# Board of Directors - Public

| SUMMARY REPORT | Meeting Date: | 22 May 2024 |
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| | Agenda Item: | 21 |

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| **Report Title:** | **Corporate Risk Register Report** | |
| **Author(s):** | Amber Wild, Head of Corporate Assurance | |
| **Accountable Director:** | Deborah Lawrenson, Director of Corporate Governance. | |
| **Other meetings this paper has been presented to or previously agreed at:** | **Committee/Tier 2 Group/Tier 3 Group** | Risk Oversight Group (RoG)<br>Executive Management Team (EMT)<br>People Committee (PC)<br>Quality Assurance Committee (QAC)<br>Finance and Performance Committee (FPC) |
| | **Date:** | 30 April 2024 (RoG)<br>2 May 2024 (EMT)<br>7 May 2024 (PC)<br>9 May 2024 (QAC)<br>9 May 2024 (FPC<br>16 May 2042 (ARC) |
| **Key points/ recommendations from those meetings** | Summary analysis of the risks on the Corporate Risk register (CRR) monitored by the Board Assurance Committees with Ulysses extract appended to the report. | |

**Summary of key points in report**

There are currently 15 risks on the corporate risk register.
This report provides a summary analysis of the risks currently on the corporate risk register assigned for oversight to the Board Assurance Committees with key items drawn to the attention of the Audit and Risk committee below via an Alert, Advise, Assure.

Details of the movement on these risks and all other risks can be found in the table in section 3 of this report.

**Alert**

**Finance and Performance Committee (FPC):**

**Risk 5051**: *There is a risk of failure to deliver the required level of savings for 2024/25. This includes reducing overspending areas through recovery plans* **(Risk score 16)**

- A new risk has been created relating to Value Improvement plans (VIP) for 2024-25.
- The new risk description is highlighted in blue text and was presented to Rog at its meeting on 30 April 2024.
- The risk score has been reduced from 20 to 16 given progress made with development of the Value Improvement plans and this has been agreed by the Executive lead.
- New actions have been added.

**FPC has approved the new risk description and scoring.**

**Advise**

**Audit and Risk Committee (ARC):**

There are no corporate risks for monitoring at Audit and Risk Committee. Two risks have been deescalated form the register since last report to ARC in January 2024:

- Risk 5070, relating to the storage of documents at President Park has been deescalated to be managed on the directorate register (risk score 9)
- Risk 4612 relating to the risk that system and data security will be compromised caused by IT systems continuing to be run on software components that are no longer supported has been deescalated to the be managed on the directorate register. (risk score 9)

**The committee noted the updates provided.**

**People Committee (PC):**

There are currently no risks on the Corporate Risk register (CRR) monitored by People Committee. There is one risk pending escalation, which has been agreed by the Executive lead and will be escalated following agreement and finalisation of the actions:

PENDING ESCALATION - **Risk 5321** *There is a risk that we are unable to meet mandatory training compliance levels caused by a lack of suitable training space for delivery of training; insufficient trainer capacity, and difficulties in staff release resulting in targets and CQC requirements not being met*. (Risk score 12).

- Work is in progress around rota management which would mitigate mandatory training staff release issues and this will be reflected in the risk.
- The Estates action is being updated following confirmation from Associate Director of Estates
- The risk has been reviewed by the Executive Director of Nursing, Professions and Quality and the risk was discussed in People Committee.

**PC have requested that further work takes place to clarify the risk in terms of clinical capacity and to reflect the work ongoing to review mandatory training requirements.**

**Quality Assurance Committee QAC):**

**Risk 4756**: *Demand for the ADHD pathway greatly outweighs the resource and capacity of the service. This is resulting in longer/lengthy wait times and high numbers of people not being screened and waiting for assessment, diagnosis and medication.* (Risk score 15) **and**

**Risk 4757** *Demand for Gender greatly outweighs the resource/capacity of the service. This is resulting in lengthy waits and high numbers of people waiting. Waiting times now further compromised by significant sickness absence in the medical team and difficulties in recruitment in other professional and admin areas* (risk score 16):

- Risk 4757 (relating to demand for the ADHD pathway) and risk 4756 (relating to demand for Gender services) will be deescalated to the directorate risk registers
- The overarching corporate risk will incorporate the response to the national challenge of waiting lists in highly specialist services, reflecting the need for a health strategy to address the demand in the city and reflecting the partnership working required.
- The risk owner has sought support from the Executive lead and the Senior Head of Service to construct a risk to reflect the national demand beyond the scope of service that sits at corporate level, and to support with the actions to mitigate this.
- Work is underway to update this on Ulysses.

**QAC noted the update provided.**

Risks 4602 and 3679 have been amalgamated to reflect the broader Ligature Anchor Point (LAP) risk in all bed- based services, as agreed by the Executive lead. The new risk description is noted in blue text

**Risk 3679**: There is a risk that service users admitted to bed-based services could ligate using fixed ligature anchor points or by using ligature items caused by not managing and removing ligature anchor points effectively resulting in service user harm. (Risk score 15)

- Actions from risk 4602 have been amalgamated into risk 3679.

- The Senior Head of Service has confirmed that ownership of the risk will sit with this role with actions from Estates and Facilities and acute services.
- The risk was discussed at RoG on 30 April 2024, where it was noted that the confirmed date for the Maple move ward will be clarified on Ulysses.
- EMT have noted the risk description and score.

**QAC have agreed the risk description and score**.

**Risk 5001 and 4001:**
These 2 risks relating to flow have been amalgamated with the following new risk description:
**Risk 5001** There is a risk to the quality and safety of patient care under the Crisis Service Line as a result of delays in accessing a mental health hospital bed. **(risk score 12)**

- RoG requested at its meeting on 30 April 2024, that further consideration be given to the wording of this risk to clarify what the cause and the consequence of the risk are.

**QAC noted the update provided.**

**NEW RISK**
**Risk 5169** There is a risk that the PROMs (Patient Reported Outcome Measures) project is either delayed or the quality negatively impacted due to dependencies on the EPR and delays to the EPR programme. EPR delays will result in the PROMs project requiring clinical teams to start using PROMs without the necessary EPR infrastructure in place or will delay roll-out and implementation of PROMs. Delays in implementation of in quality will impact statutory returns required from March 2024 **(risk score 15)**

- This risk was on the directorate risk register and was agreed for escalation to the corporate risk register by the Executive lead and confirmed at RoG on 30 April 2024.
- It has a risk score of 15, given that we are failing to report as required nationally due to the EPR delay.
- Mitigations have been identified but this risk can only be partially mitigated until EPR is in place.
- The Exec lead is the Medical Director who has confirmed the scoring at that level.
- EMT agreed the risk for onward discussion at this committee and requested that the Executive lead looks into the extent to which the delay to EPR is the cause over and above engagement across services by the team, to clarify this.
- RoG requested that the risk is shared with the interim CDIO, for information and confirmation that that this and other impacted risks from the EPR delay are picked up and reflected in the EPR risk register

**QAC approved the escalation of this risk to the corporate risk register and agreed the scoring.**

**<u>Finance and Performance Committee:</u>**

**EPR risks:**

- Governance for the EPR programme board is being reviewed and strengthened currently.
- The Executive Lead has recommended that the risk management officer attends the Programme Board to discuss EPR risks once the plan has been formulated and the revised risks are available, in May 2024.
- A risk relating to PROMs which has been escalated to the corporate risk register and which has been impacted by the EPR delay has been shared with the interim CDIO for information and confirmation that this and other impacted risks from the EPR delay are picked up and reflected in the EPR risk register**.**
- The EPR risks will be presented to the Risk Oversight Group in June**.**

**Fire safety doors related risks:**

- Two risks are on the directorate risk register relating to the doors on Endcliffe ward which have a risk score of 12 were proposed for escalation.
- The risk owner was unable to attend Risk Oversight Group as planned to discuss these risks.
- The Associate Director of Estates explained in the meeting that work is happening to address the doors on Endcliffe ward, so it is proposed that these risks remain on the directorate risk register for monitoring until the work has been completed.
- The Associate Director of Estates has confirmed that all risks relating to doors will be part of their risk

review and this will include those risks that are held in operations.
- The risk review will be taken to the Estates governance and risk group at the end of May and an update will be presented to the Risk Oversight group at its meeting in June.

**FPC noted the updates provided.**

Following the committee meeting, further actions have been taken by the Associate Director of Estates and the Director of Strategy to ensure that there are appropriately maintained fire doors throughout the estate and an update will be received at EMT on 16 May:

- An external Authorised Engineer for fire, will provide expert advice and guidance to teams and will audit policies and practice.
- An annual fire audit has been brought forward to take place in Quarter 2.
- An independent fire safety consultancy will be commissioned to undertake a condition survey of all fire doors in the owned estate which will give an expertly verified basis for prioritising the replacement and repair of fire doors.
- The internal fire safety team will verify the list of fire doors and the level of risk associated with the uses and users of each physical area, in accordance with the two-part risk assessment process described in the recently updated Part K of the Health Technical Memoranda (HTM).

