Cambridgeshire Community Services NHS Trust

Norfolk Community Health and Care NHS Trust

Agenda item:	10
Date of meeting:	21 May 2025
Report to the:	Group Trust Board
Title of report:	Cambridgeshire Community Services NHS Trust (CCS) Integrated Governance Report
Report authors & Executive sponsors:	▪ Dr Caroline Kavanagh, Medical Director ▪ Rachel Hawkins, Director of Corporate Affairs ▪ Kate Howard, Chief Nursing and Allied Health Professional Officer ▪ Anita Pisani, Chief People Officer and Deputy Chief Executive ▪ Mark Robbins, CCS Director of Finance
Recommendation:	Approve

Assurance level:	**Substantial** ✓ **Reasonable** ☐ **Partial** ☐ **Minimal** ☐
Rationale:	- 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 executive team which is outlined in the assurance framework (previously approved by the CCS Trust Board) and as detailed in this report. - Any action necessary from the rating and outcome required.

1.0 Executive Summary

1.1 This Integrated Governance Report (IGR) has been produced following the Service Assurance Committees that took place on 6th May (Children & Young People) and 7th May (Luton & Bedfordshire Adults & Older People, and Ambulatory).

1.2 The report brings together the quality, performance, workforce and finance information for February and March 2025 along with key risks and issues, to provide the Group Trust Board with assurance of delivery against the agreed strategic objectives and the updated assurance measures.

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

2.0 How the report supports tackling Health Inequalities

2.1 Progress towards delivery of the agreed equality and diversity objectives for domain 1 (see page 21) and domains 2 and 3 (see page 32) are included within this report.

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 Trust's strategic risks on the Group Board Assurance Framework and operational risks scoring 15 and above which are listed against the strategic objectives in the report.

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.

5.0 Previous consideration by Committee or Executive

5.1 Integrated Governance Report, 26 March 2025.

6.0 Key Highlights [executive summary]

6.1 This Integrated Governance Report (IGR) has been produced following the Service Assurance Committees that took place on 6th May (Children & Young People) and 7th May (Luton & Bedfordshire Adults & Older People and Ambulatory).

6.2 The Children & Young People's report provided **substantial** assurance. The Adults and Ambulatory reports provided **substantial** assurance for Luton & Bedfordshire Adult services and Dynamic Health and **reasonable** assurance for iCaSH (integrated Contraception and Sexual Health services) and Dentistry as confirmed at the May Service Assurance meetings.

6.3 The reporting period covers the quality, performance, workforce and finance information for February and March 2025 and includes the key risks and issues, to provide the Board with assurance of delivery against the agreed strategic objectives and indicators.

6.4 The Assurance Framework (Appendix 1) that is used in this report reflects the five Care Quality Commission (CQC) key lines of enquiry, and was reviewed, updated and agreed by the CCS Trust Board at the beginning of financial year 2024/25.

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

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

Assurance:

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

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

7.0 Key Matters

7.1 The outstanding care chapter in the report, providers substantial assurance ratings for Safe, Caring and Responsive. The Effective rating reduced to reasonable in this reporting period due to one of the EDS targets not being achieved and being carried forward into 2025/26; mandated safeguarding children supervision improved to target (90%) from 86% in the previous reporting period. The rationale for all ratings and the evidence to support these are detailed more fully in the main document.

7.2 In the excellent employer chapter, the assurance ratings remain as reported in the previous period.

7.3 The sustainability chapter continues to provide reasonable assurance. The Trust reported a marginal surplus for financial year 2024/25 against overall resources of £180m. There still remains some outstanding contract agreements with Local Authorities and these will now be factored into the 2025/26 financial performance.

8.0 Key Risk Register:

8.1 At the end of the reporting period there were no operational risks scoring 15 or above.

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 issues reports identify any new and emerging risks in the reporting period.

8.3 The strategic risks on the Board Assurance Framework that relate to three of the four strategic objectives are summarised at the beginning of each of the chapters in this report.

9.0 Key Issues Register:

9.1 There were 8 issues scoring 4 (Major) on the issue register and two new issues were added to the issue register for this reporting period.

9.2 For those eight issues scoring 4 or above:

- five 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.
- two are IT/digital related and have been discussed in detail at the Finance & Infrastructure Committee.

10.0 Key Escalations for noting

10.1 Matters for escalation for **noting** from the Children & Young People's Service Assurance Committee:

- Closure of the CQC 'Must Do' action related to HCP performance has been completed.
- There is a funding gap in Norfolk Speech and Language Therapy, following transfer of commissioner responsibility from the ICB to Local Authority and no additional funding agreed for uplifts.

10.2 Matters for escalation for the Board to **note** from the Luton & Bedfordshire Adults and Older People, and Ambulatory Service Assurance Committee:

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 below target – however Chief Nurse and Head of Safeguarding leading improvements in this area.
- Financial challenges within iCaSH services
- Cost improvement plans for 25/26

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11.0 Examples of outstanding practice

11.1 **Children & Young People's Services:**

- NCHC Patient story was well received and incorporated the voice of the child.
- 2024 Service plan showcased examples of great work from teams.
- Closure of the CQC 'Must do' action from 2019.

11.2 **Luton & Bedfordshire Adult and Older People, and Ambulatory, Services:**

- **Dynamic Health –** monthly shine-a-light winners for their mosque outreach work in Peterborough.
- **Dental Healthcare –** Wisbech team have started to co-produce a site film for the Wisbech dental clinic, to try to alleviate concerns or anxieties for service users visiting the service.
- **iCaSH –** service user tik tok videos
- **Focus on Health Inequalities -** Suffolk dental team have widened their scope of service to include patients with dementia, autism and learning difficulties. Dynamic Health - community assessment day in March for Peterborough patients to improve access.
- **Luton and Bedfordshire Older Peoples Services –** continued improvements in access to the ambulance stack and launch of unscheduled care hub.

12.0 Forward View for 2025/26

The key priorities for the Group are:

- Delivering the 2025/26 service/annual plans across both organisations
- Developing a 3 year rolling cost efficiency programme
- Co-producing the Group strategy and shared values and behaviours.

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Appendices:

Appendix 1: Integrated Governance Report Assurance Framework

Appendix 2: Quality Dashboard

Appendix 3: Statistical Process Control Chart

Provide Outstanding Care

A: Assurance Summary

Safe	• 21% of all Datix incidents are overdue and require closure. **(S1) (Substantial).** • 100% of all relevant Patient Safety Incidents (PSI's) and Statutory Duty of Candour were completed or there is documented rationale for why it was not appropriate to complete. **(S2) (Substantial).** • There were no 'Never Events' reported in any service during February and January 2025. **(S3) (Substantial).** • A Staff Flu Vaccination Plan is in place which includes mitigations, with a final target of 56% (2023/ 24). The current national data set shows uptake of 59.4%. **(S5) (Substantial).** • NHS England (NHSE) Safeguarding Accountability & Assurance Framework is fully adhered to and supports the Trust with compliance with all Section 11 (Children's Services) and self-assessments (Adult Services). **(S7) (Substantial).** • 100% of open action plans related to local multi-agency safeguarding reviews are on target for completion. **(S8) (Substantial).**	**Substantial**
Caring	• Friends and Family Test (FFT) scores were at 90% for 90% of services across the organisation. **(C1) (Substantial)**. • 80% of all formal complaints were responded to within the timeframes agreed with the complainant. **(C2) (Substantial).**	**Substantial**
Effective	• Overall Information Governance mandatory training levels are at 96% (target level 95%). **(E2) (Substantial).** • One of the EDS targets will be carried over to 2025-2026 **(E6) (Reasonable).** • Overall compliance with mandated safeguarding children supervision achieved target at 90%. **E7 (Substantial).**	**Reasonable**
Responsive	• All of our service areas with waiting lists have an improvement plan that is agreed and being delivered. **(R1) (Substantial).** • 90% (9/ 10) formal complaints were acknowledged within 3 working days of their receipt into the Complaints team. **(R2) (Partial).** • All valid requests for information under the Freedom of Information Act 2000 were provided to applicants within 20 working days of their receipt into the Information Governance Team. **(R3) (Substantial).** • 100% (February 2025) and 100% (March 2025) of valid Access to Records (ATR) requests under the Data Protection Act 2018 were provided to applicants within 30 calendar days of their receipt into the Information Governance team. (**R4) (Substantial).**	**Substantial**

B: Risks to Achieving Objectives
Strategic Risks:

1. ***Risk ID 3562*** *- There is a risk that service's Safeguarding work across all localities is unable to be managed within the staffing capacity available and that this may result in children, young people and adults being left without adequate safeguarding measures. (Risk Rating 12).*

2. ***Risk ID 3653*** *– There is a risk that clinical quality and patient safety could be compromised if the potential causes of this risk are not managed and mitigated. The impact of this potential could lead to an increased level of 'harm', a reduction in clinical quality across services and an increase in patient dissatisfaction. (Risk Rating 12)*

Related Operational Risks 15 and Above

None to report.

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

SECTION ONE – SAFE DOMAIN

Safe	• 21% of all Datix incidents are overdue and require closure. **(S1) (Substantial).** • 100% of all relevant PSI's and Statutory Duty of Candour were completed or there is documented rationale for why it was not appropriate to complete. **(S2) (Substantial).** • There were no 'Never Events' reported in any service during February and March 2025. **(S3) (Substantial)**. • A Staff Flu Vaccination Plan is in place which includes mitigations, with a final target of 56% (2024/25). The current national data set shows uptake of 59.4%. **(S5) (Substantial).** • NHSE Safeguarding Accountability & Assurance Framework is fully adhered to and supports the Trust with compliance with all Section 11 (Children's Services) and self-assessments (Adult Services). **(S7) (Substantial).** • 100% of open action plans related to local multi-agency safeguarding reviews are on target for completion. **(S8) (Substantial).**	**Substantial**

1.0 Patient Safety

1.1 No Patient Safety Incident Investigations (PSII's) or 'Never Events' were reported in either February or March 2025.

1.2 The Trust did not submit any PSII's for closure to the local Integrated Care Boards (ICB's) during the period.

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1.3 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:

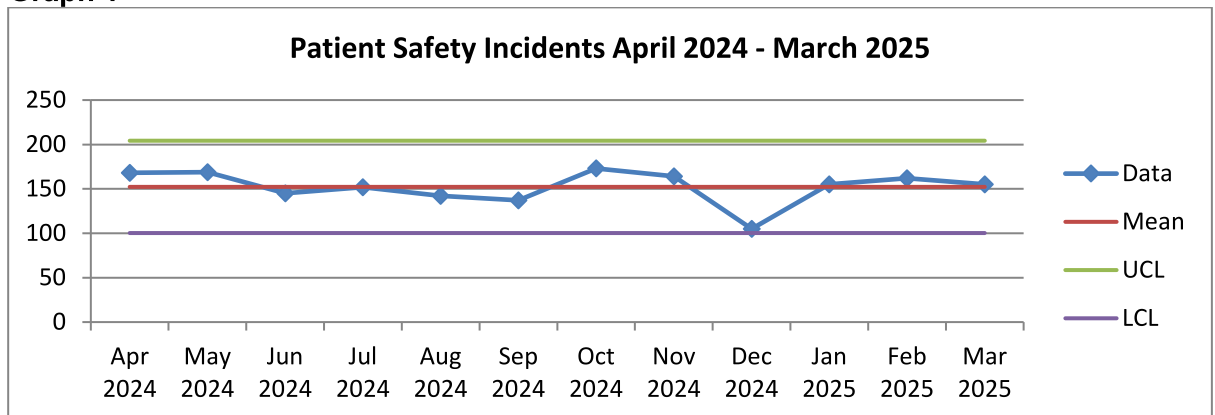
- Children's Dietetic Service (Cambridgeshire) – service specification to be reviewed with the ICB. This action is underway the Trust has met with the ICB lead and a review of the pathway, which includes one of the local acute hospitals will commence in Q1 2025 / 2026.

1.4 The weekly Safety Huddle continues to manage and consider incidents in line with the Patient Safety Incident Response Framework (PSIRF), their role is to agree next steps against the Patient Safety Framework and / or close and approve submitted reviews whilst considering whether the theme of the incident links to existing improvement plans or the agendas within the Communities of Practice.

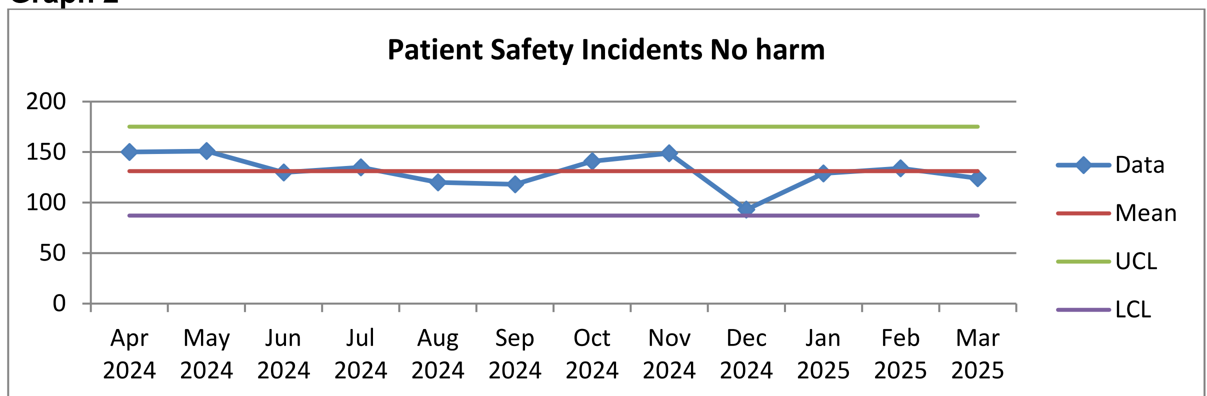
1.5 A total of eight presentations of review responses were made in February 2025, four of which had a safeguarding element. One presentation was held in March 2025, which did not have a safeguarding element.

