Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 19 January 2022

TB2022.09

Title:	**Board Assurance and Corporate Risk Register Mid-year review**

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

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

Executive Summary

1. The paper provides the Board with the Board Assurance Framework and Corporate Risk Register for 2021/22.
2. In addition, it provides assurance to the Board that:
   - the Board Assurance Framework has been routinely updated to reflect the changes in the CRR as discussed and accepted by the Risk Committee during the year. A copy of the BAF is provided as Appendix 1 to this report.
   - the Corporate Risk Register has been updated following the Risk Committee on 25 November 2021, all new risks added to the corporate risk register have been added in red text to the risk register. The Corporate Risk Register (CRR) summary for the current year has been provided as Appendix 2 of this report. A full copy of the Corporate Risk Register was circulated with the papers for reference.
   - This paper provides a summary of the assurance gained through the introduction of the Risk Committee, in the year to date. In addition, it provides an outline of the actions planned or currently in progress to the end of this financial year.

Recommendations

3. The Trust Board is asked to:
   - Review and discuss the report.

Board Assurance and Corporate Risk Register Mid-year review

1. Purpose

1.1. This paper provides the Board with the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) at 25 November 2021, when last reviewed by the Risk Committee.

1.2. This report has been compiled as a look back over the first six months of the year to provide the Board with assurance on the key processes in place during that period. In addition, it provides assurance on planned actions for the remainder of the financial year. Note the report has been written against the backdrop of the current Covid pandemic and the operational challenges that has placed on the organisation.

2. Board Assurance Framework

2.1. The Board Assurance Framework has been routinely updated to reflect the changes in the CRR as discussed and accepted by the Risk Committee during the year. A copy of the current Risk Committee approved BAF is provided as Appendix 1 to this report.

2.2. The Board is asked to note the following key elements of assurance in relation to the BAF:

- The Risk Committee formation, in 2021, has provided additional dedicated focus, at Executives and Divisional Director level, on the Divisional and Corporate risk registers. There is a rolling programme of themed risk reviews that links to the Trust's strategy and the BAF.
- The Risk Committee has a standing agenda item that facilitates the escalation of risk to the CRR and further on to the BAF and this has led to more routine updates of the BAF.
- The Assurance Strategy was reviewed and in the light of the covid pandemic only minor amendments were made in year. A more extensive update to this strategy is planned, to link with the planned change to the electronic risk register platform, as set out in the CRR section overleaf.
- The Audit Committee has a rolling programme of assurance deep dives to cover each aspect of the BAF during the year. The first theme reviewed was in relation to the Digital by Default. The next theme will be in relation to # One Team, One OUH in conjunction with the Chief People Officer.

2.3. The Integrated Assurance Committee was informed, at its last meeting, about the intension to conduct a review of assurance definitions, used as

part of the BAF, following the change in internal audit providers. An update on this will be reported to the Audit Committee in February.

3. Corporate Risk Register and Risk Management

3.1. Like the BAF, the CRR is updated following review and discussion at the Risk Committee during the year. A summary of the current Corporate Risk Register is provided as Appendix 2 of the report, for information.

3.2. The Board is asked to note the following key elements of assurance in relation to the CRR and risk management processes:

- The Risk Management Strategy and Policy were both reviewed and minor amendments made, in line with the Assurance Strategy. Further updates will be made because of the changes to the electronic risk register platform.
- Ulysses risk module development, this project has been set up and the risk and assurance team are currently working on the design and build of the new risk register package. This will lead to improvements in functionality and consistency of the risk registers and additional opportunities to undertake training and risk awareness sessions, using the change in system as the catalyst.
- As part of the Trust's recognition of the need for improvement leadership training risk master classes were added to the Clinical Directors training sessions. These sessions were held in December 2021 and has led to further follow-up actions being taken forward.
- Risk themes discussed by the Risk Committee in the year to date:
  - Capital prioritisation, covering estates compliance, medical equipment, major and minor building works, and digital infrastructure.
  - Operational performance with a focus on urgent care.
  - As noted in the BAF section the next risk theme is in relation to workforce on the One Team One OUT theme.
- The performance review process has been further embedded into Trust processes, with the commencement of the corporate performance reviews and triangulation of this with the Trust's objectives and clear link to the risk registers.
- The Director of Regulatory Compliance and Assurance has actively noted the specific risk discussions at Trust Management Executive and Integrated Assurance Committee during the year. With each meeting's discussion explicitly linked directly to the CRR on a live basis. This is captured and reflected in the CRR summary (see Appendix 2). This acts

as a live validation of the content of the CRR. This will be an area of focus for the next Risk Committee meeting on 27th January 2022.

3.3. The Trust's Internal auditors have recently undertaken a risk maturity review, to validate the Chief Assurance Officer's assessment of risk processes. This review will be used to enhance the current actions already being taken to address the consistency of the risk registers at divisional level.

3.4. Aspects of the CRR are in the process of being updated but have not yet been presented to the Risk Committee. The People of Communications Group have reviewed the #One Team One OUH risks in preparation for the next Risk Committee. In addition, the Finance Directorate are reviewing the supporting risk registers that feed into the CRR and revisions are due to be presented for consideration at the next Risk Committee meeting.

4. Recommendations

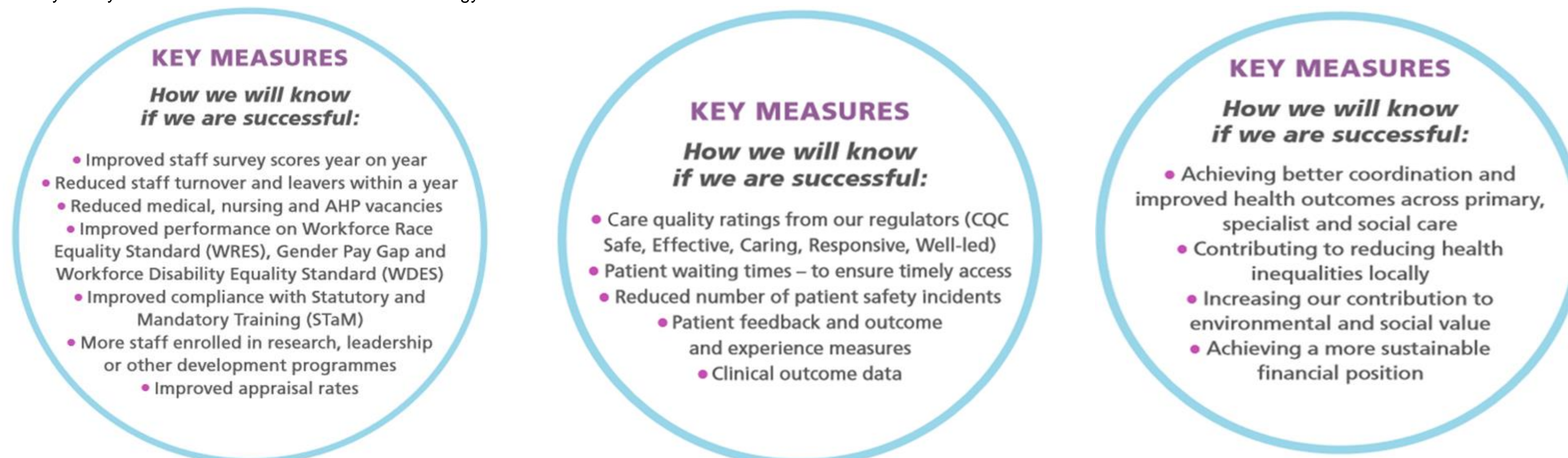
4.1. The Trust Board is asked to:

- Review and discuss the report.

