NHS
Somerset
Clinical Commissioning Group

Report to the NHS Somerset Clinical Commissioning Group on 31 March 2022

Title: Risk Management update Report	**Enclosure M**

Version Number / Status:	1
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Summary and Purpose of Paper

This paper provides an update to Governing Body on Part A Corporate Risks which are new, escalated, de-escalated, increased, decreased, or closed in the CCG Corporate Risk Register (CRR) (extract 07/02/2022) since the full review by Governing Body in November 2021.

Effective risk management underpins achievement of all the CCG corporate aims:

- Safety and quality of care
- Leading the development of strategy which will meet the needs of the Somerset population
- Improved population health for the people of Somerset
- Value for money
- Environment - ensuring Somerset's infrastructure is fit for purpose and digitally enabled wherever possible

The report also links to the Somerset STP / ICS priorities:

- Enable people to live healthy independent lives
- Ensure safe, sustainable, effective, high-quality, person-centred support
- Provide support in neighbourhood areas
- Value all people alike
- Improve outcomes for people through personalised, co-ordinated support

Recommendations and next steps

Governing Body is asked to approve the additions and amendments to the CCG Corporate Risk Register identified in this report.

Impact Assessments – key issues identified				
Equality	N/A			
Quality	As covered by risk action plans.			
Privacy	No confidential information included in Part A risks.			
Engagement	Through Lay representation of Governing Body and Health and Care Strategy Engagement.			
Financial / Resource	As covered by risk action plans.			
Governance or Legal	Meets statutory obligations of the CCG in respect of good governance and internal systems of control.			
Risk Description	No risk assessments identified for this report.			
Risk Rating	Consequence	Likelihood	RAG Rating	GBAF Ref
	N/A	N/A	N/A	N/A

New risks added to Corporate Risk Register in period

No new risks were added to the Corporate Risk Register in this period.

Risks closed from Corporate Risk Register in period

ID	Title	Description of risk	Rationale for closure	Current Rating
505	Acute Paediatric Bed Shortage	Paediatric beds in acutes being used to accommodate children with mental health/social care needs owing to shortage of placements nationwide. This is at a time when Primary Care are overwhelmed and managing COVID and RSV.	Risk transferred from Women's and Children's team to Quality and Nursing	Risk closed
236	Court of Protection cases	Changes in Case Law have resulted in an increase in the number of cases the CCG is required to take to the Court of Protection in order to ensure that individuals' human rights are not breached. Until the Liberty Protection Safeguards are implemented, there are a number of individuals who are funded by the CCG and live in a supported living environment or their own homes that may require a legal framework to authorise the Deprivation of Liberty. The only framework available is currently through the Court of Protection. This may mean that a number of individuals are not appropriately safeguarded.	Previously identified backlog completed; now working through new and re-applications of Community DoLS	Risk closed

Risks de-escalated from Corporate Risk Register in period

ID	Title	Description of risk	Rationale for de-escalation	Current Rating
38	GP Prescribing Budget	Risk that medicines management Quality, Innovation, Productive and Prevention (QIPP) programme may not deliver sufficient saving to meet growth in the prescribing budget. Inability to meet the planned budget allocated to GP prescribing.	Although the risk always exists while a challenging budget is set and its likelihood and consequence are therefore related to budget set and engagement of GP practices in delivering mitigating actions identified by the medicines management team. Budget is under control for 2021/22.	10
361	Harms from Falls	People may not be adequately protected from harm from falls due to less than optimum primary and secondary falls prevention services. If prevention strategies were successful in reducing falls related admissions this would be better for individuals who fall and the population in general in terms of resource utilisation.	There is a new falls care group that has been commissioned to support community recognition of falls and help reduce admissions and long lies. The ageing well programme, will take this risk forward once it's up and running.	9
463	CCG Financial Plan 2021/22	The CCG, as part of the wider Somerset ICS, is unable to submit a financial plan for 2021/22 which delivers the required financial targets and business rules set by NHS England and NHS Improvement.	Identified as low risk due to the H1 position being delivered, and the draft H2 financial planning submission being balanced	8
488	Succession planning for the Continuing Health Care Team	The risk is the destabilisation of the team following a number of senior retirements. The Associate Director of CHC Services is due to retire soon and a number of senior CHC members have retired or are about to.	Skilled staff are joining the team to support these functions into the future.	9

Risks reduced within Corporate Risk Register in period

No risks were reduced within the Corporate Risk Register in this period.

Risks escalated to Corporate Risk Register in period

ID	Title	Description of risk	Rationale for escalation	Current Rating
486	Community Equipment Stock Shortages	Shortages of community equipment are being experienced at the moment, including high volume items which support discharge, such as walking sticks, toilet seats and frames, walkers. This results from national supply chain issues.	Although there are several controls in place to reduce the number of items impacted at anyone time to reduce the likelihood of this risk realising, the current situation is affecting a number of pieces of equipment, and the impact of out-of-stock items is potentially significant.	12

Risks increased within Corporate Risk Register in period

ID	Title	Description of risk	Rationale for escalation	Current Rating
222	GP workforce sustainability	Compromised patient experience due to GP primary care workforce shortages, resulting in reduction in GP practice services, reduced access to appointments and consequent impact on other sectors of NHS services, such as 111, OOH and A&E.	There is still a very serious risk to the overall primary care workforce particularly because there are a large number of GPs over the age of 50 and although the CCG has a wide range of programmes in place to support primary care workforce, the risk remains significant. Although workforce levels are increasing, there are still considerable gaps impacting on ability to meet current levels of demand.	16 (from 12)

CORPORATE LEVEL RISKS (inclusive of part A and Part B risks)

5x5 Matrix heat map showing overview of ratings for all Corporate risks

November 2021

Controlled Current Risk: Corporate - 69

Severity					
5	0	0	0	0	1
4	0	4	4	9	2
3	0	3	13	12	7
2	0	4	4	5	1
1	0	0	0	0	0
	1	2	3	4	5
	Likelihood				

March 2021

Controlled Current Risk: Corporate - 64

Severity					
5	0	0	0	0	1
4	0	2	4	10	2
3	0	4	14	7	6
2	0	3	4	6	1
1	0	0	0	0	0
	1	2	3	4	5
	Likelihood				

Corporate level risks by Domain

November 2021

Domain Name	Total	12	15	16	20	25
A. Impact on the safety of patient, staff or public (physical / psychological harm)	11	6	1	3	0	1
B. Quality / complaints / audit	2	2	0	0	0	0
C. Human resources / organisational development / staffing / competence	4	0	1	2	1	0
D. Statutory duty / inspections	10	3	2	5	0	0
E. Adverse publicity / reputation	0	0	0	0	0	0
F. Business objectives / projects	2	1	0	0	1	0
G. Finance including claims	2	2	0	0	0	0
H. Service / business interruption. Environmental impact	1	0	1	0	0	0
I. Contracting and Commissioning	3	1	2	0	0	0

March 2022

Domain Name	Total	12	15	16	20	25
A. Impact on the safety of patient, staff or public (physical / psychological harm)	11	5	1	3	1	1
B. Quality / complaints / audit	2	2	0	0	0	0
C. Human resources / organisational development / staffing / competence	3	0	0	2	1	0
D. Statutory duty / inspections	9	2	2	5	0	0
E. Adverse publicity / reputation	0	0	0	0	0	0
F. Business objectives / projects	1	1	0	0	0	0
G. Finance including claims	0	0	0	0	0	0
H. Service / business interruption. Environmental impact	1	0	1	0	0	0
I. Contracting and Commissioning	3	1	2	0	0	0

