

BOARD ASSURANCE FRAMEWORK: Quarter 2 2019/20

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 | | | | | | | | | | Q 2 2019/20 | |
|---------------------------|---|-------------------------|---|---------------------------------------|-------------------------|-----------------------------|----|----------------|----|---------------------|---------|
| Assurance Overview | | | | | | Date | | September 2019 | | | |
| Strategic Objective | | Current Assurance Level | Reason for Assurance Level | Executive Lead | Assuring Committee | Quarterly assurance ratings | | | | Strategic Risk | |
| | | | | | | 18/19 | | 19/20 | | | |
| | | | | | | Q3 | Q4 | Q1 | Q2 | Principal composite | Highest |
| 1 | To provide outstanding care for our patients | | We continue to maintain systems, processes and outcome to aspire to deliver outstanding care for our patients | Chief Nurse/ Chief Medical Officer | Quality | | | | | 12 | 20 |
| 2a | To deliver our financial plan | | The Month 6 (Quarter 2) planned deficit before PSF is £8.1m. The planned position was achieved for the period ending 30.9.19 and as such the RAG rating for the Year to date is 'green'. The underlying run rate is the largest risk given there are minimal non recurrent measures available in 19/20. The current run rate has secured the Q2 position but future quarters are at risk given the quarterly improvements required to achieve the year end deficit control total of £12.5m before PSF. The Trust has agreed a fixed income contract with its main commissioners (Bradford and Airedale) which means that delivery of the financial plan inclusive of the liquidity position and capital programme is reliant on cost efficiencies and transformation. The Trust has limited opportunity to rely on growth to support the financial position. | Director of Finance | Finance and Performance | | | | | 16 | 16 |
| 2b | To deliver our key performance targets | | Finance & Performance committee was assured of slow but steady improvement against a range of key access standards. There is still limited assurance that the Trust will achieve all access standards by the end of quarter 2. Cancer: There is increased confidence in the management of cancer pathways which has resulted in significant improvement in performance against cancer 2 WW standard and 62 day standards. 2WW has now been achieved for 3 out of 4 is predicted on a sustainable basis to be achieved by the end of Q4 2019/20. All other standards have been achieved at the end of Q1. RTT: There has been a month on month improvement in RTT performance and improvement is in line with trajectory. The total waiting list has increased slightly for the last three months but performance continues to improve. There have been zero 52 week breaches for 10 months. ECS: There is limited confidence in the Trust's ability to achieve the ECS 95% standard. Demand and capacity analysis has shown that lack of physical capacity and insufficient clinical decision makers in ED is a major contributor to poor performance. Patient outcomes benchmarked positively in a recent GIRFT Emergency Medicine review. Recruitment to the additional workforce is progressing well. The improvement programme is on track and there is measurable improvement in a number of KPIs. | Chief Operating Officer | Finance and Performance | | | | | 12 | 12 |
| 3 | To be in the top 20% of employers in the NHS | | | Director of Human Resources | Workforce | | | | | | |
| 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. | Chief Medical Officer | Quality | | | | | 8 | n/r |
| 5 | To collaborate effectively with local and regional partners | | 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 | Director of Strategy and Integration | Partnerships | | | | | 10 | 12 |

