BAF	Strategic Risk	Lead Executive	Assurance Committee
1	Partnership Working	Neil Moloney	Performance Assurance Committee
2	Financial Performance	Adrian Marr	Performance Assurance Committee
3	Capital Expenditure	Adrian Marr	Performance Assurance Committee
4	Patient Safety & Quality	Giles Thorpe/Angela Tillett	Quality & Patient Safety Committee
5	Workforce	Kate Read/Debbie O'Hara	People & Organisational Development Committee
6	Elective & Emergency Care	Neill Moloney	Performance Assurance Committee
7	Estates Development & Capital Equipment	Paul Fenton	Performance Assurance Committee
8	Digital Maturity	Mike Meers	Quality & Patient Safety Committee
9	Transformation	Shane Gordon	Performance Assurance Committee

Principal Risk 1	Partnership Working					Risk rating	Initial	Current	Target	Cause	If ESNEFT does not develop effective partnerships across place, system and beyond
Risk Description	If ESNEFT does not develop effective partnerships across place, system and beyond, then it will be unable to respond to the needs of patients and public across Suffolk and North East Essex, resulting in lost opportunities to deliver the right care at the right place and at the right time to address the full range of people's needs and prevent impact on health inequalities					Consequence	4	4	3	Effect	We will be unable to respond to the needs of patients and public across Suffolk and North East Essex
Strategic Objective	SO2 - Lead the integration of care	Risk Appetite	Flexible - The Board has a flexible view of commercial risk. It is willing to pursue business opportunities with the potential for high returns alongside commercial activities of a more established nature			Likelihood	3	2	2	Impact	This will threaten the ability to achievement of ESNEFT's long term goals and impact on the needs of our patient's
Executive Lead	Neill Moloney, Managing Director & Deputy CEO	Assurance Committee	Performance Assurance Committee	Date of Review	Nov-22	Risk rating	12	8	6		

Key Controls	Sources of Assurance	Levels of Assurance 1st	2nd	3rd	Pos	Neu	Neg	Gaps in Control	How controls are measured	Agreed Action
Formal joint partnership arrangements in place with a number of external partners, ensuring strategic alignment with partners via its membership through: - West Suffolk Hospital (WSH) - East of England Ambulance Service Trust (EEAST) - SNEE ICS - ESNEFT as an Anchor organisation and Anchor Programme Board ESNEFT influences and has established structures, systems and processes to ensure that the improvement of health inequalities is at the heart of its system leadership and integration activities.	ICS and ESNEFT plan in line with National Planning Framework. Recommendations and action plan referring to partnership working regularly submitted to the Board and QPSC. - Integrated Care Board represented by ESNEFT CEO - Alliance Committee - Provider Collaborative Committee - Regional Collaboration - ESNEFT Anchors Dashboard - ESNEFT 5 year strategy - Time Matters Board and strategy - SNEE ICS Integrated Care System Design Framework Priority areas for joint working are established and identified in the annual plans, operational plans and business plans.		✔					Develop our environmental committees for Carbon Net ambitions Travel club commitments Continue ESNEFT group to ensure a joined up approach to deliver outcomes Further Analysis of the information we have to set our baseline and what could be delivered, with a full understanding of local v national spend i.e. NHS Supply Chain Share information and work with ICS to understand what collectively can be achieved. Criteria for Success – Put in place key measurable metrics, what are our targets. Social Value and Cost in Procurement being implemented from 1st April 2022 NHS TOMs (Themes Outcome Measure) - await publication Community & Voluntary Engagement - How to harness valuable resource and what can ESNEFT do as an Anchor Organisation.	Delivery of priorities and milestones through assurance committees. ICS Anchor Charter Delivery of NHS Strategy Land and asset owners commitments Communities commitments Alignment of organisational priorities	Extend the training offer of the Diagnostic Training Academy to include apprenticeships and qualifications. Explore opportunities for bursaries for leadership training targeted at BAME community leaders Funding and supporting six BAME projects for 2 year period Develop a process for measuring the impact of Volunteering Develop Social Action and Social Prescribing Projects
Formal partnerships in place to support the delivery of our goal to be a centre of excellence in research, education and innovation	Communications & Engagement Strategy		✔						Delivery of agreed Research and Innovation priorities with partner organisations including other NHS Providers and universities	
To ensure the on-going sustainability of the acute sector across the region	Work programmes in place across a range of projects to address specific issues. Pathology networks Board to Board meetings (ESNEFT/WSH/ICB). To establish good relationships and ensure strategic alignment.		✔							
GP Forum	Feeds into elective care group for any actions that cannot be resolved at that level and escalated to CRG for info and disc.		✔							
Health Education England and Faculty for Education	Medical assurance groups Medical and Nursing assurance groups Faculty of Education POD and regional meeting Member of Health Ambassador Scheme Members of Suffolk & North East Essex ICS Health & care Academy		✔					Developing a pathway into the NHS with Suffolk and NE Essex ICS and ring fence vacancies for application. ESNEFT Career start programme enablers	Measuring performance through metrics and staff groups as part of the Anchor Organisation. Procurement commitments Environmental commitments	

Principal Risk 2	**Failure to maintain revenue financial balance in future years**	**Linked Risks**	**BAF3 - Insufficient capital resources to progress investments. 1014 – Failure to maintain financial balance in current year 2023/24 1030- There is a risk that supply chain disruption may negatively impact on the business continuity, availability of products, equipment**	**Risk rating**	**Initial**	**Current**	**Target**	**Cause**	Resources are not made available to the trust in line with its underlying recurrent cost base and future costs modelling
Risk description	**If the Trust's approach to value and financial sustainability are not embedded, we will not be able to fully mitigate the variance and volatility in financial performance leading to an impact on cash flow and long-term financial sustainability**			**Consequence**	4	4	4	**Effect**	The Trust has insufficient resources to maintain patient care activity at the planned levels
Strategic Objective	**To ensure the Trust has a sustainable revenue income stream to support the delivery of its clinical strategic objectives**	**Risk Appetite**	**Flexible - The Trust has a flexible view of financial risk when making medium to long-term business decisions with transformative potential, and is prepared to make bold, but not reckless, decisions, minimising the potential for financial loss by managing risks to a tolerable level**	**Likelihood**	4	4	2	**Impact**	To maintain financial balance the trust will need to limit elective activity with a consequential impact on the length of waiting lists resulting in significant reputational damage
Executive Lead	**Adrian Marr**	**Assurance Committee**	**Performance & Assurance Committee**	**Date of Review**	Mar-23	**Risk rating**	16	16	8		

