Appendix 3: Board Assurance Framework

BAF1: Partnership Working

Strategic Objectives: **2. Lead the integration of care**			
Strategic Risk:			
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 in our communities	**Defined by**

Lead Executive	Deputy Chief Executive Officer	**Assurance committee**	Trust Board

	Impact	**Likelihood**	**Score**	**Risk trend**	**Risk rating**
Inherent	4	3	12	**Board tolerance to be confirmed**	**8**
Residual	**4**	**2**	**8**		
Target	3	2	6		

	Key Controls	**Assurances reported to Board and committees**
	a) Formal joint partnership arrangements in place with a number of external partners, including: • West Suffolk Hospital (WSH) • East of England Ambulance Service Trust (EEAST) • SNEE ICS • ESNEFT as an Anchor organisation and Anchor Programme Board • Mental health collaborative	Priority areas for joint working are established and identified in the annual plans, operational plans and business plans. ICS and ESNEFT plans in line with National Planning Framework. Recommendations and action plans referring to partnership working regularly submitted to the Board, Quality and Patient Safety Committee and PAF Committee
	b) Formal partnerships in place to support the delivery of our goal to be a centre of excellence in research, education and innovation	Board to Board meetings (ESNEFT/WSH/ICB). To establish good relationships and ensure strategic alignment.

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
Gaps in control: *Currently under review* **Gaps in assurance:** • Assurance regarding integration benefits • Shared PMO with West Suffolk not yet implemented	1. Continue to develop and enhance partnership working and relationships 2. Define timescale for delivery of benefits from partnership working

BAF2: Financial performance – value and sustainability

Strategic Objectives: ALL			
Strategic Risk: BAF2			
IF the Trust's approach to value and financial sustainability are not embedded	**Then** we will not be able to fully mitigate the variance and volatility in financial performance	**Resulting in** leading to an impact on cash flow and long-term financial sustainability	**Defined by**

Lead Executive	Director of Finance	**Assurance committee**	Performance and Finance Committee (PAF)

	Impact	**Likelihood**	**Score**	**Risk trend**	**Risk rating**
Inherent	4	4	16	**Board tolerance to be confirmed**	**16**
Residual	**4**	**4**	**16**		
Target	4	2	8		

	Key Controls	**Assurances reported to Board and committees**
	a) Rolling 3 year financial plan	Financial plan continually assessed and updated for known developments. Breakeven analysis tested using long term financial modelling. Regular reporting to PAF and Trust Board.
	b) Annual Budget setting and Cost Improvement Programme with QIA process to ensure CIP schemes are reviewed and signed off before implementation	HFMA, One NHS Finance and SDN training available to budget holders in addition to internal courses and support. DAM leadership in developing and monitoring these plans, with escalation through PAF to Trust Board.
	c) System / ICS control total and System DOFs Committee	Enables collaborative work with partners to input into resource allocation decisions
	d) Delegated accountability to Divisions for planning and delivery of divisional financial plans	Integrated Finance and HR dashboard
	e) Internal Audit Cyclical review of systems and processes and External Audit VFM review	Reporting to Audit Committee and Trust Board.
	f) Benchmarking against the HFMA Improving NHS financial sustainability checklist	Reporting to Audit Committee and Trust Board.
	g) Benchmarking using local WAU, Model system, GIRFT and other relevant datasets.	Reporting to PAF and Trust Board.
	h) Effective Procurement Systems and process	

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
Gaps in control: *Currently under review* **Gaps in assurance:** *Currently under review*	1. Continue to model different financial scenarios as intelligence becomes available 2. Support Divisions to continue identifying and delivering on CIP 3. Publicise the Regional Bite size short courses programme for Finance, business and governance and encourage BH and operational managers to sign up. 4. Review ICP strategy ambition and potential impact on service delivery 5. Implement areas of improvement identified through benchmarking, strengthening processes in relation to budget reporting and monitoring.

