Slough Borough Council

Report To:	Audit and Corporate Governance Committee
Date:	30 June 2025
Subject:	Q4 Corporate Risk Report
Chief Officer:	Annabel Scholes, Executive Director of Corporate Resources
Contact Officer:	William Green, Interim Risk Manager
Ward(s):	All
Exempt:	No
Appendices:	Appendix 'A' – Q4 Corporate Risk Profile Appendix 'B' – Q4 Corporate Risk Dashboards (summary sheets)

1. Summary and Recommendations

1.1 This report sets out

- The status of the Council risk profile in the Q4 2024/25 Risk Report.
- Breakdown of current Corporate Risks and Sub-Risks

Recommendation:

The Audit and Corporate Governance Committee is recommended to note the revised Corporate Risks and Sub-Risks as at Quarter 4 (May 2025).

Reason:

1.2 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.

1.3 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. Report

Introductory paragraph

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.

Background

2.2 To produce the Q4 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 20th May 2025 and after rigorous challenge it was signed off. The corporate risk report was then presented to the CLT on the 28h May and following discussion and challenge it was agreed that the new corporate risk CR14 (*Failure of Council Subsidiary Companies*) should focus primarily on the risks to the Council from the subsidiary James Ellison Homes. This was agreed and the changes will be incorporated in the FY2025/25 Q1 Corporate Risk report. CLT then approved the Q4 corporate risk report.

2.3 The Q4 position is that the Councils risk exposure has remained stable this quarter, but the overall exposure remains elevated. No risks scores have deteriorated, and all corporate risks are reported as being in a stable position with no notable milestones missed in respect of the delivery of identified treatment plans.

2.4 Of the fourteen identified corporate risks eleven are rated as red (risk score between 20 – 25), and three are rated as amber (risk score between 15 – 19). In Q3 fifty-three sub-risks were identified across all the corporate risks, this has now increased to fifty-eight for Q4. 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 corporate risks continue to improve their control environments which is resulting in a more stable outlook for the future where we have 86% of sub-risks are either stable or improving, with only 14% sub-risks deteriorating.

2.5 The full breakdown of our risks and sub-risks is provided in the table below.

Q4 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.

Q4 Corporate Risk and Sub-Risk Summary

	Score change & outlook change
	Outlook change, No score change

CR ref.	Corporate Risk - Sub-Risk	Impact Score	Likliehood score	Current Score	Target Score	Prev. Qtr Score	Score movement/ Outlook last quarter
CR01	**Safeguarding Children and Young People – Child Death**	**4**	**3**	**18**	**18**	*18*	→
	SR01.01: Insufficient financial resources	4	3	18		*18*	→
	SR01.02: Attraction and retention of qualified workforce	3	2	9		*13*	↑
	SR01.03: High Caseloads for frontline staff	3	2	9		*13*	↑
	SR01.04: Underperformance of staff	3	3	13		*18*	↑
	SR01.05: Data production does not support effective practice	3	4	17		*17*	↓
CR02	**Failure to meet demands on Adult Social Care**	**4**	**4**	**21**	**18**	*21*	→
	SR02.01: Inability to meet savings	4	4	21		*21*	→
	SR02.02: Inability to meet increase in demand	4	4	21		*21*	→
	SR02.03: Attraction & retention of talent	3	3	13		*13*	→
	SR02.04: Loss of health funding	3	3	13		*13*	→
CR03	**Failure of Special Educational Needs and Disability (SEND)**	**4**	**4**	**21**	**18**	*21*	→
	SR03.01: Failure to provide appropriate support to children and young people with SEND with and without an EHC plan that will impact on their life opportunities	3	3	13		*18*	↑
	SR03.02: Financial risk to the Council and the possibility of not receiving Safety Valve Agreement payments to offset the budget deficit.	4	4	21		*21*	↓
	SR03.03: Risk to the Council through complaints received through the Council's own process, LGSCO complaints and tribunals.	3	3	13		*18*	↑
	SR03.04: The service identified gaps in evidence in preparation for a Local Area Inspection which is likely to happen imminently.	4	3	18		*18*	→
CR04	**Failure to Provide Safe Temporary Accommodation within Budget**	**5**	**5**	**25**	**21**	*25*	↓
	SR04.01: Lack of Suitable Available TA	5	3	22		*24*	↑
	SR04.02: Budgetary constraints	5	5	25		*25*	↓
	SR04.03: Lack of Statutory Compliance Information	4	4	21		*21*	↑
	SR04.04: Attraction and retention of talent	4	5	23		*23*	→
	SR045.05: Ability to effectively Manage TA property and people	4	4	21		*21*	↑
CR05	**Failure to Attract Retain & Engage with Our People**	**4**	**4**	**21**	**18**	*21*	→
	SR05.01: We fail to attract and recruit a diverse and inclusive workforce for senior manager and above.	4	4	21		*21*	→
	SR05.02: We fail to identify, develop and embed the capabilities and competencies we need in our workforce	2	5	16		*16*	→
	SR05.03: We fail to maintain an energised and engaged workforce	4	3	18		*18*	→
	SR05.04: We fail to keep our turnover inline with a national average of 10%	2	2	5			NEW
CR06	**Health & Safety We fail to prevent physical injury or mental harm**	**4**	**4**	**21**	**18**	*21*	→
	SR06.01: We fail to prioritise adequately fund or manage risks associated with corporate health and safety	4	4	21		*21*	→
	SR06.02: We fail to prioritise adequately fund or manage risks associated with fire	4	4	21		*21*	→
	SR06.03: We fail to prioritise adequately fund or manage risks associated with aggressive behaviour	4	4	21		*21*	→
	SR06.04: Resource to accommodate organisational audit scrutiny and engage with training & Policy improvements	4	4	21		*21*	→
CR07	**Insufficient Operational Resilience and Crisis Management**	**4**	**4**	**21**	**18**	*21*	→
	SR07.01: Inadequate rapid emergency response capabilities to provide immediate incident co-ordination and humanitarian support to affected residents	4	4	21		*21*	↑
	SR07.02: Failure of emergency planning for specific major hazard risks in the borough, such as flooding, major fires, industrial accident	4	4	21		*21*	→
	SR07.03: Failure of Major Incident Plan	4	2	14		*18*	↑
	SR07.04: Lack of BCP's for all services responsible for delivering business critical activities	4	4	21		*21*	↓
	SR07.05: Inadequate continuity planning for specific risks	4	3	18		*18*	↓
CR08	**ICT incident resulting in significant data and/or service**	**5**	**4**	**24**	**22**	*24*	→
	SR08.01: A cyber attack causes significant data or service loss	5	4	24		*24*	↑
	SR08.02: A business continuity issue causes significant service loss	4	3	18		*18*	→
	SR08.03: An incident caused by hardware or software failure causes significant service loss	4	3	18			NEW
	SR08.04 An incident caused by legacy hardware or software failure causes significant service loss	4	3	18		*18*	→
CR09	**Failure to achieve financial sustainability and a balanced MTFS**	**5**	**4**	**24**	**22**	*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	3	18		*21*	↑
	SR09.02: Failure to achieve a balanced budget and Medium Term Financial Strategy (MTFS)	5	4	24		*24*	→
	SR09.03: Inadequate cashflow to maintain balance of liquidity to fund expenditure	4	2	14		*18*	↑
	SR09.04: Government funding formula/distribution does not reflect the needs of the Slough community and demographic	4	5	23		*23*	→
	SR09.05: Failure to recruit and retain a resilient and skilled workforce within finance	3	4	17		*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		*13*	→
	SR09.07: Failure to deliver value for money from procurement processes	3	5	20		*20*	↑
	SR09.08 Fraudulent activities resulting in financial and operational loss – NEW SUB-RISK	3	4	17			NEW
CR10	**Failure of General Fund Asset Disposal Programme**	**4**	**3**	**18**	**18**	*18*	→
	SR10.01: Property disposals not hitting financial targets and sitting outside of lower volatility levels	4	3	18		*18*	↑
	SR10.02: Pace of disposals is behind programme deliverable dates	4	3	18		*18*	↓
	SR10.03: Attraction and Retention of quality people	4	3	18		*18*	→
	SR10.04: External property market volatility	4	3	18		*18*	→
CR11	**Failure to become a Best Value Council**	**5**	**4**	**24**	**22**	*24*	→
	SR11.01: Fail to improve and transform services that impacts adversely on residents and on budgets	5	4	24		*24*	→
	SR11.02: Fail to operate as a Best Value Council	5	3	22		*22*	→
	SR11.03: Unable to deliver new operating model and medium-term financial strategy	5	4	24		*24*	→
CR12	**Failure to deliver Market Sustainability across Council**	**4**	**4**	**21**	**18**	*21*	→

CR ref.	Corporate Risk - Sub-Risk	Impact Score	Likliehood score	Current Score	Target Score	Prev. Qtr Score	Score movement/ Outlook last quarter
CR12	**Failure to deliver Market Sustainability across Council**	4	4	21	18	21	→
	SR12.01: Insufficient access to regulated services	2	2	5		8	↑
	SR12.02: Cost of fee uplifts outstripping budget	4	4	21		21	↑
	SR12.03: Provider failure	3	3	13		13	→
	SR12.04: Recruitment and retention of external workforce	3	4	17		17	→
CR13	**We fail to comply with GDPR data protection obligations**	4	3	18	18	18	→
	SR13.01: Privacy breach of personal data	4	3	18		18	↑
	SR13.02: Unlawful retention and processing of personal data	3	3	13		13	→
CR14	**Failure of Council Subsidiary Companies**	5	5	25	22		NEW
	SR14.01: JEH - Failure of the company resulting in financial losses and reputational issues for the council.	5	5	25			NEW
	SR14.02: GRES - Failure of the company resulting in financial losses and reputational issues for the council.	3	3	13			NEW
	SR14.03: SCF - Failure of the company resulting in financial losses and reputational issues for the council.	4	3	18			NEW

2.6 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.

2.7 The overall corporate risk exposure has remained stable this quarter, but the overall exposure remains elevated. No risks scores have deteriorated, and all corporate risks are reported as being in a stable position with no notable milestones missed in respect of the delivery of identified treatment plans.

The Board is asked to note the status update of the red rated corporate risks for this period:

- CR02: *(Failure to meet demands on Adult Social Care)* - the rating remains red despite an improving sub-risk outlook. The key risks driving this rating are operating within budget and compliance with carrying out annual statutory reviews.

- CR03: *(Failure of SEND)* – the rating has remained red this quarter. The Council has entered into a Safety Valve Agreement (SVA). A significantly higher level of SEND spending could threaten the additional funding being offered. The current financial challenges need to be controlled to manage the risk.

- CR04: *(Temporary Accommodation)* – the risk remains red however overall, it has stabilised. The budget pressure sub-risk continues to drive this risk.

