Appendix 2 - Board Assurance Framework as at 24 April 2024

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**
<u>Gaps in control:</u> No Integrated Care System (ICS) Clinical Strategy **<u>Gaps in assurance:</u>** • 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 and sustainability – Failure to maintain revenue financial balance in future years

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		
Residual	**4**	**4**	**16**	→ **Static**	**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. Quarterly update to EMC on Business planning progress, risks and mitigations. 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 decisions	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) Active collaborative system financial performance through the SNEE ICB Finance Committee and Regional DOFs Meetings to provide input into resource allocation decisions and expenditure control actions to support the achievement of system balance.	Implications and actions on collaborative work with partners detailed through the PAF and 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	Divisional Accountability Framework (AF) metrics reviewed annually and approved by EMC and reported to PFC for assurance. Metrics are monitored and managed through monthly through Divisional Accountability Meetings (DAMs) and escalated to EMC/PFC as appropriate. Regular use of the Integrated Finance and HR dashboard by managers and budget holders. 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 and implementing actions	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	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.

	These forums are becoming increasingly important as systems encouraged to work more collaboratively 7. To tightly manage the revenue consequences of recent and future capital investment to maximise opportunities and avoid the risks of poor implementation 8. To actively participate and influence in the SNEE long term finance plan with a specific interest concerning the increasing deficit in West Suffolk's financial position. 9. 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, 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	Divisional Management Board, Investment Group, EMC and Trust Board
e) Monitoring of national, regional and system framework and guidance in relation to capital expenditure, in particular the system in place to fund the implications of IFRS16 and the capitalisation of right of use assets for 2024-25 which is not yet clear. In addition national capital allocations announced for 2024-25 excluded the resources requested for backlog maintenance. We are at the end of the current CSR cycle and given the current political landscape it could be 2026-27 before the next CSR is agreed and published.	Planning for the use of capital needs to take into account national impacts on key controls. Reporting of performance will work 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 CSR process which may impact on our medium term capital plan. 6. This BAF risk has indirect links to the BAF risk associated with the ongoing sustainability of the organisations estate. 7. Use Regional DOF and SNEE meetings to influence discussion on capital allocations that are increasing being treated as a system total. 8. All actions are ongoing

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		
Residual	**4**	**2**	**8**	→ **Static**	**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 QPS Committee. The Integrated Performance Report (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 QPS Committee
	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	Twice yearly progress identified through sessions led by Chief Medical Officer and Chief Nurse 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. Infection Prevention and Control Board Assurance Framework (IPC BAF) reported to Board biannually via Infection Control Committee and QPS.
Health inequalities	f) ESNEFT Inequalities Strategy and associated governance	Strategy approved by Board and monitored at QPS Committee with reporting to 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, CNST Group, QPS Committee 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 2024/25 • Outcomes from Care Accreditation Programme	1. Deliver progress against Quality Priorities and Quality Programme for 2024/25 with a focus on fundamentals of care – ongoing throughout 2024/25 2. Re-scope of Quality Improvement faculty and outputs by 31 March 2024 - complete 3. Development of Care Accreditation Framework across all clinical services in ESNEFT - complete 4. Launch Care Accreditation Programme (completed), initial outcome to be reported to QPS Committee September 2024

	5. Board Healthcare inequalities self-assessment tool to be completed to identify objectives, which will be developed into an action plan, with progress reviewed annually.

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; 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 and EPR Recruitment plans 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 from 2024/25 due to vacancies created by ESEOC and EPR Healthcare Support Worker backpay calculation not yet agreed through unions.	1. Talent and succession planning process embedded within organisation from April 2024 (ongong) 2. Increase engagement of leaders in leadership development programmes to 75% by 2025/26 3. Reduce sickness absence in relation to stress, anxiety and depression; confirm baseline and targets 4. Improve staff survey results in respect of staff recommending ESNEFT as a place to work and be treated (upper quartile by 2025 survey) 5. Increase staff from global majority accessing Band 6 and above roles by at least 2% each year from 2022 baseline to ensure leaders reflect the diversity of staff in Trust 6. Recruitment plan with agreed milestones monitored on weekly basis through ESEOC and EPR Steering Groups, ongoing until August 2024 7. Banding change for AfC Band 2 staff to be enacted March 2024, proposal regarding back pay to be provided to unions March 2024. (complete) 8. Agree Healthcare Support Worker back pay with unions by May 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	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
b) ESNEFT Elective Medium Term Plan (2 year plan approved June 2023)	
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 • Building programme impact on elective services • Poor uptake of additional contractual lists • Recruitment of workforce to staff additional theatre capacity **Gaps in assurance:** • Overall number of patients on waiting list is very high • Delivery of 65 week national standard by end September 2024 reliant on new build capacity becoming operational timely.	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 (July 2024) and Colchester based Elective Orthopaedic Centre (August 2024). 3. Review clinical harm review process and align with clinical pathway reviews by April 2024 - complete 4. Review extension of Waiting List Initiative beyond end April 2024 5. Clinical configuration work to improve number of lists and productivity in line with new theatres go live (July and August 2024) 6. 'Further Faster' outpatient transformation work to reduce polling times for key specialities ongoing throughout 24/25.

