

APPENDIX D: Board Assurance Framework (BAF) Report

SM IDs	Strategic Measures	SM IDs	Strategic Measures	Risk Matrix		Consequence (C)				
						1. Negligible	2. Minor	3. Moderate	4. Major	5. Catastrophic
SM1	Satisfaction with GP access	SM6	Increase support for CYP for MH and wellbeing	Likelihood (L)	5. Almost Certain					
SM2	Decrease waiting times	SM7	Reduce average end-of-life emergency admissions		4. Highly Likely					
SM3	Flatline average NHS spend per resident	SM8	Increase early diagnosis for bowel cancer		3. Possibly					
SM4	Decrease type 1&2 ED attendances	SM9	Increase staff survey results (care of patients & service users)		2. Unlikely					
SM5	Decrease average LOS for MH admissions				1. Rare					

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										Key Controls in Place	Gaps in Controls	Actions to Strengthen the Controls in Place		1 st Line of Defence (Operational Controls)	Assurance Level	2 nd Line of Defence (Committees)	Assurance Level	3 rd Line of Defence (Audits/ Regulators/ External Submissions)	Assurance Level
BAF0001	TBC	1, 2 & 6	Maria Wogan/ Sarah Stanley	Neighbourhood Committees	Access, Experience & Inequalities	<i>If access to services is variable and not equitably distributed, and patient experience is not consistently understood or improved, then some populations will face delays, barriers to care and poorer experiences, resulting in widening health inequalities and reduced trust and outcomes for local communities.</i>	<i>Brief description of direction of measures</i>	Cautious		1. ICB Health Inequalities Strategy and Core20PLUS5 programme 2. Use of population health intelligence and JSNA data 3. Access standards monitored through regular performance reporting 4. Friends and Family Test, complaints, PALS and survey data 5. Service specifications include access requirements 6. Place partnerships and local delivery arrangements 7. Public engagement strategy and VCSE engagement 8. EIA process embedded within decision making 9. Quality committees and quality indicators 10. Digital inclusion initiatives 11. Primary care improvement programmes	1. Strategy may not be consistently translated into commissioning decisions 2. Intelligence may not be routinely used to drive service redesign 3. Reporting may focus on overall averages rather than variation between groups 4. Feedback sources fragmented and not routinely triangulated 5. Inconsistent consideration of inequalities within contracts 6. Variability in quality and delivery across places 7. Seldom-heard groups may remain underrepresented 8. Quality and consistency of EIAs may vary 9. Quality measures may not capture experience or access disparities 10. Digital transformation may unintentionally increase exclusion 11. Significant variation between localities may remain	1. Establish clear programmes linking inequalities priorities to resource allocation and delivery plans 2. Strengthen use of population segmentation and demand forecasting within commissioning cycles 3. Introduce inequality-disaggregated performance reporting by place, ethnicity, deprivation and protected characteristic 4. Implement integrated patient experience framework and thematic reporting 5. Strengthen contractual requirements relating to equitable access and experience 6. Develop system-wide expectations and oversight arrangements 7. Expand targeted engagement and co-production approaches 8. Strengthen assurance and review of equality impact assessments 9. Incorporate equity and experience measures within quality reporting 10. Undertake digital inclusion assessments and mitigation plans 11. Target support towards areas exhibiting highest need and poorest access outcomes		• Access and performance dashboards. • Referral-to-treatment monitoring. • Cancer and diagnostic waiting time reports. • Primary care access metrics. • Community and mental health access measures. • Place-based performance reviews. • Health inequalities action plans. • Patient experience reports. • Complaints trend analysis. • Equality impact assessments. • Core20PLUS5 programme reporting.		• Quality Committee scrutiny. • Population Health and Inequalities Committee oversight. • Executive performance reviews. • Board assurance reporting. • Quality governance framework. • Equality and diversity governance arrangements. • Commissioning oversight meetings. • Integrated performance reports.		• Internal audit reviews of health inequalities governance. • Internal audit reviews of commissioning effectiveness. • Independent reviews of public engagement arrangements. • NHS England oversight assessments. • CQC assessments of system working and quality governance. • External benchmarking against peer ICBs. • Independent population health evaluations.	

