Sheffield Health and Social Care NHS Foundation Trust

Board of Directors – Public

Date: 26 May 2021 **Item Ref:** **18b**

TITLE OF PAPER	**Corporate Risk Register (CRR)**
TO BE PRESENTED BY	David Walsh, Director of Corporate Governance
ACTION REQUIRED	○ To receive the updated Corporate Risk Register following its consideration by Board committees in the context of assurance and gaps arising; ○ To note the review that has been undertaken of corporate risks, supported by the Director of Corporate Governance and the Intensive Support Director; ○ To consider any assurance or triangulation in the context of other material received by Board or its committees.
OUTCOME	To have a Corporate Risk Register in place that provides assurance that corporate risks are regularly reviewed, monitored and managed.
TIMETABLE FOR DECISION	26 May 2021
LINKS TO OTHER KEY REPORTS / DECISIONS	Internal Audit Reports covering Risk Management arrangements Directorate Risk Registers Risk Management Strategy Trust Strategy
STRATEGIC AIM: **STRATEGIC OBJECTIVE:**	All All
LINKS TO NHS CONSTITUTION & OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	Provider Licence Annual Governance Statement NHS Foundation Trust Code of Governance
IMPLICATIONS FOR SERVICE DELIVERY AND FINANCIAL IMPACT	Implications of individual risks outlined on the register.
CONSIDERATION OF LEGAL ISSUES	Breach of SHSC Constitution Standing Orders Breach of NHS Improvement's Governance regulations and Provider Licence.

Author of Report	David Walsh
Designation	Director of Corporate Governance
Date of Report	26 May 2021

Sheffield Health and Social Care NHS Foundation Trust

Corporate Risk Register

1. Purpose

For approval	*For a collective decision*	*To report progress*	*To seek input from*	*For information*	*Other (Please state below)*
		✓			

2. Summary

2.1 Corporate Risk Register

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. 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	Very Low Risk
5-8	Low Risk
9-12	Moderate Risk
15-25	High Risk

2.2 Review of risks

In addition to the regular reviews of risks, there has been additional support provided to risk assessors and risk owners, as reported that there would be at the last open meeting of Board in March. This has involved additional guidance on drafting risks and the consideration of reviews by the Director of Corporate Governance, and an overview of the full Corporate Risk Register by the Intensive Support Director, which was completed earlier this month and shared with risk owners for their consideration. The outcome of those reviews has resulted in some changes to the wording of some risks, as described in section 3.

2.3 Risk Appetite Statement

Board considered risk at its Board Development session on 3 February 2021, and then at the Board Workshop on 10 February 2021 gave specific consideration to the Risk Appetite Statement in the context of the ongoing strategy development work. The Risk Appetite Statement was formally approved at the last meeting of Board in

March, and was shared with all corporate risk assessors and owners in April to be taken into account during reviews of risks.

2.4 Risk Management Strategy

In line with the timescales previously reported to Board, this item is separately detailed on this agenda with proposals for approval. It takes into account recommendations made following an advisory internal audit on our Strategic Risk Management. Some of the recommendations from that review have resulted in specific changes within this report.

3. Corporate Risk Register

3.1 Changes following reviews

As described in paragraph 2.2, many of the risk in the corporate risk register have undergone a more in-depth review since they were last seen by Board. This has resulted in some of the risk descriptions being amended as follows:

Risk Ref	Original description	Revised description
3679	The inpatient environment cannot provide adequate assurance that risk is being managed and could result in patient safety incidents and harm.	There is a risk to patient safety arising from the quality and safety of the ward environments across SHSC hospital sites, including access to ligature anchor points.
3831	There is a risk that a lack of band 5 and band 6 nurses will impact on the Trust's ability to deliver the required quality of care for its patients and an over-reliance on bank and agency staff and preceptorship nurses will affects the level of skills and experience on the ward and leadership.	There is a risk to the quality and safety of patient care and ward leadership due to an over-reliance on agency staffing and preceptorship nurses and an insufficient number of qualified, substantive, nursing staff.
4121	There is a risk to patient safety, service efficiency and access to patient information as a result of Insight Instability. This includes instances of missing documentation in 2020, and the necessary report to the ICO.	There is a risk to patient safety, caused by key clinical documents being deleted, resulting in clinical decisions being made with incomplete or limited information and potential delays to patient treatment, e.g. missed appointments.
4124	Risk of harm to staff following incidents of violence and aggression causing harm which could impact on morale, sickness rates, staff attrition and difficulty in recruitment	There is a risk of harm to members of staff through clinical incidents of violence or aggression within inpatient areas. This may adversely affect staff wellbeing, staff morale, recruitment and attrition if not appropriately mitigated.
4276	Risk of physical harm to service users due to lack of physical health checks following administration of rapid tranquilisation	There is a risk of physical harm to service users due to an absence of physical health monitoring, in

		accordance with the physical health policy and standard operating procedure, following the administration of rapid tranquilisation medication.
4330	There is a risk at SPA that at times referral demand outstrips supply resulting in an inability to complete timely triage	There is a risk that service users cannot access secondary mental health services through the Single Point of Access within an acceptable waiting time due to an increase in demand and insufficient clinical capacity.

3.2 Corporate Risk Register Snapshot

Below is a snapshot of the risks on the CRR, ordered from top to bottom by current risk score, followed by the gap between the current risk and the target risk (risks feature higher where the gap is greater). The full detail of these risks can be found in the appendix.

The icons to the right of each risk indicate whether the current score has increased, decreased or remained the same since the risk was last seen by Board. This is an addition to the report arising from the recent internal audit.

