Board of Directors - Public

SUMMARY REPORT	Meeting Date:	24 July 2024
	Agenda Item:	25

Report Title:	**Corporate Risk Register Report**	
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Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	Risk Oversight Group (RoG) Executive Management Team (EMT) People Committee (PC) Quality Assurance Committee (QAC) Finance and Performance Committee (FPC) Audit and Risk Committee (ARC)
	Date:	1 July 2024 (RoG) 4 July 2024 (EMT) 9 July 2024 (PC) 10 July 2024 (QAC) 11 July 2024 (FPC) 16 July 2024 (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 14 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 Board below via an Alert, Advise, Assure.

Alert

Finance and Performance Committee (FPC)

NEW Risk 5344: There is a risk that the integrity and safety of the fire doors have been compromised caused by inadequate maintenance through a sufficient Planned Preventative Maintenance (PPM) regime resulting in reduced effectiveness in minimising the spread of fire and smoke. (Risk score 20)

- It has been agreed at EMT, RoG and with the Executive Lead that there is overarching corporate risk relating to all Trust fire doors with a risk score of 20.
- It was clarified from discussion at RoG on 1 July 2024 that the rationale for the risk score being 20 is based upon the need for additional assurance that fire doors would perform as designed/expected in the event of a fire and not based on the likelihood of a fire occurring.
- This was discussed and agreed by Finance and Performance Committee in July 2024.
- It is anticipated that the score will be reviewed and reduced once a comprehensive survey of all fire doors has been undertaken by an independent company. This has been commissioned and it was

confirmed at the committee that the timeline for receipt of the report, which will provide a clear, current status of all of the doors, is expected by September 2024.
- A further update on timings and mitigations put in place is planned for discussion at RoG at its meeting on 22 July 2024.

The Board is asked to note the updates provided.

Advise

Quality Assurance Committee (QAC):

Risk 4756 relating to demand for the ADHD pathway **and Risk 4757** relating to the demand for Gender services have been deescalated to the directorate risk registers following agreement at the committee due to the risks having materialised into an issue of performance and this is being monitored through recovery plans overseen at the assurance committee.

- Work took place by the risk owner to create an overarching corporate risk which was presented to QAC in July 2024.
- Discussion took place at the committee where it was recommended that further work on the risk description takes place to clarify that the impact is not on the deterioration of conditions and that the impact of waiting on the service user experience is made more explicit in the description.
- Following this, a proposed new risk description has been agreed by the Senior Head of Service and the Executive lead and work is underway to input the risk onto Ulyssess.
- The newly updated risk will be discussed at the Risk Oversight Group on the 22 July prior to onward reporting to EMT and Quality Assurance committee in August and September 2024.

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 12)

- Following the decant of Maple Ward, the risk score was reduced from 15 to 12 with Executive lead approval.
- At its meeting in July, Quality Assurance Committee requested that the risk score is reviewed in line with the review of the associated BAF risk for the therapeutics environment and an update will be taken to Risk Oversight group prior to reporting to EMT and assurance committee in August and September 2024.
- It was agreed at the committee that the risk remains a corporate risk due to the ongoing Ligature Anchor Point (LAP) work in other areas.

Finance and Performance Committee (FPC)

EPR risks:
- An update of the EPR risks was presented to the Risk Oversight Group (RoG) for discussion at the meeting on 1 July, by the EPR team
- There is a comprehensive risk register for the EPR programme with owners assigned and actions in place for mitigations identified which is reviewed at the EPR programme Board, and any risks scoring 12 and above are escalated for review at the Transformation Board.
- Following discussion at RoG and FPC in July, it was agreed that 5 of the highest scoring risks on the EPR register should be escalated to the Corporate Risk register and this has been approved by the Executive Lead.
- Work is ongoing to upload the risks to Ulysses and an update will taken to RoG, for reporting to EMT and FPC in August 2024.

