

Slough Borough Council

Report To:	Audit and Corporate Governance Committee
Date:	12 November 2025
Subject:	Corporate Risk Report Quarter 2
Chief Officer:	Ian O'Donnell, Executive Director Corporate Resources (s.151 Officer)
Contact Officer:	William Green, Interim Risk Manager
Ward(s):	All
Exempt:	No
Appendices:	Appendix 'A' – Q2 FY25/26 Corporate Risk Profile Appendix 'B' – Q2 FY25/26 Corporate Risk Dashboards (summary sheets) Appendix 'C' – Risk Management Strategy

1. Summary and Recommendations

1.1 This report sets out

- The status of the Council risk profile in the Q2 FY25/26 Corporate Risk Report.
- Breakdown of current Corporate Risks and Sub-Risks

Recommendations:

The Audit and Corporate Governance Committee is recommended to consider and

- i) Note the revised Corporate Risks and Sub-Risks as at Quarter 2 FY25/26 (October 2025).
- ii) Note the updated 2025 Risk Management Strategy.

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.
- 1.4 The Risk Management Strategy was updated as part of the biennial review process and this ensures that it remains aligned with the evolving international risk management standards and council needs.

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 for the council.

Background

2.2 To produce the Q2 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 20th October 2025 and after review, it was signed off. The corporate risk report was then presented to the CLT on the 28th October.

2.3 The Q2 FY25/26 position is that the Council's risk exposure has remained stable this quarter, however the overall exposure remains elevated but is being actively managed within the resource constraints. Two risk scores have improved, and two risk scores have deteriorated. The majority of corporate risks are reported as being in a stable position, however risk scores still remain high driven in the main by financial related sub-risks. Again, this quarter no notable milestones were missed in respect of the delivery of identified treatment plans. Due to financial constraints some treatment plans have had to be revaluated, and delivery plans pushed out. Of the thirteen identified corporate risks, nine are rated as red (risk score between 20 – 25), and four are rated as amber (risk score between 15 – 19). This reduction in red risks from fourteen last quarter is due to the removal of CR11 which was reported to the committee on 10th September. The corporate risks continue to improve their control environments which is resulting in a more stable outlook for the future, however our current financial position may result in our risk profile deteriorating as we are unable to deliver treatment plans within their identified delivery timescales.

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

Q2 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.

Q2 FY25/26 Corporate Risk and Sub-Risk Summary

	Score change & outlook change
	Outlook change, No score change

CR ref.	Corporate Risk - Sub-Risk	Impact Score	Likelihood score	Current Score	Target Score	Prev. Qtr Score	Score movement/ Outlook last quarter
CR01	Failure to Safeguard Children and Young People	4	4	21	18	18	↓
	SR01.01: Insufficient financial resources	4	4	21		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	23	→
	SR02.01: Inability to meet savings	4	5	23		23	→
	SR02.02: Inability to meet increase in demand	4	3	18		18	→
	SR02.03: Attraction & retention of talent	3	3	13		13	↑
	SR02.04: Inability to carry out statutory annual reviews in clients with a Mental Health need	4	3	18		NEW	NEW
CR03	Failure of Special Educational Needs and Disability (SEND)	4	4	21	21	21	→
	SR03.01: Failure to provide timely SEND support	3	3	13		13	↑
	SR03.02: Non-receipt of Safety Valve Agreement payments	4	4	21		21	↓
	SR03.03: Financial and reputational damage from complaints	3	3	13		13	↑
	SR03.04: Inadequate inspection readiness	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 and Health & Safety Information	4	4	21		18	↓
	SR04.04: Attraction and retention of talent	4	5	23		23	→
	SR04.05: 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	18	→
	SR05.01: We fail to attract and recruit a diverse and inclusive workforce for senior manager and above.	3	4	17		17	→
	SR05.02: We fail to identify, develop and embed the capabilities and competencies we need in our workforce	2	3	8		8	→
	SR05.03: We fail to maintain an energised and engaged workforce	4	3	18		18	→
	SR05.04: We fail to keep our turnover in line with a national average of 10%	2	2	5		5	→
CR06	Health & Safety: We fail to prevent statutory obligations	4	3	18	18	21	↑
	SR06.01: We fail to prioritise adequately fund or manage risks associated with corporate health and safety	3	3	13		21	↑
	SR06.02: We fail to prioritise adequately fund or manage risks associated with fire	4	2	14		18	↑
	SR06.03: We fail to prioritise adequately fund or manage risks associated with aggressive behaviour	4	2	14		18	↑
	SR06.04: No resource to provide required staff training, policy and codes of practice improvements.	4	3	18		21	↑
	SR06.05: We fail to ensure adequate numbers of trained personnel within the Corporate Health and Safety Team	4	3	18		18	→
CR07	Insufficient Operational Resilience and Crisis Management	4	4	21	21	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 BCPs 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	24	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		14	↑
	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		10	↑
	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	4	21	18	18	↓
	SR10.01: Property disposals not hitting financial targets and sitting outside of lower volatility levels	3	3	13		18	↑
	SR10.02: Pace of disposals is behind programme deliverable dates	4	4	21		18	↓
	SR10.03: Attraction and Retention of quality people	3	3	13		18	↑
	SR10.04: External property market volatility	4	3	18		18	→
CR12	Failure to deliver adult social care market sustainability	3	4	17	18	21	↑
	SR12.01: Insufficient access to regulated services	2	2	5		5	→
	SR12.02: Cost of fee uplifts outstripping budget	3	4	17		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	24	25	→
	SR14.01: JEH - Failure of the company resulting in financial losses and reputational issues for the council.	5	5	25		25	→
	SR14.02: GRES - Failure of the company resulting in financial losses and reputational issues for the council.	3	3	13		13	↓

2.3 A synopsis of the above table is as follows:

At the closure of the Q2 FY25/26 risk dashboards, we have:

- 13 corporate risks (Q1 – 14 corporate risks) Broken down into:

- 9 RED risks (risk score between 20 – 25) – **Q1 - 10 RED (CR11 has been removed which was red)**
- 4 AMBER risks (risk score between 15 – 19) – **Q1 - 4 AMBER**
- 55 sub-risks across all corporate risks – **Q1 – 56**
 - 15 RED risks (risk score between 20 – 25) – **Q1 - 17**
 - 18 AMBER risks (risk score between 15 – 19) – **Q1 - 22**
 - 18 YELLOW risk (risk score 7 – 14) – **Q1 - 13**
 - 4 GREEN risks (risk score 1 – 6) – **Q1 - 4**
- 2 sub-risks have deteriorated in this quarter compared to 1 in Q1
- 6 sub-risks have improved in this quarter compared to 12 in Q1.

2.6 As the Councils maturity in respect of risk management improves this will ensure that we will continue to be in a better position to respond to our 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 within stable parameters this quarter, but the overall exposure remains elevated. Two risk scores have deteriorated, and two corporate risks have improved this quarter

2.2 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.

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

- CR01: (*Failure to Safeguard Children and Young People*) – the rating has moved this quarter from amber to red reflecting an above budget number of high-cost complex cases, increasing demand as well as an above budget pay settlement.
- CR02: (*Failure to meet demands on Adult Social Care within budget*) - the rating remains red with a stable sub-risk outlook. The key risk driving this rating is a forecast of a £6.7m overspend due to provider uplifts and demand related to new people/increase in need. Savings are being identified to try and reduce the overspend.
- CR03: (*Failure of Special Educational Needs and Disability (SEND)*) – the rating has remained red this quarter, reflecting ongoing high and increasing demand for SEND support that could lead to non-receipt of Safety Value Agreement payments.
- CR04: (*Failure to Provide Safe Temporary Accommodation within Budget*) – the risk remains red, however the signs of improvement in the sub-risks last quarter have now stabilised. The budget pressure on SR04.02 continues to drive this risk, linked to subsidy loss and arrears.
- CR07: (*Insufficient Operational Resilience and Crisis Management*) – the overall risk remains red. Improvements continue across nearly all sub-risks, however, significant challenges around BCP and resilience planning remain that limit potential risk score reductions.

- CR08: (*ICT incident, resulting in significant data and/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: (*Failure to achieve financial sustainability and a balanced MTFs*) – the risk remains red, driven by the sub-risk for the failure to achieve a balanced budget and Medium-Term Financial Strategy (MTFS) which is also showing a deteriorating position. New spending controls have been introduced.
- CR10: (*Failure of General Fund Asset Disposal Programme*) – This risk has moved from amber to red this quarter driven by the pace of disposals which is unlikely to be recovered before year end.
- CR14: (*Failure of Council Subsidiary Companies*) – This risk remains red and 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 has deteriorated this quarter.

There have been two deteriorating risks reported this quarter:

- CR01: (*Failure to Safeguard Children and Young People*) - The overall rating has increased from amber to red as SCF is facing unbudgeted costs including higher than expected pay settlement and more high-cost complex cases leading to a 2025/26 predicted year end overspend. This is being addressed through close financial management and liaison with SBC about an in-year budget review.
- CR10: (*Failure of General Fund Asset Disposal Programme*) - The overall rating has increased from amber to red as the pace of disposals is behind programme deliverable dates as well as late receipt of proceeds from Q4 FY24/25, although this has now been recovered in Q1 FY25/26, it is unlikely that disposals will hit their target by 2025/26-year end.

Two corporate risks improved this quarter:

- CR06: (*Health & Safety We fail to prevent physical injury or mental harm*) – The overall rating has decreased from red to amber due to the continued improvements and implementations made during Q1 and Q2 to lone working, fire risk assessments and Codes of Practice reviews.
- CR12: (*Failure to deliver adult social care market sustainability*) - The overall rating has decreased from red to amber due to funding of £2M being made available from risk reserve on a draw down basis which has eased the pressure on the budget from provider fee uplifts, as well as other inflationary pressures including energy costs, food and fuel.

2.4 As reported in the Q1 2025/26 Corporate Risk Report we had removed CR11- *Failure to become a best value council* as it was felt that it had too broad a remit. A replacement corporate risk has been proposed titled 'Failure of Internal Controls' and comprises 5 sub-risks:

- Fraud and Misappropriation
- Regulatory non-Compliance
- Inaccurate Management Information
- Change Management Failure

- Contract Management & Legal exposure

Further meetings are ongoing to ensure the proposed new corporate risk properly identifies relevant sub-risk exposures as well as designated sub-risk owners. This will then be presented to CLT before becoming adopted formally as a new corporate risk.

2.2 The updated Risk Management Strategy, which was last presented to this committee on the 22nd November 2023, is attached as a separate document in the pack to consider and note. The main differences are:

- Updated Policy, Framework and Guidance sections
- The introduction of Corporate Risk Dashboards including sub-risks
- Revised risk management programme (Risk assessment and tools)
- Governance structure

2.5A summary of the corporate risk profile is shown within Appendix A.

