Board of Directors - Public

SUMMARY REPORT	Meeting Date:	27 November 2024
	Agenda Item:	22

Report Title:	**Corporate Risk Register report**	
Author(s):	Amber Wild, Head of Corporate Assurance	
Accountable Director:	Dawn Pearson, Associate Director of Communications and Corporate Governance	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	Audit and Risk Committee (ARC) Risk Oversight Group (RoG) Executive Management Team (EMT) People Committee (PC) Quality Assurance Committee (QAC) Finance and Performance Committee (FPC)
	Date:	14 October 2024 (ARC) 29 October 2024 (RoG) 7 November 2024 (EMT). 12 November 2024 (PC) 13 November 2024 (FPC) 14 November 2024 (QAC)
Key points/ recommendations from those meetings	Summary analysis of the risks on the Corporate Risk register (CRR) following receipt through the Executive Management Team, Risk Oversight Group and the Board Assurance Committees. Audit and Risk committee requested that RoG reviews those risks on the register that have had little movement in their risk scores, and to reflect the changes and movement in the report to be able to provide assurance to committees and the Board. This work has been reflected in the updates provided in the report.	

Summary of key points in report

The Corporate Risk Register is a mechanism to manage high level risks facing the organisation from a strategic, clinical and business risk perspective. The high-level strategic risks identified in the CRR are underpinned and informed by risk registers overseen at the local operational level within Directorates. There are 12 risks on the corporate risk register for reporting to the Board in November 2024.

Key items are drawn to the attention of the committee below via an Alert, Advise, Assure and changes to risks are described in the table at section 1, with the full details of the risks can be found in the Ulyssess extract at **appendix 1**.

Alert
None to note

Advise

New risks

Four new risks have been added to the risk register since it was reported to the board in September 2024 and following approval from the respective assurance committees during October and November 2024.

The Board is asked **to note** that one of the four new risks (**risk 5410**) is yet to be considered by its monitoring committee:

Risk 5410 relating to hospital discharge of restricted patients is delayed due to administration by the Ministry of Justice. (risk score 12).
Oversight through Quality Assurance Committee, Director of Operations.

- The risk has been added to the corporate risk register following discussion at EMT in November.
- Work to finalise the actions is underway for presentation to the Risk Oversight Group in November and Quality Assurance Committee in December 2024.

The Board is asked **to approve** the new **risk 5041** following consideration and agreement of this action by Audit and Risk Committee in October:

Risk 5041: There is a risk that all corporate and clinical services cannot operate safely because technology is unavailable due to a cyber security incident (risk score 12).
Oversight through Audit and Risk Committee, Executive Lead Director of Finance.

- The risk and actions have been agreed by the Executive lead
- Four actions are in place with identified target dates for completion.

The Board is asked **to approve** the **new risk 5399** following agreement at Finance and Performance Committee in October 2024.

Risk 5399: There is a risk that a safe Electronic Patient Record (RIO) is not implemented and adopted by staff, caused by ineffective governance, poor staff engagement and design or a lack of capacity and capability resulting in a protracted or failed governance that facilitates an unsafe or substandard implementation that puts service users at risk, an unacceptable burden on staff or significant time delays and additional costs. (Risk score 16)
Oversight through Finance and Performance Committee, Executive lead Director of Finance.

- The Finance and Performance committee requested that the description is amended to clarify that poor engagement relates to staff, and this has been reflected in the description presented.
- The risk description and scoring has been approved by the Executive lead, and work is ongoing to progress the controls and mitigations.

The Board is asked **to approve** the new **risk 5409** following consideration and agreement of this action by Quality Assurance Committee in October:

Risk 5409 A risk to patient safety due medical staffing and recruitment challenges resulting in a sub-optimal level of medical capacity in inpatient and community services (risk score 16)
Oversight through People Committee, Executive Director of People

- Added to the register following discussion at the committee and Board in September to develop a risk relating to medical recruitment in inpatient services and community services
- The risk and the actions have been agreed by the Executive lead.
- There are 2 actions in place, both with target dates for April 2025.

