CORPORATE RISK REGISTER

As at: March 2022

Risk No. 3679 **v.**10 **BAF Ref:** BAF.0025	**Risk Type:** Safety / **Risk Appetite:** Zero	**Monitoring Group:** Quality Assurance Committee
Version Date: 12/05/2021	**Directorate:** Acute & Community	**Last Reviewed:** 22/02/2022
First Created: 29/12/2016	**Exec Lead:** Executive Medical Director	**Review Frequency:** Monthly

Details of Risk:

There is a risk to patient safety arising from the quality and safety of the ward environments across SHSC hospital sites, including access to ligature anchor points.

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

CONTROLS IN PLACE

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

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

Access to ceiling space to be reviewed by Estates and an options appraisal developed regarding either securing current tiles, or replacing the ceiling in Maple (en-suites) and in Stanage and Burbage en-suites and seclusion.	***The ward works on all adult acute wards is continuing onprogramme; The business case for Phase 3 was approved by Trust Board in January 2022. Phase 3 works will address Stanage and Maple en-suites, commencing July 2022 on a vacant Stanage ward and then commencing January 2023 on a vacant Maple ward. Burbage ward en-suites are currently beingaddressed on a vacant ward as part of the Phase 1 works which will be complete July2022.***	31/03/2022 Richard Scott
Estates to review and establish where flat-sided thumb turn locks are	***The ward works programme is continuing on programme***;	31/03/2022 Richard Scott

procedures to monitor changes in the needs and risks of service users. • ***14 commissioned beds in place to mitigate reduced bed base whilstrefurbishment work to remove LAP's is progressed*** • In response to s.29A Notice - action plan has been mobilised to improve environment sooner and to introduce greater clinical mitigation in the interim. • Dormitories are not in use across all inpatient environments (to be removed as part of estates strategy) • Heat maps are visible within all acute wards to highlight areas of greater risk due to access to ligature anchor points.	sited and replace with safer alternatives.	***as part of the Phase 2 worksthe flat-sided thumb turns will be replaced with saferalternatives as part of the door replacement works, which is scheduled to complete by 31 March 2022,however any remaining doors that are unable to be replaced will be addressedin Phase 3 works***.	
	Estates required to review and replace window frames which pose a ligature risk.	***Works are continuing on programme. Several wards/sites are still to beaddressed and works willcontinue into 2022.***	31/03/2022 Richard Scott
	Weekly meeting between estates andacute service line to prioritise and plan refurbishment work on live wards to remove as many ligature anchor points as possible in accordance with s.29A Warning Notice. These meetings are continuing beyond the warning notice period due to the value they have offered in progressing at pace.	***weekly meetings have beenextended beyond the s.29Awarning notice to ensure clinical assurance of estates works in live environments***.	28/02/2022 Greg Hackney

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 3831 **v.**20 **BAF Ref:** BAF.0014	**Risk Type:** Workforce / **Risk Appetite:** Low	**Monitoring Group:** People Committee
Version Date: 13/04/2021	**Directorate:** Acute & Community	**Last Reviewed:** 01/03/2022
First Created: 04/09/2017	**Exec Lead:** Executive Director - Nursing & Professions	**Review Frequency:** Monthly

Details of Risk:

There is a risk to the quality and safety of patient care and ward leadership due to an over-reliance on agency staffing and preceptorship nurses and an insufficient number of qualified, substantive, nursing staff.

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

CONTROLS IN PLACE

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

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

Support from HR business partner to update action progress.	***Action progress updated as in the action details. Deadline for feedback will be set so that process can be moved forward.***	31/03/2022 Debra Butterworth

- 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

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4078 **v.**13 **BAF Ref:** BAF.0013	**Risk Type:** Workforce **/ Risk Appetite:** Low	**Monitoring Group:** People Committee
Version Date: 12/11/2021	**Directorate:** Organisational Development	**Last Reviewed:** 24/02/2022
First Created: 26/10/2018	**Exec Lead:** Director Of Human Resources	**Review Frequency:** Monthly

Details of Risk:

There is a risk that low staff engagement caused by a number of feedback indicators via our staff survey may impact on the quality of care. (note as indicated by the Staff Surveys 2018-2020).

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

CONTROLS IN PLACE

- Listening into Action principles established (Part of wider staff Engagement and Experience approach moving forward) - (LiA no longer specifically operationally live
- Key areas identified within the themes for action and presented to People Committee, Quality Assurance Committee, Clinical Services (SDG) for oversight on progress. Specific action areas have been identified against each theme.
- Established Organisation Development team which includes staff engagement and experience which was in place in 2020. This has now changed to HRBP overseeing the staff survey and people pulse and contributing to the Staff Engagement Forums and groups
- Regular communication with staff via 'Connect' demonstrating the actions taken by TEAM SHSC in response to engagement activity
- Staff engagement measures identified and reviewed including:

- Increase in number of staff completing the staff survey 36%-40% - 41% 2020
- Trust has 50 LiA champions
- Significant number of staff responded to LiA initiatives
- Number of staff in BME staff network continue to increase (currently approx. 50)
- Lived experience group has around 20 members

- New Staff Survey Steering Group in place

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

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

• Unacceptable Behaviours Policy (informed by feedback from Bullying and Harassment Drop-in Sessions approved and to be rolled out across the Trust

• Leadership Call (Regular group with Executive)

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

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4121 **v.**19 **BAF Ref:** BAF.0021	**Risk Type:** Safety / **Risk Appetite:** Zero	**Monitoring Group:** Finance & Performance Committee
Version Date: 19/01/2022	**Directorate:** IMS&T	**Last Reviewed:** 03/03/2022
First Created: 13/12/2018	**Exec Lead:** Executive Director Of Finance	**Review Frequency:** Monthly

Details of Risk:

There is a risk to patient safety, caused by key clinical documents being deleted from Insight (EPR), resulting in clinical decisions being made with incomplete or limited information and potential delays to patient treatment, e.g. missed appointments.

