Board Meeting
Pack A - Public Papers

Meeting Date:
Tuesday 10th
December 2024

BOARD MEETING

Date:	**10th December 2024**
Venue:	Face to Face Board Members (Public via Teams), Badminton Road, Yate
Time:	14:00 – 16:45

AGENDA

			Paper/Verbal Presented by	Approx. Timings
	14:00	**MAIN MEETING (Pack A Papers)**		
		OPENING BUSINESS		
1.	**Welcome and Apologies:** Welcome to new Non-Executive Directors; and Good Governance Institute (observing)			
2.	**Our People Story** **Service User Story – *Partner2Care***		Nick Cutcliffe	14:05-14:35 (30 mins)
3.	**Declaration of Interest** Board members are asked to declare if they have any direct or indirect interest in the items to be considered at the meeting		Barbara Brown Verbal	14:35-14:45 (10 mins)
4.	**Previous Minutes and Actions – Meeting in Public** To formally approve the minutes of the meeting in public held on 11th September 2024		Barbara Brown Paper	
5.	**Chair and Non-Executive Directors' Report** To provide an update on the activities undertaken in the last quarter, and to update the Board on matters not covered elsewhere on the agenda.		Chair & NEDs Verbal	14:45-14:55 (10 mins)
6.	**Chief Executive's Report** To update the Board on significant matters of business reported by the Executive Committee, covering recent activities both internally and within the wider healthcare system		Julie Sharma Paper	14:55-15:15 (20 mins)
	15:15	**ASSURANCE REPORTING/ RISK / REGULATORY**		
7.	**Governance Framework – Good Governance Institute Development Review** To receive an outline of the work with the Good Governance Institute and progress update		Julie Sharma Paper	15:15-15:20 (5 mins)
8.	**Risk Register** To provide assurance to the Board on the position of risks with a score of 15 or more		Mary Lewis Paper	15:20-15:30 (10 mins)
	15:30-15:45 (15 mins)	**BREAK**		
9.	**Board Assurance Framework** To review the new format of the Board Assurance Framework		Julie Sharma/ Julie Young Paper	15:45-15:55 (10 mins)
10	**Business and Budget Planning for 2025-2026**		Laks Khangura/ Mike Owen/ Mel Reeks Presentation	15:55-16:05 (10 mins)

	To provide assurance on the preparation and progress of budget planning for the new financial year	(no paper)	
11	**Operational Performance – Chief Operating Officer** To provide the Board with assurance on progress against agreed action plans surrounding Winter Planning and to approve the operational winter plan for 2024/25	Andrea Gordon Paper	16:05-16:15 (10 mins)
	16:25 BOARD COMMITTEES		
12	**Quarterly Summary Report from the Quality and Outcomes Committee** To receive assurance on the work of the Committee	Paul May Paper	16:15-16:35 (20 mins)
13	**Quarterly Summary Report from the Audit, Assurance & Risk Committee** To receive the quarterly report for assurance on key discussions, actions and decisions from recent meetings from the Chair of the Committee	Lorna Harrison Paper	
14	**Quarterly Summary Report from the Finance, Estates, Environment & Digital Committee** To receive the quarterly report for assurance on key discussions, actions and decisions from recent meetings from the Chair of the Committee	Lorna Harrison Paper	
15	**Quarterly Summary Report from the Performance Committee** To receive an update report for assurance on key discussions, actions and decisions from recent meetings from the Chair of the Committee	Barbara Brown Paper	
16	**Quarterly Summary Report from the People Committee** To receive the quarterly report for assurance on key discussions, actions and decisions from recent meetings from the Chair of the Committee	Anil Patil Paper **To Follow**	
17	**People's Voice** To present to the Board the activities and achievements of the People's Voice since September 2024	Claire Valsler Verbal	
	16:45	**PUBLIC QUESTIONS (Received in advance)** Questions will be dealt with earlier in the meeting, following the agenda items the questions relate to at the Chair's discretion.	
18	**PUBLIC QUESTIONS** Board response to questions received in advance relating to this agenda	Barbara Brown	16:35-16:40 (5 mins)
19	**16:45 CHAIRS SUMMING UP & CLOSE OF PUBLIC SESSION**		

FORWARD MEETING DATES

	DATE	TIME	MEETING TYPE	VENUE
	Tue 14th January 2025	**10 – 4pm**	**Seminar**	**Yate HQ**
	12th March 2025	**2 – 5pm**	**Quarterly Public**	**Hybrid – Face to Face/Virtual**

Board Report

Date	10th December 2024	**Agenda item**	2
Title	Our People Story Service User Story – Personal Health Budgets		
Author	Katherine Watts		
Presented by	Daniela Hart, Tracey Roberts, Sam Woods	**Version**	1
For	Approval/decision ☐ Debate ☒ Assurance ☐ Information ☒		
Assurance Rating	High/Significant ☐ Medium/Partial ☐ Low/No Assurance ☐ Not applicable ☒		
If partial or no assurance, please outline steps to be taken in order to reach significant assurance, by when, and whom			

N.B. This cover paper should not exceed 2 pages.

Purpose of report and reason for submission to Board

E.g., is this a regulatory/contractual requirement, linked to our Strategic Objectives or Risks?

Supports the delivery of Sirona's Experience and Engagement Strategy:

- to ask people to give feedback
- to listen to their experiences of care
- to learn and understand what matters most to people who use our services
- to involve people in activities to improve care

Related Risk No. (If applicable)	

How has the assurance provided in this report been obtained?

What sources of information have been relied on? How has assurance been built up through the organisation?
Provide links to relevant evidence sources relied upon in this report.

Patient feedback through several meetings.

What is the process the report has been through internally

Which teams or groups have reviewed the report or the information that informs it

Experience and Engagement.

Summary and Key Issues to be highlighted
Please highlight in summary the key messages from this report, including matters of escalation from Committees, significant issues, risks and actions to address them *Alert the Board to of areas where assurance is not sufficient.* *Advise the Board of steps taken to address areas where assurance needs to be improved. (please ref relevant section of the report, where more information can be found).*
The story explores the person's life story, how they started using Personal Health Budgets and what it means to them.
Actions for the Board (including any decisions required and options for consideration)
Are there any matters that require a Board decision or discussion to address issues of concern?
Listen to the story and hear from staff on the service delivery.

1. Background

Digital patient stories provide a valuable tool for enhancing patient care, improving quality, educating staff, and fostering a culture of empathy and continuous improvement.

This methodology encourages people who use Sirona services to share their experiences, in their own words, highlighting what matters most to them. It provides personalised, emotive and memorable feedback which can also be shared widely within the organisation to celebrate great care, reflect on practice or make improvements where needed.

2. Key Points

This is a story about Annie. Annie has Muscular Dystrophy and uses a ventilator. Annie deteriorated and required 24-hour care.

The story explores the key issue of personal health budgets and what these can mean for a person's life.

3. Recommendations

The Board is asked to listen to Annie's story. Staff will be on hand to introduce the story, answer any questions and share the background to personal health budgets.

Date	Wednesday 11 September 2024
Location	Engineers House, Clifton/ *Hybrid*

Attendees

The following Board attendance was noted:

Attendees		**Present**	**Apologies**
Babara Brown	Interim Chair	✓	
Paul May	Non-Executive Director		✓
Lorna Harrison	Non- Executive Director	✓	
Simon MacSorley	Non-Executive Director		✓
Anil Patil	Non-Executive Director	✓	
Merlyn Ipinson-Fleming	Non-Executive Director (Senior independent Director)		✓
Julie Sharma	Interim Chief Executive Officer	✓	
Laks Khangura	Interim Chief Finance Officer	✓	
Andrea Gordon	Interim Chief of Operations	✓	
Julian Fleming	Chief of Digital Strategy & Delivery	✓	
Sonya Wallbank	Chief People & Culture Officer		✓
Mary Lewis	Chief Nurse and Allied Health Officer	✓	
Kathryn Bateman	Chief Medical Officer	✓	
Julie Young	Interim Director of Governance	✓	
Mike Owen Mel Reeks	Joint Interim Directors of Transformation & Business Programmes	✓	

In attendance

Domini Harewood	Deputy Director of Workforce (deputising for Sonya Wallbank)	✓
Jill Jaratina	Interim Head of Corporate Governance (Minute Taker)	
Claire Valsler	Chair of Peoples Voice	

Presenters:

Caroline Cresswell, Hayden Fraser and Christine Erasmus	Item 1 – Our People Story

Company Reg. No: 07585003 | Sirona care & health, 2nd Floor, Kingswood Civic Centre High Street, Kingswood, Bristol, BS15 9TR

Neil Hopkins	Item 9 – Equality, Diversity & Inclusion Reporting
Greg Garrett	Item 11.0- Emergency Preparedness, Resilience & Response (EPRR) Annual Report
Chair	Barbara Brown

Item	Notes	ACTIONS
1.	**Apologies:** Noted for Sonya Wallbank, Simon McSorley, Merlyn Ipinson-Fleming and Paul May	
2.	**Our People Story** Mary Lewis (ML) introduced the Board story. Barbara Brown (BB) welcomed Caroline Cresswell (CC), Hayden Fraser (HF) and Christine Erasmus (CE) who were co-presenting a story about staff experience of engaging in an After-Action Review (AAR) as part of the new Patient Safety incident response framework (PSIRF). CE advised that CC and HC had been involved in one of the very early after-action reviews, a learning response which is part of the new PSIRF. The new framework enables the staff who are involved in the incident, together with external resources where required, to discuss the incident in detail i.e what happened, what was expected to happen, why and what could be learnt from the incident. HF narrated the incident relating to a patient on the NHS@Home Frailty pathway who had delirium and an infection. The patient was seen in the community but their ongoing follow up was not arranged. The EMIS (clinical system) outage was a contributory factor as the error of omission would have been picked up on EMIS. There was no access to emails, patient caseloads, and patients' bloods during the outage. One of the Co-ordinators identified the omission during a caseload review when the EMIS system had resumed that the patient who had Acute Kidney Injury (AKI) was not receiving any visits. The omission did not result in clinical harm but the patient felt unsupported as they should have been seen sooner. The incident was reported on Ulysses (risk management system) and after discussions with the Patient Safety team, it was agreed that an after-action review would be completed as the incident could have resulted in some potential harm to the patient and there was some learning from the incident in terms of business continuity and patient safety when the EMIS system is not accessible. CE who was the Conductor during the review explained that her role was to facilitate the review in a confidential environment, to ensure that all the participants knew their roles in the review and that they would create the solutions to the issues identified in a no blame environment and foster the changes themselves. The presenters shared the learning that had been identified with the Board. The overall feedback to the Board was that the after-action review had provided a positive experience, staff involved felt that they could actively participate and the outcome of the review was positive. In response to BB's question on how the learning would be shared across the organisation, CC advised that the role as a Co-ordinator was to disseminate the learning across the organisation and this was work in progress. It was noted that the new PSIRF process was more proactive rather than reactive to incidents.	

DRAFT

Company Reg. No: 07585003 | Sirona care & health, 2nd Floor, Kingswood Civic Centre High Street, Kingswood, Bristol, BS15 9TR

	BB thanked the presenters on behalf of the Board for sharing the patient/staff story and commented that the team had not only shown that they were taking strong steps towards improvement, but they were also putting patients at the centre of everything. The presenters left the meeting.	
3.	**Declarations of Interest** There were no further declarations of interest.	
4.	**Approval of Previous Board Minutes** **Meeting in public – 11 June 2024** The minutes of the public section of the meeting held on Tuesday, 11 June were reviewed and approved as an accurate record. **Noting of Minutes recording the approval of the Medical Appraisal & Re-Validation Framework** The minutes recording the decision to approve the Medical Appraisal and Re-validation Framework were noted as a formal record.	
5.	**Chair and Non-Executive Directors Report** BB started by acknowledging Simon MacSorley who will be leaving the organisation at the end of September after 4 ½ years as a Non-Executive Director. Board members joined the Chair in thanking Simon who was unable to attend the meeting, for all his work. **Ratification of Non-Executive Director Appointments** BB presented the recommendations of the Nominations Committee in detail for the Board's consideration, noting that this was a tabled paper. The Nominations committee had given assurance that the process of recruitment, selection and interview had been rigorous and transparent in line with the objectives set by the Board regarding the new appointments. Assurance had also been given that the process had been fair and open and advertisement for the roles had been managed by Odgers Berndtson, an executive search firm. Three candidates had been recommended for appointment based on merit, the objective scoring criteria, and skill mix requirement for a three-year term. The Board was asked to support the recommendation to appoint Tim Cooper, Professor Jackie Hayden, CBE and Dr Haley Richards as Non-Executive Directors subject to completion of the necessary employment checks. A further Non-Executive Director and an Associate Non-Executive Director would be recruited over the coming months to bring additional financial and digital skills and expertise to the independent roles. Anil Patil (AP) enquired to what extent the candidates that had been recommended for recruitment would expand the inclusivity and diversity of the Board. BB advised that one of the candidates had declared a disability, two candidates were female and currently within the non- executive group there are three that identify as having ethnic minority status. The Board was moving towards diversifying the Non-Executive Directors. One of the candidates that was from an ethnic minority background withdrew their application due to time commitment. The Board noted that the Chair and Interim Director of Governance were discussing how the Non-Executive Directors would be supported in their new roles, the induction programme and Board development.	

DRAFT

Company Reg. No: 07585003 | Sirona care & health, 2nd Floor, Kingswood Civic Centre High Street, Kingswood, Bristol, BS15 9TR

	DECISION: The Board approved the appointment of Tim Cooper, Professor Jacky Hayden, CBE and Dr Hayley Richards as the three new Non-Executive Directors subject to completion of the necessary employment checks. **Chairs Report** Due to time constraints, BB provided a brief verbal update on the activities during the past quarter and advised that a detailed report would follow; • attended a number of system partner meetings during the quarter; • Work was ongoing with the governance team in terms of the governance review and framework; • had been involved in preparing for and conducting the non-executive director interviews; • All the Board Committees had met in the quarter.	
6.	**Chief Executive's Briefing** The report was taken as read, with Julie Sharma (JS) highlighting the following key points: This was Sirona's first public board meeting since the resignations of the previous Chair and Chief Executive and the national race riots. Sirona had made a firm stand with staff in terms of any aspects of abuse, racism within the organisation, any negative experiences staff were receiving from the public or patients as they were going about their duties. Positive feedback had been received from staff in terms of the support the organisation was providing. JS assured the Board that steps were being taken to ensure that the organisation remains stable and continues to go from strength to strength. The lessons learnt from the broader issues that have been identified throughout the organisation including the resignations of the Chief Executive and Chair would be shared at a future board meeting. An article had been published in the Health Service Journal (HSJ) reflecting in detail the open conversations with all staff that the organisation has held to address the acts of racism and bullying reported through the freedom to speak guardians/champions and other channels. The Lord Darzi review was due to be published in the week and the Board would have a discussion around intelligent boards at the next board seminar in October. The Board was assured that the relocation to the new headquarters in Yates was going ahead in October 2024. An extensive consultation had been completed with staff. JS acknowledged Domini Harewood and the workforce teams for completing the consultation diligently at every stage. The Digital team had responded more positively to the national digital outage in comparison with the system partners and this was a testament to the work of the team. Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB) had been informed that a new contract for patient transportation they had put in place just over a year ago had been handed back by the provider. Immediate steps had been put into place to ensure that patients continue to receive treatment, but transportation was limited, and some of the provider's staff may lose their jobs. Although this situation did not have a severe impact on Sirona, it was a reminder that things can go wrong, resulting in dire consequences even where processes have been robust. **Well Led Action Plan**	

DRAFT

Company Reg. No: 07585003 | Sirona care & health, 2nd Floor, Kingswood Civic Centre High Street, Kingswood, Bristol, BS15 9TR

	As agreed at the Board seminar on 9th July, Julie Young (JY) presented a report for assurance on the work undertaken to date. The Board noted that a 'live' work plan document is now held centrally on the Ulysses system, capturing progress with each of the 8 quality standards under the Well Led Domain, as well as being a repository for documentary evidence to support statements against each. Work was ongoing to provide the evidence for gaps that had been identified. A member of the Governance team has been instrumental in driving the work forward. The Internal Auditors had commenced an audit on the Well Led domain to assess Sirona's readiness. Also an individual from the NHS has been identified as a critical friend. JY advised that the gaps that had been identified did not cause material and due concern but the momentum that had been seen in the past few weeks must be maintained. AP commented that the organisation had recognised and dealt with the issues in the children's services and more recently heard about the challenges the internationally educated nurses were facing. The red flags were evident that Sirona needed to strengthen its anti-discrimination credentials. It would be beneficial for the organisation to understand the lived experiences to assist the board in determining the priorities of the organisation and capability. BB highlighted that Sirona should also ensure that it is meeting the statutory duties in procurement, employment and in the delivery of services. LH was concerned that she did not feel equipped for the new CQC inspection framework. ML assured the board that a session would be arranged to address the concern that LH had raised. It was suggested and agreed to change the action owner for shared culture from Chief People Officer to the Board Chair and shared direction to the Chief Executive. **Action: JY** The Board received assurance that sound progress was being made with mechanisms in place to ensure that this progress would be maintained.	
7.	**Risk Register** The report was taken as read and brought to the Board by Mary Lewis (ML) to notify and inform them of Sirona's high scoring risks and receive assurance of the management of these risks, in line with the Risk Management Policy. It was noted that while significant progress continued to be made in terms of managing the risk register, some high scoring risks were overdue for review. The risk team was working with individuals and Directors to review the risks in significant detail, so further movement will be seen in the coming months. The Board noted that the adult operational division had made some progress in terms of reviewing all their risks. Particular attention was made to the following risks which had been discussed by the relevant Committees; • **781**- Compliance with the MHRA NatPSA2023 010 Bed rail alert. If the organisation is unable to complete all the actions above, then it will not be compliant with the MHRA national Patient safety Alert), • **834** - Data Quality issues with EMIS/Electronic Patient Record • **833** - No organisation wide way of reporting when follow up appointments are due or reporting to provide oversight of which patients may be overdue an appointment. This was a new risk. Four risk scores had increased, including risk 757 (Heart Failure service, current system clinical pathway is not equitable, leading to inequity of care for patients and increasing and demand beyond current capacity in Sirona service had been escalated).	

Company Reg. No: 07585003 | Sirona care & health, 2nd Floor, Kingswood Civic Centre High Street, Kingswood, Bristol, BS15 9TR

	Although the percentage of risks that were beyond their review date had reduced in the last quarter, this was still a concern that required further intervention. **DECISION: The Board approved the content of the report and received partial assurance that the risk register is being managed in line with the Risk Management Policy.**	
8.	**Quality Reports** Presented by ML, the following reports were taken as read following scrutiny by the Quality & Outcomes Committee. The Board received the Committees recommendations to approve these annual reports. 8.1 Prevention & Control Annual Report 8.2 Health, Safety & Security Annual Report 8.2 Safeguarding Annual Report **DECISION: The Board noted the work of the various Quality & Safety areas and supported the recommendation by the committee to approve the annual reports.**	
9.	**Equality, Diversity & Inclusion Reporting** **9.1-Public Sector Equality Duty Report** Domini Harewood (DH) and Neil Hopkins (NH) co-presented the Public Sector Equality Duty (PSED) report which reviewed the work undertaken during 2023 and demonstrated Sirona care & health's commitment and actions towards fulfilling its obligations under the Equality Act 2010. There was no member of staff assigned to equality, diversity and inclusion (EDI) in the past and the report highlights the necessity to have a designated EDI lead. The organisation had maintained its level 2 accreditation of the Disability Confident Employer standard. The ongoing challenges were; the need for better workforce representation to reflect the diversity of the communities served by Sirona and insufficient patient data to identify and address disparities in service access. These areas require continued focus and strategic action to achieve significant assurance. **DECISION: The Board approved the 2023 Public Sector Equality Duty Report as an accurate reflection of the work undertaken in relation to Sirona's Public Sector Equality Duty (PSED) subject to reviewing the priorities for 2024.** **9.2-Update on Equality, Diversity and Inclusion (EDI)** DH advised that the update on Equality, Diversity and Inclusion (EDI**)** had been presented to the People Committee. The two areas of focus were the anti-racism training for the Board (October 2024 and January 2025) and the senior leadership (November 2024) and recruitment and retention. On 3rd October 2024, Ten members of staff were commencing on the "Train the Trainer programme" to deliver the anti-racism training and they would also attend team meetings to provide support. JS asked how the members of staff had been identified to attend the train the trainer course. DH advised that the selection was through expressions of interest and the process was robust. The Board noted the progress of activities related to the advancement of the EDI agenda across Sirona. **9.3-Modern Slavery Statement and Action Plan** DH presented the Modern Slavery Statement setting out Sirona's commitment to the elimination of slavery and trafficking from its supply chains. The Board noted the	

DRAFT

Company Reg. No: 07585003 | Sirona care & health, 2nd Floor, Kingswood Civic Centre High Street, Kingswood, Bristol, BS15 9TR

	regulatory requirement to publish the Modern Slavery Statement on the Sirona website at the end of September. Julian Fleming (JF) enquired how Sirona ensured that its suppliers also comply with anti-slavery and trafficking. DH advised that all of Sirona's suppliers were aware of the anti-slavery and trafficking requirements, and they provide evidence to show their compliance. Sirona staff members also receive training on anti-slavery and trafficking as part of the mandatory training. **DECISION: The Modern Slavery Statement was approved for publication in accordance with the regulatory reporting by 30 Sept 2024.**	
10.	**Annual Reports & Financial Statements for the year ending 31.03.24** Laks Khangura (LK) was welcomed to present the annual report and financial statements for the year ended 31 March 2024 for approval, and submission to Companies House following previous scrutiny by the Executive Team and the Audit, Assurance & Risk Committee. **10.1: Annual Report – Financial Statements** The Board noted that the financial statements had been audited by the External Auditors who had given their opinion that the statements provided a true and fair view of the company's affairs as at 31 March 2024. **DECISION: The Board approved the,** **i)Annual Report and Financial Statement for the year ended 31 March 2024 for Sirona care & health CIC were approved pending the amendment of the service user story** **ii) Financial Statements for the year ended 31 March 2024 for Sirona Care Services Limited.** **10.2: Annual Community Interest Report 2023/24** The Annual Community Interest Report 2023/24 was presented to the Board for approval ahead of submission to the CIC regulator. **DECISION: The Board approved the Annual CIC Report for submission to the relevant regulatory authorities** **10.3: Delegated Authority Policy/Scheme of Delegation** The scheme of delegation had been reviewed in consultation with the finance team and particularly the management accountants that work with service managers across the organisation. The Board was asked to note and approve the revisions to the scheme of delegation following approval from the Audit, Assurance & Risk Committee. **DECISION: The Board approved the Delegated Authority Policy/Scheme of Delegation.**	
11.	Emergency Preparedness, Resilience and Response (EPRR) Annual Report Greg Garrett was welcomed to present the Emergency Preparedness, Resilience and Response Annual Report to reflect the activities that had occurred across the organisation since the last report was issued for formal approval. The Board noted that Sirona had both statutory and contractual obligations as a Category 1 Responder to publicly state its readiness and preparedness activities in its annual report as well as fulfilling the regulatory reporting requirements. The Board was informed that the Accountable Emergency Officer which was a statutory role had a number of changes in personnel, but the organisation remained steady in terms of emergency	

DRAFT

	planning. A number of activities had been completed at system level. Following a confirm and challenge meeting, it was established that Sirona's assurance compliance rating improved from partially compliant in 2022 to substantially compliant in 2023, reflecting that the organisation is fully compliant against 90% of the relevant NHS EPRR Core Standards. The remaining standards were not compliant due to external factors. The senior managers on the on-call rota continued to access training in tactical command through e-learning as there is no national course catering for this requirement provision. **DECISION: The Board considered and approved the Emergency Preparedness, Resilience and Response (EPRR) Annual Report**	
12.	**People's Voice Report** Claire Valsler (CV) Chair of the People's Voice was welcomed to the meeting to present a quarterly update on the activity of the People's Voice. The draft Terms of Reference for People's Voice were still to be agreed by the members and this situation remained unresolved as the group was currently only focused on adults services only and links with the youth forum were yet to be developed. Work was ongoing to establish the purpose of the group. MLs acknowledged CV for her commitment on the Experience and Engagement Strategy which had been approved. BB thanked CV on behalf of the Board for her commitment in her role as Chair of the People's Voice The Board received the People's Voice report for information.	
13.	**Mid-Year Freedom to Speak Up Report** Taking the report as read, Julian Fleming (JF) presented the Mid-Year Freedom to Speak Up Report to give a high-level overview of the work undertaken by the Guardians. This included ensuring an awareness of the work of Freedom to Speak Up Guardians and the themes of the concerns that were being raised. The number of cases reported had increased month on month, with the main themes categorised as line management, attitudes and behaviours and pressure of work. A fully functioning module was now available on Ulysses for staff to report incidents and this was easily accessible like the incident reporting module. JS pointed out that freedom to speak up was likely to be discussed as part of the lessons learnt review at the Board Seminar in October. The Board received this report as assurance on the activities of the service. BB announced that this was JF's last Board meeting at Sirona as he was leaving the organisation at the end of the month and thanked him for the leadership and work he had contributed during his employment with Sirona. The Board members joined the Board in wishing him well.	
14.	**Consent Agenda Items** **Items 14-20 –** The quarterly assurance reports for the Board Committee meetings that were held in August were reviewed in advance and noted for assurance**.** **Item 21 – Ratification of revised Committees of the Board Terms of Reference updates** JY presented the following terms of reference that had been recommended for Board approval by the relevant Committees; • Audit, Assurance & Risk Committee	

DRAFT

	• People Committee • Finance, Estates, Environment & Digital Committee • Performance Committee • Quality and Outcomes Committee **DECISION: The Board approved the Terms of Reference.**	
22.	**Public Questions and Close of meeting in Public** The Board noted that no questions had been received for the Board to answer.	

