TRUST BOARD

Cambridgeshire Community Services NHS Trust

Title:	**Integrated Governance Report**
Action:	**For DISCUSSION**
Meeting:	**20th January 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 October and November 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 October and November 2020 and 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: Infection, Prevention and Control (IPaC) Board Assurance Framework
Appendix 3: Strategic Risks and Operational Risks 15 and above
Appendix 4: Assurance Framework
Appendix 5: Statistical Process Control Chart Key

	Name	Title
Author and Executive sponsor	Kate Howard Anita Pisani Anne Foley Mark Robbins David Vickers Rachel Hawkins	Chief Nurse Chief Executive Director or Workforce & Business Development Director of Finance & Resources Medical Director Deputy Chief Executive/Director of Governance & Service Redesign

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 communities we serve.	This project is covered by the People Participation 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
☐	☐	☐	☐	☐	☐	☐	☐	☐

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Part One – Assurance Summary and Performance for October and November 2020

Part Two – Supporting Information

SO1

Provide outstanding care

A: Assurance Summary

Overall assurance rationale:

Safe	▪ There were 2 Serious Incidents reported in October (1) and November (1) 2020, one Never Event was reported in October. ▪ 96% of incidents are low or no harm (Trust target 90%) ▪ There were no healthcare acquired infections ▪ There was one Covid19 staff outbreak ▪ The staff flu campaign 2020 commenced on 5 October (update as of 5 January is 81.03% of staff have been vaccinated) ▪ IPAC (Infection Prevention and Control) assurance framework has been reviewed and is being presented to board in January 2021 ▪ A gap analysis has been undertaken against the 10 recommendations in the key actions: infection prevention and control and testing document ▪ All staff have access to appropriate PPE (Personal Protective Equipment)	**Reasonable**
Caring	▪ Outstanding care – patient story ▪ FFT (Family & Friends Test) outcome is 96.17% (target 90%) ▪ Number of informal and formal complaints within expected variance (total of nine formal complaints received in October and five in November)	**Substantial**
Effective	▪ Mandatory training just below 94% target for October at 93% and on target for November at 94% ▪ Formal Safeguarding supervision reintroduced in July, with a rising trajectory noted ▪ Level 3 safeguarding training has been available online for staff; positive feedback received in relation to content ▪ The Heads of Safeguarding have identified a proactive programme to support parents with crying babies (ICON), this is being adopted across the systems CCS work in	**Reasonable**
Responsive	▪ Complaints response time was 100% for the 3 responses sent in October and 100% for the 2 sent in November (target 100%) ▪ RTT challenges are noted (see section 6) ▪ Covid19 incident response meets all national requirements	**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 5 major incident.

2. In addition to the overview and analysis of performance for October 2020 and November 2020, the Board can take assurance from the following sources:

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- During the Covid19 pandemic period and more recently whilst operating at a NHS level 4 then 5, 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, daily 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. Pressures in a number of our services are being reported and monitored through the daily Covid19 situation report process.

- 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. The subsequent update is presented within this paper.

- There has been one reported staff outbreak of Covid19 infection within this reporting period, which has been managed in line with national guidance.

- The Ockendon Review of Maternity Services report which was published in December 2020 has been internally reviewed and shared with the relevant services for information only. There are no actions or recommendations for the Trust to implement at this time.

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. *November result 96.17%*
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
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 / 2020 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 2019 / 2020 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 one 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% October 94% November

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. (Risk Rating12)*

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. There is a risk of protracted delays for Children requiring ASD (Autism Spectrum Disorders) / ADHD (Attention Deficit Hyperactivity Disorder) assessments due to the limited face to face appointments for routine requirements. The Covid19 pandemic has exacerbated service capacity challenges due to locum staff leaving, remote working limiting the*

volume of clinical slots and some specialist assessments required face to face (limited by social distancing). (Risk Rating 15)

2. ***Risk ID 3254 -*** *There is a risk that delivery of Covid 19 phase 3 restoration plans will not be fully implemented by March 2021 leading to the potential detrimental impacts on Children and Young people. (Risk Rating 16)*
3. ***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)*
4. ***Risk ID 3284 -*** *Workforce: There is a risk that there is insufficient local workforce currently available to safely deliver the mass vaccination programme leading to slower implementation of the vaccine programme and continued risk of adverse health caused by Covid 19.(Risk Rating 16)*

D: Overview and analysis (including information from the Quality Dashboard Appendix 1)

Additional information for this report

1. Patient Safety Incidents

1.1 The Incident Management Team 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 to the Incident Management Team meeting.

1.2 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.

1.3 Two internal root cause analysis (RCA) investigations were initiated in October: one in Luton Adults and the other in iCaSH Peterborough which was also the subject of a complaint. The incident in Luton Adults related to pressure ulcer care/review/ escalation and the iCaSH incident related to missed opportunities to escalate safeguarding concerns. A further four investigations were initiated in November: two in Bedfordshire 0-19 Service, one in the Children's and Young People's Services 0-19 Service and one in Norfolk Healthy Child Programme (HCP) (East Locality). All four incidents related to a lack of assessment / failure to escalate with regards to safeguarding concerns, initial lessons have been identified and fed back to the teams.

1.4 Two Serious Incidents have been declared in October (1) and November (1); these are both linked to safeguarding and are currently being investigated.

1.5 One never event in iCaSH services was declared in October (this was a low harm incident); the final report has been submitted and signed off by the commissioners.

1.6 The chart below highlights those patient safety incidents that occurred under our care during the two month period which totalled 278; of which 70% involved no harm, 26% low harm and 4% moderate harm.

1.7 Twelve moderate harm incidents were reported; a decrease on the previous two month period. Eleven incidents related to Luton Adults: 10 were linked to pressure ulcers and the remaining incident to a delay in referral. The final incident related to

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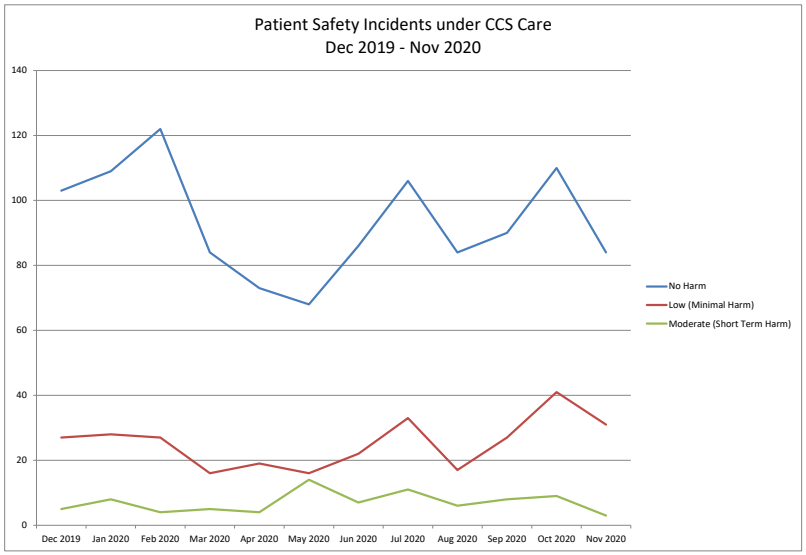
Cambridgeshire Children & Young Persons Service and a RCA investigation has been implemented (see comments above). All incidents have identified actions associated to them.



1.8 Medicines Management

1.8.1 The Community Health Services Pharmacist supporting the Luton and Bedfordshire services has left, and the remaining two pharmacists are currently supporting that area while we await the arrival of a replacement, due in March 2021.

1.8.2 One of the domiciliary pharmacy technicians working in the Luton Adult service has left. Her replacement will be deferred during the current lockdown, and discussions held at a later date regarding the potential to re-shape this team in the light of current developments with Primary Care Networks and the CCG.

1.8.3 The team continues to support the Mass Vaccination programme, and the staff Covid19 vaccination programme, this is impacting on team capacity due to the complexities of introducing the new vaccinations and associated governance. Additional resource is being sought from healthcare partners.

1.8.4 The team also continues to support business as usual, including the non-medical prescribing network; query answering, practical and legal queries, as well as providing dedicated support for the iCaSH service.

1.8.5 Following a review of national guidance and discussions with clinicians a number of Patient Group Directions have been extended due to capacity issues. There are no clinical or safety concerns identified from these extensions.

1.8.6 The profile of incidents is largely unchanged from previous reports. There have been a small number of incidents in the postage of items from iCaSH, these have been linked to information / equipment being sent through the post and not arriving at the patient's home, all of which have been resolved.

1.8.7 A number of medication risks have been raised in relation to the Mass Vaccination programme, which are kept under constant review within the programme board. The identified risks are mostly linked to gaps in vaccination

information, however once data or medication guidelines become available nationally it has been possible to close several of them.

1.8.8 Electronic transfer of prescriptions (direct from SystmOne to the community pharmacy) has still not been enabled. The Trust's Clinical Systems team has explored this with the system provider and has informed us that it is not possible due to system alignment.

2. Safeguarding

2.1 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 give assurance that safe service provision is in place. Please see brief summary of current position.

2.2 The risks are:

2.2.1 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 12; controls are being maintained.

2.2.2 The risk that our staff will not have the capacity to provide an effective safeguarding response to the increased number of complex cases that emerge 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.

2.2.3 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.

2.2.4 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.

2.3 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. 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. Psychological support for staff at the frontline and in the safeguarding teams is being actively sought as a matter of urgency from both private and public services.

2.4 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.

2.5 A proposal has been submitted to commissioners for increased non-recurrent investment) to manage the increase in safeguarding activity over the next 12 months in Bedfordshire. This has been approved, and recruitment commenced. In addition two Deputy Heads of Safeguarding are now in post, one leading work in Luton and one in Bedford.

2.6 It is acknowledged that as clinical practices are undertaken in line with Covid19 the teams are looking at new ways to proactively identify those who are at risk, this includes; texting services for advice and support and in Luton communications are on-going in terms of a different provision as children centre capacity is being reduced.

2.7 Additionally the Heads of Safeguarding have 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 have approached Bedfordshire, Luton and Cambridgeshire & Peterborough Partnership Boards to generate support for the use of the ICON; babies cry, you can cope programme across the system. There has been agreement to adopt this as a principle and the funding for this, as a support to the system, has been discussed across a variety of mechanisms with a consensus that this funding should be identified to support the system with implementation. The websites have been developed by CCS as a means to identify the support for parents with crying babies and this has been shared with partners to signpost to CCS websites.

2.8 The Safeguarding teams are continuing to strive to provide our staff with their core safeguarding expectations despite the pandemic and are responding to this using virtual platforms and blended (responsive) approaches to training and supervision. Teams are also continuing to support the multi-agency safeguarding work and are prioritising this when possible to ensure that the systems are continuing to be influenced by health voices to support adults and children at risk of abuse and neglect.

2.9 Norfolk are active participants in their system wide work stream called ‘Protecting Babies’ which includes a number of discussions about how to implement evidence based support across the system.

2.10 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.

2.11 Mandatory safeguarding training and formal safeguarding supervision is continuing to be undertaken, although delivered virtually. Professionals are reporting that the access to safeguarding professionals for support and guidance has been enhanced by the use of virtual media provision.

2.12 The Safeguarding team have also provided advice and support to the Mass Vaccination programme, this is linked to capacity assessments and providing generalised safeguarding information and training.

2.13 One Children’s Safeguarding Practice Review was published in October where CCS was a partner in care. The action plan has been completed and there are no outstanding recommendations. A further report was published in November which was linked to a family in the Luton area – CCS had minimal input in this case and no actions were assigned to us following review.

3. Infection Prevention and Control (IPaC)

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

3.2 The risk relating to supply and availability to our services of PPE is monitored weekly through the Incident Management Team and underpinned by daily sit rep information from all services.

3.3 The Board can be assured that no member of staff has been asked to undertake clinical care without appropriate Personal Protective Equipment (PPE).

3.4 In May 2020, NHS England published an *Infection Prevention and Control Board Assurance Framework* for Trusts to be able 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. Our initial detailed self-assessment against the 10 domains was presented to the Board in July and September 2020. Since then the document has been updated, with any gaps being mitigated (please see appendix 2) the document will be reviewed again at the Infection, Prevention and Control Board in February 2021.

3.5 In addition, in November NHSE published the key actions: infection prevention and control and testing document. A gap analysis has been undertaken against the 10 recommendations within this guidance; and an action plan developed, this will be monitored and reviewed within the Infection Prevention and Control Committee.

3.6 There has been one staff outbreak of Covid19 between October and November 2020, which the Infection Prevention and Control team were initially notified of when a member of staff became unwell. During the outbreak a total of nine staff were assessed and requested to have a Covid19 screen, following this an additional three members of staff reported a positive outcome. The Trust's Standard Operational Procedure was implemented and service delivery was able to continue without disruption. Shared learning from the outbreak was provided to the Trust's Incident Management Team and Service Directors. The outbreak was reported to NHSE as per national guidelines.

3.7 Eight incidents were reported during October and November 2020. These incidents are reviewed at the Infection, Prevention and Control Committee and themes identified where appropriate.

3.8 CCS's Staff Influenza campaign commenced in October in line with the national Covid19 Infection Prevention and Control guidelines. On 5 January 2021 a total number of 1508 staff had their flu vaccination (81.03%). This is the highest staff uptake the Trust has reported.

3.9 The flu vaccination programme for 2020 / 2021 has been reviewed and lessons learned have been identified for the 2021 / 2022 campaign.

3.10 The Trust is currently evaluating the national requirements for staff to receive the Covid19 vaccination via an internally led programme, it is hoped that a number of opportunities will be available for our staff in order to ensure accessibility. Staff who have identified themselves as clinically extremely vulnerable have already started to

access the vaccine via our partner organisations, this cohort is now being extended in some areas to include the high risk groups / front line staff. It should be noted that each system has a different timescale for staff vaccinations programme roll out.

3.11 There were no confirmed bacteraemia cases of MRSA (Meticillin-resistant Staphylococcus Aureus), Extended Spectrum Beta – Lactamase (ESBL) or E.Coli during October and November 2020. We have not been notified of any positive cases of C.difficile during this period.

4. Patient Experience

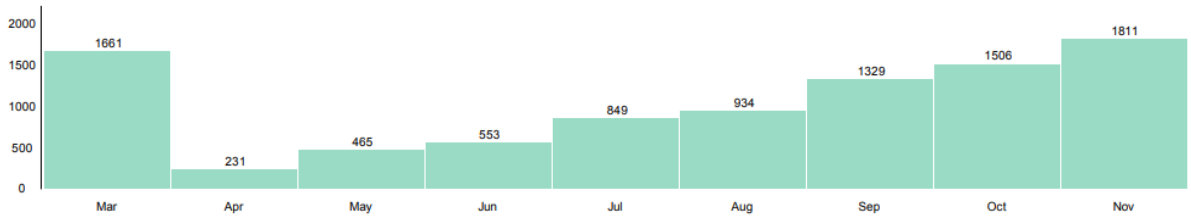
4.1 The Patient Story

4.1.1 The Patient Story that will be heard at January Board is from the Trust's Luton Adults Service. A family member will share their experience of making a formal complaint about their mother's experience of care.

4.2 Friends and Family Test (FFT)

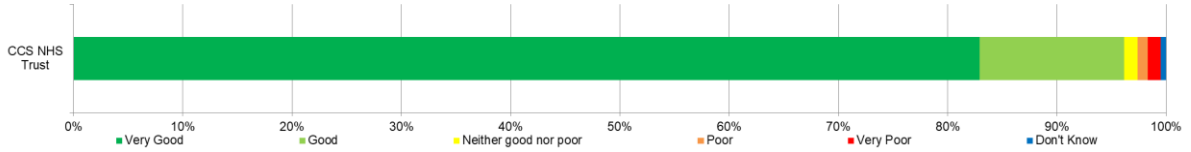
4.2.1 We continue to work in line with FFT national guidance around Covid19. Electronic feedback mechanisms following video and telephone appointments are in place across the Trust and we continue to support service users in providing feedback through the FFT and via our Patient Advice & Liaison Service.