An update will be presented to Risk Oversight Group and Finance and Performance Committee in June.

**Mental Health Legislation Committee:**

**Risk (5124)** There is a risk that the Trust is not compliant with s132/132A Mental Health Act (patient's rights). This is caused by ward staff not providing information about patient's rights in a timely manner, resulting in patient's rights not being fully protected. (Risk score 12).

**New risk description:** There is a risk that the Trust is not compliant with s132/132A Mental Health Act (the requirement to provide information to patients). This is caused by a lack of assurance that the legally required information is being provided to patients in a timely manner. This could result in the Trust breaching patients' rights and exposes the Trust to potential regulatory action.

- RoG noted, at the meeting in March, the request from MHLC to update the risk description to indicate the regulatory issues and were informed that actions have been updated and are on track.
- RoG noted that mitigations and controls being implemented include raising awareness and training and were assured that of the controls and mitigations in place.
- A new description has been added, as detailed above and the risk has been escalated to the corporate risk register
- The risk will be presented back to MHLC at its next meeting in June.

**Assure**

**Directorate and team registers**

- A Ulysses extraction report continues to take place monthly to monitor any new, high-scoring risks on the directorate and team registers and to ensure discussion takes place with Executive Leads to determine if these should be considered for escalation onto the CRR and reported through to RoG and EMT for agreement prior to circulation in the CRR to the assurance committees.
- An extraction report from April 2024, has highlighted no new risks.
- Of the 134 risks reported between September 2023 and March 2024, 7 risks remain which are being reviewed by risk owners with support from the Risk Management Officer.
- Updates of risks for potential escalation will continue to be brought to RoG for further confirm and challenge and will be presented to the committee as required.

**Internal Audit report:**

- The Risk Management Internal Audit report has been received with significant assurance.
- Actions have been agreed and progress on these will be monitored at Risk Oversight Group, EMT and Audit and Risk Committee.

**Violence and Aggression Risks:**

- A Violence Reduction Group meeting, co-chaired by the Deputy Director of People and the Deputy Head of Nursing is arranged for 15 May 2024
- The risks relating to violence and aggression have been added as an agenda item.

- The Head of Corporate Assurance will attend to support discussion

**Information Governance Risks**

- Digital and Facilities have jointly set up a records management working group which met on the 17 April 2024 with key stakeholders from across the organisation, from corporate areas.
- Staff from key areas will attend President Park to catalogue the current boxes to ascertain next steps for archiving, scanning or destroying.
- Following this, consideration will be given as to whether an overarching corporate risk will be required relating to records management.

**The Board is asked to note the updates provided.**

Detail on all of the risks overseen by the assurance committees is provided at summary level in section 3 of the report with full detail included in the Ulysses extract attached at **Appendix 1**.

Appendices attached:
**Appendix 1** Ulysses extract of the corporate risk register as at May 2024.

| **Recommendation for the Board/Committee to consider:** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Consider for Action** | | **Approval** | **x** | **Assurance** | **X** | **Information** | **X** |

The Board is asked to **confirm if the risks**, as outlined in the report for monitoring by the assurance committees and attached at Appendix 1 **remain the most significant and to agree any movement**; and is asked to **identify if there are additional risks** following discussion at the meeting that should be considered for review and escalation.

| **Please identify which strategic priorities will be impacted by this report:** | | | | |
|---|---|---|---|---|
| Effective Use of resources | *Yes* | ***X*** | *No* | |
| Deliver Outstanding Care | *Yes* | ***X*** | *No* | |
| Great Place to Work | *Yes* | ***X*** | *No* | |
| Ensuring our services are inclusive | *Yes* | ***X*** | *No* | |

| **Is this report relevant to compliance with any key standards ?** | | | | | **State specific standard** |
|---|---|---|---|---|---|
| **Care Quality Commission Fundamental Standards** | *Yes* | ***X*** | *No* | | Systems and processes must be established to ensure compliance with the fundamental standards |
| **Data Security and Protection Toolkit** | *Yes* | | *No* | ***X*** | |
| **Any other specific standard?** | | | | ***X*** | |

| **Have these areas been considered ? YES/NO** | | | | | If Yes, what are the implications or the impact? If no, please explain why |
|---|---|---|---|---|---|
| Service User and Carer Safety, Engagement and Experience | *Yes* | | *No* | ***X*** | See detailed risk register for relevant references. |
| Financial (revenue &capital) | *Yes* | | *No* | ***X*** | |
| Organisational Development /Workforce | *Yes* | | *No* | ***X*** | |
| Equality, Diversity & Inclusion | *Yes* | | *No* | ***X*** | |
| Legal | *Yes* | | *No* | ***X*** | |
| Environmental sustainability | *Yes* | | *No* | ***X*** | |

**Corporate Risk Register report**

# Section 1: Analysis and supporting detail

## Background

1.1 The Corporate Risk Register (CRR) is a tool for managing risks and monitoring actions and plans against them for risks that are scoring 12 and above or which have an organisation-wide impact.

1.2 Used correctly it demonstrates that an effective risk management approach is in operation within the Trust and supports identification of additional assurance reporting required.

1.3 Risks are evaluated in terms of likelihood and impact using the 5 x 5 matrix where a score of 1 is a very low likelihood or a very low impact and 5 represents a very high likelihood or significant impact. This simple matrix is used to classify risks as very low (green), low (yellow), moderate (amber) or high (red).

1.4 Scoring used is reflective of the current Risk Management Framework.

1.5 The Risk Oversight Group continues to meet monthly in advance of EMT, to undertake further confirm and challenge with risk owners to support onward reporting and recommendations to EMT and the Board Assurance Committees.

1.6 Work continues to address risks of 12 or above not yet escalated onto the Corporate Risk Register.

1.7 Training sessions continue to take place with teams and individuals, including a review of registers with a focus on scoring of risks.

## Top organisational Risks

2.1 There are **five** top overall risks, one of which is overseen by Finance and Performance Committee and three by Quality Assurance Committee as listed below:

- **Risk 5051** There is a risk of failure to deliver the required level of savings for 2024/25. This includes reducing overspending areas through recovery plans. (risk score of 16) (FPC). **This is a new version to reflect the risk for 2024-25 and the score has been reduced from 16 to 20 given progress made with development of the Value Improvement plans. This has been agreed by the Executive lead, and has been approved at FPC in May.**
- **Risk 4757** *Demand for gender identity services outweighing capacity/resources (risk score of 16) (QAC)*
- **Risk 4756** *Demand for the ADHD pathway greatly outweighs the resource and capacity of the service. This is resulting in longer/lengthy wait times and high numbers of people not being screened and waiting for assessment, diagnosis and medication (risk score of 15) (QAC)*
- **Risk 3679** *There is a risk that service users admitted to bed-based services could ligate using fixed ligature anchor points or by using ligature items caused by not managing and removing ligature anchor points effectively resulting in service user harm. (risk score of 15) (QAC)* New risk description. **This has been agreed by the Executive lead, and has been approved at QAC in May.**
- **NEW Risk 5169** There is a risk that the PROMs (Patient Reported Outcome Measures) project is either delayed or the quality negatively impacted due to dependencies on the EPR and delays to the EPR programme. EPR delays will result in the PROMs project requiring clinical teams to start using PROMs without the necessary EPR infrastructure in place or will delay roll-out and implementation of

PROMs. Delays in implementation of in quality will impact statutory returns required from March 2024 **(risk score 15). This has been escalated to the corporate risk register, and approved at QAC in May.**

**Detail on movement on risks overseen at the assurance committees** is provided in the table below:

Section3: Corporate Risk Register snapshot, including a summary of movement on risks in the previous quarter, overseen at the assurance committees as at May 2024.

**Audit and Risk Committee:**
There are no corporate risks for monitoring at Audit and Risk Committee.

Two risks have been deescalated form the register since last report to ARC in January 2024:

- **Risk 5070**, relating to the storage of documents at President Park. A date for the fitting of the gates has been confirmed for the summer and this has been deescalated to the be managed on the directorate register.

- **Risk 4612** relating to the risk that system and data security will be compromised caused by IT systems continuing to be run on software components that are no longer supported has been deescalated to the be managed on the directorate register. The risk will remain open until Rio is implemented and Insight is decommissioned along with the legacy software.

