| Agenda item: | 7 |
|---|---|
| Date of meeting: | 19 November 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** ☐<br>**Reasonable** ✓<br>**Partial** ☐<br>**Minimal** ☐ |
|---|---|
| Rationale: | - Key evidence contained in this report and triangulation of this information with all Committee reports, particularly the Service Assurance Committees.<br>- The recommendation of assurance from the Group Executive team.<br>- 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 August and September 2025 and 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. The report contains various examples of how our services are addressing health inequalities, across the different systems in which we operate.

## 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 was NatPSA (National Patient Safety Alerts) received in this reporting period which were applicable to either CCS or NCHC. See section 1.7.1 of part three of the report.

## 5.0 Previous consideration by Committee or Executive

5.1 Group Trust Board Integrated Governance & Performance Report, 24 September 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**
- 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 There are 3 operational risks scoring 15 or above. These are detailed as follows:

NCHC

- **5200** - Community Nursing Demand and Capacity – Trustwide (rated 16)
- **5574** - Risk of patient harm/delay in care due to missing referrals onto UCR Out of hours (OOH) – (rated 16)
- **5571** - Unfunded pharmacy, inpatient medical, social care posts in Willow staffing model (rated 15)

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 are 3 operational issues scoring 4 (Major) or above on the issue register for CCS which are summarised as follows:

- two 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 reduced pharmacist and pharmacy technician cover across the Trust and is regularly reviewed and discussed at the Quality Committee.

## 10.0 Forward View for 2025/26

10.1 The executive team will be focusing on the following areas in the next period:

- Updating the key metrics and developing dashboards for the Service Assurance Committees. These will be incorporated into this report in the coming months.
- Agreeing a risk appetite with the Group Trust Board.
- Reducing long waiting lists for patients.

## Appendices:

**Appendix 1:** Inpatient Establishment Review September 2025

## Annexes:

**Annex 1:** Waiting times for all NCHC services – November 2025

**Annex 2:** Waiting times for all CCS services – November 2025

**CONTENTS**


## Part One:

Feedback, assurance and escalation from the service assurance committees

## Part Two:

Balanced score cards for each division (under development)

## Part Three:

Themes across the organisations

## 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:** Charlotte Black
**Meeting Date:** Friday 7th November 2025

**Key matters:**
The committee had an engaging development session before the main meeting, that focussed on what had gone well over the past year, not so well and future improvements. The outputs will help shape further improvements for the committee discussions, reporting and assurance

A patient story was shared with the committee from Luton Community Nursing services. This showed the partnership work that was taking place in Luton with Noah Enterprise, a charity supporting people struggling with homelessness and exclusion. A very powerful story demonstrating the incredible positive impact the team was having on looking after the healthcare needs of rough sleepers in Luton.

Half year updates were provided for all services in relation to Clinical Audits and patient safety incidents – **substantial assurance.**

The committee also received Integrated Governance Reports for the following:

**Luton and Bedfordshire Community Adult Services – substantial assurance.**

Key points:

- Services continue to be in a good position. Stable staffing levels remain. Service reported Opel 1 and 2 throughout August and September, with no need for any escalations. One area of staffing pressure which is within pharmacy tech service. This is being managed appropriately and mitigations in place, this will be addressed when Chief Pharmacist starts in December 2025.
- Sickness rates improving, however, remain above Trust target but less than similar period in 2024.
- No patient safety investigations identified during reporting period. No contractual performance notices in place.
- Over 8,500 wound care assessments have taken place since the introduction of the wound care app and data/reporting being developed to support the service with monitoring the qualitative impact. Increased level of photography enables clearer decision making to take place. Staff compliance with using the app remains high and feedback from staff positive.
- Deep dive into needle stick incidents had taken place. Identified that the frequency of needlestick injuries is very low when compared to level of activity taking place, however, learning was identified and being implemented.
- 2 formal complaints and 2 informal complaints during the reporting period.
- Finance – small overspend (less than 1%) is currently being forecasted.
- Service has introduced several new metrics since August 2025, these are helping the service to identify areas for improvement. In addition, work is taking place on improving data quality.

**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

- All incidents reported in period were no harm.
- 3 formal complaints received and 1090 positive comments/compliments
- Current average waiting lists are:
    - 8.28 weeks for pelvic health
    - 7.78 weeks for physiotherapy
    - 4.23 weeks for specialist services

- Service is currently not maintaining urgent appointments within the two-week target; however, all red flag referrals are being seen within this time frame. Service expects to be back on track with all urgent referrals within next 4-8 weeks.

NOW MSK Service – Norfolk Health and Care NHS Trust service

- Responsive assurance rating changed from substantial to partial due to data quality issues.
- All incidents reported in period were no harm.
- New friends and family process is currently being implemented.
- 2 formal complaints received.
- Staff within the service have raised some concerns in relation to the single point of contact administration service. An improvement plan has been put in place to address these.
- Current average waiting lists:
    - Musculoskeletal Assessment & Triage service (MATS) – 4 weeks
    - Continence Service – 4.3 weeks
    - Hand therapy – 7 weeks
    - Physiotherapy – 7.7 weeks
    - Foot and ankle biomechanics – 21 weeks

- Data cleansing work continues to take place in relation to urgent two-week referrals. Service expects to complete this in time for the next reporting period.

Dental Healthcare:

- Overall assurance rating for the service changed from substantial to reasonable due to special care dentistry waiting list pressures.
- Waiting list for Peterborough Special Care Dentistry is the services biggest challenge. The service has 100 patients waiting over 52 weeks, mixture of adults and children. Data cleansing currently taking place and an action plan has been developed, which is being monitored weekly. Service is currently exploring access to additional capacity to address these pressures. Learning in relation to these pressures will be shared at the next Committee meeting. The Committee expects to receive a greater level of assurance in relation to addressing these waits at the January 2026 meeting.
- Other waiting lists:
    - Suffolk special care dentistry – average wait of 5.3 weeks
    - Minor oral surgery – average wait of 7 weeks

- Service continues to receive high demand for urgent dental access, which it is unable to fully meet however some additional urgent care appointments have been commissioned in Cambridgeshire and Peterborough.
- Overall sickness absence levels are improving and in line with target for September 2025 at 4.5%. Pressure being experienced in relation to Dental Nursing and this is being mitigated by temporarily using agency dental nurses.
- 2 formal complaints.

iCaSH:

- All incidents reported low or no harm.
- Staffing levels across services are improving with around 8-10 posts currently out to advert. Service has a high level of confidence in being able to recruit to these posts and will update further at the next meeting.
- 3 formal complaints.
- Long-Acting Reversible Contraception (LARC) – service has recommenced a waiting list in Norfolk for this service, some individuals waiting up to 12 weeks for a routine LARC appointment. There are no waiting lists for HIV PrEP.
- Service is missing a couple of key performance indicators.
    - Cambs: % of women offered access to LARC within 10 working days/2 weeks of first contact (August – 43.525 against a 90% measure; September 45.91%)
    - Peterborough – same indicator (August – 85.37% against a 90% measure; September 72.94%)
    - Additional clinics and capacity being scheduled to address these.

- Demand remains high for online STI testing. Service continues to work with commissioners in relation to this and activity is regularly monitored.
- Sickness levels across services remain above the Trust target but is being appropriately managed.
- Financial sustainability remains a focus for the service.
- Procurement process underway for new electronic patient record as the current contract expires Marh 2026.
- Update on the contract position for all services was provided to the Committee. Outcome awaited in relation to Norfolk iCaSH services.

**Key escalations:**

There is no action required by the Group Board, however, the committee would like the Group Board to be aware of:

- Luton Adults safeguarding level 3 training remains below target. Targeted approach and additional training being put in place to support improvement in this area.
- NOW MSK services – information governance training, Oliver McGowan e-learning and safeguarding level 3 training for adults below target. Improving performance in these areas remains a focus for the service.
- Dentistry services – Peterborough special care dentistry waiting list currently has 100 patients waiting over 52 weeks.

**Key risks and issues:**

No risks scoring 15 or above or issues with a consequence rating of 4 or above.

**Good practice or innovation:**

- **Bedfordshire and Luton Community Adult Services – community** nursing support to rough sleepers in Luton.
- **MSK Dynamic Health -** multiple nominations and awards achieved at the CCS annual staff awards.
- **NOW MSK Services –** the team held a dedicated training morning on neurodiversity and neurodivergence, featuring valuable contributions from neurodivergent team members.
- **Dental Healthcare –** consistently high positive friends and family feedback.
- **iCaSH –** a high number of nominations, with some winners, at the recent staff awards

## Key Matters and Escalation Report to the Group Trust Board

**Name of Committee:** Children and Young Peoples Service Assurance Committee
**Chair:** Anna Gill
**Meeting Date:** Tuesday, 04 November 2025

**Key matters**

Integrated Governance Report (IGR) key discussions:

**Overall assurance rating: Reasonable.**

- CCS Children & Young People (CYP) Integrated Governance Report provided reasonable assurance.
- NCHC CYP Integrated Governance Report provided assurance (a different grading system is utilised presently)
- Reasonable rating was agreed given the long waits for Neurodevelopmental Disorder Services (NDS) group wide.
- Waiting lists discussed as 6 services have waits longer than 52 weeks.
- In-depth discussion about NDS waiting times and plans. Almost twelve thousand children are waiting for a diagnostic assessment across the Group.
- CYP teams are engaged with digital innovation to improve services, including ambient voice technology, robotic triage, and the Federated Data Platform. Software replacing manual processes allows more time for clinical provision.
- Group wide Service Planning for the next 3-5 years being developed.

**The Committee received and discussed:**

**Norfolk CYP Place based Performance Report:**
Norfolk Community Health and Care Trust (NCH&C) do not grade assurance according to these levels; however, the Committee were **assured** on the delivery of the services.

Two risks scored 12 which included:

- Risk 4989: CYP residential short breaks - condition of estates present a risk and with partial mitigation by reducing beds available. ICB (Integrated Care Board) plans a service delivery model review.
- Risk 5504: Neurodevelopmental service long waits for diagnostic assessment.

All Services

- No Patient Safety Incident reports in the reporting period.
- Friends and Family test >90%
- Feedback positive from the One Day Assessment Clinics
- Complaints are all related to NDS waits and assessments
- Mandatory training levels >90%
- Appraisal rates <92%
- Sickness rates at 5.65%
- YTD underspend of £193k
- Long waits for NDS services remain, 3580 children are waiting >52 weeks.

- Impact of the Right-to choose framework has increased medication referrals.
- Initial health assessments not meeting 20-day target due to staff sickness, non-compliance, and placement changes; there is mitigation in place.
- Mill Lodge Adult Respite Care – NCHC agreed with the ICB to provide this service for 1 year longer than planned while ICB reviews a respite service delivery model.
- Consultant-led outpatients (non NDS) :2 patients breached >52 weeks, as they did not attend their appointments, now rebooked. Caseload reduced by 21% and expected recovery to 18-week pathway is by Q1 2026-27.

Incident themes (actions implemented to improve)

- IG related incidents
- Working hours at Mill Lodge breached due to inadequate staffing levels.
- Increased incidents related to Starfish Nurse Led medication pathway.
- 3 incidents over one weekend relating to an individual who became dysregulated

**The CCS CYP Integrated Governance Report [Reasonable Assurance]:**

Four risks scored 12 which included:

Risk 3474: CYP Dietetic Team in Cambridgeshire and Peterborough - a small team with 69 CYP waiting >52 weeks. Mitigation in place and engagement with the ICB.

Risk 3715: Cambridgeshire Children in Care: Reduced clinical capacity as part of the Peterborough Children in Care Service TUPE. Roles advertised to improve capacity.

Risk 3629: Cambridgeshire Therapy Service: Unable to deliver commissioned CYP Physiotherapy service – staffing improvements will reduce this risk shortly.

Risk 3685: CCS wide Neurodevelopmental waits: - discussed in detail (related to two listed issues, in Bedfordshire& Luton and Cambridgeshire).

All Services

- No Patient Safety Incident reports in the reporting period.
- Friends and Family test >90% in all services
- Mandatory training levels >90%
- Appraisal rates <92%
- Sickness rates at 4.5% in almost all areas
- Underspend across Healthy Child Programme in all regions due to vacancies.
- Overspend of £353K in specialist services YTD.

Universal services

- Reasonable Assurance overall for mandated visits. Performance exceeds national averages but below commissioned targets. Impacted by staff sickness.
- There is a national focus on 2.5year visits – CYP involved with this nationally.
- Just One Norfolk meeting KPIs (Urgent referrals 2 days, routine referrals 5 days).
- Initial health assessments not meeting KPIs (72% B&L, 42%C&P) impacted by non-compliance, placement changes and late referrals.

Specialist Services

- Bedfordshire and Luton Audiology – Improvements in waiting time with 202 children now waiting >52 weeks. Ongoing issues with Acute Partners capacity, which impacts on our lists.
- Cambridge Dietetics – mitigating risk by staff over establishment and 69 children waiting >52 weeks. Ongoing discussions with ICB.
- Bedfordshire Adult Dietetics – changes to service model impacted on waits, with 34 adults waiting >52 weeks. A nutrition support pathway has been implemented to provide earlier access to support.

<u>Neurodevelopmental Services (NDS) Spotlight</u>

- Accurate waiting list datasets now for NDS group wide.
- Group-wide almost 12 thousand waiting for diagnostic assessment, 8720 >52 weeks.
- The overall referral rates for NDS now are flat, but a significant backlog exists.
- Different commissioning and service provision across the Group:
  - ➢ Norfolk NDS not consultant led, therefore not reported via RTT (Referral to Treatment waiting times).
  - ➢ Bedfordshire and Luton have meaningful interventions agreed to 'stop the clock (RTT listing) but CYP remain on a Consultant Wait list.
  - ➢ ICBs have a right-to-choose option and a service for those who are >18years old.
  - ➢ Bedfordshire & Luton and Norfolk & Waveney commissioned diagnosis and treatment, C&P diagnosis only

Actions to manage the backlog include:

- Increased clinical capacity – increased staffing, job plans, skill mixing
- New pathway developments, one day assessment clinics,
- Waiting list validation
- Resources for families
- Early intervention teams, early concerns pilots
- Additional resources for external provider management of longest waits.

Digital interventions being considered/trialled include patient portal resources, digital referral processing, digital triage of referrals, ambient voice technology for clinics.

<u>Emotional health and Wellbeing Services</u>

- Positive FFT (Friends & Family Test)
- Increased referral rates across Cambridgeshire & Peterborough (C&P) and Norfolk & Waveney (N&W). Discharges in both areas not meeting targets but being monitored and plans for mitigation and management being developed.
- Data collected for Patient Recorded Outcome Measures (PROMs) via Systm1 via the patient outcome data (POD) is limited and the intraoperability is felt to be challenging.

**Key escalations**

The main escalation is that almost 12 thousand children are waiting for a diagnostic assessment for NDD with 8720 waiting >52 weeks. A validated data set for these waits is now in place and will be the one true list. Action plans are in place, and others being developed to reduce the long waits. The Committee welcomed the Group approach for NDS service plans.

**Key risks and issues:**

No risks rated 15 or above were reported.

Two issues are currently rated as 4 (major):

- **3684** - Children and Younger People (CYP) are experiencing long wait times to see a Paediatrician for specialist assessments and/ or a clinical outcome.
- **3568** - Waiting times for ASD assessments in Cambridgeshire.

**Good practice or innovation:**
Our Trust-wide Speech & Language Therapy (SLT) services were successful in their application to be part of the SLT Improvement Collaborative, NHS Elect. We will be one of 7 Trusts nationally to be involved in developing national SLT Pathway Transformation Toolkit. We were selected as a best practice example from front line services.

Starfish team won Team of the year in the Staff awards in NCHC.

Bedfordshire and Luton Community Paediatric Service Early Intervention Teams awarded Runners Up in the Staff Excellence Award in the Quality Improvement category.

CYP teams are engaged with digital innovation to improve services, examples include ambient voice technology, robotic triage, and the Federated Data Platform.

## Key Matters and Escalation Report to the Group Trust Board

**Name of Committee:** Norfolk Adults Service Assurance Committee
**Chair:** Anna Gill
**Meeting Date:** 6th November 2025

**Key matters:**

**<u>Integrated Governance Report (IGR) key discussions</u>**
**[Overall assurance rating:** *Reasonable***]**

- The top themes in relation to incidents were highlighted as Pressure Ulcers and the deteriorating patient. It was noted that the level of harm linked to the deteriorating patient is reviewed at the Safety Huddle, with a high number of incidents being downgraded from moderate to low/ no harm. Reporting of these incidents is being reviewed.
- It was noted that a severe harm (epilepsy monitoring equipment) has also been downgraded following a review of the incident. It was highlighted that this should have been logged as a 'risk' rather than an incident.
- The Safeguarding training compliance is at Trust target, changes in practice relating to the Section 42 work are starting to be seen. It was noted that the Trust is now receiving some feedback from the Local Authority around the Section 42 investigation and outcome.
- Complaint themes were discussed; it was highlighted that there is an opportunity to undertake joint learning with the Local Authority.
- The Committee noted that a new Patient Safety Incident Investigation (PSII) had been declared in relation to an infection, prevention and control incident.
- The work linked to unallocated/ deferred visits was discussed in detail, it was noted that in South Place the caseload cleansing process is having an initial impact on the reduction on unallocated visits. A transformation plan is being developed, with an emphasis on ensuring the data is central to decision making. It was identified that there are several barriers to the current community nursing and therapies pathway which include how the single point of access functions, how patients are communicated with (to let them know their visit is needing to be rearranged) and how patients are triaged. The Committee also highlighted that patients are reviewed each day, and mitigations are in place to reduce the risk of harm.
- It was identified that at any one time in Community Nursing and Therapies there is 33% staffing unavailability, which has a real impact on care delivery and morale. An update on the Trust's resources to support colleagues' wellbeing was provided, it was noted that further work will be undertaken in relation to the stress and pressure people are feeling whilst at work.
- A detailed discussion was held in terms of the organisations waiting lists, it was noted that:
    - There are now no waiters, over 52 weeks, for prosthetics and foot health.
    - Wheelchair services are on plan for delivery, against their waiting list.
    - A review of Pulmonary Rehabilitation waiting lists is underway.

- In relation to Urgent Care, the currently delivery is above the national requirement (70%), the picture is complex with an increased demand on services, as the system continues to think about how patients with urgent needs can be supported in the community. The Virtual Ward occupancy rate sits between 65-70%, it was noted that this service continues to be patchy and that occupancy depends on whether there is the staffing capacity to take the patient and also the quality of the referrals coming into the service.
- In terms of the spotlight reports, it was mentioned that there has been an increase of patient flow within the inpatient units and some fantastic work to reduce length of stay. It was highlighted that the Trust needs to understand the needs of patients with dementia and really pinpoint the requirements of this cohort.

