Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

BNSSG CCG Governing Body Meeting

Date: Tuesday 6th April 2021
Time: 2.00pm
Location: Virtual meeting. Details within the calendar invite

Agenda Number :	9.1
Title:	Corporate Risk Register (CRR) March 2021
Purpose: approval	
Key Points for Discussion:	
• The risks rated at 20 and above on the CRR • New risks added to the CRR since the last review by the Governing Body • The risks recommended to Governing Body for removal and the confirmation of the relevant committees that they are assured that the actions have been sufficient to reduce the risk score • The proposal to delay the move to a new template	
Recommendations:	The Governing Body is asked to review the CRR and approve: • The addition to the CRR of the risks detailed • The removal from the CRR of the risks detailed
Previously Considered By and feedback :	The Corporate Risk Register is reviewed monthly by Directors and received and discussed at the monthly Quality Committee, Strategic Finance Committee and Clinical Executive meetings
Management of Declared Interest:	The Committee receives a register of its members declared interests as a standing item. There are no declared interests relating the CRR and no risks regarding the management of declared interests
Risk and Assurance:	The CRR shows the current position of those risks scored at 15 and over using the 5x5 risk scoring matrix
Financial / Resource Implications:	As part of the Risk Management Strategy the risk register is used to report the impact of risks including financial risks A moderation stage is used to ensure consistency in reporting financial risks across the CCG. Financial risks reported on Directorate Risk registers are reviewed corporately and an impact risk score, as described below is applied. If the risk score is reduced, the risk is not added to the CRR and the Directorate is informed. The budget baseline applied is the CCG overall resource allocation.

Score	Impact
1	small loss/risk of claim remote

	2	Loss of 0.1% to 0.25% of budget (£1m to £3.5m)
	3	Loss of 0.25 % to 0.5% of budget (£3.5m to £7m)
	4	Loss of 0.5% to 1% of budget (£7m to £14m)
	5	Loss of > 1% of budget (£14m+)
Legal, Policy and Regulatory Requirements:	The CRR is a mechanism for reporting risk and does not have legal implications. Where there are risks relating to legal and regulatory matters these are reported on the CRR	
How does this reduce Health Inequalities:	No health inequalities issues arise from this report. The Corporate Risk Register reports significant risks; where there are risks related to Health Inequalities that are over the risk scoring threshold of 15 and above these will be reported on the register.	
How does this impact on Equality & diversity	No inequalities issues arise from this report, and there is no impact upon people with protected characteristics. The Corporate Risk Register reports significant risks; where there are risks related to equalities that are over the risk scoring threshold of 15 and above these will be reported on the register.	
Patient and Public Involvement:	Not applicable to this report	
Communications and Engagement:	The Corporate Risk Register is shared with Risk Leads, Risk Administrators and Directors for monthly updating. The Corporate Risk Register is a public document available on the CCG website	
Author(s):	Sarah Carr, Corporate Secretary	
Sponsoring Director / Clinical Lead / Lay Member:	Sarah Truelove, Chief Financial Officer	

Agenda item: 9.1

Report title: Corporate Risk Register (CRR) March 2021

1. Background

The Corporate Risk Register (CRR) provides assurance to the Governing Body that high level risks are addressed and that the actions taken are appropriate. Where a risk is linked to one or more of the CCGs principle objectives this is identified on the register. The Governing Body is responsible for ensuring that the CCG has properly identified risks and has appropriate controls in place to manage risk. The Governing Body approves the addition and removal of risks from the CRR.

Directorate Risk Registers are reviewed and updated monthly. These feed into the CRR, which is discussed by the Executive as a standing item once a month. Each committee also reviews the CRR. The committees are reminded of their responsibility to review, scrutinise and challenge the management of risks specific to their remit. Committees are asked to consider whether they have a reviewing role in relation to any new risks added to the register; committees are also asked to assure themselves that risks recommended for removal have been appropriately reviewed and risks scores are revised appropriately. The Audit, Governance and Risk Committee receives the CRR as part of its responsibility to satisfy itself that systems and processes are in place and working. The Executive team has identify executive risk leads for specific areas. Executive risk leads review risks alongside director leads to ensure complete coverage of issues and avoid potential duplications.

1. Corporate Risk Register

Those risks rated at 20 and above on the CRR are highlighted below:

ref	risk description	current risk score	Date added
BNSSG Commissioning 7	There is a risk that the extent of change/improvement required in AWP as our core mental health provider is not addressed, impacting on the care and services provided to the BNSSG population. This risk includes the challenges of the current crisis pathway that could be more effective - currently there are a high number of people placed out of area, high numbers of people on a Section in hospital and increasing pressure on the crisis team's ability to respond.	**4x5 =20**	1.05.20
BNSSG Commissioning 10	Risk of failure to recover 52 week wait performance, which has wider implications due to the potential for patient harm. There is a financial risk for the system due to the 19/20 contract stating that all 52 week breaches will incur a fine which will be divided between CCG and Provider of £5000	**4x5 =20**	1.05.20

	per patient per month. One patient could incur multiple fines. The risk of 52 week wait breaches has significantly increased due to the pausing of all routine activity in response to the Covid outbreak, and recovery will be slower due to the additional IPC requirements and continued reduction in routine activity.		

Two risks previously scored as 20 on the CRR which have been reviewed and the risk score reduced are detailed below.

ref	risk description	current risk score	new risk score
BNSSG Commissioning 11	Cancer patients are at risk of potential harm if there are delays in the cancer pathway. There is an increased risk for cancer patients as a result of the Covid pandemic- due to reduced referral levels which may result in later presentations, reduced access for some tests- especially endoscopy and issues of balance of risk for patients who are shielding.	**4x5 =20**	**4x4=16**
BNSSG Commissioning 36	As a result of long wait times for diagnostic tests and failure to meet the DMO1 standard in endoscopy, CT and MRI there is a risk of harm to patients as a result of delayed diagnosis. There is an increased risk of delay in diagnostics due to the Covid pandemic. This is due to a combination of reduced efficiency due to IPC procedures and workforce issues and capital/ space issues. The risk score for this risk has been reduced to 16	**4x5 =20**	**4x4=16**

2. Updates to the Corporate Risk Register

Risks added to the CRR are highlighted in red text on register. Updates to the CRR made since its last review are highlighted in blue on the register. Since the January review of the CRR by the Governing Body and PCCC five risks have been added to the CRR.

ref	risk description	current risk score	Committee
BNSSG Commissioning	There is a risk of increasing health inequality in patients with cancer or at risk of cancer because of potential differences in delayed diagnosis and poor outcomes across different	4x4=16	Quality Committee