- CR05: *(Failure to Attract Retain & Engage with Our People)* – the overall risk remains red. As in previous quarters the biggest exposure is the ability to attract and recruit a diverse and inclusive workforce for senior manager and above, 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. Overall the risk has now stabilised as new treatment plans come online.

- CR07: *(Insufficient Operational Resilience and Crisis Management)* – the overall risk remains red, due to the inability to deliver improvements due to staff shortage and current capability.

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

- CR09 *(Financial Sustainability)* – the risk remains red, however improvement is being shown in the sub-risks as all are stable or showing improvement. As in Q3, the sub-risk for the failure to achieve a balanced budget and Medium-Term Financial Strategy (MTFS) continues to drive 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 Q3, the sub-risk driving the overall score is the cost of care outstripping budget.

- CR14: *(Failure of Council Subsidiary Companies)* – this is a new risk that has been introduced this quarter. It is driven by the chance that JEH may fail resulting in major financial loss.

2.8 No corporate risks have improved this quarter.

2.9 There have been no deteriorating risks reported this quarter.

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

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

2.12 The Q4 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).

Figure 2 – Corporate Risk Current & Target scores (Q4 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	18	→
CR08	ICT incident resulting in significant data and/or service	24	22	→
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	18	→
CR14	Failure of Council Subsidiary Companies	25	22	NEW

2.13 The Interim Risk Manager continues to work with senior officers to promote effective risk management and to review corporate and directorate risks. He has completed the rewrite of the Risk Strategy which now includes a Risk Management Policy, Risk Management Framework and Risk Management Guidance section. The document is currently going through an assurance process and it is envisaged that the document will be presented to this committee in September 2025, with a view to then present to Cabinet for final approval.

2.14 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 4 Risk Report. 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 alignment 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 corporate risk dashboards, risks not being owned by senior leaders, corporate risk dashboards downplaying some risks and lacking action to manage 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 Corporate Risk Report. 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 Corporate Risk Report. 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

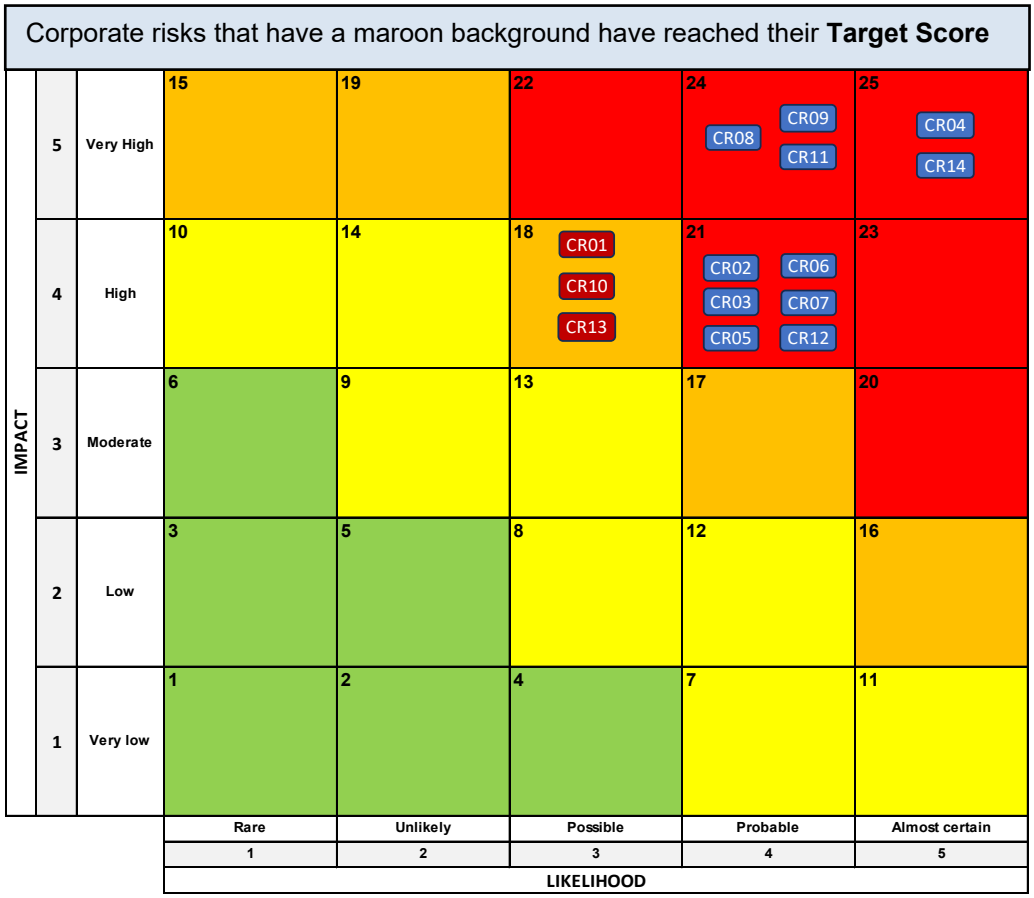
None

Appendix ‘A’ – FY2024/25 Q4 Corporate Risk Profile

The overall corporate risk profile has not changed materially in period. The corporate risks continue to improve their control environments which is resulting in a more stable outlook for the future.

Further details are provided in the risk dashboards, which includes current scoring and/or outlook, current controls and treatment plans. (see Appendix ‘B’).

Figure 1 – Corporate Risk heat map (Q4 FY24)



Corporate Risk	Corporate Risk
8CR01: 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	CR14: Failure of Council Subsidiary Companies

APPENDIX 'B' – FY 2024/25 Q4 CORPORATE RISK DASHBOARDS

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 4 Impact 3 Likelihood	18

Risk score has remained at 18 (RAG Amber) despite the current impact of poor data quality on the work of SCF. Poor data production is an underpinning risk impacting on SCFs cost effectiveness, staff satisfaction and achieving fully effective performance management. The core data is held – but across multiple systems and is not straightforward to access or keep up to date.

A number of risks remain on the corporate risk register despite now being judged as unlikely to occur. This reflects their significance and that they have been ongoing risks until recently. Two relate to staffing. The current position is that caseloads per social worker are low. Attracting and retaining permanent staff is also not a current risk reflecting work done over the past few years. A number of international recruits as they end their contracted period with SCF are looking to move to parts of Britain with lower costs of living. Nationally there is a national significant change in how childrens social services are delivered out over the next 12 months. This will mean that roles for current staff will be redesigned and competition for strong staff will increase – this could impact on retention. A number of staff are leaving as a result of performance management – most of these should exit in Q1.

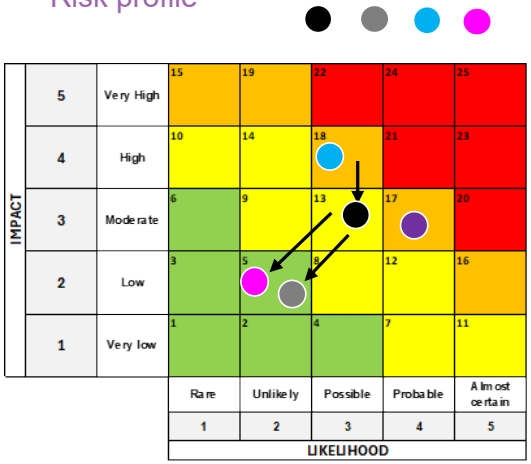
SCF in 2025/6 is expecting to deliver a balanced budget.
Children's Social Care is subject to a Statutory Direction from the Department of Education overseen by a DfE Commissioner

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 (Alex P)		SCF is currently managing within its means however there are financial challenges over the next 12 months, including external price pressures potentially being higher than budgeted for 25/6.
01.02		Attraction and retention of qualified workforce	Head of HR (Kate McCorriston)		SCF is attracting a reasonable level of applicants for most positions. Turnover has increased although largely for appropriate reasons.
01.03		High Caseloads for frontline staff	Director of Operations (Ben Short)		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 (Ben Short)		Training and development is delivered consistently. Workforce development strategy rolled out. The social care academy is being strengthened to support to roll out good practice. Performance dashboards being rolled out
01.05		Data production does not support effective practice	Head of Service, Quality Assurance and Improvement (Picklu R)		SCF is reliant on manual intervention to produce necessary reporting. There are several key IT systems from which is it hard to extract data for a variety of users. A key difficulty is combining data held across systems and the risk of error through manual evaluation.

CR01	Safeguarding Children and Young People - Child Death	S

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*	*C£250k additional surplus*	↑
KRI 2	Attraction and Retention of qualified workers 50.8% of CLA with 2+ Social Workers in a year Permanent staff:	- 0%	- -	50.8% 78.6%	→
KRI 3	Caseload monitoring: **Average caseload across the workforce, including non qualified** **Contact decisions** within 1 day **Referral decisions** within 1 day **Assessments completed in 45 days** **Child Protection Plan reviews** (within 3 or 6 months as appropriate) **ICPCs held in time** (within 15 days of s47 start): **CLA visits in time** (within 12 weeks) **CLA with qualified SW**	18 95% - 90% - - - -	- 95% - 90% 100% 83% 95% -	20.2 97.4% 98.3% 86.7% 98.1% 83.1% 90.6% 99.4%	→
KRI 4	Number of staff on performance management (formal and informal)	-	8	6	↑
KRI 5	Number of data dashboards desired but currently unable to deliver	?	?	?	→

KRI 5 information could not be provided for Q4 – the holder of this data being unavailable

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, manager training	Head of HR and OD	Needs Improvement	Academy needs to be embedded. Ongoing performance management
5	SR5	IT Systems	Manual intervention and quality control for data reporting. Some PowerBi dashboards	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/mitigationplans (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.	Roll out Workforce Development Strategy	Head of HR and OD	Oct 2026		WD Strategy developed, being rolled out
2	01.04	Social Care Academy	Strengthen and further embed within all teams	Head of HR and OD	Oct 26		Following the scheduled review additional resources are being seconded into the Academy to develop practice specific learning
3	01.05	PowerBidashboards	Articulate programme to deliver additional PowerBi performance dashboards,	Head of Service, Quality Assurance and Improvement	October 2025		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		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		There is an ongoing programme, outcomes from which are reviewed by senior staff and inform practice improvements.

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

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

Corporate risk overview

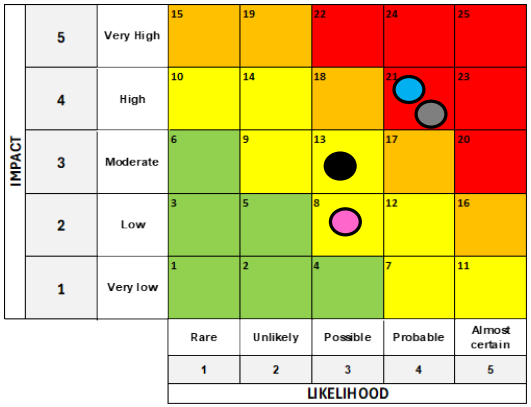
Current Risk Score 4 Impact 4 Likelihood	21
Target Risk Score 4 Impact 3 Likelihood	18

Work underway to address workforce demands and the directorate is starting to see improvements, with 3 Occupational Therapist starting in Q4 and reduce reliance on agency workforce.
The Better Care Fund 24/25 plan has been reviewed and rebalanced, with clarity of delivery and partnership agreement. Moving forward the BCF delivery programme for 25/26 will be monitored within the BCF Group which feeds into the Health and Social Care Partnership and Health and Well-Being Board.