BAF0002	TBC	2-4	Sarah Griffiths/ Fiona Head	Finance Planning and Payer Function Committee	Financial Sustainability & Value	If demand, cost pressures and system inefficiencies are not effectively managed, then the ICB and wider system will be unable to operate within available resources, resulting in failure to meet statutory financial duties and reduced ability to invest in priority services and transformation.	Brief description of direction of measures	Cautious	1. Medium-term financial plan aligned with strategic objectives, operating plans and system priorities 2. Board-approved annual revenue and capital plans, budgets and control totals 3. Standing Financial Instructions, Scheme of Reservation and Delegation, budgetary control arrangements and expenditure approval limits 4. Monthly budget monitoring, forecasting and variance reporting 5. Demand and activity planning using population, referral, waiting list and service utilisation information 6. Contract management processes, provider agreements, service specifications and performance reviews 7. Provider financial oversight through system finance arrangements and executive reviews 8. Medicines optimisation programmes, prescribing monitoring and pharmacy governance 9. Business case process, investment panel and financial appraisal requirements 10. Programme and project governance, business cases and transformation reporting 11. Procurement controls, benchmarking and service reviews 12. Financial risks recorded on corporate and directorate risk registers 13. Reserves policy and contingency arrangements 14. Capital programme, prioritisation arrangements and monitoring controls 15. General ledger controls, reconciliations, financial reporting systems and information governance 16. Budget-holder training and Finance business partnering 17. Quality impact assessment of savings and service	1. Utilisation Management processes need further development	1. Developing an ICB finance plan for 2026/7 2. Develop and implement a Central East ICB Medium-Term Financial Strategy (MTFS) and associated Financial Recovery Plan 3. Undertake robust challenge and sensitivity testing of key assumptions and clearly identify the recurrent and non-recurrent elements of the plan 4. Establish a single system planning framework, agreed assumptions, shared risk scenarios and clear accountability for delivery 5. Review and approve a consolidated financial governance framework, including budget-holder accountability and escalation arrangements 6. Introduce forecast accuracy measures, mandatory recovery plans for material variances and clearly defined escalation thresholds 7. Create a fully developed efficiency portfolio with named senior responsible owners, milestones, dependencies, benefits profiles and quality impact assessments 8. Develop an integrated demand, activity, capacity and finance model, supported by scenario planning and population health intelligence 9. Strengthen contract management through standard reporting, financial reconciliations, dispute management and early escalation of emerging pressures 10. Establish an ICB-level system sustainability assessment covering provider risks, dependencies, service consequences and potential commissioning responses 11. Strengthen forecasting, horizon scanning, formulary compliance, biosimilar use and prescribing variation reviews 12. Standardise financial and clinical controls, strengthen package review arrangements and develop an integrated complex	Utilisation Management processes in development	- Executive Team review and challenge. - Committee oversight - Utilisation Management and Quality Improvement Scrutiny - Utilisation Management Development Committee. - Board review of the system financial position. - Chief Finance Officer assurance. - Counter-fraud arrangements. - Finance Programme Board and the 5 Groups feeding into it working on: - All Age Continuing Health Care - Prescribing - Neurodiversity - Acute variable activity - Further opportunities	Aligned to the agreed 2026/27 internal audit programme
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BAF0003	TBC	2,4,7 & 8	Louis Kamfer/ Sarah Griffiths	Finance Planning and Payer Function Committee	Commissioning, Contracting & Market Management	<i>If commissioning decisions, contracting arrangements and market oversight are not robust, then services may become unsustainable, misaligned to need or fail to deliver expected performance, resulting in service disruption, reduced quality and poor value for money.</i>	<i>Brief description of direction of measures</i>	Balanced	4x3=12	- Contract management; - Procurement governance - Board-approved commissioning strategy, five-layer care model and priority pathways provide a clear basis for commissioning decisions. - A single commissioning and improvement life-cycle sets defined decision points from needs assessment and testing through business case, mobilisation, assurance and service exit. - Commissioning decisions use population health, utilisation, inequalities, quality, experience and financial intelligence. - Standard business-case, procurement, contracting and due-diligence processes test strategic fit, affordability, benefits, provider readiness and continuity. - Material contracts have named executive, commissioning and contract-management ownership, with routine review of outcomes, quality, access, utilisation, finance and contractual delivery. - The contract register and forward pipeline support timely recommissioning, while contractual remedies and escalation routes address underperformance.	- Demand and capacity modelling capability is not yet sufficiently sophisticated to identify significant market gaps. - Provider-model readiness, market capacity, financial risk-sharing and continuity plans remain variable. - Legacy commissioning, contract-management and data arrangements are not yet consistently standardised across Central East. - Significant shifts in the provider market will require greater system collaboration and maturity	- Develop an intelligence-led view of future demand, capacity and utilisation to identify market gaps and focus market development. - Apply learning from integrated neighbourhood models and integrator contracting to shape scalable provider models, risk-sharing and system collaboration. - Strengthen the payer function for existing contracts through consistent review of utilisation, outcomes, quality, variation and value, with timely contractual action where delivery is off track. - Establish common outcome measures and use them to identify and address unwarranted variation across providers, pathways and places		- Approved commissioning intentions. - Population needs assessments and pathway reviews. - Equality and health inequalities impact assessments. - Patient and public engagement reports. - Provider due-diligence records. - Contract performance dashboards. - Contract review meeting minutes. - Remedial action and service improvement plans. - Market intelligence and provider sustainability assessments.		