

BOARD ASSURANCE FRAMEWORK: Quarter 2 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 Regulation Committee being a key conduit of assurance related 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. **Received by the Board of Directors (meeting in public) on 12 November 2020.**

BOARD ASSURANCE FRAMEWORK										Q 2 2020/21	
Assurance Overview						Date		November 2020			
Strategic Objective		Current Assurance Level	Reason for Assurance Level	Executive Lead	Assuring Committee	Quarterly assurance ratings				Strategic Risk	
						19/20		20/21			
						Q3	Q4	Q1	Q2	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 adapted and improved 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	Regulation and Assurance Committee					12	15
2a	To deliver our financial plan		For the period to September 2020, the Trust reported a £17.5m deficit prior to external NHSE/I top up funding. Top up funding to offset this £17.5m deficit is included in the position to result in a reported break even position. The top up requirement is £12.8m greater than NHS England/Improvement's (NHS E/I) projection which was a pre-covid deficit of £4.7mm for the first half of 2020/21. The Trust has incurred £11.9m of spend associated with the Covid-19 pandemic. NHSE/I requires the Board to be notified that there is a potential risk that the organisation's funding position may be adversely impacted by a retrospective claw back in subsequent months relating to the Elective Incentive Scheme. If the Trust's recovery of elective and outpatient activity falls below targeted levels on a sustained basis, the risk in the remainder of 2020/21 is up to £2m.	Director of Finance	Regulation and Assurance Committee					9	9
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. During this period waiting times significantly increased and performance against access targets deteriorated. The re-establish and recovery programme has commenced, however there is potential that this will be impacted by the increased COVID presentation expected in Wave 2. A daily clinical prioritisation process continues to allocate limited resources to patients whose disease progression was time sensitive. The trust is utilising all available independent sector capacity to undertake elective activity.	Chief Operating Officer	Regulation and Assurance Committee					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 was put in place, which enabled us to maintain our focus on the achievement of and assurance associated with this strategic objective particularly around workforce supply and the well-being and resilience of our staff. This workstream continues to meet twice a week. 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	Regulation and Assurance Committee					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	Regulation and Assurance Committee					8	n/r
5	To collaborate effectively with local and regional partners		Since onset of pandemic, health & care partners have worked together on joint planning and to align decision making, for example through Outbreak Control Board and the council's Advisory Board ("Gold"). Drawing on this, BTHFT has 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. The Act as One programme has created 7 transformation programmes on behalf of the whole "place", 3 led by BTHFT Execs (access, diabetes, respiratory) and reporting to newly constituted Bradford H&C Partnership Board (chaired by BTHFT CEO) . We participate in many other collab discussions through the West Yorks Assoc of Acute Trusts (WYAAT) and the WY&H Health & Care Partnership ("Integrated Care System").	Director of Strategy and Integration	Regulation and Assurance Committee					9	9

BOARD ASSURANCE FRAMEWORK		Strategic Objective	1	To provide outstanding care for our patients		Assurance Level	19/20		20/21	
Executive Lead		Chief Medical Officer/Chief Nurse		Assuring Committee	Regulation and Assurance Committee		Q3	Q4	Q1	Q2

Positive Assurance (bold received to date in quarter)			Negative Assurance (bold received in quarter)			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source		
Monthly	Quality Dashboard and trend analysis at E&NE R Committee Quality oversight report system (weekly at QUOC and monthly at E&NE R Committee) Maternity update report QUOC (weekly) Panel	Report	Monthly	IG incident	Dashboard	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 Regulation Committee supported by a command and control infrastructure.	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 adapted and improved 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.
Quarterly	Incident and health safety compliance report – E&NE R Committee Maternity report IPC report – E&NE R Committee	Report Report Report	Quarterly	Incident and health safety compliance report – E&NE R Committee	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 2				
Quarter 2	IPC Board Assurance Framework Maternity Services Update Quality Oversight & Assurance Report Serious Incident Report Freedom to Speak Annual Report Quality Account-Draft	Report Report Report Report Report Report					

