Slough Borough Council

Report To:	Audit and Corporate Governance Committee
Date:	11 March 2026
Subject:	Quarter 3 FY2025/26 Corporate Risk Report
Chief Officer:	Ian O'Donnell, Executive Director Corporate Resources (s.151 Officer)
Contact Officer:	William Green, Risk Management Consultant
Ward(s):	All
Exempt:	No
Appendices:	Appendix 'A' – Q3 FY25/26 Corporate Risk Profile Appendix 'B' – Q3 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 Q3 FY25/26 Corporate Risk Report.
- Breakdown of current Corporate Risks and Sub-Risks

Recommendations:

The Audit and Corporate Governance Committee is recommended

A) to note the revised Corporate Risks and Sub-Risks as at Quarter 3 FY25/26 (February 2026) as set out in Appendix A and B.
B) To note the updated 2026 Risk Management Strategy at Appendix C and provide any comments for consideration by Cabinet

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.

The Audit and Corporate Governance Committee is recommended to consider and note the updated 2025 Risk Management Strategy document

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. It will be submitted to Cabinet for approval.

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 Q3 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 17th February 2026 and after review, it was signed off. The corporate risk report was then presented to the CLT on the 25th February 2026.

The Q3 FY25/26 position is that the Councils risk exposure has improved this quarter, however the overall exposure still remains elevated but is being actively managed within the resource constraints. Four risk scores have improved, and one risk score has deteriorated. The majority of corporate risks are reported as being stable or improving with only three risks reporting a deteriorating position. Certain 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. There is still confidence that the improved risk control environment will lead to further corporate risk scores improving however that is tempered by a possible lack of resources driven by financial constraints.

2.3 Of the thirteen identified corporate risks, nine are rated as red (risk score between 20 – 25), and one is rated as amber (risk score between 15 – 19) and three are rated as yellow **(**risk score between 15 – 19). In comparison to Q2 FY2025/26 there is no change to the number of risks rated red, however we had four amber and zero yellow rated risks

2.4 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.

2.5 The target risk scores have been re-assessed and will now run to March 2027. These scores are linked to the delivery of the treatment plans and are monitored on a quarterly basis.

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

Q3 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.

Q3 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	Likliehood 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	→
	SR045.05: Ability to effectively Manage TA property and people	4	4	21		21	→
CR05	**Failure to Attract Retain & Engage with Our People**	4	3	18	18	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 inline 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 BCP's for all services responsible for delivering business critical activities	4	4	21		21	→
	SR07.05: Inadequate continuity planning for specific risks	4	3	18		18	→
CR08	**ICT incident resulting in significant data and/or service**	5	4	24	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: GRE5 - Failure of the company resulting in financial losses and reputational issues for the council.	3	3	13		13	↓

At the closure of the Q3 FY25/26 risk dashboards, we have:

13 corporate risks, broken down into:

- 9 RED risks (risk score between 20 – 25) – **Q2 - 9 RED**
- 1 AMBER risks (risk score between 15 – 19) – **Q2 - 4 AMBER**
- 3 YELLOW risks **(**risk score between 15 – 19) – **Q2 0 Yellow**

- 55 sub-risks across all corporate risks **– Q2 – 55**
- 16 RED risks (risk score between 20 – 25) – **Q2 - 15**
- 11 AMBER risks (risk score between 15 – 19) – **Q2 - 18**
- 24 YELLOW risk (risk score 7 – 14) – **Q2 - 18**
- 4 GREEN risks (risk score 1 – 6) – **Q2 – 4**

2 sub-risks have deteriorated in this quarter compared to 2 in Q2
14 sub-risks have improved in this quarter compared to 6 in Q2.

2.8 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.

2.9 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 Committee 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 remains red with a deteriorating outlook this quarter being driven by a continued budget number of high-cost complex cases and increasing demand.

- 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 £4.7m which has reduced from last quarter but there is continued overspend due to provider uplifts and demand related to new people/increase in need.

- CR03: *(Failure of Special Educational Needs and Disability (SEND))* – the rating has remained red this quarter, driven by an inspection has that found widespread and/or systematic failings in local area SEND services. . The judgement was in line with predictions and evidenced clear improvements since the previous inspection.

- CR04: *(Failure to Provide Safe Temporary Accommodation within Budget)* – the risk remains red, and there are continued improvement in the sub-risks last quarte, but not sufficient to change the risk score. 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 across all sub-risks, particularly Business Continuity where additional specialist resources have been secured within Risk Management and is progressing early stages of programme design. This activity will take time to translate into reduced risks scores.

- CR08: *(ICT incident, resulting in significant data or service loss*) - the overall rating remains red with all sub-risks remaining stable or improving. The key risk driving the overall score is a breach resulting in loss of data or service disruption. Although action plans are being delivered this risk is unlikely to move out of a red score driven by the threat of a cyber-attack.

- CR09: *(Failure to achieve financial sustainability and a balanced MTFS)* – the risk remains red however it has reduced from 24 to 22 driven by the sub-risk for the failure to achieve a balanced budget and Medium-Term Financial Strategy (MTFS) where the budget has been published but is subject to cabinet approval.

- CR12: *(Failure to deliver adult social care market sustainability)* – this risk has moved from amber to red driven by funding availability in the context of the market pressures from rising costs due to increases to the National Living Wage and higher Employer National Insurance Contributions, as well as other inflationary pressures including energy costs, food and fuel.

- 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-risk for JEH has stabilised and the sub-risk for GRE5 has deteriorated this quarter.

There has been one deteriorating risk reported this quarter:

- *CR12: (Failure to deliver adult social care market sustainability)* - The overall rating has increased from amber to red which has been driven by funding availability in the context of the market pressures from rising costs due to increases to the National Living Wage and higher Employer National Insurance Contributions, as well as other inflationary pressures including energy costs, food and fuel.

Four corporate risks have improved this quarter:

- *CR05: (Failure to Attract Retain & Engage with Our People)* - The overall rating has decreased from amber to yellow due to the continued improvements of SR05.01 and SR05.02 made during Q2.

- *CR06: (Health & Safety We fail to prevent physical injury or mental harm)* – The overall rating has decreased from amber to yellow due to the continued improvements and implementations made during Q2 to lone working, fire risk assessments and training.

- *CR09: (Failure to achieve financial sustainability and a balanced MTFS)* - The overall rating has remained red but has shown a decrease in the risk score from 24 to 22. This has been due following the publication of accounts and the improving outlook of all sub-risks.

- *CR10: (Failure of General Fund Asset Disposal Programme)* – The overall risk rating has decreased for amber to yellow primarily as the pace of disposals is back on track for the 2025/26-year end. It is also driven by improvements in sub-risks SR10.03 and 10.04.

2.4 As reported in the Q1 2025/26 Corporate Risk Report we had removed CR11- *Failure to become a best value council*. Two replacement corporate risk have now been approved by the Risk Management Board ("RMB") and the Corporate Leadership Team ("CLT") and will be included in the Q4 Corporate Risk Report.

2.5 The two risks are 'Failure of Internal Controls' and 'Failure to deliver Transformation Plan'
To ensure the corporate risks accurately reflect the current state meetings with the risk owners and sub-risk owners are planned.

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.

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

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

2.8 The Q3 FY25/26 current and target risk scores are summarised below Please note:

Target scores have been re-evaluated with a deliverable timeline (March 2027).

Figure 2 – Corporate Risk Current & Target scores (Q3 FY25/26)
(Target risk scores to be delivered by March 2027)

`	CORPORATE RISK	CURRENT SCORE	TARGET SCORE	Score movement in quarter
CR01	Failure to Safeguard Children and Young People within budget	21	18	→
CR02	Failure to meet demands on Adult Social Care within budget	23	14	→
CR03	Failure of Special Educational Needs and Disability (SEND)	21	14	→
CR04	Failure to Provide Safe Temporary Accommodation within Budget	25	21	→
CR05	Failure to Attract Retain & Engage with Our People	13	13	↑
CR06	Health & Safety We fail to prevent physical injury or mental harm	14	14	↑
CR07	Insufficient Operational Resilience and Crisis Management	21	18	→
CR08	ICT incident resulting in significant data and/or service	24	22	→
CR09	Failure to achieve financial sustainability and a balanced MTFS	22	22	↑
CR10	Failure of General Fund Asset Disposal Programme	14	14	↑
CR12	Failure to deliver adult social care market sustainability	21	18	↓
CR13	We fail to comply with GDPR data protection obligations	18	18	→
CR14	Failure of Council Subsidiary Companies	25	24	→

2.13 The Risk Management Consultant 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 A Risk Management Maturity assessment was carried out to establish an objective, evidence-based picture of where the Council's risk maturity stands, and to identify the actions needed to strengthen it. With all directorates represented, the 2026 survey provides a clear perspective of the Risk Management Programme. The result of 3.5 (DEVELOPING) based on the ISO 31000:2018 Maturity Scale represents a significant uplift across all five risk maturity domains, advancing from a score of 1.32 in 2024. The full report, which is currently being written, will be presented to the Audit and Corporate Governance Committee next quarter.

2.15 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 pro-active management of risks, and to embed risk management into "business as usual" processes.

3.4 Environmental implications

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

3.5 Equality implications

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

4. Background Papers

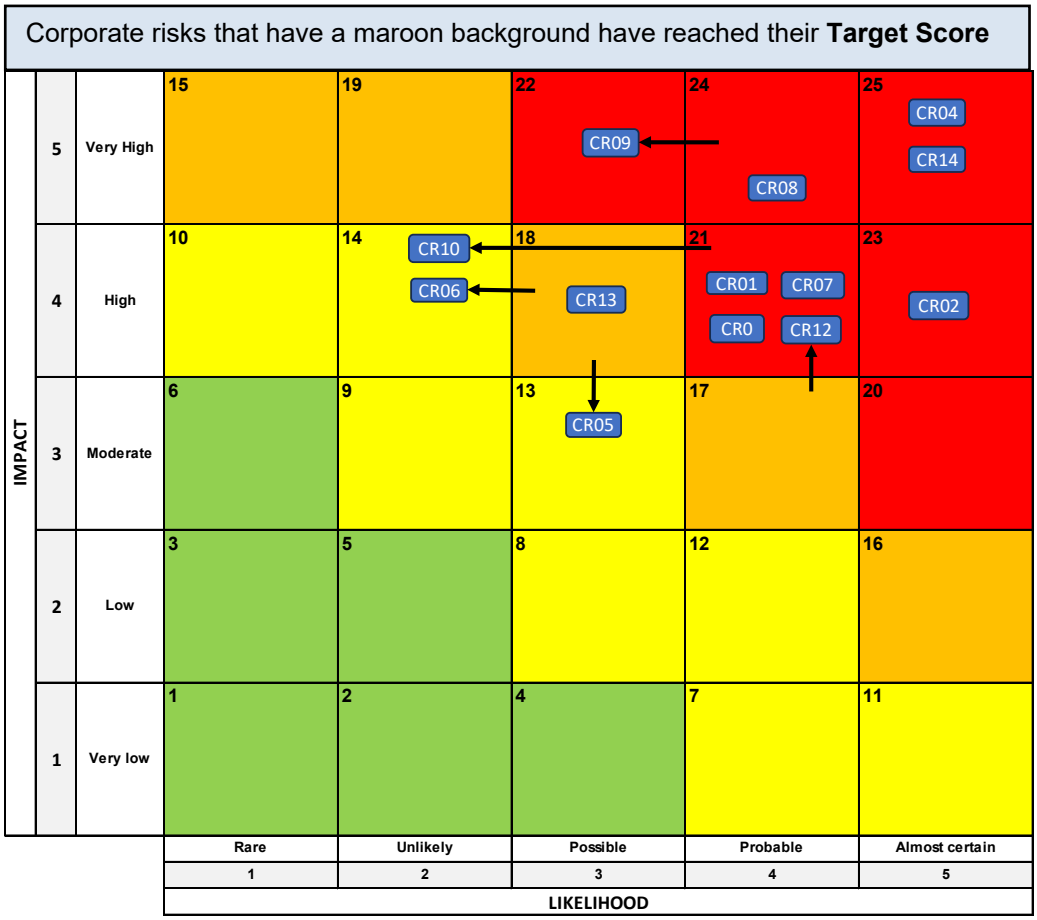
None

Appendix ‘A’ – Q2 FY2025/26 Corporate Risk Profile

The overall corporate risk profile has improved in period due to one risk deteriorating and four improvements in the risk scoring. The corporate risks continue to improve their control environments which is resulting in a more stable outlook for the future. Our current financial position may result in our risk profile deteriorating as we are unable to deliver treatment plans within their identified delivery timescales.