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

The New EPR Programme, which willdeliver a new EPR allowing Insight tobe fully retired is the full mitigation for this risk leading to its closure.	***A contract for a new EPR was signed on 31/01/2022***	31/07/2023 Andrew Male
Good controls in place for recovering from incidents and all incidents closely monitored and reported. Discuss the possibility of lowering thelikelihood and impact scores with CCIO.		29/04/2022 Andrew Male

- ***High level planning quarter-by-quarter now overseen by IMST SMT anddiscussions with Services. Seeks to make requests visible and to limit development taking place.***
- ***Any incidents of deletion and remediation action taken is presented at everymeeting of DIGG***
- ***SOP in place to handle document deletion incidents, which produces the information shared with DIGG. Incidents, which are managed under this SOPare discussed with the Caldicott Guardian***

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4124 **v.**5 **BAF Ref:**	**Risk Type:** Workforce / **Risk Appetite:** Low	**Monitoring Group:** Quality Assurance Committee
Version Date: 13/04/2021	**Directorate:** Acute & Community	**Last Reviewed:** 21/02/2022
First Created: 20/12/2018	**Exec Lead:** Executive Director - Operational Delivery	**Review Frequency:** Monthly

Details of Risk:

There is a risk of harm to members of staff through clinical incidents of violence or aggression within inpatient areas. This may adversely affect staff wellbeing, staff morale, recruitment and attrition if not appropriately mitigated.

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

CONTROLS IN PLACE

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

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

Maintaining appropriate levels of Respect training	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.	***Report on use of body scanners has been presented to RRPOG several times and to LRPOG in November 2021. An options appraisal has been completed and will be presented to LRPOG 22 February 2022.***	31/03/2022 Kim Parker
Clinical establishment review using the MHOST tool is in train, as directed by NHSEI three periods of data collection over six months will help us to establish the staffing levelsneeded for in-patient services to ensure safe staffing		31/03/2022 Emma Highfield

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4276 **v.**4 **BAF Ref:** 0025	**Risk Type:** Safety / **Risk Appetite:** Zero	**Monitoring Group:** Quality Assurance Committee
Version Date: 13/04/2021	**Directorate:** Acute & Community	**Last Reviewed:** 14/03/2022
First Created: 04/10/2019	**Exec Lead:** Executive Director - Operational Delivery	**Review Frequency:** Monthly

Details of Risk:

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.

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 and Standard Operating Procedure n 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

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

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4330 **v.**6 **BAF Ref:**	**Risk Type:** Quality / **Risk Appetite:** Low	**Monitoring Group:** Quality Assurance Committee
Version Date: 11/07/2021	**Directorate:** Acute & Community	**Last Reviewed:** 08/03/2022
First Created: 09/01/2020	**Exec Lead:** Executive Director - Operational Delivery	**Review Frequency:** Monthly

Details of Risk:

There is a risk that service users cannot access secondary mental health services through the Single Point of Access within an acceptable waiting time due to an increase in demand and insufficient clinical capacity. In the absence of an assessment, the level of need and risk presented by service users is not quantified and may escalate without timely intervention.

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

CONTROLS IN PLACE

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

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

Waiting time trajectory is reported to the Quality Assurance Committee every 2 months.	Ongoing action.	10/04/2022 Sarah Robert-Morris
VCSE offer went live in February 2022and will be evaluated in April 2022.		30/04/2022 Andy Bragg

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

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4362 **v.**4 **BAF Ref:** BAF.0023	**Risk Type:** Safety / **Risk Appetite:** Zero	**Monitoring Group:** Quality Assurance Committee
Version Date: 06/11/2020	**Directorate:** Trust Board	**Last Reviewed:** 08/02/2022
First Created: 24/03/2020	**Exec Lead:** Executive Director - Operational Delivery	**Review Frequency:** Quarterly

Details of Risk:

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

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	5	5	25
Current Risk: (with current controls):	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.	***Physical health monitoring isongoing through Bronze Command meeting since November 2021 to ensure compliance (inpatient testing on admission at 3 days and 5-7 days after admission); and following a period of leave of 24hrs or more***.	02/03/2022 Neil Robertson
Staff resilience plan - staff absence monitored daily (HR emails all operational services daily) to back fillcritical areas		02/03/2022 Neil Robertson
Programme of Covid19 vaccinationfor staff and inpatients started May-July 2021; and restarted October 2021 to present time to include the boosters.		02/03/2022 Neil Robertson

- 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: March 2022

Risk No. 4375 **v.**7 **BAF Ref:**	**Risk Type:** Business **/ Risk Appetite:**	**Monitoring Group:** Audit Committee
Version Date: 22/10/2021	**Directorate:** IMS&T	**Last Reviewed:** 09/03/2022
First Created: 21/04/2020	**Exec Lead:** Executive Director Of Finance	**Review Frequency:** Monthly

Details of Risk:

There is a risk that paper based documents currently stored at Fulwood will be compromised, the leaving Fulwood project has no current scope to scan and store paperbased documents resulting in documentation not being secured or accessible after the headquarter move.