**People Committee:**
**Movement on the Corporate Risk Register for risks, in the previous quarter, overseen at People Committee, included here for information:**

There are currently no corporate risks monitored by People Committee**.**

- **Risk 4078:** *There is a risk that SHSC is not recommended as a place to work or to receive care if we do not respond effectively to the staff survey in a timely way. These risks may present as a) reputational damage, (b) devaluation of the staff survey purpose and impact (c) survey fatigue leading to low participation rates***. (Risk score 9).**
  The risk was agreed for de-escalation by the Deputy Director of People and the Executive Lead following discussion at RoG in January 2024, and agreed at PC in March 2024**.**

- **Pending escalation: Risk 5321** *There is a risk that we are unable to meet mandatory training compliance levels caused by a lack of suitable training space for delivery of training; insufficient trainer capacity, and difficulties in staff release resulting in targets and CQC requirements not being met***. (Risk score 12).**
  The risk has been reviewed by the Executive Director of Nursing, Professions and Quality and the risk will be submitted to People Committee for approval, following work to complete the risk on Ulysses

**Quality Assurance Committee**
Movement on the Corporate Risk Register for risks, in the previous quarter, overseen at Quality Assurance Committee, included here for information:

- **Risk 5043** *There is a risk that unsafe application of moving and handling practices caused by a lack of understanding and training may result in harm or injury to both staff and service user. There may also be a wider statutory or financial organisational impact if injury occurs*. (Score 9)
  This has been de-escalated from the CRR following agreement at the Quality Assurance Committee in February 2024.

- **Risk 4965** *There is a risk that the delivery of essential Physical Health Training Needs will not be delivered due to the limited resource (both capacity and skill) available within the team. This is further affected by the availability, suitability and condition of venues in which training can be delivered. This will result in staff*

*staff will not be fully skilled and competent with regards to the management of Physical Health needs*
This has been de-escalated from the CRR following agreement at the Quality Assurance Committee in February 2024.

**NEW RISK**

- **Risk 5169** There is a risk that the PROMs (Patient Reported Outcome Measures) project is either delayed or the quality negatively impacted due to dependencies on the EPR and delays to the EPR programme. EPR delays will result in the PROMs project requiring clinical teams to start using PROMs without the necessary EPR infrastructure in place or will delay roll-out and implementation of PROMs. Delays in implementation of in quality will impact statutory returns required from March 2024 **(risk score 15).**
  This risk has been escalated to the register following agreement by the Executive lead and confirmation at RoG in April 2024.

| Risk number | Description | Score (severity x likelihood) | Risk Owner | Executive Lead and Monitoring Committee | Progress update |
|---|---|---|---|---|---|
| 4757<br><br>BAF0029 | Demand for Gender greatly outweighs the resource/capacity of the service. This resulting in lengthy waits and high numbers of people waiting. Waiting times now further compromised by significant sickness absence in the medical team and difficulties in recruitment in other professional and admin areas. | 16 (4x4)<br><br>↔ | Richard Bulmer (risk owner)<br>Mark Parker (action owner) | Director of Operations and Transformation (Neil Robertson)<br><br>Quality Assurance Committee. | Reviewed on 03/04/2024. This will be deescalated to the directorate risk registers The overarching corporate risk will incorporate the response to the national challenge of waiting lists in highly specialist service and work is underway with with support from the Executive lead and the Senior Head of Service to construct a risk, and to support with the actions to mitigate this. |
| 4756<br><br>BAF0029 | Demand for the ADHD pathway greatly outweighs the resource and capacity of the service. This is resulting in longer/lengthy wait times and high numbers of people not being screened and waiting for assessment, diagnosis and medication | 15 (3x5)<br><br>↔ | Richard Bulmer (risk owner)<br>Mark Parker, Sal Foulkes (action owners) | Director of Operations and Transformation (Neil Robertson)<br><br>Quality Assurance Committee. | Reviewed on 03/04/2024. This will be deescalated to the directorate risk registers<br>The overarching corporate risk will incorporate the response to the national challenge of waiting lists in highly specialist service and work is underway with support from the Executive lead and the Senior Head |

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| | | | | | of Service to construct a risk, and to support with the actions to mitigate this |
| 3679<br><br>BAF0025A | There is a risk that service users admitted to bed-based services could ligate using fixed ligature anchor points or by using ligature items caused by not managing and removing ligature anchor points effectively resulting in service user harm. | 15 (5x3)<br>↔ | Gemma Robinson (risk owner)<br>Adele Sabin (reviewer) | Director of Operations and Transformation (Neil Robertson)<br><br>Quality Assurance Committee. | Reviewed on 29/04/24. Risks 4602 and 3679 have been amalgamated with a new risk description to reflect the broader Ligature Anchor Point (LAP) risk in all bed- based services, as agreed by the Executive lead. |
| **NEW** 5169 | There is a risk that the PROMs (Patient Reported Outcome Measures) project is either delayed or the quality negatively impacted due to dependencies on the EPR and delays to the EPR programme. EPR delays will result in the PROMs project requiring clinical teams to start using PROMs without the necessary EPR infrastructure in place or will delay roll-out and implementation of PROMs. Delays in implementation of in quality will impact statutory returns required from March 2024 | 15(3x5) | Jonathan Burleigh | Medical Director (Helen Crimlisk)<br><br>Quality Assurance Committee. | This risk was reviewed on the 30/04/24. It was on the directorate risk register and was agreed for escalation to the corporate risk register by the Executive lead and confirmed at RoG on 30 April 2024 |
| 4697<br><br>BAF0025B | There is a risk that patients safety will be impacted out of hours as a result of not having access to spare medical devices (emergency equipment and consumables) and equipment (bariatric, moving and handling or bespoke equipment), resulting in poor patient care and possible harm. | 12 (3x4)<br>↔ | Sharlene Rowan (Risk Owner and Assessor) | Executive Director of Nursing, Professions and Quality<br><br>Quality Assurance Committee. | Reviewed on 24/04/24 and the actions have been updated. |
| 5001<br><br>BAF0025B | There is a risk to the quality and safety of patient care under the Crisis Service Line as a result of delays in accessing a mental health hospital bed. | 12 (3x4)<br>↔ | Hayley Taylor (Risk Owner and Assessor) | Director of Operations and Transformation (Neil Robertson)<br><br>Quality Assurance Committee. | Risk reviewed on 09/04/24 and updated in-line with recommendations from QAC. Therea re outstanding actions for review which has been escalated to the Executive lead, for support in progressing. |
| **Finance and Performance Committee (FPC)** | | | | | |

Movement on the Corporate Risk Register for risks, in the previous quarter, overseen at FPC, included here for information:

- **Risk 4795:** *loss of knowledge and expertise within the Project and BAU Digital Team due to key staff leaving the programme leading to delays in delivery or lack of input from Trust teams*.
  The risk score 12 reduced from 16.

- **Risk 5051:** *There is a risk of failure to deliver the required level of savings for 2024/25. This includes reducing overspending areas through recovery plans***.** A new risk has been created relating to Value Improvement plans (VIP) for 2024-25.
  The risk score has been reduced from 20 to 16 given progress made with development of the Value Improvement plans, with agreement from the Executive lead.

- **Risk 5267** *There is a risk staff will lose confidence in the system if they do not receive sufficiently timely response to issues they have raised and support as required.*
  The risk has been moved to the Transformation Programme risk register on the 14/04/24.

- **Risk 4602**: *There is a risk that there are a number of Ligature Anchor Points and Blind Spots within bed-based services caused by lack of previous actions to remove or mitigate these environmental risks resulting in potential for inpatients to attempt ligation and cause themselves serious harm*.
  Risks 4602 and 3679 have been amalgamated to reflect the broader Ligature Anchor Point (LAP) risk in all bed-based services, as agreed by the Executive lead, and as approved at EMT, RoG and QAC in March 2024. Risk 4602 has been closed on the 16 April 2024, and the actions have been amalgamated into risk 3679.

| Risk number | Description | Score (severity x likelihood) | Risk Owner | Executive Lead and Monitoring Committee | Progress update |
|---|---|---|---|---|---|
| 5051<br><br>BAF0022 | There is a risk of failure to deliver the required level of savings for 2024/25. This includes reducing overspending areas through recovery plans | 16(4x4)<br>↓ | Chris Cotton (risk owner) | Executive Director of Finance (Phillip Easthope)<br><br>Finance and Performance Committee | Risk reviewed and updated on 03/04/2024. A new risk has been created relating to Value Improvement plans (VIP) for 2024-25. The risk score has been reduced from 20 to 16 given progress made with development of the Value Improvement plans. New actions have been added |
| 4795<br>BAF 0026 | There is a risk that there could be a loss of knowledge and expertise within the Project and BAU Digital Team due to key staff leaving the programme leading to delays in delivery or | (12) 4x3<br>↔ | Chris Reynolds (risk owner) | Executive Director of Finance (Phillip | Risk reviewed and updated on 03/04/2024. |

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| | lack of input from Trust teams | | | Easthope)<br><br>Finance and Performance Committee | |
| 5272<br><br>BAF 0026 | There is a risk technical issues in the build which have surfaced post implementation of the launch of the first phase of the Electronic Patient Record (Rio) are not adequately managed resulting in lack of stabilisation of the first stage prior to launch of the second phase with the result there are delays in development and security of the reporting build infrastructure putting in jeopardy ability to move forward | 12 (4x3)<br>↔ | Chris Reynolds (risk owner) | Executive Director of Finance (Phillip Easthope) | The risk was reviewed on 04/04/2024. Actions and action owners have been updated. Risk score remains unchanged. |
| 5224<br><br>BAF0026 | There is a risk that our new electronic patient record system will fail to meet the recording and reporting requirements of our clinical services. This risk must be mitigated through rigorous User Acceptance Testing. | 12(3x4)<br>↔ | Chris Reynolds (risk owner) | Executive Director of Finance (Phillip Easthope)<br><br>Finance and Performance Committee. | Reviewed on 03/04/2024 Actions have been updated. |

**Mental Health Legislation Committee**

Movement on the Risk Register for risks overseen by MHLC:

One risk has been escalated to the corporate risk register with agreement from the Mental Health Legislation Operational Group Risk register at Directorate level and with agreement from the Executive Lead.

