Board of Directors

SUMMARY REPORT	Meeting Date:	23 November 2022
	Agenda Item:	24

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:**	The Corporate Risk register has been received at board sub-committees and the Risk Oversight Group
	Date:	8 November 2022 – People Committee 9 November 2022 – Quality Assurance Committee 10 November 2022 – Finance and Performance Committee 21 September – Risk Oversight Group
Key Points recommendations to or previously agreed at:	The Corporate Risk Register (CRR) is presented for consideration since last reported to Board in September 2022. The full CRR is attached as an appendix, and a snapshot of the risk register is detailed in the cover report. Changes and updates to individual risks are highlighted in bold, italicised text within the register.	

Summary of key points in report

Introduction

There are 23 risks on the Corporate Risk Register (CRR) and this is attached as an appendix.

Risks which have a residual risk rating of 12 or above, or risks that impact on several or all directorates/care networks are considered for inclusion onto the Corporate Risk Register. Automated risk review reminders are sent via Ulysses to risk owners every 7 days.

A Risk Oversight Group was established in August. The Risk Oversight Group meets bi-monthly to review the CRR in advance of receipt at the committees.

Risks overseen by each board sub committee are summarised below:

Audit and Risk Committee (ARC):

There are three risks on the register monitored by this committee:

- **Risk 4716*:*** relates to the risk to the Trusts network security as a result of Trust laptop devices accessing the internal network, without the required security updates. This risk has a current risk score of 12 (3 severity x 4 likelihood) and a target risk score of 4 (2 severity x 2 likelihood)**.** Additional resource has been put in place to progress updating of some older devices and weekly monitoring of progress is now in place. A new action has been created to track the progress of removing the remaining versions of Windows 10. Once completed the risk score can be reduced and it is expected that subsequently the risk be managed at department level.

- **Risk 4483** relates to the risk that trust IT systems and data could be compromised due to phishing emails. It has a current risk score of 12 (severity 3 x likelihood 4) and a target risk score of 6 (3 severity x 2 likelihood). Actions related to the phishing exercise are closed, and there are no current open actions. Results and next steps were discussed at November DIGG.

- **Risk 4612** relates to the risk that system and data security will be compromised caused by IT systems continuing to be run on software components that are no longer supported affecting the ability to achieve mandatory NHS standards. It has a current risk score of 9 (severity 3 x likelihood 3) and a target risk score of 6 (3 severity x 2 likelihood). The action was updated on 5 October 2022. It was agreed at the Risk Oversight Group to review this risk with the risk owners at its next meeting and following a further update of the actions before advising if the risk should be de-escalated given the current score is below 12.

Risk 4480 *has been closed*. It related to the risk that Insight will become increasingly instable.

Quality and Audit Committee (QAC):

There are eleven risks on the register monitored by QAC. Nine risks remain unchanged in their description and scores and one risk (Risk 4615) has a reduced current score which is detailed below. Risk 4605 has moved from being monitored by ARC to QAC.

- **Risk 3679** relates to patient safety risks arising from the quality and safety of the ward environments across SHSC hospital sites, including access to ligature anchor points. It has a current risk score of 15 (severity 5 x likelihood 3) and a target risk score of 4 (2 severity x 2 likelihood). Risk actions are overdue for review and this will be challenged at the next Risk Oversight Group in November for receipt at the next QAC meeting.

- **Risk 4124** relates to a risk of harm to members of staff through clinical incidents of violence or aggression within inpatient areas. It has a current risk score of 12 (severity 3 x likelihood 4) and a target risk score of 4 (2 severity x 2 likelihood). Risk actions were updated in September 2022. Risk owners will present an update to the Risk Oversight group on 21 November.

- **Risk 4330** relates to a risk that service users cannot access secondary mental health services through the Single Point of Access within an acceptable waiting time. It has a current risk score of 15 (severity 5 x likelihood 3) and a target score of 4 (2 severity x 2 likelihood). This risk was reviewed in September and new actions added. Risk owners will present an update to the Risk Oversight group meeting in November prior to a further update being received at committee in January.

- **Risk 4407:** relates 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. This risk has a current risk score of 12 (severity 4 x likelihood 3) and a target risk score of 4 (2 severity x 2 likelihood). Risk actions are overdue for review and this will be challenged at the next Risk Oversight Group in November for receipt at the next QAC meeting

- **Risk 4475** relates to a risk that there are no available acute beds in Sheffield at the point of need as a result of necessary refurbishment works. This risk has a current risk score of 15 (severity 3 x likelihood 5) and a target risk score of 6 (3 severity x 2 likelihood). The risk has been reviewed and actions updated: the following key update was provide to the committee and is referenced in the risk register '***we have made progress to reduce the number of out of area hospital bed nights that have been accessed. However, we continue to place service users out of area inappropriately and workstreams need to develop to have greater influence'.***

- **Risk 4605** relating to a risk that patients, especially inpatients, may fall from a height in their care environment, especially in courtyards or gardens, caused by the existing configuration of the environment, resulting in potentially catastrophic injuries. It has a current risk score of 10 (5 severity x 2 likelihood) and a target risk sore of 5 (5 severity x 1 likelihood). It was agreed at the last Risk Oversight Group that this is a risk that impacts across Trust services, that and therefore it remains on the Risk register so that Board and committees can remain sighted on it.

