Agenda item:	7
Date of meeting:	28 January 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** • **Norfolk Community Health & Care Services NHS Trust Statement of Purpose**

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 October and November 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 one NatPSA (National Patient Safety Alerts) received in this reporting period which was 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, 19 November 2025.

6.0 Assurance

6.1 The three Service 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 – **Substantial 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 number of areas with substantial assurance (4 out of 7) and only one area with partial assurance. 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 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 – **Substantial Assurance**
- iCaSH Services – **Substantial Assurance**
- Group Children & Young People (CYP) Integrated Governance Report - **Reasonable Assurance**
- Norfolk Adult Services – **Partial 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 no operational risks scoring 15 or above.

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

9.0 Key Issues Register:

9.1 There are 14 operational issues scoring 4 (Major) or above on the group-wide issue register. This is significantly higher than the last reporting period and is a result of the group now operating under a joint risk and issue management policy and subsequently several NCHC risks having now been transferred to the issue register.

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

- three relate to children and young people services and have been discussed in detail at the Children & Young People's Service Assurance Committee.
- ten relate to adult services across Norfolk and have been discussed in detail at the Norfolk Adults Service Assurance Committee.
- one relates to the reduced pharmacist and pharmacy technician cover across CCS 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:

- Tracking the progress of the plans to reduce long waiting times
- The delivery of our efficiency plans
- Reviewing and updating the key metrics for the Service Assurance Committees and this Integrated Governance Report for 2026/27

Appendices:

Appendix 1: Norfolk Community Health & Care Services NHS Trust Statement of Purpose

CONTENTS

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: Wednesday 14th January 2026

Key matters:
A staff story was shared with the committee from the Luton and Bedfordshire Adults Neurology and Early Supported Discharge (ESD) team Community Nursing services.

Half year updates were provided for all services in relation to Patient Experience:

- Ambulatory Services – **reasonable assurance**
- Bedfordshire and Luton Adults Services - **substantial assurance.**

The committee also received Integrated Governance Reports for the following:

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

Key points:

- Services remain safe and stable. Opel status predominately level 2 or less. No serious incidents. Majority of incidents reported, no or low harm. Moderate harm incidents remain within acceptable parameters, with duty of candour consistently applied.
- No formal complaints and six informal complaints received. Learning shared.
- Mandatory training compliance levels remains high, with a focus on safeguarding level, information governance and CPR in specific areas as below target levels.
- Sickness levels remain above Trust target at 7.43% for Luton Adults and 4.86% for Bedfordshire adults, against a target of 4.5%. Appraisal levels below target, mainly due to lack of reporting. Compliance levels achieved in December 2025.
- Finance – on track and budget planning for 2026/7 commenced.
- Transformation update given and the positive impact of expanding our unscheduled care hub operating hours and the improved ambulance stack performance was noted.

Ambulatory Services Division:
- MSK Dynamic Health Services – **Substantial Assurance**
- MSK Services Norfolk – **Reasonable Assurance**
- Dental Healthcare – **Substantial Assurance**
- iCaSH Services – **Substantial Assurance (upgraded from reasonable at the meeting)**

MSK Dynamic Health Services
- 35 incidents reported in period. 1 low harm, 34 no harm.
- 7 formal complaints received, however, consistent high levels of patient satisfaction reported, over 98%.

- High levels of mandatory training achieved. Increase in sickness, 5.16% in November 2025 against a target of 4.5%, expected to reduce.
- Waiting times have improved since last reporting period and average waiting times are currently:
    - 7 weeks for pelvic health
    - 6 weeks for physiotherapy
    - 4.weeks for specialist services
- Majority of urgent referrals are now being seen within 2 weeks.

NOW MSK Service – Norfolk Health and Care NHS Trust service

- All incidents reported no or low harm.
- Internal peer review completed and service received overall good as an outcome.
- Friends and family feedback positive, however, low numbers reporting. Process to capture feedback revised in December 2025 to increase uptake.
- Current average waiting times:
    - Musculoskeletal Assessment & Triage service (MATS) – 7 weeks
    - Core physio – 9.6 weeks
    - Pelvic Health – 4.3 weeks
    - Biomechanics – 9 weeks

Dental Healthcare:

- Peterborough Special Care Dentistry waiting list remains the biggest challenge. Since November 2025, list reduced by 22. Updated position shared at the meeting, 257 patients waiting for a general anaesthetic appointment, 69 of which are over 52 weeks. Plan in place to monitor improvements.
- Other waiting lists:
    - Suffolk special care dentistry – average wait of 4.7 weeks
    - Minor oral surgery – average wait of 5 weeks
- Sickness rates remain above Trust target at 6%, all cases being managed.

iCaSH:

- All incidents reported low or no harm. 2 formal complaints.
- Overall mandatory training high, however, non-compliant for safeguarding level 3.
- Long Acting Reversible Contraception (LARC) – Norfolk re-commenced a waiting list – currently 9 weeks.
- Service is missing a couple of key performance indicators.
    - Cambridgeshire: % of women offered access to LARC within 10 working days/2 weeks of first contact (October – 40.71% against a 90% measure; November 44.72%%)
    - Peterborough – same indicator (October – 71.74% against a 90% measure; November 57.14%)
- Demand remains high for online STI testing. Capped numbers increased slightly in late December.
- Sickness levels remain above the Trust target. 7.41% for Nov, all being managed.
- Service seeing an improved financial position. Several posts either out to recruitment or have been recruited too, which should help improve staff morale and sickness levels across services.

- Contract update shared with the committee and Norfolk clinic relocating in March 2026. Contract secured from April 2026.

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

- **Luton Adults** - safeguarding training, Information governance and CPR training below compliance in specific areas. Plans in place to address. Monthly sickness absence above target but starting to improve. Appraisal levels below target, mainly due to lack of reporting, compliance levels achieved in December 2025.
- **MSK Services Norfolk** – mandatory training - safeguarding, information governance and Oliver McGowan below compliance but on an upwards trend.
- **Dentistry –** mandatory training – safeguarding level 3 but plans in place to address in January 2026. Sickness levels remain above target tat 6% in November 2025.
- **iCaSH –** mandatory training – safeguarding level 3. 2 KPI's (Key Performance Indicators) as detailed and sickness levels above target.

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

Good practice or innovation:

- **Luton Adults –** overall contribution to the reduction of ambulance conveyances to the Luton and Dunstable Hospital.
- **MSK Dynamic Health** – joint work between the service and the data team to enable initial reporting of health outcomes.
- **NOW MSK Service –** patient feedback was unanimously positive, with every participant independently commenting on the significant benefit gained from the ESCAPE pain management class that Claire Baker delivered.
- **Dentistry -** Wisbech team who were shine a light winner for supporting a patient, who would otherwise have required dental treatment via general anaesthetic. Suffolk team for achieving gold award for sustainability.
- **iCaSH –** participation in local and national audits, evaluation and learning shared across the service to improve patient outcomes.

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, 13 January 2026

Key matters

Staff Story:
Lucy Smart works as an ASD/SEND (Autistic Spectrum Disorder/Special Educational Needs and Disabilities) Advisory Teacher as part of the Neurodiversity (ND) and Early Intervention Team within Beds& Luton Community Paediatrics. She spoke of her development through different roles within education and how she came into the NHS almost by accident. We have few teachers employed by CCS (Cambridgeshire Community Services NHS Trust). Her role is one of supporting families by holding workshops, drop-in sessions, support calls and visits, and school visits. She is involved with the ND early awareness pilot.
We were impressed by the breadth of her experience and enthusiasm for future innovation and developments in our Organisation.
Action will be undertaken to explore a Trust-wide network of teachers and Tas (Teaching Assistants) including many MHST (Mental Health Support Team) staff.

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

The committee received a group-wide Children and Young People's (CYP) report for the first time, and this was commended for clarity and detail. This included updates from both NCHC and CCS locality services. Key points to note:

Universal Services

- Improvements in mandated visits for Newborn visits, 6-8 week checks, and 2.5year checks.
- Just One Norfolk meeting KPIs (Key Performance Indicators).
- Some delays in Children in Care deadlines – some issues sit with Local Authorities and ICBs (Integrated Care Boards).
- Universal Services in Norfolk – out to tender with closing date 31st Jan, team working with the Director of Strategy and Transformation on this.

Specialist services:

- Long waits of greater than 52 weeks were in 6 specialist services: 3 NDS (Neurodevelopmental Service), Bedfordshire & Luton (B&L) Audiology, B&L Adult Dietetics, Cambridgeshire CYP (Children & Young People) Dietetics.
- Discussion re waits for NDS assessments – various approaches across the Group.
- Skill mix pilots for NDS waits have started in B&L and Cambridgeshire. Skill mixing aims to have other suitable team members to be involved.
- Aim to remove from Paediatricians those roles that can be undertaken by others to facilitate availability for complex cases.

- Demand currently flat with analysed data but high backlogs.
- Non-recurrent funding (short term) available from ICS (Integrated Care System) to facilitate Waiting List management.
- Discussed longer term review of service investment needs in CYP.
- Deputy Director of B&L CYP Services working in B&L system re: pathways for audiology.
- Ongoing review of respite services for CYP in Norfolk with the N&W (Norfolk & Waveney) ICB.
- Staff sickness with winter viruses about usual average, currently at 7%.

Thematic Reviews: Patient Experience in CCS – **Reasonable assurance**

- 9307 positive responses between Apr 24-Mar 25.
- 91.5% of service users via FFT (Friends and Family Test) reported experience as good or very good.
- Neutral responses – ongoing discussion as to how to break this down/make it easier for clear responses
- 107 informal complaints – 74% are about NDS services; 42% of total are downgraded.
- Themes- communications, clinical care and delays.
- Fantastic contribution by the volunteers- 828 hours provided (increase of 485hrs).
- Coproduction team involved with 9 projects.

Key escalations

- The long waits for CYP awaiting neurodevelopmental assessment across the group remains and there is work ongoing across the three localities to improve these waits.
- 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.

Key risks and issues:

Risks and issues were discussed – the plan will be to combine some risks as they are the same, but in different localities.

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

- **3751** – Group-wide Neurodevelopmental assessment waits and the risk of potential harm because of long waits. (rated 16)

Three 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.

- **3764** – High demand for follow up Community Audiology appointments in Bedfordshire & Luton.

Good practice or innovation:

- Volunteers: 828hrs provided,>1000 families supported by breast feeding buddies
- Newborn hearing screening in Beds has closed the NHSE (NHS England) quality assurance processes and in collaboration with local hospitals are achieving above national KPIs.
- Community Paediatrician from B&L presenting at Indian Academy of Paediatrics Conference.
- Cambridgeshire SALT (Speech and Language Therapy) presented at Royal College of Speech and Language Conference on delivery models and early advice sessions for families.
- C&P held its first 'Baby Week' 14-20th Nov – aimed at improving the first 1001 days from conception to 2yrs. System partnerships involved with this. Aim for 2026 is all CYP localities to be involved.
- Norfolk Epilepsy service led education sessions for pupils and staff in Colleges and Schools to improve understanding of epilepsy.
- Three weaning workshops developed and launched in Norfolk; HCP (Healthcare Professional) deputy clinical leads across Family Hub sites were well received.

Key Matters and Escalation Report to the Group Trust Board

Name of Committee: Norfolk Adults Service Assurance Committee
Chair: Anna Gill
Meeting Date: 15th January 2026

Key matters:

Patient Story:
The Committee heard an enriching patient story from the Community Physiotherapy Service from a gentleman whose health changed dramatically, and he needed a wheelchair and physiotherapy. He spoke of the challenges he faced, and how he overcame a lot of them He was very happy with the services we provided and felt supported in both his mental and physical health by our teams.

Integrated Governance Report (IGR) key discussions
Overall assurance rating: *Partial*

- Increased incident reporting, and the increase was in low/no harm. Moderate harm had decreased, and severe harm was unchanged.
- A deep dive is planned into low/no harm to look at themes for learning
- Slight increase in injurious falls of low harm. Some are due to cognitive impairment and others are assisted falls during therapy in Willow.
- IPAC (Infection Prevention and Control) - increased C. Diff variance – complexities with collecting specimens in a timely manner.
- IPAC – escalation about commode cleaning and hand hygiene – task and finish group created to ensure issues are resolved quickly.
- Community Nursing – Deep dives started, looking at standardisation and consistency of language and definitions.
- Improved UCR (Urgent Community Response) performance, now at 75%.
- Increased inpatient LOS (Length of Stay) - associated with infection, and capacity in therapy.
- SPOC (Single Point of Contact) – reported increased waits resulted in a rapid focus group review. Actions included increasing workforce, and a single S1 unit. Now improved and waits reduced form 2hours to 20 minutes
- Unallocated visits – ongoing review of what metrics should be, and the timescales for improvement will be included in the next report.
- Workforce- a combination of sickness and absence (leave for other reasons) has increased which impacts on service provision. There is a plan to standardise reporting across the new Organisation.
- Morale was felt to be good with reports that teams felt supported, were engaged and there was resilience within the teams with wellbeing support wrapped around teams.
- £1.6m gap on a recurrent basis, £0.7m will be delivered this year. Aiming to have more recurrent efficiencies in 26/27.

