Board of Directors - Public

SUMMARY REPORT	Meeting Date:	24 January 2024
	Agenda Item:	23

Report Title:	**Corporate Risk Register Report**	
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Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	Risk Oversight Group (RoG) Executive Management Team (EMT) People Committee Quality Assurance Committee Finance and Performance committee Audit and Risk Committee
	Date:	19 December 2023 (RoG) 4 January 2024 (EMT) 9 January 2024 (PC) 10 January 2024 (QAC) 11 January 2024 (FPC) 16 January 2024 (ARC)
Key points/ recommendations from those meetings	Summary analysis of the risks on the Corporate Risk register (CRR) with Ulysses extract appended to the report.	

Summary of key points in report

This report provides a summary analysis of the 23 risks currently on the corporate risk register. Risks are assigned for oversight at specific board assurance committees with overall monitoring and receipt of assurance taking place at Audit and Risk Committee. The Corporate Risk Register has been reviewed at Risk Oversight Group, Executive Management Team and at the Board Assurance committees.

The Board is asked to note for assurance changes highlighted in the corporate risk register summary report including movement on risks, confirm and challenge underway and updating taking place.

Progress with addressing risks of 12 not yet escalated onto the Corporate Risk Register is also reported. The action plan was received at Audit and Risk Committee for assurance. Progress has continued to be made since reporting to Board Assurance Committees with 12 risks currently outstanding and being followed up with the risk owners and Executive leads.

The Board is asked to note the progress made and the plans in place for strengthening assurance arrangements around monitoring of these risks below board assurance committee level.

Top risks on the Corporate Risk Register

The top overall risks have increased from **four** to **six** risks since last reported to the Board, three of which are overseen by Finance and Performance Committee and three by Quality Assurance Committee as listed

below:

- **Risk 5051**. *There is a risk of failure to deliver the required level of CIP for 2023/24* (risk score of 16)(FPC).
- **Risk 5266**: *risk of a breakdown in the relationship with the third-party implementation support team in relation to EPR* (risk score 16 (FPC) **This risk was escalated from a 12 in December 2023 and approved by the Executive lead.**
- **Risk 4795:** *loss of knowledge and expertise within the Project and BAU Digital Team due to key staff leaving the programme leading to delays in delivery or lack of input from Trust teams.* (Risk score 16) (FPC) – **This risk was escalated from a 12 in January 2024 and approved by the Executive lead.**
- **Risk 4757** *Demand for gender identity services outweighing capacity/resources* (risk score of 16). (QAC)
- **Risk 4756** *Demand for the ADHD pathway greatly outweighs the resource and capacity of the service*. *This is resulting in longer/lengthy wait times and high numbers of people not being screened and waiting for assessment, diagnosis and medication* (risk score of 15) (QAC)
- **Risk 3679** Risk of harm due to access to potential fixed ligature anchor points (risk score of 15) (QAC)

The Board is asked to **note key updates** provided for the risks received at the board sub-committees as outlined below:

<u>Areas to note from the Corporate Risk Register risks overseen at ARC</u>

Risk 4612: *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). (Scoring 9)*

- Actions have been updated
- It was noted at ARC in July 2023 that this risk would remain on the corporate risk register until Insight could be retired. Given the delay with implementation of RIO there is no further update at this time and the risk will remain on the CRR to maintain oversight.

The committee noted the update provided and agreed the recommendation for this risk to remain on the corporate risk **register** for oversight given the delay with implementation of EPR.

NEW: Risk 5070: *There is a risk of an information governance breach caused by undefined "archiving" stored in an unsecure location at President Park that could result in data breach, litigation, financial and reputational damage to SHSC. (*Risk score 9*)*

- Actions have been updated
- This risk was agreed for escalation on 6/12/23 following a performance directorate review meeting due to the wider implications of the risk.
- ROG discussed on 19.12.23 and agreed this should be a corporate risk (pan organisational) and requested that an update on progress with establishing the cross organizational group and therefore has been included on the CRR until further detail on progress with the work is received and in order for a review of the documents impacted is reflected as a control and to review whether this impacts on the scoring.
- It is proposed, to address this, that it would be beneficial to convene a meeting between Information Governance team and Facilities (who holds the risk currently), to collectively determine the appropriate ownership of this challenge. Executive leads will be kept informed.

The committee noted the update and the proposed next steps provided. It was noted that although issues relating to information governance in respect of storage of data more broadly have previously been highlighted as a risk on the corporate risk register, with this risk having been re-focussed and newly escalated as a pan organisational risk with actions in place to address issues via the new group as outlined.

The committee requested that further work takes place at the Risk Oversight Group to ascertain all risks currently on the registers that relate to storage of information and potential for breach, and this has been planned into the work programme for discussion at the meeting on the 31 January 2024**.**

<u>Areas to note from the Corporate Risk Register overseen at People Committee (PC</u><u>)</u>:

Risk 4078: *There is a risk that SHSC is not recommended as a place to work or to receive care if we do not respond effectively to the staff survey in a timely way. These risks may present as a) reputational damage,*

(b) devaluation of the staff survey purpose and impact (c) survey fatigue leading to low participation rates. (Risk score of 9).

- It was agreed by the committee to remain on the Corporate Risk Register until the outcome of the 2023 Staff survey which was received in December and detail is being shared at high level with the Board in January and via the cascade in February with the expectation this risk should be de-escalated thereafter or rescored if required.
- The SHSC submission rate for the survey is slightly improved on the previous year however on the advice of the Executive Lead this risk will remain on the corporate risk register with the score unchanged at 9 whilst work is taking place to fully review the outcome of the survey.
- Full results of the staff survey remain embargoed until March 2024, and an update will be presented to committee at its next meeting in March at which point a decision will be taken as to whether the risk can then be closed.

The committee noted the updated provided and agreed that this risk will remain on the corporate risk register with the score unchanged at 9 whilst work is taking place to fully review the outcome of the survey.

Areas to note from the Corporate Risk Register risks overseen at QAC:

Risk 3679: *There is a risk that service users admitted to Maple Ward could ligate using fixed ligature anchor points or by using ligature items caused by not managing and removing ligature anchor points effectively resulting in service user death*. (Risk score 15).

- Reviews and actions have been updated to reflect changes in Therapeutics Environment Programme (TEP) work and delays.

The committee noted the updated provided**.**

Risk 4605: *There is a risk that patients, especially inpatients, may fall from a height, where identified risks are present externally to the premises, where they are residing or visiting. In addition the falls from height can be related to inadequate window management both of these areas could cause death or serious injury to an individual which would affect the reputational and financial position of the Trust.* (Risk score 10)

- The risk assessment actions are still on track for the end of January 2024 then the next stage is to ensure that the local teams are aware of the risk assessments and hold a local level risk to highlight this.
- This risk has been reviewed by the executive lead who has confirmed the risk should remain on the corporate risk register until the risk assessments are reviewed and updated. Following completion of this, a discussion will take place with the Executive lead regarding de-escalation from the corporate risk register and an update will be provided to committee in February.

The committee noted the updated provided.

Risk 4697: *There is a risk that patients safety will be impacted out of hours as a result of not having access to spare medical devices (emergency equipment and consumables) and equipment (bariatric, moving and handling or bespoke equipment), resulting in poor patient care and possible harm.* **(Risk score 12) updated wording**

- The risk description has been updated following discussion at RoG in December 2023 to reflect the detail relating to moving and handling/ bariatric equipment.(previous risk description: *There is a risk that patients safety will be put at risk as a result of not having access to spare medical devices out of hours, such a defib, pads and batteries, suction machine and or equipment or dinamap, caused by having no central storage area for equipment or process in place to request new equipment out of hours urgently. Resulting in poor patient care and possible harm)*
- Actions and control have been updated.

The committee noted and agreed the updated risk description.

Risk 4756: *Demand for the ADHD pathway greatly outweighs the resource and capacity of the service. This is resulting in longer/lengthy wait times and high numbers of people not being screened and waiting for assessment, diagnosis and medication.* (**Risk score 15**).

- Ongoing discussion with commissioners to meet by end of Jan 2024 after DDICB have met with primary care to agree commissioning of ADHD pathway locally

- Work ongoing with a demand/capacity model to report on the reduction of the medication waitlist, as per priority for service.
- Recruitment to admin post is currently held up in VCP. HoS and GM to attend VCP to discuss the release of the post to enable support for medics as planned.

The committee noted the update provided.

Risk 4757: *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 admin areas.* **(Risk score 16)**

- GIC is part of the Trust-wide QI programme addressing issues of waiting times and waiting well.
- Work continues on medical skill mix and job planning.
- Admin absence continues to be managed through HR and is stabilising but remains an ongoing issue at this time.

The committee noted the updated provided.

Three risks have been escalated to the corporate risk register from the directorate and team risk registers and following agreement from the executive lead since the risk register was last received at Board.

Risk 4965: *There is a risk that the delivery of essential Physical Health Training Needs will not be delivered due to the limited resource (both capacity and skill) available within the team. This is further affected by the availability, suitability and condition of venues in which training can be delivered. This will result in staff will not be fully skilled and competent with regards to the management of Physical Health needs.* **(Risk score 12)**

- This was discussed and agreed for escalation at the Physical Health Committee and agreed by the Executive Lead.
- Training has occurred ad hoc within locations based on need, capacity issues within the team during Q3 has delayed workplan projects and all actions are ongoing.
- Discussion is planned at Risk Oversight Group on 28 January for further confirm and challenge.

Risk 5043: *There is a risk that unsafe application of moving and handling practices caused by a lack of understanding and training may result in harm or injury to both staff and service user. There may also be a wider statutory or financial organisational impact if injury occurs.* **(Risk score 9***).*

- This was discussed and agreed for escalation by the Executive Lead at the Physical Health Committee. The Executive lead has asked for this to be received on the CRR and the score is being reviewed.
- Work is underway by risk owners to review the scoring and to update the controls.
- Discussion is planned at Risk Oversight Group on 28 January for further confirm and challenge.

The committee noted the updates provided and agreed the escalation of the risks**.**

Risk 5001: *Patients awaiting beds are held on the at risk of admission list which is the responsibility of the home treatment. Many patients on the list are not able to engage with the home treatment team and have been waiting for a bed for some time due to significant bed shortage country wide. There is a significant risk of patient death whilst patients await a bed having already been identified as needing admission. HTT can try to manage the risks with some patients, but some cannot be seen for reasons of risk or disengagement.* **(Risk score 12).**

New description: *There is a risk that patients awaiting hospital admission are experiencing a delay in their care and treatment of acute mental illness caused by lack of beds resulting in delayed treatment and poor outcomes.(Cases Awaiting Hospital Admissions (CAHA) is the joint responsibility of home treatment, flow team and the CAT)*

- This was discussed at RoG on the 19 December where it was recommended for escalation to the corporate risk register.
- ROG requested that several key controls were added which has been actioned and has reduced the score from 16 to 12.
- ROG requested that the risk description is updated to reflect the focus on the provider aspect around accessing care in a timely way and this has been actioned with agreement from the Executive Lead.