- Executive Team scrutiny. - Finance and Performance Committee oversight. - Procurement or Provider Selection Regime assurance. - Legal Services review and external expert legal advice of high-risk decisions and contractual disputes. - Risk management oversight of commissioning and market risks.		- Aligned to the agreed 2026/27 internal audit programme: - Internal audit of strategic commissioning - Internal audit of contract management - Internal audit of Provider Selection Regime compliance. - Internal audit of the contract register and contract execution. - Internal audit of provider due diligence and market management. - External audit value-for-money work. - NHS England oversight and commissioning reviews. - Independent review of significant procurement or provider-selection decisions. - Counter-fraud review of procurement and contracting controls. - External legal review of high-risk or contested arrangements	

BAF0004	TBC	5,7,8 & 9	Sarah Stanley	Utilisation Management & Quality Improvement Committee	Quality, Safety & Reliability	<i>If quality surveillance, assurance and improvement mechanisms are not effective across commissioned services, then variation in care standards and safety risks may not be identified or addressed in a timely way, resulting in patient harm, regulatory action and loss of public confidence.</i>	<i>Brief description of direction of measures</i>	Averse	4x4 = 16	- Board-approved "Our Way" strategy and quality governance framework setting out responsibilities, reporting and escalation arrangements - UMQUIC receives regular reports on quality, safety, experience and safeguarding - Routine quality risk stratification using provider, regulatory, patient safety, safeguarding, workforce and experience information - Providers and commissioned services assessed using risk-based quality profiles - Regular review of provider quality reports and quality oversight as part of the contract review meetings with the providers - Provider mortality review processes and system review of mortality data and concerns - Processes for receiving, distributing and monitoring national patient safety alerts - Statutory safeguarding leadership, safeguarding governance and multiagency arrangements - Infection prevention arrangements, surveillance data and outbreak response processes - Medicines optimisation governance, controlled drug arrangements, prescribing surveillance and incident learning - Clinical audit, outcomes monitoring, evidence-based guidance and quality standards - Monitoring of staffing, vacancies, turnover, sickness, training and professional concerns - Medical, nursing and other professional leadership, revalidation and professional	- Arrangements may differ across predecessor ICB areas or may not clearly define accountability between ICB, place and system structures - Variation in provider processes and limited triangulation with complaints, incidents, inequalities and clinical outcomes - Quality requirements may vary between contracts or may not be sufficiently measurable and enforceable - Aggregate data may conceal poorer safety, experience or outcomes among particular communities - Quality intelligence may be variable across, dental, pharmacy and optometry services - The ICB may have less timely intelligence or weaker relationships with smaller and independent providers	Introduce an integrated risk stratification process that brings together intelligence, trends, risks, interventions and outcomes	- Provider quality and safety dashboards. - Patient safety incident and thematic reports. - Provider incident-response plans and learning reports. - Mortality reviews and learning-from-deaths reports. - Safeguarding reports. - Infection prevention and control surveillance. - Medicines safety reports. - Clinical audit findings. - Patient experience and complaints analysis. - Workforce and safe-staffing information. - Freedom to Speak Up themes. - Quality review meeting records. - Contract quality schedules. - Quality improvement and remedial action plans. - Patient safety alert compliance. - Quality impact assessments. - Provider risk profiles. - Evidence of completed and sustained improvement actions.	- UMQIC oversight. - Executive Team scrutiny. - Exec Clinical Director Assurance - System Quality Group oversight. - ICB quality assurance teams. - Safeguarding governance. - Medicines optimisation governance. - Infection prevention and control oversight. - Patient safety specialist review. - Contracting and commissioning assurance. - Corporate risk management review. - Information governance and data-quality oversight. - Population health and inequalities oversight. - Finance and Performance Committee consideration of quality consequences. - Remuneration and Workforce Committee scrutiny of workforce-related quality risks. - Formal escalation to the Board.	- Specialist external review including: - GIRFT review - Critical Care network - Trauma network etc - Internal audit of quality governance and surveillance. - Internal audit of patient safety governance. - Internal audit of safeguarding arrangements. - Internal audit of quality impact assessments. - Internal audit of contract quality management. - CQC inspections, ratings and enforcement activity. - NHS England quality and performance oversight. - Independent clinical reviews. - Royal College reviews. - Healthcare Safety Investigation Branch or successor body findings, where relevant. - External safeguarding reviews. - Independent investigations into serious service failures. - External clinical audit and accreditation. - Peer review by other ICBs or clinical networks. - External audit value-for-money consideration of quality governance where relevant.