| BOARD ASSURANCE FRAMEWORK | | Strategic Objective | 1 | To provide outstanding care for our patients | | | Assurance Level | 2018/19 | | 19/20 | |
|---|--|-------------------------|---|---|----------------------------------|---|-----------------|---------|---|-------|----|
| Executive Lead | | Karen Dawber/Bryan Gill | | Assuring Committee | Quality | | | Q3 | Q4 | Q1 | Q2 |
| | | | | | | | | | | | |
| Positive Assurance (bold received to date in quarter) | | | Negative Assurance (bold received in quarter) | | | Gaps in Assurance | | | Rationale for Assurance Level | | |
| Date | Assurance | Source | Date | Assurance | Source | Two quarterly papers (Effectiveness and learning) were not received in September due to the business of the Committee and the cancellation of the August Committee meeting. There are no exceptions to report and these will be received in October before final approval of the BAF – Now received | | | We continue to maintain systems, processes and outcome to aspire to deliver outstanding care for our patients | | |
| Monthly | Safe Staffing report Quality Committee Dashboard and trend analysis Information Governance report Quality oversight system | Report | Monthly | Safe Staffing report Quality Committee Dashboard and trend analysis Serious incident report | Report to Quality Committee | | | | | | |
| Quarterly | Incident report Leadership walk around programme ProGRESS Learning from deaths Learning Patient experience report Freedom to speak up report Maternity Services report Infection Prevention and Control report | Report | Quarterly | Incident report Clinical Effectiveness report Patient Experience report | Report to Quality Committee | | | | | | |
| Annual | Sub Committee reports Data Security Protection Toolkit Data Protection Officer Report Annual Screening reports | Report | September | Focus on IP survey results and actions Focus on Haematology | Presentation Presentation | | | | | | |
| September | Focus on Haematology Quality Improvement – Learning from each other Focus on IP survey results and action | Reports | July | Peer review Haemophilia and Haemoglobinopathy | Report | | | | | | |
| July | Focus on First Management of Fits Maternity Incentive Scheme | Reports | | | | | | | | | |

| Key performance Indicator | | Principal Risk (s) | | Potential consequences | Composite risk rating (strategic risks) | | | | | Component risks>12 | |
|---------------------------|--|--------------------|--|---|---|----------|--------|---------|---------------------|--------------------|-----------------|
| | | | | | Initial | Residual | Target | Current | Direction of travel | Number | Highest Current |
| a | To achieve the NHS quality of care standards | 1 | Failure to maintain the quality of patient services | Poor quality of care to the population that we provide services for. Reduced reputation and risk to continuity of services | 16 | 8 | 4 | 12 | ↔ | 19 | 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 | ↔ | 1 | 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 | ↔ | 2 | 12 |

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

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| BOARD ASSURANCE FRAMEWORK | Strategic Objective | 1 | To provide outstanding care for our patients | Action Plan to address Gaps in Controls and Assurance |
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|---------------------------------|---------------------------------------|--|--|-------------------------------------|--------------------------------------|
| | | | | Date of update | 26/10/19 |
| Accountability | | | | Responsibility | |
| Lead | Oversight/governance structure | | | Lead | Work-stream/operational group |
| Chief Nurse (CN) | Quality Committee | | | Head of Business Intelligence (HBI) | Going Digital Programme Board |
| Medical Director (MD) | | | | | |
| Chief Informatics Officer (CIO) | | | | | |
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| 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 – Pilot maternity | HBI | June 2018 | Q3 19/20 | O | | Maternity dashboard in final stages of testing with clinical teams. Due for launch Q3 | Draft presented as part of the Q2 maternity report | |

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| 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 | |
| | | | | | | | | | |

| BOARD ASSURANCE FRAMEWORK | | Strategic Objective | 2a | To deliver our financial plan | | Assurance Level | 18/19 | | 19/20 | |
|---------------------------|--|---------------------|----|-------------------------------|-------------------------|-----------------|-------|----|-------|----|
| Executive Lead | | Matthew Horner | | Assuring Committee | Finance and Performance | | Q3 | Q4 | Q1 | Q2 |
| | | | | | | | | | | |