- **Risk (5124)** *There is a risk that the Trust is not compliant with s132/132A Mental Health Act (patient's rights). This is caused by ward staff not providing information about patient's rights in a timely manner, resulting in patient's rights not being fully protected.* **Risk score (12).**
  The MHLC advised that the risk descriptor needs to indicate the regulatory issues and agreed that the risk should be considered for escalation to the Corporate Risk Register at its meeting in March. The risk was reviewed at Risk Oversight Group in March 2024 to review the risk description, controls and actions following which this risk has been escalated to the CRR and the new risk description will be presented back to MHLC at its next meeting in June**.**

| Risk number | Description | Score (severity x likelihood) | Risk Owner | Executive Lead and Monitoring Committee | Update |
|---|---|---|---|---|---|
| **4513** | There is a risk that Associate Mental Health Act Manager (AMHAM) Hearings will not be undertaken in a timely manner, | 12 (3x4)<br>↔ | Jamie Middleton | Mental Health Legislation | The risk was reviewed on 19/04/24. Risk remains |

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| | this being caused by an insufficient number of AMHAMs which the Trust currently has, resulting in possible breaches in human rights and potential statutory action against the Trust. | | | Committee | and efforts continue to increase number of AMHAMs |
| **5026** | There is a risk that patients who come under the Deprivation of Liberty Safeguards (DOLS) framework are detained on SHSC staffed premises with no legal authority in place to authorise this. This is caused by significant delays and backlogs within the Local Authority (who are responsible for conducting such assessments and authorisations). This could result in patient's legal rights being breached by the Trust, and the Trust potentially being challenged legally by a patient or their representative. | 12 (3x4) ↔ | Jamie Middleton | Mental Health Legislation Committee | The risk was reviewed on 19/04/2024. Risk remains. Ongoing work required to mitigate. Many factors remain outside of SHSC control. |
| **5047** | There is a risk that practice within the Trust is not compliant with the Mental Capacity Act. This is caused by multiple factors such as MCA mandatory training not being undertaken, current MCA training needing to be improved, and some organisational culture. This risk could result in patient's legal rights being breached, care not being delivered in accordance with a patient's previously expressed wishes, and legal challenge against the Trust. | 12 (3x4) ↔ | Jamie Middleton | Mental Health Legislation Committee | Risk reviewed on 19/04/2024. Actions updated; risk remains; no change to risk score |
| **5124** | There is a risk that the Trust is not compliant with s132/132A Mental Health Act (the requirement to provide information to patients). This is caused by a lack of assurance that the legally required information is being provided to patients in a timely manner. This could result in the Trust breaching patients' rights and exposes the Trust to potential regulatory action. | 12 (4x3) | Jamie Middleton | Mental Health Legislation Committee | Risk reviewed on 19/04/2024. actions updated; No change to risk score indicated |
| **5220** | There is a risk that inpatient care is not delivered in the least restrictive way, in line with national guidance and regulatory standards due to a lack of skilled trained staff on duty 24/7, 7 days a week. This is due to a combination of capacity with trainers, capacity related to release of staffing and effective rota management. The risk is that this then leads to more restrictive practice, poor patient and staff experience and progress of the strategy. | 12 (3x4) ↔ | Lorena Cain | Mental Health Legislation Committee/ Quality Assurance Committee | The risk was reviewed on 03/05/2024 and remains relevant. Training compliance remains below required standard. |

Appendix 1

# CORPORATE RISK REGISTER

As at: May 2024

| | | |
|---|---|---|
| Risk No. 3679 v.15 BAF Ref: BAF.0025A | Risk Type: Safety / Risk Appetite: Zero | Monitoring Group: Quality Assurance Committee |
| Version Date: 29/04/2024 | Directorate: Acute & Community | Last Reviewed: 29/04/2024 |
| First Created: 29/12/2016 | Exec Lead: Executive Director - Operational Delivery | Review Frequency: Monthly |

Details of Risk:

There is a risk that service users admitted to bed based services could ligate using fixed ligature anchor points or by using ligature items caused by not managing and removing ligature anchor points effectively resulting in service user harm.

| Risk Rating: | Severity | Likelihood | Score |
|---|---|---|---|
| Initial Risk (before controls): | 5 | 4 | 20 |
| Current Risk: (with current controls): | 5 | 3 | 15 |
| Target Risk: (after improved controls): | 5 | 1 | 5 |

## CONTROLS IN PLACE

- Policies and standard operating procedures are embedded, including: ligature risk reduction (which now includes blind spots), observation, risk management including DRAM and seclusion policy.
- Individual service users are risk assessed - DRAM in place and enhanced observations mobilised in accordance with observation policy.
- Inpatient environments have weekly health and safety checks and an annual formal ligature risk assessment. Plans to mitigate key risks are in place as part of the Acute Care Modernisation in the long term.
- A programme of work is underway to remove ligature points and to address blind spots with oversight of the estates strategy implementation group and a weekly clinical oversight group.
- Staff receive clinical risk training, including suicide prevention and RESPECT and all ligature incidents are reviewed.
- CQC MHA oversight (visits, report and action plans)
- Mental Health Legislation Committee with oversight of compliance in relation to seclusion facilities
- A Standard Operating Procedure is embedded which describes an elevated level of medical oversight/review when a service user requires seclusion.
- Nurse alarm system in place on all our adult wards (SAS)
- Contemporaneous record keeping is supported by standard operating

## ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON

| | | |
|---|---|---|
| Maple Ward to move to MCC site 20th March 2024 | Date delayed until July - August 2024 | 01/07/2024 Gemma Robinson |
| Access to ceiling space to be reviewed by Estates and an options appraisal developed regarding either securing current tiles, or replacing the ceiling in Maple (en-suites) and in Stanage and Burbage en-suites and seclusion. | Maple ward move due April 2024 | 01/04/2024 Adele Sabin |

procedures to monitor changes in the needs and risks of service users.

• 14 commissioned beds in place to mitigate reduced bed base whilst refurbishment work to remove LAP's is progressed

• In response to s.29A Notice - action plan has been mobilised to improve environment sooner and to introduce greater clinical mitigation in the interim.

• Heat maps are visible within all acute wards to highlight areas of greater risk due to access to ligature anchor points.

| | | |
|---|---|---|
| Risk No. 4513 v.8 BAF Ref: BAF.0024 | Risk Type: Statutory / Risk Appetite: Zero | Monitoring Group: Mental Health Legislation Committee |
| Version Date: 27/09/2023 | Directorate: Medical | Last Reviewed: 19/04/2024 |
| First Created: 24/02/2021 | Exec Lead: Executive Medical Director | Review Frequency: Monthly |

Details of Risk:

There is a risk that Associate Mental Health Act Manager (AMHAM) Hearings will not be undertaken in a timely manner, this being caused by an insufficient number of AMHAMs which the Trust currently has, resulting in possible breaches in human rights and potential statutory action against the Trust.

| Risk Rating: | Severity | Likelihood | Score |
|---|---|---|---|
| Initial Risk (before controls): | 2 | 3 | 6 |
| Current Risk: (with current controls): | 3 | 4 | 12 |
| Target Risk: (after improved controls): | 3 | 1 | 3 |

CONTROLS IN PLACE

- AMHAM recruitment underway; 4 new appointed
- Open ended AMHAM recruitment adopted
- Flexible approach to hearings being taken eg. virtual hearings if not contentious. This can improve AMHAM availability.
- New appointment process agreed which is not reliant on Trac recruitment system
- Review of remuneration which AMHAMs receive has been undertaken.
- Annual review to AMHAM rate of remuneration now in place.
- AMHAM peer support sessions have re-commenced.

ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON

| | | |
|---|---|---|
| SHSC internet site to have dedicated page for AMHAM open recruitment | 22.2.24 reviewed by HoMHL. Date has had to be revised owing to competing demands and need to work on issues of higher risk. Action remains outstanding | 30/04/2024 Jamie Middleton |
| In absence of significant interest from individuals from ethnically diverse communities, to consider a repeated advertised recruitment process for new AMHAMs | 19.4.24 4 individuals have approached the Trust for more information about the AMHAM role - expressions of interest are being encouraged for shortlisting. Review again in one month - hold off from Trust advert owing to limited staffing being available to respond to possible large numbers of enquiries | 30/04/2024 Jamie Middleton |

| | | |
|---|---|---|
| Risk No. 4697 v.7 BAF Ref: BAF.0025B | Risk Type: Safety / Risk Appetite: Low | Monitoring Group: Quality Assurance Committee |
| Version Date: 03/01/2024 | Directorate: Nursing & Professions | Last Reviewed: 24/04/2024 |
| First Created: 12/08/2021 | Exec Lead: Executive Director - Nursing & Professions | Review Frequency: Quarterly |

Details of Risk:

There is a risk that patients safety will be impacted out of hours as a result of not having timely access to spare medical devices and specialist supplies resulting in poor patient care and possible harm Eg.(emergency equipment and consumables, bariatric, moving and handling or bespoke equipment)

| Risk Rating: | Severity | Likelihood | Score |
|---|---|---|---|
| Initial Risk (before controls): | 3 | 3 | 9 |
| Current Risk: (with current controls): | 3 | 4 | 12 |
| Target Risk: (after improved controls): | 3 | 2 | 6 |

## CONTROLS IN PLACE

- Inpatient areas have a stock of essential / emergency equipment to support the frequent care interventions offered in their setting which includes stock for replacement when used
- Additional stock of equipment is available at Presidents Park. This also includes some bariatric equipment
- Robust reordering of stock process by wards
- Standard Operating Procedure developed
- Each clinical area should be completing pre/during assessments to identify needs enabling earlier identification of any equipment required
- Most clinical areas are sited with others therefore equipment can be shared across site if required

## ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON

| | | |
|---|---|---|
| Exploration of options for storage and transportation of equipment out of hours | 24/04/2024 - This remains outstanding as no longer term solutions have been found. DON still remains as overseer for this. This remains an issue trust wide for lack of accessible storage | 31/05/2024 Sharlene Rowan |
| Medical devices officer working with clinical teams to identify location plans for the admission of bariatric / complex needs service users. | this remains ongoing work locally | 31/05/2024 Sharlene Rowan |
| Ongoing work re centralization of medical devices budget to ensure wards are stocked with appropriate items, and budgets overseen by Medical Devices | business case is currently on hold so this work cannot be progressed | 31/05/2024 Sharlene Rowan |

| | | |
|---|---|---|
| Risk No. 4756 v.10 BAF Ref: BAF.0029 | Risk Type: Safety / Risk Appetite: Low | Monitoring Group: Quality Assurance Committee |
| Version Date: 03/05/2024 | Directorate: Rehabilitation & Specialist Se | Last Reviewed: 03/05/2024 |
| First Created: 28/10/2021 | Exec Lead: Executive Director - Operational Delivery | Review Frequency: Monthly |

Details of Risk:

Demand for the ADHD pathway greatly outweighs the resource and capacity of the service. This is resulting in increasing wait times and high numbers of people not being screened and waiting for assessment and diagnosis. Sheffield is an outlier for the extreme length of waits and there is a risk to the reputation of the Trust. There is no city-wide strategy or proposed clinical model to address the issue.

| Risk Rating: | Severity | Likelihood | Score |
|---|---|---|---|
| Initial Risk (before controls): | 4 | 5 | 20 |
| Current Risk: (with current controls): | 3 | 5 | 15 |
| Target Risk: (after improved controls): | 3 | 2 | 6 |

| CONTROLS IN PLACE | ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON | | |
|---|---|---|---|
| • QEIA raised to identify the demand into the ADHD pathway. | to begin screening of the referrals made to the service in Nov 2022 onwards, to effectively triage and decide whether NICE criteria met, and consequently discahrged or moved onto waiting list | Small pilot review undertaken. Review of those on screening list to be undertaken. Opt-in letters to be sent and questionnaires to complete to allow for more targeted sign posting and cleansing of list for those whose needs should be met in other services. Decision still required around staff needed to complete a full screening triage exercise. To be formulated by clinical leads/staff. | 30/06/2024 Mark Parker |
| | to develop opportunities for prescribers who have completed the UKAAN training (Day 1&2) to shadow ADHD Medics in patient | Change focus of action to those clinicians in ASD service arm who are UKAAN trained and able to | 25/08/2024 Sal Foulkes |

| | | |
|---|---|---|
| appointments with a view to establishing a "community of ADHD practitioners" who can prescribe, titrate and review medicaiton in PCMHT and SCMHT | undertake the dual diagnosis work and be supervised by the medics. this will not start until the drug titration exercise has been completed. | |
| Contracts and Directorate Leadership Team to meet with Derbyshire ICB to review how best to approach service users on the waiting list | Still working to Oct 24 for termination of contract. Need meeting with commissioner to set activity target for the remaining period for ASD & ADHD. Proposal made but needs ratification and part year funding made available. | 28/07/2024 Sal Foulkes |
| To link ADHD assessment, diagnosis and treatment with transformational change across community services in primary care and CMHTs as part of a clinical stepped care model | | 25/09/2024 Richard Bulmer |
| To link with Commissioners across ICB to align with SYICB initiatives and enter into contracting discussions for provision of pathway that is fit for purpose and able to manage demand into service | | 29/05/2024 Richard Bulmer |

# CORPORATE RISK REGISTER

As at: May 2024

| | | |
|---|---|---|
| Risk No. 4757 v.12 BAF Ref: BAF.0029 | Risk Type: Quality / Risk Appetite: Low | Monitoring Group: Quality Assurance Committee |
| Version Date: 03/05/2024 | Directorate: Rehabilitation & Specialist Se | Last Reviewed: 03/05/2024 |
| First Created: 28/10/2021 | Exec Lead: Executive Director - Operational Delivery | Review Frequency: Monthly |

Details of Risk:

There is a risk to patient health and wellbeing due to the exponential increase in demand on services that is resulting in very long waiting times. Waiting list length and waiting time increases in excess of commissioned targets have been exacerbated by historic staff absence, recruitment issues, and national specification requirements that combine to create inefficient system flow.

| Risk Rating: | Severity | Likelihood | Score |
|---|---|---|---|
| Initial Risk (before controls): | 4 | 5 | 20 |
| Current Risk: (with current controls): | 4 | 4 | 16 |
| Target Risk: (after improved controls): | 4 | 2 | 8 |

## CONTROLS IN PLACE

- Developing link with Primary Care Projects. This seeks to reduce referrals by supporting primary care to take the lead in diagnostics and support on the pathway.
- People are supported on the waiting list via the primary care provider. The clinic works with voluntary and non-statutory support services to offer support while waiting for assessment.
- Service works in line with NHS E guidance and service specification. Also work with the Northern region of providers to share best practice and collaborate with standard process development.
- Strengthening 'waiting well' initiative with team peer support workers and the appointment of a Comms Officer to address information requirements
- Third party provider appointed to undertake backlog of surgical progression second opinion assessments to progress people through the pathway
- Additional evening medical session agreed to address backlog of DR1/2 and enable people to enter the pathway

## ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON

| | | |
|---|---|---|
| Clinical process review to be undertaken by Medical Director and Head of Nursing | Job plan accepted but delays caused by new posts requiring AfC banding confirmation. To be advertised in May with recruitment aimed for end of Q2/3. | 01/05/2024 Mark Parker |
| GIC is part of the Trust-wide QI programme addressing issues of waiting times and waiting well. The QI programme will explore different ways of working to increase operational efficiency and to support and engage service users and enhance waiting well initiatives. | workstreams on referral processes, workforce plans, complexity models being developed, MDT structure and cycle of PDSA to be implemented by QI Coach. Engagement by Team is progressing well. | 29/11/2024 Sal Foulkes |

# CORPORATE RISK REGISTER

As at: May 2024

| | | |
|---|---|---|
| Risk No. 4795 v.8 BAF Ref: BAF.0026 | Risk Type: Business / Risk Appetite: Low | Monitoring Group: Finance & Performance Committee |
| Version Date: 09/05/2024 | Directorate: Digital | Last Reviewed: 09/05/2024 |
| First Created: 23/12/2021 | Exec Lead: Executive Director Of Finance | Review Frequency: Monthly |