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 (Q3 FY2025/26)



Corporate Risk

CR01: Failure to Safeguard Children and Young People
CR02: Failure to meet demands on Adult Social Care within budget
CR03: Failure of Special Educational Needs and Disability (SEND)
CR04: Failure to Provide Safe Temporary Accommodation within Budget
CR05: Failure to Attract Retain & Engage with Our People
CR06: Health & Safety We fail to prevent physical injury or mental harm
CR07: Insufficient Operational Resilience and Crisis Management

Corporate Risk

CR08: ICT incident resulting in significant data and/or service
CR09: Failure to achieve financial sustainability and a balanced MTFS
CR10: Failure of General Fund Asset Disposal Programme
CR12: Failure to deliver adult social care market sustainability
CR13: We fail to comply with GDPR data protection obligations
CR14: Failure of Council Subsidiary Companies

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

CR01 Failure to Safeguard Children and Young People within budget

Risk owner: Sue Butcher

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

Corporate risk overview

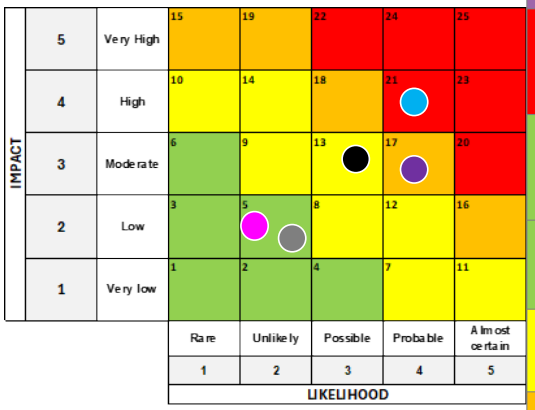
Risk score has REMAINED AT 21(RAG RED) reflecting an above budget number of high cost complex cases, increasing demand and an above budget pay settlement. Steps are in place to mitigate increased spend but an overspend against budget is still forecast.
SR01.05 remains at 17 despite a lot of foundational 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 risks 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. This is having an impact on continuity and organisational memory. 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 redesigned 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.

Risk profile



Refer to slide 7 for risk assessment score instructions

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
01.01		Insufficient financial resources	SCF Director of Finance/ Resources (Alex Pilgerstorfer)		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 of approx. £2 million This is being addressed through close financial management and liaison with SBC about an in-year budget review.
01.02		Attraction and retention of qualified workforce	Head of HR (Kate McCorriston)		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.
01.03		High Caseloads for frontline staff	Director of Operations (Joe Tynan – interim)		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. One service area still has pressures which is being addressed.
01.04		Staff capability	Director of Operations (Joe Tynan)		Training and development is delivered consistently. Workforce development strategy rolled out. Performance dashboards being rolled out which will support focussed interventions and support where required.
01.05		Data production does not support effective practice	SCF Director of Finance/ Resources (Alex Pilgerstorfer)		SCF is reliant on manual intervention to produce necessary reporting. There are several key IT systems from which is it hard to extract data for a variety of users. A key difficulty is combining data held across systems and the risk of error through manual evaluation. A joint project with SBC is exploring how to improve data processing with a delivery date next financial year.

CR01	Failure to Safeguard Children and Young Peoplewithin budget	s

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. statu	Trend
KR1	Quarterly and year end financial forecasts: expected variation from budget	*£0*	*Q2 actual £699,000 deficit*	*Q3 actual £1,579,000 deficit*	
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% 34%	41.8% 38%	
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%	15.9 93.5& 29.6% 81.2% 100% 100% 89.3%	18.3% 95.7% 24.2% 89.8% 100% 100% 90.1%	
KRI 4	Number of staff on performance management (formal and informal)	-	4	4	
KRI 5	Number of data dashboards desired but currently unable to deliver	MASH, RISE X4) Safet_+QA; core operationsal -	16	C8 in 26/7 (MASH, Adolescent support (ie Missing, Exploitation, Edge of Care); Connected Carers, Safeguarding&QA, Commissioning, SEND Controcc Finance, Virtual School, Attendance Service, Post 16, HR&Workforce- Agresso, IFA and Adoption)	

CR01	Failure to Safeguard Children and Young People within budget	Sue Butcher (Chief Executive SCF)

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

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

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR1	Financial Management	Expenditure Control Panel. Monitoring by Company Board and SBC. Strategic Commissioning Group. Delegated decision making.	Director of Finance and Resources	Effective	Currently operating within expectations.
2	SR2	Recruitment and Retention	Use of Talos system, monthly reporting to Senior Leadership Team, Staff Surveys, Exit Interviews, Shadow Board (staff feedback to improvement board). Benchmarking	Head of HR and OD	Largely Effective	Workforce Development 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 an Improvement Board	Director of Operations	Largely Effective	Currently operating within expectations.
4	SR4	Performance management	Feedback from staff, 121s, Appraisals, Quality Assurance Framework, manager training	Head of HR and OD	Needs Improvement	Ongoing performance management
5	SR5	Data interrogation	Manual intervention and quality control for data reporting. Some PowerBi dashboards. Weekly reviews of CYP core datasets (Annex A), ongoing programme of audits and dip sampling of files held on CYP to cover c10% pa	SCF Chief Executive	Needs Improvement	Further development of PowerBi dashboards; further data cleansing of HR systems; further audits of caseload data. Good foundational work being done to allow data reports to be run.

CR01	Failure to Safeguard Children and Young People within budget	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	Chief Executive	Oct 26		Following the scheduled review additional resources are being seconded into the Academy to develop practice specific learning. Performance management support has been rolled out by HR to frontline managers.
3	01.05	PowerBi dashboards	Articulate programme to deliver additional PowerBi performance dashboards,	SCF Director of Finance/ Resources (Alex P)	TBA once council confirms programme		Some dashboards have been rolled out to good effect. A desired programme has been shared with the council which needs to confirm what can be deliver FY26/27.
4	01.05	Reviews of HR data systems	Ongoing data cleansing of HR systems	Head of HR and OD	July 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). Delivery date pushed out to accommodate enhanced project deliverables.

Target Risk Score – 18 by end of date *03/2027*

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	14

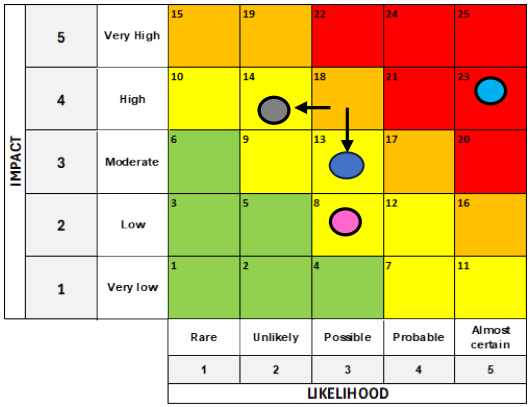
Work is underway to address workforce demands and the directorate is starting to see improvements. The permanent Director of Operations started in Nov 2025 and the permanent Head of Market Management started in Jan 2026. Discussions continue re the appointment of Head of Reablement and Independence There has been significant progress with annual reviews with more planned annual reviews taking place. We continue to monitor reviews in MH separately (02.04)
Risk Profile for 02.01 has remained at 23, as at end of P10 there is a forecast of £4.7mil overspend which includes provider uplifts and new demand related to new people/increase in need. There are controls in place to monitor this monthly. The Practice Assurance Board is fully established, which will enable assurance to be provided on a quarterly basis and there is a review underway of the People and Practice Panel. This will enable us to understand our decision making and determine what improvements/changes may be required.
The overall target risk score (due March 2027) has been reduced to 14. This is due to the proposed 26/27 budget setting being more realistic to meet the demands within ASC
KR1 in relation to increase in demand has been removed and a new KR will be developed

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.

Target Risk score by March 2027

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. Improved position on track to complete a collective total of 2053 which is more than 1656 in 2024/25
02.03		Attraction & retention of talent	Jane Senior Fadzai Tande		Permanent Director of Operations and Director of Market Management in post, discussions continue re appointment of Head of Reablement & Independence Sponsorship licence has been secured Permanent appoints being secured in MH, however AMHP recruitment is still a risk
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)~~ ~~*Number of contacts per quarter*~~ ~~*Dashboard*~~ ~~*Estimate demand to be and then what takes us over that amount and what that means?*~~ ~~*Benchmark year to year*~~ ~~*Budget pressures– increase in demand or cost*~~ ~~*Outlier in over 65+ support 7.3% national average 5.5% approx. annual data*~~ ~~*Consider rewording– meaningful from ? Dashboard*~~ ~~***REMOVE - add statement that NEW KRIs being reviewed***~~	~~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% per annum	TBC	61 agency staff currently in post asat August 2025 (28% staff are interim	52 agency staff currently in post asat Dec 2025 (25% staff are interim) Reduction of 3% from Aug 2025	
KRI 3– Stabilise ASC leadership team	New extended leadership structure in place, Three of the 5 Heads of Service are permanent. A 6th Head of Service post is being held to the newly formed PSW role. The Director of Operations has been appointed started Nov 2025 Director of Commissioning and Executive Director have permanent staff in post. Total number of posts in leadership team ~~-~~ 8 + HOS post held	20% (Vacancy/interim cover rate)	Q2 25/26 - 40%	Q3 25/26 –25%	

Feb 2026 KR1 – increase in demand removed and new KR and metrics will be developed

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

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

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

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR02.01	Strong Governance policies	DLT reviewed and thematical cycle in place, focus on finance, performance and risk	David Coleman-Groom	*Effective*	Controls are operating at an acceptable level
2	SR02.01	Cost Savings within our control	Identified Senior Responsible Owner(SRO) for each saving	David Coleman-Groom	*Effective*	Leads have been identified for each saving target, and this is discussed at eDLT regularly
3	SR02.02	One Slough Directory	Comprehensive directory of services that enables residents to find information themselves to support their daily living	Director of Commissioning (Jane Senior)	*Effective*	See VCS Contracts – One year update Cabinet January 2025 Report and Appendix One.pdf
4	SR02.02	Community Connectors	Additional resource to connect residents to local services	Director of Commissioning (Jane Senior)	*Largely effective*	See VCS Contracts – One year update to Cabinet January 2025 Report and Appendix One.pdf
5	SR02.02	ASC linked to Front Door	Skilled and trained staff linked at the front door to help advise people and enable them to access alternative support	NEW: Director of Commissioning (Jane Senior) added October 25	Needs improvement	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. **ASC Front door project has been developed to take this work forward**
6	SR02.02	Management of OT waiting lists	Waiting Well Management Methodology document in place which provides a clear structure for prioritising cases based on identified risks.	Head of Service Short Term Services (Ilona Sarulakis)	*Largely effective*	This methodology is mirrored in the Social Work Teams' Waiting Well Allocation List.

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

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

Ref his	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
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)	**10/2026 For implementation of comprehensively remodelled front door**		• 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 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 • There is a new ASC project established regarding comprehensively remodelling the Front door into ASC • Blueprint of new model delivered to project task and finish group by 31 March. Implementation from April 2026. • The Action due date has been updated from Oct 2025 to October 26 given the extent of the new project.
2	SR2.02	Tech Solutions for Adult Social Car~~eDigital Blue Printfor tech~~	In partnership with Digital, Data and Tech Service review existing tech solutions used within social care which will improve user experience and free up capacity for the workforce	**Interim Head of Strategic Commissioning (Lynn Johnson)**	**10/2026**		• Focus of work related to safeguarding Slough residents and mitigating risks related to supplier issues. Final draft expected to be shared in Q3. • Ask Sara, Jointly App and Carers UK Platform have all been implemented. • There have been a number of events undertaken to promote digital initiatives including Empowering Indepedence event in Jan 2026. This was well attended with colleagues from Frimley NHS and RBWM attending. • Magic Notes Pilot is being undertaken in Adult Social Care. • Digital Blueprint being implemented March 2026 setting out our onwards approaching to implementing digital solutions. • A draft has gone through CLT in Dec 2025 and a new project coming online

CR03 Failure of Special Educational Needs and Disability (SEND) Q3 Report Feb26

Risk owner: Sue Butcher

Current Risk Score 3 Impact 5 Likelihood	21
Target Risk Score 4 Impact 3 Likelihood	14

Corporate risk overview

Since Q2 an inspection has taken place and found widespread and/or systematic failings in local area SEND services. All the priority areas and areas for improvement were identified in our self evaluation and work was already under way to address them. The judgement was in line with predictions and evidenced clear improvements since the previous inspection. The inspection findings and the change from the Written Statement of Action to a Priority Action and Impact Plan [PAIP] has necessitated a complete review of the operating controls, mitigation plans and current risk scores. However, three of four key risks. Although the risk has increased in two areas, the overall risk score has remained at 21 and most performance indicators have remined the same

The PAIP has been approved by the DFE and a SEND Commissioner has been appointed to support our improvement journey and is working closely with SBC Finance and external commissioners. A SEND Strategic Improvement and Assurance Board [SIAB] and an Operation Delivery Group is now in place. A first action is a review of staffing levels to effectively meet statutory duties.

A SEND Transformation Programme has been agreed - Phase 1 is a Diagnostic Model Build, Phase 2 is Scenario Modelling and Insight and Phase 3 is Application and Embedding. It includes short term and medium term actions to address demand and budget. The overall plan is built on best practice by prioritising early identification and inclusion in mainstream schools.

Following the SEND Sufficiency Strategy, a Capital Investment Strategy has been approved that focused on ensuring sufficient SEND places in the future. The Early Years [EY] Strategy was written in partnership with EY experts (Dingley's Promise) and supports the overall programme. The SEND and Inclusion Strategy will be reviewed in light of the Local Area Inspection outcome.

