Appendix 2: BAF Report

Movement in Risk Score Key:	
	Risk score has improved (reduced) since previous version
	Risk score has deteriorated (increased) since previous version
	Risk score has not changed since previous version

Exec owner(s)	BAF risk
Tim Glenn	3711 **IF** we fail to innovate **THEN** we will not realise our ambition to lead nationally and internationally, nor expand our impact locally and regionally **ULTIMATELY** that will fail to maximise the additional quality added life years that our interventions make.

Additional Risk Information

Nil

Strategic Objective	Current Risk Rating: 10	Risk Movement
SO2 – Building Our Culture of Innovation, Team-Working and Learning		⟷

Linked/Mapped Risks

a. 858 - Optimisation and Development of EPR System	j. 3608 - CUH EPIC Instance Implementation Readiness	r. 3568 - Upgrading/Optimising EPIC instance at CUH
b. 3559 - New LPP Procurement Framework	k. 3617 - Increase CRA time to match that of CUH consultants	s. 3836 - Removal of Benefits for the EPR programme
c. 3564 - Accuracy of costs in OBC	l. 3620 - Lack of Resources to deliver project and BAU activities	t. 3725 - Capital constraints that limit ability to invest in infrastructure
d. 3584 - Insufficient Support for the Green Plan	m. 3708 - Government abolishment of NHSE may negatively impact EPR procurement	
e. 3585 - Lack of Coordination for the Green Plan	n. 3717 - EPR Data Quality and verification	
f. 3591 - Legal challenge to procurement	o. 3722 - Redundancies impacting CUH eHospital team	
g. 3593 - Using the new EPR properly	p. 3779 - Delivering education and training to our workforce	
h. 3594 - Cash releasing benefits not achieved	q. 3789 - Lack of Suitable Archive for Legacy Data Store - EPR	
i. 3603 - EPR Implementation team recruitment cascading		

Overseeing Committee	Date of last Committee review	Date of last Executive Director(s) review
Strategic Projects Committee		25/11/2025

Mitigations

- Development of the Trust's innovation strategy

Sources of Assurance

- Strategy Task and Finish Group
- Joint Strategic discussions with CUH & NWAFT
- Health Inequalities working group
- CQC Report and Rating
- SHMI Data

Gap in Assurance

Risk Assessors recommended actions to further reduce the risk

Development of the Trust's innovation strategy

Risk Assessment	Con	Lik	Risk Score
Inherent Risk Rating (the risk rating before any mitigations are implemented):	2	5	**10**
Current Risk Rating (ie the risk today with mitigations in place)	2	5	**10**
Target Risk Rating	2	3	**6**

Adequacy of Assurances **Amber**

Adequacy of Controls **Amber**

	Controls and Assurances
Green	Significant: No gaps in controls or assurances
Amber	Adequate: Some gaps in controls or assurances
Red	Limited/Inadequate: Significant gaps in controls or assurances

Lines of Defence

1st	Strategy Development Updates to Strategic Projects Committee (SPC), Health Inequalities working group updates to Quality & Risk Committee (Q&R), partnership working updates to SPC.
2nd	Monthly responsiveness and effectiveness monitoring through PIPR, Kaleidoscope reports to SPC. SHMI data to Q&R.
3rd	System quality board (ICB); NHSE; CQC.

Progress Notes:

[Glenn, Tim - 27/11/2025]
The first draft of the RPH Innovation Strategy was reviewed at the October meeting of the Strategic Projects Committee.

Exec owner(s)

Tim Glenn

BAF risk

3709 **IF** we fail to build relationships with wider system partners **THEN** patients will not get care in a timely, effective and efficient way **ULTIMATELY** resulting in poorer outcomes and the wasting of resources.

Additional Risk Information

Nil

Strategic Objective

SO3 – Partnering Locally and Regionally to Extend Our Impact

Current Risk Rating: 12

Risk Movement

⟷

Linked/Mapped Risks

a. 3074 - Failure to engage with national commissioning reforms
b. 3350 - Risk to patient safety through delays to treatment in TAVI service
c. 3449 - Risk to delivery of strategic partnership working
d. 3541 - multiple routes for patient referrals leading to risk of patients ending up on incorrect pathway
e. 3556 - CUH Capacity Constraints
f. 3627 - Independent campus blood transfusion services
g. 368 3- Value of campus wide EPR benefits not identified
h. 3703 - Construction Work within the CBC Campus may affect local air quality
i. 3709 - Failure to growth pathway with partners
j. 3710 - Grow pathways with partners
k. 3712 - Insufficient ILD network engagement
l. 3804 - Shared Care Record not being maintained for New EPR
m. 3805 - Lack of Integration Engine with the new EPR

Overseeing Committee

Strategic Projects Committee

Date of last Committee review

Date of last Executive Director(s) review

25/11/2025

Mitigations

- The creation of the RPH strategy is being designed to be the widest ever engagement exercise with partners that RPH has ever performed.
- The CEO has taken on the role as the system providers representative on the ICB board.
- We are utilising both existing formal fora (eg ICB Board; CBC Ltd; CUHP) and informal fora (1-2-1 relationships; system Exec groups; etc) to build joint understanding of need.
- We have worked with CUH specifically on patient pathway development (eg ACS)

Sources of Assurance

- Strategy Task and Finish Group
- Joint Strategic discussions with CUH & NWAFT
- Membership of the Integrated Care Board
- National Oversight Framework Score
- Statutory Waiting Time Data
- Health Inequalities working group
- CQC Report and Rating

Gap in Assurance

Despite controls in place SSI rates are consistently above UKHSA benchmark.

Risk Assessors recommended actions to further reduce the risk

Continue with the existing controls and extend partnership working, specifically with NWAFT.

Risk Assessment	Con	Lik	Risk Score
Inherent Risk Rating (the risk rating before any mitigations are implemented):	3	5	**15**
Current Risk Rating (ie the risk today with mitigations in place)	3	4	**12**
Target Risk Rating	3	3	**9**

Adequacy of Assurances **Amber**

Adequacy of Controls **Amber**

	Controls and Assurances
Green	Significant: No gaps in controls or assurances
Amber	Adequate: Some gaps in controls or assurances
Red	Limited/Inadequate: Significant gaps in controls or assurances

Lines of Defence

1st	Strategy Development Updates to SPC, CEO updates on ICB, Health Inequalities working group updates to Q&R, partnership working updates to SPC.
2nd	Monthly responsiveness monitoring through PIPR, Kaleidoscope reports to SPC.
3rd	System quality board (ICB); NHSE; CQC.

Progress Notes:

[Glenn, Tim - 27/11/2025]
a. Meeting of Federation of Specialist Hospitals with the Secretary of State for Health and Social Care on 21 October 2025. b. RPH has Commissioned Clinical Trials Review for national learning. c. RPH supporting national discussion on the Specialist Integrated Health Organisations policy

Exec owner(s)

Maura Screaton /Ian Smith

BAF risk

3731 **IF** effective and evidence-based care is not delivered **THEN** this could impact clinical patient outcomes and experience, poor service delivery and trust performance, loss of reputation, reduced CQC ratings and potential financial penalties.