42	population groups. Our understanding of this risk is still developing as local and national data is gathered and analysed.		
commissioning	RISK SCORE HAS INCREASED AND IS NOW REPORTED ON CRR There is a risk that due to poor data quality at Weston hospital that performance data for all services may not be accurate. This could result in lack of oversight of genuine wait times for planned care pathways and urgent care performance and activity.	4x4=16	Clinical Executive
transformation-	RISK SCORE HAS INCREASED AND IS NOW REPORTED ON CRR As a result of COVID19, there is a risk that delivery of the Long Term Plan deliverables and goals will not be achieved, and impacts cannot be measured, which may result in increasing delays, poor experience and poor value care.	5x3=15	tbc
transformation-	RISK SCORE HAS INCREASED AND IS NOW REPORTED ON CRR As a result of patients not presenting to services early There is a risk that patients will present at a later stage of cancer Which may result in patients requiring more extensive treatment and patients will not be given the best chance of survival Long Term Plan target = 75% of cancers are diagnosed at stage 1 and 2 by 2028. In 2017 of those cancers which were staged 56% were stage 1 and 2	4x4=16	tbc
Area Teams	RISK SCORE HAS INCREASED AND IS NOW REPORTED ON CRR As a result of delays to the mobilisation of the Sirona community contract due to COVID-19 and the variability of maturity of integrated partnership development across localities, there is a risk that the activation of integrated frailty service provision may be delayed in BNSSG, which may affect the realisation of benefits set out in the Integrated Frailty business case	**5x3=15**	Clinical Executive

Risks where risk scores have been reduced to below the threshold of the CRR are given below. In each case the committee with oversight confirmed that it had been assured regarding the review and revision of the risk score.

ref	risk description	current risk	Committee

		score	
commission	National outbreak of Influenza Pandemic leading to up to 50% of population affected across the country making it a national catastrophic incident February 2021: mitigation in place through seasonal influenza vaccination programme. Circulating flu figures remain low. At present this risk is reducing in nature.	3x4=12	Clinical Executive
BNSSG Commissioning 18	EU Exit (Brexit) D20 (December 2020) EU transition • Supply of medicines and vaccines; • Supply of medical devices and clinical consumables; • Supply of non-clinical consumables, goods and services; • Workforce; • Reciprocal healthcare; • Research and clinical networks • Data sharing, processing and access. Deal signed 24/12/2020.	3x4=12	Clinical Executive
-	As a result of COVID-19 there is a risk that some transformation programmes will be delayed, with the result that we will not meet our 5 year plan objectives in some areas This risk was reviewed by the Executive Team 20.01.21 and it was agreed that the risk was now covered in individual risks reported on both CRR and DRRS and through the GBAF. It was agreed to recommend the risk was closed	**1x4=4**	Clinical Executive
Transformation CYP	The EOI for the mental health support teams was submitted in March 2020 including each of the 3 areas on an equal basis. We have had confirmation that funding will be received There is a significant well recognised gap in resources in North Somerset however questions have been raised about locality readiness to implement the programme in this round in part due to the gap, and a lack of capacity while the transfer to with CCHP and AWP is completed. Feb 21 - Paper being taken with recommendation to Clinical Executive Committee 11th Feb for site of 3rd team and conclusion to this discussion Should it be approved risk will greatly reduce.	**3x4=12**	Quality Committee
Area teams	As a result of delays to the mobilisation of the Sirona community contract due to COVID-19 and the variability of maturity of integrated partnership development across localities, there is a risk that the activation of integrated frailty service provision may be delayed in BNSSG, which may affect the realisation of benefits set out in the Integrated Frailty business case CMc and HF met 03.02 to discuss risk and placement.	**3x3=9**	Clinical Executive

	Maintain hold in AD Risk reg for time being. Update on Sirona Transformation programme requested by Commissioning Dir with a proposal to be reviewed/next steps agreed by Rachel Anthwal		

3. Recommendations

The Governing Body is asked to review the CRR and approve:

- The addition to the CRR of the risks detailed
- The removal from the CRR of the risks detailed
- The migration to the new risk register template for April 2021

Appendices

Appendix 1 Corporate Risk Register

BNSSG CCG Corporate Risk Register 2020-21 March 21 V1

The Corporate Risk Register identifies the high level risks (15+) within the CCG. It sets out the controls that have been put in place to manage the risks and the assurances that have been received that show if the controls are having the desired impact.
The Corporate Risk Register is received by the Governing Body 6 Monthly, by the Audit Governance and Risk committee Quarterly and by the executives bi-monthly.
Risk is assessed by multiplying the impact/Severity of a risk materialising by the likelihood/probability of it materialising using the risk assessment matrix set out in the CCG Risk Management Strategy .
Risks are also mapped against the CCG risk appetite and accepted risk limits to provide an indicative acceptable risk level. Where a risk maps to more than one principal objective the lowest level of risk appetite and risk limit is given. It is for the Governing Body to decide if these risk limits are appropriate for each individual risk

