Appendix 2 - ESNEFT Board Assurance Framework (BAF) – 26 June 2026

BAF1: Partnership Working

Strategic Objectives: **2. Joined up care: integration and community-based delivery**			
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	Interim Chief Exec	**Assurance committee**	Trust Board

	Impact	**Likelihood**	**Score**
Inherent	4	3	12
Residual	**4**	**3**	**12**
Target	3	2	6

Risk movement (last 3 quarters)

Q2 2025/26	**Q3 2025/26**	**Q4 2025/26**
4x3=12	4x3=12	4x3=12

Risk rating

12

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) • Norfolk and Suffolk ICB (1 April 2026) • Essex ICB (1 April 2026) • ESNEFT as an Anchor organisation and Anchor Programme Board • Mental health collaborative • Faculty of Education associated with University of Suffolk, University of Essex and Anglia Ruskin University • Specialised commissioning provider collaborative (East of England) • NHS England (Regulator) • Relationship with local authorities	Priority areas for joint working are established and identified in the annual plans, strategies, operational plans and business plans. ICB 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, People and Organisational Development Committee and Performance and Finance Committee Regular updates to the Board (through Chief Executive and Programme Director) detailing implications of changes to organisational legal status and roles Monthly performance review meetings with NHSE which will be reported to the Board, next meeting 22nd June
b) Formal partnerships in place to support the delivery of our goal to be a centre of excellence in research, education and innovation • Trust is part of RRDN – Regional Research Delivery Network • Close working with HTE - Health Technology East	Board to Board meetings (ESNEFT/ICB) to establish good relationships and ensure strategic alignment. ICB Research Collaborative Chaired by ICB Medical Director,
c) Hospital and community health services provided by Trust	Reporting via Integrated Patient Safety Report through 'Performance and Finance Committee' and 'Quality and Safety Committee' to Trust Board
d) Trust is a member of system wide governance including Norfolk and Suffolk ICB Board, Finance, Medical, Nursing, Workforce and Quality, Trust regularly attends Health Overview and Scrutiny Committee (HOSC) meetings.	Updates reported to Trust Committees;

Gaps in Controls and Assurances	Actions planned to improve controls and assurance	Impact of Actions on risk
Gaps in control: Significant system reconfiguration ongoing creating potential gaps in control. **Gaps in assurance:** • Resource limitations across system partners – including mental health and social care. • Potential duplication of system wide meetings (across two systems) • Potential post code lottery through varied commissioning • Reduced opportunity for formal engagement with Essex ICB as a result of not holding partner membership on the Essex ICB Board. • Risk of instability of the NHS Health Bill going through Parliament abolishing NHSE. • Political risk to proposed local government reorganisation and boundary changes.	1.Strengthen and embed effective partnership working across ICBs, provider organisations, primary care and local authorities to support delivery of integrated care and Trust priorities. This will focus on improving alignment of plans, clarifying roles and responsibilities, and ensuring that partnership arrangements are supported by clear governance, regular engagement and effective mechanisms for managing system risks and dependencies. **Milestones:** • June 2026: Revised ICB structures in place with roles and key relationships clearly defined across the system • September 2026: Demonstrable alignment between Trust plans and NHS system/commissioning priorities • By March 2027: Partnership working consistently supporting delivery of operational and strategic objectives • April 2027: Shadow revised local government boundary changes to be enacted • April 2027 new health bill implemented with implications for operational responsibility for example specialist commissioning. • April 2028: Implementation of revised local government boundaries.	**High**
	2.Develop neighbourhood-level working and adapt to changes in the wider system, including evolving commissioning arrangements and local authority structures, to support more joined-up, community-based care. • This will include strengthening relationships with Primary Care Networks, contributing to neighbourhood planning, and ensuring the Trust is actively engaged in shaping and responding to system transformation. • **Milestones:** • September 2026: Neighbourhood priorities and system changes understood and reflected in Trust engagement • December 2026: Development of joint working arrangements in place in priority areas, including with PCNs and local partners	**High**

Target risk rating Audit committee questions

Audit and Risk Committee questions	
Based on current planned actions what will the risk rating be at end March 2027? (Include Impact and Likelihood, Overall Rating)	Whilst partnership working is developing – as articulated within the Medium-Term Plan submissions, and new ICB arrangements are developing, a significant amount of uncertainty remains, therefore this risk is expected to remain at the current rating of 4x3=12 during 2026/27
Will the actions above deliver the end March 2027 target rating (Y/N), If No, what else needs to be done to deliver the target?	No these will not deliver by March 2027, however further milestones are detailed in the actions. Delivery of the target score is reliant on external providers and partnerships as well as National policy.
When should we expect the overall target to be met (narrative description)	To be reviewed following establishment of revised commissioning landscape, this also has dependencies on the political landscape.

***NB due to strategic nature of the risks on the BAF they are unlikely to be mitigated fully in year but an indication of likely movement is required.**

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 movement (last 3 quarters)**			**Risk rating**
Inherent	4	4	16				
Residual	**4**	**4**	**16**	**Q2 2025/26**	**Q3 2025/26**	**Q4 2025/26**	**16**
Target	4	3	12	4x4=16	4x4=16	4x4=16	

Key Controls	**Assurances reported to Board and committees**
a) Medium Term Planning	The following headlines summarise the MTFP from a finance perspective. 1**. Multi-Year Financial Planning -**Three-year revenue and four-year capital settlements underpin the framework. NHS Trusts must produce multi-year revenue finance plans aligned with operational priorities. Revenue balance projected for 3 years (26/27 to 28/29). CDEL to be met in all years; - There is organisational risk with this position. **2. Allocations & Contracting** ICB allocations for 2026/27 to 2028/29 are confirmed, with guidance on: Revenue finance planning & Capital investment priorities. Draft NHS Payment Scheme (NHSPS) and NHS Standard Contract for 2026/27 are part of the financial architecture. The actual allocations to the Trust from commissioners are still to be finalised. **3. Financial Sustainability Targets** 2% annual productivity improvement mandated across systems. Emphasis on reformed payment models to incentivise care closer to home and integrated delivery. Move away from annual cycles to rules-based planning for transparency and accountability. **4. Capital Investment Four-year capital guidance** supports: Digital infrastructure (EPR). Community diagnostic centres Estate modernisation for integrated care. **5. Risk & Contingency** Framework acknowledges financial risks, including: Potential unfunded cost pressures. Systems expected to build robust contingency plans. **6. Incentives & Reform** Updated ICB funding formula and urgent & emergency care (UEC) payment reforms. Focus on fairer funding distribution and long-term transformation rather than short-term fixes. The expectation is that we will deliver revenue balance supported by the controls in the BAF (also see actions below). There will continue to be an added challenge linked to the disaggregation of Suffolk and North East Essex ICB into the new ICB form, the fact that the Trust's services now straddle two main ICBs) and the likelihood of in year productivity clawback.
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 monthly courses and local support from OFM Teams. DAM leadership in developing and monitoring these plans, with escalation through P&FC to Trust Board. An agreed financial framework is in place. Alongside the primary divisional CIP process and accountabilities, we have implemented a centralised approach to CIP identification and delivery which includes a central resource and focus to support both clinical and support service transformation (continuous improvement board; smarter support services etc)
c) The NHS National Oversight Framework (NOF) assigns organisations to segments based on Operational performance	NHS England retains powers to: • Mandate recovery plans for trusts in lower segments. • Deploy turnaround directors or leadership support. • Apply contractual levers via ICB commissioning.