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	3	4	12
Current Risk: (with current controls):	3	4	12
Target Risk: (after improved controls):	0	0	0

CONTROLS IN PLACE

• Initial survey of held records by departments.
Departments are able to access MFD and have been able to scan own records.

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

IMST staff have a quick review of some of the files stored in the Information team to assess what kinds of documents are stored and implications for data security and clinical records management.	***This is for the specific IMST files.*** ***The files need to be reviewed and determine what's requiredor to be destroyed.***	31/03/2022 John Wolstenholme
To confirm if a sweep of Fulwood hasbeen completed in order to identify any paper files within storage or office spaces, that need appropriateorganisation.	***Update to be provided following the outcomeof the leaving Fulwood meeting***.	16/02/2022 Greg Boyd
To contact teams/services within Fulwood to determine any paper documents still in use/filed, that mayrequire scanning and establishing contact/ownership for service areas.	***Update to be provided following the outcomeof the leaving Fulwood meeting.***	16/02/2022 Greg Boyd

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4376 **v.**7 **BAF Ref:**	**Risk Type:** Statutory **/ Risk Appetite:**	**Monitoring Group:** Audit Committee
Version Date: 22/10/2021	**Directorate:** IMS&T	**Last Reviewed:** 21/02/2022
First Created: 21/04/2020	**Exec Lead:** Executive Director Of Finance	**Review Frequency:** Quarterly

Details of Risk:

There is a risk that clinical records and documents could be accessed by non-SHSC due to limited physical security controls in place at Presidents Park where the documents are stored resulting in potential data and information security breaches.

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	3	3	9
Current Risk: (with current controls):	3	3	9
Target Risk: (after improved controls):	0	0	0

CONTROLS IN PLACE

- Staff supervision of external personnel when warehouse doors are open.
- Staff training in confidentiality and IG training.

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

An interim standard operating procedure to be produced, to share with Estates colleagues, to support the management of new incoming documents, and access to those records already stored at Presidents Park.	***Meeting scheduled regarding Fulwood Paper documentsand the wider documentsmanagement piece***.	28/02/2022 Megan Williamson
Estates Dept. to take ownership of improving security of records stored at President Park following DIGG acceptance of recommendations.		31/03/2022 Helen Payne

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4377 **v.**2 **BAF Ref:** BAF.0022	**Risk Type:** Financial **/ Risk Appetite:** Moderate	**Monitoring Group:** Finance & Performance Committee
Version Date: 19/05/2021	**Directorate:** Finance	**Last Reviewed:** 01/02/2022
First Created: 24/04/2020	**Exec Lead:** Executive Director Of Finance	**Review Frequency:** Monthly

Details of Risk:

Failure to deliver the required level of CIP for 2021/22. This includes closing any b/f recurrent gap and delivering the required level of efficiency during the financial year 2021/22.

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

CONTROLS IN PLACE

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

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

Work ongoing to identify any savingsfrom 21-22 there were not initially included in CIP plans. Savings will offset some of the shortfall that is currently being met non-recurrently.	30/03/2022 Matt White
22-23 CIP plans incorporating any21-22 shortfalls in their plan.	30/03/2022 Matt White

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4407 **v.**4 **BAF Ref:** BAF.0025	**Risk Type:** Environmental / **Risk Appetite:** Zero	**Monitoring Group:** Quality Assurance Committee
Version Date: 20/07/2021	**Directorate:** Acute & Community	**Last Reviewed:** 01/03/2022
First Created: 18/06/2020	**Exec Lead:** Executive Director - Operational Delivery	**Review Frequency:** Monthly

Details of Risk:

There is a risk of harm to service users, staff, and the environment caused by service users smoking or using lighters/matches in SHSC Acute and PICU wards.

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

CONTROLS IN PLACE

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

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

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

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4409 **v.**12 **BAF Ref:** BAF.0019	**Risk Type:** Workforce / **Risk Appetite:** Low	**Monitoring Group:** People Committee
Version Date: 17/12/2021	**Directorate:** Nursing & Professions	**Last Reviewed:** 08/02/2022
First Created: 19/06/2020	**Exec Lead:** Executive Director - Nursing & Professions	**Review Frequency:** Monthly

Details of Risk:

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

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	4	4	16
Current Risk: (with current controls):	4	3	12
Target Risk: (after improved controls):	3	1	3

CONTROLS IN PLACE

• Prepare registered staff Band 5 and above to act in the role of practice supervisor to support placements .

update 180820 - online training sessions in place. staff without mentorship qualification to join SHU course in September 20

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

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

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

update - decision made by DNO

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

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

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

CLiP - started discussions on Dovedale 2, good opportunity to try something new as they begin to take students in the new year. To evaluate and review for widening the project.

30/03/2022
Andrew Algar

to get some placement time in line with agreement in LEAP consortium

• Active member of the new South Yorkshire and Bassetlaw's Learning Environment and Placement (LEAP) Consortia. The aims are to meet practice placement requirements and to identify and remove barriers.