Key Controls	**Sources of Assurance**	**Levels of Assurance** 1st	2nd	3rd	**Pos**	**Neu**	**Neg**	**Gaps in Control**	**How controls are measured**	**Agreed Action**
Produce and maintain a rolling 3 year financial plan	Long term financial plan in place and continually assessed and updated for known developments Breakeven analysis tested using long term financial modelling	✔			✔			Having firm information on the system and trust glide path to get to a fair share of ICB resources over time. The current political and economic uncertainty is likely to impact negatively on NHS resources in the future. The NHS has funded £1.5bn of recurrent costs non recurrently with no recurrent funding option without Treasury support	Assumptions are continually tested and challenged internally, Models are compared at a system level, Discussion takes place at the board and other trust committees. Regional DOF and Deputy discussions to test assumptions, challenge and clarify planning at both a system and Regional level	To continue to model different scenarios as intelligence becomes available
System / ICS control total	The ability to work collaboratively with partners to input into resource allocation decisions Using the System DOFs committee to support triangulation of resource allocation to clinical strategy			✔	✔			The ultimate decision on resource allocation is with the ICB The Integrated Care Partnership (ICP) is to develop a five year Strategy for the local health and care system.	Discussion and joint approval at the ICS Director of Finance Forum Approval at ICB level	There is a risk that the ICP strategy ambition may compromise services delivery in the Trust and needs to be investigated further/ kept under review
Annual Budget setting and cost improvement programme	There is an in year and budget setting process that supports identification of our FYE budget. There is a QIA process in place than ensures that CIP schemes are reviewed and signed off before implementation HFMA, One NHS Finance and SDN training available to budget holders as well as internal courses and support. DAM leadership in developing and monitoring these plans	✔			✔			Consider including budget management training as mandatory and implement decision.	Monthly Budgetary and Cost Improvement Programme performance reporting Ongoing support from Operational Financial Management BP's which will help assess effectiveness of the DMT	Finance looking to continue support the Trust in developing finance courses for staff to access as well as maintaining 1:1 tuition, group tuition, video training and help guides. Support the divisions to continue to identify and deliver on CIP
Delegated accountability to Divisions for planning and delivery of divisional financial plans	Review meetings that corroborate that finances are being managed and clinical strategy is being implemented and clinical quality is being maintained or improved. IA have also identified further enhancement to the framework to ensure it remains adequate and effective. External Audit of Annual Accounts A combination of the old regional single and current system metrics to ensure that the Trust is aware of and can assess delivery of financial balance.	✔			✔			Deliver IA recommendation on systems of control Potential actions as a result of the external audit conclusion Develop the DAM meetings to improve the support and accountability for our Divisions based on best practice and internal feedback	Performance management of Divisions in year performance/recovery plans to address budget deficits, including regular review of forecast returns Actions agreed at DAM meetings and feedback sessions	Publicise the Regional Bite size short courses programme for Finance , business and governance and encourage BH and operational managers to sign up. The launch of the integrated finance and HR dashboard has given budget holders and managers access to improved data to support the effective management of their resources which is available 24/7. The Finance Department will promote and provide training where necessary to encourage regular use by staff
Internal Audit Cyclical review of systems and processes and External Audit VFM review	7 reports received a reasonable assurance and 3 substantial assurance. 2 reports did not require an opinion and 1 report covering Divisional Governance (re-audit) – Estates and Facilities received a partial assurance although it was recognised that their were a number of areas of improvement and a positive trend in comparison to the outcomes of our previous review in this area Annual report from External Audit including an independent review of longer term sustainability			✔	✔			Internal audit programme resources means that some controls are only reviewed on a cyclical basis	Internal audit output reports and follow up on implementation of recommendations Independent opinion by finance professionals based on evidence provided by the Trust	Continued internal review of systems and processes to ensure they are in line with best practice Implement any recommendations made by external audit in a timely fashion.
IA plan for 2023/24	IA Opinion in 2023/24 will likely state is that the organisation has an adequate and effective framework for risk management governance and internal control.			✔	✔			Deliver IA recommendation on Estates Governance and ensure and ensure all overdue management actions (3) are addressed ASAP	Internal audit reports and the number of actions required will act as a measure of how successful our controls remain.	I/A programme for 2023/24 finalised subject to some minor amendments.
Benchmarking against the HFMA Improving NHS financial sustainability checklist	Undertaking the review has given the organisation the ability to measure its procedures, processes and actions against best practice as well as having an IA review of the work	✔			✔			No gaps identified due to the nature on the review	Actions for organisations to consider have been provided by Internal Audit but a general in nature and not specific to ESNEFT.	The need to evidence the self-assessment outcomes in more detail. At times there was not enough evidence to support the position of the self-assessment "score". To ensure the self-assessment has not been seem by management as a "tick box exercise", assigning owners to take actions forward to strengthen gaps and areas for further improvement. Strengthening the processes in relation to budget reporting and monitoring including the cost improvement plan (CIP)
Benchmarking Using Local WAU, Model system, GIRFT and other relevant datasets	Using these tools will allow the organisational to challenge unexpected variances and help develop the most effective clinical pathways	✔			✔			Capacity to make full use of the data available	Decisions taken as a result of business cases and at DAMs which have both a financial and healthcare improvement	To continue to make data available to services to support them too investigate variances.
Effective Procurement Systems and processes	Transitioning ordering to NHS Supply chain where applicable, for direct ordering we are working with our supplier base to understand constraints and working to review activity in order to accurately forecast demand for ESNEFT We are engaged with the national SCCL team as a member of the national supply resilience group and working with NHSE East Of England Equipment and Supply Chain Cell and EPRR team to establish regional support for mutual aid, escalation and clinical reference groups where required.	✔			✔			There is currently significant economic uncertainty that is likely to impact on demand and supply of goods and services.	Daily update on unsatisfied lines from NHS Supply Chain We have commenced the publication of internal supply disruption reports so early insight into issues can be noted and agreement for mitigations/switches can be reached ahead of stock out.	Monthly Reports to Medical Devices Management Group and Quarterly updates to Clinical Reference Group"

Key Controls	Forms of Assurance	Levels of Assurance		Gaps in Control	Gaps in Assurance	Agreed Action
		1st	2nd			

Principal Risk 3	**Insufficient capital resources to progress investments**		**Linked Risks**	**BAF2 - Failure to maintain revenue financial balance in future years** **1014 – Failure to maintain financial balance in current year 2023/24** **1030- There is a risk that supply chain disruption may negatively impact on the business continuity, availability of products, equipment**			**Risk rating**	**Initial**	**Current**	**Target**	**Cause**	Resources (cash and / or Public Dividend Capital) are not available to the trust in line with its planned capital expenditure.
Risk description	**The risks presented if the Trust fails to achieve its CDEL (undershoot or overshoot), and does not have sufficient resources to underake its capital developments, include: 1) regulatory impact with NHSE/I and DHSC 2) external capital funding could be lost if the Trust is unable to spend it in line with expected national profiles 3) loss of external funding could jeopardise capital projects 4) reputational and patient impact if major capital projects have to be abandoned or scaled back.**						**Consequence**	4	4	4	**Effect**	The Trust has insufficient resources to progress capital developments.
Strategic Objective	**To ensure the Trust has sufficient capital resource to support the delivery of its strategic clinical objectives through improvements to its buildings,**		**Risk Appetite**	**Flexible - The Trust has a flexible view of financial risk when making medium to long-term business decisions with transformative potential, and is prepared to make bold, but not reckless, decisions, minimising the potential for financial**			**Likelihood**	4	3	2	**Impact**	1) regulatory impact with NHSE/I and DHSC; 2) external capital funding could be lost if the Trust is unable to spend it in line with expected national profiles; 3) loss of external funding and / or insufficient cash could jeopardise capital projects; 4) reputational and patient impact if major capital
Executive Lead	**Adrian Marr**	**Assurance Committee**	**Performance & Assurance Committee**		**Date of Review**	Apr-22	**Risk rating**	16	12	8		