1.6 The graphs below highlight those PSI's (Patient Safety Incident's) that occurred under our care and includes the two-month period of February and March 2025. These incidents totalled 317, this is an increase of 54. Graphs 2,3 and 4 show the degree of harm for PSI's (under the Trust's care) over the period April 2024 – March 2025.

Graph 1



Graph 2



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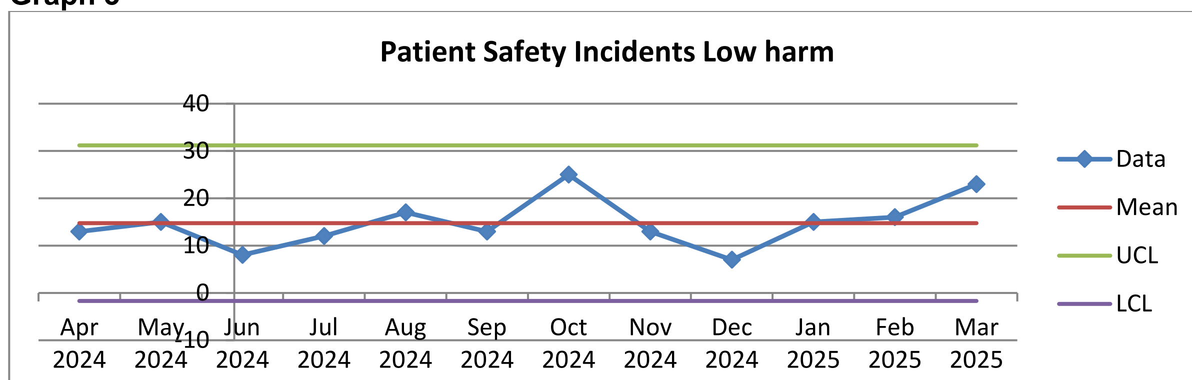
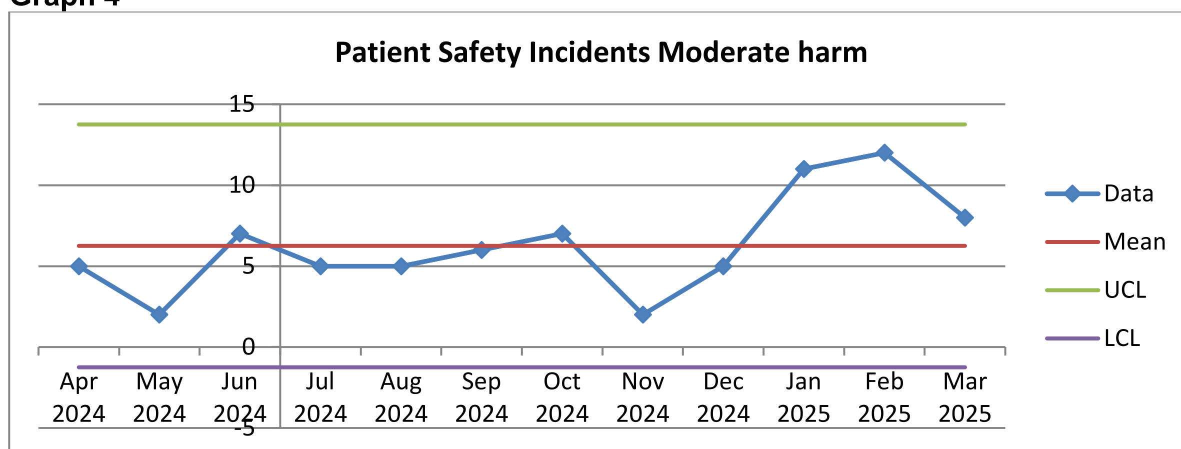
Graph 3



Graph 4



1.7 Of the 317 incidents (February and March 2025), 82% were no harm incidents, 12% low harm and 6% moderate harm (December 2024 and January 2025 were 85%, 9% and 6% respectively). This is reflective of the Trust's usual reporting pattern.

1.8 Twenty moderate harm incidents (whilst under the Trust's care) were reported, which is an increase of four incidents on the previous two-month period. Seventeen 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. The remaining incidents were reported by iCaSH Milton Keynes, Bedfordshire Community & Specialist Nursing Service and Nutrition and Dietetics (Bedford).

1.9 Moderate/ high harm incidents, whilst the person is under the care of the Trust, require the application of the statutory Duty of Candour. For the 2-month period of February and March 2025 the Statutory Duty of Candour was completed in 100% of cases (or there is documented rationale for why it was not appropriate to complete).

1.10 **Incident Themes (all incidents)**

1.10.1 Datix reports in generic categories and the categories we see reflected in the top 3 reported (for each month) are as follows:

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Table 1

February 2025	March 2025
▪ Clinical assessment and treatment **80** ▪ Access, admin, transfer and discharge **57** ▪ Patient information **44**	▪ Clinical assessment and treatment **89** ▪ Patient information **49** ▪ Access, admin, transfer and discharge **39**

1.11 **Clinical assessment & treatment**

1.11.1 Of the 169 incidents reported under this category, 167 related to patients of which; 82 were whilst under the care of the Trust, 52 another organisation, 16 domiciliary care agency and the remaining 17 were no professional health/ social care input. The remaining two incidents relate to members of the public where a staff member went to the aid of two road traffic crashes.

1.11.2 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 167 incidents, 99 related to 'developed Pressure Ulcers or MASD' with 97 being under the Luton Adults Service, one under the Children's Community Nursing Service in Bedfordshire and one under Special Needs Nursing in Luton. A further 16 incidents related to patients who 'acquired a skin tear', 15 of which are deemed to be off caseload and are 'happened upon' incidents and the remaining one incident was whilst on caseload.

1.11.3 Of the Luton Adults 97 incidents,48 (49%) were deemed to have occurred whilst the patient was on active caseload with the remainder split as follows: another Organisation 25, Domiciliary Care Agency 14, No Professional Health / Social Care input 10.

1.11.4 The trend for reporting of Pressure Ulcer incidents occurring for those patients on caseload has indicated a slight decrease (graph 5). Graph 6 shows that reporting rates remain within acceptable parameters. The mean reporting rate per month is 14.5 per month.

1.11.5 The Preventable Wounds Community of Practice has developed a new plan to ensure scrutiny and oversight of all grade 3 and 4 Pressure Ulcers monthly to identify emerging themes and further learning for wounds that the subject experts consider to be preventable. A project is being undertaken 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.

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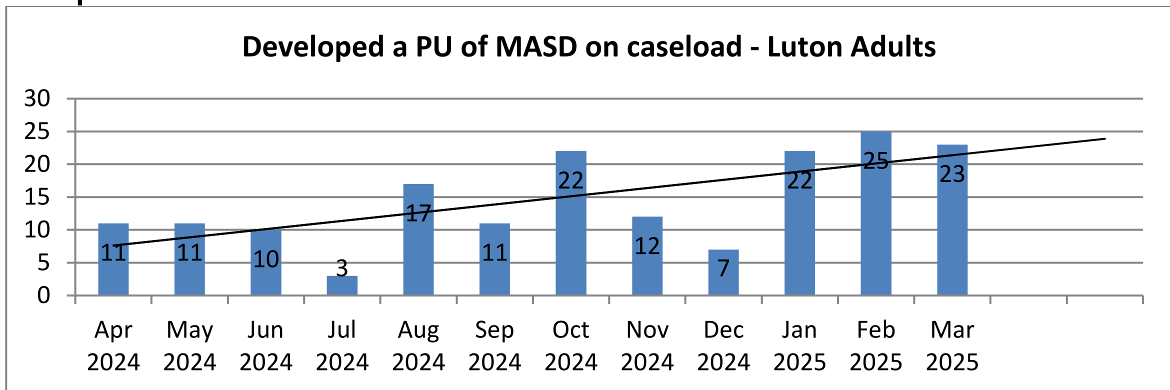
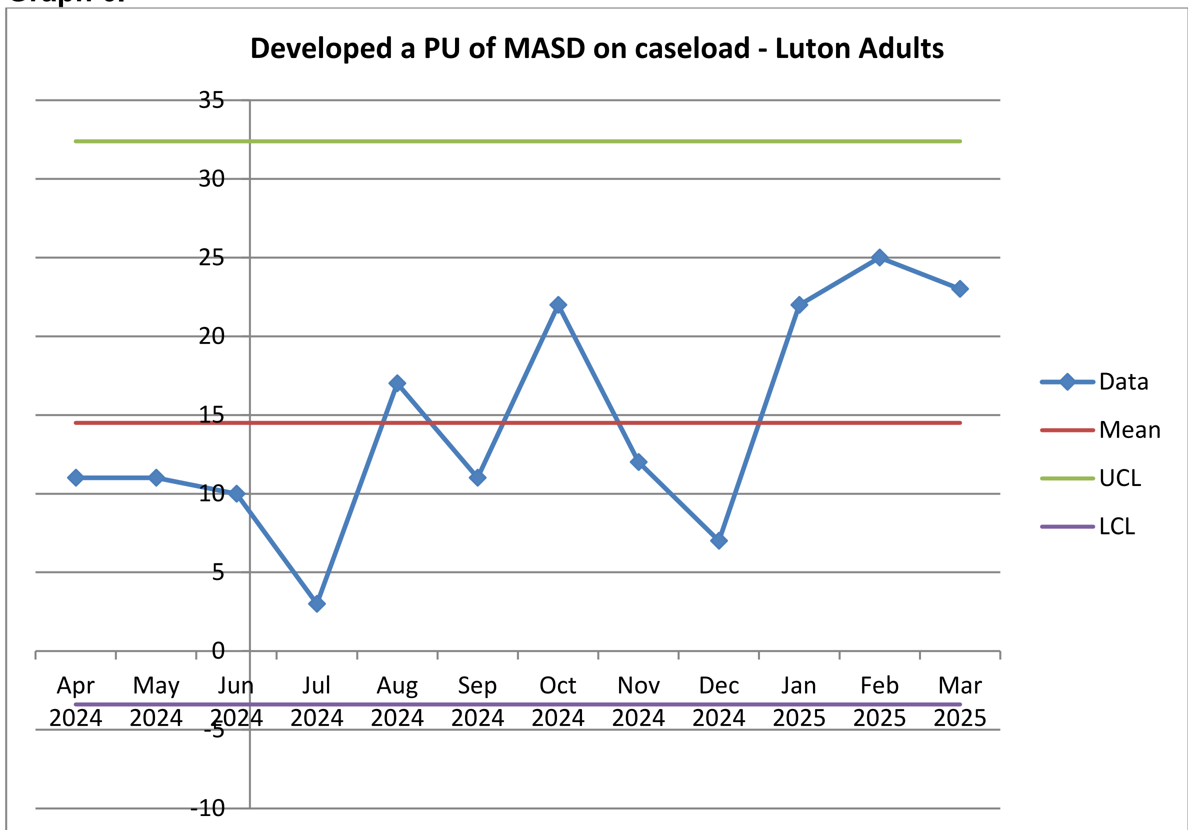
Graph 5



Graph 6.



1.12 **Access, administration, transfer, and discharge**

1.12.1 Of the 96 incidents reported under this category, 95 related to patients of which 67 were whilst under the care of the Trust, 25 whilst under the care of another organisation, three were no professional health/ social care input.

1.12.2 Of those incidents under CCS care (67), 36 were categorised as unspecified other access, admin, transfer and discharge with no common theme being identified. Twenty-eight incidents related to a failure to make an onward referral and relate to various services across the Trust. Three related to a failure to follow-up missed appointment. Of the 67 incidents, all were graded as no harm.

1.13 **Patient Information**

A total of 93 incidents were reported under this category, which relates to patient documentation and records, 83 of these were whilst under the Trust's care. All 93 incidents were graded as no harm.

1.14 **Violence and Aggression Incidents**

1.14.1 The table below identify reporting themes for the last financial year. There has been a slight increase in reporting activity with an increase from 207 in 2023-2024 to 215 in 2024-2025.

1.14.2 A full review of violent and aggressive incidents from this year will be repeated and reported to the Health and Safety Group in Quarter 1 of 2025 / 2026, this will provide detail in relation to themes, it will also provide data on the services with the highest numbers of incident.

Table 2

	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Total
Adult Abuse Identified	3	0	0	1	2	4	0	5	1	0	4	4	24
Bullying	0	0	0	0	1	0	2	2	1	0	0	1	7
Child Abuse identified	0	1	0	0	0	0	1	0	0	0	0	0	2
Distressing phone call	1	2	3	0	1	0	2	1	0	0	2	2	14
Firearms/Dangerous Weapons	0	0	0	0	0	0	1	0	0	0	0	0	1
Physical Assault	1	2	3	2	2	4	5	1	1	1	0	0	22
Racial Harassment	0	0	0	1	1	1	0	0	1	0	1	1	6
Sexual Harassment/assault	0	0	1	0	1	0	1	0	1	0	0	0	4
Unacceptable behaviour	3	1	8	6	2	4	7	4	3	8	10	4	60
Unspecified Other Violence Issue	0	0	1	1	2	0	2	0	0	1	0	0	7
Verbal Abuse	7	7	6	5	6	3	6	6	2	3	12	5	68
Total	15	13	22	16	18	16	27	19	10	13	29	17	215

1.14.3 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.

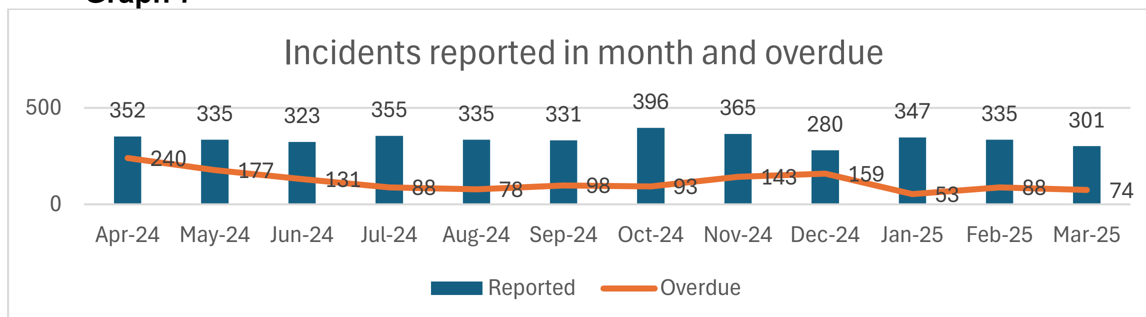
1.14.4 Support has included, specific counselling and de-brief sessions, safety plan development and where appropriate access to legal advice.