Key performance Indicator		Principal Risk (s)		Potential consequences	Composite risk rating (strategic risks)					Component risks>12	
					Initial	Residual	Target	Current	Direction of travel	Number	Highest Current
a	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)		Gaps in controls	Routine Sources of Assurance		Risk Appetite
Quality Strategy	Friends and Family test	Access to comprehensive suite of real time quality data although some is available (VTE, Sepsis, NEWS)	QUOC panel (weekly)	Infection Prevention and control report	Cautious. Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Risk management strategy	National Inpatient survey		Quality Oversight E&NE R Committee	Safe staffing report	
Patient experience strategy	Other National Patient Surveys		Patient experience report	Escalation of risks to quality from other Board Committees	
Quality Oversight System	Complaint benchmarking		Risk management report	Safe Staffing report	
Infection Prevention and Control Standards	CQC compliance action plan		Serious Incident report	Quality Dashboard and trend analysis	
LocSSIPs programme	Performance (RTT/ECS/Cancer) benchmarking		Effectiveness Report	Serious incident report	
Quality improvement collaboratives:	PLACE assessments		CQC compliance reporting	Incident report	
Incident reporting benchmarking	Freedom to Speak Up programme		Safeguarding report	Information Governance Report	
SAFER implementation programme	Bradford Accreditation Scheme		Learning report		
NICE guidance implementation programme	Workforce: Safe staffing standards, appraisal, mandatory training, sickness absence		Learning from deaths report		
Delayed Transfers of Care benchmarking	benchmarking, Placement satisfaction		Clinical Effectiveness report		
Policy and Procedure compliance benchmarking	benchmarking (medical students)				
National Audit Programme	Data Security Protection Toolkit				
Health and safety benchmarking	Internal audit reports relevant to controls				
Structured Judgement Review Programme					

BOARD ASSURANCE FRAMEWORK	Strategic Objective	1	To provide outstanding care for our patients	Action Plan to address Gaps in Controls and Assurance
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		Date of update	4/11/2020
Accountability		Responsibility	
Lead	Oversight/governance structure	Lead	Work-stream/operational group
Chief Nurse (CN)	E&NE R Committee	Deputy Medical Director (DMD)	Going Digital Programme Board
Medical Director (MD)	QUOC Panel	Deputy Chief Nurse (DCN)	
		Nurse Consultant IPCC (NCIPCC)	
		Head of Business Intelligence (HBI)	

Objective	1	To address gaps in controls that compromise the assurance related to this strategic objective						
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
1	To develop functionality to enable real time quality metric reporting	HBI	June 2018	April 2021	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, VTE, NEWS, Sepsis
2	to implement a review and improvement programme for 30 day readmissions	CMO	December 2019	April 2021	O		Programme paused due to Covid-19. Due to restart in April 2021.	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	April 2021	O		Review of Governance now underway which is likely to alter this objective as the Academy and assurance model is implemented.	

BOARD ASSURANCE FRAMEWORK		Strategic Objective	2a	To deliver our financial plan			Assurance Level	19/20	20/21		
								Q3	Q4	Q1	Q2
Executive Lead		Director of Finance		Assuring Committee		Regulation and Assurance Committee					