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

2.7 The Q2 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 (Q2 FY25/26)
(Target risk scores based on a 12-month timeline – October 2025)*

	CORPORATE RISK	CURRENT SCORE	TARGET SCORE	Score movement in quarter
CR01	Failure to Safeguard Children and Young People	21	18	↓
CR02	Failure to meet demands on Adult Social Care	23	18	→
CR03	Failure of Special Educational Needs and Disability (SEND)	21	21 Target met	→
CR04	Failure to Provide Safe Temporary Accommodation within Budget	25	21	→
CR05	Failure to Attract Retain & Engage with Our People	18	18 Target met	→
CR06	Health & Safety We fail to prevent physical injury or mental harm	18	18 Target met	↑
CR07	Insufficient Operational Resilience and Crisis Management	21	21 Target met	→
CR08	ICT incident resulting in significant data and/or service	24	24 Target met	→
CR09	Failure to achieve financial sustainability and a balanced MTF5	24	22	→
CR10	Failure of General Fund Asset Disposal Programme	21	18	↓
CR12	Failure to deliver adult social care market sustainability	17	18 Target met	↑
CR13	We fail to comply with GDPR data protection obligations	18	18 Target met	→
CR14	Failure of Council Subsidiary Companies	25	24	→

- 2.13 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. This document is part of the pack presented to this committee for noting, with a view to then present to Cabinet for final approval.
- 2.14 Members have differing roles and responsibilities in relation to risk. Cabinet members have responsibility to consider risk in relation to individual decisions and overall strategy. Scrutiny members have responsibility to consider risk when holding Cabinet and other parts of the Council to account on individual projects and functions. All elected members have a responsibility for ownership of risk by identifying, mitigating and regularly reviewing risk. This committee has a specific responsibility to provide independent assurance to the Council of the adequacy of the risk management framework and the internal control environment.

3. Implications of the Recommendation

3.1 Financial implications

- 3.1.1 This is a noting report updating Members on progress to date in improving risk management processes across the Council. There are no direct financial implications associated with the Q2 FY25/26 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 proactive 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

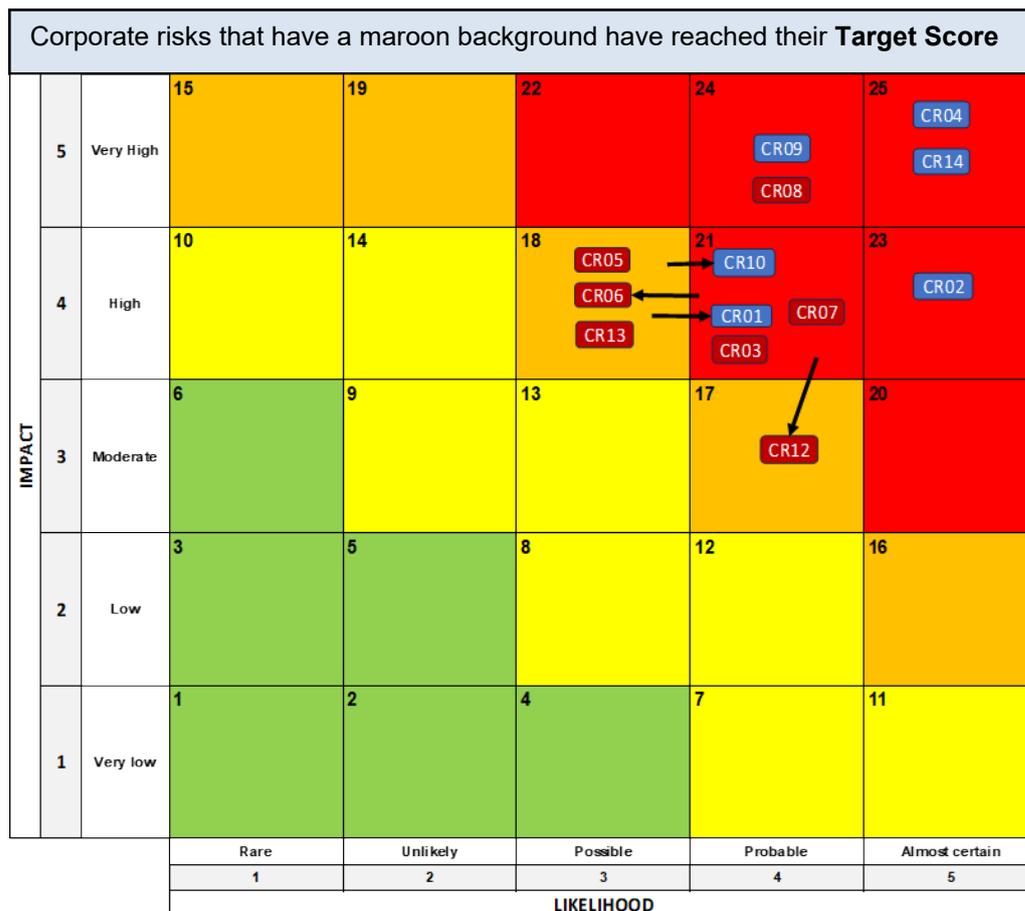
None

Appendix 'A' – Q2 FY2025/26 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 (Q2 FY2025/26)



Corporate Risk	Corporate Risk
CR01: Failure to Safeguard Children and Young People	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	CR12: Failure to deliver adult social care market sustainability
CR05: Failure to Attract Retain & Engage with Our People	CR13: We fail to comply with GDPR data protection obligations
CR06: Health & Safety We fail to prevent physical injury or mental harm	CR14: Failure of Council Subsidiary Companies
CR07: Insufficient Operational Resilience and Crisis Management	

Appendix 'B' – Q2 FY25/26 Corporate Risk Dashboards (summary sheets)

CR01 Failure to Safeguard Children and Young People Risk owner: Sue Butcher

Corporate risk overview

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

Risk score has moved from 18 to 21 (RAGRED) reflecting an above budget number of high-cost complex cases, increasing demand and an above budget pay settlement. Steps are in place to mitigate increased spend but an overspend against budget is still cast. SR01.05 remains at 17 despite a lot of foundational work is being done to improve data access however, until the data is more easily accessed the risk score is unchanged.

In relation to our staffing risk the current position is that caseloads per social worker are appropriate across all service areas, other than one where sickness has created pressures. Attracting permanent staff is also not a current risk reflecting work done over the past few years. Retention is an issue which is being monitored and reported on regularly, intervention strategies are implemented where required. The impact of a significant national change in how children's social services are delivered over the next 12 months is expected to have a further impact. Roles for current staff are being re-designed creating uncertainty. 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.

Sub risks related to this principal risk

Risk profile

Risk profile		LIKELIHOOD					Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
IMPACT		1	2	3	4	5						
5	Very High	15	19	22	24	25	01.01	●	Insufficient financial resources	SCF Director of Finance/ Resources (Alex P)	↓	SCF is facing unbudgeted costs including higher than expected pay settlement and more high cost complex cases leading to a 2025/26 predicted year end overspend. This is being addressed through close financial management and liaison with SBC about an in-year budget review.
4	High	10	14	18	21	23		●				
3	Moderate	6	9	13	17	20	01.02	●	Attraction and retention of qualified workforce	Head of HR (Kate McCorrison)	↓	In April 2026 there will be national changes in children's social work practice affecting most staff this raises the risk of staff seeking to move. Staff are feeling high levels of pressure: these changes coincide with an impending ILACs inspection and uncertainty about SCFs contract with SBC. SCF continues to attract a reasonable level of quality applicants for most roles.
2	Low	3	5	8	12	16	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. Sickness has increased caseloads within one service area which is being addressed.
1	Very low	1	2	4	7	11	01.04	●	Staff capability	Director of Operations (Ben Short)	↑	Training and development delivered consistently. Workforce development strategy rolled out. The Slough Academy has been externally reviewed to strengthen good practice. Performance dashboards being rolled out
							01.05	●	Data production does not support effective practice	SCF Director of Finance/ Resources (Alex P)	→	SCF is reliant on manual intervention to produce necessary reporting. There are several key IT systems from which it is 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 with a delivery date next financial year.

Refer to slide 7 for risk assessment score instructions

Key Risk Indicators (KRIs)



KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KR1	Quarterly and year end financial forecasts: expected variation from budget	£0	CE£629,000 overspend forecast for year end	Q2 figures not available yet	
KRI 2	Attraction and Retention of qualified workers: CLA with 2+ Social Workers in a year Average 12 month case holding Social Worker Turnover	0% -	50.8% 31%	50.8% 34%	
KRI 3	Caseload monitoring: Average caseload across the workforce, including non qualified Contact decisions within 1 day Re-Referrals Assessments completed in 45 days Child Protection Plan reviews (within 3 or 6 months as appropriate) ICPCs held in time (within 15 days of s47 start): CLA visits in time (within 12 weeks)	18 95% 22% 85% 95% 80% 90%	22.6 97.5% 23% 97.4% 99.1% 83.1% 92.3%	15.9 93.5% 29.6% 81.2% 100% 100% 89.3%	
KRI 4	Number of staff on performance management (formal and informal)	-	6	4	
KRI 5	Number of data dashboards desired but currently unable to deliver	-	16	16 (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)	

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

Control Effectiveness	Description
Effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating as intended Management is confident that the controls are effective and reliable
Largely effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating with opportunities for improvements identified
Needs improvement	<ul style="list-style-type: none"> Controls are only partially effective, require ongoing monitoring and may require redesigning, improving or supplementing Key controls and or/ management activities in place, with significant opportunities for improvement identified
Ineffective	<ul style="list-style-type: none"> Limited controls and or/ management activities in place
Weak	<ul style="list-style-type: none"> Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist Controls and or/ management activities are nonexistent 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 rolled out strategy needed. Some managers need to use Talos more efficiently.
3	SR3	Workloads	Regular reports to senior managers, monitoring of casework progress, reporting to Company Board and Improvement Board	Director of Operations	Largely Effective	Currently operating within expectations.
4	SR4	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 10% pa	SCF Chief Executive	Needs Improvement	Further development of PowerBi dashboards; further data cleansing of HR systems; further audits of caseload data. Good foundational work being done to allow data reports to be run.

CR01 Failure to Safeguard Children and Young People

Sue Butcher Chief Executive SCF

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

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
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,	SCF Director of Finance/ Resources (Alex P)	February 2026		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	SCF Director of Finance/ Resources (Alex P)	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

Risk appetite statement (Averse/Balanced/Seeking)

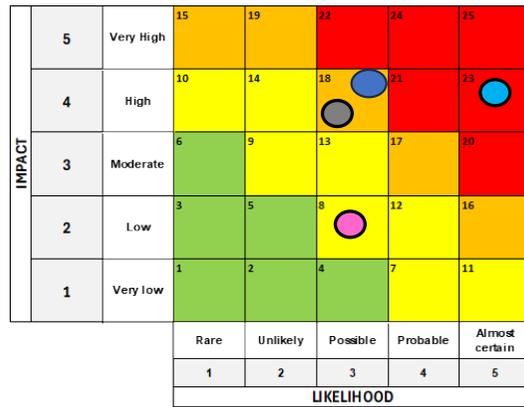
We have a balanced risk appetite as we look at ways to provide the necessary level of services required within Adult Social Care, while being aware of constraints around finances. Through practice and resource panels, controls are in place to ensure the right levels of care at the right time.

Work is underway to address workforce demands and the directorate is starting to see improvement. The permanent Director of Operations starts in Nov 2025, discussions continue re the appointment of Head of Reablement and Independence and interviews have taken place for the permanent Head of Market Management. There has been significant progress with annual reviews with more planned annual reviews taking place. We have added a risk(02.04) in relation to reviews within the Mental Health Service to enable these to be monitored separately.

Risk Profile for 02.01 has remained at 23, as at end of P2 there is a forecast of £6.7mil overspend which includes provider uplifts and new demand related to new people/increase in need. There are controls in place to monitor this monthly. There is £2mil being received from the council reserves with ASC funding £700k of the fee uplift figure.