Escalated risks

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)
Oversight through Finance and Performance Committee, Executive lead Director of Finance

- The Board is asked **to note** that the Finance and Performance committee agreed to an **increase in score from 12 to 16** at its meeting in October and the committee have requested that the risk score is reviewed again at the meeting in December 2024.

Deescalated/closed risks

Trust Board are advised **to note** that 9 risks have been deescalated since the register was reported in September 2024.
Seven of these relate to EPR (risk 5366, 5224. 5367, 5368, 5369, 5370,4795). These have been closed from the corporate risk register and will continue to be managed on the Programme Board risk register. These were approved for closure at the Finance and Performance committee in October 2024.

At the request of Audit and Risk Committee, a review of risks that have had little change to their scoring has been undertaken which has identified four risks as being static – showing no movement since they were first entered onto the risk register a year ago.
Two of these have been reviewed and discussed at Mental Health Legislation Operational Group and Risk Oversight Group in October 2024, and these have been deescalated or closed. This has been agreed by the Executive lead.
Trust Board **to note** that these risks have not yet been considered by the Mental Health Legislation committee and will be presented to the committee in December 2024.

4513 BAF0024	There is a risk that Associate Mental Health Act Manager (AMHAM) Hearings will not be undertaken in a timely manner. Mental health legislation committee, Executive medical director	Deescalated - for monitoring on the directorate risk register. Scoring reduced from 12 to 9 following mitigations in place and due to likelihood of risk being reduced.
5047 BAF0024	There is a risk that practice within the Trust is not compliant with the Mental Capacity Act caused by multiple factors such as MCA mandatory training not being undertaken,	Closed - all risks associated with mandatory training compliance are incorporated into one risk which is held and managed by People directorate

Assure

Trust Board is asked **to note** that work has taken place to have one overarching corporate risk related to mandatory training:

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; trainer capacity, 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)
Oversight through People Committee, Executive lead Director of People

- The risk description has been amended and actions are in place which will address specific subject/ compliance areas with the relevant teams.
- The finalised risk was approved at the People committee in November 2024.

Trust Board is asked **to note** that work has taken place to update the wording to the below risk description:

Risk 5385: There is a risk that reporting systems do not support an effective response to sexual safety, racism and violence caused by the culture of reporting resulting in low staff morale, wellbeing and quality of care. (risk score 12).
Oversight through People Committee, Executive lead Director of People

- Board requested an amendment to the risk description to clarify that this should be “reporting systems’
- The updated risk description was approved by the People Committee in November 2024.

Directorate and team registers

The Board can take assurance that 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

- No new risks have been highlighted as being on team or directorate risk registers between 13 September and 13 October 2024 scoring 12 or above which have not yet been escalated to the Corporate Risk Register.
- Work continues to support the directorates in preparing for the Internal Audit later in the year on directorate risk management arrangements.
- RoG received assurance from presentations received at its meeting in October 2024

Appendices:
Appendix 1: Ulysses extraction report November 2024.

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

Trust Board are asked to:
- approve risk 5041, risk 5399 and risk 5049
- note the 9 risks that have been deescalated (risks 5366, 5224, 5367, 5368, 5369, 5370,4795, and risks 4513, 5047)
- note amended risk descriptions for risks 5321, 5385.
- take assurance that directorate and team risk registers continue to be monitored for high scoring risks
- 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 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***	

Background

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.

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

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

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.

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

Risk profile

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 low (green), moderate (yellow), high (amber) or extreme (red).

The table below shows the spread of risks on the register as at November 2024. Scoring used is reflective of the current Risk Management Framework.

