

Agenda item:	7
Date of meeting:	16 July 2025
Report to the:	Group Trust Board
Title of report:	Group Integrated Governance and Performance Report
Report authors & Executive sponsors:	Group Executive Team
Recommendation:	Approve

Assurance level:	Substantial <input type="checkbox"/> Reasonable <input checked="" type="checkbox"/> Partial <input type="checkbox"/> Minimal <input type="checkbox"/>
Rationale:	<ul style="list-style-type: none"> - Key evidence contained in this report and triangulation of this information with all Committee reports, particularly the Service Assurance Committees. - The recommendation of assurance from the Group Executive team - Any action necessary from the rating and outcome required.

1.0 Executive Summary

1.1 This Integrated Governance and Performance Report (IGPR) brings together information, analysis and interrogation from the board committees to support the Group Board in overseeing the quality, performance, workforce and finance domains of the Trusts.

1.2 The report period relates to the period April and May 2025 is structured:

- firstly with the feedback and escalation from each of the Service Assurance Committees;
- secondly a high-level view of key domains in each division across the Trusts, although this is currently in development;
- thirdly salient Trust wide information that the Group Board should be cognisant of, including how risks and issues are being managed.

2.0 How the report supports tackling Health Inequalities

2.1 The metrics for Equality Delivery System (EDS) are being monitored for delivery by the People Participation and Equalities Committee. Implementation of the Equality Delivery System will help the Trust to meet the requirements of the Public Sector Equality Duty (section 149) set out within the Equality Act 2010.

3.0 Links to Board Assurance Framework / Trust(s) Risk and Issue Registers

3.1 The report assesses the strength of assurance provided in relation to the Group's strategic risks on the Group Board Assurance Framework and operational risks scoring 15 and above.

4.0 Legal and Regulatory requirements

4.1 All Care Quality Commission Key Lines of Enquiry and fundamental standards of care are addressed in this report.

4.2 There were no NatPSA (National Patient Safety Alerts) received in this reporting period which were applicable to either CCS or NCHC.

5.0 Previous consideration by Committee or Executive

5.1 CCS Integrated Governance Report, 21 May 2025.
NCHC Performance Report, 21 May 2025.

6.0 Assurance

6.1 The Group Executive recommends an overall rating of **REASONABLE** assurance:

7.0 Key Matters

7.1 The three Service Assurance Committees confirmed the following levels of assurance reported for the individual integrated governance reports:

- Luton and Bedfordshire Community Adult Services – **Substantial assurance**
- CCS MSK Dynamic Health Services – **Substantial Assurance**
- MSK Services Norfolk – **Reasonable Assurance**
- Dental Healthcare – **Reasonable Assurance**
- iCaSH Services – **Reasonable Assurance**
- Group Children & Young People (CYP) Integrated Governance Report - **Reasonable Assurance**
- Norfolk Adult Services – **Reasonable Assurance**

7.2 The key reports from the Service Assurance Committees (part one of this report) also include matters for the Board to note and examples of outstanding practice that were discussed at the meetings.

8.0 Key Risk Register:

8.1 At the end of the reporting period there 6 operational risks scoring 15 or above. These are detailed as follows:

NCHC

- **5508** – Patients referred to diabetic foot clinic not being able to book urgent transport (rated 15)
- **5315** – Deepening our integration with partners (rated 16)
- **5510** – Impact of new national nursing profiles for Band 5 and Band 6 (rated 15)
- **5320** – Non-achievement of efficiency targets 2025/26 (rated 15)
- **5200** – Community Nursing Demand and Capacity – Trustwide (rated 16)

CCS

- **3675** – Adult Services (Luton) – TB staffing levels (rated 15) *Note: this risk was reviewed and reduced to a score of 9 on 4 June 2025.*

8.2 All risks scoring 12 and above are received and reviewed by the Group Trust Board Committees including the Service Assurance Committees. The key matters and escalation reports identify any new and emerging risks in the reporting period.

9.0 Key Issues Register:

9.1 There were 6 issues scoring 4 (Major) on the issue register for CCS which are summarised as follows:

- four relate to children and young people services and have been discussed in detail at the Children & Young People's Service Assurance Committee.
- one relates to the financial pressures within the iCaSH service and is regularly reviewed and discussed through the Luton & Bedfordshire Adults and Older People, and Ambulatory Service Assurance Committee.
- one is IT/digital related and following a discussion in detail at the Finance & Infrastructure Committee has since been closed and added as a new strategic risk to the Board Assurance Framework.

10.0 Forward View for 2025/26

10.1 The future priorities for the Report, in the next period, will include:

- The key metrics & dashboards that are currently being developed,
- The focus on the recurrent delivery of efficiencies and future schemes, managed through the efficiency programme gateway process,
- The development of the clinical and care strategy.

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**Part One: Feedback, assurance and escalation from the
service assurance committees**

Key Matters and Escalation Report to the Group Trust Board

Name of Committee: Luton and Bedfordshire Adults & Older People Services and Ambulatory Care Service Assurance Committee

Chair: Anna Gill

Meeting Date: Wednesday 2nd July 2025

Key matters:

The Committee were shown a film that showed the Bedfordshire and Luton Virtual Wards in operation. This was a great example of system working across our Bedfordshire Care Alliance footprint.

The committee also received the following papers:

- Financial Plan for all services 25/26 – **reasonable assurance**
- Annual summary of previous year's incidents – **substantial assurance**
- Annual update and learning on information governance – **substantial assurance**
- Annual review of learning from improvement, service redesign and transformation work – **reasonable assurance**
- Annual summary of previous year's patient experience – **reasonable assurance**
- Annual update on impact assessments
- Review of 2025/26 annual work plan

The Committee received an integrated governance report and discussed Luton and Bedfordshire Community Adult Services – **substantial assurance**. Key points:

- Service continues with a consistent and stable position. Staffing position continues to improve, and an improvement is being seen in sickness levels, although they remain above target at just above 6%. Overall resilience of the service is evidenced by service reporting Opel 1 or Open 2 for both April and May.
- High levels of mandatory training remain (93% Luton and 97% for Bedfordshire – end May 25), however, safeguarding level 3 remains under target but is an improving picture. New approach is currently being piloted, which will provide a more flexible approach to delivery and compliance.
- Appraisal rates just below 92% target at 91.54%. Focus for improvement this year is on improving feedback on the quality of appraisals.
- Significant progress had been made in relation to staffing within TB service. Service now fully established and risk reduced to 9.
- Wound care app being rolled out from July and a monthly thematic review of all category 3 and 4 pressure ulcers is undertaken. Moderate incidents remain within expected range.
- Limited Cost Improvement Plans (CIPs) identified for 25/26.
- No patient safety investigations during the reporting period.
- 96.22% positive Friends and Family feedback.

- Update on Unscheduled Community Care Hub was given. Real improvements continue to be delivered and the volume of ambulances attending the local hospitals continue to reduce.

- Service continue to meet all its contractual key performance indicators, however, a drop in overall performance has been seen. Reporting issues are being addressed.

Ambulatory Services Division:

- MSK Dynamic Health Services – **Substantial Assurance**
- MSK Services Norfolk – **Reasonable Assurance**
- Dental Healthcare – **Reasonable Assurance**
- iCaSH Services – **Reasonable Assurance**

MSK Dynamic Health Services

- Stable position since last reporting period.
- 100% of incidents reported either no harm or low harm. Above 97% friends and family feedback for the reporting period.
- Overall mandatory training performance 98%; appraisal rates above 95%; monthly sickness at 3.38%.
- Service delivery in line with contractual requirements.
- Over 6600 patients assessed as part of waiting list initiative.
- Waiting times – average for physio if 6.97 weeks; specialist is 4.2 weeks; pelvic health 9.65 weeks.
- Finance on plan and service currently working with finance to determine efficiency plans for 25/26.
- Joint research bid has been submitted in relation to use of digital.

NOW MSK Service – Norfolk Health and Care

- 100% of incidents reported as no or low harm during reporting period.
- Overall mandatory training 87.9%. Compliance is being actively managed.
- 72% positive friends and family for May. Work is currently taking place to increase response rates. No formal complaints in reporting period.
- Average waiting time 9.7 weeks, however, variation can be seen across the different pathways.
- Sickness and turnover rates low and appraisal rate 84%.
- Service has several vacancies which are currently being reviewed.
- Finance on plan. Currently in the process of identifying efficiency plans.
- New governance structure currently being put in place.
- Staff survey improvements in place and a dedicated wellbeing work group has started.

Dental Healthcare:

- 93% incidents low or no harm in reporting period. 1 moderate harm incident in May – wrong tooth extraction. Duty of candour followed and hot debrief took place and immediate actions put in place. 99% positive friends and family for May.
- Waiting list – Cambridgeshire and Peterborough special care dentistry – average 19 weeks; Suffolk special care dentistry – average 5 weeks; minor oral surgery – average 5 weeks
- Demand continues to outstrip capacity for dental access centres.
- Overall mandatory training 96%; appraisal levels above 98% and monthly sickness at 4%.
- Finance performance predicting reasonable assurance by year end, which includes delivery of efficiency plans.

iCaSH:

- Express test online testing incident has been successfully managed and is now closed with no harm identified.
- 100% of incidents reported in April and 98% of incidents reported in May are low or no harm. 97% for April and 96% for May positive friends and family feedback.
- Service currently undertaking a clinical review of outcomes within the syphilis pathway.
- Overall mandatory training levels 98%; appraisal compliance 97%; monthly sickness for May 5.14% which is above Trust target. All cases are being appropriately managed.
- Contractual and financial update provided. Financial update showed an improving position, however, some financial challenges remain and conversations are ongoing with relevant commissioners.
- Some key performance indicators below trajectory – Peterborough Long Acting Reversible Contraception (LARC) access target – 58.75% in May against a target of 90%; Cambridgeshire LARC access target – 62.83% in May against a target of 90%. The % for this target is under review and is likely to reduce.
- Staffing challenges in Peterborough and Cambridge. Vacancies now approved and are under recruitment.

Key escalations:

There are no formal escalations to the Group Board, however, the committee would like the Group Board to be aware of:

- Safeguarding level 3 mandatory training compliance levels remain below target in some areas – however a new method of training is currently being piloted which will offer greatly flexibility.
- Efficiency plans for 25/26.

Key risks and issues:

- **3675** – Adult Services (Luton) – TB staffing levels (rated 15) *Note: this risk was reviewed and reduced to a score of 9 on 4 June 2025.*

Good practice or innovation:

- **Bedfordshire and Luton Community Adult Services** – system working in relation to delivering the virtual ward and unscheduled care hub.
- **MSK Dynamic Health** - developed a customer services training programme. HSJ nomination for 'digitising patient care'.
- **NOW MSK Services** – team members representing the Trust at the Chartered Society of Physiotherapists Annual conference.
- **Dental Healthcare** – Oral Health team attended a multitude of events in our local areas to share good brushing habits and oral health education.
- **iCaSH** – service wide conference held in July 2025. Over 200 members of staff attended and patient involvement partner attended and led one of the workshops.

Key Matters and Escalation Report to the Group Trust Board

Name of Committee: Children & Young People's Service Assurance Committee

Chair: Anna Gill

Meeting Date: Wednesday, 02 July 2025

Key matters

- The Committee plans to have a patient or staff story at the next meeting.
- Cambridgeshire Community Services (CCS) to become the lead provider for Cambridge and Peterborough (C&P) Multi Agency Safeguarding Hub (MASH), Child Protection Medicals, and Children in Care/ Looked After Children transferring service from Cambridge and Peterborough Foundation Trust (CPFT) on 01/08/2025.
- Divisional mandatory training is reported as above 90%.
- The Mutually Agreed Resignation (MARS) scheme was discussed.

The Committee received and discussed:

- CCS Children & Young People (CYP) Integrated Governance Report provided **reasonable** assurance.
- Norfolk Community Health and Care (NCHC) CYP Integrated Governance Report with provided assurance (a different grading system is utilised).
- CCS 2024/ 25 Annual Update and Learning on Information Governance.
- CCS 2024/ 25 Annual Summary of Patient Experience.
- CCS 2024/ 25 Annual Summary of Incidents.
- CCS 2024/ 25 Annual Improvement & Transformation Report.
- CCS 2024/ 25 Annual Update on Impact Assessment.
- CCS 2024/ 25 Annual Workforce Plan.

CCS CYP Integrated Governance Report [Reasonable Assurance]:

- Detailing performance, financial, risks and issues, and workforce information, broken down by Specialist, Universal and Emotional Health and Wellbeing services.
- High demand continues to be a challenge.
- Systemwide Pan Bedfordshire MASH funding and service model review underway.
- A joint Patient Safety Incident Investigation with Bedfordshire & Peterborough 0-19 services was discussed and learning will be shared.
- The Norfolk Healthy Child Service contract review by Commissioners (current contract ends September 2026).
- The financial position was outlined in summary dashboards, along with the latest efficiency plans.

Norfolk CYP Place based Performance Report:

- NCH&C do not grade assurance according to these levels; however, the Committee were assured on the delivery of the services.
- Detailing performance, financial, risks and issues, and workforce information.
- High demand continues to be a challenge.
- Spotlights on Initial Health Assessments (IHAs) and Looked After Children- discussed seasonal variation affecting outcomes (increased demand in summer months).
- Services currently underspending due to vacancies.
- The Committee agreed that the report provided sufficient assurance.
- Lack of awareness of funding for 2025/ 26 for the Healthy Child Programme (HCP) by Service Director.
- Agenda for change 3.5% uplift not received for HCP in Luton and Norfolk, and in Norfolk particularly Speech and Language services.
- Commissioners reviewing HCP contracts – due for renewal in October 26.

Key escalations (for awareness)

- There will be a national focus on the 2.5 year HCP assessments - CYP teams in Bedfordshire and Peterborough are working with the Department of Health and Social Care (DHSC) for a spotlight on these services.
- Just One Number (JON) in Norfolk are now meeting all Key Performance Indicators (KPIs).
- The Chief Medical Office (CMO) and Chief Nursing Officer (CNO) will present at the wider leadership group meeting about Quality Impact Assessments (QIAs) and Equality Impact Assessments (EIAs) and the process.

Key risks and issues:

- NCHC director concern: awaiting update of financial budget for Norfolk HCP - discussions with the Finance team were scheduled for 09.07.2025.
- Speech and Language Therapy (SALT) in Norfolk is at risk financially, due to lack of the change in the uplift which may result in the underfunding of staff and reduction in service provision. This is for discussion with the Finance team on 08.07.2025.
- A seasonal backlog of IHAs recognised, which usually peaks in the Summer as more boats arrive at the UK at that time.

Good practice or innovation:

- Bedford Luton and Milton Keynes (BLMK) have produced a video explaining about skill mixing, to provide Ophthalmology services.
- The C&P teams produced a 'Preparing young people for adulthood' video which was co-produced with young people and system partners.
- Excellent presentation of the transformation work undertaken by CYP Transformation team – to be shared with Board members.

