Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 13 July 2022

TB2022.063

Title:	**Board Assurance and Corporate Risk Register review**

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

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

Executive Summary

1. The paper provides the Trust Board with the Board Assurance Framework and Corporate Risk Register for 2022/23.
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 this has been updated to reflect the discussions at the last Risk Committee on 13 May 2022. 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 13 May 2022, 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.
    - It should be noted that the CRR has been updated since it was presented to the Risk Committee because of the successful transfer of all trust risk registers to the Ulysses Risk Management platform and due to improvements in the process in relation to the description of risks.

Recommendations

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

Board Assurance and Corporate Risk Register review

1. Purpose

1.1. This paper provides the Committee with the Board Assurance Framework (BAF) and Corporate Risk Register (CRR), when last reviewed by the Risk Committee, subject to some further updates as described below.

2. Board Assurance Framework

2.1. The Board Assurance Framework is routinely updated to reflect the changes in the CRR as discussed and accepted by the Risk Committee during the year.

2.2. It was proposed at the last Risk Committee that the BAF should be routinely reported to the Risk Committee at every meeting alongside the CRR. This will commence from the next meeting in July 2022.

2.3. A copy of the current BAF is provided as Appendix 1 to this report. Note any updates from the version as presented to the IAC in June are reflected in this document in red text. This version will now be updated to reflect the updates to the CRR following this meeting.

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.

3.2. To provide a wider update on risk management, the Board is asked to note that the draft Risk Management Policy has been circulated for trust-wide consultation and will be presented to the Risk Committee on 14th July. The Policy has been extensively revised and includes an updated more consistent method of describing risks. As a result of this change the CRR risk descriptions have been re-written, this version is included as Appendix 2 for information.

3.3. This change in methodology is being introduced to coincide with new training and the change in the risk register system, from HealthAssure to Ulysses. This transition was successfully completed on Monday 4th July and initial immediate training has been provided to Clinical Governance Risk Practitioners to enable them to view and add risks.

3.4. As reported to the last Integrated Assurance Committee work is currently in progress to assess the residual risk held across the Trust in relation to the development of the Capital Programme. The results of the first review into equipment risks are due to be reported to the Risk Committee on 14th July.

3.5. The last meeting of Integrated Assurance Committee noted the following emerging risks:

- Staff retention, turnover, and the emerging cost of living issues: it was noted that these issues link to pay drivers and the working environment, as raised by recent staff listening events: These issues are included within the detailed Corporate Risk Register.
- Cost of living risks associated with supplier contracts; it was noted that there was an expectation of increases in associated costs while noting that many costs are controlled within existing contracts. This issue will be retained as a watching brief before being added to the CRR.
- The negotiation structure for the ICS within the context of funding and budget setting process for the current year was noted as an emerging risk. This will be considered as part of the current financial risks.

4. Recommendations

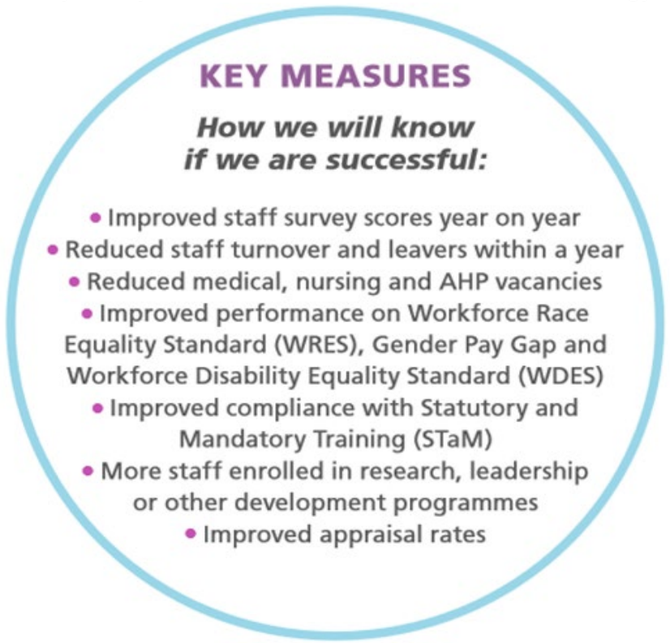
4.1. The Trust Board is asked to:

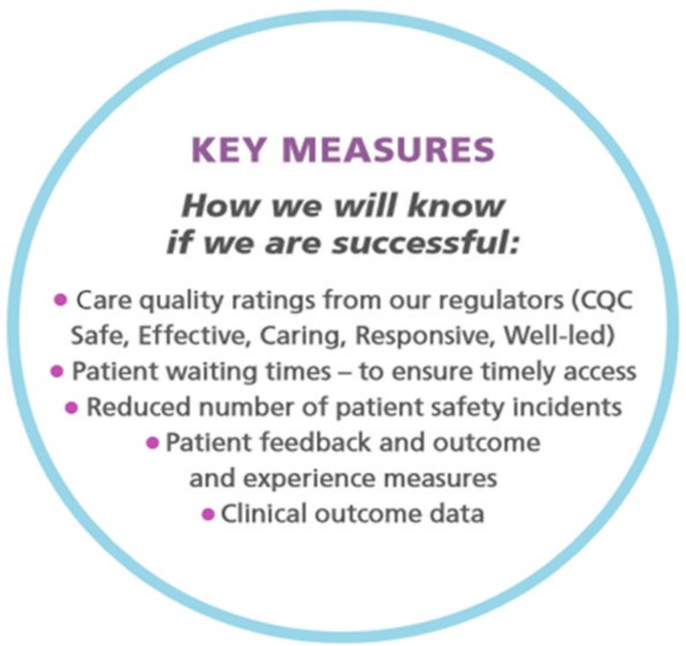
- Review and note the report.

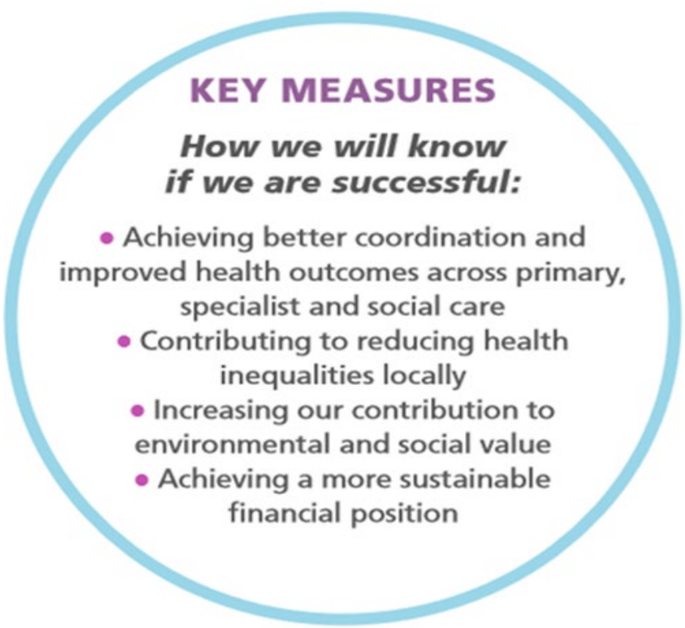
Our Board Assurance Framework has been complied with the Trust's overarching strategy at its heart

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.	updated to reflect final agreed 22/23 objectives • building a sustainable workforce and improving staff experience • developing our teams and organisational capability
OUR PATIENTS We will improve the access, quality and experience of care for all of **Our Patients.**	updated to reflect final agreed 22/23 objectives • delivering quality improvement projects • transforming the patient/staff experience
OUR POPULATIONS We will work with partners to improve the health and wellbeing of **Our Populations**, working collaboratively to deliver integrated and sustainable services.	updated to reflect final agreed 22/23 objectives • improving access for planned elective care • improving access for cancer care

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.

Strategic theme:	**Close to home**	**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.**					
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**

Failure to care for patients across providers the right place at the right time *(linked to the development of the Trust's Clinical Strategy)*	• Monitoring of performance and access targets covering DTOCs, ED and patient experience
	• Monitoring of HART team service developments – note this has since progressed / contract ceased and change in service
	• 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 – note ongoing development of Urgent Care Provider Collaborative with Oxford Health (to track during 22/23)
	• 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
		• No. of patients medically fit for discharge
		• No. of patients with delayed transfer of care
		• Home first metrics monitoring
			Covered via monthly reporting as part of IPR
			Urgent and Emergency Care Presentation to IAC Oct 2021.
			Ageing Well Background to IAC Oct 2021.
			Note Digital Plan Population Management commenced during 2021/22 will progress into 22/23
			Commentary covering gaps in control / assurance (from analysis of reporting across the theme)
			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 21/22 provides additional level 1 and level 2 assurance.
			