Initial risk score			Current risk score			Target risk score			
Impact	Likelihood	Total	Impact	Likelihood	Total	Impact	Likelihood	Total	
4409: There is a risk the Trust is unable to provide sufficient additional nursing/nursing associate placement capacity to meet demand caused by a combination of factors, combined with vacancies, skill mix challenges, and increased service demands could result in a failure to meet long term transformation targets and a shortage of nurses to meet identified recruitment shortages. This could impact on the Trust's reputation and ability to deliver existing and/or increased demand for services.									⇔
4	4	16	4	4	16	3	2	6	
3679: There is a risk to patient safety arising from the quality and safety of the ward environments across SHSC hospital sites, including access to ligature anchor points.									⇔
5	4	20	5	3	15	2	2	4	
4284: Risk of further action being taken against the Trust if significant improvements are not made in the areas identified and outlined from the CQC during their well-led inspections.									⇔
5	4	20	5	3	15	2	2	4	
4325: Risk to Health & Safety of staff, service users and others due to a lack of access to a Back Care Advisor and Moving & Handling Training at all levels.									⇔
4	4	16	3	5	15	2	2	4	
4475: There is a risk that there are insufficient beds to meet service demand; caused by bed closures linked to the eradication of dormitories and ward refurbishment; resulting in a need to place service users out of city.									⇔
3	5	15	3	5	15	3	2	6	
4121: There is a risk to patient safety, caused by key clinical documents being deleted, resulting in clinical decisions being made with incomplete or limited information and potential delays to patient treatment, e.g. missed appointments.									⇓
4	5	20	3	5	15	3	3	9	

4362: There is a risk that the Trust will be unable to provide safe patient care or protect the health and wellbeing of its workforce due to the pandemic Coronavirus (Covid-19) which will impact on all services, both clinical and corporate.								
5	5	25	4	3	12	2	2	4
4276: There is a risk of physical harm to service users due to an absence of physical health monitoring, in accordance with the physical health policy and standard operating procedure, following the administration of rapid tranquilisation medication.								
4	5	20	4	3	12	2	2	4
3831: There is a risk to the quality and safety of patient care and ward leadership due to an over-reliance on agency staffing and preceptorship nurses and an insufficient number of qualified, substantive, nursing staff.								
4	4	16	3	4	12	3	2	6
4124: There is a risk of harm to members of staff through clinical incidents of violence or aggression within inpatient areas. This may adversely affect staff wellbeing, staff morale, recruitment and attrition if not appropriately mitigated.								
3	5	15	3	4	12	2	2	4
4326: Patient safety is at risk because key clinical systems that require planned maintenance (for security and licensing reasons) rely on IMST staff working out of hours when they are not contracted to do so, and are often the single point of failure when systems require downtime out of hours. The recent January 2021 Insight penetration test will require additional downtime slots to mitigate the required corrective actions.								
4	3	12	3	4	12	2	2	4
4377: Failure to deliver the required level of CIP for 2021/22. This includes closing any b/f recurrent gap and delivering the required level of efficiency during the financial year 2021/22.								
4	3	12	4	3	12	3	3	9
4483: There is a risk that trust IT systems and data could be compromised as a result of members of staff providing personal credentials and information upon receipt of phishing emails received.								
3	4	12	3	4	12	3	2	6
4330: There is a risk that service users cannot access secondary mental health services through the Single Point of Access within an acceptable waiting time due to an increase in demand and insufficient clinical capacity.								
5	3	15	5	2	10	2	2	4
4407: There is a risk of fire on the acute wards caused by service users smoking or using lighters/matches to set fires resulting in harm to service users, staff and property/facilities								
5	4	20	3	3	9	2	2	4
4189: The Falsified Medicines Directive (FMD) comes into force on 09/02/2019. SHSC NHS Foundation will not be compliant with the legislation as at this date due to concerns about the EU Exit strategy and ready availability of the necessary software with the upgrade to the JAC system								
3	5	15	3	3	9	2	2	4
4078: Low staff engagement which may impact on the quality of care, as indicated by the Staff Surveys 2018-2020								
3	4	12	3	3	9	2	3	6
4140: There is the possibility of an issue with supply of medication after the contingency plans put in place by the UK Government for EU exit resulting in a gap in medication supply to our service users. This is due to the uncertainty regarding the UK plans for leaving the EU								
3	4	12	3	3	9	2	2	4

4079: Failure to deliver an appropriately safe quality of waste management service due to the cessation of service delivery by the contracted company, following an assessment of their service by the Environment Agency, NHSi and NHSE. Clinical waste streams are particularly affected as general waste was sub-contracted to a different provider who can continue to deliver the service. This risk/incident is being managed nationally with affected Trusts expected to have contingency arrangements in place.								
4	5	20	2	3	6	2	2	4

3.3 Closed Risks

Two risks were approved for closure at the last consideration at Board, one relating to compliance with CCG contractual requirements arising from complaints performance (4264) and the other relating to the Covid financial regime (4396).

3.4 Reduced and/or Escalated Risks

Following the review of risk 4121 (in relation to the data loss of key clinical documents) this has been slightly reduced from a total score of 16 to 15. This is after the re-assessment found that the impact actually had the potential to be slightly higher than previously assessed (from 4 to 5), but the controls now in place brought the likelihood down (from 5 to 3). The reassessment of the impact has obviously impacted on the unmitigated score too, rising to 20. This risk remains 'high' at 15 so there is no proposal to move it.

Risk 4079 has seen significant reduction in its score, with the controls now in place reducing the likelihood from 4 to 2, resulting in a total risk score of 6 from 12 previously.

This, along with risk 4330 (access to secondary mental health services through SPA), risk 4407 (fire on acute wards), risk 4189 (falsified medicines directive), risk 4078 (low staff engagement) and risk 4140 (supply of medication) will all be recommended for consideration to de-escalate when next reported to their respective committees. Consideration was given to this at the Quality Assurance Committee, but more information was requested in order for this decision to be taken.

3.5 New Risks

There are no new risks detailed in the snapshot above. However, one new risk has been added *since* the last consideration by committees – risk 4613 in relation to medical workforce vacancies. This is not included above as it has not yet been considered by committees, but does feature in the appendix for completeness.

3.5 Risk profile

The table below shows the spread of risks on the corporate risk register.

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

4. Next Steps

As detailed in the report.

5. Required actions

As detailed on the front page of the report.

Please note the future recommendations that will be made to committees in respect of those risks with a score below 12, in accordance with the Risk Management Strategy and recommendations arising from the recent internal audit.

6. Monitoring Arrangements

Significant review and of the process and monitoring arrangements is reported as part of the Risk Management Strategy.

7. Contact Details

For further information, please contact:
David Walsh, Director of Corporate Governance
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CORPORATE RISK REGISTER

As at: May 2021

Risk No. 3679 v.10 BAF Ref: BAF.0003	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee
Version Date: 12/05/2021	Directorate: Acute & Community	Last Reviewed: 12/05/2021
First Created: 29/12/2016	Exec Lead: Executive Medical Director	Review Frequency: Monthly

Details of Risk:

There is a risk to patient safety arising from the quality and safety of the ward environments across SHSC hospital sites, including access to ligature anchor points.

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

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.
- 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 at Forest Lodge and Maple Ward
- Contemporaneous record keeping is supported by standard operating procedures to monitor changes in the needs and risks of service users.

