

Report to the NHS Somerset Clinical Commissioning Group on 30 June 2022

Title: Risk Management Update Report	Enclosure H
---	------------------------

Version Number / Status:	1
Executive Lead	James Rimmer – Chief Executive and System Lead
Clinical Lead:	Kathy French - Director of Quality and Nursing
Author:	Mustafa Kahn - Risk Lead Officer

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 14/06/2022) since the full review by Governing Body in March 2022.

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 THE CORPORATE RISK REGISTER IN PERIOD

There were no risks added to the Corporate Risk Register in this period.

RISKS CLOSED ON THE CORPORATE RISK REGISTER IN PERIOD

ID	TITLE	DESCRIPTION OF RISK	RATIONALE FOR CLOSURE	CURRENT RATING
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	Procurement plans have proceeded to plan. Reasonable quality data was obtained from SFT & YDH to inform the operational/financial modelling process.	Risk closed

RISKS DE-ESCALATED FROM THE CORPORATE RISK REGISTER IN PERIOD

ID	TITLE	DESCRIPTION OF RISK	RATIONALE FOR DE-ESCALATION	CURRENT RATING
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.	Work programme well advanced with all national guidance received and Royal Assent granted to new Health and Care bill. On trajectory for CCG to complete all due diligence activities by end June 2022.	8 (reduced from 12)

RISKS REDUCED WITHIN THE CORPORATE RISK REGISTER IN PERIOD

ID	TITLE	DESCRIPTION OF RISK	RATIONALE FOR REDUCTION	CURRENT RATING
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.	Health assessment performance is slowly improving, March 2022 IHA performance was 87% against a target of 90%. There are still some gaps to address, hence the decreased risk score of 12.	12 (reduced from 15)
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.	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. QOF covering all six health checks for 2021/22 is expected to positively impact delivery.	12 (reduced from 16)

486	Community Equipment Stock Shortages	Shortages of community equipment are being experienced, including high volume items which support discharge, such as walking sticks, toilet seats and frames, walkers. This results from national supply chain issues.	There are several controls in place to reduce the number of items impacted at anyone time and to reduce the likelihood.	12 (reduced from 16)
-----	-------------------------------------	--	---	-------------------------

RISKS ESCALATED TO THE CORPORATE RISK REGISTER IN PERIOD

ID	TITLE	DESCRIPTION OF RISK	RATIONALE FOR ESCALATION	CURRENT RATING
493	SEND Joint Commissioning	Ofsted Inspection March 2020 said our Joint commissioning in Somerset with the Local Authority is limited and in its infancy with poor joint commissioning arrangements that limit leaders' ability to meet area needs, improve outcomes and achieve cost efficiencies.	Audit report recommendations identified weaknesses in processes and operational performance relating to SEND.	12 (increased from 8)
19	Quality Innovation Productivity and Prevention (QIPP) Savings	Failure to achieve cost improvement plans fails to release cash savings for in year budget and sustainable models of care.	The Somerset system is reviewing its underlying position post 2022/23 and as part of this are ensuring as much recurrent Cost Improvement Plan/QIPP is delivered in 2022/23 to reduce impact on future years.	16 (increased from 8)

RISKS INCREASED WITHIN THE CORPORATE RISK REGISTER IN PERIOD

There were no risks on the Corporate Risk Register with an increased score in this period.

CORPORATE LEVEL RISKS (inclusive of part A and Part B risks)
5x5 Matrix heat map showing overview of ratings for all Corporate Risks

March 2022

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				

June 2022

Controlled Current Risk: Corporate - 65

Severity	5	0	0	0	0	1
	4	0	2	5	12	2
	3	0	1	15	10	3
	2	0	2	5	5	0
	1	1	1	0	0	0
		1	2	3	4	5
		Likelihood				

CORPORATE LEVEL RISKS BY DOMAIN

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

June 2022

Domain Name	Total	12	15	16	20	25
A. Impact on the safety of patient, staff or public (physical / psychological harm)	14	8	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	3	1	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	2	1	0	1	0	0
H. Service / business interruption. Environmental impact	1	0	0	1	0	0
I. Contracting and Commissioning	1	0	1	0	0	0

