Agenda item:	7
Date of meeting:	18 March 2026
Report to the:	Group Trust Board
Title of report:	Group Integrated Governance and Performance Report
Report authors & Executive sponsors:	Group Executive Team
Recommendation:	Approve
	• **The Group Integrated Governance and Performance Report**

Assurance level:	**Substantial** ☐ **Reasonable** ✓ **Partial** ☐ **Minimal** ☐
Rationale:	- Key evidence contained in this report and triangulation of this information with all Committee reports, particularly the Service Assurance Committees. - The recommendation of assurance from the Group Executive team. - Any action necessary from the rating and outcome required.

1.0 Executive Summary

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

1.2 The report period relates to the period December 2025 and January 2026 and is structured into three sections:

- Feedback and escalation from each of the Assurance Committees;
- A high-level view of key domains in each division across the Trusts, although this is currently in development;
- 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 were two 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, 28 January 2026.

6.0 Assurance

6.1 The three Assurance Committees confirmed the following levels of assurance reported from 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 – **Substantial Assurance**
- iCaSH Services – **Reasonable Assurance**
- Group Children & Young People (CYP) Integrated Governance Report - **Reasonable Assurance**
- Norfolk Adult Services – **Partial Assurance**

6.2 Conclusions on assurance levels detailed in section 6.1 are all backed up by rationale and where they are reasonable or partial, specific areas of improvement or detail have been identified.

6.3 Therefore the Group Executive recommends an overall rating of **REASONABLE** assurance for the aggregated position across our entire portfolio. The rationale for this rating is based on the combined three Service Assurance Committee assurance levels in 6.1 above. This is not an exact science and not backed up by an agreed methodology for the Group but is proportionate given the detail shown in in 6.1.

6.4 The first Board reporting cycle for 2026/27 as a single organisation will have the methodology detailed out that covers our wide geography and portfolio of services, enabling the Board to have clearer rationale on overall assurance conclusions.

7.0 Key Matters

7.1 The key reports from the 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 no operational risks scoring 15 or above.

8.2 All risks scoring 12 and above are received and reviewed by the Group Trust Board Committees including the 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 11 operational issues scoring 4 (Major) or above on the group-wide issue register. They are discussed in detail at the relevant Assurance Committees.

9.2 Details of those issues currently scoring 4 or above are summarised as follows:

- Two relate to CYP services.
- Eight relate to adult services across Norfolk.
- One relates to the reduced pharmacist and pharmacy technician cover across CCS 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:

- Continue to spotlight on reducing waiting times.
- Development and implementation of the pan to improve community nursing and therapy services in Norfolk
- The work of the Board to refresh the strategic risks on the Board Assurance Framework.
- The continued work of the Executive and the Board on developing and agreeing the key metrics for the Service Assurance Committees and this Integrated Governance Report for 2026/27.

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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 Assurance Committee
Chair: Charlotte Black
Meeting Date: Wednesday 4th March 2026

Key matters:

Thematic reviews:

- Update on service level clinical audit plans for 2025-26 and proposed clinical audit plan for 2026-27 – **Substantial Assurance**.

Integrated Governance Reports:

The committee received Integrated Governance Reports for the following:

Ambulatory Services Division:

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

Key points:

MSK Dynamic Health Services:

- Waiting lists overall remain below average of 18 weeks. However, the service has forty 30 plus week waiters – 36 in core physio and 4 in specialist service. No over 52-week waiters.
- AI pathway for low back pain commenced again in November 2025.
- Sickness absence levels above target (7.3%) in December 2025 – all cases being pro-actively managed.

NOW MSK Service – Norfolk Health and Care NHS Trust service

- Friends and family satisfaction rates saw a significant improvement to 85% in January, however, response volumes remain low. Plans in place to address.
- Level 3 Adults safeguarding training remains below target at 88.3% in January 2026.
- Service not achieving urgent average 2 week waiting times. Waiting well support offered to those waiting longer. This is being closely monitored.

Dental Healthcare:

- Waiting times – Cambridgeshire and Peterborough Special Care Dentistry, average wait time 21 weeks. General Anaesthetic (GA) over 52-week waiters have reduced to 48 as of 22 February 2026. Additional capacity and external funding for the remainder of this year identified and this remains a priority area for the service and is being closely monitored.

- Sickness absence rate remains above trust target at 7.84% in December 2026.

iCaSH:

- 1 never event - linked to a coil fitting. Correct type of device however 10-year device fitted rather than a 5-year device. No harm.
- Service continues not to meet the 2 contractual key performance indicators in relation to Cambridgeshire and Peterborough women being offered access to LARC within 10 working days. Additional clinics being scheduled to increase capacity and this is being funded from existing budgets.
- Sickness levels remain above Trust target at 6.21% in December 2025. Human resources support in place and cases being managed.
- The service is currently £1.1m underspent (5%) mainly due to staff turnover and vacancies. Any underspend at the end of the year may have to be returned to the Commissioners.

Luton and Bedfordshire Community Adult Services – Substantial assurance.

Key points:

- Overall services remain safe and stable. Staff pressures well controlled which is reflected in sustained Opel 1 and 2 status throughout the winter period.
- Positive impact of the *Minuteful for Wound* care app to both the patient care provided and clinical time saved is starting to be evident.
- Safeguarding Adult level 3 training remains below target at 86% - targeted approach being used to improve compliance.
- Sickness levels remain above trust target at around 7% in December, seasonal impact, however the service has seen a sustained improvement in its rolling 12 month sickness average.
- Service continues to contribute significantly to system flow with delivery through unscheduled care hub; virtual ward and the volume of patients that the service picks up directly form the ambulance stack.

Key escalations: None

Key risks and issues: No risks scoring 15+ or issues with a consequence rating of 4+

Good practice or innovation:

- Dynamic Health – the service presented its work on health inequalities at the Integrated Care Board Health Inequalities Oversight Group in February 2026.
- Suffolk Dental team – won the gold standard green impact in Dentistry award.
- iCaSH – outreach and prevention services have expanded the reach of chlamydia screening to McDonalds, Primark and other retail outlets that have a young target audience. In addition, service has been running a project in Central Bedfordshire in collaboration with both Central Bedfordshire safety team and our own Health Visiting team, supporting Gypsy, Romany Traveller

community. The project is focussing on overall health information and access to STI testing and condoms.

- Luton Adult services – impact of the *Minuteful for Wound* care app – demonstrating an improving position month on month of the proportion of lower limb wounds healing within a target of 8 weeks.

Key Matters and Escalation Report to the Group Trust Board

Name of Committee: Children and Young Peoples Assurance Committee
Chair: Anna Gill
Meeting Date: Tuesday, 03 March 2026

Key matters

Integrated Governance Report (IGR): [Overall assurance rating: Reasonable]

The committee received a group-wide Children and Young People's (CYP) report with updates from both NCHC and CCS services. Key points to note:

- Work to reduce CYP waits for Neurodevelopmental Service (NDS) - trajectories set and reductions seen.
- Mandatory training and Information Governance (IG) compliance all substantial
- Staff sickness remains high with combined HCP (Healthy Child Programme) rate of 6.99%. Combined specialist services 4.98%. Our combined MHST (Mental Health Support Teams) services 3.8%. These were predominantly viral.
- Impact of sickness on appraisal rates now at 88-91%
- Overall financial underspend of £0.3m (4%) predominantly due to vacancies-ongoing with recruitment underway. In some CYP contracts, any inyear underspends may be required to be returned to the Commissioner.
- Ongoing work to sign off service plans and budgets by 31st Mar 26.
- New Key Performance Indicators (KPIs) released for HCP visits and a new MHST Benchmarking framework – awaiting commissioning direction
- SEND (Special Educational Needs and Disability) reforms also published-working through the impact/implications

Universal Services:

- Reduction in meeting KPIs for Healthy Child Programme (HCP) mandated visits rates
- Failure to achieve Initial Health Assessments due to LA (Local Authority) issues, increased referrals and unplanned absence
- Just One Norfolk (JON) meeting KPIs for urgent referrals. Increased referrals leading to prioritisation of routine referrals. Rolling recruitment in place.
- Norfolk HCP out to tender, awaiting the service specification – work underway
- One PSIRF case review in progress
- Finances
    - Underspend in HCP in Peterborough (£225k), Luton (£363k) Norfolk (£996k) due to vacancies
    - Overspend in HCP - Cambridgeshire (£593); Bedfordshire (£207k)

Specialist Services:

- NDS ambition - 2k reduction by 1st Apr 26 and no >52 weeks waits by 1st Apr 28

- Skill-mix pilots and pathways for NDS work in Bedfordshire & Luton and Cambridgeshire.
- Noted positive impact on staff morale that we are actively looking at the NDS waits.
- NDS work looking at both the backlog waits and a sustainable model for the future.
- Deep dive of medicines incidents with the starfish team ongoing (Norfolk).
- Luton Dietetics and Audiology waits much improved, now almost at <52 week waits
- Cambridgeshire Dietetics waits ongoing: 78 CYP waiting >52 weeks – bank staff recruited
- No 52 week waits for Community Paediatric clinics.
- Finances
    - Overall overspend of £365k
    - Underspend in MHST services

Thematic Reviews:

Service Level Clinical Audit Plans for 26/27 – **Substantial assurance**

- In depth discussion had
- All audits are completed or on plan, 10 are awaited (on plan).
- Discussion around audits pilots, and shared learning opportunities across the Group and into our new Organisation.
- Service Directors discussing about adding further audits to the planned list for 26/27.

Annual Reports

- Review of Terms of Reference & 2026-27 Annual Work Plan discussed. Will review the work plan from a balance perspective.

Key escalations:

- Long waits for CYP awaiting NDS assessment, however ongoing work is seeing an improvement.

Key risks and issues:

One risk rated 15 or above was reported which is also included on the Board Assurance Framework:

- One risk rated 16 (ID:3751) is a corporate risk held by Dr Kavanagh, CMO, regarding potential harm because of long waits for NDS assessments as above.

Two issues are currently rated as 4 (major):

- **3568** - NDS assessments waits, Groupwide (merged similar issues).

- **3764** – Bedfordshire and Luton Children's Audiology High demand for follow up appointments in – improving but remains at 4 presently.

Regulatory Updates:

- Quality Commission self-assessments were completed December 2025. Check and Challenge meetings -teams were commended for their hard work and continued commitment.
- Full ILACS inspection in Luton completed – awaiting report
- Norfolk having ILACS inspection March 26.
- UNICEF reaccreditation visit March 26 – new B6 to join team. Aiming for Gold!

Good practice or innovation:

- Aisha Raja (Orthoptist) has co-developed a training package with Bedfordshire Hospitals for a vision screening tool for practitioners if a patient has had a stroke. The ambition for the training is to roll it out nationally.
- C&P children's services were represented at the Partnership for Inclusion of Neurodiversity in Schools (PINS) conference held on 4th February 2026 with an aim of supporting primary aged children in school.
- N&W Speech and Language has improved service delivery in Norfolk's complex needs schools (CNS) collaborating with school staff and link therapists. Including a new digital request form and complex needs digital toolkit. Feedback is positive.

Key Matters and Escalation Report to the Group Trust Board

Name of Committee: Norfolk Adults Assurance Committee
Chair: Anna Gill
Meeting Date: 5th March 2026

Key matters:

Integrated Governance Report (IGR) key discussions
[Overall assurance rating: *Partial – see key escalations below*]

- Friends and Family Test, although there is an increase in response (data issues with the information provided at the meeting were noted), further work is needed to move this forward.
- The iGAS (Invasive Group A Strep) patient safety incident is stabilising, with all precautions in place. The UK Health Security Agency (UKHSA) continue to lead the response to this outbreak.
- A new section was added to the report, around violence and aggression – it was noted that best practice is being implemented across the Trusts response to this type of incident. It was noted that 11 of 16 reported incidents were linked to patients with cognitive impairment and 3 of these patients had been part of 9 incidents. A great deal of work around risk assessments and care planning is already underway. New training around 'breakaway' techniques has been commissioned for units/ areas with the higher number of high harm issues.
- An improvement in unallocated visits was noted across both Phlebotomy and Community Nursing, with a reduction of 288 (on average) per week in November 2025 to 204 per week in January.
- There were 4 deferrals in the reporting period with 1 of these being a date issue, the other 3 have all been reviewed and will be monitored.
- These improvements are against a backdrop of increased activity, it was noted that in 2024 165,000 referrals to community nursing were made, in 2025 this was 185,000, a 10.8% rise.
- The case for change for community nursing and therapies was presented; it was noted that:
  - This programme of work needs to dovetail with the end of life transformation board and the digital plan.
  - Patient and staff experience would be a critical part of transforming services and care pathways.
  - The workstream needs to include growth modelling, population health data and it needs to align to the Trusts clinical and care strategy around neighbourhoods.

- Improvements to the wheelchair waiting lists were noted, however 2 members of staff have now left the service, and it is difficult to replace like for like. This is a potential risk to the stability of the recovery plan.
- The Committee discussed staff well being at varying points across the agenda, staff are feeling jaded by change, are working hard and there are some issues with sickness and absence. It was noted that further change would need to be planned and would need to show real benefit to staff and patients.

NCHC District Nursing Benchmarking Project– *Reasonable Assurance*

- Out of every 100,000 population (over 65's) in Norfolk, the Trust receives 76,000 referrals (these are both external (87%) and internal (13%), which is above all other organisations in the bench marking exercise (bar one significant outlier).
- The teams are completing on average 6.6 visits per WTE (Whole Time Equivalent) per day, which is in line with other organisations, however the Trust is noted as having lower workforce capacity.
- Community Nursing visiting durations are also l longer, at 48 mins a visit, with the national average being 24 mins. Indicating higher complexity, and an increased number of care plans delivered to patients.
- The benchmarking also showed: the service is good value for the money spent, there is a low bank and agency spend and there is high output with lower resources.
- Next steps were discussed, with more work being undertaken in relation to the over demand position and how this links with the growth funding bid. Additionally, we need to be clear on whether the current model will meet future demand. This gives a good starting point for the case for change work that needs to happen within Community Nursing and Therapies.