The 5 risks proposed for escalation to the corporate risk register are detailed below:
- Responding to change requests for Insight becomes excessively time consuming, impacting on delivery performance (Risk score 15)
- Users are unwilling to use the system as intended (Risk score 12)
- Services cannot fully-engage with the programme due to internal capacity and prioritisation issues (Risk score 12)

- Clinical requirements are not elicited correctly leading to the system being poorly configured to meet clinical needs (Risk score 12)
- Governance processes become overly bureaucratic and cease to be agile enough to meet the programme's needs (Risk score 12)

People Committee

NEW Risk 5321 There is a risk that we are unable to meet mandatory training compliance levels caused by a variety of factors impacting on one or more training subjects including lack of suitable training space for delivery of training; access to computers for e- learning, local authority places for safeguarding and difficulties in staff release resulting in targets and CQC requirements not being met. (Risk score 12).

- The risk description was agreed by the Executive Director of People and the Executive Director of Nursing, Professions, and Quality.
- RoG agreed the description and actions at its meeting on 1 July 2024.
- An additional control regarding the safeguarding training implementation plan has been added.
- Escalation of the risk to the corporate risk register was agreed at People Committee in July.

Violence and Aggression Risks:
- The risks relating to violence and aggression were reviewed at the Psychological Safety Meeting on 15 May
- Consideration is being given for a corporate risk relating to staff wellbeing and quality of care in relation to systems not responding adequately to issues around violence, sexual safety, racism
- Discussion took place at People Committee in relation to the Wellbeing and Organisational Development Assurance Group (WODAG) Report and the Health and Safety Annual report, and the committee agreed that work to create a corporate risk should be taken forward.
- This is on the agenda for WODAG to discuss further at their meeting in July and an update will be provided to Risk Oversight Group prior to reporting to EMT and assurance committees in August and September 2024.

The Board is asked to note the updates provided.

Assure

Audit and Risk Committee (ARC):
- At its meeting in July, the committee were assured that that there is an effective and dynamic risk management process in place in relation to the Board Assurance Framework and the Corporate Risk Register.

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 July 2024, has highlighted 2 new risks.
- The Executive Leads have been informed of these new risks and work has taken place to review the risk scoring and mitigating actions
- Of the 134 risks reported between September 2023 and March 2024, there are no risks remaining.
- Meetings have been set up between July and November 2024 with the Directorate Leadership Teams (DLT) to review their entire directorate risk registers, in preparation for the Internal Audit review which will focus on the Directorate register risks.
- An update from the Directorate Leads on plans to address their risk registers will be brought to the RoG meeting in September 2024.

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 July 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. Following agreement of the risk appetite by the Board for 2024, the risk domains and risk appetite scores are being updated in the RMF and associated documents

1.5 The Risk Oversight Group meets 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 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

1.7 Training sessions continue to take place with teams and individuals, including a review of registers with a focus on scoring of risks and training materials have been updated to reflect the revised risk appetite scores.

Top organisational Risks

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

- **NEW Risk 5344** (FPC) *There is a risk that the integrity and safety of the fire doors have been compromised caused by inadequate maintenance through a sufficient Planned Preventative Maintenance (PPM) regime resulting in reduced effectiveness in minimising the spread of fire and smoke* **(Risk score 20)**
- **Risk 5169** (QAC) *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)**

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

Section 3: Corporate Risk Register snapshot, including a summary of movement on risks in the previous quarter, overseen at the assurance committees as at July 2024.

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

Movement on the Corporate Risk Register overseen at Audit and Risk Committee, included here for information:
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 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

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

- **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.

- **Newly escalated: 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 description has been agreed by the Executive Director of People and the Executive Director of Nursing, Professions, and Quality. The risk was escalated to the CRR on 25 June 2024, for approval at People Committee in July 2024.