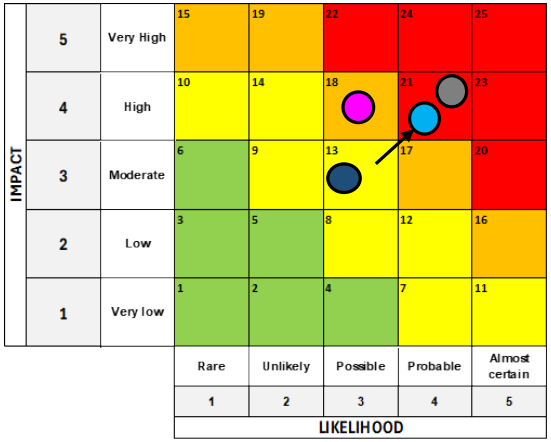
SBC successfully bid for an Inclusion Support Fund and this will provide intelligence to support the transformation programme. The Safety Valve Agreement continues and the predicted deficit at the end of the agreement has risen significantly. However, the DfE has not suggested that this will affect future payments and we are aware that the national picture for local authorities largely mirrors the Slough position. Tribunal outcomes have remained positive with no significant adverse decisions but there are still a number of LGSCO complaints arising out of previous poor practice.

Risk appetite statement (BALANCED)

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

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

Risk profile



Refer to slide 8 for risk assessment score instructions

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
03.01		Failure to provide appropriate support to children and young people with SEND with and without an EHC plan earlier enough that will impact on their life opportunities.	Neil Hoskinson		Although there were a number of positives in the Local Area Inspection, the overall judgement was that "there are widespread and/or systematic failings leading to significant concerns". Slough has been set 5 Areas for Priority Action and 3 Areas for Improvement. As a result, this area has moved back to **PROBABLE** from **POSSIBLE** and **HIGH** rather than **MODERATE**.
03.02		Financial risk to the Council and the possibility of not receiving Safety Valve Agreement payments to offset the budget deficit.	Neil Hoskinson		A new SEND Finance transformation team is overseeing the financial plan and the Safety Valve Agreement. The latest SVA monitoring report has identified the risk due to the increase in demand for EHC plans that all LAs are facing. The size of our EHC plan cohort increased by 43% from Jan 2019 to Jan 2024 and a further 13% to Jan 2025. There is no indication that payments will not be received.
03.03		Financial & reputational risk to the Council through complaints received through the Council's own process, LGSCO complaints and tribunals.	Neil Hoskinson		The level of internal complaints is constant but, due to staffing issues, the backlog has risen (not to previous levels). LGSCO judgements remain at a low level and there have still been no high-cost judgements imposed (tribunals). There has been pressure to respond to LGSCO requests on time and, although CLT has approved additional staffing resource and this is still **POSSIBLE** not **PROBABLE**, this has created a higher level of risk currently. Therefore, this area has moved from **MODERATE** to **HIGH**.
03.04		Following the SEND inspection, serious weaknesses were identified that have to be addressed before a monitoring visit in 18 months. Failure to deliver the planned improvements is a risk area.	Neil Hoskinson	NEW	A Priority Action and Impact Plan [PAIP] has been approved with the DfE and a SEND Commissioner is already in post. The PAIP sets out how we are going to address the Priority Action Areas and Areas for Improvement (5+3) and will include KPIs, timescales and leads which will be helpful for tracking improvement and mitigation of key risks. The PAIP is supported by agreed governance. Because the PAIP has been approved by the DfE and the SEND Commissioner and CLT has indicated that there will be full support so this risk is judged as **MODERATE** and **POSSIBLE**.

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

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KRI 1	Safety Valve Agreement conditions – measured via a quarterly monitoring report to the DFE. This includes RAG ratings for all conditions.	All RAG ratings to be GREEN	No change to the current RAGs 5 CONDITIONS (1 RED / 4 GREEN) 4 RISKS (2 GREEN / 2 AMBER).	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.	62 finals issued in. 26% of plans due completed within 20 weeks. Although an improvement in timeliness, still considerably below target.	Similar profile 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 risen due to staffing concerns but is still significantly lower than when this was identified as a serious concern. There are concerns around responding to LGSCO requests in time. Additional staffing capacity has been agreed by CLT.	
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 Q1	No significant change this quarter. Tribunal judgements remain positive and the level of tribunals broadly mirrors the national picture (we have not seen the dramatic increase that some LAs have). Additional staffing capacity has been agreed by CLT.	
KRI 7	Ofsted inspection reports evidence that Graduated Approach is in place within all mainstream settings.	All Ofsted inspection reports evidence strong practice.	Recent Ofsted reports for schools have remained positive.	Due to the implementation of a new Ofsted Framework, no school inspections have taken place, However, there were concerns raised around the graduated approach in the local area inspection.	
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.	New capital projects are underway and will be delivered on time to address SEND place planning needs over the next two years.	
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.	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 a round of recruitment imminently	Job descriptions have been evaluated and are now more attractive. Further recruitment is underway. We have begun a full review of the staffing levels to ensure that there is capacity to meet statutory duties.	
KRI 10	Priority Action and Impact Plan monitoring reports identify good progress as well as ongoing SEF judgements in preparation for 18 month monitoring visit.	All actions complete on time and evidence of impact.	The Written Statement of Action has now ended.	The Ofsted / CQC inspection has now taken place and the Post Inspection Plan will replace the Written Statement of Action [KRI 4]	**NEW**

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

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

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Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR03.01	New SIAB / ODG supported by thematic and support groups. Data dashboard updated	Controls are effective led by a SEND Improvement and Assurance Board [SIAB] chaired by the SEND Commissioner and supported by the DFE/CQC supported by an Operational Delivery Group [ODG].	Neil Hoskinson Director of Education	**Effective**	A new PAIP has been approved and will be monitored by a SIAB / ODG. Thematic impact groups and support sub-groups for Communication, Finance (chaired by the MHCLG Best Value Commissioner) and Data sit below the SIAB. There is an agreed monitoring schedule.
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 Head of SEND	**EFFECTIVE (Moved from Largely Effective)**	The SEF was found to be accurate and evidenced based in the inspection so this is now EFFECTIVE. A monitoring schedule supports the PAIP work including stocktakes and deep dives by the DFE / CQC, a monitoring inspection after 18 mths and a full re inspection in 3 years.
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 Head of SEND	**Effective**	Panel members include partners from education, health and social care as well as education. Panel processes were an area of strength in the local area inspection.
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 Head of SEND	**Effective**	The quality of reports, as measured by our quality assurance process, has remained strong and placement decision making was an area of strength in the local area inspection. 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.	Bryn Smart Tribunals Officer	**Largely Effective**	This changed in Q2 from "Needs Improvement" due to the significant reduction in complaints. Although there is greater pressure on responding to LGSCO requests, this has not led to any adverse action and additional staffing capacity is being secured.
8	SR03.01	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	**LARGELY EFFECTIVE (Moved from Effective)**	The Graduated Approach is largely embedded in schools and advisory teachers are checking this and embedding practice in SENDCo network meetings and the SEND Conference. However, since this is a Priority Action Area in the PAIP it has moved to LARGELY EFFECTIVE
9	SR03.01	Recruitment & Retention Plan	The Recruitment and Retention Plan was a treatment / mitigation but now is an operating control that will support recruitment.	Gary Nixon Head of SEND	**NEW**	We now have an agreed recruitment plan that has competitive salaries and other benefits to support the recruitment of staff.

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

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

Target Risk Score – *14* by end of date *03/2027*

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	03.01	*Improved Statutory Team Processes*	Additional locum EPs and a short-term interventions team will address the backlog of EHC plans and improve timeliness. Improved SEND statutory processes are improving timeliness for new cases including case management and tracking.	Neil Hoskinson Director of Education	*01/09/2026* *New target to improve timeliness. Date amended in line with the PAIP*	**New RAG**	***MOVED TO AMBER / PREVIOUS MILESTONE ACHIEVED.*** *All EP assessments are received in timescale apart from a few complex cases where a particular type of EP is required and is difficult to source. In a few cases therapeutic support is not available or there is work being carried out to identify the appropriate education setting. However, timeliness is still low and we are now addressing the annual review backlog.*
~~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.	David Tully DSG Consultant	01/09/2026 *New milestone aligned to request to DfE for reprofiling the SVA*		**NEW MILESTONE */ PREVIOUS MILESTONE ACHIEVED.*** The latest SVA was sent to the DfE and there is no change in their judgement of the position. A new refreshed HNB position was taken to School Forum in January 2026. The quality of the reports was praised by the forum. A request has been made to the DfE to reprofile the SVA ready for September 2026.
5	03.02	SEND Sufficiency, Place Planning and Capital Programme	5 Year SEND Sufficiency Analysis complete	Neil Hoskinson Director of Education	01/09/2026 *New milestone for completed capital projects*		**NEW MILESTONE */ PREVIOUS MILESTONE ACHIEVED.*** The strategy has been approved by Cabinet as well as a Capital Investment Strategy to support it in November 2025. The Capital Programme aligning to this is being taken to Cabinet in November 2025. The next milestone is ensuring that capital programmes are completed on time for September 2026
6	03.03	New Complaints Process & Additional Staffing Resource	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.	Bryn Smart Tribunals Officer	*31/03/2026* *New target to maintain the current significantly lower level of complaints*		Work is ongoing to bring in new staffing capacity and we are on track to achieve the March 2026 deadline. A new approach is being trialled and has been effective in identifying key actions needed. This is reducing the risk of failure to respond on time
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	31/12/2026 *Monitoring shows impact of increased EY outreach*		**NEW MILESTONE */ PREVIOUS MILESTONE ACHIEVED.*** The EY Resource Base has opened. Additional funding has now been allocated for EY outreach work and impact should be measurable by the end of 2026 (New Milestone)
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* *Inclusion Support Grant work to be completed.*		SBC has the opportunity to receive a SEND grant that will be used to develop an Area SEND approach on a trial basis. This will include SENDCo triads. The trial will be complete by April 2026.
9	03.01	Staffing Capacity Review and new Permanent Staff Retention Plan	The Recruitment and Retention Plan has identified that capacity is not sufficient and a full review is underway with HR and Finance. A new plan will focus on recruitment to a permanent structure.	Gary Nixon Head of SEND	*01/07/2026* *Staffing review completed and costed*	**New RAG**	***MOVED TO GREEN / PREVIOUS MILESTONE ACHIEVED.*** As a result of the previous round of recruitment, new job descriptions have been agreed and further recruitment will take place. The new milestone reflects a capacity review of the team that is underway.
10 (NEW)	03.01	PAIP and agreed project resource	A PAIP has been approved by the DfE / CQC and sets out our key actions for the next three years. This is supported by a range of monitoring – SIAB / ODG / TIGs / Support Sub Groups	Gary Nixon Head of SEND	01/06/2026 KPIs reviewed in PAIP against latest data	**New Sub Risk**	SEND Improvement and Assurance Board in place supported by an Operations Delivery Group, Transformation Impact Groups and Sub Groups for Data, finance and communications. KPIs need to be reviewd following new data analysis – May 2026 in the PAIP.

CR04 Failure to Provide Safe Temporary Accommodation within Budget

Risk owner: Pat Hayes

Corporate risk overview

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

There has been 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. The number of homeless households continues to increase and is over 1,800. The number of households in TA has also increased to over1,340. Although overall cost is stabilised and still forecast to be £34m. The overall outlook has improved but not enough to change the score.

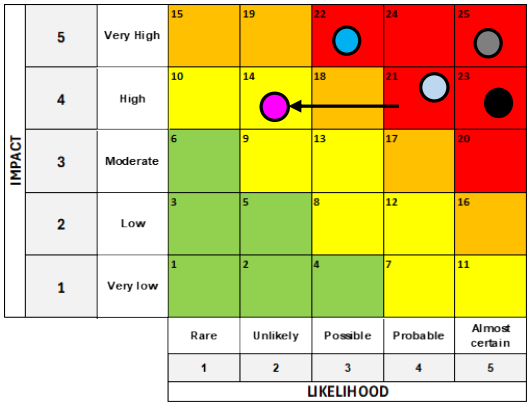
In Q3 we have recruited to the Temporary Accommodation, Allocations and Homeless Teams attempting to fill BAU and Backlog roles. We were awarded additional £400k of MHCLG grant funding to expand early intervention and move on team. Staff churn remains high and 100% reliance on interim staff means risk 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 continued 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 3 (Compliance and Health & Safety Data)) continues to be very high as a) time to decant from Galaxy and b) resource capacity to visit legacy TA units.. **Note** – compliance relating to new TA units acquired is a significantly lower risk.
- 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.
- Data reconciliation relating to PwC invoice discrepancies has been completed . Very little progress has been made in delivering PwC ICT recommendations.
- 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 now in place. Quarterly updates to Corporate Improvement Scrutiny Committee and Cabinet are now provided with additional oversight via a new Monthly Board attended by the new Housing Commissioner.