Severity

Catastrophic (5)				**1**	
Major (4)			**2**	**4**	
Moderate (3)				**5**	
Minor (2)					
Negligible (1)					
Likelihood	(1) Rare	(2) Unlikely	(3) Possible	(4) Likely	(5) Almost Certain

Section 1: Analysis and supporting detail

- Below is a snapshot of the corporate risks, ordered from top to bottom by current risk score. The full detail of these risks can be found in appendix 1 which is attached to this report.
- There are currently **five top scoring** corporate risks, one of which is overseen by the Quality Assurance Committee, three overseen by the Finance and Performance Committee, and one overseen by the People Committee as detailed below.
- New risks and risk descriptions are indicated in blue text
- Key changes have been highlighted in the Alert, Advise, Assure section of the report.

Risk number	**Description**	**Monitoring Committee Executive lead**	**Current score Severity x likelihood**	**Target score Severity x likelihood**	**Update** All risks have been updated within the recommended review frequency period.
5344 BAF0026	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	Finance and performance Committee Director of Strategy	4 x 5 =20 ⟺	1 x 4 = 4	No change to scoring at this time. On-site reviews have been completed and site-specific reports have been submitted. A report will be taken to EMT on 21 November, following which a review of the risk will take place.
5365 BAF0029	There is a risk that patient experience and quality of life maybe be negatively impacted due to longer than recommended waiting times to access highly specialist services, (ADHD and Gender Services), caused by demand exceeding commissioned capacity resulting in an impact on service user experience, staff wellbeing and reputational damage.	Quality Assurance Committee Director of Operations	4 x 4 =16 ⟺	3 x 2 = 6	Risk actions reviewed and updated with new and varying target dates with the last action target to be reviewed by April 2025.
5399 BAF0021A	NEWThere is a risk that a safe Electronic Patient Record (RIO) is not implemented and adopted by staff, caused by ineffective governance, poor staff engagement and design or a lack of capacity and capability resulting in a protracted or failed governance that facilitates an unsafe or substandard implementation that puts service users at risk, an unacceptable burden on staff or significant time delays and additional costs.	Finance and performance Committee Director of Finance	4 x 4 =16 ⟺	4 x 2 = 8	The CDIO and programme manager have updated actions following the Rio risk meeting in November. Two actions remain ongoing with a target date of November 2024 and February 2025
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.	Finance and performance Committee Director of Finance	4 x 4 = 16 ↑	3 x 3 = 6	The risk score was increased and agreed at FPC in October, and an action has been added in November to implement actions agreed to achieve additional mitigations/savings with a target date of the end of Janaury 2025.
5409 BAF0014	**NEW** A risk to patient safety due medical staffing and recruitment challenges resulting in a sub-optimal level of medical capacity in inpatient and community	People Committee Interim Medical	4 x 4 = 16 ⟺	3 x 4 =-12	Two actions are in place with target dates for April 2025.

	services	Director			
5401 BAF0021B	**NEW** There is a risk that all corporate and clinical services cannot operate safely because technology is unavailable due to a cyber security incident	Audit and Risk Committee Director of Finance	4 x 3 = 12 ⟺	4 x 1 = 4	Risk reviewed and updated target dates amended to end of December 2024.
5001 BAF0029	There is a risk to the quality and safety of patient care caused by 1) delays in accessing an acute hospital bed in Sheffield 2) poor care and experience from out of area hospital providers 3) delays in facilitating discharge from hospital beds. These issues affect the operational delivery of our acute, crisis and community services.	Quality Assurance Committee Director of Operations	3 x 4 = 12 ⟺	3 x 2 = 6	Risk reviewed and updated target dates amended to end of December 2024. One action has been closed and incorporated into the Home First Programme action.
5026 BAF0024	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.	Mental Health legislation Committee Interim Medical Director	3 x 4 = 12 ⟺	3 x 1 = 3	Risk reviewed by Head of Mental Health Legislation and actions updated. The current risk score is to remain due due to ongoing difficulties nationally in respect of demand for DOLS assessments. The action target dates have been revised to the end of January 2025.
5124 BAF0024	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.	Mental Health legislation Committee Interim Medical Director	4 x 3 = 12 ⟺	2 x 3 = 6	Risk remains and no change to scoring at this time due to incidents continuing to be submitted for non-compliance. The action target dates have been revised to the end of December 2024.
5321 BAF0014	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; trainer capacity, 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.	People Committee Director of People	3 x 4 = 12 ⟺	2 x 3 = 6	The risk description has been reviewed with the mandatory training lead and additional actions have been added, with target dates of March 2025.
5385 BAF0013	There is a risk that reporting systems do not support an effective response to sexual safety, racism and violence caused by the culture of reporting resulting in low staff morale, wellbeing and quality of care.	People Committee Director of People	3 x 4 =12 ⟺	3 x 2 = 6	Two actions are in place and have had their target dates revised to November and December 2024 following which the risk score will be reviewed.
5410 BAF0029	**NEW** There is a risk that the hospital discharge of restricted patients is delayed due to administration by the Ministry of Justice. This may adversely affect patient experience and outcomes and may significantly reduce our hospital bed capacity, causing delays in arranging hospital admission for other patients	Quality Assurance Committee Director of Operations	3 x 4 = 12	3 x 2 = 6	Added to the risk register following discussion at EMT in November 2024. Work to finalise this is underway for presentation to the Risk Oversight Group in November and Quality Assurance Committee in December 2024

