TRUST BOARD

Cambridgeshire Community Services NHS Trust

Title:	**Integrated Governance Report**
Action:	**For DISCUSSION**
Meeting:	**20th May 2021**

Purpose:
The global Covid-19 pandemic continues to dominate work within the Trust both in terms of continuing to manage through the existing pressures whilst at the same time also managing through winter and mobilising mass vaccination for Covid-19, in conjunction with our health and care system partners.

This report and Clinical Operational Boards integrated reports operates in line with the new way of working during Covid-19 and this report provides an overview of quality, performance, workforce and finance for February and March 2021 assessed in relation to the Trust's strategic objectives and associated risks of achieving these objectives.

For each objective, the 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 domains of safe, caring, effective of safe, caring, effective, responsive and well led.

Executive Summary:
The Integrated Governance Report provides a summary of Trust performance against each objective during February and March 2021 the assurance set out in each domain.

Exceptions are reported against each of the four strategic objectives within the Integrated Governance Report attached.

Recommendation:
The Board is asked to review the assessment of assurance set out above and in the assurance summary for each objective as outlined in the report and satisfy itself that the information contained in the Report supports this summary.

Supporting Information:

Appendix 1: Quality Performance Dashboard
Appendix 2: IPaC Board Assurance Framework – April 2021
Appendix 3: Health and Safety Executive (HSE) IPaC Covid19 Assurance Framework
Appendix 4: Strategic Risks and Operational Risks 15 and above
Appendix 5: Assurance Framework
Appendix 6: Statistical Process Control Chart Key

	Name	Title
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Trust Objectives

Objective	**How the report supports achievement of the Trust objectives:**
Provide outstanding care	The report assesses quality, performance, workforce and finance against each of the Trust's objectives
Collaborate with others	The report assesses quality, performance, workforce and finance against each of the Trust's objectives
Be an excellent employer	The report assesses quality, performance, workforce and finance against each of the Trust's objectives
Be a sustainable organisation	The report assesses quality, performance, workforce and finance against each of the Trust's objectives

Trust risk register
The report assesses the strength of assurance provided in relation to the Trust's strategic risks and high scoring operational risks

Legal and Regulatory requirements:
All CQC Key Lines of Enquire and fundamental standards of care are addresses in this report

Diversity and Inclusion implications:

Objective	**How the report supports achievement of objectives:**
To re-launch the Trust Staff Diversity Network and, where staff indicate a desire, to establish protected characteristics specific sub networks. The Networks to be a forum for staff to share experiences, review the Trust Diversity and Inclusion Policy and practices and to give feedback and suggestions on how the Trust can support its diverse workforce and seek to eliminate any bias.	This report covers an update on the BAME network.
To introduce reverse mentoring into all our in house management and leadership development programmes, to promote diverse leadership through lived experiences.	This project is covered by the Workforce Diversity and Inclusion Group.
We will measure the impact of our virtual clinical platforms, ensuring that they are fully accessible to the diverse	This project is covered by the People Participation

communities we serve.	Committee and is reported in a separate part of the Board meeting.
We will ensure that the recruitment of our volunteers are from the diverse communities they serve.	This project is covered by the People Participation Committee and is reported in a separate part of the Board meeting.

Are any of the following protected characteristics impacted by items covered in the paper:

Age	Disability	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and Maternity	Race	Religion and Belief	Sex	Sexual Orientation
☐	☐	☐	☐	☐	☐	☐	☐	☐

CONTENTS **Page No.**

Part One – Assurance Summary and Performance for February and March 2021

Part Two – Supporting Information

SO1 Provide outstanding care

A: Assurance Summary

Overall assurance rationale:

Safe	• 95% of incidents are low or no harm (Trust target 90%) (**S1**) • There were 0 Serious Incidents reported in February and 1 in March 2021, investigation underway, learning to be applied once identified. • No Never Events were reported in this timeframe. (**S2**) • There were no healthcare acquired infections • There were no Covid19 staff outbreaks (**S5**) • The staff flu campaign 2020 commenced on 5 October (update as of 7 May is 81.79% of staff have been vaccinated which is an increase on last year's performance (**S6**) • 81.3% of staff have received their first Covid19 vaccination • Over 240,000 vaccinations have been given to the public from CCS's 13 vaccination sites • Surge in safeguarding enquiries emerging from Covid 19 lockdown measures. • IPAC (Infection Prevention and Control) assurance framework has been reviewed and is being presented to May Board (**S8**) • All staff have access to appropriate PPE (Personal Protective Equipment) (**S9**)	**Reasonable**
Caring	• FFT (Family & Friends Test) outcome is 99.28% (target 90%) (**C1)** • Over 19,000 FFT responses received, 14,500 of these were linked to Mass Vaccination sites • Number of informal and formal complaints within expected variance (total of nine formal complaints received in October and five in November) (**C2**)	**Substantial**
Effective	• Mandatory training just below 94% target for February at 93% and over target fat the end of the financial year at 95% (**E1**) • Level 3 adult safeguarding and the Safeguarding induction package has been added to ESR and the mandatory training matrix • The Heads of Safeguarding have identified a proactive programme to support parents with crying babies (ICON), this is being launched on 1 June 2021	**Reasonable**
Responsive	• RTT challenges are noted (see section 6) (**R1**) • Complaints response time was 50% for the 4 responses sent in February and 50% for the 2 sent in March but actions from complaints are evident within the report (**R2**) 64 issues were investigated and closed via the informal complaints process during the reporting period • Covid19 incident response meets all national requirements (**R3**)	**Reasonable**

1. This report summarises the key elements of quality and safety that have been our focus since the beginning of the pandemic in March 2020. We have reprioritised our services in line with national guidance and are currently functioning in line with a level 3 incident.

2. In addition to the overview and analysis of performance for February 2021 and March 2021, the Board can take assurance from the following sources:

    - During the Covid19 pandemic period and more recently whilst operating at a NHS level 4 then 3, a number of processes underpin comprehensive management of the risks and issues associated with delivery of clinical services. These include our Incident Control Centre, Incident Management Team, situation reports from all services which include information on staffing levels, lateral flow,

PPE, risks and incidents. These processes continue whilst we operate under the NHS Major Incident framework.

- The staffing section continues to be reported in the 'Excellent Employer' objective.
- Our overall Care Quality Commission (CQC) inspection rating 'Outstanding' remains in place from August 2019 with 'Outstanding' within the caring and well-led domains.
- Assurance can be taken from the initial completion of the NHSE / I Infection, Prevention & Control Board Assurance Framework presented to the Board in September. A further update is presented within this paper.
- There has been no reported staff outbreak of Covid19 infection within this reporting period.

B: Measures for Achieving Objective – 2020 / 2021 measures

Measure	*2020 / 2021 Target*	*Data source*	*Reporting frequency*	*Current position*
Care Quality Commission standards	Improved ratings for individual KLOEs	Formal assessment	Annual	No date for formal review received
Patients / carers satisfied with care provided NB the associated metric re increasing numbers of people who give feedback is suspended due to the pandemic	90%	FFT	Monthly	Formal reporting of FFT is nationally suspended during pandemic. *March result 99.28%*
Deliver the locally agreed patient related annual Equality Delivery System objectives	Pass/Fail	Equality Delivery System	Annual	Objectives agreed at People Participation Committee 1 July 2020, these will be reviewed in July 2021
Increase the number of services supported by volunteers	TBC	People Participation Committee	6 monthly	This metric is currently paused due to the pandemic
Staff recommend the Trust as a place to work or receive treatment	Increase of 5% on 2019/20 results	FFT	Quarterly	September data shows that 80% of staff recommended the Trust as a place to work and 93% as a place to receive treatment
Safety – staff feel able to speak up about patient safety issues	Maintain 19/20 score	Freedom to Speak Up index -Staff survey	Annual	In July 2020 the Trust came first in the national Freedom to Speak Up Index, scoring 86.6%

Increase in the numbers of Serious Incident investigations that evidence involvement of patients / service users / other professionals	50% increase on 19/20 rate	Datix	Quarterly	All except 1 SI have been safeguarding driven, in these cases patient and carer involvement was not appropriate. The patient/ carer was asked to be involved in the remaining SI, they declined this offer.
Overall mandatory training	94%	ESR	Monthly	Total: 93% February 95% March

C: Risks to achieving objective

Strategic risks

1. ***Risk ID 3163*** *– There a risk that the delivery of high quality care will be adversely affected if levels of staff morale reduce.(Risk Rating 12)*
2. ***Risk ID 3164 –*** *There is a risk that the Trust is unable to maintain high quality care due to the number of services/teams facing workforce challenges.(Risk Rating 12)*
3. ***Risk ID 3165*** *– There is a risk that the Trust does not have sufficient capacity and capability to manage and meet commissioner and patients expectations, due to the complexity of system working.(Risk Rating 8)*
4. ***Risk ID 3166*** *- There is a risk that patients and service users do not receive outstanding care if services fail to remain compliant with CQC Fundamentals of Care standards. (Risk Rating 8)*
5. ***Risk ID 3260*** *– There is a risk that health outcomes for people who use our services are negatively impacted by Covid 19 restrictions due to a second wave of Covid 19. (Risk Rating 12)*
6. ***Risk ID 3300*** *– Delivery of the mass vaccination programme for our staff and to the communities across Norfolk & Waveney, Cambridgeshire & Peterborough may be impeded by a range of factors including workforce supply and vaccine which could result in continued risk to our staff, the delivery of services to patients and those communities awaiting vaccination.*
   There is also a reputational risk to the organisation in relation to delivering the 'hub' model within the required national timeframes. (Risk Rating 12)
7. ***Risk ID 3323*** *– Risk to organisational reputation of delivery of the Lead Provider Contract for the roll-out of the Mass Vaccination Programme for Cambridgeshire & Peterborough and Norfolk & Waveney given the significant pace, complexity and political profile of the programme. (Risk Rating 12)*

Related Operational risks 15 and above

1. ***Risk ID 3120*** *– Luton Community Paediatric service - There is a risk that delays for initial assessments and follow up appointments will continue, leading to continued 18 week RTT (Referral to Treatment) breaches and CYP (Children and Young people) and family delays. (Risk Rating 15)*
2. ***Risk ID 3182*** *– Safeguarding: There is a risk that abuse and neglect will not be identified and acted upon at the earliest opportunity, to prove a timely assessment and intervention to mitigate further harm to children and adults at risk due to changes in service provision. (Risk Rating 16)*

3. ***Risk ID 3072*** *– Bedfordshire Community Paediatrics: There is a risk that continued delays with children not receiving a medical assessment and follow up (including medication reviews) in a timely way may lead to i) diagnostic delays with potential impacts to childhood development, ii) undiagnosed medication side effects, iii) parental and stakeholder dissatisfaction resulting in Trust reputational damage. (Risk Rating 15)*
4. ***Risk ID 3227*** *- There is a risk services will not have the capacity to provide timely and effective response to children & adult safeguarding enquiries during the pandemic. This may result in a failure to support multiagency decision making to assess actual or likely risk of significant harm and provide timely intervention to promote the wellbeing and protect children/young people and adults at risk of harm. (Risk Rating 16)*

D: Overview and analysis (including information from the Quality Dashboard - Appendix A)

1. Quality Impact Assessment (QIA)

As highlighted at board in March the quality impact assessment reviews have been completed by clinical services, and discussed at the internal ethics committee. Further updates may be required as the services continue to recover.

The Mass Vaccination programme quality impact assessment has also been evaluated in line with the national plan and approved via the programme board.

2. Patient Safety

2.1 The NHS Patient Safety Strategy (Safer culture, safer systems, safer patients) 2019 underpins the trusts Quality and Clinical Strategy (2020 - 2023). The trust has appointed an identified Patient Safety Specialist (as part of Deputy Chief Nurse role) as requested nationally. The Patient Safety Team will review the requirements of this strategy in the next few months and provide an update to the Executive Team and Board in due course.

2.2 The Incident Management Team (IMT) continues to have oversight of safety incidents relating to the services provided throughout the Covid19 pandemic period. This is achieved through the situation reports from all services with a weekly trend summary being presented at the Incident Management Team meeting.

2.3 The numbers of incidents reported onto Datix have returned to levels seen prior to the pandemic. Scrutiny of these incidents through local service governance routes continues.

2.4 No Serious Incidents (SI) were declared in February and one Serious Incident was declared in March. No Never Events were reported within this timeframe. The serious incident was identified following external reporting of potential non-accidental injuries to a non-mobile baby. Following the notification, the service carried out an initial review. It was agreed that the case met the criteria for a Serious Incident investigation and reported accordingly. Investigations carried out under the Serious Incident Framework are conducted for the purposes of learning to prevent recurrence both internally and across the NHS.

DATIX Reference	Incident date	Service base	Case description
W63176 2021/6119	01/02/2021	Beds Community	Identification of safeguarding concerns

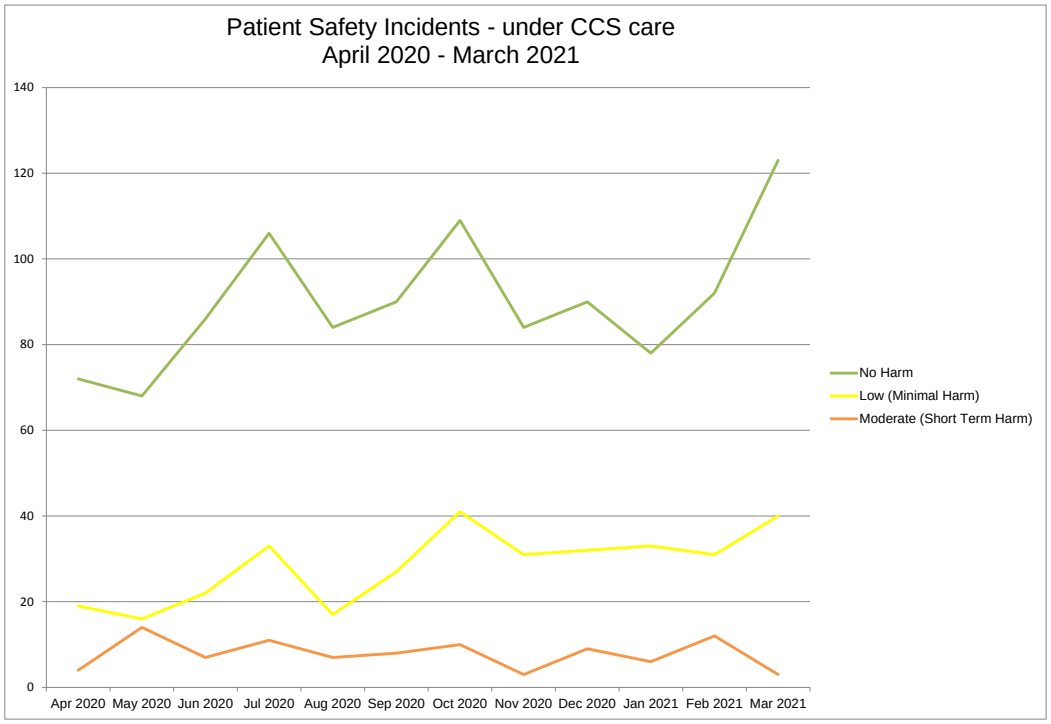
Commissioners, NHSE/I, CCG and CQC have been made aware of the incidents as per policy.

2.5 One internal investigation using recognised root cause analysis methodology (RCA) was initiated in February. This occurred in Bedfordshire 0-19 Service and related to unauthorised access to service users' records.

2.6 Five internal investigations using recognised root cause analysis methodology were initiated in March. These were:

- Bedfordshire 0-19 service where there was an Information Governance breach
- Bedfordshire 0-19 where there were record keeping concerns
- Three missed identification of safeguarding concerns and onward escalation within Norfolk Healthy Child Programme, Cambridgeshire 0-19 and iCaSH Norfolk (this incident has now be re-graded to a serious incident).

2.7 The chart below highlights those patient safety incidents that occurred under our care and includes the two month period of February and March. These incidents totalled 301 which is an increase on the previous two month period (of 57 reported); 71% involved no harm, 24% low harm and 5% moderate harm.



2.8 Fifteen moderate harm incidents (whilst under CCS care) were reported; a decrease of one incident on the previous two month period. Twelve incidents related to Luton Adult Services, all of which were linked to pressure ulcers, one to the Mass Vaccination Programme. The remaining two incidents occurred in the Beds Community Service, one of which related to the above referenced Serious Incident (2.3) and the second to the internal investigation referenced in 2.5.

Incident Themes

2.9 The top three themes of all incidents: Datix reports in generic categories and the categories we see reflected in the top 3 (for each month) reported are as follows:

Provide outstanding care

- Clinical assessment and treatment
- Access, administration, transfer and discharge
- Patient information
- Medication

February	March
Clinical, assessment & treatment: 155 Access, admin, transfer, discharge: 84 Medication: 40	Clinical assessment & treatment: 133 Access, admin, transfer, discharge: 111 Patient information: 49

2.10 Incident themes are quite specific to different service directorates due to the diversity of work undertaken. A trust wide view of themes shows that within each of the categories above the following is noted in February and March:

2.10.1 **Clinical Assessment and Treatment:** Remains unchanged from the previous two month period of December 2020 and January 2021. Luton Adult Services is the main reporter of these due to the type of work and volume of visits. The themes are related to wounds, e.g. pressure ulcers; skin damage; skin tears. These cases are often patients new to the service at the time or the reason for referral in the first place.

2.10.2 **Access, administration, transfer and discharge:** Remains unchanged from the previous two month period of December 2020 and January 2021. The theme here is predominantly a lack of referral into the Trust on discharge from another trust or an individual requiring community based care, e.g. GP / acute hospital. The Healthy Child Programme reports a theme around missing antenatal service communication.

2.10.3 **Patient information:** This theme applies Trust wide and relates to patient records with documentation being misfiled, mis-labelled or missing. It has also been recently identified, via a records audit, that a number of records have potentially not been updated within agreed timeframes; further review is being undertaken to establish the rationale for this. In the meantime, staff have been reminded of the importance of contemporaneous record keeping as detailed in Trust policy.

2.10.4 **Medication:** Medication incidents relate predominately to Luton Adult Services and the Mass Vaccination Programme and include adverse reactions to the vaccinations. Where applicable, these incidents are reported externally to the Regional Vaccination Operations Centre (RVOC).

2.10.5 Where themes are linked to external providers, any issues are picked up during liaison with the services or via the service leads.

Medicines Management

2.11 The Mass Vaccination Programme is requiring high levels of input from the Pharmacy team. The frequent changes in demands of the service by the regional and national team means that the Trust team needs to keep close to the detail on a continuous basis. One of these variations in practice has been linked to a site which has been administrating 2 differing vaccines at the same time; there have been separate processes in place alongside a dedicated vaccination team for each medication, this ensures patient safety and that the correct vaccine is being given to the patient. This level of oversight very much reduces the senior pharmacists' capacity to resume business as usual.

2.12 CCS continues to have support from pharmacy colleagues in Norfolk and Cambridgeshire to monitor compliance with medicines management requirements in the Mass vaccination centres on a weekly basis. This is very much appreciated.

2.13 The Pharmacy team were also instrumental in the switch over from the national protocol to Patient Group Direction (PGD) model for a few days whilst the national protocol was updated to include the over 40 age groups. This was a change in practice for the 13 sites and was managed with no incident.

2.14 The Medication Safety and Governance Group has resumed meeting regularly, having cancelled the January meeting due to the vaccination programme. The Group has responded magnificently to requests for urgent virtual approval of Standard Operating Procedures (SOP's) and other documents to support the vaccination programme. SOPs have required to be changed at very short notice, and it is refreshing to receive comments from members of the Group who have commented on typographical errors, or points of practice which clearly demonstrates that they have scrutinised them fully.

2.15 The Non-Medical Prescribing Network continues to meet on a quarterly basis. The last meeting was held on 21 April 2021 and was very well attended. The network agreed that good progress had been made against its work plan, and that all items remaining in the work plan fell under 'business as usual'. Therefore, it was now appropriate to change the approach to agreeing a cycle of business.

2.16 The audit programme has had to be revised several times, due to capacity of the services to cope with the workload involved. This needs to be balanced against the requirement for assurance of good practice, therefore medicines audits are resuming in April, and steps have been taken to spread the workload across the year.

2.17 The new Pharmacist aligned to Luton and Bedfordshire services is becoming established. Their presence has helped the team's capacity to support business as usual, but as described above this is still compromised. The Pharmacy team will be reviewing its work plan shortly, and will determine priorities.

3. Safeguarding

3.1 Since the beginning of the pandemic, we have been internally monitoring a number of risks relating to a potential rise in safeguarding incidents for both adults and children. The controls in place have been reviewed and assessed to give assurance that the risk is being actively managed to ensure that safe service provision is in place. Externally to the organisation, there continues to be an increased level in both volume and complexity of safeguarding concerns reported for children and adults across the system. Therefore, the Trust is working proactively with partners to carry out our statutory safeguarding duties in regards to children and adult who access our services. Partnership work has continued through February and March 2021 as Safeguarding partners take stock of the emerging safeguarding themes during the Covid19 pandemic period and the learning that can be extracted from the need to adapt to new ways of working to support families and professionals. This will be reflected in key business priorities for the safeguarding partnership boards for the next financial year. National and local will focus on: on-line exploitation and abuse, mental health, domestic abuse, neglect with the explicit impact from poverty and social isolation on these.

3.2 The risks are:

3.2.1 Risk ID: 3182 - The possible impact on children and adults from the re-prioritisation of services across the partnership system at the beginning of the pandemic including during first lockdown and continuing necessary restriction as part of Covid19 pandemic management. The time period for this risk has been extended as social distancing continues to impact on the partnership wide provision to support children and their families and adults with care needs. This risk is currently rated at 16 increased in January 2021; controls are being maintained.

3.2.2 Risk ID: 3227 - The risk that our staff will not have the capacity to provide an effective safeguarding response to the increased number of complex cases that emerges as services mobilise into the restorative phase. There has been a significant increase in safeguarding concerns in both volume and complexity. This risk is currently rated at 16; controls remains in place.

3.2.3 It should be acknowledged that these two risks are interrelated, where vulnerable children and adults have limited access to professional support across the system any safeguarding issues are likely to be identified at a later date and therefore the opportunity for early assessment and intervention may be missed.

3.2.4 The risk that staff may suffer the effects of vicarious trauma as they manage increased numbers of cases involving physical injury and neglect. This risk is currently rated at 12; controls remain in place.

3.2.5 Cambridgeshire MASH team are managing a risk related to increase in the number of enquiries sent through which is not related to the pandemic but is a result of a change in process in the Local Authority. There is strategic partnership agreement about the actions required to mitigate the impact and a weekly joint meeting is held between the Local Authority Head of Service, CCS Head of Safeguarding and CPFT Head of Safeguarding. This is having a beneficial impact week on week. The risk is currently rated at 8.

3.3 Risks are reviewed weekly by the Incident Management Team and Safeguarding Huddle (Medical Director, Chief Nurse, Heads of Safeguarding and Deputy Chief Nurse) where trust wide actions are identified and implemented, with oversight by the Strategic Safeguarding Group. The risk rating has remained static, with controls updated to reflect increased investment in the Adult and Children's safeguarding provision. Additional adult safeguarding professionals are currently being recruited into substantive and fixed term posts, to support current and predicted future demand.

3.4 Emerging data tells us that there is a substantial increase (from all agencies) in referrals into Multi Agency Safeguarding Hubs (MASH) and referrals for Child Protection medicals have shown peaks in requests at times throughout the pandemic. There has also been a rise in the number of Non Accidental Injuries (NAI) to children resulting in serious head trauma. The impact on our staff is being carefully monitored and support for individuals and teams has been arranged. Staffing levels are under constant review and local action is taken to minimise the impact. Specialist psychological support for staff at the frontline and in the safeguarding teams is being actively sought and in some cases provided from both private and public services.

3.5 Bruising and marks to non-mobile children and babies has been highlighted within a number of Child Safeguarding Practice Reviews both internally and nationally; with a significant rise in the incidence of these during Covid19. Datix reporting continues to be utilised to capture non-accidental injury (NAI) incidence across the Trust for children under the age of two years, which are the cohort of children at the greatest

risk. Weekly review of the Datix reports by the Heads of Safeguarding has identified that CCS professionals are compliant with pathways for bruising, injury and bites in immobile children. However, there has been a need to challenge other agency compliance with agreed pathways.

3.6 Heads of Safeguarding highlighted the need for a system wide proactive approach to supporting families with management of crying babies and awareness of the impact of shaking babies and presented a proposal to partnership boards in Cambridgeshire & Peterborough and Bedfordshire & Luton for the use of ICON. Agreed work streams are now in place to embed ICON into the routine Healthy Child Programme at key touch points; this is on track to go live on 1 June 2021. Work continues with partners to promote the need for a system wide public health approach. CCS Communication Teams are making community contacts to better engage fathers and other significant male carers, who are essential to the success of this campaign; males being perpetrators of 70% in abusive head trauma. Norfolk are active participants in their system wide work stream called 'Protecting Babies' and learning across the two approaches will be used to influence and enhance the local agreed systems.

3.7 MASH activity continues to be variable across the five MASHs supported by CCS professionals; there are some emerging patterns which appear to be directly correlated to the national lock down. Activity monitoring is currently being revised to allow greater interrogation of the activities undertaken by CCS professionals working in the MASH.

3.8 There has been an increase of families requiring support from the Universal Programme Plus across our Bedford healthy child programme. To mitigate the staffing challenges and high safeguarding demand a number of actions have been undertaken: joint advertisement with the Bedfordshire service has commenced, considering post rotations, the skill mix has been increased in the team and three members of staff have commenced the Level 5 Assistant Practitioner Apprenticeship.

