

Board of Directors Public

SUMMARY REPORT

Meeting Date: 20 July 2021

Agenda Item: 25

Report Title:	Corporate Risk Register		
Author(s):	David Walsh, Director of Corporate Governance		
Accountable Director:	David Walsh, Director of Corporate Governance		
Other Meetings presented to or previously agreed at:	Committee/Group:	Finance and Performance Committee, Quality Assurance Committee, Audit and Risk Committee	
	Date:	14-20 July 2021	
Key Points recommendations to or previously agreed at:	The Corporate Risk Register has been reviewed by three out of four committees. It will be presented to People Committee, and others, during the next round of meetings. There has been one significant score increase (Risk 4330) and four risks and recommended for de-escalation.		

Summary of key points in report

The Corporate Risk Register is a mechanism to manage high level risks facing the organisation from a strategic, clinical and business risk perspective. The high level strategic risks identified in the CRR are underpinned and informed by risk registers overseen at the local operational level within Directorates.

Recommendation for the Board/Committee to consider:

Consider for Action		Approval	X	Assurance	X	Information	
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- To receive the Corporate Risk Register and note changes, specifically the increased score in relation to Risk 4330;
- To approve the de-escalation of Risks 4079, 4140, 4189 and 4407 following consideration of this action by Quality Assurance Committee;
- To note that one new risk has been added since the commencement of this reporting cycle (Risk 4615), which is included in the appendix.

Please identify which strategic priorities will be impacted by this report:

Covid-19 Getting through safely	Yes	X	No	
CQC Getting Back to Good	Yes	X	No	
Transformation – Changing things that will make a difference	Yes	X	No	
Partnerships – working together to make a bigger impact	Yes	X	No	

Is this report relevant to compliance with any key standards ?					State specific standard
Care Quality Commission	Yes	X	No		"Systems and processes must be established to ensure compliance with the fundamental standards"
IG Governance Toolkit	Yes		No	X	
Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Patient Safety and Experience	Yes		No	X	Not directly in relation to this report – specific detail within the BAF for each area
Financial (revenue & capital)	Yes		No	X	
OD/Workforce	Yes		No	X	
Equality, Diversity & Inclusion	Yes		No	X	
Legal	Yes		No	X	

Section 1: Analysis and supporting detail

Background

- 1.1 Risks are evaluated in terms of likelihood and impact using the 5 x 5 matrix where a score of 1 is a very low likelihood or a very low impact and 5 represents a very high likelihood or significant impact. This simple matrix is used to classify risks as very low (green), low (yellow), moderate (amber) or high (red).
- 1.2 The aim is to draw together all high level operational risks that the Trust faces on a day-to-day basis, risks that cannot be controlled within a single directorate/care network or that affect more than one directorate/care network, and record those onto a composite risk register thus establishing the organisational risk profile. All risks which reach a residual score of 12 should be escalated.

Corporate Risk Register Snapshot

- 1.3 Below is a snapshot of the risks, ordered from top to bottom by current risk score, followed by initial risk score. The full detail of these risks can be found in the appendix. Following feedback from internal audit, an indicative arrow has been added to the right of the table to show whether the risk has remained the same, increased or decreased.
- 1.4 Changes and proposed changes to risks are described in the subsequent paragraphs.

1.5

Initial risk score			Current risk score			Target risk score		
Impact	Likelihood	Total	Impact	Likelihood	Total	Impact	Likelihood	Total
4409: There is a risk the Trust is unable to provide sufficient additional nursing/nursing associate placement capacity to meet demand caused by a combination of factors, combined with vacancies, skill mix challenges, and increased service demands could result in a failure to meet long term transformation targets and a shortage of nurses to meet identified recruitment shortages. This could impact on the Trust's reputation and ability to deliver existing and/or increased demand for services.								
4	4	16	4	4	16	3	2	6
3679: There is a risk to patient safety arising from the quality and safety of the ward environments across SHSC hospital sites, including access to ligature anchor points.								
5	4	20	5	3	15	2	2	4
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
4330: There is a risk that service users cannot access secondary mental health services through the Single Point of Access within an acceptable waiting time due to an increase in demand and insufficient clinical capacity.								

5	4	20	5	3	15	2	2	4
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. 								
4	5	20	3	5	15	3	2	6
4121: There is a risk to patient safety, caused by key clinical documents being deleted, resulting in clinical decisions being made with incomplete or limited information and potential delays to patient treatment, e.g. missed appointments. 								
4	5	20	3	5	15	1	4	4
4362: There is a risk that the Trust will be unable to provide safe patient care or protect the health and wellbeing of its workforce due to the pandemic Coronavirus (Covid-19) which will impact on all services, both clinical and corporate. 								
5	5	25	4	3	12	2	2	4
4276: There is a risk of physical harm to service users due to an absence of physical health monitoring, in accordance with the physical health policy and standard operating procedure, following the administration of rapid tranquilisation medication. 								
4	5	20	4	3	12	2	2	4
3831: There is a risk to the quality and safety of patient care and ward leadership due to an over-reliance on agency staffing and preceptorship nurses and an insufficient number of qualified, substantive, nursing staff. 								
4	4	16	3	4	12	3	2	6
4124: There is a risk of harm to members of staff through clinical incidents of violence or aggression within inpatient areas. This may adversely affect staff wellbeing, staff morale, recruitment and attrition if not appropriately mitigated. 								
3	5	15	3	4	12	2	2	4
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. The recent January 2021 Insight penetration test will require additional downtime slots to mitigate the required corrective actions. 								
4	3	12	3	4	12	2	2	4
4613: There is a risk to the quality of patient of care and to the clinical leadership of services within the Acute and Community Directorate arising due to vacancies across the medical workforce and an over-reliance upon locum medical staff. 								
5	5	15	3	4	12	1	2	6