Next meeting date	Board Seminar on 8 October 2024

DRAFT

Active Actions Arising from Board Meetings

	Completed		Progressing to plan		Minor delays		Serious delays		Not started

No	Meeting Date	Action	Officer Responsible for Action	Update to December 2024 Board Meeting	Delivery Date	Meeting where action completed/rebadged to	RAG
1.	**09.05.23**	**Programme and Priorities for 2023/24** Review of our legal/organisational form	**CEO**	The Board will begin its review of its Strategy in October 2024 to inform the Business Plan and Budgeting arrangements for 25/26. This will include an in-depth look at our governance arrangements which will help to inform any further discussions around organisational form. Propose to close.	**December 2024**		
23.	09.07.24 Seminar	**Well Led Seminar** Chair, along with NED colleagues, review and agree their Board Champion Roles	**Chair**	This item will be reviewed post the appointment of new NEDs. **Update:** New NEDs in post from 4th Nov. List of statutory/mandatory named NEDs identified. Chair/Interim Director of Governance to meet with the NEDs during December to agree NED roles.	**December 2024**		
33	11.09.24	**Commencement and Progress with the Governance Framework Review** (merged from items 9,11,12,24-27 shown on the Board actions at 11/9/24 – as all	**Interim Director of Governance**	Review commenced and areas to address were presented and discussed at the Board Seminar on 8th October 2024.	**Review December 2024**		

No	Meeting Date	Action	Officer Responsible for Action	Update to December 2024 Board Meeting	Delivery Date	Meeting where action completed/rebadged to	RAG
		these areas are part of the current Governance Framework Review)		External Organisation to support with the review identified and has commenced work. **Update:** Good Governance Institute commissioned to undertake an external Developmental Governance Review – scoping workshop held 15/11/24, input from staff and stakeholders during Nov/Dec, with a final report due at end of January 2025. Update on Agenda today. Request to consider this action closed. Governance Review and implementation plan part of Director of Governance Objectives. Progress will be reported to Executive Team and Board.			
29.	09.07.24 Seminar	**Well Led Seminar** Enquiries to be made to establish what capacity ASW (auditors) have to support an external well led review and associated cost.	**Chief Nursing Officer**	Cost agreed via Executive Committee and terms of reference for this audit agreed; Audit now underway. Integrated with Action 5.	**Dec 24**	**To close at December meeting**	

No	Meeting Date	Action	Officer Responsible for Action	Update to December 2024 Board Meeting	Delivery Date	Meeting where action completed/rebadged to	RAG
30	11.09.24 Meeting	**Well Led Action Plan** To change the action owner for shared culture from Chief People Officer to the Board Chair and shared direction to the Chief Executive	**Interim Director of Governance**	Action owners have been updated	**Dec 24**	**To close at December meeting**	
31	11.09.24 Meeting	**Public Sector Equality Duty Report** The Board approved the 2023 Public Sector Equality Duty Report as an accurate reflection of the work undertaken in relation to Sirona's Public Sector Equality Duty (PSED) subject to reviewing the priorities for 2024	**Deputy Director of HR**	DH reviewed priorities for 2024 prior to the publication of the report	**Sept 2024**	**To close at December meeting**	
32	11.09.24 Meeting	**Annual Report and Financial Statement for the year ended 31 March 2024** Annual Report and Financial Statement for the year ended 31 March 2024 for Sirona care & health CIC were approved pending the amendment of the service user story	**Chief Finance Officer**	Service user story amended prior to publishing the report	**Sept 2024**	**To close at December meeting**	

Board Report

Date	10 December 2024	**Agenda item**	5
Title	Chief Executive Report		
Author	Julie Sharma		
Presented by	Julie Sharma	**Version**	1
For	Approval/decision ☐ Debate ☐ Assurance ☐ Information ☒		
Assurance Rating	High/Significant ☐ Medium/Partial ☐ Low/No Assurance ☐ Not applicable ☒		
If partial or no assurance, please outline steps to be taken in order to reach significant assurance, by when, and whom			

N.B. This cover paper should not exceed 2 pages.

Purpose of report and reason for submission to Board	
E.g., is this a regulatory/contractual requirement, linked to our Strategic Objectives or Risks?	
The purpose of this paper is to advise the Board of any key issues not highlighted elsewhere on the agenda.	
Related Risk No. (If applicable)	

How has the assurance provided in this report been obtained?
What sources of information have been relied on? How has assurance been built up through the organisation? *Provide links to relevant evidence sources relied upon in this report.*
N/A

What is the process the report has been through internally
Which teams or groups have reviewed the report or the information that informs it
N/A

Summary and Key Issues to be highlighted

Please highlight in summary the key messages from this report, including matters of escalation from Committees, significant issues, risks and actions to address them
Alert the Board to of areas where assurance is not sufficient.
Advise the Board of steps taken to address areas where assurance needs to be improved. (please ref relevant section of the report, where more information can be found).

The key issues highlighted are:

National, System and Organisational Planning – the Board has previously received an update on the publication of the Darzi Review and the subsequent planning work to develop an NHS 10 year plan.
In this context, the government and the NHS have launched "the biggest ever conversation about the future of the NHS" through its Change NHS programme.
Sirona is currently working with system partners to support events across BNSSG over the coming months so we can hear from staff and from our communities on the three key shifts set out in the Darzi Review:

- Treatment to Prevention
- Hospital to Community
- Analogue to Digital

We are also working with partners as part of the system wide planning round for 2025/26 to identify the priorities we need to address now to put us in a strong position to respond to the shifts we all wish to see. These will include improving access to services and reducing waiting lists; addressing the demand and capacity imbalance we are seeing in many of our areas and addressing the still increasing inequalities gap across our communities.
In this context, we have been undertaking our own internal planning sessions with staff and managers across Sirona to consider the priorities for us in 2025/26 to ensure that we are in a strong position to both address the real challenges our staff are facing day in day out and enable us to contribute to the debate in a realistic and meaningful way.

Good Governance Institute – we are continuing with our work with the Good Governance Institute to help us strengthen our governance and processes within Sirona as part of our journey of continuous improvement. The team from GGI have been reviewing many of our documents and policies; observed key meetings and forums and are in the process of meeting with a range of focus groups of staff from across the organisation and working at all levels. Our plan to undertake a staff survey to seek different perspectives on where we are in terms of our governance and leadership has been put back from early December to early January given the level of surveys we have been undertaking over recent months and weeks. This will mean that the final report from GGI might be delayed by a few weeks but we will still have the majority of feedback for our seminar on 23 January with a final report and presentation in mid February.

Stabilising Executive Team – we are continuing with our plans to secure permanent appointments to our Executive Team with the recent appointment of Andrea Gordon and Laks Khangura to our substantive Chief Operating Officer and Chief Finance Officer roles respectively. The programme for the recruitment of our Chief Executive is now underway with the application process running until 20 January 2025. Final interviews are being planned for early March 2025. Proposals around out Chief Digital Information Officer and other executive positions will be shared with the Board in due course.

Winter Planning – the Board will receive a separate update regarding our planning for the increased activity expected over the Winter period which will demonstrate the actions we are taking to ensure we are in a strong position to respond to these. We are already seeing significant increases in demand for services resulting in our system tipping into the highest levels of escalation on a number of days in recent weeks. In response to this, our community teams have been delivering their highest levels of responses to hospital discharges to support the freeing up of capacity to help minimise the number of ambulances queuing outside of hospital and supporting better flow through the hospitals so that individuals can receive appropriate care in a timely manner.

National Staff Survey – the national NHS survey of staff ended on 29th November and we will share with the Board our overall response rate at our meeting. At the time of writing, information suggests that our response rate has been lower than we would wish although a final push in the last week may have helped to improve

this. Hearing the voice of our staff is key to us understanding the issues and challenges that are important to them so we can respond accordingly. Provisional results from the survey may be available early in the New Year although final figures will not be published until March 2025.

Actions for the Board (including any decisions required and options for consideration)

Are there any matters that require a Board decision or discussion to address issues of concern?

To note the CEO update report.

Board Report

Date	10th December 2024	**Agenda item**	7
Title	Governance Framework – Good Governance Institute Developmental Review		
Author	Julie Sharma, Interim Chief Executive Officer/Julie Young, Interim Director of Governance		
Presented by	Julie Sharma	**Version**	1
For	Approval/decision ☐ Debate ☐ Assurance ☐ Information ☒		
Assurance Rating	High/Significant ☐ Medium/Partial ☐ Low/No Assurance ☐ Not applicable ☐		
If partial or no assurance, please outline steps to be taken in order to reach significant assurance, by when, and whom			

N.B. This cover paper should not exceed 2 pages.

Purpose of report and reason for submission to Board	
E.g., is this a regulatory/contractual requirement, linked to our Strategic Objectives or Risks?	
Links to Strategic Objective – Governance and Leadership To provide an update for Board on the external governance developmental review, being undertaken alongside the Good Governance Institute.	
Related Risk No. (If applicable)	

How has the assurance provided in this report been obtained?
What sources of information have been relied on? How has assurance been built up through the organisation? *Provide links to relevant evidence sources relied upon in this report.*

What is the process the report has been through internally
Which teams or groups have reviewed the report or the information that informs it
Initial workshop held on 15th November 2024, to agree the scope of the review which will be forward looking, including a framework to enable as much input as possible from staff, service users, members, commissioners and partners.

Summary and Key Issues to be highlighted
Please highlight in summary the key messages from this report, including matters of escalation from Committees, significant issues, risks and actions to address them *Alert the Board to of areas where assurance is not sufficient.* *Advise the Board of steps taken to address areas where assurance needs to be improved. (please ref relevant section of the report, where more information can be found).*
Earlier this year, the Board agreed that a developmental governance review (the review) by an external organisation be undertaken during the financial year. The Good Governance Institute (GGI) has been asked to work alongside Sirona on a forward-looking review. An initial workshop was held on 15th November 2024 with the GGI to inform the scope of the review and agree the framework for capturing as many staff and stakeholder voices as possible to inform it.
Actions for the Board (including any decisions required and options for consideration)
Are there any matters that require a Board decision or discussion to address issues of concern?
The Board is asked to note the update.

1. Background

Earlier this year, the Board agreed that a developmental governance review (the review) by an external organisation be undertaken during the financial year. However, with the changes to Board shortly after this, the review had been put on hold.

The review has been re-commenced and the Good Governance Institute (GGI) asked to work alongside Sirona on a forward-looking review.

An initial workshop was held on 15th November 2024 with the GGI, Chair, Board Members, People's Voice Chair and Members representatives, to scope the review and agree the framework for capturing as many staff and stakeholder voices as possible to inform it.

2. Key Points

The initial workshop on 15th November was held to:

- Introduce the GGI's methodology and approach to the review
- Receive GGI's proposal for the review's key lines of enquiry, based on good governance principles and understanding of Sirona
- Discuss, shape and agree key lines of enquiry and areas of particularly focus for the review.

In working groups, 8 proposed key lines of enquiry were discussed. These were based on key elements of good governance in health and social care:

- Design of governance structures
- How governance structures work in practice
- Policies and guidance
- Risk Management
- Leadership to support good governance
- Culture, ethics and governance
- Learning from experience
- Stakeholder Engagement

Feedback from the groups will be collated by GGI to shape the final key lines of enquiry for the review.

The workshop was positively received, with a lot of energy in working together to talk openly about the areas in the key lines of enquiry that we were interested in; proud of; and concerned about.

There was a sense of realism of where we are now, recognition of some good work already ongoing and where we need to be for the next phase of our development as an organisation.

Informed by Sirona, the GGI will be using different types of communication methods, i.e. one to one meetings, focus groups, staff survey, etc. to enable input from staff (at all levels), service users, members, commissioners and partners. This has already commenced.

Next Steps

- GGI to collate working group feedback into a scope for the review
- Input from staff and stakeholders continues during November and December 2024
- Follow up workshop scheduled for Thursday 23rd January 2025
- Final outcome report – beginning of February 2025

3. Recommendations

The Board is asked to note the update.

Board Report

Date	10 December 2024	**Agenda item**	8
Title	Quarter 2 Risk Report		
Author	Mary Lewis Chief Nursing & AHP Officer		
Presented by	Mary Lewis Chief Nursing & AHP Officer	**Version**	1
For	Approval/decision ☐ Debate ☐ Assurance ☐ Information ☐		
Assurance Rating	High/Significant ☐ Medium/Partial ☒ Low/No Assurance ☐ Not applicable ☐		
Explanation of Assurance Rating	The number of risks that are not reviewed within the specified time frame has decreased considerably during Q1 and Q2 but the %age beyond review date is not consistent across the organisation. This continues to be a focus for the risk team and risk managers. A target for number of risks beyond review date is being considered by the risk team.		

Purpose of the report

To highlight, and give summary information on, Sirona's highest-level risks (red risks with a current risk score of 15-25). Full details can be found in Appendix 1.

Why is this report coming to the Board?

E.g., is this a regulatory/contractual requirement, linked to our Strategic Objectives or Risks?

To notify and inform the Board of Sirona's high scoring risks and receive assurance of the management of these risks, in line with the Risk Management Policy.

Related Risk No. (If applicable)	

How has the assurance provided in this report been obtained?

What sources of information have been relied on? How has assurance been built up through the organisation?
Provide links to relevant evidence sources relied upon in this report.

The content of the report is based on an extraction from the risk register for risks with a current risk score of 15 or above as at 30 September 2024 (Appendix 1).
Extractions are also taken from Power BI, updated on 26th September 2024, which may result in some slight variance between the two data sets.

What is the process the report has been through internally

Which teams or groups have reviewed the report or the information that informs it

The report has been reviewed by the Chief Nursing and AHP Officer and the Head of Clinical Governance. The information in the report has been presented to each of the Board sub committees as part of their Quarter 2 Risk Reports.

Summary and Key Issues to be highlighted

Please highlight in summary the key messages from this report, including matters of escalation from Committees, significant issues, risks and actions to address them
Alert the Board to of areas where assurance is not sufficient.
Advise the Board of steps taken to address areas where assurance needs to be improved.

Profile of the Risk Register at end of Q2 2024/2025:

- **206** risks open on the Risk Register
  149 corporate risks and **57** local risks
- **22** risks scoring 15 or above (10%)
- **29.6%** of risks for the whole risk register beyond their review date **8** of which score 15+
  Number of risks beyond review date has decreased during Q2 period
- **4** new risks opened with a score of 15+ in Q2
- **1** risk has escalated, previously scoring 12 or below, now scoring 15+.
- **4** risks have de-escalated, previously scoring of 15+, now scoring 12 or below.
- **4** risks with a previous score of 15 or above have closed since the last report.
- **21 of the current 15 + risks**, have the same score as previous month.

Progress update
At the end of Q2, the percentage of risks beyond review date for the whole risk register has decreased by 6%
Risks scoring 15+ beyond review date has decreased by 33%.
This progress follows targeted work by the risk team with risk owners to thoroughly review, amend and update risks. This work will continue.
The Executive Committee has had a targeted session to consider all the high scoring risks, (score 15+) and this will be followed with future sessions to consider significant risks (score 8-12).

Actions for the Board (including any decisions required and options for consideration)

Are there any matters that require a Board decision or discussion to address issues of concern?

The Board is asked to approve the content of the report and to receive partial assurance that the risk register is being managed in line with the Risk Management Policy.

Contents		Page
1. Background		3
2. Key points		
2.1.	**Summary of Risk Register**	3
	Table 1 - Total Number Risks open on Risk Register annual trend	4
	Table 2 - Number of Risks by Risk Category (all scores)	4
	Table 3 - Risk categories with the most risks	4
	Table 4 - Risk categories with most high scoring (15+) risks	5
2.2.	**Risks beyond review date**	5
	Table 5 – Percentage of risks beyond review date, whole risk register and 15+ risks	6
	Table 6 - Risks Beyond Review Date, by Committee (Data source Power BI)	6
2.3.	**Risks with a current score of 15 or above**	7
	Table 7 - All risks scoring 15+ all committees, by category and review status	7
	Table 8 - Summary of all risks scoring 15 or above, by Committee	7-9
2.4.	**Movement of Risks**	9
	Table 9 – Escalated risks	10
2.5.	**Open & Closed Risks**	10
	Table 10 – Opened and closed risks	10
3. Actions		11
4. Recommendations		11

1. Background

Open Risk Register as of 26th September 2024:

Active risks	194
Tolerated risks(open)	5
Controlled risks (open)	7
Total	**206**

2. Key Points

2.1 Summary of Risk Register

Status of open risks 26th September 2024 –**206** open risks

Table 1: Total Number Risks open on Risk Register trend over last 4 Quarters

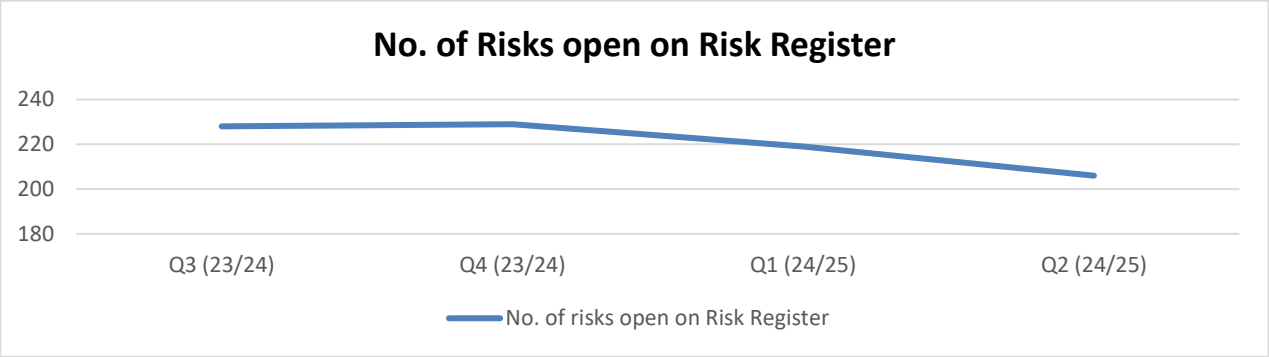


Table 2 shows **all** 206 open risks by risk category and risk rating. Please note this was extracted from Power BI, last updated 26 September 2024 so there may be slight variations in BI data from the Ulysses data.

Table 2: Number of Risks by Risk Category (all scores)

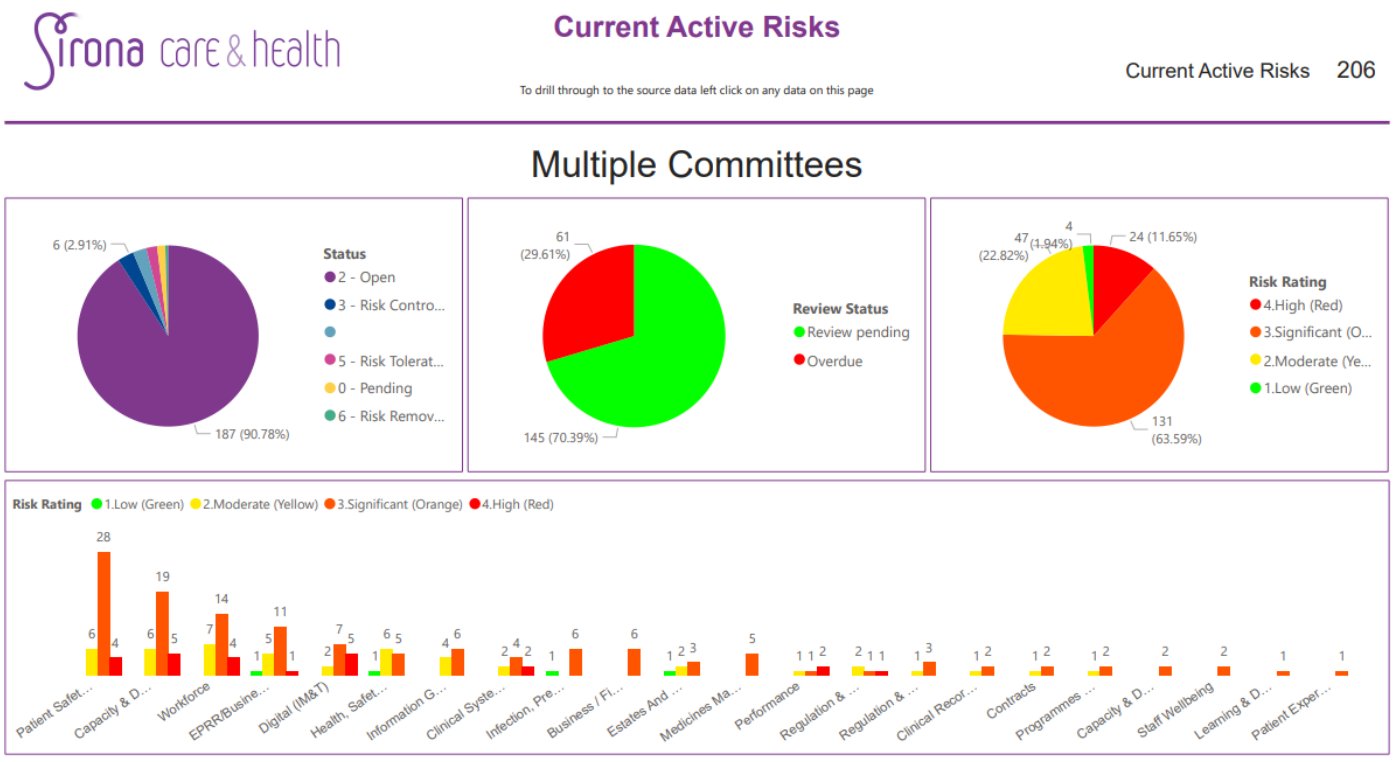


Table 3 gives a summary of the most prevalent risk categories

There is no significant change in the risk profile. The risk categories of Patient Safety/ Clinical Quality and Capacity and Demand (Operations) remain consistent with small changes in the numbers of both categories.

Table 3: Risk categories with the highest number of risks last 4 Quarters

Q3 (2023/2024)		Q4 (2023/2024)		Q1 (2024/2025)		Q2 (2024/2025)	
Ranking		**Ranking**		**Ranking**		**Ranking**	
1	Capacity & Demand (Operational) (33)	1	Capacity & Demand (Operational) (33)	**1**	Patient Safety & Clinical Quality (39)	**1**	**Patient Safety & Clinical Quality 38**
2	Patient Safety & Clinical Quality (30)		Patient Safety & Clinical Quality (33)	**2**	Capacity & Demand (Operational) (31)	**2**	**Capacity & Demand (Operational) 30**
3	Workforce (29)	2	Workforce (28)	**3**	Workforce (24)	**3**	**Workforce 25**
4	Digital (25)	3	EPRR / Business Continuity (17)	**4**	EPRR / Business Continuity (17)	**4**	**EPRR / Business Continuity 18**

Table 4 gives a breakdown of number high scoring (15+) risks in each of the most prevalent categories. Capacity and Demand (Operations) as well as being consistently in the top two categories by number also shares the highest number of risks with a score of 15+ with risks in the category of Digital (IM&T). Both with 5 red risks.
The next highest number of 15+ risks by category is shared by Patient Safety/Clinical Quality and Workforce with 4 red risks in each category

Table 4: Risk categories with most high scoring (15+) risks

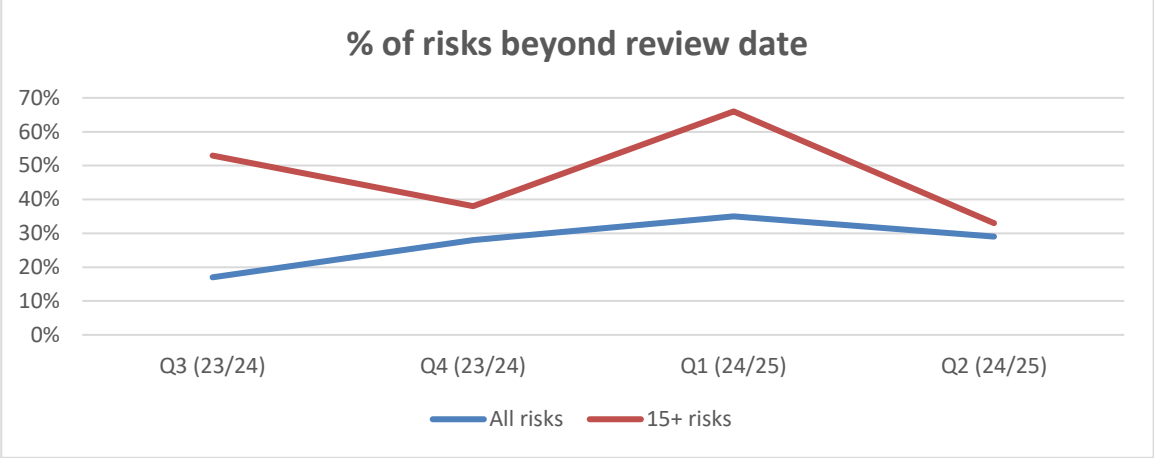
Q3 (2023/2024)		Q4 (2023/2024)		Q1 (2024/2025)		Q2 (2024/2025)	
Ranking		**Ranking**		**Ranking**		**Ranking**	
1	Digital (6)	1	Capacity & Demand (Operational) (5)	**1**	Capacity & Demand (Operational) (4)	**1**	**Capacity & Demand (Operational) 5**
2	Capacity & Demand (Operational) (5)	2	Digital (4)		Workforce (4)		**Digital (IM&T) 5**
3	Equality & Diversity (2)	3	Equality & Diversity (2)		Digital (4)		
			Clinical Systems (2)	**2**	Patient Safety & Clinical Quality (3)	**2**	**Patient Safety & Clinical Quality 4**
							Workforce 4

2.2 Risks beyond review date

29% of all risks, are beyond their review date at end of Q2 2024/2025
33% of risks scoring 15 or above, are beyond their review date at the end Q2 2024/2025

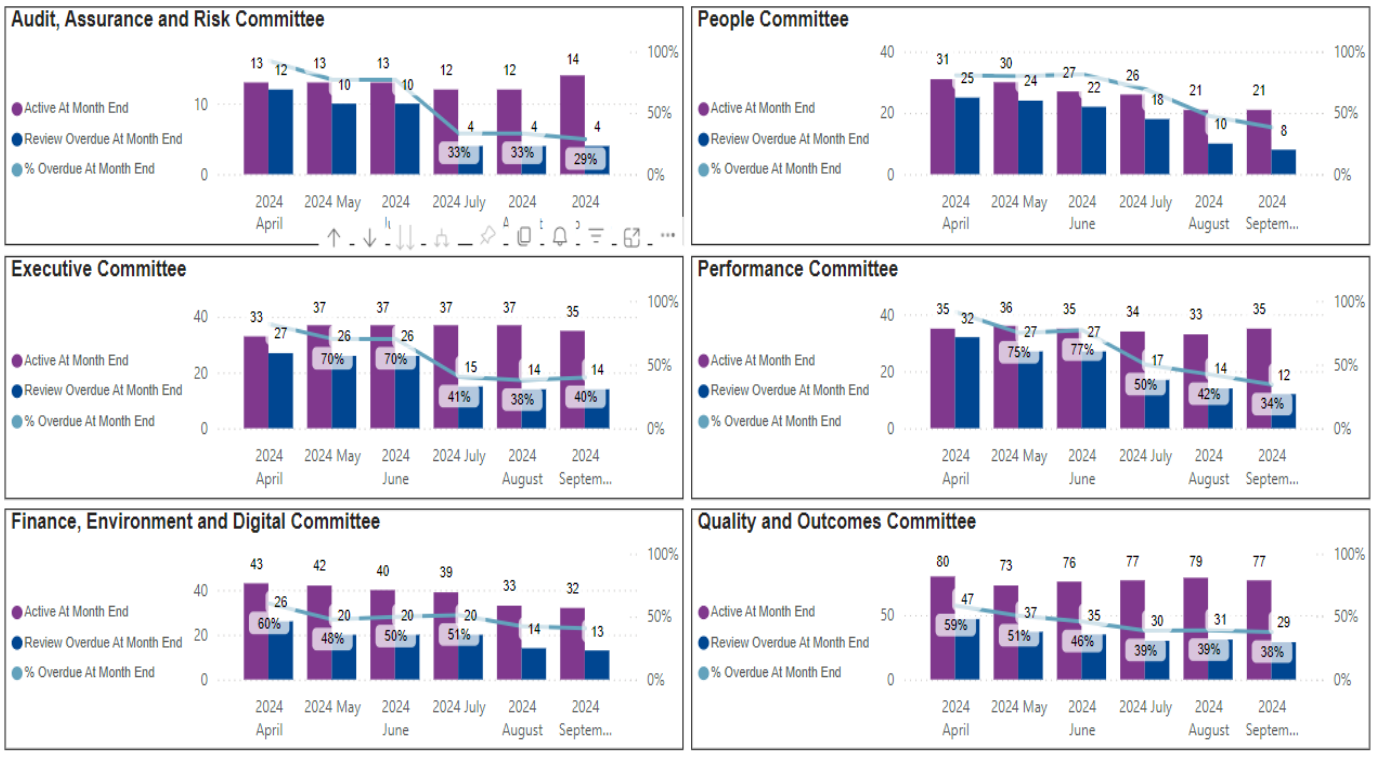
Table 5 shows the trend over the past 4 quarters of the % of risks beyond review date and shows an improving picture.

