Cambridgeshire Community Services NHS Trust

| Title: | Integrated Governance Report | |
|---|---|---|
| Report to: | Trust Board | |
| Meeting: | 27th September 2023 | Agenda item: 6 |
| Purpose of the report: | For Noting ☐ | For Decision ☑ |

**Executive Summary**

1.1 This Integrated Governance Report (IGR) has been produced following the clinical operational board meetings that took place on 12th September (Children & Young People's) and 13th September (Adults). The key issues report from these meetings are attached as supporting information, documents 1 and 2.

1.2 The report brings together the quality, performance, workforce and finance information for June and July 2023 along with key risks and issues, to provide the Board with assurance of delivery against the agreed strategic objectives and indicators.

1.3 Any exceptions are reported against each of the four strategic objectives within the body of the report.

**Recommendation**

The Board is asked to:

- discuss the report and review and the assurance summary for each objective as outlined in the report.
- confirm that the information contained in the Report, along with the key issues reports from the clinical operational board committee meetings, support the recommended overall assurance rating of **SUBSTANTIAL** assurance.

**Appendices:**

- Appendix 1: Assurance measures
- Appendix 2: Quality dashboard
- Appendix 3: Statistical Process Control chart

**Supporting Information:**

- Document 1 - Key issues report from the Children & Young Peoples Clinical Operational Board
- Document 2 - Key issues report from Adults Clinical Operational Board

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|---|---|---|---|---|
| **Assurance level:** | Substantial ☒ | Reasonable ☐ | Partial ☐ | No assurance ☐ |
| **Rationale for Assurance rating** | - Key evidence contained in this report and triangulation of this information with all Committee reports, particularly the clinical operations boards.<br>- The recommendation of assurance from the executive team which is outlined in the assurance measures that have been approved by the Trust Board and as detailed in this report.<br>- Any action necessary from the rating and outcome required | | | |
| **Assurance action** | - The Board is asked to discuss and agree the assurance rating and the actions agreed in line with the agreed escalation framework. | | | |

**How the report supports achievement of the Trust Strategic Objectives:**

| | |
|---|---|
| **Provide outstanding care** | The report assesses quality, performance, workforce and finance against each of the Trust's objectives |
| **Be collaborative** | This report does not include progress against this objective |
| **Be an excellent employer** | The report assesses quality, performance, workforce and finance against each of the Trust's objectives |
| **Be Sustainable** | The report assesses quality, performance, workforce and finance against each of the Trust's objectives |

| **Equality and Diversity Objective** |
|---|
| Progress towards delivery of the agreed equality and diversity objectives domain 1 (see pages 14-15) and domains 2 and 3 (see pages 31-32) are included with this report. |

**Links to Board Assurance Framework risks / Trust risk register**
The report assesses the strength of assurance provided in relation to the Trust's strategic risks on the Board Assurance Framework and the operational risks scoring 15 and above which are listed against the strategic objectives in the report.

**Legal and Regulatory requirements**
All Care Quality Commission Key Lines of Enquiry and fundamental standards of care are addressed in this report.

**Previous Papers (last meeting only)**

| | |
|---|---|
| **Title:** | Integrated Governance Report |
| **Date:** | 17th July 2023 |

**Executive Summary:**

1.0 This Integrated Governance Report (IGR) has been produced following the clinical operational board meetings that took place on 12th September (Children & Young People's) and 13th September (Adults). The key issues report from these meetings are attached at documents 1 and 2 to this report.

1.1 The Children & Young People's report provided **reasonable** assurance and the Adults and Ambulatory reports both provided **substantial** assurance as confirmed at the clinical operational board meetings.

1.2 The reporting period covers the quality, performance, workforce and finance information for June and July 2023 and includes the key risks and issues, to provide the Board with assurance of delivery against the agreed strategic objectives and indicators.

1.3 The assurance measures (Appendix 1) that are used in this report reflect the five Care Quality Commission (CQC) key lines of enquiry, as agreed by the Board at the beginning of the financial year.

1.4 For three of the Trust's four objective (progress against the Be Collaborative objective is now reported separately to the Board), this report provides:

- a description of the direction of travel for achieving the Trust's objectives.
- the strength of assurance the report provides in relation to the Trust's strategic risks and high scoring operational risks.
- the level of assurance that each section of the report provides for the relevant CQC domains of safe, caring, effective of safe, caring, effective, responsive and well led.
- any exceptions are reported against the strategic objectives within the body of the report.

**Assurance:**

1.5 The executive recommends an overall rating of **substantial** assurance to the Board as set out in the following chapters and summarised at the beginning of each section and in the table below:

| Strategic Objective | **Safe** | **Caring** | **Effective** | **Responsive** | **Well Led** |
|---|---|---|---|---|---|
| Provide Outstanding Care | **Substantial** | **Substantial** | **Reasonable** | **Substantial** | **-** |
| Be an Excellent Employer | **Reasonable** | **-** | **Substantial** | **-** | **Substantial** |
| Be Sustainable | **-** | **-** | **-** | **-** | **Substantial** |

## 2.0 Key Matters

2.1 Substantial assurance ratings for safe, caring and responsive are provided for outstanding care chapter and a reasonable assurance rating for effective as information governance mandatory training is lower than target. Waiting list performances were discussed at length at both clinical operational boards where the plans are scrutinised in more detail.

2.2 In the excellent employer chapter and as reported in the clinical operations boards, staffing pressures are creating challenges for some services, health visitors and in speech and language therapies for example, although there are plans in place to respond to these pressures. These are also recorded on the Issues Register. Monthly sickness rates are improving as are appraisal rates and stability is above target level for the period.

2.3 The high impact actions for the equality, diversity and improvement plan from NHSE are included in the excellent employer chapter and assurance can be given to the Board that they will be embedded in out work plans during 2023/24.

2.4 Whilst the sustainability chapter highlights the increasing risks to services, due to increasing demand, rising inflation and the identification and delivery of efficiency plans, the assurance rating for this reporting period remains as substantial as the financial performance in the reporting period is in line with plan.

## 3.0 Key Risk Register:

3.1 There are 2 risks scoring 15 and above which specifically relate to the increase in enquiries to the multi-agency safeguarding hubs and the impact of safeguarding staff vacancies.

3.2 In the previous report there were five risks that were scoring 15 and above. One risk relating to the supply of suction catheters which has now been reduced to 8 and two risks relating to Reinforced Autoclaved Aeriated Concrete (RAAC) and autism spectrum disorder (ASD) waits in Cambridgeshire have been closed on the risk register and added to the Issue register and noted below.

3.3 All risks scoring 12 and above are monitored by Board Committees.

## 4.0 Key Issues Register:

4.1 There are now nine issues scoring 4 Major on the issue register compared to six in the last reporting period.

4.2 **Waiting times** – there are several issues relating to waiting times particularly relating to community paediatrics and Education Health and Care Plan in Bedfordshire & Luton, and school age autism spectrum disorder in Cambridgeshire and Peterborough.

4.3 **Staffing** – issues have been added relating to trust wide recruitment for dental nurses, health visitors and school nurses, the psychological impacts of safeguarding on our staff within the trust and an increased level of violence and aggression towards our staff; a task and finish group has been established.

4.4 The issue relating to RAAC (that was previously recorded as a risk) is referenced within the Infrastructure Committee key issues report as it was discussed at the last Committee meeting.

4.5 **Finance** – there are financial pressures within several commissioner contracts for our services due to increased demands and increasing cost pressures and these are detailed in the sustainability chapter.

## 5.0 Outstanding practice cross reference to the Clinical Operational Board reports

5.1 The clinical operational board key issues reports (documents 1 and 2 to this report) detail the many outstanding practices that have taken place across our services during the reporting period and these are also summarised in the outstanding care chapter.

## 6.0 Forward view

6.1 In the coming months the following matters will be taken forward and the progress will feature in the next IGR report and future committee agendas and discussions:

- Inclusion in the assurance reporting of the performance for requests for information.
- Performance improvements in waiting times particularly for community paediatrics and the quantification of the number of children waiting more than 65 weeks.
- The progress of conversations with commissioners on contractual pressures including demand increases, and
- Further information on the actions to deliver the efficiency plan for the year.

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**Appendices:**

Appendix 1: Assurance measures
Appendix 2: Quality dashboard
Appendix 3: Statistical Process Control (SPC) chart

**Supporting Information:**

Document 1 – Key issues report from the Children & Young Peoples Clinical Operational Board
Document 2 – Key issues report from Adults Clinical Operational Board

# Provide Outstanding Care

## A: Assurance Summary

| | | |
|---|---|---|
| **Safe** | • 95% of incidents were categorised as no or low harm in July 2023 (**S1**).<br>• There were no 'never events' reported in June/July (**S2**).<br>• 100% of SI (Serious Incident) action plans are on target for completion. (**S3**).<br>• Staff flu vaccination –the reporting period will recommence at November's board (**S5**).<br>• The IPaC (Infection Prevention and Control) Board Assurance Framework is being monitored and highlighted to board every 6 months. Where there are gaps in practice an action plan is in place to address them **(S6).** | **Substantial** |
| **Caring** | • 100% of services received over 90% positive feedback from the FFT (Friends and Family Test). 100% of Directorates scored over 90% **(C1).**<br>• All formal complaints were responded to within the timeframes agreed by the complainant **(C2).**<br>• 100% of all Directorates and 100% of individual services received complimentary feedback **(C3).** | **Substantial** |
| **Effective** | • The Equality and Diversity Objectives are on track for delivery. **(E6)**<br>• Overall Information Governance mandatory training levels are at 92% (**E2**) | **Reasonable** |
| **Responsive** | • All of our services areas with waiting lists have an improvement plan that is agreed and being delivered (**R1**).<br>• 100% of all formal complaints are acknowledged within 3 working days (**R2**)<br>• % of valid requests for information are provided to applicants within 20 working days of their receipt into the Information Governance team. (**R3**) - **to be reported in November** | **Substantial** |

## B: Risks to Achieving Objectives

**Strategic Risks:**

1. ***Risk ID 3530*** *- There is a risk that patients may not receive high quality care, if the Trust cannot meet the requirements of the CQC's fundamental standards. The impact of this would be a poorer experience for the patient and the potential that the Trust would not maintain its outstanding rating. (Risk Rating 12).*

2. ***Risk ID 3562*** *- There is a risk services safeguarding work across all localities is unable to be managed within the staffing capacity available and this may result in children, young people and adults being left without adequate safeguarding measures. (Risk Rating 16).*
   *There is a potential for reduced staff capacity impacting negatively on emotional wellbeing and so this risk is also linked to issue 3531.*

3. ***Risk ID 3502*** *- There is a risk that if industrial action is taken within the Trust that affected areas will be unable to deliver their services, which will lead to patients/service users not receiving the care that they need and potentially negatively impacting staff morale. (Risk Rating 12).*

**Related Operational Risks 15 and Above**

1. ***Risk ID 3519*** - *There is a risk that the change in process within the Local Authority management of MASH (Multi-Agency Safeguarding Hub) enquiries in Cambridgeshire and Peterborough will have a significant impact on the demand of MASH health provision. Leading to a reduction in the number of enquiries being provided with the relevant health information upon which to base their decision about actions needed to respond to risks to a child/ren. (Risk Rating 20).*

2. ***Risk ID 3562 -*** *There is a risk that safeguarding work across all localities is unable to be managed within the staffing capacity available and that this may result in children, young people and adults being left without adequate safeguarding measures. (Risk rating 16)*
*There is potential for the reduced staffing capacity impacting negatively on emotional wellbeing and so this risk is also linked to Issue 3531.*

## C: Overview and Analysis (Including Information from the Quality Dashboard–Appendix 2)

**SECTION ONE – SAFE DOMAIN**

| | | |
|---|---|---|
| **Safe** | • 95% of incidents were categorised as no or low harm in July 2023 (**S1**).<br>• There were no 'never events' reported in June/July (**S2**).<br>• 100% of SI (Serious Incident) action plans are on target for completion. (**S3**).<br>• Staff flu vaccination – the reporting period will recommence at November's board (**S5**).<br>• The IPaC (Infection Prevention and Control) Board Assurance Framework is being monitored and highlighted to Board every 6 months. Where there are gaps in practice an action plan is in place to address them **(S6).** | **Substantial** |

### 1.0 Patient Safety

1.1 No Serious Incidents (SIs) or Never Events were declared in June or July 2023.

1.2 No SI's were submitted for closure during the period. Action plans on previously submitted SI's continue to be monitored for closure. At the time of writing, there are five actions assigned to SI's, which are not complete, however they are all progressing within their required timeframes and none of them are overdue.

1.3 Following an initial triage by the Patient Safety Team, relevant incidents are reviewed via panel discussions which are attended by Service Leads and specialists to agree next steps and/ or close and approve submitted investigation reports.

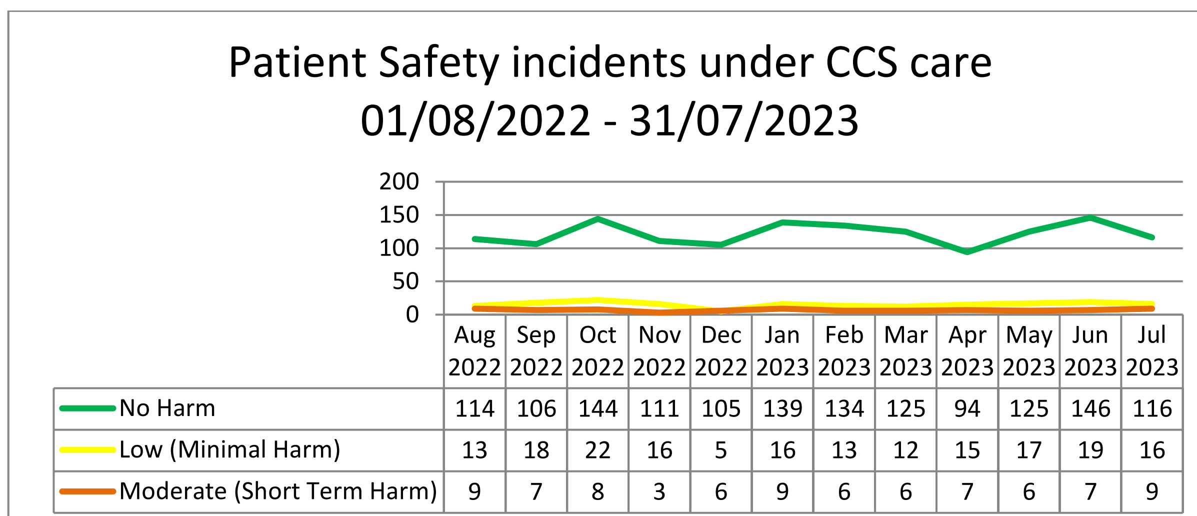
1.4 A total of fourteen panel meetings were held in June 2023; all but one of them, included a safeguarding element. Two panels resulted in a Root Cause Analysis investigation and two in a rapid review. Seven panel meetings were held in July 2023, with five having a safeguarding element.
Two panels resulted in a Root Cause Analysis investigation and three in a rapid review. The panels were a combination of reviewing final reports, discussion on next steps and

# Provide Outstanding Care

action plan reviews. Any identified initial ongoing actions were added to Datix for monitoring and completion.

1.5 The chart below highlights those patient safety incidents that occurred under our care and includes the two-month period of June and July 2023. These incidents totalled 313 which is an increase of 50 incidents on the previous two-month period.