BAF3: Insufficient capital resources to progress investments

Strategic Objectives: **ALL**			
Strategic Risk:			
IF resources (cash and / or Public Dividend Capital) are not available to the Trust in line with its planned capital expenditure.	**Then** there will be insufficient resources to progress capital developments.	**Resulting in** Potential regulatory impact, loss of external capital funding, reputational and patient impact	**Defined by** NHSE and DHSC regulatory action, adverse publicity, inability to delivery improved estate

Lead Executive	Director of Finance	**Assurance committee**	Performance and Finance Committee (PAF)

	Impact	**Likelihood**	**Score**	**Risk trend**	**Risk rating**
Inherent	4	4	16	**Board tolerance to be confirmed**	**12**
Residual	**4**	**3**	**12**		
Target	4	2	8		

	Key Controls	**Assurances reported to Board and committees**
	a) Rolling 5 year capital plan	Regularly reviewed and discussed at PAF Committee with escalation to Trust Board as required.
	b) Review and prioritisation of capital schemes	Capital position against CDEL reported and discussed at ESPG, IG, Finance and Performance Committee and Trust Board.
	c) Monitoring of approved capital schemes under construction to determine position relative to planned values	
	d) Business case framework	
	e) Monitoring of national, regional and system framework and guidance in relation to capital expenditure.	Reporting through sub committees to Trust Board as necessary
	f) SNEE System DoF meetings.	

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
Gaps in control: *Currently under review* **Gaps in assurance:** *Currently under review*	1. Long term capital programme to be regularly discussed at Performance and Finance Committee 2. Value for money assessment of schemes to be considered as part of business case development and approvals

BAF4: Quality assurance mechanisms regarding the quality and safety of patient services.

Strategic Objectives:

1. Keep people in control of their health
2. Lead the integration of care

Strategic Risk: BAF4

IF	**Then**	**Resulting in**	**Defined by**
ESNEFT does not have the correct quality assurance mechanisms in place	it may fail to maintain or improve the quality and safety of patient services	poor patient care, increased health inequalities, experience and potential harm.	Increase in patient incidents and complaints

Lead Executive	Chief Nurse	**Assurance committee**	Quality and Patient Safety Committee (QPSC)

	Impact	**Likelihood**	**Score**	**Risk trend**	**Risk rating**
Inherent	4	3	12	**Board tolerance to be confirmed**	**8**
Residual	**4**	**2**	**8**		
Target	4	1	4		

	Key Controls	**Assurances reported to Board and committees**
Patient Safety and Quality	c) Patient Safety Investigation Response Framework (PSIRF) 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 to QPSC. The IPR also contains evidence of PSIRF compliance and is reported to Trust Board.
	d) Quality and Clinical strategy in line with quality priorities	Reporting to QPSC
	e) Divisional Accountability Meetings (DAMs) have robust discussions focused on delivery of the quality governance agenda and quality metrics.	Divisional updates reported through PSG, PEG and CEG
	f) Increased training and experience in quality improvement methodologies.	Quarterly progress identified through 'speed dating' sessions led by CMO and CN to seek assurance against delivery
	g) Triangulation of quality metrics and reporting undertaken with assurance visits to wards and departments	Reporting of metrics through IPR to Board.
Health inequalitie	h) ESNEFT Inequalities Strategy and associated governance	Strategy monitored at Board Reporting to SNEE ICS Alliance Boards
	i) Health Inequalities Working Group	Reporting to CEG, QPS Committee, Performance and Finance Committee and Trust Board
Perinatal care	j) CNST Maternity Improvement Standards	Monitoring of programmes and quality/outcome metrics through DAMS, Every Birth Every Day Programme Board, QPSC and Trust Board
	k) Walk-arounds by Maternity Board Safety Champions to triangulate findings with families and staff.	LMNS reporting
	l) Perinatal mortality outcomes monitored through Learning from Deaths group	Learning from deaths group.

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
Gaps in control: *Currently under review* **Gaps in assurance:** *Currently under review*	1. Deliver progress against Quality Priorities for 2023/24 – ongoing throughout 2023/24 2. Continue review of DAM metrics through IPG to ensure robust reporting in place 3. Development of options appraisal to consider improvement partner to support increased QI capacity and capability 4. Development of Care Accreditation Framework across all clinical services in ESNEFT 5. Delivery plan set against MIS CNST Year 5 standards in maternity 6. Progress compliance with NHSE 3 year Maternity and Neonatal Services Delivery Plan

BAF5: Workforce – recruitment and retention

Strategic Objectives: **4. Support and develop our staff**			
Strategic Risk: BAF5			
IF ESNEFT is not able to attract and retain its workforce	**Then** it will not be able to deliver high quality patient care.	**Resulting in** reduced organisational resilience, impact on patient care, additional pressure on existing workforce	**Defined by** Increase in sickness, increased agency costs, potential increase in patient safety incidents.

