Board of Directors Public

SUMMARY REPORT	Meeting Date:	24 November 2021
	Agenda Item:	18a

Report Title:	**Corporate Risk Register**	
Author(s):	Amber Wild, Corporate Assurance Manager	
Accountable Director:	Susan Rudd, Director of Corporate Governance	
Other Meetings presented to or previously agreed at:	**Committee/Group:**	Finance and Performance Committee, Quality Assurance Committee, People Committee, Audit and Risk Committee.
	Date:	9-11 November 2021
Key Points recommendations to or previously agreed at:	The Corporate Risk Register has been reviewed by four committees since it was last reported to Board – Audit and Risk Committee; People Committee; Quality Assurance Committee and Finance and Performance Committee. There has been one significant score increase (Risk 4407) and six new risks are recommended for consideration.	

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.

Recommendation for the Board/Committee to consider:

Consider for Action		Approval	X	Assurance	X	Information	

1. To receive the Corporate Risk Register and note changes, specifically the increased current risk score in relation to Risk 4407; and the changed target score to Risk 4409.
2. To note the closure of six risks (4079, 4140, 4189, 4326, 4325 and 4284) following consideration of this action to Committees.
3. To note that six new risks has been added since the commencement of this reporting cycle (Risks 4376,4375, 4480, 4727, 4742, 4749), which is included in this report and the appendix.

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Recovering effectively	*Yes*	***X***	*No*	
CQC Getting Back to Good – Continuous improvement	*Yes*	***X***	*No*	
Transformation – Changing things that will make a difference	*Yes*	***X***	*No*	
Partnerships – working together to make a bigger impact	*Yes*	***X***	*No*	

Is this report relevant to compliance with any key standards ?					State specific standard
Care Quality Commission	*Yes*	***X***	*No*		"Systems and processes must be established to ensure compliance with the fundamental standards"
IG Governance Toolkit	*Yes*		*No*	***X***	

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Patient Safety and Experience	*Yes*		*No*	***X***	Not directly in relation to this report – specific detail within the BAF for each area
Financial (revenue &capital)	*Yes*		*No*	***X***	
OD/Workforce	*Yes*		*No*	***X***	
Equality, Diversity & Inclusion	*Yes*		*No*	***X***	
Legal	*Yes*		*No*	***X***	

Section 1: Analysis and supporting detail

Background

1.1 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).

1.2 The aim is to draw together all high level operational risks that the Trust faces on a day-to-day basis, risks that cannot be controlled within a single directorate/care network or that affect more than one directorate/care network, and record those onto a composite risk register thus establishing the organisational risk profile. All risks which reach a residual score of 12 should be escalated.

Corporate Risk Register Snapshot

1.3 Below is a snapshot of the risks, ordered from top to bottom by current risk score, followed by initial risk score. The full detail of these risks can be found in the appendix. Following feedback from internal audit, an indicative arrow has been added to the right of the table to show whether the risk has remained the same, increased or decreased. For further clarification, new risks are now identified with a star.