Positive Assurance						Negative Assurance			<div>Gaps in Assurance</div> <div>For future financial years, definitive plans to secure the full value of control total requirement on a recurrent and sustainable basis:</div> <div>The Covid Pandemic has impacted on the ability to identify and implement sustainable efficiency plans. A number of innovations and different ways of working have been identified and embedded during the pandemic which should release productivity improvements. The full evaluation of the improvements will be assessed as part of the capacity planning for the remainder of the year in line with restart programme. The risk is that productivity gains will be eroded by the productivity impact of Covid and the infection control measures required to safely treat patients.</div>			<div>Rationale for Assurance Level</div> <div>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.</div> <div>For the period to September 2020, the Trust reported a £17.5m deficit prior to external NHSE/I top up funding. Top up funding to offset this £17.5m deficit is included in the position to result in a reported break even position. The top up requirement is £12.8m greater than NHS England/Improvement’s (NHS E/I) projection which was a pre-covid deficit of £4.7mm for the first half of 2020/21. The Trust has incurred £11.9m of spend associated with the Covid-19 pandemic. Further overspends relating to the re-start of elective activity totalling £0.9m result in the Trust requiring the £17.5m top up funding to deliver the breakeven position.</div>		
Date	Assurance	Source				Date	Assurance	Source						
July 2019	Fixed Income Contract agreed with main commissioners (Bradford & Airedale). Improved baseline contract value compared to PbR contract	Finance Report				Sept 20	The financial regime beyond 30 September and associated control total has yet to be confirmed.	Finance report						
Sept 2019	Financial position on plan for Year to Date position ensuring PSF and FRF funding is recovered.	Finance Report				Sept 20	From September 2020, the Elective Incentive Scheme has been introduced nationally. There is a risk that national funding may be clawed back if activity falls below targeted levels.	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												
Sept 2020	The COVID 19 Financial Regime delivers a breakeven position until at least 30 Sept with all COVID 19 related costs retrospectively funded	Finance Dashboard												

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 sustainability	Damage to reputation, financial and liquidity compromise, loss of market share, regulatory action	6	9	6	9	↑	0	9

High Level Controls		Gaps in controls		Routine Sources of Assurance		Risk Appetite	
Executive led Care Group Financial performance management 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)		The covid pandemic has impacted on the standard Financial management/governance controls. This includes the planning, implementation, measurement and management of a CIP/Efficiency programme. This control (subject to the implications of a second wave in the pandemic) will need to be re-established in Q3/Q4 of 2020/21 The Covid Pandemic and financial regime prompted a cessation of normal business activities and in particular performance management arrangements associated with the delivery of Care Group/CBU financial targets		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		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
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				Date of update	4/11/2020
Accountability			Responsibility		
Lead	Oversight/governance structure		Lead	Work-stream/operational group	
Director of Finance (DoF)	Finance and Performance Academy				
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	Re-establish appropriate governance, performance management and reporting in relation to the Financial management arrangements of the organisation	DOF/COO	Q3	Q3	O				

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	Re-establish appropriate governance, performance management and reporting in relation to the Financial management arrangements of the organisation	DOF/COO	Q3	Q3	O				

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

BOARD ASSURANCE FRAMEWORK		Strategic Objective	2b	To deliver our key performance targets		Assurance Level	19/20		20/21	
Executive Lead		Chief Operating Officer		Assuring Committee	Regulation and Assurance Committee		Q3	Q4	Q1	Q2