4377: Failure to deliver the required level of CIP for 2021/22. This includes closing any b/f recurrent gap and delivering the required level of efficiency during the financial year 2021/22.								
4	3	12	4	3	12	3	3	9
4483: There is a risk that trust IT systems and data could be compromised as a result of members of staff providing personal credentials and information upon receipt of phishing emails received.								
3	4	12	3	4	12	3	2	6
4407: There is a risk of 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	3	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 2018-2020								
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
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	2	3	6	2	2	4

Closed Risks

1.6 No risks have been closed since last consideration.

Reduced/escalated risks

1.7 The Quality Assurance Committee will recommend to Board that risks 4079, 4140, 4189 and 4407 should de-escalate having received assurance in relation to the decisions leading to their scoring reducing below the 12-score threshold requiring inclusion on the Corporate Risk Register.

1.8 The risk score in relation to Risk 4330 has increased with the current score rising from 9 to 15.

New risks

- 1.9 A new risk has recently been added to the register and is included in the appendix (Risk 4615) RIDDOR regulations. This risk has not yet been considered by any committees.

Risk profile

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

1.11 **Severity**

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

Section 2: Risks

- 2.1 Failure to properly review the CRR could result in Board or its committees not being fully sighted on key risks facing the organisation
- 2.2 There are no specific corporate risks around usage of the CRR.

Section 3: Assurance

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

Section 4: Implications

Strategic Aims and Board Assurance Framework

- 4.1 All.

Equalities, diversity and inclusion

- 4.2 None directly arising from this report.

Culture and People

- 4.3 None directly arising from this report.

Integration and system thinking

- 4.4 None directly arising from this report.

Financial

- 4.5 None directly arising from this report.

Section 5: List of Appendices

1. Corporate Risk Register - Full

Risk No. 3679 v.10	BAF Ref: BAF.0003	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee			
Version Date: 12/05/2021		Directorate: Acute & Community	Last Reviewed: 04/07/2021			
First Created: 29/12/2016		Exec Lead: Executive Medical Director	Review Frequency: Monthly			
Details of Risk:		Risk Rating:		Severity	Likelihood	Score
There is a risk to patient safety arising from the quality and safety of the ward environments across SHSC hospital sites, including access to ligature anchor points.		Initial Risk (before controls):		5	4	20
		Current Risk: (with current controls):		5	3	15
		Target Risk: (after improved controls):		2	2	4

CONTROLS IN PLACE

- Policies and standard operating procedures are embedded, including: ligature risk reduction (which now includes blind spots), observation, risk management including DRAM and seclusion policy.
- Individual service users are risk assessed - DRAM in place and enhanced observations mobilised in accordance with observation policy.
- Inpatient environments have weekly health and safety checks and an annual formal ligature risk assessment. Plans to mitigate key risks are in place as part of the Acute Care Modernisation in the long term.
- A programme of work is underway to remove ligature points and to address blind spots with oversight of the estates strategy implementation group.
- Staff receive clinical risk training, including suicide prevention and RESPECT and all ligature incidents are reviewed.
- CQC MHA oversight (visits, report and action plans)
- Mental Health Legislation Committee with oversight of compliance in relation to seclusion facilities
- A Standard Operating Procedure is embedded which describes an elevated level of medical oversight/review when a service user requires seclusion.
- Nurse alarm system in place at Forest Lodge and Maple Ward
- Contemporaneous record keeping is supported by standard operating procedures to monitor changes in the needs and risks of service users.

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

Access to ceiling space to be reviewed by Estates and an options appraisal developed regarding either securing current tiles, or replacing the ceiling in Maple (en-suites) and in Stanage and Burbage en-suites and seclusion.

The ward works on Burbage Ward have commenced w/c 12 July 2021. Consideration is being given to way to accelerate the programme of works for other wards including acquisition of a modular ward decant facility and/or work on live ward environments. At the moment the Trust does not have funding for a modular ward but a bid has been submitted nationally; outcome timescale not known. An interim Project Director (KS) has been appointed to support management of the LAP eradication programme.

