**Slough Borough Council**

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| **Report To:** | Audit and Corporate Governance Committee |
| **Date:** | 10 September 2025 |
| **Subject:** | Q1 FY2025/26 Corporate Risk Report |
| **Chief Officer:** | Christopher Holme, Interim Executive Director, Finance and Commercial (S151 Officer) |
| **Contact Officer:** | William Green, Interim Risk Manager |
| **Ward(s):** | All |
| **Exempt:** | No |
| **Appendices:** | Appendix 'A' – Q1 FY25/26 Corporate Risk Profile<br>Appendix 'B' – Q1 FY25/26 Corporate Risk Dashboards (summary sheets) |

## 1. Summary and Recommendations

1.1 This report sets out

- The status of the Council risk profile in the Q1 FY25/26 Corporate 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 1 FY25/26 (August 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 Q1 2025/26 corporate risk report a full review of each of the current corporate risks was undertaken. The corporate risk report was initially presented at the Risk Management Board on the 21st August 2025 and after rigorous challenge it was signed off. The corporate risk report was then presented to the CLT on the 27th August and following discussion and challenge it was agreed that corporate risk CR02 should be renamed to *Failure to meet demands on Adult Social Care within budget* to better reflect the scope of the risk. It was also agreed that CR11 – *Failure to become a best value council* was too wide ranging and it is proposed to remove the risk and replace with a more focused one. Meetings to be arranged, before returning to CLT for review and approval. The CLT then approved the Q1 FY25/26 corporate risk report.

2.3 The Q1 FY25/26 position is that the Councils risk exposure has marginally improved this quarter, however the overall exposure remains elevated but is being actively managed within the resource constraints. One risk score has improved, and one risk score has deteriorated. 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, ten are rated as red (risk score between 20 – 25), and four are rated as amber (risk score between 15 – 19). As the risk management programme becomes more mature there has been a marked confidence that the improved risk control environment will lead to further corporate risk scores improving by quarter 2 FY25/26.

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

Q1 FY25/26 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.

| CR ref. | Corporate Risk - Sub-Risk | Impact Score | Likliehood score | Current Score | Target Score | Prev. Qtr Score | Score movement/ Outlook last quarter |
|---|---|---|---|---|---|---|---|
| CR01 | **Failure to Safeguard Children and Young People** | **4** | **3** | **18** | **18** | **18** | → |
| | SR01.01: Insufficient financial resources | 4 | 3 | 18 | | 18 | ↓ |
| | SR01.02: Attraction and retention of qualified workforce | 2 | 2 | 5 | | 5 | → |
| | SR01.03: High Caseloads for frontline staff | 2 | 2 | 5 | | 5 | → |
| | SR01.04: Staff capability | 3 | 3 | 13 | | 13 | ↑ |
| | SR01.05: Data production does not support effective practice | 3 | 4 | 17 | | 17 | → |
| CR02 | **Failure to meet demands on Adult Social Care** | **4** | **5** | 23 | **18** | 21 | ↓ |
| | SR02.01: Inability to meet savings | 4 | 5 | 23 | | 21 | ↓ |
| | SR02.02: Inability to meet increase in demand | 4 | 3 | 18 | | 21 | ↑ |
| | SR02.03: Attraction & retention of talent | 3 | 3 | 13 | | 13 | → |
| | ~~SR02.04: Loss of health funding~~ **SUB-RISK REMOVED** | ~~3~~ | ~~2~~ | ~~9~~ | | ~~9~~ | → |
| 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 | | 13 | ↑ |
| | 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 | | 13 | ↑ |
| | 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 | | 22 | ↑ |
| | SR04.02: Budgetary constraints | 5 | 5 | 25 | | 25 | ↑ |
| | SR04.03: Lack of Statutory Compliance Information | 4 | 3 | 18 | | 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** | **3** | 18 | **18** | 21 | → |
| | SR05.01: We fail to attract and recruit a diverse and inclusive workforce for senior manager and above. | 3 | 4 | 17 | | 21 | ↑ |
| | SR05.02: We fail to identify, develop and embed the capabilities and competencies we need in our workforce | 2 | 3 | 8 | | 12 | ↑ |
| | 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 | | 5 | → |
| CR06 | **Health & Safety: We fail to prevent statutory obligations** | **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 | 3 | 18 | | 21 | ↑ |
| | SR06.03: We fail to prioritise adequately fund or manage risks associated with aggressive behaviour | 4 | 3 | 18 | | 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 | 3 | 18 | | 18 | ↑ |
| | SR07.02: Failure of emergency planning for specific major hazard risks in the borough, such as flooding, major fires, industrial accident | 4 | 3 | 18 | | 21 | ↑ |
| | SR07.03: Failure of Major Incident Plan | 4 | 2 | 14 | | 14 | ↑ |
| | 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 | 3 | 2 | 9 | | 9 | → |
| | 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 | 2 | 14 | | 18 | ↑ |
| | 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 | 1 | 10 | | 14 | ↑ |
| | SR09.04: Government funding formula/distribution does not reflect the needs of the Slough community and demographic | 4 | 4 | 21 | | 21 | → |
| | SR09.05: Failure to recruit and retain a resilient and skilled workforce within finance | 2 | 5 | 16 | | 16 | ↑ |
| | SR09.06: Failure to deliver the FIP which include internal controls an effective finance system both through tech and business processes | 1 | 4 | 7 | | 7 | ↑ |
| | SR09.07: Failure to deliver value for money from procurement processes | 3 | 5 | 20 | | 20 | ↑ |
| 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 | 3 | 22 | | 24 | ↑ |
| | SR11.02: Fail to operate as a Best Value Council | 5 | 2 | 19 | | 22 | ↑ |
| | SR11.03: Unable to deliver new operating model and medium-term financial strategy | 5 | 4 | 24 | | 24 | → |

| 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 adult social care market sustainability** | 4 | 4 | 21 | 18 | 21 | → |
| | SR12.01: Insufficient access to regulated services | 2 | 2 | 5 | | 5 | → |
| | 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 | 25 | ↑ |
| | SR14.01: JEH - Failure of the company resulting in financial losses and reputational issues for the council. | 5 | 5 | 25 | | 25 | ↑ |
| | SR14.02: GRE5 - Failure of the company resulting in financial losses and reputational issues for the council. | 3 | 3 | 13 | | 13 | → |
| 🔴 | ~~SR14.03: SCF - Failure of the company resulting in financial losses and reputational issues for the council.~~ **SUB-RISK REMOVED** | 4 | 3 | 18 | | 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.

2.2 The overall corporate risk exposure has remained stable this quarter, but the overall exposure remains elevated. One risk score has deteriorated, and one corporate risk improved this quarter.

2.3 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 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 within budget)* - the rating remains red despite an improving sub-risk outlook. The key risk driving this rating is operating within budget resulting in a forecast £6.7m overspend due to provider uplifts and demand related to new people/increase in need.

- CR03: *(Failure of SEND)* – the rating has remained red this quarter. 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 started to show improvement, although not enough to reduce the overall risk score. The budget pressure on SR04.02 continues to drive this risk, however better controls could reduce overspend by approximately 50%.

- CR06: *(Health and Safety)* - the overall rating remains red. The current, elevated score is due to a lack of resources, lack of evidence-based material and a lack of data to interrogate. However, from Q3 of 2025 we have been addressing these issues and have made significant progress. Overall the risk is now improving as new treatment plans come online.

- CR07: *(Insufficient Operational Resilience and Crisis Management)* – the overall risk remains red. Improvements across nearly all sub-risks is positive, however, significant challenges remain that limit potential risk score reductions.

- 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 ongoing improvements in the sub-risks has resulted in two sub-risks reducing their risk score. As in Q4, 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 the sub-risk relating to delivery of new operating model and medium-term financial strategy. All sub-risks are reported as being stable or improving.

- CR12: *(Adult social care market sustainability across Council)* – The overall risk remains red, with the outlook deteriorating across 3 sub-risks, but not enough to increase the risk score in this quarter.

- CR14: *(Failure of Council Subsidiary Companies)* – This risk remains red despite a reported improvement, there is no score change this quarter. The corporate risk is now focussed solely on JEH and GRE5. Overall, the outlook of the sub-risks is stable to improving.

2.5 One corporate risk has deteriorated this quarter:

- CR02: Failure to meet demands on Adult Social Care within budget - the overall rating has increased and remains red as they manage a major supplier failure and there is a forecast of £6.7mil overspend driven by provider uplifts and demand related to new people/increase in need.

2.6 One corporate risk improved this quarter:

- CR05: Failure to Attract Retain & Engage with Our People – the overall rating has decreased from red to amber due to driven mainly by the restructure of operations and the HR framework.

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

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

2.9 The Q1 FY25/26 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 | Failure to Safeguard Children and Young People | 18 | 18 | → |
| CR02 | Failure to meet demands on Adult Social Care | 23 | 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 | 18 | 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 adult social care market sustainability | 21 | 18 | → |
| CR13 | We fail to comply with GDPR data protection obligations | 18 | 18 | → |
| CR14 | Failure of Council Subsidiary Companies | 25 | 22 | → |

2.15 The Interim Risk Manager continues to work with senior officers to promote and embed 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, when finished the document will be presented to this committee, with a view to then present to Cabinet for final approval.

2.16 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.

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

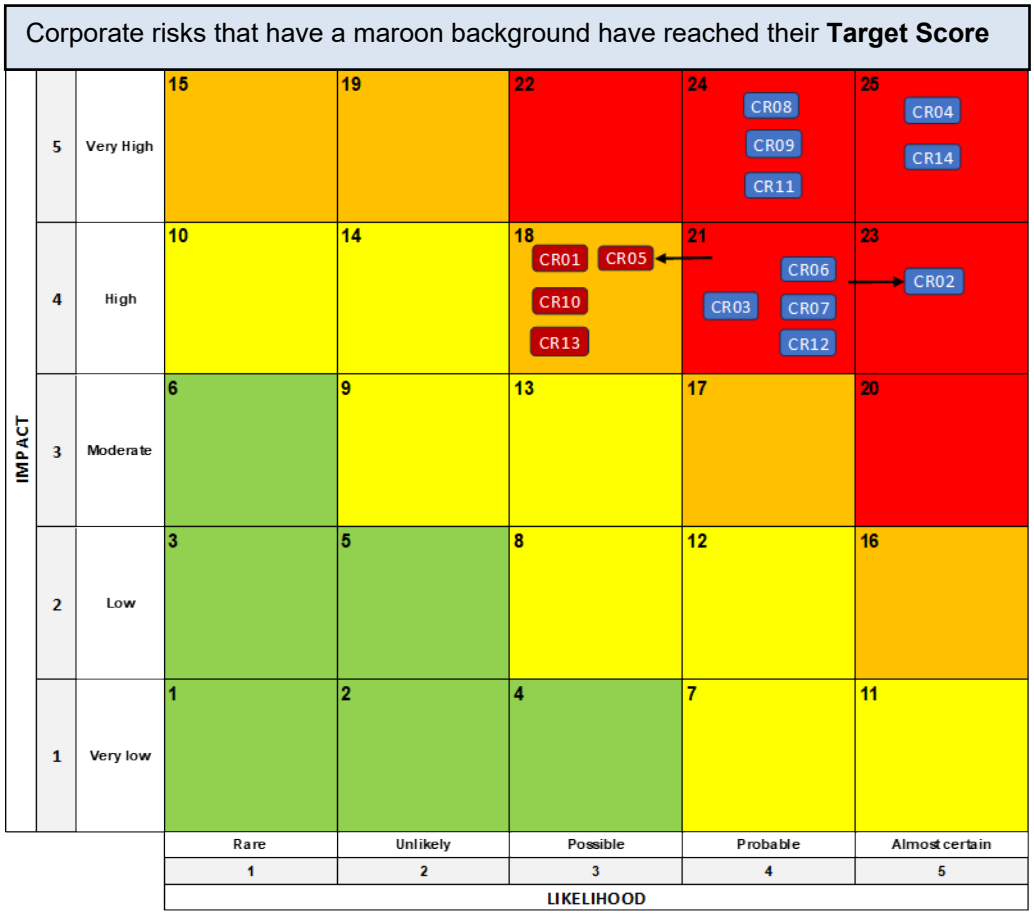
None

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

The overall corporate risk profile has marginally improved in period. The corporate risks continue to improve their control environments which is resulting in a more stable outlook for the future and the likelihood of further risk score reductions.