- **Risk 4613** relates to a risk to the quality of patient of care and to the clinical leadership of services due to vacancies across the medical workforce This risk has a current risk score of 12 (severity 3 x likelihood 4) and a target risk score of 6 (3 severity x 2 likelihood). Action progress reviews for all actions are overdue. Risk owners have been contacted to update this risk – it has been confirmed the team have had access issues to the Ulysses system and whilst this has been resolved the update is yet to be made. Discussion about this risk will take place with risk owners at the next Risk Oversight Group meeting in November.

- **Risk 4615** relates to lack of compliance with legislation "Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. This risk has a current risk score of 12 (severity 4 x likelihood 3) that has been reduced to 8 (4 severity x 2 likelihood) and a target risk score of 8 (4 severity x 2 likelihood). This risk was reviewed on 21 October 22 and the following key update noted at committee and on the register: ***The last identified action has been completed, this has reached its target score and is therefore a managed risk and will be escalated as required on review or if incidents occur to raise additional concerns***.

- **Risk 4756** relates to the demand for the Sheffield Adult Autism Neurodevelopmental Service (SAANS) which outweighs the resource and capacity of the service. The current risk score is 15 (severity 3 x likelihood 5) due to the high number of people on the waiting list. The target score for this risk is 12 (3 severity x 4 likelihood). Action progress is up to date. This risk was reviewed on 10 October and the following key update noted at committee and on the register '***Continued review of clinical processes taking place in weekly and monthly forums which leads to escalation to DMT and other boards'***

- **Risk 4757** relates to Demand for Gender service. The current risk score is 16 (severity 4 x likelihood 4) due to high number on the waiting list. The target score for this risk is 16 (4 severity x 4 likelihood). Action progress is up to date.

- **Risk 4823** relates to a risk of patients with a Learning Disability/and or with Autism being admitted onto an acute mental health ward due to the current closure of ATS at SHSC This risk has a current risk score of 16 (severity 4 x likelihood 4) and a target risk score of 8 (4 severity x 2 likelihood). Action progress was reviewed on 14 October and there are no further changes since then.

People Committee (PC):

There are six risks on the register monitored by People Committee.

- **Risk 3831** relates to the quality and safety of patient care and ward leadership due to an over-reliance on agency staffing and preceptorship nurses. This risk has a current risk score of 12 (severity 3 x likelihood 4) and a target score of 6 (3 severity x 2 likelihood). Risk reviews are up to date. There are no open actions for this risk and the last review was on 15 September after this risk was received at people Committee: ***'Critical nursing vacancies remain. Preceptors commencing over the coming month however an increase in agency staff (t2 and t3 framework) is required'***.

- **Risk 4078** relates to low staff engagement. This risk has a current risk score of 9 (severity 3 x likelihood 3) and a target risk score of 6 (2 severity x 3 likelihood). Risk reviews are up to date. The rationale provided by risk owners for it remaining on the CRR is that whilst progress has been made and the current score reflects work in place:
    - The results from 2021 survey do indicate an ongoing risk to staff retention and wellbeing
    - Other indicators such as People Pulse , show a drop in response rates, with a nominal shift in engagement, from July 2022, whilst emerging positivity this survey doesn't explore the full question set to assess an overall picture
    - 2022 results will be the time to fully assess the impact of the work done from 2021 across our Operational workforce

  The performance review actions were updated after the September People Committee: ***2022 Staff***

Survey preparation includes and considers the activity and messages from 2021 results. All teams engaged and informed about the importance of everyone having a voice that matters. Results to be analysed in conjunction with 2021 (and 2020)

- **Risk 4409** relates to the provision of sufficient additional nursing/nursing associate placement capacity. This risk has a current risk score of 12 (severity 4 x likelihood 3) and a target risk score of 3 (3 severity x 1 likelihood). A new version created of the risk was created on 20 October 2022 with an amended risk description, existing controls closed, and new controls added. Previous actions have been closed and new actions added. The risk score has remained the same. The new risk description is: ***There is a risk the Trust is unable to provide sufficient nursing placement capacity to meet demand as a result of staff shortages across SHSC. This could impact on SHSC's reputation and limit our ability to train and recruit newly qualified nurses.*** Details of the new actions and controls re highlighted in bold, italic text within the risk register.

- **Risk 4749** relates to the Trust being unable to meet the identified training needs for the existing workforce has a current risk score of 9 (severity 3 x likelihood 3) – reduced on 15 September following two new controls. The target risk score is 4 (2 severity x 2 likelihood). Action progress and reviews are up to date. This risk remains on the CRR as the new processes have not been embedded for long enough and the first reporting schedule not yet completed. The risk was reviewed on 25 October 2022 and progress updated on one action and one new action has been added.

- **Risk 4841** relates 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 no changes. This risk has a current risk score of 16 (severity 4 x likelihood 4) and a target risk score of 10 (severity 2 x 5 likelihood). Programme is on track against plan and staff are receiving appropriate support to manage the transition. Risk reviewed on 1 November and actions remain appropriate, no changes to the score.

