

Appendix 1 - BOARD ASSURANCE FRAMEWORK: Quarter 1 2021/22

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 & Assurance 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 Regulation and Assurance Committee on 11 May 2021.**

BOARD ASSURANCE FRAMEWORK										
Assurance Overview										Q1 2021/22
Strategic Objective	Current Assurance Level	Reason for Assurance Level	Executive Lead	Assuring Committee	Date April 2021				Strategic Risk	
					Quarterly assurance ratings				Principal composite	Highest
					20/21			21/22		
					Q2	Q3	Q4	Q1		
1	To provide outstanding care for our patients		Whilst we have processes in place to monitor and record patient safety and quality of care, we have now been operating in a system under extreme pressure for almost 12 months. Work that we want to do to move to 'outstanding' has been delayed throughout this period.	Chief Nurse/ Chief Medical Officer	Regulation and Assurance Committee				12	20
2a	To deliver our financial plan		The green rating for the Q4 assurance level captures the closedown to 20/21 and reflects the final outturn position, which was delivery of the income and expenditure plan. The cash position was also ahead of plan. The financial framework for Oct 20 – March 21 (H2) 20/21 will roll forward into April 21 – Sept 21 (H1 of 21/22), with block funding arrangements in place, which broadly reflect (subject to a small number of adjustments) the block values received in H2 of 20/21. The planning timeframes to establish breakeven plans at organisation, place and ICS level require the work to be undertaken during Q1 with draft submissions on the 6 th of May and final plans in June. With planning arrangements on-going, the detail of any risk for BTHFT is not currently known. As such, the current assurance rating is set at amber, reflecting the exit run rates from 21/22 but the uncertainty around cost changes, particularly in relation to the elective activity restart.	Director of Finance	Regulation and Assurance Committee				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. During this period waiting times significantly increased and performance against access targets deteriorated. The re-establish and recovery programme has commenced, however this has been impacted by the increased COVID presentation during Wave 2 and Wave 3 of the pandemic. The 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 in line with the current contractual arrangement which has now been extended until 31/10/21.	Chief Operating Officer	Regulation and Assurance Committee				16	20
3	To be in the top 20% of employers in the NHS		Whilst we have processes in place which have enabled us to maintain our focus on the achievement and assurance associated with this objective particularly around workforce supply and wellbeing and resilience of staff, we have now been operating under pressure as a Trust for 12 months which has impacted on our People experience as we now focus on recovery. This can be demonstrated through our staff absence figures and our staff survey results.	Director of Human Resources	Regulation and Assurance Committee				15	16
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 R&A Committee and the Board of Directors. However, COVID has limited training opportunities due to reduced elective operating which has impacted on surgical anaesthetic trainees. This has been mitigated where possible by allowing trainees to attend lists at The Yorkshire Clinic. There has been a loss of teaching resource in Field House as the labs have been used as part of the Vaccine Hub. Inevitably, redeployment of trainees to COVID rotas has impacted on specific training opportunities, whilst creating unprecedented experience in the management of patients in a pandemic. The Hospital vaccine hub is scheduled to close in May so the facilities should be able to be returned to Education. As elective activity increases there will be more training opportunities available.	Chief Medical Officer	Regulation and Assurance Committee				8	n/r
5	To collaborate effectively with local and regional partners		Since the onset of the 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"). 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 Bradford H&C Partnership Board (chaired by BTHFT CEO). The recent NHSE/I consultation on statutory powers for ICS led to a Trust response which was closely aligned to those from the ICS, WYAAT and Bradford Place as a result of close working and collaboration. There is extensive system-wide discussion underway in respect of winter, plus flu and Covid vaccination programmes.	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	20/21			21/22
								Q2	Q3	Q4	Q1
Executive Lead	Chief Medical Officer/Chief Nurse			Assuring Committee		Regulation and Assurance (R&A) Committee					

