Board of Directors Item number: 25
Date: 30 July 2025

confidential/ public paper:	Public
Report Title:	Corporate risk report
Author(s):	Amber Wild, Head of corporate assurance
Accountable Director:	Dawn Pearson, Associate director of communications and corporate governance
Presented by:	Dawn Pearson, Associate director of communications and corporate governance
Vision and values:	The Trust vision is to ensure we work together for service users. Risk management supports the commitment to quality, ensuring **we keep improving**, **we are inclusive**, and we our delivery care that means **we are respectful and kind.**
Purpose and key actions:	The purpose of the report is to provide a summary analysis of the risks on the corporate risk register (CRR) monitored by the assurance committees and an update on high scoring directorate/ team risks.
Executive summary:	There are **18 risks on the corporate risk register** and the detail is provided in the report. • There is one corporate risk monitored at the audit and risk committee. **Risk 5401** relating to cyber security has no change to scoring. The risk actions and controls have been updated, and one new action has been created. • One **new corporate risk 5461** relating to access to specialist medical emergency eating disorders (MEED) support has been added to the register for monitoring at the Quality Assurance Committee, approved by the executive lead. Further discussions are required to consider this as a strategic risk. • One **new corporate risk 5351** relating to medical cover in the health-based place of safety has been added to the register for monitoring at the Mental Health Legislation Committee, approved by the executive lead. • **Risk 5438** has a revised risk description following discussion at the Board of Directors in May 2025 and risk oversight group in June 2025. • A **new risk** (**risk 5474**) relating to the governance of AI tools to support or influence clinical decision-making is **proposed for the corporate risk register** has a risk score of 12 and has been approved by the executive lead. There are **four** organisational risks **scoring 16 and above** as noted below.

Risk	Description	Risk rating severity x likelihood
4756	There is a risk that demand for the ADHD pathway greatly outweighs the resource and capacity of the service, resulting in	Current 4 x 4 = 16 Target 2 x 4 = 8

	increasing wait times and high numbers of people not being screened and waiting for assessment and diagnosis. **Quality Assurance Committee**	Movement ⟷
4757	There is a risk to patient health and wellbeing due to the exponential increase in demand on gender identity services caused by historic staff absence, recruitment issues, and national specification requirements that combine to create inefficient system flow resulting in long waiting times and waiting time increases in excess of commissioned targets. **Quality Assurance Committee**	Current 4 x 4 = 16 Target 4 x 2 = 8 Movement ⟷
5001	There is a risk that patients are delayed in accessing an acute hospital bed in Sheffield caused by reduced patient flow through our acute, crisis, and community services resulting in a risk to the quality and safety of patient care **Quality Assurance Committee**	Current 4 x 4 = 16 Target 3 x 2 = 6 Movement ⟷
4100	There is a risk of deterioration in mental health and safety of patients and carers, caused by a lack of access to available mental health beds, resulting in patients being supported in the community by the older adult (OA) home treatment team **Quality Assurance Committee**	Current 4 x 4 = 16 Target 4 x 2 = 8 Movement ⟷

Work is underway to review the **risk management framework** for 2025-2026. Feedback from the divisional risk management audit undertaken during 2025-2025 has been incorporated into the revised framework and work continues to update the risk appetite and align the agreed risk domains throughout the document.

Appendices:
Appendix 1: Ulysses extraction corporate risk register

Which strategic objective does the item primarily contribute to:					
Effective Use of Resources	*Yes*	**X**	*No*		
Deliver Outstanding Care	*Yes*	**X**	*No*		
Great Place to Work	*Yes*	**X**	*No*		
Reduce inequalities	*Yes*	**X**	*No*		

What is the contribution to the delivery of standards, legal obligations and/or wider system and partnership working.

- Well-Led Development plan 'The Trust must ensure that effective governance systems are in place to assess, monitor and improve the quality and safety of services'.
- Failure to properly review risks could result in Board or its committees not being fully sighted on key risks facing the organisation.
- Failure to implement risk management processes will not support the Trust to fulfil regulatory requirements. The Trust risk management framework is consistent with internal audit good practice and is currently under review for 2025.

BAF and corporate risk/s:	All corporate risks are included and have links to the BAF risks
Any background papers/ items previously considered:	The corporate risk report is received regularly at EMT, RoG, board assurance committees and the public Board of directors.
Recommendation:	The Board of directors are asked to: • **Note** the updates provided on all the corporate risks. • **Approve** the revised risk description for risk 5438. • **Agree** risk 5461 as a strategic risk. • **Approve** risk 5351 for the corporate risk register. • **Agree** the proposed corporate risk 5474 for the corporate risk register.

Board of Directors
Corporate risk register report
30 July 2025

1. Purpose of the report

The purpose of the report is to provide a summary analysis of the risks on the corporate risk register (CRR) monitored by the assurance committees.

2. Background

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

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

The risk oversight group (RoG) meets monthly in advance of EMT, to undertake further confirm and challenge with risk owners to support onward reporting and recommendations to EMT and the Board Assurance Committees.

3. Risk profile

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 low (green), moderate (yellow), high (amber) or extreme (red).

3.1 The table below shows the spread of risks on the register as of July 2025 and scoring used is reflective of the current risk management framework.

Severity					
Catastrophic (5)			**2**		
Major (4)			**4**	**4**	
Moderate (3)				**7**	**1**
Minor (2)					
Negligible (1)					
Likelihood	(1) Rare	(2) Unlikely	(3) Possible	(4) Likely	(5) Almost Certain

4. Alerts

4.1 new risk - eating disorders service

One new corporate risk 5461 relating to access to specialist medical emergency eating disorders (MEED) support has been added to the register for monitoring at the quality assurance committee and is under further review for transfer from the corporate risk register to a strategic risk.

Risk number	Description	Monitoring Committee Executive lead	Current score Severity x likelihood	Target score Severity x likelihood	Update
NEW 5461 BAF0027	There is a risk that service users from Rotherham, Barnsley and Doncaster open to the Sheffield Eating Disorder Service cannot access specialist medical emergency in eating disorders (MEED) support in their locality. This brings a clinical risk to patients and creates a pressure upon the regional specialist adult team to respond in an unplanned way.	Quality Assurance Committee Chief operating officer	3 x 4 = 12	3 x 3 = 9	Discussed at RoG and EMT during June and being reconsidered as a strategic risk.

