Board of Directors - Public

SUMMARY REPORT	Meeting Date:	25 May 2022
	Agenda Item:	19

Report Title:	**Corporate Risk Register**	
Author(s):	Amber Wild, Corporate Assurance Manager	
Accountable Director:	Deborah Lawrenson, Director of Corporate Governance	
Other Meetings presented to or previously agreed at:	**Committee/Group:**	N/A
	Date:	
Key Points recommendations to or previously agreed at:	The Corporate Risk Register (CRR) is reported for consideration since it was last reported to Board in March 2022. Changes and updates to individual risks are highlighted in bold, italicised text within the register which is attached as an appendix, and a snapshot of the risk register is detailed in the cover report.	

Summary of key points in report

A snapshot of the risks is provided in the report, together with an indication of risk score movement since the previous report. The full Corporate Risk Register is attached as an appendix and updates that have been added to each risk are shown by bold, italicised text.

All risks highlighted in the summary report have been presented to the appropriate Board subcommittee for discussion. Risk scores need to be challenged with the risk owners for Risk 4757, Risk 4841 and Risk 4756, and these need further work before the Risk Register is next received at Committees and Board in June.

Three new risks have been added:
Risk 4545 relating to staff compliance in Information Governance and IT has a risk score of 9.
Risk 4841 relating to withdrawal of delegated Local Authority functions has a risk score of 16.
Risk 4846 relating to employment checks for third party contractor has a risk score of 0. Work is ongoing to challenge this score.

Four risks have been moved off the register since it was last presented to Board:
Risk 4742 relating to Prevent Training has been closed
Risk 4769 relating to the volunteer database has been closed.
Risk 4745 relating to complaints being responded to in a timely manner has been closed.
Risk 4276 relating to physical health monitoring of service users has been de-escalated from the Corporate Risk Register to directorate level risk.

A risk review of systems and processes is currently underway and is due to report to the Audit and Risk Committee and the Board of Directors in June 2022, after which recommendations will be followed up.

Recommendation for the Board/Committee to consider:							
Consider for Action		**Approval**	**X**	**Assurance**	**X**	**Information**	
To receive the Corporate Risk Register and note changes.							

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"
Data Security Protection Toolkit	*Yes*		*No*	***X***	
Any Other Standards					

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Service user/Carer 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***	
Organisational Development/Workforce	*Yes*		*No*	***X***	
Equality, Diversity & Inclusion	*Yes*		*No*	***X***	
Legal	*Yes*		*No*	***X***	

Section 1: Analysis and supporting detail

Background

1.1 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).

1.2 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. New risks are identifiable in bold, italicised text, in the snapshot below.

1.4 Changes to existing risks are identified by bold, italicised text within the risk register, attached in the appendix to this report.

1.5

Initial risk score		Current risk score				Target risk score			Monitoring Group
Impact	Likelihood	Total	Impact	Likelihood	Total	Impact	Likelihood	Total	
4823: There is a risk that patients with a Learning Disability/and or with Autism will be admitted onto an acute mental health ward due to the current closure of ATS at SHSC. This has and will result in patient been inappropriately placed on an Acute Mental Health Ward, this environment is not fitting to patient with Learning Disability or their sensory needs, in addition staff on Acute Mental Health wards are not appropriately trained Learning Disability Staff. It poses a risk to Adult Mental Health patients and makes them vulnerable - increases the possibility of risk of negatively impacting the mental health needs of those patient and could cause a deterioration in the behaviour that cause concern of the LD patient admitted. Green Light Working does not mitigate risk for patient with Moderate to Severe LD, it is important to continue to use Green Light Working when appropriate								**Quality Assurance Committee** ⇔
5	4	20	4	4	16	4	2	8	

4841: ***There is a risk to the capacity and morale of the clinical workforce as a result of the Local Authorityserving notice of intention to withdraw delegated Social Work and Social Care functions and the Local Authority employed workforce from Sheffield Health and Social Care.***									**People Committee**
4	5	20	4	4	16	2	5	10	
3679: There is a risk to patient safety arising from the quality and safety of theward environments across SHSC hospital sites, including access to ligature anchor points.									**Quality Assurance Committee** ⟺
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.									**Quality Assurance Committee** ⟺
5	4	20	5	3	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.									**Quality Assurance Committee** ⟺
4	5	20	3	5	15	3	2	6	
4456: There is a risk that the Specialist Community Forensic team will be unable to perform their businessas usual, specifically the provision of outstanding holistic community care for forensic service users.This is caused by a lack of clinical base for the team due to the temporary base at Fulwood House being no longer available (Leaving Fulwood Project) from approximately April 2022. Resulting in a reduction in quality of care, an inability to work cohesively as a team and systems and structureswithin the service being impacted.									**Finance and Performance Committee** ⟺
4	4	16	3	4	12	3	2	6	
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.									**People Committee** ⟺
4	4	16	3	4	12	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.									**Finance and Performance Committee** ⇩
4	5	20	3	4	12	2	3	6	
4409: There is a risk the Trust is unable to provide sufficient additional nursing/nursing associate placement capacity to meet demand caused by acombination of factors, combined with vacancies, skill mix challenges, and									**People Committee**

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	3	12	3	1	3	⟺
4615*:* Lack of compliance with legislation "Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. RIDDOR puts duties on employers, the self-employed and people in control of work premises (the Responsible Person) to report certain serious workplace accidents, occupational diseases and specified dangerous occurrences (near misses). Currently this responsibility is with Patient Safety Specialist, it has become clear, through the Health and Safety Committee, that there is a lack of connectivity between Health and Safetyinput, Ulysses incident reports and ERoster/staff absence recording resulting in lack of submissions and data sharing to ensure lesson learnt.									**Quality Assurance Committee**
4	4	16	4	3	12	4	2	8	⟺
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.									**Quality Assurance Committee**
3	5	15	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.									**Quality Assurance Committee**
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.									**Finance and Performance Committee**
3	4	12	4	3	12	3	3	9	⟺
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.									**Audit and Risk Committee**
3	4	12	3	4	12	2	3	6	⟺
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.									**Audit and Risk Committee**
3	4	12	3	4	12	3	2	6	⟺
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.									**Quality Assurance Committee**
5	4	20	4	3	12	2	2	4	⟺
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									**People Committee**