4.2.2 We received 1506 responses in October and 1811 in November to the FFT question. The number of responses in this data period increased by 1054 on the previous two months and since the initial drop in April 2020 due to Covid19 the number of responses has increased month on month.



4.2.3 The overall Trust FFT positive feedback was 96.17%, with a 2.08% negative feedback percentage. We remain above the Trust target of 90%.

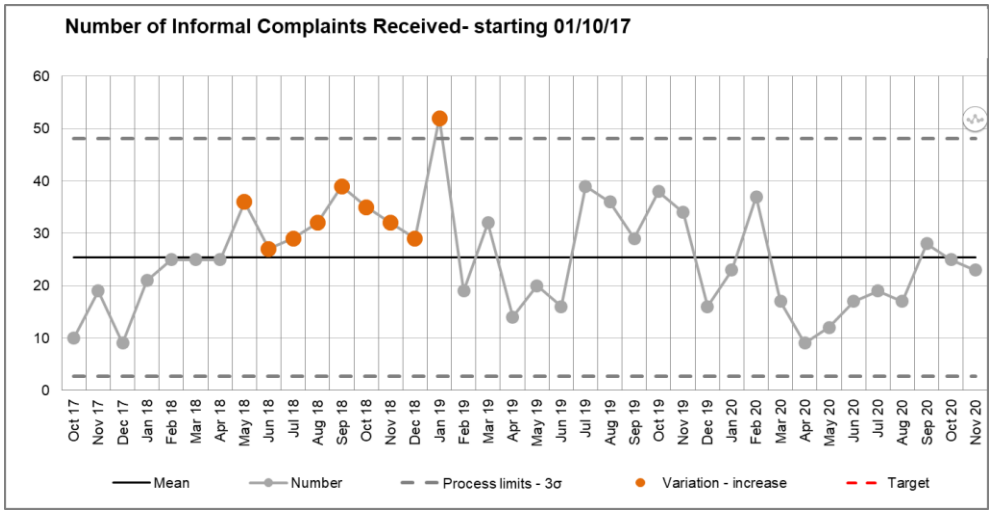
4.2.4 Below is the percentage of responses to each category of the FFT question for the overall Trust.



4.2.5 In October and November the services we provide received 4439 positive comments on surveys and feedback forms used across the Trust this is over 1600 more than in August and September.

4.3 Informal complaints received

4.3.1 The total number of informal complaints received and logged was 48 in this data period, as you can see from the table below this is within our expected variation. Four informal complaints were related to Covid19 and the impact of Covid19 on service provision offered.



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

4.4 Themes and learning from informal complaints closed in October and November 2020

4.4.1 Fifty-one informal complaints were resolved and closed in October and November 2020. The top three themes of the informal complaints closed within this period were Administration (17), Communication / Information (16) and Clinical Care (9). Administration and Communication / Information have both been themes over the previous reporting periods. Clinical Care has not been a theme in any two month period in the past 12 months. The informal complaints about clinical care have been reviewed and are discussed below.

4.4.2 Those relating to Administration included seven about Express Test and six about telephone service. Three of the concerns raised about Express Test were relating to not receiving test kits within iCaSH Cambs. All three received replacement kits.

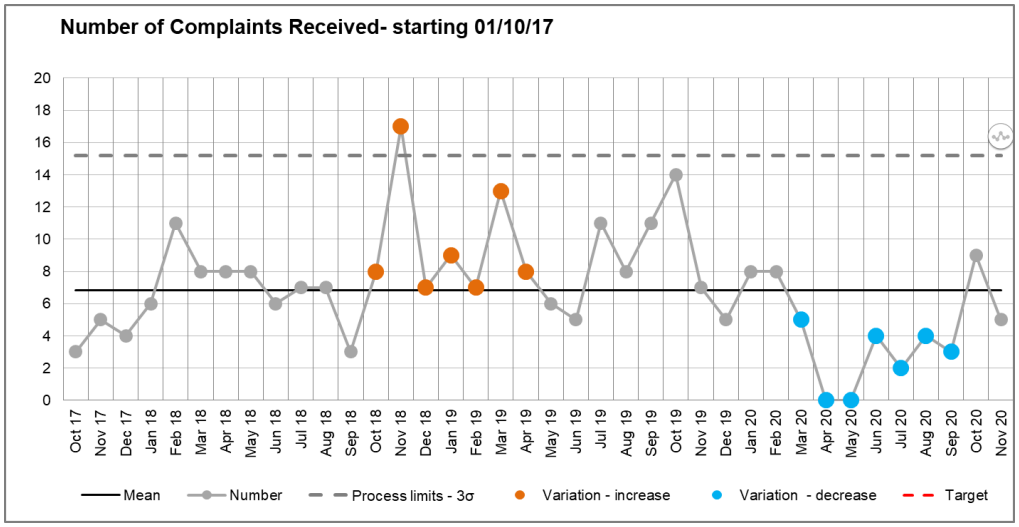
4.4.3 Those concerning Communication / Information included four about failing to communicate and three about poor communication. No themes were identified.

4.4.4 A review of the informal complaints relating to Clinical Care showed that five were dissatisfied with treatment; three identified inadequate or insufficient care and one inappropriate treatment. Four of the nine were related to MSK (Musculo-skeletal) services, the other five were split across five other services. The informal complaints about MSK focused on continued pain / ongoing problems following treatment, all have been shared with the services.

4.5 Formal Complaints

4.5.1 The Trust received 14 formal complaints in this data period. Nine were received in October which is above the average number received but within the expected variation (see below chart). This followed a significant decrease in the number of

complaints received during March to September, as shown by the blue dots on 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.

4.5.2 Five complaints were received in this period linked to Covid19, two were related to Speech & Language Therapy in Bedfordshire, one to Luton Adults Community Nursing and Palliative Care, one to Norfolk Healthy Child Programme (HCP) and one to MSK Cambridgeshire. These have all been reviewed by the Incident Management Team.

4.6 Themes and learning from formal complaints closed in August and September 2020

4.6.1 Within this data period we responded to and closed seven formal complaints. From these, five different subjects were identified: Delay in diagnosis/ treatment or referral (4), Communication/Information (3), Clinical Care (2), Quality of Care (1) and Staff Attitude (1). No themes were identified.

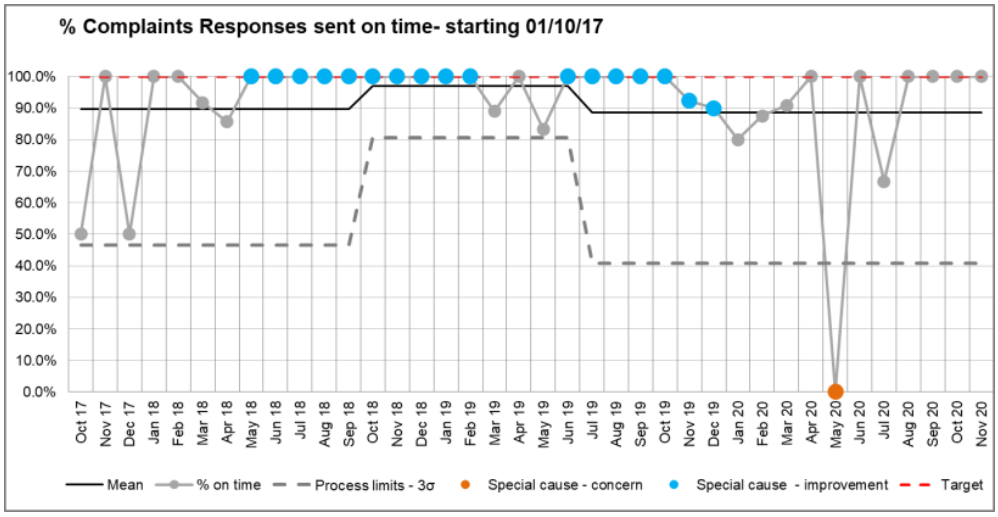
4.6.2 Learning and actions taken from complaints included:

i. MSK: We identified that a case had not been discussed with the Specialist Physio as early as it could have been, possibly due to telephone appointments being conducted by different clinicians. When scheduling reviews with patients, where possible they should be with the same clinician. It was also identified that patient notes were not thoroughly reviewed prior to each telephone appointment, which caused confusion and delay in responding to the individual's joint pain. All clinicians have been reminded to review patients' clinical records prior to appointments.

ii. Paediatric Occupational Therapy (OT): The investigation found that details of a patient were added to the wrong records; the clinician immediately marked this as an error. This hides the content but our investigation identified that further steps were needed to remove the incorrect information completely. The information has now been removed and the process for removing records has been shared Trust wide with clinical services. A review of the clinical systems will also take place to ensure that any other information marked as an error has been dealt with appropriately.

4.7 Complaint response times

4.7.1 In this data period we responded to five formal complaints (three in October and two in November), all were responded to on time as shown in the graph below.



4.7.2 April – September six month review: as the Quality, Improvement and Safety Committee has been delayed to support the internal response to Covid19 and the mass vaccination priorities a summary of the period is highlighted below:

i. We continue to receive high levels of service user/carer satisfaction evidenced by the number of compliments received and our high 96.17% positive Friends and Family Test (FFT) score. We have responded in a proactive way to any negative feedback left and have made changes based on feedback, evidenced by 'You said… We did…'

ii. Some individual services were below the Trust target. The comments associated with negative responses are reviewed monthly and actions taken if appropriate. The comments in this period related to difficulties in making contact by telephone and pausing face to face contacts during Covid19.

iii. The Patient Experience Team successfully rolled out the new FFT questions and embedded them in all services across the Trust and in response to Covid19 developed new surveys and systems to ensure that all services could continue to gather feedback.

iv. The Trust's Patient Advice & Liaison Service (PALS) and Patient Experience Team have offered a supportive and proactive service for people who use our services covering 631 contacts including questions about services provided by the Trust, signposting to other NHS and social care organisations, local resolution of informal complaints and managing responses to formal complaints. We received 34 fewer formal complaints and 62 fewer informal complaints compared to the previous six months but 176 more enquiries to PALS.

v. Based on figures provided by the Informatics Team, the decrease in the number of formal and informal complaints is considered to be due to the impact of Covid19 and the reduction in clinical contacts in our services. The specific details of the themes in all complaints are monitored and actions taken when trends are identified. Complaint themes were consistent with previous reporting periods: Communication/Information, Delay in Diagnosis / Treatment or Referral and Clinical Care; no significant trends were noted.

vi. There were four formal complaints and 22 informal complaints in this period that were related in some way to Covid19. Each of these was reviewed for possible incidents and none was found to have resulted in an incident or been the result of an incident.

vii. Of the 13 complaints closed in period, one was upheld, nine partially upheld and three not upheld.

viii. In this In this data period we responded to 81.8% of complaints on time in line with the Trust's Policy and against the agreed timelines of 25 days (for standard complaints) or 30 days for complex complaints

.

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

5.1 There continues to be significant 18 week RTT pressures in the Luton Community Paediatrics service. Insufficient service capacity to meet demand through staff sickness, recruitment challenges and locum availability are contributory factors. An action plan is in place to support the service which includes:

To sustain RTT performance:

- Ongoing use of agency locum Consultants will continue until successful recruitment into vacant medical posts.
- Staff skill mix is being utilised, Specialist Nurses are facilitating the non-complex management of ADHD medication reviews.
- Daily Nurse on call for parents / carers to access for support and advice for children on the caseload.
- SEND Facilitator (18 month seconded post funded by Flying Start) contacts families and offers support for children under 5 years

5.2 New Covid19 safe BOSA assessments are in progress, service remains challenged by long waiting times; 109 children longest wait 1 year 2 weeks. Additional clinical resource is being procured to reduce ADOS wait times.

5.3 The RTT average wait is currently 22 weeks for Bedfordshire Community Paediatric Services, against an 18 week target.

To improve RTT performance:

- Locum Consultant capacity has improved the staffing capacity.
- A Clinical Nurse Specialist from Luton has been providing support to the service.
- Additional admin resource has been recruited.

5.4 Clinicians are undertaking supportive calls with families and young people who are on the waiting list with a particular focus being on cases where there is no other health or social care service involvement. Most of the children on the waiting list do have other forms of support from differing agencies.

5.5 Clinicians continue to review the backlog of children who require face to face assessment, following a virtual consultation. Covid19 restrictions continue to impact on ADOS waits, however additional ADOS resource is currently being progressed through the procurement processes.

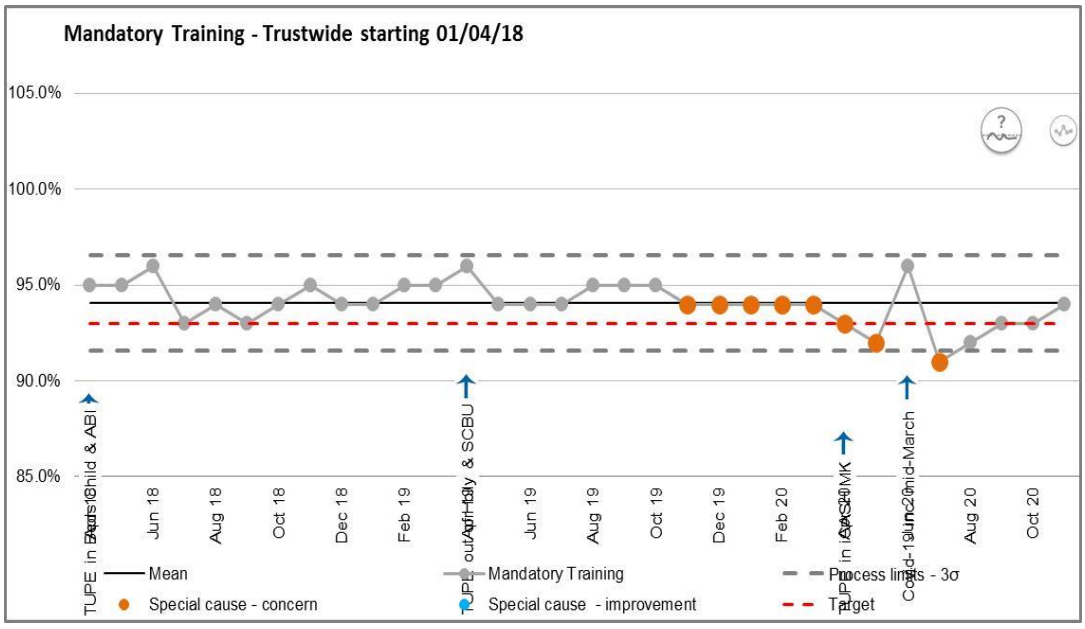
5.6 Within Bedfordshire and Luton Community Eye Service – Treatment for Amblyopia (lazy eye) has been delayed due to the suspension services in March 2020. There is a risk that, if children are not treated by 7 years old, they will experience permanent vision impairment. The service has prioritised the care of these patients to minimise risk.

5.7 In the Dental service Special Care General Anaesthetic (GA) lists have not resumed at Addenbrooke's Hospital since March 2020 however all waiting patients had been prioritised and patients were being seen at Peterborough City Hospital and West Suffolk Hospital as an alternative. This provision was unfortunately cancelled in late December due to increasing Covid19 pressures. North West Anglia NHS Foundation Trust has now offered the Trust a theatre slot, with a potential for this to be extended into February 2021. Patients waiting for surgery are being contacted by the Dental teams to assess their current situation and where needed provide advice and treatment.

