Appendix 2 - Board Assurance Framework as at 28 December 2023

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** Lack of continuity of care, poor utilisation of resources, impact on strategic and operational delivery, inequitable access to services

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

	Impact	**Likelihood**	**Score**	**Risk trend**	**Risk rating**
Inherent	4	3	12	→ **Static**	**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.
	c) Hospital and community health services provided by Trust	Reporting via Integrated Patient Safety report through Finance and Performance, Quality and Safety to Trust Board

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
Gaps in control: *No Integrated Care System (ICS) Clinical Strategy* **Gaps in assurance:** • Assurance regarding integration benefits • Shared PMO with West Suffolk not yet implemented • Resource limitations across system partners – including mental health and social care.	1. Continue to develop and enhance partnership working and relationships 2. Define timescale for delivery of benefits from partnership working 3. Contribute to development of ICS Clinical Strategy for delivery from 2024/25

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 also volatility in financial performance	**Resulting in** an impact on cash flow and long-term financial sustainability	**Defined by** The potential need to reduce services and compromise on future investment to mitigate pressure on finances

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

	Impact	**Likelihood**	**Score**	**Risk trend**	**Risk rating**
Inherent	4	4	16	→ **Static**	**16**
Residual	**4**	**4**	**16**		
Target	4	3	12		

	Key Controls	**Assurances reported to Board and committees**
	a) Medium Term Planning	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 (CIP) with QIA process to ensure CIP schemes are reviewed and signed off before implementation decisions	HFMA, One NHS Finance and SDN training available to budget holders in addition to internal courses and support. Divisional Accountability Meeting (DAM) leadership in developing and monitoring these plans, with escalation through PAF to Trust Board.
	c) Active collaborative system financial performance through the SNEE ICB Finance Committee and Regional Directors of Finance Meetings to support input into resource allocation decisions and expenditure control actions.	Implications and actions on collaborative work with partners detailed through the PAF Committee and Trust Board as necessary.
	d) Delegated accountability to Divisions for planning and delivery of divisional financial plans. Focus on the enablement of recurrent cost improvement schemes, developments and productivity concepts through the Financial Sustainability Group	Regular use of the Integrated Finance and HR dashboard and DAM review meetings. Financial Sustainability Group updates to EMC.
	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 Waited Activity Unit, Model system, GIRFT and other relevant datasets.	Reporting to PAF Committee and Trust Board.
	h) Effective Procurement Systems and process	Monthly Reports to Medical Devices Management Group and Quarterly updates to Clinical Reference Group

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
Gaps in control: All appropriate controls currently in place with Divisional Management Board review on a monthly basis. **Gaps in assurance:** Lack of direct influence on resource allocation decisions at a national level. potentially resulting in Unfunded inflationary pressures, for example	1. Continue to model different financial scenarios as intelligence becomes available 2. Support Divisions to continue identifying strategic change opportunities (eg Spec Comm) 3. Support and educate Divisions to understand and implement strong financial governance processes. 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. 6. Use Regional DoF meetings to influence the NHSE Regional DoF who in turn can attempt to influence the NHSE National DoF. 7. Tightly manage the revenue consequences of recent and future capital investment to maximise opportunities and avoid the risks of poor implementation. 8. Actively participate and influence in the SNEE ICB long term finance plan with a specific interest in West Suffolk Hospital's financial position. All actions above are ongoing.

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 income generation potential as well as reputational and patient impact	**Defined by** NHSE and DHSC regulatory action, adverse publicity, inability to deliver 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	→ **Static**	**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, Performance and Finance Committee and Trust Board.
c) Monitoring of approved capital schemes under construction to determine position relative to planned values	
d) Business case framework	Divisional Management Board, Investment Group, EMC and Trust Board
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 ICB Finance Committee meetings.	