| Positive Assurance | | | Negative Assurance | | | Gaps in Assurance | Rationale for Assurance Level |
|--------------------|---|---|--------------------|--|----------------|---|---|
| Date | Assurance | Source | Date | Assurance | Source | | |
| July 2019 | Fixed Income Contract agreed with main commissioners (Bradford & Airedale). Improved baseline contract value compared to PbR contract | Finance Report | Oct19 | Identification and implementation of sufficient cash releasing measures to ensure annual CIP target is delivered. Underspends against budgets utilised to deliver Month 6 (September/Quarter 2) position. The current run rate secured the Q2 position but future quarters are at risk given the quarterly improvements required to achieve the year end deficit control total of £12.5m before PSF. | Finance report | <p>Definitive plans to secure the full value of control total requirement on a recurrent and sustainable basis:</p> <p>The new Care Group Structures continues to bed in with a number of staff in new roles both clinical and operational. The level of understanding/operational grip and skills/capabilities continues to evolve. The CBU development programme will help facilitate this process.</p> | <p>The Month 6 (Quarter 2) planned deficit before PSF is £8.1m. The planned position was achieved for the period ending 30.9.19 and as such the RAG rating for the Year to date is <i>'green'</i>. The underlying run rate is the largest risk given there are minimal non recurrent measures available in 19/20. The current run rate has secured the Q2 position but future quarters are at risk given the quarterly improvements required to achieve the year end deficit control total of £12.5m before PSF.</p> <p>The quarterly assurance rating remains green as the Trust has secured delivery of the planned trajectory at the end of Quarter 2. The forward look risk rating below reflects the challenge faced for the remainder of the year and the requirement to improve the underlying run rate.</p> |
| Sept 2019 | Financial position on plan for Year to Date position ensuring PSF and FRF funding is recovered. | Finance Report | | | | | |
| Sept 2019 | Weekly CBU meetings focussing solely on CIP delivery | Finance Report | | | | | |
| Oct 2019 | Recovery plans requested from each Care Group and other Departments reporting off plan Forecasts by w/c 1.11.19 | Care Group Performance Review Meetings (planned from 1.11.19) | | | | | |

| Key performance Indicator | | Principal Risk(s) | | Potential consequences | Composite risk rating (strategic risks) | | | | | Component risks >12 | |
|---------------------------|--|-------------------|---|---|---|----------|--------|---------|---------------------|---------------------|-----------------|
| | | | | | Initial | Residual | Target | Current | Direction of travel | Number | Highest Current |
| a | Deliver the financial plan to secure PSF and FRF funding and deliver liquidity plan to ensure sufficient cash to protect the capital programme | 4 | Failure to maintain financial stability | Damage to reputation, financial and liquidity compromise, loss of market share, regulatory action | 12 | 6 | 6 | 16 | ↔ | 4 | 16 |

| High Level Controls | Gaps in controls | Routine Sources of Assurance | Risk Appetite |
|---|------------------|--|---|
| <p>Executive led Divisional Financial performance management</p> <p>Performance management and assurance of CIP delivery</p> <p>COO/FD led weekly CBU CIP assurance meetings</p> <p>Bradford Improvement Plan Governance</p> <p>Budget setting and business planning including issuance of Budgetary Management Framework to support new Care Groups and Clinical Business Units (CBU's)</p> <p>Quality Impact Assessment and Financial Impact Assessment process</p> <p>Standing Financial Instructions and Scheme of Delegation</p> | | <p>Director of Finance report to Finance and Performance Committee and Board – including assessment of NHSI 'Use of Resources' framework</p> <p>Internal Audit Committee Reports on controls assurance</p> <p>Audit Committee Report to Board</p> <p>Finance & Performance Committee Dashboard</p> <p>Board Integrated Dashboard</p> | <p>Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward</p> |

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| BOARD ASSURANCE FRAMEWORK | Strategic Objective | 2a | To deliver our financial plan | Action Plan to address Gaps in Controls and Assurance |
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| | | | | Date of update | 24/9/2019 |
| 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) | | | | | |

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|------------------|--|--|----------------------|-----------------------------|---------------|--------------------------|---|---|--|--|
| 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 CIP plans and additional recovery measures | DoF COO | 1.4.19 | 31.3.20 | O | | The pre-PSF control total deficit for 2019/20 is £12.5m. There is currently a gap in securing the full CIP value for the year (ie £16.2m) which is required to deliver the control total. | Finance Report to Finance & Performance Committee Outputs from CBU weekly CIP meetings | | |

