Meeting title:	Trust Board					
Date of the meeting:	14 August 2025					
Title:	Board Assurance Framework and Significant Risk Report					
Report presented by:	Director of Corporate & Legal Affairs					
Report written by:	Head of Risk Assurance					
This paper is for:	Decision/Approval		Assurance	X	Update	X
Where this report has been discussed previously	Content has been discussed at Risk Committee, Audit Committee and Board Committees.					

To your knowledge, does the report provide assurance or mitigate any significant risks?
The Board Assurance Framework provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives. The BAF contains strategic risks that are likely to have the greatest adverse impact on delivery of the strategy.

1. Purpose of the Report

The purpose of this report is to provide the Trust Board with assurance regarding the effectiveness and robustness of the Trust's overarching system of risk management and internal control. In particular, that the key risks agreed by the Board relating to the delivery of the Trust's Strategic Goals and Priorities are being managed appropriately. This report provides a summary of the following key components:

- The Board Assurance Framework (BAF)
- The Operational Risk Register

2. Recommendation

The Trust Board is invited to assure itself that the systems and processes established for the management of risk in UHL are effective and operating as intended.

3. Report detail

3.1 Development of the Board Assurance Framework (BAF)

The Board Assurance Framework (BAF) sets out the most significant strategic risks that could prevent the Trust from achieving its core goals and priorities. Each risk is clearly defined, including its cause, potential impact, and the controls in place manage it. It also brings together the evidence (assurance) that those controls are effective and highlights any remaining gaps where further attention is required.

The BAF is aligned with the Trust's strategic objectives and is designed to support the Board and its Committees in maintaining oversight of where uncertainty exists, where delivery is at risk, and where assurance remains weak or incomplete.

This report presents the new BAF for 2025/26, following a comprehensive refresh of both its structure and content. The updated framework has been developed through engagement with Executive and Non-Executive Directors, including dedicated sessions with the Trust Chair and Board members on 30 April and 12 May 2025. While the BAF would usually be presented in June, timing was adjusted to allow for appropriate review by the relevant Board Committees before submission to the full Board today.

The updated BAF reflects a systematic review of key Trust strategies and incorporates risk themes identified through analysis of the operational risk register. While no new strategic risks have been added since the previous version, several risk descriptions have been revised to better reflect current priorities and improve clarity. The BAF continues to be subject to regular independent review by the Trust's Internal Auditors as part of the Head of Internal Audit Opinion. The risks have been described in a consistent format, including:

- The risk event – what could go wrong
- The cause – the underlying condition or issue that increases the likelihood
- The impact – the potential consequences for the Trust if the risk materialises
- Controls – what the Trust has currently got in place to reduce or manage the risk
- Assurances – how the Board knows those controls are working
- Gaps – where control or assurance is not yet sufficient and we still lack grip or visibility
- Risk scores – current exposure vs. target level
- *Work in progress around* Risk appetite – whether the level of risk is within what the Board has agreed to tolerate

The format of the BAF remains consistent with the previous version, and the 21 strategic risks are grouped under six key areas aligned to the Trust's strategies:

1. ***Quality - focussing on the 4 key goals in the Quality Strategy:***
    a. Relentless Focus on Safety (safety culture)
    b. Strengthened Patient Voice and Engagement
    c. Outstanding Care Quality including for mental health needs, learning disabilities, autism, dementia, and end of life
    d. Equitable Care Experiences, especially for patients from underserved groups
2. ***Activity – focussing on:***
    a. UEC
    b. Elective Care and Diagnostics
    c. Cancer Care
3. ***Finance – focussing on:***
    a. Capital Investment
    b. Financial Sustainability
4. ***Digital – focussing on the 7 goals in the Digital Strategy:***
    a. Getting the basics right
    b. Putting users' needs first
    c. Using digital as a tool for transformation
    d. Embracing emerging technology
    e. Bringing our data together
    f. Harnessing strategic partnerships
    g. Creating and embedding one digital
5. ***Estates & Facilities – focussing on the 5 goals in the draft Estate Strategy:***
    a. Safe & compliant estate
    b. Enabling future care models
    c. Becoming a green trust
    d. Improved efficiency and productivity
    e. Skilled & resilient E&F workforce

6. ***People – focussing on the 3 themes in the draft People Strategy:***
    a. Culture – Embedding Trust values and behaviours
    b. Capability – Supporting and developing staff to ensure a skilled, high-performing organisation
    c. Capacity – Using resources well to optimise productivity

Each strategic risk is assigned to a Lead Director and a designated Board Committee. This enables effective ownership, oversight, and regular scrutiny. In May, June and July 2025, all relevant Board Committees reviewed the draft revised BAF risks and confirmed the risk descriptions following minor amendments.

Committees continue to review their assigned risks at each formal meeting, including:

- Quality Committee
- People and Culture Committee
- Finance and Investment Committee
- Operations and Performance Committee
- Our Future Hospitals and Reconfiguration Committee

The Risk Committee provides additional oversight, supporting the Lead Committees by reviewing both the BAF and the operational risk register. It plays a key role in identifying any operational risks that may warrant escalation to the BAF and supporting consistent risk management across the Trust.

Initial discussions on the Trust's risk appetite were held at the Board Development Day in July 2025. A follow-up session is scheduled for September 2025. This work will help ensure greater clarity on the levels of risk the Board is willing to accept in pursuit of its objectives, and will inform the BAF going forward.

3.2 Overview of the Strategic Risks on the BAF

There are no risks on the BAF rated 25 (extreme). The six top significant strategic risks on the BAF all rated 20 are as follows:

1. Activity risk (UEC) - There is a risk of overcrowding in ED, poor patient flow, and delayed discharges across the system, due to demand exceeding UEC capacity and misaligned system resources, leading to compromised patient safety, extended length of stay, regulatory non-compliance and failure to meet key performance targets
2. Activity risk (Elective) - There is a risk of failing to deliver timely planned care, due to a backlog from the COVID-19 pandemic and sustained growth in referrals exceeding elective capacity, leading to repeat diagnostics, patient harm, poor patient experience, and performance falling below national standards
3. Activity risk (Cancer) - There is a risk of failing to deliver timely and effective cancer care across the Trust, due to sustained demand for cancer treatment services exceeding strategic capacity, leading to non-compliance with national targets, reduced survival rates, and reputational harm
4. Financial sustainability - There is a risk the Trust fails to deliver its annual financial plan, due to significant in-year operational and inflationary cost pressures across the LLR system and internal efficiency challenges, leading to unplanned deficits, increased regulatory scrutiny, reduced flexibility in financial decision-making, and short-term impact on service delivery and patient care.

5. Cybersecurity - There is a risk of a cybersecurity breach, due to the expanded digital footprint of the organisation and evolving cyber threats, leading to service disruption, data loss, clinical safety risks, and reputational damage
6. Workforce planning – There is a risk that UHL is unable to optimise workforce productivity and sustainability, due to underdeveloped strategic workforce planning, limited adoption of digital solutions and uncoordinated use of external partnerships, leading to service gaps, inefficiencies and increased reliance on temporary staffing

An overview of the gaps associated with these six risks is shown in the tables below (noting full details for each risk are included in appendix A):

Activity risk (UEC) - Risk Description		
Risk Event	*Cause*	*Impact*
There is a risk of overcrowding in ED, poor patient flow, and delayed discharges across the system	due to demand exceeding UEC capacity and misaligned system resources	leading to compromised patient safety, extended length of stay, regulatory non-compliance and failure to meet key performance targets
Key gaps in control and assurance with key next steps		
GAP: New Transport Provider Failing to Provide Responsive Service - Leading to rebedding of patients on base wards and compromised flow out of ED **ACTION**: Implement an action plan to address responsiveness of new transport provider, noting ICB have increased contract provision from June 2025 (COO) **GAP**: UEC Action Plan Not Fully Implemented - Incomplete implementation of UEC action plan **ACTION**: Implement single UEC action plan and annual priorities focusing on admission avoidance, increasing productivity through flow, improving discharge metrics, and SDEC actions (COO) **GAP**: Bedded Capacity - Worst Case Scenario Bed Gap - Capacity constraints in the Local Authority for timely patient discharge **ACTION**: Complete year 2 final Paediatric beds re-staffing resource (COO) **ACTION**: Work with system colleagues to reduce length of stay to increase capacity (COO) **ACTION**: Work with system colleagues on supported discharges (P1 - P3) through the Discharge Improvement Group (COO) **GAP**: UTC Capacity - UTC capital funding still to be confirmed **ACTION**: Development of City UTC (NHSE submission) (COO) **ACTION**: Development of City UTC community capacity opening October (COO) **GAP**: Lack of UEC Demand Management - Ineffective demand management for UEC **ACTION**: High Frequency User / High Impact User post commence and review to be undertaken (COO) **ACTION**: UEC Recovery Plan - System - monitored via UEC Transformation Group (COO) **GAP**: Financial Allocation to Address Winter 2025 Demands - Insufficient financial allocation for winter 2025 demands **ACTION**: Develop 2025/26 Winter Plan (COO: Draft Aug 2025 / Submission Sept 2025) **ACTION**: Oversight of development of System Winter Plan (COO) **GAP**: Alignment with national NHSE UEC care plan for 2025/25 **ACTION**: Undertake gap analysis and report to OPC (COO) - completed **GAP**: Alignment with neighbourhood models **ACTION**: UHL to work with ICB on the development of neighbourhood models (COO)		

Activity risk (Elective) - Risk Description		
There is a risk of failing to deliver timely planned care	due to a backlog from the COVID-19 pandemic and sustained growth in referrals exceeding elective capacity	leading to repeat diagnostics, patient harm, poor patient experience, and performance falling below national standards

Key gaps in control and assurance with key next steps

GAP: Resource Constraints - Insufficient resources for elective care transformation (LC)
ACTION: Maximise capacity within the EMPCC at the LGH (DCOO: Fortnightly review of activity and performance progress, started Jan - review monthly)

GAP: Diagnostic Delays - MRI and other diagnostic test delays (LC)
ACTION: Monitor the impact of Hinckley's new Community Diagnostic Centre on diagnostic waiting list (COO)

GAP: Long Waits - 65 and 52-week wait targets not being met (LC)
ACTION: Increase UHL capacity through improvements in productivity, insourcing, outsourcing, and the independent sector to support 65 and 52-week targets (COO)

GAP: Financial and Workforce Constraints - Trust financial position and associated workforce controls impacting the ability to deliver needed activity levels.
ACTION: Review the profitability of WLI and insourced contracts (COO)

GAP: Emergency Care Pressures - Capacity constraints and workforce issues in the paediatric surgical unit due to staffing issues.
ACTION: Implement robust winter planning and develop a paediatric business case (CCO)

GAP: Estate limitations and limitations and aging infrastructure of the theatre estate - Ventilation issues and maintenance backlogs.
ACTION: Conduct an options appraisal for theatre maintenance (DCOO and Leigh Gates:) - Theatre downtime on Trust risk register (Risk 3140).
ACTION: Engage within the clinical services strategy (COO)

GAP: Limited Capital Funds - Limited funds for equipment replacement and investment; issues with ERF and oversubscribed capital allocation leading to equipment breakdowns and lack of investment.
ACTION: Risk 4149 on Trust risk register (There is a risk of equipment failure and prolonged downtime of core clinical services) - Managed via MEE.

