United Lincolnshire Hospitals NHS Trust

Board Assurance Framework (BAF) 2018/19 (Revised v1)

Strategic objective	Board Committee	Enabling Strategy
1. Our Patients: Providing consistently safe, responsive, high quality care	Quality Governance Committee	Clinical Strategy Quality Strategy
2. Our Services: Providing efficient and financially sustainable services	Finance Service Improvement and Delivery Committee	Digital Strategy Estates Strategy
3. Our People: Providing services by staff who demonstrate our values and behaviours	Workforce and Organisational Development Committee	People Strategy

SO 1. Providing consistently safe, responsive, high quality care

Ref	Outcome required	Executive lead	Corporate risks	Risk rating	Risk control strategy	Risk control gaps	Risk mitigation plans	Source of assurance	Assurance gaps	Assurance actions	Assurance committee	Assurance rating
1a	**Delivering harm free care: reduction in pressure ulcers, falls and infection rates**	Director of Nursing	Safety & effectiveness of nursing care	8 Medium	Quality Strategy & clinical governance / audit arrangements	Patient falls management Pressure ulcer management CAUTI management	Falls action plan Pressure ulcer action plan CAUTI action plan	Quality Report (monthly)	Quality Strategy not yet approved	Quality Strategy to be approved & reported against	Quality Governance	R Not assured
			Safety & effectiveness of medical care	12 High	Quality Strategy & clinical governance / audit arrangements	Consistency & timeliness of electronic discharge (eDDs) Inconsistent compliance with sepsis bundle	eDD Committee improvement plan Sepsis Committee improvement plan	Quality Report (monthly)	Quality Strategy not yet approved	Quality Strategy to be approved & reported against		
					Mortality Strategy & governance arrangements	HSMR alert areas Issues with co-morbidity coding Completion of mortality reviews	Alert areas identified & to be reviewed Review of coding issues Focus on performance management of mortality reviews	Quality Report (monthly)	Lack of benchmark data on mental health / learning disability deaths Information on learning from deaths Report not linked to Mortality Strategy	Development of existing report to cover assurance gaps		

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1b	**Improve our safety culture by delivering the Quality and Safety Improvement plan**	Director of Nursing	Compliance with infection control regulations & standards	12 High	Infection, prevention & control strategy & governance / audit arrangements	Sub-optimal cleaning standards in many areas Housekeeping resource issues	Matron reviews (golden hour walk rounds) & increased supervisory support Housekeeping plan & business case for resources	IPC Committee Report (monthly)	Reliability of hand hygiene audit data Progress with deep clean & housekeeping programmes	Review of audit methodology Update to be included in future reports	Quality Governance	R Not assured
			Safe use of medical devices & equipment	8 Medium	Medical equipment management processes & training strategy	Equipment inventory management Staff training & competency	Safe use of medical equipment project (QSIP)	QSIP Progress Report (monthly)	Project has not yet started to report	Updates to be included in future QSIP reports		
			Delivery of the Quality & Safety Improvement Plan	Not yet rated	Quality & Safety Improvement Board, supported by Programme Management Office	To be identified	To be identified	QSIP Progress Report (monthly)	Risk not currently recorded on Corporate Risk Register	Risk to be assessed and added to Corporate Risk Register		
			Effectiveness of safeguarding practice	12 High	Safeguarding strategy & governance / audit arrangements	Use of sedation & restraint No agreed pathway for patients with significant learning disabilities & national shortage of beds	Clinical holding & restraint training Development of pathway for children & young people with learning disabilities / mental health issues	Safeguarding Committee Report (monthly)				
			Compliance with safeguarding regulations & standards	12 High	Safeguarding strategy & governance / audit arrangements	Inconsistent compliance with safeguarding requirements Outstanding actions from Savile & Bradbury Safeguarding team capacity	Continued monitoring of audit results Savile & Bradbury actions included in QSIP project Operational review by local health service providers	Safeguarding Committee Report (monthly)				