	(e.g., elective recovery, urgent care, cancer targets). Financial sustainability (balanced or surplus position required for higher segments). Leadership capability and governance strength.	Improvement support will be tailored to segment level, with more intensive oversight for segments 4 and 5 The Trust is in segment 4 at Q3 2026-27. At Q4 there is some confidence that we will be in segment 3 which is the maximum that can be achieved when in deficit financially. The Trust will use the medium term and annual business planning processes to identify opportunities, review current ways or working and minimise waste in order to maximise resources for care. The Trust monitors and reports its performance against the NOF each Qtr., including future projections / forecasts.
d)	From April 2026, ICBs and NHS trusts must each deliver financial breakeven individually. The previous system breakeven duty (aggregate across the ICS) is removed. ICBs and trusts must work together on aligned plans addressing population health needs and priorities.	NHS England will: • Hold NHS trusts accountable for the effective delivery of services. • Hold ICBs accountable for commissioning and ensuring delivery of agreed plans. Emerging clarity around how NHSE will oversee and regulate providers as set out in the 26/27 draft NOF guidance. Continue to use Regional DOF meetings to influence the NHSE Regional DOF who in turn can attempt to influence the NHSE National DOF. To actively participate and influence in the developing commissioning landscape of the Suffolk and Norfolk ICB and the Essex ICB. This is likely to present both risks and opportunities as both Norfolk and Essex have significant deficit funding which will reduce over time.
e)	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. • Support Divisions to continue identifying strategic change opportunities (e.g. Spec Comm) • Support and educate Divisions to understand and implement strong financial governance processes. • Implement areas of improvement identified through benchmarking, strengthening processes in relation to budget reporting and monitoring. • To tightly manage the revenue consequences of recent and future capital investment to maximise opportunities and avoid the risks of poor implementation
f)	Internal Audit Cyclical review of systems and processes and External Audit VFM review	Reporting to Audit Committee and Trust Board.
g)	Benchmarking using Model Health system, GIRFT , AdviseInc, ETC	Reporting to PAF and Trust Board. Trust reviewing national bench marking data with a specific objective to improve productivity. Presentations to EMC, POD and PFC. The Darzi report refers to the need to improve productivity and contains significant data to support its conclusions and recommendations. The Trust can use this data in support of its work to maximise its efficiency and effectiveness.
h)	Effective Procurement Systems and process	Monthly Reports to Medical Devices Management Group and Quarterly updates to Clinical Reference Group, Implementation of the Trust non pay oversight group

Gaps in Controls and Assurances	Actions planned to improve controls and assurance	Impact of Actions on risk
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	1. Continue to model different financial scenarios as intelligence becomes available and review model performance on a quarterly basis	Medium
	2. Review 10 year plan and medium-term clinical strategy to assess the potential impact/opportunities for service efficiency and productivity. 30/6/2026	Medium
	3. Embed the centralised approach to CIP by Q1 2026/27	High
	4. Review and update as necessary all financial recovery plans by Q1 2026	High
	5. Review by divisions of the financial actions and expenditure controls assessment originally undertaken in Summer 2023 based on NHSE recommendations / best	High

resulting in unfunded inflationary pressures, for example	practice and HFMA guidance by Q2 2026	
	6. Produce a complete reconciliation of staff increases since 19/20 by Q1 2026	**High**
	7. Re-review and further tighten financial controls, especially in relation to pay by Q1 2026	**High**

Target risk rating Audit committee questions

Questions	Answers (include brief narrative)
Based on current planned actions what will the risk rating be at end March 2027? (Include Impact and Likelihood, Overall Rating	**12-** The planned actions are appropriate and will strengthen controls, but they do not guarantee delivery of the target rating, which depends on consistent actions by staff and managers. The finance team will continue to monitor and refine these actions in response to changes in the operating environment and emerging risks and delivery of revised financial recovery plans.
Will the actions above deliver the end March 2027 target rating (Y/N),If No, what else needs to be done to deliver the target?	**Yes, with caveats.** The position is considered deliverable as the Trust has submitted a balanced three-year revenue plan (2026/27–2028/29) in line with NHSE requirements, providing a clear framework to achieve and sustain revenue balance. However, delivery is subject to significant internal and external risks. System-wide changes—including the transition from NHSE to DHSC, ICB mergers and boundary changes, and evolving commissioning arrangements—create uncertainty around governance, financial flows, and cost pressures. These are compounded by operational challenges such as industrial action, the shift to community care, reduced ICB running costs, and leadership instability, all of which may weaken financial control. Despite this, the Trust is expected to deliver revenue balance, supported by BAF controls. The plan relies on stronger second-half performance driven by CIP phasing (e.g. Month 1 deficit of £0.6m). While credible, delivery is a stretch given the 2025/26 deficit and reliance on non-recurrent measures. Achievement of the target rating will therefore depend on: • Delivery of recurrent CIP at scale and pace • Robust and sustained cost control across all areas of expenditure and the implementation of recovery plans where appropriate • Successful implementation of any major strategic business cases • Strong financial grip and oversight during system transition In addition, the Trust's Month 2 financial position remains off plan, which heightens concern regarding the trajectory required to achieve the target rating.
When should we expect the overall target to be met? (narrative description)	March 2027 (see above). Note: Based on the above the new year Datix in year risk rating will start as a 12.

***NB due to strategic nature of the risks on the BAF they are unlikely to be mitigated fully in year but an indication of likely movement is required.**

BAF3: Insufficient capital resources to meet the strategic intentions of the MTFP

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 movement (last 3 quarters)**			**Risk rating**
Inherent	3	4	12				
Residual	**3**	**3**	**9**	**Q2 2025/26**	**Q3 2025/26**	**Q4 2025/26**	**9**
Target	3	2	6	4x3=12	3x3=9	3x3=9	

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. The Trust has had its general capital allocation and some specific allocations confirmed for 2026-27. Slippage on capital schemes presents ongoing challenges due to the inflexibility of the CDEL regime, which limits the Trust's ability to defer or reprofile capital spend across financial years and creates risks around cost management, inefficiency and funding alignment. To address this, Estates & Facilities leadership has strengthened governance over capital delivery, with enhanced programme management, tighter control of construction timelines, clearer accountability for scheme leads and more robust profiling of spend against delivery milestones. These actions are intended to reduce slippage, improve predictability of capital outturn, and ensure expenditure remains aligned with CDEL allocations The NHS 10 year plan proposes to increase capital investment to drive improvements including • Introduction of multi-year capital budgets, set on a rolling five-year basis. • Devolving more control over capital budgets to the frontline with fewer restrictions on what providers can spend their capital on and greater flexibility to spend funding between financial years. • Reforming the approvals process with at most three approval levels on the very largest nationally significant schemes (one provider level, one regional/national and one cross government). • Greater autonomy for new NHS foundation trusts. • Where capital allocations and any associated cash are still required, these will generally flow in line with a fair and transparent formula directly to the accountable organisation best placed to prioritise and deliver value for patients. • Funding to tackle maintenance backlogs directly to all providers in line with the extent of their backlogs. This leaves systems to focus on strategic capital. • The government will also consult with the NHS on reforms to public dividend capital charges. • NHS England guidance caps BAU capital at around 5% of the total capital envelope for each Integrated Care System (ICS) or provider. The aim is to prioritise strategic investment (e.g., elective recovery, diagnostics, digital transformation, RAAC remediation, and safety-critical estates) rather than routine spend. These proposals should provide greater flexibility for the trust to manage risk, however, to gain the full benefit appears to be dependent on delivery of revenue control totals. **Overall Capital Framework in the NHS MTFP** Four-year capital settlement (2026/27 to 2029/30) worth £44 billion, providing stability for long-term planning. Includes real-terms protection of operational capital, £750 million annually for estate safety, and dedicated programmes for:

	• Technology and digital transformation. • Diagnostics and elective recovery. • Urgent and emergency care. • Mental health, learning disability, and autism. • The New Hospital Programme (NHP) A key change to the capital framework advised for the planning period compared to now is that operational capital funding will be allocated at an individual organisational level (not to the system as is the case in 25/26); and region will now hold Estates Safety, Strategic capital).
b) Review and prioritisation of capital schemes	Value for money assessment of schemes to be considered as part of business case development and approvals. Capital position against CDEL reported and discussed at ESPG, IG, Finance and Performance Committee and Trust Board. The approved estates strategy will support the prioritisation of new schemes. Use of contractual terms where necessary and proactive communications and relationship building to try to mitigate any potential risks of goods and services delays.
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.	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 Use Regional DoF Meeting to raise CDEL and Cash issues which can be fed back nationally. The Spending Review 2025 could affect the Trust's 2026/27 medium-term capital plan by altering the overall level, phasing, and flexibility of CDEL funding, increasing uncertainty over future-year allocations and the deliverability of planned schemes. Capital may be more tightly prioritised against national objectives, with greater scrutiny of larger or higher-risk programmes and reduced ability to manage slippage across years. This could lead to re-profiling, deferral, or reprioritisation of schemes and create knock-on revenue pressures where anticipated efficiency or service benefits are delayed. Early assessment and scenario planning will be required by Q1 2026/27 to manage affordability and delivery risks.

Gaps in Controls and Assurances	Actions planned to improve controls and assurance	Impact of Actions on risk
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. Establish the potential impact in 2026-27 of the Spending Review 2025 on our medium-term capital plan by Q1 2026/27.	**High**
	2. Monitor the impact of the E&F enhanced scheme management on financial expenditure and financial profile by Q2 2026/27	**High**
	All actions above are ongoing. This BAF risk has indirect links to risk BAF7 associated with the ongoing sustainability of the organisation's estate.	