			Note an emerging area in relation to ICS governance that was highlighted because this was originally reflected in the BDO Audit Plan for 22/23 but has been removed from current outline 3-year plan (note could be subject to further consideration as the provider collaboratives develop – suggest that 2022/23 is too early).
			
			(Note previous high-risk issue: HART contract changes and potential impact on ED performance and patient flow – this is being tracked via discussions at TME – assurance via TME minutes, note this risk is reducing with changes in new CARE team)
			• Direct Award Procurement
				9				Assurance assessment future actions:
								• Ensure that Integrated Improvement Plan reports are noted for assurance against these risks
								• Review of assurance from current clinical networks (these are recorded in the Accreditation and Regulation Database)
								
								Note BDO assurance on:
								• Outpatient Management (21/22)
									Previous assessment: (for previous Qtr) Moderate

Inability to develop internal trust quality improvements and to influence system-wide quality improvement	• 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
	• Development of tools to promote QI in new OUH reporting system (Ulysses)
	• Adoption and delivery of a Trust Quality Priority to embed QI methodology more widely in the Trust
	• 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
	• Integrated Quality Improvement team supporting QI Hub and GIRFT Programme
	• Appointment of Quality Improvement & Innovation Fellows to support QI work.
		• Quality metrics in IPR
		• Patient experience information
		• Screening information
				8				Note BDO assurance on:
								• GIRFT (planned 22/23)
									Previous assessment: Partial

Strategic theme:	**Digital by Default**	**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.**						
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**	
Trust-wide loss of IT infrastructure and systems from Cyber attack	• 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.	• 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	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 Note revised date in external review of IG DSP Toolkit submission now due 30 June 2022 Note high risk recorded on CRR in relation to digital resilience and potential failure to provide critical systems (noted as red risk Score 20 – also linked to high risk in relation to business continuity planning)	12				Previous assessment: (for previous Qtr) Moderate
				Note BDO assurance on: • Cyber Security (planned 21/22; note still draft) • DSP Toolkit (note subject to annual review: current result significant/ moderate))				
Potential risk of failing to respond to the results of diagnostic tests *(linked to delivery of improved outcomes for our patients)*	• Result Endorsement levels are reported to clinical governance monthly by divisions • Performance managed in exec performance reviews quarterly • OCCG Quality review process (note expect new process via ICS) • 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	• % results endorsement within 7 days	**Commentary covering gaps in control / assurance (from analysis of reporting across the theme)** 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: Improvements to the reporting to TME expected in 2022/23, as discussed at the Risk Committee) Note reporting on the Integrated Improvement Plan during 21/22 provided 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: noted now included in capital programme)	9				Previous assessment: Moderate
				Assurance assessment future actions: • Discuss potential areas identified with DW				
Patients harmed because of difficulty finding information across two different systems (Paper and digital) Note failure to provide clinical digital services (inc virtual desktop / pharmacy stock control) (note risk score 20) HIMSS Level 7 implementation op risks: • Ability to prioritise Trust resource and purchases for COVID 19 recovery • Difficulty recruiting digital staff and service providers	• 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	• Digital KPIs (reported in IPR)		20				Previous assessment: Moderate
					Note BDO assurance on: • IT processes (planned 22/23) • IT change management (planned 23/24)			

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**				**Assurance assessment**
				Q1	**Q2**	**Q3**	**Q4**	
Improving key processes: Operational Performance: • New clinical standards for ED waiting times could pose a risk to the organisation's performance / distract staff • Ability to achieve expected delivery levels in line with elective recovery plan could lead to potential harm for patients • Lack of capacity to meet the elective care delivery plan for patients waiting 104 weeks and then to reduce 78 weeks • Ability to reduce the current backlog of patients waiting for cancer diagnosis and treatment might cause patient harm (note narrative refreshed following meeting with the Director of Operations – signed off by Chief Operating Officer)	• 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 (in development) • 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 operational plans in line with current planning expectations (where possible to meet 22/23 contract expectations) • 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 subject to review to reflect revised metrics)	Operational priorities to Board Jan 2021 IPR reported monthly Divisional Performance review meetings (note highest score recorded in table)	16				Previous assessment: Substantial
			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 (to be linked to planned review of BAF in 22/23 audit plan)					
			Note BDO assurance on: • Clinical Validation of waiting lists (21/22) note reported to Audit Committee as Moderate Assurance Oct 2021 • Data Quality (all three years) • Patient Flow (planned 22/23)					