1.15 **Overdue incident monitoring**

1.15.1 Work has been ongoing with the services to review reported incidents in a

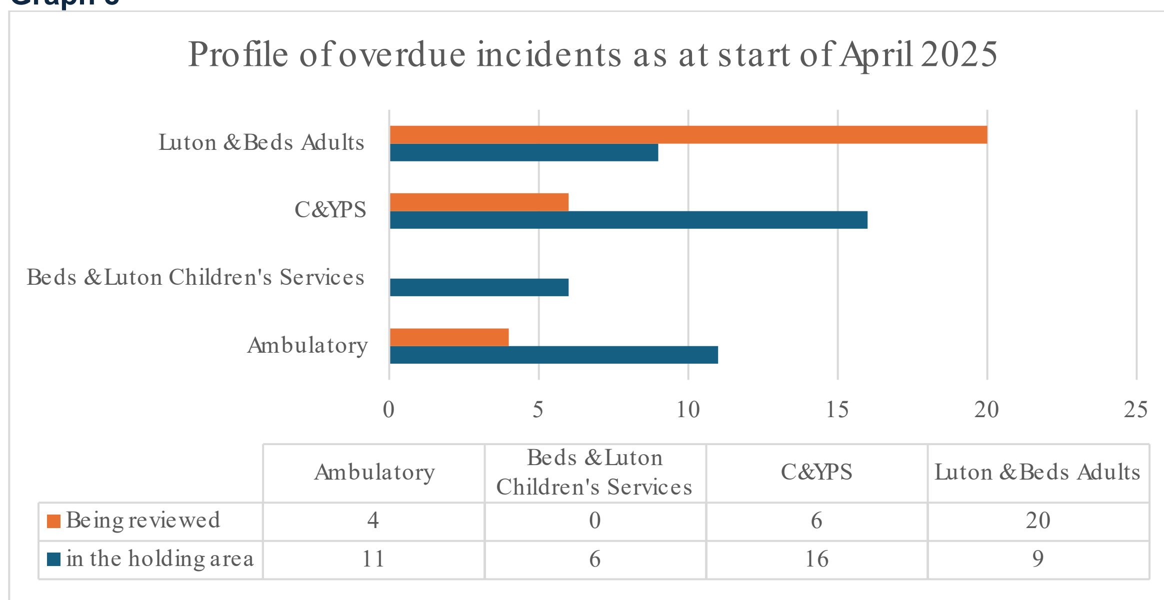
timely way. The data within the graph is based on the number of incidents reported in the month and the number of incidents overdue (exceeding the 30-day timeframe) at the start of the following month and as reported on the monthly Quality Dashboard.

Graph 7



1.15.2 Overdue incidents are separated into two areas, awaiting review and being reviewed. There is an expectation that the 'being reviewed' incidents have undergone a brief local review and are awaiting a final review.

Graph 8



	Ambulatory	Beds & Luton Children's Services	C&YPS	Luton & Beds Adults
Being reviewed	4	0	6	20
in the holding area	11	6	16	9

1.15.3 On average 340 incidents are reported pan Trust per month. At any one-time approximately 200 are in the process of 'local review'. At the end of March/ start of March 2025, 72 incidents were over the 30-day deadline, which is a decrease on the last reporting period, when the figure was 53. This equates to 21% of the total incidents which are overdue.

1.15.4 Overdue incidents are monitored and discussed at the monthly Safety Improvement Group and escalated to Service Directors and local quality governance meetings. Further escalation is sent to the Chief Nurse for action, as needed.

1.16 National Patient Safety Alerts (NatPSA)

1.16.1 Twenty-one alerts were received during February and March 2025, (8 and 13

respectively). There was one NatPSA which is listed below and is not relevant to the Trust.

- **NatPSA/2025/001/DHSC** Discontinuation of Promixin (colistimethate) 1-million-unit powder for nebuliser solution unit dose vials

2.0 Medicines Management

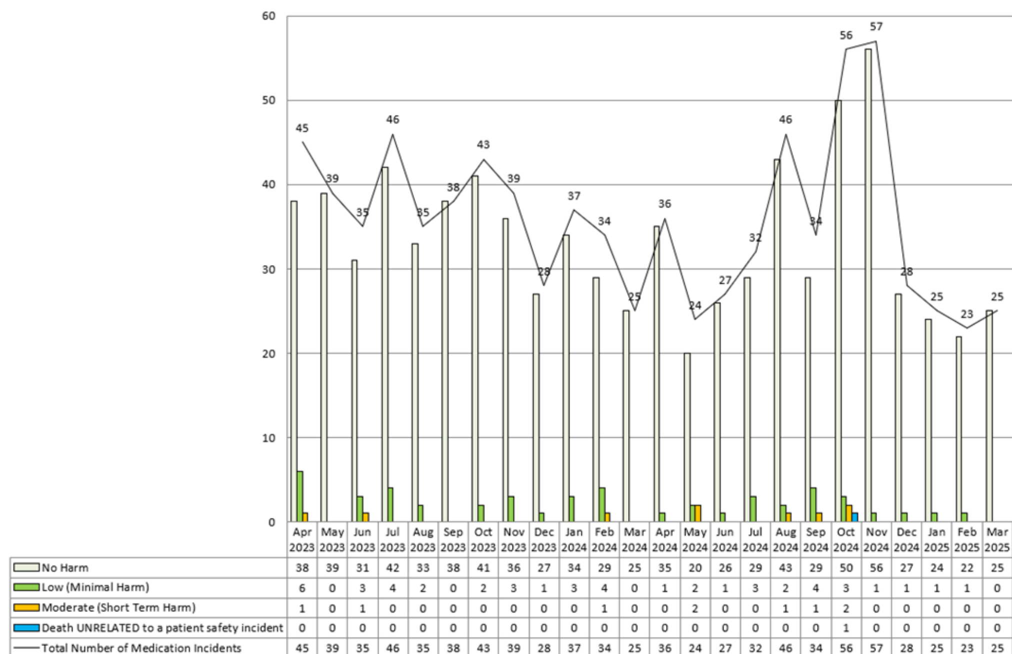
2.1 Medicines Incidents

2.1.1 The decline in the number of medication incidents reported in December 2024 and January 2025 was sustained in February and March 2025, with 23 and 25 incidents respectively reported. This reflects a wider trend in the reporting of all incidents across the Trust during this period and, in respect of trend analysis of medication incidences specifically, there is concordance between the same period in 2024.

2.1.2 Of these 48 incidents, 35 occurred under CCS care. Of the 48 total, 47 were no harm and 1 was a low harm incident which involved a patient under the Trusts care. There were no moderate or severe harm incidents reported in the reporting period. The number of incidents involving insulin remains low.

2.1.3 Chart 1 illustrates the number of medication incidents reported monthly, irrespective of whether responsibility rested with the Trust or with other organisations. In 2023 - 2024 the average number of incidents was 37 per month and in 2024 - 2025 is 34 per month. The trend is downward, which is positive.

Chart 1: Number of Medication Incidents – Trend Analysis Since April 2023

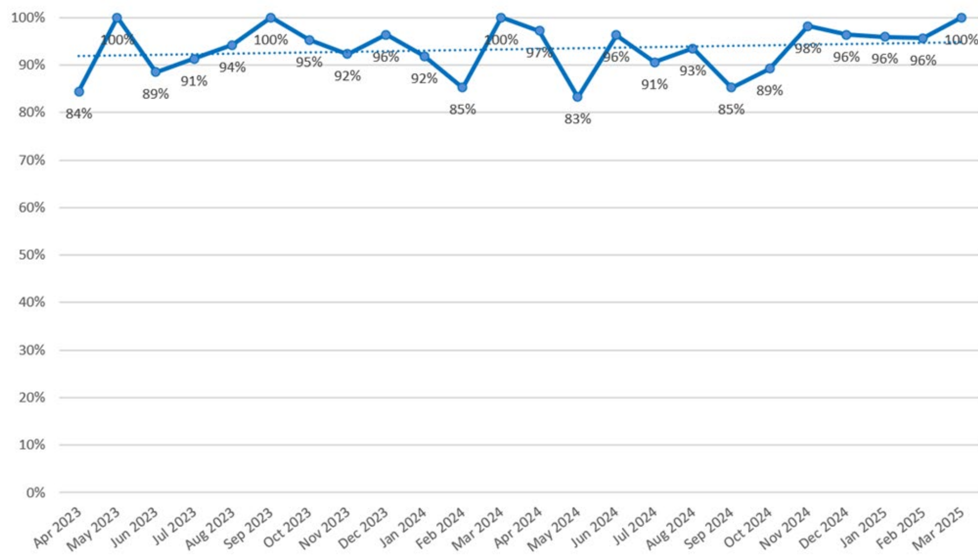


	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
No Harm	38	39	31	42	33	38	41	36	27	34	29	25	35	20	26	29	43	29	50	56	27	24	22	25
Low (Minimal Harm)	6	0	3	4	2	0	2	3	1	3	4	0	1	2	1	3	2	4	3	1	1	1	1	0
Moderate (Short Term Harm)	1	0	1	0	0	0	0	0	0	0	1	0	0	2	0	0	1	1	2	0	0	0	0	0
Death UNRELATED to a patient safety incident	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Total Number of Medication Incidents	45	39	35	46	35	38	43	39	28	37	34	25	36	24	27	32	46	34	56	57	28	25	23	25

2.2 Level of Harm

2.2.1 Chart 2 shows the percentage of no-harm medication incidents since April 2023 attributable to the Trust. The percentage of no-harm medication incidents through February and March 2025 has been maintained at a level considered to be 'normal' as an average. Encouragingly, 100% of medication incidents reported in March 2025 were of no harm. The Medicines Safety and Governance Group, encourages reporting of incidents involving medicines and the data would support that we are a high reporting, no/low harm organisation.

Chart 2: Percentage of No-Harm Medication Incidents since April 2023



2.2.2 *Moderate and Severe Harm*
There were no recorded incidents of 'moderate harm' or above during the reporting period.

2.3 Medicines Safety

2.3.1 Drug Safety Updates
The Medicines Safety and Governance Group monitors and implements actions as appropriate in respect of the Medicines and Healthcare products Regulatory Agency Drug Safety Updates, providing assurance that robust measures are in place to ensure compliance.

2.3.2 Medicines Storage and Handling Audits
These audits are being worked through to digitise them to improve data collection and reporting. This has been a collaboration of the digital team and our previous Chief Pharmacist who is working with us 2 days/week. She will also undertake other focused pieces of work in relation to medicines safety and handling over the coming months.

2.3.3 Insulin – PSIRF plans and Quality Improvement Project
The Insulin Data Oversight group monitors medication incidents involving insulin. CCS administers >2500 insulin injections each month. Although the number of incidents involving insulin increased slightly in February and March, having been on a downward trajectory, the number of incidents remains low. These incidents are reviewed monthly by the Clinical Leads, and at the Luton Quality and Risk Meeting.

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2.3.4 Chart 3 shows the total number of incidents involving insulin each month occurring under CCS care since December 2022 and Chart 4 shows the level of harm of these incidents.

Chart 3: Number of incidents involving insulin reported under CCS care

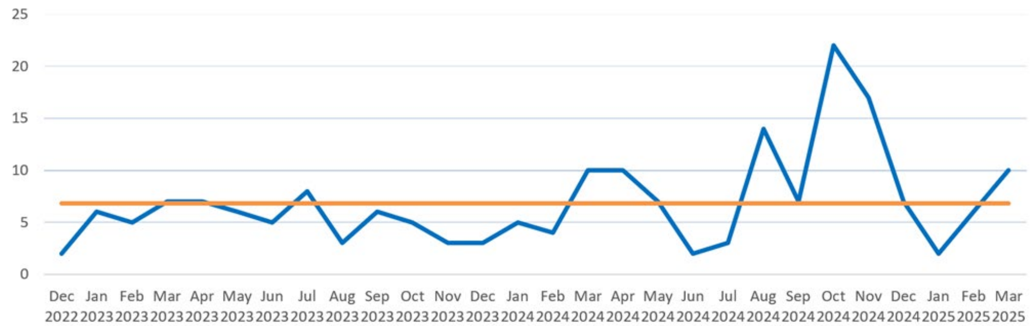
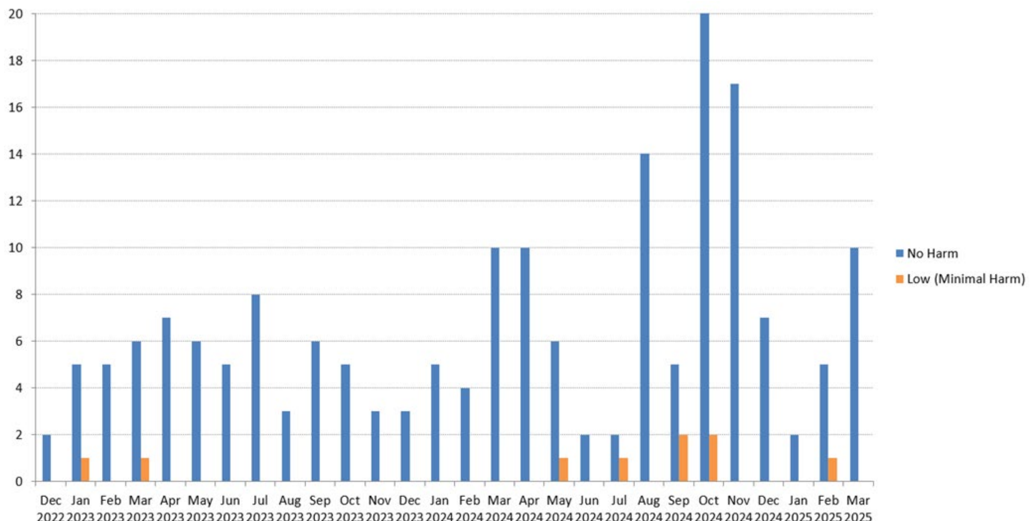


Chart 4: Harm levels of incidents involving insulin under CCS care



2.3.5 Of the 15 reported insulin incidents, there was only 1 case of low harm. There were no cases of moderate or severe harm caused.