Risk number	Description	Score (severity x likelihood)	Risk Owner	Executive Lead and Monitoring Committee	Progress update
NEW 5321 **BAF 0014**	There is a risk that we are unable to meet mandatory training compliance levels caused by a variety of factors impacting on one or more training subjects including lack of suitable training space for delivery of training; access to computers for e learning, local authority places for safeguarding and difficulties in	12 (3x4)	Karen Dickinson	Executive Director of People (Caroline Parry) People Committee	Reviewed on 25/06/24. The risk description has been updated following discussion with Executive Director of Nursing and professions and

	staff release resulting in targets and CQC requirements not being met.				Executive director of People. A further control on safeguarding training plan has been added

Quality Assurance Committee
Movement on the Corporate Risk Register for risks 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

- **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 corporate risk register following agreement by the Executive lead and confirmation at RoG in April 2024.

- **Risk 4757** *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.*
  This has been de-escalated to the directorate risk register following agreement at the Quality Assurance Committee and Risk Oversight group in March 2024

- **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*
  This has been de-escalated to the directorate risk register following agreement at the Quality Assurance Committee and Risk Oversight group in March 2024.

- **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 has been reduced from 15 to 12, following approval by the Executive lead due to the decant of Maple ward in July 2024. Further discussion has taken place at the committee in July and the risk rating will be reviewed in line with the corresponding BAF risk.

Risk number	Description	Score (severity x likelihood)	Risk Owner	Executive Lead and Monitoring Committee	Progress update
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 (Risk Owner and Assessor)	Medical Director (Helen Crimlisk) Quality Assurance Committee.	This risk was reviewed on the 24/06/24. Action progress has been updated and there are no changes to the risk at this time.
3679 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.	12 (4x3) ↓	Gemma Robinson (risk owner) Adele Sabin (reviewer)	Director of Operations (Neil Robertson) Quality Assurance Committee.	Reviewed on 24/06/24. Following the decant of Maple Ward, the risk score has been reduced from 15 to 12 with Executive lead approval. The committee requested that the risk score is reviewed in line with the review of the associated BAF risk for the therapeutics environment. The risk remains a corporate risk due to the ongoing Ligature Anchor Point (LAP) work in other areas.
4697 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) ↔	Sharlene Rowan (Risk Owner and Assessor)	Executive Director of Nursing, Professions and Quality Quality Assurance Committee.	Reviewed on 02/07/24 and the actions have been updated.
5001 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) ↔	Hayley Taylor (Risk Owner and Assessor)	Director of Operations (Neil Robertson)	Risk last reviewed on 05/07/24. Risks remain, actions updated and to be reviewed as new HTT SM

				Quality Assurance Committee.	back in post.

Finance and Performance Committee (FPC)

Movement on the Corporate Risk Register for risks 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*. (Risk score 12 reduced from 16) (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***.** 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 5272** *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***.**
  This is a duplicate of risk 5224 "There is a risk that our new electronic patient record system will fail to meet the recording and reporting requirements of our clinical services". The risk has been closed with agreement from the Executive lead.

- **Risk 5344** *There is a risk that the integrity and safety of the fire doors have been compromised caused by inadequate maintenance through a sufficient Planned Preventative Maintenance (PPM) regime resulting in reduced effectiveness in minimising the spread of fire and smoke (Risk score 20).*
  Escalated to the corporate risk register following agreement by the Executive lead, EMT, RoG**.**