31/08/2021
Geoffrey Rawlings

<ul style="list-style-type: none"> • 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) • Heat maps are visible within all acute wards to highlight areas of greater risk due to access to ligature anchor points. 	<p>Estates to review and establish where flat-sided thumb turn locks are sited and replace with safer alternatives.</p>	<p>The ward works programme has commenced on Burbage Ward w/c 12 July 2021; this includes replacement of doorsets. Consideration is being given to ways to accelerate the ward works programme including acquisition of a modular decant ward (if funds can be identified) + interim Project Director (KS) appointed to manage the LAP eradication programme</p>	<p>31/08/2021 Geoffrey Rawlings</p>
	<p>Estates required to review and replace window frames which pose a ligature risk.</p>	<p>This aspect of the project is now progressing and the contractor has identified they will be able to work simultaneously on several wards (not Burbage which has very specific scaffolding requirements) so the timescale for this is being revised.</p>	<p>31/08/2021 Geoffrey Rawlings</p>
	<p>Progress with design and tender for capital works to remove dormitories. This is a long term project due to take 12 months until completion.</p>	<p>Ward works programme has commenced on Burbage w/c 12 July 2021. Consideration is being given to ways to accelerate work on other</p>	<p>31/08/2021 Geoffrey Rawlings</p>

wards inc. work on live wards and acquisition (subject to funding) of a modular ward decant facility.

Weekly meeting between estates and acute service line to prioritise and plan refurbishment work on live wards to remove as many ligature anchor points as possible in accordance with s.29A Warning Notice.

10/09/2021
Greg Hackney

Risk No. 3831 v.20 BAF Ref: BAF.0005	Risk Type: Workforce / Risk Appetite: Low	Monitoring Group: People's Committee		
Version Date: 13/04/2021	Directorate: Acute & Community	Last Reviewed: 13/07/2021		
First Created: 04/09/2017	Exec Lead: Executive Director - Nursing & Professions	Review Frequency: Monthly		
Details of Risk:	Risk Rating:	Severity	Likelihood	Score
There is a risk to the quality and safety of patient care and ward leadership due to an over-reliance on agency staffing and preceptorship nurses and an insufficient number of qualified, substantive, nursing staff.	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.
 - recruitment and retention plan in place and now being led by Neil Robertson 16/06/2021 Emma Highfield
- Meeting to be held and SOP to be developed to clearly articulate safe minimum staffing, priority areas in the event of a shortfall of staffing and clear process of escalation to resolve staffing shortages.
 - 23/07/2021 Greg Hackney

- 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.12	BAF Ref: BAF.0005	Risk Type: Workforce / Risk Appetite: Low	Monitoring Group: People's Committee		
Version Date: 19/05/2021		Directorate: Organisational Development	Last Reviewed: 09/07/2021		
First Created: 26/10/2018		Exec Lead: Director Of Human Resources	Review Frequency: Monthly		
Details of Risk:		Risk Rating:	Severity	Likelihood	Score
Low staff engagement which may impact on the quality of care, as indicated by the Staff Surveys 2018-2020		Initial Risk (before controls):	3	4	12
		Current Risk: (with current controls):	3	3	9
		Target Risk: (after improved controls):	2	3	6

CONTROLS IN PLACE

- Listening into Action principles established (Part of wider staff Engagement and Experience approach moving forward)
- 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
- 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)

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

- | | | |
|---|--|--------------------------|
| Organisation Development Strategy to be developed. | OD Strategy agreed by People Committee in May and due to be presented to Board on 28 July 2021 | 28/07/2021
Rita Evans |
| Reviewing the Staff Survey engagement leads roles (ROI) | phase 2 July 2021 - September 2021 | 30/09/2021
Rita Evans |

- 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.6	BAF Ref: BAF.0003	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee			
Version Date: 30/03/2021		Directorate: Facilities	Last Reviewed: 13/07/2021			
First Created: 26/10/2018		Exec Lead: Executive Director Of Finance	Review Frequency: Monthly			
Details of Risk:		Risk Rating:		Severity	Likelihood	Score
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.		Initial Risk (before controls):		4	5	20
		Current Risk: (with current controls):		2	3	6
		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.
- The Trust's Waste Management lead has provided assurance the situation is now significantly mitigated and the risk rating can be reduced to a Low level.

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.

Despite chase ups to Mitie (the former provider) they have not responded. Director of FM continuing to chase for a response. Other than that no issues with the current provision of service.

30/09/2021
Helen Payne

Risk No. 4121 v.18	BAF Ref: BAF.0021	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Finance & Performance Committee			
Version Date: 26/05/2021		Directorate: IMS&T	Last Reviewed: 09/07/2021			
First Created: 13/12/2018		Exec Lead: Executive Director Of Finance	Review Frequency: Monthly			
Details of Risk:		Risk Rating:		Severity	Likelihood	Score
There is a risk to patient safety, caused by key clinical documents being deleted, resulting in clinical decisions being made with incomplete or limited information and potential delays to patient treatment, e.g. missed appointments.		Initial Risk (before controls):		4	5	20
		Current Risk: (with current controls):		3	5	15
		Target Risk: (after improved controls):		1	4	4

CONTROLS IN PLACE

- Newly purchased tools allow active monitoring of the underlying infrastructure. Spikes in activity on the servers which affect the performance and stability will be addressed as soon as they are identified.
- Improved backup infrastructure in place provides faster recovery of deleted documents.
- Hourly snapshots of data in place, which reduces the volume of data that could be lost in an incident.
- View only access to emergency INSIGHT available should the live system fail or need to be taken offline to restore data.
- There is an increase in the frequency of file logging and automatic alerting tools to identify loss of data at the earliest stage.
- Insight documents are hidden in the scanned documents folder to reduce chance of accidental deletion.
- Ongoing programme of server patching in place to ensure optimum performance and security of the application infrastructure.
- A new change management process is in place, with changes recorded in our service management system and with assessment of testing, impact and recovery plans through the Change Advisory Board (CAB).
- A new 'Information Security Group' within IMST provides a forum for discussion and planning of security and information governance actions.

