Sheffield Health and Social Care NHS Foundation Trust

Board of Directors – Public

Date: 10 March 2021 **Item Ref:** 16

TITLE OF PAPER	**Corporate Risk Register (CRR) and Risk Management**
TO BE PRESENTED BY	David Walsh, Director of Corporate Governance
ACTION REQUIRED	○ To receive information on the in-depth review of the Corporate Risk Register content which will commence imminently involving the Director of Improvement and the Director of Corporate Governance ○ To receive information on planned changes to the operational management of risk to be included in the revised Risk Management Strategy ○ To feedback on the draft Board Risk Appetite Statement following consideration at a Board Development session in February, for inclusion in the final Risk Management Strategy ○ To review the current Corporate Risk Register following its consideration by Board committees in the context of assurance and gaps arising.
OUTCOME	To have a Corporate Risk Register in place that provides assurance that corporate risks are regularly reviewed, monitored and managed. Risks have been reviewed at various levels and forums, including at the recent Performance Management Reviews, and it is anticipated that the in-depth review led by the Director of Improvement and Director of Corporate Governance will respond to some of the issues highlighted in that forum and others. The Risk Management Strategy will be presented to Audit and Risk Committee in April and this is an opportunity for Board to reflect on some of the proposed changes prior to the finalisation of that document.
TIMETABLE FOR DECISION	10 March 2021
LINKS TO OTHER KEY REPORTS / DECISIONS	Internal Audit Reports covering Risk Management arrangements Directorate Risk Registers Risk Management Strategy Trust Strategy
STRATEGIC AIM: **STRATEGIC OBJECTIVE:**	All All
LINKS TO NHS CONSTITUTION & OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	Provider Licence Annual Governance Statement NHS Foundation Trust Code of Governance
IMPLICATIONS FOR SERVICE DELIVERY AND FINANCIAL IMPACT	Implications of individual risks outlined on the register.

CONSIDERATION OF LEGAL ISSUES	Breach of SHSC Constitution Standing Orders Breach of NHS Improvement's Governance regulations and Provider Licence.

Author of Report	David Walsh
Designation	Director of Corporate Governance
Date of Report	3 March 2021

Sheffield Health and Social Care NHS Foundation Trust

SUMMARY REPORT

1. Purpose

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

2. Summary

2.1 Corporate Risk Register

The Corporate Risk Register is a mechanism to manage high level risks facing the organisation from a strategic, clinical and business risk perspective. The high level strategic risks identified in the CRR are underpinned and informed by risk registers overseen at the local operational level within Directorates. Risks are evaluated in terms of likelihood and impact using the 5 x 5 matrix where a score of 1 is a very low likelihood or a very low impact and 5 represents a very high likelihood or significant impact. This simple matrix is used to classify risks as very low (green), low (yellow), moderate (amber) or high (red).

1-4	Very Low Risk
5-8	Low Risk
9-12	Moderate Risk
15-25	High Risk

2.2 Review of risks

Ahead of the development and presentation of a revised Risk Management Strategy, the Director of Improvement has agreed to support the Director of Governance in revisiting existing risks to ensure consistency and to feedback to risk owners.

2.3 Risk Appetite Statement

Board considered risk at its Board Development session on 3 February 2021, and then at the Board Workshop on 10 February 2021 gave specific consideration to the Risk Appetite Statement in the context of the ongoing strategy development work. The first draft of the revised scoring is detailed in this report.

2.4 Risk Management Strategy

At the February meetings detailed above, some indication was given around process improvements proposed for the revised Risk Management Strategy. These are included for formal consideration in an open meeting within this report.

3. Corporate Risk Register

3.1 Corporate Risk Register Snapshot

Below is a snapshot of the risks on the CRR, ordered from top to bottom by current risk score, followed by initial risk score. The full detail of these risks can be found in the appendix.

It should be noted that the content will be subject to change following the in-depth review detailed elsewhere in the report, but this will be dealt with through the normal channels of reporting through Board and its committees.

Initial risk score			Current risk score			Target risk score		
Impact	Likelihood	Total	Impact	Likelihood	Total	Impact	Likelihood	Total
4121: There is a risk to patient safety, service efficiency and access to patient information as a result of Insight Instability. This includes instances of missing documentation in 2020, and the necessary report to the ICO.								
4	4	16	4	4	16	3	3	9
4409: There is a risk the Trust is unable to provide sufficient additional nursing/nursing associate placement capacity to meet demand caused by a combination of factors, combined with vacancies, skill mix challenges, and increased service demands could result in a failure to meet long term transformation targets and a shortage of nurses to meet identified recruitment shortages. This could impact on the Trust's reputation and ability to deliver existing and/or increased demand for services.								
4	4	16	4	4	16	2	3	6
3679: The inpatient environment cannot provide adequate assurance that risk is being managed and could result in patient safety incidents and harm.								
5	4	20	5	3	15	2	2	4
4284: Risk of further action being taken against the Trust if significant improvements are not made in the areas identified and outlined from the CQC during their well-led inspections.								
5	4	20	5	3	15	2	2	4
4325: Risk to Health & Safety of staff, service users and others due to a lack of access to a Back Care Advisor and Moving & Handling Training at all levels.								
4	4	16	3	5	15	2	2	4
4475: There is a risk that there are insufficient beds to meet service demand; caused by bed closures linked to the eradication of dormitories and ward refurbishment; resulting in a need to place service users out of city.								
3	5	15	3	5	15	2	2	4
4362: There is a risk that the Trust will be unable to provide safe patient care or protect the health and wellbeing of its workforce due to the pandemic Coronavirus (Covid-19) which will impact on all services, both clinical and corporate.								
5	5	25	4	3	12	2	2	4
4079: Failure to deliver an appropriately safe quality of waste management service due to the cessation of service delivery by the contracted company, following an assessment of their service by the Environment Agency, NHSi and NHSE. Clinical waste streams are particularly affected as general waste was sub-contracted to a different provider who can continue to deliver the service. This risk/incident is being managed nationally with affected Trusts expected to have contingency arrangements in place.								
4	5	20	4	3	12	2	2	4