Additional Risk Information

- Specialist services leading treatments and innovation meaning there is limited national guidelines NICE etc - e.g. TAVI pathways.
- Lack of capacity / capability in certain specialities e.g. services dependent on single operators
- Lack of physical capacity to do everything
- NHS financial constraints
- NHS longterm plan

Strategic Objective

SO1 – Focusing on Clinical Excellence in our Services

Current Risk Rating: 9

Risk Movement ⟷

Linked/Mapped Risks

- 3350 – Risk to patient safety through delays to treatment in TAVI service
- 3690 – Backlog of patients requiring Oximetry Tests
- 3692 – Backlog of patients requiring SDC appointments
- 3696 – Delays in Radiology Outsourcing for reporting
- 3735 – Lack of sufficient Bronchoscopes in line with increasing demands
- 3777 – Risk of CT Reporting for TAVI Patients

Overseeing Committee

Quality and Risk Committee

Date of last Committee review

27/11/2025

Date of last Executive Director(s) review

21/12/2025

Mitigations

- All new NICE guidelines reviewed for relevance to the Trust
- Mandated clinical audits of effectiveness conducted and updated to national databases as required.
- Clinical practise committee
- Engaging with wider national campaigns e.g. pressure ulcer prevention, falls, discharge
- Assessment against CQC regulatory standards
- EQUINS
- Quality Accounts as part of annual accounts and performance
- Clinical service strategies
- Document control
- Receive outlier alerts.
- Health inequalities treating tobacco dependency
- Health inequalities panel
- Patient safety initiatives
- Insourcing for CT reporting

Sources of Assurance

- National policy and guidance provide frameworks for ensuring effectiveness of care delivery.
- Using evidence-based frameworks and policy to underpin practise e.g. Getting it right first time (GIRFT), NICE guidance
- Benchmarking: Model Hospital
- Participation in National Clinical Audits mandatory and non-mandatory e.g. adult cardiac surgery updates to NICOR linked to SCTS.
- Regulatory frameworks e.g. CQC, HSIB
- National healthcare health inequalities improvement plan - CORE20PLUS5
- Long term NHS plan

Gap in Assurance

TAVI service plan
Formal review of new technology pilots
Patient Reported Outcome Measures (PROMS), Patient Reported Experience Measures (PREMS) informing service design

Risk Assessors recommended actions to further reduce the risk

- Health inequalities panel set up March 25
- Review of acute pain service in progress due for presentation May 25
- Fortnightly risk oversight of CT backlog

Risk Assessment	Con	Lik	Risk Score
Inherent Risk Rating (the risk rating before any mitigations are implemented):	4	3	**12**
Current Risk Rating (ie the risk today with mitigations in place)	3	3	**9**
Target Risk Rating	3	2	**6**

Adequacy of Assurances **Red**

Adequacy of Controls **Amber**

	Controls and Assurances
Green	Significant: No gaps in controls or assurances
Amber	Adequate: Some gaps in controls or assurances
Red	Limited/Inadequate: Significant gaps in controls or assurances

Lines of Defence

1st	Clinical speciality groups, Patient Reported Outcome Measures (PROMS), Patient Reported Experience Measures (PREMS)
2nd	Quality and Risk Management Group (QRMG), Clinical Decision Cell (CDC)
3rd	External visits e.g. Getting It Right First Time (GIRFT) ECMO, CF, PH

Progress Notes:

[Screaton, Mrs Maura - 21/12/2025]
Mortality/morbidity review of TAVI waiting list completed - no adverse effect of PSI lists noted.
Radiology outsourcing delayed - insourcing extended to mitigate. 1 severe harm incident reported as a consequence to delay in CT reporting.
Clinical meeting held to discuss RAB and effectiveness of it as a treatment

Exec owner(s)

Maura Screaton /Ian Smith

BAF risk

3730 **IF** there are not safe systems and practices in place **THEN** this could lead to patient harm, increased length of stay and poor trust performance, loss of reputation, reduced CQC ratings and potential financial penalties.

Additional Risk Information

National policy and guidance provide frameworks for ensuring quality and safety is maintained to keep service users safe and free from harm.
Key concerns relating to quality and safety compliance are:
- SSI rates - CABG inpatient and readmissions rates are above the UKHSA benchmark.

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- The trust has seen an increase in patient falls with harm in Q1 2025.
- Delays in timeline for procurement and implementation of replacement of M-ighty system for ALERT- recognising and responding to deteriorating patient.
- Vascular access capacity limited to small team of scientists which is insufficient in respect to demand.

- Pain service review has highlighted need for resource to support acute pain
- Trust has been managing an M abscessus outbreak since moving to new site 2021.
- The Trust is managing a risk in respect to fire safety

Strategic Objective

SO1 – Focusing on Clinical Excellence in our Services

Current Risk Rating: 12

Risk Movement

Linked/Mapped Risks

- 1500 – Risk of patient harm from falls
- 1827 – Risks associated with the use of sharps
- 2106 – Risk of Two Electronic Patient Record (EPR) systems that do not communicate with each other. Critical Care -CIS & Wards –Lorenzo
- 3040 – M.Abscessus
- 3162 – SSI Infections
- 3470 – Patient Automated Alerting
- 3580 – Risk of inappropriate or delayed vascular access
- 3582 – Risk in delayed treatment of pain management
- 3644 – DoLS application delay
- 3671 – Insufficient medical staffing out of hours and at weekends
- 3700 – No implementation and training for high Consequence Infectious Disease
- 3703 – Construction within the CBC Campus may affect local air quality
- 3797 – Cancer pathway delays due to external referral waiting times for Robotic Assisted Bronchoscop

Overseeing Committee

Quality and Risk Committee

Date of last Committee review

18/12/2025

Date of last Executive Director(s) review

22/12/2025

Mitigations

- Falls prevention and management work plan reviewed and revised - plan presented at Q and R ongoing monitoring through harm free care panel and QRMG. CRR 1500
- SSI oversight group in place to monitor compliance with standards. CRR 3162
- Alerting patient deterioration mitigations in place and adequate CRR 2470.
- Pain working group in place to work through actions. Current mitigations adequate - CRR 3582.
- M abscessus steering group monitoring incidence of M abscessus and compliance with all care activities. Exec oversight committee providing external assurance next meeting Sept 2025.
- Task and finish group reviewing fire policy and procedure, resource and training. Comprehensive action plan with timelines in place.

Sources of Assurance

- Annual reports
- Care Quality Commission report
- Clinical audit
- Compliance Audit
- Fundamentals of Care Review
- Health and Safety Executive Report/Feedback
- Infection Control Reports
- MDT Meetings
- Medicine and Healthcare Products Regulatory Agency
- National Institute of Clinical Excellence
- Serious Incident Reports

Gap in Assurance

Despite controls in place SSI rates are consistently above UKHSA benchmark.

Risk Assessors recommended actions to further reduce the risk

- SSI rate 3.9% March 25 SSI governance oversight continues to be in place. Improvement in compliance but risk in sustaining compliance.
- Harm free care panel overseeing action plan for prevention and management of falls. All actions on track.
- Actions to mitigate fragile M-IGHTY module for alerting ALERT team of deteriorating patients adequate with no episodes of patient harm noted.
- Good clinical engagement with M abscessus steering group all actions being worked through.
- Fire safety action plan underway - risk to delivery is resource to complete.