**Transformation and innovation key discussions:**

The Committee noted that the 2 projects that were escalated have now been reviewed and have been regraded to green status.

**Financial Plan 2025/ 2026 key discussions:**

It was noted that there are several financial pressures across the services, the cost improvement targets for the organisation will be met for 2025/ 26, however most of these savings will be non-recurrent. Several projects have been identified for financial focus in 2026/ 27 this includes stores management and a review of some of the clinical pathways.

**Key escalations:**

- There was 1 formal escalation from the Committee to the Trust Board, which was, a PSII that has been declared within the reporting period, linked to an Infection, Prevention and Control issue.

- The following items are for noting only:
  - Unallocated Community Nursing visits remain an issue, a transformation plan is being developed, however some initial work around caseload cleansing is showing some early signs of impact.
  - Waiting lists are being reported against, with plans in place to mitigate risk, and reduce waits.

**Key risks and issues:**

The Committee has 11 risks assigned to it, 2 risks score 16, 1 risk scores 15, the other 8 were all at 12. The risks were reviewed with no further actions/ updates identified.

**Good practice or innovation:**

- Urgent Community Response (UCR) performance, which is above the national requirements.
- Significant improvement in the length of stay across adult's inpatients.
- New processes and practices noted in Safeguarding, linked to the Section 42 workstream.

# Part Two: Balanced score cards for each division

**(This section is currently under development)**

# Part Three - Themes across the organisations

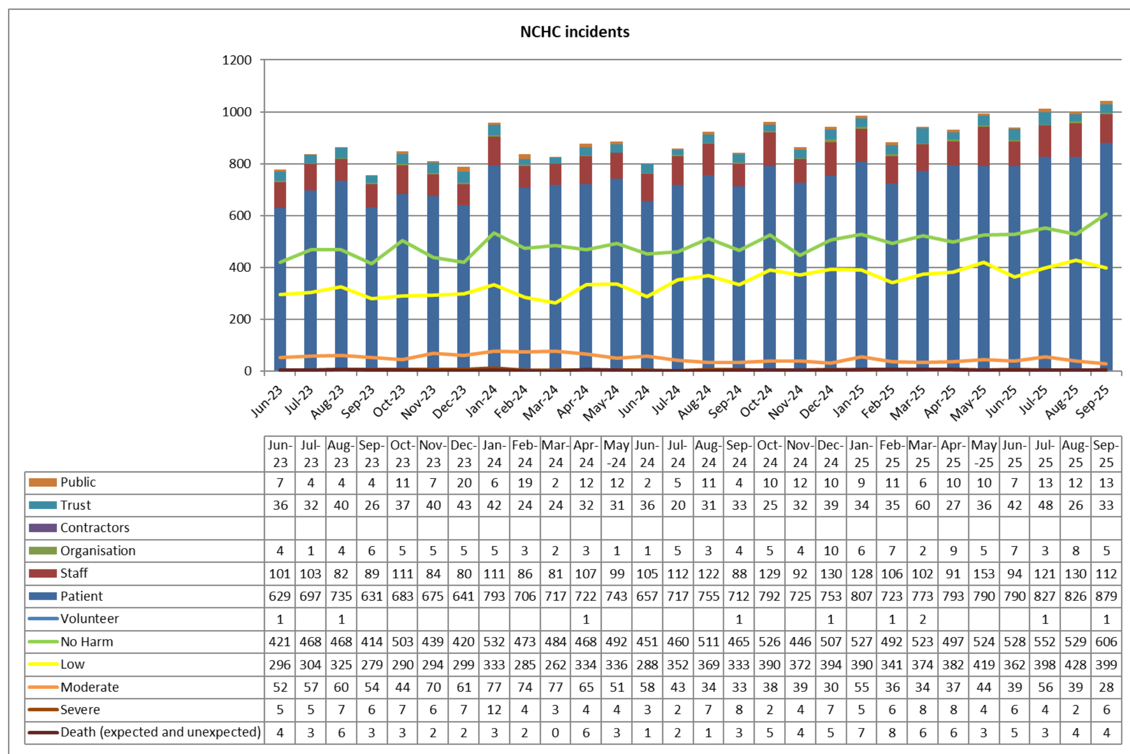
## 1.0 SAFE

*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 CCS (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**




| | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Public | 7 | 4 | 4 | 4 | 11 | 7 | 20 | 6 | 19 | 2 | 12 | 12 | 2 | 5 |
| Trust | 36 | 32 | 40 | 26 | 37 | 40 | 43 | 42 | 24 | 24 | 32 | 31 | 36 | 20 |
| Contractors | | | | | | | | | | | | | | |
| Organisation | 4 | 1 | 4 | 6 | 5 | 5 | 5 | 5 | 3 | 2 | 3 | 1 | 1 | 5 |
| Staff | 101 | 103 | 82 | 89 | 111 | 84 | 80 | 111 | 86 | 81 | 107 | 99 | 105 | 112 |
| Patient | 629 | 697 | 735 | 631 | 683 | 675 | 641 | 793 | 706 | 717 | 722 | 743 | 657 | 717 |
| Volunteer | 1 | | 1 | | | | | | | | 1 | | | |
| No Harm | 421 | 468 | 468 | 414 | 503 | 439 | 420 | 532 | 473 | 484 | 468 | 492 | 451 | 460 |
| Low | 296 | 304 | 325 | 279 | 290 | 294 | 299 | 333 | 285 | 262 | 334 | 336 | 288 | 352 |
| Moderate | 52 | 57 | 60 | 54 | 44 | 70 | 61 | 77 | 74 | 77 | 65 | 51 | 58 | 43 |
| Severe | 5 | 5 | 7 | 6 | 7 | 6 | 7 | 12 | 4 | 3 | 4 | 4 | 3 | 2 |
| Death (expected and unexpected) | 4 | 3 | 6 | 3 | 3 | 2 | 2 | 3 | 2 | 0 | 6 | 3 | 1 | 2 |

| | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Public | 11 | 4 | 10 | 12 | 10 | 9 | 11 | 6 | 10 | 10 | 7 | 13 | 12 | 13 |
| Trust | 31 | 33 | 25 | 32 | 39 | 34 | 35 | 60 | 27 | 36 | 42 | 48 | 26 | 33 |
| Contractors | | | | | | | | | | | | | | |
| Organisation | 3 | 4 | 5 | 4 | 10 | 6 | 7 | 2 | 9 | 5 | 7 | 3 | 8 | 5 |
| Staff | 122 | 88 | 129 | 92 | 130 | 128 | 106 | 102 | 91 | 153 | 94 | 121 | 130 | 112 |
| Patient | 755 | 712 | 792 | 725 | 753 | 807 | 723 | 773 | 793 | 790 | 790 | 827 | 826 | 879 |
| Volunteer | | 1 | | | 1 | | 1 | 2 | | | | 1 | | 1 |
| No Harm | 511 | 465 | 526 | 446 | 507 | 527 | 492 | 523 | 497 | 524 | 528 | 552 | 529 | 606 |
| Low | 369 | 333 | 390 | 372 | 394 | 390 | 341 | 374 | 382 | 419 | 362 | 398 | 428 | 399 |
| Moderate | 34 | 33 | 38 | 39 | 30 | 55 | 36 | 34 | 37 | 44 | 39 | 56 | 39 | 28 |
| Severe | 7 | 8 | 2 | 4 | 7 | 5 | 6 | 8 | 8 | 4 | 6 | 4 | 2 | 6 |
| Death (expected and unexpected) | 1 | 3 | 5 | 4 | 5 | 7 | 8 | 6 | 6 | 3 | 5 | 3 | 4 | 4 |

### 1.2 NCHC Patient Safety Incidents

1.2.1 Within the reporting period of August and September 2025 there were no 'Never Events' identified, with one new Patient Safety Incident Investigation (PSII) commissioned. The PSII relates to an outbreak within the community that the Trust is providing support to. This outbreak is being overseen by the UKHSA (UK Health Security Agency).

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.

1.2.3 Duty of Candour (DoC) compliance remains at 100%. A joint project between CCS and NCHC is ongoing to align process and policy,

alongside a staff information guide to support duty of candour conversations.

1.2.4 Across the two-month period a total of 1995 Incidents were reported as follows:

- 7 severe harm incidents (0.3% of total reported incidents, same as last reporting period)
- 70 moderate harm incidents (3.5% which is a 1.2% decrease on the last reporting period)
- 816 low harm incidents (41% which is a small increase on last reporting period))
- 1093 no harm incidents (54.8% which is a small increase on last reporting period)

1.2.5 No harm and low harm incidents account for 95.8% of total incidents reported. All incidents continued to be reviewed at Place level to identify any emerging themes. These themes are then addressed at Place level or escalated via Learning Huddle, Safety Group or Norfolk Assurance and Improvement Group.

**Table 1 All incidents August and September 2025 by degree of harm**

| Month | No Harm | Low | Moderate | Severe | Death (Expected) | Total |
|---|---|---|---|---|---|---|
| August 2025 | 530 | 423 | 40 | 1 | 4 | 998 |
| Sept 2025 | 563 | 393 | 30 | 6 | 4 | 996 |
| **Grand Total** | **1093** | **816** | **70** | **7** | **8** | **1994** |

***Severe Harm Incidents***

1.2.6 There were 7 severe harm incidents identified in the reporting period.

- Six incidents related to a deterioration of an existing pressure ulcer (either category 3 or unstageable) to a category 4 wound. Where indicated After Action Reviews (AAR) have been completed and action planned at the Pressure Ulcer Learning Group.

- One incident related to the difficulties in obtaining the appropriate equipment for a patient discharged home with limb contractures. This was escalated as a safeguarding concern, which when reviewed found clear evidence of multidisciplinary system working to safely manage this patient at home.

***Moderate Harm Incidents***

1.2.7 70 moderate harm incidents were reported in August and September of these the top three identified themes were:

- Nineteen incidents related to development of a category 3 pressure ulcer developed under the care of community services. All cases are reviewed in Place and local learning shared. Where additional evaluation is required, an After-Action Review is

completed and learning shared through the Pressure Ulcer Improvement Group.

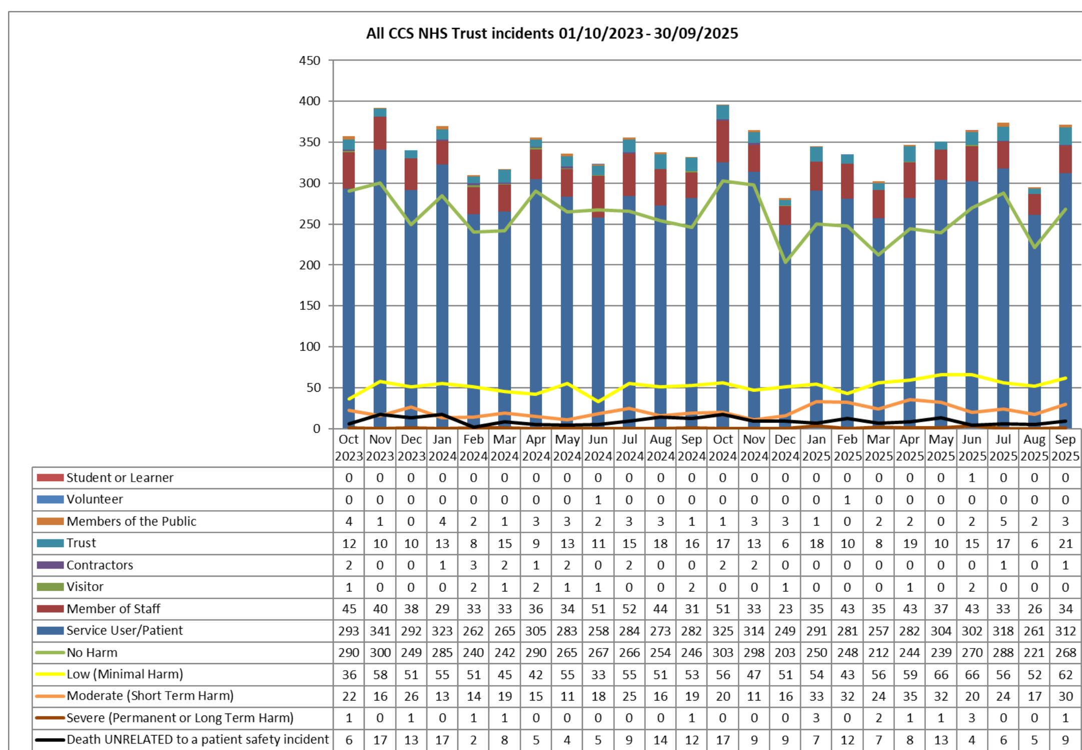
- Eighteen incidents relate to patient deterioration and transfer to acute hospital. Seven of the incidents related to patients' deterioration and requirement for transfer into acute hospital from inpatient areas. All incidents have been reviewed at the internal Learning Huddle and following review the harm level reduced. Eleven incidents identified patients requiring admission to acute hospital from home (following review by community services). Areas of good practice have been identified and learning shared.

- Six incidents related to system wide issues for patients on a palliative or end of life pathway. Three of the incidents highlight issues around the lack of appropriate levels of available care provision, resulting in families reaching crisis, identified when a referral was received into the trust. Three incidents were due to end-of-life medication issues, either access to or appropriate prescribing, impacting on effective and timely symptom management. Both of these themes are being monitored by both the internal Palliative and End of Life Care Programme and the system programme board, with actions set to mitigate and improve the pathway.

1.2.8 The remaining incidents were reviewed in the Learning Huddle. Where learning was specific to a service or event (rather than trust wide thematic learning) actions are identified and implemented in Place.

## 1.3 CCS Patient Safety Incidents

### Graph 2 CCS Incident Profile




| | 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 | Apr 2025 | May 2025 | Jun 2025 | Jul 2025 | Aug 2025 | Sep 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Student or Learner | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| Volunteer | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Members of the Public | 4 | 1 | 0 | 4 | 2 | 1 | 3 | 3 | 2 | 3 | 3 | 1 | 1 | 3 | 3 | 1 | 0 | 2 | 2 | 0 | 2 | 5 | 2 | 3 |
| Trust | 12 | 10 | 10 | 13 | 8 | 15 | 9 | 13 | 11 | 15 | 18 | 16 | 17 | 13 | 6 | 18 | 10 | 8 | 19 | 10 | 15 | 17 | 6 | 21 |
| Contractors | 2 | 0 | 0 | 1 | 3 | 2 | 1 | 2 | 0 | 2 | 0 | 0 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| Visitor | 1 | 0 | 0 | 0 | 2 | 1 | 2 | 1 | 1 | 0 | 0 | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 2 | 0 | 0 | 0 |
| Member of Staff | 45 | 40 | 38 | 29 | 33 | 33 | 36 | 34 | 51 | 52 | 44 | 31 | 51 | 33 | 23 | 35 | 43 | 35 | 43 | 37 | 43 | 33 | 26 | 34 |
| Service User/Patient | 293 | 341 | 292 | 323 | 262 | 265 | 305 | 283 | 258 | 284 | 273 | 282 | 325 | 314 | 249 | 291 | 281 | 257 | 282 | 304 | 302 | 318 | 261 | 312 |
| No Harm | 290 | 300 | 249 | 285 | 240 | 242 | 290 | 265 | 267 | 266 | 254 | 246 | 303 | 298 | 203 | 250 | 248 | 212 | 244 | 239 | 270 | 288 | 221 | 268 |
| Low (Minimal Harm) | 36 | 58 | 51 | 55 | 51 | 45 | 42 | 55 | 33 | 55 | 51 | 53 | 56 | 47 | 51 | 54 | 43 | 56 | 59 | 66 | 66 | 56 | 52 | 62 |
| Moderate (Short Term Harm) | 22 | 16 | 26 | 13 | 14 | 19 | 15 | 11 | 18 | 25 | 16 | 19 | 20 | 11 | 16 | 33 | 32 | 24 | 35 | 32 | 20 | 24 | 17 | 30 |
| Severe (Permanent or Long Term Harm) | 1 | 0 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 3 | 0 | 2 | 1 | 1 | 3 | 0 | 0 | 1 |
| Death UNRELATED to a patient safety incident | 6 | 17 | 13 | 17 | 2 | 8 | 5 | 4 | 5 | 9 | 14 | 12 | 17 | 9 | 9 | 7 | 12 | 7 | 8 | 13 | 4 | 6 | 5 | 9 |

1.3.1 No Patient Safety Incident Investigation (PSII's) were commissioned in either August of September 2025.

1.3.2 No 'Never Events' were declared in either August or September 2025.

1.3.3 One PSII was concluded in August 2025. Learning related to effective communication with external partners when requesting changes to digital systems. The extensive review found no patients were harmed and all follow up actions have been completed.

1.3.4 Action plans on previously submitted PSII's are on track for completion, and there are no overdue actions at the time of reporting.

1.3.5 A total of eleven review responses were commissioned by the Safety Huddle in August 2025, four of which had a safeguarding element. Four review responses were commissioned in September 2025, one of which had a safeguarding element.

**Table 2 (degree of harm, patient safety incidents under CCS care)**

| Month | No Harm | Low | Moderate | Total |
|---|---|---|---|---|
| August 2025 | 132 | 18 | 5 | 155 |
| Sept 2025 | 141 | 18 | 6 | 165 |
| **Grand Total** | **273** | **36** | **11** | **320** |

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

1.3.7 Ten of the moderate harm incidents were reported under the Luton Adult Service and all related to preventable wounds. The remaining one incident was reported under the Audiology service in Cambridgeshire and related to a delay in diagnosis.

1.3.8 Moderate harm incidents, whilst the person is under the care of the Trust, require the application of the statutory Duty of Candour. Of the eleven moderate harm incidents reported in the 2-month period of August and September 2025, nine have had the statutory Duty of Candour completed, one incident remans under review and the final incident, related to skin deterioration at the end of life so duty of candour was not required but follow up bereavement call to the family was made.

## 1.4 Thematic review of specific incident categories:

**NCHC Deteriorating Patients**

1.4.1 The current reporting process for patients who deteriorate and require transfer to acute services (be this from in patient or community services) is for this to be initially graded as a moderate harm incident on the Datix system. This enables trust wide data gathering and review at the twice weekly Learning Huddles. The learning huddle assesses all moderate and severe harm incidents and thematic low or no harm incidents are discussed.

1.4.2 The reviews at Learning Huddle provide an opportunity for any immediate learning to be identified and shared across relevant teams. In most cases of escalation to acute care the harm level is appropriately reduced at this point. Where further investigations are required the oversight for review of the investigations is managed via the Deteriorating Patient Group. This group also reviews the data from a thematic standpoint and reports quarterly to Safety Group.