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

Access to ceiling space to be reviewed by Estates and an options appraisal developed regarding either securing current tiles, or replacing the ceiling in Maple (en-suites) and in Stanage and Burbage en-suites and seclusion.	A decision in principle has been reached that the ceilings need to be replaced as part of the ward works improvement programme. Tenders have already been received for works for Burbage & Stanage ward and are being quality assessed. Decision awaited from ACM Programme Board on recommendation to proceed first of all with Burbage as a single phase, followed by Stanage then other areas. Two ceiling hatches were identified and have been locked off to prevent these being used as LAPs.	30/07/2021 Geoffrey Rawlings

• Business continuity plans in place during Covid-19 pandemic to minimise use of surge bed and maximise flow through alternative step-down routes. • Paper based physical health reviews are embedded into practice and audited through a daily situation report. • Dormitories are not in use across all inpatient environments (to be removed as part of estates strategy) • Heat maps are visible within all acute wards to highlight areas of greater risk due to access to ligature anchor points.	Estates to review and establish where flat-sided thumb turn locks are sited and replace with safer alternatives.	As identified replacement of thumbs turns cannot be undertaken in isolation due to an adverse impact on the integrity of the doors which are all also fire doors. A quantity of doors has been procured which will enable replacement as part of the wider ward environment improvements programme. Decision awaited via ACM Programme Board on the recommendation to proceed first with Burbage as a single phase, followed by Stanage and other areas.	30/07/2021 Geoffrey Rawlings
	Estates required to review and replace window frames which pose a ligature risk.	The window frames have been identified and replacement is part of the ward works improvement programme. Confirmation awaited via ACM Programme Board as to the order of the programme. A range of windows at Grenoside Grange have been replaced from central CIR (Critical Infrastructure Risk) funds allocated to the Trust for 2020/21, with	30/07/2021 Geoffrey Rawlings

		anti-ligature windows.	
	Progress with design and tender for capital works to remove dormitories. This is a long term project due to take 12 months until completion.	Work on Dovedale 1 and Maple wards to remove dormitories is complete. Work has been tendered (and the tender received) for eradication of dormitories on Burbage and Stanage wards; confirmation is awaited via ACM Programme Board on the programme for this. Recommendation is to do a full range of works on Burbage first as a single phase, followed by the same approach for Stanage.	30/06/2021 Geoffrey Rawlings

Risk No. 3831 v. 20 BAF Ref: BAF.0005	Risk Type: Workforce / Risk Appetite: Low	Monitoring Group: People's Committee
Version Date: 13/04/2021	Directorate: Acute & Community	Last Reviewed: 19/05/2021
First Created: 04/09/2017	Exec Lead: Executive Director - Nursing & Professions	Review Frequency: Monthly

Details of Risk:

There is a risk to the quality and safety of patient care and ward leadership due to an over-reliance on agency staffing and preceptorship nurses and an insufficient number of qualified, substantive, nursing staff.

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

- Creative ways of filling vacancies have been undertaken e.g. 2 band 5 OTs to Stanage Ward
- To improve retention and support a new 12 month preceptorship programme has been introduced whereby newly qualified nurses will receive appropriate mentoring & supervision, competency development and rotational opportunities.
- 4-weekly E-Roster Confirm and Challenge meeting embedded
- Deputy Director of Nursing Operations signs off each ward's Roster Performance prior to presentation at the Confirm and Challenge Meeting
- Deputy Director of Nursing led recruitment and retention programme for the inpatient wards.
- Development of new roles: Nurse Consultant, trainee Nursing Associate (TNA), trainee Advanced Clinical Practitioner (tACP) and Nurse Apprenticeships.
- Funding secured for additional trainees for new roles in 2020/21 from HEE.
- Fortnightly supervision for band 5 nurses.
- Advanced Clinical Practitioners (band 7) in place to support wards (quality and standards).
- Additional support from Senior Operational Managers in clinical areas, daily e-roster monitoring and escalation to executives, ongoing staff recruitment.

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

Recruitment and retention action plan in place (developed by Rapid Cell) and in the process of being delivered.	recruitment and retention plan in place and now being led by Neil Robertson	16/06/2021 Emma Highfield

- Rapid cell in place and operational reporting to Recruitment & Retention Subgroup and People Committee
- Weekly recruitment tracker in place which enables oversight of all vacancies and gaps.
- Rolling recruitment in place with identified timescales for recruitment
- SOP for Recruitment of Registered Nurses produced and embedded
- Support and Challenge meetings commence 5th November 2020 to provide e-rostering scrutiny
- SOP for Safer Staffing Escalation approved by PGG
- TRAC system in place

Risk No. 4078 v.12 BAF Ref: BAF.0005	Risk Type: Workforce / Risk Appetite: Low	Monitoring Group: People's Committee
Version Date: 19/05/2021	Directorate: Organisational Development	Last Reviewed: 20/05/2021
First Created: 26/10/2018	Exec Lead: Director Of Human Resources	Review Frequency: Monthly

Details of Risk:

Low staff engagement which may impact on the quality of care, as indicated by the Staff Surveys 2018-2020

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

CONTROLS IN PLACE

- Listening into Action principles established (Part of wider staff Engagement and Experience approach moving forward)
- Key areas identified within the themes for action and presented to People Committee, Quality Assurance Committee, Clinical Services (SDG) for oversight on progress. Specific action areas have been identified against each theme.
- Established Organisation Development team which includes staff engagement and experience.
- Regular communication with staff via 'Connect' demonstrating the actions taken by Trust in response to LIA feedback.
LiA sponsor group established and meets weekly
- Staff engagement measures identified and reviewed including:
- Increase in number of staff completing the staff survey 36%-40% - 41% 2020
- Trust has 50 LiA champions
- Significant number of staff responded to LiA initiatives
- Number of staff in BME staff network continue to increase (currently approx. 50)
- Lived experience group has around 20 members
- New Staff Survey Steering Group in place
- Unacceptable Behaviours Policy (informed by feedback from Bullying and Harassment Drop-in Sessions approved and to be rolled out across the Trust

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

Organisation Development Strategy to be developed.	OD Strategy agreed by People Committee in May and due to be presented to Board on 28 July 2021	28/07/2021 Rita Evans
Reviewing the Staff Survey engagement leads roles (ROI)	Now to be considered as part of the People Directorate review which is currently in progress.	31/07/2021 Rita Evans

- Leadership Call (Regular group with Executive)
- Development of local action planning to support staff engagement with dedicated OD resource working with service leads

Risk No. 4079 v.6 BAF Ref: BAF.0003	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee
Version Date: 30/03/2021	Directorate: Facilities	Last Reviewed: 30/03/2021
First Created: 26/10/2018	Exec Lead: Executive Director Of Finance	Review Frequency: Monthly

Details of Risk:

Failure to deliver an appropriately safe quality of waste management service due to the cessation of service delivery by the contracted company, following an assessment of their service by the Environment Agency, NHSi and NHSE. Clinical waste streams are particularly affected as general waste was sub-contracted to a different provider who can continue to deliver the service. This risk/incident is being managed nationally with affected Trusts expected to have contingency arrangements in place.