4276: Risk of physical harm to service users due to lack of physical health checks following administration of rapid tranquilisation								
4	5	20	4	3	12	2	2	4
3831: There is a risk that a lack of band 5 and band 6 nurses will impact on the Trust's ability to deliver the required quality of care for its patients and an over-reliance on bank and agency staff and preceptorship nurses will affects the level of skills and experience on the ward and leadership.								
4	4	16	3	4	12	3	2	6
4124: Risk of harm to staff following incidents of violence and aggression causing harm which could impact on morale, sickness rates, staff attrition and difficulty in recruitment								
3	5	15	3	4	12	2	2	4
4326: Patient safety is at risk because key clinical systems that require planned maintenance (for security and licensing reasons) rely on IMST staff working out of hours when they are not contracted to do so, and are often the single point of failure when systems require downtime out of hours.								
4	3	12	3	4	12	2	2	4
4377: Failure to deliver the required level of CIP for 2020/21. This includes closing any b/f recurrent gap and delivering the required level of efficiency during the financial year 2020/21.								
3	4	12	4	3	12	3	3	9
4483: There is a risk that trust IT systems and data could be compromised as a result of members of staff providing personal credentials and information upon receipt of phishing emails received.								
3	4	12	3	4	12	3	2	6
4330: There is a risk at SPA that at times referral demand outstrips supply resulting in an inability to complete timely triage								
5	3	15	5	2	10	2	2	4
4407: There is a risk of fire on the acute wards caused by service users smoking or using lighters/matches to set fires resulting in harm to service users, staff and property/facilities								
5	4	20	3	4	9	2	2	4
4189: The Falsified Medicines Directive (FMD) comes into force on 09/02/2019. SHSC NHS Foundation will not be compliant with the legislation as at this date due to concerns about the EU Exit strategy and ready availability of the necessary software with the upgrade to the JAC system								
3	5	15	3	3	9	2	2	4
4078: Low staff engagement which may impact on the quality of care, as indicated by the Staff Surveys 2018 & 2019								
3	4	12	3	3	9	2	3	6
4140: There is the possibility of an issue with supply of medication after the contingency plans put in place by the UK Government for EU exit resulting in a gap in medication supply to our service users. This is due to the uncertainty regarding the UK plans for leaving the EU								
3	4	12	3	3	9	2	2	4
4264: Failure to meet the contractual requirements set down by NHS Sheffield CCG (NHSSCCG) for conducting and completing complaints within given timescales may result in a reduced quality of service to complainants and a reduction in NHSSCCG's business confidence in the Trust.								
4	4	16	3	2	6	3	1	3

4396: The change in funding regime as a result of the COVID-19 crisis is a threat to the Trust's financial sustainability, in the short to medium term for BAU and to the Trust's current investment/transformation strategies for capital and revenue projects over the longer term. The current funding envelope is less than planned expenditure and whilst this is being met centrally in the short-term there is no certainty over funding beyond Aug '20.								
3	4	12	3	2	6	3	1	3

3.2 Closed Risks

No risks were recommended for closure when considered by Audit and Risk Committee on 19 January 2021, Finance and Performance Committee on 25 January 2021, People Committee on 28 January 2021 or Quality Assurance Committee on 22 February 2021.

3.3 Reduced and/or Escalated Risks

Quality Assurance Committee approved the de-escalation of Risk 4264, in relation to compliance with contractual requirements around the management of complaints, is de-escalated from the Corporate Risk Register and managed locally.

Following the approval of a new Complaints Policy and the adoption of new arrangements for the management of complaints from 1 October 2021, there has been an immediate improvement in performance. During Quarter 3, 91% of complaints were responded to within 25 working days of receipt. The current risk score has been reduced to '6', which is deemed to be low risk and falls well beneath the normal threshold for inclusion in the Corporate Risk Register.

The risk is included in the appendix for completeness but will be removed following ratification by Board.

Please note, the current risk score for Risk 4407, in relation to fire on acute wards, has reduced from 12 to 9, although this review took place after the production of the paper for the Quality Assurance Committee so has not been reported through the committee. It is, however, accounted for in the table at section 3.1 and within the appendix.

3.4 New Risks

Two new risks were added during the committee round, Risk 4475 (relating to bed capacity to meet demand) falls under the remit of Quality Assurance Committee and Risk 4483 (relating to Trust IT systems being compromised) falls under the Audit and Risk Committee.