Corporate Level Risks by CCG Directorate

November 2021

CCG Directorate	Total	12	15	16	20	25
Quality & Nursing	12	5	4	2	0	1
Operations	12	6	1	4	1	0
Finance, Performance and Contracting	9	4	1	4	0	0
FFMF Strategy	2	0	1	0	1	0
Managing Director's / Chairman's Office	0	0	0	0	0	0

March 2022

CCG Directorate	Total	12	15	16	20	25
Quality & Nursing	8	2	3	1	1	1
Operations	13	6	1	5	1	0
Finance, Performance and Contracting	8	3	1	4	0	0
FFMF Strategy	1	0	1	0	0	0
Managing Director's / Chairman's Office	0	0	0	0	0	0

SOMERSET CCG - CORPORATE RISK REGISTER March 2022 PART A

ID	Title	Statement of Risk	Opened	November 2021 rating	Likelihood (current)	Consequence (current)	Rating (current)	Directorate	Risk Domain	Controls in Place	Rating (Target)	Current Rationale
9	Growth across the Urgent and Emergency Care System	Increased demand on urgent and emergency care leading to delays in care in all parts of health and social care services (ambulance, A&E, GP primary care, 111 Out of Hours, transfers of care and cancellation of elective admissions). Compromising patient experience and safety and increased financial costs. Inability for capacity to meet demand of Urgent and Emergency Care across Somerset (ambulance, A&E, GP primary care, 111 Out of Hours, transfers of care and cancellation of elective admissions).	29/07/2013	16	(4) Will probably recur, but is not a persistent issue	(4) Major	16	Operations	Impact on the safety of patient, staff or public (physical/psychological harm)	Collaborative 1. Somerset Surge planning group - fortnightly 2. Escalation Calls - twice weekly/OPEL increased. 3. Somerset Urgent Care Operation Group and Somerset A&E Delivery Board. Preventative: 4. Rapid Response service - Intermediate Care Service team support to enable patients to remain at home. 5. GP 999 Car - hospital avoidance scheme 6. Monitor and Review Framework - Somerset OPEL framework. 7. Clinical Assessment Service Revalidation - Devon Doctors	8	16.06.21 - Reviewed scoring to remain at 16 due to increased demand in activity across all UEC 28/7/21 - agreed to leave scoring at 16 12/01/22 - agreed to leave scoring at 16
10	Diagnostic Treatment	The CCG fails to meet the 6 week diagnostic test target (whereby patient should expect to receive their diagnostic test or procedure within 6 weeks) as outlined in NHS Constitution, the Single Oversight Framework, Operational and 5 Year Long Term Plans, with the emergence of further access challenges as a consequence of the Covid-19 pandemic and increased unscheduled (emergency in-patient) demand. Statement of risk Longer waiting times may lead to poorer patient outcomes, and patients presenting via an emergency route (through A&E)	09/05/2013	16	(4) Will probably recur, but is not a persistent issue	(4) Major	16	Finance, Performance and Contracting	Statutory duty/inspections	Collaborative: 1. System Assurance group ICS. 2. CCG Governing Body. 3. CCG F&P and PSQ committee(s) and Quality Surveillance Group 4. ICS Execs meeting. 5. A&E, Elective care and Cancer delivery boards 6. Contract and performance meetings. 7. Activity and Performance meeting Preventative: 8. H1 Operational Plan 9. SWAG Alliance Plans 10. Local and external improvement / transformation plans and trajectories	9	Somerset patients have waited longer for their diagnostic test or procedure leading to a significant increase in the number of patients waiting in excess of 6 and 13 weeks. Diagnostic waiting times have been impacted throughout the Covid-19 pandemic due to a combination of reduced diagnostic (and day case theatre) capacity as a result of social distancing in OP/diagnostics waiting areas, compliance to IPC regulations in theatre and patients choosing to delay treatment. Routine waiting times over recent months have been further compounded by a significant increase in the number of unscheduled diagnostic tests required as a result of an increase in in-patient demand displacing routine capacity. The longer waiting times in diagnostics will have an impact upon the Cancer and RTT pathways and unmet demand for 20/21 or long wait patients from the active diagnostic waiting list could present via an emergency (A&E) route.
25	Performance Targets	The CCG fails to meet the integrated performance monitoring targets as outlined in the NHS Constitution, H2 2021-22 operational plan, Oversight Framework and the 5 Year Long Term Plan, with the legacy challenges or emergence of further access issues as a consequence of a further wave of Covid-19 (omicron) and extreme operational bed pressures as a result of increased non-covid in-patient demand. Statement of risk Inability to meet the integrated performance monitoring targets as outlined in the 2020-21 planning guidance, Oversight and Improvement Framework and the 5 Year Long Term Plan.	29/07/2013	16	(4) Will probably recur, but is not a persistent issue	(4) Major	16	Finance, Performance and Contracting	Statutory duty/inspections	Collaborative: 1. System Assurance group ICS. 2. CCG Governing Body. 3. CCG F&P and PSQ committee(s) and Quality Surveillance Group 4. ICS Execs meeting. 5. A&E, Elective care and Cancer delivery boards 6. Contract and performance meetings. 7. Activity and Performance meeting Preventative: 8. H1 Operational Plan 9. SWAG Alliance Plans 10. Local and external improvement / transformation plans and trajectories	9	For some considerable time Somerset patients have waited longer for their first definitive treatment resulting in backlogs across a range of specialities/modalities; these backlogs have been further compounded by the Covid-19 pandemic due to the reduction in Out Patient, Diagnostic and Theatre capacity throughout this period. As referrals restore to pre pandemic levels there is a risk that these backlogs will continue to accumulate due to the limitation of securing additional capacity. There are workforce constraints across a number of the specialities / diagnostic modalities due to the level of vacancies or short term issues due to staff isolation. There is a risk that patients waiting longer for treatment or those yet to present (unmet demand during 20/21) could present at the hospital via emergency routes. Over recent weeks due to the extreme operational bed pressures has led to an increase in elective cancellations.
143	Dermatology	Patients with non-urgent, urgent and 2 week wait suspected cancer services may have delays in access to treatment as a consequence of closure of the Taunton dermatology service in April 2017. This reduction in service provision is accompanied by rising demand. Patients are having to travel to Exeter and Bristol to access secondary care Dermatology Services. Current demand for 2 week waits is increasing beyond capacity available from out of county providers. The current service costs the system an additional uplift to fund locum costs at UHBW. UHBW have also stated that they do not wish to continue providing this level of service to Somerset patients in the future.	30/01/2015	12	(3) May recur occasionally	(4) Major	12	Operations	Statutory duty/inspections	1. Additional capacity -(UHBristol 2ww activity and Royal Devon and Exeter (routine activity)for patients who previously would have been seen at Musgrove Park. 2. Financial support (at a premium) provided to UHB for an additional 40 2ww appointment slots per week. 3. Weekly monitoring of referrals to understand any delays, where capacity is not meeting demand. 4. Teledermatology (routine Advice & Guidance only) 5. Service delivery model and associated implementation plan. 6. Workforce plan for dermatologists Collaborative: 7.Elective care board 8. Funding agreed for new Somerset Service. Project group commenced for new service to commence April 2022. 9. Executive Lead and project manager recruited within Trusts to take the project forward.	6	This risk is an overarching view of Dermatology. The rating matches the risk rating for the other, more specified dermatology risks. The project plan for remodelling of current service in place with the aim of a system wide service April 2022. Funding has agreed through Elective Care Board for remodelling of the service. Risk is escalated as currently some assurance is provided from the alternative measures have been put in place, however some of the service delivery is reliant on out of county provision which is not sustainable by the providers and may be withdrawn at any time (hence proximity of 31/3/21) and will affect the performance of this risk's controls. The greatest level of assurance (overseen by the system via ECB) comes from the development of systemwide plan to deliver a financially and sustainable model which will deliver stronger risk controls but not until 2022. Agreed as a priority programme of work as part of the Planned Care Transformation Group. The CCG is also pressing NHSE to convene a South West summit to address the issue as it is recognised that a regional networked solution is probably required. New funding invested into service with project group set up for commencement of new Somerset service April 2022
212	Ambulance Call Stacking	People may experience delays for ambulances due to high levels of demand (i.e. call stacking) affecting patient experience and safety. This may include urgent maternity transfers. In particular this involves stacking of Cat 2, Cat 3 and 4 outside of national thresholds calls due to the availability of resources and/or high demand and this could affect patient safety, patient experience, staff morale and performance.	21/01/2016	25	(5) Will undoubtedly recur, possibly frequently	(5) Catastrophic	25	Quality and Nursing	Impact on the safety of patient, staff or public (physical/psychological harm)	1. 999 and ED Validation within IUC Clinical Assessment Service 2. 111 Online – Validation of ED and 999 (lower acuity) dispositions 3. High Intensity Users work stream - 6 weekly Steering and implementation group. Mapped local High Intensity Users schemes and MDMs. Scheme in development for implementation Winter 2020. 4. GP999 car contract extended as an alternative to DCA. 5. Directory of Services nil returns reviewed regularly for pathway development 6. Primary Care Network. Same day requests through CAS 7. Somerset HALO- supporting both acute sites (Winter 2020) 8. Crisis Café - non medical alternative to mental health. Virtual alternatives in place. 9. 24/7 Crisis line expansion mental health services 10. Two Full time Trusted Assessors in post (YDH and MPH) to aide acute hospital flow 11. The LARCH (Listening and Responding to Care Homes) collaborative is Somerset wide – preventing avoidable hospital admission from care homes [inc. use of RESTORE2 and Treatment escalation plans]) 12. Same Day Emergency Care – admission avoidance 13. Intermediate Care/Home First redesign including doubling capacity of Rapid Response and Pathways out of hospital. (On trajectory plan for Winter 2020) 14. Trusted Assessor project	5	Unable to currently accurately assess risk score as SW system risk. The Quality Assurance Sub Group have identified that as a system, we need to look at the entire urgent care journey and not an isolated point in the urgent care flow. Therefore end to end reviews will take place to identify pain points within the our local systems and learning will be shared across the SW to improve patient flow through the urgent care system.