The Practice Assurance Board is fully established, which will enable assurance to be provided on a quarterly basis and this is under review underway of the People and Practice Panel. This will enable us to understand our decision making and determine what improvements/clearing may be required.

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)	➡	At Full Council on 6 March 2025 the position of ASC finances was shared. To manage the financial situation 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	Andrea Rodin	➡	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 David Coleman-Groom	⬆	Permanent recruitment has continued with the Director of Operations starting November 2025 and discussion continues re the appointment of Head of Reablement and Independence. Interviews took place week commencing 29 th September for the Head of market management. Offer to candidate has been made with likely start date of mid -December 25. Director of Operations starting Nov 2025
02.04	●	Inability to carry out statutory annual reviews in clients with a Mental Health need	Debra Broderick	➡	Annual reviews are monitored and there have been staff moved to focus dedicated time on reviews.

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 22/23 – 3138	Metrics being developed	
KRI 2 – Recruitment of staff	Improved approach to securing permanent staff and less reliance on agency. To monitor the length of duration of assignments. Aim to reduce by 5%	Target to be set now refresh establishment is agreed	63 agency staff currently in post asat June 2025 (29% staff are interim)	61 agency staff currently in post asat August 2025 (28% staff are interim)	
KRI 3 – Stabilise ASC leadership team	New extended leadership structure in place, Three of the 5 Heads of Service are permanent. A 6 th Head of Service post is being held to the newly formed PSW role. The Director of Operations has been appointed and will start in Nov 2025. Director of Commissioning and Executive Director have permanent staff in post.	20% (Vacancy/interim cover rate)	Q1 25/26 – 40%	Q2 25/26 – 40%	

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

Control Effectiveness	Description
Effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating as intended Management is confident that the controls are effective and reliable
Largely effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating with opportunities for improvements identified
Needs improvement	<ul style="list-style-type: none"> Controls are only partially effective, require ongoing monitoring and may require redesigning, improving or supplementing Key controls and or/ management activities in place, with significant opportunities for improvement identified
Ineffective	<ul style="list-style-type: none"> Limited controls and or/ management activities in place
Weak	<ul style="list-style-type: none"> Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist Controls and or/ management activities are nonexistent 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	<i>Effective</i>	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	<i>Effective</i>	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)	<i>Effective</i>	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)	<i>Largely effective</i>	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	NEW: Director of Commissioning (Jane Senior) added October 25	<i>Needs improvement</i>	Customer Services are being reviewed including interfaces with other departments with an aim to improve customer journey Dependency on TOM team. There is continued work to look at maximising and using prevention offer.
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)	<i>Largely effective</i>	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
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Treatment/mitigation plans (funded actions that will manage/reduce the risk level)

Ref his	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
4	SR02.04	High level action that will mitigate or reduce the risk the most		<i>Director level</i>	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.	Director of Commissioning (Jane Senior)	10/2025		<ul style="list-style-type: none"> Review of Customer Services is being undertaken by the Corporate Project Team Out of Hospital Pathway review project in place led by Commissioning with a focus on promoting independence, adequate provisions for discharges, demand management and achieving efficiencies AskSara initiative to be progressed and funded through the Acceleration reform fund AskSARA is live on SBC website This work is also part of SBC wide Transformation project Looking at maximizing portals and self-help Customer services project – linked organisational change not directorate
2	SR2.02	Digital Blue Print for tech	In partnership with Digital, Data and Tech Service review existing tech solutions used within social care which will improve user experience and free up capacity for the workforce	Vicky Tutty	10/25		<ul style="list-style-type: none"> 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
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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 21

The current risk score has remained at 21 and the target risk score has been increased to 21 reflecting ongoing financial pressures that could lead to non-receipt of Safety Value Agreement payments. The high and increasing demand for SEND support is unlikely to be resolved without a change in legislation.

SEND has 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 more 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 provided the additional funding. Nevertheless, a higher level of SEND spending could threaten the additional funding being offered in 2025/26 and the future. Demand is being proactively met through extra capacity at Arbour Vale over the next two years, an approved Sufficiency Strategy and a planned capital works programme to be considered by the next Cabinet.

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

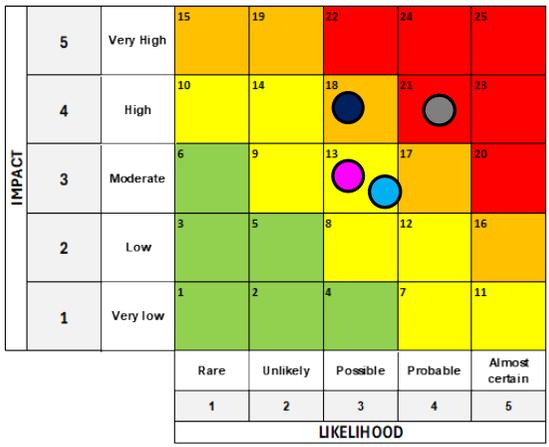
Risk appetite statement (BALANCED)

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

Sub risks related to this principal risk



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
03.01	●	Failure to provide timely SEND support	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	●	Non-receipt of Safety Valve Agreement payments	Neil Hoskinson	↓	A new SEND Finance transformation team is overseeing the financial plan and the Safety Valve Agreement. The latest SVA monitoring report forecasts a year end budget overspend 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 and reputational damage from complaints	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	●	Inadequate inspection readiness	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.

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	1 RAG rating has moved to RED relating to demand for EHC plans.	No change this quarter	
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.	65 finals issued in March. 29% of plans due completed within 20 weeks. Although an improvement in timeliness, still considerably below target.	No change this quarter	
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	The level of complaints has remained significantly lower than when this was identified as a serious concern	
KRI 4	Written Statement of Action monitoring reports identifies good progress in quarterly monitoring reports.	All actions complete on time and evidence of impact.	No actions RED rated in April report – also reduction in AMBER.	The Ofsted / CQC inspection has now taken place and the Post Inspection Plan will replace the WSoA	
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.	Maintained the positive picture from Q3	No change this quarter	
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.	SEF and Executive SEF shared with partners. Work underway to address evidence gaps but not yet complete.	The Ofsted / QCA inspection has now taken place and the SEF was found to be accurate and evidence based	
KRI 7	Ofsted inspection reports evidence that Graduated Approach is in place within all mainstream settings.	All Ofsted inspection reports evidence strong practice.	SEND and Inclusion Strategy completed for Cabinet sign off. All education setting Ofsted reports positive for inclusion.	Recent Ofsted reports for schools have remained positive	
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	Draft Sufficiency report being drafted for Cabinet now that SEN2 data is accurate	Sufficiency report has been approved by Cabinet and a capital programme report aligned to it has been drafted.	
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.	Recruitment and Retention Plan agreed – job descriptions / benchmarking ongoing	There have been delays to the recruitment and retention actions due to the inspection. However there are plans for reducing the interim roles and actioning another round of recruitment imminently.	

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

Control Effectiveness	Description
Effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating as intended Management is confident that the controls are effective and reliable
Largely effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating with opportunities for improvements identified
Needs improvement	<ul style="list-style-type: none"> Controls are only partially effective, require ongoing monitoring and may require redesigning, improving or supplementing Key controls and or/ management activities in place, with significant opportunities for improvement identified
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Weak	<ul style="list-style-type: none"> Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist Controls and or/ management activities are nonexistent 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.

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	03.01	<i>Improved Statutory Team Processes</i>	Additional locum EPs and a short-term interventions team will address the backlog of EHC plans and improve timeliness. Improved SEND statutory processes are improving timeliness for new cases including case management and tracking.	Neil Hoskinson Director of Education	31/03/2026 <i>New target to improve timeliness</i>		<i>GREEN the backlog is now significantly lower and generally the only remaining cases are where therapeutic support is not available or there is work being carried out to identify the appropriate education setting. The new target is to improve timeliness to the national average.</i>
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		AMBER. A new refreshed HNB position is being taken to School Forum on 16 Oct. This will then be incorporated into the latest Safey Value Monitoring Report.
5	03.02	SEND Sufficiency, Place Planning and Capital Programme	5 Year SEND Sufficiency Analysis complete	Neil Hoskinson Director of Education	01/12/2025		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	31/03/2026 <i>New milestone to maintain the significantly lower level of complaints</i>		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. Paul Crulley has left his role.

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

CR03 Failure of Special Educational Needs and Disability (SEND)

Risk owner: Sue Butcher

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

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
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 <i>Resource Provision to be in place</i>		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	31/03/2026 <i>Inclusion Support Grant work to be completed</i>		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	01/12 09 /2025 <i>New round of recruitment carried out</i>		There have been delays due to the recent inspection and so this has been moved to AMBER and the target date moved to 31 December. Paul Crulley has also left his role.

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

Corporate risk overview

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

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.

There has been small positive changes in some sub-risks since the last reporting period however budget pressure relating to Subsidy loss of £22m and arrears of £15m (neither of which are Housing functions) remains high and the number of homeless households continues to increase. The overall outlook has improved but not enough to change the score.

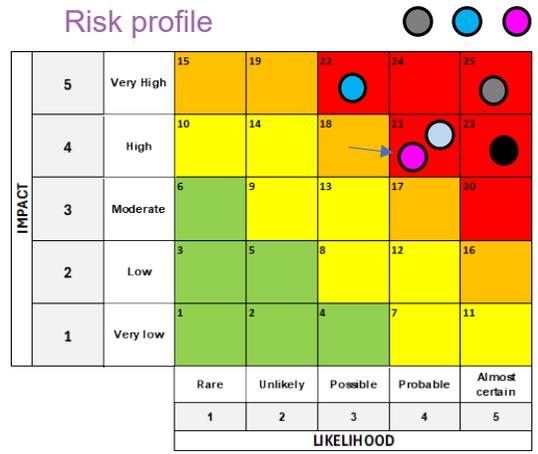
In Q2 we have continued to recruit to the Temporary Accommodation, Allocations and Homeless Teams attempting to fill BAU and Backlog roles. As of Q2, 1 role remain un-filled and staff churn remains high and 100% reliance on interim staff means risk score remains high. Projects to deal with the radical overhaul of data backlogs, improved commercial arrangements with TA providers and extensive property compliance checks have started and are making some progress.

- Current risk score is remains 25 due to sub-risk 2 (budget) being linked to subsidy loss and arrears. Also, sub-risk mitigated but sub-risk 3 (Compliance and Health & Safety Data) continuing to be very high. **Note** – this does not align with Risk Dashboard scoring matrix.
- 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 cost : income budget pressure to a forecast gap of £780k. However, the backlog created by the uploads remains a challenging task. For colleagues in benefits and income recovery.
- 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 Q2, analysis had been completed but no technical reconciliation was possible by the PwC AI tool. Backlog teams continue to manually reconcile data anomalies. A final report is due from PwC on 2nd October 2025.
- Challenges SBC face around homelessness given our location, socio economic make up and housing market in which we operate remain.
- Action to maintain the statutory and regulatory requirements that ensure the safety and wellbeing of the occupants continue.
- Additional scrutiny of actions, risk and improvement plans is scheduled for Q3 (October).
- The new service leads for TA, Allocations and Commercial Management started end of Q2.