Risk Assessment	Con	Lik	Risk Score
Inherent Risk Rating (the risk rating before any mitigations are implemented):	5	3	**15**
Current Risk Rating (ie the risk today with mitigations in place)	4	3	**12**
Target Risk Rating	3	2	**6**

Adequacy of Assurances **Amber**

Adequacy of Controls **Amber**

	Controls and Assurances
Green	Significant: No gaps in controls or assurances
Amber	Adequate: Some gaps in controls or assurances
Red	Limited/Inadequate: Significant gaps in controls or assurances

Lines of Defence

1st	Harm free care panel. ward and department score care, Datix reporting,
2nd	Monthly safe staffing reports to CPAC, Infection Prevention and Control Committee; Fundamentals of Care Board QRMG; SIERP; Quality and Risk Committee; CQC regulation assessments; IPC BAF self-assessment.
3rd	System quality board (ICB) internal auditors; NHSE; CQC. CQRG

Progress Notes:

[Screaton, Mrs Maura - 21/12/2025]
SSI rate for Q2 5.5% - decreasing trend but remains above UKHSA average. New lead for SSI stakeholder group in place with full review in progress. Revised action plan due 28/1/26.
Delay to procurement of MiGHTY replacement. Risk being reassessed to understand implications feedback on this due 18/01/26.
Fire safety training and provision and installation of evacuation equipment on track for delivery by March 2026.
Investigation report following sewage leak on level 1 hot floor completed. Actions underway to prevent/minimise impact of any future occurances and facilities reopened. No evidence of any impact on patients e.g. no infections as a consequence.
No change in current risk rating.

Exec owner(s)

Harvey McEnroe

BAF risk

3873 **IF** the Trust fails to effectively and productively manage its clinical capacity in a way that ensures timely access for patients referred to Royal Papworth for elective, emergency, cancer and or diagnostic services **THEN** this could result in unsafe, untimely and uneconomical care impacting negatively on patient outcomes and performance standards **ULTIMATELY** leading to delayed care and treatment, potential patient harm, increase in patient dissatisfaction and potential regulatory intervention.

Additional Risk Information

1. Clinical Risks:
Patient harm/deterioration: Delays in treatment can lead to worsening health conditions or complications.
Increased mortality: Longer waits for urgent cases may result in increased patient deaths.
Delayed diagnosis: Extended wait times can delay the identification and treatment of serious illnesses.
2.Operational Risks:
Capacity strain: ineffective management can cause bottlenecks, overwhelming specific departments or staff.
Resource inefficiency: Ineffective scheduling leads to underutilisation or overburdening of resources.
Backlogs: Growing waiting lists increase future workload, creating a vicious cycle of delays.

3.Financial Risks:
Increased costs: Longer waits may require more intensive, expensive treatments later.
Penalties/fines: Failure to meet NHS operational standards
Loss of income: Potential reduction in elective activity may reduce tariff income.
4.Reputational Risks:
Public trust erosion: Patients and the public lose confidence in the Trusts ability to provide timely care.
Negative media attention: Prolonged delays can attract unfavourable press coverage and media interest.
Impact on staff morale: Persistent issues and delays to care may reduce staff engagement and increase turnover.
5.Regulatory and Compliance Risks:
Non-compliance with NHS standards: Failing to meet mandated waiting time targets can trigger regulatory scrutiny and impact Trust NOF levels and oversight.
Inspection failures: Poor performance may result in negative Care Quality Commission (CQC) assessments.
Legal actions: Increased risk of complaints, litigation, or judicial reviews related to delays in care.

6.Patient Experience Risks:
Dissatisfaction: Long waits cause frustration and anxiety among patients.
Reduced accessibility: Vulnerable patients may find it harder to navigate or cope with delays.
Equity concerns: Disparities may widen if certain patient groups are disproportionately affected by waiting times.

Strategic Objective

SO6 – Getting the Basics Right

Current Risk Rating: 12

Risk Movement

Linked/Mapped Risks

223 – Activity recovery and productivity – to be merged and closed
3350 – Risk to patient safety through delays to treatment in the TAVI service
742 – Failure to meet safer staffing (NICE Guidance and NQ) – linked to BAF risk 3223
858 – Optimisation and Development of EPR System – linked to BAF risk 3223
2829 - Inability to achieve financial balance at Trust level – linked to BAF risk 3223
3362 – CT Reporting Backlog – Digital – linked to BAF risk 3443
3434 – CT Reporting Backlog – Dept – linked to BAF risk 3443
Open risks with no access plans (waiting list) attached

3696 – Delays in Radiology outsourcing for reporting
3692 – Backlog of patients requiring SDC appointments
3690 – Backlog of patients requiring oximetry tests
3673 – Oncology Standards delays – Trust performance against national compliance (62-day target)
3718 – Delay in admission under CCLI team
3365 –
3766 – Risk of backlog restoration due to unused CPAP capacity
3540 – Consultant Radiologist staffing due to vacancies

3777 – Risk of CT reporting for TAVI patients
3735 – Lack of sufficient bronchoscopes in line with increasing demands
3684 – Cardiology and Radiology / Thoracic booking team
3541 – Multiple routes for patient referrals leading to risk of patients ending up on incorrect pathway
3131 – Staffing – All pathology services

Overseeing Committee

Performance Committee

Date of last Committee review

18/12/2025

Date of last Executive Director(s) review

30/12/2025

Mitigations

1. Elective recovery programme governance, a trust level improvement programme for elective recovery, incorporating all access standards was commenced in February 2025.
2. The programme has fully worked up trajectories and detailed divisional level impact plans across all access standards.
3. Detailed specialty and divisional level trajectories worked up and signed off as part of budget setting, with approval from divisional directors and teams.

Sources of Assurance

1. Action Plan monitored by Divisions
2. Care Quality Commission Report
3. Data Validation
4. Departmental Risk Registers
5. Escalation Process
6. Monitor Compliance Standards
7. PIPR-Performance Report
8. Performance Report/Discusssion

Gap in Assurance

No gaps noted at present

Risk Assessors recommended actions to further reduce the risk

1. Three times weekly operational huddle report
2. PTL meetings reviewed with enhanced oversight, including for diagnostics and cancer
3. Weekly performance dashboard reported to executives

Risk Assessment	Con	Lik	Risk Score
Inherent Risk Rating (the risk rating before any mitigations are implemented):	4	5	**20**
Current Risk Rating (ie the risk today with mitigations in place)	4	3	**12**
Target Risk Rating	4	2	**8**

Adequacy of Assurance **Amber**

Adequacy of Controls **Amber**

	Controls and Assurances
Green	Significant: No gaps in controls or assurances
Amber	Adequate: Some gaps in controls or assurances
Red	Limited/Inadequate: Significant gaps in controls or assurances

Lines of Defence

1st	Elective access improvement dashboard; PIPR effective and responsive; PIPR activity and reporting; PIPR Finance report and monthly performance report on Finance.
2nd	Weekly senior oversight via a delivery group, overseeing each productivity plan at divisional and service level, chaired by the COO. QIAs in place for all elective productivity schemes, oversee by CNO and MD. Fortnightly Access Board in place, supported by DCEO, COO, CNO and MD with each CD and divisional reps to oversee actions to drive productivity and decares waiting times. Fortnightly ideas generation at divisional level ensuring both a pipeline of remedial and long-term actions to continue to address capacity and demand gaps. Monthly reporting at divisional level with trajectory reporting against access standards. Monthly reporting in committees outlining actuals, delivery against trajectory and remedial actions for non-delivery, all at patient level data format. Monthly reporting to Trust Board. Cancer Recovery Performance and Delivery Group; Elective Care Recovery Performance and Delivery Group; Access Board. Performance Committee
3rd	National reporting data and scorecard on elective access. Weekly PTL submission and RTT KLOE review; Planned Care Board; System Planned Care Performance meeting; ICB NHSE

Progress Notes:

[Robinson, Zoe - 30/12/2025]
Improvements continue in terms of proportion of patients waiting no longer than 18 weeks for treatment while the overall waiting list continues to reduce. Sustainable improvements to review clinic, theatre and cath lab utilisation continue to be reviewed and progressed.