Risk number	Description	Score (severity x likelihood)	Risk Owner	Executive Lead and Monitoring Committee	Progress update
NEW 5344 BAF 0026	There is a risk that the integrity and safety of the fire doors have been compromised caused by inadequate maintenance through a sufficient Planned Preventative Maintenance (PPM) regime resulting in reduced effectiveness in minimising the spread of fire and smoke	20(4x5)	Liam Casey	Director of Strategy (James Drury) Finance and Performance Committee	Agreed by Executive lead and EMT on 20 June 2024. Discussed at RoG and escalated to CRR on 1 July. Rationale for risk score being 20 is based upon the likelihood of the fire doors performing as designed/expected in the event of a fire and not based upon on the likelihood of a fire occurring
5051 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	12 (4x3) ↓	Chris Cotton (risk owner)	Executive Director of Finance (Phillip Easthope) Finance and Performance Committee	Reviewed on 01/07/2024. Review of actions, closed one, added an extra action. The risk score was reduced following approval at FPC in June 2024.
4795 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 lack of input from Trust teams	(12) 4x3 ↔	Chris Reynolds (risk owner)	Executive Director of Finance (Phillip Easthope) Finance and Performance Committee	Risk reviewed and updated on 01/07/2024. Updated actions in relation to Target Operating Module (TOM) progress.
5224 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) ↔	Chris Reynolds (risk owner)	Executive Director of Finance (Phillip Easthope) Finance and Performance Committee.	Reviewed on 05/07/2024 Actions have been updated.

Mental Health Legislation Committee

Movement on the Risk Register for risks overseen by MHLC included here for information:

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).** Approved for escalation to the CRR by the Executive Lead, RoG and MHLC 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, 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.	12 (3x4) ↔	Jamie Middleton	Mental Health Legislation Committee	Reviewed on 25/06/24. Risk remains and occasions continue when we struggle to review cases in time owing to AMHAM numbers.
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	Reviewed on 25/06/24. Risk remains - continue to have individuals who are deprived of their liberty, primarily within Birch Ave and Woodland View, but no DOLS authorisation is in place. Risk to organisation remains, as does risk of breaching patient's rights under Art 5 ECHR
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	12 (3x4) ↔	Jamie Middleton	Mental Health Legislation Committee	Reviewed on 25/06/24. Risk remains. Recent CQC visit found gaps in respect of mental capacity assessment documentation.

	wishes, and legal challenge against the Trust.				
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	Reviewed on 25/06/24. Risk remains. Incidents in respect of s132/132A and lack of assurance continues. Task & Finish group continues.
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	Reviewed on 05/07/24. Risk remains the same and action plans updated. Trust compliance remains below trust target

CORPORATE RISK REGISTER

As at: July 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: 03/07/2024
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):	4	3	12
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

Project plans to be scoped and business cases written to gain approval to move forwards on completion of LAP removal works in Forest Lodge.	Therapeutic Environments Programme Board requested an options appraisal be brought to the July programme Board. The implementation of the project at Forest Lodge will be disruptive, stakeholders will need to review options for undertaking the work and assess how that can take place. Programme Board takes place on 10th July. After the decision is taken on an option a case will be submitted to BPG. The case will not be submitted until August 2024.	31/08/2024 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.

• Maple ward project, LAP removal full business case was approved by the Trust Board of Directors in April 2024. This case allows for construction work tender to be awarded to being works in 2024/25 on Maple ward to remove all fixed LAPs and improve the environment.

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: 25/06/2024
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 website to be 'cleansed' to address conflicting web pages in respect of the AMHAM role	Action reviewed - action remains outstanding; have not been able to progress owing to competing demands. New target date set.	31/07/2024 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: 02/07/2024
First Created: 12/08/2021	Exec Lead: Executive Director - Nursing & Professions	Review Frequency: Monthly

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	this remains an ongoing issue	31/08/2024 Sharlene Rowan
Medical devices officer working with clinical teams to identify location plans for the admission of bariatric / complex needs service users.	This is an ongoing piece of work and done on an individual service basis as is needed	31/08/2024 Sharlene Rowan
Ongoing work re centralization of medical devices budget to ensure wards are stocked with appropriate items, and budgets overseen by Medical Devices	this remains on hold at the moment so is unable to be progressed	31/08/2024 Sharlene Rowan

CORPORATE RISK REGISTER

As at: July 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: 01/07/2024
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

- Effective record keeping and audit trails

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

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	Likely that we will have completed work by end of July for presentation at August board.	30/08/2024 Chris Reynolds

Risk No. 5001 v.8 BAF Ref: BAF.0025B	Risk Type: Safety / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee
Version Date: 04/06/2024	Directorate: Acute & Community	Last Reviewed: 05/07/2024
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 caused by delays in accessing an acute mental health hospital bed resulting in an impact on all services, but particularly our Community, Crisis, Liaison Psychiatry, Decisions Unit and HBPOS services.

