Board Assurance Framework (BAF) 2018/19 (Revised v27122018)

Strategic objective	Board Committee	Enabling Strategy
1. Our Patients: Providing consistently safe, responsive, high quality care	Quality Governance Committee	Clinical Strategy Quality Strategy Research Strategy
2. Our Services: Providing efficient and financially sustainable services	Finance, Performance and Estates Committee	Financial Strategy Digital Strategy Estates Strategy Environmental Strategy
3. Our People: Providing services by staff who demonstrate our values and behaviours	Workforce , OD and Transformation Committee	People Strategy Equality Diversity and Inclusion Strategy Communications and Engagement Strategy

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

Ref	Outcome required	Exec lead	How we may be prevented from meeting objective	Link to Risk Register	Link to Standards	Identified Controls	Control gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps - Where are we not getting effective evidence	How identified assurance gaps are being managed	Committee providing assurance to TB	Assurance rating
1a	Delivering harm free care: reduction in pressure ulcers, falls and infection rates	Dir of Nursing	Non compliance with infection prevention and control regulations and standards Unreliable or inaccurate harm data None compliance with policy and procedure Insufficient housekeeping resource for environment Delayed diagnosis and treatment of patient	4138 4141 4142 4144 4146	CQC Safe	**Primary** Improvement Programme for all key harms Training programme for all key harms Collaborative pathway work with CCGs Falls Ambassadors Pressure Ulcer Investigation Tool **Secondary** Engagement with NHSI for system wide improvement Ward Accreditation Programme Validation of pressure ulcers by Tissue Team Pressure Ulcer Scrutiny Panel **Tertiary** Internal Audit review of Quality Governance External Audit Review of Quality Account	No agreed pathway for patients with significant learning disabilities & national shortage of beds Training Compliance Inconsistent compliance with safeguarding requirements Outstanding actions from Savile & Bradbury Non compliance with Hygiene Code Sub-optimal cleaning standards in many areas Housekeeping resource issues	Falls action plan Pressure ulcer action plan CAUTI action plan Clinical holding & restraint training Development of pathway for children & young people with learning disabilities / mental health issues Continued monitoring of audit results Savile & Bradbury actions included in QSIP project Operational review by local health service providers IPC Review Audit Programme Matron reviews (golden hour walk rounds) & increased supervisory support Housekeeping plan & business case for resources	Clinical Strategy Integrated Performance Report Quality Dashboard Patient Experience Dashboard Quality and Safety Improvement Plan Internal Audit Review of Quality Governance Board Walkrounds Clinical Audit Programme Ward Accreditation NHS I review of infection control CQC report	Quality Strategy not yet approved Progress has been made with pressure ulcer reduction plan but impact on reducing harm not yet seen. Falls reduction plan dashboards have been created in datix but not yet rolled out	Quality Strategy approval and monitoring within QGC work programme Work being undertaken on datix to support reporting	Quality Governance Committee	A

1b	**Improve our safety culture by delivering the Quality and Safety Improvement plan**	Director of Nursing	Recruitment of leads impacting on project delivery Capacity and resource for project Staffing in Pilgrim ED	4146 4145 4156 4043 4353		Quality & Safety Improvement Board, supported by Programme Management Office	Populated dashboard required which includes outcomes		QSIP Progress Report (monthly) Annual Governance Statement CQC revisit Incident report to TB IA Review of Governance (Q3) Ext Audit review of Quality Account	Reporting Improvement Absence of a functioning populated dashboard	Improve Reporting Detail link outcomes to actions taken	Quality Governance	R
1c	**Initiate the implementation of E prescribing**	Medical Director	Delivery of the E-prescribing project to planned specification, cost & timescales	4406 4156 4157		CRIB/ FSID review of Business CMB Digital Strategy Board NHS Digital maturity assessment	Capital not identified; business case not yet approved by NHSI.	Funding application to NHSI to be re-submitted in January 2019. External funding continues to be pursued. In the meantime the project will continue to progress with internal funding sources.	Approved business case IA Review Pharmacy & Med Mgt Q4	Project not yet approved Capital required	Business Case submitted – need to monitor	Finance, Performance and Estates Committee	A