1.6




| | Aug 2022 | Sep 2022 | Oct 2022 | Nov 2022 | Dec 2022 | Jan 2023 | Feb 2023 | Mar 2023 | Apr 2023 | May 2023 | Jun 2023 | Jul 2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No Harm | 114 | 106 | 144 | 111 | 105 | 139 | 134 | 125 | 94 | 125 | 146 | 116 |
| Low (Minimal Harm) | 13 | 18 | 22 | 16 | 5 | 16 | 13 | 12 | 15 | 17 | 19 | 16 |
| Moderate (Short Term Harm) | 9 | 7 | 8 | 3 | 6 | 9 | 6 | 6 | 7 | 6 | 7 | 9 |

1.7 As referenced above, there has been an increase in the number of no harm incidents reported over the 2-month period. Two categories of incidents have seen an increase in reporting as follows:

- Access, admin transfer and discharge.
- Clinical assessment and treatment.

1.8 The increase is noted to be in services that report incidents most frequently and is not restricted to one category. There was a reduction in reporting in April/ May which may be reflective of the five bank holidays. The resumption of a more regular number of reported incidents across June/ July may account for a spike in no harm incidents, however this will be monitored in the coming months.

1.9 Of the 313 incidents (June and July), 84% were no harm incidents, 11% low harm and 5% moderate harm. These ratios are stable, with high levels of reporting of no and low harm.

1.10 Sixteen moderate harm incidents (whilst under the Trust's care) were reported, which is an increase of two incidents on the previous two-month period. The slight increase is shown in the chart below and is in line with small spikes across the last year. The increase in this case is attributed to two falls on the North Cambridgeshire hospital site.

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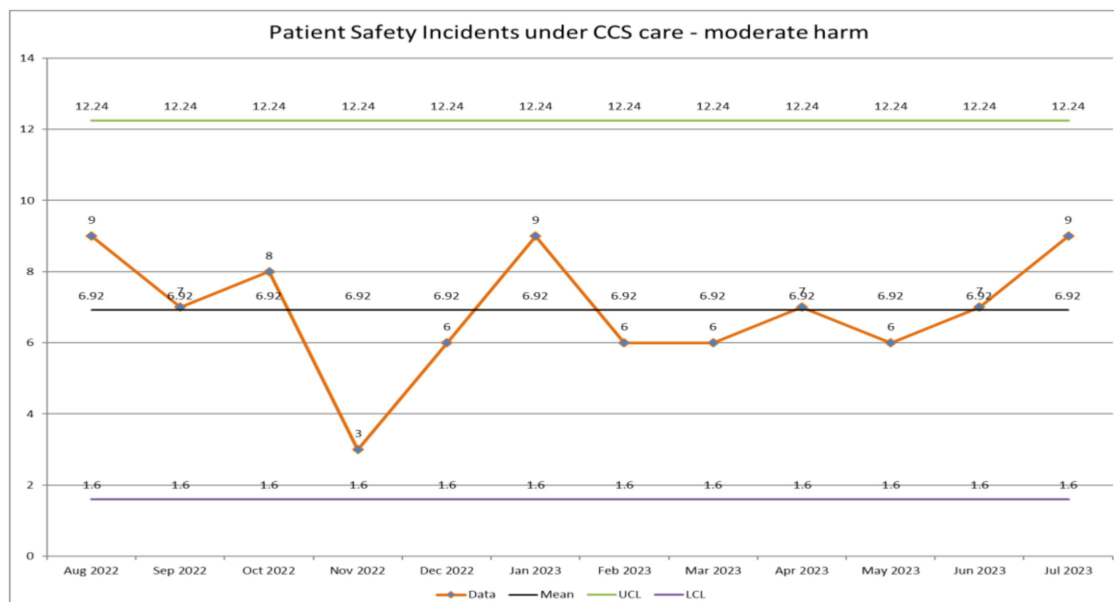
1.11




1.12 These falls occurred in the car park/ walkways of the hospital and therefore come under the jurisdiction of the Trust as landlord. A review of the site has been completed, with additional measures put in place including additional seating; signage around the temporary paths, additional portering and the purchasing of extra wheelchairs. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 reports / submissions were also completed, as required.

1.13 Fourteen of the moderate harm incidents related to the Luton Adult Service and wound management/ pressure ulcers.

1.14 For the 2-month period of June and July, statutory duty of candour was completed (or there is documented rationale for why it was not appropriate to complete) for all the relevant incidents (16).

1.15 **Incident Themes (all incidents)**
Datix reports in generic categories and the categories we see reflected in the top three reported (for each month) are as follows:

| June | July |
|---|---|
| • Clinical assessment & treatment **114**<br>• Access, admin, transfer & discharge **78**<br>• Patient information **37** | • Clinical assessment & treatment **83**<br>• Access, admin, transfer & discharge **58**<br>• Medication **44** |

1.16 Incident themes are quite specific to different service directorates due to the diversity of work undertaken. A Trust wide view of themes within each of the categories above noted the following:

1.17 **Clinical Assessment and Treatment:** All pressure ulcers and moisture-associated skin damage (MASD) were reported under this category, both for those acquired on and off caseload. Luton Adults reported the majority of these with the remaining two incidents occurring in Luton Special Needs Nursing Team and Bedfordshire Childrens Community Nursing (CCN); both were considered to have been acquired ‘off caseload’.

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1.18 The CCN teams are in the process of implementing a pressure ulcer prevention tool specifically designed for children based on Purpose-T, a recognised risk assessment tool.

1.19 Luton Adults continues the proactive care home education program successfully providing education on preventative skin care and early referral when skin deteriorates. An annual thematic review and trend analysis was completed in April 2023 and noted that there is decreasing number of pressure ulcers in the service, which may be a direct result of the introduction of the CAMPaign (Care plan, Assess, Measure, Photo). A six-month update on this approach is due at the Quality and Safety Committee in November 2023.

1.20 Access, administration, transfer, and discharge: of the 136 incidents reported under this category, 56 related to failure to refer; with 29 incidents relating to a failure (by maternity services) to provide antenatal information to the 0-19 teams. Norfolk is the biggest reporter of these, with 27 incidents, however these numbers have significantly reduced after the implementation of an improvement plan across the system. Many of these incidents are caused by movements into the county late in pregnancy. All cases are fed back by the clinical leads at the Maternity/ Healthy Child Programme liaison meetings.

1.21 Sixty incidents were reported under the generic subcategory of 'unspecified other access, admin, transfer and discharge' all of which were graded as no harm. These incorporate a wide variety of incidents with no specific themes.

1.22 Medication: There was a total of 79 incidents reported in the period with 44% (35) being whilst under the care of CCS – 92% (33) were graded as no harm and two as low harm. There was one incident graded as moderate harm and this was off caseload (patient is non-compliant with self-administration of medication). A breakdown of the subcategory and degree of harm is given below.

1.23

| | No Harm | Low | Moderate | Total |
|---|---|---|---|---|
| Administration (Meds) | 33 | 5 | 0 | 38 |
| Dispensing (by pharmacy) | 10 | 0 | 0 | 10 |
| Medication Security | 2 | 0 | 0 | 2 |
| Monitoring & Advice (Meds) | 2 | 0 | 0 | 2 |
| Prescribing | 7 | 1 | 0 | 8 |
| Unspecified Other Medication Issue | 17 | 1 | 1 | 19 |
| Total | **71** | **7** | **1** | **79** |

1.24 **National Patient Safety Alerts**

1.24.1 As previously reported there is a robust process in place for managing and acting on alerts through the Safety team which is overseen by the Deputy Chief Nurse.

1.24.2 In June and July 2023, 24 alerts were received: (June 8, July 16). There were three National Patient Safety alerts issued with one being relevant to the Trust. A Task & Finish Group has been set up, chaired by the Deputy Chief Nurse, to address the alert within time frame.

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1.24.3 The National Patient Safety Alerts were as follows:

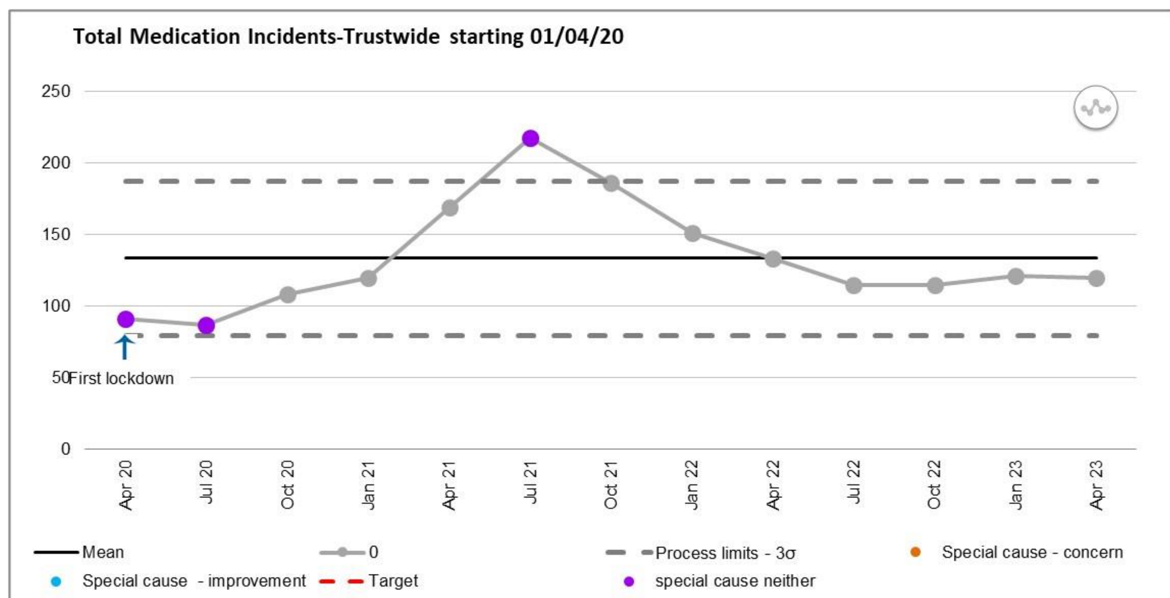
- NatPSA/2023/007/MHRA - Potential risk of underdosing with calcium gluconate
  in severe hyperkalaemia.
- NatPSA/2023/008/DHSC - Shortage of GLP-1 receptor agonists pyridostigmine
  60mg tablets.
- NatPSA/2023/009/OHID - Potent synthetic opioids implicated in heroin overdoses and deaths.

**2.0 Medicines Management**

2.1 **Medicines Incidents**

2.2 The Statistical Process Control chart below shows the number of medication incidents reported quarterly, regardless of whether responsibility rested with the Trust or with other organisations.

2.3




2.4 Please note that the dates shown represent the first month of each quarter, and the data is the total number of medication incidents reported during that quarter.

2.5 Following the turbulence after the pandemic, the number of incidents reported have stabilised for the latest four quarters.

2.6 Of the 120 incidents reported in the latest quarter, just under half were attributable to CCS (48) and 11 were not attributable to professional input. Incidents caused by staff in other organisations are reported by the Safety Team to those organisations. In addition to this, depending on the nature of the incident, they may be involved in the investigation, or informed by the member of staff detecting or investigating the incident.

2.7 The chart below shows the percentage no-harm medication incidents attributable to CCS each month over the last 18 months. The trendline remains quite steady at approximately 92%. The higher the percentage of no-harm incidents the greater the opportunities for learning.

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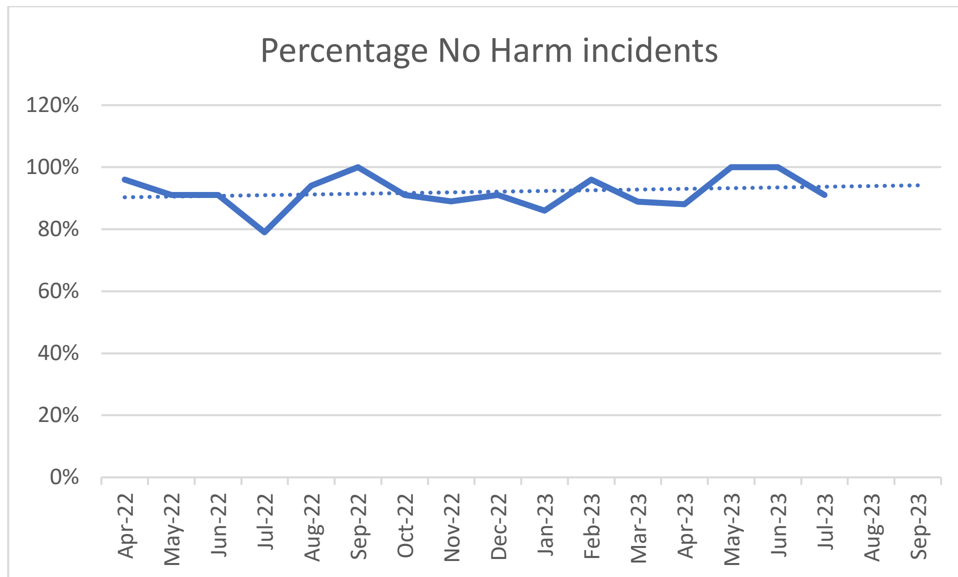
2.8




2.9 The CD (Controlled Drugs) Accountable Officer has been made aware of several incident reports in relation to CD activity in a patient's home. All appropriate steps have been taken, and further support received from safeguarding leads.

2.10 Collaborative work continues with colleagues in other organisations. Projects include the virtual ward development in Luton and Bedfordshire; joint working with colleagues in ELFT (East London Foundation Trust) and CNWL (Central Northwest London Trust) on common issues affecting community health services patients such as incident benchmarking and Medication Safety Officer (MSO) networks discussions/ learning.

**3.0 Safer Staffing**

3.1 A paper outlining the project and next steps, has been presented to the Executive Board and has been, following approval, uploaded onto Verto. A project group has been established which is being led at this time by the Quality Team.

3.2 Safer staffing activity has progressed within several services.

3.3 Luton and Bedford Adults Services have been accepted onto cohort 2 of the national Community Nursing Safer Staffing Tool pilot, the teams are currently awaiting the training required to commence the project.

3.4 The service currently produces a daily situational report in terms of staffing for all the community nursing teams – a snapshot of this is seen below. The email is sent to a core set of staff across the Trust so that if there is an issue in the team it can be escalated and supported as required. The report also includes the teams OPEL (Operational Pressure Escalation Levels, with level 1 being the lowest level of pressure and 4 being the highest) rating for that day.