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			Safe use of medicines	12 High	Quality Strategy & clinical governance / audit arrangements	Manual prescribing processes Quality of aseptic facilities	Electronic prescribing project Closure of LCH facility pending improvement works	Medicines Optimisations & Safety Committee Report (monthly)	Quality Strategy not yet approved	Quality Strategy to be approved & reported against		
			Compliance with medicines management regulations & standards	12 High	Quality Strategy & clinical governance / audit arrangements	Monitoring of manual prescribing Non-compliance of aseptic processes	Electronic prescribing project Aseptic facility improvement works	Medicines Optimisations & Safety Committee Report (monthly)	Quality Strategy not yet approved	Quality Strategy to be approved & reported against		
1c	**Initiate the implementation of E prescribing**	Medical Director?	Delivery of the E-prescribing project to planned specification, cost & timescales	Not yet rated	CRIB/ FSID review of Business CMB Digital Strategy Board NHS Digital maturity assessment	Capital not identified	Funding application to NHSI/ review of 19/20 capital priorities	ICT assurance report (quarterly?)	Bid submitted; still lack assurance re Business Case Risk not currently recorded on Corporate Risk Register	Business Case submitted – need to monitor Risk to be assessed and added to Corporate Risk Register	Finance, Service Improvement & Delivery	A Inconclusive
1d	**Strengthening our clinical governance and risk identification: developing a positive and open reporting culture as a learning organisation**	Medical Director	Compliance with clinical governance regulations & standards	12 High	Risk Management Strategy Incident management policies & procedures Clinical governance arrangements at corporate, directorate & specialty levels	Inconsistent application of the Risk Management Policy Duty of Candour compliance levels Identification & sharing of learning from SIs NICE Technology Appraisals & guidelines backlog Inconsistent specialty governance	Development of risk management training & guidance Development of Duty of Candour training, guidance & performance management New Incident Management policy & procedures Monitoring & action plan for NICE backlog New Clinical Governance directorate structure (QSIP)	Corporate Risk Report (monthly) Patient Safety Report (monthly) Operational Quality Governance Committee Report (monthly) QSIP progress Report (monthly)	Identification of learning themes from Serious Incidents Prevention of future backlog of NICE self-assessments	Additional details to be added to future reports	Quality Governance	R Not assured

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1e	**Patient experience reflects our ambition as a Trust to put patients and safety first**.	Director of HR & OD	Patient satisfaction with the quality of experience	Not yet rated	Staff Charter & Personal Responsibility Framework Complaints & patient experience policies & procedures	To be identified	To be identified	Patient Experience Report (quarterly)	Risk requires review & update	Risk to be reviewed and assessed	Quality Governance	R Not assured

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SO 2. Our Services: Providing efficient and financially sustainable services

Ref	Outcome required	Executive lead	Corporate risks	Risk rating	Risk control strategy	Risk control gaps	Risk mitigation plans	Source of assurance	Assurance gaps	Assurance actions	Assurance committee	Assurance rating
2a	**Design and implement a revised leadership and performance management framework**	Chief Executive	Delivery of an effective leadership & performance framework	Not yet rated	Leadership development programme Staff Charter & Personal Responsibility Framework	Ineffective consultation process could result in a lack of engagement	KPMG Review Task and finish group	Chief Executive's update to Trust Board	Not within Terms of Reference for a Board assurance committee Risk not currently recorded on Corporate Risk Register	All committee Terms of Reference to be reviewed Risk to be assessed and added to Corporate Risk Register	Trust Board	Not yet assessed
2b	**Preparing for a comprehensive Electronic Patient Record**	Deputy Chief Executive	Delivery of the Electronic Patient Record project to planned specification, cost & timescales	9 Medium	Business Case- CRIB / FSID review CMB / Digital Strategy Board NHS Digital Maturity Assessment	Capital funding beyond 18/19 not identified Competing demands & limited resource	STP funding application/ national funding programme for EPR (TBC)	ICT Assurance Report (quarterly)	Business Case still in process Risk not currently recorded on Corporate Risk Register	Committee will review Business Case in Sept 2018. Risk to be assessed and added to Corporate Risk Register	Finance, Service Improvement & Delivery	A Inconclusive
2c	**Delivering the trajectories to achieve operational performance targets in 2018/19 planning guidance**	Chief Operating Officer	Management of emergency demand	20 Very high	Emergency demand management arrangements Performance Management Framework	Ambulance handovers and conveyance performance. Streaming to services co-locating or outside of the Emergency Department. ED staffing levels (reliance on agency) and process inefficiencies. Admissions areas and flow management issues. Bed configuration issues across the Trust.	Acute Services Review Operational Delivery Plan Continued full engagement in STP and ASR programmes 100 day improvement programme	Performance Report (monthly)			Finance, Service Improvement & Delivery	R Not assured

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SO 2. Our Services: Providing efficient and financially sustainable services