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 Safety & effectiveness of medical care Safe use of medicines Compliance with medicines management regulations & standards Safe use of medical devices & equipment	4043 4138 4154 4155		Risk Management Strategy Incident management policies & procedures Clinical governance arrangements at corporate, directorate & specialty levels Internal Audit Review Quality Strategy & clinical governance / audit arrangements Mortality Strategy & governance arrangements Medicines management processes & safety arrangements Specific Internal Audits and Clinical Audits Medicines management processes & safety arrangements Medical equipment management processes & training strategy	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 Risk Appetite not approved Policy Backlogs Consistency & timeliness of electronic discharge (eDDs) Inconsistent compliance with sepsis bundle HSMR alert areas Issues with co-morbidity coding Completion of mortality reviews Reliance on manual prescribing processes Quality & safety of aseptic facilities Poor Incident Reporting Monitoring of manual prescribing processes Non-compliance of aseptic processes Equipment inventory management Staff training & competency	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) eDD Committee improvement plan Sepsis Committee improvement plan Alert areas identified & to be reviewed Review of coding issues Focus on performance management of mortality reviews Electronic prescribing project Closure of LCH facility pending improvement works Electronic prescribing project Aseptic facility improvement works Safe use of medical equipment project (QSIP)	Corporate Risk Report (monthly) Patient Safety Report (monthly) Operational Quality Governance Committee Report (monthly) QSIP progress Report (monthly) Patient Safety Committee Report (monthly) Quality Report (monthly) Medicines Optimisations & Safety Committee Report (bi-monthly) Medicines Optimisations & Safety Committee Report (bi-monthly) QSIP Progress Report (monthly)	Policy Backlog Terms of Reference Approval Spec Reporting Identification of learning themes from Serious Incidents Prevention of future backlog of NICE self-assessments Quality Strategy not yet approved Lack of benchmark data on mental health / learning disability deaths Information on learning from deaths Report not linked to Mortality Strategy Quality Strategy not yet approved Report against NHSI actions Quality Strategy not yet approved Project has not yet started to report	Quality Strategy to be approved & reported against Development of existing report to cover assurance gaps QGC Populated Dashboard Implement and embed Quality and Safety Operational Group	Quality Governance Committee	R

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	4081		Staff Charter & Personal Responsibility Framework Complaints & patient experience policies & procedures IA Review Duty of Candour Clinical Audit	FTT Complaint rates and responses Engagement Learning Local Ownership	Action plans to be clarified	Patient Experience Report (Monthly) PT Ex Committee Quality Strategy	Quality Strategy not in place Learning		Quality Governance Committee	R

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

Ref	Outcome required	Exec lead	How we may be prevented from meeting objective	Link to Risk register	Link to standards	Identified Controls	Control gaps	How identified control gaps are being managed	Source of assurance	Assurance Gaps – where are we not getting effective assurance	How identified assurance gaps are being managed	Committee providing assurance to TB	Assurance rating
2a	**Design and implement a revised leadership and performance management framework**	CEO	Supporting key business functions are not aligned to framework full benefits are not realised Failure to engage workforce Failure to create culture where organisation works openly together Inadequate planning for estate and technology requirements	None		Formal consultation process Communication plan	Ineffective consultation process could result in a lack of engagement	Board report detailing consultation timeline	Regular Board update reports Organisational structure signed off by Board	Risk not currently recorded on Corporate Risk Register	Risk to be assessed and added to Corporate Risk Register	Workforce, OD and Transformation Committee	A

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2b	**Preparing for a comprehensive Electronic Patient Record**	DCEO	Process takes longer than expected Staff don't adapt to change Poor clinical engagement Staff capacity for design, implementation and training	4181		**Primary Controls** Project Board / Project manager Clinical leadership and key clinical staff **Secondary Controls** Business Case- CRIB / FSID review Digital Strategy Digital Strategy Board Engagement and comms plan **Tertiary Controls** NHS Digital Maturity Assessment	Capital funding beyond 18/19 not identified	Business case supported by FSID; STP bid to Provider Digitisation Programme – Funding not yet secured. Identified as emergent risk on risk register.	ICT Assurance Report (quarterly) IA Cyber Security (Q4) IA GDPR (Q1) -significant assurance IA Data security Standards (Q4)	None	None	Finance, Performance and Estates Committee	A