6. Mandatory training

6.1 Overall mandatory training remained consistent achieving 93% October and meeting the Trust's 2020 / 2021 target of 94% in November despite the pressures staff were undergoing at this time.

6.2 Face to face training has been reintroduced for CPR and Moving and Handling of Patients to mitigate any potential risks to staff and patients through a phased approach using all the necessary safety protocols.



7. Information Governance

7.1 NHS Digital's 2020 / 2021 Data Security & Protection Toolkit (DSPT) is now available for the Trust to complete ahead of the revised Covid19 deadline of 30 June 2021.

7.2 Mandatory Information Governance and Data Security awareness training is currently 95% compliant against a target of 95%. Over recent months a proactive approach has been taken with Service Directors to provide them with details of non-compliance requesting they encourage staff to do their training which has resulted in the Trust meeting the target.

7.3 Between October and November, 36 incidents were reported under the Confidentiality Breach incident category. Most 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 sending material. The Information Governance Manager assesses all Information Governance incidents and provides advice to staff to prevent errors from re-occurring.

8. The following examples of outstanding practice or innovation were reported at the Clinical Operational Boards:

8.1 **Luton Adults:**

- Awards**:** In previous COBs we referenced our shortlisted entry to the HSJ patient safety awards. The below press release details our success:
    - *Andy Boocock, Information Analyst with Luton Adult Community Health Services designed an easy to use interactive digital data dashboard for partners across health and social care as part of a wider programme of work to meet the challenges posed by the town's growing elderly population. The tool allows elderly people to be identified, whether they are living in their own homes or care homes, so that health care plans can be put in place to avoid unnecessary hospital admissions.*
    - *The Population Health Management Tool project won the Improving Care for Older People Award category of the HSJ Patient Safety Awards recognising its outstanding contribution to healthcare.*
- Diabetes experts on Inspire FM: The Integrated Community Diabetes Service (ICDS) featured on Inspire FM Luton on Thursday 12 November. Luton-based Juliet Davies (Diabetes Specialist Nurse) was joined by Caroline Mayles (Lead Diabetes Educator) and Laura Rockett (Registered Nutritionist and Diabetes Educator) from Bedford Hospital, for an hour's discussion on diabetes and its management.
- Remote health monitoring project: As a result of a tender awarded to Doccla for remote patient monitoring in November Luton Adults began working on a 7 month trial of a remote health monitoring service to patients on our Respiratory and Heart Failure caseloads. This service is being fully funded by NHSE. Patients will use the medical equipment provided to them by Doccla to take their vital signs and then submit their readings via an encrypted smartphone. With the use of modern technology, our clinical staff can monitor the vital signs of a patient remotely, via a secure web browser.

Provide outstanding care

National Recognition:

- Huge congratulations to **Dr Tamsin Brown, Consultant Community Paediatrician** on being awarded a British Empire Medal in the New Year's Honours for the inspirational service she has delivered to children and families across Cambridgeshire.

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A: Assurance Summary

Safe	• Staffing pressures are adequately controlled, and kept under constant review as part of regular sitrep reports and bi-weekly incident management team meetings.	**Reasonable**
Effective	• Mandatory training compliance has increased to 94%. • Sickness remains constant and within control limits. Monthly sickness levels at 4.25% which is just above Trust target of 4%. • Stability continues to be above target. • Appraisal rates remain below target at 90.12%. However, these have increased since the last reporting period. Impacted by Covid-19 pressures. • The workforce related local equality delivery system objectives have been delivered for 2019/20 and are on track to deliver 2020/21 objectives.	**Reasonable**
Well Led	• Agency spend below annual target. • All BAME staff have been offered risks assessments and mitigation is in place as required • 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. • Staff vaccination programme for Covid-19 launched with priority groups identified.	**Substantial**

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

- NHS National Staff Survey 2019 results where the Trust achieved a 60% response rate. Headline results were:
  - Top nationally for all NHS providers in two themes – team working and health and wellbeing.
  - Second nationally for all NHS providers in Safe environment – bullying and harassment and third nationally for equality, diversity and inclusion and safe environment – violence.
  - Top 10 nationally for all NHS providers in morale and immediate managers.
  - Best performing Community Trust nationally in 8 out of the 11 themes, including staff engagement.

- Care Quality Commission (CQC) inspection report published in August 2019. CQC rated the Trust as Outstanding overall and Outstanding within the caring and well-

led domains. The inspection report highlights a number of areas that support the delivery of this objective.

- Successful delivery of workforce 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 and the Trust has again been identified as the best performing Trust nationally.
- Bi-annual workforce review presented to the Board in November 2019 and July 2020.
- 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.
- Professional Education Annual Report received by Quality Improvement and Safety Committee in September 2020.
- Improvement in our Trust-wide mandatory training and appraisal levels since the last reporting period.

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	Next set of results due March 2021
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	Next set of results due March 2021
*Sustain the level of overall mandatory training	94%	ESR	Monthly	*94% (increase of 1% from last report)
Achieve a good staff	Above national average	NHS Annual	Annual	Next set of

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engagement rating – all staff		staff survey		results due March 2021
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	Results available in March 2021
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	Results available in March 2021
*Available staff have had an appraisal in the last 12 months	=>94%	ESR	Monthly	*90.12 (increase of 1.26% 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	Results available in March 2021
Deliver the locally agreed staff related annual Equality Delivery System objectives	Pass/Fail	Equality Delivery System	Annual	Board Review in March 2021
Monthly sickness absence remains below 4%	4%	ESR	Monthly	4.25% (increase by 0.23% since last report)
Reduce Annual Staff Turnover	1% improvement from 2019/20 outturn (March 2020 – 13.04%)	ESR	Monthly	11.17% (increase of 0.57% since last report)
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).*

Any operational risks 15 and above

1. ***Risk ID 3284 -*** *Workforce: There is a risk that there is insufficient local workforce currently available to safely deliver the mass vaccination programme leading to slower implementation of the vaccine programme and continued risk of adverse health caused by Covid 19. (Risk Rating 16).*

D: Overview and analysis

1. Sickness

1.1. There has been a significant drop in the monthly sickness rate since March 2020 (5.78%). However, the 12 month cumulative rolling rate (November 2020 4.37%) continues to be above the Trust rolling target of 4%.

1.2. Monthly Trust wide reporting for October 5.14% (including Covid-19 sickness), 4.95%(excluding Covid-19 sickness), and for November 4.25% (including Covid-19 sickness) and 3.92% (excluding Covid-19 sickness)

1.3. The Trust wide sickness rate has increased this month, and is now above the Trust's target of 4.0% for 2020/21. Of the 4.25%, 1.85% was attributed to long term sickness and 2.41% short term sickness absence. Bedford Children Community Unit had the highest sickness rate (6.26%) and Corporate having the lowest (1.32%). The top reason is S10 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 July 2020 benchmark report for NHS Community Trusts (source: NHS Digital Workforce Statistics) which was 3.9%.

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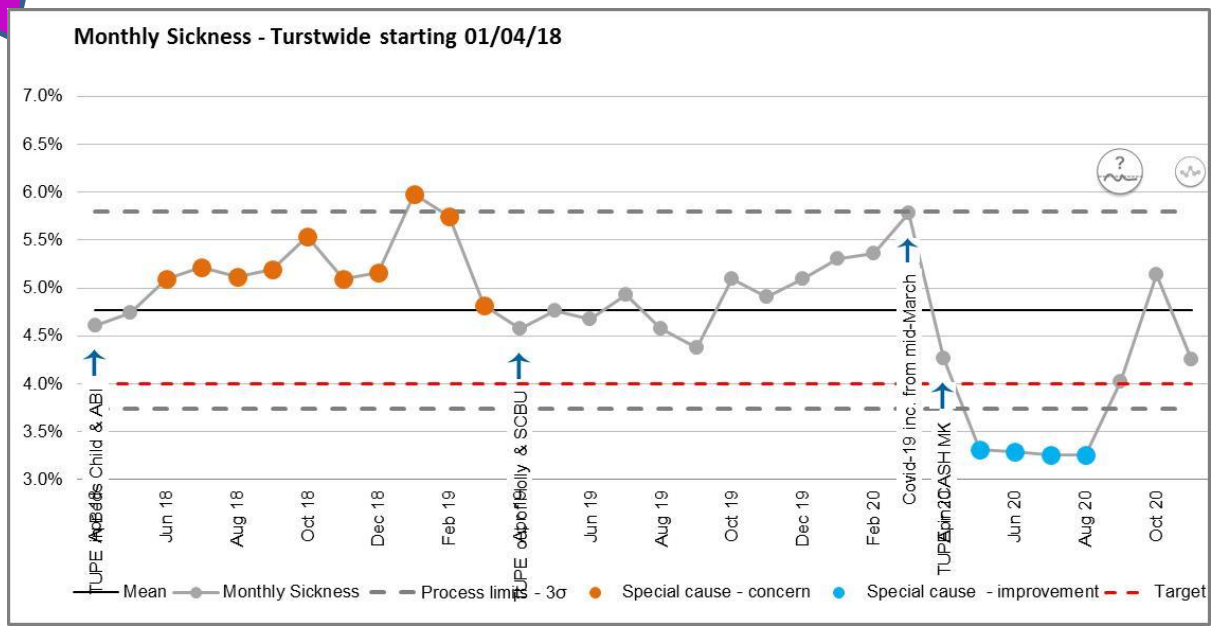
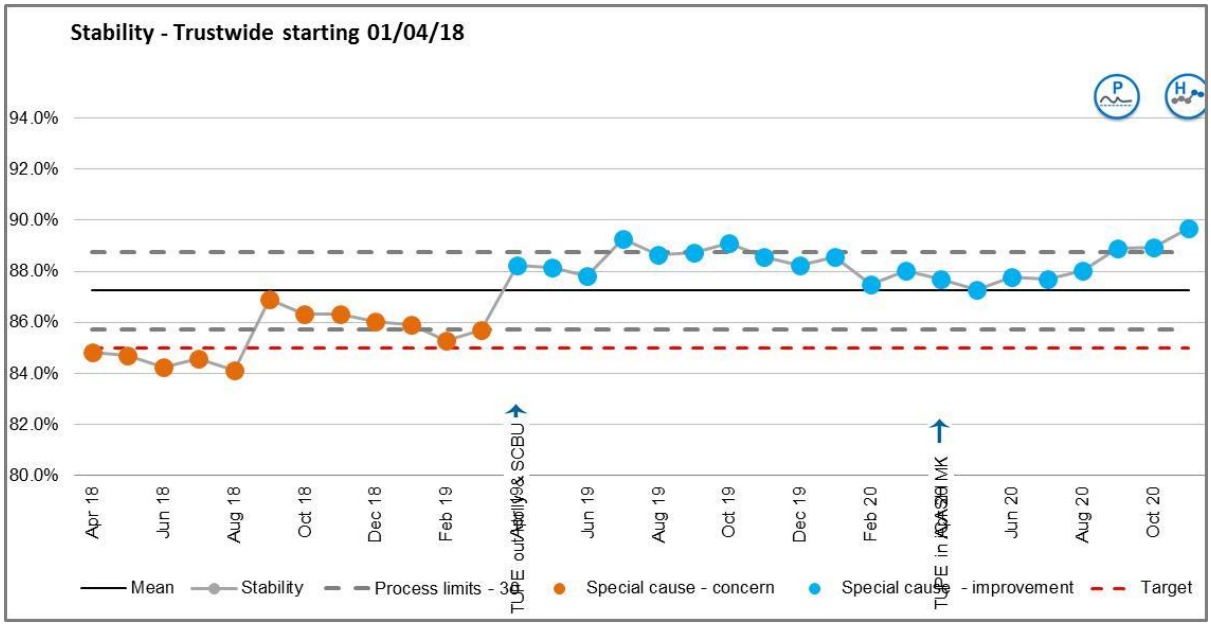


2. Stability

2.1. The following chart shows the monthly stability rate (percentage of staff employed over 1 year) – October 88.92%; November 89.68%; against the Trust target of 85%. This compares favourably to a stability rate of 85.7% for NHS Community Provider Trusts for all employees (source: NHS Digital Workforce Statistics, Aug 2020).

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



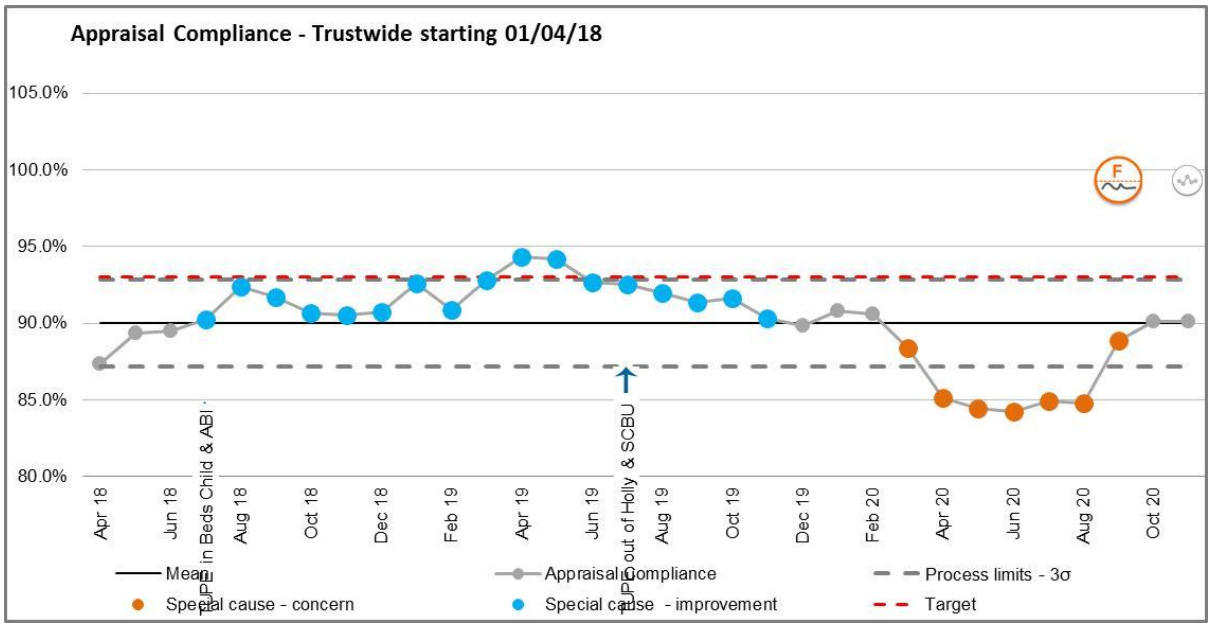
3. Appraisals

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 – October 90.09%, November 90.12%, and remains below the target of 93% for 2020/21.

3.3. Cambridgeshire & Norfolk Children's Community Unit has the lowest rate (86.29%) and Luton Community Unit the highest (94.19%). Employees, for whom a non-compliant date is held in ESR, are sent a reminder and this will continue to be done on a regular basis.



4. Staff Engagement/Support during Covid-19

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 discussed at our bi-weekly incident management team meetings each week and mitigations/actions are put in place as needed. System wide offers for more extensive psychological support are available for all staff.

4.2. All of the activities previously reported continue. We have extended the divisional monthly and bi-weekly corporate Q&A sessions continue with executive team members and Service Directors through to April 2021. Executive team members also attend team meetings and other conversations across our services as required.

4.3 The Trust achieved 58% response rate in the 2020 NHS Annual Staff Survey and results are expected February/March 2021 and these will be presented to the Board at the appropriate time.