Clinical Audit Programme 2026-27 – *Reasonable Assurance*

- The audit plan was agreed for 2026/27.
- The audits are linked to risks, issues, outcomes from the palliative care board and incidents.
- Next steps include increasing the visibility and oversight of audits, merging the processes from the 2 organisations (taking the best practice) an ensuring audit is on the agenda at the safety group.
- 3 audits were delayed in 2025-26, 2 have been rescheduled.

Projects & Efficiency - *Reasonable Assurance*

- 4 projects were escalated in the meeting.
- Systm1 project, this will now need a complete review, following a change in direction.
- Urgent Care/Unscheduled Care Coordination Hub project is at amber, due to the performance of the service being at below the 80% target. Moving forward the rag rating will be split into project delivery (this is green) and benefits (which is the 80% target, which is at amber).
- GPS (Global Positioning System) tracker, there have been issues accessing the software; however, the project will be superseded by the BRIDGID application. This project will be closed in the next month.
- IV project (Intravenous Infusions), there have been difficulties accessing funding for this from the Integrated Care Board. There has also been a delay in systemwide work – being led by the local acute provider, this has been escalated, with no resolution.
- The service has found circa 2million of the 3.1milllion cost improvement target that was set. 96% of these projects have been fully realised or in partial development.
- Next year's cost improvement target is £1,835,000.

Annual Service Plan for 2026-27

- It was recognised that this is a starting point in relation to service planning, and that a planning tracker will be developed to support achievement.
- The plan was approved.

Review of Terms of Reference & 2026-27 Work Plan

- Terms of reference were reviewed; it was noted that section 2.2 and 3.4 will be updated.
- The workplan was discussed, some further focus on meeting/ agenda timings was requested, so that important discussions are not curtailed.

Key escalations:

- IGR – partial assurance
- The reduction in unallocated visits, with a continued focus on deferral rates.
- The Committees support for commencing the Case for Change within Community Nursing and Therapies.
- The directorate audit plan 2026-27 was approved.
- The annual service plan was approved.

Key risks and issues:
There are no risks rated as 12 or above assigned to the committee.

8 issues (risks which have been realised) are rated as 4 (major).

Good practice or innovation:

- It was recognised that best practice is already being implemented across the organisation, linked to the violence and aggression agenda.
- The District Nursing benchmarking exercise was identified as a starting point for the Case for Change project.
- The UCCH was a topic of discussion at the recent Health and Well Being Board where senior leaders were very complementary about the service and its ‘exemplar’ work whilst acknowledging the need for further funding to realise potential and meet high demand.

Part Two: Balanced score cards for each division

(This section is currently under development)

Part Three - Themes across the organisations

1.0 SAFE

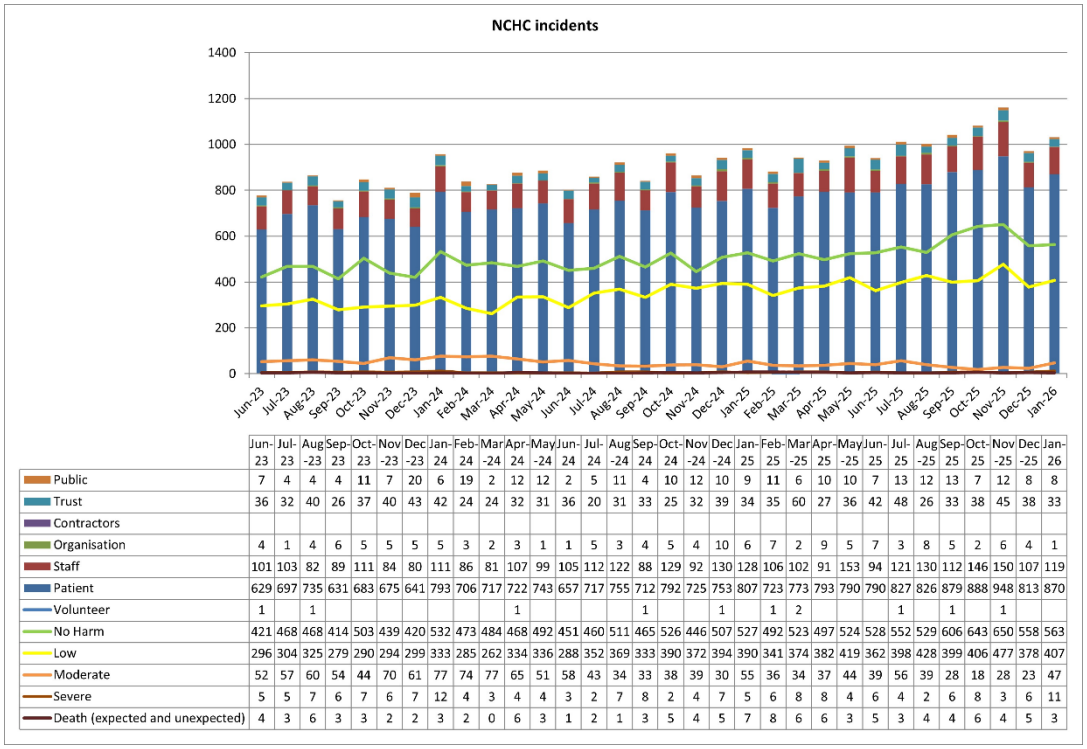
This section provides an overview of reported patient safety incidents across the group during the reporting period, with a focus on the nature and severity of harm, emerging trends, and the outcomes of investigations undertaken.

1.1 Overview of all incidents across CCS and NCHC across a 2-year period.

1.1.1 The graphs below (graph 1 and 2) demonstrate a steady profile of incident reporting. The incidents differ reflecting the type, and volume, of patient interactions across both Trusts portfolios.

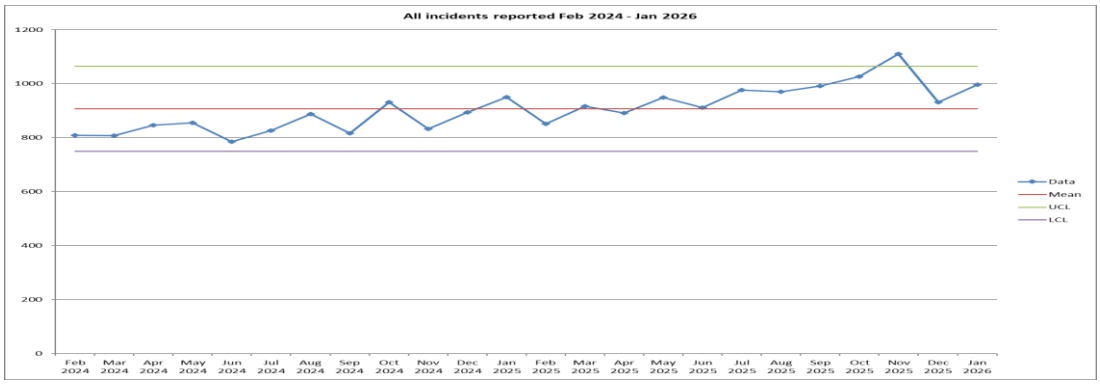
1.1.2 Statistical Process Charts (SPC 1 and 2) show reported incidents were stable and within control limits over this period (Feb 24–Jan 26)

Graph 1 NCHC Incident Profile

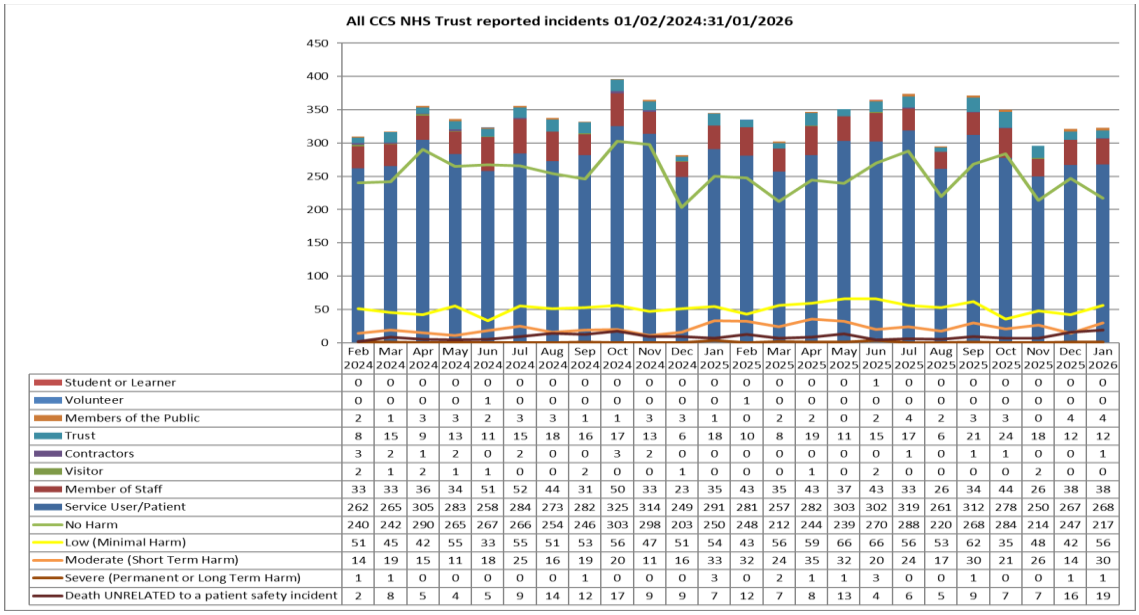


	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Public	7	4	4	4	11	7	20	6	19	2	12	12	2	5	11	4	10	12	10	9	11	6	10	10	7	13	12	13	7	12	8	8
Trust	36	32	40	26	37	40	43	42	24	24	32	31	36	20	31	33	25	32	39	34	35	60	27	36	42	48	26	33	38	45	38	33
Contractors																																
Organisation	4	1	4	6	5	5	5	5	3	2	3	1	1	5	3	4	5	4	10	6	7	2	9	5	7	3	8	5	2	6	4	1
Staff	101	103	82	89	111	84	80	111	86	81	107	99	105	112	122	88	129	92	130	128	106	102	91	153	94	121	130	112	146	150	107	119
Patient	629	697	735	631	683	675	641	793	706	717	722	743	657	717	755	712	792	725	753	807	723	773	793	790	790	827	826	879	888	948	813	870
Volunteer	1		1								1					1			1		1	2				1		1		1		
No Harm	421	468	468	414	503	439	420	532	473	484	468	492	451	460	511	465	526	446	507	527	492	523	497	524	528	552	529	606	643	650	558	563
Low	296	304	325	279	290	294	299	333	285	262	334	336	288	352	369	333	390	372	394	390	341	374	382	419	362	398	428	399	406	477	378	407
Moderate	52	57	60	54	44	70	61	77	74	77	65	51	58	43	34	33	38	39	30	55	36	34	37	44	39	56	39	28	18	28	23	47
Severe	5	5	7	6	7	6	7	12	4	3	4	4	3	2	7	8	2	4	7	5	6	8	8	4	6	4	2	6	8	3	6	11
Death (expected and unexpected)	4	3	6	3	3	2	2	3	2	0	6	3	1	2	1	3	5	4	5	7	8	6	6	3	5	3	4	4	6	4	5	3

SPC 1 NCHC All reported incidents February 2024-January 2026

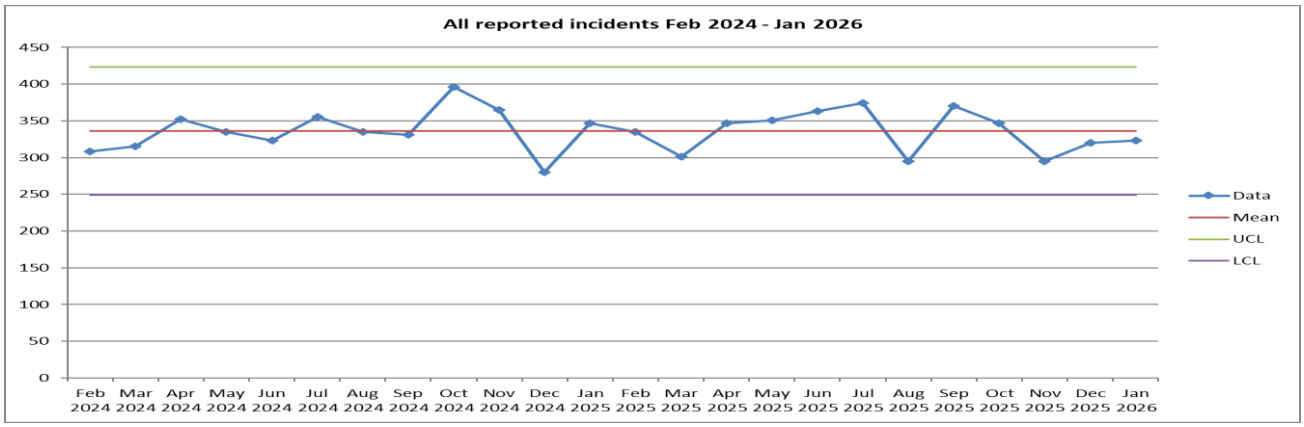


Graph 2 CCS Incident Profile



	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	Oct 2025	Nov 2025	Dec 2025	Jan 2026
Student or Learner	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Volunteer	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Members of the Public	2	1	3	3	2	3	3	1	1	3	3	1	0	2	2	0	2	4	2	3	3	0	4	4
Trust	8	15	9	13	11	15	18	16	17	13	6	18	10	8	19	11	15	17	6	21	24	18	12	12
Contractors	3	2	1	2	0	2	0	0	3	2	0	0	0	0	0	0	0	1	0	1	1	0	0	1
Visitor	2	1	2	1	1	0	0	2	0	0	1	0	0	0	1	0	2	0	0	0	0	2	0	0
Member of Staff	33	33	36	34	51	52	44	31	50	33	23	35	43	35	43	37	43	33	26	34	44	26	38	38
Service User/Patient	262	265	305	283	258	284	273	282	325	314	249	291	281	257	282	303	302	319	261	312	278	250	267	268
No Harm	240	242	290	265	267	266	254	246	303	298	203	250	248	212	244	239	270	288	220	268	284	214	247	217
Low (Minimal Harm)	51	45	42	55	33	55	51	53	56	47	51	54	43	56	59	66	66	56	53	62	35	48	42	56
Moderate (Short Term Harm)	14	19	15	11	18	25	16	19	20	11	16	33	32	24	35	32	20	24	17	30	21	26	14	30
Severe (Permanent or Long Term Harm)	1	1	0	0	0	0	0	1	0	0	0	3	0	2	1	1	3	0	0	1	0	0	1	1
Death UNRELATED to a patient safety incident	2	8	5	4	5	9	14	12	17	9	9	7	12	7	8	13	4	6	5	9	7	7	16	19

SPC 2 CCS All reported incidents February 2024 - January 2026



1.2 NCHC Patient Safety Incidents

1.2.1 No ‘Never Events’ identified, and no new Patient Safety Incident Investigation (PSII) commissioned.

1.2.2 There are three on going Patient Safety Incident Investigations:

- A PSII related to Learning Disabilities Service has begun, with initial learning identified.
- Two related to prevention of future death (Regulation 28) reports awaiting final sign off with learning and action plans progressing.