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 R&A Committee Quality oversight report system (weekly at QUOC and monthly at R&A Committee) Maternity update report Ockenden QUOC (weekly) Panel Risk Management updates to Executive Team meeting Infection control monthly Board Assurance Framework Act As One structure and workstreams	Report	Monthly	IG incident COVID Dashboard. Increase in numbers of PHSO complaints. Increase in associated harms (PU/E-Coli/Falls). Increasing numbers of incidents in relation to Mental Health and restraint. Referral to treatment (RTT) data and increase in number of long waits. Safe staffing reports. Hospital acquired COVID.	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 R&A Committee supported by a command and control infrastructure. Quality Academy has now met on 3 occasions and we are constantly reviewing the impact of the meeting.	Whilst we have processes in place to monitor and record patient safety and quality of care, we have now been operating in a system under extreme pressure for almost 12 months. Work that we want to do to move to 'outstanding' has been delayed throughout this period.
Quarterly	Incident and health safety compliance report – R&A Committee Maternity report IPC report – R&A Committee	Report Report Report	Quarterly	Incident and health safety compliance report – R&A Committee	Report		
Annual	Data Security Protection Toolkit – R&A Committee Inpatient survey – R&A Committee Health and Safety Annual report – R&A Committee	Report Report Report	Quarter 4	IPC report – Increasing line infection			
Quarter 4	IPC Board Assurance Framework Maternity Services Update Quality Oversight & Assurance Report Serious Incident Report Freedom to Speak Annual Report	Report 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	↔	14	20
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 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	↔	6	20
		9	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	↔	5	20

High Level Controls		Gaps in controls	Routine Sources of Assurance	Risk Appetite
Quality Strategy Risk management strategy Patient experience strategy Quality Oversight System Infection Prevention and Control Standards LocSSIPs programme Quality improvement collaboratives: Incident reporting benchmarking SAFER implementation programme NICE guidance implementation programme Delayed Transfers of Care benchmarking Policy and Procedure compliance benchmarking National Audit Programme	Friends and Family test National Inpatient survey Other National Patient Surveys Complaint benchmarking CQC compliance action plan Performance (RTT/ECS/Cancer) benchmarking Freedom to Speak Up programme Bradford Accreditation Scheme/Ward Quality Tool Kit Workforce: Safe staffing standards, appraisal, mandatory training, sickness absence benchmarking, Placement satisfaction benchmarking (medical students) Data Security Protection Toolkit Internal audit reports relevant to controls	Access to comprehensive suite of real time quality data although some is available (VTE, Sepsis, NEWS) Full assurance structures and reporting Committees are not in place. Currently reviewing Estates and Facilities risks including backlog maintenance and capital	QUOC panel (weekly) Quality Oversight E&NE R Committee Patient experience report Risk management report Serious Incident report Effectiveness Report CQC compliance reporting Safeguarding report Learning report Learning from deaths report Clinical Effectiveness report	<p>Cautious.</p> <p>Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.</p>

Health and safety benchmarking Structured Judgement Review Programme	Command and Control structure (Silver/Gold Command) Overview by Estates Compliance Risk and Assurance Committee Backlog maintenance programme - weighted	investment needs.	Executive Directors Outbreak Control Board	Act as One Programme Board	
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BOARD ASSURANCE FRAMEWORK	Strategic Objective	1	To provide outstanding care for our patients	Action Plan to address Gaps in Controls and Assurance
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				Date of update	23/04/21
Accountability			Responsibility		
Lead	Oversight/governance structure		Lead	Work-stream/operational group	
Chief Nurse (CN)	R&A Committee		Deputy Chief Medical Officer (DCMO)	Going Digital Programme Board Patient Safety Sub Committee	
Chief Medical Officer (CMO)	QUOC Panel		Deputy Chief Nurse (DCN)		
Chief Digital Information Officer (CDIO)	Executive Management Team		Nurse Consultant IPCC (NCIPCC)		
	Quality Academy		Head of Business Intelligence (HBI)		
			Associate Director for Quality		

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. Maternity Dashboard is now embedded. Review of overarching dashboard and indicators commenced January 2021. Deteriorating Patient (Sepsis) live on desk tops and on Command Centre tiles.	Quality dashboards, e.g., Maternity, VTE, NEWS, Sepsis Command Centre/Sepsis tile.	
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	
3	To embed Quality Academies	CN/ CMO	December 2020	September 2021	O		First Quality Academy met in January 2021.		
4	Ensure upkeep and planned and preventative maintenance is fully costed and linked to capital planning and wider strategic outline case	D of E&F	Feb 2021	21/22 capital plan and each year thereafter	O		SOC expected completion for September spending review.		