4.4 We continue to stress the importance of staff taking their annual leave, however, it is recognised that the prolonged Covid-19 pandemic situation is making this difficult for

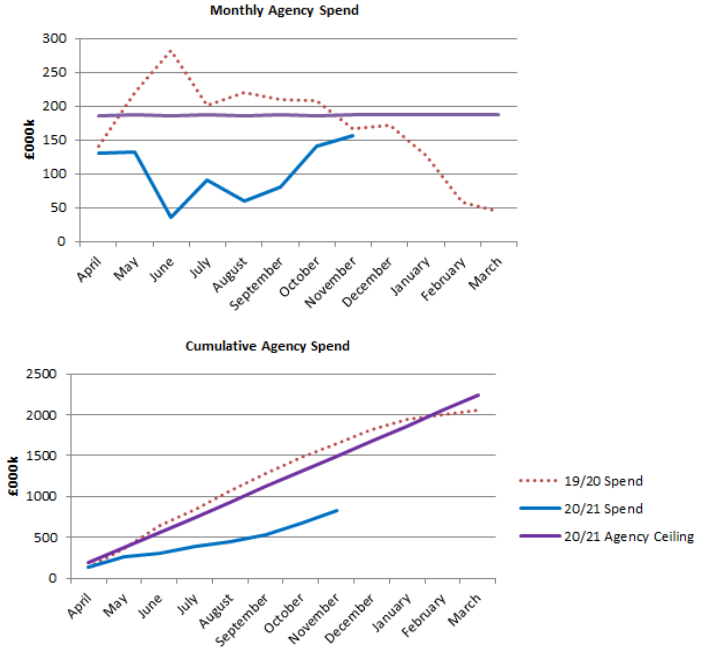
some individuals. Therefore we have reviewed our previous decision of allowing staff to carry forward 10 days annual leave into 21/22 and have now agreed with our staff side representatives that this carry forwarded leave can be taken over the next two years not just the one to relieve pressure on services during 21/22.

4.5 Significant work is being undertaken across the Trust with our acute partners to make sure that our staff have access to the Covid-19 vaccination in a timely way. We will update further at the Board meeting.

4.6 We continue to support our BAME network and Anita Pisani will continue to be the Board Ally for this network in her temporary new role as Chief Executive. A number of Board members are also linked with a Diversity mentor and we will look to share some of the learning from these conversations at a future Board meeting.

4.7 Since our last report we have held two question and answer sessions with staff on the establishment of a long term conditions and disability network. Both sessions were well attended and they were chaired by our Staff Side Chair Heather Bennett. There was significant support for establishing this staff network and dates have been set up.

5. Agency/bank spend



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

5.2. The Trust's cumulative agency spend to Month 8 is £827k against a spend ceiling of £1,491k. Covid 19 service delivery changes have reduced the demand on agency hours.

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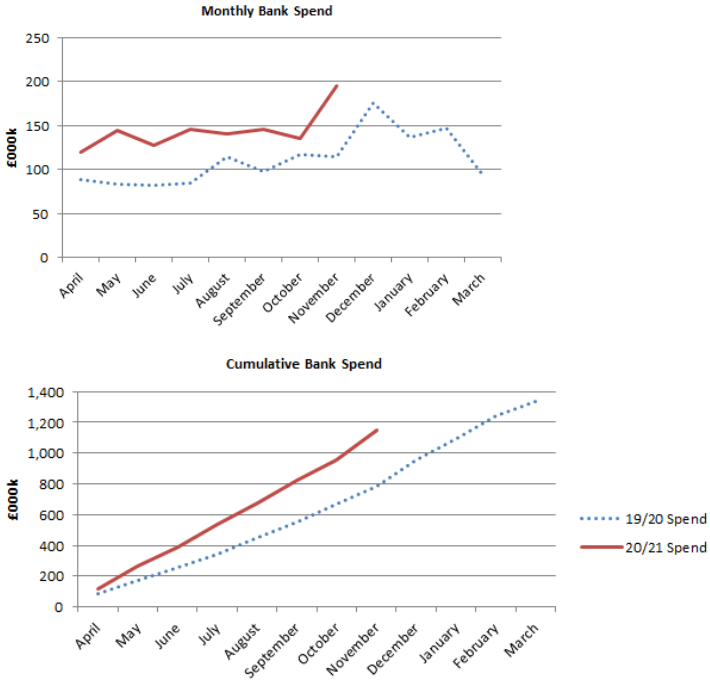


5.3. To assist the Trust to remain within the agency spend ceiling, the services have the availability of bank staff to fill short term staffing pressures. Cumulative bank spend at month 8 was £1,152k. This has increased from 2019/20 spend at month 8 of £781k, which demonstrated a positive increase in usage. Substantive staff who are working additional hours to support Trust services during Covid 19 are being paid through the bank.

5.4. The Trust has implemented a weekly bank payment process to attract more staff onto the bank and improve the talent pool available to services.

SO3 Collaborate with others

A: Assurance Summary

Well Led	• Strong collaboration taking place across our systems as evidenced in this report • Research – 95% of all CRN portfolio studies are scoped for viability against Trust services	**Substantial**

1. In addition to the overview and analysis of performance for August and September 2020, 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 has a representation on Norfolk's Children Board.
- 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.
- 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.
- Chief Executive is a member of BLMK Health Cell which is managing the BLMK health response to Covid-19.
- 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

Collaborate with others

B: Measures for Achieving Objective

Measure	20/21 Target	Data source	Reporting frequency	Current Position
The Bedfordshire Care Alliance agreement is signed	Pass/Fail	Exec Team	Annual	Discussions continue but final agreement will be delayed
The C&P Best Start in Life Strategy Implementation plan milestones are achieved	Pass/Fail	Exec Team	Quarterly	Implementation phase paused in March 2020 due to Covid-19, however, operational leads have continued to meet.
The Norfolk & Waveney CYP Service Transformation Alliance Agreement is signed	Pass/Fail	Exec Team	Quarterly	Original target was October 2020 – has been delayed due to Covid-19 and the work-stream has recently met to kick-start the work
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)

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)*

D: Overview and analysis

Strategic work-streams with others

A summary of our key system collaborations follows:

BLMK ICS

1. BLMK Partnership Board - Meeting held on 11 November 2020

1.1 Key agenda items:

- Strategic Outline Case Milton Keynes hospital expansion and redevelopment; it was agreed that the ICS would support the case.
- Digital Update; the Board was updated on progress in implementing the digital work-plan, in particular the creation of a digital shared care record.
- Flu Programme; the Board was updated on progress in delivering the flu vaccination programme.
- Inequalities; an inequalities group had been formed and would develop a work-plan and it was agreed a presentation on priorities would made to the December 2020 Board setting out the proposed approach and support required.

2. BLMK Partnership Board - Meeting held on 9 December 2020

2.1 Key agenda items:

- Strategy.
- Carnell Farrer work on strategic commissioner.
- Update on ICS objectives.
- Mental Health.
- Inequalities.
- Covid 19 and Flu vaccination programmes.

3. BLMK Partnership Board – Meeting held on 13 January 2020

3.1 Key agenda items:

- Covid-19 incident update
- Vaccination roll out
- Flu Vaccination programme update
- Workforce Programme Update and People Plan Implementation
- CCG Merger update, including proposed commissioning and financial strategies
- BLMK Strategy prioritisation and agreement on how to work collectively on the development of the system priorities
- Bedfordshire Care Alliance update

4. Bedfordshire Care Alliance - Meeting held on 12 November 2020

4.1 Key agenda items:

- Frail and Complex Care Update; it was noted that the first meeting of the Programme Oversight Board had taken place.
- Primary Care Strategy and PCN support; the meeting noted the challenges in delivering the Primary Care Strategy and discussed the ways in which community services can support.
  - Gap analysis was identified as an early action.
- IT Update: Population Health Management; funded secured for the shared care record programme.

5. Bedfordshire Care Alliance - Meeting held on 21 December 2020

5.1 Key agenda items:

- PCN Update.
- Frail and Complex Care Update.
- IT Update.
- Looking Forward; Mental Health Strategy.
- Celebrating Success 2020.

6. Collaborative partnership working with East London NHS Foundation Trust

6.1 The Joint Partnership Board continues to meet monthly and met on 30 October and 27 November 2020. December partnership board meeting was cancelled.

6.2 The Board discussed the following areas:

- Outcomes/incentive payments and contractual elements
- Transformation updates and emerging business cases.
- Covid-19 response and resilience
- Strategic developments across the partnership

Collaborate with others

7. Bedfordshire Local Resilience Forum Health and Social Care Cell

7.1 This strategic systems leaders group has continued to meet weekly. This Cell is jointly chaired by CCS Deputy Chief Executive, ELFT Interim Chief Operating Officer and Director of Adult Social Services, Bedford Borough Council. This group is supported by a whole system delivery group that meets twice a week.

7.2 The main areas of focus for the group are:

- Oversight of the Discharge Planning systems and processes across the system
- Oversight of the Adult Social Care Plans and Care Home resilience plans
- Winter planning
- Supporting effective implementation of appropriate national guidance and infection control and measures and raising any concerns related to quality assurance or safeguarding
- Determining a consistent approach in relation to testing of frontline staff, their households, patients and maximisation of testing capacity across the system
- Ensuring co-ordinated management of challenges and the provision of mutual aid
- Recognising likely demand and updated the model in light of the Covid-19 Pandemic experience across the system
- Joint problem solving and troubleshooting across the system
- Shared understanding of challenges, priorities and plans, at place, across the health and social care system

8. Bedfordshire Care Alliance – Frail and Complex Care Oversight Programme Board

8.1 In November 2020, it was agreed to change one the Health and Social Care Cell meetings each month into the Bedfordshire Care Alliance - Frail and Complex Care Oversight Board. This is a forum where all partners across health and social care system come together to undertake regular service planning and service redesign. It will work across boundaries to improve patient/client experience and clinical outcomes, by establishing partnerships and better working relationships.

8.2 Four programmes of work have been agreed for the BCA as follows:

- Working together to reduce falls and serious injuries (CCG led).
- Developing Community Multi-professional networks (acute/CCS led)
- Discharge to Assess (ELFT led)
- Same Day Emergency Care (paused)

8.3 The chair of the programme board will be rotating between Chief Executive CCS, Chief Operating Officer ELFT and Clinical Lead BCA.

Cambridge and Peterborough STP

9. C&P Integrated Care System

- The Board submitted a range of comments on the draft Integrated Care System Designation documents in December 2020.

10. C&P System Delivery and Transformation Group – 4 Jan 21

- First meeting held on 4 Jan 21, discussed TOR and overall approach.
- Forms a key component of the ICS interim governance structure and has morphed from the System Recovery Oversight Group.
- Likely to meet fortnightly.

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

- There have been no further meetings since that held in October 2020 and this meeting was summarised in the last Report.
- The next meeting is planned for 20 Apr 21.
- CPFT led on a submission – on behalf of the Contractual Joint Venture – to C&P CCG which outlines an offer to provide MH & Emotional Wellbeing Services to CYP[1] thereby potentially obviating the need for commissioners to tender the requirement. Commissioners accepted the offer and will extended CPFT's current contract. The service will commence in the summer of 2021.

12. 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.
- Additional programme support has been put in place and is establishing more robust rigour in our processes and how we capture and report on activities/progress.
- Non-core partners have welcomed the suggestion of a 'pledge' that will supplement the MOU and bind providers together more closely; this remains ongoing.
- Four place-based work-streams (Cambridge City, Central and Thistlemoor In Peterborough, Honeyhill in Peterborough, Wisbech) have met and identified local priorities.

[1] Provided currently by CHUMS.

Norfolk STP

13. Norfolk CYP Alliance Board – 26 Nov 20

13.1 Key agenda items:

- Agreement and timing for the amalgamation of Alliance Board and Children's Strategic Partnership Board into a single board - all in agreement with date of 1 April 2021.
- Update on progress with the single system outcomes framework FLOURISH.
- Summary of progress with CAMHs transformation plan and impact of COVID (some positives) from this.
- A brief update on commissioning -SALT; this tender opportunity is underway and the Trust is engaged.
- Discussion that new commissioning/changes in services should be discussed by the Board – rather than delivered as a done deal – as the members of the Board may have a good deal to contribute.

14. Norfolk Alliance Agreement Work-stream

- The proposed final draft of the Alliance Agreement[2] is on circulation for comment; intent is to finalise and sign in the next few weeks.
- The draft 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.

14.1 This was discussed at our Children and Young People's Clinical Operational Board on 12 January 2021.

15. Research Update – October/November 2020

15.1 **Clinical Research Overview**

The Department of Health and Social Care (DHSC) has requested that all Trusts develop a 'Research Restart Strategy' to ensure Trusts have a planned approach for restarting studies that were paused in March. The Trust developed a strategy which has been agreed with the Medical Director and Head of Clinical Quality and we have worked with our services to restart studies. The majority are now in the 'set-up' stage; one has not been restarted due to limited clinical capacity to support the recruitment and delivery of the trial.

Further NIHR guidance was issued on the 12 October 2020 reinforcing the message in their Restart framework, that research activity should be maintained where feasible, with vaccination and urgent public health (UPH) research still remaining the highest priority. In line with NIHR research priorities, UPH 'Virus Watch' study commenced within the Trust in Luton (Treatment centre) and Bedford (iCaSH) on the 5 October and

[2] Norfolk Alliance Agreement 2021-2029

has recruited well. Our B4 Research Assistant is currently doing venepuncture training, in order to support the 'Virus Watch' study. Participants in the 'Virus Watch' study are both adults and children.

15.2 National Institute for Health Research (NIHR) Portfolio studies:

15.2.1 The NIHR Clinical Research Network (CRN) has a Portfolio of high-quality clinical research studies which are eligible for consideration for support from the Clinical Research Network (CRN) in England. Studies the Trust is currently involved in are detailed in Table 1. The Research Team continues to scope for studies and consider their feasibility for the Trust and Chart 1 shows the number of studies considered as part of this feasibility process.

Table 1: Clinical Research Table for NIHR Portfolio Studies (accurate on 03/12//20 via ODP NIHR portal)

Key to icons:

Recruitment: Increased | no change | completed | in set up | allocated funding/prize

NIHR Portfolio studies	Speciality/ clinical area/ location	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**	4		Now open for recruitment	Supporting future smoking intervention development
Yourtube	Children & Young People's Service (CYPS) Cambridge	University of York	**0**	2		Study reopened for recruits and follow up	Building research knowledge in an area of high interest.
Balance Study	Children & Young People's Service (CYPS) Orthoptics/	Moorfields Eye Hospital	**0**	0		Study reopened 1st October	Important technology study
NESCI Study	CYPS Norfolk	University of East Anglia	**1**	1		14th October focus group	Development of intervention for smoking cessation
Babybreathe	CYPS Norfolk	University of East Anglia	**0**	0		Due to commence Dec 2020	Smoking cessation and education intervention
This mum moves	CYPS Cambs and Peterborough	Sport England/ University of Canterbury	**5***	0		*Recruitment commenced Not yet on ODP	Education and exercise intervention post pregnancy
Virus Watch	Luton Community Services	University College London	**132***	0		*Recruitment commenced. Not yet on ODP	Urgent Public Health Covid Research
Total recruitment within this period:			**138**	**296****	**RCF count for recruitment started from October 2020** (*2)**.**		**Total for all NIHR Recruitment.

(*1) All figures accurate as of 03/12/20 from the Research Impact Recording Tool (totals of Open Data Platform (ODP) and EDGE databases).
(*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.

15.3 **NIHR portfolio studies which have been considered for feasibility:**

15.3.1 During this period of time the research team has considered **508** studies for suitability for adoption into the Trust, only 9 were potentially fitting with CCS NHST services (please see Chart 1).