4.2 new risk – medical cover health-based place of safety (HBPoS)

Risk number	Description	Monitoring Committee Executive lead	Current score Severity x likelihood	Target score Severity x likelihood	Update
NEW 5351 BAF0029	There is a risk that patients in the health-based place of safety (HBPoS) will not have adequate medical oversight due to no medical budget and registered consultant (RC) cover and the use of the HBPOS as an inpatient facility resulting in a risk to service user clinical quality and safety.	Mental Health Legislation Committee Executive medical director	3 x 5 =15	3 x 1 = 3	Clinical Director to provide RC role for those repurposed/breached to HBPoS under MHA Section. Endcliffe Juniors to provide medical cover for those detained under Section 136. Still awaiting feedback from senior leaders as to plans for future practice and service provision for those repurposed/breached to HBPoS beds.

4.3 Alert new risk description

Risk number	Description	Monitoring Committee Executive lead	Current score Severity x likelihood	Target score Severity x likelihood	Update
NEW 5438 BAF0029	To be confirmed	Quality Assurance Committee Executive director of nursing professions	4 x 3=12	4 x 1 = 4	Risk reviewed 16 June. Improvement in staffing and incidents. Awaiting enhanced support plan actions to address areas of

		and quality			concern. Weekly focus meetings continue, risk level to be consdiered at next review.

4.4 Alert – proposed escalation to the corporate risk register

This risk is proposed for escalation following communication from NHS England who made it clear that NHS Trusts should stop using unregistered 'AI' scribing tools on clinical safety, medical devices, legislation, information governance. The risk oversight group has asked the risk owner to amend the risk description to reflect that this is a potential risk and not a risk triggered by an incident.

Following agreement for escalation from the Board of directors, work will take place to develop the controls and actions, and the risk will be presented to the audit and risk committee for monitoring.

Risk number	Description	Monitoring Committee Executive lead	Current score Severity x likelihood	Target score Severity x likelihood	Update
5474 BAF0029	There is a significant risk of clinical harm, data breaches, and loss of public trust caused by staff using AI tools to support or influence clinical decision-making without appropriate governance, validation, and approval. This could result in; inaccurate outputs or biased recommendations leading to harm to multiple patients; breaches of data protection regulations, (regulatory penalties >£100k) and reputational damage (MP concern / negative national media coverage > 3 days).	Audit and Risk Committee	4 x 3 = 12	4 x 2 = 8	Digital risk currently on the directorate team risk register, proposed for escalation to the corporate risk register, with approval from the exectuive lead.

5. Advise

5.1 no changes to scoring to risks monitored at the Audit and Risk Committee

Risk number	Description	Monitoring Committee Executive lead	Current score Severity x likelihood	Target score Severity x likelihood	Update
5401 BAF0021	There is a risk that all corporate and clinical services cannot operate safely because technology is unavailable due to a cyber security incident	Audit and Risk Committee Executive director of Finance and digital	4 x 3 = 12 ⟺	4 x 1 = 4	Risk reviewed on 26 June 2025. Risk reviewed, actions updated and new action created.

5.2 no changes to scoring to risks monitored at the People Committee

Risk number	Description	Monitoring Committee Executive lead	Current score Severity x likelihood	Target score Severity x likelihood	Update
5409 BAF0014	There is a risk to patient safety due to medical staffing and recruitment challenges resulting in a sub-optimal level of medical capacity in inpatient and community services	People Committee Interim medical director	3 x 4 =12 ⟺	4 x 2 =-8	Risk reviewed 27 June 2025. This risk continues to be managed with further active recruitment and additional initiatives including a recruitment event for SpRs and a special edition of Trent RCPsych Newsletter featuring SHSC Drs in July 2025. One action is overdue for review. No change recommended to the scoring.

Risk number	Description	Monitoring Committee Executive lead	Current score Severity x likelihood	Target score Severity x likelihood	Update
5385 BAF0013	There is a risk that reporting systems do not support an effective response to sexual safety, racism and violence caused by the culture of reporting resulting in low staff morale, wellbeing and quality of care.	People Committee Executive director of people	3 x 4 =12 ⟺	3 x 2 = 6	Risk reviewed 3 July 2025. Updated actions and closed actions to reflect the development of the detailed violence and aggression plan. One action is overdue for review,

Risk number	Description	Monitoring Committee Executive lead	Current score Severity x likelihood	Target score Severity x likelihood	Update
5321 BAF0014	There is a risk that we are unable to meet mandatory training compliance levels caused by a variety of factors impacting on one or more training subjects including lack of suitable training space for delivery of training; trainer capacity, access to computers for e learning, local authority places for safeguarding and difficulties in staff release resulting in targets and CQC requirements not being met.	People Committee Executive director of people	3 x 4 =12 ⟺	2 x 3 = 6	Risk reviewed 10 July 2025. Three subjects previously below 80% now above as at 02/07/2025. Mental Health Act, ILS & Rapid Tranquilisation, Interim Moving and Handling / Back Care Lead now in post and training restarting 18/07/2025 and recovery plan in place The National mandatory Training review webinar was held on 04/06/25. Three subjects are currently being reviewed to be added to nationally mandated list, patient safety, Oliver McGowan and sexual safety - further details will be provided at next webinar on 09/07/25.

