Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 27 May 2026

TB2026.41

Title:	**Board Assurance Framework and Corporate Risk Register Report**

Status:	**For Decision**
History:	**Regular report to the Committee**

Board Lead:	**Interim Chief Executive**
Author:	**Clare Winch, Director of Regulatory Compliance and Assurance**
Confidential:	**No**
Key Purpose:	Assurance

Executive Summary

1. This report provides the Board with an updated view of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR), supporting oversight of strategic risk, assurance coverage and risk appetite.
2. It highlights the refreshed BAF, including clearer links between strategic objectives, controls and sources of assurance, alongside a new dashboard and improved visibility of risks outside appetite or tolerance.
3. The report also confirms that the CRR remains under active review, with ongoing monitoring of risk movements, emerging issues and mitigating actions.

Recommendations

4. The Board is asked to:
    - review the updated BAF and CRR, and
    - re-approve the Board Risk Appetite Statement.

1. Purpose

1.1. The purpose of this paper is to provide the Board the opportunity to review and comment on the maintenance of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR).

1.2. This paper provides the Committee with latest copy of the Board Assurance Framework (BAF). In addition, it provides the current updated Corporate Risk Register (CRR). The report highlights the changes to CRR as reported to Integrated Assurance Committee.

2. Board Assurance Framework

2.1. Our BAF is informed by the Trust strategy, during 2025/26, we commenced a formal refresh of our Strategic Framework, building on the Trust Strategy 2020–2025. This work focused on reviewing strategic priorities in the context of a changing external environment and ensuring the Trust remains well positioned to deliver high-quality patient care and effective collaboration across the health and care system. The strategy refresh will be shaped by national direction, including NHS England's 10 Year Plan, the NHS Cancer Plan, and other recent policy announcements.

2.2. The four strategic pillars: Patient Care, People, Performance and Partnerships, continue to provide a consistent framework for decision-making and delivery.

2.3. The Trust's vision: to be an exemplar in healthcare delivery that is compassionate and enabled by the highest levels of research and innovation, continues to guide the strategy refresh. Delivery of this vision is grounded in the Trust's values of Learning, Respect, Delivery, Excellence, Compassion and Improvement, continue to underpin leadership, culture and organisational priorities. These values, alongside the four strategic pillars, have informed the ongoing refinement of strategic direction and the Trust's approach to long-term planning. The current strategic objectives reflected in the BAF will be reviewed and updated considering the finalisation of the Trust Strategy, but they currently remain our areas of strategic focus. Board strategy workshops are planned in June and July these will inform any updates to the BAF.

2.4. The latest version of the BAF is provided as Appendix 1. This reflects updates reported to Risk Committee in March and Audit Committee in April. A BAF guide has been developed and has been circulated to Board members in the reading room.

2.5. A log of all reports to the Board and all Board subcommittees, including Trust Management Executive has been compiled. Mapping of these

reports to the levels of assurance, in line with the definitions below has been undertaken to provide a full summary of the 2025/26 year.

2.6. Levels of Assurance (definitions):

- Level 1 – Operational (Management) – our first line of defence
- Level 2 – Oversight functions (Committees) – our second line of defence
- Level 3 – Independent (Audits / Reviews / Inspections etc.) – our third line of defence

2.7. The charts below provide an overall summary of assurance reported by assurance level for the year to date.

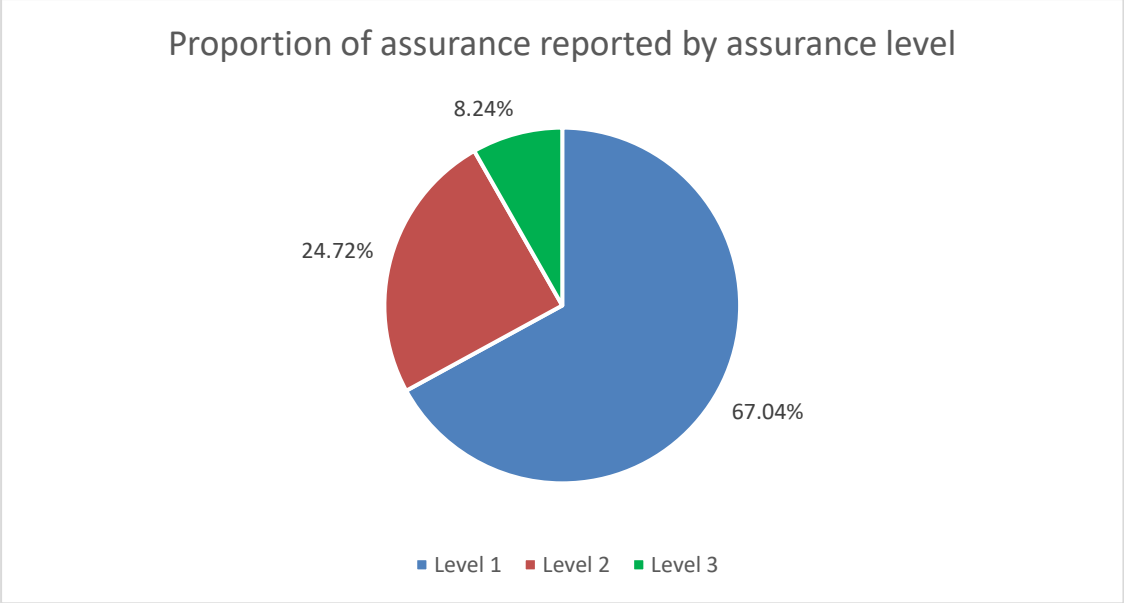


Table 1 proportion by assurance level

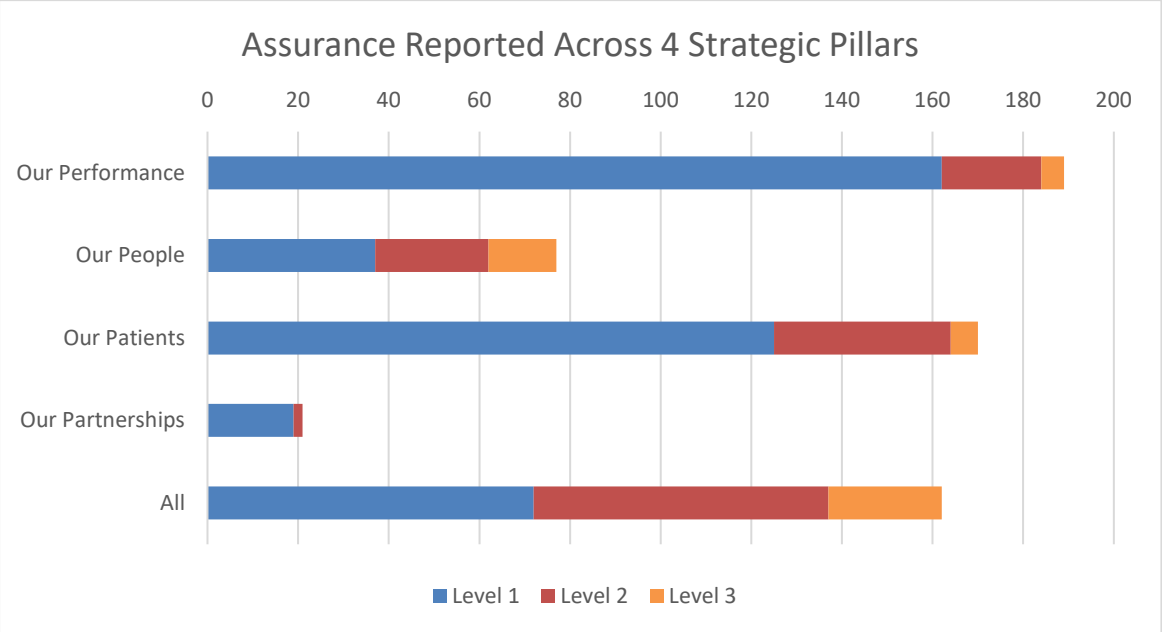


Table 2: Assurance levels by strategic pillar

2.8. Note papers such as the Integrated Performance Report have been included in the 'All' category. Level 3 assurances from the report log

have been added to the Board Assurance Framework to provide a full picture of independent assurance through the BAF.

2.9. As reported to the Audit Committee the BAF has been updated to include a BAF dashboard, this records an assessment of overall assurance rating for each strategic risk and a summary highlighting risks outside appetite and tolerance. In addition, the Chief Officers agreed that the BAF would be enhanced by adding of a short section to provide narrative / commentary on progress towards agreed plans and key milestones, this has been developed for the first time and is awaiting completion.

2.10. In initial assessment of overall assurance rating has been undertaken across all the current strategic risks. This has been done by mapping the controls to the assurance reports. The results of this initial mapping enabled additional reports to be included as sources of assurance. It also enabled a high-level assessment of any potential gaps in assurance. This is subject to further review and development during this year.