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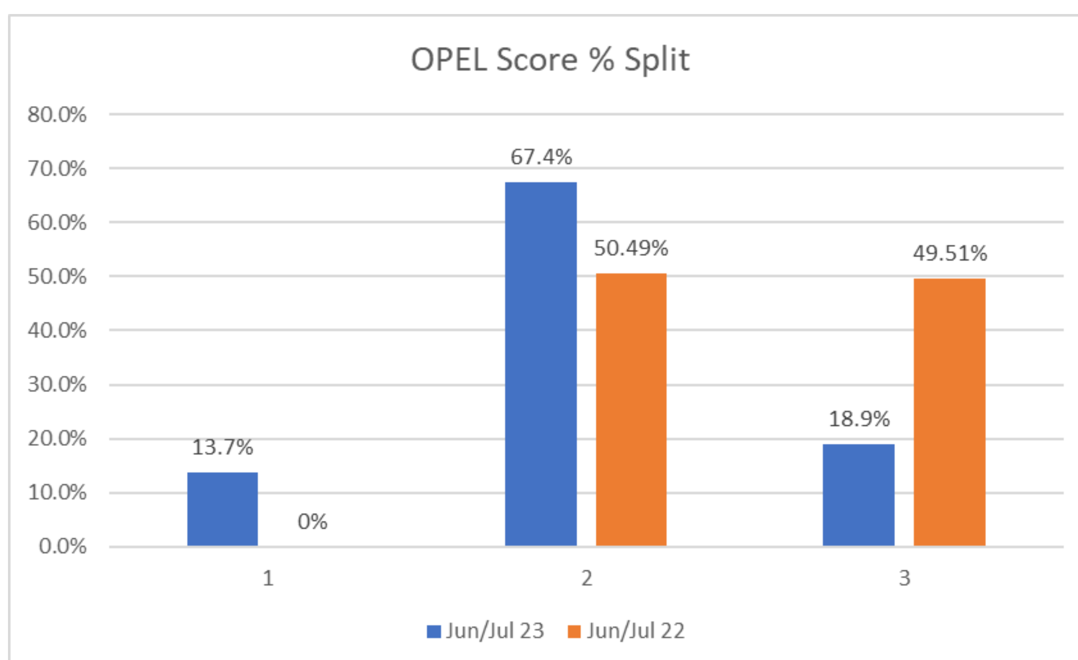
3.5

| | 11.09.23 | 12.09.23 | Total* | MAT | LTS | STS | Comp/ Carers | Study Day | | Annual Leave |
|---|---|---|---|---|---|---|---|---|---|---|
| District Nursing | | | 55 | 0 | 4 | 2 | 1 | 0 | 13% | 6 |
| Rapid Response (Day) | | | 34 | 2 | 0 | 1 | 0 | 0 | 3% | 6 |
| Rapid Response (Night) | | | 11 | 0 | 0 | 1 | 0 | 0 | 9% | 3 |
| Community Matron | | | 9 | 0 | 1 | 3 | 0 | 0 | 44% | 1 |
| IDT & GP Liaison | | | 13 | 1 | 0 | 1 | 0 | 0 | 8% | 2 |
| Palliative Care | | | 12 | 0 | 1 | 0 | 0 | 0 | 8% | 2 |

3.6 When reviewing the daily OPEL data for June and July, a clear reduction in OPEL status, illustrated in the graph below, can be seen against the score from the same period last year. This reduction in OPEL will be partially because of the transformational work the team has undertaken around international recruitment. There has been no requirement for the team to go into the BCP (Business Continuity Plan) during June/ July 2023.

3.7




3.8 In the 0-19 pathway (across the Trust), the teams have been focussed on developing a new workforce plan for the service, with the underpinning principle that the new model needs to be aligned to the five mandated contacts. A model has been approved at the Executive Board and implementation project planning has now commenced, with a varied trajectory for completion across each service. This piece of work has also achieved for the first time the provision of a universal approach to health visiting/ mandated visits and staffing across the whole organisation. It also provides the Trust with a baseline staffing provision, which can be mapped against in terms of escalation and safer staffing process development.

3.9 Next steps include meeting with the Finance, Roster and Workforce Teams regarding undertaking establishment reviews and verifying a Trust wide Safer Staffing policy.

3.10 A BAF (Board Assurance Framework) for Safer Staffing has been developed, this incorporates National Quality Board and NHS England guidance, and will measure the Trust's progress against set criteria. The Project Group is working through the partially and non-compliant aspects and is working on evidence and actions to accomplish these.

## 4.0 Safeguarding

4.1 The Trust continues to work proactively with partners to carry out its statutory safeguarding duties regarding the children and adults who access our services.

4.2 New data sets have been added to the quality dashboards to reflect safeguarding work more accurately across the Trust. This will continue to be developed alongside collection and collation of a MASH function data set across each locality.

### 4.3 Bedfordshire, Luton, and Milton Keynes (BLMK)

4.3.1 Adult safeguarding/ clinical teams completed 57 referrals to the Local Authority (LA) in June and July 2023. Twenty-two of these referrals progressed to a Section 42 enquiry. Data sets in relation to referral processes are just being established, this is an evolving piece of work which will be regularly reviewed, so that the data being sought can support change and the alignment of safeguarding practice.

4.3.2 A Standard Operating Procedure (SOP) has been drafted to support management of adult safeguarding referrals and Section 42 enquiries. This is being co-produced alongside Luton Adult services to ensure consistent roll-out and implementation. This will then be used to support all other adult focussed services. An agreed single point of contact in Luton (SPOC) is now sitting with the Adult Safeguarding Team to ensure robust oversight and follow up from all referrals made to the LA. Work is underway to support this SOP with appropriate record keeping on SystmOne, with the development of a safeguarding template.

4.3.3 Vacancies, sickness and an increased workload across the Safeguarding Teams in BLMK have been challenging, the Assistant Director of Safeguarding alongside clinical colleagues have updated the BCP and the team have been focussed on active safeguarding clinical work and de-prioritised training commitments. The team has had some successes in recruiting to the vacancies, with new colleagues commencing roles throughout July and August.

4.3.4 The Service Director and Assistant Director for Safeguarding have now met with each of the Assistant Directors of the three LA's to begin discussions related to MASH demand and capacity and prioritisation of resources within health. There is now a planned multi-agency transformation piece of work to be commenced in Central Bedfordshire to map the process and develop an understanding of the future vision for MASH.

### 4.4 Cambridge & Peterborough (C&P)

4.4.1 The MASH action plan, (following the Ofsted inspection in February) continues to be implemented (this is led by the LA), a review of the MASH front door by LA leads are expected to be shared with system partners in mid-September. Once complete the organisation can start to build its response to any changes through a new staffing model, and the potential streamlining of processes.

4.4.2 Staffing and capacity is also challenged across C&P, due to an increased demand – this is being mitigated through using business continuity planning, reprioritising workload (as highlighted above) and the use of agency and bank staff. Whilst there have been some successes, vacancies generally have been difficult to recruit into, a programme of recruitment across all safeguarding provisions is underway.

4.5 **Norfolk & Waveney (N&W)**

4.5.1 Recruitment is on-going in N&W in relation to the senior safeguarding role, as the current Named Professional has been appointed into the Trust's Head of Safeguarding role.

4.6 **Suffolk**

4.6.1 The Section 11 audit has been submitted with support from Dental and iCaSH services. Challenge events and meetings have begun to support embedding learning and offer further verbal assurance of the Trust's compliance with legislative requirements.

4.7 **Supervision**

4.7.1 The level of mandated supervision has been impacted upon by staffing capacity in the teams, however by increasing the supervision participants in a session to 8 this has provided some mitigation and has ensured staff can receive appropriate advice. Ad hoc 1:1 supervision has continued to be offered and provided to staff seeking additional support with individual cases.

**5.0 Infection Prevention and Control (IPaC)**

5.1 Assurance is provided to the Board that all the national IPaC documents have been reviewed and incorporated into Trust policies and Operating Procedures. IPaC issues continue to be discussed at the weekly IPaC Huddle and are then reported as appropriate to the Resilience Operational Huddle.

5.2 There was one IPaC related incident reported during June – July 2023. The incident related to an outbreak notification of five staff, who reported symptoms of Covid-19 following a face-to-face meeting. This was reported through the national outbreak system and all staff have since recovered.

5.3 Below is the Trust overall compliance regarding staff mandatory IPaC training as reported in the monthly Quality Dashboard (appendix 2). Compliance has dropped, due to the training moving from three yearly to yearly at the end of May - however we are seeing an upward trend (20% from June to July) of those who are out of date completing the e-learning package.

# Provide Outstanding Care

5.4

**CCS NHS Trust Quality Performance Dashboard 2023-24**
**Overall Trust**

| Standard/Indicator | Description | Contact | Annual target Ceiling or Baseline | Apr-23 CCS Overall | May-23 CCS Overall | Jun-23 CCS Overall | Jul-23 CCS Overall | Sparkline |
|---|---|---|---|---|---|---|---|---|
| SAFETY | | | | | | | | |
| Infection Prevention & Control | | | | | | | | |
| UV light compliance | All clinical teams | | 90% | 82% | 83% | 83% | 82% | |
| EFFECTIVENESS | | | | | | | | |
| Mandatory training | | | | | | | | |
| IPaC training | % of staff undertaking IPaC training | | 90% | 97% | 97% | 59% | 79% | |

| | |
|---|---|
| N/A | Data usually supplied but not available this month |
| | Not relevant/not applicable to this area |
| | Data below compliance target |

5.5 In relation to the ultraviolet (UV) hand hygiene assessment, the Trust's new compliance target has been reset at 90% - the rate of compliance for July was 82% (in August 2023 this increased to 85%). The IPaC team have added in more opportunities to train to be an assessor and have been ensuring all teams have access to the correct equipment. Each service that is under 90% compliance has an action plan in place which is monitored via the IPaC Committee.

5.6 There were no confirmed bacteraemia cases of MRSA (Meticillin-resistant Staphylococcus Aureus), Extended Spectrum Beta – Lactamase (ESBL), or any positive cases of C. difficile during this period.

**SECTION TWO – CARING**

| | | |
|---|---|---|
| **Caring** | 100% of services received over 90% positive feedback from the FFT (Friends and Family Test). 100% of Directorates scored over 90% **(C1).**<br><br>All formal complaints were responded to within the timeframes agreed by the complainant **(C2).**<br><br>100% of all Directorates and 100% of individual services received complimentary feedback **(C3).** | **Substantial** |

## 6.0 Patient Experience

### 6.1 Friends and Family Test (FFT)

6.1.1 The aim for FFT feedback is to ensure there is an opportunity for service users, parents and carers to provide feedback about their experience of care with a range of methods available that are accessible and meet service users' needs.

6.1.2 We received 2417 responses in June and 2738 in July. This is an increase of 884 on the previous two-month period. Below is a summary since December 2022.

6.1.3

| | Dec | Jan | Feb | March | April | May | June | July | Total |
|---|---|---|---|---|---|---|---|---|---|
| **Trust Overall** | 1591 | 2373 | 1693 | 2704 | 1859 | 2412 | 2417 | 2738 | 17787 |

6.1.4 The overall Trust FFT positive feedback was 96.74%, with a 1.65% negative feedback percentage. Overall, we remain above the Trust target of 90% with each service also reporting above the 90% target.

6.1.5 In previous reporting periods, Luton Domiciliary Pharmacy Technicians and Single Point of Contact were reported as not receiving any FFT feedback. This was reviewed and it was established that the best method to collect feedback would be via the clinical teams that they support. The IQVIA system has been amended to reflect this.

6.1.6 Response numbers for Norfolk and Waveney Children's Services and Cambridgeshire Children's Services continue to be monitored. The teams are starting to see the impact of the work of the Co-production Lead and Patient Experience team to promote FFT.

6.1.7 The FFT scores have been reviewed for each protected characteristic. Less than 90% of responders identifying as lesbian and Sikh rated Trust services as Very Good or Good. However, the respondent rates for these 2 groups are low, so further analysis will be undertaken as the data sets start to increase. The comments from these individual responses have been reviewed and are not related to the noted protected characteristic.

6.1.8 The only other groups that scored below the 90% Trust target were people who responded that they do not wish to disclose specific demographic information, again these individual responses have been reviewed and addressed as needed.

6.2 **Comments**

6.2.1 In June and July, the services we provide received 7592 positive comments on service user surveys and feedback forms across the Trust. This translates to over one hundred positive comments for every complaint (formal and informal). This is consistent with the last two reporting periods.

**7.0 Information Governance**

7.1 The 2022 - 2023 Toolkit was published ahead of the June 2023 publication date.

7.2 Mandatory Information Governance and Data Security Awareness training compliance as of June was 92% slightly higher from the previous month against the 95% national target. Service Directors are approached monthly with details of non-compliant staff with a request to encourage completion of the mandatory training. In addition, individual staff members receive training reminders from the Trust's internal system.

7.3 Between June 2023 and July 2023, 32 incidents (18 in June and 14 in July) were reported under the Confidentiality Breach incident category which was an increase on the 28 incidents reported in the previous period. Most incidents were related to human error or administrative issues. The Information Governance Manager assesses all information governance incidents and provides advice to staff to prevent errors from re-occurring.

# Provide Outstanding Care

## 8.0 Areas of Outstanding Practice

### 8.1 Dynamic Health

8.1.1 Ely service relocation – the team have successfully moved the location of the Physiotherapy department in Ely at the beginning of August and are now located in an area which was previously the Oliver Zangwill Centre. The newly refurbished environment provides both staff and patients with a high-quality clinical environment.

### 8.2 Dental Services

8.2.1 Plans are now in place to provide an emergency Dental service for the homeless in Peterborough working collaboratively with the Light Project and other Trust services such as Integrated Contraception and Sexual Health.

8.2.2 The team have stopped using barrier films in all dental sites as part of the work on the dental green toolkit. This will result in a reduction in plastic waste as well as a financial saving.

### 8.3 Integrated Contraception and Sexual Health (iCaSH)

8.3.1 The smallpox targeted vaccination programme (Mpox prophylaxis) for high-risk patients and staff continued into July, with second doses administered up to and including, 31 July 2023. The vaccination programme has now closed following UKHSA guidance, with vaccines only available in London sexual health clinics. iCaSH will utilise remaining vaccine stock opportunistically until locally held stock is exhausted.

### 8.4 Luton and Bedfordshire Adult Services

8.4.1 At the Staff forum the team has recently received presentations from the ELFT Recovery College and Total Wellbeing. They have come along to showcase their offer and promote access into their services.

8.4.2 In September 2023, the service has a planned talk from Andy's Man Club, a suicide prevention charity that supports mental health amongst men.

8.4.3 As outlined in the last Clinical Operations Board in July the Adults Service Co-Production Lead has been joined by a new Co-Production Co-ordinator with a focus on tackling inequalities.

### 8.5 Healthy Child Programmes

#### 8.5.1 Bedfordshire and Luton Healthy Child Programmes

8.5.2 Bedfordshire Health Child Programme achieved UNICEF Baby Friendly Gold Standard in their reaccreditation in June. For the first time, Luton Healthy Child Programme was also awarded their Gold Standard.

8.5.3 A specialist peri-natal and infant mental health, Health Visitor has contributed to a presentation delivered by the Institute of Health Visiting at a national Early Help conference. This was in relation to the collaborative work undertaken as part of the Family Hub agenda.

# Provide Outstanding Care

8.6 **Specialist Services**

8.6.1 **Bedfordshire and Luton's Community and Specialist Nursing Service**

8.6.2 Following 3 incidents of Grade 4/ unstageable pressure ulcers in the system (avoidable by other providers), the service developed a pressure ulcer risk assessment too, which is being rolled out across Bedfordshire, Luton, Cambridgeshire, and Peterborough Children's Community Nursing teams.