Table 5: Percentage of risks beyond review date, whole risk register and 15+ risks



The data in Table 6, shows a further breakdown of risks beyond their review date, shown by Monitoring Committee. The data shows a downward trend during Q1 and Q2 in the number of risks beyond review date, all scores, for all committees. Progress is noted across all committees but particularly notable improvement for risks monitored by Quality and Outcomes Committee given the high number of risks in scope compared with other committees.

Table 6: Risks Beyond Review Date, by Committee (Data source Power BI)



NB there are some minor presentation issues to be corrected to ensure that all %ages are shown are displayed on all sections of the chart.

2.3 Risks with a current score of 15 or above (Appendix 1)

22 risks on the risks register have a current score of 15+.

Table 7: All risks scoring 15+ all committees, by category and review status (26 September 2024)

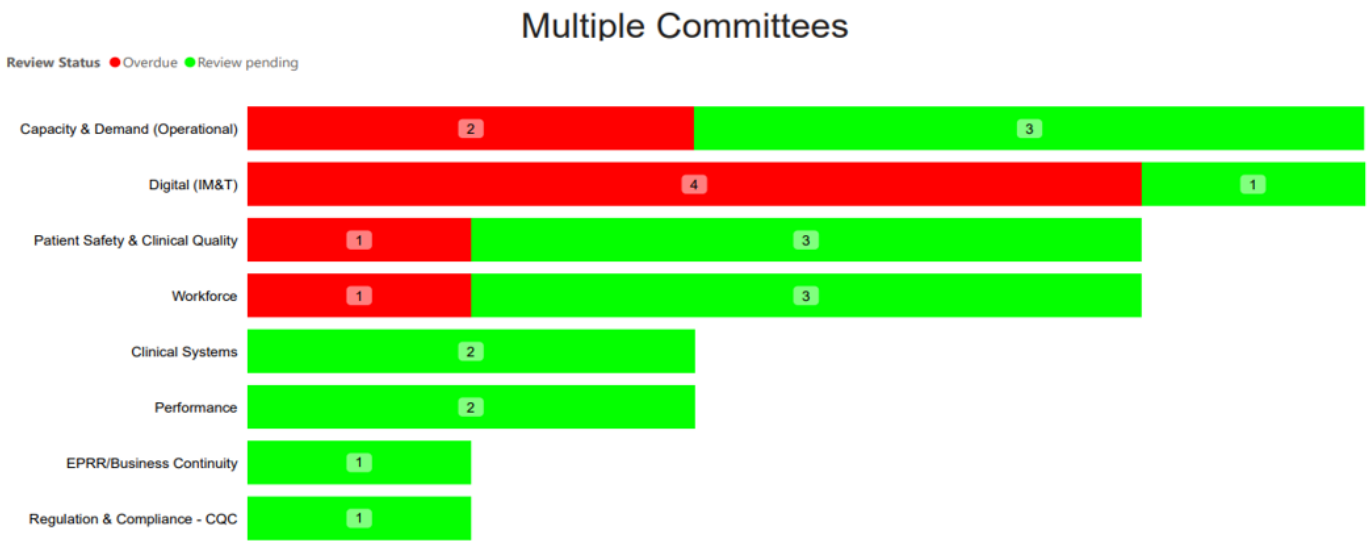


Table 8 gives a summary of the risks scoring 15+, according to the monitoring committee. NB currently no risks scoring 15+ assigned to the Audit, Assurance & Risk Committee.

Full details of all 15+ risk shown in Appendix 1 – Ulysses extraction 30 September 2024

Table 8 - Summary of all risks scoring 15 or above, by Committee:

Executive Committee						
Risk no.	**Risk Category**	**Title/Description**	**Service Affected**	**SLT Lead**	**Current Risk Score**	**Review Date**
671	EPRR / Business Continuity	Failure of the National Electricity Transmission System (NETS) - R50a	BNSSG - Adults	Andrea Gordon	**15** ↔	09/10/2024
849	Workforce*****	Risk of no community data due to inconsistent use of clinical systems	BNSSG - Adults	Kathryn Bateman	**16** ↔	13/10/2024
858	Digital**	ICB to give notice on MiDoS contract (ALAMAC kitbag replacement)	BNSSG - Adults	Julie Sharma	**20** *(new)*	16/10/2024

*Confirmation awaited whether this should re reworded and category changed to EDI
** Risk 858 deescalated 11-11-2024 to a risk score of 6 following the extension of the contract

FEED Committee						
Risk no.	**Risk Category**	**Title/Description**	**Service Affected**	**SLT Lead**	**Current Risk Score**	**Review Date**
593	Digital (IM&T)	Inadequate process for IT asset management	Sirona-wide	Julie Sharma	**16** ↔	04/09/2024
848	Clinical Systems	Risk of no community data due to underdeveloped clinical systems	Adults BNSSG	Julie Sharma	**16** ↔	23/10/2024
656	Digital (IM&T)	IT license and devices cost pressures	Sirona-wide	Julie Sharma	**15** ↔	04/09/2024
827	Clinical Systems	EPR (Adastra) for Place Based Urgent Care	Adults Urgent Care	Julie Sharma	**15** ↔	30/10/2024
665	Digital (IM&T)	Unsupported servers pose Cyber risk	Sirona-wide	Julie Sharma	**15** ↔	04/09/2024

Quality & Outcomes Committee						
Risk no.	**Risk Category**	**Title/Description**	**Service Affected**	**SLT Lead**	**Current Risk Score**	**Review Date**
781	Regulation and compliance (QCQ)	Compliance with the MHRA NatPSA2023 010 Bed rail alert. If the organisation is unable to complete all the actions above, then it will not be complaint with the MHRA national Patient safety Alert	Sirona-wide	Mary Lewis	**20** ↔	16/10/2024
768*	Patient Safety & Clinical Quality	As a result of reduced clinical and domiciliary capacity within the Podiatry service there is a risk of delayed care which could result in poor patient outcomes	Adults BNSSG - MSK	Mary Lewis	**16** ↔	23/10/2024
833	Patient Safety & Clinical Quality	No organisation wide way of reporting when follow up appointments are due or reporting to provide oversight of which patients may be overdue an appointment.	Adults BNSSG	Mary Lewis	**16** ↔	17/10/2024
135	Patient Safety & Clinical Quality	Autism Diagnostic waiting times for children and young people	Childrens BNSSG	Mary Lewis	**16** ↔	29/09/2024
831	Patient Safety & Clinical Quality	Neuro OT Waiting times	Adults BNSSG	Mary Lewis	**16** ↑ *(increased on 27/09/24 from a score of 12)*	27/10/2024
812	Patient Safety & Clinical Quality	Deferred planned nursing visits	Adults INT – BNSSG	Mary Lewis	**15** ↔	11/10/2024

* Risk 768 de-escalated 25-11-2024 to risk score of 12

People Committee						
Risk no.	**Risk Category**	**Title/Description**	**Service Affected**	**SLT Lead**	**Current Risk Score**	**Review Date**
767*****	Capacity & Demand (Operational)	As a result of national shortage of registered Podiatrists, the risk is that not able recruit staff will impact service delivery and wellbeing of existing staff members	Adults BNSSG	Andrea Gordon	**20** ↔	23/10/2024
677	Workforce	Clinical staff training and competencies	Adults INT - BNSSG	Sonya Wallbank	**16** ↔	26/10/2024
633	Workforce	BNSSG INT Staffing	Adults INT - BNSSG	Sonya Wallbank	**16** ↔	10/10/2024
790**	Workforce	Therapy Staffing is significantly affecting ability to undertake therapy activity in the South Bristol INTs	Adults INT Bristol South	Sonya Wallbank	**15** ↔	13/10/2024

*Has been transferred to Performance Committee
**Risk 790 has now de-escalated 20-11-2024 to risk score of 9

Performance Committee						
Risk no.	**Risk Category**	**Title/Description**	**Service Affected**	**SLT Lead**	**Current Risk Score**	**Review Date**
861	Performance	Strain on Sirona's systems team	BNSSG - Adults	Andrea Gordon	**20** *(new)*	23/10/2024
834	Performance	Data Quality issues with EMIS/Electronic Patient Record	BNSSG - Adults	Andrea Gordon	**16** ↔	17/10/2024
757	Capacity & Demand (Operational)	Heart Failure, current system clinical pathway is not equitable, leading to inequity of care for patients and increasing capacity and demand within current Sirona service	BNSSG – SS Heart Failure	Andrea Gordon	**16** ↔	17/10/2024
428	Capacity & Demand (Operational)	Capacity issues within Community Paediatric service to meet current demands for new referrals and children open to the service	Community Paediatrics	Andrea Gordon	**16** ↔	27/10/2024
830	Capacity & Demand Operational	There is a significant higher demand of referrals for planned therapy against predicted contracted activity in BNSSG	Adults INT BNSSG	Andrea Gordon	**15** ↔	26/10/2024
792*	Capacity & Demand (Operational)	Parkinson's Service SASS Capacity and Demand	Adults Services – BNSSG	Andrea Gordon	**15** ↔	13/10/2024

***Risk 792 de-escalated 27-09-24 to risk score of 9**

2.4 Movement of risks

Since Q1 24/25, report to Board there has been some movement in risks scores.

1 risk escalated during Q2 summary below.

Table 9 shows the risks previously scoring 12 or below, now with an increased score of 15 or above.

Table 9: Escalated risks

Risk no.	Risk Title	Risk Category	SLT Lead	Previous Risk score	Current Risk score	Details of last review:
831	Neuro OT Waiting times	Patient Safety & Clinical Quality	Mary Lewis	12	16	27/09/2024: Demand for this service remains high and the current budget for staffing does not meet this increased need for Therapy provision to this cohort. In addition, requests on this service from other parts of the organisation for expert A&G in particular to deal with complex Postural care is adding to the workload and waiting times.

(4 risks deescalated during Oct and November as noted in Table 8 above)

2.5 Open & Closed risks

The below data shows the comparison between risks opened and closed for the whole risk register in Q2:

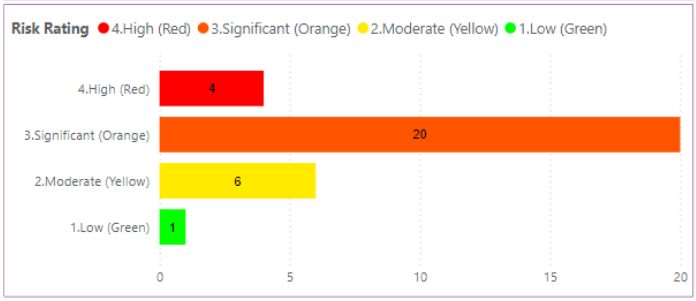
Table 10: Risks opened and closed

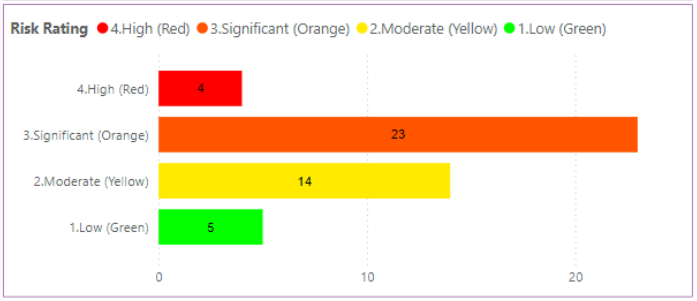
Risks Opened

month_startdate	1.Low (Green)	2.Moderate (Yellow)	3.Significant (Orange)	4.High (Red)	Total
July 2024	0	2	6	0	**8**
August 2024	0	1	8	2	**11**
September 2024	0	1	6	2	**9**
Total	**0**	**4**	**20**	**4**	**28**

Risks Closed

month_startdate	1.Low (Green)	2.Moderate (Yellow)	3.Significant (Orange)	4.High (Red)	Total
July 2024	1	4	5	1	**11**
August 2024	2	6	10	2	**20**
September 2024	2	4	8	0	**14**
Total	**5**	**14**	**23**	**3**	**45**





To summarise, since the Q1 24/25report to board:

- 28 new risks have been opened (all scores).
  4 of which were opened with a score of 15 or above (Risk refs 848, 849, 858, 861)
- 45 risks have closed (all scores)
  4 of these closed risks had a previous score of 15 or above (Risk refs 377, 468, 469, 773)

3. Actions

Risk reviews

Progress with risk reviews being undertaken within the designated time frame is noted with the considerable progress in Q1 continuing into Q2.

Risk workshops with the Risk Team, with Associate Directors and senior managers from the Adults Operational Division are now well established and are ongoing. These have significantly raised the profile of risk management and the engagement and support of the senior managers is noted. The high scoring risks that span the Integrated Network Teams geography are regularly discussed by the senior managers with appropriate check and challenge about the progress of the risk. A similar programme of workshops has started in with dates agreed into Q3 for Children's and SASS. Individual risk sessions are also planned for the digital team and for the People, Development and Communication senior managers.

Further work will be undertaken to ensure that the risk register interacts constructively with the Board Assurance Framework.

The role of the subject matter groups noted in the risk policy as having a fundamental role in supporting risk management for the organisation, is working well in some areas of the governance structure. As part of the organisational governance review the role of these groups and forums need be clarified and this in turn will support the Chief Officers with their oversight of risks related to their portfolios.

The Risk Team is available and able to support and advise any team or service in managing their risks.

4. Recommendations

Board is asked to approve this report as the position of the Risk Register as of 30 September 2024 but to note that there is small variation in data from the each of the data sources. Work is ongoing to ensure that data extracts from Power BI can align with extracts from Ulysses.

Partial assurance is recommended that the risk register is being managed in line with the Risk Management Policy.

APPENDICES:

Appendix 1: Risks with a score of 15 or above - All Monitoring Committees

Open Board 15+ Monitoring Group Report

Risk

Risk No. & Ver.	781 v.3	Date	29/01/2024	Risk Level	02 Corporate	Status	2 - Open	Initial Risk Rating (SxL=RR)	4 x 5 = 20

Risk Title

compliance with the MHRA NatPSA2023 010 Bed rail alert

Full Risk Description

If the organisation is unable to complete all of the actions above then it will not be complaint with the MHRA national Patient safety Alert
Note - the date for compliance was the 1st March - we were unable to declare compliance even though we meet 5 out of the 7 actions. Partial compliance is not recognized, and there is no extension of the deadline possible.

Services affected by Risk

Division / Specialty / Directorate
Adult Services / / Adults - BNSSG
Children's Services / / Childrens - BNSSG
Specialist Services / / Adults - BNSSG

Current Risk		Target Risk	
Likelihood	5	Likelihood	3
Severity	4	Severity	2
Risk Score	20	Risk Score	6

Categorisation & Monitoring Group

Category of Risk	Regulation & Compliance - CQC	Monitoring Group	Quality & Outcomes Committee

Controls

Details of Controls

Current Controls

this Alerts is being managed within the action planning module of Ulysses all details of meeting and actions are being recoded, providing a full audit trail.

Screening list of patients provided through the ICES contract - this amounts to around 13000.
The lists have been RAG rated based on perceived level of risk due to combination of items on site. The screening is to determine who would need follow up reviews to comply with action 6 of the alert

The final phase will require follow up to complete risk assessments and clinical reasoning where this could not be found on TCES or EMIS.
This will have an impact on clinical services given the potential numbers
Funding and resourcing not yet allocated

Actions

Action No.	1	Start Date	05/01/2024	Target Date	31/01/2024	Completion Date	/ /
Action Description							
Progress							
Action No.	2	Start Date	16/02/2024	Target Date	30/11/2024	Completion Date	/ /

Action Description	Legal advice received and task and finish group established
Progress	Ongoing task and finish group to complete work on documentation and risk assessment.

Action No.	3	**Start Date**	05/02/2024	**Target Date**	30/06/2024	**Completion Date**	25/09/2024

Action Description	Some funding was agreed to support screening, and this started Early February. Time and resource will not enable full screening of the lists - but hopefully the top 2 risk categories will be completed. Need discussion on how we manage the entire lists.
Progress	All red and orange now completed, yellow completed in South Glos, and "gap data" will be completed by end of April Still leave yellow for North Somerset and Bristol and all green, needing admin resource to complete. Follow ups not started at this stage

Action No.	4	**Start Date**	11/04/2024	**Target Date**	01/06/2024	**Completion Date**	25/09/2024

Action Description	Meeting with SLT members using SBAR drawn up be Siobhan Heeley. SLT suggesting use of BI to screen out deceased and long term inactive service users, and identify those at higher risk. General agreement about documentation suggestions
Progress	Meeting occurred on 11th April Awaiting legal advice on what constitutes adequate clinical reasoning / risk assessment and time limits on legal responsibility.

Action No.	5	**Start Date**	24/05/2024	**Target Date**	30/06/2024	**Completion Date**	17/06/2024

Action Description	Proposal for management of MHRA alert action 6
Progress	Legal advice received. meeting arranged to review on 29/7/24 due to leave periods

Action No.	6	**Start Date**	07/08/2024	**Target Date**	21/08/2024	**Completion Date**	16/08/2024

Action Description	Legal review review and proposal updated. paper to Exec Co, and upward report to Quality an outcomes Committee
Progress	

Action No.	7	**Start Date**	12/08/2024	**Target Date**	31/10/2024	**Completion Date**	/ /

Action Description	Meetings 19th August to start a task and finish group - initial meeting of this group 2nd September. Decision to strip back proposed comprehensive EMIS template - essentially too long, and the risk of duplication with TCES forms. Next meeting due 20th September
Progress	

Risk Reviews

Review Frequency 1 - Monthly (Risk Score 12-25) **Next Review** 16/10/2024

Review Date	16/09/2024	**Review Details**	Bit of a regroup following legal advice on how to respond to the alert. Task and Finish group set up - initial meeting 02/09/2024 Decision to greatly reduce the proposed EMIS template - considered too long, and too much risk of duplication. Next meeting 20/09/2024

Open Board 15+ Monitoring Group Report

Review Date	07/08/2024	**Review Details**	Updated proposal completed following legal advice, Paper being updated for August Quality & Outcomes Committee
Review Date	04/07/2024	**Review Details**	Legal advise received and added to record, review taking place further updates to follow.
Review Date	28/05/2024	**Review Details**	Legal advise update

Open Board 15+ Monitoring Group Report

Risk

Risk No. & Ver.	Date	Risk Level	Status	Initial Risk Rating (SxL=RR)
767 v.4	21/12/2023	02 Corporate	2 - Open	4 x 4 = 16

Risk Title

Podiatry staffing

Full Risk Description

As a result of national shortage of registered Podiatrists the risk is that not able recruit staff will impact service delivery and wellbeing of existing staff members
Links with risk 768 - patient safety

Services affected by Risk	Current Risk		Target Risk	
Division / Specialty / Directorate	**Likelihood**	5	**Likelihood**	3
Specialist Services / MSK / Adults - BNSSG	**Severity**	4	**Severity**	3
	Risk Score	20	**Risk Score**	9

Categorisation & Monitoring Group

Category of Risk	Capacity & Demand (Operational)	Monitoring Group	People Committee

Controls

Details of Controls

Current Controls

- Ongoing work to skill mix the workforce using the Calderdale framework to identify the correct clinician/support worker/admin staff required to do set tasks for patients or process.
- Progressing with the podiatry apprenticeship to grow our own registered workforce. Recruit apprentice each year depending on the capacity of clinical educators within the team
- engaging team in away days planned every 6 weeks and huddles to improve wellbeing
- providing rotations within the MDT's in secondary care/nail surgery/MSK F&A. and training plan for the team to help with retention
- ongoing advert for agency staff in place

Actions

Action No.	Start Date	Target Date	Completion Date
1	21/12/2023	31/10/2024	/ /

Action Description

To continue to review the skill mix of the team using the calderdale framework identify tasks that can be completed by unregistered staff

Progress

Competencies have still not had sign off by competency group. Our service manager has confirmed that we should continue to use them for our support workers and he will continue to push for outcome of sign off.

Action No.	Start Date	Target Date	Completion Date
2	01/04/2024	31/08/2024	23/09/2024

Action Description	Liaise with international lead and NEU Professionals to source podiatrists from overseas
Progress	Meeting held with Simi George and we have now set up links with NEU Professionals for overseas recruitment. We have held 2 lots of interviews of the past months and successfully recruited 4 podiatrists. 1 will not join us until 25/26 financial year. 3 are in the process of HCPC registration

Risk Reviews

Review Frequency 1 - Monthly (Risk Score 12-25) **Next Review** 23/10/2024

Review Date	23/09/2024	**Review Details**	Vacancies currently at 24% (which includes 1WTE long term sick and 0.8WTE maternity). 1WTE leaver due end of October (adverts for this lead role has only generated internal applicants) 0.8WTE loss due end of December from 2 staff taking partial retirement. Successful international recruitment 4 WTE band 5 start date TBC as HCPC registration in progress. One of these will not be expected to land with team until June/July 2025. Unfortunate loss of 1 podiatry apprentice due to work life balance. Recruitment of 1 podiatry apprentice for Sept 24 intake (this was internal team recruitment so no increase in support worker capacity).
Review Date	21/08/2024	**Review Details**	Currently at 25% vacancy within the team. On top of this we have 1wte band 7 on long term sickness/ 0.8wte band 7 on maternity leave/ 0.6wte band 7 on phased return following long term absence so extremely limited clinical capacity. Loss of 1wte apprentice due to work life balance. We have 2 new recruits starting in Sept 1wte band 6 and 1wte band 5 but also have 1wte band 7 and 1wte band 5 leaving the service in Sept/Oct Future forecast of 1.2wte band 6 vacancy due to partial retirement by end of year. Adverts out for band 6/band 7/band 5 roles using traditional route and international recruitment. Pilot suggested for use of bank nurses to help with domiciliary wound patients

Open Board 15+ Monitoring Group Report

Risk

Risk No. & Ver.	Date	Risk Level	Status	Initial Risk Rating (SxL=RR)
858 v.1	16/09/2024	02 Corporate	2 - Open	4 x 5 = 20

Risk Title

ICB to give notice on MiDoS contract (ALAMAC kitbag replacement)

Full Risk Description

As a result of Sirona's dependency upon a non-Sirona contracted platform, the risk is that Sirona will have no means of capturing the required metrics when the ICB give notice on their MiDoS contract. This will result in Sirona being unable to provide the data for the system wide dashboard. Internally, Sirona will no longer be able to use automated OPEL tool.

There is an additional consideration in that access to MiDoS is provided free of charge to Sirona. Any alternative will incur a cost which is unbudgeted.

Services affected by Risk	Current Risk		Target Risk	
Division / Specialty / Directorate	**Likelihood**	5	**Likelihood**	2
Adult Services / / Adults - BNSSG	**Severity**	4	**Severity**	2
	Risk Score	20	**Risk Score**	4

Categorisation & Monitoring Group

Category of Risk	Digital (IM&T)	Monitoring Group	Executive Committee

Controls

Details of Controls

Current Controls

- ICB facilitating discussion with MiDoS/ Intuiti to explore costs for extension of current provision. This will incur a cost and the cost pressure as to who will be responsible is not clear
- BI to inform Metrics requirements and data flows
- Engage Digital/ IT Service Delivery Manager to explore Sirona alternative system solutions to MiDoS. Business Analyst drafting Options Appraisal (progressing earlier draft)
- Business Analyst to develop Options Appraisal

Actions

Action No.	1	Start Date	16/09/2024	Target Date	31/12/2024	Completion Date	/ /
Action Description	Regular email exchange and meeting in process of being arranged						
Progress							

Risk Reviews

Risk Reviews
Risk Not Reviewed

Open Board 15+ Monitoring Group Report

Risk

Risk No. & Ver.	Date	Risk Level	Status	Initial Risk Rating (SxL=RR)
768 v.3	21/12/2023	02 Corporate	2 - Open	4 x 4 = 16

Risk Title

Podiatry patient safety

Full Risk Description

As a result of reduced clinical and domiciliary capacity within the service there is a risk of delayed care which could result in poor patient outcomes
Links with risk 767 - podiatry staffing

Services affected by Risk	Current Risk		Target Risk	
Division / Specialty / Directorate	**Likelihood**	4	**Likelihood**	3
Specialist Services / MSK / Adults - BNSSG	**Severity**	4	**Severity**	3
	Risk Score	16	**Risk Score**	9

Categorisation & Monitoring Group

Category of Risk	Patient Safety & Clinical Quality	Monitoring Group	Quality & Outcomes Committee

Controls

Details of Controls

Current Controls

- advice and guidance line for patients and HCP's
- RAG rating of our existing high risk caseload to enable to identify most at risk in this high risk group
- Urgent access clinics in each locality to enable timely access to the service for urgent cases.
- Engagement with HealthyIO minuteful for wound app to enable oversight of wound caseload especially in regards to domiciliary patients
- streamlined Podiatry pathways across BNSSG
- One EMIS
- Shared care with INT/primary care where possible

Actions

Action No.	1	Start Date	01/06/2023	Target Date	31/08/2024	Completion Date	23/09/2024

Action Description	Work through tasks with team and set up processes/competences to enable this.
Progress	Competencies in place for support workers (although not signed off by competency group we have had confirmation these can be used by service

	manager)

Action No.	2	Start Date	01/06/2024	Target Date	31/10/2024	Completion Date	/ /
Action Description	Podiatry leads reviewing patients identified as being overdue and identifying risk and who they need to be seen by (pod/Support worker/nurse) and if shared care currently in place						
Progress	Due to cause for concern which highlighted South Glos as a particular issue reviews started with the south glos caseload which has now been completed and Bristol caseload in progress. Leads have been prioritising this piece of work in their non- clinical time but recognising that 1:1's and any staff performance, support still needs to be carried out.						

