

BOARD ASSURANCE FRAMEWORK: Quarter 3 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. 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 Committee. **Received by the Board on 20 January 2022.**

BOARD ASSURANCE FRAMEWORK										
Assurance Overview								Date	Q2 2021/22	
Strategic Objective	Current Assurance Level	Reason for Assurance Level	Executive Lead	Assuring Committee	Quarterly assurance ratings				Strategic Risk	
					20/21	21/22			Principal composite	Highest
					Q4	Q1	Q2	Q3		
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 20 months. Work that we want to do to move to 'outstanding' has been delayed throughout this period. The recovery of elective activity is placing additional challenge on our processes, but progress has been made with the launch of the Quality & Patient Safety Academy and the success of the deteriorating patient tile. The clinical outcomes group has been re-launched and learning from deaths work has progressed well including thematic review of all HOCI deaths.	Chief Nurse/ Chief Medical Officer	Quality & Patient Safety Academy				12	20
2a	To deliver our financial plan		The financial framework for Oct 20 – March 21 (H2) 20/21 rolled 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 Trust has submitted a breakeven plan for the first half of 2021/22 which is in line with all other organisations in the ICS. The Trust is reporting a breakeven position for the end of month 8 (November). Given the month 8 position and projection for Month 9, the rating awarded for Q3 is green.	Director of Finance	Finance & Performance Academy				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 was impacted by the increased COVID presentation during Wave 2 and Wave 3 of the pandemic. A further increase in COVID demand is being experienced currently which is impacting on our recovery plans along with the general increase in non-elective presentations. The clinical prioritisation process continues to allocate resources to patients whose disease progression was time sensitive. The trust has developed an ambitious H2 recovery plan which is in line with the latest national operational guidance for H2. Approval will be sought from Board for a financial spending plan to allow delivery of the plan. We continue to utilise all available independent sector capacity to undertake elective activity in line with the current contractual arrangement which has now been extended in H2 as well as the agreed insourcing contract to further increase our internal capacity.	Chief Operating Officer	Finance & Performance Academy				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 20 months. This has impacted on our People experience as we now focus on recovery with COVID presentation increasing again. This can be demonstrated through our staff absence figures which are increasing again (and are worsening due to the impact of the Omicron variant), recruitment pressures and our staff survey/pulse survey results.	Director of Human Resources	People Academy				15	20
4	To be a continually learning organisation		The learning and innovation demonstrated through the rapid transformation in response to the COVID-19 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 vaccine hub closed as planned in May. Full educational services have been recommenced. Feedback from HEE has been excellent despite recent challenges. Increased elective activity has enabled increased training opportunities in theatres and outpatients. Continued work is being undertaken with partner organisations to ensure that surgical trainees have the best offer possible in relation to elective work. Orthopaedics for example has been a particular challenge, but all trainees now have an individualised training plan.	Chief Medical Officer	Quality & Patient Safety Academy				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 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). (These 7 programmes are currently suspended due to Omicron operational pressure). Work is underway across the ICS to ensure arrangements are in place to be able implement the requirements of the Health and Social Care Bill when it is anticipated to come into effect in July 2022. There is extensive system-wide discussion underway in respect of the development of the "Place Based Partnership" for Bradford District & Craven, plus the revised Strategic Partnering Agreement (SPA), submission of joint plans to NHSE and operational matters like COVID-19 vaccination programmes.	Director of Strategy and Integration	Board of Directors				9	9

BOARD ASSURANCE FRAMEWORK		Strategic Objective	1	To provide outstanding care for our patients			Assurance Level	20/21	21/22		
								Q4	Q1	Q2	Q3
Executive Lead	Chief Medical Officer/Chief Nurse			Assuring Committee		Quality & Patient Safety Academy					