5.2 no changes to scoring on risks monitored at the Quality Assurance Committee

Risk number	Description	Monitoring Committee Executive lead	Current score Severity x likelihood	Target score Severity x likelihood	Update
5001 BAF0029	There is a risk that patients are delayed in accessing an acute hospital bed in Sheffield caused by reduced patient flow through our acute, crisis, and community services resulting in a risk to the quality and safety of patient care.	Quality Assurance Committee Director of Operations	4 x 4 = 16 ⟺	3 x 2 = 6	Risk reviewed 3 July, no change to scoring at this time.
4100 BAF 0029	There is a risk of deterioration in mental health and safety of patients and carers, caused by a lack of access to available mental health beds, resulting in patients being supported in the community by the older adult (OA) home treatment team impacting on the quality and safety of care, and staff wellbeing.	Quality Assurance Committee Executive director of nursing, professions and quality	4x 4 = 16 ⟺	4 x 2 =8	Reviewed 17 June. Risk controls and actions reviewed and remain relevant. Risk score remains the same
4756 BAF 0029	There is a risk that demand for the ADHD pathway greatly outweighs the resource and capacity of the service, resulting in increasing wait times and high numbers of people not being screened and waiting for assessment and diagnosis.	Quality Assurance Committee Director of Operations	4 x 4 = 16 ⟺	2 x 4 = 8	Risk reviewed 4 July. Controls and actions updated, no change to the scoring currently.
4757 BAF 0029	There is a risk to patient health and wellbeing due to the exponential increase in demand on gender identity services caused by historic staff absence, recruitment issues, and national specification requirements that combine to create inefficient system flow resulting in long waiting times and waiting time increases in excess of commissioned targets.	Quality Assurance Committee Director of Operations	4 x 4 = 16 ⟺	4 x 2 =8	Risk reviewed 4 July. Controls and actions updated, no change to the scoring currently.
5429 BAF0024	There is a risk that section 42 enquiries are not currently being allocated and completed within statutory timeframes as stated in the Care Act 2014 caused by ongoing delays in allocation and staff capacity to complete in a timely manner resulting in a delay in sharing safeguarding information with Sheffield Adult Social Care and not working within the principles of Making	Quality Assurance Committee Executive director of nursing professions and quality	3 x 4 = 12 ⟺	3 x 1 = 3	Risk reviewed 30 June. Risk has been reviewed. No change to scoring at this time. Actions marked as completed and new action added.

	Safeguarding Personal				
5410 BAF0029	There is a risk that the hospital discharge of restricted patients is delayed due to administration by the Ministry of Justice. This may adversely affect patient experience and outcomes and may significantly reduce our hospital bed capacity, causing delays in arranging hospital admission for other patients	Quality Assurance Committee Interim Director of Operations	3 x 4 = 12 ⟺	3 x 2 = 6	Risk reviewed 5 June. No changes.

5.3 no changes to scoring on risks monitored at the Finance and Performance Committee

Risk number	Description	Monitoring Committee Executive lead	Current score Severity x likelihood	Target score Severity x likelihood	Update
5344 BAF0026	There is a risk that the integrity and safety of the fire doors have been compromised caused by inadequate maintenance through a sufficient Planned Preventative Maintenance (PPM) regime resulting in reduced effectiveness in minimising the spread of fire and smoke	Finance and performance Committee Director of Strategy	5 x 3 =15 ⟺	4 x 1 = 4	Risk reviewed 20 June. Survey for Forest Lodge now been received. Currently awaiting the associated cost estimates which will be incorporated into the programme of replacement, upgrades, and remedial works. The tender for the capital works planned for the 2025/26 financial year is scheduled to be issued this month. The anticipated start date on site is October 2025.
5051 BAF0022	There is a risk of failure to deliver the required level of savings for 2025/26 will result in the planned deficit not being met.	Finance and performance Committee Director of Finance	5 x 3 = 15 ⟺	3 x 2 = 6	Risk reviewed on 2 June. Updated information on action - focus on turning additional proposals into signed off plans in June. Month 1 shows off plan but mostly offset with underspends due to vacancies and additional income therefore score kept at 15.
5462 BAF0023	There is a risk that the Rio optimisation phase does not deliver the expected benefits or introduces additional safety	Finance and performance Committee Director of	4 x 3 = 12 ⟺	3 x 2 =6	Risk reviewed 19 June. A detailed risk profile has been developed

	and efficiency challenges to existing clinical pathways. This could result in unsafe changes that put service users at risk, an unacceptable burden on staff and/or additional costs.	Finance			for the optimisation phase, and mitigations are being developed and will be in place by end of June 2025.

5.4 no changes to scoring on risks monitored at the Mental Health Legislation Committee

Risk number	Description	Monitoring Committee Executive lead	Current score Severity x likelihood	Target score Severity x likelihood	Update
5026 BAF0024	There is a risk that patients who come under the Deprivation of Liberty Safeguards (DOLS) framework are detained on SHSC staffed premises with no legal authority in place to authorise this. This is caused by significant delays and backlogs within the Local Authority (who are responsible for conducting such assessments and authorisations). This could result in patient's legal rights being breached by the Trust, and the Trust potentially being challenged legally by a patient or their representative.	Mental Health Legislation Committee Executive medical director	3 x 4 =12 ⟺	3 x 1 = 3	Risk reviewed on 26 June 2025. Risk remains unchanged. There continues to be repeated occasions when individuals are being deprived of their liberty with no lawful authority being in place. This continues to be an issue nationally.
5124 BAF0024	There is a risk that the Trust is not compliant with s132/132A Mental Health Act (the requirement to provide information to patients). This is caused by a lack of assurance that the legally required information is being provided to patients in a timely manner. This could result in the Trust breaching patients' rights and exposes the Trust to potential regulatory action.	Mental Health Legislation Committee Executive medical director	4 x 3 = 12 ⟺	2 x 3 = 6	Risk reviewed on 26 June 2025. Actions updated. Risk score reconsidered. Not yet assured that the reduction of incidents is attributed to a demonstrable improvement in practice. New action added.

6 Deescalated/ closed risks

None.

7 Assure Directorate and team risk registers

- A Ulysses extraction report continues to take place monthly to monitor any new, high-scoring risks on the directorate and team registers and to ensure discussion takes place

with executive leads to determine if these should be considered for escalation onto the CRR and reported through to RoG and EMT for agreement prior to circulation in the CRR to the assurance committees.

- There are no risks under the auspices of this committee to highlight from the June 2025 extraction report.
- Monthly meetings take place with teams and individuals, including a review of registers with a focus on scoring of risks and any training required.

Recommendations

The Board of Directors are asked to:

- **Note** the updates provided on all the corporate risks.
- **Agree** risk 5461 as a strategic risk**.**
- **Approve** risk 5351 for the corporate risk register.
- **Agree** the proposed corporate risk 5474 for the corporate risk register.

Appendices:

Appendix 1: Ulysses extraction corporate risk register – July 2025

CORPORATE RISK REGISTER

As at: July 2025

Risk No. 4100 v. 25 BAF Ref: BAF.0029	Risk Type: Clinical ,Quality And / Safety	Risk Appetite:
Version Date: 04/02/2025	Directorate: Rehabilitation & Specialist Se	Monitoring Group: Quality Assurance Committee
First Created: 22/11/2018	Exec Lead: Director Of Nursing, Professions And Quality	Last Reviewed: 17/06/2025
		Review Frequency: Monthly

Details of Risk:

There is a risk of deterioration in mental health and safety of patients and carers, caused by a lack of access to available mental health beds, resulting in patients being supported in the community by the older adult (OA) home treatment team impacting on the quality and safety of care, and staff wellbeing.