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source		
Nov 20	ECS performance continues to above the levels delivered at the same point last year, and in the top quartile for Type 1 when compared to other organisations within the region and nationally. Attendances have increased to be in line with pre-covid levels however despite this BTHFT have continued to maintain the performance improvement in comparison to the same point the previous year. SDEC model implemented and embedded. External visit and review of programme by NHSEI Regional clinical leads for urgent care and GIRFT CQC Patient First discussion held October 2020.	NHS Improvement Daily Situation Report Formal report from NSHE/I ED dashboard	Nov 20	Second wave of COVID admissions are already above those experienced within wave 1. This will impact on the reset and restart programme. Full impact of COVID 2 nd wave unknown at this stage.		The unknown impact of 2 nd Wave of COVID makes delivery of the reset and restart plans difficult to predict. The current Independent Sector is being renegotiated by NHSE/I and therefore the terms of a future contract are not fully understood at this stage.	Regulatory committee was assured of safe management of patient care and maintenance of essential activity during the pandemic. Detailed restart activity plans have been developed and activity against plan has been achieved for August. Ongoing monitoring is in place. Cancer: 2WW has been met consistently for 6 months. 62 day standard met for July 2020 with a deterioration in 62 day standard due to plans to treat all patients over 62 days. There has been an increase in ECS performance and increased confidence in the Trusts ability to maintain this when compared to the same point last year. 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. U:\Trust HQ - Operational Management\01 - Sandra Shannon and Nahida\Operations SLT & Restart Meetings\Operations Highlight reports\20200927 Operational Performance Highlight Report.pptx U:\Trust HQ - Operational Management\01 - Sandra Shannon and Nahida\Operations SLT & Restart Meetings\Restart Meetings\00 - Covid-19 Phase 3 Re-establish and Recovery\20201001 Restart Highlight Reports.pptx U:\Trust HQ - Operational Management\01 - Sandra Shannon and Nahida\Operations SLT & Restart Meetings\Restart Meetings\00 - Covid-19 Phase 3 Re-establish and Recovery\20201001 Restart Highlight Reports.pptx
Nov 20	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 National cancer waiting time dashboard – 2WW standard achieved for the last 6 months and YTD 19/20 Focus on reducing the long wait patients who are beyond 62 days due to COVID.	National cancer waiting time monthly submission. U:\Trust HQ - Regulation Committee\2020\6 - 23 SEPTEMBER 2020\WORD\RC.9.20.24 - Performance Report.docx	Nov 20	Current performance in relation Cancer 62 day standard -62 standards not yet achieved consistently Increase in 62 day backlog during the pandemic			
Nov 20	Implementation of the restart plan to increase elective activity to pre-covid levels. Work with Independent sector to ensure patients are seen in priority order and capacity across BRI and the Independent Sector is fully utilised. Month on month improvement in RTT	U:\Trust HQ - Regulation Committee\2020\6 - 23 SEPTEMBER 2020\WORD\RC.9.20.22 - Re-establish and Recovery Report.docx	Nov 20	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 Increase in 52 week waits predicted from August			

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

High Level Controls	Gaps in controls	Routine Sources of Assurance	Risk Appetite
<p>New performance management and accountability framework</p> <p>Development of care group and CBU dashboards including national/local and contractual KPI's/standards</p> <p>ECS performance report</p> <p>Cancer improvement plan</p> <p>Detailed restart plan</p> <p>Re-establish and recovery meetings</p> <p>weekly ECS breach review meetings</p> <p>Access to health care programme</p> <p>Daily safety huddle in ED</p>	<p>There is a risk that a second wave of covid will significantly impact on the Trusts capacity to deliver all the planned restart activity.</p>	<p>Daily return to NHSI for ECS</p> <p>National cancer submission of cancer waiting times by standard</p> <p>Monthly national reporting of 18 weeks RTT through Unify</p> <p>Director of Finance - Performance report to Finance and Performance Committee and Board</p> <p>Audit Committee Report to the Board</p> <p>Contract Management Board</p> <p>Internal Audit Committee Reports on controls assurance</p> <p>Audit</p> <p>Regulatory Committee Dashboard</p> <p>Board Integrated Dashboard</p> <p>Quarterly Informatics Performance Report</p> <p>Operations highlight report</p>	<p>Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward</p>

BOARD ASSURANCE FRAMEWORK	Strategic Objective	2b	To deliver our key performance targets	Action Plan to address Gaps in Controls and Assurance
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			Date of update	4/11/2020
Accountability			Responsibility	
Lead	Oversight/governance structure	Lead	Work-stream/operational group	
Director of Operations, Unplanned Care	Urgent Care Improvement Programme	Urgent care CD	Emergency care performance meeting.	
Director of Operations, Planned Care	Re-establish and restart programme	Deputy Director of Operations	Access performance meeting	

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		July 2020	The new workforce model is in place. A further review of the acute medical model is in progress to meet the acute medical demand.	
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		July 2020	The model of same day emergency care (Blue Zone) has been fully implemented with a positive impact on ECS performance above 90% The 11 I before you walk model has been implemented	