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
Gaps in control: All appropriate controls currently in place with Divisional Management Board review on a monthly basis. **Gaps in assurance:** Lack of direct influence on resource allocation decisions at a national level potentially resulting in reduced opportunities for capital investment Mismatch between CDEL availability and cash generated by depreciation may lead to cash shortfalls in future years. – National issue Reliability on suppliers providing goods and services when needed. Project Management agreeing timelines for delivery and ability to manage procurement process and or construction plan.	1. Long term capital programme to be regularly discussed at Performance and Finance Committee and investment group 2. Value for money assessment of schemes to be considered as part of business case development and approvals. 3. Use Regional DoF Meeting to raise CDEL and Cash issues which can be fed back nationally. 4. Use of contractual terms where necessary and proactive communications and relationship building to try to mitigate any potential risks of goods and services delays. 5. From 2025-26 there will be a new Comprehensive Spending Review (CSR) process which may impact on our medium term capital plan. 6. Use Regional DoF and SNEE meetings to influence discussion on capital allocations that are increasing being treated as a system total. All actions are ongoing

Note – this risk has indirect links to the BAF7, regarding the ongoing sustainability of the organisation's estate

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	→ **Static**	**8**
Residual	**4**	**2**	**8**		
Target	4	1	4		

	Key Controls	**Assurances reported to Board and committees**
Patient Safety and Quality	a) 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.
	b) Quality and Clinical strategy in line with quality priorities	Reporting to QPSC
	c) Divisional Accountability Meetings (DAMs) have robust discussions focused on delivery of the quality governance agenda and quality metrics.	Divisional updates reported through NMAAC, PSG, PEG and CEG
	d) QI Team and workplan	Quarterly progress identified through sessions led by CMO and CN to seek assurance against delivery
	e) Triangulation of quality metrics (including falls, pressure ulcers and maternity) and reporting undertaken with assurance visits to wards and departments	Reporting of metrics through IPR to Board.
Health inequalities	f) ESNEFT Inequalities Strategy and associated governance	Strategy monitored at Board Reporting to SNEE ICS Alliance Boards
	g) Health Inequalities Working Group	Reporting to CEG, QPS Committee, Performance and Finance Committee and Trust Board
Perinatal care	h) Compliance with CNST Standards – with detailed action plan to deliver compliance with all 10 standards	Monitoring of programmes and quality/outcome metrics through DAMS, Every Birth Every Day Programme Board, QPSC and Trust Board
	i) Maternity and Neonatal Safety Champions	Findings reported through LMNS, QPS and Board
	j) Learning from deaths group	Perinatal mortality outcomes monitored through Learning from Deaths group reported through LMNS, QPS and Board

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
Gaps in control: None documented **Gaps in assurance:** • Maternity CNST compliance 2022/23 • Outcomes from Care Accreditation Programme	1. Deliver progress against Quality Priorities for 2023/24 – ongoing throughout 2023/24 2. Re-scope of Quality Improvement faculty and outputs by 31 March 2024 3. Continue to implement delivery plan set against CNST Year 5 standards in maternity by December 2023- Complete 4. Development of Care Accreditation Framework across all clinical services in ESNEFT -Launch Care Accreditation Programme during Q4 2023/24.

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	→ **Static**	**12**
Residual	**4**	**3**	**12**		
Target	4	2	8		

Key Controls	**Assurances reported to Board and committees**
a) Annual workforce plan b) Recruitment Policy and Procedures	Monitored monthly, reporting via POD Committee. Recruitment pipeline monitored monthly against planned activity, which includes leaver rate.
c) People and OD Strategy and associated calendar; EDI Strategy and associated governance: Staff Experience Committee; POD Committee; EDI Strategic and EDI Operational Groups d) EDI related awareness sessions (Active Bystander, Race Conversations, Disability and LGBTQ Awareness)	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
e) People metrics: appraisal compliance, turnover, sickness absence, Workforce Race Equality Standard (WRES) f) Retention strategy g) Talent and succession planning process h) Appraisal process with EDI specific objectives for all staff	Monitored through Performance and Finance Committee or POD Committee and reported to Board.
i) ESEOC Recruitment plan with agreed milestones	Monitored through ESEOC Steering Group and reported to EMC