CORPORATE LEVEL RISKS BY CCG DIRECTORATE

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

June 2022

CCG Directorate	Total	12	15	16	20	25
Quality & Nursing	6	2	1	2	0	1
Operations	19	12	1	4	2	0
Finance, Performance and Contracting	8	1	1	6	0	0
FFMF Strategy	0	0	0	0	0	0
Managing Director's / Chairman's Office	0	0	0	0	0	0

SOMERSET CCG - CORPORATE RISK REGISTER MAY 2022 Part A

ID	Statement of Risk	Opened	Likelihood (current)	Consequence (current)	Rating (current)	Controls in place	Rating (Target)	Current Rationale
9	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	(4) Will probably recur, but is not a persistent issue	(4) Major	16	<p>Collaborative</p> <ol style="list-style-type: none"> Somerset Surge planning group - fortnightly Escalation Calls - twice weekly/OPEL increased. Somerset Urgent Care Operation Group and Somerset A&E Delivery Board. <p>Preventative:</p> <ol style="list-style-type: none"> Rapid Response service - Intermediate Care Service team support to enable patients to remain at home. GP 999 Car - hospital avoidance scheme Monitor and Review Framework - Somerset OPEL framework. Clinical Assessment Service Revalidation - Devon Doctors 	8	<p>16.06.21 - Reviewed scoring to remain at 16 due to increased demand in activity across all UEC</p> <p>28/7/21 - agreed to leave scoring at 16</p> <p>12/01/22 - agreed to leave scoring at 16</p> <p>21/03/22 - agreed to leave scoring at 16</p> <p>09/05/22 - Reviewed and agreed that risk rating remains the same.</p>
10	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 the constitutional standards, 2022/23 Operational Plan, NHS Single Oversight Framework and the 5 Year Long Term Plan with the emergence of further access challenges as a consequence of the Covid-19 pandemic and increased unscheduled (emergency in-patient) demand.	09/05/2013	(4) Will probably recur, but is not a persistent issue	(4) Major	16	<p>Collaborative:</p> <ol style="list-style-type: none"> System Assurance group ICS. CCG Governing Body. CCG F&P and PSQ committee(s) and Quality Surveillance Group ICS Execs meeting. A&E, Elective care and Cancer delivery boards Contract and performance meetings. Activity and Performance meeting <p>Preventative:</p> <ol style="list-style-type: none"> H1 Operational Plan SWAG Alliance Plans 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 and continue to be 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 22/23 or long wait patients from the active diagnostic waiting list could present via an emergency (A&E) route.
19	<p>Failure to achieve cost improvement plans fails to release cash savings for in year budget and sustainable models of care.</p> <p>Providers in year Cost Improvement Plans (CIP) reviewed and agreed at system wide level as part of Annual Operating Plan.</p> <p>Risk of overspend or reduction in services if providers and commissioners are unable to identify and deliver QIPP workstreams impacting the financial sustainability of health services within Somerset.</p>	29/07/2013	(4) Will probably recur, but is not a persistent issue	(4) Major	16	<p>The Somerset system has submitted a balanced Financial Plan for 2022/23, aside from excess non pay inflation pressures and quarter 1 covid-19 cost pressures, which are currently classed as accepted variances.</p> <p>The system finance group are monitoring the progress against the systems savings programme on a monthly basis.</p> <p>The system is reviewing its underlying position post 2022/23, and as part of this are ensuring as much recurrent CIP/QIPP is delivered in 2022/23 to reduce the impact on future years.</p>	8	<p>The Somerset system has submitted a balanced Financial Plan for 2022/23, aside from excess non pay inflation pressures and quarter 1 covid-19 cost pressures, which are currently classed as accepted variances.</p> <p>The system finance group are monitoring the progress against the systems savings programme on a monthly basis.</p> <p>The system is reviewing its underlying position post 2022/23, and as part of this are ensuring as much recurrent CIP/QIPP is delivered in 2022/23 to reduce the impact on future years.</p>
25	The CCG fails to meet the integrated performance monitoring targets as outlined in the constitutional standards, 2022/23 Operational Plan, NHS Single 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 (onicro) and extreme operational bed pressures as a result of increased non-covid in-patient demand.	29/07/2013	(4) Will probably recur, but is not a persistent issue	(4) Major	16	<p>Collaborative:</p> <ol style="list-style-type: none"> System Assurance group ICS. CCG Governing Body. CCG F&P and PSQ committee(s) and Quality Surveillance Group ICS Execs meeting. A&E, Elective care and Cancer delivery boards Contract and performance meetings. Activity and Performance meeting <p>Preventative:</p> <ol style="list-style-type: none"> H1 Operational Plan SWAG Alliance Plans Local and external improvement / transformation plans and trajectories 	9	<p>For some considerable time Somerset patients have waited longer for their first definitive treatment resulting in backlogs across a range of specialities/modalities. These legacy backlogs have been further compounded during 2021/22 by the Covid-19 pandemic due to the reduction in Out Patient, Diagnostic and Theatre capacity throughout this period. Whilst capacity has been largely restored there remains a residual covid impact with activity not reaching the levels delivered in 2019/20. In recent months capacity has been further impacted by the extreme operational pressures (underpinned by a significant increase in the volume of patients in hospital with No Criteria To Reside) and an increase in operations cancelled at short notice.</p> <p>As referrals restore (and are sustained) at or close to pre pandemic levels and if the volume of patients with No Criteria To Reside do not reduce there is a significant risk that these backlogs will continue to accumulate and performance will continue to be impacted due to the limitation of delivering activity levels akin to 2019/20 or additional non-recurrent capacity. Other risks to delivery are the workforce constraints across a number of the specialities / diagnostic modalities due to the level of vacancies or short term issues due to staff isolation and an increase in unexpected emergency demand as a result of unmet demand from 20/21.</p>