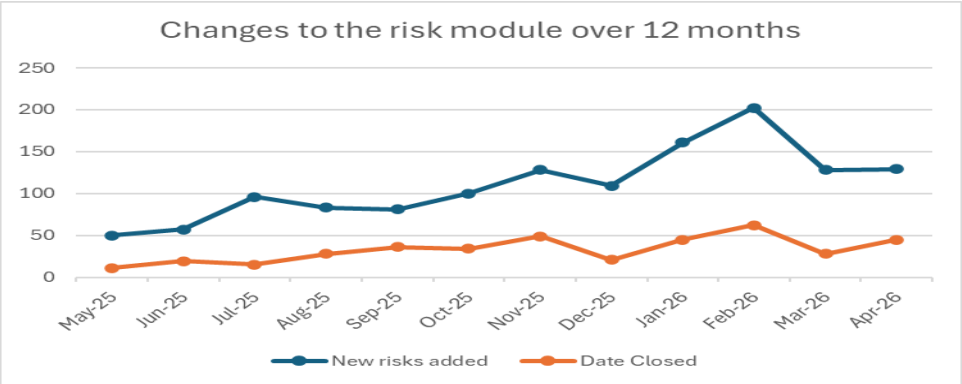
3. Corporate Risk Register (CRR)

3.1. The summary of the CRR has been provided as Appendix 2 to this report, for review and discussion. Note a detailed report extracted from the Ulysses Risk Register module has been provided to the Board in the reading room for information.

Dynamic Risk Register

3.2. There are a range of indicators that demonstrate our risk management processes across the trust are dynamic. This includes the following:

- The risk KPI's that are monitored by Risk Committee and reported to Integrated Assurance Committee (IAC).
- The Audit Committee were provided with a full summary of all changes to the CRR discussed and agreed by the Risk Committee in March.
- The changes to risks over time, summarised by the chart below.



3.3. The Corporate Risk Register summary provided as Appendix 3 also provides a summary of the changes to the corporate risk register during 2025/26. The Risk Committee this month was provided with a draft Annual Report that provided additional information on activities over the past year. In addition, the forward programme for the Risk Committee sets out a series of reviews to focus on ensuring key aspects of the corporate risk register and is kept under review and remains subject to dynamic challenge.

Risk Appetite

3.4. The Trust's Risk Appetite Framework guide (included in the reading room) was developed following a Board seminar session in 24/25, at that point the Board Risk Appetite statement was reviewed and approved by the Board.

3.5. A copy of the latest version of the Board Risk Appetite statement is included as Appendix 4 for review and approval. No changes have been made to this since the last time the Board formally approved the statement.

Emerging Risks

3.6. As part of the conversation at IAC in April several potential emerging risks were highlighted. To provide assurance the subjects raised at IAC have been summarised and cross referenced to current risks / actions in place.

Subject	Comment
BRC renewal	Linked to CRR reference 1150 CMO has oversight of this risk
Well-led preparedness	Linked to organisational culture CRR reference 2163 CPO has oversight. Well-led project is in place with updates reported to Delivery Committee.
Cyber security	Related risks currently recorded at corporate services level CIDO has oversight
Risks to the achievement of the plan	Reflected in CRR references 1133,1135,1136,2445 (operational performance risks COO has oversight, also reflected in CRR ref 1157 finance CFO has oversight
Potential risk of Industrial Action on service delivery	Currently recorded at corporate services level reference 1707 (score 8) COO has oversight

4. Recommendations

4.1. The Board is asked to:

- review the updated BAF and CRR, and
- re-approve the Board Risk Appetite Statement.

BAF Dashboard

This provides an at-a-glance view of BAF risk exposure, current reviewed assurance rating and highlighting risks outside appetite and tolerance.

Ref.	Strategic Risk	Current Aggregated Assurance Rating	Current Risk Score	In / Out of Risk Appetite	In / Out of Risk Tolerance
SR1.1	Staff may not want to come, not want to stay, (recruitment and retention)	Adequate (1.8)	9	✓	✓
SR1.2	Staff may not want to engage	Adequate (1.8)	12	✗	✓
SR2	Our culture of continuous improvement may not become embedded to deliver sustainable impacts on patient care, ensure highest levels of patient safety, effective outcomes and experience of both patients and our staff	Adequate (2)	9	✗	✓
SR3.1	We may not operate optimally and may not be able to deliver performance standards sustainably, patient care will suffer, and we may face regulatory enforcement	Adequate (2.25)	20	✗	✗
SR3.2	We may not operate effectively, and our finances may become unsustainable over the short and longer term	Adequate (1.6)	16	✗	✗
SR4	We may not deliver effective patient care, efficiency, and data security/ data stewardship	Adequate (1.7)	12	✗	✓
SR5	If we fail to plan, deliver and maintain our estates infrastructure then we will be unable to meet regulatory standards and be unable to maintain safe infrastructure to support patient care and staff wellbeing.	Adequate (2)	16	✗	✗
SR6	We may not be able to deliver reductions in health inequalities and the anticipated benefits of anchor institution	Not rated	9	✓	✓

Note overall assurance rating is current average of Level three reports – where a clear overall rating was provided, work is ongoing to further develop the aggregation of assurance ratings

Key
- Amber risk score = 9–12
- Red risk score = 16–20
- In appetite / tolerance
- Out of appetite / tolerance

Strategic Risk	Risk score				Rational for change in risk score / commentary	Changes to controls since Jan 26	Changes to assurance since Jan 26
	Previous Q2	Previous Q3	Current Mar26 Q4	Target			
Strategic Objective: To make OUH a **great place to work**; one that **promotes equality, diversity and inclusion**, **encourages talent and development**, and **enables freedom to speak up** without fear of futility or detriment.							
SR1: Staff may not want to come, not want to stay, (recruitment and retention)	C4 x L3 = 12	C3 x L3 = 9	C3 x L3 = 9	C2 x L2= 4	↔: No change	Improved as assurance rating mapping exercise has informed potential gaps and additional controls and assurance noted	
Strategic Risk 1.2: Staff may not want to engage	New	C4 x L3 = 12	C4 x L3 = 12	C2 x L2= 4	↔: No change		
Strategic Objective: To create a **culture of continuous improvement** in all that we do.							
SR2: Our culture of continuous improvement may not become embedded to deliver sustainable impacts on patient care, ensure highest levels of patient safety, effective outcomes and experience of both patients and our staff	C3 x L3 = 9	C3 x L3 = 9	C3 x L3 = 9	C3 x L1= 3	↔: No change		
Strategic Objective: To consistently achieve all operational **performance standards and financial sustainability**.							
SR 3.1: We may not operate optimally, and may not be able to deliver performance standards sustainably, patient care will suffer, and we may face regulatory enforcement	C5 x L4= 20	C5 x L4 = 20	C5 x L4 = 20	C3 x L3= 9	↔: No change		
SR 3.2: We may not operate effectively, and our finances may become unsustainable over the short and longer term	C4 x L4 = 16	C4 x L4 = 16	C4 x L4 = 16	C4 x L3= 12	↔: No change		
Strategic Objective: To make effective use of our **digital capability** to **enhance patient care** and staff **efficiency, and productivity**							
SR 4: We may not deliver effective patient care, efficiency, and data security/ data stewardship	C4 x L3= 12	C5 x L4 = 20	C5 x L4 = 20	C4 x L1= 4	↔: No change		
Strategic Objective: To have an **estate that meets the highest levels of regulatory compliance** and enhances our offer for patient care and staff wellbeing by adopting novel ideas and methods that **embrace the sustainability goals**.							
SR 5: If we fail to plan, deliver and maintain our estates infrastructure then we will be unable to meet regulatory standards and be unable to maintain safe infrastructure to support patient care and staff wellbeing.	C4 x L3= 12	C4 x L4= 16	C4 x L4= 16	C4 x L2= 8	↔: No change		
To work in **partnership** at Place and System level for the benefit of our patients and populations with effective collaboration to **reduce health inequalities** and fulfil our role as an **anchor institution**.							
SR 6: We may not be able to deliver reductions in health inequalities and the anticipated benefits of anchor institution	C3 x L3 = 9	C3 x L3 = 9	C3 x L3 = 9	C3 x L2= 6	↔: No change		

BAF showing External Review Coverage (Key: Blue= Internal Audit, Other Review body)