Action No.	3	Start Date	30/06/2024	Target Date	30/09/2024	Completion Date	23/09/2024
Action Description	To review existing BRAG rating to ensure we are able to identify the diabetes wounds and who we shouldn't be delaying care for. To review INT deferred visit RAG rating to try to align as much as possible as we share care a large volume of our domiciliary caseload . To devise more concise RAG rating for podiatry						
Progress	RAG rating signed off by leads. Presented at team meeting 3rd Sept 2024 Templates updated on EMIS to reflect new RAG Delayed caseload review now using new RAG						

Action No.	4	Start Date	01/08/2024	Target Date	31/12/2024	Completion Date	/ /
Action Description	Task and finish group to look at a pilot of using nursing bank to help support podiatry with wound care. Targeted for South Glos locality in light of cause for concern.						
Progress	PMO support from Vicky Wood with task and finish group. Meetings in diaries set up and members agreed (to include podiatry and South Glos INT) Identify on caseload review spreadsheet those that could be seen by a nurse. Report pulled from BI to see how many patients on podiatry south glos caseload are also under south glos INT for wound care. Advert sent out to bank and agency for registered nurse						

Risk Reviews

Review Frequency 1 - Monthly (Risk Score 12-25) **Next Review** 23/10/2024

Review Date	23/09/2024	Review Details	Domi delayed care review of patients underway. South glos caseload completed, Bristol in progress. New RAG rating presented to whole team and EMIS templates updated to reflect this. Staff now advised to follow new process of RAG and who could see patient (pod/support worker/nurse) Pilot task and finish group set up to look at whether bringing in a bank/agency nurse to help with wound care will improve capacity issues. ADvert for this has gone out.
Review Date	27/08/2024	**Review Details**	All domically patients who are identified as having delayed care due to the capacity issues within the team are being reviewed remotely and re-RAG rating them appropriately in a similar framework to INT deferred visits RAG. Escalation of priority of individual patients being carried out if/when appropriate. We are weekly incident reporting the number of visits not taken place due to capacity and any patients that we are seeing where a delay in treatment has caused harmed are also being incident reported. These incidents are being reviewed by the quality and safety team as part of the PSII.

Review Date	17/07/2024	**Review Details**	Podiatry learning event scheduled for 18/7/24 following independent internal review of systems and process within service to identify gaps.
Review Date	12/06/2024	**Review Details**	Incidents have highlighted delay in care causing harm. Cause for concern raised by member of staff regarding the delay in care. Staff encouraged to report any delay in care which has led to harm for the patient and they are actively doing this. Investigation in progress regarding the cause for concern. PSIRF learning to be shared with the team and divisionally. In the meantime ongoing work of EMIS processes are now enabling over sight of delayed care and work is going on to establish how we can monitor this and what we do we those patients that are over due and the service does not have the capacity to see them. Remote reviews and organising shared care needs to be established and scheduled. Continually promote the importance of following EMIS processes with staff especially for RAG rating patients. Increased risk from 12 to 16 Increased risk to

Open Board 15+ Monitoring Group Report

Risk

Risk No. & Ver.	Date	Risk Level	Status	Initial Risk Rating (SxL=RR)
833 v.1	26/06/2024	02 Corporate	2 - Open	4 x 4 = 16

Risk Title

Follow Up Waiting Lists

Full Risk Description

There is currently no standardised organisation wide process inputting a future follow up date in to EMIS. This means there is no organisation wide way of reporting when follow up appointments are due or reporting to provide oversight of which patients may be overdue an appointment. This presents a risk of appointments not being booked within the clinically required timeframe, which could in turn lead to delays in treatment or intervention causing harm.

Services affected by Risk	Current Risk		Target Risk	
Division / Specialty / Directorate	**Likelihood**	4	**Likelihood**	2
Specialist Services / / Adults - BNSSG	**Severity**	4	**Severity**	3
	Risk Score	16	**Risk Score**	6

Categorisation & Monitoring Group

Category of Risk	Patient Safety & Clinical Quality	Monitoring Group	Quality & Outcomes Committee

Controls

Details of Controls

Current Controls

Development of Patient Tracker List (PTL) and Caseload Management Dashboard in Power BI to include all patients on caseload. While this is progress in that it does now provide a list of all patients in the organisation who are on a follow up waiting list and provides a reporting platform to further develop, it does not provide the detail of when appointments are due or overdue as this is not consistently recorded in EMIS

Total caseload side included within 24/25 executive dashboard. While this doesn't provide the due date, the purpose of it's inclusion is to ensure organisational focus on the overall caseload as well as 18 week performance measures

EMIS buckets used within service to monitor patients waiting, with some use of RAG

Actions

Action No.	Start Date	Target Date	Completion Date
1	01/04/2024	31/07/2024	/ /

Action Description

Development of caseload management dashboard

Progress

PTL page on caseload management dashboard launched in May.
Further 5 pages launched 21st June

Action No.	Start Date	Target Date	Completion Date
2	01/05/2024	31/12/2024	/ /

Open Board 15+ Monitoring Group Report

Action Description	Scoping in SASS of how the due date function is currently used in each specialty - underway and further time needed to collate with end of September for a full collation and action plan. Being taken forward to implement across the SASS division. Whilst progress made this will take some time to embed.
Progress	Collated for 22/28 Specialties. This demonstrates variation in the use of due date. Uses include date of next appointment, date of expected diagnostic results to have been received, date of end of PIFU, date of option to re-engage following DNA, not used at all.

Action No.	3	**Start Date**	26/06/2024	**Target Date**	01/09/2024	**Completion Date**	09/07/2024

Action Description	SASS workshop planned for 9/7 to cover: - Current mechanisms to provide oversight of follow up waits within services - Gaps with current processes - Scoping of use of standardised use of EMIS which would enable organisation wide reporting
Progress	

Action No.	4	**Start Date**	09/08/2024	**Target Date**	16/09/2024	**Completion Date**	/ /

Action Description	Due date field to be added to the PTL
Progress	

Risk Reviews

Review Frequency 1 - Monthly (Risk Score 12-25) **Next Review** 17/10/2024

Review Date	17/09/2024	**Review Details**	Risk remains the same. Session with BI and Clinical systems team 19/9 to process outputs of workshop, options and next steps. Podiatry (high risk area) adopted use of due date and validation process underway to ensure all patients on follow up caseload have clinical risk & prioritisation information in EMIS. S.Glos Domi caseload and half of Bristol complete.
Review Date	09/08/2024	**Review Details**	Risk score remains static. Away day held to scope current assurance levels at specialty levels, map current EMIS pathways and review options. 22/29 services rate confidence of oversight of follow up pathways at 4 or 5 (out of 5, with 5 highest confidence) as a result of local processes that are in place. Podiatry had the lowest confidence (2) and have as a result re-introduced the use of due date in the service and are validating their caseload to increase oversight and recording of clinical risk. A systemic solution is still required to provide oversight across the organisation and without the need for manual or front end EMIS reporting. The outputs of the away day are in the process of being digitalised and will be reviewed w/c 12/8

Open Board 15+ Monitoring Group Report

Risk

Risk No. & Ver.	677 v.13	Date	27/04/2023	Risk Level	02 Corporate	Status	2 - Open	Initial Risk Rating (SxL=RR)	3 x 4 = 12

Risk Title

Clinical staff training and competencies

Full Risk Description

Because staff have not had full opportunity, time or support to complete essential, other clinical skills training and wider professional development the risk is that we do not have a fully trained and competent workforce and the impact is:
-delay to patient care
-dissatisfaction of staff wishing to develop leading to poor retention
-pressure on remaining staff who do have the skills
-poor compliance with statutory requirements
-inefficiency and unnecessary visiting
-increased levels of deferred visits

Services affected by Risk	Current Risk		Target Risk	
Division / Specialty / Directorate	**Likelihood**	4	**Likelihood**	2
Adult Services / Adults INT / Adults - Bris ICE	**Severity**	4	**Severity**	2
Adult Services / Adults INT / Adults - Bris ICE	**Risk Score**	16	**Risk Score**	4
Adult Services / Adults INT / Adults - Bris ICE				
Adult Services / Adults INT / Adults - Bris NW				
Adult Services / Adults INT / Adults - Bris NW				
Adult Services / Adults INT / Adults - Bris South				
Adult Services / Adults INT / Adults - Bris South				
Adult Services / Adults INT / Adults - Bris South				
Adult Services / Adults INT / Adults - BNSSG				
Adult Services / Adults Rehab Units / Rehab - N Som				
Adult Services / Adults Rehab Units / Rehab - South Glos				
Adult Services / Adults Rehab Units / Rehab - Bris				
Adult Services / Adults Rehab Units / Rehab - Bris				
Adult Services / Adults Rehab Units / Rehab - South Glos				

Categorisation & Monitoring Group

Category of Risk	Workforce	Monitoring Group	People Committee

Controls

Details of Controls

Current Controls

- PEF aligned to some services
- Preceptorship programme available
- Establishment of education and development project lead role for Bristol

Control Ineffective/not Working

- LMS platform operational and in use for staff reminders. Regular reporting of out of date training

Control No Longer In Place

- Legacy mentors model operational

Actions

Action No.	3	**Start Date**	24/05/2023	**Target Date**	31/05/2024	**Completion Date**	/ /
Action Description	Design and implement supervision matrix across all 3 Bristol localities						
Progress	Continue to work with audit results linking into PDR window in April/May Further work with L&D required for supervision training and policy changes						
Action No.	7	**Start Date**	15/08/2023	**Target Date**	30/06/2024	**Completion Date**	02/09/2024
Action Description	Individual localities to come up with plan for undertaking alongside PEFs.						
Progress	Localities have individual plans in progress working alongside PEF. Extended PEF role for further 12 months so focus of role and responsibilities on supporting this						
Action No.	8	**Start Date**	01/08/2024	**Target Date**	31/03/2025	**Completion Date**	/ /
Action Description	N SOM Ensure all staff are supported with regular clinical supervision and opportunities to undertake education and training to develop their roles						
Progress	Admin staff booking staff into training Management of expectations to cancel training during OPEL escalation PA (Stella) to scrutinise training reports and forward to appropriate manager						
Action No.	9	**Start Date**	01/08/2024	**Target Date**	31/12/2024	**Completion Date**	/ /
Action Description	Ensure patients receiving appropriate treatment following the lower limb pathway						
Progress	Pilot commencing to support further roll out of lower limb pathway						
Action No.	10	**Start Date**	01/08/2024	**Target Date**	31/03/2025	**Completion Date**	/ /

Action Description	All staff to undertake training to support clinical development						
Progress	Formalised induction/probation plan to support development of all new staff within the locality Appropriate time allocated for staff to complete online/F2F training						
Action No.	11	**Start Date**	01/08/2024	**Target Date**	31/03/2025	**Completion Date**	/ /
Action Description	Ensure effective clinical supervision and line management						
Progress	Restructure of zones from four to six / line management structure review						
Action No.	12	**Start Date**	01/08/2024	**Target Date**	31/10/2024	**Completion Date**	/ /
Action Description	Robust monitoring of clinical competencies within the locality						
Progress	PEF undertakes regular review and provides reports on competency compliance with the team. PEF identifies individual staff requirements and supports with 1 to 1 training when required. Staff asked to upload clinical competencies to LMS in preparation for clinical skills to be uploaded to Eroster. Currently vacant PEF post						
Action No.	13	**Start Date**	01/08/2024	**Target Date**	31/03/2025	**Completion Date**	/ /
Action Description	Protected elearning and competencies time each month for every staff member Monitoring of clinical competencies within the locality. Opportunities to undertake training Clinical supervision / effective line management						
Progress	All staff have protected time blocked in diaries to ensure e learning and competencies are up to date. Therapists have bitesize learning each month with clinical leads. Log obtained and presentations uploaded. PEF attending ops meeting to feedback progress on competencies Lunch and learns set up by PEF to target effective sign off competencies. Staff asked to upload clinical competencies to LMS and compliance monitored by PEF. Reviewed and amended line management structure due to Zonal working and PEF and Band 6 leading on training of clinical supervision across the locality						
Action No.	14	**Start Date**	01/08/2024	**Target Date**	31/12/2024	**Completion Date**	/ /
Action Description	For all staff to be aware of the required competencies for their role - staff to be given time to attend relevant training and development for their role Scrutiny by INT managers with support from PEF to ensure that training is up to date and training is entered into healthroster						
Progress							
Action No.	15	**Start Date**	01/08/2024	**Target Date**	31/12/2024	**Completion Date**	/ /

Action Description	- Review current induction pack - and update as required with a SG Survival Guide - Develop consistent programme for supernummery period to include visits to relevant interdependent services i.e. SPA / OOH - Develop a local induction process to be delivered following corporate induction - Ensure all new starters have a buddy as well as a line manager
Progress	

Action No.	16	**Start Date**	13/09/2024	**Target Date**	31/03/2025	**Completion Date**	/ /

Action Description	Unit leads to ensure that staff have rostered time to be able to complete their training
Progress	Unit leads rostering staff to enable them to attend and complete their required training

Action No.	17	**Start Date**	13/09/2024	**Target Date**	31/03/2025	**Completion Date**	/ /

Action Description	For all staff to be aware of the required competencies for their role - staff to be given time to attend relevant training and development for their role and ensure that their completed competencies are uploaded to LMS and eroster.
Progress	Teams focusing on critical skills and training to prioritise staff attaining key competencies

Risk Reviews

Review Frequency 1 - Monthly (Risk Score 12-25) **Next Review** 26/10/2024

Review Date	26/09/2024	**Review Details**	Updates received from Learning and development colleagues, these will be reviewed. Teams continue to work to ensure staff are able to book and attend training. Clinical skills sesssions have been set up for end of October/beginning Novemebr
Review Date	23/08/2024	**Review Details**	Risk reviewed. Service leads remain unable to view the compliance for their whole teams due to the reporting constraints of LMS Actions need to be updated to reflect the Adult division position.
Review Date	24/07/2024	**Review Details**	Work continues. Learning and development team as part of national initiative are reviewing stat/man training. Senior leads continue to not be able to see reports for all their teams. Work ongoing to identify core skills and training for individual services. PEFS are not available in all areas which impacts on the ability of services to support staff with their training needs and competencies
Review Date	27/06/2024	**Review Details**	Reviewed with Assoc. Directors and senior managers, risk description amended, risk score escalated as risk now reflects all adult services. Risk also reallocated to reflect the increasing risk score
Review Date	27/06/2024	**Review Details**	Reviewed with Associate Directors and senior managers. Risk description updated, risk score escalated to reflect BNSSG wide impact. Risk also reallocated to AD's. Risks 674, 675 and 657 will close as now included in this risk.

Open Board 15+ Monitoring Group Report

Risk

Risk No. & Ver.	Date	Risk Level	Status	Initial Risk Rating (SxL=RR)
834 v.2	27/06/2024	02 Corporate	2 - Open	4 x 5 = 20

Risk Title

Adults BNSSG. Data Quality issues with EMIS/Electronic Patient Record

Full Risk Description

Because there are inconsistencies and inaccuracies with data quality from the EPR the risk is the organisation cannot effectively, monitor, plan and accurately report contractual activity which could result in unidentified overperformance and inappropriate resource allocation, in accurate internal and external reporting.

Services affected by Risk	Current Risk		Target Risk	
Division / Specialty / Directorate	**Likelihood**	4	**Likelihood**	3
Adult Services / / Adults - BNSSG	**Severity**	4	**Severity**	2
	Risk Score	16	**Risk Score**	6

Categorisation & Monitoring Group

Category of Risk	Performance	Monitoring Group	Performance Committee

Controls

Details of Controls

Current Controls

- Local induction EMIS Training
- Local operational action plans in place
- Local data validation by individual services
- Monthly report for each service on data quality from Power BI to allow checking

Control Ineffective/not Working

- Corporate Induction EMIS training

Actions

Action No.	Start Date	Target Date	Completion Date
1	29/07/2024	01/10/2024	/ /

Action Description	SGlos. Admin teams to be rotad regular time to correct data quality errors and meet with staff for training
Progress	New data quality clerk in post, currently being inducted, current process - designated to two admin staff to run reports and monitor errors, sharing with all admin to support, weekly BI clinics being held in base for training. High admin vacancies and long term sickness within South Glos may impact this process

Action No.	2	**Start Date**	29/07/2024	**Target Date**	01/10/2024	**Completion Date**	/ /
Action Description	SGlos. Hold interviews (complete), await start date and induct						
Progress	New recruit started and is being inducted and trained						
Action No.	3	**Start Date**	29/07/2024	**Target Date**	30/08/2024	**Completion Date**	16/09/2024
Action Description	SGlos. Teams invite, invite relevant staff						
Progress	Monthly BI meeting is now BAU within South Glos Whilst BI remains an ongoing focus and risk within S Glos this aspect of the risk can be closed as the meeting is now established.						
Action No.	4	**Start Date**	29/07/2024	**Target Date**	30/08/2024	**Completion Date**	30/08/2024
Action Description	SGlos. A week where data quality will be emphasised, increased DQ admin presence, BI colleagues to come to base to support, messaging on team meetings/ TVs/email. Baseline and post data to be evaluated						
Progress							
Action No.	5	**Start Date**	29/07/2024	**Target Date**	01/10/2024	**Completion Date**	/ /
Action Description	SGlos. Allocate admin resource to compile reports and send chasing emails to staff						
Progress	Weekly reports compiled and are being sent out to staff making the errors. Emis training clinics being provided to support staff. NB - admin staffing shortages in South Glos will impact.						
Action No.	6	**Start Date**	29/07/2024	**Target Date**	02/09/2024	**Completion Date**	/ /
Action Description	N&W. Training on site to be given to all staff so they have the knowledge to use the clinical system. If data quality issues remain, they will have further sessions Time to be allocated in diaries to support this Data quality will be discussed in 1:1s Output is monitored through Power BI data - though recognise this is not live data						
Progress							
Action No.	7	**Start Date**	29/07/2024	**Target Date**	02/09/2024	**Completion Date**	/ /
Action Description	N&W. To support staff daily with EMIS corrections						
Progress							
Action No.	8	**Start Date**	29/07/2024	**Target Date**	02/09/2024	**Completion Date**	/ /
Action Description	N&W. Regularly checking data power BI and review in monthly performance meetings Emails sent to all staff to retrospectively to amend data errors Data quality issues to be discussed in 1:1 - if these continue to occur individual performance plans to be created.						
Progress							

Open Board 15+ Monitoring Group Report

Action No.	9	**Start Date**	29/07/2024	**Target Date**	02/09/2024	**Completion Date**	28/06/2024
Action Description	South. Support to be given to all staff to ensure they have the knowledge to fulfil this requirement Monitored through Power BI data and reviewed monthly by ops managers then reminders emailed to all staff						
Progress							
Action No.	10	**Start Date**	29/07/2024	**Target Date**	26/08/2024	**Completion Date**	/ /
Action Description	South. To support staff daily with EMIS corrections Request and documents completed and sent to IT						
Progress							
Action No.	11	**Start Date**	29/07/2024	**Target Date**	30/09/2024	**Completion Date**	/ /
Action Description	South. Locality admin completing internal training for new starters and individual with regular DQ errors Time to be allocated in staff diaries						
Progress							
Action No.	12	**Start Date**	29/07/2024	**Target Date**	30/09/2024	**Completion Date**	/ /
Action Description	South. Regularly checking data power BI and review in monthly performance meetings Emails sent to all staff to retrospectively to amend data errors						
Progress							
Action No.	13	**Start Date**	29/07/2024	**Target Date**	31/10/2024	**Completion Date**	/ /
Action Description	ICE/EMIS. Support to be given to all staff to ensure they have the knowledge to fulfil this requirement Monitored through Power BI data and reviewed monthly by ops managers then reminders emailed to all staff Reduction in data errors Intervention recorded accurately/ contemporaneously. All visits outcomed on completion All visits linked to the correct referral Discharge templates completed including UCR template for 2hr / non 2hr urgent response referrals All EMIS templates utilised as part of clinical intervention.Already commenced. Target date October 2024Oversight by Jo M/Lucy H/Karen Pearce (Admin Manager for ICE). Line managers to discuss at 121's						
Progress							
Action No.	14	**Start Date**	29/07/2024	**Target Date**	31/10/2024	**Completion Date**	/ /
Action Description	ICE/EMIS. To support staff with corrections Request and documents completed and sent to IT						
Progress							
Action No.	15	**Start Date**	29/07/2024	**Target Date**	31/10/2024	**Completion Date**	/ /
Action Description	ICE/EMIS. Completing internal training to support with upskilling on how to correct data errors Time to be allocated in staff diaries In process						

Progress							
Action No.	16	**Start Date**	29/07/2024	**Target Date**	31/12/2024	**Completion Date**	/ /
Action Description	ICE/EMIS. Validation of errors. Emails sent to all staff to retrospectively to amend data errors Karen Pearce ICE Admin Manager regularly checking data power BI.						
Progress							
Action No.	17	**Start Date**	01/04/2024	**Target Date**	01/04/2024	**Completion Date**	01/04/2024
Action Description	NSom. Support to be given to all staff to ensure they have the knowledge to fulfil this requirement Monitored through Power BI data and reviewed monthly by ops managers then reminders emailed to all staff Reduction in data errors Intervention recorded accurately/ contemporaneously. All visits outcomed on completion All visits linked to the correct referral Discharge templates completed including UCR template for 2hr / non 2hr urgent response referrals All EMIS templates utilised as part of clinical intervention.						
Progress							
Action No.	18	**Start Date**	26/06/2024	**Target Date**	26/06/2024	**Completion Date**	26/06/2024
Action Description	NSom. Staff to be trained as EMIS champions. To support staff daily with corrections. Request and documents completed and sent to IT.						
Progress							
Action No.	19	**Start Date**	29/07/2024	**Target Date**	31/10/2024	**Completion Date**	/ /
Action Description	NSom. Internal EMIS training Locality completing internal training to support with upskilling on how to correct data errors. Time to be allocated in staff diaries						
Progress	Commenced but ongoing - will take time to capture all staff to be at a expected standard						
Action No.	20	**Start Date**	29/07/2024	**Target Date**	31/10/2024	**Completion Date**	/ /
Action Description	NSom. Validation of errors Anna Hall is regularly checking data power BI Emails sent to all staff to retrospectively to amend data errors						
Progress	Pulling data weekly						
Action No.	21	**Start Date**	23/08/2024	**Target Date**	31/10/2024	**Completion Date**	/ /
Action Description	Bedded Units. Local training to be provided to Bedded Unit staff, who are identified to be making a high number of errors to ensure that they are able to accurately record the correct consultation type and link this to the correct referral.						
Progress	Following review of the monthly DQ error reports it has been possible to identify a number of staff who are making a high number of errors. Local training is being planned for them.						

Risk Reviews		Review Frequency 1 - Monthly (Risk Score 12-25)		Next Review 17/10/2024
Review Date	17/09/2024	**Review Details**	Organisational wide data quality meeting held August; 3 main action identified- central and local EMIS training plans to be reviewed along with review of local on boarding process	
Review Date	23/08/2024	**Review Details**	Risk remains. Division wide meeting held 21/08 to agree next steps. Bedded units planning targetted training for staff identified having a high number of errors ahead of directorate wide EMIS project that is due to commence in September 2024	
Review Date	24/07/2024	**Review Details**	Monthly reports received by service leads. Teams working to review and correct data quality errors where able. Leads highlighting wider/cross organisation issues as they are identified for discussion and agreement on way forward.	

Open Board 15+ Monitoring Group Report

Risk

Risk No. & Ver.	633 v.14	Date	17/02/2023	Risk Level	02 Corporate	Status	2 - Open	Initial Risk Rating (SxL=RR)	4 x 4 = 16

Risk Title

BNSSG INT Staffing

Full Risk Description

Because of ongoing, recruitment and retention issues for all professional groups including admin, (registered/non-registered); coupled with the known national shortages of healthcare staff, the risk is the available workforce is insufficient to meet service demand which may result in
-inability to deliver proactive care
- increase strain on substantive staff
-increase use of temporary staffing
-inability to release staff for training, limiting skills/professional development
-inability to deliver all aspects of the service specification
- increase in deferred and cancelled patient visits
-increase in incidents and complaints
-poor patient experience and outcomes

Services affected by Risk	Current Risk		Target Risk	
Division / Specialty / Directorate	**Likelihood**	4	**Likelihood**	2
Adult Services / Adults INT / Adults - N Som Weston/Worle	**Severity**	4	**Severity**	3
Adult Services / Adults INT / Adults - N Som Weston/Worle	**Risk Score**	16	**Risk Score**	6
Adult Services / Adults INT / Adults - N Som Woodspring				
Adult Services / Adults INT / Adults - N Som Woodspring				
Adult Services / Adults INT / Rehab - N Som				
Adult Services / Adults INT / Rehab - N Som				
Adult Services / Adults INT / Adults - BNSSG				

Categorisation & Monitoring Group

Category of Risk	Workforce	Monitoring Group	People Committee

Controls

Details of Controls

Current Controls

- Sirona wide agreed process for deferred visits
- Regular and frequent recruitment and retention meeting in place to monitor recruitment and to ensure effective use of resources.
- Staff well being initiatives in place to mitigate impact on staff.

Controls

Details of Controls

Current Controls
Sirona wide process in place to manage bank and agency requests.
Action Not A Control
Recording all deferred visits - linking these to Ulysses records and any adverse events leading to patients harm and staffing levels
Target recruitment, NHS job adverts, and working with HR to support staff thinking about leaving career opportunities
Control Ineffective/not Working
Utilisation of bank and agency 7 day s a week - block book staff, incentive rates for bank

Actions

Actions

No Actions recorded

Risk Reviews

Review Frequency 1 - Monthly (Risk Score 12-25) **Next Review** 10/10/2024

Review Date	10/09/2024	**Review Details**	All teams in process of developing action plans
Review Date	02/08/2024	**Review Details**	Reviewed with AD's BNSSG, risk description updated to include all BNSSG INT's, risk score escalated, risk owner changed to Cath Williams, risk actions to be updated by each locality, and target score date amended as this is a much longer term piece of work.

Open Board 15+ Monitoring Group Report

Risk

Risk No. & Ver.	Date	Risk Level	Status	Initial Risk Rating (SxL=RR)
849 v.1	09/08/2024	02 Corporate	2 - Open	4 x 5 = 20

Risk Title

Risk of no community data due to inconsistent use of clinical systems

Full Risk Description

If community data is not captured or used effectively the impact is both in terms of legal non-compliance as well as the understanding of our population (and therefore how we develop our services to meet their needs).
This may result in:
Inequitable access to services
Compromised safety, effectiveness and quality of care leading to poorer outcomes
Mismanagement of patient care
Inability to prioritise those most in need
Inability to understand who is and who isn't accessing our services
Inability to report on who is and who isn't accessing our services
People not able to understand the information they receive
People unable to make informed choices about their healthcare
People not able to manage their own health and wellbeing
Missed opportunities for prevention and early intervention
Poor planning and design of services
Non-compliance with the Equality Act and other legal duties
Complaints and incidents
Reputational damage
Risk of litigation
Deepened health inequalities.

Services affected by Risk	Current Risk		Target Risk	
Division / Specialty / Directorate	**Likelihood**	4	**Likelihood**	1
Central Services / / Adults - BNSSG	**Severity**	4	**Severity**	4
	Risk Score	16	**Risk Score**	4

Categorisation & Monitoring Group

Category of Risk	Workforce	Monitoring Group	Executive Committee

Controls

Controls In Place

No Controls in Place recorded

Open Board 15+ Monitoring Group Report

Actions

Action No.	1	**Start Date**	13/09/2024	**Target Date**	29/11/2024	**Completion Date**	/ /
Action Description	Meet with other community providers to inform our approach to community data - Pete C to arrange site visit to Oxford community health.						
Progress	Email sent to Oxford contact to arrange visit.						
Action No.	2	**Start Date**	13/09/2024	**Target Date**	24/09/2024	**Completion Date**	/ /
Action Description	Caroline to meet with PMO to discuss support						
Progress							

Risk Reviews

Review Frequency 1 - Monthly (Risk Score 12-25) **Next Review** 13/10/2024

Review Date	13/09/2024	**Review Details**	First community data sub group meeting (of HISG) to be held Thursday 26 September 2024 including service stakeholders - to regroup around work to date and next steps. Project documents created including PID / initial timeline to be circulated. Pete and Caroline met with other community providers in Oxford and Bromley. Caroline to meet with PMO to discuss PM support Monday 23 Sept.