143	<p>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.</p> <p>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.</p> <p>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.</p> <p>Inability to meet national standards for dermatology services.</p>	30/01/2015	(3) May recur occasionally	(4) Major	12	<ol style="list-style-type: none"> 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 <p>Collaborative:</p> <ol style="list-style-type: none"> 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	<p>This risk is an overarching view of Dermatology. The rating matches the risk rating for the other, more specified dermatology risks.</p> <p>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.</p> <p>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</p>
212	<p>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.</p> <p>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.</p>	07/03/2016	(5) Will undoubtedly recur, possibly frequently	(5) Catastrophic	25	<ol style="list-style-type: none"> 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	<p>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.</p>
222	<p>Over a number of years, planning for primary care workforce did not deliver the required capacity against primary care activity.</p> <p>There were specific drivers of the risk including national changes to pension and tax rules.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This risk is not in relation to a particular practice, it's relating to local GP workforce sustainability in general."</p> <p>Demands for primary care services have significantly increased as a result of the COVID19 pandemic eg COVID vaccination programme, backlogs in primary care activity, managing patients who are awaiting secondary care activity.</p>	23/01/2017	(4) Will probably recur, but is not a persistent issue	(4) Major	16	<p>Primary Care Workforce overseen by The People 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 use reflects current pressures on a weekly basis.</p>	12	<p>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.</p>