1.4.3 Across the reporting period of August and September no deteriorating patient incidents were identified that required further investigation. Of the 18 incidents related to escalation to acute, 3 were graded as low harm, the remaining 15 as no harm. There were areas of good practice identified and evidence of learning embedded from previous incidents that had been reviewed and discussed at Learning Huddle and via the Deteriorating Patient Group.

**NCHC Palliative Care and End of Life**

1.4.4 NCHC are launching a new Palliative and End of Life Care (PEOLC) programme board in November 2025. This follows on from the Better for All project but with an expanded programme with a number of different workstreams focussing on the trust wide palliative pathway, inpatient services, specialist services and education.

1.4.5 Initial priority areas identified from incidents and patient and staff feedback include:

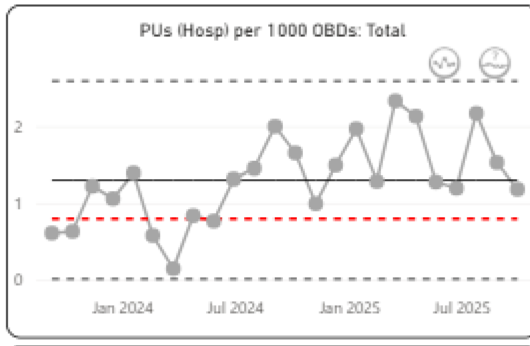
- Auditing services across the trust using the Six National Ambitions for palliative and end of life care self-assessment tool. Data to inform service improvement and pathway redesign work.
- Optimisation of the medical provision.
- Complete a quality-of-care review within the in-patient provision.
- Expanding the living well offer in collaboration with Priscilla Bacon Hospice Charity and look at accessibility for the wider population of Norfolk.
- Improving the way in which Palliative and End Of Life Care medicines are prescribed in the community by introducing a new electronic drug chart process and review of the transcribing policy.

Learning and actions are fed into the ICB/provider-led collaborative service specification redesign and system programme board.

**NCHC Pressure Ulcers**

1.4.6 Reported pressure ulcers across NCHC remain over threshold but improved from July's hospital data with the alignment and introduction of the standardised pressure ulcer wound assessment templates and associated risk assessment tools across both hospital and community nursing and therapy teams. Inpatient data continues to be reviewed to support identification of pressure damage on admission and identify opportunities to work collaboratively with partners to support and improve patient safety.

**SPC Chart 1**




**SPC Chart 2**

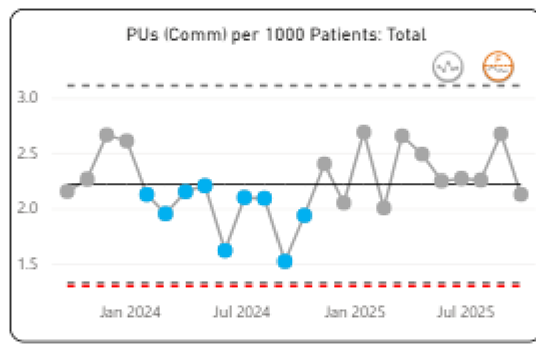



**Table 3 NCHC Pressure Ulcers by Category**

Number of Datix by Time Series

| Subcategory | August 2025 | September 2025 | Total |
|---|---|---|---|
| Pressure Ulcer acquired WITHIN the care of NCHC | 85 | 74 | 159 |
| Unstageable Pressure Ulcer acquired within the care of NCHC | 30 | 40 | 70 |
| Suspected Deep Tissue Injury acquired within the care of NCHC | 27 | 29 | 56 |
| Moisture Lesion acquired within the care of NCHC | 14 | 20 | 34 |
| Medical Device related Pressure Ulcer acquired within the care of NCHC | 3 | 4 | 7 |
| **Total** | 159 | 167 | 326 |

1.4.7 **Actions and mitigations:**

- All reported incidents are reviewed within their respective Place, with local learning shared to support immediate improvements. Where further review and analysis is required, an After-Action Review (AAR) is conducted. Learning identified through this process is disseminated via the Pressure Ulcer Improvement Group, ensuring a Trust-wide approach to improvement.
- A key area for improvement identified through these reviews is the use of the DECIDE Model (a decision-making model for more effective decision making by health care managers). This model supports structured, systematic decision-making in cases involving non-concordant patients, ensuring that decisions are made in a supported and consistent manner.
- This learning is being actively shared across all Places and is incorporated into the Trust Safeguard mandatory learning programme.
- A plan to adopt the Healthy.io. technology software to support a digitised approach to wound care has started after discussion with CCS who are using this in Luton Adults Services. This will provide standardisation, enhance safety and efficiency improvements.
- Work is ongoing to implement required changes to training, Datix, Policy and SystmOne to reflect the National Wound Care Strategy clinical categorisation recommendations.
- Implement Purpose T risk assessment tool with comprehensive training package and associated changes to policy and SystmOne.

- Pressure Ulcer Quality Specialist Group is responsible for identifying required actions to align pressure ulcer clinical pathways to the National Wound Care Strategy.

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

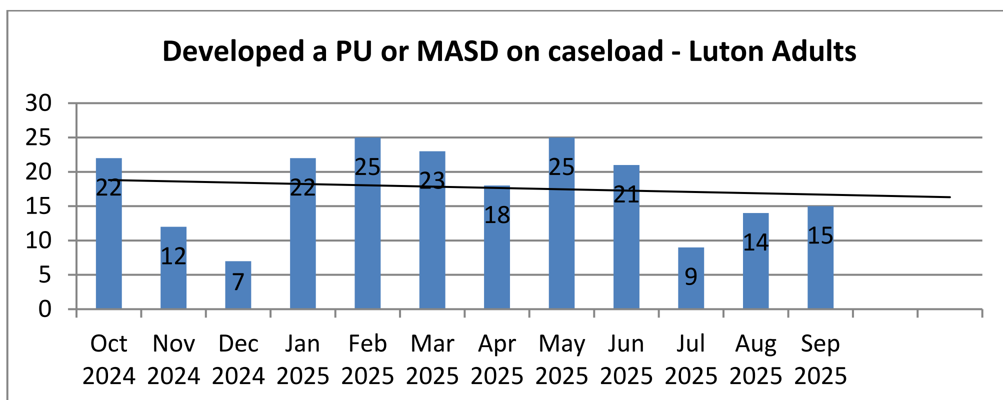
1.4.8 All Pressure Ulcers and Moisture-Associated Skin Damage (MASD) are reported under the Clinical Assessment and Treatment category, both for those acquired on and off caseload. Sixty-four incidents were reported as 'developed Pressure Ulcers or MASD' all of which were under the Luton Adults Service. A further 15 incidents related to patients who 'acquired a skin tear', all of which are deemed to be off caseload and are 'happened upon' incidents.

1.4.9 Of the Luton Adults 64 incidents, 29 (45%) were deemed to have occurred whilst the patient was on active caseload

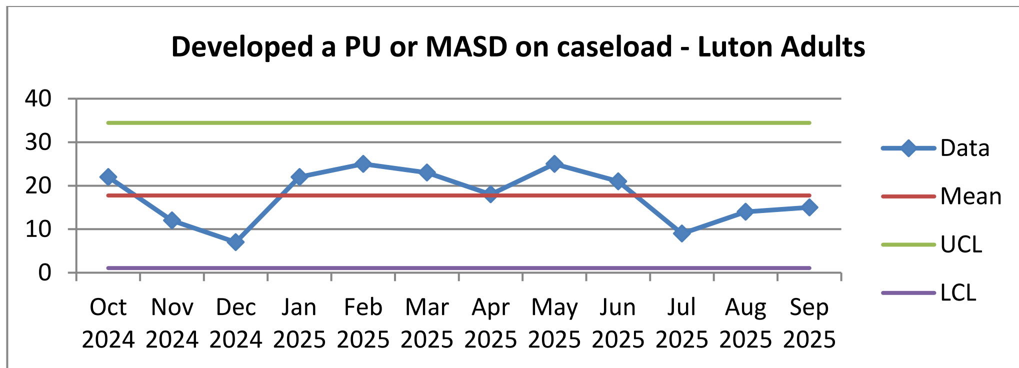
1.4.10 The trend for reporting of Pressure Ulcer incidents occurring for those patients on caseload has indicated a decrease over the last 12 months with the forecast showing the falling rate, as per Graph 4 below which shows that reporting rates remain within acceptable parameters. The overall mean reporting rate per month is 17.75 per month.

1.4.11 The Preventable Wounds Community of Practice receive a monthly thematic review of all grade 3 and 4 pressure ulcers to identify emerging themes and further learning for wounds that subject experts consider to be preventable. The wound care app *Minuteful for Wound* has been successfully implemented to support care delivery and capture outcome data. To date, 8500 wound assessments have been completed through the app, covering 689 patients and 1,462 wounds, resulting in 230 fully healed wounds. As the dataset grows, it will provide valuable insights into healing times by wound type and enable monitoring of improvements in these metrics. A Business Intelligence dashboard is currently in development to enhance reporting and provide more comprehensive analytics.

**Graph 3**



**Graph 4**



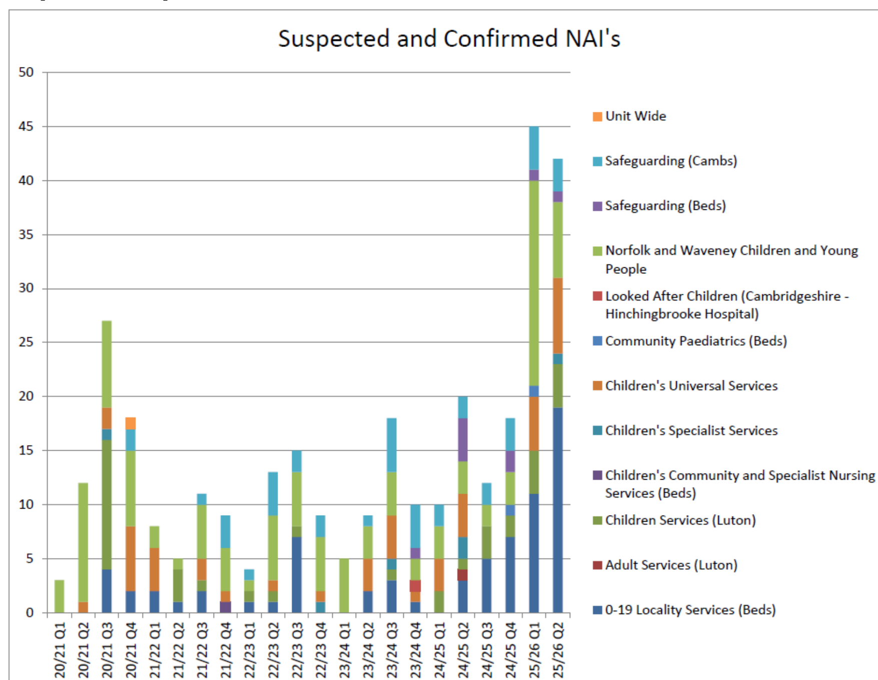

**CCS NHS Trust Non-Accidental Injuries (NAI's)**

1.4.12 CCS has identified previously through the Patient Safety & Incident Response Framework (PSIRF) that the number of reported possible non-accidental injuries has risen substantially and that this is evidenced across all the localities (see Graph 5).

1.4.13 An internal workstream across both CCS and NCHC continues to be led by the Safeguarding team. This includes supporting accurate reporting of incidents which may be related to non-accidental injuries and or preventable injuries resulting from accidents. Safety messaging campaigns about preventing accidents in babies and children is being led by the Head of Safeguarding alongside the Comms team and the clinical leads in each locality. This includes a preventing accident at Christmas campaign.

1.4.14 The trust continues to work with partners in the 3 Integrated care boards and respective local authorities, around proactive support and communication with parents and families.

**Graph 5 Suspected and Confirmed NAI's CCS NHST**



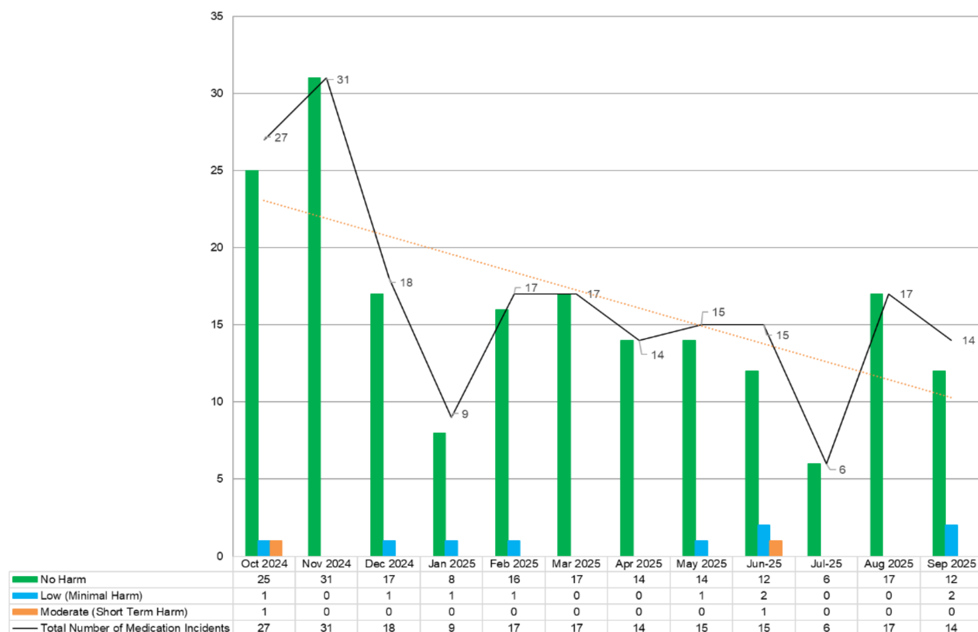
## 1.5 Medicines Optimisation

1.5.1 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. Incidents are reviewed, and actions undertaken 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 data supports that we are a high reporting, no/low harm Group.

***CCS Medication Incidents***

1.5.2 There were 31 medicines-related incidents reported during August and September 2025. Of these, 29 were no harm, and 2 were low (minimal) harm, incidents. There were no moderate or severe harm incidents.

**Graph 6 Number of Medication Incidents and Degree of Harm (Oct 2024-Sept 2025)**



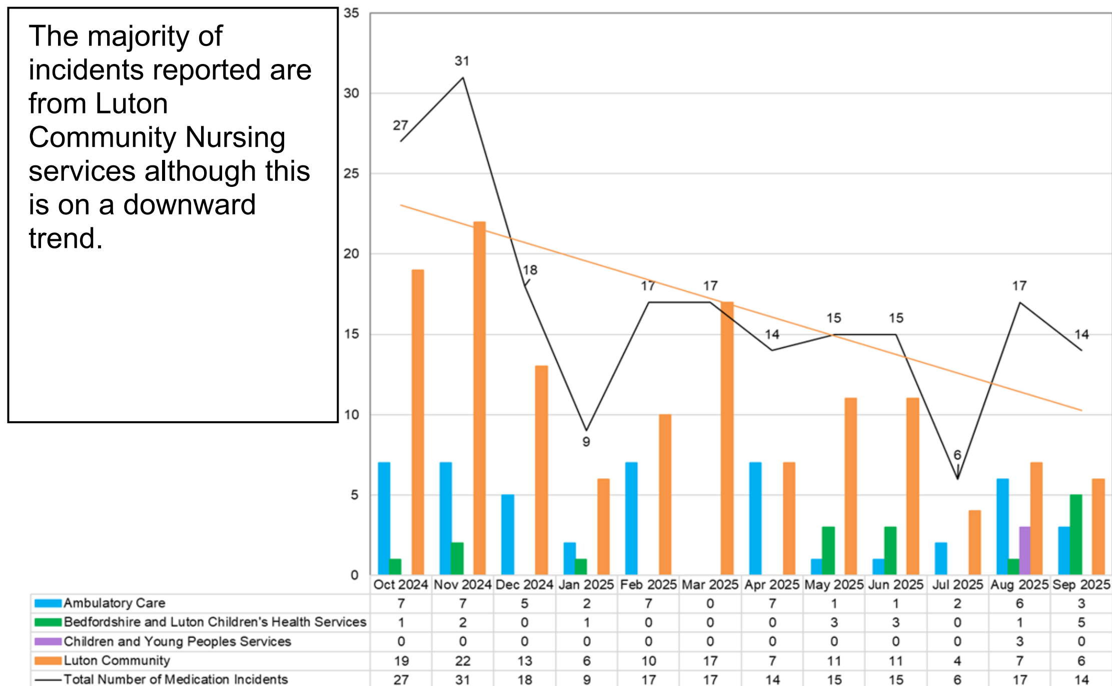
| | Oct 2024 | Nov 2024 | Dec 2024 | Jan 2025 | Feb 2025 | Mar 2025 | Apr 2025 | May 2025 | Jun-25 | Jul-25 | Aug 2025 | Sep 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No Harm | 25 | 31 | 17 | 8 | 16 | 17 | 14 | 14 | 12 | 6 | 17 | 12 |
| Low (Minimal Harm) | 1 | 0 | 1 | 1 | 1 | 0 | 0 | 1 | 2 | 0 | 0 | 2 |
| Moderate (Short Term Harm) | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| Total Number of Medication Incidents | 27 | 31 | 18 | 9 | 17 | 17 | 14 | 15 | 15 | 6 | 17 | 14 |

1.5.3 Themes of Medicines Incidents in CCS:

- Prescribing
- Documentation
- Administration

1.5.4 All incidents are reviewed locally and, on a Trust, wide basis at the Medicines Safety Governance Group. Organisational Wide Learning communications are created when necessary.