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

CONTROLS IN PLACE

- Clearly documented on the electronic patient record stating reason for admission in order for all relevant people to be able to access this information to aid prioritisation
- Discussion within the team to increase input whilst waiting for a bed, agree risk management plan within the MDT
- Supporting carers by offering them time to talk & discuss issues, sign post them to different agencies
- Link nurse in situ between Dovedale ward and G1 ward with weekly contact to look at supporting people back home where appropriate
- Ensure flow co-ordinators are aware of any potential or required admissions or MHA assessments and that they are placed on the at risk of admission list
- OA Flow team to look for an out of city bed where this is felt appropriate - following the procedure for this as detailed in local guidance
- Weekly meeting with Dovedale and wider older adult services to discuss flow between teams and prioritise referral in and out of the ward. Flow co-ordinators are updated with this.
- Monday to Friday Older Adult flow meeting will discuss anyone on the CAHA list
- Clients at risk of hospital admission (CAHA) list for consultant gatekeeping to prioritise referrals

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

Liaise with the approved mental heath practitioners to understand timeframes for assessments.	This is an ongoing action	31/08/2025 Rachel Noble
To review Flow in the system and look to increase capacity as part of inpatient campus review	Discussions within the trust regarding the use of Older adults beds and some appetite to review this when wards are based together. this is looking to progress in 26 / 27	31/12/2026 Kerri Booker
Review of individual patient visit plans to increase contact as necessary and based on risk assessment, and ensuring that reporting takes place for risk incidents and safeguarding	This is an ongoing action	31/08/2025 Chris Ludford
Ensuring that patients has access to out of team hours and crisis support information	This is an ongoing action	31/08/2025 Chris Ludford

• Daily huddle between home treatment team and community mental health teams (CMHT) • Older adult services flow meeting - daily Monday to Friday • Workplace wellbeing sessions and psychological lead monthly reflective practice session.	Ensuring that individual have an up to date safety plan which is co-produced with the patient	This is an ongoing action	31/08/2025 Chris Ludford
	Support of staff time to enable them to have access to the wellbeing/ reflective session and the staff wellbeing monthly group facilitated by peers from the team	Wellbeing sessions continue with positive outcomes however. 3 out of a planned 6 have taken place,. This will be reviewed at the end of the 6 sessions as access to psychology in the team is currently limited.	31/08/2025 Chris Ludford
	Access to senior nurses within adult flow for support at evenings and weekend.	This is an ongoing action	31/08/2025 Chris Ludford
	Escalation at flow huddle via the CAHA list where a patient risk changes	This is an ongoing action	31/08/2025 Chris Ludford

Risk No. 4756 v. 16 BAF Ref: BAF.0029	Risk Type: Strategic / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee
Version Date: 17/07/2025	Directorate: Rehabilitation & Specialist Se	Last Reviewed: 04/07/2025
First Created: 28/10/2021	Exec Lead: Director Of Operations	Review Frequency: Monthly

Details of Risk:

There is a risk that demand for the ADHD pathway greatly outweighs the resource and capacity of the service, resulting in increasing wait times and high numbers of people not being screened and waiting for assessment and diagnosis.

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

CONTROLS IN PLACE

- QEIA raised to identify the demand into the ADHD pathway.
- Monthly task and finish meeting with ICB
- Quarterly update report provided to QAC
- Weekly meetings with the team
- Model has been reviewed - structure will be applied to inform best model

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

Completion of workforce plan and job plans to enable agreement of performance trajectory for increased activity	Partial recruitment undertaken - revised model being costed for further recruitment to be carried out	31/07/2025 Alison Egginton
Engagement with ICB T&F/SDIP to explore longer term city-wide clinical model and support initiation	Monthly meeting with the ICB continue to take place	01/09/2025 Alison Egginton

Risk No. 4757 v.16 BAF Ref: BAF.0029	Risk Type: Clinical ,Quality And/ Safety	Risk Appetite: Low
Version Date: 17/07/2025	Directorate: Rehabilitation & Specialist Se	Monitoring Group: Quality Assurance Committee
First Created: 28/10/2021	Exec Lead: Director Of Operations	Last Reviewed: 04/07/2025
		Review Frequency: Monthly

Details of Risk:

There is a risk to patient health and wellbeing due to the exponential increase in demand on gender identity services caused by historic staff absence, recruitment issues, and national specification requirements that combine to create inefficient system flow resulting in long waiting times and waiting time increases in excess of commissioned targets.

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

CONTROLS IN PLACE

- Developing link with Primary Care Projects. This seeks to reduce referrals by supporting primary care to take the lead in diagnostics and support on the pathway.
- People are supported on the waiting list via the primary care provider. The clinic works with voluntary and non-statutory support services to offer support while waiting for assessment.
- Service works in line with NHS E guidance and service specification. Also work with the Northern region of providers to share best practice and collaborate with standard process development.
- Strengthening 'waiting well' initiative with team peer support workers and the appointment of a Comms Officer to address information requirements
- Third party provider appointed to undertake backlog of surgical progression second opinion assessments to progress people through the pathway
- Additional evening medical session agreed to address backlog of DR1/2 and enable people to enter the pathway
- Quarterly report provided to QAC
- Managed Clinic Network being rolled out
- NHS E QI lead started in post

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

GIC engaging with NHS E for 'deep dive' and recommendations for clinical model delivery.	Still awaiting final report	30/06/2025 Alison Egginton
Recruitment to new workforce plan for GIC to address single points of failure within operational delivery and support increased throughput.	Budget now approved by EMT. Remaining posts in the workforce model to be recruited to.	31/08/2025 Alison Egginton
Clinical process review to be undertaken by Medical Director and Head of Nursing	GIC Budget to be reviewed by EMT	30/06/2025 Alison Egginton
GIC is part of the Trust-wide QI programme addressing issues of waiting times and waiting well. The QI programme will explore different ways of working to increase operational efficiency and to support and engage service users and enhance waiting well initiatives.	NHS England QI lead now in post	31/07/2025 Alison Egginton

Risk No. 5001 v.12 BAF Ref: BAF.0029	Risk Type: Clinical ,Quality And / Safety	Risk Appetite: Low
Version Date: 03/07/2025	Directorate: Acute & Community	Monitoring Group: Quality Assurance Committee
First Created: 16/11/2022	Exec Lead: Director Of Operations	Last Reviewed: 04/07/2025
		Review Frequency: Monthly

Details of Risk:

There is a risk that patients are delayed in accessing an acute hospital bed in Sheffield caused by reduced patient flow through our acute, crisis, and community services resulting in a risk to the quality and safety of patient care.