1.2.3 Action plans on previously submitted PSII’s are on track for completion.

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

1.2.5 Duty of Candour (DoC) compliance remains at 100%.

1.2.6 1976 Incidents reported and compared to the previous reporting period:

Table 1 All NCHC incidents Dec 25 -Jan 26 by degree of harm

Month	No Harm	Low	Moderate	Severe	Death (Expected)	Total
Dec 2025	558	378	23	6	5	970
Jan 2026	563	407	23	10	3	1006
Total	**1,121**	**785**	**46**	**16**	**8**	**1976**

1.2.7 No / low harm incidents account for 96.4% of total incidents reported. A deep dive into themes is underway by the Patient Safety team.

Severe Harm Incidents

1.2.8 16 severe harm incidents identified, 13 are related to pressure ulcers. After action reviews discussed at the Pressure Ulcer Learning Group.

- 11 related to a deterioration in an existing ulcer to a category 4.
- 1 related to a pressure ulcer development where the partner organisation had decided there wasn't one.
- 1 identified a pressure ulcer misclassified by the acute organisation prior to transfer (deemed Cat 3 vs actual Cat 4)

- 2 related to diabetic foot wound deterioration. All relevant reviews and care had been given.

- 1 safeguarding incident highlighted concerns for a care home provision of care. Appropriate safeguarding referrals were initiated.

Moderate Harm Incidents

1.2.9 46 moderate harm incidents reported:

- 32 Cat 3 pressure ulcer development. Action plans to improve care underway.
- 3 contractures management – Currently reviewing all contracture management.
- 1 wound deterioration due to triage delays – review of triage pathways ongoing.
- 1 deterioration of a chronic diabetic foot wound.
- 3 deterioration in patient condition with subsequent transfer to acute services. Wound infection as contributing factor in all three.
- 2 deteriorating patients in the community with missed opportunities for earlier escalation. After Action Reviews at Place level and Primary care.
- 4 Safeguarding concerns NCHC raised for care delivered by system partners.

Other learning opportunities identified

1.2.10 The Contracture working group has been re-established to continue the contracture management and will present to the March Safety Group.

1.2.11 An End-of-Life medication deep dive has been completed by the Palliative Care Matron. Review of incidents identified:

- Incorrect/unclear prescribing (often GP-issued).
- Gaps in anticipatory prescribing.
- Delays in syringe driver set-up or dose changes.
- Out of Hours unable to administer due to prescription gaps.
- Conflicting advice provision between services.

These issues are ongoing and will be incorporated into the Norfolk Adults Palliative and End of Life Care Programme Board. This will involve system partners, including learning from our Luton Adults team.

1.3 CCS Patient Safety Incidents

1.3.1 No Patient Safety Incident Investigation (PSII's) were commissioned.

1.3.2 One 'Never Event' declared in Dec 25 for the ICASH service. An after-action review has been completed. There was no patient harm caused.

1.3.3 No PSII's concluded, and one PSII remains ongoing - an incident occurred in Beds CYP Service (previously reported).

1.3.4 Action plans on previously submitted PSII's are on track for completion.

1.3.5 Six review responses were commissioned by Safety Huddle in Dec 25, two had a safeguarding element. Five review responses were commissioned in Jan 26, one of which had a safeguarding element.

1.3.6 There were no severe harm incidents reported.

Table 1 All CCS incidents Dec 25 -Jan 26 by degree of harm

Month	No Harm	Low	Moderate	Total
December	115	16	6	137
January	112	18	12	142
Total	**227**	**34**	**18**	**279**

Moderate Harm Incidents

18 moderate harm incidents reported (increase of four incidents)

- 15 were reported related to preventable wounds.
- 1 incident due to an adverse reaction in Dental clinic
- 1 incident due to a delay in diagnosis in Audiology
- 1 incident- failure to identify/escalate safeguarding concerns in HCP

- 14 had the statutory Duty of Candour completed and letters sent; 3 cases remain under review and are actively being monitored. 1 incident - skin deterioration at the end of life, so duty of candour not completed but a follow up family bereavement call was made

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

NCHC Pressure Ulcers

1.4.1 Reported pressure ulcers (PUs) across NCHC remain above the agreed threshold across hospital, community and therapy services.

- Community acquired (PUs) numbers have had a small reduction.
- Standardised pressure ulcer assessment templates and associated risk assessment tools now embedded.
- All PUs - initial review within Place, and greater complexity/harm cases escalated to specialist forums for further scrutiny.

1.4.2 A Internal review identified inconsistent pressure ulcer risk screening from the Urgent Care Response Teams (UCR). An action plan and monitoring of progress has been implemented.

Alongside this the teams continue with their plans to adopt the:

- Healthy.io. software pilot underway - wound care app.
- Work to implement required changes reflecting the National Wound Care Strategy clinical categorisation recommendations is ongoing.

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

1.4.3 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. 83 incidents reported as 'developed Pressure Ulcers or MASD', with 82 reported under Beds and Luton Adults Services.

A further 16 incidents related to patients who 'acquired a skin tear', all of which are deemed to be off caseload and are 'happened upon' incidents.

1.4.4 Of the Beds and Luton Adults 82 incidents, 39 (48%) were deemed to have occurred whilst the patient was on the Luton Nursing caseload

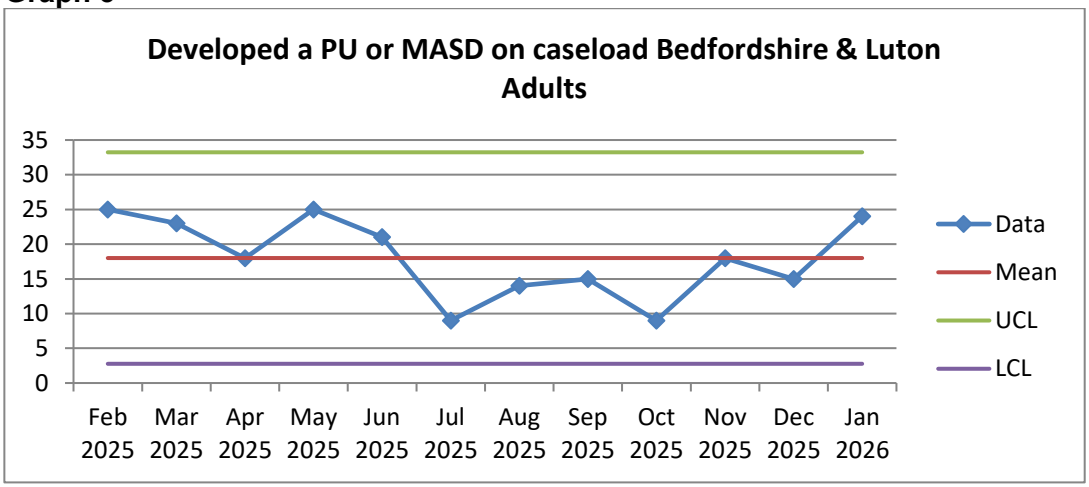
1.4.5 Pressure Ulcer incidents reporting for those patients on caseload has a decreased over the last 12 months with the forecast showing the falling rate, as per *Graph 3.* The mean reporting rate is 18 per month. In Jan 26 there is recorded increase which is being monitored currently.

1.4.6 The Preventable Wounds Community of Practice receive a monthly thematic review of all grade 3 and 4 pressure ulcers to identify emerging themes and learning for wounds that are considered preventable.

1.4.7 The annual review of 'exposed tendons' has been undertaken by the Service and will be presented to the Safety Improvement Group in March. Initial findings relate to non-compliance/concordance from service users. The Service is working with the Safeguarding Team to ensure that appropriate escalation takes place.

1.4.8 The wound care app *Minuteful for Wound* has been successfully implemented across CCS. Currently 19,382 wound assessments have been completed through the app with 457 patients currently on caseload covering 906 wounds. A recent 'Wound Photography and Measurement Audit' identified a vast improvement in labelling, accuracy, quality and healing factors of wounds since the inception of the app. The service is sharing their experiences of the app with other local Community Trusts.

Graph 3



1.5 Medicines Optimisation CCS and NCHC

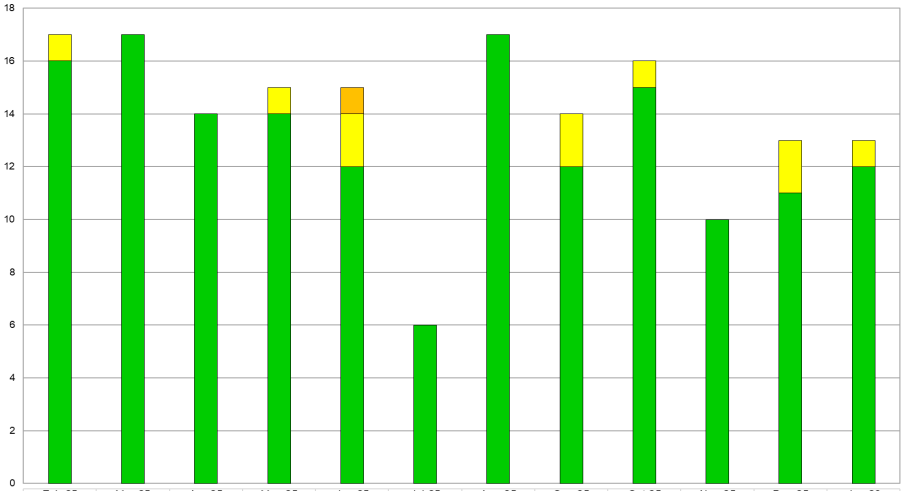
1.5.1 Governance

The Medication Safety and Governance Group (MSGG) in CCS and Medicines Optimisation Working Group (MOWG) in NCHC review all medication incidents and implement corrective actions, providing assurance of collaborative efforts to maintain outstanding patient care.

1.5.2 Overview

CCS Medication Incidents (Graph 4)

- 26 medicines-related incidents: 23 no harm, 3 low harm.
- All low harm incidents involved insulin administration - 1 dose omission due to incorrect drug storage, 2 related to incorrect dose.



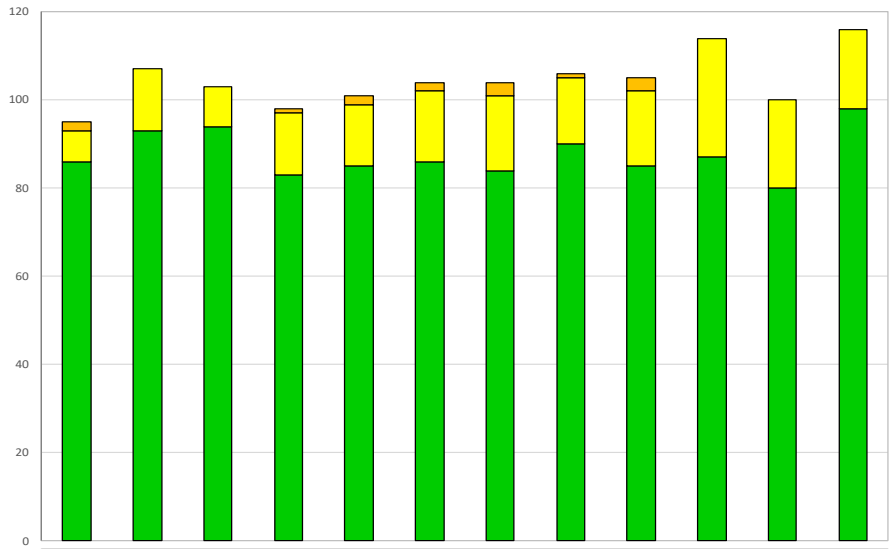
	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Moderate (Short Term) Harm	0	0	0	0	1	0	0	0	0	0	0	0
Low (Minimal) Harm	1	0	0	1	2	0	0	2	1	0	2	1
No Harm	16	17	14	14	12	6	17	12	15	10	11	12
Total Number of Medication Incidents	17	17	14	15	15	6	17	14	16	10	13	13

Graph 4: CCS Medication incidents and degree of harm (Feb 25-Jan 26)

NCHC Medication Incidents (Graph 5)

- 216 medicine related incidents: 178 no harm and 44 low harm.
- 103 incidents (82 no harm, 21 low harm) attributable to NCHC

Graph 5: NCHC Medication incidents and degree of harm (Feb 25 -Jan 26)



	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Moderate (Short Term Harm)	2	0	0	1	2	2	3	1	3	0	0	0
Low (Minimal Harm)	7	14	9	14	14	16	17	15	17	27	20	18
No Harm	86	93	94	83	85	86	84	90	85	87	80	98

1.5.3 Themes of Incidents

CCS

- Medicines administration accounted for over 50% of incidents, of which 93% involved medicines administered in patient's homes.
- Documentation clarity
- Use of Medication Administration Record (MAR) charts

NCHC

- Medicines administration remained the main cause of incidents,
- Small increases in prescribing and dispensing/supply incidents.
- Prominent issues - quality/clarity/ accuracy of prescriptions
- Syringe driver - referrals, documentation, equipment and drugs.