Section 2: Risks

Failure to properly review the corporate risk register could result in the Board or its committees not being fully sighted on key risks facing the organisation.

Section 3: Assurance

The information provided within the corporate risk register is owned by Executive Directors and reviewed/ revised by colleagues within their directorates under their leadership**.**

Strategic Priorities and Board Assurance Framework

1. Effective Use of Resources
2. Deliver Outstanding Care
3. Great Place to Work
4. Ensuring our services

Section 4: Implications

Strategic Aims and Board Assurance Framework
All.

Equalities, diversity and inclusion
None directly arising from this report.

Culture and People
None directly arising from this report.

Integration and system thinking
None directly arising from this report.

Financial
None directly arising from this report.

Compliance - Legal/Regulatory
None directly arising from this report.

Section 5: Recommendations

Trust Board are asked to:

- approve risk 5041, risk 5399 and risk 5049
- note the 9 risks that have been deescalated (risks 5366, 5224, 5367, 5368, 5369, 5370,4795, and risks 4513, 5047)
- note amended risk descriptions for risks 5321, 5385.
- take assurance that directorate and team risk registers continue to be monitored for high scoring risks
- identify if there are additional risks following discussion at the meeting that should be considered for review and escalation

Section 6: Appendices

Appendix 1: Ulysses extraction report – November 2024

CORPORATE RISK REGISTER

As at: November 2024

Risk No. 5001 v.9 BAF Ref: BAF.0025B	Risk Type: Strategic / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee
Version Date: 03/09/2024	Directorate: Acute & Community	Last Reviewed: 13/11/2024
First Created: 16/11/2022	Exec Lead: Director Of Operations	Review Frequency: Monthly

Details of Risk:

There is a risk to the quality and safety of patient care caused by 1) delays in accessing an acute hospital bed in Sheffield 2) poor care and experience from out of area hospital providers 3) delays in facilitating discharge from hospital beds. These issues affect the operational delivery of our acute, crisis and community 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.	Revised time plan established. The full gate keeping brief to be met by June 2025, but an interim plan of gate keeping all AMHP assessments has been agreed subject to additional staffing to commence December 2024. Meeting to communicate the plan to the wider team was held on the 11th November.	31/12/2024 Christopher Wood
Home First Programme mobilised and meeting on weekly basis to review 15 actions to manage grip and control of patient flow.		31/12/2024 Greg Hackney

Risk No. 5026 v.4 BAF Ref: BAF.0024	Risk Type: Statutory/ Compliance / Risk Appetite: Low	Monitoring Group: Mental Health Legislation Committee
Version Date: 29/09/2023	Directorate: Medical	Last Reviewed: 29/10/2024
First Created: 20/12/2022	Exec Lead: 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