2.3.6 The Trust Medicines Management training is planned to be revised and standardised to remove unwarranted variation. This will also provide bespoke training and support for the Luton Adults service around insulin administration.

2.3.7 The domiciliary pharmacy technician service was reviewed, with a change in skill-mix proposed to provide training and education, supporting and empowering patients to self-administer their own insulin, improving autonomy and understanding of their long-term health condition(s). We have not, as yet changed the skill set, so this has not yet been implemented.

2.3.8 **Confronting Antimicrobial Resistance 2024 to 2029**
As discussed previously, the new Board Assurance Framework for Antimicrobial Resistance has been finalised, and the action plan disseminated. There are fourteen commitments across two key themes:

- Theme 1 - Reducing the need for, and unintentional exposure to, antimicrobials
- Theme 2 - Public engagement and education

2.3.9 To support the ongoing work around Antimicrobial Stewardship (AMS), the digitisation of antimicrobial audits as part of service-level medicines management dashboards is in progress and is working towards going live for Q1 data in 2025-26.

2.3.10 A review of medicines management training, including AMS, is underway. This acknowledges the opportunity to enhance delivery of information and promote good practice via improved embedment of, and oversight by, the Trust Antibiotic Guardians, Trust Infection, Prevention & Control Lead and the Chief Nursing and Allied Healthcare Professional Officer.

2.4 Pharmacy Services Procurement with Fairview Health

2.4.1 Intensive mobilisation work continued throughout February - March 2025 in advance of the scheduled launch of the new pharmacy service delivered by Fairview Health on 1 April 2025. This included introduction of electronic ordering of pharmacy stock across the Trust and electronic prescribing of antiretroviral therapy in iCaSH.

2.4.2 The contract with Fairview includes a Service Delivery Improvement Programme (SDIP) and Data Quality Improvement Plan (DQIP), engendering partnership working, and a culture of continual improvement and development across the lifecycle of the contract.

- Development of the reporting framework, with an emphasis on digitalisation and Power BI to create a digital medicines management dashboard.
- User Acceptability Testing and user registration was completed on the electronic prescribing (RxPad) and electronic ordering (StockPad) systems.
- The upload of patient data from the iCaSH electronic patient record system (Lilie) to RxPad was successful.
- Training sessions were provided for all users on both systems.
- SOPs developed to ensure robust governance is in place.
- Medicines procurement arrangements and pathways were confirmed and plans to ensure business continuity in the case of service disruption.

3.0 Safer Staffing

3.1 Luton Adults

3.1.1 The graph set below illustrate the RAG ratings for District Nursing, Rapid Response (days) and Palliative Team over the reporting period, demonstrating the workforce pressures for District Nursing. This is taken from the daily SitRep, which, for District Nursing, analyses the staff hours available versus the hours required to fulfil the workload. For Rapid Response and Palliative Care, the data is taken from the eRoster, showing the staff hours available per day, and takes into account unavailability data.

Provide Outstanding Care

3.1.2 The RAG ratings reflect staffing available as per the eRoster. The percentage of available staff dictates the appropriate RAG level for Palliative Care and Rapid Response services. For District Nursing services, the RAG also takes account of the activity level required to fulfil the workload, so references both available staff and activity levels from the eScheduling software. These three services were identified as the most essential to ensure that staffing is safe, and priority care must be met.

3.1.3 Each service will take mitigating actions to ensure the service is safely staffed. Examples are as follows:

Amber:
- Planned non-clinical activity such as non-mandatory training and supervision will be re-scheduled
- Prioritise unplanned or urgent care
- Services will not be able to support other teams
- Staggered response to unplanned work

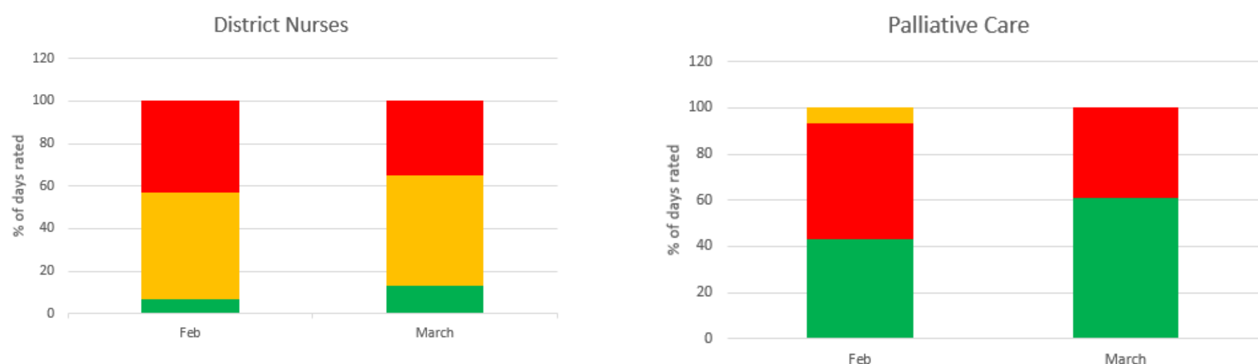
Red:
- Workforce re-allocated
- Clinical activity deferred
- Use of temporary staffing

3.1.4 When most planned care teams trigger an amber rating, they continue to be able to maintain their priority functions.

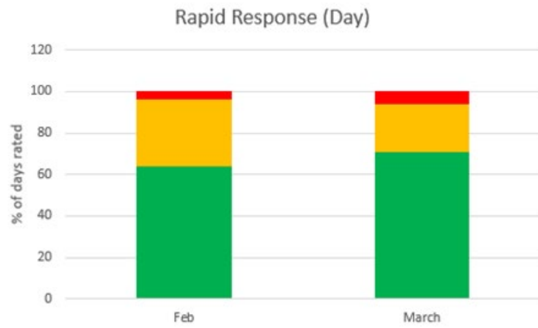
3.1.5 From April 2025 the daily SitRep has been redesigned to log mitigating actions / professional judgement taken when services are ‘red’. This will be analysed and discussed in the next Integrated Governance Report/Service Assurance Committee.

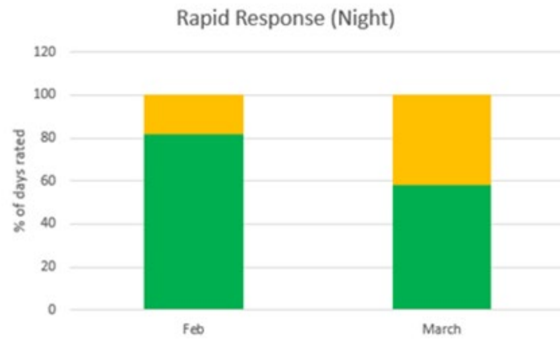
3.1.6 The graphs below illustrate the RAG status for the reporting period.

Graph set 1

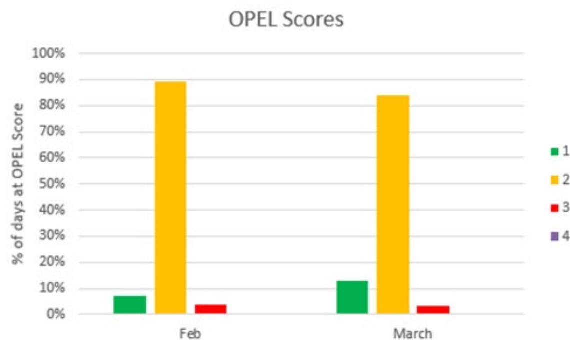


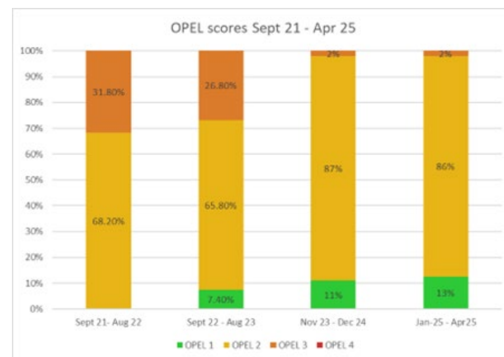
Provide Outstanding Care





Graph set 2 - OPEL Scores

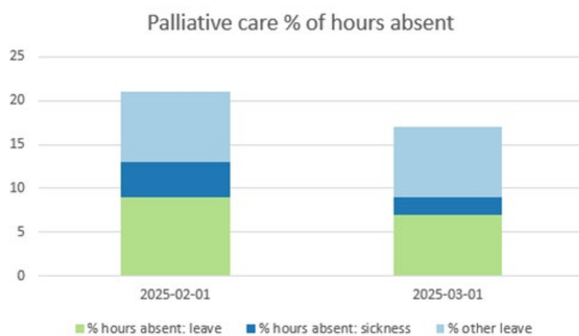


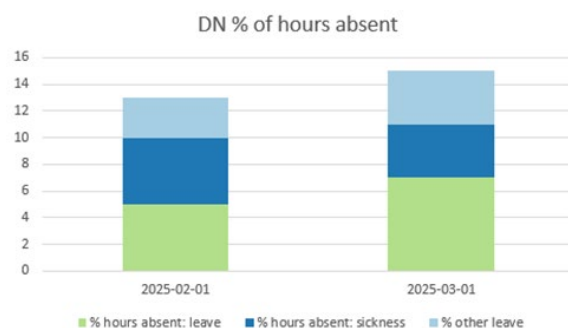


3.1.7 The charts above show that for the vast majority of February and March Luton Adults remained in an OPEL 2 position with all work covered and no need for escalation. There are also a meaningful number of days reporting an OPEL 1 position and the service reported an OPEL 3 position (with some escalation being required) less than 5% of the time. To put this into context, the second chart shows the same information over a longer period of time and shows that between September 2021 and August 2022 the service were in OPEL 3 a third of the time.

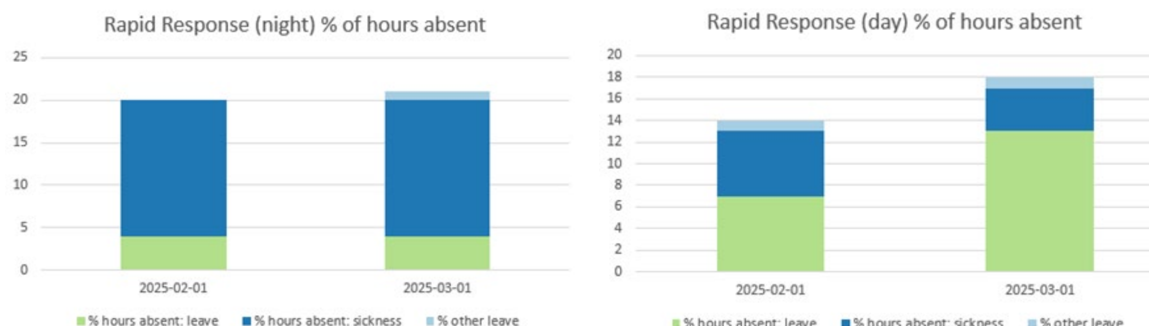
3.1.8 The OPEL scores from September 2021 to April 2025 illustrate the improved position over time, with increasing OPEL 1 and decreasing OPEL 3 scores.

Graph set 3 - Unavailability Data





Provide Outstanding Care



3.1.9 Unavailability data is calculated into the daily SitRep alongside rostered hours filled and activity data from the scheduling system. Each service's Safer Staffing Standard Operating Procedure proposes minimum staffing levels for safe delivery of service. This should correspond to agreed leave levels.

3.2 **Children's Community and Specialist Nursing Service**

3.2.1 The use of SafeCare for Cambridgeshire Children's Community Nursing Service is being explored, to provide visibility across the service, and enable recording of professional judgement in an accessible manner.

Business Continuity Triggers

February			
		Issue	**Mitigation**
C&P CYP (Cambridgeshire & Peterborough Children & Young People)	South	School Nurse (SN) vacancy, 5 x resignations, long term sickness	Transfer-in process in Business Continuity Plan (BCP). New referral criteria for SN. Digital Antenatal offer.
	Safeguarding	Long term sickness	Workload redistributed. BCP for mandated supervision, 1:4.
Norfolk CYP (Children & Young People)	Just One Norfolk (JON)	Long term sickness, admin vacancy	Agency usage, mitigations in place for urgents (not breaching). Longest waits have been reviewed.

March			
		Issue	**Mitigation**
C&P CYP	South	School Nurse (SN) vacancy, 5 x resignations, long term sickness	Transfer-in process in BCP. New referral criteria for SN. Digital Antenatal offer.

	Safeguarding	Long term sickness	Workload redistributed. BCP for mandated supervision, 1:4.
Norfolk CYP	JON	Long term sickness, admin vacancy	Agency usage, mitigations in place for urgents (not breaching). Longest waits have been reviewed.
Luton Adults	TB Service	Vacancies and long-term absence	Workforce re-allocated, clinical activity deferred

4.0 Trust wide Safeguarding

4.1 The Trust continues to work proactively with partners to carry out its statutory safeguarding duties regarding the children and adults who access our services. Assurance is provided to the Board that all policies relating to safeguarding people are reviewed and updated to align with new and emerging legislation, guidance, and actions from inspections.