1.5.4 **Insulin Incidents**

The Insulin Data Oversight Group (CCS), and Diabetes Working Group (NCHC), monitor insulin-related incidents. All were low or no harm. All are also reviewed by the relevant medicines governance group.

1.5.5 **Controlled Drugs (CDs) in NCHC**

- CDs require robust governance and remain a key focus.
- Downward trend in missing-stock events, with remaining discrepancies linked to documentation or calculation errors.

1.5.6 **Summary Group Actions**

1. **Integrated governance:**
   - April 2026 - MSGG and MOWG will amalgamate to form the Medicines Safety and Governance Group (MSOG).
2. **Documentation quality:**
   - Trial of Bridgid app (mobile app) via tablets instead of mobile phones, to improve MAR accuracy, access to up-to-date information and improve care transfer communication.
   - Review of relevant templates via which patient data is accessed to support integration with Bridgid app
3. **Insulin safety:**
   - Targeted education through Oversight Groups.
   - Promoting communication by ensuring appropriate representation at Diabetes Team meetings and District Nurse Daily Huddles.
4. **Controlled drugs (CDs):**
   - Issues involving transport of CDs now resolved.
   - Work is underway to evaluate additional accurate stock check.
   - Communications developed to promote proactive checking of patients' TTOs (To Take Out) ahead of discharge and ensure early ordering and verification of patient-held stock post medication-regime changes.Q3 CD audit findings are presented at the Ward Managers' meeting to support shared learning.
5. **Stock management:**
   - Digital temperature monitoring probes for medication fridges are being implemented across services.

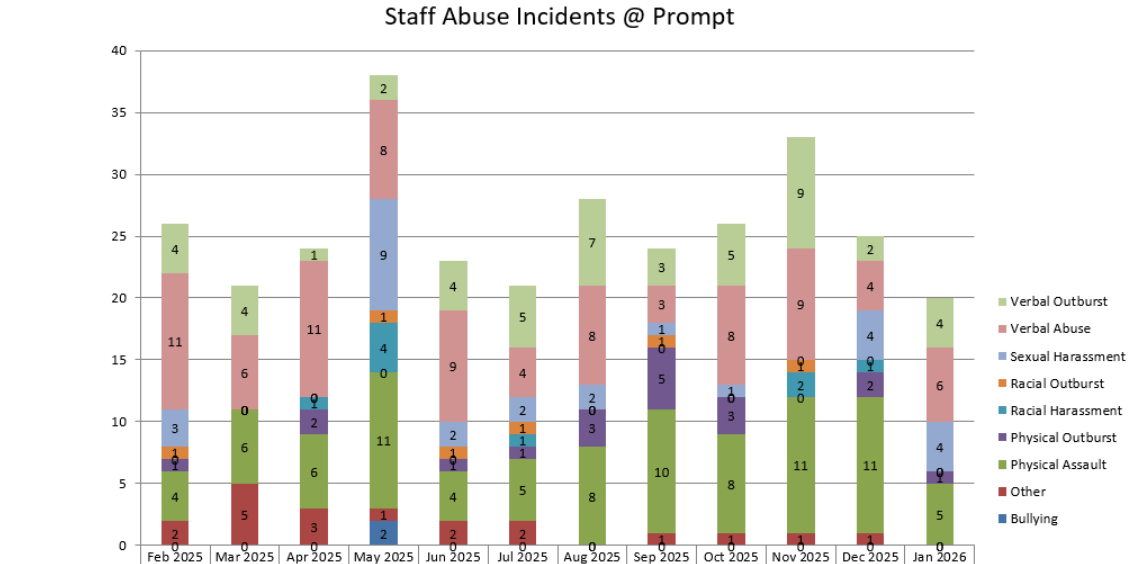
1.6 **Violence Prevention and Reduction Standard**

NCHC Violence and Aggression towards staff data

1.6.1 Reporting methodology updated to enable capture of incidents where both patient affected and staff possibly harmed. This methodology has been applied retrospectively across the 12-month data window.

1.6.2 In the current reporting period, there were 45 incidents reported affecting staff. Incidents subtypes are presented in Graph 6.

Graph 6 Number of incidents by abuse type NCHC



	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026
Verbal Outburst	4	4	1	2	4	5	7	3	5	9	2	4
Verbal Abuse	11	6	11	8	9	4	8	3	8	9	4	6
Sexual Harassment	3	0	0	9	2	2	2	1	1	0	4	4
Racial Outburst	1	0	0	1	1	1	0	1	0	1	0	0
Racial Harassment	0	0	1	4	0	1	0	0	0	2	1	0
Physical Outburst	1	0	2	0	1	1	3	5	3	0	2	1
Physical Assault	4	6	6	11	4	5	8	10	8	11	11	5
Other	2	5	3	1	2	2	0	1	1	1	1	0
Bullying	0	0	0	2	0	0	0	0	0	0	0	0

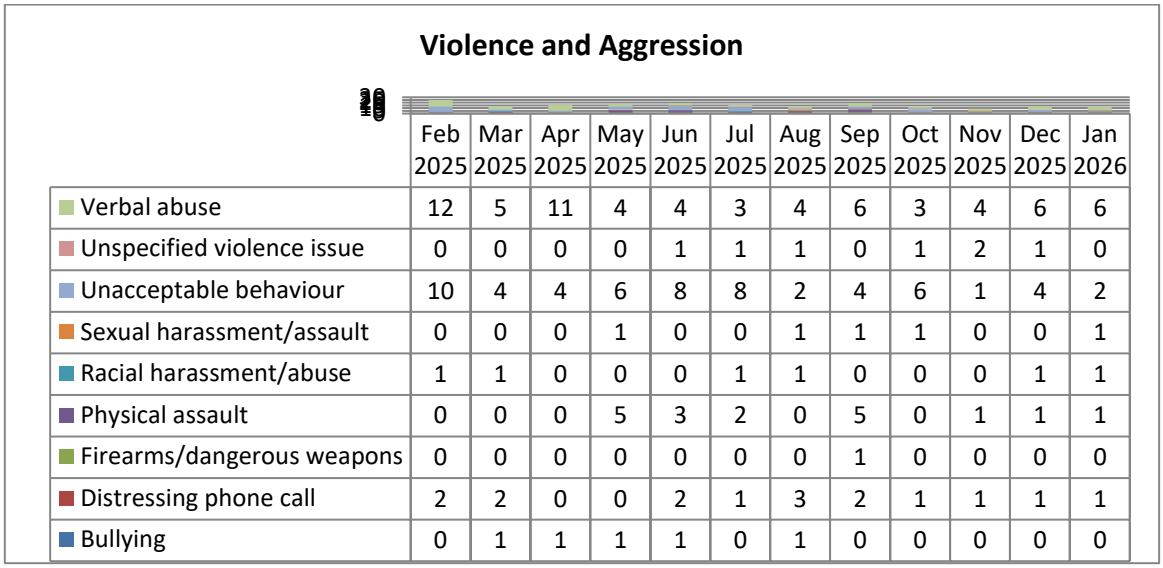
1.6.3 Abuse incidents are reviewed at the quarterly Health and Safety (H &S) committee following initial review by Place H&S meetings. Themes and learning escalated to the committee from Place. This enables trust wide analysis of trends, supporting consistent practice and response (including staff, patient and carer support), and effective shared learning.

1.6.4 Where indicated 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. Individuals are also emailed post incident to ensure bespoke support is offered to them / the team.

CCS NHS Trust Violence and Aggression towards Staff Incidents

1.6.5 Graph 7 below shows reporting themes for the last twelve months including Dec 25 and Jan 26 when 26 incidents were reported.

Graph 7 CCS Violence and aggression towards staff by category



	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026
Verbal abuse	12	5	11	4	4	3	4	6	3	4	6	6
Unspecified violence issue	0	0	0	0	1	1	1	0	1	2	1	0
Unacceptable behaviour	10	4	4	6	8	8	2	4	6	1	4	2
Sexual harassment/assault	0	0	0	1	0	0	1	1	1	0	0	1
Racial harassment/abuse	1	1	0	0	0	1	1	0	0	0	1	1
Physical assault	0	0	0	5	3	2	0	5	0	1	1	1
Firearms/dangerous weapons	0	0	0	0	0	0	0	1	0	0	0	0
Distressing phone call	2	2	0	0	2	1	3	2	1	1	1	1
Bullying	0	1	1	1	1	0	1	0	0	0	0	0

1.6.6 In addition to the 'degree of harm' caused by an incident, 'Staff Safety and Wellbeing Impact' scoring was added to the staff incident report form enabling resources and support to be targeted and specific to affected staff and service areas. Table 3 shows the impact scoring. The severe harm incident relates to unacceptable behaviour from a member of the public as the staff member was walking to the office.

Table 3

	No Impact	Minor Impact	Moderate Impact	Significant Impact	Severe Impact	Total
Dec 2025	4	9	1	0	0	14
Jan 2026	2	6	1	1	0	10
Total	6	15	2	1	0	24

1.6.7 All incidents are reviewed on an individual basis and bespoke actions/ support packages developed which 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 Four NatPSA alert was received in this reporting period which were reviewed by subject matter experts:

- NatPSA/2026/002/MHRA - Recall of Quetiapine Oral Suspension (unlicensed medicine), manufactured by Eaststone Limited due to a potential for overdosing. *Appliable to NCHC inpatient units, stock was checked none found.*
- NatPSA/2025/008/NHSPS - Risk associated with adult breathing circuits lacking a patent exhalation route. *NCHC Group reviewing*.
- NatPSA/2025/007/DHSC - Epidural Infusion Bags - *not applicable*.
- NatPSA/2026/001/DHSC - Steriflex® No. 109 (1L) and No. 171 (2L): Potassium Chloride 0.15%, Sodium Chloride 0.45%, Glucose 2.5%

Bags -*not applicable*.

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 uses the accredited Safer Nursing Care Tool on the Safecare platform to promote a consistent approach to assessing staffing levels and dependable scoring outputs (table 4 and 5).

1.8.2 Actual CHPPD is generally higher in the specialist units and the Willow rehabilitation unit, reflecting higher staff to patient 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, February 2026) assurance is provided through effective fill rates, and teams safely meet 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 Further inpatient establishment reviews will take place in Apr 26. The community establishment review tool, Community Nursing Safer Staffing Tool, will need additional resource to conduct across core community teams.

1.8.5 The NCHC Safer Staffing Escalation Group assess 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.

Mitigation plans are put in place with staffing issues. The fact that the general rehabilitation wards are operating below the national care hours per patient day, does not mean that they were unsafe in staffing levels and care to patients were compromised.

1.8.6 Tables 4 and 5 below show the CHPPD scoring.

Table 4:
December 2025

Unit	Actual CHPPD	Required CHPPD	Actual RN to Patient Ratio

Generalist Wards			
Alder Ward	5.15	6.56	1:9
Foxley Ward	5.84	8.13	1:9
North Walsham	6.79	8.71	1:8
Ogden Court	5.78	9.84	1:8
Pineheath Ward	5.42	7.53	1:8
Swaffham Hospital	6.75	9.57	1:9
Willow Nursing (Forest)	7.40	5.76	1:9
Willow Nursing (Garden)	6.58	6.13	1:8
Specialist Wards			
Beech Ward	7.38	6.68	1:8
Caroline House	10.29	10.48	1:6
PBL	8.81	5.56	1:6
Pine Cottage	9.77	7.38	1:5

Table 5:
January 2026

Unit	Actual CHPPD	Required CHPPD	Actual RN to Patient Ratio
Generalist Wards			
Alder Ward	5.06	5.87	1:9
Foxley Ward	6.33	8.13	1:9
North Walsham	6.48	8.03	1:8
Ogden Court	5.76	10.19	1:9
Pineheath Ward	5.63	7.03	1:9
Swaffham Hospital	5.65	7.59	1:9
Willow Nursing (Forest)	6.32	5.24	1:9
Willow Nursing (Garden)	5.72	6.00	1:9
Specialist Wards			
Beech Ward	6.77	6.43	1:7
Caroline House	9.09	9.68	1:8
PBL	7.07	5.14	1:7
Pine Cottage	8.87	7.64	1:6

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. OPEL 2 status means that, for services to be safely staffed and care delivered, minor mitigations may be actioned such as workload reallocated, but usually priority functions are covered.

1.8.8 The daily reports (using RAG rating scales) add assurance to the OPEL scores as 90% of shifts were on green or amber status for District

Nursing. District Nursing clinical activity deferred 4 times- mitigations taken included workforce re-allocated and temporary staffing.

1.8.9 For Rapid Response, only 4% of shifts triggered a red status; clinical activity was deferred on two occasions to mitigate staffing pressures.

1.8.10 92% of shifts were green or amber for palliative care services, triggering deferral of clinical activity on four occasions. There were no harms reported in the period.

Business Continuity

1.8.11 Business continuity plans triggered in 4 services due to staffing issues:

	Mitigations
Cambridgeshire and Peterborough 0-19 Healthy Child Service South Locality	Transfer-in change in process in place

1.9 **CCS and NCHC Safeguarding**

1.9.1 'Substantial' assurance is given against the NHS England Safeguarding Accountability & Assurance Framework 2024 that CCS and NCHC have effective safeguarding arrangements in place which seek to protect children and adults from harm caused by abuse or neglect

1.9.2 The new safeguarding training approach has begun a pilot in Norfolk Healthy Child Programme and this is being adapted and managed to ensure it is fit for purpose in terms of capture of compliance data.

1.9.3 Safeguarding children supervision (formal – compliance monitored) remains above 90% compliance target across both NCHC and CCS. Alignment of teams across the Group means some adjustment to the delivery model is required to ensure that robust support to staff is not disrupted significantly.

1.9.4 Prevent and Safeguarding People policies were written jointly by NCHC and CCS and will be launched from no later than 1st April 2026.