Key Controls	**Sources of Assurance**	**Levels of Assurance** 1st	2nd	3rd	**Pos**	**Neu**	**Neg**	**Gaps in Control**	**How controls are measured**	**Agreed Action**
Produce and maintain a rolling 5 year capital plan	-Long term capital plan in place and continually assessed and updated for known developments. Links to Estates Strategy Programme Group and Investment Group -Position against expected CDEL modelled, with various scenarios modelled to outline future possible positions.	✔			✔			-National funding settlement is only confirmed for 3 years. -Funding is confirmed only at a system level. Actual organisational allocations are determined and discussed each year within the system.	-Assumptions are continually tested and challenged internally. -Discussion takes place at the board and other trust committees (notably Investment Group) -Constant dialogue with the system to ensure there is clear awareness of likely future funding levels and to ensure the reasonableness of Trust projections and modelling.	-Long term capital programme to be regularly discussed at Trust's Performance Committee.
Review and prioritisation of capital schemes	-Prioritisation of capital schemes takes place at multiple levels (in divisions, then at Estates Strategy Programme Group, then at IG and EROC) in the organisation. This helps ensure that only essential expenditure is incurred and CDEL is adhered to. -Clinical and strateguc importance and risk associated with whether schemes progress or not is reviewed and considered by the Trust.		✔		✔			-Despite rigorous prioritisation, CDEL is often not sufficient to cover the number and importance of schemes that are identified.	-Review of capital schemes current and future is a regular standing agenda item for groups such as divisional boards, ESPG and IG.	-Framework to potentially be developed to allow prioritisation to be undertaken in a clear and transparent way.
Monitoring of approved capital schemes under construction to determine position relative to planned values.	-'Financial Management' and budget monitoring applied to capital schemes. Upon approval from IG, cost centre and budget established based on original business case values. Actual spend reported monthly against plan. -Forecasts undertaken, informed by Trust's Quantity Surveyors for the larger schemes. -Significant variances from plans discussed with Project Managers and steps taken to resolve where possible. -Capital position against CDEL reported and discussed at ESPG, IG, Performance Committee and ultimately Board.	✔			✔			-Budget management of capital schemes often not as 'direct' as revenue budgets: often dependant on works performed by a contractor and the ability to influence spend is linked to the scope and detail of contractual terms agreed. -Large number of risks associated with build phase (such as ground conditions not possible to know at business case stage) that can dramatically alter a programme and associated costs.	-Trust's capital reporting reviewed by internal and external audit.	-Greater training and dissemination of information to the wider Trust on capital expenditure, and how it is funded and managed.
Business Case Framework	-The Trust has a clear framework and process in place for business cases to be developed and approved. This ensures that cases are affordable, align strategically, are deliverable etc.	✔			✔			-Value for money / economic analysis is not clearly used as an assessment criteria as to whether a scheme should be approved or not. -For large, strategic business cases (OBC and FBC) where external monies are sought, the capital profile and projections that are highlighted then inform how PDC funding / CDEL will be assigned. National NHSE/I show no flexibility in relation to this CDEL / PDC allocation and so if the timing or amount of actual spend differs from this, this creates a significant problem for the Trust.	-Business Case Review Group ensures that business cases have been completed comprehensively and accurately before submission to IG. -Post project reviews are undertaken of business cases so that lessons can be learned for future cases (such as reasons for overspends against budget etc.).	-Value for money assessment of schemes to be considered as part of business case development and approvals.
Support from SNEE Integrated Care System including opportunities to influence and contribute discussion at the ICB Finance Board.	-In 2020/21 the NHS moved to a model of system-level operational capital envelopes to improve value for money and provide systems with greater power and responsibility for prioritising their local capital expenditure. -Systems need to ensure that overall CDEL is achieved at an aggregate system level, and so must be aware of and support those organisations that are showing significant variance from their individual targets.			✔	✔			-System monitoring and delivery only applies to operational capital.	-Monthly reporting of the system position to the ICB, and discussion at SNEE ICS Directors of Finance meeting.	-Dedicated discussion / agenda item of respective capital performance of organisations at SNEE DOF meetings.
Monitoring of national, regional and system framework and guidance in relation to capital expenditure	-The Trust ensures that it is aware of all national, regional and system updates in relation to the capital framework. These are notified to the Trust's board and sub-committees.	✔			✔			-Particularly in relation to planning for the next financial year, guidance is often released late allowing little time to then apply and work through in the Trust	-Consistency of reporting and plans externally to NHSE/I via provider finance returns and the system.	

Principal Risk 4	Patient Safety & Quality Assurance	Links to CQC Outcomes	9/4 – Care & Welfare of people who use services, 10/16 – Assessing & Monitoring the quality of service provision 11/7 – Safeguarding people who use services from abuse, 19/17 - Complaints	Risk rating	Initial	Current	Target	Cause	If the Trust does not continue to have robust oversight of quality outcomes and improvements, through a clearly defined quality governance framework
Risk description	If ESNEFT does not have the correct quality assurance mechanisms in place, then it may fail to maintain or improve the quality and safety of patient services and, resulting in poor patient care, reduced health inequalities, experience and potential harm.			Consequence	4	4	4	Effect	Potential Effect This may lead to key issues and risks not being identified early, which will prevent the Trust reacting effectively and efficiently.
Strategic Objective	SO1 - Keep people in control of their health SO2 - Lead the integration of care	Risk Appetite	Cautions/Open - The Board has a cautious view when it comes to patient safety, patient experience or clinical outcomes and places the principle of 'no harm' at the heart of every decision it takes.	Likelihood	3	2	1	Impact	Thereby minimising the opportunity to avoid harm and poor patient and staff experience. This may lead to increased Regulatory scrutiny and associated issues
Executive Lead	Dr Giles Thorpe, Chief Nurse	Assurance Committee	Quality & Patient Safety Committee	Date of Review	Nov-22	Risk rating	12	8	4

1.2 Patient Safety and Quality

Key Controls	Sources of Assurance	Levels of Assurance 1st	2nd	3rd	Pos	Neu	Neg	Gaps in Control	How controls are measured	Agreed Action
Patient Safety Investigation Response Framework (PSIRF) is in place to ensure robust investigations are undertaken in order to enhance learning and quality improvement, aligned to the national framework and safety priorities	Reporting of PSIRF through Integrated Patient Safety and Experience Report through to QPSC shows how the Trust is working within the national patient safety framework agenda. The IPR also contain evidence of PSIRF compliance for the Trust Board of Directors. Early adopter of PSIRF programme which is scrutinised externally	✔			✔				Outcomes reported through to Patient Safety Group and QPSC, with onward reporting to the Board of Directors through the IPR.	Quality priorities shared with stakeholders as part of programme of work to further develop quality strategy for the next 5 years.
	Whilst the existing quality priorities and quality improvements are robustly reported through to the Time Matters Board, EMC, QPSC and the Board, the current strategy is now under review, with updated quality priorities being shared	✔				✔				Deliver progress against existing Quality Priorities for 2022/23
Quality Strategy in line with quality priorities - This is to articulate our ambitions for quality in way that is meaningful and serves as a statement of intent that patients, carers, staff, commissioners and other stakeholders can use to hold the Trust Board to account for the delivery of high quality services.	Quality Strategy Clinical Strategy DAMs recommenced and metrics adjusted to meet national guidance and new targets. New metrics in place as Divisions mature within quality governance to determine those metrics which are most meaningful and represent key challenges. NHS Planning guidance and priorities 2022/23	✔			✔				Quality priorities and improvements are reported to Time Matters Board, EMC, QPSC and Board of Directors quarterly. Quality objectives Clinical strategy objectives and monitoring toolkit Improving safety measures Improving patient & Carers experience measures Clinical effectiveness measures Embedding the QI methodology through the QI faculty	Continued review of DAM metrics through IPG to ensure robust reporting in place
Divisional Accountability Meetings have robust discussions focussed on delivery of the quality governance agenda and quality metrics	Clinical Friday programme in place which triangulates and utilises issues from data to drive oversight. Further work to be done through quarterly quality rounds, 15 steps programme to commence post Covid19 restrictions relaxed and executive visits occurring through Time Matters Days	✔			✔				Outcomes from DAM meetings are reported to the Performance Committee and Board of Directors to evidence oversight of proxy metrics against CQC Domains	Development of options appraisal to consider improvement partner to support increased QI capacity and capability
Increased training and experience in quality improvement methodologies	Quarterly progress identified through 'Speed Dating' sessions led by Chief Medical Officer and Chief Nurse to seek assurance against delivery – Quarter 2 sessions completed and evidenced progress.	✔			✔				Quality Improvement progress is discussed at Patient Safety Group, Clinical Effectiveness Group and scheduled updates are presented to the Quality and Patient Safety Committee.	Launch of 15 steps programme following Covid19 restrictions being relaxed
Triangulation of quality metrics and reporting undertaken with assurance visits to wards and departments	whilst QI activities continue capacity challenges exist, which are being worked through to determine the right approach to increase capacity and capability	✔				✔			Reporting from Time Matters Day reported through to Time Matters Board and Clinical Friday programme reported to Nursing Midwifery and AHP Advisory Committee and onwards to EMC	
Divisional reporting mechanisms in place to evidence learning, highlight risks and share progress against localised quality priorities through business planning and ongoing monitoring delivery of improvements	DAM meeting packs Divisional Deep dives	✔							Divisional level quality priorities and programmes of work are reported through to Patient Safety Group, Patient Experience Group, and Clinical Effectiveness Group, with onward reporting of highlights to QPSC	