Sub risks related to this principal risk

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
04.01	●	Lack of Suitable Available TA	Director of Housing (Lisa Keating /)	➡	<ul style="list-style-type: none"> We continue to rely heavily on high-cost units (over 65% of TA stock).. Private Lease Agreement and Private Licence Agreements for improved negotiations and possible cost efficiencies are now in place and being issued out to providers. 42 transfers to better value accommodation has estimated annual saving of c. £518k . Project to enter long term leases for 25 homes that will save £1.1m p.a. was nearing completion. Out of borough placements policy implemented. Action plan to re-negotiate with TA providers 50% completed. 65 of 65 providers contacted by end April 2025. Intensive activity to gather compliance and other commercial documents on-going. <p>There has been a small positive change since the last reporting period i.e. the third quarter in a row but not enough to change the overall score</p>
04.02	●	Budget Pressure (Cost vs Income and subsidy loss)	Director of Housing (Lisa Keating / Dave McNamara)	➡	<ul style="list-style-type: none"> The number of homeless households (in relief or full duty accepted) has increased in the quarter by 70 to 1,736, with 1,116 placed in TA. 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 £780k in September 25, down from £4.72m in April 25 and compared to over £10m in Q3 2024/25. The forecast actual spend at P6 is £34.8m with income forecast of £30.04m. The forecast subsidy loss remains at £22m. <p>There has been a positive change since the last reporting period i.e. the third quarter in a row. but not enough to change the overall score. The acknowledgment of subsidy loss is why the risk remains 25.</p>

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 and Health & Safety Information	Director of Housing (Lisa Keating)		<ul style="list-style-type: none"> Recruitment of dedicated resource has enabled a 100% desktop review of statutory compliance matters. Physical inspections of TA, B&B and HMO accommodation is approximately 30% complete . Planned decant of families from noncompliant properties (c. 300 properties – Galaxy, UNO and Aptus are main non-compliant provider) on-going. 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. Incorrect licence agreement issued to Galaxy residents. Identifying and re-issuing correct licences to these placements and others will be concluded by 31st March 2026.. Further independent health check of TA remains a recommendation. Risk remains high while manual collection and storage of compliance documents remains. ICT solution is required. <p>There has been small positive improvement in Compliance in process. However, the immediate outlook has deteriorated because an unknown number of incorrect licences have been issued. Risk score increased from 18 to 21 until this issue is corrected.</p>
04.04		Attraction and retention of talent	Director of Housing (Lisa Keating / Bal Toor)		<ul style="list-style-type: none"> In Q2, the TA Manager, Housing Allocations Manager and the TA Commercial Manager left the Service – all three were replaced and started in Q2. 5 new backlog officers joined. 100% of TA team remains interim – no permanent members of staff. HSG Demand backlog team and early intervention team recruited – started September 25 Continued investigation into on-going fraud matters. Deep dive with external expert support has been initiated. Likely to impact on staff retention issues. <p>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 was considered in Q2 and partly implemented. Additional leavers and new starters in Q2 means outlook remains consistent.</p>
04.05		Ability to effectively Manage TA property and people	Director of Housing (Lisa Keating)		<ul style="list-style-type: none"> Limited capacity to effectively contract manage TA providers increasing the risk of poor accommodation. Limited capacity to manage households in accommodation and move them on to permanent affordable accommodation increasing risk to homeless households Departure of New Commercial Manager appointed April 2025, replaced with new appointment (started September) who has experience but will take time to get up to full speed. Lack of ICT system significantly hampers the pro-active management of providers. Checks and balances are reliant on manual reviews and interventions. <p>There has been improvement in Q2 but the overall outlook remains stable. A dedicated commercial manager has been re-appointed and top 65 provider meetings have been completed. Work is underway to execute plans regarding contract management of the TA Providers and additional resources are in place to conduct visits to households in TA out of the borough and households in B & B</p>

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 (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	
KRI 5 - Budget	Cost of TA to be matched by income from Housing Benefit and Rent.	95% of rent charges to be covered by HB by April 2026 (accepted that HB does not cover all rent charges and residents have to pay their own contribution)	55%	85%	

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

Control Effectiveness	Description
Effective	<ul style="list-style-type: none"> • Controls and or/ management activities properly designed and operating as intended • Management is confident that the controls are effective and reliable
Largely effective	<ul style="list-style-type: none"> • Controls and or/ management activities properly designed and operating with opportunities for improvements identified
Needs improvement	<ul style="list-style-type: none"> • Controls are only partially effective, require ongoing monitoring and may require redesigning, improving or supplementing • Key controls and or/ management activities in place, with significant opportunities for improvement identified
Ineffective	<ul style="list-style-type: none"> • Limited controls and or/ management activities in place
Weak	<ul style="list-style-type: none"> • Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist • Controls and or/ management activities are nonexistent 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 andDPS) 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 asno 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.

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

Control Effectiveness	Description
Effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating as intended Management is confident that the controls are effective and reliable
Largely effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating with opportunities for improvements identified
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Weak	<ul style="list-style-type: none"> Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist Controls and or/ management activities are nonexistent 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 on shortlisting 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)	Largely Effective	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)	Largely Effective	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
1	1	Affordable TA	To implement immediate short term solutions with existing providers while agreeing and implementing a long term acquisition strategy that significantly reduces dependency on nightly spot rate purchase.	Head of Service (Janet Weekes)	October 2025		Lease agreements are being issued to providers. Project to enter long term lease with institutional investor started. Increasing relationships with local Registered providers.
4	2	Invoice Payment Monitoring	To quickly improve invoice payment experience, we can then negotiate TA rates, current dissatisfaction felt by many providers, this is challenging if not impossible and we risk losing supplier.	Head of Service (Janet Weekes)	-September 2025		Dedicated officer checking invoices vs placement. There are capped rates for nightly paid accommodation – breach of that approved by TA Manager / Head of Service. Work by PwC has highlighted additional challenges.. Inability to link Agresso to NEC & Jigsaw placement reference continues to be a challenge. New solution required to manage invoice arrangements as current invoice arrangements are not fit for purchase.
5	2	Expensive placement monitoring.	Review applicants who have been in TA the longest, why they are there, develop plan to tackle oldest cases improving engagement with such residents consistently	Head of Service (Janet Weekes)	October 2025		Review underway. Some reallocated to cheaper TA but availability of large properties is an issue. But staff churn has delayed progress in this.
6	2	Rents and HB	To ensure income is maximised by assuring all households have a rent account, charges and HB claim.	Head of Service (Janet Weekes)	October 2025		Data reconciliation has clarity, but legacy backlog and some complex cases has slowed progress. Additional income recovery and benefit resource required – NOT Housing Responsibility.
7	3	TA Visits	Quarterly visits to self contained units. Monthly visits to B&B and hotel accommodation. Review of transfer applicants on the housing register with neighbourhood services as if we move some of them, we create chain transfers and may unlock better/larger units as a result.	Head of Service (Janet Weekes)	October 2025		New resource in place. Physical visits increasing and programme of visits to be established for the financial year
8	3	Lease Agreements for TA	The new agreements will state clearly the obligation of the providers including compliance certificates and reporting any changes with the Provider, the property and occupancy.	Head of Service (Janet Weekes)	June 2026		Agreements drafted by April 2025. No Very few PSL / PLA agreements signed. Resource re recruited in September. Re-starting process late Q2. New target date Jan 2026.
9	3	NEC Provider Model	Implement the NECPSL module to record key information and hold related compliance data.	Head of Service (Janet Weekes)	October 2025		Project team has been diverted to data reconciliation. Kick-off meeting end of March – NEC project team only funded to July 2025.

CR04

Failure to Provide Safe Temporary Accommodation within Budget

Risk owner: Pat Hayes

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

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
10	4	Recruitment	Immediately fill vacant posts with interim placement.	Head of Service (Janet Weekes)	September 2025		Internal HR / Matrix mostly resolved. Interim posts have been filled- funding and support from CLT. Moving toward temp to perm solution.
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**

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 through its restructuring now only has 2 vacancies across the function in the HR policy and partnering space. All other vacancies have been recruited to; however, it may take some weeks for staff to run at pace.

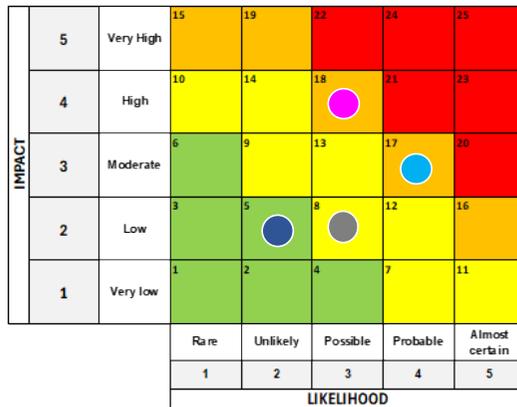
Market conditions do not assist HR in attracting permanent talent for critical roles and therefore we remain reliant on interims for parts of our delivery, however our newly appointed G8 recruitment lead will be partnering all EDs to review the usage of interims with the view to agreeing workforce plans. We remain with our risk that 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, we have recruited a G7 employee engagement officer who is embarking on several cultural workstreams to improve declaration drives so that we better understand our staff make up. We have also tabled two community recruitment fairs so that we have a greater presence in the community.
05.02	●	We fail to identify, develop and embed the capabilities and competencies we need in our workforce	Bal Toor	➡	Our line managers programme LEAD continues to be rolled out with over 50% of line managers having completed the programme. We are also launching our career pathway over October, which further strengthens our staff skills.
05.03	●	We fail to maintain an energised and engaged workforce	Bal Toor	➡	Our mini pulse check has indicated (of the 500 staff who participated) is positive about the lowest performing areas of the previous annual staff survey. However, staff remain negative about ability to collaborate across the business. The employee engagement officer will be seeking innovative ways to bring staff together.
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.

Key Risk Indicators (KRIs)



KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KRI 1	Staff Turnover	Staff turnover inline with last published civil service average.	Red Low 0-3% High >14% Amber Low 3-7% High 12-14% Green 7-12%	11.9% (end Sep 24) 10.0% (end Mar 25) 9.7% (end Jun 25) 8.3% (end Aug 25)	
KRI 2	Number of working days lost due to sickness absence per FTE employee	In line with CS average.	Red >90 days overdue Amber 1-90 days overdue Green not due / due & on track	8.1% Green 9.6 days/FTE (end Mar 25) 9.3 days/FTE (end Jun 25) 9.6 days/FTE (end Aug 25)	
KRI 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	51 active (this has increased in the last ¼)	
KRI 4	Overall completion of all mandatory learning across SBC	50% of staff should have completed all 7 modules	25.6%	26.5%	Due to an adjustment in reporting on 7 mandatory modules not 6, this has lowered the completion rate.

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

Control Effectiveness	Description
Effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating as intended Management is confident that the controls are effective and reliable
Largely effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating with opportunities for improvements identified
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Weak	<ul style="list-style-type: none"> Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist Controls and or/ management activities are nonexistent 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 3 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 3 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 3 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	18
Target Risk Score	4	Impact	3	Likelihood	18

The overall risk score has reduced significantly for this quarter, due to the continued improvements and implementations we have made during Q1 and Q2 to lone working, fire risk assessments and Codes Of Practice reviews. There has been no improvement to training requirements as we have been prioritising the implementation of the new, interactive accident reporting form and data capture. We aim to address the training requirements during Q3. It should be noted that **SR06.01, SR06.02, SR06.03 & SR06.04** have reduced their risk scores this quarter and overall, the risk is trending in the right direction. SBC currently faces multiple, simultaneous risks – with a common root cause. Lack of data, communication and synergy of management/ownership/reporting. However, these are all being addressed in a priority-based system and will continue to be addressed in Q3. The work undertaken to address the threat of escalating, aggressive behaviour to front facing staff – means that the overall risk score has been reduced to 18. The systematic and controlled manner in which we are addressing high priority issues will result in the reduction of the risk score from Q3, which will be a permanent, stable improvement. However, a new risk has been placed on the Register **SR06.05 - 'We fail to ensure adequate personnel within the Corporate Health and Safety Team'** due to the fact that during Q1 and Q2, it has become clear that the risk of not complying with our statutory and regulatory requirements is high due to workload issues and a lack of adequate cover for illness or injury in the long or short term. This leaves SBC at major risk of not being able to provide a service to staff or the public.