3.5 Risk profile

The table below shows the spread of risks on the corporate risk register and indicates a movement towards a greater number of higher risks.

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

4. Risk Appetite Statement

4.1 Discussion at Board Workshop

The current Risk Appetite Statement, agreed in February 2020, is detailed in the report on the Board Assurance Framework.

As part of the workshop on 10 February 2020, Board discussed Risk Appetite (that which we are open to take as part of our strategy) in the context of Risk Tolerance (that which we accept we take as part of our business.

4.2 Safety (of patients, staff or public) and Statutory (duties and compliance)

It was accepted that the existing 'zero' appetite for risks in these areas was still reflected.

4.3 Quality (of care and services) and Workforce (capability and capacity, culture)

It was accepted that the existing 'low' appetite for risks in these areas was still reflected.

4.4 Reputation (with public, partners, regulators, commissioners)

The existing risk appetite in this area was documented as 'moderate'. There was view given the journey the organisation had been on that more caution was required in this area as we look to rebuild our reputation through the improvements made in the last year. The risk appetite was now generally considered to be 'low', although there may be situations when it was important to the strategic direction of the organisation that 'moderate' risks would be acceptable.

4.5 Business (objectives and projects)

The existing risk appetite in this area was documented as 'moderate'. This was generally maintained, although it was felt there may be situations when it was important to the strategic direction of the organisation that 'high' risks would be acceptable.

4.6 Finance (investment and revenue costs)

The existing risk appetite in this area was documented as 'moderate'. There was uncertainty whether this reflected conversations around the organisation's financial position, and it was proposed that a 'low' risk appetite would be more suitable.

4.7 Environmental (risk to us from environmental factors or to environment caused by us)

The existing risk appetite in this area was documented as 'zero'. While it was felt this remained the case in relation to our working environments, in the context of improvements to Estates, it was felt that in terms of wider environmental risks a 'low' risk appetite would be more appropriate.

Board is invited to further feedback on these findings, within the meeting or otherwise, in advance of the Risk Management Strategy being further developed.

5. Risk Developments / Risk Management Strategy

The Risk Management Strategy is proposed for presentation to Audit and Risk Committee in April, and to Board thereafter. Among the proposals for inclusion, presented now for information and initial feedback within the meeting or otherwise, are:

- Monthly reporting alongside the BAF to increase visibility and awareness, ensure more up-to-date registers exist and build around refreshed committee process;
- Review of scoring thresholds to ensure reflective of Risk Appetite Statement and consistently applied;
- Establishment of easy-to-read register to be viewed alongside existing detailed appendix;
- Establishment of Risk Oversight Group (as detailed in the separate report on Committee governance) to sit below and report into Audit and Risk Committee, for quality control, compliance and to promote consistency;
- Training to be rolled out led by new Corporate Assurance Team;
- New process to be established to ensure consistent and regular reviewing of risks; and
- Maximum review date on Ulysees to be reduced from 90 days to 30 days.

6. Next Steps

As detailed in the report.

7. Required actions

As detailed on the front page of the report.

8. Monitoring Arrangements

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

9. Contact Details

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

As at: March 2021

Risk No. 3679 v.7 BAF Ref: BAF.0003	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee
Version Date: 24/02/2020	Directorate: Crisis & Emergency Care	Last Reviewed: 25/02/2021
First Created: 29/12/2016	Exec Lead: Executive Medical Director	Review Frequency: Monthly

Details of Risk:

The inpatient environment cannot provide adequate assurance that risk is being managed and could result in patient safety incidents and harm.

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

CONTROLS IN PLACE

- Policies and standard operating procedures are embedded, including: ligature risk reduction (which now includes blind spots), observation, risk management including DRAM and seclusion policy.
- Individual service users are risk assessed - DRAM in place and enhanced observations mobilised as required.
- 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.
- Routine programme of updating equipment to latest anti-ligature fixtures and fittings.
- Staff receive clinical risk training, including suicide prevention and RESPECT and all ligature incidents are reviewed.
- CQC MHA oversight (visits, report and action plans)
- Mental Health Legislation Committee with oversight of compliance in relation to seclusion facilities
- A Standard Operating Procedure is embedded which describes an elevated level of medical oversight/review when a service user requires seclusion.
- Nurse alarm system in place at Forest Lodge and Maple Ward
- Contemporaneous record keeping is supported by standard operating procedures to monitor changes in the needs and risks of service users.

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

Progress with design and tender for capital works to remove dormitories. This is a long term project due to take 12 months until completion.	Work commenced on Dovedale and Maple August 2020	30/06/2021 Geoffrey Rawlings
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.	Estates have undertaken and completed a review of access to ceiling space and identified that: existing ceiling tiles cannot be secured in all ensuites apart from recently refurbished anti lig rooms(these have solid ceilings). Option under consideration is removal of ceiling tiles and replacement with solid ceiling. For Burbage and Stanage this would be included in planned refurbishment	31/10/2020 Mark Gamble