	24/25	25/26	26/27	27/28
To make OUH a **great place to work**; one that **promotes equality, diversity and inclusion**, **encourages talent and development**, and **enables freedom to speak up** without fear of futility or detriment.				
SR1: Staff may not want to come, not want to stay, and not want to engage	• Temporary Staffing Reduction Programme • EDI Maturity (Advisory) • Bullying & Harassment • Establishment Controls	• ISO45001 H&S / Well-being	• Retention	• Sickness Absence Management • Temporary Staffing
To create a **culture of continuous improvement** in all that we do.				
SR2: Our culture of continuous improvement may not become embedded to deliver sustainable impacts on patient care, ensure highest levels of patient safety, effective outcomes and experience of both patients and our staff	• CQC Well Led Preparation (Advisory) • PSIRF • Accreditation program	• Waiting List Management • Directorate Risk Management • Accreditation program	• Complaints • MHA/MCA Administration • Accreditation program	• Accreditation program
To consistently achieve all operational **performance standards and financial sustainability**.				
SR 3.1: We may not operate optimally and may not be able to deliver performance standards sustainably, patient care will suffer, and we may face regulatory enforcement		• E-Rostering	• Discharge Planning • Medical Workforce Productivity Review	• NICE Guidelines • Divisional Governance
SR 3.2: We may not operate effectively, and our finances may become unsustainable over the short and longer term	• Overpayments • Cash Management (Advisory) • Finance Month-End Closedown Procedures • Compliant Direct Awards	• Key Financial Systems – Accounts Payable & Receivable • Divisional Finance Controls • Stock Management	• Forecasting • Budgeting • Procurement • Medical Variable Pay	• Capital Programme • Business Case Benefits Realisation
To make effective use of our **digital capability** to **enhance patient care** and staff **efficiency, and productivity**				
SR 4: We may not deliver effective patient care, efficiency, and data security/ data stewardship	• Cyber Security • DSP Toolkit • Data Quality – UEC Datasets	• DSP Toolkit • IT Asset Management • Medical Device Management • Data Quality – DM01 • ISO27001 SDE	• DSP Toolkit	• DSP Toolkit • Cyber Security • Freedom of Information

	24/25	25/26	26/27	27/28
To have an **estate that meets the highest levels of regulatory compliance** and enhances our offer for patient care and staff wellbeing by adopting novel ideas and methods that **embrace the sustainability goals**.				
SR 5: If we fail to plan, deliver and maintain our estates infrastructure then we will be unable to meet regulatory standards and be unable to maintain safe infrastructure to support patient care and staff wellbeing.	• Waste Management • Environment Agency Review	• ISO45001 H&S • Environment Agency Review • Fire Safety Audit • External Review of ICU estates	• Data Quality – ERIC	• Estates Compliance
To work in **partnership** at Place and System level for the benefit of our patients and populations with effective collaboration to **reduce health inequalities** and fulfil our role as an **anchor institution**.				
SR 6: We may not be able to deliver reductions in health inequalities and the anticipated benefits of anchor institution	• Research & Development (Advisory)	• BRC Mid-term Review		

Strategic Objective	To make OUH a **great place to work**; one that **promotes equality, diversity** and **inclusion**, **encourages talent and development**, and **enables freedom to speak up** without fear of futility or detriment.
Strategic Risk 1.1	Staff may not want to come and, not want to stay (recruitment and retention)
Strategic Risk 1.2	Staff may not want to engage or be able to develop

Cause	Risk	Effect
As a result of: • *our staff not having a sense of belonging and fulfilment* • *external factors of cost of living, congestion charge* • *failure to recruit and retain key staff* • *Lack of training and development opportunities*	*…there is a risk that staff may not want to come, not want to stay*	*Which could result in…* • *Potential loss of high-quality staff,* • *Lack of support for each other /lack of sense of belonging / not meeting the expectations of our people* • *Higher financial costs* • *Lack of consistency of care / reduction in quality of care/ Potential harm to patients, staff, and reputation* • *Lack of discretionary effort Reduced productivity* • *Reliance on temporary staffing* • *Restricted succession planning / career development*
• *Lack of training and development opportunities* • *Not feeling able to speak up, due to poor inclusive safety culture (inc psychological safety)* • *IT elements (from feedback from listening events)*	*…there is a risk that staff may not want to engage or be able to develop*	• *We may not get the most out of our people* • *Poor staff moral / well-being / staff experience / poor employee relations* • *Bullying and harassment* • *Staff sickness (potential for increased anxiety etc)* • *Potential mistrust, presenteeism*

Risk Score		Consequence	Likelihood	Score
Current risk score (1.1)		3	3	9
Target risk score (1.1)		2	2	4
Current risk score (1.2)		3	4	12
Target risk score (1.2)		2	2	4
Risk Lead	Chief People Officer	**Risk Appetite Domain**		People / Patient
		Risk Appetite Level		Cautious / Avoid

Controls (note cover both risks)	Assurance on controls reported to Board and Committees
• People Plan 2025-28 and supporting annual priorities (P&C) – L2 • Well-being check-ins • Bullying and harassment eradication plan (L3) Adequate • Active Bystander training (PPR) – L1 • Clear core training policy and appraisal policies, monitored via workforce metrics (to inc. EDI Training) (PPR) L1 • Sexual safety charter (L1)	**First line of defence:** • Chief People Officer's Update Reports to TME, IAC and Board, specific reports on Temporary Staffing and Pay Panel results, • People Performance report (PPR) • Sexual Safety Assurance Framework (TME November) • WRES/ DES report (IAC August 2025) • FTSU 6 monthly reports to TME and Board

Controls (note cover both risks)	Assurance on controls reported to Board and Committees
• Employee relations meetings (covered via SLA) and addressing of medical concerns. (L1) • International Educated nursing (IEN) action implementation (to inc. IEN development) • Well supported staff networks to assist with the delivery of EDI Peer Review Programme. • FTSU speak up culture and plans (L1) • Leadership Development Programme TNA for all staff (link to nursing) (New director of non-medical education link to new controls re this aspect) (P&C) – L2 • Growing Stronger Together Plan with metrics and related actions (DPR) – L2 • Plan for learning from staff survey and implementation of related actions (L1) • Service specific development programmes in place (DPR) – L2 • Workforce Reduction Plan, Workforce establishment programme, vacancy control process (L3) Adequate **Governance Structure:** • HR Governance to review all KPIs (Chair CPO, Frequency: Monthly) • People and Communications Committee (Chair CPO, Frequency: Bi-monthly) • Health and Safety Committee (Chair CNO, Frequency Bi-monthly) • Productivity Committee (Chair: CEO, Frequency: Monthly) • TME (Chair: CEO, Frequency: Two weekly) • Integrated Assurance Committee (Chair: Trust Chair, Frequency: Bi-monthly)	• Staff survey report to TME and Board • Employee relations report to private Board **Second line of defence:** • Divisional Performance Review meetings (DPR) • Guardian of Safe Working Hours Reports • People and Communications Committee Reports to TME (P&C) **Third line of defence:** • Internal Audit Report (24/25): Temporary Staffing Reduction Programme (Design: Moderate, Effectiveness: Moderate) (Adequate) • Internal Audit Report (24/25): EDI Maturity (Adequate) • Internal Audit Report (24/25): Bullying and Harassment (design: Moderate, operation: Moderate) (Adequate) **Other External Reports** • ISO45001 Occupational Health and Safety Management system review (Adequate) • Staff survey results (Limited)
Gaps in controls and assurance	**Actions to address gaps**
• Mapping identified potential gap in reporting of well-being check-ins, assessment of impact of staff networks and if there is a need to review IEN implementation in the light of visa changes. • Staff survey actions linked to people plan	•
Strategic Risk Owner Commentary (note to be completed by the Chief People Officer)	
Under development	

ID	Score	Summary corporate risk description / link to corporate risk register
1616	16(high)	There is a risk that sickness absence levels continue above the KPI that might impact patient care, leading to excessive workloads potential H&S issues including work related stress
2443	12 (medium)	Risk to implementation of staff Sexual Safety Charter, that might impact staff wellbeing
2163	12(medium)	Culture - There is a risk for leaders and managers not being able to participate in our central programmes to support a culture whereby everyone feels included and valued as part of #OneTeamOneOUH due to operational pressures and bandwidth resulting in leaders do not have the skills and confidence to tackle bullying and harassment (impacting on staff well-being).
3324	16(high)	Due to local interest groups and other external factors there is a risk to staff morale and well-being leading to increased sickness, absences and poor staff engagement and low staff confidence.