222	GP workforce sustainability	"Over a number of years, planning for primary care workforce did not deliver the required capacity against primary care activity. There were specific drivers of the risk including national changes to pension and tax rules. ""Compromised patient experience due to GP primary care workforce shortages, resulting in reduction in GP practice services, reduced access to appointments and consequent impact on other sectors of NHS services, such as 111, OOH and A&E. Current mitigations include skill-mix particularly through the utilisation of the PCN reimbursable roles programme, recruitment campaigns and retention schemes, developing extended practitioner roles and larger practice groups to share operating functions. Risk of reduced access to GP primary medical care in a defined area/s should a GP service decide to give notice on their contract or suffer short term shortage of medical workforce. Reduced quality of GP service due to reduction in GP workforce numbers. This risk is not in relation to a particular practice, it's relating to local GP workforce sustainability in general." Demands for primary care services have significantly increased as a result of the COVID19 pandemic e.g. COVID vaccination programme, backlogs in primary care activity, managing patients who are awaiting secondary care activity.	23/01/2017	12	(4) Will probably recur, but is not a persistent issue	(4) Major	16	Operations	Human resources/organisational development/staffing/competence	Primary Care Workforce overseen by Local Workforce Action Board. CCG sustainability policy used to monitor, engage and support practices experiencing critical workforce challenges on a case by case basis. Primary care heatmap in development to reflect current pressures	12	There is still a very serious risk to the overall primary care workforce particularly because there are a large number of GPs and Nurses over the age of 50 and although the CCG has a wide range of programmes in place to support primary care workforce, the risk remains significant. Although workforce levels are increasing, there are still considerable gaps impacting on ability to meet current levels of demand.
248	Access to CYP Services	There is a risk that CYP with mental health needs are not getting the support they require, especially as needs and routes of access are changing as a result of COVID.	04/10/2017	12	(3) May recur occasionally	(4) Major	12	Operations	Impact on the safety of patient, staff or public (physical/psychological harm)	Single Point of Access and additional CAMHS Transformation services all fully operational, and MHST services are continuing to expand with 2 additional teams due to come online in 2021/22. Re data, we have invested with SFT to do a detailed piece of work to ensure all applicable activity is captured and upskilling clinicians to include this accordingly. This has also been supported by the national change in definition. The latest local data suggests that performance is circa 60% on the new definition, and almost 30% on the 2 contacts definition.	8	Latest data shows fairly static performance. However, we know that the issues with data completeness mean that this is not an accurate picture. As demand for CYP services continues to grow due to COVID, there is no change to the risk level.
255	SWASFT Category 1 and Category 2 Performance	Ambulance staff vacancy rate, being mitigated through recruitment campaign and rota re-alignment to better match service demand. Under-performance against Category 1 and Category 2 Mean and 90th Percentile target. Ambulances may not reach the patient within a timely manner. Breach of Category 1 and Category 2 SWASFT Ambulance Response Performance (ARP) standard.	01/02/2018	16	(4) Will probably recur, but is not a persistent issue	(4) Major	16	Operations	Statutory duty/inspections	Collaborative: 1. SWASFT 2 weekly meetings (performance, activity levels, handover, workforce). 2. FICSC - Monthly meetings. Dorset CCG (contract lead for performance, contract, activity). 3. Hospital (YDH and SFT) handover meetings via A&E Somerset Delivery Board - monthly 4. A&E Somerset Delivery Board - monthly 5. Devon Doctors and Care UK - to reduce 999 and ED dispositions to enable resourcing to be able to meet Cat 1 ARP standards. 6. Validation programme - to establish which calls do not require Cat 1 and Cat 2 disposition and ED. 7. High Intensity (HRU) task and finish group - frequent access to UC services. Preventative: 8. Our people plan - SWASFT workforce plan. 9. Mental Health Directory of Service revision. 10. GP 999 Car provision.	6	During August 2021 SWAST reported an Internal Critical Incident. The declaration is in relation to demand, we had a stack of over 500 calls overnight and started today with over 300. We have had poor call answering performance and over 20 calls at any one time waiting for answer. We currently have 341 calls waiting for response. Yesterday we lost almost 900hrs due to Acute Trust handover delays. VH58 is in place as are all REAP and Escalation actions – we have stood up all resourcing to respond to the major incident as per our IRP. SWAST de-escalated from our MI status on 10th September 1126 this morning but remain in an internal critical incident at OPEL 4 and surge level 4. Whilst we are in a slightly better more stable position we are still seeing high levels of activity with in excess of 250 waiting calls and significant handover delays at a number of our regional EDs. Obviously we will give you the county level details on the 1230 call It was agreed to not change the Risk score on due to the following: 1) Increased number of Covid Positive cases within SWAST and the Acute Trusts coupled with Covid related staff abstraction. 2) System continues to support by maintaining minimal handover delays and IUC CAS validation reducing lower acuity patients in 999 stack 3) GP999 Car resources in place to attend high acuity calls 12/01/22 - Risk discussed and scoring to remain the same, due to ongoing staffing pressures around staff abstractions and fatigued staff
285	Cancer Targets	The CCG fails to meet the cancer access target (2 week, 31 and 62 day and 28 day faster diagnosis standards), constitutional standards, H1 Operational Plan, NHS Oversight Framework and the 5 Year Long Term Plan with the emergence of further access challenges as a consequence of the Covid-19 pandemic	09/08/2018	16	(4) Will probably recur, but is not a persistent issue	(4) Major	16	Finance, Performance and Contracting	Statutory duty/inspections	Collaborative: 1. System Assurance group ICS. 2. CCG Governing Body. 3. CCG F&P and PSQ committee(s) and Quality Surveillance Group 4. ICS Execs meeting. 5. A&E, Elective care and Cancer delivery boards 6. Contract and performance meetings. 7. Activity and Performance meeting Preventative: 8. H1 Operational Plan 9. SWAG Alliance Plans 10. Local and external improvement / transformation plans and trajectories	9	Somerset patients have experienced longer waiting times following a suspected cancer referral or for their first definitive cancer treatment (31 and 62 day pathway). Cancer waiting times (for suspected cancer referral and treatments) were initially impacted by the Covid-19 pandemic due as a result of reduced out-patient, diagnostic and theatre capacity as a result of social distancing in OP/diagnostics, compliance to IPC regulations in theatre and the loss of theatre capacity to support critical care expansion. There continues to be a residual impact from Covid-19 with social distances and enhanced IPC measures remaining in place. To further compound waiting times have been further impacted as a result of the extreme operational pressures during recent weeks also resulting in delays in tertiary centres impacting upon the patient pathway. The combination of these factors have resulted in an increase the number of patients waiting in excess of 62 days or 104 days for the first definitive cancer treatments (against the 62 day standard). The reduction in suspected cancer referrals during 20-21 increases the risk that some of this unmet demand could present via emergency routes and lead to patients presenting with a later stage of cancer and lead to poorer outcomes.
292	Workforce Sustainability	Workforce to support high quality and safe care is becoming increasingly challenging to sustain. Rural location and lack of University makes bringing in new recruits challenging. HEE Funding changes includes the removal of funding for nurse training. Additionally, an aging demographic and staff population with large proportion of workforce retiring increases the need to recruit.	30/09/2018	16	(4) Will probably recur, but is not a persistent issue	(4) Major	16	Quality and Nursing	Human resources/organisational development/staffing/competence	Collaborative: 1. Local Workforce Action Board (LWAB) chaired by Chris Squire. 2. Social care network forum and Primary Care Workforce Implementation Groups set up under LWAB to identify priorities and actions needed across the system 3. Workforce planning groups Detective: 4. Independent review workforce analysis conducted to inform LWAB and local providers with recommendations. Preventative: 5. Early Adopter site for Maternity Care Assistants and working with Universities to Assist. 6. Local pathways development programme by Providers to support staff into registrant roles. 7. Strategic apprenticeships plan. 8. Nurse degree training access via local provider. 9. Breaking barriers project 10. Clear project. 11. HEE Pooled training allocation budgets. 12. Long term plan workforce plan. 13. Local Workforce Action Board action plan. 14. Degree pathway 15. Career pathways for critical roles. 16. One year system workforce / NHS People Plan.	8	collaboratively look at 'hot topic' areas across the system. HEE Bridgwater and Taunton College have now made the decision to achieve a partnership with UWE given their commitment to support local delivery of FdSc Nursing Associate from September 2020 and BSc Nursing from September 2021, subject to NMC approval. Long term plan submitted with significant plans for workforce. LWAB Terms of Reference have been reviewed and governance structure verified to align delivery groups to system workforce priorities. Breaking barriers project commenced, building community capacity & resource. Somerset high performing on numbers of apprenticeships with many in development (e.g. pharmacy technician). Agreed degree pathway now developed for TNA in Somerset. Successful bid to develop system wide health and wellbeing offer for staff. Breaking barriers project agreed to support Somerset. Number of career pathways mapped out on critical roles. 4 workforce planning groups being set up to workforce development funding to fund projects including increasing PACR and NMP training courses. One year system workforce action plan developed, integrated with NHS People Plan with a number of initiatives underway. Last LWAB highlight report status was amber. Gov 50k workforce plan Somerset/South West on track to meet target for overseas nurse recruitment. Apprentice force programme is also on track, therefore risk reduced to 12. Increase in risk due to challenges in recruitment to acutes, primary care and social care. System wide issues. •Rural location – whilst Somerset remains rural the approval from NMC to receive nursing student at the Bridgewater College as part of UWE means that nurse training can now be local and offer with increased numbers . I am thinking that the reduction in HEE funding refers to the stopping of the bursary. The situation currently is- •Offer of Apprenticeships with 18 general and 10 mental health students started in October . this is a 4 year course. •Nursing associate -two cohorts of 30 now in place , with option once complete to top up RN. •Primary Care are part of the programme and have 5 places on the apprentice programme.
318	Risk of Children Looked After Health services not being delivered within statutory time frames	Somerset Children Looked After who are resident both in and out of Somerset are at risk of not receiving timely health services due to complex administrative processes, last minute and frequent movement of children outside of Somerset, lack of good quality placements inside Somerset, late notification of changes by the Local Authority, difficulties getting timely consent from biological parents, increasing capacity issues in other Health providers outside of Somerset and difficulties establishing system wide working across Health providers in Somerset. An additional risk has also been identified in respect of the current capacity of the Adoption Medical Advisor services which is addressed in the separate Risk form numbered 436.	20/05/2019	15	(5) Will undoubtedly recur, possibly frequently	(3) Moderate	15	Quality and Nursing	Statutory duty/inspections	x	8	Risk remains at 15 due to lack of improvement in overall performance of IHAs and number of complex issues negatively impacting on the system's ability to deliver this service on time. New reporting structure will take several months to clearly illustrate overall performance once the numbers of non engaging children and those who were not brought are removed from the data.