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

CONTROLS IN PLACE

- Risk under management of Trust's Emergency Planning arrangements led by Clive Clarke as Executive Lead for emergency planning
- Significant contingency plans have been drawn up under the co-ordination of Sarah Ellison, Trust Lead for Waste Management
- NHSi, NHSE and the Environment Agency are working jointly to resolve this matter which is a national incident and not confined to this Trust (Trusts within the Yorkshire & Humber Consortium for waste management affected)
- NHSi have identified an alternative waste management provider but contingency arrangements are in place and will apply for several months.
- Communications about this matter are being co-ordinated via NHSi and with the Trust's communications service
- During the C-19 pandemic specific guidance is being regularly issued to staff about correct practice for disposal of infectious (Orange bag) waste and steps are being taken to ensure as far as is possible that we have sufficient quantities of both bags and containers to manage the situation.
- The Trust's Waste Management lead has provided assurance the situation is now significantly mitigated and the risk rating can be reduced to a Low level.

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

PHS are continuing to provide the new clinical waste collection service. However further teething problems have emerged. The service continues to experience delivery problems and requires frequent intervention from the local waste management lead. There are significant issues with invoicing as we will not sign off on payments we believe to be incorrect. Support from the centre is being withdrawn.	The Trust's waste management lead has now provided assurance this risk is significantly mitigated and can be reduced to a Low level; albeit it will continue to be monitored while ever the Covid pandemic continues.	30/06/2021 Helen Payne

Risk No. 4121 v.17 BAF Ref: BAF.0007	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Finance & Performance Committee
Version Date: 19/05/2021	Directorate: IMS&T	Last Reviewed: 19/05/2021
First Created: 13/12/2018	Exec Lead: Executive Director Of Finance	Review Frequency: Monthly

Details of Risk:

There is a risk to patient safety, caused by key clinical documents being deleted, resulting in clinical decisions being made with incomplete or limited information and potential delays to patient treatment, e.g. missed appointments.

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	4	5	20
Current Risk: (with current controls):	3	5	15
Target Risk: (after improved controls):	3	3	9

CONTROLS IN PLACE

- Newly purchased tools allow active monitoring of the underlying infrastructure. Spikes in activity on the servers which affect the performance and stability will be addressed as soon as they are identified.
- Improved backup infrastructure in place provides faster recovery of deleted documents.
- Hourly snapshots of data in place, which reduces the volume of data that could be lost in an incident.
- View only access to emergency INSIGHT available should the live system fail or need to be taken offline to restore data.
- There is an increase in the frequency of file logging and automatic alerting tools to identify loss of data at the earliest stage.
- Insight documents are hidden in the scanned documents folder to reduce chance of accidental deletion.
- Ongoing programme of server patching in place to ensure optimum performance and security of the application infrastructure.
- A new change management process is in place, with changes recorded in our service management system and with assessment of testing, impact and recovery plans through the Change Advisory Board (CAB).
- A new 'Information Security Group' within IMST provides a forum for discussion and planning of security and information governance actions.

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

Remaining critical and high penetration test issues for the Insight Application to be assessed and potentially external support used to resolve them. Target date is for that assessment.	Date extended for the assessment to take place. A brief was issues and a quotation received. Next step is approval of necessary funding and time commitment from development team. in order to progress this.	30/06/2021 Andrew Male
A SOP to respond to document deletion incidents with reviews of the potential impact by clinicians and the process to restore documents will be formalised.	An outline SOP was provided at the last meeting of the Data and Information Governance Group (DIGG) on 19/04/2021, but further refinement is required to make it fully operational. A formal SOP for approval will be taken to the next meeting of DIGG.	28/06/2021 Ben Sewell

Software development roadmap to limit non-essential developments to the system which could cause instability.	Objective is that development roadmaps are to be defined by Systems Roadmap Group. This group aims to meet for the first time in June or early July. In the meantime discussions on development priorities including Insight are being held as required with CCIO and other senior staff.	14/07/2021 Ben Sewell
Business case for required resources to maintain Insight for an extended period of time due to delays with EPR replacement programme now required.	Current timescales for producing the business case are not achievable. It is possible that we may choose to retire this action depending on the outcome of prioritisation discussions on Insight related work, assessment from Chess and acceptance of updated residual risk in light of the new EPR Programme. Decision pending these outcomes.	30/06/2021 Ben Sewell
If assessment by Chess suggests that they can provide direct support to improving the security of Insight then a further quotation will be obtained		02/08/2021 Andrew Male

and work scheduled. At the time of writing the scope and cost of this work is not known. Assessment outcome could also be an assessment of the risk as manageable with current or modified controls.

Risk No. 4124 v.5 BAF Ref: BAF.0005	Risk Type: Workforce / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee
Version Date: 13/04/2021	Directorate: Acute & Community	Last Reviewed: 21/05/2021
First Created: 20/12/2018	Exec Lead: Executive Director - Operational Delivery	Review Frequency: Monthly

Details of Risk:

There is a risk of harm to members of staff through clinical incidents of violence or aggression within inpatient areas. This may adversely affect staff wellbeing, staff morale, recruitment and attrition if not appropriately mitigated.

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):	2	2	4

CONTROLS IN PLACE

- Policy and governance structure in place to ensure incidents are properly reviewed and lessons learned
- Safe staffing levels monitored and reviewed with Executive Medical Director every 2 weeks.
- A minimum of 3 x Respect trained staff on each shift
- Safety & Security Task & Finish Group in place
- Security service in place for all 24/7 bedded services.
- Monthly interface with South Yorkshire Police
- 24/7 senior clinical leadership in place
- Body Cam system in place
- Alarm system upgrade agreed and work underway (completed at Forest Lodge and Maple Ward although delay to other ward areas due to Covid-19)
- Ongoing training programme in place for preceptor nurses to support effectiveness on the ward.
- Partial funding received to increase therapeutic input onto wards - recruitment underway.
- All staff received RESPECT training to de-escalate and/or safely manage violence.