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| 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 | 1.4.19 | 31.3.20 | O | | The current plans identified do not secure full delivery of the CIP target for the year. Underspends reported across a number of expenditure lines are partially offsetting the gaps at the end of Month 6 (September/Quarter 2). | Finance Report to Finance & Performance Committee Outputs from CBU weekly CIP meetings | | |
| 2 | | | | | | | | | | |

| BOARD ASSURANCE FRAMEWORK | | Strategic Objective | 2b | To deliver our key performance targets | | Assurance Level | 2018/19 | | 19/20 | |
|---------------------------|--|---------------------|----|--|-------------------------|-----------------|---------|----|-------|----|
| Executive Lead | | Sandra Shannon | | Assuring Committee | Finance and Performance | | Q1 | Q4 | Q1 | Q2 |
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| Positive Assurance | | | Negative Assurance | | | Gaps in Assurance | Rationale for Assurance Level |
|--------------------|---|--|--------------------|---|--|--|---|
| Date | Assurance | Source | Date | Assurance | Source | Data quality issues in 18 week PTL which limits the Trust's ability to provide a weekly report | Finance & Performance committee was assured of slow but steady improvement against a range of key access standards. There is still limited assurance that the Trust will achieve all access standards by the end of quarter 2. Cancer: There is increased confidence in the management of cancer pathways which has resulted in significant improvement in performance against cancer 2 WW standard and 62 day standards. 2WW has now been achieved for 3 out of is predicted on a sustainable basis to be achieved by the end of Q4 2019/20. All other standards have been achieved at the end of Q1. RTT: There has been a month on month improvement in RTT performance and improvement is in line with trajectory. The total waiting list has increased slightly for the last three months but performance continues to improve. There have been zero 52 week breaches for 10 months. ECS: There is limited confidence in the Trust's ability to achieve the ECS 95% standard. Demand and capacity analysis has shown that lack of physical capacity and insufficient clinical decision makers in ED is a major contributor to poor performance. Patient outcomes benchmarked positively in a recent GIRFT Emergency Medicine review. Recruitment to the additional workforce is progressing well. The improvement programme is on track and there is measurable improvement in a number of KPIs. |
| 25/10/19 | Implementation of the action plan to improve the ECS performance. Improvement plan update provided to F&P committee on 29/5/19 Daily performance reporting of ECS to NHSI Improved performance for ambulance handover. 33% of patients treated on SDEC | ECS improvement Plan 2019/20 F&P agenda item F9.19.16 NHS Improvement Daily Situation Report GIRFT review 10/10/19 | 25/10/19 | Current performance in relation to ECS standard 1 Consultant vacancies for acute medicine – recruitment in process | Performance Report to Finance & Performance Committee | | |
| 25/10/19 | Implementation of the action plan to improve the Cancer 62 Day performance - improvement plan update provided to F&P committee on 26/6/19 Increase in the number of patients seen within 2 weeks of referral Month on month reduction in 62 day backlog National cancer waiting time dashboard – 2WW standard achieved 3 out of 4 months 62 day standard achieved in July 19. All other standards achieved. YTD improvement across all CWT standards. | Cancer 62 day performance improvement Plan – F&P agenda item F.9.19.15 National cancer waiting time monthly submission. | 25/10/19 | Current performance in relation Cancer 62 day standard – 62 standard not yet achieved consistently | National cancer waiting time monthly submission | | |
| 25/10/19 | Implementation of the plan to reduce elective waiting times – improvement plan update provided to F&P committee on 13/7/19 RTT waiting list below March 18 level in line with national target. RTT % improvement month on month. There have been no 52 week waiters for 11 months. | ECR action plan F&P agenda item – F7.19.13 18 week national return | 25/10/19 | RTT incomplete standard not yet achieved | Performance Report to Finance & Performance Committee F.9.19.15 18 week incomplete waiting list - | | |

| 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 ECS & 18 weeks RTT | 3 | Failure to maintain operational performance | Damage to reputation, regulatory action | 20 | 6 | 6 | 12 | ↓ | 3 | 12 |

| High Level Controls | Gaps in controls | Routine Sources of Assurance | Risk Appetite |
|---|--|---|---|
| New performance management and accountability framework Development of care group and CBU dashboards including national/local and contractual KPI's/standards ECS improvement plan Cancer improvement plan Elective care improvement plan Weekly Access Meetings 2 weekly ECS breach review meetings Urgent Care Programme board Planned care programme board | ECS- the current staffing model is not sufficient to meet current emergency demand | 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 Quarterly Informatics Performance Report | Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward |

