BOARD ASSURANCE FRAMEWORK: Quarter 1 2020/21

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. 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. In response to the COVID-19 Pandemic changes to the operational delivery model of the Trust and governance infrastructure led to a revised approach to assurance associated with the delivery of the Trust's strategic objectives, with the Executive and Non-Executive Regulation Committee being a key conduit of assurance relate to the Trust's response and performance. The Board Assurance Framework reflects the impact of the Trust's pandemic response in relation to the achievement of its strategic objectives. This revised approach has been reviewed and assured using Audit Yorkshire's Governance Checklist and presented to the Audit and Assurance Committee and will be received by the Board of Directors.

BOARD ASSURANCE FRAMEWORK												Q 1 2020/21	
Assurance Overview							Date				June 2020		
Strategic Objective		Current Assurance Level	Reason for Assurance Level	Executive Lead	Assuring Committee	Quarterly assurance ratings				Strategic Risk	
						19/20			20/21		
						Q2	Q3	Q4	Q1	Principal composite	Highest
1	To provide outstanding care for our patients		Despite the requirement for us to rapidly transform the way we provide services and respond to the treatment and care needs of patient affected by COVID19, we have maintained our focus on our objective to provide outstanding care for our patients, ensuring our command and control response and infrastructure is clinically led and operationally supported. We have maintained our quality oversight system and ensured that key elements of our quality management system are sustained. The gaps in assurance in relation to the achievement of this objective are subject to Executive Director scrutiny and assessment of risk.	Chief Nurse/ Chief Medical Officer	Quality					12	15
2a	To deliver our financial plan		The established financial regime has been suspended and replaced with a simplified framework in response to the COVID-19 Pandemic. This simplified framework is designed to ensure providers receive sufficient cash to facilitate the required response to the pandemic while delivering a breakeven position. For April 2020, the Trust reported a £2.1m deficit prior to top up funding. This deficit is £1.3m greater than NHS England/Improvement's (NHS E/I) projection. At a summarised level this £1.3m adverse variance can be explained by: baseline issues (£1.9m), variances on non-pay due to reduced clinical activity £2.0m and COVID-19 related expenditure (£1.4m). A total of £2.1m of top up funding is reflected in the Month 1 position to deliver the break-even position required by NHSE/I. It should be noted that there remains a risk to full recovery of this accrued top up income should NHSE/I not consider some of the identified COVID-19 costs to be appropriate.	Director of Finance	Finance and Performance					6	6
2b	To deliver our key performance targets		In response to the Covid-19 pandemic there was a national directive to halt all routine and non-essential activity. This was to enable additional critical care and in-patient beds to be available for the treatment of Covid-19 patients and to release staff to provide care to Covid-19 patients. As a result waiting times for RTT and cancer standards significantly increased. A daily clinical prioritisation process was undertaken to allocate limited resources to patients whose disease progression was time sensitive.	Chief Operating Officer	Finance and Performance					12	12
3	To be in the top 20% of employers in the NHS		As a result of our response to the COVID19 pandemic a command and control infrastructure was implemented, of which a key executive led work-stream related to our workforce, which enabled us to maintain our focus on the achievement of and assurance associated with our strategic objective and the well being and resilience of our staff. The gaps in assurance in relation to the achievement of this objective are subject to Executive Director scrutiny and assessment of risk.	Director of Human Resources	Workforce					9	12
4	To be a continually learning organisation		The learning and innovation demonstrated through the rapid transformation in response to the COVID19 pandemic during Q1 2020/21 has been reported to the E&NE R Committee and the Board of Directors. The clinically led Command and Control infrastructure, together with clear governance and risk escalation process as described in the operational response plan provides evidence to support our confidence in the achievement of this objective.	Chief Medical Officer	Quality					8	n/r
5	To collaborate effectively with local and regional partners		Since onset of pandemic, health & care partners have worked together to support joint planning and where necessary aligned decision making, for example through City-wide Gold command. BTHFT has recently met with PCN clinical leads (alongside Airedale FT) to ensure new service models are fit for future and not simply a re-boot of what existed previously: huge opportunity created out of a difficult situation. There are 7 individual transformation programmes now underway on behalf of the whole system, 3 being led by BTHFT Execs (access, diabetes, respiratory) and reporting to newly constituted Bradford H&C Partnership Board (chaired by BTHFT CEO) .	Director of Strategy and Integration	Partnerships					9	9

Bradford Teaching Hospitals NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK	Strategic Objective	1	To provide outstanding care for our patients		Assurance Level	19/20			20/21
						Q2	Q3	Q4	Q1
Executive Lead	Chief Medical Officer/Chief Nurse		**Assuring Committee**	**Quality/ E&NE R Committee**					

