Cover Sheet

Trust Board Meeting in Public: Wednesday 14 May 2025

TB2025.47

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

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

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

Executive Summary

1. The purpose of this paper is to provide the Board with assurance on the maintenance of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR).

2. This paper provides the Board with a year-end review of the Board Assurance Framework (BAF). In addition, it provides the current updated Corporate Risk Register (CRR) for 2025/26, this has been presented to Trust Management Executive and a further update will be reviewed and provide to Risk Committee later this month.

Recommendations

3. The Trust Board is asked to:

   • Review and take assurance from year-end position included in the report.

Board Assurance Framework and Corporate Risk Register Report

1. Purpose

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

1.2. This paper provides the Board with a year-end review of the Board Assurance Framework (BAF). In addition, it provides the current updated Corporate Risk Register (CRR) for 2025/26, this has been presented to Trust Management Executive and a further update will be reviewed and provide to Risk Committee later this month.

2. Board Assurance Framework

2.1. The latest version of the BAF is provided as Appendix 1. This has been updated to reflect feedback following its review and discussion at the Risk Committee in March and Audit Committee in April.

2.2. Analysis of all assurance reports taken to the Board and its-subcommittees for 2024/25 was undertaken to provide the assurance picture for the year. This was provided to the Audit Committee and the chart in figure 1 shows the summary analysis of all reports for the whole year across of each of the strategic pillars.
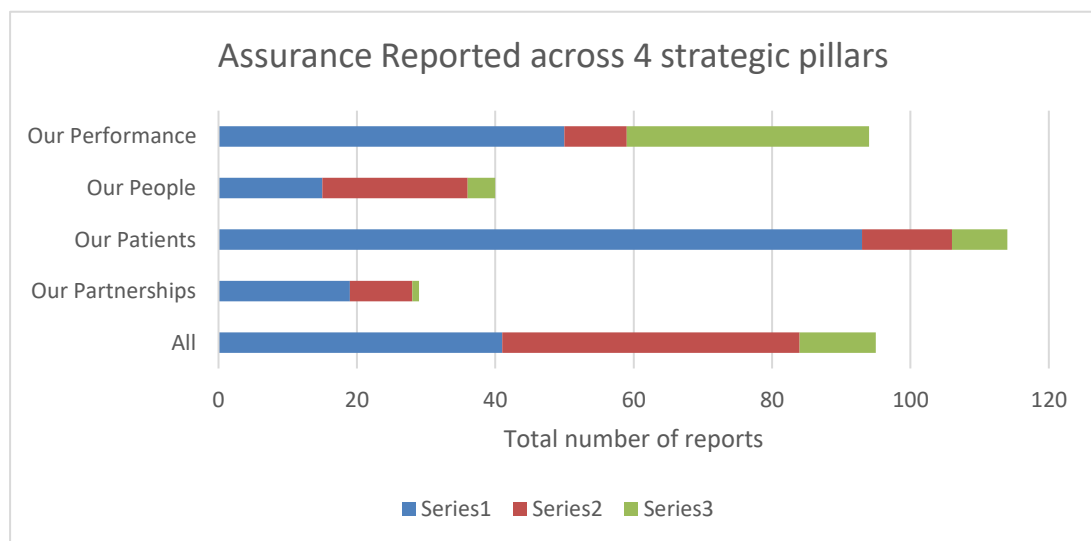

Figure 1

2.3. The information in figure two shows the split of assurance reporting across the Board and board sub-committees by assurance level for the whole year. With our assurance levels defined as follows:
- 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
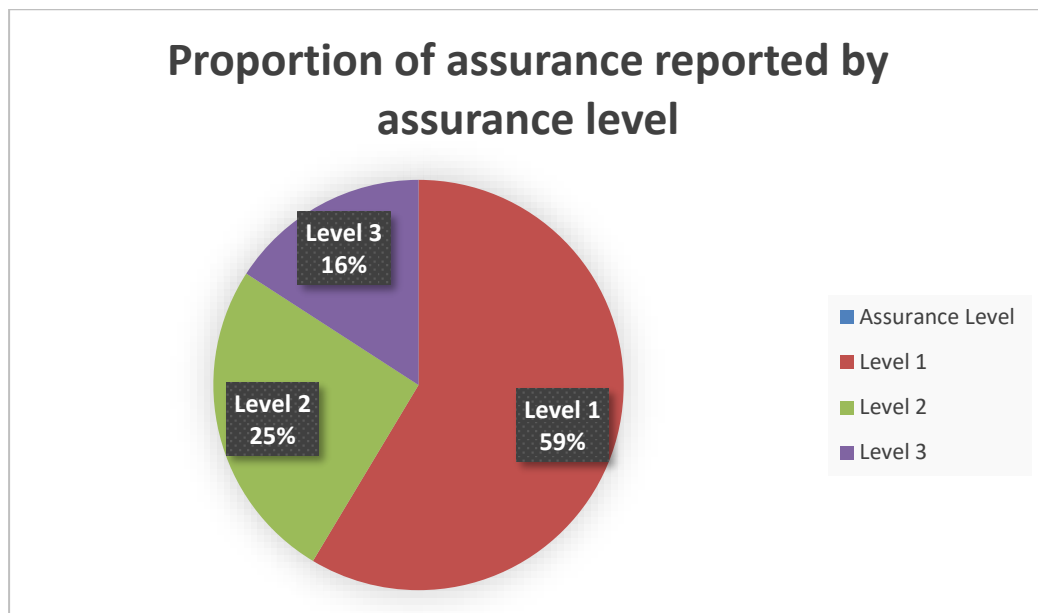
Figure 2