248	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	(3) May recur occasionally	(4) Major	12	<p>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.</p> <p>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.</p> <p>The latest local data suggests that performance is circa 60% on the new definition, and almost 30% on the 2 contacts definition.</p>	8	<p>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.</p>
255	<p>Ambulance staff vacancy rate, being mitigated through recruitment campaign and rota re-alignment to better match service demand.</p> <p>Under-performance against Category 1 and Category 2 Mean and 90th Percentile target. Ambulances may not reach the patient within a timely manner.</p> <p>Breach of Category 1 and Category 2 SWASFT Ambulance Response Performance (ARP) standard.</p>	01/02/2018	(4) Will probably recur, but is not a persistent issue	(4) Major	16	<p>Collaborative:</p> <ol style="list-style-type: none"> 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. <p>Preventative:</p> <ol style="list-style-type: none"> 8. Our people plan - SWASFT workforce plan. 9. Mental Health Directory of Service revision. 10. GP 999 Car provision. 	6	<p>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.</p> <p>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</p> <p>It was agreed to not change the Risk score on due to the following:</p> <ol style="list-style-type: none"> 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 <p>12/01/22 - Risk discussed and scoring to remain the same, due to ongoing staffing pressures around staff abstractions and fatigued staff</p> <p>21/03/22 - Risk reviewed and remains the same - Cat 1 & 2 response times continue to deteriorate, leading to patient safety incidents</p> <p>09/05/22 - Reviewed and agreed that risk rating remains the same - Cat 1 & 2 response times continue to deteriorate, leading to patient safety incidents.</p>
285	The CCG fails to meet the cancer access target (2 week, 31 and 62 day and 28 day faster diagnosis standards), constitutional standards, 2022/23 Operational Plan, NHS Single 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	(4) Will probably recur, but is not a persistent issue	(4) Major	16	<p>Collaborative:</p> <ol style="list-style-type: none"> 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 <p>Preventative:</p> <ol style="list-style-type: none"> 8. H1 Operational Plan 9. SWAG Alliance Plans 10. Local and external improvement / transformation plans and trajectories 	9	<p>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 distancing and enhanced IPC measures remaining in place to some extent and 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.</p> <p>The extreme operational pressures have further compound waiting times and access to timely treatment as a result of the extreme operational pressures and across SFT and YDH there were 249 patients (as at 5/5/22) with No Criteria To Reside which is impacting upon elective bed capacity. This has led to an increase the number of patients waiting in excess of 62 and 104 days for their first definitive cancer treatments (against the 62 day standard). To ensure delivery of the elective activity plans (including cancer) an ambitious reduction plan has been agreed across the System to deliver a 72.6% reduction the volume of patient with No Criteria To Reside (-204) by September 2022.</p>
292	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	(4) Will probably recur, but is not a persistent issue	(4) Major	16	<p>Collaborative:</p> <ol style="list-style-type: none"> 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 <p>Detective:</p> <ol style="list-style-type: none"> 4. Independent review workforce analysis conducted to inform LWAB and local providers with recommendations. <p>Preventative:</p> <ol style="list-style-type: none"> 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	<p>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 oversea's nurse recruitment. Apprentice force programme is also on track, therefore risk reduced to 12.</p> <p>Increase in risk due to challenges in recruitment to acutes, primary care and social care. System wide issues.</p>

318	<p>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.</p> <p>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.</p>	20/05/2019	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	<p>Provision of additional 2 WTE Band 6 CLA nurses in post from May 2022</p> <p>Improved scrutiny of health assessment pathway and targeting of assessments that are likely to be late</p> <p>Improved accuracy in performance data</p> <p>Improved multi agency collaborative working</p>	8	<p>Health assessment performance is slowly improving, March 2022 IHA performance was 87% against a target of 90%. There are still some gaps to address, hence the decreased risk score of 12.</p>
327	<p>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.</p> <p>There is a risk to patient safety and wellbeing if a person is deprived of their liberty without the authorisation of due legal process.</p> <p>There is also a risk of a breach of CCG duties, breach of articles 5 and 8 of the Human Rights Act, along with financial claims all arising from the inability to implement the Liberty Protection Safeguards (LPS).</p>	15/08/2019	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	NA	6	<p>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.</p> <p>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.</p> <p>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</p> <p>9.5.22 draft code now out for consultation but implementation date not being released until after end of consultation period, unclear still when implementation will occur. CCG LPS business case declined - no funding allocated for 22/23 for new statutory requirements for CCG Responsible Body duties - health system partners already secured funding and recruited to LPS posts so no system wide solution available.</p>
363	<p>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.</p>	02/09/2019	(5) Will undoubtedly recur, possibly frequently	(4) Major	20	<ol style="list-style-type: none"> 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 IUCS) 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 IUCS) to support shift fill live from June 2021 8. 12 week Clinical Workforce Plan completed 	9	<p>CCG expect performance to be consistently over 80% overall shift fill before risk can be reduced.</p> <p>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.</p> <p>Following RMG in June, it was decided this risk should be a 12.</p> <p>CCG expect performance core shift fill to be consistently above 80% overall shift fill before risk can be reduced.</p> <p>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</p> <p>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</p> <p>09/05/22 - Reviewed and agreed that risk rating remains the same.</p>
364	<p>Delay in out-of-hours - triage 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.</p>	02/09/2019	(5) Will undoubtedly recur, possibly frequently	(3) Moderate	15	<p>Collaborative:</p> <ol style="list-style-type: none"> 1. Touch point calls - weekly with CQC, Devon Doctors and Devon CCG. 2. Contract review meeting with Devon Doctors. <p>Preventative:</p> <ol style="list-style-type: none"> 2. CQC improvement plan - performance and quality. 3. Clinical recruitment plan. 4. Integrated Urgent Care lead clinician with the Clinical Advisory Service. 	9	<p>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.</p> <p>28/7/21 - agreed to increase the scoring of this risk to 15 due to, triage performance, fluctuating home visit performance</p> <p>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</p>