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

Annual Clinical Establishment Review to be conducted by Head of Nursing to ensure safe staffing against evidence based research.		01/10/2021 Emma Highfield
Maintaining appropriate levels of Respect training	RESPECT training compliance is monitored bi-monthly at ward level	31/03/2022 Khatija Motara
Body scanners to be installed across all acute wards and to be operational by June 2021 to detect metal objects that may cause harm.	operationalisation of body scanners is dependent on creation of a standard operating procedure regarding their deployment. Target date changed to end of July 2021	31/07/2021 Khatija Motara

Risk No. 4140 v.1 BAF Ref: BAF.0003	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee
Version Date: 21/01/2019	Directorate: Medical	Last Reviewed: 23/03/2021
First Created: 21/01/2019	Exec Lead: Executive Medical Director	Review Frequency: Monthly

Details of Risk:

There is the possibility of an issue with supply of medication after the contingency plans put in place by the UK Government for EU exit resulting in a gap in medication supply to our service users. This is due to the uncertainty regarding the UK plans for leaving the EU.

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

CONTROLS IN PLACE

- UK Government six-week medicines stockpiling activity remains a critical part of the Department's UK-wide contingency plan, medicines and medical products will be prioritised on alternative routes to ensure the flow of all these products will continue unimpeded after 29 March 2019.
In the event of delays caused by increased checks at EU ports, the Department will continue to develop the UK-wide contingency plan for medicines
- Agreement with other Chief pharmacists across the Sheffield footprint to support medication supply in an emergency situation
- Alternate medication choice and advice in the event of availability issues
- Stockholding in pharmacy of certain medications revised in line with usage figures

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

The UK is out of Transitional arrangements and has left the EU. UK Government contingency plans for medicines disruption in place. Five months after exit no discernable impact on supply of medication to The Trust from wholesalers. Business as usual. Therefore it is appropriate to step down the risk from the BAF currently and keep it on a local register in the event of a change in circumstance

21/05/2021
Abiola Allinson

Risk No. 4189 v.2 BAF Ref: BAF.0007	Risk Type: Statutory / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee
Version Date: 22/11/2019	Directorate: Medical	Last Reviewed: 21/05/2021
First Created: 01/04/2019	Exec Lead: Executive Medical Director	Review Frequency: Monthly

Details of Risk:

The Falsified Medicines Directive (FMD) comes into force on 09/02/2019. SHSC NHS Foundation will not be compliant with the legislation as at this date due to concerns about the EU Exit strategy and ready availability of the necessary software with the upgrade to the JAC system

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	3	5	15
Current Risk: (with current controls):	3	3	9
Target Risk: (after improved controls):	2	2	4

CONTROLS IN PLACE

- The Trust has approved the purchase of the upgraded JAC system which has FMD compliance.
- There is a concern that if the UK leaves without a deal, the FMD will no longer be applicable in the UK
- Embedded practice to check on a fortnightly basis the validity of suppliers in the chain for medicines (Whole Dealers Licence).
- EU exit by the UK means there is no UK access to the FMD database. This risk should be de-escalated to local level for monitoring for when an access pathway is agrees

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

With exit from the EU there is no access to FMD database. SHSC have purchased hardware and with the planned upgrade to the WellSky operating system scheduled for November 2021, will be better placed once an agreed framework solution is reached in the UK or partnership with the EU.

01/12/2021
Abiola Allinson

Risk No. 4276 v.4 BAF Ref: BAF.0003	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee
Version Date: 13/04/2021	Directorate: Acute & Community	Last Reviewed: 06/05/2021
First Created: 04/10/2019	Exec Lead: Executive Director - Operational Delivery	Review Frequency: Monthly

Details of Risk:

There is a risk of physical harm to service users due to an absence of physical health monitoring, in accordance with the physical health policy and standard operating procedure, following the administration of rapid tranquilisation medication.

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):	2	2	4

CONTROLS IN PLACE

- Physical Health Policy and Standard Operating Procedure n place for each service.
- Use of rapid tranquilisation is monitored through reducing restrictive practice group
- Physical health checks following rapid tranquilisation are recorded and monitored on the weekly data for reducing restrictive practice.
- Governance officers undertake monthly audit of physical health checks following rapid tranquilisation
- Local seclusion tracker in place. Ward Managers lead on reviewing compliance with physical health checks following rapid tranquilisation leading to seclusion.
- Physical Health Group established and led by the Associate Clinical Director (SPC Network). The group provides oversight and monitoring of the effective application of Physical Health Policy and all associated requirements as well as setting overarching Trust priorities in relation to physical health.
- Executive-led Physical Health Oversight Group in response to Section 29a notice led by Executive Director of Nursing and Professions
- Daily situational reporting to clinical huddle and Gold Command. Significant improvement in compliance with the exception of 1 area which has been asked to produce a recovery plan which is now complete.

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

Finalise IT tool (NEWS2), initiate training and roll out and update of local Standard Operating Procedures to reflect the change.	Clinical Safety Case completed and approved. NEWS2 mobilization plan in in place. Stanage complete Maple completed, Dovedale in progress, all other wards will be live by end of May 2021. Management and identification of deteriorating patient policy in draft. As the restrictive practice module development is on pause with not plans to restart at this stage to use of TAGS and activity codes is being implemented along side associated assurance reports. Daily sitrep ensuring compliance with physical health checks post RT are in	31/05/2021 Christopher Wood

		place.	
	Development of an IT based system to support accurate recording and data gathering of all physical health checks following rapid tranquilisation.	see above	30/06/2021 Christopher Wood

CORPORATE RISK REGISTER

As at: May 2021

Risk No. 4284 v.6 BAF Ref: BAF.0002	Risk Type: Statutory / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee
Version Date: 01/07/2020	Directorate: Nursing & Professions	Last Reviewed: 21/05/2021
First Created: 12/11/2019	Exec Lead: Executive Director - Operational Delivery	Review Frequency: Monthly

Details of Risk:

Risk of further action being taken against the Trust if significant improvements are not made in the areas identified and outlined from the CQC during their well-led inspections.

