Slough Borough Council

Report To:	Audit and Corporate Governance Committee
Date:	30 April 2025
Subject:	Q3 Corporate Risk Update
Chief Officer:	Annabel Scholes, Executive Director Corporate Resources
Contact Officer:	William Green, Interim Risk Manager
Ward(s):	All
Exempt:	NO
Appendices:	Appendix 'A' - Corporate Risk Profile Appendix 'B' - Q3 2024-25 Corporate Risk Dashboards (summary sheets)

1. Summary and Recommendations

1.1 This report sets out:

- The status of the Council risk profile in the Q3 2024/25 Risk Update.
- Breakdown of current Corporate Risks and Sub-Risks

Recommendations:

1.2 The Audit and Corporate Governance Committee is recommended to note the revised Corporate Risks and sub-risks as at Quarter 3 (February 2025).

Reasons

1.3 Summarising the Council's corporate risks for the Audit & Governance Committee ensures that Members are advised of the key risks facing the Council, and the extent to which they are being managed.

1.4 Producing information in a format that supports the communication of the Council's risk profile to Members is important to demonstrate good governance, and provide assurance that officers understand the nature of the Corporate Risks we face and are managing them effectively.

Commissioner Review

This report is outside the scope for pre-publication commissioner review; please check the Commissioners' instruction 5 to CLT to sign off papers for further details.

2. Background

2.1 The Council deals with risk every day from managing its infrastructure, delivering its services, managing its supply chains, maintaining safe systems for staff and residents

and delivering on its strategic aims. Effective risk management is concerned with identifying material risks, assessing them in a consistent manner, and managing them to levels that are acceptable.

2.2 To produce the Q3 2024/25 corporate risk report a full review of the current corporate risks was undertaken. The corporate risk report was presented at the Risk Management Board on the 11th February 2025 where it was signed off. The risk report was then presented to the CLT on the 26th February where it received a final sign off. The CLT also agreed and signed off on the inclusion of a new corporate risk CR14 (*Failure of Council Subsidiary Companies*) which will be incorporated in the Q4 corporate risk report. The current position is that out of thirteen identified corporate risks ten are rated as red (risk score between 20 – 25), down from twelve in the previous quarter, and three are rated as amber (risk score between 15 – 19). In Q2 forty-eight sub-risks were identified across all the corporate risks, this has now increased to fifty-three for Q3. It should be noted that this increase is not the result of our risk profile position becoming worse, but the fact that the new risk management approach is providing the opportunity to provide a fuller analysis of our current corporate risks. The full breakdown of our risks and sub-risks is provided in the table below (Q3 Corporate Risk and Sub-Risk).

Q3 Corporate Risk and Sub-Risk Summary Note:

Red risks are high-impact, high-likelihood risks that pose a severe threat to our objectives, operations, or strategic initiatives.

These risks require immediate attention and robust mitigation strategies.

	Score change & outlook change
	Outlook change, No score change

CR ref.	Corporate Risk - Sub-Risk	Impact Score	Likliehood score	Current Score	Score movement/Outlook last quarter
CR01	**Safeguarding Children and Young People – Child Death**	**4**	**3**	**18**	→
	SR01.01: Insufficient financial resources	4	3	18	↑
	SR01.02: Unsuccessful staff recruitment and retention	3	3	13	→
	SR01.03: High Caseloads	3	3	13	→
	SR01.04: Inexperienced staff and staff who are underperforming	4	3	18	→
CR06	**Health & Safety We fail to prevent physical injury or mental harm**	**4**	**4**	**21**	→
	SR06.01: We fail to prioritise adequately fund or manage risks associated with corporate health and safety	4	4	21	→
	SR06.02: We fail to prioritise adequately fund or manage risks associated with fire	4	4	21	→
	SR06.03: We fail to prioritise adequately fund or manage risks associated with aggressive behaviour	4	4	21	→
	SR06.04: Resource to accommodate organisational audit scrutiny and engage with training & Policy improvements	4	4	21	→
CR07	**Insufficient Operational Resilience and Crisis Management**	**4**	**4**	**21**	→
	SR07.01: Inadequate rapid emergency response capabilities to provide immediate incident co-ordination and humanitarian support to affected residents	4	4	21	NEW
	SR07.02: Failure of emergency planning for specific major hazard risks in the borough, such as flooding, major fires, industrial accident	4	4	21	NEW
	SR07.03: Failure of Major Incident Plan	4	3	18	NEW
	SR07.04: Lack of generic resilience arrangements for all services responsible for delivering business critical activities	4	4	21	NEW
	SR07.05: Inadequate continuity planning for specific risks	4	3	18	NEW
CR08	**ICT incident resulting in significant data and/or service**	**5**	**4**	**24**	→
	SR08.01: A cyber attack causes significant data or service loss	5	4	24	→
	SR08.02: A business continuity issue causes significant service loss	4	3	18	→
	SR08.03: An incident caused by hardware or software failure causes significant service loss	4	3	18	↑
CR09	**Failure to achieve financial sustainability and a balanced MTFS**	**5**	**4**	**24**	→
	SR09.01: Failure to deliver audited financial reports (SOA) to identify any additional financial liabilities to the council which will impact on financial sustainability	4	4	21	↓
	SR09.02: Failure to achieve a balanced budget and Medium Term Financial Strategy (MTFS)	5	4	24	↓
	SR09.03: Inadequate cashflow to maintain balance of liquidity to fund expenditure	4	2	14	→
	SR09.04: Government funding formula/distribution does not reflect the needs of the Slough community and demographic	4	5	23	↓
	SR09.05: Failure to recruit and retain a resilient and skilled workforce within finance	3	4	17	↓
	SR09.06: Failure to deliver the FIP which include internal controls an effective finance system both through tech and business processes	3	3	13	→
	SR09.07: Failure to deliver value for money from procurement processes - **NEW SUB-RISK**	3	5	20	NEW
CR10	**Failure of General Fund Asset Disposal Programme**	**4**	**3**	**18**	↑
	SR10.01: Property disposals not hitting financial targets and sitting outside of lower volatility levels	4	3	18	↑
	SR10.02: Pace of disposals is behind programme deliverable dates	4	3	18	→
	SR10.03: Attraction and Retention of quality people	4	3	18	→
	SR10.04: External property market volatility	4	3	18	→

CR11	**Failure to become a Best Value Council**	**5**	**4**	**24**	→
	SR11.01: Fail to improve and transform services that impacts adversely on residents and on budgets	5	4	24	→
	SR11.02: Fail to operate as a Best Value Council	5	3	22	→
	SR11.03: Unable to deliver new operating model and medium-term financial strategy	5	4	24	→
CR12	**Failure to deliver Market Sustainability across Council**	**4**	**4**	**21**	→
	SR12.01: Insufficient access to regulated services	2	3	8	↑
	SR12.02: Cost of care outstripping budget	4	4	21	↑
	SR12.03: Provider failure	3	3	13	↑
	SR12.04: Recruitment and retention of external workforce	3	4	17	NEW
CR13	**We fail to comply with GDPR data protection obligations**	**4**	**3**	**18**	→
	SR13.01: Privacy breach of personal data	4	3	18	→
	SR13.02: Unlawful retention and processing of personal data	3	3	13	→

2.3 As the Councils maturity in respect of risk management improves this will ensure that we will be in a better position to respond to complex and multi-factorial risks that reflect the cross departmental and multi-agency working needed and the key role that the Council needs to play.

2.4 The Councils risk exposure has not changed this quarter and although elevated, all risks are reported as being in a stable position other than CR04 (*Failure to Provide Safe Temporary Accommodation within Budget*).

2.5 It should be noted that in this quarter, two risks reached their target score, CR01 (*Safeguarding Children and Young People*) and CR10 (*Failure of General Fund Asset Disposal Programme*).

2.6 As previously stated, the Councils risk exposure has remained stable with the following risks rated as red:

- CR02 (*Failure to meet demands on Adult Social Care*) - the rating is red with all sub-risks currently stable. The key risks driving this rating are service delivery and savings targets. It has been reported that savings targets have been met for this financial year, but once the new financial year starts, this will possibly have a deteriorating effect on the risk

- CR03 (*Failure of SEND*) – the overall rating is red and has been stable this quarter. The Council has entered into a Safety Valve Agreement (SVA). Therefore, as well as impacting on the overall Council budget position, a significantly higher level of SEND spending could threaten the additional funding being offered by the DfE if the SVA targets are not achieved. The current financial challenges need to be well managed to manage the risk.

- CR04 (*Temporary Accommodation*) – the risk remains red however it is in a deteriorating position which has resulted in an increase in the risk score. Two sub-risks are driving the overall score, which are related to cost effective and fit for purpose accommodation and budgetary constraints. An improvement plan is currently being developed to address the identified risks.

- CR05 (*Failure to Attract Retain & Engage with Our People*) – the overall risk is red. As in previous quarters the biggest exposure is the ability to attract and retain a diverse and inclusive workforce, which is driving the overall rating of the risk.

- CR06 (*Health and Safety*) - the overall rating remains red. the combination of escalating, aggressive behaviour to front facing staff, aged and inadequate Risk Assessments (and subsequent controls) & Policies, COP's & Procedures not revised to modern, practical standards. Due to proactive management the risk has become stable and is no longer viewed as deteriorating.

- CR07 (*Insufficient Operational Resilience and Crisis Management*) – the overall risk remains red, as we do not have robust plans to address, prepare for, and respond to disruptive events and civil emergencies.

- CR08 (*ICT incident, resulting in significant data or service loss*) - the overall rating remains red with all sub-risks are currently stable or improving. The key risk driving the overall score is the potential loss of data or service disruption.

- CR09 (*Financial Sustainability*) – the risk remains red, with one sub-risk showing a deteriorating trend, however, not enough to cause a score change. As in Q2, the sub-risk for the failure to achieve a balanced budget and Medium-Term Financial Strategy (MTFS) is driving the overall score of the risk.

- CR11 (*Best Value Council*) – the overall risk remains red driven by sub-risks relating to the improvement and recovery actions specified in the Directions and required in the Best Value Intervention Guidance. All sub-risks are reported as being stable.

- CR12: (*Market Sustainability across Council*) – The overall risk remains red, however there is an overall improvement in the management of the risk. As in Q2, the sub-risk driving the overall score is the cost of care outstripping budget.

2.7 Two corporate risks have improved in this quarter:

- CR01: (*Safeguarding Children and Young People – Child Death*) – The overall rating has decreased from red to amber due to active demand management and improved practice has reduced costs reflecting greater confidence that there will be sufficient financial resources.

- CR10: (Failure of General Fund Asset Disposal Programme) – The overall risk rating has decreased from red to amber due to overall financial returns from disposals benefitting from better sales proceeds within the programme.

2.8 There has been one deteriorating risk reported this quarter.

- CR04 (*Failure to Provide Safe Temporary Accommodation within Budget*): The overall rating has remained red, however the risk score has moved from 24 to 25. This has been driven by the increasing number of people requiring temporary accommodation which has resulted in increased spending above budget.

2.9 A summary of the corporate risk profile is shown within Appendix A.

2.10 The corporate risk dashboard summary sheets are shown within Appendix B.

2.11 The Q3 current and target risk scores are summarised below Please note:

- Important to understand that target scores are based initially on a 12-month deliverable timeline (October 2025).
- This will be updated in Q4 FY24/25

Figure 2 – Corporate Risk Current & Target scores (Q3 FY24/25)
(Target risk scores based on a 12-month timeline – October 2025)

CR ref.	CORPORATE RISK	CURRENT SCORE	TARGET SCORE	Score movement in quarter
CR01	Safeguarding Children and Young People – Child Death	18	18	↑
CR02	Failure to meet demands on Adult Social Care	21	18	→
CR03	Failure of Special Educational Needs and Disability (SEND)	21	18	→
CR04	Failure to Provide Safe Temporary Accommodation within Budget	25	21	↓
CR05	Failure to Attract Retain & Engage with Our People	21	18	→
CR06	Health & Safety We fail to prevent physical injury or mental harm	21	18	→
CR07	Insufficient Operational Resilience and Crisis Management	21	17	→
CR08	ICT incident resulting in significant data and/or service	24	19	→
CR09	Failure to achieve financial sustainability and a balanced MTFS	24	22	→
CR10	Failure of General Fund Asset Disposal Programme	18	18	↑
CR11	Failure to become a Best Value Council	24	22	→
CR12	Failure to deliver Market Sustainability across Council	21	18	→
CR13	We fail to comply with GDPR data protection obligations	18	14	→

2.12 The Interim Risk Manager continues to work with senior officers to promote effective risk management and to review corporate and directorate risks. He is also reviewing and updating the current Risk Strategy which will now include a Risk Management Policy, Risk Management Framework and Risk Management Guidance section. The revised document will be presented to the Risk Management Board and CLT in May 2025, with a view to presenting to this to the Committee at the Q1 2025/26 meeting for recommendation to Cabinet for approval.

2.13 Members have differing roles and responsibilities in relation to risk. Cabinet members have responsibility to consider risk in relation to individual decisions and overall strategy. Scrutiny members have responsibility to consider risk when holding Cabinet and other parts of the Council to account on individual projects and functions. All elected members have a responsibility for ownership of risk by identifying, mitigating and regularly reviewing risk. This committee has a specific responsibility to provide independent assurance to the Council of the adequacy of the risk management framework and the internal control environment.

3. Implications of the Recommendation

3.1 Financial implications

3.1.1 This is a noting report updating Members on progress to date in improving risk management processes across the Council. There are no direct financial implications associated with the Quarter 3 Risk Update. However, the failure to identify and mitigate risks could result in events materialising that result in financial loss. Further, in the absence of a robust risk management methodology, excessive mitigation of perceived risks could result in unnecessary expenditure.

3.2 Legal implications

3.2.1 The Council has a best value duty under the Local Government Act 1999. This is the duty the Council has been found to have failed to meet, and this has resulted in the Council being under statutory direction of the Ministry of Housing, Communities and Local Government (MHCLG) and having appointed commissioners under a formal direction. A new statutory direction was issued in November 2024 and contains specific actions which are linked to management of risk. This includes preparation and implementation of an improvement and recovery plan, which includes as a minimum a review of the Authority's progress to risk maturity and how well its functions and processes enable risk-aware decisions that support the achievement of strategic objectives. In addition, there is an action to undertake in the exercise of any of its functions any action that the Commissioners may reasonably require to avoid so far as practicable incidents of poor governance or financial mismanagement that would, in the reasonable opinion of the Commissioners, give rise to the risk of further failures by the Authority to comply with the best value duty. Effective risk management is a critical part of good governance. The committee has a separate report on its agenda updating on the action plan in the Council's Annual Governance Statement for 2023/24. This requires the Council to update its risk management strategy and framework to ensure compliance with HM Government Orange Book and implement training programme to embed risk management. Progress is marked as substantially complete in the end of year progress update.

3.2.2 The Council's external auditors issued a statutory recommendation in July 2021 which required reporting on a root and branch review of progress to Full Council and this included reporting on risk management. The auditors' interim value for money report was previously presented to committee and the auditors have deemed that this recommendation has not been met. Since then the Council has agreed to report at least 6 monthly on updates against its improvement and recovery plan and the committee will also be producing an annual report following a self-assessment and this will be reported to Full Council.

3.2.3 MHCLG has issued guidance on the best value standards and intervention. This confirms the importance of effective risk management. It sets out characteristics of well and poorly performing authorities. Characteristics of a well performing authority include use of performance indicators, data and benchmarking to manage risk, innovation being encouraged and supported within the context of a mature approach to risk management, robust systems being in place and owned by members for identifying, reporting, mitigating and regularly reviewing risk, risk awareness and management informing every decision and robust systems being in place to identify, report, address and regularly review risk. Indicators of potential failure include risk management not being effective, owned corporately and/or embedded throughout the organisation, lack of meaningful risk registers at a corporate level, risks not being owned by senior leaders, risk registers

downplaying some risks and lacking action to mitigate risk, risks being covered up to protect reputations, excessively risky borrowing and investment practices with inadequate risk management strategy in place, failure to manage risks associated with companies, joint ventures and arms-length bodies, high dependency on high-risk commercial income to balance budgets and unusual or novel solutions being pursued which lack rigour or adequate risk appraisal.

3.3 Risk Management implications

3.3.1 Enhancing the Council's risk management arrangements via a combination of the introduction of appropriate tools, processes and oversight will help to ensure the pro-active management of risks, and to embed risk management into "business as usual" processes.

3.4 Environmental implications

3.4.1 There are no specific environmental implications associated with the Risk Update. However, effective risk management will help the Council consider the impact of its decisions on its environment and the impact of environmental risks at a local, national, and international level on its functions.

3.5 Equality implications

3.5.1 There are no equality implications associated with the Risk Update. However effective risk management will help ensure the Council complies with its equality duties and considers and meets the needs of its diverse communities.