The Trust's Deprivation of Liberty Safeguards policy is currently being reviewed. A significant re-write is needed as much of current content is in respect of supervisory body duties as opposed to the Trust's duties, and some gaps in process have been identified which require resolution. Action is to complete the DOLS policy review	31/01/2025 Jamie Middleton
New DOLS register to be created as the one which was created is not working as effectively as we had hoped.	31/01/2025 Jamie Middleton

Risk No. 5051 v.4 BAF Ref: BAF.0022	Risk Type: Financial / Risk Appetite: Sustainability	Monitoring Group: Finance & Performance Committee
Version Date: 01/04/2024	Directorate: Finance	Last Reviewed: 05/11/2024
First Created: 01/02/2023	Exec Lead: 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):	3	2	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

Implement actions agreed to achieve additional £2m mitigations and savings required. Actions being monitored at Exec finance huddle with Exec responsible for each action.

31/01/2025
Phillip Easthope

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
- Additional Financial controls implemented from 1st October including vacancy freeze for non clinical non critical roles and Exec approval for agency and locum usage.

Risk No. 5124 v.5 BAF Ref: BAF.0024	Risk Type: Statutory/ Compliance / Risk Appetite: Zero	Monitoring Group: Mental Health Legislation Committee
Version Date: 21/03/2024	Directorate: Medical	Last Reviewed: 29/10/2024
First Created: 15/05/2023	Exec Lead: 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. 5321 v.11 BAF Ref: BAF.0014	Risk Type: Workforce / Risk Appetite: Low	Monitoring Group: People Committee
Version Date: 31/10/2024	Directorate: People	Last Reviewed: 31/10/2024
First Created: 14/03/2024	Exec Lead: Director Of People	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; trainer capacity, access to computers for e learning, 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 EMT prior to being presented 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
- Manager and Supervisor Self Service on ESR gives teams visibility of staff training records since 01/04/2024

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.	Weekly meetings are in place chaired by clinical ops (Neil or Greg) to track and monitor: 1. Workforce utilisation 2. Bank and Agency usage 3. AL/Study/Sickness (headroom allowances) These are still in place and will continue until the end of the financial year.	31/03/2025 Stephen Sellars
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.	No further updates received.	31/03/2025 Liam Casey

Next steps are to agree costs and timeframes for completion. lack of suitable training space is impacting on compliance for Resus Level 2 and 3; Moving and Handling Level 2.		
implement immediate level actions from the national Optimise, Rationalise, Reform work programme on StatMand training and test readiness for medium and long term actions	further updates following November national review meeting.	31/12/2024 Karen Dickinson
The issues regarding the capacity of the Respect training team to deliver the required amount of courses have been mitigated to some extent by the employment of another trainer. Staff turnover is also impacting and Respect Lead is working with training to provide extra courses - 160 places made available for level 1 between the 21st - 25th Oct. further work required to look at level 3		31/03/2025 Gregory Hughes

Risk No. 5344 v.5 BAF Ref: BAF.0026	Risk Type: Strategic / Risk Appetite:	Monitoring Group: Finance & Performance Committee
Version Date: 01/07/2024	Directorate: Facilities	Last Reviewed: 05/11/2024
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):	5	4	20
Target Risk: (after improved controls):	1	4	4

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

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.	Still awaiting report from Kingsway, to back up the excel sheet data sent.	30/11/2024 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.	As per action 17268, meeting with Procurement/Capital to discuss the Kingsway contract on 4th November 2024.	30/11/2024 Andy Probert
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	Draft reports have been received. To review with the Fire Team on 7th November 2024, prior to receiving the finalised reports from Sircle.	31/12/2024 Andy Probert

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 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.	Meeting with Procurement/Capital, on 4th November, to discuss the contract with Kingsway.	30/11/2024 Andy Probert
Appoint an Authorised Person (Fire Safety Maintenance) within the Estates team.	Re-planned in for 06Nov24.	30/11/2024 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.	I have added this to the quarterly report Q1 with details of the outstanding actions but feel it needs to go into Q2 before sign off of the action is completed (H&SC November 2024 sign off).	27/11/2024 Samantha Crosby