3.9 Mandatory safeguarding induction presentation is now linked to ESR; this will improve access for new starters and allow compliance monitoring, requiring new starters to have safeguarding induction within six weeks of their start date. As part of this induction package new starters are made aware of the safeguarding provisions within the Trust and who they can contact for immediate support it also makes them aware of their mandatory safeguarding training and supervision requirements.

3.10 Safeguarding supervision continues to be provided as a priority across the Trust in a risk based approach and for those staff who have a mandated requirement to access this. Ad hoc supervision and advice has been maintained throughout the pandemic. Professionals are reporting that the use of Microsoft Teams facilitated ease of access and flexibility and is of mutual benefit to safeguarding specialist and practitioners. A revised safeguarding children supervision model has been developed and is on track to be implemented from July 2021.

3.11 PREVENT and WRAP training has been maintained at above the target level across the Trust and is at 96% and 95% for February and March respectively. The first PREVENT forum since October 2020 took place on 13 April 2021 and going forward it is proposed that this is incorporated into the local Operational Safeguarding Meetings which take place every two months.

4. Infection Prevention and Control (IPaC)

4.1 We continue to follow all national guidance relating to preparing for and managing the current Covid19 pandemic. This work is being led by our Accountable Emergency Officer (Director of Governance & Service Redesign) and Medical Director.

4.2 The risk relating to supply and availability to our services of Personal Protective Equipment (PPE) is monitored fortnightly through the Incident Management Team (IMT) and underpinned by daily sit rep information from all services.

4.3 The Board can continue to be assured that no member of staff has been asked to undertake clinical care without appropriate PPE.

4.4 In May 2020 NHS England published an Infection Prevention and Control Board Assurance Framework (IPaC BAF) for trusts to demonstrate that their approach to the management of Covid19 is in line with Public Health England (PHE) Infection Prevention and Control guidance and that gaps have been identified and mitigating actions taken.

4.5 Our initial detailed self-assessment against the 10 domains was presented to the Board in September and then again in January 2021. As per the cycle of business the IPaC Board Assurance Framework (BAF) was reviewed at the Trust's Infection Prevention and Control Committee in February and May. The IPaC BAF was revised at the beginning of April, and has been updated accordingly (Appendix B); no new risks were identified following this review.

4.6 The Infection Prevention and Control Committee also reviewed the Health Executive Safety Report 'Summary of findings – hospital spot check inspections' and from the subsequent gap analysis; no issues have been identified, however some further actions have been identified to strengthen our processes. This review is highlighted in Appendix C.

4.7 No staff outbreaks were reported in this period.

4.8 A total of 21 incidents were reported during this period:

4.8.1 February:

- Eight incidents were reported: one was linked to a waiting area; the remaining seven related to needlestick injuries of which three were clean needle incidents and the remaining four related to a used needle. Of the seven needlestick incidents, five originated from the Mass Vaccination Centres (MVCs).

4.8.2 March:

- Thirteen incidents were reported: one related to a notification of low levels of legionella from one water outlet; two related to staff practice; two related to clean needle incidents and the remaining eight were dirty needlestick incidents. Out of the 10 needlestick incidents, nine originated from the MVCs.
- The needlestick injuries have been reviewed at both the Infection Prevention and Control Committee and within the Mass Vaccination programme governance processes. The percentage of incident in relation to the number of vaccines given is currently 0.0008%, all staff have been appropriately trained and are given regular breaks when vaccinating. Sharps boxes and vaccination areas are altered on a daily basis based on the practitioners own

requirements and follow up is in place for all vaccinators and patients who are affected. Staff follow the national protocols for vaccinations and each site undertakes a monthly Infection, Prevention and Control audit, with any key messages and lessons being disseminated as part of the daily huddle.

- The legionella incident has now been fully resolved.

4.9 The Trust's seasonal influenza campaign commenced in October 2020 in compliance with the national Covid19 guidelines. As of 2 March 2021, the total percentage of staff that had their flu vaccination is recorded as 81.79%. This is the highest staff uptake the Trust has reported. The 2020 / 2021 campaign has now been reviewed to help develop the Trust's 2021 / 2022 campaign, an initial task and finish group has been held to start to map the programme.

4.10 The Trust has supported all staff to access the national Covid19 vaccination programme through a variety of routes; the current percentage of staff that have had their first vaccine is 81.3% (at the time of writing the report). Individual support and conversations are being offered to staff who would like to discuss any issues relating to the vaccine and the Medical Director and Chief Nurse have been attending team meetings, Question & Answer sessions and the BAME / Disability network discussions. Internal communications have been weekly and specialist advice and support has been developed to provide vaccine information to our Minority Ethnic colleagues, the Chief Nurse has also written to all staff that have not had a vaccination status recorded.

4.11 Staff based in our various geographies continues to access appropriate Covid19 swabbing facilities if symptomatic.

4.12 Other infections: There were no confirmed bacteraemia cases of MRSA (Meticillin-resistant Staphylococcus Aureus), Extended Spectrum Beta – Lactamase (ESBL) or E.Coli during February and March. We have not been notified of any positive cases of C.difficile during this period.

5. Patient Experience

5.1 The Patient Story

5.1.1 The Patient Story that will be heard at May Trust Board is from the Trust's 0-19 Healthy Child Programme in Norfolk. A service user will share their experience of having a baby diagnosed with a heart condition during the pandemic. They will discuss receiving care from Health Visitors, the Infant Feeding team and Just One Number Single Point of Access.

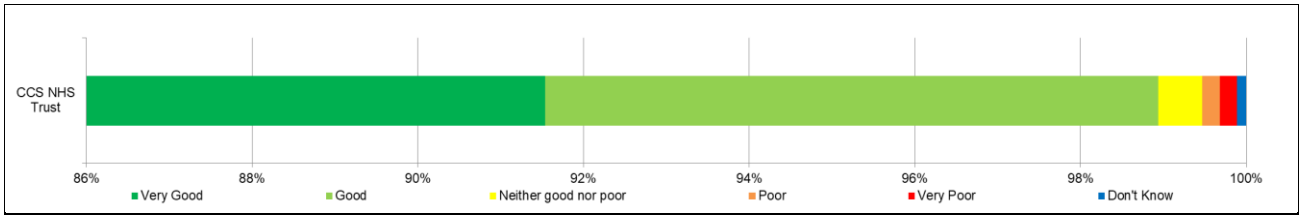
5.2 Friends and Family Test (FFT)

5.2.1 We continue to work in line with FFT national guidance around Covid19. Electronic feedback mechanisms following video and telephone appointments are in place across the Trust and we continue to support service users in providing feedback through the FFT and via our Patient Advice & Liaison Service.

5.2.2 We received 4965 responses in February and 11,905 in March to the FFT question. The number of responses in this data period increased significantly due to the increase in feedback received from service users accessing our Mass Vaccination sites. Mass Vaccination feedback accounts for 3208 response in February and 9891 in March.

5.2.3 The overall Trust FFT positive feedback was 99.28%, with a 0.22% negative feedback percentage. We remain above the Trust target of 90%.

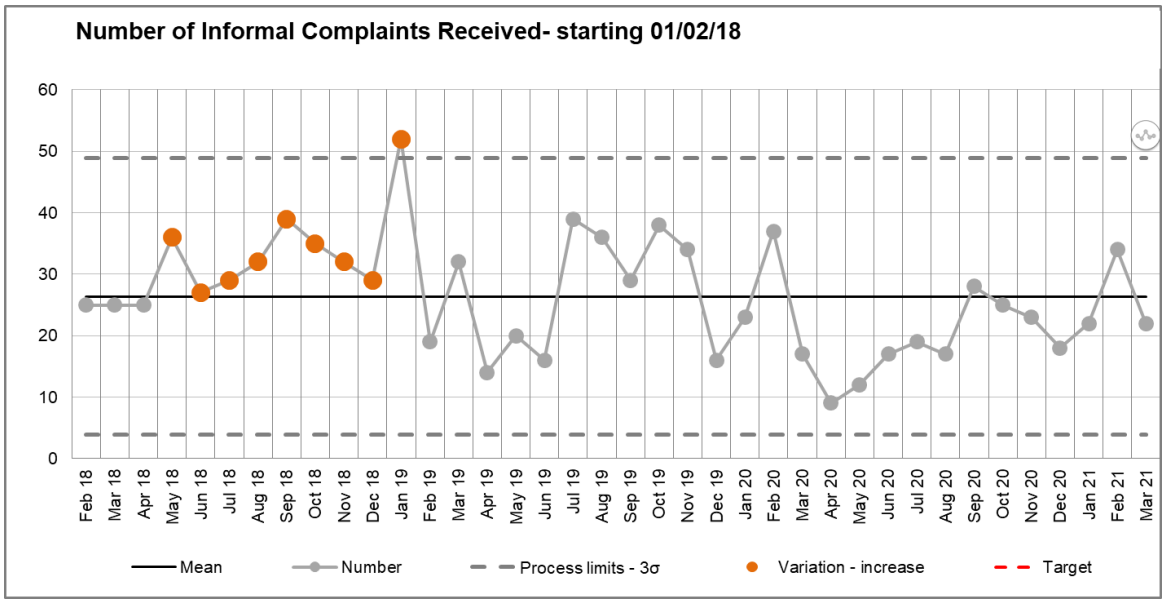
5.2.4 Below is the percentage of responses to each category of the FFT question for the overall Trust.



5.2.5 In February and March the services we provide received over 19,900 positive comments on surveys and feedback forms used across the Trust, with over 14,500 for Mass Vaccinations and over 5400 for all other services.

5.3 Informal complaints received

5.3.1 The total number of informal complaints received and logged was 56 in this data period; as you can see from the table below; this is within our expected variation. Seventeen informal complaints were related to change in service offer due to Covid19, logistics and infection prevention and control at mass vaccination sites and all have been followed up; no related incidents or risks were associated with the feedback received.



NB change in process of logging all informal complaints in January 2018.

5.4 Themes and learning from informal complaints closed in February and March 2021

5.4.1 Sixty-four informal complaints were resolved and closed in February and March. The top three themes of the informal complaints closed within this period were Communication and information (12), Clinical care (11) and Delay in diagnosis, treatment or referral (10).

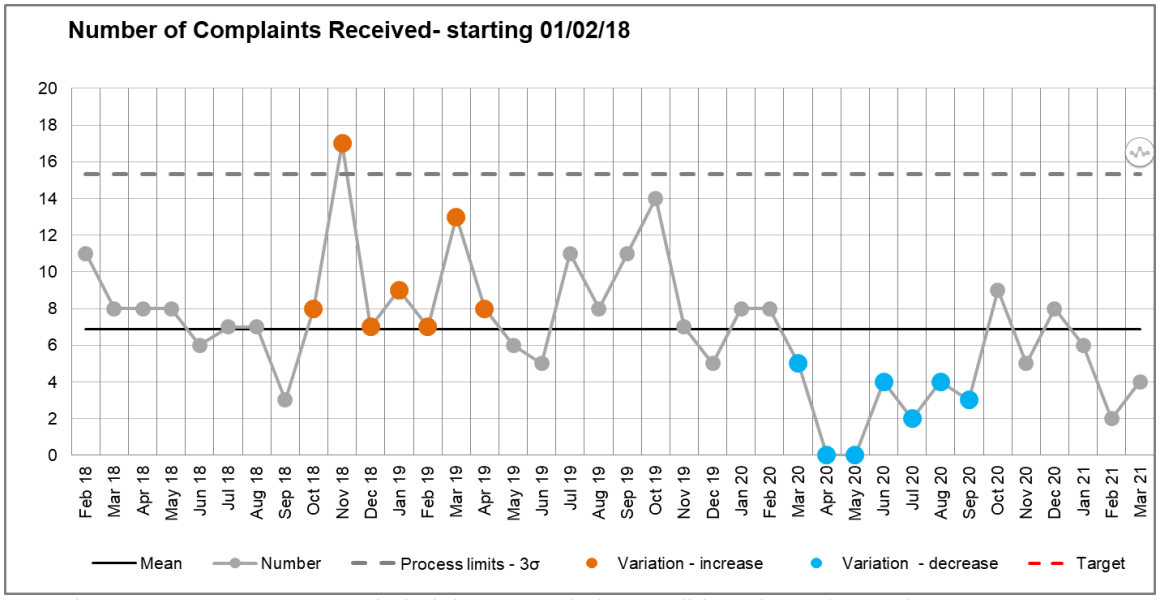
5.4.2 There are no themes in the services involved in the informal complaints about Communication and Information or in the specific details of them.

5.4.3 Review of the informal complaints about clinical care shows that in eight of the informal complaints the service user believed care provided was inadequate or insufficient. All of these have been followed up, clinically reviewed and feedback given to the service users/carers. There are no themes in the services involved.

5.4.4 There are no themes in the services involved in the informal complaints about delays or in the specific details of them.

5.5 Formal Complaints

5.5.1 The Trust received six formal complaints in this data period: two were received in February and four in March. This is within the expected variation, as shown in the graph below.



NB: The Lower Process Control Limit is -0.7. It is impossible to have fewer than 0 complaints in a month so this is not shown on the graph above.

5.5.2 One complaint received in this period related to Covid19 and delays in receiving speech and language therapy in Bedfordshire. CCS have acknowledged and apologised that the individual had not been offered an appointment, which has now been arranged with the service. Furthermore, the teams have started a service redesign project with the aim of reducing waiting times and increasing efficiency.

5.5.3 All formal and informal complaints relating to Covid19 are currently reviewed by the Incident Management Team on a monthly basis to support the early review of any themes or concerns related to feedback from service users/carers in relation to reduced services in response to the pandemic.

5.6 Themes and learning from formal complaints closed in February and March 2021

5.6.1 Within this data period we responded to and closed 10 formal complaints; 18 subjects / themes were identified. Communication and Information was the most

frequently occurring theme (8) in three complaints. There were four themes of clinical care in four complaints and three themes of delays in diagnosis, treatment or referral in three complaints. These themes are the same as those noted within the informal complaints.

5.6.2 The complaints were reviewed and six related to Musculoskeletal Services (MSK), although it is to be noted that they are not specific to one geographical location. Two complaints about MSK accounted for seven of the communication/ information themes which included issues with information about pathway of care and referral.

5.6.3 There were no other themes to note.

5.6.4 Learning and actions taken from complaints included:

- MSK Cambridge & Ely – Patient had concerns around the lack of information given to them about their care and on-going referral. The investigation found that there had been miscommunication around different services. In this case the clinical decision-making was found to be correct but the communication and explanation to the patient was not clear. This learning has been shared with the team and the clinicians involved have reflected on the feedback in order to improve communication in the future.

- Bedfordshire Community Paediatrics – Parent raised concerns about time taken to get feedback and diagnosis following their child's Autism Diagnostic Observation Schedule (ADOS) assessment and difficulties in contacting the service. The investigation found that there were delays due to Covid19 and pressures on the service and that information about the process was not communicated clearly to the parent. The service has been working to reduce the need for clinic appointments and their waiting times and has introduced a skill mix approach where the Specialist Nurses are able to provide feedback (including diagnosis), to families without the need for a medical appointment with a Paediatrician.

5.7 Complaint response times

5.7.1 In this data period CCS responded to six formal complaints (four in February and two in March); two of the four responded to in February and one of the two responded to in March were sent on time. The three complaints that were late were received in December and January and were under our previous response times. Due to a vacancy within the complaints team of no manager and service pressure these responses were late (the complainants were updated in relation to the delay). During quarter four we changed our Trust timeline as stated in 5.7.2, to support capacity as part of Trust governance response to the on-going pandemic.

5.7.2 Target timeframes for complaints received since February have been extended by 10 days to 35 days for complaints involving one service and up to 5 issues and 40 working days for complex, often involving more than one service, Trusts or organisation. However, we continue to acknowledge complaints (within three working days as per the Complaint Regulations), log them on Datix, triage them for any immediate issues of patient safety, practitioner performance or safeguarding and take immediate action where necessary.

6. Access to our services including Referral To Treatment (RTT)

6.1 Dental

The service has 133 patients who have waited over 52 weeks for either treatment under General Anaesthetic or Intravenous sedation. The service is prioritising patients on clinical need as recovery across the system re-starts.

6.2 Dynamic Health

The 18 week breaches across the service dropped in February 2021 to 178 but have risen by 48 in March 2021 to 266. Although Specialist Waits for first appointment are reducing, 18 week waits are continually impacted by Covid19 delays within secondary care in terms of diagnostics. Routine diagnostics have now started at the beginning of April across the area but many patients had been waiting a while for intervention.

6.3 iCaSH

There has been increasing LARC wait times due to the initial roll back to essential services in 2020 (lockdown1) and pause of routine LARC in Norfolk, Cambridgeshire and Peterborough to support staff redeployment to Large Scale Vaccination sites. Routine LARC provision is now running across all services, but there are waiting lists held in majority of localities.

6.4 Bedfordshire and Luton Community Eye Service

Treatment for Amblyopia (lazy eye) was delayed due to the suspension services in March 2020. There is a risk that, if children are not treated by 7 years old, they will experience permanent vision impairment. The service has prioritised the care of these patients to minimise risk. The screening service has continued to work with schools and offer community clinics and is projecting to have screened all 6 year olds by the end of the academic year.

6.5 Bedfordshire and Luton Occupational Therapy Service

The team are currently experiencing four primary challenges restricting pre-Covid19 performance levels:

- Demand for EHCP assessments has risen during the Covid19 Pandemic restricting capacity to meet the needs for Children with universal needs.
- Staff absence due to Covid19 factors.
- Backlog of Children on the waiting list due to the limits in place surrounding face to face appointments.
- Additional time required between face to face appointments to allow safe movement around the site for patients / staff, donning / doffing of PPE and additional cleaning measures.

In March 2020, 100% of children were seen within 18 weeks and this has reduced to only 44% of children in February 2021. Demand and capacity work is being prioritised to detail workforce requirements, in the interim the service is recruiting an additional therapist to support with this service pressure.

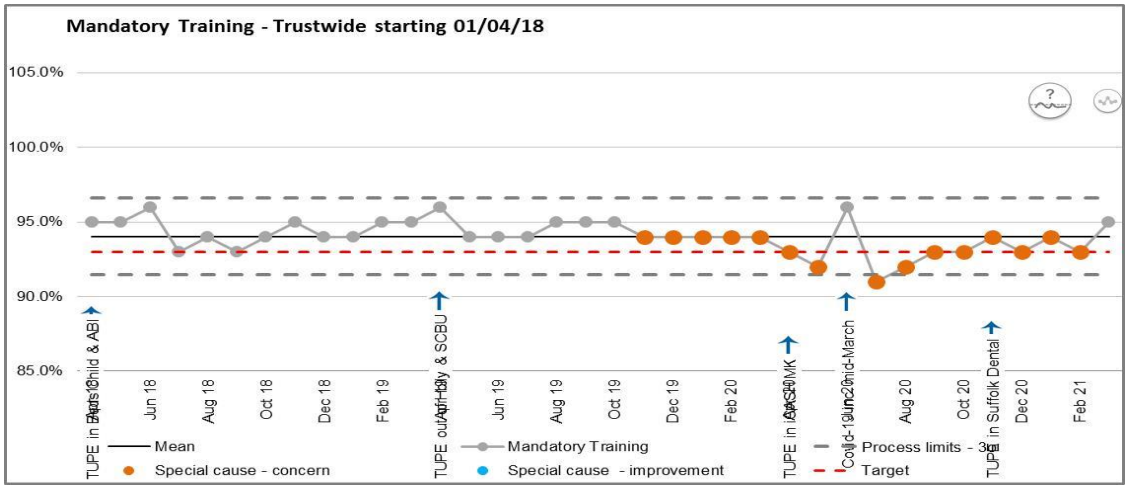
6.6 Bedford and Luton Community Paediatric Service

- The average RTT wait in Bedfordshire is 21 weeks (18 week national KPI) with the longest wait at 33 weeks, there have been some notable improvements in the past two months.
- The average RTT wait in Luton is 42 weeks. Long term staff sickness (unrelated to Covid19) and Medical vacancies are impacting on service capacity. Locum

Medical staff are in place with further resource required to address the accumulated waits.

- Recruitment to substantive Medical posts continues to be a challenge in both services. Trust-wide Consultant Paediatrician posts are being advertised with joint recruitment with our ELFT colleagues being explored. Interest has been received for 2 fixed term Medical posts with recruitment being progressed. A Clinical priority booking system is also being used to safely manage referrals.
- 203 Children (Bedfordshire service) and 109 Children (Luton service) are waiting for an Autism assessment and / or diagnostic outcome. School assessments have been limited due to closures and facilitation of the Autism diagnostic tool (ADOS / BOSA) has been delayed due to face to face requirements. However the service has secured additional non-recurrent investment (£300,000) from commissioners to address the ADOS / BOSA backlog. A weekly recovery meeting is in place with additional assessments being procured, additional Specialist Nurses being recruited and extra hours offered.
- In the Luton service 130 children are overdue ADHD medication reviews, with the longest wait being 7 weeks. Specialist Nurses are clinically prioritising waits and reviewing children, there have been no imminent risks identified.

7. Mandatory training



- Overall Trust compliance was recorded as 93% in February and 95% in March. The overall compliance rate for Moving and Handling of Patients was 78% in March. In order to increase this rate the team have re-introduced blended face to face sessions, but have identified issues around training rooms, one of the key sites is currently being used as a mass vaccination centre therefore work is underway to find suitable other Covid19 secure venues.

8. Information Governance

8.1 NHS Digital's 2020/2021 Data Security & Protection Toolkit (DSPT): all 111 mandatory evidence items have been completed as well as all the non-mandatory evidence items. The 42 assertions are awaiting sign off before final submission of the Toolkit to ensure new data could be added (e.g. possible updates to the November 2020 mandatory Information Governance and Data Security training figure). The deadline for final submission is 30 June 2021.

8.2 Mandatory Information Governance and Data Security awareness training is currently at 94% (March 2021) against a target of 95%. In March, when mandatory training was

re-introduced, a proactive approach was taken whereby Service Directors were provided with details of non-compliance and requested that they encourage staff to do their training.

8.3 Between February and March 2021, 33 incidents were reported under the Confidentiality Breach incident category which is slightly up from the previous figure of 32 incidents. The majority of the incidents related to human error or administrative issues: for example, staff placing the wrong letter in an envelope or not double-checking details before using material. The Information Governance Manager assesses all Information Governance incidents and provides advice to staff to prevent errors from re-occurring.

9. People Participation- Co-production

9.1 During this data period the Trust services have continued to engage and work within our co-production approach.

9.2 Since January, some of the co-production leads have been re-deployed internally to support trust wide projects related to the ongoing pandemic, this has included supporting our workforce and recruitment team with interviews of volunteers and staff to our vaccination sites. One of our leads has been supporting the lateral flow testing process for our staff. Several of the co-production leads have also supported the trusts PALS and Complaints team, as the demand of these services saw an increase since January.

9.3 The main areas where co-production has been able to continue with full support from their co-production leads have been in our Bedfordshire and Luton areas, below are some examples of the outstanding practice work that has been achieved in this period February to March.

10. Areas of Outstanding Practice

10.1 Bedfordshire and Luton Community Paediatrics Service

- A post diagnosis resource pack is being co-produced in collaboration with parents, young people and stakeholders for young people and their parents following a diagnosis of a neuro developmental disorder. Work has been ongoing and is due for completion in June.
- Membership of the project includes Bedfordshire and Luton community paediatrics services, speech and language therapy service, Child and Adolescent Mental Health Services (CAMHS), Bedford Borough, Central Bedfordshire and Luton Borough local authorities, Parent Carer Forums and third sector stakeholders such as Autism Beds and FACES spectrum support, together with parent representatives and consultation with young people.
- The pack will be hosted online and will include printable resources and multi-media information and support; including videos, infographics and animations. It will be accessible to all via the 'recite me' tool (translations, easy read and voice reader') and provisions will be made at the point of signposting for those that do not have access to the internet.
- The post diagnosis resource pack co-production project has also been submitted as a poster presentation for the Royal Collage of Paediatrics and Child Health (RCPCH) annual conference taking place in June 2021.

10.2 **SEND and Co-Production (Central Bedfordshire Written Statement of Action)**

- Bedfordshire community health services have joined together with key stakeholders and Central Bedfordshire local authority to develop co-production and joint working with parents and young people across the local area in support of the Central Bedfordshire Written Statement of Action.
- Bedfordshire community health service designed a training package and supported schools across the local area to host internal co-production workshops for young people in line with Covid-19 working. 173 pupils with special educational needs and disabilities across 15 different schools participated in the workshops.
- The feedback from these workshops will form various resources to support co-production into the future, such as a Co-Production Charter, a top-10 tips for professionals, a co-production definition and a strap line, an e-learning package for professionals, as well as provided key themes for improvement for health and local authority services.

10.3 **Bedfordshire and Luton School Nursing – ChatHealth Rap**

- Bedfordshire and Luton community Health services launched a competition to submit a spoken word or rap to promote the ChatHealth service in February 2021. The winning entry was chosen from Jayden, age 14 and Jayden's rap was launched to promote ChatHealth on social media channels and via schools in March 2021.
- ChatHealth National are using the rap on their website and evidence page for school nursing teams across the country and have commented 'this is a great example of how to engage young people in promoting the service'.
- ITV Anglia have filmed a news report segment for local news channels about the ChatHealth rap including an interview from a Luton school nurse.