Target risk rating Audit committee questions

Questions	Answers (include brief narrative)
Based on current planned actions what will the risk rating be at end March 2027? (Include Impact and Likelihood, Overall Rating	**6 -** The actions listed above is considered appropriate as means to potentially improve the controls but is not in itself a guarantee that the target will be met, as that is directly influenced by the actions of a number of staff and managers as well as the condition of the overall estate. The finance team will keep the actions under review and update, alongside the monitoring and approval through investment group, to remove or add to as the working environment evolves and changes.
Will the actions above deliver the end March 2027 target rating (Y/N),If No, what else needs to be done to deliver the target?	**Yes** - The balanced capital position for 2026/27 has already been affected by slippage from 2025/26, creating pressure to rebalance the programme. The current assessed risk should at a minimum remain in place until the additional pressure within the 2026/27 programme is resolved.
When should we expect the overall target to be met? (narrative description)	Given the actions listed above the expectation is that this could be delivered by 31/12/2026.

***NB due to strategic nature of the risks on the BAF they are unlikely to be mitigated fully in year but an indication of likely movement is required.**

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

Strategic Objectives:
1.Improving health: not just treating illness, moving from treatment to prevention
2.Joined up care: integration and community-based delivery
3.Excellent 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.	Poorer clinical outcomes. Increase in patient incidents, serious incidents and complaints.

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

	Impact	**Likelihood**	**Score**
Inherent	4	3	12
Residual	**4**	**3**	**12**
Target	3	2	6

Risk movement (last 3 quarters)

Q3 2025/26	**Q4 2025/26**	**Q1 2026/27**
4x3=12	4x3=12	4x3=12

Risk rating

12

	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, including bi-monthly deep-dives, and quarterly update to committee. November deep dive into PACS implementation.
	c) Divisional Accountability Meetings (DAMs) have robust discussions focused on delivery of the quality governance agenda and quality metrics.	Divisional updates reported through NMAAC, PEG and PSCEG
	d) QI Team and workplan	Twice yearly progress identified through sessions led by Chief Medical Officer and Chief Nurse to seek assurance against delivery, reported through PSCEG to QPS and Trust Board.
	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 Integrated Patient Safety and Experience (IPSE) Report to Board. Infection Prevention and Control Board Assurance Framework (IPC BAF) reported to Board biannually through Infection Control Committee and QPS. Infection Control Annual Report 2024/25
	f) Strengthened oversight arrangements for corridor care and boarding within ED: revised SOP with reduced capacity for Boarding (in Colchester ED) from end June 2025	Assurance reporting to Fundamentals of Care Board, through to QPS and Trust Board. Assurance regarding completion of actions provided to CQC.
	g) Fundamentals of Care Board (FoCB) established to drive and oversee improvements in the quality of care and ensure timely response to CQC findings.	Chaired by Chief Nurse, reporting to EMC, QPS Committee and Trust Board. Separate Evidence Assurance Group established to review evidence in support of the Trust's improvement actions. Assurance regarding completion of actions provided to CQC (September, October and November 2025, January, April 2026).
	h) Bures Ward model intervention	Evaluation and progress of the implementation of the Bures ward model is reported through the FoCB and EMC.
	i) Nursing and Midwifery Skill Mix Review/Acuity	Reported through People and Organisational Development Committee and Performance and Finance Committee to Board.
Health Inequalities	j) ESNEFT Health Inequalities Strategy and associated governance (including Health Inequalities Working Group)	Strategy approved by Board and overseen through structured governance arrangements, including the Health Inequalities Working Group, with reporting through PSCEG, QPS Committee, Performance and Finance Committee and Trust Board.
Perinatal care	k) 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, Maternity and Neonatal Improvement Board with reporting through EMC and QPS Committee to Trust Board. Maternity and Neonatal Assurance Report
	l) Maternity and Neonatal safety governance,	Structured governance and monitoring through CNST Group and

	including CNST compliance, Safety Champions and delivery of the Maternity improvement plan.	Maternity and Neonatal Improvement Board, with reporting to EMC, QPS Committee and Trust Board, supported by the Maternity and Neonatal Assurance Report
	m) Learning from deaths group	Perinatal mortality outcomes monitored through Learning from Deaths group reported through LMNS, Maternity and Neonatal Improvement Board, QPS and Trust Board

Gaps in Controls and Assurances	Actions planned to improve controls and assurance	Impact of Actions on risk
Gaps in control: • Inconsistent triangulation of quality metrics. • Full Epic quality metric reporting remains in development. • Further enhancement of governance framework **Gaps in assurance:** • Lack of assurance regarding clinical outcomes – including patient experience and effectiveness of clinical interventions. • Concerns regarding quality of care raised by CQC following inspections of medical wards and urgent and emergency care at Colchester and Ipswich Hospitals.	1.Develop and deliver an overarching Quality Improvement (QI) programme to strengthen quality governance, patient experience and clinical outcomes through: • Implementation of a Trust-wide QI plan encompassing care accreditation, fundamentals of care, infection prevention and control, timely access and discharge improvement, and harm reduction • Embedding of processes to demonstrate learning and assurance of sustained improvement (including audit, benchmarking and embeddedness testing) • Alignment of QI activity to divisional and corporate governance structures **Milestones:** • June 2026: QI plan finalised and embedded within governance and divisional delivery plans • September 2026: Demonstrable delivery of improvement actions with evidence of embedded learning • March 2027: Sustained quality improvement evidenced through improved clinical outcomes and patient experience metric to QPS Committee.	**Medium**
	2. Improve visibility and triangulation of quality, safety and performance data through: • Development and implementation of Epic dashboards to support reporting of key quality metrics • Integration of quality, workforce, performance and finance data to support triangulated assurance • Strengthening of reporting processes across governance structures **Milestones:** • September 2026: Priority Epic dashboards developed and validated • September: Improved visibility of data across services and governance meetings • March 2027: Fully embedded reporting supporting triangulated assurance and decision-making	**High**
	3.Enhance and implement a formal governance framework to provide clear oversight, accountability and assurance of programme delivery and risk management through: • Design and approval of a standardised governance structure, including defined roles, responsibilities and reporting arrangements • Establishment of clear oversight forums and escalation routes aligned to Trust governance • Integration of performance, risk and assurance reporting into governance processes to support effective decision-making **Milestones:** • December 2026: Enhanced governance framework defined, approved and communicated across relevant services • March 2027: Governance structure embedded with regular reporting and oversight in place • June 2027: Demonstrable improvement in clarity of accountability and decision-making processes • September 2027: Sustained governance arrangements providing effective oversight and assurance	**High**

	4.Deliver the Trust's quality priorities for 2025/26–2026/27 to improve safety, effectiveness and patient experience across all services through: • Identification and oversight of priority quality outcomes at service level • Implementation of key programmes including maternity single delivery plan, health inequalities programme and Accrediting Care at ESNEFT (ACE) • Embedding of clinical tools and standards (e.g. TEP, ReSPECT, reduction in restrictive practice, end-of-life care improvements) **Milestones:** • June 2026: Priority quality outcomes defined and embedded across all clinical services • September 2026: Demonstrable improvements in key quality indicators (harm reduction, patient experience) • March 2027: Sustained delivery of priority quality outcomes across the organisation	**High**
	5.Deliver actions arising from CQC inspections and external regulatory reviews to improve quality of care and strengthen assurance through: • Implementation of targeted improvement plans addressing findings from urgent and emergency care and medical ward inspections • Oversight through the Fundamentals of Care Board and Trust governance structures • Regular reporting and assurance submission to CQC on progress and sustainability of improvements **Milestones:** • June 2026/27: All CQC actions incorporated into structured improvement plans • September 2026/27: Demonstrable improvement against key areas of concern • March 2027: Sustained compliance with regulatory standards and improved inspection readiness	**Medium**

Target risk rating Audit committee questions

Audit and Risk Committee questions	
Based on current planned actions what will the risk rating be at end March 2027? (Include Impact and Likelihood, Overall Rating)	Aiming to reduce the risk to either 9 or 8 depending on if we see changes to impact or likelihood through the implementation of actions by the end of Q4 2026/27.
Will the actions above deliver the end March 2027 target rating (Y/N), If No, what else needs to be done to deliver the target?	Yes – the actions are designed to improve controls and deliver sufficient improvements to reduce the rating by year end. The delivery of the governance framework is planned to complete in September 2027 as this is delayed awaiting the start of the new Director of Governance however milestones are in place to achieve that goal.
When should we expect the overall target to be met (narrative description)	The actions currently being implemented are expected to deliver a reduction in the risk rating, with initial impact likely to be realised during 2026/27. That said, in light of existing gaps in assurance and the long-term nature of the actions required to embed improvement, it is unlikely that the risk can be reduced to the target level within the foreseeable future.