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			The DQ improvement programme has now recommenced. A full validation of the RTT waiting lists has been undertaken.	U:\Trust HQ - Operational Management\Sandra Shannon and Nahida\Operations SLT & Restart Meetings\Restart Meetings\02 - 03.09.20\20200903 Re-establish & recovery highlight report RW.pptx
2	18 weeks RTT- To reduce the number of patients waiting more than 40 weeks to zero my April 2020.	COO	June 19	April 21			Daily huddle has now recommenced. Recovery plans have been agreed with all specialties as part of the re-establish and recovery programme. Scheduled completion date revised to take account of increased waits during the pandemic.	U:\Trust HQ - Operational Management\01 - Sandra Shannon and Nahida\Operations SLT & Restart Meetings\Restart Meetings\00 - Covid-19 Phase 3 Re-establish and Recovery\20200923 Re-establish and Recovery Report - NOT FOR ONWARD CIRCULATION.docx

BOARD ASSURANCE FRAMEWORK		Strategic Objective	3	To be in the top 20% of employers in the NHS		Assurance Level	19/20		20/21	
							Q3	Q4	Q1	Q2
Executive Lead	Director of HR			Assuring Committee	Regulation and Assurance Committee					

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source	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 Regulation Committee supported by a command and control infrastructure. Covid governance checklist also completed.	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 was put in place, which enabled us to maintain our focus on the achievement of and assurance associated with our strategic objective particularly around workforce supply and the well being and resilience of our staff. This s now meets twice a weekThe gaps in assurance in relation to the achievement of this objective are subject to Executive Director scrutiny and assessment of risk.The People Academy has been established from September 2020 with supporting workstreams in development.
Monthly	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	Report to ENRC and Board Report	Quarter 2	Potential impact of test and trace on staff absence rates/provision of a safe working environment and staff complying with social distancing rules	Report/risk register		
Q2	IPC Board Assurance Framework and IPC Report	Report to Board	July 2020	Performance in relation to staff absence rates	Dashboard/report		
	Freedom to Speak Up Annual Report	Report to Board and ENRC					
	Maternity Services report	Report to Board and ENRC					
	Equality Report	Report to Board					
	WRES/WDES Action Plans	Report to ENRC					
	Guardian of Safe Working Hours report	Report to Board and ENRC					
	Staff resilience/health and well being update covering risk assessments and absence	Report to ENRC					
	Workforce Committee Annual Report	Report to ENRC					
	Establishment of People Academy and response to the NHS People Plan 2020/21	Report to Board					

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		Gaps in controls	Routine Sources of Assurance		Risk Appetite
Care Group Performance management Workforce dashboard	Staff survey action plan Bi -Annual review of nurse and midwife	Contemporaneous staff experience data	Workforce report Workforce Committee Dashboard	Workforce Race Equality Standard Report	Seeking – Preference for safe delivery options particularly in relation to nurse

Monitoring of safe staffing Monitoring of recruitment against budget Time to talk/We are Bradford/OD Plan Our People Strategy 2017 and annual workplans Personal responsibility framework Guardian of Safe Working Hours reports Workforce planning Leadership strategy Equality Plan	staffing establishments Mandatory training and appraisal performance management Education and workforce Committee Human Resources Policies and Procedures Equality objectives/ WRES Action plan/Equality plan GMC reports Staff friends and family NHS Staff Survey	– Workforce transformation support Workforce plan to match clinical services strategy in development	Board Integrated Dashboard HEE/NHSI workforce return/workforce plan Junior Doctor fill rates Update report on staff survey action plan Nurse recruitment and retention plan GMC survey Nurse staffing data publication report Bi-annual review report of nurse and midwife staffing Medical appraisal and revalidation report Quarterly ‘freedom to speak up guardian’ return	Guardian of safe working hours report Staff Friends and Family Test Model Hospital portal for benchmarking purposes Audit reports Staff Advocate service contacts and outcomes Leadership walkarounds	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
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BOARD ASSURANCE FRAMEWORK	Strategic Objective	3	To be in the top 20% of Employers in the NHS	Action Plan to address Gaps in Controls and Assurance
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			Date of update	4/11/2020
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		20/21	
Executive Lead		Chief Medical Officer		Assuring Committee		Regulation and Assurance Committee		Q3	Q4	Q1	Q2