Infection Prevention and Control

NCHC IPAC Board Assurance Framework (BAF)

1.10.1 One non-compliant metric relates to work on anti-microbial stewardship. This work is underway in an integrated way across the medicines and IPAC services of NCHC and CCS. There is one partially compliant metric relating to FIT testing of clinical staff, an action plan is in place and is being monitored via the infection control group.

1.10.2 NCHC and CCS will have one joint IPaC BAF by April 1st, 2026.

CCS IPAC Board Assurance Framework

1.10.3 It is expected that the remaining partial compliance criterion will become fully compliant by the end of quarter 4. This is:

- *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. Progress is being overseen in the commissioning meetings held between the Labs and Cambridgeshire University Hospitals.

National Mandatory Surveillance

1.10.4 As part of the national mandatory surveillance, and to enable learning and best practice sharing, 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 as Clostridium Difficile) infections.

1.10.5 NCHC reported 2 Clostridioides difficile. CCS reported 0 cases.

Update PSII (Patient Safety Incident Investigation)

1.10.6 The PSII relates to an outbreak which is being overseen by the UKHSA (UK Health Security Agency) and is on-going. An after-action review was completed and presented to clinical services and the Executive team. Actions are monitored via the Norfolk Adults assurance group.

1.11 Staff Flu Vaccination Programme

1.11.1 The staff seasonal flu vaccination programme commenced on 1 Oct 25. Reported uptake amongst clinical-facing staff is reported below.

1.11.2 CCS and NCHC offering staff access to flu vaccination until 31st Mar 26.

Table 6 Staff Seasonal Flu Vaccination data

	NHS Federated Data Platform	NHSE target
NCHC	60.2% (06.02.2026)	54.5%
CCS	62.0% (06.02.2026)	63.3%

2.0 CARING

2.1 NCHC Patient Experience

Friends and Family Test (FFT)

Table 7

	% Positive	% Negative	Total FFT Responses	Contacts	Response Rate
Children and Young Peoples	100.00%	0.00%	19	3318	0.57%
Infection Prevention and Control	100.00%	0.00%	3	588	0.51%
Intermediate Care and Urgent Community Response	98.59%	0.00%	142	4620	3.07%

North	94.74%	0.00%	19	7707	0.25%
Norwich	100.00%	0.00%	48	9612	0.50%
South	94.44%	3.33%	90	10895	0.83%
West	97.79%	1.47%	136	11246	1.21%
Trust wide	**97.59%**	**1.09%**	**457**	**47986**	**0.95%**

2.1.1 The Trust received 183 responses in Dec 25 and 274 in Jan 26. Table 8 summarises total responses since June 2025. A reduction in response numbers is observed at North Place, and across South and West areas.

Table 8

	June	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Total**
Trust Overall	360	359	312	392	396	328	183	274	2604

2.1.2 Positive FFT themes highlight friendly approachable staff who explain care well, are efficient, knowledgeable and respectful. Patients and carers comment frequently about being well cared for, informed and involved in decision making and their care planning.

2.1.3 Themes from negative feedback relate to inpatient food quality and the length of time between community nurse visits. All FFT feedback is regularly reviewed and monitored in Place alongside other feedback to ensure services are listening and responding to feedback to improve care. Examples of “you said, we did” are reported at the Patient, Carer Experience and Involvement Working Group. Feedback relating to food is reviewed and acted upon within the Patient Environment group, and the community nursing model is being reviewed by the transformation team, with a view to developing a quality improvement plan.

2.1.4 All surveys with the FFT question ask to what extent the service user felt they were treated with respect and dignity. In Dec and Jan 450 service users answered and scoring for each directorate is shown below.

Table 9

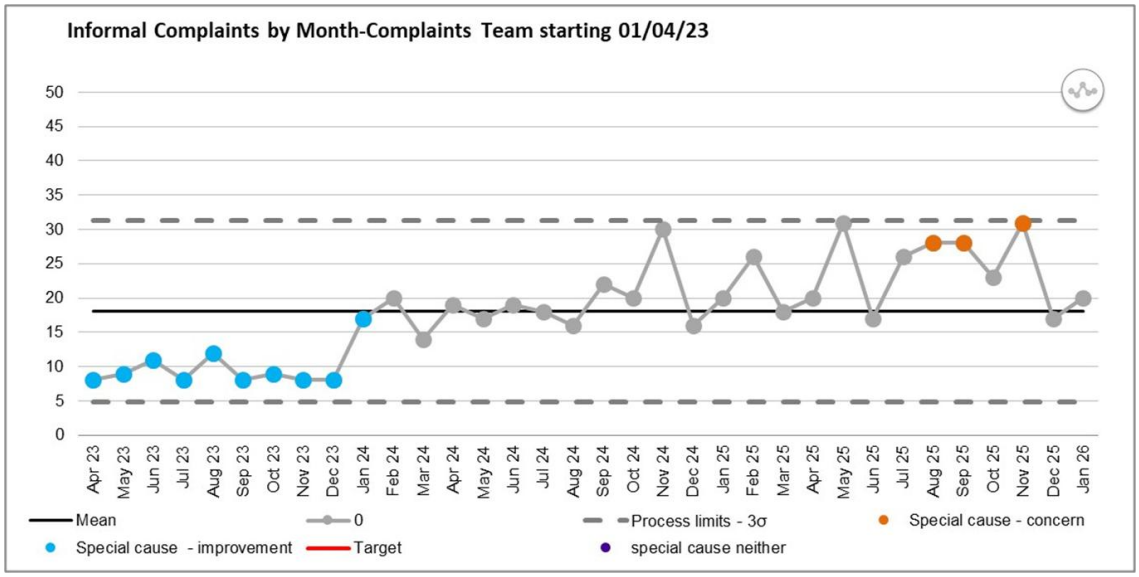
	Respect and Dignity Score
Children and Young Peoples	97.22%
Infection Prevention and Control	100.00%
Intermediate Care and Urgent Community Response	95.98%
North	97.50%
Norwich	99.48%
South	98.28%
West	99.44%
Trust wide	**97.94%**

Compliments

2.1.5 There were 179 compliments received in the reporting period, a slight increase from the previous period, and they were spread across all Places. West Place received and logged the highest number. Themes throughout compliments highlight the gratitude of patients and their families to staff who have looked after them with comments specifically on the kindness, compassion and skill with which they were treated.

Complaints

SPC Chart 5



Informal Complaints received

2.1.6 The Trust received 37 locally resolved, informal complaints in this reporting period: 17 in December and 20 in January. There were 47,986 contacts equating to one informal complaint for every 1,297 contacts.

2.1.7 100% of informal complaints were contacted within three working days, and no informal complaints were escalated to a formal complaint.

Themes from informal complaints received in December and January

2.1.8 The prominent themes identified in December were:

- Timeliness of appointments across both months: A key theme, with four complaints specifically linked to community nursing visits and delayed wound care or leg-ulcer dressing visits. This reflects a 50% reduction compared to November.

- Staff attitude: seven complaints, with three relating to communication issues at the point of discharge or around appointment cancellations. Learning/feedback has been provided to the staff involved.

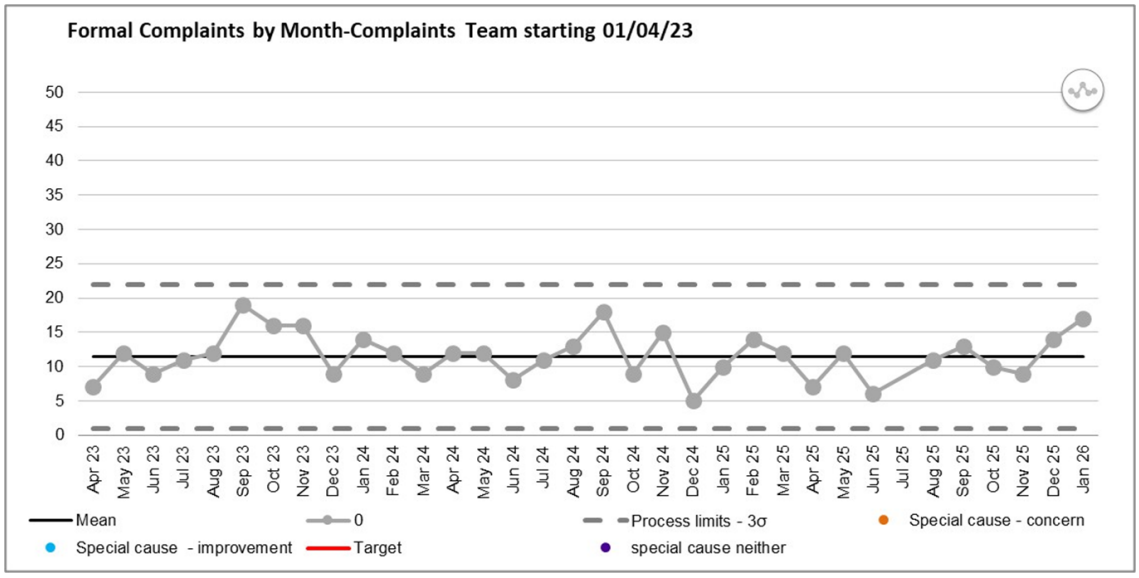
- Standard of care: 6 complaints, including concerns related to leg-ulcer care, catheter management, perceived premature discharge from a ward, and a patient unhappy with wheelchair services.

Formal Complaints received

2.1.9 The Trust received 31 formal complaints in this data period, 14 in December and 17 in January. There were 47,986 contacts which equates to one formal complaint for every 1,548 contacts.

The chart below demonstrates an increase in formal complaints received over the data period but remains within expected limits.

SPC Chart 6



2.1.10 100% of formal complaints were responded to within three working days.

Themes from formal complaints received in December and January

2.1.11 Children and Young People Services (CYP): Seven complaints were received, relating to the Neurodevelopmental Service (NDS), focusing on assessment waiting times, assessment outcomes and communication.

2.1.12 Wheelchair Services: Two complaints were received - one theme was waiting times and another regarding advice and treatment provided.

2.1.13 The remaining complaints were dispersed across seven Places with no consistent or emerging themes.

Member of Parliament (MP) Contacts

2.1.14 There were five MP contacts within the reporting period.

2.1.15 In December, three complaints were recorded, all categorised as Level 2.

- One complaint upheld within North Place relating to waiting times for community physiotherapy following hospital discharge.
- One complaint partially upheld within South Place, focused on the perceived lack of district nursing availability for home visits.
- The third complaint was not upheld, (North Place), concerning issues raised regarding continence assessments and capacity within community physiotherapy services.

2.1.16 In January, two complaints were recorded, all categorised as Level 2.

- One complaint within North Place, was a reopened complaint from following further concerns from the patient's son regarding waiting times for community physiotherapy following hospital discharge.
- The second complaint within Children and Young Persons's services, focused on Neurodevelopmental Service long waits and a child being discharged prior to being seen.

2.2 CCS Patient Experience

Friends and Family Test (FFT)

2.2.1 This provides opportunities for service users, parents and carers to provide feedback on their experience of care. Varying methods are available to ensure this is accessible and meets service users' needs.

2.2.2 The Trust received 2070 responses in Dec and 1979 in Jan. This is 500 fewer than the previous two-month period.

2.2.3 The overall Trust FFT positive feedback was 94.00%, with a 1.73% negative feedback percentage.

FFT scores for Cambridgeshire and Peterborough and Norfolk and Waveney Children's Services was below the Trust target of 90%, as shown in table 10. This score lower because within the Mental Health Support Teams, young people respond neither good nor poor more than in other services and Mental Health Support Team's get more FFT responses than other CYP services.

The comments are reviewed each month and vast majority are positive, even when they haven't said good or very good.

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 10

	% Positive	% Negative	Total FFT Responses	Contacts	Response Rate
Ambulatory Care	96.95% ↓	1.57% ↓	2167 ↓	38986 ↑	5.56% ↓
Bedfordshire and Luton Children and Young People's Service	97.52% ↑	1.06% ↑	564 ↓	38753 ↓	1.46% =
Bedfordshire and Luton Adults Community Service	96.00% ↓	1.00% ↑	200 ↓	26990 ↑	0.74% ↓
Cambridgeshire and Peterborough Children and Young People's Service	85.28% ↓	2.76% ↑	652 ↑	30541 ↓	2.13% ↑
Norfolk and Waveney Children and Young People's Service	87.34% ↓	2.15% ↓	466↓	32535 ↓	1.43% ↑
Trustwide	94.00% ↓	1.73% ↑	4049 ↑	167805 ↓	2.41% ↓

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 December and January 3720 service users answered this question and a score for each directorate is shown below.

Table 11

	Respect and Dignity Score
Ambulatory Care	96.80%
Bedfordshire and Luton Children and Young People's Service	97.78%
Bedfordshire and Luton Adults Community Service	96.57%
Cambridgeshire and Peterborough Children and Young People's Service	96.80%
Norfolk and Waveney Children and Young People's Service	87.23%
Trustwide	95.71%

Comments/Compliments

2.2.6 In December and January, the services we provide received 6606 positive comments, this is over 640 fewer than the last reporting period. We received more than 100 positive comments for every complaint received.