Further details are provided in the risk dashboards, which includes current scoring, 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 within budget | 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' – Q1 FY2025/26 CORPORATE RISK DASHBOARDS

## CR01 Failure to Safeguard Children and Young People

**Risk owner: Sue Butcher**

### Corporate risk overview

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

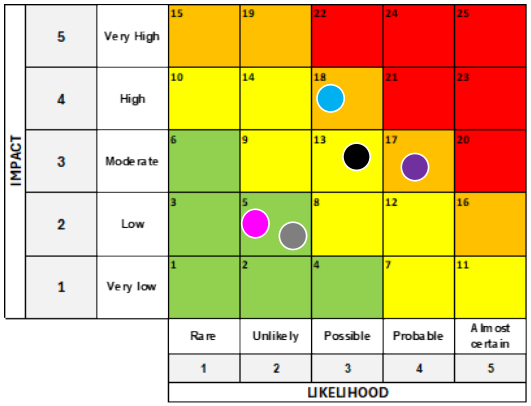
From Q1 risk title changed to Failure to Safeguard Children and Young People.
Risk score has remained at 18 (RAG Amber) despite the current impact of poor data quality on the work of SCF. Poor data production is an underpinning risk impacting on SCFs cost effectiveness, staff satisfaction and achieving 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 appropriate. Attracting permanent staff is also not a current risk – reflecting work done over the past few years. Retention is an issue, with reasons for leaving being monitored and reported on regularly, intervention strategies are implemented where required. The impact of the a significant national change in how childrens social services are delivered out over the next 12 months may have a further impact, this is yet to be determined. This will mean that roles for current staff will be redesigned and competition for strong staff will increase..
SCF in 2025/6 is forecasting a budget overspend and engaging with SBC
Children's Social Care is subject to a Statutory Direction from the Department of Education overseen by a DfE Advisor

### 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 facing some unbudgeted costs including higher than expected pay settlement leading to a predicted year end overspend for 2025/26. This is being addressed through close financial management and liaison with SBC on a potential in year budget review. |
| 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 but actions to address this are expected to reduce turnover by October 2025 |
| 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 Improvement Advisor. They are currently largely within range, reflecting a reduction in demand and a more stable workforce. Until recently they were much higher. |
| 01.04 | | Staff capability | Director of Operations (Ben Short) | | Training and development is delivered consistently. Workforce development strategy rolled out. The Slough Academy is being strengthened to support 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. A joint project with SBC is exploring how to improve data processing |

## CR01 | Failure to Safeguard Children and Young People | S

### Key Risk Indicators (KRIs)

| KRI | KRI explanation | Tolerance/Threshold | Previous qtr. status | Current qtr. statu | Trend |
|---|---|---|---|---|---|
| *KR1* | Quarterly and year end financial forecasts: expected variation from budget | *£0* | *£0* | *C£629,000 overspend forecast for year end* | |
| KRI 2 | Attraction and Retention of qualified workers:<br>50.8% of CLA with 2+ Social Workers in a year<br>Average 12 month case holding Social Worker Turnover | 0%<br>- | *51.9%*<br>*31%* | 50.8%<br>31% | |
| KRI 3 | Caseload monitoring:<br>**Average caseload across the workforce, including non qualified**<br>**Contact decisions** within 1 day<br>**Re-Referrals**<br>**Assessments completed in 45 days**<br>**Child Protection Plan reviews** (within 3 or 6 months as appropriate)<br>**ICPCs held in time** (within 15 days of s47 start):<br>**CLA visits in time** (within 12 weeks) | 18<br>95%<br>-<br>90%<br>-<br>-<br>- | 20.2<br>97.4%<br>15%<br>86.7%<br>98.1%<br>83%<br>92.6%<br>- | 22.6<br>97.5%<br>23.%<br>97.4%<br>99.1%<br>83.1%<br>92.3%<br>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 | - | 16 | 16<br>(MASH, YJS, Adolescent support (ie Missing, Exploitation, Edge of Care); Connected Carers, Safeguarding&QA, Commissioning, SEND Controcc Finance, Virtual School, Attendance Service, Post 16, HR&Workforce-Agresso, IFA and Adoption) | |

| CR01 | Failure to Safeguard Children and Young People | 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<br>• 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<br>• 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<br>• 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.<br>Some managers need to use Talos more efficiently. |
| 3 | SR3 | Workloads | Regular reports to senior managers, monitoring of casework progress, reporting to Company Board an Improvement Board | Director of Operations | Largely Effective | Currently operating within expectations. |
| 4 | SR4 | Performance management | 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 | Data interrogation | Manual intervention and quality control for data reporting. Some PowerBi dashboards. Weekly reviews of CYP core datasets (Annex A), ongoing programme of audits and dip sampling of files held on CYP to cover c10% pa | SCF Chief Executive | Needs Improvement | Further development of PowerBi dashboards; further data cleansing of HR systems; further audits of caseload data |

| CR01 | Failure to Safeguard Children and Young People | 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 | Integration of system access to automate dashboards | A plan is being worked up | AD Quality Practice and Improvement | Tbc by SBCI | | SBC/SCF data working group has had it's second meeting and a programme has been agreed. |

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

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

## Corporate risk overview

| | | |
|---|---|---|
| Current Risk Score | 4 Impact 5 Likelihood | 23 |
| Target Risk Score | 4 Impact 3 Likelihood | 18 |

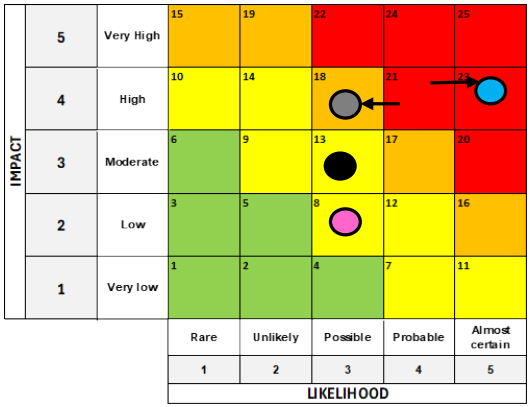
Work is underway to address workforce demands and the directorate is starting to see improvements. Recruitment is in progress for Director of Operations and Head of Reablement and Independence. There has been significant progress with annual review with more planned annual reviews taking place.

Risk Profile for 02.01 has moved to 23 as at end of P2 there is a forecast of £6.7mil overspend which includes provider uplift and new demand related to new people/increase in need. There are controls in place to monitor this monthly.
Risk SR02.04 has been removed as this was added as a risk due to initial concerns in relation to CHC requests being declined across East Berkshire, therefore removed as currently no evidence of being a risk for Slough and will be monitored at DLT

## 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 Care, while being aware of constraints around finances. 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) | | Monthly at eDLT all savings are reviewed, and RAG rating status reviewed. All savings have a lead identified. |
| 02.02 | | Inability to carry out statutory annual reviews | Ilona Sarulakis (HOS)<br>Andrea Rodin<br>Debra Broderick | | Annual reviews are monitored and are reported as overdue; this data is now being broken down into length of delay and the oldest reviews will be targeted first. |
| 02.03 | | Attraction & retention of talent | Jane Senior<br>David Coleman-Groom | | Number of interims increased by 3 in June 2025. Permanent recruitment is underway for Director of Operations and Head of Reablement and Independence |
| ~~02.04~~ | | ~~Loss of health funding~~ | ~~Vicky Tutty (HOS)~~<br>~~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~~<br>~~Section 117 Aftercare ( Health funding)~~ |

| CR02 | Failure to meet demands on Adult Social Care within budget | 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<br>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.<br>Aim to reduce by 5% | Target to be set now refresh establish is agreed | | 63 agency staff currently in post asat June 2025 | |
| 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%<br>(Vacancy/interim cover rate) | ~~Q1 60%~~<br>Q4 – 40% | ~~Q2 40%~~<br><br>Q1 25/26 – 40% | |

| CR02 | Failure to meet demands on Adult Social Care within budget | 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<br>• 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<br>• 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<br>• 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 | *Effective* | Controls are operating at an acceptable level |
| 2 | SR02.01 | Cost Savings within our control | Identified Senior Responsible Owner(SRO) for each saving | David Coleman-Groom | *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) | *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 within budget | Risk owner:David Coleman~~Groom~~ |
|---|---|---|

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

| Ref | Sub risk ref | Action title | Action details | Action owner | Action due date | Action plan status | Status update |
|---|---|---|---|---|---|---|---|
| ~~1~~ | ~~*SR02.04*~~ | ~~*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<br>• 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<br>• 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 | | • Focus of work related to safeguarding Slough residents and mitigating risks related to supplier issues. Final draft expected to be shared in Q3. |

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

# CR03 Failure of Special Educational Needs and Disability (SEND)

**Risk owner: Sue Butcher**

## 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. Recruitment planning / benchmarking is occurring for permanent staff .

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. We ended the 2024/25 financial year with a £3M deficit but the DfE have indicated that they will still provide the additional funding. Nevertheless a significantly higher level of SEND spending could threaten the additional funding being offered in the future.

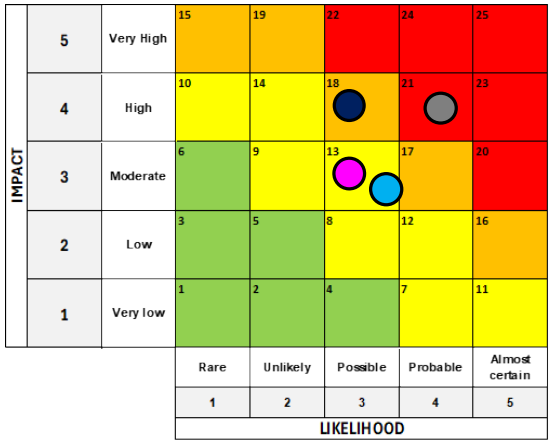
The ongoing reduction in complaint numbers is continuing, but a risk remains given historic poor practice resulting in ongoing risk of tribunal cases.