Strategic Objective	To ensure high quality clinical services and create a **culture of continuous improvement** in all that we do.
Strategic Risk 2	Our culture of continuous improvement may not become embedded to deliver sustainable impacts on patient care to ensure highest levels of patient safety, effective outcomes and experience of both patients and our staff

Cause	Risk	Effect
As a result of: • *high clinical / staff workloads, a tired workforce* • *strong reliance on discretionary effort to deliver quality improvement training and initiatives,* • *failure to educate and empower staff in QI.* • *a fear of change / low risk appetite, /lack of leadership capacity QI* • *Inability to effect change (capability and capacity)* • *Not able to embed this across all staff groups and all services, corporate and clinical functions.* • *Ability to actively engage with research activity/Ability to drive patient engagement.* • *Changing internal / external agendas/ Ability to invest in QI resources for improvement / Insufficient resources in continuous improvement*	*…there is a risk that high quality care and a culture of continuous improvement may not become embedded, hindering the adoption of improvements and best practice, leading to patient harm and leaving staff disempowered with low morale*	*… which could result in…* • *poor patient outcomes – more harm* • *poor quality, efficiency, productivity, waste and poor financial performance placing increased pressure on services and staff that might lower engagement and morale.* • *Service improvement opportunities not taken forward / less novel emerging therapies/ lower ability to deliver new treatment options* • *Unsustainability of continuous improvements* • *Impact on staff motivation and retention / staff may not feel empowered to make improvements* • *Impact on reputation*

Risk Score		**Consequence**	**Likelihood**	**Score**
Current risk score		3	2	6
Target risk score		3	1	3
Risk Lead	Chief Medical Officer Chief Nursing Officer Chief Operating Officer	**Risk Appetite Domain**	Patient / People / Change	
		Risk Appetite Level	Avoid / Cautious / Seek	

Controls	Assurance on controls reported to Board and Committees
• Quality improvement initiatives (IQI) L1 • Focus on key areas e.g. fracture NoF pathway at JR (L1) • Oversight of Trust Quality priorities (L1) • Maintenance of Clinical Audit Programme (L1) • Integrated Quality Improvement Programme (to TME) (IQI) L1 • QI Education Programme, including of delivery (IQI) L1 • Ulysses Assurance module (via CGC reports) L1 • QI continuous improvement methodology and support (IQI) L1 • PSIRF framework for learning from incidents including key patient safety themes (LFD – L1, DPR L2)	**First line of defence:** • Key quality and outcome metrics in Integrated Performance Report • PSIRF and Learning from deaths reports (LFD) to IAC and Board • IPC Annual Report • Maternity Incentive Scheme Annual Review (Substantial) • Public Engagement, Patient Experience and Complaints Annual Report • Quality priority reporting (QP) • Clinical Audit Plan paper to Audit Committee and Clinical Audit Programme update to IAC • Integrated Quality Improvement Programme update to TME (IQI) • Patients on Outlier Wards (IAC Feb 25)

Controls	Assurance on controls reported to Board and Committees
• Feedback mechanisms from patients (L3) Adequate • Patient experience team (L2) • Series of development programmes in place aimed at further reducing moderate and major harms and mortality rates, for example falls and pressure ulcer reduction (IQI, QP) L1 • Standardised quality reports (to divisions and CGC) (L2) • External Reviews Policy (update and reported to IAC June 2025) (L1) **Governance Structure:** • Clinical Improvement Committee (CIC) (Chair: DCMO, Frequency: Monthly) • Clinical Governance Committee (CGC) (Chair: CMO/CNO, Frequency: Monthly) • TME (Chair: CEO, Frequency: Two weekly) • Integrated Assurance Committee (Chair: Trust Chair, Frequency: Bi-monthly) • Inpatient Survey Delivery Group (Chair CNO) • Focussed Quality Programmes, e.g. Ophthalmology Quality Group (Chair: CMO, Frequency: monthly), Fragility Fracture Improvement Group (Chair: Divisional Director, monthly)) • Patient Experience & Engagement Committee	• 7 Day Services Review (IAC June 25) • Annual accreditation and regulation report (AC Feb 26) **Second line of defence:** • Divisional Performance Review meetings (DPR) • Delivery Committee monitoring • CGC reports to TME • Safeguarding Annual Report • Guardian of Safe Working Hours Report • Annual Clinical Effectiveness Report • Patient Experience Annual Report **Third line of defence:** **Internal Audit Reports** • GIRFT (23/24 design: moderate, operation: moderate) Adequate • Medicines Security (23/24 design: moderate, operation: moderate) Adequate • CQC Well-led (24/25 Advisory) (not rated) • PSIRF Review (24/25 design: substantial, operation: moderate) Adequate **Other external reports** • Standardised Hospital Mortality Indicator (SHMI) • Hospital Standardised Mortality Ratio (HSMR) • GIRFT and other external clinical audit/review reports – reported via CIC • CQC reports (note Maternity and Neonatal services due) • Hip Fracture database report • CQC inpatient survey (November Board) Adequate • Children and Young People's Patient Experience Survey 2024: CQC Benchmark report (Adequate) • CQC Maternity inpatient survey (Adequate) • MBBRACE summary Report to Board (Adequate) • PLACE survey
Gaps in controls and assurance	**Actions to address gaps**
• Depth of QI knowledge across the Trust	• Explore the potential for a digital solution to align audit data to automate data collection and enable audit • Delivery of planned service developments, in accordance with annual planning • Review and strengthen/streamline clinical governance structures and reporting • Local action to follow-up completion of PSIRF actions
Strategic Risk Owner Commentary (note completed by the Chief Nursing Officer and Chief Medical Officer)	
Progress has been made in defining and delivering Quality Priorities of most importance to our patients and Quality Improvement (QI) training has been rolled out to more than 2000 staff. Focussed QI support is supporting improvement work in key areas including urgent & emergency care, cancer, standard work, and ophthalmology.	

Controls	Assurance on controls reported to Board and Committees
The new Patient Safety Incident Response Framework (PSIRF) was launched in October 2023 and is now well embedded. Work is ongoing to develop and roll out metrics to monitor and continually improve the key pillars of PSIRF. Incident reporting does not identify any increase in patient safety risks requiring escalation currently, with gradual reductions in key safety metrics including pressure ulcers and falls. However there has been an increase Never Events in 2026/27, key themes from which are being addressed. The SHMI and HSMR remain below national benchmarks. The Clinical Audit Programme and External Clinical Reviews continue to be overseen by the Clinical Improvement Committee, Clinical Governance Committee, and the Integrated Assurance Committee (IAC). Action Plans are developed to address all recommendations and clinical audits providing limited levels of assurance are escalated to TME and IAC, with targeted deep dives at IAC as appropriate. A new Patient Experience & Engagement Committee has been established, and a Trust Patient Engagement Plan has been drafted. Nine Patient Safety Partners have been recruited to ensure service user input into patient safety improvement work. Supported by development and delivery of clear action plans to improve patient experience, including a Quality Priority around Maternity Experience, results from the PLACE Survey and CQC maternity patient experience survey have improved and both the volume and content of maternity patient feedback has significantly improved.	

ID	Score	Summary risk description
3	20 (high)	Vulnerability of the Bedford computer system (CSSD 1415-09)
2944	12	Due to the current control environment, there is a risk around the potential for increase in avoidable harm and poor patient experience due to falls, pressure ulcers, violence and aggression
2945	12	Due to resourcing capacity, there is a potential risk on the poor turnaround in complaints response rates leading to poor morale and adverse publicity
2888	12	Due to reductions in staffing and our inability to increase resources there is a risk to the delivery of new treatments (e.g. approved NICE TAs) that may mean the provision, quality or safety of services is affected.
3088	16	Due to local interest group views, there is a risk that we are perceived by members of the public and our patients as providing unsafe care and that we fail to listen, learn and respond compassionately to our patients leading to increases in complaints and regulatory scrutiny.
70	16	Sustained increase in emergency surgical demand, combined with limited capacity and discharge delays, may result in inability to deliver timely, safe surgical care and compromise patient outcomes (SWON)

Strategic objective	To consistently **achieve all operational performance standards** and **financial sustainability.**
Strategic Risk 3.1	We may not operate optimally and may not be able to deliver planned performance standards sustainably, patient care may suffer and we may face increased regulatory enforcement. (note operational performance standard element)

Cause	Risk	Effect
As a result of… • *ICS effectiveness / ICB boundaries* • *Wider landscape changes (ICS reorganisations)* • *Ageing population with multiple co-morbidities* • *Industrial action* • *Changes to Specialist commissioning* • *Expectations linked to the National Plan* • *Availability of workforce / loss of experience staff / aging workforce* • *Lack of capital development on aging estate (capital deterioration)* • *Income mismatch with demand (Cancer, UEC, Routine elective)* • *Primary care and Tertiary demand* • *Potential industrial action*	*…there is a risk that we may not operate optimally, and may not be able to deliver* ***sustainable performance to plan***	*… which could result in…* • *Poor access times / longer waits for patients leading to harm and poor experience* • *Ability to invest in capital developments to enable OUH to plan over time,* • *Not having the right people of the right quality / different capacity (human and physical)* • *Inability to deliver Cancer, DMO1, RTT and UEC standards* • *productivity decreasing* • *Staff morale decreasing*

Risk Score		Consequence	Likelihood	Score
Current risk score		5	4	20
Target risk score		3	3	9
Risk Lead	Chief Operating Officer	**Risk Appetite Domain**	Service Delivery	
		Risk Appetite Level	Cautious	