BAF5: Workforce – recruitment and retention

Strategic Objectives: **4. Developing staff: supporting our teams and building for the future**			
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	Chief People Officer	**Assurance committee**	People and Organisational Development (POD) Committee

	Impact	**Likelihood**	**Score**	**Risk movement (last 3 quarters)**			**Risk rating**
Inherent	4	4	16				
Residual	**4**	**2**	**8**	**Q2 2025/26**	**Q3 2025/26**	**Q4 2025/26**	**8**
Target	4	2	8	4x2=8	4x2=8	4x2=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; Faculty of Education Strategy 2024-29; 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, outreach to schools, 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. Retention conversations continuing, expanding to moves intra-Trust. Voluntary turnover at 5.98%
i) Active Staff networks	EDI Operational Group and EDI Steering Groups reporting to POD

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**	**Impact of Actions on risk**
<u>Gaps in control:</u> None documented **<u>Gaps in assurance:</u>** • Sickness absence rates • Representation from BAME individuals is not balanced across staff groups • Potential impact of implementing new national bands 4-9 Nursing and Midwifery Profiles	1. Increased focus on return to work interviews through revised process, management of short and long term sickness absence through ER processes, support for staff via OH and Well being services. Improved Reasonable adjustments passport in final stages development. End of March 2028/29	**High**
	2. Work towards proportional representation (amongst ESNEFT staff) from BAME individuals accessing Band 7 and above roles to ensure leaders reflect the diversity of staff in Trust – by increasing representation from 17% (2024/25) to 26% by end 2028/29	**Medium**
	3. To support national band 4-9 Nursing and Midwifery profiles, job descriptions to be concluded and evaluation panels to be established. Band 4 and 5 going through evaluation currently – to complete during Q4	**Medium**

• Approval via Resident Doctors Forum (RDF) regarding location verification in relation to additional hours payments as part of the 10 Point Plan.	and Q1 2026/27; Band 6 to 9 to be scheduled following completion of bands 4 and 5.	
	4. Secure formal agreement via the Resident Doctors Forum on the proposed location verification process for additional hours payments, supported by clear procedural guidance. Agreement reached at Resident Doctors Forum (RDF) April 2026. Monitoring via Medical Staffing, Guardians of Safe Working and 10 Point Plan Champions. Reporting to POD on twice annual basis.	**Medium**

Target risk rating Audit committee questions

Audit and Risk Committee questions	
Based on current planned actions what will the risk rating be at end March 2027? (Include Impact and Likelihood, Overall Rating)	The risk was reduced to its target rating during 2025/26, it remains record on the BAF to support the monitoring of controls and assurances.
Will the actions above deliver the end March 2027 target rating (Y/N), If No, what else needs to be done to deliver the target?	Yes – the actions outlined are expected to maintain the risk at the target rating. The current actions focus on sustaining the controls that have enabled the Trust to achieve the target position, including improvements in recruitment, retention, workforce planning and staff experience. Ongoing monitoring through People and Organisational Development Committee, Divisional Accountability Meetings and Trust governance will ensure that emerging risks are identified and addressed promptly
When should we expect the overall target to be met (narrative description)	Currently achieved

***NB due to strategic nature of the risks on the BAF they are unlikely to be mitigated fully in year but an indication of likely movement is required.**

BAF6: Sustainable delivery of elective performance targets

Strategic Objectives: **3.Excellent care: improved outcomes, increasing personalisation and co-production**			
Strategic Risk:			
IF demand and waiting list size cannot be reduced and activity levels fail to increase	**Then** performance within RTT and DM01 will not meet agreed planning and National Priorities.	**Resulting in** unintended harm to patients due to longer waiting times which may result in delayed diagnosis, disease progressions and poor outcomes. An increase in public and regulatory scrutiny with a potential for loss of confidence of stakeholders.	**Defined by** regulatory action and/or reputational damage. Loss of public confidence. Increased complaints. Increased harm to patients.

Lead Executive	Chief Operating Officer for Elective Care	**Assurance committee**	Performance and Finance Committee (PAF)

	Impact	**Likelihood**	**Score**	**Risk movement (last 3 quarters)**			**Risk rating**
Inherent	5	4	20				
Residual	**5**	**3**	**15**	**Q2 2025/26**	**Q3 2025/26**	**Q4 2025/26**	**15**
Target	5	2	10	5x3=15	5x3=15	5x3=15	

Key Controls	**Assurances reported to Board and committees**
a) ESNEFT Elective Medium-Term Plan 2026-2028 (2-year plan to be approved by EMC). Plan based on National Priorities and including internal "stretch" targets to support delivery of National Priorities.	Performance and Finance 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 ESNEFT Chief Operating Officer for Elective Care
b) Internal governance oversight of operational and change delivery inc. risk and issue management reporting into Trust Committees including Performance & Finance; and Quality and Patient Safety: Includes: ➢ Elective Care Programme Board – Oversight of collaboration between ICB, WSFT and ESNEFT with a particular focus on delivery of ICB Commissioning Intention (inc. 'left shift' opportunities) and alignment of practice to national guidance (inc. GIRFT) ➢ Divisional Accountability Framework and associated meetings to ensure delivery of performance, quality, productivity, and finance commitments (inc. PTL management)	Performance and Finance Committee (PAF) - Monthly reporting and periodic deep dives. Regular reporting to Executive Leadership Team and Elective and Emergency care programme boards. Reporting to ICB wide Elective Care Programme Board chaired by ESNEFT Chief Operating Officer for Elective Care
c) Weekly in service PTL meetings with regular PTL meetings lead centrally. Purpose to monitor performance against national and stretch targets, identify any concerns or slippage in order to support early intervention.	Reports into the Elective Care Programme Board

Gaps in Controls and Assurances	Actions planned to improve controls and assurance	Impact of Actions on risk
Gaps in control: None identified **Gap in assurance:** None identified	1.Deliver the ESNEFT Elective Medium-Term Plan (2025–2027) to improve activity, reduce waiting times and align performance to national standards through: • Translation of plan objectives into specialty-level delivery trajectories and capacity plans • Implementation of programme governance through Elective Care Programme Board and Divisional Accountability Meetings • Monitoring delivery against RTT, DM01 and waiting list reduction trajectories **Milestones:** • June 2026: Review of first delivery against divisional milestones as per medium term plan and identification of gaps in delivery. • September 2026: Demonstrable reduction in long waits and improved activity levels • December 2026: Sustained improvement in RTT performance against plan • March 2027: Delivery of National Priorities through Trust Plan.	High
	2.Identify and implement productivity improvement opportunities to support delivery of performance trajectories and mitigate capacity constraints through: • Systematic identification of productivity opportunities across clinical and operational services (including benchmarking against GIRFT and national standards) • Development and implementation of targeted improvement plans (e.g. theatre utilisation, outpatient productivity, workforce efficiency) • Ongoing monitoring of productivity metrics through Divisional Accountability Meetings and programme governance **Milestones:** • June 2026: Productivity reporting through to Elective Care Programme Board by Division. • December 2026: Implementation of targeted productivity improvement actions across key services • March 2027: Measurable improvement in productivity metrics (e.g. utilisation, output per session) • March 2027: Sustained productivity improvements contributing to delivery of performance and capacity requirements	High
	3.Include stretch targets and performance within the elective care highlight report for the divisions to present end of July 2026	Medium

Target risk rating Audit committee questions

Audit and Risk Committee questions	
Based on current planned actions what will the risk rating be at end March 2027? (Include Impact and Likelihood, Overall Rating)	It is considered that the risk rating will be 10, likelihood 2, consequence 5.
Will the actions above deliver the end March 2027 target rating (Y/N), If No, what else needs to be done to deliver the target?	Yes - We have plans to increase delivery through stretch targets and increased productivity in the actions above. Currently we are on target with our National Priorities. This is dependent upon the delivery of the divisions. Progress will be closely monitored through Divisional Accountability Meetings, Elective Programme governance and Performance and Finance Committee oversight, with escalation processes in place where delivery deviates from trajectory
When should we expect the overall target to be met (narrative description)	The current strategy being implemented delivers the reduction in risk by March 2027

***NB due to strategic nature of the risks on the BAF they are unlikely to be mitigated fully in year but an indication of likely movement is required.**

BAF6A: Sustainable delivery of emergency care performance targets

Strategic Objectives: **3.Excellent care: improved outcomes, increasing personalisation and co-production**			
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	Managing Director	**Assurance committee**	Performance and Finance Committee (PAF)

	Impact	**Likelihood**	**Score**	**Risk movement (last 3 quarters)**			**Risk rating**
Inherent	5	4	20				
Residual	**5**	**3**	**15**	**Q4 2024/25**	**Q1 2025/26**	**Q2 2025/26**	**15**
Target	5	2	10	5x3=15	5x3=15	5x3=15	