										Risk Rating						
Directorate or Project	Risk Ref	Principle Objective Ref	Date Logged	Description of Risk *As a result of …* *There is a risk that …* *Which may result in ...*	Mitigating Actions	Progress on Actions	Gaps in Mitigating Actions	Committee Responsible for Reviewing	Director	Risk Owner (for Updates)	Initial Risk (LxI)	Current Risk (LxI)	Movement of current risk	Residual (Target) Risk (LxI)	Target date for completion of actions	Risk open or closed (If closed specify date)	Last reviewed
Commissioning Directorate	11	N/A	13.04.18	~~Cancer patients are at risk of potential harm if there are delays in the cancer pathway.~~ ~~There is an increased risk for cancer patients as a result of the Covid pandemic- due to reduced referral levels which may result in later presentations, reduced access for some tests- especially endoscopy and issues of balance of risk for patients who are shielding. There is an risk of potential harm~~ ~~Which may result in later presentation of suspected cancer~~ **As a result of delays in cancer pathways due to the Covid pandemic due to reduced referrals, reduced access to some investigations and issues of balancing the risk for patients who are shielding** **There is a risk that patients will present at a later stage of cancer** **Which may result in patients requiring more extensive treatment and patients will not be given the best chance of survival**	~~Clinical validation of waiting lists completed by providers and reviewed by the CCG Quality team monthly.~~ ~~Where providers identify potential harm CCGs require evidence of mitigating actions~~ ~~Contractual systems in place to monitor and manage performance through APG and ICQPM's~~ ~~Hospital focussed improvement programmes~~ ~~Monthly breach meetings with providers~~ ~~Partnership engagement in STP-wide cancer system working~~ ~~Engagement with SWAG Cancer Alliance~~ ~~Monthly review of cancer performance indicators~~ ~~Ongoing monitoring of patient harm through existing CCG quality governance~~ ~~Oversight of funding for projects associated with Alliance national support fund~~	**March 21: No new actions** Jan/Feb 2021: P1 and P2 activity is still prioritised and patients are still prioritised for suspected cancer. Mutual aid has been sought as required to support safe and timely management of cancer patients. The surge plan for EGTC has been activated meaning that additional P2 cancer work for breast, urology and plastics will be protected as bed pressures are still an issue. Dec 2020: P1 and P2 activity is still prioritised and patients are still prioritised for suspected cancer. There is ongoing review of the possibility of mutual aid being sought if needed but this has not been activated as yet. Nov-2020: The acute trust have undertaken a route to diagnosis audit to identify if there has been an increase in emergency presentations as a result of Covid. Both trust have not noted in significant increase in emergency presentations but have identify a decrease in lung diagnosis. Any further work on this by the trusts has been delayed due to operational pressures.	Monitoring of position continuing The PPE and drug limitations and the ability to continue the cancer work as demand starts to increase will be closely monitored.	Quality Committee Commissioning Leadership Team / Clinical Executive	Rosi Shepherd Lisa Manson	Associate Director of Quality Gemma Artz	20 (4x5)	**16 (4x4)**	↔	10 (2x5)	Mar-20	Open	**Mar-21**
As above	As above	As above	As above	As above	NEW ACTIONS: - There has been communications nationally and locally to patients about ensuring that patients present with suspicious symptoms "NHS is open" campaign - new patient leaflets have been shared with primary care to encourage patients to engage with cancer pathways - remote options for initial and follow up appointments have been started at pace- including increase use of teledermaotlogy to support cancer pathways. - cancer urgent surgery has continued throughout and there has been enough capacity to maintain what is needed - if this is clinically on the balance of risk recommended for patients. The independent sector capacity has also been used to support cancer pathways for surgery. **- ongoing monitoring of patient harm through existing CCG quality governance** **- mutual aid agreement in place with SWAG Cancer Alliance**	09-Oct-2020: Definition of harm is being reviewed by the quality team who will feed back to the cancer STP in November. Cancer patients waiting >104 days from referral to treatment is deemed as a never event, and the numbers have been of national focus. There are also known delays to cancer pathways due to fewer TWW referrals, diagnostics, PCI procedures and patient choice, as well as suspension of screening programmes. There are mitigating & remedial actions in place to address these issues which are showing positive results.	As above	As above	As above	As above	As above	As above	As above	As above	As above	As above
Commissioning Directorate	5	N/A	10.08.18 01.04.19 1.05.20	Risk of failure to recover A&E performance, which has wider implications due to the potential for patient harm.	04-May-2020: Covid-19 Command & Control structure established, operational and embedded. Surge plans in place. • Contractual systems in place to monitor and manage performance through ICQPM's • System Management call process and procedure being further refined and developed • Partnership engagement in BNSSG-wide system architecture to support urgent care performance, specifically Clinical Oversight Group • Monthly review of urgent care dashboard's at a system level manage A&E performance and associated areas for improvement • Ongoing monitoring of potential for patient harm through existing CCG quality governance	**March 2021 no change** **Jan/Feb 2021: During December and January there were significant outbreaks of COVID within WGH which led to the introduction of pathway changes through the WGH ED service. The system has continued to focus on ensuring that there is a safe Urgent Care service to its patients.** Dec 20; December continued to be a very challenging month for A&E performance. this continues to be driven by COVID operational pressures. Nov -20; operational pressures as a consequence of COVID has significantly impacted on the operational performance within the A&E's within the system. significant amount of work is being undertaken to try and manage the consequences of the additional demand. additionally phase 4 planning is about to begin which will aim to get the demand and capacity balance right.	This risk is linked to the risk PO5 on the GBAF (2019/20 under review) which contains more detail on this risk in relation to delivering the Urgent and Emergency Model of Care	Commissioning Leadership Team / Clinical Executive/ Quality Committee	Lisa Manson	Niall Prosser	20 (5x4)	**16 (4x4)**	↔	2x5=10	31/12/2021	Open	**Mar-21**
			as above	as above	as above		as above	as above	as above	as above	as above	as above	**as above**	as above	as above	as above	as above	as above
Commissioning Directorate	7	PO4	10.08.18 01.04.19 1.05.20	There is a risk that the extent of change/improvement required in AWP as our core mental health provider is not addressed, impacting on the care and services provided to the BNSSG population. This risk includes the challenges of the current crisis pathway that could be more effective - currently there are a high number of people placed out of area, high numbers of people on a Section in hospital and increasing pressure on the crisis team's ability to respond.	Effective contract management processes with the current provider. Joint working with BSW on contract requirements Joint Planning and delivery of the Estates Project and CCG leading consultation Joint Technology improvement plan AWPs transformation programme Driving forward the work of the Integrated Mental Health Strategy Framework to focus on prevention and defining optimal service provision that is more reflective of the needs of our population and how they present to services CCG investment in Mental Health Investment Standard CCG commenced 19/20 contract negotiations on behalf of BNSSG and BSW Support provided to AWP for winter pressures	**March 2021 Routine referrals have opened back up and the number of outbreaks on wards and levels of staff sickness have reduced. The introduction of the support to SWAST in the ambulance hub has started to have an impact on hear and treat. Modelling work has started on PICU and a workshop has taken place with partners across BNSSG and BSW and a task and finish group will be formed to take the work forward. A new finance system group has been set up and will oversee the system savings plan. The CMHF submission and specification are being developed, ensuring that it supports the whole system with focus on prevention.** February 2021:A funding bid for the crisis pathway has been approved, due for implementation from April 21. The service specifications and KPIs have been drawn up and approved for the PD and SMI business cases, with DES/CHL already approved. Recruitment is underway for all schemes. AWP have closed to non-urgent referrals in response to pressure on core services from staff sickness and ward outbreaks including male PICU and assessment ward. This is under weekly review and AWP are currently in an improving position. Street triage has seen increasing activity and is up to full capacity. Sanctuary service has opened to face to face support. January 2021: Discharge funding awarded at £825k to support over winter. Community mental health programme discovery phase concluding, with submission to NHSE this month. The new face to face offer from the Sanctuary to support the crisis pathway should open this month. Very low numbers of adults placed out of area now, however numbers in PICU continue to be challenging. Recruitment is underway for the dementia and PD services, as part of the Wave 3/Covid business case. Street and Control triage are being remodelling and the new MH ambulance service will start in January	□This risk is linked to the risk PO6 on the GBAF (2019/20 under review) which contains more detail on Mental Health services □Define the lead indicators including patient reported measures and reports from primary care localities. □Development of MH data set focussing on the IAF indicators underway, more work required to identify trends in reporting.	Commissioning Leadership Team / clinical executive	Lisa Manson	Emma Moody	20 (4x5)	**20 (4x5)**	↔	4x4=16	**Apr-21**	Open	**Mar-21**