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										concerns processes										
										14. Service specifications include quality standards, outcomes and reporting requirements										
										15. Contract review processes, quality schedules, remedial action plans and contract sanctions										
										16. Review of provider Quality Accounts and supporting evidence										
										17. Monitoring of CQC ratings, inspection reports, enforcement action and other regulatory findings										
										18. Complaints, surveys, PALS, Healthwatch, engagement and patient feedback										
										19. ICB and provider complaints monitoring and thematic review										
										20. Provider and ICB Freedom to Speak Up arrangements										
										21. Primary care quality and performance arrangements, clinical leadership and improvement support										
										22. Contract monitoring and quality reporting requirements for independent providers										
										23. Quality monitoring of placements, package reviews, safeguarding and provider concerns										
										24. Quality improvement programmes, clinical networks and improvement support										
										25. Provider continuity plans and escalation arrangements for service disruption										
										26. Defined datasets, validation processes and provider reporting requirements										
										27. System learning forums, bulletins, networks and shared improvement activity										

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BAF0005	TBC	9	Karen Barker	Remuneration and Workforce Committee	Organisational Capacity, Capability & Culture	<i>If the ICB does not have sufficient capacity, capability, leadership and the right organisational culture, then it will be unable to effectively plan, prioritise and deliver its strategic objectives, resulting in underperformance, missed opportunities and reduced system impact.</i>	<i>Brief description of direction of measures</i>	Balanced	3x4=12	1. Annual workforce review aligned to financial plan and operating plan 2. Approved organisational structure and scheme of delegation 3. Recruitment controls, establishment control process, retention initiatives 4. Leadership development programmes 5. Annual appraisal and objective-setting process 6. Mandatory training and professional development programmes 7. Staff survey, pulse surveys and staff engagement programme 8. EDI strategy and workforce monitoring 9. Corporate objectives and performance review process 10. Change programmes and transition governance 11. Wellbeing strategy, occupational health support and employee assistance programme	1. Workforce plan focuses on establishment numbers rather than strategic capability requirements 2. Uncertainty over capacity in new structure. 3. Vacancies in specialist roles 4. Limited succession planning for key leadership roles 5. No systematic identification of high-potential staff 6. Training provision not linked to future organisational capability requirements 7. Differential staff experience not fully addressed 8. Linkage between workforce capability and strategic delivery 9. Risk of change fatigue 10. Rising workload, burnout or sickness trends	1. Develop a strategic workforce plan aligned to organisational objectives and transformation priorities 2. Undertake mid year appraisals to quickly understand capacity and priorities. 3. Develop targeted recruitment and retention strategy for critical posts 4. Implement formal succession planning and talent management framework 5. Conduct capability assessment and establish targeted development programmes where relevant 6. Implement culture improvement plan with measurable outcomes 7. Introduce workforce performance metrics into organisational performance reporting 8. Deliver structured organisational development and change management programme 9. Develop proactive workforce wellbeing and resilience plan		- Workforce plan delivery reports. - Vacancy and turnover reporting. - Sickness absence monitoring. - Appraisal completion rates. - Mandatory training compliance. - Recruitment metrics. - Staff survey action plans. - Organisational development programme reporting. - Executive workforce reviews. - Directorate workforce dashboards.		- Remuneration and Workforce Committee - EDI governance reporting. - Workforce planning reviews. - Benchmarking against NHS workforce indicators		- Internal audit review - External audit value-for-money reviews. - NHS England oversight assessments. - CQC Well-Led assessments. - Independent staff survey benchmarking.	

BAF0006	TBC	2,4,7 & 8	Louis Kamfer	Finance Planning and Payer Function Committee	Data, Digital & Intelligence	<i>If data quality, digital infrastructure and analytical capability are insufficient or fragmented, then decision-making, performance oversight and service transformation will be constrained, resulting in inefficiencies, missed insights and poorer outcomes for the population.</i>	Brief description of direction of measures	Open	3x3=9	1. An approved strategy aligned to the ICB's strategic objectives and transformation priorities 2. Executive and committee oversight of digital, information and intelligence priorities 3. Defined roles for the ICB, providers, places, shared services and system partners 4. Architecture standards and review processes for new systems and integrations 5. Managed networks, devices, cloud services, collaboration tools and connectivity arrangements 6. Application inventories, licensing controls and system ownership 7. Shared care records, interfaces, data integration platforms and agreed technical standards 8. Data models, data warehouses, integration platforms and common definitions 9. Named information asset owners, data owners and data stewards 10. Common definitions, coding standards, metadata and business rules 11. Agreed reference data for providers, services, geographies, workforce and organisational structures 12. Integrated performance dashboards and routine executive and committee reporting 13. Use of trends, variation analysis and statistical process control where appropriate 14. Population health management tools, segmentation, needs assessment and inequalities analysis 15. Analysis by deprivation, ethnicity, geography and other relevant population characteristics 16. Business intelligence teams, public health expertise and analytical networks 17. Peer review, methodology documentation, version control and reproducibility requirements	1. Strategies may remain fragmented across predecessor organisations or focus on technology rather than business and population outcomes 2. Accountability may be dispersed across digital, performance, transformation, finance and information governance functions 3. Responsibilities for infrastructure, applications, analytics, data quality and support may be unclear following organisational change 4. Legacy applications and local solutions may lead to duplication, poor interoperability and increased support costs 5. Infrastructure may vary across locations, teams and legacy organisations, with inconsistent resilience and user experience 6. Multiple systems may perform