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2c	**Delivering the trajectories to achieve operational performance targets in 2018/19 planning guidance**	COO	Failure to manage emergency demand Failure to implement streaming arrangements Inappropriate activity defaults to Trust Sustainability of services due to workforce risks Availability of equipment and resources ASR/STP progress Failure to manage demand for outpatient appointments	4175 4176 4368		**Primary Controls** Emergency demand management arrangements Performance Management Framework Elective & outpatient demand management arrangements Performance Management Framework **Secondary Controls** **Tertiary Controls**	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. 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.	Acute Services Review Operational Delivery Plan Continued full engagement in STP and ASR programmes 100 day improvement programme 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) Winter Plan Urgent and Emergency Care Board NHSI Performance Review Meetings NHSE national ranking NHSE Performance Data System escalation meetings and system support	ED staffing remains heavily dependent on agency. Risk of not recruiting remains high Recovery plans which can demonstrate how closing gap to achieve trajectory	FPEC to routinely monitor risks to delivery FPEC to monitor recovery plans monthly	Finance, Performance and Estates Committee	R

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2d	**Deliver financial target agreed by Trust Board**	Director of Finance, Procurement & Corporate Affairs	Schemes do not cover extent of savings required FRP remains adverse to plan Continued reliance on agency and locum staff to maintain services at substantially increased cost. Unplanned expenditure or financial penalties Failure to secure all income linked to coding or data quality issues	4382 4383 4384	CQC Well Led	Financial Strategy & Annual Financial Plan Performance Management Framework Turnaround Director and Team appointment Financial Turnaround Group (FTG) oversight of FRP Income improvement plan	Reliance on temporary staff to maintain services, at increased cost Deliverable FRP schemes do not cover the extent of savings required. Clinical coding & data quality issues. Operational ownership of income at directorate level. Lack of control over local demand reduction initiatives.	Recruitment & retention initiatives to reduce reliance on temporary staff Review of all planned FEP schemes. Short term income review project (Grant Thornton) Income improvement plan for each directorate. Engagement with commissioners. Review of back office functions	Monthly Finance Report to Trust Board Turnaround report to Board Annual Head of Internal Audit opinion FSM meetings with NHSI/NHSE IA - General Ledger (Q3) IA Key financial systems (Q3) IA Pay expenditure (Q3/4)	Require details of plan to deliver savings by month Details of plans to improve coding and data quality	Turnaround report to Board FSM meetings with NHSI/NHSE Non Exec attendance at FTG	Finance, Performance and Estates Committee	R

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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 Compliance with fire safety regulations & standards Critical estates infrastructure failure Quality of the patient environment Compliance with water safety regulations & standards Insufficient decant facility Large volume of work to address ageing building	3520 3687 3690 4403 3720 3722 3721 3688 3689 4398 4402 4397 4404 4003 4401		Estates Strategy development & delivery programme Fire safety policies, training & governance Monaghans backlog report 2017 and capital investment planning PLACE Audits and action plans Water Safety Plan & compliance monitoring	Capacity in team to deliver estates strategy interdependencies with clinical service strategy & availability of capital funds Issues identified in Fire Service enforcement notice Capacity to maintain essential revenue compliance maintenance activities Lack of Capital Investment to address backlog maintenance Lack of Capital investment to modernise outdated facilities and patient environments Water Safety Plan still in development	Business case for additional support to deliver estates strategy Fire Improvement Programme Risk management procedures and prioritisation of activity Existing backlog investment programmes Asset Management & PPM Programme Completion of Water Safety Plan supported by training & prioritised activity	EIEC Assurance Report (monthly) Backlog maintenance programme Fire Service Inspections PLACE Audits IA Estates ordering/ invoicing (Q3) IA Fire Enf Funding (Q3)	Insufficient data quality on statutory and regulatory requirements to achieve assurance Not sighted on delivering backlog maintenance Subject to fire enforcement notices	FPEC request for dashboard to assure on statutory and regulatory requirements Regular review by fire service	Finance, Performance and Estates Committee	R
2f	**Delivering the ULH related elements of the Lincolnshire Single System Plan**	CEO	ASR covered by objective 2g Cancer/ Urgent Care and Planned Care covered by objective 2c System working			Streaming work Winter Plan Partnership working STP SET LCB STP Exec	As a Board not to consider where assurance comes from overall.			As a Board not to consider where assurance comes from overall.		Finance, Performance and Estates Committee	A