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
<u>Gaps in control:</u> None documented **<u>Gaps in assurance:</u>** Substantial establishment increase due to vacancies created by ESEOC.	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. Reduce sickness absence in relation to stress, anxiety and depression; confirm baseline and targets 5. Improve staff survey results in respect of staff recommending ESNEFT as a place to work and be treated (upper quartile by 2025) 6. Increase staff from global majority accessing Band 6 and above roles by at least 2% each year from 2022 baseline. 7. Increase number of diversity partners to support recruitment and selection processes from 8 to 20 by March 2024 8. Increase staff survey engagement to be in line with national mean (2023 survey) 9. International and national recruit campaign with agreed suite of incentives to fill ESEOC vacancies to enable induction completion by August 2024

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 delivery timely patient care (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** 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	→ **Static**	**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 b) ESNEFT Elective Medium Term Plan (2 year plan approved June 2023)	Joint Programme Board between ESNEFT and West Suffolk Executive Management Committee (EMC) Performance Assurance Committee (PAF) - 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. Reporting to ICB wide Elective Care Programme Board chaired by Director of Elective Care
c) SNEE Elective Programmes Strategic and Diagnostic Committee	Reporting to System Oversight Assurance Committee
d) Divisional Accountability Framework	Monthly performance packs to monitor productivity and activity
e) Performance and Finance Committee	Regular reporting to Trust Board including periodic deep dives

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
Gaps in control: • Impact of industrial action on capacity • Impact of theatre build programme on capacity • Poor uptake of additional contractual lists **Gaps in assurance:** • Overall number of patients on waiting list is very high • Not all patients in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will have received a first outpatient appointment by 31 October 2023.	1. Deliver the ESNEFT Elective Medium term plan which sets out the objectives and KPI's for the next 2 years. (ongoing) 2. Increase elective capacity through completion of new Ipswich theatres (May 2024) and Colchester based Elective Orthopaedic Centre (August 2024). 3. Review clinical harm review process and align with clinical pathway reviews (by April 2024).

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 inability to deliver timely patient care (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** Increased morbidity and 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	→ **Static**	**15**
Residual	**5**	**3**	**15**		
Target	5	2	10		

Key Controls	**Assurances reported to Board and committees**
Operational and Strategic Executive Management Committee (EMC) overseeing deliverables including admission prevention and avoidance, front door transformation, patient pathways, virtual wards, acute respiratory infection hubs and ED sustainability as detailed within the following plans: • Urgent and emergency care medium term plan • Community care medium term plan • SNEE One plan • Seasonal variation 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 reporting to Urgent Emergency Care Alliance Committee (SNEE ICB)
Alliance Operational Group	Highlight report feed up to ICB Strategic Operational Group
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	Monthly Divisional Accountability Meetings (DAMs) supported by Executive Director, finance and performance teams. This enables 'confirm and challenge' to Divisional management teams around specialty level recovery plans; and review the progress against detailed divisional plans, with escalation to PAF Committee as necessary.
Peer reviews of UEC pathways at Colchester and Ipswich hospitals and associated actions plans	Reporting of outcomes through PAF Committee and System Oversight Assurance Committee.
Covid and Flu vaccination programme	Performance and Quality Report to PAF Committee, and onward report to Trust Board.

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
Gaps in control: • Potential covid/flu impact on patients and staff • Physical capacity limitations to support surge (Colchester site) **Gaps in assurance:** • Lack of assurance that national allocated discharge funds are assisting patients leaving hospital earlier when ready for discharge.	1. Seasonal variation planning – system wide emergency approach with finances to be agreed by end November 2023 – complete. 2. Establish appropriate system governance to influence and gain assurance regarding improving timely patient pathways 3. Winter 2023/24 covid and flu vaccination programme 4. Open Ipswich Urgent Treatment Centre and Emergency Department by August 2024

BAF6B: Timely cancer diagnosis and treatment

Strategic Objectives: **1. Keep people in control of their health**			
Strategic Risk:			
IF there is insufficient capacity to match demand and failure to delivery timely patient care (achieve operational performance targets)	**Then** the Trust will be unable to provide timely cancer diagnosis and treatment	**Resulting in** unintended harm to patients and non-compliance with national standards	**Defined by** delayed diagnosis; increased disease progression; excess deaths; increasing number and severity of incidents and claims; regulatory action; reputational damage