Work to update the risk, as described above, took place following presentation of the report to the committee in January and will be presented to the committee at its meeting in February prior to receipt at the March Board meeting.

In addition, **Risk 4001** is **pending escalation** to the Corporate Risk Register for oversight at QAC.

The current risk description has been under review with the risk owners and the Executive Lead and has been agreed as:

There is a risk of patients having to wait for long periods in the emergency department or on the medical wards due to lack of identified mental health bed when needed. This will potentially cause patients being supported in an environment which is not suitable for their mental health needs (Risk score 12)

Discussion took place at Risk Oversight Group (RoG) on 19 December for the risk to be considered for escalation to the corporate risk register under its original title following on from this, the Executive Lead, in response to feedback from the Chief Executive, has requested that a review takes place of all of the risks relating to people not receiving timely responsive support in an inpatient bed due to pressure and increased need across the acute and crisis pathway and this work will take place for reporting to the committees and EMT in February, and to the Board in March.

In addition, at the ROG meeting in December,

- ROG noted a number of key controls were missing which it felt should bring the score to a 12. It has been agreed by the Executive lead to reduce the score from 16 to 12, and for the risk to remain on the directorate risk register whilst further work takes place to review all in patient bed related risks.
- ROG also asked for the description to be updated and potentially separated into two risks as one element related specifically to 16- and 17-year-olds not being able to access the decisions unit which it felt was a separate issue. 16 and 17 year olds are not allowed to access the decision unit and this has been removed from the risk description (see amended risk description above).

Areas to note from the Corporate Risk Register risks overseen at FPC

Risk 4602: *There is a risk that there are a number of Ligature Anchor Points and Blind Spots within bed-based services caused by lack of previous actions to remove or mitigate these environmental risks resulting in potential for inpatients to attempt ligation and cause themselves serious harm.* **(Risk score 12)**

- A new Head of Estate Services/Hard FM is in post and has been identified as the new risk owner
- This will be further discussed in conjunction with the owner of risk 3679 (operational risk) and the respective Executive Leads to ensure that both of the risks reflect an accurate position.

The committee noted the updates provided.

Risk 5051: *There is a risk of failure to deliver the required level of CIP for 2023/24. This includes closing any b/f recurrent gap and delivering the required level of efficiency during the financial year.* **(Risk score 16)**

- Actions have been updated

The committee noted the updates provided.

Risks related to EPR

Risk 5224: *There is a risk that our new electronic patient record system will fail to meet the recording and reporting requirements of our clinical services. This risk must be mitigated through rigorous User Acceptance Testing.* **(Risk score 12)**

- There is a key action to be completed in order to provide assurance around the data capture practices within RiO.
- Discussed fortnightly at the Clinical Executive Safety Delivery Group (CESG) and the EMT
- Actions have been updated

The committee noted the updates provided.

Risk 4795: *There is a risk that there could be a loss of knowledge and expertise within the Project and BAU Digital Team due to key staff leaving the programme leading to delays in delivery or lack of input from Trust teams.* **(Risk score 16)**

- The risk score has been increased from 12 to 16 with agreement of the Executive Lead and due to Change Agent and contracted/seconded staff contracts ending in December.
- Discussions are taking place with EMT and planned with FPC and Board on resource requirement and next steps
- Actions have been updated

The committee noted the updates provided and agreed the increased risk score.

Risk 5225: *There is a risk that we fail to train our staff in the use of our new electronic patient record system in preparation for the go live date. This will mean that clinical staff are unable to access the system. This risk must be mitigated through a considered training delivery plan, which is governed on a weekly basis with operational grip and control*. (**Risk score 9).**

- Actions have been updated.
- The committee agreed at the December meeting for the risk, with a score of 9, to remain on the corporate risk register to maintain oversight whilst the launch of the EPR remains delayed.
- The planned shift to online training is ongoing but there is only minimal resource in place resulting in a reduction in capacity which is impacting this.

The committee noted the updates provided.

Risk 5266: *There is a risk that a breakdown in the relationship with the third-party implementation support team for delivery of the Electronic Patient Record system (EPR), or insufficient capacity available from them, will impact negatively on ability to deliver the project safely, effectively and to the required timeframe.* **(Risk score 16)**

- Actions have been updated

The committee noted the updates provided.

Risk 5267: *There is a risk staff will lose confidence in the system if they do not receive sufficiently timely response to issues they have raised and support as required.* **(Risk score 12)**

- Actions have been updated

The committee noted the updates provided.

Risk 5272: *There is a risk technical issues in the build which have surfaced post implementation of the launch of the first phase of the Electronic Patient Record (Rio) are not adequately managed resulting in lack of stabilisation of the first stage prior to launch of the second phase with the result there are delays in development and security of the reporting build infrastructure putting in jeopardy ability to move forward***. (Risk score 12).**

- Actions have been updated

The committee noted the updates provided.

<u>Progress with addressing risks of 12 or above not yet escalated onto the Corporate Risk Register</u>

Good progress has been made on the risks not yet escalated onto the Corporate Risk Register. Of the 100 plus risks scoring 12 reported to the Board in September 2023 as not having been escalated onto the Corporate Risk register by risk owners, a majority of these risks have been reviewed, de-escalated or closed following awareness raising and engagement with risk owners and teams. Currently there are **12** remaining (a reduction from the 27 reported to assurance committees in January, the latest position was reported to the Audit and Risk Committee).

Of the 12 remaining risks being reviewed:

- 2 have been identified for potential oversight by Audit and Risk Committee
- 1 by Mental Health Legislation Committee
- 7 by Finance Performance Committee
- 2 by Quality Assurance Committee

Work is continuing to review these remaining risks with risk owners and updates are reflected on the action plan which is being monitored at EMT and Audit and Risk Committee. Audit and Risk Committee commended the significant progress made since September and asked that further reflection take place on processes to ensure a backlog of risks scoring 12 or above and not appropriately escalated onto the Corporate Risk Register does not re-emerge.

Committees have been assured that training sessions continue to take place with teams and individuals and includes a review of registers with a focus on scoring of risks.

The Board is asked to note the update provided for information and assurance on the progress made.

Appendices attached:
Appendix 1 Ulysses extract of the corporate risk register - January 2024

Recommendation for the Board/Committee to consider:							
Consider for Action		**Approval**		**Assurance**	**X**	**Information**	**X**
The Board is asked to take **assurance** from the updates provided and **to confirm if the risks**, as outlined in section 4 and overseen by the Board Assurance committees, **remain the most significant**; and **identify if there are additional risks** following discussion at the meeting that should be considered for review and escalation.							

Please identify which strategic priorities will be impacted by this report:				
Effective Use of Resources	*Yes*	***X***	*No*	
Deliver Outstanding Care	*Yes*	***X***	*No*	
Great Place to Work	*Yes*	***X***	*No*	
Ensuring our services are inclusive	*Yes*	***X***	*No*	

Is this report relevant to compliance with any key standards ?					**State specific standard**
Care Quality Commission Fundamental Standards	*Yes*	***X***	*No*		Systems and processes must be established to ensure compliance with the fundamental standards
Data Security and Protection Toolkit	*Yes*		*No*	***X***	
Any other specific standard?				***X***	

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Service User and Carer Safety, Engagement and Experience	*Yes*		*No*	***X***	See detailed risk register for relevant references.
Financial (revenue &capital)	*Yes*		*No*	***X***	
Organisational Development /Workforce	*Yes*		*No*	***X***	
Equality, Diversity & Inclusion	*Yes*		*No*	***X***	
Legal	*Yes*		*No*	***X***	
Environmental sustainability	*Yes*		*No*	***X***	

Corporate Risk Register report

Section 1: Analysis and supporting detail

Background

1.1 The Corporate Risk Register (CRR) is a tool for managing risks and monitoring actions and plans against them for risks that are scoring 12 and above or which have an organisation-wide impact.

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

1.3 Risks are evaluated in terms of likelihood and impact using the 5 x 5 matrix where a score of 1 is a very low likelihood or a very low impact and 5 represents a very high likelihood or significant impact. This simple matrix is used to classify risks as very low (green), low (yellow), moderate (amber) or high (red).

1.4 The Risk Oversight Group will be meeting monthly from January 2024 to undertake further confirm and challenge with risk owners to support onward reporting and recommendations to EMT the Board Assurance Committees.

1.5 Scoring used is reflective of the current Risk Management Framework.

1.6 Work is taking place to address risks of 12 or above not yet escalated onto the Corporate Risk Register. These currently total 23. Of these 2 would potentially fall under the oversight of Audit and Risk Committee.

2. Movement on the Risk Register

2.1 Movement on CRR as reported to Audit and Risk Committee

- **NEW Risk 5070:** *There is a risk of a information governance breach caused by undefined "archiving" stored in an unsecure location at President Park that could result in data breach, litigation, financial and reputational damage to SHSC. (*Risk score 9*)*

This risk was agreed for escalation on 6/12/23 following a performance directorate review meeting due to the wider implications of the risk. Further discussions on this and other information governance risks will take place at ROG in January.

2.2 Movement on CRR as reported to People Committee

- **Risk 5134:** *There is a risk that SHSC will not fully utilise the apprenticeship levy caused by a combination of factors culminating in reduced demand for apprenticeships resulting in a risk that SHSC will lose unspent levy funds at the expiry date* **Risk score 9.**

This risk has been de-escalated to the directorate risk register on 12/12/23 following agreement at the People Directorate Quality and Governance group in November and agreed by the Executive lead. The actions are completed, and adequate controls are in place, and on track to spend the levy for 2023/24. The current risk score has been reduced from 12 (3x4) to 9 (3x3). The risk will continue to be monitored at Directorate level**.**

2.3 Movement on CRR as reported to Quality Assurance Committee

- **Risk 4965** relating to delivery of essential Physical Health Training has been escalated to the corporate risk register following agreement at the Physical health Committee and agreed by the Executive lead.
- **Risk 5043** relating to a risk of unsafe application of moving and handling practices has been escalated to the corporate risk register following agreement at the Physical health Committee and agreed by the Executive lead.
- **Risk 5001** relating to patients awaiting beds are held on the at risk of admission list which is the responsibility of the home treatment team has been escalated to the corporate risk register following discussion and agreement at QAC and ROG in December.
- **Risk 4001** relating a risk of patients having to wait for long periods in the emergency department or on the medical wards is pending escalation to the corporate risk register following discussion and agreement at ROG in December and a review will take place of all of the risks relating to people not receiving timely responsive support in an inpatient bed due to pressure and increased need across the acute and crisis pathway and this work will take place for reporting to the committees and EMT in February, and to the Board in March.