- **Risk 4896** relates to individuals giving false information during the recruitment process. no changes. It has a current risk score of 12 (3 severity x4 likelihood) and a target risk score of 9 (3 severity x 3 likelihood). Action updates and reviews are overdue since the 31 August 2022. Risk owners have been contacted to update this risk, and check and challenge will take place at the next Risk Oversight group, in November.

Finance and Performance Committee (FPC):

There are three risks on the register monitored by FPC.

- **Risk 2177** relates to staff, service users or other persons suffering injury or harm from the effects of a fire within a premise for which the Trust holds a duty of care. The previous current risk score of 10 (5 severity x 2 likelihood) has reduced to 5 (5 severity x 1 likelihood). The target risk score is 5 (5 severity x 1 likelihood). The risk has been reviewed on 11 October: ***there will always be a risk of this within the premises, however all control measures are in place and will be monitored via compliance statistics and incident reports on Ulysses. The fire doors (risk 4744) is a risk on its own but in relation to the overall risk is low.*** The risk has reached its target score, but it remains on the risk register and this will be reviewed in November by the Risk Oversight Group.

- **Risk 4121** relates to patient safety, caused by key clinical documents being deleted from Insight. It has a current risk score of 9 (3 severity x3 likelihood) and a target score of 6 (2 severity x 3 likelihood). The risk was reviewed on 22 October: ***since September there have been three instances of documents deleted from Insight, involving four documents in total. Two were restored from backup, one was re-created by the user and one was advised by the user to be not needed.***

- **Risk 4456** relates to a risk that the Specialist Community Forensic team will be unable to perform their business as usual, caused by a lack of clinical base. It has a current risk score of 12 (3 severity x 4 likelihood) and a target risk score of 6 (3 severity x 2 likelihood). The risk was reviewed on 11 October, and there are no changes.

Mental Health Legislation Committee (MHLC):

- There are no risks on the CRR currently which fall under the auspices of this committee.

Recommendation for the Board/Committee to consider:

Consider for Action		**Approval**	**X**	**Assurance**	**X**	**Information**	

The board is asked to receive the Corporate Risk Register and consider assurances provided, and how the levels of risk reported triangulate with other information considered by Board and its committees.

To receive the Corporate Risk Register and note changes highlighted in the summary report specifically:

- To note the new risk description, controls and actions to Risk 4409
- To note the additional actions to Risk 4841
- To note the move of Risk 4605 to QAC
- To note the change in score of Risk 4615
- To note the changes to Risk 2177.
- To note the update to Risk 4121.
- To note risks for further confirm and challenge at Risk Oversight Group for: Risks 4612; 3679; 4124; 4330; 4407; 4613; 4896; 2177
- To note that Risk 4480 has been closed

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***	
Sustainability	*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 the initial risk score. The full detail of these risks can be found in the full risk register attached 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 inthe appendix to this report.

1.5

Initial risk score			**Current risk score**			**Target risk score**		
Impact	Likelihood	Total	Impact	Likelihood	Total	Impact	Likelihood	Total
1. 4823 (QAC) 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 beeninappropriately 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								
5	4	20	4	4	16 ⟺	4	2	8

2. 4841 (PC) 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.								
4	5	20	4	4	16 ⇔	2	5	10
3. 4757 (QAC) Demand for Gender greatly outweighs the resource/capacity of the service. This resulting in lengthy waits and high numbers of people waiting								
4	5	20	4	4	16 ⇔	4	4	16
4. 3679 (QAC) 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.								
5	4	20	5	3	15 ⇔	2	2	4
5. 4756 (QAC) 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								
4	5	20	3	5	15 ⇔	3	4	12
6.4330 (QAC) 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.								
5	4	20	5	3	15 ⇔	2	2	4
7. 4475 (QAC) 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
8. 4456 (FPC) 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.								
4	4	16	3	4	12 ⇔	3	2	6

9. 3831 (PC)
There is a risk to the quality and safety of patient care and ward leadership due to an over-reliance on agency staffing and preceptorshipnurses and an insufficient number of qualified, substantive, nursing staff.

4	4	16	3	4	12 ⇔	3	2	6

10. 4409 (PC)
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 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

11. 4124 (QAC)
There is a risk of harm to members of staff through clinical incidents ofviolence 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

12. 4613 (QAC)
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 dueto vacancies across the medical workforce and an over-reliance upon locum medical staff.

3	5	15	3	4	12 ⇔	3	2	6

13. 4716 (ARC)
There is a risk to the Trusts network security as a result of Trust laptop devices accessing the internal network, without the required security updates. This has been identified through device use and management, across departments and services. The impact of this risk could compromise the internal network, but also service operations and delivery, whilst these updates are applied.

3	5	15	3	4	12 ⇔	2	2	4

14. 4483 (ARC)
There is a risk that trust IT systems and data could be compromisedas 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

15. 4407 (QAC)
There is a risk of fire on the acute wards caused by service users smoking or using lighters/matches to set fires resulting in harm to service users, staff and property/facilities.