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	2	6

CONTROLS IN PLACE

- Daily meetings between CRHTT, flow and AMHPs keeps overview of the list
- Review of CAHA monthly in governance meetings.
- Escalating concerns or incidents via incident reporting procedures
- Daily CAHA meetings rescheduled to inform bed allocation meeting and to promote productivity of CAHA
- the care and support being delivered by CRHTT, Liaison Psychiatry or other crisis service (albeit not in accordance with the assessed need for admission)
- standard SOP in place to ensure all staff are following same process in the event of a delay
- clinical prioritisation for admission
- reducing delayed discharges to make a hospital bed available at the point of need
- CRHTT in-reach to support earlier discharge from hospital
- Efficient delivery of hospital care (less than 38 day length of stay)
- Development of the HOME FIRST program in SHSC. This will help aid patient flow, and reduce need for admissions.

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

Look at development of MDT support between CRHTT interface nurses, discharge coordinators and facilitators to improve communication around patient flow.	Ongoing work toward HTT taking full control of gatekeeping, this is part of the wider Home Program.	30/07/2025 Christopher Wood

Risk No. 5026 v.4 BAF Ref: BAF.0024	Risk Type: Statutory/ Compliance / Risk Appetite: Low	Monitoring Group: Mental Health Legislation Committee
Version Date: 29/09/2023	Directorate: Medical	Last Reviewed: 27/06/2025
First Created: 20/12/2022	Exec Lead: Medical Director	Review Frequency: Monthly

Details of Risk:

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

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

CONTROLS IN PLACE

- The Trust has a Deprivation of Liberty Safeguards (DOLS) policy in place to facilitate referrals being made to the Local Authority in a timely manner.
- There is a recognition nationally that the DOLS processes are not fit for purpose and that DOLS is expected to be replaced by a new legal process known as the Liberty Protection Safeguards (LPS) - although there is no date for when this will be enacted by Government.
- Most individuals admitted to SHSC wards are admitted under the Mental Health Act for the treatment of mental disorder. Most inpatients would therefore not be eligible for DOLS.
- The Local Authority has introduced a triage system to prioritise DOLS assessments
- Forum in place, by means of the citywide Mental Capacity Act Action Network (MCAAN), where issues in relation to DOLS can be discussed at a partnership level.

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

Risk No. 5051 v.5 BAF Ref: BAF.0022	Risk Type: Financial / Risk Appetite: Moderate	Monitoring Group: Finance & Performance Committee
Version Date: 01/04/2025	Directorate: Finance Sustainability	Last Reviewed: 07/07/2025
First Created: 01/02/2023	Exec Lead: Director Of Finance	Review Frequency: Monthly

Details of Risk:

There is a risk of failure to deliver the required level of savings for 2025/26 will result in the planned deficit not being met.

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	4	4	16
Current Risk: (with current controls):	5	3	15
Target Risk: (after improved controls):	3	2	6

CONTROLS IN PLACE

- Cost Improvement Programme Board and Working Groups established to confirm targets, identify and establish schemes, review Scheme Initiation Documents, ensure QEIA process undertaken and monitor progress.
- Transformation projects programme board and benefits realisation monitoring and oversight
- Performance Management Framework is in place with overspending areas required to have a monthly Performance review meeting
- Trust Business Planning Systems and Processes, Including CIP monitoring, QEIA and Executive oversight of the CIP programme Board and each of the 3 working groups focussed on Out of Area, Agency and all other schemes
- Forms part of routine finance reporting to FPC, Board, ICB and NHSE
- Additional controls added with EMT reviewing and making any investment decisions in light of increased system oversight and need for Exec level group to oversee new expenditure commitments.
- Executive Management Team being added back into SFIs and Scheme of Delegation under Board Sub committee's as a decision making forum above BPG.
- Additional controls agreed by EMT to help support financial recovery and reduce the expenditure run rate and overall deficit. This include the cessation of non essential expenditure. Exec led vacancy panels for non frontline roles

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

Finance and PMO working with Leads to deliver further VIP plans and reduce gaps from target.	Additional £1.4m plans in June, further £1m proposal found to be unviable but have added further £1m proposals to offset. Have reintroduced weekly Executive VIP huddle to escalate and progress actions quickly so that signed off plans over £8m as soon as possible.	31/07/2025 Chris Cotton

and various other controls.

- Formal recovery plans for any areas overspending by over £50k.
- EMT Finance huddles in place to provide additional oversight and challenge on savings plans and financial performance
- Additional Financial controls implemented from 1st October 2024 including vacancy freeze for non clinical non critical roles and Exec approval for agency and locum usage.
- Home First programme board in place to improve Out of Area usage - this includes working with and escalating to System partners to improve discharge pathways to reduce inpatient demand and discharge delays.
- VIP Programme Board monitoring progress of plans and delivery throughout the year.

Risk No. 5124 v.5 BAF Ref: BAF.0024	Risk Type: Statutory/ Compliance / Risk Appetite: Moderate	Monitoring Group: Mental Health Legislation Committee
Version Date: 21/03/2024	Directorate: Medical	Last Reviewed: 26/06/2025
First Created: 15/05/2023	Exec Lead: Medical Director	Review Frequency: Monthly

Details of Risk:

There is a risk that the Trust is not compliant with s132/132A Mental Health Act (the requirement to provide information to patients). This is caused by a lack of assurance that the legally required information is being provided to patients in a timely manner. This could result in the Trust breaching patients' rights and exposes the Trust to potential regulatory action.