4. Background Papers

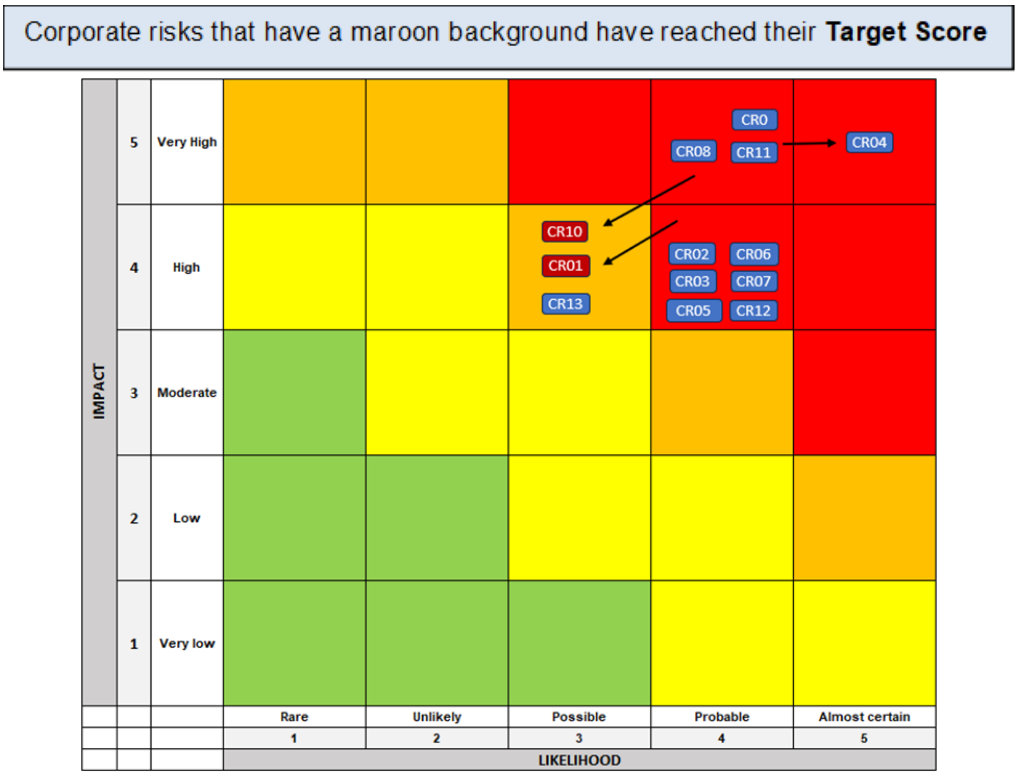
4.1 None.

Appendix ‘A’ - Corporate Risk Profile

The overall principal risk profile has not changed materially in period, however, there has been some positive movement of two of the corporate risks and the overall risk environment is being better managed which is resulting in a more stable outlook.

Further details are provided in the risk dashboards, which includes current scoring and/or outlook, current controls and treatment plans.

Figure 1 – Corporate Risk heat map (Q2 FY24)



Corporate Risk	Corporate Risk
CR01: Safeguarding Children and Young People – Child Death	CR08: ICT incident resulting in significant data and/or service
CR02: Failure to meet demands on Adult Social Care	CR09: Failure to achieve financial sustainability and a balanced MTFS
CR03: Failure of Special Educational Needs and Disability (SEND)	CR10: Failure of General Fund Asset Disposal Programme
CR04: Failure to Provide Safe Temporary Accommodation within Budget	CR11: Failure to become a Best Value Council
CR05: Failure to Attract Retain & Engage with Our People	CR12: Failure to deliver Market Sustainability across Council
CR06: Health & Safety We fail to prevent physical injury or mental harm	CR13: We fail to comply with GDPR data protection obligations
CR07: Insufficient Operational Resilience and Crisis Management	

Appendix 'B' – Q3 2024-25 Corporate Risk Dashboards (summary sheets)

CR01	Safeguarding Children and Young People – Child Death	Risk owner: Sue Butcher

Corporate risk overview

Current Risk Score 4 Impact 3 Likelihood	18
Target Risk Score 3 Impact 3 Likelihood	18

Risk score has moved to 18 (RAG Amber) reflecting greater confidence that there will be sufficient financial resources (Risk 01) and a change in likelihood of insufficient resources from 'Probable' to 'Possible'. SCF in 2024/5 has delivered a balanced budget and been able to return some of the Core Contract payment to the Council reflecting positive balances. A budget has been prepared for 2025/6 that should meet service needs. There are potential external pressures that could occur, however regular monitoring, robust contract management and the in-year budget contract mechanism with the Council mean that the risk is no longer considered 'Probable'.
There is an increased number of experienced staff as SCF, a healthy number of applications for vacancies, improving induction and performance management. More transparent, challenging performance management has resulted in some staff leaving which should result in improved services over time.
If children and young people are not adequately safeguarded there is the risk of a child death or a significant impairment to a child's physical, mental or emotional health. This exposes the authority to additional scrutiny from regulators which can result in a negative judgement, reputational risk both nationally and locally and a loss of trust. In additional such tragic events can increase referrals from communities and partner agencies who can become risk adverse.

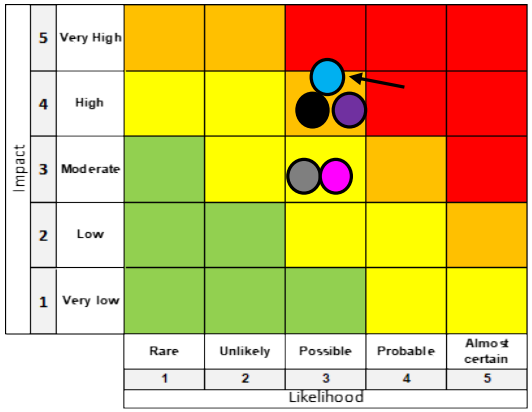
Children's Social Care is subject to a Statutory Direction from the Department of Education overseen by a DfE Commissioner

Risk appetite statement (Averse/Balanced)

The risk SCF risk appetite is supported by robust evidence informed service planning.

The safety of children is paramount to the organisation however it is not possible to prevent child deaths or serious harm from taking place.

Risk profile



Refer to slide 7 for risk assessment score instructions

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
01.01		Insufficient financial resources	SCF Director of Finance/ Resources		SCF is currently managing within its means however there are financial challenges over the next 12 months. Active demand management and improved practice has reduced costs, however external price pressures could be higher than budgeted for 25/6.
01.02		Attraction and retention of qualified workforce	Head of HR		SCF is attracting a reasonable level of applicants for most positions. Turnover has increased although largely for appropriate reasons. A number of vacancies are being held reflecting changing demand.
01.03		High Caseloads for frontline staff	Director of Operations		Caseloads are monitored on a weekly basis and reported to the Improvement Board chaired by the DfE Commissioner. They are currently largely within range reflecting a reduction in demand and a more stable workforce. Until recently they were much higher.
01.04		Underperformance of staff	Director of Operations		Training and development is delivered consistently. A workforce development strategy would support a more strategic approach. A social care academy will be launched. Performance dashboards are allowing more transparent, challenging conversations which has led to some staff leaving.
01.05		Systems and Data that do not support good practice	TBA		SCF is reliant on manual intervention to produce quality reporting. It has ambition to create further performance dashboards that cannot currently be met

CR01	Safeguarding Children and Young People – Child Death	Sue Butcher Chief Exec SCF

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KR1	Quarterly and year end financial forecasts: expected variation from budget	*£0*	*£0*	*£0*	
KRI 2	Number of vacancies	0-8%	*11%*	11%	
KRI 3	Caseload monitoring: Targeted Early Help 26 26 Assessment Service 19.8 18.4 Decrease Safeguarding and Family Support 15.8 14.1 Looked After and Support 14.2 13.2 PA 27.2 26.9 Conference Chairs 40.5 41.1 Increase IRO 46.2 59.4	? ? ? ? ? ? ?	26 19.4 15.8 14.2 27.2 40.5 46.2	26 18.4 14.1 13.2 26.9 41.1 59.4	
KRI 4	Number of staff on performance management	?	?	?	
KRI 5	Quarterly reporting of number of out of time: • Visits • Supervision • Plans	? ? ?	? ? ?	? ? ?	

Current quantitative data relating to KRI 4 & KRI 5unavailable and/or unreliable.
KRI's will be established for the Q4 submission.

CR01	Safeguarding Children and Young People – Child Death	Sue Butcher (Chief Executive SCF)

Controls - Identify current operating controls that are managing the sub risks

Control Effectiveness	Description
Effective	• Controls and or/ management activities properly designed and operating as intended • Management is confident that the controls are effective and reliable
Largely effective	• Controls and or/ management activities properly designed and operating with opportunities for improvements identified
Needs Improvement	• Controls are only partially effective, require ongoing monitoring and may require redesigning, improving or supplementing • Key controls and or/ management activities in place, with significant opportunities for improvement identified
Ineffective	• Limited controls and or/ management activities in place
Weak	• Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist • Controls and or/ management activities are non-existent or have major deficiencies and don't operate as intended

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR1	Financial Management	Expenditure Control Panel. Monitoring by Company Board and SBC. Strategic Commissioning Group. Delegated decision making.	Director of Finance and Resources	Effective	Currently operating within expectations.
2	SR2	Recruitment and Retention	Use of Talos system, monthly reporting to Senior Leadership Team, Staff Surveys, Exit Interviews, Shadow Board (staff feedback to improvement board). Benchmarking	Head of HR and OD	Largely Effective	Workforce Development strategy needed. Some managers need to use Talos more efficiently.
3	SR3	Workloads	Regular reports to senior managers, monitoring of casework progress, reporting to Company Board and Improvement Board	Director of Operations	Largely Effective	Currently operating within expectations.
4	SR4	Underperforming staff	Feedback from staff, 121s, Appraisals, Quality Assurance Framework.	Head of HR and OD	Needs Improvement	Academy needs to be embedded.
5	SR5	Systems and data	Oversight by DfE Commissioner	SCF Chief Executive	Needs Improvement	Further development of PowerBi dashboards; further data cleansing of HR systems; further audits of caseload data

CR01	Safeguarding Children and Young People – Child Death	Sue Butcher Chief Executive SCF

Treatment/mitigation plans (funded actions that will manage/reduce the risk level)

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	01.04	Workforce Development Strategy.	Develop Workforce Development Strategy	**Head of HR and OD**	March 2025	Amber	Information is available but there isn't an overall strategic plan. Timescale to be decided at Senior Leadership Team Meeting. Needs pace
2	01.04	Social Care Academy	Embed and monitor results	**Head of HR and OD**	March 2025	Amber	On track
3	01.05	PowerBi dashboards	Articulate programme to deliver additional PowerBi performance dashboards	**Head of Service, Quality Assurance and Improvement**	October 2025	Amber	Some dashboards have been rolled out to good effect, others are desired but cannot be provided due to IT capacity issues. Need to define desired programme for dashboards and potential workarounds
4	01.05	Reviews of HR data systems	Ongoing data cleansing of HR systems	**Head of HR and OD**	March 2026	Amber	A project to improve reporting of staff protected characteristics has recently completed. Much reporting is manual and there is a structured programme for quality checking (largely manual)
5	01.05	Audits of data held on children and young people	Ongoing programme of audits of caseload data	**Head of Service, Quality Assurance and Performance**	March 2026	Green	There is an ongoing programme outcomes from which are reviwed by senior staff and inform practice improvements.

Target Risk Score – *18* by end of date *10/2025*

CR02	Failure to meet demands on Adult Social Care	Risk owner: David Coleman-Groom

Corporate risk overview

Current Risk Score 4 Impact 4 Likelihood — 21

Target Risk Score 4 Impact 3 Likelihood — 18

Nationally demands on Adult Social Care continue to rise and are putting pressure on local authorities. If the adult social care transformation programme does not deliver sustainable changes in a timely and effective way there will be a negative impact on quality of service for residents, savings will not be achieved, demand will continue to grow and a balanced budget will not be delivered.

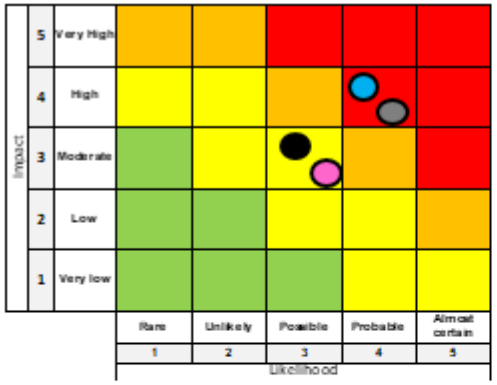
Discharge to Assess Team proactive in rightsizing provisions of care following hospital discharge, as well as identifying suitable people for Reablement to provide interventions which promote independence and eliminate the need for on-going support.

Staffing has remained the same which means that any increased demand will result in an impact to services. A strengths-based and evidence-based approach underpins all frontline practice, so that people are directed to community-based services wherever possible.
During 2025 the directorate is exploring the art of the possible with the use of Artificial Intelligence to reduce duplication of data processing and free up professional capacity.

Risk appetite statement (Averse/Balanced/Seeking)

We have a balanced risk appetite as we look at ways to provide the necessary level of services required within Adult social services, while being aware of constraints around financial. Through practice and resource panels, controls are in place to ensure the right levels of care at the right time.

Risk profile



Refer to slide 7 for risk assessment score instructions

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
02.01		Inability to meet savings	David Coleman- Groom (lead)		22nd January all savings reviewed and RAG rating status reviewed. Monthly reviews ongoing.
02.02		Inability to deliver statutory duties given increase in demand and complexity of incoming work in operational services	Ilona Sarulakis (HOS) Andrea Rodin		Business case was approved by HR ECP – improve skill set of hospital team. Measures to ensure the right use of equipment and equipment related expenditure are controlled. Low staffing levels as well as the balance of qualified/unqualified staff remains a challenge to delivering all operational services within ASC in time and meeting regulatory requirements
02.03		Attraction & retention of talent	Jane Senior David Coleman-Groom		Focus on growing our own and improved use of Matrix. Now beginning work with HR to support permanent recruitment
02.04		Loss of health funding	Vicky Tutty (HOS) Andrea Rodin (HOS)		Better Care Fund(BCF) review of expenditure of 24/25 and workshop in place to confirm approach to 25/26 Health funding – review of approach and policy for Continuing Health Care(CHC). Berkshire LA's concerned about the shift in Health funding, full review being commissioned by ICB Section 117 Aftercare (Health funding)

CR02	Failure to meet demands on Adult Social Care	Risk owner: David Coleman-Groom

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
Example - customer complaints	*Total customer complaints* *(To identify a KRI: 1) look for what is already measured regarding this risk such as a KPI and adapt it – see tolerance/threshold column on the right, or 2) if there isn't a measure to easily adapt look to the risk's key/root causes and what the triggers are. Triggers that can be measured make good KRIs as they serve as early warning signals of risk)*	*Target 30% reduction per annum* *(Provide a range, if a relevant KPI exists you can adapt it to create a KRI by lowering the KPI's threshold by 5-10%, e.g. KPI target = 30,000 – 10% = KRI tolerance of 27000)*	*Q1 23/24 - 5000*	*Q2 23/24 - 4800*	
KRI 1 – Increase in Demand	Demand from new clients continues to rise and less people are connected to community and voluntary, seeing an increase in the number of referrals in to full care act assessments *(STS001 SALT 1a +1b)*	24/25 - 2547	23/24-2568 22/23 – 3138	Metrics being developed	
KRI 2 – recruitment of staff	Increase the number of permanent staff appointed to lead, implement and deliver the savings and manage demand	Target to be set now refresh establish is agreed		Metrics being developed	
KRI 3 – Stabilise ASC leadership team	New extended leadership structure in place, Three of the 5 Heads of Service are permanent. A 6th Head of Service post is being held	20%	Q1 60%	Q2 40%	
KRI 4 – Prescription of Care	Ensure the level of care is proportionate to the needs, compared to other SE LA's			Metrics being developed	

CR02	Failure to meet demands on Adult Social Care	Risk owner: David Coleman-Groom

Controls - Identify current operating controls that are managing the sub risks

Control Effectiveness	Description
Effective	• Controls and or/ management activities properly designed and operating as intended • Management is confident that the controls are effective and reliable
Largely effective	• Controls and or/ management activities properly designed and operating with opportunities for improvements identified
Needs improvement	• Controls are only partially effective, require ongoing monitoring and may require redesigning, improving or supplementing • Key controls and or/ management activities in place, with significant opportunities for improvement identified
Ineffective	• Limited controls and or/ management activities in place
Weak	• Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist • Controls and or/ management activities are non-existent or have major deficiencies and don't operate as intended

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR02.01	Strong Governance policies	DLT reviewed and thematical cycle in place, focus on finance, performance and risk	David Coleman-Groom	*Largely effective*	*Newly implemented since 1 October 2024*
2	SR02.01	Cost Savings	Identified Senior Responsible Owner(SRO) for each saving	David Coleman-Groom	*Largely effective*	Leads have been identified for each saving and this is discussed at DLT regularly
3	SR02.02	One Slough Directory	Comprehensive directory of services that enables residents to find information themselves to support their daily living	Director of Commissioning (Jane Senior)	*Largely effective*	See VCS Contracts – One year update Cabinet January 2025 Report and Appendix One.pdf
4	SR02.02	Community Connectors	Additional resource to connect residents to local services	Director of Commissioning (Jane Senior)	*Largely effective*	See VCS Contracts – One year update to Cabinet January 2025 Report and Appendix One.pdf
5	SR02.02	ASC linked to Front Door	Skilled and trained staff linked at the front door to help advise people and enable them to access alternative support	Head of Service Short Term Services (Ilona Sarulakis)	Needs improvement	Treatment plan in place
6	SR02.02	Management of OT waiting lists	Waiting Well Management Methodology document in place which provides a clear structure for prioritising cases based on identified risks.	Head of Service Short Term Services (Ilona Sarulakis)	*Largely effective*	This methodology is mirrored in the Social Work Teams' Waiting Well Allocation List.