**SECTION THREE – EFFECTIVE**

| | | |
|---|---|---|
| **Effective** | • The Equality Diversity Objectives are on track for delivery. (**E6**)<br>• Overall Information Governance mandatory training levels at 92%. (**E2**) | **Reasonable** |

**9.0 Equality & Diversity Objectives**

9.1 An update on the organisations Equality and Diversity Objectives.

| Objective | Update |
|---|---|
| To ensure access to iCaSH services is fully inclusive by improving the telephony platform and providing an online booking facility, following service-user involvement. | iCaSH along with the rest of the Trust will be moving to the British Telecom platform (in line with project timeframes) which will allow improved functionality for managing phone calls.<br><br>Several other projects are running across iCaSH services to support improved telephony access, such as:<br>• Central call taking in Norfolk, improving call response waits and sustainability.<br>• First hour of day focusses on targeted capacity (in terms of call taking) across all geographies except Norfolk and Waveney.<br>• An online booking platform pilot was launched in Bedfordshire in May with further roll-outs planned during 2023.<br>• Bedfordshire also launched a pilot of online ordering for repeat Progestogen Only Pill (POP) in June, with roll-out in Norfolk and Suffolk planned for this summer. |
| Continued service-user-led improvement within Trust wide iCaSH services, giving consideration to creative ways of obtaining patient feedback. | The Ambulatory Care Co-production Lead has been in post for 6 months now and is working on various projects within iCaSH.<br><br>iCaSH have been the first service to use an 'Involvement Partner' to both shortlist and recruit to the service.<br><br>The Co-production Lead is currently investigating new ways to gather feedback on missed HIV appointments. |
| Ensure the external approaches to iCaSH and Luton Adult Chronic Respiratory Service clinics are well-lit and well-maintained, to enhance a sense of safety. | The Estates Team have confirmed that the external approaches are well-lit, have CCTV and are well-maintained.<br><br>Our iCaSH clinics are in town or city centres, with good public transport links. |

| | |
|---|---|
| | Some estates are within shared health sites, such as Dunstable, Great Yarmouth, Cambridge, and Huntingdon – so facilities will be shared.<br><br>Clinics are AccessAble registered and compliant. |
| Have access to the new Co-production Co-ordinator for Luton Adults, to help engage with service users who may be vulnerable or unconfident, and co-produce service improvement for Luton Adult Chronic Respiratory service. | The Co-production Coordinator has been in post since June 2023. |
| Trust wide: expand the scope of demographic data capture on our main Trust wide system (Systm One), with discussions about expanding data capture in Lilie (iCaSH) and Dentily (Dentistry). | The Trusts Equality, Diversity and Inclusion Lead and Workforce Lead (Data) are leading the discussions at the Data Quality Group and are working with clinical systems to expand our demographic scope.<br><br>The Trust are currently recruiting small pilot groups from each area to test the templates, initially on SystmOne, aiming for a pilot to commence in September 2023.<br><br>A bench marking exercise highlighted that the Trust are the only organisation we are aware of doing this work in such a robust way, therefore we are not able to access peer support with this project.<br><br>Training for staff (to support staff to ask the questions) has been developed with Co-production leads. |

## 10.0 Mandatory Training

10.1 Following the recent additions to Mandatory Requirements on ESR compliance rates are as follows:

| Compliance Name | Compliance % |
|---|---|
| Patient Safety – Level 1 – 3 Years\| | 87.19% |
| Patient Safety – Level 2 – 3 Years\| | 80.04% |
| The Oliver McGowan Mandatory Training on Learning Disability and Autism Part 1 eLearning\| | 81.20% |

10.1.1 The figures identified above in 10.1 identify a positive initial position for the Trust in terms of the training trajectory.

10.1.2 The overall trust compliance for Mandatory training in June and July was 93% against a target of 90%.

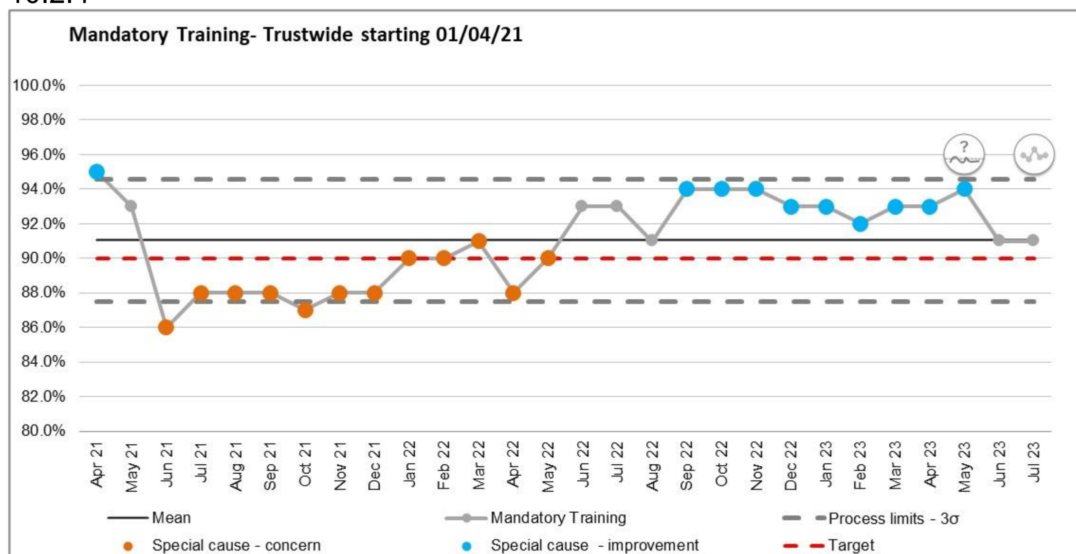
10.2 **Ongoing / Future changes:**

10.2.1 Suicide Training will be promoted following alignment of the training link within the Electronic Staff Record (ESR) and develop a 'how to' guide to enable recording within the individual's matrix once completed. The training is currently delayed whilst the Digital Desk Team update the IT settings for the training to run through ESR.

10.2.2 Palliative Care modules are still in progress; they will be aligned to the required staff groups once agreed.

10.2.3 Autism (Oliver McGowan) training face to face sessions are being organised with the first sessions due to take place September/ October 2023.

10.2.4




## 11.0 Care Quality Commission (CQC)

11.1 Work continues to progress the Trust's Must-Do action:
*The service must continue to monitor and actively recruit to ensure that there is an adequate number of nursing staff with the appropriate skill mix to care for children and young people in line with national guidance and to ensure that service provision can be maintained.*

11.2 Using Quality Improvement (QI) methodology, a Trust wide review of the Healthy Child Programme (HCP) Workforce Model has been completed following a remit of meeting the timescales of mandated contacts. It is based on a tiered approach at universal, targeted and specialist pathways. It offers a stepped approach given the levels of vulnerabilities for each articulated circumstance. For the most vulnerable service users this model maintains the professional expertise of the Specialist Community Public Health Nurse (SCPHN) role and enables a broader skill mixed workforce, taking into consideration wider Registered Nursing roles as well as support roles with the foundation knowledge of early years development. The skill mix roles will be supported in practice with robust competency frameworks offering assurance of a suitably qualified workforce with the ability to deliver outstanding personalised care.

11.3 The Model will introduce Health Care Assistants (HCP's) and Nursing Associates (NA's) into the Health Care Professional (HCP) workforce for the first time and offers a sustainable, future-proof model that addresses current workforce pressures. By reinvesting the current long-term vacancies within the new model, more children and families will receive a higher quality offer from the services as staff availability will be greater and more robust.

11.4 Following Executive approval, and in conjunction with Commissioners, a transformation programme plan will commence within Trust wide HCP's with support from the Improvement and Transformation Team. Key to the successful implementation of the project is staff engagement and leadership support.

11.5 New roles, responsibilities and competency frameworks will be developed, and supervision will be reviewed and strengthened to encourage retention of staff, both existing and new. Partnership working with Family Hubs and system partners will be further strengthened.

11.6 It is anticipated that this will be a long-term project and the improved outcomes on children and families will take some time to become evident.

11.7 The Trust's 'should do' actions continue to be reviewed on a quarterly basis, most of which are now considered to be business as usual.

11.8 The internal CQC self-assessment and peer assessment processes will be reviewed again, firstly to ensure alignment with the new CQC framework, and secondly to identify how our learning from other external inspection reports should influence our processes.

**SECTION FOUR – RESPONSIVE**

| | | |
|---|---|---|
| **Responsive** | • All of our service areas with waiting lists have an improvement plan that is agreed and being delivered (**R1**).<br>• 100% of all formal complaints are acknowledged within 3 working days (**R2**)<br>• % of valid requests for information are provided to applicants within 20 working days of their receipt into the Information | **Substantial** |

## 12.0 Access to Our Services Including Referral To Treatment (RTT)/Waiting Times

### 12.1 Dynamic Health

12.1.1 The service position on waiting times is evidencing improvements, a data analysis of the last 16 weeks shows the following:

- +37% increase in weekly referrals at service level in both Physiotherapy and Specialist Services.
- -11% decrease of patients on the waiting lists (-1,271 patients).
- -71% decrease in patients breaching 18 weeks (-2,443 patients) – this is mainly in the Physiotherapy element of the service.
- There has been a +25% increase in new contacts (150 patients) and a +13% increase in Follow Up contacts (100 patients).
- The service has less vacancies compared to 3 months ago, and the international recruits are all now fully trained and working at capacity.

12.2 **Dental Services**

12.2.1 **Cambridge and Peterborough Special Care Dentistry (SCD)**
The trajectory of performance indicates that without capacity being maximised or increased the SCD waitlist will increase. The team are actively monitoring those waiting over 52 weeks to ensure that long waiters are not penalised with the arrival of urgent shorter waiters into the system.

12.2.2 The Transformation Plan aims to ensure that the service is maximising all capacity and the service anticipate that the programme will complete in approximately three months after which time improvements will be identifiable.

12.2.3 During the reporting period the service have worked closely with the Integrated Care Board (ICB) and have reviewed our acceptance criteria with a view to ensuring the appropriate patients are referred to our service. In addition, we have offered training to high referring general dentists.

12.2.4 The team are working with the ICB, Local Dental Network Chair and National Lead of Child Friendly dental practices to develop a network of general dental practices with enhanced skills in paediatric dentistry which will reduce the numbers entering the system.

12.2.5 Following data cleansing and service improvements the service can report an improved position against dental waiting times. Additional work is being carried out as part of the transformation project with an aim to further improve waiting times in the service.

12.2.6 Waiting lists in Bury St Edmunds remain consistent, with the availability of appointments in 8 weeks and Ipswich at 9 weeks. The team anticipate Ipswich waiting lists will be within service level (8 weeks) by October when they will see the impact of two new dentists starting in September.

12.3 **Minor Oral Surgery**

The service has an average waiting time of 7 weeks which is an improvement of 2 weeks since the last report. There are 797 patients with open waits, with 5% above 18 weeks. The longest waiters have cancelled multiple times, and all have booked appointments. The service actively offers appointments at less busy clinics.

12.3.1 The General Anaesthetic (GA) lists for Peterborough, Huntingdon and Wisbech have all patients pre-booked with average waiting times of 23 weeks which has increased from 22 during the period. This is because the Monday GA lists have been disrupted by Bank Holidays which are not re-instated by the Acute Trust. Furthermore, lists have been cancelled due to the Consultant strikes. Requests have been made to utilise any spare Theatre space to re-instate this lost capacity. Suffolk patients requiring a GA are being seen at 4 weeks, a further one-week reduction on the last report. Suffolk GA lists are not affected by the increased Bank Holidays due to the day of the week they are planned.

12.3.2 Cambridge patients requiring a GA are listed for GA at West Suffolk Hospital (WSH). Patients are being assessed to determine need with urgent cases being booked from 8 weeks. The remaining patients will be seen within 40 weeks which is a three-week improvement on previous reporting period. The

referral numbers into the service are increasing and therefore the current theatre capacity no longer meets the demand.

12.3.3 The following mitigating actions are being taken to reduce waiting times:

- Exploring options to provide additional lists at West Suffolk Hospital.
- Cancelled lists are being rescheduled in addition to existing lists.
- Working towards the redistribution of lists between Cambridgeshire and Suffolk so there is less geographical difference in waiting times.
- Benchmarking session with SCD's to ensure consistent GA pathway management.
- Oral health information provided for those with long waits to manage ongoing dental health.

## 12.4 Integrated Contraception and Sexual Health (iCaSH)

12.4.1 Waiting lists for routine Long-Acting Reversible Contraception (LARC) and PrEP provision continue in some iCaSH localities.

- LARC: Previously reported at 851 has seen an increase of 158 since the last report.
- PrEP: Previously reported at 22 has seen a reduction of 19 since the last report.

12.4.2

| iCaSH Site | Number of patients on LARC waiting list as of July 23 | Average wait times from initial call to LARC pre-assess | Average wait times from LARC pre-assess to procedure | Number of patients on PrEP waiting list as of July 23 | Actions to mitigate waits |
|---|---|---|---|---|---|
| **Bedfordshire** | 303 | 9 - 12 weeks | Within 4 weeks | 0 | • Triage/red flag/fast track assessments and emergency appointments.<br>• GP federation support, bank staff and excess hours in some localities.<br>• Use of underspend and any commissioner awarded emergency funding.<br>• Expanding the supply/issue of PrEP under PGD with a supported nurse training and supervision package.<br>• Active risk register entry to record risk of waiting times and increased demand. |
| **Dunstable** | 45 | 8 weeks | Within 2 weeks | 0 | |
| **Cambridgeshire** | 78 | 5 weeks | Within 3 weeks | 0 | |
| **Norwich** | 326 | 8 weeks | Within 2 weeks | 0 | |
| **King's Lynn** | 129 | 6 weeks | Within 2 weeks | 0 | |
| **Great Yarmouth** | 28 | 2 weeks | Within 2 weeks | 0 | |
| **Milton Keynes** | 97 | 7 weeks | Within 4 weeks | 0 | |
| **P'Boro** | 3 | 4 weeks | Within 2 weeks | 0 | |
| **Ipswich** | 0 | 5 - 6 weeks | Within 6 weeks | 0 | |
| **Bury St Eds** | 0 | 4 weeks | Within 3 days (implants)<br>Within 4 weeks (coils) | 0 | |

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| | | | | | |
|---|---|---|---|---|---|
| **Lowestoft** | 0 | Within 1 week | 2 weeks (Implant)<br>4 weeks (coils) | 3<br><br>(7 – 14 day wait) | • Dedicated PrEP clinics commenced in C&P.<br>• Increased reporting of demand and capacity data in each locality, including waiting times to help with service planning.<br>• 'LARC-athons' can be mobilised when required.<br>• C&P reporting of LARC KPI changing for Cambs to align to P'Boro KPI reporting.<br>• LARC training for clinical staff. |
| **Totals** | **LARC** | **1009** | **PrEP** | **3** | |

12.4.3 Some impact on service provision has been seen during the Consultant strikes, however the waiting times for PrEP have seen a positive reduction.

12.5 **Specialist Services**

12.5.1 A key indicator for tracking the experience of people using specialist services, is the time that they spend waiting for their appointment. The services have put a number of initiatives in place to support people who are waiting, including triage of any risk factors, check-in phone calls and increased digital offers.

12.5.2 Across all Children and Young People's service geographies, the teams are engaged in improvement work with our system partners to improve service waits and experience. One of the core issues in managing waits is the volume of referrals received, notably within Neurodiverse pathways, Audiology and Bedfordshire Speech and Language Therapy.

12.5.3 The table below shows the total number of children/ young people waiting to start their care pathway in specialist services, and the variance over the last year.