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source		
Annual	Data Security Protection Toolkit – R&A Committee Safeguarding Adult Annual board report Safeguarding Children Annual Report Health and Safety Annual report – Board	Report Report Report Report	Annual	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. Inpatient survey – Quality & Patient Safety Academy	Dashboard Report	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 & Patient Safety Academy has now met monthly since January 2021 and we are constantly reviewing the impact of the meeting. An interim review of effectiveness of the Quality & Patient Safety Academy has been conducted and changes implemented.	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 20 months. Work that we want to do to move to 'outstanding' has been delayed throughout this period. The recovery of elective activity is placing additional challenge on our processes, but progress has been made with the launch of the Quality & Patient Safety Academy and the success of the deteriorating patient tile. The clinical outcomes group has been re-launched and learning from deaths work has progressed well including thematic review of all HOCl deaths.
Quarter 3	IPC Board Assurance Framework Quality Dashboard and trend analysis at Quality & Patient Safety Academy Quality oversight report system (weekly at QUOC and monthly at Quality & Patient Safety Academy) Risk Management updates to Executive Team meeting, Academy and Board Infection control monthly Board Assurance Framework Act As One structure and workstreams Safeguarding Adults and Children Quarterly Reports Research Activity in the Trust <u>Internal audit reports:</u> End of Life Care – Patients with LDs (significant assurance) Incident reporting (significant assurance) Hospital acquired infections (significant assurance) Patient safety – pressure ulcers (significant assurance)	Report Dashboard Report Report Report Minutes Report Report Internal Audit	Quarter 3	IPC report Serious incident report Learning from deaths – HOCl deaths HOCl outbreaks	Report Report Report Report		

Key performance Indicator		Principal Risk (s)		Potential consequences	Composite risk rating (high level risks)					Component risks ≥15	
					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	↔	18	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	↔	16	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	↔	8	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	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	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	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	Infection Prevention and control report Safe staffing report Escalation of risks to quality from other Board Committees Safe Staffing report Quality Dashboard and trend analysis Serious incident report	Cautious. Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential

Delayed Transfers of Care benchmarking Policy and Procedure compliance benchmarking National Audit Programme Health and safety benchmarking Structured Judgement Review Programme	benchmarking (medical students) Data Security Protection Toolkit Internal audit reports relevant to controls Command and Control structure (Silver/Gold Command) Overview by Estates Compliance Risk and Assurance Committee Backlog maintenance programme - weighted	Facilities risks including backlog maintenance and capital investment needs.	Learning from deaths report Clinical Effectiveness report Executive Directors Outbreak Control Board	Incident report Information Governance Report Act as One Programme Board	for reward.
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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	06/01/2022
Accountability			Responsibility		
Lead	Oversight/governance structure		Lead	Work-stream/operational group	
Chief Nurse (CN)	QUOC Panel		Deputy Chief Medical Officer (DCMO)	Going Digital Programme Board Patient Safety Sub Committee	
Chief Medical Officer (CMO)	Executive Management Team		Deputy Chief Nurse (DCN)		
Chief Digital Information Officer (CDIO)	Quality & Patient Safety Academy		Nurse Consultant IPCC (NCIPCC)		
			Head of Business Intelligence (HBI)		
			Associate Director for Quality		

Objective	2	To address gaps in assurance related to achievement of this strategic objective							
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence	
1	To ensure that 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.	
2	To ensure continual progress against the risk and risk mitigation is reported to the Board of Directors	D of E&F	February 2021	Ongoing	C		Updated provided as part of high level risk papers.		

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	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.		

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

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source		
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		N/A		For future financial years, definitive plans to secure the full value of control total requirement on a recurrent and sustainable basis.	The financial framework for Oct 20 – March 21 (H2) 20/21 rolled 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 Trust has submitted a breakeven plan for the first half of 2021/22 which is in line with all other organisations in the ICS. The Trust is reporting a breakeven position for the end of month 8 (November). Given the month 8 position and projection for month 9 the rating awarded for Q3 is green.
June 2021	The Trust is reporting a surplus position at the end of month 2	Finance Dashboard & Finance Report to Regulation and Assurance Committee and Board of Directors				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.	
July 2021	The national planning parameters are indicating a 1.5% efficiency requirement for 2021/22, to be reflected in the H2 allocations (not yet confirmed). Communication to the CBUs requesting engagement with Finance colleagues to undertaken detailed run rate and forecasting exercise to understand potential gap and explore run rate improvement opportunities was issued in July 2021.	Finance Report (including CBU Communication) to Finance & Performance Committee (July)					
Oct 2021	The financial planning parameters for the second half (H2) of 2021/22 have been published nationally which have been translated into ICS and organisational allocations. An efficiency target of 0.82% has been applied to commissioning block allocations, indicating a net reduction in block values of £4.5m (when all variables are taken into account). The forecast run rate for H2 provides a degree of confidence that the required breakeven position will be delivered	Finance Report H2 Plan Report to F&P (October 2021)					
Jan 2022	The Trust has delivered a break even position to Month 7 which is in line with the H2plan.	Finance Report					

Key performance Indicator		Principal Risk(s)		Potential consequences	Composite risk rating (high level risks)					Component risks ≥15	
					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
Executive led financial performance management Budget setting and business planning Quality Impact Assessment and Financial Impact Assessment process Standing Financial Instructions and Scheme of

Gaps in controls
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).