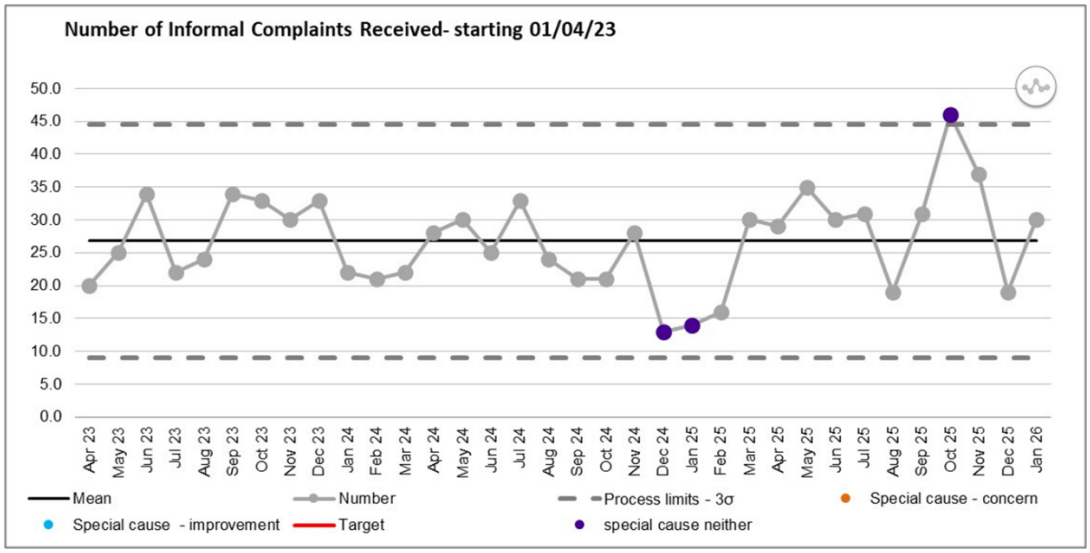
Complaints

2.2.7 There were 49 informal complaints, and 17 formal complaints received in December and January. There were 167,805 contacts which equates to one formal complaint for every 9,416 contacts and one informal for every 2,042 contacts, this is fewer than in the previous reporting period.

Informal complaints received

2.2.8 The Trust received 49 informal complaints in this data period: 19 in December and 30 in January. Both months were within the expected variation.

SPC Chart 7



2.2.9 Forty four of the 47 complainants were contacted within four working days to discuss resolution of their concerns. One complainant made contact via their GP and declined contact from the Trust's Patient Advice and Liaison Service (PALS). Three delays were due to a delay in the service

forwarding the informal complaint to PALS, the service user not being available and a delay in the service making contact.

Themes from informal complaints closed in October and November

2.2.10 Fifty-three informal complaints were resolved and closed in December and January with 63 subject issues identified.

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

- Delays (25)
- Clinical Care (16)
- Communication and Information (9)

2.2.12 Thirteen of 25 issues related to Delays, for Bedfordshire and Luton CYP and six Cambridgeshire CYP services - related to waiting times.

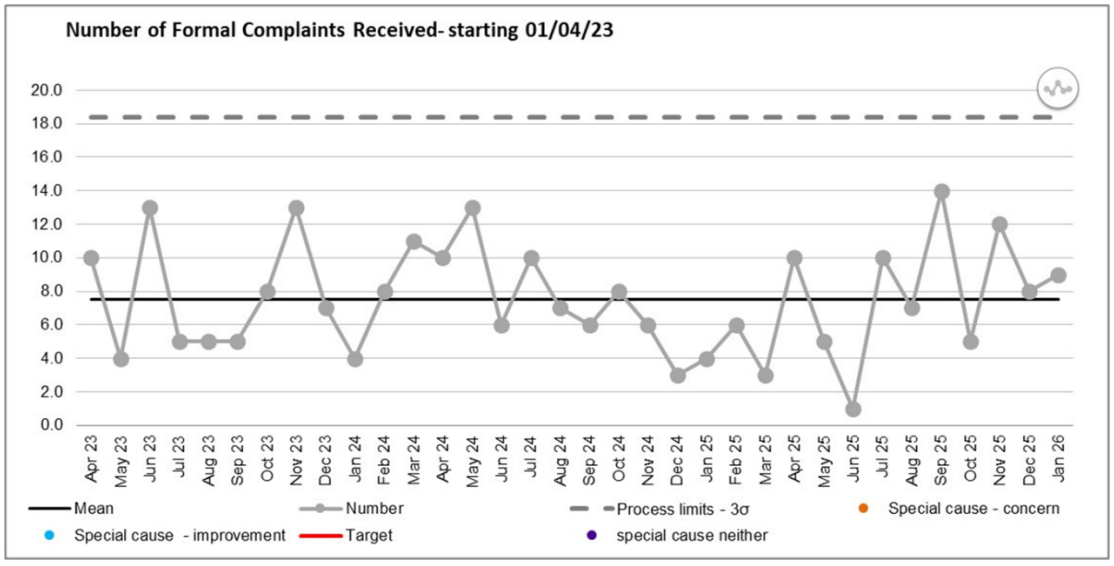
2.2.13 No themes seen in services involved in complaints about Clinical Care.

2.2.14 Three of the informal complaint issues about Communication and Information related to Cambridgeshire CYP services with no themes.

Formal Complaints Received

2.2.15 The Trust received 17 formal complaints in this data period, eight in December and nine in January. As shown below, this is within the expected variation.

SPC Chart 8



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 October and November 2025

2.2.16 Within this data period the Trust responded to and closed 13 formal complaints. In these, 26 subjects were identified.

2.2.17 Staff Attitude was the most frequently occurring subject within seven complaints (increased, but no themes identified)

2.2.18 Clinical Care was the second most frequent with six complaints. Delays were identified as an issue five times.

2.2.19 Four of the complaints about Clinical Care were about DynamicHealth Services relating to inadequate or insufficient care provision. Of these complaints one was upheld, one partially upheld and two not upheld.

Formal Complaint Response Times

2.2.20 In this data period, 13 formal complaints were responded to, two in Dec and 11 in Jan. A summary of the response times is shown below.

Table 12

	October	November	December	January
Number of standard complaint responses sent within a 35-day timeframe.	5/6	7/8	1/2	6/11
Percentage of standard complaint responses sent within the 35-day timeframe.	83%	88%	50%	55%
Number of complex complaint responses sent within the 40-day timeframe.	2/2	4/4	0/0	0/0
Percentage of complex complaint responses sent within the 40-day timeframe.	100%	100%	N/A	N/A
Average number of working days to respond to standard complaints.	30	30	36	35
Average number of working days to respond to complex complaints.	33	33	N/A	N/A

2.2.21 The percentage of standard complaint responses sent within the 35 working day timeframe dropped in December and January, the average number of days taken to respond also increased.

The reasons for the late responses include time taken to investigate, draft and sign off.

Member of Parliament (MP) Contacts

2.2.22 In this period there were nine contacts received via an MP, all were enquiries. One was a question about recruitment and temporary nursing roles in Bedfordshire and Luton Adult Community Nursing, four were about Bedfordshire and Luton Children's Services, one about a declined referral, one accessing home phlebotomy, one following up on a formal complaint response and one requested a letter for Disability Living Allowance tribunal.

Supporting Services with Correspondence with Service Users

2.2.23 The PALS team did not support with any correspondence to services users in December or January.

3.0 EFFECTIVE

3.2 **Sickness rates across the workforce:**

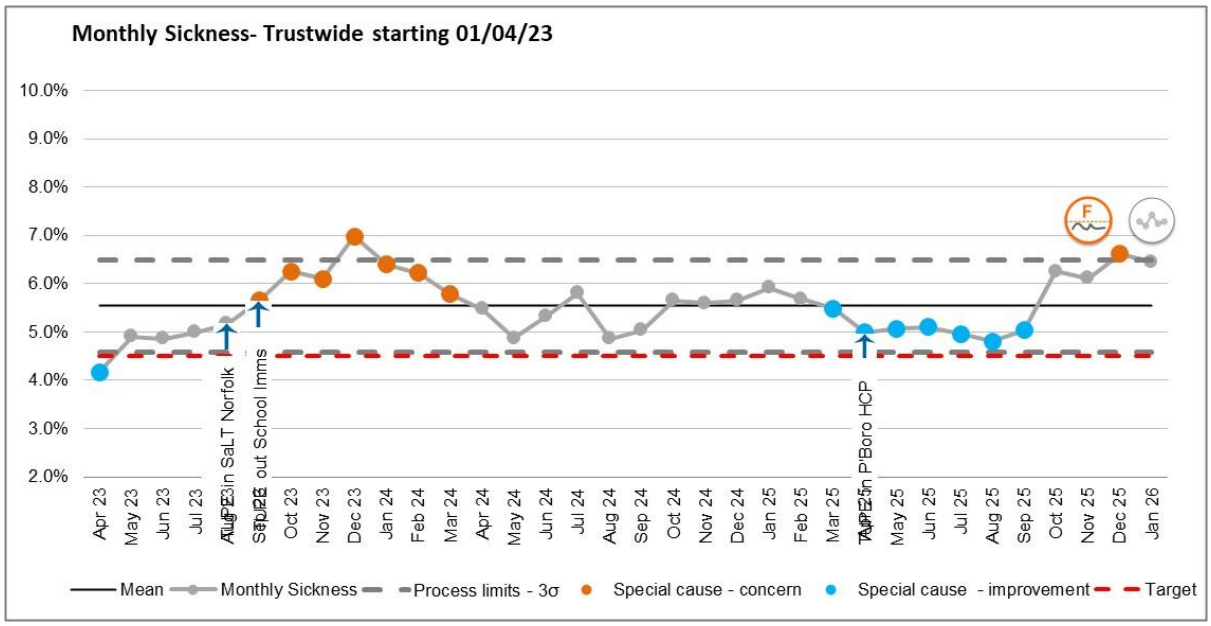
CCS

3.2.1 The 12-month cumulative rolling rate (December 2025 – 5.50%, January 2026 – 5.54%) remains above the Trust rolling target of 4.5%.

3.2.2 Monthly Trust wide rate for December 2025 was 6.61% and for January 2026 was 6.45%.

3.2.3 The Trust wide sickness rate has 3.3% was attributed to long term sickness and 3.16 % short term sickness absence.

3.2.4 The Trust monthly sickness rate is above the November 2025 benchmark reported for NHS Community Trusts (source: NHS Digital Workforce Statistics) which was 6.3%.

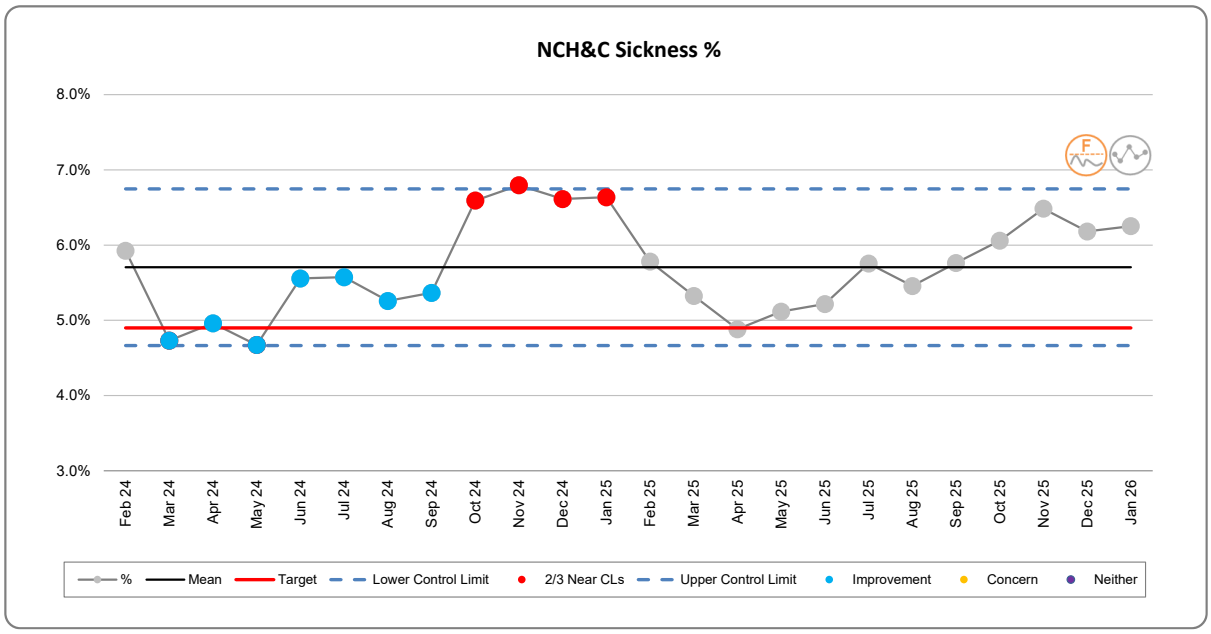


NCHC

3.2.5 The 12-month rolling rate (December 2025 – 5.72%, January 2026 – 5.69%) remains above the Trust target of 4.9%.

3.2.6 Monthly Trust wide rate for December 2025 was 6.18% and for January 2026 was 6.25%.

3.2.7 The Trust wide sickness rate has 3.42% attributed to long term sickness and 2.26 % short term sickness.

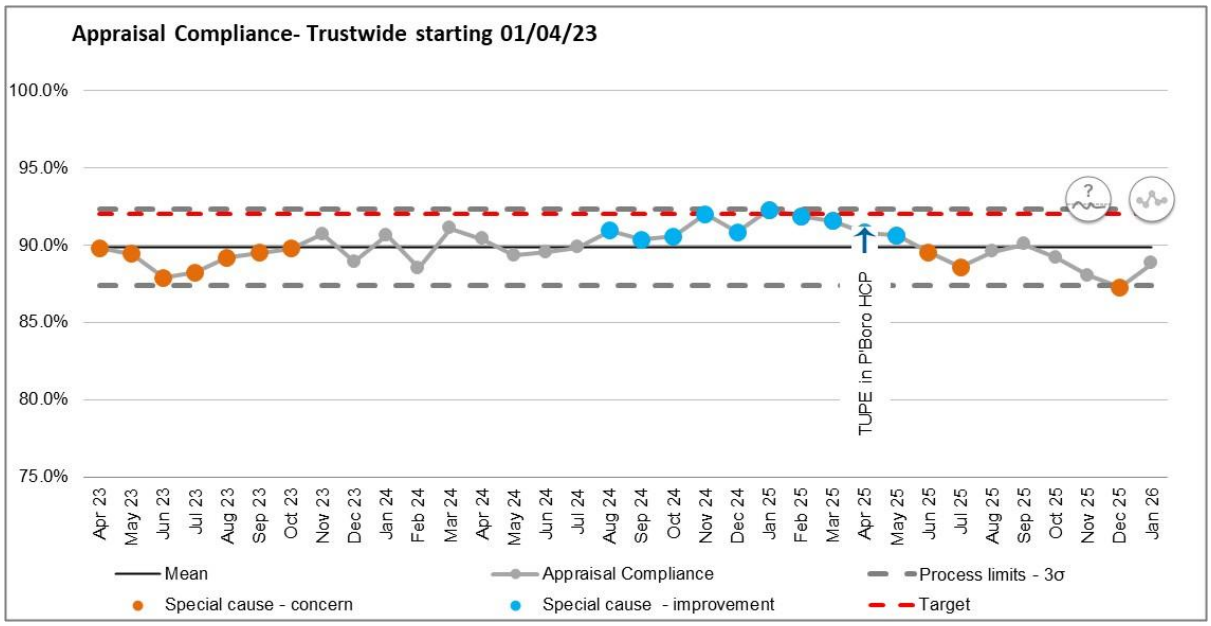


3.3 Appraisal rates across the workforce

CCS

3.3.1 The following chart shows the percentage of available employees with a current (i.e., within last 12 months) appraisal date.