# Provide Outstanding Care

Total waiters Mar 22-

Total waiters

| Locality | Service 2 | Service | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Jun-23 | Jul-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bedfordshire | Continence | Continence | 39 | 44 | 50 | 43 | 54 | 33 | 49 | 61 | 63 | 61 | 57 | 65 | 54 | 52 | 51 | 57 |
| | Dietetics | Dietetics | 107 | 133 | 138 | 143 | 151 | 172 | 167 | 173 | 176 | 184 | 198 | 202 | 206 | 213 | 201 | 205 |
| | Eye | Eye | 460 | 514 | 517 | 475 | 350 | 299 | 280 | 388 | 398 | 490 | 485 | 510 | 486 | 503 | 603 | 573 |
| | OT | OT | 219 | 205 | 177 | 155 | 135 | 144 | 144 | 133 | 124 | 131 | 131 | 126 | 112 | 101 | 105 | 107 |
| | Paediatrics | Paediatrics - Consultant led | 1076 | 1131 | 1198 | 1267 | 1281 | 1259 | 1276 | 1340 | 1368 | 1313 | 1209 | 1294 | 1302 | 1406 | 1472 | 1556 |
| | | Paediatrics - Nurse led | 103 | 105 | 90 | 79 | 79 | 84 | 100 | 111 | 121 | 131 | 133 | 146 | 142 | 143 | 140 | 158 |
| | SaLT | SaLT - ECST only | 43 | 34 | 34 | 26 | 30 | 42 | 70 | 41 | 12 | 53 | 48 | 66 | 71 | 56 | 63 | 38 |
| | | SaLT - non ECST | 571 | 578 | 587 | 606 | 608 | 601 | 610 | 645 | 682 | 740 | 799 | 879 | 901 | 883 | 1009 | 934 |
| Cambs & Peterborough | Audiology | Audiology | 193 | 151 | 180 | 173 | 141 | 82 | 77 | 80 | 79 | 106 | 111 | 151 | 183 | 172 | 203 | 220 |
| | Dietetics | Dietetics | 357 | 393 | 393 | 445 | 511 | 559 | 603 | 600 | 626 | 630 | 672 | 741 | 759 | 711 | 755 | 706 |
| | OT | OT | 165 | 131 | 165 | 175 | 126 | 123 | 111 | 100 | 88 | 110 | 105 | 95 | 104 | 123 | 100 | 122 |
| | Paediatrics | Paediatrics | 413 | 408 | 428 | 483 | 420 | 453 | 422 | 432 | 431 | 425 | 422 | 440 | 466 | 472 | 582 | 549 |
| | PT | PT | 56 | 70 | 85 | 91 | 77 | 58 | 55 | 45 | 33 | 56 | 50 | 45 | 47 | 61 | 53 | 65 |
| | SaLT | SaLT | 430 | 400 | 340 | 255 | 220 | 284 | 365 | 431 | 416 | 514 | 500 | 464 | 446 | 443 | 346 | 274 |
| Luton | Audiology | Audiology | 697 | 686 | 732 | 740 | 635 | 654 | 720 | 733 | 829 | 907 | 989 | 1129 | 1195 | 1200 | 1259 | 1338 |
| | Paediatrics | Paediatrics | 1336 | 1408 | 1479 | 1576 | 1491 | 1478 | 1501 | 1497 | 1515 | 1435 | 1249 | 1265 | 1174 | 1096 | 1237 | 1188 |
| Norfolk & Waveney | SaLT | SaLT | 1696 | 1948 | 2115 | 2372 | 1496 | 1414 | 1356 | 1413 | 1424 | 1445 | 1389 | 1230 | 1071 | 898 | 1255 | 987 |
| Grand Total | | | 7961 | 8339 | 8708 | 9104 | 7805 | 7739 | 7906 | 8223 | 8385 | 8731 | 8547 | 8848 | 8719 | 8533 | 9434 | 9077 |

12.5.4 There are 3 primary factors contributing to the number of children waiting to start their care pathway. These are that the demand is greater than service capacity, there is an increased complexity of need and the balance of triaging new referrals alongside the existing waiting lists.

12.5.5 For Bedfordshire and Luton Community Paediatrics, the service is not currently funded to address the backlog which has accumulated. The service has commenced an early intervention element of the service, it is anticipated this will help to support a reduction in the number of children who are waiting to start their care pathway.

12.5.6 The table below shows the longest waits across specialist services:

| Service Area | Longest wait (in weeks) | Previous reporting period |
|---|---|---|
| Bedfordshire Community Paediatrics | 73 ↑ | 69 |
| Luton Community Paediatrics | 70 ↑ | 64 |
| Bedfordshire and Luton Speech and Language Therapy | 89 ↔ | 89 |
| Norfolk and Waveney Speech and Language Therapy | 65 ↓ | 69 |

12.5.7 There is a national expectation that waiting times for consultant led pathways will not exceed 65 weeks by March 2024. This will apply to our Community Paediatric Services. It is recognised that this target will be a challenge within existing resources. Dialogue with our local ICB's has commenced, to explore collectively how this will be achieved.

12.6 **Bedfordshire and Luton Community Paediatric Services**

12.6.1 Actions being taken to improve waits in Bedfordshire and Luton Community Paediatrics include:

- A new triage pilot, to commence in September 2023, with a focus on early intervention and a 'needs led', rather than a diagnostic approach.
- A pilot is in place to offer digital access to support offers for the backlog of children waiting long period. Initial feedback is very positive with a 70% + response rate from parent/ carers.
- The service is expanding the Early Intervention team, including increasing the number of Specialist Advisory Teachers.
- Non recurrent funding requirements have been shared with the BLMK ICS (integrated Care System) to address the waiting list.
- The service is actively involved in the BLMK ICS transformation work to review the system wide offer for Children with Neuro-disability needs.
- A working group has been established with the Milton Keynes Community Paediatric service to share change ideas and to take a BLMK systematic approach to the demand challenges.

12.7 **Bedfordshire and Luton Speech and Language Therapy**

12.7.1 Speech and Language Therapists posts remain hard to recruit to as previously reported, which impacts on service waits.

12.7.2 Historic funding shortfalls from each LA, and the ICB, contribute to longer wait times. LA non-recurrent funding has been agreed from both Luton and Central Bedford Council during the last period, with conversations progressing with the ICB.

12.7.3 Bedford Borough LA has invested in additional capacity over the last 14 months which has enabled the service to focus support with mainstream schools. During this time, the caseload numbers have reduced by more than 50%, with children's speech, language and communication needs being managed by the right level in the system graduated response. Waiting times for initial assessments in mainstream schools have reduced to 32 weeks as a result. This approach will be replicated in Central Bedfordshire and Luton.

12.8 **Cambridgeshire Community Paediatrics**

12.8.1 The Community Paediatric Service in Cambridgeshire has reduced its waiting times for assessment. This has been through increasing the number of ADOS (Autism Diagnostic Observation Schedule) assessments carried out by Psychology and engagement in a system wide pilot with Education colleagues – Early Identification in Autism (EIA) Project.

**13.0 Informal complaints received**

13.1 Fifty-five informal complaints were received and logged in this data period: 33 in June and 22 in July. Both months were within the expected variation based on 36 months of data.

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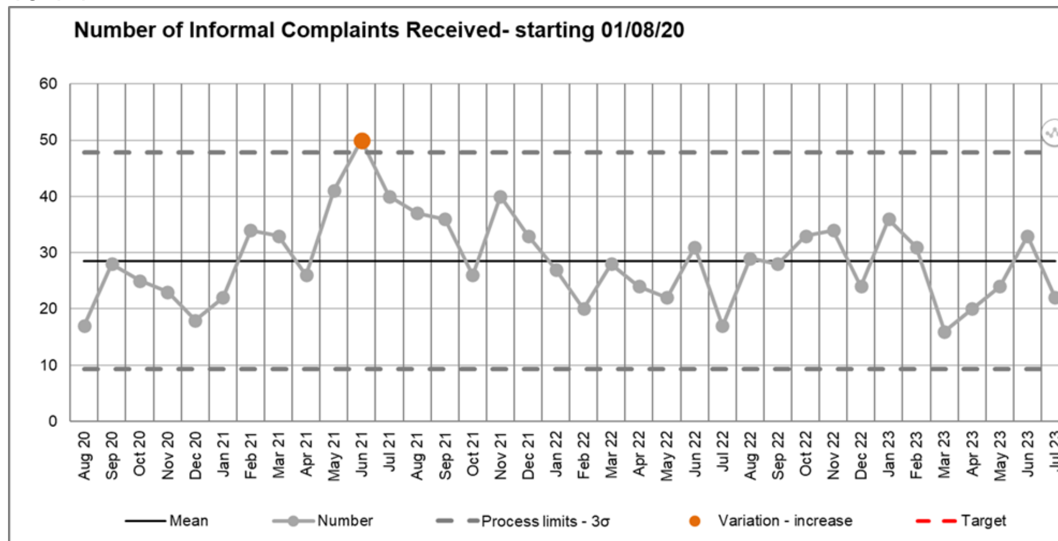
13.1.1




13.1.2 Fifty-four of 55 complainants were contacted within four working days to discuss resolution of their concerns. In the one remaining case three telephone calls were made within four working days but these were not answered by the complainant, contact was made outside of the timeframe and the informal complaint was successfully resolved.

**13.2 Themes and learning from informal complaints closed in June and July 2023**

13.2.1 Sixty-one informal complaints were resolved and closed in June and July, with 74 themes/ issues identified.

The top three themes of the informal complaints closed within this period were:

- Communication and Information (20).
- Clinical Care (19).
- Delays (12).

13.2.2 Four issues about Communication and Information were raised in three informal complaints about Norfolk and Waveney 0-19 Children's Services and four issues in four informal complaints about Cambridgeshire Children's Specialist Services. Several different actions have been undertaken following receipt of these informal complaints this has included discussions/ training with staff and reflective supervision/ practice.

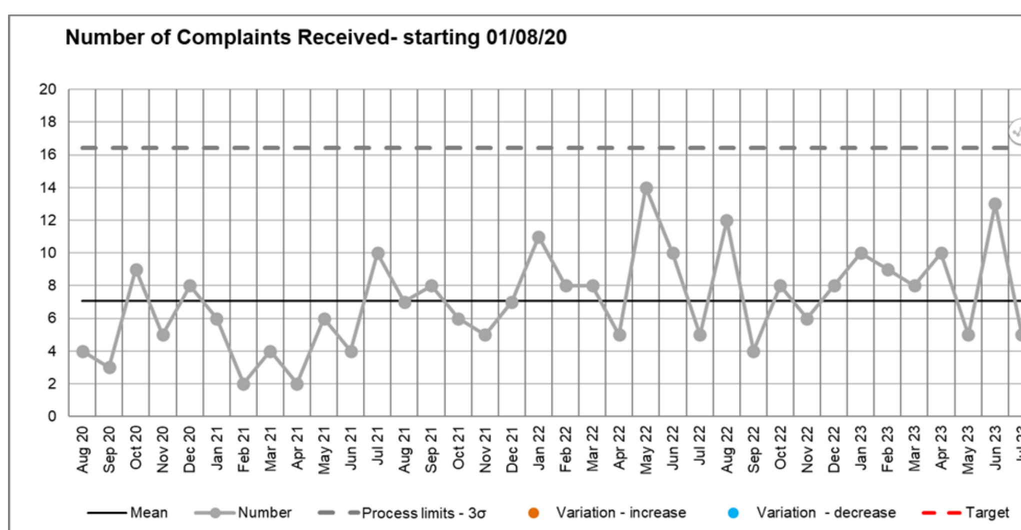
13.2.3 The Trust received three complaints about Cambridgeshire Children's Specialist Services related to referrals being declined by the Community Paediatric Service. Two complaints were not upheld, and one complaint was partially upheld. Learning from this complaint has resulted in caseload reviews taking place more often to ensure that issues are identified, and parents are kept up to date on progress.

13.2.4 Five of the informal complaints about Clinical Care were related to Dynamic Health Services, in three the service user was dissatisfied with the treatment provided. Investigation found that the correct treatment was given in two cases but in one case the treatment was not as expected due to a change in clinical staff. Two complainants believed that inappropriate treatment had been given, which was not upheld, however it was noted that there had been a communication issue in relation to first stage treatment in one of the cases.

13.2.5 Six of the informal complaints about Delays related to Bedfordshire Community Paediatric Services. Five were upheld, one was not upheld. Learning included the need to provide parents with realistic timeframes and updates during the waiting period.

**13.3 Formal Complaints**

13.3.1 The Trust received 18 formal complaints in this data period. Thirteen were received in June and five July. As shown in the graph below, this is within the expected range which means it is not significantly different to previous months, based on data for the number of complaints received since August 2020.




*NB It is impossible to have fewer than 0 complaints in a month, so the lower process limit is not shown on the graph above.*

13.3.2 From 1 July 2023 complaints related to Primary Care services will be managed by the local ICB rather than NHS England. Therefore, going forwards the Trust will work with ICBs in relation to these types of joint complaints.

**13.4 Themes and learning from formal complaints closed in June and July 2023**

13.4.1 Within this data period the Trust responded to and closed 19 formal complaints. In these there were 27 subjects/ themes identified.

13.4.2 Clinical care was the most frequently occurring subject identified in the complaints received followed by staff attitude, then communication/ information and delays.

13.4.3 Clinical Care and Communication and Information were also the most frequently occurring themes in the previous three reporting periods. Staff Attitude was the second most frequently occurring in the April and May period. A deep dive into the Communication and Information theme was presented at the People Participation Committee in August, further 'themed' reviews will be scheduled as part of the Quality Improvement and Safety Committee agenda.

13.4.4 Five of the formal complaints concerned Clinical Care relating to Bedfordshire Children's Specialist Services, two regarding Speech and Language Therapy and one for each of Continuing Care, Community Paediatrics and Occupational Therapy. In the two complaints about Speech and Language Therapy parents were dissatisfied with the treatment provided, however the investigation found that in both cases the therapy plan met the clinical needs of the child.

13.4.5 Three of the formal complaints in Clinical Care concerned Dental Services, two were not upheld. In the complaint that was upheld it was found that there was significant changes in oral health management between appointments, so the treatment options changed, this was not communicated effectively with the service user and their carer which resulted in them believing that required treatment was not being provided.

13.4.6 There were no themes in the services involved in formal complaints about Staff Attitude.

### 13.5 Formal Complaint Response Times

13.5.1 In this data period we responded to 20 formal complaints, (11 in June and nine in July). A summary of the response times is shown below:

| | April | May | June | July |
|---|---|---|---|---|
| Number of standard complaint responses sent within 35-day timeframe | 3/5 | 6/7 | 4/7 | 5/9 |
| Percentage of standard complaint responses sent within the 35-day timeframe | 60% | 85.71% | 57.14% | 55.65% |
| Number of complex complaint responses sent within 40-day timeframe | 0/1 | 0/2 | 2/4 | 0/0 |
| Percentage of complex complaint responses sent within 40-day timeframe | 0% | 0% | 50% | N/A |
| Average number of working days to respond to standard complaints | 36.17 | 34 | 35.4 | 34 |
| Average number of working days to respond to complex complaints | 45 | 49.5 | 42.3 | N/A |

13.5.2 There was improvement on the previous two months for the percentage of complex complaint responses sent within the 40 working day timeframes, but a reduction for standard complaint responses.

13.5.3 The average days to respond to standard complaints was just outside of the 35 working day target in June and within target for July. For complex complaints the average number of days was over the 40 working day timeframe in June, there were no complex responses sent in July. The reasons for delay are recorded and monitored and included investigation allocation and time taken to investigate the complaint (those which are complex or have safeguarding elements to them).

If a complaint response is delayed the complainant is kept fully informed of this and where appropriate provided with the reasoning for this.

**14.0 Demographics of complainants**

14.1 All complainants are asked to complete a form to provide demographic information about themselves and the service user if they are complaining on behalf of someone else. It is voluntary for complainants to provide this information. Since April 2023, one complainant has chosen to do so. There were no responses in June or July.