Spotlight Reports:
The Committee received the following reports:

- Pressure Ulcer Wound Care
  The work that has been ongoing regarding pressure ulcers demonstrated a structured review of key themes and issues. Accounts 38% of nursing care plan activity. Themes include policies reviews, training, digital solutions, service constraints and access, and workforce. 26 incidents record weekly, and this is still a cause of severe harm across the Trust. Most waiting times are <12 weeks. There is also consideration about unseen harm to patients with caseloads reviewed. There is work ongoing staging the delivery of the national would care strategy in a structured way.

- Projects & Efficiency – **reasonable assurance**
  All projects are on track – 91% are either fully delivered, or on track for delivery in this financial year. There has been a good interest in more projects being developed.

Thematic Reviews:
The Committee received the following half yearly reviews:

- Clinical Audit – **substantial assurance**
  Plans are already in place for the must-do audits next year. There had previously been a backlog, and they have almost caught up now. The RESPECT (Recommended Summary Plan for Emergency Care and Treatment) audit was completed and shared with the Norfolk Acute partners. National audits are on track.
  Discussion about ensuring our planned audits are strategically aligned with our Trust wide risks and issues.
- Patient Experience – **partial assurance**
  Themes for review included community nursing appointments, long waits, Nursing EOLC (Educational Level of Competence) and staff behaviours and attitudes.
  FFT (Friends and Family Test) moving to IQVIA presently. Co-production needs strengthened and developed further which is planned for 26/27.
- Incidents – **reasonable assurance**
  Trend is upwards for incident reporting; this is in low/no harm incidents.
  Work ongoing to ensure learning from incidents is shared.
  Alignment of the PSIRF (Patient Safety Incident Response Framework) process across the group ongoing.

Key escalations:

- IGR – partial assurance
- Patient Experience – partial assurance
- No other escalations to Board.

Key risks and issues:
No risks rated 15 or above.

There are 10 issues (risks which have been realised) which are rated as 4 (major).

Good practice or innovation:

- 91% of projects across NCHC are either fully delivered or on track to be fully delivered by end of Q4.
- A much more structured approach to the themes and challenges around Pressure Ulcer issues.
- Improvement in UCR and SPOC KPIs (Key Performance Indicators).
- Norfolk and Suffolk System has been in business continuity and NCHC teams have worked hard with system partners to provide flow and increased beds for patients – 5 surge beds in Willow and 8 spot beds purchased to support the system.

Part Two: Balanced score cards for each division

(This section is currently under development)

Part Three - Themes across the organisations

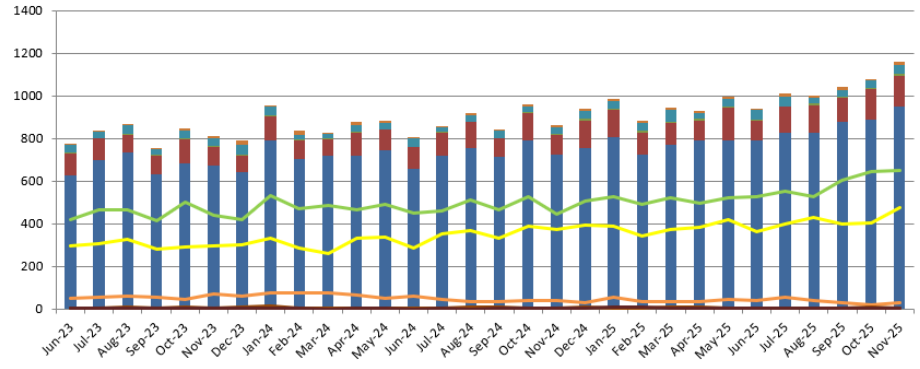
1.0 SAFE

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	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
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
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
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
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	148
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
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	646	650
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	403	476
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	27
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
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

1.2 NCHC Patient Safety Incidents

1.2.1 Within the reporting period of October and November 2025 there were no ‘Never Events’ identified, and no new Patient Safety Incident Investigation (PSII) commissioned.

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

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%.

1.2.4 During the two-month period a total of 2123 Incidents were reported:

- 10 severe harm incidents (0.47% of total reported incidents, which is a small increase on last reporting period)
- 42 moderate harm incidents (1.9% which is a 1.6% decrease on the last reporting period)
- 824 low harm incidents (39% which is a small decrease on last reporting period)
- 1238 no harm incidents (58.3% which is a small increase on last reporting period)

1.2.5 No harm and low harm incidents account for 97.3% 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 October and November 2025 by degree of harm

Month	No Harm	Low	Moderate	Severe	Death (Expected)	Total
Oct 2025	588	400	19	7	5	1019
Nov 2025	650	424	23	3	4	1104
Grand Total	**1238**	**824**	**42**	**10**	**9**	**2123**

Severe Harm Incidents

1.2.6 There were 10 severe harm incidents identified in the reporting period.

- 8 related to a deterioration in an existing pressure ulcer (either category 3 or unstageable) to a category 4 wound. Where indicated After Action Reviews have been completed and action planned at the Pressure Ulcer Learning Group.
- 1 incident related to the deterioration of a diabetic foot wound. Contributing factors included an identified delay in equipment provision. Incident has been reviewed at Place level and local learning implemented.
- 1 incident related to the deterioration of a chronic leg ulcer. Review of the care provided showed that all steps had been taken to treat and care for the patient. The deterioration in wound related to an overall deterioration in their medical condition.

Moderate Harm Incidents

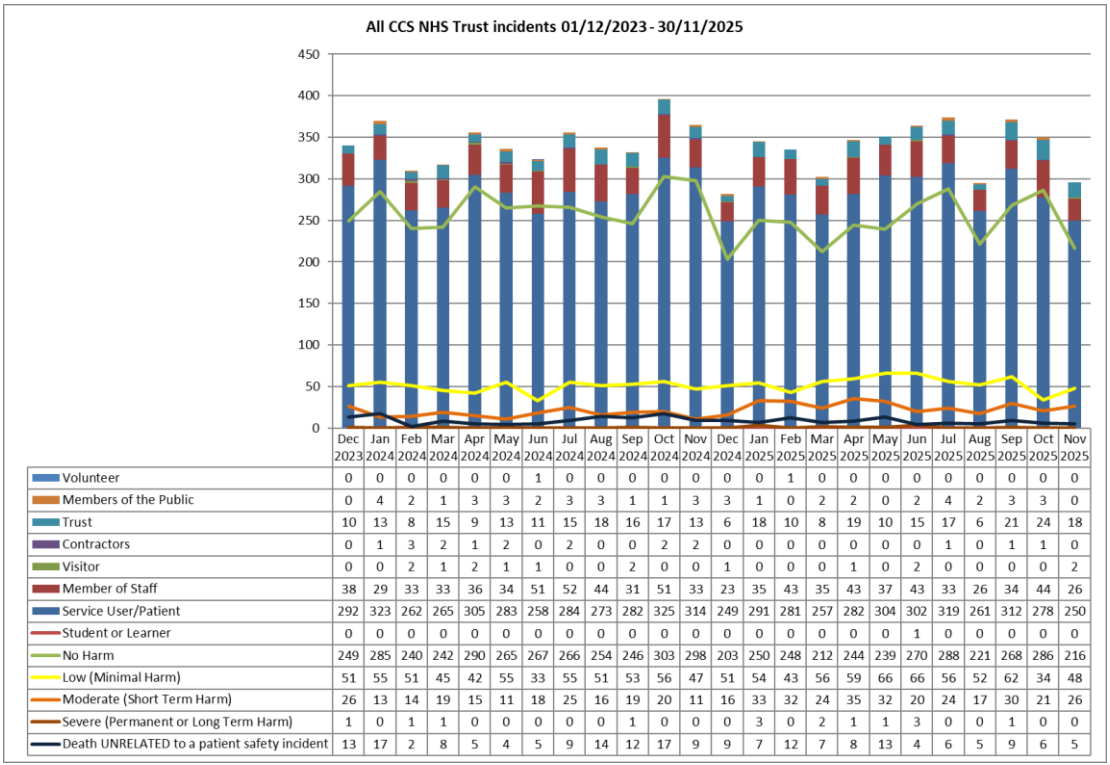
1.2.7 42 moderate harm incidents were reported. The highest report incident category relates to pressure ulcer development at category 3. No other significant themes were identified in the remaining incidents.

1.2.8 23 incidents relate to development of a category 3 pressure ulcer whilst under community services. Section 1.4.1 provides a spotlight exploring themes and action plans to mitigate and improve care in this treatment pathway.

1.2.9 All 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



	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	Oct 2025	Nov 2025
Volunteer	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Members of the Public	0	4	2	1	3	3	2	3	3	1	1	3	3	1	0	2	2	0	2	4	2	3	3	0
Trust	10	13	8	15	9	13	11	15	18	16	17	13	6	18	10	8	19	10	15	17	6	21	24	18
Contractors	0	1	3	2	1	2	0	2	0	0	2	2	0	0	0	0	0	0	0	1	0	1	1	0
Visitor	0	0	2	1	2	1	1	0	0	2	0	0	1	0	0	0	1	0	2	0	0	0	0	2
Member of Staff	38	29	33	33	36	34	51	52	44	31	51	33	23	35	43	35	43	37	43	33	26	34	44	26
Service User/Patient	292	323	262	265	305	283	258	284	273	282	325	314	249	291	281	257	282	304	302	319	261	312	278	250
Student or Learner	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
No Harm	249	285	240	242	290	265	267	266	254	246	303	298	203	250	248	212	244	239	270	288	221	268	286	216
Low (Minimal Harm)	51	55	51	45	42	55	33	55	51	53	56	47	51	54	43	56	59	66	66	56	52	62	34	48
Moderate (Short Term Harm)	26	13	14	19	15	11	18	25	16	19	20	11	16	33	32	24	35	32	20	24	17	30	21	26
Severe (Permanent or Long Term Harm)	1	0	1	1	0	0	0	0	0	1	0	0	0	3	0	2	1	1	3	0	0	1	0	0
Death UNRELATED to a patient safety incident	13	17	2	8	5	4	5	9	14	12	17	9	9	7	12	7	8	13	4	6	5	9	6	5

1.3.1 One Patient Safety Incident Investigation (PSII's) was commissioned in November 2025. The incident occurred in Beds Community Paediatric Service and relates to clinic processes and a subcontractor. A full review is underway.

1.3.2 No 'Never Events' were declared in either October or November 2025.

1.3.3 One PSII was concluded in October 2025. Focused on accuracy of growth monitoring and faltering growth in babies and young people. The policy and related education and training has been updated. The training highlights to our staff how to escalate concerns and importance of supervision to underpin cases of concern. We are working with system partners on ensuring consistency of practice.

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 eight review responses were commissioned by the Safety Huddle in October 2025, three of which had a safeguarding element. Five review responses were commissioned in November 2025, two of which had a safeguarding element.

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

Month	No Harm	Low	Moderate	Total
October	151	11	5	167
November	118	16	9	143
Grand Total	**269**	**27**	**14**	**310**

1.3.6 Fourteen 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 following services all reported one moderate harm incident. Audiology (delay in diagnosis), Dental (wrong tooth filled), Norfolk HCP (delay in recognising complications) and iCaSH (missing implant).

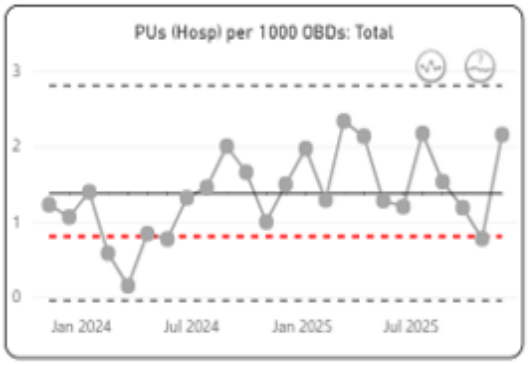
1.3.8 Moderate harm incidents, whilst the person is under the care of the Trust, require the application of the statutory Duty of Candour. Of the fourteen moderate harm incidents reported in the 2-month period of October and November 2025, eleven have had the statutory Duty of Candour completed, one letter is currently being drafted, and two incidents remain under review. The three remaining Duty of Candours monitored via the weekly Safety Huddle and plan in place for completion.