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

	Impact	**Likelihood**	**Score**	**Risk trend**	**Risk rating**
Inherent	5	4	20	→ **Static**	**15**
Residual	**5**	**3**	**15**		
Target	3	2	6		

Key Controls	**Assurances reported to Board and committees**
Monitoring of 62 day performance in relation to 28 Faster Diagnosis national standard (ensuring diagnosed patients are treated as soon as possible)	Reporting through SNEE Operational Delivery Group Reporting through PAF Committee, QPS Committee, Executive Management Committee and Board Clinical outcomes from National Cancer Audits report to QPS Patient experience feedback through National Patient Survey report to QPS
SNEE-wide Cancer Operational Group and Committee	
ESNEFT Trust-wide Cancer Board (bimonthly)	
Site specific weekly MDT meetings.	
Cancer Recovery Programme for specific tumour sites	
Operational Performance Targets – national and Trust standard monitored through Divisional Accountability Framework	Monthly Divisional Accountability Meetings (DAMs) supported by Executive Director with escalation to PAF Committee as necessary.
Long wait and industrial action KLOEs impact assessment template	Reporting to NHS England
Cancer Patient Panel feedback	Reporting through QPS to EMC.

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
Gaps in control: Reduction in capacity due to industrial action (consultants) impacting waiting times for first appointments and delaying treatment **Gaps in assurance:** Not meeting 28 day FDS national standard (due to colorectal diagnosis performance), although position improving due to new pathways introduced in Colchester	1. Trajectory to achieve 28 day faster diagnosis (28FDS) compliance by December 2023 to meet national deadline of March 2024. 2. Rescheduling of appointments and treatment where these are impacted by industrial action (ongoing) 3. Introduce new colorectal pathway at Ipswich (successfully implemented in Colchester) from November 2023 – complete 4. Continue working with GPs on appropriate referral pathways for cancer patients (ongoing)

BAF Extract - BAF7: Estates Development and Capital Equipment

Strategic Objectives: **5. Drive technology enabled care**			
Strategic Risk:			
IF there is insufficient investment available and made 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** a dilapidated, inconsistent and dated estate leading to an inability of the Trust to provide high-quality care; poor patient, staff and visitor experiences; and potential regulatory action.	**Defined by** Worse care - Cancelled or delayed appointments; Delayed diagnosis; Less modern care; Inconvenient locations Worse experience - Increase in complaints; Greater frequency and severity of incidents; Worse staff retention Worse governance - Increased unforecast reactive spend; Regulatory action; Increased Health & Safety risk Failure to reduce carbon footprint

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

	Impact	**Likelihood**	**Score**	**Risk trend**	**Risk rating**
Inherent	5	4	20		
Residual	**4**	**4**	**16**	↑ **Increased**	**16**
Target	3	2	6		

Key Controls	**Assurances reported to Board and committees**
a) Estates and Facilities Divisions Strategies and Plans: a. Estates Strategy 2019-2024 b. Property Strategy c. Green Plan 2024-2027 d. Master Control Plan and Development Control Plan for each major site.	Each of the strategies is taken through the divisional DMT, Estates Strategy Programme Group (ESPG) one of the Committees (depending on content) and then the Board. Separately, the estates and property strategies are submitted to the ICB Estates Committee to ensure alignment to the wider system strategy. Annual ERIC (Estates Returns Information Collection) return to NHS England
b) Estates and Facilities Plans and Business Cases a. Master Control Plan and Development Control Plan for each major site. b. Annual Backlog Maintenance Plan c. 5 year annual capital and maintenance plan d. Annual property plan	Six Facet Survey Specific condition reports (when deemed necessary) Each of the plans and business cases are taken through the Investment Group, BFBC Group (Building for Better Care) and/or ESPG with appropriate escalation to Trust Board and ICB Estates Committee
c) Estates and Facilities Performance metrics and KPIs Full suite of performance metrics and/or KPIs for each component of the division e.g. % planned and statutory PPM performed in month; % catering patient satisfaction scores	Annual PLACE (Patient Led Assessments of the Care Environment) Survey Annual PAM (Premises Assurance Model) survey HTM sub committees Health & Safety Committee
d) Estates and Facilities financial reports Monthly divisional and Assistant Director level monthly report and forecast analysis	Monthly Divisional finance SMT meeting Monthly DMT meeting Monthly DAM Monthly Capital spend meeting