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 operate within budget	David Coleman- Groom (lead)		22nd January 2025 all savings reviewed and RAG rating status reviewed. Monthly reviews ongoing.
02.02		Inability to carry out statutory annual reviews	Ilona Sarulakis (HOS) Andrea Rodin Debra Broderick		Annual reviews are monitored and are reported as overdue, this data is now being broken down in to length of delay and the oldest reviews will be targeted first.
02.03		Attraction & retention of talent	Jane Senior David Coleman-Groom		Increased number of new starts in Q4. Reduction by 2 interim staff between Feb and March 2025
02.04		Loss of health funding	Vicky Tutty (HOS) Andrea Rodin (HOS)		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
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 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	Improved approach to securing permanent staff and less reliance on agency. To monitor the length of duration of assignments. Aim to reduce by 5%	Target to be set now refresh establish is agreed		64 agency staff currently in placement	
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%	

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*	Controls are operating at an acceptable level
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 target, and this is discussed at eDLT 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	Customer Services are being reviewed including interfaces with other departments with an aim to improve customer journey Dependency on TOM team
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/mitigationplans (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		• Review of Customer Services is being undertaken by the Corporate Project Team • Out of Hospital Pathway review project in place led by Commissioning with a focus on promoting independence, adequate provisions for discharges, demand management and achieving efficiencies • AskSara initiative to be progressed and funded through the Acceleration reform fund
2	SR2.02	Digital Blue Printfor 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	Vicky Tutty	10/25		• Discussion have been held with a couple of suppliers to understand the art of the possible. Further meeting arranged 14/2/25
3	SR2.02	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		• Waiting well approach implemented across operational services. • OT and OTA waiting well register significantly reduced Delivered – look at control to manage risk Qtr 1
4	SR2.03	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	30/06/25		• 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 Delivered – look at control to manage risk Qtr 1

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

CR03 Failure of Special Educational Needs and Disability (SEND)

Risk owner: SueButcher

Corporate risk overview

Current Risk Score 3 Impact 5 Likelihood	**21**
Target Risk Score 4 Impact 3 Likelihood	**18**

The current risk score has remained at 21 despite improved performance in the SEND team and improved complaints management. The target risk score remains unchanged at 18..

SEND is subject to a Statutory Direction from the Department of Education overseen by a DfE Commissioner. There is increased demand for Education Health and care Plans and greater level of SEND complexity in Slough schools. This creates two risks monitored separately, a risk to the education and life chances of children and young people, and a risk to the Council's finances.

Short term additional staffing is resolving the backlog in requests for EHC plans, thereby supporting CYP.

The Council has entered into a Safety Valve Agreement (SVA) which provided additional resources subject to conditions being met. The High Needs Block Budget Recovery Plan is supported by regular monitoring and reporting. A significantly higher level of SEND spending could threaten the additional funding being offered.

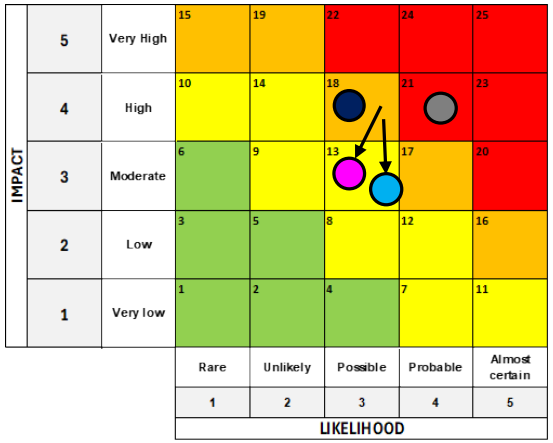
The ongoing reduction in complaint numbers is continuing, but a risk remains given historic poor practice resulting in ongoing risk of tribunal cases.

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.

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		Demand for SEND support is increasing in line with the national picture, the statutory SEND team is improving and is producing a higher level of EHC plans. Education settings inspection reports evidence strong inclusive practice. This is now judged to be **POSSIBLE** rather than PROBABLE and **MODERATE** rather than HIGH.
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. The latest SVA monitoring report has identified due to the increase in demand for EHC plans that all LAs are facing. Therefore this risk remains **HIGH a**nd **PROBABLE** in Q4.
03.03		Financial & reputational risk to the Council through complaints received through the Council's own process, LGSCO complaints and tribunals.	Neil Hoskinson		The backlog has now been cleared. There has also been a significant reduction in the level of new complaints. Tribunals remain a risk but are being managed with no high cost judgements imposed. LGSCo judgements have been received in Q4 based on poor practice historically; going forward this pressure will reduce given the current reduction in complaints. Therefore there is an improvement in score from 18 to 13.
03.04		The service identified gaps in evidence in preparation for a Local Area Inspection which is likely to happen imminently.	Neil Hoskinson		The Evidence Bank has now been quality assured but there are still one or two gaps to be filled before this risk is removed. Nevertheless this has now moved to **POSSIBLE** but is still viewed as a **HIGH** risk.

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*	1 RAG rating has moved to RED relating to demand for EHC plans.	
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	65 finals issued in March. 29% of plans due completed within 20 weeks. Although an improvement in timeliness, still considerably below target.	
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	Maintained the positive picture from Q3	
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	No actions RED rated in April report – also reduction in AMBER.	
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	Maintained the positive picture from Q3 .	
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	SEF and Executive SEF shared with partners. Work underway to address evidence gaps but not yet complete.	
KRI 7	Ofsted inspection reports evidence that Graduated Approach is in place within all mainstream settings.	All Ofsted inspection reports evidence strong practice.	Newly added KRI in Q4	SEND and Inclusion Strategy completed for Cabinet sign off. All education setting Ofsted reports positive for inclusion.	**New**
KRI 8	Sufficiency plan shows effective place planning to meet demand for SRP and Special Schools over a five year period.	Sufficiency plan agreed and on track	Newly added KRI in Q4	Draft Sufficiency report being drafted for Cabinet now that SEN2 data is accurate.	**New**
KRI 9	Reduction in number of Statutory SEND officers and EPs on interim contracts.	Recruitment and Retention Plan agreed and recruitment to evaluated job descriptions.	Newly added KRI in Q4	Recruitment and Retention Plan agreed – job descriptions / benchmarking ongoing.	**New**

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
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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	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	**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 reviewed by the DfE adviser and feedback has been used to improve the document. A Summary (Executive) SEF has been shared with the Improvement Board and partners.
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	**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	**Effective**	The quality of reports, as measured by our quality assurance process, has remained strong and the team of EPs is now stable. However, some risk remains due to interim contracts for all EPs.
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**	The historical financial position has been re-profiled but further work is needed to assess the likely pressure from backlog assessments. Therefore, this is still judged to "Need Improvement".
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 increasing pressure for EHC plans is now rated RED and further mitigations are needed.
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**	This changed in Q3 from "Needs Improvement" due to the significant reduction in complaints and the effectiveness of responding and taking action to concerns raised. This has been maintained.
8	SR3.01	Graduated Approach	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	**Effective**	***Moved from Mitigations in Q3.*** *Graduated Approach Document is launched. Evidence of practice being embedded in recent Ofsted inspections. Strategy completed for Cabinet coproduction events. "Soft" launch with schools at the January SEND Conference.*

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

Treatment/mitigationplans (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	*31/08/2025* *New due date for achieving targets.*		*GREEN because timeliness isimproving and the backlog is reducing. However this will need to be maintained to remove the backlog completely and to get the percentage completed in 20 weeks above the national baseline and to achieve our 80% target.*
~~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. It was expected that all the historic issues would have been removed by Q4 and this is the case. However further work is needed to assess the impact of backlog cases which is why this has remained AMBER.
5	03.02	SEND Sufficiency, Place Planning and Capital Programme	5 Year SEND Sufficiency Analysis complete	Neil Hoskinson Director of Education	01/10/2025 *New milestone for completed strategy.*		As expected this has moved to GREEN in Q4 because we now have the sufficiency data and have drafted a high level strategy to present to Cabinet in May. New milestone for the completed analysis.
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	31/08/2025 *New milestone to assess the impact of phase transfer.*		In Q3 there was a significant reduction in complaints with all in time. This has been maintained so the action is GREEN. This will not be closed to make sure that phase transfer does not lead to a significan increase in complaints.
7	03.01	Wider Universal Offer to meet need for CYP with SEND before the end of Year 1.	New treatment plan. Details being finalised				
8	03.01	Team Around the SENDCo Approach	New treatment plan. Details being finalised				
9	03.01	Recruitment and Retention Plan	New treatment plan. Details being finalised				

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

CR04 | Failure to Provide Safe Temporary Accommodation within Budget

Risk owner: Pat Hayes

Corporate risk overview

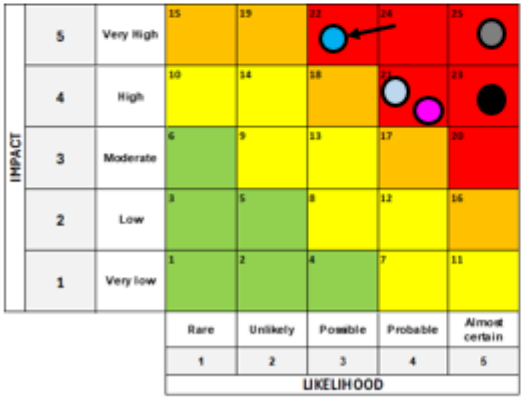
Current Risk Score 5 Impact 5 Likelihood	25
Target Risk Score 4 Impact 4 Likelihood	21

- In Q4 we have redefined the Temporary Accommodation, Allocations and Homeless Teams structure. Once recruitment is in place it will be fit for purpose and the radical overhaul of **data** backlogs, lack of **prevention** and improved **allocations** will happen.
- Current risk score remains 24 to 25 due to sub-risk 2 (budget).
- Un-scheduled uploads of rent accounts in late December 2024 and February 2025 increased budget pressure by £4m.
- The savings plans put forward after after the project room activity in October 2024 is being monitored closely but is reliant on:
  - Capability of staff and difficulty recruiting and retaining workforce. 100% of the TA team remains interim.
  - Lack of reliable quality data to inform business decisions.
- MHCLG visited in January and March 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 in line with a doubling of demand. Budget has been allocated but there is a c. 2–3-month lag in recruiting and on-boarding.