Positive Assurance			Negative Assurance			Gaps in Assurance		Rationale for Assurance Level	
Date	Assurance	Source	Date	Assurance	Source	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 Regulation Committee supported by a command and control infrastructure		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.	
MONTHLY	Quality Dashboard and trend analysis at E&NE R Committee Quality oversight report system (weekly at QUOC and monthly at E&NE R Committee QUOC (weekly) Panel	Report	MONTHLY	Serious Incident Report	Quality Committee				
QUARTERLY	Incident and health safety compliance report – E&NE R Committee IPC report – E&NE R Committee	Report Report Report	QUARTERLY						
ANNUALLY	Inpatient survey – E&NER Committee Health and Safety Annual report-E&NER Committee	Report Report Report	ANNUALLY						
Quarter 2	IPC Board Assurance Framework Quality Oversight & Assurance Report Serious Incident Report Freedom to Speak Annual Report Maternity Services Update Quality Account-Draft	Report Report Report Report Report Report							

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

High Level Controls	Gaps in controls	Routine Sources of Assurance	Risk Appetite
Research Committee Organisational learning system Trust's Improvement Programme Quality oversight system National Audit Programme (Improvement) Patient safety/Clinical Effectiveness/workforce and education Sub-Committee NHS QUEST AHSN Improvement Academy, BIHR Centre for applied health research, HEE HEICQC Compliance Action Plan GMC National Training Survey 2019	Lack of easily identifiable measures.	Quarterly learning report National Education Surveys ESR reports Board Integrated Dashboard National Audits GIRFT Data Packs/ Visits	Open: There is a willingness to support staff to innovate in methods of delivering continuous learning and improvement

BOARD ASSURANCE FRAMEWORK	Strategic Objective	4	To be a continually learning organisation	Action Plan to address Gaps in Controls and Assurance
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				Date of update	4/11/2020
Accountability			Responsibility		
Lead	Oversight/governance structure		Lead	Work-stream/operational group	
Dr Bryan Gill	E&NE R Committee		QI Lead	Quality Improvement programme	
			Director of Research	BIHR	
			Director of Education	Delivery of Education Plan	
			Associate Director for Quality	Quality Academy	

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	April 2021	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		Review of Governance now underway which is likely to alter this objective as the Academy and assurance model is implemented.		

BOARD ASSURANCE FRAMEWORK		Strategic Objective	5	To collaborate effectively with local and regional partners		Assurance Level	19/20		20/21	
Executive Lead		Director of Strategy and Integration		Assuring Committee	Regulation and Assurance Committee		Q3	Q4	Q1	Q2

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source		
3 Nov 2020	<p>Since onset of pandemic, health & care partners have worked together on joint planning and to align decision making, for example through Outbreak Control Board and the council's Advisory Board ("Gold").</p> <p>Drawing on this, BTHFT has 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. The Act as One programme has created 7 transformation programmes on behalf of the whole "place", 3 led by BTHFT Execs (access, diabetes, respiratory) and reporting to newly constituted Bradford H&C Partnership Board (chaired by BTHFT CEO) .</p> <p>We participate in many other collab discussions through the West Yorks Assoc of Acute Trusts (WYAAT) and the WY&H Health & Care Partnership ("Integrated Care System").</p>	<p>CEO report to Board (10/9) Bo.9.20.7 and Chair's annual report to Regulation Committee (23/9) RC.9.20.5 .</p> <p>Director of S&I update to Board (10/9) in respect of (former Partnerships Committee workstreams: Bo.9.20.24. And Board Development session on "People Partners Place" (8/10)</p> <p>Monthly Health & Care Partnership Board jointly chaired by our CEO (most recent 25/9)</p> <p>Regular discussion in Exec Team Meetings</p>				<p>During the COVID 19 pandemic, routine reporting (as per the work plans) has been suspended.</p> <p>This has been mitigated by exception reporting to the Regulation Committee on a case by case basis, and supported by a command & control management structure.</p>	<p>Confident.</p> <p>This was the consistent judgement of the Partnership Committee, now discontinued; in future the Assurance level will be based on Board discussion.</p> <p>We are heavily involved in the Act as One programme (Bradford place) and working across WY&H (the integrated care system and WYAAT). Our plan for the year ahead is "People Partners & Place" (Nov 2020) which emphatically reinforces our commitment to partnership working, including the 10 shared priorities. Our relevant strategic risks have been/are being re-drawn to emphasise the risk of a missed opportunity to integrate care seamlessly for patients, rather than emphasising the risk of downsides of working collaboratively.</p> <p>Partnership work is necessarily dependent on the input and co-operation of external organisations. Within that context, we believe our mitigations are effective.</p>