CR02	Failure to meet demands on Adult Social Care	Risk owner: David Coleman-Groom

Treatment/mitigation plans (funded actions that will manage/reduce the risk level)

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
~~1~~	~~SR02.01~~	~~*High level action that will mitigate or reduce the risk the most*~~		~~*Director level*~~	~~*Dd mm yyyy (within the next 12 months)*~~	~~*(RAG)*~~	~~*REQUIRE MORE DETAIL AND TREATMENT PLANS*~~
1	SR2.02	ASC linked to Front Door	Also, as part of strategies at the Front Door, increased use of the ASC Portal is being looked into to provide greater resident and staff awareness and improved functionality.	Head of Service Short Term Services (Ilona Sarulakis)	10/2025	RAG status	Further work is planned as part of the council target operating model. • Link between Occupational Therapy (OT) and Customer Services (CS) working well • Review of resident's journey commenced. • Use of digital options for residents (AskSara).to facilitate self- assessment, and provision of information and advice being explored with CS's and PM.
		Digital Blue Print for tech	In partnership with Digital, Data and Tech Service review existing tech solutions used within social care which will improve user experience and free up capacity for the workforce	David Coleman-Groom	10/25		• Discussion have been held with a couple of suppliers to understand the art of the possible. Further meeting arranged 14/2/25
		Waiting Well	Ensuring those people who have contacted ASC and may need assistance are not just added to a waiting list and that they remain 'well and safe' whilst waiting for further support	Head of Long Term Service (Andrea Roddin) and Head of Short Term Services (Illona Sarulakis)	31/3/25		• Framework has been developed and currently being consistently implemented across teams • Need to evaluation the framework and ensure people remain well and safe
		Workforce Development	Develop a clear and robust workforce plan that supports the ASC strategy, staff survey and the Social Work Health Check	David Coleman-Groom	31/3/25		• Extend the existing ASC Improvement Plan to include workforce and culture. This will be monitored in DLT and will be supported by the HR Business Partner

Target Risk Score – *18* by end of date *10/2025*

CR03	Failure of Special Educational Needs and Disability (SEND)	Risk owner: Sue Butcher	Signed-off by : Y / N

Corporate risk overview

Current Risk Score 4 Impact 4 Likelihood	21
Target Risk Score 4 Impact 3 Likelihood	18

Slough has a statutory duty, under the SEND Code of Practice, to provide educational resources to all children and young people with SEND living in Slough. SEND is subject to a Statutory Direction from the Department of Education overseen by a DfE Commissioner. If SEND services are not effective, then the exit from intervention will continue which impacts negatively on the Council as a whole.

Currently all LAs are seeing an increased demand for Education Health and care Plans and greater level of SEND complexity in our schools. Failure to provide an effective service would mean that children and young people do not receive the right support early enough. As a result, their educational outcomes as well as their life opportunities may be limited.

The Council has entered into a Safety Valve Agreement (SVA). Therefore, as well as impacting on the overall Council budget position, a significantly higher level of SEND spending could threaten the additional funding being offered by the DfE if the SVA targets are not achieved. The current financial challenges need to be well managed to mitigate risk.

There is a reputational risk of a poor local area inspection. Slough, as with all local authorities are currently seeing a significant level of appeals to the Tribunal Service. Tribunals, alongside internal complaints and LGSCo adverse judgements present another risk.

***Update Jan25** – the service has seen a sharp decline in the number of complaints and the level of positive feedback. There are still concerns raised by settings and families, but this is at a significantly lower level. Improvements in the quality of the service and, in particular, better communication are the key factors behind this improvement. However further improvement is needed to change the risk score.*

Risk appetite statement (BALANCED)

SBC currently has a **balanced range of risk acceptance**, aiming to reduce exposure where possible, accepting a moderate degree of risk where the risk/reward ratio is deemed reasonable. Innovation is applied to improve service delivery where this is reasonable.

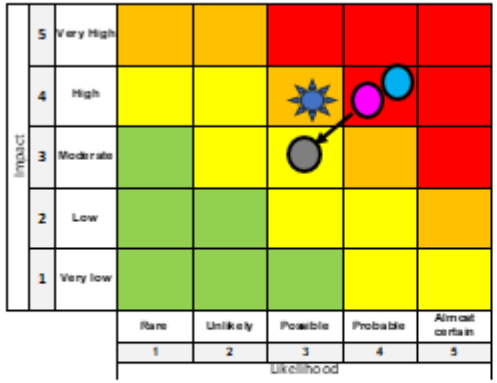
Although underperformance of children and young people with SEND is not something that we wish to accept and which we strive to minimise as much as possible, the current national picture for SEND means that no LA can completely remove the risks and the SEND Code of Practice limits our possible responses.

There is a separate Risk Register for SEND that breaks down the overall risk into specific areas. This includes the actions to mitigate the risk as much as possible.

The performance of children and young people with SEND is overseen by a SEND Improvement Board that includes partners from health, social care, education settings and families. This Board is supported by an Operational Group. The Board oversees the transformation journey that is addressing the areas of risk for SEND.

SEND performance is overseen by the DFE through the Written Statement of Action monitoring process including oversight by a SEND adviser and a SEND commissioner.

Risk profile



Refer to slide 8 for risk assessment score instructions

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
03.01		Failure to provide appropriate support to children and young people with SEND with and without an EHC plan earlier enough that will impact on their life opportunities.	Neil Hoskinson		Although the demand for SEND support is increasing in line with the national picture, the statutory SEND team is improving and is managing this risk so this is judged as a POSSIBLE risk. Nevertheless, given the pressure all LAs are facing this has to be seen as a HIGH risk.
03.02		Financial risk to the Council and the possibility of not receiving Safety Valve Agreement payments to offset the budget deficit.	Neil Hoskinson		A new SEND Finance transformation team is overseeing the financial plan and the Safety Valve Agreement and we are currently on track to achieve targets. The latest monitoring report has been accepted by the DfE and a follow up meeting arranged to discuss additional support for the LA.
03.03		Risk to the Council through complaints received through the Council's own process, LGSCO complaints and tribunals. These are all as a result of poor practice historically but the risk is current and HIGH.	Neil Hoskinson		The new mitigations to address complaints and tribunals has been highly effective and has nearly cleared the backlog. At the same time there has been a significant reduction in the level of new complaints. Nevertheless, judgements from the LGSCO are likely to be negative given the poor practice historically that they are now reviewing.
03.04		The service identified gaps in evidence in preparation for a Local Area Inspection which is likely to happen imminently.	Neil Hoskinson	**NEW**	This additional risk has been added in Q3 2025 due to the likelihood of a Local Area Inspection. Work is being carried out to prepare the evidence bank and make sure arrangement are in place. Once the Improvement Board are happy with the evidence bank this risk will be removed.

CR03	Failure of Special Educational Needs and Disability (SEND)	Risk owner: Sue Butcher

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KRI 1	Safety Valve Agreement conditions – measured via a quarterly monitoring report to the DFE. This includes RAG ratings for all conditions.	All RAG ratings to be GREEN	*3 Amber RAG Ratings*	Still 3 Amber RAG Ratings	→
KRI 2	EHC plan completion rates, and timeliness within the 20-week statutory timescale.	35 EHC plans completed a month with 80% completed within statutory timescales.	29 plans pm / under 15% timeliness	January 57 plans completed but only 19% were in time.	↑
KRI 3	Responding to complaints within timescale and reducing the number of complaints	Number of complaints per quarter reduces	Consistent level of tribunals and complaints	Significant reduction in the number of complaints received and all complaints now in time.	↑
KRI 4	Written Statement of Action monitoring reports identifies good progress in quarterly monitoring reports.	All actions complete on time and evidence of impact.	6 actions RED rated	2 Action RED rated	→
KRI 5	Preparedness for tribunals – tracker shows all tribunals due and the preferred outcome.	All tribunals prepared for and tracker up to date. 90% of tribunals have preferred outcome.	Not included in Q2	Tracker in place and all tribunals recorded. Not able to assess preferred outcome until tribunals have taken place.	↑
KRI 6	Local Area Inspection Preparation – Evidence base (including Annex A) ready for uploaded on first day of the inspection.	Inspection plan shows all evidence collated and up to date.	Not included in Q2	Still some data gaps and evidence not yet fully collated into the evidence bank	→

Jan 25 KRI 3 (Complaints) changed to improving due to the significant reduction in complaints
KR3 is now purely complaints and tribunals added as a new risk (KR5)
New risk also added (KR6) regarding preparedness for the Local Area Inspection

CR03	Failure of Special Educational Needs and Disability (SEND)	Risk owner: Sue Butcher

Controls - Identify current operating controls that are managing the sub risks

Control Effectiveness	Description
Effective	• Controls and or/ management activities properly designed and operating as intended • Management is confident that the controls are effective and reliable
Largely effective	• Controls and or/ management activities properly designed and operating with opportunities for improvements identified
Needs improvement	• Controls are only partially effective, require ongoing monitoring and may require redesigning, improving or supplementing • Key controls and or/ management activities in place, with significant opportunities for improvement identified
Ineffective	• Limited controls and or/ management activities in place
Weak	• Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist • Controls and or/ management activities are non-existent or have major deficiencies and don't operate as intended

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR03.01	SEND Improvement Board action plan and data dashboard.	Controls are effective and are overseen by DFE advisers and the SEND commissioner.	Neil Hoskinson Director of Education	**Highly Effective**	The action plan and data dashboard are reviewed at every Improvement Board Meeting and inform the DfE WSoA monitoring visits. Surveys and deep dives gather evidence.
2	SR03.01	SEND Self Evaluation Framework	Controls are effective and the SEF is regularly reviewed by the SEND Improvement Board that includes DFE advisers and the SEND Commissioner.	Gary Nixon Local Area Inspection LANO	**Largely Effective**	The SEND SEF has been updated against the inspection framework, the WSoA evidence of progress and other information. It will be reviewed by the DfE adviser and may need further work.
3	SR03.01	SEND Panel Processes	Panel advises the Nominated Officer regarding placement and other funding decisions. The process has been quality assured by the DfE adviser and external partners.	Gary Nixon Principal EP	**Highly Effective**	Panel members include partners from health and social care as well as education. The panel is regularly joined by finance officers, the Director of Education and the DfE adviser to quality assure.
4	SR03.01	Educational Psychology[EP] reports	All funding and placement decisions are informed by impartial assessments of need based on evidence provided by the education setting and the family.	Gary Nixon Principal EP	**Highly Effective**	For the last few months, an interim EP team has been in place. The quality of reports, as measured by our quality assurance process, has improved significantly. Where necessary, EPs are changed.
5	SR03.02	High Needs Block [HNB] Recovery Plan	A SEND Transformation Team has been established to oversee the HNB recovery programme using the DFE template and overseen by the Finance Board and the Commissioner.	Neil Hoskinson Director of Education	**Needs Improvement**	This is judged as "Needs Improvement" because, although the current processes and recent progress is good, the historical financial position was not accurate and will need to be re-profiled.
6	SR03.02	Safety Valve Agreement [SVA] monitoring reports	The SVA has a number of agreed conditions that have the overall aim of balancing the HNB budget by the end of 2025/26. Progress is reported quarterly to the DFE SVA team.	Neil Hoskinson Director of Education	**Needs Improvement**	This is judged as "Needs Improvement" because, although the current processes and recent progress is good, the historical financial position was not accurate and will need to be re-profiled.
7	SR03.03	SEND complaints and tribunal tracker	A recently implemented complaints tracker identifies agreed timescales, the lead officer and measures progress. A new approach has been introduced with key staff identified.	Paul Crulley Operational Lead for Statutory SEND	**Largely Effective**	Jan 25 – this has changed from "Needs Improvement" due to the significant reduction in complaints and the effectiveness of responding and taking action to concerns raised.

CR03	Failure of Special Educational Needs and Disability (SEND)	Risk owner: Sue Butcher

Treatment/mitigation plans (funded actions that will manage/reduce the risk level) SOME MOVE TO CONTROLS

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	03.01	*Improved Statutory Team Processes*	Additional locum EPs and a short-term interventions team will address the backlog of EHC plans and improve timeliness. Improved SEND statutory processes are improving timeliness for new cases including case management and tracking.	Neil Hoskinson Director of Education	*31/03/2025* *Add Milestone*		*GREEN because of progress already achieved that is measurable and quality assured externally.*
2	03.01	Improvements to Inclusion in all Slough Education Settings	Slough SEND and Inclusion Strategy to be agreed by all partners to ensure that the Code of Practice is followed. A Team Around the School Approach will support inclusion in schools supported by Inclusion Champions.	Samantha Caley Inclusion Lead	31/12/2024 *Add Milestone*		*GREEN because of progress already achieved in developing a coproduced strategy. Draft document ready for sharing with headteachers on 8th November 2024.*
3	03.01	Support for all children and young people with SEND but no EHC plan.	Following the launch of the Graduated Approach Document	Samantha Caley Inclusion Lead	01/04/2025 *Add Milestone*		*GREEN because Graduated Approach Document is already launched and available on the Local Offer website. Future work will embed practice.*
4	03.02	High Needs Block Recovery Programme	There is a HNB Budget Recovery Plan supported by a programme of monitoring and reporting. Currently the Council is on track to achieve the budget position set out in the SVA.	Zain Rizvi HNB Finance Manager	30/11/2024 *Add Milestone*		AMBER because historic inaccuracies mean that there is a need for the recovery programme and the SVA conditions to be re-profiled. A meeting has been arranged with the DfE to move this on with the expectation that this will be GREEN in Q4.
5	03.02	SEND Sufficiency, Place Planning and Capital Programme	5 Year SEND Sufficiency Analysis complete	Neil Hoskinson Director of Education	31/12/2024 *Add Milestone*		AMBER still in Q3 because, although work is nearing completion, there are still some gaps to fill. A programme has been agreed to cleanse and extrapolate all data and this is expected to move to GREEN in Q4.
6	03.03	New Complaints Process	A new approach has been agreed with the Monitoring Officer and the Complaints Team to address this risk. A complaints and communication tracker is now in place. Power Bi	Paul Crulley Operational Lead for Statutory SEND	01/11/2024 *Add Milestone*		Jan 25 – this has changed to Green due to the significant reduction in complaints and the effectiveness of responding and taking action to concerns raised.

Target Risk Score – *13* by end of date *10/2025*

CR04 Failure to Provide Safe Temporary Accommodation within Budget

Risk owner: Pat Hayes

Corporate risk overview

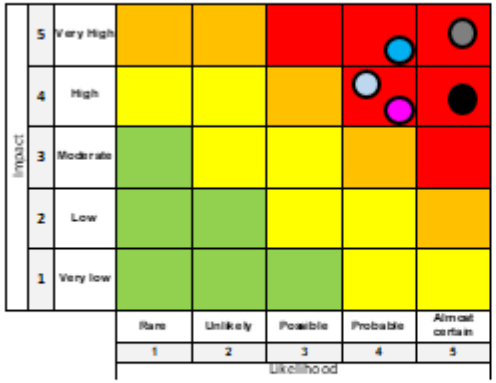
Current Risk Score 5 Impact 5 Likelihood	25
Target Risk Score 4 Impact 4 Likelihood	21

- In Q3 we have continued reviewing and analysing the current Temporary Accommodation, Allocations and Homeless Teams structure. It is not fit for purpose and a radical overhaul of the service is needed to deal with the **data** challenges, backlogs, lack of **prevention** and poor performance across the services.
- Current risk score has moved from 24 to 25 due to sub-risk 2 (budget).
- The savings plans put forward after after the project room activity in October 2024 is being monitored closely but is reliant on:
  - Capability of managers and front-line staff and difficulty recruiting and retaining workforce. 100% of the TA team is interim.
  - Lack of reliable quality data to inform business decisions.
  - Recruitment- delays due to difficulty attracting capable candidates , recruitment freeze, exiting incapable staff
- MHCLG visited in January 2025, confirming our TA usage per 1,000 remains the highest in England outside of London.
- Challenges SBC face around homelessness given our location, socio economic make up and housing market in which we operate remain.
- The provision of TA carries statutory and regulatory requirements to ensure the safety and wellbeing of the occupants . The Council therefore needs to have in place an approved inspection regime in accordance with the Housing Health and Safety Regulations which is currently not resourced.
- The new Director has developed an improvement plan to cover the risks identified at corporate and operational level.
- The primary risk is lack of resources that have not grown inline with a doubling of demand.

Risk appetite statement (Balanced)

The service is delivered within a framework of statutory obligations including the obligation to house homeless people and to place people in safe, compliant and affordable homes. As such, we have a balanced risk appetite where we try and use different mechanisms to ensure that we provide the necessary service levels and stay within budget.

Risk profile



Refer to slide 8 for risk assessment score instructions

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
04.01		Lack of Suitable Available TA	Director of Housing (Lisa Keating)		• We continue to rely heavily on high-cost units. • In process of reviewing Private Rented Sector offer. • HB Law have drafted Private Lease Agreement and Private Licence Agreements for improved negotiations and possible cost efficiencies . • February 2025 Cabinet paper seeking permission to enter into long term leases for 25 homes that will offer even great value for money, stability and safety to residents • Out of borough placements policy awaiting EQIA to enable this to be fully implemented. • Downsizing, transfer and allocations activity is helping households move on **There has been a positive change since the last reporting period.**
04.02		Budget Pressure (Cost > Income)	Director of Housing (Lisa Keating)		• The number of people in TA has more than doubled from 650 in 2022 to circa 1,528 in January 2025. (number is still being verified). • The budget has not increased in line with demand. Actual spend in 23/24 was £19.6m. Budget for 24/25 was £8m. • The forecast actual spend at P9 is £19.89m with a year-end forecast of £29m. Budget pressure is c. £10m. **There has been a negative change since the last reporting period.**

CR04	Failure to provide safe Temporary Accommodation within Budget	Risk owner: Pat Hayes	Signed-off by owner: Y / (N)

Sub-Risks continued.