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/ RS	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.	Completed via Board review of governance.	
2	To ensure that interim reporting and governance processes are robust and integrate into evolving ways of working.	KD/ RS	December 2020	Ongoing	O		During COVID we have introduced a governance light approach. This has resulted in more emphasis on command and control and real time awareness of incidents. It is important that we maintain the levels of insight whilst transitioning back into a revised (traditional) structure.	Clinical Reference Group minutes/notes. QUOC oversight dashboard.	
3	To ensure continual progress against the risk and risk mitigation is reported to the Board of Directors (or Regulation Committee)	D of E&F	February 2021	May 2021	O		Quarterly report to be produced by D of E&F in relation to progress against strategic risk – First report due May 2021 (covering Q4)		

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

BOARD ASSURANCE FRAMEWORK		Strategic Objective	2a	To deliver our financial plan			Assurance Level		20/21			21/22
Executive Lead		Director of Finance		Assuring Committee		Regulation and Assurance Committee			Q2	Q3	Q4	Q1

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source		
Financial Year 2019/20	The Trust entered into a Fixed Income Contract arrangement with its main commissioners (Bradford & Airedale). Improved baseline contract value compared to PbR contract and provided greater certainty The targeted financial position was delivered for the year ending 31.3.20 producing a UoR rating of 1.	Finance Report Annual Statutory Accounts. Final Statutory Accounts and Annual Report finalised June 2020.	Dec 20	Forecast delivery of the allocated financial target for the year ending 31.3.21 in light of the target set and the requirement to deliver an efficiency requirement based on the projected cost profile.	Finance report	For future financial years, definitive plans to secure the full value of control total requirement on a recurrent and sustainable basis. 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 operational planning work for the second half of 21/22. 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.	The green rating for the Q4 assurance level captures the closedown to 20/21 and reflects the final outturn position, which was delivery of the income and expenditure plan. The cash position was also ahead of plan. The financial framework for Oct 20 – March 21 (H2) 20/21 will roll forward into April 21 – Sept 21 (H1 of 21/22), with block funding arrangements in place, which broadly reflect (subject to a small number of adjustments) the block values received in H2 of 20/21. The planning timeframes to establish breakeven plans at organisation, place and ICS level require the work to be undertaken during Q1 with draft submissions on the 6 th of May and final plans in June. With planning arrangements on-going, the detail of any risk for BTHFT is not currently known. As such, the current assurance rating is set at amber, reflecting the exit run rates from 21/22 but the uncertainty around cost changes, particularly in relation to the elective activity restart.
April 2020 – Sept 2020	The COVID 19 Financial Regime introduced for the first six months of 2020/21 delivered a breakeven position up to 30 September with all COVID 19 related costs retrospectively funded	Finance Dashboard & Finance Report to Regulation and Assurance Committee and Board of Directors	Dec 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. The potential impact to date is not included in the reported position.	Finance Report		
Dec 2020	The financial regime based on a block allocation and covering the remainder of the year, commenced on 1 October 2020. The Trust reported a breakeven position in the first month of the regime which included a proportionate amount of the required savings target	Finance Dashboard & Finance Report to Regulation and Assurance Committee and Board of Directors					
Feb 2021	The underlying run rate reported for Q3, representing the first 3 months of the updated financial regime for 20/21 produced a surplus of £1.5m	Finance Dashboard & Finance Report to Regulation and Assurance Committee and Board of Directors	Jan 21	Whilst the Elective Incentive Scheme remains, its application of the thresholds will now be managed at an ICS. BTHFT triggered all thresholds in Oct, Nov and December and as such should not have a penalty applied. The financial impact for September of the scheme was £111k. March 2021 Update – Recent correspondence has notified that the EIS will not be applied for Sept and October. As such this negative assurance is now removed.			
March 2021	The majority of the risks that challenged delivery of the financial plan have either been mitigated or removed	Finance Dashboard & Finance Report to Regulation and Assurance Committee and Board of Directors					
April 2021	The majority of the risks that challenged delivery of the financial plan have either been mitigated or removed. The financial Plan for 20/21 has been delivered.	Finance Dashboard & Finance Report to Regulation and Assurance Committee and Board of Directors					