Lead Executive	Director of People & Organisational Development	**Assurance committee**	People & Organisational Development (POD) Committee

	Impact	**Likelihood**	**Score**	**Risk trend**	**Risk rating**
Inherent	4	4	16	**Board tolerance to be confirmed**	**12**
Residual	**4**	**3**	**12**		
Target	4	2	8		

Key Controls	**Assurances reported to Board and committees**
m) Annual workforce plan n) Recruitment Policy and Procedures	Monitored monthly, reporting via POD Committee. Recruitment pipeline monitored monthly against planned activity, which includes leaver rate.
o) People and OD Strategy; EDI Strategy and associated governance: Staff Experience Committee; POD Committee; EDI Strategic and EDI Operational Groups	Strategies focus on: approach to equality diversity and inclusion, staff experience including ensuring staff feel confident in speaking up, educating and training our workforce, supporting staff well-being and providing high quality leadership development opportunities. Staff Experience Committee monitors performance against key controls, reports to POD Committee, POD Committee reporting to Board. EDI Operational Group monitors performance against WRES/WDES/GPG/PSED Data and Annual Reports/Action Plans and reports to EDI Strategic Group and POD Committee
p) People metrics: appraisal compliance, turnover, sickness absence, Workforce Race Equality Standard (WRES) q) Retention strategy r) Flexible working policy s) Talent and succession planning process t) Staff Experience Committee u) Appraisal process	Monitored through Performance and Finance Committee, POD Committee and reported to Board.

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
<u>Gaps in control:</u> None documented **<u>Gaps in assurance:</u>** Limited engagement with staff survey (38% of staff 2022/23)	1. Talent and succession planning process embedded within organisation from Autumn 2023 2. Increase apprenticeship programme utilisation to 75% of levy by 2024/2025 3. Increase engagement of leaders in leadership development programmes to 75% by 2025/26 4. OD calendar to be developed and implemented across organisation, responding to key themes raised through the staff survey and in communication with our staff experience committee by September 2023 with 12 month rolling calendar. 5. Reduced sickness absence in relation to stress, anxiety and depression; confirm baseline and targets 6. Increased engagement of all staff with EDI agenda; 100% of staff to have EDI specific objective set during 2023/24 appraisal process. 7. Improved staff survey results in respect of staff recommending ESNEFT as a place to work and be treated (upper quartile by 2025) 8. Increase staff from global majority accessing Band 6 and above roles by at least 2% each year from 2022 baseline. 9. Expand the provision of EDI related awareness sessions (Active Bystander, Race Conversations, Disability and LGBTQ Awareness) 10. Increase number of diversity partners to support recruitment and selection processes

BAF6: Sustainable delivery of elective performance targets

Strategic Objectives: **1. Keep people in control of their health**			
Strategic Risk:			
IF there is insufficient capacity to match demand and failure to achieve operational performance targets	**Then** wait times and delays for treatment will increase	**Resulting in** unintended harm to patients due to longer waiting times which may result in delayed diagnosis, disease progressions and poor outcomes; impact on financial outcomes and ability to deliver annual plan	**Defined by** increasing number and severity of incidents and claims; regulatory action or reputational damage

Lead Executive	Director of Elective Care	**Assurance committee**	Performance and Finance Committee (PAF)

	Impact	**Likelihood**	**Score**	**Risk trend**	**Risk rating**
Inherent	5	4	20	**Board tolerance to be confirmed**	**15**
Residual	**5**	**3**	**15**		
Target	5	2	10		

	Key Controls	**Assurances reported to Board and committees**
	a) Elective Care Charter which supports the development of the elective care element of the ESNEFT strategy	ICB Elective Care Programme Board Joint Programme Board between ESNEFT and West Suffolk Executive Management Committee (EMC) Performance Assurance Committee (PAC) - Monthly reporting and periodic Deep Dives Topic based Deep dives presented to Council of Governors and Performance and Finance Committee Regular reporting to Executive Leadership Team and Elective and Emergency care programme boards
	b) ESNEFT Elective Medium Term Plan	
	c) SNEE Elective Recovery and Emergency Care Charter	Reporting to Elective Care Programme Board Chaired by SNEE Director.
	d) Divisional Accountability Framework	Monthly performance packs to monitor productivity and activity
	e) Director of Elective Care	Regular reporting to Trust Board including periodic deep dives

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
Gaps in control: *Currently under review* **Gaps in assurance:** *Currently under review*	1. Implement the ESNEFT Elective Medium term plan which sets out the objectives and KPI's for the next 2 years.