2.4. As would be expected there is a greater proportion of level 1 assurance reported, these are Chief Officer's reports in relation to aspects of delivery against their portfolios of work. A Board seminar session is be planned during 2025/26 to explore the relationship between the assurance levels, risk appetite and the assurance reporting flows on delivery of the Year Two Plan with the aim to assist the development of the cycle of business for Board and subcommittees.

3. Corporate Risk Register (CRR)

3.1. The 2025/26 planning processes, and planning submissions have been used as a catalyst for the review of the contents of the CRR.

3.2. The Director of Regulatory Compliance and Assurance has undertaken the following:

- A series of meetings with most Executive leads / risk owners of individual risks on the CRR.

- Attended the most recent People and Communications Group meeting, where the related People and Communications Risk Register was presented.

- Attended the Divisional Planning Stocktake session, this was used to cross reference emerging and consistent themes across all four divisions, to identify potential risks for inclusion in the CRR.

- Additional meetings with corporate services risk owners linked the development of the risk register and as part of the annual reporting process.

3.3. The Integrated Assurance Committee at its last meeting identified the following emerging risks.

- 2025/26 planning assumptions - note this has been reflected in suggested change to the description of the in-year financial risk (1153).

  - Cash and cash support - note this is already in the CRR (1157) but an increase in the current risk score has been proposed due to the current level of uncertainly in relation to external cash management processes

  - Emergency Village – provided funding was approved, ability to deliver within required timescales in the context of the ambitious capital programme – Note this is being reflected as an action / mitigation regarding ED waiting times (1133)

  - Capacity for transformation and implementation of initiatives – note is this now reflected in the proposed culture risk (2163)

  - Capacity of estates team to deliver 25/26 capital programme – note this has been reflected in a change to the description of the major capital projects risk (1138)

3.4. The results of this activity and discussions at IAC were formulated into the summary of changes to the CRR, included in Appendix 2, and summarised as follows:

  - There has been an extensive review of the risks related to 'Our Patients' to reflect those themes identified during the divisional planning stock take session.

  - A series of changes to the risks associated with 'Our People' have been made based on the review of risks at People and Comms Committee.

  - Most of the risks related to 'Our Performance' remain largely the same, however the supporting detail in terms of cause, controls and actions are in the process of being updated.

  - The risks recorded on the CRR relating to 'Our Partners have been reviewed and updated to reflect the current causes.

3.5. The full summary of the 2025/26 CRR has been provided as Appendix 2 to this report, for review and discussion. As part of the discussion at Trust Management Executive it was recommended that a reconciliation of risks included in planning submission documents be undertaken, this is being considered.

4. Recommendations

4.1. The Trust Board is asked to:

  - Review and take assurance from year-end position included in the report.

Strategic Risk	Risk score			Rational for change in risk score / commentary	Changes to controls since April 2025	Changes to assurance since April 2025
	Previous Feb 25	Current April 25	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, and not want to engage	C4 x L3 = 12	C4 x L3 = 12	C2 x L2= 4	↔: No change	No additions	Report to Audit Committee added (BDO Report)
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 L1= 3	↔: No change –	No additions	
Strategic Objective: To consistently achieve all operational **performance standards and financial sustainability**.						
SR 3.1: We may not operate effectively, and may not be able to deliver performance standards sustainably, patient care will suffer, and we will face regulatory enforcement	C5 x L4= 20	C5 x L4 = 20	C3 x L3= 9	↔: No change –	No additions	Report to IAC February 2025 added
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 L3= 12	↔: No change	No additions	Reports to Audit Committee added (BDO Reports)
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	C4 x L3= 12	C4 x L1= 4	↔: No change	No additions	Report to Audit Committee added (BDO Report)
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 L3= 12	C4 x L2= 8	↔: No change	No additions	
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 L2= 6	↔: No change	No additions	