1.2 Health Inequalities - Ensure equitable access to our services and improve health outcomes for all our patients

Key Controls	Sources of Assurance	Levels of Assurance 1st	2nd	3rd	Pos	Neu	Neg	Gaps in Control	How controls are measured	Agreed Action
ESNEFT inequalities strategy - Setting our vision to close the health inequity gap for our patients and communities across North East Essex, Ipswich & East Suffolk. 4 Key objectives: 1. Get everyone involved in equity 2. Identify and monitor health and healthcare inequalities using data 3. Understand the caused of inequities and barriers resulting in them 4. Create change together with our partners and communities measure its impact	Development of the Inequalities strategy monitored at Board. - Health Inequalities working group - Quality Improvement plan and strategy - Clinical strategy - Public Health strategy delivery plan - Tobacco treatment services for inpatients - CO15 'nourish' pilot for children & young people - Clacton Diagnostic hub - Virtual clinics - Making every contact count (MECC) - Core 20plus5 - Asthma management for C&YP - ESNEFT as an Anchor organisation - Future care model - NHS long term plan (5 priority areas)		✔					Plan underway to expand into community settings	ESNEFT Quality Improvement (QI) approaches Inequalities dashboard, developing approached to population health Strategic success measures • Tobacco Treatment: All inpatients to receive smoking cessation support by 2024 • MECC: Uptake of referrals to support lifestyle changes • Reduction in DNA rates from those in our most deprived areas • Reduction in ED attendance from our most deprived areas • Proportion of diagnostics performed in Clacton for the Tendering population • Improved survival rates for patients diagnosed with lung cancer in areas of deprivation • 75% of cancer cases diagnosed at Stages 1 or 2 by 2028	
External reporting	Alliance boards - to support the delivery of the ICS priority domains SNEE ICS		✔						Key Performance Indicators (KPIs)	
Internal reporting	Clinical Effectiveness Group (CEG) Quality & Patient Safety Committee (QPSC) Trust Board Performance Assurance Committee (PAC) Health Inequalities working group	✔							Key Performance Indicators (KPIs) Operational performance Financial balance (ESNEFT and ICS) Waiting list (numbers and Waiting times) Accreditation, Regulatory compliance and CQC outcomes	
Mortality and Morbidity	Mortality reviews Structured Judgement Reviews (SJR) in place Reports to QPSC Service level meetings and Divisional presentations to Learning from Deaths group Regional M&M (Chaired by CMO) Medical examiners regional team reporting into LFD (Attended by CMO)	✔	✔							

Principal Risk 5	Workforce					Risk rating	Initial	Current	Target	Cause	Failure to have an appropriately resourced, focussed, resilient workforce in place that meets service requirements
Risk description	If ESNEFT is unable to deliver the priorities set out in the People Pan, then it may not be possible to attract and retain a suitably qualified workforce in ESNEFT, resulting in missed opportunities to deliver improved services					Consequence	4	4	4	Effect	Then it may not be possible to attract and retain a suitably qualified workforce in ESNEFT
Strategic Objective	SO4 - Support and develop our staff		Risk Appetite	High/Seek - The Board has a flexible view to Workforce and is prepared to take decisions that would have an eff		Likelihood	4	3	2	Impact	Which may lead to not having the right staff with the right skills in the right place at the right time to deliver the most effective patient care.
Executive Lead	Kate Read - Director of People & OD	Assurance Committee	People & Organisational Development Committee	Date of Review	Nov-22	Risk rating	16	12	8		

1.1 Workforce Planning, Recruitment & Retention - We will develop, implement and embed a systematic approach to workforce planning which will enable us to respond to the changing requirements of our services and patients. The aim is that by strengthening our ESNEFT workforce planning capability we can ensure that we have the right staff with the right skills in the right place at the right time, to deliver the most effective patient care.

Key Controls	Sources of Assurance	Levels of Assurance 1st	2nd		Pos	Neu	Neg	Gaps in Control	How controls are measured	Agreed Action
People Strategy (strategic objectives, key performance indicators and measures)	Vacancy Factor Time to hire Increase in workforce diversity (as evidenced through WRES and WDES) Agency spend Resourcing partners in place CQC well led domain assessment rated good CQC Regulation 18 - Staffing	✔		✔	✔			Develop the People Strategy	POD receives progress reports in relations to the agreed outcome measures associated with each of the 3 pillars of the people plan. CQC Inspection report 2019	Develop delivery plan and KPIs for the People Strategy objective workforce planning, resourcing and retention.
ESNEFT Recruitment Policy and Procedures	Monitoring of Workforce Statistics - Vacancy Factor - Time to Hire - Workforce Diversity (WRES / WDES) - Agency Spend Resourcing Partners in post and new starters meetings monitored.	✔						National skills shortage in the key professional staffing groups means recruitment to some essential posts remains difficult . Reduction of EU nationals in the Trust's workforce following Britain's withdrawal from the EU.		To recruit to Recruitment Retention and Career Partner positions (NHSI funding for 12 months fixed term)
Retention Strategy	Monitoring of Workforce Statistics - Turnover rate - Stability index Retention Partners in post	✔						There is national encouragement for workforce planning at system, as well as organisational level, but systems and resources are lacking		Evaluate and develop business case for substantive Recruitment Retention and Career Partner positions
	Turnover 8.86% against a target of 5.5%.	✔					✔			
Exit interviews and survey	Monitoring and trend analysis reporting. Exit Survey	✔								Pilot recruitment of international midwives
Flexible Working Policy (Sept '21 and due review 2024)	Policy in place and supported by flexible working toolkit (version 2.0) Monitoring as per policy section 6: Annual case review and feedback on effectiveness of policy	✔			✔					
	Flexible working Policy is available on the intranet from Sept '21 and current.	✔								
International Recruitment (Pipeline for registered nurses and midwives)	Monitoring of staff in post against plan	✔								
Succession pipelines	Monitoring of internal secondment opportunities (all roles) Monitoring of number of staff with protected characteristics obtaining AFC band 6 posts (target 10% - cross reference WRES/WDES plan)	✔								

1.2 Staff Experience - We want to be known as an organisation where our people feel engaged, valued and supported, and are empowered to deliver excellent patient care and services that they are proud of.