Chart 1: NIHR Portfolio studies considered for feasibility in October/November 2020

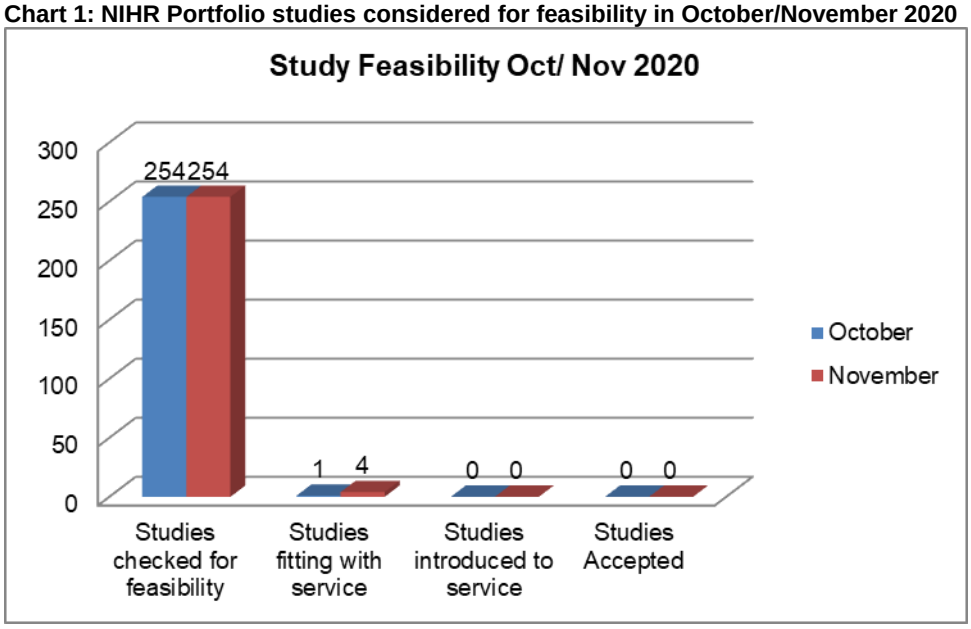
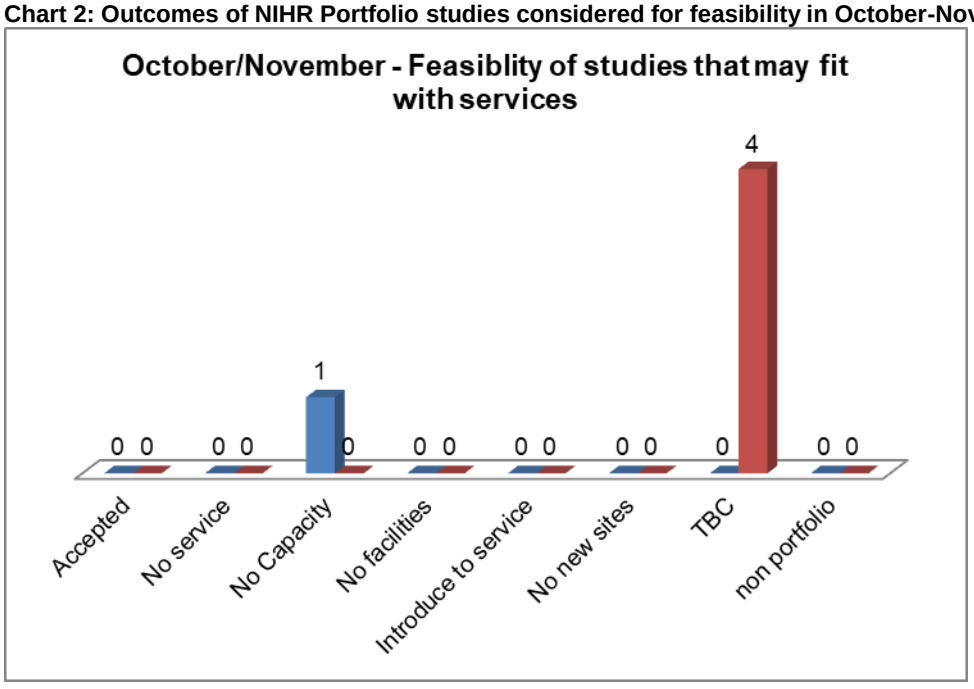


Chart 2: Outcomes of NIHR Portfolio studies considered for feasibility in October-November 2020



15.4 **Non-Portfolio studies – projects and research studies which have been considered for feasibility and/or submitted for HRA Approval:**

15.4.1 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 Health Research Authority (HRA) for approval. This process includes ethics and project approval and sign off by the host NHS site. There were no non-portfolio studies submitted to HRA in this reporting period.

15.4.2 The Exploring Interventions for Glue Ear during Covid-19 study, sponsored by the Trust, with Chief Investigator Dr Tamsin Brown, Paediatrician, commenced recruitment during this period. Successfully recruiting participants from the day HRA approvals and trust approvals were in place. This study provides a valuable service to families who were on a waiting list for surgery that were cancelled due to Covid-19. Recruitment now stands at 24 and follow up is currently ongoing.

15.4.3 The 'Ferrari' study continues to seek patients within the MSK Physiotherapy service in Cambridge and Ely in collaboration with Cambridge University Hospitals.

15.5 **Student Studies and Non-Student studies – Local Permissions:** During this reporting period there was one student and no non-student studies submitted for local Trust permissions. There were also two MSc major projects for which clinicians wanted advice regarding feasibility.

Table 3: October/November Update of MSc studies considered for permissions and feasibility from August & September

Study considered	Speciality/ clinical area/ location	Study overview	Collaboration with University/ University Trust	Barrier/s or potential barrier/s to undertaking
MSc programme in sleep hygiene	CYPS Bedfordshire	Sleep issues in children with autism and ADHD. Study	University of Oxford	Cost is £10,460 per year (2 year course). Application has been successful. Course has commenced.
MSc Masters in Nursing Sciences	i-CaSH Peterborough	Questionnaire to sexual health nurses about sexual harassment at work in England.	Italy	MSc has been submitted for assessment. A paper from the dissertation has been written and submitted for consideration for publication.

15.6 **Fellowships, Internships 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 (HEE). In this reporting period there were no staff who were planning to submit a Fellowship application and no staff who had commenced a new Fellowship, but staff have recommenced Fellowships which were on hold due to Covid-19 (see Table 4).

15.7 **Grants:** A NIHR Research for Patient Benefit (RfPB) stage 1 application, for a study exploring homebased music therapy with patients who have had strokes (see Table 4) was re-submitted to the NIHR grant panel in July 2020. We heard in October that the outcome of this re-submission was successful and the grant is able to proceed to the second, and final, submission stage. There was a quick turnaround and the completed stage 2 grant was submitted at the end of the November.

Table 4: Summary Table for Fellowships/Internships and NIHR Grant Submission/s Applied for and results within this reporting period:

NIHR Fellowships/grant	Area	Numbers	Trend	Collaborations	Impacts/potential impacts
NIHR Research for Patient Benefit (RfPB)	**Ambulatory Care Neuro-rehab Bedford**	One submission of stage one.	**Decision Oct 2020 - successful. Stage 2 submitted end of Nov 2020.**	Research Fellows from ARU, 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	**CYPS Norwich & Luton**	Two	Fellowship commenced January 2020 for 12/12. Both **extended to December 2021**.	Applied Research Collaboration (ARC)	Working with children in geographical areas of high health needs.
NIHR/HEE Internship	**CYPS Cambs (OT)**	One	Commenced Jan 2020, due to finish June 2020. Now extended to December 2020 due to Covid-19.	Health Education East (HEE)	Exploring parental distance learning video teaching sessions on life skills for children with dyspraxia.
HEE/NIHR ICA Pre-doctoral Clinical Academic Fellow	**CYPS Cambs (SALT)**	One	Commenced Sept 2019. 2.5 years duration. Progress has continued throughout lockdown.	University of London	Includes MRes in Applied research in human communication disorders.

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

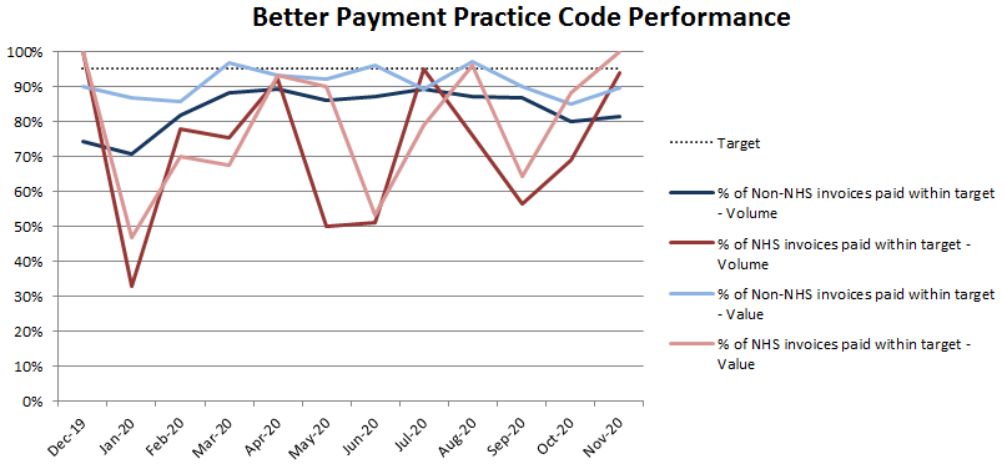
- **Health Research Authority (HRA)** national and ethical approval (where appropriate) has been obtained for all the NIHR Portfolio and Non-Portfolio studies.

- **NIHR National Performance Metrics** – Performance in Initiating (PII) and Performance in Delivering (PID) had been re-instated and collated by the DHSC. Q2 was placed on the Trust internet. We have been notified by the DHSC that Q3 and Q4 performance metrics collation and publication are going to be delayed until March/April of 2021.

15.8 **Published papers and posters within this period**

15.8.1 There was one paper and no posters published during this period. The paper was published in 'Digital Health' and was written by S Fordington and Tamsin Holland Brown, entitled 'An evaluation of the Hear Glue Ear mobile application for children aged 2-8 years old with otitis media with effusion'.

16. Public sector prompt payments



a. The average in month prompt payment results across the four categories was 81% in month 7 and 91% in month 8.

b. With regards to NHS invoices, performance improved in Month 8 to 94% and 100% from 69% and 88% in Month 7 for Volume and Value respectively. The Trust has worked hard to improve the NHS performance.

c. With regards to Non-NHS invoices, achievement in both categories has been relatively consistent across both categories in the last 8 months – with an average of 89% achievement in both categories over this period.

d. 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.

Be a Sustainable Organisation

A: Assurance Summary

Well led	I&E in line with budget	**Substantial**
	Recovery of COVID-19 costs	
	CIP in line with plan (paused for Covid-19)	
	Capital spend in line with budget	
	Reduced travel mileage spend	

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 the 2 risks Strategic Risks numbers 3156 and 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 its "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. The Trust's year to date financial performance is showing a favourable position against the original plan, and he reasons for this are explained more fully 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)*

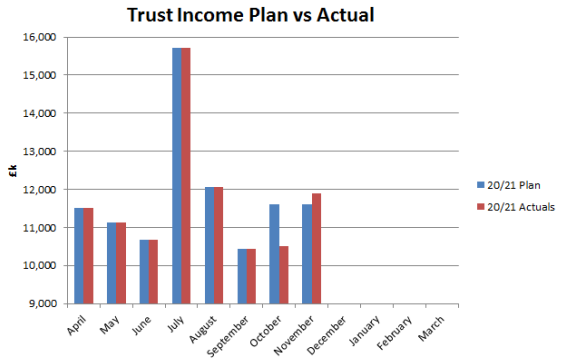
Any operational risks 15 and above

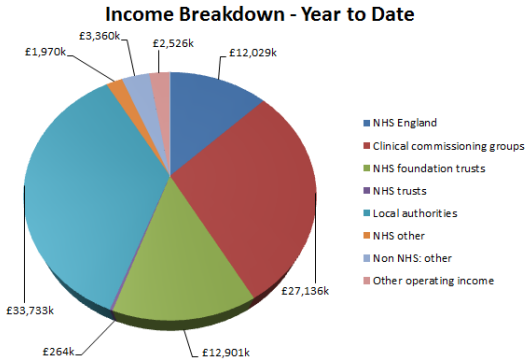
D: Overview and analysis

Finance scorecard

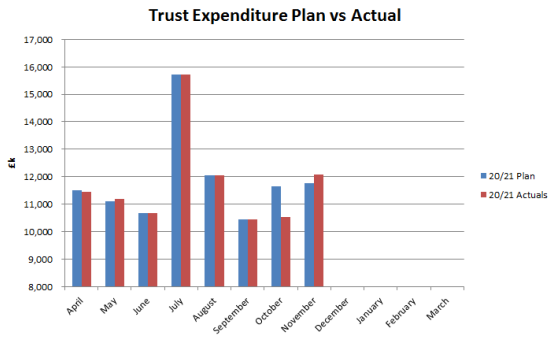
Finance Dashboard	Section in Report	Plan M8	Actual M8	Variance M8
Operating income	1	£94,710k	£93,919k	(£791k)
Employee expenses	1	(£59,638k)	(£60,411k)	(£773k)
Operating expenses excluding employee expenses	1	(£34,083k)	(£32,519k)	£1,564k
Trust Surplus/(Deficit)	1	(£217k)	(£217k)	£0k
Closing Cash Balance	2	£16,856k	£14,880k	(£1,976k)
Capital Programme	4	£2,900k	£2,682k	(£218k)
Agency Spend	SO2 - 4	£922k	£827k	£95k
Bank Spend	SO2 - 4	£774k	£1,152k	£378k

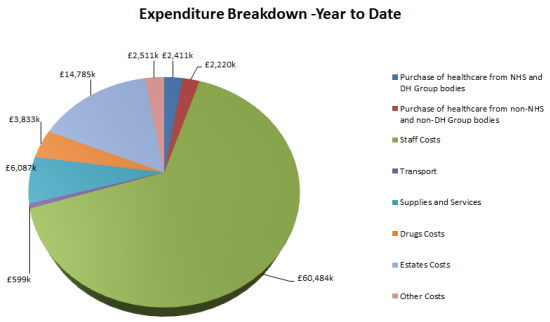
1. Income and expenditure





S04 Be a Sustainable Organisation





1.1. Due to Covid 19 pandemic, interim block funding arrangements are in operation for 20/21, based on and uplift of 2.8% on 2019/20 contract values. This arrangement is to continue for the financial year, with monthly financial monitoring of cash flows.