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
04.03	●	Lack of Statutory Compliance Information	Director of Housing (Lisa Keating)	→	• The team has acted on the Pennington's compliance health check from July 2024. • The light touch review of TA identified a lack of resource in the TA teams responsible for compliance checks and fire safety management, • No dedicated resource in the team and actions are ongoing and need significant focus and resource to complete. • Further TA specific health check recommended. • Limited number of inspections of B&B and some HMO accommodation have been undertaken • New draft Private Sector Leasing and Private Licence Agreements have explicit clauses requiring TA providers to provide compliance certificates and to ensure the home is fit for purpose i.e. free from damp & mould. **There has been no demonstrable improvement in Compliance although good progress is being made in developing the solution.**
04.04	●	Difficulty recruiting and retaining workforce	Director of Housing (Lisa Keating)	↓	• In quarter 3, 1 manager and 4 officers have left • Director has been unable to replace all posts in Q3 and the team is currently under resourced. • 100% of TA team is interim – no permanent members of staff • Still need to recruit to a permanent Head of Service and reorganise the wider Housing Needs service, then recruit permanent staff to establish service stability. **There has been a negative change since the last reporting period. More officers have left, recruitment at SBC salaries remains difficult and the Council has implemented a recruitment freeze.**
04.05	●	Ability to effectively Manage TA property and people	Director of Housing (Lisa Keating)	→	• Limited capacity to effectively contract manage TA providers increasing the risk of poor accommodation. • Limited capacity to manage households in accommodation and move them on to permanent affordable accommodation increasing risk to homeless households **New risk added Jan 25.**

CR04	Failure to provide safe Temporary Accommodation within Budget	Risk owner: Pat Hayes

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KRI 1 – Compliance	SBC to hold H&S compliance information for all TA units	5% (Established Hotel Accommodation to be exempt)	Existing	Currently little or no confirmation that TA units are FLAGEL compliant, and lack of evidence	
KRI 2 – Staff	Permanent recruitment of TA team	10%	Existing	5% complete	
KRI 3 - Policies	Current policies for TA Acquisition, Housing Allocations, Out of Borough placement	0%	Existing	All policies in draft awaiting updates and formal launch	
KRI 4 – Data	Jigsaw, NEC and Agresso Data align. A slight tolerance allowed as manual process in place means a natural 'time lag'	5%	Existing	50% complete. More data anomalies identified and being rectified.	
KR1 5 - Budget	Cost of TA to be matched by income from Housing Benefit and Rent.	5%	Existing	Q3 24/25 60% complete	

CR04	Failure to provide safe Temporary Accommodation within Budget	Risk owner: Pat Hayes

Controls - Identify current operating controls that are managing the sub risks

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Weak	• Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist • Controls and or/ management activities are non-existent or have major deficiencies and don't operate as intended

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	1	Increasing Availability	Allocations, PRS offer, empty homes review, medium and long term leases, downsizing.	Head of Service (Mitch Powell)	Needs Improvement	Weekly review of available empty homes in HRA and PRS. All allocations are signed-off by the manager. Includes sign-off form and how shortlisting and nomination. PRS incentives in-place but being reviewed. Control measure would be more effective if SBC could enter longer leases.
2	2	Budget setting and control	Checking that budget reflects cost of TA vs income from HB.	Head of Service (Mitch Powell)	Needs Improvement	Weekly team meeting and monthly senior management meetings to track costs and income. Control measure would be more effective with increased resource and increased supply of cheaper accommodation.
3	2	TA resource budget setting and control	Ensuring budget for resources is aligned to scale of the	Head of Service (Mitch Powell)	Ineffective	Budget setting as part of Corporate Budget has not involved Director of Housing. The control measure needs improvement because the budget for resource is a) set once a year but TA demand outstrips the resource b) not a true reflection of trends in demand and cost.
3	3	Compliance Certification	SBC to hold a record of compliance information against all units of TA	Head of Service (Mitch Powell)	Ineffective	Historically no ICT system, high staff churn, ad hoc arrangements in place which limit the effectiveness of the control measure.
4	4	Recruitment and retention of workforce	Recruit and retain suitably capable staff to manage TA	Head of Service (Mitch Powell)	Ineffective	Recruitment freeze, competitive market and low salary band at SBC is limiting the effectiveness of the control measure
5	5	TA Management (Property & People)	Effective placement into TA with rent account, charges and HB in place. Quarterly visits (monthly if in B&B), case review and move on to permanent accommodation.	Head of Service (Mitch Powell)	Needs Improvement	Processes in place but capacity and capability of current resource is limiting the effectiveness of the control measure.

CR04	Failure to Provide safe Temporary Accommodation within Budget	Risk owner: Pat Hayes

Treatment/mitigation plans from initial 10- point plan (sept 24) while service improvement plan is developed - (part funded actions that will manage/reduce the risk level further work underway)

Target Risk Score – *21* by end of date *10/2025*

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	1	Affordable TA	PLA and PSA agreements being drafted. Seeking permission to enter into long term lease with institutional investor. Increasing relationships with local Registered providers. Increasing use of JEH homes.	Head of Service (Mitch Powell)	October 2025		PLA / PSA at final drafting. Long erm lease paper to Cabinet 17th Feb. Now utilising 46 JEH homes.
2	1	Allocations and PRS	Weekly review of available empty HRA homes and PRS. All allocations are signed-off by the manager. Includes sign-off form and how shortlisting and nomination.	Head of Service (Mitch Powell)	March 2025		Allocation into HRA homes remains minimal due to availability. PRS offer is under review as incentives scheme ineffective.
3	1	Downsizing and Transfer	Increase downsizing incentive offer to free up family sized properties, with resultant void going to homeless households as per point 1 above. Downsizing offer needs to be more than financial and might include arranging and paying for removals, carpets, curtains etc.	Head of Service (Mitch Powell)	March 2025		Monthly review of under-occupiers and transfer requests now in place. We have begun work with reviewing how many UC on housing register, on Homeswapper and working with Neighbourhoods to engage those waiting with suitable offer and package of assistance
4	2	Invoice Payment Monitoring	To quickly improve invoice payment experience, we can then negotiate TA rates, current dissatisfaction felt by many providers, this is challenging if not impossible and we risk losing supplier.	Head of Service (Mitch Powell)	June 2025		Dedicated officer checking invoices vs placement. There are capped rates for nightly paid accommodation – breach of that approved by TA Manager / Head of Service.
5	2	Expensive placement monitoring.	Review applicants who have been in TA the longest, why they are there, develop plan to tackle oldest cases improving engagement with such residents consistently	Head of Service (Mitch Powell)	March 2025		Review underway. Some re-allocated to cheaper TA but availability of large properties is an issue.
6	2	Rents and HB	To ensure income is maximised by assuring all households have a rent account, charges and HB claim.	Head of Service (Mitch Powell)	March 2025		Over 200 new rent accounts created. C. 500 new accounts being created in Jan2025. Challenge will be associated HB claims processing.
7	3	TA Visits	Quarterly visits to self-contained units. Monthly visits to B&B and hotel accommodation. Review of transfer applicants on the housing register with neighbourhood services as if we move some of them, we create chain transfers and may unlock better/larger units as a result.	Head of Service (Mitch Powell)	June 2025		Minimal visits by enforcement team – mainly focused on B&B and HMO. Capacity is preventing full implementation.
8	3	PLA / PSA Agreements	The new agreements will state clearly the obligation of the provider to provide compliance certificates.	Head of Service (Mitch Powell)	June 2025		Revised draft agreements on target for March 2025. Need resource to implement in Q1 25/26.
9	3	NEC Provider Model	Implement the NEC provider module to record key information and hold related compliance data.	Head of Service (Mitch Powell)	June 2025		Project team has been diverted to data reconciliation.

CR04	Failure to Provide Safe Temporary Accommodation within Budget	Risk owner: Pat Hayes

Treatment/mitigation plans from initial 10- point plan (Sept 24) while service improvement plan is developed - (part funded actions that will manage/reduce the risk level further work underway)

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
10	4	Homeless and TA Structure	Review and establish the current staffing structure for the TA and Housing Needs Department to meet the service needs and ensure a lawful service us in place	Director of Housing (Lisa Keating)	April 2025		Underway
11	4	Recruitment	Immediately fill vacant posts with interim placement (due to recruitment freeze).	Head of Service (Mitch Powell)	March 2025		Proactively advertising and interviewing for new staff. Availability and capability is challenging
12	4	Prevention	Review cases currently at Prevention, and where possible in Relief on Jigsaw to see if there are any other options to stop them converting in TA placements down the line.	Head of Service (Mitch Powell)	October 2025		New Government Funding announced, team is planning resource to increase prevention activity.
13	5	Systems & Reporting	Engage ICT project team to continue system implementations, integrations and Power BI reporting Suite	Head of Service (Mitch Powell)	October 2025		Business Case re. funding for the team still to be agreed.
14	5	Policy	Allocations, TA acquisition, Out of Borough Placement to be reviewed	Head of Service (Mitch Powell)	March 2025		A full review of all policies will be completed for RSH inspection in April 2025
15	5	Procedures	As is and To be procedures to be mapped and new processes implemented.	Head of Service (Mitch Powell)	June 2025		Approx. 30% of processes mapped as part of the TA project room. Resource capacity issues to finalise and implement this.

Target Risk Score – *21* by end of date *10/2025*

CR05 | Failure to Attract, Retain & Engage with Our People

Risk owner: Bal Toor

Corporate risk overview

Current Risk Score 4 Impact 4 Likelihood	21
Target Risk Score 4 Impact 3 Likelihood	18

RAG status: Overall status remains red (with a score of 21) because of the risk exposure in 06.01 which in turn impacts 06.02 as contributary causes.

The HR function continues to operate whilst carrying multiple vacancies and is forecasting for a reorganisation between now and May 1st which should further strengthen skills and capabilities aligned to business need. This slows progress in some areas a little, but key discovery phases are on track, to ensure HR products are fit for purpose.

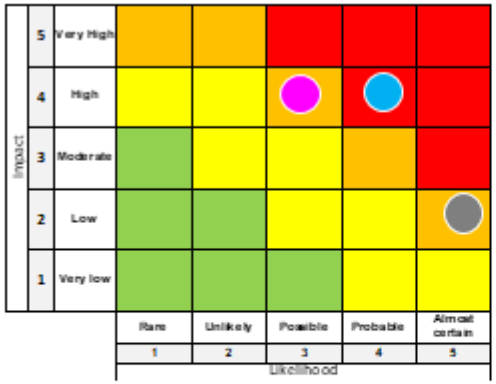
Market conditions and media coverage persist in affecting the possibility of failing to attract talent for critical roles. SBC competes with local London Borough pay scales which means we often lose our staff to neighbouring councils, therefore we have an issue with attracting and in some instances maintaining our talent pool.

Risk appetite statement - **Balanced**

We are willing to accept a balanced amount of risk to deliver on objectives but aim to reduce exposure where possible.

We aim to attract and retain the right people with the right skills in the right role at the right time. We accept there will be internal or external circumstances and / or organisational changes which may result in a negative, short-term impact on employee engagement, productivity, attraction or retention but seek to minimise this where possible.

Risk profile



Refer to slide 7 for risk assessment score instructions

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
05.01		We fail to attract a diverse and inclusive workforce	Bal Toor		This risk remains as is, however a mitigating action in place is now a redesign of the recruitment pages (both internal and external) for SBC. This includes a specific section on attracting local residents and advice on how to make a good application.
05.02		We fail to identify, develop and embed the capabilities and competencies we need in our workforce	Bal Toor		Continuing to define capture workforce skills via the launch of the new 1:1 and appraisal form, This will then help develop understanding of gaps and career pathways. We also have a low number of apprenticeships, however have recently launch a Data apprenticeship as a pilot to developing other ones for ED areas. We have begun communicating the new 1:1 and EOY review form, which includes a skills library which will now capture staff skills and this will be linked to the development of a talent pool in 25/26.
05.03		We fail to maintain an energised and engaged workforce	Bal Toor		Employee engagement continues to be detrimentally impacted by negative press and the impact of actions taken in Our Futures 2 years ago. Recent staff survey will provide a refreshed baseline. The recent staff survey has provided a fresh baseline and focus for HR; staff engagement remains relatively static for SBC overall, but LD and Vision/Leadership are key areas that required focused action for 2025/26.

CR05	Failure to Attract, Retain & Engage with Our People	Risk owner: Bal Toor

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KRI 1	Staff Turnover	Staff turnover inline with last published civil service average.	Red Low 0-3% High >14% Amber Low 3-7% High 12-14% Green 7-12%	11.9% (end Sep 24)	
KRI 2	Number of working days lost due to sickness absence per FTE employee	In line with CS average.	Red >90 days overdue Amber 1-90 days overdue Green not due / due & on track	8.1% Green	
KR 3	Number of Apprentices across key business areas	Minimum of 10 (i.e. 10% of the perm staff cohort) across SBC at any one time	n/a	41 (this has increased in the last ¼)	

CR05	Failure to Attract, Retain & Engage with Our People	Risk owner: Bal Toor

Controls - Identify **current** operating controls that are managing the sub risks

Control Effectiveness	Description
Effective	• Controls and or/ management activities properly designed and operating as intended • Management is confident that the controls are effective and reliable
Largely effective	• Controls and or/ management activities properly designed and operating with opportunities for improvements identified
Needs improvement	• Controls are only partially effective, require ongoing monitoring and may require redesigning, improving or supplementing • Key controls and or/ management activities in place, with significant opportunities for improvement identified
Ineffective	• Limited controls and or/ management activities in place
Weak	• Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist • Controls and or/ management activities are non-existent or have major deficiencies and don't operate as intended

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
2	SR05.01	1. Attraction channels 2. Apprenticeship scheme 3. Line Management upskilling	1 Review of how we work with Talos and 3rd party suppliers to advertise roles, to include working with Matrix on hard to fill vacancies 2. Continuation of learning from newly established Data apprenticeship to replicate positive impact across new apprenticeship schemes 3. Reviewing staff survey results to ensure feedback on line managers is taken into account when developing LM development scheme	Bal Toor	All controls effective, and on a continuous improvement cycle.	The HR function continues to operate whilst carrying multiple vacancies. This slows progress in some areas a little, but key discovery phases are on track, to ensure HR products are fit for purpose.
3	SR05.02	2. Apprenticeship scheme	1 Review of how we work with Talos and 3rd party suppliers to advertise roles, to include working with Matrix on hard to fill vacancies 2. Continuation of learning from newly established Data apprenticeship to replicate positive impact across new apprenticeship schemes 3. Reviewing staff survey results to ensure feedback on line managers is taken into account when developing LM development scheme	Bal Toor	All controls effective, and on a continuous improvement cycle.	The HR function continues to operate whilst carrying multiple vacancies. This slows progress in some areas a little, but key discovery phases are on track, to ensure HR products are fit for purpose.
4	SR05.02 - 03	3. Line Management upskilling	1 Review of how we work with Talos and 3rd party suppliers to advertise roles, to include working with Matrix on hard to fill vacancies 2. Continuation of learning from newly established Data apprenticeship to replicate positive impact across new apprenticeship schemes 3. Reviewing staff survey results to ensure feedback on line managers is taken into account when developing LM development scheme	Bal Toor	All controls effective, and on a continuous improvement cycle.	The HR function continues to operate whilst carrying multiple vacancies. This slows progress in some areas a little, but key discovery phases are on track, to ensure HR products are fit for purpose. The LM programme is now live and we are continuously monitoring feedback.

CR05	Failure to Attract, Retain & Engage with Our People	Risk owner: Bal Toor

Treatment/mitigation **plans** (funded actions that will manage/reduce the risk level)

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	SR05.01 - 03	As the take up of the new 121 and Appraisal form takes place, staff will add their skills for us to analyse.	System has been revamped and developed. Soft launch Oct 2024, with ramp up of comms over next 4 months.	Director	31/3/25	On track	On track and managed through the Plans in place for FY25. Comms continues over Jan-March to engage staff in use of 121 form and EOY review forms which has been extensively enhanced.
2	SR05.01	Establish broader offer of Apprenticeships	Pilot of Data apprenticeship launched with 12 Apps. If work with Multiverse *provider, is successful, further apprenticeship schemes will be developed and launched.	Director	31/3/25	On track	On track and managed through the Plans in place for FY25. We have successfully taken on a second DDAT apps cohort, increasing our numbers to 41. DDAT apps are new for SBC in 24/25.
3	SR05.01 - 03	Review of Recruitment end to end	6 month project from Dec-June 2025 will review our EVP, way in which we interview, EDI and leadership competency.	Director	01/06//25	On track	On track and managed through the Plans in place for FY25. Interim lead began Jan 20th, first focus has been review of website.

Target Risk Score – 18 by end of date *10/2025*

CR06	Health & Safety: We fail to prevent statutory obligations	Risk owner: Pat Hayes

Corporate risk overview

Current Risk Score 4 Impact 4 Likelihood	21
Target Risk Score 4 Impact 3 Likelihood	18

Although the risk score remains the same the risk environment remains stable.
SBC currently faces multiple, simultaneous risks of an intolerable nature – with a common root cause. Lack of data, communication and synergy of management/ownership/reporting;
The combination of escalating, aggressive behavior to front facing staff, aged and inadequate Risk Assessments (and subsequent controls) & Policies, COP's & Procedures not revised to modern, practical standards – derives into a High Likelihood and Impact ratio of **21** in its' present condition.

These matters evidence a fundamentally flawed and inadequate HSMS.
This score may be elevated due to a lack of reliable data and inter-departmental synergy and communication. There may, likely, be processes and controls that are not formally registered or communicated. However, without adequate qualitative/quantitative data – a conservative Risk Rating must be indicated.

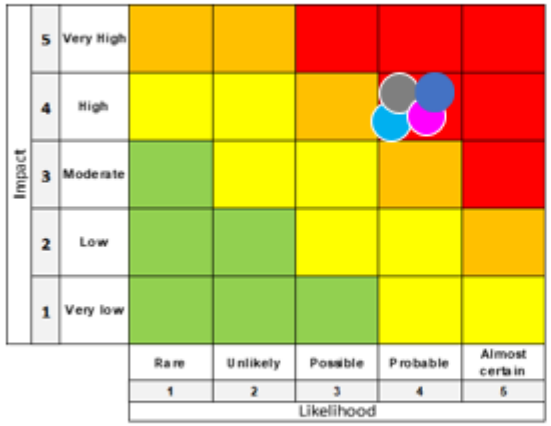
The actions, consistent with most highlighted risks have the initial milestone of data review and audit – tangible actions/systems, deadlines, ownerships and delegations can thereafter be allocated.