• Other possibilities to increase placement capacity have been considered; such as utilising technology and the CLiP programme.

• ***Final 6 weeks of placement can be worked in substantive position aboveallocated places, consolidation placement***

• ***Utilisation of spare placement capacity outside of fixed placements atstudents discretion***

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4456 v.6 BAF Ref:	***Risk Type: Financial / Risk Appetite:***	***Monitoring Group: Finance & Performance Committee***
Version Date: 23/02/2022	***Directorate: Rehabilitation & Specialist***	***Last Reviewed: 17/01/2022***
First Created: 18/09/2020	***Exec Lead: Director of Special Projects (Strategy)***	***Review Frequency: Quarterly***

Details of Risk:

There is a risk that the Specialist Community Forensic team will be unable to perform their businessas usual, specifically the provision of outstanding holistic community care for forensic service users.This is caused by a lack of clinical base for the team due to the temporary base at Fulwood House being no longer available (Leaving Fulwood Project) from approximately April 2022. Resulting in a

reduction in quality of care, an inability to work cohesively as a team and systems and structureswithin the service being impacted.

Risk Rating:	***Severity***	***Likelihood***	***Score***
Initial Risk (before controls):	***4***	***4***	***16***
Current Risk: (with current controls):	***3***	***4***	***12***
	0	***0***	***0***
Target Risk: (after improved controls):			

CONTROLS IN PLACE

- ***Work being done w/c 21st to identify alternative internal or external suitablepremises as matter of urgency. No alternative to original plan has been agreed.***
- ***Has been escalated to exec level for awareness.***
- ***Potential location identified by Head of Estates and Project Director. Awaitfurther information from Estates on progress with this.***
- ***Reviewed monthly within IPQR, remains a significant risk as the sale andleaving Fulwood consultation is in progress for a leave from March/April.***

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

Potential new base of Fairlawns,await progress news from CCG discussions.	***Email sent to HoS and Execs to identify progress on discussions 25.02.22***	16/03/2022 Richard Bulmer

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4475 **v.**5 **BAF Ref:** BAF.0025	**Risk Type:** Statutory / **Risk Appetite:** Low	**Monitoring Group:** Quality Assurance Committee
Version Date: 06/07/2021	**Directorate:** Acute & Community	**Last Reviewed:** 08/03/2022
First Created: 23/10/2020	**Exec Lead:** Executive Director - Nursing & Professions	**Review Frequency:** Monthly

Details of Risk:

There is a risk that there are no available acute beds in Sheffield at the point of need as a result of necessary refurbishment works, including the eradication of dormitories and the removal of Ligature Anchor Points, to meet standards of quality and safety. This results in delays in accessing an acute bed and the requirement to place service users in an out of area acute bed without clinical justification. This creates a corporate risk for the organisation in fulfilling the requirements of section 140 of the Mental Health Act 1983 to provide appropriate accommodation for people requiring hospital care.

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	4	5	20
Current Risk: (with current controls):	3	5	15
Target Risk: (after improved controls):	3	2	6

CONTROLS IN PLACE

- Clinical Director/Head of Service approval required to authorise out of area bed within hours. Executive Approval required out of hours to ensure exhaustion of local provision.
- OOC placements sought via Flow coordinators to meet service users need
- Crisis Resolution and Home Treatment Service to gatekeep all admissions and to support all discharges from acute wards.
- Revised clinical model brings shared ownership across inpatient and community services to manage local bed base.
- Daily operational and clinical leadership oversight of patient flow to and from out of area placements.
- Daily crisis and acute service huddle to plan and organise timely patient flow.
- Weekly Medically Fit for Discharge meeting held by the Head of Service to engage partner organisations in supporting service user flow.
- Out of Area bed managed in post from September 2021 to assure of the quality of care from out of area providers
- A weekly senior clinical oversight group to be established to hold clinical oversight of all patients waiting for admission.

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

Trust approval through the Quality Committee and Financial Management Group in February 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.	additional 12 acute beds procured - block booked - 6 females and 6 males Additional PICU beds, spec not updated so pending progression via procurement	31/03/2022 Khatija Motara
Purposeful Inpatient Admission Model to be developed with collaboration across inpatient and community services.	Purposeful admission is now in situ on Stanage, progressing in pilot on Maple, and planned roll out at Dovedale 2 and Endcliffe wards.	31/03/2022 Kate Oldfield
Crisis Home Treatment and Resolution Service to be developed with investment from Sheffield	Recruitment underway to fulfil this action.	30/09/2021 Sarah Roberts-Morris

	Clinical Commissioning Group to include gatekeeping function for all inpatient admissions.		
	Comprehensive action plan generated by the Triumvirate to improve the rate of patient flow through crisis and acute service line.Triumvirate have assigned senior leaders to support implementation	***Actions to be rolled out and impact reviewed at the end of April 2022.***	30/04/2022 Greg Hackney

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4480 **v.**6 **BAF Ref:**	**Risk Type:** Business **/ Risk Appetite:**	**Monitoring Group:** Audit Committee
Version Date: 01/12/2021	**Directorate:** IMS&T	**Last Reviewed:** 04/10/2021
First Created: 19/11/2020	**Exec Lead:** Executive Director Of Finance	**Review Frequency:** 6 Monthly

Details of Risk:

There is a risk that Insight will become increasingly unstable and functionality restricted by continual development of the system, which is built on some obsolete and unsupported software components resulting in poor performance, higher chances of failure, increased support and maintenance overheads for IMST and limitations with the trust adhering to NHS Digital and legislation standards including NHS Digital DSPT, Cyber Essentials and NIS.