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	4	Failure to maintain financial sustainability	Damage to reputation, financial and liquidity compromise, loss of market share, regulatory action.	6	6	6	6	↓	0	-

High Level Controls	Gaps in controls	Routine Sources of Assurance	Risk Appetite
Executive led financial performance management Budget setting and business planning Quality Impact Assessment and Financial Impact Assessment process Standing Financial Instructions and Scheme of Delegation	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 any subsequent wave in the pandemic) will need to be re-established (likely Q2 of 2021/22).	Director of Finance report to Finance and Performance Academy and Board Internal Audit Committee Reports on controls assurance Audit Committee Report to Board Finance & Performance Academy Dashboard Board Integrated Dashboard Quarterly Capital Report to Finance and Performance Academy	Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Issuance of Budgetary Management Framework to support new Care Groups and Clinical Business Units (CBUs)	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.	Quarterly Treasury Management Report to Finance and Performance Academy	
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BOARD ASSURANCE FRAMEWORK	Strategic Objective	2a	To deliver our financial plan	Action Plan to address Gaps in Controls and Assurance
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				Date of update	15/04/21
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	Q2 2021/22	Q2 2021/22	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	Q2 2021/22	Q2 2021/22	O			

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

BOARD ASSURANCE FRAMEWORK		Strategic Objective		2b	To deliver our key performance targets					20/21				21/22
										Q2	Q3	Q4	Q1	
Executive Lead		Chief Operating Officer			Assuring Committee		Regulation and Assurance Committee		Assurance Level					

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level	
Date	Assurance	Source	Date	Assurance	Source	<p>The impact of 2nd and 3rd wave of COVID made delivery of the reset and restart plans undeliverable. Further wave expected in May / June 21 which may impact on elective recovery.</p> <p>The current Independent Sector contract has been extended until 30th September 2021 and the future status of this is unknown.</p>	<p>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 this has been impacted by the increased COVID presentation during Wave 2 and Wave 3 of the pandemic. The 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 in line with the current contractual arrangement. The latest planning and operational guidance outlines the required standards that need to be delivered from April 21.</p>	
Apr 21	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 since the first wave of the pandemic, 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. 111 talk before you walk initiative implemented from Nov 20	NHS Improvement Daily Situation Report Formal report from NHSE/I ED dashboard	Apr 21	2 nd and 3 rd wave of COVID admissions were significantly above those experienced within wave 1. This has impacted on the reset and restart programme. Although numbers have reduced currently modelling suggestive of the fact that we are likely to see another increase during May and June 21.				
Apr 21	Implementation of the action plan to improve the Cancer 62 Day performance - improvement / reset and restart update provided to F&P / Regulation committee. 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. Focus on reducing the long wait patients who are beyond 62 days due to COVID.	National cancer waiting time monthly submission. Performance Report	Apr 21	Current performance in relation Cancer 62 day standard - standards not yet achieved consistently. Increase in 62 day backlog during the pandemic and unable to reducing in line with expectations as a result of 2 nd wave of COVID.				
Apr 21	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. Maximising elective activity in line with current independent sector contract extended up until 30 th September 2021. New operational and planning guidance for 21/22 published outlining priority areas of focus..	Re-establish and Recovery Report NHSE	Apr 21	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 and continue to grow as patients are prioritised into the limited capacity based on clinical urgency.				