Open Board 15+ Monitoring Group Report

Risk

Risk No. & Ver.	593 v.5	Date	14/12/2022	Risk Level	02 Corporate	Status	2 - Open	Initial Risk Rating (SxL=RR)	4 x 4 = 16

Risk Title

Inadequate Process for IT Asset Management

Full Risk Description

Sirona currently has an ineffective process for managing IT assets with respect to new joiners, movers and leavers. Existing IT assets (laptops etc.) are not returned upon an employee leaving, but are retained by the line manager for re-issue. The machines are not wiped, rebuilt and do not receive a health check prior to re-issue. In addition, new machines are being procured when potentially reusable machines are retained within the organisation, presenting financial risk.

Machined managed in this way present cyber security risk and information governance risk as the contents of the machines are not actively reviewed or managed prior to re-issue.

Services affected by Risk	Current Risk		Target Risk	
Division / Specialty / Directorate	**Likelihood**	4	**Likelihood**	2
Central Services / Digital / Central Services BNSSG	**Severity**	4	**Severity**	2
	Risk Score	16	**Risk Score**	4

Categorisation & Monitoring Group

Category of Risk	Digital (IM&T)	Monitoring Group	FEED Committee

Controls

Details of Controls

Current Controls

Item 19 from Acceptable Use of IT Systems & Devices Policy

19. Leaving Company Employment
When informed by the HR/Personnel department or applicable line manager that a member of staff has ceased employment, the IT Department will remove access to computer resources and delete their email account and U drive unless a prior request is made to hold the account for a temporary basis by the line manager.
If staff cease employment with the Company - they must take responsibility steps to hand-over all appropriate electronic files either by forwarding them to their line manager or by copying them to a shared area, or by simply deleting them. All information gained whilst an employee of the Company remains the property of the Company.
All equipment gained must be returned on leaving the employment of the Company (e.g. swipe card, ID badges, mobile phones, laptops etc).

Certero and MECM will discover all domain connected devices. Mobile iron audits mobile phones and tablets

Controls

Details of Controls

Current Controls

450 laptops remaining requiring patching - these will be prioritised as part of the windows 11 rollout. Servers on extended support are planned to be upgraded to new supported servers before Oct 2024

Action Not A Control

JML Process now starting to work effectively, laptops are being returned and re utilised or disposed of.

Actions

Action No.	2	**Start Date**	30/01/2023	**Target Date**	03/02/2023	**Completion Date**	/ /
Action Description	Confirm new equipment ordered from suppliers since Apr 2020 - to include Galtec, Dell and NHSE						
Progress							
Action No.	4	**Start Date**	08/06/2023	**Target Date**	29/06/2023	**Completion Date**	/ /
Action Description	Nick - please confirm on the timescales of migrating to Ivanti						
Progress							
Action No.	5	**Start Date**	03/06/2024	**Target Date**	31/10/2024	**Completion Date**	/ /
Action Description	450 laptops remaining requiring patching - these will be prioritised as part of the windows 11 rollout. Servers on extended support are planned to be upgraded to new supported servers before Oct 2024						
Progress							
Action No.	6	**Start Date**	05/08/2024	**Target Date**	31/10/2024	**Completion Date**	/ /
Action Description	Asset management will be included in the new ITSM software which will be implemented within the next 12 weeks						
Progress							

Risk Reviews

Risk Reviews

Risk Not Reviewed

Open Board 15+ Monitoring Group Report

Risk

Risk No. & Ver.	848 v.2	Date	09/08/2024	Risk Level	02 Corporate	Status	2 - Open	Initial Risk Rating (SxL=RR)	4 x 5 = 20

Risk Title

Risk of no community data due to underdeveloped clinical systems

Full Risk Description

If there is a lack of accessible/appropriate/consistent data systems (clinical records) the impact is both in terms of legal non-compliance as well as the understanding of our population (and therefore how we develop our services to meet their needs).

This may result in:
Inequitable access to services
Compromised safety, effectiveness and quality of care leading to poorer outcomes
Mismanagement of patient care
Inability to prioritise those most in need
Inability to understand who is and who isn't accessing our services
Inability to report on who is and who isn't accessing our services
People not able to understand the information they receive
People unable to make informed choices about their healthcare
People not able to manage their own health and wellbeing
Missed opportunities for prevention and early intervention
Poor planning and design of services
Non-compliance with the Equality Act and other legal duties
Complaints and incidents
Reputational damage
Risk of litigation
Deepened health inequalities.

Services affected by Risk	Current Risk		Target Risk	
Division / Specialty / Directorate	**Likelihood**	4	**Likelihood**	1
Central Services / / Adults - BNSSG	**Severity**	4	**Severity**	4
	Risk Score	16	**Risk Score**	4

Categorisation & Monitoring Group

Category of Risk	Clinical Systems	Monitoring Group	FEED Committee

Controls

Controls In Place

No Controls in Place recorded

Actions

Actions

No Actions recorded

Risk Reviews

Review Frequency 1 - Monthly (Risk Score 12-25) **Next Review** 23/10/2024

Review Date	23/09/2024	**Review Details**	This pertains to the level of standardisation more widely across services, and is being considered by the clinical records groups. Sirona colleagues are working with other community providers to understand how data is being captured in a standardised way.

Open Board 15+ Monitoring Group Report

Risk

Risk No. & Ver.	428 v.10	Date	16/11/2021	Risk Level	02 Corporate	Status	2 - Open	Initial Risk Rating (SxL=RR)	3 x 4 = 12

Risk Title

Capacity issues within Community Paediatric service regarding to meet current demands for new referrals and children open to the service

Full Risk Description

The risk of increasing demand vs capacity could result in;
children unable to be seen in a timely fashion for there initial assessments this increases the impact of their unrecognised or untreated medical issues which could have a negative impact on their outcomes.
Potential increase of harm
Significant delays in the triage process.
Unable to meet the 18 week target to treatment which is one of the key performance indicators for Community Paediatrics there will be challenge from the Commissioners with potential implications both financial and reputational.
Children who are open to the service are not see in a timely fashion there is a risk that their health needs will not be met.
Clinicians with high caseloads are experiencing significant stress and anxiety which could result in increased sickness rates and issues with recruitment and retention

Services affected by Risk	Current Risk		Target Risk	
Division / Specialty / Directorate	**Likelihood**	4	**Likelihood**	4
Children's Services / Community Paediatrics / Childrens - S Glos	**Severity**	4	**Severity**	3
Children's Services / Community Paediatrics / Childrens - BNSSG	**Risk Score**	16	**Risk Score**	12
Children's Services / Community Paediatrics / Childrens - North Somerset				
Children's Services / Community Paediatrics / Childrens - Bristol				
Children's Services / Community Paediatrics / Childrens - Bristol				
Children's Services / Community Paediatrics / Childrens - Bristol				

Categorisation & Monitoring Group

Category of Risk	Capacity & Demand (Operational)	Monitoring Group	Performance Committee

Controls

Details of Controls

Current Controls

- Clinicians have flagged children who need to be prioritised for follow up
- Enhanced payments agreed for clinicians and admin staff to offer addtional sessions
- Job planning under way
- Clinical validation of the waiting list is taking place to review the safety and appropriatness of their prioritisation

Controls

Details of Controls

Current Controls

SOP being produced

Following validation of the waiting list and recruitment current clinical capacity has been increased. This has lead to reduction in the waiting lists, although waiting times continue to be very long for P3 children. There is ongoing work regarding clinical capacity to try and maximise this.

Process established to validate and actively monitor waiting lists to ensure that children are on appropriate lists. Process to be developed to ensure families on waiting lists are contacted at regular intervals and signposted to appropriate support resources

Formal escalation process in place to enable referrers to escalate concerns. Template developed to ensure consistent clinical decision making regarding clinical prioritisation.

Control Ineffective/not Working

Locums had been employed to offer some additional capacity .However due to the identified quality issues with their work the short term locum's contract was ended early

Recruitment to vacant post being undertaken - no applicants received

Control No Longer In Place

Waiting list initiative funding being offered to clinicians to offer additional clinical sessions

Permanent member who are part time have been offered increased sessions

Actions

Action No.	9	**Start Date**	01/05/2023	**Target Date**	30/09/2024	**Completion Date**	/ /

Action Description	Skilled mixed workforce for daytime on call for strategy discussions When skill mixed service is established refocus of Community Paediatric daytime on call workforce
Progress	Funding to agree the pilot by 1 year agreed by ICB. Still need evidence of effectiveness of pilot but postive verbal feedback to date

Action No.	10	**Start Date**	17/04/2023	**Target Date**	30/09/2024	**Completion Date**	/ /

Action Description	Community Paediatric service to prioritise IHAs by converting general clinic slots to IHA clinics as interim solution whilst longer term options are developed including refocusing of Comm Paed daytime on call rota through skill mixing
Progress	Middle grades on call for Safeguarding still supporting with IHA's. The increase of IHA's have meant that clinics for community paediatric have been released back for general community paediatric appointments. All appointments are being handed back within timeframe. Still requirement for 72 appointment slots a month to allow for the IHA's to be seen within timeframe and continue to monitor on a monthly basis the availability of on call slots to allow to free up clinical capacity for general community paediatric clinics. Will still need ongoing monitoring Risk re no long term funding identified for Safeguarding nursing pilot.

Action No.	11	**Start Date**	31/07/2023	**Target Date**	30/09/2024	**Completion Date**	/ /

Open Board 15+ Monitoring Group Report

Action Description	CDIP agreed to look at transformation across Children's Services.
Progress	Initial meeting of Steering group held 31/7/23 to review plan, TOR etc.

Action No.	12	**Start Date**	01/10/2023	**Target Date**	30/09/2024	**Completion Date**	/ /

Action Description	Harm review to take place - KB to lead Job planning to take place - KB, BB and CC to lead Reviews of the ratio of appointments to take place
Progress	Job planning should now be complete. Meeting needed with Ben Burrows, LIndsey Macintosh, Clive Coombs & Harry Lawrence, to transfer job planning results into the Sirona demand and capacity tool to demonstrate the actual service capacity, and the expected deliverable outcomes from the community paediatric service for the remainder of the 2024/25 year.

Risk Reviews

Review Frequency 1 - Monthly (Risk Score 12-25) **Next Review** 27/10/2024

Review Date	27/09/2024	**Review Details**	Meeting took place with KB and BB and SLT leads within childrens to review the options. To be completed within 2 weeks Options and costing to be reviewed and created. Risk of negativley impacting progress of Neuro profiling trial and retender.
Review Date	30/08/2024	**Review Details**	COO Andrea Gordon request to increase to reflect priority and risk

Open Board 15+ Monitoring Group Report

Risk

Risk No. & Ver.	Date	Risk Level	Status	Initial Risk Rating (SxL=RR)
757 v.7	09/11/2023	02 Corporate	2 - Open	3 x 4 = 12

Risk Title

Heart Failure - current system clinical pathway is not equitable, leading to inequity of care for patients and increasing capacity and demand within current Sirona service

Full Risk Description

Because of the increasing demand for Heart Failure services and the ongoing, but incomplete transformation/funding work by the ICB for the Heart Failure pathways
The risk is that Heart Failure team do not have the capacity or capability to offer patients timely diagnostic investigations and initiation of treatment
That could result in compromise to patient care, continuing inequity and gaps in provision of service and increasing pressure on Sirona staff

Services affected by Risk	Current Risk		Target Risk	
Division / Specialty / Directorate	**Likelihood**	4	**Likelihood**	3
Specialist Services / Specialist Adult / Adults - BNSSG	**Severity**	4	**Severity**	3
	Risk Score	16	**Risk Score**	9

Categorisation & Monitoring Group

Category of Risk	Monitoring Group
Capacity & Demand (Operational)	Performance Committee

Controls

Details of Controls

Current Controls

Increased waits for urgent diagnostic pathway , due to demand across the whole system and lack of system agreement and funding to develop pathway.
1) Monitoring of referral and waiting times
2) Development of EPR recorded Consultant triage process
3) Working with system partners regarding pathway review and transformation
4) Review of estate provision and clinic set up to ensure maximising appointment potential, working with UHBW clinical team in this review and planning as delivering this aspect of the service
5)Work with acute providers to consider SBAR to level across waiting times for both urgent and routine referrals, whilst ongoing consideration of pathway moving forward.

Control No Longer In Place

Details of risk 49 closed and merged into this one current risk

Details of risk 375 closed and merged into this one current risk - so representative of current risk situation

Actions

Action No.	Start Date	Target Date	Completion Date
1	09/11/2023	30/11/2024	/ /

Action Description
Attend and engage with system pathway meetings to support pathway development and implementation , including development of business case for

	system wide pathway development
Progress	SMS continues have contributed to Sirona service data to support wider understanding of system activity as part of SMS work. Awaiting sharing of data from Acute colleagues as part of this piece of work. NO timeline currently on outcome of SMS or agreed model of delivery Currently no ICB board or governance structure around CVD reporting.

Action No.	4	**Start Date**	28/05/2024	**Target Date**	31/10/2024	**Completion Date**	/ /

Action Description	1)SBAR produced to support agreement for all 3 providers to work together to level across waits for urgent referrals, with proposed agreement for Sirona to refer on % of urgent referrals to the acutes to action and manage. UHBW in agreement, currently waiting on NBT feedback 2) Internal work on ensuring all appointments are optimised 3) Internal estate review to see if can optmise and increase appointments by running consultant clinic side by side , rather than one stop shop
Progress	Internal Exec paper submitted for review and consideration of potential next steps regarding the current diagnostic pathway challenges. NBT have now offered some echo support over a small period of time to complete some echos for us to reduce the waiting time. UHBW Consultants have offered x 2 PAs in supporting the reporting and actioning of the echos

Risk Reviews

Risk Reviews

Risk Not Reviewed

Open Board 15+ Monitoring Group Report

Risk

Risk No. & Ver.	Date	Risk Level	Status	Initial Risk Rating (SxL=RR)
135 v.24	09/07/2020	02 Corporate	2 - Open	3 x 4 = 12

Risk Title

Autism Diagnostic waiting times for children and young people

Full Risk Description

Because children and young people continue to wait, likely for more than 2 years for an Autism assessment, the risk is that there condition is not well managed that could result in those with mental health difficulties deteriorating, and those experiencing difficulties managing education may experience educational placement break down and or home breakdown. In addition recent harm reviews have identified potential harm being caused by lack of intervention and support during long waits.

Services affected by Risk	Current Risk		Target Risk	
Division / Specialty / Directorate	**Likelihood**	4	**Likelihood**	2
Children's Services / Therapies/Autism/SEND / Childrens - BNSSG	**Severity**	4	**Severity**	3
Children's Services / Community Paediatrics / Childrens - Bristol	**Risk Score**	16	**Risk Score**	6

Categorisation & Monitoring Group

Category of Risk	Patient Safety & Clinical Quality	Monitoring Group	Quality & Outcomes Committee

Controls

Details of Controls

Current Controls

- During lockdown SLT are offering telephone consults and some video assessments to reduce amount of face-to-face assessment time needed.
  Learning from lockdown has resulted in a blended digital/face-to-face pathway. All families have a telephone consultation at the start of the assessment.
- Children and young people on the waiting list are being stratified for clinical complexity. Those rated 'red' are being seen as a priority however there is not the capacity to actively manage the waiting list once CYP are on it
- Parent/carers are not being provided with information about the length of the wait for their child's assessment as the data is not robust or reliable enough. They are sign-posted to support and advice available if they contact the service
- Increased capacity has not reduced waiting times as demand continues at a level above capacity
- Waiting List Initiative operational from Jan-March 24 aims to reduce the waiting times . Due to the increased demand the WLI is assessing additional CYP but is not have a meaningful effect on wait times as the underlying list of >4000 is growing month on month
- Waiting list initiative is seeing on average 44 additional children for an autism assessment each month
- Clinical pathways have been streamlined to maximise clinical efficiency
- 13 needs-led support offers funded by CCG and delivered by a range of organisations went live on 1st April. These offers will provide support to children and families while they wait for an assessment.

Controls

Details of Controls

Current Controls

- Prioritisation Process in place - parent/carers and referrers can request that a child's assessment is prioritised due to escalating concerns about the child's health and wellbeing, and increasing risk of family or education placement breakdown.
- Additional advice and guidance pages have been added to the CCHP website to support families while they wait
- Harm review undertaken - see summary notes in risk description
- Additional funding from the ICB for outsourcing assessments to Healios (339) to be completed by the end of March 2024
- WLI funding extended through £155K from ICB and additional £711K from ICB - caveat is that the funding needs to support WLI and transformation / Interim model .
- ICB led Interim and Transformational Neurodiversity project groups . Involves both ASD and ADHD services/ waiting lists.

Control Ineffective/not Working

- Children who are 11+ and approaching secondary school age are prioritised
- Young people who are 16 years + and approaching adulthood are prioritised

Control No Longer In Place

- Helpdesk remains live , has been incorporated into the CBT team

Actions

Action No.	10	**Start Date**	24/02/2023	**Target Date**	31/12/2024	**Completion Date**	/ /
Action Description	Business Planning Day 4 has taken place. Sirona submitted request for non-recurrent funding to continue the ASD WLI. No formal decision from ICB to date						
Progress	Interim and Transformation Neurodiversity projects underway led by the iCB. Review date set as above for progress						
Action No.	11	**Start Date**	07/08/2023	**Target Date**	30/09/2024	**Completion Date**	/ /
Action Description	Produce a detailed action plan to include an internal and external approach to the management of Waiting times.						
Progress	Action plan has been presented to CEO with request then made for dates for achievement and trajectories for improvement. Ongoing monitoring by CEO and Exec Committee will be in place.						
Action No.	12	**Start Date**	01/08/2023	**Target Date**	30/09/2024	**Completion Date**	/ /
Action Description	Children's Delivery Programme to be established.						
Progress	Previously allocated to CM - allocated to the new COO						
Action No.	13	**Start Date**	01/11/2023	**Target Date**	31/07/2024	**Completion Date**	/ /

Action Description	ICB have agreed to fund an external provider, Healios to deliver 339 online assessments by end March 2024 to increase capacity.
Progress	all Healios assessments forecast to be completed by 31/07/24

Action No.	14	**Start Date**	01/10/2023	**Target Date**	31/12/2024	**Completion Date**	/ /

Action Description	A harm review was undertaken in October led by Kathryn Bateman , Karen Evans & Victoria Bates. The initial output was that the wait in itself was not causing harm but that inadvertently the actors around the child could potentially take their hands off .
Progress	Review Harm review progress at mid point of Interim Neurodiversity model

Action No.	15	**Start Date**	01/12/2023	**Target Date**	31/03/2025	**Completion Date**	/ /

Action Description	Board approval that these posts (at a total cost of £1.16M)can be made substantive from 1/04/24 . However no additional ICB funding identified therefore all staff will be at risk of redeployment . HR process underway
Progress	all FTC staff have been offered substantive posts by Sirona but aware there is no supporting monies past March 2025 therefore at risk of redeployment.

Action No.	16	**Start Date**	06/11/2023	**Target Date**	31/12/2024	**Completion Date**	/ /

Action Description	ICB led Interim and Transformational projects to identify and gain traction for a Neurodiversity service approach , focussing on timely intervention and not a purely diagnostic model
Progress	Neurodiversity Transformation project at Gate 1 accelerated design model pilot neurodiversity profiling live from 01/09/2024 150 assessments outsourced to Healios to ensure assessment capacity maintained during pilot 5000 CYP still on waiting list in total demand still outstrips capacity waiting list will continue to grow during pilot harm still a risk to cYP on waiting list

Risk Reviews

Risk Reviews

Risk Not Reviewed

Open Board 15+ Monitoring Group Report

Risk

Risk No. & Ver.	Date	Risk Level	Status	Initial Risk Rating (SxL=RR)
831 v.2	04/06/2024	01 Local	2 - Open	4 x 4 = 16

Risk Title

Neuro OT Waiting times

Full Risk Description

Wait times leading to an increased clinical risk associated with, worsening of condition and increasing complexity due to the delays

Services affected by Risk	Current Risk		Target Risk	
Division / Specialty / Directorate	**Likelihood**	4	**Likelihood**	2
Specialist Services / Specialist Adult / Adults - BNSSG	**Severity**	4	**Severity**	2
	Risk Score	16	**Risk Score**	4

Categorisation & Monitoring Group

Category of Risk	Patient Safety & Clinical Quality	Monitoring Group	Quality & Outcomes Committee

Controls

Details of Controls

Current Controls

Capacity and demand study has been done for this service with trajectories to better understand the ongoing impact of this high level of referral to enable improved planning

Migration to One EMIS to assist with improved clarity of caseload across all areas, use of linked episodes to appropriately stop the clock when one profession starts their involvement with an individual

Prior to the increase in referral rates this service had reduced wait times through a series of optimisation strategies and had reduced wait times to an all time low, these principles remain in place

Request to retain funding that was reduced when ICSS separated from Neuro and accept this cost pressure as the capacity and demand demonstrate that a further reduction in staffing would have a greater impact on increasing waiting times

Demand remains high and the trajectory of wait times continues to increase for both OT and Physio across the Neuro service. Further submission to escalate within the directorate started to look at possible mechanisms to control this. Previous optimisation with previous level of referrals was managing this well.
Current demand can not be met with current staffing levels

Actions

Action No.	2	Start Date	14/08/2024	Target Date	18/09/2024	Completion Date	/ /

Action Description	Prepare and submit supportive documentation to Specialist Services manager and Divisional Director
Progress	

Risk Reviews		Review Frequency	1 - Monthly (Risk Score 12-25)	Next Review	27/10/2024
Review Date	27/09/2024	**Review Details**	Demand for this service remains high and the current budget for staffing does not meet this increased need for Therapy provision to this cohort. In addition requests on this service from other parts of the organisation for expert A&G in particular to deal with complex Postural care is adding to the workload and waiting times.		

Open Board 15+ Monitoring Group Report

Risk

Risk No. & Ver.	Date	Risk Level	Status	Initial Risk Rating (SxL=RR)
671 v.3	26/04/2023	02 Corporate	2 - Open	5 x 3 = 15

Risk Title

Failure of the National Electricity Transmission System (NETS) - R50a

Full Risk Description

If there is a failure of the National Electricity Transmission System (NETS)...
then there is a risk that supplies of water, food, heating, lighting, road fuel and all telecommunications are impacted partially or completely for up to seven days...
meaning that the business continuity of some or all of Sirona's critical services will directly affected placing the health, safety and welfare of staff and service users under threat

Services affected by Risk	Current Risk		Target Risk	
Division / Specialty / Directorate	**Likelihood**	3	**Likelihood**	3
Central Services / EPRR / Adults - BNSSG	**Severity**	5	**Severity**	3
	Risk Score	15	**Risk Score**	9

Categorisation & Monitoring Group

Category of Risk	Monitoring Group
EPRR/Business Continuity	Executive Committee

Controls

Details of Controls

Current Controls

Some back-up power generation in some facilities (SBCH, Clevedon Hospital).

Actions

Action No.	Start Date	Target Date	Completion Date
2	29/06/2023	31/03/2025	/ /

Action Description: Power outage task & finish group

Progress: LHRP BMG plan not progressed due to late delivery of LRF NPO plan. However this is now known to be very high level, so LHRP plan required. This is beyond Sirona's sphere of influence.

Action No.	Start Date	Target Date	Completion Date
3	01/09/2023	30/09/2024	01/09/2024

Action Description: Identify and source a resilient telecommunications system

Progress: Presented SBAR to DSG, agreed in principle. LF has SBAR, JF agreed to funding.

Action No.	Start Date	Target Date	Completion Date
4	24/01/2024	31/03/2025	/ /

Action Description	Progress local arrangements, contribute where possible and continue to request formalised plans
Progress	Moved to Q4

Risk Reviews	**Review Frequency** 1 - Monthly (Risk Score 12-25)	**Next Review** 09/10/2024

Review Date	09/09/2024	**Review Details**	Risk score remains current - further mitigation required

Risk

Risk No. & Ver.	Date	Risk Level	Status	Initial Risk Rating (SxL=RR)
656 v.5	30/03/2023	02 Corporate	2 - Open	4 x 5 = 20

Risk Title

IT license and devices cost pressures

Full Risk Description

The Joiner, movers and leavers process is not robust enough to capture and remove all types of user in Sirona. i.e. student, substantive, contractor, Locums etc
As an example there are circa 14,657 accounts in active directory. There are circa 1,500 surplus (old) accounts on glasscubes with an additional cost to Sirona of circa £38k.
Mitigation work is already underway to assess and remove these excessive license and reclaim unused devices.

Services affected by Risk	Current Risk		Target Risk	
Division / Specialty / Directorate	**Likelihood**	5	**Likelihood**	3
Central Services / Digital / Central Services BNSSG	**Severity**	3	**Severity**	1
	Risk Score	15	**Risk Score**	3

Categorisation & Monitoring Group

Category of Risk	Digital (IM&T)	Monitoring Group	FEED Committee

Controls

Details of Controls

Current Controls

Surplus Glasscubes accounts removed. Taking the number from 6184 licenses to 4244

03/04/23 - I attended the "turnaround programme" to discuss licensing and assets.

Awaiting further direction - We will need additional resources from Digital PMO and the comms team.

12.05.23 - 3299 obsolete user accounts have been successfully disabled and moved to orbiter.banes-pct.nhs.uk/Disabled Accounts/Obsolete Accounts

I have been advised to place this task on hold and to not disable further accounts. I will await direction.

24.07.23 - Awaiting further direction

19.07.23 - Awaiting further direction

08.06.23 - Awaiting further direction

26.05.23 - Awaiting further direction

Action Not A Control

Controls

Details of Controls

Action Not A Control

27.07.23 - Working with Malcolm Blair in creating a controlled "RDP group" to ensure only end users who require access to our remote desktop servers are granted access.

16.08.23 - Chased Malcolm for an update

24.08.23 - Malcolm still investigating

Actions

Action No.	2	Start Date	12/05/2023	Target Date	13/10/2023	Completion Date	/ /

Action Description	To confirm and advise on the next steps in disabling the inactive domain accounts.
Progress	Accounts that have been inactive for 2 months have been disabled. This process will continue each month. Glasscubes account are reviewed on a weekly basis.

Risk Reviews

Review Frequency 1 - Monthly (Risk Score 12-25) **Next Review** 04/09/2024

Review Date	05/08/2024	Review Details	Significant savings have been implemented by removal of dormant accounts. Ongoing work to monitor JML process.

Risk

Risk No. & Ver.	827 v.3	Date	20/05/2024	Risk Level	02 Corporate	Status	2 - Open	Initial Risk Rating (SxL=RR)	3 x 4 = 12

Risk Title

EPR (Adastra) for Place Based Urgent Care

Full Risk Description

Adastra Management / Maintenance

Because of the limited internal knowledge of Adastra, there is a risk that back-end changes made by the provider (Advanced) have consequences to the front-end which Sirona are unaware of. This has resulted in issues with data validity, post event messaging, etc.

Clinical System / BI Capacity

As a result of high demand on the Clinical Systems and BI team, and insufficient dedicated resource to manage the Adastra platform, there is a risk that the Adastra

Optimisation requirements will not be delivered in a timely manner. This may result in continued non-compliance with CQC requirements and further disengagement of staff working in the service.