1.4 Changes and proposed changes to risks are described in the subsequent paragraphs.

1.5

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	1	3	
4742: Staff may fail to identify and report individuals who are susceptible to radicalisation as defined in the Prevention of Terrorism Act. SHSC has failed to train the required staff groups in PREVENT level 3 WRAP training as outlined in the NHSE guidance for Health Providers and as stipulated in DHSC Prevent training framework, updated 2021 commenced 2015.									★
4	4	16	4	4	16	4	1	4	
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	
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	4	20	5	3	15	2	2	4
4727: There is a risk that staff will fail to identify, act upon, report and manage safeguarding risks in their line of duty which will result in harm to patients and/or their families and children. this is a statutory responsibility								
5	3	15	5	3	15	5	1	5
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.								
4	5	20	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	1	4	4
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
4375: There is a risk that paper based documents currently stored at Fulwood will be compromised, the leaving Fulwood project has no current scope to scan and store paper based documents resulting in documentation not being secured or accessible after the headquarter move.								
3	4	12	3	4	12	0	0	0
4749: There is a risk that the Trust is unable to meet the identified training needs for the existing workforce because of a lack of budget resulting in failing to meet workforce transformation priorities								
3	4	12	3	4	12	2	2	4
4613: 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.								
3	5	15	3	4	12	3	2	6
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
4407: 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.								
5	4	20	4	3	12	2	2	4
4376: There is a risk that clinical records and documents could be accessed by non-SHSC due to limited physical security controls in place at Presidents Park where the documents are stored resulting in potential data and information security breaches.								
3	3	9	3	3	9	0	0	0
4078: There is a risk that low staff engagement caused by a number of feedback indicators via our staff survey may impact on the quality of care. (note as indicated by the Staff Surveys 2018-2020).								
3	4	12	3	3	9	2	3	6
4480: There is a risk that there will be an increased chance of Insight instability and restrictions in functionality caused by. continual development on the Insight system which is built on some obsolete and unsupported software components resulting in poor system performance, higher chances of system failure, increased support and maintenance overheads for IMST and limitations with the trust adhering to NHS Digital and legislation standards including NHS Digital DSPT, Cyber Essentials and NIS.								
4	3	12	3	3	9	3	3	9

Closed Risks

1.6 **The following risk have been moved from the Corporate Risk Register.**

Risk 4284 (relating to CQC inspection) on the grounds that the risk no longer applies in the form as stated following the most recent CQC inspection which returned an outcome of 'Requires Improvement'. It should be noted that action plans aligned to improvements required under Section 29a and Section 31, along with new 'must do' and 'should do' improvements following the most recent inspection, are being managed through the Back to Good Board.

Risk 4325 (relating to Health & Safety of staff, service users and others due to a lack of access to a Back Care Advisor and Moving & Handling Training) was considered for closure at the Audit and Risk Committee.

Risk 4326 (relating to key clinical systems that require planned maintenance (for security and licensing reasons) was considered for closure at Audit and Risk Committee.

Risk 4189 (relating to Falsified Medicines Directive), **Risk 4079** (relating to Waste Management service) and **Risk 4140** (relating to medicine supply following Brexit) have been closed/de-escalated since last consideration.

Reduced/escalated risks

1.7 The Quality Assurance Committee will recommend to Board that **Risk 4407** (relating to the 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) be considered for escalation and returned to the register following a review of this risk, an amendment to the risk description and an increase score from 9 to 12.

1.8 **Risk 4409:** The target risk score has been reduced from 6 to 4.

New risks

1.9 Six new risks have recently been added to the register having been considered by committees and the details are included in the appendix: **Risk 4376** (relating to clinical records); **Risk 4375** (relating to paper records); **Risk 4480** (relating to Insight instability); **Risk 4727** (relating to safeguarding); **Risk 4742** (relating to PREVENT training); **Risk 4749** (relating to training needs budget).

Risk profile

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

1.11 **Severity**

Catastrophic (5)			**3**		
Major (4)			**2**	**4**	
Moderate (3)			**3**	**6**	**2**
Minor (2)					
Negligible (1)					
Likelihood	(1) Rare	(2) Unlikely	(3) Possible	(4) Likely	(5) Almost Certain

Section 2: Risks

2.1 Failure to properly review the CRR could result in Board or its committees not being fully sighted on key risks facing the organisation

2.2 There are no specific corporate risks around usage of the CRR.

Section 3: Assurance

3.1 The information provided within the CRR is 'owned' by Executive Directors and reviewed/revised by colleagues within their directorates under their leadership.