Risk appetite statement (AVERSE)

We have no appetite for safety risk exposure that could result in fatality or serious harm (physical and mental) to our employees, supply chain partners or member of the public through our actions, inactions, inadequacies (or decisions).

Recognising that risks should be reduced to As Low As Reasonably Practicable (ALARP), this may mean that residual risk scores remain elevated to highlight priority to enforce suitable and sufficient risk mitigation(s).

Risk profile



Refer to slide 8 for risk assessment score instructions

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
06.01		We fail to prioritise, adequately fund or manage risks associated with corporate health and safety	Roger Smith		Standardised, organizational ownership, recording, monitoring and reporting of key risks & statutory obligations. Efficiencies and organizational buy-in to be achieved by new shared software system sufficient training and standardized reporting mechanisms.
06.02		We fail to prioritise, adequately fund or manage risks associated with fire	Roger Smith		Fire Risk assessments to be scrutinized as to quality and content and, actions deriving to be prioritized, budgeted and forecast effectively.
06.03		We fail to prioritise, adequately fund or manage risks associated with aggressive behaviour	Roger Smith		Recognition of national and demographic antipathy to Local Government due to economic hardships and service reduction. Through policy and procedure, ensure our staff, public and derived representatives receive reasonably practicable safeguarding and support mechanisms.
06.04		Resource to accommodate organisational audit, scrutiny and engage with training & Policy improvements.	Roger Smith		Currently, both internal H&S Operative resource & externally commissioned assistance are under Business Case to mitigate and assist this key shortfall.

CR06	Health & Safety: We fail to prevent statutory obligations	Risk owner: Pat Hayes

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KR 1	*tba*	*tba*	*tba*	*tba*	
KRI 2	*tba*	*tba*	*tba*	*tba*	
KRI 3	*tba*	*tba*	*tba*	*tba*	

Current quantitative data relating to the above is unavailable and/or unreliable – and forms part of the deriving risk categories and actions.
KRI's cannot ethically be established until audit of existing shortfalls provides historic/present data.
TBA.

CR06	Health & Safety: We fail to prevent statutory obligations	Risk owner: Pat Hayes

Controls - Identify current operating controls that are managing the sub risks

Control Effectiveness	Description
Effective	• Controls and or/ management activities properly designed and operating as intended • Management is confident that the controls are effective and reliable
Largely effective	• Controls and or/ management activities properly designed and operating with opportunities for improvements identified
Needs improvement	• Controls are only partially effective, require ongoing monitoring and may require redesigning, improving or supplementing • Key controls and or/ management activities in place, with significant opportunities for improvement identified
Ineffective	• Limited controls and or/ management activities in place
Weak	• Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist • Controls and or/ management activities are non-existent or have major deficiencies and don't operate as intended

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR06.02	Fire Risk Assessments	Conduct regular fire risk assessments in all council buildings to identify potential hazards (Consideration for other Compliances).	*Director level*	Needs improvement	No centralized data. No RP's, quality checks or evidence of tangible, prioritized remediation timelines in order of risk/priority.
2	SR06.01 – 0.3	Training and Awareness:	Provide health and safety training to staff, including safe manual handling, correct use of tools and machinery, and ergonomic advice. Requirement of HASAWA.	*Director level*	*Ineffective*	Generic, mandatory training elements (largely unattended), not relevant to certain Service Areas or engaged in.
3	SR06.01 – 0.3	Risk Assessments	Carry out regular risk assessments to identify areas where injuries are more likely to occur, such as maintenance workshops, vehicle depots, and public spaces	*Director level*	Weak	*No evidence of training/competence of Risk Assessors. Inadequate centralized data (Records & Monitoring).*
4	SR06.01 – 0.4	Policies & Procedures	Organisational/departmental policy to detail obligations, practice and ownerships within specific areas.	Director Level	Weak	Policies & C.O.P.'s in place from 2019, generalized in require modernisation, communication and evidence of implementation.
5	SR06.01 – 0.4	HSMS Data Recording, Monitoring & Reporting	Ensure suitable & sufficient HSMS to enable recording, monitoring, managing and reporting of key risks and statutory obligations regarding Health and Safety.	Director Level	Ineffective	Existing HSMS deemed inadequate by external commission and Interim manager. Aged, inadequate data management and effective organizational comms and engagement.
6	SR06.03	Violence & Aggression	Provide reasonably practicable controls (Policy, Equipment & Systems) to protect staff from unreasonable behaviour.	Director level	Weak	Increasing (proven trends in reporting) occasions of Unreasonable Behaviour aimed towards SBC staff. Requires Policy and Controls that are reasonably practicable/suitable & sufficient.

CR06	Health & Safety: We fail to prevent statutory obligations	Risk owner: Pat Hayes

Treatment/mitigation plans (funded actions that will manage/reduce the risk level)

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	**SR06.01 – 0.4**	*FRA Audit & Review*	*Review of existing data, quality therein – address shortfalls (in terms of survey/actions) urgently.*	*Peter Walsh/Leo Yousef*	*02.12.24*		Risk Register to be communicated & action owners delegated to.
2	**SR06.01 – 0.4**	Training Level audit & analysis (E-learning & Mandatory Management)	*Review of existing data, quality therein – address shortfalls (in terms of survey/actions) urgently.*	Anthony Walker	02.12.24		Mechanism for qualitative & quantititive data to be derived prior to audit.
3	**SR06.01 – 0.4**	Risk Assessment audit & analysis.	Task (H&S Committee & Comms) Departments with RAMS review, advise, guide and assist.	Anthony Walker / Shameem Din	02.04.25		Yet to begin at point of writing.
4	**SR06.01 – 0.4**	Policies & Procedures audit & analysis.	Through internal (& external?) commission – review and revise current Policies, Procedures/COP's.	Anthony Walker / Shameem Din	02.04.25		Time/resource to be scheduled consistently, some work already underway (H&S Policy revised).
5	**SR06.01 – 0.4**	HSMS Data Recording, Monitoring & Reporting	Establish and implement a modernized, improved method of organizational H&S data recording, monitoring, reporting & sharing	Anthony Walker/ IT representative/Shameem Din	02.04.25		Existing Sharepoint inadequate. Procure & Implement organizational software system to enable key stakeholders to input, store and provide key metrics for qualitative and quantitative reporting.
6	**SR06.03**	Violence & Aggression policies & protocols	Develop organizational – and derived service area specific policies & protocols relating to unreasonable behaviour, ensure support (EAP/HR) mechanisms in place, instill additional, reasonable controls (i.e. security/support) within key public-facing services.	Anthony Walker/HR/Service Areas	02.04.25		HR (Shahilla Barok) tasked with Business Case to provide Security professional training (SIA) to Facilities Officers in Corporate Buildings. Draft Unreasonable Behaviour Policy (General) foir approval at H&S Board.

Target Risk Score – **18** by end of date: ***04/25***

CR07 Insufficient Operational Resilience and Crisis Management

Risk owner: Tessa Lindfield

Corporate risk overview

Current Risk Score 4 Impact 4 Likelihood	21
Target Risk Score 4 Impact 3 Likelihood	17

In Q3 the risk has been reviewed and new/revised sub-risks identified which better reflects the corporate risk.

Failure to sufficiently prepare for, respond to and recover from disruptive events and civil emergencies that may lead to disruption to business-critical functions, failure to meet rapid and unforeseen increases in demand, and failure to deliver core response functions in response to major civil emergencies, or terrorist events.

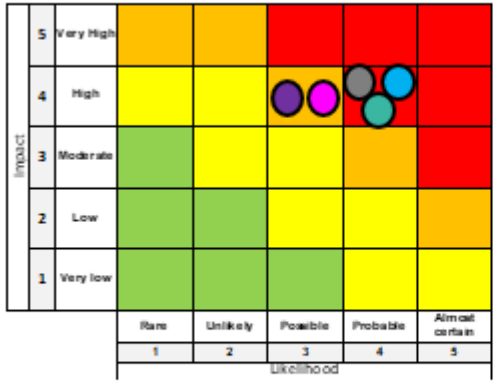
Business Continuity relates to the ability of an organisation to continue delivery of mission critical functions following disruptions. Disruptions affecting delivery can range from relatively frequent events that affect individual services, to less frequent, higher-impact events that may affect whole organisations (such as cyber-attacks and loss of premises). Appropriate Business Continuity Planning seeks to ensure that services maintain plans and preparations to adapt and recover from disruption before service failure.

Failure of the Council to adequately respond to a major civil emergency such as such as major fires, industrial accidents, transport incidents, flooding, terrorism, infectious diseases etc. that results in significant impacts to residents. Outcomes of these events are likely to include displacements, homelessness, injuries and deaths, environment damage and disruption to services and utilities. As a core responding agency, the Council maintains arrangements to deploy 'special arrangements' to lead the humanitarian response, limit and control impact to public realm and environmental impacts, co-ordinate with emergency services and other key partners, warn and inform the public, and lead the recovery effort.

Risk appetite statement **(Averse)**

This is a high-risk area with significant consequences. Mitigations are available. Risk appetite is averse.

Risk profile



Refer to slide 7 for risk assessment score instructions

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
CR07.01		Inadequate rapid emergency response capabilities to provide immediate incident co-ordination and humanitarian support to affected residents	Laura Robertson	NEW	Additional resource agreed to boost development of EP function. On call LALOs and Duty EPOs. Wider on-call functions of the Council. Review of current incident response capabilities needed
CR07.02		Failure of emergency planning for specific major hazard risks in the borough, such as flooding, major fires, industrial accident etc.	Laura Robertson	NEW	Identification of local hazard risks requires completion. Flood officer for the Council appointed very recently which should support review of tactical flood plans.
CR07.03		Failure of Major Incident Plan	Laura Robertson	NEW	Review of Major Incident Plan – currently in draft form. Gold Training. Training programme for on call staff in place. Redevelopment of Emergency Operations Centre. Currently no Silver Officers in place
CR07.04		Lack of generic resilience arrangements for all services responsible for delivering business critical activities	Laura Robertson	NEW	Business Continuity management programme exists, but requires review, improvement and engagement. Service level Business Impact Analyses and Business Continuity plans are out of date
CR07.05		Inadequate continuity planning for specific risks	Laura Robertson	NEW	Continuity planning for specific risks that pose a threat to organisational continuity, such as cyber-attacks, loss of facilities/buildings, supply chain disruption, utility disruption, loss of staff

CR07	Insufficient Operational Resilience and Crisis Management	Risk owner: xxx

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KRI1	Number of Trained Gold Commanders on rota 24/7/365	Minimum 6	7	7	
KRI2	Number of trained Silver Commanders on rota 24/7/365	Minimum 6	2	2	
KRI3	Number of trained Incident Managers on rota (new, in development) 24/7/365	Minimum 6	0	0	
KRI4	Number of trained Local Authority Liaison Officers (LALOs) on rota 24/7/365	Minimum 6	10	10	
KRI5	Number of training Rest Centre Managers on rota 24/7/365	Minimum 6	0	0	
KRI6	Number of trained Incident Responders (Volunteer / paid on-call)	(Min 48 / 24)	0	0	
KRI7	Training programme, including attendance records	All officers attend minimum of 1 training session and 1 exercise per year	TBC	TBC	
KRI8	Testing/exercising of major incident capabilities and arrangements				
KRI9	Service level Business Impact Analysis completed and reviewed in year	100%			
KRI10	Service level Business Continuity Plans completed and reviewed in year	100%			
KRI11	Service level Business Continuity Plans tested/exercised in year	100%			
KRI12	Risk specific planning completed for each risk/threat identified				
KRI13	Strategic/corporate level Business Continuity exercises completed	1 per year			

CR07	Insufficient Operational Resilience and Crisis Management	Risk owner: Tessa Lindfield

Controls - Identify current operating controls that are managing the sub risks

Control Effectiveness	Description
Effective	• Controls and or/ management activities properly designed and operating as intended • Management is confident that the controls are effective and reliable
Largely effective	• Controls and or/ management activities properly designed and operating with opportunities for improvements identified
Needs improvement	• Controls are only partially effective, require ongoing monitoring and may require redesigning, improving or supplementing • Key controls and or/ management activities in place, with significant opportunities for improvement identified
Ineffective	• Limited controls and or/ management activities in place
Weak	• Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist • Controls and or/ management activities are non-existent or have major deficiencies and don't operate as intended

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR07.3	Current draft plan in place	MIP has been signed off by CLT, providing basis for training and current response	Director level	Needs improvement	Current plan requires improvement, a review of duplicative content and development of a set of action cards
2	SR07.01,2,3,4,5	Additional temporary capacity for EP.	CLT permission has been gained for additional temporary capacity for EP support	Director	Needs improvement	Appointment made on part-time basis – full-time from April
3	CR07.1	Stand-by response teams	Gold, LALOs currently available	Director	Weak	No Silver Commanders, and no deployable emergency welfare/shelter responders.
4		Mutual aid for Duty EPOs	West Barks JEPU currently providing cover for Silver/Duty EPO role until local capacity can be developed	Director	Needs improvement	Arrangements until end February only
5	CR07.1,3	Emergency Operations Centre	Facility to co-ordinate the Council's response to major incidents	Director	Needs improvement	Facility exists, but needs improvement
6	CR07.1,2	Emergency humanitarian support	Ability to deploy emergency humanitarian support service to the affected public to meet immediate practical and psychological needs	Director	Weak	Basic outline plans for evacuation shelters. Condition of emergency equipment stores are unknown. No trained staff
7	SR07.04	Corporate Business Continuity Programme	A programme of activity for the development and maintenance of Business Continuity planning	Director level	Needs improvement	Poor engagement. Needs review to bring into line with standards and align to Risk and Business Planning processes
8	CR07.5	Risk identification	Identification and monitoring of potential corporate level business continuity risks	Director	Weak	No process for identification of corporate risks that may impact on service delivery
9	CR07.4	Service level Business Impact Analyses	Services are required to complete a Business Impact Analysis that supports an understanding of the service, inputs and deliverables.	Director	Needs improvement	Current BIA process and outputs require improvement. BIAs out of date. Poor understanding of criticality to inform planning priorities and service needs.
10	CR07.4	Service level Business Continuity Plans	Business Continuity Plans for all service detailing how services will maintain critical activities following disruption	Director	Needs improvement	Service level Business Continuity Plans exist; however, the plans are highly generic and require review and improvement.

CR07	Insufficient Operational Resilience and Crisis Management	Risk owner: Tessa Lindfield

Treatment/mitigation plans (funded actions that will manage/reduce the risk level)

Target Risk Score – *17* by end of date *10/2025*

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	SR07.1,2,3, 4,5	Increased capacity for EP function	Additional short-term increase in capacity	Laura Robertson	December 2024	A	*Recruitment completed – part-time only – full-time from April 2025*
2	SR07.1	Recruitment and training of Incident Managers	Recruitment of a team of incident managers to take on the role of Duty EPOs	Laura Robertson / David McClory	March 2025	A	Identifying potential candidates
3	SR07.3	Redrafting and testing of MIP	MIP to be reviewed and refined, action cards added, tested through exercise and learning applied	Laura Robertson / David McClory	August 2025	A	Requires review, consultation and approval
4	SR07.1	Recruitment and training of responders	Recruitment of operational volunteers to deliver key incident response services	Laura Robertson / David McClory	May 2025	A	Planning of recruitment campaign and training needs analysis
5	SR07.1,2	Re-establishing Tactical/Silver level of management	Training of corporate managers to be Tactical/Silver Commanders and placed on-standby rotas	Laura Robertson / David McClory	June 2025	A	Proposal development
6	SR07.1	Training for all on-call response staff	Training programme for Strategic Gold, Director on call, LALO, Silver	Laura Robertson / David McClory	June 2025	A	Training continue following delay due to staff sickness
7	SR07.1	Improved guidance and equipment for incident responders	Provision of suitable PPE and response equipment for operational responders	Laura Robertson / David McClory	May 2025	A	Identifying required response roles, establishing responsibilities and H&S Risk Assessments
8	SR07.1,2,3	Improvements to Emergency Operations Centre	Improvements to emergency control centre facilities, resources and systems	Laura Robertson / David McClory	Sept 2025	A	Discussions with Facilities to move Emergency Operations Centre to new location
9	SR07.2	Major hazard risk assessments and register	Identification and assessment of major hazard risks, and creation of a risk register	Laura Robertson / David McClory	December 2025	A	
10	SR07.4	Review of Business Continuity Policy and Programme	Review of the policy, process and strategy for Business Continuity planning and management for the organisation	Laura Robertson / David McClory	May 2025	A	Additional resource agreed by CLT – ECP and recruitment underway
11	SR07.5	Alignment of Business Continuity Policy to Risk and Business Planning policies	Seek alignment of policies	Laura Robertson / David McClory	June 2025	A	Seeking opportunities with Risk and Business Planning
12	SR07.4	Review of the Business Continuity establishment in organisation	BC programme currently sits with Emergency Planning, which is primarily focused on preparing for and responding to external risks and threats.	Laura Robertson	?	A	Initial viability assessment – *would Business Continuity Planning be more appropriately placed with an internally facing corporate service*
13	SR07.4,5	Development of Business Continuity Plans	Plans to respond and recover from, including maintenance of critical services, suspension of non-critical functions, redeployment of staff	Laura Robertson / David McClory	August 2025	A	Discovery work re school plans in place and proposal in development for CLT.
14	SR07.4,5	Testing and exercising of Business Continuity Plans	Testing and exercising regime to ensure plans are fit for purpose	Laura Robertson / David McClory	September 2025	A	No change
15	SR07.5	Identification of specific risks/threats for business contingency planning	Identification of specific risks/threats to service/organisational continuity (e.g. cyber-attacks, supply chain disruption, utility failure, etc.)	Laura Robertson / David McClory	August 2025	A	No change

CR08 | ICT incident resulting in significant data and/or service loss

Risk owner: Martin Chalmers

Corporate risk overview

There is no change to the risk score this quarter.