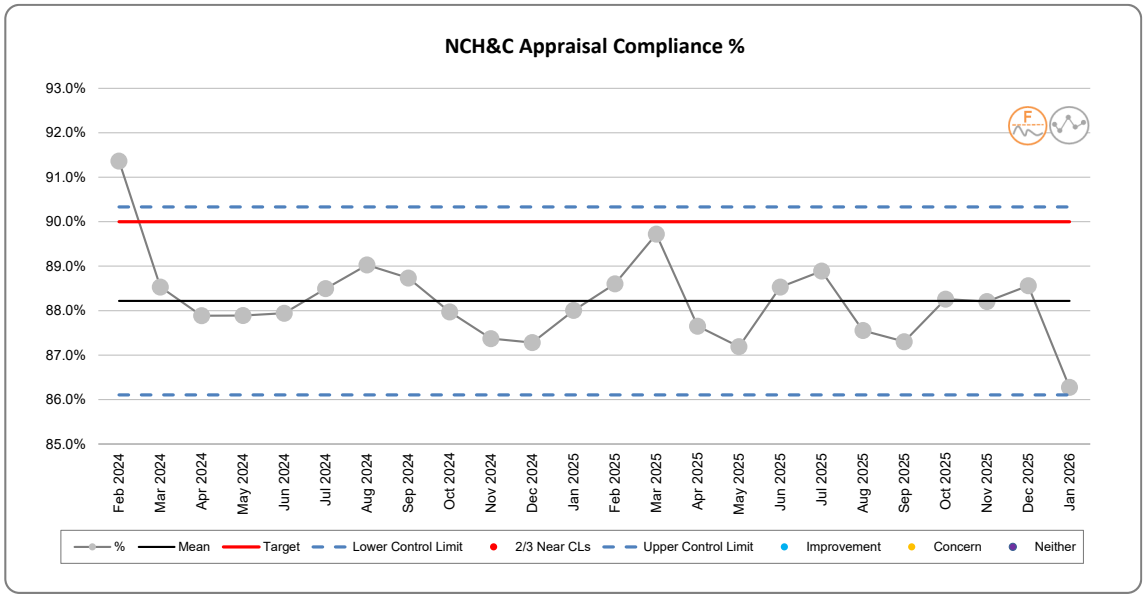
3.3.2 The Trust wide Appraisal rate increased in December 2025 –87.27% and January 2026 – 88.8%.



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.

3.3.5 The Trust wide Appraisal rate has been variable over recent months but is still falling short of target. December 2025 – 88.56%, January 2026 – 86.27%.

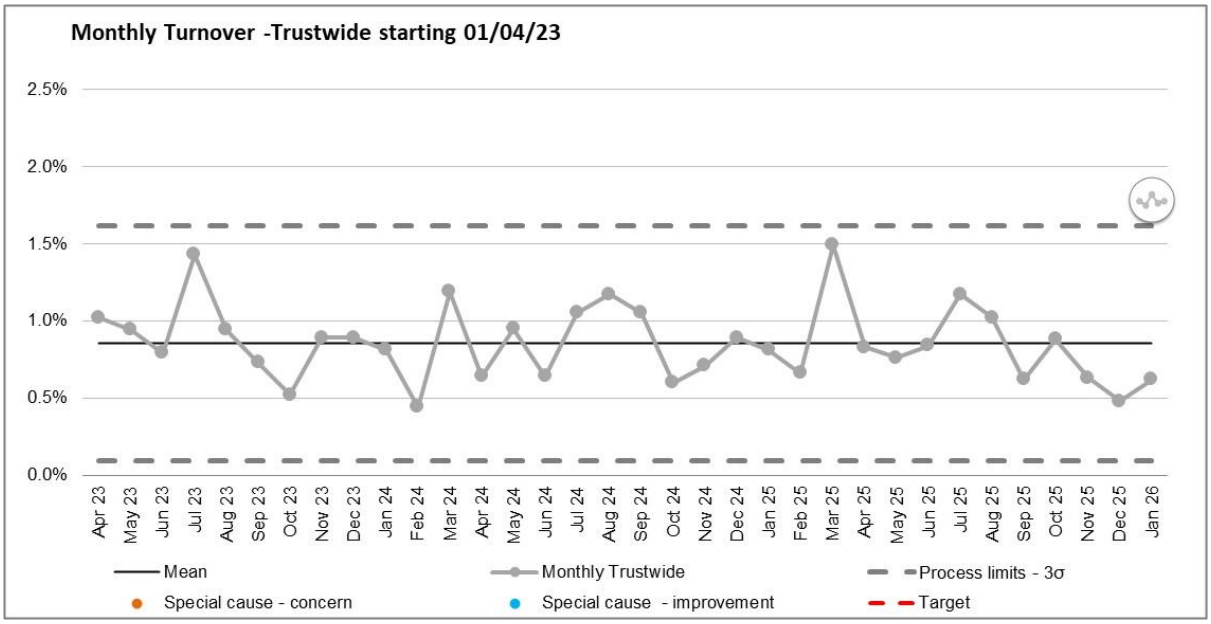


3.4 Turnover rates across the workforce

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: Voluntary Redundancies, end of a fixed-term contracts, mutually acceptable resignation scheme leavers and employee transfers.

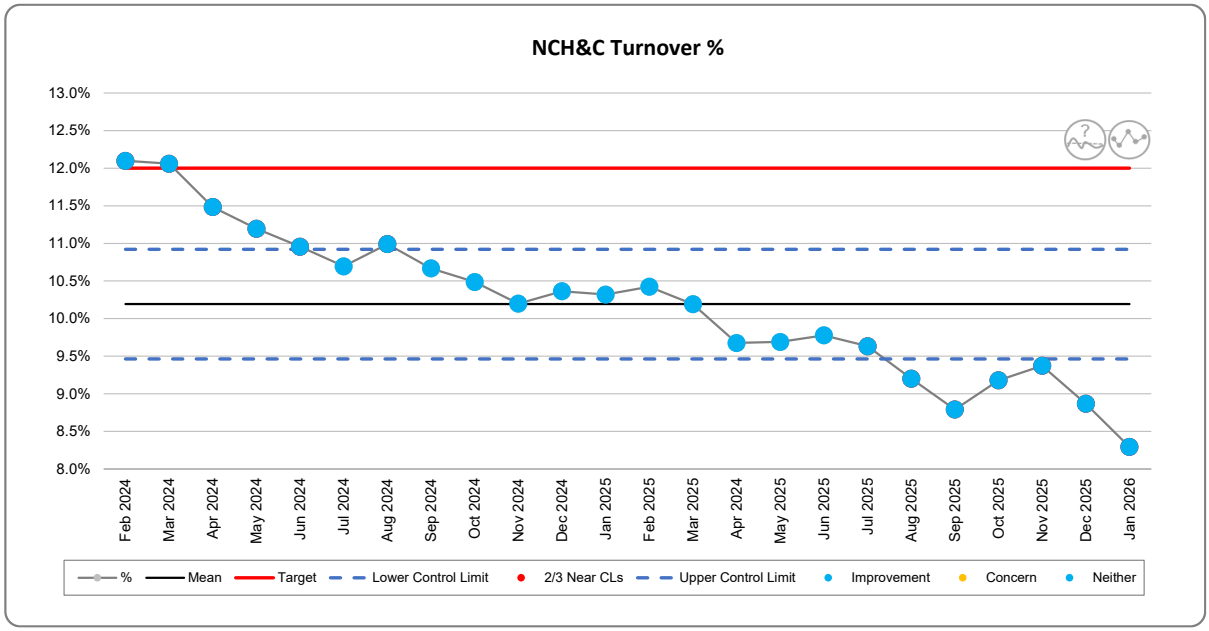
3.4.2 The Trust's Rolling Year Turnover Rate is currently 9.36% (December 2025 – 10.36%, January 2026 – 9.36%), which is in line with our plans.



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 8.29%, which sits below our Trust wide target of 12% but within the tolerance of +/- 4 %.

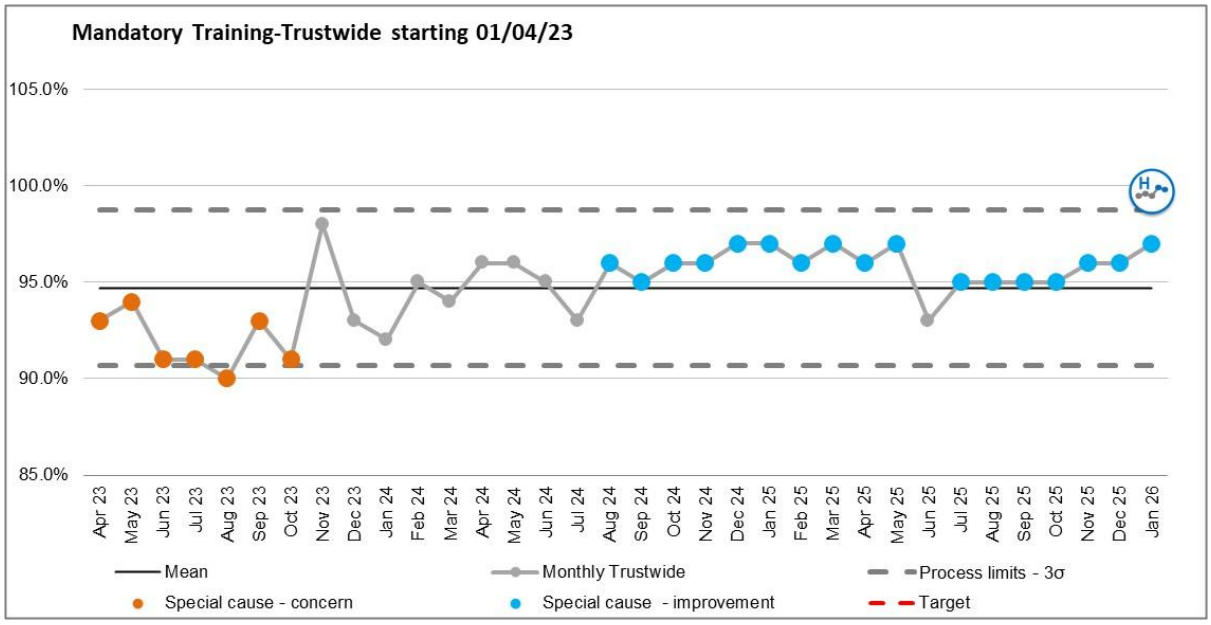


3.5 Overall Mandatory Training levels across the workforce

CCS

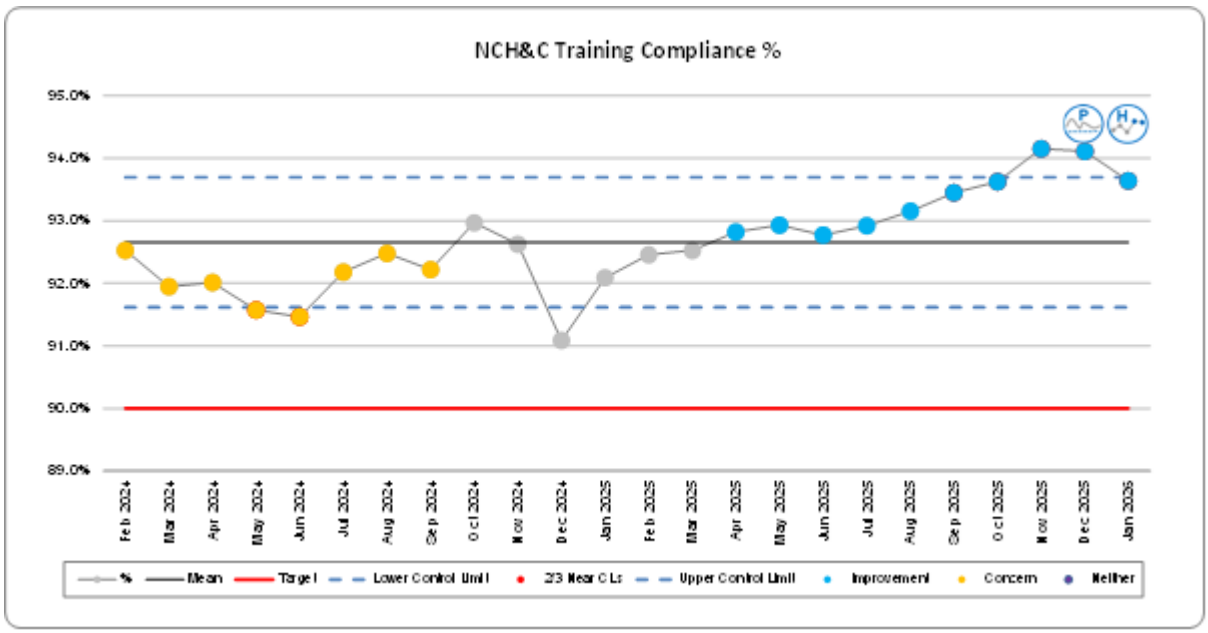
3.5.1 The following chart shows monthly Mandatory Training rates for the Trust which are based on the "Permanent" workforce (i.e., those employed via Fixed Term Contracts, Bank, Internal Secondment and Permanent). Staff who are within their first 3 months of employment are excluded along with staff on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

3.5.2 The Trust wide Mandatory Training rate remained stable in December 2025 – 96%, however increased in January 2026 – 97%, has reached target of 92% for 2025/26.