as above	as above	as above	as above	as above	as above	December 2020: The funding for winter has been secured and plans are being implemented at pace. Additional funding to support bed flow and discharges has just been announced which will arrive in December. Initial submission for the CMHF has been made to NHSE. System governance structure for the transformation of mental health services has been finalised.	as above	as above	as above	as above	as above	**as above**	as above	as above	as above	as above	as above
Commissioning Directorate	10	N/A	29.11.18 01.04.19 1.05.20	Risk of failure to recover 52 week wait performance, which has wider implications due to the potential for patient harm. There is a financial risk for the system due to the 19/20 contract stating that all 52 week breaches will incur a fine which will be divided between CCG and Provider of £5000 per patient per month. One patient could incur multiple fines. The risk of 52 week wait breaches has significantly increased due to the pausing of all routine activity in response to the Covid outbreak, and recovery will be slower due to the additional IPC requirements and continued reduction in routine activity.	□ Contractual systems in place to monitor and manage performance through APG and ICQPM's □ Hospital focussed improvement programmes □ Partnership engagement in BNSSG-wide trauma and orthopaedic / MSK system working □ Monthly review of RTT performance indicators including weekly updates of long waiters (over 46 weeks) □ Ongoing monitoring of patient harm through existing CCG quality governance NEW ACTIONS: - Independent sector capacity via the national contract is being utilised to support and manage elective surgery, initially this will be predominantly urgent and cancer surgery but then long waiting patients would be prioritised. - Feedback to the national and regional teams on the importance of managing patients in order and by clinical priority through the crisis period.	**March 2021 No new actions** Jan/Feb 2021: There are no new actions. The system are continuing with the action highlighted in the adapt and adopt programme. The new IS framework has been released and we are working to ensure we use as much IS capacity as possible within the rules of the framework. Dec 2020: There are no new actions. The system are continuing with the action highlighted in the adapt and adopt programme. The new IS framework has been released- this does provide an opportunity that is being explored to ensure maximal capacity is commissioned to support the trusts recovery but there is also a risk that due to private backlogs that the IS may be offering less than before- this is being worked through in readiness for new contracts at the end of December. 12-Nov-2020: 52 week waits continue to increase and are projected to continue increasing, specialties specifically effected by long waits are: T&O, Dental, Ophthalmology, Gynaecology. Programmes are in place to support specialties with long waits, clinical validation continues.	There is uncertainty on a regional plan for how the fines will be applied and the monies reinvested. This has been escalated via NHSE/I and the CCG and providers are awaiting a response. There is uncertainty on the national contract with IS beyond the end of June. Even with additional capacity of IS, likely to still be a significant short fall for routine activity.	Commissioning Leadership Team / clinical Executive	Lisa Manson	Gemma Artz	9 (3x3)	**20 (4x5)**	↔	1x1=1	Mar-20	Open	**Mar-21**
as above	as above	as above	as above	as above	as above		as above	as above	as above	as above	as above	**as above**	as above	as above	as above	as above	as above
Commissioning Directorate	21	PO5	05.04.19	Due to long waits for adult ADHD services in AWP there is a risk to patient experience which may result In a detrimental impact on their wellbeing. There is a further risk that for patients waiting over 52 weeks the CCG and AWP could incur 52 week breach fines	A contract performance notice has been issued a joint investigation has started. Key actions include updating booking processes and reviewing the waiting list. The CCG have requested data on the number of patients waiting over 18 weeks so that a review can be undertaken	Feb 2021: The LES is being implemented across BNSSG. Current uptake is ca. 20 out of 83 GP practices. The CCG are still awaiting the advised trajectory and the proposals for the resource changes. January 2021: LES is being implemented across all practices where interest has been expressed. CCG are supporting AWP to produce an updated trajectory for the reduction of waiting lists based on their proposed additional resource changes, to be delivered in early January 2021 - CCG involved in setting service user experience measures to ensure this is implemented without negative impact on service user experience. Service specification being developed by AWP for approval in early 2021 by clinical executive, with support of CCG, to establish the future design for the service in response to historical challenges.	Recurrent funding for the waiting list approved as part of this new model. Need to establish a framework for management of requests for assessments by other providers under right to choose Due to the complexity of resolving this issue, wait times have not reduced over the period that this has been being reviewed.	Clinical Executive	Lisa Manson	Gemma Artz/ Emma Moody	16 (4x4)	**16 (4x4)**	↔	1x1=1	**Mar-21**	OPEN	Feb-21
as above	as above	as above	as above	as above	as above	December 2020: LES is being implemented across all practices where interest has been expressed. CCG are supporting AWP to produce an updated trajectory for the reduction of waiting lists based on their proposed additional resource changes, to be delivered on 4th December - CCG involved in setting service user experience measures to ensure this is implemented without negative impact on service user experience. Service specification being developed by AWP, with support of CCG, to establish the future design for the service in response to historical challenges.	as above	as above	as above	as above	as above	**as above**	as above	as above	as above	as above	as above