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

NCHC Pressure Ulcers

1.4.1 Reported pressure ulcers across NCHC remain over threshold across both hospital and community and therapy teams. The introduction of the standardised pressure ulcer wound assessment templates and associated risk assessment tools across both hospital and community nursing, and therapy teams have further enhanced practice and reporting. All pressure ulcers are reviewed within their respective Place for initial learning, before escalation to specialist forums where complexity or harm indicate.

SPC Chart 1



SPC Chart 2

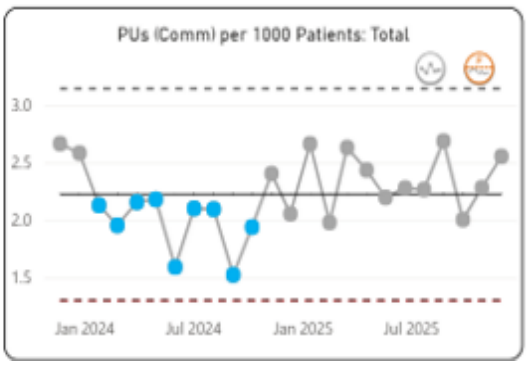


Table 3 NCHC Pressure Ulcers by Category

Number of Datix by Time Series

Subcategory	October 2025	November 2025	Total
Medical Device related Pressure Ulcer acquired within the care of NCHC	5	4	9
Suspected Deep Tissue Injury acquired within the care of NCHC	20	31	51
Moisture Lesion acquired within the care of NCHC	33	28	61
Unstageable Pressure Ulcer acquired within the care of NCHC	50	43	93
Pressure Ulcer acquired WITHIN the care of NCHC	87	107	194
Total	195	213	408

1.4.2 **Actions and mitigations:**

- A key area for improvement identified through the internal review process is a review of pressure ulcer risk screening from the Urgent Care Response Teams (UCR). An action plan has been designed to support consistent and timely screening. Implementation will be monitored through the Trust-wide Pressure Ulcer Quality Group, Wound Care Group and Safety Group.
- Plans to adopt the Healthy.io. technology software to support a digitised approach to wound care continues with ongoing discussion with CCS who are using this in Luton Adults Services. A pilot is commencing in January 2026.
- Work to implement required changes to training, Datix, Policy and SystmOne to reflect the National Wound Care Strategy clinical categorisation recommendations is ongoing.
- Actions to align pressure ulcer clinical pathways to the National Wound Care Strategy are monitored through the bimonthly Trust-wide Pressure Ulcer Quality Specialist Group.
    - Updating Datix templates is underway.
    - Changes required to SystmOne are delayed due to the transition to a single SystmOne unit.
    - The team are developing a training package to support clinical staff.

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. Sixty-eight incidents were reported as ‘developed Pressure Ulcers or MASD’ all of which were under the Luton Adults Service. A further 14 incidents related to patients who ‘acquired a skin tear’, all of which are deemed to be off caseload and are ‘happened upon’ incidents.

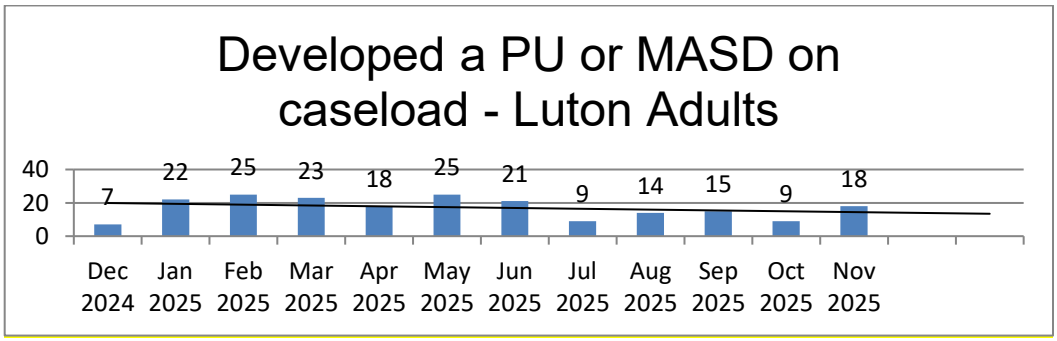
1.4.4 Of the Luton Adults 64 incidents, 27 (40%) were deemed to have occurred whilst the patient was on active caseload

1.4.5 The trend for reporting of Pressure Ulcer incidents occurring for those patients on caseload has indicated a decrease over the last 12 months

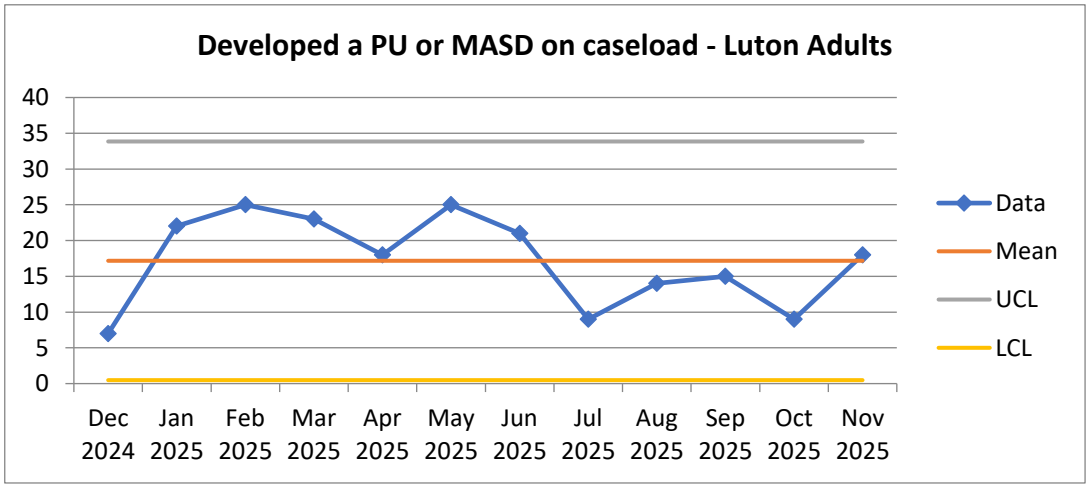
with the forecast showing the falling rate, as per Graph 4 below which shows that reporting rates remain within acceptable parameters. The overall mean reporting rate per month is 17.17 per month.

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 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, 13,471 wound assessments have been completed through the app, covering 438 patients and 917 wounds, resulting in 851 fully healed wounds. The median heal time is seven weeks. 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. It is the intention to have a community of practice that spans the whole group to maximise shared learning. NCHC is working with CCS on commissioning the wound care app.

Graph 3



Graph 4



CCS NHS Trust – Identification and Management of child sexual abuse

1.4.7 Thematic learning has been identified through the PSIRF process related to identification and management of child sexual abuse. A review of cases identified across the CCS footprint has been completed and the learning which has been identified is being addressed through development of a Human Factors & Trauma Informed Practice training package that will be rolled out across NCHC & CCS in 2026-2027.

1.5 Medicines Optimisation CCS and NCHC

1.5.1 Governance

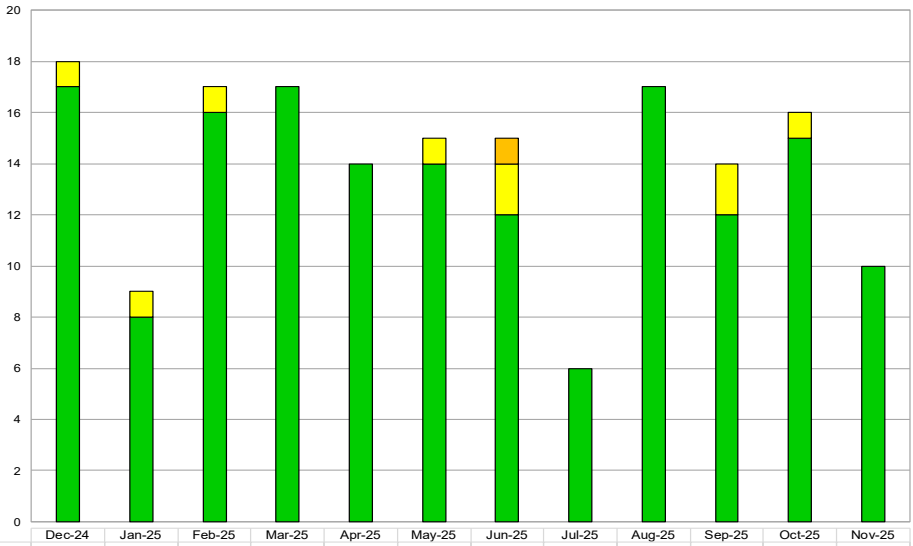
The Medication Safety and Governance Group (MSGG) in CCS and the Medicines Optimisation Working Group (MOWG) in NCHC systematically review all medication incidents and implement corrective actions, providing assurance of collaborative efforts to maintain outstanding patient care. Reporting of medicines-related incidents is actively encouraged; the high proportion of no/low harm events evidences a positive, learning-focused reporting culture.

1.5.2 Overview

CCS Medication Incidents
Data presented in this section refers only to incidents attributable to CCS.

A total of 26 medicines-related incidents were reported, 25 were no harm and 1 was low harm (Graph 5). The low-harm incident concerned a potential adverse reaction following an injection and CCS causality was subsequently excluded. Most incidents originated from Luton Community Nursing, partly reflecting proactive reporting of insulin-related events (see 1.5.4).

Graph 5: Medication incidents reported under CCS care and their degree of harm (Dec 2024-Nov 2025)



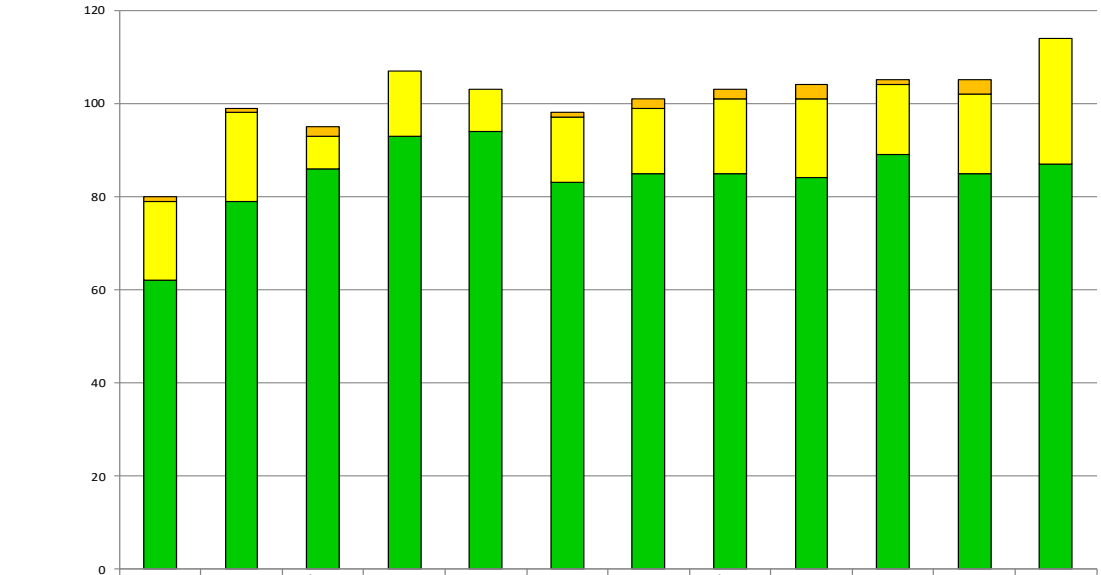
	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Moderate (Short Term Harm)	0	0	0	0	0	0	1	0	0	0	0	0
Low (Minimal Harm)	1	1	1	0	0	1	2	0	0	2	1	0
No Harm	17	8	16	17	14	14	12	6	17	12	15	10
Total Number of Medication Incidents	18	9	17	17	14	15	15	6	17	14	16	10

NCHC Medication Incidents

Data includes all medicine-related incidents reported by NCHC, including those not directly attributable to NCHC, to capture wider system impacts—particularly transfer-of-care incidents.