10.4 **Luton and Bedford Adults**

- The Tissue Viability Nursing and District Nursing teams won the Shine a Light award for March based on the extremely positive feedback from a patient which highlighted the wonderful care shown to them during recent months.
- Development of the Community Discharge App – as part of the BLMK discharge work CCS continues its work leading on the development of the Community discharge App. Working with a developer called Phew we are looking to replicate the system that is currently in the acute trusts to be able to oversee patients in health funded beds across the community.
- Since March we now have all community bed patients loaded into the App and this is now being used to drive the discussion at community Multi-Disciplinary Team Meeting's. We worked with Phew to develop a simple dashboard showing the status of all patients in community beds with a focus on Length of Stay and any barriers to discharge. Users are able to drill down from any section of the dashboard to patient specific data to enable decisions to be made around patient care.

10.5 **Dynamic Health**

- Further contracts have been awarded to CCS NHS Trust for additional First Contact Physiotherapists following contract meetings.

- The team service has increased their Apprenticeships within the Administrative aspect of the unit over the last 12 month. We have also entered current staff onto NVQ programmes to increase their knowledge and development.
- Our social media push demonstrates excellent results for recruitment and profiling about our service. Twitter had 610 engagements during November to January. Our video showcasing our self-referral process has been viewed numerous times and over half of the people that visit our website (53%) come to us direct. The self-referral page is still our most popular and accounts for around 32% of page views on the service's site. We had 7,528 users on our site in March 2021 compared to 6,745 in February, which is a fantastic 11% increase.
- BAME Health and Care awards – at the time of writing we are waiting on the outcome of these awards. We submitted the South Asian Females function rehabilitation class into two categories (Outstanding achievement of the year and community initiative of the year).

10.6 **iCaSH**

- Pilot undertaken successfully at iCaSH Beds for online screening of Mycoplasma Genitalium (MenGen) and trichomonas vaginalis (TV), concluding in April 2021.
- Portia Jackson, Lead Pharmacist for iCaSH has been selected to represent Pharmacy on the National BASSH HIV and BBV special interest group.
- Supported with a poster for BASHH / BHIVA poster on 'Outcome of GU referrals following Covid19 guidance' by Dr Sarah Edwards.
- The iCaSH campaign for HIV Testing Week 2021 helped to create attitude and behaviour change towards HIV testing, demonstrated by a good engagement rate with posts (1.9%) and a reach of over 40,000. Three message types were adopted – simple, affective and complex.

10.7 **Mass Vaccination**

- All sites to date have delivered in excess of 240,000 vaccines.
- East of England Showground opened to delivering Moderna Vaccine on 15 April 2021. Site is delivering Moderna alongside AstraZeneca as first multi-vaccination site in Trust. Regional Chief Pharmacist visited and commended the site on its organisation and processes around Moderna delivery.

SO2

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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 • Staffing pressures kept under constant review as part of regular sitrep reports and weekly incident management team meetings. (**S4**)	**Reasonable**
Effective	• Mandatory training compliance increased overall to 95% (**E1**) • Appraisal rates at or above target levels across 80 % of services and no more than 2 services are more than 5% below target Overall appraisal rates remain below target at 86.54% .(**E2**) • Rolling sickness rates as at end of March was 3.97% compared to latest NHS England rate for community Trusts of 5% (as at November 2020) (**E3**) • Stability continues to be above target at 90.47%. (**E4**) • The majority of local Equality Delivery System objectives on track for delivery and this is evidenced through a robust plan of work as presented to the PPC on 12th May. The reason for not achieving full compliance was due to the Covid pandemic (**E6**).	**Reasonable**
Well Led	• Agency spend below annual target. (**WL6**) • All BAME staff have been offered risks assessments and mitigation is in place as required (**WL8**) • All staff with high risk factors to COVID-19 are offered staff risk assessments and mitigation is in place as required. These are being regularly reviewed. (**WL9**) • All staff have been offered Covid-19 vaccination and targeted work in this area continues to take place. Current compliance is 81.3%.	**Substantial**

1. In addition to the overview and analysis of performance for February 2020 and March 2020, the Board can take assurance from the following sources:

- NHS National Staff Survey 2020 results where the Trust achieved a 58% response rate. Headline results were:
    - Best performing Community Trust nationally in 8 out of the 10 themes, including staff engagement.

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- 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 a number of areas that support the delivery of this objective.

- Successful delivery of people strategy implementation plan. Four out of the five programmes of work all support the delivery of this objective.

- The Freedom to Speak Up index published on 9th July 2020. The Trust was again identified as the best performing Trust nationally.

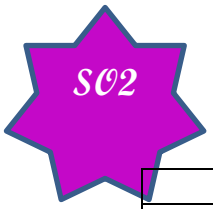
- Workforce review presented to the Board in March 2021.

- Daily staffing sitreps and Incident Management Team meetings to manage staffing pressures during the current Covid-19 pandemic. Risks 3163 and 3164 cover these pressures and are reviewed regularly.

- Discussions within the three Clinical Operational Boards that took place in May 2021.

B: Measures for Achieving Objective

Measure	20/21 Target	Data source	Reporting frequency	Current position as at end May 2020
Staff recommend the Trust as a good place to work	Above national average	NHS Annual Staff Survey	Annual	Achieved
Our staff feel able to speak up about patient safety issues	Maintain 2018/19 score	Freedom to Speak Up Index and Annual Staff Survey	Annual	Top NHS Trust nationally in July 2020 FTSU Index report
Staff engagement rating	Above national average	NHS Annual Staff Survey	Annual	Achieved
*Sustain the level of overall mandatory training	94%	ESR	Monthly	95% - exceeded target
Improve experience for Black, Asian, Minority, Ethnic (BAME) staff	Decrease the numbers of BAME staff experiencing discrimination at work from manager/team leader or other colleagues in the last 12 months. (2019 baseline – 7.9%)	NHS Annual Staff Survey	Annual	Not achieved – increased to 11.9%.



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Improve experience for disabled staff	Decrease in the numbers of disabled staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties (2019 baseline 18.3%)	NHS Annual Staff Survey	Annual	Achieved – reduced to 15.3%
*Available staff have had an appraisal in the last 12 months	=>94%	ESR	Monthly	*86.54% (decrease of 1.75% since last report)
Available staff have had a good quality appraisal in the last 12 months	Improvement achieved from 2019 results	NHS Annual Staff Survey	Annual	Not included in this years survey
Deliver the locally agreed staff related annual Equality Delivery System objectives	Pass/Fail	Equality Delivery System	Annual	First objective has been fully met and the second one partially met due to the Covid pandemic
Monthly sickness absence remains below 4%	4%	ESR	Monthly	3.78% - exceeded target
Reduce Annual Staff Turnover	1% improvement from 2019/20 outturn (March 2020 – 13.04%)	ESR	Monthly	10.59% - exceeded target
Maintain Mindful Employer Status	Pass/Fail	HR Team	Monthly	PASS

*achievement rate impacted due to Covid-19 pandemic. NB: Appraisals and Mandatory training full compliance suspended on 28th March 2020 following receipt of reducing burden and releasing capacity letter from Amanda Pritchard, Chief Operating Officer NHS England & NHS Improvement, however, introduced later on in the year.

Strategic risks

1. ***Risk ID 3163 -*** *There is a risk that the delivery of high quality care will be adversely affected if levels of staff morale reduce. (Risk Rating 12)*

2. ***Risk ID 3164 –*** *There is a risk that the Trust is unable to maintain high quality care due to the number of services/teams facing workforce challenges. (Risk Rating 12)*

3. ***Risk ID 3166 -*** *There is a risk that patients and service users do not receive outstanding care if services fail to remain compliant with CQC Fundamentals of Care standards. (Risk Rating 8).*

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Any operational risks 15 and above

D: Overview and analysis

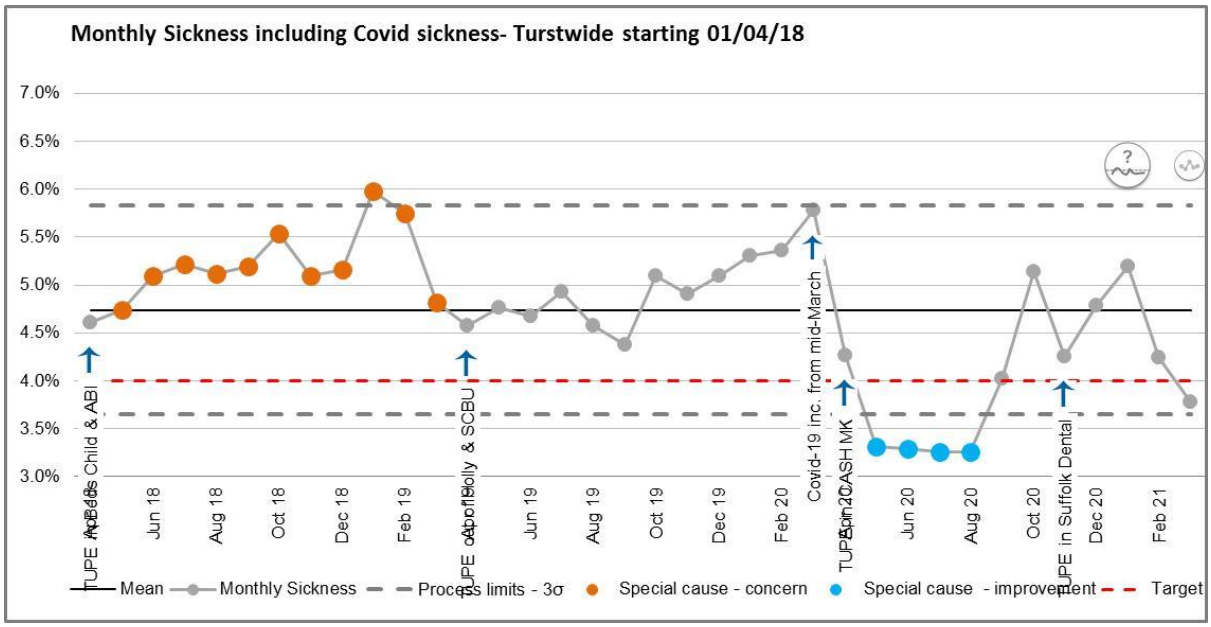
1. Sickness

1.1. There has been a significant drop in the monthly sickness rate since March 2020 (5.78%) and the 12 month cumulative rolling rate (March 2021 – 3.97%) is now below the Trust rolling target of 4%.

1.2. Monthly Trust wide reporting for February 2021 4.24% (including Covid-19 sickness), 3.71%(excluding Covid-19 sickness), and for March 2021 3.78% (including Covid-19 sickness) and 3.62% (excluding Covid-19 sickness)

1.3. The Trust wide sickness rate has decreased this month, and is now below the Trust's target of 4.0% for 2020/21. Of the 3.78%, 2.32% was attributed to long term sickness and 1.46% short term sickness absence. Luton Children and Young Peoples Services had the highest sickness rate (5.83%) and Corporate services the lowest (1.96%). The top reason is anxiety/stress/depression/other psychiatric illnesses; 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 November 2020 benchmark report for NHS Community Trusts (source: NHS Digital Workforce Statistics) which was 5.0%.



2. Stability

2.1. The following chart shows the monthly stability rate (percentage of staff employed over 1 year) – February 2021 89.36%; March 2021 90.45%; against the Trust target of 85%. This compares favourably to a stability rate of 88.1% for NHS Community Provider Trusts for all employees (source: NHS Digital Workforce Statistics, Sep 2020).

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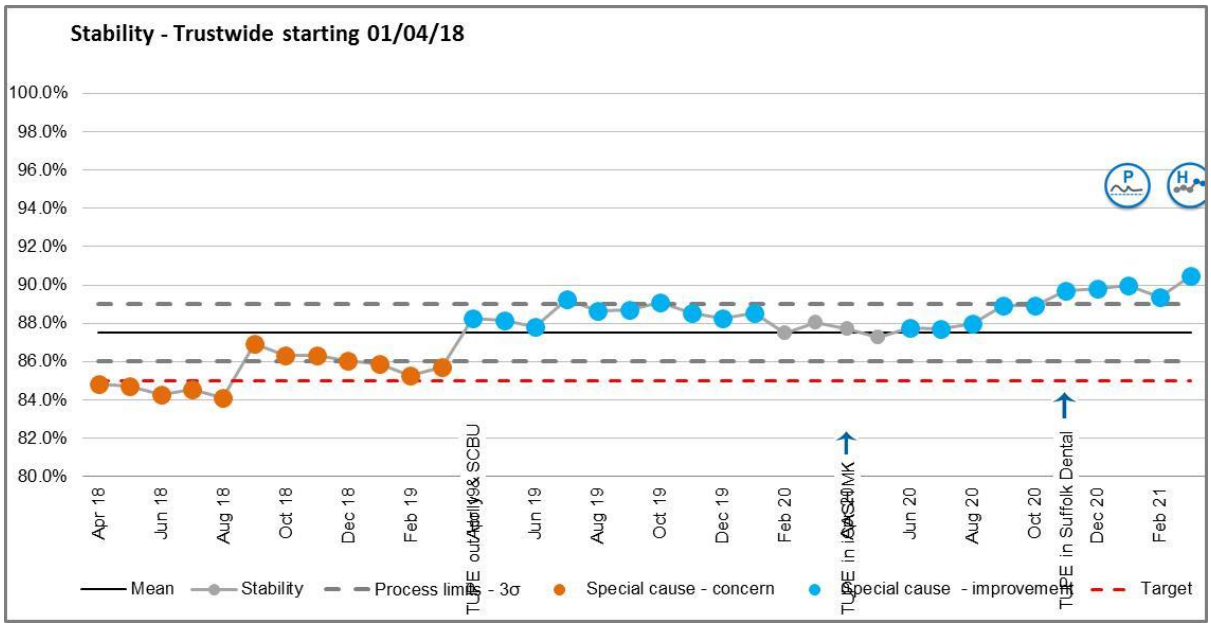
2.2. Stability rates for the Trust are based on the permanent workforce (ie: those on a fixed-term contract of less than one year are excluded).



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 has remained stable – February 2021 91.64%, March 2021 86.54%, and remains below the target of 93% for 2020/21.

3.3. Cambridgeshire & Norfolk Children's & Young People Service has the lowest rate (75.36%) and Luton adults Community Unit the highest (95.02%). 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.

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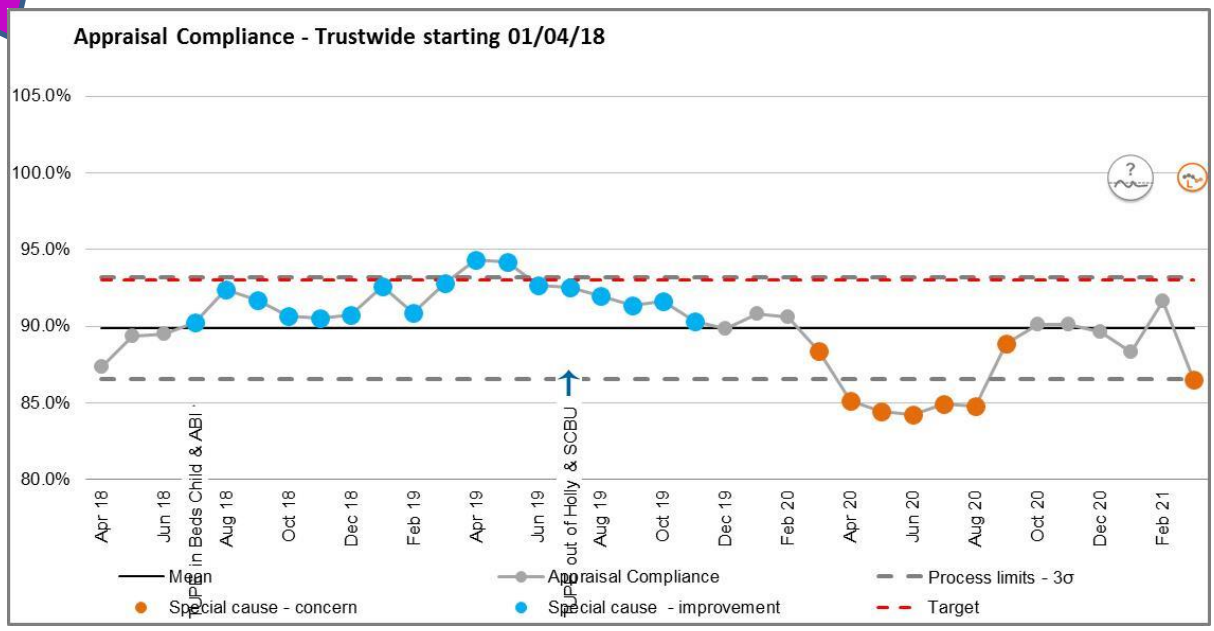


4. Staff Engagement activities

4.1. Significant support continues to be put in place to support all staff. We continue to focus on individual's health and wellbeing, personal resilience and morale. Workforce challenges and staff morale is reviewed and discussed at our weekly incident management team meetings. System wide offers for more extensive psychological support are available for all staff and these are constantly promoted.

4.2 All of the activities previously reported continue. We have continued with the monthly service and bi-weekly corporate Q&A sessions for all staff with executive team members and Service Directors.

4.3 A significant focus continues with our staff to make sure they have access to the Covid-19 vaccination and all staff have been offered the opportunity of having their 1st vaccine. Our Chief Nurse and Medical Director have been leading conversations with staff in relation to any concerns/questions that they may have in relation to having the vaccine. Our staff covid vaccination rates as at 11 May 2021 are 81.3% for 1st dose and 64.45% for 2nd dose.

4.4 Our BAME Network and Long Term Conditions and Disability Networks continue to meet on a regular basis. The Trust is also looking to establish a LGBTQ+ network and has sent out an invite to all staff to join Q&A sessions during May 2021 to ascertain whether there is interest from staff in setting this up. Anita Pisani will chair the initial discussions and a further update will be shared with the Board in July 2021. Initial feedback to the invite has been positive.

5. Staff Opinion Survey – update on next steps

5.1 Results from the National 2020 Staff Survey continue to be shared and discussed far and wide across the Trust. Both Trust wide and service specific feedback is being looked at in detail.

5.2 In relation to our Trust-wide improvement plan, the following three objectives have been identified and will be taken forward by our partnership group during 21/22. The objectives are:

- To undertake a review of staff views on the quality of care in their service and to review this feedback and take action as required.
- To support staff who are experiencing work related stress
- To support staff to minimise MSK issues and to access early interventions.

5.3 Service level improvement plans will also be developed and HR Business Partners are working with the service teams to identify these.

6. Creating a Culture of Civility and Respect

6.1 Bullying and harassment have no place in the NHS and in our Trust. The NHS Long term plan recognised that levels of bullying and harassment have to come down if the NHS is to achieve its aim of being an employer of excellence.

Key messages from our staff survey results 2020 for bullying and harassment:

- As a Trust, our performance was as good as “best organisations”. Whilst this is positive, the score is 8.9 and as a Trust we should be aiming for a score of 10.
- There are some services where their score was below the Trust score and we need to support these services to change this.

6.2 To support a change in the levels of bullying and harassment, NHS England and NHS Improvement have produced a toolkit for organisations to use to promote a culture of civility and respect. Incivility and disrespect include:

- Overt, rude or unkind behaviours and micro-behaviours and attitude e.g. tone of voice, raised voice, rolling eyes, sharp comments, being overtly critical
- Covert behaviours, including gossiping, undermining and excluding people
- Low intensity poor behaviour – characterised by rudeness and discourtesy where the intent to cause harm is not clear
- Behaviours that are so subtle that may not fit a formal definition of bullying or discrimination contained in HR policies

6.3 Research has shown that grouping this range of behaviours under one term such as bullying does not provide the right level of focus. Instead, a focus on incivility and disrespect enables employees and employers to recognise, understand and take proactive action to address underlying behaviours. It also enables witnesses/bystanders to call out unprofessional behaviours and set expected standards with one another.

Key messages for us as Trust:

- Policy and language shift – from focusing on a formal bullying and harassment process and policy to creating a culture of civility and respect.
- As part of creating a culture of civility and respect we need to shift to early intervention and promoting the restoration of working relationships before they escalate.
- To support the above shifts we will:
  - Develop our HR team skills and competencies

- Develop staff and management support and competencies to have "courageous" conversations and address issues as they arise.

7. Future Ways of Working – post Covid-19

7.1 In response to the Covid-19 pandemic, our Trust has adapted, transformed and delivered essential services, during the most unprecedented, demanding, and challenging time the NHS, the country and the world has experienced. Our response has broken through cultural and technological barriers that previously prevented remote/virtual working and connections across the large geographical footprint that we operate in.

7.2 Our approach to working and delivering services has been characterised by a significant shift to virtual consultations and remote working, although several services have continued to deliver face-to face services in patient's homes and in clinic settings.

7.3 The change in the way we and other organisations have been working and delivering services over the last 12 months, has created new expectations for both patients/service users **and** for our employees and a desire for these to continue to be met.

7.4 As we progress towards the end of the government's roadmap to easing lockdown, we are considering "what next" – what is our approach and plan for future working arrangements; moving from what was a Plan B, crisis response, to one that enables us to respond to patients/service user and employee needs and expectations.

7.5 It is unlikely that there will be a one size fits all, given the range of services that we deliver. However, our approach(es) will need to:

- Be informed by the insights that we and other organisations have gained from the experience we have had from remote/virtual working or a blended approach of remote and site/setting based (including patient's homes).
- Be able to leverage and maximise the benefits as well as addressing the challenges associated with the way we have been working over the last 12 months.
- Bear in mind the importance of diversity and inclusion in any decisions or plans made – from ensuring that decisions don't discriminate against certain groups of employees to fostering an inclusive working environment that takes account of the different experiences people have had during the pandemic.

7.6 To support services consider their future working arrangements we have developed a discussion framework, with a series of questions to aid conversations, that include:

- What is needed/wanted
- Practicalities
- Social and psychological impacts
- Changes to processes, policies, and procedures

7.7 Service Directors will work together to ensure that decisions are equitable and fair across the Trust.

7.8 Whatever approach(es) are taken, these will be reviewed and monitored regularly to understand the impact on service delivery and employee experience.

8. Review of Investigation and Disciplinary Policy and Procedures

8.1 NHS England/Improvement have requested that all NHS organisations review their investigation and disciplinary policy and procedures to make sure that they are as compassionate, supportive and inclusive as they can be. This review follows a tragic event that occurred in 2016 at Imperial College Healthcare NHS Trust. Following this event an independent investigation was commissioned by the Trust and a number of recommendations were made. Full details can be found here: https://www.imperial.nhs.uk/about-us/news/investigation-disciplinary-process-actions-and-learning-for-trust.

8.2 We are currently in the process of reviewing our policies, procedures and internal systems with our staff side colleagues to ensure that we address the recommendations made. A brief summary of these are detailed below:

- Adhering to best practice
- Applying a rigorous decision making methodology
- Ensuring people are fully trained and competent to carry out their role
- Assigning sufficient resources
- Decisions relating to the implementation of suspensions/exclusions are not made by one person alone.
- Safeguarding individuals health and wellbeing
- Appropriate Board-level oversight

8.3 We are expected to publish our updated policy by 30 June 2021. A gap analysis and any improvement actions will be brought to our June Trust Board session for further discussion and sign off. Our current disciplinary policy is very closely aligned to the revised Imperial College produced following learning from their incident and is in line with ACAS best practice. We have over the past couple of years revised a number of our policies in line with our people first focus and have reviewed them through the lens of a 'fair and just culture'.

9. Current workforce challenges

9.1 At our Clinical Operational Boards in early May the following workforce challenges were highlighted. No action is required by the Trust Board as local actions and mitigations are in place to address these. A summary is below:

- The impact of the longevity of the pandemic on the health and wellbeing of our staff. This is monitored and reviewed regularly by our senior leaders and through our weekly Incident Management Team (IMT). Variable impact on teams and individuals at different times and for different reasons. Constant review and promotion of our health and wellbeing stepped offer takes place and access to more intensive/targeted psychological support is put in place where needed at both a team and individual level. (Risk 3163 and Risk 3164). The health and wellbeing of our workforce remains a key focus in all recovery and restoration planning conversations Trust-wide.

- 0-19 Health Child Programme – Trust-wide. Staffing pressures in some of our Health Visiting and School Nursing teams. Skill mix options and joint advertisements in place. The Trust is also supporting 3 members of staff in our Bedfordshire and Luton teams to undertake the Level 5 Assistant Practitioner

apprenticeship. To mitigate risks our services are working in line with our agreed escalation/business continuity frameworks and our Clinical Leads continue to meet on a regular basis with our Deputy Chief Nurse to share and learn together.

- Community Paediatrics – Luton and Bedfordshire. Details of the pressures and actions being taken to address this area is covered in the Outstanding Care part of this report, section 6.6.

- Cambridgeshire Children's Community Nursing Services. Provision of a 7 day services remains a challenge, however, some non-recurrent funding has been secured for 21/22 to address the pressures for this year.

- Luton District Nursing Services. Recruitment and retention is a challenge. Vacancy rate has increased in recent months. The service has launched a recruitment campaign recently and is also looking to grow a multi-skilled bank. To support the service it has been agreed to bring in additional recruitment and retention expertise and capacity and this will be in place imminently.