GAP: Digital Maturity - Limited ability to adopt new technologies affecting overall productivity and activity levels (LC)
ACTION: Collaborate with the PAS Project team to test new system impacts on elective activity and participate in AI pilots to improve productivity (DCOO and DMD)

GAP: Paediatric HDU Beds - Lack of beds causing treatment delays (LC)
ACTION: Paediatric super week planned for July 2025 to see potentially an additional 20 ENT Paed patients (DCOO)

Activity risk (Cancer) - Risk Description		
There is a risk of failing to deliver timely and effective cancer care across the Trust	due to sustained demand for cancer treatment services exceeding strategic capacity	leading to non-compliance with national targets, reduced survival rates, and reputational harm

Key gaps in control and assurance with key next steps

GAP: Further industrial action; urgent and emergency care and winter pressures; capacity constraints; workforce constraints
ACTION: Prioritise cancer patients where possible, and conduct demand and capacity reviews to minimise impact on cancer care (COO)

GAP: Data Quality and Reporting - concerns about the accuracy and timeliness of cancer performance data, affecting decision-making and reporting
ACTION: Strengthen data governance frameworks and data management practices. Implement regular audits to ensure data integrity (COO)

GAP: Sufficient capacity to meet Faster Diagnosis standard to have more than 80% of patients diagnosed within 28 days of referral by March 2026
ACTION: Review of referrals, FDS performance and demand and capacity gap with mitigations by service to improve numbers of cancer diagnosed within target (COO)

GAP: 62 day performance affected by capacity impacting the ability to date patients within 62 days of referral
ACTION: Progress made in 2024/25. Revised 2025/26 internal backlog trajectory to achieve no more than 152 patients waiting more than 62 days and less than 10 patients waiting more than 104 days on combined pathways. Review opportunities for improved turnaround times to support 62-day performance. Recovery Action Plans (RAPs), weekly patient level tracking, and daily backlog reports in place (Review- COO)

GAP: 31 day radiotherapy demand and backlogs for prostate and breast patients
ACTION: 5th Linac in place, reduction of wait times across 25/26 and by Q4 24/25. Regional mutual aid to support in place (COO)

GAP: 31 day surgical capacity affecting the ability to deliver more than two thirds of patients treatments within 31 days of a decision to treat (target of 96%)
ACTION: Robust application of CWT, offering patient choice with alternative clinicians where appropriate. Improving theatre productivity. Following surgical demand and capacity review (Nov 2024), implement actions to improve dating processes with alternative clinicians where appropriate to improve 31-day surgical performance (COO)

GAP: Systemic Anti-Cancer Therapy capacity to meet 31 day target
ACTION: Review progress on 31-day performance to deliver 96% anti-cancer regimes via weekly PTL meetings and Oncology RAP (COO)

GAP: In month review of activity and 62 day performance oversight with services
ACTION: 62 day performance oversight with services via RAP meetings to explore opportunities to improve including peer benchmarking (COO)

GAP: Reduction in EMCA funding to support delivery of cancer services and transformational change
ACTION: Consolidate and review priority areas for funding, focus on improving efficiency and productivity to mitigate risk, consider schemes which may need to cease (COO)

Financial Sustainability risk - Risk Description		
There is a risk the Trust fails to deliver its annual financial plan	due to significant in-year operational and inflationary cost pressures across the LLR system and internal efficiency challenges	leading to unplanned deficits, increased regulatory scrutiny, reduced flexibility in financial decision-making, and short-term impact on service delivery and patient care
Key gaps in control and assurance with key next steps		
GAP: Lack of fully developed and implemented CIPs and funded workforce establishment plans aligned to 2025/26 financial targets, creating a gap in financial sustainability delivery **ACTION**: Sustain additional financial grip & control measures e.g. pay controls (CFO/CPO) **ACTION**: Review services with negative financial contribution (CFO) **ACTION**: Ensure CMG and corporate delivery plans are realistic and aligned to financial and quality objectives (CFO)		

ACTION: Maximise productivity (within existing resources/cost) whilst maintaining high standards of patient safety and quality (CFO/COO)

GAP: Income recovery plan
ACTION: Develop Income recovery plan (CFO)

GAP: Financial allocation to address winter 2025 demands
ACTION: Monitor Winter programme, including any resourcing, with the LLR ICB (CFO)

GAP: LLR System cash flow arrangements
ACTION: Work with LLR System partners to support cash requirements within the System and facilitate access to cash (CFO)

Digital & Data - Cybersecurity risk - Risk Description		
There is a risk of a cybersecurity breach	due to the expanded digital footprint of the organisation and evolving cyber threats	leading to service disruption, data loss, clinical safety risks, and reputational damage
Key gaps in control and assurance with key next steps		
Withheld from public reporting		

Workforce planning - Risk Description		
There is a risk that UHL is unable to optimise workforce productivity and sustainability	due to underdeveloped strategic workforce planning, limited adoption of digital solutions and uncoordinated use of external partnerships	leading to service gaps, inefficiencies and increased reliance on temporary staffing
Key gaps in control and assurance with key next steps		

GAP: Digital automation benefits not fully realised across People Services - outdated systems and limited digital optimisation
ACTION: Deliver Wave 2 of People Services automation programme - on capacity release and user experience (CPO)

GAP: Workforce metrics and data use not yet standardised - risk of workforce gaps and misalignment with future needs
ACTION: Develop and implement standardised workforce KPI dashboards (CPO)

GAP: Lack of alignment in local workforce planning approaches
ACTION: Equip leaders with workforce planning tools and training (CPO)

GAP: Lack of a coordinated partnership strategy - No unified collaborative workforce plan across system partners
ACTION: Launch Trust-wide collaborative workforce strategy (CPO)

GAP: Medical and temporary staffing inefficiencies persist - Temporary staffing office (LC)
ACTION: Deliver centralised temporary staffing office and recruitment strategy (CPO)
ACTION: Reduce temporary spend (CPO)

During this reporting period, there have been no changes to risk scores, there have been no new risks entered and no risks have been closed on the BAF.

A copy of the current BAF is attached as Appendix A.

3.3 Operational Risk Register Process

The operational risk register sets out the key clinical and non-clinical risks identified across the Trust's Clinical Management Groups (CMGs) and corporate directorates. These risks relate to the day-to-day running of services and the delivery of core activities at ward, departmental, CMG, and Trust-wide levels.

Operational risks cover a broad range of concerns that may affect the achievement of objectives – quality and safety; service delivery; compliance; finances. They include risks to the delivery of activities and objectives in Wards / Areas; Specialties / Departments; CMGs / Directorates and Trust-wide initiatives where multiple services are impacted.

Each risk is assessed based on its underlying cause, the potential impact if it were to occur, and the likelihood of it happening. The Trust uses a standard 5x5 risk matrix to score risks and prioritise action. New risks are reviewed and formally approved by the relevant CMG or corporate leadership team before being added to the register.

This review process includes an evaluation of current controls, an assessment of how effective those controls are, and the development of actions to close any gaps between the current (residual) risk score and the intended target level.

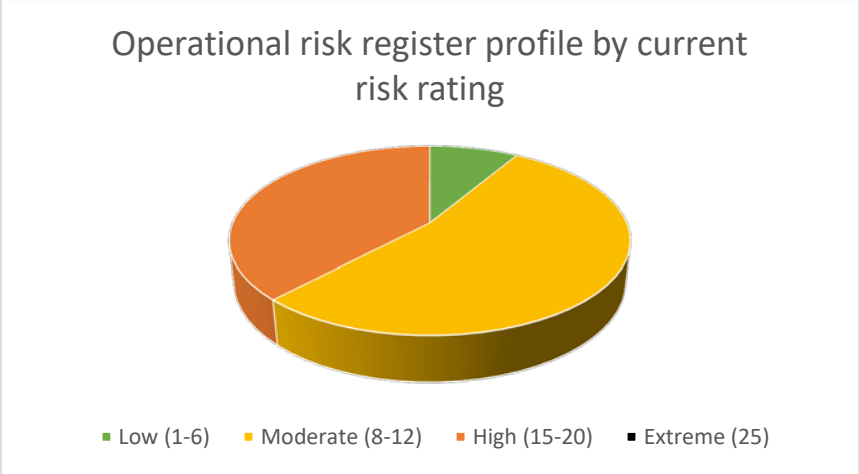
Significant operational risks - typically those with a residual score of 15 or above - are subject to additional scrutiny and may be escalated for executive oversight. Where an operational risk is judged to have potential Trust-wide impact, or where it directly threatens delivery of a strategic objective, it may be escalated further for consideration within the BAF (as a new risk or gap for an existing risk). This escalation process ensures that risks are managed at the appropriate level, and that the BAF remains focused on the most significant threats to the Trust's strategic priorities.

3.4 Overview of Risks on the Operational Risk Register

As reported to the August 2025 Risk Committee, the Datix operational risk register currently holds 413 open risks. Of these:

- No risks have an extreme current rating (risk rating of 25).
- 168 are significant risks (rated 15-20).
- 198 are moderate risks (rated 8-12).
- 47 are low risks (rated 1-6).

All risks are assigned to a risk owner and a breakdown of the risks is shown below:



The monthly Risk Committee continues to review all newly identified significant risks (those scored 15 and above), as well as closed risks and risks that have Trust-wide impact. In parallel, CMGs and Corporate Directorates submit regular assurance reports summarising progress in managing significant risks within their areas of accountability.

Operational risk registers are standing items at CMG Board meetings and are reviewed monthly to support risk-based decision-making. In addition, each CMG's risk performance is monitored at monthly Performance Review Meetings (PRMs), where specific attention is given to risks that are overdue for review or have actions that have passed their target completion dates. CMGs are expected to provide assurance to the Leadership Team at these meetings, setting out the actions taken to address any areas of concern in their risk data.

Risk register performance - particularly the proportion of operational risks with overdue reviews - has remained below the target of less than 10% and continues to be monitored by the Risk Committee. This metric is also included in the Quality and Safety Dashboard, which is reported monthly to the Quality Committee.

A thematic analysis of operational risks confirms alignment with the strategic risks set out in the BAF. The following key themes appear consistently across both operational and strategic risk registers:

- **Workforce Gaps**: Risks related to recruitment, retention, and appropriate skill mix - affecting both clinical and non-clinical services. These risks are captured as a strategic risk within the BAF under workforce sustainability.
- **Patient Activity and Flow**: Risks linked to capacity constraints in urgent and emergency care, backlogs in elective care, and delays in cancer pathways. These issues are reflected in BAF risks relating to timely access to care and flow through the system.
- **Estates and the Environment**: Risks associated with ageing clinical environments - particularly in theatres and critical care - as well as broader issues with the estate. These are being addressed through backlog maintenance plans and future redevelopment work under the New Hospital Programme. Relevant estate-related risks also feature in the BAF.
- **Equipment and Supplies**: Risks around ageing clinical equipment and the reliability and capability of digital systems. Digital infrastructure is recognised as a strategic risk in the BAF.
- **Finances**: Risks concerning the availability of capital to address infrastructure needs, manage cost pressures, and maintain long-term financial sustainability. These are reflected in the BAF strategic risk on financial resilience and sustainability.