Current Risk Score 4 Impact 4 Likelihood	24
Target Risk Score 4 Impact 2 Likelihood	19

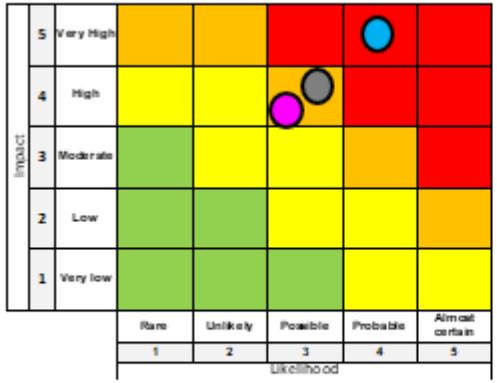
Updates are:-

- There is an open tender underway for the procurement for Disaster Recovery as a Service and Backup as a Service. This is in the final stage of supplier evaluation. Recruitment of a project manager is in progress but is proving challenging owing to market conditions. That role will manage the implementation and ensure the Council's business continuity plans are in place and aligned to the procured IT Solution.
- There is a potential option to enter a 6-month managed service pilot programme for a Security Incident Event Monitoring (SIEM) solution. The pilot programme is commissioned by MHCLG. If this option is not suitable, the Council will undertake an open tender procurement exercise, a specification for this has been prepared and is ready.
- A permanent Cyber Security Lead role has now been recruited to the Digital Data and Technology (DDaT) team who will be leading on cyber security for the council.
- Work is ongoing with MHCLG on the Council's cyber security treatment plan. Quarterly meetings continue to take place to discuss progress on the remaining actions. This includes implementing cloud-based backups, SIEM logging and removal of legacy operating systems.
- Successful completion of the MHCLG getting Cyber Assessment Framework (CAF) ready programme for local government in December 2024. The Council will be receiving £15,000 grant funding to support our ongoing cyber security resilience activities.

Risk appetite statement **(Averse)**

There is a low appetite for a successful cyber attack or significant data risk impacting the Council, not only for the operational impacts it can cause to our essential service but also the reputation and regulatory impacts it would cause. The Council wishes to minimise the risk to the extent possible given affordability constraints.

Risk profile



Refer to slide 6 for risk assessment score instructions

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period/ outlook	Management Review/ Explanation of movement
08.01		A cyber attack causes significant data or service loss	Colin Power		Even though progress has been made this quarter, there are no technological advancements so the outlook for the sub risk remains unchanged. Updates are: • Award of contract of new Disaster Recovery and Backup solution due end of February 25 • Approach on implementation of Security Event Management solution to be agreed by end of February • MTFS and 25/26 budgets to be agreed at full council at end of February 25 • PSN status classified as "Deferred" as agreed with Cabinet Office
08.02		A business continuity issue causes significant service loss	Colin Power		• Engagement with the new Emergency Planning team underway however operational risks remain for legacy backup solutions resulting in no change to sub risk.
08.03		An incident caused by hardware or software failure causes significant service loss	Colin Power		The sub risk is still improving this quarter as legacy systems continue to be decommissioned:- Updates below • Removal of the legacy hardware and software underway. • Removal of Citrix will decommission 17 servers (due end of March) • Migration of Liquid Logic to the cloud will decommission 22 servers. (expected end of October 25) • New hardware for Data Centre procured and due to by installed by end of March 25

CR08	ICT incident resulting in significant data and/or service loss	Risk owner: Martin Chalmers

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
[The indicators in the table below are illustrative of thinking in this area, as there are not currently any measures in formal operation. I am confirming just what is measurable and whether baseline data exists.]					
KRI 1	Number of cyber incidents	0	-	0	
KRI 2	% staff completed cyber training	95%	-	Currently 80 per cent completion rate. Based on 1062 completions against 1329 employees.	
KRI 3	Number of ICT incidents substantively impacting one or more services (hardware / software failure P1 major incident)	1		3	
KRI 4	Notifications of compromise / risk from the National Cyber Security Centre (NCSC) active cyber defence service (ACD) early warning service	3	-	1	
KRI 5	Result of Phishing simulations showing level of awareness and reporting of phishing attempts to the service desk	To be confirmed following initial phishing exercise	-	No phishing exercises undertaken	

CR08	ICT incident resulting in significant data and/or service loss	Risk owner: Martin Chalmers

Controls - Identify current operating controls that are managing the sub risks

Control Effectiveness	Description
Effective	• Controls and or/ management activities properly designed and operating as intended • Management is confident that the controls are effective and reliable
Largely effective	• Controls and or/ management activities properly designed and operating with opportunities for improvements identified
Needs improvement	• Controls are only partially effective, require ongoing monitoring and may require redesigning, improving or supplementing • Key controls and or/ management activities in place, with significant opportunities for improvement identified
Ineffective	• Limited controls and or/ management activities in place
Weak	• Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist • Controls and or/ management activities are non-existent or have major deficiencies and don't operate as intended

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR08.01	Application of government security standards	SBC is currently externally assessed against the PSN (Public Sector Network) requirements and conducts self-assessments based on Cyber Essentials criteria. Controls implemented include annual IT Healthcheck, patching, vulnerability monitoring, and clear processes around incident management	Colin Power	Largely effective	• Successful completion of MHCLG getting Cyber Assessment Framework (CAF) ready programme • PSN status classified as "Deferred" as agreed with Cabinet Office • Quarterly internal vulnerability scanning undertaken
2	SR08.01	Communications and training	Training is provided to new joiners with annual refresher training for all staff; awareness training is disseminated via newsletters and specific warning emails	Alex Cowen	Needs improvement	• Cyber Security Lead now in place • Training compliance and awareness to be reviewed and improvement actions identified
3	SR08.01 & SR08.02	Business continuity planning	Business continuity and disaster recovery planning both within DDaT and across the wider organisation	Colin Power	Ineffective	• DDaT have engaged with the new Emergency Planning team. • The new Project Manager (action 3 above) to align and support EP team with business continuity and disaster recovery planning.
4	SR08.03	Technology refresh	Technology (hardware and software) is kept up to date for both resilience and security reasons.	Colin Power	Needs improvement	Refer to treatment actions 1, 2 & 3 overleaf.
5	SR08.03	Incident root cause analysis and remediation	Where incidents do occur, action is taken to identify and address the root cause, to avoid repetition	Alex Cowen	Effective	Control operating as expected

CR08	ICT incident resulting in significant data and/or service loss	Risk owner: Martin Chalmers

Treatment/mitigation plans (funded actions that will manage/reduce the risk level)

Target Risk Score – *19* by end of date *10/2025*

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	SR08.01 & SR08.03	Completion of application cloud migration	Completion of an outstanding cloud migration project is a prerequisite for meeting government security standards and mitigating a vulnerability	Alex Cowen	October 2025 (Full Council Meeting Approval at end of Feb 25)	G (previously A)	• Initial proposals of the MTFS bids have been accepted • Full council approval due end of February. 2025. • Completion date of end of October currently on track (pending confirmation from Supplier).
2	SR08.01	Introduction of managed service for Security Incident and Event Monitoring	Outstanding action from modernisation programme; requires procurement and then implementation	Colin Power	October 2025 (Agree approach by end of Feb 25)	G (previously A)	• Potential option to enter a 6-month managed service pilot programme for a SIEM solution by MHCLG. • If not suitable, the Council to undertake an open tender procurement exercise. • Decision on which approach to progress will be made by the end of February 2025.
3	SR08.01 & SR08.02	Introduction of Disaster Recovery as a Service and Backup as a Service	Outstanding action from modernisation programme; requires procurement and then implementation	Martin Chalmers	November 2025 (Contract Award due by end of Feb 25)	G (previously A)	• Open tender underway for DRaaS/BaaS and in final stages of supplier evaluation. • Award of contract expected for end of February 2025. • Implementation expected to be completed by end of November 2025. • A Project Manager has been appointed and due to start on 4th Feb
4	SR08.01 & SR08.02	Completion of Business Continuity and Disaster Recovery Planning	This refers not only to planning within the DDaT area but to action with other services so that the consequences of cyber attack are factored into wider business continuity plans	Martin Chalmers	November 2025 (PM engagement with EP team due mid February 25)	A	• DDaT have engaged with the new Emergency Planning team. • The new Project Manager (action 3 above) to align and support EP team with business continuity and disaster recovery planning.
5	SR08.01	Improve takeup of mandatory training	Takeup in SBC of mandatory refresher training Is 60%. Action is needed to address this through a combination of communication and enforcement.	Martin Chalmers	March 2025 (Agree Action plan with L&D by end of February)	A	• Cyber Security Lead now in place • Training compliance and awareness to be reviewed and improvement actions identified
6	SR08.01	Email phishing simulation campaign	Conduct quarterly email phishing simulation campaign to measure the success of cyber awareness training and reporting of incidents.	Colin Power		A	• Cyber Security Lead now in place. • Initial phishing campaign to be scoped and deployed and timescales agreed.

CR09 | Failure to achieve financial sustainability and a balanced MTFS

Risk owner: Annabel Scholes

Corporate risk overview

Current Risk Score 5 Impact 4 Likelihood	24
Target Risk Score 5 Impact 3 Likelihood	22

There has been no change in the risk score and the RAG status remains red.

A new sub-risk has been added SR09.07 'Failure to deliver value for money from procurement processes'

If the Council fails to significantly improve its financial planning and management and its internal control and financial reporting in the medium to longer-term the Council will not become a financially self-sustaining council.

The final local government finance settlement was announced 3 February 2025. The 2025/26 budget will be approved prior to the 11 March statutory deadline.

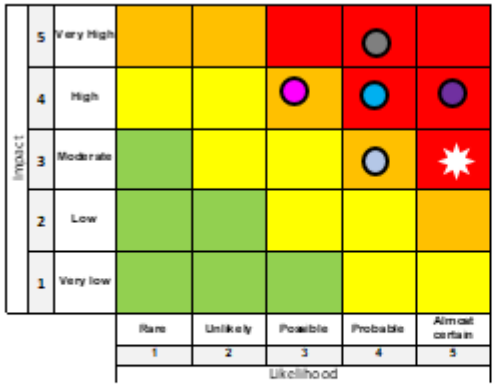
For 2026/27, the financial strategy will align with the corporate planning cycle with preparation work having commenced.

Risk appetite statement **(Averse – Balanced)**

We have a very low appetite to being in a position where we are unable to maintain sufficient liquidity to fund operations and to meet our liabilities as they fall due.

We seek to maintain a level of liquidity to have confidence in the ability to manage adverse events beyond forecast sensitivities without undue reliance on uncommitted funding.

Risk profile



Refer to slide 8 for risk assessment score instructions

Sub risks related to this principal risk

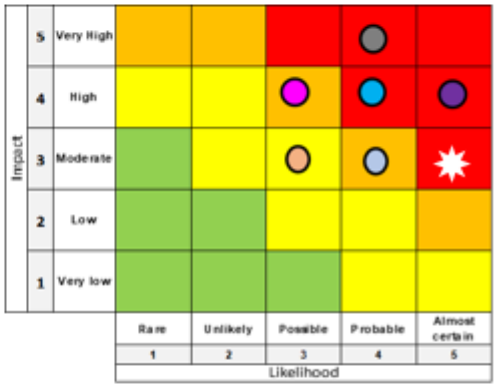
Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
09.01		Failure to deliver audited financial reports (SOA) to identify any additional financial liabilities to the council which will impact on financial sustainability.	Chris Holme		Outlook is improving but not sufficient to change risk score. Draft statement of accounts for 2021/22 and 2022/23 published and currently in statutory public inspection period. Audited accounts will be approved by Audit Committee on 20 February. 2023/24 draft statement of accounts will be published for public inspection February 2025. 2024/25 statement of accounts to be published within statutory deadlines.
09.02		Failure to achieve a balanced budget and Medium Term Financial Strategy (MTFS)	Dave McNamara		The is the baseline position and reflects failure to (as at Nov 24) to agree a balanced MTFP and need to bring forward 26/27 and 27/28 Capitalisation Directions to deliver a balanced budget for 2025/26. Following the LGFS announcement there was a budget gap of £2.471m. Proposal to be developed for Cabinet consideration. Pressures continue in 24/25 on achieving a balanced outturn.
09.03		Inadequate cashflow to maintain balance of liquidity to fund expenditure	Chris Holme		Q3 position reflects ongoing 2024/25 spend pressures and position following government announcement on council tax increases which may require the council to borrow more than anticipated, putting further strain on our cash position. The treasury management strategy for 2025/26 considered by Audit Committee approved 20 January for approval by Full Council in March 2025.

CR09	Failure to achieve financial sustainability and a balanced MTFS	Risk owner: Annabel Scholes	Signed-off by owner: Y / N

Corporate risk overview - Continued

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
09.04		Government funding formula/distribution does not reflect the needs of the Slough community and demographic	Dave McNamara		LGFS was a better than expected settlement with additional funding distributed on need. However total core funding and specific grants remain insufficient to finance Slough BC demand pressures
09.05		Failure to recruit and retain a resilient and skilled workforce within finance	Vicki Palazon		Outlook is improving but not sufficient to change risk score. Baseline reflects reliance on a significant number of interims and difficulties in recruiting permanent staff with appropriate skills, experience and qualifications Recruitment supplier – award of contract w/c 10/02/2025. Finance Director roles and key senior roles permanent recruitment commences.
09.06		Failure to deliver the FIP which include internal controls, an effective finance system both through tech and business processes	Vicki Palazon		Baseline reflects progress to date against the agreed FIP. Although the outlook is stable, there has been a deterioration this quarter, but not enough to affect the risk score. Early January, FIP activity temporarily paused to enable resources and council officers to deliver the budget. Work will resume late February. However, key activities such as data cleansing and internal controls has continued including activities where resources are not involved in the budget, for example production of 2023/24 statement of accounts.
09.07		**(NEW SUB-RISK)** Failure to deliver value for money from procurement processes	Chris Holme	**NEW**	The current position reflects current position regarding the following. • Procurement Act compliant contract procedure rules, but no procurement strategy. • Imbalance of requisite skills and qualifications within procurement team • Lack of a robust contracts register • Preparedness for implementation of Procurement Act



CR10	Failure to achieve financial sustainability and a balanced MTFS	Risk owner: Annabel Scholes

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KRI 1	*In year budget monitoring highlights a pressure that can't be balanced*	Check performance measure	*Q2 2024/25 - £2m pressure*	*Q3 position £5.571m pressure*	Trend?
KRI 2	Key balance sheet and system reconciliations are not embedded and completed in accordance with agreed timetable	Less than 5% behind agreed timetable	Work ongoing as part of backlog accounts process to provide baseline and we will measure from Q4	Work ongoing as part of 2023/24 accounts to provide baseline position in time for Q4	Trend?
KRI 3	Data quality and MI is not improved to inform the financial forecasts	TBC			Trend?
KRI 4	*Level of external debt as a proportion of net revenue budget*	Reduce by 5% pa	*Q1 24/25 - 17.1%*	Q3 24/25 - 17.1%	Trend?
KRI 5	Proportion of Internal Audit Opinions with Minimal Assurance	Reduce by 30% from 23/24 Outturn	Q1 24/25 – 100%	Q2 24/25 -	Trend?
KRI 6	Statement of Accounts Published within Statutory Deadlines	Publish all accounts to 2022/23 by December 2024 and 2023/24 SOA by February 2025	Audited SOAs for 2018/19	Final SOAs for 2019/20 and 2020/21 Draft SOAs for 2021/22 and 2022/23	Upwards
KRI 7	Stability in workforce with a reduction in interims. Training / CPD in place for permanent staff. All permanent staff completed an appraisal and training plan Attrition rate	Reduction of 10% reliance on interims 100% appraisals / training plan in place			Trend?
KRI 8	FIP remains on track, milestones achieved	On track or better	No data	Finance Improvement Plan has been temporarily paused whilst our resources concentrate on the final stages to set next year's budget	Amber - paused
KRI 9	Proportion of off contract spend as a proportion of TP expenditure	TBA	No data		Red – in development

CR10	Failure to achieve financial sustainability and a balanced MTFS	Risk owner: Annabel Scholes

Controls - Identify current operating controls that are managing the sub risks

Control Effectiveness	Description
Effective	• Controls and or/ management activities properly designed and operating as intended • Management is confident that the controls are effective and reliable
Largely effective	• Controls and or/ management activities properly designed and operating with opportunities for improvements identified
Needs improvement	• Controls are only partially effective, require ongoing monitoring and may require redesigning, improving or supplementing • Key controls and or/ management activities in place, with significant opportunities for improvement identified
Ineffective	• Limited controls and or/ management activities in place
Weak	• Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist • Controls and or/ management activities are non-existent or have major deficiencies and don't operate as intended