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

Look at development of MDT support between CRHTT interface nurses, discharge coordinators and facilitators to improve communication around patient flow.	HT back in post as SM for HTT from 1/7/24, U&C launch has no impact upon CAHA management. Development of HTT as interface between community and all inpatient admissions currently under review	30/08/2024 Christopher Wood
Further develop CAHA SOP to include wider community team support.	HT back in post as SM for HTT since 1/7/24, will meet with CW and NC to see any work to review SOP has commenced.	16/08/2024 Hayley Taylor
Review work load of CAHA and propose the staffing required to safely clinically manage alongside existing community provision those awaiting hospital admission.	Unclear if this review has taken place, HT back in position of SM from 1/7/24, will discuss and review with CW and NC	16/08/2024 Natalie Cotton

		Ongoing work across SHSC related to patient flow, specifically delayed discharge, length of stay and out of area reduction.	30/08/2024 Christopher Wood

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: 25/06/2024
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

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: 25/06/2024
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	21.5.24 reviewed; action remains; new target date needed as having to prioritise completion of the new MHA mandatory training material. Risk mitigated in interim - Head of MH Legislation, and MHA office, available to provide advice on specific case where necessary.	12/07/2024 Jamie Middleton
One off bespoke MCA training to be designed and delivered to Birch Avenue		30/08/2024 Jamie Middleton
Review to be undertaken to identify teams where there is less than 80% attainment in completing mandatory MCA training; where identified, service managers to be asked to	Work commenced but bigger piece of work than anticipated. Timescale updated	02/08/2024 Jamie Middleton

provide recovery plan to Mental Health Legislation Operational Group

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: 01/07/2024
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	3	12
Target Risk: (after improved controls):	4	2	8

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

Collection of final plans to include QEIA where required and presented back to EMT	Schemes continue to be presented at QEIA panels - many schemes have been approved. Will all be completed within July so that final plans can be approved and progressed.	31/07/2024 Chris Cotton
PMO and Finance team to attend monthly meeting in each Directorate to report monitoring of their schemes		31/07/2024 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: 25/06/2024
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

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 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
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	31/12/2024 Jamie Middleton

		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.	
	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 Jamie Middleton

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: 24/06/2024
First Created: 18/07/2023	Exec Lead: Executive Medical Director	Review Frequency: Monthly

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	Joint working between Digital and Clinical Effectiveness. Developing plan to cover readiness for Rio and interim arrangements	31/03/2025 Jonathan Burleigh
To engage with clinical services over need repeat training workshops	Action currently underway	31/03/2025 Jonathan Burleigh

Risk No. 5220 v.10 BAF Ref: BAF.0024	Risk Type: Quality / Risk Appetite: Low	Monitoring Group: Mental Health Legislation Committee
Version Date: 05/07/2024	Directorate: Nursing & Professions	Last Reviewed: 05/07/2024
First Created: 26/09/2023	Exec Lead: Executive Director - Nursing & Professions	Review Frequency: Monthly

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 4 trained practitioner role	additional hours in team enabling more courses to be put on however places not filled is an issue. review of team funding will allow a substantive band 4 post	05/08/2024 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 escalation meeting that looks to resolve staffing gaps across the Trust.	safe staffing review and oversight continues. minimal reports of less thatn 3 respect trained staff. however compliance remains below the trust target	05/08/2024 Simon Barnitt