Section 4: Implications

Strategic Aims and Board Assurance Framework

4.1 All.

Equalities, diversity and inclusion

4.2 None directly arising from this report.

Culture and People

4.3 None directly arising from this report.

Integration and system thinking

4.4 None directly arising from this report.

Financial

4.5 None directly arising from this report.

Compliance - Legal/Regulatory

4.6 None directly arising from this report.

Section 5: List of Appendices

1. Corporate Risk Register - Full

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: 11/11/2021
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.	The ward works on Burbage Ward have commenced w/c 12 July 2021. Consideration is being given to way to accelerate the programme of works for other wards including acquisition of a modular ward decant facility and/or work on live ward environments. At the moment the Trust does not have funding for a modular ward but a bid has been submitted nationally; outcome timescale not known. An interim Project Director (KS) has been appointed to support management of the LAP eradication programme.	31/08/2021 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. • In response to s.29A Notice - action plan has been mobilised to improve environment sooner and to introduce greater clinical mitigation in the interim. • 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.	The ward works programme has commenced on Burbage Ward w/c 12 July 2021; this includes replacement of doorsets. Consideration is being given to ways to accelerate the ward works programme including acquisition of a modular decant ward (if funds can be identified) + interim Project Director (KS) appointed to manage the LAP eradication programme	31/08/2021 Geoffrey Rawlings
	Estates required to review and replace window frames which pose a ligature risk.	This aspect of the project is now progressing and the contractor has identified they will be able to work simultaneously on several wards (not Burbage which has very specific scaffolding requirements) so the timescale for this is being revised.	31/08/2021 Geoffrey Rawlings
	Progress with design and tender for capital works to remove dormitories. This is a long term project due to take 12 months until completion.	Ward works programme has commenced on Burbage w/c 12 July 2021. Consideration is being given to ways to accelerate work on other	31/08/2021 Geoffrey Rawlings

		wards inc. work on live wards and acquisition (subject to funding) of a modular ward decant facility.	
	Weekly meeting between estates and acute service line to prioritise and plan refurbishment work on live wards to remove as many ligature anchor points as possible in accordance with s.29A Warning Notice. These meetings are continuing beyond the warning notice period due to the value they have offered in progressing at pace.		30/12/2021 Greg Hackney

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: 11/11/2021
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

Clinical establishment reviews using the MHOST tool have commenced in Sept 2021. This process will help to more accurately define the staffing needs of our in-patient services

15/03/2022
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.13 BAF Ref: BAF.0005	Risk Type: Workforce / Risk Appetite: Low	Monitoring Group: People's Committee
Version Date: 12/11/2021	Directorate: Organisational Development	Last Reviewed: 12/11/2021
First Created: 26/10/2018	Exec Lead: Director Of Human Resources	Review Frequency: Monthly

Details of Risk:

There is a risk that low staff engagement caused by a number of feedback indicators via our staff survey may impact on the quality of care. (note 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) - (LiA no longer specifically operationally live
- 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 which was in place in 2020. This has now changed to HRBP overseeing the staff survey and people pulse and contributing to the Staff Engagement Forums and groups
- Regular communication with staff via 'Connect' demonstrating the actions taken by TEAM SHSC in response to engagement activity
- 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

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

Organisation Development Strategy to be developed.	Responsible owner amended - actions remain	31/12/2021 Sarah Bawden
Reviewing the Staff Survey engagement leads roles (ROI)	People review continues as at 12th Nov	31/12/2021 Sarah Bawden

- Unacceptable Behaviours Policy (informed by feedback from Bullying and Harassment Drop-in Sessions approved and to be rolled out across the Trust
- 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. 4121 v.18 BAF Ref: BAF.0021	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Finance & Performance Committee
Version Date: 26/05/2021	Directorate: IMS&T	Last Reviewed: 01/11/2021
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):	1	4	4

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

A strategy of isolation to deal with the remaining pen test actions is being explored and findings will be presented to DIGG in October.	As the last update indicated the internal team required to take part in any assessment are working on other Trust priorities such as MHDSv5 and the QUIT programme. This issue will be surfaced to DIGG as part of a review of risks.	31/10/2021 Andrew Male
Software development roadmap to limit non-essential developments to the system which could cause instability.	The work required to support clinical services means that the roadmap cannot be limited to the desired extent. Continuing conversations about prioritisation and other mechanisms to limit development activity	30/11/2021 Ben Sewell

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: 26/10/2021
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. This includes monitoring through the IPQR.
- 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
- Head of Service and Head of Nursing hold weekly oversight of unreviewed incidents and raise with relevant service.
- Alarm system upgrade installation complete across acute and PICU wards.
- 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. 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: 26/10/2021
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. 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

• Web-form used across all inpatient areas which is reported upon weekly and reviewed fortnightly by Executive Director of Nursing.