5	4	20	4	3	12 ⇔	2	2	4

16. 4896 (PC)
Risk relating to employing / re-employing individuals giving false information; specifically:
An employee has secondary employment, the employee could continue to work at their secondary employment during a period that they are being paid by the organisation (eg; sickness, paid absences, suspension, normal working hours)
An individual providing false or failing to declare the correct information during the recruitment process eg; no right to work in the UK, false identification, ID theft, false references, not qualified, not registered, criminal convictions

4	4	16	3	4	12 ⇔	3	3	9

17. 4605 (QAC)
There is a risk that patients, especially inpatients, may fall from a height in their care environment, especially in courtyards or gardens, caused by the existing configuration of the environment, resulting in potentially catastrophic injuries.

5	3	15	5	2	10 ⇔	5	1	5

18. 4121 (FPC)
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	3	9 ⇓	2	3	6

19. 4078 (PC)
Low staff engagement which may impact on the quality of care, asindicated by the Staff Surveys 2018-2020

3	4	12	3	3	9 ⇔	2	3	6

20. 4749 (PC)
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 failingto meet workforce transformation priorities

3	4	12	3	3	9 ⇔	2	2	4

21. 4612 (ARC)
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)

4	3	12	3	3	9 ⇔	3	2	6

22. 4615 (QAC)
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 lessonlearnt.

4	4	16	4	2	8 ⇓	4	2	8

23. 2177 (FPC)
Staff, service users or other persons my suffer injury or harm from the effects

of a fire within a premise for which the Trust holds a duty of care.								
5	4	20	5	1	5 ⇩	5	1	5

Risk profile

1.10 The table below shows the spread of risks on the register

Severity					
Catastrophic (5)	**1**	**1**	**2**		
Major (4)		**1**	**2**	**3**	
Moderate (3)			**4**	**7**	**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.

3.2 A Risk Oversight Group has been set up to oversee the effective implementation of the Risk Management Strategy across theTrust and to provide an opportunity for confirm and challenge on the Corporate Risk register in advance of discussion at board sub committees. The Risk Oversight Group meets bi-monthly and reports into

the Audit and Risk Committee for reporting.

Section 4: Implications

Strategic Priorities and Board Assurance Framework
4.1 All

Equalities, diversity and inclusion
4.2 Reflected in specific risks as appropriate

Culture and People
4.3 Reflected in specific risks as appropriate

Integration and system thinking
4.4 Reflected in specific risks as appropriate

Financial
4.5 Reflected in specific risks as appropriate

Sustainable development and climate change adaptation
4.6 Reflected in specific risks as appropriate

Compliance - Legal/Regulatory
4.7 Reflected in specific risks as appropriate

Section 5: List of Appendices

Corporate Risk Register – November 202

CORPORATE RISK REGISTER

As at: November 2022

Risk No. 2177 **v.**18 **BAF Ref:**	**Risk Type:** Statutory **/ Risk Appetite:** Zero	**Monitoring Group:** Finance & Performance Committee
Version Date: 11/10/2022	**Directorate:** Facilities	**Last Reviewed:** 11/10/2022
First Created: 13/05/2013	**Exec Lead:** Director Of Special Projects (Strategy)	**Review Frequency:** Quarterly

Details of Risk:

There is a risk that occupants (staff, service users or other persons) could suffer injury or harm from the effects of a fire within a premise for which the Trust holds a duty of care. There appropriate maintenance and recorded evidence is consistently required to provide assurance that all measures have been taken to reduce the risk occurring.

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	5	4	20
Current Risk: (with current controls):	***5***	***1***	***5***
Target Risk: (after improved controls):	5	1	5

CONTROLS IN PLACE

• SHSC has a Fire Safety Policy which provides some direction of fire safety management and is further enhanced by the use of fire safety protocols. These have a clear review date so that they remain relevant and accurate and ensure that the RRO is adhered too.

• Automatic fire alarm system installed within SHSC premises with 24/7 monitoring by Switchboard Operators.

• SHSC premises have a fire risk assessment in place and this is reviewed at agreed intervals, as per the risk rating undertaken on the assessment. This ensures the assessment remains relevant and up to date and any actions required are clearly identified via an action plan that is monitored by the fire safety and security co-ordinator. This also ensures compliance with RRO is adhered too.

• Fire safety training is completed at induction and at regular intervals through employment. This is monitored via a training compliance table that is available to all managers, staff also can access their own training requirements vis ESR.

• SHSC has a external consultant (fire) appointed to advise on specific projects if requested to do so but also to complete an audit of the fire safety management systems at SHSC to ensure that they remain relevant and accurate and adhere to all legislative requirements.

• Fire Warden training is in place and fire wardens allocated, and training compliance is monitored via the Fire and Security Officer but this system is not

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

fully robust and will need further work to enhance the programme.

• Line managers and staff have a responsibility to undertake mandatory training of which fire safety is one of the courses.

• Environmental (workplace) risk assessments are in place for SHSC premises these have a small amount relating to fire safety.

• Estates Services Manager implements a programme of planned maintenance of fire safety preventative and precautionary measures this is monitored via the Estates Fire Compliance Meeting that is chaired by the security and fire officer.

• Fire incidents within SHSC remit are reviewed by departmental managers however the fire and security officer and fire safety and security co-ordinator receive copies of relevant incidents in order that they can support with any items that required remedial actions.

• The Fire Risk Assessment (FRA) process has been amended so that the assessor will audit the team (ward) level risk for management of smoking by service users on wards and if considered incorrectly assessed will escalate this to senior clinical operations managers as required and record this on the FRA for governance/audit purposes.