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
	• 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
	• Planning around draft scenarios – charitable donations, national bidding, commercial profits, and asset disposal options
	• Price Weighted Activity Plan (across ICS)
		• 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
		• Statement of Financial Position (SOFP)
			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 reviewed and updated these risks
			
			Note highest risk score recorded on table reflects change in year and anticipated increase in risk score as a result – due to current level of uncertainty in financial outturn position in current planning submissions)
				16				Previous assessment: Substantial

			Note BDO assurance on: • Financial systems (note current results significant/ moderate) (planned all 3 years) • Payroll controls (21/22)					

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**				**Assurance assessment**
				Q1	**Q2**	**Q3**	**Q4**	
	• ICS development of process to monitor delivery of elective activity against Elective Recovery Fund (ERF) (against weighted activity thresholds)							
Quality governance: • Inability 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 9)	• Quality Priorities agreed for 2022/23 with stakeholder input, focussing on priority areas • Quality Impact Assessment (QIA Policy updated) • Support from the Integrated Quality Improvement Programme for specific projects • 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. • 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 • Implementation of national Infection Prevention & Control (IPC) guidance • Regular communication of IPC guidance to staff via email, intranet and staff briefings, including any changes to guidance • Up to date information on Trust intranet, including Frequently Asked Questions • Root cause analysis of nosocomial COVID-19 cases to identify learning • Extension of COVID-19 testing for patients and staff in line with national guidance • Clear messages provided to all staff who do not pass a fit check that they should not undertake a high-risk procedure or work in a high-risk clinical area • The Trust has made available a wide range of information to staff, including videos, on the appropriate processes for fit checking. • Regular checks of PPE equipment by staff • Appropriate multi-disciplinary management of delirious or aggressive patients with COVID-19 to minimise the risk of transmission.	**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				Previous assessment: Substantial Note BDO assurance on: • Infection Prevention and Control (21/22) (reported to Audit Committee Oct 2021 Moderate Assurance) • 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.
Capital Strategy / Planning: • Lack of sufficient capital funding to cover all major capital schemes, means that certain services are delivered in poorer estate for a longer period • Significant backlog maintenance program, means that certain areas of the estate may be likely to breakdown this might lead to poor estates compliance • Lack of sufficient capital funding to cover all the	• 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 Programme updates • 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. PFI themed performance review provided assurance (note PFI risk register under development)	12				Previous assessment: Substantial Note BDO assurance on: • Capital Projects (planned 23/24)

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**		**Q1 / Q4**	**Assurance assessment**
Trust's equipment needs, means that certain services are more likely to experience some equipment breakdowns that might impact on service delivery					
Estates Compliance: (Note risks as at y/e – full review in progress to align to 2 facet survey and backlog maintenance results) – note revised largest risk Electrical infrastructure • 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 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)	• 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 • 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)	• 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 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.	15 Note BDO assurance on: • PFI Contract Management (21/22) • Security Management (21/22) • Estates Compliance (21/22) • H&S (planned 22/23) Note Estates Compliance Audit expected to be reported to Audit Committee April 22 • PFI Contract Management • Estates Compliance (noted as draft) • Technologies Advisory Group See comments re capital risk, this is also under review to link to results of 2 facet survey Note extensive update to Supporting PFI risk Register also in progress (fully corporate performance review)	Previous assessment: Substantial

	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				
Existing Risks:	**Controls**	**Performance Indicators**		**Q1 / Q4**	**Assurance assessment**
Right staff resources linked to recruitment, retention, and attendance:	• Engagement and retention strategy and plan • Develop rolling programme targeted interventions to address key areas of risk	• Vacancy rates • Staff sickness rates (rolling 12 months)	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 March 2022.	16 Note BDO assurance on:	Previous assessment:

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**				**Assurance assessment**
				Q1	**Q2**	**Q3**	**Q4**	
• Note current highest risk staff absence (sickness rates) • Note training and development and talent management risks have now included in the People and Communications Risk Register and managed via the People and Communications Committee reporting higher scored risks into Risk Committee	• 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 • 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 • Director of Culture and Leadership with responsibility for Training and develop the appraisal process and policy. • Project lead for the LMS upgrade (Totara). Totara project and communications provided. • HR infrastructure changes in place • Core Training Policy in place • Culture and Leadership Delivery Plan	(Covid related absence rates) • Staff turnover rates • Whole time equivalent numbers (bank, agency) • Statutory & Mandatory training rates (target 85%) • Non-medical appraisal rates (target 90%) • Staff survey results	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 March 2022 (so this theme is subject to extensive revision) Note additional risk: Vaccination as Condition of Deployment (this risk has been tracked via TME and into Risk committee and has now reduced to be monitored via People and Communications Committee) 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	• Consultant Job Planning (planned 22/23) • Equality & Diversity (planned 22/23) • Recruitment (planned 22/23) • Retention (planned 23/24)				Substantial
			Commentary covering gaps in control / assurance (from analysis of reporting across the theme)	Not in CRR				
			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. 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.	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. • OUH Digital and Oxford NIHR BRC closely engaged, developing BRC4 bid documentation that outlines data infrastructure 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	• To be considered	• CEO Report to Board • Annual R&D Report • Annual AHSN Report • Papers in relation to TRE	6				
				Note BDO assurance on: • Research governance (planned 23/24)				Previous assessment: limited
			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. 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.					
	• Regular research approvals group set up	• NHIR Bid KPIs	Assurance is gained on this theme from reports that cut across all themes and from reports covering R&D and innovations introduced	9				

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**	
Trust' involvement and engagement in research and development activities • If the trust is not able to continue the portfolio of research activity there is a risk to reputation/finance • If the approach to research in relation to CRF management is not set up in line with Trust governance processes this presents additional risks to the Trust	• Vaccine and UPH studies ongoing • BRC application in process • Monitoring at JEG and SPB • Clear link to current trust governance processes • MOU in progress • CQC registration status (confirmed as covered as a satellite site under OUH registration) • CNST status (confirmed) • CRF working group developing governance processes. • NIHR reporting	• CGC Reporting via Specialist Services	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. (Note this risk is reducing with the development of a draft MoU covering CRF arrangements)	Note BDO assurance on: • Research governance (planned 23/24)				Previous assessment: partial

BAF process summary:
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.
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	The report highlights weaknesses in the design or operation of controls that might have a significant impact on the delivery of the strategic objectives. No 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 ***BDO definition:*** *Design opinion: For all risk areas there are significant gaps in the procedures and controls. Failure to address in-year affects the quality of the organisation's overall internal control framework. Findings: Poor system of internal control.* *Effectiveness Opinion: Due to absence of effective controls and procedures, no reliance can be placed on their operation. Failure to address in-year affects the quality of the organisation's overall internal control framework. Findings: Non-compliance and/or compliance with inadequate controls.*
Limited	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. ***BDO definition:*** *Design opinion: A number of significant gaps identified in the procedures and controls in key areas. Where practical, efforts should be made to address in-year. System of internal controls is weakened with system objectives at risk of not being achieved.* *Effectiveness Opinion: A number of reoccurring exceptions found in testing of the procedures and controls. Where practical, efforts should be made to address in-year. Non-compliance with key procedures and controls places the system objectives at risk.*
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. ***BDO definition:*** *Design opinion: In the main, there are appropriate procedures and controls in place to mitigate the key risks reviewed, albeit with some that are not fully effective. Generally a sound system of internal control designed to achieve system objectives with some exceptions.* *Effectiveness Opinion: A small number of exceptions found in testing of the procedures and controls. Evidence of noncompliance with some controls that may put some of the system objectives at risk.*
Substantial	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. ***BDO definition:*** *Design opinion: Appropriate procedures and controls in place to mitigate the key risks. There is a sound system of internal control designed to achieve system objectives.* *Effectiveness Opinion: No, or only minor, exceptions found in testing of the procedures and controls. The controls that are in place are being consistently applied.*

NB: yellow highlight denotes risk discussed at the particular meeting and supported the bredth of conversation on risk across meetings overtime

