Slough Borough Council

Report To:	Audit and Corporate Governance Committee
Date:	22 July 2026
Subject:	Q1 2026/27 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' – Q1 2026/27 Corporate Risk Profile Appendix 'B' – Q1 2026/27 Corporate Risk Dashboards (summary sheets) Appendix 'C' – Risk Management Maturity Assessment 2026

1. Summary and Recommendations

1.1 This report sets out

- The status of the Council risk profile in the Q1 2026/27 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 of Q1 2026/27, set out in Appendix A and B.
B) To note the Risk Management Maturity Assessment 2026 at Appendix 'C'

Reason:

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

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

Commissioner Review

One of the core functions of the committee is to provide independent assurance of the adequacy of the risk management framework, monitor the effective development and operation of risk management and progress in addressing risk-related issues reported to the Council. This is the first Corporate Risk Report for the current financial

year and should represent a collation of the risks identified and assessed as significant to the Council's ability to meet its strategic and operational objectives.

There are 15 risks outlined in the Corporate Risk Register that are considered to have a significant impact on the achievement of the Council's objectives and obligations. The commissioners note the nature of the risk, mitigations and scores, several of which are static. Efforts to embed a culture of good risk management across the Council should continue, risk management should be sufficiently resourced and considered in the context of wider performance and financial management.

The Council under its statutory directions are required to complete a review of its progress to risk maturity and how well its functions and processes enable risk-aware decisions that support the achievement of strategic objectives. The maturity assessment has been undertaken internally based on ISO Maturity Model and the latest version of this review reveals the internally assessed strengths and gaps in the risk processes, constraints and a draft action plan. In addition, an independent external review of the Risk Management programme has been commissioned to assess current performance and comparable organisations, to provide insight into how the Council is positioned relative to its peers.

The Council should consider bringing together the outcome of the two reviews, in developing the final action plan and recognising that technology and resource gaps that reduce the effectiveness and audit trail of processes, threaten the pace of delivery as outlined in this overarching CRR are not accepted constraints in an effective and mature approach to risk management.

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 inform the June 2026 Corporate Risk Report, a full review of all current corporate risks was undertaken. The report was initially presented to the Risk Management Board on 18 June 2026, where it was reviewed and approved, and subsequently presented to the Corporate Leadership Team (CLT) on 8 July 2026.

The latest position indicates that the Council's overall risk exposure has improved during the quarter, although it remains elevated. Risk continues to be actively managed; however, faster improvement is constrained by ongoing financial and workforce capacity pressures. Four risk scores have improved, while two have deteriorated, with the majority of risks assessed as stable or improving and only one risk reflecting a worsening outlook. The start of the new financial year has contributed to some score reductions, particularly where previous pressures were linked to budget uncertainty and associated sub-risks.

Delivery of risk treatment plans remains broadly on track, with no significant milestones missed. However, there is an emerging trend of revised delivery timescales, primarily driven by financial and resource constraints. This is moderating the pace of improvement in the control environment, although overall it continues to strengthen. There remains a reasonable level of confidence that further improvements in corporate risk scores will be achieved; however, this is contingent on the availability of sufficient resources in the context of ongoing financial pressures.

Corporate Risk Reporting

2.3 This quarter, the number of corporate risks has increased to fifteen, reflecting the inclusion of risks identified through the Council's continuous, year-round risk review process. This process does not operate on a fixed financial year cycle, rather, it is informed by ongoing engagement with directorates and services through regular stakeholder discussions, risk workshops, and targeted reviews. The two new risks are:

CR11: *(Failure to deliver Transformation Portfolio)*
CR15: *(Failure of Governance, Controls and Assurance)*

Currently, nine are rated as red (risk score between 20 – 25), four are rated as amber (risk score between 15 – 19) and two are rated as yellow **(**risk score between 15 – 19). In comparison to Q4 FY2025/26 although we have added two new risks, both rated red there is no change to the total number of risks rated red, with the balance of one amber and three yellow rated risks.

2.3 The control environment across corporate risks continues to improve, contributing to a more stable overall outlook, as reflected in eleven risks being assessed as stable this quarter. Delivery of risk treatment plans remains broadly on track, with no significant milestones missed. However, there is an increasing trend of revised delivery timescales, primarily driven by financial and workforce capacity constraints. This is moderating the pace of improvement in the control environment and has led to increased scrutiny over any further requests to amend delivery deadlines.

2.4 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.

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

Q1 2026/27 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.

Q1 2026/27 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
CR01	**Failure to Safeguard Children and Young People within budget**	4	4	21	18	21	→
	SR01.01: Insufficient financial resources	4	4	21		21	→
	SR01.02: Attraction and retention of qualified workforce	2	3	8		8	→
	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		13	↓
CR02	**Failure to meet demands on Adult Social Care within available resources and budget**	4	3	18		23	↑
	SR02.01: Inability to operate within budget and available resources	4	3	18		23	↑
	SR02.02: Inability to meet increase in demand	4	2	14		14	→
	SR02.03: Attraction & retention of talent	2	3	8		8	→
	SR02.04: Inability to carry out statutory annual reviews in clients with a Mental Health need	3	2	9		13	↑
CR03	**Failure of Special Educational Needs and Disability (SEND)**	4	4	21	14	21	→
	SR03.01: Failure to provide timely SEND support	4	4	21		21	→
	SR03.02: Non-receipt of Safety Valve Agreement payments	4	3	18		21	↑
	SR03.03: Financial and reputational damage from complaints	4	3	18		18	→
	SR03.04: Failure to deliver the planned inspection improvements	3	3	13		13	→
CR04	**Failure to Provide Safe Temporary Accommodation within Budget**	4	5	23	21	25	↑
	SR04.01: Lack of Suitable Available TA	5	3	22		22	→
	SR04.02: Budgetary constraints	4	5	23		25	↑
	SR04.03: Lack of Statutory Compliance and Health & Safety Information	4	2	14		14	→
	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**	2	4	12	13	13	↑
	SR05.01: We fail to attract and recruit a diverse and inclusive workforce for senior manager and above.	3	2	9		13	↑
	SR05.02: We fail to identify, develop and embed the capabilities and competencies we need in our workforce	2	4	12		8	↓
	SR05.03: We fail to maintain an energised and engaged workforce	2	3	8		13	↑
	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 meet statutory obligations**	4	3	18	14	14	↓
	SR06.01: We fail to prioritise adequately fund or manage risks associated with corporate health and safety	3	3	13		13	→
	SR06.02: We fail to prioritise adequately fund or manage risks associated with fire	4	2	14		14	→
	SR06.03: We fail to prioritise adequately fund or manage risks associated with aggressive behaviour	4	2	14		14	→
	SR06.04: No resource to provide required staff training, policy and codes of practice improvements.	4	3	18		13	↓
	SR06.05: We fail to ensure adequate numbers of trained personnel within the Corporate Health and Safety Team	3	2	9		9	→
CR07	**Insufficient Operational Resilience and Crisis Management**	4	4	21	18	21	→
	SR07.01: Inadequate rapid emergency response capabilities to provide immediate incident co-ordination and humanitarian support to affected residents	4	3	18		18	→
	SR07.02: Failure of emergency planning for specific major hazard risks in the borough, such as flooding, major fires, industrial accident	4	2	14		18	↑
	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	3	18		21	↑
	SR07.05: Inadequate continuity planning for specific risks	4	4	21		21	→
CR08	**ICT incident resulting in significant data and/or service**	5	4	24	22	24	→
	SR08.01: A cyber attack causes significant data or service loss	5	4	24		24	→
	SR08.02: A business continuity issue causes significant service loss	4	3	18		18	→
	SR08.03: An incident caused by hardware or software failure causes significant service loss	3	2	9		9	→
	SR08.04 An incident caused by legacy hardware or software failure causes significant service loss	3	3	13		18	↑
CR09	**Failure to achieve financial sustainability and a balanced MTFS**	5	3	22	22	22	→
	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	3	22		22	→
	SR09.03: Inadequate cashflow to maintain balance of liquidity to fund expenditure	4	1	10		10	→
	SR09.04: Inadequate Government funding to meet Slough's spending needs	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 Finance Improvement Programme	1	4	7		7	→
	SR09.07: Failure to deliver value for money from procurement processes	3	5	20		20	→
CR10	**Failure of General Fund Asset Disposal Programme**	4	3	18	14	14	↓
	SR10.01: Property disposals not hitting financial targets and sitting outside of lower volatility levels	4	3	18		13	↓
	SR10.02: Pace of disposals is behind programme deliverable dates	4	2	14		14	→
	SR10.03: Attraction and Retention of quality people	4	2	14		9	↓
	SR10.04: External property market volatility	4	3	18		9	↓

CR ref.	Corporate Risk - Sub-Risk	Impact Score	Likliehood score	Current Score	Target Score	Prev. Qtr Score	Score movement/ Outlook last quarter
CR11	**Failure to deliver Transformation Portfolio - NEW**	4	4	21		NEW	→
	SR11.01: Failure to Procure and Mobilise an Appropriate Transformation Delivery Partner	4	2	14		NEW	→
	SR11.02: Portfolio Insufficient to Deliver Required Savings and Benefits	4	4	21		NEW	→
	SR11.03: Delivery Capacity, Governance and Organisational Readiness Failure	4	4	21		NEW	→
	SR11.04: Failure to Manage Cross-Portfolio Dependencies and Change Impacts	4	3	18		NEW	→
	SR11.05: Failure to Realise Benefits Due to Weak Data, Measures and Accountability	4	3	18		NEW	→
CR12	**Failure to deliver adult social care market sustainability**	3	3	13	13	21	↑
	SR12.01: Insufficient access to regulated services	2	2	5		5	→
	SR12.02: Cost of fee uplifts outstripping budget	1	2	2		21	↑
	SR12.03: Provider failure	3	3	13		13	→
	~~SR12.04: Recruitment and retention of external workforce -~~ REMOVED	0	0	#N/A		0	Removed
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	→
	SR13.03: Failure to detect, report and remediate personal data breaches	4	3	18		NEW	→
	SR13.04: Inadequate governance, training and assurance arrangements for GDPR compliance	4	2	14		NEW	→
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	2	9		18	↑
CR15	**Failure of Governance, Controls and Assurance - NEW**	5	4	24	21	NEW	→
	SR15.01: Fraud and Misappropriation	4	5	23		NEW	→
	SR15.02: Regulatory Non-Compliance	4	5	23		NEW	→
	SR15.03: Inaccurate Management Information	4	3	18		NEW	→
	SR15.04: Contract Management & Legal exposure	5	4	24		NEW	→

2.7 A synopsis of the above table is as follows:

At the closure of the Q1 2026/27 risk dashboards, we have:

15 corporate risks, broken down into:

- 9 RED risks (risk score between 20 – 25) – **Q4 - 9 RED**
- 4 AMBER risks (risk score between 15 – 19) – **Q4 - 4 AMBER**
- 2 YELLOW risks **(**risk score between 7 – 14) – **Q4 0 Yellow**

- 64 sub-risks across all corporate risks **– Q4 – 55**
- 17 RED risks (risk score between 20 – 25) – **Q4 - 16**
- 15 AMBER risks (risk score between 15 – 19) – **Q4 - 11**
- 28 YELLOW risk (risk score 7 – 14) – **Q4 - 24**
- 4 GREEN risks (risk score 1 – 6) – **Q4 – 4**

4 sub-risks have deteriorated in this quarter compared to 2 in Q4
10 sub-risks have improved in this quarter compared to 14 in Q4.

2.2 As the Council's risk management arrangements continue to mature, it will be better positioned to respond effectively to complex, multi-factorial risks. These risks increasingly require coordinated cross-departmental and multi-agency approaches, alongside a clear understanding of the Council's strategic leadership role.

2.3 The overall corporate risk exposure has remained within stable parameters this quarter, but the overall exposure remains elevated. Two risk scores have deteriorated, and four corporate risks have improved this quarter.

2.4 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.

2.5 The Committee is asked to note the status update of the red rated risks which remain concentrated in key service and cross-cutting areas and continue to reflect structural demand, financial pressures, and external factors.

- CR01: *(Failure to Safeguard Children and Young People)* – the rating remains red with a stable outlook this quarter. Ongoing demand and high-cost complex cases are putting managing cost within the 2026/27 budget at risk.