Risk appetite statement (Balanced)

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

Risk profile



Refer to slide 8 for risk assessment score instructions

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
04.01		Lack of Suitable Available TA	Director of Housing (Lisa Keating /)		• We continue to rely heavily on high-cost units (over 80% 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. 54 transfers to better value accommodation has estimated annual saving of £699k . • Project to enter long term leases for 25 homes that will save £1.1m p.a. nearing completion but delayed while commercial analysis is completed. • Out of borough placements policy implemented. • Action plan to re-negotiate with TA providers 75% completed. 65 of 65 providers contacted by end April 2025. Intensive activit y to gather compliance and other commercial documents completed with annual cycle of collection re-started. • A pipeline of over 500 new homes has been identified that the Council will purchase. Progress is slow but Rigby Lodge will b e ready for Q1 2026/27. **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 because we are still reliant nightly let homes.**
04.02		Budget Pressure (Cost vs Income and subsidy loss)	Director of Housing (Lisa Keating / Dave McNamara)		• The number of homeless households (in relief or full duty accepted) has increased in the quarter to over 1,800, with 1,360 placed in TA. • Forecast budget pressure remains £780k in December 25. • The forecast subsidy loss reduces a little to £21m (63% of HB spend) as the cost of TA units decreases and closer to 2011 LHA rates. **There has been a positive change since the last reporting period i.e. the fourth quarter in a row. but not enough to change the overall score. The acknowledgment of subsidy loss is why the risk remains 25.**

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)		• Retention ofdedicated resourcehas enabled a 100% desktop review of statutory compliance matters. • Physical inspections of TA, B&B and HMO accommodation is approximately 45% complete including 180 out of Borough visits withi and team • Planned decant of families from non-compliant properties (c. 300 properties – Galaxy, UNO and Aptus are main non-compliant provider) on-going with less than 150 families insitue • New agreed Private Sector Leasing and Private Licence Agreements have explicit clauses requiring TA providers to provide dampe 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 – still on track to be completed by 31st March 2026.. • Further independent health check ofTA remains a recommendation. • Risk remains high while manual collection and storage of compliance documents remains. ICT solution is required. **There has been a positive improvement in Compliance in process. The immediate outlook is challenging because an unknown number of incorrect licences have been issued but robust processes are in place and the 2nd annual cycle of collection has started. Risk score reduced from 21 to 14. The likelihood of not having a document is low because of new resources and process. The impact of not having a document e.g. for Gas could be hig**
04.04		Attraction and retention of talent	Director of Housing (Lisa Keating / Bal Toor)		• In Q3, new TA Manager, Housing Allocations Manager and the TA Commercial Manager joined the Service. 5 new backlog officersjoined in Q2 and retained during Q3.. • 100% of TA team remains interim – no permanent members of staff. • HSG Demand backlog team and early intervention team retained during Q3 • Continued investigation into on-going fraud matters. Deep dive with external expert support has been initiated. Likely to impact on staff retention issues. • Director of Housing is leaving mid of Q4 – HR are now advertising two director roles (Housing Management & Director of Homeless and Support) • All interim staff in homeless, TA and housing contracts end March 26. Business case being written to extend by 6 months. **There has been a small decline in recruitment and retention of the workforce particularly the retention of recruited staff and lack of future going forward. The risk remains 23 because 100% of TA are interim and flight risk is very high and Director Leaving**
04.05		Ability to effectively Manage TA property and people	Director of Housing (Lisa Keating)		• Limited capacity to effectively contract manage TA providers increasing the risk of poor accommodation. • Limited capacity to manage households in accommodation and move them on to permanent affordable accommodation increasing risk homeless households • New Commercial Manager started September and is now up to speed. But still a small interim team. • Lack of ICT system significantly hampers the pro-active management of providers. Checks and balances are reliant on manual reviews and interventions. **There has been improvement in Q3 but the overall outlook remains stable. A dedicated commercial manager has been 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**

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

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KRI 1– Compliance	SBC to hold H&S compliance information for all TA units	95%of private TA to be FLAGEL compliant by October 2025 (Established Hotel Accommodation to be exempt)	75%	95%	
KRI 2– Staff	Permanent recruitment of TA team	90% of Team to be permanent employees by April 2026	0%	0%	
KRI 3- Policies	Current policies (currently 12) e.g. TA Acquisition, Housing Allocations, Out of Borough placement	100% in place by April 2026	10%	10% (changed from red to amber)	
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	55%	75% changed from red to amber)	
KR1 5 - Budget	Cost of TA to be matched by income from Housing Benefit and Rent. To ensure that every household placed in TA has correct housing benefit documentation	100% of TA households should HB documentation (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)	85%	90% (increased with new manager and retained staff ….but year end will be next period))	

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

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

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

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	1	Increasing Availability of TA	Agreements with current providers, negotiations with new providers,, long term leases, procurement of market properties.	Head of Service (Janet Weekes)	Needs Improvement	The controls are improved due to a dedicated resource who will embed further control measures as part of a wider strategy. This will look at negotiating lower rates, procuring and managing good quality, affordable and compliant TA with effective long- term leases. The effectiveness of this control description will continue to improve when a) Legacy issues are concluded, b) The acquisition strategy is embedded, c) ICT solution (PSL and DPS) is in place and d) the current structure is in place to deliver this e) we have an Approved list of Providers who can support with increasing affordable and good quality TA [no change]
2	2	Budget setting and control	Checking that budget reflects cost of TA vs income from HB.	Finance Business partner Carol Maduka	Effective	New control measures in place with clear two stage escalation – if variance id £5 / night then TA manager approves. If >£10 / night or higher the head of Service approves .
3	2	TA resource, budget setting and control	Ensuring budget for resources is aligned to scale of the risk	Head of Service (Janet Weekes)	Effective	Fortnightly meeting with Finance partner / TA Head of Service. Re-forecast undertaken if variance is identified.
3	3	Compliance Certification	SBC to hold a record of compliance information against all units of TA	Head of Service (Janet Weekes)	Largely effective	Measures have improved significantly with recruitment of compliance officers and a new SharePoint solution. However, still at risk as no ICT system, high staff turnover, ad hoc arrangements in place which limit the effectiveness of the control measure. The control measure needs a supported ICT solution.
4	4	Recruitment and retention of workforce	Recruit and retain suitably capable staff to manage TA	Head of Service (Janet Weekes)	Largely effective	Control is impacted by 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.. Note – the property element has significantly improved and could move to 'green' and ' effective. However, people element is much harder due to capacity of small team.

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

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

Control Effectiveness	Description
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Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
6	6	Allocations and PRS	Weekly review of available empty HRA homes and PRS. All allocations are signed-off by the manager. Includes sign-off form and checks onshortlisting and nominations.	Head of Service (Janet Weekes)	Largely effective	The meetings happen and clarity on 60% nominations to TA but not enough HRA homes to significantly reduce TA demand. 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)	[June 2026]		Short term solution is in place. Lease agreements are being issued to providers. Increasing relationships with local Registered providers and new RP roundtable due to start Q4 25/26. Deadline extended due to resource capacity issues.
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)	[May 2026	Amber to Green	Dedicated officers undertaking forensic review of invoices - £25k reclaimed in one example. 3 providers payments are on hold. Until a baseline of process is finalised, negotiations on improved payment terms can't start.
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)	[June 2026]	Changed from Amber	Review completed. Some re-allocated to cheaper TA but availability of large properties is an issue but being worked through. Deadline extended due to backlog of cases that need review.
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)	[April 2026]	Changed from red	The TA team has completed its work on backlog cases and new cases have HB forms issued. Collection of HB, rents and arrears is the responsibility of Finance and Benefits colleagues and is subject to an application to increase benefits and income collection resource..
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)	[June 2026]	Changed from amber	New resource in place. Physical visits increasing and programme of visits to be established for the financial year. Out of Borough visits with fraud team has also taken place. New grant funding secure to commission external company to undertake some visits.. Deadline amended due to resource constraints.
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. None / Very few PSL / PLA agreements signed. Resource re-recruited in September. Re-starting process late Q2. New model – current LA +£25 + contribution to insurance being discussed with finance. New target date Jan 2026.
9	3	NEC Provider Model	Implement the NEC PSL module to record key information and hold related compliance data.	Head of Service (Janet Weekes)	No target date available	No change	No DDaT resource available to support the business progress this module.

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	[October 2026]		Internal HR / Matrix mostly resolved. Interim posts have been filled- funding and support from CLT. Moving toward temp to perm solution. ne deadline set to align with new Director appointment and review of recruitment freeze for TA and Housing Demand
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	Changed from Amber	New Government Funding allocated to early intervention and prevention team. Immediate impact– over 35 preventions in Q3.
12	5	Systems & Reporting	Engage ICT project team to continue system implementations, integrations and Power BI reporting Suite	Head of Service (Janet Weekes	June 2026		Business Case re. funding for the team still to be agreed. Will be in Budget Cabinet Paper in March.
13	5	Policy	Allocations, TA acquisition, Out of Borough Placement to be reviewed	Head of Service (Janet Weekes	[December 2026]		A full review of all policies was completed for RSH inspection in April 2025. New Heads of Service, RSH lead, Graduate apprentice and Campbell Tickel have started the re-drafting of key policy and strategy. Remains amber due to scale of the project with limited resources. New deadline set as a) external resource had to be appointed and b) quantum of policies required and c) consultation timelines
14	5	Procedures	As is and To be procedures to be mapped and new processes implemented.	Head of Service (Janet Weekes)	[June 2026]		Approx. 30% of processes mapped as part of the TA project room. Transformation team changes / resource capacity issues t finalise and implement new processes has held up the action. Target date amended as resource from Transformation team is n longer available for us to develop at pace.

Target Risk Score – *21* by end of date *03/2027*

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

Risk owner: Bal Toor

Corporate risk overview

Current Risk Score	4 Impact 3 Likelihood	13
Target Risk Score	4 Impact 3 Likelihood	13

Overall the risk score has moved to 13 (yellow) from 18 (Amber) due to improvements in SR05.01 & SR05.03.

Whilst recruitment has improved across the business, for specialised roles i.e. Digital and Finance, Slough has not attracted suitably experienced or qualified candidates. We believe this is down to, Slough is not a preferred employer, due to its reputation or in some instances, we attract candidates who are not suitably experienced to tackle the challenges. We continue to review our reliance on interims and support EDs with workforce plans.

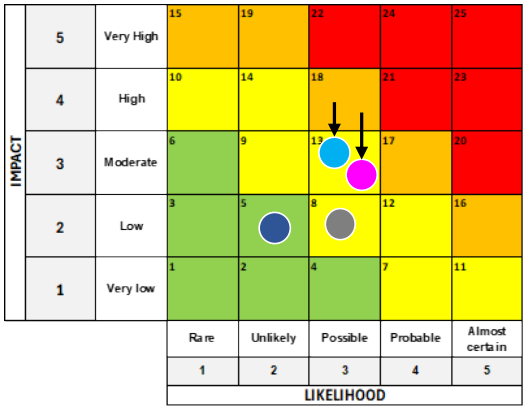
We retain the risk that SBC competes with local London Borough pay scales which will impact our attraction.

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		We continue to work with local schools and colleges to attract school leavers and are embarking on apprenticeships for each ED area (Subject to CLT approval). At senior level; Tiers 1-3, we have recently recruited a diverse calibre of Directors and HoS.
05.02		We fail to identify, develop and embed the capabilities and competencies we need in our workforce	Bal Toor		We continue to support our line managers in upskilling themselves on key skills and understanding of systems to support their people management. Our work in career pathways for all staff is just starting.
05.03		We fail to maintain an energised and engaged workforce	Bal Toor		Our mini pulse check has indicated positive incremental changes in key areas of visible leadership and comms however staff are not reporting they are always able to collaborate across the business. The main survey is due in April.
05.04		We fail to keep our turnover in line with a national average of 10%	Bal Toor		Currently our turnover is at 8% and has been maintained at that level for the last quarter.

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

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KRI 1	Staff Turnover	Staff turnover inline with last published civil service average.	Red Low 0-3% High >14% 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) 9.9% (end Sep 25) 9.8% (end Dec 25)	
KRI 2	Number of working days lost due to sickness absence per FTE employee	In line with CS average.	Red above 10–11 days per FTE Amber 8–10 days per FTE Green below 7 days per FTE	9.6 days/FTE (end Mar 25) 9.3 days/FTE (end Jun 25) 9.5 days/FTE (end Sep 25) 9.5 days/FTE (end Dec 25)	
KR 3	Number of Apprentices across key business areas	Minimum of 10 (i.e. 10% of the perm staff cohort) across SBC at any one time	51	47 (due to graduations)	
KR 4	Overall completion of all mandatory learning across SBC	50% of staff should have completed all 7 modules	26.5%	26.1%	

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

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

Control Effectiveness	Description
Effective	• Controls and or/ management activities properly designed and operating as intended • Management is confident that the controls are effective and reliable
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Control Ref		Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
2		SR05.01	1. Attraction channels 2. Apprenticeship scheme 3. Line Management upskilling	1 Review of how we work with Talos and 3rd party suppliers to advertise roles, to include working with Matrix on hard to fill vacancies. 2. Continuation of learning from newly established Data apprenticeship to replicate positive impact across new apprenticeship schemes. 3. Reviewing staff survey results to ensure feedback on line managers is taken into account when developing LM development scheme	Bal Toor	All controls effective, and on a continuous improvement cycle.	HR is onboarding new staff which means there is a short period for them to be fully inducted and deliver on all objectives, however this should not impact deliver, but may impact speed.
3		SR05.02	2. Apprenticeship scheme	1 Review of how we work with Talos and 3rd party suppliers to advertise roles, to include working with Matrix on hard to fill vacancies. 2. Continuation of learning from newly established Data apprenticeship to replicate positive impact across new apprenticeship schemes. 3. Reviewing staff survey results to ensure feedback on line managers is taken into account when developing LM development scheme	Bal Toor	All controls effective, and on a continuous improvement cycle.	We have delivered a 3 fold increase in staff being offered and taking up apprenticeship opportunities, we are now focused on offering opportunities to external school leavers etc
4		SR05.02 - 03	3. Line Management upskilling	1 Review of how we work with Talos and 3rd party suppliers to advertise roles, to include working with Matrix on hard to fill vacancies. 2. Continuation of learning from newly established Data apprenticeship to replicate positive impact across new apprenticeship schemes. 3. Reviewing staff survey results to ensure feedback on line managers is taken into account when developing LM development scheme	Bal Toor	All controls effective, and on a continuous improvement cycle.	We have completed our contract with the external supplier and are prepping to deliver this programme in house from April 2026, thus increasing coverage.
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 window is now open, we have responded to feedback making the tool easier to use, which should impact positively the completion rates.