**Graph 7 Monthly total number of incidents by Directorate (Oct 24-Sept 25)**




| | Oct 2024 | Nov 2024 | Dec 2024 | Jan 2025 | Feb 2025 | Mar 2025 | Apr 2025 | May 2025 | Jun 2025 | Jul 2025 | Aug 2025 | Sep 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ambulatory Care | 7 | 7 | 5 | 2 | 7 | 0 | 7 | 1 | 1 | 2 | 6 | 3 |
| Bedfordshire and Luton Children's Health Services | 1 | 2 | 0 | 1 | 0 | 0 | 0 | 3 | 3 | 0 | 1 | 5 |
| Children and Young Peoples Services | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 0 |
| Luton Community | 19 | 22 | 13 | 6 | 10 | 17 | 7 | 11 | 11 | 4 | 7 | 6 |
| Total Number of Medication Incidents | 27 | 31 | 18 | 9 | 17 | 17 | 14 | 15 | 15 | 6 | 17 | 14 |

***Number of incidents involving insulin reported under CCS care and their level of harm (Oct 24-Sept 25)***

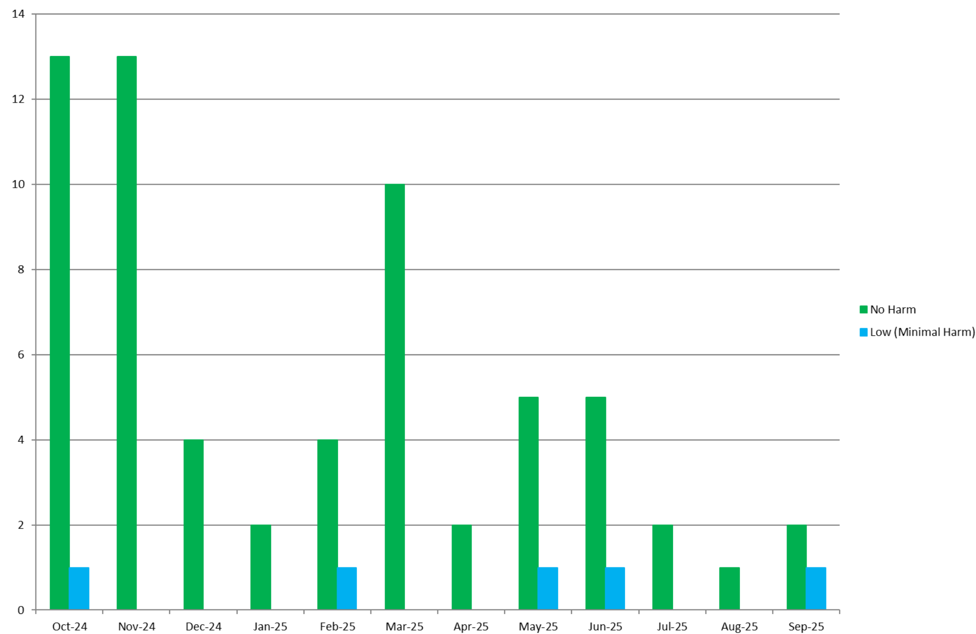
1.5.5 Medication incidents involving insulin monitored by the Insulin Data Oversight Group, reviewed by the Clinical Leads, and at Luton Quality and Risk Meeting. The number of incidents occurring during the reporting period decreased by 50% compared to the previous 2-month period, primarily attributed to a drop in no harm incidents since June 2025.

***NCHC Medication Incidents***

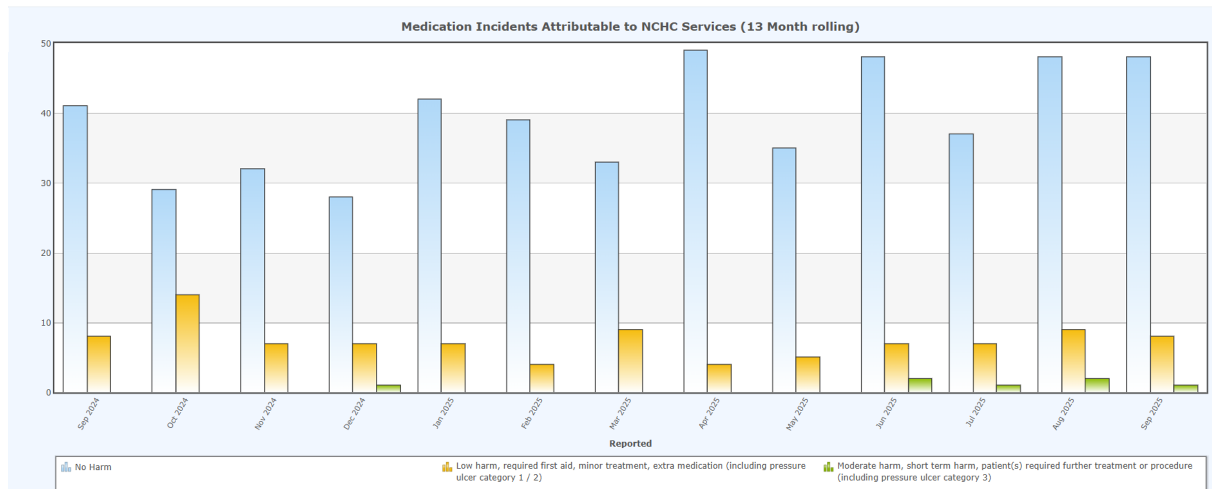
1.5.6 There were 210 medicines related incidents reported during Aug-Sept 2025 (174 no harm, 32 low harm and 4 moderate harm).

1.5.7 Of these incidents 116 were considered attributable to NCHC (96 no harm, 17 low harm, 3 moderate harm).

**Graph 8 NCHC Medication incidents**




**Graph 9 Number of Medication Incidents attributable to NCHC and Degree of Harm (Sept 2024-Sept 2025)**




1.5.8 All incidents are reviewed locally and, on a Trust-wide basis by the Medicines Safety Officer. A medicines safety report is developed every two months and discussed at the Medicines Optimisation Working Group.

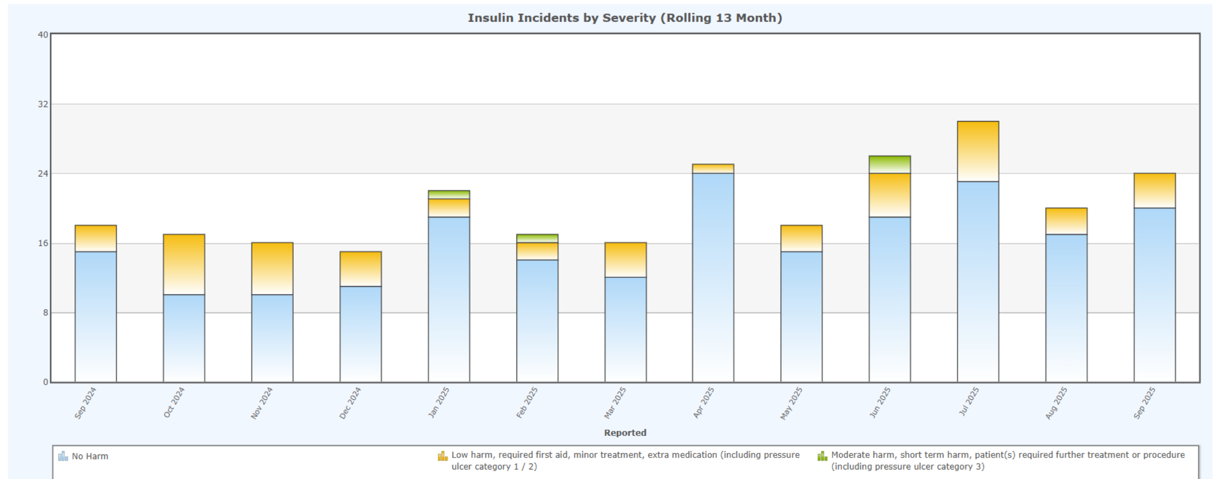
1.5.9 Themes of Medicines Incidents in NCHC:

- Prescribing
- Documentation
- Administration
- Medicine Availability
- Referral/Allocation

1.5.10 These themes inform targeted learning and safety improvement initiatives across the organisation. Learning from medicine related

incidents is shared through an organisation-wide learning (OWL) or 'Take 5' email.

**Graph 10 Number of incidents involving insulin reported under NCHC care and level of harm**




1.5.11 **Insulin key themes identified (Community Settings Predominantly)**

- Dose changes not implemented
- Missed or Unallocated Visits
- Wrong Dose or Insulin Administered
- Expired Insulin or Equipment Used
- Self-Administration Errors

1.5.12 All incidents were classified as No Harm or Low Harm.

<u>Action taken includes:</u>

- Developing learning materials around insulin handling.
- A Take5 resource was recently shared on hypoglycaemia.

1.5.13 Most areas are showing positive improvement, and outcomes from local processes will be fed back to the Diabetes Working Group for Trust-wide implementation.

## 1.6 Violence Prevention and Reduction Standard

1.6.1 NCHC and CCS are working collectively to ensure compliance with the Violence Prevention and Reduction Standards (2024). Action plans have been aligned, and plans are in place for a merged assessment and plan for 2025/2026.

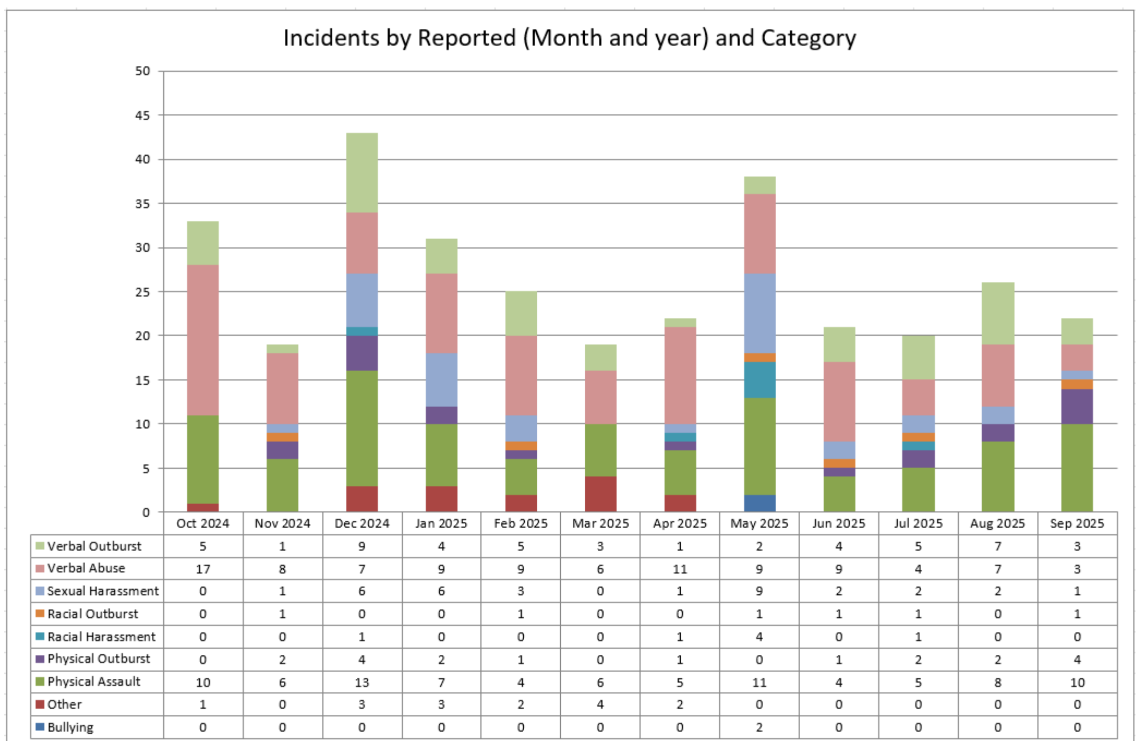
**NCHC Violence and Aggression towards staff data**

1.6.2 There were 45 incidents reported affecting staff during this reporting period.

1.6.3 An overview of all Health and Safety (H&S) related incidents, including abuse incidents, are presented at the H & S committee. Additionally, teams discuss specific incidents during their quarterly local H&S place meetings and escalate to the committee. Incident leads coordinate support for staff members wellbeing and follow up.

1.6.4 Mitigation options are available to colleagues, such as requesting enhanced care support, specialist input (including mental health team review or use of specialist mental health agency workers) and security provision. Internal controls such as ward side rooms or double up visits in the community are utilised as needed. Break away, de-escalation and mental health awareness training is under active development. The H&S team attend multidisciplinary team meetings regarding specific patients, where an incident has or could occur, to provide advice guidance to teams locally.

**Table 4 Number of incidents by abuse type NCHC**




| | Oct 2024 | Nov 2024 | Dec 2024 | Jan 2025 | Feb 2025 | Mar 2025 | Apr 2025 | May 2025 | Jun 2025 | Jul 2025 | Aug 2025 | Sep 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Verbal Outburst | 5 | 1 | 9 | 4 | 5 | 3 | 1 | 2 | 4 | 5 | 7 | 3 |
| Verbal Abuse | 17 | 8 | 7 | 9 | 9 | 6 | 11 | 9 | 9 | 4 | 7 | 3 |
| Sexual Harassment | 0 | 1 | 6 | 6 | 3 | 0 | 1 | 9 | 2 | 2 | 2 | 1 |
| Racial Outburst | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 1 | 0 | 1 |
| Racial Harassment | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 4 | 0 | 1 | 0 | 0 |
| Physical Outburst | 0 | 2 | 4 | 2 | 1 | 0 | 1 | 0 | 1 | 2 | 2 | 4 |
| Physical Assault | 10 | 6 | 13 | 7 | 4 | 6 | 5 | 11 | 4 | 5 | 8 | 10 |
| Other | 1 | 0 | 3 | 3 | 2 | 4 | 2 | 0 | 0 | 0 | 0 | 0 |
| Bullying | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 |

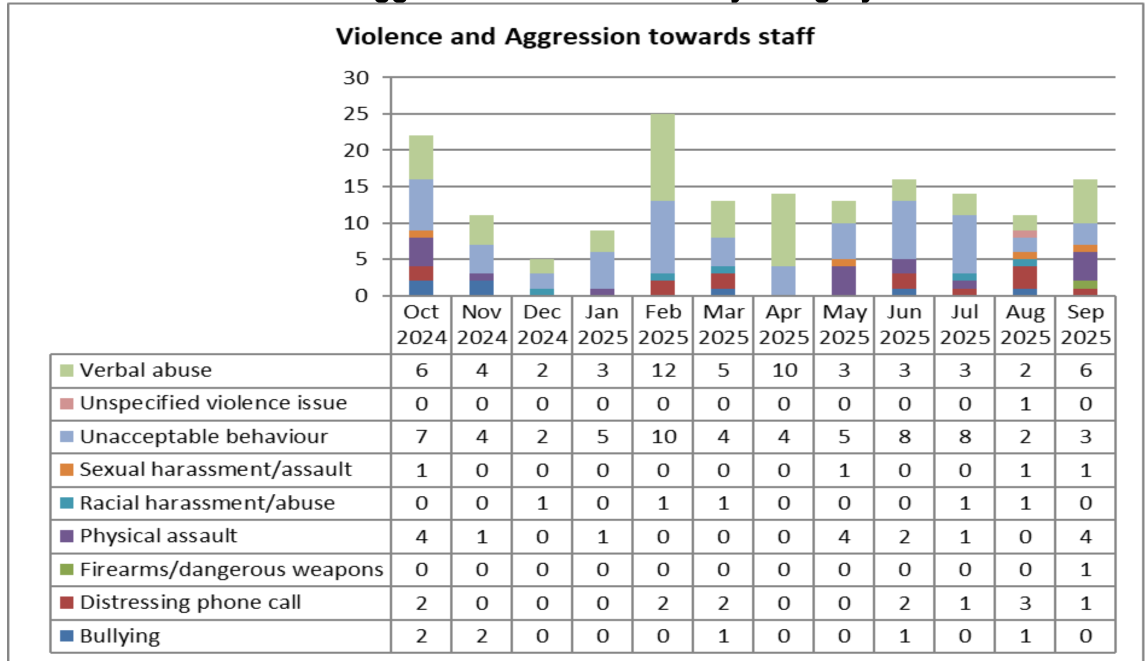
1.6.5 Physical assaults show an upward variance over the reporting periods; An initial review indicates that a small number of patients were responsible for 7 out of 18 events recorded. Leadership teams are ensuring support and review of the patients. Positive behavioural planning, risk assessments, and appropriate one to one support care plans (including antecedent, behaviour and consequence planning) were in place in each instance. Additional good practice highlighted showed effective working with Norfolk and Suffolk Foundation Trust to enable both proactive support on the units where appropriate as well as rapid assessment and transfer under the Mental Health Act where this was an identified requirement.

1.6.6 An assessed lack of capacity has been identified as a potential theme for further review. Datix changes will be requested to enable further exploration of this data in future reporting, which will enable understanding and monitoring of this potential trend. If indicated this will initiate a review of the current policy and practice to meet the needs of the patient group and our staff teams needs most appropriately.

**CCS NHS Trust Violence and Aggression towards Staff Incidents**

1.6.7 Table 4 below shows reporting themes for the last two months and number of cases. A total of 27 incidents were reported.

**Table 5 CCS Violence and aggression towards staff by category**




| | Oct 2024 | Nov 2024 | Dec 2024 | Jan 2025 | Feb 2025 | Mar 2025 | Apr 2025 | May 2025 | Jun 2025 | Jul 2025 | Aug 2025 | Sep 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Verbal abuse | 6 | 4 | 2 | 3 | 12 | 5 | 10 | 3 | 3 | 3 | 2 | 6 |
| Unspecified violence issue | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| Unacceptable behaviour | 7 | 4 | 2 | 5 | 10 | 4 | 4 | 5 | 8 | 8 | 2 | 3 |
| Sexual harassment/assault | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 |
| Racial harassment/abuse | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 1 | 0 |
| Physical assault | 4 | 1 | 0 | 1 | 0 | 0 | 0 | 4 | 2 | 1 | 0 | 4 |
| Firearms/dangerous weapons | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Distressing phone call | 2 | 0 | 0 | 0 | 2 | 2 | 0 | 0 | 2 | 1 | 3 | 1 |
| Bullying | 2 | 2 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 1 | 0 |

1.6.8 In addition to the 'degree of harm' caused by an incident, 'Staff Safety and Wellbeing Impact' scoring has been added to the Datix incident report form for incidents affecting staff. This will enable resources and support to be targeted and specific to affected staff and service areas. All incidents are reviewed on an individual basis and bespoke actions/ support packages are developed this may include; increased supervision, incident de-briefs or letters of expectation being sent to patients.

## 1.7 National Patient Safety Alerts (NatPSA)

1.7.1 One NatPSA alert was received in this reporting period which was applicable to either CCS or NCHC. This has been shared with relevant services and mitigating action in place as per the alert.

- NatPSA/2025/005/NHSPS Harm from delayed administration of rasburicase for tumour lysis syndrome.

## 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).

1.8.2 Actual CHPPD is generally 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. When reviewed against other data such as shift fill rate (reviewed through the Quality Committee Safer Staffing Report, October 2025) assurance is provided through effective fill rates, and teams safely meet our patients care requirements.

1.8.3 CHPPD does not comprehensively articulate safe staffing when viewed in isolation. An example in practice that highlights this is where a group of patients requiring enhanced observations increase the required CHPPD but a ward team may cohort them safely in a bay and require minimal additional staffing. This mitigation is not captured in CHPPD data alone. Direct review confirms that registered nurse ratios have remained satisfactory, and appropriate mitigations have ensured patient safety on the wards highlighted as red in Tables 5 and 6 during the reporting period. There were no incidents raised during this period correlating to impacts of staffing shortfalls due to this mitigation approach.

1.8.4 Inpatient Establishment Reviews took place in September (please see **Appendix 1**), to triangulate the evidence-based tools' data outputs, professional judgement and patient outcomes as per recommendations from NQB Guidance and Workforce Safeguards. Next establishment reviews will take place in April 2026.