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

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|---|---|---------------------------|
| Remaining critical and high penetration test issues for the Insight Application to be assessed and potentially external support used to resolve them. Target date is for that assessment. | Internal team who would need to work with external supplier have been diverted to other Trust priorities. Will escalate the outstanding actions to DIGG providing clarity on the resources required to do this assessment and impact on other Trust priorities. | 30/06/2021
Andrew Male |
| Software development roadmap to limit non-essential developments to the system which could cause instability. | Objective is that development roadmaps are to be defined by Systems Roadmap Group. This group aims to meet for the first time in June or early July. In the meantime discussions on development priorities including Insight are being held as required with CCIO | 14/07/2021
Ben Sewell |

and other senior staff.

Business case for required resources to maintain Insight for an extended period of time due to delays with EPR replacement programme now required.

Current timescales for producing the business case are not achievable. It is possible that we may choose to retire this action depending on the outcome of prioritisation discussions on Insight related work, assessment from Chess and acceptance of updated residual risk in light of the new EPR Programme. Decision pending these outcomes.

30/06/2021
Ben Sewell

If assessment by Chess suggests that they can provide direct support to improving the security of Insight then a further quotation will be obtained and work scheduled. At the time of writing the scope and cost of this work is not known. Assessment outcome could also be an assessment of the risk as manageable with current or modified controls.

02/08/2021
Andrew Male

Risk No. 4124 v.5	BAF Ref: BAF.0005	Risk Type: Workforce / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee			
Version Date: 13/04/2021		Directorate: Acute & Community	Last Reviewed: 11/07/2021			
First Created: 20/12/2018		Exec Lead: Executive Director - Operational Delivery	Review Frequency: Monthly			
Details of Risk:		Risk Rating:		Severity	Likelihood	Score
There is a risk of harm to members of staff through clinical incidents of violence or aggression within inpatient areas. This may adversely affect staff wellbeing, staff morale, recruitment and attrition if not appropriately mitigated.		Initial Risk (before controls):		3	5	15
		Current Risk: (with current controls):		3	4	12
		Target Risk: (after improved controls):		2	2	4

CONTROLS IN PLACE

- Policy and governance structure in place to ensure incidents are properly reviewed and lessons learned. This includes monitoring through the IPQR.
- Safe staffing levels monitored and reviewed with Executive Medical Director every 2 weeks.
- A minimum of 3 x Respect trained staff on each shift
- Safety & Security Task & Finish Group in place
- Security service in place for all 24/7 bedded services.
- Monthly interface with South Yorkshire Police
- 24/7 senior clinical leadership in place
- Head of Service and Head of Nursing hold weekly oversight of unreviewed incidents and raise with relevant service.
- Alarm system upgrade installation complete across acute and PICU wards.
- Ongoing training programme in place for preceptor nurses to support effectiveness on the ward.
- Partial funding received to increase therapeutic input onto wards - recruitment underway.
- All staff received RESPECT training to de-escalate and/or safely manage violence.

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

- | | | |
|--|--|------------------------------|
| Annual Clinical Establishment Review to be conducted by Head of Nursing to ensure safe staffing against evidence based research. | | 01/10/2021
Emma Highfield |
| Maintaining appropriate levels of Respect training | RESPECT training compliance is monitored bi-monthly at ward level | 31/03/2022
Khatija Motara |
| Body scanners to be installed across all acute wards and to be operational by June 2021 to detect metal objects that may cause harm. | operationalisation of body scanners is dependent on creation of a standard operating procedure regarding their deployment. Target date changed to end of July 2021 | 31/07/2021
Khatija Motara |

Risk No. 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: 22/06/2021			
First Created: 21/01/2019		Exec Lead: Executive Medical Director	Review Frequency: Monthly			
Details of Risk:		Risk Rating:		Severity	Likelihood	Score
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.		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

The UK is out of Transitional arrangements and has left the EU. UK Government contingency plans for medicines disruption in place. Five months after exit no discernable impact on supply of medication to The Trust from wholesalers. Business as usual. Therefore it is appropriate to step down the risk from the BAF currently and keep it on a local register in the event of a change in circumstance

21/05/2021
Abiola Allinson

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: 22/06/2021			
First Created: 01/04/2019		Exec Lead: Executive Medical Director	Review Frequency: Monthly			
Details of Risk:		Risk Rating:		Severity	Likelihood	Score
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		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).
- EU exit by the UK means there is no UK access to the FMD database. This risk should be de-escalated to local level for monitoring for when an access pathway is agreed

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

With exit from the EU there is no access to FMD database. SHSC have purchased hardware and with the planned upgrade to the WellSky operating system scheduled for November 2021, will be better placed once an agreed framework solution is reached in the UK or partnership with the EU.