Our Board Assurance Framework has been complied with the Trust's overarching strategy at its heart

STRATEGIC OBJECTIVES	OUR OBJECTIVES
OUR PEOPLE We will make OUH a great place to work by delivering the best staff experience and wellbeing for all **Our People**, supported by a sustainable workforce model and a compassionate culture.	• **Improving staff experience and wellbeing**: Enabling healthy lives; Including and valuing everyone; Keeping our staff • **Supporting everyone to achieve their potential:** Supporting personal and professional development; Identifying and managing our talent; Supporting great teams • **Building a sustainable workforce**: Fit for future workforce model; Attracting the right people with the right skills; Releasing time to care
OUR PATIENTS We will improve the access, quality and experience of care for all of **Our Patients.**	• **Delivering high quality care**: Delivering outstanding patient centred care; Building a culture of clinical effectiveness and improvement • **Continuously improving patient safety**: Ensuring a safety culture; Ensuring safe staffing and environment • **Working with patients to improve their health, care and experience**: Working with patients to manage their health and wellbeing; Increasing Patient and Public Involvement
OUR POPULATIONS We will work with partners to improve the health and wellbeing of **Our Populations**, working collaboratively to deliver integrated and sustainable services.	• **Providing integrated care, close to home:** Transforming outpatients; working with primary care, community services, BOB ICS; Developing regional and national networks and impact • **Improving the health and wellbeing of the communities we serve and reducing our environmental impact**: Prevention and public health; Reducing health inequalities; Reducing environmental impact • **Delivering sustainable services:** Making the best use of our financial resources to ensure sustainability across the system; Designing and delivering services at the right level

Summary of key measures for success noted in our strategy are:



The delivery of our strategic ambitions are supported by specific delivery plans, these plans have / will be used to form the basis on the Board Assurance Framework, as it is the delivery of these plans overtime that should enable us to provide assurance that we are moving towards achieving the strategic ambitions. As such the detailed content of the Board Assurance Framework have been mapped against the supporting Strategic Themes that act as the enablers to delivery of the strategic objectives. Note updates have been added in red text.

<table>
<tr><td>Strategic theme:</td><td>Close to home</td><td colspan="7">We will work with GP and community healthcare partners to transform outpatient services, modernise the Horton General Hospital and support out of hospital care, close to home by working in a more integrated way across acute, primary and community settings.</td></tr>
<tr><td rowspan="2">Existing Risks:</td><td rowspan="2">Controls</td><td rowspan="2">Performance Indicators</td><td rowspan="2">Assurance Reported
(summary of reports across the theme NB excludes reports across all themes)</td><td colspan="4">Risk score</td><td rowspan="2">Assurance assessment</td></tr>
<tr><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td rowspan="3">Failure to care for patients across providers the right place at the right time
(linked to the development of the Trust's Clinical Strategy)</td><td rowspan="3">• Monitoring of performance and access targets covering DTOCs, ED and patient experience
• Monitoring of HART team service developments
• Physician in ED (Additional Support) to reduce admissions and signpost to primary care support where necessary
• Increase the number of care hours delivered beyond 110,000 threshold
• Complete the integration of supported discharge
• Partnership working (Quality Priority) Implementation and monitoring of quality priority 2: safe discharge and priority 4: stakeholder engagement and partnership working
• Accountable care working principles
• BOB work streams to address DTOC and flow issues
• Urgent care improvement plan
  ○ NHS 111 First project
  ○ Home First across Oxfordshire (measured via reablement team pick-ups)
• Weekly monitoring programme of 4 hour wait and urgent care
• Emergency Planning across the system
• Covid Operational Measures Dashboard
• Population Health within Cerner will help to give increased visibility and joined up care
• Procurement and rollout of Cerner population health functionality will improve the Trust's capability to deliver integrated care records within the region. Discussions ongoing within the ICS and the broader region on joined up data for care and secondary purposes.
• Identify opportunities for supporting the sustainability of primary care
• Improvement of GP engagement channels
• Implementation and delivery of Care 24/7 project and monitoring of action plans.
• Bi-weekly liaison meetings
• Integrated Quality Improvement Programme (Outpatients)
  ○ Patient Initiated Follow-ups (PIFU)
  ○ Attend Anywhere blended clinics
  ○ Remote Blood Testing
  ○ Outpatient Improvement Steering Group</td><td rowspan="3">• No. of patients medically fit for discharge
• No. of patients with delayed transfer of care
• Home first metrics monitoring</td><td>(note assurance level mapping under review)</td><td>6</td><td>6</td><td></td><td></td><td>Current assessment: Partial</td></tr>
<tr><td>Commentary covering gaps in control / assurance
(from analysis of reporting across the theme)</td><td colspan="4" rowspan="2">Assurance assessment future actions:
• Ensure that Integrated Improvement Plan reports are noted for assurance against these risks
• Review of assurance from current clinical networks (ensure these are recorded in the Accreditation and Regulation Database
Note BDO assurance on:
• Outpatient Management (21/22)
• ICS & partnership governance (planned 22/23)</td><td rowspan="2">Previous assessment: (for previous Qtr) Partial</td></tr>
<tr><td rowspan="3">Assurance is gained on these risks from those reports that cut across all themes for example on the IPR has noted the collaborative working across the ICS. In addition, the digital innovations introduced because of Covid have been reported through the covid update reports.

Note reporting on the Integrated Improvement Plan during 21/22l provides additional level 1 and level 2 assurance.

The emerging area in relation to ICS governance that was highlighted because of the previous analysis is now reflected in the BDO Audit Plan for 22/23.