similar functions, with unclear ownership, duplicated costs and fragmented information 7. Information may not flow reliably between primary, community, mental health, acute and social care services 8. Data may be stored across multiple platforms without a single authoritative source or consistent identifiers 9. Data-quality management may be reactive, inconsistent or focused on national submissions rather than operational decision-making 10. Ownership may be unclear for cross-directorate and system datasets 11. Metrics may be calculated differently across reports, places and providers 12. Inconsistent reference data may prevent reliable comparison and consolidation 13. Reports may be manually produced, retrospective or inconsistent across committees 14. Intelligence may not be consistently translated into commissioning, resource allocation 15. Aggregate reporting may conceal significant variation and poorer outcomes for particular communities 16. Capability may be distributed unevenly, with duplicated activity, skill gaps and key-person dependencies 17. Analytical teams may be dominated by reactive requests and routine reporting, limiting strategic analysis	1. Develop a single Central East ICB Data, Digital and Intelligence Plan with clear priorities, outcomes, investment requirements and accountable owners 2. Agree a target operating model supported by a responsibility matrix, service catalogue and formal service-level arrangements 3. Develop an enterprise architecture roadmap covering applications, data, integration, infrastructure, security and retirement of legacy systems 4. Complete an infrastructure baseline assessment and implement a prioritised convergence and remediation plan 5. Establish a complete application register and rationalisation programme based on strategic fit, cost, risk, interoperability and user need 6. Develop an interoperability roadmap with prioritised use cases, common standards, data-sharing arrangements and measurable benefits 7. Develop a system data architecture map identifying authoritative datasets, data flows, ownership, retention and integration requirements 8. Implement an ICB-wide Data Quality Framework with agreed dimensions, standards, owners, thresholds and escalation requirements 9. Assign accountable data owners and operational stewards for all critical datasets and reporting products 10. Establish a controlled metric library and data dictionary with agreed definitions, lineage, calculation rules and approval arrangements 11. Introduce master data controls and common reference datasets across analytical and reporting systems 12. Develop a single integrated performance architecture with automated dashboards, common definitions and clear	• Digital and data strategy delivery reports. • Data-quality dashboards and exception reports. • Information asset and system registers. • Data owner and steward attestations. • Performance dashboard validation records. • Data dictionaries and metric definitions. • Analytical peer-review records. • Cybersecurity monitoring and vulnerability reports. • Patching and access-control reports. • Information governance incident reports. • Data Protection Impact Assessments. • Data-sharing agreement registers. • Service desk and system availability reports. • Business continuity and disaster recovery test results. • Supplier performance reports. • Digital programme delivery reports. • Benefits realisation reports. • Clinical safety cases and hazard logs. • User adoption and satisfaction data. • Digital inclusion assessments.	• Executive Team scrutiny. • Board or committee oversight of digital and intelligence priorities. • Finance and Performance Committee review of information quality. • Audit and Risk Committee oversight of cybersecurity, data and control risks. • Quality Committee review of clinical safety and quality intelligence. • Chief Information Officer or equivalent executive assurance. • Data Protection Officer oversight. • Caldicott Guardian assurance. • Senior Information Risk Owner oversight. • Clinical safety officer review. • Corporate information governance arrangements. • Cybersecurity governance. • Data-quality and performance assurance groups. • Enterprise architecture and digital investment review. • Programme management office assurance. • Internal risk management review.	• Internal audit of data quality and performance reporting. • Internal audit of digital governance and investment controls. • Internal audit of information governance and records management. • Internal audit of cybersecurity and access controls. • Independent penetration testing and security assessments. • Independent review of business continuity and disaster recovery. • External assurance over relevant national data-security requirements. • External audit review of information supporting financial and performance reporting. • Independent clinical safety review. • Independent evaluation of significant digital transformation programmes. • Peer review by another ICB or NHS digital leadership network. • Supplier assurance certifications and independent control reports.
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										and analytical projects 36. Mandatory training, specialist development and digital literacy support 37. Portfolio and programme management arrangements for digital transformation	accountability and human review 37. Lawful processing may be considered without sufficiently assessing fairness, public acceptability or unintended consequences 38. Digital and data literacy may vary across Board members, managers and operational teams 39. Dependencies, resources and benefits may not be managed consistently across programmes	logs for relevant technologies 27. Implement standard change-control requirements proportionate to operational, information and clinical risk 28. Require digital inclusion and equality assessments for patient-facing digital changes, with measurable mitigations 29. Establish a digital investment framework covering strategic fit, whole-life cost, interoperability, security, clinical safety and benefits 30. Assign benefit owners, agreed baselines and post-implementation review requirements to material digital investments 31. Establish tiered supplier assurance based on data sensitivity, clinical significance, criticality and substitutability 32. Introduce an AI and automation governance framework with risk classification, impact assessment, testing, monitoring and accountable human oversight 33. Develop data ethics principles and review arrangements for high-impact or novel uses of data 34. Develop role-based capability programmes covering data interpretation, digital leadership, cyber awareness and responsible use of AI 35. Maintain a prioritised digital portfolio with delivery confidence ratings, dependency mapping and escalation triggers							