405	<p>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.</p> <p>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.</p> <p>Physical health needs not being met for vulnerable groups.</p>	10/06/2020	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	<p>Preventative:</p> <ol style="list-style-type: none"> 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 continued into 2022/23 <p>Collaborative:</p> <ol style="list-style-type: none"> 4. Multi-directorate programme board established with 3 underpinning working groups. 5) Touch points meetings with NHSEI. 6) Regular reporting 	6	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>
406	<p>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.</p> <p>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)</p>	10/06/2020	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	<p>Preventative:</p> <ol style="list-style-type: none"> 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. <p>Collaborative:</p> <ol style="list-style-type: none"> 5. MHLDA cell and public health meetings. 6. CCG and NHSEI/ 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	<p>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.</p> <p>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.</p> <p>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.</p>
409	<p>There is a risk that suicides will increase as a result of COVID 19 and its longstanding aftermath.</p> <p>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.</p>	10/06/2020	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	<p>Collaborative:</p> <ol style="list-style-type: none"> 1. Suicide prevention strategic partnership board (quarterly). <p>Preventative:</p> <ol style="list-style-type: none"> 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	<p>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.</p>
413	<p>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.</p> <p>Patients with complex needs are accessing care in which the CCG does not have sufficient oversight of the quality of care provision</p>	12/06/2020	(3) May recur occasionally	(4) Major	12	<p>Preventative:</p> <ol style="list-style-type: none"> 1) Patients with complex needs (inc. S117 provision) Proposal. <p>Collaborative:</p> <ol style="list-style-type: none"> 2) Complex case panel. 	6	<p>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.</p> <p>Proposal under discussion to move to a more integrated approach with local authority, SFT and CCG sharing the risk and activities.</p> <p>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</p>

