Bradford Teaching Hospitals NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK: Quarter 3 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 3 2019/20
Assurance Overview						Date	December 2019					
Strategic Objective		Current Assurance Level	Reason for Assurance Level	Executive Lead	Assuring Committee	Quarterly assurance ratings				Strategic Risk		
						18/19	19/20					
						Q4	Q1	Q2	Q3	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	16	
2a	To deliver our financial plan		The Month 8 (planned deficit before PSF is £8.8m). The planned position was achieved for the period ending 30.11.19 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 and is likely to secure the Q3 position but future quarters are at risk given the quarterly improvement required to achieve the year end deficit control total of £12.5m before PSF. The quarterly assurance rating remains green as the Trust has secured delivery of the planned trajectory at the end of Quarter 2, with a predicted delivery of Q3. 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. The rational for the assurance level does not include any financial impact associated with the unwind of the financial arrangements relating to the Wholly Owned Subsidiary. Discussions continue with NHSI and the ICS.	Director of Finance	Finance and Performance					16	16	
2b	To deliver our key performance targets			Chief Operating Officer	Finance and Performance					12	12	
3	To be in the top 20% of employers in the NHS		The Committee are assured that effective are controls in place, there are no additional gaps in controls or assurance and that we are delivering our work-plans associated with this strategic objective to time and target.	Director of Human Resources	Workforce					9	20	
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		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					12	12	

BOARD ASSURANCE FRAMEWORK	Strategic Objective	1	To provide outstanding care for our patients		18/19	19/20		
					Q4	Q1	Q2	Q3
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** **Patient experience report** **Freedom to speak up report** **Clinical Effectiveness Report** **IPC report**	Report
Annual	**Sub Committee reports** **Data Security Protection Toolkit** **Data Protection Officer Report** **Safeguarding: Adults and Children (biannual)** **Inpatient survey**	Report
Nov	**ICO has closed remaining the 2 reportable incidents** **Safer Invasive Procedures report- Quality Committee** **Sustainable Quality Improvement update**	Report
Dec 2019	Paediatric Diabetes Service Anaesthetic service peer review Infectious Disease service update Sepsis progress update 30 day readmissions CQC compliance	Report

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
Dec 2019	**Infectious Disease service update** **Sepsis progress update** **30 day readmissions**	Report to Quality Committee

Gaps in Assurance

Rationale for Assurance Level
We continue to maintain systems, processes and outcome to aspire to deliver outstanding care for our patients

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:	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,
Delayed Transfers of Care benchmarking	mandatory training, sickness absence
Policy and Procedure compliance benchmarking	benchmarking, Placement satisfaction
National Audit Programme	benchmarking (medical students)
Health and safety benchmarking	Data Security Protection Toolkit
Structured Judgement Review Programme	Internal audit reports relevant to controls

Gaps in controls
Implementation of always events **Fulsome** real time quality data÷

Routine Sources of Assurance	
Exception reports from Sub Committees (from February 2019)	Quality Oversight System report
Patient experience report	Infection Prevention and control report
Risk management report	Safe staffing report
Serious Incident report	Escalation of risks to quality from other Board Committees
Effectiveness Report	Safe Staffing report
CQC compliance reporting	Quality Committee Dashboard and trend analysis
Safeguarding report	Serious incident report
Learning report	Incident report
Learning from deaths report	Information Governance Report
Quality Committee Dashboard	
Clinical Effectiveness report	

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	18/12/2019
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 2020	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			
4.	to implement a review and improvement programme for 30 day readmissions	CMO	December 2019	December 2020	O		Programme of improvement presented to QC in December 2019	Paper presented to QC

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	

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

Positive Assurance

Date	Assurance	Source
July 2019	Fixed Income Contract agreed with main commissioners (Bradford & Airedale). Improved baseline contract value compared to PbR contract	Finance Report
Sept 2019	Financial position on plan for Year to Date position ensuring PSF and FRF funding is recovered.	Finance Report
Sept 2019	Weekly CBU assurance meetings focussing solely on CIP delivery	Finance Report
Nov 2019	Recovery plans provided by each Care Group totalling £1.9m	Care Group Performance Review Meetings
Dec 2019	System (ICS) flexibilities and over performance elsewhere in West Yorkshire being reviewed to assess deliverability of overall ICS control total	ICS DOFs meeting and SOAG

Negative Assurance

Date	Assurance	Source
Sept 19	Identification and implementation of sufficient cash releasing measures to ensure annual CIP target is delivered. Underspends against budgets utilised to deliver Month 5 (August) position. The current run rate secured Q2 and will likely delivery Q3 but future quarters are at risk given the Q4 improvement required and the expected pressures to achieve the year end deficit control total of £12.5m before PSF.	Finance report

Gaps in Assurance

Definitive plans to secure the full value of control total requirement on a recurrent and sustainable basis:

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.