2.4 Movement on CRR as reported to Finance and Performance Committee

- **Risk 4795** relating to a risk that there could be a loss of knowledge and expertise within the Project and BAU Digital Team has an increased risk score from 12 to 16, following agreement by the Executive lead.

Section 3: Risks

3.1 Corporate Risk Register snapshot, ordered from highest to lowest current risk score within committee groupings and as at 17 January 2024.

Risk number	Description	Score (severity x likelihood)	Risk Owner	Executive Lead and Monitoring Committee	Progress update
Audit and Risk Commitee					
Risk 4612	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).	9 (3x3)	Adam John Handley	Pete Kendal Audit and Risk Committee	Last reviewed on 09/01/23. No further update as this risk has the implementation of Rio and the decommission of Insight as its key dependencies.
Risk 5070 NEW	There is a risk of an information governance breach caused by undefined "archiving" stored in an unsecure location at President Park that could result in data breach, litigation, financial and reputational damage to SHSC.	9 (3x3)	Samantha Crosby	Audit and Risk Committee	Last reviewed on 20/12/2023. Written confirmation from Head of Estates services that the weight on the mezzanine should be fine, now awaiting confirmation that the cost will be funded.
Finance and Performance Committee					

Risk number	Description	Score (severity x likelihood)	Risk Owner	Executive Lead and Monitoring Committee	Progress update
5051 BAF0022	There is a risk of failure to deliver the required level of CIP for 2023/24. This includes closing any b/f recurrent gap and delivering the required level of efficiency during the financial year.	16 (4x4) ↔	James Sabin (risk owner) Phillip Easthope (actions owner)	Executive Director of Finance (Phillip Easthope)	**Top risk on the Corporate Risk Register**. The risk was reviewed on 22/12/23 and 04/01/24 and actions have been updated.
5266 BAF 0026	There is a risk that a breakdown in the relationship with the third-party implementation support team for delivery of the Electronic Patient Record system (EPR), or insufficient capacity available from them, will impact negatively on ability to deliver the project safely, effectively and to the required timeframe.	16 (4x4) ↔	Pete Kendal (risk owner)	Executive Director of Finance (Phillip Easthope)	**Top risk on the Corporate Risk Register**. The risk was reviewed on 27/12/2023 and actions have been updated.
4795 BAF 0026	There is a risk that there could be a loss of knowledge and expertise within the Project and BAU Digital Team due to key staff leaving the programme leading to delays in delivery or lack of input from Trust teams	16 (4x4) ↑	Pete Kendal	Executive Director of Finance (Phillip Easthope) Finance and Performance Committee	**Top risk on the Corporate Risk Register**. The risk was reviewed on 27/12/2023, with a score increase from 12 to 16, following agreement by the Executive Lead.
5267 BAF 0026	There is a risk staff will lose confidence in the system if they do not receive sufficiently timely response to issues they have raised and support as required	12 (3x4) ↔	Pete Kendal (risk owner)	Executive Director of Finance (Phillip Easthope)	The risk was reviewed on 27/12/2023 and actions have been updated.
5272 BAF 0026	There is a risk technical issues in the build which have surfaced post implementation of the launch of the first phase of the Electronic Patient Record (Rio) are not adequately managed resulting in lack of stablisation of the first stage prior to launch of the second phase with the result there are delays in development and security of the reporting build infrastructure putting in jeopardy ability to move forward	12 (4x3) ↔	Pete Kendal (risk owner)	Executive Director of Finance (Phillip Easthope)	The risk was reviewed on 27/12/2023 and actions have been updated.
5224	There is a risk that our new electronic patient record system	12(3x4)	Pete Kendal (risk	Executive	Risk reviewed on 27/12/2023

Risk number	Description	Score (severity x likelihood)	Risk Owner	Executive Lead and Monitoring Committee	Progress update
BAF0026	will fail to meet the recording and reporting requirements of our clinical services. This risk must be mitigated through rigorous User Acceptance Testing.	↔	owner)	Director of Finance (Phillip Easthope) Finance and Performance Committee.	and actions have been updated.
4602 BAF.0025A	There is a risk that there are a number of Ligature Anchor Points and Blind Spots within bed-based services caused by lack of previous actions to remove or mitigate these environmental risks resulting in potential for inpatients to attempt ligation and cause themselves serious harm.	12 (4x3) ↔	Andy Probert (risk owner)	Director of Operations and Transformation Neil Robertson)	The risk was reviewed on 04/01/23. The new Head of Estate Services/Hard FM is in post and has been identified as risk owner. The full picture in relation to the LAP programme is not currently clear, and will be discussed in conjunction with the owner of risk 3679 (operational risk) to ensure the risk are accurate and relevant to the actual current position.
5225 BAF0026	There is a risk that we fail to train our staff in the use of our new electronic patient record system in preparation for the go live date. This will mean that clinical staff are unable to access the system. This risk must be mitigated through a considered training delivery plan, which is governed on a weekly basis with operational grip and control.	9 (3 x 3 ↔	Pete Kendal (risk owner)	Executive Director of Finance (Phillip Easthope) Finance and Performance Committee.	The risk was last reviewed on 7/12/2023. Clinical teams who have undertaken the training are reporting that the system does not reflect the design of that which they were trained on and so they are struggling to use the system as required. Ongoing work to address the system design is underway. Risk reviewed on 27/12/2023, some actions updated.

Risk number	Description	Score (severity x likelihood)	Risk Owner	Executive Lead and Monitoring Committee	Progress update
Quality Assurance Committee					
Risk number	**Description**	**Score (severity x likelihood)**	**Risk Owner**	**Executive Lead and Monitoring Committee**	**Progress update**
4757 BAF0029	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 admin areas.	16 (4x4) ↔	Richard Bulmer (risk owner) Mark Parker (action owner)	Director of Operations and Transformation (Neil Robertson)	The risk was last reviewed on 03/01/2024. Actions and controls have been updated.
4756 BAF0029	Demand for the ADHD pathway greatly outweighs the resource and capacity of the service. This is resulting in longer/lengthy wait times and high numbers of people not being screened and waiting for assessment, diagnosis and medication	15 (3x5) ↔	Richard Bulmer (risk owner) Mark Parker, Sal Foulkes (action owners)	Director of Operations and Transformation (Neil Robertson) Quality Assurance Committee.	The was last reviewed on 03/01/24. All actions have been updated.
3679 BAF0025A	There is a risk that service users could ligate using fixed ligature anchor points or by using ligature items caused by our estate not managing and removing ligature anchor points effectively resulting in service user death	15 (5x3) ↔	Laura Wiltshire (risk owner) Gemma Robinson (assessor)	Director of Operations and Transformation (Neil Robertson) Quality Assurance Committee.	The risk was last reviewed on 03/01/2024. Actions have been updated to reflect changes in TEP work and delays.
4697 BAF0025B	There is a risk that patients safety will be impacted out of hours as a result of not having access to spare medical devices (emergency equipment and consumables) and equipment (bariatric, moving and handling or bespoke equipment), resulting in poor patient care and possible harm.	12 (3x4) ↓	Sharlene Rowan (Risk Owner and Assesor)	Executive Director of Nursing, Professions and Quality	The risk was last reviewed on 03/01/2024 and the risk description and actions updated following discussion at Risk Oversight Group presentation to Quality Committee. The new risk

Risk number	Description	Score (severity x likelihood)	Risk Owner	Executive Lead and Monitoring Committee	Progress update
					description has been approved by the Executive lead.
5001 **NEW** BAF0025B	There is a risk that patients awaiting hospital admission are experiencing a delay in their care and treatment of acute mental illness caused by lack of beds resulting in delayed treatment and poor outcomes. (Cases Awaiting Hospital Admissions (CAHA) is the joint responsibility of home treatment, flow team and the CAT)	12 (3x4)	Hayley Taylor (Risk Owner and Assesor)	Director of Operations and Transformation (Neil Robertson)	New risk being added to CRR. This was presented to Risk oversight group on 19 December. Work has taken place to update the risk description, amend the scoring to 12 and update controls and actions as requested at RoG. The amended risk description has been sent to the Executive lead for approval.
4965 **NEW** BAF0025B	There is a risk that the delivery of essential Physical Health Training Needs will not be delivered due to the limited resource (both capacity and skill) available within the team. This is further affected by the availability, suitability and condition of venues in which training can be delivered. This will result in staff staff will not be fully skilled and competent with regards to the management of Physical Health needs	12 (3 x 4)	Sue Barnitt (risk owner)	Executive Director of Nursing, Professions and Quality	This was discussed and agreed for escalation at the Physical Health Committee. Training has occurred ad hoc within locations based on need, capacity issues within the team during Q3 has delayed workplan projects and all actions are ongoing. Discussion is planned at Risk Oversight Group on 28 January for further confirm and challenge
4605 BAF0025A	There is a risk that patients, especially inpatients, may fall from a height, where identified risks are present externally to the premises, where they are residing or visiting. In addition the falls from height can be related to inadequate window	10(5x2) ↔	Samantha Crosby (risk owner)	Director of Strategy (currently held by the Director of Operations and	Reviewed on 01/12/2023. The risk assessment actions are still on track for the end of January 2024

Risk number	Description	Score (severity x likelihood)	Risk Owner	Executive Lead and Monitoring Committee	Progress update
	management both of these areas could cause death or serious injury to an individual which would affect the reputational and financial position of the Trust.			Transformation Neil Robertson)	then the next stage is to ensure that the local teams are aware of the risk assessments and hold a local level risk to highlight this after which de-escalation will be considered following agreement by the Executive Lead.
5043 **NEW** BAF0025B	There is a risk that unsafe application of moving and handling practices caused by a lack of understanding and training may result in harm or injury to both staff and service user. There may also be a wider statutory or financial organisational impact if injury occurs.	9 (3x3)	Sue Barnitt (risk owner)	Executive Director of Nursing, Professions and Quality	This was discussed and agreed for escalation at the Physical Health Committee. Work is underway by risk owners to review the scoring and to update the controls. Discussion is planned at Risk Oversight Group on 28 January for further confirm and challenge.
People Committee					
4078 BAF0013	There is a risk that SHSC is not recommended as a place to work or to receive care if we do not respond effectively to the staff survey in a timely way. These risks may present as a) reputational damage, (b) devaluation of the staff survey purpose and impact (c) survey fatigue leading to low participation rates.	9 (3x3) ↔	Sally Hockey (risk owner and actions owner)	Executive Director of People (Caroline Parry) **People Committee**.	The risk was last reviewed 02/01/2024. It was agreed by the committee to remain on the Corporate Risk Register until the outcome of the 2023 Staff survey which was received in December. The SHSC submission rate