3	4	12	3	4	12	2	2	4	⟺
4756: Demand for the SAANS greatly outweighs the resource and capacity of the service. This is resulting in longer/lengthy wait timesand high numbers of people waiting									**Quality Assurance Committee**
4	5	20	3	4	12	3	4	12	⟺
4757: Demand for Gender greatly outweighs the resource/capacity of the service. This resulting in lengthy waits and high numbers of people waiting									**Quality Assurance Committee**
4	5	20	3	4	12	4	4	16	⟺
4612: There is a risk that system and data security will be compromised caused by IT systems continuing to run on software components that areno longer supported resulting in loss of critical services, data and inability to achieve mandatory NHS standards (Data Security Protection Toolkit)									**Audit and Risk Committee**
4	3	12	3	3	9	3	2	6	
4078: Low staff engagement which may impact on the quality of care, asindicated by the Staff Surveys 2018-2020									**People Committee**
3	4	12	3	3	9	2	3	6	⟺
4480: There is a risk that Insight will become increasingly unstable and functionality restricted by continual development of the system, which is built on obsolete and unsupported software components resulting in poor performance, higher chances of failure, increased support and maintenance overheads for IMST and limitations with the trust adhering to NGS Digital and legislation standards including NHS Digital DSPT, Cyber Essentials and NIS									**Audit and Risk Committee**
4	3	12	3	3	9	3	2	6	⟺
4376: There is a risk that clinical records and documents could be accessedby non-SHSC due to limited physical security controls in place at PresidentsPark where the documents are stored resulting in potential data and information security breaches.									**Audit and Risk Committee**
3	3	9	3	3	9	3	2	6	⟺
4545: There is a risk that staff are not compliant in Information Governance and IT security training as thecurrent mandatory training policy target deadline is set within 90 days from the start of employment in post. This results in staff using trust computer systems without the correct level of information security, information governance and cyber security awareness. This also impacts on the trust not being able to meet the Data Security Protection Toolkit (DSPT) requirement of 95%trust wide compliance.									**Finance and Performance Committee**
3	4	12	3	3	9	2	2	4	
4362: There is a risk that the Trust will be unable to provide safe patient careor 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									**Quality Assurance Committee**
5	5	25	3	3	9	2	2	4	⬇

4804: There is a risk that Back to Good progress will be impacted during the Omicron variant wave resulting in missed delivery dates of required actions. This will impact on quality, safety, and regulatory requirements.									**Quality Assurance Committee** ⟺
4	4	12	2	3	6	1	1	1	
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 statutory responsibility.									**Quality Assurance Committee** ⇩
5	2	10	5	1	5	4	0	4	
4846: There is a risk that third party contractors are not subject to the same employment checks and in employment supervision as substantive or Bank staff resulting in people working on our premiseswithout adequate checks or supervision									**People Committee**
3	2	6	0	0	0	0	0	0	

Closed Risks

Risk 4742 relating to Prevent Training has been closed
Risk 4769 relating to the volunteer database has been closed.
Risk 4745 relating to complaints being responded to in a timely manner has been closed. This risk is controlled to an acceptable level.
Risk 4276 relating to physical health monitoring of service users has been de-escalated from the Corporate Risk Register to directorate level risk. A reduction in risk rating is now managed through tendable audit to more acceptable level.

New risks

Risk 4545 relating to staff compliance in Information Governance and IT security, is a new risk to the Corporate Risk register and has been presented to Finance and Performance Committee in April 2022.
Risk 4841: there is ongoing work with recommended governance around this yet to be agreed. New controls and a new target score of 10 has been added. Two actions have been completed on 31.03.22**.** The most recent risk review states: ***Awaiting formal governance structure to effectively support the change process.***
Risk 4846: this is a risk that is being monitored by People Committee. Ongoing work with the risk owners has been offered to support their work with the risk score.

Other

Risk 4777: action progress has been updated, and three new actions added but work is ongoing with the risk owners to identify the appropriate monitoring group before it is presented to Board.
Risk 4804: it has been recommended to discuss this risk at the Back to Good Programme Board to ensure appropriate action progress and review.
Risk 4377: It has been agreed at Finance and performance Committee that this risk is no longer applicable as it was regarding 21/22. A new risk for year 22/23 will be added to the Corporate Risk Register for year 22/23 to replace risk 4377.
Risk 4727: relating to the risk that staff managing safeguarding risks had been reduced from a current risk score of 10 to 5, following a review (***There is robust evidence that staff are reporting incidents and seeking advice on safeguarding matters in the line of their duties. concerns have increased and team activity has increased to demonstrate this upturn in staff awareness. training is now rolling at L3 for adults.***
Risk 4362: relating to Covid 19 has been reduced from a current risk score of 12 to 9.