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR09.01	*Backlog Accounts Programme*	*Dedicated Recovery Team finalising accounts*	*Chris Holme*	*Largely Effective*	*Dedicated team have completed 2019/20, 2020/21, 2021/22 and 2022/23 draft accounts. 2019/20 and 2020/21 are now final accounts and for 2021/22 and 2022/23, they will become final accounts in Q4. Team close to conclusion of draft accounts for 2023/24 with audit due to be completed April 2025. Preparatory work for 2024/25 Statement of Accounts to commence Q4, and completion Q1 2025/26.*
2	SR09.01	Balance Sheet Review	Dedicated ongoing review on risk basis of the Balance Sheet to identify and quantify liabilities arising prior years transactions and incorrect accounting	Chris Holme	Largely Effective	Significant work has been done to narrow down the scale of potential liabilities arising from prior years and as part of the 2023/24 statement of accounts finalisation of material items will be concluded
3	SR09.02	Design Authority	Design Authority established to undertake due diligence on all proposals impacting Council's finances. With ongoing review of delivery	Dave McNamara	Needs Improvement	Regular meetings of the Design Authority have been established with engagement from all services that contributes to the improving effectiveness of the control measure.
4	SR09.02	Monthly Monitoring Reports	Services review their performance and produce monthly forecasts. The forecasts are collated and reported to CLT and Lead members for their consideration and recommendation	Dave McNamara	Needs Improvement	It's important that services are confident in the accuracy of their forecasts as this informs management action, particularly as the year progresses and there is less time to react to changes
5	SR09.02	Regular MTFS Reviews	The Financial planning forecast are updated and reported regularly	Dave McNamara	Needs Improvement	The MTFS is not yet balanced and further work is required to achieve this.
6	SR09.02	Financial Controls	No PO No Pay and the Expenditure Control Process (ECP) allows the authority to have complete visibility over its commitments and ability to approve only essential and statutory expenditure	Dave McNamara	Needs Improvement	ECP process has been reviewed and new process implemented
7	SR09.02	Quarterly TMS updates	Triangulation of Capital Expenditure, Capital Financing and Financial Management gives visibility on changes to a very significant proportion of Council expenditure	Chris Holme	Needs improvement	Processes need to be embedded

CR10	Failure to achieve financial sustainability and a balanced MTFS	Risk owner: Annabel Scholes

Controls - Identify current operating controls that are managing the sub risks

Control Effectiveness	Description
Effective	• Controls and or/ management activities properly designed and operating as intended • Management is confident that the controls are effective and reliable
Largely effective	• Controls and or/ management activities properly designed and operating with opportunities for improvements identified
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Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
8	SR09.04	*Relative Need*	*Local Government Funding is distributed in a number of ways and we need to monitor the effectiveness and ensure relative need is reflected in the distribution model used.*	Dave McNamara	Largely Effective	We will continue to make the case for a more distributive funding that reflects the needs of the Borough.
9	SR09.1 - 06	Financial policies and procedure	All financial policies flow from Financial Procedure Rules	Chris Holme	Needs Improvement	Improvement is being delivered through treatment plan reference number 1
10	SR09.1 - 06	Balance Sheet Reconciliations	Balance Sheet items must be reconciled daily/ weekly/ monthly by nominated finance officers and reporting improved to ensure management oversight	Chris Holme	Needs Improvement	Documented reconciliation processes with clear ownership to ensure all control and suspense accounts are balanced each month
11	SR09.1 - 06	Balance Sheet Reporting	Key balance sheet items reported to management/ Cabinet as part of monthly monitoring processes	Chris Holme	Needs Improvement	Embed monthly reporting for key balance sheet items (incl cash, debtors, creditors, reserves
12	SR09.1 - 06	Audit Trail	All financial transactions to have source document evidence to demonstrate evidence for every posting in accounts	Chris Holme	Needs Improvement	More work to ensure no posting without evidence
13	SR09.1 - 06	Process Reviews	Rolling review of financial processes based on risk assessment	Vicki Palazon	Needs Improvement	Scheduled to commence Q1 2025/26

CR10	Failure to achieve financial sustainability and a balanced MTFS	Risk owner: Annabel Scholes

Treatment/mitigation plans (funded actions that will manage/reduce the risk level)

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	SR09.1 - 06	Review of Key Financial Policies and Procedures	Key Financial policies to be reviewed annually or biannually and changes agreed through appropriate governance	Chris Holme	31/10/2025	Amber	Currently paused January 2025 – end February 2025 **Activity temporarily paused to enable resources and council officers to deliver the budget**
2	SR09.1 - 06	Balance Sheet Review	Finalisation as part of 2023/34 Accounts	Chris Holme	31/03/2025	Green	On track – based on revised timetable
3	SR09.05	Review and update HR policies and procedures	6 month HR project from Dec-June 2025	Bal Toor	30/06/2025	Green	On track and managed through the Plans in place for FY25. Interim lead began Jan 20th, first focus has been review of website.
4	SR09.05	Undertake staff appraisals	Undertake staff appraisals including training and development plans in accordance with HR policies and procedures	DLT	31/03/2025	Green	To be scheduled to meet corporate deadlines
5	SR09.05	Staff capacity and skills assessment	Undertake an assessment of staff competencies	DLT	31/03/2025	Amber	Currently paused January 2025 – end February 2025 **Activity temporarily paused to enable resources and council officers to deliver the budget**
6	SR09.05	Training and Development Plan	All staff to have training and development plans	DLT	31/03/2025	Green	Linked to PDRs
7	SR09.06	FIP project plan	Proactive project management of the FIP projects including RAID	Vicki Palazon	31/03/2025	Amber	Currently paused January 2025 – end February 2025 **Activity temporarily paused to enable resources and council officers to deliver the budget**
8	SR09.06	Internal Control Framework	Create the project plan for Internal Controls (including Agresso system controls)	Vicki Palazon	31/12/2024	Green	Ongoing
9	SR09.06	Internal Control Framework project	Ensure that the FIP project 37 – Internal Controls is on track to deliver set milestones that have a target date prior to 31/03/2025	Vicki Palazon	31/03/2025	Amber	Priority areas have continued during the FIP being paused

Target Risk Score – *22* by end of date *10/2025*

CR10 | Failure of General Fund Asset Disposal Programme

Risk owner: Pat Hayes

Corporate risk overview

CURRENT SCORE 4 Impact 3 Likelihood **18**
TARGET SCORE 4 Impact 3 Likelihood **18**

Overall Risk has been reduced to 18 from 21 during Q3 FY24/25 due to the likelihood of Risk 10.1 (Property disposals not hitting financial targets and sitting outside lower volatility levels) moving from 'Probable' to 'Possible'.

The GF Asset Disposal Programme enables the sale of under-utilised assets falling within the Council's Asset Disposals Strategy. The programme supports a reduction in the Council's future financial commitments by generating receipts from property sales at the earliest opportunity to reduce the Council's borrowing and MRP, as well reducing operating costs.

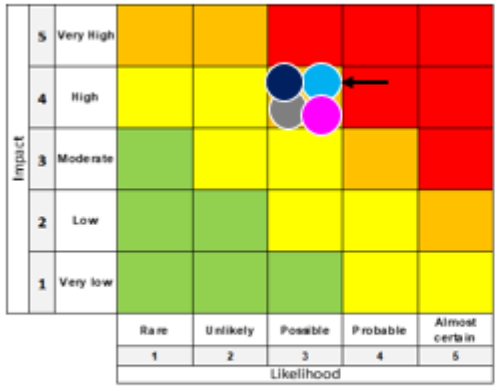
The 'net net proceeds' baseline target approved by Cabinet for the overall GF Disposals Programme is £27.402m. Though there have been adjustments in terms of the available property portfolio for disposal (both additions and ommissions), the total Disposals Programme target remains materially unadjusted at £27.404m.

During Q3 FY24/25, quarterly disposals are £0.364m behind plan (–14.9%) due to SUR – Haymills being traded for less than anticipated, however we are confident that this shortfall will be made up in Q4 FY24/25 with a number of transactions likely to outperform budget.

Risk appetite statement **(Balanced)**

To achieve planned Sales Proceeds within the agreed time period, the Disposals Programme naturally has a balanced approach to commercial risk. As business continuity and quality of service delivery is key, on a property-by-property basis the Disposals Programme naturally has a lower risk appetite to accommodate the delivery of operational and especially statutory services.

Risk profile



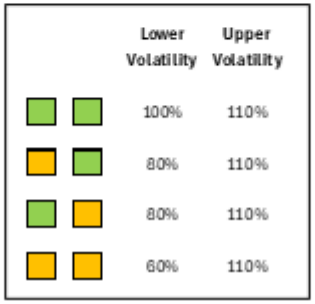
Refer to slide 7 for risk assessment score instructions

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
10.01		Property disposals not hitting financial targets and sitting outside lower volatility levels	Ian Church		None – overall progress as anticipated. Any underperformance is currently being compensated by better Sales Proceeds elsewhere.
10.02		Pace of disposals is behind programme deliverable dates	Ian Church		None – progress as anticipated. Requires close monitoring and CLT support as pace of sale is dictated by timely approval by Members.
10.03		Attraction and Retention of quality people	Ian Church		Having sufficient resources of the right quality to deliver the programme. Transition from interim to FT staff while maintaining momentum, quality and corporate knowledge.
10.04		External property market volatility	Ian Church		Market is currently stable after a downward trend. Positive movement is anticipated which will allow better sales proceeds and positive volatility.

CR11	Failure of General Fund Asset Disposal Programme	Risk owner: Pat Hayes

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
Sales Proceeds	The proceeds of sales falls outside of the Lower Volatility thresholds as designated based on Asset Classification. 	**FY 24 / 25** Target Sales : £ 11.8m Lower Threshold : £ 11.6m **FY 25 / 26** Target Sales : £ 22.5m Lower Threshold : £ 19.0m **FY 26 / 27** Target Sales : £ 4.7m Lower Threshold : £ 3.3m			
Pace of Sales	The pace of sale drops below the anticipated plan	**FY 24 / 25** – 13 sales PA **FY 25 / 26** – 30 sales PA **FY 26 / 27** – 8 sales PA			
Risk of Judicial Review	Not following prescribed procedures or a lack of thoroughness in consultation, understanding operational needs or similar.	1 permission / 6 months 1 successful hearing / 2 years			
Team Attrition	An unplanned loss to the disposals team (either permanent or interim)	10% unplanned loss per annum			
Green / Amber assets move to RED	Unforeseen circumstances mean that Sales Proceeds reduce due to properties planned for disposal move to RED due to force-majeure like issues.	2 demotions per quarter			
Commercial Interest	Ensuring that all active sales generate sufficient market interest to generate a competitive sales environment and 'deal tension' by generating significant EOI, bidders and BAFOs	At least 10 EOI per sale At least five 5 Bidders / BAFO per sale			

CR10	Failure of General Fund Asset Disposal Programme	Risk owner: Pat Hayes

Controls - Identify current operating controls that are managing the sub risks

Control Effectiveness	Description
Effective	• Controls and or/ management activities properly designed and operating as intended • Management is confident that the controls are effective and reliable
Largely effective	• Controls and or/ management activities properly designed and operating with opportunities for improvements identified
Needs improvement	• Controls are only partially effective, require ongoing monitoring and may require redesigning, improving or supplementing • Key controls and or/ management activities in place, with significant opportunities for improvement identified
Ineffective	• Limited controls and or/ management activities in place
Weak	• Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist • Controls and or/ management activities are non-existent or have major deficiencies and don't operate as intended

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR10.01	Market / Economy	• Market Intelligence and Engagement • Consider reordering disposals due to market sentiment	Ian Church	*Largely Effective*	Monthly review of deals in near pipeline to consider reordering as necessary
2	SR10.02	Sales below expectations	• Engagement of correct agents and sales routes • Preparation of quality bid materials and supporting docs • Ensuring properties pitched to correct pool of purchasers	Ian Church	*Largely Effective*	
3	SR10.03	Abortive Sales	• EY AADF framework in use as SBC internal gateway • All pipeline assets have impairments assigned	Ian Church	*Needs Improvement*	Earlier use of AADF in project screening now implemented
4	SR10.04	Programme Target	• Revised GF disposal plan submitted to cabinet in November, and timely receipt of Members approval in future • Monthly adjustment and refinement of programme	Ian Church	*Largely Effective*	
5	SR10.05	Records	• Document register now better • Better archiving needed (physical and electronic)	Ian Church	*Ineffective*	Time has been invested. Documents are in much better condition, physically and online. Looking to move to "Largely Effective" next quarter
6	SR10.06	Skills / Capability	• Review team engagement as tempo of disposals increases • Move away from interims to permanent team	Ian Church	*Needs Improvement*	Establishment for FY25/26 still under review which will impact Interim to Permanent transition.
7	SR10.07	Protocol / Process	• Review ongoing approved processes being followed	Ian Church	*Needs Improvement*	Disposals flowchart now in place to guide consistent process moving forward.

CR10	Failure of General Fund Asset Disposal Programme	Risk owner: Pat Hayes

Treatment/mitigation plans (funded actions that will manage/reduce the risk level)

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	SR11.03	Abortive Sales	More rigorous use of EY AADF framework to support disposal process. Possibly arrange internal training by competent party to drive engagement.	Ian Church	*1. End Q1 FY 25 / 26* *2. End Q2 FY 25 / 26*		1. Review use of AADF and necessity for training.
2	SR11.05	Records	Electronic and physical archiving needs improvement., including review of off-site storage facility in Reading for documents that need retention.	Ian Church	*1. End Q4 FY 24 / 25* *2. End Q1 FY 25 / 26*		1. Review progress. Move to "Largely Effective"?
3	SR11.06	Skills / Capability	No more than one further extension for all current interims, with either conversion or recruitment to be actioned.	Ian Church	*1. End Q2 FY 25 / 26*		Execution to commence as soon as Establishment confirmed for FY25/26
4	SR11.07	Protocol / Process	Limited or no written processes being followed. Need to identify and consider documenting key processes.	Ian Church	*1. End Q4 FY 24 / 25* *2. End Q2 FY 25 / 26*		1. Create flowchart and refine during quarter 2. Formally embed as corporate process

Target Risk Score – *18* by end of date *10/2025*

CR11 Failure to become a best value council

Risk owner: Sonia Khan

Corporate risk overview

Current Risk Score 5 Impact 4 Likelihood	24
Target Risk Score 4 Impact 3 Likelihood	22

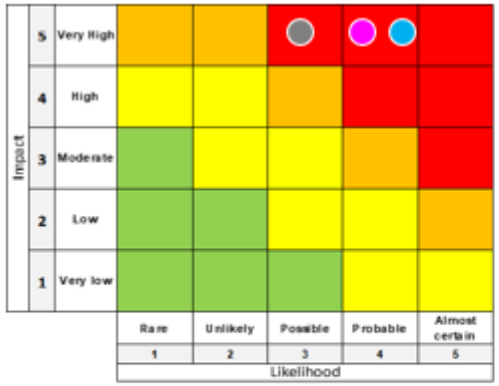
The Council fails to become a Best Value Council, because the improvement and recovery actions specified in the Directions and required in the Best Value Intervention Guidance are not delivered or do not have the impact expected.

Overall risk remains stable, but treatment and mitigating actions are on target for Q3 and Q4 and on track to be achieved for Q1 2025/26
Key updates for Q3:
Improvement and Recovery Plan 6 month plan adopted by January Cabinet
Two year Improvement and Recovery Plan going to March Cabinet
Governance and control proposals drafted ready for implementation by April 2025
Resourcing for team being finalised for 25/26
Operating model – transformation director in post and working on 25/26 mitigating actions- update going to March Cabinet

Risk appetite statement (Balanced)

We have a balanced appetite for this risk. Delivery of a plan that systematically addresses how we become a Best Value Council and exit intervention, meeting all directions is what is needed. The focus needs to be on deriving benefits for residents and becoming financially sustainable. This is about getting the basics right and so there is less room for innovation, but there should be a commitment to seeking to add social value in the way the plan is delivered, for example, involving residents and partners in assessing progress, providing feedback and co-creating solutions.

Risk profile



Refer to slide 8 for risk assessment score instructions

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
11.01		Fail to improve and transform services that impacts adversely on residents and on budgets	Director of Strategy, Change and Resident Engagement		The same because current financial context and medium term context for Slough and nationally remains extremely challenging and transformation programmes should have started 2-3 years ago
11.02		Fail to operate as a Best Value Council	Director of Strategy, Change and Resident Engagement		Upward because stability in corporate leadership and the confirmed extension of the intervention should support a strong focus on improvement and recovery.
11.03		Unable to deliver new operating model and medium-term financial strategy	Hamish Dibley		The same because current financial context and medium term context for Slough and nationally remains extremely challenging and transformation programmes should have started 2-3 years ago

CR11	Failure to become a best value council	Risk owner: Sonia Khan

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KRI 2	Resident survey for 2026 continues to show low satisfaction - currently 30% of Slough respondents said they were very or fairly satisfied with the way Slough Council runs things compared to 60% of national respondents.	10% increase by 2026	N/A	Next survey: April 2025	N/A
KRI 3	Improvement and recovery plan progress is systematically tracked and updates aret provided to appropriate board on a quarterly basis	4 per year		Not started yet	
KRI 4	Operating model is not fully tied to MTFS by 2026 and this is clear by September 2025 (to develop into fully measurable KRI)	N/A			
KRI 5	Bulk of complaints continues to be driven by basic failure to respond to resident or to deliver an appropriate standard of service.	Reduce by 10 percentage points		63% (24/25 to date)	

CR11	Failure to become a best value council	Risk owner: Sonia Khan

Controls - Identify current operating controls that are managing the sub risks

Control Effectiveness	Description
Effective	• Controls and or/ management activities properly designed and operating as intended • Management is confident that the controls are effective and reliable
Largely effective	• Controls and or/ management activities properly designed and operating with opportunities for improvements identified
Needs improvement	• Controls are only partially effective, require ongoing monitoring and may require redesigning, improving or supplementing • Key controls and or/ management activities in place, with significant opportunities for improvement identified
Ineffective	• Limited controls and or/ management activities in place
Weak	• Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist • Controls and or/ management activities are non-existent or have major deficiencies and don't operate as intended

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
2	SR1102	Fail to operate as a Best Value Council	Improvement and recovery plan is aligned to best value guidance and adopted by Cabinet by January 2025 and sets out incremental steps to becoming a best value council which are programme managed.	Director of Strategy, Change and Resident Engagement	Needs improvement	Improvement and Recovery Plan 6 month plan adopted by January Cabinet Two year Improvement and Recovery Plan going to March Cabinet Governance and control proposals drafted ready for implementation by April 2025 Resourcing for team being finalised for 25/26
3	SR11.03	Unable to deliver new operating model and medium-term financial strategy	Outline direction of travel for operating model setting out key features for future council	Hamish Dibley	Effective	Direction of travel adopted by Cabinet in November 2024

CR11	Failure to become a best value council	Risk owner: Sonia Khan

Treatment/mitigation plans (funded actions that will manage/reduce the risk level)

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	SR11.01	Establish a Transformation Programme aligned to implementation of future operating model	Identify key transformation opportunities and deliver corporately supported programmes to be implemented by 2026	Director of Strategy, Change and Resident Engagement	September 2025		New Programme Director started in January and is identifying key elements of transformation enable move to new operating model by 2026/27-update will go to Cabinet in March 2025.
3	SR11.02	Improvement and recovery plan resourcing of programme management	Improvement and Recovery PMO is fully recruited to along with other PMOs for Corporate Programmes and Operating Model.	Director of Strategy, Change and Resident Engagement	April 2025		Resourcing for team being finalised for 25/26
4	SR11.02	Improvement and recovery plan control and governance	Review and reset all projects and programmes linked to the Improvement and Recovery Plan aligned to reset of governance to focus on RAG rating whether benefits are being realised.	Director of Strategy, Change and Resident Engagement	April 2025		Governance and control proposals drafted ready for implementation by April 2025
5	SR11.03	Operating model route map	Operating model route map is adopted by Cabinet by the end of the 24/25 municipal year and mapped to MTFS	Hamish Dibley	March 2025		-Update going to March Cabinet
6	SR11.03	Operating model programme director appointed to bring expertise to programme and develop route map	Programme director engaged by January 2025	Hamish Dibley	December 2024		Operating model – transformation director in post and working on 25/26 mitigating actions
7	SR11.03	Strategic partners identified	Strategic partners engaged by Q4 2024/25	Hamish Dibley	March 2025		Proposals being developed – procurement is being progressed.