Key Controls	**Assurances reported to Board and committees**
a) UEC medium term plan setting out Trust wide change priorities through to 2028. Delivered through the UEC improvement and resilience programme led by Director of Operations and supported by Deputy Chief Nurses and Medical Directors. Programme reports ODOG and EMC. Delivery of the medium term plan includes seasonal variation planning the basis of which is bed capacity modelling and response to capacity gaps.	Reports to EMC via ODOG monthly. Overview of SVP approach to May 2026 PFC. First draft of plan to June 2026 EMC.
b) Aligned to the Trusts Accountability Framework, Divisional performance against plan is monitored.	Reports to DAM, EMC, PAF and QPS performance metrics, through the Trusts broader Governance model.
c) Sustainability review completed in 2024 by SNEE ICB identified 60% of bed capacity across system being consumed by 1% of population. The main system response to manage demand focusses on left shift and neighbourhoods. Norfolk and Suffolk ICB has created 26-28 “left shift” investment fund which is to proactively manage admissions avoidance. For some schemes we are the provider of services and for all schemes in Ips and East Suffolk we are the planned beneficiary in terms of reduced demand on our acute services. We are delivering this work as a Trust to deliver this in Suffolk and influence this work in Essex.	UEC admissions avoidance overseen by either UEC improvement and resilience programme or the elective care programme. Both programmes report to EMC via ODOG. ESNEFT’s engagement and support to delivery of the ICB’s ‘Left Shift’ Investment Fund is managed via the UEC Improvement & Resilience Programme where they relate to UEC.
d) UEC performance in Tier 2 and monthly regional accountability meetings in place. Regional support agreed as required	Monthly meetings in place from Q4 2025/26.
e) Consistent implementation of the Trust’s Patient Flow and Escalation Policy	All Trust policies have identified owners and review dates, plus metrics, audit and reporting arrangements via Trust governance as above.

Gaps in Controls and Assurances	Actions planned to improve controls and assurance	Impact of Actions on risk
Gaps in control: • Insufficient bed and staff capacity analysis within ESNEFT to support predicted population growth • Epic demand and capacity dashboard to include bed prediction and forecasting • Embedding existing Trust policies and monitoring outcomes to positively impact capacity constraints **Gaps in assurance:** • Monitoring compliance with policies through UEC Improvement and Resilience Board	1.Develop and implement the Trust's contribution to the National Neighbourhood Framework in partnership with ICBs and system partners to support demand management and 'left shift' of care through: • Co-production of system-wide neighbourhood plans with ICBs and partner organisations • Alignment of Trust operational plans to neighbourhood model priorities • Active participation in delivery of agreed neighbourhood initiatives impacting UEC demand **Milestones:** • April 2026: Neighbourhood framework response co-produced with system partners and submitted to NHSE • June 2026: Agreed neighbourhood delivery plans translated into Trust operational actions • December 2026: Initial neighbourhood schemes demonstrating impact on admission avoidance and demand • March 2027: Sustained contribution to system-wide demand reduction through neighbourhood model	**High**
	2.Deliver the Trust-wide Urgent and Emergency Care (UEC) Improvement and Resilience Programme to improve flow, capacity and performance through: • Implementation of standardised patient flow processes (including board rounds, escalation protocols and discharge planning) • Delivery of actions arising from Tier 2 assurance and NHS England oversight • Strengthening divisional performance management through DAM and EMC governance **Milestones:** • June 2026: CTA reviews completed and actions incorporated into programme delivery • June 2026: Patient flow SOPs implemented across all sites • Sept 2026: Sustained improvement in flow metrics (length of stay, corridor care reduction) • March 2027: UEC performance trajectory aligned to planning standards	**High**
	3.Strengthen capacity planning and alignment to demand through: • Completion and implementation of Trust-wide bed modelling reflecting 2026/27 demand • Ongoing seasonal variation planning based on demand forecasts • Integration of modelling outputs into operational decision-making and escalation processes **Milestones:** • June 2026: Seasonal variation plans aligned to modelling outputs • December 2026: Demonstrable improvement in occupancy and flow metrics • March 2027: Capacity aligned to demand within acceptable thresholds	**High**
	4.Improve visibility and proactive management of demand and capacity through: • Delivery of Epic demand and capacity dashboards (including bed forecasting functionality) • Alignment of reporting with NHSE requirements and internal governance processes • Embedding of real-time data into operational decision-making • **Milestones:** • June 2026: Epic dashboard developed and validated • December 2026: Dashboard embedded within operational and governance meetings • June 2026: Epic dashboard developed and validated • December 2026: Dashboard embedded within operational and governance meetings	**Medium**

	5.Strengthen programme management and delivery assurance through: • Development of "Plan on a Page" for all UEC programme workstreams (including milestones, risks and benefits) • Strengthened oversight through UEC Programme Board, ODOG and EMC • Alignment of programme delivery with BAF risk reduction trajectory **Milestones:** • May 2026: Plans on a Page completed for all workstreams • June 2026: Programme governance fully embedded • Q3 2026/27: Clear evidence of delivery against milestones • March 2027: Programme delivering sustained improvement in performance	**Medium**

Target risk rating Audit committee questions

Audit and Risk Committee questions	
Based on current planned actions what will the risk rating be at end March 2027? (Include Impact and Likelihood, Overall Rating)	We consider that the actions above would achieve the target score of 10.
Will the actions above deliver the end March 2027 target rating (Y/N), If No, what else needs to be done to deliver the target?	The target risk rating is expected to be achieved by March 2027 through delivery of the UEC Improvement and Resilience Programme. This will be achieved through: • 2026/27 (Recovery Phase): Improvement in flow, capacity alignment and reduction in delays through delivery of core programme actions • Ongoing (Sustainability Phase): Continued system working and demand management through ICB 'left shift' programmes While the target rating is expected by March 2027, elements of system transformation and demand management will continue beyond this period to sustain performance
When should we expect the overall target to be met (narrative description)	March 2027

***NB due to strategic nature of the risks on the BAF they are unlikely to be mitigated fully in year but an indication of likely movement is required.**

BAF6B: Timely cancer diagnosis and treatment

Strategic Objectives: **3.Excellent care: improved outcomes, increasing personalisation and co-production**			
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	Chief Operating Officer for Elective Care	**Assurance committee**	Performance and Finance Committee (PAF)

	Impact	**Likelihood**	**Score**
Inherent	5	4	20
Residual	**5**	**3**	**15**
Target	3	2	6

Risk movement (last 3 quarters)			**Risk rating**
Q2 2025/26	**Q3 2025/26**	**Q4 2025/26**	**15**
5x3=15	5x3=15	5x3=15	

Key Controls	**Assurances reported to Board and committees**
a) ESNEFT Cancer Medium-Term Plan 2026-2028 (2-year plan to be approved by EMC, based on national priorities and Trust MTP)	Reporting through Norfolk & Suffolk ICB Cancer Ops group (TBC) 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 Committee deep dive into PACS implementation
b) Internal governance oversight of operational and change delivery inc. risk and issue management reporting into Trust Committee's inc. Performance & Finance; and Quality and Patient Safety: Includes: • ESNEFT Cancer Committee – Incs. oversight of performance, ICB feedback, National Programmes, patient feedback, project pilots. • Divisional Accountability Framework and associated mtgs to ensure delivery of performance, quality, productivity, and finance commitments (inc. delivery of constitutional stds and Trust commitments, PTL mgt, review of effectiveness of Clinical Review Panel, productivity improvements aligned to national guidance (inc. GIRFT), full participation in the Trust's Support Services Review) • Cancer Accountability Board – Cancer Clinical leads, Operational Managers, Service Improvement with focus on delivery of national standards, pathway improvement and implementation and innovation in line with national cancer 10 year plan (first meeting in April), feeds through to Improving Cancer Care workstreams. Diagnostic stewardship programme underway	Monthly Divisional Accountability Meetings (DAMs) supported by Executive Director with escalation to EMC and PAF Committee as necessary. Cancer Accountability Board reports into EMC. Pilots undertaken from Cancer Accountability Board include the recent WID Easy pilot which is proving a success in reduce wait times in Gynaecology
c) External controls inc. • GIRFT assessments and NHS England Cancer Alliance direct reporting • Norfolk & Suffolk ICB and Essex ICB - Cancer Operational Group and Committee – focused on collaborative delivery of change with heightened focus on 'left shift' opportunities as well as potential opportunities to strengthen commissioning of community-based services (still in process of setting up)	Reporting and oversight of NHS England aligned to NOF