Risk profile

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

1.11 **Severity**

Catastrophic (5)	1		**2**		
Major (4)			**4**	**2**	
Moderate (3)			**6**	**10**	**1**
Minor (2)			**1**		
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 – May 2022

CORPORATE RISK REGISTER

As at: May 2022

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:** 29/04/2022
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 and a weekly clinical oversight group.
- Staff receive clinical risk training, including suicide prevention and RESPECT and all ligature incidents are reviewed.
- CQC MHA oversight (visits, report and action plans)
- Mental Health Legislation Committee with oversight of compliance in relation to seclusion facilities
- A Standard Operating Procedure is embedded which describes an elevated level of medical oversight/review when a service user requires seclusion.
- Nurse alarm system in place at Forest Lodge and Maple Ward
- Contemporaneous record keeping is supported by standard operating

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 all adult acute wards is continuing on programme; The business case for Phase 3 was approved by Trust Board in January 2022. Phase 3 works will address Stanage and Maple en-suites, commencing July 2022 on a vacant Stanage ward and then commencing January 2023 on a vacant Maple ward. Burbage ward en-suites are currently being addressed on a vacant ward as part of the Phase 1 works which will be complete July 2022.	31/07/2023 Richard Scott
Estates required to review and replace window frames which pose a	Works are continuing on programme. Several	31/03/2022 Richard Scott

procedures to monitor changes in the needs and risks of service users. • 14 commissioned beds in place to mitigate reduced bed base whilst refurbishment work to remove LAP's is progressed • In response to s.29A Notice - action plan has been mobilised to improve environment sooner and to introduce greater clinical mitigation in the interim. • 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.	ligature risk. 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.	wards/sites are still to be addressed and works will continue into 2022. ***risk reviewed. estates work progressing and due for completion July 2023. Interim mitigation in place but creating challenges in maintaining patient flow.***	26/05/2022 Greg Hackney

CORPORATE RISK REGISTER

As at: May 2022

Risk No. 3831 **v.**20 **BAF Ref:** BAF.0014	**Risk Type:** Workforce / **Risk Appetite:** Low	**Monitoring Group:** People Committee
Version Date: 13/04/2021	**Directorate:** Acute & Community	**Last Reviewed:** 29/04/2022
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

• 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

• ***HR Business Partner teams integrated into Directorate Management teamswith oversight on recruitment. Regular reporting through IPQR***

CORPORATE RISK REGISTER

As at: May 2022

Risk No. 4078 **v.**13 **BAF Ref:** BAF.0013	**Risk Type:** Workforce **/ Risk Appetite:** Low	**Monitoring Group:** People Committee
Version Date: 12/11/2021	**Directorate:** Organisational Development	**Last Reviewed:** 10/05/2022
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

Reviewing the Staff Survey engagement leads roles (ROI)	Recruitment to new OD and Staff Engagement posts in progress	30/04/2022 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

CORPORATE RISK REGISTER

As at: May 2022

Risk No. 4121 **v.**21 **BAF Ref:** BAF.0021	**Risk Type:** Safety **/ Risk Appetite:** Zero	**Monitoring Group:** Finance & Performance Committee
Version Date: 16/05/2022	**Directorate:** IMS&T	**Last Reviewed:** 01/05/2022
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 from Insight (EPR), 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***	***4***	***12***
Target Risk: (after improved controls):	2	3	6

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

The New EPR Programme, which will deliver a new EPR allowing Insight to be fully retired is the full mitigation for this risk leading to its closure.	A contract for a new EPR signed on 31/01/2022	31/07/2023 Andrew Male

• High level planning quarter-by-quarter now overseen by IMST SMT and discussions with Services. Seeks to make requests visible and to limit development taking place.

• Any incidents of deletion and remediation action taken is presented at every meeting of DIGG

• SOP in place to handle document deletion incidents, which produces the information shared with DIGG. Incidents, which are managed under this SOP are discussed with the Caldicott Guardian

CORPORATE RISK REGISTER

As at: May 2022

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:** 16/05/2022
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

Maintaining appropriate levels of Respect training	***Reviewed - monitoring on going with areas of non compliance addressed***	31/07/2022 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.	***Fixed Body scanners not operational at present due to Trust wide work to focus on this***	30/09/2022 Lorena Cain

CORPORATE RISK REGISTER

As at: May 2022

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:** 03/05/2022
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.	31/08/2022 Laura Wiltshire
VCSE offer went live in February 2022and will be evaluated in May 2022.		31/05/2022 Andy Bragg

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).

CORPORATE RISK REGISTER

As at: May 2022

Risk No. 4362 **v.**6 **BAF Ref:** BAF.0023	**Risk Type:** Safety **/ Risk Appetite:** Zero	**Monitoring Group:** Quality Assurance Committee
Version Date: 18/05/2022	**Directorate:** Trust Board	**Last Reviewed:** 18/05/2022
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):	***3***	***3***	***9***
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
- 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
- Review of business critical services in event of future restrictions / lockdown
- Escalation and Decision Making Logs maintained in line with EPRR requirements

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.	***Risk reviewed. Following wave four of COVID, the mass vaccination programme, and new guidance for the public and services the risk of COVID topatient, staff and business continuity has reduced. We are operating services effectively despite the virusbeing endemic. We remain in a L4 critical NHSE incident, so our gold, silver and bronze command structure remain in place to respond proactively to further waves.***	30/06/2022 Neil Robertson
Staff resilience plan - staff absence monitored daily (HR emails all operational services daily) to back fill	Risk reviewed. Following wave four of COVID, the mass vaccination	02/03/2022 Neil Robertson

• 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.

• 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

• 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.

critical areas

programme, and new guidance for the public and services the risk of COVID to patient, staff and business continuity has reduced. We are operating services effectively despite the virus being endemic. We remain in a L4 critical NHSE incident, so our gold, silver and bronze command structure remain in place to respond proactively to further waves.