Key Matters and Escalation Report to the Group Trust Board

Name of Committee: Norfolk Adults Service Assurance Committee

Chair: Graham Nice

Meeting Date: 3rd July 2025

Key matters

Integrated Governance Report (IGR) key discussions:

Overall assurance rating: Reasonable

- The safeguarding Section 42 review is ongoing; this will be received by the Committee in September's meeting.
- The Committee noted the percentage increase in good and very good ratings (97%) from the Friends and Family Test.
- Pressure Ulcer work continues, with some positive outputs within inpatient units. The Pressure Ulcer Group is still reviewing actions from incidents and ensuring they link with the national Wound Care Strategy.
- A Regulation 28 has been received in relation to Pressure Ulcer care, unallocated visits and community staffing provision. A group is being convened to map the work that has been completed and identify gaps.
- Unallocated visits continue to be an issue, there is variation across the services in terms of how visits are planned and how teams work. The Chief Information Officer has visited one of the teams and has identified some duplication in the process. A plan will be developed for Community Nursing, which will encompass unallocated visits, staffing, processes, digital management, and models of care, which will be co-produced with colleagues.
- It was noted from the data and associated narrative that there are some emergent issues within Priscilla Bacon Lodge, this is linked to staffing levels and some recent patient/ carer feedback.
- Community Dietetics was identified as a growing risk, with the number of waiters increasing, against growing demand. The service is currently working through a recovery plan.
- The 2 hour performance in Urgent Community Response (UCR) has improved significantly it is currently at 77% - this exceeds the national target. The team are now reviewing their processes to see where they can streamline their response times further.
- The teams have triaged 2,600 referrals in May – which has played a large part in taking patients who are waiting for ambulance support at category 3-6. The plan moving forward would be to use the growth money to expand the community response to UC and reduce admissions to the acutes.
- The patient flow for inpatients was also discussed. Length of Stay is now static; however, it is a much-improved position on previous years. The average wait for an Intermediate Care bed is now 4.9 days, with a target of 3 days. Another improvement is linked to an increased number of patients being discharged on a Friday or over the weekend.
- The 4.9% target for absence, is not being met, the highest causes of sickness are mental ill health and muscular skeletal issues, however

the uptake of Trust resources to support these 2 conditions are underutilised. Several actions have been put in place by Human Resources to support individuals and managers with absence management.

- The Directorate is £250,000 overspent, mostly linked to the inpatient wards. There are some plans in place to meet the efficiency target, however non-recurrent savings may need to be included in this year's plans.
- Following the Information Governance Report (IGR) discussion, the Chair summarised the 'hotspots' areas which will need some further exploration and focus within the Committee:
 - Budget overspend.
 - Community Dietetic Service.
 - Waiting lists.
 - Pressure Ulcer care (at home).
 - Sickness and absence.
 - Priscilla Bacon Lodge staffing.
 - Community Nursing unallocated visits.
 - The patient cohort in Willow alongside its workforce challenges.

Transformation and innovation key discussions:

- The transition of adult learning disabilities and autism services to another organisation has now been completed.
- The reduction in waiting times for the wheelchair service continues, however it was noted that long term the cost of equipment will impact on service provision.

Financial Plan 2025/ 2026 key discussions:

- It was noted that NHS England has committed to fully fund the pay rise for NHS contracted staff.
- Moving forward this paper will be merged into the IGR.

Committee annual work plan key discussion:

The annual work plan for 2025-26 was approved, with an addition to include a review of safer staffing.

Key escalations:

There were no formal escalations from the Committee to the Trust Board. The following items are for noting only:

- Unallocated Community Nursing visits remain an issue, a plan is being developed, built on previous work – which will encompass several themes within Community Nursing e.g., staffing, unallocated visits, skill mix, models of care.

- The emergent risk linked to Dietetic Services and their increase in waiters/ waiting times.
- Financial pressures within the Directorate, i.e., overspend and plans to meet the efficiency targets.

Key risks and issues:

The Committee has six risks assigned to it, 5 risks score 12, 1 risk scores 16 – this risk is: Community Nursing Demand and Capacity (Trust wide). The Risk Register was discussed, and it was recognised that further work to triangulate the risk content, by risk owners would be needed.

Good practice or innovation:

- UCR performance, which is above the national requirements.
- Performance linked to triaging and supporting East of England Ambulance service with the category 3 – 6 patients.
- Significant improvement in the time it takes for patients to be admitted to the Intermediate Care beds, after referral.
- The improvements in friend and family feedback – 97% of the respondents in May stated the services were good/ very good.
- The work being undertaken in relation to Pressure Ulcer care within the inpatient units.
- Improved performance within the wheelchair services. meaning a reduction of people waiting for equipment.

Part Two: Balanced score cards for each division

(This section is currently under development and will be included in the next report)

Part Three - Themes across the organisations

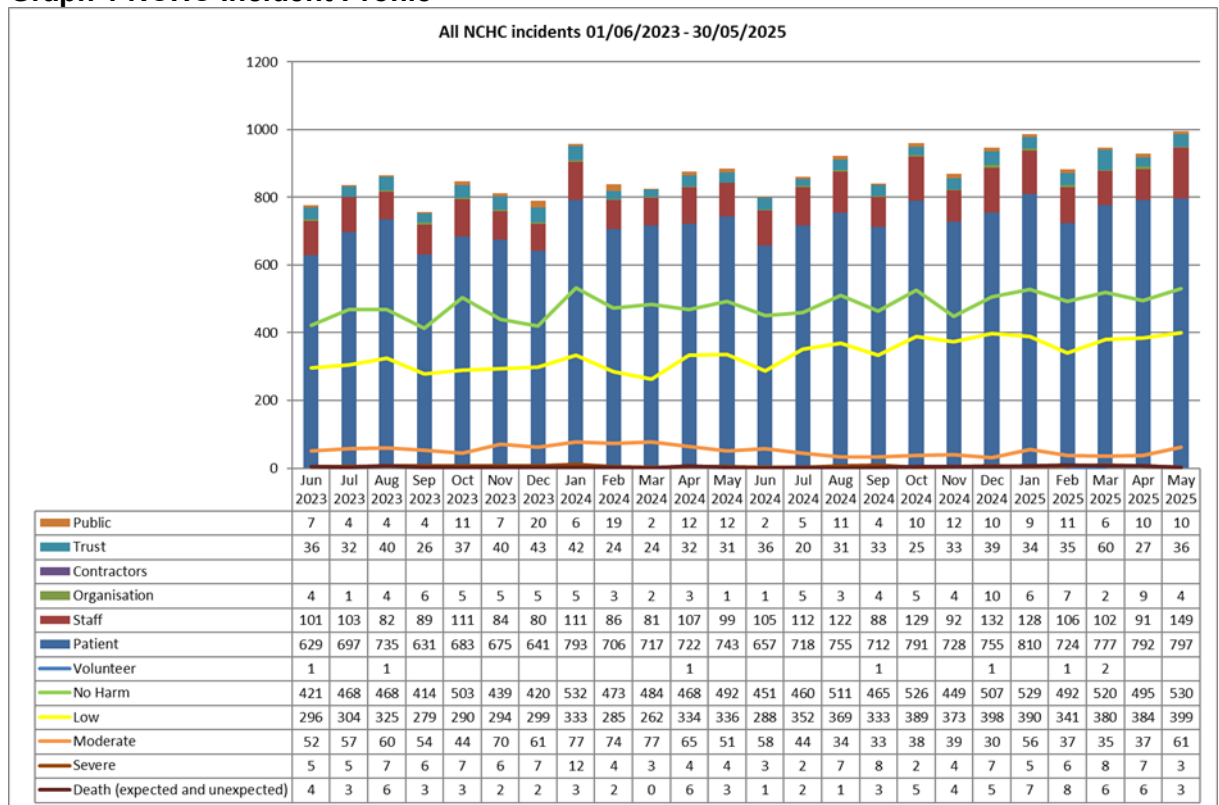
1.0 SAFE

Patient Safety Incidents are any unintended or unexpected incidents that could have or did lead to harm for one or more patient's receiving healthcare. Incidents that resulted in significant harm or had the potential to do so, are investigated using the formal Patient Safety Incident Investigation (PSII) process. This section provides an overview of reported patient safety incidents across the group during the reporting period, with a focus on the nature and severity of harm, emerging trends, and the outcomes of investigations undertaken.

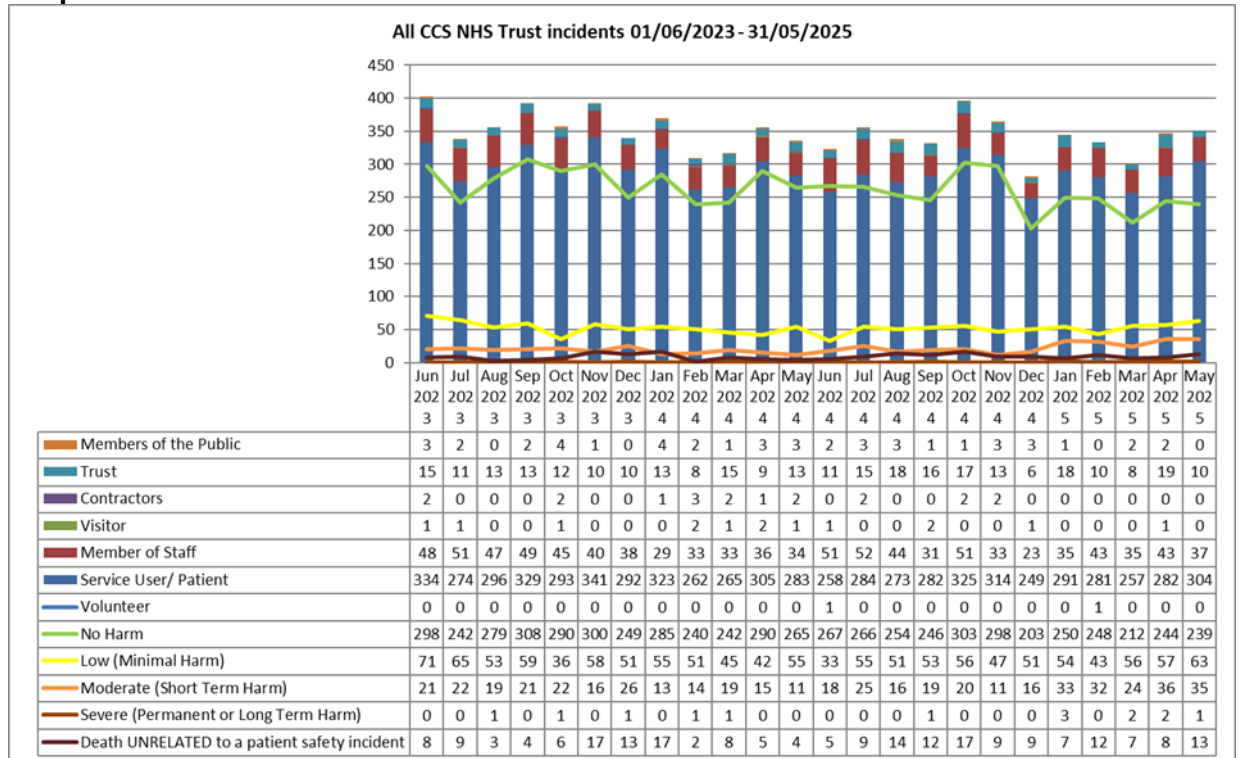
1.1 Overview of all incidents across NCHC (Norfolk Community Health and Care Trust) and CCSNHST (Cambridgeshire Community Services NHS Trust) across a two-year period.

1.1.1 The graphs shown below (graph 1 and 2) provide an overview of the incident profile for both trusts. These show a steady profile of incidents being reported, with the majority being in the no and low harm category. The volume and type of incidents is different reflecting the type and volume of patient interactions across the two trusts different portfolios.

Graph 1 NCHC Incident Profile



Graph 2 CCS Incident Profile



1.2 NCHC Patient Safety Incidents

1.2.1 Within the reporting period of April and May 2025 there were no 'Never Events' identified, and no new Patient Safety Incident Investigations (PSII) commissioned. Two PSII's continue to progress. One related to Regulation 28 actions (expected completion date September 2025), the second relates to care provided within the Learning Disabilities Team.

1.2.2 No Serious Incidents (SI's) or national PSII's were submitted for closure to the local Integrated Care Boards (ICB's) during the period. There are no overdue actions from previous PSII's outstanding.

1.2.3 In terms of Duty of Candour compliance 95.24% (20/22) of all incidents had the process completed within the required timeframes.

1.2.4 Across the 2-month period a total of 1850 Incidents were reported as follows:

- 12 severe harm incidents (0.65% of total reported incidents)
- 82 moderate harm incidents (4.4%)
- 805 low harm incidents (43.5%)
- 942 no harm incidents (50.9%)

1.2.5 No harm and low harm incidents account for 94.4% of total incidents reported.

Table 1 All incidents April and May 2025 by degree of harm

Month	No Harm	Low	Moderate	Severe	Death (expected)	Grand Total
Apr 25	462	380	37	8	6	893
May 25	480	425	45	4	3	957
Grand Total	942	805	82	12	9	1850

Severe Harm Incidents

1.2.6 There were 12 severe harm incidents reported across the reporting period.

- 9 related to a deterioration in an existing pressure ulcer (either category 3 or unstageable) to a category 4 wound. Where required and indicated After Action Reviews (AAR) have been completed and action planned at the Pressure Ulcer Learning Group.
- 1 incident related to a patient developing contractures whilst in the reablement beds, following a review of the case an AAR has been requested.
- 1 incident related to the deterioration of an existing foot ulcer. A complex case multi-disciplinary meeting has been arranged to agree the most appropriate plan of care.
- 1 safeguarding/self-neglect related to a patient within the Learning Disabilities Team and mental health services. NCHC safeguarding team is liaising with the new provider to ensure appropriate actions and follow up continues following the transfer of service.
- There were 9 expected deaths during the reporting period. One death was LeDeR (Learning from Lives and Deaths) reportable and required actions completed.

Moderate Harm Incidents

1.2.7 There were 82 moderate harm incidents reported in April and May of these:

- 29 related to development of a category 3 pressure ulcer whilst under community services.
- 26 related to patients deteriorating and requiring transfer into acute hospital from in patient areas. All of these incidents have been reviewed at the internal Learning Huddle and following discussion the harm level subsequently lowered. One incident however does require further investigation via an AAR.
- 5 are related to patient falls, 2 patients were on anticoagulants and therefore required further investigations at the acute hospital (no injuries were identified).
- 10 moderate harm incidents were patients requiring admission to acute hospital from home (following review by community services).

- 2 incidents reported following patient harm due to delays in receiving equipment. These have been raised with Medequip (equipment provider).
- 2 incidents related to concerns that NCHC teams identified in relation to the care provided to patients in residential care homes. Internal and external safeguarding referrals have been completed, and the local authorities have been notified.

1.2.8 The remaining 8 incidents were reviewed, and no themes were identified.

1.3 CCS Patient Safety Incidents

1.3.1 No Patient Safety Incident Investigations (PSII's) were commissioned in April 2025. One local PSII was commissioned in May 2025. This PSII relates to a thematic review of two incidents that identified a failure to follow the Trust faltering growth policy. The review is ongoing with an expected completion date of 30 June 2025.

1.3.2 No 'Never Events' were declared in either April or May 2025.

1.3.3 No Serious Incidents (SI's) or national PSII's were submitted for closure to the local Integrated Care Boards (ICB's) during the period.

1.3.4 Action plans on previously submitted SI's/ PSII's continue to be reviewed and support to make improvements identified from actions is provided. There is currently one overdue action relating to previous SI's/ PSII's as follows:

- Children's Dietetic Service (Cambridgeshire) – service specification to be reviewed with the ICB The Trust has met with the ICB lead who advised that a review of the pathway, which includes one of the local acute hospitals will commence in Q1 2025/26.

1.3.5 A total of eight presentations of review responses were made in April 2025 to the weekly safety huddle none of which had a safeguarding element. Twelve presentations were provided in May 2025, two of which had a safeguarding element.

Table 2

Month	No Harm	Low	Moderate	Grand Total
Apr 25	121	10	14	145
May 25	121	28	12	161
Grand Total	242	38	26	306

1.3.6 Twenty-six moderate harm incidents (whilst under the Trust's care) were reported, which is an increase of six incidents on the previous two-month period.

1.3.7 Twenty-two of these incidents were reported under the Luton Adult Service and all related to preventable wounds. The increase has been identified at the Safety Huddle and is being monitored via the Community of Practice for Preventable Wounds with monthly thematic reports being provided. The remaining incidents were reported by Beds 0-19 Service, Audiology Service, Children's Specialist Services (Cambs) and Dental Services.

