Board Assurance Framework (BAF) 2018/19 (Revised v270219)

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 Sub-optimal cleaning standards in hardest areas. Delayed diagnosis and treatment of patient Compliance with water safety regulations & standards	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 + falls Scrutiny Panel +CAUTI **Tertiary** Internal Audit review of Quality Governance External Audit Review of Quality Account National Benchmarking position (external) CQC feedback Monthly cleaning audits (MICAD) and action plans	Non compliance with Hygiene Code (Criterion 2) Audits show sub-optimal cleaning standards on a number of wards Housekeeping vacancies transitioning structure – Move to new structure not completed Training doesn't meet standards Water safety plan compliance + monitoring	Falls action plan Pressure ulcer action plan CAUTI action plan IPC Review (NHSI) Audit Programme Housekeeping plan & business case for resources STEIS Ward Assurance Ward Accreditation reviews and assessments Water safety plan still in development IPCommittee monthly review QSOG review	Quality 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 SQD	Quality Strategy not yet approved Confidence in all harm-free care data	Quality Strategy approval and monitoring within QGC work programme Data quality group in place	Quality Governance Committee	A

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1b	**Improve our safety culture by delivering the Quality and Safety Improvement plan** **Safeguarding**	Director of Nursing	Recruitment of leads impacting on project delivery Capacity and resource for project Staffing in Pilgrim ED Impact of individual acting does not lead to sustained improvement owing to organisational mood.	4146 4145 4156 4043 4353		Quality & Safety Improvement Board, supported by Programme Management Office Overall culture change programme in People strategy	Populated dashboard required which includes outcomes Consistent application of and engagement with governance processes. Particularly those that enable learning. See id	Review of Q501 programme to incorporate actions to address "hearts & minds" issue. Quality Improvement Programme (QSIR) to be at heart of change	QSIP Progress Report (monthly) Annual Governance Statement CQC revisit Incident report to TB IA Review of Governance (Q3) Ext Audit review of Quality Account National staff survey data	Reporting Improvement Absence of a functioning populated dashboard Continued lower survey score suggests inconsistent engagement with process.	Improve Reporting Detail link outcomes to actions taken Remains an issue but work has commenced in conjunction with committee on dashboard with completion planned for March 2019 Staff engagement seniors with values / staff charter on part of TOM OD Programme Review of approach to leadership development Delivery QI of Programme	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 Work has commenced internally funded at risk to the Trust pending capital funding.	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 – core learning compliance	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) TOM OD Plan	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) NHS Staff Survey results	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 Staff engagement with process of learning not consistent Education and Learning Strategy	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 Staff engagement seniors with values / staff charter on part of TOM OD Programme Review of approach to leadership development Delivery of QI Programme	Quality Governance Committee	R

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1e	**Patient experience reflects our ambition as a Trust to put patients and safety first**.	Director of HR & OD	If we have low staff morale & they do not feel valued this can be reflected in their day to day work resulting in perceived lack of compassion and care. If wards are frequently escalated and workforce gaps are not filled then staff capacity to handle demand is reduced potentially leading to lower quality care, patient harms, complaints and concerns. If services do not put patients at the heart / central to care then patient time will not be valued resulting in waits and delays and poor experience. If services are not seeking and listening to patient feedback and concerns we will fail to learn from their experience resulting in required improvements not being identified and delivered. If we do not have robust governance and ownership of patient experience feedback we will consistently fail to deliver what matters to patients.	4081		Staff Charter & Personal Responsibility Framework See it My Way – complaints and concerns procedure. FAB Academy initiatives FAB Experience Champions framework Ward Accreditation PX metrics Patient Stories Staff & Patient Experience initiatives Patient & Carer Experience Strategy & associated workplan NHSI Patient Experience Improvement Framework 'Using Patient Feedback' module in leadership programme	Consistently below average FFT recommendation rates <80% complaints responded to within expected timescales Lack of engagement with PXG Lack of local operational ownership of PX data and required Lack of sharing lessons learned Lack of attendance to 'Using Patient Feedback' leadership modules Lack of understanding of 'patient centred care' within some services.	Patient Experience Strategy workplan and milestones Patient Experience Group Development of FAB Experience Champions Ward accreditation PX metrics PX metrics within PRMs Development of meaningful and manageable data PX Pop-in programme Patient Safety Walkrounds	Monthly PX reports. Patient Experience Group (PXG) S.U.P.E.R.B dashboard PRMs Patient stories to Trust Board Quality Strategy National Surveys Care Opinion Counting Compliments Themes and trends from PX data analysis	Quality Strategy not yet in place Evidence of YSWD Sharing lessons learned Patient & Carer Experience Strategy & associated workplan due for renewal 2019 Not all FAB Experience Champions yet identified	PX work programme (in development)	Quality Governance Committee	A