327	Implementation of Liberty Protection Safeguards	There is a risk that the CCG may not be able to fully implement The Liberty Protection Safeguards (LPS) which were due to be implemented in October 2020 and now have been delayed until April 2020. The LPS gives new duties and powers to CCGs and hospitals to authorise a deprivation of liberty. This function was previously undertaken by Local Authorities. As a responsible body, if the CCG and the trusts do not implement systems and processes they risk being responsible for breaching articles 5 and 8 of the Human Rights Act for any affected individuals. There is also a risk of damages being awarded to any individual who is adversely affected.	15/08/2019	12	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	Quality and Nursing	Impact on the safety of patient, staff or public (physical/psychological harm)	The Regulations, the Code of Practice and the Impact Assessment have not yet been published. The Code of Practice has not yet been released for consultation. All these documents will provide statutory guidance on how the scheme will be implemented and will describe the funding available to do this. These documents will set out the controls that will be needed but this has not been published at this time Therefore, until the documents are released, detailed planning about implementation of the controls cannot be undertaken. However, some actions are being taken which provide early controls 1. ICS governance for implementation has been established with a joint LPS board supported by an operational group 2. The trusts have been reporting the number of people who are deprived of their liberty via the safeguarding adults dashboard for the past 18 months. this will provide data enabling the scoping of cost, services and planning for delivery. This has been a validated by a snapshot audit that took place in February 3. CHC team to scope number of people likely to need assessments 4. Two CCG staff members have gained the qualification necessary to complete the assessment of people who are objecting to their care arrangements. The CCG funded this training 5. CCG Designated Nurse undertaking awareness raising sessions for relevant teams within the CCG and in other relevant forums outside the CCG 6 NHS England have provided a training day for executives which was attended by all three trusts and are supporting a regional working group for LPS that will feed into the SW NHS EI ICS areas through the Designated Professionals Forum 7 Business case for funding implementation 8 Staff training; including GP practices 9 Development of system wide tools and process	6	A parliamentary Statement has been released in relation to the Mental Capacity Amendment Act (2019) in relation to the Liberty Protection Safeguards (LPS). The original intention was for the LPS to be implemented in October 2020. The statement notes that this is now no longer possible. A draft code of practice and regulations will be made available in due course; the statement advises that this will happen well in advance of the target date which is currently unknown. Because the LPS will not be implemented for a minimum of 9 months the current consequence is moderate because it does not apply as yet 19 March 2020 -Update the risk score and rationale above remain the same pending publication of the code of practice. Local LPS Board will be recommencing and NHS England and NHS Improvement South West Group has begun to provide support and oversight of implementation Update 26 May 2021-The Risk score and rationale remain the same due to the pending Code of practice not yet shared for consultation. There is no official confirmation that there will be a delay in the implementation of the LPS in April 2022. 10/01/2022 confirmation April 22 is no longer the implementation date. 12 week consultation on stat guidance, any decisions on funding streams and new implementation date will not be made until after the consultation period has ended. CCG business case still requires finalising.
363	Somerset Integrated Urgent Care Service - Clinical Shift Fill	There is pressure on operations as a result of the level of clinical uptake in shifts and the reducing pool of clinicians who are regularly filling shifts. This leads to pressures on operational capacity and clinical safety of the service. Inability to fill to core levels triage and face to face shifts.	02/09/2019	20	(5) Will undoubtedly recur, possibly frequently	(4) Major	20	Operations	Human resources/organisational development/staffing/competence	1, Twice weekly shift fill information with enhanced information on shift fill / clinician type per day / per hour starting 22 Jul 2021 2, Daily sitrep including GP OOH Opel score and validation position 3.. Contract Review meeting - monthly.43. Fortnightly CQC meetings and reports 4. Twice weekly IUC Capacity Cell Calls (Somerset and Devon IUCSs) alongside further updates at Somerset system escalation calls 5. Currently in discussion with DDOC to development a combined clinical queue between Devon and Somerset IUCS to support resilience of both services 6. Dx operating model in place from 18th January 2021 and review of rota requirements being undertaken by DDOC 7. Summer incentive scheme (covering both Somerset and Devon IUCSs) to support shift fill live from June 2021 8. 12 week Clinical Workforce Plan completed	9	CCG expect performance to be consistently over 80% overall shift fill before risk can be reduced. 20/5/21 - From April the new IR35/OP21 arrangements have come into place and this is causing DDOC significant shift fill issues, we are working with them on a mutual aid SOP. Following RMG in June, it was decided this risk should be a 12. CCG expect performance core shift fill to be consistently above 80% overall shift fill before risk can be reduced. 20/5/21 - From April the new IR35/OP21 arrangements have come into place and this is causing DDOC significant shift fill issues, we are working with them on a mutual aid SOP. As at 28 July 2021, development of mutual aid SoP along with Escalation SoP (linked to service delivery issues due to shift fill) is progressing: as updated at MCRM 28 July 2021 Following RMG in June, it was decided this risk should be a 12. Due to ongoing challenges and deteriorating position, impacted further by knock-on system pressures, CCG discussed increasing risk score to 20 with provider at MCRM 28 July 2021 12/01/22 - Discussed risk, ongoing pressures with rota fill due to various factors including mass vaccination and clinician fatigue, as well as Covid extractions.
364	Somerset Integrated Urgent Care Service - OOH Service Problems	Delay in out-of-hours - calls and visits There is a risk of patient harm due to delays in call back and visits. Risk relates to high service demand and reduced fill of clinical rota. Inability to provide safe out of hours services.	02/09/2019	15	(5) Will undoubtedly recur, possibly frequently	(3) Moderate	15	Operations	Impact on the safety of patient, staff or public (physical/psychological harm)	Collaborative: 1. Touch point calls - weekly with CQC, Devon Doctors and Devon CCG. 2. Contract review meeting with Devon Doctors. Preventative: 2. CQC improvement plan - performance and quality. 3. Clinical recruitment plan. 4. Integrated Urgent Care lead clinician with the Clinical Advisory Service.	9	Strong controls and partnership with monitoring by CQC. However risk remains high due to workforce hazards. Awaiting DX code performance (implemented end Oct 2020) - report has been received and currently working on the data that has been submitted by DDOC. 28/7/21 - agreed to increase the scoring of this risk to 15 due to, triage performance, fluctuating home visit performance 12/01/22 - Discussed and risk remains the same. Although ongoing challenges with rota fill, impacting performance, DDOC has developed systems to support patient safety as part of its CQC improvement work