## 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 the risk due to the increase in demand for EHC plans that all LAs are facing. The size of our EHC plan cohort increased by 43% from Jan 2019 to Jan 2024 and a further 13% to Jan 2025. |
| 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. |
| 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. |

| 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<br>• 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<br>• 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<br>• 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 additional treatments have been added to support the current mitigations (see 4,5,7,8 on next page) |
| 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)

| 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*<br><br>*New due date for achieving targets.* | | *GREEN because timeliness is improving 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 | 30/11/2025<br><br>*New milestone* | | AMBER. Backlog cases now below 40 so work can now take place to assess the impact. This will be complete for the next SVA Monitoring Report in the Autumn – hence amended milestone date. |
| 5 | 03.02 | SEND Sufficiency, Place Planning and Capital Programme | 5 Year SEND Sufficiency Analysis complete | Neil Hoskinson Director of Education | 01/12/2025<br><br>*New milestone for completed capital programme.* | | The strategy has been approved by Cabinet and a new Capital Programme aligning to this is being taken to Cabinet in November 2025. Therefore the milestone has been amended against this. |
| 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 is being explored to report key data. | Paul Crulley Operational Lead for Statutory SEND | 31/08/2025<br><br>*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 significant increase in complaints. |
| 7 | 03.01 | Wider Universal Offer to meet need for CYP with SEND before the end of Year 1. | The Early Years Strategy is agreed with inclusion as a key theme and a new Early Years SEND resource provision is being established. This will support early identification and support for SEND to reduce future levels of support needed . | Clare Thompson Head of Service Early Education | 01/10/2025<br><br>*Resource Provision to be in place* | | Capital work is taking place over the Summer to allow the resource base to open in September. |
| 8 | 03.01 | Area SEND Approach | The Team Around the SENDCo approach is now fully embedded and is being used to support all schools. However this treatment has been updated to an Area SEND approach. | Sam Caley Head of Inclusion | *01/05/2025*<br><br>*Area SEND trial completed.* | | SBC has the opportunity to receive a SEND grant that will be used to develop an Area SEND approach on a trial basis. This will include SENDCo triads. The trial will be complete by April 2026. |
| 9 | 03.01 | Recruitment and Retention Plan | Benchmarking has been carried out to look at the market for SEND staff and a new refreshed structure is being agreed that will be attractive to potential applicants. | Paul Crulley Operational Lead for Statutory SEND | *01/09/2025* | | A refreshed team structure has been developed and is now being costed / evaluation ready for a recruitment campaign. Therefore this is still on track. |

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** |

There has been a positive change since the last reporting period however budget pressure remains a high risk as number of homeless households continues to increase. The outlook has improved but not enough to change the score.
In Q1 we have continued to recruit to the Temporary Accommodation, Allocations and Homeless Teams attempting to fill BAU and Backlog roles. As of Q1, 9 roles remain un-filled however projects to deal with the radical overhaul of **data** backlogs, improved **commercial** arrangements with TA providers and extensive property **compliance** checks have started and are making good progress.

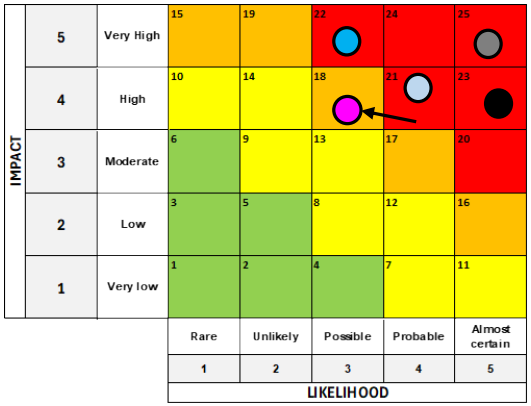
- Current risk score is reduced to 23 due to sub-risk 2 (budget) being mitigated but sub-risk 4 (staffing) continuing to be very high.
- Un-scheduled uploads of rent accounts in late December 2024 and February 2025 increased budget pressure by £4m but intensive work by the TA backlog team and the Income Recovery Team has reduced overall debt to below £10m from £12m in Q2 2024/2025.
- The savings plans put forward after the project room activity in October 2024 is being monitored closely but continues to be reliant on:
  - Capability of staff and difficulty recruiting and retaining workforce. 100% of the TA team remains interim.
  - A continuing lack of reliable quality data to inform business decisions.
- PwC were commissioned to undertake a forensic analysis of invoice vs cost data at the start of May 2025. At the end of Q1, analysis is still ongoing but some further data inconsistencies have been identified.
- Challenges SBC face around homelessness given our location, socio economic make up and housing market in which we operate remain.
- The statutory and regulatory requirements that ensure the safety and wellbeing of the occupants are being addressed by the new compliance officers.
- The new Director has developed an improvement plan to cover the risks identified at corporate and operational level.

. The new Head of TA and Allocations (Janet Weekes) started end of Q1, replacing Mitch Powell.

## 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 (over 50% of TA stock)..<br>• Private Lease Agreement and Private Licence Agreements for improved negotiations and possible cost efficiencies are now in place and being issued out to providers. 18 transfers to better value accommodation has estimated annual saving of c. £435k.<br>• Project to enter long term leases for 25 homes that will save £1.1m p.a. was tarted.<br>• Out of borough placements policy implemented.<br>• Action plan to re-negotiate with TA providers 50% completed. 65 of 65 providers contacted by end April 2025. Intensive activit y to gather compliance and other commercial documents on-going.<br>**There has been a positive change since the last reporting period i.e. the second quarter in a row. but not enough to change the overall score** |
| 04.02 | ● | Budget Pressure (Cost > Income) | Director of Housing (Lisa Keating / Dave McNamara) | ↑ | • The number of homeless households has increased in the quarter by 102 to 1,666, with 1,302 placed in TA, a reduction of 64 placements.<br>• The budget (spend) for 2025/26 has been more accurately calculated and is aligned with likely demand. Critically, the Council now understands that spend should be off-set by income (via Housing Benefit) and as such the forecast budget pressure is reduced to £4.72m compared to over £10m in Q3 2024/25.<br>• The forecast actual spend at P3 is £35.6m with income forecast of £30.8m.<br>**There has been a positive change since the last reporting period i.e. the second quarter in a row. but not enough to change the overall score.** |

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

## 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) | | • Recruitment of dedicated resource has enabled a 100% desktop review of statutory compliance matters.<br>• Physical inspections of TA, B&B and HMO accommodation is approximately 20% complete .<br>• Planned decant of families from noncompliant properties (c. 300 properties – UNO and Aptus are main non-compliant provider)<br>• 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.<br>• Further independent health check of TA remains a recommendation.<br><br>**There has been positive improvement in Compliance although good progress is being made in developing the solution. The outlook has improved enough to change the overall score from 21 to 18.** |
| 04.04 | | Attraction and retention of talent | Director of Housing (Lisa Keating / Bal Toor) | | • In Q1, the Head of Service left (for perm position in another Borough), replaced with new HoS end of Q1. 4 new front-line officers joined.<br>• In Q1, the internal SBC recruitment process delayed the recruitment of remaining staff. Alternative solutions being sought.<br>• 100% of TA team remains interim – no permanent members of staff.<br>• TA Backlog team (6.5 staff) has 5.5. in post.<br>• Business case to recruit HSG Demand backlog team approved – 11 roles to be recruited to.<br>• Continued investigation into on-going fraud matters. Deep dive with external expert support has been initiated. Likely to impact on staff retention issues.<br><br>**There has been a small improvement in recruitment and retention of the workforce. Although backlog recruitment is going well for TA, BAU recruitment is in progress with rolling adverts out and previous quality of candidates contributed to the time taken to continue to attract and onboard talent at pace. Shortlisting and interviews are planned over the next two weeks. The structure of the workforce to deliver TA including a review of the recruitment and retention of talent will be undertaken in Q2** |
| 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.<br>• Limited capacity to manage households in accommodation and move them on to permanent affordable accommodation increasing risk to homeless households<br>• New Commercial Manager in post from April 2025 – making excellent progress in gathering compliance certification and renegotiating commercial arrangements.<br>• Lack of ICT system significantly hampers the pro-active management of providers. Checks and balances are reliant on manual reviews and interventions.<br><br>**There has been improvement in Q1 but the overall outlook remains stable. A dedicated commercial manager has been appointed and top 65 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 compliant by October 2025<br><br>(Established Hotel Accommodation to be exempt) | 15% | 75% | |
| KRI 2– Staff | Permanent recruitment of TA team | 90% of Team to be permanent employees by April 2026 | 0% | 12.7% | |
| 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% reconciliation by April 2026 | 75% | 55% 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<br><br>(accepted that HB does not cover all rent charges and residents have to pay their own contribution) | 55% | 85% | |

| 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<br>• 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<br>• 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<br>• 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 of TA | Agreements with current providers, negotiations with new providers,, long term leases, procurement of market properties. | Head of Service (Janet Weekes) | Needs Improvement | The controls are improved due to a dedicated resource who will embed further control measures as part of a wider strategy. This will look at negotiating lower rates, procuring and managing good quality, affordable and compliant TA with effective long term leases. The effectiveness of this control description will continue to improve when a) Legacy issues are concluded, b) The acquisition strategy is embedded, c) ICT solution (PSL and DPS) is in place and d) the current structure is in place to deliver this e) we have an Approved list of Providers who can support with increasing affordable and good quality TA |
| 2 | 2 | Budget setting and control | Checking that budget reflects cost of TA vs income from HB. | Head of Service (Janet Weekes) | Needs Improvement | Weekly team meeting and monthly senior management meetings to track costs and income. Control measure would be more effective with a) increased resource b) jigsaw / NEC / Agresso integration and c) increased supply of cheaper accommodation. |
| 3 | 2 | TA resource, budget setting and control | Ensuring budget for resources is aligned to scale of the risk | Head of Service (Janet Weekes) | Needs Improvement | Budget setting as part of Corporate Budget has improved and now involves 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 (Janet Weekes) | Needs Improvement | Measures have improved with recruitment of compliance officers and a new SharePoint solution. However, still at risk as no ICT system, high staff turnover, 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 (Janet Weekes) | 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 (Janet Weekes) | 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<br>• 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<br>• 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<br>• 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 checks onshortlisting and nominations. | Head of Service (Janet Weekes) | Needs Improvement | The meetings happen and clarity on 60% nominations to TA but not enough HRA homes to significantly reduce TA demand. The Social Lettings Team were disbanded leaving a gap in procuring and securing PRS properties to discharge duty and reduce households in TA and manage TA demand at the front door. A full review of the allocations policy and process is underway and will be concluded by end of Q4 2025/26. As part of the TOM, the structure of team to manage and deliver TA and allocations will assist with future improvement. |
| 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 (Janet Weekes) | Largely Effective | The policy and process is now understood but not enough downsizing opportunities to significantly reduce TA Demand |
| 8 | 8 | Highly skilled staff and collaborative partnership | Increase the number of staff that are HHSRS (Housing Health and Safety Rating System) trained. In addition, increase collaborative working with Private Sector Housing & Enforcement Team, Fire Brigade and NRLA to enable this control measure to be delivered at pace. | Head of Service (Janet Weekes) | NEW | By increasing the number of staff trained in HHSRS SBC will increase the provision and quality of safe temporary accommodation. |
| 9 | 9 | Establish Partnership arrangements to support with providing safe TA | Increase collaborative working with Private Sector Housing & Enforcement Team, Fire Brigade and NRLA | Head of Service (Janet Weekes) | NEW | By establishing and embedding partnership arrangements this will enable this control measure to be delivered at pace. |
| | | | | | | |

| 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 | Recruitment | Immediately fill vacant posts with interim placement (due to recruitment freeze). | Head of Service (Janet Weekes | September 2025 | | Proactively advertising and interviewing for new staff. Availability and capability is challenging. Held up by internal HR process. Not advertised until mid-June 2025. |
| 11 | 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 (Fola Akinsowon) | October 2025 | | New Government Funding announced, team is planning resource to increase prevention activity. Early intervention and prevention team structure agreed. Recruitment starting. |
| 12 | 5 | Systems & Reporting | Engage ICT project team to continue system implementations, integrations and Power BI reporting Suite | Head of Service (Janet Weekes | October 2025 | | Business Case re. funding for the team still to be agreed. |
| 13 | 5 | Policy | Allocations, TA acquisition, Out of Borough Placement to be reviewed | Head of Service (Janet Weekes | March 2026 | | A full review of all policies was completed for RSH inspection in April 2025. New Head of Service recruited so delay in starting the policy review. |
| 14 | 5 | Procedures | As is and To be procedures to be mapped and new processes implemented. | Head of Service (Janet Weekes) | September 2025 | | Approx. 30% of processes mapped as part of the TA project room. Transformation team changes / resource capacity issues to finalise and implement new processes has held up the action. |