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	16	↔	6	20
		5	Failure to deliver the required transformation of services	Reduced reputation and risk to continuity of services	12	8	8	8	↔	1	20

High Level Controls	Gaps in controls	Routine Sources of Assurance	Risk Appetite
New performance management and accountability framework Development of care group and CBU dashboards including national/local and contractual KPI's/standards ECS performance report Cancer improvement plan Detailed restart plan Re-establish and recovery meetings weekly ECS breach review meetings Access to health care programme Daily safety huddle in ED	2 nd and 3rd wave of covid has significantly impacted on the Trust's capacity to deliver all the planned restart activity. Further COVID impact expected in May / June 21.	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 Regulation & Assurance Committee Dashboard Board Integrated Dashboard Quarterly Informatics Performance Report Operations highlight report	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
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			Date of update	15/04/21
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	C	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	C	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	C	Dec 20	The DQ improvement programme has now recommenced. A full validation of the RTT waiting lists has been undertaken.	Re-establish & recovery highlight report	
2	18 weeks RTT- To reduce the number of patients waiting more than 40 weeks to zero by April 2020.	COO	June 19	April 21	O		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.	Re-establish and Recovery Report	

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

BOARD ASSURANCE FRAMEWORK		Strategic Objective	3	To be in the top 20% of employers in the NHS		Assurance Level	20/21			21/22
Executive Lead		Director of HR		Assuring Committee	Regulation and Assurance Committee		Q1	Q2	Q3	Q4

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source		
Q1	IPC learning from Covid-19	Presentation to Quality Committee 01/21	Q1	Impact of test and trace and Covid related absence. Provision of a safe working environment and staff complying with social distancing rules	Report/risk register	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 & Assurance Committee supported by a command and control infrastructure. Covid governance checklist also completed.	Whilst we have processes in place which have enabled us to maintain our focus on the achievement and assurance associated with this objective particularly around workforce supply and wellbeing and resilience of staff, we have now been operating under pressure as a Trust for 12 months. This has impacted on our People experience which can be demonstrated through our staff absence figures and our staff survey results.
	Positive benchmarking in relation to the number of disciplinary cases compared to other Trusts	People Academy 01/21		NHS Staff Survey results where statistically significant reduction in staff experience	People Academy 03/21 & Board of Directors		
	Growing for the Future: recruitment plans for Registered Nurses and HCAs	People Academy 02/21		Performance in relation to staff absence rates	Dashboard/report	The People Academy has now been established and is meeting monthly. The People Dashboard is currently being revised and developed to ensure it meets the Academy needs.	
	Guardian of Safe Working Hours report Q3	People Academy 02/21		Nurse staffing report. Reduction in fill rates	Regulation and Assurance Committee 03/21		
	Compliance with RO regulations and medical appraisal	People Academy 02/21					
	NHS People Plan 2020/21: Delivery update	People Academy 03/21					
	NHS Staff Survey update and results	Presentation to People Academy and Board of Directors 03/21					
	FTSU Q2 and Q3 report	People Academy 03/21					
	Dashboard metrics re turnover, bank and agency usage	Report to Regulatory Committee 02/21					
	Infection Prevention and Control report	Report to Regulatory Committee 02/21					
	Reduction in nurse staffing risks	Report to People Academy 03/21					

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	15	↔	3	16
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
People Academy dashboard Monitoring of safe staffing Monitoring of recruitment against budget Time to talk/We are Bradford/OD Plan	Bi -Annual review of nurse and midwife staffing establishments NHS People Plan Human Resources Policies and Procedures	Contemporaneous staff experience data Workforce transformation support	Workforce report People Academy Dashboard Board Integrated Dashboard HEE/NHSI workforce return/workforce plan	Workforce Race Equality Standard Report Guardian of safe working hours report Staff Friends and Family Test	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