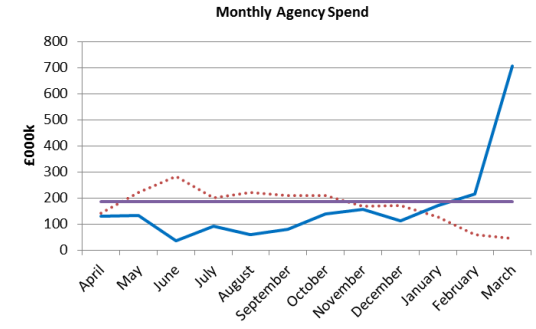
- Dynamic Health. This service currently has a number of clinical vacancies in both physiotherapy and specialist services. Recruitment is ongoing and the team is working closely with its recruitment team to ensure vacancies are advertised, processed and appointed to rapidly.

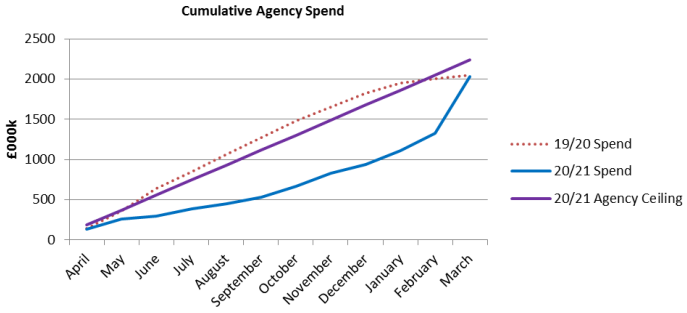
- Mass Vaccination Services. These services have been operating within the Trust since 18th January 2021. As at the beginning of May the Trust had 2000 individuals registered on our health roster supporting our mass vaccination centres. In addition to this the Trust has been supported by a volunteer workforce through RVS; St Johns Ambulance and Voluntary Norfolk. Between January and March 2021 our centres have benefitted from 6500 St Johns Ambulance hours and over 46,000 general volunteering hours. This is significant workforce growth for the Trust which has unfortunately led to a number of internal system and process challenges. Main areas being pay issues/queries and recruitment delays.

- Additional resources have been brought into the Trust to address these areas and it can be confirmed that all pay queries are being addressed and our historical recruitment activities will be completed by end May 2021. Faster payments were made to individuals who were not paid in the April salary run. From 1st April 2021, the Trust is now operating an electronic rostering system for this group of staff which should ensure less pay issues occur in the future.

- We still have vacancies for Registered Practitioners and Clinical Operational Leads at some of our sites and we are currently out to advert for these. The team is also working with local systems to identify additional resources for the period mid-June – mid-August to enable the Trust to manage a known peak in activity.

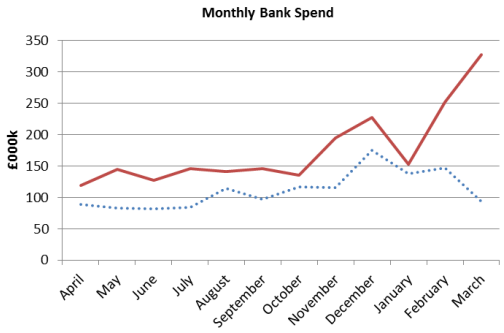
10. Agency/bank spend

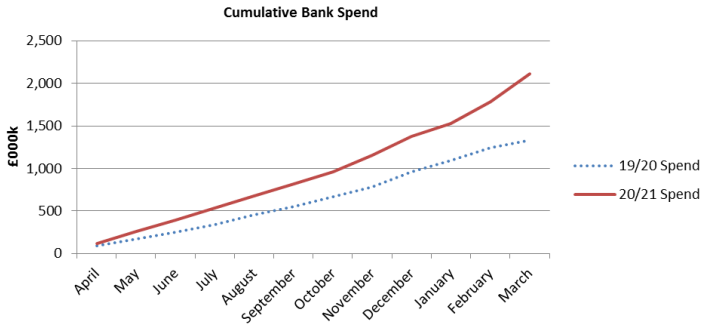




10.1. The Trust's agency spend ceiling for 2020/21 totals £2,240k, which is the same as in 2019/20.

10.2. The Trust's cumulative agency spend for 2020/21 was £2,032k against the spend ceiling of £2,240k. The delivery of the mass vaccination service has increase agency usage over the final periods of the year.





Be an excellent employer

10.3. To assist the Trust to remain within the agency spend ceiling, the services have the availability of bank staff to fill short term staffing pressures. The Trust's cumulative bank spend for 2020/21 was £2,109k. This has increased from 2019/20 spend of £1,333k, which demonstrates a positive increase in usage. The delivery of the mass vaccination service has increase bank usage over the final periods of the year. Substantive staff who are working additional hours to support the mass vaccination service are being paid through the bank.

Collaborate with others

A: Assurance Summary

Well Led	• Strong collaboration taking place across our systems as evidenced in this report (**WL7**)	**Substantial**
Effective	• Research – 95% of all CRN portfolio studies are scoped for viability against Trust services (**E5**)	**Restricted due to C19**

1. The Board can take assurance of the Trust's approach to collaborating with others from the following sources:

- The Trust has in place robust collaborations with Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), East London NHS Foundation Trust (ELFT) and across the provider landscape in Luton.
- The Trust fully participates in STP/ICS activities in Cambridgeshire and Peterborough and in Bedfordshire, Luton and Milton Keynes (BLMK) and is represented on Norfolk's Children Board and Norfolk Alliance.
- Chair and Chief Executive participate in Cambridgeshire and Peterborough STP Board and BLMK ICS Partnership Board.
- Chief Executive is a member of the Cambridgeshire and Peterborough System Leaders group, BLMK CEO group and Bedfordshire Care Alliance CEO group.
- Chair, Chief Executive and Deputy Chief Executive actively involved with other NHS Partners across Bedfordshire and Luton in the development of the Bedfordshire Care Alliance and its core principles.
- Chair attends Leaders and Chairs group across BLMK ICS.
- Deputy Chief Executive jointly chairs the Bedfordshire Local Resilience Forum Health and Social Care Cell with Deputy Chief Executive from ELFT and Director of Adult Social Services from Bedford Borough Council. This forum is managing the Bedfordshire and Luton Out-of-Hospital response to Covid-19.
- Deputy Chief Executive is a member of BLMK Health Cell which is managing the BLMK health response to Covid-19.
- Deputy Chief Executive chairs the BLMK Local People Board and is an active member of the Cambridgeshire and Peterborough Local People Board and the East of England Regional People Board. She is the chair of both the BLMK and Cambridgeshire and Peterborough Leadership and Organisational Development sub-group.
- Executive Leads attend Local Authority System level Health and Wellbeing Boards
- Collaboration is at the core of the Trust's research activities.
- Director of Governance and Director of Finance and Resources are a member of Cambridgeshire and Peterborough STP gold response to Covid-19.
- Research Bi-annual Report received at Quality Improvement and Safety Committee which provided substantial assurance.
- The Trust has made appropriate contributions to system operational plan narratives for 2021/22.

Collaborate with others

B: Measures for Achieving Objective[1]

Measure	20/21 Target	Data source	Reporting frequency	Current Position
The Bedfordshire Care Alliance agreement is signed	Pass/Fail	Exec Team	Annual	Discussions continue and agreement will be pulled together in line with implementation of the White Paper.
The C&P Best Start in Life Strategy Implementation plan milestones are achieved	Pass/Fail	Exec Team	Quarterly	Update on progress in this area is contained in this report.
The Norfolk & Waveney CYP Service Transformation Alliance Agreement is signed	Pass/Fail	Exec Team	Quarterly	Alliance Agreement signed in March 2021
Achieve our target to recruit patient/service users to research studies	Pass/Fail	Exec Team	Quarterly	Recruitment restricted at present due to Covid-19

C: Risks to achieving objective

Strategic risks

1. ***Risk ID 3167*** *– As the NHS is performance managed and discharges accountability at system level, there is a risk that the Trust is treated only through the view of the challenged Cambridgeshire/Peterborough system and therefore access to capital; revenue support and discretionary national transformation monies are not available to the organisation. (Risk Rating 8)*

2. ***Risk ID 3165*** *– There is a risk that the Trust does not have sufficient capacity and capability to manage and meet commissioner and patients expectations, due to the complexity of system working.(Risk Rating 8)*

3. ***Risk ID 3164*** *- there is a risk that the Trust is unable to maintain high quality care due to the number of services/teams facing workforce challenges.(Risk Rating 12)*

4. ***Risk ID 3300*** *- Delivery of the mass vaccination programme for our staff and to the communities across Norfolk & Waveney, Cambridgeshire & Peterborough may be impeded by a range of factors including workforce supply and vaccine which could result in continued risk to our staff, the delivery of services to patients and those communities awaiting vaccination.(Risk Rating 12)*

[1] New indicators will be developed for Board approval in June 21.

5. ***Risk ID 3323 -*** *Risk to organisational reputation of delivery of the Lead Provider Contract for the roll-out of the Mass Vaccination Programme for Cambridgeshire & Peterborough and Norfolk & Waveney given the significant pace, complexity and political profile of the programme.(Risk Rating 12)*

Operational risks

1. ***Risk ID 3227 -*** *There is a risk services will not have the capacity to provide timely and effective response to children & adult safeguarding enquiries during the pandemic. This may result in a failure to support multiagency decision making to assess actual or likely risk of significant harm and provide timely intervention to promote the wellbeing and protect children/young people and adults at risk of harm. (Risk Rating 16)*

2. ***Risk ID 3072 -*** *Bedfordshire Community Paediatrics: There is a risk that continued delays with Children not receiving a medical assessment and follow up (including medication reviews) in a timely way may lead to diagnostic delays with potential impacts to Childhood development, undiagnosed medication side affects e.g. arrhythmias and parental and stakeholder dissatisfaction resulting in Trust reputational damage (Risk Rating 15)*

D: Overview and analysis

Strategic work-streams with others

A summary of key system collaborations follows:

BLMK ICS

1. BLMK Partnership Board

Meeting held on 3 February 2021 - Key agenda items:

- On-going response to the Covid pandemic; the Board recorded their thanks to all those involved in managing the response to the pandemic.
- Flu closure report; the Board recorded their thanks to all those involved in delivering the extensive programme.
- Modernising mental health services in Bedfordshire; the Board supported a proposal for an inpatient MH facility in Bedford.
- Health inequalities; no decisions taken.
- Population Health Management; no decisions taken.

Meeting held on 7 April 2021 - Key agenda items:

- Public questions; none tabled.
- Executive lead update; noted, no actions.

- Covid vaccination programme update; the Board received a comprehensive update including a focus on efforts to vaccinate hard-to-reach communities.
- Strategic priorities – outcomes from workshops; the Board was briefed on 2 workshops held in March 2021 that focussed on ICS strategic priorities and desired outcomes for the population.
- Board membership; it was agreed the Board would receive a report at a future meeting (note agenda for 5 May 21 meeting below).
- Milton Keynes Care Alliance update; noted by the Board.
- Finance update; noted by the Board.

Meeting held on 5 May 2021 - Key agenda items:

- Public questions.
- Executive lead update.
- Financial Out-turn 20/21 and Financial Plan 21/21.
- BLMK Plan 21/22.
- Diagnostic Hubs – Cancer Strategy Paper.
- Partnership Board Membership.
- Strategic Priorities – Patient and Public Engagement.
- Consultation of NHS Oversight Framework 21/22.
- Bedfordshire Care Alliance Update.

2. Bedfordshire Care Alliance (BCA)

Meeting held on 18 March 2021 - Key agenda items:

- Report from BCA Frail & Complex Care Oversight Group.
- Falls Review Recommendations; the review revealed an opportunity to improve outcomes for the population and the system with short and medium term recommendations and a desired future state.
- Discharge to Assess; scope to improve the discharge function and community service offers. The vehicle to resolve this is the better care fund and will be discussed at the health cell.
- Primary Care; The Alliance noted the opportunity to bolster capacity in Primary Care using the additional role re-imbursement and the associated training opportunities.

<u>Cambridgeshire and Peterborough STP (C&P)</u>

3. C&P Integrated Care System

- Draft paper setting out the rationale and next steps for forming a Children's and Young Peoples Collaborative has been prepared for review by System Leaders.
  - In time this will embrace the Best Start in Life (BSiL) (see below)

- Contribution to system operational plan for 2021/22 (submitted in draft 6 May 21 and final submission due early June 2021.

4. Joint Children's Partnership Board - CCS/CPFT contractual joint venture

Meeting held on 20 April 2021 - Key agenda items:

- Partnership for delivering children and young people's mental health services between CPFT/CCS/Centre 33 and Ormiston Families.
- Integrated Governance Report for joint services.

5. Cambridgeshire and Peterborough Best Start in Life Strategy

- This work continues to be led by John Peberdy our Service Director for Children and Young Peoples Services across Cambridgeshire and Peterborough.
- The place-based work-streams (Cambridge City, Central and Thistlemoor in Peterborough, Honeyhill in Peterborough, Wisbech) have benefited from LA-funded project management support and are making good progress; a detailed update is available if required.
- Programme will link with ICS resources around digital, branding, estates and workforce.

6. North and South Alliances

- The Trust continues to be represented at the North and South Alliances; the focus remains on creating integrated neighbourhoods.

NORFOLK STP

7. Norfolk CYP Alliance Board 18th March (first meeting of the Joint Shadow Board)

- Children and Young Peoples Strategic Partnership and the Children's Alliance Board will operate a new governance arrangement from April 2021.
  - Governance review; TOR adopted; and membership reviewed.
  - Name of Board agreed: Norfolk Children and Young People Strategic Alliance, with choice of branding to follow.

- Board will function in 2 parts:

  - Part A - New Strategic Board which will act as a guardian, agree strategic priorities and ensure delivery of the Children and Young People's Partnership Plan, also monitor performance in relation to securing impact and outcomes. Agree strategic commissioning and transformation priorities and promote co-production with service users and stakeholders. This Board will also advocate on behalf of children and young people within wider partnerships and boards.

- Part B – Commissioning Executive – who will have a clear oversight around any collaborative commissioning arrangements and other arrangements for pooling and sharing resources, to oversee commissioning/contractual action to promote improvement of existing services, look at alternative providers. Make recommendations on the further development, or conduct, of any procurement within the market for children and young people's services in Norfolk and Waveney. They will also oversee the development of the Alliance Contract and agreements (commissioner only aspects).

- Endorsed FLOURISH impact and outcomes framework (shared at COB).
- Subgroups**:**
  - Alliance Executive Management Group -To ensure delivery of the actions, impacts and outcomes for children and young people's mental health arising out of the Norfolk and Waveney Children and Young People's Alliance (mental health) transformation programme.
  - SEND - multi agency steering group.
  - Early Prevention Board.
  - Need for a MASH Strategic Group as sub group under review.

- Speech and Language; the joint strategic planning and commissioning of Children and Young People's Speech and Language Therapy Services has been jointly led by NCC working closely with the CCG and a range of stakeholders. It will be overseen going forwards by the Norfolk Children and Young People's Strategic Alliance.

8. Norfolk Alliance Agreement Work-stream

- The Alliance Agreement[2] has been signed.

9. Research Update – February to March 2021

Clinical Research Overview

9.1 We have continued to successfully work with the Trust services to restart the National Institute for Health Research (NIHR) Portfolio studies. The studies running within the Trust are either in the 'set-up' stage or have been or about to restart. In 2020-21 a total of 14 research studies (11 portfolio and three non-portfolio studies) were running within the Trust; 332 participants were recruited into the portfolio research and 626 into non-portfolio and other studies, during the preceding 12 month period. The total being 958 subjects enrolled in research studies.

[2] Norfolk Alliance Agreement 2021-2029 - The Agreement describes how parties will collaborate "*to ensure integrated, high quality, affordable and sustainable mental and physical health and care services are delivered in the most appropriate way to ensure the greatest and fastest possible improvement in the health and wellbeing of Children and Young peoples (CYP) in Norfolk and Waveney*" and sits alongside commissioning contracts.

SO3

Collaborate with others

9.2 The Clinical Research Network (CRN) East of England has agreed to fund 2.0wte Research Facilitators for this coming year (2021-2022). We have also applied for additional ad-hoc funding from the CRN to support Trust funded roles to further expand our research capacity within services across the Trust. We are currently covering the essential research activities and prioritising supporting the NIHR portfolio studies.

9.3 **National Institute for Health Research (NIHR) Portfolio studies:**
The NIHR Clinical Research Network has a portfolio of high-quality clinical research studies which are eligible for consideration for support from the CRN in England. Studies the Trust is currently involved in are detailed in Table 1.

Table 1: Clinical Research for NIHR Portfolio Studies (accurate to 01/04/21 via ODP NIHR portal)

Key to icons:					
Recruitment:	Increased	No change	Completed	in set up	allocated funding/prize

NIHR Portfolio studies	Clinical Area	Collaboration with University/ University Trust	Numbers this reporting period (*1)	Total for financial year	Trend	Highlights	Impacts
ESCAPE Study (Cessation of smoking in patients with mental health)	Trust Wide (staff)	University of Bristol	**0**	48		Open for recruitment	Supporting future smoking intervention development
Yourtube	Children & Young People's Service (CYPS) Cambridge	University of York	**2**	4		Study open for recruits and follow up	Building research knowledge in an area of high interest.
Balance Study	CYPS Bedford Orthoptics	Moorfields Eye Hospital	**0**	2		Study reopened 1st October	Important technology study
NESCI Study	CYPS Norfolk	University of East Anglia	**0**	1		closed	Development of intervention for smoking cessation
Babybreathe	CYPS Norfolk	University of East Anglia	**0**	0		Recruitment delayed	Smoking cessation and education intervention
This Mum Moves	CYPS Cambridge and Peterborough	Sport England/ University of Canterbury	**6**	8		Recruitment commenced	Education and exercise intervention post pregnancy
Virus Watch	Luton Adult and Children's	University College London	**6**	117		Phase 1 Recruitment complete	Urgent Public Health Covid-19 Research
Venus 6	Luton Adults	Manchester University	**0**	0		Due to commence recruitment May 2021	Venous Ulcer RCT
Total recruitment within this period:			**14**	**332**	**RCF count for recruitment started from October 2020** (*2)**.**		**Total for all NIHR Recruitment.

(*1) All figures accurate as of 01/04/21 from the Research Impact Recording Tool (totals of Open Data Platform (ODP) and EDGE databases) due to database delay, known figures vary).
(*2) Research Capability Funding (RCF) is allocated to research-active NHS health care providers if they recruited at least 500 individuals to non-commercial studies, conducted through the NIHR Clinical Research Network (CRN), during the previous NIHR CRN reporting period of 1 October – 30 September. This was achieved for the last 2 financial years.

Collaborate with others

9.4 **NIHR portfolio studies which have been considered for feasibility:**
During this period of time the Research team has considered 120 studies for suitability for adoption into the Trust. None of the studies were considered for adoption, due to not fitting with Trust services.

9.5 **Non-Portfolio studies – projects and research studies which have been considered for feasibility and/or submitted for Health Research Authority (HRA) approval:**
Non-portfolio studies are studies that do not meet the criteria for adoption by NIHR and are, therefore, not entitled to Clinical Research Network (CRN) funding or support. However, if studies are defined as research then projects are still required to be submitted to the HRA for approval. This process includes ethics, project approval and sign off by the host NHS site. There were no non-portfolio studies submitted to the HRA in this reporting period.

9.6 **Student studies and non-student studies – Local Permissions:**
During this reporting period there were two students (Trust staff) and no non-student studies submitted for local Trust permissions. There were also two MSc major projects which clinicians were undertaking; both are looking at remote patient assessment: one study is in Norfolk and the other will be undertaken in Luton (Table 2).

9.7 A clinical project about to commence is on 'BAME children in special needs school – parental feedback of CCS services'. The leads for this project are paediatricians in Bedfordshire.

Table 2: Update of MSc studies receiving permissions and considered for feasibility

Study considered	Speciality/ clinical area/ location	Study overview	Collaboration with University/ University Trust	Barrier/s or potential barrier/s to undertaking
Clinical Project	Children & Young People's Service (CYPS) Bedfordshire	BAME children in special needs school – parental feedback of CCS services.	n/a	Nil, is being done as part of a service evaluation. Other Paediatricians will participate.
MSc in Advanced Clinical Practice	CYPS Luton	Staff views and barriers to undertaking virtual consultations.	University of Bedfordshire	Demands of working full time, working differently.
MSc	CYPS Norfolk	Evaluation of Resilience and Emotional Health Practitioner interventions via a remote consultation platform. Investigating their impact compared to face to face	Anglia Ruskin University	Thematic analysis is being undertaken. Self-funded for MSc and study leave. Timelines for university ethics have delayed start of project.

9.8 **Fellowships, Internships, PhD Programmes and Grants:**
The Fellowships and Internships are very competitive and are typically funded by the NIHR or the NIHR in conjunction with Health Education East of England (HEEoE) (HEE). In this reporting period there was one member of staff from adult physiotherapy who submitted a NIHR Fellowship application for the next round and no staff had commenced a new Fellowship (see Table 3). A member of staff, from iCaSH, who had applied to two PhD programmes at different universities in the last reporting period, has now applied for another PhD programme.

9.9 **Grants:**
A NIHR Research for Patient Benefit (RfPB) stage 2 application for a study exploring home-based music therapy with patients who have had strokes (see Table 3) was submitted in November 2020; we are awaiting the outcome.

Table 3: Summary table for Fellowships/Internships/PhD Programmes and NIHR Grant Submission/s Update on applications and results within this reporting period

NIHR Fellowships/ grant	Area	Numbers	Trend	Collaborations	Impacts/potential impacts
PhD programme	Ambulatory Care iCaSH	3 applications by one clinician	3 applications submitted, awaiting outcome	University of Edinburgh University College London Kings College, London	Great for clinical staff to apply for these opportunities.
NIHR Research for Patient Benefit (RfPB)	Neuro-rehab Team Bedford	One submission to Stage 2	Stage 2 submitted end of Nov 2020. Unsuccessful	Research Fellow from Anglia Ruskin University, Research team and Neuro Rehab team	Potential to have a music therapy grant running in Neuro-rehab, Bedford
NIHR/HEE Applied Research Collaboration (ARC) Fellowships	Children & Young People's Service (CYPS) Norwich & Luton	Two	Fellowship commenced January 2020 for 12 months. Both extended to December 2021.	Applied Research Collaboration (ARC)	Working with children in geographical areas of high health needs.
NIHR/HEE Internship	CYPS Cambs (Occupational Therapy)	One	Commenced Jan 2020, due to finish June 2020. Was extended to March 2021 due to Covid-19.	Health Education East of England	Exploring parental distance learning video teaching sessions on life skills for children with dyspraxia.
HEE/NIHR Integrated Clinical Academic Programme (ICA Pre-doctoral Clinical Academic Fellow	CYPS Cambs (Speech & Language Therapy)	One	Commenced Sept 2019. 2½ years duration. Progress has continued throughout lockdown.	University of London	Includes MRes in Applied Research In Human Communication Disorders.

9.10 **National High Level Objectives (HLO)** as determined by the Department of Health & Social Care (DHSC) and monitored by the CRN Eastern. These objectives have been refreshed and re-activated, as part of the NIHR Restart Programme.

9.11 **Health Research Authority (HRA)** national and ethical approval (where appropriate) has been obtained for all the NIHR Portfolio and Non-Portfolio studies.

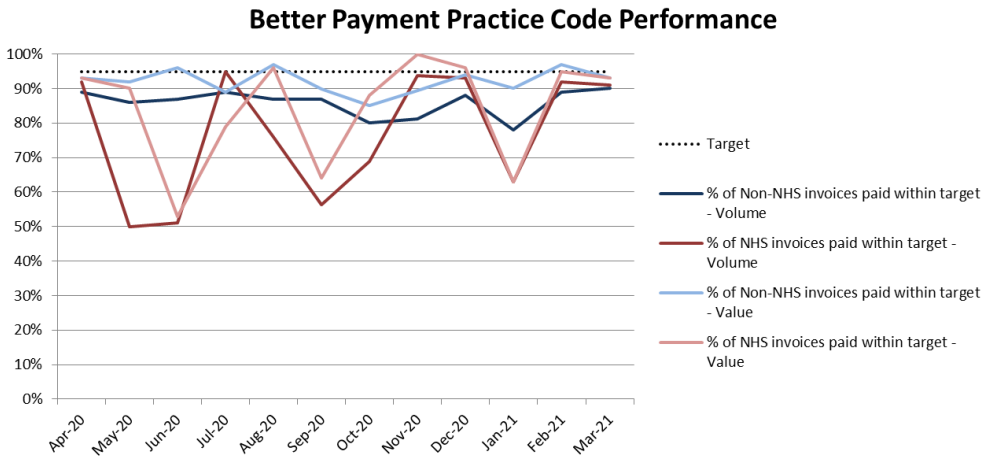
9.12 **NIHR National Performance Metrics** – Performance in Initiating (PII) and Performance in Delivering (PID) had been re-instated and collated by the DHSC. We have been notified by the DHSC that Quarter 3 and Quarter 4 performance metrics collation and publication are going to be delayed until April 2021.

9.13 **Published papers & posters within this period:**

- There have been five posters presented: four were at the Royal College of Paediatrics and Child Heath (RCPCH) Virtual International Conference in March 2021 and one was at the British Paediatric Neurology Association Conference, jointly with Cambridge University Hospital.

- There was one paper and one poster published during this period. The paper was an invited one for the journal of 'Developmental Medicine and Child Neurology'.

10. Public sector prompt payments



10.1 The average in month prompt payment results across the four categories was 93% in month 11 and 92% in month 12.

10.2 With regards to NHS invoices, performance remained high over the period with an average achievement in each category of 92% and 94% for Volume and Value respectively. The Trust is worked hard to consistently improve the NHS performance.