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

CONTROLS IN PLACE

- ***Through discussion minimising direct development of Insight and newdevelopments undertaken using other technology where possible***
- ***Adherence to Software standards***
- ***CCIO and CSO are promoting the use of clinical safety cases whencommissioning and signing off new developments***
- ***Where possible components that Insight relies on are upgraded, but this isnot possible for all elements***
- ***Infrastructure such as servers, backup and restore facilities provide goodservice resilience***.

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

re-review this risk following the deployment of: MHSDS CJIT QUIT programme	***This work is still underway and review date is being extended to reflect that.***	28/02/2022 Ben Sewell
SQL Server 2012 to be upgraded to SQL Service 2019		30/06/2022 Ben Sewell
Scandocs server to be upgraded from Windows Server 2008 to 2012 or above		29/04/2022 Ben Sewell
IMST to present to SDG the rationale for restricting any further development of Insight and to get support for this decision.		15/04/2022 Andrew Male

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4483 **v.**3 **BAF Ref:**	**Risk Type:** Safety **/ Risk Appetite:**	**Monitoring Group:** Audit Committee
Version Date: 12/01/2021	**Directorate:** IMS&T	**Last Reviewed:** 07/01/2022
First Created: 25/11/2020	**Exec Lead:** Executive Director Of Finance	**Review Frequency:** Quarterly

Details of Risk:

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

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

CONTROLS IN PLACE

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

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

Improvements required are a component of cyber security programme. Business case in development due completion early 2022

28/02/2022
Andrew Male

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4612 v.3 BAF Ref: BAF.0021	*Risk Type: Business / Risk Appetite:*	*Monitoring Group: Audit Committee*
Version Date: 16/07/2021	*Directorate: IMS&T*	*Last Reviewed: 11/03/2022*
First Created: 20/05/2021	*Exec Lead: Executive Director Of Finance*	*Review Frequency: Monthly*

Details of Risk:	*Risk Rating:*	*Severity*	*Likelihood*	*Score*
There is risk that system and data security will be compromised caused by IT systems continuing tobe run on software components that are no longer supported resulting in loss of critical services, data and inability to achieve mandatory NHS standards (Data Security Protection Toolkit).	*Initial Risk (before controls):*	*4*	*3*	*12*
	Current Risk: (with current controls):	*3*	*3*	*9*
		3	*2*	*6*
	Target Risk: (after improved controls):			

CONTROLS IN PLACE

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

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

Microsoft Access 2003 runtime must be retired. At this time Insight is dependent on this software. The onlymitigation is replacing and retiring Insight entirely.	01/10/2023 Andrew Male
Actions from NHS Digital to provide supporting information to isolate the Clinic Booking solution based on Exchange 2010.	30/06/2022 Adam John Handley
Implementation of NHS Digital Advice, followed by Penetration Testto provide the supporting information to NHS Digital.	
Last remaining Windows 2008 Server to be decommissioned	30/04/2022 Ben Sewell

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4613 **v.**1 **BAF Ref:**	**Risk Type:** Workforce / **Risk Appetite:** Low	**Monitoring Group:** Quality Assurance Committee
Version Date: 20/05/2021	**Directorate:** Acute & Community	**Last Reviewed:** 28/02/2022
First Created: 20/05/2021	**Exec Lead:** Executive Medical Director	**Review Frequency:** Monthly

Details of Risk:

There is a risk to the quality of patient of care and to the clinical leadership of services within the Acute and Community Directorate arising due to vacancies across the medical workforce and an over-reliance upon locum medical staff.

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	3	5	15
Current Risk: (with current controls):	3	4	12
Target Risk: (after improved controls):	3	2	6

CONTROLS IN PLACE

- Repeated efforts to recruit to vacant posts are being made.
- Locum medical staff in post across inpatient areas and interim arrangements in place within community services.
- Locum medical staff in post in community areas, at significant cost.
- Recruitment strategy being developed by Clinical Director.

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

Consultant Psychiatrist for the SouthRecovery Service post advertised 31st January 2021	***Substantive medical recruitment - advert out 04.02.22 for South Recoveryteam. Recent advert for EWS - a candidate was interviewed but not appointed***	31/03/2022 Robert Verity
Additional Locum consultant to berecruited due to unsuccessful recruitment to EWS.	***Locum Consultant in SPA will continue in post. Locum consultant, with previous experience with the Trust is working on Maple ward. Locum Consultant working in Recovery north team Locum Consultant in EIS - covering long-term sickness ; expected to be in post for afurther 2 months.***	31/03/2022 Robert Verity