TME March	IAC April	TME 14 April	TME 28 April	TME 12 May	Trust Board May	TME 26/5	TME 30/6				21/22	22/23	22/23	
Risk ID	Risk ID	Risk ID	Risk ID	Risk ID	Risk ID	Risk ID	Risk ID	Risk Lead	Summary Risk Description	Proximity	Q4	M1	Q1	Target
									Close to Home					
C1	C1	C1	C1	C1	C1	C1	C1	DW	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.	3-6 months	9	9	9	6
C3	C3	C3	C3	C3	C3	C3	C3	AS	Due to the lack of capacity and resources available for QI there is a risk to the delivery of internal trust quality improvements and to influence system-wide quality improvement effecting the learning and improvement culture across the ICS	3-6 months	9	9	9	6
									Digital by Default					
D1	D1	D1	D1	D1	D1	D1	D1	DW	As a result of IT infrastructure vulnerabilities and external factors there is a risk that the Trust may suffer from the loss of IT infrastructure and systems (e.g., from Cyber-attack, loss of services etc) this may effect operational service delivery and finances in the long term.	12 months	12	12	12	3
D2	D2	D2	D2	D2	D2	D2	D2	AS	Due to inconsistencies in the process and behaviours there is a risk that there may be a failure to respond to the results of diagnostic tests that may effect patient care	Immediate	9	9	9	4
D4	D4	D4	D4	D4	D4	D4	D4	DW	As a result of lack of knowledge of the processes, ability to find certain information and a mix of paper and IT record systems there is a risk of increased patient safety incidents that may effect patient care.	Immediate	6	6	6	3
D5	D5	D5	D5	D5	D5	D5	D5	DW	Due to the potential for power failure in level 0 there is a risk that there may be a failure to provide clinical digital services, including virtual desktop and pharmacy stock control that will effect the delivery of clinical services and core critical infrastructure	12 months	20	20	20	8
D6	D6	D6	D6	D6	D6	D6	D6	DW	The risk that the Trust is unable to provide safe patient care and the accurate reporting of NEWS2 scoring in Cerner.	Immediate	20	15	15	6
									Getting the Basics Right					
G6	G6	G6	G6	G6	G6	G6	G6	JD	As a result of inconsistent in year budget setting assumptions, targets and monitoring there is a risk that there may be a failure to deliver the in-year break even financial plan and NHSI Financial Control total plan that might effect the trust's ability to secure future captial funding and lead to increased regulatorty scrutiny	12 months	8	12	16	8
G7	G7	G7	G7	G7	G7	G7	G7	JD	As a result of growth in costs over income over time there is a risk that there may be an inability to sustain finanical break-even duty over 3-5 years this might effect the ability to invest in the longer term.	12 months	12	12	12	4
G9	G9	G9	G9	G9	G9	G9	G9	AS	Due to a lack of awareness of Trust qualities priorties and capacity within teams assigned to the priorities there is a risk that the Trust may be unable to deliver Quality Priorities effecting the achievement of specific goals and improvement outcomes for patients.	12 months	6	9	6	4
G11	G11	G11	G11	G11	G11	G11	G11	AS	If 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 effect standards are care.	Immediate	9	9	9	3
G12	G12	G12	G12	G12	G12	G12	G12	AS	Due to lack of knowledge and lack of implementation plans there is a risk that there may be potential harm to patients from never events and other serious incidents effecting peception of the Trust	Immediate	4	4	4	2
ReCo5	ReCo5	ReCo5	ReCo5	ReCo5	ReCo5	ReCo5	ReCo5	AS	If there are poor IPC practices there is a risk of potential harm to patients, staff and the public from nosocomial COVID-19 exposure that effects patient outcomes.	Immediate	6	6	8	3
tbc						G39	G39	SF	Insufficient capital funding 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 effect service delivery	12 months	new	new	12	8
tbc						G40	G40	SF	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	3-6 months	new	new	12	8
tbc						G41	G41	SF	Lack of sufficient capital funding to cover all the Trust's equipment needs means that there is a risk that certain services are more likely to experience some equipment breakdowns that might impact on service delivery	3-6 months	new	new	12	4
G17	G17	G17	G17	G17	G17	G17	G17	SF	Due to areas of poor fabric of certain buildings there is a 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 effecting certain services	Immediate	to review	to review	to review	10
G19	G19	G19	G19	G19	G19	G19	G19	SF	Due to aging power plan there is a risk of loss of electrical power across JR and NOC sites resulting in potential of major loss of clinical services.	3-6 months	to review	to review	to review	8
G20	G20	G20	G20	G20	G20	G20	G20	SF	Due to poor fabric on the buidling 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	3-6 months	to review	to review	to review	4