Key Controls	Sources of Assurance	Levels of Assurance 1st	2nd		Pos	Neu	Neg	Gaps in Control	How controls are measured	Agreed Action
People Strategy (strategic objectives, key performance indicators and measures)	ESNEFT People Strategy - Performance against this is monitored by the People and Organisational Development Committee (POD)	✔							Performance against this is monitored by the People and Organisational Development Committee (POD)	
Appraisal Toolkit	Qualitative and Quantitative analysis of staff appraisals	✔								
Well-being conversations (1-2-1 with Line Manager)	Monitoring of 1-2-1 conversations via ESR Staff Survey Results (ESNEFT takes positive action on wellbeing)	✔								
Well-being services (Self-care information)	Monitoring of workforce statistics	✔								
Well-being services (Psychology)	Psychologist in post Monitoring of workforce statistics Monitoring of referrals Monitoring of accessibility	✔								
Well-being services (Occupational Health)	Monitoring of workforce statistics	✔								
Well-being services (Mental Health, Mental Health First Aiders	Monitoring of workforce statistics Number of staff trained as mental health first aiders	✔								
Staff Networks (LBTQ+)	Bi-monthly meetings	✔								
Staff Networks (EMBRACE)	Bi-monthly meetings	✔								
Staff Networks (ESNABLE)	Bi-monthly meetings	✔								
Communications and Engagement Strategy	Strategy in place and implementation plan	✔								
	Communications and Engagement Strategy Jan '22 to Jan '24 approved by Board January 2021.		✔		✔					
Consistent, regular and high quality communications channels reaching all staff	Monitoring of All Staff Briefing and Senior Leaders Briefings Staff Survey	✔				✔				
	2020 national staff survey show 66% of ESNEFT responders 'they were very likely or likely to recommend ESNEFT as a place to work. 52% as a place to train and 65% as a place to be treated. Pulse Survey			✔	✔					
	500 staff participated in the survey and not all questions were completed therefore not statistically significant): 2021 Pulse Survey shows 46.1% staff would recommend ESNEFT as a place to work, 58.6% as a place to be treated.			✔	✔					
Celebrating success	Staff Awards Staff Commendations Monitoring media presence	✔								

1.3 Education, Training and Leadership Development - We are committed to supporting our staff to develop the skills and abilities needed to transform our services and deliver excellent patient care, wherever they work in the Trust and throughout their career. Our education and training strategy will enhance job satisfaction, individual skill sets and increase the flexibility of our available workforce.

Key Controls	Sources of Assurance	Levels of Assurance 1st	2nd		Pos	Neu	Neg	Gaps in Control	How controls are measured	Agreed Action
People Strategy (strategic objectives, key performance indicators and measures)	Our People Strategy	✔						KPI measures update		
Faculty of Education	Faculty of Education and post recruited									
	Faculty of Education established and steering group reporting to Executive Management Committee.	✔			✔					

Training programmes (Mandatory Training)	Mandatory training compliance (target 90%) 85.3% (increase from 83.4%) holding steady in context of COVID-19 pressures. Each division have identified their top 5 areas of risk and put trajectories in place.			✔						
Training programmes / opportunities (CPD)	Monitoring staff access to CPD (target 10% increase from baseline of X) Review of non-medical funding allocation (by CNO and Director of HR & OD)									
Talent Management Strategy & Plan 2021 -2024	Talent Strategy (DRAFT on intranet) Monitoring of internal promotion (target 25% of AFC band 5 and above roles are filled from internal candidates) Monitoring of talent management conversations (target 80% of AFC band 8a and above to have talent conversation)									
Competency Framework (Middle managers leadership passport)	Monitoring of competency framework statistics									
Succession pipeline	Monitoring of internal secondment opportunities (all roles) Monitoring of number of staff with protected characteristics obtaining AFC band 6 posts (target 10% - cross reference WRES/WDES plan)									
Apprenticeship Programme	Monitoring of apprenticeship levy spend (target of 75% for 2021/22) Monitoring of apprenticeship headcount (target 2.5%)									

Principal Risk 6	Prolonged and/or substantial failure to meet operational performance targets					Risk rating	Initial	Current	Target	Cause	If there is insufficient capacity to match demand and failure to achieve operational performance targets (reasons for lack of capacity)
Risk description	Sustainable delivery of elective performance targets					Consequence	5	5	5	Effect	Wait times and delays for treatment will increase
Strategic Objective	SO1 - Keep people in control of their health	Risk Appetite	Cautious/Open - The Board has a cautious appetite when it comes to compliance and regulatory issues			Likelihood	4	3	2	Impact	Impacting on; 1) Unintended harm to patients due to longer waiting times which may result in delayed diagnosis, disease progressions and poor outcomes, including excess deaths; 2) Increasing number and severity of incidents and claims; 3) Financial delivery of CIP and use of resources, productivity and efficiency; 4) Regulatory action or reputational damage; 5) Ability to deliver the Trust's annual plan
Executive Lead	Neill Moloney, managing Director and Deputy CEO	Assurance Committee - Performance Assurance Committee		Date of Review	Nov-22	Risk rating	20	15	10		

1.1 RTT

Key Controls	Sources of Assurance	Levels of Assurance 1st	2nd	3rd	Pos	Neu	Neg	Gaps in Control	How controls are measured	Agreed Action
Elective Care Charter which supports the development of the elective care element of the ESNEFT strategy. Programme Risks	ICB Elective Care programme Board.- Chaired by ICB CEO Time Matters Board (Chaired by Managing Director (MD) Joint Programme Board between ESNEFT and West Suffolk - This reports to Time Matters Board. Executive Management Committee (EMC) Operational Delivery Group (ODG) and Divisional Accountability Meetings - Operational Accountability Oversight Performance Assurance Committee (PAC) - Monthly reporting and periodic Deep Dives Programme risks and issues monitored by Elective Recovery Board and TMB GIRFT - High Volume/Low Complexity Contained within Elective Care Charter CEG and QPSC and in QI and part of Quality prog Topic based Deep dives presented to Council of Governors and Performance Assurance Committee Regular reporting to Executive Leadership Team and Elective and Emergency care programme boards		✔					Resource requirements, Suffolk and North East Essex system Financial gaps? Patient COVID-19 status has added an additional level of complexity to decision making.	Each project has their own individual deliverables which support the achievement of the care programme deliverables listed within the Elective care charter: Cardiology Inc. Right care Neurology (2 linked projects NEE and IES) MSK and T&O Ophthalmology (2 linked projects NEE and IES) Gastroenterology (2 linked projects NEE and IES) ERS - ALLCAS Roll out and primary care interface 100 Day challenge Elective Management Demand (2 linked projects NEE and IES) Stroke Diabetes Cancer Respiratory Seasonal Variation Plan	
Elective Care Programme Board by SNEE Director	Command and control structure are monitoring effectiveness of response. SNEE Elective recovery Emergency Care Charter		✔						ESNEFT Internal Governance Monthly Highlight reports which tracks key deliverables	
Time Matters Board, chaired by MD	Metrics monitored by: Time Matters Board Operations Delivery Groups Performance Assurance Committee		✔						Highlight reports tracking progress, risks, actions and escalations	
Elective and Emergency Care Board Operational Delivery Group (ODG) Board reports Performance Assurance Committee reports and dashboards Executive Management Committee (EMC) Executive Leadership Team meetings (ELT)	Performance dashboards and reporting, contains statistical performance data on key areas. This can be broken does into specific areas. Review is taken on a patient by patient basis. Detailed breakdown of performance monitored by committees, as well as the Board, which has continued throughout the pandemic		✔					Extensive clinically-led validation of outpatient and inpatient waiting lists by operational Divisions . Categorisation of elective patients against national criteria in order to ensure that existing capacity is used for the most urgent patients. Specialty specific action plans developed for high	Performance Assurance Committee	
Divisional Accountability Frameworks (DAM) for surgical Divisions	Monthly performance packs to monitor productivity and activity	✔	✔						Executive level support and data monitoring, escalated and reported to PAC for oversight	
Operational Delivery Group (ODG), Chaired by MD	ODG weekly and performance data pack		✔							