4.1.1 Assurance is given that Section 11 reporting for Children's Partnership Boards and self-assessment tools for Adult Safeguarding Partnership Boards in each locality are responded to within the specified timescales and completed in collaboration with all relevant services in that locality. This quarter there have been no Section 11 reports completed and no requests for participation in reflective events to consider ongoing action plans.

4.1.2 A combined action plan for published external safeguarding reviews has been developed, this is to ensure learning is captured and any relevant actions completed. It is overseen quarterly by all locality Safeguarding Leads and the Strategic Safeguarding Group meetings. Further work has also been undertaken with the Safety team to produce an up-to-date data base of all current safeguarding reviews being completed in each locality.

4.1.3 Risks are managed and overseen through the Strategic Safeguarding Group and Quality Improvement and Safety Committee (QISComm). These are also discussed in each of the locality safeguarding operational groups.

4.2 **Cambridgeshire & Peterborough**

4.2.1 From 1 April 2025 Cambridgeshire and Peterborough Foundation Trust (CPFT) Healthy Child Service have TUPE'd (Transfer of Undertakings Protection of Employment) across to the Trust. The Safeguarding Children Team have been working alongside the operational leads to ensure a safe transfer of the service. An induction day was supported by the Assistant Director of Safeguarding to ensure the teams were aware of the safeguarding

processes and the provision on offer. Further work has been undertaken to consider high risk cases and ensure staff transferring over are fully supported with case management.

4.3 **Norfolk and Suffolk**

4.3.1 Work to support safe transition of safeguarding work to a group model has been ongoing alongside Norfolk Community & Health Care (NCHC) Trust. A workplan has been developed to consider policy alignment, staffing model and governance processes within both organisations and further scrutiny is supporting alignment of the governance processes for safeguarding oversight. Strategic group meetings will be held jointly on the same day but will maintain own adherence to the terms of reference for each organisation. Agreement to amend the terms of reference to accommodate an aligned and combined group model is in place and will be addressed in the second quarter of the year.

4.4 **Bedfordshire & Luton & Milton Keynes**

4.4.1 The Business Continuity Plan has been updated in Q4 2024 - 2025, to ensure that core safeguarding functions can be maintained. Staffing vacancies have been recruited to within the team and start dates anticipated within the next 2 - 3 months.

4.5 **Children's Multi-Agency Safeguarding Hub (MASH) Health Function**

4.5.1 Management oversight of Cambridgeshire & Peterborough MASH functions is now directed through the operational Healthy Child Programme (HCP) leadership in the locality. Recruitment to roles in the MASH functions has been actively undertaken and staff will commence in post in early 2025. Agency staff continue to support this function until 3 May 2025.

4.5.2 Norfolk & Waveney MASH health function remains under the management oversight of the Safeguarding team. The review of the MASH and front door functions is now supporting wider discussions across the system to consider the health input into the MASH.

4.5.3 Bedfordshire and Luton MASH function is subject to an ICB review of commissioning, model provision and delivery. The Assistant Director of Safeguarding is supporting operational leadership with discussions related to risk management.

5.0 Infection Prevention and Control (IPaC)

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

5.1.1 All clinical staff are required to be assessed on their hand decontamination techniques in line with the Trust's Infection Prevention and Control Policy. The compliance target is 90%. In February the Trust achieved 90% however, this dropped to 89% in March. Progress is monitored through the IPaC huddle with solutions being individualised for each service, the outcomes are

also discussed at the IPaC Huddle, with the IPaC Champions and at the IPaC Committee.

5.1.2 The Trust's 2024- 2025 staff seasonal influenza campaign closed at the end of March in line with the national programme. The latest national dataset (up to January 2025) shows a compliance rate of 59.4% for frontline staff. The national average is 40.6% and 40.8% regional average. Work has already started for the 2025-2026 campaign.

5.2 Other infections

5.2.1 As part of the national mandatory surveillance, the Trust 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.

5.2.2 This is so we can learn lessons and share best practice across the system. Whilst the Trust has 0 cases of any of those listed above, staff will care for patients in the community who have contracted these infections from hospital or other healthcare facilities.

5.2.3 Additional Surveillance data (national and regional) is provided by United Kingdom Health Security Agency (UKHSA) including epidemiological data for specific organisms such as Norovirus, Seasonal Influenza, Respiratory Syncytial Virus (RSV) and notifiable diseases such as Measles and Pertussis (Whooping cough). This information allows us to predict patterns where increased cases may occur such as seasonal viruses. It also identifies increased cases of new and existing diseases allowing us to communicate to staff and contractors including cleaning and Occupational Health services.

5.2.4 This gives the Trust an opportunity to communicate with staff and ensure the right IPaC measures are in place. Though the number of incidences has reduced, the team continue to focus on Measles and Pertussis prevention and have been working with Occupational Health to ensure relevant staff can be vaccinated against Pertussis. The team are also coordinating information as required, regarding the latest Mpox, Norovirus, Respiratory Syncytial Virus (RSV) and influenza surveillance data and national guidance as it is made available.

SECTION TWO – CARING

Caring	• FFT scores were at 90% for 90% of services across the organisation. **(C1) (Substantial)**. • 80% of all formal complaints were responded to within the timeframes agreed with the complainant **(C2) (Substantial)**.	**Substantial**

Provide Outstanding Care

6.0 Patient Experience

6.1 Friends and Family Test (FFT)

6.1.1 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.

6.1.2 The Trust received 2686 responses in February and 3194 in March. This is over 800 more than the previous two-month period. Below is a summary since August 2024.

	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
Trust Overall	2430	2517	3230	3442	2143	2931	2686	3194	22577

6.1.3 The overall Trust FFT positive feedback was 92.57%, with a 1.43% negative feedback percentage. Cambridgeshire 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) in Norfolk and Cambridgeshire which detract from the positive FFT score. This has been identified as an issue in previous reporting periods. In December and January there was an improvement but, in this period, the positive FFT score has decreased.

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

6.1.5 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.

	% Positive	% Negative	Total FFT Responses	Contacts	Response Rate
Ambulatory Care	96.94%	1.51%	3103	33577	9.24%
Bedfordshire and Luton Children and Young People's Service	97.02%	1.10%	638	40434	1.58%
Bedfordshire and Luton Adults Community Service	96.18%	0.32%	629	29604	2.12%
Cambridgeshire Children and Young People's Service	74.09%	1.73%	1096	28490	3.85%
Norfolk and Waveney Children and Young People's Service	96.38%	2.17%	414	30794	1.34%
Trust wide	**92.57%**	**1.43%**	**5880**	**162899**	**3.61%**

6.1.6 All surveys with the FFT question also ask to what extent the service user felt that they were treated with respect and dignity. 4980 service users answered this question and a score for each directorate is shown below. This is a newly reported indicator for the Trust, with the results being fed back to services for review and action.

	Dignity and Respect Score
Ambulatory Care	95.98%
Bedfordshire and Luton Children and Young People's Service	97.41%
Bedfordshire and Luton Adults Community Service	92.99%
Cambridgeshire Children and Young People's Service	82.35%
Norfolk and Waveney Children and Young People's Service	94.20%
Trust wide	**93.57%**

6.2 **Comments**

6.2.1 In February and March, the services we provide received 8050 positive comments across the Trust, this is over 500 fewer than the last reporting period. We received over 151 positive comments for every complaint (formal and informal).

6.2.2 Comments come from service user surveys, feedback forms and other sources, for example Google reviews.

SECTION THREE – EFFECTIVE

Effective	• Overall Information Governance mandatory training levels are at 96% (target level 95%). **(E2) (Substantial).** • One of the EDS targets will be carried over to 2025-2026 **(E6) (Reasonable).** • Overall compliance with mandated safeguarding children supervision achieved target at 90%. **E7 (Substantial).**	**Reasonable**

7.0 Information Governance (IG)

7.1 The Data Security Protection Toolkit (DSPT) for2024 - 2025 has been updated to include the National Cyber Security Centre's Cyber Assessment Framework as a basis for cyber security and IG assurance. An interim response to NHS England was completed on 18 December 2024 which provided an initial indication of the expected level of achievement each outcome measures across 5 overall objectives.

7.2 An external audit of the Toolkit has been conducted by RSM in March 2025, the result feedback by the Auditors were positive but awaiting audit report. The final deadline for publication included supporting statements for all 47 outcome measures is 30 June 2025.

7.3 Mandatory Information Governance (IG) and Data Security Awareness training compliance for both February 2024 was 95% and in March 2025 was 96% (against the 95% Trust target).

7.4 Between February 2025 and March 2025 there were 35 incidents (22 in February and 13 in March) reported under the Confidentiality Breach incident category which was a small increase on the 32 incidents reported in the previous period. Most incidents related to human error or administrative issues; no specific trends were identified.

7.5 No incidents met the threshold for reporting to the Information Commissioner's Office (ICO). A review of human error incidents has taken place to see if lessons can be learnt, this has been reported back though the Quality Improvement Group to the Quality Improvement and Safety Committee. The Information Governance Manager assessed all Information Governance incidents, themes, issues as appropriate and provides advice to staff to prevent errors from reoccurring. A learning slide has been produced and will be presented at relevant Governance meetings.

8.0 Equality Diversity Objectives Updates

8.1 Equality Delivery System (EDS) Domain 1: 'Commissioned or Provided Services'

8.1.1 Five equality objectives were identified from the EDS 2023 report, one remains active / ongoing and is being progressed:

Linked to EDS Equality Outcome	2023 Equality Objective	Progress (to end of March 2025)
1A: Patients (service users) have required levels of access to the service.	1. Reduce service user 'Did Not Attends (DNAs) by enhancing accessibility of communication methods with reminders and ability to respond via text.	Status: in progress – Next step is to review the DNA rates and check if a text message was sent. – If a reduction in DNA rates is seen, this will be rolled out across the Trust.

8.2 Equality Delivery System (EDS) 2024 – Domain 1: Commissioned and Provided Services

8.2.1 The services highlighted for the EDS 2024 are Trust wide Speech and Language Therapy, Trust wide Dental and Family Nurse Partnership in Cambridgeshire and Peterborough. Dental and Family Nurse Partnership are linked to CORE20PLUS5.

8.2.2 The indicative ratings and future objectives for Domain 1 were reviewed and approved by the People Participation and Equality Committee in February. The overall score for Domain 1 was 12, out of a maximum of 12. The full EDS report was presented as part of the Equality Diversity and Inclusion Annual Report at the Public Board in March.

8.2.3 Trust wide objectives have been agreed and will be reported through Trust wide Working Together Group and People Participation and Equality Committee.

9.0 Mandatory Training

9.1 The team are working with the Quality Improvement training team to add this to ESR and allow staff to book onto training directly through ESR.

9.2 The team continue to offer and work with services to add Essential to Job Role training onto the Electronic Staff Record (ESR) and have widened the offer to teams who offer skills training within the Trust and recording this on ESR.

9.3 The service is working on identifying a pilot group to test the new Safeguarding Level 3 provisions and Higher Level Prevent radicalisation training, which now has an added annual requirement.

9.4 Staff within the Trust are going to be moving from ESR Limited access to ESR Full access, which will give greater flexibility and more functionality to book onto training, this will allow access to complete an online Safeguarding Level 3 passport along with other Self-Service aspects of the system.

9.5 The overall mandatory training compliance for March 2025 was 97%.

SECTION FOUR – RESPONSIVE

Responsive	• All of our service areas with waiting lists have an Improvement Plan that is agreed and being delivered. **(R1) (Substantial).** • 90% (9 / 10) formal complaints were acknowledged within 3 working days of their receipt into the Complaints team. **(R2) (Partial).** • All valid requests for information under the Freedom of Information Act 2000 were provided to applicants within 20 working days of their receipt into the Information Governance team. **(R3) (Substantial).** • 100% (February 2025) and 100% (March 2025) of responses to all valid Access to Records (ATR) requests under the Data Protection Act 2018 were provided to applicants within 30 calendar days of their receipt into the Information Governance team. **(R4) (Substantial).**	**Substantial**

10.0 Access to Our Services Including Referral to Treatment (RTT) / Waiting Times

10.1 **Children and Young People's Specialist Services**

Cambridgeshire Community Paediatrics

10.1.1 The ICB have created a task and finish group for a Children's Needs-led Neurodevelopmental Assessment Pathway, which will take forward the work commenced in 2024.

10.1.2 Wait times are continuing to increase with over 400 children waiting longer than a year at the end of March 2025. The longest current wait is circa 107 weeks. Eighty-one children transitioned from Year 6 to 7 in 2024 with approx. 300 children approaching year 6. Currently, the Trust is still waiting for a decision on the management of these assessments, alongside another provider.

Cambridge Audiology Service

10.1.3 Waiting times have increased due to reduced capacity; the longest new referral wait is circa 20 weeks. Clinical oversight and management of the

waiting list is in place. It is though anticipated that the staffing position should improve in May 2025, which will positively impact on waiting times.

10.2 **Dynamic Health**

10.2.1 The service implemented a waiting list initiative which includes the following workstreams with the following patient numbers (recorded up to Mid-April):

i. Community Assessment Day in Peterborough, which saw 186 patients
ii. Super Saturdays and Super Sundays which saw 964 patients. This workstream continues in Cambridge/Ely until beginning of May 25
iii. Employment of locum agency staff, which impacted 1147 patients, this workstream continues until end of April 25
iv. Revalidation of the physiotherapy waiting list across the service, which saw 407 patients discharged
v. Flok Health -low back pain pathway, 2028 patients sent to Flok's digital clinic up to 10th April 2025. This workstream continues until mid-May when the outcome will be reviewed.

10.3 **Dental Services**

Cambridge and Peterborough (C&P) Special Care Dentistry

10.3.1 All waiters are reviewed weekly via Patient Tracking List meetings to ensure that patients are prioritised where needed and any impact of unexpected delays, such as cancelled clinics, is minimised.

Suffolk Special Care Dentistry

10.3.2 Suffolk activity remains consistently within service level with longest waiters all having booked appointments.

10.3.3 The service continues to review all patients via weekly tracking to ensure that new patients are being seen within 8 weeks of referral for an initial assessment.