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	Assessment by Strategy & Integration team of progress towards seamless care across BHCPB Encompasses i) . "vertical" integration, ie closer working with primary and community care at place, plus ii) acute service collaboration with Airedale NHS FT. This is no longer categorised as a discrete objective but now seen as part of the "way we do" Act as One.	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										

High Level Controls
<p>ETM Governance</p> <p>Implementation of Clinical Services Strategy 2017-2022 through CBU service planning and ETM updates</p> <p>Cross system participation in :</p> <ul style="list-style-type: none"> ICS System Leadership Exec Group; System

Gaps in controls
<p>There is no discrete Committee or Academy for "partnerships" so we are reliant on discussion in Board an associated bodies to assess our progress – this will require discipline to ensure the theme does not get "lost in the mix"</p>

Routine Sources of Assurance
<ol style="list-style-type: none"> Stakeholder engagement survey WYAAT Programme Director's Report (feeds in to Committee in Common, WYAAT CEOs and sub groups eg FDs, Med Directors, Strategy & Ops). Also shared in Closed Board Papers for ICS System Leadership Executive and System Oversight & Assurance Group (by exception) Partnerships Dashboard for Board

Risk Appetite
<p>Seek: Eager to be innovative and to choose options offering potentially higher business rewards</p>

<p>Oversight & Assurance Group; Partnership Board</p> <ul style="list-style-type: none"> Bradford & Districts Health & Wellbeing Board Bradford Districts & Craven Executive Group which oversees.... 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. 		<p>5. Papers for place based Executive Board</p> <p>6. Act as One programmes, reporting to Health & Care Partnership Boards</p>	
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BOARD ASSURANCE FRAMEWORK	Strategic Objective	5	To collaborate effectively with local and regional partners	Action Plan to address Gaps in Controls and Assurance
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			Date of update	4/11/2020
Accountability		Responsibility		
Lead	Oversight/governance structure	Lead	Work-stream/operational group	
Director of Strategy and Integration	Partnerships now considered in Regulation Committee and main BTHFT Board rather than discrete Committee	Head of Policy	Act as One Respiratory Programme Lead; Horizontal integration (WYAAT/ICS);	
		Head of Partnerships	Act as One Diabetes Programme Lead; 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 in order to more accurately record progress.	JH	Nov 2019	January 2020			Dashboard under review- we do not anticipate developing specific metrics for partnerships	
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		30 August 2020	Airedale Collaboration no longer a separate programme but encapsulated by Act as One and the new governance arrangements.	Act as One Programme Board papers; communication to all staff regarding transition of acute collaboration work into Act as One (eg Let's Talk BTHFT staff magazine, August 2020)
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 2018	Appointee started 9 July 2018	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		6 April 2020	Appointee started 6 April 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		22 March 2020	Appointee started 22 March 2020	Advert on NHS Jobs; HR paperwork

Annex 1 - Principle Risks

PRINCIPAL RISKS (Overview)

	Principal Risk	Proposed Overall Risk Rating					Risk Appetite	
		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	↑	Seeking	
3	Failure to maintain operational performance	20	6	6	12	↓	Cautious	
4	Failure to maintain financial sustainability	6	9	6	9	↑	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	6	6	9	↓	Seeking	
8	Failure to maintain a safe environment for staff patients and visitors	12	6	4	12	↔	cautious	
9	Failure to meet regulatory expectations and comply with laws, regulations and standards	12	8	6	8	↔	cautious	
10	Failure to demonstrate that the organisation is continually learning and improving the quality of care to our patients	12	8	6	8	↔	open	

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