• 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 2022

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:** 16/05/2022
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):	**2**	***3***	***6***

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

To review the remaining IMST paperdocuments that are still currently located at Fulwood House.	***JW is aware of this action and will attempt to complete the review withinthe timescales identified.***	30/06/2022 John Wolstenholme
To confirm if a sweep of Fulwood has been completed in order to identify any paper files within storage or office spaces, that need appropriate organisation.	***A final sweep of all areas tobe undertaken when teamshave moved in August/September 2022.***	05/09/2022 Greg Boyd
To contact teams/services within Fulwood to determine any paper documents still in use/filed, that may require scanning and establishing contact/ownership for service areas.	***The teams continue to assess what paper records are held; still no significant volume of paper records found other the HR. The process is ongoing. There has been no off site storagerequired to date from Fulwood.***	30/06/2022 Greg Boyd

CORPORATE RISK REGISTER

As at: May 2022

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:** 16/05/2022
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):	***3***	***2***	***6***

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

Action reviewed,further work is required and discussion and minuting at the facilities directorate meeting, aim to have completed by the 8th June 2022.	08/06/2022 Samantha Crosby

CORPORATE RISK REGISTER

As at: May 2022

Risk No. 4377 **v.**2 **BAF Ref:** BAF.0022	**Risk Type:** Financial **/ Risk Appetite:** Moderate	**Monitoring Group:** Finance & Performance Committee
Version Date: 19/05/2021	**Directorate:** Finance	**Last Reviewed:** 01/02/2022
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

22-23 CIP plans incorporating any 21-22 shortfalls in their plan.	***Discussed at FPC - action to be reviewed and incorporated into new risk***	30/06/2022 Matt White
discussed at FPC - risk is now obsolete as it was regarding 21/22. Anew risk will be added to the CRR foryear 22/23 to replace this risk.		30/06/2022 Matt White

CORPORATE RISK REGISTER

As at: May 2022

Risk No. 4407 **v.**4 **BAF Ref:** BAF.0025	**Risk Type:** Environmental / **Risk Appetite:** Zero	**Monitoring Group:** Quality Assurance Committee
Version Date: 20/07/2021	**Directorate:** Acute & Community	**Last Reviewed:** 29/03/2022
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

• each ward has a designated safety monitor who does intermittent checks of ward environment including smoking and fire risks

CORPORATE RISK REGISTER

As at: May 2022

Risk No. 4409 **v.**12 **BAF Ref:** BAF.0019	**Risk Type:** Workforce / **Risk Appetite:** Low	**Monitoring Group:** People Committee
Version Date: 17/12/2021	**Directorate:** Nursing & Professions	**Last Reviewed:** 29/04/2022
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	3	12
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

• Project leads in place to implement placement expansion in Learning Disabilities

• Reduced placement time for some cohorts of students to enable all students

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

working with SHU placement allocation team to establish demandfor 'make up placements' through the summer and Autumn. If demandfor make-up is reduced we will alleviate some, but not all of the pressure for placement

30/09/2022
Andrew Algar

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.

• Final 6 weeks of placement can be worked in substantive position above allocated places, consolidation placement

• Utilization of spare placement capacity outside of fixed placements at students discretion

CORPORATE RISK REGISTER

As at: May 2022

Risk No. 4456 **v.**6 **BAF Ref:**	**Risk Type:** Financial **/ Risk Appetite:** Low	**Monitoring Group:** Finance & Performance Committee
Version Date: 23/02/2022	**Directorate:** Rehabilitation & Specialist Se	**Last Reviewed:** 05/04/2022
First Created: 18/09/2020	**Exec Lead:** Director Of Special Projects (Strategy)	**Review Frequency:** Quarterly

Details of Risk:

There is a risk that the Specialist Community Forensic team will be unable to perform their business as usual, specifically the provision of oustanding hoslistic community care for forensic service users. This is caused by a lack of clinical base for the team due to the temporary base at Fulwood House being no longer available (Leaving Fulwood Project) from approximately April 2022. Resulting in a reduction in quality of care, an inability to work cohesively as a team and systems and structures within the service being impacted.

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

- Work being done w/c 21st to identify alternative internal or external suitable premises as matter of urgency. No alternative to original plan has been agreed.
- Has been escalated to exec level for awareness.
- Potential location identified by Head of Estates and Project Director. Await further information from Estates on progress with this.
- Reviewed monthly within IPQR, remains a significant risk as the sale and leaving Fulwood consultation is in progress for a leave from March/April.
- Meeting booked in for 25th March between to discuss progress of plans for new location.

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

Potential new base of Fairlawns, await progress news from CCG discussions.	***Still awaiting further update from discussions with CCG***	30/06/2022 Richard Bulmer
Plans for relocation discussed within monthly IPQR directorate meetings	***Continue to be updated progress at IPQR meetings***	30/06/2022 Richard Bulmer
SCFT can work from home to allow business as usualto continue. Staff have the necessary equipment to support this. Storage for office equipment would need tobe identified. Systems to support staff wellbeing would need to be clear and introduced by leadership team and GM	***Staff equipped to work at home when needed and move from Fulwood likely tobe later in the summer***	30/06/2022 Laura Wiltshire

CORPORATE RISK REGISTER

As at: May 2022

Risk No. 4475 **v.**5 **BAF Ref:** BAF.0025	**Risk Type:** Statutory / **Risk Appetite:** Low	**Monitoring Group:** Quality Assurance Committee
Version Date: 06/07/2021	**Directorate:** Acute & Community	**Last Reviewed:** 10/05/2022
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 2021 to assure of the quality of care from out of area providers
- A weekly senior clinical oversight group to be established to hold clinical oversight of all patients waiting for admission.