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

	Nov-20					
Division Level	Income £'000	Pay £'000	Non-Pay £'000	Net Total £'000	Net Budget £'000	Variance £'000
Ambulatory Care Service	686	(12,891)	(5,659)	(17,864)	(19,573)	1,709
Bedfordshire Community Unit	817	(8,785)	(1,533)	(9,501)	(9,332)	(169)
Childrens & Younger Peoples Services	1,526	(19,573)	(1,714)	(19,761)	(20,462)	701
Luton Community Unit	1,278	(12,677)	(2,203)	(13,602)	(14,166)	564
Other Services	89,611	(6,485)	(22,615)	60,511	63,316	(2,805)
CCS Total @ 31st November 2020	**93,918**	**(60,411)**	**(33,724)**	**(217)**	**(217)**	-

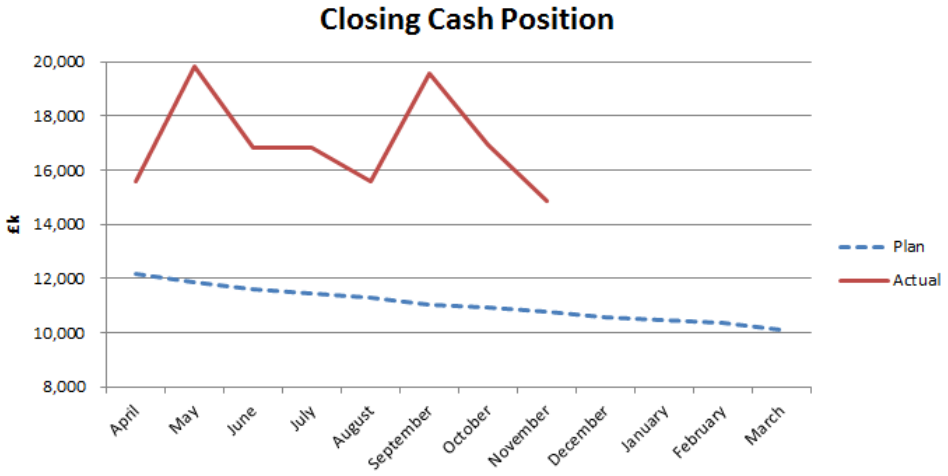
1.2.1. Ambulatory Care Services delivered an overspend of £75k in month 7 and an underspend of £118k in month 8. The main reason for the cumulative underspend, which is mainly in non-pay expenditure, is due to the reduction in service activity resulting from Covid 19, particularly in pathology costs in the iCaSH services.

1.2.2. Bedfordshire Community Unit delivered a £74k overspend in month 7 and a £130k overspend in month 8. The main reason for the overspend is due to pay locum spend in Community Paediatrics, and a business case is being prepared for additional funding.

1.2.3. Children's & Younger Peoples Services delivered an underspend of £42k in month 7 and a £96k underspend in month 8. The main reason for the underspend is a fall in non-pay expenditure, particularly reduced travel costs as a result of Covid 19.

1.2.4. Luton Community Unit (including Luton Children's Services) delivered an underspend of £11k in month 7 and a £51k overspend in month 8. The cumulative underspend position is due to pay establishment savings in both Adult and Children's services.

2. Cash position



2.1 The cash balance of £14.9m at month 8 represents an overall decrease of £4.7m on the previously reported position at month 6. The Trust has improved its payables position and increased its receivables position over the period to reduce the cash balance.

3. Statement of Financial Position

	November 2020 £'000	September 2020 £'000
Non-Current Assets		
Property, plant and equipment	55,086	55,074
Intangible assets	262	272
Total non-current assets	**55,348**	**55,346**
Current assets		
Inventories	41	41
Trade and other receivables	17,996	15,735
Cash and cash equivalents	14,884	19,580
Total current assets	**32,921**	**35,356**
Total assets	**88,269**	**90,702**
Current liabilities		
Trade and other payables	(21,707)	(23,923)
Provisions	(622)	(622)
Total current liabilities	**(22,329)**	**(24,545)**
Net current assets	**10,592**	**10,811**
Total assets less current liabilities	**65,940**	**66,157**
Non-current liabilities		
Trade and other payables	(1,045)	(1,045)
Provisions	(1,264)	(1,264)
Total non-current liabilities	**(2,309)**	**(2,309)**
Total assets employed	**63,631**	**63,848**
Financed by taxpayers' equity:		
Public dividend capital	2,245	2,245
Retained earnings	43,740	43,957
Revaluation Reserve	19,299	19,299
Merger Reserve	(1,653)	(1,653)
Total Taxpayers' Equity	**63,631**	**63,848**

3.1 Trade and other receivables have increased over the reporting period by £2.3m and trade and other payables have decreased over the reporting period by £2.2m.

3.2 Total trade receivables increased by £1.7m in October to £12.6m and then increased by £0.7m in November to £13.3m. The breakdown in November is £2.5m (18%) from NHS organisations; £10.4m (79%) from Local Authorities; and £0.4m (3%) from other parties.

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

Cambridgeshire County Council	£2.8m
Luton Borough Council	£1.7m
Norfolk County Council	£1.6m
East London Foundation Trust	£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 8) Luton Borough Council, Cambridgeshire County Council and Norfolk County Council have subsequently paid £0.1m, £0.4m and £1.2m respectively to reduce their outstanding balance.

4. Capital spend

4.1 Capital spend to date is £2.7m against a plan of £2.9m. The main areas of spend are IT equipment (£1.4m) and North Cambs Hospital building works (£0.6m).

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	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Sparkline
			CCS Overall	CCS Overall	CCS Overall	CCS Overall	CCS Overall	CCS Overall	CCS Overall	CCS Overall	CCS Overall	CCS Overall	CCS Overall	CCS Overall	
SAFETY															
Patient safety															
Classic safety thermometer	% Harm free care	H Ruddy	97.78%	82.10%	95.88%	87.50%									
	% New harm free care		100%	99.38%	100%	98.21%									
Incidents															
Total number of new Datix incidents reported in month	New patient safety incidents including SIs, Never Events and medication incidents	L Ward	131	134	156	112	96	106	108	150	107	124	162	116	
	Severe harm		0	0	1	0	0	0	0	1	0	0	1	0	
	Moderate harm		5	8	4	7	3	14	7	28	8	8	9	4	
	Low harm		26	22	27	20	20	23	20	14	16	27	41	28	
	No harm		100	104	124	85	73	69	81	107	83	89	111	84	
Serious incidents	New SIs declared requiring investigation		0	1	0	0	0	0	0	1	0	0	1	1	
Never Events	Number of never events reported in month		0	0	0	0	0	0	0	0	0	0	1	0	
Medicines Management	Number of medication incidents reported (CCS)	A Darvill	16	19	18	16	17	10	14	14	8	13	20	9	
	% CCS medication incidents no harm		88%	89%	94%	81%	94%	100%	93%	100%	88%	100%	95%	89%	
Infection Prevention & Control															
High Impact Interventions	Children's Community/Nursing Teams only	C Sharp	100%	100%	100%	100%									
Essential Steps	Compliance with spread of infection indicator		100%	100%	100%	100%									
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	
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	94%	94%	94%	94%	93%	92%	92%	91%	92%	93%	93%	94%	
Safeguarding training (Children)	Level 1: % staff trained		97%	97%	97%	97%	97%	97%	96%	95%	96%	97%	97%	97%	
	Level 2: % staff trained		97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	98%	
	Level 3: % staff trained		89%	88%	88%	87%	83%	77%	80%	83%	84%	84%	85%	86%	
	Level 4: % staff trained		100%	80%	100%	100%	100%	100%	70%	70%	78%	89%	78%	67%	
Safeguarding training (adults)	SOVA		95%	95%	95%	95%	95%	95%	94%	93%	93%	94%	94%	94%	
	Mental Capacity Act		93%	92%	91%	91%	90%	90%	88%	88%	86%	87%	87%	90%	
	Deprivation of Liberty		94%	96%	96%	96%	93%	95%	93%	91%	91%	92%	93%	94%	
Prevent Basic Awareness	% of staff undertaking Prevent training		97%	95%	94%	94%	94%	93%	94%	94%	95%	96%	97%	97%	
WRAP3	% of staff undertaking WRAP training		92%	92%	92%	93%	91%	88%	88%	87%	89%	89%	89%	90%	
Manual handling	% of staff undertaking manual handling (patients)		89%	90%	91%	89%	90%	89%	84%	84%	89%	88%	85%	77%	
Fire safety	% of staff undertaking fire safety training		90%	91%	92%	90%	91%	90%	91%	90%	92%	93%	92%	94%	
CPR/Resus	% of staff undertaking CPR/Resus training		90%	91%	89%	92%	91%	88%	89%	87%	90%	90%	91%	92%	
IPaC training	% of staff undertaking IPaC training		96%	97%	96%	96%	96%	96%	96%	95%	96%	96%	97%	97%	
Information governance	% of staff undertaking IG training		94%	93%	94%	93%	93%	93%	93%	92%	93%	94%	95%	95%	
Safeguarding															
Safeguarding supervisions (Children)	% eligible staff	D Andrews D Shulver	91.78%	89.73%	79.35%	76.16%	N/A	N/A	N/A	N/A	57.22%	72.22%	87.41%	88.36%	
Workforce/HR															
Sickness	Monthly sickness absence rate	R Moody	5.09%	5.31%	5.36%	5.78%	4.26%	3.31%	3.29%	3.26%	3.26%	4.02%	5.14%	4.25%	
	Short-term sickness absence rate		2.53%	3.05%	2.89%	3.12%	1.61%	1.00%	1.35%	1.49%	1.51%	2.17%	2.25%	2.41%	
	Long-term sickness absence rate		2.56%	2.21%	2.47%	2.66%	2.65%	2.30%	1.94%	1.77%	1.75%	1.85%	2.89%	1.85%	
	Rolling cumulative sickness absence rate		4.51%	4.47%	4.50%	4.96%	3.09%	4.82%	4.70%	4.55%	4.44%	4.41%	4.42%	4.37%	
Turnover	Rolling year turnover		13.66%	0.14	13.76%	13.04%	12.98%	12.32%	12.81%	13.21%	11.38%	10.60%	11.39%	11.17%	
Bank staff spend	Bank staff spend as % of pay (financial YTD)		1.54%	N/A	1.58%	N/A	1.60%	1.84%	1.81%	1.18%	1.82%	1.83%	1.90%	1.98%	
Agency staff spend	Agency staff spend as % of pay (financial YTD)		2.85%	N/A	2.63%	N/A	1.63%	1.55%	1.11%	1.11%	1.02%	0.99%	1.12%	1.43%	
Stability	% of employees over one year which remains constant		88.25%	88.55%	87.47%	88.02%	87.70%	87.29%	87.78%	87.71%	88.01%	88.90%	88.92%	89.68%	
Appraisals	% of staff with appraisals		89.81%	90.83%	90.63%	88.36%	85.12%	84.47%	84.26%	84.96%	84.76%	88.86%	90.09%	90.12%	
Staff Friends & Family test	Recommending CCS as place for treatment - Quarterly reporting	P Davies/ L Thomas	Not available in Q3			93.55%			N/A			93.00%			
	Recommending CCS as place to work - Quarterly reporting					83.88%			N/A			80.00%			
EXPERIENCE															
Patient experience (monthly targets)															
Complaints	No. of formal complaints received in month	D McNeill	7	8	11	5	0	0	4	3	4	3	9	5	
	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	
	Percentage responded to within target timeframe						100%	0.00%	100%	66.67%	100%	100%	66.70%	100%	
Informal complaints	No. of informal complaints received in month		14	21	33	17	9	10	17	20	15	29	24	23	
Complaints upgraded	No. of complaints upgraded (informal to formal)						0	0	0	1	0	0	2	2	
Complaints downgraded	No. of complaints downgraded (formal to informal)						0	0	0	2	1	2	2	1	
Friends & Family test score	Patients who would recommend our services		97.08%	96.51%	95.85%	95.73%	97.39%	97.20%	95.54%	94.46%	95.07%	93.60%	95.22%	96.96%	
	No. of responses to FFT						230	465	560	849	934	1328	1506	1811	
Patient Feedback	Total number of patients surveyed						298	515	630	973	983	1510	1663	1944	
	No. of positive comments recorded on IQVIA						320	600	713	1125	1207	1616	1965	2464	
QEWTT (Quality Early Warning Trigger Tool)															
QEWTT	Number of responses received by scoring threshold	25+	0	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
		16-24	5	5	7	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
		10-15	18	22	19	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
		0-9	64	63	63	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Number of two consecutive non-responses		2	1	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Number of single non-responses		5	2	4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Total number of responses received		87	90	89	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Total number of Teams		94	93	93	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 Dashboard

Cambridgeshire Community Services NHS Trust

Infection Prevention and Control Board Assurance Framework

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**
Systems and processes are in place to ensure: 1. Infection risk is assessed at the front door and this is documented in patient notes	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.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
2. Patients with possible or confirmed Covid19 are not moved unless this is essential to their care or reduces the risk of transmission	This relates to in-patient settings.	N/A Reviewed: N/A 05/11/2020 (IPaC Committee) Reviewed: N/A 31/12/2020	
3. Compliance with the national guidance around discharge or transfer of	This relates to in-patient settings. The CCS Discharge Planning Team based at Luton & Dunstable Hospital ensure that the Covid19 status of all patient discharges (including patients at	No gaps identified Reviewed: No gaps	

	Covid1919 positive patients	the end of their lives) that they are responsible for is communicated to relevant parties including families and care homes. PPE is supplied for carers where appropriate. 31/10/2020 The CCS Discharge team based at the Luton and Dunstable hospital are working with the system to ensure that the Discharge to assess (2) is applied safely and consistently 31/12/2020 The Trust's Discharge team based at the Luton & Dunstable hospital continue to work as per 31/10/2020	identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
4.	Patients and staff are protected with PPE, as per the PHE national guidance	IPC Policy and IPC supporting manual in place with IPC guidance for infections. Covid19 related IPC guidance specific to PPE is reviewed by the IPC group (Chief Nurse as Director of Infection Prevention & Control, Medical Director, Deputy Chief Nurse and IPC Matron) and actions discussed, recorded and agreed through our Incident Management Team (IMT) process. Director Infection Prevention & Control, Medical Director and IPC Matron are all members of Incident Management Team. Updated communication to staff regarding changes in practice required are agreed through this route and shared via FAQ mechanism from Medical Director / Chief Nurse. Incident Management Team oversight of all IPC incidents and risks including those relating to PPE Robust PPE stock management system in place and overseen by Quality Team. Key PPE link for each service identified and joins weekly PPE oversight session led by Deputy Chief Nurse. Good engagement with Procurement and Estates Teams re PPE	Reviewed: 31/10/2020 Occasional reported evidence that some elements of guidance is not followed by individuals. Where this is raised, appropriate conversations with staff are held. Any incident or outbreak is reviewed with the teams affected. Communication remains consistent and in line with current government guidance. Reviewed: No change identified 05/11/2020 (IPaC Committee)	Weekly incident oversight in place Sitrep reporting on PPE in place Plans for observations to be part of environmental audits for 2020/21 alongside opportunistic site visits by IPC Matron i.e. for Fit testing

Appendix 2 – IPaC Board Assurance Framework

	distribution and guidance. Regular Q&A sessions with all staff by directorate includes opportunities for staff to raise any PPE issues. Examples logged with Incident management Team re changes to practice that are outside specified guidance which have been agreed due to staff concern/anxiety or appropriate rational for particular scenarios. All guidance is updated on the appropriate intranet pages. Outbreak investigations identified common themes, this has been shared across the organisation via a communications brief.	Reviewed 31/12/20: The learning from the outbreaks has been shared with the Trust and will be discussed at the Trust's next Infection Prevention and Control Committee in February 2021.	
5. National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	IPC Matron, Director of Infection Prevention & Control, Medical Director and deputy Chief Nurse all part of Incident Management Team where all PHE and other IPC guidance is directly received via EPRR route. This is then logged, reviewed by the IPC Team and actions agreed and disseminated via FAQs to all staff – directly from medical Director and Chief Nurse. Staff intranet updated as changes to practice made. Screen savers and an IPC Awareness week communicated to staff.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
6. Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	As above – any changes to IPC related guidance are reviewed by IPC group (members described above) and follow same process – relevant updates and associated risks managed through Incident Management Team Risks and incidents reported through internal governance processes. IPC Committee to meet August 2020 – cycle of Business to focus on IPC compliance and assurance.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	