425	<p>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.</p> <p>Inability to maintain quality of service for ADHD and ASC.</p>	12/06/2020	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	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	<p>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.</p> <p>Spread of COVID as a result of health and care service delivery - meaning spread of COVID infection for people working, visiting or staying overnight in a health or care setting</p> <p>Full testing in Acute services and partial in other services.</p> <p>There is a difference between how a cluster and an outbreak is defined.</p> <p>Inadequate infection prevention and control measures for community and acute settings.</p>	15/06/2020	(4) Will probably recur, but is not a persistent issue	(4) Major	16	<p>Collaborative.</p> <ol style="list-style-type: none"> Quarterly IPC Committee Fortnightly huddles with DIPC Fortnightly operational IPC leads meetings across system Weekly COVID19 Health Protection Board across system. Members of IPC SW Steering group. Attendance to outbreak meetings and IMTs Vaccination programme across the community and health care sector. <p>Preventative</p> <ol style="list-style-type: none"> PHE guidance on the use of PPE for staff and where appropriate for patients and visitors in health and care settings. Protocol for Restriction of non-essential visitors to health and care settings. Protocol for the Practice of social distancing principles, especially where PPE is not being used in health and care settings. IPC strategy Outbreak management plans (from providers) Infection Prevention Control (IPC) action plan IPC Workforce capacity increase. COVID19 vaccination programme. 	12	<p>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 reviewed bi-weekly.</p>
449	<p>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, 78 and 104 weeks. These access standards are outlined within the NHS Constitution, Single Oversight Framework, 22/23 operational and 5 Year Long Term Plan guidance. RTT access issues due to the Covid-19 pandemic have further compounded the legacy backlog.</p>	29/09/2017	(4) Will probably recur, but is not a persistent issue	(4) Major	16	<p>Collaborative:</p> <ol style="list-style-type: none"> System Assurance group ICS. CCG Governing Body. CCG F&P and PSQ committee(s) and Quality Surveillance Group ICS Execs meeting. A&E and Elective care delivery boards Contract and performance meetings Activity and Performance meeting Adherence to prioritisation according to the Royal College of Surgeons Prioritisation Guidance to ensure patients are treated in order of urgency to avoid harm Weekly review of the Patient Treatment List (PTL) to review urgency and escalation of any patients identified as at risk of clinical harm Adherence to new RTT MDS dashboard 	9	<p>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 which is underpinned by a significant increase in the volume of patients with No Criteria to Reside (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.</p>
476	<p>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.</p> <p>Providing more support for people who have inadvertently become dependent on opioid painkillers will help them with managing their condition/s in regard of pain control and overall health and wellbeing and reduce escalating demand and cost on health and social care services. It will for most people significantly improve their quality of life and their immediate circle of social contacts.</p> <p>To prevent the increasing incidence of prescribed opioid dependence there needs to be changes in clinical practice to ameliorate the growth of inadvertent prescribed opioid dependence.</p>	07/04/2021	(5) Will undoubtedly recur, possibly frequently	(3) Moderate	15	<p>Prescribing Incentive Scheme to reduce prescribing of opioid pain killers.</p> <p>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"</p>	6	<p>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:</p> <ul style="list-style-type: none"> 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
485	<p>1 - Impact of increased demand in attendances at Weston Hospital</p> <p>2 - Staffing risks impacting on patient flow</p>	16/06/2021	(4) Will probably recur, but is not a persistent issue	(4) Major	16		0	<p>Discussed at CEC on 2 June 2021</p> <p>28/7/21 - agreed to keep scoring the same to be assured that BNSSG are putting actions in place.</p> <p>17/01/22 - agreed to keep scoring the same until next review</p> <p>21/03/22 - reviewed and agreed to keep the risk scoring the same</p> <p>09/05/22 - Reviewed and agreed that risk rating remains the same, as still seeing ongoing impact from the Weston position.</p>

486	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	(3) Moderate	12	<ul style="list-style-type: none"> •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 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 any time and to reduce the likelihood.
493	<p>"Ofsted Inspection March 2020 said our Joint commissioning in Somerset with the Local Authority is limited and in its infancy with poor joint commissioning arrangements that limit leaders' ability to meet area needs, improve outcomes and achieve cost efficiencies.</p> <p>We have started work to develop systems and processes to improve governance and move things forward, but this is taking longer than it should.</p> <p>This means that, in a period of declining budgets, opportunities to pool resources to tackle areas of need in the area are underutilised.</p> <p>"</p>	20/07/2021	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	<p>"</p> <ul style="list-style-type: none"> • In September 2020 CCG and LA commissioned and independent review by Institute for Public care (IPC) • Updated Joint commissioning Sub group of WSOA IP4 with representatives for health, social care and education. • Detailed plan in WSOA monitored by SEND Improvement Board • Agreement to explore a shadow budget <p>Update CCG Governing body at Development session on 25 Feb 2021</p> <p>"</p> <ul style="list-style-type: none"> * Joint CCG and LA workplan drafted and currently being shared with key stakeholders • Established review of shadow budget and further work to define the scope of the budget. • Ongoing work to establish scope of Children's joint commissioning team • Current CAMHS out of scope to be discussed with MH Team potential opportunities <p>"</p>	12	<p>"</p> <ul style="list-style-type: none"> • In September 2020 CCG and LA commissioned and independent review by Institute for Public care (IPC) • Updated Joint commissioning Sub group of WSOA IP4 with representatives for health, social care and education. • Detailed plan in WSOA monitored by SEND Improvement Board • Agreement to explore a shadow budget <p>Update CCG Governing body at Development session on 25 Feb 2021</p> <p>"</p>
498	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	(5) Will undoubtedly recur, possibly frequently	(3) Moderate	15	Administrative and nursing support is now in place to support the adoption pathway	2	Recruitment to the WREN team ongoing. Once this has taken place and the new post holder is in place it is expected that this information will be provided in line with a Service Development and Improvement Plan and the risk will begin to decrease.