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):	2	3	6

CONTROLS IN PLACE

- Ward staff are aware of their obligations under s132
- The MHA office will submit incident reports when compliance cannot be evidenced
- Mental health legislation incidents, which includes reporting when we cannot evidence compliance with s132/132A, are reported on as a standard agenda item at the Mental Health Legislation Operational Group.
- A provision of information to patients under s132/132A policy is place.
- The importance of providing information to patients under s132/132A Mental Health Act is covered in the current mandatory Mental Health Act training
- The paperwork which staff need to fulfil duties under s132/132A Mental Health Act is available on Jarvis.

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

Head of Mental Health Legislation to liaise with Mental Health Act office to review incident data in respect of non-compliance, with a view to establishing whether decrease in incidents is because of improved compliance, or because of other reason.

04/07/2025
Jamie Middleton

CORPORATE RISK REGISTER

As at: July 2025

Risk No. 5321 v.11 BAF Ref: BAF.0014	Risk Type: Workforce / Risk Appetite: Low	Monitoring Group: People Committee
Version Date: 04/02/2025	Directorate: People	Last Reviewed: 10/07/2025
First Created: 14/03/2024	Exec Lead: Director Of People	Review Frequency: Monthly

Details of Risk:

There is a risk that we are unable to meet mandatory training compliance levels caused by a variety of factors impacting on one or more training subjects including lack of suitable training space for delivery of training; trainer capacity, access to computers for e learning, and difficulties in staff release resulting in targets and CQC requirements not being met.

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):	2	3	6

CONTROLS IN PLACE

- Mandatory Training governance group reporting to Workforce and Recruitment assurance group
- monitoring of mandatory training compliance at Directorate IPQR meetings
- Mandatory training recovery plans reported at EMT prior to being presented at People Committee - this is now taken through Trust SLT
- Mandatory Training compliance reports sent to all managers every Month (updated from May 2025 - in line with other Trust reporting)
- Monitoring of physical health training compliance at Physical Health group reporting into Quality assurance Committee
- Safeguarding Training Implementation Plan
- Manager and Supervisor Self Service on ESR gives teams visibility of staff training records since 01/04/2024
- Mandatory Training now a standing item at the Operation Management Group - who will also act as the internal Mandatory Training oversight committee
- NHS England leading a national mandatory training review
- Mandatory Training Update received by Trust SLT every month & Mandatory Training Lead attends every month to Alert, Advise and Assure. Teams under 80% compliance have formal recovery plans monitored through SLT

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

A focus on rostering to support managers to plan training more effectively and ensure that they roster staff across the year and within headroom parameters.	Target date extended while the work is reviewed and embedded	31/10/2025 Stephen Sellars
A plan for improvement and expansion of training space at Chestnut cottage has been presented by Estates and agreed with the training teams who use the space. Next steps are to agree costs and timeframes for completion. lack of suitable training space is impacting on compliance for Resus Level 2 and 3; Moving and Handling Level 2.	date extended as no work has started on this as yet	31/12/2025 Liam Casey
Full time Interim Moving and Handling / Back Care Lead in post for 6 months - June - December 2025 Moving and handling Level 2 training restarting 18th July 2025 - and training sessions planned to achieve		31/10/2025 Lindsay Wood

80% by end of October 2025

Risk No. 5344 v.6 BAF Ref: BAF.0024	Risk Type: Statutory/ Compliance / Risk Appetite: Moderate	Monitoring Group: Finance & Performance Committee
Version Date: 13/12/2024	Directorate: Facilities	Last Reviewed: 20/06/2025
First Created: 21/06/2024	Exec Lead: Director Of Strategy	Review Frequency: Monthly

Details of Risk:

There is a risk that the integrity and safety of the fire doors have been compromised caused by inadequate maintenance through a sufficient Planned Preventative Maintenance(PPM) regime resulting in reduced effectiveness in minimising the spread of fire and smoke

Risk Rating:	Severity	Likelihood	Score
Initial Risk (before controls):	4	5	20
Current Risk: (with current controls):	5	3	15
Target Risk: (after improved controls):	4	1	4

CONTROLS IN PLACE

• Fire Risk Assessments (FRA) have been completed in every Trust building. The primary aim of such assessments is to ensure the safety of all individuals present within Trust premises in the event of a fire.

Fire Doors form part of this assessment. the FRA have identified the overall risk as low risk. However, when applying the HTM risk assessment methodology, the risk has been identified as Moderate.

• Bi-Weekly Task and Finish Group established to monitor completion of actions

• Business case for fire door survey and installation of new fire doors approved at BPG on the 18th June

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

Renew the Kingsway Doors service contract and ensure that any additional doors, which may have been installed since the contract's inception, are included in the service visits.	Contract to be agree and signed. Will be in place before the next six monthly inspection is due.	31/07/2025 Andy Probert
Conduct a comprehensive survey of all fire doors. This survey should be undertaken by an independent company, which does not supply and fit fire doors, and should provide detailed information on the specific faults of each door. The survey should explain why each door fails to comply with standards and suggest precise remedial actions using approved techniques, rather than defaulting to the wholesale replacement of door sets.	Final survey report, for Forest Lodge and Forest close, has been received. Awaiting the costings report for items highlighted.	31/07/2025 Andy Probert

	Implement a comprehensive fire door maintenance regime on all standard fire doors. Integrate data from the asset tagging project into the department's PPM management system, with each door scheduled for six-monthly PPM, or more frequently if deemed necessary by a risk assessment as per NHS standards guidance.	Fire doors are being inspected by Porters. Kingsway contract, for Kingsway doors, to be signed prior to next 6 monthly inspection.	31/07/2025 Andy Probert

CORPORATE RISK REGISTER

As at: July 2025

Risk No. 5351 v.7 BAF Ref: BAF.0029	Risk Type: Clinical ,Quality And / Safety	Risk Appetite: Low
Version Date: 17/07/2025	Directorate: Acute & Community	Monitoring Group: Mental Health Legislation Committee
First Created: 04/07/2024	Exec Lead: Medical Director	Last Reviewed: 28/05/2025
		Review Frequency: Monthly

Details of Risk:

There is a risk that patients in the health based place of safety (HBPoS) will not have adequate medical oversight due to no medical budget and registered consultant (RC) cover and the use of the HBPOS as an inpatient facility resulting in a risk to service user clinical quality and safety.

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	1	3

CONTROLS IN PLACE

- Emergency and Crisis Care Directorate's clinical director provides cover for the 'RC' responsibilities for those detained to the HBPoS
- Endcliffe Ward's junior medical team provide support in the case of medical emergencies.