BAF0007	TBC	1,4,6 & 7	Maria Wogan	Neighbourhood Committees	Partnerships, Neighbourhoods & Integration	<i>If collaboration and alignment across system partners is ineffective, then services will remain fragmented and opportunities for integrated care will not be realised, resulting in poorer patient experience, inefficiencies and suboptimal population outcomes.</i>	Brief description of direction of measures	Balanced	1. Integrated care strategy setting out shared system priorities and intended population outcomes 2. Joint Forward Plan developed with NHS providers and informed by wider system priorities 3. Formal partnership boards, place partnerships, provider collaboratives and programme governance 4. Partnership arrangements involving the ICB, local authorities and wider partners 5. Place partnerships and place-based leadership arrangements 6. Integrated neighborhood teams and neighborhood-level planning arrangements 7. Scheme of Reservation and Delegation and place-level decision arrangements 8. Named executive, place and programme leadership 9. Partnership agreements or memoranda of understanding defining roles and ways of working 10. Joint planning and commissioning arrangements with local authorities and other partners 11. Section 75 agreements, Better Care Fund arrangements and other pooled or aligned budgets 12. Better Care Fund plans, metrics and partnership oversight 13. Provider collaborative governance and joint transformation programmes 14. Primary care networks, primary care leadership and neighborhood development programmes 15. Joint governance and working arrangements with upper-tier and district or borough councils 16. Joint pathways, discharge arrangements and integrated commissioning 17. Joint commissioning and partnership arrangements across health, education	1. Strategic priorities may be expressed broadly without clear delivery responsibilities, milestones or measures 2. Organisational plans may not fully align with the Joint Forward Plan or may contain conflicting assumptions 3. Governance may be complex, duplicated or unclear, particularly following the formation of Central East ICB 4. Strategic agreements may not consistently translate into operational delivery 5. Place maturity, authority and capability may vary significantly across the Central East geography 6. Neighbourhood definitions, leadership, services and maturity may be inconsistent 7. Decision rights may be unclear between the ICB, places, neighbourhoods, providers and local authorities 8. Partnership accountability may be collective in principle but unclear when delivery fails 9. Agreements may be outdated, inconsistent or insufficiently specific about accountability and escalation 10. Joint commissioning may be fragmented across pathways and localities, with different processes and priorities 11. Financial responsibilities, risk-sharing and benefits may not be sufficiently transparent 12. Delivery may focus on national process requirements instead of sustainable service integration and outcomes 13. Provider priorities may not align fully with ICB commissioning intentions or wider partnership objectives 14. Primary care capacity, engagement and maturity may vary, limiting its ability to lead or participate in integration 15. Different financial pressures, statutory responsibilities and political priorities may constrain alignment 16. Operational pressures may lead to cost-shifting, disputes or fragmented patient pathways 17. Fragmented accountability may continue across SEND, mental health, safeguarding and complex care pathways 18. VCSE partners may be consulted but not consistently involved in design, decision-making or delivery 19. Partnership priorities may be shaped primarily by	1. Translate the strategy into a jointly owned delivery plan with defined outcomes, accountable partners, milestones and measures 2. Establish an annual alignment and assurance process covering ICB, provider, place and partnership plans 3. Develop a single partnership governance framework showing the purpose, authority, membership and reporting route of each forum 4. Establish a clear route from Integrated Care Partnership priorities to funded programmes, accountable delivery groups and outcome reporting 5. Define a consistent minimum operating model for places while allowing proportionate local flexibility 6. Agree a Central East neighbourhood framework covering population footprints, core functions, leadership, governance and development expectations 7. Produce a clear delegation map identifying reserved, delegated, shared and advisory responsibilities 8. Assign a single accountable lead for each priority outcome, supported by jointly agreed responsibilities for contributing partners 9. Review and standardise partnership agreements, including decision-making, dispute resolution, information sharing and exit arrangements 10. Develop a joint commissioning framework and a prioritised pipeline of opportunities for integrated commissioning 11. Introduce standard financial governance, risk-sharing, monitoring and benefits-realisation requirements for pooled arrangements 12. Connect Better Care Fund schemes to wider neighbourhood, urgent care, prevention and admission-avoidance priorities	• Integrated care strategy delivery plans. • Joint Forward Plan progress reports. • Place and neighbourhood development plans. • Partnership agreements and memoranda of understanding. • Delegation schedules and responsibility maps. • Section 75 and pooled-budget monitoring. • Better Care Fund reporting. • Joint commissioning plans. • Provider collaborative delivery reports. • Integrated pathway performance reports. • Neighbourhood population health profiles. • Integrated workforce plans. • Multidisciplinary team activity and outcome measures. • Partnership programme risk registers. • Joint financial and benefits reports. • Patient experience and community feedback. • Health inequalities impact assessments. • Programme evaluations. • Service continuity and escalation plans. • Minutes and action logs from partnership forums.	• Executive Team scrutiny. • Board oversight of system integration and partnership delivery. • Relevant Board committee oversight. • Integrated Care Partnership review. • Place leadership and assurance arrangements. • Finance review of pooled and joint funding arrangements. • Quality oversight of integrated pathways. • Population health and inequalities assurance. • Corporate governance review of delegation and partnership agreements. • Legal review of joint working, delegation and pooled-budget arrangements. • Programme management office assurance. • Risk management review of partnership and integration risks. • Information governance oversight. • Workforce and organisational development review. • Internal commissioning assurance	• Internal audit of partnership governance. • Internal audit of place and delegated decision-making arrangements. • Internal audit of Section 75 agreements and pooled budgets. • Internal audit of Better Care Fund governance and delivery. • Independent evaluation of neighbourhood health programmes. • External audit value-for-money work. • NHS England oversight or peer review. • Independent governance review of partnership structures. • External legal review of complex delegation and joint commissioning arrangements. • Peer review by another ICB or system. • Independent evaluation of integrated pathways and population outcomes. • Independent assessment of partnership or neighbourhood maturity.