01/12/2021
Abiola Allinson

Risk No. 4276 v.4	BAF Ref: BAF.0003	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee			
Version Date: 13/04/2021		Directorate: Acute & Community	Last Reviewed: 04/07/2021			
First Created: 04/10/2019		Exec Lead: Executive Director - Operational Delivery	Review Frequency: Monthly			
Details of Risk:		Risk Rating:		Severity	Likelihood	Score
There is a risk of physical harm to service users due to an absence of physical health monitoring, in accordance with the physical health policy and standard operating procedure, following the administration of rapid tranquilisation medication.		Initial Risk (before controls):		4	5	20
		Current Risk: (with current controls):		4	3	12
		Target Risk: (after improved controls):		2	2	4

CONTROLS IN PLACE

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

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

- | | | |
|---|--|--------------------------------|
| Finalise IT tool (NEWS2), initiate training and roll out and update of local Standard Operating Procedures to reflect the change. | Clinical Safety Case completed and approved. NEWS2 mobilization plan in place. Stange complete Maple completed, Dovedale in progress, all other wards will be live by end of May 2021. Management and identification of deteriorating patient policy in draft. | 31/05/2021
Christopher Wood |
| | As the restrictive practice module development is on pause with not plans to restart at this stage to use of TAGS and activity codes is being implemented along side associated assurance reports. | |
| | Daily sitrep ensuring compliance with physical health checks post RT are in | |

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

place.

Development of an IT based system to support accurate recording and data gathering of all physical health checks following rapid tranquilisation.

see above

30/06/2021
Christopher
Wood

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: Nursing & Professions	Last Reviewed: 13/07/2021			
First Created: 12/11/2019		Exec Lead: Executive Director - Operational Delivery	Review Frequency: Monthly			
Details of Risk:		Risk Rating:		Severity	Likelihood	Score
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.		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

- 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.
- 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 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

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

- | | | |
|---|--|-----------------------------|
| Implement improvement action plan once developed. | Action plan ongoing with a significant number of items closed following implementation and assurance. a small number of items remain in exception and overseen by the Back to Good Board | 31/07/2021
Zoe Sibeko |
| Refurbishment of Bungalow 3 to be completed | The revised BC remains outstanding and there may now be a need to divert some of the Trust's capital resource to support accelerated eradication of LAPs. To retain under review. | 30/09/2021
Helen Payne |
| Actions being undertaken in line with action plan and progress reported through Back to Good Board. | Back to Good Board has progressed and closed a number of items for | 31/07/2021
Salli Midgley |

purposes.

- Business as usual governance reporting and monitoring have been identified as improvement action transfer back to services to ensure continued oversight.

assurance however there remain a number of actions open for progression.

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: 01/06/2021			
First Created: 09/01/2020		Exec Lead: Executive Director Of Finance	Review Frequency: Monthly			
Details of Risk:		Risk Rating:		Severity	Likelihood	Score
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.		Initial Risk (before controls):		4	3	12
		Current Risk: (with current controls):		3	4	12
		Target Risk: (after improved controls):		2	2	4
The recent January 2021 Insight penetration test will require additional downtime slots to mitigate the required corrective actions.						

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

Review list of which key trust IT Systems with need to undertake out of hours maintenance. 30/07/2021
Ben Sewell

Risk No. 4330 v.6	BAF Ref: BAF.0004	Risk Type: Quality / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee			
Version Date: 11/07/2021		Directorate: Acute & Community	Last Reviewed: 11/07/2021			
First Created: 09/01/2020		Exec Lead: Executive Director - Operational Delivery	Review Frequency: Monthly			
Details of Risk:		Risk Rating:		Severity	Likelihood	Score
There is a risk that service users cannot access secondary mental health services through the Single Point of Access within an acceptable waiting time due to an increase in demand and insufficient clinical capacity. In the absence of an assessment, the level of need and risk presented by service users is not quantified and may escalate without timely intervention.		Initial Risk (before controls):		5	4	20
		Current Risk: (with current controls):		5	3	15
		Target Risk: (after improved controls):		2	2	4

CONTROLS IN PLACE

- All referrals to be triaged within 24 hour period to quantify need and to determine urgency for assessment.
- Nurse Consultant to attend daily crisis huddle to report on exceptions to ability to triage all referrals within 24 hour period.
- Alternative assessment provision available i.e. Decisions Unit, Liaison
- Call Centre Manager in post to improve flow of calls / call response time / caller experience.
- Customer Service Improvement Programme Manager in post
- New leadership team in place.
- Standardised service offer (customer service improvement programme)
- All service users waiting for assessment receive written information and advice about how to access help in a crisis, whilst awaiting an assessment.
- To manage increased demand, staff have been diverted from other functions to support SPA
- Mobilised 24/7 increased capacity to support staff and service users during Covid-19 pandemic.
- Weekly review of SPA demand and staff activity data through the covid-19 command structure.
- recovery plan presented to the Quality Assurance Committee in March 2021

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

Waiting time trajectory is reported to the Quality Assurance Committee every 2 months.