Positive Assurance (bold received to date in quarter)		
Date	Assurance	Source
Monthly	Quality Committee Dashboard and trend analysis Quality oversight system Maternity update report QUOC (weekly) Panel	Report
Quarterly	Incident and health safety compliance report – E&NE R Committee Maternity report IPC report – E&NE R Committee	Report Report Report
Annual	Data Security Protection Toolkit – E&NER Committee Inpatient survey – E&NER Committee Health and Safety Annual report-E&NER Committee	Report Report Report
Quarter 1	IPC Board Assurance Framework CQC Compliance report and action plan Maternity Improvement Plan COVID response update Staff well-being and resilience Serious Incident Report Cyber Security Internal Audit Report Digital Strategy delivery Internal Audit Report	Report Report Report Report Report Report Report Report

Negative Assurance (bold received in quarter)		
Date	Assurance	Source
Monthly	IG incident	Dashboard
Quarterly	Incident and health safety compliance report – E&NE R Committee	Report
Quarter 4		

Gaps in Assurance
During the COVID 19 response routine reporting was suspended, meaning a number of routine reports have not been submitted for Committee review. This has been mitigated through exception reporting to the Executive and Non-Executive Regulation Committee supported by a command and control infrastructure.

Rationale for Assurance Level
Despite the requirement for us to rapidly transform the way we provide services and respond to the treatment and care needs of patient affected by COVID19, we have maintained our focus on our objective to provide outstanding care for our patients, ensuring our command and control response and infrastructure is clinically led and operationally supported. We have maintained our quality oversight system and ensured that key elements of our quality management system are sustained. The gaps in assurance in relation to the achievement of this objective are subject to Executive Director scrutiny and assessment of risk.

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	12
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
Making use of 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	10/6/2020
Accountability		**Responsibility**	
Lead	**Oversight/governance structure**	**Lead**	**Work-stream/operational group**
Chief Nurse (CN)	Quality Committee	Deputy Medical Director (DMD)	Going Digital Programme Board
Medical Director (MD)		Deputy Chief Nurse (DCN)	Clinical Audit and Effectiveness Sub-Committee
		Nurse Consultant IPCC (NCIPCC)	
		Head of Business Intelligence (HBI)	

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

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
1	To develop functionality to enable real time quality metric reporting	HBI	June 2018	June 2020	**O**	First phase (maternity) now in place	This is part of ongoing work to optimise the data available from EPR and its associated analytics. Several dashboards have been developed to date. Oversight Dashboard being trialled. Item to be closed once trial complete.	Quality dashboards, e.g., Maternity
2	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. Programme paused until understand impact of Covid

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 routine assurance reports are risk assessed and added to the appropriate Board Committee work-plan following the Board approval of the proposed new Board and Committee governance infrastructure	KD/ BG	April 2020	November 2020	**O**			

BOARD ASSURANCE FRAMEWORK	Strategic Objective	2a	To deliver our financial plan	Assurance Level	19/20			20/21
					Q2	Q3	Q4	Q1
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
Mar 2020	The year end control total was successfully delivered (subject to audit).	Draft Annual Statutory Accounts. Final Statutory Accounts and Annual Report finalised June 2020.
June 2020	The COVID 19 Financial Regime delivers a breakeven position until at least 31 July with all COVID 19 related costs retrospectively funded	Finance Dashboard

Negative Assurance		
Date	**Assurance**	**Source**
Jan 20	The control total for 2019/20 was successfully delivered at year end (subject to audit). The financial regime beyond 31 July has yet to be confirmed.	Finance report

Gaps in Assurance

For future financial years, 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 established financial regime has been suspended and replaced with a simplified framework in response to the COVID-19 Pandemic. This simplified framework is designed to ensure providers receive sufficient cash to facilitate the required response to the pandemic while delivering a breakeven position. For April 2020, the Trust reported a £2.1m deficit prior to top up funding. This deficit is £1.3m greater than NHS England/Improvement's (NHS E/I) projection. At a summarised level this £1.3m adverse variance can be explained by: baseline issues (£1.9m), variances on non-pay due to reduced clinical activity £2.0m and COVID-19 related expenditure (£1.4m). A total of £2.1m of top up funding is reflected in the Month 1 position to deliver the break-even position required by NHSE/I. It should be noted that there remains a risk to full recovery of this accrued top up income should NHSE/I not consider some of the identified COVID-19 costs to be appropriate