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

Trust approval through the Quality Committee and Financial Management Group in February 2021 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.	***Commissioning of block booked acute beds to continue for a 12 month period to allow refurbishment of acute hospital wards.***	01/03/2023 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
Comprehensive action plan generated by the Triumvirate to improve the rate of patient flow	***Deadline for all actions extended to end of June 2022.***	30/06/2022 Greg Hackney

through crisis and acute service line. Triumvirate have assigned senior leaders to support implementation

CORPORATE RISK REGISTER

As at: May 2022

Risk No. 4480 **v.**6 **BAF Ref:**	**Risk Type:** Business **/ Risk Appetite:**	**Monitoring Group:** Audit Committee
Version Date: 01/12/2021	**Directorate:** IMS&T	**Last Reviewed:** 05/04/2022
First Created: 19/11/2020	**Exec Lead:** Executive Director Of Finance	**Review Frequency:** Quarterly

Details of Risk:

There is a risk that Insight will become increasingly unstable and functionality restricted by continual development of the system, which is built on some obsolete and unsupported software components resulting in poor performance, higher chances of 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***	***2***	***6***

CONTROLS IN PLACE

- Through discussion minimising direct development of Insight and new developments undertaken using other technology where possible
- Adherence to Software standards
- CCIO and CSO are promoting the use of clinical safety cases when commissioning and signing off new developments
- Where possible components that Insight relies on are upgraded, but this is not possible for all elements
- Infrastructure such as servers, backup and restore facilities provide good service resilience.
- SHSC New EPR Governance Group and sign off process to ensure that new Insight development suggestions are minimised.

Key messages delivered via clinical and corporate delivery groups.

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

re-review this risk following the deployment of: MHSDS CJIT QUIT programme	***Work is still ongoing, but progressing with some key milestones completed and notice given to the existing system supplier. Target date extended.***	29/04/2022 Ben Sewell
SQL Server 2012 to be upgraded to SQL Service 2019	***Quotes for the cost of purchasing SQL Server 2012 extended support have been requested with a view to notupgrading, while still being able to maintain security.*** ***This would avoid any potential for disruption andis preferable considering that the plan is to replace Insight early next year.***	30/06/2022 Ben Sewell

Scandocs server to be upgraded from Windows Server 2008 to 2012 or above	***Upgrade to scanneddocs server in progress with aim to complete this work by theend of April 22.***	29/04/2022 Ben Sewell
Present to SDG the requests or IMSTplans that will continue to be actioned and those that will not or are at risk.		27/05/2022 Ben Sewell

CORPORATE RISK REGISTER

As at: May 2022

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:** 05/04/2022
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.
- Alert setup to monitor cases and appropriate actions taken with individuals identified.

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

Phishing exercise to be undertaken before DSPT submission on 30th June	***Exercise to be scheduled for a targeted section of staff. Previous exercises have been with wider ranges of staff, but this does not provide insight into where susceptibility is highest.***	03/06/2022 Andrew Male

CORPORATE RISK REGISTER

As at: May 2022

Risk No. 4545 **v.**5 **BAF Ref:**	**Risk Type:** Statutory **/ Risk Appetite:** Low	**Monitoring Group:** Finance & Performance Committee
Version Date: 10/03/2022	**Directorate:** IMS&T	**Last Reviewed:** 03/05/2022
First Created: 11/04/2021	**Exec Lead:** Executive Director Of Finance	**Review Frequency:** Monthly

Details of Risk:

There is a risk that staff are not compliant in Information Governance and IT security training as thecurrent mandatory training policy target deadline is set within 90 days from the start of employment in post. This results in staff using trust computer systems without the correct level of information security, information governance and cyber security awareness. This also impacts on

the trust not being able to meet the Data Security Protection Toolkit (DSPT) requirement of 95% trust wide compliance.

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

- ***Regular reports from ETD to support identification of staff who are notcompliant.***
- ***Data query and tools in place to identify and email relevant staff and theirmanagers who have either expired or will expire within the next 30 days.***
- ***Action from DIGG to escalate decision of a revised training needs analysis (TNA) to people committee to enable the induction period from 90 days to 5working days and refresher periods to remain the same.***
- ***Target of 95% set for IG training compliance over the standard 80% targetfor other mandatory training.***

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

Communications to be drafted and sent out to ask managers to support their staff to complete IG mandatorytraining and reference to the reporting available to support them.

31/05/2022
Andrew Male

CORPORATE RISK REGISTER

As at: May 2022

Risk No. 4612 **v.**3 **BAF Ref:** BAF.0021	**Risk Type:** Business **/ Risk Appetite:**	**Monitoring Group:** Audit Committee
Version Date: 16/07/2021	**Directorate:** IMS&T	**Last Reviewed:** 03/05/2022
First Created: 20/05/2021	**Exec Lead:** Executive Director Of Finance	**Review Frequency:** Monthly

Details of Risk:

There is risk that system and data security will be compromised caused by IT systems continuing to be run on software components that are no longer supported resulting in loss of critical services, data and inability to achieve mandatory NHS standards (Data Protection Security Toolkit).

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	2	6

CONTROLS IN PLACE

- Windows 10 replacement programme and continued application of updates and patches improves security posture.
- new EPR Programme provides a medium term route to reducing dependency on software components that are no longer supported
- The IMST Department conducts Microsoft Exchange back-ups every evening to an alternative storage medium, in the event of a catastrophic system failure. This could involve loss of staff emails and calendars, however the data will be available to recovered within reasonable timescales.
- Historic clinic booking data is stored within Insight (Patient Record)
- Continued patching of Insight and other server infrastructure in place and monitored at a department level and reported to DIGG
- Regular audit of OS and patching status performed using SCCM to inform upgrade and patching schedules
- Clinic booking project aims to retire some old software components
- We have software assurance from Microsoft meaning that can always update to latest versions where possible.