(note current high risk issue: HART contract changes and potential impact ED performance and patient flow – this is being tracked via discussions at TME – assurance via TME minutes)</td></tr>
<tr><td rowspan="2">Ability to develop internal trust quality improvements and to influence system-wide quality improvement</td><td rowspan="2">• Quality Improvement events and tools in place at OUH and other providers
• Forums to promote quality improvement across the system in place
• System wide GIRFT review program in development
• Improvement and Finance team input to support dissemination of QI initiatives including GIRFT expected
• Development of tools to promote QI in new OUH reporting system (Ulysses)
• Integrated Quality Improvement Programme – Quality Improvement and Safety Programme.
  ○ Quality Service Improvement and Redesign (QSIR) methodology to be embedded in OUH and introduced across BOB
  ○ QI integration – QI stand-ups and QI hub
  ○ GIRFT / 7 Day Services processes developed</td><td rowspan="2">• Quality metrics in IPR
• Patient experience information
• Screening information</td><td>8</td><td>8</td><td></td><td></td><td>Current assessment: Partial</td></tr>
<tr><td colspan="4">Note BDO assurance on:
• GIRFT (planned 22/23)</td><td>Previous assessment: Partial</td></tr>
</table>

<table>
<tr><th>Strategic theme:</th><th>Digital by Default</th><th colspan="7">We will use digital services to transform our services and the way we work, improving population health, patient outcomes and experience and by making things easier for staff. We will secure our digital salutation to industry standards to ensure the information we hold can be safely accessed, form anywhere and that data is protected by the strongest cyber security and information governance controls.</th></tr>
<tr><th rowspan="2">Existing Risks:</th><th rowspan="2">Controls</th><th rowspan="2">Performance Indicators</th><th rowspan="2">Assurance Reported
(summary of reports across the theme NB excludes reports across all themes)</th><th colspan="4">Risk score</th><th rowspan="2">Assurance assessment</th></tr>
<tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td rowspan="2">Trust-wide loss of IT infrastructure and systems from Cyber attack</td><td rowspan="2">• Cyber security task force – use of the DSP Toolkit
• Delivery of improvement plan following NHS Digital review of IT services
• To reach the cyber essentials accreditation
• Major incident plan
• Templar Associates review completed. Action plan developed and progress underway.
• PACS workstation replacement programme, IM&T replacement programme.</td><td rowspan="2">• DSP toolkit results
• Information governance training compliance
• IT service desk performance
• Cyber status (viruses blocked, SPAM blocked etc.)
• FOI numbers and response
• Data security breach numbers
• Subject access request numbers</td><td rowspan="2">Detailed assurance map presented to Audit Committee: summary of existence of controls noted the following:
• Cyber security - 79% controls verified at TME level
• Results endorsement (using the IT system to improve this activity) - 67% controls verified at TME level
• The current hybrid paper and digital approach to patient record -76% controls verified at TME level
• IT / digital infrastructure resilience - 50% controls verified at TME level</td><td>12</td><td>12</td><td></td><td></td><td>Current assessment: Moderate</td></tr>
<tr><td colspan="4">Note BDO assurance on:
• Cyber Security (planned 21/22)
• DSP Toolkit (planned 21/22)</td><td>Previous assessment: (for previous Qtr) Moderate</td></tr>
<tr><td rowspan="2">Potential risk of failing to respond to the results of diagnostic tests
(linked to delivery of improved outcomes for our patients)</td><td rowspan="2">• Result Endorsement levels are reported to clinical governance monthly by divisions
• Performance managed in exec performance reviews quarterly
• OCCG Quality review process
• Reporting – by user level for quality purposes.
• Integrated Quality Improvement Programme (Outpatients)
  ○ Ophthalmology Single Point of Access and transfer of images
• Digital Diagnostics Capability Programme</td><td rowspan="2">• % results endorsement within 7 days</td><td>Commentary covering gaps in control / assurance
(from analysis of reporting across the theme)</td><td>9</td><td>9</td><td></td><td></td><td>Current assessment: Moderate</td></tr>
<tr><td rowspan="3">The Internal Audit plan 21/22 included audits on: Cyber Security and the DSP Toolkit. It was acknowledged at TME that the reporting from the Digital Oversight Committee to TME will provide an opportunity for improved assurance / visibility on digital programmes of work.

Note reporting on the Integrated Improvement Plan during 21/22 will provide additional level 1 and level 2 assurance.

Potential areas for further assurance need to consider Digital Plan. There is a need to consider some of the larger platforms / areas of work: ESR / EPR) it would be useful to consider how the data quality work will cover these larger platforms and performance information, perhaps to include the development of clinical governance information.

(note deep dive into this strategic theme undertaken and presented to Audit Committee in October 2021 – see summary above)

(note area of focus Maternity EPR procurement linked to MIS year 4 requirements and CQC inspection report actions, reported via Clinical Governance Committee and TME)</td><td colspan="4">Assurance assessment future actions:
• Discuss potential areas identified with DW</td><td>Previous assessment: Moderate</td></tr>
<tr><td rowspan="2">Patients harmed because of difficulty finding information across two different systems (Paper and digital) HIMSS Level 7 implementation op risks:
• Ability to prioritise Trust resource and purchases for COVID 19 recovery
• Difficulty recruiting digital staff and service providers</td><td rowspan="2">• Incident reporting metrics
• Reporting against digitised processes
• Paper light working across whole Trust
• Medical and Nursing documentation implementation
Mitigation and contingency: -
• A process to identify and remediate the root cause (scan and remove old paper)
• Faster migration to 100% digital solutions from present paper processes to new digital solutions
• CDW 2.0 case (if approved and implemented) the programme will deliver a detailed data baseline to support quality improvement
• Integrated Quality Improvement Programme (Outpatients)
  ○ Admin and Digital Integration (Admin Review) process map project</td><td rowspan="2">• Digital KPIs (reported in IPR)</td><td>6</td><td>6</td><td></td><td></td><td>Current assessment: Moderate</td></tr>
<tr><td colspan="4">Note BDO assurance on:
• IT processes (planned 22/23)
• IT change management (planned 23/24)</td><td>Previous assessment: Moderate</td></tr>
</table>