Our People Strategy 2017 and annual workplans Personal responsibility framework Guardian of Safe Working Hours reports Workforce planning Leadership strategy Equality Plan E&D Council set up	Equality objectives/ WRES Action plan/Equality plan GMC reports Staff friends and family/ Pulse surveys NHS Staff Survey	Full assurance structures and committees not in place	Junior Doctor fill rates GMC survey Bi-annual review report of nurse and midwife staffing Medical appraisal and revalidation report Quarterly 'freedom to speak up guardian' return	Model Hospital portal for benchmarking purposes Audit reports Staff Advocate service contacts and outcomes Executive Team Meetings	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	
				Date of update	20/04/21		
Accountability			Responsibility				
Lead	Oversight/governance structure		Lead		Work-stream/operational group		
Director of Human Resources (DHR)	People Academy		DHR		Workforce and Medical Workforce Meetings		
Chief Nurse (re: Nurse Staffing)	Executive Team Meetings		Deputy Director of Human Resources (DDHR)				
Chief Medical Officer (re: Medical Staffing)			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 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	May 2021	C	April 2021	Review of governance and new structure implemented	Completed Board review of governance
2	Revision of the People Dashboard		DHR	February 2021	May 2021	O		Task and Finish Group reviewing metrics	

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

BOARD ASSURANCE FRAMEWORK		Strategic Objective	4	To be a continually learning organisation			Assurance Level	20/21			21/22
Executive Lead		Chief Medical Officer		Assuring Committee		Regulation and Assurance Committee		Q2	Q3	Q4	Q1

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source	During the early part of the COVID 19 response routine reporting was suspended, meaning a number of routine reports were not submitted for Committee review. This has been mitigated through exception reporting to the Regulation Committee supported by a command and control infrastructure. During the first quarter of 2021 with the inception of the Quality Academy, there has been a gradual change to a more normal level of reporting and assurance	The learning and innovation demonstrated through the rapid transformation in response to the COVID19 pandemic during Q1 2020/21 has been reported to the R&A Committee and the Board of Directors. However, COVID has limited training opportunities due to reduced elective operating which has impacted on surgical anaesthetic trainees. This has been mitigated where possible by allowing trainees to attend lists at The Yorkshire Clinic. There has been a loss of teaching resource in Field House as the labs have been used as part of the Vaccine Hub. Inevitably, redeployment of trainees to COVID rotas has impacted on specific training opportunities, whilst creating unprecedented experience in the management of patients in a pandemic. The Hospital vaccine hub is scheduled to close in May so the facilities should be able to be returned to Education During the early part of the COVID 19 response routine reporting was suspended, meaning a number of routine reports were not submitted for Committee review. This has been mitigated through exception reporting to the Regulation Committee supported by a command and control infrastructure. During the first quarter of 2021 with the inception of the Quality Academy, there has been a gradual change to a more normal level of reporting and assurance.
ANNUALLY	Inpatient survey – R&A Committee Health and Safety Annual report- R&A Committee Quality Account	Report Report Report	MONTHLY	Serious Incident Report Strategic Risks relevant to the Academy (QA)	Report Report		
January 2021	Quality Team (QA) Patient Safety Group – Highlight report (QA) Quality Oversight and Assurance Exception Profile report – November 2020 (BoD) Infection Prevention and Control Learning during COVID-19 (QA) Ockenden Maternity Review (QA) Perinatal Mortality Review Tool Quarterly Report – January 2021 (QA) Maternity Services Update – December 2020 (BoD) Care Quality Commission Action Plan Update (BoD) Covid-19 Vaccination Process (BoD) Ockenden Review of Maternity Services – December 2020 and BTHFT Assurance Assessment Tool (BoD)	Presentation Presentation Presentation Presentation Report Report Presentation Presentation Report Report	QUARTERLY				
February 2021	Quality Academy Dashboard – December 2020 (RA C) Quality Oversight and Assurance exceptions report – December 2020 (RA C) Serious Incident Report – December 2020 (RA C) Quality Strategic Risks – January 2021 (RA C) Quality Academy Dashboard – January 2021 (QA) Quality Oversight and Exception Profile – January 2021 (QA) Strategic Risks relevant to the Academy (QA) Patient Safety Sub Committee – Highlight Report February 2021 (QA) Serious Incident Report – January 2021 (QA) Guardian of Safe Working Report (PA) Annual Organisational Audit (PA) Infection Prevention and Control Board Assurance Framework (QA and RA C) Infection Prevention and Control Report – August to December 2020 (RA C) Ockenden Assurance Submission (QA) Outstanding Maternity Programme (QA) MAGNET Programme (QA) Growing for the Future: Nursing and HCA recruitment update (PA) Maternity Services Update – January 2021 (RA C) Ockenden Assurance Submission (RA C) PHSO Report (RA C) Covid-19 Vaccination Programme Update (RA C)	Presentation Presentation Report Report Report Report Presentation Report Report Report Report Report Presentation Presentation Presentation Report Report Report Presentation	ANNUALLY				
March 2021	Research in the Trust – March 2021 (BoD) Guardian of Safe Working Hours – Quarter 3 (BoD) Quality Dashboard – January 2021 (RA C) Quality Oversight and Assurance Exception Profile – January 2021 (RA C) Quality Strategic Risks (RA C) Serious Incident Report – January 2021 (RA C) Guardian of Safe Working Hours Report – Quarter 3 2020/21 (RA C) Annual Organisational Audit 2019-20 (RA C) Quality Academy Dashboard – February 2021 (QA)	Report Report Report Report Report Report Report Report Report Report					