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BAF0008	TBC	2, 4 & 5	Sarah Stanley	Utilisation Management & Quality Improvement Committee	Transformation & Delivery Discipline	<i>If transformation and improvement programmes are not prioritised, governed and delivered with sufficient and proportionate rigor and pace, then required changes will not be implemented at scale, resulting in failure to deliver strategic objectives, benefits realisation and national policy requirements.</i>	<i>Brief description of direction of measures</i>	Open	4x4 = 16	- Transformation and priority improvement priorities aligned to the ICB's Our Way strategy, Joint Forward Plan and national planning requirements - Clearly articulated commissioning lifecycle to support consistent delivery at pace. - Commissioning lifecycle includes clear process for sunsetting programmes as appropriate. - Executive or committee processes for identifying and approving transformation programmes - Delivery plan articulating transformation and improvement priorities for the ICB - Delivery Unit oversight of progress and reporting function for priority programmes, including assurance framework. - Clear governance including senior responsible owners. - Matrix working to support delivery, with key programmes have access to BI analysts, improvement advisors, clinical leads etc. - Resident involvement and co-production. - Business cases and option appraisals for major transformation proposals - Routine monitoring of key milestones and deliverables, including stock take meetings for priority programmes - Clinical and professional leaders involved in programme governance and pathway redesign - Transformation plans linked to place and neighbourhood priorities - Business case and investment approval arrangements - Intended financial, operational, quality and population benefits identified in business cases - Commissioning intentions, service specifications and contractual mechanisms	- Programmes may be approved individually without considering total capacity, affordability, dependencies or opportunity cost - Programme governance may vary in maturity, impacting on programme delivery. - The volume of transformation and improvement priorities, alongside limited resource, may impact on the timescales for delivery. - Business cases may not contain sufficiently robust baselines, implementation plans, workforce implications or benefit assumptions - Programmes may begin before scope, funding, ownership, capacity and expected benefits are sufficiently defined - Repeated slippage may be accepted without re-planning, escalation or intervention - Risks may be recorded but not quantified, escalated or connected to the corporate risk framework - Scope may expand incrementally without evaluating cumulative impact on capacity, affordability or benefits - Programmes may depend on staff delivering transformation alongside substantive business as usual duties - Representation at meetings may not translate into organisational commitment, capacity or delivery - Central programmes may not reflect local context, while local initiatives may duplicate system activity - Patients and communities may be involved too late to influence programme design - Investment may be spread across too many initiatives, limiting successful delivery at scale - Savings may not be recurrent or may be claimed by more than one programme - Baseline information may be incomplete or unavailable, making impact difficult to demonstrate - Digital dependencies may be identified late or assume infrastructure and interoperability that are not yet available - Existing contracts may not support new models or may create financial and operational barriers - Programmes may not adequately plan for	- Ongoing review and refinement of delivery plan. - Define minimum governance standards for all material transformation and improvement programmes, including lighter governance where required to support innovation and programme ownership. - Confirm accountabilities, decision rights, expected capacity and escalation responsibilities for each senior responsible owner - Ongoing development of tier 3 governance to support oversight and delivery. - Require documented comparison of options, including costs, benefits, risks, equality effects, deliverability and the consequences of doing nothing - Require clear reporting with improvement lens to articulate aim, anticipated impact (for residents and from utilisation perspective), timeframes, actions and next steps. - Standardise programme risk management and define escalation routes to corporate risks, committees and the BAF - Maintain decision logs, identify required decision-makers and establish timescales for critical decisions - Establish realistic programme resource plans and identify protected capacity for critical transformation activity - Define clinical and professional leadership requirements for relevant transformation programmes - Map transformation and improvement activity across system, place and neighbourhood levels - Build proportionate engagement and co-production into programme initiation, design and evaluation - Require early assessment, measurable mitigations and post-implementation	- Transformation programme business cases and initiation documents. - Programme-level risk logs. - Programme board/ priority programme minutes and decision logs. - Equality and quality impact assessments. - Delivery Unit stock takes and reporting for priority programmes. - Priority programme oversight meetings - Relevant local data analysis - Provider and local quality/ performance reports - Resident/ patient experience, complaint's themes.	- Executive Team review - Board and relevant committee oversight - Commissioning and contracting assurance. - Procurement and legal review. - Corporate risk register and Board Assurance Framework - Population health and inequalities assurance.	- Internal audit to assess relevant aspects including programme oversight, improvement approach and impact. - Independent evaluation of major transformation or improvement programmes. - NHS England oversight of national programmes/ priorities - Peer review by another ICB or public-sector organisation. - External legal, commercial or technical review of complex programmes where indicated.