BAF6A: Sustainable delivery of emergency care performance targets

Strategic Objectives: **1. Keep people in control of their health**			
Strategic Risk:			
IF there is insufficient capacity to match demand and failure to achieve operational performance targets	**Then** waiting times and delays for treatment will increase	**Resulting in** unintended harm to patients due to longer waiting times which may result in delayed diagnosis, disease progressions and poor outcomes; impact on financial outcomes and ability to deliver annual plan	**Defined by** excess deaths; increasing number and severity of incidents and claims; regulatory action or reputational damage

Lead Executives	Deputy CEO Director of Operations and NEECS	**Assurance committee**	Performance and Finance Committee (PAF)

	Impact	**Likelihood**	**Score**	**Risk trend**	**Risk rating**
Inherent	5	4	20	**Board tolerance to be confirmed**	**15**
Residual	**5**	**3**	**15**		
Target	5	2	10		

Key Controls	**Assurances reported to Board and committees**
Operational Executive Management Committee (EMC) overseeing deliverables including admission avoidance, front door transformation, patient pathways, virtual wards and ED sustainability as detailed within the following plans: • Urgent and emergency care medium term plan • Community care medium term plan • SNEE One plan	Programme risks and issues monitored by Emergency Care Programme Board, and escalated to EMC and Trust Board as appropriate. System Alliance Operational Group undertakes deep-dives, including ambulance handovers, seasonal variation, cancer and diagnostics with reporting through Performance and Finance Committee to Trust Board. Reporting through SNEE Operational Delivery Group
SRO for Urgent & Emergency Care - Director of Operations	Regular reporting to Trust Board including periodic deep dives
Alliance Operational Group	Highlight reports which feeds up to Strategic Operational Group in the ICB
Emergency Care Programme Board	Performance management reporting arrangements between Divisions, Service Lines and Executive Team.
Operational Performance Targets – national and Trust standard monitored through Divisional Accountability Framework	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, with escalation to PAF Committee as necessary.

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
Gaps in control: *Currently under review* **Gaps in assurance:** Lack of assurance that increased system social care spend is benefiting the Trust	1. Winter planning – system wide emergency approach 2. Establish appropriate system governance to influence and gain assurance regarding improving timely patient pathways

BAF7: Estates Development and Capital Equipment

Strategic Objectives: **5. Drive technology enabled care**			
Strategic Risk:			
IF there is insufficient investment available in respect of the Trust's estate,	**Then** the Trust will be unable to maintain, develop and transform the physical estate of the Trust,	**Resulting in** adverse impact on the ability of the Trust to provide high-quality care and patient experience, potential regulatory action	**Defined by**

Lead Executive	Director of Estates and Facilities	**Assurance committee**	Performance and Finance Committee (PAF)

	Impact	**Likelihood**	**Score**	**Risk trend**	**Risk rating**
Inherent	4	4	16	**Board tolerance to be confirmed**	**12**
Residual	**4**	**3**	**12**		
Target	3	2	6		

	Key Controls	**Assurances reported to Board and committees**
	a) Estates Strategy 2019-2024	Reporting through Estates Strategy Programme Group (EPSG) with appropriate escalation to Trust Board
	b) Facet Survey to assess the estate relative performance and fitness for purpose (Physical condition, statutory standards, functional suitability, quality, space utilization, environmental management audit).	
	c) PLACE annual programme (Patient Led Assessments of the Care Environment)	
	d) Premises Assurance Model (PAM)	Reports to Fire, Med Gas and Water Safety Groups, which report to Health and Safety Committee, Infection Control and QPS with appropriate escalation to Trust Board.
	e) Monitoring Committees/Groups	
	f) Prioritised backlog maintenance plan	

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
<u>Gaps in control:</u> *Currently under review* **<u>Gaps in assurance:</u>** *Currently under review*	1. Prioritisation of Capital schemes for 23/24 to be confirmed. 2. Ward Improvement Plan prioritisation following outcome of 6 facet survey and Infection Control Audit. 3. Annual PAM report to be submitted to Board prior to submission to NHSE.