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 (WIP)	• 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 effectively, and may not be able to deliver performance standards sustainably, patient care will suffer, and we will face regulatory enforcement		• E-Rostering	• Discharge Planning	• 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	• Forecasting • Procurement	• 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 (WIP) • Data Quality – UEC Datasets (WIP)	• DSP Toolkit • IT Asset Management • Medical Device Management • Data Quality – • ISO27001 SDE	• DSP Toolkit • Data Quality – DM01	• 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	• Stock Control • ISO45001 H&S		• 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)		• ICS Governance • Population Health / Health Inequalities	

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	Staff may not want to come, not want to stay and not want to engage

Cause	Risk	Effect
As a result of: • *our staff not having a sense of belonging and fulfilment* • *external factors of cost of living* • *failure to recruit and retain key staff* • *Not feeling able to speak up, due to poor inclusive safety culture (inc psychological safety)* • *Lack of training and development opportunities*	*…there is a risk that staff may not want to come, not want to stay and may not want to engage or be able to develop*	*Which could result in…* • *Potential loss of high-quality staff, higher turnover / recruitment and retention challenge* • *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* • *We may not get the most out of our people* • *Poor staff moral / well-being / staff experience / poor employee relations* • *Bullying and harassment* • *Reliance on temporary staffing* • *Staff sickness (potential for increased anxiety etc)* • *Restricted succession planning / career development* • *Potential mistrust, presenteeism*

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

Controls	Assurance on controls reported to Board and Committees
• People Plan 2022-25 and supporting annual priorities - Delivery of year 3 of the plan • TNA for all staff (link to nursing) (New director of non-medical education link to new controls re this aspect) • Growing Stronger Together Plan with metrics and related actions • Well-being check-ins • FTSU speak up culture and plans • Bullying and harassment eradication plan • Kindness into action and related training plan • Clear core training policy and appraisal policies, monitored via workforce metrics (to inc. EDI Training)	**First line of defence:** • Chief People Officer's Update Reports to TME, IAC and Board, specific reports on Temporary Staffing and Pay Panel results • Workforce Issues Heatmap (Reported bi-monthly) • People and Communications Committee (Chair: CPO, Frequency: Bi-monthly) • Sexual Safety Assurance Framework (TME November)

Controls	Assurance on controls reported to Board and Committees
• Sexual safety charter • Employee relations meetings (covered via SLA) and addressing of medical concerns. • International Educated nursing (IEN) action implementation (to inc. IEN development) • Well supported staff networks to assist with the delivery of EDI Peer Review Programme. • ICB partnerships to address workforce issues. • Plan for learning from staff survey and implementation of related actions • Educational supervisors training for medical appraisal • Service specific development programmes in place **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)	**Second line of defence:** • Planned review as part of Corporate Performance Review meetings. • Divisional Performance meetings **Third line of defence:** • Internal Audit Report (24/25): Temporary Staffing Reduction Programme (Design: Moderate, Effectiveness: Moderate) • Internal Audit Report (24/25): EDI Maturity **Other External Reports** • NHS Staff Survey results (note confidential results to TME Jan 25) • CQC reports on OCC (not rated) and HGH MLU (RI rated) and action plan monitoring via governance structure • Independent cultural reviews • National Inquiry Reviews
Gaps in controls and assurance	**Actions to address gaps**
• Proportion of staff receiving well-being check-in • Medical recruitment SLA and reporting • Comprehensive temporary staffing controls and measures of impact	• Monitoring via divisional performance review meetings • Medical Recruitment SLA needs TME approval and implementation • Temporary Staffing Reduction Programme needs completion and impact assessed * • Collate Cultural Connectedness and Development Programme progress for OCC and Neonatal Unit

ID	Score	Summary risk description
1614	12(medium)	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 (in the context of the merging cost of living crisis)
1616	12(medium)	Due to persistent increased workloads there is a risk that sickness absence levels continue to rise and that staff will suffer increased levels of mental ill health effecting staff turnover levels.
2443	12(medium)	Risk to implementation of staff Sexual Safety Charter, that might impact staff wellbeing. (note proposed to de-escalate)
2595	15(high)	Ability to meet 700 temp staff reduction target (noted description updated)
2596	12(medium)	Impact of temp staff reduction on staff and patients
New	16 (high)	Workforce Growth – added as new risk
2163	12(medium)	Culture – escalated from CPO risk register

Strategic Objective	To 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 / all 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 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* • *Sustainability of continuous improvements* • *Impact on staff motivation and retention / staff may not feel empowered to make improvements* • *Increased mortality/ 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	**Risk Appetite Domain**	Patient / People / Change	
		Risk Appetite Level	Avoid / Cautious / Seek	