Commission a survey of structural fire compartmentation and fire dampers, and also include an update to the compartmentation drawings.	All four sites have been completed. All documents to be reviewed during the first week in Nov24.	30/11/2024 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.	Audit is booked for the 25th September 2024.	30/11/2024 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	The audit is booked for the 25th September 2024.	30/11/2024 Samantha Crosby

	should provide recommendations for addressing any identified training or education gaps.		
	Ensure that the annual independent fire safety audit report is first 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.	Audit is booked for the 25th September 2024.	30/11/2024 Samantha Crosby

Risk No. 5365 v.2 BAF Ref:	Risk Type: Clinical ,Quality And/ Safety	Risk Appetite: Moderate
Version Date: 02/08/2024	Directorate: Rehabilitation & Specialist Se	Monitoring Group: Quality Assurance Committee
First Created: 23/07/2024	Exec Lead: Director Of Operations	Last Reviewed: 05/11/2024
		Review Frequency: Monthly

Details of Risk:

There is a risk that patient experience and quality of life maybe be negatively impacted due to longer than recommended waiting times to access highly specialist services, (ADHD and Gender Services), caused by demand exceeding commissioned capacity resulting in an impact on service user experience, staff wellbeing and reputational damage.

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):	3	2	6

CONTROLS IN PLACE

- National issue of demand exceeding available resource. Known by national and local commissioners. Currently close working with PLACE/ICB commissioners to consider longer term city-wide delivery plans to include health and social care stakeholders.
- Recognition that this is a national issue and not just a local one by ICB and NHS E. Collaboration with services to consider resource and clinical models for service delivery and to consider control measures to address demand on specialist providers.
- Strong oversight of Exec Board and SMT

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

Other clinical staff within the Trust who have received UKAAN training to be seconded into the team to undertake ADHD diagnostic assessments to support the restart of new assessment streams.	Lead clinicians have implemented plans for Clinicians that are appropriate trained (profession and UKAAN) in other SHSC services are required to carry out routine ADHD assessment within their areas. Training was delivered by Dr S and Dr L from SAANS and a plan is in place to provide support and answer queries as necessary. Will be reviewed	31/12/2024 Mark Parker
SAANS staff who are UKAAN trained to commence assessment for ADHD where co-morbidity is indicated with ASD, under the supervision of senior medical staff	This is currently being piloted - agreed to give 6 months to review effectiveness and impact	31/12/2024 Holly Johnson

To identify current funding into SAANS specifically related to ADHD provision and ensure that funding is fully utilised for recruitment of appropriately qualified nursing staff	Posts have been agreed at VCP - currently with AFC for band match review. Plan to advertise in November	30/11/2024 Mark Parker
Termination of Derbyshire contract to reduce numbers waiting for Sheffield services. Ensure safe transfer of patient information to Derbyshire commissioners.		25/11/2024 Mark Parker
Engagement with ICB T&F/SDIP to explore longer term city-wide clinical model and support initiation		31/03/2025 Mark Parker
EDT to engage with commissioners through the CMG to explore the possibility of increased funding to expand the service.	Engaging with ICB through monthly SDIP meeting - will be raised through this forum	30/11/2024 Neil Robertson
Recruitment to new workforce plan for GIC to address single points of failure within operational delivery and support increased throughput.	Senior Practitioners have been recruited to and due to start in Jan 2025. Peer Recovery worker recruited and now in post. Pathway Coordinator recruited and due to start. Vacant posts to be reviewed.	31/12/2024 Mark Parker

	GIC engaging with NHS E for 'deep dive' and recommendations for clinical model delivery.	NHS England and Levy review to take place on 12th November - actions to be carried out accordingly	30/11/2024 Mark Parker

Risk No. 5385 v.4 BAF Ref: BAF.0013	Risk Type: Clinical ,Quality And / Safety	Risk Appetite:
Version Date: 22/10/2024	Directorate: People	Monitoring Group: People Committee
First Created: 29/08/2024	Exec Lead: Director Of People	Last Reviewed: 07/11/2024
		Review Frequency: Bi-Monthly

Details of Risk:

There is a risk that reporting systems do not support an effective response to sexual safety, racism and violence caused by the culture of reporting resulting in low staff morale, wellbeing and quality of care.