Strategic theme:	Getting the basics right	We will focus on getting the basics right across our estates, resources and key processes to support us in achieving our strategic objectives.						
Existing Risks:	**Controls**	**Performance Indicators**	**Assurance Reported (summary of reports across the theme NB excludes reports across all themes)**	**Risk score Q1**	**Q2**	**Q3**	**Q4**	**Assurance assessment**
Improving key processes: Operational Performance: • New clinical standards for ED waiting times could pose a new risk to the organisation's performance / distract staff • Clinical prioritisation to the waiting list could lead to patients waiting longer than they would have hoped and could have the potential to cause harm to patients • Lack of capacity to meet the demand for patients waiting 52 weeks or longer • Ability to achieve the 85% of patients treated within 62 days of cancer diagnose across all tumour sites	• Develop metrics to measure and report on LoS, 111 performance and impact and short stay patient co-hort • Ongoing implementation of urgent care plan • Acute Care Collaborative across Thames Valley • Daily review of A&E breaches by Deputy Director for Urgent Care • Hourly monitoring of number of patients checked into A&E • Site capacity meeting x 4 times a day • OPEL Escalation triggers in place in ED, EAU and SEU • Daily & weekly stranded patient reviews with system colleagues • Urgent Care Improvement plan in place with 8 key priorities • Divisional performance meetings • Urgent care system wide group and improvement plan • Monthly A&E Delivery Board monitoring performance– Urgent care Improvement Plan • Emergency Standards (explicit responsibilities to admit, new comms and at a glance') • Note 'Emergency Village' concept being considered • Develop metrics to measure compliance with clinical prioritisation process • Prioritise elective waiting lists and wider recovery ○ Actions to clinically risk assess and prioritise patients' access to the available capacity, plans to increase capacity in collaboration with system partners • Patient Deferment policy • BOB challenged specialty task and finish groups in place • Divisions developing plans for recovering day to day clinical activities within the parameters of revised modelling for ongoing COVID-19 cases and the availability of staff, Personal Protective Equipment (PPE), medicines and estates. • New ways of working are being pursued with consideration to the safety and quality of services and improvements to operational performance. • Use of the Independent Sector to increase capacity in some services and explore pathway management options within the BOB ICS • Link to development of the trust's clinical strategy • Theatre productivity monitoring could create additional capacity to meet 52ww demands, if better more visible data / information is generated and used.	Patient waiting times information (in IPR) • 18 week incomplete (target 92%) • % diagnostic waits 6 weeks / more (target 1%) • RTT over 52 weeks (target 0) • ED performance (target 95%) • Cancer targets (in IPR) • 2 week urgent cancer wait (target 93%) • 31 day diagnostic to treatment (target 96%) • 62 day diagnostic to treatment (target 85%) • Length of stay (LOS over 21 days) • Waiting list size over time • Elective cancellations and 28 day readmission rates	(note assurance level mapping under review) **Commentary covering gaps in control / assurance (from analysis of reporting across the theme)** Note this commentary provides a summary across the whole theme. This is the strongest theme in terms of volume and breadth of coverage, as would be expected. Strong assurance is gained in relation to financial reporting, operational performance reporting and clinical governance reporting. Note specific audits included in the Internal audit plan have been profiled against the risks, as they have been grouped, the majority of the potential areas for consideration have been included in the Internal Audit plans over the next 3 years. The following areas are still to be considered. • Patient safety culture (note this could be linked to the divisional governance review included in the BDO Audit plan) • Development of performance information reporting Assurance assessment future actions: • Ensure that the additional areas identified are considered with the relevant Executive Director • Understand the process for the completion of actions following the Financial Governance review	20 Note BDO assurance on: • Clinical Validation of waiting lists (21/22) • Data Quality (all three years) • Patient Flow (planned 22/23)	20			Current assessment: Significant Significant

Improving key processes: Financial Performance:
• Failure to deliver the in-year break even financial plan and NHSI Financial Control total plan (risk score 16)
• Inability to sustain break-even duty over 3-5 years (risk score 12)
	• Business planning process aligns: activity, workforce and finances
	• Centralisation of controls of over discretionary spending
	• Performance management of Divisions and Directorates not on track.
	• Management of capital and working capital
	• Contingency against underperformance
	• In-year reforecasting process and mitigation plans
	• Budget setting policy
	• Develop a set of responses to financial governance arrangements/review recommendations
	• Right sizing planning projects to improve workforce planning
	• Increase capacity to deliver major change projects
	• Commercial ventures to cross subsidise NHS care.
	• Develop and deliver long term financial recovery plan, that links to wider ICS and BOB
	• Development of Master Plans for all sites
		• Budget v actual (in IPR) subjective analysis by:
		  ○ Income
		  ○ Pay & Non-pay
		  ○ Covid
		  ○ R&D
		• Spend analysis against NHSE/I guidance
		• By division (in month and year to date)
		• Income by source
		• Run rate by month
		  ○ Pay and temporary staffing
		• Cash flow
		• Capital expenditure
			Reported to the Board / IAC
			• Financial Reports
			• IPR Reports
			Reported elsewhere:
			• Reports to Audit Committee
			• Audit Committee Reports to Board
			
			Note the Finance Directorate have undertaken and extensive review of the current risks and have substantially reviewed and updated these risks – to be taken back to the Risk Committee in January 2022 (so this subject to some revision)
				16
				
				Note BDO assurance on:
				• Financial systems (planned all 3 years)
				• Budgetary Control (planned 22/23)
				• Procurement (planned 23/24)
				• Payroll controls (21/22)
					16			Current assessment: Significant
								