Appendix A - UHL Board Assurance Framework - Dashboard

BAF Risk Ref No	Executive Lead	Board committee workplan	Risk Theme	Trust Goal & Annual Priority	Deliverables / Strategy	Risk Description *There is a risk of (this is the uncertain risk event)* *Due to (this is the existing condition)* *Leading to (this is the impact on the goal)*			Current risk rating L x I = Current (Likelihood of event occurring x Impact of event)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
						Risk Event	Existing condition	Impact													
01-Quality-1	Julie Hogg, CN & Andrew Furlong, MD	Quality Committee	Quality - Safety Culture	Goal: High-quality care for all Being a great place to work Research and education excellence Annual Priority: Transform patient care Strengthen our culture	Quality - Relentless Focus on Safety Deliver year one of the quality strategy Increase the number of colleagues taking part in research	There is a risk that a positive **safety culture** is not consistently embedded across services	due to underreporting and variable staff confidence in raising concerns and learning from incidents	leading to patient harm, low morale, reputational damage, and non-compliance with safety standards	Almost certain (5) x Moderate (3) = 15	Almost certain (5) x Moderate (3) = 15	Almost certain (5) x Moderate (3) = 15	Almost certain (5) x Moderate (3) = 15	Almost certain (5) x Moderate (3) = 15								
01-Quality-2	Julie Hogg, CN & Andrew Furlong, MD	Quality Committee	Quality - Harm-Free Care	Goal: High-quality care for all Annual Priority: Transform patient care	Quality - **Relentless Focus on Safety** Deliver year one of the quality strategy	There is a risk that **hospital-acquired infections** and harm do not reduce as planned	due to inconsistent delivery of fundamentals of care, overcrowding and variable protocol compliance	leading to avoidable harm, longer stays, cost pressures, and reduced confidence in care	Almost certain (5) x Moderate (3) = 15	Almost certain (5) x Moderate (3) = 15	Almost certain (5) x Moderate (3) = 15	Almost certain (5) x Moderate (3) = 15	Almost certain (5) x Moderate (3) = 15								
01-Quality-3	Julie Hogg, CN & Andrew Furlong, MD	Quality Committee	Quality - Patient and Carer Engagement	Goal: High-quality care for all Annual Priority: Transform patient care	Quality - **Strengthened Patient Voice** Deliver year one of the quality strategy *Establish the LLR Health Innovation Hub*	There is a risk that **patients, families, and carers are not fully engaged** in service development and feedback	due to limited access to and responsiveness of engagement mechanisms	leading to unmet needs, dissatisfaction, and increased complaints	Almost certain (5) x Moderate (3) = 15	Almost certain (5) x Moderate (3) = 15	Almost certain (5) x Moderate (3) = 15	Almost certain (5) x Moderate (3) = 15	Almost certain (5) x Moderate (3) = 15								
01-Quality-4	Julie Hogg, CN & Andrew Furlong, MD	Quality Committee	Quality - Quality of Care for Vulnerable Groups	Goal: High-quality care for all Annual Priority: Transform patient care	Quality - **Outstanding Care Quality** Deliver year one of the quality strategy *Roll out a new approach to continuous improvement*	There is a risk that care for patients with **mental health needs, learning disabilities, autism, dementia, or at end of life** remains inconsistent	due to variable screening, staff training, and service capability	leading to poorer outcomes, readmissions, and non-compliance with national standards	Almost certain (5) x Moderate (3) = 15	Almost certain (5) x Moderate (3) = 15	Almost certain (5) x Moderate (3) = 15	Almost certain (5) x Moderate (3) = 15	Almost certain (5) x Moderate (3) = 15								
01-Quality-5	Julie Hogg, CN & Andrew Furlong, MD	Quality Committee	Quality - Health Equity and Accessibility	Goal: High-quality care for all Annual Priority: Transform patient care	Quality - **Equitable Care Experiences** Deliver year one of the quality strategy *Establish the LLR Health Innovation Hub*	There is a risk that **patients from underserved groups** continue to experience poorer access, communication, and outcomes	due to insufficient data insights, inconsistent reasonable adjustments, and language/cultural barriers	leading to continued health inequalities and dissatisfaction among diverse patient groups, missed appointments, and reputational damage	Almost certain (5) x Moderate (3) = 15	Almost certain (5) x Moderate (3) = 15	Almost certain (5) x Moderate (3) = 15	Almost certain (5) x Moderate (3) = 15	Almost certain (5) x Moderate (3) = 15								
02-Activity(UEC)-1	Jon Melbourne, COO	Operations & Performance Committee	Activity - UEC	Goal: High-quality care for all Partnerships for impact Annual Priority: Transform patient care	Deliver national planned care targets and transform UEC pathways	There is a risk of overcrowding in ED, poor patient flow, and delayed discharges across the system	due to demand exceeding UEC capacity and misaligned system resources	leading to compromised patient safety, extended length of stay, regulatory non-compliance and failure to meet key performance targets	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20								
02-Activity(Elective & Diagnostics)-2	Jon Melbourne, COO	Operations & Performance Committee	Activity - Elective Care & Diagnostics	Goal: High-quality care for all Partnerships for impact Annual Priority: Transform patient care	Deliver national planned care targets and transform UEC pathways	There is a risk of failing to deliver timely planned care	due to a backlog from the COVID-19 pandemic and sustained growth in referrals exceeding elective capacity	leading to repeat diagnostics, patient harm, poor patient experience, and performance falling below national standards	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20								
02-Activity(Cancer)-3	Jon Melbourne, COO	Operations & Performance Committee	Activity - Cancer Care	Goal: High-quality care for all Partnerships for impact Annual Priority: Transform patient care	Deliver national planned care targets and transform UEC pathways	There is a risk of failing to deliver timely and effective cancer care across the Trust	due to sustained demand for cancer treatment services exceeding strategic capacity	leading to non-compliance with national targets, reduced survival rates, and reputational harm	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20								
03-Finance (capital)-1	Lee Bond, CFO	Finance Investment Committee	Finance - Capital	Goal: High-quality care for all Annual Priority: Transform patient care Deliver our financial plan	Deliver our financial plan Deliver major digital change	There is a risk of insufficient **capital** to meet Trust priorities	due to competing demands and limited funding	leading to disruption to services and non-compliance with statutory requirements, such as health and safety standards and legislation, and address backlog maintenance requirements (concerning medical equipment, estate and Digital & Data)	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16								
03-Finance (revenue and sustainability-Delivery of the Annual Financial Plan (Short-Term)-1	Lee Bond, CFO	Finance Investment Committee	Finance - Financial Sustainability - short term	Goal: High-quality care for all Annual Priority: Transform patient care Deliver our financial plan	Deliver our financial plan Deliver our workforce plan as part of our financial plan	There is a risk the Trust fails to deliver its **annual financial plan**	due to significant in-year operational and inflationary cost pressures across the LLR system and internal efficiency challenges	leading to unplanned deficits, increased regulatory scrutiny, reduced flexibility in financial decision-making, and short-term impact on service delivery and patient care	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20								
03-Finance (sustainability-Long-Term Financial Sustainability (Medium to Long-Term)-2	Lee Bond, CFO	Finance Investment Committee	Finance - Financial Sustainability - long term	Goal: High-quality care for all Annual Priority: Transform patient care Deliver our financial plan	Deliver our financial plan Deliver our workforce plan as part of our financial plan	There is a risk the Trust is unable to achieve **long-term financial sustainability**	due to structural financial challenges across the LLR system, recurrent cost pressures, and limited availability of capital and transformation funding	leading to continued misalignment with the medium-term financial plan (MTFP), reduced capacity to invest in workforce, digital, and estates improvements, and a negative impact on the quality and sustainability of patient services	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20								
04-Digital-1	Will Monaghan, Group CIO	Our Future Hospitals & Transformation Committee	Digital - Failure to deliver a unified, reliable digital foundation	Goal: High-quality care for all Being a great place to work Annual Priority: Transform patient care Strengthen our culture Deliver our financial plan	Getting the Basics Right Creating and Embedding One Digital Governance/process gaps Technical reliability challenges	There is a risk that the Group will fail to deliver a robust, consistent, and reliable digital infrastructure and operating model	due to legacy systems, fragmented platforms, and immature Group-wide governance and capability	leading to operational inefficiencies, staff frustration, and limited readiness for large-scale transformation	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16								
04-Digital-2	Will Monaghan, Group CIO	Our Future Hospitals & Transformation Committee	Digital - Misalignment between digital solutions and care delivery needs	Goal: High-quality care for all Being a great place to work Annual Priority: Transform patient care Strengthen our culture Deliver our financial plan	Putting Users' Needs First Using Digital as a Tool for Transformation *Usability and workforce impact* *Equity and accessibility concerns*	There is a risk that digital solutions will fail to meet the clinical, operational, and patient needs of the Group and fail to address digital poverty	due to inadequate co-design, inconsistent user engagement, and fragmented integration with transformation and service improvement programmes	leading to poor adoption, inefficient workflows, and reduced impact on care quality and experience	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16								

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
2	**BAF Risk Ref No**	**Executive Lead**	**Board committee workplan**	**Risk Theme**	**Trust Goal & Annual Priority**	**Deliverables / Strategy**	**Risk Description** ***There is a risk of (this is the uncertain risk event)*** ***Due to (this is the existing condition)*** ***Leading to (this is the impact on the goal)***			**Current risk rating L x I = Current (Likelihood of event occurring x Impact of event)**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
17	04-Digital-3	Will Monaghan, Group CIO	Our Future Hospitals & Transformation Committee	Digital - Inability to harness data, innovation, and partnerships for transformation	Goal: High-quality care for all Being a great place to work Annual Priority: Transform patient care Strengthen our culture Deliver our financial plan	Embracing Emerging Technology Bringing Our Data Together Harnessing Strategic Partnerships *Research, AI, FDP, and commercial risks*	There is a risk that the Group will not fully harness the value of integrated data, emerging technologies, and strategic partnerships	due to limitations in digital maturity, workforce capability, and commercial frameworks	leading to missed opportunities for innovation, research, income generation, and population health improvement	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16									
18	04-Digital-4 **Withheld from public report**	Will Monaghan, Group CIO	Our Future Hospitals & Transformation Committee	Digital - Cybersecurity	Goal: High-quality care for all Annual Priority: Transform patient care Strengthen our culture Deliver our financial plan	Digital - Cybersecurity Breach	There is a risk of a cybersecurity breach	due to the expanded digital footprint of the organisation and evolving cyber threats	leading to service disruption, data loss, clinical safety risks, and reputational damage	Likely (4) x Extreme (5) = 20	Likely (4) x Extreme (5) = 20	Likely (4) x Extreme (5) = 20	Likely (4) x Extreme (5) = 20	Likely (4) x Extreme (5) = 20								
19	05-Estate-01	Ben Widdowson, DEF	Finance Investment Committee	Estates - Statutory compliance and productivity	Goal: High-quality care for all Being a great place to work Partnerships for impact Annual Priority: Transform patient care Strengthen our culture Deliver our financial plan	Estates - Safety, Compliance and productivity	There is a risk that the estate does not support safe, compliant, and productive healthcare delivery	due to ageing infrastructure, unresolved £125m backlog maintenance (excluding VAT fees of circa £75m), and poor space utilisation	leading to safety incidents, enforcement action, service disruption, and inefficient use of resources	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16								
20	05-Estate-02	Simon Barton, Deputy Chief Executive Officer & Ben Widdowson, DEF	Our Future Hospitals & Transformation Committee	OFH	Goal: High-quality care for all Being a great place to work Partnerships for impact Annual Priority: Transform patient care Strengthen our culture Deliver our financial plan	Enabling Future Care Models	There is a risk that the Trust fails to meet net zero carbon targets by 2040/2045	due to reliance on outdated systems and insufficient green investment	leading to higher emissions and regulatory non-compliance breaches	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16								
21	05-Estate-03	Ben Widdowson, DEF	Our Future Hospitals & Transformation Committee	Estates - Sustainability - Net zero carbon	Goal: High-quality care for all Being a great place to work Partnerships for impact Annual Priority: Transform patient care Strengthen our culture Deliver our financial plan	Estates - Becoming a Green Trust	There is a risk that reconfiguration of acute and community hospital services is not delivered by 2030	due to delays in national capital funding and complex programme dependencies	leading to increased clinical risk and service inefficiencies	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16								
22	06-People-1	Clare Teeney, CPO	People & Culture Committee	People – Culture (merging: Staff and learner experience; EDI; Inclusive leadership; Safe and healthy workplace)	Promoting a culture that embodies our Trust values and behaviours - It is our aim that we promote a culture that embodies our trust values and behaviours	Deliver year one of our People Strategy People - Staff and learner experience and engagement People - A sense of belonging for all (EDI) People - Compassionate and inclusive leadership	There is a risk that UHL does not consistently embed a culture that promotes inclusion, psychological safety and values-led behaviours	due to inconsistent response to **staff feedback and experience survey actions,** variation in **leadership capability**, and inconsistent delivery of **EDI objectives across teams**	leading to reduced morale, engagement, and staff retention	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16								
23	06-People-2	Clare Teeney, CPO	People & Culture Committee	People – Capability (merging: Talent development; High performing leadership)	Harnessing and developing the talents of all our people, to ensure we are a high performing, capable and skilled organisation - It is our aim to harness and developing the talents of all our people, to ensure we are a high performing, capable and skilled organisation	Deliver year one of our People Strategy People - Harnessing the talents of all our people People - High performing leadership and management People - A safe and healthy workplace	There is a risk that UHL does not fully harness and develop the talents of all its people	due to **variation in leadership development**, lack of clear, equitable **talent and succession pathways** and inconsistent access to or uptake of **wellbeing support**	leading to reduced performance, staff progression and organisational resilience	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16	Likely (4) x Major (4) = 16								
24	06-People-3	Clare Teeney, CPO	People & Culture Committee Finance Investment Committee	People – Capacity (merging: Partnership working; Digital enablement; Workforce planning)	Using our resources well to ensure that we are maximising our organisational capacity to optimise productivity - It is our aim to use our resources well to ensure that we are maximising our organisational capacity to optimise productivity	Deliver year one of our People Strategy People - Maximising partnership working People - Accelerate the use of digital (systems, processes, skills) Deliver our workforce plan as part of financial plan delivery People - Strategic workforce planning	There is a risk that UHL is unable to optimise workforce productivity and sustainability	due to underdeveloped **strategic workforce planning**, limited adoption of **digital solutions** and uncoordinated use of **external partnerships**	leading to service gaps, inefficiencies and increased reliance on temporary staffing	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20	Almost certain (5) x Major (4) = 20								