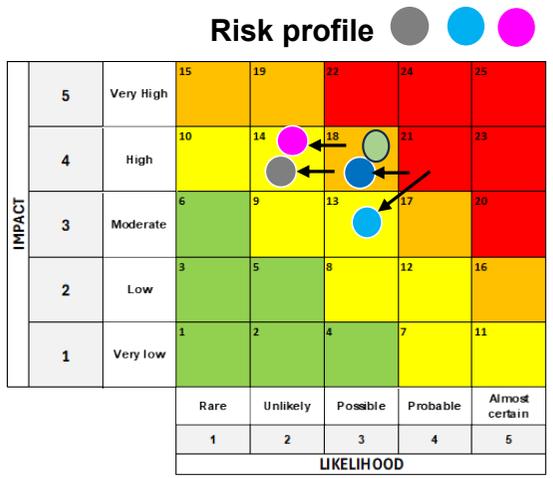
Risk appetite statement (AVERSE)

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 enforce suitable and sufficient risk mitigation(s).



Sub risks related to this principal risk



Refer to slide 11 for risk assessment score instructions

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 buyin 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. 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. 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	●	No resource to provide 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

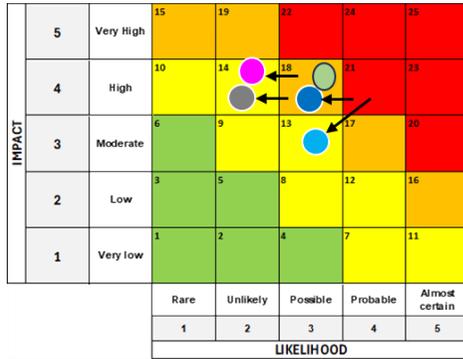
Corporate risk overview

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



Sub risks related to this principal risk

Risk profile



Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
06.05		We fail to ensure adequate numbers of trained personnel within the Corporate Health and Safety Team	Craig Hill		Recognition to ensure that adequate numbers of trained personnel within the Corporate Health and Safety Team are enough to enable the delivery of statutory duties to SBC. Redundancy within the team to be able to cover roles and duties in case of illness, injury or staff leaving service

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KR 1	Reported Accidents/Incidents	80	39	41	
KRI 2	Reported RIDDOR Incidents	1	0	1	
KRI 3	Completed Fire Risk Assessments	4	0	0	
KRI 4	Weekly/Monthly Routine Personal Safety Device Checks	100	155	179	
KRI 5	Emergency Personal Safety Device Activations (Red/Amber alerts)	8	2	1	
KRI 6	Health and Safety Training Completed	TBA	0	0	
KRI 7	Health and Safety Policies Reviewed and Completed	7	8	8	
KRI 8	Health and Safety Staff Levels and Attrition	3	2	2	

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

Control Effectiveness	Description
Effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating as intended Management is confident that the controls are effective and reliable
Largely effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating with opportunities for improvements identified
Needs improvement	<ul style="list-style-type: none"> Controls are only partially effective, require ongoing monitoring and may require redesigning, improving or supplementing Key controls and or/ management activities in place, with significant opportunities for improvement identified
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Weak	<ul style="list-style-type: none"> Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist Controls and or/ management activities are non-existent or have major deficiencies and don't operate as intended

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR06.01	Accident & Incident Reporting	Capture and analyse accident and incident data to investigate occurrences and identify accident trends within the organisation	Director level	Needs Improvement	Existing HSMS deemed inadequate by external commission and Interim manager. 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 reinspection of fire provisions on a 6 month rolling programme to ensure actions are being undertaken and no more issues are found	Director Level	Largely effective	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 rewritten, if necessary, within 2025/2026

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

Control Effectiveness	Description
Effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating as intended Management is confident that the controls are effective and reliable
Largely effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating with opportunities for improvements identified
Needs improvement	<ul style="list-style-type: none"> Controls are only partially effective, require ongoing monitoring and may require redesigning, improving or supplementing Key controls and or/ management activities in place, with significant opportunities for improvement identified
Ineffective	<ul style="list-style-type: none"> Limited controls and or/ management activities in place
Weak	<ul style="list-style-type: none"> Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist Controls and or/ management activities are non-existent or have major deficiencies and don't operate as intended

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
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	Largely effective	Increasing (proven trends in reporting) occasions of Unreasonable Behaviour aimed 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 and COP'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.
12	SR06.05	Staffing Levels	Audit and Review of staffing levels within the H&S team to ensure compliance of statutory requirements	Director Level	Weak	The review and actions of Q1 and Q2 have shown that the H&S team are at risk of not being compliant due to a lack of staff (illness, injury etc)

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	SR06.01-0.3	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 3 rd in just over 1 year
4	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		All FRA documents and actions are discussed as standard practice at SBC H&S Board meetings and dedicated FRA action meetings
5	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		Lone Worker policies and documentation is being updated and Personal Protection devices and protocols for unreasonable behaviour honed.
6	SR06.04	Training Level audit & analysis (Learning & Mandatory Management)	Review of existing data, quality therein address shortfalls (in terms of survey/actions) urgently.	Craig Hill	31.03.26		Liaison with L&D being undertaken, and action(s) to be discussed before Jan 26
7	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		Review and update of any risk assessments to be standard after any form of accident or incident as of 01.10.25
8	SR06.04-0.3	Policies & Procedures audit & analysis.	Thorough internal commission- review and revise current Policies, Procedures/COP's	Craig Hill / Shameem Din	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 COP's per quarter, per annum

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
9	SR06-05	Trained Personnel within the Corporate Health and Safety Team	Review and analyse the possible requirements for additional staff to ensure compliance with statutory requirements	Craig Hill/ Shameem Din	31.03.26		An internal audit to determine if the Corporate H&S Team require additional staff to undertake all duties correctly

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

Corporate risk overview

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

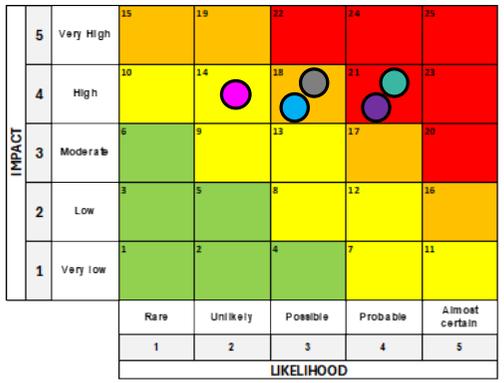
Risk appetite statement(Averse)
 This is a highrisk area with significantconsequences. Mitigations are available. Risk appetite is averse.

Improvements across nearly all sub-risks indicating risks is moving in the right direction. However, significant challenges remain that limit potential risk score reductions. While all emergency planning sub-risks have seen improvements (although not as significant improvements as had been predicted), sub-risks relating to Business Continuity have not yet improved. As a result, the Target Risk Score has been adjusted to recognise the limitations in risk reductions.

Incident response capabilities have improved through recruitment and development of additional responders for Incident Managers, LALOs and other incident response roles, increasing capacity and building resilience in response arrangements. Recent incidents have further tested new arrangements increasing confidence in incident response arrangements. The Emergency Operations Centre improvements are close to completion, Silver Commander training has been delivered by the UK Resilience Academy, with Silvers expected to be incorporated into arrangements soon. The Corporate Resilience Group has been operating since July is and currently reviewing the Council’s position against the 7 set priorities.

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, weak programme and absence of relevant, current and practical business continuity arrangements at any level. A financial package to fund a business continuity programme has been approved and the Public Protection is identifying a suitable specialist to drive this programme.

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 responders. 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. Emergency Shelter planning underway.
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	↑	New Corporate Incident Management Plan in consultation phase and CLT consultation/ approval in late October. Redevelopment of Emergency Operations Centre close to completion. Silver training delivered. Gold ex planned for November.
SR07.04	●	Lack of BCP’s for all services responsible for delivering business critical activities	Laura Robertson	→	Review of Business Continuity Programme complete. Funding identified for a programme to redevelop BC Management Programme, seeking professional 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.

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		Stable – 2 further officers to include on rota
KRI2	Number of trained Silver Commanders on rota 24/7/365	Minimum 6 (8)	0	8		Silver training delivered
KRI3	Number of trained Incident Managers on rota (new, in development) 24/7/365	Minimum 6 (8)	7	8		1 additional member trained and included on rota
KRI4	Number of trained Local Authority Liaison Officers (LALOs) on rota 24/7/365	Minimum 12 (16)	5	10		Additional officers trained – not yet at full capacity
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	2		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	40	36		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	2		1 Rest Centre induction exercise Ex Pegasus – national level pandemic exercise Gold ex planned for November

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

Control Effectiveness	Description
Effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating as intended Management is confident that the controls are effective and reliable
Largely effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating with opportunities for improvements identified
Needs improvement	<ul style="list-style-type: none"> Controls are only partially effective, require ongoing monitoring and may require redesigning, improving or supplementing Key controls and or/ management activities in place, with significant opportunities for improvement identified
Ineffective	<ul style="list-style-type: none"> Limited controls and or/ management activities in place
Weak	<ul style="list-style-type: none"> Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist Controls and or/ management activities are nonexistent 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	Incident / Crisis management arrangements	Crisis and incident management structure, capacity and procedures to support a rapid and robust response to major incidents and emergencies.	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 capacity for resilience activities	Professional expertise in development and design of incident management, emergency planning and resilience activities	Director	Largely effective	Appointment of an interim Resilience Manager and Business Continuity Manager. EP team members returning from long term absence.
3	SR07.2	Community resilience and preparedness	Supporting communities and residents to be better prepared for emergencies and disasters	Director	Weak	Further work required to engage with communities, explain the risks, how they can be prepared for emergencies and empower them to take action to enhance resilience and support their communities during incidents.
4	SR07.2	Emergency planning	Planning and preparations for particular risks and threats through emergency planning activities	Director	Needs improvement	Emergency planning team provide expert guidance and support in the development of emergency plans, supporting the organisation through the planning process and engagements
5	SR07.1,2,4,5	Governance and Assurance	Assurance that organisation is meeting resilience expectations and aspirations.	Director	Largely effective	Corporate Resilience Group established to bring together representatives of all Directorates to discuss risks priorities and identify how the organisation can be better prepared with support from risk and resilience experts.
6	SR07.1,2	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	CR07.2,5	Risk identification	Identification and monitoring of risks and threats from major hazards and business disruptions (and incorporating corporate 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. Resilience priorities for Corporate Resilience Group identified.
8	SR07.04	Corporate Business Continuity Programme	A Business Continuity Management System to support the organization to prepare for, respond to, and recover from disruptive incidents	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