There were 219 medicine-related incidents: 172 no harm, 44 low harm, and 3 moderate harm.
Of these 112 (86 no harm, 25 low harm and 1 moderate harm) were attributable to NCHC services. A slight upward trend is observed, which is in line with increased patient numbers.

Graph 6: Medication incidents reported under NCHC care and their degree of harm (Dec 2024-Nov 2025)



	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025
Moderate harm	1	1	2	0	0	1	2	2	3	1	3	0
Low harm	17	19	7	14	9	14	14	16	17	15	17	27
No Harm	62	79	86	93	94	83	85	85	84	89	85	87

1.5.3 Themes of Incidents

CCS

Medicines administration accounted for over 50% of incidents (n=15), of which 14 occurred with medicines administered to patients in their homes. Documentation clarity and use of Medication Administration Record (MAR) charts were recurring themes. To address this, a mobile application enabling real-time, editable access to the electronic patient record is being piloted.

NCHC

Similar to CCS, medicines administration accounts for a significant proportion of incidents (n=98) in NCHC. Other themes identified across NCHC include:

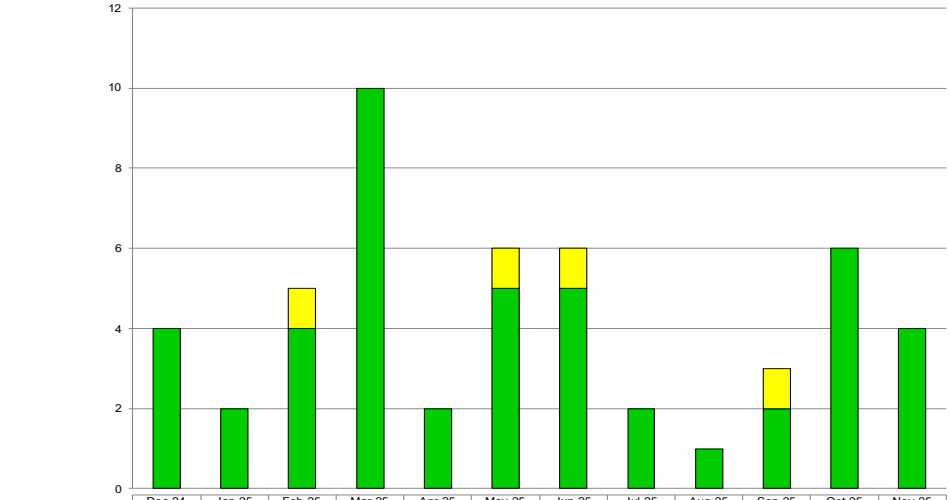
- Prescribing issues such as unclear or incorrect prescriptions
- Syringe driver concerns such as delays, incomplete charts, compatibility or equipment issues.
- Discharge and transfer challenges including missing TTOs, absent referrals, and unclear medication changes.
- Pharmacy supply delays and inappropriate storage or medication left out of fridges.

1.5.4 Insulin Incidents

CCS

Insulin-related incidents are monitored by the Insulin Data Oversight Group. Each month, over 6,000 insulin visits are undertaken; on average only 6 each month (0.1%) result in an incident report, and half of those are not attributable to CCS. Graph 7 demonstrates a consistent downward trend in incidents attributable to CCS; all incidents in the reporting period were no harm.

Graph 7: Medication incidents involving insulin reported under CCS care and their level of harm (August 2024-November 2025)

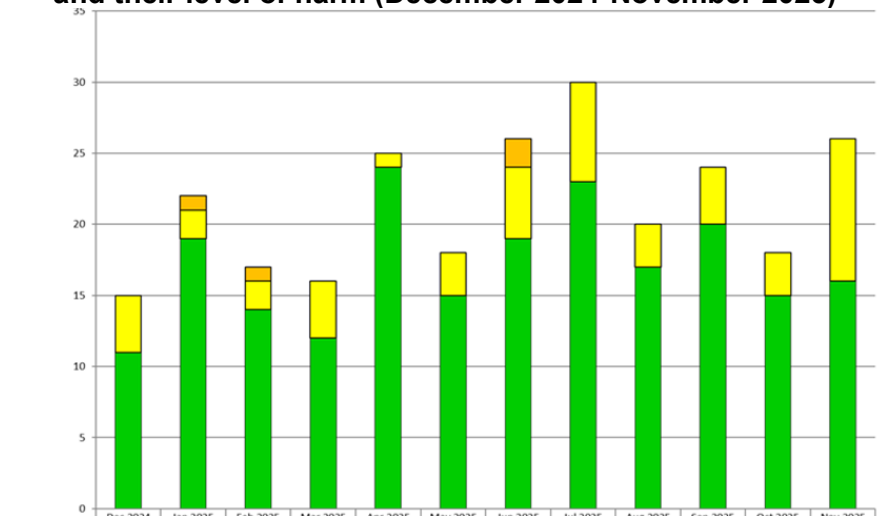


	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Low (Minimal Harm)	0	0	1	0	0	1	1	0	0	1	0	0
No Harm	4	2	4	10	2	5	5	2	1	2	6	4
Total	4	2	5	10	2	6	6	2	1	3	6	4

NCHC

There have been targeted interventions including insulin handling learning materials and a 'Take5' publication on hypoglycaemia insulin-related incidents. There remains a priority focus on unimplemented dose changes, documentation gaps, and missed visits as these issues remain significant.

Graph 8: Medication incidents involving insulin reported under NCHC care and their level of harm (December 2024-November 2025)



	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025
Moderate harm	0	1	1	0	0	0	2	0	0	0	0	0
Low harm	4	2	2	4	1	3	5	7	3	4	3	10
No Harm	11	19	14	12	24	15	19	23	17	20	15	16

1.5.5 **Controlled Drugs**

Controlled drugs carry strong regulatory requirements and are an area of focus within NCHC. Trust audits have identified issues and areas for improvement including recording errors in patients' homes and storage issues. Improvement actions will include targeted training and an awareness campaign, including podcasts, to strengthen CD governance and compliance.

Table 4

	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025
No Harm	21	26	29	26	29	26	28	14	23	29	23	31
Low harm	6	6	2	2	4	7	1	3	7	5	9	6
Moderate harm	1	0	0	0	0	1	0	1	1	0	2	0

1.5.6 **Summary Group Actions**

- **Integrated governance:** Consolidation of MSGG and MOWG to become Medicines Safety and Governance Group (MSOG).
- **Documentation quality:** Explore wider role out within CCS of EPR mobile app pilot if metrics demonstrate improved MAR accuracy and timeliness, improve care transfer communication.
- **Insulin safety:** Maintain targeted education and share learning through the Insulin Data Oversight Group
- **Controlled drugs:** Implement focused training and awareness podcasts, reinforce audit recommendations, and monitor incident trends.
- **Stock management:** ensuring appropriate storage conditions are maintained with the implementation of digital temperature monitoring probes.

1.6 Violence Prevention and Reduction Standard

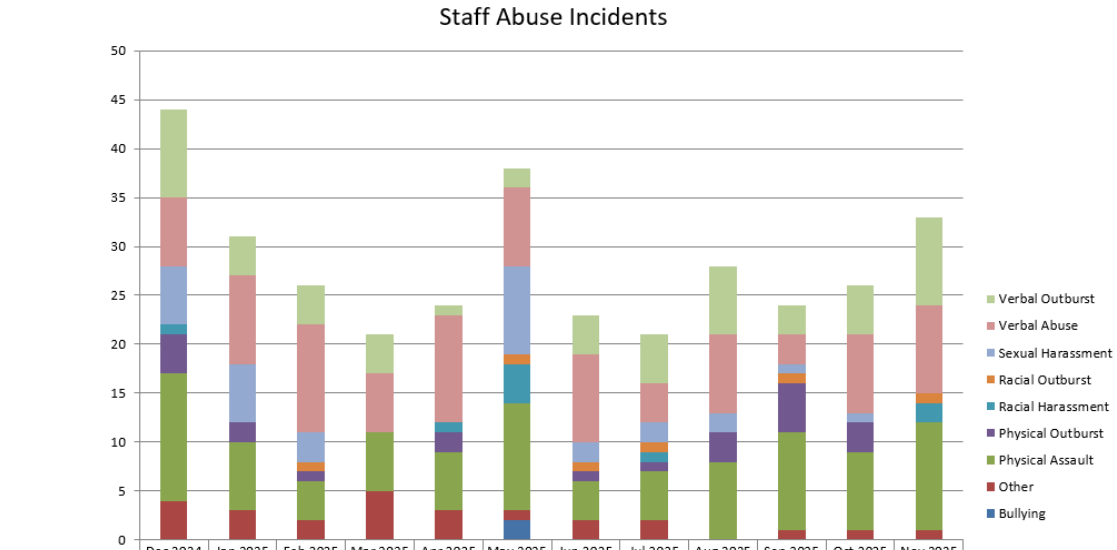
1.6.1 NCHC and CCS are working collectively to ensure compliance with the Violence Prevention and Reduction Standards (2024). Action plans have been aligned, and plans are in place for a merged assessment and plan for 2026-27.

NCHC Violence and Aggression towards staff data

1.6.2 Reporting methodology updated to enable capture of incidents initially recorded as the patient was affected but the incident detail on review also identifies that a staff member was harmed. This methodology has been applied retrospectively across the 12-month data window.

In the reporting current period there were 59 incidents reported affecting staff. Incidents subtypes are presented in Graph 9.

Graph 9 Number of incidents by abuse type NCHC



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

1.6.3 Abuse incidents are presented and reviewed at the quarterly Health and Safety (H &S) committee following initial review by Place H&S meetings. Themes and learning are 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.

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.

1.6.4 Break away, de-escalation and mental health awareness (MHA) training is under active development. The clinical training team are undertaking a train the trainer program in January 2026. Training rollout will commence in Q1, targeting areas with higher risk and incident reporting as priority.

1.6.5 Physical assaults remain elevated for the second reporting period. One patient was involved in 4 out of 19 events reported. Review confirms that positive behavioural planning, risk assessments, and appropriate one to one support care plans (including antecedent, behaviour and consequence planning) were appropriately in place in each instance assessed. 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 assessment including an identified lack of mental capacity has been identified as a potential theme for further review through incident analysis and review at the H&S Committee. Further work to understand this

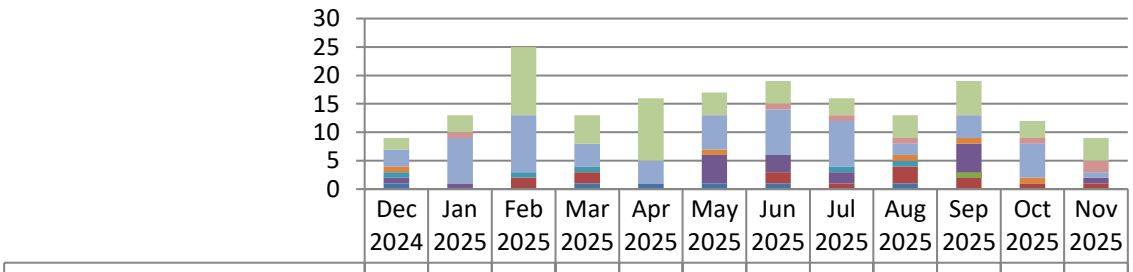
includes how better data can be provided to break down the capacity cause to a more granular level (consider dementia, delirium, brain injury). This will allow for targeted action plans to be developed. A link to the MHA training (and further curriculum development) will be developed as required and impact of the training assessed.

The exploration of functionality on Datix to report the provision of warning letters is also under progress. These developments will improve both the management (and pre-emption) of incidents and improve assurance of effective use of systems and support staff, patients and carers.

CCS NHS Trust Violence and Aggression towards Staff Incidents

1.6.7 Graph 10 below shows reporting themes for the last two months and number of cases. A total of 21 incidents were reported.

Graph 10 CCS Violence and aggression towards staff by category



	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025
Verbal abuse	2	3	12	5	11	4	4	3	4	6	3	4
Unspecified violence issue	0	1	0	0	0	0	1	1	1	0	1	2
Unacceptable behaviour	3	8	10	4	4	6	8	8	2	4	6	1
Sexual harassment/assault	1	0	0	0	0	1	0	0	1	1	1	0
Racial harassment/abuse	1	0	1	1	0	0	0	1	1	0	0	0
Physical assault	1	1	0	0	0	5	3	2	0	5	0	1
Firearms/dangerous weapons	0	0	0	0	0	0	0	0	0	1	0	0
Distressing phone call	0	0	2	2	0	0	2	1	3	2	1	1
Bullying	1	0	0	1	1	1	1	0	1	0	0	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.