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
Gaps in control: • Lack of dedicated Property Team, Property strategy and annual property plan • Lack of development control plan • Lack of up-to-date backlog maintenance plan • Lack of specific condition surveys for high risk areas • Lack of up to date and consistent KPIs and performance metrics **Gaps in assurance:** • Lack of consistent governance process for reviewing full suite of Estates & facilities performance metrics and KPIs • No Oversight Group in place to monitor Premises Assurance Model (PAM) action plans and escalation • Lack of consistent quality assurance model for New Works and Capital Projects	1. Recruitment of dedicated property and estates strategy AD (Dec 23) 2. External support to bring together property data (Dec 23) 3. Development of property strategy and annual property plan (Apr 24) 4. Use property and estates strategy to develop updated development control plans (Jul 24) 5. Update backlog maintenance plan based upon latest Six facet survey and local knowledge 6. Identify higher risk areas and engage supplier to carry out condition surveys (Apr 24) 7. Review and implement updated performance metrics and KPIs (Jan 24) 8. Complete governance review (Jan 24) and then develop a governance assurance model and implement 9. Introduce PAM Assurance Group (Jan 24) 10. Review existing operating model and design new model (Mar 24) 11. Implement new operating model (Apr 24)

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	→ **Static**	**8**
Residual	**4**	**2**	**8**		
Target	2	2	4		

Key Controls	**Assurances reported to Board and committees**
a) Digital and Data Strategy	Approved by Board September 2023 Monthly highlight reports to eHealth Group monitor KPIs. Quarterly reporting to ICS Strategic Digital Investment Assurance Committee.
b) Annual Capital Programme	EMC reporting through to Board.
c) Prioritisation of IT Capital Programme through Investment Group	Funding agreed for all programmes, reporting to PAF Committee
d) Safe digital practice	Data Security and Protection Toolkit submission and internal audit findings reported to Audit Committee
e) EPR Programme and Clinical Informatics Development	Regular reporting through EPR Programme Steering Group to EMC and Trust Board
f) Frontline Digitisation funding award	
g) Board approved EPR Full Business Case	

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
Gaps in control: • Regional and national approval of FBC **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 November 2023 Board – completed and approved. 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 2025/26.

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 and adapt to changing NHS requirements	**Then** this will limit the Trust's ability to deliver its strategic goals and achieve long term financial sustainability	**Resulting in** loss of regulator/public confidence and consequent regulator intervention; inability to deliver 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	→ **Static**	**12**
Residual	**4**	**3**	**12**		
Target	4	2	8		

Key Controls	**Assurances reported to Board and committees**
a) People Strategy	Monitored through People and OD Committee and reported to Trust Board
b) Quality Strategy	Monitored through Quality and Patient Safety Committee and reported to Trust Board
c) Digital and Data Strategy	Monthly highlight reports to eHealth Group monitor KPIs. Quarterly reporting to ICS Strategic Digital Investment Assurance Committee
d) Communications and Engagement Strategy	
e) Estates Strategy	Monitored through Estates Strategy Programme Group with regular updates provided to Trust Board
f) Diagnostics Strategy	
g) Research & Innovation Strategy	Monthly monitoring through Executive Management Committee with quarterly reporting to Board
h) Strategic Plan	Quarterly reporting to EMC and then Trust Board
i) ESNEFT 2024-2029 Clinical Strategy	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. Performance, quality and finance reporting to NHS England and ICB as required. Performance against success measures reported quarterly to Board. Endorsed by ICB November 2023

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
Gaps in control: None identified: strategy sets out challenges, opportunities and the Trust response to these. **Gaps in assurance:** Sub-strategy refresh dates not reported to Board	1. Deliver the 2024 to 2029 strategy – defined key measures of success reported to Trust Board quarterly.