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	Completed	25/26 closed on over 50apprenticeships across SBC. Ambition is to grow each year; broadening beyond DDAT ones. This plan has been completed. 26/27 is now focused on growing Apps for external applicants.
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	Completed	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.
4		Review of complete employee life cycle	Now HR has new perm folk in place, HR is reviewing complete handshakes between HR processes to improve onboarder and leaver experiences	Director	31/10/26	On Track	Starting with Onboarding and mandatory learning: By Feb 1st: review of onboarding– ensuring all paperwork is stored in Unit 4, recommendation of Rec Audit complete and induction booked. Learning: By May 1st, review of all mandatory learning and pathway effectiveness and how team builds culture of learning across SBC, with measurables.

Target Risk Score – *13* by end of date *03/2027*

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

Corporate risk overview

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

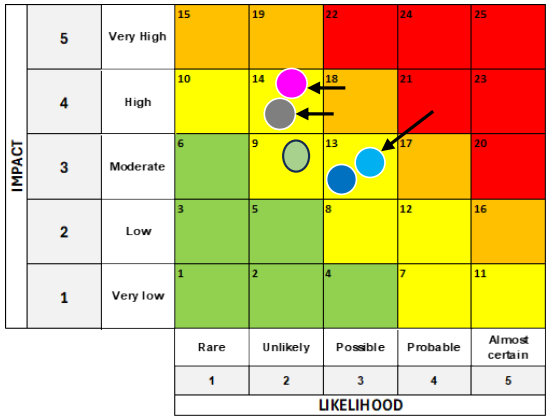
The overall risk score has reduced significantly for this quarter, due to the continued improvements and implementations we have made during Q1 and Q2 to lone working, fire risk assessments and Codes Of Practice reviews. There has been no improvement to training requirements as we have been prioritising 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 14. The systematic and controlled manner in which we are addressing high priority issues will result in the reduction of the risk score in Q4, which will be a permanent, stable improvement.

Risk appetite statement (AVERSE)

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

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

Risk profile



Refer to slide 11 for risk assessment score instructions

Sub risks related to this principal risk

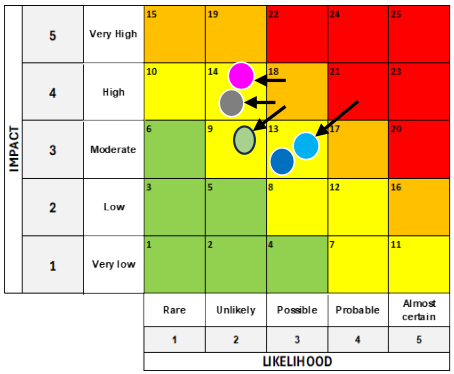
Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
06.01		We fail to prioritise, adequately fund or manage risks associated with corporate health and safety	Craig Hill		A new accident/incident reporting system is in place and working effectively. Standardised organizational ownership, recording, monitoring and reporting of key risks & statutory obligations. Efficiencies and organizational buy-in to be achieved by new shared software system sufficient training and standardized reporting mechanisms.
06.02		We fail to prioritise, adequately fund or manage risks associated with fire	Craig Hill		The risk score has moved from **21 to 18** this quarter with an improving outlook. 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 assis 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

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
06.05		We fail to ensure adequate numbers of trained personnel within the Corporate Health and Safety Team	Craig Hill		Risk reduced due to the H&S Dept having access to a part time employee as well as current staff. Recognition to ensure that adequate numbers of trained personnel within the Corporate Health and Safety Team are enoughto 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

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

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KR 1	Reported Accidents/Incidents	**80**	**41**	**73**	
KRI 2	Reported RIDDOR Incidents	**1**	**1**	**1**	
KRI 3	Completed Fire Risk Assessments	**4**	**0**	**0**	
KRI 4	Weekly/Monthly Routine Personal Safety Device Checks	**100**	**179**	**40**	
KRI 5	Emergency Personal Safety Device Activations (Red/Amber alerts)	**8**	**1**	**0**	
KRI 6	Health and Safety Training Completed	**TBA**	**0**	**0**	
KRI 7	Health and Safety Policies Reviewed and Completed	**7**	**8**	**13**	
KRI 8	Health and Safety Staff Levels and Attrition	**3**	**2**	**2**	

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

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

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

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	**SR06.01**	**Accident & Incident Reporting**	Capture and analyse accident and incident data to investigate occurrences and identify accident trends within the organisation	Director level	Largely Effective	A new, improved system of data collation is now in place and operational. Early indications show it is improving reporting and data collation.
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	Needs Improvement	This has raised slightly as the H&S Team now have access to part-time help from an SBC Employee. A new structure has been devised where additional staffing will be funded. The score will remain the same until the new staff member is in place and trained effectively.
5	**SR06.02**	**Fire Risk Assessments**	All SBC Buildings will have a fire risk assessment completed on an annual basis, with FRA Actions highlighted for improvement	Director level	Largely Effective	SLA undertaken for SBC properties on an annual basis. No centralised storage for FRA access or FRA Action(s) completion
6	**SR06.02 – 0.2**	**Fire Risk Assessment re-inspections**	All SBC buildings have a re-inspection of fire provisions on a 6 month rolling programme to ensure actions are being undertaken and no more issues are found	Director Level	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 re-written, if necessary, within 2025/2026

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

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

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

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
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 UnreasonableBehaviouraimed towards SBC staff. Requires monthly checks on device activations and usage
9	**SR06.03 – 0.3**	**Lone Working**	Personal Safety Devices can be activated in an emergency and assistance/help sought as well as locating the staff member via GPS when activated	Director Level	Needs Improvement	To ensure that any emergency activation is attended to professionally and in line with SBC protocols, Also, if an emergency activation is required, an accident form is completed so lessons learned can be analysed and shared
10	**SR06.04**	**Health and Safety Training**	All SBC staff members to receive adequate and relevant H&S Training to enable them to safely perform their job descriptions	Director level	Weak	No effective management control on H&S training, limited budget to undertake all training. No official reviews of training material. Not enough personnel to deliver 37 courses. Looking to automate or convert some courses to advice modules for managers (pregnancy, Risk Assessment etc) which may reduce physical burden on trainers.
11	**SR06.04 – 0.2**	**Policy Development**	All SBC Policies andCOP's are required to be reviewed and updated if required over a set amount of time to ensure relevance and adequate advice is available	Director level	Largely effective	As of Q1 25/26 all policies and COP's will be reviewed by the Health and Safety Team, with reviews and adopted policies escalated to H&S Board as standard, and CLT if required for approval.
12	**SR06.05**	**Staffing Levels**	Audit and Review of staffing levels within the H&S team to ensure compliance of statutory requirements	Director Level	Needs Improvement	This has loweredslightly as the H&S Team have access to part time help from SBC. A restructure has been devised where additional staffing will be funded. The score will remain the same until the new staff member is in place and trained effectively.

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

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

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	**SR06.01**	HSMS Data Recording, Monitoring & Reporting	Establish and implement a modernized, improved method of organizational H&S data recording, monitoring, reporting & sharing	Craig Hill/ IT representative/Shameem Din	30.03.26		Existing SharePoint inadequate. Procure & Implement organizational software system to enable key stakeholders to input, store and provide key metrics for qualitative and quantitative reporting.
2	**SR06.01**	HSMS Data Recording, Monitoring & Reporting	H&S Team can use the current system, but issues such as lost time accidents (days lost) cannot be determined with the current system	Craig Hill / Shameem Dil	30.03.26	Completed	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	30.03.2026		New interim Head of Corporate Health and Safety started 22.04.25 – the 3rd 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	Completed	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 (E-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 x 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 – **13** by end of date: ***03/2027***

CR07 Insufficient Operational Resilience and Crisis Management

Risk owner: Tessa Lindfield

Corporate risk overview

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

Improvements across all sub-risks, particularly Business Continuity where additional specialist resources has been secured within Risk Management and is progressing early stages of programme design. This activity will take time to translate into reduced risks scores.

Incident response capabilities have improved through further recruitment and development of responders for all response roles as well as increasing numbers of council staff expressing an interest in volunteering to be trained as responders. This is undermined by the loss of several *Incident Managers* and *Gold* level officers who perform important response roles and must be replaced to maintain response capabilities.

The council's Corporate Incident Management Plan has been approved, the Emergency Operations Centre redevelopment is complete, and a Gold exercise has been carried out, providing additional assurance that response arrangements are improving.

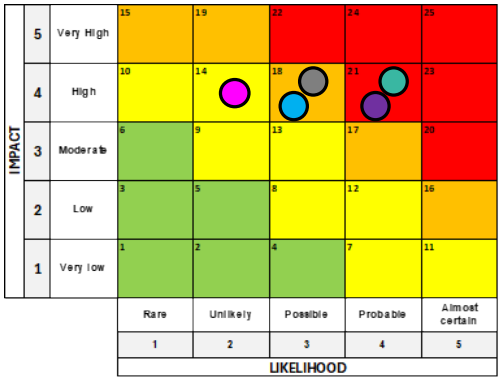
Welfare response capabilities remain a concern. This is the core local authority responsibility during incident response. Volunteer numbers continue to improve but is limited by training capacity. An agreement with the British Red Cross for response support and training delivery mitigates some local capability limitations.

Reductions in Emergency Planning team capacity following resignation of on officer and ongoing health related challenges with another create expert capacity challenges in driving the improvement plan and risk reduction activities. This is having an impact on ability to meet risk controls as set out in this document.

Risk appetite statement **(Averse)**

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

Risk profile



Refer to slide 7 for risk assessment score instructions

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
SR07.01		Inadequate rapid emergency response capabilities to provide immediate incident co-ordination and humanitarian support to affected residents	Laura Robertson		Further increase in the number of trained responders, particularly LALOs and informal volunteers. Loss of 50% of *Incident Managers* due to separate issue creates capacity risks. New agreement with British Red Cross for response support and training. Emergency Shelter planning underway and training expected in March.
SR07.02		Failure of emergency planning for specific major hazard risks in the borough, such as flooding, major fires, industrial accident etc.	Laura Robertson		Corporate Resilience Group is performing well at reviewing existing level of risk across the 9 identified priorities, including flooding, cyber-attacks and tower-block safety but little progress made so far in driving action to reduce risks. Work underway to access borough level RBFRS risk information.
SR07.03		Failure of corporate major incident management arrangements	Laura Robertson		Corporate Incident Management Plan completed and approved. Redevelopment of Emergency Operations Centre complete. Silver training delivered to 1/3 of Silvers. Gold exercise delivered in November. Silver rota now in place.
SR07.04		Lack of BCP's for all services responsible for delivering business critical activities	Laura Robertson		New Business Continuity Programme Manager has started under Risk Management. A forward plan for Business Continuity development has been created. A 'critical function analysis' is underway to identify critical functions of the council as a first stage of Business Continuity programme.
SR07.05		Inadequate resilience planning for specific risks	Laura Robertson		Limited improvements largely focused on cyber-attack preparedness, mainly as a result of DDaT activities (see separate risk), and new notification and activation arrangements that incorporate council's Duty Incident Manager as first point of contact of significant cyber-attacks. Other risks to be addressed – loss of facilities, supply chain, utility failures, loss of staff

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

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/ Threshold	Previous qtr. status	Current qtr. status	Trend	Comments
KRI1	Number of Trained Gold Commanders on rota 24/7/365	Minimum 6 (8)	7	5	↓	Stable
KRI2	Number of trained Silver Commanders on rota 24/7/365	Minimum 6 (8)	8	22	↑	Silver training delivered - only 1/3 attended. Looking to re-schedule UK Resilience Academy
KRI3	Number of trained Incident Managers on rota 24/7/365	Minimum 6 (8)	8	4	↓	Loss of Incident Managers due to leaving council, compassionate leave, changing roles
KRI4	Number of trained Local Authority Liaison Officers (LALOs) on rota 24/7/365	Minimum 12 (16)	10	12	↑	4 more on training programme
KRI5	Number of training Emergency Shelter Managers on rota 24/7/365	Minimum 6 (8)	0	0	→	3 identified volunteer Emergency Shelter Managers. Training to commence with Red Cross in March
KRI6	Number of trained informal volunteer responders	(Min 40)	2	6 (trained) 20 (untrained)	↑	Volunteer programme seeing significant numbers. Training deman and supply bottleneck.
KRI7	Number of trained DecisionLoggists	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	36	40	↑	
KRI9	Testing/exercising of major incident capabilities and arrangements	1 major exercise per year	2	2	↑	Ex Pegasus Council Gold Exercise