• Business continuity plans in place during Covid-19 pandemic to minimise use of surge bed and maximise flow through alternative step-down routes. • Paper based physical health reviews are embedded into practice and audited through a daily situation report. • Dormitories are not in use across all inpatient environments (to be removed as part of estates strategy)		work. Plan to be developed for Maple and Dovedale 1.	
	Estates to review and establish where flat-sided thumb turn locks are sited and replace with safer alternatives.	Review undertaken by Estates. Burbage - round Stanage - round Dovedale 1 - round. Maple only acute ward with flat side thumb turns - 12 identified. Replacement of thumb turns could impact on integrity of fire door hence replacement of doors preferred option. Plan under development.	31/10/2020 Mark Gamble
	Estates required to review and replace window frames which pose a ligature risk.	To be scheduled within the ward redevelopment programme. Plan under development.	30/11/2020 Mark Gamble
	Bins in inpatient areas to be replace further to risk identified in relation to metal risers (bins in service user areas already removed).	Assurance sought from Kim Tissington	28/02/2021 Khatija Motara

Risk No. 3831 v.17 BAF Ref: BAF.0005	Risk Type: Workforce / Risk Appetite: Low	Monitoring Group: People's Committee
Version Date: 09/02/2021	Directorate: Crisis & Emergency Care	Last Reviewed: 09/02/2021
First Created: 04/09/2017	Exec Lead: Executive Director - Nursing & Professions	Review Frequency: Monthly

Details of Risk:

There is a risk that a lack of band 5 and band 6 nurses will impact on the Trust's ability to deliver the required quality of care for its patients and an over-reliance on bank and agency staff and pre-ceptorship nurses will affects the level of skills and experience on the ward and leadership.

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

CONTROLS IN PLACE

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

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

Recruitment and retention action plan in place (developed by Rapid Cell) and in the process of being delivered.	31/03/2021 Brenda Rhule

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

Risk No. 4078 v.11 BAF Ref: BAF.0005	Risk Type: Workforce / Risk Appetite: Low	Monitoring Group: People's Committee
Version Date: 15/01/2021	Directorate: Organisational Development	Last Reviewed: 18/01/2021
First Created: 26/10/2018	Exec Lead: Director Of Human Resources	Review Frequency: Quarterly

Details of Risk:

Low staff engagement which may impact on the quality of care, as indicated by the Staff Surveys 2018 & 2019

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

CONTROLS IN PLACE

- Leadership Engagement Network
- Listening into Action principles established (Part of wider staff Engagement and Experience approach moving forward)
- Key areas identified within the themes for action and presented to People Committee, Quality Assurance Committee, Clinical Services (SDG) for oversight on progress. Specific action areas have been identified against each theme.
- Established Organisation Development team which includes staff engagement and experience.
- Regular communication with staff via 'Connect' demonstrating the actions taken by Trust in response to LIA feedback.
LiA sponsor group established and meets weekly
- Staff engagement measures identified and reviewed including:
- Increase in number of staff completing the staff survey 36%-40% - 41% 2020
- Trust has 50 LiA champions
- Significant number of staff responded to LiA initiatives
- Number of staff in BME staff network continue to increase (currently approx. 50)
- Lived experience group has around 20 members
- Bullying and Harrasment drop in sessions delivered across Trust sites.
Twenty delivered as of July 2020. These sessions gather rich and qualitative information to inform action planning

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

Organisation Development Strategy to be developed.	Aligning Draft OD Enabling strategy with People Strategy and Delivery Plan	31/03/2021 Rita Evans
Reviewing the Staff Survey engagement leads roles (ROI)	posts in place and ongoing review of need and ROI	31/03/2021 Rita Evans

- 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)
- Development of local action planning to support staff engagement with dedicated OD resource working with service leads

Risk No. 4079 v.4 BAF Ref: BAF.0003	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee
Version Date: 03/02/2021	Directorate: Facilities	Last Reviewed: 02/03/2021
First Created: 26/10/2018	Exec Lead: Executive Director Of Finance	Review Frequency: Monthly

Details of Risk:

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

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	4	5	20
Current Risk: (with current controls):	4	3	12
Target Risk: (after improved controls):	2	2	4

CONTROLS IN PLACE

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

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

PHS are continuing to provide the new clinical waste collection service. However further teething problems have emerged. The service continues to experience delivery problems and requires frequent intervention from the local waste management lead. There are significant issues with invoicing as we will not sign off on payments we believe to be incorrect. Support from the centre is being withdrawn.	Trust has changed to a new sub-contractor. Very early days and will be assessing their performance. No issues to date.	31/03/2021 Helen Payne

Risk No. 4121 v.13 BAF Ref: BAF.0007	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Finance & Performance Committee
Version Date: 22/02/2021	Directorate: IMS&T	Last Reviewed: 11/02/2021
First Created: 13/12/2018	Exec Lead: Executive Director Of Finance	Review Frequency: Monthly

Details of Risk:

There is a risk to patient safety, service efficiency and access to patient information as a result of Insight Instability.
This includes instances of missing documentation in 2020, and the necessary report to the Information Commissioners Office.