31/08/2021
Sarah
Robert-Morris

which illustrates a reduction in the number of service users waiting at 30 service users each month (achieving waiting list of zero by April 2022 based upon projections of demand/capacity).

Risk No. 4362 v.4 BAF Ref: BAF.0001	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee			
Version Date: 06/11/2020	Directorate: Trust Board	Last Reviewed: 17/06/2021			
First Created: 24/03/2020	Exec Lead: Executive Director - Operational Delivery	Review Frequency: Quarterly			
Details of Risk:		Risk Rating:	Severity	Likelihood	Score
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.		Initial Risk (before controls):	5	5	25
		Current Risk: (with current controls):	4	3	12
		Target Risk: (after improved controls):	2	2	4

CONTROLS IN PLACE

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

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

Ensure audit and compliance with Inpatient Testing Guidance following gaps in assurances identified in September 2020 audit. ongoing monitoring through physical health monitoring but compliance issues are noted 31/07/2021 Beverley Murphy

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

- Trust has received RCOP suggestions for use of vitamin D for BAME staff and provided supplementary information to support staff.
- Environmental risk assessments carried out on all buildings. Risk Assessments accessible for all staff. Maximum numbers of staff per room signage present and guidance to staff on flow through communal areas.
- Staff facilitated to work from home through digital solutions and work on rotation to access buildings to comply with COVID Secure.
- 7 day clinical, operational and business support arrangements in place to support business continuity and provide national reporting returns.
- COVID Staff Helpline in place 24/7. Health & Wellbeing widget on the intranet. Structured staff support to return to work from COVID absences.
- Mobilisation plans developed for the roll out of COVID vaccine offer for staff and patients in line with national programme requirements.
- Review of Trust estate to support greater opportunity for social distancing. Removal of dormitories on Maple and Dovedale; Stanage and Burbage by the end of 2020. Building changes to the Crisis Hub to commence 15.12.20, creating more break out staff and clinical staff working areas.
- Monitoring of staff with up-to-date Covid Risk Assessments now reported on a monthly basis to Gold Command and reviewed at HR SMT.

CORPORATE RISK REGISTER

As at: July 2021

Risk No. 4377 v.2 BAF Ref: BAF.0022	Risk Type: / Risk Appetite: Moderate	Monitoring Group: Finance & Performance Committee			
Version Date: 19/05/2021	Directorate: Finance	Last Reviewed: 09/07/2021			
First Created: 24/04/2020	Exec Lead: Executive Director Of Finance	Review Frequency: Monthly			
Details of Risk:		Risk Rating:	Severity	Likelihood	Score
Failure to deliver the required level of CIP for 2021/22. This includes closing any b/f recurrent gap and delivering the required level of efficiency during the financial year 2021/22.		Initial Risk (before controls):	3	4	12
		Current Risk: (with current controls):	4	3	12
		Target Risk: (after improved controls):	3	3	9

CONTROLS IN PLACE

- Trust Business Planning Systems and Processes, including CIP monitoring, QIA and Executive oversight.
- Forms part of routine finance reporting to FPC, Board and NHSE/I
- Performance Management Framework
- Additional transformation and cost reduction objectives. Procurement led savings, agency reduction and control.
- Cost Improvement Programme Working Group has now been set up to confirm targets, monitor Progress, review Scheme Initiation Documents, and ensure QEIA process undertaken

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

- | | | |
|---|---|----------------------------|
| Cost Improvement Programme (CIP) working Group set up to monitor the Programme: Expect progress towards identified schemes by end of Q1, at which point Control Risk Rating may change | Work progressing via the CIP working group. Reporting underway into AIPG and will progress routinely on quarterly basis via BPG and FPC. First report will cover qtr 1
Majority of corporate schemes identified and progressing via the QEIA process. Clinical plans are being offset NR in the short term via MHIS slippage and Covid funds | 31/08/2021
Lisa Collett |
| Review benchmarking & productivity data to help drive efficiency and better use of resources. To work with Performance Team to triangulate data through the appropriate governance routes and | Currently weekly meetings being held between Planning, Performance and Finance, to formalise and align to this piece of work. | 31/08/2021
Lisa Collett |

identify an annual work programme for Benchmarking to enable timely and robust input and review of outputs

CORPORATE RISK REGISTER

As at: July 2021

Risk No. 4407 v.3 BAF Ref: BAF.0003	Risk Type: Safety / Risk Appetite: Zero	Monitoring Group: Quality Assurance Committee			
Version Date: 13/04/2021	Directorate: Acute & Community	Last Reviewed: 22/06/2021			
First Created: 18/06/2020	Exec Lead: Executive Director - Operational Delivery	Review Frequency: Monthly			
Details of Risk:		Risk Rating:	Severity	Likelihood	Score
There is a risk of harm to service users, staff, and the environment caused by service users smoking or using lighters/matches in SHSC Acute and PICU wards.		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 registers to raise awareness through review.
- Annual fire risk assessment undertaken by South Yorkshire Fire Service and the Trust fire safety officers
- All staff complete fire safety training
- Incident reporting system in place re any incidents related to fire
- Weekly Smoke-Free Task and Finish group in place, which includes representatives from each ward and senior staff.
- Operational plan to support robust implementation of smoke free policy, with relevant key milestones in place and reviewed weekly by Task and Finish Group
- Service users are prohibited from smoking in inpatient environments as of September 2020.