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

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

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

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	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	Largely effective	New Corporate Incident Management Plan, improved management structure. Introduction of Silver role (in development). Some concerns re operational capacity. Action point 1 and 3 delivered
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	Needs improvement	Interim Resilience Manager and interim Business Continuity Programme Manager. Loss of one Emergency Planning Officer, ongoing return to work arrangements for second Emergency Planning Officer. Actions 12 & 13 delivered
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 risks, how they can be prepared for emergencies. No existing capacity to deliver Work to be prioritised in 2026/27 business plan with strong partnership interest.
4	SR07.2	Emergency planning	Hazard specific 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. Capacity challenges in Emergency Planning to deliver.
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	Ineffective	Improvements planned, including for shelter site plans, British Red Cross support agreement and training, identification of responders and equipment inventory check and audit. Agreements with British Red Cross provides additional contingency capacity.
7	CR07.2,5	Risk identification	Identification and monitoring of risks and threats from major hazards and business disruptions (incorporating corporate risks)	Director	Needs improvement	Corporate Resilience Group. Further work is needed in identifying, assessing and codifying risks and resilience priorities.
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	Needs improvement	Business Continuity Programme Manager in place, is leading the review and redevelopment of business continuity programme. Action 12 delivered

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

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

Target Risk Score – *21* by end of date *03/2027*

Ref	Sub risk ref	Control Ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
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. Volunteer rates are improving although 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	May 2026	A	Silver reestablished on Duty Incident Management Team. Only 1/3 of Silvers trained. Further training to be organised in April (awaiting for ECP approval) – target date adjusted from March to May 2026
6	SR07.1	1	Training for all on-call 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. Training continues as a priority. Red Cross shelter training scheduled for March.
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	May 2026	A	H&S risk assessments underway. Delayed due to capacity in EP Team. Delivery date adjusted from March to May
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	August 2026	A	A best endeavours risk priorities set by Corporate Resilience Group. No definitive register of major hazard risks in the borough. Conversation ongoing with RBFRS
11	SR07.2	7	Major Hazard Risk Management process	Creation of a Major Hazard process and policy.	Laura Robertson / David McClory	August 2026	A	No internal capacity to deliver this at this time.
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	June 2026	A	Underway following appointment of BC programme manager. Delivery date adjusted from March to June 2026
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	April 2026	A	Shelters identified, activation and establishment plans to be completed.
18	SR07.1	6	Development of a Humanitarian Assistance Plan	Nominate and train an Exec Director to lead the humanitarian response to any major incident	Laura Robertson / David McClory	TBC	R	ED of Adults and ED of Children's nominated as Humanitarian Assistance Lead Officers. Both leaving. Delivery date TBC
19	SR07.1	6	Emergency Shelter training	Development and delivery of Emergency Shelter training to designated officers	Laura Robertson / David McClory	May 2026	A	British Red Cross to be commissioned to deliver this training, initial milestone March. Delivery date adjusted from March to May
20	SR07.2	4	Recovery Management Planning	Development of Emergency Recovery Plan and procedures	Laura Robertson / David McClory	TBC	R	Exec Director of Property and Environment identified as Recovery Lead Officer. No internal capacity to deliver this at this time.
21	SR07.2	3	Community resilience strategy	Development of a strategy for engaging with and supporting resilience of	Laura Robertson / David McClory	May 2026	A	Further work to be prioritised in 2026/27 business plan with strong partnership interest.
Completed since last review								
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.
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	G	Business Continuity temporarily moved to Risk Management.
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 secured. BC Programme Manager employed.
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 (complete) Third phase – Resilient comms and CCTV (commence 2026/27)

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

Corporate risk overview

Current Risk Score 5 Impact 4 Likelihood	24
Target Risk Score 4 Impact 4 Likelihood	21

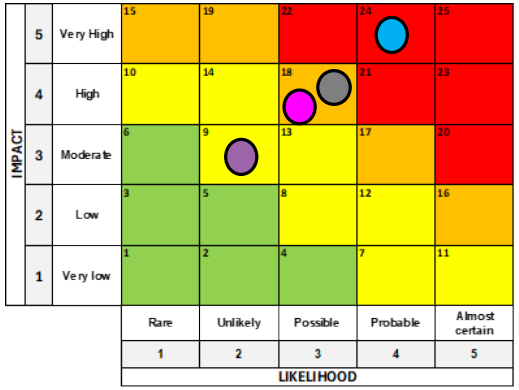
Updates are:-

- Cloud based immutable backups are now live and fully operational. Work is now focused on commissioning and testing the Council's Disaster Recovery service.
- Work has commenced to introduce new data feeds into our managed SOC/SIEM service. These feeds include firewalls, select nominated on-premises systems and Indicators of Compromise from the WARP.
- MHCLG have awarded SBC a £200k grant to support our work against the Cyber Assessment Framework (CAF) to improve our cyber resilience. DDaT have engaged with MHCLG on the next steps in the support programme.
- December saw the launch of a cyber awareness campaign which included hosting of a cyber focused Talkabout bitesize and deployment of a corporate phishing simulation. Results if these simulations will now be the baseline for our KPIs
- The Defend as One Team at MHCLG have invited SBC to take part in a funded workshop exercise to create cyber incident response playbooks to support our incident response planning. SBC have accepted the invitation and will engage with MHCLG about next steps.
- Work has continued on the ITHC remediation actions with approx. 90% of the high vulnerabilities resolved. Projects are underway to remediate against the remaining high vulnerabilities. There is a meeting with the Cabinet Office on 6th Feb to review progress.

Risk appetite statement (Averse)

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

Risk profile



Refer to slide 6 for risk assessment score instructions

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period/ outlook	Management Review/ Explanation of movement
08.01		Significant data or service loss lasting over 4 weeks (e.g cyber attack, loss of data centre)	Colin Power		• BaaS completed with Cloud based immutable backups now live • A managed SOC/SIEM service is now implemented and fully operational • Work is underway to complete the actions identified in the MHCLG CAF assessment • Work has continued on the ITHC remediation actions with approx. 90% of the high vulnerabilities resolved. Projects are underway to remediate against the remaining high vulnerabilities.
08.02		Lack of IT business continuity within DDaT and service areas causes significant service loss	Colin Power		• DDaT Business Continuity Plan drafted and under review. • DRaaS planning has started and infrastructure configurations being defined.
08.03		An incident caused by hardware or software failure causes significant service loss	Colin Power		• Support and maintenance in place for supported hardware & software • Supported software receives security updates/patches from manufacturer • End user devices have been upgraded to Windows 11.
08.04		An incident caused by legacy hardware or software failure causes significant service loss	Colin Power		• The sub risk is still improving this quarter as legacy systems continue to be decommissioned. • Old legacy UCS hardware has been replaced. • A new project have been commissioned to look at the remaining out of support servers and put action plans in place. • Projects for moving CAFM and D360 to the cloud have been commissioned and are underway.

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

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
[The indicators in the table below are illustrative of thinking in this area, as there are not currently any measures in full operation. I am confirming just what is measurable and whether baseline data exists.]					
KRI 1	Number of successful cyber breach incidents	0	0	0	
KRI 2	% staff completed cyber training (Information Security)	90%	83%	83%	
KRI 3	Number of ICT incidents substantively impacting one or more services (hardware / software failure P1 major incident)	1	4	1	
KRI 4	Notifications of compromise / risk from the National Cyber Security Centre (NCSC) active cyber defence service (ACD) early warning service	3	0	3	
KRI 5	Result of Phishing simulations showing level of compromise by staff	<5%	See Note Below	9.06%.	
KRI 6	Notification of vulnerabilities from Government Digital Service (GDS) Extended Monitoring Scheme	To be baselined	Active by Q3/4	Now active. Will baseline at next quarter after sustained full quarter of being active	New KPI

KRI 5 – Delivered 1855 / 1225 Opened / 407 clicked link / 168 entered credentials (compromised) 9.06% / 667 Deleted / 242 Reported (13.05%)

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

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

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

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR08.01	Compliance to government security standards	Ongoing compliance with PSN (Public Sector Network), meet the control standards of the Cyber Assessment Framework (CAF) and adhere to the security, assurance and data handling obligation set out in the DWP Memorandum of Understanding (MOU)	Colin Power	Largely effective	• PSN status classified as "Deferred". Meeting on 16th Feb to review status of IT healthcheck remediations actions and agree next steps for PSN compliance. • Work is underway to complete the actions identified in the MHCLG CAF assessmen • Annual DWP MOU completed. Compliance audit scheduled for May 2026
2	SR08.01	Staff Awareness	Cyber awareness is embedded into staff induction, reinforced through ongoing communications on emerging threats. Supported by quarterly phishing simulations to continually strengthen organisational resilience.	Alex Cowen/Colin Power	Largely effective	• Cyber awareness included in staff induction. • Annual requirement to complete mandatory training on Information Security • Ongoing Comms and awareness of cyber threats via Astro Announcements • Completion of quarterly cyber phishing simulations
3	SR08.01 & SR08.02	Introduction of Backup as a Service (BaaS) and Disaster Recovery as a Service (DRaaS)	The introduction of BaaS and DRaaS delivers scalable, secure, cloud-based backup and recovery capabilities that ensure rapid restoration of systems and data during outages or cyber incidents.	Colin Power/Colin Watson	Needs improvement *(Treatment Plan 2)*	• BaaS completed with Cloud based immutable backups now live • Data being replicated to DR provider cloud platform • DRaaS configuration and runbooks underway • ICT Disaster Recovery Policy live (next review date April 2026)
4	SR08.01 & SR08.02	DDAT and Service Area Business continuity planning	IT business continuity and disaster recovery planning within DDaT and across the wider organisation	TBC	Needs improvement *(Treatment Plan 2)*	• DDaT continue to attend the Corporate Resilience Group • DDaT Business Continuity Plan drafted and under review • DDaT are reliant on service area's business continuity plans being drafted
5	SR08.03 & SR08.04	Up to date hardware, software and applications.	Technology (hardware, software and applications is kept up to date for both resilience and security reasons.	Colin Power/Colin Watson	Needs improvement *(Treatment Plan 1 & 7)*	• Quarterly internal vulnerability scans undertaken and remediation actions resolved • Applications management by Intune with monthly Microsoft updates automatically pushed out to end user devices • Projects are underway to upgrade/decommission out of support systems
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	• 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.
7	SR08.01	Active participation in industry/peer support cyber networks	Actively engages with industry and peer cyber security networks to share intelligence, collaborate on emerging threats, and strengthen organisational cyber resilience.	Colin Power	Effective	• Subscription to the South East Warning Advisory Reporting Point (WARP) • Participation in the Microsoft Local Gov Innovation Cyber Sub Group • Regular receipt of MHCLG / GDS cyber alerts & use Active Cyber Defence services

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

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

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	SR08.01 & SR08.04	Remove legacy or out of support systems and hardware	Upgrade/decommission out of support systems	Colin Watson	Milestone May 26 (Remove 10 servers this quarter)	A	• Contracts awarded for new Crem IT System and Liquid Logic Cloud Hosting Platform. • System migrations scheduled over the next 3 months with out of the support systems being decommissioned following go live. This will result is 54 servers going down to 44 • Trend IPS deployed to all legacy servers has mitigation for out of support operating systems.
2	SR08.01 & SR08.02	Introduction of Disaster Recovery as a Service (DRaaS)	The introduction of DRaaS delivers scalable, secure, cloud-based backup and recovery capabilities that ensure rapid restoration of systems and data during outages or cyber incidents.	Colin Watson	Milestone (Q1-Q2 Project Delivery)	A	• Data being replicated to DR provider cloud platform • DRaaS configuration underway • DR test to be scheduled following DRaaS setup
3	SR08.01 & SR08.03	Implementation of Azure Arc	Implement Azure Arc for unified governance, security across platforms	Colin Power/Colin Watson	Milestone (Delivery Plan by end of March 26)	G	• New treatment. Exploratory work into Azure Arc to commence • This is treatment is linked to No 5 (Implementation of further data feeds into the SIEM).
4	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	Completed: Campaign Launched in Dec 25	G	• Cyber awareness campaign was launched in Dec 25 and included hosting of cyber focused Talkabout bitesize and deployment of a corporate phishing simulation. Results if these simulations will how be the baseline for our KPIs • Campaign has now been delivered, and quarterly simulations will start from April 26
5	SR08.01	Implementation of further data feeds into the SIEM which will be proactively monitored by the Security Operation Centre (SOC)	Ingest further data feeds (firewalls, select nominated on-premises systems and Indicators of Compromise (IOCs) from the WARP)	Onyere Kene	March 2026 (Data feeds live)	G	• WARP IOCs being tested and will be introduced to our Live SOC. • Network Infrastructure Team working on subscribing to IOCs to block network traffic to and from IOC networks • Engaged with SOC to onboard new data sources. DDaT to complete configuration of services to collect logs and monitoring.
6	SR08.01	Compliance against CAF and DWP MOU	Meet the control standards of the Cyber Assessment Framework (CAF) and adhere to the security, assurance and data handling obligation set out in the DWP Memorandum of Understanding (MOU)	Colin Power	Milestone: May 26 (Completion of DWP MOU Audit)	G	• Annual DWP MOU completed. Compliance audit scheduled for May 2026 • £200k grant awarded by the MHCLG to further aim the Council cyber resilience activities. • Work continues on meeting the CAF control standards
7	SR08.01 & SR08.04	Completed of the 2025 IT Healthcheck Remediation Actions	Remediate against the 156 high vulnerabilities as identified in the 2025 IT healthcheck	Sarah Power	February 26 (ITHC Project Completed)	A	• Approx 90% of the high vulnerabilities resolved. • Projects are underway to remediate against the remaining high vulnerabilities. There is a meeting with the Cabinet Office on 6th Feb to review progress

Target Risk Score – 21 by end of date *03/2027*

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	**22**
Target Risk Score 5 Impact 3 Likelihood	**22**

Following an improvement in SR09.02 from 24 to 22 due to publication of accounts, however the 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.