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	4	4	16
Current Risk: (with current controls):	4	4	16
Target Risk: (after improved controls):	3	3	9

CONTROLS IN PLACE

- Newly purchased tools allow active monitoring of the underlying infrastructure. Spikes in activity on the servers which affect the performance and stability will be addressed as soon as they are identified.
- Improved backup infrastructure in place which allow improved recovery time. Hourly snapshots of data in place meaning data older than an hour is not lost.
- View only access to emergency INSIGHT available should the live system fail.
- Ongoing programme of server patching to ensure optimum performance and security of the infrastructure on which INSIGHT sits.
- There is an increase in the frequency of file logging to identify loss of data at the earliest stage.
- Hide Insight documents in scanned documents folder to reduce change of further missing files.
- Business continuity complete in preparation for the weekend upgrade. Offline folders with supporting templates created led by the CCIO. Link added to Emergency Insight to direct staff to the folder for appropriate clinical noting while INSIGHT is down.

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

Software development roadmap to limit non-essential developments to the system which could cause instability.	20/02/2021 Ben Sewell
Business case for required resources to maintain Insight for an extended period of time due to delays with EPR replacement programme now required.	27/02/2021 Ben Sewell

Risk No. 4124 v.3 BAF Ref: BAF.0005	Risk Type: Workforce / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee
Version Date: 23/09/2019	Directorate: Crisis & Emergency Care	Last Reviewed: 25/02/2021
First Created: 20/12/2018	Exec Lead: Executive Director - Operational Delivery	Review Frequency: Monthly

Details of Risk:

Risk of harm to staff following incidents of violence and aggression causing harm which could impact on morale, sickness rates, staff attrition and difficulty in recruitment

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	3	5	15
Current Risk: (with current controls):	3	4	12
Target Risk: (after improved controls):	2	2	4

CONTROLS IN PLACE

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

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

Maintaining appropriate levels of Respect training	Current levels of Respect are in line with Trust targets	31/03/2021 Khatija Motara
Annual Clinical Establishment Review to be conducted by Head of Nursing to ensure safe staffing against evidence based research.		01/10/2021 Emma Highfield

Risk No. 4140 v.1 BAF Ref: BAF.0003	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee
Version Date: 21/01/2019	Directorate: Medical	Last Reviewed: 24/12/2020
First Created: 21/01/2019	Exec Lead: Executive Medical Director	Review Frequency: Quarterly

Details of Risk:

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

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

CONTROLS IN PLACE

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

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

Risk No. 4189 v.2 BAF Ref: BAF.0007	Risk Type: Statutory / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee
Version Date: 22/11/2019	Directorate: Medical	Last Reviewed: 24/12/2020
First Created: 01/04/2019	Exec Lead: Executive Medical Director	Review Frequency: Quarterly

Details of Risk:

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

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

CONTROLS IN PLACE

- The Trust has approved the purchase of the upgraded JAC system which has FMD compliance.
- There is a concern that if the UK leaves without a deal, the FMD will no longer be applicable in the UK
- Embedded practice to check on a fortnightly basis the validity of suppliers in the chain for medicines (Whole Dealers Licence).

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

An order for the upgraded JAC system compliant with the FMD has been placed/ When available it will be fully tested following which the JAC system will be upgraded.	V2019 will be considered in the Autumn 2020. This will need to be factored in with IMST and dependent on the EU exit agreement term with respect to access to the database	30/11/2020 Abiola Allinson
Continued access to the database is one of the critical aspects to this risk. This is dependent on the agreed terms of exiting the EU		31/12/2020 Abiola Allinson

Risk No. 4264 v.4 BAF Ref: BAF.0002	Risk Type: Business / Risk Appetite: Moderate	Monitoring Group: Quality Assurance Committee
Version Date: 03/03/2021	Directorate: Corporate Governance	Last Reviewed: 17/01/2021
First Created: 05/09/2019	Exec Lead: Director Of Corporate Governance	Review Frequency: Quarterly

Details of Risk:

Failure to meet the contractual requirements set down by NHS Sheffield CCG (NHSSCCG) for conducting and completing complaints within given timescales may result in a reduced quality of service to complainants and a reduction in NHSSCCG's business confidence in the Trust.

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	4	4	16
Current Risk: (with current controls):	3	2	6
Target Risk: (after improved controls):	3	1	3

CONTROLS IN PLACE

- Internal governance processes in place to ensure effective oversight of performance and compliance, including quarterly report to QAC, reports to Board via significant issues report.
- Quarterly Quality Review Group provides external scrutiny and oversight of performance via agreed action plan which includes a trajectory for incremental improvement in achievement of targets for complaints and fastracks.
- All 'backlog' complaints completed and system now working in 'real time'. Compliant by end of Q1 as required under CCG action plan.
- Internal Audit Advisory Report completed Oct 2019 highlighting good practice and identifying further actions which have been incorporated into the action plan. Due for completion by end of October 2020
- Lean processes in place for complaints, FOIs and compliments which will improve internal systems of control. Further changes agreed with effect from 1 October 2020.
- Backlog Fastracks cleared and Fastrack process ceased from 1 October 2020
- New process for processing complaints resulted in 91% response rate within timescales of measurable complaints during Q3.