Controls	Assurance on controls reported to Board and Committees
• Quality improvement initiatives • Continue to improve fracture NoF pathway at JR • Maintenance of Clinical Audit Programme • Integrated Quality Improvement Programme (to TME) • QI Hub • Monitoring of education numbers of staffing being trained • Ulysses Assurance module • QI continuous improvement methodology / PSIRF process as enabler to learning from themes.	**First line of defence:** • Learning from deaths reports • IPC Annual Report • Maternity Incentive Scheme Annual Review • Public Engagement, Patient Experience and Complaints Annual Report • Quality priority paper to IAC August 24 • Clinical Audit Plan paper to Audit Committee Oct 24 • Integrated Quality Improvement Programme update to TME (Jan 25) • Patients on Outlier Wards (IAC Feb 25)

Controls	Assurance on controls reported to Board and Committees
• Feedback mechanisms from staff • Feedback mechanisms from patients • Patient experience team • Series of development programmes in place aimed at further reducing moderate and major harms and mortality rates, for example falls and pressure ulcer reduction • Standardised quality reports (to divisions and CGC) **Governance Structure:** • Clinical Improvement Committee (Chair: DCMO, Frequency: Monthly) • Clinical Governance Committee (Chair: CMO/CNO, Frequency: Monthly) • Cancer Improvement Programme Board (Chair: TBC, Frequency TBC) • Urgent Care improvement Programme Board (Chair COO, Frequency: Monthly) • TME (Chair: CEO, Frequency: Two weekly) • Integrated Assurance Committee (Chair: Trust Chair, Frequency: Bi-monthly) • Critical Care Safety Group (Chair: CMO) • Inpatient Survey Delivery Group (Chair CNO)	**Second line of defence:** • Performance review meetings • Delivery Committee monitoring • CGC reports • Safeguarding Annual Report • Infection Prevention and Control Committee Reports • Guardian of Safe Working Hours (November Board) **Third line of defence:** **Internal Audit Reports** • Divisional Governance (22/23 design: operation: • GIRFT (23/24 design: moderate, operation: moderate) • Medicines Security (23/24 design: moderate, operation: moderate) • CQC Well-led (24/25 Advisory) • PSIRF Review (24/25 design: substantial, operation: moderate) **Other external reports** • CQC reports on OCC (not rated) and HGH MLU (RI rated) and action plan monitoring via governance structure • Hip Fracture database report • CQC inpatient survey (November Board)
Gaps in controls and assurance	**Actions to address gaps**
• Depth of QI knowledge across the Trust • Return of Clinical Audit data in a timely manner • Robust follow-up of PSIRF Action plans	• Explore the potential for a digital solution to align audit data to automate data collection and enable audit • Delivery of 24/25 planned service developments, in accordance with three-year plan. • Deliver 24/25 planned governance changes in accordance with three-year plan. • Establish planned 24/25 KPIs and dashboards in accordance with three-year plan. • Local action to Follow-up of completion of PSIRF actions

ID	Score	Summary risk description
85	9 (medium)	MRC - Managing medical patients in outlier wards - there is a risk of harm to patients and increased length of stay (Note escalated to CRR Q1 24/25)
67	16 (high)	SWON OR 0004 - Limited ICU capacity - due to staffing and space issues there is a potential risk that ICU demand may outstrip current capacity
3	16 (high)	Vulnerability of the Bedford computer system (CSSD 1415-09)
new	New	Note four new risks proposed in CRR under development

Strategic objective	To consistently **achieve all operational performance standards** and **financial sustainability.**
Strategic Risk 3.1	We may not operate effectively and may not be able to deliver performance standards sustainably, patient care will suffer and we will face regulatory enforcement.

Cause	Risk	Effect
As a result of… • *Our ability to participate in ICS / APC* • *ICS effectiveness / failure of ICS policy framework / ICB boundaries* • *Wider landscape changes in-year/ short termism in NHS* • *National / regional restructure* • *Ageing population with multiple co-morbidities* • *Industrial action* • *Changes to Specialist commissioning* • *National planning guidance* • *Availability of workforce / loss of experience staff aging workforce* • *Poor theatre utilisation / Poor estate* • *Lack of capital development* • *Lack of mutual aid / funding*	*…there is a risk that we may not operate effectively, and may not be able to deliver* ***sustainable performance standards***	*… which could result in…* • *Ability to plan over time,* • *Not having the right people of the right quality / different capacity (human and physical)* • *Strategic planning in the broader sense* • *Inability to deliver Cancer and other standards* • *Additional oversight from ICB, regional and national team – system oversight process* • *Increased use of temporary staffing* • *Poor access times / longer waits for patients leading to harm* • *Poor patient experience* • *Poor productivity*

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
• Activity plan • Performance management framework • GIRFT Action Plan • Planning / staff briefings on strike action • Improvement Programmes covering: elective care, outpatients, cancer, theatres, diagnostics and urgent care. • Implementation of ED staffing business case (IAC April 24) • Roll out mobile lung check service for 50-75yr olds*	**First line of defence:** • Divisional management reports • Chief Operating Officer's Update Reports to TME, Audit Committee, IAC, and Board • Integrated Quality Improvement Programme update to TME (Jan 25) • Winter Plan Update (IAC Feb 25) **Second line of defence:** • IAC, AC, Board • Annual Reports: EoL, Infection Control, Learning from Deaths