- CR03: *(Failure of Special Educational Needs and Disability (SEND)* – the rating remains red, driven by the recent inspection outcome identifying systemic weaknesses. Improvement activity is underway and progress has been evidenced since the previous inspection.

- CR04: *(Failure to Provide Safe Temporary Accommodation within Budget)* – remains red but is stabilising, with a reduced score (25 to 23). Although the overall score reduced the primary driver of the risk is still the availability of suitable accommodation to meet demand, as opposed to just the cost of accommodation.

- CR07: *(Insufficient Operational Resilience and Crisis Management)* – the overall risk remains red. Improvements continue across all sub-risks with improved scores. Business Continuity remains the key driver. A project is on time to deliver business continuity plans which when delivered is expected to support movement out of the red rating.

- 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 due to the external cyber threat environment, despite ongoing control improvements.

- CR09: *(Failure to achieve financial sustainability and a balanced MTFS)* – the risk remains red and is reported as being stable. It is still driven by the sub-risk for the failure to achieve a balanced budget and Medium-Term Financial Strategy (MTFS).

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

There have been two deteriorating risks reported this quarter:

- CR06: Health and Safety – Failure to Meet Statutory Obligations – The overall rating increased from yellow to amber, driven by SR06.04 following the loss of the

Health and Safety Manager. This has since been mitigated through the appointment of external consultants.

- CR10: Failure of General Fund Asset Disposal Programme – The overall rating increased from yellow to amber, driven by SR10.01 due to market volatility and delays to completion.

Four corporate risks have improved this quarter:

- CR02: Failure to meet demands on Adult Social Care within available resources and budget – The overall rating reduced from red to amber, driven by improvement in SR02.01.

- CR04: Failure to Provide Safe Temporary Accommodation within Budget – The overall score reduced from 25 to 23, although the risk remains red. This improvement was driven by SR04.02, the budgetary sub-risk.

- CR05: Failure to Attract, Retain and Engage Our People – The overall rating remains yellow, but the score reduced from 13 to 12.

- CR12: Failure to Deliver Adult Social Care Market Sustainability – The overall rating improved from red to green, driven by SR12.02, as fee uplifts are now expected to remain within budget.

2.2 As previously intimated two new corporate risks have now been approved by the Risk Management Board ("RMB") and the Corporate Leadership Team ("CLT") have now gone live this quarter, as previously stated they are:

- CR11: Failure to Deliver the Transformation Portfolio
- CR15: Failure of Governance, Controls and Assurance

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

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

2.4 The June 2026 Corporate Risk current and target risk scores are summarised below and now also include the quarterly trend outlook:

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

*figure 2 – Corporate Risk Current & Target scores (*Q1 2026/27*)*

(Target risk scores to be delivered by March 2027)

	CORPORATE RISK	QUARTERLY TREND	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 available resources and budget	→	18	14	↑
CR03	Failure of Special Educational Needs and Disability (SEND)	→	21	14	→
CR04	Failure to Provide Safe Temporary Accommodation within Budget	→	23	21	↑
CR05	Failure to Attract Retain & Engage with Our People	→	12	13	↑
CR06	Health & Safety: We fail to meet statutory obligations	→	18	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	↓	18	14	↓
CR11	Failure to deliver Transformation Portfolio - NEW	NEW	21	TBC	NEW
CR12	Failure to deliver adult social care market sustainability	↑	13	13	↑
CR13	We fail to comply with GDPR data protection obligations	→	18	18	→
CR14	Failure of Council Subsidiary Companies	→	25	24	→
CR15	Failure of Governance, Controls and Assurance	NEW	24	21	NEW

2.16 The Risk Management Consultant continues to work with senior officers to promote and embed effective risk management and to review corporate and directorate risks. In addition, an independent external review of the Risk Management Programme has been commissioned to assess current performance and to use the external experts knowledge of comparable organisations to provide insight into how the Council is positioned relative to its peers. This will be delivered end July 2026 and then presented to the committee in September

Risk Management Maturity Assessment

2.17 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. This is attached under Appendix C for noting.

2.18 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 June 2026 Corporate 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' 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

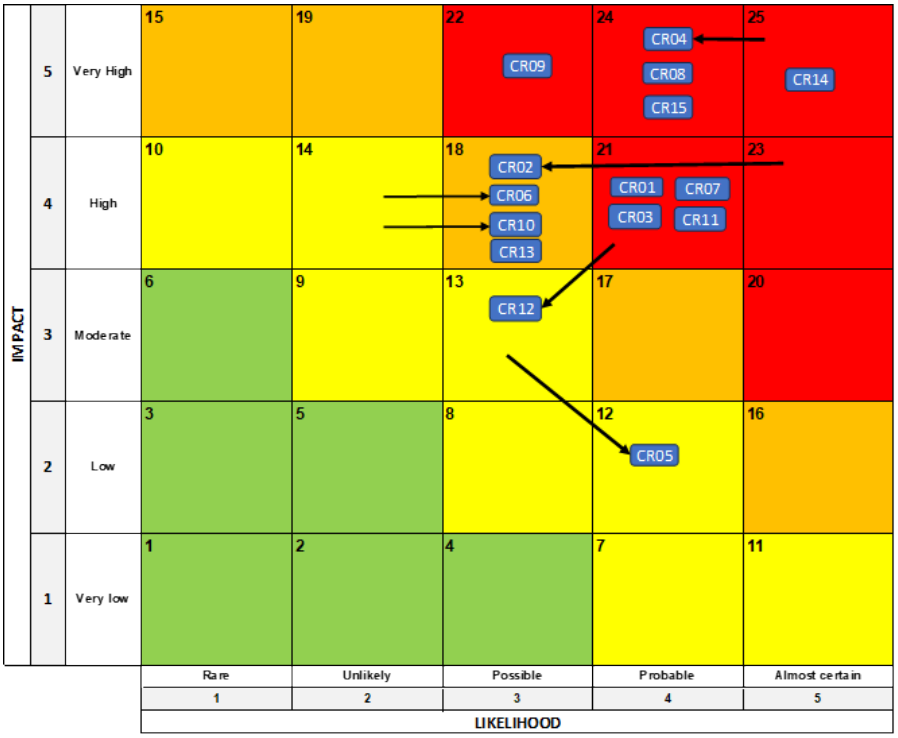
None

Appendix ‘A’ – Q1 2026/27 Corporate Risk Profile

The overall corporate risk profile has improved during the period, with four risk scores improving and two deteriorating. Control environments continue to strengthen, supporting a more stable outlook overall. However, the current constrained financial and resources position may adversely affect the profile further, as delivery of some treatment plans is unlikely to be achieved within the identified timescales.

Further detail is provided in the risk dashboards, including current scores, outlook, controls, and treatment plans. (see Appendix B).

Figure 1 – Corporate Risk heat map (June 2026)



Corporate Risk

CR01: Failure to Safeguard Children and Young People within budget
CR02: Failure to meet demands on Adult Social Care within available resources and 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 meet statutory obligations
CR07: Insufficient Operational Resilience and Crisis Management
CR08: ICT incident resulting in significant data and/or service

Corporate Risk

CR09: Failure to achieve financial sustainability and a balanced MTFS
CR10: Failure of General Fund Asset Disposal Programme

CR11: Failure to deliver Transformation Project - **NEW**
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
CR15: Failure of Governance, Controls and Assurance - **NEW**

Appendix 'B' – Q1 2026/27 Corporate Risk Dashboards (summary sheets)

CR01 Failure to Safeguard Children and Young People within budget

Risk owner: Debbie Jones

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

Corporate risk overview

Financial pressures remain significant with an overspend in 2026/27. SCF has kept SBC aware and submitted an in-year request to resolve this. 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 staffing risks caseloads per social worker are largely appropriate across most service areas. However, there are two where sickness has created pressures. Attracting permanent staff is not a current risk, reflecting work done over the past few years, although retention is. 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.

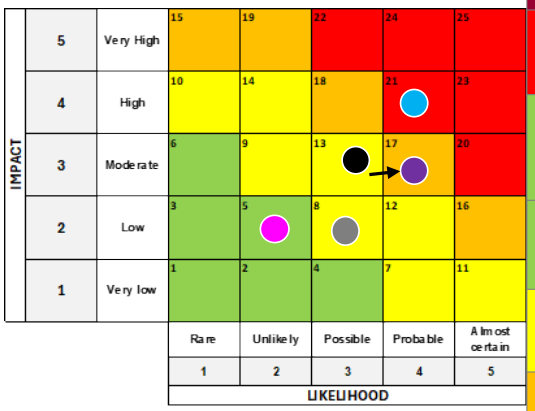
Children's Social Care is subject to a Statutory Direction from the Department of Education overseen by a DfE Advisor

Risk appetite statement Averse

The SCF risk appetite is AVERSE 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	Director of Finance/ Resources (Alex Pilgerstorfer)		SCF ended 2026/7 with a deficit of £1,734,000 and has submitted an in-year request to cover this. Costs remain high in2026/7 and a request has been made to the Council to fund these emerging demand pressures. Should this be agreed the risk score would reduce.
01.02		Attraction and retention of qualified workforce	Head of HR (Kate McCorriston)		Staff are feeling high levels of pressure: these changes coincide with an impending ILACs inspection and national changes in social work practice. SCF continues to attract a reasonable lev of quality applicants for most roles. The senior team has had significant change with interims covering a number of these roles.
01.03		High Caseloads for frontline staff	Director of Ops (Rashida Baig)		Caseloads are monitored on a weekly basis and reported to the Improvement Board chaired by th DfE Improvement Advisor. There is variability and while most are two service areas still have pressures which are being addressed.to Resource has been agreed.
01.04		Staff capability	Director of Ops(Rashida Baig)		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	Director of Finance/ Resources (Alex Pilgerstorfer)		SCF is reliant on manual intervention to produce necessary reporting as several key IT systems make it hard to extract data. 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. External expert support to interrogate data has been brought in. QA is supporting team leaders in oversight of input of accurate data. Extra capacity to be brought in to write performance reports.

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*	*Q3 actual £1,579,000 deficit*	Q4 deficit £1,734,000	
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% -	41.8% 38%	43.9% 39%	
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%	18.3% 95.7% 24.2% 89.8% 100% 100% 90.1%	22.7% 95.1% 20.5% 84.9% 100% 88% 93.4%	
KRI 4	Number of staff on performance management (formal and informal)	-	4	2	
KRI 5	Number of data dashboards desired but currently unable to deliver	MASH, RISE X4) Safet_+QA; core operationsal -	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)	8 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)	

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	The controls are operating within expectations and are identifying emerging additional demand costs.
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	Additional resources have been identified which should address the two areas where caseloads are too high
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. SomePowerBidashboards. 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 ofPowerBidashboards; further data cleansing of HR systems; further audits of caseload data. Good foundational work being done to allow data reports to be run.
6	SR6	Building on basics	Performance is inconsistent and variable. Children's social services continue with additional resources being directed to areas of greatest need. Treatment plans in place.	Director of Operations	Needs Improvement	To address basicscaseloadsneed to be brought down and Early Help waiting lists resolved. Additional financial resource has been agreed by the Council to allow this.

CR01	Failure to Safeguard Children and Young People within budget	Risk owner: Debbie Jones

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.
5	01.06	Improvement plan and ongoing QA work	Extra interim expert staff; additional QA activity; resetting of priorities	Director of Operations	July 2027		Work is largely complete to identify areas requiring improvement; improvement actions will take time to embed.