Risk No. 4330 v.6 BAF Ref: BAF.0004	Risk Type: Quality / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee
Version Date: 11/07/2021	Directorate: Acute & Community	Last Reviewed: 26/10/2021
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. In the absence of an assessment, the level of need and risk presented by service users is not quantified and may escalate without timely intervention.

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

- All referrals to be triaged within 24 hour period to quantify need and to determine urgency for assessment.
- Nurse Consultant to attend daily crisis huddle to report on exceptions to ability to triage all referrals within 24 hour period.
- Alternative assessment provision available i.e. Decisions Unit, Liaison
- Call Centre Manager in post to improve flow of calls / call response time / caller experience.
- Customer Service Improvement Programme Manager in post
- New leadership team in place.
- Standardised service offer (customer service improvement programme)
- All service users waiting for assessment receive written information and advice about how to access help in a crisis, whilst awaiting an assessment.
- 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 data through the covid-19 command structure.
- recovery plan presented to the Quality Assurance Committee in March 2021

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

Waiting time trajectory is reported to the Quality Assurance Committee every 2 months.	Ongoing action.	31/12/2021 Sarah Robert-Morris

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).

Risk No. 4362 v.4 BAF Ref: BAF.0001	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee
Version Date: 06/11/2020	Directorate: Trust Board	Last Reviewed: 14/09/2021
First Created: 24/03/2020	Exec Lead: Executive Director - Operational Delivery	Review Frequency: Quarterly

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: November 2021

Risk No. 4375 v.7 BAF Ref:	Risk Type: Business / Risk Appetite:	Monitoring Group: Audit Committee
Version Date: 22/10/2021	Directorate: IMS&T	Last Reviewed: 16/11/2021
First Created: 21/04/2020	Exec Lead: Executive Director Of Finance	Review Frequency: Monthly

Details of Risk:

There is a risk that paper based documents currently stored at Fulwood will be compromised, the leaving Fulwood project has no current scope to scan and store paperbased documents resulting in documentation not being secured or accessible after the headquarter move.

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):	0	0	0

CONTROLS IN PLACE

• Initial survey of held records by departments.
Departments are able to access MFD and have been able to scan own records.

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

IMST staff have a quick review of some of the files stored in the Information team to assess what kinds of documents are stored and implications for data security and clinical records management.	JW to review remaining records held by IMST only. Check any patient records for those past minimum retention period and destroy with remaining records to be repatriated to the responsible directorate.	30/11/2021 John Wolstenholme
Raise this issue with Leaving Fulwood Group.		31/12/2021 Phillip Easthope
To contact Greg Boyd regarding actions from 8/11 Leaving Fulwood Project meeting.		26/11/2021 Mathew Needham

Risk No. 4376 v.7 BAF Ref:	Risk Type: Statutory / Risk Appetite:	Monitoring Group: Audit Committee
Version Date: 22/10/2021	Directorate: IMS&T	Last Reviewed: 22/10/2021
First Created: 21/04/2020	Exec Lead: Executive Director Of Finance	Review Frequency: Quarterly

Details of Risk:

There is a risk that clinical records and documents could be accessed by non-SHSC due to limited physical security controls in place at Presidents Park where the documents are stored resulting in potential data and information security breaches.

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

CONTROLS IN PLACE

- Staff supervision of external personnel when warehouse doors are open.
- Staff training in confidentiality and IG training.