Risk number	Description	Score (severity x likelihood)	Risk Owner	Executive Lead and Monitoring Committee	Progress update
					for the survey is slightly improved on the previous year. On the advice of the Executive Lead this risk will remain on the corporate risk register with the score unchanged at 9 whilst work is taking place to review the outcome of the survey. Results of the staff survey remain embargoed until March 2024, and an update will be presented to committee at its next meeting in March.
Mental Health Legislation Committee					
Risk number	**Description**	**Score (severity x likelihood)**	**Risk Owner**	**Executive Lead and Monitoring Committee**	**Update**
4513	There is a risk that Associate Mental Health Act Manager (AMHAM) Hearings will not be undertaken in a timely manner, this being caused by an insufficient number of AMHAMs which the Trust currently has, resulting in possible breaches in human rights and potential statutory action against the Trust.	12 (3x4) ↔	Jamie Middleton	Mental Health Legislation Committee	The risk was reviewed on 08/01/24. Risk remains unchanged. 2 of the 4 applicants who were appointed to become AMHAMs are no longer able to take up role, meaning only 2 new AMHAMs are starting. These new AMHAMs are still in training and shadowing.
5026	There is a risk that patients who come under the Deprivation of Liberty Safeguards (DOLS) framework are detained on SHSC	12 (3x4) ↔	Jamie Middleton	Mental Health Legislation	Risk reviewed on 08/01/24. Actions have been updated

Risk number	Description	Score (severity x likelihood)	Risk Owner	Executive Lead and Monitoring Committee	Progress update
	staffed premises with no legal authority in place to authorise this. This is caused by significant delays and backlogs within the Local Authority (who are responsible for conducting such assessments and authorisations). This could result in patient's legal rights being breached by the Trust, and the Trust potentially being challenged legally by a patient or their representative.			Committee	and amended accordingly. Risk remains and likely to remain for prolonged period of time owing to this risk related to a national problem.
5047	There is a risk that practice within the Trust is not compliant with the Mental Capacity Act. This is caused by multiple factors such as MCA mandatory training not being undertaken, current MCA training needing to be improved, and some organisational culture. This risk could result in patient's legal rights being breached, care not being delivered in accordance with a patient's previously expressed wishes, and legal challenge against the Trust.	12 (3x4) ↔	Jamie Middleton	Mental Health Legislation Committee	Reviewed on 08/01/24. Risk remains unchanged; actions to mitigate risk continue to be needed.
5220	There is a risk that inpatient care is not delivered in the least restrictive way, in line with national guidance and regulatory standards due to a lack of skilled trained staff on duty 24/7, 7 days a week. This is due to a combination of capacity with trainers, capacity related to release of staffing and effective rota management. The risk is that this then leads to more restrictive practice, poor patient and staff experience and progress of the strategy.	12 (3x4) ↔	Lorena Cain	Mental Health Legislation Committee/ Quality Assurance Committee	Risk was last reviewed on 08/01/24. The action plan has been reviewed and updated.

Risk number	Description	Score (severity x likelihood)	Risk Owner	Executive Lead and Monitoring Committee	Progress update
Risk 5070	*There is a risk of a information governance breach caused by undefined "archiving" stored in an unsecure location at President Park that could result in data breach, litigation, financial and reputational damage to SHSC. (scoring 9)*	9 (3x3)	Samantha Crosby	Audit and Risk Committee	Lat reviewed on 20/12/2023. Next review date is 19/03/2024

CORPORATE RISK REGISTER

As at: January 2024

Risk No. 3679 v.13 BAF Ref: BAF.0025A	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee
Version Date: 01/11/2023	Directorate: Acute & Community	Last Reviewed: 03/01/2024
First Created: 29/12/2016	Exec Lead: Executive Director - Operational Delivery	Review Frequency: Monthly

Details of Risk:

There is a risk that service users admitted to Maple Ward could ligate using fixed ligature anchor points or by using ligature items caused by not managing and removing ligature anchor points effectively resulting in service user death.

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):	5	1	5

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 on all our adult wards (SAS)
- 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.	Maple ward move due April 2024	01/04/2024 Laura Wiltshire
Estates required to review and replace window frames which pose a ligature risk.	as part of TEP prorgamme maple will have new windows when work starts in April 2024	01/04/2024 Laura Wiltshire

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.

• Heat maps are visible within all acute wards to highlight areas of greater risk due to access to ligature anchor points.

CORPORATE RISK REGISTER

As at: January 2024

Risk No. 4078 v.14 BAF Ref: BAF.0013	Risk Type: Workforce / Risk Appetite: Low	Monitoring Group: People Committee
Version Date: 03/07/2023	Directorate: Organisational Development	Last Reviewed: 02/01/2024
First Created: 26/10/2018	Exec Lead: Director Of Human Resources	Review Frequency: Quarterly

Details of Risk:

There is a risk that SHSC is not recommended as a place to work or to receive care if we do not respond effectively to the staff survey in a timely way. These risks may present as a) reputational damage, (b) devaluation of the staff survey purpose and impact (c) survey fatigue leading to low participation rates.

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):	3	2	6

CONTROLS IN PLACE

- 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
- 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)

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

Triannual Performance Reviews, from June 2023 include staff engagement and experience as an area of performance to report against.	Some teams reporting through the performance reviews. Discussed November Performance Review content and need to consider how to help teams report using org data, where no team data available. People Plans by Clinical Service and Corporate teams can help leaders to tell their engagement and experience story with actions that respond to collective people metrics as provided by workforce.	28/01/2024 Sally Hockey
Review and analyse Staff Survey 2023 results upon receipt		14/01/2024 Sally Hockey

• 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 be used 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 • Support activity will be put in place and will work with teams on identified areas to improve engagement. Both standardized and tailored offers will be in place to influence change. Data for 2022 being used to identify teams. • People Committee (all parties) asked to invite discussion about staff survey 4 questions linked to the People Strategy focus areas and staff survey action plans when visiting services and teams, to raise the profile of work invested in staff engagement and wellbeing. • New OD Staff Engagement and Wellbeing Practitioner recruited in August 2023. This role will proactively engage with services and team to support participation rates and provide timely data for results cascade to leaders	Team Meetings attended across a number of clinical areas to support staff survey engagement and 2023 communication campaign, which aims to build trust in the confidentiality and anonymity of the survey.	Visited teams during Q3 of 2023. Acute and Rehab team focus.	31/01/2024 Sally Hockey

Risk No. 4513 v.8 BAF Ref: BAF.0024	Risk Type: Statutory / Risk Appetite: Zero	Monitoring Group: Mental Health Legislation Committee
Version Date: 27/09/2023	Directorate: Medical	Last Reviewed: 08/01/2024
First Created: 24/02/2021	Exec Lead: Executive Medical Director	Review Frequency: Monthly

Details of Risk:

There is a risk that Associate Mental Health Act Manager (AMHAM) Hearings will not be undertaken in a timely manner, this being caused by an insufficient number of AMHAMs which the Trust currently has, resulting in possible breaches in human rights and potential statutory action against the Trust.

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

CONTROLS IN PLACE

- AMHAM recruitment underway; 4 new appointed
- Open ended AMHAM recruitment adopted
- Flexible approach to hearings being taken eg. virtual hearings if not contentious. This can improve AMHAM availability.
- New appointment process agreed which is not reliant on Trac recruitment system
- Review of remuneration which AMHAMs receive has been undertaken.
- Annual review to AMHAM rate of remuneration now in place.
- AMHAM peer support sessions have re-commenced.

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

SHSC internet site to have dedicated page for AMHAM open recruitment	28.11.23 reviewed by HoMHL. Bigger piece of work needed than anticipated. Target date now updated to 31.1.24	31/01/2024 Jamie Middleton
Written guidance to be jointly produced between mental health legislation and workforce setting out new AMHAM appointment process.	24.11.23 - Completed tasks to date: advertising outside of Trac, shortlisting outside of Trac, interviews, pre-employment checks, registered onto ESR, SHSC email accounts	31/01/2024 Jamie Middleton

Risk No. 4602 v.7 BAF Ref: BAF.0025A	Risk Type: Safety / Risk Appetite:	Monitoring Group: Finance & Performance Committee
Version Date: 01/11/2023	Directorate: Facilities	Last Reviewed: 04/01/2024
First Created: 11/05/2021	Exec Lead: Executive Director - Operational Delivery	Review Frequency: Monthly

Details of Risk:

There is a risk that there are a number of Ligature Anchor Points and Blind Spots within bed based services caused by lack of previous actions to remove or mitigate these environmental risks resulting in potential for inpatients to attempt ligation and cause themselves serious harm

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	5	3	15
Current Risk: (with current controls):	4	3	12
Target Risk: (after improved controls):	4	1	4

CONTROLS IN PLACE

- A Ligature Anchor Point Plan has been developed which identifies both very high risk (>36 scored) and lower rated (<36) risks; this is being used as a basis for monitoring progress against the identified items in the identified locations
- The majority of the blind spots identified have been mitigated by installation of specialist mirrors, although a small number of requests for additional mirrors continue to be received and are actioned.
- Other smaller/lower cost estates items have either been completed or are in process of being completed; these will continue to be monitored until they are all completed/fully mitigated
- More extensive works need to be carried out especially on the adult acute MH wards, to mitigate the LAPs. A ward works sequencing programme has been agreed so these can be undertaken sequentially on empty wards. However a S29A Notice issued by the CQC on 9 June 2021 has identified insufficient progress; a meeting arrange for 15 June to decide what additional works can be undertaken on live wards to accelerate the LAP eradication/mitigation programme
- A weekly report is produced showing progress against mitigation of the identified LAPs, for assurance
- A Project Director has been engaged for a temporary period to co-ordinate delivery of the LAP eradication programme

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

A meeting to be held between Laura Wiltshire (risk 3679), Adele Sabin and Andy Probert (Head of Estate Services/Hard FM) to discuss the two risks and ensure they work collaboratively together and to agree the scoring taking into account the outstanding position and the incidents that have occurred.	31/01/2024 Samantha Crosby
Request a report on the logged, fixed ligature anchor point, incidents for the past twelve months. This to be used at the meeting between AP, AS and LW to support the scoring process.	15/01/2024 Samantha Crosby

- Phase 1 of the LAP eradication plan has been completed.
- Phase 2 of the LAP eradication plan has been completed. Plans have been drawn up for Phase 3.
- The business case for Phase 3 was ratified by FPC at its January 2022 meeting. The process of tendering for the required works is underway

Risk No. 4605 v.4 BAF Ref: BAF.0025A	Risk Type: Safety / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee
Version Date: 01/11/2023	Directorate: Facilities	Last Reviewed: 02/01/2024
First Created: 11/05/2021	Exec Lead: Executive Director - Operational Delivery	Review Frequency: Monthly

Details of Risk:

There is a risk that patients, especially inpatients, may fall from a height, where identified risks are present externally to the premises, where they are residing or visiting. In addition the falls from height can be related to inadequate window management both of these areas could cause death or serious injury to an individual which would affect the reputational and financial position of the Trust.