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RISK ID	Date open	SM ID	Risk Owner	Committee	Risk Title	Risk Description	Rationale for current risk score	Risk Appetite	Current risk score L x C = RS	Mitigations			Risk Directional Movement	Assurance					
										Key Controls in Place	Gaps in Controls	Actions to Strengthen the Controls in Place		1 st Line of Defence (Operational Controls)	Assurance Level	2 nd Line of Defence (Committees)	Assurance Level	3 rd Line of Defence (Audits/ Regulators/ External Submissions)	Assurance Level
										supporting transformation 18. Procurement and legal advice available to programme teams 19. Quality improvement methods, testing cycles and evaluation 20. Flexible resource within the ICB to prioritise transformation and improvement programmes.	disruption, delay or failure during transition 19. Technical or structural change may be delivered without sufficient behavioural or cultural adoption 20. Lessons may be documented but not systematically applied to future programmes 21. Impact assessments including quality and equality may not be robustly completed whilst processes are being established.	monitoring of differential impacts 14. Require multidisciplinary impact assessments at key programme gateways 15. Concentrate resources on a smaller number of high-impact, deliverable priorities 16. Require Finance sign-off of financial baselines, attribution, timing and recurrent impact 17. Define clear outcome, process, balancing and patient defined measures for all programmes 18. Confirm data requirements, sources, quality and analytical capacity at programme initiation 19. Develop suite of improvement focused templates and tools to support programme delivery 20. Identify required contractual changes early and align commissioning, procurement and contract timelines with programme plans 21. 22. Ongoing refining of criteria for testing, adaptation, scaling, stopping and transferring improvements into business as usual 23. Maintain a central lessons repository and require evidence that relevant learning informs new programmes 24. Integrate national requirements into the ICB's delivery plan 25. ICB wide mapping across Directorates to understand wider controls, gaps and mitigations relevant to BAF risk.							

BAF0009	TBC	4 & 6-8	Maria Wogan	Neighbourhood Committees	Population Health Outcomes	<i>If prevention and early intervention and action on wider determinants are insufficiently prioritised, then avoidable ill health will persist or increase, particularly in vulnerable groups, resulting in worsening population health outcomes and increased long-term system demand.</i>	<i>Brief description of direction of measures</i>	Averse	1. Health inequalities priorities and Core20PLUS5 programmes 2. Prevention priority programmes covering primary, secondary and tertiary prevention 3. Place partnerships use local intelligence to identify and address population need 4. VCSE partnerships, social prescribing, community outreach and locally trusted organisations 5. Engagement, co-production and community participation arrangements 6. Identifiable budgets and investment supporting prevention and early intervention 7. Use of public health evidence and clinical guidance 8. Public health and analytical teams produce population profiles and insight 9. Outcomes are analysed by deprivation, ethnicity, geography and other relevant characteristics 10. Public health expertise, analytical capacity and prevention skills across the system	1. Priorities may be broad, numerous or insufficiently connected to investment and operational delivery 2. Access, uptake and effectiveness may vary significantly between places and population groups 3. Programmes may be short-term, inconsistently funded or poorly integrated with clinical pathways 4. The ICB may have limited direct control and unclear influence over non-health determinants 5. Differing priorities, geographic footprints and financial pressures may weaken alignment 6. Place-level priorities and delivery capability may vary across Central East 7. Capacity pressures, variable performance and inconsistent incentives may constrain delivery 8. VCSE involvement may be short-term, project-based or unsupported by sustainable funding 9. Investment may remain weighted towards crisis and specialist services 10. Programmes may operate separately without a shared outcome framework 11. Aggregate uptake may conceal poorer coverage among particular communities 12. Short-term financial and operational pressures may displace preventive investment 13. Allocation may remain driven by historical expenditure or current service utilisation 14. Prevention expenditure may not be visible or protected during financial recovery 15. Traditional appraisal may undervalue benefits accruing over longer periods or across partner organisations 16. Contracts may focus on activity and process measures rather than prevention and outcomes 17. Benefits may be difficult to attribute, emerge after programme funding ends or accrue outside the investing organisation 18. Analytical capacity may be dominated by statutory reporting and reactive requests 19. Financial and operational plans may rely primarily on historic activity trends	1.	- Population health strategy delivery reports. - Place and neighbourhood population health plans. - Joint Strategic Needs Assessments and needs profiles. - Population segmentation and risk-stratification products. - Prevention programme delivery reports. - Core20PLUS5 and inequalities action plans. - Screening and vaccination uptake reports. - Primary and secondary prevention indicators. - Inclusion-health programme reports. - Provider and primary care improvement plans. - Outcome and inequalities dashboards. - Resource-allocation and investment decisions. - Community engagement and co-production evidence. - Joint commissioning and partnership plans. - Pooled-budget monitoring. - Programme evaluation and economic analysis. - Benefits-realisation reports. - Demand and prevalence modelling. - Contractual outcome reports. - Risk and issue registers.	- Executive Team scrutiny. - Board oversight. - Population Health and Inequalities Committee or equivalent. - Integrated Care Partnership review. - Quality Committee consideration of outcomes and inequalities. - Finance and Performance Committee scrutiny of investment and demand implications. - Place and neighbourhood assurance arrangements. - Director of Public Health and public health specialist challenge. - Chief Medical Officer and Chief Nursing Officer assurance. - Commissioning and contracting assurance. - Finance review of investment and benefits. - Corporate risk management review. - Equality and health inequalities assurance. - Analytical quality assurance. - Programme management office review of delivery and benefits.	- Internal audit of population health governance. - Internal audit of health inequalities arrangements. - Internal audit of prevention investment and benefits realisation. - Independent evaluation of major prevention programmes. - External public health evaluation or academic review. - External audit value-for-money work. - NHS England oversight or peer review. - Independent review of resource-allocation methodology. - Peer review by another ICB or local authority public health team. - Independent assessment of population health management maturity. - External evaluation of community and neighbourhood interventions.
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