1.8.5 The NCHC Safer Staffing Escalation Group assesses and prioritise staffing daily to minimise impact of staffing shortalls by effective utilisation of staff across all units, helping ensure the maintenance of safe staffing levels and reducing temporary staffing costs.

1.8.6 Tables 6 and 7 below show the CHPPD scoring. Other complimentary mechanisms ensure staffing is evaluated and challenged daily. This includes the daily safer staffing escalation group meeting. This forum provides daily support, confirmation and challenge conversations with ward leaders. Outcomes include facilitating professional judgment and risk management decisions to move staff between wards where required to enable patient safety and quality of care to be maintained. Additionally, staff from the Enhanced Support Team can be utilised where patients need 1-2-1 or enhanced levels of care and assessment.

**Table 6**

**August 2025**

| Unit | Actual CHPPD | Required CHPPD | Actual RN to Patient Ratio |
|---|---|---|---|
| **Generalist Wards** | | | |
| Alder Ward | 6.20 | 7.77 | 1:9.46 |
| Foxley Ward | 6.15 | 7.43 | 1:8.56 |
| North Walsham | 5.88 | 8.56 | 1:8.11 |
| Ogden Court | 6.02 | 9.57 | 1:8.52 |
| Pineheath Ward | 6.32 | 7.78 | 1:9.33 |
| Swaffham Hospital | 6.74 | 7.58 | 1:8.28 |
| Willow Nursing (Forest) | 7.89 | 4.54 | 1:7.92 |
| Willow Nursing (Garden) | 9.89 | 4.85 | 1:5.10 |
| **Specialist Wards** | | | |
| Beech Ward | 8.58 | 6.80 | 1:11.22 |
| Caroline House | 9.86 | 10.05 | 1:6.92 |
| PBL | 8.18 | 7.15 | 1:6.35 |
| Pine Cottage | 6.34 | 4.32 | 1:8.21 |

**Table 7**
**September 2025**

| Unit | Actual CHPPD | Required CHPPD | Actual RN to Patient Ratio |
|---|---|---|---|
| **Generalist Wards** | | | |
| Alder Ward | 6.56 | 7.78 | 1:9.51 |
| Foxley Ward | 6.28 | 7.48 | 1:8.26 |
| North Walsham | 6.32 | 8.73 | 1:7.82 |
| Ogden Court | 6.03 | 9.39 | 1:8.43 |
| Pineheath Ward | 5.60 | 7.89 | 1:9.07 |
| Swaffham Hospital | 7.27 | 7.64 | 1:8.61 |
| Willow Nursing (Forest) | 10.79 | 4.75 | 1:5.52 |
| Willow Nursing (Garden) | 7.15 | 4.76 | 1:7.21 |
| **Specialist Wards** | | | |
| Beech Ward | 7.08 | 6.76 | 1:8.40 |
| Caroline House | 10.61 | 10.34 | 1:6.41 |
| PBL | 8.64 | 7.35 | 1:5.84 |
| Pine Cottage | 7.05 | 4.30 | 1:7.39 |

**CCS Safer Staffing**

***Luton Adults***

1.8.7 The service continues to evidence improved resilience; the OPEL (Integrated operational pressures escalation levels) score was 2 for 92% of the reporting period, with the remainder being 1.

1.8.8 This was further supported by 88% of shifts for District Nursing being rated as green or amber. Clinical activity was deferred on two occasions for District Nursing: other mitigations taken included workforce being re-allocated and temporary staffing being deployed.

***Business Continuity***

1.8.9 Norfolk and Waveney's Dysphagia service is working at reduce staffing capacity due to unplanned staff absence, so the Business Continuity Plan (BCP) was triggered. Mitigations taken include:

- **New referrals** are prioritised and triaged.
- **Face-to-face appointments** are suspended except in exceptional cases.
- **Video consultations** are offered when clinically necessary.
- **Routine reviews** are postponed.
- **Advice and support** is available via Just One Norfolk for call-backs.
- **Training** is cancelled for schools that previously received it.
- **Training** is being provided to new settings that haven't had it before.

1.9 **CCS and NCHC Safeguarding**

1.9.1 The Group Board is being given 'Substantial' assurance against the NHS England 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.

1.9.2 The Group 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 risk register that relates to this gap, and a pilot of safeguarding adult sessions have been carried out. A mapping exercise has been undertaken with a view to discussing further with CCS safeguarding leadership team to determine how adult supervision can be implemented across the group model.

1.9.3 CCS Safeguarding training compliance target is set at 90% for all levels (1, 2 & 3) and compliance is above this for each level in adults and children's safeguarding. Induction training should be completed within 6 weeks of commencing in post and although there is no Trust board target for this, the compliance levels are 99%. CCS have a new safeguarding training strategy which is going to be piloted alongside the Norfolk safeguarding children team, Healthy Child Service and ESR team to ensure compliance and competence process is achievable and any adaptations required are put in placet. The pilot has been delayed due to some issues with the ESR template; this has been escalated by CCS

ESR team. However, the comms to teams has been commenced and teams are being made aware of all the planned changes.

1.9.4 NCHC training compliance is now sitting at 90% which meets Trust targets, for adults and children level 3. The corresponding risks on the risk register have been reviewed to capture this with a clear plan to close in November if the compliance remains the same or higher. There are robust plans in place with services to ensure that the compliance can be maintained.

1.9.5 Safeguarding supervision is provided in accordance with guidance from the Intercollegiate Documents for children and adults. Some staff are designated to require mandatory safeguarding children supervision which supports them in their role and is noted to improve the impact of decision making and actions taken to safeguard. The Group monitors the compliance of this for designated groups such as health visitors and specialist nursing teams. Compliance is monitored through the operational and strategic safeguarding groups and has been improved to above target level for all localities more consistently. Business continuity plans are in place to ensure staff have access to appropriate and consistent support as needed should safeguarding capacity reduce due to unplanned leave or absence.

1.9.6 An annual audit plan is in place in CCS and audit completed in September for Q1 was related to the quality of referrals made to both adult and children's social care. The report findings suggest significant improvements have been made in the last year in the quality of referrals, record keeping practice, data collection and analysis of information presented in the referrals to local authorities.

1.9.7 NCHC safeguarding team have completed a Trust wide MCA (Mental Capacity Act) audit. The audit showed reasonable assurance in the quality of MCA assessments completed by clinical staff. A robust action plan has been devised, and shared with operational colleagues, and a date has been set for re-audit.

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. The Group board can take assurance that the IPaC BAF's for both organisations are regularly updated and monitored with input from all relevant subject matter experts.

***NCHC IPAC Board Assurance Framework***

1.10.1 There is currently one area of non-compliance outstanding, which is:

*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 December 2025.

***CCS IPAC Board Assurance Framework***

1.10.3 There has been progress in some of the partial compliances, and it is anticipated that some will become fully compliant by the end of quarter 3. Two of the partial compliance will remain partial as CCS have limited influence over these due to external factors. They are linked to:

- *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 NCHC reported 4 Clostridium difficile *toxins* (3 in August and 1 in September). CCS reports 0 cases of any of those listed above.

1.10.6 All positive results from NCHC inpatients and primary care are seen in real time via direct upload from laboratory allowing rapid diagnostic confirmation, prevention and management response. All cases of Clostridium difficile (C. diff) undergo a root cause analysis and are taken to a Post Infection Review (PIR) meeting to identify any potential gaps or learning.

1.10.7 IPaC nurses provide advice to NCHC teams on patient placement, transmission-based precautions and treatment at all stages of an outbreak or where management is required.

## 1.11 Staff Flu Vaccination Program

1.11.1 The staff seasonal flu vaccination programme commenced on 1 October 2025. Current uptake amongst clinical-facing staff is:

- **NCHC:** 28.4%
- **CCS:** 40.7%

1.11.2 Colleagues are encouraged to report if they have declined the vaccine or received it outside of the organisation. As well as offering both bookable and walk in clinics, the vaccination team continue to attend conferences, team meetings, and events upon request to promote uptake and accessibility.

## 2.0 CARING

### 2.1 NCHC Patient Experience

***Friends and Family Test (FFT)***

**Table 8 NCHC FFT Responses for August and September**

| | **% Positive** | **% Negative** | **% Neither good nor poor** | **Don't Know** | **Total FFT Responses** |
|---|---|---|---|---|---|
| Community Inpatient Services | 92% | 2% | 6% | 0.1% | 1. 127 |
| Community Nursing Services | 96% | 1% | 2% | 0.3% | 2. 334 |
| Rehabilitation and Therapy Services | 95% | 0.5% | 0% | 0% | 3. 195 |
| Specialist Services | 93% | 0% | 0% | 0% | 4. 30 |
| Children and Family Services | 100% | 0% | 0% | 0% | 5. 18 |
| Community Healthcare - Other | 0% | 0% | 0% | 0% | 6. 0 |
| **Trust-wide** | 96% | 0.9% | 3% | **0.4%** | **7. 704** |

2.1.1 For August and September FFT was above the target of 95% Good or Very Good with September responses higher than previous months but remaining below a peak in April of 505. This peak in April correlates with increased promotion to Places from the Lived Experience team and transfer from Envoy reporting to MS Forms. A data quality error has been identified that identifies incorrect FFT data was provided in the previous Group Board report (June and July). The correct data has been updated to align with NHSE National submission.

2.1.2 The Trust received 312 responses in August and 392 in September. Table 9 below is a summary of total responses since February 2025.

**Table 9**

| | Feb | March | April | May | June | July | Aug | Sep | Total |
|---|---|---|---|---|---|---|---|---|---|
| **Trust Overall** | 308 | 299 | 505 | 413 | 360 | 359 | 312 | 392 | 2948 |

2.1.3 Positive FFT themes highlight friendly approachable staff who explain care well, are very knowledgeable and respectful. Patients and carers also comment frequently about being well cared for and informed.

2.1.4 Themes from negative feedback relate to answering call bells at night in our inpatient units, and changes to appointments and visits. FFT feedback is regularly reviewed and monitored in Place alongside other forms of feedback to ensure services are listening and responding to their patient and carer feedback to improve care. Examples of "you said, we did" are reported at the Patient, Carer Experience and Involvement Working Group and within the Voice newsletter to help clearly triangulate actions to feedback.

2.1.5 NCH&C Lived Experience team are working closely with CCS Patient Experience team to transition FFT to one analytical tool. As part of the transition process the Trust hierarchy for reporting within services and Places has been updated. and a review of FFT feedback forms has been carried out enabling optimum capture of patient and carer feedback, demographic data. The inclusion of optional questions is under review regarding to support further involvement in opportunities for co-production work, building membership to the Patient Advisory Group.

***Healthwatch Feedback report***

2.1.6 Following a re-launch of the Healthwatch Pink Feedback Box in May 25 rotating around Places and venues in NCH&C the Norwich Community Hospital feedback report (July 2025) was submitted by Healthwatch Norfolk. Of the 50 responses there was an average rating of 4.7 out of 5 with Physiotherapy services the most frequently mentioned department. Patients were asked to rate services out of five for the categories of Care, Staff Attitude, Communication, Waiting times and Food. Feedback indicated that patients were happy with the care they received from Norwich Community Hospital with people specifically praising the helpful attitudes of the staff. A further report is expected in October following visits to North Walsham, Kelling Hospital and the Willow Unit.

***Compliments***

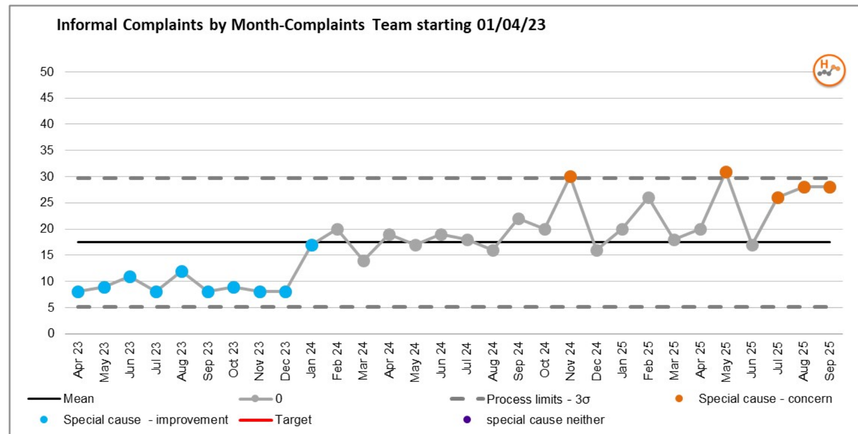
2.1.7 There were 150 compliments received which were spread across all Places, with West Place having received and logged the highest number

but with a notable increase for the Intermediate Care Beds and Urgent Care Response Teams (ICUCR) Place. Themes throughout compliments often highlight the gratitude of patients and their families to staff who have looked after them and comment specifically on their kindness, compassion and skill with which they were treated.

**Complaints**

2.1.8 There were 57 locally resolved, informal complaints and 23 formal complaints received in August and September.

**SPC Chart 3**




***Informal Complaints received***

2.1.9 The Trust received 57 locally resolved, informal complaints in this data period: 29 in August and 28 in September. The above chart demonstrates a sustained upwards trend in informal complaints received, with both months remaining significantly above the average.

2.1.10 100% of informal complaints were contacted within the Trust timeframe of three working days, and no informal complaints were escalated to a formal complaint.

***Themes from informal complaints received in August and September***

2.1.11 The prominent themes of concern were identified as lack of access to community services and not receiving the appropriate frequency of visits for care provided.

2.1.12 Lack of communication regarding delayed visits remains a Trust-wide risk and actions are being taken by the Quality Matrons to support this. Actions include:

- Daily OPEL meetings
- Patients triaged according to clinical need
- Staff providing a clearer explanation to patients (for example by advising them that they will receive two visits per week, instead of pre-determined days).

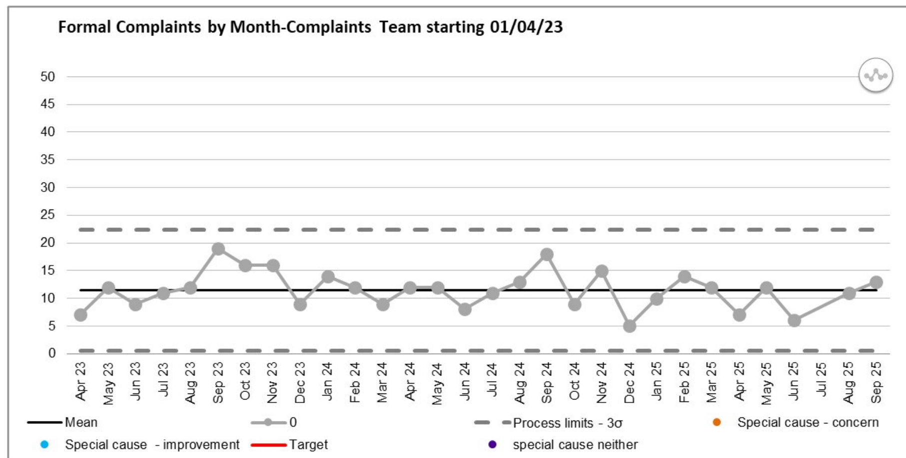
2.1.13 The prominent themes of concern in September were consistent with those raised in August with the additional complaints received regarding insufficient notification regarding changes to planned visits. The West

Place Quality Team have initiated conversations with support services to enquire about potential digital solutions to support and resolve this ongoing theme.

***Formal Complaints received***

2.1.14 The Trust received 23 formal complaints in this data period, 10 in August and 13 in September. As shown below, this is within the expected variation and below the Trust threshold for this data period.

**SPC Chart 4**




2.1.15 100% of formal complaints were responded to within the Trust's timeframe of three working days.

***Themes from formal complaints received in August and September***

2.1.16 There were no prominent themes identified in formal complaints received in August. The key theme of concern in September for formal complaints relate to communication issues. Two complaints involved delays in community nursing visits, with no notification provided regarding the delay or rescheduling. This remains a theme that has identified and addressed for further improvement.

***Formal Complaint Response Times***

2.1.17 In this data period, the Trust responded to 14 formal complaints, 3 in August and 11 in September. The Trust continued to respond to all formal complaints within the agreed timeframe achieving a 100% response rate for this data period

***Member of Parliament (MP) Contacts***

2.1.18 There were two MP contacts in August, one was a formal complaint the other was an informal complaint. There was one MP contact in September, this was an informal complaint.

## 2.2 CCS Patient Experience

***Friends and Family Test (FFT)***

2.2.1 The Friends and Family Test provide 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 2316 responses in August and 2122 in September. This is almost 2000 fewer than the previous two-month period. The reduction was expected based on previous years data and the summer period including school holidays. Below is a summary since February 2025.

**Table 10**

| | Feb | March | April | May | June | July | Aug | Sept | Total |
|---|---|---|---|---|---|---|---|---|---|
| **Trust Overall** | 2687 | 3194 | 2753 | 2502 | 2989 | 3439 | 2316 | 2122 | **22002** |

2.2.3 The overall Trust FFT positive feedback was 95.83%, with a 1.78% negative feedback percentage.

FFT scores for all directorates were above the Trust target of 90%, as shown in table 11.

2.2.4 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 11**

| | % Positive | % Negative | Total FFT Responses | Contacts | Response Rate |
|---|---|---|---|---|---|
| Ambulatory Care | 96.28% | 2.17% | 2256 | 32299 | 6.98% |
| Bedfordshire and Luton Children and Young People’s Service | 97.99% | 1.29% | 698 | 36914 | 1.89% |
| Bedfordshire and Luton Adults Community Service | 97.24% | 0.64% | 471 | 28107 | 1.68% |
| Cambridgeshire and Peterborough Children and Young People’s Service | 97.64% | 1.47% | 339 | 28094 | 1.21% |
| Norfolk and Waveney Children and Young People’s Service | 90.21% | 1.93% | 674 | 32570 | 2.07% |
| Trustwide | 95.83% | 1.78% | 4438 | 157984 | 2.81% |

2.2.5 All surveys with the FFT question also ask to what extent the service user felt that they were treated with respect and dignity. In August and September 4169 service users answered this question and a score for each directorate is shown below. Norfolk and Waveney Children’s Services was slightly below 90%, review showed that this is due to the neutral responses provided by Children and Young People accessing the Mental Health Support Teams.

2.2.6 In response to feedback from young people that they did not understand what being treated with dignity means the following additional text was added to the question: Being treated with respect and dignity means you are listened to, your feelings are considered, and people are kind, fair and polite.