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

CONTROLS IN PLACE	ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON		
• Physical Health Improvement Group reconstituted with Executive Director leadership and direction, enabling a focused remit on physical health monitoring, including post restrictive intervention and enabling changes in clinical practice. • Business case approved regarding Forest Close (bungalow 3). However work has been suspended due to the bungalow being used as an isolation unit during Covid 19. • Monitoring of progress on required actions through Back to Good Board with monthly reporting and exception reporting to Board in place.	Implement improvement action plan once developed.	Action plan ongoing with a significant number of items closed following implementation and assurance. a small number of items remain in exception and overseen by the Back to Good Board	31/07/2021 Zoe Sibeko
• Daily monitoring of physical health checks and staffing undertaken and reported into lead executive. • PMO approach to improvement workstreams established with leadership agreed for each workstream. • Nurse call and staff attack system in place and operational at Forest Lodge. • Supervision rates at reaching target level (80%) • Mandatory training meeting compliance rates	Refurbishment of Bungalow 3 to be completed	The clinical service have requested consideration of an alternative refurbishment of Bungalow 3. Revised business case being submitted for approval, led by clinical services with support from estates.	30/07/2021 Helen Payne
• Weekly Improvement Dashboards established, initially developed from monitoring of Section 29A, continuing to monitor training, staffing, supervision but additional subjects added such as Flue Vaccination. • Monthly reporting of progress to the Quality Committee for assurance	Actions being undertaken in line with action plan and progress reported through Back to Good Board.	Back to Good Board has progressed and closed a number of items for	31/07/2021 Salli Midgley

purposes.

• Business as usual governance reporting and monitoring have been identified as improvement action transfer back to services to ensure continued oversight.

assurance however there remain a number of actions open for progression.

Risk No. 4325 v.3 BAF Ref: BAF.0003	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: People's Committee
Version Date: 24/03/2020	Directorate: Central Clinical Operations	Last Reviewed: 27/04/2021
First Created: 09/01/2020	Exec Lead: Executive Director Of Finance	Review Frequency: Monthly

Details of Risk:

Risk to Health & Safety of staff, service users and others due to a lack of access to a Back Care Advisor and Moving & Handling Training at all levels.

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	4	4	16
Current Risk: (with current controls):	3	5	15
Target Risk: (after improved controls):	2	2	4

CONTROLS IN PLACE

- People Handling & Risk Assessment Key Trainer's Certificate (RoSPA Quals Level 4) training has been delivered in December 2018 and May 2019.
- Moving & Handling trainer identified to work two days a week for six months to support the delivery of training in key areas.
- Moving and Handling Task & Finish Group established which oversees the development and delivery of Moving & Handling Training; and establishment of Back Care Advisor Role.
- Each Key Trainer/service area is supported by a lead clinician (Kate Scott, Physiotherapy Clinical Lead and Gargi Srivastava, Physiotherapy Mental Health Team). The lead clinicians are available to offer support around any service user issue related to moving and handling and also to advise Key Trainers around training delivery.
- 'Air and Share' support sessions for Key Trainers in place
- List of Key Trainers by service area agreed and shared across the Trust to raise awareness.
- From January 2020 trust induction incorporates level 1 and level 2 M&H training

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

Implement recruitment processes for Back Care Advisor	Back Care Advisor commences employment May 2021	30/06/2021 Anita Winter
All Key Trainers to develop an action plan detailing how they will achieve 85% compliance for their staff team	Mandatory training compliance as at 22 March 2021 is: Moving & Handling Level 1 - 80.78% Moving & Handling Level 2 - 93.35%	30/06/2021 Anita Winter

CORPORATE RISK REGISTER

As at: May 2021

Risk No. 4326 v.4 BAF Ref: BAF.0004	Risk Type: Quality / Risk Appetite: Low	Monitoring Group: People's Committee
Version Date: 26/01/2021	Directorate: IMS&T	Last Reviewed: 05/03/2021
First Created: 09/01/2020	Exec Lead: Executive Director Of Finance	Review Frequency: Monthly

Details of Risk:

Patient safety is at risk because key clinical systems that require planned maintenance (for security and licensing reasons) rely on IMST staff working out of hours when they are not contracted to do so, and are often the single point of failure when systems require downtime out of hours.

The recent January 2021 Insight penetration test will require additional downtime slots to mitigate the required corrective actions.

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

CONTROLS IN PLACE

- TMG and Trust Operations confirm that unplanned maintenance on key systems is not always feasible outside core hours. Agreement that business continuity plans and alternate working practices can be effected by clinical areas as required.
- Operational and clinical areas have access to read only systems in emergency and business continuity plans are in place.
- ERostering is now live and unsociable hours and overtime payments are standardised in line with Trust policy.

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

Risk No. 4330 v.4 BAF Ref: BAF.0004	Risk Type: Quality / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee
Version Date: 13/04/2021	Directorate: Acute & Community	Last Reviewed: 13/04/2021
First Created: 09/01/2020	Exec Lead: Executive Director - Operational Delivery	Review Frequency: Monthly

Details of Risk:

There is a risk that service users cannot access secondary mental health services through the Single Point of Access within an acceptable waiting time due to an increase in demand and insufficient clinical capacity.

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	5	3	15
Current Risk: (with current controls):	5	2	10
Target Risk: (after improved controls):	2	2	4

CONTROLS IN PLACE

- Triage of all referrals establishing risk, urgency and priority
- Nurse Consultant supports the team
- Alternative assessment provision available i.e. Decisions Unit, Liaison
- Call Centre Manager appointed
- Customer Service Improvement Programme Manager in post
- New leadership team in place.
- Standardised service offer (customer service improvement programme)
- New consultant in post (Apr 20).
- To manage increased demand, staff have been diverted from other functions to support SPA
- Mobilised 24/7 increased capacity to support staff and service users during Covid-19 pandemic.
- Weekly review of SPA demand and staff activity
- recovery plan presented to the Quality Assurance Committee in March 2021 which illustrates a reduction in the number of service users waiting at 30 service users each month (achieving waiting list of zero by April 2022 based upon projections of demand/capacity).

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

Risk No. 4362 v.4 BAF Ref: BAF.0001	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Board Of Directors
Version Date: 06/11/2020	Directorate: Trust Board	Last Reviewed: 21/05/2021
First Created: 24/03/2020	Exec Lead: Executive Director - Operational Delivery	Review Frequency: Monthly

Details of Risk:

There is a risk that the Trust will be unable to provide safe patient care or protect the health and wellbeing of its workforce due to the pandemic Coronavirus (Covid-19) which will impact on all services, both clinical and corporate.