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

Commence daily safety huddles on ward areas to raise fire safety risks Get assurance from ward managers/matrons for Acute and PICU wards re daily safety huddles being embedded 14/05/2021
Khatija Motara

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: 13/07/2021
First Created: 19/06/2020		Exec Lead: Executive Director - Nursing & Professions	Review Frequency: Monthly

Details of Risk: There is a risk the Trust is unable to provide sufficient additional nursing/nursing associate placement capacity to meet demand caused by a combination of factors (commitment to increase placements in 19/20; Project 5000 targets; and extension of current student placements due to Covid-19 impact). This combined with vacancies, skill mix challenges, and increased service demands could result in a failure to meet long term transformation targets and a shortage of nurses to meet identified recruitment shortages. This could impact on the Trust's reputation and ability to deliver existing and/or increased demand for services.	Risk Rating:	Severity	Likelihood	Score
	Initial Risk (before controls):	4	4	16
	Current Risk: (with current controls):	4	4	16
	Target Risk: (after improved controls):	3	1	3

CONTROLS IN PLACE

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

- Additional resource in practice placement team (ETD) to provide peripatetic assessment.

update 180820 - complete: 3 days a week resource now back in place in PQF team following Covid absence and 3hours per week practice support at endcliffe ward.

- All registered nurses now have responsibility for supporting student learning.

update - decision made by DNO

- 15 staff registered for mentor preparation training at SHU
- Project leads in place to implement placement expansion in Learning Disabilities

- 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.

Risk No. 4475 v.5	BAF Ref:	Risk Type: Statutory / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee			
Version Date: 06/07/2021		Directorate: Acute & Community	Last Reviewed: 06/07/2021			
First Created: 23/10/2020		Exec Lead: Executive Director - Nursing & Professions	Review Frequency: Monthly			
Details of Risk:			Risk Rating:	Severity	Likelihood	Score
There is a risk that there are no available acute beds in Sheffield at the point of need as a result of necessary refurbishment works, including the eradication of dormitories and the removal of Ligature Anchor Points, to meet standards of quality and safety. This results in delays in accessing an acute bed and the requirement to place service users in an out of area acute bed without clinical justification. This creates a corporate risk for the organisation in fulfilling the requirements of section 140 of the Mental Health Act 1983 to provide appropriate accommodation for people requiring hospital care.			Initial Risk (before controls):	4	5	20
			Current Risk: (with current controls):	3	5	15
			Target Risk: (after improved controls):	3	2	6

CONTROLS IN PLACE

- Clinical Director/Head of Service approval required to authorise out of area bed within hours. Executive Approval required out of hours to ensure exhaustion of local provision.
- OOC placements sought via Flow coordinators to meet service users need
- Crisis Resolution and Home Treatment Service to gatekeep all admissions and to support all discharges from acute wards.
- Revised clinical model brings shared ownership across inpatient and community services to manage local bed base.
- Daily operational and clinical leadership oversight of patient flow to and from out of area placements.
- Daily crisis and acute service huddle to plan and organise timely patient flow.
- Weekly Medically Fit for Discharge meeting held by the Head of Service to engage partner organisations in supporting service user flow.

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

- | | | |
|---|---|------------------------------|
| Trust approval through the Quality Committee and Financial Management Group in February to procure 6 OOA acute beds and 3 OOA PICU beds on a block contract basis. Procurement exercise to be progressed and completed by end of April. | tender for acute beds procurement due to be published Monday 24th May. Target date updated. PICU spec under revision and yet to be issued | 31/07/2021
Khatija Motara |
| Purposeful Inpatient Admission Model to be developed with collaboration across inpatient and community services. | Ongoing. Initial change ideas and trails have led to the development of a standardised process for admission assessment and formulation process This will be trialled across 2 wards. | 31/07/2021
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

Risk No. 4483 v.3	BAF Ref:	Risk Type: Safety / Risk Appetite:	Monitoring Group: Audit Committee		
Version Date: 12/01/2021		Directorate: IMS&T	Last Reviewed: 01/07/2021		
First Created: 25/11/2020		Exec Lead: Executive Director Of Finance	Review Frequency: Monthly		
Details of Risk:		Risk Rating:	Severity	Likelihood	Score
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.		Initial Risk (before controls):	3	4	12
		Current Risk: (with current controls):	3	4	12
		Target Risk: (after improved controls):	3	2	6

CONTROLS IN PLACE

- Increased password security length.
- IT and data security is covered in mandatory training and in accessible Trust policies, for guidance.
- Increased tracking of IG training compliance and supporting toolset to raise overall trust awareness.