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

Microsoft Access 2003 runtime must be retired. At this time Insight is dependent on this software. The only mitigation is replacing and retiring Insight entirely.	***EPR Programme underway. Additionally we are gathering data on other users of Access across the Trust with the aim of retiringdatabases, which have not been accessed for a period of time.***	01/10/2023 Andrew Male
Actions from NHS Digital to provide supporting information to isolate the Clinic Booking solution based on Exchange 2010. Implementation of NHS Digital Advice, followed by Penetration Test to provide the supporting information to NHS Digital.	**Based on recommendationsfrom IMST all email inboxeshave been moved from Exchange 2010 to Exchange 2016, however public folders remain on the old service to support EPR clinic bookings. A penetration system will be commissioned as a next step.**	30/06/2022 Adam John Handley

	Last remaining Windows 2008 Server to be decommissioned	***Action overdue, due to securing the staff time to complete. Detailed internal discussion through IMST Information Security Group taking place.***	30/04/2022 Ben Sewell

CORPORATE RISK REGISTER

As at: May 2022

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:** 28/02/2022
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.
- Locum medical staff in post in community areas, at significant cost.
- Recruitment strategy being developed by Clinical Director.

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

Consultant Psychiatrist for the South Recovery Service post advertised 31st January 2021	***no applications however a potentialcandidate has been identified***.	30/06/2022 Robert Verity
Additional Locum consultant to be recruited due to unsuccessful recruitment to EWS.	***EIS consultant compliment now complete with substantive consultants. Candidate for SPA or EWS identified, potential for appointment starting February 2023***	29/07/2022 Robert Verity
Split post for Substance misuse team and North recovery team is planned.	***Advertisement live and application expected***	31/08/2022 Robert Verity
Recruitment to Consultant appointments - Repeated efforts to recruit to vacant posts are being made.	***Potential candidates have been identified for recovery north/substance misuse postand EWS/SPA posts.***	31/08/2022 Robert Verity

		The former has been advertisedand application is expected.Latter potential candidate will be eligible to apply for apost from August 2022.	
	succession planning for two staff grades and some retiring consultants that will be leaving the Trust	***Doctor moved from rehab and specialist services to acute and community, replaced Dr who left the trust. Retiring Consultant has agreed to return for 2 year contract***	29/07/2022 Robert Verity

CORPORATE RISK REGISTER

As at: May 2022

Risk No. 4615 **v.**3 **BAF Ref:**	**Risk Type:** Statutory **/ Risk Appetite:** Moderate	**Monitoring Group:** Quality Assurance Committee
Version Date: 24/01/2022	**Directorate:** Facilities	**Last Reviewed:** 09/05/2022
First Created: 03/06/2021	**Exec Lead:** Director Of Special Projects (Strategy)	**Review Frequency:** Monthly

Details of Risk:

Lack of compliance with legislation "Reporting if Injuries, Diseases and Dangerous Occurrences Regulations 2013.
RIDDOR puts duties on employers, the self-employed and people in control of work premises (the Responsible Person) to report certain serious workplace accidents, occupational diseases and specified dangerous occurrences (near misses). Currently this responsibility is with the risk department, it has become clear, through the Health and Safety Committee, that there is a lack of connectivity between Health and Safety input, Ulysses incident reports and ERoster/staff absence recording resulting in lack of submissions and data sharing to ensure lesson learnt.

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	4	4	16
Current Risk: (with current controls):	4	3	12
Target Risk: (after improved controls):	4	2	8

CONTROLS IN PLACE

- Ulysses is available for recording incidents
- Risk Department are submitting RIDDOR reports
- Health and Safety Committee are getting some statistics in relation to RIDDOR submitted
- Staff absence reports being received both from ERostering and ESR and sent through to risk department
- RIDDOR is briefly mentioned within the Incident Management Policy and Procedure (including serious incidents)
- Human Resources do receive an email if there is a staff injury reported on Ulysses - however this may not always be linked to staff absence or reportable incident.
- Daily incident huddle is in place that can be utilised to highlight possible areas of concern.

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

Provide full training to the Health and Safety team on Ulysses to ensure up to date knowledge on how to raise queries and concerns that will support the correct identification of logged events that potentially meet RIDDOR requirement.	***This has been requested but this will not fully impact on RIDDOR being undertaken but it may support the identification of where thereare gaps***.	28/02/2022 Samantha Crosby

CORPORATE RISK REGISTER

As at: May 2022

Risk No. 4727 **v.**5 **BAF Ref:** BAF.0024	**Risk Type:** Statutory **/ Risk Appetite:** Zero	**Monitoring Group:** Quality Assurance Committee
Version Date: 15/03/2022	**Directorate:** Nursing & Professions	**Last Reviewed:** 29/04/2022
First Created: 12/09/2021	**Exec Lead:** Executive Director - Nursing & Professions	**Review Frequency:** Quarterly

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	2	10
Current Risk: (with current controls):	***5***	***1***	***5***
Target Risk: (after improved controls):	4	1	4

CONTROLS IN PLACE

- safeguarding team has been enhanced and now has additional practitioner capacity and administration function. key leaders are safeguarding leads across the organisation
- Rapid development plan implemented which includes bitesize training for adults, all staff have met L3 childrens safeguarding, enhaned safeguarding corporate function and addtional manager training. audits and monitoring of implementation of policies in place
- Level 2 safeguarding adult training is at compliance and the plans for L3 training are in place. Childrens safeguarding compliance is near 90% and monitored through IPQR monthly with targets set trustwide. L3 training is a new requirement, additional bitesize training, conferneces and quality checks have demonstrated good knowledge of reporting safeguarding concerns

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

develop and roll out level 3 safeguarding adult training to all registered clinical staff	***there is robust evidence thatstaff are reporting incidentsand seeking advice on safeguarding matters in theline of their duties. concernshave increased and team activity has increased to demonstrate this upturn in staff awareness. training is now rolling at L3 for adults.***	31/12/2022 Hester Litten