405	Physical Health Checks for vulnerable groups (e.g. SMI, LD, ED and dementia)	There is a risk that we will not deliver physical health checks to identified vulnerable groups, including failing to meet the national target for people on the GP Severe Mental Illness (SMI) register as well as patients on the GP Learning Disabilities register having an evidence-based physical health care assessment on an annual basis. COVID restrictions have had a significant impact on the physical health check work programme, as the majority of the intervention would have taken place routinely in primary care; unfortunately as much routine activity was stood down due to COVID, a quarter of a year's progress has been lost. In addition to this, if social distancing restrictions continue to be in effect, it is possible not all 6 physical health checks will be able to be carried out to meet the check requirements.	10/06/2020	16	(4) Will probably recur, but is not a persistent issue	(4) Major	16	Operations	Impact on the safety of patient, staff or public (physical/psychological harm)	Preventative: 1) 4 Physical health support workers (SFT), aligned to the Open MH model. 2) Contractual arrangement for health checks with primary care under the PCIS. 3) Winter funding/outreach funding. Collaborative: 4. Multi-directorate programme board established with 3 underpinning working groups. 5) Touch points meetings with NHSEI. 6) Regular reporting	6	The physical health check programme was subject to a national pause in the early part of 2020/21, thus reducing the opportunity to undertake physical health checks and appropriate follow up interventions. Proximity of June 2021 due delay in data for the national standard of physical health checks for vulnerable groups 2020/21. For 2021/22, NHSEI has announced that QOF will now cover all six health checks under the SMI programme which will make a huge difference in delivery in 2021/22. Due to the ongoing pressures relating to COVID, which reduce F2F opportunities for care, and increasing demand on primary care as a whole (particularly as we move into winter), the health check programme has been significantly impacted. There is no automatic data flow in place from primary care, and therefore the data set is not as full as other areas. However, there is a national programme to set this up in place. The consequences relate to patient health and wellbeing, noting the significant mortality gap between those with an SMI/LD and those without, as well as reputational risk and regulatory action, noting that regionally there is intense and increasing scrutiny on performance in this area.
406	COVID-19: Increased demand for mental health services	There is a risk that there could be insufficient capacity in mental health and wellbeing services to meet the increased levels of demand arising as a result of COVID. This is due to the direct consequences of COVID on individual health and wellbeing as well as the indirect, longer term consequences (e.g. recession, unemployment, child development). It is also possible that while numbers in raw terms will not increase, complexity/acuity may increase, therefore utilising more capacity of services. There is a risk that COVID-related mental health demand could outstrip supply in mental health services across NHS and VCSE services. It is unclear how long the primary impacts on emotional wellbeing and mental health will last, nor the secondary impacts (e.g. recession, unemployment, child development)	10/06/2020	12	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	Operations	Impact on the safety of patient, staff or public (physical/psychological harm)	Preventative: 1. Alliance additional capacity (CMHS transformation workstream) 2. Demand and capacity model. 3. Prevention agenda (emotional wellbeing, resilience and wider determinants of health) included in mental health response. 4. Funding to meet anticipated increase in demand. Collaborative: 5. MHLDA cell and public health meetings. 6. CCG and NHSE/I meetings 7. Non-recurrent funding has been made available nationally to support anticipated rise in demand this financial year 8. COMF allocation via Public Health is contributing towards managing demand/need in the context of COVID 9. Dedicated winter pressures funding to support systems (again non-recurrent).	6	Given the ongoing health and socio-economic implications of COVID, including further national lockdowns, it is likely that demand for mental health services will increase, as well as an increase in acuity/complexity. There is already some evidence that demand is growing. If capacity is unable to keep pace with growth in both demand and complexity, existing services could be overwhelmed with some patients getting insufficient support to meet their needs. This could have consequent risks of deterioration of condition and therefore increased intensity and cost of intervention (thereby increasing the demand to inpatient facilities and thus increasing the risk of out of area placements), increased suicide rates and self harm, alongside workforce burnout. Demand and capacity modelling work is underway at SFT and due to commence in CCG June 2021. CCG continuously monitoring demand for services in the context of COVID19. CCG aim to harness increase in community support (as a result of COVID19) going forward. Awaiting the national model of future demand to inform the local response, required funding and completion of the Somerset demand and capacity model. Further review of this risk will then take place to ensure consequence of the risk and controls needed reflect the needs of Somerset. Due to the pressures on local primary care services, PCNs have not been in a position to engage with the CMHT programme as originally envisioned. Awaiting clarification of whether additional funding will be made available nationally to support increase in demand for mental health services. In addition, there is a supplementary financial risk from putting in place additional and/or expanded services that were not planned for (e.g. expansion of the Mindline, complex bereavement service), and will generate ongoing financial pressure on the mental health budget.
409	Preventable deaths from suicide in relation to COVID19 and aftermath	There is a risk that suicides will increase as a result of COVID 19 and its longstanding aftermath. A number of initiative have been introduced to assist the decrease of suicides. May and June was an increase but reduced to lower rates. Outreach for middle aged men is in place and we have stepped up services midline (24 7) and expansion of MH services. The MH Trust has a lead. PH are the lead statutory body for suicide across the nation. People who commit suicide as percentage of population has increased was 40 then 80. The SW is not high for COVID19 infection but the impact to Somerset people is the same. Midline red calls received 134 calls cumulative calls since march - this is significant. Mindline provides red flag data reports which, if means and intent for suicide, we can see the numbers of callers. Mind Line funded from COVID response. MH strategic cell is in place - standard item on weekly cell is suicide (cell originated for COVID) but is the strategic cell for MH (CCG, SCC, PH, social care, MH Trust and Volunteers). If people are acutely ill and commit suicide this is more of a concern for the effectiveness of MH services - 50% of suicides have previous self harm; 60% people have visited GP in the last 12 months. The system receives confirmed suicide numbers approx. 2 years after dead. Coroner gives the verdict from death. System gets real time observation of unexpected deaths which can be used as proxy measure. For every suicide, there is an impact cost of £1.7m.	10/06/2020	12	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	Operations	Impact on the safety of patient, staff or public (physical/psychological harm)	Collaborative: 1. Suicide prevention strategic partnership board (quarterly). Preventative: 2. Mind Line 3. Outreach for middle aged men, and additional funding being provided by NHSEI for 2021/22 4. Somerset FT and volunteer providers earlier intervention programme (long term plan, Community MH services expansion- Primary care focus) with growing numbers of referrals. 5. Crisis home treatment services	9	Risk escalated considering all evidence including pandemics and research, increase is expected although ambition is zero suicides. Impact of COVID19 will not be known 2021 to 2022 so risk remains at score 12. Two thirds of people who commit suicide are not in contact with health providers so a system focus is needed. Heat map of areas deprivation and intelligence mapping is a recognised opportunity for the improvements of suicides. Increase funding for suicide prevention for Somerset (MH investment standard) to be utilised to improve the decrease of suicides & early intervention. Proximity set due to unknown impact of hazards from COVID19. The men's outreach piece is being progressed by PH, with funding ready to be commissioned for the procurement/allocation process.