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. • HB Law have finalised Private Lease Agreement and Private Licence Agreements for improved negotiations and possible cost efficiencies . • Cabinet paper seeking permission to enter into long term leases for 25 homes that will save £1.1m p.a. was approved at April Cabinet meeting. Soft market test process has started. • Out of borough placements policy implemented. • Action plan to re-negotiate with top 20 TA providers (80% stock) completed. 45 of 82 providers contacted by end April 2025. **There has been a positive change since the last reporting period.**
04.02		Budget Pressure (Cost > Income)	Director of Housing (Lisa Keating / Dave McNamara)		• The number of homeless households continues to increase, rising from 1,528 in January 2025 to 1,564 in March 2025 with 1,302 placed in TA. • 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 light touch review of TA identified a lack of resource in the TA teams responsible for compliance checks and fire safety management, • Recruitment process has finished, dedicated resource is in place and conducting visits. And gathering compliance information. • Further TA specific health check recommended. • Limited number of inspections of B&B and some HMO accommodation have been undertaken . • New agreed 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. • 28 units from Cromwood accepted and being used for families in B&B > 6 weeks. **There has been positive improvement in Compliance although good progress is being made in developing the solution. The outlook has improved but not enough to change the overall score.**
04.04		Attraction and retention of talent	Director of Housing (Lisa Keating / Bal Toor)		• In quarter 4, 2 TA officer (BAU) have left • In Q4 the BAU team structure for 25/26 and a TA recovery taskforce was agreed. 2x BAU resource recruited and 1x Recovery resource recruited. • 100% of TA team remains interim – no permanent members of staff. • Head of Housing Needs service has also left, new recruit joined mid-April. • Head of TA and allocations leaves early May 2025. Recruitment process started. • TA Backlog team (10.5 staff) has 7.5. in post. • Business case to recruit HSG Demand backlog team submitted to Annabel Scholes 29.04.25. **There has been no demonstrable improvement in recruitment and retention of workforce. Although backlog recruitment is going well for TA, new requirement identified in Housing Demand.**
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 Commercial Manager in post from April 2025. • New backlog officers undertaking some BAU work but BAU team still be recruited. **There has been improvement in Q4 but not enough to change the overall score. A dedicated commercial manager has been appointed and top 20 provider meetings have been completed.**

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	95%of private TA to be FLAGEL co mpliant by October 2025 (Established Hotel Accommodation to be exempt)	5%	15%	
KRI 2– Staff	Permanent recruitment of TA team	90% of Team to be permanent employees by April 2026	0%	0%	
KRI 3- Policies	Current policies for TA Acquisition, Housing Allocations, Out of Borough placement	100% in place by April 2026	10%	10%	
KRI 4– Data	Jigsaw, NEC and Agresso Data align. A slight tolerance allowed as manual process in place means a natural ‘time lag’	95% reconcilliation by April 2026	50%	75% complete	
KR1 5 - Budget	Cost of TA to be matched by income from Housing Benefit and Rent.	95% of rent charges to be covered by HB by April 2026 (accepted that HB does not cover all rent charges and residents have to pay their own contribution)	50%	55%	

CR04	Failure to provide safe Temporary Accommodation within Budget	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	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)	Needs Improvement	Budget setting as part of Corporate Budget has now 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. The control measure needs a supported ICT solution.
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

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
6	6	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)	Largely Effective	The meetings happen and clarity on 60% nominations to TA but not enough HRA homes to significantly reduce TA demand.
7	7	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)	Largely Effective	The policy and process is now understood but not enough downsizing oportunities to significantly reduce TA Demand
8	8	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.	Director of Housing (Lisa Keating)	Needs Improvement	The TA structure for BAU and Catch-up has been agreed and recruitment on-going. New Business case for Housing needs has been submitted for review.

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

Treatment/mitigationplans 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
1	1	Affordable TA	PLA and PSA agreements are finalised 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 delayed until April 2025. Now utilising 46 JEH homes.
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 tac 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. But staff churn has delayed progress in this.
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)	October 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. Dedicated resource starting end March. TA provider meetings scheduled for 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. Kick-off meeting end of March– NEC project team only funded to July 2025.

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~~		Complete – new BAU and recovery teams defined and funded.
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. Held up by internal HR process. Not advertised until mid-March 2025.
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 has concluded its restructure which will see 9 vacancies across the function. Whilst we aim to deliver BAU without disruption, ability to be innovative and progress on some actions at pace will be impacted.

Market conditions do not assist HR in attracting permanent talent for critical roles and therefore we remain reliant on interims for parts of our delivery 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.

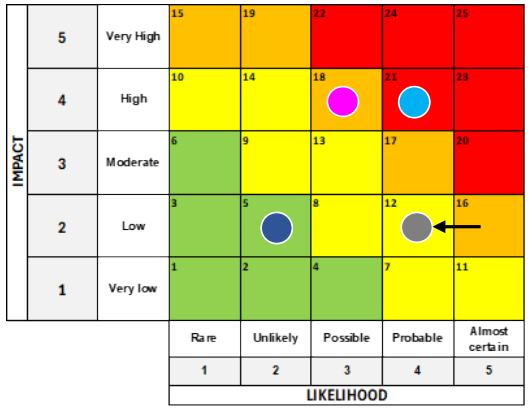
A new risk has been introduced this quarter to reflect staff turnover.

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.

Whilst we aim to attract and recruit the right skills for required to deliver our business (both through perm, interim employment and restructures), we accept this may result in a negative, short-term impact on employee engagement, productivity, attraction or retention but seek to minimise this where possible through some of the bolder initiatives in the workforce strategy addressing aspects such as reward and recognition.

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 and recruit a diverse and inclusive workforce for senior manager and above.	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		Our EOYR and 1:1 platform has been revamped making them simpler to use and removing the requirement for paper. Our EOYR delivery was 90% across SBC, with dip sampling indicating staff have inputted the required level of detail. In tandem to this we have revamped our internet pages, making them updated and easier to navigate, as part of our ambition to attract the local community to join our workforce. We have also begun our work on career pathways for all staff, which recognises the key competencies and learning required for roles across SBC. This therefore have lowered our risk profile rating.
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.
05.04		We fail to keep our turnover inline with a national average of 10%	Bal Toor	NEW	Currently our turnover is at 8% and has been maintained at that level for the last quarter.

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) 10.0% (end Mar 25)	
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 9.6% (end Mar 25)	
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) 37 active (This is a decrease, due to falls out from multiverse apprentices)	
KR 4	Overall completion of all mandatory learning across SBC	50% of staff should have completed all 7 modules	n/a	25.6%	New KRI, will be updated in Q1

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.
1		SR05.01 - 03	4. Engagement of staff in monthly and end of year discussions	As the take up of the new 121 and Appraisal form takes place, staff will add their skills for us to analyse	Bal Toor	All controls effective, and on a continuous improvement cycle.	EOYR effectively being used. 121 take up will be monitored and staff supported to use over next 3 months.

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
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	31/12/25	On track	24/25 closed on over 30 apprenticeships across SBC. Ambition is to grow each year; broadening beyond DDAT ones. This will form part of workforce plans for each ED area.
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	31/12//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.

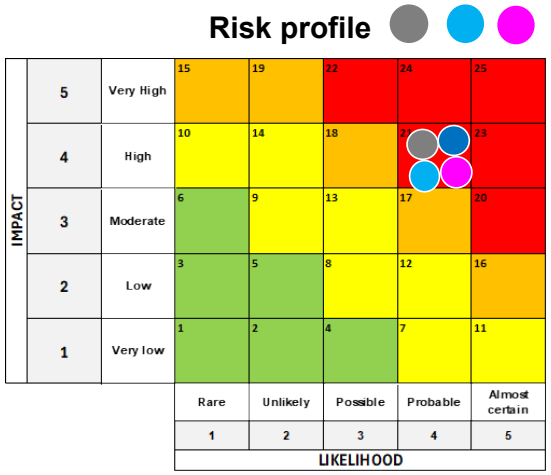
The actions, consistent with most highlighted risks have the initial milestone of data review and audit – tangible actions/systems, deadlines, ownerships and delegations can thereafter be allocated.

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	Craig Hill		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	Craig Hill		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	Craig Hill		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.	Craig Hill		Currently, both internal H&S Operative resource & externally commissioned assistance are under Business Case to mitigate and assist this key shortfall.

CR06	Health & SafetyWe 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	Reported Accidents/Incidents	**80**	**30**		
KRI 2	Reported RIDDOR Incidents	**1**	**0**		
KRI 3	Completed Fire Risk Assessments	**4**	**25**		
KRI 4	Weekly/Monthly Routine Personal Safety Device Checks	**100**	**150**		
KRI 5	Emergency Personal Safety Device Activations (Red/Amber alerts)	**8**	**2**		
KRI 6	Health and Safety Training Completed	**?**	**0**		
KRI 7	Health and Safety Policies Reviewed and Completed	**7**	**1**		
KRI 8	Health and Safety Staff Levels and Attrition	**2**	**2**	**2**	

CR06	Health & SafetyWe 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	SR06.01	**Accident & Incident Reporting**	Capture and analyse accident and incident data to investigate occurrences and identify accident trends within the organisation	Director level	Needs Improvement	Existing HSMS deemed inadequate by external commission and Interim manager. Aged, inadequate data management and effective organizational comms and engagement.
2	SR06.01 – 0.2	**RIDDOR Reporting**	Capture information for RIDDOR reportable incidents. Investigate all reported RIDDOR incidents, report to Senior management on findings and recommendations	Director level	Largely Effective	As of Q1 25/26 all reported RIDDOR incidents will be investigated by the Health and Safety Team, with reports, findings and recommendations escalated to H&S Board as standard, and CLT if required.
3	SR06.01 – 0.3	**Post Fire Investigations and Lessons Learned**	All reported fire incidents within SBC buildings will be effectively investigated by trained staff members. Conclusions, recommendations and any lessons learned will be utilised within other relevant buildings/operations	Director Level	Largely Effective	As of Q1 25/26 all reported Fire incidents will be investigated by the Health and Safety Team, with reports, findings and recommendations escalated to H&S Board as standard, and CLT if required.
4	SR06.01 -0.4	**H&S Staff levels and Attrition**	SBC H&S staffing levels are maintained at 2 persons. Business case and statutory requirements dictate a minimum of 2 trained members of staff within the Department	Director Level	Weak	Due to funding issues, the ability to raise the staffing levels of the H&S Team are non-existent, even though current work requirements suggest at least one more employee is required.
5	SR06.02	**Fire Risk Assessments**	All SBC Buildings will have a fire risk assessment completed on an annual basis, with FRA Actions highlighted for improvement	Director level	Weak	SLA undertaken for SBC properties on an annual basis. No centralised storage for FRA access or FRA Action(s) completion
6	SR06.02 – 0.2	**Fire Risk Assessment re-inspections**	All SBC buildings have a re-inspection of fire provisions on a 6 month rolling programme to ensure actions are being undertaken and no more issues are found	Director Level	Weak	No centralised calendar or backup for re-inspections. No lead colleague or monthly meetings undertaken
7	SR06.03	**Lone Working**	Provide reasonably practicable controls (Policy, Equipment & Systems) to protect staff from unreasonable behaviour.	Director Level	Needs Improvement	All related policies to be scrutinised and re-written, if necessary, within 2025/2026