1.6.9 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. The alert will be managed and monitored via the medicines safety groups.

NatPSA/2025/006/NHSPS Harm from incorrect recording of a penicillin

allergy as a penicillamine allergy

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 5 and 6).

1.8.2 Actual CHPPD is generally higher in the specialist units and the rehabilitation unit Willow, reflecting the 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, 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 The next inpatient establishment reviews will take place in April 2026. The community establishment review tool, Community Nursing Safer Staffing Tool, has been trialled in North Place and has highlighted some areas to address with the national team in effective implementation to ensure accurate recommendations. Once this has been resolved, the Quality Team will identify the resource needed to implement across all 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.

1.8.6 Tables 5 and 6 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 5:
October 2025

Unit	Actual CHPPD	Required CHPPD	Actual RN to Patient Ratio
Generalist Wards			
Alder Ward	5.89	7.27	1:9.70
Foxley Ward	6.51	7.57	1:8.25
North Walsham	6.61	8.26	1:8.82
Ogden Court	6.04	9.49	1:8.19
Pineheath Ward	5.69	8.19	1:9.00
Swaffham Hospital	6.34	7.40	1:8.91
Willow Nursing (Forest)	6.87	4.80	1:9.16
Willow Nursing (Garden)	6.23	5.28	1:8.81
Specialist Wards			
Beech Ward	7.93	7.19	1:7.26
Caroline House	10.71	10.49	1:5.53
PBL	10.16	7.50	1:5.06
Pine Cottage	6.66	4.36	1:7.68

Table 6:
November 2025

Unit	Actual CHPPD	Required CHPPD	Actual RN to Patient Ratio
Generalist Wards			
Alder Ward	5.23	6.7	1:9.10
Foxley Ward	6.18	7.61	1:8.22
North Walsham	5.89	8.29	1:8.03
Ogden Court	5.70	8.7	1:8.51
Pineheath Ward	4.98	7.55	1:9.34
Swaffham Hospital	6.62	6.98	1:8.44
Willow Nursing (Forest)	7.20	5.23	1:8.70
Willow Nursing (Garden)	6.61	7.58	1:9.12
Specialist Wards			
Beech Ward	6.87	6.87	1:8.29
Caroline House	11.11	10.78	1:5.25
PBL	10.33	7.67	1:4.97
Pine Cottage	6.40	4.56	1:7.81

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 96% 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 SitRep RAG ratings add further assurance to the OPEL scores as 95% of shifts were on green or amber status for District Nursing. District Nursing clinical activity was deferred on two occasions: other mitigations taken included workforce being re-allocated and temporary staffing being deployed.

Business Continuity

1.8.9 BCP was triggered in four services owing to staffing issues:

Mitigations	
0-19 Bedford Team	Universal and targeted antenatal contacts being offered only for first-time parents (specialist contacts continue as usual) Development review clinics cancelled and appointments rescheduled
C&P 0-19 South Locality	Transfer-in change in process in place
Falls Service	Visits re-scheduled, empty phone slots used for face-to face contacts, urgent visits replace care home scheduled visits
Safeguarding Children Team	Safeguarding supervision continues but other services re-prioritised

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 and NCHC have 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 Intercollegiate Document for children and young people & children and young people in care has been published in November 2025 and a briefing of the changes in the document has been presented to the strategic safeguarding group. The document supports the new trust safeguarding training strategy and offers us the additional opportunity to review level 1&2 safeguarding training.

1.9.3 Safeguarding supervision is provided in accordance with guidance from the Intercollegiate Documents for children and adults. Some staff are designated to require formal (previously called mandatory) safeguarding children supervision. Compliance with this continues to be monitored within the children's safeguarding teams across the group model, with

compliance rates showing above or just below the 90%. Adult safeguarding supervision is now a formal offer in some teams, but all services have access to a duty line for advice and guidance and adhoc supervision as needed.

1.9.4 An annual audit plan is in place in CCS and audit underway to review practice for large sibling groups which will be completed and reported by end of Q4. Audit for the Multi Agency Safeguarding Hub /Multi agency Risk Assessment Conference interface were completed, and an action plan has been progressed across each locality.

1.9.5 Safeguarding teams have agreed on join up as a group model to go live from 1st January 2026. Line management has been agreed and the proposals for a risk-based approach to the safeguarding work and join up are in place.

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 (BAF)

1.10.1 Following the completion of the Antimicrobial Stewardship Report the BAF is now fully compliant.

1.10.2 NCHC and CCS plan to 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 identified as Clostridium Difficile) infections.

1.10.5 NCHC reported 2 Clostridioides difficile toxins (2 in October). 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 Clostridioides 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. 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.

Update PSII (Patient Safety Incident Investigation)

1.10.7 The PSII relates to an outbreak which is being overseen by the UKHSA (UK Health Security Agency) and is on-going but reducing. An after-action review has been completed and presented to clinical services and the trust Executive. 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 October 2025. As of 18 December 2025 reported uptake amongst clinical-facing staff is reported in table 7 below.

1.11.2 NHS England prescribed stretch targets for all trusts to build on the previous years vaccination rates by 5%. NCHC have exceeded the target whilst CCS remain slightly below target.

1.11.3 Both NCHC and CCS continue to offer staff access to flu vaccination until the end of March 2026.

Table 7 Staff Seasonal Flu Vaccination data

	NHS Federated Data Platform	NHSE target
NCHC	59.3% (21.12.25)	54.5%
CCS	62.5% (21.12.25)	63.3%

2.0 CARING

2.1 NCHC Patient Experience

Friends and Family Test (FFT)

Table 8 NCHC FFT Responses for October and November

	% Positive	% Negative	% Neither good nor poor	Don't Know	Total FFT Responses
Community Inpatient Services	93%	1%	4%	2%	1. 102
Community Nursing Services	94%	1.5%	3.5%	1%	2. 369
Rehabilitation and Therapy Services	95.5%	3%	1.5%	0%	3. 180
Specialist Services	98%	0%	2%	0%	4. 53
Children and Family Services	100%	0%	0%	0%	5. 16
Community Healthcare - Other	100%	0%	0%	0%	6. 4
Trust-wide	95%	1.5%	3%	0.5%	**7. 724**

2.1.1 For October and November the FFT score was at the target of 95% Good or Very Good with October responses higher than previous four 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.

2.1.2 The Trust received 396 responses in October and 328 in November. Table 9 below is a summary of total responses since February 2025. The drop in responses sits within Community Inpatients and Rehab and Therapy services across all Places.

Table 9

	Feb	March	April	May	June	July	Aug	Sep	Oct	Nov	Total
Trust Overall	308	299	505	413	360	359	312	392	396	328	3672

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

2.1.4 Themes from negative feedback relate to food quality and expectations regarding Physiotherapy/exercise in our inpatient units. All 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. Feedback relating to food and the patient environment is reviewed and acted upon within the Patient Environment group.

2.1.5 NCHC Lived Experience team continue to work closely with CCS Patient Experience team to transition FFT to one analytical tool from January 2026. The inclusion of optional questions has been agreed enabling opportunities for co-production work, building membership to the Patient Advisory Group. Place Quality Teams and the Lived Experience team have received training on the new system and a communication plan is under development.

Healthwatch Feedback report

2.1.6 The Healthwatch Pink Feedback Box report received in October covered 30 reviews from a range of Community Hospitals and Outpatient services. The reviews report an average rating of 4.5 stars out of 5. North Walsham Hospital was the most frequently mentioned service, with 12 individual reviews. Cleanliness was the most highly rated category with a score of 4.8/5 followed by care and staff attitude at 4.7/5. Patients also provide written feedback about their care. Feedback indicated that overall people were very happy with the care they received. Many highlighted how staff were friendly, helpful and good communicators. A couple of responses suggested that the food could be improved, such as offering more food choices.

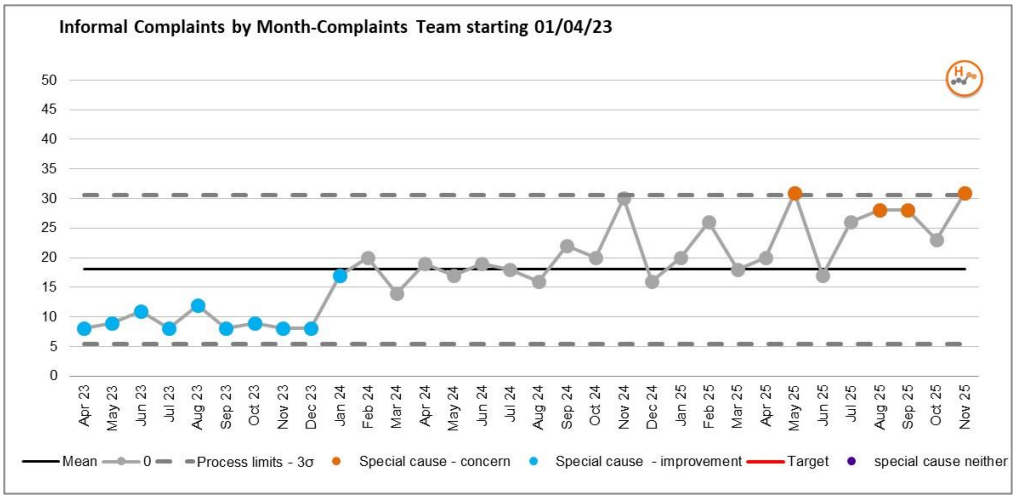
Compliments

2.1.7 There were 174 compliments received in this reporting period, a slight increase from the previous reporting period. West Place having received and logged the highest number of compliments, with a continued increase for the Intermediate Care Beds and Urgent Care Response Teams (ICUCR) Place. Themes throughout compliments 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. Several compliments provide detailed examples of what patients have been able to achieve since they have received their care and treatment, often going on to have greater independence and confidence in their recovery and maintaining levels of fitness and wellbeing.

Complaints

2.1.8 There were 54 locally resolved, informal complaints and 19 formal complaints received in October and November.

SPC Chart 3



Informal Complaints received

2.1.9 The Trust received 54 locally resolved, informal complaints in this data period: 23 in October and 31 in November. SPC chart 3 above, 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.

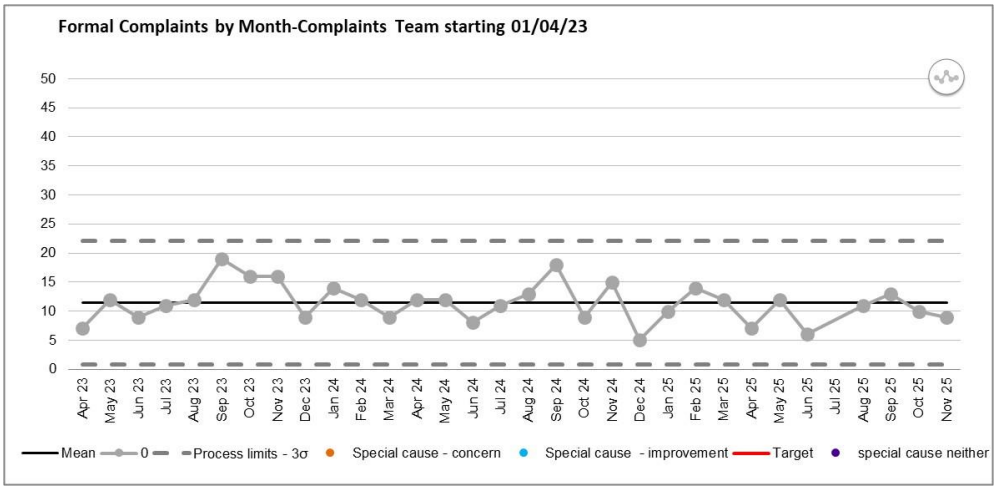
Themes from informal complaints received

2.1.11 The prominent themes of complaints remains consistent with those identified in the previous reporting period. They centre on demand and capacity challenges in community service visits, and insufficient notification regarding changes to scheduled visits.

Formal Complaints received

2.1.12 The Trust received 19 formal complaints in this data period. As shown in SPC chart 4 below, this is within the expected variation with both months dropping below the trust average.

SPC Chart 4



2.1.13 100% of formal complaints were responded to within the Trust's timeframe of three working days.

Themes from formal complaints received

2.1.14 There were no prominent themes identified in formal complaints received in October. The complaints range from concerns over length of time waiting for a review from services, staff behaviour and attitude, and facilities services.