- Beds 0-19, Failure to identify and escalate safeguarding concerns; an after action review is being completed.
- Audiology -Delay to diagnosis of permanent hearing loss, learning review and duty of candour completed.
- Children's Specialist Services information governance disclosure in error. Review and Duty of Candour completed.
- Dental -wrong tooth extracted – this is no longer classed as a Never Event, Hot Debrief undertaken an apology and Duty of Candour completed.

1.3.8 Moderate/high harm incidents, whilst the person is under the care of the Trust, require the application of the statutory Duty of Candour. Of the 26 moderate harm incidents reported in the 2-month period of April and May 2025, 22 have the statutory Duty of Candour completed. The remaining four incidents are under review due to the nature of the incident (safeguarding) x1, assessing the degree of harm x2 and the patient being in hospital x1.

1.3.9 One severe harm incident was reported. This relates to a missed opportunity to follow faltering growth monitoring policy and is one of the incidents referenced in the thematic PSII.

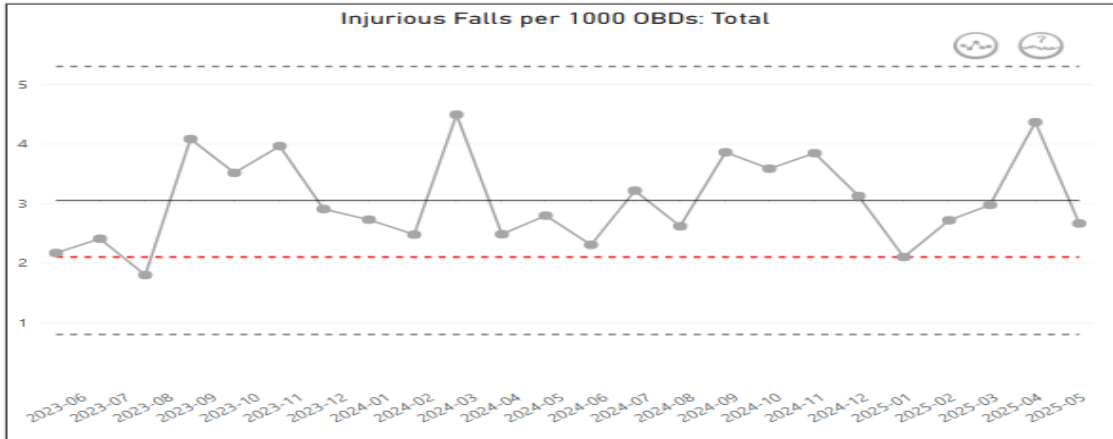
1.4 **Thematic review of specific incident categories:**

NCHC Falls incidents

1.4.1 Trust injurious falls per 1,000 OBDs remain slightly above threshold but have fallen below the mean monthly average (Statistical Process Chart – SPC - 1). Temporal analysis over the past year demonstrates all units experiencing fluctuations in falls rates which is driven by the requirement to promote activity to ensure patients are fit to move safely and reduce hospital-acquired deconditioning in a frail patient cohort. Focus will now be on:

- review and impact of the newly published NICE guidance for Falls associated to community and inpatient pathways.
- Urgent Care Falls Response, including long lie pathways and head injury management
- Collation of community falls data to support pathway redesigns with system partners

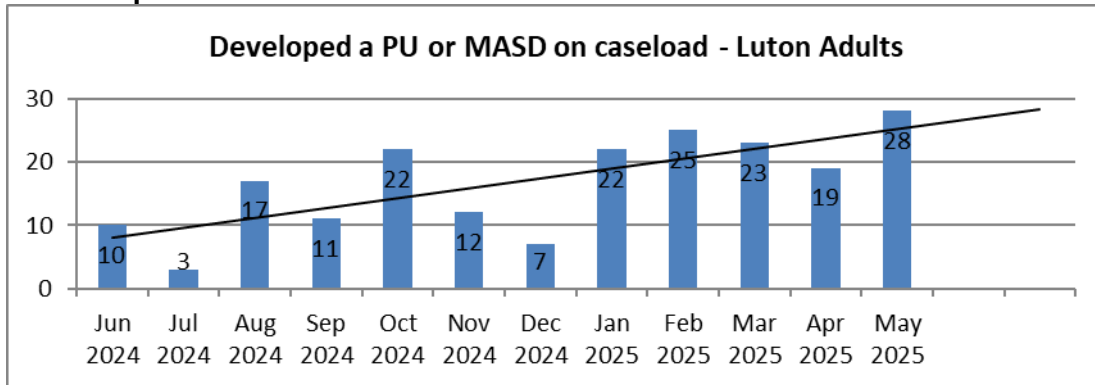
SPC Chart 1 Injurious falls



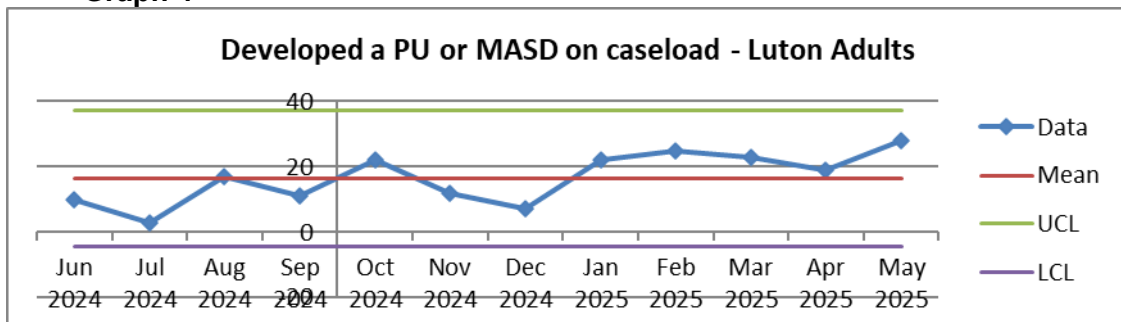
CCS NHS Trust Pressure Ulcers and Moisture Associated Skin Damage (Luton Adults)

- 1.4.2 All Pressure Ulcers and Moisture-Associated Skin Damage (MASD) are reported under the Clinical Assessment and Treatment category, both for those acquired on and off caseload. Of the reported 168 incidents, 86 related to 'developed Pressure Ulcers or MASD' with all being under the Luton Adults Service. A further 18 incidents related to patients who 'acquired a skin tear', all of which are deemed to be off caseload and are 'happened upon' incidents.
- 1.4.3 Of the Luton Adults 86 incidents, 47 (55%) was deemed to have occurred whilst the patient was on active caseload with the remainder split as follows: another Organisation 22, Domiciliary Care Agency 9, No Professional Health /Social Care input 8.
- 1.4.4 The trend for reporting of Pressure Ulcer incidents occurring for those patients on caseload has indicated a slight decrease in April (graph 3) however, the forecast is for increase reporting of such incidents. Graph 4 shows that reporting rates remain within acceptable parameters. The overall mean reporting rate per month is 16.48 per month.
- 1.4.5 The Preventable Wounds Community of Practice receive a monthly thematic review of all grades 3 and 4 Pressure Ulcers to identify emerging themes and further learning for wounds that the subject experts consider to be preventable.
- 1.4.6 A project plan is underway to implement the newly procured wound care app, with the aim of better, more accurate decision making and wound care management, by making safety, economic and efficiency improvements.

Graph 3



Graph 4



CCS NHS Trust Non-Accidental Injuries

1.4.7 Local reviews via the safety huddle and incidents identified an increase in the reporting of possible non accidental injuries to children and babies under the age of 2 years. This has led to weekly scrutiny of this data at the safety huddles, which evidenced an increase in the reporting of injuries but also demonstrated that some may also be attributable to preventable accidents. Therefore, a Trust wide workstream is in development and will be further progressed in 2025-2026 which will address our role in accidental and non-accidental injury prevention. This includes working with partners such as public health and local authorities in accident prevention strategies.

1.4.8 This trend has been reported into the relevant safeguarding meetings and to the ICB leads, as system wide evidence is also suggesting an increase in these types of injuries being seen in the acute hospitals.

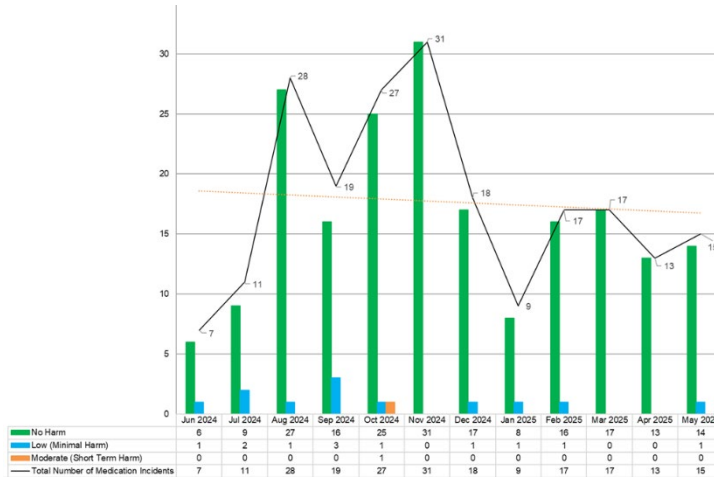
1.5 Medicines Optimisation

The Medication Safety and Governance Group (MSGG) in CCS and the Medicines Optimisation Working Group (MOWG) in NCHC ensure integrated governance arrangements are in place for medication safety across the Group and that incidents are reviewed, and actions provide a high degree of assurance of collaborative efforts to ensure outstanding care continues to be provided to service users. We encourage reporting of incidents involving medicines and the data would support that we are a high reporting, no/low harm organisation.

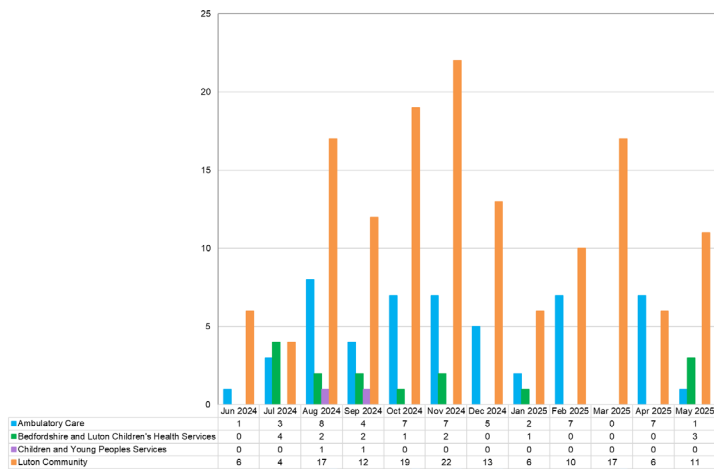
CCS Medicines incidents

1.5.1 There were 28 medicines related incidents reported during April-May 2025 (17 no harm, 1 low harm).

Graph 5: Number of Medication Incidents and Degree of Harm (June 2024- May 2025)



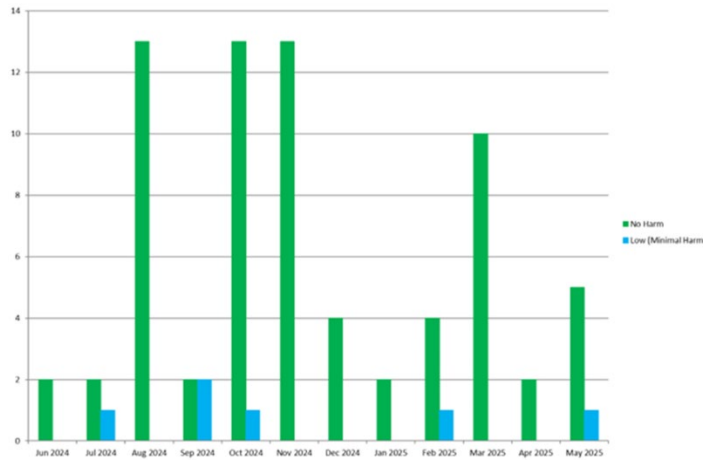
Graph 6: Total number of incidents reported by Directorate per month



1.5.2 Graph 5 shows that most incidents are of low or no harm. There were no moderate or severe harm incidents. Graph 6 shows that majority of these are with Luton Community Nursing services.

1.5.3 Medication incidents involving insulin are monitored by the Insulin Data Oversight Group and reviewed by the Clinical Leads, and at the Luton Quality and Risk Meeting. Graph 7 demonstrates an overall reduction in the number of incidents compared to the previous 2-month period.

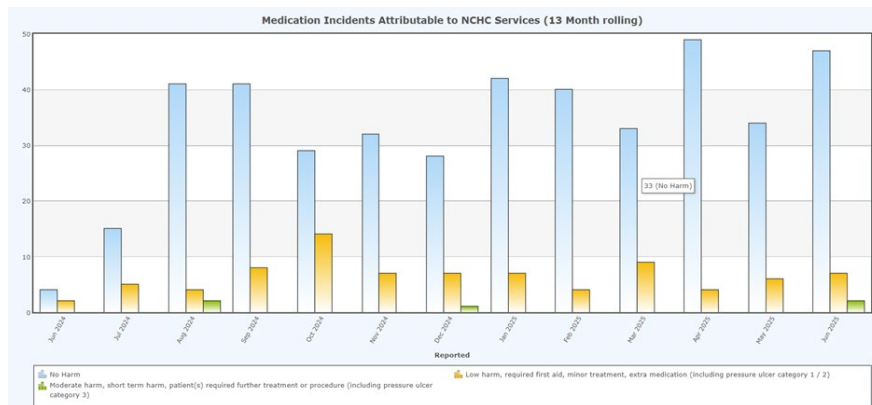
Graph 7: Number of incidents involving insulin reported under CCS care and their level of harm



NCHC Medicines Incidents

1.5.4 There were 199 medicines related incidents reported during April-May 2025 (173 no harm, 25 low harm, 1 moderate harm). Of these incidents 93 were considered attributable to NCHC (83 no harm, 10 low harm, no moderate harm).

Graph 8: Number of Medication Incidents and Degree of Harm (June 2024-May 2025)



Graph 9: Number of incidents involving insulin reported under NCHC care and their level of harm



- 1.5.5 All incidents are reviewed locally, and information is shared to identify any learning and themes through an organisation-wide learning (OWL) email.
- 1.5.6 Themes of Medicines Incidents in NCHC:
- Medicines Omitted or delayed
 - Wrong dose medication given
 - Syringe driver incidents
 - Administration of ferrinject
- 1.5.7 Incidents are also reviewed on a Trust wide basis by the Medicines Safety Officer and a medicines safety report is developed every two months, which is shared at the Medicines Optimisation Working Group.

1.6 Violence Prevention and Reduction Standard

NCHC Violence and Aggression towards staff

- 1.6.1 The Violence Prevention and Reduction Standard (VPRS) continues to be reviewed along with updates to ensure it is current with the operational needs of the Trust. The VPRS currently is at amber for compliance which means *Working toward* in the R-A-G rating. The action plan related to the standard focuses on improvements to the below criteria which will allow it to move to Green meaning *Fully meeting*.
- Resources.
 - Strategy internal and partner linking.
 - Protected Characteristics and identifying groups that may incur more of these types of incidents.
 - Objectives and Measurements - including what metrics the Trust want to report and deliver on.
 - Communication.
- 1.6.2 Due to a few reported incidents around animals where a staff member received a bite from a dog there appeared to be ambiguity on how staff should deal with this hazard. A Safe System of Work (SSOW) for animals was implemented which gives staff clear instruction on how to proceed during the initial visit to the home, subsequent visits, as well as emergency procedures. The SSOW also informs those staff members working in Single Point of Care/Triage teams to ask these questions during referral as well as reminding all staff to ensure alerts are added to SystemOne.
- 1.6.3 There were 57 Incidents reported during the reporting period under the Abuse Type heading where staff were the victim (see table 3). These totals include incidents that occurred on NCHC sites and within a community setting.