Gaps in Controls and Assurances	Actions planned to improve controls and assurance	Impact of Actions on risk
Gaps in control: • Challenges in pathology consultant workforce in combination with increasing demand on service, three new pathologists appointed start dates to be confirmed • Surgical capacity constraints in relation to preference to only undertake robotic procedures. • Capacity challenges within tertiary centres (diagnostic and treatment) • Accuracy of Epic cancer dashboards • Endoscopy capacity at Ipswich doesn't meet demand patients offered Clacton and Colchester appointments until Ipswich CDC opened. **Gaps in assurance:** • Challenge with reducing the number of patients waiting over 62 days in colorectal and urology (recovery plans in place) • Robust recovery plans for radiology – Tom Whybrow. • Not meeting 28 day FDS national standard for colorectal. • The 28 day FDS national standard is not being consistently • met across some tumour sites • Full resolution of PACS implementation issues • Pathology reporting delays – Three new Pathologists appointed start date to be confirmed. • Booking staff to complete timely booking for patients with the end of FTC in March 2026 and the ongoing impact of ringfenced roles for internal staff identified in CAT B – Centralised to Ipswich site in June 2026.	1.Deliver the ESNEFT Elective (including diagnostics) and Cancer Medium-Term Plan (2026–2028) to drive sustained improvement in elective and cancer performance through: • Translation of plan objectives and KPIs into specialty-level delivery trajectories • Implementation of programme governance and performance monitoring to ensure delivery **Milestones:** • June 2026/27: Specialty-level trajectories and KPIs embedded within divisional plans • December 2026/27: Demonstrable delivery against key elective and cancer performance metrics • March 2027: Delivery against national cancer standards • March 2028: Full delivery of plan objectives and KPI improvements	**High**
	2.Support delivery of the Targeted Lung Screening programme across Ipswich and East Suffolk practices to improve early cancer diagnosis and outcomes through: • Phased rollout of screening for eligible patients across GP practices **Milestones:** • September 2026/27: Initial rollout completed across priority practices • March 2027 2026/27: Programme expanded to full Ipswich and East Suffolk coverage • March 2028: Reportable improvement in early-stage cancer detection rates • March 2029: Programme fully embedded as part of routine population health management	**Low**
	3. Deliver the Pathology Recovery Plan to address capacity and demand pressures and ensure timely and sustainable diagnostic performance, building on completed modelling, activity analysis and value for money assessment. **Milestones:** • **Completed:** Capacity and demand model established, activity segmented (Cancer, Urgent, Routine), and value for money assessment of temporary resourcing undertaken • **15 June 2026:** Engagement with temporary resourcing teams to confirm procurement route for insourcing (tender vs direct award) • **16 June 2026:** Clinical Delivery Group presents recovery plan and proposed approach to Divisional Management Team (DMT) • **22 June 2026:** Procurement approach confirmed, including requirement for tender (if applicable) • **September 2026:** If required, procurement process completed (up to 12 weeks) and agreed resourcing model implemented • **Ongoing:** Locum support maintained to manage demand and support service continuity during implementation • **December 2026:** Demonstrable improvement in pathology capacity and turnaround times • **March 2027:** Sustained delivery of recovery plan supporting cancer and urgent diagnostic pathways	**Medium**
	4.Deliver targeted recovery plans for colorectal and urology cancer pathways to reduce long waits and improve compliance with national cancer standards through: • Implementation of tumour-specific recovery actions	**High**

	addressing identified pathway delays • Delivery of cancer diagnostics within agreed turnaround times • Monitoring delivery and escalation through Cancer Board and Divisional Accountability governance • **Milestones:** • June 2026/27: Recovery plans finalised and agreed for colorectal and urology pathways • October 2026/27: Key actions implemented with early reduction in 62-day breaches • December 2026/27: Sustained improvement in pathway performance across both tumour sites • March 2027: Delivery of planned recovery trajectories aligned to national standards •	
	5.Improve quality and reliability of cancer performance data and reporting through: • Resolution of Epic reporting and dashboard issues (including 28-day FDS tracking, 104 day breach reporting) • Implementation of robust patient tracking and timeline validation processes • Strengthening harm review processes and visibility of long waits **Milestones:** • July 2026/27: Epic data issues impacting cancer reporting resolved • October 2026/27: Full visibility of pathway performance across tumour sites • January 2027: Reliable performance reporting embedded in governance	**High**

Target risk rating Audit committee questions

Audit and Risk Committee questions	
Based on current planned actions what will the risk rating be at end March 2027? (Include Impact and Likelihood, Overall Rating)	Reduce the risk to the target scoring of impact 3 likelihood 2.
Will the actions above deliver the end March 2027 target rating (Y/N), If No, what else needs to be done to deliver the target?	Yes – the actions outlined are expected to deliver the target risk rating by March 2027. This is based on the implementation of structured recovery programmes, increased diagnostic and treatment capacity, and strengthened performance management and governance arrangements, which collectively address the key drivers of the current risk. Delivery will be closely monitored through established governance routes, including Divisional Accountability Meetings, Cancer Board and Performance and Finance Committee oversight, with escalation processes in place where progress deviates from trajectory.
When should we expect the overall target to be met (narrative description)	March 2027

***NB due to strategic nature of the risks on the BAF they are unlikely to be mitigated fully in year but an indication of likely movement is required.**

BAF7: Estates Development and Capital Equipment

Strategic Objectives: **5.Using technology to improve care: digital, technology and innovation – shifting from analogue to digital 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 and Safety risk Failure to reduce carbon footprint

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

	Impact	**Likelihood**	**Score**
Inherent	5	4	20
Residual	**3**	**3**	**9**
Target	3	2	6

Risk movement (last 3 quarters)			**Risk rating**
Q2 2025/26	**Q3 2025/26**	**Q4 2025/26**	**9**
4x4=16	4x4=16	4x3=12	

Key Controls	**Assurances reported to Board and committees**
a) Estates and Facilities Division's Strategies and Plans: a. Property and Estates Strategy 2025-2030 b. Property Strategy c. Green Plan 2024-2027 d. Master Control Plan and Development Control Plan for each major site.	Aligned with Clinical Strategy. 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 and Medium Term Backlog Maintenance Plans c. 5 year annual capital and maintenance 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 Includes metrics for reactive and PPM works; HTM compliance; National standards of cleanliness; Food hygiene standards; environment standards; nutrition standards; waste segregation requirements; violence prevention and reduction standard; MHRA medical device regulations.	Annual PLACE (Patient Led Assessments of the Care Environment) Survey Annual PAM (Premises Assurance Model) survey HTM sub committees Health and Safety Committee EMC Compliance Report National standards of cleanliness report, cleanliness audits, food hygiene inspections to IPC Committee MHRA Compliance report to Medical Devices Management Group
d) Estates and Facilities financial reports Monthly divisional and Assistant Director level monthly report with performance metrics and forecast analysis. Monthly CIP and monthly departmental financial performance meetings	Monthly Divisional finance SMT meeting Monthly DMT meeting Monthly DAM and then EMC Monthly Capital spend meeting CIP Tracker report to Divisional Management Team and Divisional Accountability Meeting
e) Comprehensive asset register	Reporting to ESP Group, provides recommendations through Investment Group to BFBC Group with appropriate escalation to Trust Board.
f) Authorising Engineer audit reports	HTM Compliance tracker, Report to relevant HTM Groups, reporting to Health and Safety Committee, EMC and on to Trust Board.

Gaps in Controls and Assurances	Actions planned to improve controls and assurance	Impact of Actions on risk
Gaps in control: • None documented **Gaps in assurance:** • User satisfaction – hard and soft estate. • Progress with capital maintenance programme • Future PFI concession arrangements	1. With funding from DOH, deliver the ESNEFT Property & Estate Strategy (2025–2030) to ensure a safe, functional, sustainable and value-for-money estate that supports clinical and operational delivery through: • Translation of estate strategy priorities into annual operational plans aligned to Trust business planning cycles • Development and delivery of estate programmes through the defined business case pathway • Implementation of estate strategy governance through the Estates Strategy Programme Group (ESPG) and Building for Better Care Programme Board • Ongoing prioritisation and delivery tracking via the IPSOF programme and estate dashboard **Milestones (from Strategy Roadmap & Business Case Process):** • September 2026: Estate priorities translated into divisional operational plans and IPSOF tracking in place • December 2026: Priority schemes progressed through PID and SOC stages with governance approval • December 2027: Schemes progressed through OBC/FBC stages in line with business case timelines (up to 67–88 weeks depending on scale) • March 2027: Initial delivery of priority estate schemes with governance oversight and reporting through ESPG	Low
	2. Deliver a prioritised programme to reduce backlog maintenance and improve estate safety, compliance and functionality through: • Implementation of a risk-based backlog maintenance programme across all sites • Alignment of capital investment to high and significant risk backlog priorities • Integration of backlog reduction within all refurbishment and development schemes **Milestones:** • December 2026: Delivery of high-risk backlog reduction schemes underway • March 27: Measurable reduction in high and significant risk backlog and improved estate safety compliance	High
	3. Develop and deliver the estate capital programme aligned to clinical strategy priorities and system requirements through: • Progression of key schemes (e.g. outpatient capacity, diagnostics, theatres, bed capacity) through business case stages • Alignment of estate development with clinical adjacencies and service models • Identification and securing of funding streams for priority schemes **Milestones:** • September 2026: Priority schemes defined and aligned to clinical strategy and capital pipeline • December 2026: Business cases developed (SOC/OBC) for major schemes • March 2027: Approved schemes progressed to delivery phase or FBC stage	Medium
	4. Strengthen governance and assurance of the estate to ensure delivery, compliance and continuous improvement through: • Oversight of estate strategy delivery via ESPG and programme governance • Monitoring of compliance through PAM, ERIC and internal assurance processes • Regular review and refresh of estate strategy, priorities and delivery plans **Milestones:** • September 2026: Governance structure fully embedded with reporting through ESPG and Trust committees • December 2026: Improved assurance reporting across estate performance, compliance and risk • March 2027: Sustained governance supporting delivery and continuous improvement	Medium