Rationale for Assurance Level

The Month 8 (planned deficit before PSF is £8.8m). The planned position was achieved for the period ending 30.11.19 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 and is likely to secure the Q3 position but future quarters are at risk given the quarterly improvement required to achieve the year end deficit control total of £12.5m before PSF.

The quarterly assurance rating remains green as the Trust has secured delivery of the planned trajectory at the end of Quarter 2, with a predicted delivery of Q3. 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.

The rational for the assurance level does not include any financial impact associated with the unwind of the financial arrangements relating to the Wholly Owned Subsidiary. Discussions continue with NHSI and the ICS.

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**	↓	**2**	**16**

High Level Controls

Executive led Care Group Financial performance management
Bradford Improvement Plan Governance
Performance management and assurance of CIP delivery (including weekly CIP assurance meetings for each CBU)
Budget setting and business planning
Quality Impact Assessment and Financial Impact Assessment process
Standing Financial Instructions and Scheme of Delegation
Issuance of Budgetary Management Framework to support new Care Groups and Clinical Business Units (CBU's)

Gaps in controls

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
Quarterly Capital Report to Finance and Performance Committee
Quarterly Treasury Management Report to Finance and Performance Committee

Risk Appetite

Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward

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

			Date of update	24/12/2019
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 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 assurance meetings

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 offsetting the gaps at the end of Month 8 (November).	Finance Report to Finance & Performance Committee Outputs from CBU weekly CIP assurance meetings

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

BOARD ASSURANCE FRAMEWORK	Strategic Objective	2b	To deliver our key performance targets		18/19	19/20		
					Q4	Q1	Q2	Q3
Executive Lead	Sandra Shannon		Assuring Committee	Finance and Performance	Assurance Level			

Positive Assurance		
Date	Assurance	Source
17/12/19	Implementation of the action plan to improve the ECS performance. Improvement plan update provided to F&P committee on 25/10/19 Daily performance reporting of ECS to NHSI Improved performance for ambulance handover. Business case for revised staffing model approved at Trust Board on 7/3/19 . External visit and review of programme by NHSEI Regional clinical leads for urgent care and GIRFT Increase in the number of patients treated on same day emergency care pathway -33%	ECS improvement Plan 2019/20 F&P agenda item F9.19.16 NHS Improvement Daily Situation Report Closed Board – agenda item BC.3.19.8 Formal report from NSHE/I
17/12/19	Implementation of the action plan to improve the Cancer 62 Day performance - – improvement plan update provided to F&P committee on 30/10/19 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 for the last 3 months and YTD 19/20 62 day standard achieved in July 19. Reduction in 62 day backlog. YTD improvement across all CWT standards.	Cancer 62 day performance improvement Plan – F&P agenda item F10.19.15 National cancer waiting time monthly submission. Performance report to Board of Directors agenda item BO11.19.42
17/12/19	Implementation of the plan to reduce elective waiting times – improvement plan update provided to F&P committee on 30/10/19 Month on month improvement in RTT There have been no 52 week waiters for 12 months.	ECR action plan F&P agenda item – F.7.19.13i 18 week national return Performance report to Board of Directors agenda item BO11.19.42

Negative Assurance		
Date	Assurance	Source
17/12/19	Current performance in relation to ECS standard Still relatively low numbers of patients transferred directly from ED to same day emergency care/ ambulatory pathway Consultant vacancies for acute medicine – recruitment in process	Performance Report to Finance & Performance Committee F10.19.14
17/12/19	Current performance in relation Cancer 62 day standard -62 standards not yet achieved consistently	National cancer waiting time monthly submission Performance Report to Finance & Performance Committee F10.19.14
17/12/19	RTT incomplete standard not yet achieved	Performance Report to Finance & Performance Committee F10.19.14 18 week incomplete waiting list -

Gaps in Assurance
A Cerner software bug which means the Trust is unable to report complete RTT pathways

Rationale for Assurance Level

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
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 weekly ECS breach review meetings Urgent Care Programme board Daily safety huddle in ED Planned care programme board

Gaps in controls
ECS- the current workforce is not sufficient to meet current emergency demand . Recruitment ongoing but consultants reluctant to undertake additional sessions and a reduction in middle grade trainees has offset the impact of recruitment.

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 Quarterly Informatics Performance Report

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	17/12/19
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	

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 recruit to a new workforce model that matches staff resource with emergency demand	COO	May 19	30/10/20			Revised workforce model agreed. Business case approved at Trust Board and recruitment has commenced. Recruitment progressing well to nursing and ACP vacancies. However due to pensions tax issue consultants are reluctant to undertake additional sessions. There has also been a reduction in middle grade trainees which has offset the impact of recruitment.	
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	31/11/20			Plan for blue zone has been agreed. 5 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) Business case for Blue Zone goes to Board in January 20. The design team has been appointment and planning commenced.	