Table 3 Number of incidents by abuse type for two months

Category	Total
Bullying	2
Other	2
Physical Assault	15
Physical Outburst	1

Racial Harassment	5
Racial Outburst	1
Sexual Harassment	9
Verbal Abuse	19
Verbal Outburst	3
Total	57

CCS NHS Trust Violence and Aggression towards Staff Incidents

1.6.4 Table 4 below shows reporting themes for the last two months financial years and number of cases.

1.6.5 A full review of violent and aggressive incidents from this year has been completed and will be reported to the Health and Safety Group in Quarter 2 of 2025/26.

Table 4

Category	Total
Physical Assault	4
Sexual Harassment/assault	1
Unacceptable behaviour	9
Verbal Abuse	13
Total	27

1.6.6 Initiatives to encourage staff to report these incidents include when an incident is logged on Datix, the team/ individual gets an email from the Patient Safety team offering support and signposting to the Professional Advocate clinicians, additionally an email is also sent from either the Chief Nurse or Deputy Chief Executive specifically to understand how the member of staff(s) is and to see what further help could be provided.

1.6.7 Support includes, specific counselling and de-brief sessions, safety plan development and where appropriate access to legal advice.

1.6.8 The violence prevention reduction standard has been completed and has been scored as being 'amber' a joint meeting is being held in July between CCS and NCHC, with union colleagues, to develop a comprehensive action plan for this piece of work.

1.7 National Patient Safety Alerts (NatPSA)

1.7.1 There were no NatPSA alerts received in this reporting period which were applicable to either CCS or NCHC.

1.8 Safer Staffing

NCHC Safer Staffing: Inpatient Units

- 1.8.1 Care Hours Per Patient Per Day (CHPPD) indicates the difference between patient demand (from acuity and dependency) and the available staffing in the inpatient teams. NCHC has implemented refreshed metrics and ratings in late 2024 and is promoting consistent adoption to ensure dependable scoring outputs (table 5 and 6). In future reports this data will be provided in a 12-month rolling heat map enabling trends between wards and months to be highlighted.
- 1.8.2 CHPPD is higher in the specialist units reflecting the lower patient to staff ratios set in establishments. The rehabilitation wards experience greater challenges in maintaining required CHPPD due to higher fluctuations in demand, including for enhanced care needs.
- 1.8.3 The NCHC Safer Staffing Escalation Group assesses and prioritise staffing daily to minimise impact of staffing shortfalls by effective utilisation of staff across all units, helping ensure the maintenance of safe staffing levels and reducing temporary staffing costs.
- 1.8.4 Care Support Worker (CSW) vacancies remain the area of most significant recruitment and retention challenge. Work is under way to develop new pathways to both attract and retain this staffing group and ensure that the correct support and skill training is available early in their recruitment journey.
- 1.8.5 For noting the current headroom for clinical staff is undergoing a benchmarking exercise to ensure it is set at the correct level to enable establishments to meet demand.
- 1.8.6 The tables below show the outcomes of one of the tools used to review safer staffing, they are several other ways that staffing is evaluated and challenged daily – this includes the safer staffing meeting (which is held every morning), the confirm and challenge conversations with ward leaders and also the professional judgment conversations between the wards to move staff, think about acuity and understand and share risk. Additionally support from the peripatetic team can be utilised where patients need more 121 care and treatment.

Table 5

Month	Apr-25		
Unit	Actual CHPPD	Required CHPPD	Actual RN to Patient Ratio
Generalist Wards			
Alder Ward	5.90	7.17	1:9

Pineheath Ward	5.44	7.75	1:8
Swaffham Hospital	5.81	7.78	1:8
Foxley Ward	6.24	7.91	1:9
North Walsham	6.53	7.87	1:8
Ogden Court	6.29	10.51	1:9
Specialist Wards			
Beech Ward	7.13	6.95	1:11
Caroline House	9.68	11.08	1:6
PBL	8.21	7.08	1:6
Pine Cottage	6.16	4.79	1:8

Table 6

Month May-25

Unit	Actual CHPPD	Required CHPPD	Actual RN to Patient Ratio
Generalist Wards			
Alder Ward	6.10	7.89	1:10
Pineheath Ward	6.06	7.96	1:9
Swaffham Hospital	6.27	7.45	1:8
Foxley Ward	6.87	8.00	1:9
North Walsham	5.44	7.41	1:9
Ogden Court	6.77	10.86	1:8
Specialist Wards			
Beech Ward	8.31	6.63	1:11
Caroline House	9.78	9.61	1:6
PBL	8.20	7.37	1:7
Pine Cottage	6.37	4.76	1:8

1.9 CCS and NCHC Safeguarding

- 1.9.1 The Trust Board is being given 'substantial level' assurance against the NHS England.
- 1.9.2 Safeguarding Accountability & Assurance Framework 2024 that CCS has effective safeguarding arrangements in place which seek to protect children and adults from harm caused by abuse or neglect occurring regardless of their circumstance.
- 1.9.3 The Trust Board is being given 'Reasonable' assurance that NCHC is meeting their responsibilities in line with the NHS England Safeguarding

Accountability Assurance Framework 2024. It is noted as 'Reasonable Assurance' due to NCHC not currently delivering adult safeguarding supervision in line with the Adults revised Intercollegiate Document (2024). There is a risk on the Trust Register that relates to this gap, and a pilot of safeguarding adult sessions have been carried out, with a view to rolling this out once a mapping process has been undertaken.

- 1.9.4 Safeguarding training compliance target is set at 90% for all levels (1,2 &3). A review of level 3 safeguarding training has been undertaken with a new model being piloted within CCS, this new approach will help support increased compliance.

Table 7 Safeguarding Adults Compliance

Adult Safeguarding Training	April 2025	May 2025
CCS		
Level 1 Mandatory for all staff	98%	98%
NCHC		
Level 1	97%	97%
CCS		
Level 2 - Mandatory for all clinical and nonclinical staff in regular contact with parents, children and young people	98%	98%
NCHC		
Level 2	93%	93%
CCS		
Level 3 - Mandatory for all staff predominantly working with children, young people and adults	88% ↓	89% ↓
NCHC		
Level 3	84% ↓	83% ↓

Table 8 Safeguarding Children Compliance

Children's Safeguarding Training	April 2025	May 2025
CCS		
Level 1 Mandatory for all staff	98%	98%
NCHC		
Level 1	96%	96%
CCS		
Level 2 - Mandatory for all clinical and nonclinical staff in regular contact with parents, children and young people	98%	98%
NCHC		
Level 2	93%	93%
CCS		
Level 3 - Mandatory for all staff predominantly working with children, young people and adults	89% ↓	91%
NCHC		
Level 3	87% ↓	85% ↓

- 1.9.5 NCHC typically reports Safeguarding Children Supervision data on a quarterly basis rather than monthly, the supervision year commences from January to December. Currently the compliance figures for NCHC sit at 74% for April and May.
- 1.9.6 Staff who are identified as non-compliant have already been emailed directly alongside their line managers to ensure support of attendance. The Head of Safeguarding will review compliance at the end of Q1 to ensure target has been achieved.
- 1.9.7 Safeguarding children supervision is offered to staff as both formal (mandated) and informal opportunities within which they can reflect on their practice and to consider case management within the multi-agency context. The staff who are expected to access formal safeguarding supervision, are within children's services such as health visiting, school nursing, children's community nursing, community children's specialist services and Community Paediatrics (for NCHC) and the compliance with this offer is tracked and reported through the clinical and operational safeguarding groups in each area. Robust processes are in place to support staff with their compliance for the mandated supervision offer, which includes direct liaison with service leads to ensure that they can work with staff to enable their attendance.
- 1.9.8 NCHC safeguarding supervision compliance is monitored by the Children's Quality Matron. The Head of Safeguarding and the Quality Matron are currently reviewing the supervision and monitoring processes within NCHC and will meet with CCS Assistant Director of Safeguarding and Head of Safeguarding to ensure safeguarding reporting is aligned.
- 1.9.9 The Intercollegiate Document for Adults has been updated in 2024; this includes an expectation that supervision and reflective discussions are available to all staff working with adults at risk and families. Reflective/restorative safeguarding sessions are available to staff in

Integrated Contraception and Sexual Health (iCaSH) and adult services as needed, and CCS Adult services in Luton are now being offered formal safeguarding supervision. NCHC offer joint adult and children supervision to Wheelchair services and in Q1 have piloted an adult focused safeguarding supervision session for staff working in Adult Respite services, this was very well received by the staff.

- 1.9.10 The data captured within Table 9 (below) refers to the total amount of safeguarding referrals made by CCS and NCHC staff in relation to patient care, as there is a low conversion rate from number of referrals made to number of referrals progressed by CCS in April and May and a lower rate of conversion in May for NCHC, work is being started to understand why the numbers being progressed are low and whether there are issues with the quality of the referrals being made.

Table 9 Adult Safeguarding Referrals and Section 42 Enquiries

April 2025	By CCS	By NCHC
Referrals to Adult Social Care	25	19
Safeguarding Referrals progressed to Section 42	2	21 Including from other referrers
Safeguarding Referrals Identifying Possible Organisational Abuse	0	10
Organisational Abuse Substantiated	0	0
Number of Outcomes awaited	8	8
Number of Escalations	24	2

May 2025	By CCS	By NCHC
Referrals to Adult Social Care	30	18
Safeguarding Referrals progressed to Section 42	5	3
Safeguarding Referrals Identifying Possible Organisational Abuse	0	0
Organisational Abuse Substantiated	0	0
Number of Outcomes awaited	14	7
Number of Escalations	2	1

1.10 Infection Prevention and Control (IPaC)

The National Infection Prevention and Control (IPaC) board assurance framework (BAF) is issued by NHS England for use by organisations to enable them to respond using an evidence-based approach to maintain the safety of patients, services users, staff and others.

NCHC IPAC Board Assurance Framework

- 1.10.1 The board can take assurance that the IPaC BAF is regularly updated and monitored with input from all relevant subject matter experts. There is one area of non-compliance outstanding. The area in question:

The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.

- 1.10.2 Following discussions with the Head of Medicines Management, NCHC will be fully compliant across all 10 criteria of the BAF by 31st July 2025.

CCS IPAC Board Assurance Framework

- 1.10.3 The board can take assurance that the CCS IPaC BAF is regularly updated and monitored with input from all relevant subject matter experts. There are two area of non-compliance outstanding, these are actions that CCS have limited influence over, due to external factors. These are:

- *The Trust is awaiting the formal annual ventilation reports and action plans from the specialist contractors for the Podiatry department at the Oak Tree Centre and the Endoscopy department at the North Cambridgeshire Hospital. Once received and the identified remedial works have been actioned, the criteria will then become compliant.*
- *The UKHSA Laboratory service in Cambridge confirmed that there is a project plan and timelines in place to resubmit application for accreditation either at the end of 2025 or at the beginning of 2026.*

National Mandatory Surveillance

- 1.10.4 As part of the national mandatory surveillance, both CCS and NCHC supports all relevant local investigations to identify if staff have had any involvement with patients who have tested positive for the following:

- MRSA (Methicillin-Resistant Staphylococcus Aureus) bacteraemia.
- MSSA (Methicillin-Sensitive Staphylococcus Aureus) bacteraemia.
- Extended Spectrum Beta – Lactamase (ESBL) bacteraemia.
- Clostridioides difficile (previously identified as Clostridium Difficile) infections.

This is so we can learn lessons and share best practice across the system.

- 1.10.5 Both Trusts has 0 cases of any of those listed above.
- 1.10.6 CCS was notified of two laboratory-confirmed Mpox cases during this reporting period from different iCaSH services, following discussions with the UKHSA (UK Health Security Agency) it is not thought the two cases are linked. Following the incidents, the Trust's Mpox standard operating procedure was updated whilst awaiting updated national guidance.

1.11 IPAC Audit standards

Hand Hygiene

- 1.11.1 All clinical staff are required to be assessed on their hand decontamination techniques in line with both the Trust's Infection Prevention and Control Policies. The compliance target is 90%.

- CCS currently 87%
- NCHC currently 79%

- 1.11.2 For CCS staff who are non-compliant are being targeted via their manager and individually, further UV kits have been bought to support the Muscular Skeletal teams to improve their compliance, and colleagues et the opportunity to complete their assessment off the back of some face to face mandatory training courses.
- 1.11.3 For NCHC the data represents the staff observation audit based on selected clinical areas. The main gaps identified relate to compliance to the organisation's uniform policy, areas of non-compliance are discussed with colleagues at team meetings, with the IPaC link Champions and within the IPaC Committee.

2.0 CARING

2.1 NCHC Patient Experience

Friends and Family Test (FFT)

- 2.1.1 In March 2025 fifty FFT paper questionnaires were sent across to all Trust services. This was to support with the external provider ceasing their contract with Norfolk Community Health and Care (NCHC) and the transition across to a new provider. This has seen a sustained increase in the volume of FFT responses. It is recognised that whilst there is an increase in response rate, this remains low in comparison to volume of FFT questionnaires shared. The Lived Experience Team are actively engaging with patients, carers and the public at sites across the Trust, to improve compliance and target those from the seldom heard groups. Through the Patient and Carer Experience and Inclusion Group (PCEI) FFT data will be triangulated with complaints and reported incidents and take actions to embed learning and improvement.

Table 10 April 2025 FFT Data

	% Positive	% Negative	% Neither good nor poor	Total FFT Responses
Community Inpatient Services	90%	2%	8%	49
Community Nursing Services	98%	1%	1%	112
Rehabilitation and Therapy Services	94%	1%	5%	249
Specialist Services	96%	0%	4%	25
Children and Family Services	100%	0%	0%	18
Community Healthcare - Other	88%	0%	12%	52
Trust-wide	89%	1%	10%	505

Table 11 May 2025 FFT Data

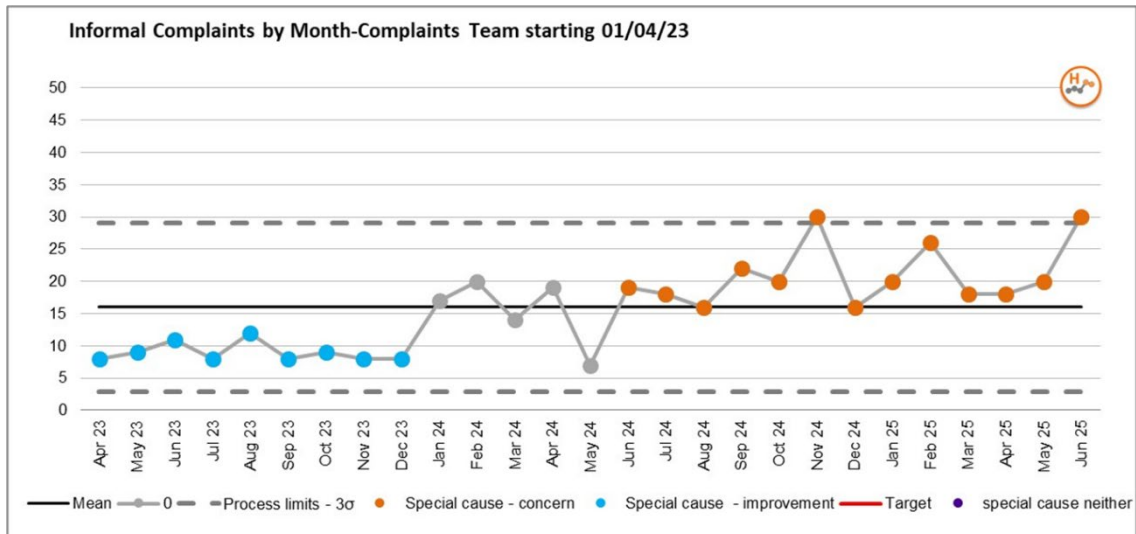
	% Positive	% Negative	% Neither good nor poor	Total FFT Responses
Community Inpatient Services	86%	2%	12%	51
Community Nursing Services	99%	0%	1%	192
Rehabilitation and Therapy Services	100%	0%	0%	103
Specialist Services	86%	5%	9%	22
Children and Family Services	100%	0%	0%	18
Community Healthcare - Other	92%	0%	8%	27
Trust-wide	97%	0.48%	3%	413

Complaints

Informal Complaints

- 2.1.2 There was a total of 38 locally resolved, informal complaints across April and May. Initial contact and response were within the Trust timeframe of three working days, and no informal complaints were escalated to a formal complaint.
- 2.1.3 The prominent themes of concern related to NCHC ceasing care at Mill Lodge and community nursing services communication with patients, particularly listening to patient concerns and/or preference of need.