Target Risk Score – *21* by end of date *10/2026*

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

## Risk owner: Bal Toor

### Corporate risk overview

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

RAG status: Overall status has moved to AMBER 18 because SR 5.01 is being addressed through several actions.

The HR function has concluded its restructure which will see 7 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.

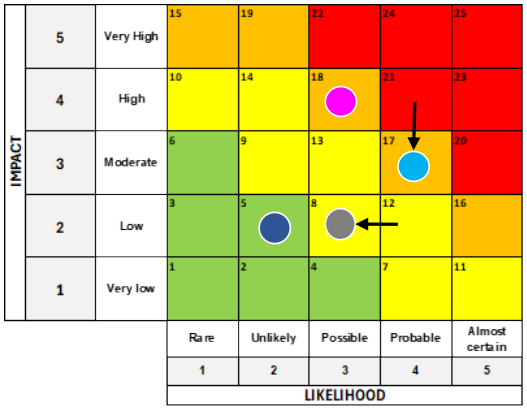
Market conditions do not assist HR in attracting permanent talent for critical roles and therefore we remain reliant on interims for parts of our delivery SBC competes with local London Borough pay scales which means we often lose our staff to neighbouring councils, therefore we have an issue with attracting and in some instances maintaining our talent pool.

### 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; however the mitigating actions are now focused on improving declarations so that we can improve our actions to be targeted on which areas on diversity at senior levels require strengthening. In addition the revamp of the recruitment framework will support diverse candidates applying to SBC. |
| 05.02 | | We fail to identify, develop and embed the capabilities and competencies we need in our workforce | Bal Toor | | We have worked with our Line Managers to relaunch the annual development scheme, which is grounded in areas they wished to develop. In tandem, we in the final stages of confirming our Career Pathways so all staff have generic learning options. Our drive for managers to use Cornerstone to capture all 1:1s also allows manager to discuss skills staff have identified. |
| 05.03 | | We fail to maintain an energised and engaged workforce | Bal Toor | | We are awaiting the results of the People Poll pulse check which should indicate whether our recent focus on culture has impacted employee engagement. |
| 05.04 | | We fail to keep our turnover in line with a national average of 10% | Bal Toor | | 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%<br>Amber Low 3-7% High 12-14%<br>Green 7-12% | 11.9% (end Sep 24)<br>10.0% (end Mar 25)<br>9.7% (end Jun 25) | |
| KRI 2 | Number of working days lost due to sickness absence per FTE employee | In line with CS average. | Red >90 days overdue<br>Amber 1-90 days overdue<br>Green not due / due & on track | 8.1% Green<br>9.6 days/FTE (end Mar 25)<br>9.3 days/FTE (end Jun 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)<br>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 | 25.6% | 17% | Due to an adjustment in reporting on 7 mandatory modules not 6, this has lowered the completion rate. |

| 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<br>• 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<br>• 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<br>• 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. Whilst take up remain low, we are partnering EDs with information on managers that need to use the 121 system. |

| 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 | 9 month project from Dec-Oct 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 which is now complete. We have now shifted our focus to revamping the framework for line managers to use when designing and advertising roles consistently. The second stage will be reviewing how we interview, moderate and offer roles consistently. |

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 |

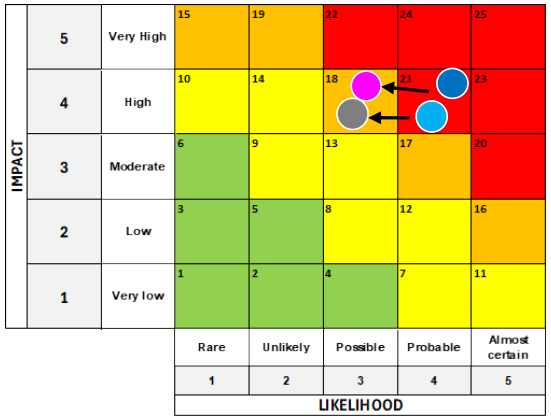
The overall risk score has stayed the same for this quarter, irrespective of the improvements and implementation we have made during Q1 to lone working, fire risk assessments and Codes Of Practice reviews, because there has been no improvement on data collation and training requirements. We aim to address this during Q3. It should be noted that **SR06.02 & SR06.03** have moved from **red to amber** this quarter and overall, the risk is trending in the right direction.
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. However, these are being addressed in Q2 and continue to be addressed in Q3.
The threat 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 – means that the overall risk score remains at **21.** These are ALL being addressed in a systematic and controlled manner, which will result in the reduction of the risk score from Q3, which will be a permanent, stable improvement.
The current, elevated score is due to a lack of resources, lack of concrete evidenced based material and a lack of data to interrogate. However, from Q3 of 2025 we are addressing these issues and have made significant progress in most fields within H&S at SBC.
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 11 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 | | The risk score has moved from **21 to 18** this quarter with an improving outlook.<br>Fire Risk assessments are scrutinized as to quality and content and, actions deriving are prioritized, budgeted and forecast effectively. This is now a standardised, monthly activity. |
| 06.03 | | We fail to prioritise, adequately fund or manage risks associated with aggressive behaviour | Craig Hill | | The risk score has moved from **21 to 18** this quarter with an improving outlook.<br>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 engage with legally required staff training, policy and codes of practice improvements. | Craig Hill | | Currently, both internal H&S Operative resource & externally commissioned assistance are under Business Case to mitigate and assist this key shortfall. Key training modules and all Codes Of Practice to be kept up to date, relevant and cover legal requirements. |

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

## Key Risk Indicators (KRIs)

| KRI | KRI explanation | Tolerance/Threshold | Previous qtr. status | Current qtr. status | Trend |
|---|---|---|---|---|---|
| **KR 1** | Reported Accidents/Incidents | **80** | **30** | **39** |  |
| **KRI 2** | Reported RIDDOR Incidents | **1** | **0** | **0** |  |
| **KRI 3** | Completed Fire Risk Assessments | **4** | **25** | **0 (all FRA's completed in Q1)** |  |
| **KRI 4** | Weekly/Monthly Routine Personal Safety Device Checks | **100** | **150** | **155** |  |
| **KRI 5** | Emergency Personal Safety Device Activations (Red/Amber alerts) | **8** | **2** | **2** |  |
| **KRI 6** | Health and Safety Training Completed | **?** | **0** | **0** |  |
| **KRI 7** | Health and Safety Policies Reviewed and Completed | **7** | **1** | **8** |  |
| **KRI 8** | Health and Safety Staff Levels and Attrition | **2** | **2** | **2** |  |

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

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

| Control Effectiveness | Description |
|---|---|
| **Effective** | • Controls and or/ management activities properly designed and operating as intended<br>• 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<br>• 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<br>• 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. A new, improved system of data collation is being devised internally. |
| **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 | Largely Effective | 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 |
|---|---|
| **Effective** | • Controls and or/ management activities properly designed and operating as intended<br>• 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<br>• 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<br>• 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 |
|---|---|---|---|---|---|---|
| **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 | Needs Improvement | 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/mitigation plans (funded actions that will manage/reduce the risk level)

| Ref | Sub risk ref | Action title | Action details | Action owner | Action due date | Action plan status | Status update |
|---|---|---|---|---|---|---|---|
| 1 | **SR06.01** | 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 | | Security assessments for The Curve and Observatory House now completed and measures are in effect. Coupled with Lone Worker and Personal Protection devices and updated protocols for unreasonable behaviour. |
| 7 | **SR06.04** | Training Level audit & analysis (Elearning & 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. |

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

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

| Ref | Sub risk ref | Action title | Action details | Action owner | Action due date | Action plan status | Status update |
|---|---|---|---|---|---|---|---|
| | **SR06.04 – 0.2** | Risk Assessment audit & analysis | Task (H&S Committee & Comms) Departments with RAMS review, advise, guide and assist. | Craig Hill/ Shameem Din | 01.10.25 | | Yet to begin at point of writing. |
| | **SR06.04 – 0.3** | Policies & Procedures audit & analysis. | Thorough internal commission – review and revise current Policies, Procedures/COP's | Craig Hill/ Shameem Dil | 31.03.26 | | Project underway as of 12.05.25. Some work already underway (H&S Policy completed). The plan is to review and authorise at least 3 x COP's per quarter, per annum |

Target Risk Score – **18** by end of date: ***10/25***

# CR07 Insufficient Operational Resilience and Crisis Management

**Risk owner: Tessa Lindfield**

## Corporate risk overview

| | |
|---|---|
| **Current Risk Score 4 Impact 4 Likelihood** | **21** |
| **Target Risk Score 4 Impact 3 Likelihood** | **18** |

Improvements across nearly all sub-risks indicating risks is moving in the right direction. However, significant challenges remain that limit potential risk reductions.

Incident response capabilities have improved through recruitment and development of responders for Incident Manager and LALO roles, increasing capacity in these areas and making up shortfalls created by in-quarter reductions as officers leave the council or resign from response positions due to other reasons. Recent incidents have tested some of these capabilities, particularly Golds, Incident Managers, LALOs and reporting arrangements, increasing confidence in incident response arrangements.

Emergency Operations Centre improvements are well underway, with the completion of the Emergency Operations Centre expected by October. Silver Commander training has been scheduled for September, with an expected incorporation of Silvers into the command structure by October. This will facilitate a series of incident management exercises for Gold, Silver and Bronze responders.