Diagnostic waits within sleep continue to improve with options appraisals completed for longer term sustainability of the service model. Radiology demand and capacity required and planned to be included as part of the medium term planning cycle. Echo wait times remain static however validation of the DM01 continues to ensure it is reflective of the actual waiting list.

Strengthened daily operational oversight for cancer 62 day waits continues to result in patients being treated within the relevant time period. However, there is an anticipated decline in December and January in line with the trajectory.

Patient Access Policy has been reviewed and underlying processes attached will need to be reviewed and refined once the Patient Access Policy is approved.

Exec owner(s)
Liz Sanford

BAF risk
3649 **IF** the Trust does not fully adopt sustainable development approaches into its culture and all aspects of its operations,**THEN** it may not achieve its required contribution to NHS Net Zero, **ULTIMATELY** meaning that the Trust fails to fulfil its role to society and the community that it serves and that it will be insufficiently prepared to adapt to the impact of climate change upon the future patterns of healthcare and the physical environment in which the Trust must operate.

Additional Risk Information
Further to the above, inability to deliver system financial plans in the current financial year could impact on the award of incentive funding to the system from NHSE in 2025/26 onwards. This could impact on the Trust's ability to afford the medium-term capital replacement programme, including the replacement EPR.

Strategic Objective
SO2 – Building Our Culture of Innovation, Team-Working and Learning

Current Risk Rating: 12

Risk Movement
⟷

Linked/Mapped Risks
- 3583 – Failure to embed sustainability into the culture and operations of the Trust

Overseeing Committee
Performance Committee

Date of last Committee review
18/12/2025

Date of last Executive Director(s) review
25/11/2025

Mitigations
Board approved Sustainability Strategy in place and subject to annual review by the Strategic Projects Committee.
The Chief Executive is designated Board lead for sustainability and delivery of NHS Net Zero Targets.
A Green Plan has been established as the vehicle by which to undertake a programme of embedding sustainability into the organisation and is subject to annual review and update every three years.
A Sustainability Board has been established to oversee the programme of sustainability activities and specifically to monitor progress against the Green Plan. The Sustainability Board reports to the Performance Committee on a six-monthly basis.
Updates on sustainability activities and progress are provided to the public via the Trust's annual report. Such updates are prepared in accordance with the requirements of the Taskforce on Climate-related Financial Disclosure (TCFD) as adopted for NHS annual accounting processes.
Dedicated Environmental Officer/Sustainability Officer roles exist within the Estates and Facilities department.

Sources of Assurance
a. Sustainability Team lead on the activity to develop and support carbon reduction and net zero as per national targets.
b. Green Plan (25-27) now completed and published on both intranet and internet.
c. Sustainability Programme Lead now in post to progress activity with team over duration of the Green Plan timeline.
d. Workstream leads identified and in place to develop activity.
e. Reporting to Sustainability Board, Performance Committee and Trust Board in relation to progress.
f. Governance, reporting and monitoring plans have been embedded, alongside completion of the Green Plan for the period 25-27.
g. Additional capacity and capability in place to progress with plans. This includes review of the organisation's culture of sustainability and how this is embedded into everyday practices.

Gap in Assurance
Work continues on corporate policies and other strategies (e.g. procurement, workforce, finance etc) progress in review to ensure alignment to environmental sustainability ambitions, and this is underway as part of strategy refresh.
Strategic review with Private Finance Iinitiative(PFI) provider and other estate services of future plans for building enhancements and delivery of sustainability measures as part of future plans well into development, with a number of opportunities identified for further investigation.

Risk Assessors recommended actions to further reduce the risk
Progress regarding delivery of Green Plan actions will require regular review via the Sustainability Board, with additional assistance/resources identified as necessary to ensure national targets within the plan are delivered to timescale.
Sustainability Board to be reconstituted to further enhance its programme oversight role; revised membership has been reviewed and approved by the Executive Committee.
Further programme of engagement and training activities will be required, aided by recent re-establishment of a network of Green Champions.

Risk Assessment	Con	Lik	Risk Score
Inherent Risk Rating (the risk rating before any mitigations are implemented):	4	4	**16**
Current Risk Rating (ie the risk today with mitigations in place)	4	3	**12**
Target Risk Rating	4	2	**8**

Adequacy of Assurances **Amber**

Adequacy of Controls **Amber**

	Controls and Assurances
Green	Significant: No gaps in controls or assurances
Amber	Adequate: Some gaps in controls or assurances
Red	Limited/Inadequate: Significant gaps in controls or assurances

Lines of Defence

1st	
2nd	Sustainability Board; Performance Committee; Trust Board
3rd	

Progress Notes:
[Mainds, Kirsty - 25/11/2025]
Gaps in assurance and sources of assurance updated.

Exec owner(s)	BAF risk
Liz Sanford	2904 **IF** the ICS does not achieve financial balance in the current year and beyond, **THEN** the ICS and Trust may be subject to regulatory action and potential funding flow changes which could impact on the Trust and ICS's ability to provide high quality, sustainable services to patients now and in the future.

Additional Risk Information

Further to the above, inability to deliver system financial plans in the current financial year could impact on the award of incentive funding to the system from NHSE in 2025/26 onwards. This could impact on the Trust's ability to afford the medium-term capital replacement programme, including the replacement EPR.

Strategic Objective	Current Risk Rating: 16	Risk Movement	Linked/Mapped Risks		
SO3 – Partnering Locally and Regionally to Extend Our Impact		⟷	•2829 – Inability to achieve financial balance at Trust level •3074 – Failure to engage with national commissioning reforms	•3261 – Industrial Relations •3449 – Risk to delivery of strategic partnership working	

Overseeing Committee	Date of last Committee review	Date of last Executive Director(s) review
Performance Committee	18/12/2025	19/12/2025

Mitigations

- System CFO meeting regularly to escalate system financial risks and develop plans to mitigate/manage these risks.
- Wider ICS governance structure includes senior oversight of ICS financial position.
- Long term ICS financial modelling being developed to understand the scale of future challenges.
- Ad-hoc modelling of national funding to support impact of Industrial Action or other key risks as and when relevant.
- ICS wide productivity workstreams set up to explore opportunities for productivity gains and closer working across corporate services.
- National and ICB approval of strategic business cases to ensure collective agreement to material investment decisions that could impact the financial position (e.g. EPR, capital strategic projects incl new hospital programme builds).
- ICB CFO engagement in regional specialised commissioning forum governing delegation approach.
- Maximising out of system funding flows to support system financial position.

Sources of Assurance

- System CFO meeting regularly to escalate system financial risks and develop plans to mitigate/manage these risks
- Wider ICS governance structure includes senior oversight of ICS financial position and the action plans in partner organisations
- Long term ICS financial modelling being developed to understand the scale of future challenges
- Modelling of national funding to support impact of Industrial Action, national reforecast exercise undertaken November 2023 on the back of additional funding provided by government (reduction of elective targets and additional targeted funding). Additional work undertaken in January in response to strike action.