Controls	Assurance on controls reported to Board and Committees
• Cash Improvement Plan (Reported to IAC August 24) **Governance Structure:** • Productivity Committee • Cancer Improvement Programme Board • Urgent Care improvement Programme Board • TME • Tier 1 Oversight meetings (fortnightly with NHSE regional / national team as required)	• Planned review as part of Corporate Performance Review meetings • Productivity review of major programmes **Third line of defence:** **Internal Audit reports:** • Clinical Validation of Waiting Lists (21/22: design: moderate, operation: moderate) • Performance Framework (23/24 design: significant, operation: moderate)- lead CDPO • Outpatient Management (23/24 advisory review) lead- COO
Gaps in controls and assurance	**Actions to address gaps**
Assurance on ED staffing business case to come to IAC October 24	• Delivery of 24/25 planned service developments, in accordance with three-year plan. • Establish planned 24/25 KPIs and dashboards in accordance with three-year plan. • Deliver planned measures to mee NHSE operational requirements in accordance with 24/25 actions in the three-year plan.

ID	Score	Summary risk description
1133	15 (high)	Ability to improve ED waiting times (a minimum of 78% of patients seen within 4 hours by March 2025) potential risk to operational performance impacting on patient experience and outcomes
1135	15 (high)	Bed capacity, staffing and ERF funding/ support poses a risk to meeting the elective care delivery plan that might affect patient outcomes and experience (Note summary description updated in line with 24/25 delivery plan)
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 effect patients in terms of harm or poor outcomes (Note summary description updated in line with 24/25 delivery plan)
2445	12(medium)	Ability to meet delivery plan trajectories for the achievement of Cancer targets that might impact on patient outcomes (Note new risk added in line with 24/25 delivery plan)
67	16 (High)	SWON OR 0004 - Limited ICU capacity - due to staffing and space issues there is a potential risk that ICU demand may outstrip current capacity (Note escalated to CRR Q1 24/25) (also noted in our patients risk)

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

Cause	Risk	Effect
As a result of…	*…there is a risk that we may not operate effectively, and our* **finances may become unsustainable** *over the short and longer term*	*… which could result in…*
• *Our ability to participate in ICS/ICS effectiveness / failure of ICS policy framework / ICB boundaries* • *Wider landscape changes in-year/ short termism in NHS* • *Unsustainable financial model* • *Approach to NHS capital budget* • *Specialist commission landscape changes* • *National planning guidance* • *Lack of grip/ Poor control of pay and non-pay budgets* • *Lack of delivery of productivity goals*		• *Lack of ability to fund emerging therapies/ new treatment options.* • *Support financially or for our people skills provision to be delivered in a different way* • *Ability to plan over time, new investments.* • *Additional oversight from ICB, regional and national team – system oversight process* • *Increased use of temporary staffing* • *Poor patient care /Poor staff morale* • *Increased pressure on cash potentially leading to need to cut services*

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
• Capital project benefit realisation reviews • Improvement Programmes • Operational finance support • Workforce controls (link to LLPs) • Pay and non- pay controls in place and communicated trust wide (Reported via TME 11/4/24) • Temporary staffing work programme (monitored via Productivity Committee) • Delivery to 24/25 financial plan, inc. 6% efficiency target. • Finance Training for non-finance staff (Audit Committee Oct 24) **Governance Structure:** • Productivity Committee (Chair: CEO Frequency: Monthly)	**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 (IAC Oct 23) **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:** • HFMA Financial Sustainability (22/23) Advisory – lead CFO • Key Financial Systems (22/23: design S,: operation: M)- lead CFO • Financial Governance and HFMA action plan (23/24 design: moderate, operation: moderate)- lead CFO

Controls	Assurance on controls reported to Board and Committees
- Delivery Committee (Chair: CEO Frequency: Monthly) - TME (Chair: CEO Frequency: Monthly) - Investment Committee (Chair: CEO Frequency: Monthly) - Integrated Assurance Committee (Chair: CEO Frequency: Monthly)	- Cash Management (24/25) Advisory – lead CFO - Salary Overpayments (24/25: design: Moderate, operation: Limited) – lead CFO / CPO - Month End Closedown procedures (24/25 design: Moderate, operation Moderate) – lead CFO - Compliant Direct Awards (24/25: design: Moderate, operation: Moderate) – lead CFO
Gaps in controls and assurance	**Actions to address gaps**
	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 24/25 of the three-year plan.