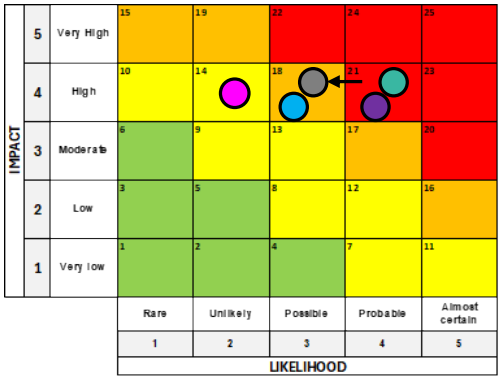
The establishment of the Corporate Resilience Group in July, with excellent cross-departmental engagement provides the framework for risk identification, organisational resilience and emergency planning, with direct governance through reporting to Assurance CLT.

Business Continuity continues to be an area of poor performance. A review of Business Continuity arrangements in the Council has revealed a lack of structure, a weak programme and absence of relevant, current and practical business continuity arrangements at any level.

## 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 |
|---|---|---|---|---|---|
| SR07.01 | | Inadequate rapid emergency response capabilities to provide immediate incident co-ordination and humanitarian support to affected residents | Laura Robertson | | Further increase in the number of trained LALOs, Incident Loggists and Incident Managers. Loss of some operational volunteer responders due to leaving the council or changes in working arrangements. Challenges remain in recruiting volunteer responders particularly for humanitarian response. |
| SR07.02 | | Failure of emergency planning for specific major hazard risks in the borough, such as flooding, major fires, industrial accident etc. | Laura Robertson | | An early Borough Risk and Hazard Register has been started to capture known risks and locations. Audit of existing plans reveals few practicable plans in place. New Corporate Resilience Board established as a key building block for organisational resilience, risk identification and planning. |
| SR07.03 | | 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, phase 1 complete – improvement works underway. Silver training booked. |
| SR07.04 | | Lack of BCP's for all services responsible for delivering business critical activities | Laura Robertson | | Review of Business Continuity complete. Business Impact Assessment template complete and being trialled via Adults services. Assessing options for redeveloping programme and acquiring additional resource. Greater alignment of BC to business planning, and Risk Management processes. |
| SR07.05 | | Inadequate resilience 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: Tessa Lindfield |
|---|---|---|

## Key Risk Indicators (KRIs)

| KRI | KRI explanation | Tolerance/Threshold | Previous qtr. status | Current qtr. status | Trend | Comments |
|---|---|---|---|---|---|---|
| KRI1 | Number of Trained Gold Commanders on rota 24/7/365 | Minimum 6 (8) | 5 | 7 |  | 2 Golds added to rota following training |
| KRI2 | Number of trained Silver Commanders on rota 24/7/365 | Minimum 6 (8) | 0 | 0 |  | Silver training scheduled for September |
| KRI3 | Number of trained Incident Managers on rota (new, in development) 24/7/365 | Minimum 6 (8) | 8 | 7 |  | 1 resigned due to changes in working arrangements. |
| KRI4 | Number of trained Local Authority Liaison Officers (LALOs) on rota 24/7/365 | Minimum 6 (8) | 6 | 5 |  | 1 resigned due to leaving council. 1 resigned due to changes in working arrangements |
| KRI5 | Number of training Rest Centre Managers on rota 24/7/365 | Minimum 6 (8) | 0 | 0 |  | No new volunteers received despite volunteer campaign |
| KRI6 | Number of trained informal volunteer responders | (Min 40) | 0 | 0 |  | 2 new volunteers identified for training. Poor uptake on volunteer campaign and promotions. |
| KRI7 | Number of trained Decision Loggists | Minimum 6 (8) | 6 | 6 |  | No change |
| KRI8 | Number of officers attending training of all types | All officers attend minimum of 1 training session and 1 exercise per year | 20 | 40 |  | Large increase in training provision, particularly for potential LALOs and Incident Loggists. |
| KRI9 | Testing/exercising of major incident capabilities and arrangements | 1 major exercise per year | 0 | 0 |  | Gold ex planned for September |

| 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<br>• 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<br>• 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<br>• 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 Incident Management plan requires improvement. Plan is being re-written to make it more accessible and reflect changing response arrangements. New, simplified response structure. |
| 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. Additional resource required for Business Continuity. |
| 3 | CR07.1 | Stand-by response teams | Gold, Silver, Incident Managers, LALOs, Emergency Shelter Managers, volunteer responders, currently available | Director | Needs improvement | Silver Commanders training for all Directors and Heads of Service planned for September. No deployable emergency humanitarian response. |
| 5 | CR07.1,3 | Emergency Operations Centre | Facility to co-ordinate the Council's response to major incidents | Director | Largely effective | Operations Centre had been moved to 1st floor and is operable. Improvement works 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 | Full audit of available equipment complete and additional requirements being identified. No trained staff. No evac centre plans. No Humanitarian Assistance Lead Officer. Priority for service in actions plans |
| 7 | CR07.5 | Risk identification | Identification and monitoring of potential corporate level business continuity risks | Director | Needs improvement | Risk Manager represents Corp Risk Register at Corporate Resilience Group. Initial Borough Risk and Hazard Register being developed. 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 | Ineffective | Review completed. Programme needs review to bring into line with standards. Business Continuity now aligning with both Business Planning and Risk Management. 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 | Ineffective | BIA template reviewed and being trialled. Existing service BIAs out of date, and few returns. Poor understanding of critical functions to inform planning priorities and service needs. Lack of capacity in driving programme. |
| 10 | CR07.4 | Service level Business Continuity Plans | Business Continuity Plans for all service detailing how services will maintain critical activities following disruption | Director | Ineffective | Few service level Business Continuity Plans exist; and where they do exist, plans are out of date, highly generic and offer little value. |

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

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

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

| Ref | Sub risk ref | Control Ref | Action title | Action details | Action owner | Action due date | Action plan status | Status update |
|---|---|---|---|---|---|---|---|---|
| 3 | SR07.3 | 1 | 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 | 3 | Recruitment and training of responders | Recruitment of operational volunteers to deliver key incident response services | Laura Robertson / David McClory | May 2025 | A | Campaign underway via corp comms, intranet, all staff messaging, direct staff engagement. Poor volunteering rates so far. |
| 5 | SR07.1,2 | 3 | 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 | Sept 2025 | A | Training booked with UK Resilience Academy for September. Trainee booking to commence and of July. |
| 6 | SR07.1 | 3, 4 | 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 continuing at pace, particularly for Incident Managers, Decision Loggists and LALOs. New training designed and delivered. |
| 7 | SR07.1 | 3, 4 | 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. H&S risk assessments for response roles needed. |
| 8 | SR07.1,2,3 | 5 | Improvements to Emergency Operations Centre | Improvements to emergency control centre facilities, resources and systems | Laura Robertson / David McClory | Sept 2025 | G | First phase complete – moved to 1st floor, improvement works planned. Improvements under Phase 2 underway |
| 9 | SR07.2 | 7 | 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 | Borough Risks and Hazards register in early stages of development. |
| 12 | SR07.4 | 8 | 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 | A business case for additional resources to support business continuity programme underway. |
| 13 | SR07.4 | 9 | Development of Business Impact Analysis | Review and redevelopment of BIA process and template to bring into line with business planning, risk and BC best practice | Laura Robertson / David McClory | August 2025 | G | BIA template reviewed and redeveloped to meet programme needs. Being trialled with high-priority Adult Social Care service. |
| 14 | SR07.4,5 | 9, 10 | 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 | No change |
| 15 | SR07.4,5 | 9, 10 | 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 |
| 16 | SR07.5 | 10 | 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 |
| 17 | SR07.1 | 6 | Identification and planning for evacuations shelters | Identification of potential buildings with appropriate facilities to use as evacuation shelters | Laura Robertson / David McClory | August 2025 | A | *New* |
| 18 | SR07.1 | 6 | Identification of a Humanitarian Assistance Lead Officer | Nomination and training of an Exec Director to lead the humanitarian response to any major incident | Laura Robertson / David McClory | October 2025 | A | *New* |

# 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** |

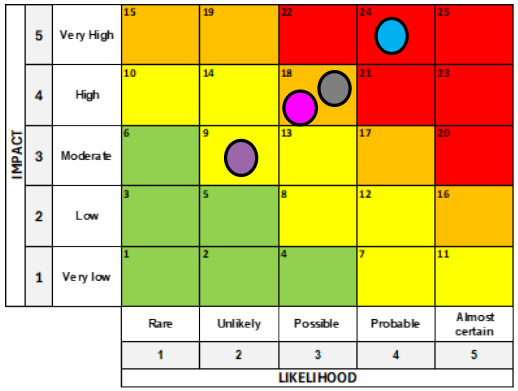
Updates are:-

- Disaster Recovery as a Service (DRaaS) and Backup as a Service (BaaS) implementation underway. M365 backups to the new BaaS now running. Backups for the on-premises systems to be completed by October 25.
- 6-month managed Security Operation Centre (SOC) pilot programme for a Security Incident Event Monitoring (SIEM) solution finishes at the end of July. The pilot was a success in protecting and alerting DDaT to cyber threats and incidents. To ensure the Council has continued security monitoring operations post July, a procurement exercise is underway to purchase an ongoing SOC/SIEM managed service.
- Submitted assessment for the next stage of the MHCLG Cyber Assessment Framework (CAF) for local government to assess and improve the Council's cyber resilience. Awaiting feedback and remediation recommendations.
- Completed the annual IT Healthcheck (ITHC) which included external and internal vulnerability scanning. A full report of findings and remediation actions have been provided. A project is being set up to manage and track the completion of the required actions.
- DDaT have enrolled slough.gov.uk internet presence with the Government Digital Service (GDS) Extended Monitoring Scheme to monitor and alert for any vulnerabilities so they can be quickly addressed.