10.3 With regards to Non-NHS invoices, achievement in both categories has been relatively consistent in the last 12 months – with an average of 89% achievement over this period. Over the current period, the average achievement in each category of 90% and 95% for Volume and Value respectively.

10.4 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.

SO4

Be a Sustainable Organisation

A: Assurance Summary

Well led	• I&E in line with budget (**WL1**) • Recovery of COVID-19 costs (**WL2**) • CIP in line with plan (paused for Covid-19) (**WL3**) • Capital spend in line with budget (**WL4**) • Use of resources figure is a 1(**WL5**) • Reduced travel mileage spend by 50% against budget (**WL10**)	**Substantial**

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 Risk number 3167, 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 it's "Value for Money conclusion" of the Trust's 2019/20 accounts. Internal Auditor's assessments during 2019/20 provided a conclusion 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 COVID-19 pandemic has required emergency funding measures to be put in place for the current and potential future financial reporting period. In 2020/21 the Trust achieved an overall balanced position for the year. A explanation of the financial performance of the clinical directorates is included in the Income and Expenditure section below.

B: Measures for Achieving Objective

Measure	20/21 Target	Data source	Reporting frequency	19/20 Delivery
Sustain a 'Finance and Use of Resources' score of 1	1	NHSI Finance Return	Monthly	Achieved
To secure that share of contract revenue that is directly linked to performance	Pass	Contract Report	Quarterly	Achieved
To deliver a rolling 12 month programme of capital investment at a minimum average of 6% of the capital base value per annum	Pass	Finance Report	Annual	Achieved
Sustainable Development Assessment Tool	Above national average	Annual Self Assessment	Annual	Achieved
Revenue remains above a minimum threshold	>£75m pa	Finance Report	Annual	Achieved

C: Risks to achieving objective

Strategic risks

1. ***Risk ID 3167*** *- As the NHS is performance managed and discharges accountability at system level, there is a risk that the Trust is treated only through the view of the challenged Cambridgeshire/Peterborough system and therefore access to capital; revenue support and discretionary national transformation monies are not available to the organisation. (Risk Rating 8)*

Any operational risks 15 and above

1. ***Risk ID 3072 -*** *Bedfordshire Community Paediatrics: There is a risk that continued delays with Children not receiving a medical assessment and follow up (including medication reviews) in a timely way may lead to diagnostic delays with potential impacts to Childhood development, undiagnosed medication side affects e.g. arrhythmias and parental and stakeholder dissatisfaction resulting in Trust reputational damage (Risk Rating 15)*

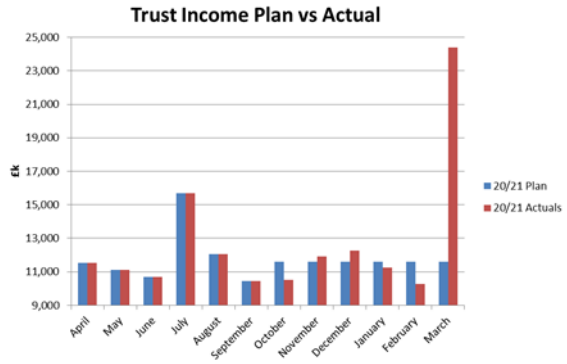
D: Overview and analysis

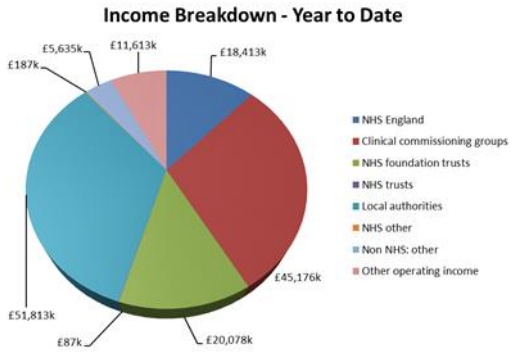
Finance scorecard

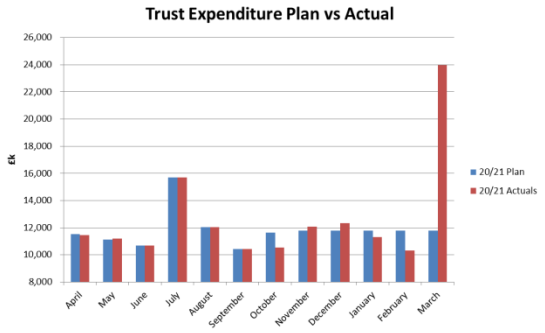
Finance Dashboard	Section in Report	Plan M12	Actual M12	Variance M12
Operating income	1	£141,106k	£153,002k	£11,986k
Employee expenses	1	(£89,554k)	(£97,841k)	(£8,287k)
Operating expenses excluding employee expenses	1	(£52,465k)	(£54,860k)	(£2,395k)
Trust Surplus/(Deficit)	1	(£913k)	£0k	£913k
Closing Cash Balance	2	£11,416k	£20,382k	£8,966k
Capital Programme	4	£4,880k	£5,069k	(£189k)
Agency Spend	SO2 - 4	£1,122k	£2,032k	(£910k)
Bank Spend	SO2 - 4	£1,262k	£2,109k	£847k

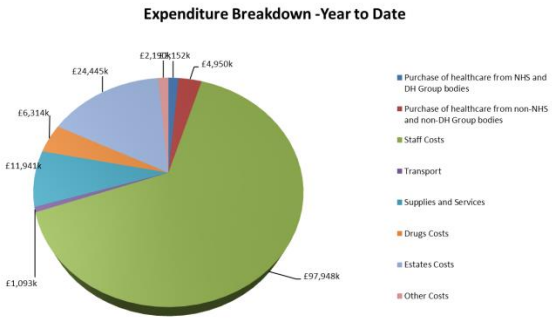
S04 Be a Sustainable Organisation

1. Income and expenditure









1.1. Due to the Covid 19 pandemic, interim block funding arrangements are in operation for 2020/21, based on an uplift of 2.8% on 2019/20 contract values. The Trust was required to report a breakeven position for 2020/21, which was a change from the revised plan position with a forecast deficit of £913k. The revised position was achieved through the redistribution of funding within the Cambridge & Peterborough system.

1.2. Income and expenditure increased at year end due to the reporting recognition of the additional 6.3% employer's pension contribution, which is paid directly by NHSE (£4.1m), mass vaccination income and expenditure and DHSC centrally procured inventories.

1.3. The direct clinical service budget position in each Service Division is:

	Mar-21					
Division Level	Income £'000	Pay £'000	Non-Pay £'000	Net Total £'000	Net Budget £'000	Variance £'000
Ambulatory Care Service	1,375	(19,721)	(9,375)	(27,721)	(29,801)	2,080
Bedfordshire Community Unit	1,419	(13,704)	(2,160)	(14,445)	(14,001)	(444)
Childrens & Younger Peoples Services	2,327	(29,437)	(2,657)	(29,767)	(31,003)	1,236
Luton Community Unit	2,017	(19,253)	(3,376)	(20,613)	(21,252)	640
Other Services	141,766	(11,627)	(37,593)	92,545	96,057	(3,512)
CCS Total @ 31st March 2021	**148,904**	**(93,742)**	**(55,162)**	-	-	-

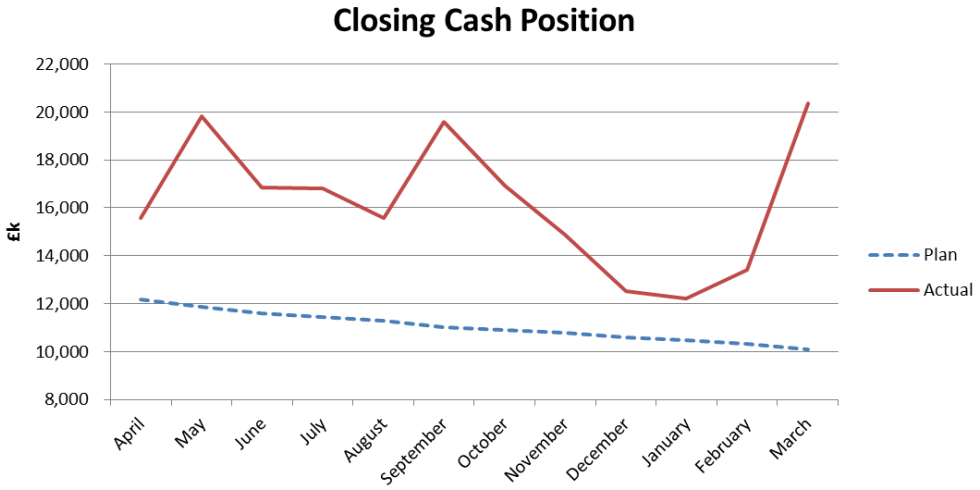
1.3.1. Ambulatory Care delivered a final year end surplus position of £2,080k. The main reason for the underspend, which is mainly in non-pay expenditure, is due to the reduction in service activity resulting from Covid 19, particularly in pathology costs in the iCaSH services. This position is offset in part due to the reduction in income received from out of area patients and recorded in "Other Services" in the table above.

1.3.2. Bedfordshire Community Unit delivered a final year end deficit position of £444k. The main reason for the overspend is due to locum pay spend in Community Paediatrics.

1.3.3. Children's & Younger Peoples Services delivered a final year end surplus position of £1,236k. The main reason for the underspend is a fall in non-pay expenditure, particularly reduced travel costs as a result of Covid 19.

1.3.4. Luton Community (including Luton Children's Services) delivered a final year end surplus position of £640k. The underspend position is due to pay establishment savings in both Adult and Children's services.

2. Cash position

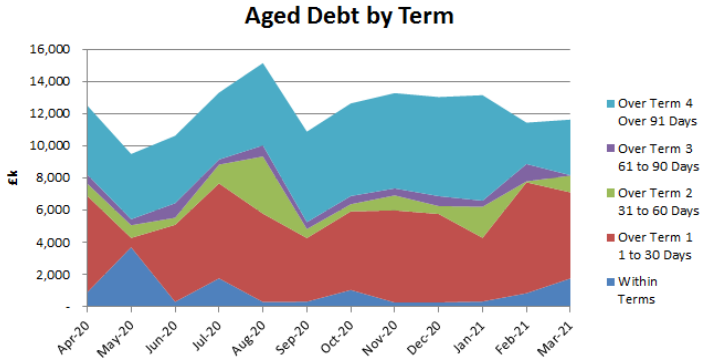


2.1 The cash balance of £20.4m at month 12 represents an overall increase of £8.2m on the previously reported position at month 10. The Trust has received cash funding of £6.4m in month 12 for the provision of the mass vaccination service. Additionally, payables have increased and receivables have decreased over the period.

3. Statement of Financial Position

	March 2021 £'000	January 2021 £'000
Non-Current Assets		
Property, plant and equipment	56,131	55,811
Intangible assets	336	251
Total non-current assets	**56,467**	**56,062**
Current assets		
Inventories	342	41
Trade and other receivables	16,902	17,907
Cash and cash equivalents	20,386	12,210
Total current assets	**37,630**	**30,158**
Total assets	**94,097**	**86,220**
Current liabilities		
Trade and other payables	(26,838)	(19,774)
Provisions	(910)	(622)
Total current liabilities	**(27,748)**	**(20,396)**
Net current assets	**9,882**	**9,762**
Total assets less current liabilities	**66,349**	**65,824**
Non-current liabilities		
Trade and other payables	(1,045)	(1,045)
Provisions	(968)	(1,264)
Total non-current liabilities	**(2,013)**	**(2,309)**
Total assets employed	**64,336**	**63,515**
Financed by taxpayers' equity:		
Public dividend capital	2,434	2,245
Retained earnings	44,256	43,624
Revaluation Reserve	19,299	19,299
Merger Reserve	(1,653)	(1,653)
Total Taxpayers' Equity	**64,336**	**63,515**

3.1 Trade and other receivables have decreased over the reporting period by £1.0m and trade and other payables have increased over the reporting period by £8.2m. The cash received for the mass vaccinations has not been fully expended. Any funds unutilised at the year end (£3.2m) are reported as a payable.



3.2 Total trade receivables decreased by £1.7m in February to £11.4m and then increased by £0.2m in March to £11.6m. The breakdown in March is £2.8m (24%) from NHS organisations; £8.2m (71%) from Local Authorities; and £0.6m (5%) from other parties.

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

Norfolk County Council	£2.6m
Cambridgeshire County Council	£2.5m
Luton Borough Council	£1.5m

3.4 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 (Month 12) Norfolk County Council and Cambridgeshire County Council have subsequently paid £2.6m and £1.8m respectively to reduce their outstanding balance.

4. Capital spend

4.1 Capital spend to date is £5.1m against a plan of £4.9m. The main areas of spend are IT equipment (£2.5m), North Cambs Hospital building works (£1.0m) and Princess of Wales Hospital development (£0.9m). The Trust received additional CIR funding for the spend over plan.

5. Use of resources

5.1 This metric is currently not being reported on due to Covid 19 and the emergency financial measures in place.

6. Contract performance

6.1 Due to COVID-19 contracted processes performance monitoring have been suspended, and focus is on working with commissioners to prepare for and respond to the emergency and relax local monitoring requirements. The Trust continues to monitor and report contracted KPI's within the Clinical Operational Boards.

PART TWO

Supporting Information

CCS NHS Trust Quality Performance Dashboard

Standard/Indicator	Description	Contact	Apr-20 CCS Overall	May-20 CCS Overall	Jun-20 CCS Overall	Jul-20 CCS Overall	Aug-20 CCS Overall	Sep-20 CCS Overall	Oct-20 CCS Overall	Nov-20 CCS Overall	Dec-20 CCS Overall	Jan-21 CCS Overall	Feb-21 CCS Overall	Mar-21 CCS Overall	Sparkline
SAFETY															
Patient safety															
Classic safety thermometer	% Harm free care	H Ruddy													
	% New harm free care														
Incidents															
Total number of new Datix incidents reported in month	New patient safety incidents including SIs, Never Events and medication incidents	L Ward	96	106	108	150	107	124	162	116	144	119	125	172	
	Severe harm		0	0	0	1	0	0	1	0	0	0	0	0	
	Moderate harm		3	14	7	28	8	8	9	4	12	7	8	4	
	Low harm		20	23	20	14	16	27	41	28	40	32	32	43	
	No harm		73	69	81	107	83	89	111	84	92	80	85	125	
Serious incidents	New SIs declared requiring investigation		0	0	0	1	0	0	1	1	0	3	0	1	
Never Events	Number of never events reported in month		0	0	0	0	0	0	1	0	0	0	0	0	
Medicines Management	Number of medication incidents reported (CCS)	A Darvill	17	10	14	14	8	13	20	9	16	16	11	21	
	% CCS medication incidents no harm		94%	100%	93%	100%	88%	100%	95%	89%	94%	100%	89%	90%	
Infection Prevention & Control															
High Impact Interventions	Children's Community Nursing Teams only	C Sharp													
Essential Steps	Compliance with spread of infection indicator														
Clinical Interventions Audit	Compliance with spread of infection indicator		N/A	N/A	N/A	98.44%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
UV light compliance	All clinical teams - data pending		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
EFFECTIVENESS															
Mandatory training															
Overall mandatory training	In line with Trust Training Needs Analysis	J Michael	93%	92%	92%	91%	92%	93%	93%	94%	93%	94%	93%	95%	
Safeguarding training (Children)	Level 1: % staff trained		97%	97%	96%	95%	96%	97%	97%	97%	96%	96%	96%	97%	
	Level 2: % staff trained		97%	97%	97%	97%	97%	97%	97%	98%	97%	98%	97%	97%	
	Level 3: % staff trained		83%	77%	80%	83%	84%	84%	85%	86%	87%	86%	85%	90%	
	Level 4: % staff trained		100%	100%	70%	70%	78%	89%	78%	67%	78%	75%	67%	67%	
Safeguarding training (adults)	SOVA		95%	95%	94%	93%	93%	94%	94%	94%	93%	94%	94%	95%	
	Mental Capacity Act		90%	90%	88%	88%	86%	87%	87%	90%	89%	92%	93%	94%	
	Deprivation of Liberty		93%	95%	93%	91%	91%	92%	93%	94%	94%	94%	93%	95%	
Prevent Basic Awareness	% of staff undertaking Prevent training		94%	93%	94%	94%	95%	96%	97%	97%	95%	96%	95%	96%	
WRAP3	% of staff undertaking WRAP training		91%	88%	88%	87%	89%	89%	89%	90%	91%	93%	94%	95%	
Manual handling	% of staff undertaking manual handling (patients)		90%	89%	84%	84%	89%	88%	85%	77%	76%	76%	73%	78%	
Fire safety	% of staff undertaking fire safety training		91%	90%	91%	90%	92%	93%	92%	94%	93%	93%	92%	94%	
CPR/Resus	% of staff undertaking CPR/Resus training		91%	88%	89%	87%	90%	90%	91%	92%	92%	93%	91%	92%	
IPaC training	% of staff undertaking IPaC training		96%	96%	96%	95%	96%	96%	97%	97%	97%	97%	96%	97%	
Information governance	% of staff undertaking IG training		93%	93%	93%	92%	93%	94%	95%	95%	93%	94%	93%	94%	
Safeguarding															
Safeguarding supervisions (Children)	% eligible staff	D Andrews D Shulver	N/A	N/A	N/A	N/A	57.22%	72.22%	87.41%	88.36%	85.51%	85.00%	86.43%	86.23%	
Workforce/HR															
Sickness	Monthly sickness absence rate	R Moody	4.26%	3.31%	3.29%	3.26%	3.26%	4.02%	5.14%	4.25%	4.79%	5.20%	4.24%	3.78%	
	Short-term sickness absence rate		1.61%	1.00%	1.35%	1.49%	1.51%	2.17%	2.25%	2.41%	2.06%	2.45%	1.58%	1.46%	
	Long-term sickness absence rate		2.65%	2.30%	1.94%	1.77%	1.75%	1.85%	2.89%	1.85%	2.72%	2.74%	2.66%	1.46%	
	Rolling cumulative sickness absence rate		3.09%	4.82%	4.70%	4.55%	4.44%	4.41%	4.42%	4.37%	4.34%	4.32%	4.23%	3.97%	
Turnover	Rolling year turnover		12.98%	12.32%	12.81%	13.21%	11.38%	10.60%	11.39%	11.17%	10.18%	11.84%	11.47%	10.59%	
Bank staff spend	Bank staff spend as % of pay (financial YTD)		1.60%	1.84%	1.81%	1.18%	1.82%	1.83%	1.90%	1.98%	2.07%	1.53%	N/A	N/A	
Agency staff spend	Agency staff spend as % of pay (financial YTD)		1.63%	1.55%	1.11%	1.11%	1.02%	0.99%	1.12%	1.43%	1.43%	1.48%	N/A	N/A	
Stability	% of employees over one year which remains constant		87.70%	87.29%	87.78%	87.71%	88.01%	88.90%	88.92%	89.68%	89.81%	89.99%	89.36%	90.45%	
Appraisals	% of staff with appraisals		85.12%	84.47%	84.26%	84.96%	84.76%	88.86%	90.09%	90.12%	89.61%	88.29%	91.64%	86.54%	
Staff Friends & Family test	Recommending CCS as place for treatment - Quarterly reporting	P Davies/ L Thomas			N/A			93.00%			No data collection in Q3			No data collection in Q4	
	Recommending CCS as place to work - Quarterly reporting				N/A			80.00%							
EXPERIENCE															
Patient experience (monthly targets)															
Complaints	No. of formal complaints received in month	D McNeill	0	0	4	3	4	3	9	5	8	6	3	4	
	No. of responses sent on time by total number of responses sent		3/3	0/1	1	2/3	1/1	2/2	2/3	2/2	0/2	0/4	2/4	1/2	
	Percentage responded to within target timeframe		100%	0.00%	100%	66.67%	100%	100%	66.70%	100%	0.00%	0.00%	50.00%	50.00%	
Informal complaints	No. of informal complaints received in month		9	10	17	20	15	29	24	23	18	21	29	22	
Complaints upgraded	No. of complaints upgraded (informal to formal)		0	0	0	1	0	0	2	2	2	1	0	0	
Complaints downgraded	No. of complaints downgraded (formal to informal)		0	0	0	2	1	2	2	1	1	2	0	2	
Friends & Family test score	Patients who would recommend our services		97.39%	97.20%	95.54%	94.46%	95.07%	93.60%	95.22%	96.96%	96.68%	96.99%	96.18%	96.57%	
	No. of responses to FFT		230	465	560	849	934	1328	1506	1811	1536	2096	1757	2014	
Patient Feedback	Total number of patients surveyed		298	515	630	973	983	1510	1663	1944	1618	2159	3280	2125	
	No. of positive comments recorded on IQVIA		320	600	713	1125	1207	1616	1965	2464	1765	2668	2784	2700	
QEWTT (Quality Early Warning Trigger Tool)															
QEWTT	Number of responses received by scoring threshold	25+	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
		16-24	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
		10-15	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
		0-9	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Number of two consecutive non-responses		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Number of single non-responses		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Total number of responses received		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Total number of Teams		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	

*Note: all sickness figures include C19 sicknesses

N/A	Data usually supplied but not available this month
	Not relevant/not applicable to this area

Appendix 1 – Quality Performance Dashboard

NHS
Cambridgeshire
Community Services
NHS Trust

Infection Prevention and Control Board Assurance Framework – Revised version

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

• Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice.
  • Staff adherence to hand hygiene?
  • Staff social distancing across the workplace.
  • Staff adherence to wear FRSM in;
  ▪ Clinical
  ▪ Non-clinical setting
• Monitoring staff compliance with wearing appropriate PPE, within the clinical setting – consider implementing the role of PPE guardians/safety champions to embed and encourage best practice.
• Implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems in
	CCS NHS Trust does not provide in-patient facilities.
	
	For clinic based services, telephone / virtual assessment is undertaken prior to a face to face appointment being offered. If symptomatic, the service user is advised to follow national guidance re self-isolation and testing. This is recorded in patient notes. Audit of IPC practices is conducted by the leads within the various facilities.
	
	Audits which include hand hygiene and PPE use are included in the UV Hand Hygiene audit and the environmental audit, which have continued throughout the pandemic.
	
	Frequency of the environmental audit has been increased in the Mass vaccination Centres to monthly from April 2021.
	
	Unannounced environmental monitoring and Clinical Intervention audits undertaken by IPAC team.
		No gaps identified 14/04/2021	

Appendix 2 – IPaC Board Assurance Framework – April 2021

place to monitor results and staff test and trace. • Additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team. • Training in IPC standard infection control and transmission-based precautions are provided to all staff. • IPC measures in relation to COVID-19 should be included in all staff induction and mandatory training • All staff (clinical and non-clinical) are trained in donning and doffing PPE: know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance. • There are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene	Buddy System in place for individual teams where required e.g. aerosol generating procedures. Twice weekly lateral flow testing has been made available for all staff to access in line with national recommendations. This is led by the Trust's governance team, producing monthly reports to IMT. Mass Vaccination Centres, provide lateral flow testing for staff and volunteers working in the facility. Additional targeted testing of staff is instigated as and when the nosocomial rate rises. IPAC training is mandatory for all staff. Uptake figures are provided on a monthly basis within the Quality dashboard. Additional training on Covid-19 has been provided when staff are required to be fit tested for FFP3, including donning and doffing at local level. Training is also in place for mass vaccination staff. Lessons learned feedback provided to staff following outbreaks. IPAC updates provided via Team's meetings IPAC newsletter distributed		New guidance / regulations to be shared with the Trust's IPAC link champions

and maintaining physical distance both in and out of the workplace.	The Trust uses screensavers and poster information containing IPC precautions and standards. Laminated information sheets e.g. do not use this work station, or 2m distance markers on the floor are also used.		
• National IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way. • Changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted.	The IPC team receive regular information from the Infection Prevention Society, attend relevant webinars, work closely with networking partners to share knowledge/information (monthly, Operational IPAC teams meeting), weekly PHE surveillance information, PHE Covid literature search, regular checking of doh.gov website. Information is communicated via the weekly IPC huddle, IMT, IPAC committee and Trust Board.		
• Risks are reflected in risk registers and the Board Assurance Framework (BAF) where appropriate.	Covid specific risks are updated on a weekly basis and presented to the Trust's IMT and discussed at Trust board.		
• Robust IPC risk assessment processes non-COVID-19 infections and pathogens.	IPC risk assessment processes/ policies are place for all infections; these are reported in line with national expectations.		
• The Trust CEO, Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner.	Sit reps completed as per national guidelines.		
• The BAF is reviewed, and evidence of assessments are made available and discussed at Trust Board.	The Chief Nurse discusses BAF at the Trust Board. Evidenced in Trust Board minutes.		

Appendix 2 – IPaC Board Assurance Framework

• Ensure Trust Board has oversight of ongoing outbreaks and action plans. • There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas.	When outbreaks occur, this is escalated to Trust Board by the Chief Nurse or Medical Director, and action plans are reviewed. Executives and senior leaders attend multiple virtual meetings to discuss and provide an opportunity for staff to ask any questions. Reports are discussed at executive level where challenges are discussed.		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas. • Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas. • decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance. • Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management. • Increased frequency, at least twice daily, of cleaning in areas that have higher	This relates to in-patient facilities. This relates to in-patient facilities. Rooms decontaminated as per national guidelines following Aerosol Generating Procedures within dentistry. Decontamination of equipment guidance circulated by the Trust and included within the IPC manual. Processes are in place to ensure appropriate cleaning regimes are in place following an outbreak – these are monitored via the service reports at the IPACC. Increased cleaning regimes are in place, with any issues being reported directly to the cleaning contract providers.	Some teams have undertaken their annual environmental IPAC audit which will be presented at the next IPACC. Mass Vaccination Centres completing monthly assessments in relation to Covid-19 Best Practice.	Audits are underway and are being reviewed by a panel on a weekly basis. Outcomes from the audits e.g. ordering screens for reception areas are being undertaken in a timely manner.