UHL Board Assurance Framework - Full Report

BAF Risk Ref No.	Executive Lead	Board committee oversight	Risk Theme	Trust Goal & Annual Priority	Deliverables / Strategy	Risk Description *There is a risk of (this is the uncertain risk event)* *Due to (this is the existing condition)* *Leading to (this is the impact on the Trust)*			Current risk rating L x I = Current (Likelihood of event occurring x Impact of event)	Key controls in place now *(Impact control = IC or Likelihood control = LC)*	Key sources of assurance *(3 lines of defence - independent or internal)* *(Assurance rating)*	Key gaps in control and assurance with key next steps (to address gaps in controls or assurance)	Tolerable risk rating (L x I) Under review	Aim risk rating (L x I) under review
						Risk event	Existing condition	Impact						
01-Quality-1	Julie Hogg, CN & Andrew Furlong, MD	Quality Committee	Quality - Safety Culture	Goal: High-quality care for all Being a great place to work Research and education excellence Annual Priority: Transform patient care Strengthen our culture	Quality - Relentless Focus on Safety Deliver year one of the quality strategy Increase the number of colleagues taking part in research	There is a risk that a positive **safety culture** is not consistently embedded across services	due to underreporting and variable staff confidence in raising concerns and learning from incidents	leading to patient harm, low morale, reputational damage, and non-compliance with safety standards	Almost certain (5) x Moderate (3) = 15	Preventive Controls: Implementation of PSIRF Safety culture working group NHS Patient Safety Syllabus training Incident reporting forms NICE and faculty guidance processes Duty of Candour and incident reporting policy Clinical policies, procedures, and standards Freedom to Speak Up Process & Guardians Quality Improvement Methodology Clinical audit programs Corrective Controls: Staff wellbeing support mechanisms (e.g., peer support, Trauma Risk Management) Incident review panels, feedback loops, and restorative debriefs Exit interview process Peer support Counselling for staff involved in incidents	Staff Survey results Compliance with Duty of Candour Feedback from PSII Getting it right first time (GIRFT) Policies and Guidelines report to PSC (Internal Assurance) Freedom to Speak Up reports to Board Internal audit programme Participation in National Clinical Audits Culture reporting	**GAP: Concerns in Maternity and neonatology about culture and safe staffing** **ACTION: CQC improvement in the safety rating to RI. Will be monitored via maternity & neonatal improvement programme (CN/MD: Sep 2025)** **GAP: Freedom to speak up concerns around culture in the Clinical Research Facility at LRI** **ACTION:OD plan in development (MD/CPO: Sep 2025)** **GAP: Fragility of perfusion workforce** **ACTION: Ongoing development plan with the college (MD: Mar 2026)** **GAP: Culture within the cardiac surgery service. CQC inspection and RCSIRM have identified ongoing concerns re: culture and behaviour of consultant workforce.** **ACTION: Ibex Gale Learning Cultural Review (cardiac surgery service) report received. Action plan developed along with externally facilitated OD programme to complete the 32 LCR recommendations. Awaiting formal reports but immediate action being taken on the basis of verbal feedback. Report to PCC. (MD: Dec 2025)** **GAP: Culture within specific services - Linked to People BAF Risk 01 - Culture, CPO** **ACTION: Gynaecology Improvement plan developed and peer review (CN/MD: Dec 2025)** **ACTION: Improvement plan for histopathology (COO: Dec 2025)** **GAP: Inconsistent reporting of safety concerns and preventive measures including underreporting in some teams/settings** **ACTION: Internal audit of PSIRF implementation in 2025/26 (CN/MD: Mar 2026)** **ACTION: Develop a simplified incident reporting tool and monitor uptake of Good Care incident reporting (CN: Mar 2026)** **GAP: Quality Improvement methodology is not embedded (LC)** **ACTION: Noting the QI Programme business case for additional resource not successful in 2025, focus on achieving the annual QI staff training target and advancing the organisation's QI maturity rating (MD: Mar 2026)**	Possible (3) x Moderate (3) = 9	Unlikely (2) x Moderate (3) = 6 High sensitivity to staff/patient harm and safety breaches
01-Quality-2	Julie Hogg, CN & Andrew Furlong, MD	Quality Committee	Quality - Harm-Free Care	Goal: High-quality care for all Annual Priority: Transform patient care	Quality - **Relentless Focus on Safety** Deliver year one of the quality strategy	There is a risk that **hospital-acquired infections** and harm do not reduce as planned	due to inconsistent delivery of fundamentals of care, overcrowding and variable protocol compliance	leading to avoidable harm, longer stays, cost pressures, and reduced confidence in care	Almost certain (5) x Moderate (3) = 15	Preventive Controls: Harm Free Care Programme Fundamentals of Care audits LEAF accreditation Training on pressure ulcer prevention, CAUTIs, falls Clinical policies, procedures, and standards Infection prevention & control agenda, annual work plan, mandatory training programme and audit programme Compliance with NHSIE Infection Prevention & Control Assurance Framework Quality Impact Assessment Corrective Controls: Targeted interventions for infection control Root cause analysis following incidents Use of first-line decision-making tools for pressure ulcers Review of incidents/outbreaks of infection and sharing learning and actions for improvement	Quality dashboard Infection rates and trends LEAF and QI training and performance insights External audits and inspections Patient safety incident data CQC inspections Internal audit programme Peer reviews Pressure ulcer decision-making tool (first-line tool) IP BAF TIPAC	**GAP**: We did not meet the nationally set trajectories for hospital acquired infections in 2024/25 **ACTION**: Establish clear plan for a reduction trajectory including Antimicrobial Stewardship (CN/MD: Mar 2026) **GAP**: Fundamental care compliance not consistently embedded **ACTION**: Roll out of the fundamentals of care programme (CN/MD: Mar 2026) **ACTION**: Embed regular ward-based audits of fundamental care needs (CN/MD: Sep 2025) **GAP**: Increasing ambulance handover delays; Crowding within the ED and normalisation of boarding; Delayed supported discharges; Delays to planned care **ACTION**: Cross reference with BAF Risk 02-Activity(UEC)-1 - Delivery of the UEC improvement plan (COO: Mar 2026) **GAP**: Failure to implement the National Cleaning Standards **ACTION**: Implementation of the National Cleaning Standards (CN: Mar 2026) **GAP:** The estate is aged and doesn't meet modern standards for healthcare including ventilation, water and lifts **ACTION:** Review of compliance and backlog maintenance with proposed plan (DoEF: October 2026) **GAP:** Known and unknown risks as a result of the roll out of the new Patient Administration System (PAS) **ACTION:** Ongoing PAS implementation continues to identify and remedy identified concerns (CDIO: Ongoing) **GAP**: The financial position at UHL is significantly challenged - leading to a £92million CIP programme with proposed headcount reductions **GAP**: Failure to Deliver Cost Improvement Plans (CIPs) Safely: Pressure to deliver savings rapidly could result in rushed implementation of CIPs without robust clinical engagement or risk mitigation, heightening risk of harm **GAP**: Deterioration in Staff Wellbeing and Psychological Safety: Ongoing uncertainty about job security and workload increases may lead to presenteeism, rising sickness, and reluctance to speak up - masking early signs of harm or dysfunction. **GAP**: ICS Financial Pressures Impacting Shared Services: Financial recovery plans across the ICS could reduce support services (e.g. community capacity, mental health input, diagnostics), intensifying acute pressures at UHL. **ACTION**: Deliver Rise programme (Execs: Mar 2026)	Possible (3) x Moderate (3) = 9	Unlikely (2) x Moderate (3) = 6 Low tolerance for avoidable harm, but accepts some residual variation
01-Quality-3	Julie Hogg, CN & Andrew Furlong, MD	Quality Committee	Quality - Patient and Carer Engagement	Goal: High-quality care for all Annual Priority: Transform patient care	Quality - **Strengthened Patient Voice** Deliver year one of the quality strategy *Establish the LLR Health Innovation Hub*	There is a risk that **patients, families, and carers are not fully engaged** in service development and feedback	due to limited access to and responsiveness of engagement mechanisms	leading to unmet needs, dissatisfaction, and increased complaints	Almost certain (5) x Moderate (3) = 15	Preventive Controls: PALS 'Call 4 Concern' 'Ask Me' campaigns Martha's Rule initiatives UHL Carers Passport pilot and Carers Charter forums Digital feedback platforms Community outreach programs Patient-centered care models Patient experience surveys Corrective Controls: DART clinical team follow-up for urgent concerns Thematic reviews of PALS service Evaluations of engagement initiatives Formalised systems for reporting and investigating incidents, complaints, and near-misses Call 4 Concern	Patient safety and complaints report to QC FFT Survey results Feedback from carers and patient advocacy groups PALS response rate audits Response times to concerns raised Patient and carer forum minutes Patient story themes at Board / Committees Digital feedback analytics Internal audits CQC Insight report	**GAP**: Lack of patient and carer involvement in Shared Decision Making **ACTION**: Development and roll-out of patient and carer involvement in care via Shared Decision making - Included in patient experience priorities. Will be monitored via QC (CN: Aug 2025) **GAP**: Variability in response rates and experiences among different groups. **ACTION**: Expand and promote engagement services, particularly for underrepresented communities (CN: Dec 2025) **GAP**: Carers not consistently identified or supported across services **ACTION**: Implement Carers Passport Trust-wide (CN: Dec 2025) **GAP**: Incomplete roll out of Martha's Rule in the Children's hospital **ACTION**: Full implementation of Martha's Rule (CN/MD: Aug 2025) **GAP**: Unable to provide safe staffing in the freestanding midwifery unit **ACTION**: Temporary closure of unit from 7th July 2025 and consideration of next steps (CN: Regular review)	Possible (3) x Moderate (3) = 9	Unlikely (2) x Moderate (3) = 6 Engagement depends on culture change, but impact is reputational
01-Quality-4	Julie Hogg, CN & Andrew Furlong, MD	Quality Committee	Quality - Quality of Care for Vulnerable Groups	Goal: High-quality care for all Annual Priority: Transform patient care	Quality - **Outstanding Care Quality** Deliver year one of the quality strategy *Roll out a new approach to continuous improvement* *Establish the LLR Health Innovation Hub*	There is a risk that care for patients with **mental health needs, learning disabilities, autism, dementia, or at end of life** remains inconsistent	due to variable screening, staff training, and service capability	leading to poorer outcomes, readmissions, and non-compliance with national standards	Almost certain (5) x Moderate (3) = 15	Preventive Controls: Safeguarding expertise in the Trust LD nurses Dementia working group Oliver McGowan Mandatory Training Mental Health Liaison Service Education programs for clinicians Corrective Controls: Enhanced Patient Observation Service Admiral Nurse support Specialist Palliative Care team interventions Targeted support programs Integration of community resources Corrective action plans following clinical audit results	Training completion rates NACEL Dementia Audit outcomes Feedback from patients with mental health conditions and learning disabilities GIRFT reviews	**GAP**: EoL patients not always recognised in time **ACTION**: Roll out swan programme (CN/MD: Dec 2025) **GAP**: Low uptake of mandatory training in some staff groups **ACTION**: Monitor by CQC RI to good group (CN/MD: Dec 2025) **GAP**: Dementia friendly Wards **ACTION**: Develop Dementia-friendly environment project with Estates (CN: Apr 2026) **GAP**: Increasing attendances and length of stay in ED for mental health patients **ACTION**: System UEC plan (CN/MD/COO: Mar 2026)	Possible (3) x Moderate (3) = 9	Unlikely (2) x Moderate (3) = 6 Quality variation is unacceptable in principle, but complex to control
01-Quality-5	Julie Hogg, CN & Andrew Furlong, MD	Quality Committee	Quality - Health Equity and Accessibility	Goal: High-quality care for all Annual Priority: Transform patient care	Quality - **Equitable Care Experiences** Deliver year one of the quality strategy *Establish the LLR Health Innovation Hub*	There is a risk that **patients from underserved groups** continue to experience poorer access, communication, and outcomes	due to insufficient data insights, inconsistent reasonable adjustments, and language/cultural barriers	leading to continued health inequalities and dissatisfaction among diverse patient groups, missed appointments, and reputational damage	Almost certain (5) x Moderate (3) = 15	Preventive Controls: UHL Health Equality Partnership (UHEP) EDI intelligence Accessible Information Standard process (AIS) AIS Group Community outreach programs Language and communication support services Regular patient and carer forums Board level Director (Director Of Health Equality and Inclusion) Corrective Controls: Regular Outreach reviews and service redesign with communities Access to interpreters, sign language providers, and easy-read formats Targeted improvement plans Enhanced accessibility measures Thematic reviews of PALS service Reasonable Adjustments Digital Flag	'Did Not Attend' (DNA) rates by protected group FFT feedback by community leaders/language/ethnicity AIS compliance audits Patient satisfaction surveys Engagement metrics Performance data from AIS and Reasonable Adjustments Digital Flag Internal audit reviews	**GAP**: Variability in engagement and accessibility **ACTION**: Expand community engagement and enhance accessibility of services (DHEI: Dec 2025) **GAP**: Equity insights not yet embedded in every specialty **ACTION**: Implement Pro-Equity Framework in all services (DHEI: Dec 2025) **GAP**: Some demographic data missing in PAS/EPR **ACTION**: Improve demographic capture in digital systems (CDIO/DHEI: Dec 2025) **GAP**: Perinatal mortality remains 5% greater than expected **ACTION**: Continue to implement the perinatal safety improvement programme (/MD: Dec 2025) **GAP**: Compliance with accessible information standards (AIS) **ACTION**: Develop AIS roadmap to compliance (DHEI: Mar 2026)	Likely (4) x Moderate (3) = 12	Unlikely (3) x Moderate (3) = 9 Equity improvement is essential, but involves complex system-wide change