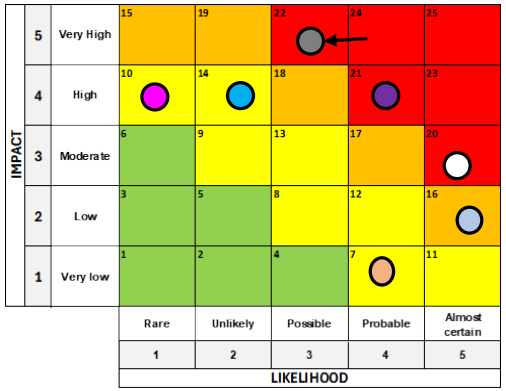
For 2026/27, urgent work is underway to deliver a balanced budget.

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

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

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

Risk profile



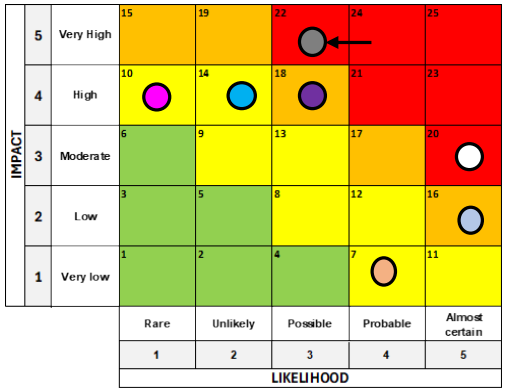
Refer to slide 8 for risk assessment score instructions

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
09.01		Failure to deliver audited financial accounts within statutory deadlines	Nick Penny		Statement of Accounts for 2023/24 signed off at audit committee in January 2026 and 2024/25 accounts signed off at February audit committee. The 24/25 accounts were subject to a short piece of audit work focussed on in year transactions. Work is ongoing to prepare for 2025/26 close including finalising the timeline, provide training for accountants and budget holders. It is critical that the council produces these accounts for the 30th June 2026 statutory deadline to enable a full audit to be completed, which is the next step on the path towards a clean audit opinion.
09.02		Failure to achieve a balanced budget and Medium-Term Financial Strategy (MTFS)	Mark Hak-Sanders		2024/25 outturn has been published, with the associated opening reserves statement for 2025/26. The Q3 update showed a £15.5m overspend on the general fund budgets for 2025/26, improved from £17.5m at Quarter 2 and £21m earlier in the year. Work is underway to capture and report on the success of the mitigations in place. 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 was estimated to be £20.520m with a sensitivity analysis of up to £36.967m. The Council's 2026/27 budget has been published but is subject to approval by Cabinet and Council and approval from MHCLG on a £43m EFS request. A three -year balanced MTFS has also been published, subject to approval and delivery. Until these documents are approved, the likelihood remains possible and the impact is still very high. This means the sub risk has improved from a 24 to 22.
09.03		Inadequate cashflow to maintain balance of liquidity to fund expenditure	Nick Penny		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. A significant amount of debt refinancing has already been undertaken during the financial year.

CR09	Failure to achieve financial sustainability and a balanced MTFS	Risk owner	Ian O'Donnell

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		MHCLG have provided SBC with a multi-year settlement which has increased funding by c.£47m over three years. This has improved the situation considerably and reduced the likelihood to a possible and the risk score to 18. However, the Council's overall funding still relies on approval to follow from MHCLG on the EFS request. The EFS request is partly required because the improved funding is phased in over 3 years, with only a partial benefit in 2026/27.
09.05		Failure to recruit and retain a resilient and skilled workforce within finance	Mark Hak-Sanders, Nick Penny		Two Finance Directors - commenced September 2025 Strategic Finance Manager – commenced September 2025 and January 2026. Other senior roles. Finance Managers 4 offers made (2 internal). Finance Assistants 1 offer made. The next batch of recruitment is due to begin in Feb 2026.
09.06		Failure to deliver the FIP which include internal controls, an effective finance system both through tech and business processes	Vicki Palazon		Implemented full project management approach. This is providing greater clarity and oversight of the deliverables.
09.07		Failure to deliver best value from procurement processes	Nick Penny		Some improvement on compliance reflected by: 2025/26 pipeline report produced in April 25 and updated in Dec 25. Work is ongoing to prepare the 18 month pipeline report for April 2026 cabinet. A procurement improvement plan has been prepared which is being implemented over the first 6-9 months of 2026 on a priority order basis. A consultant has been brought in to do a diagnostic piece to assess where the function is and where improvements can be made. As part of this contract expenditure is being reviewed for savings opportunities.



CR09	Failure to achieve financial sustainability and a balanced MTFS	Risk owner: Ian O'Donnell

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KRI 1 (MHS)	*In year budget monitoring highlights a pressure that can't be balanced*	Check performance measure	*Q2 Position £17.5m overspend*	Q3 position showing a £15.5m overspend.	Amber
KRI 2 (NP)	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	Report presented to DLT	Amber
KRI 3 (MHS)	Data quality and MI is not improved to inform the financial forecasts	To be reviewed	To be reviewed	To be reviewed	To be reviewed
KRI 4 (NP)	*Level of external debt as a proportion of net revenue budget*	Reduce by 5% pa	Q3 24/25 - 17.1%	Q4 17.1%. A debt strategy has been produced which reduces the level of debt to c10% of the net revenue budget over the next 10 years.	Amber
KRI 5 (VP)	Proportion of outstanding Internal Audit actions (Finance & Commercial) Legacy	Reduce by 30% from 23/24 Outturn	Q1 25 closed, 3 not due, 22 overdue of which 9 were closed in July 2025 -	As at 31st Jan 2026 6 out of 50 internal audit actions outstanding	Green
KRI 6 (NP)	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	All backlog SOA's published. Work ongoing to prep for 25/26 closing.	Amber
KRI 7 (MHS, NP)	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	Interims retained where critical to do so, work on a 2026 recruitment campaign beginning.	Amber
			Q1 2025/26 assurance	FIP has been reprioritised to	

CR09	Failure to achieve financial sustainability and a balanced MTFS	Risk owner: Ian O'Donnell

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

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

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR09.01	*Backlog Accounts Programme*	*Dedicated Recovery Team finalising accounts*	*Nick Penny*	*Largely Effective*	*Team now left as backlog accounts been completed.*
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	the balance sheet review work continues as part of monthly work towards the 2025/26 close.
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 but still needs embedding.
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 proposed MTFS is balanced over a three-year period, but a timetable of review, aligned with setting the 2027/28 budget needs to be established so that regular reviews are programmed in at set intervals.

CR09	Failure to achieve financial sustainability and a balanced MTFS	Risk owner: Ian O'Donnell

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

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

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
6	SR09.02	Financial Controls	No PO No Pay and the Expenditure Control Process (ECP) allows the authority to have complete visibility over its commitments and ability to approve only essential and statutory expenditure	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.
8	SR09.04	*Relative Need*	*Local Government Funding is distributed in a number of ways and we need to monitor the effectiveness and ensure relative need is reflected in the distribution model used.*	Mark Hak-Sanders	Largely Effective	MHCLG has published a three year settlement. This control will need to stay in place to ensure the Council budgets for funding streams effectively, aligned with need.
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	Work continues in this area.
13	SR09.1 - 06	Process Reviews	Rolling review of financial processes based on risk assessment	Vicki Palazon	Largely effective	Remain static during period. Control still effective

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 *03/2027*

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	Complete	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	Complete	Amber	Complete
4	SR09.05	Undertake staff appraisals	Undertake staff appraisals including training and development plans in accordance with HR policies and procedures	DLT	TBC	Red (Paused)	Activity temporarily paused to enable resources and council officers to deliver the budget. Revised target date 31 August
5	SR09.05	Staff capacity and skills assessment	Undertake an assessment of staff competencies what control does this link to?	DLT	31/08/2026	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	TBC	Green	Work currently paused
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	Delivery of project (Internal controls) to strengthen existing ERP system internal controls and processes	Vicki Palazon	30/09/2026	Green	Milestone delivered- Project plan

CR10 | Failure of General Fund Asset Disposal Programme | Risk owner: Peter Hopkins

Corporate risk overview

CURRENT SCORE 4 Impact 4 Likelihood 14
TARGET SCORE 4 Impact 3 Likelihood 14

Overall Risk has decreased from 18 to 14 as SR10.02 is back on track for FY2025/26 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.

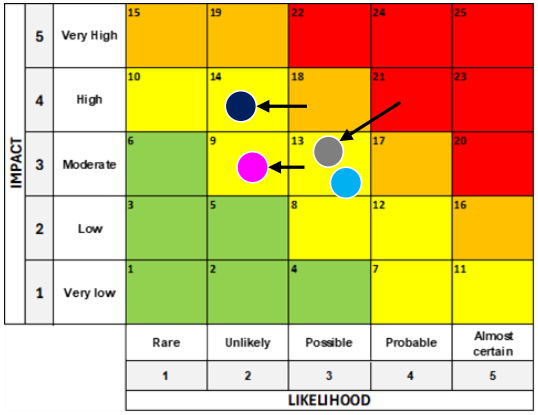
Property and finance have worked to refresh the treasury management strategy which subject to Cabinet and Commissioner approval will see a new stretch target of FY26/27 £27.73 m reducing to £21.36M in FY27/28 subject to ongoing due diligence and ongoing appraisals. These challenging assumptions are underpinned by the successful achievement of completing projects 14 & 15 of the FIP.

Due to the vagaries of market conditions and approvals for disposals still to be sought this risk will be regularly reviewed and subject to change in FY26/27.

Risk appetite statement (Balanced)

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

Risk profile



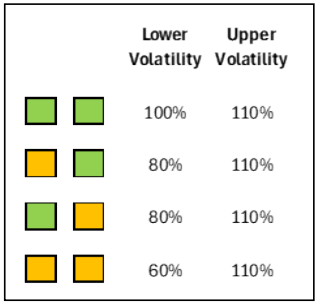
Refer to slide 7 for risk assessment score instructions

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
10.01		Property disposals not hitting financial targets and sitting outside lower volatility levels	Peter Walsh		Sales Proceeds on track to be achieved or exceeded, however cashflow is slowing in FY25/26. Any Underperformance is being self compensated by better Sales Proceeds.
10.02		Pace of disposals is behind programme deliverable dates	Peter Walsh		Programme has stabilised for the rest of FY25/26
10.03		Attraction and Retention of quality people	Peter Walsh		One new general fund Disposals Surveyors in Transition from interim to permanent staff still to be implemented. Restructure of the department proceeding on 27th January
10.04		External property market volatility	Peter Walsh		Market remains in a stable with a positive outlook which is resulting in better sales proceeds and positive cash flow.