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

CR02 | Failure to meet demands on Adult Social Care within resources and budget | Risk owner: Jonathan Price

Corporate risk overview

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

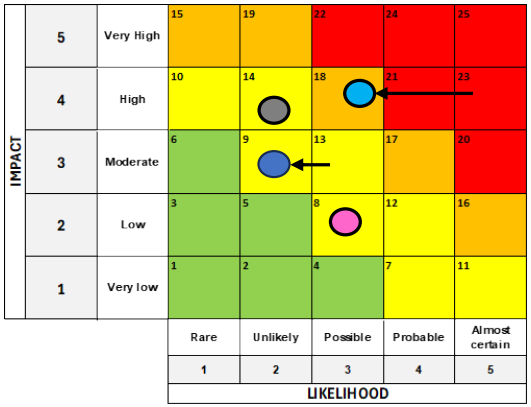
Work is underway to address workforce demands and the directorate is starting to see improvements. The permanent Director of Operations started in Nov 2025 and the permanent Head of Market Management started in Jan 2026. Discussions continue re the appointment of Head of Reablement and Independence and PSW Role 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 decreased due to a right sized budget for 26/27 ~~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
2.01 has been expanded to consider resource in our broadest terms, incorporating budget

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 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 and available resources	Jonathan Price (lead)		Budget 26/27 was agreed with a right-sized budget. This risk is also considering the wider risks in relation to resources. There is possible decrease in health funding eg CHC, Better Care Fund, S117 that ASC is monitoring and considering potential impact in Slough.
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 **Reviews 62.2% completed in 25/26**
02.03		Attraction & retention of talent	Jane Senior Fadzai Tande		Permanent Director of Operations and Head of Market Management in post, discussions continue re appointment of Head of Reablement & Independence. Head of Commissiong to be advertised in June. A sponsorship licence has been secured Permanent appoints being secured in MH, however AMHP recruitment is still a risk. Top teams have vacancies with limited applications; vacancies are being covered by locum staff. There is good retention once staff are in permanent positions in SBC. Whilst there is an operational decline this is not a a level to affect the risk score
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. Reviews being done by exception eg review of high cost placement

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
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 as~~at ~~August 2025~~ ~~(28% staff are interim~~ 52 agency staff currently in post as at Dec 2025 (25% staff are interim) Reduction of 3% from Aug 2025	As at March 2026; 48 interims in post Reduction of 8% Longest tenures 5+ years	
KRI 3– Stabilise ASC leadership team	Updated Q4 New extended leadership structure in place~~,Three~~ Four of the~~5~~ 7Heads of Service are permanent. ~~A 6th Head of Service post is being held to the newly formed PSW rol~~Director of Operations and Director of Commissioning permanent with an Interim Executive Director in post from May 2026. PSW and Head Reablement currently being recruited. Head of Commissioning recruitment to start June 2026 SM NOTE– I think there are 10 including Debra who I don't think was included previous~~ly~~ need to finalise this figure	20% (Vacancy/interim cover rate)	Q3 25/26 –25%	Q4 – 30%	

Need to review and ADD new KRIs – look at the data that comes to eDLT

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

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	Jonathan Price	*Effective*	Controls are operating at an acceptable level
2	SR02.01	Cost Savings within our control	Identified Senior Responsible Owner(SRO) for each saving	Jonathan Price	*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.

CR03 Delayed SEND Support Affecting Life chances Q3 Report Feb26

Risk owner: Debbie Jones

Current Risk Score 4 Impact 4 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.

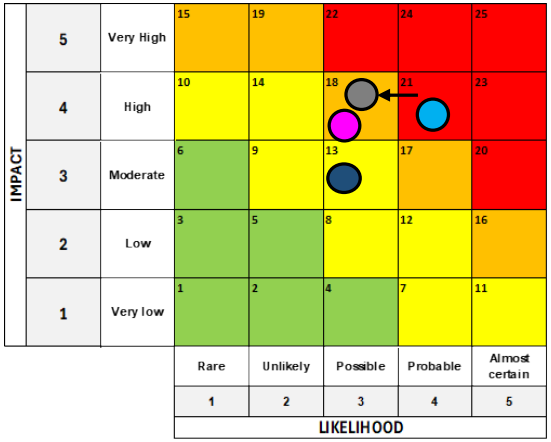
SBC successfully bid for an Inclusion Support Fund and this will provide intelligence to support the transformation programme. The Safety Valve Agreement continues and the predicted deficit at the end of the agreement has risen significantly. However, the DfE has not suggested that this will affect future 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 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
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.
03.02		Failure to secure Safety Value funding 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 and reputational impact of complaints and legal challenges	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		SEND improvement plan not delivered to required timescales'.	Neil Hoskinson	→	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**.

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**

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

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

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR03.01	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.

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

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	03.01	*Improved Statutory Team Processes*	Additional locum EPs and a short-term interventions team will address the backlog of EHC plans and improve timeliness. Improved SEND statutory processes are improving timeliness for new cases including case management and tracking.	Neil Hoskinson Director of Education	*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.

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

CR04 Failure to Provide Safe Temporary Accommodation within Budget

Risk owner: Will Tuckley

Corporate risk overview

Current Risk Score 5 Impact 5 Likelihood	**23**
Target Risk Score 4 Impact 4 Likelihood	**21**

There has been small positive changes in some sub-risks since the last reporting period. Although subsidy loss is now budgeted to be £21m that is based on an average of 1,250 homeless households during 2026/27. We are currently operating with 1,460 homeless households and the refore likely to incur additional unbudgeted subsidy loss. In addition, current & former arrears of £13.4m ((neither of which are Housing functions) remains. The overall outlook has improved with total risk score reducing slightly to reflect the lower un-budgeted subsidy loss.

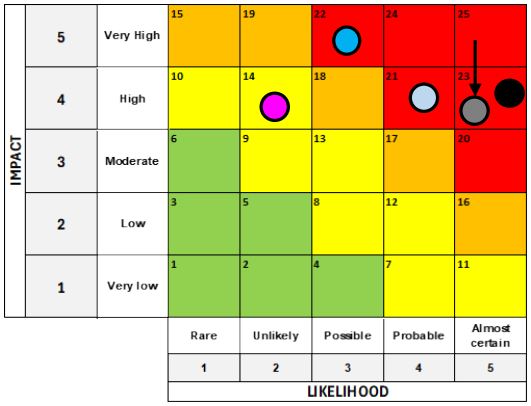
In this period, we have created and recruited to the new Interim Director of Housing Needs and Support. A new head of TA and Allocations was recruited in April 2026 and a new Allocations Manager was recruited in May 2026. Staff churn remains high and 100% reliance on interim staff means risk score remains 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. Our project to increase move-on has stalled while 4 providers are onboarded.

- Current risk score is reduced to 23 due to sub-risk 2 (budget) being linked to lower un-budgeted subsidy loss and arrears.
- 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.
- Risk relating to data and ICT systems remain very high. A project to integrate Jigsaw and NEC has started but will not conclude until January 2027 at the earliest. This means our risk relating to effective management of TA remains high.
- 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 bi-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 82% 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. At the end of May 2026 73 transfers to better value accommodation has estimated annual saving of £800k . • Project to enter long term leases for 25 homes that will save £1.1m p.a. is delayed while commercial analysis is completed. When repairs and management costs are added the benefits of 10 yr – 1 day leasing are negligible. • Action plan to re-negotiate with TA providers re-started. Intensive activity 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 Q2 2026/27. **There has been no demonstrable change since the last reporting period. The overall score remains high because we are still reliant on 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 remained at just over 1,800, with 1,460 placed in TA. • The forecast subsidy loss remains £21m (66% of HB spend). The cost of TA units remains at roughly £2,200 / household and is no closer to 2011 LHA rates. • The business expects a revised subsidy loss to be reported as there are currently 210 more families in TA than budgeted for. This is due to a backlog of relief cases identified in February / March 2026 being granted a full duty and moving into TA. **Q1 2026/27, the £21m subsidy loss will be budgeted. As such the score has reduced to 21.**

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	Interim Director of Housing Needs and Support (Karen Shaw)		• Physical inspections of TA, B&B and HMO accommodation continues with over 600 visits completed. Reduced resource capacity in April-June 26 means risk has increased. • 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 130 families remain in Galaxy units. • New agreed Private Sector Leasing and Private Licence Agreements have explicit clauses requiring TA providers to provide damp free certificates and to ensure the home is fit for purpose i.e. free from damp & mould. Project delayed as these have been re-drafted by our new Commercial manager. • Further independent health check of TA remains a recommendation. • Risk remains high while manual collection and storage of compliance documents remains. ICT solution and / or DPS solution required. **There has been no demonstrable change in the in Compliance risk. The immediate outlook continues to be challenging because an unknown number of incorrect licences have been issued but robust processes are in place and the 2nd annual cycle of certification is starting. Risk score remains at 14. The likelihood of not having a document is low because of new resources and process. The impact of not having a document is high as could be high.**
04.04		Attraction and retention of talent	Interim Director of Housing Needs and Support (Karen Shaw)		• Recently, a new Interim Director, Head of TA Service were recruited. In May 2026 a new Housing Allocations Manager was recruited. • 100% of TA team remains interim – only one part-time (0.4 fte) permanent member of staff in place. • HSG Demand backlog team and early intervention team retained during Q4 • All contracts for interim staff in Housing Needs and Support end September 26. Full review of structure and employment model being undertaken by the new Interim Director. **There has been no demonstrable change in recruitment and retention of the workforce particularly the retention of recruited staff and lack of structure going forward. In fact, with three senior members of the team leaving in the period the risk could increase. However re-recruitment keeps the score at 23 because 100% of TA are interim and flight risk is very high.**
04.05		Ability to effectively Manage TA property and people	Interim Director of Housing Needs and Support (Karen Shaw)		• 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 • Commercial Manager started September but still has only a small interim team to procure new accommodation or undertake occupancy and compliance visits. • 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 no demonstrable change 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 capacities are in place to conduct visits to households in TA out of the borough and households in TA. Project to procure an ICT recovery and delivery partner is underway.**

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	100% of private TA to be FLAGEL compliant by October 2026 (Established Hotel Accommodation to be exempt)	95% ~~75%~~	tbc% (changed from green to amber)	
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%	
KRI 4– Data	Jigsaw, NEC and Agresso Data align. A slight tolerance allowed as manual process in place means a natural 'time lag'	95% reconciliation by April 2026	75% ~~55%~~	75% (manual interventions remain. When staff on a/l we can tell alignment dips)	
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 have HB application. (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)	90% ~~85%~~	90%	

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 (Roberto Bruni)	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 . New sign-up tracker used to track new placements and transfer placements on a weekly basis.
3	2	TA resource, budget setting and control	Ensuring budget for resources is aligned to scale of the risk	Head of Service (Roberto Bruni)	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 (Roberto Bruni)	Needs Improvement	Measures improved significantly with recruitment of compliance officers and a new SharePoint solution. Staff retention issues mean compliance visits down in period. However, still at risk asno ICT system, high staff turnover, ad hoc arrangements in place which limit the effectiveness of the control measure. The control measure needs a supported ICT solution.
4	4	Recruitment and retention of workforce	Recruit and retain suitably capable staff to manage TA	Head of Service (Roberto Bruni)	Needs Improvement	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 (Roberto Bruni)	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.

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

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

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
6	6	Allocations and PRS	Weekly review of available empty HRA homes and PRS. All allocations are signed-off by the manager. Includes sign-off form and checks onshortlisting and nominations.	Head of Service (Roberto Bruni)	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 (Roberto Bruni)	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 (Roberto Bruni)	Needs Improvement	By increasing the number of staff trained in HHSRS SBC will increase the provision and quality of safe temporary accommodation.. Staff retention issues mean compliance visits down in period.
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 (Roberto Bruni)	Largely Effective	By establishing and embedding partnership arrangements this will enable this control measure to be delivered at pace.

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 (Roberto Bruni)	[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. At risk due to staff capacity.
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 (Roberto Bruni)	[May 2026]	Green to Amber	Dedicated officers undertaking forensic review of invoices - 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 (Roberto Bruni)	[June 2026]		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.At risk due to staff capacity
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 (Roberto Bruni)	[April 2026]	Changed from amber to green	All new placements 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 (Roberto Bruni)	[June 2026]		External company used to undertake 200 visits. New visiting officers recruited in April / May 26. Number of follow-up action is large and requires analysis to determine impact on risk score.
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 (Roberto Bruni)	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.At risk due to staff capacity
9	3	NEC Provider Model	Implement the NEC PSL module to record key information and hold related compliance data.	Head of Service (Roberto Bruni)	No target date available		No DDaT resource available to support the business progress this module. QLP review recommended re-implementation o NEC but that no new modules to be implemented

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 (Roberto Bruni)	[October 2026]		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~~ June 2026		Backlog team working well. Numbers in prevention stage down 80 in period. Number of cases in relief down from 630 to 400 in period. New Government Funding allocated to early intervention and prevention team. Immediate impact– over 79 preventions in Q4.
12	5	Systems & Reporting	Engage ICT project team to continue system implementations, integrations and Power BI reporting Suite	Head of Service (Roberto Bruni)	~~June 2026~~ January 2027		Cabinet approval to procure a re implementation partner. Procurement started in April 26. Integration project manager allocated from Transformation team. Project due to deliver integration January 2027. Power BI resource left Fab 2026. New officer to join June 2026.
13	5	Policy	Allocations, TA acquisition, Out of Borough Placement to be reviewed	Head of Service (Roberto Bruni)	[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 (Roberto Bruni)	[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. At risk due to staff capacity. Needs input from transformation partner.