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
2	**BAF Risk Ref No.**	**Executive Lead**	**Board committee oversight**	**Risk Theme**	**Trust Goal & Annual Priority**	**Deliverables / Strategy**	**Risk Description** ***There is a risk of (this is the uncertain risk event)*** ***Due to (this is the existing condition)*** ***Leading to (this is the impact on the Trust)***			**Current risk rating L x I = Current (Likelihood of event occurring x Impact of event)**	**Key controls in place now** ***(Impact control = IC or Likelihood control = LC)***	**Key sources of assurance** ***(3 lines of defence - independent or internal)*** ***(Assurance rating)***	**Key gaps in control and assurance with key next steps** **(to address gaps in controls or assurance)**	**Tolerable risk rating (L x I)** **Under review**	**Aim risk rating (L x I)** **under review**
9	02-Activity(UEC)-1	Jon Melbourne, COO	Operations & Performance Committee	Activity - UEC	Goal: High-quality care for all Partnerships for impact Annual Priority: Transform patient care	Deliver national planned care targets and transform UEC pathways	There is a risk of overcrowding in ED, poor patient flow, and delayed discharges across the system	due to demand exceeding UEC capacity and misaligned system resources	leading to compromised patient safety, extended length of stay, regulatory non-compliance and failure to meet key performance targets	Almost certain (5) x Major (4) = 20	UEC (action) Plan covering flow in, flow through and flow out of the Trust with oversight through UEC Steering Group, reporting into TLT and the Operational Performance Committee (LC) Winter Plan (LC) Transformation support and UEC Programme Manager to implement UEC action plan (LC) SDEC plan (LC) Tactical meetings to monitor operational performance and pressures at Trust and System level (LC) Streamlined patient pathways, including early discharge initiatives, enhanced clinical triage, and expanded discharge-to-assess models to relieve ED pressures (LC) Cross-agency partnerships with community and primary care to reduce ED admissions and support rapid discharge options (LC) System led GP collective action group (LC) Industrial Action Plans and Planning Group - EPRR (ILC/IC)	UEC (Action) Plan monitored through UEC Transformation Group and UEC Partnership Board (Internal Assurance) Internal and System escalation calls (Internal Assurance) Winter Plan paper to TB described High Impact Interventions (appendix 1) (Internal Assurance) UHL Discharge: Programme of Work reporting to Strategic Patient Discharge Group and OPC (Internal Assurance) Transformation Team work plans with allocated resource to support the implementation of the UEC action plan (Internal Assurance) Monitor implementation of SDEC strategy and actions through UEC Steering Group (Internal Assurance) Frailty work programme (Internal Assurance) Organisation wide understanding of Trust operational position four times daily reflected in the UHL Capacity Report, alongside a daily (up to 3 times daily) (Internal Assurance) Operational Pressures Escalation Level (OPEL) Framework (Internal Assurance) SHREWD Primary Care OPEL national reporting tool (Internal Assurance) Adherence to UHL Rapid Flow and Boarding Policy's (Internal Assurance) Release to Respond Protocol (Internal Assurance) UHL Performance Metrics (2a. - weekly ambulance handover, 2b. weekly metrics report, FFT) (Internal assurance) Industrial Action Plans and Planning Group reporting - (Internal Assurance) UEC Strategy (Internal Assurance)	**GAP:** New Transport Provider Failing to Provide Responsive Service - Leading to rebedding of patients on base wards and compromised flow out of ED **ACTION:** Implement an action plan to address responsiveness of new transport provider, noting ICB have increased contract provision from June 2025 (COO: Oct 2025) **GAP:** UEC Action Plan Not Fully Implemented - Incomplete implementation of UEC action plan **ACTION:** Implement single UEC action plan and annual priorities focusing on admission avoidance, increasing productivity through flow, improving discharge metrics, and SDEC actions (COO: Q4 2025/26) **GAP: B**edded Capacity - Worst Case Scenario Bed Gap - Capacity constraints in the Local Authority for timely patient discharge **ACTION:** Complete year 2 final Paediatric beds re-staffing resource (COO: Aug 2025) **ACTION:** Work with system colleagues to reduce length of stay to increase capacity (COO: Sep 2025) **ACTION:** Work with system colleagues on supported discharges (P1 - P3) through the Discharge Improvement Group (COO: Oct 2025) **GAP:** UTC Capacity - UTC capital funding still to be confirmed **ACTION:** Development of City UTC (NHSE submission) (COO: Sep 2025) **ACTION:** Development of City UTC community capacity opening October (COO: Oct 2025) - paper C & D **GAP:** Lack of UEC Demand Management - Ineffective demand management for UEC **ACTION:** High Frequency User / High Impact User post commence and review to be undertaken (COO: next review Nov 2025) **ACTION:** UEC Recovery Plan - System - monitored via UEC Transformation Group (COO: Nov 2025) **GAP:** Financial Allocation to Address Winter 2025 Demands - Insufficient financial allocation for winter 2025 demands **ACTION:** Develop 2025/26 Winter Plan (COO: Draft Aug 2025 / Submission Sept 2025) **ACTION:** Oversight of development of System Winter Plan (COO: Sept 2025) **GAP:** Alignment with national NHSE UEC care plan for 2025/25 **ACTION:** Undertake gap analysis and report to OPC (COO: July 2025) - completed **GAP:** Alignment with neighbourhood models **ACTION:** UHL to work with ICB on the development of neighbourhood models (COO: Oct 2025)	Likely (4) x Moderate (3) = 12	Possible (3) x Moderate (3) = 9
10	02-Activity(Elective & Diagnostics)-2	Jon Melbourne, COO	Operations & Performance Committee	Activity - Elective Care & Diagnostics	Goal: High-quality care for all Partnerships for impact Annual Priority: Transform patient care	Deliver national planned care targets and transform UEC pathways	There is a risk of failing to deliver timely planned care	due to a backlog from the COVID-19 pandemic and sustained growth in referrals exceeding elective capacity	leading to repeat diagnostics, patient harm, poor patient experience, and performance falling below national standards	Almost certain (5) x Major (4) = 20	System recovery plan and underpinning workstreams covering the 8 elective care interventions with oversight through the Elective Recovery Committee (LC): Productivity & releasing constraints OP transformation Pathway changes Validation of the waiting List Additional capacity Mutual aid Use of the independent Sector Elective Recovery Fund (ERF) EMPCC phase 2 opened in Jan 2025 (LC) Theatre downtime Business Continuity arrangements (LC) Industrial Action Plans and Planning Group - EPRR (ILC/IC)	Access and Performance meetings with UHL Specialities - Specialty validation (Internal Assurance) Weekly joint elective meetings with UHN and UHL (Internal Assurance) Monthly Theatre Productivity Board (Internal Assurance) Monthly Outpatient Board (Internal Assurance) Internal Audit: Waiting List Management (Internal Assurance: Limited) Industrial Action Plans and Planning Group - EPRR (Internal Assurance) Elective Care & Diagnostics RTT and DM 01 monthly report to OPC (Internal Assurance) Monthly Planned Care Partnership meeting (Independent Assurance) National performance profile monitoring (Independent Assurance) Industrial Action Plans and Planning Group reporting - (Internal Assurance) Hinckley Community Diagnostic Centre opened end of June 25 (Internal Assurance)	**GAP:** Resource Constraints - Insufficient resources for elective care transformation (LC) **ACTION:** Maximise capacity within the EMPCC at the LGH (DCOO: Fortnightly review of activity and performance progress, started Jan - review monthly) **GAP:** Diagnostic Delays - MRI and other diagnostic test delays (LC) **ACTION:** Monitor the impact of Hinckley's new Community Diagnostic Centre on diagnostic waiting list (COO: Sep 2025) **GAP:** Long Waits - 65 and 52-week wait targets not being met (LC) **ACTION:** Increase UHL capacity through improvements in productivity, insourcing, outsourcing, and the independent sector to support 65 and 52-week targets (COO: ongoing) **GAP:** Financial and Workforce Constraints - Trust financial position and associated workforce controls impacting the ability to deliver needed activity levels. **ACTION:** Review the profitability of WLI and insourced contracts (COO: Aug 2025) **GAP:** Emergency Care Pressures - Capacity constraints and workforce issues in the paediatric surgical unit due to staffing issues. **ACTION:** Implement robust winter planning and develop a paediatric business case (CCO: Sep 2025) **GAP:** Estate limitations and limitations and aging infrastructure of the theatre estate - Ventilation issues and maintenance backlogs. **ACTION:** Conduct an options appraisal for theatre maintenance (DCOO and Leigh Gates: Jul 2025) - Theatre downtime on Trust risk register (Risk 3140). **ACTION:** Engage within the clinical services strategy (COO: Sep 2025) **GAP:** Limited Capital Funds - Limited funds for equipment replacement and investment; issues with ERF and oversubscribed capital allocation leading to equipment breakdowns and lack of investment. **ACTION:** Risk 4149 on Trust risk register (*There is a risk of equipment failure and prolonged downtime of core clinical service* s) - Managed via MEE. **GAP:** Digital Maturity - Limited ability to adopt new technologies affecting overall productivity and activity levels (LC) **ACTION:** Collaborate with the PAS Project team to test new system impacts on elective activity and participate in AI pilots to improve productivity (DCOO and DMD: Sep 2025) **GAP:** Paediatric HDU Beds - Lack of beds causing treatment delays (LC) **ACTION:** Paediatric super week planned for July 2025 to see potentially an additional 20 ENT Paed patients (DCOO, Sep 2025)	Likely (4) x Moderate (3) = 12	Possible (3) x Moderate (3) = 9