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
- 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)
- SHSC Health and Safety Policy in place

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

The existing risk assessment for Firshill requires a full review and updated as necessary to ensure remain accurate and relevant, but to reflect that the building is currently not open.	31/01/2024 Charlie Stephenson
The existing risk assessment for Forest Close requires a full review and updated as necessary to ensure remain accurate and relevant.	31/01/2024 Charlie Stephenson
The existing risk assessment for Forest Lodge requires a full review and updated as necessary to ensure remain accurate and relevant, but to reflect that the building is currently not open.	31/01/2024 Charlie Stephenson
The existing risk assessment for Michael Carlisle Centre requires a full review and updated as necessary to	31/01/2024 Charlie Stephenson

	ensure remain accurate and relevant, but to reflect that the building is currently not open.	
	The existing risk assessment for Longley Centre requires a full review and updated as necessary to ensure remain accurate and relevant, but to reflect that the building is currently not open.	31/01/2024 Charlie Stephenson
	The existing risk assessment for Grenoside Grange requires a full review and updated as necessary to ensure remain accurate and relevant, but to reflect that the building is currently not open.	31/01/2024 Charlie Stephenson
	Risk Owner to ascertain from head of Estate Services/Hard FM as to what is the written process in regard to window replacement and safety management and what evidence can be provided to provide assurance of ongoing checks and maintenance of all windows.	31/01/2024 Samantha Crosby

Risk No. 4612 v.3 BAF Ref: BAF.0021A	Risk Type: Safety / Risk Appetite: Low	Monitoring Group: Audit And Risk Committee
Version Date: 16/07/2021	Directorate: Digital	Last Reviewed: 09/01/2024
First Created: 20/05/2021	Exec Lead: Executive Director Of Finance	Review Frequency: Quarterly

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.	Awaiting implementation of Rio and decommission of Insight before proceeding with removal of software. Rio implementation has been delayed.	31/03/2024 Adam John Handley

Risk No. 4697 v.7 BAF Ref: BAF.0025B	Risk Type: Safety / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee
Version Date: 03/01/2024	Directorate: Nursing & Professions	Last Reviewed: 09/01/2024
First Created: 12/08/2021	Exec Lead: Executive Director - Nursing & Professions	Review Frequency: Quarterly

Details of Risk:

There is a risk that patients safety will be impacted out of hours as a result of not having timely access to spare medical devices and specialist supplies resulting in poor patient care and possible harm Eg.(emergency equipment and consumables, bariatric, moving and handling or bespoke equipment)

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

CONTROLS IN PLACE

- Inpatient areas have a stock of essential / emergency equipment to support the frequent care interventions offered in their setting which includes stock for replacement when used
- Additional stock of equipment is available at Presidents Park. This also includes some bariatric equipment
- Robust reordering of stock process by wards
- Standard Operating Procedure developed
- Each clinical area should be completing pre/during assessments to identify needs enabling earlier identification of any equipment required
- Most clinical areas are sited with others therefore equipment can be shared across site if required

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

Exploration of options for storage and transportation of equipment out of hours	09/01/2024 - still with DON for discussions	31/03/2024 Sharlene Rowan
Medical devices officer working with clinical teams to identify location plans for the admission of bariatric / complex needs service users.	Medical devices officer has commenced conversations in response to request by DoN regarding bariatric plan. SHSC already have equipment in clinical services that accommodate larger weights.	31/01/2024 Sharlene Rowan
Increased awareness and training for staff regarding the use of equipment to manage changeable needs	for context OT and Physio staff completed a training needs analysis on competencies in relation to equipment. Completed by all staff. areas of training identified. query about whether a training package	31/01/2024 Sharlene Rowan

		could be paid for out of PH budget. This has been confirmed as a no. Training package delivery to be funded through Professional Development Group	
	Raise awareness with clinical services to improve/increase the completion of admission pre-assessments to ensure that admissions are safe and appropriate	Risk assessment has been developed along with M&H risk assessment	31/01/2024 Philip Nartey
	Ongoing work re centralization of medical devices budget to ensure wards are stocked with appropriate items, and budgets overseen by Medical Devices	Further Discussions re Business Case for Role to be discussed at QEIA and Business planning Group 11/12 Jan 2024	31/03/2024 Sharlene Rowan

Risk No. 4756 v.8 BAF Ref: BAF.0029	Risk Type: Safety / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee
Version Date: 18/09/2023	Directorate: Rehabilitation & Specialist Se	Last Reviewed: 03/01/2024
First Created: 28/10/2021	Exec Lead: Executive Director - Operational Delivery	Review Frequency: Monthly

Details of Risk:

Demand for the ADHD pathway greatly outweighs the resource and capacity of the service. This is resulting in longer/lengthy wait times and high numbers of people not being screened and waiting for assessment, diagnosis and medication

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

- Ongoing discussions with Place re current and required resource. This extends to Derbyshire ICB also for existing contracts for ASD and ADHD
- Agreement to split ADHD and ASD pathways and report separately in data performance, contracting, workforce model and escalations
- 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
- QEIA raised to identify the demand into the ADHD pathway.
- Stepped care model proposal presented to MHLDA Board in April 2023. Awaiting agreement to progress plans as part of community transformation
- Medication pathway revision to ensure current workforce and skill mix can

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

Contracts and Directorate Leadership Team to meet with Derbyshire ICB to review how best to approach service users on the waiting list	Ongoing discussion with commissioners to meet by end of Jan 2024 after DDICB have met with primary care to agree commissioning of ADHD pathway locally	29/02/2024 Sal Foulkes
Establish clinic booking / appointments / job plans for Medics to support reduction of medication waiting list	Currently being reviewed and implemented - in process - expeceted by end of Jan 2024	31/01/2024 Jonathan Mitchell
review of medication pathway, and production of SOP to ensure that a standardised approach is taken to medication assessment and titration	delayed due to staff sickness, but being picked up with job planning, clinic booking processes	31/01/2024 Sharon Brooks
Provision of an accurate activity and performance dashboard to ensure assurance in IPQR and to	Work ongoing with a demand/capacity model to report on the reduction of	31/01/2024 Julia Cayless

respond to medication list. Plan to reduce waiting list within 6 months	commissioners - and to support demand capacity planning for tiered model transformation	the medication waitlist, as per priority for service.	
	to begin screening of the referrals made to the service in Nov 2022 onwards, to effectively triage and decide whether NICE criteria met, and consequently discahrged or moved onto waiting list	Currently on hold due to lack of staffing resource to undertake the task. Lack of clinical resource available - has to be a clinician led triage. To be discussed with DLT in the context of the transformation plan and further actions to be outlined.	29/02/2024 Sharon Brooks
	recruitment of Admin specifically for ADHD to support clinic booking, appointments and processes to underpin clinical activity	Post currently held up in VCP. HoS and GM to attend VCP to discuss the release of the post to enable support for medics as planned	31/01/2024 Sharon Brooks
	to develop opportunities for prescribers who have completed the UKAAN training (Day 1&2) to shadow ADHD Medics in patient appointments with a view to establishing a "community of ADHD practitioners" who can prescribe, titrate and review medicaiton in PCMHT and SCMHT		24/01/2024 Sal Foulkes

Risk No. 4757 v.11 BAF Ref: BAF.0029	Risk Type: Quality / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee
Version Date: 31/10/2023	Directorate: Rehabilitation & Specialist Se	Last Reviewed: 03/01/2024
First Created: 28/10/2021	Exec Lead: Executive Director - Operational Delivery	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	2	8

CONTROLS IN PLACE

- 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.
- Strengthening 'waiting well' initiative with team peer support workers and the appointment of a Comms Officer to address information requirements
- Third party provider appointed to undertake backlog of surgical progression second opinion assessments to progress people through the pathway

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

Clinical process review to be undertaken by Medical Director and Head of Nursing	Work continues on medical skill mix and job planning. Funding for posts identified, but speciality recruitment remains problematic given the scarcity of trained resource nationally. Identified possibility of further Specialist medic, and enquiries being led by Clinical Director. Decision to be reached by end of Q4 (23-24).	31/03/2024 Mark Parker
HIgh levels of sickness absence in medic and admin team specifically	Admin absence continues to be managed through HR and is stabilising but still remains an ongoing issue at this time. Absentees now being reintroduced back into the workplace and supported to	31/01/2024 Mark Parker

		stay well. Medic absence remains an issue and it is hoped that a RTW will happen in Jan 24, but is likely to be phased.	
	GIC is part of the Trust-wide QI programme addressing issues of waiting times and waiting well. The QI programme will explore different ways of working to increase operational efficiency and to support and engage service users and enhance waiting well initiatives.	This is a long term initiative on the part of the Trust that recognises the importance of cultural as well as operational change. A coach has been appointed to the team and is in the early stages of engagement with the staff group. It is expected the changes to operations will be explored over the next 12 months and impact measured.	31/10/2024 Sal Foulkes

Risk No. 4795 v.7 BAF Ref: BAF.0026	Risk Type: Business / Risk Appetite: Low	Monitoring Group: Finance & Performance Committee
Version Date: 06/12/2023	Directorate: Digital	Last Reviewed: 04/01/2024
First Created: 23/12/2021	Exec Lead: Executive Director Of Finance	Review Frequency: Monthly

Details of Risk:

There is a risk that there could be a loss of knowledge and expertise within the Project and BAU Digital Team due to key staff leaving the programme leading to delays in delivery or lack of input from Trust teams.