								Previous assessment: Significant

Strategic theme:	Getting the basics right	We will focus on getting the basics right across our estates, resources and key processes to support us in achieving our strategic objectives.						
Existing Risks:	**Controls**	**Performance Indicators**	**Assurance Reported (summary of reports across the theme NB excludes reports across all themes)**	**Risk score Q1**	**Q2**	**Q3**	**Q4**	**Assurance assessment**
	• Planning around draft scenarios – charitable donations, national bidding, commercial profits, and asset disposal options • Price Weighted Activity Plan (across ICS) • ICS development of process to monitor delivery of elective activity against Elective Recovery Fund (ERF) (against weighted activity thresholds)	• Statement of Financial Position (SOFP)						
Quality governance: • Unable to deliver Quality Priorities due to competing demands between on staff time (Risk score 8) • Aspects of medicines management were identified as an area that required improvement during the reviews across all divisions (risk score 9) • Potential harm to patients via never events through staff not following policies (LocSSIPS) (Risk score 4) • Potential harm to patients, staff, and the public from nosocomial COVID-19 exposure (Risk score 6)	• Quality Priorities – some carried forward from 20/21, as amended due to Covid • QIA • Improvement Programme • Development of local metrics to monitor achievement of local quality goals, included in Board Reports • Local weekly checks on medicine storage. • Trust-wide and Divisional action plans monthly monitoring via CGC. • Reported at Audit Committee KPMG audits. • Medication on electronic ordering and invoicing low risk and high bulk items on NHS Supply chain, • Safe storage of medicine reviews by pharmacy • Medicines Safety Group • Project manager appointed in Pharmacy • Dissemination of new LocSSIPS and communications to raise awareness • SSIP developing single LocSSIPS for 85% all interventions • LocSSIP auditing performed by Divisions • WHO checklist compliance monitoring • Incident reporting policy	**Patient Experience measures:** • Friends and Family Test results • Inpatient survey results • VTE performance % • Outpatient DNA rates • Patient safety improvements (safety huddles, WHO checklist compliance, LocSSIPs development, Investigation turnaround times, learning across divisions) **Clinical effectiveness:** • GIRFT information **Patient Outcome measures:** • HSMI / SHMI • Medicine reconciliation rates • MRSA / MSSA / CDiff rates • Theatre utilisation rates (target elective 80%, emergency 70%)	**Reported to the Board / IAC** • Learning from Deaths • Patient Perspective: • Infection Prevention and Control Plan • National Inpatient Survey • Adults and Children's Safeguarding Annual Report; • Patient Experience, PALS and Complaints Annual Report; • Quality Account Reports **Reported Elsewhere** • Paterson Inquiry Gap Analysis; • Annual Report on Tissue Viability; IAC • Clinical Governance Committee Six Monthly Report IAC • Cervical Screening Annual Report; IAC	9 Note BDO assurance on: • Infection Prevention and Control (21/22) • Medicine Management (planned 23/24) • Consent (planned 23/24) • Technology Appraisal Group (21/22) Further action to consider how the divisional governance review in the BDO plan could cover clinical governance.	9			Current assessment: Significant Previous assessment: Significant
Capital Strategy / Planning: • The Trust Master Plan from 2017 – 2047 may not be developed to point of delivery (6) • Ability to develop and use premises and major equipment (estates and facilities (16) • Major capital projects have the potential to impact on service delivery (9)	• Head of Architecture & Capital • Space Allocation/ Management Policy • Capital Programme. • 5 Year Capital Plan to align with Master Plan • Prepare a plan of sites for investment/ acquisition and disposal • Agree prioritisation of sites and capital funding, including investment in infrastructure, IT and medical equipment • Revised procedure in place for the management of capital projects from business case to delivery. • Non-capital solution: Development of the Trust Financing Policy. • Investment Policy and Capital Procedures Policy • Masterplan in place which addresses any lack of clarity • QIA of projects	• Capital spend • Capital expenditure • Statement of Financial Position (SOFP)	**Reported to the Board** • Capital Control Limit Reports • Investment Committee Reports **Reported Elsewhere** • Validity of Going Concern • External Audit Progress Report, • Investment Committee activity Note subject to review at performance review meetings and Risk Committee as consistent theme.	16 Note BDO assurance on: • Capital Projects (planned 23/24)	16			Current assessment: Significant Previous assessment: Significant
Estates Compliance: • Risk to patient and staff from smoke ingress from potential fires due to poor fabric of the building / fire alarm systems in certain sites (15) • Risk of loss of electrical power across JR and NOC	• Staff training for fire marshal role and for fire incident co-ordinator role • Stat & Man training on fire (2 yearly review period) • Fire Drills and testing of operation of drills • Proactive monitoring of high risk areas by H&S team and Fire Manager • Monthly check of local areas in known high risk areas (by trained fire marshal) • Annual Fire Safety Audit of area by local manager • JR PFI controls: Children's Hospital carpark closed. Fire patrols in place hourly and 24/7 to provide increased surveillance of potential hazards	• Statutory & Mandatory training rates (target 85%) • Health and safety reporting in IPR	**Reported to the Board** • Emergency Preparedness Annual Report, • Estates Compliance Reports • Health and Safety Annual Report **Reported Elsewhere** • Estates Compliance Update Reports • H&S Committee reporting • Estates Compliance Group reporting • Additional assurance provided by external AE reviews and reports	15 Note BDO assurance on: • PFI Contract Management (21/22) • Security Management (21/22)	15			Current assessment: Significant Previous assessment:

Strategic theme:	Getting the basics right	We will focus on getting the basics right across our estates, resources and key processes to support us in achieving our strategic objectives.						
Existing Risks:	**Controls**	**Performance Indicators**	**Assurance Reported (summary of reports across the theme NB excludes reports across all themes)**	**Risk score Q1**	**Q2**	**Q3**	**Q4**	**Assurance assessment**
sites may lead to loss of clinical services. (12) • Risk of potential slips, trips and falls due to poor fabric of the Estate in old parts of the Churchill (12) • Risk to patients and staff due to poor repair to ventilation systems in certain areas (6) • Risk of self-harm if an individual were to climb over the existing balustrade (JR WW stairs) (5)	• Churchill PFI controls: regular fire patrols in place 24/7 to provide increased surveillance of potential hazards, design team appointed progressing, OFRS on automatic call out upon receipt of call. • Local service continuity assessments in place and business continuity plans in place. • Uninterrupted power supplies in higher risk areas such as theatres. • Reliance on generators (tested off line) (PFI generators tested overnight) • Clinical equipment has battery backup and tested regularly batteries are replaced in line with manufacturers recommendations • Relevant actions to mitigate risk of slips in local areas owned by local managers. • Replacement of areas of damaged flooring as a result of water damage. • Churchill PFI: collection receptacles above ceilings in place to avoid ingress into patient areas (no reported incidents) • Annual testing and Air monitoring • Close monitoring regular testing of legionella • Normal pump to a tank and fed off a tank normally get 4-6 hours of water supply, in time for a mobile tanker to arrive • Business Continuity Plans • Regular recorded building fabric inspections take place. • Staff understand MH patients level of need and take additional mitigations, where necessary. • Initial assessment of cladding undertaken with view to develop any potential rectification plan • Technical inspection carried out by Gleeds Surveyors confirmed compliance. (WW stair)		Note further action: estates compliance assurance to be further mapped to ensure this is more visible to the organisation and the Board Note subject review at performance review meetings and Risk Committee as consistent theme Note subject to element of review by HSE, verbal feedback only provides positive assurance.	• Estates Compliance (21/22) • Fire Safety and H&S (21/22) • H&S (planned 22/23)				