11	02-Activity(Cancer)-3	Jon Melbourne, COO	Operations & Performance Committee	Activity - Cancer Care	Goal: High-quality care for all Partnerships for impact Annual Priority: Transform patient care	Deliver national planned care targets and transform UEC pathways	There is a risk of failing to deliver timely and effective cancer care across the Trust	due to sustained demand for cancer treatment services exceeding strategic capacity	leading to non-compliance with national targets, reduced survival rates, and reputational harm	Almost certain (5) x Major (4) = 20	Internal cancer centre team target of no more than 7 days between tracking of patients (IC) Increased workforce (LC) Weekly PTL with individual tumour sites (IC) Daily tracking of backlog (IC) Recovery Action Plans (RAP) with all tumour sites (LC) Utilisation of all available capacity within the UHL (LC) Industrial Action Plans and Planning Group - EPRR (ILC/IC)	Tumour site Recovery & Performance meetings established on weekly/fortnightly/monthly basis contingent on level of risk within each tumour site (Internal Assurance) Reporting to Cancer Board monthly (Internal Assurance) Dual reporting to UHL Operations & Performance Committee and LLR Quality & Performance Sub Group monthly (Internal Assurance) Harm Review undertaken of all patients who breach 104 days reported to Quality Committee (Internal Assurance) Industrial Action Plans and Planning Group reporting - (Internal Assurance)	**GAP:** Further industrial action; urgent and emergency care and winter pressures; capacity constraints; workforce constraints **ACTION:** Prioritise cancer patients where possible, and conduct demand and capacity reviews to minimise impact on cancer care (COO: Mar 2026) **GAP:** Data Quality and Reporting - concerns about the accuracy and timeliness of cancer performance data, affecting decision-making and reporting **ACTION:** Strengthen data governance frameworks and data management practices. Implement regular audits to ensure data integrity (COO: Dec 2025) **GAP:** Sufficient capacity to meet Faster Diagnosis standard to have more than 80% of patients diagnosed within 28 days of referral by March 2026 **ACTION:** Review of referrals, FDS performance and demand and capacity gap with mitigations by service to improve numbers of cancer diagnosed within target (COO: Mar 2026) **GAP:** 62 day performance affected by capacity impacting the ability to date patients within 62 days of referral **ACTION:** Progress made in 2024/25. Revised 2025/26 internal backlog trajectory to achieve no more than 152 patients waiting more than 62 days and less than 10 patients waiting more than 104 days on combined pathways. Review opportunities for improved turnaround times to support 62-day performance. Recovery Action Plans (RAPs), weekly patient level tracking, and daily backlog reports in place (Review- COO: Mar 2026) **GAP:** 31 day radiotherapy demand and backlogs for prostate and breast patients **ACTION:** 5th Linac in place, reduction of wait times across 25/26 and by Q4 24/25. Regional mutual aid to support in place (COO: Dec 2025) **GAP:** 31 day surgical capacity affecting the ability to deliver more than two thirds of patients treatments within 31 days of a decision to treat (target of 96%) **ACTION:** Robust application of CWT, offering patient choice with alternative clinicians where appropriate. Improving theatre productivity. Following surgical demand and capacity review (Nov 2024), implement actions to improve dating processes with alternative clinicians where appropriate to improve 31-day surgical performance (COO: Dec 2025) **GAP:** Systemic Anti-Cancer Therapy capacity to meet 31 day target **ACTION:** Review progress on 31-day performance to deliver 96% anti-cancer regimes via weekly PTL meetings and Oncology RAP (COO: Dec 2025) **GAP:** In month review of activity and 62 day performance oversight with services **ACTION:** 62 day performance oversight with services via RAP meetings to explore opportunities to improve including peer benchmarking (COO: Dec 2025) **GAP:** Reduction in EMCA funding to support delivery of cancer services and transformational change **ACTION:** Consolidate and review priority areas for funding, focus on improving efficiency and productivity to mitigate risk, consider schemes which may need to cease (COO: Jul 2026)	Likely (4) x Moderate (3) = 12	Possible (3) x Moderate (3) = 9
12	03-Finance (capital)-1	Lee Bond, CFO	Finance Investment Committee	Finance - Capital	Goal: High-quality care for all Annual Priority: Transform patient care Deliver our financial plan	Deliver our financial plan Deliver major digital change	There is a risk of insufficient **capital** to meet Trust priorities	due to competing demands and limited funding	leading to disruption to services and non-compliance with statutory requirements, such as health and safety standards and legislation, and address backlog maintenance requirements (concerning medical equipment, estate and Digital & Data)	Likely (4) x Major (4) = 16	Prioritised three year capital plan overseen by the Capital Management Investment Committee (LC) Medium Term Capital Plan (LC) System Capital Group established, chaired by UHL's Chief Financial Officer (LC) Strategic Planning Group to advise on strategic capital priorities and ensure alignment with clinical and estates strategies (LC) Dialogue with Regional and National teams (LC) Estates & Facilities Backlog Maintenance Programme (LC) EPRR Team and Business Continuity Plans (IC) Medical Equipment Executive meetings (LC)	Internal management capital oversight provided by capital scheme leads (Internal Assurance) Finance updates to Trust Board and FIC (Internal Assurance) Significant operational risks relating to Estates, Digital and Medical Equipment are reported on the risk register to Risk Committee (Internal Assurance) Estates operational update to FIC quarterly (Internal Assurance) Internal Audit Reporting on the annual audit work programme (External Assurance) External Audit opinion on the Annual Report and Accounts (External Assurance)	**GAP:** There is an absence of a strategic, long term, infrastructure replacement programme. Key capital risks have been deferred from 2024/25 to 2025/26 and the capital budget is under pressure when unexpected failures occur (equipment and or buildings related) **ACTION:** Development of the 2025/26 Capital expenditure plan including any Estates, Digital and Medical Equipment Risk (CFO: Aug 2025)	Likely (4) x Moderate (3) = 12	Possible (3) x Moderate (3) = 9
13	03-Finance (revenue and sustainability-Delivery of the Annual Financial Plan (Short-Term)-1	Lee Bond, CFO	Finance Investment Committee	Finance - Financial Sustainability - short term	Goal: High-quality care for all Annual Priority: Transform patient care Deliver our financial plan	Deliver our financial plan Deliver our workforce plan as part of our financial plan	There is a risk the Trust fails to deliver its **annual financial plan**	due to significant in-year operational and inflationary cost pressures across the LLR system and internal efficiency challenges	leading to unplanned deficits, increased regulatory scrutiny, reduced flexibility in financial decision-making, and short-term impact on service delivery and patient care	Almost certain (5) x Major (4) = 20	Annual Planning process & Annual Plan; alignment of activity, workforce and finance inc investment (LC) Investment principles articulated in the 2025/26 Annual Plan (LC) Financial Recovery Plan (LC) Financial Sustainability Governance Framework including Quality Impact and Risk Assessment of all schemes (LC) Fraud Champion (LC) Results Delivery Office (RDO) Monthly CMG Performance Review Meetings (PRM) Monthly CMG Finance & Workforce meetings with CFO & CPO	Risks to delivering the 2025/26 financial plan (inc the potential impact and TB and sub-committee oversight) articulated in 2025/26 annual plan (Internal Assurance) Monthly Financial Report to FIC and Board (Internal Assurance) Results Delivery Office (RDO) inc Minimum Dataset / dashboard (Internal Assurance) CMG Performance Review Meeting Actions (Internal Assurance) Oversight of delivery of the Annual Operating Plan via FIC (Internal Assurance) Operational Risk Register (Internal Assurance) Financial Sustainability Governance Framework including Quality Impact and Risk Assessment of all schemes (Internal Assurance) Data integrity is checked through internal reviews (Data Quality Forum) and external audits External and Internal Audit reports (External Assurance) Industrial Action planning and reporting re financial impacts - (Internal Assurance)	**GAP:** Lack of fully developed and implemented CIPs and funded workforce establishment plans aligned to 2025/26 financial targets, creating a gap in financial sustainability delivery **ACTION:** Sustain additional financial grip & control measures e.g. pay controls (CFO/CPO: Jul 2025) **ACTION:** Review services with negative financial contribution (CFO: Jul 2025) **ACTION:** Ensure CMG and corporate delivery plans are realistic and aligned to financial and quality objectives (CFO: Jul 2025) **ACTION:** Maximise productivity (within existing resources/cost) whilst maintaining high standards of patient safety and quality (CFO/COO: Dec 2025) **GAP:** Income recovery plan **ACTION:** Develop Income recovery plan (CFO: Jul 2025) **GAP:** Financial allocation to address winter 2025 demands **ACTION:** Monitor Winter programme, including any resourcing, with the LLR ICB (CFO: Oct 2025) **GAP:** LLR System cash flow arrangements **ACTION:** Work with LLR System partners to support cash requirements within the System and facilitate access to cash (CFO: Oct 2025)	Possible (3) x Major (4) = 12	Unlikely (2) x Major (4) = 8
14	03-Finance (sustainability- Long-Term Financial Sustainability (Medium to Long-Term)-2	Lee Bond, CFO	Finance Investment Committee	Finance - Financial Sustainability - long term	Goal: High-quality care for all Annual Priority: Transform patient care Deliver our financial plan	Deliver our financial plan Deliver our workforce plan as part of our financial plan	There is a risk the Trust is unable to achieve **long-term financial sustainability**	due to structural financial challenges across the LLR system, recurrent cost pressures, and limited availability of capital and transformation funding	leading to continued misalignment with the medium-term financial plan (MTFP), reduced capacity to invest in workforce, digital, and estates improvements, and a negative impact on the quality and sustainability of patient services	Almost certain (5) x Major (4) = 20	See for risk 03-01 (annual plan) above	See for risk 03-01 (annual plan) above	**GAP:** Lack of clarity on national and regional financial regime limits Trust's ability to plan with confidence - E.g. annual cycles versus long term plan **ACTION:** National exercise to support the Trust to develop an organisational MTFP (CFO: Dec 2025) **GAP:** Financial planning is limited to annual cycles, reducing long-term strategic alignment **ACTION:** Develop and implement a multi-year financial model to inform strategic and operational planning (CFO: Mar 2026) **GAP:** In-year financial pressures are not consistently modelled, limiting proactive planning and risk mitigation **ACTION:** Enhance financial modelling to include in-year and future pressures to support decision-making (CFO: Mar 2026) **GAP:** Absence of approved Organisational and Clinical strategies limits alignment of priorities and investment **ACTION:** Finalise and approve Organisational and Clinical Strategies to guide delivery of Trust objectives (CFO: Mar 2026)	Possible (3) x Major (4) = 12	Unlikely (2) x Major (4) = 8