G21	G21	G21	G21	G21	G21	G21	G21	SF	As ventilation plant is old in some locations there is a risk to patient and staff safety that may effect regulatory compliance	Immediate	to review	to review	to review	8
G22	G22	G22	G22	G22	G22	G22	G22	SF	As a result of actions identifited 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.	3-6 months	to review	to review	to review	8
G24	G24	G24	G24	G24	G24	G24	G24	SF	Due the the height of the JR WW stairwell there is a risk of potential self harm if an individual were to climb over the existing balustrade/glazing effecting safety.	12 months	5	6	6	3
G29	G29	G29	G29	G29	G29	G29	G29	SR	Due the to introduction of new clinical standards for ED waiting times there could be a risk to the organisation's performance of the national urgent care targets effecting patient experience	In 3 months	12	12	12	9
G30	G30	G30	G30	G30	G30	G30	G30	SR	High bed occupancy and staffing capacity means there is a risk to our ability to achieve expected delivery levels in line with elective recovery plan that could lead to potential harm for patients	In 3 months	15	15	15	6
G31	G31	G31	G31	G31	G31	G31	G31	SR	Lack of capacity in beds and staffing means there is a risk to meeting the elective care delivery plan for patients waiting 104 weeks and then to reduce 78 weeks tat might effect patient outcomes and experience	In 3 months	12	9	9	9
G32	G32	G32	G32	G32	G32	G32	G32	SR	Due to issues with diagnostic capacity there is a risk to our ability to reduce the current backlog of patients waiting for cancer diagnosis and treatment might cause patient harm	In 3 months	16	16	16	6
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 there is risk that makes recruitment more difficult this could effect the delivery of services	12 months	6	6	6	3
G34	G34	G34	G34	G34	G34	G34	G34	SF	Due to 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	In 3 months	9	9	9	3
G35	G35	G35	G35	G35	G35	G35	G35	SR	Business Continuity Plans may not be effective there is a risk that if certain systems fail there may be an impact on service delivery in the short term	In 3 months	16	16	16	12
G36	G36	G36	G36	G36	G36	G36	G36	SR	If Lab A fails then there is a risk that this could lead to the inability to perform Emergency PCI work effecting patient outcomes	Immediate	15	15	15	12
G38	G38	G38	G38		G38	G38	G38	AS	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	In 3 months	9	9	9	6
						G42	G42	SR	Due to introduction of new ICS governance arrangements there is a risk to service delivery that might effect patitent outcomes	3-6 months	new	new	6	3
									One Team One OUH					
PC002	PC002	PC002	PC002	PC002	PC002	PC002	PC002	TR	As a result of the reliance on the internal bank there is a risk the we will not be able to ensure sufficient temporary staffing to sustain services and maintain the wellbeing of our own staff effecting patient safety	3 months	12	12	12	9
PC003	PC003	PC003	PC003	PC003	PC003	PC003	PC003	TR	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.	3 months	12	16	16	9
PC006	PC006	PC006	PC006	PC006	PC006	PC006	PC006	TR	Potential failure of the trust to respond to the Covid19 impact in providing a modified secure and safe working environment including adequate rest areas and equipment	6 months	12	12	12	4
PC005	PC005	PC005	PC005	PC005	PC005	PC005	PC005	TR	Due to poor workforce ocntrols there is a risk that OUH staff establishment could continue to grow and become out of line with activity and incomewhich could effect financial sustainablilty	3 months	12	12	12	4
PC001	PC001	PC001	PC001	PC001	PC001	PC001	PC001	TR	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)	3 months	12	12	12	9
PC008	PC008	PC008	PC008	PC008	PC008	PC008	PC008	TR	Due to excessive workload and lack of understanding of the process there is a risk of not achieving our VBA targets and our staff not having meaningful appraisals that celebrate their successes, identify clear objectives and development needs and discuss career goals effecting staff morale.	6 months	12	12	12	4
									World Class Impact					
W1	W1	W1	W1	W1	W1	W1	W1	DW	Due to potential relationship management issues there is a risk of failure to develop robust plans to support the Trust's Joint Strategy with Universities, including clarity on the clinical strategy that might impact the trust's reputation	12 months	6	6	6	6
W2	W2	W2	W2	W2	W2	W2	W2	AS	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 delivery of research avitivy that might effect reputation/finance	12 months	6	6	6	2
W3	W3	W3	W3	W3	W3	W3	W3	JD	As a result of the new approach to research in relation to CRF; there is a risk to the delivery of certain research acitivty (e.g. Covid-19 controlled human challenge model) this might effect other research activity and regulatory compliance	3-6 months	9	9	9	6