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 Joint Forward 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 reports 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.
Enhanced Boarding arrangement and procedures	
SHREWD (Single Health Resilience Early Warning Database) system resilience dashboard with live data feed to monitor system pressures and support management of clinical risk	

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
<u>Gaps in control:</u> • Infection control impact on patients and staff – and impact on availability of beds • Physical and staffing capacity limitations to support surge • Reduced flow through Trust due to high number of medically optimised patients • Insufficient capacity and skills to care for patients with acute mental health conditions *(continues over-page)*	1. Work with partners to influence and gain assurance regarding improving timely patient pathways for medically optimised patients - ongoing 2. Work with partners to influence and gain assurance regarding improving timely care for patients with acute mental health conditions - ongoing 3. Open Ipswich Urgent Treatment Centre and Emergency Department by September 2024 4. Strengthen oversight of boarding patients and patients who have multiple bed-moves - complete

Gaps in assurance: • Lack of assurance that national allocated discharge funds are assisting patients leaving hospital earlier when ready for discharge. • Limited social care capacity impacting length of stay • Bed closures in relation to infection control • Ambulance escalation protocol increasing pressure on ED • Significant number of patients waiting over 12 hours in ED	5. Internal programme of work to support patient flow and safety – clinically ready to proceed and professional standards – ongoing March 2025 6. Review Colchester Hospital bed capacity in relation to capacity released by movement to ESEOC 7. Seek approval of revenue case to appoint staff recurrently, into positions currently funded non-recurrently, relating to community at the front door and urgent community response teams – by May 2024. 8. Implement Home for lunch quality initiative to release capacity earlier, reduce patient safety risks and improve experience from May 2024 and then ongoing.

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 Committee to EMC.

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
Gaps in control: Reduction in capacity due to industrial action, impacting waiting times for first appointments and delaying treatment **Gaps in assurance:** • Not meeting 28 day FDS national standard within colorectal and urology	1. Review implementation of new colorectal pathway to address performance variance by end February 2024 and achieve 28 day faster diagnosis standard by national deadline of end March 2024 – 28 FDS achieved for 23/24. Focus remains on improving performance within colorectal and urology. 2. Rescheduling of appointments and treatment where these are impacted by industrial action (ongoing) 3. Continue working with GPs on appropriate referral pathways for cancer patients (ongoing) 4. Cancer Board to review clinical outcomes across cancer groups and identify areas for improvement by end August 2024

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	→ **Static**	**16**
Residual	**4**	**4**	**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 e. 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
e) Comprehensive asset register	Reporting to ESP Group, provides recommendations through Investment Group to BFBC Group with appropriate escalation to Trust Board.

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 specific condition surveys for high risk areas **Gaps in assurance:** • Lack of consistent governance process for reviewing Estates & facilities KPIs • Lack of consistent quality assurance model for New Works and Capital Projects	1. Recruitment of dedicated property and estates strategy AD (Completed) 2. External support to bring together property data (Completed) 3. Development of property strategy and annual property plan (May 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 (Completed) 6. Periodic review of backlog maintenance plan to ensure validity 7. Identify higher risk areas from backlog maintenance plan and engage supplier to carry out condition surveys (Completed) 8. Review effectiveness of new performance metrics (June 24) 9. Complete governance review (Completed) 10. Develop a governance assurance model and implement (Completed) 11. Reintroduce PAM Assurance Group (Completed) 12. Design New Works quality assurance operating model (Jun 24)

BAF8: Improvements to patient quality, safety and experience through implementation of an EPR