**Table 12**

| | Respect and Dignity Score |
|---|---|
| Ambulatory Care | 97.10% |
| Bedfordshire and Luton Children and Young People's Service | 97.76% |
| Bedfordshire and Luton Adults Community Service | 95.92% |
| Cambridgeshire and Peterborough Children and Young People's Service | 96.43% |
| Norfolk and Waveney Children and Young People's Service | 89.96% |
| Trustwide | 95.92% |

***Comments/ Compliments***

2.2.7 In August and September, the services we provide received 6454 positive comments across the Trust, this is over 2000 fewer than the last reporting period. This is expected as fewer surveys were completed in this period. We received over 92 positive comments for every complaint (formal and informal).

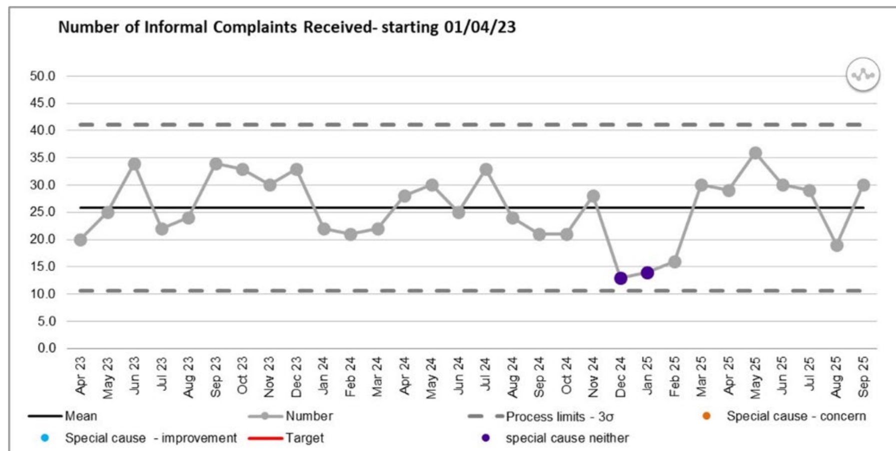
***Complaints***

2.2.8 There were 49 informal complaints, and 21 formal complaints received in August and September. There were 157,984 contacts which equates to one formal complaint for every 7,523 contacts and one informal for every 3,224 contacts, this is fewer for informal but more for formal than the previous reporting period.

***Informal complaints received***

2.2.9 The Trust received 49 informal complaints in this data period: 19 in August and 30 in September. Both months were within the expected variation.

**SPC Chart 5**




2.2.10 Forty six of the 49 complainants were contacted within four working days to discuss resolution of their concerns. In two cases there was a delay in the service forwarding the informal complaint to PALS. In one case contact was attempted by the service within four working days but the telephone call was not answered, there was successful contact on day 6.

***Themes from informal complaints closed in August and September***

2.2.11 Fifty-four informal complaints were resolved and closed in August and September with 73 subject issues identified.

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

- Clinical Care (21)
- Communication and Information (19)
- Delays (12)

2.2.13 Of the 21 issues related to Clinical Care five were about Dynamic Health. The detail of these informal complaints are a missed referral for rehabilitation, lack of clarity in the management plan and service user desire for a scan or further investigation.

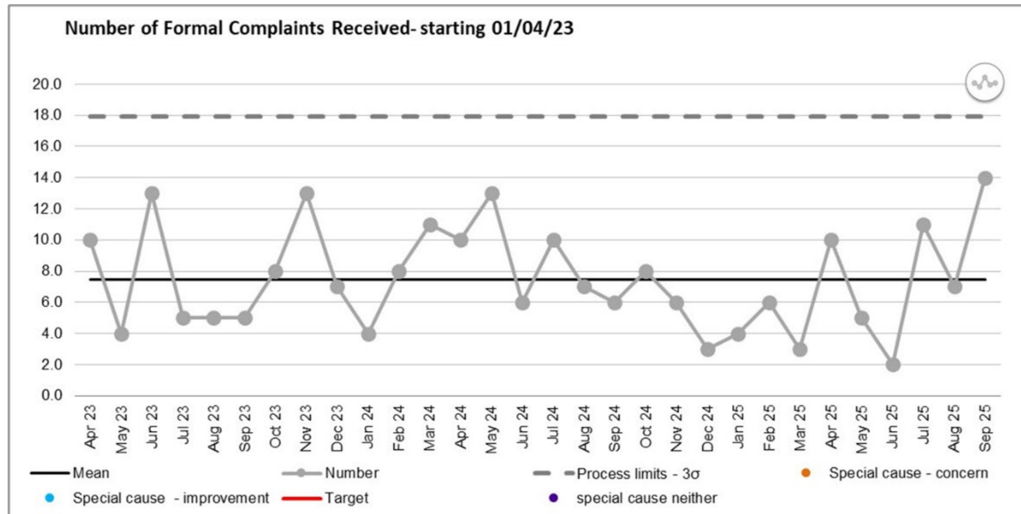
2.2.14 Six of the informal complaints about Communication and Information related to Dynamic Health and three were related to Cambridgeshire and Peterborough 0-19 Children's Services. There were no themes in the detail of these.

2.2.15 Three of the 12 issues related to Delays, were about Paediatric Occupational Therapy in Bedfordshire, they were related to declined referrals and discharge from the service.

***Formal Complaints Received***

2.2.16 The Trust received 21 formal complaints in this data period, seven in August and 14 in September. More complaints were received in September that in any month since April 2023. As shown below, this is within the expected variation.

**SPC Chart 6**




*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 August and September 2025***

2.2.17 Within this data period the Trust responded to and closed 14 formal complaints. In these there were 30 subjects identified.

2.2.18 Clinical Care and Communication and Information were the most frequently occurring subjects. There were nine issues about Clinical Care and Communication and Information was identified as an issue nine times. The other subjects were Staff Attitude (4) and Systems Failure (4).

2.2.19 In six of the formal complaints about clinical care the service user raised concerns about inadequate of insufficient care being provided. This includes being unhappy with decision to discharge and expected treatment not being provided.

2.2.20 Eleven services were named in the formal complaints responded to in August and September. There were no themes in the services involved.

***Formal Complaint Response Times***

2.2.21 In this data period, the Trust responded to 14 formal complaints, three in August and eleven in September.

2.2.22 The percentage of standard complaint responses sent within the 35 working day timeframes fell in August, this was due to there being just one complaint response and this was outside of timeframe. In September 63% of standard complaints were sent within timeframes. All complex complaint responses were sent within timeframes in August, two out of three were within timeframes in September.

***Member of Parliament (MP) Contacts***

2.2.23 In this period there were seven contacts received via an MP, six enquiries and one informal complaint. The informal complaint was about a declined referral in Community Paediatrics in Bedfordshire and Luton.

Three enquiries were about iCaSH services related to test kit access, staffing levels and services processes. Two enquiries were about waiting times in Community Paediatrics in Bedfordshire and Luton. One was about the provision of services in Bedfordshire Paediatric Occupational Therapy.

***Supporting Services with Correspondence with Service Users***

2.2.24 The PALS team supported with writing two letter to service users in August.

## 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 across the workforce:**

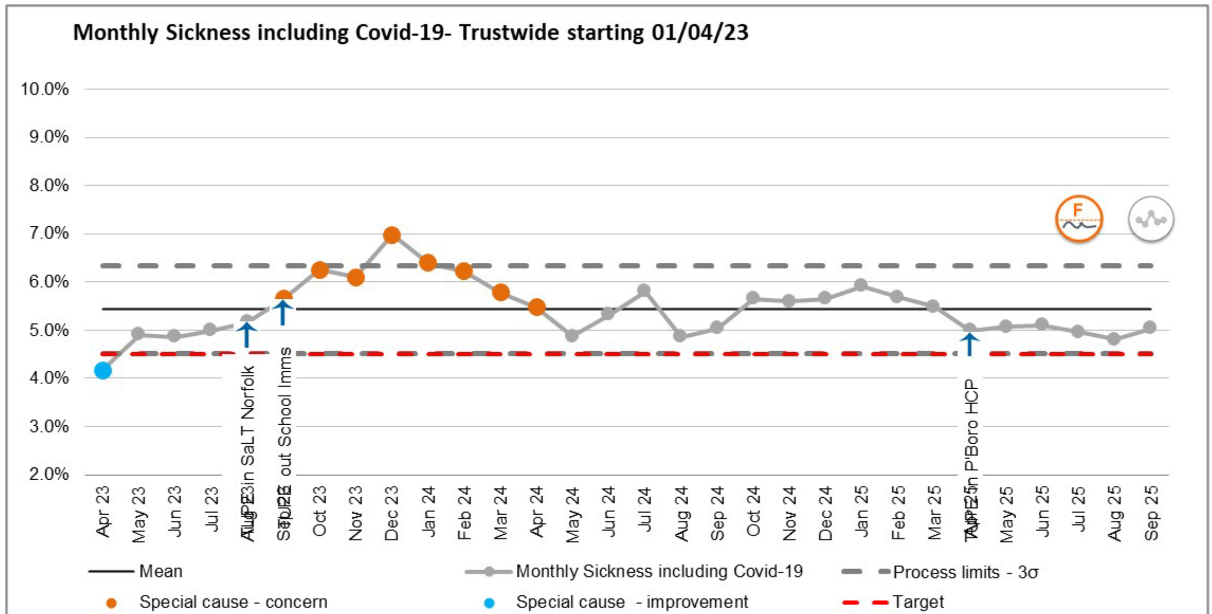
### CCS

3.2.1 The 12-month cumulative rolling rate (August 2025 – 5.33%, September 2025 – 5.33%) remains above the Trust rolling target of 4.5%.

3.2.2 Monthly Trust wide rate for August 2025 was 4.81% and for September 2025 was 5.04%.

3.2.3 The Trust wide sickness rate has 2.33% was attributed to long term sickness and 2.72 % short term sickness absence. Beds & Luton Adults had the highest sickness rate (6.09%) and Support Services the lowest (2.84%). The top reason Cold, Cough, Flu - Influenza (23.42%); 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 July 2025 benchmark reported for NHS Community Trusts (source: NHS Digital Workforce Statistics) which was 5.4 %.

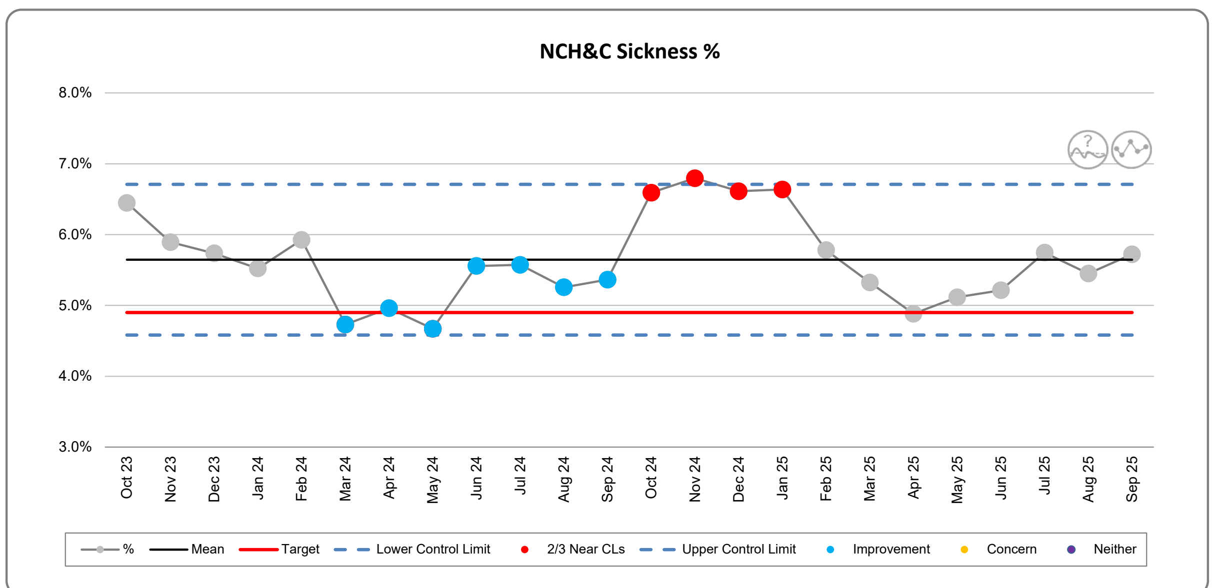



## NCHC

3.2.5 The 12-month rolling rate (August 2025 – 5.79%, September 2025 – 5.82%) remains above the Trust target of 4.9%.

3.2.6 Monthly Trust wide rate for August 2025 was 5.45% and for September 2025 was 5.72%.

3.2.7 The Trust wide sickness rate has 3.55% attributed to long term sickness and 2.28 % short term sickness. Norwich Place had the highest sickness rate (7.34%) and Ambulatory Services the lowest (2.36%). The reason of ***Anxiety/stress/depression/other psychiatric illnesses*** continues to be the highest reason for absence and accounts for 26.5% of time lost.



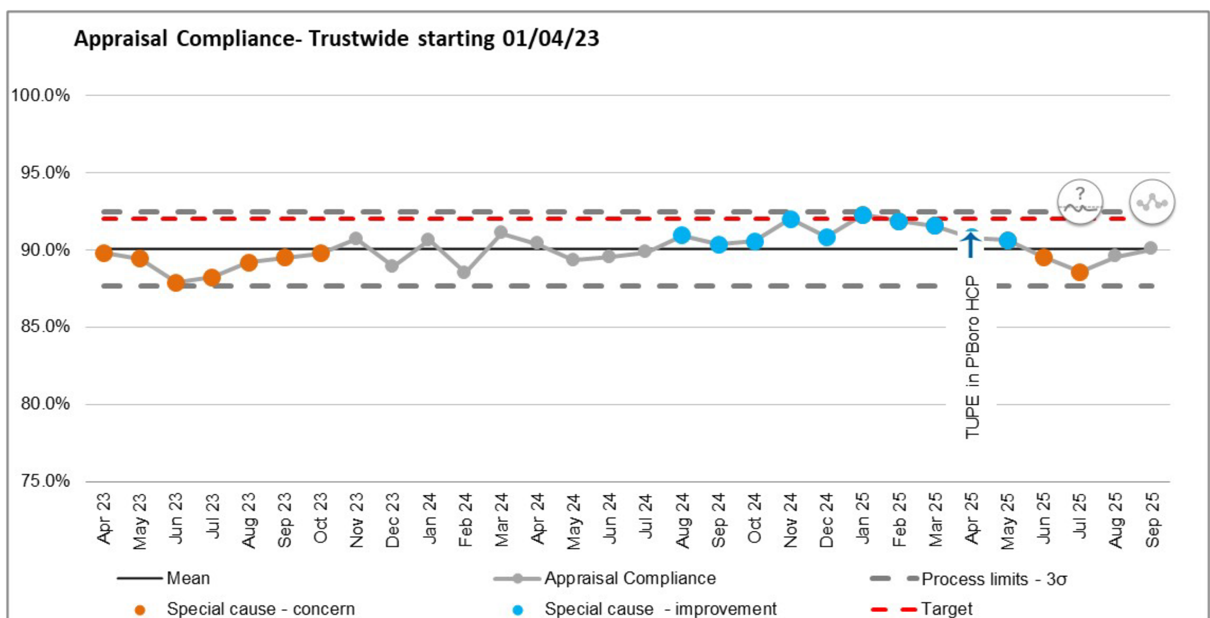
## 3.3 Appraisal rates across the workforce

### CCS

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

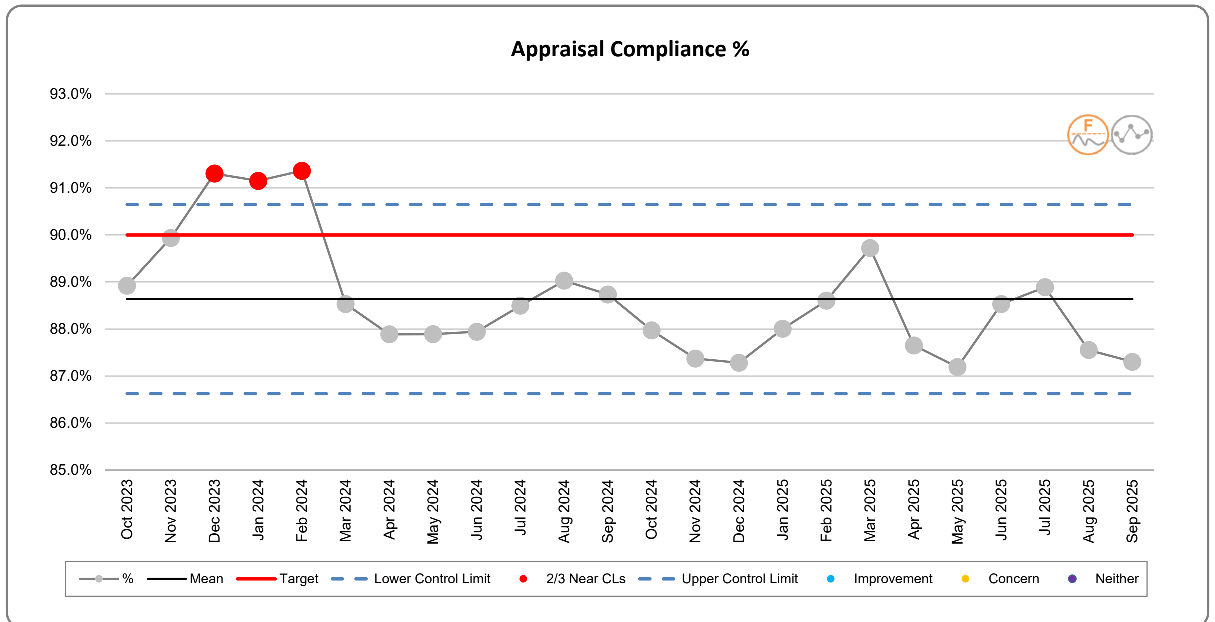
3.3.2 The Trust wide Appraisal rate increased in August 2025 – 89.56 % and September 2025 – 90.03%, which remains below the Trust target of 92%.

3.3.3 Support Services has the lowest rate (71.76%), Ambulatory Care has the highest rate (96.18%). 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.




### 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 and internal secondments are included (the Trust target of 90% gives a 10% tolerance for any staff unable to complete an appraisal). Staff on Career Break, suspension and new starters within their first 12 months of services are excluded.




3.3.5 The Trust wide Appraisal rate has been variable over recent months but is still falling short of the 90% target. August 2025 – 87.55%, September 2025 – 87.30%.