SPC Chart 2



- 2.1.4 Special cause variation is seen for informal complaints due to a recorded increase in this area. It is acknowledged that the increase could be reflective of the demand on community nursing being greater than staffing provision; with rescheduling of visits without communication to patients and/or carers as the main concern. This is a recognised Trust-wide risk with controls in place to reduce the risk of patient harm and improve service delivery.
- 2.1.5 The decision for NCHC to not continue care provision to Mill Lodge from 1st October 2025 is recognised as the other cause for the increase of informal complaints. Parents and carers have raised concerns regarding service provision from 1st October 2025, whilst making it clear that they have no concerns about the current quality of clinical care delivery. NCHC have been working with Norfolk and Waveney ICB to ensure communication is shared. A dedicated ICB email has been created to enable parents and carers to send concerns and queries for service provision after 30th September 2025. As a result of this no further complaints of this subject have been raised with NCHC.

Learning from Informal Complaints

- 2.1.6 Compassion fatigue and communication e-learning training has been shared with Place Senior Leaders, with recommendations for community staff to complete. Work is in progress to triangulate data from After

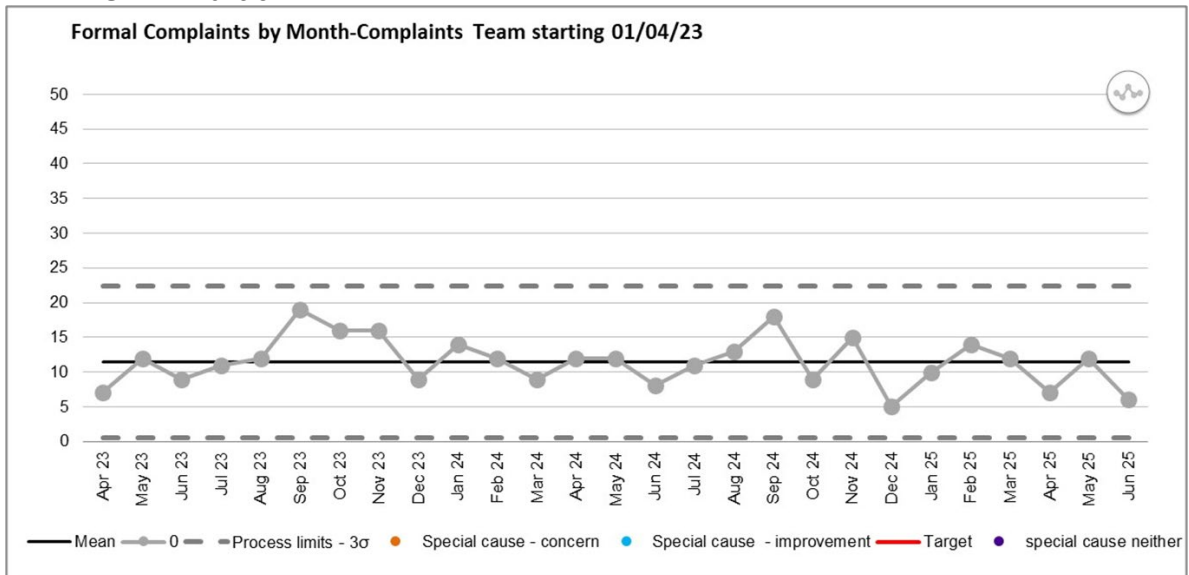
Action Reviews where communication improvements are identified, complaints monitoring and staff feedback. Following this an action plan will be developed to support with embedding communication improvements across the Trust and improving patient and carer experience.

Formal Complaints

2.1.7 Eighteen formal complaints were received in April and May. Initial contact with all complainants were made within one working day of the complaint being received, with a mixture of telephone and email complaints being received. There were no breaches in the final response deadline, with one holding letter sent to enable further Place review.

2.1.8 Two themes of complaint were prominent, one of the strands has been identified earlier in the section and links to communication with patients, when community nursing visits need to be rescheduled.

SPC Chart 3



2.1.9 Formal complaints remain below the Trust threshold in month, with the main theme being nursing care delivery and appropriate escalation to system partners. NCHC Quality Matrons are working with clinicians to monitor, advise, and improve care delivery. Learning hubs, place quality assurance measures and Learning Huddle enables further support of this.

Comments/ Compliments

2.1.10 In April and May, the services received 184 positive comments across the Trust, an increase of 12 since the last reporting period. NCHC received over 3 positive comments for every complaint (formal and informal).

2.2 CCS Patient Experience

Friends and Family Test (FFT)

2.2.1 The Friends and Family Test provides the opportunity for service users, parents and carers to provide feedback on their experience of care. A range of methods are available to ensure that providing feedback is accessible and meets service users' needs.

2.2.2 The Trust received 2753 responses in April and 2502 in May. This is over 600 fewer than the previous two-month period. Below is a summary since October 2024.

Table 12

	Oct	Nov	Dec	Jan	Feb	March	April	May	Total
Trust Overall	3230	3442	2144	2932	2686	3194	2753	2502	22883

2.2.3 The overall Trust FFT positive feedback was 94.44%, with a 1.6% negative feedback percentage. Norfolk and Waveney Children's and Young People's Service 'good and very good' FFT score was below Trust target. Review of the data shows that this is because there were a significant number of neutral responses ('neither good nor poor' or 'Don't Know') within the Mental Health Support Teams (MHST) which detract from the positive FFT score.

2.2.4 Work has continued to gain assurance that these responses accurately reflect the feedback from the young people and are not because of any processes in collecting and inputting the feedback.

2.2.5 The comments related to the poor and very poor scores are reviewed and followed up with the services each month by the Co-production Lead.

Table 13

	% Positive	% Negative	Total FFT Responses	Contacts	Response Rate
Ambulatory Care	96.99%	1.60%	2690	33695	7.98%
Bedfordshire and Luton Children and Young People's Service	96.90%	1.64%	548	40752	1.34%
Bedfordshire and Luton Adults Community Service	96.75%	0.34%	585	29392	1.99%
Cambridgeshire and Peterborough Children and Young People's Service	91.84%	3.06%	392	30778	1.27%
Norfolk and Waveney Children and Young People's Service	86.25%	1.73%	1040	33851	3.07%
Trustwide	94.44%	1.60%	5255	168468	3.12%

2.2.6 All surveys with the FFT question also ask to what extent the service user felt that they were treated with respect and dignity. 5024 service users answered this question and a score for each directorate is shown below.

Table 14

	Respect and Dignity Score
Ambulatory Care	96.87%
Bedfordshire and Luton Children and Young People’s Service	97.48%
Bedfordshire and Luton Adults Community Service	94.06%
Cambridgeshire and Peterborough Children and Young People’s Service	96.83%
Norfolk and Waveney Children and Young People’s Service	87.28%
Trustwide	94.59%

Comments/ Compliments

2.2.7 In April and May, the services we provide received 7759 positive comments across the Trust, this is 291 fewer than the last reporting period. We received over 96 positive comments for every complaint (formal and informal).

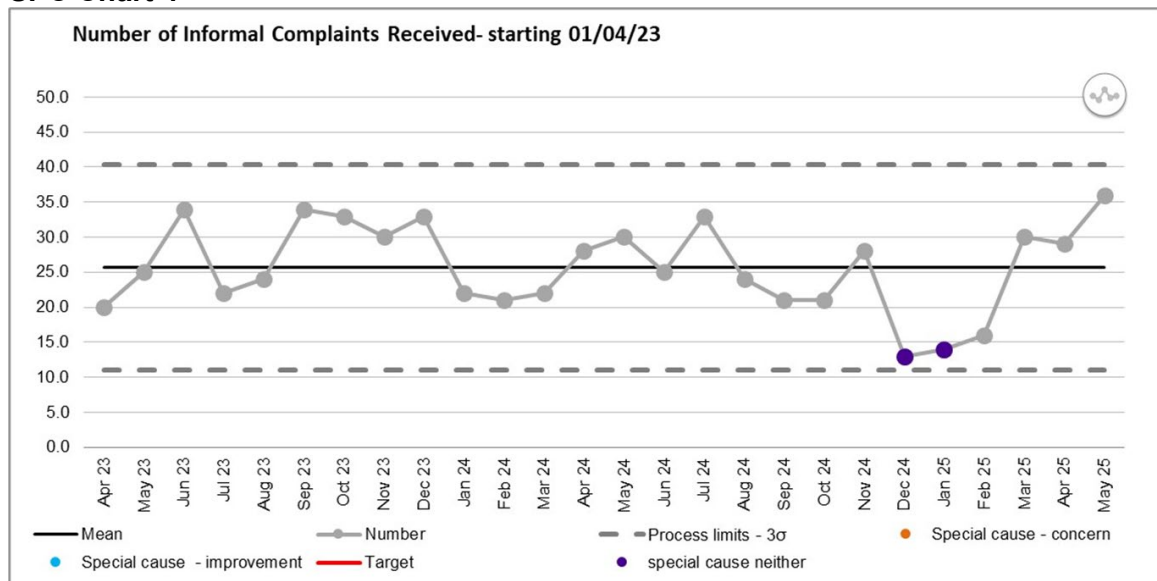
Complaints

2.2.8 There were 65 informal complaints, and 15 formal complaints received in April and May. There were 168,518 contacts which equates to one formal complaint for every 11,234 contacts and one informal for every 2592 contacts.

Informal complaints received

2.2.9 The Trust received 65 informal complaints in this data period: 29 in April and 36 in May. Both months were within the expected variation. The chart below shows that the number of informal complaints received in April and May was above average.

SPC Chart 4



2.2.10 Sixty two of the 64 applicable complainants were contacted within four working days to discuss resolution of their concerns. One complaint was

made via and managed by the GP so it was not appropriate for the PALS team or clinical service to make direct contact. Two other complainants were contacted on days 9 and 11, the delay was because services did not let the complaints team know the issues had been received.

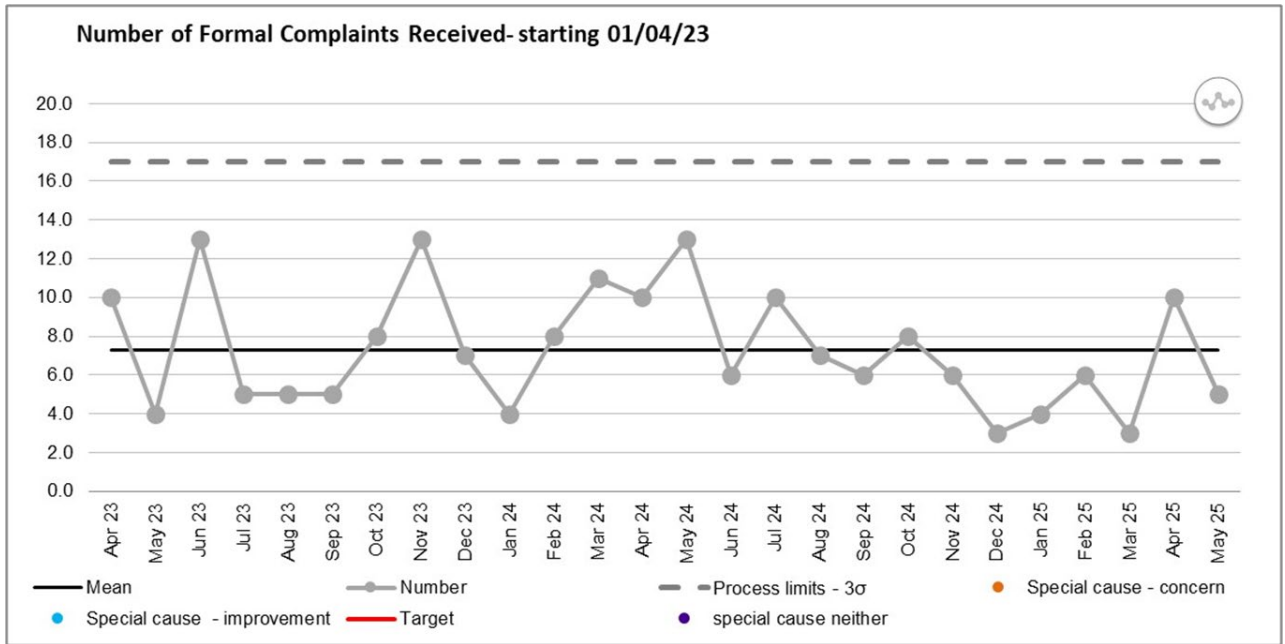
Themes from informal complaints closed in April and May

- 2.2.11 Sixty-three informal complaints were resolved and closed in April and May with 78 subjects issues identified.
- 2.2.12 The top three themes of the informal complaints closed within this period were:
- Communication and Information (24)
 - Clinical Care (17)
 - Delays (16)
- 2.2.13 In terms of trends in the services involved in complaints there were six issues about Communication and Information in relation to DynamicHealth Services; two were from the same complainant. There were four relating to Community Paediatric in Cambridgeshire, two from the same complainant.
- 2.2.14 The Dynamic Health Service was the most frequently involved in complaints about clinical care with five, however none of these were upheld.
- 2.2.15 Fourteen of the 16 issues related to Delays, were about Community Paediatric Services, six in Luton, five in Cambridgeshire and three in Bedfordshire.

Formal Complaints Received

- 2.2.16 The Trust received 15 formal complaints in this data period, five in April and ten in May. As shown below, this is within the expected variation.

SPC Chart 5



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

Themes from formal complaints closed in April and May 2025

- 2.2.17 Within this data period the Trust responded to and closed nine formal complaints. In these there were 17 subjects identified.
- 2.2.18 Clinical Care was the most frequently occurring subject with seven issues identified in seven complaints. Communication and Information was identified as an issue five times in five complaints. The other subjects were with Administration (2), Staff Attitude (2) and Delays (1).
- 2.2.19 Six services were named in the formal complaints responded to in April and May. There were no themes in the services involved. Four services in Luton Adult’s Services were involved in complaints, two iCaSH Cambridgeshire and two DynamicHealth.

Formal Complaint Response Times

2.2.20 In this data period, the Trust responded to nine formal complaints (four in April and five in May). A summary of the response times is shown below.

Table 15

	February	March	April	May
Number of standard complaint responses sent within a 35-day timeframe.	3/3	4/5	3/4	2/3
Percentage of standard complaint responses sent within the 35-day timeframe.	100%	80%	75%	67%
Number of complex complaint responses sent within the 40-day timeframe.	0/1	1/1	0/0	2/2
Percentage of complex complaint responses sent within the 40-day	0%	100%	N/A	100%

timeframe.				
Average number of working days to respond to standard complaints.	31	29	34	34
Average number of working days to respond to complex complaints.	72	35	N/A	28

2.2.21 The percentage of standard complaint responses sent within the 35 working day timeframes decreased in April and May. Two standard complaint responses were sent outside of 35 days due to the complexity of the investigation.