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

Situation escalated to Head of Service.
Advised to add to the risk register and escalate to a directorate level.

04/07/2024
Paul Harding

Head of service escalated the concerns around the current medical cover arrangements for the HBPoS.

Currently Section 136 service users should be supported by the Endcliffe medical team although this is not part of their agreed job plan.

Service users who are detained to a repurposed HBPoS bed, under the MHA have the clinical director as the allocated RC.

Initial escalation was raised in June 2024, this has been followed up on occassion without any feedback to

31/07/2025
Paul Harding

the HBPOS team.

Risk No. 5385 v.4 BAF Ref: BAF.0013	Risk Type: Clinical ,Quality And/ Safety	Risk Appetite: Moderate
Version Date: 22/10/2024	Directorate: People	Monitoring Group: People Committee
First Created: 29/08/2024	Exec Lead: Director Of People	Last Reviewed: 03/07/2025
		Review Frequency: Monthly

Details of Risk:

There is a risk that reporting systems do not support an effective response to sexual safety, racism and violence caused by the culture of reporting resulting in low staff morale, wellbeing and quality of care.

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

- incident reporting through Ulysees
- Daily Incident huddles
- Violence and Aggression reduction group reports into WODAG chaired jointly by Sarah Bawden and Vanessa Garrity
- A workshop was held in October 2024 with managers and other stakeholders to look at how to improve reporting of racism and other types of harassment and discrimination
- Violence and Aggression reduction group
- IPQR reporting includes relevant measures reviewed at Trust and service level monthly
- Violence prevention and reduction standard (2024 rev)
- Violence and reduction plan is in place
- Keeping our staff safe Campaign and Reducing Violence and reduction plan includng sexual safety, and racism

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

Development of SOP for reporting	SOP incorporated in to Policy and linked with plan. Timeframes for actions adjusted to reflect this as a whole piece of work	31/08/2025 Liz Johnson
Helen Wright to complete updating of the new ESR portal and make link available for testing	Delayed due to oversight of reporting being reviewed in line with the plan and consideration of whether ESR the most appropriate point. SS to provide fuirther update and close or amend action at this point	31/07/2025 Helen Wright
Review the role of risk assessment and ensure that our risk assessment governance is adequate including service user and service environment risk and how they fit together.	Planning completed. This work is linked to the Culture of Care programme and the Trust is a pilot site. Individual wards have been identified to pilot new	31/10/2025 Darren McCarthy

approach. Will require input onto new Jarvis system. Training underway Trust-wide.

Risk No. 5401 v.3 BAF Ref: BAF.0021B	Risk Type: Business / Risk Appetite: Moderate	Monitoring Group: Audit And Risk Committee
Version Date: 10/10/2024	Directorate: Digital	Last Reviewed: 27/06/2025
First Created: 01/09/2024	Exec Lead: Director Of Finance	Review Frequency: Monthly

Details of Risk:

There is a risk that all corporate and clinical services cannot operate safely because technology is unavailable due to a cyber security incident

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):	4	1	4

CONTROLS IN PLACE

- Governance group in place reporting into Audit committee
- Care Certs monitored and applied when appropriate
- Penetration Test takes place annually and recommendations actioned
- Security Awareness and Training takes place for all staff using IG training - compliance target of 80% is consistently met
- Phishing simulation exercise takes place annually. Results are analysed and actioned.
- Multi Factor authentication is now in place for all accounts.
- A suite of Security policies are in place
- Firewalls review inbound and outbound traffic into SHSC data centres. These are fully resiliant.
- Intrusion Detection and Prevention System. This monitors for suspicious activity as part of the firewall infrastructure
- Virtual Private Network is in place to provide secure, encrypted access to SHSC systems over the internet.
- Web security. We provide a web filtering tool that restricts access to websites when connected to the corporate network
- email security: anti spam, malware scanning and malicious URL detection is in place.

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

Creation of cyber incident response plan	Final CIRP still be to completed.	31/07/2025 Adam John Handley
Joining SHSC devices to control access to 365	Further updates to be completed to create conditional access rules which need to be created and tested.	31/07/2025 Emma Porter
Phishing Campaign		31/10/2025 Adam John Handley
Implementation of SASE Solution (Zscaler) to replace legacy web filtering and VPN solutions.	Zscaler solution has been implemented and legacy web filtering solution has expired. Finalising migration from FortiClient to Zscaler. Target date extended.	11/07/2025 Adam John Handley

• Public wireless network is secured and seperate from corporate network • Network Monitoring: We have a tool that monitors network usage. • Network segmentation: We seperate out corporate network traffic from non SHSC devices. This ensures that corporate services are not vunerable to threats from non SHSC devices. • As part of Microsoft licencing arrangement, our microsoft end points are part of a national infrastructure. This ensures it is monitored by ourselves and NHS E. We also use Sophos to provide anti malware protection • Mobile Device management: we use MS products to enforce our security policies on our corporate devices, This allows us to control software that is deployed to these devices, • All end user devices are secured using an encryption tool • We control access to systems by setting up and maintaining access to active directory. We manage what staff can access (network folders) through this • We control access to systems for staff who need administrative rights (system managers controlling configuration and user accounts) by using a privleged access management system • Cyber Assessment Framework Regional (ICS led) Audits took place in August 2024	Technical training on cyber security and/or cyber security system Action 2025 Pen Test remediation plan	Ongoing cyber training CISSP being completed by Emma Porter - IT Operations Lead Zscaler administration training completed by members of the Digital team on Tuesday 18th March Office 365 Security training completed by Systems Engineer in February.	31/10/2025 Adam John Handley 30/09/2025 Emma Porter

Risk No. 5409 v.3 BAF Ref: BAF.0014	Risk Type: Workforce / Risk Appetite: High	Monitoring Group: People Committee
Version Date: 17/07/2025	Directorate: Medical	Last Reviewed: 27/06/2025
First Created: 01/11/2024	Exec Lead: Medical Director	Review Frequency: Monthly

Details of Risk:

There is a risk to patient safety due medical staffing and recruitment challenges resulting in a sub-optimal level of medical capacity in inpatient and community services

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):	4	2	8

CONTROLS IN PLACE

- Medical Workforce Planning Group sets strategies to retain and recruit high quality medical staff.
- Ongoing recruitment aiming to fill gaps in medical staffing, particularly inpatient posts
- Ongoing projects to promote Psychiatry as a specialty choice for medical students and resident doctors
- Work to promote SHSC as employer of choice and identify potential recruits as they progress through the regional training scheme