	Quality Oversight and Assurance Profile (QA) Strategic Risks relevant to the Academy (QA) Internal Audit Update (QA) Patient Safety Group - Highlight Report March 2021 (QA) Serious Incident Report (QA) NHS England/Improvement Patient Safety Collaborative – Yorkshire and Humber plans for 2021-22 (QA) Education Service Annual Report 2020/21 (PA) New Appraisal Management System (PA) Infection Prevention and Control Board Assurance Framework – Covid Update (RA C) Magnet 4 Europe (QA) Safeguarding Adults and Children SBAR report (QA) Quality Improvement Infection Control Project – Neonatal Unit (QA) Growing for the Future: Recruitment and Retention (PA) New Ways of Working and Delivering Care (PA) Freedom to Speak Up: Quarterly Report (PA) Safeguarding Adults and Children SBAR report (Closed BoD) Ockenden Assurance Submission (RA C and BoD) Outstanding Maternity Services Programme Update (RA C) Maternity Services Update – February 2021 (RA C) Covid-19 Vaccination Programme Update (RA C) Nurse Staffing Report – December 2020 to February 2021 (RA C) Mental Health Strategy 2021/23 (BoD)	Presentation Report Report Presentation Report Presentation Report Discussion Presentation Presentation Report Presentation Discussion Discussion Report Report Presentation Report Report Report Presentation Report							
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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	To achieve 5% year on year training of clinical staff in Quality Improvement	10	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 easily identifiable measures.

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
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				Date of update	15/04/21
Accountability			Responsibility		
Lead	Oversight/governance structure	Lead	Work-stream/operational group		
Dr Ray Smith	R&A 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	RS	December 2019	April 2021	C	April 2021	Review of Governance complete and new structure has been implemented	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/RS	April 2020	November 2020	C	April 2021	Review of Governance complete and new structure has been implemented		

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

BOARD ASSURANCE FRAMEWORK		Strategic Objective	5	To collaborate effectively with local and regional partners		Assurance Level	20/21			21/22
Executive Lead		Director of Strategy and Integration		Assuring Committee	Regulation and Assurance Committee		Q2	Q3	Q4	Q1