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

CONTROLS IN PLACE

- Effective record keeping and audit trails
- Proposal regarding additional substantive resource to be written for review by DOF by end of December - moved to actions

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

Trust Training Manager Wilma Sheehan leaved mid-Oct23 and no replacement currently identified. This would impact on BAU training beyond initial Go Live.	FD has confirmed willingness to sign off on January contract extension costs week commencing 2nd Jan 24. Information provided 4th Jan '24. Awaiting confirmation	31/01/2024 Pete Kendal
Uncertainty over internal Change Agent retention means there is a risk that Change Agents may leave before the end of the project.	Agreement reached on substantive resource requirements to be submitted to DOF but not yet confirmed by Board as necessary. As such no replacement resources can be brought into the Team. Change Agent contracts only run to end of Dec as do most of the contract/seconded staff working on EPR.	31/01/2024 Pete Kendal

Contract negotiations are underway with Apira following delay with 2nd go-live. Intention is for these to extend the end contract date	Apira have offered 10% discount on standard rates. A letter has been issued to them from the CEX challenging them to address the failed EPR implementation and seeking to agree a way forward that offsets the expenditure currently made. Reference has been made to legal challenge.	31/01/2024 Pete Kendal
Proposal regarding additional substantive resource to be written for review by DOF by end of December		12/01/2024 Pete Kendal

Risk No. 4965 v.3 BAF Ref: BAF.0025B	Risk Type: Safety / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee
Version Date: 02/01/2024	Directorate: Nursing & Professions	Last Reviewed: 02/01/2024
First Created: 24/10/2022	Exec Lead: Executive Director - Nursing & Professions	Review Frequency: Monthly

Details of Risk:

There is a risk that the delivery of essential Physical Health Training Needs will not be delivered due to the limited resource (both capacity and skill) available within the team. This is further affected by the availability, suitability and condition of venues in which training can be delivered. This will result in staff staff will not be fully skilled and competent with regards to the management of Physical Health needs

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

CONTROLS IN PLACE

- Training Needs Analysis developed which informs required skills and competencies
- Range of PA and ACP roles across services to support clinical services to meet the needs of service user Physical Health Needs
- Physical Health Team now fully staffed
- Business case for funding submitted to support completion of essential works to ensure suitable and safe working environment
- Interim arrangement in place for alternative temporary venue
- Health and safety plan agreed with estates and H&S team to support safe use of existing venue at Chestnut Cottage
- Physical Health Team providing additional local training where possible to improve compliance and skill.
- Mandatory trainers have been supporting with Moving and Handling. But this is still not sufficient
- Training Needs Analysis is in progress.

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

Work with Estates team to explore longer term solution for training venue which enables the team to deliver high quality training	delays experienced with renewal of Chestnut roof therefore team unable to move back into training venue. conversations ongoing regarding longer term venue	31/03/2024 Penelope Fati
Development of bitesize training resources on jarvis to support local delivery of key topics	Absence within the team continues to impact on delivery of this action as team have not had the capacity to progress.	30/04/2024 Penelope Fati
Explore a model of delivery for training with clinical teams in their location	Training has occurred ad hoc within locations based on need, Capacity issues within the team during Q3 has delayed workplan projects.	31/03/2024 Penelope Fati

	action ongoing	
Explore exisiting competency frameworks to establish the key skills required for our clinical teams	Absence within the team continues to impact on delivery of this action as team have not had the capacity to progress.	30/04/2024 Penelope Fati
Based on learning from review of competency frameworks, agree and develop the SHSC approach	Absence within the team continues to impact on delivery of this action as team have not had the capacity to progress.	30/04/2024 Penelope Fati
Scoping exercise in progress for TNAs to support with Tracy Wear and the HONs.	Absence within the team continues to impact on delivery of this action as team have not had the capacity to progress.	30/04/2024 Penelope Fati
Scoping to see if the new nurses who have joined SHSC from aboard can support with PH training.	Absence within the team continues to impact on delivery of this action as team have not had the capacity to progress.	29/02/2024 Penelope Fati

Risk No. 5001 v.4 BAF Ref: BAF.0025B	Risk Type: Safety / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee
Version Date: 03/01/2024	Directorate: Acute & Community	Last Reviewed: 03/01/2024
First Created: 16/11/2022	Exec Lead: Executive Director - Operational Delivery	Review Frequency: Monthly

Details of Risk:

There is a risk that patients awaiting hospital admission are experiencing a delay in their care and treatment of acute mental illness caused by lack of beds resulting in delayed treatment and poor outcomes.(Cases Awaiting Hospital Admissions (CAHA) is the joint responsibility of home treatment, flow team and the CAT)

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	4	4	16
Current Risk: (with current controls):	3	4	12
Target Risk: (after improved controls):	3	2	6

CONTROLS IN PLACE

- Daily meetings between CRHTT, flow and AMHPs keeps overview of the list
- Review of CAHA monthly in governance meetings.
- Escalating concerns or incidents via incident reporting procedures
- Daily CAHA meetings rescheduled to inform bed allocation meeting and to promote productivity of CAHA

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

Review work load of CAHA and propose the staffing required to safely clinically manage alongside existing community provision those awaiting hospital admission.	19/02/2024 Natalie Cotton
Daily meetings between central AMHP team, SHSC flow team and CRHTT to review EPR of everyone on the list, to liaise with patient (this is usually not possible due to risk, engagement) carer/family, other SHSC services, other services involved such as housing/social care. Care plan created and updated daily. This action monitors the list and ensures that the right people are aware and maintaining contact where possible, however this fails when service users are not known to any other services and refuse any community support leaving the	30/01/2024 Hayley Taylor

CRHTT holding responsibility for risk that cannot be mitigated for service users who are not being seen. This group make up a large portion of the CAHA list of service users. When service users feel able to engage with any community input, CRHTT will take onto the caseload and step down from CAHA list, CRHTT are proactively checking daily for any indication of a service user wanting to engage in order to treat in the least restrictive way possible.	
Review the timings and priority of meetings: CAHA, morning crisis meeting, bed management meeting.	05/02/2024 Hayley Taylor
Ongoing work across SHSC related to patient flow, specifically delayed discharge, length of stay and out of area reduction.	01/02/2024 Christopher Wood
Look at development of MDT support between CRHTT interface nurses, discharge coordinators and facilitators to improve communication around patient flow.	19/02/2024 Christopher Wood
Further develop CAHA SOP to include wider community team support.	19/02/2024 Hayley Taylor

Risk No. 5026 v.4 BAF Ref: BAF.0024	Risk Type: Statutory / Risk Appetite: Zero	Monitoring Group: Mental Health Legislation Committee
Version Date: 29/09/2023	Directorate: Medical	Last Reviewed: 08/01/2024
First Created: 20/12/2022	Exec Lead: Executive Medical Director	Review Frequency: Monthly

Details of Risk:

There is a risk that patients who come under the Deprivation of Liberty Safeguards (DOLS) framework are detained on SHSC staffed premises with no legal authority in place to authorise this. This is caused by significant delays and backlogs within the Local Authority (who are responsible for conducting such assessments and authorisations). This could result in patient's legal rights being breached by the Trust, and the Trust potentially being challenged legally by a patient or their representative.

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	3	5	15
Current Risk: (with current controls):	3	4	12
Target Risk: (after improved controls):	3	1	3

CONTROLS IN PLACE

- SHSC is fulfilling its duty by making referrals to the Local Authority when DOLS authorisations are required.
- There is a recognition nationally that the DOLS processes are not fit for purpose and that DOLS is expected to be replaced by a new legal process known as the Liberty Protection Safeguards (LPS) - although there is no date for when this will be enacted by Government.
- Most individuals admitted to SHSC wards are admitted under the Mental Health Act for the treatment of mental disorder. Most inpatients would therefore not be eligible for DOLS.
- The Local Authority has carried out a review of their DOLS work, intending on reducing DOLS referral backlogs.
- Forum in place, by means of the citywide Mental Capacity Act Action Network (MCAAN), where issues in relation to DOLS can be discussed at a partnership level.

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

Data to be included in Head of Mental Health Legislation quarterly reports setting out numbers of patients/residents who are being deprived of their liberty but no legal authority is in place, and for what duration of time this has been the case.	Action reviewed by HoMHL; action not yet due	31/01/2024 Jamie Middleton
Escalation process in respect of service users who are being deprived of their liberty, but for whom there is no DOLS authority in place to authorise this, to be established with Local Authority.	Reviewed by HoMHL; completion date not yet due	31/01/2024 Jamie Middleton
Discussion to take place with SHSC risk department about incident reporting with respect of people deprived of their liberty with no lawful authority; to explore current	8.1.24 reviewed by HoMHL; new target date set as unable to progress this action owing to separate court proceedings	31/01/2024 Jamie Middleton

								system and whether any new incident types are needed so these can be identified and monitored more effectively.		(unrelated to this) which had to be dealt with and prioritized.	

Risk No. 5043 v.3 BAF Ref: BAF.0025B	Risk Type: Safety / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee
Version Date: 02/01/2024	Directorate: Nursing & Professions	Last Reviewed: 02/01/2024
First Created: 17/01/2023	Exec Lead: Executive Director - Nursing & Professions	Review Frequency: Quarterly

Details of Risk:

There is a risk that unsafe application of moving and handling practices caused by a lack of understanding and training may result in harm or injury to both staff and service user. There may also be a wider statutory or financial organisational impact if injury occurs.