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 2 Impact 4 Likelihood	12
Target Risk Score 3 Impact 3 Likelihood	13

The risk score has improved to 12 (yellow) from 13 (yellow). The risk continues to track in the right direction with two sub risks improving and one slightly deteriorating.

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 not being 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.

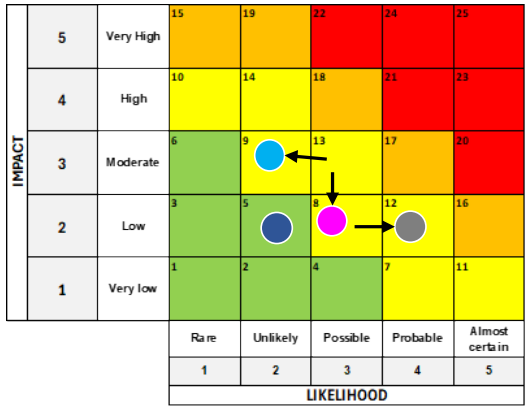
We retain the risk that SBC competes with local London Borough pay scales which will impact our attraction.

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. We are revisiting our LD offer to include revision of career pathways for all staff.
05.03		We fail to maintain an energised and engaged workforce	Bal Toor		Our employee net promoter score has increased by over 10% alongside our staff stating resilient as their preferred word to describe the Council.
05.04		We fail to keep our turnover in line with a national average of 10%	Bal Toor		Turnover 8.59% remains broadly the same however we have seen a increase in internal promotions and reducing interims, replaced by perm opportunities

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KRI 1	Staff Turnover	Staff turnover (voluntary) inline with last published civil service average. 10% average	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)	8.59%	
KRI 2	Number of working days lost due to sickness absence per FTE employee	In line with CS average.	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)	9.44/FTE	
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	47 (due to graduations)	39	
KR 4	Overall completion of all mandatory learning across SBC	50% of staff should have completed all 7 modules	26.1%	46%	

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

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

Control Ref		Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
2		SR05.01	1. Attraction channels 2. Apprenticeship scheme 3. Line Management upskilling	1 Review of how we work with Talos and 3rd party suppliers to advertise roles, to include working with Matrix on hard to fill vacancies. 2. Continuation of learning from newly established Data apprenticeship to replicate positive impact across new apprenticeship schemes. 3. Reviewing staff survey results to ensure feedback on line managers is taken into account when developing LM development scheme	Bal Toor	Effective.	The Workforce Strategy year 1 has implemented many actions in relation to reviewing the employee life cycle and ensuring staff have a seamless and positive experience. With the recent staff survey results, this allows us the opportunity to review our efforts, ensuring they remain relevant.
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	Effective. .	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 and graduates 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	Effective.	We have completed our contract with the external supplier and are prepping to deliver this programme in house from July 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	Effective. .	EOYR completion rates were 97% this year, however feedback will ensure the tool is further enhanced for next year.
5			HR Policies	Maintain up-to-date HR policies aligned to ACAS guidance, approved through governance, communicated to staff, and reviewed periodically to ensure fair and consistent application	Bal Toor	Largely effective	We continue to review our policies - noting all of them are ACAS compliant.

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

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1		Review of complete employee life cycle	Now HR has new perm folk in place, HR is reviewing complete handshakes between HR processes to improveonboarder 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. PROPOSED CLOSE– new work will begin as per the refresh of the Workforce Strategy.
2		Workforce Strategy					
3		L&D					
4		Career Development					
5		HR Restructure					
6		Review of Pay & Reward					

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

CR06	Health & Safety We fail to meet statutory obligations	Risk owner: Ian O'Donnell

Corporate risk overview

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

The overall risk score increased from 14 - 18 following a review by consultants. The council currently faces multiple, simultaneous risks – with a common root cause. Lack of data, communication, ownership/reporting, and failure to recruit a permanent Corporate Health and Safety Manager remains a concern, however, a consultancy has been appointed to ensure that the council continues to have full oversight and professional advice where and when required.

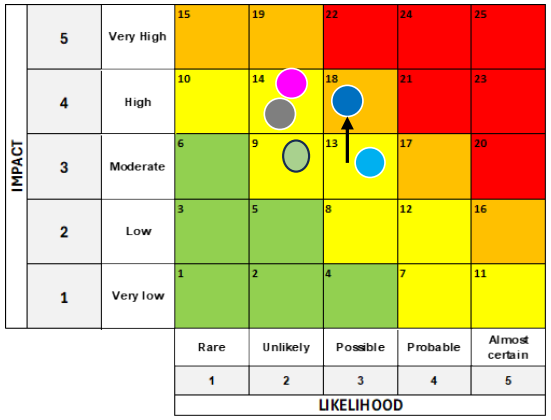
The consultancy are reviewing the polices and guidelines to ensure with 42 codes of practices being updated during 26/27.
A corporate wide health and safety training e-learning is being developed and once ready will be rolled out to all staff. Assessment of areas to focus on is being carried out to ensure that the key criteria and weaknesses are addressed.

Risk appetite statement (AVERSE)

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

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

Risk profile



Refer to slide 11 for risk assessment score instructions

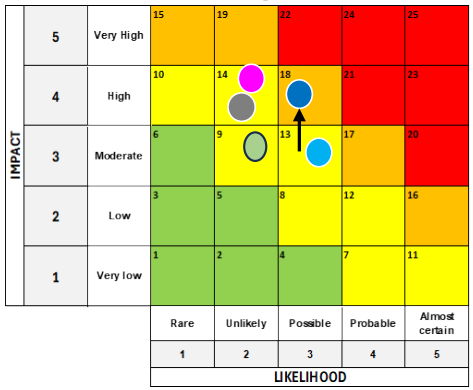
Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
06.01		We fail to prioritise, adequately fund or manage risks associated with corporate health and safety	Paula Pulley		A new accident/incident reporting system is in place and working effectively. Standardised organizational ownership, recording, monitoring and reporting of key risks & statutory obligations. This has moved to BAU and trends continue to be monitored.
06.02		We fail to prioritise, adequately fund or manage risks associated with fire	Paula Pulley		The risk score has seen no movement over the last period. 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	Paula Pulley		The risk score has seen no movement over the last period. 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		Inability to provide required staff training, policy and codes of practice improvements.	Paula Pulley		The risk has been reassessed following the appointment of consultants to reflect the current position. An e-learning module for all staff, will be developed and become part of the yearly training programme. However, staff currently having to rely on codes of practices that are issued on internal website

Corporate risk overview

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

Risk profil



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		Insufficient trained staff in the Corporate Health and Safety Team	Gordon Allan		The risk has remained the same as last period. Permanent recruitment of a H&S Manager and an H&S Advisor are underway. Expert advice in the form of consultancy has beeprocured, this will ensure that the organisation continues to have access to fully trained staff.

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/ Threshold	Previous qtr. status	Current qtr. status	Trend
KR 1	Reported Accidents/Incidents	**80**	**73**	**48**	
KRI 2	Reported RIDDOR Incidents	**1**	**1**	**1**	
KRI 3	Completed Fire Risk Assessments	**4**	**0**	**1**	
KRI 4	Weekly/Monthly Routine Personal Safety Device Checks	**100**	**40**	**118**	
KRI 5	Emergency Personal Safety Device Activations (Red/Amber alerts)	**8**	**0**	**3**	
KRI 6	Health and Safety Training Completed	**85%**	**0**	**3.3%**	
KRI 7	Health and Safety Policies Reviewed and Completed	**7**	**13**	**0**	
KRI 8	Health and Safety Staff Levels and Attrition	**3**	**2**	**2**	

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

Control Effectiveness	Description
Effective	• 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	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.
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	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.
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	A new re-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. An Interim H&S Manager is providing high level advise and support to the current team of one.
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	Audit underway to assess all FRA's - frequency, prioritisation of actions, category and all open actions.
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. to target services with specific issues.
7	SR06.03	**Lone Working**	Provide reasonably practicable controls (Policy, Equipment & Systems) to protect staff from unreasonable behaviour.	Director Level	Needs Improvement	An overarching Health and Safety Policy will be presented to Cabinet in 26/27, as well as updated guidelines and practices which will be released during the year

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
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	Ineffective	There are Codes of Practices that staff can access, however, no formal H&S training is currently given. A new e-learning module is being produced, however, should this continue to be ineffective, then a third party provider will be procured to deliver in person training.
11	**SR06.04 – 0.2**	**Policy Development**	All SBC Policies and COP's are required to be reviewed and updated if required over a set amount of time to ensure relevance and adequate advice is available	Director level	Largely effective	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.

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	Gordon Allan/ 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	Gordon Allan / Shameem Din	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	Gordon Allan / Shameem Din	30.08.2026	AMBER	To appoint new Corporate Health and Safety Manager the role is currently being covered by Interim Consultant.
4	**SR06.01 – 0.4**	FRA Audit & Review	Review of existing data, quality therein- address shortfalls (in terms of survey/actions) urgently.	Gordon Allan/Shameen Din	01.07.2026	AMBER	All FRA documents and actions are discussed as standard practice at SBC H&S Board meetings and dedicated FRA action meetings. FRA Audit scheduled to ensure priorities are categorised by status and within a specific timeline.
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	01.12.26	AMBER	Lone Worker policies and documentation is being updated and Personal Protection devices and protocols for unreasonable behaviour honed. All policies to be reviewed to ensure they are robust and fit for purpose– on going .
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.	Gordon Allan	01.12.2026	AMBER	Interim H&SMgr to review proposed elearning modules prioritised and aligned to absence levels, this requires a complete rework as existing Eleaning modules.
7	**SR06.04 – 0.2**	Risk Assessment audit & analysis	Task (H&S Committee & Comms) Departments with RAMS review, advise, guide and assist.	Shameem Din	01.09.2026	tbc	Review and update of any risk assessments to be standard after any form of accident or incident as of 01.10.25 - Monitor RA completion and implementation.
8	**SR06.04 – 0.3**	Policies & Procedures audit & analysis.	Thorough internal commission- review and revise current Policies, Procedures/COP's	Gordon Allan / Shameem Din	01.12.2026	AMBER	All COP and policies to be reviewed and consolidated this task is scheduled with the new Interim H&S Manager

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
9	**SR06-05**	Trained Personnel within the Corporate Health and Safety Team	Review andanalysethe possible requirements for additional staff to ensure compliance with statutory requirements	Peter Walsh	31.08.26		Restructure implemented which allows for one additional H&S Advisor to be recruited

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**

No change to risk score. Improvements across all resilience sub-risks continue. Significant recent focus on fuel disruption planning because of international geopolitical activity and disruptions to international logistics and fuel supplies.

Business Continuity has completed the first phase of the improvement programme – identification of critical functions across all directorates and service areas. The programme has now progressed to the Business Impact Analysis phase.

Incident response capabilities continue to improve, although pace of development has slowed with reduced frequency of training activities and challenges around ongoing maintenance of Gold and Silver arrangements due to staff turnovers. Welfare response capabilities remain a concern. Review of existing, pre-identified facilities have revealed several are inappropriate as shelters during day-time working hours due to presence of infant day-care services with shared ablutions, creating unavoidable safeguarding concerns.

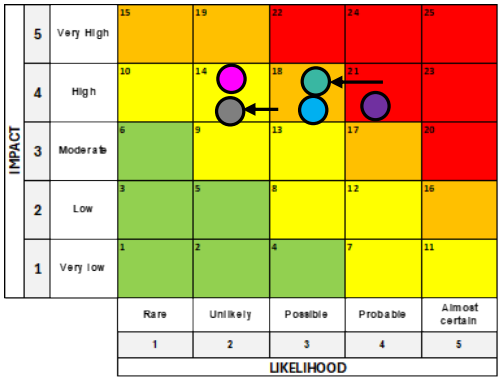
The Corporate Resilience Group is functioning well, engaging with all directorates and ensuring a proactive approach to risks. The Group has now completed the organisation's Fuel Disruption Management Plan; establishing a time limited Task and Finish Group under the direction of a Director with programme management support and resilience advice to oversee and drive development of the Council's preparations.

Further reductions in Emergency Planning team capacity with the departure of a second officer. Part-time business support has commenced and recruitment for a full-time Emergency Planning Manager expected to commence in June.