Minor Oral Surgery

10.3.4 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.

10.3.5 Cambridge patients requiring a GA are listed for GA at West Suffolk Hospital (WSH). Patients are being assessed to determine need with urgent cases being booked from 10 weeks. The remaining patients are now seeing reduced waits currently at 38 weeks, which is a six-week improvement on last report.

10.3.6 Suffolk Patients having GA's at West Suffolk Hospital are within service level being booked from 6 weeks which is a three-week improvement compared to last report.

10.6 **Integrated Contraceptive and Sexual Health Services (iCaSH)**

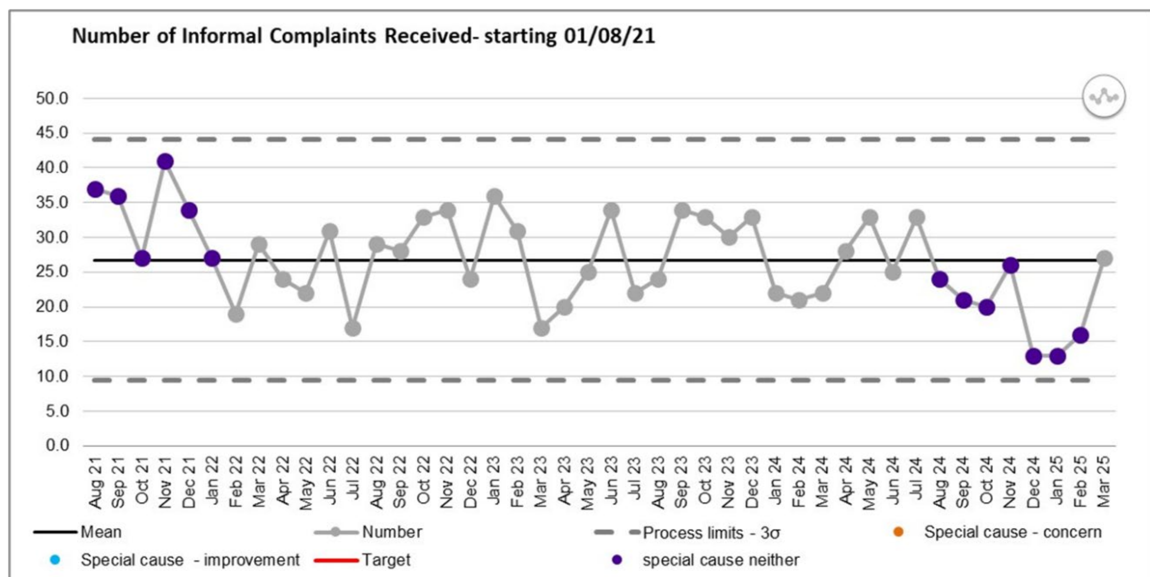
10.6.1 There are no patients on current waiting lists (as at submission) for LARC (Long-Acting Reversible Contraception).

10.6.2 There are no waiting lists for HIV PrEP (Pre-Exposure Prophylaxis).

11.0 Complaints

11.1 Informal complaints received.

11.1.1 We received 43 informal complaints in this data period: 16 in February and 27 in March. Both months were within the expected variation. The chart below shows that the number of informal complaints received in March was above average, the previous seven months were below the average for the period since August 2021.



11.1.2 Forty two of the 43 complainants were contacted within four working days to discuss resolution of their concerns. One complainant was contacted on day six. This informal complaint was managed by the service before logging on Datix.

11.2 Themes and learning from formal complaints closed in February 2025 and March 2025

11.2.1 Forty-four informal complaints were resolved and closed in February and March with 51 subjects / issues identified.

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

- Communication and Information (15)
- Delays (14)
- Clinical Care (13)

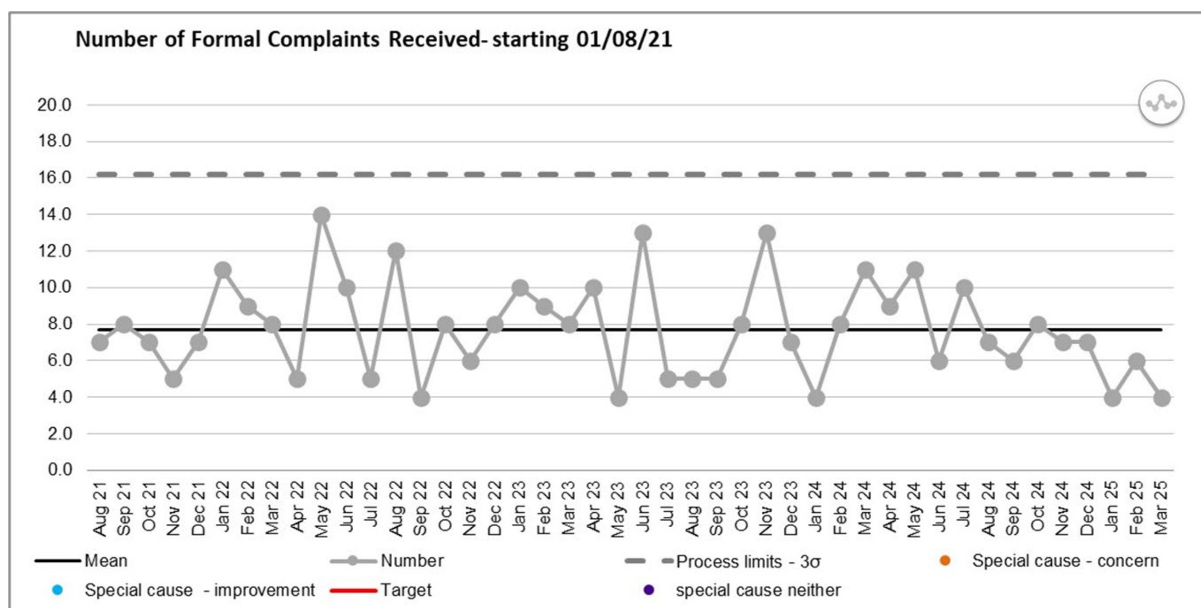
11.2.3 There were three issues about Communication and Information in relation to Children's Audiology in Luton, two were from the same complainant.

11.2.4 Of the ten issues related to Delays, there were three related to the Community Paediatric Service in Bedford.

11.2.5 There were no themes in the services identified in the informal complaints about Clinical Care, the 13 issues were spread over nine services.

11.3 Formal Complaints

11.3.1 The Trust received ten formal complaints in this data period, six in February and four in March. As shown in the graph below, this is within the expected range based on data for the number of complaints received since August 2021.



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.

11.4 Themes and learning from formal complaints closed in February 2025 and March 2025

11.4.1 Within this data period we responded to and closed ten formal complaints. In these there were 21 subjects identified. All ten of these were not upheld.

11.4.2 Clinical Care was the most frequently occurring subject with five identified in five complaints. Communication and Information was identified an as issue five times in four complaints and there were three issues of Delays and Staff Attitude.

11.4.3 Eight services were named in the ten formal complaints responded to in February and March. There were no themes in the services involved.

11.5 Formal Complaint Response Times

11.5.1 In this data period, we responded to ten formal complaints (four in February and six in March). A summary of the response times is shown below.

	December	January	February	March
Number of standard complaint responses sent within a 35-day timeframe.	2/5	1/4	3/3	4/5
Percentage of standard complaint responses sent within the 35-day timeframe.	40.00%	20.00%	100.00%	80.00%

Number of complex complaint responses sent within the 40-day timeframe.	0/0	1/1	0/1	1/1
Percentage of complex complaint responses sent within the 40-day timeframe.	N/A	100.00%	0.00%	100.00%
Average number of working days to respond to standard complaints.	41.20	36.50	31.33	28.60
Average number of working days to respond to complex complaints.	N/A	31.00	72.00	35.00

11.5.2 The percentage of standard complaint responses sent within the 35 working day timeframes increased in February and March. One standard complaint response was sent on day 37, one complex response was sent on day 72 (see appendix 5).

11.6 **Member of Parliament (MP) Contacts**
In this period there were two contacts received via an MP, one about waiting times in Bedfordshire and Luton Community Paediatrics and one about parking provision for District Nursing staff completing home visits.

11.7 **Parliamentary Health Service Ombudsman (PHSO)**
There were no complaints referred to the PHSO in February and March.

11.8 **Supporting Services with Correspondence - With Service Users**
The Patient Experience Team supported the writing of three letters of expectation in February and March, one for Dental Services, one MSK Dynamic Health and one for Cambridgeshire 0-19 services.

12.0 Freedom of Information (FOI) requests

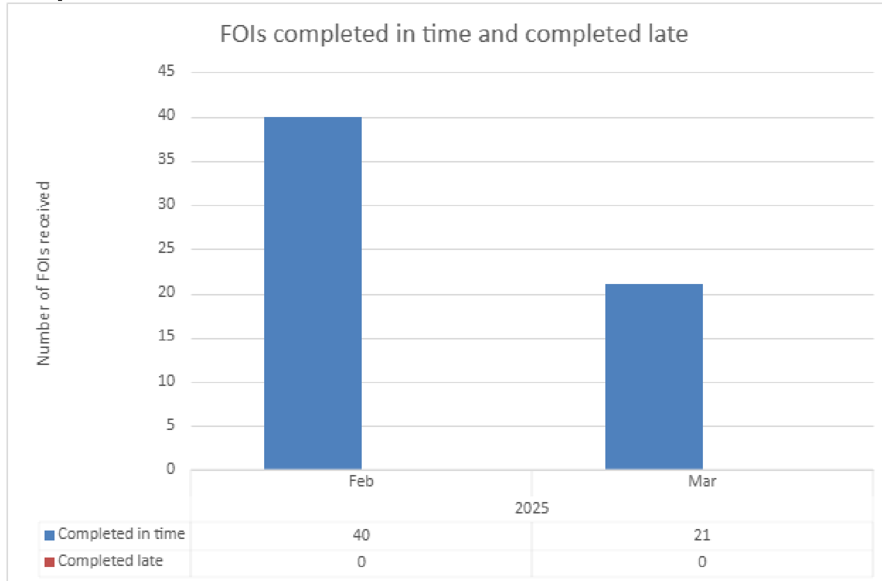
12.1 In February and March 2025, the Trust reported 100% achievement of the responses required for Freedom of Information requests within the 20-day timeframe. The total number of requests received by Directorate are set out in the table below.

Table 3.

FOI's – Directorate	**February 2025**	**March 2025**
Total for CCS	40	25
Support Services	35	23
Ambulatory	0	0
Cambridgeshire and Norfolk Children's and Young People's Health Services (CYPHS)	0	1
Bedfordshire Community Health Services (Children)	1	1
Luton Children and Adults Community Health Services	4	0

Provide Outstanding Care

Graph 9.



NB: There are 4 outstanding FOI's for the March period, but still within the 20-day timeframe.

12.2 Work is ongoing to produce a chart based on FOI themes that would be helpful for public consumption.

13.0 Access to Records (ATR) requests

13.1 In both February and March 2025, the Trust reported 100% achievement of the responses required to ATR requests within the 30-calendar day timeframe. The total number of requests received by Directorate are set out in the table below.

Table 4.

ATR's - Directorate	February 2025	March 2025
Total for CCS	62	87
Support Services	0	1
Ambulatory	34	42
Cambridgeshire & Norfolk Children's and Young People's Health Services	10	18
Bedfordshire Community Health Services (Children)	14	14
Luton Children and Adults Community Health Services	4	12

14.0 Care Quality Commission (CQC)

14.1 The CQC self-assessment tool has been refined to reflect the CQC's simplified scoring system and has been re-distributed to all services for submission at the end of June 2025. The actions from the previous round of self-assessments have been uploaded to Datix and have been reported to Clinical Governance meetings.

14.2 The Statement of Purpose has been updated to reflect the addition of the Peterborough Healthy Child programme following TUPE from CPFT on the 1 April 2025 as well as the addition of Oral Health Improvement Team in parts of Essex.

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A: Assurance Summary

Safe	• Staffing pressures are adequately controlled, plans agreed with commissioner for prioritising service delivery and service plans in place to reduce staffing pressures **(S4) (Reasonable)** • Freedom to Speak Up mandatory training (Speak Up) has been completed by 90% employees **(S6) (Substantial)**. Achieved 99%.	**Reasonable**
Effective	• Mandatory training compliance is 97% - above target of 90% **(E1) (Substantial)** • Overall Information Governance mandatory training levels at or above target level (95%). Achieved 96%. **(E2) (Substantial)** • Appraisal rates 91.54% - target level 92% **(E3) (Substantial)** • Monthly sickness rates in March 2025 5.48% compared to latest NHS England rate for community Trusts of 6.2% for January 25. **(E4) (Substantial)** • Stability 89% and is above target of 85% **(E5) (Substantial)** • Equality Delivery System (EDS) objectives agreed and being delivered upon. **(E6) (Substantial).**	**Substantial**
Well Led	• Agency spend within overall agency ceiling **(WL4) (Substantial)**	**Substantial**

In addition to the overview and analysis of performance for February and March 2025 the Board can take assurance from the following sources:

- NHS National Staff Survey 2024 results where the Trust 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.

- Care Quality Commission (CQC) inspection report published in August 2019. CQC rated the Trust as Outstanding overall and Outstanding within the caring and well-led domains. The inspection report highlights several areas that support the delivery of this objective.
- The positive staff feedback the Trust has received via staff survey results in relation to speaking up.
- Risks 3619 and 3620 cover these pressures and are reviewed regularly (these have since been closed owing to them being at target for some time).

- Discussions within the two Service Assurance Committees that took place in May 2025.
- Update on the delivery of our People Strategy (including the delivery of Programme 2 Diversity and Inclusion for all and the Equality Delivery System Objectives) presented to the Board – November 2024.
- Annual Freedom to Speak Up report being presented to the Board – May 2025.
- Presentation of Staff Survey Results to Public Trust Board meeting – March 2025.
- Presentation of Equality, Diversity and Inclusion Annual Report – March 2025.