Routine Sources of Assurance
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

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

Delegation 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 Capital Report to Finance and Performance Academy 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	06/01/22			
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 2021/22	Q3 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	Q3 2021/22	Q3 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		Assurance Level	20/21	21/22		
							Q4	Q1	Q2	Q3
Executive Lead	Chief Operating Officer			Assuring Committee		Finance & Performance Academy				

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source		
Oct 21	Internal Audit report – Patient readiness for theatre (significant assurance) Management of Patient Flow (high assurance)	Internal audit	Nov 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. In line with modelling work undertaken, which identified the Delta variant as the prevalent strain we are currently experiencing a 4 th COVID wave. Although numbers are lower than the 3d wave we are seeing a much younger cohort of patients being admitted to hospital with increased acuity. Increasing non-elective demand being experienced which has led to high bed occupancy levels and leading to overcrowding in the ED impacting on ambulance handover performance.		The impact of 2 nd , 3 rd and 4 th wave of COVID made delivery of the reset and restart plans undeliverable. Careful planning in place due to the risk of increased hospitalisation associated with the new Delta variant.	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, Wave 3 and wave 4 of the pandemic. The clinical prioritisation process continues to allocate 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 by from April 22. The Board have recently approved a financial plan to support the delivery of aspirations in the H2 planning guidance.
Nov 21	ECS performance continues to be delivered within the top quartile for Type 1&3 when compared to other organisations within the region and nationally. Attendances have increased significantly since the first wave of the pandemic, however despite this BTHFT have continued to maintain a positive performance position. SDEC model implemented and embedded and will be further enhanced with the handover of ward 2 & 5 as the Surgical SDEC area.. ED isolation area works complete and area to be fully operational in Nov 21. 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. Outputs from RCEM patient flow report highlights above average performance.	NHS Improvement Daily Situation Report Formal report from NHSE/I ED dashboard	Sep 21	Current performance in relation Cancer 62 day standard - standards not yet achieved consistently. Increase in 62 day backlog during the pandemic has reduced due to the targeted work but not currently at pre-covid levels.		The current Independent Sector contract has been extended in to H2 of 21/22.	
Nov 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 now back pre-pandemic levels. National cancer waiting time dashboard – 2WW standard achieved consistently. Focus on reducing the long wait patients who are beyond 62 days due to COVID with a good level of reduction already demonstrated and maintained weekly monitoring continues through the Access meetings.	National cancer waiting time monthly submission. Performance Report	Sep 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 and 104 week waits in comparison to previous year due to limited capacity for patients requiring routine elective procedures.			
Nov 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 into H2. . New operational and planning guidance for 21/22 published outlining priority areas of focus for H2. Financial plan to support delivery of H2operational plan submitted to Board and supported. Insourcing contract agreed at ETM and commenced from July 21 delivering additional in-week and weekend operating capacity.	Re-establish and Recovery Report NHSE					

Key performance Indicator		Principal Risk (s)		Potential consequences	Composite risk rating (high level risks)					Component risks ≥15	
					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	↔	10	20
	5	Failure to deliver the required transformation of services		Reduced reputation and risk to continuity of services	12	8	8	8	↔	3	20

High Level Controls New performance management and accountability framework Development of care group and CBU dashboards including national/local and contractual KPI's/standards ECS 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	Gaps in controls 2 nd , 3 rd and 4 th wave of covid has significantly impacted on the Trust's capacity to deliver all the planned restart activity.	Routine Sources of Assurance Daily return to NHSI for ECS National cancer submission of cancer waiting times by standard Monthly national reporting of 18 weeks RTT through Unify Director of Finance - Performance report to Finance and Performance Committee and Board Audit Committee Report to the Board Contract Management Board Internal Audit Committee Reports on controls assurance Audit Regulation & Assurance Committee Dashboard Board Integrated Dashboard Quarterly Informatics Performance Report Operations highlight report	Risk Appetite Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
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BOARD ASSURANCE FRAMEWORK	Strategic Objective	2b	To deliver our key performance targets	Action Plan to address Gaps in Controls and Assurance
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				Date of update	06/01/22
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
	N/A							