## 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 lasting over 4 weeks | Colin Power | | Progress has been made this quarter with the following updates:<br>• DRaaS/ BaaS implementation underway.<br>• A procurement underway to purchase an ongoing SOC/SIEM managed service<br>• Submitted assessment for the next stage of the MHCLG CAF for local government<br>• Completed the annual ITHC<br>• Enrolment in the GDS Extended Monitoring Scheme<br>• PSN status classified as "Deferred" as agreed with Cabinet Office |
| 08.02 | | Lack of IT business continuity within DDaT and service areas causes significant service loss | Colin Power | | • DDaT members of the Corporate Resilience Group and attended the first meeting in July.<br>• DDaT Business Continuity Plan drafted and under review. |
| 08.03 | | An incident caused by hardware or software failure causes significant service loss | Colin Power | | • Support and maintenance in place for supported hardware & software<br>• Supported software receives security updates/patches from manufacturer<br>• Project underway to upgrade end user devices to Windows 11 before Windows 10 goes end of life in October 25. |
| 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<br>• New server and network hardware for Data Centre currently being installed. Completion dates expected October 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 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 (Information Security) | 90% | 79% completion rate<br><br>Based on 1074 completions against 1353 employees (279 overdue) | 86% |  |
| KRI 3 | Number of ICT incidents substantively impacting one or more services (hardware / software failure P1 major incident) | 1 | 3 | 4 |  |
| KRI 4 | Notifications of compromise / risk from the National Cyber Security Centre (NCSC) active cyber defence service (ACD) early warning service | 3 | 1 (Feb 25) | 0 |  |
| 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 | Q3 2025 | Q3 2025 |  |
| KRI 6 | Notification of vulnerabilities from Government Digital Service (GDS) Extended Monitoring Scheme | To be baselined | Active by Q3/4 | Active by Q3/4 | New KPI |

| 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<br>• 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<br>• 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<br>• 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<br>• Q3 internal vulnerability scanning scheduled for 19th July Completed annual IT Health Check<br>• Submitted assessment for the next stage of the MHCLG Cyber Assessment Framework (CAF) for local government<br>• A procurement underway to purchase an ongoing SOC/SIEM managed service<br>• 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.<br>• Cyber awareness now included in refreshed DDaT section in staff induction<br>• Refer to treatment action 5 |
| 3 | SR08.01 & SR08.02 | DDaT Business continuity planning | IT Business continuity and disaster recovery planning within DDaT | Colin Power | Needs improvement | • DRaaS/ BaaS implementation underway.<br>• DDaT Business Continuity Plan drafted and under review<br>• Refer to treatment action 4 |
| 4 | SR08.01 & SR08.02 | Service Area Business continuity planning | IT Business continuity and disaster recovery planning across the wider organisation | TBC | Needs improvement | • DDaT members of the Corporate Resilience Group and attended the first meeting in July.<br>• Refer to treatment action 5 |
| 5 | SR08.03 & SR08.04 | 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. |
| 6 | SR08.03 & SR08.04 | 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)

| 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 | March 2026 (Cabinet approval in Sept 25) | A | • There has been slippage in cabinet approval from July to September.<br>• 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 (Procurement to be completed by mid August) | G | • Pilot of a managed Security Operation Centre (SOC) using a cloud-based Security Event Management solution finishes mid August 25<br>• A procurement underway to purchase an ongoing SOC/SIEM managed service. |
| 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 | Implementation completed by November 2025 | G | • DRaaS/ BaaS implementation underway.<br>• Implementation expected to be completed by end of November 2025. |
| 4 | SR08.01 & SR08.02 | Completion of DDaT Business Continuity and Disaster Recovery Planning | Planning within the DDaT area so that the consequences of a cyber attack are factored into business continuity plans | Martin Chalmers | November 2025 | G | • DDaT Business Continuity Plan drafted and under review |
| 5 | SR08.01 & SR08.02 | Completion of Service Areas Business Continuity and Disaster Recovery Planning | Planning with Service Areas so that the consequences of cyber attack are factored into business continuity plans | TBC | TBC | A | • DDaT members of the Corporate Resilience Group and attended the first meeting in July. |
| 6 | 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 | • Increase in completion from last quarter<br>• Cyber awareness continues to be included in refreshed DDaT section in staff induction |
| 7 | 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. |

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

# 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.

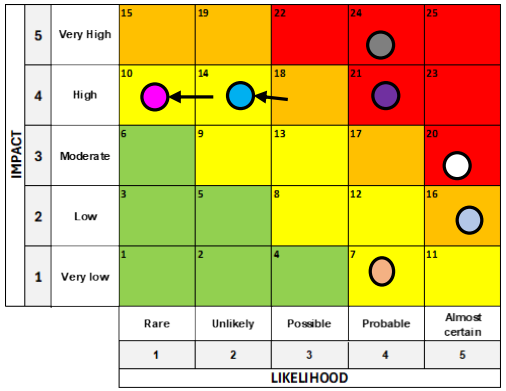
For 2026/27, the financial strategy will align with the corporate planning cycle with preparation work having commenced.

## 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



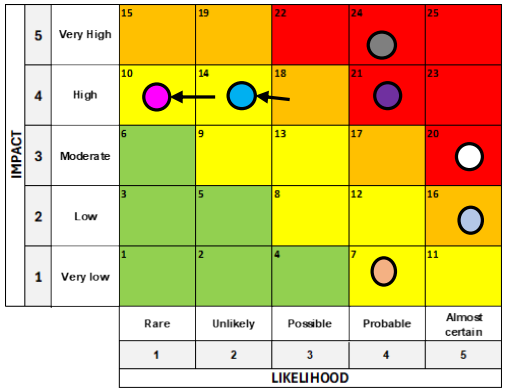

Refer to slide 8 for risk assessment score instructions

| 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 | | Position continues to be improving trajectory on delivery of SOAs, but impact on useable reserves (£14.75m) severely impacting on financial sustainability as accounts show worsening position. We have now prepared provisional 2023/24 accounts for presentation to A&CG Cttee in July. 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, and so prior to publication of draft accounts, and independent risk-based B/S review will be undertaken, along with discussions with MHCLG on option for additional EFS.<br>2024/25 draft Outturn almost complete for reporting to Cabinet in July and will continue to reflect a worsening financial position with likelihood of further call on useable reserves. Additional work required for 2023/24 has meant we will not be able to complete 24/25 draft accounts within prescribed deadline, with publication now scheduled for Q2 25/26, and external audit commencing during Q2. |
| 09.02 | | Failure to achieve a balanced budget and Medium Term Financial Strategy (MTFS) | Dave McNamara | | Balancing the 2024/25 Outturn is challenging and needs to be resolved; a range of actions are being pursued.<br>In terms of outlook, a refresh of the MTFS to Cabinet was presented in July 2025, which included impact of 2023/24 & 2024/25 accounts. The Budget gap is estimated to b e£20.520m with a sensitivity analysis of up to £36.967 m.<br>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 | | Q1 25/26 position reflects need to offset ongoing spend pressures and delays to asset sales. Liquidity threshold not breached since Q1 24/25, but likelihood that all external debt repaid during 2025/26 will need to be refinanced, with risk that external debt borrowing reductions, set out in treasury management strategy for 2025/26, not met. Improved cash forecasting means liquidity risk is being effectively 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 | | Failure to receive adequate Government funding formula/distribution to 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 | | Offers of appointment made – 2 Finance Directors (due to commenced September 2025)<br>Other senior roles. Senior Finance Manager 1 offer made. Finance Managers 4 offers made (2 internal). Finance Assistants 1 offer made. Next stage of recruitment campaign begun. Interims remain in situ to provide capacity. |
| 09.06 | | Failure to deliver the FIP which include internal controls, an effective finance system both through tech and business processes | Vicki Palazon | | Improving position with Project Initiation Documents development in progress. Q1 2025/26 assurance report discussed with leadership team for onward discussion at July 2025 Finance Improvement Board. Several reports have now been developed to support budget holders in undertaking their roles and responsibilities including reports to support corporate dashboards. System roles and responsibilities project commenced and due to complete end September 2025. Resource plan funding approved. |
| 09.07 | | Failure to deliver best value from procurement processes | Chris Holme | | Some improvement on compliance reflected by:<br>2025/26 Pipeline of procurement over £214k approved by Cabinet in April<br>CLT Compliance reporting from end Q1<br>Development of contracts register, with further improvements to processes during Q2<br>Restructure of team to be finalised during Q2 but some changes already made<br>Steps in train to ensure compliance with Procurement Act 2023, but procurement strategy still to be developed – draft due Q2.<br>Imbalance of requisite skills and qualifications within procurement team<br>There is a significant improvement programme in progress, but it is too early to be reflected in changes to the current risk score<br>Supplier failure a significant risk |



| 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 (DMcN) | *In year budget monitoringhighlights a pressure that can't be balanced* | Check performance measure | *Q4 position £8.8m pressure* | Q1 position yet to be finalised | Amber |
| KRI 2 (CH) | 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 (DMcN) | Data quality and MI is not improved to inform the financial forecasts | Data by Q2 | Data by Q2 | Data by Q2 | Data by Q2 |
| KRI 4 (CH) | *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 (CH) | Proportion of outstanding Internal Audit actions (Finance & Commercial) Legacy | Reduce by 30% from 23/24 Outturn | Q2 24/25 - | Q1 25 closed, 3 not due, 22 overdue of which 9 were closed in July 2025 | Amber |
| KRI 6 (CH) | 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 to 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 (VP) | Stability in workforce with a reduction in interims.<br>Training / CPD in place for permanent staff. All permanent staff completed an appraisal and training plan<br>Attrition rate | Reduction of 10% reliance on interims<br>100% appraisals / training plan in place | | All appraisals scheduled to be completed by end of April. Improving position on recruitment, next stage of campaign, however, interims to continue until end October 2025 for posts not yet recruited to. | Amber |
| KRI 8 (VP) | FIP remains on track, milestones achieved | On track or better | Amber | Q1 2025/26 assurance report improving | Green |

| 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<br>• 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<br>• 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<br>• 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 and final accounts. Team close to conclusion of draft accounts for2023/24, and will be published for public inspection during. Final accounts to follow in Q3. 24/25 Draft accounts expected to be published at end of Q2 with audit due to be completed Feb 2026.* |
| 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, Independent risk-based review to be conducted during Q2 prior to publication of draft accounts. |
| 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<br>• 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<br>• 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<br>• 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 HR issues 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 | Largely Effective | Reporting processes subject to internal audit found to be largely compliant with Cipfa COP, with improvements implemented from Q1 |
| 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 (cl 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 | Largely effective | FIP project 1 PID now approved - contains processes. Work also continuing on systen process improvements |

| 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<br>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 | 30/6/2025 | 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. |
| 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 (Paused) | 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 | 30/09/2025 | 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 | Projects moving to full project management with PIDs and Project work books |
| 8 | SR09.06 | Internal Control Framework | Create the project plan for Internal Controls (including Agresso system controls) | Vicki Palazon | 30/09/2025 | Green | Cost centre hierarchy and procurement approvals complete (now BAU management)<br>Roles and responsibilities system work now underway – due to complete 30/09 |

# 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.

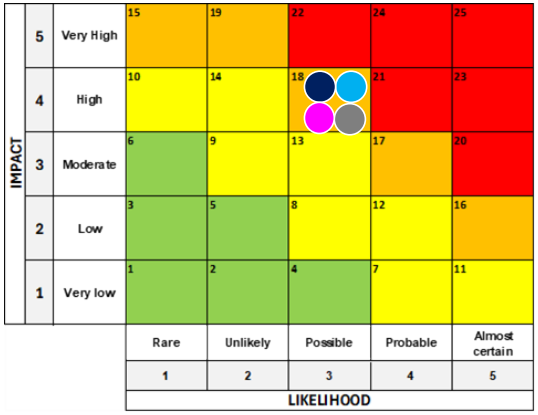
The 'total Sales Proceeds' baseline target approved by Cabinet is £38.968m, with the Treasury Management Strategy Statement 2025/26 Baseline being £37.900m. Though there have been adjustments in terms of the available property portfolio for disposal (both additions and omissions), total expected Sales Proceeds has increased during the previous quarter to £41.824m.

Since the onset of the adopted Disposals Program, £8.358m of sales have been generated versus a target of £12.812m (underperformance of 34.8%). This is due to Hatfield Car Park, SUR Wexham and Woodlands being in delay. Details as follows: Hatfield Car Park due to protracted negotiations, Woodland Avenue due to encroachment issues and SUR Wexham delay due to geotechnical issues,. There is confidence that most if not all of the foregoing can be recovered over time, however it is likely that this catch up will be negatively impacted due to a delay in Completion of SMP's Disposal.