Commissioning Directorate	14	n/a	01.05.20	RISK SCORE HAS INCREASED AND IS NOW REPORTED ON CRR National outbreak of Influenza Pandemic leading to up to 50% of population affected across the country making it a national catastrophic incident	• Robust Influenza Pandemic Plans/ Business Continuity Plans in place in all acute and community providers. • Part of annual training and exercising calendars for Local Resilience Forum and all NHS organisations • Avon and Somerset Local Health Resilience Forum (LHRP)strategic framework in place and exercised through table top exercises. • Avon and Somerset LHRP/LRF operational plan out for consultation. • NHS England South West North leading on development of operational response plans for Antiviral Collection Points. • To be reviewed at EPRR oversight delivery group • Pandemic flu plan in place	**February 2021: Seasonal Influenza is low due to Covid-19 circulating virus being dominant and lockdown enhances social distancing and reduces transmission.** January 2021: Further National Lockdown (3) to support the NHS who is overwhelmed. Covid outbreaks continue to be monitored and escalated. Vaccination programme in progress December 2020 - BNSSG are in Tier 3 following second lockdown. Cases are now starting to plateau. Note Avian Influenza (H5N8) is a potential risk to the community. Case identified in Gloucester at Slimbridge.	**February 2021: mitigation in place through seasonal influenza vaccination programme. Circulating flu figures remain low. At present this risk is reducing in nature.** Feb 2020: All Pandemic Flu planning is 2013. Should be for review as EU Exit date closes and national teams revert to business as usual. Mar 2020: Draft Plans in place with additional SOPs for Local Coordination Centre April 2020 : Evolving incident response with reviewed Governance of command and Control arrangements in line with EPRR framework. Recovery and system reset planning on Horizon scanning with engagement of LRF recovery plans.	EPRR Oversight Delivery Group	Lisa Manson	Janette Midda / John Wintle	4x4=16	**12 (3x4)**	↓	2x4=8	Mar-20	OPEN	**Feb-21**
Commissioning Directorate	36	n/a	18.02.20	RISK SCORE HAS INCREASED AND IS NOW REPORTED ON CRR ~~As a result of long wait times for diagnostic tests and failure to meet the DMO1 standard in endoscopy, CT and MRI there is a risk of harm to patients as a result of delayed diagnosis.~~ **As a result of long waits for diagnostic tests and failure to meet the DMO1 standard for endoscopy, CT and MRI** **There is an risk of potential harm to patients as a result of delayed diagnostics** **Which may result in a later diagnosis of their condition and the commencement of appropriate treatment** There is an increased risk of delay in diagnostics due to the Covid pandemic. This is due to a combination of reduced efficiency due to IPC procedures and workforce issues and capital/ space issues.	There are remedial action plans agreed for UHB and NBT. Weston have been issued a contract performance notice and the CCG await a remedial action plan. There is additional money in the system from NHSE/I for additional outsourcing and insourcing capacity which has a plan against it which will prevent further deterioration and stabilise the position for year end. There is a diagnostic advisory group as part of the STP long term plan which are focussing on endoscopy, CT and MRI. Capacity and demand planning is ongoing. Referrals are triaged and urgent and 2ww wait referrals are prioritised. NEW ACTIONS: The diagnostics advisory group are working on how best to use the available capacity to reduce the risk of harm to patients and to make sure that the most valuable diagnostics tests are available. The independent sector will be providing additional capacity to help with the significant backlog that has been created in endoscopy as a result of the Covid risks for the procedure. Routine work has currently stopped, but a plan is to go to clinical cabinet on how best to restart referrals to diagnostics from primary care.	Feb 2021: The biobank additional capacity is now online the ANA projects are ongoing. Endoscopy activity is in line with phase three plans / Further options are being explored to address the backlog. Jan 2021: The Biobank contract is signed and providing additional MRI capacity. The A&A projects are still ongoing. Endoscopy activity is back in line with BAU levels but more needs to be done to fully understand and clear the backlog (this should be aided by the 5 additional admin staff that have been approved). 2 key actions for the additional capacity include opening of a second room at SBCH (once the new stack arrives on site this room can open) and additional capacity commissioned from Prime Endoscopy. Dec 2020: The Biobank contract is signed which will bring on additional MRI capacity from December 7th. The A&A projects are still ongoing, including recruitment of additional radiography staff and ordering of a new CT scanner for UHBW. Endoscopy activity is back in line with BAU levels but more needs to be done to clear the backlog. 2 key actions for the additional capacity include opening of a second room at SBCH and additional capacity being commissioned with Prime Endoscopy.	There are workforce issues and space issues related to endoscopy that need to be addressed in the medium and long term which may be a limiting factor with capacity in the short term recovery. The workforce and space issues with endoscopy are exacerbated with the procedures needed for IPC which will significantly reduce efficiency.	Clinical Executive Commissioning Leadership Team	Lisa Manson	Gemma Artz	4x3=12	**(4x4) 16**	↓	tbc	**31/03/2021**	OPEN	Feb-21
as above	as above	as above	as above	as above	as above		as above	as above	as above	as above	as above	**as above**	as above	as above	as above	as above	as above