• There is a renewed application of the Smoke Free Wards initiative which is having a good effect on the management of service users attempting to smoke while on the inpatient wards. This is monitored via the smoking cessation team and they provide support when required.

• Managers with responsibility for workplace activities and/or mitigating fire risks in work premises, liaise with the security and fire officer where any significant changes are planned or after significant incidents, to review and prioritise risk mitigation measures.

• Fire equipment is maintained at regular intervals (annual for most) and the certification is maintained and overseen by the fire safety and security co-ordinator.

• Each department has one fire drill in every 12 month period, this is recorded and is part of the KPI set monitored via the Health and Safety Committee.

- ***Premises Fire Alarm detection systems are maintained by estates engineers, this is recorded via Planet and is overseen by the maintenance manger and the estates compliance officer provides reports of compliance/non compliance.***
- ***Premises fire alarm activations can be monitored via patriot which is accessible by switchboard however it does not show individual wards it onlyshows buildings.***
- ***A scheduled programme of planned maintenance has been devised and implemented by the estates manager for the weekly testing, and maintenanceof the fire alarm and detections systems by an appropriate electrical trained individual and this is monitored and recorded via Planet.***

CORPORATE RISK REGISTER

As at: November 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:** 01/11/2022
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: November 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:** 08/11/2022
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 Managment teams with oversight on recruitment. Regular reporting through IPQR

• Escalation process regarding critical nursing gaps reviewed and robust system updated

CORPORATE RISK REGISTER

As at: November 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:** 27/09/2022
First Created: 26/10/2018	**Exec Lead:** Director Of Human Resources	**Review Frequency:** Quarterly

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

2022 Staff Survey preparation includes and considers the activity and messages from 2021 results. All teams engaged and informed about the importance of everyone having avoice that matters. Results to be analyzed in conjunction with 2021 (and 2020)

31/12/2022
Sally Hockey

• 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

• Ongoing on Directorate and Team Engagement Plans active. Staff Engagement Steering Group re named and invites extended across SHSC services.

• ***Local People Pulse results from Jan April and July surveys continue to beused to understand staff engagement and experience. Results/activity discussed at Steering Group and Assurance Level with OD***.

• ***2022 Staff Survey results used as a control to measure change from 2018-2022***

Risk No. 4121 **v.**22 **BAF Ref:** BAF.0021	**Risk Type:** Safety **/ Risk Appetite:** Zero	**Monitoring Group:** Finance & Performance Committee
Version Date: 02/10/2022	**Directorate:** IMS&T	**Last Reviewed:** 22/10/2022
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***	***3***	***9***
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.	Project timeline and scope agreed and full implementation underway	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: November 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:** 01/11/2022
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

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
Maintaining appropriate levels of respect training	Respect training compliance is monitored bi-monthly at ward level and monthly within our IPQR	18/12/2022 Khatija Motara

CORPORATE RISK REGISTER

As at: November 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:** 01/11/2022
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 September

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

Waiting time trajectory is reported to the Quality Assurance Committee every 2 months.	Reported in September QAC with detailed actions prepared by General Manager Paul Harding	05/02/2023 Laura Wiltshire
VCSE colleagues to work with SPA to support reduction of our waiting list. Andy Bragg and Paul Harding to explore new ways of working with VCSE in line with actions in line with recovery plan actions outlined in September 2022.		18/12/2022 Laura Wiltshire

2022 which illustrates a number of new actions identified by General Manager for Crisis with the SPA manager. It indicates that there are no untriaged crisis referrals and actions including the senior practitioner working alongside the admin call handler to provide better front end advice and signposting.

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:** 01/11/2022
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: November 2022

Risk No. 4409 **v.**13 **BAF Ref:** BAF.0019	**Risk Type:** Workforce / **Risk Appetite:** Low	**Monitoring Group:** People Committee
Version Date: 20/10/2022	**Directorate:** Nursing & Professions	**Last Reviewed:** 20/10/2022
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 nursing placement capacity to meet demand as a result of staff shortages across SHSC. This could impact on SHSC's reputation and limit our ability to train and recruit newly qualified nurses.

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.
- Additional resource in practice placement team (ETD) to provide peripatetic assessment.
- All registered nurses have responsibility for supporting student learning.
- Project leads in place to implement placement expansion in Learning Disabilities
- 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.***
- ***Final 6 weeks of placement can be worked in substantive position aboveallocated places, consolidation placement***
- ***Utilization of spare placement capacity outside of fixed placements atstudents discretion***
- ***SHSC is a member of the Learning Environment and Placement (LEAP)Consortium and linked delivery groups***.

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

Recruitment into Peripatetic Assessor post underway	31/01/2023 Andrew Algar
Learning Environment Manager meetings to be re-established to create network for sharing good practice and collaborative support mechanism.	28/02/2023 Andrew Algar

- ***Funding to recruit to Peripatetic Assessor post agreed and established.***
- ***Attendance by Prof ETD Lead at the critical staffing meetings to provide clearoversight of staffing pressures, enabling resources to be tragetted at areas of greatest need.***
- ***Monthly meetings between Prof ETD and SHU Director of Placements.***
- ***SHU Lead link lecturer attends SHSC weekly Placement Quality Team (PQT)meetings***.