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

Target Risk Score – 21 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	March 2026	G	Plan drafted and circulated for consultation. Scheduled for approval CLT late October. Testing November and March.
4	SR07.1	1	Recruitment and training of responders	Recruitment of operational volunteers to deliver key incident response services	Laura Robertson / David McClory	March 2026	A	Recruitment campaigning is ongoing. Some successes however numbers remain below required levels.
5	SR07.1.2	1	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	Dec 2025	A	Training with UK Resilience Academy delivered in September. Only 1/3 take up of training. Incorporation of Directors onto Silver Rota from November. Additional training advised.
6	SR07.1	1	Training for all oncall response staff	Training programme for Strategic Gold, Silver, Incident Managers, LALO, Loggists, informal Volunteer Responders	Laura Robertson / David McClory	March 2026	G	Training programme in place for all roles with exception of Emergency Shelters and Incident Managers. Training continues as a priority.
7	SR07.1	1	Improved guidance and equipment for incident responders	Provision of suitable PPE and response equipment for operational responders	Laura Robertson / David McClory	March 2026	G	Equipment for LALOs and Incident Managers issued. H&S risk assessments for all roles underway.
8	SR07.1,2,3	1	Improvements to Emergency Operations Centre	Improvements to emergency control centre facilities, resources and systems	Laura Robertson / David McClory	October 2025	G	First phase – move existing facility to new location (complete) Second phase – upgrading of info display (completion in October) Third phase – Resilient comms and CCTV (commence 2026/27)
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 place. Governance and management arrangements to be developed.
11	SR07.2	7	Major Hazard Risk Management process	Creation of a Major Hazard process and policy.	Laura Robertson / David McClory	March 2026	G	Not yet started
12	SR07.4	2 & 8	Review of the Business Continuity establishment in organisation	BC programme currently sits with Emergency Planning which is unsuited for BCMS programme delivery.	Laura Robertson / David McClory	November 2025	A	A review of the current BCMS Programme has been completed and exploration of other services options being explored.
13	SR07.4&5	2&8	Additional BC Resources	Secure funding for additional BC resource for design and delivery of a Business Continuity Programme	Laura Robertson / David McClory	March 2026	G	Additional funding for BC programme Business case for additional resources to support business continuity programme underway.
14	SR07.4	8	Redevelopment of a Business Continuity Management System	Redevelopment of a BCMS, with clear Policy, scope of activities, resilience analysis and resilience planning	Laura Robertson / David McClory	March 2026	G	Not yet started
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	March 2025	A	Shelters identified, activation and establishment plans to be completed.
18	SR07.1	6	Development of a Humanitarian Assistance Plan	Nomination and training of an Exec Director to lead the humanitarian response to any major incident	Laura Robertson / David McClory	March 2026	A	Recommendation for all Strategic lead roles included in submission of Corporate Incident Management Plan to CLT in October
19	SR07.1	6	Emergency Shelter training	Development and delivery of Emergency Shelter training to designated officers	Laura Robertson / David McClory	March 2026	G	Not yet started
20	SR07.2	4	Recovery Management Planning	Development of Emergency Recovery Plan and procedures	Laura Robertson / David McClory	March 2026	G	Work expected to be delivered between October and March.
21	SR07.2	3	Community resilience strategy	Development of a strategy for engaging with and supporting resilience of	Laura Robertson / David McClory	March 2026	G	Not yet started

Corporate risk overview

Updates are:-

- Backups to the new BaaS are on track to completed by 19th October. DRaaS configuration to commence in Q3 followed by testing of the DR service.
- The procurement of the managed SOC/SIEM service was completed and is now operational. DDaT are working with the new provider on enhancing the service and increasing logging sources, SPAM monitoring and reviewing authority to act actions including out of hours cover. Liaising with emergency planning to include alerts to the emergency duty rota.
- DDaT are now completing the actions as identified in the CAF assessment.
- ITHC remediation project has now commenced and identified issues are being worked on, an interim resource has started with the DDaT team to support the remediation activities.
- Internal audit have conducted a Cyber Crime Audit in August. 6 recommendations were provided. DDaT on track to complete these recommendations before the due dates.

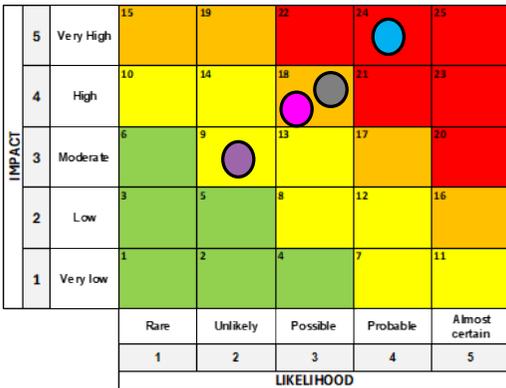
Despite management for SR08.01, we are unlikely to see a reduction in the risk score therefore we are increasing the target risk score to 24.

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

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



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	↑	<ul style="list-style-type: none"> • BaaS due to be completed by 19th October. DRaaS planning to started in Q3. • A managed SOC/SIEM service is now implemented and fully operational • Work is underway to complete the actions identified in the MHCLG CAF assessment Project underway to complete the remediations actions from the ITHC.
08.02	●	Lack of IT business continuity within DDaT and service areas causes significant service loss	Colin Power	↔	<ul style="list-style-type: none"> • DDaT Business Continuity Plan drafted and under review. • DRaaS planning to started in Q3
08.03	●	An incident caused by hardware or software failure causes significant service loss	Colin Power	↔	<ul style="list-style-type: none"> • Support and maintenance in place for supported hardware & software • Supported software receives security updates/patches from manufacturer • Majority of the Council's end user devices have been upgraded to Windows 11. Project on track to be completed this month.
08.04	●	An incident caused by legacy hardware or software failure causes significant service loss	Colin Power	↑	<ul style="list-style-type: none"> • The sub risk is still improving this quarter as legacy systems continue to be decommissioned. Projects for moving CAFM and D360 to the cloud have been commissioned and are underway. • Migration to new datacentre hardware on track to be completed on 19th October, operations team will remove redundant legacy hardware following migrations.

Refer to slide 6 for risk assessment score instructions

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
<p><i>[The indicators in the table below are illustrative of thinking in this area, as there are not currently any measures in full operation. I am confirming just what is measurable and whether baseline data exists.]</i></p>					
KRI 1	Number of successful cyber breach incidents	0	0	0	
KRI 2	% staff completed cyber training (Information Security)	90%	86%	83%	
KRI 3	Number of ICT incidents substantively impacting one or more services (hardware / software failure P1 major incident)	1	4		
KRI 4	Notifications of compromise / risk from the National Cyber Security Centre (NCSC) active cyber defence service (ACD) early warning service	3	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		New KPI

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

Control Effectiveness	Description
Effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating as intended Management is confident that the controls are effective and reliable
Largely effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating with opportunities for improvements identified
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Weak	<ul style="list-style-type: none"> Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist Controls and or/ management activities are nonexistent 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 IHealthcheck patching, vulnerability monitoring, and clear processes around incident management	Colin Power	Largely effective	<ul style="list-style-type: none"> PSN status classified as "Deferred" as agreed with Cabinet Office Remediations actions identified in the 2025 ITHC currently being completed. Resource has been brought in to focus on these actions. Work is underway to complete the actions identified in the MHCLG CAF assessment
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	Largely effective	<ul style="list-style-type: none"> Cyber update delivered to the Corporate Resilience Group in Sept Developing a cyber awareness campaign and are liaising with Communications regarding approach. Cyber awareness included in staff induction. Ongoing Comms and awareness of cyber threats
3	SR08.01 & SR08.02	DDaT Business continuity planning	IT Business continuity and disaster recovery planning within DDaT	Colin Power	Needs improvement	<ul style="list-style-type: none"> DRaaS configuration and planning due for Q3 following completion of the BaaS project. DDaT Business Continuity Plan drafted and under review 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	<ul style="list-style-type: none"> DDaT continue to attend the Corporate Resilience Group 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	<ul style="list-style-type: none"> Refer to treatment actions 1, 2 & 3 overleaf.
6	SR08.01	Managed SOC/SIEM	Managed SOC/SIEM in operation to undertake proactive monitoring, detection, and response to security threats, ensuring robust protection of organisational assets and data	Colin Power	Effective	<ul style="list-style-type: none"> Managed SOC/SIEM procured and now fully operational Where incidents do occur, action is taken to identify and address the root cause, to avoid repetition

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/Colin Watson	Milestone- Dec 25 (Cabinet approval for contract award)	G	<ul style="list-style-type: none"> There has been further slippage in cabinet approval. This is expected in December 25. Completion date to be confirmed pending engagement with Supplier.
2	SR08.01	Introduction of managed service for Security Incident and Event Monitoring	Outstanding action from modernisation programme; requires procurement and then implementation	Colin Power	Completed	G	<ul style="list-style-type: none"> Managed SOC/SIEM now fully operational. This has now been delivered and has now become a control.
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	Colin Watson	BaaS Implementation completed by 3 rd October 2025 (Milestone)	G	<ul style="list-style-type: none"> BaaS implementation to complete on 19 Oct DRaaS planning and configuration due in Q3
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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> DDaT are reliant on service area's business continuity plans being delivered from the Corporate Resilience Group
6	SR08.01	Communications awareness and training	Ongoing communications and awareness to staff	Colin Power	Completed	G	<ul style="list-style-type: none"> This has now been delivered and has now become a control.
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	<ul style="list-style-type: none"> Developing a cyber awareness campaign and are liaising with Communications regarding approach.

Target Risk Score – 24 by end of date 10/2025

CR09 Failure to achieve financial sustainability and a balanced MTFS

Risk owner: Ian O'Donnell

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 despite the deterioration in SR09.02 following the qtr1 budget monitoring position and therefore RAG status remains red.

If the Council fails to identify significant mitigations to offset the 2025/26 position and improve its financial planning and management, it's internal control and financial reporting in the medium to longer-term, then the Council will not become a financially self-sustaining.

For 2026/27, urgent work is underway to deliver a balanced budget.

Risk appetite statement(Averse- Balanced)

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

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



Risk profile



IMPACT	5	Very High	15	19	22	24	25
	4	High	10	14	18	21	23
	3	Moderate	6	9	13	17	20
	2	Low	3	5	8	12	16
	1	Very low	1	2	4	7	11
		Rare	Unlikely	Possible	Probable	Almost certain	
		1	2	3	4	5	
		LIKELIHOOD					

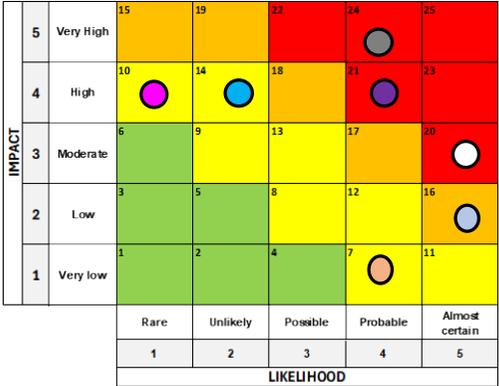
Refer to slide 8 for risk assessment score instructions

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
09.01	Blue circle	Failure to deliver audited financial accounts within statutory deadlines	Nick Penny	Green up arrow	Position continues to be improving on delivery of outstanding SOAs, but impact on useable reserves (£14.75m) arising from Provisional 23/24 accounts has severely impacted on financial sustainability without approval of additional Exceptional Financial Support for year. Approval has been assumed in the draft accounts which will be published week commencing 13th October. This is a critical year as the closing balances 2023/24 become the 2024/25 opening balances and 2024/25 is the first year for several years when the accounts will be fully audited. As such prior to publishing the draft 24/25 accounts, an independent risk-based B/S review has been undertaken, along with positive discussions with MHCLG on option for additional EFS. The 2024/25 audit commences on Monday 13th October. Publication of draft 24/25 accounts likely to be November 25, with audited accounts scheduled to be completed within statutory deadline of February 2026.
09.02	Grey circle	Failure to achieve a balanced budget and Medium-Term Financial Strategy (MTFS)	Mark Hak-Sanders	Red down arrow	Balancing the 2024/25 Outturn is challenging and needs to be resolved; a range of actions are being finalised. The q1 update showed a £20.7m overspend on the general fund budgets for 2025/26. Process for identification of mitigations has commenced including strengthening spending controls. 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 for 2026/27 is estimated to be £20.520m with a sensitivity analysis of up to £36.967 m. This will form the baseline position for the 2026/27 – 2029/30 MTFS, along with reflecting emerging pressures from 2025/26.
09.03	Pink circle	Inadequate cashflow to maintain balance of liquidity to fund expenditure	Nick Penny	Green up arrow	The council's cashflow is robustly monitored and managed to ensure the Council remains liquid to fund the in-year expenditure which is over the budgeted level on both the general fund and DSG. CE60m of loans are payable during 2025/26 with c£40m falling due in October, new loans have been taken out to pay back these loans whilst providing an improved debt profile.