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	5	5	25
Current Risk: (with current controls):	4	3	12
Target Risk: (after improved controls):	2	2	4

CONTROLS IN PLACE

- Major incident and pandemic flu plans enacted (gold, silver and bronze command structure in place). Integrated into the wider system Health & Social Care Gold Command Structures
- Business continuity plans in place for all teams and services
- Minimum staffing levels in place for all teams and services
- Process in place for recording and monitoring of staff absences. Back to the floor initiative being mobilised to support front line team's resilience
- Procedures in place to test and isolate symptomatic patients
- Systematic review of all National and Local Guidance through command structures. Use of Clinical Reference Group and Working Safely Groups to develop local guidance. Use of COVID Information Hub to cascade all guidance to teams
- As part of the Integrated Care System, there is a multiagency group of health partners co-ordinating the city-wide response.
- Daily situational review of PPE in place and appropriate processes to replenish stock through mutual aid.
- Incident control centre in place together with a single point of contact operating 7 days per week.
- Voluntary peer support arrangements enacted at staff and team level

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

Ensure audit and compliance with Inpatient Testing Guidance following gaps in assurances identified in September 2020 audit.	ongoing monitoring through physical health monitoring but compliance issues are noted	31/07/2021 Beverley Murphy

- Review of business critical services in event of future restrictions / lockdown
- Escalation and Decision Making Logs maintained in line with EPRR requirements
- Additional indemnity cover provided to staff under the new Coronavirus Act 2020 for clinical negligence liabilities that arise when healthcare professionals and others are working as part of the Coronavirus response.
- Mutual aid (training, advice and support) for physical health care associated with positive COVID tested patients.
- Access to twice weekly asymptomatic testing for all front line staff. Symptomatic and Asymptomatic testing arrangements in place with STHFT. Antibody testing continues.
- Processes in place to ensure that essential face to face mandatory training is delivered in line with PPE requirements. All non essential face to face training diverted to virtual platforms
- Staff communication and engagement in place and being regularly reviewed to ensure key information and messages are both given and received via a variety of mechanism including daily Covid-19 brief, facebook page and line management routes.
- Recovery Co-ordinating Group meeting weekly to which commissioners are invited
- Resilience arrangements in place for role of Emergency Planning Manager and Lead Nurse for Infection Prevention and Control.
- Weekly reassessment of known risks and mitigating actions via Command Structure. Agreed processes for escalation of new risks.
- Individual workplace risk assessments available for all staff
- To support wellbeing, staff are be actively encouraged to take annual leave, bank holidays and time owing.
- HR Helpline in place to support staff
- Daily monitoring and access to Oxygen and defibrillator stock

• Trust has received RCOP suggestions for use of vitamin D for BAME staff and provided supplementary information to support staff.

• Environmental risk assessments carried out on all buildings. Risk Assessments accessible for all staff. Maximum numbers of staff per room signage present and guidance to staff on flow through communal areas.

• Staff facilitated to work from home through digital solutions and work on rotation to access buildings to comply with COVID Secure.

• 7 day clinical, operational and business support arrangements in place to support business continuity and provide national reporting returns.

• COVID Staff Helpline in place 24/7. Health & Wellbeing widget on the intranet. Structured staff support to return to work from COVID absences.

• Mobilisation plans developed for the roll out of COVID vaccine offer for staff and patients in line with national programme requirements.

• Review of Trust estate to support greater opportunity for social distancing. Removal of dormitories on Maple and Dovedale; Stanage and Burbage by the end of 2020. Building changes to the Crisis Hub to commence 15.12.20, creating more break out staff and clinical staff working areas.

• Monitoring of staff with up-to-date Covid Risk Assessments now reported on a monthly basis to Gold Command and reviewed at HR SMT.

CORPORATE RISK REGISTER

As at: May 2021

Risk No. 4377 v.2 BAF Ref: BAF.0006	Risk Type: Financial / Risk Appetite: Moderate	Monitoring Group: Finance & Performance Committee
Version Date: 19/05/2021	Directorate: Finance	Last Reviewed: 19/05/2021
First Created: 24/04/2020	Exec Lead: Executive Director Of Finance	Review Frequency: Monthly

Details of Risk:

Failure to deliver the required level of CIP for 2021/22. This includes closing any b/f recurrent gap and delivering the required level of efficiency during the financial year 2021/22.

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):	3	3	9

CONTROLS IN PLACE

- Trust Business Planning Systems and Processes, Including CIP monitoring, QIA and Executive oversight.
- Forms part of routine finance reporting to FPC, Board and NHSE/I
- Performance Management Framework
- Additional transformation and cost reduction objectives. Procurement led savings, agency reduction and control.
- Cost Improvement Programme Working Group has now been set up to confirm targets, monitor Progress, review Scheme Initiation Documents, and ensure QEIA process undertaken

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

Cost Improvement Programme (CIP) working Group set up to monitor the Programme: Expect progress towards identified schemes by end of Q1, at which point Control Risk Rating may change	First Meeting held 20th May 2021. Kick off meeting to: Agree ToR, CIP Targets, any current Scheme Initiation Documents (SIDs) and identify work streams	30/06/2021 Lisa Collett
Review benchmarking & productivity data to help drive efficiency and better use of resources. To work with Performance Team to triangulate data through the appropriate governance routes and identify an annual work programme for Benchmarking to enable timely and robust input and review of outputs	Currently weekly meetings being held between Planning, Performance and Finance, to formalise and align to this piece of work.	31/07/2021 Lisa Collett

Risk No. 4407 v.3 BAF Ref: BAF.0003	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee
Version Date: 13/04/2021	Directorate: Acute & Community	Last Reviewed: 05/05/2021
First Created: 18/06/2020	Exec Lead: Executive Director - Operational Delivery	Review Frequency: Monthly

Details of Risk:

There is a risk of harm to service users, staff, and the environment caused by service users smoking or using lighters/matches in SHSC Acute and PICU wards.