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 FRF funding and deliver liquidity plan to ensure sufficient cash to protect the capital programme	3	Failure to maintain financial stability	Damage to reputation, financial and liquidity compromise, loss of market share, regulatory action	6	6	6	6	→	0	6

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	15/6/2020
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**

Objective	**2**	**To address gaps in assurance related to this strategic objective**						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**

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

BOARD ASSURANCE FRAMEWORK	Strategic Objective	2b	To deliver our key performance targets		19/20			20/21
					Q1	Q2	Q3	Q1
Executive Lead	Sandra Shannon		Assuring Committee	Finance and Performance	Assurance Level			

Positive Assurance		
Date	Assurance	Source
26/5/20	Implementation of the action plan to improve the ECS performance. Reduced ED attendances have had a positive impact on ECS performance 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%	NHS Improvement Daily Situation Report Formal report from NSHE/I ED dashboard ..\..\..\..\Trust HQ - Operational Management\Sandra Shannon and Nahida\Operations SLT\00 - Highlight Reports\201200428 Highlight Report to Ops Senior Leadership Team.pptx
Bo.3.20.28	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 – lowest ever in Trust 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.	National cancer waiting time monthly submission.
Bo.3.20.28	Implementation of the plan to reduce elective waiting times – improvement plan update provided to F&P committee on 12/3/20 Month on month improvement in RTT There have been no 52 week waiters for 17 months.	Planned care improvement programme U:\Trust HQ - Finance and Performance Committee\2020\2 - 26 FEBRUARY 2020\WORD\F.2.20.10 - Planned Care Improvement Programme Update.docx 18 week national return Performance report to Board of Directors agenda12/3/20 agenda item: Bo.3.20.28

Negative Assurance		
Date	Assurance	Source
Bo.3.20.28	Current performance in relation to ECS standard	Performance Report to Finance & Performance Committee F.2.10.10
Bo.3.20.28	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 F.2.20.10
Bo.3.20.28	RTT incomplete standard not yet achieved Increase in the number of patients over 40 weeks on the incomplete RTT waiting list due to cessation of routine elective activity in preparation for the covid-19 pandemic	Performance Report to F& P Committee F.2.20.10 18 week incomplete waiting list Ops SLT highlight report

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

Rationale for Assurance Level
Finance & Performance committee was assured of slow but steady improvement against a range of key access standards. Cancer: 2WW and 62 day standard met for March 202. . RTT: There has been a month on month improvement in RTT performance and improvement is in line with trajectory. There have been zero 52 week breaches for 17 months. ECS: There is limited confidence in the Trust's ability to achieve the ECS 95% standard. The improvement programme is on track and there is measurable improvement in a number of KPIs. The need to stop all routine outpatients and elective activity to prepare the management response for the Covid-19 pandemic.

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	23/1/2020
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. The trust is achieving 33% SDEC.	U:\Trust HQ - Operational Management\Sandra Shannon and Nahida\Operations SLT\00 - Highlight Reports\20200119-Highlight Report to Ops Senior Leadership Team FINAL.pptx

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.	
2	18 weeks RTT- To reduce the number of patients waiting more than 40 weeks to zero my April 2020.	COO	June 19	April 20			Daily huddle in place. Recovery plans agreed for all specialties which are being tracked by the Director of Ops weekly.	U:\Trust HQ - Operational Management\Sandra Shannon and Nahida\18 weeks RTT\20200123. Care Group Performance Recovery plan.xlsx

BOARD ASSURANCE FRAMEWORK	Strategic Objective	3	To be in the top 20% of employers in the NHS	Assurance Level	19/20			20/21
					Q2	Q3	Q4	Q1
Executive Lead	Pat Campbell	**Assuring Committee**	**Workforce**					

Positive Assurance		
Date	Assurance	Source
Quarter 1 2020	Monthly: Workforce dashboard trends Staff resilience and well being (report to Exec/non-exec regulation committee) including well being support sickness rates and Bame risk assessment process	Reports
	Covid 19 response updates re workforce	Presentation
	IPC Board Assurance Framework	Report
	Health and Safety Annual Report	Report
	Maternity Improvement Plan	Report
	Payroll Audit	Report

Negative Assurance		
Date	Assurance	Source
Quarter 1	Potential impact of test and trace on staff absence rates/provision of a safe working environment	Report/risk register

Gaps in Assurance

During the COVID 19 response routine reporting was suspended, meaning a number of routine reports have not been submitted for Committee review. This has been mitigated through exception reporting to the Executive and Non-Executive Regulation Committee supported by a command and control infrastructure

Rationale for Assurance Level

As a result of our response to the COVID19 pandemic a command and control infrastructure was implemented, of which a key executive led work-stream related to our workforce, which enabled us to maintain our focus on the achievement of and assurance associated with our strategic objective and the well being and resilience of our staff.
The gaps in assurance in relation to the achievement of this objective are subject to Executive Director scrutiny and assessment of risk.