B: Risks to Achieving Objectives

Strategic Risks

1. ***Risk ID 3619 -*** *There is a risk that staff morale falls, the delivery of high-quality care will be adversely affected. (Risk rating 8 – closed in April 2025)*

2. ***Risk ID 3620 –*** *There is a risk that should a service experience a high level of unplanned absence and/or vacancies the delivery of high-quality care may be adversely affected. (Risk rating 8 – closed in April 2025).*

Related Operational Risks 15 and above

1. *None.*

C: Overview and analysis

1.0 Freedom to Speak Up Mandatory Training

1.1 All staff complete 'Speak Up' Mandatory Training when they join the Trust. Core training is essential for all employees and covers what speaking up is and why it matters. It will help learners understand how to speak up and what to expect when they do. The annual target is 90% and the Trust achieved this throughout February 2025 (98%) and March 2025 (99%).

2.0 Sickness

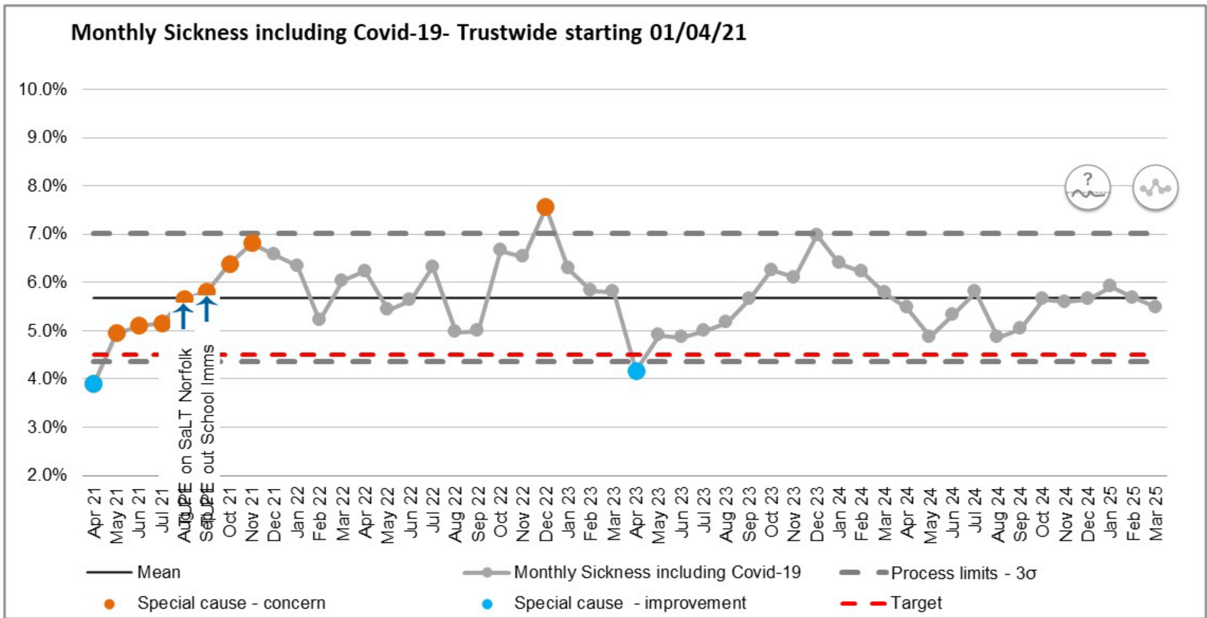
2.1 The 12-month cumulative rolling rate (February 2025 – 5.43%, March 2025 – 5.44%) remains above the Trust rolling target of 4.5%.

2.2 Monthly Trust wide rate for February 2025 was 5.68% and for March 2025 was 5.48%.

2.3 The Trust wide sickness rate has 3.02% was attributed to long term sickness and 2.45 % short term sickness absence. Beds & Luton had the highest sickness rate (7.81%) and Support Services the lowest (2.88%). The top reason Cold, Cough, Flu - Influenza (22.02%); work continues to reduce those absences attributed to unknown/other reasons as much as possible.

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

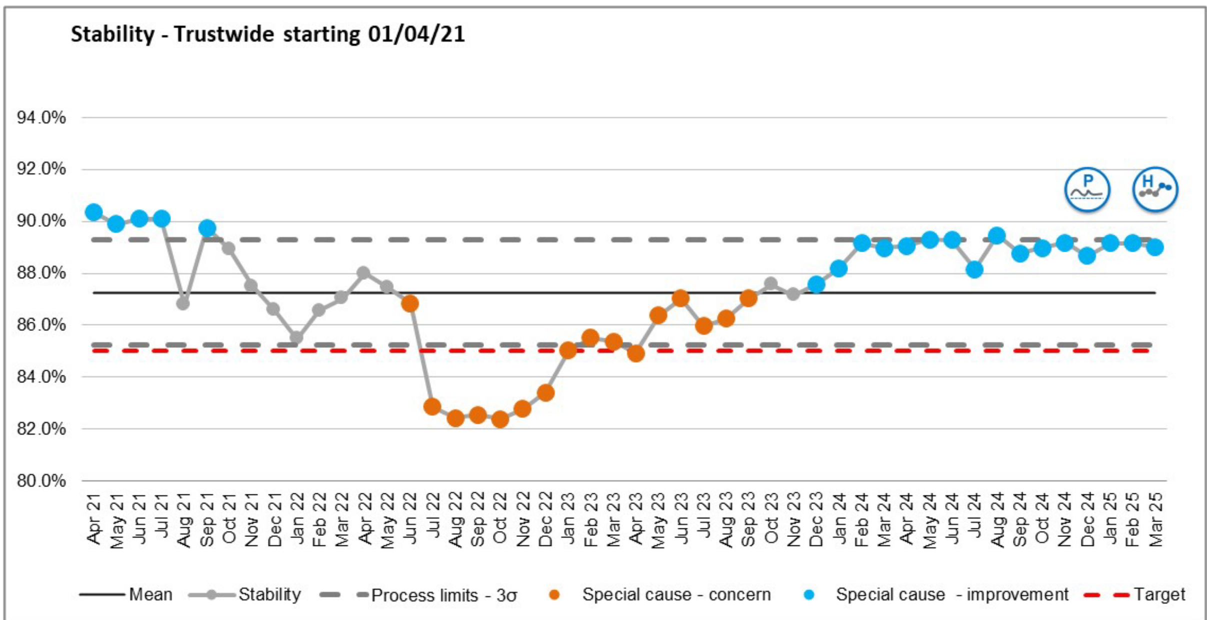
6.2 %.



3.0 Stability

3.1 The following chart shows the monthly stability rate (percentage of staff employed over 1 year) – February 2025 – 89.15%, March 2025 – 89.01%, against the Trust target of 85%. This compares favourably to a stability rate of 88.6% for NHS Community Provider Trusts for all employees (source: NHS Digital Workforce Statistics, December 2024).

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



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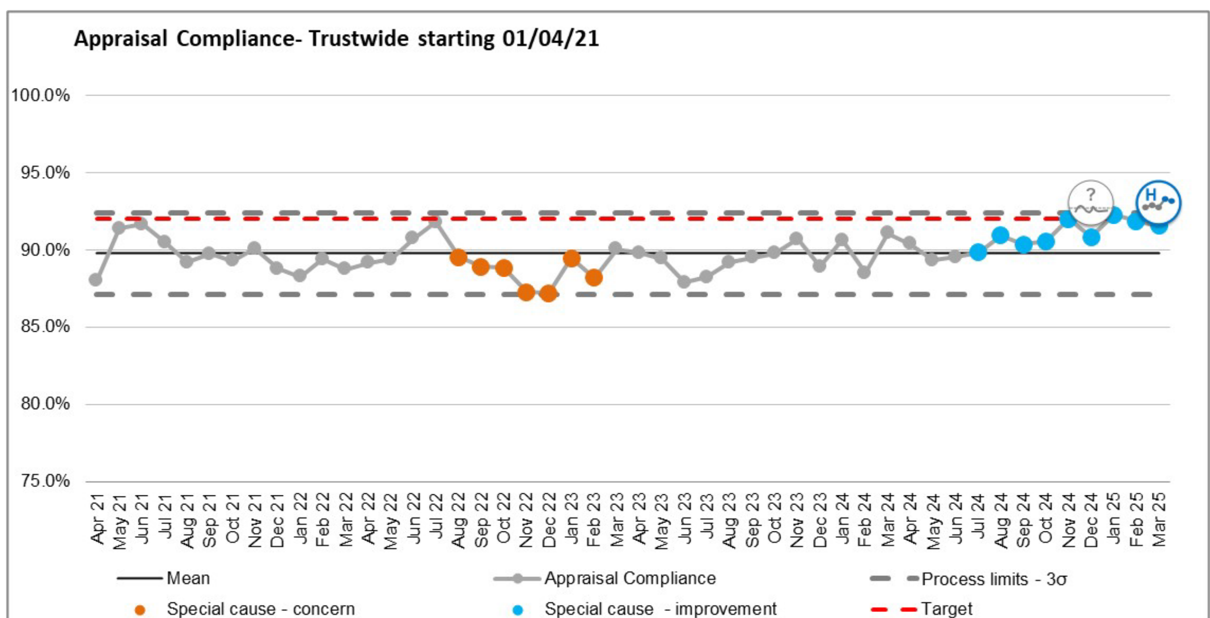
4.0 Appraisals

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

4.2 The Trust wide Appraisal rate decreased in February 2025 – 91.86 % and March 2025 – 91.54%, has reached target of 92% for 2024/25.

4.3 Luton Children has the lowest rate (86.61%), Ambulatory Care has the highest rate (95.76%). 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.



5.0 Turnover

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

5.2 The Trust’s Rolling Year Turnover Rate is currently 11.13% (February 2025 – 10.83%, March 2025 – 11.13%) 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”).

5.3 Ambulatory Care currently has the highest Rolling Year turnover rate at 11.81%, with Beds & Luton Adults having the lowest at 9.91%.

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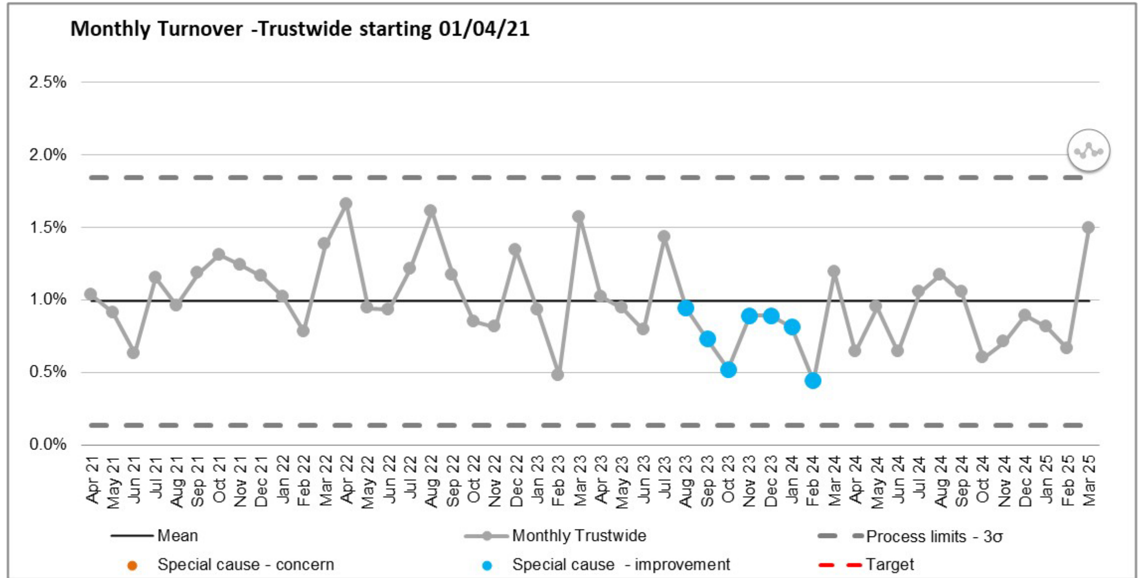

6.0 Delivery of Equality Delivery System – Domain 2 - Workforce Health and Wellbeing and Domain 3 - Inclusive Leadership Objectives – 2024/5 end of year position

Domain 2: Workforce health and well-being objectives	End of year position:
1. When at work, staff are provided with support to manage obesity, diabetes, asthma, Chronic Obstructive Pulmonary Disease (COPD) and mental health conditions. 2. When at work, staff are free from abuse, harassment, bullying and physical violence from any source. 3. Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source. 4. Staff recommend the organisation as a place to work and receive treatment.	The Trust delivered against each of these objectives. Staff health and wellbeing is a core programme in our people strategy and includes a focus on tackling health inequalities. In addition, numerous actions and activities have taken place throughout the year in relation to reducing abuse, in all forms, and reducing violent and aggressive incidents. We also received very positive feedback in the 2024 staff survey in relation to recommending the organisation as a place to work and received treatment.

Domain 3: Inclusive Leadership Objectives	
1. To continue the roll out of the inclusive leadership programme across the Trust over the next 18 – 24 months.	We continue to roll our inclusive leadership across the Trust, and this continues to be a focus in 25/26. We will look to do this across our group.
2. Year 3 Service Plans to continue to identify their contributions towards addressing Health Inequalities.	Year 3 service plans did identify contributions to addressing health inequalities across our different services and populations.
3. Trust Board and senior leaders to continue to take a leading role in the delivery of the Trust's ambitions in inclusive leadership.	Trust Board members and senior leaders have personal anti-racism/inclusivity pledges in place.

7.0 National Review of nursing and midwifery job matching profiles:

7.1 Following a request made by the Royal College of Nursing (RCN) and the Royal College of Midwives (RCM) to the NHS Staff Council in 2021, the NHS Job Evaluation Group has been undertaking a review of the national job matching profiles for nursing and midwifery (band 4 and above) to ensure that the profiles accurately reflect current nursing and midwifery practice, training, and role development.