Member of Parliament (MP) Contacts

2.2.22 In this period there were seven contacts received via an MP. One enquiry about iCaSH testing kits, five informal complaints, of which four were about waiting times for Community Paediatrics, and one formal complaint about incorrect information provided by iCaSH services.

Supporting Services with Correspondence - With Service Users

2.2.23 One letter of expectation was sent for Dental Services, and one was a duty of candour template letter for preventable wounds.

3.0 EFFECTIVE

3.1 Insight from our staff:

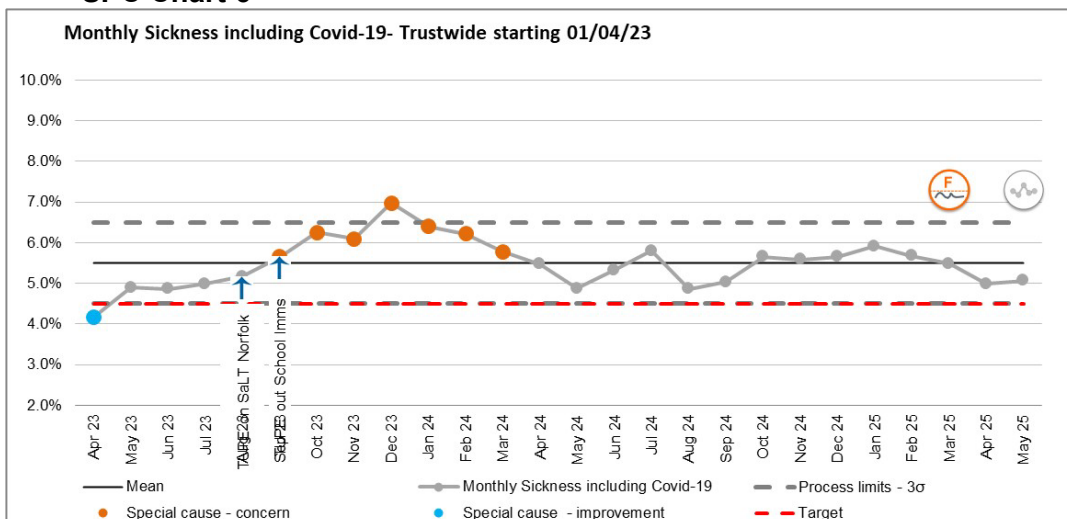
- NHS National Staff Survey 2024. CCS achieved a 61% response rate. Headline results were:
 - Best performing or joint best performing Community Trust Nationally in 8 of the 9 People Promise themes/areas. Majority improved from 2023 results.
- NHS National Staff Survey 2024. NCHC achieved a 67% response rate. Healthline results were:
 - Slightly above average results in 6 of the 9 People Promise themes/areas. 2 areas rated average and 1 slightly below average. Majority declined from 2023 results.

3.2 Sickness rates in the workforce:

CCS

- 3.2.1 The 12-month cumulative rolling rate (April 2025 – 5.40%, May 2025 – 5.38%) remains above the Trust rolling target of 4.5%.
- 3.2.2 Monthly Trust wide rate for April 2025 was 4.99% and for May 2025 was 5.07%.
- 3.2.3 The Trust wide sickness rate has 2.81% was attributed to long term sickness and 2.26 % short term sickness absence. Beds & Luton had the highest sickness rate (6.27%) and Support Services the lowest (3.76%). The top reason **Cold, Cough, Flu - Influenza (18.99%)**; work continues to reduce those absences attributed to unknown/other reasons as much as possible.
- 3.2.4 The Trust monthly sickness rate is below the January 2025 benchmark reported for NHS Community Trusts (source: NHS Digital Workforce Statistics) which was 6.2 %.

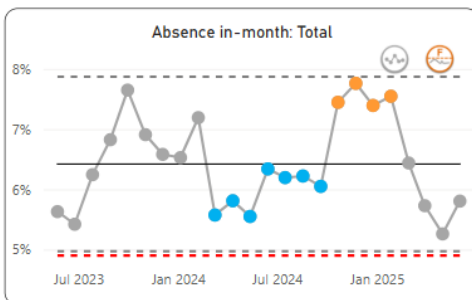
SPC Chart 6



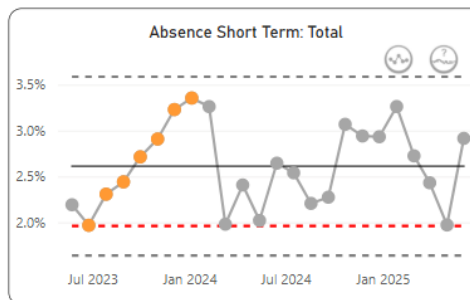
NCHC

- 3.2.5 The 12-month rolling rate (April 2025 – 5.76%, May 2025 – 5.79%) remains above the Trust target of 4.9%.
- 3.2.6 Monthly Trust wide rate for April 2025 was 4.89% and for May 2025 was 5.14%.
- 3.2.7 The Trust wide sickness rate has 3.42% attributed to long term sickness and 2.37 % short term sickness. Norwich Place had the highest sickness rate (7.28%) and Support Services the lowest (3.20%). The reason of **Anxiety/stress/depression/other psychiatric illnesses** accounts for 28.40% of time lost due to sickness.

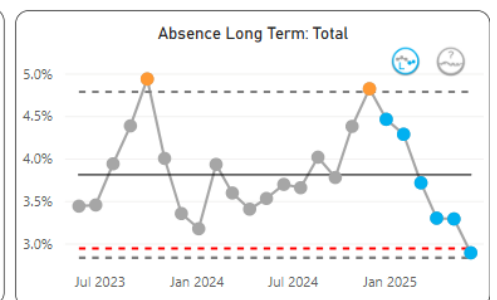
SPC Chart 7



SPC Chart 8



SPC Chart 9

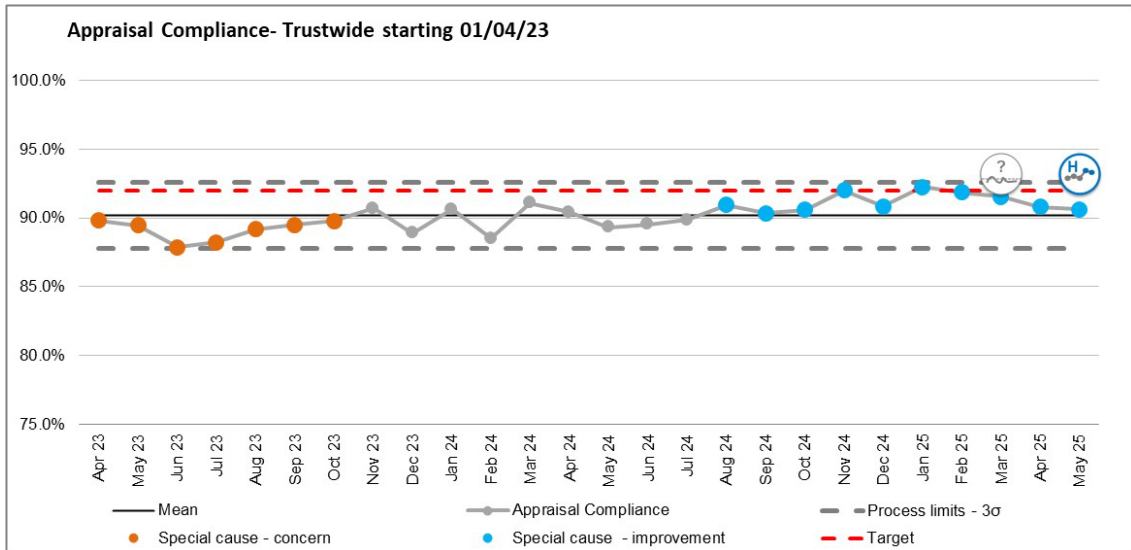


3.3 Appraisal rates across the workforce

CCS

- 3.3.1 The following chart 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.
- 3.3.2 The Trust wide Appraisal rate decreased in April 2025 – 90.79 % and May 2025 – 90.63%, against a target of 92%.
- 3.3.3 Support Services has the lowest rate (77.93%), Ambulatory Care has the highest rate (96.12%). 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.

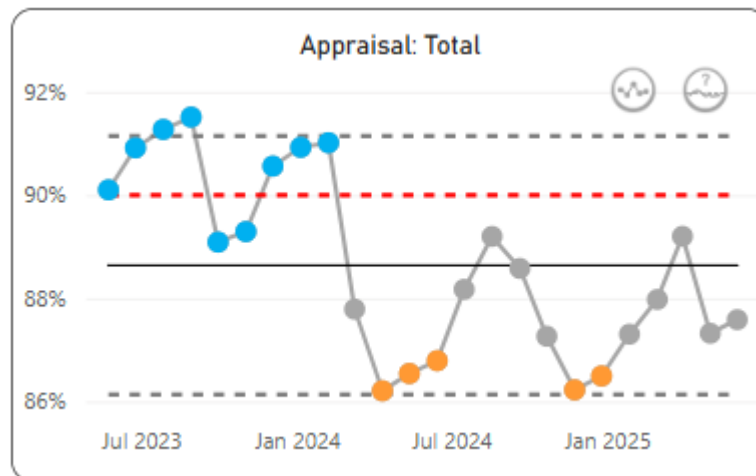
SPC Chart 10



NCHC

3.3.4 The following chart shows the percentage of eligible staff who have completed an appraisal within the last 12 months of services. Staff on long term sickness, maternity, internal secondments are included (the Trust target of 90% gives a 10% leeway for any of these staff unable to complete an appraisal). Staff on career Break, suspension and new starters within their first 12 months of services are excluded.

SPC Chart 11



3.3.5 The Trust wide Appraisal rate continues to fall slightly under target of 90%, April 2025 – 87.65%, May 2025 – 87.19%.

3.3.6 West place has the lowest rate (79.50%), Norwich place has the highest rate (92.58%).

3.4 Turnover rates across the workforce

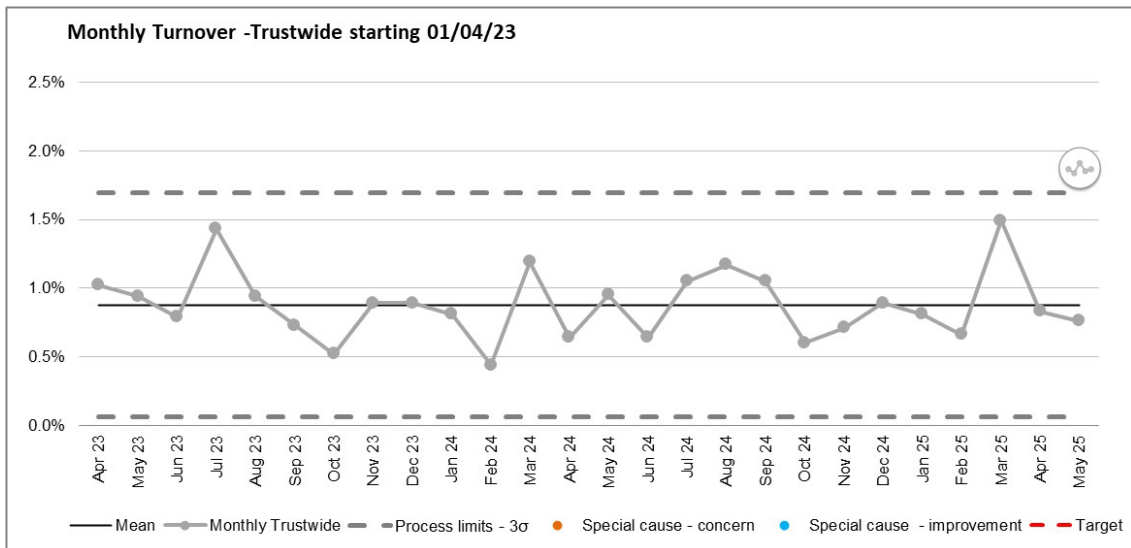
CCS

3.4.1 The following chart shows monthly turnover rates for CCS which are based on the “Permanent” workforce (i.e., those employed on a current fixed term contract of less than one year are excluded). Leavers for the following reasons are also excluded: end of a fixed term contract and employee transfers.

3.4.2 Rolling year turnover rate is currently 10.96% (April 2025 – 11.09%, May 2025 – 10.96%) compared to an annual average Leaver rate for Community Provider Trusts of 11.9% (Source: NHS Digital Workforce Statistics – January 2025, based on “all Leavers” and “total Workforce”).

3.4.3 Luton Children currently has the highest rolling year turnover rate at 12.10%, with Beds & Support Services having the lowest at 8.11%.

SPC Chart 12



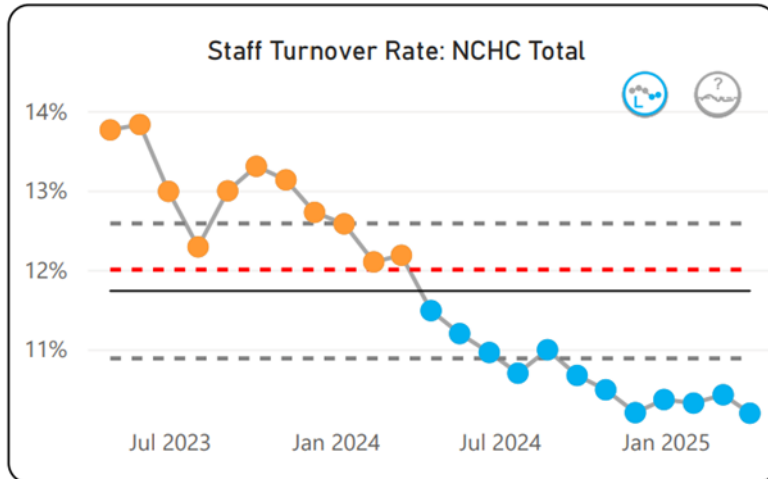
NCHC

3.4.4 The following chart shows the rolling 12 month rolling turnover rates for the Trust. Both permanent and fixed term staff are included. voluntary turnover includes all voluntary reasons and retirements.

3.4.5 NCHC rolling year turnover rate is currently 9.69%, which sits below the Trust wide target of 12%.

3.4.6 Norwich place has the highest rate at 11.43%, with West Place having the lowest at 6.80%.

SPC Chart 13



4.0 RESPONSIVE

4.1 Referral to Treatment (RTT) / Waiting Times

Children and Young People's Specialist Services

Cambridgeshire Community Paediatrics

- 4.1.1 Waiting times continue to increase for school aged Neurodevelopmental Disorder (NDD) referrals, with circa 350 children waiting longer than 65 weeks at the end of May 2025. The longest current wait is 109 weeks. The management of year 6 children from 2024 is to be a 50/50 split with the local mental health provider, but the management of the current year 6 children (300 children) has not yet been agreed by the ICB. As previously reported, the Board actions to assure that patients are waiting well are replaced.

Cambridge Audiology Service

- 4.1.2 Regular meetings with ICB and NHS England continue. The PASQAT Audiology NHSE site report has been received and distributed. An action plan is being formulated.

- 4.1.3 Waiting times have increased due to reduced capacity. The longest new referral waits are 32 weeks, clinical oversight and management of the waiting list is already in place. Harm review processes will be commenced in June 25 across audiology services, as needed.

Cambridgeshire Dietetics

- 4.1.4 The pressures in the service continue, there are currently 575 children on the waiting list, with 40 children waiting over 1 year, all referrals are clinically triaged. For the HEF (Home Enteral Feeding) pathway in Peterborough, the team has over established to mitigate the clinical risks, but this creates a significant financial cost pressure. The first ICB led system discussion has now taken place to review the dietetic pathway which spans the acute services and the Trust.