Ref	Outcome required	Executive lead	Corporate risks	Risk rating	Risk control strategy	Risk control gaps	Risk mitigation plans	Source of assurance	Assurance gaps	Assurance actions	Assurance committee	Assurance rating
			Management of planned care	8 Medium Queried by FSID for review	Elective & outpatient demand management arrangements Performance Management Framework	Too much inappropriate activity defaults to ULHT. ASR / STP not agreed / progressing at required pace (left shift of activity). Sustainability of a number of specialties due to workforce constraints.	Engagement in local Acute Services Review (ASR) Engagement in Sustainability & Transformation Partnership (STP) 100 day improvement programme. Delivery of Theatre productivity programme Delivery of outpatient productivity programme	Performance Report (monthly)				R Not assured
2d	**Deliver financial target agreed by Trust Board**	Director of Finance, Procurement & Corporate Affairs	Substantial unplanned expenditure or financial penalty	20 Very high **(TBC)**	Financial Strategy & Annual Financial Plan Performance Management Framework Turnaround Director appointment	Reliance on temporary staff to maintain services, at increased cost	Recruitment & retention initiatives to reduce reliance on temporary staff	Finance Report (monthly) Internal Audit reports (ad hoc) Head of Internal Audit opinion (annual)			Finance, Service Improvement & Delivery	R Not assured
			Substantial unplanned income reduction or missed opportunities	16 High **(TBC)**	Income improvement plan	Clinical coding & data quality issues. Operational ownership of income at directorate level. Lack of control over local demand reduction initiatives.	Short term income review project (Grant Thornton) Income improvement plan for each directorate. Engagement with commissioners.	Income Report (monthly)				
			Delivery of the Financial Recovery Plan (FRP)	20 Very High **(TBC)**	Financial Turnaround Group (FTG) oversight of FRP	Deliverable FRP schemes do not cover the extent of savings required.	Turnaround Director to review all planned FRP schemes.	FRP Report (monthly)				

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Ref	Outcome required	Executive lead	Corporate risks	Risk rating	Risk control strategy	Risk control gaps	Risk mitigation plans	Source of assurance	Assurance gaps	Assurance actions	Assurance committee	Assurance rating
2e	**Development of estates strategy and investment programme to reduce backlog maintenance and eradicate critical infrastructure risk**	Director of Estates & Facilities	Delivery of planned objectives within the Estates Strategy	16 High **(TBC)**	Estates Strategy development & delivery programme	Estates Strategy to be approved; interdependencies with clinical service strategy & availability of capital funds	Development & implementation of approved Estates Strategy	EIEC Assurance Report (monthly)			Finance, Service Improvement & Delivery	A Inconclusive
			Compliance with fire safety regulations & standards	16 High **(TBC)**	Fire safety policies, training & governance	Issues identified in Fire Service enforcement notice	Fire Improvement Programme	EIEC Assurance Report (monthly)				
			Critical estates infrastructure failure	12 High **(TBC)**	Monaghans backlog report 2017 and capital investment planning	Capacity to maintain essential revenue compliance maintenance activities Lack of Capital Investment to address backlog maintenance	Risk management procedures and prioritisation of activity Existing backlog investment programmes	EIEC Assurance Report (monthly)				
			Quality of the patient environment	12 High **(TBC)**	PLACE Audits and action plans	Lack of Capital investment to modernise outdated facilities and patient environments	Asset Management & PPM Programme	EIEC Assurance Report (monthly)				
			Compliance with water safety regulations & standards	12 High **(TBC)**	Water Safety Plan & compliance monitoring	Water Safety Plan still in development	Completion of Water Safety Plan supported by training & prioritised activity	EIEC Assurance Report (monthly)				

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Ref	Outcome required	Executive lead	Corporate risks	Risk rating	Risk control strategy	Risk control gaps	Risk mitigation plans	Source of assurance	Assurance gaps	Assurance actions	Assurance committee	Assurance rating
2f	**Delivering the ULH related elements of the Lincolnshire Single System Plan**	Deputy Chief Executive	Delivery of the Trust's elements of the STP to planned specification, cost & timescales	Not yet rated	ULHT plan (incorporates single system plan required) BAF and Board performance report STP Exec	Trust Objectives not aligned to single system plan Failure of system to deliver their elements of ULHTs plans Failure of ULHT to delivery Annual Plan objectives	STP single plan by monitoring process	STP Exec Board performance reports	Monitoring / not assessing the SSP yet. Risk not currently recorded on Corporate Risk Register	Risk to be assessed and added to Corporate Risk Register	SET	A Inconclusive
2g	**Design, consultation and implementation of Acute Services Review**	Deputy Chief Executive	Delivery of the Acute Services Review to planned specification, cost & timescales	Not yet rated	ASR steering group Clinical Strategy Review Board 2021 Programme Board SET/LCB NHSE/NHSI oversight	Failure of system to agree clinical models Failure to complete pre consultation Business case Failure to consult in a timely manner Failure to attract capital/revenue to support change	Lack of single governance model	Clinical Strategy report to 2021 Board Trust Board review	PCBC may fail to deliver on time	Agreement of decision making process / governance models at LCB / SET	SET LCB	A Inconclusive
2h	**Deliver inpatient ward reconfiguration at Pilgrim Hospital Boston**	Chief Operating Officer	Delivery of the Pilgrim Hospital inpatient ward configuration to planned specification, cost & timescales	Not yet rated	Project management through Reconfiguration group / Productive Services Delivery Board	Unable to reconfigure staffing models and complete workforce change in the required timescale Unable to finalise 8b ward upgrade Risk of delivery due to competing demands, resource	Project risk management plans	Operational Plan updates (ad hoc)	No assurances received Risk not currently recorded on Corporate Risk Register	Assurance report sought for meeting in August Risk to be assessed and added to Corporate Risk Register	Finance, Service Improvement & Delivery	A Inconclusive