Principal Risk 6	**Prolonged and/or substantial failure to meet operational performance targets**					**Risk rating**	**Initial**	**Current**	**Target**	**Cause**	If there is insufficient capacity to match demand, due to the low bed base per population
Risk description	**Sustainable delivery of emergency care performance targets**					**Consequence**	5	5	5	**Effect**	we will fail to meet operational performance targets and patients will not be able to access emegency care when needed.
Strategic Objective	**SO1 - Keep people in control of their health**	**Risk Appetite**	**Cautious/Open - The Board has a cautious appetite when it comes to compliance and regulatory issues**			**Likelihood**	4	3	2	**Impact**	Impacting on; 1) Unintended harm to patients due to longer waiting times which may result in delayed diagnosis, disease progressions and poor outcomes, including excess deaths; 2) Increasing number and severity of incidents and claims; 3) Financial delivery of CIP and use of resources, productivity and efficiency; 4) Regulatory action or reputational damage; 5) Ability to deliver the Trust's annual plan
Executive Lead	**Neill Moloney, managing Director and Deputy CEO**	**Assurance Committee - Performance Assurance Committee**		**Date of Review**	**Mar-23**	**Risk rating**	20	15	10		

1.2 Emergency Care

Key Controls	Sources of Assurance	Levels of Assurance 1st	2nd	3rd	Pos	Neu	Neg	Gaps in Control	How controls are measured	Agreed Action
Emergency Care Charter which supports the delivery of the emergency care elements for the ESNEFT strategy, Future care model, NHS Long Term Plan, ESNEFT UEC ambitions and future care models	Urgent & Emergency Care Programme Board Time Matters Board (Chaired by Managing Director (MD)) Each project has their own individual deliverables which support the achievement of the care programme deliverables listed within the Emergency care charter: - Admission avoidance - both sites - Front door transformation - both sites - Patient flow - both sites - ED sustainability - both sites - Virtual Ward - both sites Deep Dives undertaken: - Ambulance handovers - Seasonal variation - Cancer - Diagnostics Programme risks and issues monitored by Emergency Care Programme Board and TMB Gap in assurance from ICB regarding social care system spend and how this impacts the Trust		✔			✔			Every patient measured to acertain compliance with '4-hour wait' time (95% target) Every ambulance handover measured to acertain compliance against 15/30/60 minutes delays (zero target) Daily bed meetings and SITREPs to measure bed occupancy rates Length of every in-patient say measured to acertain numbers of stranded patients (14 to 20 days) and super stranded patients (21 days and over)- target to reduce to levels seen in 2019-2020 Deep Dives reported to Performance Assurance Committee KPI metrics and targets for Divisions monitored through the Assurance Framework-reported to Executive Management Committee and Performance Assurance Committee Monthly Highlight reports to TMB and PAC Seasonal Variation Plan	14/03/23 - Following the winter period, all key control measures are being reviewed and programme charters and bed models updated within the 2023-2024 business planning process. These will be presented at TMB,ECPB and Business Planning Group.
Deep dives reported to Performance & Finance Committee	Reports to F&P monthly	✔				✔				
Urgent and Emergency Recovery meetings and escalation in place to monitor operational targets -	SRO for Urgent & Emergency Care - Director of Operations Colchester Progress monitored by ODG (chaired by MD) and TMB (chaired by MD) Clinical numbers are monitored and reviewed by the group, delays are reported and escalated to ensure timely progress along patient pathway. Work is undertaken to regularly triangulate operational demand, workforce availabiltiy and financial impacts Monitoring figures for ED performance and capacity via bed meetings and dashboards. Short, medium and long term plans.	✔				✔			ESNEFT Internal Governance Monthly Highlight reports which tracks key deliverables Metrics monitored by: Time Matters Board Operations Delivery Groups Performance Assurance Committee	
Membership to the Alliance operational group	Highlight reports which feeds up to SOAG in the ICB	✔				✔			Alliance reporting feeds into the Time Matters Board for consideration of impacts and requests for Alliance action	
Emergency Care Programme Board (Chaired by Director of Operations Colchester)	Operational plan and performance tracker reports Monitoring the implementation of the seasonal variation plan. Performance management reporting arrangements between Divisions, Service Lines and Executive Team. Proposals for capital investment to support emergency care, being monitored through TIme Matters Board Reducing length of Stay (LOS)- Escalation of LOS monitored via Performance Assurance Committee and Operational Delivery Group	✔				✔		There is a gap between the demand for Emergency Care services provided by the Trust, and the capacity of the Trust to provide those services. This is, in part, affected by decisions by partners and at a system level, which the Trust needs to influence, to better manage care to match demand to the available capacity (such as emergency admission avoudance schemes)		
Operational Performance Targets	Chief Operating Officers Group held weekly - A performance report is produced which includes: - ED standards. Bed capacity Divisional Accountability Meetings (DAM) take place monthly and are supported by Executive Director, finance and performance teams. This enables 'confirm and challenge' to Divisional management teams around specialty level recovery plans; and provides an opportunity to review the progress against the detailed divisional plans.	✔				✔				
Operational Delivery Group (ODG), Chaired by MD	ODG weekly and performance data pack	✔				✔				
Divisional Accountability Frameworks (DAM) for surgical Divisions	Monthly performance packs to monitor productivity and activity	✔				✔			Executive level support and data monitoring, escalated and reported to PAC for oversight	

Principal Risk 6	**Prolonged and/or substantial failure to meet operational performance targets**				**Risk rating**	**Initial**	**Current**	**Target**	**Cause**	If there is insufficient capacity to match demand due to an increase in referrals and failure to achieve operational performance targets.
Risk description	Sustainable delivery of cancer performance targets				**Consequence**	5	5	3	**Effect**	Wait times and delays for treatment will increase and key standards will be missed.
Strategic Objective	**SO1 - Keep people in control of their health**	**Risk Appetite**	**Cautious/Open - The Board has a cautious appetite when it comes to compliance and regulatory issues**		**Likelihood**	4	3	2	**Impact**	Impacting on; 1) Unintended harm to patients due to longer waiting times which may result in delayed diagnosis, disease progressions and poor outcomes, including excess deaths; 2) Increasing number and severity of incidents and claims; 3) Financial delivery of CIP and use of resources, productivity and efficiency; 4) Regulatory action or reputational damage; 5) Ability to deliver the Trust's annual plan
Executive Lead	Neill Moloney, managing Director and Deputy CEO	**Assurance Committee - Performance Assurance Committee**	**Date of Review**	Mar-23	**Risk rating**	20	15	6		