Bedfordshire and Luton Community Paediatric Services

- 4.1.5 In Bedfordshire there are 1840 RTT Children waiting and a total of 2752 children waiting to see a Paediatrician. In Luton there are 1777 RTT children waiting and a total of 2392 children waiting to see a Paediatrician. In Bedfordshire and Luton RTT clocks stop when a child has started their care pathway, this maybe through support from our early intervention team, a nurse led intervention or confirmation our early support workshop has been accessed.

- 4.1.6 All Children are clinically triaged weekly with no backlog at present. Whilst waiting to see a Paediatrician a number of resources have been developed. Positive feedback from parents and carers suggest good effectiveness.

Bedfordshire and Luton Audiology
4.1.7 The number of children waiting over 52 weeks is gradually reducing following increased clinical capacity, choose and book processes and a range of change ideas monitored weekly for effectiveness. All children waiting are risk assessed and prioritised accordingly. There is a national shortage of clinical supervisors available to sign off Audiologists through the Higher Training Scheme (HTS), issue 3662. The service is working with our Cambridge Audiology team to increase supervisor capacity within the system.

Bedfordshire and Luton Community Eyes
4.1.8 During the reporting period we have continued to experience capacity and demand challenges within the service. A full review of services delivered has taken place with a QIA/EIA completed, focused on prioritising delivery. From May 2025 the service will no longer provide eye tests to children with a suspected mild vision loss at school screening. This cohort are low risk patients who have alternative pathways to high street opticians for a free eye test and glasses via NHS vouchers.

Norfolk & Waveney (NCHC) Children's Services

18-week RTT

4.1.9 Under performance is driven by NDS, a **7.2%** 18-week RTT rate in May.

Consultant Led 18-week RTT

4.1.10 Children's Consultant Outpatients has missed the 92% 18-week RTT target since Jun-23. However, over the last six months, the caseload has reduced by **957** (21.2%) and 18-week compliance is on an upward trend.

4.1.11 **181** 18-week breaches in May (71.1%). There were **two** 52-week breaches recorded last month. After investigation, these were not genuine waits, they were both data quality issues and the SystemOne patient records have been updated to reflect this.

4.1.12 To meet the 18-week RTT, a maximum caseload of 3,250 is required. This is forecast to happen in Dec-25.

Over 30-week waiters

4.1.13 **3,910** – all but **81** (Community Paediatricians) are attributable to NDS. There are **36** Community Paediatric patients in the West waiting over 30-weeks who do not yet have an appointment booked.

4.1.14 **Four** CYP have waited over 40-weeks, two of which have DNA'd two appointments, and two patients are awaiting specific Neuro disability clinics. There is one child that has waited over 52 weeks which is a data quality issue, not a genuine waiting time and the SystemOne patient record has been updated to reflect this.

Ambulatory

CCS MSK (Muscular Skeletal)

4.1.15 **18-Week RTT Consultant-Led Compliance:**

By March 2025, compliance had risen to 81.62%, followed by further improvements in April and May 2025, reaching 88.65%. Although still below the peak performance seen in early 2024, this upward trend suggests positive progress toward restoring service timeliness and meeting patient access targets. The service continues to focus on the improvement plans to push the trend upwards.

4.1.16 **Over 30-Week Waiters:**

Since February, the numbers have been on a downward trajectory, 131 in April, and 85 in May 2025. This represents a 52% reduction from the February peak and signals encouraging progress in addressing long-waiting patients.

4.1.17 **Over 52-Week Consultant-Led Waiters:**

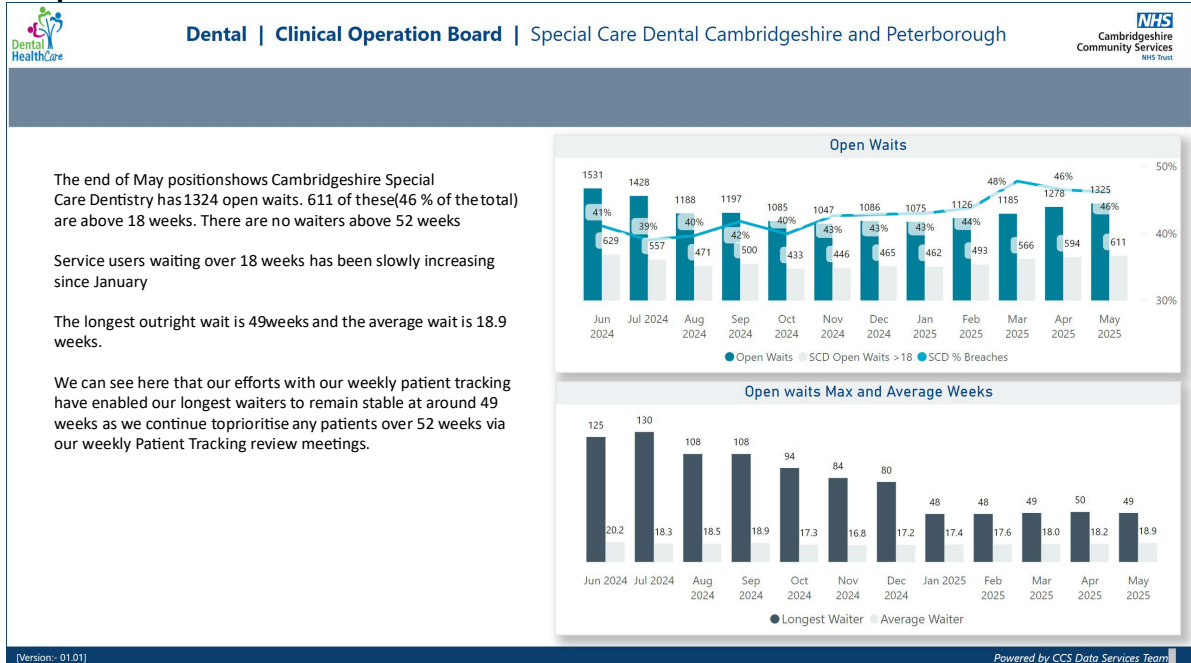
Over the past year, the number of patients waiting more than 52 weeks for consultant-led care has remained low, with counts typically being reported as 1 per month. There was 1 patient in April and 2 in May 2025 reported, however both patients waiting over 52 weeks in May were from the MSK Assessment and Triage service, and this has since been resolved.

4.1.18 Median waits rose to 8.6 weeks in April and climbed further to 9.7 weeks in May 2025. The May 2025 breakdown highlights considerable variation across services. While some services maintained relatively short waits (such as MSK Assessment and Triage West (2.4 weeks) and Occupational Therapy/Hand Therapy (7.2 weeks)) others experienced significantly longer delays. MSK Physiotherapy and MSK Assessment and Triage reported median waits of 9.7 and 10.9 weeks, respectively, aligning closely with the overall median.

4.1.19 More challenging are the high waits seen in MSK Biomechanics (25 weeks) and MSK Podiatry (43.9 weeks), which have substantially affected the overall figures for the service. These outliers indicate specific capacity or pathway issues within these services that may require targeted intervention to reduce delays and improve access equity across the MSK pathway. The service is focused on identifying improvement that could positively impact these waits.

4.1.20 **Cambridge and Peterborough (C&P) Special Care Dentistry**
With the 18-week waiters having increased and open waits in general increasing the service are initiating a Task and Finish group to focus on discharging patients in C&P that, by virtue of the fact have been with the service for many years, could be seen in a general dental practice. This group is starting in June and will work collaboratively with commissioning colleagues and co-production/PALS to minimise the challenges presented by the lack of NHS dentists in some of the areas the Trust serves.

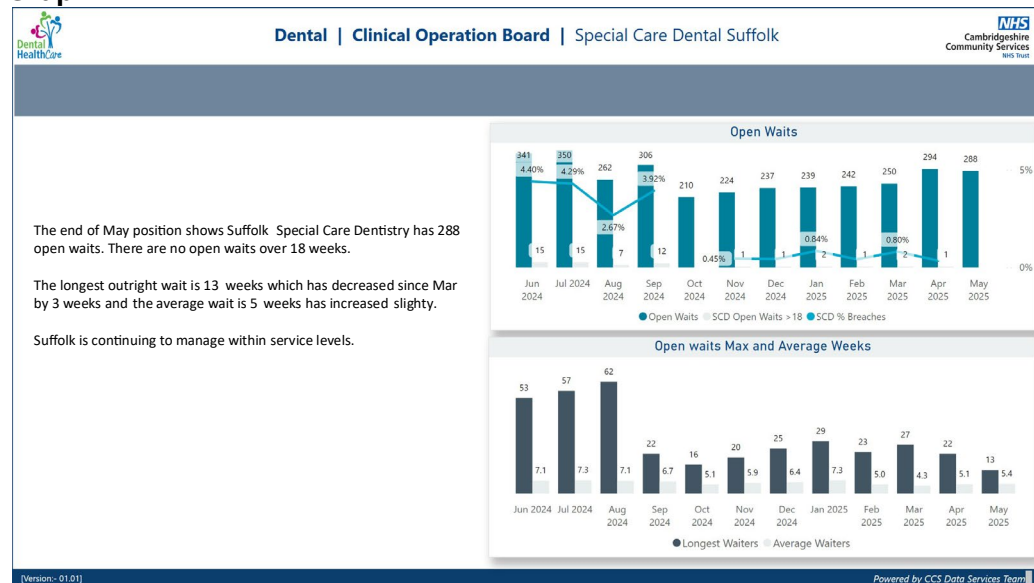
Graph 10



Suffolk Special Care Dentistry

- 4.1.21 Suffolk activity remains consistent with no waits over 18 weeks, and an average wait of 5 weeks.

Graph 11



Minor Oral Surgery

- 4.1.22 The General Anaesthetic (GA) lists for Peterborough, Huntingdon and Wisbech have all patients pre booked with waiting times of 3 weeks due to a change in anaesthetics acceptance criteria resulting in less children being appropriate to be seen on this GA list.
- 4.1.23 Cambridge patients requiring a GA are listed for GA at West Suffolk Hospital (WSH). Patients are being assessed to determine need with urgent cases being prioritised and all remaining waiting patients now

having an appointment booked within the next 14 weeks. The team anticipate that towards the end of quarter 3 they should be working within service levels having completed the backlog which has been a result of theatre capacity changes

- 4.1.24 Suffolk Patients having GA's at West Suffolk Hospital are within service level being booked from 3 weeks which is a three-week improvement compared to last report and well within service level targets.

Dental Access in C&P – urgent dental care (DAC)

- 4.1.25 The service has established an internal target for C&P that accounts for the current vacancies, to effectively measure our performance against actual workforce numbers for the year. Currently, the team are working at full capacity based on workforce actuals and are confident they will meet the year-end internal target, assuming staffing levels remain consistent.

- 4.1.26 The Internal annual target (patient contacts) is 8190 per annum and the service has achieved 1774 contacts in the first 2 months of this year.

iCASH (Integrated Contraception and Sexual Health) Service

- 4.1.27 LARC (Long Action Reversible Contraception): There are no patients on current waiting lists, as at report submission. A one-stop implant model has been agreed in Reproductive Health workstream, which is leading standardisation of service delivery across iCaSH.

- 4.1.28 There are no waiting lists for HIV PrEP (Pre-Exposure Prophylaxis) or LARC.

NCHC Norfolk Adults Services RTT

- 4.1.29 The data for NCHC Norfolk Adult Services in May 2025 identifies 28 services with 1 or more patients waiting for 18+ weeks. Table 16 provides six months of comparable data for the 5 services with the highest cumulative level of patients waiting over 18, 30 and 52 weeks as reported in May 2025.

Table 16

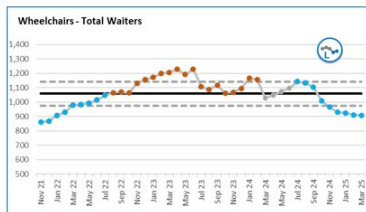
Service	18-30 Week Waiters			30-52 Week Waiters			52+ Week Waiters			Grand Total		
	Jan 25	Mar 25	May 25	Jan 25	Mar 25	May 25	Jan 25	Mar 25	May 25	Jan 25	Mar 25	May 25
Wheelchair Provision	226	158	133	203	247	203	104	101	95	533	506	431
Pulmonary Rehabilitation	13	133	20	0	0	90	0	0	0	13	133	110
Community Dietetics	106	99	72	5	8	10	0	0	0	111	107	82
Wheelchair Repair Service	14	17	13	7	4	5	6	4	4	27	25	22
Speech and Language Community (Central)	4	6	22	0	0	0	0	0	0	4	6	22
Totals	363	413	205	215	259	308	110	105	99	688	777	667

4.1.30 Further narrative and detail to highlight mitigation in place to address and reduce the waiting times and waiting safely actions are provided for the three services, Wheelchair Provision, Pulmonary Rehabilitation and Community Dietetics, which have the highest total cumulative 18+ week waiting times in May 2025.

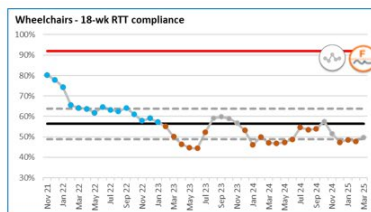
Wheelchair Provision

4.1.31 The Wheelchair Provision Service has the highest number of patients waiting to be seen of all NCHC Norfolk Adult services; 133 18-30 week waiters, 203 30-52 week waiters and 95 52+ week waiters, giving a total of 431 18+ week waiters. Chart 6 below demonstrates the waiting list trajectory to March 2025.

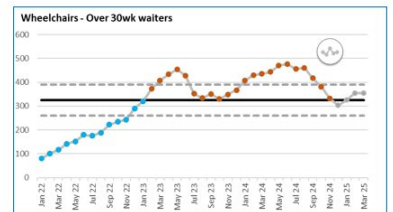
SPC Chart 14



SPC Chart 15

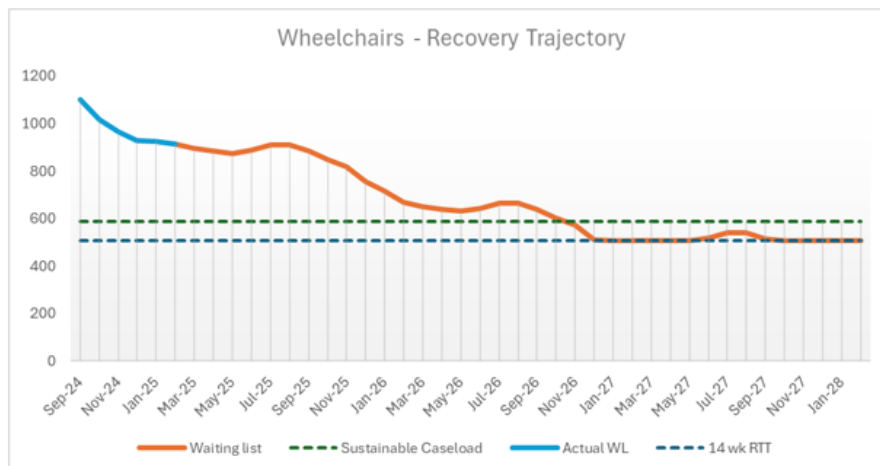


SPC Chart 16



4.1.32 Whilst waiting list numbers remain high, the service is in a positive trajectory with mitigation and plans in place to continue this improvement. The recovery trajectory (as shown in chart 7) forecasts the service returning to a sustainable caseload (505) by October 2026. There would then be an additional 3 months required to meet the target of a 14 week RTT.

SPC Chart 17



Date to reach sustainable	Oct-26
Date to reach 14wk RTT	Jan-27

Mitigation and Actions:

4.1.33 Mitigation and actions for this service have been in place since 2024/25 and have demonstrated effective reductions in waiting times. Key actions are detailed below.