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

Skill mix review confirmed Complaints Manager at band 7 to be recruited substantively	Job readvertised in Dec 2020 and interviews took place on 8 Jan 2021. Candidate selected and pre-employment checks commenced.	29/01/2021 David Walsh

Risk No. 4276 v.3 BAF Ref: BAF.0003	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee
Version Date: 27/05/2020	Directorate: Crisis & Emergency Care	Last Reviewed: 08/12/2020
First Created: 04/10/2019	Exec Lead: Executive Director - Operational Delivery	Review Frequency: Monthly

Details of Risk:

Risk of physical harm to service users due to lack of physical health checks following administration of rapid tranquilisation

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	4	5	20
Current Risk: (with current controls):	4	3	12
Target Risk: (after improved controls):	2	2	4

CONTROLS IN PLACE

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

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

Finalise IT tool (NEWS2), initiate training and roll out and update of local Standard Operating Procedures to reflect the change.	Server has now been successfully upgraded, NEWS2 is currently in a pilot phase on Stanage ward. Wider roll out will progress once clinical safety case in place. Daily sit rep monitors compliance with physical health checks following rapid tranquilization.	31/01/2021 Christopher Wood
Development of an IT based system to support accurate recording and data gathering of all physical health checks following rapid tranquilisation.	Development is been reviewed to identify a way forward. As an interim measure Activity codes and TAGS have been incorporated into the system enabling recording of restrictive	31/01/2021 Christopher Wood

interventions in to insight. To be trialed on Maple before wider implementation. Associated reports to give assurance are being designed. Current compliance assured through daily sit rep

Risk No. 4284 v.6 BAF Ref: BAF.0002	Risk Type: Statutory / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee
Version Date: 01/07/2020	Directorate: Medical	Last Reviewed: 09/02/2021
First Created: 12/11/2019	Exec Lead: Executive Director - Operational Delivery	Review Frequency: Monthly

Details of Risk:

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

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

CONTROLS IN PLACE	ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON		
• Physical Health Improvement Group reconstituted with Executive Director leadership and direction, enabling a focused remit on physical health monitoring, including post restrictive intervention and enabling changes in clinical practice. • Business case approved regarding Forest Close (bungalow 3). However work has been suspended due to the bungalow being used as an isolation unit during Covid 19.	Implement improvement action plan once developed.	Action plan submitted to the CQC 290520, in line with required timescales. Target date now amended to reflect actions set out within submitted plan.	31/03/2021 Andrea Wilson
• Monitoring of progress on required actions through Back to Good Board with monthly reporting and exception reporting to Board in place. • Daily monitoring of physical health checks and staffing undertaken and reported into lead executive. • PMO approach to improvement workstreams established with leadership agreed for each workstream.	Nurse call system to be installed in remaining inpatient areas.	Rollout of installation delayed due to staffing capacity as a result of Covid-19. Timescales to be reviewed.	31/10/2020 Helen Payne
• Nurse call and staff attack system in place and operational at Forest Lodge. • Supervision rates at reaching target level (80%) • Mandatory training meeting compliance rates • Weekly Improvement Dashboards established, initially developed from monitoring of Section 29A, continuing to monitor training, staffing, supervision but additional subjects added such as Flue Vaccination. • Monthly reporting of progress to the Quality Committee for assurance	Refurbishment of Bungalow 3 to be completed	Work halted due to need to use Bungalow 3 as a isolation unit during Covid-19 pandemic. Timescale extended	31/10/2020 Helen Payne

purposes.	Actions being undertaken in line with action plan and progress reported through Back to Good Board.	31/07/2021 Andrea Wilson

Risk No. 4325 v.3 BAF Ref: BAF.0003	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: People's Committee
Version Date: 24/03/2020	Directorate: Central Clinical Operations	Last Reviewed: 23/02/2021
First Created: 09/01/2020	Exec Lead: Executive Director Of Finance	Review Frequency: Monthly

Details of Risk:

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

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

CONTROLS IN PLACE

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

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

Implement recruitment processes for Back Care Advisor	Moving & Handling Back Care Advisor post to be re-advertised January 2021 with a view to interviews early March.	30/06/2021 Anita Winter
All Key Trainers to develop an action plan detailing how they will achieve 85% compliance for their staff team	Moving and Handling Training compliance for the Trust a s at 16 December 2020 is as follows: 93.96% for Level 1 81.22% for Level 2	31/03/2021 Anita Winter

Risk No. 4326 v.4 BAF Ref: BAF.0004	Risk Type: Quality / Risk Appetite: Low	Monitoring Group: People's Committee
Version Date: 26/01/2021	Directorate: IMS&T	Last Reviewed: 30/10/2020
First Created: 09/01/2020	Exec Lead: Executive Director Of Finance	Review Frequency: Quarterly

Details of Risk:

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

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

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

CONTROLS IN PLACE

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

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

Risk No. 4330 v.3 BAF Ref: BAF.0004	Risk Type: Quality / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee
Version Date: 24/04/2020	Directorate: Crisis & Emergency Care	Last Reviewed: 19/01/2021
First Created: 09/01/2020	Exec Lead: Executive Director - Operational Delivery	Review Frequency: Quarterly

Details of Risk:

There is a risk at SPA that at times referral demand outstrips supply resulting in an inability to complete timely triage.