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 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
SR07.01		Inadequate operational incident response and coordination	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. Delivery of emergency shelter training by British Red Cross creating some response capacity.
SR07.02		Inadequate Major Hazard risk profiling and resilience preparations	Laura Robertson	↑	Corporate Resilience Group performing well at reviewing the nine identified resilience priorities. Excellent demonstration of emergency preparedness policy through fuel disruption planning. Risk awareness remains poor.
SR07.03		Failure of corporate major incident management arrangements	Laura Robertson	↑	Management arrangements in place. Incorporation of Silver level requires further development, with training to be scheduled for July/August. Turnover at Gold and Silver level creating challenges to duty rota and training needs.
SR07.04		Lack of BCP's for all services responsible for delivering business critical activities	William Green	↑	Critical Function Analysis has been completed, identifying all critical functions across all directors, identifying criticality and recovery time requirements for all critical functions. The programme has now progressed to Business Impact Analysis phase.
SR07.05		Inadequate resilience planning for specific risks	William Green	↑	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. Fuel supply disruption planning support through the identification of fuel dependent critical services for prioritisation of support and preparations.

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/ Threshold	Previous qtr. status	Current qtr. status	Trend	Comments
KRI1	Number of Trained Gold Commanders on rota 24/7/365	Minimum 6 (8)	5	5		Stable but numbers remain below required minimum
KRI2	Number of trained Silver Commanders on rota 24/7/365	Minimum 6 (8)	22	14		Further training for Silvers in July
KRI3	Number of trained Incident Managers on rota 24/7/365	Minimum 6 (8)	4	5		Numbers of Incident Managers remains below required levels
KRI4	Number of trained Local Authority Liaison Officers (LALOs) on rota 24/7/365	Minimum 12 (16)	12	14		
KRI5	Number of training Emergency Shelter Managers on rota 24/7/365	Minimum 6 (8)	0	0		5 completed initial training. Require further training before inclusion on rota
KRI6	Number of trained informal volunteer responders	(Min 40)	0	4 (trained) 31 (untrained)		Increase in volunteer numbers. Poor attendance at Red Cross training
KRI7	Number of trained Decision Loggists	Minimum 6 (8)	6	3		No change
KRI8	Number of officers attending training of all types	All officers attend minimum of 1 training session and 1 exercise per year	40	25		Drop due to capacity limitations and conflicting priorities (fuel planning)
KRI9	Testing/exercising of major incident capabilities and arrangements	1 major exercise per year	2	1		Major Decant of Residential Properties Exercise (RBFRS)

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

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

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR07.1	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	SR07.1	Training and development of responders	Training and development of all responders, including Gold, Silver, Incident Manager, LALOs, Rest Centre Staff, Volunteers and specialists	Director level	Largely effective	Training programme in place for all response roles. Attendance challenges and training delivery capacity due to emergency planning staff shortages
3	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. Emergency Planning Team has 2 vacancies. Recruitment to Emergency Planning and Resilience Manager to commence in June
4	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.
5	SR07.2	Emergency planning	Hazard specific planning and preparations for particular risks and threats through emergency planning activities	Director	Largely effective	Development of Council Fuel Disruption Management Plan through Corporate Resilience Group complete. Good example of organisational engagement with resilience activities.
6	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.
7	SR07.1,2	Emergency local humanitarian support and shelter	Ability to deploy emergency humanitarian support service to the affected public to meet immediate practical and psychological needs	Director	Ineffective	Improvements to capabilities. British Red Cross training for operational responders has provided some capacity. Pre-identified rest centre locations being assessed and mapped. HALO training attended by Director of Adult Social Care Operations.
8	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 working on top 8 risk priorities. Further work is needed in identifying, assessing and codifying risks and resilience priorities.
	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. Phase 1 critical function assessment completed and approved. Programme moving to Business Impact Analysis phase.

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

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)

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

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:-

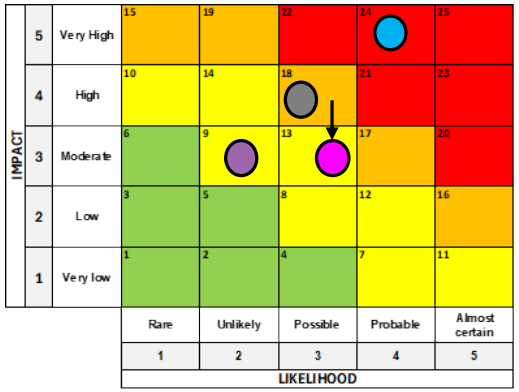
- DDoS protection implemented for external website to reduce exposure to denial of service attacks
- DR initial testing underway with further phases to be scoped and scheduled
- Decommissioning of legacy system continues with CAFM, Altia and Lalpac moved to supported platforms
- Out of hours cyber response arrangements now live and aligned to council incident management processes
- M365 security improvement plan in delivery to strengthen controls across Teams, Sharepoint and core platform services.
- DWP compliance audit completed – awaiting final report

The sub risk 08.04 how reduced this quarter. With the ongoing decommissioning of legacy systems reducing, the potential impact of failure now assessed as moderate.

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 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
08.01		Significant data or service loss lasting over 4 weeks (e.g cyber attack, loss of data centre)	Colin Power		• Work continues on completing actions identified in the MHCLG CAF assessment • 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 • Data being replicated to DR provider cloud platform Initial DR testing underway with further phases to be scoped and scheduled
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
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. • Lalpac (Licencing) and CAFM have migrated onto supported platforms. Xpress (Elections) is scheduled for end of June SBC Insite on track to be migrated to mid July and Crematorium forecasted to be migrated in September.

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 for 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%	SBC – 86% SCF – 75%	
KRI 3	Number of ICT incidents substantively impacting one or more services (hardware / software failure P1 major incident)	1	1	1	
KRI 4	Notifications of compromise / risk from the National Cyber Security Centre (NCSC) active cyber defence service (ACD) early warning service	3	3	3	
KRI 5	Result of Phishing simulations showing level of compromise by staff	<5%	9.06%.	To be undertaken in June	
KRI 6	Notification of vulnerabilities from Government Digital Service (GDS) Extended Monitoring Scheme	3	Now active. Will baseline at next quarter after sustained full quarter of being active	1	

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"CoCo submission to Cabinet Office aimed for mid June. • Work is underway to complete the actions identified in the MHCLG CAF assessment • DWP Compliance audit completed in May 2026 - waiting receipt of final report.
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	Disaster Recovery & Council Business continuity	Disaster Recovery as a Service (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)*	• Data being replicated to DR provider cloud platform • DDaT continue to attend the Corporate Resilience Group • DRaaSconfiguration and runbooks underway • Service area business continuity (BC) plans being reviewed by the BC team
4	SR08.01 & SR08.02	DDAT business continuity	IT businesscontinuity and disaster recovery planning within DDaT and across the wider organisation	TBC	Largely effective	• DDaT Business Continuity Plan drafted • Meeting with the Business Continuity team in June to review Business Impact Assessments.
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)*	• Quarterly internal vulnerability scans undertaken and remediation actions resolved • Applications management by Intune with monthly Microsoft updates automatically pushed out to end user devices • 2026 annual health check currently being scoped • 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. • Out of hours cyber emergency response arrangements now live and aligned to the Council's incident management response.

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
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
8	SR08.01	System hardening	Applying security configurations and restrictions to systems and services to reduce vulnerabilities and limit exposure to cyber threats	Colin Power	Effective	• Distributed Denial of Service (DDOS) enhanced protection now applied to Slough.gov website

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	• Projects are underway to remediate against the remaining high vulnerabilities: Lalpac (Licencing) and CAFM have migrated onto supported platforms. Xpress (Elections) is scheduled for end of June, SBCinsite on track to be migrated to mid July and Crematorium forecasted to be migrated in September. • Project planning underway for the migration for the social care applications to the cloud – projected end date Jan 2027. Options for migrating file shares being explored ahead of any potential SharePoint migration.
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 • Initial DR testing underway with further phases to be scoped and scheduled.
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	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.
5	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	• DWP Compliance audit completed in May 2026 - waiting receipt of final report. • £200k grant awarded by the MHCLG to further aim the Council cyber resilience activities. • Work continues on meeting the CAF control standards
6	SR08.01	Personal devices	Blocking access to SBC network on personal devices	Colin Power	Aug 2026	G	• Bring your own device pilot complete for Android devices with IOS devices pilot due for completion by the end of June. • Access to SBC network via personal devices will then be blocked from 31 July 26.
7	SR08.01	M365 security improvements	Enhancement of Microsoft 365 security controls to reduce risk and protect data.	Colin Power	Dec 2026	G	• Improvement plan currently being actioned and security settings implemented in MS Teams. Sharepoint and other M365 products.

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 a review of the risk quarter it remains stable and the risk score is unchanged at 22.

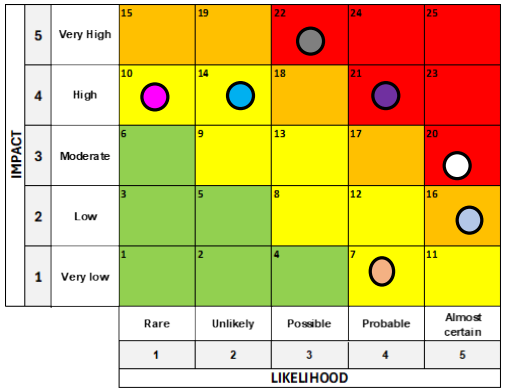
The Council set a balanced budget in February 2026 for 2026/27 through to 2028/29, this is reliant on exceptional financial support in 2026/27 and 2027/28 but by 2028/29 it is anticipated that the Council will be able to deliver on a balanced budget without the reliance on EFS.

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

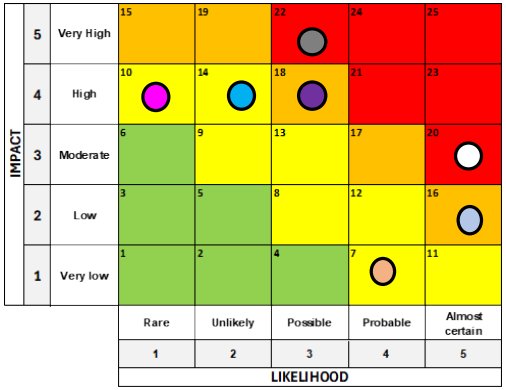


Refer to slide 8 for risk assessment score instructions

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		The Council has published statement of accounts for all financial years up until 2024/25. The 24/25 accounts were subject to a short piece of audit work focussed on in year transactions. The 2025/26 are progressing well and inline with the agreed timeline with the expectation they will be published by 30th June 2026. The management accounts position has been finalised and work is now focussed on the closing notes and pulling together the SOA. These will be first set of accounts subject to a full audit process and in preparation for this additional reviews have been undertaken both internally and using external experts to ready the Council for this.
09.02		Failure to achieve a balanced budget and Medium-Term Financial Strategy (MTFS)	Mark Hak-Sanders		The 2025/26 financial outturn is being finalised with an overspend of £13.2m, which is an improvement of c£2.3m on the Quarter 3 reported position of £15.5m. A 3 year balanced budget was approved at February Council, this budget is reliant on c£65m of EFS across 2026/27 and 2027/28, however by 2028/29 due to the planned investment in transformation to deliver ongoing revenue savings it is expected that the Council can deliver services within the agreed budget which does not include any EFS.
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. Debt refinancing is required during 2026/27 as well as new borrowing to fund the approved capital programme which includes essential investment in Council buildings and Equipment/Vehicles as well as investment in Capital Transformation to generate ongoing revenue savings.

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		Inadequate Government funding to meet Slough's spending needs	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		Strategic Finance Manager – 2 new recruited in the last few months of 2025/26. Further recruitment across SFM and other roles in train – interviews in June 2026.
09.06		Failure to deliver the Finance Improvement Programme	Vicki Palazon		The overall direction of travel for the Finance Improvement Programme has remained positive. Note - there is an update going to July ACG&C
09.07		Failure to deliver best value from procurement processes	Nick Penny		A diagnostic piece on the current state of the procurement service in Slough has been undertaken in Jan – April 2026, with short term improvements made but 25 further recommendations identified which are to be implemented over the coming months. Some of the key areas include: Introducing contract management training and promoting improved contract management across the Council. Review of third party expenditure with a view to reducing 3rd party expenditure. Review of the team structure to ensure adequately resourced and the right people in the right roles to improve the teams performance and commercial view. A new HOS started In May 2026.