Appendix 2 – IPaC Board Assurance Framework

environmental contamination rates as set out in the PHE and other national guidance.			
• Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses. manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products as per national guidance.	All contracted environmental cleaning is conducted with neutral detergent and a chlorine-based disinfectant. Cleaning regimes form part of our standard cleaning contracts. Mainly applicable to in-patient areas. Covid secure work place risk assessments conducted with IPC Matron oversight.		
• Frequently touched surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids.	Cleaning of frequent high touch surfaces such as keys, fobs, mobile phones - Information discussed at IPC group, Incident Management Team and with service leads. Information included within FAQ and screen savers for staff to access.		
• Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily	Appropriate cleaning schedules in place for clinic based areas ie Dental Dental services Standard Operating procedure		
• Rooms / areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily).	Areas are cleaned as required.		
• Linen from possible and confirmed COVID-19 patients is managed in line with PHE and	No in-patient facilities		

Appendix 2 – IPaC Board Assurance Framework

other national guidance and the appropriate precautions are taken. • Single use items are used where possible and according to Single Use Policy. • reusable equipment is appropriately decontaminated in line with local and PHE and other national policy. • Ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment. • Ensure the dilution of air with good • ventilation e.g. open windows in admission and waiting areas to assist the dilution of air. • Monitor adherence to environmental decontamination with actions in place to mitigate any identified risk. • Monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk.	IPC manual outlines all relevant guidance re single use items. No single use PPE items designated multiple use during pandemic period. IPC manual outlines all relevant guidance re decontamination of equipment. Cleaning standards in place for all work environments. Cleaning monitoring is managed via Estates & Facilities Manager Covid secure risk assessments undertaken with every service led by Service Directors and Estates Team. Review by IPC Matron. 3 phase plan in place for rectifying actions by order of priority. Process overseen at Incident management team Clinical teams currently updating their building risk assessments.	As above	As above
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • Arrangements around antimicrobial stewardship are maintained.	This section applied mainly to iCaSH, Dental, Children's Community Nursing and Adult Nursing services.	No gaps identified 14/04/2021	

Appendix 2 – IPaC Board Assurance Framework

• Mandatory reporting requirements are adhered to and Boards continue to maintain oversight.	Arrangements for antimicrobial stewardship remain in place including a standardised formulary. Medical Director and Principal Pharmacist have oversight of prescribing data and all prescribing related incidents. Actions related to previous quarterly antimicrobial audits continue to be implemented by services. Audit outcomes continue to be presented at Medicine management committee and IPACC, with escalations undertaken as needed. Reporting requirements have continued.		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	N/A to CCS as In-patient settings only All work places both clinical and non-clinical have been assessed against the Covid secure workplace guidance. These risk assessments have been overseen by Service Directors with assistance from the Estates Team and IPC Matron.	No gaps identified 14/04/2021	
• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access.	Posters re appropriate safety measures e.g. social distancing have been circulated and are being displayed. These are a mixture of those produced by PHE and our Communications Team. Clinical teams currently updating their building risk assessments.		
• information and guidance on COVID-19 is available on all Trusts websites with easy read versions.	Information for staff available via dedicated Covid19 intranet page. The Trust's internet page direct users to the PHE national site.	To strengthen our compliance	

Appendix 2 – IPaC Board Assurance Framework

• Infection status is communicated to the receiving organization or department when a possible or confirmed COVID-19 patient needs to be moved. • There is clearly displayed and written information available to prompt patients' visitors to comply with Hands, Face and Space advice.	Mainly applicable to In patient settings - Information of any infectious status would be included in the patient's transfer information by clinicians. Messages to callers re: Covid19 awareness available through a number of media sources e.g. social media and departments messaging services. Covid19 precautions poster displays are available in all areas.	we will review the literature available to ensure it is available in a number of different formats.	
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Screening and triaging of all patients as per IPC and NICE Guidelines within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases. • Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection as per national guidance. • Staff are aware of agreed template for triage questions to ask. • Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	This relates mainly to in-patient settings Clinical based patients are currently triaged by the departments to ascertain the level of risk prior to their assessment / treatment by clinicians. Mainly relates to in-patient facilities. However, guidance relating to patients and visitors attending NHS premises has been shared widely in trust wide Medical Director and Chief Nurse FAQs and included within service environmental risk assessments. Patients will be asked to attend appointments with face coverings or offered masks upon entering the department. Part of the service Covid19 secure workplace risk assessments process. Services are reviewing their building risk assessment. These will be reviewed by IPAC and Estates in line with	No gaps identified 14/04/2021	

• Face coverings are used by all outpatients and visitors.	the national plan and signed off by the Trust's Chief Nurse.14/04/2021		
• Face masks are available for all patients and they are always advised to wear them.	Weekly Risk assessment reviews in place with representations from Estates, IPAC and services.	No Gaps identified 14/04/2021	
• Provide clear advice to patients on use of face masks to encourage use of surgical face masks by all in-patients (particularly when moving around the ward) if this can be tolerated and does not compromise their clinical care.	Not applicable		
• Monitoring of inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so).	Not applicable		
• Ideally segregation should be with separate spaces, but there is potential to use screens, e.g to protect reception staff.	As per national guidelines		
• To ensure 2 metre social & physical distancing in all patient care areas.	As per national guidelines		
• Isolation and instigation of contract tracing for patients with new-onset symptoms, is achieved until proven negative.	CCS staff would direct patients to the national PHE screening process if identified as symptomatic.		
• Patients that test negative but display to go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly.	For in patient areas only. CCS staff would direct patients to the national PHE screening process if identified as symptomatic.		
• There is evidence of compliance with routine patient testing protocols in line with Key actions, Infection Prevention and Control testing document.	Many services operating a remote first contact.		

Appendix 2 – IPaC Board Assurance Framework

• Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Patients are assessed via the departments triage for COVID-19 service prior to being assessed. If deemed high risk a dedicated assessment / treatment room would already be organised. Staff would direct patients to the national PHE screening process if identified as symptomatic.		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Separation of patient pathways and staff flow to minimize contact between pathways e.g. this could include provision of separate entrances/exits (if available) of use of one-way entrance/exit systems, clear signage, and restricted access to communal areas. • All staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their. personal safety and working environment is safe • All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it. • A record of staff training is maintained.	Patient pathways are incorporated within the Covid-19 building risk assessments. Where a separate entrance and exit are not possible, clear demarcation is in place directing patients. All clinical staff undertake IPC training which incorporates standard precautions. This is recorded on the Electronic Staff Record and reported on the Quality Dashboard. This is monitored for each service via the relevant clinical Operational Board. Enhanced training on additional precautions including donning and doffing is discussed / demonstrated during respirator fit testing for staff undertaking Aerosol Generating Procedures. A record of all respirator fit testing is held by the IPC matron supported by the Quality Team in collaboration with service leads.	No gaps identified 14/04/2021	

• Adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk. • Hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimize COVID-19 transmission such as; ○ Hand hygiene facilities including instructional posters. ○ Good respiratory hygiene measures. ○ Staff maintain physical distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care. ○ Staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace. Frequent decontamination of Equipment and environment in both clinical and non-clinical areas. ○ Clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas. • Staff regularly undertake hand hygiene and observe standard infection control precautions. • The use of hand air dryers should be avoided in all clinical areas. Hands should	Revised national guidance distributed to all staff via the FAQ bulletins from the Medical Director and Chief Nurse. Relevant information available on trust intranet. Queries received either via the Incident Control centre or directly to IPC Team. Frequent Q&A sessions with all staff offer further opportunity to raise queries. Specific IPC Q&A sessions undertaken by Medical Director/Chief Nurse as requested – recent examples include iCaSH and Community Paediatrics Enhanced training on additional precautions including donning and doffing is discussed / demonstrated during respirator fit testing for staff undertaking AGP. All clinical areas have paper towels in place to dry hands. Where practical, hand dryers have been replaced with hand towels in non-clinical areas. To be confirmed by the Trust's Estates lead. Services are reviewing their building risk assessment. Hand washing techniques are displayed on walls and on the soap / hand sanitizer dispensers. No formal PPE audit of practice programme in place currently. Need to consider as part of other IPC audits ie environmental audits, Clinical Intervention audits etc		

Appendix 2 – IPaC Board Assurance Framework

be with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance. • Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas. • Staff understand the requirements for uniform laundering where this is not provided for on site. • All staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms. • A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organization onset cases (staff and patient/individuals). • Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings.	Clinical teams currently undertaking annual IPAC environmental audits and monthly assessments at the Mass Vaccination Centres. Audits reviewed by IPAC and appropriate action taken immediately by auditor. These are being presented and discussed at the IPACC. Various methods employed for reminding staff re hand hygiene through the pandemic ie at Q&A sessions, in FAQs from medical Director and Chief Nurse, screen savers and IPC awareness week. Limited annual hand hygiene standards audits in place – challenges with compliance due to limited opportunities for some staff to access facilities. Quarterly patient feedback on staff hand hygiene practice currently on hold. Re introduction of Clinical Intervention Audits currently being planned. This will provide an additional route of assurance for relevant clinical services going forward. Staff reminded of revised national guidance from PHE. An update to staff had been included in the Trust's FAQ. IPC Team have supported services with conversations re appropriate uniform/work wear in a number of settings. Clinical Intervention audits have resumed and are now included within the Quality Monthly Dashboard. These are included in the service's quarterly report which is discussed at the IPACC. Staff reminded of symptoms and processes through FAQ, intranet and PHE website. Management of Staff Outbreak Standard Operating Procedure currently being approved through IPC Team and Incident management team.		

Appendix 2 – IPaC Board Assurance Framework

	Queries raised through Incident Control centre or directly with IPC Team. Q&A sessions provide additional opportunities for staff to raise issues. Where staff have arrived to their workplace displaying symptoms, they have been told to go home and self-isolate as per national guidelines.		
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff. • Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas. • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate. • areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	N/A in-patient facilities only N/A relates to in-patient areas N/A relates to in-patient areas N/A relates to in-patient areas	N/A	

Appendix 2 – IPaC Board Assurance Framework

• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Community services based guidance continues as previously and is outlined in the IPC manual		
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • Testing is undertaken by competent and trained individuals. • Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance. • Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available. • Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (corrected recorded data). • Screening for other potential infections takes place. • That all emergency patients are tested for COVID-19 on admission. • That those inpatients that go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise.	Where staff have been involved in taking swabs from patients, they have been trained by appropriate experts i.e. Luton Adult services by members of the Clinical Professional Development Team. Other testing has been undertaken by appropriately trained staff i.e. for antibody testing iCaSH staff and Luton based Phlebotomists Staff testing via national swabbing system through local swabbing centres. Patient testing only as part of initial Luton based support to care Homes. N/A relates to inpatient only. Lateral flow testing kit initially distributed to patient facing clinical staff as per volume dictates. Lateral flow kits now distributed to the majority of clinical areas including Mass Vaccination Centres, Dental and iCaSH. Regular reports of staff uptake are discussed at the Trust's IMT. This continues as clinically indicated N/A relates to in-patient areas.	No gaps identified 14/04/2021	

• That those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission.	N/A relates to in-patient areas.		
• That sites with high nosocomial rates should consider testing COVID negative patients daily.	N/A relates to in-patient areas		
• That those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organization prior to discharge.	N/A relates to in-patient areas		
• That those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting where they should complete their isolation.	N/A relates to in-patient areas		
• That all elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.	N/A relates to in-patient areas		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • Staff are supported in adhering to all IPC policies, including those for other alert organisms.	All IPC guidelines continue to be implemented. Covid related guidance is communicated through FAQs, via Q&A sessions are on the Intranet.	No Gaps identified 14/04/2021	Audits have been updated to include PPE adherence.

Appendix 2 – IPaC Board Assurance Framework

• Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff. • All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance • PPE stock is appropriately stored and accessible to staff who require it.	IPC Team are supporting all services with ad hoc queries and requests for specific guidance. All changes to national guidance are reviewed by the IPC team and logged at Incident Management Team. Staff are informed of all changes and alerts relating to PPE through the trust wide FAQs from the Medical Director and Chief Nurse and updated on the staff intranet. This is coordinated by the Trust's PPE lead (Head of Clinical Quality) with the support of the Trust's Deputy Chief Nurse and IPC Matron. Guidance distributed through FAQ in conjunction with the Trust's Waste lead. PPE is stored centrally at HQ and delivered to various facilities when required. Environmental audits (which include waste management) are discussed at the Trusts IPC committee meeting. Although paused during the initial phase of the pandemic, the audits were reinstated in November 2020.		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported. • That risk assessment(s) is/are undertaken and documented for any staff members in an at risk or shielding groups, including	Individual staff risk assessments have been undertaken throughout the pandemic. This included staff in extremely high risk groups so that they could be identified as 'shielding'. Additional support required by staff, i.e. working from home, is managed by the individual's line manager.	No gaps identified 14/04/2021	

Black, Asian and Minority Ethnic and pregnant staff. • staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally. • Staff who carry out fit test training are trained and competent to do so. • All staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used. • A record of the fit test and result is given to and kept by the trainee and centrally within the organization. • For those who fail a fit test, there is a record given to and held by trainee and centrally within the organization of repeated testing on alternative respirators and hoods. • For members of staff who fail to be adequately fit tested a discussion should be had, regarding re-deployment opportunities	Comprehensive details of a variety of support available to staff is communicated via FAQs including MSK exercise and Mindfulness sessions (run by our MSK Physios and Psychologists) The Health and well-being Group has continued to meet to ensure that appropriate levels of support are offered to our staff. Staff side representatives have been fully engaged, helping to identify additional support that staff tell us they would like. Q&A sessions also held with BAME staff Additional support staff's wellbeing is located here. https://nww.cambscommunityservices.nhs.uk/docs/default-source/coronavirus/health-and-wellbeing-stepped-offer-09-10-2020.pdf?sfvrsn=9f76cad1_2 All staff required to wear FFP3 respirators are trained by experts identified and educated by the IPAC Matron. As different types of masks arrive via supply chain, staff are re-tested. Individual requirements are supported where staff fail multiple types of masks (fit test). Those trained are recorded locally with oversight by the IPC matron Those trained are recorded locally with oversight by the IPC matron. Mainly applies to Acute settings – where possible, Community teams try to ensure consistency of staff members attending different patients to minimise risk of spread of infection.		

Appendix 2 – IPaC Board Assurance Framework

and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. • A documented record of this discussion should be available for the staff member and held centrally within the organization, as part of employment record including Occupational Health. • Following consideration of reasonable adjustments e.g. respiratory hoods, personal reusable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational Health service record. • consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways as per national guidance. • All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas. • Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	Currently no member of staff has failed, if this was a concern the process would be managed in conjunction with HR and OH. Multiple messages out to staff re the importance of social distancing through FAQS from Medical Director/Chief Nurse, posters, Q&A sessions, screen savers and IPC awareness week. Staff reminded that NHS guidance is 2 metres despite national public move to 1m plus. Regular messages re appropriate us of face masks and face coverings (i.e. if staff travel to work on public transport)		

Appendix 2 – IPaC Board Assurance Framework

• Staff are aware of the need to wear facemask when moving through COVID-19 secure areas. • Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing. • Staff that test positive have adequate information and support to aid their recovery and return to work.	Risk assessments for Covid19 secure work places undertaken. The Trust will be using the national supporting excellence in Infection Prevention Control 'Every Action Counts' campaign toolkit. Campaign materials currently being reviewed by IPAC and Comms. Line managers are supported by HR colleagues to ensure staff who are absent from work through sickness, shielding or self-isolating are supported. All usual OH service support remains available. Links to all relevant PHE guidance for staff and their households are communicated through FAQs and available on staff intranet. Support from line managers and HR team.		

Reference:
Infection Prevention and Control Board Assurance Framework
Updated February 12th 2021 V1.5

Version control			
Version	Approved by	**IMT**	**Trust Board**
V1 July 2020	IPAC team/DIPC & Medical director	**6 July 2020**	**15 July 2020**
V2 October 2020	IPAC team/DIPC & Medical director		
V3 April 2021 (amendments from February 2021 revised BAF)	IPAC team/DIPC & Medical director		

Appendix 2 – IPaC Board Assurance Framework

HSE Hospital spot check inspections re Covid–19
Best practice as identified by HSE – March 2021

NHS Cambridgeshire Community Services NHS Trust

1. Management arrangements			
Best practice	Evidence	Gaps in Assurance	Mitigating Actions
Gold and Silver command established with high level leadership. Frequent leadership meetings and briefings.	In place.	No gaps identified 26.03.2021	
Board and senior leadership team engaged with front line staff	Attend virtual team meetings, comms messages	No gaps identified 26.03.2021	
Incident commander centre staff 24/7 by senior management	On call system in place.	No gaps identified 26.03.2021	
Strong links between IPAC, H&S and Occ Health	OH has regular meetings with HR (who manage contract) IPAC has strong links with H&S and OH. The IPAC Matron sits on the H and S group and a representation from Estates attends the IPACC	No gaps identified 26.03.2021	
Procedure in place for raising concerns	Procedure in place.	No gaps identified 26.03.2021	
Departmental managers have access to support from H&S team with NEBOSH professional qualifications	Support in place via CCS normal processes.	No gaps identified 26.03.2021	
IPAC BAF used to monitor progress and identifying risks	Compliant with best practice. Reviewed quarterly at IPAC Committee and at Trust Board.	No gaps identified 26.03.2021	
Trade Unions engaged and actively encouraged to attend H&S committee	Trade union representative attends H&S committee chaired by Estates.	No gaps identified 26.03.2021	
Monitoring of compliance with policies and procedures	Compliance is feedback through the internal governance process	No gaps identified 26.03.2021	

Appendix 3 – HSE IPaC Covid19 Assurance Framework

Risk assessment control measures are audited	As per above.	No gaps identified 26.03.2021	
Staff behaviour is challenged when non-compliance is seen by managerial	The Trust's staff survey outcome which states that a high number of staff are happy to challenge poor or unsafe practice. Process in place to support this action.	No gaps identified 26.03.2021	
Management arrangements continued			
Best practice	Evidence	Gaps in Assurance	Mitigating Actions
Managerial staff are aware of their responsibilities for monitoring and maintaining Covid controls	Compliant with best practice. Roles and responsibilities have been cascaded through the following routes; communications, screen savers, the Covid-19 risk assessment process, environmental audit updates and reviews, policy changes, Q and A's with staff and incident management support following Covid-19 cases within staffing groups	No gaps identified 26.03.2021	
Sharing of good practice	Lessons learnt are shared by the IPAC team with the clinical services. A tick box form promotes team leaders to discuss with their teams. lessons-learned-from -outbreak-manageme Practice is also shared via the IPAC operational group i.e. multi organisational attendance – monthly , QISCom and IMT meetings	No gaps identified 26.03.2021	

Appendix 3 – HSE IPaC Covid19 Assurance Framework

HSE Hospital spot check inspections re Covid–19
Best practice as identified by HSE – March 2021

NHS Cambridgeshire Community Services NHS Trust

2. Risk assessment			
Best practice	Evidence	Gaps in Assurance	Mitigating Actions
Appropriate risk assessment training is provided for those undertaking risk assessments	Risk assessment training will be carried out by the Incident, Risk Management and Safety Team to those staff who require this.	No gaps identified 26.03.2021	
H&S committee review risk assessments	As per standard. Covid related – risk assessments are reviewed and discussed by the Trust's Incident Management Team and service leads at local level.	No gaps identified 26.03.2021	
Dissemination of risk assessments to the workforce	Risk assessment process has been disseminated via the service leads, with clear guidance on how to support managers to have risk based conversations with staff.	No gaps identified 26.03.2021	
Risk assessments are carried out for all areas	All areas have had an environmental risk assessment – these are in the process of being updated in line with the Trusts roadmap.	No gaps identified 26.03.2021	

3. Personal Protective Equipment (PPE)			
Best practice	Evidence	Gaps in Assurance	Mitigating Actions
Staff carrying out Fit testing have undergone appropriate training.	Key staff trained in fit testing. Respirator fit testing record is held by the Trust Governance team. Training is also provided on an ad hoc basis dependant on the type/ make of FFP3 mask the Trust has.	No gaps identified 26.03.2021	

Appendix 3 – HSE IPaC Covid19 Assurance Framework

HSE Hospital spot check inspections re Covid–19
Best practice as identified by HSE – March 2021

NHS Cambridgeshire Community Services NHS Trust

Face fit information is held centrally and on the person's file	Held on file in the clinical departments and centrally via the Trust's Governance team.	No gaps identified 26.03.2021	
Staff entering red zones checked to ensure RPE fit testing record is available for the respirator being worn	Clinicians given ample stock and responsibility of all staff to monitor stock levels.	No gaps identified 26.03.2021	
Non clinical staff in red zones are fit tested.	N/A Only clinical staff work in these areas.	No gaps identified 26.03.2021	
A buddy system is used to ensure fit check is carried out – siting of a mirror to be used for lone workers or when the buddy system is impracticable	Buddy system in place in high risk areas e.g. dental. Mirrors are provided for lone workers.	Lone workers e.g. children's nurses	Parents/guardians/carer used as "buddy"
PPE stock is in good supply with a variety of respirators available	Stock held centrally and managed by specific individuals. Departments monitor weekly stock level via established processes.	No gaps identified 26.03.2021	
RPE/PPE co-ordinator nominated to monitor usage and stock control	Managed by specific individuals and departmental leads.	No gaps identified 26.03.2021	
Staff using reusable RPE have received training in changes cartridges, decontaminating and storing their equipment	Training provided. A training record is kept centrally.	No gaps identified 26.03.2021	
Staff have received training in donning and doffing procedure	Training provided. A training record is kept centrally	No gaps identified 26.03.2021	
Personal Protective Equipment (PPE) continued			

Appendix 3 – HSE IPaC Covid19 Assurance Framework

HSE Hospital spot check inspections re Covid–19
Best practice as identified by HSE – March 2021

NHS Cambridgeshire Community Services NHS Trust

Best practice	Evidence	Gaps in Assurance	Mitigating Actions
There is a separate donning and doffing area whilst maintaining a one-way system with adequate storage and accommodation for reusable RPE	Compliant with best practice and staff control flow of traffic within department's clinical setting. Community teams have developed their own Standard operating procedures which includes staff telephoning beforehand to triage in relation to Covid-19 as per national guidelines. This includes ensuring adequate space for staff to don and doff their PPE's. Staff are responsible to ensure they have adequate stock of PPE's prior to seeing the patient.  staff-ppe-information -pack-review-septeml	No gaps identified 26.03.2021	
Reusable RPE is stored appropriately and labelled with the individual's name	All reusable RPE is labelled with the individual's name and stored appropriately.	No gaps identified 26.03.2021	
RPE must be located close to the place of use	Compliant with best practice.	No gaps identified 26.03.2021	
Contingency planning in place for sourcing and swapping RPE/PPE	Where sourcing for additional RPE / PPE The Trust has an established procedure which is managed by the Trust's designated PPE Team. This is linked to the overall procurement hub which is able to liaise with other Trust's to work in a collaborative process.	No gaps identified 26.03.2021	
Daily monitoring of wearing PPE	Spot checks by departmental teams. Additional audit to be incorporated into the Trust's monthly Clinical Intervention Audits.	No gaps identified 26.03.2021	Additional audit have been incorporated into the Trust's monthly

Chris Sharp – Matron for IPAC
Marlis Emery – IPAC clinical nurse specialist
Version 4
March 2021

Appendix 3 – HSE IPaC Covid19 Assurance Framework

			Clinical Intervention Audits.
PPE panel meeting twice weekly to discuss stock levels and consider introduction of replacement items	PPE group meet/review stock weekly. Led by Trust Governance team and Procurement.	No gaps identified 26.03.2021	

4. Social distancing			
Best practice	Evidence	Gaps in Assurance	Mitigating Actions
One way system introduced with linear marking on the floor and signage on the walls	One way system where possible. Floor stickers, posters additional resources in place to raise awareness. Where not possible patients brought in, in a controlled way by the clinician.	No gaps identified 26.03.2021	
Separate entrances/exits for staff and patients in clinical settings.	Compliant where possible, otherwise controlled by the department.	No gaps identified 26.03.2021	
Plastic privacy curtains to allow easy cleaning and disposal.	Disposable privacy curtain available e.g. physio. Changed annually or when contaminated as per national guidelines.	No gaps identified 26.03.2021	
Hand sanitiser at all entrances/exits, for staff, visitors and outpatients.	Alcohol hand sanitisers at all entrances and at point of use.	No gaps identified 26.03.2021	
Staff member stationed at entrance/exit to hand out masks, offer hand sanitiser.	All areas have additional masks for staff/public access. Clinician assesses risk.	No gaps identified 26.03.2021	

Appendix 3 – HSE IPaC Covid19 Assurance Framework

HSE Hospital spot check inspections re Covid–19
Best practice as identified by HSE – March 2021