ID	Score	Summary risk description
1119	20 (high)	Long term financial sustainability.
1153	20 (high)	Failure to effectively ~~control pay and non-pay costs~~ manage delivery of workforce, activity and CIP plans (to planning assumptions) resulting in overspends against budget and inability to achieve financial targets
1157	20 (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 • Digital Strategy • DSP toolkit assessment and action plan • Contract management of systems • Software licences • SDE oversight and go live in 24/25 **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:** • Corporate Performance Review meetings • SDE Maturity Assessment reported to IAC August 24 **Third line of defence:** **Internal Audit reports on:** • Cyber Security (22/23: design; moderate, operation: moderate) – Lead CDPO • IT Disaster Recovery (22/23: design: moderate, operation: moderate) – Lead: CDPO • Business Continuity (22/23: S:M) – Lead COO • Data Quality (22/23) – Lead CDPO • IT Project Benefits Realisation (22/23) – Lead CDPO • DSP Toolkit (23/24 design: substantial, operation: moderate) - Lead CDPO

Controls	Assurance on controls reported to Board and Committees
	• Outpatient Management (23/24 advisory review) – lead COO • SDE Cyber Security (24/25 design: Moderate, operation: Moderate) – lead CDO
Gaps in controls and assurance	**Actions to address gaps**
• From cyber security review: some unsupported systems • From IT disaster Recovery: Plans to be tested and training to handle major incident	• Continue programme of upgrade of systems. • DOC work with stakeholder on delivery / risk assessment • Go Live of new Laboratory Information Management System (LIMS) in line with 24/25 of the three-year plan • Maximise use of automation in Pharmacy for efficiency gains, in line with 24/25 of the three-year plan

ID	Score	Summary risk description
1115	De-escalated	As a result of a mix of paper and IT record systems there is a risk of increased patient safety incidents that may effect patient care.(note agreed to de-escalate to Chief Information and Digital Risk Register)
1398	10 (Medium)	Unsupported Hardware or Software fails and cannot be recovered; causes cyber security vulnerability; or becomes incompatible with supported systems ('technical debt' management).

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* • *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 modern and fit for purpose healthcare facilities.* • *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* • *Poor patient care*

Risk Score		Consequence	Likelihood	Score
Current risk score		4	3	12
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 • Premises Assurance Model assessment • Capital Infrastructure Plan • Backlog maintenance review and targeted programme delivery • PFI management full estates line of site across all estate, PFI and retained estate. • Transport contract in place (presented to TME 11/4/24) • Continue to improve and deliver net zero savings and reduction in our carbon footprint **Governance Structure:**	**First line of defence:** • E & F Management Committee • Divisional Performance Reviews • Estates compliance committee **Second line of defence:** • Director of Estates and Facilities Reports to TME and IAC (Capital Schemes Updates, PFI updates, specific business case / project reports / backlog maintenance risk review update / ventilation compliance update) • Estates Compliance paper to IAC August 24 • Planned review as part of Corporate Performance Review meetings

Controls	Assurance on controls reported to Board and Committees
• Estates Compliance Committee • Medical Equipment Prioritisation Group • Capital Management Group • Health & Safety Committee • Investment Committee Review, IAC, Board • Board seminar session • Various Estates safety groups (e.g. Ventilation)	• Business continuity plan • Investment Committee Review, IAC, Board • Premises Assurance Model Report Board **Third line of defence:** **Internal Audit Reports:** • PFI Contract Management (22/23) Advisory • Estates Compliance (22/23: design: M, operation :M) – lead CE&FO • Business Continuity (22/23: design: S, operation :M) – lead COO • Environmental Sustainability (23/24 advisory review)- lead CE&FO **Other External Reports** • Health and Safety Executive positive responses to reviews • HTM Safety Groups
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 • Estates staff capacity • From PFI contract management review: KPIs, workflow documentation	• Estates Compliance meeting review of estates related risks across clinical divisions • Continue implementation of estates and facilities business case • Internal Audit actions to be completed in line with agreed deadlines. • Implementation of sustainable Travel and Transport Strategy • In line with 24/25 of the three-year plan, continue to make improvements in the estate environment and the hard and soft FM services

ID	Score	Summary risk description
1124	De-escalate	As a result of Insufficient capital funding to cover all major capital schemes there is a risk that certain services are delivered in poorer estate for a longer period this may effect service delivery (note proposed to de-escalate to Chief Estates and Facilities Officer Risk register)
1125	12(medium)	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 (note proposed to de-escalate to Chief Estates and Facilities Officer Risk register)
1128	De-escalate	Due to aging power plant there is a risk of loss of electrical power across JR and NOC sites resulting in potential of major loss of clinical services.
1129	De-escalate	Due to poor fabric on the building in certain locations there is a risk of potential slips, trips and falls and to staff and visitors in old parts of the Churchill effecting patient and public safety (note proposed to de-escalate to Chief Estates and Facilities Officer Risk register)
1130	De-escalate	As ventilation plant is old in some locations there is a risk to patient and staff safety that may effect regulatory compliance (note proposed to de-escalate to Chief Estates and Facilities Officer Risk register)
1131	De-escalate	As a result of actions identified via audits and poor fabric of the estates there is a risk to patient and staff safety from the water systems in certain buildings effecting the trust reputation. (note proposed to de-escalate to Chief Estates and Facilities Officer Risk register)
1138	9(medium)	Due to the capacity of the estates team and the scale of the ~~amount of changes in relation to~~ major capital projects there is a risk of potential impacts on service delivery that might effect 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 research and innovation outcomes for the benefit of 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 Digital and Partnerships Officer / Chief Operating Officer	**Risk Appetite Domain**	Patient / People	
		Risk Appetite Level	Avoid / Cautious	