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*	2% overspend contained within contingency	*Q3 position showing a £15.5m overspend.*	11.5% 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	Report presented to DLT	Reported presented to DLT – 5 main bank account recs signed off May 2026.	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 financing costs as a proportion of net revenue budget*	. A debt strategy has been produced which reduces the level of debt to c10% of the net revenue budget over the next 10 years.	Methodology reviewed following publishing of debt repayment strategy	Quarter 1 - £15.1%	Amber
KRI 5 (VP)	Proportion of outstanding Internal Audit actions (Finance & Commercial) Legacy	Reduce by 30% from 23/24 Outturn	As at 31st Jan 2026 6 out of 50 internal audit actions outstanding -	49 out of 50 closed, the remaining open recommendations requires an agreed timesclale	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	All backlog SOA's published. Work ongoing to publish 25/26 accounts by 30th June deadline	.Complete and accounts published . New KRI for 2025/26	Green
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	Interims retained where critical to do so, work on a 2026 recruitment campaign beginning	Current reduction above 10%. 2 x incomplete appraisals, addressed with managers and discussed with the individuals.	Green
KRI 8 (VP)	FIP remains on track, milestones achieved	On track or better	FIP has been reprioritised to focus on regulatory and compliance to be signed off by March board	Slightly behind as some red projects	Amber

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

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

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
6	SR09.02	Financial Controls (Spending)	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 (incl cash, debtors, creditors, reserves
12	SR09.1 - 06	Audit Trail	All financial transactions to have source document evidence to demonstrate evidence for every posting in accounts	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

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	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	March 2027	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	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	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
9	4	Monthly monitoring	Monthly monitoring will also be expanded to cover milestone delivery of savings	MHS	?		
10	10, 11, 12?	Quality of financial statements		NP			

Target Risk Score – *22* by end of date *03/2027*

CR10 | Failure of General Fund Asset Disposal Programme | Risk owner: Ian O'Donnell

Corporate risk overview

CURRENT SCORE 4 Impact 4 Likelihood **18**
TARGET SCORE 4 Impact 3 Likelihood **14**

The risk has deteriorated from 13 (yellow) to 18 (amber) driven by market volatility which directly affects our disposal financial targets. Additional measures are being implement to ensure that market expertise is being sought for GF disposals. Data remains a key part and a new system will provide accurate data confidence both internally and within legal packs.

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

Disposals programmes now in place for both General Fund and HRA. HRA sites no detriment impact is supporting the GF receiptsand has continued to help make up the shortfall.

The HRA market for smaller sites such as Garages or small piece of non residential land is continuing to remain strong.

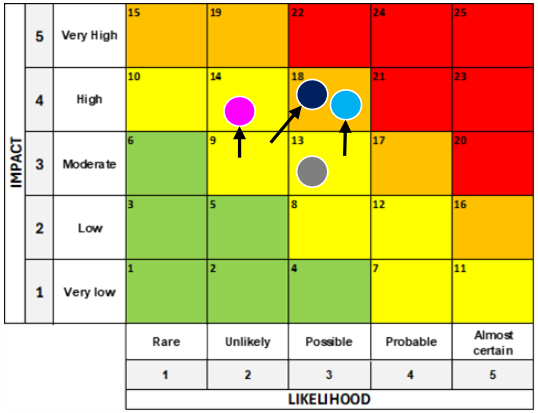
The market volatility in the General Fund programme continues, with geopolitical impact and market cooling resulting in institutional investors taking a more cautious or short-term approach, whereas overseas investors are still looking at opportunities, however, this may result in a longer disposals period.

The programme is now into its fourth year and as a result the sites on the programme are more complex and challenging. Politically there are some tough decisions to be made, as it is likely that sites will need to be sold at less then debt/original purchase price and understanding of political appetite still remains to be seen.

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

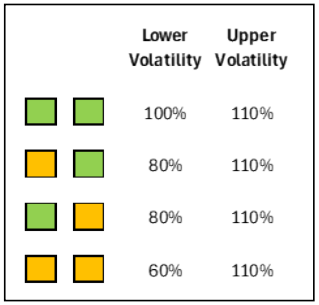


Refer to slide 6 for risk assessment score instructions

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
10.01		Property disposals not hitting financial targets and sitting outside lower volatility levels	Peter Walsh		Continuing volatile market means that consideration needs to be taken when releasing sites to the market. Complex sites and disposals likely to result in delays through legals and agreements
10.02		Pace of disposals is behind programme deliverable dates	Peter Walsh		Opportunities to pull forward some sites from future years to cover deals are not materialising as quickly as forecasted, however, will depend on political appetite during the lead up to elections.
10.03		Attraction and Retention of quality people	Peter Walsh		Following the departmental restructure, recruitment of permanent workforce is proving hard. Continuation of reliance on Interims
10.04		External property market volatility	Peter Walsh		Market remains volatile with institutional investors taking a cautious approach. Overseas investors still looking at opportunities

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 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			

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 Walsh	*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 Walsh	*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 Walsh	*Effective*	Working as expected
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 Walsh	*Largely Effective*	Working as expected
5	SR10.05	Records	• Document register now better • Better archiving needed (physical and electronic)	Peter Walsh	*Needs Improvements*	Property Database still needs to be incorporated to ensure both accurate current and historic data iscaptured and full audit trail can be seen.
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 Walsh	*Largely Effective*	Working as expected. Reliance on Avison Young as property Advisors who have been part of the programme from 2022.
7	SR10.07	Protocol / Process	• Review ongoing approved processes being followed	Peter Walsh	*Effective*	Working as expected

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 Walsh	*April 2027*		Continuing to review progress, likely move to move to "Largely Effective" Q1 FY26/27
3		Independent Review	Scope being developed to bring in third party to carry out a review of the disposals programme and continue oversight.	Peter Walsh	*October 2026*		Currently ongoing but will provide confidence to the organisation.
4		Market Assessments	For all General Fund disposals, market assessments are now being carried out, including SWOT analysis to ensure that we are releasing the sites to the right market.	Peter Walsh	*July 2026*		This will provide more assurance to the organisation.

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

CR11	**Transformation** We fail to scope and deliver a comprehensive Transformation Programme aligned with a sustainable Target Operating Model	Risk owner: Ian O'Donnell

Corporate risk overview

Current Risk Score X Impact X Likelihood	21
Target Risk Score X Impact X Likelihood	18

Corporate Risk Overview
The Council's Transformation Programme is moving from strategy and governance establishment into active delivery of the 2026/27 transformation portfolio. The programme is a critical enabler for delivering the Medium-Term Financial Strategy (MTFS) and the Target Operating Model (TOM).
During the quarter, the Council has:

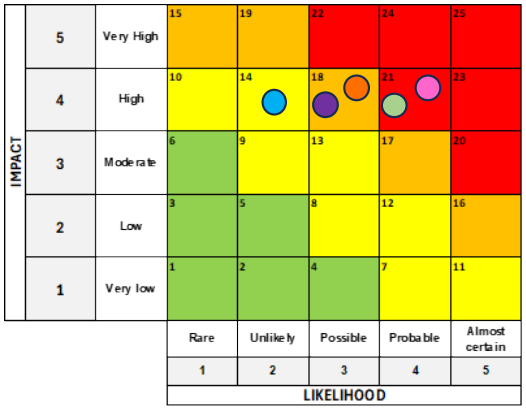
- established Transformation Governance arrangements;
- begun to mobilise a live portfolio of 2026/27 transformation projects;
- commenced procurement activity for a Transformation Delivery Partner to support the hub-and-spoke delivery model;

The overall risk profile remains high due to the scale, pace and interdependency of the Transformation Programme, combined with the Council simultaneously delivering savings, service improvement and organisational recovery activity.

Risk appetite statement **(Balanced)**

A balanced range of risk acceptance from low residual risk, aiming to reduce exposure where possible, through to acceptance of a moderate degree of risk where the risk/reward ratio is deemed reasonable. Applying innovation only where successful delivery is likely.

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 (Director)	Change in period / outlook	Management Review/ Explanation of movement
SR11.01		Failure to Procure and Mobilise an Appropriate Transformation Delivery Partner	MC		Low probability as procurement projects in place and on track, and market interest strong
SR11.02		Portfolio Insufficient to Deliver Required Savings and Benefits	MC		Some uncertainties in benefits have emerged from confidence review, and broader pressures have increased, which will in turn increase scale of savings required
SR11.03		Delivery Capacity, Governance and Organisational Readiness Failure	MC		This assessment reflects current position. Currently governance is immature, delivery capacity is lacking and there are known organisational readiness issues

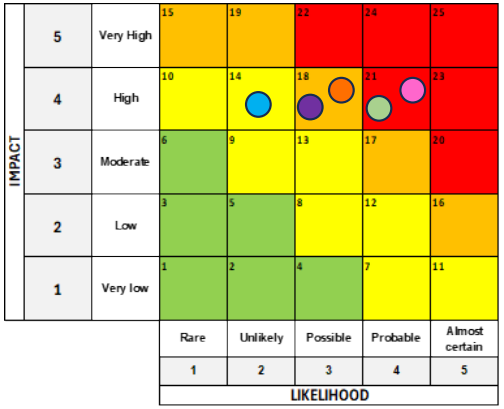
CR11	**Transformation** We fail to deliver transformation aligned to a sustainable Target Operating Model	Risk owner: Ian O'Donnell

Corporate risk overview

Current Risk Score 4 Impact 4 Likelihood	20
Target Risk Score 4 Impact 3 Likelihood	18

Sub risks related to this principal risk

Risk profile



Refer to slide 7 for risk assessment score instructions

Ref	Status	Risk title	Sub-risk owner (Director)	Change in period / outlook	Management Review/ Explanation of movement
SR11.04		Failure to Manage Cross-Portfolio Dependencies and Change Impacts	MC		Robust dependency management mechanisms are not yet in place but it is expected that they will be by the time significant volumes of project work commence
SR11.05		Failure to Realise Benefits Due to Weak Data, Measures and Accountability	MC		For current projects – primarily in Adults' Services – strong benefits tracking is in place. While there are weaknesses in other areas, it is expected that they will be addressed, not least through partner assurance, as part of each project.

CR11	**Transformation:** We fail to scope and deliver a comprehensive Transformation Programme aligned with a sustainable Target Operating Model	Risk owner: Ian O'Donnell

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KRI 1	Delivery Partner procurement and mobilisation progress against agreed commercial, governance and onboarding milestones.	**Green:** All milestones on track **Amber:** Minor delay or clarification required **Red:** Significant delay, procurement challenge or mobilisation risk		Green	
KRI 2	Forecast portfolio benefits and savings compared to approved MTFS requirements.	**Green:** Forecast benefits and savings at or above target **Amber:** Forecast benefits and savings between 90% and 99% of target **Red:** Forecast benefits and savings below 90% of target		Amber	
KRI 3	Percentage of approved transformation projects operating through agreed governance arrangements, stage-gate controls, delivery standards and approved resource plans.	**Green:** Greater than 95% **Amber:** Between 80% and 95% **Red:** Below 80%		Green	
KRI 4	Number of significant unmanaged dependencies, cross portfolio conflicts or change impact issues identified through portfolio assurance reviews.	**Green:** No significant unmanaged issues identified **Amber:** Limited issues requiring intervention and active management **Red:** Multiple issues impacting delivery, benefits realisation or organisational performance		Green	
KRI 5	Percentage of transformation projects with validated baseline data, approved KPIs, named benefits owners and active benefits tracking arrangements.	**Green:** Greater than 90% **Amber:** Between 70% and 90% **Red:** Below 70%		Red	

CR11	**Transformation:** We fail to scope and deliver a comprehensive Transformation Programme aligned with a sustainable Target Operating Model	Risk owner: Ian O'Donnell

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KRI 1	Delivery Partner procurement and mobilisation progress against agreed commercial, governance and onboarding milestones.	**Green:** All milestones on track **Amber:** Minor delay or clarification required **Red:** Significant delay, procurement challenge or mobilisation risk		Green	
KRI 2	Forecast portfolio benefits and savings compared to approved MTFS requirements.	**Green:** Forecast benefits and savings at or above target **Amber:** Forecast benefits and savings between 90% and 99% of target **Red:** Forecast benefits and savings below 90% of target		Amber	
KRI 3	Percentage of approved transformation projects operating through agreed governance arrangements, stage-gate controls, delivery standards and approved resource plans.	**Green:** Greater than 95% **Amber:** Between 80% and 95% **Red:** Below 80%		Green	
KRI 4	Number of significant unmanaged dependencies, cross portfolio conflicts or change impact issues identified through portfolio assurance reviews.	**Green:** No significant unmanaged issues identified **Amber:** Limited issues requiring intervention and active management **Red:** Multiple issues impacting delivery, benefits realisation or organisational performance		Green	
KRI 5	Percentage of transformation projects with validated baseline data, approved KPIs, named benefits owners and active benefits tracking arrangements.	**Green:** Greater than 90% **Amber:** Between 70% and 90% **Red:** Below 70%		Red	

CR11	**Transformation** We fail to scope and deliver a comprehensive Transformation Programme aligned with a sustainable Target Operating Model	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	SR01	Transformation Delivery Partner Procurement and Mobilisation Framework	A structured procurement and mobilisation approach including defined governance requirements, operating model expectations, PMO assurance responsibilities, capability transfer expectations, implementation milestones and onboarding arrangements overseen through CLT Transformation Board governance.	Martin Chalmers	**Largely effective**	Procurement in train and interim governance arrangements being developed in preparation for mobilisation
2	SR02	Portfolio Design and Benefits Challenge Process	The Transformation Delivery Partner provides independent challenge and assurance of business cases, delivery assumptions and benefits forecasts to ensure proposals are realistic, deliverable and aligned to MTFS requirements. During mobilisation, the Delivery Partner identifies additional opportunities to strengthen the portfolio while Transformation Spokes maintain a continuous pipeline of improvement initiatives to address emerging gaps and opportunities.	Martin Chalmers	**Needs improvement**	Return to green requires the transformation partner to be in place.