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
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Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
8	**SR06.03 -0.2**	**Lone Working**	Identified staff members have been given personal safety devices to assist if required in certain circumstances	Director Level	Weak	Increasing (proven trends in reporting) occasions of UnreasonableBehaviouraimed towards SBC staff. Requires monthly checks on device activations and usage
9	**SR06.03 – 0.3**	**Lone Working**	Personal Safety Devices can be activated in an emergency and assistance/help sought as well as locating the staff member via GPS when activated	Director Level	Needs Improvement	To ensure that any emergency activation is attended to professionally and in line with SBC protocols, Also, if an emergency activation is required, an accident form is completed so lessons learned can be analysed and shared
10	**SR06.04**	**Health and Safety Training**	All SBC staff members to receive adequate and relevant H&S Training to enable them to safely perform their job descriptions	Director level	Weak	No effective management control on H&S training, limited budget to undertake all training. No official reviews of training material. Not enough personnel to deliver 37 courses. Looking to automate or convert some courses to advice modules for managers (pregnancy, Risk Assessment etc) which may reduce physical burden on trainers.
11	**SR06.04 – 0.2**	**Policy Development**	All SBC Policies andCOP's are required to be reviewed and updated if required over a set amount of time to ensure relevance and adequate advice is available	Director level	Largely effective	As of Q1 25/26 all policies and COP's will be reviewed by the Health and Safety Team, with reviews and adopted policies escalated to H&S Board as standard, and CLT if required for approval.

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

Treatment/mitigationplans (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**	HSMS Data Recording, Monitoring & Reporting	Establish and implement a modernized, improved method of organizational H&S data recording, monitoring, reporting & sharing	Craig Hill/ IT representative/Shameem Din	30.03.26		Existing SharePoint inadequate. Procure & Implement organizational software system to enable key stakeholders to input, store and provide key metrics for qualitative and quantitative reporting.
2	**SR06.01**	HSMS Data Recording, Monitoring & Reporting	H&S Team can use the current system, but issues such as lost time accidents (days lost) cannot be determined with the current system	Craig Hill / Shameem Dil	30.03.26		Use of current systems is difficult and time consuming if correct data is to be gleaned
3	**SR06.01**	Accident and Incident Reporting Data	All accident forms sent to H&S Team will be analysed and input onto the SBC system. Any incident that may require further attention will be addressed as a matter of course	Craig Hill / Shameem Dil	30.03.26		This is now standard practice within SBC H&S Team. Monthly analysis will be undertaken to attempt to spot trends occurring.
4	**SR06.01 – 0.2**	RIDDOR Reporting and Investigation	All official RIDDOR incidents will automatically be investigated thoroughly. Any lessons learned will be incorporated into daily H&S tasks/policies/COP's and training courses.	Craig Hill / Shameem Dil	01.10.25		This is now standard practice within SBC H&S Team. Pertinent lessons learned will be disseminated correctly and when required.
4	**SR06.01 – 0.3**	Health and Safety Staff Attrition	A minimum of 2 staff members for the Department has been set. Any less, or a change in personnel could hinder H&S progress	Craig Hill / Shameem Din	01.10.25		New interim Head of Corporate Health and Safety started 22.04.25 – the 3rd in just over 1 year
5	**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	01.10.25		Risk Register to be communicated & action owners delegated to. FRA's will be 'sense checked' by qualified fire professionals to ensure SBC monies are spent wisely. All FRA documents and actions will be discussed as standard practice at SBC H&S Board meetings
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, instil additional, reasonable controls (i.e. security/support) within key public facing services.	H&S/HR/Service Areas	01.10.25		HR (ShahillaBarok) tasked with Business Case to provide Security professional training (SIA) to Facilities Officers in Corporate Buildings. Draft Unreasonable Behaviour Policy (General) for approval at H&S Board. **EDIT: now left SBC awaiting update**
7	**SR06.04**	Training Level audit & analysis (Learning & Mandatory Management)	Review of existing data, quality therein address shortfalls (in terms of survey/actions) urgently.	Craig Hill	31.03.26		Mechanism for qualitative & quantitative data to be derived prior to audit.

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 18

Limited Incremental improvements have been achieved in this risk over the last quarter, particularly with regards to sub-risks 01, 02 and 03, which focus on incident response and emergency planning. A temporary resource has started full-time in April, bringing additional capacity and expertise in addressing these risks. Responder capacity has been increased with the establishment of an on-call group of Incident Managers to provide stand-by incident management capabilities for the council, removing the need for external support. Greater confidence in corporate incident management arrangements driven by training of Golds and a better appreciation of preparation and organisation capacity.

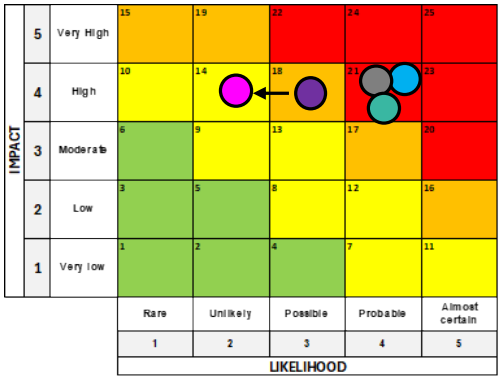
However, this is balanced by increasing pressures on response roles as three trained volunteer responders depart the council or step-down as a result of changing personal commitments. Business continuity is an ongoing concern, with out-of-date plans, lack of resilience awareness and an increasingly dynamic and uncertain national and international political and economic environment that translates to operational and strategic risk. This is particularly relevant to supply chains, power and fuel certainty, and cyber-security. The council lacks capacity in the emergency planning team to address this and other risks concurrently.

Expected pace of improvements will increase over the next quarter. The establishment of a proposed *Corporate Resilience Group* will support the organisation's ability to drive the resilience programme throughout the organisation. Sub-risks 01, 02 and 03 remain the priority for action due to the level of risk the organisation is exposed to in terms of responding to significant major incidents.

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	↑	Additional resource agreed to boost development of EP function. On call LALOs and Incident Managers. Review of current incident response capabilities underway. Operational response procedures being developed. Loss of some operational volunteer responders due to leaving the council.
CR07.02	●	Failure of emergency planning for specific major hazard risks in the borough, such as flooding, major fires, industrial accident etc.	Laura Robertson	→	Understanding of local risk environment remains poor. Flood officer for the Council appointed very recently which should support review of tactical flood plans. Audit of existing plans ongoing with few risk specific plans in place.
CR07.03	●	Failure of corporate major incident management arrangements	Laura Robertson	↑	Review of Major Incident Plan ongoing. Introduction of simpler management structure. Gold training delivered. Redevelopment of Emergency Operations Centre ongoing at slow pace. Plan to redevelop Silver management level.
CR07.04	●	Lack of BCP's for all services responsible for delivering business critical activities	Laura Robertson	↓	Business Continuity management programme exists, but requires review, improvement and engagement. Service level Business Impact Analyses and Business Continuity plans are increasingly out of date
CR07.05	●	Inadequate continuity planning for specific risks	Laura Robertson	↓	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. Increasingly uncertain operating environment.

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	0	0	
KRI3	Number of trained Incident Managers on rota (new, in development) 24/7/365	Minimum 6	0	8	
KRI4	Number of trained Local Authority Liaison Officers (LALOs) on rota 24/7/365	Minimum 6	8	6	
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	Number of trained Decision Loggists	Minimum 6	0	6	
KRI8	Number of officers attending training of all types	All officers attend minimum of 1 training session and 1 exercise per year	0	20	
KRI9	Testing/exercising of major incident capabilities and arrangements	1 major exercise per year	0	0	

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	Largely effective	Appointment made on part-time basis – full-time from April
3	CR07.1	Stand-by response teams	Gold, Silver, Incident Managers, LALOs, Emergency Shelter Managers, volunteer responders, currently available	Director	Needs improvement	No Silver Commanders, and no deployable emergency welfare/shelter responders. Incident Manager now in place, providing some consolidation
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 significant improvement. Plans to move to new facility on 1st floor agreed between Facilities and Emergency Planning, planning underway.
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. No Humanitarian Assistance Lead Officer. Identified as a priority for service in actions plans
7	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. No register of major hazard risks in the borough. Target set of a borough specific risk register for 2025/26 year.
8	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. Plans for preliminary improvements identified
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 critical functions or services 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/mitigationplans (funded actions that will manage/reduce the risk level)

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

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
2	SR07.1	Establishment of a corporate leadership for leadership	Establishment of a corporate group to oversee and drive resilience activities across the organisation	Laura Robertson / David McClory	July 2025	G	Proposal to CLT in May. ToRs drafted. Identifying potential chair and membership. Draft list of priorities.
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	G	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. Delayed due to other commitments, but increasing priority.
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. Prices identified. Rollout planning needed
6	SR07.1	Training for all on-call response staff	Training programme for Strategic Gold, Director on call, LALO, Silver, Loggists	Laura Robertson / David McClory	June 2025	G	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	G	Equipment for LALOs and incident managers purchased and issued. Operational manuals for Incident Managers. New SitRep reporting system introduced. Health and Safety risk assessments needed for all response roles.
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 – locations decided. Move behind schedule.
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	March 2026	G	Initial scoping of risks underway
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	
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	Divesting from schools BC work – little income generation benefit to disproportionate capacity commitment
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

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

There is a change to the target risk score this quarter. This is due to the more realistic rating of likelihood

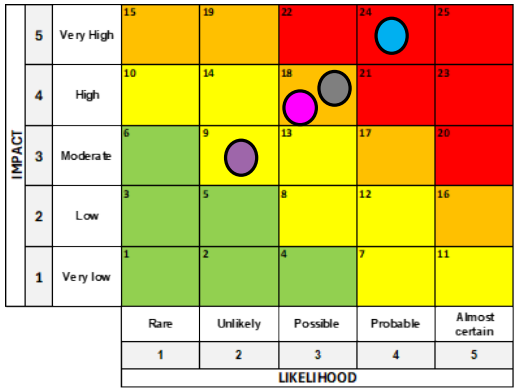
Updates are:-

- Contract has now been awarded for a Disaster Recovery as a Service and Backup as a Service . Currently in the final stages of finalising the contract. An interim project manager has been appointed to implement the new solution and complete related business continuity activities with service areas.
- Implemented a 6-month managed service pilot programme for a Security Incident Event Monitoring (SIEM) solution. The pilot programme is commissioned by MHCLG and due to end in July 2025 . Options analysis underway regarding provision of this service after the pilot.
- Agreement received to create a Cyber Security Apprentice role within DDaT. Currently liaising with Learning & Development regarding apprentice courses and need to liaise with HR regarding evaluation of job description.
- Engaged with MHCLG on the next stages of the Cyber Assessment Framework (CAF) for local government to assess and improve the Council's cyber resilience.
- The Council now has an approved IT Disaster Recovery Policy following approval from CLT in April 25