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

- incident reporting through Ulysees
- Daily Incident huddles
- Psychological Safety group
- A workshop was held in October 2024 with managers and other stakeholders to look at how to improve reporting of racism and other types of harassment and discrimination
- Violence and Aggression reduction group

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

Development of SOP for reporting	Draft SOP developed needs signing off after piloting of ESR portal	30/11/2024 Liz Johnson
sexual safety raising awareness activity to take place in September 2024 and improvements to reporting incidents relating to staff will be in place from September 2024.	Listening events commenced. Poster campaign	31/12/2024 Sarah Bawden

Risk No. 5399 v.4 BAF Ref: BAF.0021A	Risk Type: Strategic / Risk Appetite: High	Monitoring Group: Finance & Performance Committee
Version Date: 01/10/2024	Directorate: Digital	Last Reviewed: 06/11/2024
First Created: 28/09/2024	Exec Lead: Director Of Finance	Review Frequency: Monthly

Details of Risk:

There is a risk that a safe Electronic Patient Record (RIO) is not implemented and adopted by staff, caused by: ineffective / slow governance; poor staff engagement due to a lack of operational capacity; poor quality implementation due to digital staff leaving; key Digital staff being directed to non EPR work by other initiatives / changes to Insight; lack of clear leadership from board level. This may result in a protracted, unsafe or failed implementation that puts service users at risk, an unacceptable burden on staff or significant time delays and additional costs.

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

• Proposal to restructure digital department will eliminate the risk that staff will leave and support mechanisms will be poor.

12 roles will be at risk. 12 roles are on fixed term contracts and 4 roles are on secondment.

• Key Staff in every service need to reserve time to contribute to the work to design and test rio and its reports.

Regular engagement with deputy director of Ops plus service heads to ensure that they are aware of services who are not engaging

• Establish clear governance and terms of reference with executive clinical and operational ownership. Expectations are set within Terms of Reference. Work with internal governance mechanisms and escalate to SRO, when quick decisions are needed.

Use digital capital and revenues budgets appropriately to manage unforeseen financial requests.

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

Funding for 25/26 for digital to be confirmed by EMT in October	new proposal to be presented at EMT on 21/11	30/11/2024 Chris Reynolds
User acceptance testing for system performance and reporting is underway for older adult.	Testing on system performance is complete. No concerns with smartcard deployment.	03/02/2025 Julian Young
Clinical and operational staff need to be available for testing to sign off rio and its reporting.	For tranche two testing does not start until dec 9th.	
Managers and executives need to prepared for a change to performance in services as they standardise and move to national definitions.		

Clinical Executive design group meets weekly.

Rio Assurance group meets fortnightly.

Insight changes must go through a robust process, that includes Rio project team.

- Ensure the Rio work is prioritised within transformation portfolio.
- Ensure staff are well-trained and supported and that training reflects service processes.

Make process documentation widely available.

Ensure processes are simple

- External Assurance provided by St Vincents Consulting. Weekly meetings take place.

Risk No. 5401 v.3 BAF Ref: BAF.0021B	Risk Type: Business / Risk Appetite:	Monitoring Group: Audit And Risk Committee
Version Date: 10/10/2024	Directorate: Digital	Last Reviewed: 08/11/2024
First Created: 01/09/2024	Exec Lead: Director Of Finance	Review Frequency: Monthly

Details of Risk:

There is a risk that all corporate and clinical services cannot operate safely because technology is unavailable due to a cyber security incident

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):	4	1	4

CONTROLS IN PLACE

- Governance group in place reporting into Audit committee
- Care Certs monitored and applied when appropriate
- Penetration Test takes place annually and recommendations actioned
- Security Awareness and Training takes place for all staff using IG training - compliance target of 80% is consistently met
- Phishing simulation exercise takes place annually. Results are analysed and actioned.
- Multi Factor authentication is now in place for all accounts.
- A suite of Security policies are in place
- Firewalls review inbound and outbound traffic into SHSC data centres. These are fully resiliant.
- Intrusion Detection and Prevention System. This monitors for suspicious activity as part of the firewall infrastructure
- Virtual Private Network is in place to provide secure, encrypted access to SHSC systems over the internet.
- Web security. We provide a web filtering tool that restricts access to websites when connected to the corporate network
- email security: anti spam, malware scanning and malicious URL detection is in place.