CORPORATE RISK REGISTER

As at: November 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:** 08/11/2022
First Created: 18/09/2020	**Exec Lead:** Director Of Special Projects (Strategy)	**Review Frequency:** Monthly

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.
- Confirmed base as Wainwright. Plans have been drawn up and shared.

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

Plans for relocation discussed within monthly IPQR directorate meetings	***Continue to be updated progress at IPQR meetings***	15/12/2022 Gemma Robinson

CORPORATE RISK REGISTER

As at: November 2022

Risk No. 4475 **v.**6 **BAF Ref:** BAF.0025	**Risk Type:** Statutory / **Risk Appetite:** Low	**Monitoring Group:** Quality Assurance Committee
Version Date: 15/09/2022	**Directorate:** Acute & Community	**Last Reviewed:** 01/11/2022
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
- Experience and engagement officers along with OOA Bed Manager to make contact with all service users placed in our of area hospital beds.
- 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 General Manager for acute and older adults 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

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

Comprehensive action plan generated by the Directorate Leadership tEAM to improve the rate of patient flow through crisis and acute service line. Senior leaders to support implementation	This work has been defined into 5 workstreams, reporting into the out of area cost improvement programme.	30/12/2022 Greg Hackney
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	31/03/2023 Robert Verity

oversight of all patients waiting for admission.

- ***Oversight of OOA use and reduction within the OOA project board***

at Dovedale 2 and Endcliffe wards.

CORPORATE RISK REGISTER

As at: November 2022

Risk No. 4483 **v.**3 **BAF Ref:**	**Risk Type:** Safety **/ Risk Appetite:**	**Monitoring Group:** Audit And Risk Committee
Version Date: 12/01/2021	**Directorate:** IMS&T	**Last Reviewed:** 24/10/2022
First Created: 25/11/2020	**Exec Lead:** Executive Director Of Finance	**Review Frequency:** Monthly

Details of Risk:

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

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

CONTROLS IN PLACE

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

CORPORATE RISK REGISTER

As at: November 2022

Risk No. 4605 **v.**3 **BAF Ref:**	**Risk Type:** Safety **/ Risk Appetite:** Low	**Monitoring Group:** *Quality Assurance Committee*
Version Date: 23/11/2021	**Directorate:** Facilities	**Last Reviewed:** 13/11/2022
First Created: 11/05/2021	**Exec Lead:** Executive Director - Nursing & Professions	**Review Frequency:** Monthly

Details of Risk:

There is a risk that patients, especially inpatients, may fall from a height in their care environment, especially in courtyards or gardens, caused by the existing configuration of the environment, resulting in potentially catastrophic injuries.

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	5	3	15
Current Risk: (with current controls):	5	2	10
Target Risk: (after improved controls):	5	1	5

CONTROLS IN PLACE

- A risk assessment has been completed, of specific sites, regarding identification of potential areas of concern. These are held on the shared drive for all to access, have been shared with the relevant teams and are updated by the Health and Safety Risk Advisor and reviewed when required.
- A range of improvements have been carried out in the courtyard/internal garden space of Maple Ward, where a serious untoward incident occurred, to mitigate risk
- The Head of Health & Safety is leading a working group to review this risk and make further recommendations
- Legal advice has been sought about the extent of the Trust's responsibilities in this matter, documentation is available.
- Risk Assessments for external falls from height (Firshill, Forest Close, Grenoside, Longley Centre and MCC) have been completed and sent to the two triumvirates and will go to health and safety committee (23.11.2021)

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

Ensure the specific identified areas have entered a risk on the local risk register regarding this area of concern.	***Have changed the date as tillDecember 2022 as the risk assessments are currently being reviewed by the health and safety advisor and again he will need to go through with the relevant manager to put a risk on at local level. As they continue to not do this as requested.***	31/12/2022 Charlie Stephenson

CORPORATE RISK REGISTER

As at: November 2022

Risk No. 4612 **v.**3 **BAF Ref:** BAF.0021	**Risk Type:** Business **/ Risk Appetite:**	**Monitoring Group:** Audit And Risk Committee
Version Date: 16/07/2021	**Directorate:** IMS&T	**Last Reviewed:** 05/10/2022
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 retiring databases, which have not been accessed for a period of time.	
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.	***Works still outstanding but availability now to review actions required and to make the necessary changesrequired by NHS Digital***.	
All Windows 10 devices to be upgraded to Windows 21H2	***95% of devices have now been migrated to 21H2.***	***136***devices left on 1909 and 4

devices left on 1809. These are being actively worked on.