Controls	Assurance on controls reported to Board and Committees
• Agreed Activity plan with divisional signoff (L1) • Planning / staff briefings on strike action (L1) • Performance management framework (PAF) - Established planned KPIs and dashboards in accordance with three-year plan. (L2) • GIRFT Action Plan (L2 - via CGC and Div Performance Reviews) • Improvement Programmes covering: elective care, outpatients, cancer, theatres, diagnostics and urgent care. (L2) • NPAF published segmentation (L2) • Cross divisional theatre capacity work (L2 - via IQI report) • Winter Planning processes (L1) • Outpatient transformation programme (L1)	**First line of defence:** • IPR report to TME, IAC, & Board • Winter Plan Lessons Learned (Delivery Committee March 26) (Board Sept 26 – for 26/27) • Surgical Elective Centre (SEC) Updates (Investment Committee) **Second line of defence:** • Divisional performance management monthly and quarterly reviews (reported) • Integrated Quality Improvement (IQI) Programme updates to Delivery Committee and TME • Delivery Committee, Productivity Committee oversight • Investment Committee reports to Board • Annual Reports: EoL, Infection Control, Learning from Deaths • Productivity review of major programmes

Controls	Assurance on controls reported to Board and Committees
• Business continuity plans **Governance Structure:** • Check and Challenge • Productivity Committee • Elective Delivery Group • Cancer Strategy Group • Outpatient Improvement Group • Theatre Improvement Group • Urgent Emergency Care Delivery Group • TME • NOF Oversight meetings • Acute Provider Collaborative	• Provider Capability Self-assessment to Board **Third line of defence:** **Internal Audit reports:** • Performance Framework (23/24 design: significant, operation: moderate)- lead CDPO (Adequate) • Outpatient Management (23/24 advisory review) lead- COO (not rated) • Data Quality - UEC Data Sets (24/25 design: Substantial, operation; Substantial) (Substantial) • Waiting list management (25/26 design: Substantial, operation; Moderate)- Lead COO (Adequate) • Data Quality – DM01 (25/25 design: Moderate, effectiveness: Moderate) (Adequate) • Discharge Audit – Planned 26/27 (Q2)
Gaps in controls and assurance	**Actions to address gaps**
Medi-rota Rota cover Elective operating capacity to enable delivery to plan	• Delivery of planned service developments, in accordance with three-year plan and four-year capital plan. • Deliver planned measures to meet NHSE operational requirements in accordance with actions in the three-year plan. • UEC Level 1 reconfiguration – Programme Board oversight • SEC development – Programme Board oversight
Strategic Risk Owner Commentary (note to be completed by the Chief Operating Officer)	
Under development	

ID	Score	Summary risk description
1133	12 (medium)	Ability to improve ED waiting times potential risk to operational performance impacting on patient experience and outcomes
1135	16 (high)	Bed capacity, staffing and funding/ support poses a risk to meeting the elective care delivery plan that might affect patient outcomes and experience
1136	16 (high)	Due to issues with diagnostic capacity, there is a risk to our ability to reduce the current backlog of patients waiting for elective care and cancer diagnosis and treatment this might affect patients in terms of harm or poor outcomes
2445	12(medium)	Ability to meet delivery plan trajectories for the achievement of Cancer targets that might impact on patient
3087	12(medium)	Due to internal and external resourcing challenges and patient demand there is a risk that the trust might not deliver the Winter Plan leading to increased operational pressures and impact on operational performance targets (systems risk). (de-escalated)
31	16 (high)	Due to challenges in the community, there is a risk of deconditioning of patients and increased length of stay due to delays in discharge. (MRC)

Strategic objective	To consistently **achieve all operational performance standards** and **financial sustainability.**
Strategic Risk 3.2	We may not operate effectively, and our finances may become unsustainable over the short and longer term (Financial performance element)

Cause	Risk	Effect
As a result of… • *ICS effectiveness ICB boundaries* • *Wider landscape changes in-year/ short termism in NHS* • *Unsustainable financial model* • *Approach to NHS capital budget* • *Specialist commissioning landscape changes* • *National planning guidance* • *Lack of grip/ Poor control of pay and non-pay budgets* • *Lack of delivery of productivity goals*	*…there is a risk that we may not effectively manage our **finances so that it may become unsustainable** over the short and longer term*	*… which could result in…* • *Lack of ability to fund the capacity required to achieve operational performance standards* • *Lack of ability to fund emerging therapies/ new treatment options* • *A reduction in the quality of care delivered to patients* • *Poor staff morale and a reduction in our ability to invest in improvements for staff wellbeing* • *An inability to plan over time and deliver new investments.* • *Additional oversight from ICB, regional and national team – system oversight process* • *Increased pressure on cash potentially leading to delayed payments to suppliers*

Risk Score		Consequence	Likelihood	Score
Current risk score		4	4	16
Target risk score		4	3	12
Risk Lead	Chief Finance Officer	**Risk Appetite Domain**	Finance	
		Risk Appetite Level	Avoid	

Controls	Assurance on controls reported to Board and Committees
• Process for annual planning, budgeting and forecasting (L3) • Establishment control policy (L3) • Monthly and quarterly performance cycles for divisional and corporate financial performance (L2) • Additional controls applied to services that are missing their budgets (L2) • Cost Improvement Plans overseen by Productivity Committee and divisional CIP Boards and including cross-cutting programmes such as the stock management system (L2) • Programme Management Office (L2) • Capital project benefit realisation reviews (L2) • Finance Training programmes for non-finance staff (e.g. budget manager training and finance modules of LDP, ELP and MLP) (L1) • SFIs and Scheme of Delegated Authorities (L1) **Governance Structure:**	**First line of defence:** • Chief Finance Officer's Update Reports to TME, Audit Committee, IAC, Investment Committee and Board (e.g. Costing Assurance Audit) • Finance Forecast • Going Concern Assessment • Assurance of Coding and counting clinical activity **Second line of defence:** • Divisional Performance Review meetings – Reports to: TME • Productivity review of major programmes – Reports to: Productivity Committee **Third line of defence:** **Internal Audit reports:** • Cash Management (24/25) Advisory – lead CFO (not rated) • Salary Overpayments (24/25: design: Moderate, operation: Limited) – lead CFO / CPO (Limited)

Controls	Assurance on controls reported to Board and Committees
• Productivity Committee (Chair: CEO Frequency: Fortnightly) • Delivery Committee (Chair: CEO Frequency: Monthly) • TME (Chair: CEO Frequency: Monthly) • Investment Committee (Chair: CEO Frequency: Monthly) • Integrated Assurance Committee (Chair: CEO Frequency: Monthly) • NED Finance Briefing (Chair: Audit Chair Frequency: Monthly)	• Month End Closedown procedures (24/25 design: Moderate, operation Moderate) – lead CFO (Adequate) • Compliant Direct Awards (24/25: design: Moderate, operation: Moderate) – lead CFO (Adequate) • Establishment Controls (24/25: design: Moderate, operation: Limited) – lead CPO (Limited) • Divisional Financial Controls (25/26: design: Moderate, operation: Limited) – Lead CFO (Limited) • Stock Control (25/26 design: Moderate, operation: Limited) – Lead CFO (Limited) • E-Rostering (25/26 design: Substantial, effectiveness; Moderate) (Adequate) • HIAO to Audit Committee (Adequate) • External Audit Reports to Audit Committee including annul opinion on VFM (Adequate) • LCFS Report to Audit Committee (Adequate)
Gaps in controls and assurance	**Actions to address gaps**
• Assurance on stock management /non-pay will remain limited until the completion of the programme of activity including Atticus rollout and kitting & carting roll out. • Assurance on divisional financial control will remain limited until the completion of the restructure of divisional finance teams (Q3 26/27)	Manage the Trust's finance's sustainably delivering our share of the system financial target while providing sufficient resources to deliver safe and timely care in line with national standards and agreed parameters set out for the three-year plan. PMO toolkit and guidance
Strategic Risk Owner Commentary (note completed by the Chief Finance Officer)	
• The Trust's underlying deficit for 2025/26 was estimated at £70m / 4.1% of turnover during planning for 2026/27. • Our overall productivity remains 3.5% below pre-pandemic levels (Jan 2026 data) and our costs per WAU are 1% below the national average. • Our workforce productivity is now estimated by NHSE to be 1.3% better than pre-pandemic, with higher non-pay costs driving our overall reduction in productivity. • The drivers of our deficit are therefore likely to be our decline in productivity since 2019/20 and an element of being underpaid. We are pulling together an additional programme of work on non-pay costs, we should consider a more in-depth analysis of the drivers of our deficit.	