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source		
20 Apr 2021	<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>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 Bradford H&C Partnership Board (chaired by BTHFT CEO) . The recent NHSE/I consultation on statutory powers for ICS led to a Trust response which was closely aligned to those from the ICS, WYAAT and Bradford Place as a result of close working and collaboration.</p> <p>There is extensive system-wide discussion underway in respect of winter, plus flu and Covid vaccination programmes.</p>	<p>CEO and Chair reports to Board (18/03/21) (incl. refresh of Strategic Partnering Agreement) Bo.3.21.6</p> <p>Board Development session on "Refreshing Corporate Strategy" (08/04/21)</p> <p>Director of S&I updates to Board (18/031/21) on NHS white paper (Bo.3.21.14)</p> <p>Monthly Health & Care Partnership Board jointly chaired by our CEO (most recent 16/04/21)</p> <p>ETM discussions</p>				<p>We do not currently have a credible metric to demonstrate the degree of collaboration/integration and measure progress, however in the November 2020 "Integrating Care" document, NHSE/I states that "Next year we will introduce new measures and metrics to support ... [stronger system working]... including an "integration index" for use by all systems"</p>	<p>Confident.</p> <p>Discussed amongst the Strategy & Integration team and reviewed by Exec Team in monthly meeting.</p> <p>BTHFT is heavily involved in the Act as One programme (Bradford place) and working across WY&H (the integrated care system and WYAAT). We helped shape the ICS and Place responses to NHSE consultation on ICS statutory powers. 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 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 continue to be 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	-
2	ICS/WYAAT system-wide planning & decisions ("horizontal" integration) assessment by Strategy & Integration team of progress towards effective WYHCP collaboration.										

High Level Controls	Gaps in controls	Routine Sources of Assurance	Risk Appetite
<p>ETM Governance</p> <p>Implementation of Clinical Services Strategy 2017-2022 through CBU service planning and ETM</p> <p>Cross system participation in :</p> <ul style="list-style-type: none"> ICS System Leadership Exec Group; System Oversight & Assurance Group; Partnership Board Bradford & Districts Health & Wellbeing Board Bradford Districts & Craven Executive Group which oversees.... <ul style="list-style-type: none"> 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>There is no discrete Committee or Academy for "partnerships" so we are reliant on discussion in Academies, Reg & Assurance Committee, Board, and associated bodies to assess our progress – this will require discipline to ensure the theme does not get "lost in the mix"</p>	<ol style="list-style-type: none"> Stakeholder engagement survey WYAAT Programme Director's Report (feeds in to Committee in Common, WYAAT CEOs and sub groups eg FDs, Med Directors, Strategy & Ops). Also shared in Closed Board Papers for ICS System Leadership Executive and System Oversight & Assurance Group (by exception) Partnerships Dashboard for Board Papers for Place-based Executive Board Act as One programmes, reporting to Health & Care Partnership Boards 	<p>Seek: Eager to be innovative and to choose options offering potentially higher business rewards</p>

BOARD ASSURANCE FRAMEWORK	Strategic Objective	5	To collaborate effectively with local and regional partners	Action Plan to address Gaps in Controls and Assurance
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			Date of update	20/04/2021
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	C	4 Dec 2020	This has been a longstanding issue now overtaken by events: NHSE/I has announced plans for an integration index to be introduced nationally and used in all areas (Nov 2020)	NHSE/I's consultation document “Integrating Care” (Nov 2020) sets out a number of proposals in this area (e.g.integration index para 2.57, system oversight framework 2.58)	
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	C	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	C	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	C	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	C	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	C	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	C	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	C	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	C	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	C	22 March 2020	Appointee started 22 March 2020	Advert on NHS Jobs; HR paperwork	

Annex 1 - Principal 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	<p>Reviewed and approved at meeting of the Board of Directors on 9/1/2020.</p> <p>On 20/1/2021, the Board of Directors agreed that the risk appetite profile agreed on 9/2/2020 would continue and would be re-considered as part of the review of the Risk Management Strategy which is due to take place during Q1 of 2021/22.</p>
2	Failure to recruit and retain an effective and engaged workforce	15	6	4	15	↔	Seeking	
3	Failure to maintain operational performance	20	6	6	16	↔	Cautious	
4	Failure to maintain financial sustainability	6	6	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	9	↓	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	8	↔	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?	3	Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward
Positive Assurance	What evidence have we of progress towards or achievement of our strategic objective?	4	Seek	Eager to be innovative and to choose options offering potentially higher business rewards
Negative Assurance	What evidence have we of progress towards our strategic objectives being compromised?	5	Mature	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
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			
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