Gap in Assurance

1. Macroeconomic environment, including supply constraints, potential for unfunded pay awards or material changes in banding profiles for registered nursing staff, inflation and pressure on public sector finances may lead to additional financial pressure above funded levels or reduction in funding available to Trust. Ability to control these largely outside system's direct control. Limited control over the financial and operational performance of other organisations in the ICB which could impact the Trust's financial position moving forward.
2. Lack of clarity on the changes in the 2025/26 (and beyond) financial architecture and the impact on the position.
3. Clarity on the financial implications of strategic development programmes on the medium-term position (e.g. NPH, EPR etc).

Risk Assessors recommended actions to further reduce the risk

- Assessment of the impact of unmitigated financial risks for 25/26 by system partners.
- Clarity on the financial implications of three EPR programmes on the medium term position and mitigations available.
- Clarity on the financial framework for 2025/26 and beyond.
- Negotiations with Commissioners to agree settlement for FY27.

Risk Assessment	Con	Lik	Risk Score
Inherent Risk Rating (the risk rating before any mitigations are implemented):	4	5	20
Current Risk Rating (ie the risk today with mitigations in place)	4	4	16
Target Risk Rating	4	3	12

Adequacy of Assurances: Amber

Adequacy of Controls: Amber

	Controls and Assurances
Green	Significant: No gaps in controls or assurances
Amber	Adequate: Some gaps in controls or assurances
Red	Limited/Inadequate: Significant gaps in controls or assurances

Lines of Defence

1st	Nil
2nd	Performance Committee; Trust Board
3rd	Nil

Progress Notes:

Sanford, Liz – 19/12/2025
The risk has been reviewed in light of the current FY performance which at month 8 is indicating significant risk that two providers within the ICS may not be able to deliver their financial plan; however, recovery actions are underway. There is a risk that ICS brokerage will not be able to manage this position. Whilst this is unlikely to result in regulatory action being taken against RPH, failure to manage the position will result in a loss of incentive funding to the ICS in FY27 which could negatively impact the Trust's settlement. For FY27, the Trust has submitted a deficit plan at point of first submission and has not got a plan that is aligned with Commissioners.

Exec owner(s)
Liz Sanford

BAF risk
2829 **IF** the Trust does not achieve financial balance in the current year and beyond **THEN** the Trust (and ICS) will be subject to regulatory action which will impact on the Trust's ability to provide high quality, sustainable services to patients now and in the future.

Additional Risk Information
No further detail - risk outlined fully in description

Strategic Objective
SO6 – Getting the Basics Right

Current Risk Rating: 20

Risk Movement

Linked/Mapped Risks
- 858 – Optimisation and Development of EPR System
- 1854 – Unable to recruit the required number of staff at the required of skills and experience
- 2116 – Procurement declarations of interest
- 2904 – Inability to achieve financial balance at ICS level
- 3074 – Failure to engage with national commissioning reforms
- 3223 – Activity recovery and productivity
- 3261 – Industrial Relations

Overseeing Committee
Quality and Risk Committee

Date of last Committee review
18/12/2025

Date of last Executive Director(s) review
19/12/2025

Mitigations
- Monthly reporting of cash, I&E and activity position through Performance Committee and Trust Board
- Cash flow forecasting over rolling 12-month period
- Part-block clinical income contracts with NHSE and key ICB partners
- Activity recovery plans being implemented where necessary through operational and service teams. These plans are being monitored through Performance Committee
- Cost investment controls through weekly vacancy control panel, monthly Investment Group and Performance Committee cycles
- Long term financial modelling updates
- CFCO involvement in ICB Finance forum which monitors risk
- Trust working with specialised commissioning on future funding frameworks and strategy for NHSE
- Potential for utilisation of non-recurrent financial recovery initiatives to support breakeven position
- Current national funding mechanism is providing additional support through the Trust's fixed income arrangements to mitigate the 24/25 position
- EPR replacement programme ongoing with business case process expected to clarify the financial implications as well as possible mitigations
- Development of proposals for the growth of private care to support longer term financial sustainability
- Strengthening of control environment for agency and temporary staffing
- Number of linked actions in relation to industrial relations described under risk BAF 3261
- Additional support being brought into the CIP Programme Manager Office to supercharge CIP delivery and mitigate delivery risk versus plan.

Sources of Assurance
- Business Development Plan (ATIR)
- Corporate Meetings
- Departmental Risk Register
- External Audit
- Finance Report
- Investment Committee
- Compliance Standards
- NHS England/Improvement Reports/Feedback
- PIPR/Performance Committee
- Performance Report/Discussion

Gap in Assurance
1. Macroeconomic environment, including supply constraints, potential for unfunded pay awards or material changes in banding profiles for registered nursing staff, inflation and pressure on public sector finances may lead to additional financial pressure above funded levels or reduction in funding available to Trust. Ability to control these largely outside Trust's direct control.
Lack of clarity on the changes in the 2025/26 (and beyond) financial architecture and the impact on the position.

Risk Assessors recommended actions to further reduce the risk
- Greater clarity on the net cost impact of the EPR programme.
- This is expected following OBC and FBC completion. This may include securing additional funding to support the costs of the programme.
- Clarity on funding envelopes and framework for 2025/26 and beyond.
- Closure of the CIP gap for 2025/26.
- Agreement of contractual positions for FY27.
- Development of FY27 CIP Plan.

Risk Assessment	Con	Lik	Risk Score
Inherent Risk Rating (the risk rating before any mitigations are implemented):	4	5	20
Current Risk Rating (ie the risk today with mitigations in place)	4	5	20
Target Risk Rating	4	2	8

Adequacy of Assurances **Amber**

Adequacy of Controls **Amber**

	Controls and Assurances
Green	Significant: No gaps in controls or assurances
Amber	Adequate: Some gaps in controls or assurances
Red	Limited/Inadequate: Significant gaps in controls or assurances

Lines of Defence

1st	1. Cash flow forecasting over rolling 12-month period 2. Part-block clinical income contracts with NHSE and key ICB partners 3. Activity recovery plans being implemented where necessary through operational and service teams. These plans are being monitored through Performance Committee and Divisional groups 4. Cost investment controls through weekly vacancy control panel, monthly Investment Group and Performance Committee cycles 5. Long term financial modelling updates 6. CFCO involvement in ICB Finance forum and risk mitigation 7. Trust working with specialised commissioning on future funding frameworks and strategy for NHSE 8. Potential for utilisation of non-recurrent financial recovery initiatives to support breakeven position in 2023/24 9. National funding mechanism change in 2023/24 (non-recurrent) is providing additional support through the Trust's fixed income arrangements to mitigate the 23/24 position 10. EPR replacement programme ongoing with business case process expected to clarify the financial implications as well as possible mitigations 11. Enhanced design and operation of temporary staffing controls
2nd	1. Monthly reporting of cash, I&E and activity position through Performance Committee and Trust Board 2. Updates on NHS Financial Regime provided to Performance Committee, Divisions and BoardOversight of business planning process through Performance Committee and Board 3. Papers outlining proposal for the development of private care to support longer term financial sustainability- 4. Updates on NHS Financial Regime provided to Performance Committee, Divisions and Board 5. Oversight of business planning process through Performance Committee and Board
3rd	1. External audit 2. Internal audit - review of key financial controls on an annual basis. Assurance over the design and effectiveness of controls through this report and reviewed by Audit Committee. 3. Feedback from NHSE

Progress Notes:
[Sanford, Liz – 19/12/2025]
Risk scored amended to 20 to reflect current status of FY27 Plan - a deficit of £2.5m versus a requirement to breakeven. FY27 CIP Plan at opportunity stage of development. Negotiation timetable in place with ICB to agree contract value. Work on going to develop CIP schemes.