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
	N/A							

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		
								Q4	Q1	Q2	Q3
Executive Lead		Director of HR		Assuring Committee		People Academy					

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source	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.	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 20 months. This has impacted on our People experience as we now focus on recovery with COVID presentation increasing again. This can be demonstrated through our staff absence figures which are increasing again (and are worsening due to the impact of the Omicron variant), recruitment pressures and our staff survey/pulse survey results.
Q2	People Academy dashboard metrics Workforce report Guardian of Safe Working Hours report FTSU Quarterly report CBU to Executive meetings re appraisal performance Health & Safety Annual Report Covid-19 Vaccination Programme Update Nursing recruitment and retention update Nurse staffing – actions in place Freedom to Speak Up Internal Audit Report – significant assurance IPC BAF – in relation to the following indicator: ‘Have a system in place to manage the occupational health needs and obligations of staff in relation to infection’	People Academy 07/21 People Academy 07/21 People Academy 07/21 People Academy 07/21 Report to Board 09/21 Presentation to Board 09/21 People Academy 09/21 People Academy 09/21 Internal audit report Quality & Patient Safety Academy 09/21	Q2	Safe staffing reports/discussion on staffing risks Increasing sickness absence and staff isolation FTSU report re number of H&B cases WRES Disciplinary Data submission change – worse position	People Academy 07/21 / 09/21 People Academy 07/21 / 09/21 People Academy 07/21 People Academy 09/21		
Q3	People Academy dashboard metrics Workforce report Guardian of Safe Working Hours report FTSU Quarterly report Healthcare Worker Influenza Vaccination Programme 2021-22 and Best Practice Management Checklist Temporary Workforce Audit Report – significant assurance People Winter Plan Maternity Incentive Scheme - Safety Action 4 Staffing Assurance Framework for Winter 2021 Preparedness Attendance controls for locum doctors – significant assurance	People Academy 10/21 and 11/21 People Academy 11/21 People Academy 11/21 People Academy 11/21 People Academy 10/21 People Academy 10/21 / Internal audit report People Academy 10/21 People Academy 11/21 People Academy 11/21 Internal audit report	Q3	High level risks relevant to the Academy	People Academy 10/21 and 11/21		

Key performance Indicator		Principal Risk (s)		Potential consequences	Composite risk rating (high level risks)					Component risks ≥15	
					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	↔	5	20
B	Retain: Maintain a turnover rate between 10 -14% Develop:										
C	Ensure all eligible staff have an effective annual appraisal monitoring both completion rates [95%] and quality [through staff survey]										
D	Attract and Lead: To employ a workforce representative of our local communities in line with our Equalities Objectives/WRES action plan to include monitoring against our agreed equality objectives.										
E	Happy, healthy and here: achieve sickness absence rates of less than 4.50% in 2019/20										

High Level Controls		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 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	Bi -Annual review of nurse and midwife staffing establishments NHS People Plan Human Resources Policies and Procedures Equality objectives/ WRES Action plan/Equality plan GMC reports Staff friends and family/ Pulse surveys NHS Staff Survey	Contemporaneous staff experience data Workforce transformation support Full assurance structures and committees not in place	Workforce report People Academy Dashboard Board Integrated Dashboard HEE/NHSI workforce return/workforce plan 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	Workforce Race Equality Standard Report 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 Executive Team Meetings	Seeking – Preference for safe delivery options particularly in relation to nurse staffing that have a low degree of inherent risk to patient safety and may only have limited potential for reward. Is now willing to consider all potential options including the introduction of new workforce models and new ways of working whilst also providing an acceptable level of reward

BOARD ASSURANCE FRAMEWORK		Strategic Objective	3	To be in the top 20% of Employers in the NHS		Action Plan to address Gaps in Controls and Assurance	
				Date of update	06/01/22		
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
2	Revision of the People Dashboard		DHR	February 2021	January 2022	O		Task and Finish Group has reviewed metrics. Likely date for completion January 2022 following ETM & Academy oversight	

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	Quality & Patient Safety Academy		Q4	Q1	Q2	Q3