CR11	**Transformation** We fail to scope and deliver a comprehensive Transformation Programme aligned with a sustainable Target Operating Model	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
3	SR03	Transformation Governance, Delivery Assurance and Gateway Framework	Transformation projects operate through agreed governance arrangements, CLT sponsorship and a formal gateway process covering business case approval, mobilisation, delivery and benefits realisation. Corporate PMO and the Transformation Delivery Partner maintain minimum standards for governance, reporting, RAID management, benefits tracking, dependency management and escalation. Portfolio assurance provides oversight of delivery performance, resource capacity, governance compliance and organisational readiness.	Martin Chalmers	**Ineffective**	This area is currently immature. It is a priority both for the Transformation Partner and for interim activity prior to the appointment of the Partner. The establishment of the Transformation Board and the processes around it is a critical early step.
4	SR04	Management of Cross Portfolio Dependencies, Synergies and Change Impacts	Portfolio-level assurance arrangements identify, monitor and manage key dependencies across transformation spokes, programmes and services. Design Authority governance ensures alignment to the Target Operating Model, organisational design principles and strategic outcomes. It also identifies overlaps between initiatives, maximising synergy and assuring coherence. Change activity is coordinated through integrated planning, communications and engagement arrangements to minimise duplication, manage organisational impacts and maintain a coherent transformation narrative.	Martin Chamers	**Needs improvement**	The Design Authority is in place but there is a need to clarify its remiit and strengthen/broaden membership

CR11	**Transformation** We fail to scope and deliver a comprehensive Transformation Programme aligned with a sustainable Target Operating Model	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
5	SR05	Benefits Management and Data Assurance Framework	Business cases are challenged and assured prior to approval. Each project maintains defined KPIs, leading indicators, measurable outcomes and named benefits owners. The mechanisms underpinning benefits measurement and reporting are appropriately assured by the Transformation Partner, with input from specialists such as Finance and DDaT where required. Performance is tracked through Transformation governance and periodically validated by the Transformation Partner in its assurance role. Benefits accountability is clearly assigned and tracked through project and programme governance arrangements.	Martin Chalmers	**Ineffective**	While there is self-reporting currently in place for the small number of live projects, the broader framework and assurance arrangements envisaged are dependent on appointment of the Transformation partner
6						

CR11	**Transformation** We fail to scope and deliver a comprehensive Transformation Programme aligned with a sustainable Target Operating Model	Risk owner: Ian O'Donnell

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

Target Risk Score – 18 by end of date *12/26*

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	SR11.01	Procure Transformation Partner	Complete procurement of partner via ESPO business services framework	Martin Chalmers	03/08/26	G	ITT was released on 2 June 2026. Target dates are being maintained. 24 bidders remain interested. Biggest risk is that all 24 bid, slowing evaluation.
2	SR11.02	Validate portfolio	Manage partner to complete robust portfolio validation as part of its initial stage	Martin Chalmers	30/10/26	A	Risk is that suppliers unable to complete process in this time. Bid process, which involves their providing a plan and fixed price, is a mitigation for this
3	SR11.03	Establish effective interim governance framework	Put in place interim arrangements for governance prior to appointment of parter	Martin Chalmers	26/06/26	G	Work in hand to do this; governance principles agreed by CLT on 03/06/26
4	SR11.03 SR11.04 SR11.05	Establish ongoing governance via Transformation Partner	Manage establishment of portfolio management by Partner	Martin Chalmers	31/08/26	G	We are proposing that partner's PMO should be mobilised at award+10d so this date allows some contingency

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

CR12 Failure to deliver adult social care market sustainability

Risk owner: Jonathan Price

Corporate risk overview

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

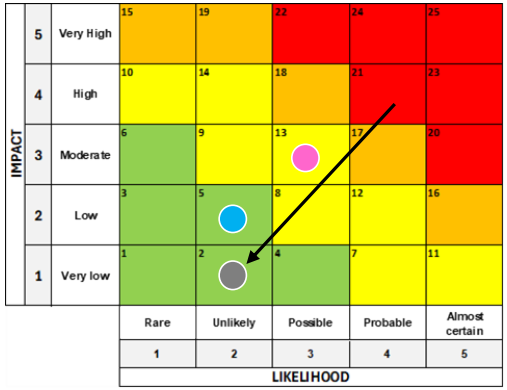
The risk is predominantly driven by funding availability in the context of the market pressures:

- 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 risk score has decreased as there was a standard rate increased applied this will be reviewed in Qtr2
- 12.04 has been deleted and is encompassed within 12.03
- Target Risk score by March 2027 - 13

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 6 for risk assessment score instructions

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
12.01		Insufficient access to care services	Neda **Mazraeh** (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. A new specialist provision come online in Slough Autumn 25.**
12.02		Cost of fee uplifts outstripping budget	Neda **Mazraeh** (HOS)		**Fee uplift for 26/27 agreed at a standard rate, except for exceptional circumstances.**
12.03		Provider failure	Neda **Mazraeh** (HOS)		**Monthly reports of care quality and provider failure risks provided to CMMB, DLT and Care Governance Board**

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KRI 1 - loss of care	The number of providers suspended due to quality concerns on a monthly basis – temporary loss of care	+% increase per quarter	Update Q3 25/26 Providers Suspended Due to Quality Concerns 3 x Care Home 1 x Supported Living Providers 1 x Home Care Provide	Qtr 4 Update Q4 25/26 Providers Suspended Due to Quality Concerns 2 x Care Home 1 x Home Care Provider	
KRI 2 – Contract handbacks	The number of contract hand backs on a monthly basis	0	Update Q3 25/26 0 Contract Handbacks	Update Q4 25/26 1 Contract Handback	

New KRIs to be considered

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	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)	Effective	Additional support to Care Homes was ~~be~~ provided by NHS Frimley ICB through joint quality visits with SBC's Provider Quality Assurance Team and training offers. This support ended March 2026 Options are being explored to see if alternative support can be provided.

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 Internal Quality Assurance Framework	Quality Assurance Framework Review	Neda Mazraeh	Sept 2026	Green	Initial draft has been completed and requires finalisation
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	Neda Mazreah	December 2026	Amber	Rated amber as currently no capacity within team to deliver Delivery date updated to December 2026
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	Sept 2026	Green	Annual review of MPS scheduled to go to Cabinet in Sept 2026
4	12.03	Development of Internal Contract Management Guidance/Framework	Draft has been completed needs to be finalised and risk matrix developed	Neda Mazraeh	Sept 2026	~~Green~~	

Target Risk Score– *13* 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

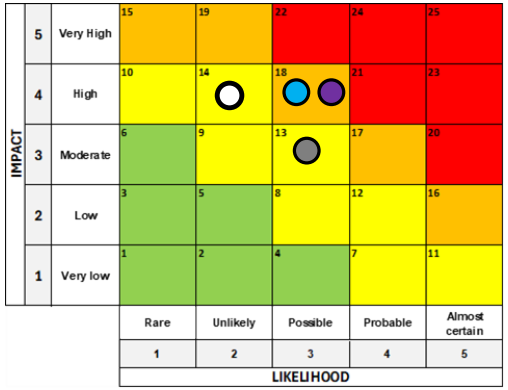
Updates are:

- GDPR training compliance has remained consistent this quarter. This continues to be monitored at the monthly IGG meetings for both SBC and SCF.
- A briefing on GDPR and information security continues to be included in the corporate induction programme which is deliveredto all new roles within the first 2 months of their start date.
- Continue to review and update GDPR policies and guidance in align with their annual review dates. Updated documents are circulated and approved by IGG.
- Increased corporate oversight of Information governance due to a fixed slot at the monthly assurance CLT meeting.
- Information Governance Improvement Plan is now embedded and managing key activities including governance and accountability, records management, data assurance and compliance, FOI/SAR transformation, training and culture and technology and controls
- Interim IG officer in place. Permanent recruitment to Information and Records Information Lead imminent following ECP approval.
- The risk rating remains unchanged this quarter.

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		Risk treatment plans relating to systems, process and training have been identified. Staff's mindfulness of the importance of security and privacy is critical in avoiding materialisation of the risk
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.
13.03		Failure to detect, report and remediate personal data breaches	Alex Cowen	New	New Sub Risk– Risk is currentlystable, This may arise from low staff awareness or unclear processes. Mitigations include a defined breach reporting process (via Astro and DPO), mandatory training, established investigation/response procedures identified, assessed, contained, reported where required, and addressed with corrective actions and learning embedded.
13.04		Inadequate governance, training and assurance arrangements for GDPR compliance	Alex Cowen	New	New Sub Risk– Risk is currently stable, possible weak oversight, gaps in staff understanding, or lack of effective monitoring. Mitigations include established governance, mandatory training and induction, regular policy review, and ongoing monitoring and assurance to ensure compliance is maintained and improvements are identified and implemented.

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	86% - SBC 75% - SCF	
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	18	19 (Jan – Mar 26)	
Number of Information Commissioner Office (ICO) reportable incidents / complaints	Incidents that meet the threshold for reporting to the ICO, or complaints received by the ICO in relation to failure to comply with UK GDPR principles.	1	0	0	
Turnaround time for DPO (Data Protection Officer) to review (Freedom of Information) FOI responses	The turnaround time for the Data Protection Officer to review and provide confirmation that the response to an FOI is permissible within GDPR regulations.	48 Hours	24 Hours	24 hours	

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

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

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
1	SR13.01	Mandatory Training	New staff are obliged to complete eLearning and an annual refresher course is also mandatory. New staff are also required to attend corporate induction within 2 months of start date.	Martin Chalmers	Largely Effective	• Take up of training remains below target (90%) but consistently above80%.
2	SR13.01	Governance, policy and process	An Information Governance Board is in place. Processes for breach reporting, DPIAs, etc have been established	Martin Chalmers	Effective	• All GDPR policies are updated annually and approved by IGG. Subsequent updates will be monitored through the monthly IGG meetings. • IG improvement plan approved, live and being monitored through IGG
3	SR13.01	IG Resources	An Information Governance officer role in place	Martin Chalmers	Needs improvement	• Interim IG Officer in place • Permanentrecruitment for Information & Records Lead about to commence
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 on hold pending recruitment to IG roles
5	SR13.02	Retention Policy on Backups	Backup retention policies in place	Naveed Khan	Effective	• Retention policies are in place on the Council's backups. Maximum retention is 7 years.