Appendix 2 – IPaC Board Assurance Framework

	IPC Committee to meet November 2020 – cycle of Business to focus on IPC compliance and assurance. IPC Committee to meet February 2021 – cycle of Business to focus on IPC compliance and assurance.		
7. Risks are reflected in risk registers and the Board Assurance Framework where appropriate	All Covid19 related risks are reviewed and monitored by the Incident Management Team i.e 2x risks relating to PPE (staff anxiety and supply are currently being monitored at trust level through this process. Daily sitreps to the Incident Management Team where risks, changes in guidance and PPE stocks are reviewed. Updates have been reported through the Clinical Operational Boards (May 2020) and Board (May 2020). Non Executives have been updated fortnightly by the Chief Executive and Deputy Chief Executive. The Datix risk management system is used to record all risks and incidents and was amended at the beginning of the pandemic to identify Covid19 risks and incidents. 31/10/2020 Covid19 related risks continue to be reviewed weekly at IMT. Risk related to PPE /Staff Morale and Service delivery updated to reflect on going nature of the pandemic. 31/12/2020 Covid19 related risks continue to be reviewed weekly at IMT. Risk related to PPE /Staff Morale and Service delivery updated to reflect on going nature of the pandemic	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
8. Robust IPC risk assessment processes and practices are in place for non Covid19 infections and pathogens	As above- risks reported and monitored through the IMT and governance structures at service Clinical Governance and management meetings, Clinical Operational Boards and Board. Trust wide IPC Risks are owned by the Trust's Chief Nurse (Director Infection Prevention Control) and Medical Director (Covid19 lead) with the support of the Deputy Chief Nurse and Matron Infection Prevention and Control. The Risks assessment are updated and discussed on a weekly basis at IMT.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	

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	The IPC Team meet weekly to discuss all IPC issues including those that are non Covid19 related. IPC Committee to meet August 2020 reporting into QIS Committee. IPC Committee to meet November 2020 reporting into QIS Committee. Liaison with the Trust's contracted Consultant Microbiologist by Chief Nurse and IPC matron throughout the pandemic. IPC training on line continues with monitoring via Quality Dashboard.Staff continue to risk assess processes and practices for non Covid19 infections and pathogens supported by the IPC team. 31/12/2020 Following the small number of outbreaks within the Trust, departments and building site leads have been asked to update their risk assessment to maintain a Covid19 secure area and minimise the possibility of cross contamination. 31/12/2020		

Appendix 2 – IPaC Board Assurance Framework

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: 1. Teams with appropriate training are assigned to care for and treat patients in Covid19 isolation or cohort areas	Not fully applicable as no in-patient facilities within the Trust service portfolio. Dental services offer at risk patients early morning appointments and the last appointments of the emergency sessions for known Covid19 positive patients. Appropriate cleaning arrangements are in place.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
2. Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to Covid19 isolation or cohort areas.	This relates to in-patient facilities. Dental areas as above	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
3. Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	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.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	

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4. Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance. Attention to the cleaning of toilets/bathrooms, as Covid19 has frequently been found to contaminate surfaces in these areas 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	Request for contracted cleaners to increase cleaning frequencies in clinical premises. 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. Covid19 secure work place risk assessments conducted with IPC Matron oversight. Cleaning of frequent high touch surfaces such as keys, fobs, mobile phones - Information discussed at IPaC group, Incident Management Team and with service leads. Information included within FAQ and screen savers for staff to access. Appropriate cleaning schedules in place for clinic based areas i.e. Dental. Dental services have a Standard Operating procedure for cleaning.	Reviewed: 31/10/20 Programme of environment audits paused since beginning of pandemic – timings to restart currently being considered. This will offer formal opportunity to test cleaning regimes in practice. Program of environment audits pending dates. Reviewed: 31/12/2020 Clinical Teams have been asked to complete their own environmental audit and submit their audit to the Trust's Clinical Audit team. These will be discussed/ reviewed at the next Infection Prevention and Control Committee in February 2021.	Monitoring of all cleaning related incidents at the IPaC Huddle / Committee. Information is in the FAQs section of the intranet re: additional cleaning that individuals should undertake in workplace i.e. surfaces and equipment.

Appendix 2 – IPaC Board Assurance Framework

	national guidance Frequently touched' surfaces, eg 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 electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily 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)			
5.	Linen from possible and confirmed Covid19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	No In Patient facilities – N/A	N/A Reviewed: N/A 05/11/2020 (IPaC Committee) Reviewed: N/A 31/12/2020	
6.	Single use items are	IPC manual outlines all relevant guidance re single use items;	No gaps identified	

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	used where possible and according to Single Use Policy	this has been disseminated to services.	Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
7.	Reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	IPC manual outlines all relevant guidance re decontamination of equipment. No single use PPE items designated multiple use during pandemic period.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
8.	Review and ensure good ventilation in admission and waiting areas to minimize opportunistic airborne transmission	Covid19 secure risk assessments undertaken with every service led by Service Directors and Estates Team. Review completed by IPC Matron. 3 phase plan in place for rectifying actions by order of priority. Process overseen at Incident Management Team Meeting	Gap due to prioritisation phases Reviewed: unchanged 05/11/2020 (IPaC Committee) Reviewed: Unchanged 31/12/2020	Mitigating actions identified for services/properties where gaps identified and increased face to face contact is expected as part of restarting services i.e. temporary Perspex shields, additional face visors where appropriate. Actions are undertaken as needed following assessment.
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		Arrangements for antimicrobial stewardship remain in place	Reviewed:	Continued oversight

to ensure: 1. Arrangements around antimicrobial stewardship are maintained	including a standardised formulary. This section applied mainly to iCaSH, Dental, Children's Community Nursing and Adult Nursing services. 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 No related patient safety incidents reported up to 30/06/2020. Actions related to previous quarterly antimicrobial audits continue to be implemented by services. 11 related patient safety incidents reported during quarter 2 (July- September) related to lack of PPE usage / availability within care homes / care staff. Antimicrobial audits continue to be undertaken by clinical teams. Quarter 2 report is currently being reviewed by the Trust's Principle Pharmacist. 31/12/2020. The report will be discussed at the next Infection Prevention and Control Committee in February 2021.	31/10/2020 Quarterly Antimicrobial audits paused at beginning of pandemic by Medical Director and Principle Pharmacist. The timing for re-introduction is currently being considered. No gaps identified as antimicrobial audit reintroduced for quarter 1. Reviewed: 31/12/2020 Awaiting Q2 antimicrobial audit report.	of prescribing data and prescribing/medicines incidents. Medicines Governance group continues to meet monthly
2. Mandatory reporting requirements are adhered to and boards continue to maintain oversight	Reporting requirements have continued. IPaC Committee has continued. Reporting to Trust Board has continued via the Integrated Governance report.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	

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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: 1. Implementation of national guidance on visiting patients in a care setting	N/A – In patient settings only	N/A Reviewed: N/A 05/11/2020 (IPaC Committee) Reviewed: N/A 31/12/2020	
2. Areas in which suspected or confirmed Covid19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	All work places both clinical and non-clinical have been assessed against the Covid19 secure workplace guidance. These risk assessments have been overseen by Service Directors with assistance from the Estates Team and IPC matron. 3 phase action plan identified with prioritisation to clinical areas. Posters re appropriate safety measures is social distancing have been circulated and are being displayed. These are a mixture of those produced by PHE and our Communications Team.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
3. Information and guidance on Covid19 is available on all Trust websites with easy read versions	Information for staff available via dedicated COVID-19 intranet page. The Trust's internet page direct users to the PHE national site.	Further information re information for patient required i.e. in accessible format	
4. Infection status is communicated to the receiving organisation or department when a possible or confirmed Covid19 patient needs to be moved	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.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps	

		identified 31/12/2020	
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: 1. Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed Covid19 symptoms and to segregate them from non Covid19 cases to minimise the risk of cross-infection	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.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
2. Mask usage is emphasized for suspected individuals.	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.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
3. ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	Part of the service Covid19 secure workplace risk assessments process. 3 phase action plan produced.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: 31/12/20 NHS now at a level 5	Services have identified appropriate interim mitigation i.e. temporary perspex shields for some reception areas until permanent fixtures available.

		incident therefore this will have an impact on the phase 3 plans. Staff safety still a key priority with risk and environmental assessments being undertaken.	
4. For patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	For in patient areas only. CCS staff would direct patients to the national PHE screening process if identified as symptomatic.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
5. Patients with suspected Covid19 are tested promptly	For in patient areas only. CCS staff would direct patients to the national PHE screening process if identified as symptomatic.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
6. Patients that test negative but display or go on to develop symptoms of Covid19 are segregated and promptly re-tested	For in patient areas only. CCS staff would direct patients to the national PHE screening process if identified as symptomatic.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
7. Patients that attend for	Many services operating a remote first contact.	No gaps identified	

routine appointments who display symptoms of Covid19 are managed appropriately	Patients are assessed via the departments triage for Covid19 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.	Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	

Appendix 2 – IPaC Board Assurance Framework

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: 1. 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 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.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
2. 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	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.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
3. A record of staff training is maintained	Via Electronic Staff Record. A record of all respirator fit testing is held by the IPC matron	No gaps identified Reviewed: No gaps	

	supported by the Quality Team in collaboration with service leads.	identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
4. Appropriate arrangements are in place that any reuse of PPE in line with the <u>CAS alert</u> is properly monitored and managed	Any items reused would be designated single patient use and disinfected where required e.g. eye goggles or as sessional use e.g. gowns. Individual items would be risk assessed and agreed with the Trust's IPC Team.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
5. Any incidents relating to the re-use of PPE are monitored and appropriate action taken	Incidents are reported via the Trust's Datix system. All Covid19 related incidents are monitored via Incident Management Team.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
6. Adherence to PHE <u>national guidance</u> on the use of PPE is regularly audited	No formal PPE audit of practice programme in place currently. Need to consider as part of other IPC audits i.e. environmental audits and Clinical Intervention audits.	Reviewed: No formal audits in place Reviewed: 31/10/20 Audit planned for social distancing and face mask used in addition to the IPAC intervention audit. Reviewed: 31/12/20 An audit tool has been developed will	Incidents monitored via individual services and highlighted on daily sit reps to Incident management Team.

		be rolled out in January. The tool is to aide spot checks by staff to demonstrate compliance to national guidance.	
7. Staff regularly undertake hand hygiene and observe standard infection control precautions	Various methods employed for reminding staff re hand hygiene through the pandemic i.e. 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.	Reviewed: Limited audits in place Reviewed: 31/10/20 IPAC audits reintroduced September 2020, steady increase in compliance with these noted. Reviewed: 31/12/20 UV Hand hygiene compliance continues to increase. Details of the increase will be discussed at the next Infection Prevention and Control Committee in February 2021.	Multiple routes of sharing relevant messages re: importance of increased hand hygiene is in place.
8. Hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but	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.	Reviewed: 31/10/20 Position to be confirmed by the Trust's Estates lead. Reviewed: 31/12/20 Confirmation has been received	

beyond the risk of splash contamination, as per national guidance			
9. Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	Hand washing techniques are displayed on walls and on the soap / hand sanitizer dispensers.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
10. Staff understand the requirements for uniform laundering where this is not provided for on site	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.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
11. All staff understand the symptoms of Covid19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	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. 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 at their workplace displaying symptoms, they have been told to go home and self-isolate as	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	

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	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: 1. Patients with suspected or confirmed Covid19 are isolated in appropriate facilities or designated areas where appropriate	N/A In-patient facilities only	N/A Reviewed: N/A 05/11/2020 (IPaC Committee) Reviewed: N/A 31/12/2020	
2. Areas used to cohort patients with suspected or confirmed Covid19 are compliant with the environmental requirements set out in the current PHE national guidance	N/A in patient areas only	N/A Reviewed: N/A 05/11/2020 (IPaC Committee) Reviewed: N/A 31/12/2020	
3. 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.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
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:	Where staff have been involved in taking swabs from patients, they have been trained by appropriate experts i.e. Luton Adult	No gaps identified	

1. Testing is undertaken by competent and trained individuals	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.	Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
2. Patient and staff Covid19 testing is undertaken promptly and in line with PHE and other national guidance	Staff testing via national swabbing system through local swabbing centres. Patient testing only as part of initial Luton based support to care Homes Lateral flow testing kit initially distributed to patient facing clinical staff as per volume dictates.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
3. Screening for other potential infections takes place	This continues as clinically indicated.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
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: 1. Staff are supported in adhering to all IPC policies, including those for other alert organisms	All IPC guidelines continue to be implemented. Covid19 related guidance is communicated through FAQs, via Q&A sessions and on the Intranet. IPC Team are supporting all services with ad hoc queries and requests for specific guidance.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	

Appendix 2 – IPaC Board Assurance Framework

2. Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	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.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
3. All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	Guidance distributed through FAQ in conjunction with the Trust's Waste lead.	Environmental audits which include correct disposal of waste have been paused during the pandemic. Reviewed: No update identified 05/11/2020 (IPaC Committee) Reviewed: Updated 31/12/2020	Environmental audits currently being re scoped and timeframe for re- introduction to be agreed. Incidents related to waste are reviewed by IPC matron in liaison with our Waste Lead. 31/12/2020 Clinical Teams have been asked to complete their own environmental audit and submit their audit to the Trust's Clinical Audit team. These will be discussed at the next Infection Prevention and Control Committee in February 2021.
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	Individual staff risk assessments have been undertaken	No gaps identified	

processes are in place to ensure: 1. Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	throughout the pandemic. This included staff in extremely high risk groups so that they could be identified as 'shielding'. All staff have been encouraged to have a conversation with their line manager to identify any additional support that they require ie working from home. 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. Our Staff side representatives have been fully engaged with 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.	Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
2. Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	All staff that are required to wear FFP3 respirators are trained by experts identified by the IPC matron. As different types of masks arrive through our supply chain, staff are retested (as needed). Individual requirements are supported where staff fail	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps	

	multiple types of masks. Those trained are recorded locally with oversight by the IPC matron.	identified 31/12/2020	
3. 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	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.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
4. All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	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. Regular messages re appropriate use of face masks and face coverings (ie if staff travel to work on public transport). Staff reminded that NHS guidance is 2 metres despite national public move to 1m plus. Risk assessments for Covid19 secure work places undertaken.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
5. Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	Assessed as part of the service and building risk assessments.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee)	

Appendix 2 – IPaC Board Assurance Framework

		Reviewed: No gaps identified 31/12/2020	
6. Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Line managers are supported by HR colleagues to ensure that staff who are absent from work through sickness, shielding or self-isolating are supported. All usual Occupational Health service support remains available. Staff working remotely are encouraged to join the regular Q&A sessions for support. Access to testing arrangements is in place for staff and arrangements have been communicated via FAQs and on the intranet. Lateral flow testing is in place across the organisation.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	
7. Staff that test positive have adequate information and support to aid their recovery and return to work.	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.	No gaps identified Reviewed: No gaps identified 05/11/2020 (IPaC Committee) Reviewed: No gaps identified 31/12/2020	

Version Control
V1 July 2020

Approval
IPC Team / DIPC and Medical Director: 30 June 2020
IMT: 6 July 2020
Trust Board: 15 July 2020

Appendix 2 – IPaC Board Assurance Framework

Revised: 31 October 2020
Reviewed: IPaC Committee 5 November 2020
Revised: 31 December 2020
Reviewed: Trust Board 20 January 2021

Appendix 2 – IPaC Board 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**: 31/03/2021
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:	Source of Risk:	Risk level Current:	Last Review Date:
Collaborate with others, Provide outstanding care	Meetings	High	11/01/2021

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 11/01/21 15:25:48] No change to scoring. System collaborations and system working continues across our footprint and Trust leads embedded into these discussions where needed.