BAF8: Digital Maturity and major disruptive outage

Strategic Objectives: **5. Drive technology enabled care**			
Strategic Risk: BAF8 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			
IF investment of appropriate enabling and dependency work is not achieved	**Then** the Electronic Patient Record (EPR) programme delivery will not meet minimum digital maturity levels	**Resulting in** delays to EPR delivery, financial burden and risk of non-compliance with national reporting requirements	**Defined by** Inefficiencies within service models and patient pathways, impact on financial viability

Lead Executive	Director of Digital Logistics and Operations	**Assurance committee**	Quality and Patient Safety Committee (QPSC)

	Impact	**Likelihood**	**Score**	**Risk trend**	**Risk rating**
Inherent	4	3	12	**Board tolerance to be confirmed**	**8**
Residual	**4**	**2**	**8**		
Target	2	2	4		

	Key Controls	**Assurances reported to Board and committees**
	i) Digital and Data Strategy	Approved by Executive Management Committee (EMC) August, recommended to Board for approval. Monthly highlight reports to eHealth Group monitor KPIs. Quarterly reporting to ICS Strategic Digital Investment Assurance Committee.
	j) Annual Capital Programme	EMC reporting through to Board.
	k) Prioritisation of IT Capital Programme through Investment Group	Funding agreed for all programmes, reporting to PAF Committee
	l) Safe digital practice	Data Security and Protection Toolkit submission and internal audit findings reported to Audit Committee
	m) EPR Programme and Clinical Informatics Development	Outline Business Case approved by Board November 2022. Regular reporting through EPR Programme Steering Group to EMC and Board.
	n) EPR Outline Business Case	
	o) Frontline Digitisation funding award	

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
Gaps in control: • Full business case for EPR system not yet finalised for Board approval. **Gaps in assurance:** • Well Led Review identified 'The Trust has a relatively low level of digital maturity due to an intentional decision to delay implementation of an EPR system'	1. Delivery of full Business Case for EPR system by end October 2023 Board. 2. Regional and National approval of Business case by end January 2024 3. EPR contract award by end March 2024 4. EPR Implementation from April 2024 ongoing to quarter two 2024/25. 5. DPST Internal audit action plan compliance. Delivery ICT Key Controls Operational report quarterly to Audit committee.

BAF9: Transformation

Strategic Objectives: **2. Lead the integration of care** **3. Develop our centres of excellence**			
Strategic Risk: If we do not transform through strategy and its delivery then we will be unable to achieve long term sustainability leading to regulator intervention			
IF we are unable to transform though strategy	**Then** this will limit the Trust's ability to deliver its strategic goal and achieving long term financial sustainability	**Resulting in** loss of regulator/public confidence and consequent regulator intervention; inability to delivery strategic objectives.	**Defined by**

Lead Executive	Director of Strategy, Research & Innovation	**Assurance committee**	Trust Board

	Impact	**Likelihood**	**Score**	**Risk trend**	**Risk rating**
Inherent	4	4	16	**Board tolerance to be confirmed**	**12**
Residual	**4**	**3**	**12**		
Target	4	2	8		

	Key Controls	**Assurances reported to Board and committees**
	a) ESNEFT 2019-2024 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 2022/23 the Trust achieved breakeven. Deloitte Well Led review 2023
	b) People Strategy	Monitored through People and OD Committee and reported to Trust Board
	c) Quality Strategy	Monitored through Quality and Patient Safety Committee and reported to Trust Board
	d) Digital and Data Strategy	Monthly highlight reports to eHealth Group monitor KPIs. Quarterly reporting to ICS Strategic Digital Investment Assurance Committee
	e) Communications and Engagement Strategy	
	f) Estates Strategy	Monitored through Estates Strategy Programme Group with regular updates provided to Trust Board
	g) Diagnostics Strategy	
	h) Research & Innovation Strategy	Monthly monitoring through Executive Management Committee with quarterly reporting to Board

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
Gaps in control: *Currently under review* **Gaps in assurance:** *Currently under review*	1. Trust 5 Year Clinical Strategy to be approved by Board in Q3 2023/24.