Exec owner(s)

Liz Sanford

BAF risk

3725 **IF** the Trust is unable to access a sufficient capital envelope, **THEN** it may not be able to invest in critical service infrastructure or infrastructure that supports innovation and strategic development. **ULTIMATELY** this may lead to a deterioration in the quality of digital, medical device and estate infrastructure; an inability to purchase items that could mitigate clinical risk, impacting on the delivery of safe, high quality patient care; an inability to innovate or deliver strategic change; missed opportunities to maximise productivity; and an inability to provide an appropriate working environment for staff.

Additional Risk Information

This could lead to additional revenue costs being incurred to mitigate capital unavailability, leading to a further risk of deteriorating value for money in resource deployment.

Strategic Objective

SO1 – Focusing on Clinical Excellence in our Services

Current Risk Rating: 20

Risk Movement

Linked/Mapped Risks

Nil

Overseeing Committee

Performance Committee

Date of last Committee review

18/12/2025

Date of last Executive Director(s) review

24/11/2025

Mitigations

- Short term and long term capital planning and prioritisation of capital investments. This is overseen by Investment Group, Performance Committee and ultimately the Board;
- Access to alternative funding sources and mechanisms actively considered;
- Robust business cases and investment cases to support effective prioritisation of available resource envelopes and to build support with NHS England for additional CDEL in the case of the EPR programme;
- Effective system-wide working and active engagement re CDEL envelopes, particularly in the context of the EPR programme;
- Trust representation and influencing power through membership of the Federation of Specialist Hospitals and active participation in policy discussions.

Sources of Assurance

- Investment Group monitoring reports,
- Finance report monitoring up to Performance Committee and Board;
- Annual approval of capital plan through Information Governance and Performance Committee;
- Routine capital reporting to NHSE;
- ICFO system discussions including EPR OBC

Gap in Assurance

CDEL is to be allocated at a Provider level from FY27. The new arrangement will require that we continue to work closely with System colleagues to honour agreements that were made under previous arrangements where the ICB played a key role in managing System allocations. There is a lack of clarity over how CDEL is allocated, and the Trust has a lack of control over the total NHS capital envelope. More locally, following the 5 Year Strategy Refresh the Trust will undertake a revised capital prioritisation exercise to link capital deployment to strategic objectives.

Risk Assessors recommended actions to further reduce the risk

- Working with system partners, influence improved processes for capital prioritisation at system level to secure greater clarity and consistency on how CDEL is allocated and ensure CDEL is being prioritised effectively across the system.
- Review of clinical divisional input to the prioritisation processes at Medical Device Group and Digital Strategy Board to provide enhanced assurance that available capital is being deployed in support of core Trust priorities.
- Following the development of the new 5 Year Strategy, a re-mapping of the Trust's 5 year capital plan against expected capital envelopes to understand opportunity, risk and areas for planned mitigation (including funding routes).

Risk Assessment	Con	Lik	Risk Score
Inherent Risk Rating (the risk rating before any mitigations are implemented):	5	5	**25**
Current Risk Rating (ie the risk today with mitigations in place)	4	5	**20**
Target Risk Rating	3	3	**9**

Adequacy of Assurances **Amber**

Adequacy of Controls **Amber**

	Controls and Assurances
Green	Significant: No gaps in controls or assurances
Amber	Adequate: Some gaps in controls or assurances
Red	Limited/Inadequate: Significant gaps in controls or assurances

Lines of Defence

1st	day to day reporting from clinical teams, estates and digital, including risk monitoring.
2nd	Divisional Performance Review Meetings; Investment Group monitoring reports from Digital, Estates and Medical Devices Group; Digital Strategy Board minutes and reports; monitoring against Digital action plans; finance report monitoring of capital deployment; annual approval of capital plan through Investment Group and Performance Committee; routine capital reporting to NHSE; ICS CFO, Strategy and COO discussions re capital allocations and ongoing reporting of system capital expenditure; prioritisation at system level of RPH EPR capital.
3rd	external audit annual audit of financial statements; regulator review of significant capital business cases

Progress Notes:

[Sanford, Liz - 24/11/2025]
Risk currently in draft. Sufficient capital envelope in place for 25/26, medium term risk remains live.

Exec owner(s)	BAF risk
Andy Raynes	1021 **"IF"** the trust is underprepared for a digital related outage and/or lacks resilience to recover from a digital incident. **"THEN"** the risk of the trust instigating a Business Continuity or Critical incident increases. **"ULTIMATELY"** This event could cause impact on accessing systems (clinical and nonclinical) causing disruption at an organisation level that leads to delay in providing patient care due to system availability. Disruption will impact not only an organisation level but regional and national levels. The impact may last for a prolonged period, necessitating cancellations and delays to all aspects of patient care, which could lead to staff burnout. Additionally, it poses a risk to the Trust's reputation, in the patient care that can be given and in rare cases even loss of life and extensive time and cost to recover.

Additional Risk Information

Digital Incident Recovery and Risk Mitigation Recovering from any digital outage requires careful planning to minimise disruptions and restore services swiftly. Typically, recovery from an incident equates to twice the length of disruption. For example, two days of disruption will require four days for full recovery to allow for system validation and integrity checks.		

Strategic Objective	Current Risk Rating: 20	Risk Movement	Linked/Mapped Risks		
SO6 – Getting the Basics Right		⟷	a. 3864 - Cyber Security b. 3536 - Trusts ability to recover from a digital incident c. 3481 - Server 2012 fleet replacement d. 1938 - Cardiovascular Information System	e. 3271 - Patch and reboot schedules (security) for servers containing clinical data f. 2207 - Hacking Risk M-ighty g. 2628 - Use of Split Tunnel VPN for Attend Anywhere	h. 3174 - Generic login for Fysicon instenad of individual user logins i. 3358 - Metavision Server Reboot J. 3466 - Outdated exercise room computer equipment (windows 7)

Overseeing Committee	Date of last Committee review	Date of last Executive Director(s) review
Performance Committee & Strategic Projects Committee	18/12/2025	**20/11/2025**

Mitigations	Sources of Assurance	
a. Priority Systems and Applications Disaster Recovery and Backup Procedures b. Regularly review backups of applications, systems and servers c. Ensure monthly/yearly backups to physical tape are sent offside as soon as visibility possible. d. Ensuring the integrity of backups. e. Disaster Recovery Planning is undertaken yearly. f. Yearly tabletop exercises are preformed, and recommendations/actions are fed back and actioned accordantly. g. Bespoke Disaster Recovery plan is in place for system, applications and key services. h. Cyber Security Incident Response Plan i. Conduct business impact analyses, finalize and continuously review BCPs, and coordinate with emergency response teams to ensure plans are practical and effective j. Adopting EPRR National Guidance for best practices.	a. External Audit Reviews b. ICB Review c. Incident Investigations d. After-Action Reviews e. Tabletop and/or simulation exercises f. Internal reviews	