**15.0 Parliamentary Health Service Ombudsman (PHSO)**

15.1 There were no complaints referred to the PHSO or recommendations received from the PHSO in June or July.

# Be an Excellent Employer

## A: Assurance Summary

| | | |
|---|---|---|
| **Safe** | • staffing pressures are adequately controlled, plans agreed with commissioner for prioritising service delivery and service plans in place to reduce staffing pressures (**S5**) | **Reasonable** |
| **Effective** | • Mandatory training compliance is 91% - above target of 90% (**E1**)<br>• Overall Information Governance mandatory training levels at or above target level (95%). Achieved 92%. (**E2)**<br>• Appraisal rates 88.23% - target level 92% (**E3**)<br>• Monthly sickness rates in June 4.86% and in July 4.99% compared to latest NHS England rate for community Trusts of 5.19% for January 2023 (**E4**)<br>• Stability increased to 86.96% and is above target of 85% (**E5**)<br>• Equality Delivery System (EDS) objectives agreed and being delivered upon. (**E6**). | **Substantial** |
| **Well Led** | • Agency spend within agreed plan (**WL4**) | **Substantial** |

In addition to the overview and analysis of performance for June and July 2023 the Board can take assurance from the following sources:

- NHS National Staff Survey 2022 results where the Trust achieved a 47% response rate. Headline results were:
- Best performing or joint best performing NHS Trust in East of England in all 9 People Promise themes, including staff engagement.
- Care Quality Commission (CQC) inspection report published in August 2019. CQC rated the Trust as Outstanding overall and Outstanding within the caring and well-led domains. The inspection report highlights several areas that support the delivery of this objective.
- Workforce Assurance presentation at Board Development Session on 19th October 2022.
- The positive staff feedback the Trust has received via staff survey results in relation to speaking up.
- Risks 3533 and 3540 cover these pressures and are reviewed regularly.
- Discussions within the two Clinical Operational Boards that took place in July 2023.
- Update on the delivery of our People Strategy presented to the Board – May 2023.
- Annual Freedom to Speak Up report being presented to the Board – May 2023.

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## B: Risks to Achieving Objectives

### Strategic Risks

1. ***Risk ID 3533 -*** *There is a risk that the delivery of high-quality care will be adversely affected if staff morale falls and/or services experience significant workforce challenges. (Risk rating 12)*

2. ***Risk ID 3540 –*** *There is a risk that we do not have sufficient leadership capacity to deliver our overall trust strategy, strategic objectives, and operational service plans. (Risk rating 12 – reduced to 8 in August 2023)*

### Related Operational Risks 15 and above

1. ***Risk ID 3562*** *- There is a risk that safeguarding work across all localities is unable to be managed within the staffing capacity available and that this may result in children, young people and adults being left without adequate safeguarding measures. There is potential for the reduced staffing capacity impacting negatively on emotional wellbeing and so this risk is also linked to Issue 3531.*

## C: Overview and analysis

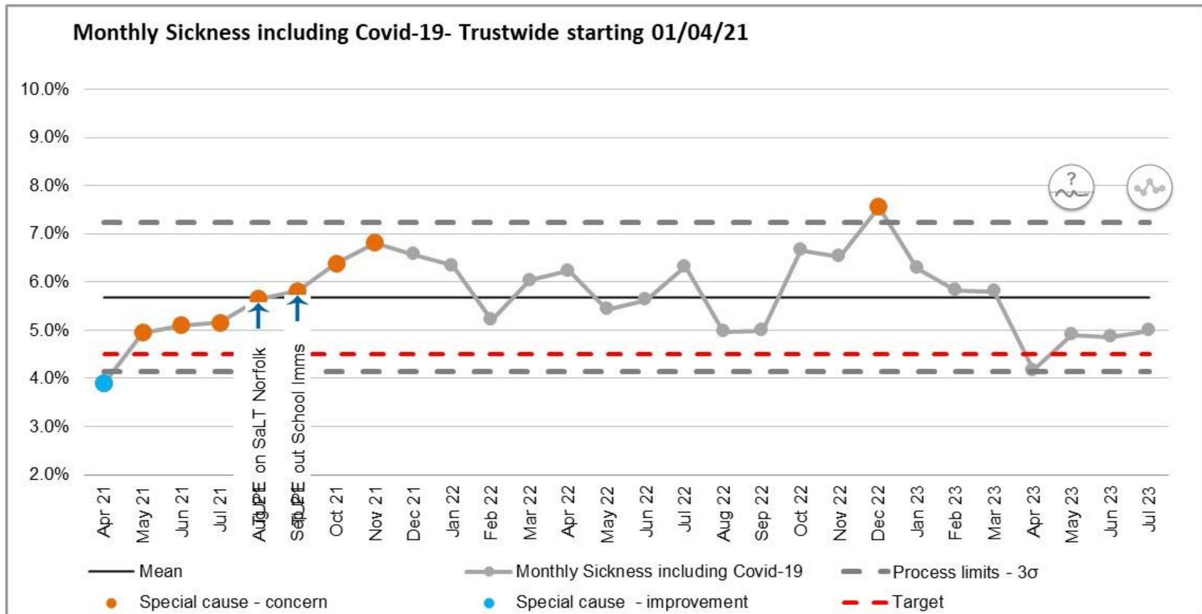
## 1.0 Sickness

1.1. The 12-month cumulative rolling rate (June 2023 –5.71%, July 2023 – 5.60%) remains above the Trust rolling target of 4.5%.

1.2. Monthly Trust wide rate for June 2023 was 4.86% and for July 2023 was 4.99%.

1.3. The Trust wide sickness rate has increased and remains above the Trust's target of 4.5% for 2023/24. Of the 4.99%, 2.49% was attributed to long term sickness and 2.50% short term sickness absence. Beds and Luton Adult Service had the highest sickness rate (7.53%) and Luton Children the lowest (3.01%). The top reason Anxiety/stress/depression/other psychiatric illnesses (19%); work continues to reduce those absences attributed to unknown/other reasons as much as possible.

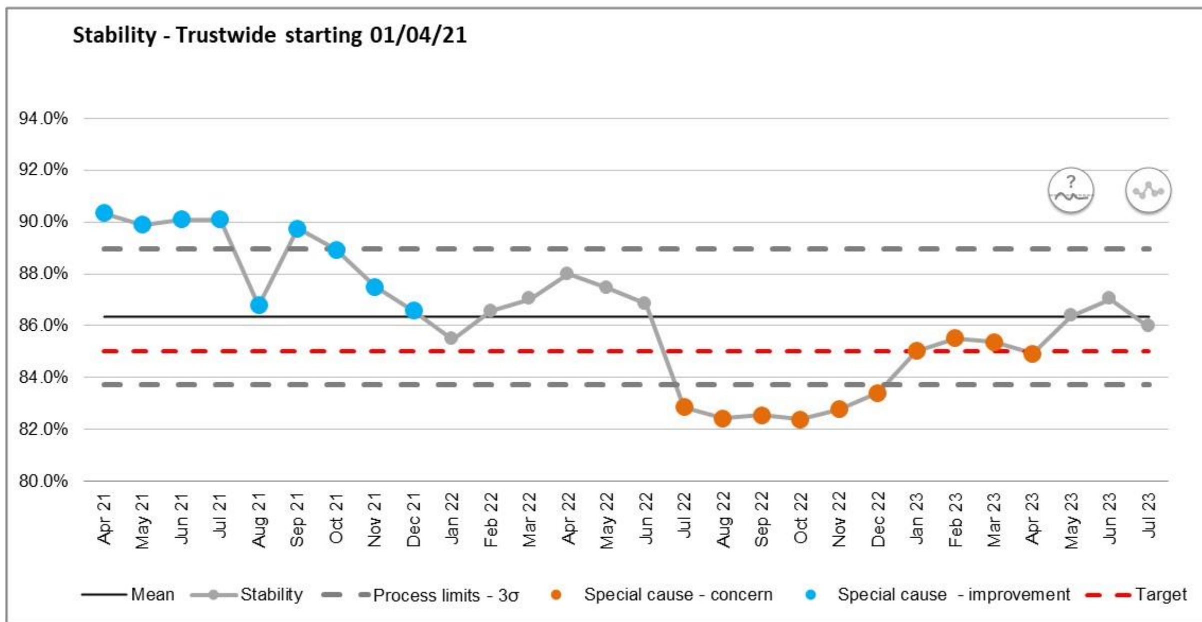
1.4. The Trust monthly sickness rate is below the March2023 benchmark reported for NHS Community Trusts (source: NHS Digital Workforce Statistics) which was 5.19%.




## 2. Stability

2.1. The following chart shows the monthly stability rate (percentage of staff employed over 1 year) – June 2023 87.04%, July 2023 85.96%, against the Trust target of 85%. This compares favourably to a stability rate of 84.5% for NHS Community Provider Trusts for all employees (source: NHS Digital Workforce Statistics, Apr 2023).

2.2. Stability rates for the Trust are based on the permanent workforce (i.e.: those on a fixed-term contract of less than one year are excluded).



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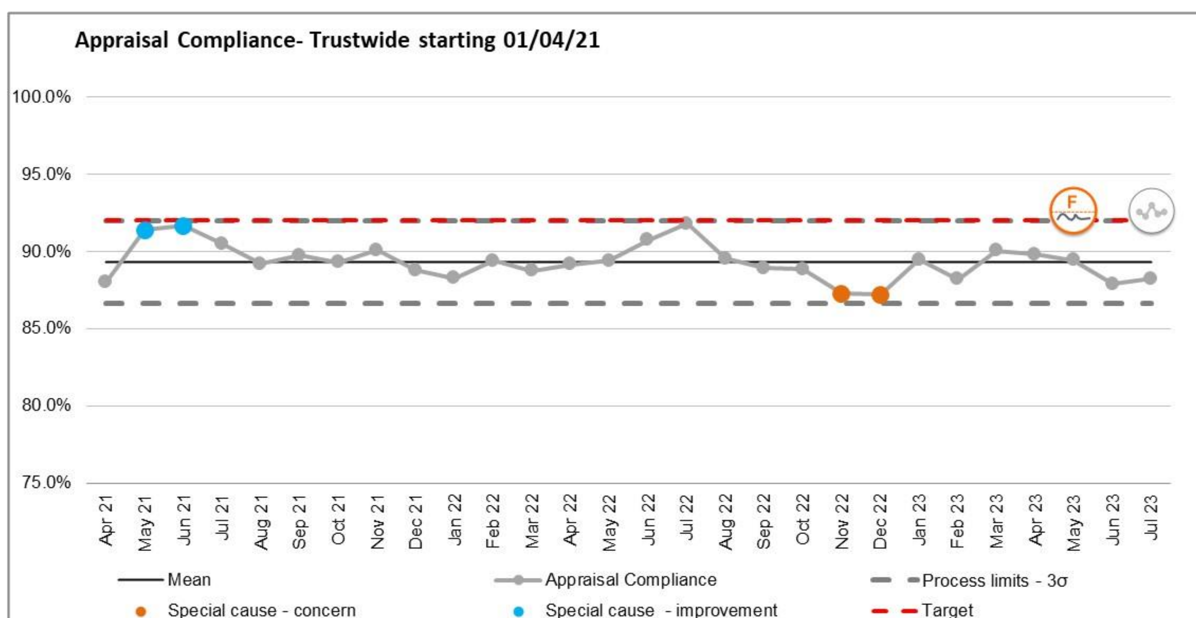
## 3. Appraisals

3.1. The following chart shows the percentage of available employees with a current (i.e., within last 12 months) appraisal date. Staff unavailable includes long term sickness, maternity leaves, those suspended, on career breaks or on secondment. New starters are given an appraisal date 12 months from date of commencement.

3.2. The Trust wide Appraisal rate increased slightly – June 2023 87.88%, July 2023 88.23%, and remains below the target of 92% for 2022/23.

3.3. Support Service has the lowest rate (81.48%), Beds & Luton Adults Service has the highest rate (92.57%). Employees, for whom a non-compliant date is held in ESR, are sent a reminder and this will continue to be done on a regular basis.




## 4. Turnover

4.1. The following chart shows monthly Turnover rates for the Trust which are based on the "Permanent" workforce (i.e., those employed on a current Fixed Term Contract of less than one year are excluded). Leavers for the following reasons are also excluded: Voluntary Redundancies, end of a FTC, MARs and Employee Transfers.

4.2. The Trust's Rolling Year Turnover Rate is currently 13.54% (June 2023 13.74%, July 2023 13.54%) compared to an annual average Leaver rate for Community Provider Trusts of 15.4% (Source: NHS Digital Workforce Statistics – Apr 2023, based on "all Leavers" and "total Workforce").

4.3. Ambulatory Care Service currently has the highest Rolling Year turnover rate at 14.34%, with Support Services having the lowest at 8.74%.

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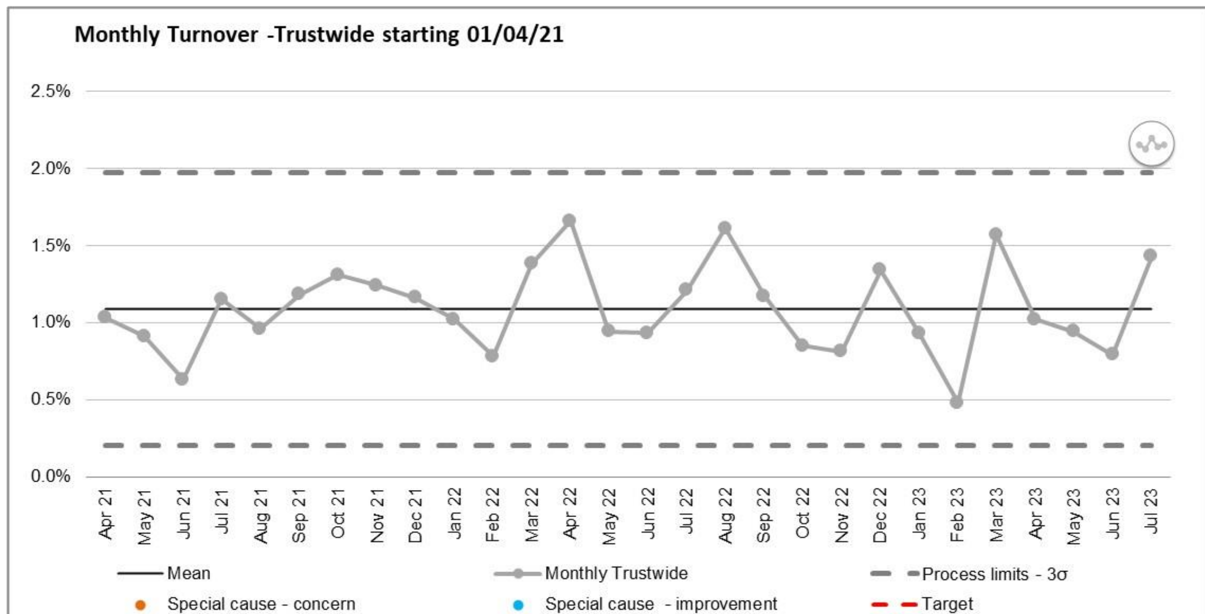


**5. Current workforce challenges**

5.1 At our Clinical Operational Boards in September 2023 current workforce challenges were discussed across our portfolio of services. Where these are impacting on our delivery of care, further details can be found in the outstanding care section of this report.