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

Build investment cases to keep current tools up to date as part of business planning	We need to upgrade for software on data centre network onto the latest version. Business case to go to BPG in December - Approx 9k for 24/25 capital plan. Considering conditional access for all N365 endpoints.	31/12/2024 Adam John Handley
Build investment case for new tools for cyber - zero trust products		28/02/2025 Emma Porter
Creation of cyber incident response plan	Plan to be drafted and the go through governance forums.	28/02/2025 Adam John Handley

• Public wireless network is secured and seperate from corporate network • Network Monitoring: We have a tool that monitors network usage. • Network segmentation: We seperate out corporate network traffic from non SHSC devices. This ensures that corporate services are not vunerable to threats from non SHSC devices. • As part of Microsoft licencing arrangement, our microsoft end points are part of a national infrastructure. This ensures it is monitored by ourselves and NHS E. We also use Sophos to provide anti malware protection • Mobile Device management: we use MS products to enforce our security policies on our corporate devices, This allows us to control software that is deployed to these devices, • All end user devices are secured using an encryption tool • We control access to systems by setting up and maintaining access to active directory. We manage what staff can access (network folders) through this • We control access to systems for staff who need administrative rights (system managers controlling configuration and user accounts) by using a privleged access management system	Joining SHSC devices to control access to 365	31/03/2025 Emma Porter

Risk No. 5409 v.2 BAF Ref: BAF.0014	Risk Type: Workforce / Risk Appetite: High	Monitoring Group: People Committee
Version Date: 01/11/2024	Directorate: Medical	Last Reviewed: / /
First Created: 01/11/2024	Exec Lead: Medical Director	Review Frequency: Monthly

Details of Risk:

A risk to patient safety due medical staffing and recruitment challenges resulting in a sub-optimal level of medical capacity in inpatient and community services

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):	3	4	12

CONTROLS IN PLACE

- Medical Workforce Planning Group sets strategies to retain and recruit high quality medical staff.
- Ongoing recruitment aiming to fill gaps in medical staffing, particularly inpatient posts
- Ongoing projects to promote Psychiatry as a specialty choice for medical students and resident doctors
- Work to promote SHSC as employer of choice and identify potential recruits as they progress through the regional training scheme

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

Reconfigure inpatient staffing model to enable consultant staff to work across more clinical teams	01/04/2025 Jonathan Mitchell
Review wider clinical staffing model to reduce risk arising from ongoing sub-optimal level of medical staffing	01/04/2025 Jonathan Mitchell

Risk No. 5410 v.1 BAF Ref: BAF.0029	Risk Type: Clinical ,Quality And / Safety	Risk Appetite: Monitoring Group: Quality Assurance Committee
Version Date: 08/11/2024	Directorate: Acute & Community	Last Reviewed: / /
First Created: 08/11/2024	Exec Lead: Director Of Operations	Review Frequency: Bi-Monthly

Details of Risk:

There is a risk that the hospital discharge of restricted patients is delayed due to administration by the Ministry of Justice. This may adversely affect patient experience and outcomes and may significantly reduce our hospital bed capacity, causing delays in arranging hospital admission for other patients

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

- Liaising with the MHA Office
- Regular discussion of progress in the Clinically Ready for Discharge Meeting
- Proactive clinical oversight to ensure appropriate management E.G use of leave

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

Consideration of alternative accommodation e.g rehab	01/04/2025 Jessica Green

Total: 12