ID	Score	Summary corporate risk description
1119	20 (high)	Long term financial sustainability.
1153	20 (high)	Failure to effectively manage-delivery of workforce, activity and CIP plans (to planning assumptions)-resulting in overspends against budget and inability to achieve financial targets
1157	16 (high)	Failure to deliver in year Financial Plan (Cash Impact): Decreasing liquidity ratio leads to: Increased regulatory reporting and potential delays in paying suppliers (Note escalated to CRR by Risk Committee in July) Score increased in Q1 25/26

Strategic Objective	To make effective use of our **digital capability** to **enhance patient care** and staff **efficiency,** and **productivity**
Strategic Risk 4	We may not deliver effective patient care, efficiency, and data security/ data stewardship

Cause	Risk	Effect
As a result of… • *Inadequate digital integration or cyber security measures…* • *Digital capability to support trust staff to do the job (resource and finance)* • *Inadequate resourcing of digital function/ Real time data capture and availability /Training and ability of staff to use systems* • *Lack of prioritisation on digital agenda/ System wide integration of IT systems across the ICB* • *Engagement with patients on digital innovation* • *infrastructure capacity to cope with digital solutions.*	*…there is a risk to patient care, efficiency, and data security/ data stewardship*	*… which could result in…* • *a failure to align with clinical workflows/integration.* • *Our patients, staff, and public losing trust in us /Potential for poorer quality of care* • *The potential for reputational damage/ Poorer compliance and lack of drive for efficiency* • *Lack of delivery of improvements in operational delivery* • *Systems that are implemented are not user friendly / staff become frustrated with IT provision*

Risk Score		Consequence	Likelihood	Score
Current risk score		4	3	12
Target risk score		4	1	4
Risk Lead	Chief Digital and Partnerships Officer	**Risk Appetite Domain**	Finance / Patient / Change	
		Risk Appetite Level	Minimal / Avoid / Seek	

Controls	Assurance on controls reported to Board and Committees
• Digital Plan (L1) • Digital Strategy (L1) • DSP toolkit assessment and action plan (L3) • Contract management of systems (L1) • Software licences (L2) • SDE oversight (L2) • IT infrastructure programme (hardware and software refresh) **Governance Structure:** • Digital Oversight Committee (DOC) • Cyber Security Task Force	**First line of defence:** • Update Reports to TME and IAC (Frequency: Quarterly) **Second line of defence:** • SDE Maturity Assessment **Third line of defence:** **Internal Audit reports on:** • DSP Toolkit (24/25 design: substantial, operation: moderate) (adequate) - Lead CDO (note 25/26 advisory) (not rated) • Outpatient Management (23/24 advisory review) – lead COO (not rated) • SDE Cyber Security (24/25 design: Moderate, operation: Moderate) – lead CDO (Adequate) • IT Asset Management (25/26 design: Limited, operation: Moderate) – Lead CDO (Limited) • Medical Device Management (25/26 Design: Moderate, Effectiveness: Moderate) (Adequate)
Gaps in controls and assurance	**Actions to address gaps**
• From cyber security review: some unsupported systems	• Continue programme of upgrade of systems.

Controls	Assurance on controls reported to Board and Committees
• From IT disaster Recovery: Plans to be tested and training to handle major incident	• DOC work with stakeholder on delivery / risk assessment • Maximise use of automation in Pharmacy for efficiency gains, in line with the three-year plan • Digital transformation – e-form rollout, Patient Engagement Portal refresh, Ambient Voice Technology and EPR optimisation

Strategic Risk Owner Commentary (note to be completed by the Chief Information and Digital Officer)
Under development

ID	Score	Summary corporate risk description
		Note no risks currently escalated to CRR level

Strategic Objective	To have an **estate that meets the highest levels of regulatory compliance** and enhances our offer for patient care and staff wellbeing by adopting novel ideas and methods that **embrace the sustainability goals**.
Strategic Risk 5	If we fail to plan, deliver and maintain our estates infrastructure then we will be unable to meet regulatory standards and be unable to maintain safe infrastructure to support patient care and staff wellbeing.

Cause	Risk	Effect
As a result of… • *The NHS financial regime* • *If the trust does not develop and enhance clinical demand and capacity plans to identify a medium/ long-term site development control plan and strategy with identified funding* • *If the trust's estates infrastructure and environment is not improved…*	*…there is a risk that we may not be able to plan deliver and maintain estates infrastructure to keep services functioning, meet statutory compliance regulations and provide enhancements / improvements for patient care and staff wellbeing.*	*… which could result in…* • *The trusts' ability to run its services efficiently and effectively in the right place with the right provision at the right time in healthcare facilities that are fit for purpose.* • *Future site development plans may not be fit for purpose* • *Less ability to ascertain NHS capital or alternative financial support for the future development of our sites* • *Infrastructure problems/ Business continuity problems* • *Estate compliance infrastructure / Regulatory Compliance issues* • *Loss of services and productivity* • *Impact on environment for patients and staff/ Poor staff experience and impact on morale and engagement* • *Poor patient care* • *Legal implications and reputational impact*

Risk Score		Consequence	Likelihood	Score
Current risk score		4	4	16
Target risk score		4	2	8
Risk Lead	Chief Estates and Facilities Officer	**Risk Appetite Domain**	Service Delivery/ Regulatory	
		Risk Appetite Level	Cautious / Avoid	

Controls	Assurance on controls reported to Board and Committees
• Capital Programme (L2) • Premises Assurance Model assessment (L2) • Capital Infrastructure Plan (L2) • '6' Facet survey in place (L1) • Backlog maintenance review and targeted programme delivery (link to PAM L2) • PFI management full estates line of site across all estate, PFI and retained estate. (L1) • Transport contract in place (L1) • Continue to improve and deliver net zero savings and reduction in our carbon footprint (L1) • Interim framework strategy (L1)	**First line of defence:** • E & F Management Committee • Divisional Performance Reviews • Estates compliance committee • Capital Programme update report (Investment Committee) **Second line of defence:** • Chief Estates and Facilities Officer Reports to TME and IAC (Capital Schemes Updates, PFI updates, specific business cases reviewed by Business Planning Group (BPG) / project reports / backlog maintenance risk review update / ventilation compliance update) • Business continuity plan (EPRR Annual Report) • Investment Committee Review, IAC, Board • Premises Assurance Model Report IAC

Controls	Assurance on controls reported to Board and Committees
• Travel and Transport Strategy for JR (L2) • UEC level 1 bid submission (L2) • Green Plan (L1) **Governance Structure:** • Business Planning Group • Corporate Estates Compliance Committee • E&F Health and Safety Meeting • Medical Equipment Prioritisation Group • Capital Management Group • Health & Safety Committee • Investment Committee, • IAC, Board • Board seminar sessions • Various Estates safety groups (e.g. Ventilation) • Fire Safety Strategy Group • Fire Safety group (Operational) • Women's Centre Fire Delivery Board • Critical Infrastructure Risk (CIR) delivery board • Sustainability Steering Group	• Health and Safety Annual Report to Board **Third line of defence:** **Internal Audit Reports:** • Environmental Sustainability (23/24 advisory review)- lead CE&FO (not rated) **Other External Reports** • Health and Safety Executive positive responses to reviews • HTM Safety Groups and annual AE reports • Fire AE report to TME (Adequate) • AtkinsRealis Fire Report to TME (Adequate) • EXI report on Critical Infrastructure (not rated) • EXI report on risk (not rated)
Gaps in controls and assurance	**Actions to address gaps**
• Ability to cross reference risks across teams, collective understanding of risk reduction from potential changes to capital programme • Capital staff capacity to handle large volume of capital projects • Operations team capacity and capability to support capital projects and deliver a safe and sustainable estate • Revenue available to support Operational Pay/ Non pay • From PFI contract management review: KPIs, workflow documentation • Estates backlog maintenance may not be funded adequately • Increase in backlog maintenance programme • Fire Audit recommendations highlight gaps in controls • Strategic intent of Travel & Transport strategy across OUH • Travel and Transport strategy for OUH with ensuing staff patient impact • Travel and transport strategy for CH/NOC/HGH • Framework Travel strategy - permanent	• Estates Compliance meeting review of estates related risks across clinical divisions • Continue implementation of estates and facilities business case • Implementation of sustainable Travel and Transport Strategy with clear board direction leading to CH/NOC/HGH travel and transport strategy • Continue to make improvements in the estate environment and the hard and soft FM services • Fire Audit Action Plan to be monitored via Delivery Committee and Fire Safety Strategy Group • ISO 50001 Energy Management certification • Heat Network Efficiency Scheme