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

CONTROLS IN PLACE

- Triage of all referrals establishing risk, urgency and priority
- Nurse Consultant supports the team
- Alternative assessment provision available i.e. Decisions Unit, Liaison
- Call Centre Manager appointed
- Customer Service Improvement Programme Manager in post
- New leadership team in place.
- Standardised service offer (customer service improvement programme)
- New consultant in post (Apr 20).
- To manage increased demand, staff have been diverted from other functions to support SPA
- Mobilised 24/7 increased capacity to support staff and service users during Covid-19 pandemic.
- Weekly review of SPA demand and staff activity

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

Reviewing demands linked to recovery/surge capacity requirements during Covid-19 which will inform workforce requirements post Covid-19.	Demand reviewed through the team performance review. Good evidence of waiting times coming down. Good recruitment of staff also supporting the service function under COVID-19 pressures.	28/02/2021 Michelle Fearon

CORPORATE RISK REGISTER

As at: March 2021

Risk No. 4362 v.4 BAF Ref: BAF.0001	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Board Of Directors
Version Date: 06/11/2020	Directorate: Trust Board	Last Reviewed: 03/02/2021
First Created: 24/03/2020	Exec Lead: Executive Director - Operational Delivery	Review Frequency: Monthly

Details of Risk:

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

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

CONTROLS IN PLACE

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

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

Review of Trust Estate and Digital means to support staff to comply with social distancing in the workplace	IMST equipment being rolled out as delivered. Work has commenced on site at NGH with expected completion of end of March 2021.	31/03/2021 Anita Winter
Completion of COVID Risk Assessments for all staff	92% of staff have now had an updated risk assessment. Targeted work continues with individuals and line managers to complete outstanding. Weekly compliance shared with silver and gold.	26/02/2021 Caroline Parry
Ensure audit and compliance with Inpatient Testing Guidance following gaps in assurances identified in September 2020 audit.	Roll out of testing codes across all inpatient sites has taken place. Daily monitoring continues via sitrep calls. Weekly	05/03/2021 Beverley Murphy

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

monitoring of compliance via Silver to understand further support needs. Heads of Service continuing to review through BAU governance arrangements.

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

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

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

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

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

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

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

Risk No. 4377 v.1 BAF Ref: BAF.0006	Risk Type: Financial / Risk Appetite: Moderate	Monitoring Group: Finance & Performance Committee
Version Date: 24/04/2020	Directorate: Finance	Last Reviewed: 18/01/2021
First Created: 24/04/2020	Exec Lead: Executive Director Of Finance	Review Frequency: Monthly

Details of Risk:

Failure to deliver the required level of CIP for 2020/21. This includes closing any b/f recurrent gap and delivering the required level of efficiency during the financial year 2020/21.

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

CONTROLS IN PLACE

- Trust Business Planning Systems and Processes, Including CIP monitoring, QIA and Executive oversight.
- Forms part of routine finance reporting to FPC, Board and NHSE/I
- Performance Management Framework
- Additional transformation and cost reduction objectives. Procurement led savings, agency reduction and control.

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

Continue to close b/f CIP gaps from 2019/20 which were only met non recurrently within the directorates or not met at all at the Directorate level but offset from wider Trust overperformance	Directorates continue to work on closing the CIP recurrent gap but this is being linked into 21/22 planning given the impact on Covid	31/03/2021 James Sabin
Continue to plan for the efficiency requirement for August to March. Utilise the time to develop plans and achieve sign off for the appropriate QIA.	Progress on CIP identification has stalled linked to responding to Covid. This is being fed into planning for 21/22	31/03/2021 James Sabin
Review benchmarking and productivity data to help inform further areas to focus on re driving efficiency and VFM.	In final stages of redefining TOG ToRs under BPG.	31/03/2021 James Sabin

Risk No. 4396 v.4 BAF Ref: BAF.0007	Risk Type: Financial / Risk Appetite: Moderate	Monitoring Group: Finance & Performance Committee
Version Date: 18/01/2021	Directorate: Finance	Last Reviewed: 18/01/2021
First Created: 01/06/2020	Exec Lead: Executive Director Of Finance	Review Frequency: Quarterly

Details of Risk:

The change in funding regime as a result of the COVID-19 crisis is a threat to the Trust's financial sustainability, in the short to medium term for BAU and to the Trust's current investment/transformation strategies for capital and revenue projects over the longer term. The current funding envelope is less than planned expenditure and whilst this is being met centrally in the short-term there is no certainty over funding beyond Aug '20.

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	3	4	12
Current Risk: (with current controls):	3	2	6
Target Risk: (after improved controls):	2	4	8

CONTROLS IN PLACE

- Financial reporting of; the underlying financial position, funding gaps against revised regime and monitoring of COVID-19 expenditure is taking place through the routine Finance report.
- Communications with Commissioners around LTP & MHIS investment and developing the new normal continue despite the temporary regime
- Finance staff are linked into the appropriate intelligence cells, intel shared through Silver and Gold command where appropriate.
- Direct Costs of COVID-19 response are being managed through a separate cost centre to maintain transparency and financial probity; significant finance decisions are being made via Silver and Gold command, and necessary QEIA are completed where appropriate.
- Direction of expenditure to be monitored in line with the anticipated trend highlighted by NHSE/I.
- The Capital Programme is being managed within the reduced financial remit mandated by the STP in response the COVID-19 crisis; this is being routinely reported via Capital Board and the monthly Financial Report.