	Split post for Substance misuse team and North recovery team is planned.	***A potential candidate fromthe higher trainee who hasexpressed an interest is eligible to apply and could take up a post in August 2022.***	31/08/2022 Robert Verity
	Recruitment to Consultant appointments - Repeated efforts torecruit to vacant posts are being made.	***Consultant from South Recovery team has been appointed to AOT. Consultant appointed to work part-time with University of Sheffield and Older Adult Memory Serviceto start end of March/ beginning of April. One medic has received AC status in December and is now jointly covering Stanageward with existing Consultant who as reduced to hours. They will be interviewed for the specialist Doctor role and will do CESR training to join the specialist register.***	30/04/2022 Robert Verity
	succession planning for two staff grades and some retiring consultantsthat will be leaving		

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4615 v.3 BAF Ref:	*Risk Type: Statutory / Risk Appetite: Moderate*	*Monitoring Group: Quality Assurance Committee*
Version Date: 24/01/2022	*Directorate: Facilities*	*Last Reviewed: 24/01/2022*
First Created: 03/06/2021	*Exec Lead: To Be Confirmed*	*Review Frequency: Monthly*

Details of Risk:

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

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

CONTROLS IN PLACE

- *Ulysses is available for recording incidents*
- *Risk Department are submitting RIDDOR reports*
- *Health and Safety Committee are getting some statistics in relation toRIDDOR submitted*
- *Staff absence reports being received both from ERostering and ESR and sentthrough to risk department*
- *RIDDOR is briefly mentioned within the Incident Management Policy andProcedure (including serious incidents)*

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

Provide full training to the Health andSafety team on Ulysses to ensure up to date knowledge on how to raise queries and concerns	*This still needs to be completed. To request training in the New Year.*	28/02/2022 Samantha Crosby
Ensure a formal link is made with thelegal department in relation to potential RIDDOR incidents that could result in personal injury claimsthis could support the requirement for statement collecting at the time of the incident.	*The legal part is now completed externally so will need to explore if this link is even possible.*	28/02/2022 Samantha Crosby

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4727 **v.**4 **BAF Ref:** BAF.0024	**Risk Type:** Statutory / **Risk Appetite:** Zero	**Monitoring Group:** Quality Assurance Committee
Version Date: 08/02/2022	**Directorate:** Nursing & Professions	**Last Reviewed:** 08/02/2022
First Created: 12/09/2021	**Exec Lead:** Executive Director - Nursing & Professions	**Review Frequency:** Quarterly

Details of Risk:

There is a risk that staff will fail to identify, act upon, report and manage safeguarding risks in their line of duty which will result in harm to patients and/or their families and children. this is a statutory responsibility

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	5	3	15
Current Risk: (with current controls):	5	2	10
Target Risk: (after improved controls):	4	1	4

CONTROLS IN PLACE

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

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

develop and roll out level 3 safeguarding adult training to all registered clinical staff	***Training plan agreed with external training company. trajectories reset to support this plan. monitored throughsafeguarding committee andback to good board***	31/12/2022 Hester Litten
roll out safeguarding supervision through action learning sets across inpatient services and recovery teams	***Initial training completed with inpatient matrons, however roll out plan has not been agreed nor has communications been prepared. policy in place but needs further discussion andagreement for action***	31/03/2022 Hester Litten

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4742 **v.**4 **BAF Ref:** BAF.0024	**Risk Type:** Statutory / **Risk Appetite:** Zero	**Monitoring Group:** Quality Assurance Committee
Version Date: 08/02/2022	**Directorate:** Nursing & Professions	**Last Reviewed:** 08/02/2022
First Created: 19/10/2021	**Exec Lead:** Executive Director - Nursing & Professions	**Review Frequency:** Quarterly

Details of Risk:

There is a risk that staff may fail to appropriately report individuals who are susceptible to radicalisation as defined in the Prevention of Terrorism Act and aligned to the training requirementsfor Prevent L3.

Risk Rating:	**Severity**	**Likelihood**	**Score**
Initial Risk (before controls):	4	4	16
Current Risk: (with current controls):	4	2	8
Target Risk: (after improved controls):	4	1	4

CONTROLS IN PLACE

- staff have completed either level 1 or level 2 Prevent training but this does not give the necessary knowledge for registered practitioners who require level 3
- ***Level 2 training from HEE meets the standards for Level 3 prevent, this hasnow been updated with local information for Sheffield and reporting mechanisms to ensure that staff that report appropriately***

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

training trajectories agreed to meetL3 compliance with new updates, plan to meet by 30.9.22	08/02/2022 Hester Litten

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4745 v.1 BAF Ref: BAF.0024	***Risk Type: Quality / Risk Appetite: Low***	***Monitoring Group: Quality Assurance Committee***
Version Date: 21/10/2021	***Directorate: Nursing & Professions***	***Last Reviewed: 02/02/2022***
First Created: 21/10/2021	***Exec Lead: Executive Director - Nursing & Professions***	***Review Frequency: Monthly***

Details of Risk:	***Risk Rating:***	***Severity***	***Likelihood***	***Score***
There is a risk that complaints will not be responded to in a timely manner which will give rise to breaches of contractual standards and dissatisfaction from service users, carers and families. The untimely delays could lead to a failure to learn and correct issues in a timely manner and ensure good quality care/prevent future issues arising.	***Initial Risk (before controls):***	***3***	***5***	***15***
	Current Risk: (with current controls):	***3***	***5***	***15***
		3	***2***	***6***
	Target Risk: (after improved controls):			