Target Risk Score – 22 by end of date *10/2025*

CR12 | Failure to deliver market sustainability across the Council

Risk owner: David Coleman-Groom

Corporate risk overview

Current Risk Score 3 Impact 4 Likelihood	21
Target Risk Score 3 Impact 4 Likelihood	18

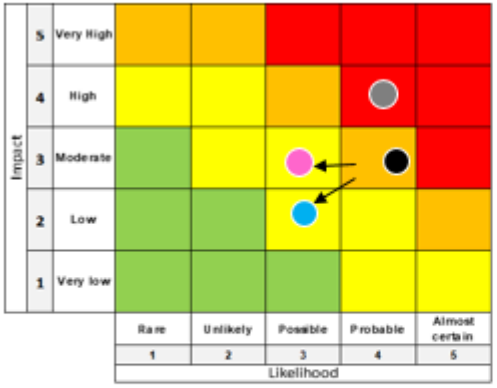
Risk score remains unchanged, although there is an overall improvement in the management of the risk.
Market Sustainability is assessed across four specific areas:

- Sufficiency - how we shape the market and ensure we have commissioned sufficient, diverse and effective provision to meet the needs of people in Slough
- Value for Money – ensuring we are paying a fair price to enable providers to recruit and retain staff, cover overheads and make a reasonable profit in the context of increasing costs
- Quality – do local services provide good quality and outcomes measured through our Quality Assurance oversight and clear escalation processes for provider concerns
- Workforce – the ability of care providers to recruit and retain their workforce and support their learning and development

Risk appetite statement (Balanced)

We have a balanced risk appetite as we look at ways to provide the necessary level of services required within Adult Social Care while being aware of constraints around financials, working with providers to ensure they deliver quality services and pay a fair rate to the workforce. Ability to ensure we have sufficient access to the right care at the right price to meet demand

Risk profile



Refer to slide 7 for risk assessment score instructions

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
12.01		Insufficient access to care services	Lynn Johnson (HOS)		Commissioning and Market Management Board (CMMB) receives reports from the brokerage team and analysis of out of borough placements is used to inform refresh of Market Position Statement (MPS)
12.02		Cost of fee uplifts outstripping budget	Lynn Johnson (HOS)		Fee uplift process provides assurance through open book accounting and scrutiny of providers' costs, benchmarking rates to ensure that a fair price is paid. Cost avoidance of £2.1im delivered to date in 24/25 No contracts handed back.
12.03		Provider failure	Lynn Johnson (HOS)		Quality Assurance Framework developed to pre empt quality concerns through proactive and reactive visits to assure care quality of local providers. Monthly reports of care quality provided to CMMB and Care Governance Board
12.04		Recruitment and retention of external workforce	Lynn Johnson (HOS)		New sub-risk Staffing shortages and high turnover as care roles have low pay and high emotional and physical demands which means staff get burned out easily, causing high turnover. Wage pressures and meeting higher wage standard is essential for staff retention. Regulatory compliance requires consistent and up to date training in place. Addressing employee burnout and mental health involves building robust mental health support and wellbeing programmes which can be challenging for cost-sensitive businesses.

CR12	Failure to deliver market sustainability across the Council	Risk owner: David Coleman-Groom

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
Example - customer complaints	*Total customer complaints* *(To identify a KRI: 1) look for what is already measured regarding this risk such as a KPI and adapt it – see tolerance/threshold column on the right, or 2) if there isn't a measure to easily adapt look to the risk's key/root causes and what the triggers are. Triggers that can be measured make good KRIs as they serve as early warning signals of risk)*	*Target 30% reduction per annum* *(Provide a range, if a relevant KPI exists you can adapt it to create a KRI by lowering the KPI's threshold by 5-10%, e.g. KPI target = 30,000 – 10% = KRI tolerance of 27000)*	*Q1 23/24 - 5000*	*Q2 23/24 - 4800*	
KRI 1 - loss of care	The number of providers suspended due to quality concerns on a monthly basis – temporary loss of care	Metrics are being developed		Providers Suspended Due to Quality Concerns 1 Care Home 3 Supported Living Providers 3 Home care Providers 0 Contract Handbacks	
KRI 4 -	The number of contract hand backs on a monthly basis	Metrics are being developed			

Current metrics relating to the above are unavailable and/or being developed.
Further update in Q4 submission

CR12	Failure to deliver market sustainability across the Council	Risk owner: David Coleman-Groom

Controls - Identify current operating controls that are managing the sub risks

Control Effectiveness	Description
Effective	• Controls and or/ management activities properly designed and operating as intended • Management is confident that the controls are effective and reliable
Largely effective	• Controls and or/ management activities properly designed and operating with opportunities for improvements identified
Needs improvement	• Controls are only partially effective, require ongoing monitoring and may require redesigning, improving or supplementing • Key controls and or/ management activities in place, with significant opportunities for improvement identified
Ineffective	• Limited controls and or/ management activities in place
Weak	• Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist • Controls and or/ management activities are non-existent or have major deficiencies and don't operate as intended

LJ/SM to tidy up

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR12.01	Market sufficiency	Brokers monitor availability of the care market, using tools such as the NHS Capacity Tracker	Interim Head of Market Management (Lynn Johnson)	Largely effective	Brokers provide weekly updates on sufficiency issues – bed availability or post code issues for home care to HOS
2	SR12.02	Cost of fee uplift	Business cases developed for Fee Uplift requests are considered at both DECP and if recommended ECP	Interim Head of Market Management (Lynn Johnson)	Effective	Rightsizing costs of placements to ensure provision is sustainable and contracts are not handed back
3	SR12.03	Quality Assurance	Quality assurance of local commissioned provider market undertaken by SBC Provider Quality Assurance Team	Interim QA Manager (Phylis Maynard(	Largely effective	Risk assessment and scoring determines priority and frequency of visits across local markets to assess quality provision
4	SR12.03	Quality Assurance	CMMB and Slough Care Governance Board monthly meetings; OGB to consider suspension of providers if quality concerns have been identified and will review quality data and trends	Interim Head of Market Management (Lynn Johnson)	Effective	Quality concern themes identified and training identified and included in Quality improvement Cafes for local providers Contractual remedies can also be instigated through joint working between QA and ASC Contracts Management Team
5	SR 12.03	Quality Assurance	Intensive support to providers where quality concerns identified to minimise periods of suspension and embargo of new referrals	Interim Head of Market Management (Lynn Johnson)	Largely effective	Additional support to Care Homes can be provided by NHS Frimley ICB through joint quality visits with SBC's Provider Quality Assurance Team
6	SR 12.04	Workforce	Analysis of Skills for Care Workforce Data to understand challenges across Slough	Interim Head of Market Management (Lynn Johnson)	Needs improvement	Local data collection to be developed and external workforce strategy co produced with care maret

CR12	Failure to deliver market sustainability across the Council	Risk owner: David Coleman-Groom

Treatment/mitigation plans (funded actions that will manage/reduce the risk level)

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	*S16.01*	*High level action that will mitigate or reduce the risk the most*		*Director level*	*Dd-mm-yyyy (within the next 12 months)*	*(RAG)*	
2		Review of Quality Assurance Framework	Addressing quality issues – investment in Clinical Pharmacist role to extend medicines optimisation support through NHS Frimley ICB to home care and Supported Living Providers		March 2025	Green	Recruitment underway through NHS Frimley ICB
3		Development of local external Adult Social Care Workforce Strategy	Understand local, regional and national responses to workforce issues and how the local authority can better support care providers with recruitment and retention		March 2026	Amber	Workshops with care markets and Skills for Care planned April 2025
4		Review of Market Position Statement	Identify gaps in market and new models of care and signal new opportunities to the market to address any sufficiency issues		June 2025	Amber	Accuracy of data collection a challenge
5			—				

Target Risk Score – *18* by end of date *10/2025*

CR13	We fail to comply with data protection obligations	Risk owner: Martin Chalmers

Corporate risk overview

Current Risk Score 4 Impact 3 Likelihood	18
Target Risk Score 4 Impact 2 Likelihood	14

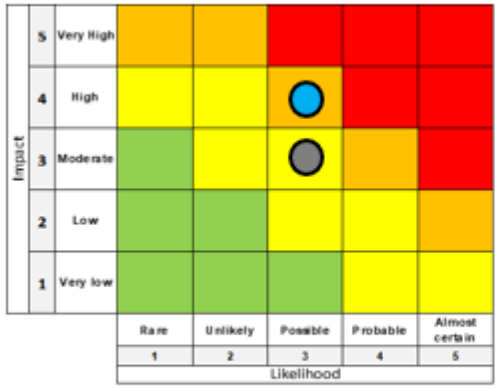
There is no change to the Risk Score.

- GDPR training compliance is now monitoring at the monthly IGG meetings for both SBC and SCF. Current completion rate is for SCF – 98% - and SBC – 80%
- A briefing on GDPR and information security is now included in the corporate induction programme which is delivered to all new roles within the first 2 months of their start date.
- Review and updating of the GDPR policies and guidance has been completed in align with their annual review dates. Updated documents were circulated and approved by IGG. In addition, a "Our Data Responsibilities" guidance has been developed and promoted to all staff via corporate communications and staff briefings.
- The Council has now migrated to Microsoft Secure Email for email encryption. This has enabled integration with Microsoft Outlook allowing for a easier route to sending secure emails.
- The risk rating remains unchanged this quarter. While, as indicated, there has been good progress on training and communications, the incidents that have occurred indicate that there is further to go in embedding knowledge and awareness throughout the organisation.

Risk appetite statement **(Averse)**

Averse – the Council wishes to minimise this risk to extent possible within affordability constraints. The is low appetite for a significant data risk impacting the Council is driven both by the potential impact to reputation and by financial risks under the GDPR regime.

Risk profile



Refer to slide 7 for risk assessment score instructions

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
13.01		Privacy breach of personal data	Alex Cowen		This risk relates primarily to accidental disclosure of information; cyber attack is covered by CR09. Risk treatment plans relating to systems, process and training have been identified. The latter is of particular relevance here, where staff mindfulness of the importance of security and privacy is critical in avoiding materialisation of the risk. • The sub risk remains stable this quarter. Improvements have been to increase staff awareness but a high turnover in staff remains challenging. • Mandatory training compliance increased by 20% • Ongoing awareness on GDPR sent out in regular corporate communications as well as the corporate induction programme
13.02		Unlawful retention and processing of personal data	Alex Cowen		While the same risk treatment plans are relevant to this sub-risk as to 18.01, the probability is assessed as lower as the regime around Data Privacy Impact Assessments is well embedded. • The sub risk remains stable with no major changes envisaged.

CR13	We fail to comply with data protection obligations	Risk owner: Martin Chalmers

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
Note: These measures have been introduced from the start of Q3 and will be reported in the next quarterly report, with targets informed by baselines. For Q2, data is either not available or not confirmed.					
Completion rate of mandatory training	*Rate of completion of mandatory data protection and cyber security training, reported separately for SBC and SCF*	90%	[SBC: 60% SCF: 95% - TBC]	SBC: 80% SCF: 98%	
Number of data protection incidents	Reported instances of data protection incidents, This information is available through the data breach log for both SBC & SCF.	??	-	SBC & SCF = 30 in total	
Number of Information Commissioner Office (ICO) reportable incidents / complaints	Incidents that meet the threshold for reporting to the ICO, or complaints received by the ICO in relation to failure to comply with UK GDPR principles.	1	-	1	
~~(FOI) & (SAR's) obligations are complied with.~~ Turnaround time for DPO (Data Protection Officer) to review (Freedom of Information) FOI responses	~~FOI are subject to completion within 20 working days and SAR;s within one month (although can be extended for a further two months), risks associated with breaches to these timescales are warnings / sanctions from the ICO for not adhering to the UK GDPR duties.~~ The turnaround time for the Data Protection Officer to review and provide confirmation that the response to an FOI is permissible within GDPR regulations.	48 Hours	-		

CR13	We fail to comply with data protection obligations	Risk owner: Martin Chalmers

Controls - Identify current operating controls that are managing the sub risks

Control Effectiveness	Description
Effective	• Controls and or/ management activities properly designed and operating as intended • Management is confident that the controls are effective and reliable
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Ineffective	• Limited controls and or/ management activities in place
Weak	• Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist • Controls and or/ management activities are non-existent or have major deficiencies and don't operate as intended

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR13.01	Training and communications	New staff are obliged to complete eLearning and an annual refresher course is also mandatory. Awareness of data protection responsibilities boosted through emails and staff newsletter	Martin Chalmers	Largely effective (Changed from Needs improvement)	Takeup of training in SBC is well below target (60%) although takeup in SCF has been increased from a similar figure to in excess of 90% • GDPR training increased by 20%. • Awareness on GDPR sent in regular corporate communications as well as the corporate induction programme • Engagement underway with the Learning & Development team to further drive up compliance. • Quarterly GDPR newsletter in development. Due for release Q1 25/26.
2	SR13.01	Governance, policy and process	An Information Governance Board is in place. Policy was agreed in 2023. Processes for breach reporting, DPIAs, etc have been established	Martin Chalmers	Effective	Audit actions relating to this area have been closed • All GDPR policies are updated annually and approved by IGG. • Subsequent actions will be monitored through the monthly IGG meetings.
3	SR13.01	Resourcing	An Information Governance officer role in place ~~has been established~~	Martin Chalmers	Largely effective	Role is filled by an interim; permanent recruitment urgent given budget limitations • Currently filled by interim resource but will be replaced by FTE. • The Information Government Officer role is currently out to advert, closing on 21st Feb. • Shortlisting to commence WC 24th Feb 25. • Intention to have permanent member of staff in place by 1st April 25.

CR13	We fail to comply with data protection obligations	Risk owner: Martin Chalmers

Treatment/mitigation plans (funded actions that will manage/reduce the risk level)

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	SR13.01 & SR13.02	Mandatory training compliance	The first step will be to agree a plan for this with the Information Governance Group This action is to improve the current control about training	Alex Cowen	~~March 2025~~ October 2025 (FTE in place by 1st April 25)	G (previously A)	• GDPR training increased by 20%. • Awareness on GDPR sent in regular corporate communications as well as the corporate induction programme
2	SR13.01 & SR13.02	Tighten governance of unstructured data	There is a need to tighten the governance of unstructured data, eg files held on shared drives. It is intended that this be done as part of the planned migration to SharePoint	Alex Cowen	October 2025	G (previously A)	• A Project Initiation Document is currently being drafted and due for completion XXX. Scope to include document retention policies and implementing Microsoft Purview
3	SR13.02	Ensure retention policies factored into the Disaster Recovery and Backup as a Service (DRaaS/BaaS) project	It will be important to ensure that retention policies are considered as part of the Backup as a Service project so ensure that data is not inappropriately retained	Alex Cowen	~~February 2025~~ November 2025 (Contract Award due by end of Feb 25)	G (previously A)	• Open tender underway for DRaaS/BaaS and in final stages of supplier evaluation. • Award of contract expected for end of February 2025. • Implementation expected to be completed by end of November 2025. • A Project Manager has been appointed and due to start on 4th Feb
4	SR13.01	Resourcing	An Information Governance officer role has been established	Martin Chalmers	~~March 2025~~ April 2025	G (previously A)	• Currently filled by interim resource but will be replaced by FTE. • The Information Government Officer role is currently out to advert, closing on 21st Feb. • Shortlisting to commence WC 24th Feb 25. • Intention to have permanent member of staff in place by 1st April 25.
5	SR13.01	Clarify protective marking guidance	Agree with CLT a policy for the marking and handling of OFFICIAL-SENSITIVE data, including but not limited to personal data. Communicate and embed the policy.	Martin Chalmers	September 2025	A	• New proposed action

Target Risk Score – 14 by end of October 2025