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		Progress has been made this quarter with the following updates:, • Sealing of contract of new Disaster Recovery and Backup solution due May 25 • Implementation of managed Security Operation Centre (SOC) using a cloud -based Security Event Management solution • Engaged with MHCLG on the next stages of the Cyber Assessment Framework (CAF) for local government to assess and improve the Council's cyber resilience • PSN status classified as "Deferred" as agreed with Cabinet Office
08.02		Lack of business continuity within service areas issue causes significant service loss	Colin Power		• The Council now has an approved IT Disaster Recovery Policy following approval from CLT in April 25 • 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	New	• Support and maintenance in place for supported hardware & software • Supported software receives security updates/patches from manufacturer
08.04		An incident caused by legacy 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 Citrix will decommission 17 servers (completed April 25) • Removal of the legacy hardware and software underway. • Budget approved for the migration of Liquid Logic (social care platform) to the cloud will decommission 22 servers. • New hardware for Data Centre due to by installed in Summer 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 full operation. I am confirming just what is measurable and whether baseline data exists.]					
KRI 1	Number of successful cyber breach incidents	0	0	0	
KRI 2	% staff completed cyber training	90%	Currently 80 per cent completion rate. Based on 1062 completions against 1329 employees.	79% completion rate Based on 1074 completions against 1353 employees (279 overdue)	
KRI 3	Number of ICT incidents substantively impacting one or more services (hardware / software failure P1 major incident)	1	3	3	
KRI 4	Notifications of compromise / risk from the National Cyber Security Centre (NCSC) active cyber defence service (ACD) early warning service	3	1	1 (Feb 25)	
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	Q3 2025	

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	• PSN status classified as "Deferred" as agreed with Cabinet Office • Quarterly internal vulnerability scanning undertaken • Commissioned annual IT Health Check • Engaged with MHCLG on the next stages of the Cyber Assessment Framework (CAF) for local government • Weekly external vulnerability scans conducted by MHCLG SOC
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	• Developing a cyber awareness campaign and are liaising with Communications regarding approach. • Cyber awareness now included in refreshed DDaT section in staff induction • Refer to treatment action 5
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	• IT Disaster Recovery policy approved • About to commence refresh of service areas Business Impact Assessment (BIA's) and will engage with the Emergency Planning team. • Project Manager aligned to support business continuity and disaster recovery planning. • Refer to treatment action 4
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 – 22 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 (Cabinet approval in Jul 25)	G	• Budget approval received for 25/26. • Cabinet approval required for contract award (expected July 25) • Completion date to be confirmed pending engagement with 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	August 2025 (Options paper to be complete by end of May 25)	G	• Implemented a pilot of a managed Security Operation Centre (SOC) using a cloud-based Security Event Management solution • Options analysis underway regarding provision of this service after the pilot.
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 Sealed in May 25)	G	• Evaluation completed and contract awarded. Contract to be sealed May 25 • Implementation expected to be completed by end of November 2025.
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 (Contract sealing due May 25)	G (Previously A)	• IT Disaster Recovery policy approved by CLT (April 25) • DDaT have engaged with the new Emergency Planning team. • Project Manager aligned to support business continuity and disaster recovery planning.
5	SR08.01	Improve take up of mandatory training	Improve compliance for IT security training	Martin Chalmers	October 25 (In line with Corporate Risk - CR13)	A	• Agreement received to create a Cyber Security Apprentice role within DDaT. • Cyber awareness now included in refreshed DDaT section in staff induction
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	Q3 2025	A	• Developing a cyber awareness campaign and are liaising with Communications regarding approach.

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 overall risk score and therefore RAG status remains red. Two sub-risks have reduced, SR09.01 mo ving from red to amber and SR09.03 moving from amber to yellow.

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.

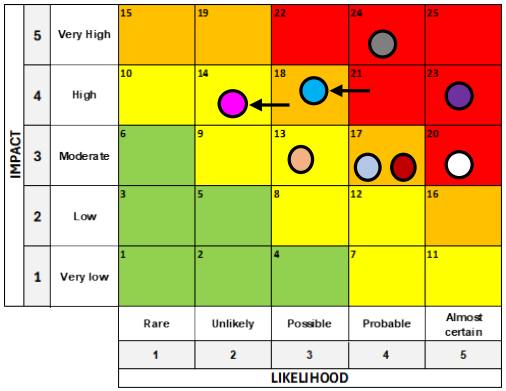
A **new sub-risk** has been added SR09.08 covering fraud.

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

We havea very lowappetite 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

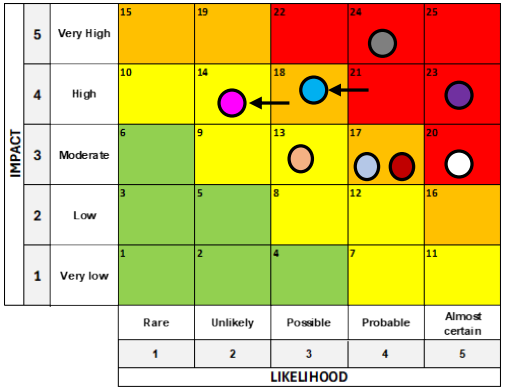
Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
09.01		Failure to deliver audited financial reports (SOA) to identify any additional financial liabilities to the council which will impact on financial sustainability.	Chris Holme		Outlook has stabilised since previous quarter. Although we have now published final audited accounts for 2021/22 & 2022/23, significant issues have come to light which has required delay in publishing 2023/24 draft accounts. This is a critical year as the closing balances 2023/24 become the 2024/25 opening balances and 2024/25 is the first year in a long time when those accounts will be fully audited. Publication of 2023/24 will show a worsening financial position as we undertake more detailed balance sheet reviews. 2024/25 final 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 2024/25 Outturn is challenging and will be resolved by the end of May. In terms of outlook, there will a refresh of the MTFS to Cabinet in July 2025, which will include impact of 2023/24 & 2024/25 accounts. This will form the baseline position for the 2026/27 – 2029/30 MTFS. and reflect emerging pressures of 2025/26.
09.03		Inadequate cashflow to maintain balance of liquidity to fund expenditure	Chris Holme		Q4 position reflects ongoing 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 approved by Full Councill in March 2025. Improved cash forecasting means risk is being mitigated

CR09	Failure to achieve financial sustainability and a balanced MTFS	Risk owner: Annabel Scholes

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		HMG have referenced the introduction of multi-year settlements and a focus on distribution of funding to meet need . There is also a consultation on Resetting the business rates retention system. This also has the potential to reward business rates growth but it's important to ensure the reset baseline is realistic.
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. Recruitment process commencing.
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. FIP activity restarted early March for paused projects. 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		Failure to deliver value for money from procurement processes	Chris Holme		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 • Poor compliance with the Council's CPRs • Preparedness for implementation of Procurement Act Work to finalise a procurement pipeline in progress for consideration by Cabinet in April 2025 There is a significant improvement programme in progress, but it is too early to be reflected in changes to the current risk score
09.08		Fraudulent activities resulting in financial and operational loss – NEW SUB-RISK	**Chris Holme**	**NEW**	Fraud team investigates fraudulent activities brought to their attention Part of National Fraud Initiative Financial controls Fraud and anti-corruption policy Whistleblowing policy Fraud risk assessments



CR09	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 monitoringhighlights a pressure that can't be balanced*	Check performance measure	*Q3 position £5.571m pressure*	Q4 position yet to be finalised	Amber
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 2023/24 accounts to provide baseline position in time for Q4	Work on 2023/24 still to be finalised	Amber
KRI 3	Data quality and MI is not improved to inform the financial forecasts	TBC	TBC	To be assessed following year end	TBC
KRI 4	*Level of external debt as a proportion of net revenue budget*	Reduce by 5% pa	Q3 24/25 - 17.1%	Q4 17.1%	Amber
KRI 5	Proportion of Internal Audit Opinions with Minimal Assurance	Reduce by 30% from 23/24 Outturn	Q2 24/25 -	Q4 STATS being finalised	Amber
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	Final SOAs for 2019/20 and 2020/21 Draft SOAs for 2021/22 and 2022/23	We were unable to conclude the 2023/24 Draft Statement of Accounts within the government deadlines, but we are aiming to regularise from 2024/25	Amber
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		All appraisals scheduled to be completed by end of April. Recruitment process has commenced for permanent replacements for 2nd, 3rd and 4th tier officers within Finance	Amber
KRI 8	FIP remains on track, milestones achieved	On track or better	Finance Improvement Plan restarted March 2025	Q4 STATS	Amber

CR09	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
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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	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. The DA has been reset for 2025/26.
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. New processes are in place for 2025/26 and will need to be supported to become embedded.
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 over the four-year period and further work is required to achieve this. The MTFS should reflect the corporate plan and work is being done to ensure that the MTFS is aligned to the Corporate Plan cycle.

CR09	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
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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
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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
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	The ECP process has been retained for HRIssues but a new focus is to be based on compliance and developing a suite of reports for review/assurance by CLT and Departmental Management Teams
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
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. There is consultation on resetting the business rates retention system and the Government are considering revisions to the LG funding system.
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

CR09	Failure to achieve financial sustainability and a balanced MTFS	Risk owner: Annabel Scholes

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

Target Risk Score – *22* 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	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	31/6/2025	Amber	Due to identification of specific issues arising from the 23/24 accounts, more detailed balance sheet analysis has been required which has meant target date has been put back to 30th June.
3	SR09.05	Review and update HR policies and procedures	6 month HR project from DecJune 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	30/09/2025	Green	Most staff appraisals were undertaken by the end of April. Training and development plans to be delivered by Sept.
5	SR09.05	Staff capacity and skills assessment	Undertake an assessment of staff competencies	DLT	31/08/2025	Red	Activity temporarily paused to enable resources and council officers to deliver the budget. Revised target date 31 August
6	SR09.05	Training and Development Plan	All staff to have training and development plans	DLT	31/03/2025	Green	Now revised to Sept due to large intake of new staff
7	SR09.06	FIP project plan	Proactive project management of the FIP projects including RAID	Vicki Palazon	31/03/2026	Green	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	30/06/2025	Green	Ongoing

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

Corporate risk overview

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

Overall Risk has remained at 18 during Q4 FY24/25 despite expected revenue that will be received in Q1 FY25/26

The GF Asset Disposal Programme enables the sale of underutilised 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 as the earliest opportunity to reduce the Council's borrowing and MRP, as well reducing operating costs.