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	5	4	20
Current Risk: (with current controls):	3	3	9
Target Risk: (after improved controls):	2	2	4

CONTROLS IN PLACE

- The Trust Has a smoke Free policy in place and all staff have been issued with smoke free policy and related documents.
- The Trust has a vaping policy and vaping project ongoing
- The Trust has training programme to support staff to offer assessments of Nicotine replacement therapy
- The Trust has Blanket restriction registers regarding prohibited items, ie lighters and fire setting materials are not allowed on the ward
- Fire risk on local team risk registers
- Annual fire risk assessment undertaken by SYFire and Trust fire safety officers
- All staff complete fire safety training
- Incident reporting system in place re any incidents related to fire
- Weekly Smoke-Free Task and Finish group in place, which includes representatives from each ward and senior staff.
- Operational plan to support robust implementation of smoke free policy, with relevant key milestones in place and reviewed weekly by Task and Finish Group
- Service users are prohibited from smoking in inpatient environments as of September 2020.

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

Commence daily safety huddles on ward areas to raise fire safety risks	Get assurance from ward managers/matrons for Acute and PICU wards re daily safety huddles being embedded	14/05/2021 Khatija Motara
SOP required for use of body scanners on acute wards to detect ferrous metals which will include lighters	SOP development with Quality team	31/05/2021 Lorena Cain

Risk No. 4409 v.11 BAF Ref: BAF.0005	Risk Type: Workforce / Risk Appetite: Low	Monitoring Group: People's Committee
Version Date: 20/01/2021	Directorate: Nursing & Professions	Last Reviewed: 21/05/2021
First Created: 19/06/2020	Exec Lead: Executive Director - Nursing & Professions	Review Frequency: Monthly

Details of Risk:

There is a risk the Trust is unable to provide sufficient additional nursing/nursing associate placement capacity to meet demand caused by a combination of factors (commitment to increase placements in 19/20; Project 5000 targets; and extension of current student placements due to Covid-19 impact). This combined with vacancies, skill mix challenges, and increased service demands could result in a failure to meet long term transformation targets and a shortage of nurses to meet identified recruitment shortages. This could impact on the Trust's reputation and ability to deliver existing and/or increased demand for 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	2	6

CONTROLS IN PLACE	ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON		
• Prepare registered staff Band 5 and above to act in the role of practice supervisor to support placements . update 180820 - online training sessions in place. staff without mentorship qualification to join SHU course in September 20 • Additional resource in practice placement team (ETD) to provide peripatetic assessment. update 180820 - complete: 3 days a week resource now back in place in PQF team following Covid absence and 3hours per week practice support at endcliffe ward. • All registered nurses now have responsibility for supporting student learning. update - decision made by DNO • 15 staff registered for mentor preparation training at SHU • Project leads in place to implement placement expansion in Learning Disabilities	consider the use of community staff to support in patient practice placements	due to ongoing capacity and operational challenges the date for this action has been reviewed and moved to 30/06/21	30/06/2021 Andrew Algar

• Reduced placement time for some cohorts of students to enable all students to get some placement time in line with agreement in LEAP consortium

• Active member of the new South Yorkshire and Bassetlaw's Learning Environment and Placement (LEAP) Consortia. The aims are to meet practice placement requirements and to identify and remove barriers.

CORPORATE RISK REGISTER

As at: May 2021

Risk No. 4475 v.4 BAF Ref:	Risk Type: / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee
Version Date: 23/04/2021	Directorate: Acute & Community	Last Reviewed: 21/05/2021
First Created: 23/10/2020	Exec Lead: Executive Director - Nursing & Professions	Review Frequency: Monthly

Details of Risk:

There is a risk that there are no available acute beds in Sheffield at the point of need as a result of necessary refurbishment works, including the eradication of dormitories, to meet standards of quality and safety. This results in delays in accessing an acute bed and the requirement to place service users in an out of area acute bed without clinical justification.

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

CONTROLS IN PLACE

- Clinical Director/Head of Service approval required to authorise out of area bed within hours. Executive Approval required out of hours to ensure exhaustion of local provision.
- OOC placements sought via Flow coordinators to meet service users need
- Crisis Resolution and Home Treatment Service to gatekeep all admissions and to support all discharges from acute wards.
- Revised clinical model brings shared ownership across inpatient and community services to manage local bed base.
- Daily operational and clinical leadership oversight of patient flow to and from out of area placements.
- Daily crisis and acute service huddle to plan and organise timely patient flow.
- Weekly Medically Fit for Discharge meeting held by the Head of Service to engage partner organisations in supporting service user flow.

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

Trust approval through the Quality Committee and Financial Management Group in February to procure 6 OOA acute beds and 3 OOA PICU beds on a block contract basis. Procurement exercise to be progressed and completed by end of April.	tender for acute beds procurement due to be published Monday 24th May. Target date updated. PICU spec under revision and yet to be issued	31/07/2021 Khatija Motara
Purposeful Inpatient Admission Model to be developed with collaboration across inpatient and community services.		31/05/2021 Kate Oldfield
Crisis Home Treatment and Resolution Service to be developed with investment from Sheffield Clinical Commissioning Group to include gatekeeping function for all inpatient admissions.		30/09/2021 Sarah Roberts-Morris

Risk No. 4483 v.3 BAF Ref:	Risk Type: Safety / Risk Appetite:	Monitoring Group: Audit Committee
Version Date: 12/01/2021	Directorate: IMS&T	Last Reviewed: 12/04/2021
First Created: 25/11/2020	Exec Lead: Executive Director Of Finance	Review Frequency: Monthly

Details of Risk:

There is a risk that trust IT systems and data could be compromised as a result of members of staff providing personal credentials and information upon receipt of phishing emails received.

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

- Increased password security length.
- IT and data security is covered in mandatory training and in accessible Trust policies, for guidance.

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

Email to staff following latest Phishing exercise as quick follow up to show how to spot a phishing email.	31/05/2021 Andrew Male
If appropriate trial a new tool that will continually send phishing emails to improve awareness and understanding	30/06/2021 Andrew Male

CORPORATE RISK REGISTER

As at: May 2021

Risk No. 4613 v.1 BAF Ref: BAF.0004	Risk Type: Workforce / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee
Version Date: 20/05/2021	Directorate: Acute & Community	Last Reviewed: 21/05/2021
First Created: 20/05/2021	Exec Lead: Executive Medical Director	Review Frequency: Monthly

Details of Risk:

There is a risk to the quality of patient of care and to the clinical leadership of services within the Acute and Community Directorate arising due to vacancies across the medical workforce and an over-reliance upon locum medical staff.

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	2	6

CONTROLS IN PLACE

- Repeated efforts to recruit to vacant posts are being made.
- Locum medical staff in post across inpatient areas and interim arrangements in place within community services.

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

Clinical Director to review medical job plans to quantify capacity against demand.	30/06/2021 Robert Verity

Total: 20