Commissioning Directorate	18	n/a	20.12.18	RISK SCORE HAS INCREASED AND IS NOW REPORTED ON CRR EU Exit (Brexit) D20 (December 2020) EU transition • Supply of medicines and vaccines; • Supply of medical devices and clinical consumables; • Supply of non-clinical consumables, goods and services; • Workforce; • Reciprocal healthcare; • Research and clinical networks • Data sharing, processing and access.	• EPPR colleagues progressing the National requirements for local SW EU Exit plans (Local and regional NHSE and NHSI teams in place)	**January 2021: Deal signed on 24/12/2020. EU transition complete at 2300 hours on 31/12/2021. To monitor supplies as the expectation is there will be some delays moving forwards.** December 2020: talks are underway but no deal at present; all organisations to plan for no deal and 60-80% of supplies entering the UK	**December 2020: talks remain in progress. Weekly webinar with Keith Willets and weekly LRF SCG agenda. First assurance has been completed. Risk increased as only 15 working days to exit. Deal signed 24/12/2020.**	EPRR Oversight Delivery Group	Lisa Manson	Janette Midda	4x4=16	**3x4+12**	↓	5x2=10	31/12/2020	OPEN	**Jan-21**
Commissioning Directorate	**24**	**n/a**	**06/06/2019**	**RISK SCORE HAS INCREASED AND IS NOW REPORTED ON CRR** **There is a risk that due to poor data quality at Weston hospital that performance data for all services may not be accurate. This could result in lack of oversight of genuine wait times for planned care pathways and urgent care performance and activity.**	**An information breach notice has been issued CCG are attending the RTT board CCG are working with IST and trust to review and ensure actions in the IST report are followed up Staffing issues in Weston leading to difficulty in progressing suggested actions from NHSI. Support is being provided by UHB as part of the due diligence process for RTT in particular. The trust are yet to share the report with the CCG. There is further financial risk due to previously unknown risk of 52 week breaches in the trust.**	**Jan 2021: Weston are still in the process of validating their data and seeking support from the IST. Dec 20: Weston are in the process of validating their data and seeking support from the IST 12-Nov-2020: Validation of waiting list continues. .**		**CLINICAL Executive Committee**	**Lisa Manson**	**Gemma Artz**	**4x4=16**	**4x4=16**	↑		01/04/2021	**OPEN**	**Mar-21**
~~Commissioning Directorate~~ Transformation Directorate		n/a	27.11.20	~~There is a risk of increasing health inequality in patients with cancer or at risk of cancer because of potential differences in delayed diagnosis and poor outcomes across different population groups. Our understanding of this risk is still developing as local and national data is gathered and analysed.~~ **As a result of the Covid-19 pandemic There is a risk of increasing health inequalities in patients with cancer of at risk if cancer because of potential differences in delayed diagnosis Which may result in poorer outcomes across different population groups** **Our understanding of this risk is still developing as local and national data is gathered and analysed**	1. A review of the data is required to understand the current situation and expand on the risk and identify mitigating actions. 2. Work is underway using the PHM data set to target work on specific populations where adverse outcome is most likely – current focus on lung referrals	Feb 2021 Targeted communications have been developed as part of a wider communications plan encouraging people to present to their GP if they have concerning symptoms. A BNSSG cancer inequalities group is being set up to focus specifically on actions to address inequalities in cancer care. A separate project is investigating more granular understanding of performance data at a population level.	**Improved information required on cancer outcomes and performance by different population groups**	BNSSG STP Cancer Programme Board Quality Committee	Peter Brindle	Andy Newton/ Gemma Artz	4x4=16	4x4=16	↔		31/3/2021	open	Feb-21
Commissioning Directorate	12	n/a	19/12/2018	RISK SCORE HAS INCREASED AND IS NOW REPORTED ON CRR Infectious disease outbreak including high consequence infectious diseases. (VHF Ebola / SARS / MERS/Coronavirus)	• Robust Outbreak Plans / Business Continuity Plans in place across health system. • Outbreak planning is part of winter plans and surge; training and exercising for Local • Resilience Forum and all NHS Organisations • CCG Governing Body receives report on Emergency Preparedness, Response and Resilience preparedness annually. 01-Sep-2020 - Local Outbreak Management Plans and surveillance database in place for local monitoring and implementation of lockdown plans October 2020 - NHSEI Communicable Disease Framework v4 for all health premises to manage outbreaks.	**March 2021: Numbers of outbreaks are decreasing in both Hospitals and Care Homes. Vaccination programme working well. BNSSG have been involved in asymptomatic surge testing for the Kent variant E484K.** February 2021: Weston outbreak now closed. Wave 3 appears to have peaked though numbers in hospital settings remain high. Planning is in place to support discharge to assess in community and social care placements. Vaccination programme under way in BNSSG. The Covid-19 virus is mutating; surveillance continues January 2021 - System dealing with major outbreak at Weston General Hospital requiring mutual aid from BRI site, NBT & Somerset Partnership Trust. Case rates are rising, hospital admissions & critical care are rising. National lockdown (3) declared for 6 January 2021. Covid-19 vaccination programme in progress - aim to complete by mid February. December 2020 - Hospital admissions have peaked within BNSSG during wave 2. Numbers appear to have plateaued. Outbreaks continue to be reported in schools, care homes, hospitals & primary care.	January 2021: All outbreak reporting through OKTA (NHS Foundry). CCG IPC have recently recruited additional staff to support outbreak management processes. Linked to System Command & Control. December 2020: Outbreak Framework in place and available on NHS Foundry. CCG IPC colleagues leading on this work. Risk increased to 3x4 as numbers increasing within Covid and impacting on health & social care flow as beds are closed.	**Clinical Executive Committee** EPRR Oversight Delivery Group	Lisa Manson	Janette Midda	4x5=20	**4x4=16**	↔	2x4=8	31/03/2021	OPEN	**Mar-21**
Nursing & Quality	BNSSG QD 021	N/A	6.12.18	Patients are at risk of harm from call incident stacking at SWASFT causing a delay to ambulance response times	Urgent care Strategy in place A&E Delivery Board reviews performance on monthly basis Processes in place to manage demand across system including: Daily system escalation calls Handover SOP in place with acute Trusts NHS 111 Clinical validation of Category 3 calls Monitoring of patients safety and experience through Incidents, Complaints and Feedback	Feb 2021: Received assurances from SWASFT regarding the wellbeing of staff, and that SOPS are in place. This is being managed as a regional piece of work. Urgent care work stream progressing to ensure appropriate use of Ambulance services. No rise in SI's, Datix or complaints identified, pertaining to call incident stacking. End to End patient pathway reviews are being undertaken, these have not yet identified any harms. Recommendation: appropriateness of risk score to be discussed at next Quality Committee meeting. Dec 20 risk remains unchanged Nov 2020: SWAST Risk score for Call Stack Risk is reviewed by all cluster CCG's. BNSSG CCG score remains at 16. Actions to mitigate risk discussed with performance colleagues. SWAST escalation with Ambulance Joint Consultation Committee in progress.	none identified currently; monitoring of position continuing	Quality Committee	Director of Nursing & Quality	Associate Director of Quality	16 (4x4)	**4x4 = 16**	↔	8 (2x4)	Mar-20	Open	Feb-21