5.2 The Trust continues to focus on delivery of the recruitment and retention plan for our 0-19 Healthy Child Programme services across the Trust. A revised staffing model has been developed and is being worked up across all our 0-19 services to enable a Universal, Targeted and Specialist offer to be delivered.

**6. Diversity and Inclusion for All – Programme 2 People Strategy**

6.1 **Equality Delivery System 2022 (EDS22) – Local Workforce Objectives – 23/24**

6.1.1 The Board agreed its EDS 2022, 2023/24 objectives in March 2023. The 3 domains are:

- Domain 1: Commissioned or provided services.
- Domain 2: Workforce health and well-being.
- Domain 3: Inclusive leadership.

6.1.2 The objectives agreed for domains 2 and 3 are:

**Domain 2: Workforce health and well-being**

- To work with our Occupational Health providers to support staff to manage obesity, diabetes, asthma, COPD, and mental health conditions.

- We will take all reasonable steps to prevent abuse of any kind and will always act to support staff when it does occur.

**Domain 3: Inclusive leadership**

- To continue to work towards achieving the Trust Board's anti-racism pledge.
- Ensure that all Trust Board/Committee papers/reports detail how they are addressing health inequalities.

6.1.3 Under **Domain 2**, we have published information to support staff with these conditions on our Live Life Well pages. We will offer others support once an offer is agreed with our OH provider.

6.1.4 A small group was established, chaired by our Assistant Director for Organisational and System development, to identify additional actions to prevent abuse towards our people. A number of improvement actions/activities were identified, and these are now being actioned both trust-wide and locally within services/teams. In addition, Kate Howard (Chief Nurse) led a discussion on this at Leadership Forum in September, raising the profile of our Zero tolerance commitment and actions being undertaken.

6.1.5 Under **Domain 3** our Trust anti-racism plan for 23-24 is in place alongside our UNISON pledge and Board member personal pledges. New Board members are in the process of agreeing their own personal pledges and these will be shared across the Trust at a later date.

6.1.6 The template for all Trust Board and Committee papers has been updated to include how the report addresses health inequalities, if appropriate.

6.2 **Diversity on Recruitment Panels**

6.2.1 The Board will recall in April 2023 we mandated that all recruitment panels will have a culturally diverse individual on them, this was in response to our delivery of the national 'no more tick boxes' recommendations which is focused on removing any discrimination from our recruitment and onboarding systems and processes.

6.2.2 This is proving challenging in some areas, and we are working in partnership with our Cultural Diversity Network to continuously review and update the way that we are implementing this.

6.3 **Update on Staff Networks**

6.3.1 In response to feedback, a new Staff Network was launched in June 2023. This network is for anyone with caring responsibilities. The first meeting was very well attended. It was clear from the conversations that there is a need for peer support in this area and it was agreed to establish this as a formal network.

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6.3.2 The network is being jointly chaired by Eva King, Senior Dental Officer and Sharon Lapoe, Contracts Administrator. Next meeting is due to take place on 13th September 2023.

6.4 **NHS England Equality, Diversity, and Inclusion Improvement Plan**

6.4.1 NHS England have published six high impact actions that they expect all Trusts to implement, and these are detailed below. Most of the areas identified are already part of our overall People Strategy. Progress on these will be reported through our People Participation Committee.

| High Impact Action | Actions |
|---|---|
| **Action 1**<br><br>**Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable** | Every board and executive team member must have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and be assessed against these as part of their annual appraisal process (by March 2024). |
| | Board members should demonstrate how organisational data and lived experience have been used to improve culture (by March 2025). |
| | NHS boards must review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework (by March 2024). |
| **High Impact Action** | **Actions** |
| **Action 2**<br><br>**Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity** | Create and implement a talent management plan to improve the diversity of executive and senior leadership teams (by June 2024) and evidence progress of implementation (by June 2025). |
| | Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan. This should include the creation of career pathways into the NHS such as apprenticeship programmes and graduate management training schemes (by October 2024). Impact should be measured in terms of social mobility across the integrated care system (ICS) footprint. |
| **High Impact Action** | **Actions** |
| **Action 3**<br><br>**Develop and implement an improvement plan to eliminate pay gaps** | Implement the Mend the Gap review recommendations for medical staff and develop a plan to apply those recommendations to senior non-medical workforce (by March 2024). |
| | Analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards. Reflecting the maturity of current data sets, plans should be in place for sex and race by 2024, disability by 2025 and other protected characteristics by 2026. |
| | Implement an effective flexible working policy including advertising flexible working options on organisations' recruitment campaigns. (March 2024). |
| **High Impact Action** | **Actions** |

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| | |
|---|---|
| **Action 4**<br><br>**Develop and implement an improvement plan to address health inequalities within the workforce** | Line managers and supervisors should have regular effective wellbeing conversations with their teams, utilising resources such as the national NHS health and wellbeing framework. (By October 2023). |
| | Work in partnership with community organisations, facilitated by ICBs working with NHS organisations and arm's length bodies, such as the NHS Race and Health Observatory. For example, local educational and voluntary sector partners can support social mobility and improve employment opportunities across healthcare (by April 2025). |
| **High Impact Action** | **Actions** |
| **Action 5**<br><br>**Implement a comprehensive induction, onboarding and development programme for internationally recruited staff** | Before they join, ensure international recruits receive clear communication, guidance and support around their conditions of employment; including clear guidance on latest Home Office immigration policy, conditions for accompanying family members, financial commitment and future career options (by March 2024). |
| | Create comprehensive onboarding programmes for international recruits, drawing on best practice. The effectiveness of the welcome, pastoral support and induction can be measured rom, for example, turnover, staff survey results and cohort feedback (by March 2024). |
| | Line managers and teams who welcome international recruits must maintain their own cultural awareness to create inclusive team cultures that embed psychological safety (by March 2024). |
| | Give international recruits access to the same development opportunities as the wider workforce. Line managers must proactively support their teams, particularly international staff, to access training and development opportunities. They should ensure that personal development plans focus on fulfilling potential and opportunities for career progression (by March 2024). |
| **High Impact Action** | **Actions** |
| **Action 6**<br><br>**Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur** | Review data by protected characteristic on bullying, harassment, discrimination and violence. Reduction targets must be set (by March 2024) and plans implemented to improve staff experience year-on-year. |
| | Review disciplinary and employee relations processes. This may involve obtaining insights on themes and trends from trust solicitors. There should be assurances that all staff who enter formal processes are treated with compassion, equity and fairness, irrespective of any protected characteristics. Where the data shows inconsistency in approach, immediate steps must be taken to improve this (by March 2024). |
| | Ensure safe and effective policies and processes are in place to support staff affected by domestic abuse and sexual violence (DASV). Support should be available |

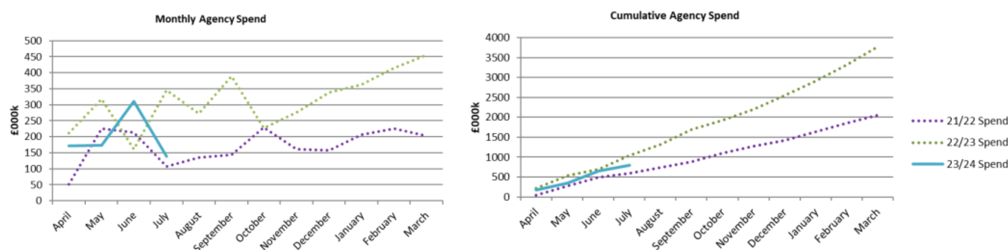
| | |
|---|---|
| | for those who need it, and staff should know how to access it. (By June 2024). |
| | Create an environment where staff feel able to speak up and raise concerns, with steady year-on-year improvements. Boards should review this by protected characteristic and take steps to ensure parity for all staff (by March 2024). |
| | Provide comprehensive psychological support for all individuals who report that they have been a victim of bullying, harassment, discrimination, or violence (by March 2024). |
| | Have mechanisms to ensure staff who raise concerns are protected by their organisation. |

**7. Trust Wide Staff Survey Improvement Actions**

7.1 Since the last reporting period we have launched our conversations with our culturally diverse employees in relation to understanding more fully the disparity that we saw in last year's staff survey. We saw a 23% difference in relation to their experience of equal opportunities and career progression compared to our white members of staff. We have launched these conversations in our Bedfordshire and Luton Community Adult Services and have a rolling programme in place to ensure all individuals are offered this focussed conversation by end March 2024.

7.2 Feedback and any themes will be included as part of our bi-annual update on delivery of our Trust-wide People Strategy.

**8. Agency/bank spend**




8.1 The Trust's cumulative agency spend at month 4 was £794k. The spend in the equivalent period in 2022/23 was £986k (excluding mass vaccination service spend).

8.2 The highest areas of spend were in Community Paediatrics in Luton and Bedford, £338k and £159k respectively. Usage has started to reduce in June, and this spend has been partially funded. There has been spend also for the Integrated Front Door service, £117k, which is fully funded.

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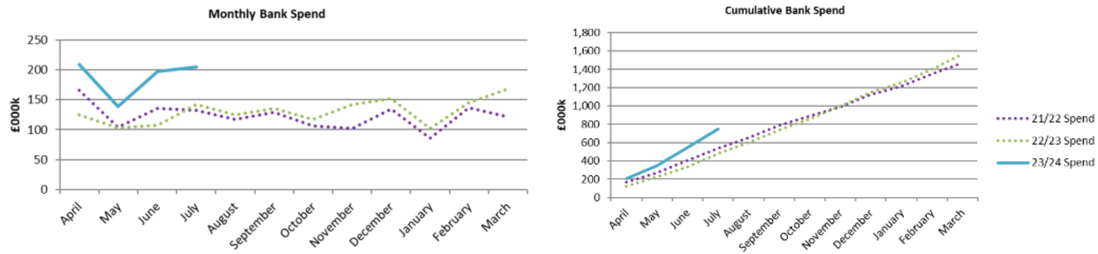



8.3 To reduce the usage of agency, the services have the availability of bank staff to fill short term staffing pressures. The Trust's cumulative bank spend at month 4 was £750k. This is higher than the equivalent period in 2022/23, when spend was £478k (excluding mass vaccination service spend).

8.4 The highest areas of spend were Healthy Child Programme in Norfolk, Cambs and Bedford, with £122k, £100k and £79k respectively, and District Nursing in Luton with £98k.

# Be Sustainable

## A: Assurance Summary

<table>
<tr><td rowspan="3">Well led</td><td>WL1 I&E in line with budget</td><td rowspan="3">Substantial</td></tr>
<tr><td>WL2 Delivery against efficiency target in line with plan</td></tr>
<tr><td>WL3 Capital spend in line with budget</td></tr>
</table>

1. In accordance with the Trust's Assurance Framework, the Board receives assurance from the reporting of the Trust's financial sustainability and performance from Strategic Risks 3514 and 3529, and Clinical Operational reporting of financial performance and escalation processes.

2. The Trust Board will also take assurance from External Auditor's Unqualified opinion and its "Value for Money conclusion" of the Trust's 2022/23 accounts. Internal Auditor's assessments during 2022/23 provided a conclusion that the Trust has an adequate and effective framework for risk management, governance, and internal control. The Trust's Local Counter Fraud Service (LCFS) annual report included a summary of work carried out during the year which concludes the Trust has a strong anti-fraud culture.

3. The Trust's financial performance for the period to date is in line with budget, however due to increased pay and non-pay inflation and the demand on our services above existing funding, there is an increased risk to delivering the Trust's overall financial target for 2023/24. These pressures are also impacting the identification of the Trust's Efficiency programme summarised in Section 5 of this report.

4. The Trust has progressed negotiations with a number of its Local Authority Commissions and additional funding has been agreed which will in part mitigate in part these increasing financial challenges. Discussions are also in progress with all key commissioners to identify a range of service interventions that can ensure financial sustainability and safe delivery of services.

## B: Risks to achieving objective

### Strategic risks

1. ***Risk ID 3514*** – *There is an increased risk of cyber-attack upon the Trust which could result in a potential loss or disablement of services which would directly impact patients, service users and staff. (Risk Rating 12).*

2. ***Risk ID 3529*** – *Failure to deliver our financial plan (on a sustainable basis addressing the increasing cost pressures and the challenging efficiency target and our contribution to the wider system) could impact on the development and innovation of our services resulting in reduced quality of care. (Risk rating 12)*

# Be Sustainable

**Related Operational Risks 15 and above**

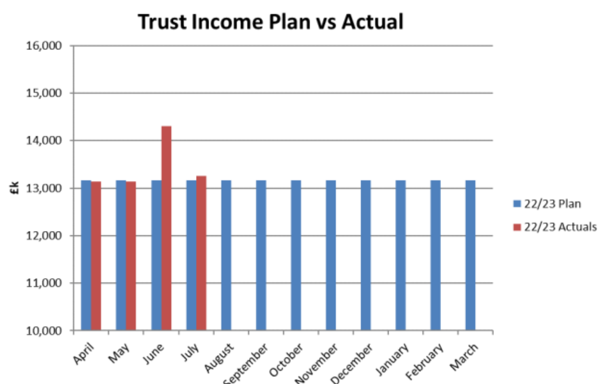
1. ***Risk ID 3562 -*** *There is a risk that safeguarding work across all localities is unable to be managed within the staffing capacity available and that this may result in children, young people and adults being left without adequate safeguarding measures. (Risk rating 16)*
   *There is potential for the reduced staffing capacity impacting negatively on emotional wellbeing and so this risk is also linked to Issue 3531.*

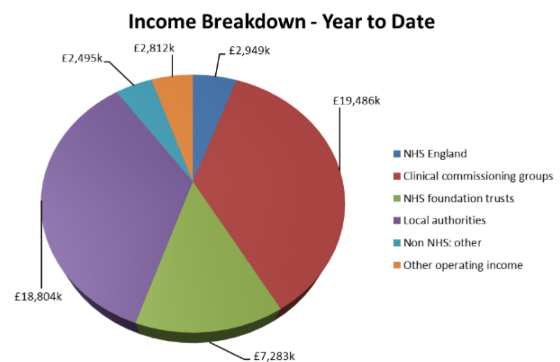
## C: Overview and analysis

### Finance scorecard

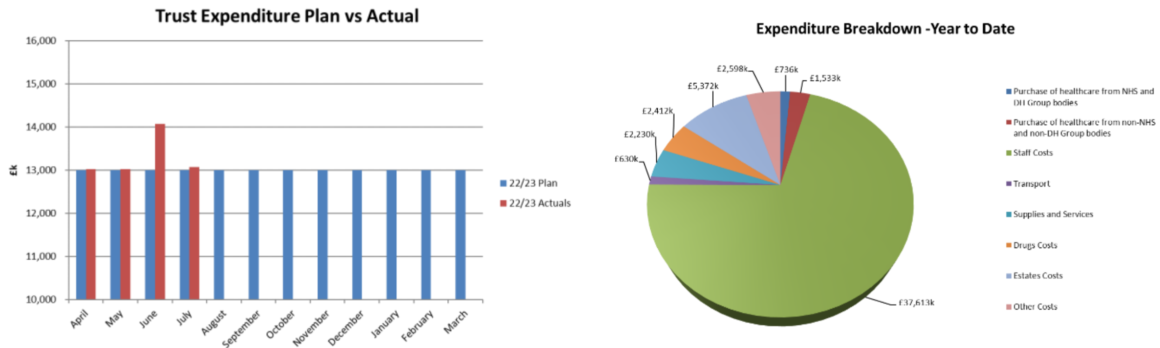
| Finance Dashboard | Section in Report | Plan M4 | Actual M4 | Variance M4 |
|---|---|---|---|---|
| Operating income | 1 | £52,662k | £53,829k | £1,167k |
| Employee expenses | 1 | (£35,402k) | (£37,566k) | (£2,164k) |
| Operating expenses excluding employee expenses | 1 | (£16,618k) | (£15,558k) | £1,060k |
| Trust Surplus/(Deficit) | 1 | £0k | £0k | £0k |
| Closing Cash Balance | 2 | | £3,662k | |
| Capital Programme | 4 | £1,572k | £1,548k | (£24k) |
| Agency Spend | SO2 - 4 | £572k | £794k | (£222k) |
| Bank Spend | SO2 - 4 | £450k | £750k | (£300k) |

## 1. Income and expenditure



# Be Sustainable




1.1 Block contract income funding arrangements remain in place for ICBs, NHSE and Local Authority Public Health Commissioners for 2023/24.