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2g	**Design, consultation and implementation of Acute Services Review**	DCEO	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	None		**Primary Controls** ASR steering group Clinical Strategy Review Board 2021 Programme Board **Secondary Controls** SET/LCB **Tertiary Controls** NHSE/NHSI oversight	Sustaining and delivering clinical services Activity shift from acute to community models fail to deliver Operational management capacity	Use of locum and agency staff Contingency planning. Whole system working	Clinical Strategy report to 2021 Board Trust Board review GIRFT Specialised Commissioner Reviews	PCBC may fail to deliver on time Risk not currently recorded on Corporate Risk Register	Agreement of decision making process / governance models at LCB / SET Risk to be assessed and added to Corporate Risk Register	Finance, Performance and Estates Committee	A
2h	**Deliver inpatient ward reconfiguration at Pilgrim Hospital Boston**	COO	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	4175		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)	Reconfiguration complete	Reconfiguration complete	Finance, Performance and Estates Committee	G

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

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3a	**Workforce skills and numbers: A workforce that is fit for purpose, reflects our clinical strategy and is affordable**	Director of HR & OD	Inability to recruit and retain a suitably skilled workforce to meet demand resulting in unplanned and indefinite closure of multiple services across the Trust. Failing to reduce high vacancy rates of consultants and doctors Significant proportion of clinical workforce approaching retirement age Reliance on deanery positions to cover staffing gaps Inadequate workforce planning process	4362 4082		Access to workforce business intelligence People Strategy & Annual Workforce Plan Recruitment & retention strategies and plans People management policies & procedures Core learning & leadership development programmes Interim service model in place Vacancy controls Agency cost reduction plan	Age profile of the clinical workforce Accuracy of all workforce information Impact of Brexit on staff from EU countries Capacity within the business to support the process Shortage of sufficient numbers of staff in key areas, impacting on vulnerable services and potential risk to maintain safe services	Focus on nursing & medical staff engagement & development; exploration of new staffing models Review approach to recruitment to deliver at greater pace and scale Review of age profile & People Strategy to mitigate impact Communication & engagement with EU staff & their managers KPMG are providing additional capacity and capability; skill building at STP level Recruitment programme Development of sustainable service model NHSI Retention Project	People Strategy Additional management support Sourcing of recruitment partner Staff survey results March 2019 Data quality work	Fully populated workforce plan Progress in addressing vacancy rates skill mix requirements not yet fully identified	Focus through financial recovery group Workforce oversight group being established Additional resources allocated to address workforce priorities and projects	Workforce, OD and Transformation Committee	R

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

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3b	**Engagement through change: A workforce that is engaged with what the Trust is seeking to achieve and its values**	Director of HR & OD	A fundamental loss of workforce engagement which could result in a culture of low morale and motivation that impacts on the quality & safety of services throughout the Trust and permanently damages its reputation	4083 4351 4363		Staff charter and vision and values Freedom To Speak Up Guardian role Staff engagement strategies & plans (including staff surveys) Focus on drivers of engagement: Engagement of staff in 2021 programme Opportunities for staff voice to be heard Work on staff charter and values Leadership and management development 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) Consistent quality of local leadership and management Staff engagement and belief in 2021 as means of bringing improvement	Trust-wide response to staff survey results to inform revised People Strategy. Localised directorate action plans in response to staff survey results. Reviewing the current recognition agreement to modernise it and ensure it is fit for purpose. Leadership and management development programmes Review of communications and approach in 2021	CQC report Workforce Committee KPIs including vacancy rates, appraisals, turnover, core learning, agency usage Pulse survey Staff Survey Quarterly FTSU Guardian report to Board TB FTSU Self Assessment Staffside representative feedback IA Review Public Sector Equality Duty	Current levels of staff engagement including medical engagement Staff survey publication March 2019 Referrals to FTSU Guardian remain low. Some areas of self assessment scored not met Relationships with staff side representatives is challenged by the scale of organisational change required.	Feedback from Staff Survey to be reported once available FTSU Action Plan to promote awareness FTSU action plan to address areas not met. Staffside and Executive Joint Working Workshops Staff engagement group meets monthly – cross section of staff	Workforce, OD and Transformation Committee	R

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The BAF management process

The Trust Board has assigned each strategic objective of the 2021 Strategy to a lead assurance committee. Outcomes under each strategic objective are aligned to a lead 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 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 at Committee by executive leads
- The lead committee identifies any gaps in controls or assurance and ensures there are appropriate plans in place to address them
- The lead committee decides on an assurance rating for each required outcome, based on evidence provided in identified sources of assurance

To facilitate this process, each committee will receive regular reports from specialist 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 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 — Effective controls may not be in place and/or appropriate assurances are not available to the Board

A — Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient

G — Effective controls are definitely in place and Board are satisfied that appropriate assurances are available