CORPORATE RISK REGISTER

As at: May 2022

Risk No. 4749 **v.**8 **BAF Ref:** BAF.0014	**Risk Type:** Workforce / **Risk Appetite:** Moderate	**Monitoring Group:** People Committee
Version Date: 04/05/2022	**Directorate:** Human Resources	**Last Reviewed:** 04/05/2022
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
- 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

Review of study leave policy and processes for collecting . prioritising and agreeing training needs which will enable a clear picture of any training gaps	***Service delivery group agenda item 6 April to review process for learning needs and resource allocation.*** ***study leave policy to be reviewed July 22***	31/07/2022 Karen Dickinson

CORPORATE RISK REGISTER

As at: May 2022

Risk No. 4756 **v.**3 **BAF Ref:**	**Risk Type:** Safety **/ Risk Appetite:**	**Monitoring Group:** Quality Assurance Committee
Version Date: 15/02/2022	**Directorate:** Rehabilitation & Specialist Se	**Last Reviewed:** 16/05/2022
First Created: 28/10/2021	**Exec Lead:** Executive Director - Nursing & Professions	**Review Frequency:** Quarterly

Details of Risk:

Demand for the SAANS greatly outweighs the resource and capacity of the service. This is resulting in longer/lengthy wait times and high numbers of people waiting

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

CONTROLS IN PLACE

- Ongoing discussions with CCG current and required resource
- CCG have proposed investment and staff model has been drafted and is being finalised
- Agreement to split ADHD and ASD pathways
- Project / steering group (with PMO oversight) in place to review position, actions and update on a monthly basis
- Agreement with the CCG to work together with the Trust for the development of a neurodiversity pathway incorporating an all-age pathway. This will look at managing more referrals at a primary care level
- People on the waiting list are managed safely by the service communicating with primary care that they retain responsibility while the patient awaits assessment. The service also provides a range of support materials on the internet and hardcopy.

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

Review of clinical process to be undertaken with Medical Director and Head of Nursing	***Review undertaken into both arms of the service. A deep dive was called to drillinto underlying clinical models and benchmarking with national providers. TheDeep dive is the first stageof a broader process of review that will link to CCG visioning of provision to neurodiverse populations.***	30/09/2022 Mark Parker
Recruitment	***Successful recruitment strategy put in place. All vacant posts now completedfor recruitment or currentlyout at advert. To remain on risk register until all positions in post.***	29/07/2022 Mark Parker

CORPORATE RISK REGISTER

As at: May 2022

Risk No. 4757 **v.**4 **BAF Ref:**	**Risk Type:** Safety **/ Risk Appetite:**	**Monitoring Group:** Quality Assurance Committee
Version Date: 16/05/2022	**Directorate:** Rehabilitation & Specialist Se	**Last Reviewed:** 29/04/2022
First Created: 28/10/2021	**Exec Lead:** Executive Director - Nursing & Professions	**Review Frequency:** Quarterly

Details of Risk:

Demand for Gender greatly outweighs the resource/capacity of the service. This resulting in lengthy waits and high numbers of people waiting . Waiting times now further compromised by significant sickness absence in the medical team and difficulties in recruitment in other professional and adminareas.

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	4	5	20
Current Risk: (with current controls):	3	4	12
Target Risk: (after improved controls):	4	4	16

CONTROLS IN PLACE

- Project / steering groups in place (overseen by PMO) to review monitor and set actions to reduce the waiting times
- Successful NHS E bid for additional investment agreed and in the process of being finalised - this will enhance staff model
- Developing link with Primary Care Projects. This seeks to reduce referrals by supporting primary care to take the lead in diagnostics and support on the pathway.
- People are supported on the waiting list via the primary care provider. The clinic works with voluntary and non-statutory support services to offer support while waiting for assessment.
- Service works in line with NHS E guidance and service specification. Also work with the Northern region of providers to share best practice and collaborate with standard process development.

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

Recruitment	***2 key clinical posts appointed. Other positions at advert so definite progress. Concerns still remain at difficulties in retention and the delay thatinevitable occurs when combining notice periods and the need to train new starters in the speciality of gender medicine. This inevitably takes up scant clinical resource. Unlikely that any practical impact on process will be felt before Autumn 2022.***	29/07/2022 Mark Parker
Clinical process review to be undertaken by Medical Director and Head of Nursing	***Clinical triumvirate leaning-in successfully. Review process tied in withdeveloping model of***	29/07/2022 Mark Parker

		Trans Health Pilot. Currently working on a proposal inline with NHS E call. Problems with development caused by very significant sickness absence within the team. HR and Medical Director input to support process.	
	HIgh levels of sickness absence in medic and admin team specifically	***Direct impact on team ability to offer diagnostic confirmation assessment and progress hormone interventions. No initial assessment possible at this time as no medic on-site. High levels of stress createdin remaining nurse and AHP. Triumvirate oversight in place and senior management appraised. HRinvolved in procedure and management of process.***	29/07/2022 Mark Parker

CORPORATE RISK REGISTER

As at: May 2022

Risk No. 4804 **v.**2 **BAF Ref:** BAF.0024	**Risk Type:** Quality / **Risk Appetite:** Zero	**Monitoring Group:** Quality Assurance Committee
Version Date: 08/02/2022	**Directorate:** Nursing & Professions	**Last Reviewed:** 10/05/2022
First Created: 28/12/2021	**Exec Lead:** Executive Medical Director	**Review Frequency:** Monthly

Details of Risk:

There is a risk that Back to Good progress will be impacted during the Omicron variant wave resulting in missed delivery dates of required actions. This will impact on quality, safety and regulatory requirements.