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SO 3. Our People: Providing services by staff who demonstrate our values and behaviours

Ref	Outcome required	Executive lead	Corporate risks	Risk rating	Primary risk controls	Risk control gaps	Risk mitigation plans	Source of assurance	Assurance gaps	Assurance actions	Assurance committee	Assurance rating
3a	**Workforce skills and numbers: A workforce that is fit for purpose, reflects our clinical strategy and is affordable**	Director of Human Resources & Organisational Development	Workforce capacity & capability (recruitment, retention & skills)	20 Very high	People Strategy & operational plans Recruitment & retention framework People management policies & procedures Core learning & leadership development programmes	Nurse recruitment & retention Vacancy rates for consultants & middle grade doctors Age profile of the clinical workforce Impact of Brexit on staff from EU countries	Focus on nursing & medical staff engagement & development; exploration of new staffing models Review of age profile & People Strategy to mitigate impact Communication & engagement with EU staff & their managers	Workforce Reports (bi-monthly)	Lack of workforce data in reports	Development of KPIs for future reporting	Workforce & Organisational Development	R Not assured
			Workforce planning process	12 High	Workforce strategy, planning processes & management information	Capacity within the business to support the process	KPMG are providing additional capacity and capability; skill building at STP level	People Strategy Report (bi-monthly)	Lack of workforce data in reports	Development of KPIs for future reporting		
			Paediatric service medical workforce at Pilgrim Hospital	12 High **(TBC)**	Workforce planning processes Temporary staffing arrangements	Shortage of sufficient numbers of Middle Grade doctors to maintain safe services	Interim structure to be in place from August 2018 Development of sustainable service model	Fragile services report (bi-monthly)				

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Ref	Outcome required	Executive lead	Corporate risks	Risk rating	Primary risk controls	Risk control gaps	Risk mitigation plans	Source of assurance	Assurance gaps	Assurance actions	Assurance committee	Assurance rating
3b	**Engagement through change: A workforce that is engaged with what the Trust is seeking to achieve and its values**	Director of Human Resources & Organisational Development	Staff engagement, morale & productivity	12 High	Staff charter and vision and values Freedom To Speak Up Guardian role Staff engagement strategies & plans (including staff surveys) People management policies, systems, processes & training Management of organisational change policies & procedures	Impact of the cost reduction programme, Special Measures & scale of organisational change on staff morale (evidenced in 2017 Staff Survey)	Trust-wide response to staff survey results to inform revised People Strategy Localised directorate action plans in response to staff survey results	Staff engagement report (bi-monthly?) Quarterly Report from FTSU Guardian to Board	Feedback from Pulse Survey and improvement programmes not yet available FTSU Guardian report not received at W&OD Committee	Feedback from Pulse Survey and improvement programmes to be reported once available	Workforce & Organisational Development	R Not assured

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The BAF management process

The Trust Board assigns each strategic objective to a lead assurance committee. Required outcomes under each strategic objective are either assigned to a lead assurance committee or reserved for review by the Trust Board.

The process for routine review and update of the BAF is as follows:

- The corporate risk register is maintained by the lead executive, in accordance with the Risk Management Policy
- The BAF is updated with any changes to those corporate risks recorded within it; the Trust Board decides which corporate risks are significant enough to warrant inclusion on the BAF, based on recommendations from lead committees
- The lead assurance committee (or Trust Board, where applicable) reviews the management of risks to each required outcome(as part of their regular work programme), through evaluation of reports and risk assessments provided by executive leads
- The lead assurance committee identifies any gaps in primary controls or assurance and ensures there are appropriate plans in place to address them
- The lead assurance committee decides on an assurance rating for each required outcome, based on evidence provided in identified sources of assurance

To facilitate this process, each assurance committee will receive regular reports from specialist multi-disciplinary groups, executive leads and other sources which provide management information and analysis of relevant key risks, to enable the committee to make a judgement as to the level of assurance that can be provided to the Board. All reports to assurance committees should first have been reviewed and approved by the executive lead.

When deciding on the assurance rating for each outcome the following key should be used:

R

Red = **Not assured**. the Committee is not satisfied that risks to this objective are being managed effectively

A

Amber = **Inconclusive**. the Committee has received insufficient evidence to determine whether or not risks to this objective are being managed effectively

G

Green = **Assured**. the Committee is satisfied that risks to this objective are being managed effectively