Staff familiarisation / Changes in processes / Inter-Database Operability

Staff in the MIU have had to adjust to new ways of working, especially when EMIS had external systems built in, such as CPIS, Connecting Care and Medicines.

Work has been undertaken so that CPIS is now enabled in Adastra and the Summary Care Record (patient medication and allergies etc) is also now embedded in Adastra.

Work has proceeded to allow data to be shared and automatically uploaded to Connecting Care. However, this has yet to be fully embedded.

MIU staff have also had to familiarise themselves with a standard history taking template, when they had been used to having clinical templates for multiple conditions.

Optimisation

Further work needs to be undertaken to ensure that optimisation happens in the next 6 months to ensure that all areas undertaken in the scoping from a 'must have' are enabled to resolve existing concerns from the operational, clinical, and management staff.

This would also improve the medicines management element of Adastra as there are areas that could be improved to ensure compliance with the ICB formulary and better prescribing practices.

This will ensure that multiple sources are not needed to be accessed when staff need to find information

Services affected by Risk	Current Risk	Target Risk

Open Board 15+ Monitoring Group Report

Division / Specialty / Directorate	Likelihood	5	Likelihood	2
Adult Services / Adults Urgent Care / UC - Bris	Severity	3	Severity	3
Adult Services / Adults Urgent Care / UC - South Glos	Risk Score	15	Risk Score	6
Adult Services / Adults Urgent Care / UC - N Som				

Categorisation & Monitoring Group

Category of Risk	Clinical Systems	Monitoring Group	FEED Committee

Controls

Details of Controls

Current Controls

New detailed SOP's are in place to ensure staff know what processes to follow.

Staff are able to review the summary care record in the patients record on Adastra, reducing prescribing errors.

CPIS (Child Protecting Information System) is now embedded and allows Clinicans to see with one click if the child has a child projection plan in place.

Actions

Action No.	1	Start Date	20/05/2024	Target Date	30/06/2024	Completion Date	/ /

Action Description

a) Undertake a full review of the market, including Adastra, to understand the options and identify the most appropriate solution for the service. This wil include consideration of how other place-based urgent care services use EPR platforms and seeking first hand feedback on their functionality. This exercise will result in an options paper which is likely to include the following options:

- o Do nothing.
- o Optimise the current Adastra platform.
- o Migrate onto a new, purpose built Adastra platform.
- o Procure an alternative EPR platform.

b) Given that the service will continue to operate on the existing Adastra platform for at least the next 12 months, identify the improvements that must b made to enable the service to function safely and effectively during this time

Progress

Action No.	2	Start Date	20/05/2024	Target Date	30/06/2024	Completion Date	/ /

Action Description

Staff to review the rankings for the 'Must, Should Have' then have this fed into by BI, Clinical Systems.

This then needs to be lead by a project manager which needs to be identified.

Progress

Risk Reviews

Review Frequency 1 - Monthly (Risk Score 12-25) **Next Review** 30/10/2024

Review Date	30/09/2024	**Review Details**	Workflow work still ongoing. Discussions around contract and alternative suppliers continues.
Review Date	13/09/2024	**Review Details**	Process mapping continues - there is a new supplier of EPR at Brisdoc - PC is arranging a viewing of the new supplier. We have a new PM who has commenced to support this project.
Review Date	12/08/2024	**Review Details**	JB currently undertaking process mapping with PBUC's colleagues in order to understand the issues more fully. Once completed, there will be an opportunity to update the SOP's and consider a market appraisal for solutions.

Open Board 15+ Monitoring Group Report

Risk

Risk No. & Ver.	Date	Risk Level	Status	Initial Risk Rating (SxL=RR)
790 v.6	16/02/2024	02 Corporate	2 - Open	3 x 5 = 15

Risk Title

Therapy Staffing is significantly affecting ability to undertake therapy activity in the multiple INTs

Full Risk Description

High Therapy Vacancy Rate (recruitment and retention challenges) leading to an increased planned therapy waiting list that is an outlier across the Organisation and the patient's of South Bristol having an inequitable planned therapy offer.

Services affected by Risk	Current Risk		Target Risk	
Division / Specialty / Directorate	**Likelihood**	5	**Likelihood**	3
Adult Services / Adults INT / Adults - Bris South	**Severity**	3	**Severity**	2
Adult Services / Adults INT / Adults - Bris South	**Risk Score**	15	**Risk Score**	6
Adult Services / Adults INT / Adults - Bris South				

Categorisation & Monitoring Group

Category of Risk	Workforce	Monitoring Group	People Committee

Controls

Details of Controls

Current Controls

Revalidation of waiting list being undertaken with clinical lead therapists to identify and escalate patients who have deteriorated whilst waiting and need a sooner response

Actions

Actions

No Actions recorded

Risk Reviews

Review Frequency 1 - Monthly (Risk Score 12-25) **Next Review** 13/10/2024

Review Date	Review Details
13/09/2024	Reviewed at Risk workshop. Teams affected amended to only relate to South Bristol

Open Board 15+ Monitoring Group Report

Risk

Risk No. & Ver.	Date	Risk Level	Status	Initial Risk Rating (SxL=RR)
665 v.7	06/04/2023	02 Corporate	2 - Open	5 x 4 = 20

Risk Title

Un supported servers pose Cyber risk

Full Risk Description

9 servers require urgent remedial action

27 Servers need remedial action before October

23 servers need remedial action as part of an ongoing BAU patching exercise.

This is linked to the devices cyber threat risk, the lack of technical skills in IT risk, the lack of IT management capability and the co-managed contract risk.

There is a substantial resource requirement to fix these issues - as they are happening.

If the servers are not upgraded, and patched appropriately, we will be a risk to the NHS infrastructure and could prove to be catastrophic.

Services affected by Risk	Current Risk		Target Risk	
Division / Specialty / Directorate	**Likelihood**	3	**Likelihood**	2
Adult Services / Digital / Adults - BNSSG	**Severity**	5	**Severity**	2
Central Services / Digital / Adults - BNSSG	**Risk Score**	15	**Risk Score**	4
Children's Services / Digital / Childrens - BNSSG				
Specialist Services / Digital / Adults - BNSSG				

Categorisation & Monitoring Group

Category of Risk	Digital (IM&T)	Monitoring Group	FEED Committee

Controls

Details of Controls

Action Not A Control

Discussed with Softcat who are our licensing provider. They confirm we have paid for the following support over the last few years.

SG 550 FullGuard 24x7 and Central Extended Support for W7/8.1/2008 R2/2012/2012 R2

I have attached the latest renewal invoice from Softcat

Actions

Action No.	1	Start Date	26/05/2023	Target Date	30/06/2023	Completion Date	/ /

Action Description	MECM/Technical Architect required to advise on best practices and complete this exercise. The resource would be of network architecture level with a good understanding of systems administration, database management and Cyber security. I have a number of contacts who i have worked with on large government/enterprise contracts who have the necessary skillsets to remedy this risk.
Progress	

Action No.	2	**Start Date**	01/06/2023	**Target Date**	31/08/2023	**Completion Date**	/ /

Action Description	To manually update the Windows servers with latest patches
Progress	52 servers now updated and patched. 11 servers are legacy and offline 14 servers require commissioning 7 servers are hosted and managed directly by NODE4

Action No.	3	**Start Date**	15/10/2023	**Target Date**	30/11/2023	**Completion Date**	/ /

Action Description	Extended Microsoft support has been purchased from Node4. This will be implemented in November and will continue on a rolling monthly basis until the servers are upgraded or decommissioned.
Progress	

Risk Reviews

Risk Reviews

Risk Not Reviewed

Open Board 15+ Monitoring Group Report

Risk

Risk No. & Ver.	812 v.5	Date	09/04/2024	Risk Level	02 Corporate	Status	2 - Open	Initial Risk Rating (SxL=RR)	3 x 4 = 12

Risk Title

Deferred planned nursing visits

Full Risk Description

Due to increased demand, inability to decline referrals, caseload complexity and acuity across BNSSG INTs including Out of Hours services the risk is patient schedules are deferred resulting in a negative impact and delay to patient care, patient harm (delayed wound care, missed insulin), extended length of stay on caseload, patient deterioration, risk to reputation and increased complaints and moral distress of staff.

Services affected by Risk	Current Risk		Target Risk	
Division / Specialty / Directorate	**Likelihood**	5	**Likelihood**	3
Adult Services / Adults INT / Adults - Bris ICE	**Severity**	3	**Severity**	2
Adult Services / Adults INT / Adults - Bris ICE	**Risk Score**	15	**Risk Score**	6
Adult Services / Adults INT / Adults - Bris ICE				
Adult Services / Adults INT / Adults - Bris NW				
Adult Services / Adults INT / Adults - Bris NW				
Adult Services / Adults INT / Adults - Bris South				
Adult Services / Adults INT / Adults - Bris South				
Adult Services / Adults INT / Adults - Bris South				
Adult Services / Adults INT / Adults - N Som Weston/Worle				
Adult Services / Adults INT / Adults - N Som Weston/Worle				
Adult Services / Adults INT / Adults - N Som Woodspring				
Adult Services / Adults INT / Adults - N Som Woodspring				
Adult Services / Adults INT / Adults - South Glos				
Adult Services / Adults INT / Adults - South Glos				
Adult Services / Adults INT / Adults - South Glos				
Adult Services / Adults INT / Adults - South Glos				

Categorisation & Monitoring Group

Category of Risk	Patient Safety & Clinical Quality	Monitoring Group	Quality & Outcomes Committee

Controls

Controls

Details of Controls

Current Controls

RAG framework to ensure patients are prioritised in order of risk.
Caseload reviews to ensure correct RAG rating and optimised treatment plans in place
regular allocation of clinical visits by registered clinicians
Deferred Visit SOP
Quality metrics monitoring at Clinical Governance Forum and Quality and Outcomes Committee
Deferred Wound Care SOP

Actions

Action No.	1	**Start Date**	09/04/2024	**Target Date**	30/09/2024	**Completion Date**	/ /
Action Description	Ensure all localities have caseload review process in place and scheduled regularly (to be considered equivalent to a red visit)						
Progress	Workshop undertaken as part of the INT development programme which will look to agree standardised approach to caseload reviews, handovers, zonal reviews, named nursing. Await outcome and plan for implementation						

Action No.	3	**Start Date**	01/07/2024	**Target Date**	30/09/2024	**Completion Date**	/ /
Action Description	Upskill CSW staff in basic wound care, venepuncture, catheter care etc. to achieve signed off competencies. Close working across teams to identify where colleagues are visiting from more than 1 team and see where visits may be able to be completed by or team rather than 2						
Progress							

Action No.	4	**Start Date**	01/07/2024	**Target Date**	31/10/2024	**Completion Date**	/ /
Action Description	Identify current and upcoming vacancies to alert recruitment and undertake in a timely way Have a thorough and robust induction for new colleagues to ensure they feel valued and part of the team to reduce attrition						
Progress							

Action No.	5	**Start Date**	01/07/2024	**Target Date**	30/09/2024	**Completion Date**	/ /
Action Description	Work with nursing leads to introduce new system of working. Use weekly staffing projections alongside planned schedules to manage resources. Set up a process whereby we highlight days of week/hour of day where activity and demand is higher or there are gaps and to match this against staffing projection data						
Progress							

Action No.	6	**Start Date**	01/07/2024	**Target Date**	31/12/2024	**Completion Date**	/ /
Action Description	Staff to use deferred template and ensure sitrep completion is accurate						
Progress							
Action No.	7	**Start Date**	01/07/2024	**Target Date**	31/12/2024	**Completion Date**	/ /
Action Description	Zonal caseload reviews to be diarised monthly Zonal reviews to occur monthly- Team Leaders, ACP and team in the zone to meet and review complex people Support staff in confidence in regards to discharge of patients and referral on to other services such as GP Regular handover and safety briefing for peer supervision and review of patients.						
Progress							
Action No.	8	**Start Date**	01/07/2024	**Target Date**	30/09/2024	**Completion Date**	/ /
Action Description	Upskill CSW staff in basic wound care, venepuncture, catheter care etc. to achieve signed off competencies						
Progress							
Action No.	9	**Start Date**	01/07/2024	**Target Date**	31/12/2024	**Completion Date**	/ /
Action Description	Identify current and upcoming vacancies to alert recruitment and undertake in a timely way						
Progress							
Action No.	10	**Start Date**	01/07/2024	**Target Date**	31/08/2024	**Completion Date**	20/06/2024
Action Description	Work with nursing leads to introduce new system of working. Use weekly staffing projections to manage resources						
Progress							
Action No.	11	**Start Date**	01/07/2024	**Target Date**	31/08/2024	**Completion Date**	14/07/2024
Action Description	Call out rota to be in place and introduce initial volunteers to focus on 2hr response						
Progress							
Action No.	12	**Start Date**	01/07/2024	**Target Date**	31/12/2024	**Completion Date**	/ /
Action Description	South Bristol - Staff to use deferred template and ensure sitrep counting is accurate						
Progress							
Action No.	13	**Start Date**	01/07/2024	**Target Date**	31/12/2024	**Completion Date**	21/07/2024
Action Description	Support staff to have management time to undertake reviews at least monthly Support staff in confidence in regards to discharge of patients and referral on to other services such as GP						

	Twice weekly handover minimum to give opportunity for peer supervision and review of patients.
Progress	

Action No.	14	Start Date	01/07/2024	Target Date	31/07/2024	Completion Date	/ /
Action Description	Work to highlight days of week/hour of day where activity and demand is required and to match this against staffing projection data.						
Progress							

Action No.	15	Start Date	01/07/2024	Target Date	31/12/2024	Completion Date	/ /
Action Description	CSW staff to be trained in 6 basic competencies, i.e. basic wound care, venepuncture, catheter care etc. This is already in place and is ongoing.						
Progress							

Action No.	16	Start Date	01/07/2024	Target Date	31/12/2024	Completion Date	/ /
Action Description	Ensure staff have adequate skills to support red visits. Ensure rotation of all locality staff onto UCR pathway. Continue to develop culture of shared responsibilities across pathways						
Progress							

Action No.	17	Start Date	01/07/2024	Target Date	31/08/2024	Completion Date	/ /
Action Description	INT Manager to run in house workshop with band 6's to put into action lessons learned from INT standardisation workshop.						
Progress							

Action No.	18	Start Date	01/08/2024	Target Date	31/12/2024	Completion Date	/ /
Action Description	Consistent use of RAG framework to ensure patients are prioritised Regular allocation of clinical visits by registered clinicians Use of deferred visit SOP Use of wound care SOP Regular caseload reviews to ensure appropriate care is planned						
Progress							

Action No.	19	Start Date	01/08/2024	Target Date	31/10/2024	Completion Date	/ /
Action Description	Weekly allocation to have better control of deferred visits, reduce the need to defer.						
Progress	Weekly allocation now underway, work allocated Mon, Tues for the following week. Allocation currently been undertaken by x2 regular staff each week until process finessed. Long term plan to disseminate task to individual band 6 as part of zonal changes in line with further band 6 recruitment.						

Action No.	20	Start Date	01/08/2024	Target Date	31/10/2024	Completion Date	/ /

Action Description	Caseload reviews being undertaken as part of detailed weekly allocation.
Progress	Allocated time to undertake weekly allocation to incorporate reviews.

Action No.	21	**Start Date**	01/08/2024	**Target Date**	31/10/2024	**Completion Date**	/ /

Action Description	Embed use of deferral SOP to ensure appropriate safe delivery of care
Progress	Team following deferral SOP

Action No.	22	**Start Date**	01/08/2024	**Target Date**	31/12/2024	**Completion Date**	/ /

Action Description	Weekly allocation to better manage oversight of deferred visits
Progress	Due to reduction in temporary staffing in line with budget we have seen an increase in deferrals and the team have struggled to do effective weekly allocation. Resource being protected to do full caseload reviews of all Zones prior to starting Zonal working , which is due to start in a few weeks. which should mean more focused caseload review at point of allocation which should improve efficiency of allocation When Zonal working starts , Allocation meetings are being set up 2x week so plan resource across the locality to enable Band 6s to know what staff is available ahead of time for allocation and mitigate any further staffing challenges to manage deferrals.

Action No.	23	**Start Date**	01/08/2024	**Target Date**	31/12/2024	**Completion Date**	/ /

Action Description	Continue to embed and promote the use of deferred visit template
Progress	

Action No.	24	**Start Date**	01/08/2024	**Target Date**	31/10/2024	**Completion Date**	/ /

Action Description	Implement zonal working
Progress	

Action No.	25	**Start Date**	01/08/2024	**Target Date**	31/10/2024	**Completion Date**	/ /

Action Description	Move to and implement weekly allocation for planned nursing pathway
Progress	

Action No.	26	**Start Date**	01/08/2024	**Target Date**	30/11/2024	**Completion Date**	/ /

Action Description	Implement regular zonal and caseload reviews
Progress	

Action No.	27	**Start Date**	01/08/2024	**Target Date**	31/03/2025	**Completion Date**	/ /

Action Description	Continue to embed RAG rating framework as well as utilisation of the new EMIS slot types - this will be reviewed during zonal and caseload reviews
Progress	

Open Board 15+ Monitoring Group Report

Action No.	28	**Start Date**	01/08/2024	**Target Date**	31/03/2025	**Completion Date**	/ /
Action Description	Promote communication between pathways in the LCC - with an ultimate aim of moving from 2 LCC's in SG to one						
Progress	Continue to embed role of manager of the day						
Action No.	29	**Start Date**	01/08/2024	**Target Date**	31/12/2024	**Completion Date**	/ /
Action Description	Implement rota for managing unplanned call outs within community nursing						
Progress							

Risk Reviews	**Review Frequency** 1 - Monthly (Risk Score 12-25)	**Next Review**	11/10/2024
Review Date	11/09/2024	**Review Details**	All teams requested to update action plans

Open Board 15+ Monitoring Group Report

Risk

Risk No. & Ver.	830 v.3	Date	03/06/2024	Risk Level	02 Corporate	Status	2 - Open	Initial Risk Rating (SxL=RR)	4 x 5 = 20

Risk Title

There is a significant higher demand of referrals for planned therapy against predicted contracted activity in BNSSG

Full Risk Description

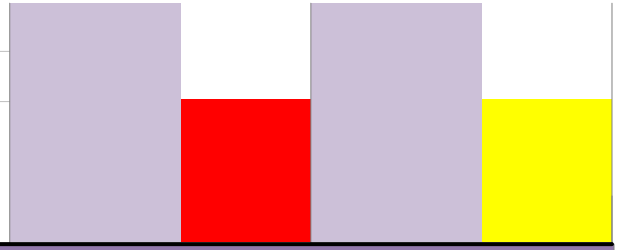
AS a result of increased referral demand within planned therapy pathway, alongside of the ongoing system priority on P1 discharges and urgent community response, there is a risk that we are not able to meet the referral demand and subsequent activity placed on this pathway. This includes inability to meet the 18 week waiting period.

This could result in:
-Reputational damage
-Poor patient experiences and poorer patient outcomes
-Deterioration of patients on the waiting list, and consequent unplanned use of urgent care services
-Increase of complaints
-Staff morale
-Challenged for recruitment and retention

Services affected by Risk	Current Risk		Target Risk	
Division / Specialty / Directorate	**Likelihood**	5	**Likelihood**	3
Adult Services / Adults INT / Adults - Bris ICE	**Severity**	3	**Severity**	2
Adult Services / Adults INT / Adults - Bris ICE	**Risk Score**	15	**Risk Score**	6
Adult Services / Adults INT / Adults - Bris ICE				
Adult Services / Adults INT / Adults - Bris NW				
Adult Services / Adults INT / Adults - Bris NW				
Adult Services / Adults INT / Adults - Bris South				
Adult Services / Adults INT / Adults - Bris South				
Adult Services / Adults INT / Adults - Bris South				
Adult Services / Adults INT / Adults - N Som Weston/Worle				
Adult Services / Adults INT / Adults - N Som Weston/Worle				
Adult Services / Adults INT / Adults - N Som Woodspring				
Adult Services / Adults INT / Adults - N Som Woodspring				
Adult Services / Adults INT / Adults - South Glos				
Adult Services / Adults INT / Adults - South Glos				

Adult Services / Adults INT / Adults - South Glos

Adult Services / Adults INT / Adults - South Glos



Categorisation & Monitoring Group

Category of Risk	Capacity & Demand (Operational)	Monitoring Group	Performance Committee

Controls

Details of Controls

Current Controls

- Regularly highlighted on the contract report
- Introduction of remote assessment
- Regular caseload reviews undertaken by appropriate members of the teams

Actions

Action No.	1	Start Date	03/06/2024	Target Date	30/09/2024	Completion Date	24/09/2024
Action Description	Reinstate the Sirona organisation wide task and finish group, for planned therapy, in order to undertake a deep dive to scope our current processes with an aim for standardisation.						
Progress	T&F group has been reinstated.						

Action No.	2	Start Date	24/09/2024	Target Date	24/09/2024	Completion Date	/ /
Action Description	Unregistered workforce utilization to undertake appropriate level initial assessments introduced and BAU						
Progress	Introduction complete, Ongoing						

Action No.	3	Start Date	24/09/2024	Target Date	31/03/2025	Completion Date	/ /
Action Description	Various skill mixing models tested across individual localities to scope other clinical models across P1, allowing therapists to focus upon more complex therapy requirements whilst providing advice and guidance to support other clinical colleagues.						
Progress	Various models currently being tested, eg paramedics, RNs, APs.						

Action No.	4	Start Date	24/09/2024	Target Date	29/11/2024	Completion Date	/ /
Action Description	Re-write of INT service specification to share with ICB contracts team This will include focus upon rehabilitation, performance thresholds, review of referral criteria, review of domiciliary policy.						
Progress	Re-write of INT service specification has commenced.						

Risk Reviews		Review Frequency 1 - Monthly (Risk Score 12-25)		Next Review 26/10/2024
Review Date	26/09/2024	**Review Details**	All actions reviewed and additional actions added.	

Board Report

Date	10th December 2024	**Agenda item**	9
Title	New format of the Board Assurance Framework (BAF)		
Author	Julie Young, Interim Director of Governance		
Presented by	Julie Young, Interim Director of Governance	**Version**	1
For	Approval/decision ☒ Debate ☐ Assurance ☒ Information ☐		
Assurance Rating	High/Significant ☐ Medium/Partial ☐ Low/No Assurance ☐ Not applicable ☐		
If partial or no assurance, please outline steps to be taken in order to reach significant assurance, by when, and whom	An extract of the BAF in its new format is being presented for Board approval, following discussion and support at the Audit, Assurance and Risk Committee (AARC) in November 2024. As part of the currently work on Business Planning for 2025/26, the BAF in its new format will form a suite of documents including the Business Plan and Financial Plan 2025/26 which will be presented to Board in March 2025. The proposed format has been developed by University Hospitals Plymouth NHS Trust and we have their permission to use it. It was recommended by our Internal Auditors as best practice example.		

N.B. This cover paper should not exceed 2 pages.

Purpose of report and reason for submission to Board
E.g., is this a regulatory/contractual requirement, linked to our Strategic Objectives or Risks?
To provide the Board with the proposed new format of the BAF which was supported by the Audit, Assurance and Risk Committee, for approval. Due to the size of the BAF, only an extract entry is attached, as an example. The new overview BAF dashboard has also been provided.

Related Risk No. (If applicable)	

How has the assurance provided in this report been obtained?
What sources of information have been relied on? How has assurance been built up through the organisation? *Provide links to relevant evidence sources relied upon in this report.*
Via the Audit, Assurance and Risk Committee

What is the process the report has been through internally
Which teams or groups have reviewed the report or the information that informs it
The proposed BAF format was presented for the first time to the Audit, Assurance and Risk Committee.

Summary and Key Issues to be highlighted

Please highlight in summary the key messages from this report, including matters of escalation from Committees, significant issues, risks and actions to address them
Alert the Board to of areas where assurance is not sufficient.
Advise the Board of steps taken to address areas where assurance needs to be improved. (please ref relevant section of the report, where more information can be found).

The BAF sets out the organisation's strategic objectives, the risks to achieving them and the controls and assurance mechanisms that have been put in place to manage risk and deliver the objectives. The BAF clearly articulates the controls in place to ensure that the principal risks are being managed and the sources of assurance (evidence) that these controls are operating effectively.

As a result of an initial review of the governance and the strengthening of Sirona's position against the CQC Well Led Standards, it was clear that the BAF required a refresh to:

- Ensure that it is robust, easy to read and clearly identifies the main points for Board's attention.
- Reduce the overall level of detail, without losing the strength of assurance.

The Audit, Assurance and Risk Committee considered the proposed format in terms of its 'useability' to gain the assurance required and discussed any areas where improvements could be made.

The current BAF remains and is being updated through the Executive Team.

As part of the current work on Business Planning for 2025/25, the BAF in its new format reflecting the new organisational priorities, will form a suite of documents including the Business Plan and Financial Plan 2025/26 which will be presented to Board in March 2025.

Actions for the Board (including any decisions required and options for consideration)

Are there any matters that require a Board decision or discussion to address issues of concern?

The Board is asked to note the update and approve the new BAF format.

Sirona care & health

Board Assurance Framework

December 2024

CQC Domain – Well Led			
Strategic Objective 3: Governance and Leadership Develop and implement a 'frontline to board' governance assurance framework and strengthen overall governance arrangements to support and demonstrates compliance with external requirements and our internal control regime.			
Strategic Risk Title: SR4- Leadership			
Lead Executive: Julie Young	**Assurance Committee:** Audit, Assurance and Risk Committee	**Committee Review Date:** February 2025	**Risk Tolerance: 9**

Risk Description:

We know that health and care is changing with more focus on caring for people in their own homes to ensure the right care in the right place at the right time. We need to make sure that we make the right strategic changes in a steadfast way with a firm focus on the people who benefit from what we do.

Rationale:
We are committed to further developing and implementing a 'front-line to board' governance assurance framework that demonstrates compliance with external requirements and our internal control regime. To achieve this we are reviewing our Board composition and committee structure as well as mapping assurances across the organisation to strengthen our arrangements. In addition, we are planning this year to strengthen our governance and assurance arrangements taking an integrated approach that encompasses the thinking embedded in the Care Quality Commission's well-led framework and the Open Compliance and Ethics Group's GRC (Governance Risk and Compliance) approach.

Risk Score Trend				Inherent Risk Score (pre mitigation)			Residual/Current Risk Score (with mitigation in place)			Target Risk Score (with further mitigation applied		
Q1 (Score)	Q2 12	Q3 (Score)	Q4 (Score)	Likelihood	Consequence	Overall	Likelihood	Consequence	Overall	Likelihood	Consequence	Overall
				4	5	20	3	4	12	2	5	10

Risk Position/Assurance Statement
Increased momentum on recruitment of Board Members – Non-Executives and Executive Directors. Good Governance Developmental Review commenced, due for report at end of January/beginning February 2025.