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| BOARD ASSURANCE FRAMEWORK | Strategic Objective | 2b | To deliver our key performance targets | Action Plan to address Gaps in Controls and Assurance |
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| | | | | Date of update | 25/10/19 |
| 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 | |

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|------------------|---|--|----------------------|-----------------------------|---------------|--------------------------|--|---|--|
| 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 the revised staffing model that matches staff resource with emergency demand | COO | May 19 | 30/10/18 | | | Revised workforce model agreed. Business case approved at Trust Board and recruitment has commenced. Due to the education timetable the majority of medical posts will not be filled until April 20. Recruitment progressing well to nursing and ACP vacancies. | | |
| 2 | ECS – to increase the number of patients who attend ED who are treated by same day emergency care and avoid overnight admission | COO | May 19 | 31/11/19 | C | | Plan for blue zone has been agreed. 4 ambulatory pathways have commenced and the number of patients transferred from ED to ACU and avoiding 4 hour breach has increased from 7-8 to 15-20 per day. There is a total opportunity of approximately 70 patients who could be transferred to same day emergency care (blue zone) | GIRFT review showed 33% of patients treated as SDEC | |

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| 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 | 18 weeks RTT- To implement a DQ improvement programme | COO | June 19 | Dec 19 | | | Programme commenced. Detailed action plan in place. | Minutes of meeting 27/8/19 | |

| BOARD ASSURANCE FRAMEWORK | | Strategic Objective | 4 | To be a continually learning organisation | | | Assurance Level | 18/19 | | 19/20 | |
|---------------------------|------------|---------------------|---|---|--|-------------------|-----------------|-------|----|-------|----|
| | | | | | | | | Q2 | Q3 | Q1 | Q2 |
| Executive Lead | Bryan Gill | | | Assuring Committee | | Quality Committee | | | | | |

| Positive Assurance | | | | Negative Assurance | | | | Gaps in Assurance | Rationale for Assurance Level |
|--|---|--|--|--------------------|-------------------------|-------------------|--|---|-------------------------------|
| Date | Assurance | Source | | Date | Assurance | Source | | Identification of risks associated with the delivery of the objectives. | |
| MONTHLY | Serious Incident Report | Quality Committee | | MONTHLY | Serious Incident Report | Quality Committee | | | |
| QUARTERLY | Combined Learning Report Leadership Walk round update Learning from Deaths Patient Experience Guardian of Safe Working Hours | Quality Committee Quality Committee Quality Committee Quality Committee Workforce Committee | | QUARTERLY | | | | | |
| ANNUALLY | Safer Procedures Patient Safety Sub- Committee Report Research Translation & Innovation Report Quality Account | Quality Committee Quality Committee Quality Committee | | ANNUALLY | | | | | |
| 26/06/2019 26/06/2019 26/06/2019 24/07/2019 25/09/2019 25/09/2019 | Quality Improvement Presentation 7 Day Services Self –Assessment Annual Report Medical Appraisal Revalidation GMC National Training Survey Embedding 7 Day Services Quality Assurance of Postgraduate Medical Training | Quality Committee Workforce Committee Workforce Committee Workforce Committee Workforce Committee Workforce Committee | | | | | | | |
| 20/06/2019 24/06/2019 25/06/2019 13/08/2019 21/08/2019 10/10/2019 | Intensive & Critical Care Visit Breast Surgery Visit Care of the Elderly Visit Imaging & Radiology Visit Respiratory Visit Emergency Medicine Visit | GIRFT GIRFT GIRFT GIRFT GIRFT GIRFT | | | | | | | |

| 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 |
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| Lack of a single dashboard to reflect this strategic objective. |