413	Patients with complex needs (inc. S117 provision)	There is a financial and quality risk in relation to individual patients funded outside of normal pathways who are not sighted by the CCG nor SFT in terms of healthcare reviews. These patients are often joint funded with the Local Authority. Patients with complex needs are accessing care in which the CCG does not have sufficient oversight of the quality of care provision	12/06/2020	12	(3) May recur occasionally	(4) Major	12	Operations	Impact on the safety of patient, staff or public (physical/psychological harm)	Preventative: 1) Patients with complex needs (inc. S117 provision) Proposal. Collaborative: 2) Complex case panel.	6	It is moderately likely that there are patients with health needs that are not being reviewed in a timely manner because of the lack of a streamlined process for reviews of packages outside of normal pathways. Proposal under discussion to move to a more integrated approach with local authority, SFT and CCG sharing the risk and activities. It is likely that we will overspend on our S117/complex cases allocation this financial year; however, because of the MHIS categorisation changes this is likely to support achievement of the MHIS
425	Ofsted/CQC SEND Inspection and Neurodevelopmental pathway:	There is a risk of increased complaints relating to the fragmented pathway for ADHD and ASC. This is caused by the lack of a Somerset whole-system neurodevelopmental pathway with significant gaps and variable commissioning arrangements for ASC and ADHD; pre-diagnosis, assessment and post-diagnosis. Currently, CAMHS receiving increased requests for assessment and intervention for cases that do not meet MH criteria nor have a significant mental health presentation requiring CAMHS specialist response. Inability to maintain quality of service for ADHD and ASC.	12/06/2020	12	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	Operations	Quality/complaints/ audit	Looking to commission a new whole system neurodevelopmental pathway. CCG lead identified. A series of multi-agency meetings have been taking place in regard to this work programme.	6	A team lead has been identified to develop the pathway and work is underway with system partners. Further sessions have been scheduled with partners, with decisions expected to be made by end March 2021
428	COVID - nosocomial transmission	To exercise the highest level of infection prevention and control possible in health and care settings to the highest standard possible in order to minimise the impact of the COVID pandemic. This will reduce harm and mortality to the lowest level possible. Spread of COVID as a result of heath and care service delivery - meaning spread of COVID infection for people working, visiting or staying overnight in a health or care setting Full testing in Acute services and partial in other services. There is a difference between how a cluster and an outbreak is defined. Inadequate infection prevention and control measures for community and acute settings.	15/06/2020	16	(5) Will undoubtedly recur, possibly frequently	(4) Major	16	Quality and Nursing	Impact on the safety of patient, staff or public (physical/psychological harm)	Collaborative: 1. Quarterly IPC Committee 2. Fortnightly huddles with DIPC 3. Fortnightly operational IPC leads meetings across system 4. Weekly COVID19 Health Protection Board across system. 5. Members of IPC SW Steering group. 6. Attendance to outbreak meetings and IMTs 7. Vaccination programme across the community and health care sector. Preventative 6. PHE guidance on the use of PPE for staff and where appropriate for patients and visitors in health and care settings. 7. Protocol for Restriction of non-essential visitors to health and care settings. 8. Protocol for the Practice of social distancing principles, especially where PPE is not being used in health and care settings. 9. IPC strategy 10. Outbreak management plans (from providers) 11. Infection Prevention Control (IPC) action plan 12. IPC Workforce capacity increase. 13. COVID19 vaccination programme.	12	Somerset, the CCG co-commission Weston Hospital which takes 20% of its patients from Somerset. Outbreaks are monitored and managed through PH and IPC team through outbreak notifications. Risk likelihood increased to 4 due to reduction of effectiveness of controls. This is due to a new highly contagious variant, reduction in compliance of IPC policies and practice in care homes, PPE fatigue, incorrect assumptions on transmission in care homes (especially for homes where staff have received their COVID19 vaccination). Risk escalated due to outbreak cases increase significantly in a short period of time in care homes (and subsequent death rate), reducing capacity for IPC to meet demand to support care homes and to address areas on non-compliance; additionally possibility of further variants and unknown efficacy of COVID19 vaccine. Proximity of 14/02/2021 to reflect these factors and potential further increases from relaxation of lockdown during latter 2020 together with winter pressures until end March 2021. IPC team post successfully interviewed and offer accepted Dec 2020. 06/01/2022 Review with LEH. Risk has been increased to 20 due to the Omicron infectivity and transmission. All guidance and mitigations are being followed as per PHE recommendations. Frequent meetings/escalation call are taking place with all system partners. This risk will be review bi-weekly.
443	Influenza Vaccination Season 2021/22	Flu vaccinations are provided to staff, trusts and GP practices or third party care providers. Somerset has 65 GP Practices NHS E/I target for 20/21 is 75% of at risk age group who are people over the age of 65 (previous year's target was 55%). Later in 2020 this will include people over the age of 50. In total this is a total of 120k Somerset increase on top of the normal at risk list. This is a GP quota as we as a CCG would have to find additional capacity. Vaccines should take place in October 2020 and November 2020 as the vaccine needs 28 days to generate antibodies. Additional social distancing within the practice of delivering the flu vaccination may provide venue challenges to deliver the clinics. Workforce: • Capacity to deliver the increase in demand may provide a challenge to the delivery of the flu vaccination. The CCG are holding interview in Aug for staff outside of GP workforce. • Third party provider procurement would be required if GPs do not have the capacity to deliver the flu vaccination. Running the procurement may cause a resource issue. Due to social distancing restrictions providing this volume of vaccinations for practices will be extremely challenging and will need support from the system. Data for flu vaccinations is provided by the IT system Inform. James Warren has access to this data. There is a reputational risk to the CCG as well as a risk to not achieving the NHSE/I target – additional risk to acute hospital flow and urgent care services. The CCG have sent a survey to GPs to see what their plans are to deliver the flu vaccination programme and what this provision will look like e.g. additional clinics in village halls, drive through, or different model to cope with demand. Some practices have enquired about finances to deliver this target. PPE - 20/8/20 updated PPE guidance confirmed sessional use of PPE and aprons no longer required. GPs order their own flu vaccines and orders went in Feb 2020 prior to pandemic and prior to NHSE/I increase in target	26/08/2020	12	(3) May recur occasionally	(4) Major	12	Finance, Performance and Contracting	Quality/complaints/audit	Collaborative: 1. Somerset system flu group (meet every 2 weeks) Preventative 2. NHS E Guidance document for flu programme. 