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 3 – 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**: 31/03/2021
Clinical Group: Trust Wide		**Risk committee**: Board

Risk Title: Impact of second wave of covid19 on community service care delivery and phase 3 restoration plans

Risk Grading:

	L	C	
Initial:			**16**
Current:	Possible - 3	Major - 4	**12**
Target:	Unlikely - 2	Major - 4	**8**

Principle Trust Objective:	Source of Risk:	Risk level Current:	Last Review Date:
Provide outstanding care	Risk assessment	High	07/01/2020

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:
[Webb, Liz 07/01/21 16:46:54] Risk reviewed and for discussion at IMT w/c 11 January 2021 with regard raising to extreme in response to the 2nd wave and system pressures.

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 workin

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.

Risk ID: 3300	Risk owner: Pisani, Anita	Risk handler: Howard, Kate
Directorate: Trustwide		**Date recorded**: 15/12/2020
Specialty: Not Applicable		**Anticipated completion date**: 30/06/2021
Clinical Group: Not applicable		**Risk committee**: Board
Risk Title: Mass Vaccination		
Principle Trust Objective: Collaborate with others, Provide outstanding care		**Source of Risk**: Risk assessment

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

Risk level Current: High

Last Review Date: 12/01/2021

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.

Progress update:
[Howard, Kate 12/01/21 17:41:06] Updated risk on the 12.01.2021 - linked the overarching mass vaccination risk to the mass vaccination programme board risks (which are 12 and above).

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 3 – Strategic Risks and Operational Risks 15 and above

Risk ID: 3163	Risk owner: Foley, Mrs Anne	Risk handler: Foley, Mrs Anne
Directorate: Trustwide		**Date recorded**: 09/03/2020
Specialty: Not Applicable		**Anticipated completion date**: 19/02/2021
Clinical Group: Trust Wide		**Risk committee**: Board

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

Risk Grading:			
	L	C	
Initial:			8
Current:	Possible - 3	Major - 4	12
Target:	Rare - 1	Major - 4	4

Principle Trust Objective:	**Source of Risk**:	**Risk level Current:**	**Last Review Date:**
Be an excellent employer, Provide outstanding care	Meetings	High	11/01/2021

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 11/01/21 15:18:01] Risk score to stay at 12. Length of pandemic is affecting individuals and teams in different ways - morale is variable across teams/services. Individuals feeling fatiqued and sickness levels increasing in some teams. Question and Answer sessions continue and staff networks in place with staff actively taking part. Regular sitreps continue across all services and regular conversation at IMT on what more can be done to support staff. 1;1s, team and service conversations continue to take place and managers continuously reminded to check in with their staff. Health and wellbeing offer regularly publicised and set up as a screen saver. New BLMK health and wellbeing offer being publicised from today offering psychological support to staff. Agreement also in place for CPFT Psychology team to provide some bespoke support to our safeguarding teams. Stepped health and wellbeing offer continues to be available for all. This risk also links to risk number 3250 - emotional impact on staff as consequence of increased safeguarding issues. Also looking to roll out lateral flow testing to all staff in clinical teams as currently some administrative staff are unable to access this and they want to and this is creating a feeling of unfairness. Central team looking at how to address this.

Significant Hazards:
Demands of the service exceeding capacity available
Insufficient staff to deliver service
Turnover
Vacancies
Staff absences - sickness; maternity; training etc

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 Early Warning Trigger Tool
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
Back to the Floor feedback, discussions and resulting actions
Live Life Well Activities
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

Risk ID: 3167	Risk owner: Pisani, Anita	Risk handler: Pisani, Anita
Directorate: Trustwide		**Date recorded**: 11/03/2020
Specialty: Not Applicable		**Anticipated completion date**: 01/02/2021
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:
12/01/2021

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.

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

Progress update:
[Robbins, Mark 12/01/21 17:23:19] The financial framework for the second half of 20/21 across revenue and capital has been finalised and CCS's funding requirements are incorporated in full.
System engagement continues across all footprints, with continued key stakeholder involvement in the POW developed.

Appendix 3 – 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**: 31/03/2021
Clinical Group: Trust Wide		**Risk committee**: Board

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

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

Principle Trust Objective:	Source of Risk:	Risk level Current:	Last Review Date:
Be an excellent employer, Provide outstanding care	Risk assessment	High	11/11/2020

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 11/11/20 16:05:04] Risk reviewed remains unchanged.

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 wo

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

Appendix 3 – Strategic Risks and Operational Risks 15 and above

Risk ID: 3164	Risk owner: Foley, Mrs Anne	Risk handler: Foley, Mrs Anne
Directorate: Trustwide		**Date recorded**: 09/03/2020
Specialty: Not Applicable		**Anticipated completion date**: 31/03/2021
Clinical Group: Trust Wide		**Risk committee**: Board

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

Risk Grading:

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

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

Source of Risk:
Meetings

Risk level Current:
High

Last Review Date:
11/01/2021

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 11/01/21 15:23:01] No change to risk scoring. Workforce challenges being kept under review and discussed at every IMT meeting. Sickness absence levels in some teams increasing and concerning but not a Trust-wide picture.
Demand on some services also increasing and relevant Service Director taking time to understand the cause and will feedback at future IMT meetings. Impact will be kept under regular review. Regular sitreps taking place across all services. This risk also links with risk number 3250 around emotional impact to staff on increased safeguarding issues.

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

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 3 – Strategic Risks and Operational Risks 15 and above

Risk ID: 3254	Risk owner: Peberdy, John	Risk handler: Harwin, Simon

Directorate: Children and Young Peoples Services	**Date recorded**: 02/10/2020
Specialty: CYPS Trustwide (Risk Register Only)	**Anticipated completion date**: 31/03/2021
Clinical Group: Trust Wide	**Risk committee**: Children's and Young People Clinical Operational Board

Risk Title: Covid 19 phase 3 restoration plans,

Principle Trust Objective:	**Source of Risk**:
Provide outstanding care	Risk assessment

Risk Grading:

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

Risk level Current: Extreme

Last Review Date: 23/12/2020

Risk description:
There is a risk that delivery of Covid 19 phase 3 restoration plans will not be fully implemented by March 2021 leading to the potential detrimental impacts on Children and Young people.

Progress update:
[Peberdy, John 23/12/20 13:57:30] Risk reviewed. No change to risk score or narrative

Significant Hazards:
There are three primary causes:
- A surge in service demand;
- Increased staff sickness/ absence caused by Covid 19 symptoms, isolation requirements or parental responsibilities; and
- National or local incidents of Covid 19 impacting on service delivery

Controls in place:
- 0300 SPoA's established for all CYP services with clinical pathways defined in each of the Trust's geographies;
- Restoration plans are reviewed regularly by each service with flexibility to phase services up and down as required;
- A clinical priority system is in place for all services ensuring clinical needs are addressed appropriately;
- Website updated clearly detailing resources and service access points;
- Social media campaigns in place;
- Workstreams are in place to ensure children and young people with an EHCP and/or complex needs receive the services they require; and
- Where a Practitioner is concerned, considers a safe option to attend the child's home/school with appropriate social distance/PPE

Appendix 3 – 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**: 23/05/2021
Clinical Group: Children's Community Paediatrics - Edwin Lobo (Luton)		**Risk committee**: Bedfordshire & Luton Clinical Operational Board, Children's and Young People

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: Provide outstanding care	**Source of Risk**: Meetings	**Risk level Current:** Extreme	**Last Review Date:** 07/01/2021

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.
There is a risk of protracted delays for Children requiring ASD/ ADHD assessments due to the limited face to face appointments for routine requirements.
The COVID-19 pandemic has exacerbated service capacity challenges due to locum staff leaving, remote working limiting the volume of clinical slots and some specialist assessments required face to face (limited by social distancing) and staff self- isolating due to Track & Trace or sickness.

Progress update:
[Williams, Augustina Mrs 07/01/21 16:49:52] 0Agency Locum due to start 5.01.2020 working off site now delayed due to personal commitments in Germany- requesting to work from Germany; awaiting response from COVID Corporate team. No candidate appointed from Consultant interviews 18.12.2020.Service Director & Clinical Lead reviewing medical recruitment. 1.0 wte Band 5 12 month secondment System One / Service Support now in post on induction on to work across Luton & Beds Comm Paeds to standardise data capture and reporting and deputise for band 6 Operational Manager in Luton Comm Paeds.
4 staff off sick- 3 clinical(0.6 wte Consultant off long term) & one admin; 1 admin staff member positive Lateral Flow Test (arranging PCR test). Staff member has not been in work environment since . 2 admin staff shielding working from home. Lessons learned meeting being arranged with CCS IT, service representatives and EPUT to feedback issues from Windows 10 & Olympus software upgrade. Increased off site working for admin staff supported due to current situation with pandemic- meeting taking place next week to ensure staff are supported and robust plan in place. Contract finalised for external procurement of BOSA (COVID safe ADOS assessments)- awaiting feedback from Corporate COVID team regards infection control issue raised. Lead Nurse post across both Comm Paeds Services approved- JD/ PS progressed to panel for approval. Recruitment to be progressed. CCS collaborating with CCG to contact service users with Learning Disabilities/ Autism identified as meeting criteria to access Winter Funding support which will be delivered by Autism Beds.
Grievance investigations almost concluded- Clinical Staff members has withdrawn complaint.
Vulnerable staff able to access COVID vaccine via Luton primary care Network this week.
Service data updates available next week.

Significant Hazards:
Covid 19 causal factors are as follows:
- Covid 19 restrictions have limited the locum staff available and minimised face to face consultations leading to increased waits and new waits for Children requiring routine physical assessments.
- Due to excessive demand the roll out of IT equipment has not matched the service requirements, limiting mobile working options.
- Covid 19 impacts have delayed the business case for recurrent funds being considered by commissioners.
Non Covid related factors:
- Increased time required for the management of complex cases
-Thresholds within the system drive stakeholders to seek medical diagnosis for children's to access support as opposed to being needs led.
- Service capacity does not currently match demand (Service demand has increased since April 2013 approx. 150 referrals/ month to 400 / month).

Controls in place:
- Clinical Service manager and Clinical lead have agreed and implemented a clinical prioritisation method.
- 2 Consultant posts are currently advertised along with a further registrar position.
- Staffing resource has been sourced for ADOS assessments, however Covid restrictions limit the pace backlogs can be addressed. Adaptations to ADOS are currently being scoped.
- Staff shielding have been identified to IT for equipment they require to work remotely. There is currently insufficient IT resource to provide this within a timely manner.
- IT prioritisation is now in place for hardware roll outs.
- Targeted locums are being sourced to increase service capacity, including a potential locum starting in August.
- A comprehensive demand & capacity model has been submitted to commissioners with funding requirements to fully resource the service.
- Joint communication from all stakeholders is planned to CYP and families detailing the system delays, rationale and plan.
- Team colleagues are fully involved in the improvement plan and being listened to... informing the improvements.
- Leaders are reflecting on styles and approach, including staff perceptions to improve overall morale.
- Programme of Service Redesign in place.

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

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:
06/01/2021

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:
[Andrews, Dawn 06/01/21 08:16:46] Review of risk at weekly Safeguarding Huddle agreed risk remains the same with controls in place. National lockdown commenced yesterday, this may impact on the ability of professionals to identify abuse & neglect, although at the current time demand continues to peak. Risk to be reviewed weekly at the safeguarding huddle.

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
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.

Risk ID: 3284	Risk owner: Foley, Mrs Anne	Risk handler: Foley, Mrs Anne
Directorate: Trustwide		**Date recorded**: 15/12/2020
Specialty: Not Applicable		**Anticipated completion date**: 31/03/2021
Clinical Group: Not applicable		**Risk committee**: Executive Team Meeting

Risk Title: Workforce: There is a risk that there is insufficient local workforce currently available to safely deliver the mass vaccination programme leading to slower implementation of the vaccine programme and continued risk of adverse health caused by Covid 19.

Risk Grading:			
	L	C	
Initial:			12
Current:	Likely - 4	Major - 4	16
Target:	Possible - 3	Major - 4	12

Principle Trust Objective:	**Source of Risk**:	**Risk level Current:**	**Last Review Date:**
Be an excellent employer, Provide outstanding care	Risk assessment	Extreme	08/01/2021

Risk description:
Workforce: There is a risk that there is insufficient local workforce currently available to safely deliver the programme leading to slower implementation of the vaccine programme and continued risk of adverse health caused by covid 19.

Progress update:
[Foley, Anne Mrs 11/01/21 23:10:28] reviewed by programme board

Significant Hazards:
insufficient suitably competent workforce

Controls in place:
National recruitment campaigns run by NHSP and for ST Johns ambulance.
Regional posts have been advertised by the lead provider for a number
Mutual aid requested from local Trusts
Agreements in place to use other trust's bank workers
Agreement of national model so vaccination can be undertaken by non registered workers
Agreement that assessments can be undertaken by a range of clinical staff not just nurses.
Request for support to other health providers including dentists
review of national model being undertaken as a result of actual practice developed in PCN and acute vaccination centres
Training programmes available on line and face to face as necessary
Roving trainers identified to sign off competencies
Recruitment and active social media campaigns underway

Appendix 3 – 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, using three levels of Strong, Medium and Low. The table below sets out the framework for each level.

Strong	Medium	Low
Controls are suitably designed with evidence that they are consistently applied and effective	Information on controls is incomplete or the risk has been recently identified with insufficient time to assess the effectiveness of controls	There are significant gaps in controls with little or no evidence that they are consistently applied or that the controls are effective

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	Substantial Assurance	Reasonable Assurance	Partial Assurance	No Assurance
Safe	That our patients are protected from abuse and avoidable harm.	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
		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.
		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.
		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
		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

		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
		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
		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.
		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	Substantial Assurance	Reasonable Assurance	Partial Assurance	No Assurance
Caring	Do our services involve and treat people with compassion, kindness, dignity and respect?	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
		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
		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
		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	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	- 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
		-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
		- rolling sickness rates are within average and no higher than the NHS England rate for Community Trusts -stability figures at or above target levels	-rolling sickness within control total but show an increase for last 6 months -stability figures within control total but show a decrease for last 6 months	-rolling sickness above upper control total for both months reported - stability figures below lower control total for both months reported	-rolling sickness outside upper control total for last four months -stability figures below lower control total for last four months
	Research	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	Substantial Assurance	Reasonable Assurance	Partial Assurance	No Assurance
Responsive	Are Trust Services responsive to patients' needs?	- 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
		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
		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**

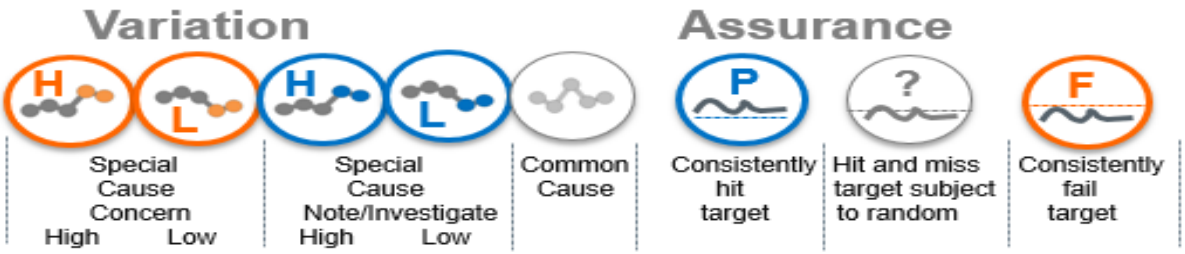
Domain	Assurance being sought	Substantial Assurance	Reasonable Assurance	Partial Assurance	No Assurance
Well led	Are effective governance processes in place underpinning a sustainable organisation?	- income and expenditure in line with budget and any variation is not anticipated to have a detrimental 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%
		- 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
		- 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%
		-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
		- 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

		- 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%
		- 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
		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
		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

		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 5 - Key for statistical process control charts