Direct Issue Model Implementation

- Direct issue is the process applied to non-complex patients, at a very low risk in terms of posture, who have been referred to the service who require a basic chair. Based on the patient's measurements (provided by the patient) a chair is prescribed without the need for a face-to-face assessment. The chair is ordered and then delivered directly to the patient's home. The wheelchair repair technician will set the chair up and ensure that the chair meets the need of the patient.
- The direct issue model is fully implemented and active, with new referrals processed through a triage tool that allocates patients to the appropriate caseload. There has been a steady increase in demand identified as appropriate for direct issue as the team have become accustomed to the new way of working.
- A 'chair in a day' model has been utilised for direct issue, which enables patients to be measured and receive equipment in the same day.
- Collaboration with the Children's Services OT team is ongoing, aimed at enhancing coordinated care efforts. In-house training has been successfully completed to support this initiative.

Asset Database Utilisation

- The service is utilising the asset database to monitor medical devices, ensuring regulatory compliance and improving service efficiency.

- The service is performing regular data quality audits to enhance overall compliance.

Waiting safely actions:

4.1.34 In line with waiting safely quality standards 1-5 the team:

- Manage the current high caseload, the service continues to prioritise patients based on medical need.
- Two staff members have been specifically allocated to focus on long-waiting patients.

Pulmonary Rehabilitation

4.1.35 The community dietetics service has the second highest number of patients waiting to be seen; 20 18-30 week waiters and 90 30-52 week waiters, giving a total of 110 18+ week waiters. There are currently no patients waiting over 52 weeks.

4.1.36 The total number of 18+ week waiters is decreasing, however there was an increase in waiters from January 2025 (13) to May 2025 (110). There was a significant increase in 18-30 week waiters between January 2025 (13) to March 2025 (133) and by May 2025 this has significantly reduced to 20. There were no 30-52 week waiters prior to May 2025 where there were 90, indicating that those patients had moved into a 30+ week wait.

4.1.37 The increased waits are due to the Trust securing a tender for delivery of West pulmonary rehabilitation services, which included the transfer of a large waiting list. The service moved over to NCHC on 1st October 2024, with a transition period of mobilisation until 1st January 2025. The existing resource did not allow recovery of the back log, this has been escalated to the ICB who are providing additional funding to enable the reduction of the waiting list. There is a mitigation and action plan in place with trajectory. The Central and West services are reviewing the service model to ensure equity across Norfolk and to ensure the reduced wait times can be sustained once achieved.

Mitigation and Actions:

- An agreed investment of £170,000 over two years will double the capacity of Central and West teams to meet targeted 12 week wait times. Investment will be focussed on Band 6, Band 4 and venue hire.
- A trajectory from the start of the investment of 23 weeks to achieve the 12 week target is in place.
- The service has developed a programme to align with Norfolk and Waveney ICS Service Specification for pulmonary rehabilitation, including British Thoracic Society (BTS) guidelines.
- The service has developed and enhanced pathways with key stakeholders such as Respiratory/Oxygen team, Primary Care, Post Covid Assessment Service team.
- Patient involvement and co-production in service design and evaluation.
- All new staff attended BTS training and enhanced first aid training
- Created education sessions that are patient focussed to maximise patient interaction.

- Two patients now volunteer with the service to support patient evaluation, peer support and additional support tasks.

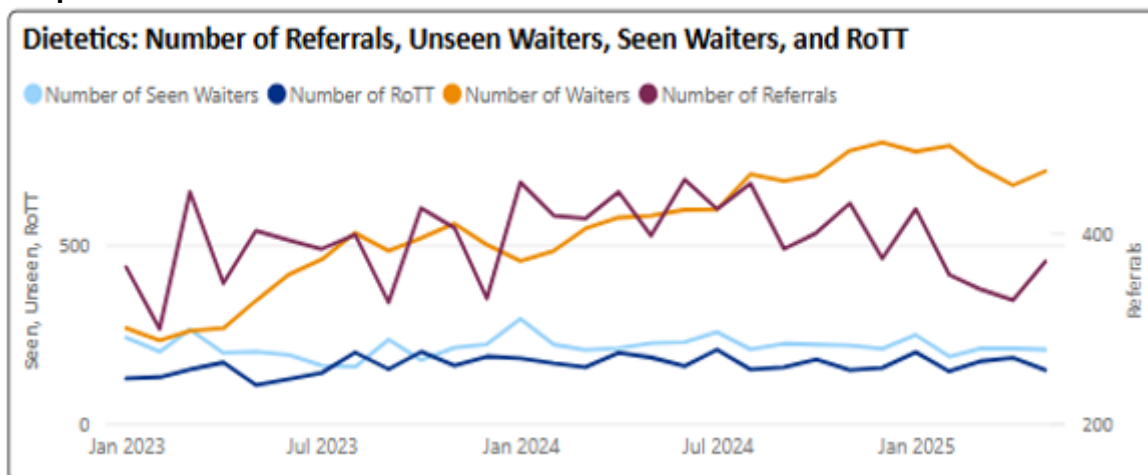
Waiting safely actions:

- 1.4.38 In March 2025 the West leadership group reviewed the service against the waiting safely standards. Compliance with quality standards 1-5 assessed as good with identified areas of focus for additional improvement in time to triage required.
- 1.4.39 In line with quality standard 7 the team direct patients to <https://www.norfolkcommunityhealthandcare.nhs.uk/pulmonary-rehabilitation>. A revised website is under development to provide an enhanced level of guidance under this standard.

Community Dietetics

- 1.4.40 The community dietetics service has the third highest number of patients waiting to be seen; 72 18-30 week waiters and 10 30-52 week waiters, giving a total of 82 18+ week waiters. There are currently no patients waiting over 52 weeks.
- 1.4.41 The 18-week RTT compliance issue is mainly affecting the General Community Dietetics Team, which provides Dietetic service to patients over the age of 16 registered with a GP practice in the central Norfolk Primary Care Network (PCN) area, North Norfolk, Norwich and South Norfolk PCN. Team covers population of 634,700 patients.
- 1.4.42 The service is in a positive trajectory with mitigation and plans in place to continue this improvement. With current referral levels, the service has capacity to meet demand and slowly recover the 700+ total waiter’s (below and above 18 weeks wait) position. Internal productivity and efficiency actions will continue to be reviewed and developed to support the delivery of the service and reduce waiting times. Referral numbers have reduced since 2024, any significant upward trend on this metric would challenge recovery plans.

Graph 12



Mitigation and Actions:

- Quality improvement care home pilot project aimed to enable more effective dietetic care to be delivered in the community. Outcomes include decreased waiting times for assessment, increasingly efficient assessment and optimisation of skill mix.
- Dietetic group sessions for IBS (irritable bowel syndrome) and Coeliac disease management implemented. Evaluation indicates that group intervention is time and cost-effective for this patient group.
- Better use of technology, utilising telephone, video and face to face consultations.
- SystemOne ledgers have been redesigned for individual clinicians with a weekly review to ensure that all available appointments are being utilised.
- Pilot to utilise Band 4's more efficiently to undertake basic nutritional assessment. Enabling determination of complexity (using validated complexity tool), provide first line dietary advice/supplements, where indicated, to provide more timely intervention for at risk patients.
- Demand and capacity model completed.

Waiting safely actions:

- 1.4.43 The service keeps patients safe by ensuring continuous review and changes to the service are completed regularly. To date the service has developed clear triage guidance, clear acceptance criteria, and adapted service provision in line with waiting safely quality statements 1-5.
- 1.4.44 In accordance with waiting safely quality standard 7 the team provide information related to dietary conditions which can be safely implemented before dietary assessment.
- 1.4.45 In accordance with waiting safely quality standard 7 the team provide information related to dietary conditions which can be safely implemented before dietary assessment.

5.0 Well led

5.1 Ability to raise concerns:

Freedom to Speak Up Mandatory Training

5.1.1 All staff complete 'Speak Up' Mandatory Training when they join each Trust. Core training is essential for all employees and covers what speaking up is and why it matters. It helps our workforce understand how to speak up and what to expect when they do. The annual target is 90% and CCS achieved 99% compliance in May and NCHC achieved 95.33%.

5.1.2 Both organisations have a Freedom to Speak Up Guardian, Freedom to Speak Up Executive Lead and Freedom to Speak Up Non-Executive Lead in place and several Freedom to Speak Up Champions.

5.1.3 NCHC Freedom to Speak Up policy has been updated and is now in line with national policy.

5.2 Finance

Table 17 NCH&C Metrics

				Assurance levels (N4)			
Finance Board level indicators				2025/26 Variance to plan as at Month 2			
	Plan	Actual	Variance	Substantial Assurance	Reasonable Assurance	Partial Assurance	No Assurance
£'000	YTD	YTD	YTD				
Total Financial Performance							
N1 Revenue financial performance	(589)	(587)	2	0%			
N2 Capital financial performance			-	0%			
Efficiencies							
Recurrent	155	265	110	71%			
Non-Recurrent	457	438	(20)			(4%)	
Total Efficiencies	612	702	90	15%			
Temporary staffing expenditure							
Agency spend	(202)	(42)	160	79%			
Bank spend	(735)	(960)	(225)				(31%)
N3 Total temporary staffing expenditure	(937)	(1,002)	(65)				(7%)
Cash Balance							
As at month end	39,973	42,088	2,115	5%			
Combined assurance level:						Partial assurance	

Table 18 CCS Metrics

Finance Board level indicators	Plan	Actual	Variance	Assurance levels (N4)			
				2025/26 Variance to plan as at Month 2			
£'000	YTD	YTD	YTD	Substantial Assurance	Reasonable Assurance	Partial Assurance	No Assurance
Total Financial Performance							
Revenue financial performance	-	-	-	0%			
Capital financial performance	599	585	(14)	0%			
Efficiencies							
Recurrent	882	982	100	25%			
Non-Recurrent	404	504	100	11%			
Total Efficiencies	1,286	1,486	200	16%			
Temporary staffing expenditure							
Agency spend	260	162	(98)	38%			
Bank spend	242	260	18				7%
Total temporary staffing expenditure	502	422	(80)				
Cash Balance							
As at month end	7,053	2,181	(4,872)				69%
				Combined assurance		Partial assurance	

Metric Notes

N1 Adjusted financial performance as monitored by NHSE for REVENUE

N2 Total capital expenditure as tracked internally by the Trust - a combination of CDEL, Donated and Centrally funded asset expenditure

N3 30% & 10% NHS E reduction in Agency & Bank respectively is built into NCHC Plan but not CCS plan - separate commentary to be provided

N4 Assurance levels are presented for in grey above and the parameters below for information only at this stage, these are currently under consideration by Trust management.

Table 19

Parameters for Assurance Level assessment	H1: YTD Variance to plan H2: FOT Variance to plan			
	Substantial Assurance	Reasonable Assurance	Partial Assurance	No Assurance
Actual performance YTD (H1) Projected forecast overrun (H2) Capital Expenditure always based on FOT	Favourable to plan or on plan	Up to 2.5% adverse variance to plan	2.5% - 5% adverse variance to plan	>5% adverse variance to plan
Combined assessment for overall rating*	4 or more domains at substantial assurance AND none at no assurance	4 or more domains in substantial or reasonable assurance AND non at no assurance	5 or more domains in partial assurance AND up to 1 in no assurance	>1 with No Assurance

* IF Revenue Financial performance domain assurance level is partial or no assurance, the combined assessment rating can be no higher than "Partial assurance"

* Efficiencies at the total level

NCHC Finance commentary

5.2.1 NCHC is on track to deliver its financial plan, reporting an adjusted financial position year to date £2k favourable to plan. This includes achieving delivery of efficiency savings, £90k ahead of plan.

- 5.2.2 A target from NHS E on bank spend has been set for the year. Based on a 10% reduction of the 2024/25 forecast spend, as at January 2025. This equates to a total spend of no more than £4.4m for 2025/26.
- 5.2.3 To the end of May, the £960k of bank spend represents 131% of the YTD cap. During June, the £4.4m budget for bank spend will be allocated across the services within the Trust. This will give each area a clear target to focus towards.
- 5.2.4 Risks not accounted for in the financial plan include funding of the additional 0.8% Agenda for Change (AfC) pay award which is approximately an additional £1m and the current nursing AfC review. It has subsequently been confirmed that national funding will be provided for the higher than planned AfC pay award.
- 5.2.5 Whilst the recent Spending Review reported an increase in DoHSC budget, at the time of writing, it is unclear how this will impact the Trust or the region.
- 5.2.6 Board are asked to note that the Finance and Infrastructure Committee approved the Corporate Benchmarking submission that was due to NHS E on 30th May 2025, the Trust has £0.7m of corporate savings which have predominantly been delivered during 2024/25.

CCS Finance commentary

- 5.2.7 As at M2 CCS delivered a planned breakeven position. This included the delivery of efficiency savings that were £200k ahead of plan.
- 5.2.8 Overall Bank and Agency spend was lower than the reduced targets agreed with NHSE. However, in M1 the Trust's Bank spend above the plan resulting in overall position of 7% above target.
- 5.2.9 Risks not accounted for in the financial plan include funding of the additional 0.8% Agenda for Change (AfC) pay award and the 4% uplift in medics pay, and the current nursing AfC review where the impact is still to be determined.
- 5.2.10 The Trust spent £585k on capital which included completion works at North Cambs Hospital in Wisbech and in relation to the Multi Storey carpark at the Princess of Wales Hospital in Ely.
- 5.2.11 The Board is asked to note that the Finance and Infrastructure Committee approved the Corporate Benchmarking target savings submission that was due to NHS E on 30th May 2025. The Trust has agreed a reduced target of £1m, and this will be delivered from existing and new vacancies.

5.3 Efficiency Programme

- 5.3.1 The Group efficiency target for 2025/26 totals £17.4m and was based upon the NHS planning assumptions of a 2.8% pay award for Agenda for Change (AfC) staff nationally together with known changes to employer National Insurance contributions. NHSE have confirmed that NHS Commissioned service contracts will be increased to take account

of the impact of the pay award uplift to 3.6%.

- 5.3.2 To date in CCS efficiency programmes totalling £8,932k of schemes have been planned, including £2,080k of schemes yet to be identified which are held as central provisions. The table below summarises these schemes:

Table 20

Category	Non-Recurrent £	Recurrent £	Total £
Pay	3,318,842	729,754	4,048,596
Non-pay	216,000	583,580	799,580
Income	517,105	3,566,689	4,083,794
Total	4,051,947	4,880,023	8,931,970

- 5.3.3 To date in NCH&C efficiency programmes totalling £8,823k of schemes have been planned, including £2,562k of schemes yet to be identified which are held as central provisions. The table below summarises these schemes:

Table 21

Category	Non-Recurrent £	Recurrent £	Total £
Pay	1,691,594	2,105,582	3,797,176
Non-pay	1,347,433	2,486,253	3,833,686
Income	1,101,617	90,521	1,192,138
Total	4,140,644	4,682,356	8,823,000

- 5.3.4 The Efficiency programme operates in a three stage Gateway process as follows:

- **Gateway 1** – “Ideas Generated” within services and presented.
- **Gateway 2** – “Approval” including calculation of savings and completion of Impact Assessments and agreement of schemes by Executives.
- **Gateway 3** – “Delivery” The scheme has been approved and is delivering savings.

- 5.3.5 The following table shows the breakdown of all efficiency schemes across CCS and NCH&C by their current gateway:

Table 22

Trust	Gateway	%	No. schemes	Value £
CCS	Gateway 1	82.7%	71	£8,580,386
	Gateway 2	3.7%	3	£72,500
	Gateway 3	13.6%	11	£279,084
	Total		85	£8,931,970
NCH&C	Gateway 1	92.2%	35	£8,430,500
	Gateway 2	2.6%	1	£93,000
	Gateway 3	5.2%	2	£299,500
	Total		38	£8,823,000

Please note that the Gateway process has only been introduced in NCH&C from 01 April 2025 and work is needed to fully impact assess all the identified efficiency schemes currently in the NCH&C efficiencies programme.