CR10	Failure of General Fund Asset Disposal Programme	Risk owner: Peter Hopkins

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
Sales Proceeds	The proceeds of sales falls outside of the Lower Volatility thresholds as designated based on Asset Classification. 	**FY 24 / 25** Achieved Sales : £ 6.147m **FY 25 / 26** Target Sales : £ 8.713m Lower Threshold : £ 8.379m **FY 26 / 27** Target Sales : £ 21.346m Lower Threshold :£ 19.718m			
Pace of Sales	The pace of sale drops below the anticipated plan	**FY 24 / 25**– 9 sales PA **FY 25 / 26**– 21 sales PA **FY 26 / 27**– 22 sales PA			
Risk of Judicial Review	Not following prescribed procedures or a lack of thoroughness in consultation, understanding operational needs or similar.	1 permission / 6 months 1 successful hearing / 2 years			
Team Attrition	An unplanned loss to the disposals team (either permanent or interim)	10% unplanned loss per annum			
Green / Amber assets move to RED	Unforeseen circumstances mean that Sales Proceeds reduce due to properties planned for disposal move to RED due to force-majeure like issues.	2 demotions per quarter			
Commercial Interest	Ensuring that all active sales generate sufficient market interest to generate a competitive sales environment and 'deal tension' by generating significant EOI, bidders and BAFOs	At least 10 EOI per sale At least five 5 Bidders / BAFO per sale			

CR10	Failure of General Fund Asset Disposal Programme	Risk owner: Peter Hopkins

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

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

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR10.01	Market / Economy	• Market Intelligence and Engagement • Consider reordering disposals due to market sentiment	Peter Hopkins	*Largely Effective*	Monthly review of deals in near pipeline to consider reordering as necessary
2	SR10.02	Sales below expectations	• Engagement of correct agents and sales routes • Preparation of quality bid materials and supporting docs • Ensuring properties pitched to correct pool of purchasers	Peter Hopkins	*Effective*	Sales Proceeds on track, however time to Complete needs improvement.
3	SR10.03	Abortive Sales	• EY AADF framework in use as SBC internal gateway • All pipeline assets have impairments assigned	Peter Hopkins	*Effective*	Treatment delivered
4	SR10.04	Programme Target	• Revised GF disposal plan submitted to cabinet in November, and timely receipt of Members approval in future • Monthly adjustment and refinement of programme.	Peter Hopkins	*Largely Effective*	Working as expected
5	SR10.05	Records	• Document register now better • Better archiving needed (physical and electronic)	Peter Hopkins	*Effective*	Time has been invested, documents are in much better condition, physically and online.
6	SR10.06	Skills / Capability	• Review team engagement as tempo of disposals increases • Move away from interims to permanent team, to retain corporate memory	Peter Hopkins	*Largely Effective*	Treatment 3 delivered with roll out on 27th January
7	SR10.07	Protocol / Process	• Review ongoing approved processes being followed	Peter Hopkins	*Largely Effective*	Treatment 4 delivered

CR10	Failure of General Fund Asset Disposal Programme	Risk owner: Peter Hopkins

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	SR10.05	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	SR10.06	Skills / Capability	Putting in place job adverts before launch of permanent disposal roles from Jan 2026	Peter Hopkins	*Dec 2025*		DELIVERED
4	SR10.07	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*		DELIVERED

Target Risk Score – *14* by end of date *03/2027*

CR12 Failure to deliver adult social care market sustainability

Risk owner: David Coleman-Groom

Corporate risk overview

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

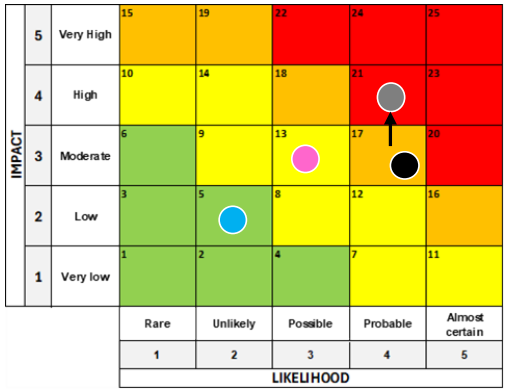
The risk is predominantly driven by funding availability in the context of the market pressures:

- Rising Costs: From increases to the National Living Wage and higher Employer National Insurance Contributions, as well as other inflationary pressures including energy costs, food and fuel
- A failure to address these pressures could result in provider failure and/or contract handback which would have impact on people who rely on care services, potentially disrupting
- Most providers operate on very slim margins, and smaller providers, which make up the vast majority of the market, are particularly vulnerable.
- While Provider Failure due to quality will always be a possibility the Quality Assurance Framework (QAF) and the work of the Provider Quality Assurance Team seeks to pre-empt quality concerns becoming significant leading to suspension
- 12.02 (links with CRO2 risk 02.01) risk has increased to 21 due to not receiving £2.1mil from risk reserve

Risk appetite statement (Balanced)

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

Risk profile



Refer to slide 7 for risk assessment score instructions

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
12.01		Insufficient access to care services	Lynn Johnson (HOS)		**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		Cost of fee uplifts outstripping budget	Neda **Mazraeh** (HOS)		**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. ASC need to find savings in 25/26 to mitigate against £2,7m pressure unfunded. (No funding available through risk reserve) No provider hand backs received**
12.03		Provider failure	Neda **Mazraeh** (HOS)		**Monthly reports of care quality provided to CMMB, DLT and Care Governance Board. No provider failures linked to quality in Q3.**
12.04		Recruitment and retention of external workforce	Lynn Johnson (HOS)		**Ability to recruit and retain staff is linked to rates we pay providers, who are facing significant cost pressures in relation to pay – increases in NLW/ERNIC. Providers in our local market have arrange of different terms and conditions. Vacancies are often filled by agency staff with higher costs as a consequence. Fair Pay Agreement impact will need to be better understood locally.**

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

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	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	Update Q3 26/26 Providers Suspended Due to Quality Concerns 3 x Care Home 1 x Supported Living Providers 1 x Home Care Provide	
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	Update Q3 25/26 0 Contract Handbacks	

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

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

Control Effectiveness	Description
Effective	• Controls and or/ management activities properly designed and operating as intended • Management is confident that the controls are effective and reliable
Largely effective	• Controls and or/ management activities properly designed and operating with opportunities for improvements identified
Needs improvement	• Controls are only partially effective, require ongoing monitoring and may require redesigning, improving or supplementing • Key controls and or/ management activities in place, with significant opportunities for improvement identified
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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	Head of Market Management (Neda Mazraeh)	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	Head of Market Management (Neda Mazraeh)	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	Head of Market Management (Neda Mazraeh)	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	Head of Market Management (Neda Mazraeh)	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

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

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

Ref	Control ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	12.03	Review of Quality Assurance Framework	Quality Assurance Framework Review	~~Lynn Johnson~~ Neda Mazraeh	December 2025	Green	Review of QAF has been completed – awaiting signoff
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
4	12.03	Addressing Quality Issues	Investment in Clinical Pharmacist role to extend medicines optimisation support through NHS Frimley ICB to home care and Supported Living Providers	Neda Mazraeh	December 2025	Red	Recruitment unlikley due to changes proposed to ICBs and staffing reduction NHS Frimley ICB/ICB

Target Risk Score – *18* by end of date *03/2027*

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

Corporate risk overview

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

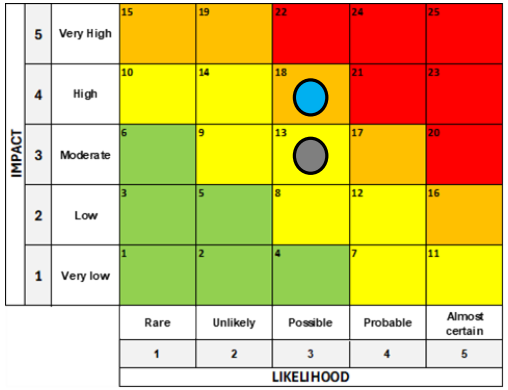
Updates are:

- GDPR training compliance has remained at 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.
- Both the IG officer and Information Records Manager roles are vacant and we are going out to recruitment next quarter.
- The risk rating remains unchanged this quarter despite an increase in the number of reported data protection incidents. Progress continues on enforcing training and communications across SBC and SCF further embedding knowledge and awareness throughout the organisations.

Risk appetite statement (Averse)

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

Risk profile



Refer to slide 7 for risk assessment score instructions

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
13.01		Privacy breach of personal data	Alex Cowen		This risk relates primarily to accidental disclosure of information; cyber attack is covered by CR08. Risk treatment plans relating to systems, process and training have been identified. The latter is of particular relevance here, where staff mindfulness of the importance of security and privacy is critical in avoiding materialisation of the risk. • The sub risk remains stable this quarter. Improvements have 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 newletter drafted and awaiting feedback and template from Communications. Expecting circulation before next quarter.
13.02		Unlawful retention and processing of personal data	Alex Cowen		While the same risk treatment plans are relevant to this sub risk as to 13.01, the probability is assessed as lower as the regime around Data Privacy Impact Assessments is well embedded. • The sub risk remains stable with no major changes envisaged.

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

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
Note: These measures have been introduced from the start of Q3 and will be reported in the next quarterly report, with targets informed by baselines. For Q2, data is either not available or not confirmed.					
Completion rate of mandatory training	*Rate of completion of mandatory data protection and cyber security training, reported separately for SBC and SCF*	90%	SBC: 83% 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	14	18	
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	

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

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

Control Effectiveness	Description
Effective	• Controls and or/ management activities properly designed and operating as intended • Management is confident that the controls are effective and reliable
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Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR13.01	Training	New staff are obliged to complete æLearning and an annual refresher course is also mandatory.	Martin Chalmers	Largely effective	• 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 2025. Processes for breach reporting, DPIAs, etc have been established	Martin Chalmers	Effective	• Audit actions relating to this area have been closed • All GDPR policies are updated annually and approved by IGG. • Subsequent actions will be monitored through the monthly IGG meetings. • Retention policy updated and circulated in Dec 25
3	SR13.01	Resourcing	An Information Governance officer role in place	Martin Chalmers	Needs improvement	• Interim for Information & Record Lead is vacant Permanent recruitment as part of DDaT restructure is still in plan. Information governance officer role currently vacant and is being filled currently by an internal resource, although recruitment is in progress to replace.
4	SR13.01	Communications	Awareness of data protection responsibilities boosted through emails and staff newsletter	Martin Chalmers	Largely effective	• 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 newletter drafted and awaiting feedback and template from Communications. Expecting circulation before next quarter.

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

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

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	SR13.01 & SR13.02	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	Planning to start review of requirements by Q1 26/27	G	• 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.
2	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	• Treatment plan is now completed New Backup as a Service now live with current retention policies in place.
3	SR13.01	Resourcing	Permanent recruitment to the IG roles within DDaT	Alex Cowen	March 2026 (Advertise Role)	G	• Both permanent and interim resources in the IG roles are no longer with the SBC. Service Improvement Lead supporting in this area as additional hours but now there is a need to start recruitment again
4	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	Purview POC Completion (March 2026)	G	• Currently linked to the Purview implementation • Purview POC due to be completed March 26, wider role out to be planned in Q1 26/27
5	SR13.02	Completion of the Corporate Memory Audit	Completing recommendations from the Corporate Memory internal audit	Alex Cowen	March 2026	G	• There is a Corporate Memory audit underway to further review the Council's retention policies. Changes to backup retention will follows as applicable.

Target Risk Score – 18 by end of 03/2027

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**

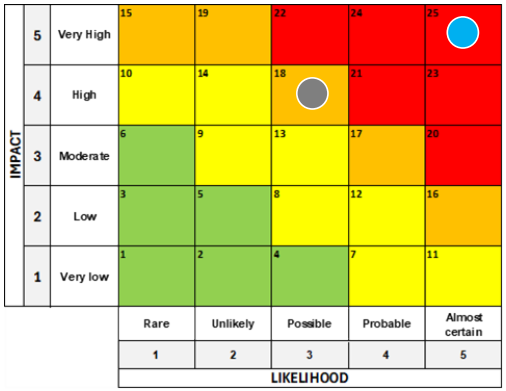
- Governance, oversight & financial council exposure as Shareholder across James Elliman Homes (JEH), and GRE5
- Risk that retained losses across the companies continue to be underwritten by the Council
- JEH 12-month Business case approved by cabinet on the 17th March 2025. Implementation is underway 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

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

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KRI 1 – JEH current financial performance (2024/25 outturn)	The financial performance of the company does not deteriorate further since August 2024 and improves on previous year performance	<£1.8m		£1.6m	
KRI 2 – JEH Balance Sheet health	The company reports total assets greater than liabilities	Total net assets		Net assets	
KRI 3 – JEH – Business plan 2025/26	The Shareholder has approved a business plan for 2025/26	Approved business plan		Pending – March 2025 Cabinet approval	
KRI 4 – JEH outstanding loans	Company has a confirmed strategy to repay the loan and the balance is reduced	<£51.7m		Baselined	
KRI 5 – JEH options appraisal	An options appraisal is completed to enable a Shareholder decision on the future strategic direction of the company	Decision		Pending	
KRI 6 – JEH FIP plan	All activities are completed on the FIP plan regarding company governance, oversight and financial governance	Completed by 31/05/2025		Slippage – FIP paused	
KRI 7 – JEH Special Resolutions	The special resolutions issued to the company have been fully discharged	Discharged by Q1 2025/26		In progress	
KRI 1 – GRE 5 current financial performance (2024/25 outturn)	The financial performance of the company does not deteriorate further since August 2024 and improves on previous year performance, recognising the Company has no material income but has expenditure liabilities.	tbc			
KRI 4 – GRE 5 outstanding loans	Company has a confirmed strategy to repay the loan and the balance is reduced	£2.2m by 31/03/2024		£2.2m	
KRI 5 – GRE 5 FIP plan	All activities are completed on the FIP plan regarding company governance, oversight and financial governance	Completed by 31/05/2025		Slippage – FIP paused	

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

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

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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 occurbi monthly	GRE5 Directors	Ineffective	GRE5 appointing new CoSec external Support to regularise
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CR14	**Failure of Council Subsidiary Companies (Suggested name)**	Risk owner: Pat Hayes

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

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	*SR01.01*	*High level action that will mitigate or reduce the risk the most*		*Director level*	*Dd-mm-yyyy (within the next 12 months)*	*(RAG)*	
2	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– *18* by end of date *03/2027*