Controls	Assurance on controls reported to Board and Committees
Strategic Risk Owner Commentary (note completed by the Chief Estates and Facilities Officer)	
Our portfolio includes buildings of varying age, condition and design, which inevitably present a broad range of risks, including maintenance backlogs, and compliance requirements. We mitigate these risks through the assurance controls detailed in this framework. We further mitigate them by continuing to identify maintenance backlog risks, which are then prioritised in the capital plan. We maintain full line-of-sight across both retained and PFI estate, supported by planned maintenance and/or robust contract management arrangements where required. Sustainability is also embedded within our approach, with continued progress towards net zero and carbon reduction forming a core component of our activities, and with the management of wider enablers such as the emerging Travel and Transport Strategy. Our governance arrangements provide assurance, with dedicated groups such as the Estates Compliance Committee, Capital Management Group, Health & Safety Committee and Investment Committee they ensure risks are regularly reviewed, escalated and acted upon, with reporting through to the Trust Management Executive, Integrated Assurance Committee and Board. While these arrangements are robust, we recognise there are areas requiring continued focus, including estates resources/capacity to deliver an expanding capital programme, address backlog maintenance pressures, and respond to findings from fire safety audits and reviews. We are addressing these gaps through established governance routes, ensuring a continuous cycle of improvement and a strengthening of assurance across the estate. As such, there has been a continued focus on strengthening the control environment across Estates and Facilities, particularly regarding statutory compliance and assurance. Progress has been made in maintaining the delivery of core compliance programmes; however, there remain areas of residual risk related to assurance processes and the timely completion of safety-critical actions. Several actions are in progress to address these, including closer executive oversight of high-risk areas (notably fire safety and water assurance), improved tracking of audit actions, and clearer accountability for delivery. The current risk position, therefore, reflects a controlled but not yet fully optimised position, with further work required to ensure consistent assurance, strengthen data quality, and provide the Board with greater confidence that risks are being proactively identified and managed. Trajectory is expected to improve over the coming quarter as these actions are embedded and evidenced through routine reporting.	

ID	Score	Summary corporate risk description
1124	12 (medium)	Insufficient capital funding / inability to spend current capital to cover all major capital schemes means that there is a risk that certain services are delivered in poorer estate for a longer period this may affect service delivery
1125	12 (medium)	Significant backlog maintenance program means there is a risk that certain areas of the estate may be more likely to breakdown this might lead to poor estates compliance and potential system failures impacting on operational performance, staff and patient / public safety
1138	9 (medium)	Due to the capacity of the estates team and the scale of the major capital projects there is a risk of potential impacts on service delivery that might affect patient care and a risk to delivery of the capital programme

Strategic objective	To work in **partnership** at Place and System level for the benefit of our patients and populations with effective collaboration to **reduce health inequalities** and fulfil our role as an **anchor institution**.
Strategic Risk 6	*We may not be able to deliver reductions in health inequalities and the anticipated benefits of anchor institution*

Cause	Risk	Effect
As a result of: • *Our ability to participate in ICS.* • *ICS effectiveness / failure of ICS policy framework* • *Wider landscape changes in-year/ short termism in NHS* • *Inability to collaborate* • *Difficulty in maintaining relationships with university partners*	*There is a risk that we may not be able to deliver reductions in health inequalities and the anticipated benefits of anchor institution.* *There is a risk of not delivering education, research and innovation outcomes for the benefit of our patients* *There is a risk if research trial set up and delivery performance metrics are not good enough that we lose NIHR and commercial funding for R&D with an impact on research opportunities and impact and the benefits this provides for our patients.*	*… which could result in:* • *Less novel emerging therapies/ lower ability to deliver new treatment options.* • *Not having the right people of the right quality / different capacity (human and physical)* • *Lack of consistency of care / reduction in quality of care* • *Potential harm to patients, staff, and reputation*

Risk Score		Consequence	Likelihood	Score
Current risk score		3	3	9
Target risk score		3	2	6
Risk Lead	Chief Operating Officer Chief Medical Officer (R&D)	**Risk Appetite Domain**	Patient / People	
		Risk Appetite Level	Avoid / Cautious	

Controls	Assurance on controls reported to Board and Committees
• ICS governance map (to date) (L1) • MoU for Acute provider collaborative across Thames Valley ICB (TVICB) (L1) • Research governance framework and committee signed off (TME August 25) (L1) • Collaboration with Oxford University through Joint Executive Group (and subcommittees) and Strategic Partnership Board (L2) • Research delivery groups in place (L1) • Health inequality dashboards (L1) • Learning Disability Plan (L1) **Governance Structure:** • UEC Delivery Group Elective Delivery Group	**First line of defence:** • Director of Strategy Update Reports to TME • Provider collaborative update reports • Research & Development Update Report (IAC Feb 25) **Second line of defence:** • R&D Performance Report • CRN TV & South Midlands update **Third line of defence:** **Internal Audit Report:** • Research & Development Review (24/25: advisory) (not rated)

• Acute Provider Collaborative Board (Chair, 25/26 Trust Chair, Frequency bi-monthly) • BRC Steering Committee (Chair: CMO, Frequency: monthly/alt months) • R&D Committee (Chair: Director of R&D, Frequency: monthly) • Priority Health inclusion groups	
Gaps in controls and assurance	**Actions to address gaps**
• Study management process by Joint Research Office needs to be understood and improved • Social Impact objectives in procurement	• Review of Joint Research Office in collaboration with OU and OAHP • Annual Marmot Place review

Strategic Risk Owner Commentary (note completed by the Chief Medical Officer (CMO) and Interim Chief Strategy Officer

The Acute Provider Collaborative to date has been useful in fostering a culture of collaboration both for care of patients, and in relation to corporate services. The change in leadership, and merger of ICBs creates a key opportunity to make the APC more effective. An APC Executive workshop is scheduled for 18 June 2026.

Bilateral engagement is ongoing through the Joint Executive Group and Strategic Partnering Board to strengthen partnership working with the University of Oxford. In parallel, CMO is working closely with Oxford Academic Health Partners (OAHP) and the Deputy Head of Medical Sciences Division / BRC Director to oversee a review of the Joint Research Office to strengthen trial setup and delivery.

Significant work is ongoing at TVICS and Trust level to respond to the 10-year plan which will place a greater prominence on the importance of addressing health inequalities.

An annual Health Inequalities Programme Plan is developed and overseen through the Health Inequalities Steering Committee and Delivery Committee. This triangulates with system partners through the Oxfordshire Inclusive Economic Partnership (OIEP) among other forums. OIEP is a key forum to deliver anchor aspirations, focusing on a shared approaches to apprenticeships and work experience for young people.

ID	Score	Summary risk description
1150	16 (high)	If the trust is not able to maintain or increase the portfolio of research activity (and innovation activity) due to staff capacity and financial constraints ~~to~~ leading to a risk to delivery of research activity that might effect reputation/finance (note increase in risk score – Jul 25)
1111	9 (medium)	Due to lack of capacity and ineffective working practices across the system there is a risk that patients might not receive the right care in the place at the right time which may affect patient outcomes, experience and staff morale.

Key: Assurance ratings

Level	Details
Substantial	The scope of assurances noted on the current BAF demonstrate that the **controls are effectively managing the risk/ cause / effect.**
Adequate	There are a **full range of assurances in place**, and **no material issues** have been **identified** with the effectiveness of controls. Assurances are reflecting the **need to fully embed the controls**.
Limited	**Either** some of the assurances noted on the current BAF demonstrate that the **controls in place are not effectively managing the risk/ cause** and action is required to address and/ **or there are gaps in assurance**.
None	**No assurance can be taken/ is available** that the controls relied upon are working. **Action** needs to be taken **to address** the **improvement of controls and assurance provided**.

Assurance rating assessment to date

Note this element is under development and will be refined during 26/27. Step undertaken so far include:

- Map of controls to current recorded sources of assurance
- Re-ordering of controls to enable more effective mapping of controls to assurance.
- Identification of any potential gaps in control or assurance as a result of mapping.
- Assignment of assurance rating to each level 3 assurance source included in the BAF in line with the above definitions and recording of these in the BAF.
- Initial collation of ratings up to overarching aggregated result, based on assigning a score to each individual rating (Limited:1, Adequate 2, Significant 3) and calculating the average score.

Next steps for Quarter 2 include:

- Review and discussed gaps identified with relevant Chief Officer (Strategic Risk Owner).
- Discuss assurance ratings and aggregation methodology with Strategic Risk Owners.
- Present mapping results to Risk Committee for views on process and next steps.
- Continue to develop aggregation process / consider individual assessment of controls effectiveness based on results of feedback.
- Further review of other Level two and three sources of assurance to assess individual assurance rating.