1.2 The Trust will analysing the main cost drivers, which have been affected by the increased inflationary pressures, to inform accurate forecasting during the year, and budgets will be adjusted following the increase in cost and funding for the NHSE pay award.

1.3 The Agenda for Change pay award for 2022/23 and 2023/24 was processed and paid to employees in June 2023. The Trust received funding for the 2022/23 payment and an uplift in contracts for the 2023/24 increase.

1.4 The clinical services direct budget position as at July 2023 for each Service Division is:

| Division Level | Income £'000 | Pay £'000 | Jul-23<br>Non-Pay £'000 | Net Total £'000 | Net Budget £'000 | Variance £'000 |
|---|---|---|---|---|---|---|
| Ambulatory Care Service | 778 | (7,498) | (3,903) | (10,623) | (10,172) | (451) |
| Bedfordshire Community Unit | 650 | (5,443) | (825) | (5,618) | (5,517) | (101) |
| Childrens & Younger Peoples Services | 3,359 | (12,834) | (1,486) | (10,961) | (11,315) | 354 |
| Luton Community Unit | 373 | (8,025) | (1,977) | (9,629) | (10,004) | 375 |
| Other Services (see breakdown below) | 48,671 | (3,768) | (8,072) | 36,831 | 37,008 | (177) |
| **CCS Total @ 31st July 2023** | **53,831** | **(37,568)** | **(16,263)** | - | - | - |
| | | | | | | |
| **Other Services** | | | | | | |
| Contract Income and Reserves | 44,493 | 223 | (25) | 44,691 | 44,325 | 366 |
| Corporate Services | 2,328 | (3,985) | (4,978) | (6,635) | (6,119) | (516) |
| Estates | 1,850 | (6) | (3,069) | (1,225) | (1,198) | (27) |
| | **48,671** | **(3,768)** | **(8,072)** | **36,831** | **37,008** | **(177)** |

1.5 Ambulatory Care Services delivered a cumulative overspend of £451k to month 4. The main reasons for the cumulative overspend are due to establishment funding and budget pressures across the division and non-pay expenditure pressures in the iCaSH services. The main areas of cost pressure are in pathology, testing and drugs due to increased activity. Proactive negotiations continue with iCaSH commissioners with proposals for additional funding to cover increases in activity.

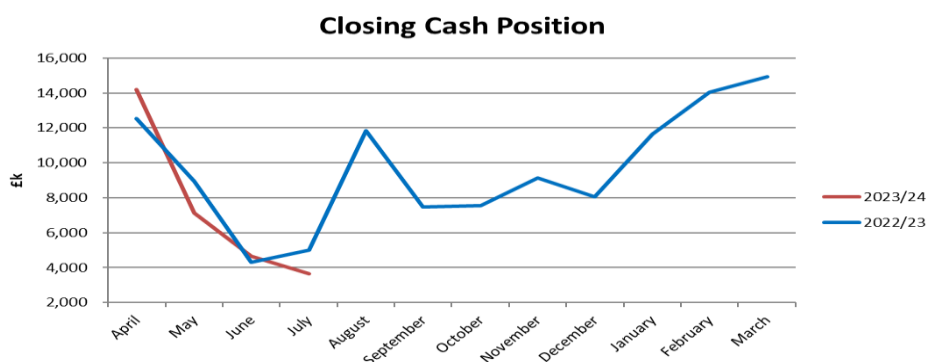
1.6 Bedfordshire Community Unit delivered a cumulative overspend of £101k to month 4. The main reason for the overspend is due to establishment pressures. There has been a recent increase in vacancies across the service, which will help reduce the overspend.

1.7 Children's & Younger Peoples Services delivered a cumulative underspend of £354k to month 4. The main reason for the cumulative underspend is vacancies across the services.

1.8 Luton Community Unit (including Luton Children's Services) delivered a cumulative underspend of £375k to month 4. The cumulative underspend position is due to establishment savings across Adult services.

1.9 The Contract Income and Reserves year to date position includes income for services provided to the Integrated Commissioning Boards and Public Commissioners and Reserves used Trust wide to support service delivery. The overspend variance to date of £177k is mainly to offset the net cost improvement support agreed with services ahead of formal plans being delivered.

## 2. Cash position




2.1 The cash balance of £3.7m at month 4 represents an overall decrease of £3.5m on the previously reported position at month 2. The change in the Trust's cash position is due payment for outstanding supplier payables.

## 3. Statement of Financial Position

| | July 2023 £'000 | May 2023 £'000 |
|---|---|---|
| **Non-Current Assets** | | |
| Property, plant and equipment | 61,492 | 63,514 |
| Right of use assets | 23,070 | 27,024 |
| Intangible assets | 153 | 179 |
| **Total non-current assets** | **84,715** | **90,717** |
| | | |
| **Current assets** | | |
| Inventories | 56 | 56 |
| Trade and other receivables | 30,678 | 31,661 |
| Cash and cash equivalents | 3,662 | 7,125 |
| **Total current assets** | **34,396** | **38,842** |
| | | |
| **Total assets** | **119,111** | **129,559** |
| | | |
| **Current liabilities** | | |
| Trade and other payables | (17,443) | (24,256) |
| Borrowings | (2,807) | (3,267) |
| Provisions | (670) | (670) |
| **Total current liabilities** | **(20,920)** | **(28,193)** |
| | | |
| **Net current assets** | **13,476** | **10,649** |
| | | |
| **Total assets less current liabilities** | **98,191** | **101,366** |
| | | |
| **Non-current liabilities** | | |
| Trade and other payables | 0 | 0 |
| Borrowings | (20,388) | (23,889) |
| Provisions | (847) | (847) |
| **Total non-current liabilities** | **(21,235)** | **(24,736)** |
| | | |
| **Total assets employed** | **76,956** | **76,630** |
| | | |
| **Financed by taxpayers' equity:** | | |
| Public dividend capital | 12,683 | 12,683 |
| Retained earnings | 41,925 | 41,599 |
| Revaluation Reserve | 24,001 | 24,001 |
| Merger Reserve | (1,653) | (1,653) |
| **Total Taxpayers' Equity** | **76,956** | **76,630** |

3.1 The main movements in the reporting period were Trade and other receivables which decreased by £1.0m and Trade and other payables which also decreased over the reporting period by £6.8m.

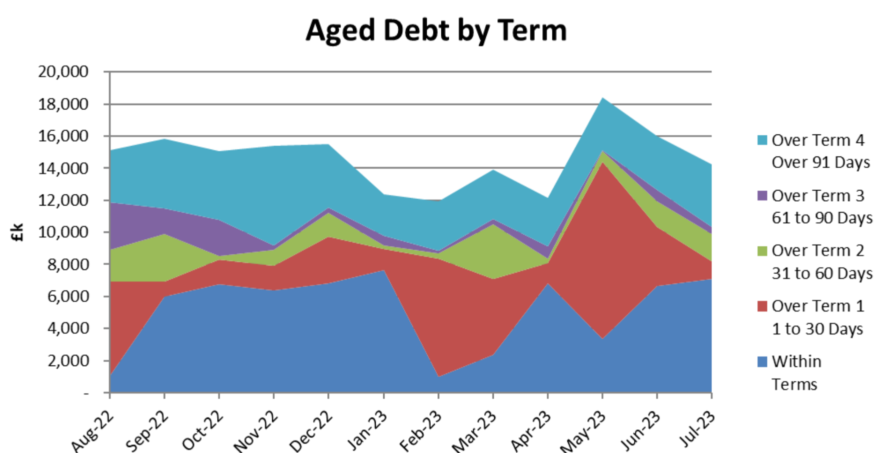
# Be Sustainable

## 3.2 Statement of Cashflow

| Cash Flow | Apr-23 & May-23 | Jun-23 | Jul-23 |
|---|---|---|---|
| **Cash flows from operating activities** | **(£'000)** | **(£'000)** | **(£'000)** |
| Operating surplus/(deficit) | 305 | 224 | 176 |
| Depreciation and amortisation | 1,019 | 492 | 441 |
| (Increase)/decrease in receivables | (4,875) | 9,611 | (1,863) |
| (Increase)/decrease in other current assets | 0 | 0 | 0 |
| (Increase)/decrease in other assets | 0 | 0 | 0 |
| (Increase)/decrease in inventories | 0 | 0 | 0 |
| Increase/(decrease) in trade and other payables | (3,416) | (11,818) | 730 |
| Increase/(decrease) in other liabilities | 496 | 0 | 0 |
| Increase/(decrease) in provisions | 0 | 0 | 0 |
| **Net cash generated from / (used in) operations** | **(6,471)** | **(1,491)** | **(516)** |
| **Cash flows from investing activities** | | | |
| Purchase of property, plant and equipment and investment property | (522) | (557) | (64) |
| Proceeds from sales of property, plant and equipment and investment property | 0 | 0 | 0 |
| Initial direct costs, up-front payments and (lease incentives) in respect of new right of | 0 | 0 | 0 |
| **Net cash generated from/(used in) investing activities** | **(522)** | **(557)** | **(64)** |
| **Cash flows from financing activities** | | | |
| Public dividend capital received | 0 | 0 | 0 |
| Public dividend capital repaid | 0 | 0 | 0 |
| Capital element of lease liability payments | (494) | (208) | (227) |
| Interest element of lease liability payments | (44) | (13) | (18) |
| PDC dividend (paid)/refunded | (261) | (211) | (158) |
| **Net cash generated from/(used in) financing activities** | **(799)** | **(432)** | **(403)** |
| **Increase/(decrease) in cash and cash equivalents** | **(7,792)** | **(2,480)** | **(983)** |
| **Cash and cash equivalents at the beginning of the period** | **14,917** | **7,125** | **4,645** |
| **Cash and cash equivalents at the end of the period** | **7,125** | **4,645** | **3,662** |

3.3 Cashflow for the year has decreased due to the payment of two capital bonds, totalling £7.6m, where cash funding was received in 2022/23 and the delayed payment from local authority receivables.

3.4




3.5 Total Trade Receivables decreased by £2.4m in June to £16.0m and then decreased again by £1.7m in July to £14.3m. The breakdown in July is £2.7m (19%) from NHS organisations; £10.1m (71%) from Local Authorities; and £1.4m (10%) from other parties.

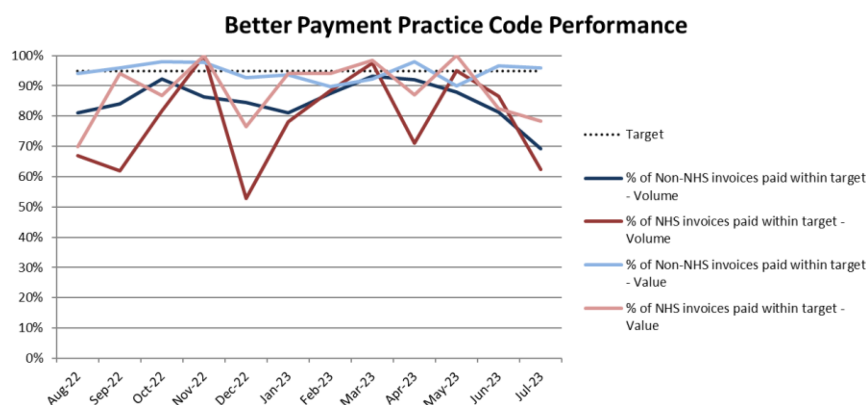
3.6 Of the receivables over terms, the main organisations contributing to the balances are:

| | |
|---|---|
| Norfolk County Council | £3.3m |
| Cambridgeshire County Council | £3.2m |
| Luton Borough Council | £1.7m |
| East London NHSFT | £1.5m |

3.7 For the debt over 90 days old, as this is predominantly due from NHS and Local Authority bodies, it is not deemed necessary to raise a Provision against these balances as the risk of non-recovery is low. After this reporting period, Norfolk CC paid £2.8m, Cambridgeshire CC paid £1.6m, Luton BC paid £1.5m and East London NHSFT paid £1.5m and to reduce their outstanding balances.

3.8 The finance team has implemented a more stringent monitoring process for Local Authority bodies debt to ensure any overdue receivables are paid promptly in order to support the cash flow position.

## 4. Public sector prompt payments




4.1 The average in month prompt payment results across the four categories was 87% in month 3 and 77% in month 4.

4.2 With regards to NHS invoices, performance declined from in month 3 and again in month 4, with the Trust achieving an average of 75% in volume and 80% in value across the two periods. The Trust is working hard to consistently improve NHS payment performance and performance is expected to improve in August.

4.3 With regards to Non-NHS invoices, achievement in both categories has remained relatively consistent in the last 12 months – with an average of 90% achievement over this period. Over months 3 and 4, the average achievement in each category is 75% and 97% for Volume and Value respectively, which is a decline in the Volume category but an improvement in Value on the previous reporting period.

4.4 The Finance team will continue to work closely with the teams and services to ensure all invoices are processed promptly. Further processes are being implemented to increase the monitoring of invoices and improve their allocation to services.

## 5. Capital

5.1 Capital spend on CCS core projects was £1.5m against a plan of £1.6m. The main area of spend is the continued development works at North Cambs Hospital in Wisbech and spend has returned in line with planned spend year to date. The capital programme is expected to deliver on the plan for the year.

5.2 The Trust received Public Dividend Capital in March 2023 to fund works at North Cambs Hospital and Princess of Wales Hospital. The works support the national Community Diagnostic Centres (CDC) scheme which is part of delivering the Diagnostic recovery and renewal programme.

5.3 The value of completed works at month 4 for the CDC projects are £2.3m at Ely, £2.4m for North Cambs Hospital and £1.4m for the MSCP at Ely.

## 6. Efficiency Programme

6.1 The table below summarise the identified Cost Improvement Plans identified to date and in progress against the Trusts overall target for 2023/24.

| Department | PLAN FYE 2023.2024 £'000 |
|---|---|
| Ambulatory Care Service | 275 |
| Bedfordshire Community Unit | 422 |
| Childrens & Younger Peoples Services | 28 |
| Luton Community Unit | 297 |
| Corporate Services | 1,212 |
| CIP in Development/to be Developed | 2,873 |
| **Grand Total** | **5,107** |

6.2 There continue to be challenges in identifying recurrent efficiencies alongside the pressure of increasing unfunded costs due to inflation and demand.

6.3 The agreement of additional funding will have a positive impact on the delivery against the target, and the Trust has invested in additional management resource to support all services in identifying further efficiencies.

6.4 The year-to-date position is being delivered by efficiencies identified to date and non-recurrent savings in discretionary budgets, and the Finance team will continue to work with and support services in identifying additional efficiencies to support the delivery of planned target.