Details of Risk:

There is a risk that there could be a loss of knowledge and expertise within the Project and BAU Digital Team due to key staff leaving the programme leading to delays in delivery or lack of input from Trust teams.

| Risk Rating: | Severity | Likelihood | Score |
|---|---|---|---|
| Initial Risk (before controls): | 4 | 5 | 20 |
| Current Risk: (with current controls): | 4 | 3 | 12 |
| Target Risk: (after improved controls): | 4 | 2 | 8 |

| CONTROLS IN PLACE | ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON | | |
|---|---|---|---|
| • Effective record keeping and audit trails | Target Operating model, to identify substantive resources required for a sustainable Digital team in light of the new EPR implementation is to be created for review by FD | Target Operating Model to be described and documented along with risks and mitigations.<br><br>Series of workshops in the diary for late april / may. | 30/05/2024<br>Chris Reynolds |

| | | |
|---|---|---|
| Risk No. 5001 v.5 BAF Ref: BAF.0025B | Risk Type: Safety / Risk Appetite: Low | Monitoring Group: Quality Assurance Committee |
| Version Date: 09/04/2024 | Directorate: Acute & Community | Last Reviewed: 09/04/2024 |
| First Created: 16/11/2022 | Exec Lead: Executive Director - Operational Delivery | Review Frequency: Monthly |

Details of Risk:

There is a risk to the quality and safety of patient care under the Crisis Service Line as a result of delays in accessing a mental health hospital bed.

| Risk Rating: | Severity | Likelihood | Score |
|---|---|---|---|
| Initial Risk (before controls): | 4 | 4 | 16 |
| Current Risk: (with current controls): | 3 | 4 | 12 |
| Target Risk: (after improved controls): | 3 | 2 | 6 |

## CONTROLS IN PLACE

- Daily meetings between CRHTT, flow and AMHPs keeps overview of the list
- Review of CAHA monthly in governance meetings.
- Escalating concerns or incidents via incident reporting procedures
- Daily CAHA meetings rescheduled to inform bed allocation meeting and to promote productivity of CAHA
- the care and support being delivered by CRHTT, Liaison Psychiatry or other crisis service (albeit not in accordance with the assessed need for admission)
- standard SOP in place to ensure all staff are following same process in the event of a delay
- clinical prioritisation for admission
- reducing delayed discharges to make a hospital bed available at the point of need
- CRHTT in-reach to support earlier discharge from hospital
- Efficient delivery of hospital care (less than 38 day length of stay)

## ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON

| | | |
|---|---|---|
| Further develop CAHA SOP to include wider community team support. | | 16/04/2024<br>Hayley Taylor |
| Review work load of CAHA and propose the staffing required to safely clinically manage alongside existing community provision those awaiting hospital admission. | To look at ongoing need for resources and provisioon to safely manage CAHA workload | 16/04/2024<br>Natalie Cotton |
| Daily meetings between central AMHP team, SHSC flow team and CRHTT to review EPR of everyone on the list, to liaise with patient (this is usually not possible due to risk, engagement) carer/family, other SHSC services, other services involved such as housing/social care. Care plan created and updated daily. This action monitors the list and ensures that the right people are aware and maintaining contact where possible, however this fails when service users are not known to | | 16/04/2024<br>Hayley Taylor |

| | | |
|---|---|---|
| any other services and refuse any community support leaving the CRHTT holding responsibility for risk that cannot be mitigated for service users who are not being seen. This group make up a large portion of the CAHA list of service users.<br>When service users feel able to engage with any community input, CRHTT will take onto the caseload and step down from CAHA list, CRHTT are proactively checking daily for any indication of a service user wanting to engage in order to treat in the least restrictive way possible. | | |
| Review the timings and priority of meetings: CAHA, morning crisis meeting, bed management meeting. | Time changed to 8:30am daily to enable more effective outcomes of meeting. Time still remains an issue, due to acuity across CRHTT and flow. New proposed times would be 9am. | 16/04/2024<br>Hayley Taylor |
| Ongoing work across SHSC related to patient flow, specifically delayed discharge, length of stay and out of area reduction. | | 30/08/2024<br>Christopher Wood |
| Look at development of MDT support between CRHTT interface nurses, discharge coordinators and | Ongoing work required in the longer term in consideration of current | 16/05/2024<br>Christopher Wood |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | facilitators to improve communication around patient flow. | changes to crisis services and introduction of U&C. To consider further development of Interface team and roles within part of service. | |

| | | |
|---|---|---|
| Risk No. 5026 v.4 BAF Ref: BAF.0024 | Risk Type: Statutory / Risk Appetite: Zero | Monitoring Group: Mental Health Legislation Committee |
| Version Date: 29/09/2023 | Directorate: Medical | Last Reviewed: 19/04/2024 |
| First Created: 20/12/2022 | Exec Lead: Executive Medical Director | Review Frequency: Monthly |

Details of Risk:

There is a risk that patients who come under the Deprivation of Liberty Safeguards (DOLS) framework are detained on SHSC staffed premises with no legal authority in place to authorise this. This is caused by significant delays and backlogs within the Local Authority (who are responsible for conducting such assessments and authorisations). This could result in patient's legal rights being breached by the Trust, and the Trust potentially being challenged legally by a patient or their representative.

| Risk Rating: | Severity | Likelihood | Score |
|---|---|---|---|
| Initial Risk (before controls): | 3 | 5 | 15 |
| Current Risk: (with current controls): | 3 | 4 | 12 |
| Target Risk: (after improved controls): | 3 | 1 | 3 |

## CONTROLS IN PLACE

- SHSC is fulfilling its duty by making referrals to the Local Authority when DOLS authorisations are required.
- There is a recognition nationally that the DOLS processes are not fit for purpose and that DOLS is expected to be replaced by a new legal process known as the Liberty Protection Safeguards (LPS) - although there is no date for when this will be enacted by Government.
- Most individuals admitted to SHSC wards are admitted under the Mental Health Act for the treatment of mental disorder. Most inpatients would therefore not be eligible for DOLS.
- The Local Authority has carried out a review of their DOLS work, intending on reducing DOLS referral backlogs.
- Forum in place, by means of the citywide Mental Capacity Act Action Network (MCAAN), where issues in relation to DOLS can be discussed at a partnership level.

## ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON

| | | |
|---|---|---|
| Escalation process in respect of service users who are being deprived of their liberty, but for whom there is no DOLS authority in place to authorise this, to be established with Local Authority. | 19.4.24 reviewed by HoMHL - further meeting held with Local Authority. Problems with escalation process identified and unable to be resolved at this stage. Started to have a list of people referred to the LA and whether this matches with SHSC systems as starting point. May need to move towards more internal reviews than escalations. Details still being worked through. Review again 1 month. | 17/05/2024 Jamie Middleton |
| Discussion to take place with SHSC risk department about incident reporting with respect of people | 19.4.24 reviewed by HoMHL - links closely with getting accurate and effective DOLS | 17/05/2024 Jamie Middleton |

| | | | |
|---|---|---|---|
| | deprived of their liberty with no lawful authority; to explore current system and whether any new incident types are needed so these can be identified and monitored more effectively. | register - this work is ongoing; review again 1 month | |
| | DOLS Register to be set up to improve governance | 19.4.24 reviewed - new DOLS register being improved - most data at present only for Woodland View. Ongoing work needed to make register effective. Review again in 1 month. | 31/05/2024 Jamie Middleton |

| | | |
|---|---|---|
| Risk No. 5047 v.3 BAF Ref: BAF.0024 | Risk Type: Statutory / Risk Appetite: Zero | Monitoring Group: Mental Health Legislation Committee |
| Version Date: 29/09/2023 | Directorate: Medical | Last Reviewed: 19/04/2024 |
| First Created: 23/01/2023 | Exec Lead: Executive Medical Director | Review Frequency: Monthly |

Details of Risk:

There is a risk that practice within the Trust is not compliant with the Mental Capacity Act. This is caused by multiple factors such as MCA mandatory training not being undertaken, current MCA training needing to be improved, and some organisational culture. This risk could result in patient's legal rights being breached, care not being delivered in accordance with a patient's previously expressed wishes, and legal challenge against the Trust.

| Risk Rating: | Severity | Likelihood | Score |
|---|---|---|---|
| Initial Risk (before controls): | 3 | 4 | 12 |
| Current Risk: (with current controls): | 3 | 4 | 12 |
| Target Risk: (after improved controls): | 3 | 1 | 3 |