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	Failure to fully populate structure Failure to engage workforce Lack of support offer from non clinical functions Lack of clarity of requirements Failure to create culture where organisation works openly together	None		Formal consultation process and wider engagement process Ways of working documentation Communication plan Trust Operating Model OD Plan Description of governance/performance management within TOM Rigorous recruitment process	Remaining unfilled vacancies	Recruitment tracker and appointment of interim staff	Regular Board update reports Organisational structure signed off by Board TOM earned autonomy arrangement Progress of recruitment OD implementation plan TOM task and Finish Group Tom Board	No gaps identified	No gaps identified	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 Capital funding not in place beyond 2018/19	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. Trust proceeding at risk continuing to pursue capital 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 Lack of staffing capacity	4175 4176 4368		**Primary Controls** Emergency demand management arrangements Performance Management Framework Elective & outpatient demand management arrangements Performance Management Framework **Secondary Controls** Workforce planning **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. Loads of effective & proactive workforce planning	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) Committee rec'd greater assurance on 52WW and RTT. 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 Assurance being received on specific interventions in ED. Not yet able to see this translating in to improved 4hr position Recovery plans which can demonstrate how closing gap to achieve trajectory Demand + capacity in fragile services.	FPEC to routinely monitor risks to delivery. Some success seen in middle grade recruitment Further impact report to be received at FPEC FPEC to monitor recovery plans monthly Workforce review in fragile services	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 Failure to reduce overall workforce cost to achieve recruitment targets	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 and governance of FEP framework underway. To FPEC in Feb 2019 Short term income review project (Grant Thornton). Formal learning report awaited. 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) Sig Ass given Jan 2019 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 Recruitment success - increase in numbers in post in right areas	Improved reporting of FRP to Board has commenced Jan 2019 FSM meetings with NHSI/NHSE Coding improvement work commenced and included in contracting report to committee. Improved recruitment + retention reporting	Finance, Performance and Estates Committee	A

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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) Limited assurance received Jan 2019 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. Work on dashboard has commenced due March 2019 Regular review by fire service. Fire compliance update monthly to committee	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 Engagement with System working Skills / capacity gap			Streaming work Winter Plan Partnership working STP SET LCB STP Exec STP Workforce Plan	As a Board need to consider where assurance comes from overall. High level Workforce Plan	LWAB-led work on Workforce planning System leadership work to increase engagement	Regular reporting to CMB	Gap in providing Board and Committee oversight	TOM OD Plan includes leadership, development and will accompany system leadership	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 Failure to attract appropriate workforce	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 STP workforce plan	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 Committee agreed reporting schedule for assurances in workplan	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

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
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 Talent management + succession planning arrangements	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 -Talent Academy NHSI Retention Project	People Strategy Additional management support Sourcing of recruitment partner Staff survey results March 2019 Data quality work Data on effective application of people management policies. Absence management arrangements in Trust GMC Surveys	Fully populated workforce plan Progress in addressing vacancy rates skill mix requirements not yet fully identified -Future workforce modelling Junior doctor experience	Focus through financial recovery group Workforce oversight group established Additional resources allocated to address workforce priorities and projects New workforce planning process to be introduced in 2019/20 Review of approach to calculation + junior doctor experience in particular	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 Inclusion strategy	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 -2021 Marketing plan	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 Report on application of people policies - Sickness absence, disciplines, grievances	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. Quality of leadership Perception of bullying + harassment	Developing new vision for staff as a narrative for engagement 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 Quality Improvement Programme (QSIR) ti be central to improvement programme Review of approach to leadership development	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