Nursing & Quality	BNSSGQD043	n/a	05/05/202	Patients have an enhanced risk of potential harm through contracting MRSA Bacteraemia due to the high numbers in the local area.	Ongoing review of all monthly cases - plan to review and close all 2019/20 cases. Share findings with system partners through the Quarterly HCAI group to identify further specific actions to minimise risk further. Capture and share current provider improvement projects across the system. Continue partnership working and the development of initiatives through the Design Council project, noting the high incidence of Persons Who Inject Drugs in our local data set. Undertake assurance exercises in line with the HCAI quality schedule. Detailed analysis of individual MRSA cases, with whole system approach pre and post diagnosis. Bi-Monthly BNSSG Healthcare Acquired Infection meeting with partner organisations to monitor and support MRSA improvements. Separate MRSA task and finish group established. Work ongoing with the design council to assist with the reduction of MRSA.	**Mar 2021: Business case for Chlorhexidine wipes has been approved, discussions are ongoing with the Local Authorities to finalise details of the roll out plan.** Feb 2021: Funding has been secured for the system switch to Chlorhexidine wipes. Ongoing discussions with commissioning colleagues within the local authority regarding process steps. 2020/21 case reviews remain suspended, meeting scheduled with NHS E regarding rapid review process. Year to date 24. The risk will be reviewed following evaluation of initiative after three months. Jan 2021: There has been a 25% reduction in cases within BNSSG compared to 2019/20. Funding has been agreed by DPH for Bristol for Chlorhexidine wipes, roll out plan and evaluation plan being developed. Dec 2020: Chlorhexidine wipes meeting has been held, business case is now being drafted	none identified currently; monitoring of position continuing	Quality Committee	Director of Nursing & Quality	Associate Director of Quality	20 (4x5)	**15 (3x5)**	↔	10 (2x5)	Mar-21	Open	**Mar-21**
Transformation	MSK	PO1	28.05.20	As a result of COVID 19 and the fact that routine MSK services have been put on hold, there is a risk that waiting times for MSK services will increase which may result in people having to wait, often in pain, for many months to see a Physio or for surgery	* The use of the national contract with the Independent Sector to try to restart Ortho surgery and to use the IS Physios to see patients * Sanchit Mahendale has agreed to be the clinical lead to implement a single T&O directorate for BNSSG which would enable the most efficient use of resources to reduce waiting times * We plan to introduce more support at the start of the pathway to prevent the need for surgery later on , such as ESCAPE-pain courses, shared decision making, First Contact Practitioners working in Primary Care Networks, Health Optimisation, community based pain management * We are working closely with the Regional Getting it Right First Time (GIRFT) team to learn from other areas to create more capacity within the system to manage the number of people waiting.	**March 2021:** **There is still very reduced Orthopaedic surgery due to COVID** *** Sirona have just re-started providing virtual ESCAPE-pain courses, but the acute trusts are still not running any courses. We are working with 3 gym providers to agree contracts to enable them to provide courses at no cost to service users.** *** Sirona are providing First Contact Physios for South Glouc PCNs and North and West Bristol PCNs. Other PCNs have also recruited FCPs and Liz Bradshaw has been appointed to the FCP Fellowship role, starting in May, to create a network to ensure they are integrated in to the MSK pathways.** ***The Health Optimisation pilot went live at the start of November, but is only providing a limited service currently as staff have been moved to contact tracing.** ***134 people attended the one hour Shared Decision Making training. All 6 three hour skills based sessions have taken place and been well attended. We have organised another 3 three hour training sessions for July, September and October and these will be promoted at the SDM workshop being run for the Clinical Cabinet on the 21st of April. Work continues on the knee SDM decision aid.** ***The roll out of the getUBetter self-management app is going well and we are on track to have completed the roll out in primary care by the end of April, alongside the MSK staff in NBT, UHBW and Sirona. We are also working on a roll out to Care Homes. Over 800 people are currently using the app** ***The Joint school app is being promoted to the people waiting for a joint replacement at both NBT and Weston.** ***We have approval for the draft clinical model for one T&O service for BNSSG and we have started stage 2 of the project to do the detailed work on finance, BI, workforce and contracting.**	**We are agreeing contracts so the virtual ESCAPE-pain courses can start as soon as the gyms re-open. We have not been able to move forward on the integrated pain service work or the integrated physiotherapy deliverable as approximately 30% of the acute and Sirona outpatient physiotherapists are still redeployed onto the wards and into the community to support COVID.** We have secured funding for gym based ESCAPE pain courses and we are agreeing contracts so the virtual courses can start as soon as the gyms re-open. * Gyms are not in a position to run ESCAPE-pain courses and we still haven't secured funding for these local gym based courses. * We have not been able to move forward on implementing an integrated pain service or an integrated physiotherapy service as approximately 30% of the acute and Sirona outpatient physiotherapists have been redeployed onto the wards and into the community to support hospital discharge. We plan to start work on these two deliverables in April 2021	MSK Programme Board	Medical Director	Elizabeth Williams	(4x4) 16	**(4 x 4) 16**	↔	**(3x3) 9**	**Mar-21**	Open	**Mar-21**
as above	as above	as above	as above	as above	as above	Feb 2021 Very little Orthopaedic surgery is happening during this current wave of COVID * Only Sirona are providing virtual ESCAPE-pain courses, although the acute trusts are planning to run virtual courses in the new year. We have secured funding to enable gyms to provide courses at no cost to service users. We are working with 3 gym providers to agree contracts. The courses will be run virtually * Sirona are providing First Contact Physios for South Glouc PCNs and North and West Bristol PCNs. Other PCNs have also recruited FCPs and the Training Hub is interviewing for the FCP Fellowship role in January to create a network to ensure they are integrated in to the MSK pathways. *The Health Optimisation pilot went live at the start of November. *134 people attended the one hour Shared Decision Making training. We have 6 three hour skills based sessions organised for February to April. Work continues on the knee SDM tool. *We have secured funding for the roll out of the getUBetter self-management app and 6 Primary Care Networks are going live in January and plans for the remaining PCNs to have gone live by the end of March, alongside the MSK staff in NBT, UHBW and Sirona. We are also working on a roll out in the 280 Care Homes. Patients are starting to use the app *The Joint school app is being promoted to the people waiting for a joint replacement at both NBT and Weston. *We have approval for the draft clinical model for one T&O service for BNSSG and we have started stage 2 of the project to do the detailed work on finance, BI, workforce and contracting. Jan 2021 reviewed no update	as above	as above	as above	as above	as above	as above	as above	as above	as above	as above
Transformation		PO1	09.06.20	As a result of COVID-19 there is a risk that some transformation programmes will be delayed, with the result that we will not meet our 5 year plan objectives in some areas	The Directorate is working closely with the Healthier Together Team and System COVID response to accelerate transformation change as part of COVID19 recovery planning. This will be undertaken alongside a review of 5 year plan objectives, priorities and deliverables	Ongoing as part of Recovery Planning	This risk was reviewed by the Executive Team 20.01.21 and it was agreed that the risk was now covered in individual risks reported on both CRR and DRRS and through the GBAF. It was agreed to recommend the risk was closed				(4x4) 16	**1x4**	–				**Jan-21**
Transformation	CYP	PO4 PO6	25/05/2020	RISK SCORE HAS INCREASED AND IS NOW REPORTED ON CRR The EOI for the mental heath support teams was submitted in March 2020 including each of the 3 areas on an equal basis. We have had confirmation that funding will be received There is a significant well recognised gap in resources in North Somerset however questions have been raised about locality readiness to implement the programme in this round in part due to the gap, and a lack of capacity while the transfer to with CCHP and AWP is completed.	Once the detail of the EOI outcome is known, a formal, transparent process for agreeing which areas should be phased in by when. Criteria are likely to include operational readiness and local needs analysis.	Feb 21 - Paper being taken with recommendation to Clinical Executive Committee 11th Feb for site of 3rd team and conclusion to this discussion (NT). Jan 21 - two of the three areas now agreed to proceed. (Bristol and SG). Conversations continue between CCG and AWP to confirm status of North Somerset in this wave. Now escalated to exec / CEO level Dec.2020 - Risk has become an issue with formal notification of risks to delivery in North Somerset. As a result ongoing conversations taking place between Victoria Bleazard, Emma Moody, Matthew Page and Lisa Manson to agree ways forward and position.	Recommendation to CEC needs to be approved and communicated. Should it be approved risk will greatly reduce. Decision still needs be made and communicated to partners especially with North Somerset LA.	Quality Committee Children and Young People's MH Sub Group	Deborah El Sayed	Neil Turney	(4 x 3) 12	**12 (3x4)**	↓	–	Feb-21	open	Feb-21