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

Reconfigure inpatient staffing model to enable consultant staff to work across more clinical teams	Inability to recruit substantive staff still means changes cannot be implemented at present. Clinical Director working with colleagues on plan to use MPACs to cover approved clinician responsibilities which may enable functioning with less consultant medic time.	01/04/2025 Jonathan Mitchell

Risk No. 5410 v.1 BAF Ref: BAF.0029	Risk Type: Clinical ,Quality And/ Safety	Risk Appetite: Moderate
Version Date: 08/11/2024	Directorate: Acute & Community	Monitoring Group: Quality Assurance Committee
First Created: 08/11/2024	Exec Lead: Director Of Operations	Last Reviewed: 05/06/2025
		Review Frequency: Bi-Monthly

Details of Risk:

There is a risk that the hospital discharge of restricted patients is delayed due to administration by the Ministry of Justice. This may adversely affect patient experience and outcomes and may significantly reduce our hospital bed capacity, causing delays in arranging hospital admission for other patients

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

- Liaising with the MHA Office
- Regular discussion of progress in the Clinically Ready for Discharge Meeting
- Proactive clinical oversight to ensure appropriate management E.G use of leave
- Executive management oversight
- MHA (1983) Authorisation of S17 Leave Policy

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

Consideration of alternative accommodation e.g rehab	Remains ongoing. Work commenced with Home First Project looking at forensic service users and pathways	08/11/2025 Toni Dickinson
Head of Service and Consultant Psychologist meeting to discuss Pathway and Offer for 37/41 patients	work within the Home First Project has started, this is to support the ward teams with understanding pathways for forensic service users and ensuring following process and procedures	08/11/2025 Jessica Green

Risk No. 5429 v.2 BAF Ref: BAF.0024	Risk Type: Statutory/ Compliance / Risk Appetite: Low	Monitoring Group: Quality Assurance Committee
Version Date: 17/07/2025	Directorate: Nursing & Professions	Last Reviewed: 30/06/2025
First Created: 06/02/2025	Exec Lead: Director Of Nursing, Professions And Quality	Review Frequency: Monthly

Details of Risk:

There is a risk that section 42 Enquiries are not currently being allocated and completed within statutory timeframes as stated in the Care Act 2014 caused by ongoing delays in allocation and staff capacity to complete in a timely manner resulting in a delay in sharing safeguarding information with Sheffield Adult Social Care and not working within the principles of Making Safeguarding Personal

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

CONTROLS IN PLACE

- Current process of allocation using a distribution list of trained staff is ineffective. Current process allows the Safeguarding Administrator to allocate on a rotational basis based on details of trained staff that have been provided by SASP Training Team and SHSC Training Team. However staff have declined to complete enquiries resulting in multiple reallocations and delay in completion.
- Adult Safeguarding Policy offers guidance on what a Section 42 Enquiry is using Making Safeguarding Personal Principles to complete investigations
- Section Enquiry Standard Operating Procedure is in place to support management and allocation process for the Safeguarding Team
- Patient Safety Oversight Panel (PSOP) continues to have sight of approved enquiries.
- Completed S42 Enquiries are reviewed by Head of Safeguarding and Director of Dept. Director of Nursing approves completed enquiries to improve timeliness of submissions to the LA.

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

Ensure all General Managers have an accurate list of trained staff in their service lines so they can allocate accurately to trained staff.	11/07/2025 Hester Litten

previous role

• Wellbeing question is now within the staff survey which is fed back to the improvement group weekly

• Fortnightly reflective practice sessions for staff, facilitated by external professional to the team, in addition to internal reflective practice

• Fortnightly meeting established for senior leadership (Head of Nursing) to feedback on Improvement Plan progress and engage staff in the programme of improvements.

• Fortnightly meetings with commissioners (SYB PC) regarding enhanced monitoring and Improvement Plan updates.

• Substantive staff offered overtime payments for additional hours worked

CORPORATE RISK REGISTER

As at: July 2025

Risk No. 5461 v.4 BAF Ref: BAF.0027	Risk Type: Clinical ,Quality And / Safety	Risk Appetite:
Version Date: 17/07/2025	Directorate: Rehabilitation & Specialist Se	Monitoring Group: Quality Assurance Committee
First Created: 20/05/2025	Exec Lead: Director Of Operations	Last Reviewed: 27/06/2025
		Review Frequency: Monthly

Details of Risk:

There is a risk that service users from Rotherham, Barnsley and Doncaster open to the Sheffield Eating Disorder Service cannot access specialist medical emergency in eating disorders (MEED) support in their locality. This brings a clinical risk to patients and creates a pressure upon the regional specialist adult team to respond in an unplanned way.

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	3	9

CONTROLS IN PLACE

- Escalated as concern to ICB commissioners
- Raise directly with commissioners when individual cases arise.

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

Continue to raise via commissioning boards as risk and gap for patients requiring MEED admission and support outside of Sheffield	31/08/2025 William Gann

CORPORATE RISK REGISTER

As at: July 2025

Risk No. 5462 v.3 BAF Ref: BAF.0021A	Risk Type: Clinical ,Quality And Safety /	Risk Appetite:
Version Date: 20/05/2025	Directorate: Digital	Monitoring Group: Finance & Performance Committee
First Created: 20/05/2025	Exec Lead: Director Of Finance	Last Reviewed: 19/06/2025
		Review Frequency: Monthly

Details of Risk:

There is a risk that the Rio optimisation phase does not deliver the expected benefits or introduces additional safety and efficiency challenges to existing clinical pathways. This could result in unsafe changes that put service users at risk, an unacceptable burden on staff and/or additional costs.

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	2	6

CONTROLS IN PLACE

- Investment of 400k capital agreed by Trust Board
- Rio Programme Governance
- Rio/SystmOne Improvement Board (CSO, IG, Clinical System Management, Cyber Security represented)
- Supplier Engagement (The Access Group are part of the programme board)
- External Assurance - St Vincents Consulting are providing external assurance
- Trust is investing in Digital department to ensure support for Rio is fit for purpose
- testing of the solution

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

draft plan including other SHSC initiatives	Changed target date as we define deliverables for other programmes.	30/06/2025 Julian Young

Total: 18