## 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



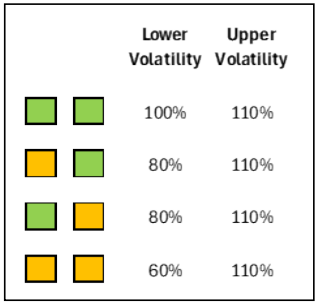

Refer to slide 7 for risk assessment score instructions

## 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 Sales Proceeds on track to be achieved or exceeded, however cashflow is slowing in FY25/26. Any Underperformance is being self-compensated by better Sales Proceeds |
| 10.02 | | Pace of disposals is behind programme deliverable dates | Ian Church | | Late receipt of proceeds from Q4 FY24/25 has now been fully recovered in Q1 FY25/26. This is unlikely to be fully recovered by YE. |
| 10.03 | | Attraction and Retention of quality people | Ian Church | | Two new HRA-focused Disposals Surveyors in place with strong improvements deal flow apparent. Transition from interim to permanent staff still to be implemented. |
| 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. |

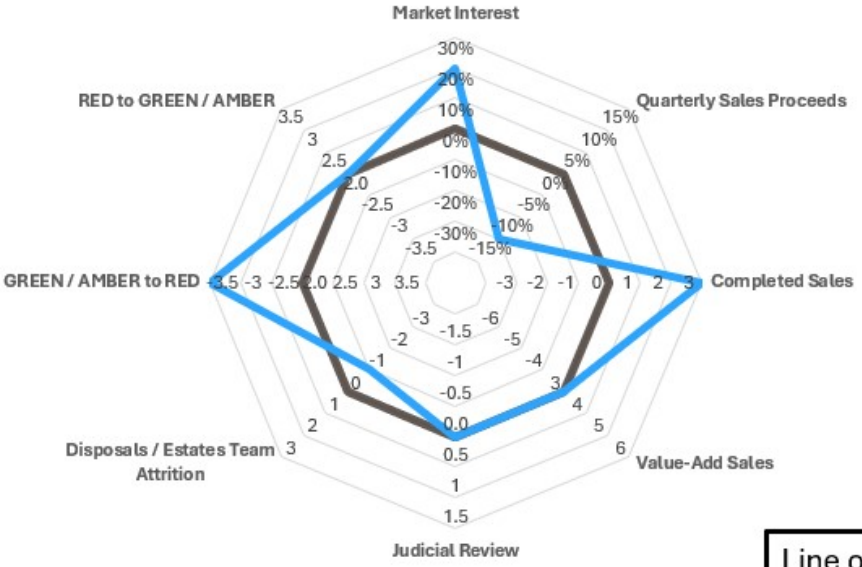
| CR11 | Failure of General Fund Asset Disposal Programme | Risk owner: Pat Hayes |
|---|---|---|

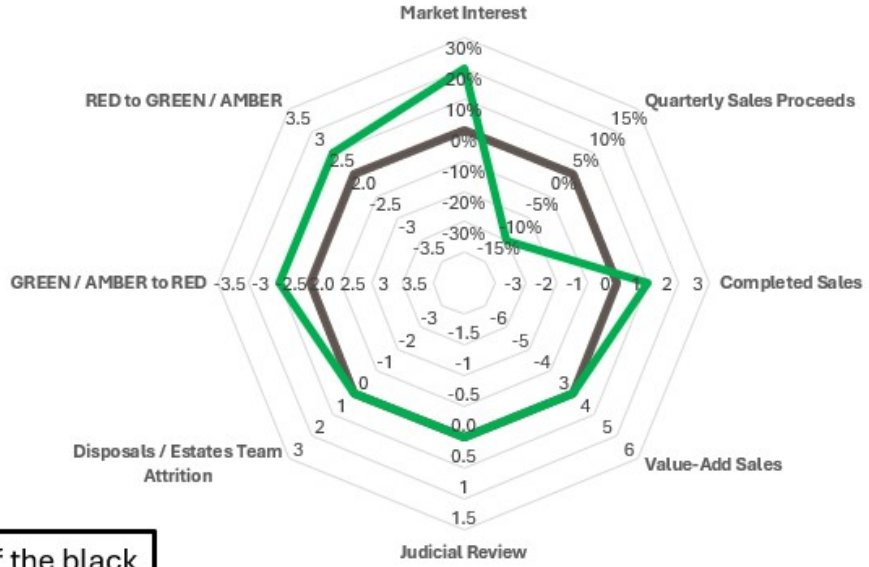
## Key Risk Indicators (KRIs)

| 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.<br>  | **FY 24 / 25**<br>Achieved Sales : £ 8.358m<br><br>**FY 25 / 26**<br>Target Sales : £ 22.1m<br>Lower Threshold : £ 20.9m<br><br>**FY 26 / 27**<br>Target Sales : £ 14.5m<br>Lower Threshold : £ 10.5m | | | |
| Pace of Sales | The pace of sale drops below the anticipated plan | **FY 24 / 25**– 9 sales PA<br>**FY 25 / 26**– 21 sales PA<br>**FY 26 / 27**– 22 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<br>1 successful hearing / 2 years | | | |
| Team Attrition | An unplanned loss to the disposals team (either permanent or interim) | 10% unplanned loss per annum | | | |
| Green / Amber assets move to RED | Unforeseen circumstances mean that Sales Proceeds reduce due to properties planned for disposal move to RED due to force-majeure like issues. | 2 demotions per quarter | | | |
| Commercial Interest | Ensuring that all active sales generate sufficient market interest to generate a competitive sales environment and 'deal tension' by generating significant EOI, bidders and BAFOs | At least 10 EOI per sale<br><br>At least five 5 Bidders / BAFO per sale | | | |
| | | | | | |
| | | | | | |

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

## Key Risk Indicators (KRIs)




Q1 FY25/26

Line outside of the black baseline shows over-performance

To_Date

| KPI | Baseline Definition | | | | | | | | Q3 24/25 | Q4 24/25 | Q1 25/26 | To_Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Market Interest | 10 EOI per sale / 5 Bidders or BAFO per sale | -30% | -20% | -10% | 0% | 10% | 20% | 30% | 20% | 20% | 20% | 20% |
| Quarterly Sales Proceeds | Sales Proceeds Target (less 2.5% costs) | -15% | -10% | -5% | 0% | 5% | 10% | 15% | -15.0% | -15.0% | -15% | -15.0% |
| Completed Sales | Approved Deal Flow as Disposals Programme | -3 | -2 | -1 | 0 | 1 | 2 | 3 | 0 | 0 | 3 | 1 |
| Value-Add Sales | Three per annum | -6 | -5 | -4 | 3 | 4 | 5 | 6 | 3 | 3 | 3 | 3 |
| Judicial Review | 1 permission / 6 months, 1 successful hearing / 2 years | -1.5 | -1 | -0.5 | 0.0 | 0.5 | 1 | 1.5 | 0.0 | 0.0 | 0.0 | 0.0 |
| Disposals / Estates Team Attrition | 10% unplanned losses per annum | -3 | -2 | -1 | 0 | 1 | 2 | 3 | 0 | 0 | -1 | 0 |
| GREEN / AMBER to RED | Two demotions per quarter | 3.5 | 3 | 2.5 | 2.0 | -2.5 | -3 | -3.5 | 2.0 | -3.5 | -3.5 | -2.5 |
| RED to GREEN / AMBER | Two promotions per annum | -3.5 | -3 | -2.5 | 2.0 | 2.5 | 3 | 3.5 | 2.5 | 3.5 | 2 | 2.5 |

| 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<br>• 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<br>• 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<br>• 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<br>• 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<br>• Preparation of quality bid materials and supporting docs<br>• Ensuring properties pitched to correct pool of purchasers | Ian Church | *Effective* | Sales Proceeds on track, however time to Complete needs improvement. |
| 3 | SR10.03 | Abortive Sales | • EY AADF framework in use as SBC internal gateway<br>• 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<br>• Monthly adjustment and refinement of programme | Ian Church | *Largely Effective* | |
| 5 | SR10.05 | Records | • Document register now better<br>• 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<br>• 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. Limited progress only. |
| 7 | SR10.07 | Protocol / Process | • Review ongoing approved processes being followed | Ian Church | *Needs Improvement* | Improving however additional time required to bed in. |

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

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

| Ref | Sub risk ref | Action title | Action details | Action owner | Action due date | Action plan status | Status update |
|---|---|---|---|---|---|---|---|
| 1 | SR11.03 | Abortive Sales | More rigorous use of EY AADF framework to support disposal process. Possibly arrange internal training by competent party to drive engagement. | Ian Church | *1. End Q1 FY 25 / 26* |  | Internal AADF training complete. |
| 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 Q1 FY 25 / 26* |  | Continuing to review progress, likely move to move to "Largely Effective" Q2 FY25/26? |
| 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 Q2 FY 25 / 26* |  | Flowchart now complete. Embed as corporate process by end Q2 FY25/26 |

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

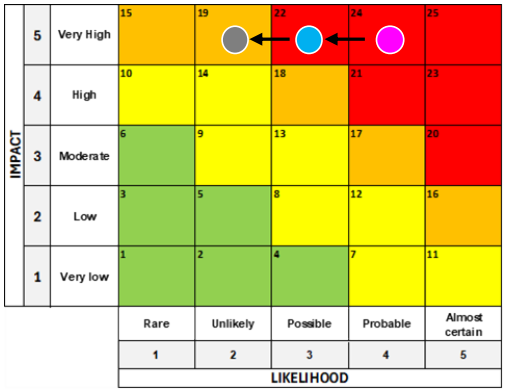
| | |
|---|---|
| Current Risk Score 5 Impact 4 Likelihood | 24 |
| Target Risk Score 4 Impact 3 Likelihood | 22 |

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 Q1 25/26.
Key updates for Q1:
Full Two year Improvement and Recovery Plan was adopted by March Cabinet and April Council
Full team has been mobilised across improvement and recovery and transformation programmes
Operating Model consultancy has been secured and work started late in Q1
Permanent Strategy and Performance and Programmes and Change Heads of Service were successfully recruited and have started
Transformation Programme has started – focusing on front door, adults, children