3.3.6 West Place has the lowest rate (84.21%), South Place has the highest rate (90.08%).

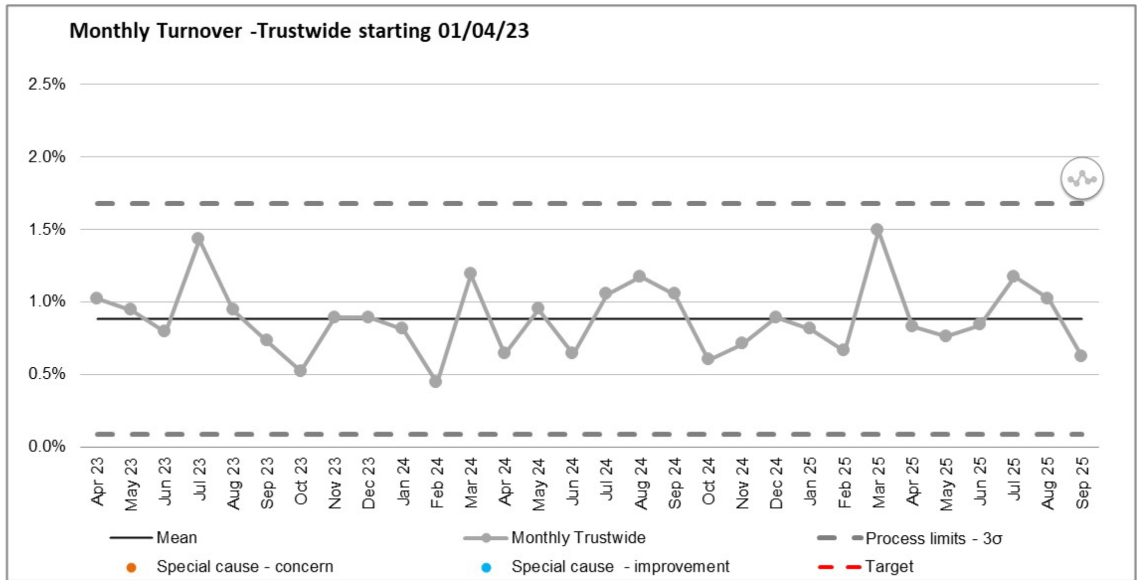
## 3.4 Turnover rates across the workforce

### CCS

3.4.1 The following chart shows monthly Turnover rates for the Trust which are based on the "Permanent" workforce (i.e., those employed on a current Fixed Term Contract of less than one year are excluded). Leavers for the following reasons are also excluded: end of a fixed-term contract, mutually agreed resignation scheme and Employee Transfers.

3.4.2 The Trust's Rolling Year Turnover Rate is currently 11.17% (August 2025 – 11.09%, September 2025 – 10.64%) compared to an annual average Leaver rate for Community Provider Trusts of 11.6% (Source: NHS Digital Workforce Statistics – July 2025, based on "all Leavers" and "total Workforce").

3.4.3 Luton Children currently has the highest Rolling Year turnover rate at 19.76%, with Support Services having the lowest at 5.29%. Further work will take place to understand the reasons for leaving for those working within Luton children services.

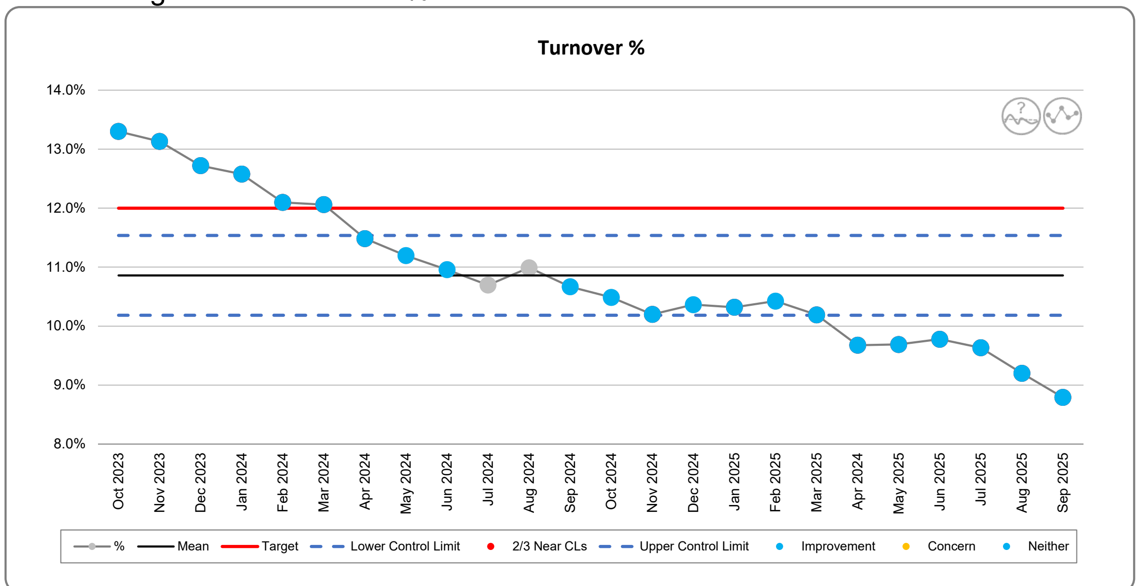



### NCHC

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

3.4.5 The Trust's Rolling 12-month Turnover Rate is currently 8.79%, which sits below our Trust wide target of 12% but within the tolerance of +/- 4 %.

3.4.6 Ambulatory Services has the highest rate at 12.99%, with West Place having the lowest at 6.93%.



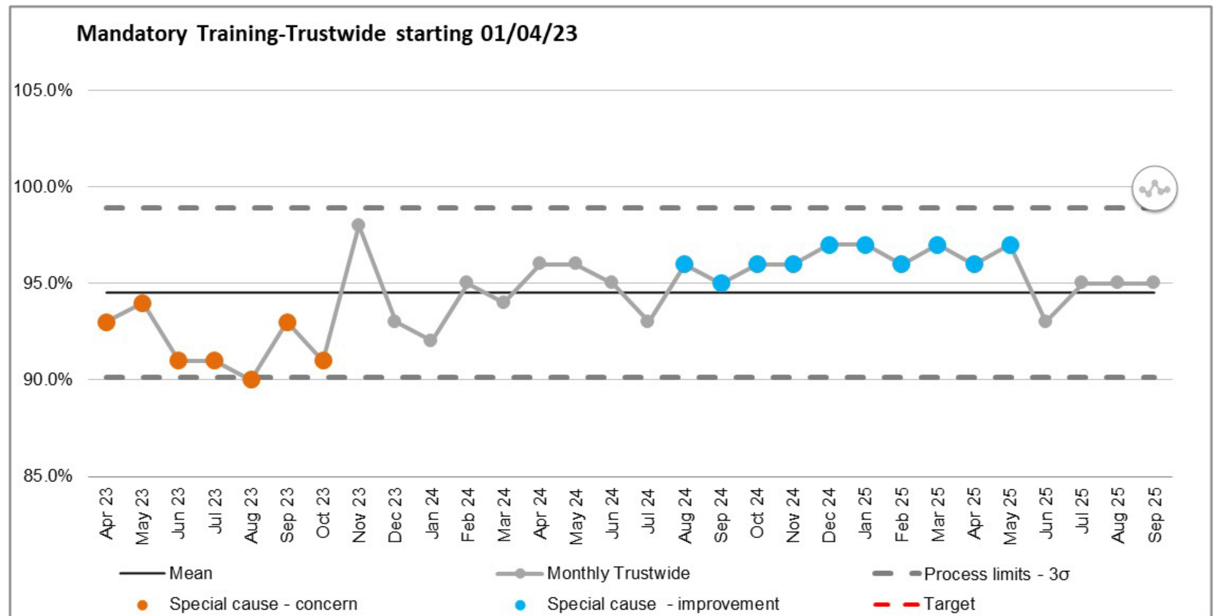

## 3.5 Overall Mandatory Training levels across the workforce

### CCS

3.5.1 The following chart shows monthly Mandatory Training rates for the Trust which are based on the "Permanent" workforce (i.e., those employed via Fixed Term Contracts, Bank, Internal Secondment and Permanent). Staff who are within their first 3 months of employment are excluded along with staff on sickness, Maternity or Paternal leave.

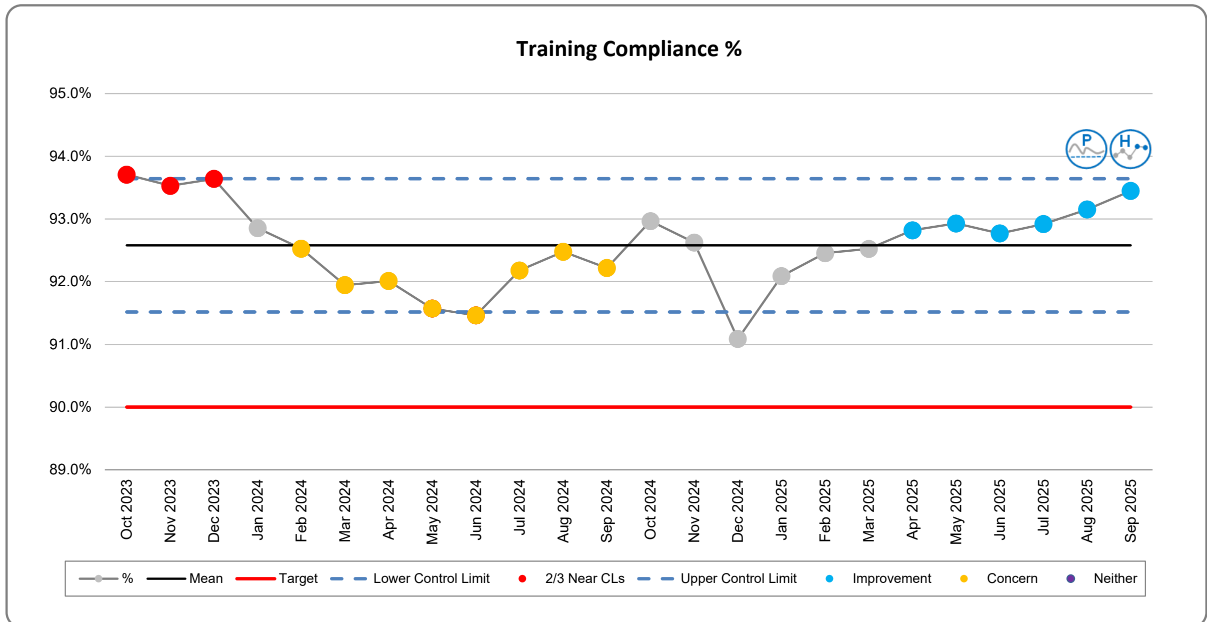
3.5.2 The Trust wide Mandatory Training rate remained stable in August 2025 – 95%, and September 2025 – 95%, both months being above the 92% target.

3.5.3 Cambridgeshire, Norfolk and Peterborough Children has the lowest rate (88%), Ambulatory Care have the highest rate (98%). Employees, for whom a non-compliant date is held in ESR, are contacted by the ESR/OLM Team and encouraged to complete their compliance. Service Leads, Team Managers & Line Managers have access to BI reporting within ESR and QD data Information to review Compliance.




### NCHC

3.5.4 The following chart shows the training compliance rate for the 12 Core Mandatory training subjects for our substantive workforce. Staff on Long term sickness, maternity, internal secondments are included (the Trust target of 90% gives a 10% tolerance for any of these staff unable to complete their training).




3.5.5 The training rate has remained consistently above the 90% target threshold. August 2025 – 93.15%, September 2025 – 93.45%.

3.5.6 Corporate Services has the highest rate at 95.70%, with Ambulatory Services having the lowest at 90.47%. All areas except for Palliative Care are above target.

## 3.6 Improving the Working Lives of Resident Doctors – 10 Point Plan

3.6.1 NHS England has set out 10 ways in which the NHS needs to improve resident doctors working conditions under the recently published 10 Year Health Plan for England.

3.6.2 There are 75,000 resident doctors working across the NHS. In CCS we employ 13 resident doctors, working across paediatric and iCaSH services, and 10 General Practice (GP) trainees. In NCHC we employ two resident doctors and three GP trainees. The 10-point plan covers the following areas:

1. Trusts should take action to improve the working environment and wellbeing of resident doctors.
2. Resident doctors must receive work schedules and rota information in line with the Code of Practice.
3. Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing.
4. All NHS trust boards should appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to trust boards.
5. Resident doctors should never experience payroll errors due to rotations.
6. No resident doctor will unnecessarily repeat statutory and mandatory training when rotating.

7. Resident doctors must be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours. (National workstream)
8. Resident doctors should receive reimbursement of course related expenses as soon as possible.
9. We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery. (National workstream)
10. We will minimise the practical impact upon resident doctors of having to move employers when they rotate. (National workstream)

3.6.3 The Trust is responsible for implementing 7 out of 10 points within the plan. Our Chief Medical Officer and Chief People Officer are working together to ensure that both Trusts achieve compliance in all areas. We will keep the Board updated with progress.

3.6.4 Our Chief Medical Officer is our identified senior leader responsible for resident doctor issues across both Trusts. In relation to identifying the one peer representative who is a resident doctor, we are working with our local acute partners to identify these individuals.

3.7 **National Staff Survey 2025**

Both Trusts launch the 2025 National Staff Survey as planned during the week of 22nd September. The survey runs through until 28th November and as of 7th November we have achieved the following response rates:

- CCS – 44.1% (2024 – 61% achieved)
- NCHC – 48.8% substantive staff (2024 – 67% achieved)

## 4.0 RESPONSIVE

### 4.1 Neurodevelopment waiters update (as of 07.11.2025)

4.1.1 The table below shows all children waiting for an initial neurodevelopmental appointment across our group-wide CYP services. A neurodevelopmental appointment relates to children referred for suspected Autism and/or ADHD.

| Number of CYP waiting for their 'Initial neurodevelopmental appointment' (7th November 2025) | | | | |
|---|---|---|---|---|
| | Bedfordshire & Luton | Cambridgeshire | Norfolk | Groupwide |
| 0-18 weeks | 386 | 553 | 278 | 1217 |
| 18-52 weeks | 1052 | 812 | 630 | 2494 |
| 52-104 weeks | 2055 | 860 | 1718 | 4633 |
| 104-156 weeks | 1697 | 79 | 1461 | 3237 |
| 156-208 weeks | | | 362 | 362 |
| 208-260 weeks | | | | |
| 260-312 weeks | | | | |
| >312 weeks | | | | |
| Total | 5190 | 2304 | 4449 | 11943 |

4.1.2 The table below shows a sub-set of the data above and shared nationally otherwise known as 'Referral To Treatment' (RTT) figures (as of October 2025).

| Number of CYP waiting: Referral to Treatment (RTT) – October 2025 | | | | |
|---|---|---|---|---|
| | Bedfordshire & Luton | Cambridgeshire | Norfolk | Groupwide |
| 0-18 weeks | 341 | 518 | 352 | 1211 |
| 18-52 weeks | 883 | 846 | 182 | 1911 |
| 52-104 weeks | 1459 | 853 | 2 | 2314 |
| 104-156 weeks | 930 | 58 | | 988 |
| 156-208 weeks | | | | |
| 208-260 weeks | | | | |
| 260-312 weeks | | | | |
| >312 weeks | | | | |
| Total | 3613 | 2275 | 536 | 6424 |

4.1.3 We have provided additional non-recurrent waiting list initiatives to manage those children waiting longest for an NDS diagnostic assessment. This will reduce our waiting time from 156-208 weeks to below 156 weeks. The impact on our waits is detailed in the table below.

4.1.4 The Table below provides a projection of the waiting list position expected from April 2026.

| Number of CYP waiting for their ‘Initial neurodevelopmental appointment’ (Projection - April 2026) | | | | |
|---|---|---|---|---|
| | Bedfordshire & Luton | Cambridgeshire | Norfolk | Groupwide |
| 0-18 weeks | 386 | 553 | 278 | 1217 |
| 18-52 weeks | 1052 | 812 | 630 | 2494 |
| 52-104 weeks | 2055 | 860 | 1718 | 4633 |
| 104-156 weeks | 1684 | 66 | 1449 | 3199 |
| 156-208 weeks | | | | 0 |
| 208-260 weeks | | | | 0 |
| 260-312 weeks | | | | 0 |
| >312 weeks | | | | 0 |
| Total | 5177 | 2291 | 4075 | 11543 |

4.1.5 We are reviewing other ways to increase capacity to further reduce those waiting up to 156 week and will be focused detailing the number of weeks waiting (e.g. 155 weeks, 154 weeks etc) to reduce those longest waits. We will involve system partners and different ways of working to achieve this reduction.

4.2 **Waiting times/Waiters**

In the following tables we have identified Services with waiting times challenges based on either, or a combination of, total waiters, low RTT compliance, high levels of 30+ week waiters, 52+ week waiters for both Trusts.

Note: **Annexes 1 & 2** contain the waiting times for all services for both Trusts.

4.2.1 **Top five NCHC services** (Data as at 03/11/2025)

| Core Service | Number of Waiters | Median Wait (Weeks) | 18 Week RTT | Max Wait (Weeks) | 18+ Week Waiters | 52+ Week Waiters | Last raised in SAC IGR on: |
|---|---|---|---|---|---|---|---|
| NDS | 4488 | 94.6 | N/A | 260.1 | 4210 | 3580 | Nov |

**Summary narrative:**
A service transformation programme is underway with the following elements:
- Improved waiting well resources and self-care information on Just One Norfolk
- Implementation of a digital referral form and process
- Implementation of one day assessments clinics (ODACS) to increase flow through the pathway
- ‘Fast Track’ process for cases received from Specialist Resource Bases (SRB)
- Streaming of caseloads (Dec 2025) to ensure that level of assessment matches need
- Coproduction with wider system collaborative partners and families of needs-led model and future neighbourhood health model
- All 18+ young people transferred at the end of October to ICB-funded assessment pathway
- All Norfolk Framework Right To Choose providers will be required to share assessments completed within the next reporting period to enable these cases to be discharged from current wait list

| Core Service | Number of Waiters | Median Wait (Weeks) | 18 Week RTT | Max Wait (Weeks) | 18+ Week Waiters | 52+ Week Waiters | Last raised in SAC IGR on: |
|---|---|---|---|---|---|---|---|
| Wheelchairs | 1044 | 16.6 | 54.2% | 129.6 | 478 | 71 | Nov |

**Summary narrative:**
The Wheelchairs Service comprises two elements, a Wheelchair Assessment service and a Wheelchair Repair service.

A new operating model has been implemented, a ‘direct issue’ model, with new referrals processed through a triage tool that allocates patients to the appropriate caseload, helping minimise the need for clinical intervention.

Of the 52-week waiters, the majority (95%) have had a first assessment (clock stops at equipment handover, not first assessment). 34 have an equipment handover in November, this position will continue to improve into December and January, with clearance of all 52+week waiters expected by the end of January 2026.