CONTROLS IN PLACE

- ***Band 5 complaints officer employed to support the administration andprocessing of complaints in a timely manner***
- ***Oversight and assurance of complaints has moved to the Quality Directorate,which will track complaints weekly through SI and Complaints panel with the clinical directorates.***
- ***Rapid Improvement Plan developed and monitored through QualityAssurance Committee.***
- ***New Band 7 Complaints Manager recruited and in post from January 2022.***
-

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

Implement actions outlined in Complaints Improvement Plan.	28/02/2022 Tania Baxter

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4749 **v.**5 **BAF Ref:** BAF.0014	**Risk Type:** Workforce / **Risk Appetite:** Moderate	**Monitoring Group:** People Committee
Version Date: 17/02/2022	**Directorate:** Human Resources	**Last Reviewed:** 17/02/2022
First Created: 26/10/2021	**Exec Lead:** Director Of Human Resources	**Review Frequency:** Monthly

Details of Risk:

There is a risk that the Trust is unable to meet the identified training needs for the existing workforce because of a lack of budget resulting in failing to meet workforce transformation priorities

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

CONTROLS IN PLACE

- Governance process in place to monitor progress through Workforce Planning and Transformation Group and report to People committee
- Business case approval for a centralised training budget
- Report with proposals to address implementation problems taken to Service Delivery Group and Workforce Transformation group and escalated as a risk to People Committee
- HEE funding used to meet funding gaps where staff meet criteria ie CPD, support staff

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

Review of study leave policy and processes for collecting . prioritising,and agreeing training needs which will enable a clear picture of any training gaps	***study leave policy - requested 2nd extensionto 30 July 2022 - pending approval at policy governance group 22 February.*** ***process for collecting learning needs to be put in place for 22/23*** ***changed target date***	31/07/2022 Karen Dickinson

CORPORATE RISK REGISTER

As at: March 2022

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

Details of Risk:	*Risk Rating:*	*Severity*	*Likelihood*	*Score*
Demand for the SAANS greatly outweighs the resource and capacity of the service. This is resultingin longer/lengthy wait times and high numbers of people waiting	*Initial Risk (before controls):*	*4*	*5*	*20*
	Current Risk: (with current controls):	*3*	*4*	*12*
	Target Risk: (after improved controls):	*0*	*0*	*0*

CONTROLS IN PLACE	*ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON*	
• Ongoing discussions with CCG current and required resource *• CCG have proposed investment and staff model has been drafted and isbeing finalised* *• Agreement to split ADHD and ASD pathways* *• Project / steering group (with PMO oversight) in place to review position,actions and update on a monthly basis*	*Finalise the split of ASD and ADHDpathways and the associated requirement to support this* *Review of clinical process to be undertaken with Medical Director and Head of Nursing*	*01/04/2022* *Mark Parker* *31/03/2022* *Mark Parker*
• Agreement with the CCG to work together with the Trust for the development of a neurodiversity pathway incorporating an all-age pathway.This will look at managing more referrals at a primary care level *• People on the waiting list are managed safely by the service communicatingwith primary care that they retain responsibility while the patient awaits assessment. The service also provides a range of support materials on the internet and hardcopy.*	*Recruitment*	*31/03/2022* *Mark Parker*

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4757 v.3 BAF Ref:	*Risk Type: Safety / Risk Appetite:*	*Monitoring Group: Quality Assurance Committee*
Version Date: 15/02/2022	*Directorate: Rehabilitation & Specialist Se*	*Last Reviewed: 16/02/2022*
First Created: 28/10/2021	*Exec Lead: Executive Director - Nursing & Professions*	*Review Frequency: Quarterly*

Details of Risk:	*Risk Rating:*	*Severity*	*Likelihood*	*Score*
Demand for Gender greatly outweighs the resource/capacity of the service. This resulting in lengthy waits and high numbers of people waiting	*Initial Risk (before controls):*	*4*	*5*	*20*
	Current Risk: (with current controls):	*3*	*4*	*12*
	Target Risk: (after improved controls):	*0*	*0*	*0*

CONTROLS IN PLACE	*ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON*	
• Project / steering groups in place (overseen by PMO) to review monitor andset actions to reduce the waiting times	*Recruitment*	*31/03/2022 Mark Parker*
• Successful NHS E bid for additional investment agreed and in the process ofbeing finalised - this will enhance staff model	*Clinical process review to be undertaken by Medical Director and Head of Nursing*	*31/03/2022 Mark Parker*
• Developing link with Primary Care Projects. This seeks to reduce referrals bysupporting primary care to take the lead in diagnostics and support on the pathway.		
• People are supported on the waiting list via the primary care provider. The clinic works with voluntary and non-statutory support services to offer supportwhile waiting for assessment.		
• Service works in line with NHS E guidance and service specification. Alsowork with the Northern region of providers to share best practice and collaborate with standard process development.		

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4769 v.3 BAF Ref: BAF.0024	*Risk Type: Statutory / Risk Appetite: Zero*	*Monitoring Group: Quality Assurance Committee*
Version Date: 08/02/2022	*Directorate: Nursing & Professions*	*Last Reviewed: 08/02/2022*
First Created: 18/11/2021	*Exec Lead: Executive Director - Nursing & Professions*	*Review Frequency: Monthly*

Details of Risk:

There is a risk of legal challenge as the volunteer database is not held in line with GDPR requirements, In addition the database has not been maintained to ensure volunteers complete safeguarding training, refresh DBS or complete required mandated induction training. there is noclear log of supervision or of the hours volunteers are working to ensure they are appropriately

supported. details of volunteers are held on a spreadsheet.