512	<p>Outcomes for people who attend A&E frequently are worse than the general population, with higher mortality and greater dissatisfaction due to unmet needs. This group of patients may not receive the appropriate care, be signposted correctly or engage with appropriate services and add unnecessarily to the demand on both the ambulance and unscheduled care services. In turn this impacts upon the availability of services within our communities. Less than 1% of England population attends A&E more than 5 times however a recent study outlines that this cohort account for 29% of all ambulance arrivals at A&E, 26% of all Emergency Admissions, 16% of all visits to A&E and 2% of all inpatient bed days. The Ubuntu service is currently in place however this is a small and limited service who are only able to support a small cohort of patients (currently 32 on the project). Recurrent funding has been received to fund this on an ongoing basis but developing an enhanced service would be able support more patients.</p> <p>Given the challenges in the system with high demand into UEC services, there is a requirement to ensure that people use services appropriately and are supported to do this, therefore this service is vitally important. Without recurrent funding for this service, there will be no provision in place to support these users and will therefore result in additional use of UEC services. There is an opportunity to explore an enhanced service for the Somerset System, to support a larger quantity of our High Intensity Users, if additional funding could be made available. This is a high profile area of work and included on the SWAST Transformation Plan as a priority focus for all systems.</p>	19/01/2022	(4) Will probably recur, but is not a persistent issue	(3) Moderate	12	Ubuntu service has received recurrent funding to continue to support patients. Weekly meetings are in place.	6	<p>10/02/22 - during October - December 21, HIU accounted for 1708 calls to SWAST, which subsequently accounted for over 2141 hours of resource time and 139 hours of call handler time, this will have an impact on call answering time for other patients in the community and Ambulance Response Times (ARP). In 2020/21 HIU accounted for 20,983 A&E attendances 8,427 admissions which is having an impact on ongoing system pressures.</p> <p>21/03/22 - Reviewed and risk scoring to remain the same, as waiting the outcome of the HIU Business Case</p> <p>10/05/22 - Reviewed and risk to remain at 12. Funding has been secured to continue to support the ubuntu service however the High Intensity User Network group identified that an enhanced service would better support the population.</p>
524	<p>There is a financial risk to the CCG due to not having provision in place to monitor policies, protocols and precedents that need clarification in relation to children with complex needs which sit outside of business as usual (including SEND). Resulting in escalating costs to the CCG</p>	09/02/2022	(3) May recur occasionally	(4) Major	12	Business case being submitted to support a designated medical officer role to support tribunal, EHCP medical advice and monitor plans for children with complex needs from a medical perspective.	8	Business case being submitted to support a designated medical officer role to support tribunal, EHCP medical advice and monitor plans for children with complex needs from a medical perspective.
536	<p>There is a risk that the quality and safety of maternity and neonatal services will be compromised due to the upcoming merger of SFT and YDH resulting in potential increased poor outcomes for women and babies. Notes- Reporting of Serious incidents - SFT</p>	25/04/2022	(3) May recur occasionally	(4) Major	12	To be updated	12	To be updated