2.0 WTE staff members are about to commence maternity leave, there will be an impact on the recovery trajectory. The service is currently mitigating potential harm to patients by working with colleagues in the community to support handing over equipment. The service is also developing more accredited prescribers within the community to support patient pathways. The revised trajectory to returning to a

sustainable caseload indicates a longer recovery period to April 2027 to reach a sustainable caseload, and to December 2027 to achieve a 14-week RTT.

| Core Service | Number of Waiters | Median Wait (Weeks) | 18 Week RTT | Max Wait (Weeks) | 18+ Week Waiters | 52+ Week Waiters | Last raised in SAC IGR on: |
|---|---|---|---|---|---|---|---|
| MSK Services (NCHC) | 9250 | 7.7 | 85.7% | 51.6 | 900 | 0 | N/A |
| MSK Services (ECCH) | 6686 | 8.0 | 89.6% | 51.3 | 697 | 0 | N/A |

**Summary narrative:**
There are high volumes of long waiters across the NoW MSK service. Priority (Urgent) patients are invited to book an appointment within two weeks.

The service is actively collaborating with the external administration provider to enhance communication with priority patients and optimise diary management, ensuring more appointments are booked within the 2-week timeframe. Appointment utilisation is being closely monitored, with regular feedback provided to the administrative team to drive ongoing improvement. A detailed review of Physiotherapy priority patients breaching the 2-week target is currently underway to identify themes and implement targeted solutions.

In September, NCHC MSK Physiotherapy and Biomechanics services were highlighted as the services with the longest median wait time, highlighting a bottleneck in this area. There has been a reduction in workforce within the Physiotherapy team. There was also a general reduction in capacity over the summer months due to annual leave.

Community Appointment Days (CADs) and Super Clinics were successfully delivered throughout August and September, supported by GIRFT FF funding. While clinician availability limited capacity, these sessions provided valuable additional access for patients during the summer period.

Recruitment activity resumed following financial review post-transformation to align staffing with service income and expenditure. Despite recent staff changes, recruitment has been positive, resulting in the appointment of two Band 6 Physiotherapists (internal promotions) and three Band 5 MSK rotational Physiotherapists (new posts).

Physiotherapy capacity is expected to gradually improve as recruitment progresses, with full recovery anticipated by December. In the interim, routine patients continue to receive high-quality self-management support, including tailored advice, exercise plans, and clear contact information should their symptoms change.

The service is targeting 85% of priority patients to be seen within two weeks by the end of December. Achievement of this goal is supported through close collaboration between NCHC and ECCH teams, enhanced diary management by the ECCH administration service, improved data quality, and effective prioritisation of appointments.

| Core Service | Number of Waiters | Median Wait (Weeks) | 18 Week RTT | Max Wait (Weeks) | 18+ Week Waiters | 52+ Week Waiters | Last raised in SAC IGR on: |
|---|---|---|---|---|---|---|---|
| Children's Consultant Outpatients | 535 | 12.0 | N/A | 68.6 | 183 | 2 | Sept |

**Summary narrative:**

Children's Consultant Outpatients has not met the 92% 18-week RTT target since Jun-23. A combination of higher demand, appointment capacity within West Norfolk and Consultant long term absence has seen performance decline since mid-2023.

Despite the volume of new referrals into the service, the number of waiters has dropped from 800 to 540 in the last 12 months. This has been alongside the implementation of a follow-up audit focussing on discharging CYP who are not actively being assessed, as well as increasing appointments in the West to address the number of waiters.

There are 2 x 52-week waiters recorded for Children's Consultant Outpatients. Both of these patients were booked in at 48 weeks when the service was under pressure, they have both DNA'd appointments resulting in 52-week breaches.

| Core Service | Number of Waiters | Median Wait (Weeks) | 18 Week RTT | Max Wait (Weeks) | 18+ Week Waiters | 52+ Week Waiters | Last raised in SAC IGR on: |
|---|---|---|---|---|---|---|---|
| Pulmonary Rehabilitation | 250 | 6.7 | 80.4% | 56.9 | 49 | 4 | N/A |

**Summary narrative:**

The Pulmonary Rehabilitation Service took on additional demand in late 2024, inheriting 198 long-waiting patients from the previous provider. Since then, the service has strived to reduce this backlog while facing higher referral rates than its new patient capacity allows for (the service now sees an average of 5.6 new referrals per week with a capacity of 4.0).

There are currently four patients with waits over 52 weeks. These patients all have appointments booked and have been contacted via telephone to ensure waiting safely principles are being applied.

To support improving waiting times, West Pulmonary Rehab patients are offered access to Central Team venues if they are close to the team boundaries (access is initially determined by GP surgery). Extra slots due to other patients dropping out are also offered when they become available.

Recovery Plan and Investment
A £170,000 two-year investment is planned across the Central and West teams, though this funding is still being arranged by the ICB. This will increase the capacity of both teams to meet the 12-week wait time target. The current trajectory estimates a 13-weeks from the start of the capacity increase for the West team and 23 weeks for the Central team for this impact to be seen.

Note: Because of timing when datasets were extracted, and waitlist cleansing/patient records being updated/data quality errors rectified in the meantime, these figures are slightly different to what was reported in the SAC IGRs. This is the up-to-date position as of 03/11/2025.

4.2.2 **Top five CCS services** (Data as at 03/11/2025)

| Core Service | Number of Waiters | Median Wait (Weeks) | 18 Week RTT | Max Wait (Weeks) | 18+ Week Waiters | 52+ Week Waiters | Last raised in SAC IGR on: |
|---|---|---|---|---|---|---|---|
| Beds Community Paediatrics | 2755 | 86.0 | N/A | 154.0 | 2580 | 2058 | Nov |
| Luton Community Paediatrics | 2435 | 85.0 | N/A | 142.0 | 2224 | 1694 | Nov |

**Summary narrative:**

Combined narrative for Bedfordshire and Luton Community Paediatric services.
* Since July 2025 (last reporting period) wait times peaked in August (120 children increase) due to high referral numbers, however they have now reduced.
* Longest wait has decreased by 16 weeks in Luton, however increased by 11 weeks in Bedfordshire. This is due to staff leavers in Bedfordshire.
* Children waiting over 52 weeks has decreased by 28 children in Bedfordshire and 44 in Luton since July 2025.

Improvements in children waiting over 52 weeks has been achieved by increased scrutiny of clinic cancellations, changes to job plans and additional temporary medical capacity

| Core Service | Number of Waiters | Median Wait (Weeks) | 18 Week RTT | Max Wait (Weeks) | 18+ Week Waiters | 52+ Week Waiters | Last raised in SAC IGR on: |
|---|---|---|---|---|---|---|---|
| Cambs Community Paediatrics | 2304 | 42.0 | N/A | 152.0 | 1751 | 939 | Nov |

**Summary narrative:**

A number of Quality Improvement initiatives are in place including:
* ND Digital Support Pack to support parents whilst waiting
* A Waiting List Validation process is embedded
* Increasing clinical productivity with the optimisation of digital dictation and job planning
* A skill mix model has been scoped and is now being mapped out in more detail including impact projections and costings
* An initial workshop was held to explore using Agentic AI to improve administrative and clinical capacity efficiencies. The next step will be to assess feasibility and conduct cost/benefit analysis
* The Early Concerns/Needs Led School Age pilot work is developing in Cambridgeshire and is embedded in the ‘Inclusion for All’/SEND strategic work.

| Core Service | Number of Waiters | Median Wait (Weeks) | 18 Week RTT | Max Wait (Weeks) | 18+ Week Waiters | 52+ Week Waiters | Last raised in SAC IGR on: |
|---|---|---|---|---|---|---|---|
| Luton Paed Audiology | 1058 | 24.0 | N/A | 75.0 | 644 | 157 | Nov |

**Summary narrative:**

* Since July 2025 (last reporting period) 496 children have been seen and removed from the wait list, longest wait has reduced from 81 to 75 weeks.
* Improvements achieved by increased clinical capacity and the introduction of choose and book processes.
* By Q1 2026/27 it is anticipated all children waiting over 52 weeks will have been seen. Ideas monitored weekly for effectiveness. All children waiting are risk assessed and prioritised accordingly.

| Core Service | Number of Waiters | Median Wait (Weeks) | 18 Week RTT | Max Wait (Weeks) | 18+ Week Waiters | 52+ Week Waiters | Last raised in SAC IGR on: |
|---|---|---|---|---|---|---|---|
| Cambs Dental GA | 330 | 31.3 | 32.1% | 161.9 | 224 | 105 | Nov |

**Summary narrative:**

Peterborough, Huntingdon and Wisbech have all patients pre booked with waiting times of 2 weeks due to a change in anaesthetics acceptance criteria resulting in less children being appropriate to be seen on this GA list. This change has had a greater impact on the Peterborough City Hospital long case list which has historically been managed by the Acute provider. We are currently reviewing theatre options with PCH to ensure that our patient waiting times are optimised.

Note: Because of timing when datasets were extracted, and waitlist cleansing/patient records being updated/data quality errors rectified in the meantime, these figures are slightly different to what was reported in the SAC IGRs. This is the up-to-date position as of 03/11/2025.

# 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 August and September and NCHC achieved 95.75% and 96.06% compliance, respectively.

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

## 5.2 Finance

**Table 13 NCHC Metrics**

| Statement of comprehensive income September 2025 | Plan | Actual | Variance | Plan | Forecast | Variance | On plan? |
|---|---|---|---|---|---|---|---|
| £'000 | YTD | YTD | YTD | Full year | Full year | Full year | Full year |
| **Statement of comprehensive income** | | | | | | | |
| Income | 86,133 | 85,879 | (255) | 173,361 | 172,669 | (692) | |
| Pay | (63,746) | (64,679) | (933) | (126,674) | (126,333) | 341 | |
| Non-Pay | (23,307) | (22,544) | 763 | (46,662) | (47,265) | (602) | |
| Non-operating | (412) | 35 | 447 | (959) | (101) | 858 | |
| **Accounting surplus / (deficit)** | **(1,332)** | **(1,310)** | **22** | **(934)** | **(1,030)** | **(96)** | |
| Accounting performance adjustments | 486 | 519 | 33 | 934 | 1,030 | 96 | |
| **Adjusted financial surplus / (deficit)** | **(846)** | **(791)** | **55** | **0** | **0** | **0** | Yes |
| | | | | | | | |
| **Efficiencies** | | | | | | | |
| Recurrent | 1,187 | 1,134 | (53) | 4,692 | 3,135 | (1,557) | |
| Non-Recurrent | 2,087 | 2,149 | 62 | 4,131 | 5,688 | 1,557 | |
| **Total Efficiencies** | 3,274 | 3,283 | 9 | 8,823 | 8,823 | - | Yes |
| | | | | | | | |
| **Agency expenditure** | | | | | | | |
| Agency spend | (606) | (197) | 409 | (1,212) | (812) | 400 | Yes |
| Bank spend | (2,204) | (2,929) | (725) | (4,408) | (6,971) | (2,563) | No |

**Table 14 CCS Metrics**

| Statement of comprehensive income MONTH YEAR | Plan | Actual | Variance | Plan | Forecast | Variance | On plan? |
|---|---|---|---|---|---|---|---|
| £'000 | YTD | YTD | YTD | Full year | Full year | Full year | Full year |
| **Statement of comprehensive income** | | | | | | | |
| Income | 88,683 | 90,366 | 1,683 | 177,366 | 179,735 | 2,369 | |
| Pay | (62,880) | (63,583) | (703) | (125,760) | (127,147) | (1,387) | |
| Non-Pay | (24,189) | (25,453) | (1,264) | (48,378) | (49,975) | (1,597) | |
| Non-operating | (1,614) | (1,330) | 284 | (3,228) | (2,613) | 615 | |
| **Accounting surplus / (deficit)** | - | - | - | - | - | - | |
| Accounting performance adjustments | - | - | - | - | - | - | |
| **Adjusted financial surplus / (deficit)** | - | - | - | - | - | - | Yes |
| | | | | | | | |
| **Efficiencies** | | | | | | | |
| Recurrent | 2,664 | 2,988 | 324 | 6,180 | 6,180 | - | |
| Non-Recurrent | 1,212 | 1,312 | 100 | 2,420 | 2,420 | - | |
| **Total Efficiencies** | | | 424 | | | - | Yes |
| | | | | | | | |
| **Temporary staffing expenditure** | | | | | | | |
| Agency spend | 780 | 472 | 308 | 1,560 | 944 | (616) | Yes |
| Bank spend | 726 | 746 | (20) | 1,452 | 1,452 | - | Yes |

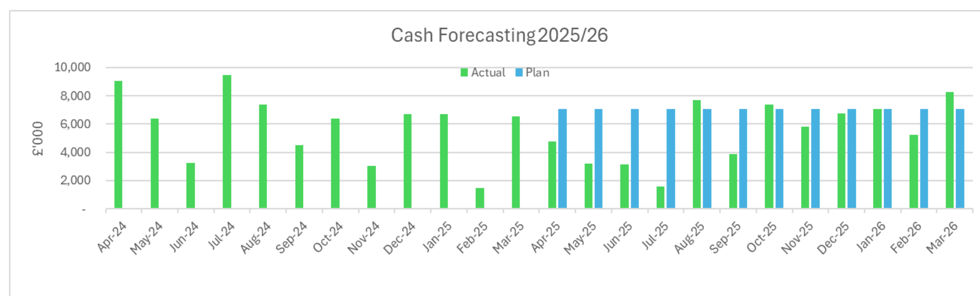
**Commentary**

5.2.1 Both Trusts are currently on plan for revenue, with efficiencies broadly tracking expectations albeit with a higher proportion of non-recurring savings than planned.

5.2.2 The cash balance position on 30 September was:

- NCHC had £41.0m of cash. This is £1.3m above plan and represents 2.9 months of operating cash outflows.

- CCS had £3.9m of cash. Although a slight increase from the July position of £2.3m, it was £3.2m below plan and represents one week of operating cash outflows. This is predominately due to timing of receipts, with £2.6m received between 1-3 October. The cash balance at 31 October was £7.8m, with aged debt falling from £12.4m in July to £4.1m in September. A CCS cashflow forecast for the remainder of this year is below.




5.2.3 Agency expenditure is below plan for both Trusts; NCHC by £0.4m (69%) and CCS by £0.3m (39%). However, staff bank expenditure is above plan in NCHC by £0.7m (32%) and forecasted to increase to a £2.6m (60%) overspend by year end. This is predominately driven by a change in staffing models and skills mix in our inpatient wards in Norfolk Adults.

5.2.4 Capital expenditure to date is:

- NCHC: £1.3m - £3.0m behind plan
- CCS: £1.2m - £538k behind plan

Both variances are primarily due to timing of lease recognition. For NCHC this includes a new £2m lease for the relocation of our Community Nursing and Integrated Care teams in Norfolk East, now expected in November. Both Trusts expect to deliver their full year capital plans.

5.3 The Group efficiency target for 2025/26 totals £17.4m (NCHC £8.8m and CCS £8.6m), with £7.6m delivered to date (44%). Efficiency delivery overall at the reporting period remained on plan in both organisations, but there is a £5.1m gap in recurrent schemes which impacts the planning target for 2026/27.

5.4 The following table summarises the overall risk profile for the 2025/26 efficiency programme as follows:

| RAG Rating | Recurrent £000's | Non-Recurrent £000's | 2025/26 Total £000's | % |
|---|---|---|---|---|
| High Risk | 3,666 | - | 3,666 | 21% |
| Moderate Risk | 1,824 | 1,078 | 2,902 | 17% |
| Low Risk | 6,245 | 4,610 | 10,855 | 62% |
| **Total** | **11,735** | **5,688** | **17,423** | |

5.5 The £3,666k of high-risk schemes are all within the CCS portfolio. Contract income which has yet to be agreed with commissioners' accounts for £1,230k whilst the remaining £2,436 represents recurrent unidentified schemes across the Divisions and Support Service Directorates. Work is ongoing to develop recurrent efficiency schemes and progress these projects through governance to reduce delivery risk.

5.6 The element of non-recurrent savings in the 2025/26 efficiency programme has reduced from 47% to 33% as more recurrent projects have been identified in year. However, the non-recurrent pay savings has increased from 19% to 30%. As in previous years, under-delivery against recurrent efficiency targets is expected to be offset by non-recurrent savings and use of reserves this year.

**Financial Plan - Key Risks at 30 September 2025**

| Rating | BAF Risk | Risk description | Mitigations |
|---|---|---|---|
| High | 3708 | A low cash balance in CCS of £3.9m. This is £3.2m below plan and represents one week of operating cash outflows. | Focus on working capital, supplier payments and aged debt has fallen from £12.4m to £4.1m. Weekly focus meetings lead by Director of Finance and enhanced cash monitoring and reporting. |
| Medium | 3707 & 3691 | There is a risk that a higher proportion of savings will be delivered non-recurrently, shifting the financial pressure into future years and delaying progress toward sustainability. | Efficiencies are expected to be found through service level initiatives or non-recurrent measures, although the longer-term focus remains on securing recurrent savings. |
| Medium *NEW* | 3707 | Continuing overspends in NCHC inpatient units, predominately in bank and agenda staff spend, represent a risk to delivery of the full year plan. Forecast full year overspend is £1.2m (3%). | Forecast underspends and reserves will be used to offset the overspend. The inpatient service model is under review and being benchmarked against other trusts to support development of a sustainable, recurring model. |
| Low | 3707 | Bank staff spend is ahead of plan in NCHC by £0.7m (32%). | Focus has been on reducing agency expenditure, which is £0.4m below plan and partially offsets higher bank spend. NHSE |

| Rating | BAF Risk | Risk description | Mitigations |
|---|---|---|---|
| | | | has confirmed that overspends on bank staffing will not be penalised provided the overall financial plan is delivered. |

**Financial management expectations, tools, interventions and oversight**

5.7 The document titled “2025/26 Financial Management Expectations, Tools, Interventions and Oversight” issued by NHS England (NHSE) outlines changes to the financial governance framework, emphasising greater transparency, financial discipline and accountability across Boards.

5.8 A key update is the rollout of productivity metrics for all NHS Trusts, based on cost and activity data, which will be published nationally from November 2025. In the East of England, NCHC and CCS Trusts show positive productivity growth, though data gaps in the Community Services Dataset (CSDS), such as excluded services, pose challenges that will need further analysis and clarification.

| Org name | Productivity growth estimate Q1 2025/26 |
|---|---|
| Cambridgeshire Community Services NHS Trust | 5.2% |
| Norfolk Community Health and Care NHS Trust | 3.3% |

5.9 In parallel, NHSE initiated a Baseline Impact Assessment recently to support the move away from block (fixed price) contracts. This exercise is not intended to be a financial reconciliation but aims to assess the impact of transitioning away from block arrangements. While data limitations, particularly affecting Mental Health and Community Trusts have been acknowledged, NHSE has confirmed there will be no financial impact for these Trusts in 2026/27 as efforts focus on improving data quality and coding.