Strategic theme:	One Team One OUH	We will take forwards the ambition of the national NHS People Plan to ensure an inclusive, compassionate and positive culture that engages and inspires all of our people and creates the right environment to deliver high quality patient care as OneTeam One OUH.						
Existing Risks:	**Controls**	**Performance Indicators**	**Assurance Reported (summary of reports across the theme NB excludes reports across all themes)**	**Risk score Q1**	**Q2**	**Q3**	**Q4**	**Assurance assessment**
Right staff resources linked to recruitment, retention, and attendance: • Having the right staff in the right place at the right (risk score 16) • Ability to attract, deliver and retain the workforce (risk score 16) • Low retention of non-medical workforce in some professions and clinical areas 'hot spots' leading to ongoing recruitment challenges (8) • Increase in absence due to mental health related issues linked to Covid (TBC) • Staff staffing levels (risk score 8) • Excessive use of temporary nursing staff pose a risk to the	• Engagement and retention strategy and plan • Develop rolling programme targeted interventions to address key areas of risk • Substantive staff work additional hours on NHSP Intrapartum toolkit in use to measure acuity of workload on a 4 hourly basis • Monitoring of sickness and occupational health input when appropriate • Birth Rate + used to monitor acuity of patients against staff levels • Twice daily monitoring of safe staffing levels on all sites and staff moved to mitigate clinical risk, shift by shift. • Weekly monitoring of all temporary staff including medical locums and nursing • Use of recognised framework agencies in line with NHS England's directive. • Local induction of agency staff • Vacancy levels monitored monthly by Divisions • Review of trust plans against national People Plan • Staff well-being actions in place	• Vacancy rates • Staff sickness rates (rolling 12 months) (Covid related absence rates) • Staff turnover rates • Whole time equivalent numbers (bank, agency)	The Risk Committee on 25 November agreed that this strategic theme would be the next risk theme for discussion at the next Risk Committee in January 2022. An outline assurance map is being compiled to assist with this discussion Note the People and Communications Group have undertaken and extensive review of the current risks and have substantially reviewed and updated these risks – to be taken back to the Risk Committee in January 2022 (so this theme is subject to extensive revision)	16 Note BDO assurance on: • Consultant Job Planning (planned 22/23) • Equality & Diversity (planned 22/23) • Recruitment (planned 22/23) • Retention (planned 23/24)	16			Current assessment: Significant Previous assessment: Significant

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Existing Risks:	**Controls**	**Performance Indicators**	**Assurance Reported** **(summary of reports across the theme NB excludes reports across all themes)**	**Risk score**				**Assurance assessment**
				Q1	**Q2**	**Q3**	**Q4**	
quality of service delivered and lead to increased workforce costs (risk score 6) • Employee relations (TBC) • The use of fixed term contracts for large numbers of A&C staff could create uncertainty (risk score 9)	• Growing stronger together programme • Review of trust plans against national People Plan • Workforce planning and right sizing in divisions • Improved strategic workforce planning • Culture and Leadership Delivery Plan							
Training and Development: • Insufficient provision of appropriate education and learning development opportunities (risk score12) • Failure to achieve targets for Appraisals means an assessment of competency is not completed (risk score 12)	• Note update from action log IAC: Totara Director of Culture and Leadership with responsibility for Training and develop the appraisal process and policy. A new policy in about to enter consultation. • Project lead for the LMS upgrade (Totara). • Totara project and communications provided. • New HR infrastructure • The StatMan Policy and processes have been reviewed and about to enter consultation. • Cross Divisional Working group formed to review funding and budgeting process with an emphasis on how the Trust can better allocate training resources to meet identified skills deficiencies. • Culture and Leadership Delivery Plan • (note linked to Annual Plan objective A; support health and well-being)	• Statutory & Mandatory training rates (target 85%) • Non-medical appraisal rates (target 90%) • Staff survey results	**Commentary covering gaps in control / assurance (from analysis of reporting across the theme)**	12	12			Current assessment: Moderate
			The current reporting provides a good level of assurance across a number of workforce themes. It was noted that there has been a deep dive on the Culture and Leadership Delivery Plan at a Board Seminar in May 2021. Areas that could be considered for further assurance are as follows: • Actions taken following the staff survey results to consider staff well-being and staff engagement • Workforce planning and the 'right sizing' reviews Note the following was highlighted as potential future subjects for the Internal audit plan: • Statutory & mandatory training (linked to My Learning hub implementation) – competency assessment • Succession planning and talent management. To be further discussed with the relevant Executive Director	Note BDO assurance on: • Cultural Maturity (planned 23/24)				Previous assessment: Moderate

Strategic theme:	World Class Impact	We will focus on building on the unique research, education and innovation partnerships the Oxford offers by strengthening our research culture, education partnerships and driving improvement through innovation.						
Existing Risks:	**Controls**	**Performance Indicators**	**Assurance Reported (summary of reports)**	**Risk score**				**Assurance assessment**
				Q1	**Q2**	**Q3**	**Q4**	
Failure to develop robust plans to support the Trust's Joint Strategy with Universities, including clarity on the clinical strategy *(linked to driving innovation)*	• Identify issues on which skills, expertise and resources of local universities have potential to make an invaluable contribution to effective and innovative solutions • Address issues which are a result of the interface between the Trust and the University of Oxford • Transformation Programme underpinned by research • OUH Director of R&D, working as Director of the Oxford Academic Health Partners. This group, comprising OUH and OH as well and UO and OB universities, is working to identify key result areas where co working will deliver benefits for the Trust(s) • UO-OUH Data and IP working group (DIP) established. Joint working across Governance, Value and Infrastructure work streams will propose a new basis for data and IP transactions to support realisation of clinical, research, commercial and other benefits within and across OUH and UO • OUH Digital and Oxford NIHR BRC closely engaged, developing BRC4 bid documentation that outlines data infrastructure (and corresponding benefits) delivered so far, as well as setting out the	• To be considered	(note assurance level mapping under review)	6	6			Current assessment: Partial
				Note BDO assurance on: • Research governance (planned 23/24)				Previous assessment: Partial
			Commentary covering gaps in control / assurance (from analysis of reporting across the theme)					
			Assurance is gained on this theme from reports that cut across all themes and from reports covering R&D and innovations introduced during Covid including those noted in relation to the digital innovations introduced as a result of Covid have been reported through the covid update reports.					

Strategic theme:	World Class Impact	We will focus on building on the unique research, education and innovation partnerships the Oxford offers by strengthening our research culture, education partnerships and driving improvement through innovation.						
Existing Risks:	**Controls**	**Performance Indicators**	**Assurance Reported (summary of reports)**	**Risk score**				**Assurance assessment**
				Q1	**Q2**	**Q3**	**Q4**	
	vision for shared capability to support future translational research and development. • Work underway with UO data science and medical science researchers to develop simple and advanced research scenarios / use cases, which may be used to support and test future policy making. This work is taking place through the UO-OUH DIP		Additional assurance to be reported to TME on digital innovations developed via The Hill, note the reporting of this will come via the Digital Oversight Committee to TME during 21/22.					
If the trust is not able to increase the portfolio of research activity to pre covid levels the is a risk to reputation/finance	• Regular research approvals group set up • Vaccine and UPH studies ongoing • Regular reports to TME • BRC application in process • Monitoring at JEG and SPB	TBC		TBC				Current Assessment Partial
				Note BDO assurance on: • Research governance (planned 23/24)				Previous assessment (not assessed as new in 21/22)
New approach to research in relation to CRF; Covid-19 controlled human challenge model presents additional risks to the Trust	• Clear link to current trust governance processes • MOU in progress • CQC registration status (now confirmed as covered as a satellite site under OUH registration) • CNST status (confirmed)	• NHIR Bid KPIs • Clinical Governance Reporting via Specialist Services		9	9			Current Assessment Partial
				See comment above				Previous assessment (not assessed as new in 21/22)