Gap in Assurance	Risk Assessors recommended actions to further reduce the risk
Lack of digital specialists within organisation due to funding within Digital. An ongoing program of education and Knowledge sharing between teams is in place to mitigate.	1. Data Backup and Disaster Recovery - Critical Systems Identification: Key systems identified based on business needs to prioritise protection. Disaster Recovery Plan(s): All systems part of the organisations essential functions holds a bespoke disaster recovery plan(s). Plans are regularly reviewed to address risks, update recovery objectives, and maintain readiness. 2. Regular Backups: Systems backed up daily and monthly, with tapes securely stored onsite and offsite for quick accessibility. Regular backups of system, applications and servers happen daily. Subsequent month backups are stored at an off-site location. 3. Business Continuity Planning (BCP) - Business Continuity Plan (BCP): The Digital department holds a BCP ensuring continuity in the event of system, service or workforce availability. Business Impact Analysis: Ongoing reviews and updates to business impact analysis, Business continuity plan ensure continuity plans remain effective. 4. Staff Engagement: Regular communication between business, emergency response, and digital teams keeps continuity efforts aligned. The BCP process is communicated to staff via monthly briefings, NewsBites, intranet updates, and screensavers. 5. Preparedness Tools: "Battle boxes" with essential resources and instructions are provided to enable staff to act efficiently during incidents. 6. EPR Disaster Recovery Machines: Each ward has a dedicated disaster recovery machine which in the event of unplanned EPR unavailability can be used to print/view key patient vital information for continuing patient care and treatment. 7. External Backup and Disaster Recovery as a Service procurement - The trust benefits from an external partner to provide Backup and Disaster Recovery as a Service (BaaS & DRaaS) capabilities.

Risk Assessment	Con	Lik	Risk Score
Inherent Risk Rating (the risk rating before any mitigations are implemented):	5	4	**20**
Current Risk Rating (ie the risk today with mitigations in place)	5	4	**20**
Target Risk Rating	4	4	**16**

Adequacy of Assurances **Amber**

Adequacy of Controls **Amber**

	Controls and Assurances
Green	Significant: No gaps in controls or assurances
Amber	Adequate: Some gaps in controls or assurances
Red	Limited/Inadequate: Significant gaps in controls or assurances

Lines of Defence	
1st	Incident Investigations After-Action Reviews Tabletop and/or simulation exercises Internal Reviews
2nd	Digital Strategic Board IG Steering Group Performance Committee Strategic Projects Committee Trust Board
3rd	External Audit Reviews ICB Reviews

Progress Notes:

[Ford, Wayne - 20/11/2025]
This BAF has now been changed from a "Cyber" risk to a Digital Business continuity risk. the original 1021 Cyber risk has been recreated to a corporate risk 3864 this Baf will now be fed by the linked records

Exec owner(s)

Oonagh Monkhouse

BAF risk

3732 **IF** we do not develop and embed an inclusive leadership culture **THEN ULTIMATELY**, we risk negatively impacting staff engagement and failing to address the discrimination, bullying, abuse and violence, including sexual abuse, that exists in the organisation.

Additional Risk Information

The Trust has historically had lower levels of staff and engagement and morale than our peer group and we have very high reported levels of bullying and discrimination particularly from staff from an ethnic minority background. We have also consistently had feedback from staff that they do not feel that we provide good opportunities for our staff to progress their careers in the Trust. This may lead to low staff morale, increased turnover and sickness absence, detract from our ability to recruit and ultimately to an adverse impact on the quality of care we provide and our financial plans. There are particular staff groups and departments were staff engagement is lower than the Trust average either as a result of specific issues within a Department or a wider national context. Resident doctors are one group were there are concerns regarding staff engagement and wellbeing. During 24/25 the Trust Board identified a need to focus on valuing and prioritising excellent leadership skills and an inclusive leadership culture. In addition to internal factors the national industrial relations environment and cost of living pressures experienced by our staff could impact on staff engagement and morale and in particular for staff in the lower pay grades. Industrial action in recent years is likely to have negatively impacted on the perceptions of staff about feeling valued by the government/public and consequently negatively impact on staff engagement.

Strategic Objective

SO5 –Ensuring All

Current Risk Rating: 15

Risk Movement

Linked/Mapped Risks

- 2247 – Stress in the workplace
- 3816 – Sickness absence levels in excess of the KPI
- 3817 – Appraisal compliance in below the KPI and there is low levels of satisfaction with the quality of appraisals
- 3818 – Reported high levels of bullying and harassment

3819 - Reported levels of high discrimination

Overseeing Committee

Workforce Committee

Date of last Committee review

27/11/2025

Date of last Executive Director(s) review

30/12/2025

Mitigations

The Compassionate and Collective Leadership Programme encompasses a number of workforce programmes to improve staff engagement and ensure a high care quality culture. We have a number of support mechanisms in place to enable staff to work safely and to receive support for their health and wellbeing.
During 25/26 we continued to provide a Staff Support Scheme to support staff with the cost of transport and food.
There is a monthly all staff briefing and weekly managers briefings to keep staff informed and provide the opportunity to recognise and appreciate the contribution of staff/teams. A weekly digital newsletter provides the opportunity to focus on particular items in more detail.
The BME, LGBT, Womens and Disability Staff Networks provide the forum for proactively working with staff to improve engagement and inclusivity.
The Transformational Reciprocal Mentoring Programme is a key aspect of our EDI Improvement Plan. Good line management is an important aspect of building high staff engagement and the line managers development programme has been refreshed to encompass the Inclusive Leaders Behaviour Framework.
The Workforce Strategy describes the approach to developing leaders.
In May 2024 a project commenced to review the job descriptions, bandingline managers and improving staff engagement and metrics for tracking progress.
The Trust Board regularly reviews their strategic approach and leadership of EDI and culture. A further event with the Trust's leadership focused on culture and engagement is planned for April 2026.
A Nursing Career Development Programme has reviewed the job descriptions and banding for all nursing roles and introduced annual career conversations in order to proactively address the concerns being raised by Trade Unions and staff about career progression.
A revised structure has been implemented in the Workforce Directorate which includes dedicated capacity for talent management and career pathways.
The EDI High Impact Action Plan details all of the actions that we are taking to address the high levels of inequality. There are actions plans which have been approved by the Trust Board.
OD practitioners have been trained in a team development model and pilots are being conducted with two teams.

Sources of Assurance

- Action Plan - monitored by Division
- Compliance Audit
- Departmental Risk Register
- External Audit
- Internal Audit
- NHS England/Improvement Report/Feedback
- NHS Staff Survey
- Number of Complaints
- Number of Incidents
- PIPR - Performance Report
- Performance Report/Discussion
- Pulse Survey
- Royal College or Deanery Reports
- Staff Surveys
- Staff Turnover

Gap in Assurance

No gaps noted at present. Progress against the Workforce Strategy Action plan is reported to the Workforce Committee, and this identifies when specific actions are reprioritized to match

Risk Assessors recommended actions to further reduce the risk

- To improve career pathways and development plans for staff to reduce the instances of staff having to leave to develop their careers.
- Work has commenced but full roll out has been delayed as a result of prioritisation of resources.

Risk Assessment	Con	Lik	Risk Score
Inherent Risk Rating	4	5	**20**
Current Risk Rating	5	3	**15**
Target Risk Rating	4	3	**12**

Adequacy of Assurances **Amber**

Adequacy of Controls **Amber**

	Controls and Assurances
Green	Significant: No gaps in controls or assurances
Amber	Adequate: Some gaps in controls or assurances
Red	Limited/Inadequate: Significant gaps in controls or assurances

Lines of Defence

1st	Departmental reviews of action plans, Audits, KPIs detailed in Workforce Strategy,
2nd	Workforce Committee, Guardian of Safe Working Reports
3rd	External audits, NHS Staff Survey, Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) report, Equality Delivery System (EDS), Gender Pay Gap Audit, General Medical Council (GMC), National Education Training Survey (NETS), National Quarterly Pulse Survey (NQPS) Freedom To Speak Up Guardian Report

Progress Notes:

[Monkhouse, Oonagh - 30/12/2025]
Risk reviewed and section on action being taken has been updated.