Transformation	IPS (Individual Placement and Support) mental health employment		27/05/2020	As a result of: • CCG late take-up of the 2019/20 NHSE Wave-2 IPS funding • AWP's agreement to deliver but subsequent non-prioritisation of the service • the COVID-19 crisis there is now a risk that we do not establish the new IPS service, which may result in: • People in secondary MH services not receiving evidence-based support into paid employment • Our (already reduced) two year NHSE funding and the opportunity it presented being lost • Failure to meet the national requirements for rapid IPS further investment and expansion through the LTP.		**08.03.2021 - • IPS now live & taking referrals & working to support. Business case developed to repurpose existing employment support going through system currently which may resolve this.** 08.02.2021 Richmond fellowship staff now appointed, AWP manager is out to advert. Risk re: coverage still live due to funding decision which is still awaited. 13.01.2021 - • AWP leading the implementation with Richmond Fellowship. New trajectory proposed for recruitment of staff, taking referrals and people starting paid work from Feb 2021 to June 21. Risks: The new service will not provide full BNSSG coverage (in the Bristol Recovery service) without further investment in 21/22 as existing IPS capacity across BNSSG has reduced from 2.4WTE to 1WTE since the Wave 2 bid and LTP plans were submitted.	The NHSE expectation is for a steep trajectory of CCG investment in IPS over the next five years. BNSSG have not budgeted such investment in for this and it remains at the 21/22 (lower than required) level. **Business case in development to address**	Mental Health Programme Board	Deborah El-Sayed	Victoria Bleazard	(4 x 3) 12	5 x 3 (15)	↔	(2 x 3) 6	Jul-20	Open	**Mar-21**
Transformation - Planned Care	COVID19 Impact		22/05/2020	**RISK SCORE HAS INCREASED AND IS NOW REPORTED ON CRR** As a result of COVID19, there is a risk that delivery of the Long Term Plan deliverables and goals will not be achieved, and impacts cannot be measured, which may result in increasing delays, poor experience and poor value care.	March 21 - 21/22 planning is focussed on elective care recovery. Embedding transformation of elective care services will be central to development of 21/22 plans. For planned care, this will include recovery of routine care in line with planned care strategy. Where possible, services should be recovered in ways which further the objectives of the long term plan. Where this is not possible, plans should be revised and updated to reflect the unavoidable service changes. Phase 3 recovery has included investment in additional capacity across planned care specialise and diagnostics for recovery to near pre-COVID activity levels. Planning for 21/22 will now include capacity and demand work to reduce the backlog. The planned care board has established a work programme to deliver the high level principles.	The Planned Care Strategic Plan and 5 year plan objectives and 20/21 deliverables are being used to shape planning across planned care services. System capacity and recovery plans have been developed as part of phase 3 recovery and 21/22 planning, and mitigations developed.	The impact of some of the unavoidable service changes is not yet known (for examples, capacity constraints and backlog clearing of routine elective waiting lists). Capacity constraints will lead to longer waiting lists and increasing numbers of patients waiting. This is be monitored by the performance and oversight group and the planned care board, with mitigating actions being developed.	System Change Command, Planned Care Board, and STP Cancer Board and Cancer Cell, Diagnostic and Outpatient Cells	Evelyn Barker (Planned Care) and Peter Brindle (Cancer)	Andy Newton	(5x3) 15	(5x3) 15	New Risk	(3x3) 9	Mar-22	Open	**Mar-21**
Transformation - Planned Care	Cancer Transformation		04.02.21	**RISK SCORE HAS INCREASED AND IS NOW REPORTED ON CRR** As a result of patients not presenting to services early There is a risk that patients will present at a later stage of cancer Which may result in patients requiring more extensive treatment and patients will not be given the best chance of survival Long Term Plan target = 75% of cancers are diagnosed at stage 1 and 2 by 2028. In 2017 of those cancers which were staged 56% were stage 1 and 2	This risk has been transferred from the Cancer Programme Board risk register A CCG plan will need to developed in collaboration with the Cancer Alliance and the STP Acute Care Collaboration steering group in order to deliver priorities for cancer identified in the long term plan Targeted communications / national media campaigns to highlight need to present to their GP early	02.02.21 Paper to go the Commissioning Execs February / March to update on proposed pilot of GP Support tool funded by the Cancer Alliance 16.12.20 Meeting held on 10th December to review GP support tool - outcome of meeting was for CCGs to review the requirements drawn up pre Covid and decide if existing tools are able to offer what is needed or if procurement of a new tool is needed. GP comms sent highlighting reduced 2WW lung referrals 27.10.20 PCN data packs in development to support DES. CRUK supporting individual practices if requested. On going discussion with SWAG over GP support tool. Meeting held with Comms teams re targeted communications. Initial work - urgent referral letter to be translated into 14 languages 10.09.20 PCN DES Earlier cancer diagnosis - PCN clinical leads webinar held on 11th August attended by 13 out of the 18 PCNs. This work is being supported by CRUK		BNSSG STP Cancer Programme Board	Peter Brindle	Andy Newton	(4 x 3) 12	4 X = 16	New Risk	(3 x 3) 9	2028	Open	**Mar-21**
Area Teams	AD02	PO4	23.09.20	RISK SCORE HAS INCREASED AND IS NOW REPORTED ON CRR As a result of delays to the mobilisation of the Sirona community contract due to COVID-19 and the variability of maturity of integrated partnership development across localities, there is a risk that the activation of integrated frailty service provision may be delayed in BNSSG, which may affect the realisation of benefits set out in the Integrated Frailty business case 10.09.20 Risk being reviewed and recast by Clare McInerney/Colin Bradbury - update to follow in September submission 24.08.20 Previously BS16 recast as BNSSG wide Area Directorate Risk to become AD02	Sirona contract mobilisation oversight meetings to recommence; Frailty programme board reporting to ICSG to be established to maintain progress on transformational elements of Sirona bid including development of Locality frailty Hubs and LARC offer. Revision of Sirona mobilisation plan to reflect phased implementation, in consideration of Covid impact Programme management responsibility for integrated frailty to be defined Delivery group to be set up under Integrated Care Steering Group for implementation of mobilisation and detail timeline of when LARC chairs / Hubs will be put ion place.	**22.02.21 CMc and HF met 03.02 to discuss risk and placement. Maintain hold in AD Risk reg for time being. Update on Sirona Transformation programme requested by Commissioning Dir with a proposal to be reviewed/next steps agreed by Rachel Anthwal 25.02.21. New timelines agreed will inform trajectory for frailty mobilisation and development of PID documentation for ICSG approval March/April.** 26.01.21 System pressure and the diversion of Sirona resource to REACT and D2A will necessitating a review on Transformation resources required for Sirona to develop locality plans for 4 priority areas identified by ICSG in November 20. Update on frailty deliverables to be presented to ICSG Feb 21. Initial locality plans have been updated via PMO, however fully described plans against agreed contractual deliverables not yet in place. Meeting to be arranged with Clare McInerney and Helena Fuller to discuss placement of this risk. 23.12.20 First draft of Locality Frailty Mobilisation templates submitted on 21.12.20. Mapping of high level milestones, risks and interdependencies to be completed in January; preliminary view of plans has identified substantive gaps and need for further milestone development and assurance on deliverables, linking with Commissioning directorate. Project and Programme level management in place. 26.11.12 Frailty delivery group has now been set up re. mobilisation of LARC chairs and domiciliary care service and community hubs. First meeting led by Mike Jenkins took place this week. Update going to December meeting of ICSG	Sirona mobilisation plans to reflect phased implementation - in consideration of covid impact	ICSG	Colin Bradbury	Clare McInerney	3x3=9	**3x3=9**	↓	**2x3=6**	**Apr-20**	**closed**	**Mar-21**