Physical distancing of 2 metres, unless providing clinical or personal care and wearing appropriate PPE	Compliant with best practice. Additional audit to be incorporated into the Trust's IPAC audit programme focusing on non- clinical areas.	No gaps identified 26.03.2021	Additional audit has been incorporated into the Trust's IPAC audit programme focusing on non- clinical areas.
Maximum occupancy numbers displayed on entrance to rooms to maintain social distancing	Numbers displayed on meeting rooms, clinical areas, kitchen and lounge areas. Staff encouraged to work from home wherever possible (in line with national guidance).	No gaps identified 26.03.2021	
Stagger shift times and breaks to allow for social distancing	Staff encouraged to work from home wherever possible. Risk assessments in place as needed. Departmental manager staggers break times to minimise risk.	No gaps identified 26.03.2021	The flexible working policy is being updated and reviewed to support staff well-being.
Sinks adjacent to each are taken out of use	Compliant with best practice. In addition some dishwashers taken out of action to reduce risk of Legionella.	No gaps identified 26.03.2021	
Storage provision for clothing is available	In all clinical areas.	No gaps identified 26.03.2021	
Changing facilities and lockers are close to the place of work	In all clinical areas.	No gaps identified 26.03.2021	
Virtual training where practicable	Majority of training sessions are run virtually. Where not possible social distancing is in place as well as reminders around using face masks and sanitising hands. Training rooms have been assessed in relation to environmental requirements e.g. ventilation.	No gaps identified 26.03.2021	

Chris Sharp – Matron for IPAC
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Version 4
March 2021

Appendix 3 – HSE IPaC Covid19 Assurance Framework

HSE Hospital spot check inspections re Covid–19
Best practice as identified by HSE – March 2021

Videos produced to minimise classroom time	On line learning is in place – which includes a variety of approaches.	No gaps identified 26.03.2021	
Rooms ventilated before and after use and at break times	Compliant with best practice. Spot checks provide some level of assurance.	No gaps identified 26.03.2021	
Introduce rotas to minimise staff attendance when working from home is not an option	Managed by departmental leads.	No gaps identified 26.03.2021	The flexible working policy is being updated and reviewed to support staff well-being.
Screens provided at reception to provide separation between visitors/patients and staff	Perspex screens at all patient/visitor facing reception areas as per building risk assessment.	No gaps identified 26.03.2021	
Layouts redesigned to avoid face to face working	Combination of resources e.g. tape, laminated signs, room layout changes.	No gaps identified 26.03.2021	

5. Hygiene and cleaning regimes			
Best practice	Evidence	Gaps in Assurance	Mitigating Actions
Additional cleaning machines to remove the need for transfer between departments	Although not acute, and no inpatient facilities, Cleaning contractors have additional machines to support clinical practice.	No gaps identified 26.03.2021	
Dedicated cleaning teams allocated to individual clinical areas	Contracted cleaners allocated to specific facilities/departments.	No gaps identified 26.03.2021	
Deep clean teams provided and overseen by IPAC	Available on request to the Cleaning contractors via IPAC or department lead.	No gaps identified 26.03.2021	

Appendix 3 – HSE IPaC Covid19 Assurance Framework

HSE Hospital spot check inspections re Covid–19
Best practice as identified by HSE – March 2021

Clear instructions on responsibilities for cleaning	Information on cleaning responsibilities of clinical staff found in the IPAC manual. Cleaning contractors clean as per specification.	No gaps identified 26.03.2021	
Enhanced cleaning in libraries and education	N/A allowed access to Hinchingbrooke Hospital library. Electronic access to journals.	No gaps identified 26.03.2021	
Cleaning of frequent touch points and multi-user equipment is clear and monitored	Decontamination of certain equipment - Guidelines in IPAC manual. Staff reminded via Covid 19 FAQs. Increased cleaning regimes in place in 'high touch' areas. Staff have access to appropriate cleaning products so that keyboards and 'hot desks' etc can be cleaned during the day.	No gaps identified 26.03.2021	
Toolbox talks and bulletins to remind staff of IPAC procedures and update on changes	Bulletins in Mass vaccination centres. High risk teams e.g. dental, community nurses etc. who carry out AGPs, provided with newsletters and IPAC attend team meetings. Mass vaccination centres have all had a IPAC assessment prior to opening, these will continue on a monthly basis.	No gaps identified 26.03.2021	
Cleaning supervisor monitors cleaning daily and is monitored by a manager	Daily monitoring is carried out by staff and communicated to Cleaning Contractors.	No gaps identified 26.03.2021	
Laminated cards are in place to identify equipment/furniture that has been used and requires cleaning	In place throughout all Mass Vaccination Centres, patient attending clinical appointments are brought straight through by the clinician and then clinicians responsibility to clean post visit. Entry to other clinical areas is controlled in order to reduce numbers of patients congregating and waiting rooms being used. Set appointments are given to patients who are	No gaps identified 26.03.2021	

Appendix 3 – HSE IPaC Covid19 Assurance Framework

	instructed to attend on their own, seating and touch points are cleaned when the patient vacates seating or assessment area.		
Comprehensive cleaning regime is in use which covers, changing areas, rest rooms staff toilets etc.	In place, wipes, equipment and guidance in addition to the Contracted cleaners.	No gaps identified 26.03.2021	
Local instructions for cleaning are available at the point of use	Compliant with best practice.	No gaps identified 26.03.2021	
Cleaning materials are available at the point of use	Compliant with best practice.	No gaps identified 26.03.2021	

6. Ventilation			
Best practice	Evidence	Gaps in Assurance	Mitigating Actions
AHUs checked regularly for velocity, dilution and dwell times	The Trust does not have any augmented care areas; however, in areas where AGPs are conducted, the regular checks of AHUs are contracted out and conform to national guidance.	No gaps identified 26.03.2021	This Trust provides Community services and does not have inpatients
Site wide survey of all mechanically ventilated rooms to identify any issues and rebalance the ventilation system	A site wide survey began pre-covid and forms part of the programme of work going forward. A programme of work is being developed which will be monitored via the Trust's IPAC Committee	No gaps identified 26.03.2021	
There is a schedule of cleaning and maintenance of all AHUs systems	First generation evidence held on the CBRE portal and on the Premises Assurance Model.	No gaps identified 26.03.2021	

Appendix 3 – HSE IPaC Covid19 Assurance Framework

AGPs are carried out in rooms with the greatest number of air changes where the clearance time is shorter	Rooms assessed by operational leads in conjunction with IPAC and Estates and Facilities manager. The only clinical rooms used for AGPs are within dental facilities.	No gaps identified 30.03.2021	
Management regularly communicate to their teams about the need to open windows to introduce fresh air	Staff reminded via Covid 19 FAQs and staff Q and A sessions.	No gaps identified 30.03.2021	

7. Dealing with suspected cases			
Best practice	Evidence	Gaps in Assurance	Mitigating Actions
There is an established arrangement for staff displaying Covid-19 symptoms	Advice for staff is found on Coronavirus staff information pack FAQs re: self isolating and arranging for a test. Information for staff on dedicated Covid-19 intranet page includes directions to PHE national site. Lateral flow processes are embedded across the clinical services.	No gaps identified 26.03.2021	

Appendix 3 – HSE IPaC Covid19 Assurance Framework

Risk ID: 3165	Risk owner: Pisani, Anita	Risk handler: Pisani, Anita
Directorate: Trustwide		Date recorded: 09/03/2020
Specialty: Not Applicable		Anticipated completion date: 30/06/2021
Clinical Group: Trust Wide		Risk committee: Board

Risk Title: Complexity of System Working

Risk Grading:

	L	C	
Initial:			12
Current:	Unlikely - 2	Major - 4	8
Target:	Unlikely - 2	Major - 4	8

Principle Trust Objective:
Collaborate with others, Provide outstanding care

Source of Risk:
Meetings

Risk level Current:
High

Last Review Date:
12/05/2021

Risk description:
There is a risk that the Trust does not have sufficient capacity and capability to manage and meet commissioner and patients expectations, due to the complexity of system working.

Progress update:
[Pisani, Anita 12/05/21 18:09:44] No change to scoring at target level. Continue to work collaboratively across the many systems in which the Trust operates and also actively leading on a number of system wide issues in the areas that the Trust operates.

Significant Hazards:
Complexity of system working
Maturity of working relationships
Ability for all system partners to collaborate
Competition
Insufficient capacity and capability to work effectively across and within different systems

Controls in place:
Joint Partnership Board with Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) - chaired by Non-Executive Directors
Board to Board with CPFT as required
Integrated Leadership Structure for 0-19 services across Cambridgeshire and Peterborough
Joint Transformation Board with Commissioners - Cambridgeshire and Peterborough Children Services
Joint Partnership Board with East London Foundation NHS Trust - Executive led
Variety of joint work streams in place with East London Foundation NHS Trust on delivery of Bedfordshire Community Health Services
Joint Away Days taking place within Bedfordshire Community Health Services
Bedfordshire Care Alliance
Luton Provider Alliance - co-chaired by CCS and Luton and Dunstable Chief Executives
Programme Director in place for delivery of Enhanced Models of Care across Luton system
Luton Transformation Board
CEO and Chair member of Cambridgeshire and Peterborough STP Board
CEO and Chair attend BLMK wide Executive meetings
Monthly internal meeting of virtual internal systems development team
Additional capacity created from April 2020 to focus on systems working/development activities
Service Director for Cambridgeshire and Peterborough Services SRO for Best Start in Life Programme of work

Appendix 4 – Strategic Risks and Operational Risks 15 and above

Risk ID: 3260	Risk owner: Howard, Kate	Risk handler: Howard, Kate
Directorate: Trustwide		Date recorded: 14/10/2020
Specialty: Not Applicable		Anticipated completion date: 30/06/2021
Clinical Group: Trust Wide		Risk committee: Board

Risk Grading:			
	L	C	
Initial:			16
Current:	Likely - 3	Major - 4	12
Target:	Unlikely - 2	Major - 4	8

Risk Title: Impact of covid19 on community service care delivery

Principle Trust Objective:	Source of Risk:	Risk level Current:	Last Review Date:
Provide outstanding care	Risk assessment	High	11/05/2021

Risk description:
There is a risk that health outcomes for people who use our services are negatively impacted by Covid 19 restrictions due to a second wave of Covid 19.

Progress update:
[Howard, Kate 11/05/21] Reviewed with the Service Directors and based on a recent review of their risks - the score has been reduced from 16 to 12.

Significant Hazards:
The significant hazards are:
- Staff morale and fatigue due to the on-going impact of covid19 on life (work and home life).
- Impact of changes in practice required to meet new service delivery models ie technology based assessments and home based working
- Reduced contacts with families/children/ adults at risk or identified as vulnerable
- Staffing reductions due to current requirements for self isolation/ shielding
- Service users already delayed in receiving healthcare condition deteriorating and requiring more complex treatment or care
- Increased anger from service users unable to access services directed at staff.

Controls in place:
Children & Young people:
3180 - detailed records of telephone calls, face to face visits for those families identified as vulnerable, video based assessments, SOP in place for particular vulnerable groups, Appropriate PPE available for visits if required
3184 - telephone assessment, Child protection medicals continuing as essential service, each child's needs assessed on individual basis, appropriate PPE available
3181 - Single Point of Access established and clinical pathways established across all geographies, web site updated with universal offer, social media campaigns, staff not required to support essential services are maintaining small amount of non essential activity, workstreams in place to ensure children on EHCP and with complex needs receive the services they require through alternative methods, where considered appropriate and safe the practitioners will visit following risk assessment if required
3183- The needs of children requiring EHCP input/complex needs are being stratified, plans in place to keep in touch with families to satisfy requirements to deliver 'reasonable endeavour', Single Points of Access established with clinical pathways across all geographies
3182 - safeguarding SOPs developed re face to face/ technology based contacts, routine safeguarding caseload supervision suspended and replaced by increased ad hoc sessions and supervision 'surgeries', continued involvement with each LSCB/LSAB where papers sent for virtual consideration, business continuity plan in place across the trust for safeguarding function, Heads of safeguarding involved in regular system based safeguarding discussions, continued work on SCRs and SI reports
MSK - risk 3178 -all referrals triaged by clinical lead or deputy;hot line with acutes for immediate advice and collaborative clinical decision making
Dental risks 3177 & 3191 PPE;levels 1 & 2 triage, following NHSE SOP,remote prescribing antibiotics
Neuro rehab risks 3177 & 3191 escalation process agreed and liaison with LA colleagues re future care after 48 hrs
Luton Adult services
3096 - all service areas have developed RAG rating criteria for prioritisation during Covid pandemic with risk stratification to determine cohort, process being developed for delaying/suspending green rated non essential visits and identified process for how this will be monitored and risks mitigated, caseload monitoring by staff working remotely, discussions with patients, carers and families re what to look out for and how to access support if required.
Staff - swabbing to facilitate earlier return to work for identified staff
Further controls under review re wound care and caseload prioritisation measures
All underpinning service risks have been reviewed as part of this process including those identified as a result of the QIAs. Each of these has mitigating actions and controls identified and are reviewed at the Incident Management Team weekly.
Lateral flowing testing now in place to support service delivery.

Appendix 4 – Strategic Risks and Operational Risks 15 and above

Risk ID: 3300	Risk owner: Winn, Matthew	Risk handler: Howard, Kate
Directorate: Trustwide		Date recorded: 15/12/2020
Specialty: Not Applicable		Anticipated completion date: 30/09/2021
Clinical Group: Not applicable		Risk committee: Board, Mass Vaccination Programme COB
Risk Title: Mass Vaccination		

Risk Grading:			
	L	C	
Initial:			12
Current:	Possible - 3	Major - 4	12
Target:	Unlikely - 2	Major - 4	8

Principle Trust Objective:	Source of Risk:	Risk level Current:	Last Review Date:
Collaborate with others, Provide outstanding care	Risk assessment	High	11/05/2021

Risk description:
Delivery of the mass vaccination programme for our staff and to the communities across Norfolk & Waveney, Cambridgeshire & Peterborough may be impeded by a range of factors including workforce supply and vaccine which could result in continued risk to our staff, the delivery of services to patients and those communities awaiting vaccination.

There is also a reputational risk to the organisation in relation to delivering the 'hub' model within the required national timeframes.

Progress update:
[Howard, Kate 11/05/21] Risk reviewed, score remains at 12.

Significant Hazards:
The vaccination- (Pfizer, Moderna and the Oxford vaccine)
The hub environment- e.g. internet connection, IT equipment
Workforce issues- not enough staff available to staff the vaccination hubs

Controls in place:
A number of controls are in place to support the mass vaccination programmes these include:
- Training packages are identified for staff in differing types of roles (including vaccinator specific education)
- day 1 information pack has been developed for all staff at the mass vaccination sites (which includes updates on key topics such as incident reporting and safeguarding)
- Rotas are being developed for the mass vaccination sites so that gaps can be identified and planned for
- Recruitment is underway, with a number of roles being advertised (including volunteers)
- Governance process in place to ensure practices are safe and have been assessed and approved internally
- Communication plan has been developed to support the mass vaccination programme
- National communication messages are being utilised as needed (including using nationally developed booklets for vaccine specific details)
-Emergency protocols are in place for anaphylaxis post vaccination, emergency equipment has been ordered and will be available as needed
-Teams have been advised not to have high numbers of staff vaccinated on the same day due to any potential side effects
-Consent flowchart has been developed for the mass vaccination site folders, phone numbers for safeguarding support have also been included
-Safeguarding training/ updates will be available for staff working within the vaccination site
- Quality assurance meetings are taking place with NHSE prior to sites opening - quality assurance processes are being undertaken and submitted regionally and the Trust has undertaken a local QIA and IPaC audit in relation to the programme
-

Appendix 4 – Strategic Risks and Operational Risks 15 and above

Risk ID: 3323	**Risk owner:** Winn, Matthew	**Risk handler:** Winn, Matthew	**Risk Grading:**
Directorate: Mass Vaccination		**Date recorded:** 27/01/2021	
Specialty: Mass Vaccination		**Anticipated completion date:** 30/09/2021	
Clinical Group: Trust Wide		**Risk committee:** Board, Mass Vaccination Programme COB	
Risk Title: Organisational Reputational Risk for Co-Vid Mass Vaccination Centre Lead Provider Contract			
Principle Trust Objective: Collaborate with others, Provide outstanding care		**Source of Risk:** Risk assessment	**Risk level Current:** High
Last Review Date: 07/04/2021			

	L	C	
Initial:			12
Current:	Possible - 3	Major - 4	12
Target:	Unlikely - 2	Major - 4	8

Risk description:
Risk to organisational reputation of delivery of the Lead Provider Contract for the roll-out of the Mass Vaccination Programme for Cambridgeshire & Peterborough and Norfolk & Waveney given the significant pace, complexity and political profile of the programme.

Progress update:
[Pisani, Anita 07/04/21 17:57:42] Change of risk owner and handler to Matthew Winn on his return to CEO role.

Significant Hazards:
Hazards include:
- inadequate programme leadership or governance and/or insufficient programme resourcing is not sufficient to deliver a high quality programme
-poor risk identification and/or management/escalation
-Executive Committee and Board not sufficiently sighted on major risks and/or receiving assurance on mitigation
-vaccine supply is not forthcoming (risk x refers)
-insufficient workforce to fill rosters across multiple sites (risk x refers)
-equipment supply is not forthcoming or sufficient to safely open sites
-flow is not well-managed and or/not co-vid secure
-capacity for delivery and/or vaccine supply does not allow pace through the cohorts in line with other parts of the region or country

Controls in place:
-leadership team directly accountable to CEO
-weekly formal programme reporting to Executive Committee with regular informal briefings throughout the week
- programme risks being signed off and the highest risks reported weekly to Executive Committee
-bi monthly Mass Vaccination Clinical Operational Board set up from March 2021
-leadership team participating in national, regional and local programme governance
-collaborative and effective partnerships established with all key partner organisations
-strong communications support to ensure clear messaging and management of expectations

Appendix 4 – Strategic Risks and Operational Risks 15 and above

Risk ID: 3163	Risk owner: Pisani, Anita	Risk handler: Pisani, Anita
Directorate: Trustwide		Date recorded: 09/03/2020
Specialty: Not Applicable		Anticipated completion date: 30/06/2021
Clinical Group: Trust Wide		Risk committee: Board

Risk Grading:			
	L	C	
Initial:			8
Current:	Possible - 3	Major - 4	12
Target:	Unlikely - 2	Major - 4	8

Risk Title: Reduction in staff morale could adversely affect the delivery of high quality care

Principle Trust Objective:	Source of Risk:	Risk level Current:	Last Review Date:
Be an excellent employer, Provide outstanding care	Meetings	High	12/05/2021

Risk description:
There is a risk that the delivery of high quality care will be adversely affected if levels of staff morale reduce.

Progress update:
[Pisani, Anita 12/05/21] Risk score to stay at 12 as levels of staff morale continues to be variable across the Trust due to continuing to manage a national pandemic situation as well as providing all of our services across our different service lines and localities. Morale kept under constant review via our weekly incident management team and daily sitreps. Services are reviewing staff survey feedback and agreeing improvement actions to address feedback as appropriate both at Trust wide and service level.

Significant Hazards:
Demands of the service exceeding capacity available
Insufficient staff to deliver service
Turnover
Vacancies
Staff absences - sickness; maternity; training etc
Length of the Covid-19 pandemic and pace at which services/individuals are expected to respond.

Controls in place:
Annual staff survey and delivery of improvement plans - Trust-wide and local plans - Staff morale feedback - best in class and 8th nationally for all NHS providers
Quarterly staff friends and family surveys
Discussions and resulting actions from Wider Executive team meeting
Appraisal rates and quality of appraisals
1:1s and team meetings
Monthly quality dashboard
Quality Dashboard
Clinical Operational Boards
Freedom to Speak Up Guardian and Champions
Guardian of Safe Working role in place to support junior doctors
GMS survey feedback
Raising Matters of Concern log
Bespoke Leadership and Team Development Sessions
Deloitte external review of Well-led and Care Quality Commission Inspection Feedback - last inspection report August 2019 - Outstanding for Well-led
Live Life Well Activities - Health and Wellbeing Champions
Staff Side Chair - confidential helpline in place
Corporate Induction and local induction systems and processes
Bi-annual workforce reviews
Daily Incident Management Team meeting
Daily sitrep
Digital Q&A sessions put in across all Divisions - first set taking place week of 6th April 2020
Detailed FAQs regularly shared with all staff
JCNP Formal meeting structures / Regular contact with Staff Side Chair
Rolling out of staff vaccination programme

Appendix 4 – Strategic Risks and Operational Risks 15 and above

Risk ID: 3167	Risk owner: Winn, Matthew	Risk handler: Winn, Matthew
Directorate: Trustwide		Date recorded: 11/03/2020
Specialty: Not Applicable		Anticipated completion date: 30/06/2021
Clinical Group: Trust Wide		Risk committee: Board

Risk Title: System planning

Risk Grading:			
	L	C	
Initial:			12
Current:	Unlikely - 2	Major - 4	8
Target:	Unlikely - 2	Major - 4	8

Principle Trust Objective:
Be a sustainable organisation, Collaborate with others

Source of Risk:
External assessment

Risk level Current:
High

Last Review Date:
12/05/2021

Risk description:
As the NHS is performance managed and discharges accountability at system level, there is a risk that the Trust is treated only through the view of the challenged Cambridgeshire/Peterborough system and therefore access to capital; revenue support and discretionary national transformation monies are not available to the organisation

Progress update:
[Hawkins, Rachel 12/05/21 no change to the risk. ICS work and engagement continues.

Significant Hazards:
1. national Policy to move to "system by default"
2. Provider financial health is more directly linked to the financial health of the "system"
3. Cambs/Pet has the one of the largest financial deficit in the NHS

Controls in place:
1. The Trust has spread its income and expenditure base across two STP footprints to more readily reflect its regional footprint
2. the Trust to play its full part in the service areas of MSK and Children in Cambs/Pet - but nothing else
3. full stakeholder relationships and executive visibility in place to influence the relevant decisions being made

Appendix 4 – Strategic Risks and Operational Risks 15 and above

Risk ID: 3166	Risk owner: Howard, Kate	Risk handler: Howard, Kate
Directorate: Trustwide		Date recorded: 10/03/2020
Specialty: Not Applicable		Anticipated completion date: 31/05/2021
Clinical Group: Trust Wide		Risk committee: Board

Risk Grading:

	L	C	
Initial:			4
Current:	Unlikely - 2	Major - 4	8
Target:	Unlikely - 2	Major - 4	8

Risk Title: There is a risk that patients and service users do not receive outstanding care if services fail to remain compliant with CQC

Principle Trust Objective:	Source of Risk:	Risk level Current:	Last Review Date:
Be an excellent employer, Provide outstanding care	Risk assessment	High	11/05/2021

Risk description:
There is a risk that patients and service users do not receive outstanding care if services fail to remain compliant with CQC Fundamentals of Care standards

Progress update:
[Howard, Kate 11/05/21 Risk reviewed, score and mitigations remain the same.

Significant Hazards:
A number of factors (some of which are listed below) could combine which would then result in poor patient experience and increased patient safety incidents.
(This will also negatively impact on compliance with regulatory standards)
- Staff absence at work due for a variety of reasons including sickness
- Limited availability of staff in certain professional groups ie specialist professions which are nationally difficult to recruit to
- Staff lack of understanding of what constitutes delivery of outstanding care and their role within that.
new hazard identified - Covid19 pandemic requiring new ways of working

Controls in place:
Relaunch of 'Our Quality Improvement Way'
Rolling Peer Review Programme outcomes triangulated with annual service CQC self assessments
Quality Early Warding Trigger Tool monthly completion by all teams
Quality reports to Clinical Operational Boards and Board
Bi annual Workforce review to Board (May and November Public Boards)
Back to the floor programme continues - summary taken to Wider Exec Team
Ongoing annual CQC inspection cycle which now includes staff focus groups and inspector attendance at key meetings ie Board
Staff feedback (including staff survey)
Whistleblowing and raising Concerns processes well embedded with report to Board x 2 (Chief Executive report) and annually from freedom to Speak Up Guardian reports
Clinical audit programme - reports to Clinical Operational Boards and Quality Improvement and Safety Committee
Patient and Staff feedback mechanisms ie FFT
Patient Stories to Board
Internal audit programme (Quality elements)
Improvement plan for the CQC identified 'Areas for Improvement' August 2019
Establishment of trust wide 0-19 services clinical leads group - This group feeds into the trust wide quarterly Children's services group
Oversight of actions at Wider Exec group
Quality Data continues to be regularly triangulated with Workforce information at Service, Clinical Operational Board and Board level
Major incident management process invoked with daily trust wide sit rep meetings including escalation of issues ie staffing, IP&C, maintenance of essential services.
Robust Major incident governance structure in place with daily situation reporting of staffing, incidents, risks and PPE situation.
new control - IP&C Board Assurance Framework initial self assessment undertaken and presented to Trust Board - will be monitored monthly by IPC Huddle and at each IPC Committee
new control - Safeguarding risks/ issues are reviewed at the Safeguarding huddle and via the Safeguarding Committee
new control - 10 recommendations IPaC and testing (published in Nov 2020) has been reviewed via a gap analysis - any actions will be monitored via the IPaC Committee
Internal governance log and thematic reviews (e.g. pressure ulcers) continue to be circulated

Appendix 4 – Strategic Risks and Operational Risks 15 and above

Risk ID: 3164	Risk owner: Pisani, Anita	Risk handler: Pisani, Anita
Directorate: Trustwide		Date recorded: 09/03/2020
Specialty: Not Applicable		Anticipated completion date: 30/06/2021
Clinical Group: Trust Wide		Risk committee: Board

Risk Grading:

	L	C	
Initial:			12
Current:	Possible - 3	Major - 4	12
Target:	Unlikely - 2	Major - 4	8

Risk Title: Workforce challenges affecting ability of services to maintain high quality care

Principle Trust Objective:
Be an excellent employer, Collaborate with others, Provide outstanding care

Source of Risk:
Meetings

Risk level Current:
High

Last Review Date:
12/05/2021

Risk description:
There is a risk that the Trust is unable to maintain high quality care due to the number of services/teams facing workforce challenges.