Risk score: The risk score shown is the score assessed for the end of the quarter taken from the detailed scores as included in the Corporate Risk Register. Where more than one risk is listed in the Assurance Framework the score shown will be the highest risk score from the individual risks listed. (Note individual current risk scores are shown in brackets after each risk listed, where these are combined)
Reported to Board: This will record the report name and paper reference number as included in the Board agenda, together with the month in which the report was presented to the Board (reports include public and private board reports recorded in the BAF)
Reported Elsewhere: This will record the report name and paper reference number as included in the board sub-committee agenda, together with the date in which the report was presented. (Note TME reported are not currently included as part of the BAF, this is currently being reviewed)
Assurance assessments: This is based on an overview of the items listed as Assurance Reported and will be reviewed and updated by the Director of Regulatory Compliance and Assurance on a quarterly basis. The assurance assessment definitions in the grid below will be used as a guide to inform the overview.

Assurance assessment definitions:

Assurance view	Outline descriptor
No / Limited	The report highlights weaknesses in the design or operation of controls that might have a significant impact on the delivery of the strategic objectives. **Limited** assurance can be given on the system to prevent risks from impacting on the achievement of the strategic objectives. Assurance indicates low effectiveness of controls. **Or** The volume of reporting and assurance levels of those reports do not enable a meaningful assurance view to be gained
Partial	The report highlighted some weaknesses in the design or operation of controls that might have an impact on the delivery of the some of the strategic objectives. **Partial** assurance can be given on the system to prevent risks from impacting on the achievement of the strategic objectives. **Or** The volume of reporting and assurance levels of those reports enables only a partial level assurance view to be gained.
Moderate	The report did not highlight any weaknesses in the design or operation of controls that would in overall terms impact on the delivery of the strategic objectives. However some control weaknesses that might impact on certain objectives were identified. **Moderate** assurance can be given on the system to prevent risks from impacting on the achievement of the strategic objectives. Some assurance in place or still maturing so the effectiveness cannot be fully assessed but is likely to improve. **Or** The volume of reporting and assurance levels of those reports enables a fuller assurance view to be gained.
Significant	The report did not highlight any weaknesses in the design or operation of controls that would in overall terms impact on the delivery of the strategic objectives. Some low impact control weaknesses were identified and if addressed would improve overall performance. **Significant** assurance can be given on the system to prevent risks from impacting on the achievement of the strategic objectives. High level of assurance can be provided over the effectiveness of controls **Or** The volume of reporting and assurance levels of those reports enables a meaningful assurance view to be gained and provides an evidence base to support a significant assurance view.

Note Yellow highlight notes the risks that formed part of the meeting discussion, as noted 'live' in the meeting by the Director of Regulatory Compliance and Assurance.