2.1.15 The prominent themes of concern in November centred within Children and Young Persons services (CYP). Six of the nine formal complaints this month sat within different services within the CYP directorate. Of these six complaints, there were no themes identified. Concerns were raised regarding length of wait (or refusal) for assessments, clinical treatment offered, and communication.

Formal Complaint Response Times

2.1.16 In this data period, the Trust responded to 19 formal complaints. 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

2.1.17 There were four MP contacts within the reporting period.

Two in October, one of which was a level 2 formal complaint relating to concerns over the length of wait for a specialist wheelchair to be fitted. The second was an informal complaint relating to concerns about possible early inappropriate discharge from Alder Ward.

There were two MP contacts in November, both assigned level 2 formal complaint status. One was related to concerns that a child was left not able to mobilise through lack of a wheelchair and another was related to a concern regarding the refusal of an autism assessment.

2.2 CCS Patient Experience

Friends and Family Test (FFT)

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

2.2.2 The Trust received 2361 responses in October and 2203 in November. This is 126 more than the previous two-month period. Below is a summary since April 2025.

Table 10

	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Total**
Trust Overall	2753	2502	2989	3439	2316	2122	2361	2203	**20685**

2.2.3 The overall Trust FFT positive feedback was 96.49%, with a 1.60% 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	97.13% ↑	1.74% ↓	2651 ↑	33291 ↑	7.96% ↑
Bedfordshire and Luton Children and Young People's Service	97.43% ↓	0.96% ↓	622 ↓	42537 ↑	1.46% ↓
Bedfordshire and Luton Adults Community Service	97.21% ↓	0.47% ↓	430 ↓	26922 ↓	1.60% ↓
Cambridgeshire and Peterborough Children and Young People's Service	95.53% ↓	1.84% ↑	380 ↑	31953 ↑	1.19% ↓
Norfolk and Waveney Children and Young People's Service	91.89% ↑	2.49% ↑	481 ↓	34789 ↑	1.38% ↓
Trustwide	96.49% ↑	1.60% ↓	4564 ↑	169492 ↑	2.69% ↓

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 October and November 3935 service users answered this question and a score for each directorate is shown in table 12 below.

Table 12

	Respect and Dignity Score
Ambulatory Care	97.31%
Bedfordshire and Luton Children and Young People's Service	97.49%
Bedfordshire and Luton Adults Community Service	94.87%
Cambridgeshire and Peterborough Children and Young People's Service	97.29%
Norfolk and Waveney Children and Young People's Service	94.60%
Trustwide	96.78%

Comments/ Compliments

2.2.6 In October and November, the services we provide received 7249 positive comments across the Trust, this is over 750 more than the last reporting period. We received over 71 positive comments for every formal and informal complaint received.

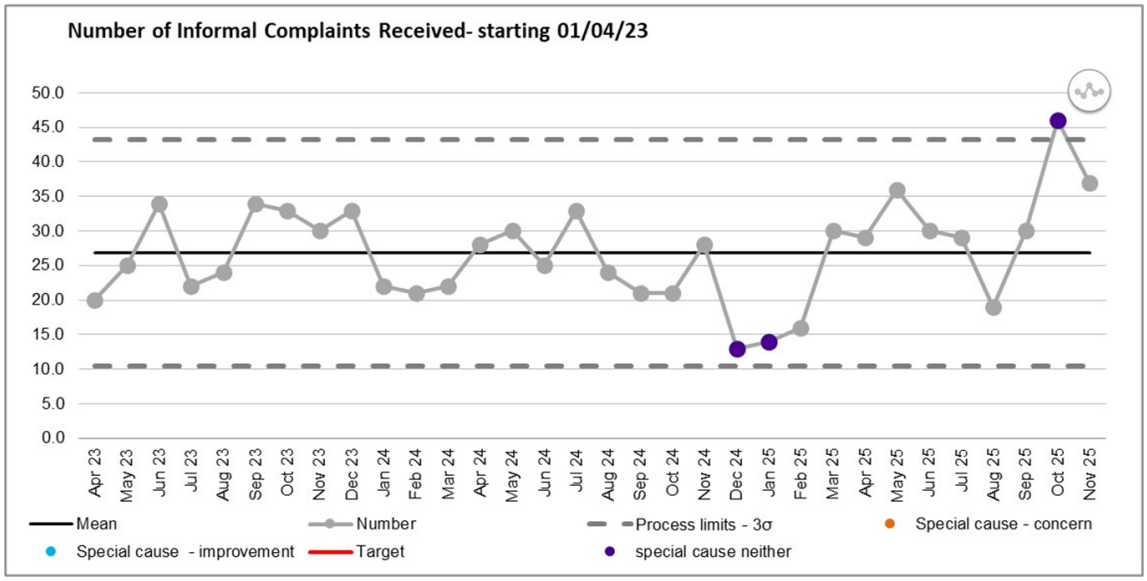
2.2.7 ***Complaints***

Informal complaints received

2.2.8 The Trust received 83 informal complaints in this data period: 46 in October and 37 in November. The number received in October was above the expected variation. In October, 12 informal complaints were

initially formal complaints that were locally resolved so downgraded to informal.

SPC Chart 5



2.2.9 Seventy eight out of the 83 complainants were contacted within four working days to discuss resolution of their concerns. In three cases there was a delay in the service forwarding the informal complaint to Patient Advice and Liaison Service (PALS) or logging on Datix. In one, there was confusion about whether it was a new complaint as the complainant had recently been in contact with the service, and one was delayed due to staff shortage in the PALS Team.

Themes from informal complaints closed in October and November

2.2.10 Seventy-seven informal complaints were resolved and closed in October and November with 86 subject issues identified.

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

- Delays (30)
- Communication and Information (15)
- Clinical Care (11)

2.2.12 Twelve of the 30 issues related to Delays, were about Bedfordshire and Luton Community Paediatrics and five Cambridgeshire Community Paediatrics, they were related to waiting times to be seen. Seven were about Dynamic Health related to delays in diagnosis and treatment.

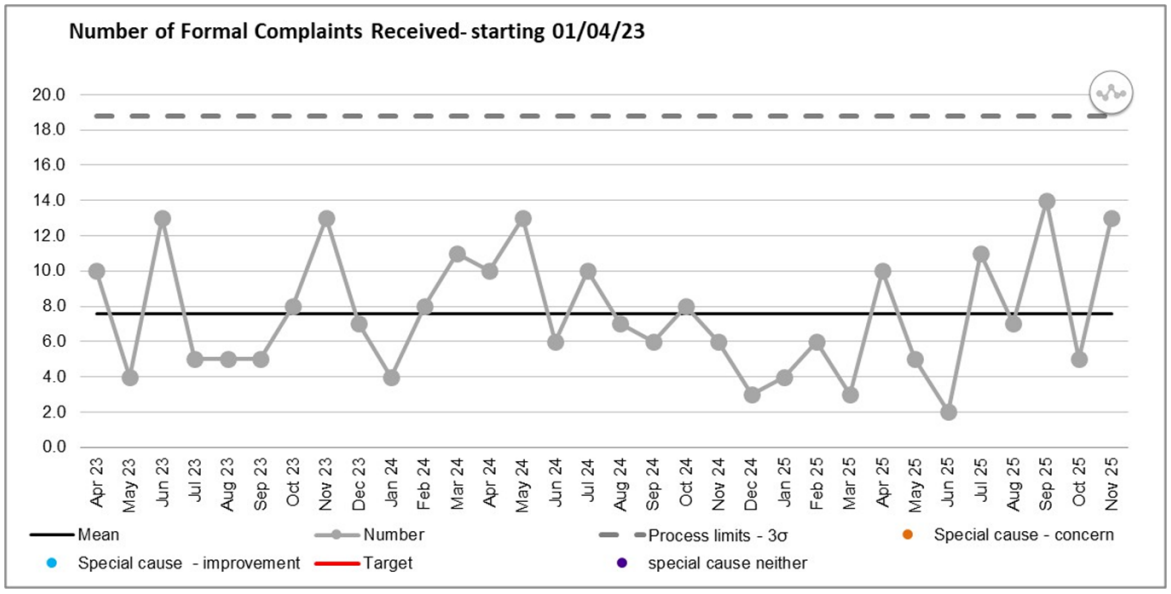
2.2.13 Four of the informal complaints about Communication and Information related to Dynamic Health and three Bedfordshire and Luton Community Paediatrics. There were no themes in the detail of these.

2.2.14 Of the 11 issues related to Clinical Care five were about Dynamic Health. These relate to concerns about the assessment and lack of treatment received.

Formal Complaints Received

2.2.15 The Trust received 18 formal complaints in this data period, five in October and 13 in November. 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 October and November 2025

2.2.16 Within this data period the Trust responded to and closed 20 formal complaints. In these there were 33 subjects identified.

2.2.17 Communication and Information was the most frequently occurring subject with 11 issues identified in nine complaints. Clinical Care was the second most frequently occurring with nine in nine complaints. Delays was identified as an issue six times in six complaints. The other subjects were Staff Attitude (3), Administration (2), Systems Failure (1) and Access (1).

2.2.18 Five of the issues about communication and information were about Record Keeping. This included concerns about safeguarding information on records and reports, not receiving a letter following a telephone call and the service not having a record of referral. None of these were upheld following investigation.

2.2.19 Twelve different services were named in the formal complaints responded to in October and November. Cambridgeshire Community Paediatrics were named in five and Dynamic Health in four.

Formal Complaint Response Times

2.2.20 In this data period, the Trust responded to 20 formal complaints, eight in October and 12 in November. A summary of the response times is shown in table 13 below.

Table 13

	August	September	October	November
Number of standard complaint responses sent within a 35-day timeframe.	0/1	5/8	5/6	7/8
Percentage of standard complaint responses sent within the 35-day timeframe.	0%	63%	83%	88%
Number of complex complaint responses sent within the 40-day timeframe.	2/2	2/3	2/2	4/4
Percentage of complex complaint responses sent within the 40-day timeframe.	100%	67%	100%	100%
Average number of working days to respond to standard complaints.	36	34	30	30
Average number of working days to respond to complex complaints.	25	36	33	33

2.2.21 The percentage of standard complaint responses sent within the 35 working day timeframe improved in October and in November, the number of responses sent was also higher than in the previous two months. All complex complaint responses were sent within timeframes in October and November.

The reasons for the late responses include delay in starting the investigation and time taken to investigate.

Member of Parliament (MP) Contacts

2.2.22 In this period there were four contacts received via an MP, one enquiry and three informal complaints. The informal complaints were about Community Paediatrics in Bedfordshire and Luton and related to waiting times, breach of confidentiality and transfer to adult services. The enquiry was about a service user being unable to return equipment to Dynamic Health.

Supporting Services with Correspondence with Service Users

2.2.23 The PALS team supported with a duty of candour letter for the Bedfordshire and Luton Community Paediatric Service in November.

Regulatory Update (NCHC)

2.2.24 The NCHC Care Quality Commission (CQC) statement of purpose has been reviewed and updated. The proposed amendments are highlighted below:

- **Birch Unit:** Norfolk Community Health and Care NHS Trust (NCHC) no longer provide this bedded inpatient unit. This patient group is now cared for by Willow Therapy Unit. Change effective date 13th March 2025.

  Additional information for Board: Pine Cottage will transfer to the building following refurbishment completion in February *2026. However, as Pine Cottage will retain its name and purpose, the registration will not need to be updated at this point, with the previous registration remaining valid and correct.*

- **Priscilla Bacon Lodge:** Moved from under Colman site subheading to separate subsection for increased clarity and to improve document navigation.
- **Sexual Assault Referral Centre (SARC):** Norfolk Community Health and Care NHS Trust (NCHC) no longer provide the Safeguarding Paediatric Consultant input to this service. Change effective 31st of April 2024.
- **Squirrels Short Break respite service:** Following updates and review of health service building notes the number of available overnight beds has been reduced from five to two. Change effective 1st of September 2023.
- **Assessment or Medical Treatment for persons detained under the 1983 (Mental Health) Act:**

2.2.25 Following review of the CQC guidance Assessment or medical treatment for people detained under the Mental Health Act 1983 - Care Quality Commission the following units are out of scope for this regulated activity:

- Woodlands House
- Colman Hospital
- Norwich Community Hospital
- Dereham Hospital
- Kelling Hospital
- Swaffham Community Hospital
- North Walsham Community Hospital
- Ogden Court.