Progress update:
[Pisani, Anita 12/05/21] No change to risk score. Workforce challenges remain and are discussed at IMT. Recovery and restoration underway with a real focus on staff health and wellbeing.

Significant Hazards:
Vacancies - hard to recruit to posts
Turnover
Staff Morale
Sickness levels
Demands on services
Numbers of Covid positive cases
Length of Covid pandemic and lockdown restrictions

Controls in place:
Monthly workforce KPI data shared with all Service Directors - turnover; sickness; stability; appraisal and mandatory training compliance
Bi-annual workforce reviews with all service areas - May and November each year
Quality Dashboard
Quality Early Warning Trigger Tool
Raising Matters of Concern log and actions
Bi-monthly Trust Board Quality Report
Staff side chair identified as confidential link
Freedom to Speak Up Guardian and Champions
Live Life Well activities
Workforce Race Equality Action Plan
Back to the Floor feedback and actions
Local Recruitment and Retention Premia in place where appropriate
Staff Survey results and actions plans
Care Quality Commission feedback
Peer Reviews
Business Continuity Plans
Service self-assessments against 5 Care Quality Commission Domains
Incident reporting
2 times per week Incident Management Team Meetings

Appendix 4 – Strategic Risks and Operational Risks 15 and above

Risk ID: 3072	Risk owner: Williams, Mrs	Risk handler: Harwin, Simon
Directorate: Bedfordshire Community Health Services		Date recorded: 18/10/2019
Specialty: Community Paediatrics (Beds)		Anticipated completion date: 31/12/2021
Clinical Group: Community Paediatrics (Beds)		Risk committee: Children & Young People's Clinical Operational Board

Risk Grading:			
	L	C	
Initial:			
Current:	Almost Certain - 5	Moderate - 3	15
Target:	Likely - 4	Moderate - 3	12

Risk Title: Delays in clinical assessment and treatment (Initial and follow up appointments)

Principle Trust Objective:
Be a sustainable organisation, Collaborate with others, Provide outstanding care

Source of Risk:
Risk assessment

Risk level Current:
Extreme

Last Review Date:
06/05/2021

Risk description:
There is a risk that continued delays with Children not receiving a medical assessment and follow up (including medication reviews) in a timely way may lead to:
- Diagnostic delays with potential impacts to Childhood development
- Undiagnosed medication side affects e.g. arrhythmias,
- Parental and stakeholder dissatisfaction resulting in Trust reputational damage

Progress update:
[Williams, Mrs Augustina - 06/05/2021 21:09:49] 2.0wte 12 month fixed term Locum Consultants recruited subject to satisfactory pre- employment checks. Average RTT waiting time 20 weeks; 406 children waiting longest wait 46 weeks., 326 children waiting for ADHD medication review (not including Specialist Nurse caseload) longest wait 1 year 4 weeks (child within special school was not brought to appointment Feb 2021. 211 children waiting for ADOS/ BOSA assessment (7 booked) longest wait 1 year 39 weeks. Service continues to be impacted by sickness- admin & medical; 1 admin staff member COVID related; Consultant due to return to work next week. Chaperone rota in place for child protection medicals.
Plan in place and progressing to address Autism diagnostic waits- 70 assessments procured externally using local providers to commence 8.05.2021 (see attached). SBS supporting procurement for 200+ ADOS/ BOSA assessments-tender now live, evaluation of bids 2.06.2021.
One Community Paediatric service model- joint workshop with Luton & Beds Paediatricians to progress implementation of ASD & ADHD clinical pathways positive outcome.

Significant Hazards:
- Increasing volume of referrals.

Controls in place:
- Overdue ADHD Medication Reviews and EHCP reviews are clinically prioritised.
- All referrals are clinically prioritised with face to face assessments offered if clinically required (this accounts for a small volume of Children).
- Monthly meeting with parent carer forums in place to update on changes.
- Bi- weekly tele-conferences to track improvements
- Demand and capacity model in development to inform CCG discussions on the resource required.
- Additional locum medical resource & weekend working in place.
- Additional Specialist Nurse starts September .
- Weekend clinics are in place.

Appendix 4 – Strategic Risks and Operational Risks 15 and above

Risk ID: 3182	Risk owner: Howard, Kate	Risk handler: Howard, Kate
Directorate: Trustwide		Date recorded: 03/04/2020
Specialty: Safeguarding		Anticipated completion date: 31/08/2021
Clinical Group: Trust Wide		Risk committee: Adult's Clinical Operational Board, Children's and Young People Clinical Operational Board, Strategic Safeguarding Group

Risk Grading:			
	L	C	
Initial:			12
Current:	Likely - 4	Major - 4	16
Target:	Rare - 1	Major - 4	4

Risk Title: Safeguarding children and adults at risk during Covid-19 Pandemic

Principle Trust Objective:	Source of Risk:	Risk level Current:	Last Review Date:
Provide outstanding care	Risk assessment	Extreme	11/05/2021

Risk description:
Safeguarding There is a risk that abuse and neglect will not be identified and acted upon at the earliest opportunity, to provide a timely assessment and intervention to mitigate further harm to children and adults at risk due to changes in service provision through the Covid19 pandemic.

Progress update:
[Shulver, Debbie 11/05/21] Risk reviewed and rating remains the same. Risk & controls to be discussed at the next Strategic Safeguarding Board meeting scheduled for the 24th May 2021 considering the impact of the implementation of services & wider partnership restoration plans and social distancing easements.

Significant Hazards:
Redefinition of 'Essential services' during Covid 19 pandemic including delivery mode ie reducing face to face contact with clients and therefore opportunities for staff to undertake holistic assessment of need
There has been a decrease in the face to face and direct contact with clients and a greater reliance on virtual platforms for contacts due to social distancing government directive. This is likely to lead to a reduction in the opportunities to undertake holistic assessments of clients and therefore reduce identification of abuse and neglect.

Controls in place:
Robust leadership across Trust
SOP's issued to staff around face-to-face contact
Regular system meetings/oversight in place via SitRep meetings and senior leadership meetings attended by safeguarding teams.
Business continuity Plan in place and being updated at each element of change noted to include decision making and assurances.
Caseload risk assessments are in place for each service and are being reviewed by caseholders and supported by team managers.
Safeguarding is an essential service, the expectations that professionals will continue to exercise their safeguarding responsibilities.
Safeguarding provisions remain in place to support MASH and adult safeguarding concerns.
Safeguarding professionals continue to provide advice, guidance and ad hoc supervision.
Incidents continue to be reviewed and monitored via governance process.
The adult safeguarding provision has been increased to support the increase of workload.

Appendix 4 – Strategic Risks and Operational Risks 15 and above

Risk ID: 3120	Risk owner: Williams, Mrs	Risk handler: Williams, Mrs Augustina
Directorate: Luton Community		Date recorded: 23/12/2019
Specialty: Children Services (Luton)		Anticipated completion date: 31/12/2021
Clinical Group: Children's Community Paediatrics - Edwin Lobo (Luton)		Risk committee: Bedfordshire & Luton Clinical Operational Board, Children's and Young People Clinical Operational Board
Risk Title: Service Capacity within Luton Community Paediatric Service		

Risk Grading:			
	L	C	
Initial:			
Current:	Almost Certain - 5	Moderate - 3	15
Target:	Likely - 4	Moderate - 3	12

Principle Trust Objective:	Source of Risk:	Risk level Current:	Last Review Date:
Provide outstanding care	Meetings	Extreme	06/05/2021

Risk description:
There is a risk that delays for initial assessments and follow up appointments will continue, leading to continued 18 week RTT breaches and CYP and family delays.

Progress update:
[Williams, Mrs Augustina - 06/05/2021 20:22:12] Job descriptions & person specs for long standing vacant Consultant & Speciality Drs posts reviewed by Interim Clinical Lead to progress recruitment in addition to new post of Children's Clinical Director across the Trust. Plan in place and progressing to address Autism diagnostic waits- 70 assessments procured externally using local providers to commence 8.05.2021 (see attached). SBS supporting procurement for 200+ ADOS/ BOSA assessments-tender now live, evaluation of bids 2.06.2021.
One Community Paediatric service model- joint workshop with Luton & Beds Paediatricians to progress implementation of ASD & ADHD clinical pathways positive outcome.
Service performance data not available at time of report

Significant Hazards:
- Covid 19 restrictions have limited locum staff availability.
- Staff sickness COVID and non COVID related.
- Challenges in recruiting to 2 vacant Consultant Paediatrician posts.

Non Covid related factors:
- Service demand does not meet commissioned cap

Controls in place:
- 2 Consultant and registrar posts advertised
- Additional ADOS/ BOSA assessments are being procured.
- A comprehensive demand & capacity model has been submitted to commissioners.
- Monthly check in with parent carer forums and stakeholder is in place.
- Additional specialist Nurses have been recruited.
- Duty line and a SEN facilitator are now in post to support Children and families on the waiting list.

Appendix 4 – Strategic Risks and Operational Risks 15 and above

Risk ID: 3227	Risk owner: Howard, Kate	Risk handler: Andrews, Dawn
Directorate: Trustwide		Date recorded: 03/08/2020
Specialty: Unit Wide		Anticipated completion date: 31/10/2021
Clinical Group: Trust Wide		Risk committee: Adult's Clinical Operational Board, Children's and Young People Clinical Operational Board, Strategic Safeguarding Group

Risk Grading:

	L	C	
Initial:			12
Current:	Likely - 4	Major - 4	16
Target:	Rare - 1	Major - 4	4

Risk Title: Surge of safeguarding enquiries

Principle Trust Objective:
Collaborate with others, Provide outstanding care

Source of Risk:
Risk assessment

Risk level Current:
Extreme

Last Review Date:
27/04/2021

Risk description:
There is a risk services will not have the capacity to provide timely and effective response to children & adult safeguarding enquiries during the pandemic. This may result in a failure to support multiagency decision making to assess actual or likely risk of significant harm and provide timely intervention to promote the wellbeing and protect children/young people and adults at risk of harm.

Progress update:
[Howard, Kate 21/04/21 08:53:10] Reviewed, and remains the same in relation to risk, mitigations and score.

Significant Hazards:
Peak demand in safeguarding activities will result in a challenge to provide timely and effective assessments & interventions to mitigate harm to children & adults at risk

Controls in place:
Safeguarding surge needs to be managed by systems wide approach this cannot be addressed in isolation
Request immediate assurance that the anticipated surge in safeguarding enquiries is a key focus of the existing systems wide Covid 19 pandemic Incident Management process inclusive of commissioners & other health providers
The internal safeguarding team has been reviewed and resource has been increased in order to provide extra support for adult safeguarding work.
Cover for Named Doctor in Bedfordshire in place over 4 weeks commencing 27/04/2021
Inform strategic health and safeguarding partnership decision making process and implementation of agreed safeguarding processes
Develop and implement mechanism for early alert to emerging demand and capacity issues to facilitate timely and effective response
Step up frequency of analysis safeguarding activity monitoring at local operational and central Trust wide levels, inclusive of MASH, MARAC, CPMA (inclusive of NAI) Adult safeguarding concerns raised by CCS professionals & Adult safeguarding enquiries inclusive of Provider Lead and Section 42 enquiries
Consider the need to capture HCP & Specialist Children's Services & Luton Adult's safeguarding activities inclusive of reports & participation in meetings as safeguarding partnership agreements.
Consider the need to step back to essential service provision for specific Children & Adult Services Trust wide as part of strategised response to manage safeguarding enquiries and timely effective interventions, as part of our safeguarding partnership systems responsibility.
Consider the need to stream line or postpone quality assurance mechanisms inclusive of internal and external audit & statutory Adult and Children Case Reviews and non-essential development works teams as Relevant Safeguarding Partners
Develop mechanism for efficient and responsive communication system; to ensure that all professionals are made aware of their service and individual responsibilities to participate in safeguarding enquiries as integral to clinical responsibilities and timely communication of any change to existing internal or external safeguarding processes.
Enhance ease of access to specialist safeguarding professional expertise for advice guidance, supervision to support case management and escalation as required, this may will require redeployment of professional to support MASH/MARAC operational processes
Awareness and support for staff who may be subjected to vicarious trauma. Increase need for both line management and specialist psychological support
Service Director meetings to explore Trust wide options. Demand & capacity work to inform increases in funding. Commissioning conversations (Beds & Luton) to explore funding options.
new control: increase capacity in Luton and Bedford via additional posts (short term and permanent)

Appendix 4 – Strategic Risks and Operational Risks 15 and above

Assurance Framework for the Integrated Governance Report

Part A

The Executive Summary to the Integrated Board Report provides an overall assessment of the level of assurance in relation to the Trust's strategic risks and operational risks at 15 and above.

Part B

The Executive Summary to the Integrated Board Report provides an overall assessment of the level of assurance in relation to the domains of safe, effective, caring, responsive and well led, using the assurance opinion categories of the Trust's internal audit programme.

The table below sets out the overarching framework for each category against each such domain tailored to the Trust's service portfolio and approach to board assurance. The framework does not and is not intended to cover all parameters set out in the CQC domains – many of these would be evidenced in other ways on an inspection such as by service visits. When services are referred to in the framework this is a whole service (ie MSK, universal children's service).

The assurance level set out in the Executive Summary relates to the two month reporting period of the Integrated Governance Report.

Domain	Assurance being sought	Ref	Substantial Assurance	Reasonable Assurance	Partial Assurance	No Assurance
Safe	That our patients are protected from abuse and avoidable harm.	**S1**	90% patient safety incidents reported in period are no/low harm	75% patient safety incidents reported in period are no/low harm	50% patient safety incidents reported in period are no/low harm	25% patient safety incidents reported in period are no/low harm
		S2	No never events reported in any service.	Adequate progress on action plans for previously reported Never event .	Never Event occurred in one service.	Never Event occurred in two or more services. Or similar Never Event occurred in the same service.
		S3	Evidence of lessons learnt from Serious Incidents	Adequate progress on action plans for previously reported SI.	SI occurred in two or more services and process is behind SI timeframe for investigation	SI occurred in two or more services with no or minimal evidence of action plans being implemented.
		S4	staffing pressures are adequately controlled with minimal impact on service delivery	staffing pressures are adequately controlled, plans agreed with commissioner for prioritising service delivery and service plans in place to reduce staffing pressures	staffing pressures resulting in reduced service delivery and no commissioner agreed plan or internal service plan in place	staffing pressures resulting in reduced service delivery and no commissioner agreed plan or internal service plan in place in same service for two or more reporting periods
		S5	No outbreaks of covid19 due to nosocomial transmission in any service	One outbreak of covid19 due to nosocomial transmission within our services	Two or more outbreaks of covid19 due to nosocomial transmission within our services	Multiple outbreaks identified in our services attributed to nosocomial transmission

		S6	staff flu vaccination compliance at or above plan	staff flu vaccination compliance below plan but at same level or improved on last year	Staff flu vaccination compliance below plan and below last year's level with an action plan in place	staff flu vaccination compliance below plan and below last year's level with no action plan in place
		S7	All service changes have a quality impact assessment and equality impact assessment in place.	Majority of service changes have a quality impact assessments and equality impact assessments undertaken	Some service changes have a quality impact assessments and equality impact assessments undertaken	No quality impact assessments or equality impact assessments have been undertaken for services that have changed
		S8	IPAC Assurance Framework completed and all requirements in place.	IPAC Assurance Framework completed with a plan in place to ensure any gaps identified are addressed.	IPAC Assurance Framework completed but no plan in place to address identified gaps.	IPAC Assurance Framework not completed.
		S9	All services and staff have access to at least 1 week's supply of appropriate PPE.	Less than 1 week's supply of any essential element of PPE but mitigation in place	Less than 1 week's supply of any essential element of PPE and no mitigation in place	no stock of 1 or more items of PPE and no mitigation in place

Domain	Assurance being sought	Ref	Substantial Assurance	Reasonable Assurance	Partial Assurance	No Assurance
Caring	Do our services involve and treat people with compassion, kindness, dignity and respect?	**C1**	Friends and Family Test scores are more than 90% with no more than 2% of services below the score.	Trust wide Friends and Family Test scores more than 90% with no more than 5 % of services below this score	Friends and Family Test scores more than 90% across 75% of services with plans in place to improve scores in the 25% below this figure	Friends and Family Test scores more than 90% in less than 75% of services
		C2	Number of complaints and informal Complaints are within the expected variation	Number of complaints and informal complaints above mean but within upper control limit.	Number of complaints and concerns above upper control limit for both months reported.	Number of complaints and concerns above upper control limit for last four months
		C3	95% of all complainants offered local resolution within 4 days.	85% or more of all complainants offered local resolution within 4 days	50% or more of all complainants offered local resolution within 4 days	25% or less of all complainants offered local resolution within 4 days
		C4	Clear evidence of caring and compassionate care is contained within the patient story.	Issues raised in patient story about manner of staff and action plan in place to address issues	Issues raised in patient story about manner of staff and no action plan in place to address issues	Issues raised in patient story at previous Board about manner of staff and no action plan in place to address issues

*** Compliments received to be developed for September**

Domain	Assurance being sought	Ref	Substantial Assurance	Reasonable Assurance	Partial Assurance	No Assurance
Effective	That people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence	**E1**	- mandatory training and supervision at or above target levels	- mandatory training and supervision at or above target levels across 85% of services and remaining services are no more than 5 % below target	- mandatory training and supervision at or above target levels across 75% of services and no more than 2 services are more than 5 % below target	- mandatory training and supervision is 74% or less of target levels or 3 or more services are more than 5 % below target
		E2	-appraisal rates are at or above target levels	- appraisal rates at or above target levels across 90% of services and remaining services are no more than 5% below target	- appraisal rates at or above target levels across 80 % of services and no more than 2 services are more than 5% below target	- appraisal rates at or above target levels across 79 % of the Trust and 3 or more services are more than 10% below target
		E3	- rolling sickness rates are within average and no higher than the NHS England rate for Community Trusts	-rolling sickness within control total but show an increase for last 6 months	-rolling sickness above upper control total for both months reported	-rolling sickness outside upper control total for last four months
		E4	-stability figures at or above target levels	-stability figures within control total but show a decrease for last 6 months	- stability figures below lower control total for both months reported	-stability figures below lower control total for last four months
	Research	**E5**	95% of all CRN portfolio studies are scoped for viability against Trust services.	75 % of all CRN portfolio studies are scoped for viability against Trust services.	50% of all CRN portfolio studies are scoped for viability against Trust services.	25% of all CRN portfolio studies are scoped for viability against Trust services.

			- All four local equality delivery system objectives are on track for delivery and this is evidenced through robust plan of work	- Majority of local Equality Delivery System objectives on track for delivery and this is evidenced through a robust plan of work	- Local Equality Delivery System objectives in place but no plan in place to ensure that the Trust meets these	-No local Equality Delivery System Objectives in place

*** Outcomes/delivery of commissioned contracts – to be developed for September**

*** Quality/continuous improvement work to be developed for September**

Domain	Assurance being sought	Ref	Substantial Assurance	Reasonable Assurance	Partial Assurance	No Assurance
Responsive	Are Trust Services responsive to patients' needs?	**R1**	- all consultant-led services meet 18 week referral to treatment target	- the Trust average across all relevant patients in consultant-led services is up to 1% below the 18 week referral to treatment target	- the Trust average across all relevant patients in consultant-led services is between 1 and 3% below the 18 week referral to treatment target	- the Trust average across all relevant patients in consultant-led services is more than 3% below the 18 week referral to treatment target
		R2	95% or above of all complaints responded to within timeframe and there is evidence of actions being implemented.	90% or above of all complaints responded to within timeframe and there is evidence of actions being implemented.	75% or above of all complaints responded to within timeframe and some evidence of actions being implemented	50% complaint responded to outside timeframe by more than 5 days and no evidence in two reporting periods of actions being implemented
		R3	Responsive to C19 requests: • Implementation of guidance met required deadlines 100% on time • In month sitrep submissions 100% on time	Responsive to C19 requests: • Implementation of guidance met required deadlines 90% on time • In month sitrep submissions 90% on time	Responsive to C19 requests: • Implementation of guidance met required deadlines 80% on time • In month sitreps submissions 80% on time	Responsive to C19 requests: • Implementation of guidance met required deadlines less than 80% on time • In month sitreps submissions less than 80% on time

*** C19 Restoration plans delivery – to be developed for September**

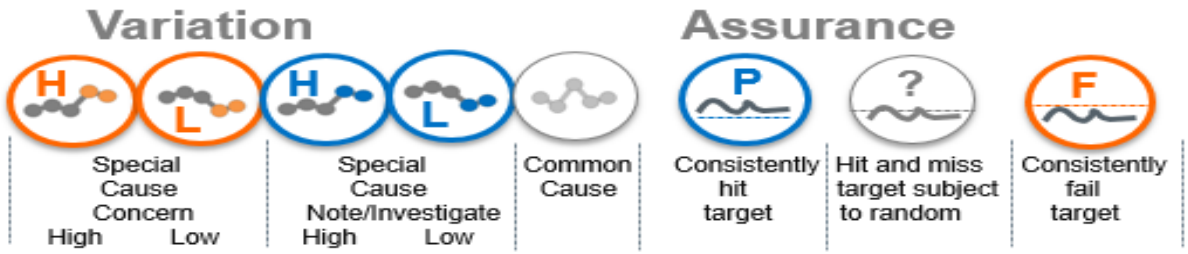
Domain	Assurance being sought	Ref	Substantial Assurance	Reasonable Assurance	Partial Assurance	No Assurance
Well led	Are effective governance processes in place underpinning a sustainable organisation?	**WL1**	- income and expenditure in line with budget and any variation is not anticipated to have a detrimental impact on year end out turn against plan	- income less than or expenditure more than budget with an anticipated detrimental impact on year end out turn against plan by no more than 1%	- income less than or expenditure more than budget with an anticipated detrimental impact on year end out turn against plan by no more than 2% with no action plan in place	- income less than or expenditure more than budget with an anticipated detrimental impact on year end out turn against plan by more than 2% with no action plan in place for two reporting periods or with an anticipated detrimental impact on year end out turn by more than 5%
		WL2	- The trust processes for identifying and recovering 100% of the additional costs relating to COVID-19 are approve by NHSE / I	- The trust processes for identifying and recovering 75% of the additional costs relating to COVID-19 are approve by NHSE / I	- The trust processes for identifying and recovering 50% of the additional costs relating to COVID-19 are approve by NHSE / I	- The trust processes for identifying and recovering 25% of the additional costs relating to COVID-19 are approve by NHSE / I
		WL3	- CIP in line with plan and any variation is not anticipated to have a detrimental impact in achieving the overall efficiency savings	-CIP under plan by no more than 5% with action plan in place	-CIP under plan by no more than 5% with no action plan in place	-CIP under plan by no more than 5% with no action plan in place for two reporting periods or under plan by more than 5%
		WL4	-capital spend is in line with budget and any variation will not have a detrimental impact on overall capital plan	- capital plan revised within ceiling and approved by estates committee	- capital plan revised within ceiling but not approved by estates committee	- capital plan exceeded and not approved by regulator
		WL5	- use of resources figure is a 1	- use of resources figure a 2 with plan to be a 1 by next reporting period	- use of resources figure a 2 with no plan to be a 1 by next reporting period	- use of resources figure a 2 for 2 reporting periods or a 3 or 4 for reporting period

		WL6	- agency spend controlled within Trust ceiling with no anticipated change throughout the year	- agency spend above ceiling by no more than 5% with plan to achieve overall ceiling by year end	- agency spend above ceiling by no more than 5% with no plan to achieve overall ceiling by year end	- agency spend above ceiling by no more than 5% with no plan to achieve overall ceiling by year end for two reporting periods or agency spend above ceiling by more than 5%
		WL7	- strong governance evidenced of collaborations	- gaps in evidence of governance of collaborations	- gaps in evidence of governance of collaborations for two reporting periods	- breakdown in governance of one or more collaboration involving chair or chief executive for resolution
		WL8	100% of black, Asian and minority ethnic (BAME) offered staff risk assessments. All mitigation over and above the individual risk assessments in place	>90% of black, Asian and minority ethnic (BAME) offered staff risk assessments. Majority of mitigation over and above the individual risk assessments in place	>80% of black, Asian and minority ethnic (BAME) offered staff risk assessments. Some mitigation over and above the individual risk assessments in place	>70% black, Asian and minority ethnic (BAME) offered staff risk assessments. No mitigation over and above the individual risk assessments in place
		WL9	100% of staff with high risk factors to COVID19 are offered staff risk assessments. All mitigation over and above the individual risk assessments in place.	>90% of staff with high risk factors to COVID19 are offered staff risk assessments. Majority of mitigation over and above the individual risk assessments in place	>80% of staff with high risk factors to COVID19 are offered staff risk assessments. Some mitigation over and above the individual risk assessments in place	>70% of staff with high risk factors to COVID19 are offered staff risk assessments. No mitigation over and above the individual risk assessments in place

		WL10	Reduced travel mileage spend by 50% against budget	Reduced travel mileage spend by 30% against budget	Reduced travel mileage spend by 20% against budget	Reduced travel mileage spend by 10% against budget

***Positive feedback on digital interactions to be developed for September**

SPC key



Appendix 6 - Key for statistical process control charts