Exec owner(s)	BAF risk
Oonagh Monkhouse	3733 **IF** the Trust does not have an affordable workforce plan and delivery plan that is integrated with operational and financial planning **ULTIMATELY** we may fail to secure a pipeline of appropriately skilled staff and/or deploy staff in the most effective manner.

Additional Risk Information

• Vacancy and turnover have decreased over the previous two years, and we are in a position where we are required by national planning guidance to meet operational targets with no growth in workforce numbers. • We are also required to reduce our spend on agency workers. • As we develop our new 5-year strategy we will set our ambitions in relation to the development of our services, our role locally, regionally and nationally and the 10 Year Plan.	• In order to meet our strategic, operational and financial ambitions and plans we will need to ensure that there is effective workforce planning that considers the types of skills and competencies that we need in our workforce and how we will develop/recruit this future workforce, providing clear and sustainable career pathways. • We will need to effectively plan for no growth in overall numbers, maintenance of low vacancy and turnover rates and upskilling our workforce. • We will also need to plan for the new skills and training required for the deployment of a new EPR in the next two years. Failure to manage these risks could result in staff shortages and skill gaps leading to insufficient numbers of staff available in key areas and a subsequent impact on the quality of patient care, our ability to develop clinically effective services for the future, an increase in agency usage and financial pressures, and a decrease in morale which will affect both the staff and patient experience. • We effectively utilise an electronic rostering system to ensure efficient deployment of non-medical clinical staff. We need to consider how to improve the rostering of medical staff to support effective deployment and monitoring.

Strategic Objective		Risk Movement	Linked/Mapped Risks
SO6 – Getting the Basics Right	**Current Risk Rating: 12**		• 3374 – Medical Staff Rostering – No centralised roster • 3815 – Failure to implement the NHS Job Evaluation Scheme • 3820 – Temporary staffing spend and usage in excess of budgeted plans

Overseeing Committee	Date of last Committee review	Date of last Executive Director(s) review
Workforce Committee	27/11/2025	30/12/2025

Mitigations

- Integrated operational, workforce and financial planning processes in place.
- The Workforce Directorate is improving the support for Divisions and Directorates with workforce planning.
- Programme in place to develop career pathways, starting with nursing career pathways.

Sources of Assurance

- Business Unit Meetings
- Corporate Meetings
- Departmental Risk Register
- External Audit
- Healthroster Rota Reporting
- IPR – Performance Report
- Performance Report/Discussion
- Training Records

Gap in Assurance

Despite controls in place SSI rates are consistently above UKHSA benchmark.

Risk Assessors recommended actions to further reduce the risk

We need to develop an Apprenticeship plan.

Risk Assessment	Con	Lik	Risk Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	3	12
Target Risk Rating	3	3	9

Adequacy of Assurances **Amber**

Adequacy of Assurances **Amber**

	Controls and Assurances
Green	Significant: No gaps in controls or assurances
Amber	Adequate: Some gaps in controls or assurances
Red	Limited/Inadequate: Significant gaps in controls or assurances

Lines of Defence

1st	Roster Check and Support Meetings, Operational Planning processes, Workforce Strategy action plan
2nd	Performance Committee, Workforce Committee
3rd	External Audit, regulators

Progress Notes:

[Monkhouse, Oonagh - 30/12/2025]
The Workforce Committee wants to review the risk rating at the January meeting.

Exec owner(s)
Liz Sanford

BAF risk
2985 **"IF"** the Trust is reliant on key suppliers to deliver commissioner requested services "**THEN"** the Trust has a higher likelihood of being exposed to financial and service delivery risks.

Additional Risk Information
Digital Incident Recovery and Risk Mitigation

Strategic Objective &

Linked/Mapped Risks
8 Medical Devices use and procurement
2984 EDC Gold procurement failure
3009 Risk to continuity of servies from supply chain disruption
3344 Risk to patient care through lack of angio packs

Current Risk Rating: 10

Risk Movement ⟷

Overseeing Committee
Performance Committee & Trust Board

Date of last Committee review
18/12/2025

Date of last Executive Director(s) review
19/12/2025

Mitigations
a.Contracts are entered into the Atamis Contract register and a classification is entered based on the Government Commercial Function tiering tool.
b.Additionally, a risk score is assigned to each contract to indicate the level of risk to the Trust based on criticality of supply, ease of change and size of supply market. This determines the level of contract management that the lead stakeholder will need to apply.
c.Contracts are managed at department level with spot checks to be carried out by Procurement to ensure that contract management is taking place.

Sources of Assurance
a.The Chief Finance and Commercial Officer is in dialogue with suppliers to resolve issues surrounding the commercial elements of proposed contracts.

Gap in Assurance
The assurance is based on the continued desire of both parties to come to a resolution that will benefit the Trust its suppliers

Risk Assessors recommended actions to further reduce the risk
a.A supplier audit will allow the Trust to monitor the suppliers financial stability and service delivery standards so that the Trust can identify or examine risks before they become a problem.
b.Supplier audits to be carried out by Trust contract managers on Gold contracts every 6 months and annually on silver contracts. Review dates to be added to the Atamis contract register and reminders sent out to all contract owners prior to review date. This audit shall include a review of the annual financial statements of the suppliers to monitor financial stability with assistance from the Trust finance business partners.
c.For each new procurement cycle the Trust will need to carry out a strategic review of the services being delivered to determine the most appropriate strategy to apply to reduce the level of risk to the Trust.

Risk Assessment	Con	Lik	Risk Score
Inherent Risk Rating	5	5	25
Current Risk Rating (ie	5	2	10
Target Risk Rating	5	2	10

Adequacy of Assurances Amber

Adequacy of Controls Green

	Controls and Assurances
Green	Significant: No gaps in controls or assurances
Amber	Adequate: Some gaps in controls or assurances
Red	Limited/Inadequate: Significant gaps in controls or assurances

Lines of Defence

1st	
2nd	
3rd	

Progress Notes:

[Liz Sanford – 19/12/2025]
No further update/action required. Contracts are classified and managed in accordance with the classification as per the Trust's contract management arrangements.

Trust risk scoring matrix and grading

	Likelihood				
Consequences	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Risk Assessment	Grading
15 - 25	Extreme
8 - 12	High
4 - 6	Medium
1 - 3	Low

Strategic Objectives		Executive Owner (s)	BAF Risks
SO1	Focusing on Clinical Excellence in Our Services	Maura Screaton; Ian Smith; Liz Sanford	3730; 3731; 3075
SO2	Building our Culture of Innovation, Team-working and Learning	Tim Glenn; Liz Sanford	3711; 3649
SO3	Partnering Locally and Regionally to Extend our Impact	Tim Glenn; Liz Sanford	3709; 3733
SO4	Leading Nationally and Internationally in Heart and Lung Care	Tim Glenn; Oonagh Monkhouse; Ian Smith	
SO5	Ensuring All Staff are Valued and Empowered	Oonagh Monkhouse	3732; 2904
SO6	Getting the Basics Right	Liz Sanford; Andy Raynes; Harvey McEnroe; Oonagh Monkhouse	3873; 2829; 1021