7.2 Updated profiles will be published with accompanying technical guidance from the national Job Evaluation Group in early June 2025. NHS employers have issued guidance on its suggested approach to job description reviews and the steps needed to ensure good job evaluation practice.

7.3 We need to ensure that we have the capacity required to cope with a potential increase in job evaluation activity. To meet this, the human resources team will adopt its own job evaluation training package, supported and developed in collaboration with our Staff Side Chair. This will be in line with training that is currently provided in Norfolk Community Health and Care NHS Trust (NCHC). The human resources team have reached out to service leads for nominations for staff members to be trained and to attend matching panels to meet any increase in demand.

7.4 Following publication of the confirmed national profiles and subsequent national guidance updates, a task and finish group will be created to review roles across the Trust. There will be a review of job descriptions and person specifications to ensure one standard template to be used across the Trust, locality differences will be incorporate where needed. Each standard template will be evaluated.

7.5 It is not currently predicted that this will result in a high level of re-banding requests from our staff or significant changes to job bandings. We will however keep this under review.

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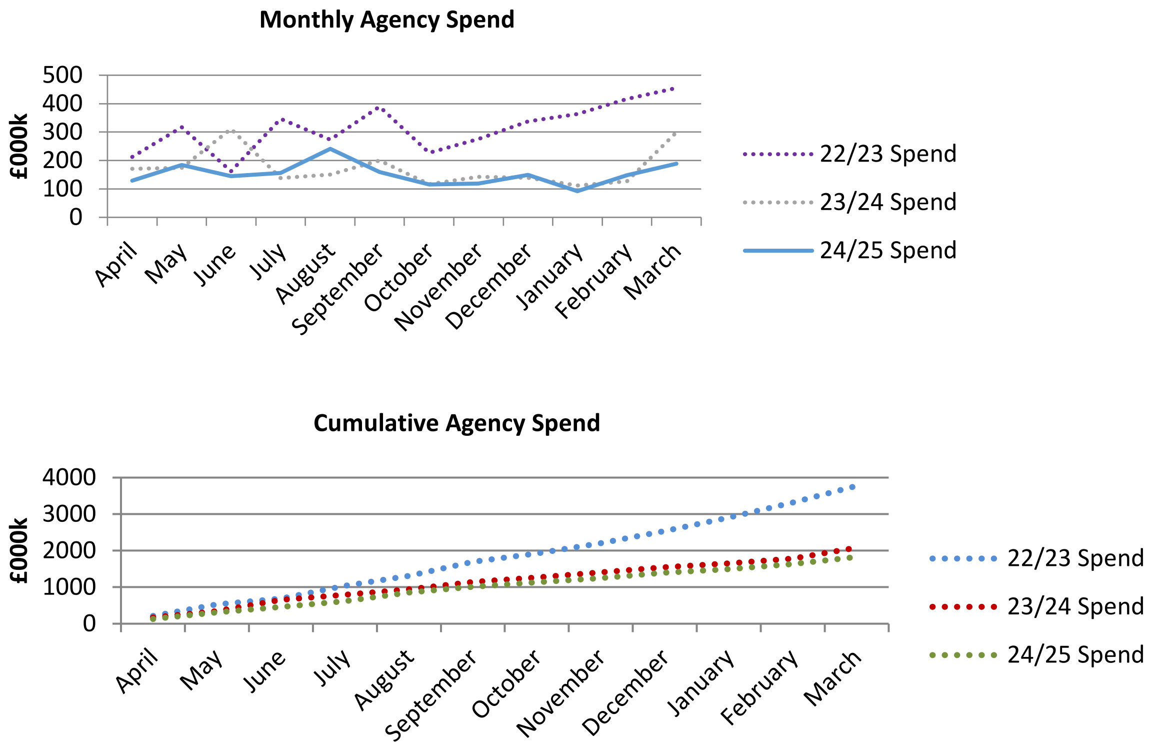
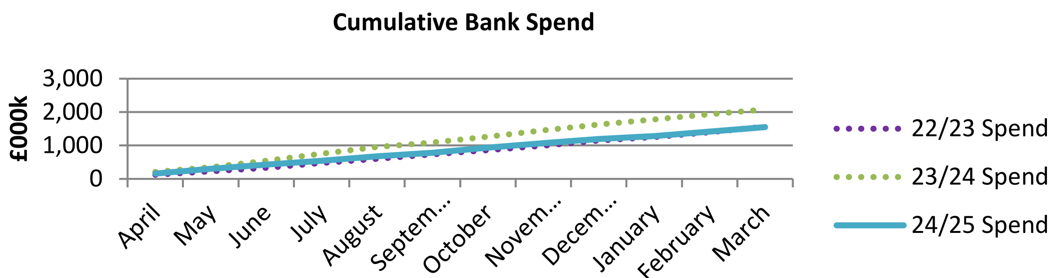
8.0 Agency/bank spend



8.1 The Trust's cumulative total agency spend for the year was £1,827k, which is a decrease in the total when compared to the same period in 2023/24, which was £2,082k

8.2 The Trust does not have an identified agency spend ceiling, however the Cambridgeshire and Peterborough system, which is our primary reporting system, has an agency ceiling across all its providers. This is 3.2% of the total system provider's pay costs. At month 12, the Trust's agency spend was 1.5% of its total planned pay costs.



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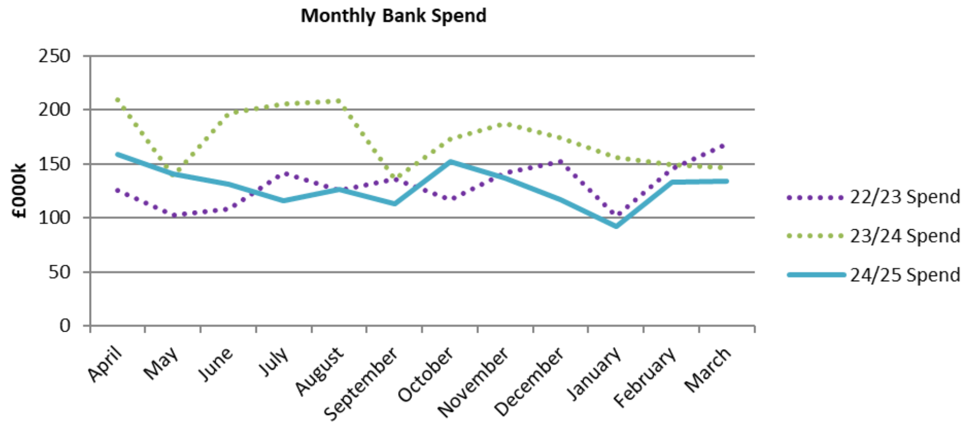

8.3 To reduce the usage of agency, the services have the availability of bank staff to fill short term staffing pressures. The Trust's cumulative bank spend for the year was £1,551k. This is lower than the equivalent period in 2023/24, when spend was £2,079.

Be Sustainable

A: Assurance Summary

Well led	**WL1** I&E in line with budget **(Substantial)**	**Reasonable**
	WL2 Delivery against efficiency target in line with plan **(Partial)**	
	WL3 Capital spend in line with budget **(Substantial)**	

1. In accordance with the Trust's Assurance Framework, the Board receives assurance from the reporting of the Trust's financial sustainability and performance from Strategic Risk 3621, and Clinical Operational reporting of financial performance and escalation processes.

2. The Trust Board will also take assurance from External Auditor's Unqualified opinion and its "Value for Money conclusion" of the Trust's 2023/24 accounts. Internal Auditor's assessments during 2023/24 concluded that the Trust has an adequate and effective framework for risk management, governance, and internal control. The Trust's Local Counter Fraud Service (LCFS) annual report included a summary of work carried out during the year which concluded the Trust has a strong anti-fraud culture.

3. The Trust's financial performance for the year April 2024 to March 2025 summarised in Section 1, was a £53k surplus Operating position being delivered against a year-to-date Trust wide revenue totalling £180.1m. As a result of the Trust full valuation of its Non-Current Assets as at 31st March 2025, an overall net Impairment of £6.035m was written down into the Income and Expenditure account as a non-operating expense.

4. Section 2 of this Overview section of this report includes a summary of the yearly cashflow with overall cash balance increasing in the period due to a reduction in Trade Receivables and Capital project funding.

5. The Trust's overall performance against the Public Sector Payment Policy performance for reporting period is detailed in Section 4 of this report. During February and March 2025 performance improved when compared to the previous reporting period.

6. The Trust Capital programme includes the construction of the Multi-Storey Car park and the completion of the Community Diagnostic Centre at the Princess of Wales Hospital in Ely, and the costs associated with the removal and demotion and associated works of a RAAC affected building on the North Cambridgeshire Hospital site in Wisbech.

7. Section 6 of the of Overview section of this report includes a summary of the overall performance of the Efficiency Schemes for 2024/25. A wide range of pay and non-pay schemes are also being developed for delivery during 2025/26 with emphasis on multi-year programme delivery.

Be Sustainable

B: Risks to achieving objective

Strategic risks

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

2. ***Risk ID 3621*** *– There is a risk that due to increasing inflationary pressures and a challenging efficiency target, the Trust may not deliver a balanced financial plan for 2024/25 which could impact on the delivery of services. (Risk Rating 8 – closed in April 2025 and replaced with a new risk for financial year 2025/26).*

Related Operational Risks 15 and above

None.

C: Overview and analysis

Finance scorecard

Finance Dashboard	Section in	Plan	Actual	Variance
	Report	M12	M12	M12
Operating income	1	£152,310k	£171,543k	£19,233k
Other operating income	1	£8,966k	£7,839k	£704k
Employee expenses	1	(£110,751k)	(£127,733k)	(£16,982k)
Operating expenses excluding employee expenses	1	(£50,525k)	(£51,592k)	(£1,067k)
Operating Trust Surplus	1	£0k	£53k	
Closing Cash Balance	2		£6,575k	

1. Income and expenditure

1.1 Our clinical services are funded by Block contract income totalling £171.5m for the 12 months ended 31/03/25, received from our Commissioning bodies including Integrated Care Boards, NHS England and Local Authority Public Health Commissioners

1.2 The Trust delivered an overall breakeven position for the reporting period April 24 to March 25, with a closing underspend of £57k. The position was achieved with a combination of delivering efficiencies totalling £5.3m, overall cost controls and agreement of additional unplanned contract income.

1.3 As a result of the Trust full valuation of its Non-Current Assets as at 31st March 2025, an overall Impairment of £7.575m was written down into the Income and Expenditure account as a non-operating expense.

1.4 The Ambulatory Care Services delivered an overall cumulative surplus position of £70k. During the year this position has improved due to additional income in the Dental

service to support the patient backlog in our iCaSH (integrated Contraception and Sexual Health) and Dynamic Health services and a reduction in estates costs. The remaining overspend position includes the purchase of additional clinical equipment and estates costs in Dental services and the net impact of the pay award.

1.5 Bedfordshire Community Unit delivered a cumulative overspend position of £152k. The main reason for the overspend is due to above budget estate costs, pay costs and withing Children's Speech and Language Therapy due to income credits.

1.6 Children & Young People's Services delivered a cumulative overspend position of £374k. The position has improved during the year due to additional income for the Integrated Front Door service and in our Specialist Therapy Services. The main reason for the cumulative overspend is due to the unfunded element of the pay award in Healthy Child Programme in Cambridgeshire and Norfolk and in Norfolk Speech and Language service.

1.7 Luton Community Unit (including Luton Children's Services) delivered a cumulative overspend position of £876k. The cumulative overspend position is due to further cost pressures within Continuing Care, Community Audiology, and Health Child Programme and estates costs.

2. Cash position

2.1 The cash balance of £6.6m at month 12 represents an overall increase of £2m on the previously reported position at month 10. The change in the Trust's cash position is due to the receipt of PDC (Public Dividend Capital) funding for the RAAC (Reinforced Autoclaved Aerated Concrete) works at NCH (North Cambridgeshire Hospital) and a reduction in trade receivables over the period.

2.2 The current monthly cashflow continues to be monitored closely and managed daily with proactive action taken as required to ensure an appropriate level of liquidity.

3. Public Sector Prompt Payments (PSPP)

3.1 The last 2 months overall showed an improved position than the previous reporting period.

3.2 The performance fluctuated during the year due to a large number of outstanding queries following the issuing of the agreement of balances exercise. The Finance team will closely monitor dates of invoice approval and payment runs to ensure the 30-day target is achieved.

4. Capital

4.1 The main area of capital spend during the year 2024/25 included the continued development works and RAAC remediation at North Cambridgeshire Hospital in Wisbech and the Multi-storey car park at Princess of Wales (PoW) Hospital in Ely.

4.2 In addition, the Trust completed and delivered the new Community Diagnostics Centre at the PoW Hospital in Ely.

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5. Efficiency Programme

5.1 The table below summarises the identified Cost Improvement Plans identified and delivered in the year against the total allocated target of £5.3m. As we move into 2025/26, new schemes are added and where relevant, a Quality Impact Assessment (QIA) and Equality Impact Assessment (EIA) are completed and reviewed by the Medical Director and Chief Nurse.

5.2 Of the £5.5m of schemes delivered in 2024/25, 31% were recurrent savings.

5.3 The Schemes were evaluated using the Trust's Cost Improvement Programmes (CIP) Gateway process:

- **Gateway 1** – "Ideas Generated" within services and presented.
- **Gateway 2** – "Scoping and 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.

Gateway	April 2025 No. schemes	November Total £
1	-	-
2	3	91,544
3	69	5,385,380
	72	**5,476,924**
	24/25 Target	**5,268,451**

Category	Non-Recurrent £	Recurrent £	Grand Total £
INCOME	728,648	441,845	1,170,493
NON-PAY	98,000	604,039	702,039
PAY	2,937,196	667,196	3,604,392
	3,763,844	**1,713,080**	**5,476,924**