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	Mark Hak-Sanders		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		Two Finance Directors - commenced September 2025 Strategic Finance Manager – commenced September 2025 Other senior roles. 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. PIDs - 17 approved, 10 in final draft, 6 to be drafted and 1 awaiting project closure. Q2 2025/26 assurance report being drafted for leadership team for onward discussion at October 2025 Finance Improvement Board.
09.07		Failure to deliver best value from procurement processes	Nick Penny		Some improvement on compliance reflected by: 2025/26 Pipeline of procurement over £180 approved by Cabinet in April and monthly progress reported to CLT, with an update report for the remainder of 2025/26 and first 6 months of 2026/27 going to Cabinet in December Further, but limited improvements include: <ul style="list-style-type: none"> • CLT Compliance reporting from end Q1 • Development of contracts register, with further improvements to processes during Q3 • Restructure of team to be finalised during Q3 but some changes already made • Steps in train to ensure compliance with Procurement Act 2023, but procurement strategy still to be developed – draft due Q3. • Imbalance of requisite skills and qualifications within procurement team • There is a significant improvement programme in progress, but it is too early to be reflected in changes to the current risk score • Supplier failure remains a significant risk



CR09

Failure to achieve financial sustainability and a balanced MTFS

Risk owner **tan O'Donnell**

Key Risk Indicators (KRIs)



KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KRI 1 (MHS)	<i>In year budget monitoring highlights a pressure that can't be balanced</i>	Check performance measure	Q4 position £8.8m pressure	Q1 position showing a £20.7m overspend with £7m mitigations.	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 (MHS)	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)	<i>Level of external debt as a proportion of net revenue budget</i>	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. Training / CPD in place for permanent staff. All permanent staff completed an appraisal and training plan Attrition rate	Reduction of 10% reliance on interims 100% appraisals / training plan in place		All appraisals scheduled to be completed by end of April. 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

KRI's for this quarter have not been fully updated by the risk owners

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

Control Effectiveness	Description
Effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating as intended Management is confident that the controls are effective and reliable
Largely effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating with opportunities for improvements identified
Needs improvement	<ul style="list-style-type: none"> Controls are only partially effective, require ongoing monitoring and may require redesigning, improving or supplementing Key controls and or/ management activities in place, with significant opportunities for improvement identified
Ineffective	<ul style="list-style-type: none"> Limited controls and or/ management activities in place
Weak	<ul style="list-style-type: none"> Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist Controls and or/ management activities are nonexistent 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	<i>Backlog Accounts Programme</i>	<i>Dedicated Recovery Team finalising accounts</i>	<i>Nick Penny</i>	<i>Largely Effective</i>	<i>Dedicated team have completed 2019/20, 2020/21, 2021/22 and 2022/23 draft and final accounts. 2023/24 Accounts to be published later this week (commencing 13th October). 2024/25 Draft accounts expected to be published in Q3 with audit due to be completed Feb 2026.</i>
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	Nick Penny	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 riskbased review 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.	Mark Hak-Sanders	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	Mark Hak-Sanders	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. Monthly monitoring will also be expanded to cover milestone delivery of savings.
5	SR09.02	Regular MTFS Reviews	The Financial planning forecast are updated and reported regularly	Mark Hak-Sanders	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.

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

Control Effectiveness	Description
Effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating as intended Management is confident that the controls are effective and reliable
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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	Mark Hak-Sanders	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. Non-staff ECP has been reintroduced, but further work is required on No PO no pay.
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	Nick Penny	Largely Effective	Reporting processes subject to internal audit found to be largely compliant with CIPFA COP, with improvements suggested by new Exec Director being implemented. Monthly meeting with ED, Director of Finance, treasury lead and external TM advisors with internal officer meeting in between. .
8	SR09.04	<i>Relative Need</i>	<i>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.</i>	Mark Hak-Sanders	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	Nick Penny	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	Nick Penny	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	Nick Penny	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	Nick Penny	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 system process improvements

CR09

Failure to achieve financial sustainability and a balanced MTFS

Risk owner: Ian O'Donnell

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

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

Ref	Control 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	Nick Penny	31/10/2025	Amber	PID signed off and to be followed as BAU to ensure timely review and changes agreed through appropriate governance.
2	SR09.1-06	Balance Sheet Review	Finalisation as part of 2023/34 Accounts	Nick Penny	30/6/2025	Amber	Accounts are to be published week commencing 13th October
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 what control does this link to?	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 what control does this link to?	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 Projectwork books
8	SR09.06	Internal Control Framework	Create the project plan for Internal Controls (including Agresso system controls)	Vicki Palazon	30/09/2025	Green	In final draft ready for SRO review. Activity ongoing

Treatments for this quarter have not been fully updated by the risk owners

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

Corporate risk overview

CURRENT SCORE Impact 4 Likelihood 21
TARGET SCORE Impact 3 Likelihood 18

Overall Risk has increased from 18 to 21 as SR10.02 will not be back on track before FY2025 end.

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 SMP being in delay. Details as follows: Hatfield Car Park due to protracted negotiations, and SUR Wexham delay due to parish council inactivity. 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.

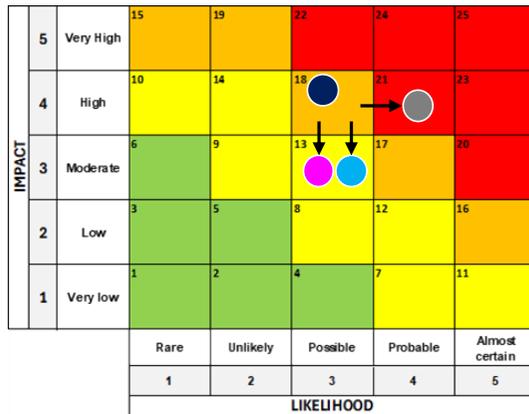
Risk appetite statement (Balanced)

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



Sub risks related to this principal risk



Refer to slide 7 for risk assessment score instructions

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
10.01	Light Blue	Property disposals not hitting financial targets and sitting outside lower volatility levels	Peter Walsh	Green Up Arrow	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	Grey	Pace of disposals is behind programme deliverable dates	Peter Walsh	Red Down Arrow	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	Pink	Attraction and Retention of quality people	Peter Walsh	Green Up Arrow	One new general fund Disposals Surveyors in Transition from interim to permanent staff still to be implemented.
10.04	Dark Blue	External property market volatility	Peter Walsh	Yellow Right Arrow	Market is currently stable after a downward trend. Positive movement is anticipated which will allow better sales proceeds and positive volatility.

Key Risk Indicators (KRIs)



KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend															
Sales Proceeds	<p>The proceeds of sales falls outside of the Lower Volatility thresholds as designated based on Asset Classification.</p> <table border="1"> <thead> <tr> <th></th> <th>Lower Volatility</th> <th>Upper Volatility</th> </tr> </thead> <tbody> <tr> <td></td> <td>100%</td> <td>110%</td> </tr> <tr> <td></td> <td>80%</td> <td>110%</td> </tr> <tr> <td></td> <td>80%</td> <td>110%</td> </tr> <tr> <td></td> <td>60%</td> <td>110%</td> </tr> </tbody> </table>		Lower Volatility	Upper Volatility		100%	110%		80%	110%		80%	110%		60%	110%	<p>FY 24 / 25 Achieved Sales : £ 8.358m</p> <p>FY 25 / 26 Target Sales : £ 22.1m Lower Threshold : £ 20.9m</p> <p>FY 26 / 27 Target Sales : £ 14.5m Lower Threshold : £ 10.5m</p>			
	Lower Volatility	Upper Volatility																		
	100%	110%																		
	80%	110%																		
	80%	110%																		
	60%	110%																		
Pace of Sales	The pace of sale drops below the anticipated plan	<p>FY 24 / 25 – 9 sales PA FY 25 / 26 – 21 sales PA FY 26 / 27 – 22 sales PA</p>																		
Risk of Judicial Review	Not following prescribed procedures or a lack of thoroughness in consultation, understanding operational needs or similar.	<p>1 permission / 6 months 1 successful hearing / 2 years</p>																		
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	<p>At least 10 EOI per sale At least five 5 Bidders / BAFO per sale</p>																		

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

Control Effectiveness	Description
Effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating as intended Management is confident that the controls are effective and reliable
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Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR10.01	Market / Economy	<ul style="list-style-type: none"> Market Intelligence and Engagement Consider reordering disposals due to market sentiment 	Peter Hopkins	<i>Largely Effective</i>	Monthly review of deals in near pipeline to consider reordering as necessary
2	SR10.02	Sales below expectations	<ul style="list-style-type: none"> Engagement of correct agents and sales routes Preparation of quality bid materials and supporting docs Ensuring properties pitched to correct pool of purchasers 	Peter Hopkins	<i>Effective</i>	Sales Proceeds on track, however time to Complete needs improvement.
3	SR10.03	Abortive Sales	<ul style="list-style-type: none"> EY AADF framework in use as SBC internal gateway All pipeline assets have impairments assigned 	Peter Hopkins	<i>Largely Effective</i>	Treatment delivered
4	SR10.04	Programme Target	<ul style="list-style-type: none"> Revised GF disposal plan submitted to cabinet in November, and timely receipt of Members approval in future Monthly adjustment and refinement of programme 	Peter Hopkins	<i>Largely Effective</i>	
5	SR10.05	Records	<ul style="list-style-type: none"> Document register now better Better archiving needed (physical and electronic) 	Peter Hopkins	<i>Largely Effective</i>	Time has been invested, documents are in much better condition, physically and online.
6	SR10.06	Skills / Capability	<ul style="list-style-type: none"> Review team engagement as tempo of disposals increases Move away from interims to permanent team, to retain corporate memory 	Peter Hopkins	<i>Needs Improvement</i>	Establishment for FY25/26 still under review which will impact Interim to Permanent transition. Limited progress only.
7	SR10.07	Protocol / Process	<ul style="list-style-type: none"> Review ongoing approved processes being followed 	Peter Hopkins	<i>Needs Improvement</i>	Improving however additional time required to bed in.