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 20			Programme commenced. Detailed action plan in place. Due to additional DQ issues identified, the completion date for this action has been extended. A proposal for additional resource to support DQ improvement will be submitted to SLT in January 20.	

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

Positive Assurance

Date	Assurance	Source
December 2019	Monthly: Workforce dashboard trends Nurse Staffing data publication Education and Workforce Sub Committee	Report Report Minutes
	Bi-Monthly: detailed workforce report Development Sessions	Report Presentation
	Quarterly: Freedom to speak up report Guardian of safe working hours	Report Report
	6 Monthly: Equality report incorporating WRES/WDES People Strategy workplan update Nursing & midwifery establishment review Nursing recruitment & retention action plan update NHS Staff Survey action plan update Seven Day Services	Reports
	Annual: NHS Staff Survey Annual Report Annual Organisational Audit (AOA) QA of Postgraduate medicine training report	Reports

Negative Assurance

Date	Assurance	Source
December 2019	Workforce Dashboard and trends Nurse Staffing Report	 Report
	Guardian of safe working hours	Report
	ED/Obs & Gynae negative outlier in respect of workload	Report

Gaps in Assurance

Routine access to comparator data in some areas

Rationale for Assurance Level

The Committee are assured that effective are controls in place, there are no additional gaps in controls or assurance and that we are delivering our work-plans associated with this strategic objective to time and target.

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	Overall:Retain above average overall staff engagement indicator scores benchmarked against acute Trusts with a target of top 20% by 2021/22	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	9	←	7	20
B	Retain: Maintain a turnover rate between 10 -14% Develop:										
C	Ensure all eligible staff have an effective annual appraisal monitoring both completion rates [95%] and quality [through staff survey]										
D	Attract and Lead:To employ a workforce representative of our local communities in line with our Equalities Objectives/WRES action plan to include monitoring against our agreed equality objectives.										
E	Happy, healthy and here :achieve sickness absence rates of less than 4.50% in 2019/20										

High Level Controls

Care Group Performance management	Staff survey action plan
Workforce dashboard	Bi -Annual review of nurse and midwife staffing establishments
Monitoring of safe staffing	Mandatory training and appraisal performance management
Monitoring of recruitment against budget	Education and workforce Committee
Time to talk/We are Bradford/OD Plan	Human Resources Policies and Procedures
Our People Strategy 2017 and annual workplans	Equality objectives/ WRES Action plan/Equality plan
Personal responsibility framework	GMC reports
Guardian of Safe Working Hours reports	Staff friends and family
Workforce planning	NHS Staff Survey
Leadership strategy	
Equality Plan	

Gaps in controls

Contemporaneous staff experience data
–
Workforce transformation support
Workforce plan to match clinical services strategy in development

Routine Sources of Assurance

Workforce report	Workforce Race Equality Standard Report
Workforce Committee Dashboard	Guardian of safe working hours report
Board Integrated Dashboard	Staff Friends and Family Test
HEE/NHSI workforce return/workforce plan	Model Hospital portal for benchmarking purposes
Junior Doctor fill rates	Audit reports
Update report on staff survey action plan	Staff Advocate service contacts and outcomes
Nurse recruitment and retention plan	Leadership walkarounds
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	

Risk Appetite

Seeking – Preference for safe delivery options particularly in relation to nurse staffing that have a low degree of inherent risk to patient safety and may only have limited potential for reward. Is now willing to consider all potential options including the introduction of new workforce models and new ways of working whilst also providing an acceptable level of reward

BOARD ASSURANCE FRAMEWORK	Strategic Objective	4	To be a continually learning organisation	Assurance Level	18/19	19/20		
					Q4	Q1	Q2	Q3
Executive Lead	Bryan Gill		Assuring Committee	Quality Committee				

Positive Assurance		
Date	**Assurance**	**Source**
MONTHLY	Serious Incident Report	Quality Committee
QUARTERLY	Combined Learning Report	Quality Committee
	Leadership Walk round update	Quality Committee
	Learning from Deaths	Quality Committee
	Patient Experience	Quality Committee
	Guardian of Safe Working Hours	Workforce Committee
	Clinical Effectiveness Report	Quality Committee
ANNUALLY	Safer Procedures	Quality Committee
	Patient Safety Sub- Committee Report	Quality Committee
	Research Translation & Innovation Report	
	Quality Account	Quality Committee
30.10.2019	Sustainable Quality Improvement Update	Quality Committee
	GMC National Training Survey 2019	Quality Committee
	Quality Plan	Quality Committee
21/11/2019	WYVAS GIRFT meeting	GIRFT
13/12/2019	WYAAT Pathology Meeting	GIRFT
18/122019	Paediatrics Diabetes Update	Quality Committee
18/12/2019	Peer review; Royal college of Anaesthetists	Quality Committee
18/12/2019	Sepsis update	Quality Committee
18/12/2019	Readmissions review	Quality Committee

Negative Assurance		
Date	**Assurance**	**Source**
MONTHLY	Serious Incident Report	Quality Committee
QUARTERLY		
ANNUALLY		
30.10.2019	GMC National Training Survey 2019	Quality Committee

Gaps in Assurance
Identification of risks associated with the delivery of the objectives.