Target risk rating Audit committee questions

Audit and Risk Committee questions	
Based on current planned actions what will the risk rating be at end March 2027? (Include Impact and Likelihood, Overall Rating)	Following an approved reduction at March 2026 Board to reduce to 9 this is the anticipated scoring for March 2027
Will the actions above deliver the end March 2027 target rating (Y/N), If No, what else needs to be done to deliver the target?	Yes – the actions outlined are expected to maintain the current reduced risk rating through 2026/27. The focus of the actions is on sustaining delivery of the Property and Estate Strategy, including ongoing management of backlog maintenance, progression of capital schemes and continued strengthening of governance and oversight. These actions will ensure the controls that have reduced the risk are maintained, with monitoring and escalation arrangements in place to respond to any emerging pressures or deterioration
When should we expect the overall target to be met (narrative description)	While the planned actions are expected to deliver a further reduction in the risk rating during the second quarter of 2026/27, the target rating of 6 represents a substantial improvement from the current position. As a result, achievement of the target rating is not forecast within 2026/27.

***NB due to strategic nature of the risks on the BAF they are unlikely to be mitigated fully in year but an indication of likely movement is required.**

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

Strategic Objectives:

5. Using technology to improve care: digital, technology and innovation – shifting from analogue to digital care

Strategic Risk: BAF8

IF we are unable to	**Then** we will	**Resulting in**	**Defined by**
realise the benefits of our Electronic Patient Record (EPR) in accordance with the agreed benefits realisation plan	significantly constrain the delivery of linked digital and strategic goals regarding improvements to patient quality, safety, experience, outcomes and clinical integration	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	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	Managing Director	**Assurance committee**	Quality and Patient Safety Committee (QPSC)

	Impact	**Likelihood**	**Score**
Inherent	4	3	12
Residual	**4**	**2**	**8**
Target	2	2	4

Risk movement (last 3 quarters)			**Risk rating**
Q2 2025/26	**Q3 2025/26**	**Q4 2025/26**	**8**
4x2=8	4x2=8	4x2=8	

Key Controls	**Assurances reported to Board and committees**
a) Digital, Data and Technology Strategy 2023-26 – New strategy to be developed for October 2026	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 and Structure with clinical, operational and patient engagement	There will be Practice Councils (to replace Rapid Decision Groups) and Unit Based Councils which support the change request process. Underpinning the governance structure is the Ambassador Network. Practice Councils report to Advisory Councils and Design Authorities, through the EPR Programme Delivery Group to EPR Programme Board meeting, reporting to EMC, QPS Committee and Trust Board Independent internal audit of EPR programme governance concluded reasonable assurance Benefits Realisation Group, chaired by Managing Director 'Epic Benefits Realisation' presented to February 2026 Performance and Finance Committee
d) EPR Full Business Case, contract, implementation plan, benefits realisation and programme delivery team.	Full Business Case approved by Trust Board and NHS England. Benefits Realisation Group tracks benefits, reported through EPR Programme Governance to Trust Board.
e) Digital leadership development, Digital Fellows to support and lead digital health transformation and innovations. Credentialed Trainers (seconded clinicians) training clinical colleagues within nursing and midwifery, AHPs and health sciences	Digital leadership workshops with Trust Board Epic Executive Briefing EPR programme governance
f) Epic programme continues beyond October 2025 go-live into optimisation and business as usual activities.	Focused 'Turbo rooms' supporting operational staff. Reporting through EPR Programme Governance to Trust Board

Gaps in Controls and Assurances	Actions planned to improve controls and assurance	Impact of Actions on risk
Gaps in control: • No Benefits Realisation Manager in post – to start Aug 2026 **Gaps in assurance:** • Demand for Epic trained/experienced workforce from other Trust's creating risk of high turnover within delivery team	1.Deliver and monitor the EPR Benefits Realisation Programme to ensure achievement of planned clinical, operational and financial benefits through: • Implementation of structured benefits tracking across all divisions aligned to the Full Business Case • Delivery of targeted benefit initiatives (including administrative and clerical reduction, drug spend optimisation and clinical informatics improvements) • Strengthened governance through the Benefits Realisation Group to monitor performance and escalate delivery risks **Milestones:** • June 2026: Trajectory for cash releasing benefits for 2026/27 agreed • Dec 2026: Demonstrable delivery of measurable benefits across key areas • March 2027: Sustained delivery of benefits aligned to business case	**High**
	2.Strengthen digital workforce capability and resilience to support EPR delivery and optimisation through: • Implementation of a digital workforce development programme (including training across applications and career pathways) • Reduction of reliance on key individuals through cross-skilling and succession planning • Targeted retention initiatives to mitigate risk of loss of Epic-experienced staff **Milestones:** • August 2026: Digital restructure completed with defined roles and development pathways • December 2026: Cross-training implemented across key applications • March 2027: Improved workforce stability and reduced risk of critical skill gaps •	**Medium**
	3.Strengthen independent assurance of the EPR programme through: • Completion of NHS England Gateway Review (Level 5) and implementation of recommendations • Ongoing internal audit review of programme governance and delivery • Reporting of assurance findings through Trust governance structures **Milestones:** • July 2026: Gateway Review completed and findings reported • August 2026: Action plan developed and agreed in response to review • December 2026: Delivery of key assurance actions with evidence of improvement •	**Low**
	4.Implement a strengthened post go-live EPR governance structure to support effective decision-making, change control and clinical engagement through: • Establishment of Practice Councils, Advisory Councils and Design Authorities • Embedding of governance processes for change requests and prioritisation • Alignment of governance reporting into EPR Programme Board, EMC and Committees **Milestones:** • July 2026: Governance processes embedded and operating effectively • December 2026: Evidence of timely decision-making and prioritised system optimisation	**Medium**

Target risk rating Audit committee questions

Audit and Risk Committee questions	
Based on current planned actions what will the risk rating be at end March 2027? (Include Impact and Likelihood, Overall Rating)	Rating is anticipated to remain at 8
Will the actions above deliver the end March 2027 target rating (Y/N), If No, what else needs to be done to deliver the target?	The actions outlined will significantly contribute to delivery of the target risk rating, through structured benefits realisation, strengthened governance and improved workforce capability supporting EPR optimisation. Delivery will be actively monitored through the Benefits Realisation Group, EPR Programme Board and Trust governance, with clear escalation routes where benefits are not being realised in line with plan
When should we expect the overall target to be met (narrative description)	Following the refresh of the strategy by October 2026 more detail can be provided.

BAF9: Transformation

Strategic Objectives: ALL
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	Interim Chief Exec	**Assurance committee**	Trust Board

	Impact	**Likelihood**	**Score**
Inherent	4	4	16
Residual	**4**	**3**	**12**
Target	4	2	8

Risk movement (last 3 quarters)

Q3 2025/26	**Q4 2025/26**	**Q1 2026/27**
4x3=12	4x3=12	4x3=12

Risk rating **12**

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 and Innovation Strategy	Monthly monitoring through Executive Management Committee, quarterly strategic update report and Research and Innovation annual report to Trust Board
h) Strategic Plan	Quarterly reporting to EMC and then Trust Board
i) ESNEFT 2026-2031 Clinical Strategy	Financial sustainability. CQC well led review outcome anticipated July 2026 Performance, quality and finance reporting to NHS England and ICB as required. Quarterly Strategic update to Trust Board reports performance against strategy success measures. Delivery of new operating theatres (Ipswich Hospital), Urgent and Emergency Care Centre (Ipswich Hospital) ESEOC (Colchester Hospital). Approval of business case for Ipswich Community Diagnostic Centre. Trust Board approved Medium Term Plan submission submitted to NHS England, February 2026.