Controls	Assurance on controls reported to Board and Committees
• ICS governance map (to date) • MoU for provider collaborative with OH • MoU for Acute provider collaborative across BOB • Involvement in ICB structure consultation reported to IAC August 24 **Governance Structure:** • A&E Delivery Board (Chair: COO, Frequency: Monthly) • Place Based Board (Chair: TBC, Frequency: TBC) • Acute Provider Collaborative Board (Chair, 25/26 Trust Chair, Frequency bi-monthly)	**First line of defence:** • Director of Strategy Update Reports to TME • Provider collaborative update reports • Clinical Strategy Implementation Plan (IAC Oct 23) • Research & Development Update Report (IAC Feb 25) **Second line of defence:** • Planned review as part of Corporate Performance Review meetings • R&D governance Report • CRN TV & South Midlands update **Third line of defence:** **Internal Audit Report:** • Clinical Research Network (CRN) (22/23: design: Significant, operation: Moderate) • Research & Development Review (23/24: advisory)

Gaps in controls and assurance	Actions to address gaps
• Review of CRN SoD • Is this embedded in the business case process (for consideration of service change)	• SoD to be reviewed and ratified annually via LCRN

ID	Score	Summary risk description
1150	4 (Low)	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 pre covid levels leading to a risk to delivery of research activity that might effect reputation/finance
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 effect patient outcomes, experience and staff morale.

Risk ID	Title	24/25 Q4	25/26 Q1	Target	TME reviewed suggested revisions
	Patient Care		Proposed		
67	SWON OR 0004 - Limited ICU capacity - due to staffing and space issues there is a potential risk that ICU demand may outstrip current capacity	16	16	4	Retain as this was an escalated risk from divisional risk register (held on CRR as watching brief)
85	MRC - Managing medical patients in outlier wards - there is a risk of harm to patients and increased length of stay	9	9	6	Retain as this was an escalated risk from divisional risk register (held on CRR as watching brief)
3	Vulnerability of the Bedford computer system (CSSD 1415-09)	20	20	4	Retain as this was an escalated risk from divisional risk register (held on CRR as watching brief)
1114	Due to inconsistencies in the processes and behaviours there is a risk that there may be a failure to respond to the results of diagnostic tests that may affect patient care	9	De-esc	4	Propose to move off CRR and hold at CMO Risk Register - with escalation if actions off track
1115	As a result of a mix of paper and IT record systems there is a risk of increased patient safety incidents that may affect patient care.	6	De-esc	3	Propose to move off CRR and hold at CIDO Risk Register - with escalation if actions off track
1121	As a result of poor medicine safety audits and the lack of ability to progress actions there is a risk that medicines may not be stored securely and safely and in line with regulatory requirements that might affect standards are care.	9	De-esc	3	Propose to move off CRR and hold at CMO Risk Register - with escalation if actions off track
1128	Due to aging power plant there is a risk of loss of electrical power across JR and NOC sites resulting in potential of major loss of clinical services.	12	De-esc	4	Propose to move off CRR and hold at CE&FO Risk Register - with escalation if actions off track
1129	Due to poor fabric of the building in certain locations there is a risk of potential slips, trips and falls and to staff and visitors in old parts of the Churchill effecting patient and public safety	8	De-esc	8	Propose to move off CRR and hold at CE&FO Risk Register - with escalation if actions off track
1130	As ventilation plant is old in some locations there is a risk to patient and staff safety that may affect regulatory compliance	12	De-esc	8	Propose to move off CRR and hold at CE&FO Risk Register - with escalation if actions off track
1131	As a result of actions identified via audits and poor fabric of the estates there is a risk to patient and staff safety from the water systems in certain buildings effecting the trust reputation.	12	De-esc	8	Propose to move off CRR and hold at CE&FO Risk Register - with escalation if actions off track
1141	If there are poor controls over the administration of medical air as opposed to oxygen there is a risk of increased incidents effecting patient safety	9	De-esc	6	Propose to move off CRR and hold at CMO Risk Register - with escalation if actions off track
new	Due to the current control environment there is a risk of a potential increase in harm free incident categories (falls, pressure ulcers, violence and aggression) leading to potentially poor patient outcomes	new	TBC	TBC	Identified as consistent theme from divisional stocktake presentation
new	As a result of resourcing capacity there is a risk around the poor turnaround in complaints response rates leading to additional adverse patient feedback	new	TBC	TBC	Identified as consistent theme from divisional stocktake presentation
2888 (new)	Reductions in staffing and inability to increase resources to deliver new treatments (e.g. approved NICE TAs) may mean there is a risk to the provision, quality or safety of services impacting on patients.	new	12	4	Identified by review of CMO risks reflecting potential impact of headcount reduction on clinical service
new	Due to the Trust control environment, resource capacity and changes to service delivery there may be a risk in relation to patient experience (LoS, cancellations on the day and equity of access) causing additional adverse feedback	new	TBC	TBC	Identified as consistent theme from divisional stocktake presentation
	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	12	12	4	Remain on CRR Note Target amended via People and Comms from 9 to 4
new	Workforce Growth - There is a risk that the Trust will continue to grow its workforce resulting in the Trust not delivering its headcount and pay targets	new	16	6	Currently in development via People and Comms Risk Register (move the CRR)
2595	~~Ability to meet 700 temp staff reduction target~~ due to capacity issues there is a risk that the Trust may not be able to reduce our temporary staffing and missing our NHSE control target	15	15	6	Risk Description amended to reflect current year aim
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	4	To remain on CRR, as per People and Comms Risk Register
1616	Due to persistent increased workloads there is a risk that sickness absence levels continue to rise and that staff will suffer increased levels of mental ill health effecting staff turnover levels.	12	12	6	Remain on CRR, identified as a consistent theme from divisional stocktake presentations (Note target amended by People and Comms from 9 to 6)