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source		
ANNUALLY	Inpatient survey – R&A Committee Health and Safety Annual report- R&A Committee Quality Account Guardian of Safe Working Annual Report Patient Experience Annual Report (QA) Quality Account 2020/2 Medical Appraisal and Revalidation Annual Report (PA)	Report Report Report Report Report Report Report	Annually	Serious Incident Report Strategic Risks relevant to the Academy (QA)	Report Report	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 & Patient Safety Academy, there has been a gradual change to a more normal level of reporting and assurance	<p>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.</p> <p>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.</p> <p>The vaccine hub closed as planned in May. Full educational services have been recommenced. Feedback from HEE has been excellent despite recent challenges. Increased elective activity has enabled increased training opportunities in theatres and outpatients. Continued work is being undertaken with partner organisations to ensure that surgical trainees have the best offer possible in relation to elective work. Orthopaedics for example has been a particular challenge, but all trainees now have an individualised training plan.</p>
Quarter 3 2021	Quality & Patient Safety Academy Dashboard (QA) Quality Oversight and Assurance Exception Profile (QA) Strategic Risks Relevant to the Academy (QA) Patient Safety Group Highlight Report (QA) Research in the Trust – November 2021 (QA) Serious Incident Report – November 2021 (QA) Guardian of Safe Working Hours – Quarterly Report (PA) Infection Prevention and Control Board Assurance Framework (QA) Maternity Services Update – November 2021 (QA) Quarterly Safeguarding Adults’ Report (QA) Quarterly Safeguarding Children’s Report (QA) Patient Safety Specialist Update (ETM and Board) Infection Prevention and Control Highlight Report (QA) Patient Experience Quarterly Report (QA) Covid-19 Vaccination Programme Update (Board)	Report Report Report Presentation Presentation Report Report Report Report/ Report/ Presentation Report/ Presentation Report/ Presentation Report Report Presentation					

Key performance Indicator		Principal Risk (s)		Potential consequences	Composite risk rating (high level risks)					Component risks ≥15	
					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

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 Appraisal and Revalidation reports

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

NHS QUEST AHSN Improvement Academy, BIHR Centre for applied health research, HEE HEICQC Compliance Action Plan GMC National Training Survey 2019			
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BOARD ASSURANCE FRAMEWORK	Strategic Objective	4	To be a continually learning organisation	Action Plan to address Gaps in Controls and Assurance
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			Date of update	06/01/22
Accountability		Responsibility		
Lead	Oversight/governance structure	Lead	Work-stream/operational group	
Dr Ray Smith	Quality & Patient Safety Academy	QI Lead	Quality Improvement programme	
		Director of Research	BIHR	
		Director of Education	Delivery of Education Plan	
		Associate Director for Quality	Quality & Patient Safety 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
	N/A							

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
	N/A							

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		
								Q4	Q1	Q2	Q3
Executive Lead		Director of Strategy and Integration		Assuring Committee		Board of Directors					

Positive Assurance			Negative Assurance			Gaps in Assurance	Rationale for Assurance Level
Date	Assurance	Source	Date	Assurance	Source		
Jan 22	<p>Since the onset of the pandemic, health & care partners have worked together on joint planning and to align decision making, for example through 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). (These 7 programmes are currently suspended due to Omicron operational pressure).</p> <p>Work is underway across the ICS to ensure arrangements are in place to be able implement the requirements of the Health and Social Care Bill when it is anticipated to come into effect in July 2022. There is extensive system-wide discussion underway in respect of the development of the "Place Based Partnership" for Bradford District & Craven, plus the revised Strategic Partnering Agreement (SPA), submission of joint plans to NHSE and operational matters like COVID-19 vaccination programmes.</p>	<p>CEO and Chair reports to Board (18/11/21)</p> <p>Board feedback on draft Corporate Strategy" Dec 21/Jan 22)</p> <p>Director of S&I updates to Board on SPA (20/05/21 - Bo.5.21.12) and ICS developments (23/09/21 – Bo.9.21.25)</p> <p>Monthly Health & Care Partnership Board jointly chaired by our CEO</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". Further updates are awaited (Jan 2022)</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 Joint working continues with partners across Bradford District and Craven to make good our CEO's commitment to align our forthcoming refreshed BTHFT strategy with the emergent place-based strategy. Our relevant strategic risks 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 (high level risks)					Component risks ≥15	
					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, 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	
				Date of update	06/01/22		
Accountability			Responsibility				
Lead	Oversight/governance structure		Lead	Work-stream/operational group			
Director of Strategy and Integration	Partnerships now considered in main BTHFT Board rather than discrete Committee		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
	N/A								

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
	N/A								

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 currently ongoing.</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	6	↔	Open	
5	Failure to deliver the required transformation of services	12	8	8	8	↔	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?	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