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**	**Impact of Actions on risk**
Gaps in control: Refresh of strategic plans alongside development of Medium Term Plan currently in progress **Gaps in assurance:** • Concerns regarding quality of care raised by CQC following inspections of medical wards and urgent and emergency care at Colchester and Ipswich Hospitals • Awaiting CQC Well-led inspection (November 2025) report	1.Deliver the Trust's strategic plans, including the Medium-Term Plan, by aligning key priorities with divisional delivery, embedding clear performance trajectories and governance, and ensuring sustained implementation across clinical, operational and corporate areas. Clear performance trajectories and KPI's for year one of the medium term plan have been approved by Trust Board in March 2026. **Milestones** • December 2026**:** Demonstrable progress against 2026/27 Medium-Term Plan priorities, with delivery monitored through governance and escalation processes • March 2027: Year 2 of medium term plan approved by Trust Board in readiness for 2027/28	**High**

	• March 2027**:** Evidence of delivery against key strategic objectives, with alignment between strategy and operational performance • March 2027**:** Sustained delivery of Medium-Term Plan priorities embedded across the organisation	

Target risk rating Audit committee questions

Audit and Risk Committee questions	
Based on current planned actions what will the risk rating be at end March 2027? (Include Impact and Likelihood, Overall Rating)	This risk is the most strategic of the risks on the BAF, and is linked to many of the other risks. The strategies in place and the plans being developed in the short term are designed to support strategic delivery over the longer-term, aligned to the NHS 10 year plan. The actions are not designed to reduce the risk by year end, but to articulate the plan to deliver key milestones locally. The risk will remain at its current rating of 4x3=12
Will the actions above deliver the end March 2027 target rating (Y/N), If No, what else needs to be done to deliver the target?	Yes - year one delivery of medium term priorities as agreed per Trust Business Plan. 5 year medium term priorities will be delivered over the course of 2026/2031
When should we expect the overall target to be met (narrative description)	This will require further review once the longer-term milestones have been articulated within the MTP.

***NB due to strategic nature of the risks on the BAF they are unlikely to be mitigated fully in year but an indication of likely movement is required.**

BAF10: Digital resilience

Strategic Objectives:
5. Using technology to improve care: digital, technology and innovation – shifting from analogue to digital care

Strategic Risk: BAF8

IF we are	**Then**	**Resulting in**	**Defined by**
underprepared for a cyber-attack and/or have insufficient digital resilience to recover from a digital incident	there is a risk of significant impact to patients, staff and the organisation due to inaccessibility of information	disruption to services due to non-availability of clinical and non-clinical information. Potential data loss across key clinical and non-clinical systems.	delays and cancellation of treatment. Inability to accurately report activity Significant reputational damage, financial impact, regulator scrutiny and reduced workforce retention. Delay to delivery of transformation services.

Lead Executive	Director of Digital Logistics and Operations	**Assurance committee**	Audit and Risk Committee

	Impact	**Likelihood**	**Score**	**Risk movement (last 3 quarters)**			**Risk rating**
Inherent	4	4	16				
Residual	**4**	**2**	**8**	**Q2 2025/26**	**Q3 2025/26**	**Q4 2026/27**	**8**
Target	4	1	4	4x2=8	4x2=8	4x2=8	

Key Controls	**Assurances reported to Board and committees**
a) Digital, Data and Technology Strategy 2023-26 • Cyber security strategy and associated strategic model, aligned to national DSPT and CAF.	Approved by Board September 2023, with annual review. Periodic highlight reports to EPR Programme Board and Trust Board. Bi-monthly ICT Operational Security Controls report provided to Audit and Risk Committee
b) Cyber Security Strategy Covers all hardware, software and data assets – including information technology, operation technology, connected medical devices, network components (both on our premises and in the cloud, including 3rd party managed assets). Deploy Network Detection and Response (NDR) tool	Data Security and Protection Toolkit (DSPT) submission and internal audit findings reported to Audit and Risk Committee. Quarterly cyber reports detailing patch compliance, Operating System compliance and threat detection rates, Cyber Assessment Framework (CAF) IT key controls report provided to Audit Committee quarterly. Briefings on cyber security and EPR provided to Trust Board. Annual Penetration Testing, simulated phishing exercises. Participation in cyber security incident exercises
c) Application of cyber security notifications from NHS England and the National Microsoft Defender for Endpoint tenant.	Completed actions are reported back to the NHS England Cyber Responding Service or the NHS England Advanced Threat Protection service.
d) Business continuity and disaster recovery plans – reviewed and updated in line with outage incident 11/02/26	EPRR Working Group - Digital and Cyber Security, reporting to Strategic Oversight Group through to Executive Management Team.
e) ICT Operational Security Team supported by: • NHS England Digital - Cyber Security Operations Centre (SCOC) • Sophos - Central Managed Detection and Response service (MDR) • Rubrik Ransomware Response Team (RTT) • Downtime resilience group (monthly meeting) report to EPRR Cyber and Digital Security	Included in Monthly ICT Operational Security Controls report provided to Audit and Risk Committee.

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**	**Impact of Actions on risk**
Gaps in control: • Compliance with DSPT requirement regarding server operating systems **Gaps in assurance:** Security governance Board (SecGOV) to be established and onward governance route established.	1.Deliver a Trust-wide upgrade of end-user devices to supported operating systems to maintain compliance with national cyber security standards and reduce vulnerability risk through: • Deployment of Windows 11 and extended support arrangements across all Trust devices • Removal or upgrade of unsupported systems in line with national requirements • Ongoing monitoring of compliance against DSPT standards	Medium

	Milestones: • May 2026: Deployment programme underway across all priority devices • September 2026: Majority of devices upgraded to supported operating systems • March 2027: Full compliance with supported operating systems across Trust estate	
	2.Implement the annual technology refresh programme to maintain secure, modern and supported digital infrastructure through: • Planned replacement and upgrade of hardware and core infrastructure • Alignment of refresh programme with clinical and operational priorities • Integration of refreshed assets into cyber security and monitoring frameworks **Milestones:** • September 2026: Annual refresh programme prioritised and approved • December 2026: Delivery of priority infrastructure upgrades • March 2027: Sustained infrastructure compliance and reduced technical risk	**Medium**
	3.Develop and implement a comprehensive asset management framework to ensure full visibility and prioritisation of digital assets through: • Creation of a complete inventory of IT and clinical systems, including dependencies • Assessment of asset criticality aligned to clinical and corporate risk • Integration of asset data into risk, resilience and incident response planning **Milestones:** • April 2026: Initial asset register completed post-EPR go-live • Q2 2026/27: Criticality framework applied across all key systems • Q3 2026/27: Asset data embedded into resilience and incident response processes • March 2027: Fully operational asset management framework supporting risk reduction	**High**

Target risk rating Audit committee questions

Audit and Risk Committee questions	
Based on current planned actions what will the risk rating be at end March 2027? (Include Impact and Likelihood, Overall Rating)	It is considered that the risk rating will remain 8 throughout the year
Will the actions above deliver the end March 2027 target rating (Y/N), If No, what else needs to be done to deliver the target?	Yes – the actions outlined are expected to deliver the target risk rating by March 2027. This is based on delivery of the core elements required to reduce digital resilience risk, including: • Removal of unsupported operating systems and improved compliance with national cyber security standards • Improved visibility and prioritisation of critical digital assets • Strengthening of cyber governance and oversight arrangements These actions collectively reduce the likelihood of a significant digital or cyber incident and improve the organisation's ability to respond and recover effectively. Delivery will be monitored through established governance arrangements, including regular reporting to the Audit and Risk Committee, with escalation where progress deviates from plan
When should we expect the overall target to be met (narrative description)	This will be reviewed following the refresh of strategies in October 2026.

Definitions

BAF

The Board Assurance Framework (BAF) is designed to provide the Board with a simple but comprehensive method for effective and focused review of strategic risk. The BAF enables the Board to receive assurance from its committees that strategic risks are being appropriately managed.

Strategic risk

Strategic risks are those that represent major threats to achieving the Trust's strategic objectives or to its continued existence. Strategic risks also include key operational failures. Being clear about strategic risk allows the Board to ensure that the information it receives is pertinent to achievement of objectives and facilitates a clearer starting point for mitigation and control as well as business planning. These risks form the core content of the Board Assurance Framework.

Impact of actions (on controls / assurances)

For each of the actions recorded on the BAF, the impact (on controls / assurances) of completing these actions is indicated as either 'low', 'medium' or 'high'. This supports the effective evaluation of how planned actions are expected to strengthen control or assurance and reduce risk exposure.

High, medium low impact are defined as follows:

HIGH	Action is expected to significantly strengthen controls or close a major assurance gap. Potential residual risk rating reduction on completion.
MEDIUM	Action is expected to partially enhance controls or address a limited aspect of the risk. Improvement in control or assurance is expected but risk level will remain largely stable in the short term.
LOW	Action maintains or reinforces current control or assurance effectiveness; risk position likely unchanged.