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

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

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| BOARD ASSURANCE FRAMEWORK | Strategic Objective | 4 | To be a continually learning organisation | Action Plan to address Gaps in Controls and Assurance |
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| | | | | Date of update | 25/10/2019 |
| Accountability | | | Responsibility | | |
| Lead | Oversight/governance structure | | Lead | Work-stream/operational group | |
| Dr Bryan Gill | Quality Committee & Patient Safety Sub Committee | | DMD | | |
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| 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 | | | | | | | | | |

| BOARD ASSURANCE FRAMEWORK | | Strategic Objective | 5 | To collaborate effectively with local and regional partners | | | Assurance Level | 2018/19 | | 19/20 | |
|---------------------------|-------------|---------------------|---|---|--|-----------------------|-----------------|---------|----|-------|----|
| | | | | | | | | Q3 | Q4 | Q1 | Q2 |
| Executive Lead | John Holden | | | Assuring Committee | | Partnership Committee | | | | | |

| Positive Assurance | | | Negative Assurance | | | Gaps in Assurance | Rationale for Assurance Level |
|--------------------|---|----------------------------------|--------------------|------------------------|------------------|---|--|
| Date | Assurance | Source | Date | Assurance | Source | | |
| July 2019 | Positive progress across “horizontal” and “vertical” integration and as well as Acute service collaboration with Airedale NHS FT. | Report to partnerships Committee | July 2019 | Partnerships dashboard | Dashboard | Ability to ensure other committees are sighted on the risks that may be generated by the work of the Airedale Collaboration | 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 |
| July 2019 | WYAAT Programme Directors report | Closed Board | | | | | |
| July 2019 | Partnerships dashboard | Dashboard | | | | | |

| Key performance Indicator | | Principal Risk (s) | | Potential consequences | Composite risk rating | | | | | Component risks >12 | |
|---------------------------|---|--------------------|---|--|-----------------------|----------|--------|---------|---------------------|---------------------|-----------------|
| | | | | | Initial | Residual | Target | Current | Direction of travel | Number | Highest Current |
| 1 | Local integrated care (“vertical” integration): assessment of strategy and integration directorate of progress towards BTHFT’s strategic goals in this area. | 7 | Failure to deliver strategic partnerships | Missed opportunity to implement clinical strategy and improve patient care due to e.g. destabilised clinical services, loss of market share, reputational damage, financial loss, operational issues | 12 | 6 | 6 | 10 | ↔ | 6 | 12 |
| 2 | System-wide planning & decisions (“horizontal” integration): assessment of strategy and integration directorate of progress towards BTHFT’s strategic goals in this area. | | | | | | | | | | |
| 3 | Acute service collaboration with Airedale NHS FT: assessment of strategy and integration directorate of progress towards BTHFT’s strategic goals in this area. | | | | | | | | | | |

| High Level Controls | Gaps in controls | Routine Sources of Assurance | Risk Appetite |
|--|--|---|---|
| <p>EMT Governance</p> <p>Implementation of Clinical Services Strategy 2017-2022 through CBU service planning and EMT updates</p> <p>Participation in :</p> <ul style="list-style-type: none"> ICS System Leadership Exec Group, and System Oversight and Assurance 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 Programme exec (CEOs) and Committee in Common and Exec directors groups. | <p>Need to better co-ordinate activity and information within the trust (exec and senior managers) related to vertical and horizontal integration.</p> | <ol style="list-style-type: none"> Stakeholder engagement survey WYAAT Programme Director’s Report (feeds in to Committee in Common, WYAAT CEOs and sub groups eg FDs, Med Directors, Strategy & Ops) Papers for ICS System Leadership Executive and System Oversight and Assurance Group (by exception) Papers for Acute Provider Collaboration Programme (with ANHSFT) Partnerships Dashboard Papers for Integration and Change Board, and Health and Care Partnership Board (by exception) Papers for Integrated Management Board of Bradford Provider Alliance (currently chaired by BTHFT). | <p>Seek: Eager to be innovative and to choose options offering potentially higher business rewards</p> |