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

An interim standard operating procedure to be produced, to share with Estates colleagues, to support the management of new incoming documents, and access to those records already stored at Presidents Park.	Recommendations accepted by DIGG 20 Oct 2021. Liaise with Estates Dept. on SOP.	30/11/2021 Megan Williamson
Estates Dept. to take ownership of improving security of records stored at President Park following DIGG acceptance of recommendations.		31/03/2022 Helen Payne

Risk No. 4377 v.2 BAF Ref: BAF.0022	Risk Type: / Risk Appetite: Moderate	Monitoring Group: Finance & Performance Committee
Version Date: 19/05/2021	Directorate: Finance	Last Reviewed: 07/09/2021
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

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	Corporate Benchmarking submitted early August, outputs will be utilised to inform CIP planning in corporate areas.	30/09/2021 Lisa Collett
Develop CIP on a page to ensure how we do CIP is fit for purpose and clearly communicated		07/10/2021 Olga Lycett

Risk No. 4407 v.4 BAF Ref: BAF.0003	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee
Version Date: 20/07/2021	Directorate: Acute & Community	Last Reviewed: 11/11/2021
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):	4	3	12
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 to raise awareness through review.
- Annual fire risk assessment undertaken by South Yorkshire Fire Service and the 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

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: 02/11/2021
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	1	3

CONTROLS IN PLACE

• 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

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

Meeting with STH - to access assessor training. Old mentors that could have become assessors have left the Trust, so new ones must be identified. Training can now be accessed via STH, but all nurses must complete supervisor training.	20/11/2021 Andrew Algar
CLiP - started discussions on Dovedale 2, good opportunity to try something new as they begin to take students in the new year. To evaluate and review for widening the project.	30/03/2022 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.

• Other possibilities to increase placement capacity have been considered; such as utilising technology and the CLiP programme.

Risk No. 4475 v.5 BAF Ref:	Risk Type: Statutory / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee
Version Date: 06/07/2021	Directorate: Acute & Community	Last Reviewed: 16/11/2021
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 and the removal of Ligature Anchor Points, 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. This creates a corporate risk for the organisation in fulfilling the requirements of section 140 of the Mental Health Act 1983 to provide appropriate accommodation for people requiring hospital care.

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.
- Out of Area bed managed in post from September to assure of the quality of care from out of area providers

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.	additional 12 acute beds procured - block booked - 6 females and 6 males Additional PICU beds, spec not updated so pending progression via procurement	31/03/2022 Khatija Motara
Purposeful Inpatient Admission Model to be developed with collaboration across inpatient and community services.	Purposeful admission is now in situ on Stanage, progressing in pilot on Maple, and planned roll out at Dovedale 2 and Endcliffe wards.	31/03/2022 Kate Oldfield
Crisis Home Treatment and Resolution Service to be developed with investment from Sheffield	Recruitment underway to fulfil this action.	30/09/2021 Sarah Roberts-Morris

Clinical Commissioning Group to include gatekeeping function for all inpatient admissions.

CORPORATE RISK REGISTER

As at: November 2021

Risk No. 4480 v.4 BAF Ref:	Risk Type: Business / Risk Appetite:	Monitoring Group: Audit Committee
Version Date: 04/10/2021	Directorate: IMS&T	Last Reviewed: 04/10/2021
First Created: 19/11/2020	Exec Lead: Executive Director Of Finance	Review Frequency: 6 Monthly

Details of Risk:

There is a risk that there will be an increased chance of Insight instability and restrictions in functionality caused by. continual develoment on the Insight system which is built on some obselete and unsupported software componnts resulting in poor system performance, higher chances of system failure, increased support and maintenance overheads for IMST and limitations with the trust adhering to NHS Digital and legislation standards including NHS Digital DSPT, Cyber Essentials and NIS.

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

CONTROLS IN PLACE

- Restriction in software development.
- Adherence to Software standards
- Clinical Safety Sign Off Required.

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

re-review this risk following the deployment of:
MHSDS
CJIT
QUIT programme

24/12/2021
Ben Sewell

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: 12/11/2021
First Created: 25/11/2020	Exec Lead: Executive Director Of Finance	Review Frequency: Quarterly

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.
- Increased tracking of IG training compliance and supporting toolset to raise overall trust awareness.