• identified leads for RP at ward team level • security officer support team in place • response protocol in place includes support of shared alarm system • 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 • support to ensure bank and agency staff have necessary skills to ensure Least restrictive practice • team based risk register for RESPECT team identifying controls and action to achieve required number of courses offered to ensure compliance . • 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 • local ward Restrictive practice development meetings supported by Nurse Consultant and/or respect team. • relevant policies that support such as Use of Force Policy and Seclusion Policy	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.	band 4 in post . to go out substantively following budget review	05/08/2024 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	compliance remains below Trust target due to inability to put on enough level 1 courses and issues with places filled and DNA rate. action remains applicable	05/08/2024 Lorena Cain

CORPORATE RISK REGISTER

As at: July 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: 05/06/2024
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

Work to mitigate this is covered through different phases of the project: Discover, Build	Discover phase completes 2/8/24.	31/01/2025 Kelly Collier

Risk No. 5321 v.7 BAF Ref: BAF.0014	Risk Type: Workforce / Risk Appetite: Low	Monitoring Group: People Committee
Version Date: 25/06/2024	Directorate: People	Last Reviewed: 25/06/2024
First Created: 14/03/2024	Exec Lead: Director Of Human Resources	Review Frequency: Monthly

Details of Risk:

There is a risk that we are unable to meet mandatory training compliance levels caused by a variety of factors impacting on one or more training subjects including lack of suitable training space for delivery of training; access to computers for e learning, local authority places for safeguarding and difficulties in staff release resulting in targets and CQC requirements not being met.

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):	2	3	6

CONTROLS IN PLACE

- Mandatory Training governance group reporting to Workforce and Recruitment assurance group
- monitoring of mandatory training compliance at Directorate IPQR meetings
- Mandatory training recovery plans reported at People committee
- Mandatory Training compliance reports sent to all managers every three weeks
- Monitoring of physical health training compliance at Physical Health group reporting into Quality assurance Committee
- Safeguarding Training Implementation Plan

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

A focus on rostering to support managers to plan training more effectively and ensure that they roster staff across the year and within headroom parameters.	processes in place to monitor headroom for trainingand plan rostering effectively	31/07/2024 Stephen Sellars
implement immediate level actions from the national Optimise, Rationalise, Reform work programme on StatMand training and test readiness for medium and long term actions	completed NHSE initial scoping form and signed up to national webinairs	30/07/2024 Karen Dickinson
A plan for improvement and expansion of training space at Chestnut cottage has been presented by Estates and agreed with the training teams who use the space. Next steps are to agree costs and timeframes for completion	alternative venues for training delivery under review	31/03/2025 Liam Casey

Risk No. 5344 v.5 BAF Ref: BAF.0026	Risk Type: Safety / Risk Appetite:	Monitoring Group: Finance & Performance Committee
Version Date: 01/07/2024	Directorate: Facilities	Last Reviewed: 21/06/2024
First Created: 21/06/2024	Exec Lead: Director Of Strategy	Review Frequency: Monthly

Details of Risk:

There is a risk that the integrity and safety of the fire doors have been compromised caused by inadequate maintenance through a sufficient Planned Preventative Maintenance(PPM) regime resulting in reduced effectiveness in minimising the spread of fire and smoke

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	4	5	20
Current Risk: (with current controls):	4	5	20
Target Risk: (after improved controls):	0	0	0

CONTROLS IN PLACE

• Fire Risk Assessments (FRA) have been completed in every Trust building. The primary aim of such assessments is to ensure the safety of all individuals present within Trust premises in the event of a fire.

Fire Doors form part of this assessment. the FRA have identified the overall risk as low risk. However, when applying the HTM risk assessment methodology, the risk has been identified as Moderate.