2.2.26 The Board is asked to **approve** the amendments and updates to the Statement of Purpose (Appendix 1).

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:**

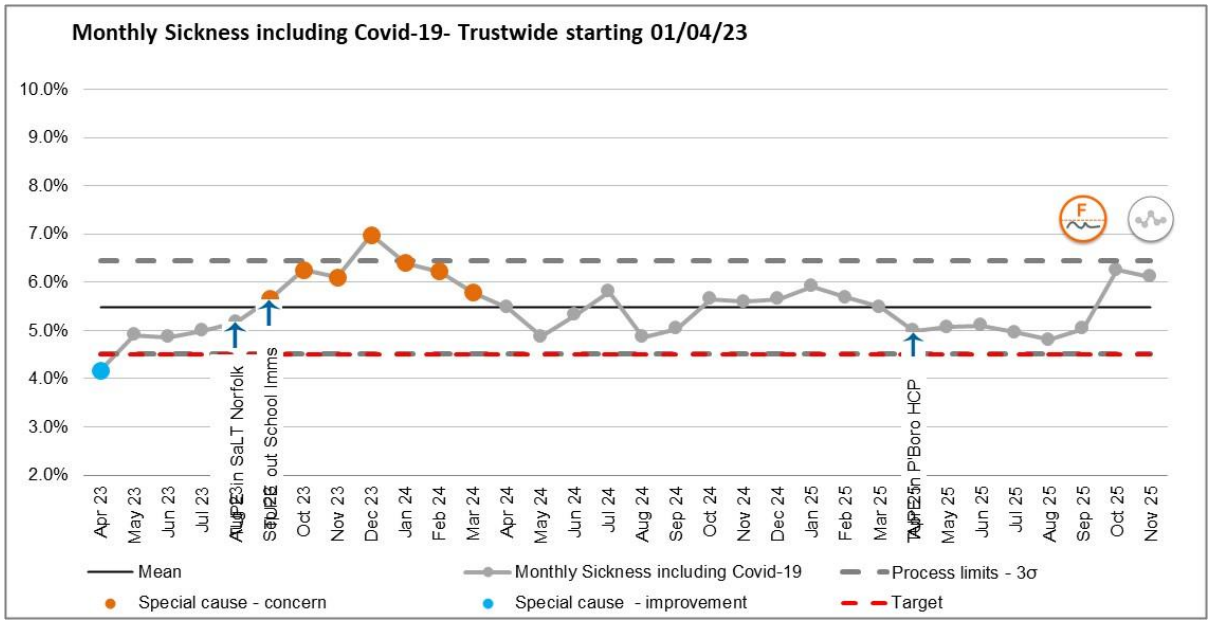
CCS

3.2.1 The 12-month cumulative rolling rate (October 2025 – 5.38%, November 2025 – 5.42%) remains above the Trust rolling target of 4.5%.

3.2.2 Monthly Trust-wide rate for October 2025 was 6.25% and for November 2025 was 6.11%.

3.2.3 The Trust-wide sickness rate has 3.21% was attributed to long term sickness and 2.91 % short term sickness absence. Beds & Luton Adults had the highest sickness rate (7.10%) and Support Services the lowest (1.68%). The top reason Cold, Cough, Flu - Influenza (26.35%); work continues to reduce those absences attributed to unknown/other reasons as much as possible.

3.2.4 The Trust monthly sickness rate is above the September 2025 benchmark reported for NHS Community Trusts (source: NHS Digital Workforce Statistics) which was 5.8 %.

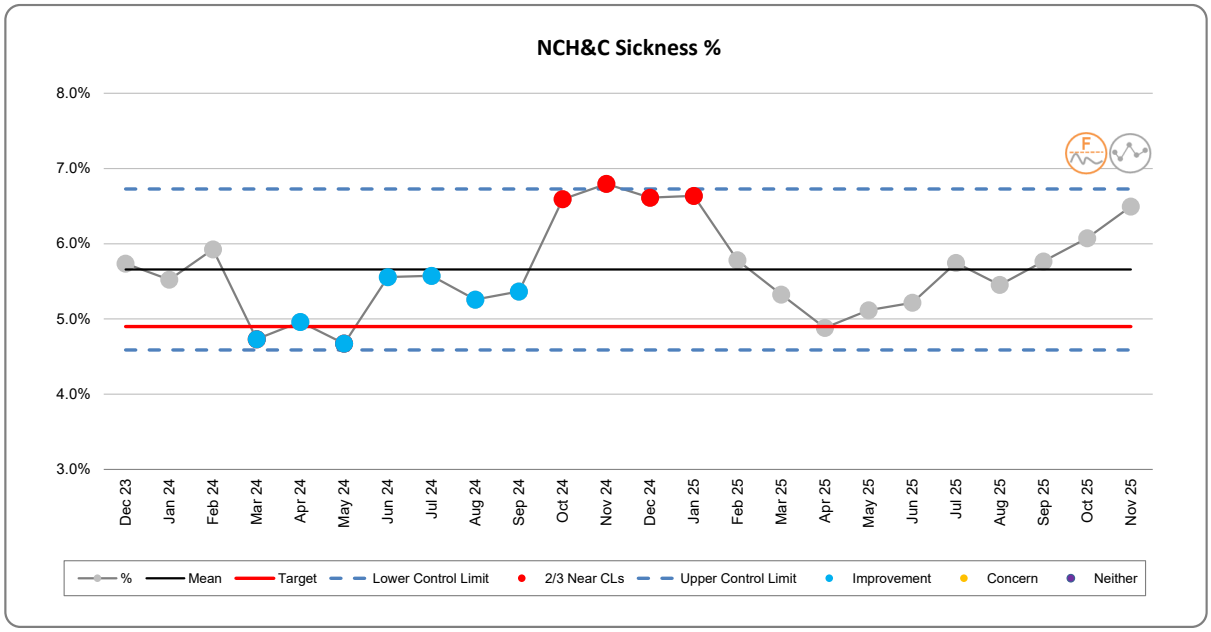


NCHC

3.2.5 The 12-month rolling rate (October 2025 – 5.78%, November 2025 – 5.76%) remains above the Trust target of 4.9%.

3.2.6 Monthly Trust wide rate for October 2025 was 6.07% and for November 2025 was 6.50%.

3.2.7 The Trust wide sickness rate has 3.65% attributed to long term sickness and 2.84 % short term sickness. West Place had the highest sickness rate (7.99%) and Corporate Services the lowest (3.01%). The reason of ***Anxiety/stress/depression/other psychiatric illnesses*** continues to be the highest reason for absence and accounts for 26.9% of time lost.



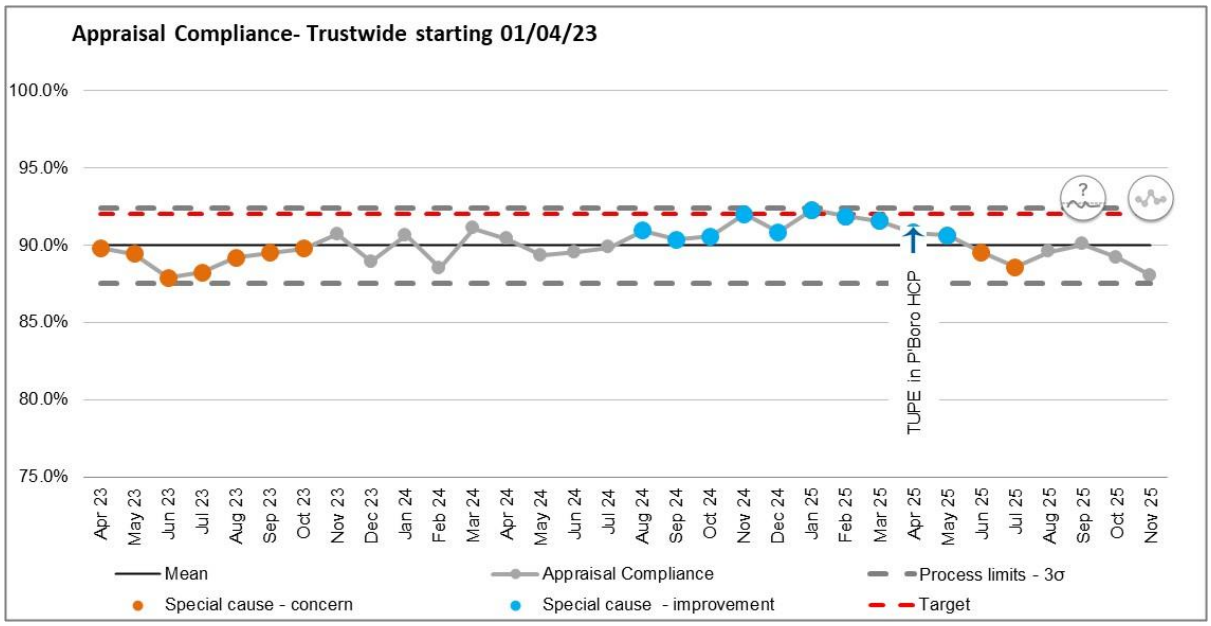
3.3 Appraisal rates across the workforce

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.

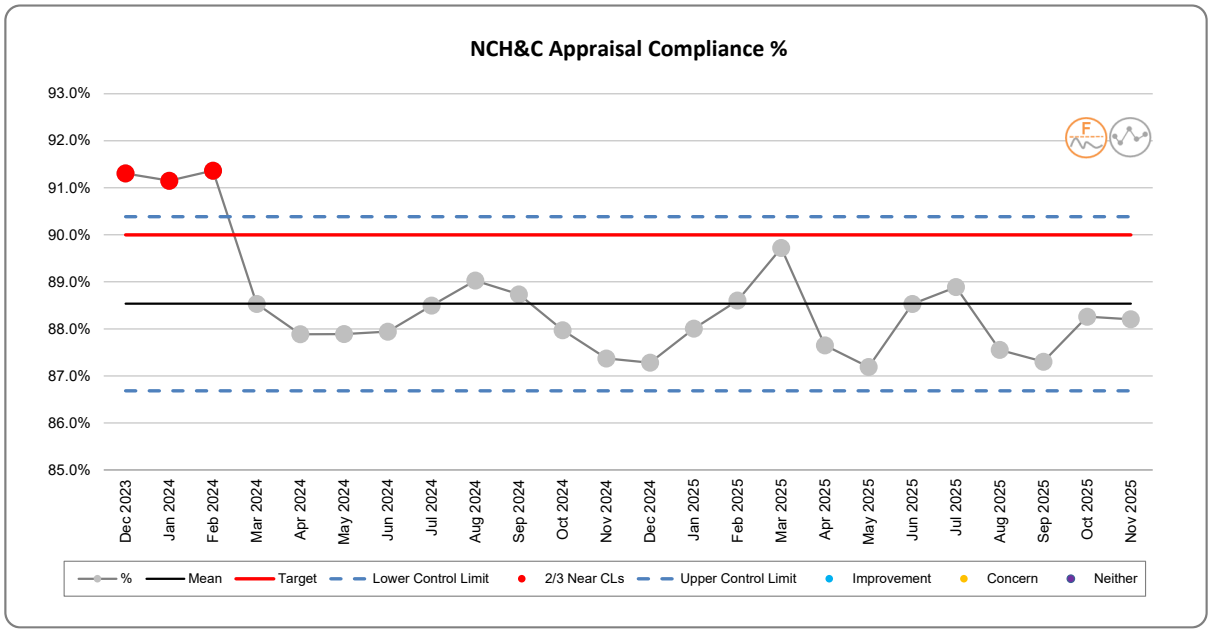
3.3.2 The Trust wide Appraisal rate increased in October 2025 – 89.19% and November 2025 – 88.02%, has reached target of 92% for 2025/26.

3.3.3 Support Services has the lowest rate (68.9%), Luton Children & Young People have the highest rate (92.75%). 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 target. October 2025 – 88.26%, November 2025 – 88.20%.