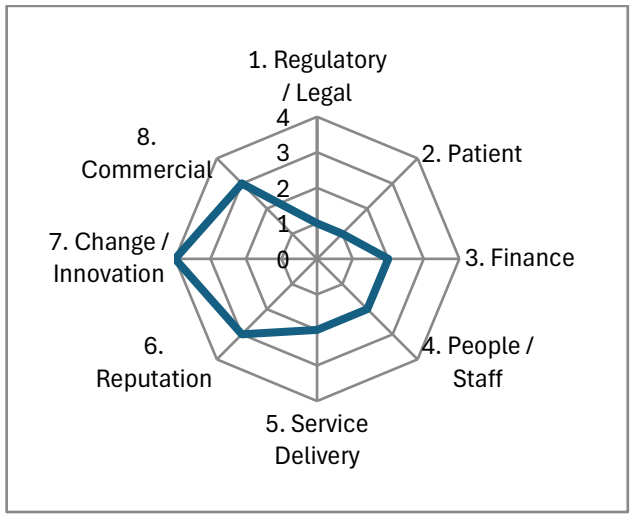
This shows the changes to risk during 2025/26, with some new risks currently under development.

Risk ID	Description	Q1	Q2	Q3	Q4	Target	Review comments
	Patient Care						
3	Vulnerability of the Bedford computer system (CSSD 1415-09)	20	20	20	20	4	
2944	Due to the current control environment, there is a risk around the potential for increase in potential avoidable harm and poor patient experience due to falls, pressure ulcers, violence and aggression	12	12	12	12	8	
2945	Due to resourcing capacity, there is a potential risk on the poor turnaround in complaints response rates leading to poor morale and adverse publicity	12	12	12	12	6	
2888	Due to reductions in staffing and our inability to increase resources there is a risk to the delivery of new treatments (e.g. approved NICE TAs) that may mean the provision, quality or safety of services is affected.	12	12	12	12	4	
3088	Due to local interest group views, there is a risk that we are perceived by members of the public and our patients as providing unsafe care and that we fail to listen, learn and respond compassionately to our patients leading to increases in complaints and regulatory scrutiny.	new	16	16	16	12	
70	Sustained increase in emergency surgical demand, combined with limited capacity and discharge delays, may result in inability to deliver timely, safe surgical care and compromise patient outcomes (SWON)			esc	16	6	Escalated at Risk Committee March 2026
	People						
1614	Due to national staff shortages, there is a risk that we will not be able to recruit and retain sufficient numbers of substantive staff to maintain our current level and quality of service	4	4	4	4	4	
2948	Due to the current control environment, there is a risk that the Trust will not deliver its headcount reduction target (575 posts in total) and will continue to grow its workforce rather than reduce it resulting in increased external scrutiny and impacting on financial performance and year end position.	9	12	12	archive	6	y/e review and to be archived - new risk developed
2595	Not able to reduce our temporary staffing and missing our NHSE control target	15	12	12	archive	6	y/e review and to be archived - new risk developed
2596	Impact of temp staff reduction on staff and patients - Meeting our financial controls could have an adverse impact on patients and staff.	12	12	12	De-esc	4	Risk Committee agreed to de-escalate as impact not materialised (score reduced as a result)
1616	There is a risk that sickness absence levels continue above the KPI that might impact patient care, leading to excessive workloads potential H&S issues including work related stress	12	12	12	16	6	
2163	Culture - There is a risk for leaders and managers not being able to participate in our central programmes to support a culture whereby everyone feels included and valued as part of #OneTeamOneOUH due to operational pressures and bandwidth resulting in leaders do not have the skills and confidence to tackle bullying and harassment (impacting on staff well-being).	12	12	12	12	4	
2443	Risk to implementation of staff Sexual Safety Charter, that might impact staff wellbeing	12	12	12	12	6	
3324	Due to local interest groups and other external factors, there is a risk to staff morale and well-being leading to increased sickness, absences and poor staff engagement and low staff confidence.			new	16	8	
	Performance						
1153	Failure to effectively manage delivery of workforce, activity and CIP plans (to planning assumptions) resulting in overspends against budget and inability to achieve financial targets	20	16	16	16	8	
1157	Failure to deliver in year Financial Plan (Cash Impact) Decreasing liquidity ratio leads to: Increased regulatory reporting and potential delays in paying suppliers	16	16	16	16	4	
1119	As a result of productivity levels that are insufficient to cover costs based national average funding levels there is a risk that there may be an inability to breakeven over 3-5 years that might affect the Trust's ability to sustain safe care.	20	20	20	20	12	
1124	Insufficient capital funding / inability to spend current capital to cover all major capital schemes means that there is a risk that certain services are delivered in poorer estate for a longer period this may affect service delivery	12	12	12	12	8	

Risk ID	Description	Q1	Q2	Q3	Q4	Target	Review comments
1125	Significant backlog maintenance program means there is a risk that certain areas of the estate may be likely to breakdown this might lead to poor estates compliance and potential system failures impacting on operational performance and patient / public safety	12	12	12	12	8	
1138	Due to the capacity of the estates team and the scale of the major capital projects there is a risk of potential impacts on service delivery that might affect patient care and a risk to delivery of the capital programme	9	12	12	12	3	
1133	Ability to improve ED waiting times (a minimum of 78% of patients seen within 4 hours by March 2026 potential risk to operational performance impacting on patient experience and outcomes	12	12	12	12	9	
1135	Bed capacity, staffing and access to funding/ uncertain levels of ICB support poses a risk to meeting the trust trajectory for RTT 52 week waits that might affect patient outcomes and experience	16	16	16	16	9	
1136	Due to issues with diagnostic capacity, there is a risk to our ability to reduce the current backlog of patients waiting for elective care and cancer diagnosis and treatment this might affect patients in terms of harm or poor outcomes	16	16	16	16	6	
2445	Ability to meet delivery plan trajectories for the achievement of 62-day cancer targets that might impact on patient outcomes	12	12	12	12	8	
31	Due to challenges in the community, there is a risk of deconditioning of patients and increased length of stay due to delays in discharge. (MRC)	esc	16	16	16	8	
1398	Unsupported Hardware or Software fails and cannot be recovered; causes cyber security vulnerability; or becomes incompatible with supported systems ('technical debt' management).	10	Closed	Closed	Closed	8	
3087	Due to internal and external resourcing challenges and uncertain patient demand there is a risk that the trust might not deliver the Winter Plan leading to increased operational pressures and impact on operational performance targets.	new	16	16	De-esc	8	Reviewed and risk score reduced to target and to be de-escalated from CRR
	Partnerships						
1111	Due to lack of capacity in the system and patient behaviours there is a risk that patients might not be directed to the right care pathway which may affect patient outcomes, experience and staff morale.	9	9	9	9	6	
1150	If the trust is not able to maintain or increase the portfolio of research activity (and innovation activity) due to staff capacity and financial constraints leading to a risk to delivery of research activity that might affect reputation/finance	12	12	12	16	2	score increased following review by CMO

Risk Appetite

The Trust Board recognises that the Trust's long-term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners, including our staff, wherever possible.
This risk appetite statement has individual statements across eight key risk areas (domains). The statements and the supporting definitions seek to establish our capacity for taking and absorbing risk and will act as guiding principles for the management of risk across the Trust. They also link with our overarching strategy and to the CQC key questions.



Key Risk Areas / Domain: Appetite level

1. Regulatory/ Legal: Minimal

Regulatory compliance is a key organisational objective linking to the *'Our Performance'* strategic theme. We will aim to work with our regulators to help shape the regulatory landscape. We will implement controls to ensure compliance and have limited tolerance for action which could be subject to legal challenge.

2. Patient: Minimal

We will not accept risks that materially impact on patient safety and outcomes, linking to *'Our Patients'* strategic objective. We will listen to the experiences of our patients and seek to maintain and improve patient experience. (CQC Safe / Caring)

3. Finance: Cautious

We have limited tolerance for actions that mean current service delivery is not financially sustainable. (CQC Well Led)

4. People / Staff: Cautious

We are open to recruiting people provided they have the competencies and values that complement the Trust. We will invest in the learning and development of our staff, linking with the '*Our People'* theme and complementing our research academic and teaching agenda. (CQC caring / Well Led)

5. Service Delivery: Cautious

We are prepared to consider all service delivery options and will select those with the best impact on patient outcomes that can be delivered in a financially sustainable manner. This links to the *'Our Performance'* strategic theme.

We will consider both transformational and incremental change. (CQC Effective / Responsive)

6. Reputation: Open

We will be mindful of our reputation and the way in which our patients and the public view the services we deliver. We will make changes that enhance services and the level of confidence gained for our local community, linking to '*Our Patients and Our Partners'* strategic themes. (CQC Caring / Responsive)

7. Change / Innovation: Seek

We are open to change and improvement, innovation is supported to improve service delivery this links to the *'Our Performance'* strategic theme.

We want to introduce change but only if this doesn't have a negative impact on our patient outcomes or our partners linking to *'Our Partners'* strategic theme. (CQC Well Led)

8. Commercial: Open

We will be open to exploring commercial innovation as part of the Trust's commercial and investments strategies. This links to *'Our Partners'* strategic theme. (CQC Well Led)