3. Communication plan (reducing reputational hazard and increasing uptake). 4. CCG implementation plan (plan to outline GP plans and or CCG additional capacity including workforce). 5. National Guidance for Social distancing.	4	Risk escalated with regard to ability to achieve 75% at risk groups ambition target, this is largely due to the pace of distribution of available vaccine stock, and there are some smaller at risk groups that have a lower uptake. It should be noted that the Somerset System is in line with our peer groups regionally, however risk remains that this may have an impact on urgent care from the cohort of patients within the flu vaccine target. Somerset CCG continues to hold bi-weekly flu meetings with key system partners to discuss operational and strategic challenges and issues, generate additional guidance for Primary Care to support General Practice to facilitate influenza vaccination clinics and offer financial reimbursement for any additional influenza vaccine clinic costs that Primary Care incurs due to Covid 19 and Social distancing requirements and the increased ambition targets. 12/01/22 - Discussed and risk score to remain the same
449	Referral to Treatment	Patients' experience delays in treatment as the CCG is failing to meet the Referral to Treatment (RTT) targets (whereby patient should expect to receive their first definitive treatment within 18 weeks) and that there should be zero incidence of 52 and (and latterly) 104 weeks. These access standards are outlined within the NHS Constitution, Single Oversight Framework, 21/22 operational and 5 Year Long Term Plan guidance. RTT access issues due to the Covid-19 pandemic have further compounded the legacy backlog. Statement of Risk Longer waiting times may lead to poorer patient outcomes, and patients presenting via an emergency route (through A&E)	29/09/2017	16	(4) Will probably recur, but is not a persistent issue	(4) Major	16	Finance, Performance and Contracting	Statutory duty/inspections	Collaborative: 1. System Assurance group ICS. 2. CCG Governing Body. 3. CCG F&P and PSQ committee(s) and Quality Surveillance Group 4. ICS Execs meeting. 5. A&E and Elective care delivery boards 6. Contract and performance meetings 7. Activity and Performance meeting 8. Adherence to prioritisation according to the Royal College of Surgeons Prioritisation Guidance to ensure patients are treated in order of urgency to avoid harm 9. Weekly review of the Patient Treatment List (PTL) to review urgency and escalation of any patients identified as at risk of clinical harm 10. Adherence to new RTT MDS dashboard Preventative: 11. Phase 3 Covid Re-Start Plans 20/21 12. Operational planning 21/22 13. Improvement / transformation plans and trajectories	9	Somerset patients have experienced longer waiting times for their first definitive treatment (and delays in the diagnostic phase of the pathway will lead to a deterioration in longer waiting times. RTT Out Patient (non-admitted) and In Patient (admitted) waiting times have been impacted throughout the Covid-19 pandemic due to reduced out-patient, diagnostic and theatre capacity as a result of social distancing in OP/diagnostics, compliance to IPC regulations in theatre, the loss of theatre capacity to support critical care expansion and patient choice (covid and non-covid related). The combination of these factors in addition to extreme operational bed pressures (leading to an increase in elective cancellations) has resulted in an increase the number of patients waiting in excess of 52 and 78 weeks and 24 months. The reduction in routine and suspected cancer referrals during 20-21 increases the risk that some of this unmet demand could present via emergency routes and lead to patients presenting with a later stage of cancer and lead to poorer outcomes.
476	Prescribed opioid dependency	There are significant numbers of people who have become dependent on prescribed opioid painkillers. Increasing doses no longer achieve adequate pain control and additionally present their own problems caused by the depressive nature of opioids causing lethargy, inability and loss of motor function, loss of interest in social interaction with friends and family and ability to work and damaging drug seeking behaviours. Treatment for drug dependence is complex and difficult. Whilst there are services to support people dependent on illicit drugs there is a lack of expertise and capacity to treat those dependent on prescribed drugs. Somerset has a higher than average rate of Opioid prescribing rate <Shaun Insert data>. Further more over recent years there have been high profile incidents where patients have died in relation to events surrounding their dependence (see the Somerset CCG Toft report recommendations and SEA Datix reference <Jonathan insert reference> Dependence on prescription medicines is linked to deprivation. Poor quality of life and increased demands on health and care services created by people dependent on prescribed opioids.	07/04/2021	15	(5) Will undoubtedly recur, possibly frequently	(3) Moderate	15	Strategy/ FFMF	Commissioning and Contracting	Prescribing Incentive Scheme to reduce prescribing of opioid pain killers. Recognised clinical risk with considerable clinical evidence and publication which does assist with shaping clinical prescribing practice, including Public Health England Review published September 2019 "Dependence and withdrawal associated with some prescribed medicines: An evidence review"	6	Although there are initiatives ongoing to reduce prescribing rates, there are significant numbers of people in Somerset dependent on prescribed opioids with inadequate support available to them to: - find better ways to manage their pain - improve the consequent adverse effects on their quality of life, health and wellbeing - reduce the continuing cost and demand on health and social care services