Cancer

Key Controls	**Sources of Assurance**	**Levels of Assurance** 1st	2nd	3rd	**Pos**	**Neu**	**Neg**	**Gaps in Control**	**How controls are measured**	**Agreed Action**
Cancer performance strategy?	Reports to TMB							Any internal audits on our waiting lists to provide assurance these are being managed appropriately and clock stops are applied correctly? Ask Pat when last one was.	Performance against cancer KPIs	
ICS strategy? Alliance strategy being put together atm										
Cancer performance board	Cancer recovery weekly meetings									
Diagnostics strategy	Part of the diagnostic recovery programme									
Weekly Cancer Recovery Programme (Chaired by Director of Operations Colchester). The Elective Care Charter supports the delivery of the Cancer recovery programme	Monitoring of; - Tumour sites - Non deliverables - Backlog - RTT recovery - Diagnostic recovery - Risks	✔								remove from Emergency Care BAF

Principal Risk 7	Estate Development					Risk rating	Initial	Current	Target	Cause	If we do not have agreed Future Models of Care or the Capital Investment to deliver the ESNEFT Estates Strategy
Risk description	If there is insufficient investment available in respect of the Trust's estate, the Trust will be unable to develop and transform the physical estate of the Trust, which may adversely impact the ability of the Trust to provide high-quality care and patient experience using the latest treatment methods."					Consequence	4	4	3	Effect	This will effect our ability to deliver the overall trust wide strategy and ICS objectives
Strategic Objective	SO3 - Develop our centres of excellence		Risk Appetite	Cautious/Open - The Board will take a cautious approach when investing in building and equipment maintenance and replacement		Likelihood	4	3	2	Impact	Leading to an impact upon providing a safe, compliant and functionally suitable environment for patients, visitors and staff.
Executive Lead	Paul Fenton - Director of Estates & Facilities	Assurance Committee	Quality & Patient Safety Committee	Date of Review	Nov-22	Risk rating	16	12	6		

1.1 Failure to Maintain and Develop the Trust's Estates

Key Controls	Sources of Assurance	Levels of Assurance 1st	2nd	3rd	Pos	Neu	Neg	Gaps in Control	How controls are measured	Agreed Action
Estates Strategy 2019-2024 which describes how we will respond to the opportunities by the ESNEFT merger and the needs of the local people, as expressed through the STP to improve the estate which we operate	ESNEFT allocated £69.3milion ICS Capital funds. £13.4M of Targeted Infrastructure Funding (TIF) – linked to the Colchester Elective Orthopaedic Centre Project and associated moves. Risk 971, agreed capital schemes may fail to deliver, and risk 17, ESNEFT Estate may be inappropriately developed monitors progress through the year and are regularly reported to DMT. Allocation of capital spend for estates risks agreed by ESNEFT Investment Group Strategy report to Board in Feb 2022 reported the Building for Better Care programme is on track. Estates Strategy Programme Group (EPSG) - In place to manage the optimisation, development utilisation, expansion or reduction of the trusts estate and ensure that all investment decisions in driving forward the ESNEFT Estate strategy are made for the benefits of patients, visitors and staff in accordance with clinical need. EPSG reports to Trust Board.	✔			✔			Governance Process over receipt, review, prioritisation and shortlisting of divisional capital scheme requirements and new works. Delays in capital development through the Covid 19 response.	Estate Strategy Programme Group and Estates Strategy Reports encompassing the built environment and capital equipment. The Estates visions and objectives	The local ICS is driving a more holistic approach to planning for the estate and as a result of a recent policy announcement, we are now able to put forward business cases to acquire estate owned and leased from NHS Property Services. In our area there are a number of sites of interest including several community hospitals. We will pursue this opportunity in discussion with ICS partners.
6 Facet Survey which assess the estate relative performance and fitness for purpose. This examines: - Physical condition - Statutory standards (sub divided into fire safety compliance and H&S issues - Functional suitability - Quality - Space utilisation - Environmental management audit	6 facet survey complete for acute sites and revised backlog maintenance capital programme agreed 22/23. Backlog maintenance is £2.5million covering all the high and significant risks within the assessment. Risk 972 monitors the backlog maintenance programme.	✔			✔			The investments described in the estates strategy and associated site disposals will, as a by product, resolve most if not all backlog maintenance issues, in the parts of the estate concerned. However, other areas of backlog will remain and these will need to be tackled as part of the trust's ongoing business as usual estate management and capital investment.	Backlog maintenance programme update reports to Investment Group	
Premises Assurance Model (PAM), the main benefits of PAM are to: - Allow NHS funded providers of healthcare to demonstrate to their patients, commissioners and regulators that robust systems are in place to assure that their premises and associated services are safe - Provide a consistent basis to measure compliance against legislation and guidance across the NHS - Prioritise investment decisions to raise standards in the most advantageous way	Reports to Fire, Med Gas and Water Safety Groups. Medical Gas sub group has managed oxygen supply during Covid. All groups now meet at least quarterly and report into H&S committee, Infection Control Committee (for Water and Ventilation safety) and QPS. A compliance dashboard is shared with each group and feeds into the PAM report. The report has been compiled for 2021/22 which is due to be shared with EFM DMT in February 2022 and will be submitted to IAC March '22. Upload to the National Portal in July 2022 TIF Funding includes the following: Move of Neuro Physiology to villa 2 Waste Yard Deliver maximum option EOC (additional 3 theatres and 1 ward) Northern Approach Road Development (Planning) Endoscopy reprocessing unit move			✔	✔			Annual PAM assessment and action plan Process control reports (Fire, Medical Gas, Water Safety etc.) Authorised engineers / approved persons in place and annual reports. Estates Return Information Collection (ERIC) and Model Hospital Data.	PAM assurance groups which assess the 5 domains The results of the assessments are uploaded onto the NHS E/I portal which is a mandatory requirement for all NHS Trusts.	
	All Authorised Engineers/approved persons posts covered.	✔			✔					
PLACE annual programme (Patient Led Assessments of the care environment)	Annual PLACE Inspection and Programme Health watch involvement			✔				PLACE reports (this assurance is currently suspended due to Covid-19)	PLACE reports	
Monitoring Committees/Groups	Water Safety Group Fire Safety Group HTM Groups Health & Safety Committee Building for better care programme board Investment Group ICB Estates Committee Estates Strategy Programme Group (EPSG)		✔						H&S Committee- QPS - IPC Trust Board ICB Trust Board	
Master Control plan - The delivery of our aspiration to be more effective in the delivery of long terms care involves ESNEFT working with the whole system as part of the East Suffolk and North Essex Alliances.	Reports to Trust Board Details programme risks reported to TMB Risks & Issues reported at TMB		✔					c		

Principal Risk 8 Digital Maturity and Major Disruptive outage						Risk rating	Initial	Current	Target	Cause	If investment of the appropriate enabling and dependency work is not achieved the EPR programme delivery will not meet minimum digital maturity levels in line with DOH&SC directives, HIMSS level 5
Risk description	In order to achieve digital maturity, clinical, operational and technical processes are required to align in a structured governance model with the support of a digital literacy education programme					Consequence	4	4	2	Effect	Delays to EPR delivery will have a knock on financial burden and risk of noncompliance to national reporting requirements.
Strategic Objective	SO5 - Drive technology enabled care	Risk Appetite	Open - The Board are keen to pursue new technologies as a key enabler of operational delivery			Likelihood	3	2	2	Impact	This will impact on the delivery of the Trust's strategic objectives such as maximising use of resources and efficiency of service models/patient pathways and embracing new ideas to deliver new , technology - enabled financially viable ways of working. The impact on sustainability and the ability to realise savings through innovation will be significantly diminished.
Executive Lead	Mike Meers, Director of ICT & Logistics	Assurance Committee	Performance Assurance Committee	Date of Review	Nov-22	Risk rating	12	8	4		