Rationale for Assurance Level

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
HEICQC Compliance Action Plan
GMC National Training Survey 2018

Gaps in controls
Lack of quantifiable measures of assurance

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	Undertake a review of this strategic objective given the strong learning that is embedded in all the other strategic objectives	CMO	December 2019	01/06/2020	**O**		Reported to quality Committee	Report to Board of Directors

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	5	To collaborate effectively with local and regional partners	Assurance Level	18/19	2019/20		
					Q4	Q1	Q2	Q3
Executive Lead	John Holden		Assuring Committee	Partnership Committee				

Positive Assurance		
Date	**Assurance**	**Source**
26 Nov 2019	Progress reports to Partnerships Committee on "horizontal" & "vertical" integration and Airedale APC	Report to partnerships Committee
7 Nov 2019	WYAAT Programme Director's report reported to Closed Board	WYAAT PMO
7 Nov 2019	Partnerships dashboard noted at Open Board	Compiled by Strategy & Integration team

Negative Assurance		
Date	**Assurance**	**Source**
7 Nov 2019	Partnerships dashboard noted at Open Board	Compiled by Strategy & Integration team
10-12 Dec 2019	Suggestion that despite our efforts, previous BTHFT reputation as "isolationist" has not been entirely dispelled	Questions to CEO from CQC (during "Well Led")

Gaps in Assurance

Lack of metrics to measure progress within Partnership dashboard categories - currently reliant on subjective narrative.

Rationale for Assurance Level

Confident. Partnership work for all acute collaboration and vertical integration is necessarily dependent on the input and co-operation of external organisations. Elements of partnership work will always be beyond the direct influence and control of BTHFT though we can do a lot to shape the environment.

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 by Strategy & Integration team of progress towards seamless care across BHCPB	7	Failure to deliver benefits of strategic partnerships	Missed opportunity to deliver seamless care for Bradford population due to lack of coherent approach, and possible adverse impacts e.g. destabilised clinical services, loss of market share, reputational damage, financial loss, operational issues	12	6	6	9	↔	6	12
2	System-wide planning & decisions ("horizontal" integration) assessment by Strategy & Integration team of progress towards effective WYHCP collaboration										
3	Acute service collaboration with Airedale NHS FT: assessment by Strategy & Integration team of progress towards APC's stated ambitions										

High Level Controls

SLT Governance
Implementation of Clinical Services Strategy 2017-2022 through CBU service planning and SLT updates

Cross system participation in :

- ICS System Leadership Exec Group; System Oversight & Assurance Group; Partnership Board
- Bradford & Districts Health & Wellbeing Board
- Bradford Districts & Craven Integration & Change Board (ICB)
- Bradford Health & Care Partnerships Board (programme board for place-based integrated care)
- Integrated Management Board (IMB) of Bradford Provider Alliance
- WYAAT Programme Exec (CEOs); Committee in Common (chaired by BTHFT's chair); Exec Directors' groups.

Gaps in controls

Need to better co-ordinate activity and information exchange within the trust (Exec and senior managers) related to vertical and horizontal integration

Need a more transparent/systematic measure of progress to permit consistent reporting of depth/span of 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). Also shared in Closed Board
3. Papers for ICS System Leadership Executive and System Oversight & Assurance Group (by exception)
4. Papers for Acute Provider Collaboration Programme (with ANHSFT)
5. Partnerships Dashboard
6. Papers for Integration & Change Board, and Bradford Health & Care Partnership Board (by exception)
7. Papers for Integrated Management Board of Bradford Provider Alliance.

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	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 (local "place" ie Bradford & districts); 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
7	Create metrics for dashboard areas (outside of stakeholder engagement) in order to more accurately record progress.	JH	Nov 2019	January 2020			Work ongoing but no firm conclusions yet	
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			Paper has been sent to Director of Corporate Affairs to obtain Chair's agreement to be used ahead of January board with all committee chairs.	
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 changes**
1	Failure to maintain the quality of patient services	16	8	4	12	↔	Minimal	To be review in light of Board discussion on 9/1/2020
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