## 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 | | Upward because improvement plan is now in place along with transformation resource, but remain cautious. |
| 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: results expected by Sept 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 | | Reported to Best Value 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 | | A Transformation Plan is under development for October 2025 tied to MTFS. | |
| 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 | | 33 rated amber or green our of 48 as of July 25 | |

| 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<br>• 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<br>• 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<br>• Controls and or/ management activities are non-existent or have major deficiencies and don't operate as intended |

| Control Ref | Sub risk ref | Control Title | Control Description | Control owner | Control Effectiveness | Comments |
|---|---|---|---|---|---|---|
| 2 | SR1102 | Fail to operate as a Best Value Council | Improvement and recovery plan is aligned to best value guidance and adopted by Cabinet by January 2025 and sets out incremental steps to becoming a best value council which are programme managed. | Head of Programmes and Change | **Largely effective** | Improvement and Recovery workstreamss moblilised<br>KPIs for improvement and recovery including in corporate performance framework<br>Governance and control measures have been mobilised with monthly highlight reports<br>Resourcing mobilised<br>Scrutiny working group set up– to meet from September 2025- Feb 26 with forward plan agreed<br>Cost benefit impact asssessment under development |
| 3 | SR11.03 | Unable to deliver new operating model and medium-term financial strategy | Outline direction of travel for operating model setting out key features for future council | Director of Strategy, Change and Resident Engagement | **Needs improvement** | Work is needed to ensure comprehensive transformation programme is in place by October 2025 – with clear route map for delivery and review points |

| 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 | | Full Transformation Team mobilised but opportunities yet to be identified deadline is to have full plan in place by October 2025 |
| 2 | SR11.02 | Improvement and recovery plan review of workstreams and impact | Review of impact and reset of workstreams to ensure impact | Head of Programmes and Change | January 2026 | | Not started |
| 3 | 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 in place although need to be under review to ensure they are having the impact needed. |
| 4 | SR11.03 | Strategic partner identified to work on operating model | Strategic partners engaged by Q4 2024/25 | Director of Strategy, Change and Resident Engagement | March 2025 | | Partner on site- June 2025 |
| 5 | SR11.03 | Develop full implementation plan for operating model | Integrate operating model plans into transformation plan and identify resourcing needed | Director of Strategy, Change and Resident Engagement | October 2025 | | Not started |
| 5 | SR11.03 | Develop full transformation plan | A Transformation Plan aligned to corporate strategy, the MTFS and workforce plans, underpinned by a coherent invest to save plan. The plan should frame a more detailed refresh of the improvement and recovery plan in January 2026. | Director of Strategy, Change and Resident Engagement | October 2025 | | Not started |

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

# CR12 Failure to deliver adult social care market sustainability

**Risk owner: David Coleman-Groom**

## Corporate risk overview

| | | |
|---|---|---|
| **Current Risk Score 3 Impact 4 Likelihood** | **21** |
| **Target Risk Score 3 Impact 4 Likelihood** | **18** |

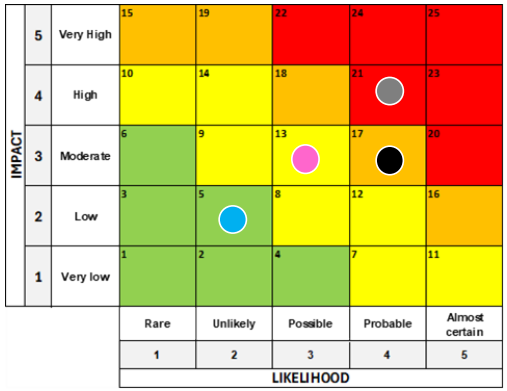
The risk is predominantly driven by funding availability in the context of the market pressures:

- Rising Costs: From increases to the National Living Wage and higher Employer National Insurance Contributions, as well as other inflationary pressures including energy costs, food and fuel
- A failure to address these pressures could result in provider failure and/or contract handback which would have impact on people who rely on care services, potentially disrupting
- Most providers operate on very slim margins, and smaller providers, which make up the vast majority of the market, are particularly vulnerable.
- While Provider Failure due to quality will always be a possibility the Quality Assurance Framework (QAF) and the work of the Provider Quality Assurance Team seeks to pre-empt quality concerns becoming significant leading to suspension

## 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) | | **Monthly reports presented to Commissioning and Market Management Board (CMMB) confirm sufficiency of supply across home care and care home markets. Some specialist provision sourced out of borough, but volumes of placements are low. New specialist provision coming on stream in Slough Autumn 25.** |
| 12.02 | | Cost of fee uplifts outstripping budget | Lynn Johnson (HOS) | | **Risk reserve established for discretionary fee uplift process 25/26. Current best case scenario estimated at £3.2m as uplifts for each provider not yet agreed by CLT. This represents cost avoidance of £1.2m. Risk of providers handing back contracts/serving notice assessed as high.** |
| 12.03 | | Provider failure | Lynn Johnson (HOS) | | **Provider Failure can be linked to quality and/or cost – i.e. provider going into administration or insolvency event. To pre empt quality concerns Provider Quality Assurance Team undertakes proactive visits to assure care quality of local providers. Monthly reports of care quality provided to CMMB, DLT and Care Governance Board. No provider failures linked to quality in Q1. Notice was served to terminate a contract due to a care provider's insolvency and alternative placements secured.** |
| 12.04 | | Recruitment and retention of external workforce | Lynn Johnson (HOS) | | **Ability to recruit and retain staff is linked to rates we pay providers, who are facing significant cost pressures in relation to pay – increases in NLW/ERNIC. Providers in our local market have arrange of different terms and conditions. Vacancies are often filled by agency staff with higher costs as a consequence. Fair Pay Agreement impact will need to be better understood locally.** |

| CR12 | **Failure to deliver adult social care market sustainability** | Risk owner: David Coleman-Groom |
|---|---|---|

## Key Risk Indicators (KRIs)

| KRI | KRI explanation | Tolerance/Threshold | Previous qtr. status | Current qtr. status | Trend |
|---|---|---|---|---|---|
| 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 | Q4 24/25<br><br>Providers Suspended Due to Quality Concerns<br>2 x Care Homes<br>3 x Supported Living Providers<br>0 x Home Care Providers | Update Q1 25/26<br><br>Providers Suspended Due to Quality Concerns<br>2 x Care Homes<br>3 x Supported Living Providers<br>0 x Home Care Providers |  |
| KRI 2 – Contract handbacks | The number of contract hand backs on a monthly basis | 0 | Q4 24/25<br>0 Contract Handbacks | Update Q1 25/26<br>0 Contract Handbacks |  |

| CR12 | **Failure to deliver adult social care market sustainability** | 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<br>• 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<br>• 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<br>• 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 | 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 by individual provider are developed for Fee Uplift requests and are considered at DLT and CLT | Interim Head of Market Management (Lynn Johnson) | Effective | Assuring costs of placements using open book accounting and benchmarking tools 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, support and training identified for local providers<br><br>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 and training offers |
| 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 market |

| CR12 | **Failure to deliver adult social care market sustainability** | Risk owner: David Coleman-Groom |
|---|---|---|

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

| Ref | Sub risk ref | Action title | Action details | Action owner | Action due date | Action plan status | Status update |
|---|---|---|---|---|---|---|---|
| 1 | | 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 | Red | Recruitment paused due to changes proposed to ICBs and staffing reduction NHS Frimley ICB |
| 2 | | 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 Autumn 2025 |
| 3 | | 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 |

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 |

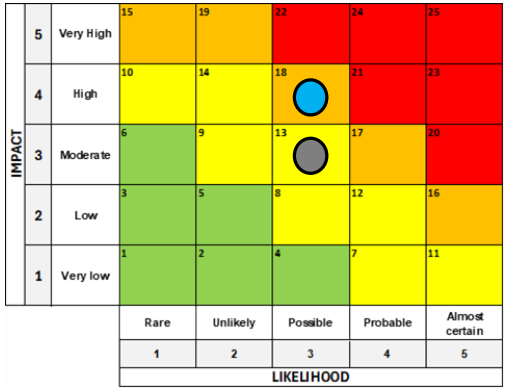
Updates are:

- GDPR training compliance increased to 86% this quarter. This continues to be monitored at the monthly IGG meetings for both SBC and SCF. 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 deliveredto 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 circulated and approved by IGG.
- Permanent recruitment to Information Governance Officer role completed. Michael Rowen started on 28th July 25. Now looking at the Information & Record Lead role to begin recruitment as part of DDaT restructure.
- 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.<br>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.<br>• The sub risk remains stable this quarter. Improvements have made in the increase of staff compliance in the mandatory training. awareness but a high turnover in staff remains challenging.<br>• Mandatory training compliance increased to 86% this quarter.<br>• 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.<br>• 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: 79%<br>SCF: No stats this quarter due to change in learning platform | SBC: 86%<br>SCF: No stats this quarter |  |
| 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 | 13 | 19 |  |
| 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 | 0 |  |
| 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 | 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<br>• 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<br>• 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<br>• Controls and or/ management activities are non-existent or have major deficiencies and don't operate as intended |

| Control Ref | Sub risk ref | Control Title | Control Description | Control owner | Control Effectiveness | Comments |
|---|---|---|---|---|---|---|
| 1 | SR13.01 | Training and communications | New staff are obliged to complete eLearning and an annual refresher course is also mandatory.<br><br>Awareness of data protection responsibilities boosted through emails and staff newsletter | Martin Chalmers | Largely effective | • Take up of training remains below target (90%). Improvements have been made this quarter to 86% (76% last quarter). There are no statistics for SCF this quarter.<br>• Awareness on GDPR sent in regular corporate communications as well as the corporate induction programme<br>• Engagement underway with the Learning & Development team to further drive up compliance.<br>• 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<br>• All GDPR policies are updated annually and approved by IGG.<br>• Subsequent actions will be monitored through the monthly IGG meetings. |
| 3 | SR13.01 | Resourcing | An Information Governance officer role in place | Martin Chalmers | Largely effective | • Permanent Information Governance Officer has now started (28th July). Now looking at the recruitment of the Information & Records Lead. |

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

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

| Ref | Sub risk ref | Action title | Action details | Action owner | Action due date | Action plan status | Status update |
|---|---|---|---|---|---|---|---|
| 1 | SR13.01 & SR13.02 | Mandatory training compliance | Improve compliance for GDPR training | Alex Cowen | October 2025 | 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 | • Sharepoint & Purview project to be reignited. Scope to include document retention policies and implementing Microsoft Purview<br>• Review of retention schedules underway. This will be completed to staff once completed. |
| 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 | G | • Implementation expected to be completed by end of November 2025. |
| 4 | SR13.01 | Resourcing | An Information & Records Lead role is currently being drafted with permanent recruitment to follow | Martin Chalmers | November 2025 | G | • Permanent Information Governance Officer has now started (28th July). Now looking at the recruitment of the Information & Records Lead. |
| 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 | G | • 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 5 Impact 4 Likelihood** **24**

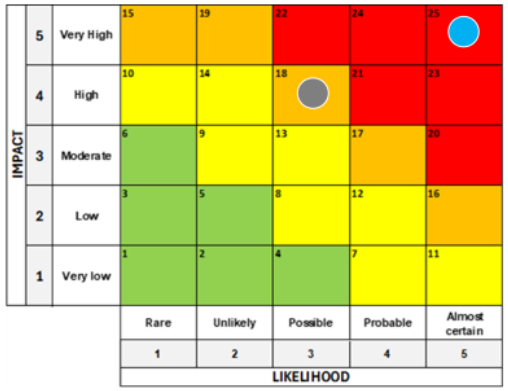
- Governance, oversight & financial council exposure as Shareholder across James Elliman Homes (JEH), and GRE5
- Risk that retained losses across the companies continue to be underwritten by the Council
- JEH 12-month Business case approved by cabinet on the 17th March 2025. Implementation is underway 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.
- Ownership of the corporate risk now being retained by Executive Director.
- GRE5 Sole remaining managing director has resigned, Active campaign to appoint 2 x director for GRE5.

### 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. | Pat Hayes | | 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. |

| 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<br>• 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<br>• 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<br>• 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 | | Board meetings | | | | |
| 3 | | Letter of assurance | | | | |
| 4 | | Business Plan | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | | | | | | |
| 10 | | | | | | |

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

NEW RISK – TO BE ADVISED