CORPORATE RISK REGISTER

As at: November 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 for the above, however a potential candidate has been identified.	30/06/2022 Robert Verity
Additional Locum consultant to be recruited due to unsuccessful recruitment to EWS.	EIS consultant compliment now complebete 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		

		former has been advertised and application is expected. Latter potential candidate will be eligible to apply for a post 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
	Successful recruitment to EWS, new Consultant to Start Feb 23. interview for vacancy of consultant on Stanage ward on 16/09/22 SPA and Maple wards have stable cover from locum consultants. Recovery teams have 1 half time vacnacy for consultant currently		31/03/2022 Robert Verity

Risk No. 4615 **v.**4 **BAF Ref:**	**Risk Type:** Statutory **/ Risk Appetite:** Moderate	**Monitoring Group:** Quality Assurance Committee
Version Date: 21/10/2022	**Directorate:** Facilities	**Last Reviewed:** 21/10/2022
First Created: 03/06/2021	**Exec Lead:** Director Of Special Projects (Strategy)	**Review Frequency:**

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***	***2***	***8***
Target Risk: (after improved controls):	4	2	8

CONTROLS IN PLACE

- Ulysses is available for all staff to record incident, accidents and near misses.
- Risk Department are submitting RIDDOR reports and the Health and Safety Committee are able to access the submission figures.
- Health and Safety Committee are getting 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.
- The incident report (Ulysses) should be reviewed within 5 working days of the incident and the absence element is mandatory at this stage that should support the identification of the need to RIDDOR report.

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

CORPORATE RISK REGISTER

As at: November 2022

Risk No. 4716 **v.**2 **BAF Ref:**	**Risk Type:** Business **/ Risk Appetite:** Low	**Monitoring Group:** Audit And Risk Committee
Version Date: 18/07/2022	**Directorate:** IMS&T	**Last Reviewed:** 22/10/2022
First Created: 26/08/2021	**Exec Lead:** Executive Director Of Finance	**Review Frequency:** Monthly

Details of Risk:

There is a risk to the Trusts network security as a result of Trust laptop devices accessing the internal network, without the required security updates. This has been identified through device use and management, across departments and services. The impact of this risk could compromise the internal network, but also service operations and delivery, whilst these updates are applied.

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

- The laptop devices that have not accessed the Trusts network and received the required security updates within 60 days are disabled. These are re-enabled when the user contacts the IT Service Desk.
- There is a category available within the IT Service Desk Service Management Tool (Sunrise) to be able to log incoming tickets and requests for devices that need to be re-enabled, to allow the review and identification of key themes and areas where this occurs.
- There is an available report for checking the patching for only enabled Windows 10 devices. This allows us to confirm of those enabled, how many are patched and how many aren't.
- There is a current SOP in place for decommissioning of devices, used by the IT Service Desk.
- There are network security controls, in place, managed by the IMST operations and infrastructure team.

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

All Trust devices are running Windows 10 21H2 and those that are not have been disconnected from the network.	***External contractors have been engaged and good progress has been made. There is now a focus on the remaining 1909 devices.***	30/11/2022 Adam John Handley

CORPORATE RISK REGISTER

As at: November 2022

Risk No. 4749 **v.**13 **BAF Ref:** BAF.0014	**Risk Type:** Workforce / **Risk Appetite:** Moderate	**Monitoring Group:** People Committee
Version Date: 25/10/2022	**Directorate:** Human Resources	**Last Reviewed:** 25/10/2022
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	3	9
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
- HEE funding used to meet funding gaps where staff meet criteria ie CPD, support staff
- New education and training group reporting to workforce assurance group.
- Study leave policy updated and approved

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

new reporting structure agreed for education and training group to monitor access to training and training expenditure	***new reporting schedule in place. ETSG meeting 15 November will receive a report on directorate level training spend***	30/11/2022 Karen Dickinson
report on CPD spend at nursing Council 1 November with a view to maximizing use of available training resources to meet identified learningneeds.		04/11/2022 Karen Dickinson

CORPORATE RISK REGISTER

As at: November 2022

Risk No. 4756 **v.**5 **BAF Ref:**	**Risk Type:** Safety **/ Risk Appetite:**	**Monitoring Group:** Quality Assurance Committee
Version Date: 06/09/2022	**Directorate:** Rehabilitation & Specialist Se	**Last Reviewed:** 10/10/2022
First Created: 28/10/2021	**Exec Lead:** Executive Director - Nursing & Professions	**Review Frequency:** Monthly

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	5	15
Target Risk: (after improved controls):	3	4	12

CONTROLS IN PLACE

- Ongoing discussions with Place re current and required resource. This extends to Derbyshire ICB also for existing contracts for ASD and ADHD
- CCG have proposed investment and staff model has been drafted and is being finalised
- Agreement to split ADHD and ASD pathways and report separately in data performance, contracting, workforce model and escalations
- Directorate Management Team governance meeting in place to review position, actions and update on a monthly basis
- Agreed understanding with Sheffield Place to work together with the Trust for the development of a neurodiversity pathway incorporating an all-age pathway. This will include liaising with ICB in Nov 2022 and then reviewing Sheffield requirements which will include PCNs, MH transformation and other stakeholders
- 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.
- Quality Assurance and Recovery Papers to be submitted as appropriate to Board for both ASD and ADHD to outline escalations, clinical risk management and progress to date on the actions below

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

Review of clinical process to be undertaken with Medical Director and Head of Nursing	***Continued review of clinicalprocesses taking place in weekly and monthly forumswhich leads to escalation toDMT and other boards***.	28/12/2022 Mark Parker
ADHD staffing at critical level. Nurse Consultant to be redeployed to another area, 1XACP leaving, 1xACP to go on mat leave, 4xb6 practitioners appointed but 2 going on mat and posts out to secondment with low chance of internal deployment, b7 NMP unsuccessful recruitment. Work ongoing with Directorate senior management and clinical leads to address model and recruitment strategy. Posts at advert for secondment and await outcome.		31/10/2022 Sal Foulkes