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):	3	2	6

CONTROLS IN PLACE

- Moving and Handling working group established chaired by Head of Clinical Quality Standards. Improvement plan in place
- Training needs analysis of bed based services completed
- Moving and handling lead role in place
- Falls prevention lead OTs review in place
- Incident reporting requirement for all falls and moving and handling incidents
- Moving and handling training being delivered and compliance recorded/monitored through mandatory training
- MFFRA document in place for all bed based services
- Development and implementation of intermediate level training for wards where service users are essentially mobile
- Development and implementation of Quality Assurance visit programme to inpatient wards.
- Moving and handling risk assessment available for staff to complete - needs to be added to RIO.
- Back care and M&H policy in place which incorporates risk assessment documentation.
- Moving and Handling working group to be established

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

Development of E learning package to support theoretical learning	Action remains ongoing. F2F ward based training dates for acute ward areas scheduled along with level 2 training.	29/02/2024 Philip Nartey
Development of short practical videos to support theory	Action remains ongoing. Some resources have been developed though yet to be published on Jarvis however cascade to teams as appropriate. Plan to be established re final content with comms	29/02/2024 Philip Nartey
Develop SOP for supporting inpatient areas with complex M&H needs	Action remains ongoing though aspects of implementation impacted by delays in RIO roll out.	29/02/2024 Philip Nartey

• New bed stock to be introduced at OA wards and Woodland view. Delivery of beds will be supported by training which will be cascaded to staff by identified lead

Risk No. 5047 v.3 BAF Ref: BAF.0024	Risk Type: Statutory / Risk Appetite: Zero	Monitoring Group: Mental Health Legislation Committee
Version Date: 29/09/2023	Directorate: Medical	Last Reviewed: 08/01/2024
First Created: 23/01/2023	Exec Lead: Executive Medical Director	Review Frequency: Monthly

Details of Risk:

There is a risk that practice within the Trust is not compliant with the Mental Capacity Act. This is caused by multiple factors such as MCA mandatory training not being undertaken, current MCA training needing to be improved, and some organisational culture. This risk could result in patient's legal rights being breached, care not being delivered in accordance with a patient's previously expressed wishes, and legal challenge against the Trust.

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	1	3

CONTROLS IN PLACE

- Mandatory training is provided in respect of the Mental Capacity Act
- Advice can be sought from Head of Mental Health Legislation where needed
- A process is in place which allows the Trust to instruct external solicitors in more complex cases
- New Mental Capacity Act (MCA) Essential Level training has been introduced
- New Mental Capacity Act (MCA) Level 1 training has been introduced
- New Mental Capacity Act (MCA) Level 2 training has been introduced
- New position statement agreed regarding the Trust's response to enquiries under section 49 Mental Capacity Act

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

Bitesize training video to be produced regarding use of restraint under Mental Capacity Act	8.1.24 review - new target date entered owing to carrying out different work linked with a court case which had to take priority.	31/01/2024 Jamie Middleton
Bitesize training video to be produced regarding using Mental Capacity Act vs. Mental Health Act	8.1.24 review - new target date entered owing to carrying out different work linked with a court case which had to take priority.	31/01/2024 Jamie Middleton
Bitesize training video to be produced regarding Powers of Attorney	8.1.24 review - new target date entered owing to carrying out different work linked with a court case which had to take priority.	31/01/2024 Jamie Middleton

CORPORATE RISK REGISTER

As at: January 2024

Risk No. 5051 v.2 BAF Ref: BAF.0022	Risk Type: Financial / Risk Appetite:	Monitoring Group: Finance & Performance Committee
Version Date: 16/05/2023	Directorate: Finance	Last Reviewed: 22/12/2023
First Created: 01/02/2023	Exec Lead: Executive Director Of Finance	Review Frequency: Monthly

Details of Risk:

There is a risk of failure to deliver the required level of CIP for 2023/24. This includes closing any b/f recurrent gap and delivering the required level of efficiency during the financial year.

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	4	4	16
Current Risk: (with current controls):	4	4	16
Target Risk: (after improved controls):	2	3	6

CONTROLS IN PLACE	ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON		
• Cost Improvement Programme Board and Working Groups established to confirm targets, identify and establish schemes, review Scheme Initiation Documents, ensure QEIA process undertaken and monitor progress. • Transformation projects programme board and benefits realisation monitoring and oversight • Performance Management Framework which will be operationally put into practise more formally from quarter 1. • Trust Business Planning Systems and Processes, Including CIP monitoring, QEIA and Executive oversight of the CIP programme Board and each of the 3 working groups focussed on Out of Area, Agency and all other schemes • Forms part of routine finance reporting to FPC, Board, ICB and NHSE • Additional controls added with EMT reviewing and making any investment decisions in light of increased system oversight and need for Exec level group to oversee expenditure commitments above £10k. • Executive Management Team being added back into SFIs and Scheme of Delegation under Board Sub committee's as a decision making forum above BPG. • Additional controls agreed by EMT to help support financial recovery and reduce the expenditure run rate and overall deficit. This include the cessation of non essential expenditure. Exec led vacancy panels for non frontline roles	Work up the finer detail of the corporate benchmarking CIP workstream	All plans developed are now feeding into the 24/25 CIP plans. Nothing has been delivered in 23/24 other than within finance. To feed in next iteration of 24/25 CIPS to February's FPC.	28/02/2024 Phillip Easthope
	Work up further CIP workstreams and opportunities to reduce reliance on the M12 profiled technical CIP (£0.5M)	Non essential expenditure controls will Non recurrently help mitigate the reduced level of CIP delivery. Particularly linked to delayed OOA progress and extended agency usage re EPR.	31/03/2024 Phillip Easthope
	Review the year 2 and year 3 CIP plans and bring forward where possible. If savings are realised in year one or delivered as part of other	Further updates on CIP planning for 24/25 due at FPC in February. This will include the changing impact	31/03/2024 Phillip Easthope

and various other controls.

• Formal recovery plans have been requested from all areas over £100k overspent at M5 (Clinical) and £50k over at M5 (Corporate). These are being collated in November for review and reporting via EMT in Nov and FPC (Dec). Projected impact to be quantified before further measures are considered.

workstreams, then reduce the future CIP expectations. (i.e EPR savings may reduce if some are brought forward and delivered under the Corporate Benchmarking)

of the recovery plans and 23/24 outturn. All the corporate overhead plans are now being rolled into 24/25 CIP planning.

Risk No. 5070 v.3 BAF Ref:	Risk Type: Statutory / Risk Appetite: Low	Monitoring Group: Audit And Risk Committee
Version Date: 06/12/2023	Directorate: Facilities	Last Reviewed: 20/12/2023
First Created: 27/02/2023	Exec Lead: Executive Director - Operational Delivery	Review Frequency: Quarterly

Details of Risk:

There is a risk of a information governance breach caused by undefined "archiving" stored in an unsecure location at President Park that could result in data breach, litigation, financial and reputational damage to SHSC.

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):	3	2	6

CONTROLS IN PLACE

- Paxton access to warehouse
- Structural engineer report stating load bearing weight limit

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

Obtain confirmation form Associate Director that this will be funded (cost pressure) and awaiting this confirmation in order to get a date for fitting the gates.	17/01/2024 Samantha Crosby

CORPORATE RISK REGISTER

As at: January 2024

Risk No. 5220 v.5 BAF Ref: BAF.0024	Risk Type: Quality / Risk Appetite: Low	Monitoring Group: Mental Health Legislation Committee
Version Date: 08/01/2024	Directorate: Nursing & Professions	Last Reviewed: 08/01/2024
First Created: 26/09/2023	Exec Lead: Executive Director - Nursing & Professions	Review Frequency: Monthly

Details of Risk:

There is a risk that inpatient care is not delivered in the least restrictive way, in line with national guidance and regulatory standards due to a lack of skilled trained staff on duty 24/7, 7 days a week. The is due to a combination of capacity with trainers, capacity related to release of staffing and effective rota management. The risk is that this then leads to more restrictive practice, poor patient and staff experience and progress of the strategy.

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

CONTROLS IN PLACE

- Respect training available which now includes ward based AHPs and psychology staff. offer includes all bank staff and can be extended to block booked agency staff
- Audits on Tendable which enable oversight of restrictive practice and compliance with standards
- Incident reporting procedure in place and Incident huddle for monitoring use and flagging concern
- Governance groups in place for oversight and scrutiny of data, indicating any areas for concerns and where improvement actions are required
- Least Restrictive Strategy in place with a timeframe workplan including action owners. Progress is reported quarterly via the LRPOG and MH legislation Committee
- Use of Force Policy which includes minimum number of RESPECT trained staff required per shift
- Lead nurse/Nurse Consultant with dedicated capacity to oversee RPs
- Monitoring of minimum trained respect staff on duty via Matron leads and operational oversight
- Medical training and audit of seclusion reviews
- team based instructors on some wards. plan to develop further

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

Increased capacity in the respect team to work into clinical teams with complex cases by the funding and appointment of a band 6 professional registrant role	updated review of composition completed and plans to revise structure of team, review job descriptions and create more capacity within the team. some bank shifts are being used by team based trainer to cover	15/03/2024 Lorena Cain
There is a monthly confirm and challenge meeting before the rotas are approved for sign off. This includes ensuring we are using our substantive staff effectively across the rota period. Every weekday morning there is a meeting between the Ward Managers and Matron to review staffing over the next 24 hours, and any issues that cannot be resolved internally within the service	update safer staffing and relevant dashboards to support, continue to be overseen by Head of Nursing. Relevant incidents are flagged as part of DISH and sent to HoN	15/03/2024 Simon Barnitt

• identified leads for RP at ward team level • security officer support team in place • response protocol in place includes support of shared alarm system • rota management system in place - safer staffing levels meeting in place and process for daily review, monitoring and escalation. this includes the number of RESPECT trained staff on shift • support to ensure bank and agency staff have necessary skills to ensure Least restrictive practice • team based risk register for RESPECT team identifying controls and action to achieve required number of courses offered to ensure compliance . • other training that supports being Least restrictive such as Human Rights training, cultural awareness training and HOPES training is available and offered to staff either as part of the RESPECT programme or as stand alone training	line are taken to a daily staffing escalation meeting that looks to resolve staffing gaps across the Trust. This includes ensuring all areas have a minimum of 3 x Leverl 3 RESPECT trained staff.		
	Increase capacity in the RESPECT team to deliver training and ensure enough course are available to meet the required compliance.	update review meeting completed and recommendations to be progressed related to job description reviews, team composition and oversight lead. bank hours by team based instructors are being filled. compliance with training will remain an issue until more capacity secured in team however this month training compliance for both level one and level three has increased	15/03/2024 Lorena Cain
	Provide monthly training reports to ward teams on RESPECT and work with ward managers to identify staff who are out of date and ensure they are booked on	update action as above. Training session for review managers in planning	15/03/2024 Lorena Cain

Risk No. 5224 v.2 BAF Ref: BAF.0021A	Risk Type: Quality / Risk Appetite: Low	Monitoring Group: Finance & Performance Committee
Version Date: 10/10/2023	Directorate: Digital	Last Reviewed: 27/12/2023
First Created: 09/10/2023	Exec Lead: Executive Director Of Finance	Review Frequency: Monthly

Details of Risk:

There is a risk that our new electronic patient record system will fail to meet the recording and reporting requirements of our clinical services. This risk must be mitigated through rigorous User Acceptance Testing.