Risk Rating:	*Severity*	*Likelihood*	*Score*
Initial Risk (before controls):	*4*	*5*	*20*
Current Risk: (with current controls):	*3*	*3*	*9*
Target Risk: (after improved controls):	*2*	*1*	*2*

CONTROLS IN PLACE

- *The risk has been exposed and the policy is fit for purpose. it is the practicealigned to policy that is of concern. work has commenced to cleanse the database and agree the required steps to bring the database and volunteers into compliance*
- *the database has been reviewed in full and active volunteers identified. thissignificantly reduces the number of volunteers who could be out of date with training and DBS checks. the final list is under 30 volunteers to be actively managed.*

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

A rapid development plan will be agreed and implemented by 30/4/22 to assign actions and owners to deliver the required improvements tothe delivery of volunteer practice to the Trust Policy. Oversight from Teresa Clayton	*actions are underway. volunteers who are active identified and a plan to refresh DBS and to request safeguarding and other training is updated. timeline for completion of this action including a letter to all volunteers to remind itis time to refresh requirements will be completed by 30.4.22*	*30/04/2022 Salli Midgley*
all volunteers must have supervision from their base workplace which is recorded in the Trust supervision log.the volunteer manager will		

		rvision occurs aligned to the requirements of the supervision policy for volunteers	**Work has been completed to cleanse and confirm dataheld within the volunteer database. The majority of active volunteers now havea supervisor identified and work underway to ensure that supervisors are aware**	25/02/2022 Mia Bajin

CORPORATE RISK REGISTER

As at: March 2022

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

Details of Risk:	*Risk Rating:*	*Severity*	*Likelihood*	*Score*
There is a risk that Back to Good progress will be impacted during the Omicron variant wave resulting in missed delivery dates of required actions. This will impact on quality, safety and regulatory requirements.	*Initial Risk (before controls):*	*4*	*3*	*12*
	Current Risk: (with current controls):	*2*	*3*	*6*
	Target Risk: (after improved controls):	*1*	*1*	*1*

CONTROLS IN PLACE	*ACTIONS PLANNED & MOST RECENT PROGRESS WITH TARGET DATE/RESP. PERSON*	
• Back to Good delivery group monitors monthly to offer support and keepactions on track. Back to Good Programme Board seeks assurance or escalation of actions at risk for further support.	*where a risk to delivery is noted, prioritisation exercises will take placeto consider the impact of delay and the potential support available to complete the action or to request extension where support will not deliver the action*	*31/03/2022 Salli Midgley*
• Trust Command Structure for incident management (pandemic) increased in frequency to support managers on a day to day basis to manage the impact of the pandemic, giving capacity to monitor and deliver on actions		
• Robust governance structures across teh Trust including Directorate and team performance and quality reviews to keep local managers focussed onachieving actions and trajectories. Reporting through to QAC		

CORPORATE RISK REGISTER

As at: March 2022

Risk No. 4823 v.3 BAF Ref:	*Risk Type: Safety / Risk Appetite:*	*Monitoring Group: Quality Assurance Committee*
Version Date: 24/02/2022	*Directorate: Rehabilitation & Specialist Se*	*Last Reviewed: 01/03/2022*
First Created: 26/01/2022	*Exec Lead: Executive Director - Nursing & Professions*	*Review Frequency: Monthly*

Details of Risk:

There is a risk that patients with a Learning Disability/and or with Autism will be admitted onto an acute mental health ward due to the current closure of ATS at SHSC. This has and will result in patient been inappropriately placed on an Acute Mental Health Ward, this environment is not fittingto patient with Learning Disability or their sensory needs, in addition staff on Acute Mental Health

wards are not appropriately trained Learning Disability Staff. It's poses a risk to Adult mental health patients and makes them vulnerable - increases the possibility of risk of negatively impacting the mental health needs of those patient, and could cause a deterioration in the behaviour that cause concern of the LD patient admitted. Green Light Working does not mitigate risk for patient with Moderate to Sever LD, it is important to continue to use Green Light Working when appropriate

Risk Rating:	*Severity*	*Likelihood*	*Score*
Initial Risk (before controls):	*5*	*4*	*20*
Current Risk: (with current controls):	*4*	*4*	*16*
Target Risk: (after improved controls):	*0*	*0*	*0*

CONTROLS IN PLACE

- *Admission Avoidance*

The Community Intensive Support Team and Community Learning Disability team are working closely with service users and providers to support into thecommunity

- *The LD MDT will inreach into the wards to provide support, care plan coordinators and training to acute mental health staff in order to providespecalist support.*
- *A new Standard Operating Procedures for emergency admission avoidance/admissions has been developed, with escalation to the Head ofNursing and Clinical Director.*
- *There is a list of CQC rated Good ATS inpatient setting across the country totry and source alternative out of City (if an admission cannot be avoided) however, these are currently all full and not taking admission.*

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

Ongoing work within the LD Programme board and the development of a new community enhanced model for Sheffield.	31/03/2022 Melanie LarderLee
Discussison with Regional Commissioners about future planning for LD beds at an ICS/Regional Level	30/04/2022 Richard Bulmer