		24/25	25/26		
Risk ID	Title	Q4	Q1	Target	TME reviewed suggested revisions
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).	Esc	12	4	Currently on People and Comms Risk Register (move the CRR)
2443	Risk to implementation of staff Sexual Safety Charter, that might impact staff wellbeing	12	De-esc	6	Propose to move off CRR and hold at People and Comms Risk Register - with escalation if actions off track
1707	Potential strike action, across nursing, resident doctor and other AHPs (including primary care staff), leading to operational performance issues and impact on patient safety and potential impact on ED and RTT performance	5	De-esc	5	Propose to move off CRR and hold at COO Risk Register - with escalation if actions off track
Performance					
1153	Failure to effectively ~~control pay and non-pay costs~~ manage-delivery of workforce, activity and CIP plans (to planning assumptions)-resulting in overspends against budget and inability to achieve financial targets	20	20	8	To remain on CRR, as per Finance, Procurement and Commercial Risk Register
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	20	4	To remain on CRR, as per Finance, Procurement and Commercial Risk Register (note proposed increase in current score)
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	12	To remain on CRR, as per Finance, Procurement and Commercial Risk Register
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	De-esc	8	Propose to move off CRR and hold at CE&FO Risk Register - with escalation if actions off track, this one has been queried for further discussion
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	12	12	8	To remain on CRR, as per Estates and Facilities Risk Register
1138	Due to the capacity of the estates team and the scale of the ~~amount of changes in relation to~~ 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	9	3	To remain on CRR, as per Estates and Facilities Risk Register (note suggested amendment in description)
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	15	15	9	To remain on CRR, as per Chief Operating Risk Register
1135	Bed capacity, staffing and ~~ERF~~ access to funding/ uncertain levels of ICB support poses a risk to meeting the ~~elective care delivery plan~~ trust trajectory for RTT 52 week waits that might affect patient outcomes and experience	16	16	9	To remain on CRR, as per Chief Operating Risk Register (note suggested amendment in description)
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	6	To remain on CRR, as per Chief Operating Risk Register
2445	Ability to meet delivery plan trajectories for the achievement of 62-day cancer targets that might impact on patient outcomes	12	12	8	To remain on CRR, as per Chief Operating Risk Register (note suggested amendment in description)
1398	Unsupported Hardware or Software fails and cannot be recovered; causes cyber security vulnerability; or becomes incompatible with supported systems ('technical debt' management).	10	10	8	To remain on CRR, as per Chief Information and Digital Officer Risk Register (note digital risk register under review)
Partnerships					
1111	Due to lack of capacity ~~and ineffective working practices across~~ in the system and patient behaviours there is a risk that patients might not be directed to the right receive the right care pathway ~~in the place at the right time~~ which may affect patient outcomes, experience and staff morale.	9	9	6	To remain on CRR, as per Chief Operating Risk Register (note suggested amendment in description)
1150	Due to staff capacity and financial constraints there is a risk that the trust may not be able to maintain or increase delivery of the portfolio of research activity (and innovation activity) ~~to pre covid levels~~ that might affect the Trust's reputation/finances	4	4	2	To remain on CRR, as per Chief Medical Officer Risk Register (note suggested amendment in description)