TME May	IAC June	TME 10 June	TME 1 July	TME 15 July	IAC 11 Aug	TME 12 Aug	TME 26 Aug	TME 9 Sep	TME 30 Sept	TME 7 Oct	IAC Oct	TME 11 Nov	TME 25 Nov	IAC Dec	TME 9 Dec				21/22	21/22	
Risk ID	Risk ID	Risk ID	Risk ID	Risk ID	Risk ID	Risk ID	Risk ID	Risk ID	Risk ID	Risk ID	Risk ID	Risk ID	Risk ID	Risk ID	Risk ID	Risk Lead	Summary Risk Description	Proximity	Q1	Q2	Updated target 21/22
																	Close to Home				
C1	C1	C1	C1	C1	C1	C1	C1	C1	C1	C1	C1	C1	C1	C1	C1	DW	Failure to care for patients correctly across providers at the right place and the right time.	3-6 months	9	9	6
C3	C3	C3	C2	C2	C2	C2	C2	C2	C2	C2	C2	C2	C2	C2	C2	MP	Ability to develop internal trust quality improvements and to influence system-wide quality improvement	3-6 months	9	9	6
																	Digital by Default				
D1	D1	D1	D1	D1	D1	D1	D1	D1	D1	D1	D1	D1	D1	D1	D1	DW	Trust-wide loss of IT infrastructure and systems (e.g. from Cyber attack, loss of service etc)	12 months	12	12	3
D2	D2	D2	D2	D2	D2	D2	D2	D2	D2	D2	D2	D2	D2	D2	D2	MP	Potential risk of failing to respond to the results of diagnostic tests	Immediate	9	9	4
D4	D4	D4	D4	D4	D4	D4	D4	D4	D4	D4	D4	D4	D4	D4	D4	DW	Patient harmed because of diffculty finding information across two systems (paper and digital)	Immediate	6	6	3
					D5	D5	D5	D5	D5	D5	D5	D5	D5	D5	D5	DW	Failure to provide clinical digital services, including virtual desktop and pharmacy stock control	new		20	8
																	Getting the Basics Right				
G6	G6	G6	G6	G6	G6	G6	G6	G6	G6	G6	G6	G6	G6	G6	G6	JD	Failure to deliver the in-year break even financial plan and NHSI Financial Control total plan	In 3 months	16	16	8
G7	G7	G7	G7	G7	G7	G7	G7	G7	G7	G7	G7	G7	G7	G7	G7	JD	Inability to deliver sustainable break-even duty over 3-5 years	12 months	12	12	4
G9	G9	G9	G9	G9	G9	G9	G9	G9	G9	G9	G9	G9	G9	G9	G9	MP	Unable to deliver the Quality Priorities due to competing demands between on staff time	3-6 months	8	8	4
G11	G11	G11	G11	G11	G11	G11	G11	G11	G11	G11	G11	G11	G11	G11	G11	MP	Aspects of Medicine Management identified as needing improvement	Immediate	9	9	3
G12	G12	G12	G12	G12	G12	G12	G12	G12	G12	G12	G12	G12	G12	G12	G12	MP	Potential harm to patients via never events through staff not following policies (LocSSIPS)	Immediate	4	4	2
ReCo5	ReCo5	ReCo5	ReCo5	ReCo5	ReCo5	ReCo5	ReCo5	ReCo5	ReCo5	ReCo5	ReCo5	ReCo5	ReCo5	ReCo5	ReCo5	MP	Potential harm to patients, staff and the public from nosocomial COVID-19 exposure.	Immediate	6	6	3
G14	G14	G14	G14	G14	G14	G14	G14	G14	G14	G14	G14	G14	G14	G14	G14	SF	The Trust Master Plan from 2017 – 2047 may not be developed to point of delivery	12 months	6	6	3
G16	G16	G16	G16	G16	G16	G16	G16	G16	G16	G16	G16	G16	G16	G16	G16	SF	Ability to develop and use premises and major equipment (estates and facilities) sufficiently to support service capacity requirements, linked to Covid recovery	12 months	16	16	2
G17	G17	G17	G17	G17	G17	G17	G17	G17	G17	G17	G17	G17	G17	G17	G17	SF	Risk to patient and staff safety as a result of smoke ingress from potential fires due to poor fabric of the building in certain sites	Immediate	15	15	10
G19	G19	G19	G19	G19	G19	G19	G19	G19	G19	G19	G19	G19	G19	G19	G19	SF	Risk of loss of electrical power across JR and NOC sites resulting in potential of major loss of clinical services.	3-6 months	12	12	8
G20	G20	G20	G20	G20	G20	G20	G20	G20	G20	G20	G20	G20	G20	G20	G20	SF	Risk of potential slips, trips and falls and to staff and visitors due to poor fabric of the Estate in old parts of the Churchill	3-6 months	12	12	4
G21	G21	G21	G21	G21	G21	G21	G21	G21	G21	G21	G21	G21	G21	G21	G21	SF	Risk to patient and staff safety as a result of poor repair to ventilation systems in certain areas	Immediate	8	8	4
G24	G24	G24	G24	G24	G24	G24	G24	G24	G24	G24	G24	G24	G24	G24	G24	SF	JR WW stairwell - risk of self harm if an individual were to climb over the existing balustrade/glazing	Immediate	10	10	5
ReCo3	ReCo3	ReCo3	ReCo3	ReCo3	ReCo3	ReCo3	ReCo3	ReCo3	ReCo3	ReCo3	ReCo3	ReCo3	ReCo3	ReCo3	ReCo3	TR	Potential for issues with the ability to maintain safe staffing levels during recovery	In 3 months	8	8	8
G29	G29	G29	G29	G29	G29	G29	G29	G29	G29	G29	G29	G29	G29	G29	G29	SR	New clinical standards for ED waiting times could pose a new risk to the organisation's performance / distract staff	new	12	12	9
G30	G30	G30	G30	G30	G30	G30	G30	G30	G30	G30	G30	G30	G30	G30	G30	SR	Clinical prioritisation to the waiting list could lead to patients waiting longer than they would have hoped and could have the potential to cause harm to pa	new	15	15	6
G31	G31	G31	G31	G31	G31	G31	G31	G31	G31	G31	G31	G31	G31	G31	G31	SR	Lack of capacity to meet the demand for patients waiting 52 weeks or longer	new	12	12	9
G32	G32	G32	G32	G32	G32	G32	G32	G32	G32	G32	G32	G32	G32	G32	G32	SR	Ability to achieve the 85% of patients treated within 62 days of cancer diagnosis across all tumour sites	new	12	12	6
G33	G33	G33	G33	G33	G33	G33	G33	G33	G33	G33	G33	G33	G33	G33	G33	SR	The use of fixed term contracts for large numbers of A&C staff could create uncertainty and lead to potential issues in the control environment	new	9	9	3
G34	G34	G34	G34	G34	G34	G34	G34	G34	G34	G34	G34	G34	G34	G34	G34	SF	Major capital projects have the potential to impact on service delivery	new	9	9	3
					G35	G35	G35	G35	G35	G35	G35	G35	G35	G35	G35	SR	Business Continuity Plans may not be effective	new		16	12
							G36	G36	G36	G36	G36	G36	G36	G36	G36	SR	If Lab A fails then this would lead to the inability to perform Emergency PCI work	new		15	12
													G38			MP	Poor controls over the administration of medical air as opposed to oxygen, leading to potential patient safety issue	new		tbc	
																	One Team One OUH				
O1	O1	O1	O1	O1	O1	O1	O1	O1	O1	O1	O1	O1	O1	O1	O1	SF	Excessive use of agency staff may pose a risk to the quality of service delivered	In 3 months	6	6	2
O2	O2	O2	O2	O2	O2	O2	O2	O2	O2	O2	O2	O2	O2	O2	O2	TR	Failure to achieve targets for Appraisals and Statutory/Mandatory Training (NB inc Information Governance linked to DSP toolkit).	Immediate	12	12	6
O3	O3	O3	O3	O3	O3	O3	O3	O3	O3	O3	O3	O3	O3	O3	O3	TR	Ability to recruit, retain and engage staff to work together to deliver compassionate excellence and fulfil their potential	Immediate	16	16	8
O6	O6	O6	O6	O6	O6	O6	O6	O6	O6	O6	O6	O6	O6	O6	O6	TR	Insufficient provision of appropriate education and learning development opportunities	3-6 months	12	12	3
O7	O7	O7	O7	O7	O7	O7	O7	O7	O7	O7	O7	O7	O7	O7	O7	TR	Low retention of non-medical workforce in some professions and clinical areas (hot spots) leading to ongoing recruitment challenges	Immediate	12	12	8
O8	O8	O8	O8	O8	O8	O8	O8	O8	O8	O8	O8	O8	O8	O8	O8	TR	Increase in absence due to mental health related issues linked to Covid	new	TBC		TBC
O9	O9	O9	O9	O9	O9	O9	O9	O9	O9	O9	O9	O9	O9	O9	O9	TR	Employee relations (risk description to be developed)	new	TBC		TBC
O10	O10	O10	O10	O10	O10	O10	O10	O10	O10	O10	O10	O10	O10	O10	O10	TR	Having the right staff in the right place at the right time (to include organisational development and the workforce strategy and workforce planning	new	16	16	TBC
													O11	O11		TR	National change in mandatory vaccination for NHS staff may lead to loss of staff in front line roles.	new		tbc	
																	World Class Impact				
W1	W1	W1	W1	W1	W1	W1	W1	W1	W1	W1	W1	W1	W1	W1	W1	DW	Failure to develop robust plans to support the Trust's Joint Strategy with Universities, including clarity on the clinical strategy	12 months	6	6	6
W2	W2	W2	W2	W2	W2	W2	W2	W2	W2	W2	W2	W2	W2	W2	W2	MP	If the trust is not able to increase the portfolio of research activity (and innovation activity) to pre covid levels the is a risk to reputation/finance	new	TBC		TBC
W3	W3	W3	W3	W3	W3	W3	W3	W3	W3	W3	W3	W3	W3	W3	W3	JD	New approach to research in relation to CRF; Covid-19 controlled human challenge model presents additional risks to the Trust	new	9	9	6