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

| | | | | |
|--------------------------------------|---------------------------------------|----------------------|--|-----------|
| | | | Date of update | 23/9/2019 |
| 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 |
| 6 | Create process to ensure other committees are sighted on the risk generated by the Airedale collaboration work (assigned in July 2019 partnerships committee) | JH | 23 July 2019 | November 2019 | | | | |
| 5 | Ensuring there is regular formal but also flexible oversight from EDs as partnership work with Airedale quickly gathers pace Ensuring the trust monitors the programme from both a strategic and programme management perspective | JH | Jan 31 2019 | 30 July 2019 | | 30 July 2019 | EDs are sitting on governance board for the Airedale collaboration and the work is a standing item at EMT. In initial months of the programme, the Trust will monitor to ensure this provides sufficient oversight. | Airedale Programme Board ToR, EMT agenda. |
| 4 | 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 is gained from EDs. This feedback is then assessed by S&I team against overall KPIs. This will be supplemented by assessing the externally produced reports that created as part of the collaborative programmes. | Email to EDs 20 November |
| 3 | 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 drafted risk on Datix, approved at IRGC. | Datix reference 3260 |
| 2 | 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, approved by IGRC | Datix reference 3255; IGRC I.6.18.5 |
| 1 | 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 | Comments were sought on SPA (key opportunity to influence its development) and this BAF. NB SPA now finalised and signed | Email to Partnerships Committee |

| | | | | | | | | |
|------------------|--|--|----------------------|-----------------------------|---------------|--------------------------|---------------------------|----------------------------------|
| Objective | 2 | To address gaps in assurance related to achievement of this strategic objective | | | | | | |
| No | Action | Lead | Date Assigned | Scheduled completion | Status | Actual Completion | Comments | Evidence |
| 1 | Appoint dedicated "Head of Partnerships" to oversee and co-ordinate vertical integration | JH | 1 Feb 2018 | 6 June 2018 | | 9 July | Appointee started 9 July. | Advert on NHS Jobs; HR paperwork |

Annex 1 Strategic Risk Register

STRATEGIC RISK REGISTER: PRINCIPAL RISKS (Overview)

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

| Appendix 2: Board Assurance Framework Legend | | | | | |
|--|---|------------------------|----------|---|--|
| Descriptors | | Defining risk appetite | | | |
| Principal Risk | What could prevent the Strategic Objective from being achieved? | 0 | Avoid | Avoidance of risk is a key organisational objective | |
| High Level Controls | What controls/systems do we have in place to assist secure delivery of the objectives? | 1 | Minimal | (as little as reasonable possible) preference for ultra- safe delivery options that have a low degree of inherent risk | |
| Gaps in Controls | Are there any gaps in the effectiveness of controls or systems? | 2 | Cautious | Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward | |
| Sources of assurance | Where can we gain evidence in relation to the effectiveness of the controls/systems which we are relying on? | | | | |
| Positive Assurance | What evidence have we of progress towards or achievement of our strategic objective? | 3 | Open | Willing to consider all potential delivery options and choose while also providing an acceptable level of reward | |
| Negative Assurance | What evidence have we of progress towards our strategic objectives being compromised? | 4 | Seek | Eager to be innovative and to choose options offering potentially higher business rewards | |
| Gaps in Assurance | Where can we improve the evidence about the effectiveness of one or more of the key controls/systems which we are relying on? | 5 | Mature | Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust | |
| Rationale for assurance level | (see Appendix 2) a description of the reason for the decision in relation to assurance level agreed by the assuring committee | | | | |
| Risk Appetite | The level of risk the organisation is prepared to tolerate in relation to the secure delivery of each individual strategic objective | | | | |
| Levels of assurance | | | | | |
| little or no confidence | Low. No evidence of necessary structure/processes supporting mitigation of risk associated with the achievement of strategic objective | | | Risk | |
| limited confidence | Compromised. Limited evidence of necessary structure/processes mitigation of risk associated with the achievement of strategic objective | | | Risk | |
| confidence | Confident. Range of structures and processes in place supporting mitigation of risk associated with the achievement of strategic objective available and used by the organisation | | | Opportunities for change and improvement | |
| High Confidence | Trust. Comprehensive evidence of effective and sustainable mitigation of risk associated with achievement of the strategic objectives | | | Opportunities for learning | |