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

CONTROLS IN PLACE

- Back to Good delivery group monitors monthly to offer support and keep actions on track. Back to Good Programme Board seeks assurance or escalation of actions at risk for further support.
- Trust Command Structure for incident management (pandemic) increased in frequency to support managers on a day to day basis to manage the impact of the pandemic, giving capacity to monitor and deliver on actions
- Robust governance structures across the Trust including Directorate and team performance and quality reviews to keep local managers focused on achieving actions and trajectories. Reporting through to QAC

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

There are 4 actions in exception which remain impacted in part by omicron by also by staffing issues outwith the impact of omicron. managed through governance routesand oversight from QAC/QIB

30/06/2022
Salli Midgley

CORPORATE RISK REGISTER

As at: May 2022

Risk No. 4823 **v.**3 **BAF Ref:**	**Risk Type:** Safety **/ Risk Appetite:**	**Monitoring Group:** Quality Assurance Committee
Version Date: 24/02/2022	**Directorate:** Rehabilitation & Specialist Se	**Last Reviewed:** 16/05/2022
First Created: 26/01/2022	**Exec Lead:** Executive Director - Nursing & Professions	**Review Frequency:** Monthly

Details of Risk:

There is a risk that patients with a Learning Disability/and or with Autism will be admitted onto an acute mental health ward due to the current closure of ATS at SHSC. This has and will result in patient been inappropriately placed on an Acute Mental Health Ward, this environment is not fitting to patient with Learning Disability or their sensory needs, in addition staff on Acute Mental Health wards are not appropriately trained Learning Disability Staff. It's poses a risk to Adult mental health patients and makes them vulnerable - increases the possibility of risk of negatively impacting the mental health needs of those patient, and could cause a deterioration in the behaviour that cause concern of the LD patient admitted. Green Light Working does not mitigate risk for patient with Moderate to Sever LD, it is important to continue to use Green Light Working when appropriate

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

CONTROLS IN PLACE

• Admission Avoidance
The Community Intensive Support Team and Community Learning Disability team are working closely with servcie users and providers to support into the community

• The LD MDT will inreach into the wards to provide support, care plan coordinators and training to actue mental health staff inorder to provide specalist support.

• A new Standard Operating Procedures for emergency admission avoidance/admissions has been developed, with escalation to the Head of Nursing and Clinical Director.

• There is a list of CQC rated Good ATS inpatient setting across the country to try and source alternative out of City (if an admission cannot be avoided) however, these are currently all full and not taking admission.

• The Standard Operating Procedures for admission avoidance/admissions has been developed, with escalation to the Head of Nursing and Clinical Director.

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

Ongoing work within the LD Programme board and the development of a new community enhanced model for Sheffield.	***Clinical Model developed and presented at LD Board, feedback received to incorporated changes***	30/06/2022 Melanie LarderLee
Discussison with Regional Commissioners about future planning for LD beds at an ICS/Regional Level	***Update provided to Contract and Performance Group regarding the CCG and ISC ongoing discussion,***	30/06/2022 Richard Bulmer
Ongoing discussion are taking place at both system and place based within the ICB regarding commissioning of beds with no clear plan agreed	***A ICB meeting will take placew/c 23 May. It was agreed to set up a meeting with key stakeholders to finally***	30/06/2022 Richard Bulmer

bottom off and agree what the ICS position will be for commissioning ATU beds and also Crisis Beds/Safe Place Provision. Membership including attendees from all CCG's, LA's, RDaSH and SHSC.

Head of Commissioning, LDACommissioning Managers and Finance to be in attendance

CORPORATE RISK REGISTER

As at: May 2022

Risk No. 4841 **v.**1 **BAF Ref:**	**Risk Type:** Workforce / **Risk Appetite:** High	**Monitoring Group:** People's Committee
Version Date: 22/02/2022	**Directorate:** Acute & Community	**Last Reviewed:** 10/05/2022
First Created: 22/02/2022	**Exec Lead:** Executive Director - Nursing & Professions	**Review Frequency:** Monthly

Details of Risk:

There is a risk to the capacity and morale of the clinical workforce as a result of the Local Authority serving notice of intention to withdraw delegated Social Work and Social Care functions and the Local Authority employed workforce from Sheffield Health and Social Care.

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	4	5	20
Current Risk: (with current controls):	4	4	16
Target Risk: (after improved controls):	2	5	10

CONTROLS IN PLACE

- Staff support structures mobilised by SHSC and the LA.
- Joint leadership (SHSC and SCC) established to support the proposed changes and to mitigate impact.

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

CORPORATE RISK REGISTER

As at: May 2022

Risk No. 4846 **v.**1 **BAF Ref:** BAF.0014	**Risk Type:** Workforce **/ Risk Appetite:** Low	**Monitoring Group:** People Committee
Version Date: 24/02/2022	**Directorate:** Human Resources	**Last Reviewed:** 18/05/2022
First Created: 24/02/2022	**Exec Lead:** Director Of Human Resources	**Review Frequency:**

Details of Risk:

There is a risk that third party contractors are not subject to the same employment checks and in employment supervision as substantive or Bank staff resulting in people working on our premises without adequate checks or supervision

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	3	2	6
Current Risk: (with current controls):	0	0	0
Target Risk: (after improved controls):	0	0	0

CONTROLS IN PLACE

- All contractors must be on our Procurement frameworks
- Supervision policy requirements and monthly monitoring

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

Procurement to confirm all checks for third party contractors	***No update form Procurement. These do not relate to employees***	30/06/2022 Nicola Woodhead
Aufit all third party contractors location, dates of working, framework emplyed through	***No further update from procurement due to workload. forwarded thereview date on***	30/06/2022 Nicola Woodhead
Review supervision policy in light of the paterson report	***Discussed with LW. Unsure if Paterson report implicatessupervision policy.***	30/06/2022 Linda Wilkinson