1.2 Digital Maturity

Key Controls	Sources of Assurance	Levels of Assurance 1st	2nd	3rd	Pos	Neu	Neg	Gaps in Control	How controls are measured	Date	Agreed actions
ICT Strategy in place and approved by Board of Directors Nov 2019	Report on strategic objectives provided to each Board by the Director of Digital and Logistics		✔					Plan to issue a refresh strategy of ICT into Digital and Data Strategy by end of Q4 2022 to support EPR Digital Transformation.	Board strategy updates related to EPR, presented to BoD Oct 22. Board seminar Oct 22.	Sep-22	Refresh ICT strategy into Digital and Data Strategy by March 2023 including self assessment against Minimum Digital Foundations and what good looks like. Development of Digital Edication Centre
Annual Capital programme (ESNEFT)	First report provided to EMC in July 2022. Report provided positive assurance.	✔						Outline investment approved from ICS for three additional system led work programmes.	KPI's to monitor delivery of the IT Strategy (monthly IT Programme Highlight Report to eHealth Group).	Oct-22	Electronic Patient Record (EPR) outline business case to EMC and Trust Board in Nov 22. To support the delivery on Frontline Digitalisation target for 2025.
Annual prioritisation of Trust IT Capital Programme through Investment group	Updated to reflect move to 22/23 year. Funding has been agreed for all capital programmes. (Positive Assurance)		✔					Delivery 2022/23 IT capital programme	Six monthly and annual report to Executive Management Committee - progress against strategy and annual plan		Next update December 2022
	ICT Strategy approved by BOD Nov '19	✔							Oversight of Trust ICS ICT funded Digital Programmes the Strategic Digital Investment Assurance Board at ICS level.	Sep-22	
									Annual IT capital programme 2022/23	Sep-22	Monthly reporting to Investment group
									Report to Time Matters Board on the Digital and EPR Programme	Sep-22	
Safe digital practice (assurance against cyber, information governance, digital clinical safety, digital ethics)	Annual Data Security and Protection Toolkit (DPST) submission and annual audit of submission	✔		✔	✔				Annual Internal Audit of DSPT submission	Oct-22	Internal Audit Action Plan compliance
									Annual penetration testing and actions plan		

1.2 Major Disruptive Outage

Key Controls	Sources of Assurance	Levels of Assurance 1st	2nd	3rd	Pos	Neu	Neg	Gaps in Control	How controls are measured	Date	Agreed actions
IT on-call and escalation support provided 24/7 and IT Security Team in post.	Annual external Cybersecurity assessment and network penetration testing.			✔					Operational Highlight Reports to eHealth Group.		
ESNEFT IT Business Continuity Plan in place	Reporting to E- Health Group shows no concerns and controls working.	✔			✔			To ensure ongoing compliance with cyber standards and supported versions of windows 10 it has been Identified that there are 1300 devices that are end of support and will not receive updates. These devices require updating to a supported version. 1300 equates to 13% of the Trust Estate. Upgrades or mitigations to be put in Place by mid May 22 to reduce to an acceptable level.	Annual disaster recovery tests of core systems. IT Security Controls Assurance reporting EMC on Migration to Supported versions of Widows 10 and NHS CareCert Compliance Annual external Cybersecurity assessment and network penetration testing. Rolling Internal Audit Programme of operational IT component areas		
Trust has received NHS Digital Accreditation for its O365 tenancy for secure email in Feb 22 and can now commence NHS.Net Migration to ESNEFT.NHS.UK for secure email purposes.	Data Security and Protection Toolkit submitted no weaknesses identified. IA advisory review undertaken with recommendations. (Unsatisfactory Assurance) Next Toolkit submission June 21 and subject to IA.	✔					✔				
Data Security and Protection Toolkit (DSPT)	Data Security and Protection Toolkit submitted no weaknesses identified. IA advisory review undertaken with recommendations. (Unsatisfactory Assurance)	✔									
Disaster mitigation testing	Lorenzo Disaster Migration Test Successful in Sep 21 as part of Cloud Migration.	✔									
	Evolve Cloud Migration complete	✔									
	IT Security Controls Assurance reporting EMC on Widows 10 Migration and NHS CareCert Compliance										
ESNEFT Secure Email environment and achieve NHS Digital Accreditation.											Reduce number of Windows 10 EOS devices across the Estate to an acceptable level. It has been Identified that there are 1300 devices that are end of support and will not receive updates. 1300 equates to 13% of the Trust Estate.

Principal Risk 9	Transformation					Risk rating	Initial	Current	Target	Cause	If we are unable to transform though strategy
Risk description	If we do not transform through strategy and its delivery then we will be unable to achieve long term sustainability leading to regulator intervention.					Consequence	4	4	4	Effect	This will limit the Trust's ability to deliver its strategic goal and achieving long term financial sustainability
Strategic Objective	SO2 - Lead the integration of care SO3 - Develop our centres of excellence		Risk Appetite	Open - The Board has an open view of innovation that support quality, patient safety and operational effectiveness		Likelihood	4	3	2	Impact	Loss of regulator/public confidence and consequent regulator intervention, Potential Impact and the loss of coordination of business plans and operational plans, and/or an inability to implement the strategy will result in failure to transform and deliver strategic objectives.
Executive Lead	Dr Shane Gordon, Director of Strategy, Research & Innovation	Assurance Committee	Performance Assurance Committee	Date of Review	Feb-23	Risk rating	16	12	8		

Key Controls	Sources of Assurance	Levels of Assurance 1st	2nd	3rd	Pos	Neu	Neg	Gaps in Control	How controls are measured	Agreed Action
Trust strategy and enabling strategies (aligned with the 5 year ICS Plan)	FBC for Emergency Care approved by NHSE/I FBC for Elective Care approved by NHSE/I Business cases for additional capacity in Orthopaedic Centre and new theatres at Ipswich approved by NHSE Sustainability of finance - for financial year 2021/22 the Trust has forecast breakeven.			✔	✔				Long term financial model (breakeven) Strategy update reports Strategic Plan Report (Deliverable) Quarterly to board External reviews	
	Trust 5 Year Strategy approved by Board August 2019.		✔			✔				
	Deloitte Well Led review 2023			✔	✔					
People Strategy	People Strategy approved by Board 2022.		✔			✔			People & OD committee	
Quality Strategy	Quality Strategy approved by Board 2022. Inequalities Strategy approved by Board 2023.		✔			✔		Deliver Quality Strategy priorities	Quality Strategy update reports to TMB	
ICT Strategy	ICT Strategy approved by Board		✔			✔		Deliver ICT plan for 2022/23	ICT Strategy update reports to TMB (assurance being	
Communications and Engagement Strategy	Communication & Engagement Strategy approved by Board		✔			✔		Deliver Communications and Engagement Strategy	Communication & Engagement Strategy update reports to	
Estates Strategy	Big Builds communications plan reported to Board. Estates Strategy approved by Board October 2019. Estates strategy updates provided monthly to Board	✔	✔			✔		Deliver Estates plan for 2022/23	Estates Strategy update reports to EMC (as part of Building for Better Care report)	
Diagnostic Strategy	Diagnostic Strategy approved by Board in Oct 21. Business cases approved for Clacton CDC by NHSE in 2021/22 and 2022/23		✔			✔		Deliver digital histopathology East of England Diagnostic Imaging Network maturity	Diagnostic Strategy update reports	
Research & Innovation Strategy	R&I Strategy approved 2019. KPI's and measures identified in strategy - all KPIs exceeded in annual report 2022/23		✔		✔				R&I KPIs	