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

Seek a quotation from Assurance 360 for small scale repeated Phishing exercises that seeks to better understand the groups that are more susceptible to phishing emails.

Quotation received. A plan for implementing the proposal is required as a next step.

31/07/2021
Andrew Male

CORPORATE RISK REGISTER

As at: July 2021

Risk No. 4613 v.1	BAF Ref: BAF.0004	Risk Type: Workforce / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee
Version Date: 20/05/2021		Directorate: Acute & Community	Last Reviewed: 11/07/2021
First Created: 20/05/2021		Exec Lead: Executive Medical Director	Review Frequency: Monthly

Details of Risk: There is a risk to the quality of patient of care and to the clinical leadership of services within the Acute and Community Directorate arising due to vacancies across the medical workforce and an over-reliance upon locum medical staff.	Risk Rating:	Severity	Likelihood	Score
	Initial Risk (before controls):	3	5	15
	Current Risk: (with current controls):	3	4	12
	Target Risk: (after improved controls):	3	2	6

CONTROLS IN PLACE	ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON
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<ul style="list-style-type: none"> Repeated efforts to recruit to vacant posts are being made. Locum medical staff in post across inpatient areas and interim arrangements in place within community services. 	<table border="0"> <tr> <td style="width: 60%;">Clinical Director to review medical job plans to quantify capacity against demand.</td> <td style="width: 30%;">Clinical Director and Accountant to meet with Executive Medical Director and Deputy Chief Executive to review medical requirements in July.</td> <td style="width: 10%; text-align: right;">31/08/2021 Robert Verity</td> </tr> <tr> <td>Clinical Director and Medical Director to meet to agree strategy for medical recruitment</td> <td></td> <td style="text-align: right;">30/07/2021 Robert Verity</td> </tr> </table>	Clinical Director to review medical job plans to quantify capacity against demand.	Clinical Director and Accountant to meet with Executive Medical Director and Deputy Chief Executive to review medical requirements in July.	31/08/2021 Robert Verity	Clinical Director and Medical Director to meet to agree strategy for medical recruitment		30/07/2021 Robert Verity
Clinical Director to review medical job plans to quantify capacity against demand.	Clinical Director and Accountant to meet with Executive Medical Director and Deputy Chief Executive to review medical requirements in July.	31/08/2021 Robert Verity					
Clinical Director and Medical Director to meet to agree strategy for medical recruitment		30/07/2021 Robert Verity					

Risk No. 4615 v.1	BAF Ref:	Risk Type: Statutory	/ Risk Appetite: Moderate	Monitoring Group: To Be Confirmed					
Version Date: 03/06/2021		Directorate:		Last Reviewed: / /					
First Created: 03/06/2021		Exec Lead: To Be Confirmed		Review Frequency: Monthly					
Details of Risk:				Risk Rating:					
Lack of compliance with legislation "Reporting if Injuries, Diseases and Dangerous Occurrences Regulations 2013. RIDDOR puts duties on employers, the self-employed and people in control of work premises (the Responsible Person) to report certain serious workplace accidents, occupational diseases and specified dangerous occurrences (near misses). Currently this responsibility is with Patient Safety Specialist, it has become clear, through the Health and Safety Committee, that there is a lack of connectivity between Health and Safety input, Ulysses incident reports and ERoster/staff absence recording resulting in lack of submissions and data sharing to ensure lesson learnt.				Severity					
				Initial Risk (before controls):	4	Likelihood	4	Score	16
				Current Risk: (with current controls):	4	Likelihood	4	Score	16
				Target Risk: (after improved controls):	4	Likelihood	2	Score	8

CONTROLS IN PLACE

- Ulysses is available for recording incidents

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

Continue to discuss where the responsibility for RIDDOR submission sits within the Trust.	01.07.2021 Discussion continue regarding this and has not been resolved.	01/08/2021 Samantha Crosby
Health and Safety Team to have full access to Ulysses to ensure awareness of incidents so that relevant questions can be raised.	01.07.2021 H7S Manager receives a daily extract of reports from Ulysses, this is via an excel report and not actually on Ulysses. Although the element of questions can be raised it still does not allow H&S team full access to Ulysses to be able to formally request information from reporter/manager etc.	01/08/2021 Samantha Crosby

Ascertain if the RIDDOR and staff absence question on Ulysses can be made mandatory as they appear to be left blank the majority of the time.	Email has been sent to Vin Lewin to raise this question.	20/07/2021 Vin Lewin
Provide full training to the Health and Safety team on Ulysses to ensure up to date knowledge on how to raise queries and concerns	Health and Safety Manager received introduction to Ulysses but now has access to the system so has more questions to raise.	31/07/2021 Debbie Sanderson
Clarification required on how staff absence (work related) is recorded and if this is cross referenced with Ulysses and how this is then reported and by who.		27/07/2021 Samantha Crosby

Total: 20