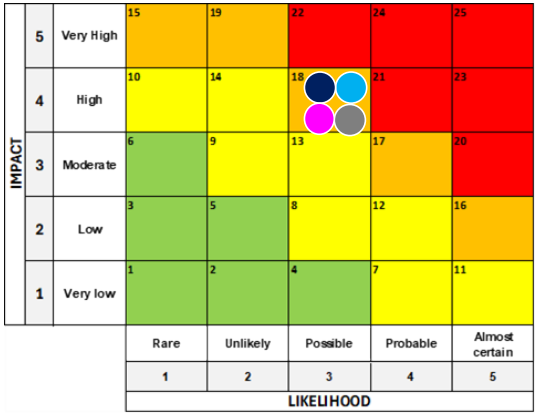
The 'net net proceeds' baseline target approved by Cabinet for the overall GF Disposals Programme is £27.402m. Though there have been adjustments in terms of the available property portfolio for disposal (both additions and omissions), the total Disposals Programme target has increased during the previous quarter to £29.051m.

Since the onset of the newly reset Disposals Program, £5.993m of sales have been generated versus a target of £9.881 (underperformance of 39.34%). This is due to late receipt of proceeds slipping into Q1 FY25/26 rather than poor sales performance. Details as follows Hatfield Car Park delay due to scrutiny from unsuccessful bidders, Woodland Avenue encroachment issues, Shelley Close Car Park requiring Title Insurance and a delay in settlement of the GF Houses (x 4) to HRA transfer. There is confidence that most if not all of the foregoing can be recovered during Q1 FY25/26.

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



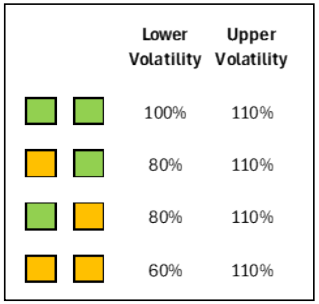
Refer to slide 7 for risk assessment score instructions

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		Worsening performance due to late receipt of proceeds slipping into Q1 FY25/26 rather than poor sales performance. Exchanges generally on track however.
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.

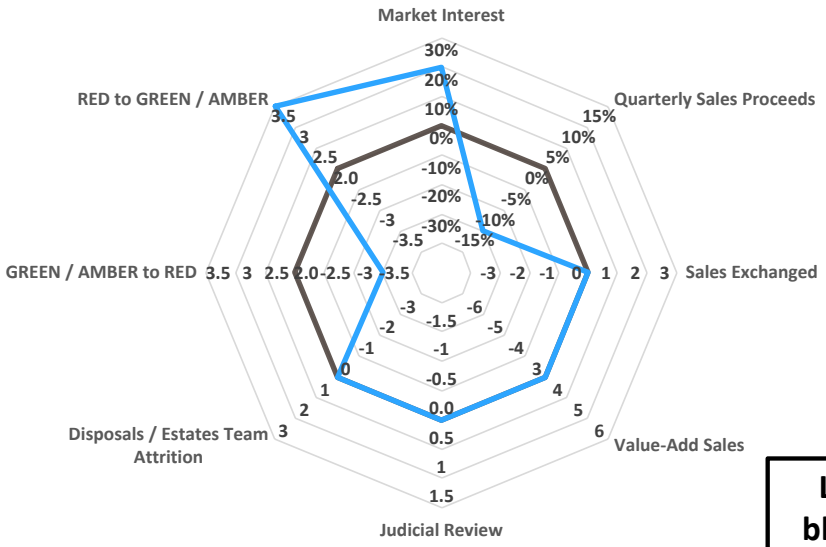
CR11	Failure of General Fund Asset Disposal Programme	Risk owner: Pat Hayes

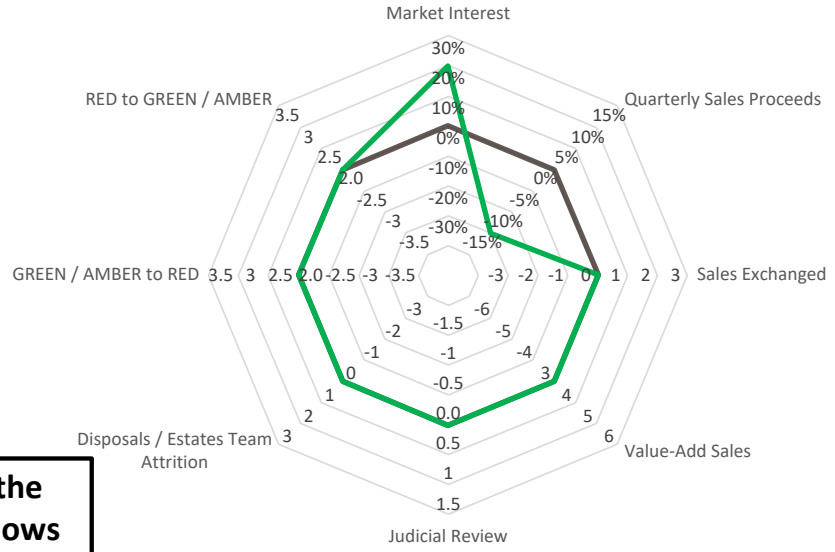
Key Risk Indicators (KRIs)

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 forcemajeure 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			

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

Key Risk Indicators (KRIs)





Q4 FY24/25

Line outside of the black baseline shows over-performance

YTD FY24/25

KPI	Baseline Definition
Market Interest	10 EOI per sale / 5 Bidders or BAFO per sale
Quarterly Sales Proceeds	Sales Proceeds Target (less 2.5% costs)
Sales Exchanged	Approved Deal Flow as Disposals Programme
Value-Add Sales	Three per annum
Judicial Review	1 permission / 6 months, 1 successful hearing / 2 years
Disposals / Estates Team Attrition	10% unplanned losses per annum
GREEN / AMBER to RED	Two demotions per quarter
RED to GREEN / AMBER	Two promotions per annum

KPI									Q3	Q4	FY24/25
Market Interest	-30%	-20%	-10%	0%	10%	20%	30%	9	20%	20%	20%
Quarterly Sales Proceeds	-15%	-10%	-5%	0%	5%	10%	15%	9	-15.0%	-15.0%	-15.0%
Sales Exchanged	-3	-2	-1	0	1	2	3	9	0	0	0
Value-Add Sales	-6	-5	-4	3	4	5	6	9	3	3	3
Judicial Review	-1.5	-1	-0.5	0.0	0.5	1	1.5	9	0.0	0.0	0.0
Disposals / Estates Team Attrition	-3	-2	-1	0	1	2	3	9	0	0	0
GREEN / AMBER to RED	3.5	3	2.5	2.0	-2.5	-3	-3.5	9	2.0	-3.5	2.0
RED to GREEN / AMBER	-3.5	-3	-2.5	2.0	2.5	3	3.5	9	2.5	3.5	2.0

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	*Effective*	
3	SR10.03	Abortive Sales	• EY AADF framework in use as SBC internal gateway • All pipeline assets have impairments assigned	Ian Church	*Largely Effective*	
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	*Largely Effective*	Time has been invested, documents are in much better condition, physically and online.
6	SR10.06	Skills / Capability	• Review team engagement as tempo of disposals increases • Move away from interims to permanent team, to retain corporate memory	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*	Improving however additional time required to bed in. Treatment due to be delivered Q3 FY25/26

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

Treatment/mitigationplans (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 offsite 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 Q3 FY 25 / 26*		1. Flowchart now complete 2. More time needed to 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

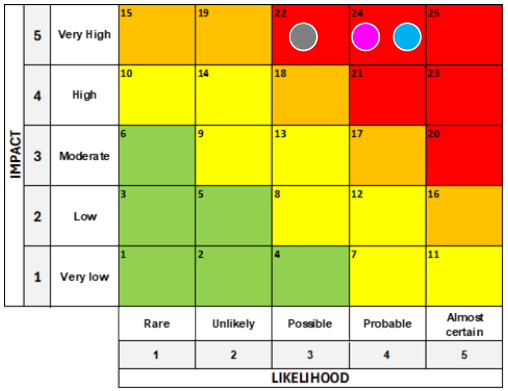
Current Risk Score 5 Impact 4 Likelihood	24
Target Risk Score 4 Impact 3 Likelihood	22

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 Q4:
Improvement and Recovery Plan 6 month plan was adopted by January Cabinet and full Two year Improvement and Recovery Plan was adopted by March Cabinet and April Council
6 month Progress update on progress towards becoming a Best Value Council was submitted to MHCLG commissioners
Governance and control measures have been mobilised so that quarterly performance reports can be produced
Most of team supporting this work is made up of interims and secondments and funded from reserves. Plans for team were finalised but as budget was only agreed in March 2025, there has been a delay in mobilising team. Permanent Strategy and Performance and Programmes and Change Heads of Service were not recruited to due to recruitment freeze, but permission was requested to start process in Q1
Operating model – transformation director in post since January and working on development of operating model and transformation programmes

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 – work so far is putting foundations in place.
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. Work so far is putting foundations in place

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: May/June 2025	N/A
KRI 3	Improvement and recovery plan progress is systematically tracked and updates are provided to appropriate board on a quarterly basis	4 per year –going to Best Value		This in place for first BV Board in July	
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)	
KR6	RAG rating of improvement and recovery dashboard	RAG rating shows mostly Amber or Green and upward trend by Jan 2026			

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	SR11 02	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 was adopted by January Cabinet and full Two year Improvement and Recovery Plan was adopted by March Cabinet and April Council 6 month Progress update on progress towards becoming a Best Value Council was submitted to MHCLG commissioners Governance and control measures have been mobilised so that quarterly performance reports can be produce Resourcing for team being finalised for 25/26 but as budget was only agreed in March 2025, there has been a delay in mobilising team.
3	SR11.0 3	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**	Operating model– transformation director in post since January and working on development of operating model and transformation programmes Direction of travel adopted by Cabinet in November 2024 and further update provided in March 2025

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

Treatment/mitigationplans (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, update will go to Cabinet in March 2025, Transformation Programme under development
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		Most of team supporting this work is made up of interims and secondments and funded from reserves. Plans for team were finalised but as budget was only agreed in March 2025, there has been a delay in mobilising team. Permanent Strategy and Performance and Programmes and Change Heads of Service were not recruited to due to recruitment freeze, but permission was requested to start process in Q1
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 went 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		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		Procurement is currently under way – revised date June 2025

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

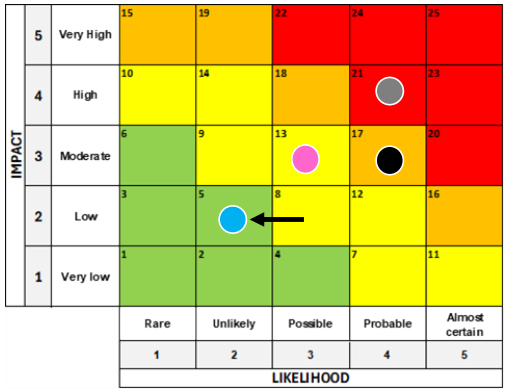
Risk score remains unchanged, although there is an overall improvement in the management of the risk.
Market Sustainability is assessed across four specific areas:

- 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) New home care providers onboarded to increase local market sufficiency**
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. Process complete for 24/25 with £1.2 pressure against initial budget.**
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. No provider failures in 24/25**
12.04		Recruitment and retention of external workforce	Lynn Johnson (HOS)		**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. Risk remains stable.**

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	+% increase per quarter	Q3 Providers Suspended Due to Quality Concerns 1 Care Home 3 Supported Living Providers 3 Home care Providers	Update Q4 Providers Suspended Due to Quality Concerns 2 x Care Homes 3 x Supported Living Providers 0 x Home Care Providers	
KRI 2 – Contract handbacks	The number of contract hand backs on a monthly basis	0	0 Contract Handbacks	0 Contract Handbacks	

CR12	Failure to deliver market sustainability across the Council	Risk owner: David ColemanGroom

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; CGB 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/mitigationplans (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~~	~~516.01~~	~~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	Lynn Johnson	December 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	Lynn Johnson	March 2026	Green	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	Lynn Johnson	September 2025	Green	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 3 Likelihood	**18**

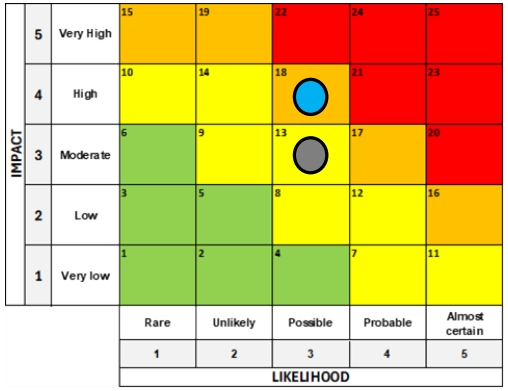
There is a change to the target risk score this quarter. This is due to the more realistic rating of likelihood.

- GDPR training compliance continues to be monitored at the monthly IGG meetings for both SBC and SCF. Current completion rate is for SBC – 79%. No statistics from SCF this quarter due to change in learning management platform .
- A briefing on GDPR and information security continues to be included in the corporate induction programme which is delivered to all new roles within the first 2 months of their start date.
- Continue to review and update GDPR policies and guidance in align with their annual review dates. Updated documents are circu lated and approved by IGG.
- "Our Data Responsibilities" guidance has been recirculated to SBC and SCF to remind staff of their obligations when handled personal data.
- The risk rating remains unchanged this quarter despite a reduction in the number of reported data protection incidents. Progress continues on enforcing training and communications across SBC and SCF further embedding knowledge and awareness throughout the organisations.

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 personaldata	Alex Cowen		This risk relates primarily to accidental disclosure of information; cyber attack is covered by CR08. Risk treatment plans relating to systems, process and training have been identified. The latter is ofparticular relevancehere, 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 remains stable • 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 13.01, 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: 80% SCF: 98%	SBC: 79% SCF: No stats this quarter due to change in learning platform	
Number of data protection incidents	Reported instances of data protection breaches, This information is available through the data breach log for both SBC & SCF.	30	SBC & SCF = 30 in total	13	
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	1	
Turnaround time for DPO (Data Protection Officer) to review (Freedom of Information) FOI responses	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	-	24 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
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	SR13.01	Training and communications	New staff are obliged to complete æLearning 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)	• Take up of training remains below target (90%). SBC remains stable at 79% (80% last quarter). For SCF there are no statistics due to change learning management platform. • 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 Q2 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	• Recruitment for a permanent Information Governance Officer has been completed. Start date for the successful candidate to be confirmed but aiming for before the end of May 25.

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

Treatment/mitigationplans (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	October 2025 (FTE in place by 1st June 25)	G	• 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	• A Project Initiation Document has been drafted and need to be approved by DDaT Project Board (aiming 2nd Jun 25). Scope to includedocument 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	November 2025 (Contract Award due by end of Feb 25)	G	• Evaluation completed and contract awarded. Contract to be sealed May 25 • Implementation expected to be completed by end of November 2025. • IT Disaster Recovery policy approved by CLT (April 25)
4	SR13.01	Resourcing	An Information Governance officer role has been established	Martin Chalmers	~~April 2025~~ May 2025	G	• Recruitment for a permanent Information Governance Officer has been completed. Start date for the successful candidate to be confirmed but aiming for before the end of May 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	• Policy to be drafted by DDaT

Target Risk Score – 18 by end of October 2025

CR14	Failure of Council Subsidiary Companies	Risk owner: Pat Hayes

Corporate risk overview

Current Risk Score 5 **Impact** 5 **Likelihood** 25

Target Risk Score X **Impact** X **Likelihood** 22

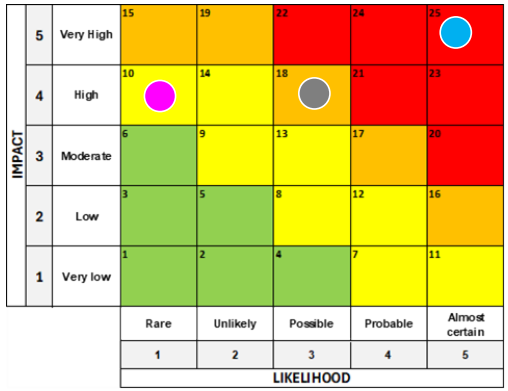
- Financial council exposure as Shareholder across James Elliman Homes (JEH), GRE5 & Slough Children First
- Risk that retained losses across the companies continue to be underwritten by the Council
- JEH 12-month Business case approved by cabinet on the 17th March 2025. Implementation is underway on a rolling programme.
- GRE5 – post building work completion, failure to identify any viable disposal route to recover final outstanding council funding. Engaging with Homes England to identify probable additional grant payment.

Risk appetite statement **(Balanced)**

SBC as shareholder has a balanced range of risk acceptance across the various companies. However where it is possible as Shareholder the aim is to reduce risk where possible and accepting a reasonable level of commercial risk for the wider organisations benefits.

The Companies operate within the law governing the running of registered companies and therefore operate within the bounds of the registered Articles of each of the companies.

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
14.01		JEH - Failure of the company resulting in financial losses and reputational issues for the council.	Peter Hopkins		The company is at high risk of failure and requires the council to provide assurance that liabilities will be underwritten. From a cash flow perspective the company is able to meet its liabilities as they become due but unable to repay the loan . £51.7m of loan has been provided by the council. The company has total net assets on the balance sheet. The business plan has been approved by Cabinet and are now awaiting registration to be accepted by Companies House. Once registration is accepted likelihood will reduce which will in turn reduce the overall score. Pending review of the full options appraisal due in Q1 2025/26. The council is exposed to financial and reputation risk if the company fails.
14.02		GRE5 - Failure of the company resulting in financial losses and reputational issues for the council.	Peter Hopkins		The company has net liabilities as at 31 March 2024 of £3.1m which includes the loan to the council of £2.2m. The business plan for 2025/26 was approved at November Cabinet. The council has set aside a provision for underwriting the liabilities should it become necessary. The future direction of the company is pending review.
14.03		SCF - Failure of the company resulting in financial losses and reputational issues for the council.	Sue Butcher		The company is at a low risk of failure. A company secretary was appointed to ensure all these duties are performed. The company has current assets as at 31 March 2024 of £5.1m and no retained losses. The company has a loan of £5.0m provided by the council. The business plan was approved at December 2024 Cabinet.

CR14	**Failure of Council Subsidiary Companies (Suggested name)**	Risk owner: Pat Hayes

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KRI 1 – JEH current financial performance (2024/25 outturn)	The financial performance of the company does not deteriorate further since August 2024 and improves on previous year performance	<£1.8m		£1.6m	
KRI 2 – JEH Balance Sheet health	The company reports total assets greater than liabilities	Total net assets		Net assets	
KRI 3 – JEH – Business plan 2025/26	The Shareholder has approved a business plan for 2025/26	Approved business plan		Pending – March 2025 Cabinet approval	
KRI 4 – JEH outstanding loans	Company has a confirmed strategy to repay the loan and the balance is reduced	<£51.7m		Baselined	
KRI 5 – JEH options appraisal	An options appraisal is completed to enable a Shareholder decision on the future strategic direction of the company	Decision		Pending	
KRI 6 – JEH FIP plan	All activities are completed on the FIP plan regarding company governance, oversight and financial governance	Completed by 31/05/2025		Slippage – FIP paused	
KRI 7 – JEH Special Resolutions	The special resolutions issued to the company have been fully discharged	Discharged by Q1 2025/26		In progress	
KRI 1 – GRE 5 current financial performance (2024/25 outturn)	The financial performance of the company does not deteriorate further since August 2024 and improves on previous year performance	tbc			
KRI 4 – GRE 5 outstanding loans	Company has a confirmed strategy to repay the loan and the balance is reduced	£2.2m by 31/03/2024		£2.2m	
KRI 5 – GRE 5 FIP plan	All activities are completed on the FIP plan regarding company governance, oversight and financial governance	Completed by 31/05/2025		Slippage – FIP paused	

CR14	**Failure of Council Subsidiary Companies (Suggested name)**	Risk owner: Pat Hayes

Key Risk Indicators (KRIs) **PAGE 2**

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KRI 1 – SCF current financial performance (2024/25 outturn)	The financial performance of the company does not deteriorate further since August 2024 and improves on previous year performance	tbc			
KRI 2 – SCF 5 Balance Sheet health	The company reports total assets greater than liabilities	Net assets		£5.1m	
KRI 3 – SCF 5 – Business plan 2025/26	The Shareholder has approved a business plan for 2025/26	Approved business plan		Approved – December 2024 Cabinet	
KRI 4 – SCF 5 outstanding loans	Company has a confirmed strategy to repay the loan and the balance is reduced	<£5m by 31/03/2024		In progress	
KRI 5 – SCF FIP plan	All activities are completed on the FIP plan regarding company governance, oversight and financial governance	Completed by 31/05/2025		Slippage – FIP paused	

CR14	**Failure of Council Subsidiary Companies (Suggested name)**	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~~	~~SR01.01~~	~~*controls that are managing the sub risks*~~		~~*Director level*~~		
2						
3						
4						
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10						

NEW RISK – TO BE ADVISED

CR14	**Failure of Council Subsidiary Companies (Suggested name)**	Risk owner: Pat Hayes

Treatment/mitigationplans (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	*SR01.01*	*High level action that will mitigate or reduce the risk the most*		*Director level*	*Dd-mm-yyyy (within the next 12 months)*	*(RAG)*	
2							
3							
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15							

Target Risk Score – *score* by end of date *mm/yy*

NEW RISK – TO BE ADVISED