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. Recruitment to the Records and Information Lead role within DDaT and working alongside services to manage risks associated with unstructured data.	Alex Cowen	Role expected to be in place by 1st Sept 26	G	• ECP approval received • Permanent recruitment to being in June 2026 with the aim to have the role filled by 1st Sept 26..
2	SR13.01	IG Officer Resourcing	Permanent recruitment to the IG Officer role within DDaT	Alex Cowen	TBC (dependant on DDaT restructure)	A	• Interim resource in place • Permanent recruitment depend on restructure
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	Labelling Pilot to start July 2026	G	• Purview POC completed April 26 • Labelling to be piloted within DDaT. Expected start date - end of July 2026.
5	SR13.02	Completion of the Corporate Memory Audit	Completing recommendations from the Corporate Memory internal audit	Alex Cowen	April 2026	C	• Corporate Memory audit completed

Target Risk Score – 18 by end of 03/2027

CR14 Failure of Council Subsidiary Companies

Risk owner: Ian O'Donnell

Corporate risk overview

Current Risk Score 5 Impact 5 Likelihood 25

Target Risk Score 5 Impact 4 Likelihood 24

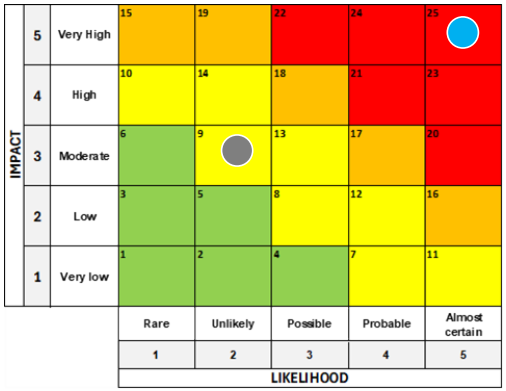
- Governance, oversight & financial council exposure as Shareholder across James Elliman Homes (JEH), and GRE5. Work continues to manage eventual discharge of Grant Thornton's statutory external audit recommendation
- Risk that retained losses across the companies continue to be underwritten by the Council
- JEH – Business plan 206/27 and future strategy pending approval by Cabinet. All legacy accounting issues now remedied including move to independent finance system. Loan exposure / intercompany transactions remain significant risks
- GRE5 – Significant improvement in failure risk following Cabinet approval of the exit strategy and partial deed of release to improve the company's balance sheet

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.

Risk profile



Refer to slide 7 for risk assessment score instructions

Sub risks related to this principal risk

Ref	Status	Risk title	Sub-risk owner	Change in period / outlook	Management Review/ Explanation of movement
14.01		JEH - Failure of the company resulting in financial losses and reputational issues for the council.	Peter Walsh		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 third-party liabilities as they become due but unable to repay the loan or pay all intercompany balances. £51.7m of loan has been provided by the council. 2024/25 accounts not filed by 31/03/2025 deadline. The council is exposed to financial and reputation risk if the company fails. 2025/26 accounts drafted to enable consolidation into the council's draft accounts. Future strategy and business plan 2026/27 to be approved by Cabinet
14.02		GRE5 - Failure of the company resulting in financial losses and reputational issues for the council.	Peter Walsh		The company has net liabilities as at 31 March 2025 of £3.1m which includes the loan to the council of £5.2m. March 2026 Cabinet approved partial write off of the loan – deed of release £4.6m, the exit strategy and business plan for 2026/27. The risk of failure has reduced significantly and positions the company into a solvent wind up once all actions in the exit strategy are completed. 2025/26 accounts drafted and company audit commences June 2026.

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		£2.0m	
KRI 2 – JEH Balance Sheet health	The company reports total assets greater than liabilities	Total net assets		Net liabilities	
KRI 3 – JEH – Business plan 2025/26	The Shareholder has approved a business plan for 2025/26	Approved business plan		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		No change	
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 30/09/2026		Some slippage due to pending decision on future strategy	
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.	< £3.090m negative equity		£3.049m as at 31/03/2025	
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		£1.2m as at 31/03/2026	
KRI 5 – GRE 5 FIP plan	All activities are completed on the FIP plan regarding company governance, oversight and financial governance	Completed by 30/09/2026		On track	

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

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

Control Ref	Sub risk ref	Control Title	Control Description	Control owner	Control Effectiveness	Comments
2	SR14.01 SR14.02	Board meetings- Shareholder	Regular Shareholder meeting now scheduled being chaired by Chief Executive	Chief Executive	Largely effective	Meetings scheduled every six weeks. Company reports considered by Panel. Meetings are minuted. SRO and Board effectiveness reviews to be scheduled
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 / Exit Strategy	In place Business Plans currently Live and providing Strategic Direction to the Companies	Company Directors for GRE5 & JEH	Needs Improvement	GRE5 – Business plan and exit strategy approved by Cabinet March 2026 – effective JEH – Draft business plan 2026/27 due to be approved by Cabinet alongside next steps for future strategy - Needs improvement (due to slippage)
5	SR14.02	Board meetings- Company	GRE5 Board meetings occur bi-monthly	GRE5 Directors	Effective	GRE5 Directors and Company Secretary in place. Board meetings scheduled
6						
7						
8						
9						
10						

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

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	*SR01.01*	*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 (GRE5)	Recruitment undertake during to appoint 2 new directors	Peter Hopkins	30 Oct 2025	Green	Complete - Directors appointed and on Companies House March 2026
3	SR14.02	Trading position (GRE5)	Updating letters of Assurance to make the company a going concern	Peter Hopkins	31 December 2025	Green	Complete – Accounts for2024/25 filed at Companies House
4	SR14.02	Right To Manage (RtM) (GRE5)	Transition service charge management to new Right to Manage company successfully	Peter Walsh	30/06/2026	Green	On track. Liaison between company and RtM company positive
5	SR14.02	Exit strategy (GRE5)	Approval and delivery of the exit strategy. This includes: Subrogation of insurance claim, disposal of freehold, loan partial deed of release and winding up of company	Peter Walsh	30/06/2027	Green	All on track per the exit strategy and as approved by Cabinet in March 2026
6	SR14.01	Articles of Association (AoA) (JEH)	Approve new Articles of Association that incorporate reserve matters and Board membership	Peter Walsh	31/07/2026	Amber	AoA approved by council as Shareholder and to be filed by company. New Directors to be appointed once future strategy has been approved by Cabinet
7	SR14.01	Intercompany balances (JEH)	Ensure that intercompany balances are all transacted	Peter Walsh	30/04/2026	Green	Complete
8	SR14.01	Exit strategy and business plan (JEH)	Approval and delivery of the exit strategy including business plan for 2026/27	Peter Walsh	31/10/2028	Amber	Business plan 2026/27 in draft and exit strategy in draft. Pending Cabinet decision.
9							
10							
11							
12							
13							
14							
15							

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

CR15	Failure of Governance, Controls and Assurance	Risk owner: Ian O'Donnell/ Sarah Wilson

Corporate risk overview

Current Risk Score 4 Impact 5 Likelihood **24**

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

There is a risk that the authority's internal control framework may fail to operate effectively through weak design, inconsistent application, or deliberate circumvention, resulting in financial loss, fraud, misappropriation of public funds, non-compliance with legislation, regulations and internal policies, inaccurate management information, poor decision-making, and damage to the authority's reputation and public trust.

Politics roles and responsibilities not clearly understood.
Restructure of CLT which has resulted in a move to interim from FTE.
Head of Internal Audit opinion for 2025/26 limited assurance
Mazars forensic audit of housing systems - TA and housing allocations

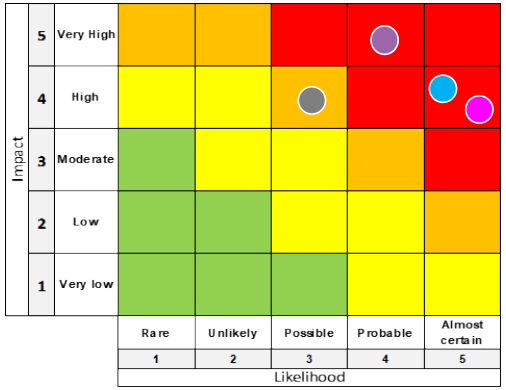
Risk appetite statement **(Averse)**

We have a very low appetite for failures in internal control that may compromise financial integrity, legal compliance, the accuracy of management information, or public trust.

We expect control frameworks to be properly designed, consistently applied, and subject to regular review, so that weaknesses, errors, and potential fraud are prevented or detected quickly and remediated without delay.

There is a view that as the council becomes more mature, we could move to an **AVERSE–BALANCED** position

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
11.01		Fraud and Misappropriation	Ian Kirby		Fraud or financial loss arising from weak segregation of duties, override of controls, or deliberate circumvention of processes.
11.02		Regulatory Non-Compliance	Sarah Wilson		Failure to comply with statutory, regulatory, or policy requirements due to weak oversight, unclear responsibilities, or poor understanding of procedures.
11.03		Inaccurate Management Information	Nick Penny		Inaccurate, incomplete, or untimely management information caused by system, process, or data quality failures, leading to poor decisien making.
11.05		Contract Management & Legal exposure	Nick Penny		Ineffective & limited oversight, monitoring, and management of contracts and suppliers leading to financial exposure, legal breach, or service failure.

Key Risk Indicators (KRIs)

KRI	KRI explanation	Tolerance/Threshold	Previous qtr. status	Current qtr. status	Trend
KRI 1	**Number of Fraud or Financial Irregularity enquiries and referrals** – Tracks confirmed or suspected fraud, error, or irregularity cases to identify control breakdowns and emerging patterns of loss or misconduct.	Zero tolerance for confirmed material fraud, with any incident escalating immediately.			
KR2	**Number of successful prosecutions and/or sanctions** – Tracks formal action outcomes that relate to fraud, error or irregularity.	Zero tolerance for confirmed material fraud, with any incident escalating immediately.			
KRI 3	**Percentage of Internal Audit Recommendations Implemented on Time** – Measures the proportion of agreed actions implemented by the target date, indicating whether control weaknesses are being addressed promptly.	Target of 90-100% on time, with overdue high-risk actions flagged.			
KRI 4	**Reported policy or delegated authority breaches** – Monitors reported instances of non-compliance with policies, procedures, or delegated authority, highlighting behavioural or control weaknesses.	Threshold based on volume, severity, or repeat occurrences.			
KRI 5	**Mandatory internal control and compliance training completion** – Measures completion of mandatory training by relevant staff, supporting awareness and consistent application of controls.	95%+ completion			
KRI 6	**High-risk control deficiencies identified and unresolved** – Counts significant control weaknesses identified through self-assessment or review, showing whether material gaps are emerging in the control environment.	Threshold based on number of high-risk findings open beyond target date			

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	SR11.01	Quarterly Counter Fraud monitoring/ reporting	Quarterly reporting was introduced in 2025/26: reporting is currently to DLT, CLT and Audit & Corporate Governance Committee	Head of Service	**Needs Improvement**	Reporting is 'developing' and needs to be more embedded and impactful.
2	SR11.01	Fraud Awareness Training	Fraud awareness is an integral part of corporate induction A new all staff and member elearning training module has been developed and tested. Rollout will occur from Q2 2026/27	Head of Service	**Needs Improvement**	Induction content needs revising. Following its introduction the new elearning module, HR/CFT will need to capture and respond to feedback.
3	SR11.01	Work with Communications to publicise successful prosecutions	Publicising successful prosecutions has been shown to have a deterrent to further, similar, activity and is a means of re emphasising the Council's zero tolerance approach to fraud and corruption.	Head of Service/Service Manager	**Largely Effective**	The team also uses intelligence gathered through networks such as NAFN and the London Fraud Group to raise awareness of patterns/emerging fraud risk e.g. career polygamy during 2025/26.
4						
5						
6						
7						
8						
9						
10						

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

Ref	Sub risk ref	Action title	Action details	Action owner	Action due date	Action plan status	Status update
1	SR11.01	Housing Fraud investigators	Two Housing Fraud Investigators, funded by the HRA, supplement the team to enable focused counter-fraud activity to address housing-specific fraud enquiries, referrals and investigations.	Head of Service/Service Manager	31 March 2027		Funding is in place for the entirety of 2026/27 and having demonstrable impact. Example would include Operation Eden in 2025/26 to proactively address tenant/landlord fraud and irregularity.
2	SR11.01	Network subscriptions	Being part of NAFN (National Anti-Fraud Network) and London Fraud Group enable access to data and intelligence to inform data matching, emerging fraud activity awareness, proactive communication and cross-organisation/boundary working.	Head of Service/Service Manager	31 March 2027		Subscription form part of the approved budget for 2026/27.
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							

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