• Bi-Weekly Task and Finish Group established to monitor completion of actions

• Business case for fire door survey and installation of new fire doors approved at BPG on the 18th June

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

Complete a fire door asset tagging project to create an accurate inventory detailing how many fire doors are installed throughout the Trust and where. This will provide the Trust with an accurate asset register and ensure that all doors are captured within a regular Planned Preventive Maintenance (PPM) regime moving forward. This project is underway and due to be completed by July 2024.	12/07/2024 James Clarke
Conduct a review of the directorate's governance processes and meeting structure in order to establish a robust governance framework which will ensure the safe, effective, and efficient operation of engineering services. This includes clear accountability and responsibility structures, policies, and procedures.	31/08/2024 Liam Casey

Request supporting documentation from Kingsway Doors for any repairs undertaken in November 2023 and investigate if any work was performed on identified door gaps. If the work is not completed, establish an urgent action plan to undertake this work.	Awaiting a report from Kingsway, detailing all repairs and replacements, that have taken place over the last 9 months.	28/06/2024 Andy Probert
Renew the Kingsway Doors service contract and ensure that any additional doors, which may have been installed since the contract's inception, are included in the service visits.	Quotation for service contract received. Team to assess the contract to ensure all doors are captured, the specification is correct and to discuss costs with finance.	19/07/2024 Andy Probert
Ensure that all fire door inspections are reported to the Health and Safety Committee, including any defects and subsequent repairs		31/07/2024 Samantha Crosby
Conduct a comprehensive survey of all fire doors. This survey should be undertaken by an independent company, which does not supply and fit fire doors, and should provide detailed information on the specific faults of each door. The survey should explain why each door fails to comply with standards and suggest precise remedial actions using approved techniques, rather than		31/08/2024 Andy Probert

defaulting to the wholesale replacement of door sets.	
Implement a comprehensive fire door maintenance regime on all standard fire doors. Integrate data from the asset tagging project into the department's PPM management system, with each door scheduled for six-monthly PPM, or more frequently if deemed necessary by a risk assessment as per NHS standards guidance.	12/07/2024 Andy Probert
Appoint an Authorised Person (Fire Safety Maintenance) within the Estates team.	30/08/2024 Andy Probert
Review the processes and procedures within the Fire Safety Management team to ensure thorough monitoring and timely completion of risk-reducing actions identified within fire risk assessments. Additionally, these actions should be reported to the Health and Safety Committee for oversight.	31/07/2024 Samantha Crosby
Commission a survey of structural fire compartmentation and fire dampers, and also include an update to the compartmentation drawings.	30/08/2024 Andy Probert

	Ensure that the annual independent fire safety audit, conducted by the Trust's Authorising Engineer (Fire), assesses whether the Fire Safety Management team's processes and procedures meet the updated requirements and standards of the Health Technical Memorandum. The audit should specifically focus on the quality of the Trust's Fire Risk Assessments, the effectiveness of the risk-reducing actions identified in those assessments, and the overall management and monitoring processes. It should also provide recommendations for compliance where gaps are identified.	30/08/2024 Samantha Crosby
	The annual fire safety audit should also include a competency assessment of the Trust Fire Risk Assessment process to ensure that the FRA meets the competency standards outlined in the 'Approved Code of Practice: A National Framework for Fire Risk Assessor Competency.' Additionally, the audit should provide recommendations for addressing any identified training or education gaps.	30/08/2024 Samantha Crosby
	Ensure that the annual independent fire safety audit report is first	30/08/2024 Samantha

	presented to the Board Level Director with fire safety responsibility, James Drury, as specified in the Health Technical Memorandum, before being forwarded to the Fire Safety Management team for action. Regular updates and proposed resolutions should be reported to the Health and Safety Committee. This procedure will ensure that any high-risk issues are promptly escalated and that the actions and recommendations detailed in the audit report receive appropriate oversight.	Crosby
	In high-risk areas, a review of fire safety protocols and control measures should be conducted, including evacuation exercises and mandatory training levels, to ensure they are up-to-date and relevant. This review should be performed every six months until the fire doors have been assessed, repaired, or replaced	12/07/2024 Samantha Crosby