486	Community Equipment Stock Shortages	Shortages of community equipment are being experienced at the moment, including high volume items which support discharge, such as walking sticks, toilet seats and frames, walkers. This results from national supply chain issues.	25/06/2021		(4) Will probably recur, but is not a persistent issue	(4) Major	12	Operations	Impact on the safety of patient, staff or public (physical/psychological harm)	•Equipment Amnesty – including contacting care homes, home care providers, informing VCSE, village agents and health coaches •Review equipment grading criteria for items being recycled •Provider has already increased resources in their decontamination team to speed up the cleaning process. (It now takes 1 day instead of 2 or 3 days to process a piece of equipment) •Change communication to service users to remind the request a collection once the item is no longer required. •The provider is now collecting the low supply items as a matter of priority to help ease demand. •Hospital teams are working to improve the quality of the booking in and out at the peripheral stores, to keep a tighter control of the stock they have. •Musgrove OT team are working to improve the planning of hospital discharges to reduce the need for urgent deliveries (to pre-empt the need for equipment). •Millbrook are communicating weekly the stock status on Millflow Newsflash, to assist all teams with planning •In addition, there is an option to introduce a rota to support Millbrook to make decisions for equipment where demand outstrips supply, resulting in equipment being be issued by priority •Prescribers are being made aware of stock supply issues and are advised to inform service users of potential delays. * OT post in place to review back log of orders and support with prioritisation.	6	The current situation is affecting a number of pieces of equipment, the impact of out of stock items is potentially significant. However there are several controls in place to reduce the number of items impacted at anyone time and to reduce the likelihood.
498	Provision of obstetric and neonatal information for the assessment of Looked After children	A commissioning gap has been identified in respect of the provision of obstetric and neonatal information, collated on a British Associate of Adoption and Fostering, (BAAF) developed template, and utilised to inform the statutory Initial Health Assessment for looked after children and subsequently as part of The Adoption Agencies Regulations, (2005), health assessments for children who are being considered for adoption. This requirement is usually included in local Maternity Providers contracts but has not been included in Somerset to date.	26/07/2021	15	(5) Will undoubtedly recur, possibly frequently	(3) Moderate	15	Quality and Nursing	Statutory duty/inspections	Administrative and nursing support is now in place to support the adoption pathway	4	Yeovil District Hospital have begun to build a partly digital solution to provide obstetric and neonatal information to the adoption and CLA health assessment process. Somerset Foundation Trust have not yet had the capacity to begin this work. Next meeting to review progress scheduled for 31.01.2022.
499	Non-Emergency Patient Transport Service (NEPTS) Re-Procurement	The Somerset system (CCG & Somerset FTs) intends to secure new NEPTS ambulance provision. The Procurement Project Board has identified a number of risks associated with the new services: 1. Discharges, Transfers & Qualified Crew (Somerset only service) 2. Mental Health & Secure 3. Re-negotiated 'retained' E-zec Service The procurement is happening during the pandemic. Delays in process, reduced market interests, raised costs, reduced performance	27/07/2021	12	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	Finance, Performance and Contracting	Commissioning and Contracting	Project lead times that allow time to prepare, evaluation and mobilise new services Market engagement event to raise market interest and assess likely response Undertake robust financial modelling Consider levers and sanctions ref E-zec negotiations	4	Procurement plans have proceeded to plan. Reasonable quality data was obtained from SFT & YDH to inform the operational/financial modelling process. There appears to be reasonable market interest for the Discharge /Transfer /Qualified Crew lot but some concern around the Mental Health & Secure Lot. Bids close on 27.01.21., after which risks will be re-assessed. Contractual arrangements with E-zec have been signed off.
513	Delayed discharges of children looked after on acute paediatric wards in Somerset	Children Looked After, (CLA), remain inpatients on acute paediatric units in Somerset after they are deemed fit for discharge. This is because there is a national shortage of Local Authority funded social care beds available in the community. similarly here is a national shortage of therapeutic placements in the community for those children and young people who do not require a Tier 4 mental health bed.	20/01/2022		(5) Will undoubtedly recur, possibly frequently	(3) Moderate	15	Quality and Nursing	Impact on the safety of patient, staff or public (physical/psychological harm)	Daily multi agency meetings to review and monitor situation for each child Use of escalation process when required CCG provide support to both Trusts CAMHS Liaison and CAMHS Outreach working with individual children Local Authority provide support workers whilst child is an inpatient	9	There is a national shortage of high quality placements for CLA both nationally and locally. There are also an increasing number of CLA who require specialist therapeutic placements. There is a waiting list of CLA requiring placements at welfare secure units and there are over 50 children awaiting such a placement at any one time. In order to avoid admission to an acute paediatric bed CLA in crisis are also suffering long waits in Emergency Departments whilst Local Authorities attempt to find more suitable placements for them. Less suitable options are to place CLA in short term holiday accommodation and provide agency carers to support them whilst a search for more suitable placements are found. This is a very expensive alternative and rarely meets the child or young person's needs. It is not unusual for the Local Authority to approach over 200 providers to attempt to find a placement for a child and be unable to find one at the end of the search. Somerset County Council are working with their partners to commission two local properties to provide crisis accommodation and ensure children do no block beds on acute paediatric wards but these are not likely to be in place until August 2022 at the earliest. In the meantime whenever a child's s placement is at risk or has broken down the CCG works with SCC and its partners to find an early and safe alternative that does not involve a paediatric admission unless of course the CLA's presenting health needs require this.
485	Impact of Weston Hospital Activity on the Somerset System	1 - Impact of increased demand in attendances at Weston Hospital 2 - Staffing risks impacting on patient flow	16/06/2021		(4) Will probably recur, but is not a persistent issue	(4) Major	16	Operations	Impact on the safety of patient, staff or public (physical/psychological harm)		9	Discussed at CEC on 2 June 2021 28/7/21 - agreed to keep scoring the same to be assured that BNSSG are putting actions in place. 17/01/22 - agreed to keep scoring the same until next review
501	Somerset ICS Transition	The CCG does not take the necessary steps to be established as ICS NHS body within the new Somerset ICS system by July 2022. The CCG does not take the necessary steps to become established as an ICS NHS body within the new Somerset ICS system by April 2022. this includes the appropriate closedown activities and transfer activities in respect of the CCG.	10/09/2021		(3) May recur occasionally	(4) Major	12	Operations	Statutory duty/inspections	Development of ICS constitution - structure and decision making processes etc. Completion of required due diligence People transition, HR process to support transition Appointment and recruitment process for chair and senior leadership roles Transfer of functions to NHS ICS Body including NHS E/I functions	4	Work programme well established. Risks have been identified due to delay in establishment date. Further national guidance awaited due to change in timescales. Therefore we don't expect there to be any issues but until the full guidance is released, it is a possibility there may be delays in some of the work areas.