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	SR11.05	Records	Electronic and physical archiving needs improvement., including review of offsite storage facility in Reading for documents that need retention.	Peter Hopkins	March 2026		Continuing to review progress, likely move to move to "Largely Effective" Q4 FY25/26?
3	SR11.06	Skills / Capability	Putting in place jobadverts before launch of permanent disposal roles from Jan 2026	Peter Hopkins	Dec 2025		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.	Peter Hopkins	1. End Q2 FY 25 / 26		Flowchart now complete. Embed as corporate process by end Q2 FY25/26. Corporate asset panel meeting monthly.- Delivered

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

Corporate risk overview

Current Risk Score	3	Impact	4	Likelihood	17
Target Risk Score	3	Impact	4	Likelihood	18

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

- 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 12.02 has moved from 21 down to 17 due to £2mil from risk reserve; however, a £700k shortfall for ASC to fund. ASC has identified how to meet this shortfall.

Risk profile



Sub risks related to this principal risk



IMPACT	5	Very High	15	19	22	24	25
	4	High	10	14	18	21	23
	3	Moderate	6	9	13	17	20
	2	Low	3	5	8	12	16
	1	Very low	1	2	4	7	11
		Rare	Unlikely	Possible	Probable	Almost certain	
		1	2	3	4	5	
LIKELIHOOD							

Refer to slide 7 for risk assessment score instructions

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
12.01	Blue circle	Insufficient access to care services	Lynn Johnson (HOS)	Yellow arrow	No change 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	Grey circle	Cost of fee uplifts outstripping budget	Lynn Johnson (HOS)	Green arrow	CLT agreed proposed provider uplifts fo 25/26 in August 2025 totalling £3.1m, which reduces to £2.7m when offset by budget provision for inflation. Funding made available to draw down from risk reserve £2m; ASC need to find savings in 25/26 to mitigate against £0.700m of pressure unfunded. Providers notified of uplift August 2025, uplifts backdated to 1 April 25; risk of providers handing back contracts/serving notice assessed as low to medium.
12.03	Pink circle	Provider failure	Lynn Johnson (HOS)	Yellow arrow	Monthly reports of care quality provided to CMMB, DLT and Care Governance Board. No provider failures linked to quality in Q2. Notice was served to terminate a contract due to a care provider's insolvency and alternative placements secured.
12.04	Black circle	Recruitment and retention of external workforce	Lynn Johnson (HOS)	Yellow arrow	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.

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	Q1 25/26 Providers Suspended Due to Quality Concerns 2 x Care Homes 3 x Supported Living Providers 0 x Home Care Providers	Update Q2 25/26 Providers Suspended Due to Quality Concerns 1 x Care Home 1 x Supported Living Providers 0 x Home Care Providers	
KRI 2 – Contract handbacks	The number of contract hand backs on a monthly basis	0	Q1 25/26 0 Contract Handbacks	Update Q2 25/26 0 Contract Handbacks	

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

Control Effectiveness	Description	
Effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating as intended Management is confident that the controls are effective and reliable 	
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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 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

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

Ref	Control ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	12.03	Review of Quality Assurance Framework	Addressing quality issues – investment in Clinical Pharmacist role to extend medicines optimisation support through NHS Frimley ICB to home care and Supported Living Providers	Lynn Johnson	December 2025	Green	No Change Recruitment paused due to changes proposed to ICBs and staffing reduction NHS Frimley ICB/ICB
2	12.03	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	Amber	Workshops with care markets and Skills for Care planned Q1 2026/27 Rated amber as currently no capacity within team to deliver
3	12.01	Review of Market Position Statement (MPS)	Identify gaps in market and new models of care and signal new opportunities to the market to address any sufficiency issues	Lynn Johnson	June 2026	Green	Action plan status has been changed from red to green as review of MPS delayed and deferred to Q1 2026/27

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

Corporate risk overview

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

Updates are:

- GDPR training compliance has reduced slightly to 83% this quarter. This continues to be monitored at the monthly IGG meetings for both SBC and SCF. SCF reviewing compliance statistics following change in learning management platform .
- A briefing on GDPR and information security continues to be included in the corporate induction programme which is delivered to all new roles within the first 2 months of their start date.
- Continue to review and update GDPR policies and guidance in align with their annual review dates. Updated documents are circulated and approved by IGG.
- Updated the corporate retention schedules and communicated to staff.
- Interim now in place for Information & Record Lead. Looking at permanent 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



Sub risks related to this principal risk



IMPACT	5	Very High	15	19	22	24	25
	4	High	10	14	18	21	23
	3	Moderate	6	9	13	17	20
	2	Low	3	5	8	12	16
	1	Very low	1	2	4	7	11
		Rare	Unlikely	Possible	Probable	Almost certain	
		1	2	3	4	5	
		LIKELIHOOD					

Refer to slide 7 for risk assessment score instructions

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
13.01	●	Privacy breach of personal data	Alex Cowen	↑	<p>This risk relates primarily to accidental disclosure of information; cyber attack is covered by CR08.</p> <p>Risk treatment plans relating to systems, process and training have been identified. The latter is of particular relevance here, where staff mindfulness of the importance of security and privacy is critical in avoiding materialisation of the risk.</p> <ul style="list-style-type: none"> • 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. • Mandatory training compliance is at 83% this quarter. • Ongoing awareness on GDPR sent out in regular corporate communications as well as the corporate induction programme • IG newsletter drafted and awaiting feedback and template from Communications. Expecting circulation before next quarter.
13.02	●	Unlawful retention and processing of personal data	Alex Cowen	→	<p>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.</p> <ul style="list-style-type: none"> • The sub risk remains stable with no major changes envisaged.

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 formed by baselines. For Q2, data is either not available or not confirmed.					
Completion rate of mandatory training	<i>Rate of completion of mandatory data protection and cyber security training, reported separately for SBC and SCF</i>	90%	SBC: 86% SCF: No stats this quarter	SBC: 83% 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	19	14	
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	0	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	

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

Control Effectiveness	Description
Effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating as intended Management is confident that the controls are effective and reliable
Largely effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating with opportunities for improvements identified
Needs improvement	<ul style="list-style-type: none"> Controls are only partially effective, require ongoing monitoring and may require redesigning, improving or supplementing Key controls and or/ management activities in place, with significant opportunities for improvement identified
Ineffective	<ul style="list-style-type: none"> Limited controls and or/ management activities in place
Weak	<ul style="list-style-type: none"> Controls do not meet an acceptable standard, as many weaknesses/inefficiencies exist Controls and or/ management activities are non-existent or have major deficiencies and don't operate as intended

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR13.01	Training	New staff are obliged to complete Learning and an annual refresher course is also mandatory.	Martin Chalmers	Largely effective	<ul style="list-style-type: none"> Take up of training remains below target (90%) but consistently above 80%.
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	<ul style="list-style-type: none"> Audit actions relating to this area have been closed All GDPR policies are updated annually and approved by IGG. Subsequent actions will be monitored through the monthly IGG meetings.
3	SR13.01	Resourcing	An Information Governance officer role in place	Martin Chalmers	Largely effective	<ul style="list-style-type: none"> Interim now in place for Information & Record Lead. Looking at permanent recruitment as part of DDaT restructure.
4	SR13.01	Communications	Awareness of data protection responsibilities boosted through emails and staff newsletter	Martin Chalmers	Largely effective	<ul style="list-style-type: none"> Awareness on GDPR sent in regular corporate communications as well as the corporate induction programme Engagement underway with the Learning & Development team to further drive up compliance. IG newsletter drafted and awaiting feedback and template from Communications. Expecting circulation before next quarter.

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	<ul style="list-style-type: none"> Treatment plan is now completed as the control is now in place
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	<ul style="list-style-type: none"> Due to the directive on essential spend only, the re-ignition of the Sharepoint & Purview project has been pushed back to 2026. This treatment plan will be reviewed in Q3. Updated the corporate retention schedules and communicated to staff.
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	<ul style="list-style-type: none"> 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 (Advertise Role)	G	<ul style="list-style-type: none"> Advertise role in November 25 with the aim to fulfil role permanently from April 26. An Interim is currently in place for the role.
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	December 2025 (Policy drafted)	G	<ul style="list-style-type: none"> 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

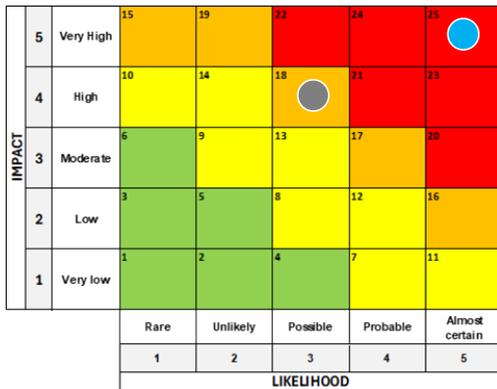
- Governance, oversight & financial council exposure as Shareholder across James Elliman Homes (JEH), and GRE5
- Risk that retained losses across the companies continue to be underwritten by the Council
- JEH 12-month Business case approved by cabinet on the 17th March 2025. Implementation is underway 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 Successful and currently being onboarded
- Risk that Right To Manage has been enacted by residents but liabilities remain with the company which are being explored legally and with Homes England

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. Two new directors are being onboarded and will then focus on settling outstanding grant claims, clarifying Right to Manage and provide a managed exit strategy for the council

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, recognising the Company has no material income but has expenditure liabilities.	tbv			
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	

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	

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

Control Effectiveness	Description
Effective	<ul style="list-style-type: none"> Controls and or/ management activities properly designed and operating as intended Management is confident that the controls are effective and reliable
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Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
2	SR14.01 SR14.02	Board meetings- Shareholder	Regular Shareholder meeting now scheduled being managed by Law & Governance	Sukdave Ghuman	Needs Improvement	Since the first meeting, areas of improvement identified by implementing greater clarity and forward planning of key decisions required by Company Directors
3	SR14.01 SR14.02	Letter of assurance	Letters enable the companies to continue	Executive Corporate Director of Resources (S1.151 Officer)	Effective	Letters are updated annually to provide assurance to the Company Directors enabling the companies to trade financially
4	SR14.01 SR14.02	Business Plan	In place Business Plans currently Live and providing Strategic Direction to the Companies	Company Directors for GRE5 & JEH	Needs Improvement	Business planning for both companies is underway to ensure continuity of alignment to the Council (as shareholder) directions
5	SR14.01 SR14.02	Board meetings- Company	GRE5 Board meetings occur monthly	GRE5 Directors	Ineffective	GRE5 appointing new CeSec external Support to regularise
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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	SR01.01	<i>High level action that will mitigate or reduce the risk the most</i>		<i>Director level</i>	<i>Dd-mm-yyyy (within the next 12 months)</i>	<i>(RAG)</i>	
2	SR14.02	New Director Appointments	Recruitment undertake during to appoint 2 new directors	Peter Hopkins	30 Oct 2025	Amber	One Director appointed to the Council but not to the company. 2nd director in process of Council Onboarding
3	SR14.02	Trading position	Updating letters of Assurance to make the company a going concern	Peter Hopkins	31 December 2025	Green	Annual letter requires updating
4	SR14.02	Right To Manage	Ongoing legal due diligence regarding position of undertaking managing agent role	Peter Hopkins	Peter Hopkins	Red	Company External Solicitors undertaking evaluation of the Right to Manage process to ensure a valid process that is legally compliant has been followed by Nova House RTM company
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Target Risk Score– 24 by end of date 10/2025