Key Controls	Sources of Assurance	Level of Assurance (3 line of defence)			Positive	Neutral	Negative
		1st	2nd	3rd			
Board composition and terms of reference	Well-led assessment New NEDs appointed Substantive Executives recruitment commenced		✓				
Board committee structure in place	GGI review outcome		✓				
Good Governance Institute development review	GGI final report and action plan from recommendations			✓			

Overall Assurance Level			

Gaps in Controls/Assurance	Action to address gap	Action Owner	Due Date	RAG Completed On Track Overdue	At Risk Update/Notes *No written update required if action is on track with confidence in delivery*
Recruitment of new NEDs with review of roles	New NEDS appointed and started on 4th November 2024	Director of Governance	Nov 2024	Completed	
Recruitment of remaining vacant NED and Associate NED roles	Recruitment process commenced, supported by external agency.	Director of Governance	Jan 2025	On Track	
Executive vacancies recruitment as a result of the Executive Re-structure paused in Qtr 1. Re-commence recruitment	Executive restructure completed. Recruitment to substantive Executive posts completed for Chief Finance Officer and Chief Operating Officer. Plan for remaining Executive recruitment by end Qtr1 25/26	CEO	June 2025	On Track	
Redesign and implementation of a new Board Assurance Framework, for approval at December's Board.	BAF redesigned and refreshed. Template reviewed by Audit, Assurance and Risk Committee in November. Reviewed new format BAF to Board for approval in December 2024.	Director of Governance	Dec 2024	On Track	
Assurance mechanism to be developed and in place for Well Led Domain.	Mechanism in place as a repository for status against each standard and documentary evidence to support this position. Internal audit assessment of the Well Led position near completion (by 31 December).	Director of Governance	Dec 2024	On Track	
Committee review aligned to the BAF discussed at Board seminar	New BAF format shows Assurance Committee for each BAF Strategic Risk.	Director of Governance	Dec 2024	Completed	
Redesign and implementation of a new board committee and executive assurance committee structure	Await the outcome of the Good Governance Institute review report due Qtr 4.	Director of Governance	Feb 2025	On Track	
Development of an assurance map setting out which assurances go where, how frequently, and what is done with them	Working group reviewing the groups that report into the Board Sub Committees – drafting the structure of these groups. Ensure that this work aligns with the outcome of the governance review due in Qtr 4.	Director of Governance	Feb 2025	On Track	

Related risks on the Risk Register		
No.	**Risk title**	**Risk Score**

CQC Domain – Well Led			
Strategic Objective 3: Governance and Leadership Develop and implement a 'frontline to board' governance assurance framework and strengthen overall governance arrangements to support and demonstrates compliance with external requirements and our internal control regime.			
Strategic Risk Title: SR5-Governance and Assurance			
Lead Executive: Julie Young	**Assurance Committee:** Audit, Assurance and Risk Committee	**Committee Review Date:** February 2025	**Risk Tolerance: 9**

Risk Description:

Visibility from the front line to the board and reverse is important. If we do not strengthen our assurance and governance arrangements, we could miss opportunities to prevent problems from happening.

Rationale:
We are committed to further developing and implementing a 'front-line to board' governance assurance framework that demonstrates compliance with external requirements and our internal control regime. To achieve this we are reviewing our Board composition and committee structure as well as mapping assurances across the organisation to strengthen our arrangements. In addition, we are planning this year to strengthen our governance and assurance arrangements taking an integrated approach that encompasses the thinking embedded in the Care Quality Commission's well-led framework and the Open Compliance and Ethics Group's GRC (Governance Risk and Compliance) approach.

Risk Score Trend				Inherent Risk Score (pre mitigation)			Residual/Current Risk Score (with mitigation in place)			Target Risk Score (with further mitigation applied		
Q1 (Score)	Q2 16	Q3 (Score)	Q4 (Score)	Likelihood	Consequence	Overall	Likelihood	Consequence	Overall	Likelihood	Consequence	Overall
				4	5	20	4	4	16	2	4	8

Risk Position/Assurance Statement
Increased momentum on recruitment of Board Members – Non-Executives and Executive Directors. Good Governance Developmental Review commenced, due for report at end of January/beginning February 2025.

Key Controls	Sources of Assurance	Level of Assurance (3 line of defence)			Positive	Neutral	Negative
		1st	2nd	3rd			
Risk management policy and training	Risk training records		✓				
Risk Register and BAF	Risk Management Internal Audit. Newly reviewed BAF		✓				
Well-led review self-assessment	Self Assessment Review completed. Internal audit review of Well-led due to report in December 2024.			✓			
Risk reports to be, up to date with information relevant to the respective committee; clear, simple and informative.	Risk reports have been redesigned and presented at the relevant Committees. Received positively by Committees.		✓				
Good Governance Institute development review	GGI final report and action plan from recommendations			✓			

Overall Assurance Level			

Gaps in Controls/Assurance	Action to address gap	Action Owner	Due Date	RAG Completed On Track Overdue	At Risk Update/Notes *No written update required if action is on track with confidence in delivery*
Recommendations from the GGI review	Implement recommendations/actions	Director of Governance	February 2025	On Track	
(Same gaps as SR4)					

Related risks on the Risk Register		
No.	**Risk title**	**Risk Score**

Example of the BAF dashboard

Strategic Objective	Strategic Risk Entry	Our current risk score	Our current overall assurance	Target	Tolerance	Score Trend
Strategic objective 1: Equality, Diversity, and Inclusion	SR1-Diverse workforce	16	Neutral	10	8	⟷
Strategic objective 2: Delivering Quality Through Partnership	SR2-Demand and Capacity	20	Negative	12	8	↑
	SR3-Regulatory Compliance	15	Neutral	10	8	⟷
Strategic objective 3: Governance and Leadership	SR4-Leadership	12	Neutral	10	9	⟷
	SR5-Governance and Assurance	16	Neutral	8	9	↓

Board Report

Date	10th December 2024	**Agenda item**	11
Title	Winter Plan 2024/25		
Author	Teresa Candfield Interim Deputy Chief Operating Officer		
Presented by	Andrea Gordon	**Version**	1
For	Approval/decision ☒ Debate ☐ Assurance ☒ Information ☐		
Assurance Rating	High/Significant ☐ Medium/Partial ☐ Low/No Assurance ☐ Not applicable ☐		
If partial or no assurance, please outline steps to be taken in order to reach significant assurance, by when, and whom			

N.B. This cover paper should not exceed 2 pages.

Purpose of report and reason for submission to Board
E.g., is this a regulatory/contractual requirement, linked to our Strategic Objectives or Risks?
The purpose of this report is to share Sirona's Winter Plan with the Board to outline our winter and surge planning response, work with the system and governance through the period. The reason for sharing with the Board is approval of the winter plan.

Related Risk No. (If applicable)	

How has the assurance provided in this report been obtained?
What sources of information have been relied on? How has assurance been built up through the organisation? *Provide links to relevant evidence sources relied upon in this report.*
The plan has been developed through the operational services, involving ADs and Heads of Services from across the organisation. Also, learning has been taken from previous years and strengthening Sirona's systems and processes that underpin operational clinical service delivery, notwithstanding the recognition of all supporting services and functions that enable this. The delivery of specific aspects of the plan will be monitored through the operational governance routes.

What is the process the report has been through internally

Which teams or groups have reviewed the report or the information that informs it

A draft of the report has been presented to the Operational Delivery Group and the final report has been to the Executive Committee and the Performance Committee for assurance.

Summary and Key Issues to be highlighted

Sirona's 20243/25 winter plan recognises core elements that will support critical service delivery as part of the annual 'seasonal' planning process. Winter planning goes beyond internal planning, and there is a focus on whole system and partner collaboration to ensure preparedness across BNSSG. Winter planning is led through the BNSSG ICB and focus on delivery around the Urgent and Emergency Care Recovery key actions.

Focus for 2024/25 is to maintain business as usual delivery through normal operational routes and revised operational management processes, utilising escalation routes as required. The OPEL framework and actions taken aim to mitigate delivery issues and maintain a business as usual approach whenever possible. Also linked is our EPRR revised and strengthened Tactical and Strategic arrangements, as well as the cold weather plan and key actions for service delivery in the advent of adverse weather conditions.

Sirona's staff vaccination programme is a core element of our winter preparedness, and it should be recognised that the Executive Committee have previously received a summary on the vaccination programme delivery (24/25). Helping keep staff healthy and at work is pivotal to delivering our services.

The plan for operational services focuses on those services that are adding additional capacity for winter, e.g. the Pathway 1 Surge response as support to wider system patient flow pressures in the acutes and staffing above the commissioned headcount in Place Based Urgent Care to support patients receiving the right care in the right place with minor injuries and some illnesses.

Delivery against these will be monitored through the operational performance reporting process. Keeping teams in business as usual and out of escalation is the overarching ambition. Creating additional capacity to support surge and system escalation is challenging, noting the increasing referrals across many clinical services. There are embedded processes that support prioritisation of care delivery across Sirona's clinical services at times of extreme surge.

Actions for the Board (including any decisions required and options for consideration)

Are there any matters that require a Board decision or discussion to address issues of concern?

The Board is asked to review and approve the Operational Winter Plan for 2024/25.

Contents

1. Executive Summary 4
2. Background 4
3. Operational Management and Operational Pressures Escalation Levels (OPEL) 5
4. Command & Control / Escalation Arrangements 5
5. Cold Weather Plan 6
6. Vaccination Programmes 7
7. Infection, Prevention & Control 7
8. People & Development 8
9. Communications 9
10. Operational Adult Services 11
11. Community Children's Services 13

1. Executive Summary

The development of this 24/25 winter plan brings to the forefront acknowledgement of Sirona's successful service delivery and resilience achieved throughout last year (and previous years), and identifies improvements and lessons learned to take us forward for this winter season and all the pressures that it is likely bring. This plan has been written, recognising that during the spring, summer, and autumn this year has not seen previous reductions in demands across services across the whole system. Despite these challenges we can celebrate a range of operational and service delivery processes that will strengthen our delivery in the coming months.

As we continue to develop and learn, the Committee is assured of supporting actions that we bring with us into the forthcoming winter season. Sirona have fully participated and continue to do so with system planning and actions that relate to escalation and service delivery. There are many improvements across services that's have been taken, that continue to stabilise service delivery, despite the known and growing demands on services, for example:

- Through the INT development programme all clinical services now apply and adhere to robust roster planning, ensuring that senior operational managers maintain strict oversight and scrutiny
- Rosters are prepared on a rolling six weekly cycle with monitoring and diligence over planning for annual leave and staff training, to minimise gaps in rotas
- The temporary staffing team have worked to increase staff who are actively working and, on our bank, therefore reducing dependency on agency, supporting continuity of care within teams, and supporting safe roster fill
- There will be a deep dive on all clinical rotas at the beginning of December to ensure appropriate Christmas cover is achieved (a 12-week roster has been introduced and closely monitored); this is overseen in conjunction with the weekly allocation for patient visits
- Teams have been working collaboratively, so when one area is in escalation, supporting teams review to respond and release support
- A review of 4x4 response and best endeavour drivers, should the need arise to mobilise the vehicles on stand-by
- Tactical and Strategic on call rotas have undergone a full review and have been strengthened, both in numbers and completion of an internal training programme
- Oversight and monitoring of the impact from GP collective action continues, and escalation internally will be through the daily operational flow meeting, and when required into the system flow or other relevant governance escalation meetings. Business information team are working to enable monitoring of key trends so we can identify emerging referral pressures within teams.

2. Background

Sirona's 2024/25 winter plan recognises core elements that will support critical service delivery as part of the annual 'seasonal' planning process. Winter planning goes beyond internal planning, and there is a focus on whole system and partner collaboration to ensure preparedness across BNSSG, to ensure that each part of the health and care system can function effectively to meet the anticipated surge in demand for healthcare services.

Sirona has continuously made improvements within its EPRR planning and delivery that supports a command and control / incident response when indicated. We have also strengthened the internal operational delivery of services, the supporting governance, information reporting and business as usual and escalation framework. By working closely with operational leads and our Senior Leadership Team, by means of Strategic Oversight planning, the following describes Sirona's winter planning approach this year, and the forthcoming GP Collective Action and currently unknown impacts across BNSSG health and care partners.

This plan forms part of the organisation's assurance in support of surge planning and should be considered in conjunction with the Surge Plan 24/25. In addition to this plan there is a requirement to have close oversight of Operational Christmas and New Year Delivery, although noting this is being undertaken as part of health-roster rotas in teams. The Senior Operational Management will also have scrutiny of senior operational cover and a process is in place that reviews this continually.

3. Operational Management and Operational Pressures Escalation Levels (OPEL)

Most of the winter delivery will be managed through the existing governance arrangements within Sirona. This includes our Daily Operations and Flow meetings which has input from all operational critical service areas of the business (e.g. bedded units, INTs, PBUC, and SPA), along with Communications daily, Infection Prevention Control twice weekly, and the Temporary Staffing Team as required. This DOF meeting is currently supported Monday-Friday, and weekend planning meetings are held at INT geography level, and weekend sitrep reporting is managed up through the on-call managers to the on-call Strategic Director. The Strategic Director represents Sirona on the weekend flow meetings, and in support of the Tactical Managers who field all escalation and operational queries from teams out of hours and at weekends.

There is a weekly Senior Operational Meeting, which will take items of escalation from the DOF or from within services, in line with the appropriate escalation process and other items that require urgent action to support the safe operational delivery of services. If escalation falls outside of the timing of this meeting, extraordinary escalation to the Chief Operating Officer, or on call Strategic Director is followed; this is in accordance with the robust internal escalation framework and recognises the need to continue to review, to ensure it is fit for purpose. All supporting documents and processes can be found in the DOF folder within glasscubes: Daily Operations & Flow Meetings (glasscubes.com) and the Operational Delivery Folder Operational Delivery Group (glasscubes.com)

Sirona has developed a suite of tools to support a consistent approach in determining the daily OPEL declaration. This has been undertaken with support from service leads and Business Intelligence and has successfully led to automation (based on data inputted into MIDOS), which has been weighted and generates a daily OPEL score. This is a tool, so at any time the chair of Daily Operations and Flow (DOF) can use overriding judgment with Sirona's final daily OPEL declaration. It is also notable that it offers a snapshot at the time of the declaration, and there are likely to be situations that could trigger business continuity events, which might require amendment to the OPEL declaration and an incident response.

4. Command & Control / Escalation Arrangements

Sirona has developed a suite of supporting policies as a response to escalation and Incident Response management. These can be accessed on Workplace/ Knowledge Library / Policies and

procedures / EPRR policies. Those most relevant in support of winter planning can be accessed below:

Best Endeavour Policy

Business Continuity Management Policy

Cold Weather Plan 2022

EPRR policy

Incident Command & Control policy

Incident Response Plan

A significant review and strengthening of the Tactical and Strategic on call rotas have been completed this year due to major gaps that arose due primarily to staff changes. Sirona are required to have a 24/7 on call Tactical and Strategic Manager, and due to lower levels of operational managers out of hours and at weekends the on call Tactical managers field all operational escalation queries from teams, putting additional responsibility onto this role / critical function.

A complete overhaul of the training materials and internal training programme has been rolled out and most staff members have completed this now.

5. Cold Weather Plan

This plan is based on the National Cold Weather Plan for England, issued by UK Health Security Agency (UKHSA). It should be read in conjunction with this document and local Business Continuity Plans.

The Incident Response Plan should be adhered to and recognises that every member of staff within Sirona care & health CIC plays a vital role in ensuring a professional response to an incident. It is therefore essential that all members of staff are familiar with how the organisation will respond during such an event and most importantly, the individual roles within our response and how other organisations interact with Sirona care & health CIC.

Sirona care & health is committed to ensure critical functions of all services will be available even during disruptions by severe weather. The main meteorology risk is snow and ice in the winter. In some areas Sirona there is the additional risk of flooding, although 4x4 training doesn't support the use of vehicles in flood situations due to additional unknown risks and hazards. In cases of flooding, the Hazardous Area Response Team (HART) would support essential access to patients requiring urgent treatment. To mitigate, Sirona has a contract with A&D 4x4 Ltd, a private hire company and has secured several off-road capable vehicles on a stand-by arrangement with the ability to pull down up to 20 vehicles in the event of snow.

There are quite a few Sirona staff and volunteers have either received training in 4x4 driving or have declared competence in using either hired or personally owned vehicles which are serviced, maintained, and insured for business use. Each locality holds an updated best endeavour drivers list, as well as the Out of Hours teams (NHS@Home currently agreeing requirements).

A Memorandum of Understanding (MOU) also exists between Severn Side Integrated Urgent Care (BrisDoc) and Sirona whereby BrisDoc would offer support to Sirona in the event of adverse

weather, providing 4x4 vehicles and drivers during weekday daytime, subject to their own staffing and service needs.

Furthermore, Sirona have a business account with Enterprise Care Hire to provide 4x4 resources. This has been established as a resilience measure as there are relatively high associated costs and risks. Sirona's 4x4 Vehicle Management Policy organises the annual winter response, including 4x4 vehicle hire, driver recruitment roles and responsibilities and the command and control structure.

6. Vaccination Programmes

Sirona has consistently been one of the best performing NHS funded staff vaccination organisations in the country. Sirona is committed to delivering a robust vaccination programme to promote staff and service user well-being. The delivery of which is coordinated and led by the Head of Specialist Services for Children and Sirona Integrated Immunisation Services.

Sirona has a comprehensive vaccination programme, that incorporates the staff seasonal influenza staff vaccination and Covid programmes, to maximise co-ordination of resources and minimise the operational impact. All bookings are managed via Vaccination Track.

Due to the modelled risks of co-circulating COVID-19 and flu and in alignment with national requirements, Sirona has already initiated both staff Flu and Covid vaccination programmes for 24/25. The patient vaccination programmes have been managed centrally and Sirona's Integrated Network Teams will not be required to vaccinate people in their own homes for 24/25.

The team will continue to support the flu / covid vaccination programme for our hard to reach and underserved populations.

7. Infection, Prevention & Control

Sirona Care and Health has an infection prevention and control (IPC) team, comprising of the Chief Nursing Officer who is the designated Director of Infection Prevention and Control, a Head of Patient Safety and Infection Control, two Band 7 Lead IPC Nurses and three Band 6 IPC posts. The team have a robust work programme in place which incorporates winter planning, and the plan is monitored on a quarterly basis at the Infection Prevention and Control meeting.

Out of hours escalation for IPC is managed via the on call tactical manager. An on-call microbiologist for the inpatient units is also available via the Acute Trusts. For urgent IPC advice and notification of an outbreak during weekend working hours and out of hours Public Health South-West can be contacted via 0300 303 8162.

There are a comprehensive suite of policies and standard operating procedures available on the Sirona Workplace as part of the Knowledge Library which are regularly reviewed and updated which include an overarching infection control policy, policies related to outbreaks, Hand Hygiene, Diarrhoea and Vomiting to name but a few. The IPC team are linked into the Strategic Oversight Group for integrated Immunisations and the BNSSG High Consequences Infectious Diseases (HCID) Group. The team are also linked to the BNSSG healthcare associated infection groups, and the South-West Regional Infection Control group.

The IPC team have an infection prevention and control link practitioner group and these individuals act a point of contact in their teams and service for IPC advice and education cascade.

The IPC team also provide bespoke training on request. As part of the winter planning arrangements the team are preparing related IP&C presentations to be delivered to the rehabilitation units as part of the work programme.

8. People & Development

Workforce

Our overall aim is to continue to ensure Sirona is a great and inspiring place to work. We have identified six key aims as part of our 3 Year People Strategy, which was launched in autumn 2023. All of these will strengthen our workforce approach and therefore underpin wider workforce actions in support of winter planning, escalation, and surge. These are:

- Engage, retain, reward, and recognise our people
- Attract, recruit, develop and resource effectively
- Create a positive organisational culture
- Be inclusive supportive and healthy
- Be well led
- Deliver a responsive, innovative, and collaborative People service.

During daily operations and flow meetings Sirona monitors the impact that staff sickness is having on service delivery, noting themes in causes (especially infection, prevention and control causes over winter). In addition, we will introduce more detailed analysis and impact on service delivery of other sickness types and this will be reported through Accountability Meetings and a summary of year on year findings to the February Performance Committee.

Temporary Staffing Supply

Our Temporary Staffing service is being reviewed and will focus on more proactive work to build the size and competence of our Bank. This will help us to meet our targets to reduce agency usage and spend, while maintaining safe staffing and ensuring organisational agility. We have successfully reduced the use of off-framework agencies by 95% and will maintain existing agency controls to make sure this does not increase unnecessarily during the winter period.

Break glass alternative will be available when the premium rates are removed in December in exceptional circumstances. The protocols to support this are in development at the time of writing this plan.

Bank

Over the winter period our Bank workers remain critical to the continued successful delivery of many of our services and the latest data shows many services benefitting from an effective supply while others continue to rely quite heavily on Agency Temp Workers. The ‘Bank First’ approach is well-established, and the online Bank booking system (Bank Staff) is working well.

The bank needs greater capacity however, and our focus for this winter continues to be to hire more bank workers and to increase the average number of hours that each of them works. We are targeting monthly increases in Bank Capacity and expect (on average over the period) to increase it

by C. 2,000 hours per month with more emphasis on those services that are not as well supplied. This will be achieved through targeted recruitment activity and continuous proactive bank fill conversations with those Bank Only Workers, who individually may have more capacity.

We also expect to further improve the quality of Bank staff available to our services through a programme funding clinical competence (essential to role training) and staffing in the team to support quality assurance. Support to services has been expanded to provide an emergency Out of Hours service. If necessary and after review, this can be enhanced for the demands of the winter period.

We have already significantly increased our bank hours filled to approx. 35K per month. In support of the aim of increasing bank fill, all BNSSG system partners have reviewed bank fill incentives, and we are able to implement a menu of revised incentives that have been partially harmonised across BNSSG. During October we will consider options for implementation of the full range to enable us to pinpoint services, shifts and occasions along with strict control over where and when each type of incentive may be deployed for maximum shift fill during the Winter season.

Agency

The ICB operates a partnership agreement with Retinue to supply agency nursing and clinical support staff and AHP workers. Agency staff make up around half of our temporary staffing supply and Retinue are performing particularly well for Sirona at around 75% shift fill. We have reduced TNS off framework supply to less than 5% of all agency shifts, and they can now be considered as an emergency only use if needed for short term red flag situations only.

We expect this level of supply chain performance to continue through the winter period. The arrangements with Retinue have enabled us to access the widest possible number of Temporary Staff Agencies with appropriate governance mechanisms for clinical competence and experience. We will continue to work closely with Retinue through the winter to ensure effective provision of agency staff where needed.

Learning and Development

The 4x4 training is funded and sourced via EPRR and the L&D team advertise the courses. The training is part of our resilience on occasion of bad weather etc. and to aid clinical/non-clinical staff in getting to bases/patient homes where necessary.

The training of E2R skill is a complex and expensive issue with funding currently with the teams direct and not central. Working on an approach to increase capacity of teams to sign off competency of additional skills.

Depending on Sirona's operational delivery status, the OPEL actions will determine wider consideration for staff accessing clinical stat / man training. All efforts are made to protect staff attendance to essential clinical training, as it supports safe delivery of patient care, but if in extremis this would be reviewed under the escalation process.

9. Communications

Sirona's Communication Team is represented at a BNSSG Tactical and Strategic Comms level and supports all areas of internal escalation and warning and informing. This year's approach to winter

is similar to previous years, with a system tactical group representing our ICS providers working with oversight from the Strategic Comms Group.

The winter communications plan plans to cover:

- Right Care, First Time – Choosewell
- Home First
- Winter vaccinations – including staff flu and covid and children's flu
- Admission avoidance
- Mental Health 111
- Violence and aggression
- Winter Resilience - PR and social media
- Stay Well This Winter – supporting comms plan developed by system. Includes HANDiApp, vaccinations, NHS11, staying warm, staying well, eating well, staying active, cost of living

This embedded integrated approach enables an even wider cascade for community specific messages as the channels of all partners are utilised. It also enables shared funding of graphics, videos, social marketing and evaluation. The team is making sure materials are available in printed format as well as digital.

Insight from the BNSSG Citizens Panel and other engagement activities is being used to tailor the messages within our communities. The joined-up approach also enables additional support when we need to cascade urgent messages to partners such as GPs and hospital staff – this was particularly helpful during our recent digital outage.

In addition, our communications team is supporting our staff 'flu / Covid booster vaccination and school immunisation campaigns with representatives from our Communications Team on relevant planning and delivery groups.

Our Workforce recruitment and resourcing team will be supported by a Communications post for targeted recruitment messaging using social media, local recruitment event support and advertising messages. Recruitment is underway to fill a vacancy, with an anticipation that the post will be filled in November 2024. Work is underway to grow our library of always-relevant recruitment content for use online (website, social media, job adverts etc).

The team are also providing communications support to Sirona's Health Links Team, improving inclusion and accessibility of messaging particularly for individuals whose first language is not English.

As well as the planned work, the team is involved in reactive messaging if business continuity incidents occur, causing potential disruption to services. It supports our EPRR team with warning and informing the public, partners staff and service users about adverse weather, or situational issues and any implications for services and staff as a result. It also provides communication support for escalation through our EPRR structures and for specific Internal Control Centres when they are being run. The Team is also linked into the Local Resilience Forum communications network.

10. Operational Adult Services

Operational Services will continue to run business as usual through the winter period, ongoing work through the specific services and usual governance will continue to monitor the delivery of services in line with national local and contractual requirements.

In addition, some areas are undertaking further actions to support the demand through the winter period and related to the Urgent Emergency Care priority actions; as well as an ongoing Pathway 1 recovery response plan that is occurring in November and December. This recovery plan aims to reduce the acute no criteria to reside before the peak winter pressures set in, and Sirona has invested in the additional that supports this initiative.

10.1 Adult Services

Single Point of Access: The service has continued to increase its Advanced Practice roles to support higher levels of clinical reasoning, positive risk taking and clinical escalation. This is largely due to investment to deliver the F-ACE service. We will provide senior clinical staff to F-ACE, Direct referrals from SWAST stack and to provide a point of clinical escalation for the service.

F-ACE provides care coordination for frail patients that are heading towards hospital admission, taking most cases from GP's and Paramedics on scene. Direct referrals from SWAST stack, Category 3,4,5 patients that appear to fit a UCR remit will be directed to Sirona for a Remote Assessment assisting delays in response from ambulance services.

There is an increased pool of temporary / bank staff that can support service delivery in times of surge activity or escalation. The IVR enables the most vulnerable and/or unwell patients to be prioritised through the telephony system. SPA use robust forecasting tools that support staff planning as well as being able to review real time capacity and demand to maintain response times. This information then supports structured decision making in line with the service OPEL matrix.

Urgent Community Response: Throughout the winter period Sirona will continue to work with the Same Day urgent care system across BNSSG to assure priorities and changes in service delivery are aligned with service provision. Urgent referrals are managed through Sirona's Single Point of Access (SPA) and clinically triaged as appropriate, enabling services to respond in the required time.

UCR capacity is identified daily across each locality and monitored throughout the day. An aligned operating model between UCR and NHS@Home is developing to enable step up capacity for the winter period. This is supported by a three weekly board round, which provides opportunities to discuss current and potential patients and facilitate step up care into a virtual ward in an effective timeframe as appropriate.

NHS@Home: This service allows individuals to receive care in their own homes, ensuring their safety and reducing the need for hospital admission. It includes early supported discharge from hospital or preventing hospital admission altogether. NHS@Home uses a mixture of digital monitoring on a virtual ward, telephone support and face to face visits from specialist teams providing hospital level clinical care where required.