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	12	↑	2	12
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	3	To be in the top 20% of Employers in the NHS	Action Plan to address Gaps in Controls and Assurance

		Date of update	27/2/2019
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 but not able to be pursued. Gap reflected on Board Assurance Framework.
2	To undertake a scoping exercise for a strategic workforce review	DDHR	06.2018	2/10/2019	**C**		Action reviewed and refreshed. Meeting held with Director of Transformation as workforce transformation support now in place.	
1	To ensure all gaps in assurance are risk assessed and added to the appropriate Board Committee work-plan following the Board approval of the proposed new Board and Committee governance infrastructure	DHR	April 2020	November 2020	**O**			

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

Positive Assurance		
Date	**Assurance**	**Source**
MONTHLY	Serious Incident Report	Report
QUARTERLY		
ANNUALLY		
Q1	COVID Response update IPC Board Assurance Framework Staff Well being and resilience Quality Oversight system	Report Report Report Report

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

Gaps in Assurance
During the COVID 19 response routine reporting was suspended, meaning a number of routine reports have not been submitted for Committee review. This has been mitigated through exception reporting to the Executive and Non-Executive Regulation Committee supported by a command and control infrastructure

Rationale for Assurance Level
The learning and innovation demonstrated through the rapid transformation in response to the COVID19 pandemic during Q1 2020/21 has been reported to the E&NE R Committee and the Board of Directors. The clinically led Command and Control infrastructure, together with clear governance and risk escalation process as described in the operational response plan provides evidence to support our confidence in the achievement of this objective.

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 2019

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	10/6/2020
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 . deferred due to Board review of future governance arrangements. Working towards an 'Academy' approach which is expected to provide a greater opportunity to identify learning metrics	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**
1	To ensure all gaps in assurance are risk assessed and added to the appropriate Board Committee work-plan following the Board approval of the proposed new Board and Committee governance infrastructure	KD/ BG	April 2020	November 2020	**O**			

BOARD ASSURANCE FRAMEWORK	Strategic Objective	5	To collaborate effectively with local and regional partners	Assurance Level	2019/20			20/21
					Q2	Q3	Q4	Q1
Executive Lead	John Holden	Assuring Committee	Partnership Committee					

Positive Assurance		
Date	**Assurance**	**Source**
16 Jun 2020	Since onset of pandemic, health & care partners have worked together to support joint planning and where necessary aligned decision making, for example through City-wide Gold command. BTHFT has recently met with PCN clinical leads (alongside Airedale FT) to ensure new service models are fit for future and not simply a re-boot of what existed previously: huge opportunity created out of a difficult situation. 7 individual transformation programmes on behalf of whole system, 3 being led by BTHFT Execs (access, diabetes, respiratory) and reporting to newly constituted Bradford H&C Partnership Board.	CEO report to Board (27/5) and to Regulation Committee (25/3 & 29/4). Director of S&I update to Board (27/5) in respect of Partnerships Committee workstreams New Bradford Health & Care Partnership Board (chaired by our CEO) 29/5 Regular discussion in Exec Management Team meetings

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

Gaps in Assurance
During the COVID 19 pandemic, routine reporting (as per the work plans) has been suspended. This has been mitigated by exception reporting to the Executive and Non-Executive regulation committee on a case by case basis, and supported by a command & control management structure. In addition the 'COVID governance checklist' that we completed has now been shared with the Audit Committee

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	↓	0	9
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
ETM Governance Implementation of Clinical Services Strategy 2017-2022 through CBU service planning and ETM 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) – to be reconstituted as Exec Group • 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 (to be reconstituted), 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	8/1/20
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
2	Appoint new “Head of Policy” to replace previous incumbent who formally moved post on 7 Dec 2019 (but has continued to provide some ad hoc support to mitigate risks)	JH	7 Dec 2019	14 Feb 2020			Closing date for job advert 10 Jan 2020	Advert on NHS Jobs; HR paperwork
3	Appoint new “Policy Manager” to replace previous incumbent who formally moved post on 22 Nov 2019	AS	22 Nov 2019	17 Jan 2020			Interviews w/c/ 13 Jan 2020; two candidates shortlisted	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	Reviewed and approved at meeting of the Board of Directors 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	6	↓	Open	
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	↓	Open	
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