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

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: 26/10/2021
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

Risk No. 4727 v.1 BAF Ref: BAF.0024	Risk Type: Statutory / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee
Version Date: 12/09/2021	Directorate: Nursing & Professions	Last Reviewed: 13/11/2021
First Created: 12/09/2021	Exec Lead: Executive Director - Nursing & Professions	Review Frequency: Monthly

Details of Risk:

There is a risk that staff will fail to identify, act upon, report and manage safeguarding risks in their line of duty which will result in harm to patients and/or their families and children. this is a statutory responsibility

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

CONTROLS IN PLACE

- a rapid development plan has been implemented to ensure the corporate safeguarding team have the capacity and capability to discharge the organisational safeguarding duties. staff have been trained to level 1 & 2 in adult safeguarding and level 3 in childrens safeguarding.
- safeguarding team has been enhanced and now has additional practitioner capacity and administration function. key leaders are safeguarding leads across the organisation

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

develop and roll out level 3 safeguarding adult training to all registered clinical staff	training commenced. to agree plan with CCG and set trajectories. interim training completed to ensure staff know how to refer	31/03/2022 Hester Litten
roll out safeguarding supervision through action learning sets across inpatient services and recovery teams	Initial training completed with inpatient matrons, however roll out plan has not been agreed nor has communications been prepared. policy in place but needs further discussion and agreement for action	31/03/2022 Hester Litten

Risk No. 4742 v.1 BAF Ref: BAF.0024	Risk Type: Statutory / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee
Version Date: 19/10/2021	Directorate: Nursing & Professions	Last Reviewed: 26/10/2021
First Created: 19/10/2021	Exec Lead: Executive Director - Nursing & Professions	Review Frequency: Monthly

Details of Risk:

Staff may fail to identify and report individuals who are susceptible to radicalisation as defined in the Prevention of Terrorism Act. SHSC has failed to train the required staff groups in PREVENT level 3 WRAP training as outlined in the NHSE guidance for Health Providers and as stipulated in DHSC Prevent training framework, updated 2021 commenced 2015.

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):	4	1	4

CONTROLS IN PLACE

- staff have completed either level 1 or level 2 Prevent training but this does not give the necessary knowledge for registered practitioners who require level 3
- Level 3 elearning package has been identified within the Elearning course catalogue which can be identified as mandated training.

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

align staff who require L3 training in PREVENT On ESR to ensure staff are aware who requires L3 training and reporting can take place through IPQR/Mandatory training report	work planned to be completed by 31st December	31/12/2021 Jennifer Wilson
Report out monthly on compliance trajectories to reach Level 3 PREVENT in line with Intercollegiate document	reporting will commence when new competencies aligned.	31/12/2021 Jennifer Wilson
develop face to face training package for PREVENT L3. commission initial training places		31/12/2021 Salli Midgley

Risk No. 4749 v.2 BAF Ref: BAF.0004	Risk Type: Workforce / Risk Appetite: Moderate	Monitoring Group: People's Committee
Version Date: 01/11/2021	Directorate: Human Resources	Last Reviewed: / /
First Created: 26/10/2021	Exec Lead: Director Of Human Resources	Review Frequency: Monthly

Details of Risk:

There is a risk that the Trust is unable to meet the identified training needs for the existing workforce becuase of a lack of budget resulting in failing to meet workforce transformation priorities

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):	2	2	4

CONTROLS IN PLACE

- Governance process in place to monitor progress through Workforce Planning and Transformation Group and report to People committee
- Business case approval for a centralised training budget
- Report with proposals to address implementation problems taken to Service Delivery Group and Workforce Transformation group and escalated as a risk to People Committee
- HEE funding used to meet funding gaps where staff meet criteria ie CPD, support staff

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

Escalation of issues together with potential solutions related to inability to implement business case decision.

01/12/2021
Karen Dickinson