal Audit Recommendations

The Committee challenged latest status regarding completion of Internal Audit recommendations and was satisfied with progress.

2.3 Counter Fraud Progress Report

The Committee noted with satisfaction the latest progress in counter fraud activities within the Trust.

The Committee noted the data recently issued by the NHS Counter Fraud Authority analysing the estimated amounts of fraud loss by thematic area across the NHS. The Committee asked that Counter Fraud and Internal Audit give consideration to whether the Trust's counter fraud and internal audit activity is weighted appropriately in accordance with these loss levels.

The Committee was pleased to note that Counter Fraud is assisting in strengthening the Trust's processes and controls to reduce revenue losses relating to the treatment of overseas visitors.

2.4 2018/19 Annual Accounts Update

The Committee received an update regarding latest developments in Accounting Standards and their limited actual or potential impacts upon the Trust relating to:

- Revenue from contracts with customers (IFRS 15)

- Financial instruments (IFRS 9)
- Leases (IFRS 16), applicable from 2020/21

The Committee received an update from Finance and External Audit regarding the two most significant accounting and audit issues facing the Trust this year:

- Valuation of Trust assets, and the adoption of Modern Equivalent Asset Value (MEAV)

- The accounting implications of the existence of and the potential commencement of activity by the Trust's wholly owned subsidiary, Bradford Healthcare Facilities Management Limited.

Both of the above issues will be further considered at the Committee's April meeting, when further information should be available.

2.5 Assurance regarding third party providers to the Trust

The Audit Committee Self Assessment exercise earlier in the year identified as good practice ensuring assurance regarding all key third party providers to the Trust. The Deputy Director of Finance provided a further update regarding work to ensure that all key third party providers to the Trust have been identified and that the ability of each provider to support the Trust is assured. Work on this continues and a further progress report will be provided to the Committee at its April meeting.

2.6 Internal Audit Report Process

The Director of Finance presented a proposal that instead of all Internal Audit reports being formally tabled at Executive Management Team meetings this should be restricted to Limited and No Assurance reports only. Given that all Internal Audit reports, regardless of opinion rating, are presented to and discussed with the relevant Executive Director(s) the Committee agreed that this seemed appropriate.

The Committee did request that it was ensured that all Internal Audit reports are shared with the Chief Executive, as the Trust's Accountable Officer.

2.7 Audit & Assurance Committee revised terms of reference

The Committee formally approved the revised terms of reference emanating from the Committee Self Assessment process earlier in the year and incorporating the revised relationship with other Board Committees. The revised terms of reference will be presented at the Board meeting on 7 March for Board approval.

2.8 CQC Inspection Report and Compliance Actions

The Committee received a helpful and reassuring progress update from the Director of Governance and Corporate Affairs.

Meeting Title	Board of Directors		
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2.9 Update on Provider to Provider Limited Assurance Internal Audit Report

The Chief Operating Officer provided the Committee with reassurance that effective and timely progress has been made to rectify deficiencies in provider to provider contracts and contract management procedures, processes and controls.

2.10 Data Quality

In the absence of the Chief Digital and Information Officer, the Chief Operating Officer provided a verbal update regarding data quality within the Trust, focussing predominantly upon EPR data quality.

The Chief Digital and Information Officer is to attend the Committee's April meeting to provide assurance regarding processes and controls to ensure Trust-wide data quality, and the quality of information flowing from that data.

2.11 Self-Certification of the NHS Provider Licence

The Audit Committee Self Assessment exercise earlier in the year identified as good practice ensuring assurance regarding the Trust's compliance with its licence conditions. The Director of Governance and Corporate Affairs provided to the Committee an update on enhanced procedures and controls to ensure and demonstrate compliance, prior to the self-certification being further considered by the Committee in April and by the Board in May.

2.12 Board Assurance Framework (BAF)

The Director of Governance and Corporate Affairs presented the latest version of the BAF and Corporate Risk Register and pointed to the need/opportunity to improve how the BAF is populated and used. Closer and more frequent cooperation with Executive Directors is planned, and BAF training is to be made available to Non-Executive Directors.

3. Other matters

3.1 Matters to escalate to Corporate Risk Register

None

3.2 Other matters to escalate to the Board of Directors

None

4 Recommendation

The Board of Directors is asked to note this report and the reassurance and assurance that it provides.