• Discussions with Sheffield PLACE to explore sub-contracting with independent provider for ADHD	Sheffield PLACE replacing proposed summit with a more targeted 'workshop' to consider service delivery in the face of overwhelming demand and to consider inclusion of universities as significant referral growth from this sector.	31/12/2022 Mark Parker
	Discussion with Sheffield PLACE 05/09/22. Agreement to explore sub-contracting options for ADHD. Summit/workshop to be progressed. Data to be provided to look at 'double referrals' for those already sent to Psychiatry UK who may also be on the books for SAANS ADHD.	30/11/2022 Sal Foulkes

CORPORATE RISK REGISTER

As at: November 2022

Risk No. 4757 **v.**6 **BAF Ref:**	**Risk Type:** Safety **/ Risk Appetite:**	**Monitoring Group:** Quality Assurance Committee
Version Date: 21/10/2022	**Directorate:** Rehabilitation & Specialist Se	**Last Reviewed:** 21/10/2022
First Created: 28/10/2021	**Exec Lead:** Executive Director - Nursing & Professions	**Review Frequency:** Monthly

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 signifcant sickness absence in the medical team and difficulties in recruitment in other professonal and admin areas.

Risk Rating:	**Severity**	**Likelihood**	**Score**
Initial Risk (before controls):	4	5	20
Current Risk: (with current controls):	4	4	16
Target Risk: (after improved controls):	4	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.
- Recruitment into the service including MHN, PA, GPwER

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

Recruitment	**PSych now start in NOv 22. 2x RMN appointments - hoping in place by Dec 22. PA in post. 2 x GPwER in post. Comms officer interviewed and awaiting decision. SLT at advert. Difficulty remains in getting people to be supervised andtrained but working with a range of internal and external providers to develop a solution. Lean in from gender trained *psychiatrist from another SHSC MH team is being helpful in managing some ofthe development needs***	30/11/2022 Mark Parker
Clinical process review to be undertaken by Medical Director and	**1 x medic now on phased return with support of**	**Clin**

	Head of Nursing	***Director. Awaiting interview with Clin Lead at end of Nov 22 to confirm progress.***	
	HIgh levels of sickness absence in medic and admin team specifically	***Continue to be supported by Clin Director and HoN. Some internal transfer of resource to support. Work with northern commissioner did not produce any significant level of medical interventionthat would allow direct patient care/assessment to take place. Will await plans for return of Clin Lead end of Nov***	30/12/2022 Mark Parker

CORPORATE RISK REGISTER

As at: November 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:** 11/11/2022
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.

• The New Clinical Director has been appointed and has oversight of this risk

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

Discussison with Regional Commissioners about future planning for LD beds at an ICS/Regional Level	James Sutherland from the CCG is organising a discussion on the future of inpatient beds in September 22	30/09/2022 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	Further discussions needed with the ICB. Awaiting outcome of meeting with James Sutherland	30/09/2022 Richard Bulmer

CORPORATE RISK REGISTER

As at: November 2022

Risk No. 4841 **v.**1 **BAF Ref:**	**Risk Type:** Workforce **/ Risk Appetite:** High	**Monitoring Group:** People Committee
Version Date: 22/02/2022	**Directorate:** Acute & Community	**Last Reviewed:** 01/11/2022
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.
- SHSC planning and implementation group mobilised and highlight report produced to be made available to community mental health transformation programme.
- The Local Authority will work with SHSC to issue fortnightly communication with all staff affected by the disaggregation to provide a programme update.

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

Co-location of workforce to be determined. Costings to be provided by SHSC estates and SCC to decide upon feasibility.	30/11/2022 Pat Keeling
EPR accessibility and inter-operability to agreed between IMST leads within SHSC and SCC	30/11/2022 Andrew Male
Capacity and demand modelling to be conducted as part of the community mental health transformation programme, which is inclusive of the social care disaggregation	30/11/2022 Christopher Wood

CORPORATE RISK REGISTER

As at: November 2022

Risk No. 4896 **v.**1 **BAF Ref:**	**Risk Type:** Workforce **/ Risk Appetite:**	**Monitoring Group:** People Committee
Version Date: 01/06/2022	**Directorate:** Human Resources	**Last Reviewed:** 15/08/2022
First Created: 01/06/2022	**Exec Lead:** Director Of Human Resources	**Review Frequency:** Monthly

Details of Risk:

Risk relating to employing / re-employing individuals giving false information; specificly:

An employee has secondary employment, the employee could continue to work at their secondary employment during a period that they are being paid by the organisation (eg; sickness, paid absences, suspension, normal working hours)

An individual providing false or failing to declare the correct information during the recruitment process eg; no right to work in the UK, false identification, ID theft, false references, not qualified, not registered, criminal convictions

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	3	9

CONTROLS IN PLACE

- Recruitment process involves references
- Essential qualifications checked
- Annual national fraud exercise carried out to identify duplicate employees
- Interface between ESR, NMC, GMC and HCPC to check information

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

HR to consider best practice approach with 360 Fraud Lead	31/08/2022 Sarah Bawden