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

Risk No. 4407 v.2 BAF Ref: BAF.0003	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee
Version Date: 25/02/2021	Directorate: Crisis & Emergency Care	Last Reviewed: 25/02/2021
First Created: 18/06/2020	Exec Lead: Executive Director - Operational Delivery	Review Frequency: Monthly

Details of Risk:

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

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

CONTROLS IN PLACE

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

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

Commence daily safety huddles on ward areas to raise fire safety risks	Inconsistent compliant safety huddles. Further work needed to embed safety huddles.	31/03/2021 Khatija Motara
Explore positioning of scanners with estates for MCC and Maple areas	The work for the lobby has gone in, awaiting for the Contractors to inform us of a start date for the work. However, there has been a delay with the order and Estates are following this up with the Contractor.	28/02/2021 Naomi Hebblewhite

Risk No. 4409 v.11 BAF Ref: BAF.0005	Risk Type: Workforce / Risk Appetite: Low	Monitoring Group: People's Committee
Version Date: 20/01/2021	Directorate: Nursing & Professions	Last Reviewed: 23/02/2021
First Created: 19/06/2020	Exec Lead: Executive Director - Nursing & Professions	Review Frequency: Monthly

Details of Risk:

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

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

CONTROLS IN PLACE	ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON		
• Prepare registered staff Band 5 and above to act in the role of practice supervisor to support placements . update 180820 - online training sessions in place. staff without mentorship qualification to join SHU course in September 20	consider the use of community staff to support in patient practice placements	due to ongoing capacity and operational challenges the date for this action has been reviewed and moved to 30/06/21	30/06/2021 Andrew Algar
• Additional resource in practice placement team (ETD) to provide peripatetic assessment. update 180820 - complete: 3 days a week resource now back in place in PQF team following Covid absence and 3hours per week practice support at endcliffe ward. • All registered nurses now have responsibility for supporting student learning.	Development of online resources (MYePAD) by Sheffield Hallam University and Midlands and Yorkshire placement Partnership to support in house training. in house training needs development using CPD resources.		31/03/2021 Andrew Algar
update - decision made by DNO • 15 staff registered for mentor preparation training at SHU • Project leads in place to implement placement expansion in Learning Disabilities	Working with the SYB ICS Learning Environment and Placement Expansion consortium we will be completing a Trust Capacity Modelling exercise which should		31/03/2021 Andrew Algar

• Reduced placement time for some cohorts of students to enable all students to get some placement time in line with agreement in LEAP consortium • Active member of the new South Yorkshire and Bassetlaw's Learning Environment and Placement (LEAP) Consortia. The aims are to meet practice placement requirements and to identify and remove barriers.	identify areas across the organisation where there is potential to expand placement capacity. Andy is looking to procure online training for supervisors and assessors to improve compliance with clinical staff being able to do the training as and when rather than to set dates and times. Julie Sheldon is reviewing all data in relation to placement audit/capacity and will work with LEMs to understand barriers to taking students in numbers audited to take	31/03/2021 Andrew Algar 23/02/2021 Julie Sheldon

CORPORATE RISK REGISTER

As at: March 2021

Risk No. 4475 v.2 BAF Ref:	Risk Type: Safety / Risk Appetite:	Monitoring Group:
Version Date: 27/10/2020	Directorate: Crisis & Emergency Care	Last Reviewed: 25/02/2021
First Created: 23/10/2020	Exec Lead: Executive Director - Nursing & Professions	Review Frequency: Monthly

Details of Risk:

There is a risk that there are insufficient beds to meet service demand; caused by bed closures linked to the eradication of dormitories and ward refurbishment; resulting in a need to place service users out of city.

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	3	5	15
Current Risk: (with current controls):	3	5	15
Target Risk: (after improved controls):	0	0	0

CONTROLS IN PLACE

- Clinical Director/Head of Service approval required to authorise out of area bed within hours. Executive Approval required out of hours to ensure exhaustion of local provision.
- OOC placements sought via Flow coordinators to meet service users need
- HTT actively manage repatriation
- Revised clinical model brings shared ownership across inpatient and community services to manage local bed base.
- Daily operational and clinical leadership oversight of patient flow to and from out of area placements.

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

Explore and agree contingency plans which enables service users to be cared for as close to home as possible	Ongoing work with reduction in length of stay. Winter pressures money identified for alternative to hospital admission. Work started on the purposeful admission project. Agreement with provider in Harrogate for overflow beds is being negotiated	31/03/2021 Richard Bulmer
Trust approval through the Quality Committee and Financial Management Group in February to procure 6 OOA acute beds and 3 OOA PICU beds on a block contract basis. Procurement exercise to be progressed and completed by end of April.		30/04/2021 Khatija Motara

Purposeful Inpatient Admission Model to be developed with collaboration across inpatient and community services.	31/05/2021 Kate Oldfield
Crisis Home Treatment and Resolution Service to be developed with investment from Sheffield Clinical Commissioning Group to include gatekeeping function for all inpatient admissions.	30/09/2021 Sarah Roberts-Morris

CORPORATE RISK REGISTER

As at: March 2021

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

Details of Risk:

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

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

CONTROLS IN PLACE

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

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

Phishing marketing campaign to raise awareness of phishing attacks and how to respond and help prevent and protect data and information.	26/02/2021 Ben Sewell
Communications in progress with key messages.	31/03/2021 Andrew Male