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
2	**BAF Risk Ref No.**	**Executive Lead**	**Board committee oversight**	**Risk Theme**	**Trust Goal & Annual Priority**	**Deliverables / Strategy**	**Risk Description** ***There is a risk of (this is the uncertain risk event)*** ***Due to (this is the existing condition)*** ***Leading to (this is the impact on the Trust)***			**Current risk rating L x I = Current (Likelihood of event occurring x Impact of event)**	**Key controls in place now** ***(Impact control = IC or Likelihood control = LC)***	**Key sources of assurance** ***(3 lines of defence - independent or internal)*** ***(Assurance rating)***	**Key gaps in control and assurance with key next steps** **(to address gaps in controls or assurance)**	**Tolerable risk rating (L x I)** **Under review**	**Aim risk rating (L x I) under review**
15	04-Digital-1	Will Monaghan, Group CIO	Our Future Hospitals & Transformation Committee	Digital - Failure to deliver a unified, reliable digital foundation	Goal: High-quality care for all Being a great place to work Annual Priority: Transform patient care Strengthen our culture Deliver our financial plan	Getting the Basics Right Creating and Embedding One Digital Governance/process gaps Technical reliability challenges	There is a risk that the Group will fail to deliver a robust, consistent, and reliable digital infrastructure and operating model	due to legacy systems, fragmented platforms, and immature Group-wide governance and capability	leading to operational inefficiencies, staff frustration, and limited readiness for large-scale transformation	Likely (4) x Major (4) = 16	Modernisation & Cloud Strategy (LC): Phased digital infrastructure programme to unify systems and upgrade devices/networks Consolidation and simplification of platforms and tools across sites to reduce complexity Focused cybersecurity, clinical safety, and data protection frameworks Group-wide Programme Management Office (PMO) to oversee decision making, governance and prioritisation Digital and Data teams aligned under "one digital" identity and governance	Digital Hospital Board oversight and shared decision-making forums Planned service-level targets for device delivery and issue resolution (e.g. reduce device delivery time from 6 weeks to 1; resolve urgent IT issues within 1 hour) IT helpdesk response data and asset management records Digital maturity tracked through industry frameworks (using recognised standards - e.g. What Good Looks Like, HIMSS) IT System Performance & Reliability Reports (network uptime above 99.9%) Regular Scalability & Infrastructure Reviews Staff survey feedback on system usability	**GAP**: Use of a local tenant resulting in operational inefficiencies and barriers to cross-organisational collaboration **ACTION**: Phase one transition to the central M365 tenant (GCIO: Aug 2025) **ACTION**: Phase two transition to the central M365 tenant; PowerApps, on-premises data, PowerBI, Single Sign On (GCIO: Nov 2025) **ACTION**: Develop new protocols for managing cross-tenant collaboration (GCIO: Dec 2025) **ACTION**: Build internal capacity on M365 tools and best practices (GCIO: Dec 2025) **ACTION**: Legacy system decommissioning timelines to be confirmed (GCIO: Aug 2025)	Possible (3) x Major (4) = 12	Possible (3) x Moderate (3) = 9
16	04-Digital-2	Will Monaghan, Group CIO	Our Future Hospitals & Transformation Committee	Digital - Misalignment between digital solutions and care delivery needs	Goal: High-quality care for all Being a great place to work Annual Priority: Transform patient care Strengthen our culture Deliver our financial plan	Putting Users' Needs First Using Digital as a Tool for Transformation *Usability and workforce impact* *Equity and accessibility concerns*	There is a risk that digital solutions will fail to meet the clinical, operational, and patient needs of the Group and fail to address digital poverty	due to inadequate co-design, inconsistent user engagement, and fragmented integration with transformation and service improvement programmes	leading to poor adoption, inefficient workflows, and reduced impact on care quality and experience	Likely (4) x Major (4) = 16	User-centred design and co-production with clinicians, operational leads, and patients Centralised prioritisation and decision-making model ed by clinical and operational staff for digital initiatives - preventing the purchase (or use of free software) that does not follow this process Continuous improvement model with post-implementation optimisation Integration of digital into all major transformation and service redesign projects Digital Champions Standards for usability and accessibility (including adaptive & assistive technology) Patient-Centric Digital Tools: Multi-language & accessible interfaces to reduce inequalities and improve access for all	EPR benefits register Roadmap due June 2025 outlining system rationalisation and decommissioning?? Monitoring of Digital Service Uptake - Staff surveys on digital experience and usability Programme-level reporting on uptake, training, and time savings Inclusion of digital in transformation governance forums Patient accessibility & digital literacy through equity-focused digital design and evaluation Equality Impact Assessments	**GAP**: Different Electronic Patient Record across UHL and UHN impedes real-time data exchange, continuity of care, and digital innovation. **ACTION**: Expand peer-led support networks (GCIO: Dec 2025) **ACTION**: Align the innovation pipeline with funding sources and capability (GCIO: Dec 2025) **GAP**: Digital Transformation not joined up with other teams leading change (LC) **ACTION**: Establish a multi disciplinary team to work with CMGs to deliver EPR transformation (GCIO: Oct 2025) **GAP**: Staff survey (the majority of respondents feel digital tools do not support patient care) and inclusion of admin and non-clinical staff in solution design **ACTION**: Deliver 'Inclusive Digital Leadership' training (GCIO: Oct 2025) **ACTION**: Partner with patient groups to evaluate accessibility (GCIO: Oct 2025) **GAP**: Continued reliance on paper records (IC) **GAP**: Multitude of different digital systems in use (LC) **ACTION**: Deliver the technology roadmap (GCIO: review Dec 2025)	Possible (3) x Major (4) = 12	Possible (3) x Moderate (3) = 9
17	04-Digital-3	Will Monaghan, Group CIO	Our Future Hospitals & Transformation Committee	Digital - Inability to harness data, innovation, and partnerships for transformation	Goal: High-quality care for all Being a great place to work Annual Priority: Transform patient care Strengthen our culture Deliver our financial plan	Embracing Emerging Technology Bringing Our Data Together Harnessing Strategic Partnerships *Research, AI, FDP, and commercial risks*	There is a risk that the Group will not fully harness the value of integrated data, emerging technologies, and strategic partnerships	due to limitations in digital maturity, workforce capability, and commercial frameworks	leading to missed opportunities for innovation, research, income generation, and population health improvement	Likely (4) x Major (4) = 16	Investment in Federated Data Platform (FDP) and group-wide analytics AI Academy and Data Academy established to upskill staff AI guidance, FAQs and operational support available through the UHL & UHN's Digital and Data Team's intranet portal Framework for ethical and secure data use and commercialisation Participation in national pilots (e.g. automation centre of excellence, FDP accelerator) Business Intelligence Team - to provide predictive modelling and operational insights Clinical Coding Team - to support accurate revenue, data quality, and planning AI governance office and ethical frameworks for data sharing and AI use	External recognition (e.g. FDP pioneer site, NHS automation centre of excellence) Tracking of research use cases, data access, and commercial collaborations with academia and industry Strategy publication milestones (e.g. data strategy; emerging tech plan) Partnership governance with NHS England and tech providers Periodic AI performance and impact assessments for safe adoption of AI Concerns or incidents related to AI-generated outputs must be reported via the IT Service Management process - operational assurance	**GAP**: Limited AI training for staff and workforce confidence in using emerging tech remains variable **ACTION**: Create an AI Academy to train staff, ensure safe and effective adoption of technology, and foster innovation (GCIO: Oct 2025) **GAP**: No Strategy and resourcing plan for emerging technology **ACTION**: Develop a strategy and resourcing plan for emerging technology (GCIO: Oct 2025) **GAP**: No PowerBI Governance Framework and commercial models under development (e.g. Data as a Service, licensing dashboards) (LC) **ACTION**: Develop a PowerBI Governance Framework (GCIO: Oct 2025) **GAP**: Lack of Trust wide PowerBI licence (LC) **ACTION**: Explore options for a Power BI Centre of Excellence (GCIO: Oct 2025) **ACTION**: Transition from Qlik to PowerBI (GCIO: post implementation of the M365 tenant) **GAP**: Limited Clinical Coding capacity, capability and accuracy. No Clinical Coding automation (LC) **ACTION**: Implement the Clinical Coding Action Plan (GCIO: Oct 2025) **GAP**: Fragmented data quality research and operational data (A) **ACTION**: Develop a Data Strategy including a plan for liberating our data for research and commercial opportunities (GCIO: Aug 2025)	Possible (3) x Major (4) = 12	Possible (3) x Moderate (3) = 9
18	04-Digital-4 **Withheld from public report**	Will Monaghan, Group CIO	Our Future Hospitals & Transformation Committee	Digital - Cybersecurity	Goal: High-quality care for all Annual Priority: Transform patient care Strengthen our culture Deliver our financial plan	Digital - Cybersecurity Breach	There is a risk of a cybersecurity breach	due to the expanded digital footprint of the organisation and evolving cyber threats	leading to service disruption, data loss, clinical safety risks, and reputational damage	Likely (4) x Extreme (5) = 20	**[Withheld from public reporting]:**	**[Withheld from public reporting]:**	**[Withheld from public reporting]:**	Possible (3) x Major (4) = 12	Possible (3) x Moderate (3) = 9
19	05-Estate-01	Ben Widdowson, DEF	Primary Oversight: Finance Investment Committee (in line with FIC quarterly update) Secondary Oversight: Our Future Hospitals & Transformation Committee	Estates - **Statutory compliance and productivity**	Goal: High-quality care for all Being a great place to work Partnerships for impact Annual Priority: Transform patient care Strengthen our culture Deliver our financial plan	Estates - Safety, Compliance and productivity	There is a risk that the estate does not support safe, compliant, and productive healthcare delivery	due to ageing infrastructure, unresolved £125m backlog maintenance (excluding VAT fees of circa £75m), and poor space utilisation	leading to safety incidents, enforcement action, service disruption, and inefficient use of resources	Likely (4) x Major (4) = 16	Preventative Controls: Planned Preventative Maintenance (PPM) Programme partially in place Compliance monitoring via Estates Return Information Collection (ERIC) and Premises Assurance Model (PAM) Risk-based prioritisation (HTM, SFG20) BMS to monitor HVAC in some areas Prioritised capital investment Commercial strategy and income development Capital programme targeting BLM monitored through CMIC to support prioritisation of capital based on clinical & infrastructure risks Corrective Controls: Emergency response processes Fire risk mitigation protocols Contractor-led repairs Space reconfiguration projects	Health and Safety assurance reports (Internal Assurance) Risk Register and Risk Committee oversight (Internal Assurance) Capital investment reviews and monitoring reports to Capital Management Investment Committee (CMIC) (Internal Assurance) Statutory compliance audit remedials reported to UHL Health & Safety Committee (Internal Assurance) E&F policies and procedures updated based on outcomes of audits (Internal Assurance) External AE Audit Reports covering E&F relevant workstreams, with actions captured in non-compliance assurance registers (External Assurance) Specialist Technical Groups (including ventilation) (Internal Assurance) Estates Return Information Collection (ERIC) and Premises Assurance Model (PAM) reporting (Internal Assurance) Asset management database (Internal Assurance) Estates occupancy and utilisation data (Internal Assurance)	**GAP**: Limited real-time access to asset, compliance and utilisation data **ACTION**: Implement high priority / statutory elements of CAFM/Asset Management system (DEF: Sep 2025) **ACTION**: Implement full asset inventory updated (DEF: Jun 2026) **GAP**: Underfunding and lack of long-term investment plan to reduce high-risk BLM Note: Mitigations in 25/26 include central funding of £7.2m to address high risk estates safety issues. Along with £2.6m Cdel funding this meets the annual level of funding required to have an impact on overall backlog within the Trust but needs to be repeated each year in a 10-year plan **ACTION**: Develop investment plan (DEF: Sep 2025) **ACTION**: £10m-£12m/year capital investment needed to address BLM (DEF: annual review, Mar 2026) **GAP**: Statutory compliance workforce resource gaps (e.g. Head of Health & Safety) **ACTION**: Evaluate E&F compliance workforce requirements (DEF: Sep 2025) **GAP**: No productivity dashboard **ACTION**: Develop E&F productivity report (DEF: Sep 2025)	Possible (3) x Major (4) = 12	Possible (3) x Moderate (3) = 9
20	05-Estate-02	Ben Widdowson, DEF	Our Future Hospitals & Transformation Committee	Estates - **Sustainability - Net zero carbon**	Goal: High-quality care for all Being a great place to work Partnerships for impact Annual Priority: Transform patient care Strengthen our culture Deliver our financial plan	Estates - Becoming a Green Trust	There is a risk that the Trust fails to meet net zero carbon targets by 2040/2045	due to reliance on outdated systems and insufficient green investment	leading to higher emissions and regulatory non-compliance breaches	Likely (4) x Major (4) = 16	Preventative Controls: UHL Green Plan Energy & Infrastructure Group oversight BREEAM standards Corrective Controls: Sustainability Impact Assessments Low-carbon infrastructure upgrades	Carbon footprint tracking Green Plan audits NHS Net Zero compliance Sustainable transport solutions (Internal Assurance) Leicester City Council and UHL Joint Working Group (Internal Assurance) University of Leicester and UHL Joint Working Group (Internal Assurance) Premises Assurance Model (PAM) (Internal Assurance) Estates Return Information Collection (ERIC) (Internal Assurance)	**GAP**: Updated Green Plan and no sustainability dashboard **ACTION**: Refresh Final Green Plan including Travel Plan (DEF: Oct 2025) **ACTION**: Develop performance dashboard (DEF: Oct 2025) **GAP**: Behavioural engagement weaknesses **ACTION**: Launch behavioural engagement campaign (DEF: Sep 2025)	Possible (3) x Major (4) = 12	Possible (3) x Moderate (3) = 9
21	05-OFH-03	Simon Barton, Deputy Chief Executive Officer & Debra Green, OFH Programme Director	Our Future Hospitals & Transformation Committee	**OFH**	Goal: High-quality care for all Being a great place to work Partnerships for impact Annual Priority: Transform patient care Strengthen our culture Deliver our financial plan	Enabling Future Care Models	There is a risk that the reconfiguration of acute and community hospital services as part of the New Hospitals Programme (NHP) is not delivered by 2034	due to delays in national capital funding and complex programme dependencies	leading to prolonged and potentially increased clinical risk and operational service inefficiencies	Likely (4) x Major (4) = 16	Preventative Controls: Our Future Hospitals Programme governance National/ICS estates alignment Clinical review of the impact of the delay to clinical risks on associated services with a programme of activities to support the services during the interim.	OFH Programme progress reports to OFH&TC ICS engagement UHL is a Wave 2a scheme and funding for the following has been allocated for 25/26: NHP funded internal Core Delivery Team LRI Enabling FBC pending approval & proceed to construction LRI/GH In-coming power BC development & approval Additional funding may be available for discreet agnostic pieces of work if funding becomes available through slippage of the Wave 1 schemes.	**GAP**: Uncertainty around funding as a consequence of the NHP Wave 2a timeline **ACTION**: Maintain regular engagement with the NHP - ongoing **GAP:** Until clinical risk identification work is complete, the total impact of the deferral on clinical services and patient outcomes is unknown. **ACTION:** OFH are facilitating plans for each CMG, who will then own and manage identified risks, and develop of mitigation plans (Oct 2025) **GAP:** Until clinical risk identification work is complete, the impact of prolonged use and failing, or non-compliant estate cannot be quantified **ACTION:** OFH are facilitating plans for each CMG, who will then own and manage identified risks, and develop of mitigation plans - Estates are fully embedded in this process (Oct 2025)	Possible (3) x Major (4) = 12	Possible (3) x Moderate (3) = 9