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

- User acceptance testing for system performance and reporting is already underway with assurance provided through reports to Programme Board/EMT
- Operational oversight through EPR programme Board and supporting workstreams
- Strategic oversight of weekly Executive Management Team group
- Reporting to the Board on progress and actions required.

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

Testing completed but some actions identified as outstanding. Re-testing is underway following some modifications made to forms and mitigants put in place where work cannot be completed in time for Tranche 2.	Contract from incumbent supplier due to expire at month end. System does not currently function as it should. The Access Group (TAG) have formally reviewed system functionality and identified multiple areas of failure. SHSC do not have any of the skills necessary to address these and so are proposing to use the expertise of TAG to quickly rework the system,, supporting an exercise to address all T1 issues before progressing to T2 implementation. However, the proposal from TAG has not yet been approved by EMT and also requires the release of	29/02/2024 Pete Kendal

		budget to address shortcomings of incumbent system. Paper to be taken to EMT for approval week commencing 1st January 2024	
	Subject to confirmation by Board to release necessary budget to commission TAG to implement EPR, detailed programme of work will need to be agreed between TAG and EPR Programme Board with appropriate clinically driven priorities		31/01/2024 Pete Kendal

Risk No. 5225 v.1 BAF Ref: BAF.0021A	Risk Type: Quality / Risk Appetite: Low	Monitoring Group: Finance & Performance Committee
Version Date: 09/10/2023	Directorate: Digital	Last Reviewed: 04/01/2024
First Created: 09/10/2023	Exec Lead: Executive Director Of Finance	Review Frequency: Monthly

Details of Risk:

There is a risk that we fail to train our staff in the use of our new electronic patient record system in preparation for the go live date. This will mean that clinical staff are unable to access the system. This risk must be mitigated through a considered training delivery plan, which is governed on a weekly basis with operational grip and control.

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):	1	1	1

CONTROLS IN PLACE

- Training delivery plans in place and being driven through Clinical Operations
- Training ongoing to support compliance across clinical teams for Tranche 2
- Training levels are reported to EMT/CSDG and CESG on a weekly basis managed under a programme of work led by Ops

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

Reports have been received from clinical teams that the system they trained in does not reflect the look and feel of the system that they arae now expected to use. TAG have proposed to rebuild the system and if the cost of this is approved by the Board, will train internal staff in use of the system. With a reduction in staff, a shift will be made to video training to ensure training is appropriate	proposal has not yet been approved by the Board. Shift to online training is ongoing but there is only minimal resource in place so there is a reduction in capacity	31/01/2024 Pete Kendal
Development of online training modules can only commence once system has been reworked to reflect end-state. Awaiting confirmation of Board approval for release of budget to bring in 3rd party to redevelop system		31/01/2024 Pete Kendal

CORPORATE RISK REGISTER

As at: January 2024

Risk No. 5266 v.1 BAF Ref: BAF.0026	Risk Type: Business / Risk Appetite: Low	Monitoring Group: Finance & Performance Committee
Version Date: 11/12/2023	Directorate: Digital	Last Reviewed: 27/12/2023
First Created: 11/12/2023	Exec Lead: Executive Director Of Finance	Review Frequency: Monthly

Details of Risk:

There is a risk that a breakdown in the relationship with the third-party implementation support team for delivery of the Electronic Patient Record system (EPR), or insufficient capacity available from them, will impact negatively on ability to deliver the project safely, effectively and to the required timeframe.

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

CONTROLS IN PLACE

- Governance arrangements in place
- Assurance provided through reports to Programme Board/EMT
- Operational oversight through EPR programme Board and supporting workstreams
- Strategic oversight of weekly Executive Management Team group
- Reporting to the Board on progress and actions required.
- Effective record keeping and audit trails

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

Put in place revised agreement and arrangements for ongoing support	Verbal offer of resource at no cost was not referenced in the written proposal received, which was for a limited subset of resources discounted by 10% but still significantly higher than those same resources available in the commercial marketplace. TAG have been approached to complete the implementation and to provide skills transfer into staff within the department, but this is subject to EMT agreeing the proposal and releasing the necessary budget	31/01/2024 Pete Kendal
Identify backfilling arrangements for key individuals leaving posts and	EPR implementation delayed further following	31/01/2024 Pete Kendal

	sharing of knowledge for BAU training beyond initial go-live	reviews by TAG of the way the system has been built. Apira contract expires at the end of December. Additional budget has not yet been signed off and all staff resources brought in under contract to support the EPR, and concluding at the end of December. A Target Operating Model proposal is being written for the Digital Team, to be reviewed by the DOF and which will identify essential resources to sustain a BAU state for the EPR. As such there is no skills transfer in place happening at the time of writing	
	Uncertainty over internal Change Agent retention means there is a risk that Change Agents may leave before the end of the project.	All change Agent contracts/secondments are due to finish at the end of December due to budgetary constraints. Due for review by EMT week beginning Jan 1st	31/01/2024 Pete Kendal
	Re- negotiate options around the current end of contract date for third	Proposal to bring in TAG to complete the EPR	31/01/2024 Pete Kendal

	party provider.	implementation in lieu of Apira (with whom there is an ongoing dispute about accountability) is due to be reviewed by EMT week beginning 1st January	
	Substantive staff member acting in EPR PM role, in the absence of the third party roles of PM, the CA Manager and the Training Manager	Proposal received. Due to be reviewed by EMT week beginning 1st January 2024. If approved, we will recruit on a fixed term basis into those roles	31/01/2024 Pete Kendal

CORPORATE RISK REGISTER

As at: January 2024

Risk No. 5267 v.1 BAF Ref: BAF.0026	Risk Type: Business / Risk Appetite: Low	Monitoring Group: Finance & Performance Committee
Version Date: 11/12/2023	Directorate: Digital	Last Reviewed: 27/12/2023
First Created: 11/12/2023	Exec Lead: Executive Director Of Finance	Review Frequency: Monthly

Details of Risk:

There is a risk staff will lose confidence in the system if they do not receive sufficiently timely response to issues they have raised and support as required

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

- Availability of floor walkers providing support, Help lines and guidance information/communications processes
- Weekly meeting with Tranche 1 service to ensure challenges are understood and feedback on progress
- Assurance provided through reports to Programme Board/EMT
- Operational oversight through EPR programme Board and supporting workstreams.
- Strategic oversight of weekly Executive Management Team group
- Reporting to the Board on progress and actions required

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

Review communication plan	From Jan 1st there will not be a Communication lead in place for the EPR implementation as all contracts will finish at the end of December	31/01/2024 Pete Kendal
The proposal by TAG is to upskill support staff to transition post implementation into a BAU state where the Trust can support itself with skills developed over the next three to four months		29/03/2024 Pete Kendal

CORPORATE RISK REGISTER

As at: January 2024

Risk No. 5272 v.1 BAF Ref: BAF.0026	Risk Type: Business / Risk Appetite: Low	Monitoring Group: Finance & Performance Committee
Version Date: 11/12/2023	Directorate: Digital	Last Reviewed: 04/01/2024
First Created: 11/12/2023	Exec Lead: Executive Director Of Finance	Review Frequency: Monthly

Details of Risk:

There is a risk technical issues in the build which have surfaced post implementation of the launch of the first phase of the Electronic Patient Record (Rio) are not adequately managed resulting in lack of stablisation of the first stage prior to launch of the second phase with the result there are delays in development and security of the reporting build infrastructure putting in jeopardy ability to move forward.

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

CONTROLS IN PLACE

- Governance arrangements
- Expertise of the internal and external teams
- Assurance provided through reports to Programme Board/EMT
- Operational oversight through EPR programme Board and supporting workstreams
- Strategic oversight of weekly Executive Management Team group
- Reporting to the Board on progress and actions required.
- Data migration plan in place - monitoring and assurance provided through reports to Programme Board/EMT
- Additional staff brought in from across the organisation to support manual migration
- Prioritisation of known core (mandatory) reports within project, ensuring that we focus first on the reports with the greatest impact if not completed. There is further work in assessing all of the reports in scope
- Communication of change to stakeholders so they can set expectations and work out arrangements with local service users around any delays.
- New staffing model to accommodate the delays and bring the projected overspend within 10-15% of the budget, reducing the severity to 4.

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

Awaiting confirmation of scale of issue regarding manual data migration from third party provider.	Manual data migration now understood to be significantly more complex than previously believed. All resources involved in data migration, with the exception of the CNIO, have now left the Trust and so the workstream must be paused pending receipt of additional budget.	31/01/2024 Pete Kendal
New Roadmap on Monday.com to be populated by Rob Nottingham and Jack Baring	Board still requires updating as many areas are unclear.	31/01/2024 Jack Baring
Take paper to CSEG outlining recover plan for DWR project.	Resources not yet committed to address shortfall. All contractors finish at end of Dec and EMT has not yet agreed a budget	31/01/2024 Jack Baring

• Regular meetings in place with New EPR Project so that impact of delays to deliverables on DWR are clear. • Closer engagement with New EPR team to ensure there is better consideration of reporting requirements as part of the change process and configuration • A list of reports was solicited from individual services liaising through the business analysts. These have been prioritised based on first submission following go-live and flexibility in order to minimise the impact of unavoidable delays to delivery • Data migration plan in place - monitoring and assurance provided through reports to Programme Board/EMT • Additional staff brought in from across the organisation to support manual migration		to extend EPR implementation	
	Data Warehouse and Reporting team to assist Data Migration lead in delivering a successful trial load as this is a prerequisite for DW&R. Most of the team resource to be diverted to working on Data Migration until this is delivered	Go-live will not now be the start of January. System review by TAG has determined the Apira build of the EPR to be problematic in a number of areas. Additional time is now available to support automated data migration and evidence a successful trail load	31/01/2024 Jack Baring
	Prioritise custom assessment forms so as to reduce the delay in producing key dataset returns.	Ron Constant has now left the employ of the Apira who are the incumbent implementation partners and has not documented his work sufficiently. The Apira configuration workstream lead who left in early November and has not been replaced did not document assessment form build priorities. The build of assessment forms will extend beyond T1 and T2 and, subject to agreement by EMT for the	31/01/2024 Ron Constant

		release of money, will be picked up by TAG whilst a skills transfer takes place	
	Delivery reports according to priority list to minimise the impact of disruptions	Rebuild has not been agreed by Trust Board @4th Jan 2024. Discussions requested with Mark Dundon (NED) and James Drury (Director of Strategy and Estates) prior to proposal being taken to FPC for approval	29/02/2024 Jack Baring

Total: 23