## CONTROLS IN PLACE

- Mandatory training is provided in respect of the Mental Capacity Act
- Advice can be sought from Head of Mental Health Legislation where needed
- A process is in place which allows the Trust to instruct external solicitors in more complex cases
- New Mental Capacity Act (MCA) Essential Level training has been introduced
- New Mental Capacity Act (MCA) Level 1 training has been introduced
- New Mental Capacity Act (MCA) Level 2 training has been introduced
- New position statement agreed regarding the Trust's response to enquiries under section 49 Mental Capacity Act

## ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON

| | | |
|---|---|---|
| Bitesize training video to be produced regarding using Mental Capacity Act vs. Mental Health Act | 22.2.24 update: Training material on pause owing to potential need to change content in response to some incidents and feedback of concern. Likely that consultation on this training material will be much wider than originally anticipated. New date added. | 30/04/2024 Jamie Middleton |
| Mental capacity training to be delivered to Trust medics | | 24/04/2024 Jamie Middleton |
| Competency/assessment questions for MCA mandatory training to be changed | 19.4.24 review - action remains, unable to complete owing to competing demands. Review again 1 month. | 17/05/2024 Jamie Middleton |

| | | |
|---|---|---|
| Risk No. 5051 v.4 BAF Ref: BAF.0022 | Risk Type: Financial / Risk Appetite: | Monitoring Group: Finance & Performance Committee |
| Version Date: 01/04/2024 | Directorate: Finance | Last Reviewed: 04/04/2024 |
| First Created: 01/02/2023 | Exec Lead: Executive Director Of Finance | Review Frequency: Monthly |

Details of Risk:

There is a risk of failure to deliver the required level of savings for 2024/25. This includes reducing overspending areas through recovery plans.

| Risk Rating: | Severity | Likelihood | Score |
|---|---|---|---|
| Initial Risk (before controls): | 4 | 4 | 16 |
| Current Risk: (with current controls): | 4 | 4 | 16 |
| Target Risk: (after improved controls): | 2 | 3 | 6 |

## CONTROLS IN PLACE

- Cost Improvement Programme Board and Working Groups established to confirm targets, identify and establish schemes, review Scheme Initiation Documents, ensure QEIA process undertaken and monitor progress.
- Transformation projects programme board and benefits realisation monitoring and oversight
- Performance Management Framework is in place with overspending areas required to have a monthly Performance review meeting
- Trust Business Planning Systems and Processes, Including CIP monitoring, QEIA and Executive oversight of the CIP programme Board and each of the 3 working groups focussed on Out of Area, Agency and all other schemes
- Forms part of routine finance reporting to FPC, Board, ICB and NHSE
- Additional controls added with EMT reviewing and making any investment decisions in light of increased system oversight and need for Exec level group to oversee expenditure commitments above £10k.
- Executive Management Team being added back into SFIs and Scheme of Delegation under Board Sub committee's as a decision making forum above BPG.
- Additional controls agreed by EMT to help support financial recovery and reduce the expenditure run rate and overall deficit. This include the cessation of non essential expenditure. Exec led vacancy panels for non frontline roles

## ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON

| | | |
|---|---|---|
| Confirm and Challenge process between Finance and leads to ensure plans are viable and achievable, all schemes are RAG rated by Finance and shared with EMT to review. | 29/04 - currently have £7.2m of initial plans | 03/05/2024 Chris Cotton |
| Collection of final plans to include QEIA where required and presented back to EMT | | 24/05/2024 Chris Cotton |

and various other controls.

- Formal recovery plans for any areas overspending by over £50k.
- EMT Finance huddles in place to provide additional oversight and challenge on savings plans and financial performance

| | | |
|---|---|---|
| Risk No. 5124 v.5 BAF Ref: BAF.0024 | Risk Type: Statutory / Risk Appetite: Zero | Monitoring Group: Mental Health Legislation Committee |
| Version Date: 21/03/2024 | Directorate: Medical | Last Reviewed: 19/04/2024 |
| First Created: 15/05/2023 | Exec Lead: Executive Medical Director | Review Frequency: Monthly |

Details of Risk:

There is a risk that the Trust is not compliant with s132/132A Mental Health Act (the requirement to provide information to patients). This is caused by a lack of assurance that the legally required information is being provided to patients in a timely manner. This could result in the Trust breaching patients' rights and exposes the Trust to potential regulatory action.

| Risk Rating: | Severity | Likelihood | Score |
|---|---|---|---|
| Initial Risk (before controls): | 3 | 4 | 12 |
| Current Risk: (with current controls): | 4 | 3 | 12 |
| Target Risk: (after improved controls): | 2 | 3 | 6 |

## CONTROLS IN PLACE

- Ward staff are aware of their obligations under s132
- The MHA office will submit incident reports when compliance cannot be evidenced
- The importance of s132/132A Mental Health Act is covered in the current mandatory Mental Health Act training
- Provision of information policy is in place and available on SHSC intranet
- Compliance incidents are reported on to Mental Health Legislation Operational Group and Mental Health Legislation Committee
- Provision of information to patients under s132/132A documentation is available to staff on Jarvis

## ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON

| | | |
|---|---|---|
| Meeting to be arranged with the Trust's Lead Social Worker about the possibility of authorising social workers to provide information to patients under s132/132A | 19.4.24 update - Lead social worker has been approached - date in process of being arranged | 17/05/2024 Jamie Middleton |
| Meeting to be arranged with the Trust's Lead for Allied Health Professionals (AHPs) to discuss the possibility of authorising AHPs to provide information to patients as per s132/132A MHA | 19.4.24 update - Liaising with Exec Director of Professions to involve most appropriate senior lead | 17/05/2024 Jamie Middleton |
| Knowledge Nibble training video to be produced specifically in respect of s132 | 19.4.24 reviewed; need to postpone this action as discussions from the s132 Task and Finish Group means processes will be changing - the training needs to reflect these changes as opposed to delivering training which only has to be re-delivered | 31/12/2024 Jamie Middleton |

| | | | |
|---|---|---|---|
| | | to take into account new ways of working. This will need to moved towards the latter part of the Task and Finish Group duration. Date changed to end of 2024. | |
| | Knowledge Nibble training video to be produced specifically in relation to s132A | 19.4.24 reviewed; need to postpone this action as discussions from the s132 Task and Finish Group means processes will be changing - the training needs to reflect these changes as opposed to delivering training which only has to be re-delivered to take into account new ways of working. This will need to moved towards the latter part of the Task and Finish Group duration. Date changed to end of 2024. | 31/12/2024 Jamie Middleton |
| | Target risk assessment to be reviewed by Mental Health Legislation Operational Group on 25.3.24 | 3.4.24 action reviewed by HoMHL. Human error meant action not considered as planned at MHLOG on 25.3.24. To be rescheduled for MHLOG meeting on 22.4.24 | 22/04/2024 Jamie Middleton |

| | | |
|---|---|---|
| The Duty to Give Information under s132, 132A and s133 MHA Policy will need to be revised and updated to take into account the changes identified by the s132/132A Task and Finish Group. This will need to be undertaken when the work of the Task and Finish Group has been completed and changes agreed by Mental Health Legislation Operational Group. | | 31/12/2024<br>Jamie Middleton |
| Meeting to be arranged with the Trust's Psychology Leads to discuss the possibility of authorising psychologists to provide information to patients as per s132/132A MHA | 19.4.24 update - Liaising with Exec Director of Professions to involve most appropriate senior lead | 17/05/2024<br>Jamie Middleton |

# CORPORATE RISK REGISTER

As at: May 2024

| | | |
|---|---|---|
| Risk No. 5169 v.3 BAF Ref: | Risk Type: Quality / Risk Appetite: | Monitoring Group: Quality Assurance Committee |
| Version Date: 02/05/2024 | Directorate: Medical | Last Reviewed: 01/02/2024 |
| First Created: 18/07/2023 | Exec Lead: Executive Medical Director | Review Frequency: Quarterly |

Details of Risk:

There is a risk that the PROMs (Patient Reported Outcome Measures) project is either delayed or the quality negatively impacted due to dependencies on the EPR and delays to the EPR programme. EPR delays will result in the PROMs project requiring clinical teams to start using PROMs without the necessary EPR infrastructure in place, or will delay roll-out and implementation of PROMs. Delays in implementation of in quality will impact statutory returns required from March 2024.

| Risk Rating: | Severity | Likelihood | Score |
|---|---|---|---|
| Initial Risk (before controls): | 3 | 3 | 9 |
| Current Risk: (with current controls): | 3 | 5 | 15 |
| Target Risk: (after improved controls): | 0 | 0 | 0 |

## CONTROLS IN PLACE

- Joint working between EPR programme and PROMs project in order to find solutions to the gaps in IT infrastructure that may negatively effect PROMs use.

## ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON

| | |
|---|---|
| PROMs project to continue working with IT/EPR to find solutions that will enable quality collection of PROMs | 31/03/2024 Jonathan Burleigh |
| To engage with clinical services over need repeat training workshops | 31/03/2024 Jonathan Burleigh |

| | | |
|---|---|---|
| Risk No. 5220 v.8 BAF Ref: BAF.0024 | Risk Type: Quality / Risk Appetite: Low | Monitoring Group: Mental Health Legislation Committee |
| Version Date: 03/05/2024 | Directorate: Nursing & Professions | Last Reviewed: 03/05/2024 |
| First Created: 26/09/2023 | Exec Lead: Executive Director - Nursing & Professions | Review Frequency: Quarterly |

Details of Risk:

There is a risk that inpatient care is not delivered in the least restrictive way, in line with national guidance and regulatory standards due to a lack of skilled trained staff on duty 24/7, 7 days a week. The is due to a combination of capacity with trainers, capacity related to release of staffing and effective rota management. The risk is that this then leads to more restrictive practice, poor patient and staff experience and progress of the strategy.

| Risk Rating: | Severity | Likelihood | Score |
|---|---|---|---|
| Initial Risk (before controls): | 4 | 3 | 12 |
| Current Risk: (with current controls): | 4 | 3 | 12 |
| Target Risk: (after improved controls): | 4 | 2 | 8 |

CONTROLS IN PLACE

- Respect training available which now includes ward based AHPs and psychology staff. offer includes all bank staff and can be extended to block booked agency staff
- Audits on Tendable which enable oversight of restrictive practice and compliance with standards
- Incident reporting procedure in place and Incident huddle for monitoring use and flagging concern
- Governance groups in place for oversight and scrutiny of data, indicating any areas for concerns and where improvement actions are required
- Least Restrictive Strategy in place with a timeframe workplan including action owners. Progress is reported quarterly via the LRPOG and MH legislation Committee
- Use of Force Policy which includes minimum number of RESPECT trained staff required per shift
- Lead nurse/Nurse Consultant with dedicated capacity to oversee RPs
- Monitoring of minimum trained respect staff on duty via Matron leads and operational oversight
- Medical training and audit of seclusion reviews
- team based instructors on some wards. plan to develop further

ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON

| | | |
|---|---|---|
| Increased capacity in the respect team to work into clinical teams with complex cases by the funding and appointment of a band 6 professional registrant role | updated. band 6 post remains vacant however is currently back in process for re-advertisement pending CIPs. Monies are currently being used from April 2024 for a band 4 practitioner on secondment | 11/06/2024 Lorena Cain |
| There is a monthly confirm and challenge meeting before the rotas are approved for sign off. This includes ensuring we are using our substantive staff effectively across the rota period. Every weekday morning there is a meeting between the Ward Managers and Matron to review staffing over the next 24 hours, and any issues that cannot be resolved internally within the service line are taken to a daily staffing | update safer staffing meetings and oversight continue. | 11/06/2024 Simon Barnitt |

| | | | |
|---|---|---|---|
| • identified leads for RP at ward team level<br>• security officer support team in place<br>• response protocol in place includes support of shared alarm system<br>• rota management system in place - safer staffing levels meeting in place and process for daily review, monitoring and escalation. this includes the number of RESPECT trained staff on shift<br>• support to ensure bank and agency staff have necessary skills to ensure Least restrictive practice<br>• team based risk register for RESPECT team identifying controls and action to achieve required number of courses offered to ensure compliance .<br>• other training that supports being Least restrictive such as Human Rights training, cultural awareness training and HOPES training is available and offered to staff either as part of the RESPECT programme or as stand alone training<br>• local ward Restrictive practice development meetings supported by Nurse Consultant and/or respect team. | escalation meeting that looks to resolve staffing gaps across the Trust. This includes ensuring all areas have a minimum of 3 x Level 3 RESPECT trained staff. | | |
| | Increase capacity in the RESPECT team to deliver training and ensure enough course are available to meet the required compliance. | updated. band 6 post remains vacant however is currently back in process for re-advertisement pending CIPs. Monies are currently being used from April 2024 for a band 4 practitioner on secondment | 11/06/2024<br>Lorena Cain |
| | Provide monthly training reports to ward teams on RESPECT and work with ward managers to identify staff who are out of date and ensure they are booked on | update<br>data continues to be presented to local teams and DNA rates flagged as part of this. Communicated via the Quality Directorate IPQR | 11/06/2024<br>Lorena Cain |

# CORPORATE RISK REGISTER

As at: May 2024

| | | |
|---|---|---|
| Risk No. 5224 v.2 BAF Ref: BAF.0021A | Risk Type: Quality / Risk Appetite: Low | Monitoring Group: Finance & Performance Committee |
| Version Date: 10/10/2023 | Directorate: Digital | Last Reviewed: 03/04/2024 |
| First Created: 09/10/2023 | Exec Lead: Executive Director Of Finance | Review Frequency: Monthly |

Details of Risk:

There is a risk that our new electronic patient record system will fail to meet the recording and reporting requirements of our clinical services. This risk must be mitigated through rigorous User Acceptance Testing.

| Risk Rating: | Severity | Likelihood | Score |
|---|---|---|---|
| Initial Risk (before controls): | 3 | 4 | 12 |
| Current Risk: (with current controls): | 3 | 4 | 12 |
| Target Risk: (after improved controls): | 3 | 2 | 6 |

## CONTROLS IN PLACE

- User acceptance testing for system performance and reporting is already underway with assurance provided through reports to Programme Board/EMT
- Operational oversight through EPR programme Board and supporting workstreams
- Strategic oversight of weekly Executive Management Team group
- Reporting to the Board on progress and actions required.
- The value of User acceptance testing following functional testing is recognised by the implementing leads in the EPR programme. new testing regime being developed now, to be established once revisions of existing build are underway

## ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON

| | | |
|---|---|---|
| Testing completed but some actions identified as outstanding. Re-testing is underway following some modifications made to forms and mitigants put in place where work cannot be completed in time for Tranche 2. | T1 service stablisation being led by simon barnitt<br><br>T2 planning being led by Julian Young. | 30/04/2024<br>Chris Reynolds |

| | | |
|---|---|---|
| Risk No. 5272 v.2 BAF Ref: BAF.0026 | Risk Type: Business / Risk Appetite: Low | Monitoring Group: Finance & Performance Committee |
| Version Date: 06/03/2024 | Directorate: Digital | Last Reviewed: 04/04/2024 |
| First Created: 11/12/2023 | Exec Lead: Executive Director Of Finance | Review Frequency: Monthly |

Details of Risk:

There is a risk technical issues in the build which have surfaced post implementation of the launch of the first phase of the Electronic Patient Record (Rio) are not adequately managed resulting in lack of stablisation of the first stage prior to launch of the second phase with the result there are delays in development and security of the reporting build infrastructure putting in jeopardy ability to move forward.

| Risk Rating: | Severity | Likelihood | Score |
|---|---|---|---|
| Initial Risk (before controls): | 4 | 3 | 12 |
| Current Risk: (with current controls): | 4 | 3 | 12 |
| Target Risk: (after improved controls): | 4 | 2 | 8 |

## CONTROLS IN PLACE

- Governance arrangements
- Assurance provided through reports to Programme Board/EMT
- Operational oversight through EPR programme Board and supporting workstreams
- Strategic oversight of weekly Executive Management Team group
- Reporting to the Board on progress and actions required.
- Data migration plan in place - monitoring and assurance provided through reports to Programme Board/EMT
- Additional staff brought in from across the organisation to support manual migration
- Prioritisation of known core (mandatory) reports within project, ensuring that we focus first on the reports with the greatest impact if not completed. There is further work in assessing all of the reports in scope
- Communication of change to stakeholders so they can set expectations and work out arrangements with local service users around any delays.
- New staffing model to accommodate the delays and bring the projected overspend within 10-15% of the budget, reducing the severity to 4.
- Regular meetings in place with New EPR Project so that impact of delays to deliverables on DWR are clear.

## ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON

| | | |
|---|---|---|
| Prioritise custom assessment forms so as to reduce the delay in producing key dataset returns. | Assessment forms being reviewed. 360 forms exist from approx 50 services/teams. This leaves 20 services to engage with. | 30/08/2024 Julian Young |
| Delivery reports according to priority list to minimise the impact of disruptions | Draft List of reports available. Needs confirmation by Performance and analytics manager(Rob Nottingham) | 01/09/2024 Jack Baring |

- Closer engagement with New EPR team to ensure there is better consideration of reporting requirements as part of the change process and configuration
- A list of reports was solicited from individual services liaising through the business analysts. These have been prioritised based on first submission following go-live and flexibility in order to minimise the impact of unavoidable delays to delivery
- Data migration plan in place - monitoring and assurance provided through reports to Programme Board/EMT
- Additional staff brought in from across the organisation to support manual migration