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
2	**BAF Risk Ref No.**	**Executive Lead**	**Board committee oversight**	**Risk Theme**	**Trust Goal & Annual Priority**	**Deliverables / Strategy**	**Risk Description** ***There is a risk of (this is the uncertain risk event)*** ***Due to (this is the existing condition)*** ***Leading to (this is the impact on the Trust)***			**Current risk rating L x I = Current (Likelihood of event occurring x Impact of event)**	**Key controls in place now** ***(Impact control = IC or Likelihood control = LC)***	**Key sources of assurance** ***(3 lines of defence - independent or internal)*** ***(Assurance rating)***	**Key gaps in control and assurance with key next steps** **(to address gaps in controls or assurance)**	**Tolerable risk rating (L x I)** **Under review**	**Aim risk rating (L x I)** **under review**
22	06-People-1	Clare Teeney, CPO	People & Culture Committee	People – **Culture** (merging: Staff and learner experience; EDI; Inclusive leadership; Safe and healthy workplace)	Promoting a culture that embodies our Trust values and behaviours - It is our aim that we promote a culture that embodies our trust values and behaviours	Deliver year one of our People Strategy People - Staff and learner experience and engagement People - A sense of belonging for all (EDI) People - Compassionate and inclusive leadership	There is a risk that UHL does not consistently embed a culture that promotes inclusion, psychological safety and values-led behaviours	due to inconsistent response to **staff feedback and experience survey actions**, variation in **leadership capability**, and inconsistent delivery of **EDI objectives across teams**	leading to reduced morale, engagement, and staff retention	Likely (4) x Major (4) = 16	Behavioural framework (LC) Staff engagement programmes such as NHS Staff Survey and National Education Training Survey (NETS) (LC) Culture dashboards (LC) EDI strategy (LC) Equality Delivery System (LC) Anti-discrimination statement (LC) Leadership and Management behaviours & competence framework (LC) Just & restorative learning approach (LC) Civility & Respect programme (LC) Resolution, disciplinary and capabilities policies (LC) Trust values campaign (LC) Freedom to Speak Up Guardians (LC) Exit interview process (LC) Oversight review meetings to review progress of culture review recommendations (LC)	Staff Survey results NETS results Culture heatmaps and reporting WRES/WDES/GPG metrics Pulse survey feedback Employee relations reduction trends 360 feedback Junior Doctors Contract Guardian of Safe Working report Sexual Safety NHS Charter reporting	**GAP**: Inconsistent implementation of inclusive leadership and values into everyday team behaviours **ACTION**: Launch and promote Trust-wide values and RISE campaign (CPO: Sep 2025) **GAP**: Framework and guidance for fostering recognition culture/local level **ACTION**: Develop recognition framework with guidance to launch - fostering recognition culture/local level (CPO: Sep 2025) **GAP**: Culture within the cardiac surgery service **ACTION**: Ibex Gale Learning Cultural Review (cardiac surgery service) report received. Action plan developed along with externally facilitated OD programme to complete the 32 LCR recommendations. Report to PCC. (CPO / MD: Dec 2025) **GAP**: Culture within specific services **ACTION**: Linked with Quality Action Plan (BAF Risk 01 - Quality) **GAP**: Inconsistent delivery and limited local ownership of EDI objectives and staff cultural issues across teams **ACTION**: Launch EDI Strategy (CPO: Sep 2025) **ACTION**: Launch Trust Anti-discrimination and Anti-racism position statement and staff pledges (CPO: Sep 2025) **ACTION**: Develop and embed departmental dashboard & metrics (Equality and Health Inequality Impact Assessment) (CPO: Sept 2025) **GAP**: Inconsistent embedding of inclusive behaviours into team development **ACTION**: Deliver "What's Your Team's VIBE" OD team-based sessions (Sep 2025) **GAP**: Gaps in appraisal processes and leadership behavioural alignment and accountability frameworks **ACTION**: Update and redesign Trust appraisal system and documentation (to embed the civility and respect and active bystander behaviours into leadership appraisals) and 360 feedback tools (to incorporate values and leadership competencies) (CPO: Sep 2025)	Possible (3) x Major (4) = 12	Possible (3) x Moderate (3) = 9
23	06-People-2	Clare Teeney, CPO	People & Culture Committee	People – **Capability** (merging: Talent development; High performing leadership)	Harnessing and developing the talents of all our people, to ensure we are a high performing, capable and skilled organisation - It is our aim to harness and developing the talents of all our people, to ensure we are a high performing, capable and skilled organisation	Deliver year one of our People Strategy People - Harnessing the talents of all our people People - High performing leadership and management People - A safe and healthy workplace	There is a risk that UHL does not fully harness and develop the talents of all its people	due to **variation in leadership development**, lack of clear, equitable **talent and succession pathways** and inconsistent access to or uptake of **wellbeing support**	leading to reduced performance, staff progression and organisational resilience	Likely (4) x Major (4) = 16	Leadership & Talent Academy (LC) Learning and Development (Mandatory and Statuary training) (LC) Coaching and mentoring Programme (LC) Core and senior leadership essentials (LC) Senior leadership programme (LC) Sponsorship pilot (LC) Succession planning (in development) (LC) Internal role support (LC) AMICA Staff Counselling and Psychological Support Services (LC) Occupational Health (LC) Health & Wellbeing services (LC) TRiM, Schwartz rounds (LC) Mental health awareness training (LC) H&S and Security Services (LC) The Leicester Employment Hub apprenticeship programme (LC) Project Search (LC)	Appraisal outcomes Leadership programme uptake Staff feedback on leadership Wellbeing report Absence data Staff feedback from wellbeing usage Reports to H&S Committee	**GAP**: Talent management is not consistently embedded across the employee lifecycle **ACTION**: Finalise and implement the UHL Talent Management Plan (CPO: Sep 2025) **GAP**: Lack of clear, equitable talent and succession pathways and structured career development support varies across services□ **ACTION**: Launch the Leadership & Talent Academy with supporting resources (CPO: Oct 2025) **GAP**: Variation in leadership development and onboarding - Leadership expectations not yet standardised due to awaiting national framework□ **ACTION**: Launch UHL Leadership Way (once national framework confirmed) (CPO: Oct 2025) **GAP**: High-potential staff lack clear advancement pathways **ACTION**: Evaluate and expand sponsorship, mentoring and coaching offers (CPO: Oct 2025) **GAP**: Gaps in Appraisal processes in three core areas (Board and VSM, Consultant Medical Staff (SARD), and all other staff□ **ACTION**: Implement refreshed appraisal process, which will include more emphasis on talent and succession planning (CPO: Oct 2025) **GAP**: Limited awareness and inconsistent access and tracking of wellbeing support and response **ACTION**: Publish annual "Report & Support" review and wellbeing dashboard (CPO: Sep 2025) **ACTION**: Launch mental health awareness course (CPO: Sep 2025)	Possible (3) x Major (4) = 12	Possible (3) x Moderate (3) = 9
24	06-People-3	Clare Teeney, CPO	Primary Oversight: People & Culture Committee Secondary Oversight: Finance Investment Committee	People – **Capacity** (merging: Partnership working; Digital enablement; Workforce planning)	Using our resources well to ensure that we are maximising our organisational capacity to optimise productivity - It is our aim to use our resources well to ensure that we are maximising our organisational capacity to optimise productivity	Deliver year one of our People Strategy People - Maximising partnership working People - Accelerate the use of digital (systems, processes, skills) Deliver our workforce plan as part of financial plan delivery People - Strategic workforce planning	There is a risk that UHL is unable to optimise workforce productivity and sustainability	due to underdeveloped **strategic workforce planning**, limited adoption of **digital solutions** and uncoordinated use of **external partnerships**	leading to service gaps, inefficiencies and increased reliance on temporary staffing	Almost certain (5) x Major (4) = 20	Strategic workforce planning tools (LC) Medical recruitment strategy (LC) People Services automation (Wave 1&2) (LC) Anchor institution framework (LC) ESR optimisation (LC) Cross-boundary recruitment offers (LC) Job planning and rostering improvements (LC) Vacancy controls (LC) Industrial Action Plans and Planning Group - EPRR (LC)	Vacancy rate trends Time to hire metrics Bank and agency KPIs Levels of Attainment (LoA) metrics System usage data and feedback Joint initiatives with UHN Collaborative bank metrics Vacancy reduction data Inclusion outcomes Industrial Action planning and reporting re workforce matters - (Internal Assurance)	**GAP**: Digital automation benefits not fully realised across People Services - outdated systems and limited digital optimisation□ **ACTION**: Deliver Wave 2 of People Services automation programme - on capacity release and user experience (CPO: Mar 2026) **GAP**: Workforce metrics and data use not yet standardised - risk of workforce gaps and misalignment with future needs **ACTION**: Develop and implement standardised workforce KPI dashboards (CPO: Sep 2025) **GAP**: Lack of alignment in local workforce planning approaches□ **ACTION**: Equip leaders with workforce planning tools and training (CPO: Sep 2025) **GAP**: Lack of a coordinated partnership strategy - No unified collaborative workforce plan across system partners□ **ACTION**: Launch Trust-wide collaborative workforce strategy (CPO: Sep 2025) **GAP**: Medical and temporary staffing inefficiencies persist - Temporary staffing office (LC) **ACTION**: Deliver centralised temporary staffing office and recruitment strategy (CPO: Sep 2025) **ACTION**: Reduce temporary spend (CPO: Mar 2026)	Possible (3) x Major (4) = 12	Possible (3) x Moderate (3) = 9

Risk scoring matrix KEY:

Likelihood is a reflection of how likely it is the risk event will occur ‘x’ **impact** is the effect of the risk event if it was to occur

Likelihood	Impact: Rare	Minor	Moderate	Major	Extreme
Extremely unlikely	1	2	3	4	5
Unlikely	2	4	6	8	10
Possible	3	6	9	12	15
Likely	4	8	12	16	20
Almost certain	5	10	15	20	25

Score	Rating
1-6	Low
8-12	Moderate
15-20	High
25	Extreme