It operates across 5 different pathways: Frailty, Respiratory, Heart Failure, OPAT, General medical and surgical. Through winter, opportunities to improve capacity are being developed including maximising the use of self-administration for IV medications where appropriate, pharmacy

enhancements to reduce reliance on external companies' provision of medicines. Enhanced capacity in General pathway will be realised through appointment of new infections consultant.

Placed Based Urgent Care: This service area has a well-established OPEL escalation framework, which is used on a near-daily basis. All units have regular communication with the local ED's and have a clear process in place if they need to restrict referrals from their respective ED's alongside utilising the DoS system.

All PBUC Units will continue to manage flow through the departments in line with recent measures following the significant upturn in activity. Each unit has strategies including initial assessment & See & Treat models with an option to restrict access for temporary periods.

Discharge to Assess: Usual service provision will continue through the winter period noting that there is an expected reduction in the number of Pathway 2 and Pathway 3 beds that will be available over the winter period. The programme of work that is in place currently focuses on improvements to be made in both the demand into pathway one capacity but also on reductions in the LOS in Pathway 2 beds and reduction in variation. These are monitored through the D2A Project group and operational governance meetings.

In addition, the system D2A Programme has access to a contingency fund that will enable mitigating actions to be put in place in the event of significant pressures within the system. These include:

- Expand the Bridging service over winter, to include step-down into bridging directly from P2
- Fully fund overnight care and support to increase capacity.
- Increase number of beds in South Bristol Community Hospital by 4 (pending landlord agreement).

These actions will be managed through the D2A programme as part of the winter response.

9.2 Specialist Services

Advice and Guidance

Support continues to HCPs across the system from services through direct telephone and email lines to specialist service staff in:

- Respiratory (7 days per week)
- Diabetes
- Dietetics
- Heart failure
- Bladder & bowel
- Learning disability
- Musculoskeletal
- Podiatry
- Dermatology
- Wound Care

Aim of these is to support clinical decision making, enable utilisation of secondary care A&G for more complex queries with aim of reducing admissions to hospital.

Other

- Support to the Integrated network teams through virtual MDTs, specialist reviews and joint visits and project work with aim to improve quality and reduce visits where appropriate.
- The ALDHS acute liaison service continues to support people with a learning disability and / or autism during hospital admissions to ensure timely discharge.

11. Community Children's Services

Work within the Children's Directorate includes a diverse range of approaches that will support children during the quarter 3 winter months. The work plan has focussed on:

- School Aged Immunisation Programme
- Provision of an extended school aged flu programme to include reception to year 11 (Primary and Secondary school aged children). From 18th September to 15th December in school and until 22nd December community clinics.
- Pop-up IM flu sessions are being hosted in schools and community venues where vaccination uptake is known to be poor due to many children and young people being unable to accept the intranasal flu vaccine due to porcine gelatin content or due to missing their school's session.
- Intramuscular Flu vaccinations are accessible at special schools and Secondary schools alongside the nasal flu programme to improve accessibility, with the aim to improve uptake.

RSV mitigation and viral surge planning

Lifetime service and Public Health Nursing working in partnership with the wider system wide including CCG, acute, primary and community children's services across BNSSG to develop collective response.

Actions agreed by Sirona Children's services:

- Lifetime Service will provide telephone advice to patients on their caseload across BNSSG re; management of Respiratory symptoms, liaising with the relevant professionals involved e.g. GP's, Consultant leads, with the aim to children and young people on the Lifetime caseload remain at home and minimise the need for hospital admission. Home visit if required. We do complete this as part of our CCN service with regards to illnesses so can confirm this offer.
- Lifetime Service will support with RSV vaccinations in North Somerset only as the UHBW acute team support the Bristol and South Gloucestershire children and are just pending training for our Core Community Children's Nurses.
- Public Health Nursing Services across BNSSG regularly discuss vaccinations, signs, symptoms, and management of minor illnesses with families during visits and at Baby Hub sessions, as well as recommending what to store at home to assist with managing symptoms.

End of Winter Plan

Committee Assurance Report to Board

Date	10 December 2024	**Agenda item**	12
Title	Quarterly Summary Report from Quality and Outcomes Committee		
Author	Mary Lewis		
Presented by	Paul May	**Version**	1
For	Approval/decision ☐ Debate ☐ Assurance ☒ Information ☐		

This report is based on the Quality and Outcomes Committee meeting held on 3 December 2024.

Area of the Committees Responsibilities	**Related Agenda Items** (Assurance level given in the report, if different to the level determined by the Committee)	**Assurance Level Determined by the Committee** High/Significant Medium/Partial Low/No Assurance	**Actions & Mitigations Highlighted by the Committee**	**Matters to escalate or highlight to the Board** ***Alert*** *the Board to of areas where assurance is not sufficient.* ***Advise*** *the Board of steps taken to address areas where assurance needs to be improved.* ***Assure*** *the Board where there is sufficient assurance*
Emerging Issues	• Quality • Operational • Clinical		System escalation to OPEL4 noted.	
Looked After Children (LAC)	Update received about the System Wide Action Plan for (LAC).		**Initial Health Assessments (IHA's)** - Continued challenges in receiving documentation from Local Authorities to enable Sirona to meet the mandatory 20-day deadline.	Advise – 20-day deadline not being achieved - ML and JS will agree escalation route (suggested Local Executive Group or System Quality and Outcomes meeting). Further work to establish parameters for those children not seen within the 20 days.

			Review Health Assessments (RHA's) - 50-60% seen within time frame despite appointment being offered three months in advance. Work taking place with foster carers to stress importance of RHA's for children and young people.	**Advise** – Agreed Harm Review to measure the impact on those children and young people who are not seen, to feedback to ICB Performance and Outcomes meeting with triangulation to the Clinical Outcomes Framework and as a wider group piece, SCARF.
Children's Services	Children's Interim Neurodiversity Model Update Report	For information	Sirona is taking part in the system pilot (ending 31 March 2025) - early findings are positive.	**Advise** - Further update after system evaluation.
Quality Reporting	Clinical Governance Forum (CGF) Q2	Medium/Partial	Agreed to each meeting having a specific deep dive into one of the divisions (Adults, Children and SASS). Specific discussion topics: -Potential harm to patients on waiting lists in both adults and children's services -Podiatry services capacity and patient safety concerns -Impact on patients when nursing schedules are deferred because of capacity and demand pressures - Heart failure system and complexity of model. -Parkinson's Service, higher prevalence than	**Advise** - CGF has shown good progress since the first meeting (February 2024). Notable support from operational colleagues has led to improved and better triangulated reporting, discussion, and challenge.

			other area so increased follow up times, noted leading to protracted length of stay. Received the Medicines Optimisation Q1 Report – work taking place to address how we better report the refusal of medication rather than as an error/omission.	
Quality Reporting	Quality Report Q2	Medium/Partial	**PSIRF** - formally launched on 1st July gradual embedding within Sirona. An increase in adverse reporting in Q2 with 58% being patient safety incidents. 19 After Action Reviews (AAR) (investigations completed withing 2 weeks of the incident happening) 7 SWARMs (investigation completed in 72hrs by the team/service). Learning is emerging from this new approach. Unsatisfactory Discharge – Patient Safety Teams linking with Acute Patient Safety Teams to improve. Noted need for formal escalation process suggested via ICB	**Advise** - Reporting includes an additional a dashboard which is a summary of the key metrics with our quality schedule of our community contracts (Adults and Childrens) The Quality report format will be revised next quarter to include outcomes and impact of actions supported by more triangulated data which will be possible following Quality Assurance service visits and PSIRF learning outcomes.

			Performance and Outcomes meetings. **Experience and Engagement:** There were 17 complaints in Q2, a 12% increase compared the previous quarter. Poor communication is a common theme. Work ongoing to improve the amount of feedback received from service users. **CAS alerts** - Bed Rail Alert work is still ongoing, and we remain non-compliant with this alert. It is currently (risk 20) and SM and Siobhan working to improve following legal advice. **NICE guidance** - none issued during Q2 relevant to Sirona.	**Advise** – Exec Co to review the Risk score (currently 20) following legal advice and work planned to write to care providers offsetting our responsibility.
Quality Reporting	Quality Improvement Priorities Progress Report	High/Significant	Majority of agreed quality priorities are on track and steady progress has been made at this stage in the year. Reduce criteria to reside in the community pathways priority has been delayed due to unforeseen circumstances.	**Advise -** A temporary new Lead to cover this priority is being sought.

Quality Reporting	Care Quality Commission Fundamental Standards of Care Report Quarter 2 2024/25	Medium/Partial	Peer reviews launched successfully. 100% completed against plan with all 10 services reviewed rated Good. Good progress made with central services in gathering self-assessment evidence.	**Advise** – Action taken to arrange Board service visits for NEDs who may have been omitted.
Safeguarding	Safeguarding Q2 and Annual Report	High/Significant		
Health, Safety and, Security	Health, Safety and Security Q2 and Annual Report	High/Significant		
Infection Prevention, and Control.	Infection Prevention and Control Q2 and Annual Report	High/Significant		
NHS@Home	NHS@Home Q2 and Annual Report	Medium/Partial	The serviced has completed a review of patient experience data for Q1&2 with themes being positive to care delivered and high Friends and Family feedback. Previously delayed roll out of EMIS to partners noted. Further work continuing in Q3&.4 to maximise further functions of EMIS.	**Advise** - Further work continuing in Q3&4 to maximise further functions of EMIS.

End of Life	End Of Life Group Q2 and Annual Report	Medium/Partial	Respect Plus training rate has improved due to focused work in Q2 improved results and is now part of Corporate Induction. Bereavement consistent themes from quality audits highlight bereavement support / information is lacking however has improved in Q2. Engagement and Experience have developed a card to support postal alternative with bereavement packs, launched end of Q2. Person centred assessment and care planning improving position, work to continue to raise awareness and include other faiths and cultures including a workshop in early November. Learning from deaths / mortality reviews; decline in overall care over the last couple of months from the samples reviewed looking at the 12month average.	**Advise** – Work is taking place with the Patient Safety Team to look at key concerns and priorities going into Q3.
Risk	QOC Risk Report	Medium/Partial	Risk Responsible Managers to continue to ensure risks are fully	**Advise** - Patient safety and Clinical quality remains the predominant risk category. Risk profile has remained unchanged during Q2.

			reviewed within the prescribed periods, outlined in the policy. Subject Matter Group Chairs to ensure risks relating to their subject matter are being considered according to the risk management policy for onward reporting to QOC. Risk Responsible Managers to ensure compliance with the requirement to have relevant and appropriate controls and actions in place.	All areas of high risk were discussed throughout the committee meeting and cross referenced within reports.

Audit Committee Assurance Report to Board

Date	10 December 2024	**Agenda item**	13
Title	Audit, Assurance and Risk Meeting Summary for board		
Author	Lorna Harrison		
Presented by	Lorna Harrison	**Version**	1
For	Approval/decision ☐ Debate ☐ Assurance ☒ Information ☐		

This report is based on the Audit, Assurance and Risk Committee meeting held 5 November 2024.

Area of the Committees Responsibilities	**Related Agenda Items** (Assurance level given in the report, if different to the level determined by the Committee)	**Assurance Level Determined by the Committee** High/Significant Medium/Partial Low/No Assurance	**Actions & Mitigations Highlighted by the Committee**	**Matters to escalate or highlight to the Board** ***Alert*** *the Board to of areas where assurance is not sufficient.* ***Advise*** *the Board of steps taken to address areas where assurance needs to be improved.* ***Assure*** *the Board where there is sufficient assurance*
RISK	**Quarterly update on Risk Management**	Medium/Partial	Good progress has been made to the process in the area of updating the risks on a timely manner. The number of risks overdue for review has decreased across the different committees. The report has improved further showing this with the new dashboard style, there is more work to do on this still.	There was a deep dive report on Risk 590 - a risk that has been on the data base for some time with a score of 15. This risk means we are not compliant with IG. The committee agreed an action plan needs to be done and presented to Executive committee and then an update paper to Audit. This needs to be raised at Board to ensure focus is put to resolving or mitigating this risk.

Area of the Committees Responsibilities	**Related Agenda Items** (Assurance level given in the report, if different to the level determined by the Committee)	**Assurance Level Determined by the Committee** High/Significant Medium/Partial Low/No Assurance	**Actions & Mitigations Highlighted by the Committee**	**Matters to escalate or highlight to the Board** ***Alert*** *the Board to of areas where assurance is not sufficient.* ***Advise*** *the Board of steps taken to address areas where assurance needs to be improved.* ***Assure*** *the Board where there is sufficient assurance*
				Risk 660 - No proactive auditing of system access – this risk has been on the register for a few years. There was a discussion about the governance structure to review the risks that needs to be checked. The committee wanted to escalate this risk to board for further discussion.
	BAF	Medium/Partial	BAF was reviewed and agreed with feedback from the committee.	BAF now needs to become a document actively used by the Board along with a SWAT analysis
Corporate Governance	**Framework Review**	Assurance	Ongoing review with support from GGI	Plan to action the review for first quarter to be in place.
Corporate Governance	**Policy Review**	Medium/Partial	Organisational policy compliance had declined from 91% to 80%. There is a process of sifting ongoing and there will be an improving position.	Medium assurance, review to be done at next meeting.
	Internal Audit	Medium/Partial	3 of the 4 audits were underway. Agreed actions from previous audits are overdue for action.	Focus needs to ensure the remaining audits are completed on time. The overdue actions are to be raised at executive team. For information to board.

Finance, Estates, Environment & Digital (FEED) Committee Assurance Report to Board

Date	10 December 2024	**Agenda item**	14
Title	Finance, Estates, Environment & Digital (FEED) Meeting Summary for board		
Author	Lorna Harrison Non Executive Director		
Presented By	Lorna Harrison Non Executive Director	**Version**	1
For	Approval/decision ☐ Debate ☒ Assurance ☐ Information ☐		

This report is based on the Finance, Estates, Environment & Digital (FEED) meeting held 14 November 2024.

Area of the Committees Responsibilities	**Related Agenda Items** (Assurance level given in the report, if different to the level determined by the Committee)	**Assurance Level Determined by the Committee** High/Significant Medium/Partial Low/No Assurance	**Actions & Mitigations Highlighted by the Committee**	**Matters to escalate or highlight to the Board** ***Alert*** *the Board to of areas where assurance is not sufficient.* ***Advise*** *the Board of steps taken to address areas where assurance needs to be improved.* ***Assure*** *the Board where there is sufficient assurance*
Financial	**Finance Report – Month 6**	Medium/Partial	A YTD favourable, is only due to interest on funds held in the bank account. Actually we are overspending by £3M YTD. Overspends are being identified, and improvement in INT and PBUC now being seen. DrDoctor was discussed but FEED has not seen the objectives financialised with timings as yet.	Risk is interest rates are reducing and the ICB process of prepaying may stop in the future, therefore our bank interest would be lower. Mel Reeks is to bring a paper to next FEED with this detail. Alert the board to the fact we still are doing major projects without showing clear timeline, objectives and savings/benefits.

Area of the Committees Responsibilities	**Related Agenda Items** (Assurance level given in the report, if different to the level determined by the Committee)	**Assurance Level Determined by the Committee** High/Significant Medium/Partial Low/No Assurance	**Actions & Mitigations Highlighted by the Committee**	**Matters to escalate or highlight to the Board** ***Alert*** *the Board to of areas where assurance is not sufficient.* ***Advise*** *the Board of steps taken to address areas where assurance needs to be improved.* ***Assure*** *the Board where there is sufficient assurance*
Financial	**Medium Term Financial Plan**	Medium/Partial	Medium Term Financial plan shows a potential non sustainable model in cash in 2 years. Also, the risk of the Childrens contract due to end in April 2027. Executives are working on the CIP Plan, contractual arrangements, other opportunities and risks.	**Alert** – Laks, Mike, Mel to bring to the board action plan of the overarching Strategic plan.
Environmental/Estates	**Estates Assurance Report**	High/Significant	Progress on estates strategy being seen. HO is operational. Next focus in North Somerset all being seen as in budget Currently.	**Alert** - A Brief timed / financial/ benefits/ project plan to be presented at next meeting. This needs to be made normal in tracking projects.
RISK	**Risk**	Medium/Partial	No one available to talk through the risks from governance. Paul Poynter gave an overview of risk 593 Lorraine McMullen presented Risk 817.	**Alert** - Risk 817 Funding gap for the Public Health Nursing service – South Glos. And North Somerset unable to fund the pay award in 23/24 and 24/25. Board needs to discuss – difficult to pull the services. Working within the budget is affecting staff wellbeing. This has been raised at the ICB. Financial risk and understanding of the true cost of running the PHN services needs to be evaluated.

Committee Assurance Report to Board

Date	10th December 2024	**Agenda item**	15
Title	Performance Committee Assurance Report to Board		
Author	Dr Barbara Brown, deputised as Chair		
Presented by	Dr Barbara Brown	**Version**	1
For	Approval/decision ☐ Debate ☐ Assurance ☒ Information ☒		

This report is based on the Performance Committee meeting held on 18th November – **The Alert, Assure, Advise detailed slides are saved to Glasscubes for Board Reference**

Area of the Committees Responsibilities	**Related Agenda Items** (Assurance level given in the report, if different to the level determined by the Committee)	**Assurance Level Determined by the Committee** High/Significant Medium/Partial Low/No Assurance	**Actions & Mitigations Highlighted by the Committee**	**Matters to escalate or highlight to the Board** *Alert the Board to of areas where assurance is not sufficient.* *Advise the Board of steps taken to address areas where assurance needs to be improved.* *Assure the Board where there is sufficient assurance*
Operational Performance	**Adults**	Medium/Partial Assurance	***Assure*** Ongoing system flow challenges has led to the implementation of the P1 recovery plan (uplift to 196P1 patient slots from 180 pw). Commenced 28th October. It will run over a 6-8 week period and reports through system Performance Operational Meeting. ***Assure*** INT development programme continues to progress	**Alert** Demand and capacity in INTs Deferred Patient Schedules an ongoing concern. Raised 13& demand and capacity gap within INTs at Sirona's contract meetings. Now prioritising the INT service specification reviews (over Locality Hub Specification review). **Advise** Data Quality remains an issue with deep dives in teams to address issues ***Alert*** INT Planned Rehabilitation referrals are 44.38% above YTD target (a slight drop) but well above what they

			on key priority areas (e.g. zoning, standardisation, ways of working, across all localities). A review of how unallocated and deferred visits are reported is within the INT programme to ensure that reporting is standardised and accurate. ***Assure*** Risk management continues to improve and cross locality reviews of collective risks embedded in monthly reviews with all localities. ***Assure*** PSIRF continues to be embedded in operational delivery.	need to be. Thereis a group established to review pressures and associated risks**.** ***Advise*** PBUC resourcing discussed at the contract meeting and is now on the ICB 25/26 system planning round. No decision made by the ICB as yet, regarding under-resourcing to the activity being delivered. Staff morale being impacted. **Alert** 2 hour response is over-performing to meet the 70% target to see patients within 2hours and is currently achieving 81.89% YTD. Advise **Advise** Discharges - Ongoing key priority to review caseloads in teams to optimise effectiveness and create capacity to meet demand in new referrals **Alert** Internal group reviewing unsatisfactory discharges to break the cycle in recurring issues and in support of patient safety. ***Advise*** P1 recovery action plan in place to identity ways to increase P1 slot capacity • P2 therapists undertaking P1 assessments where appropriate • Clinical lead therapists in INTs and CToCH undertaking initial assessments • Increase locality cross-boundary working with SOP in place • Review of P1 initial assessment and plan to reduce duration

	Specialist Adult Services		**Assure** Patient Tracking List (PTL) and associated weekly PTL meetings embedded for patients awaiting first appointment. Number of patients waiting over 52 weeks reduced from 54 at the start of Q1 to 2 at the end of Q2. Proposed solution to current lack of consistent process for recording and therefore monitoring follow up waiting times under review by BI, with aim to introduce this in Q4. (Risk 833) **Assure** NHS@home: • Data sharing agreement signed and move to 1 EPR system underway (risk 723) • Vacancy position remains better than forecast, with associated increase in capacity (risk 568) • Commencement of new daily aligned process with UCR to both support identification of patients suitable for NHS@home, increasing specialist clinical advice and signposting to alternative pathways • Proactive work being undertaken to minimise impact of specific Respiratory workforce challenges ahead of winter.	**Alert** Podiatry – PSII has commenced alongside wider improvement work. Pilot in S.Glos to introduce Nursing role as part of shared care approached with INTs has started. Proposal to introduce Domiciliary criteria under consideration. External Psychology support commissioned for team sessions planned to start in January. (Risks 767 & 768) ***Advise*** Service Specification reviews continue. All SASS internal reviews will be completed in Q3, with dates for ICB review awaited. Route to resolution for a number of issues raised still required, and will be escalated through *ICQPMG.* ***Alert*** MSK 18 week performance: • MSK Physiotherapy performance has remained static, with an average waiting time of 15 weeks and RTT performance of c60%, driving the overall Divisional performance. Internal work to maximise capacity continues, but limited by turnover. Limited work on system wide pathway, with other providers now also experiencing increasing waiting times (Risk 7) • MSK Interface – waiting list size increased from c4.6k at the end of Q1 to 5.6k at the end of Q2, driven by 26% increase in referrals year on year. Work underway to understand cause of demand and remedial action options. (Risk 865) ***Advise*** 18 week performance: • Pathway mapping commenced in Respiratory to support streamlining pathways, to be rolled out in other areas

			Assure Heart Failure diagnostic capacity – after a period of increased demand resulting in longer than clinically acceptable waiting times, appointments are now being offered within 4 weeks (2 weeks best practice, 4 weeks appropriate for majority of patients) (Risk 757) Escalation of wider issue with overall Heart Failure pathway has resulted in system wide work commencing, including potential opportunities for collaboration Health Transformation Partnerships	• Neurology: 50% YoY increase in referrals, impacting 18 week performance (risk 831). Agreed via Service Specification reviews to collaboratively develop revised service specification to provide most effective service within financial envelope • ICSS: 18 week performance stabilised, with reduction inlongest waiters with ongoing support from Speech and Language Therapy team (risk 704) ***Alert*** ALDHS - Forensic provision – following increased escalation of the situation, ICB and AWP discussions have commenced around alternative pathways. (Risk 61)
Risk Monitoring	**Childrens' Services**	Partial Assurance	***Assure*** Y dive issues raised at execs and digital lead identified to explore options. ***Assure*** Waiting lists exceeding NHS 52 week wait guidance. ASD – demand exceeds capacity. Comm Paeds – 70% demand ADHD (risks 135 & 426)	***Alert*** Storage of safeguarding information over multiple platforms.Risk has remained 12+ for over 2 years. (risk 590) ***Advise*** Project management support has been requested. ***Alert*** Concept paper prepared to share with ICB CEO on the 25/11/2024to describe options to iradicate the Recovery plans in place with ICB to meet NHSE national scrutiny. ***Advise*** Neuro-profiling pilot launched 1st of October 2024. WL management Internal meeting Sept 19th to

		Low	***Assurance*** PHN service reductions to be agreed. Chronology and options papers to be reshared. ***Assure*** Internal steering group set up to manage the potential risk.	consider waiting list plan & review options and plan actions with internal exec colleagues. To be presented at execs early Nov. ***Alert***** Local Authorities unable to fully fund pay award in 2023/24 & 2024/25. (Risk 817) ***Advise*** PHN funding gap that includes historical South Glos deficit and last years and next yearsAFC pay.. ***Alert*** GP referral change – standardised form / letter – risk of referrals meant for hospitals being sent to Sirona, as well as not receiving the correct information. Action advised to start for November 24. (Risk 873) ***Advise*** Escalated to Teresa Candfield – organisational risk to be added onto Ulysses. Working group has been established with Emma Bradley engaged from Paeds Offered to use On call Paed team for on call triaging – Ops leads has oversight to ensure volume monitored and access available.
Risk	Committee Risk approach – deep dive	Medium/Partial Assurance	***Assure*** Resource to support actions that could release the Podiatry operational team to deliver other priorities. PMO support currently within the team, with an ask for this to be maintained. Additional PMO or Operational support would support actions to be addressed more quickly • Podiatry workforce task and finish group being supported and prioritised through corporate	***Alert*** *Focussed Report Risk 768,Category Capacity & Demand Current Risk Score 20*: The Sirona service has had a vacancy rate of up to 24%(c 14WTE) over the last 2-3 years. As a result the, clinical capacity of the service is challenged with issues managing the demands on the service. There is an additional risk recorded on Ulysses in the category Patient Safety/Clinical Quality as the ability of the service to manage demand is resulting in delays to care (Staff wellbeing is also being impacted.

			teams (Learning & Development, International recruitment, HR, advance practice, Organisational Development) to ensure pace of delivery. ***Assure*** • The organsiational T&F Group for Planned Therapy has been reinstated to undertake a deep dive into current processes and possible efficiencies with an aim for standardisation. • Review of clinical skill mix with a view to identifing other clinical professions who can undertake generalised clinical activity allowing registered therapists to focus on complex indivudals whilst providing an overview and advice and guidane to other colleagues. – • Review of INT service specification • Ongoing targeted recruitment campaigns into those roles that require a registered therapist.	***Alert*** *Focussed Report Risk 830 Significant higher demand of referrals for planned therapy against predicted contracted activity in BNSSG. Current Score 15* Controls and Actions developed to manage this risk are preventing a deteriorating position but are insufficient to address the core issue of increased demand and complexity of referrals. System discussions over the last 2 years have not resolved the use of therapy staff across the system System focus on discharge management (P1) and Urgent care services continue to widen the gap in funding, service delivery and visibility of planned services (Therapy and Nursing). Issue discussed in Nov ICPQRM and will be taken forward as part of system planning ***Advise – For Consideration*** *Additional actions could include any or all of the following.* *1. A merger of CTOCH into Spa might help prevent waiting time to triage, whilst freeing up INT therapists to undertake additional visits.* *2.* *To consider – closure of this waiting list to new referrals until such time as the waiting list is resolved.*

Chairs Summing Up:

Sirona's Operational Winter Plan 2024/2025 reviewed and recommended for approval by Board.

****Escalated to Board - *Local Authorities unable to fully fund pay award in 2023/24 & 2024/25. (Risk 817)***

The Slides to Committee on Alert, Assure and Advise, shared with the Board via Consent Agenda referred:

- Demand and capacity challenges across all 3 divisions are evident within the body of the report, with a range of impacts on service delivery decreased performance, and in some cases over-performance against contracted baseline). Many of the most pressured issues are being taken through contract discussions with the ICB and fall within internal programmes of work to address or mitigate them.For adults concerns are the demand and capacity within the INTs, significant increases in demand in some SASS services, oversight of Heart Failure contractually, Podiatry actions to support safe delivery of care and MSK waiting list position.

- Specialist Health Advisors for SEND achieved 304/310 reports completed within the 6-week timeframe despite increased requests for contributions to needs assessments.
- Children in Care - Initial Health Assessments - holding regular monthly focus meetings with LAs and
- ICB are ongoing to improve information timeliness. Review Health Assessments saw a significant increase in notifications observed, the average is 12 per month, however in August and September - 24 this increased to 35 per month.