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. December 2026 94.11%, January 2026 – 93.64%.

3.6 **National Staff Survey 2025**

The 2025 survey results will be published on 12th March 2026 and will be presented at the Trust Board meeting on the 18th March 2026.

3.7 **Feedback from GP Rotation – NCHC placement – August 2025**

As the Board is aware we do not have sufficient GP trainee feedback to be included in the annual GMC survey, however, we are pleased to report that we received exemplary feedback, via the Deanery, from our recent NCHC GP trainee who had a placement with us. Overall summary of the feedback was ‘Excellent community placement, would recommend to all trainees’.

4.0 RESPONSIVE

4.1 **Summary:** This section details the waiting list across both organisations in the Group. Waiting time initiatives are active all services with 52+ week waits.

Detailed work is being undertaken on the resources and approach that is needed to reduce the neuro-developmental service (NDS) waiting times to the Government standard of 18 weeks (maximum wait) by the end of the Parliamentary cycle.

The Board can be assured that data and oversight is accurate and focused on finding solutions to reducing our waiting times.

4.2 **NCHC services at a glance:**

4.2.1 The project to improve waiting times in the Norfolk wheelchair services continues to make good progress below.

4.2.2 There has been some progress made with NDS assessments in Norfolk, with a sustained reduction in long waits over the past 3 months.

4.2.3 There were 6 patients recorded as waiting >52 weeks waits for the Community Nursing and Community Nursing Clinic services but this has been checked and these are all due to data quality (DQ) issues caused by problems with the Data Transfer not being completed fully. All DQ errors have been fed back to Places and for remedial action and these breaches will be removed in due course.

4.3 **CCS services at a glance:**

4.3.1 4,987 people are waiting over 52 weeks for a service to commence (reduced from 5192 in the last period).

4.3.2 Additionally, 5,638 people are waiting between 18 and 52 weeks for a service to commence, with 33% of those waits in our Musculo-skeletal service.

4.3.3 There has been progress made with NDS assessments in Bedfordshire and Luton with a sustained reduction in the past 2 months.

4.4 **Neurodevelopment waiters update**

4.4.1 The neuro-developmental services are working with the Integrated Care Boards (ICBs), NHS England (NHSE) and the Board to have a fully funded plan to eradicate 52+ week waiters (as the first step) and then improvements to achieve the national 18-week maximum wait performance.

4.4.2 The current aim is to have no CYP waiting >52 weeks for NDS assessments by April 2028. There are designated leads reviewing both the backlog of CYP waiting for an assessment, and to look at a sustainable model in the future to prevent further backlogs of CYP waiting for assessments. They have developed plans to reduce the waits with includes insourcing from external agencies, as well as new internal skill mixing teams across some localities.

4.4.3 There is a sustained focus to reduce the NDS waiting times. There is engagement with all the teams involved, some of whom are not used to working with external agencies. There has been a review in Norfolk by one of our Community Paediatricians of 19 randomly chosen cases managed by the external resources and they were happy with the standard of provision.

4.4.4 The table below shows the validated position of 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. The improvement can be seen over the last 4 months.

Group wide	25-Oct	25-Nov	25-Dec	26-Jan	26-Feb
0-18 weeks	1217	645	1040	1035	1046
18-52 weeks	2494	2766	2336	2186	2127
52-104 weeks	4633	4428	4402	4217	4098
104-156 weeks	3237	3452	3616	3620	3539
156-208 weeks	397	487	440	366	241
208-260 weeks	2	0	0	0	0
260-312 weeks	2	0	0	0	0
>312 weeks	0	0	0	0	0
Total	11982	11778	11834	11424	11051
Monthly Change		**-204**	**56**	**-410**	**-373**
Cumulative Change		**-204**	**-148**	**-558**	**-931**

Note: *February data is outside of this reporting period but is included here due to the importance of showing the reductions that are being funded by NHS England.*

4.5 **Waiting times position for all NCHC services over 52 weeks:**

4.5.1 Below is the summary of waiting times in services breaching 52 weeks. All over service lines have waiting times under this figure.

Note: *Because of timing when datasets were extracted, and waitlist cleansing/patient records being updated/data quality errors rectified in the meantime, these figures may slightly differ to what was reported in the Service Assurance Committees IGRs.*

NCHC Service lines with patients waiting over 52 weeks	Number of Waiters	Median Wait (Weeks)	18 Week RTT Compliance	Max Wait (Weeks)	18+ Week Waiters	52+ Week Waiters
SCSCYP Neurodevelopmental Services	3681	98.9	6.1%	214.0	3541	3035
Wheelchairs	1011	15.9	52.2%	114.6	474	46
Community Nursing Clinic	502	2.9	93.6%	527.9	32	6*
Community Nursing	2300	1.4	99.7%	129.9	8	2*
Childrens Specialist Continence	60	4.6	88.3%	71.4	7	1*
Childrens Shortbreaks Home Based	5	3.4	80.0%	97.4	1	1*
Total						3091

* These are known data errors with different reasons. This will be corrected in the next reporting cycle.

4.6 **Waiting times position for CCS services over 52 weeks:**

4.6.1 Below is the summary of waiting times in services breaching 52 weeks. All over service lines have waiting times under this figure.

Note: *Because of timing when datasets were extracted, and waitlist cleansing/patient records being updated/data quality errors rectified in the meantime, these figures may be slightly different to what was reported in the Service Assurance Committees IGRs.*

CCS Service lines with patients waiting over 52 weeks	Number of Waiters	Median Wait (Weeks)	18 Week RTT Compliance	Max Wait (Weeks)	18+ Week Waiters	52+ Week Waiters
Beds Community Paediatrics	2606	97	N/A	155	2458	2040
Luton Community Paediatrics	2379	87	N/A	152	2189	1666
Cambs Community Paediatrics	2385	51	N/A	136	1907	1137

Cambs Paed Dietetics	551	14	59.3%	90	224	72
Cambs Dental GA (Peterborough)	247	30	42.5%	144.0	142	41
Cambs Dental SCD and DOM	1517	21	43.6%	57.0	855	11
Beds Adult Dietetics	387	15	60.7%	90	152	7
Luton Paed Audiology	1005	8	N/A	89	373	7
Beds Paed SaLT	878	5	83.6%	64	144	4
Beds Paed Dietetics	294	14	70.4%	55	87	1
Suffolk Dental MOS	669	7	91.2%	54.0	59	1
Total	28908				10625	4987

5.0 WELL LED

5.1 Ability to raise concerns:

Freedom to Speak Up Mandatory Training

- 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 December and January and NCHC achieved 96% compliance, respectively.

- 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

NCHC Metrics

Statement of comprehensive income January 2026	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	144,307	143,584	(723)	173,361	172,669	(692)	
Pay	(105,931)	(106,936)	(1,005)	(126,674)	(126,333)	341	
Non-Pay	(38,890)	(37,999)	891	(46,662)	(47,265)	(602)	
Non-operating	(771)	(4)	766	(959)	(101)	858	
Accounting surplus / (deficit)	**(1,285)**	**(1,355)**	**(70)**	**(934)**	**(1,030)**	**(96)**	
Accounting performance adjustments	781	874	93	934	1,030	96	
Adjusted financial surplus / (deficit)	**(504)**	**(481)**	**23**	**0**	**0**	**0**	Yes
Efficiencies							
Recurrent	2,123	1,703	(420)	4,692	3,097	(1,595)	
Non-Recurrent	2,925	3,349	424	4,131	5,726	1,595	
Total Efficiencies	5,048	5,052	4	8,823	8,823	-	Yes
Agency expenditure							
Agency spend	(1,010)	(364)	646	(1,212)	(812)	400	Yes
Bank spend	(3,673)	(4,785)	(1,112)	(4,408)	(6,971)	(2,563)	No

Balance sheet January 2026	Plan	Actual	Variance	Plan	Forecast	Variance	On plan?
£'000	Month end	Month end	Month end	Full Year	Full Year	Full Year	Full year
Statement of Financial Position							
Non-current assets	109,144	94,529	(14,615)	109,068	109,068	-	
Current assets	46,796	51,898	5,102	48,868	48,868	-	
Current liabilities	(29,059)	(34,471)	(5,412)	(29,432)	(29,432)	-	
Non-current liabilities	(6,516)	(3,562)	2,954	(6,577)	(6,577)	-	
Total net assets employed (equity)	**120,365**	**108,394**	**(11,971)**	**121,927**	**121,927**	-	
Operating cashflow							
Cash at bank	41,693	38,631	(3,063)	41,804	41,804	-	Yes
Number of months of operating cash cover	2.7	2.9	0.2	3.1	3.1	-	
Capital expenditure							
Total capital expenditure	5,035	6,430	1,395	8,034	10,728	2,694	Yes
System capital limit (CDEL) spend	4,994	6,385	1,391	7,757	10,494	2,737	Yes
Receivables							
Debt over 90 days		955			1,250		
Bad debt provision		1,350					
Debtor days		42		15			
Payables							
BPPC by number	95.0%	91.5%	-3.5%	95.0%	95.0%	-	No
BPPC by value	95.0%	90.2%	-4.8%	95.0%	95.0%	-	No

CCS Metrics

Statement of comprehensive income January 2026	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	147,806	151,394	3,588	177,366	180,539	3,173	
Pay	(104,800)	(105,258)	(458)	(125,760)	(126,303)	(543)	
Non-Pay	(40,316)	(44,040)	(3,724)	(48,378)	(51,784)	(3,406)	
Non-operating	(2,690)	(2,044)	646	(3,228)	(2,452)	776	
Accounting surplus / (deficit)	**-**	**-**	**52**	**-**	**-**	**-**	
Accounting performance adjustments	-	-	-	-	-	-	
Adjusted financial surplus / (deficit)	-	-	52	-	-	-	Yes
Efficiencies							
Recurrent	5,008	5,120	112	6,180	6,078	(102)	
Non-Recurrent	2,018	2,120	102	2,420	2,522	102	
Total Efficiencies			214			-	Yes
Temporary staffing expenditure							
Agency spend	1,300	837	463	1,560	1,005	(555)	Yes
Bank spend	1,210	1,217	(7)	1,452	1,452	-	Yes

Balance sheet January 2026	Plan	Actual	Variance	Plan	Forecast	Variance	On plan?
£'000	Month end	Month end	Month end	Full Year	Full Year	Full Year	Full year
Statement of Financial Position							
Non-current assets	112,757	99,734	(13,023)	112,757	99,811	(12,946)	
Current assets	21,922	29,062	7,140	21,922	21,929	7	
Current liabilities	(19,285)	(28,709)	(9,424)	(19,285)	(19,900)	(615)	
Non-current liabilities	(21,970)	(20,511)	1,459	(21,970)	(21,988)	(18)	
Total net assets employed (equity)	**93,424**	**79,576**	**(13,848)**	**93,424**	**79,852**	**(13,572)**	
Operating cashflow							
Cash at bank	7,053	7,204	151	7,053	7,053	-	Yes
Number of months of operating cash cover	0.5	0.5	0	0.5	0.5	-	
Capital expenditure							
Total capital expenditure	5,495	3,327	(2,168)	4,393	4,393	0	Yes
System capital limit (CDEL) spend	2,995	3,327	332	4,393	4,393	0	Yes
Receivables							
Debt over 90 days		3,032					
Bad debt provision		758					
Debtor days		42		30			
Payables							
By Number	95.0%	87.8%	-7.2%	95.0%	95.0%	-	Yes
By Value	95.0%	88.1%	-6.9%	95.0%	95.0%	-	Yes

Commentary

5.2.1 Both Trusts are currently on plan for revenue, with efficiencies tracking in line with expectations.

5.2.2 The cash balance position on 31 January 2026 was as follows:

- NCHC had £38.6m of cash. This is £3.1m below plan and represents 2.9 months of operating cash outflows.

- CCS had £7.2m of cash. This is £0.2m above plan and represents two weeks of operating cash outflows – which is in line with national benchmarking. This is an improved position from previous months.

5.2.3 Agency expenditure is below plan for both Trusts; NCHC by £0.7m (64%) and CCS by £0.8m (30%). However, staff bank expenditure is above plan in NCHC by £1.1m (30%). This is predominately driven by a change in frailty and acuity of patients and absence in our inpatient wards in Norfolk Adults.

5.2.4 Capital expenditure to date is:

- NCHC: £5.0m, which is £1.4m behind plan
- CCS: £3.3m, which is £0.3m behind plan

Both variances are primarily due building lease recognition, with two leases now expected not to be renewed. This is partly offset at both Trusts by spending on capital projects that were not included in the original plan. Most of these new projects are centrally funded and 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 £14.0m delivered to end of January (81%). Efficiency delivery overall at the reporting period remained on plan in both organisations, but there is a £5.1m gap in recurrent schemes which affects the planning target for 2026/27.

Financial Plan - Key Risks at 31 January 2026

Rating	BAF Risk	Risk description	Mitigations
Medium	3708	A low cash balance in CCS of £7.3m. This represents two weeks of operating cash outflows.	The cash balance for the merged trust will be around six weeks of operating cashflows, this represents a low risk. The risk rating has therefore been reduced from high to medium.
Medium	3707 & 3691	A higher proportion of savings will be delivered non-recurrently, shifting the financial pressure into future years and delaying progress toward sustainability.	The forecast under-delivery of recurrent efficiencies in 2025/26 has been built into 2026/27 financial planning. There is a focus on identifying recurring savings for 26/27 onwards, with a budget ask that all efficiencies in plan are on a recurring basis.
Medium	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 £1.1m (30%).	No mitigations being taken on bank spend. Focus has been on reducing agency expenditure, which is £0.7m below plan. NHS England has confirmed that overspends on bank staffing will not be penalised provided the overall financial plan is delivered.