Strategic Objectives: **5. Drive technology enabled care**			
Strategic Risk: BAF8			
IF we are unable to realise the benefits of our Electronic Patient Record (EPR) in accordance with the agreed benefits realisation plan	**Then** we will significantly constrain the delivery of linked digital and strategic goals regarding improvements to patient quality, safety, experience, outcomes and clinical integration	**Resulting in** an inability to standardise clinical processes and mitigate clinical risk associated with the lack of interoperability between legacy systems and processes. Non-compliance with national reporting requirements, reduced workforce satisfaction and workforce inefficiencies	**Defined by** Inefficient service models and patient pathways, characterised by limited visibility of patient information (including history), limited interoperability between acute and community, lack of digital support tools for clinical safety, continued reliance on paper processes and records, inability to fully integrate medical technology into patient pathway. Significant reputational damage, financial impact, regulator scrutiny and reduced workforce retention

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, Data and Technology Strategy 2023-26	Approved by Board September 2023, with annual review. Periodic highlight reports to EPR Programme Board and Trust Board.
b) Annual Capital Programme with prioritisation of IT Capital Programme through Investment Group	Reviewed monthly and reported through PAF Committee to Trust Board.
c) EPR Programme Governance	EPR Programme Board meeting monthly from April 2024, reporting to EMC, QPS Committee and Trust Board
d) EPR Full Business Case, contract, implementation plan, benefits realisation and programme delivery team	Full Business Case approved by Trust Board and NHS England. Tracking of benefits reported through EPR Programme Governance to Trust Board.
e) Cyber Security Strategy	Data Security and Protection Toolkit submission and internal audit findings reported to Audit Committee. IT key controls report provided to Audit Committee quarterly. Briefings on cyber security and EPR provided to Trust Board.
f) Digital leadership development	Digital leadership workshops with Trust Board Epic Executive Briefing

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
<u>Gaps in control:</u> • Limited digital literacy across Trust • Limited clinical and operational participation in digital leadership **<u>Gaps in assurance:</u>** • Demand for Epic trained/experienced workforce from other Trust's creating risk of high turnover within delivery team	1. Sign contract with Epic by March 2024 – complete 2. Alignment of digital literacy programme to Faculty of Education by quarter two 2024/25 a. Digital literacy survey – complete b. Digital literacy training programme to run in parallel to process review and Epic training 3. Epic EPR Implementation from April 2024 ongoing to quarter three 2025/26. a. Epic accreditation training for Project Team staff March to June 2024

	b. Epic orientation week, June 2024 with ongoing programme thereafter. c. Extensive engagement with clinical and operational teams via 'become an Epic expert' change network approach to support process review, standardisation, design, build, training and testing - ongoing d. Intensive staff training to commence 10 weeks prior to go-live

BAF9: Transformation

Strategic Objectives:

1. **Keep people in control of their health**
2. **Lead the integration of care**
3. **Develop our centres of excellence**
4. **Support and develop our staff**
5. **Drive technology enabled change**

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	**Then** this will limit the	**Resulting in** loss of	**Defined by**
transform though strategy and adapt to changing NHS requirements	Trust's ability to deliver its strategic goals and achieve long term financial sustainability	regulator/public confidence and consequent regulator intervention; inability to deliver strategic objectives.	Being unable to meet the needs of our patients, stakeholders and communities; regulatory action

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	Monitored through People and OD Committee and reported to Trust Board
e) Estates Strategy	Monitored through Estates Strategy Programme Group with regular updates provided to Trust Board
f) Diagnostics Strategy	Monitored through EMC and reported to Trust Board via strategic update.
g) Research & Innovation Strategy	Monthly monitoring through Executive Management Committee with quarterly reporting to Trust 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 FBC for Electronic Patient Record approved by Trust Board and NHSE Green Plan approved by Trust Board. Financial sustainability. Deloitte Well Led review 2023. Performance, quality and finance reporting to NHS England and ICB as required. Quarterly Strategic Update to Board reports performance against strategy success measures. Endorsed by ICB November 2023

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**
Gaps in control: No Environmental Sustainability Strategy **Gaps in assurance:** Sub-strategy refresh dates not reported to Board	1. Deliver the 2024 to 2029 strategy – reporting key measures of success to Trust Board quarterly (ongoing) 2. Develop Environment Sustainability Strategy during 2024/25.