3.3.6 North Place has the lowest rate (83.13%), C&YP has the highest rate (94.42%).

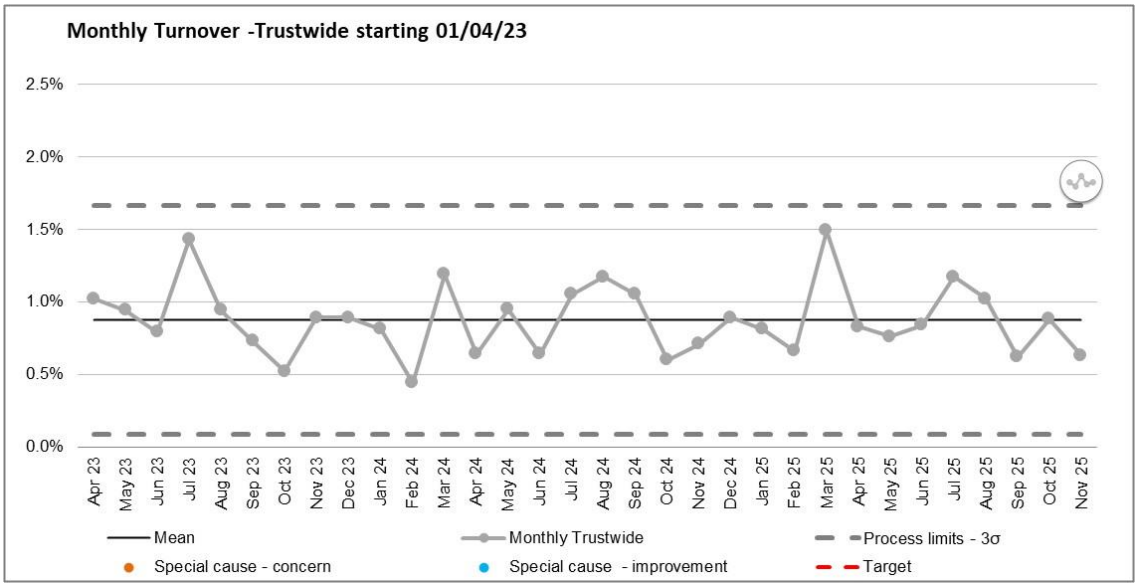
3.4 Turnover rates across the workforce

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 FTC, MARs and Employee Transfers.

3.4.2 The Trust's Rolling Year Turnover Rate is currently 10.88% (October 2025 – 10.95%, November 2025 – 10.88%) compared to an annual average Leaver rate for Community Provider Trusts of 11.1% (Source: NHS Digital Workforce Statistics – September 2025, based on "all Leavers" and "total Workforce").

3.4.3 Luton Children currently has the highest Rolling Year turnover rate at 22.43%, with Support Services having the lowest at 5.85%.

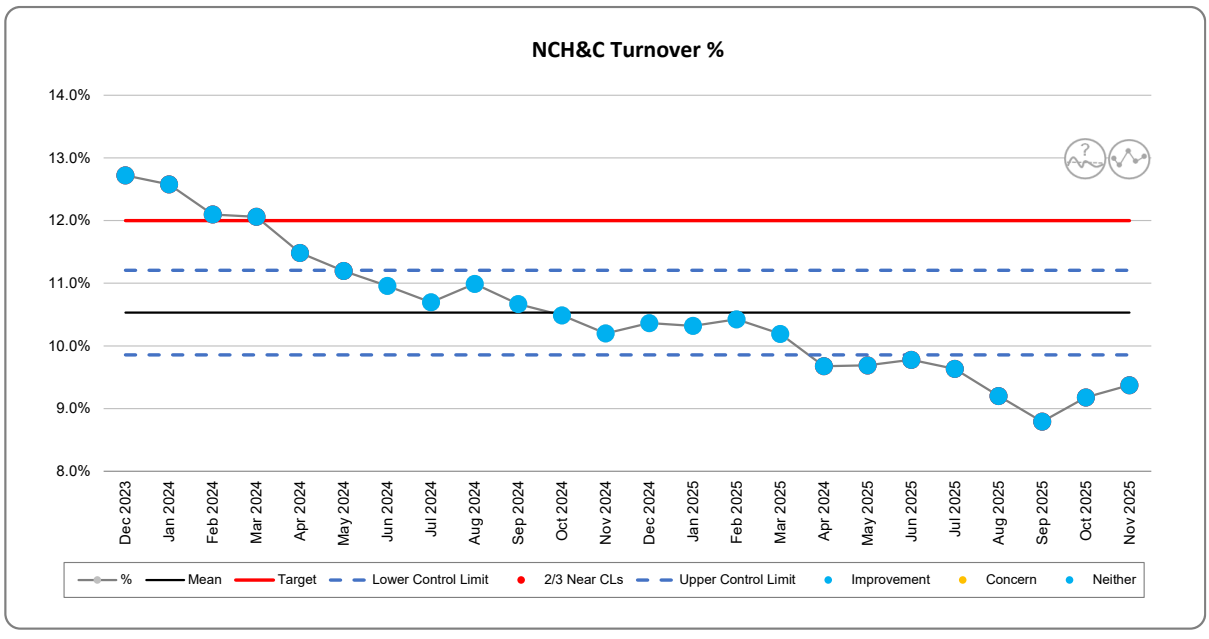


NCHC

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 9.37%, 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 12.55%, with North Place having the lowest at 7.66%.



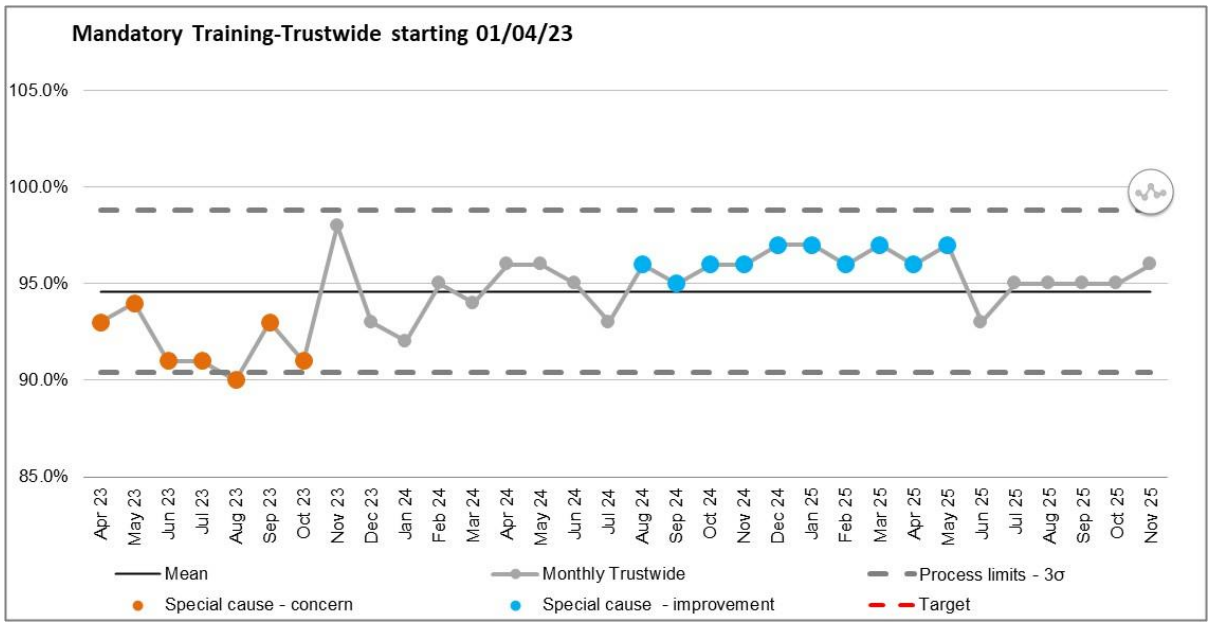
3.5 Overall Mandatory Training levels across the workforce

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.

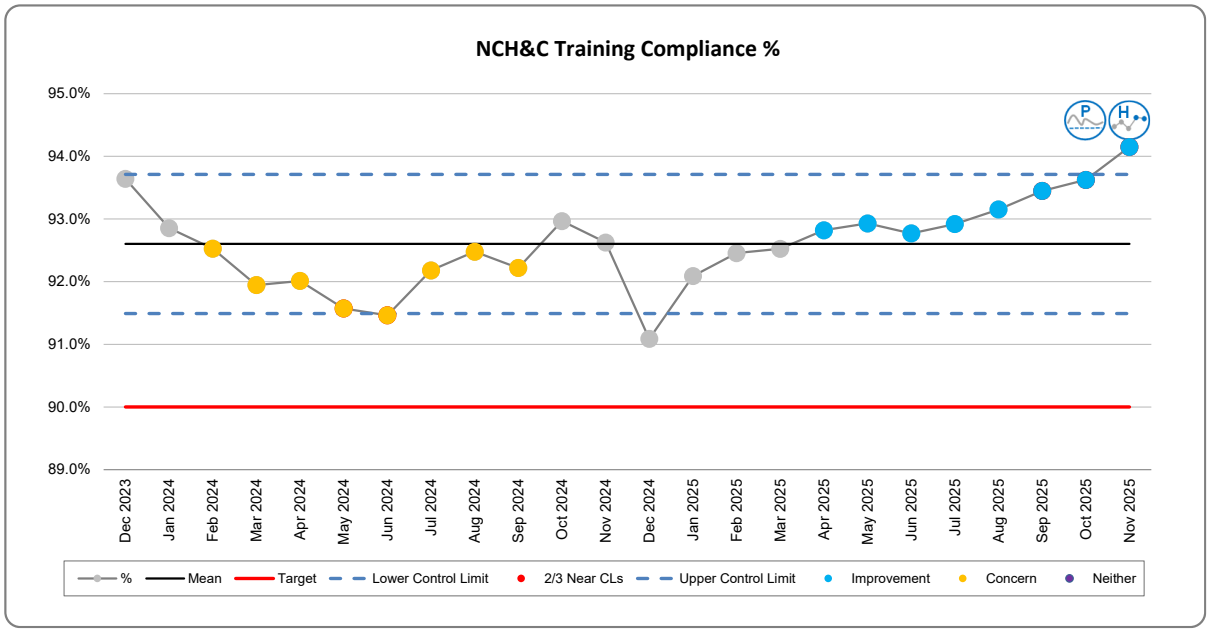
3.5.2 The Trust wide Mandatory Training rate remained stable in October 2025 – 95%, however increased in November 2025 – 96%, has reached target of 92% for 2025/26.

3.5.3 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).



3.6 **National Staff Survey 2025**

The 2025 survey ran from 22nd September 2025 – 28th November 2025. Response rates achieved:

- CCS – 54% (2024 – 61% achieved)
- NCHC – 61% (2024 – 67% achieved)

Results will be shared with the Board at our March 2026 Board meeting.

3.7 **Update on performance against the NHS England – Sexual Safety Assurance Framework**

Both Trust's have signed up to the NHS England Sexual Safety Charter. This charter includes 10 principles and an update on actions taken to address each principle is detailed below.

Sexual Safety Charter principle – Assurance Statement	Actions to taken to support each principle
1. We will actively work to eradicate sexual harassment and abuse in the workplace.	National Policy implemented and promoted across in both organisations.
2. We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.	Board leads agreed – Chief Nurse and AHP Officer (Domestic Abuse and Sexual Violence Lead) and Chief People Officer. All policies and processes promote a culture of openness and transparently and are clear on standards of behaviours expected. Various communications have been shared in relation to supporting our staff. Values and behaviour statements in place in both organisation and our new values and ways of working will be launched and embedded in our new organisation. Discussions with leadership teams and embedded into internal leadership programmes.
3. We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.	Discussions have taken place with staff networks, and these will continue. Sharing of staff survey results and discussions have taken place in relation to this with our leadership teams.
4. We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.	A suite of support is in place in both organisations and bespoke support can be commissioned if required. This includes access and guidance from our safeguarding experts.
5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.	Policy implemented is clear and supportive. Ad-hoc communications take place throughout the year and standards of behaviour shared widely in both organisations and embedded into induction processes.
6. We will ensure appropriate, specific, and clear policies are in place. They will	In place in both organisations and publicised via internal communication routes and all available on the intranet. Human Resources Business

include appropriate and timely action against alleged perpetrators.	Partners raise the profile of these with line managers and individuals regularly.
7. We will ensure appropriate, specific, and clear training is in place.	National e-learning training package promoted, targeted groups have completed this and is available to all. Promoted to line managers as a tool to increase knowledge in this area. We also promote the reading of the policy to all managers.
8. We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.	Embedded in both organisations via datix reporting systems and Freedom to Speak Up systems and processes. This includes being able to report anonymously. Investigations take place in line with people policies as appropriate.
9. We will take all reports seriously and appropriate and timely action will be taken in all cases.	All reports are reviewed and investigated in line with people policies as appropriate. Support put in place for individuals as required, including students and other workers in our organisation.
10. We will capture and share data on prevalence and staff experience transparently.	Staff survey results shared across both Trusts and within teams. Incidents within the Trust are reviewed by Chief Nurse and AHP Officer and Chief People Officer/FTSU Executive Lead and appropriate support put in place.

In addition, NHS England wrote to all Trusts in December 2025 requesting all NHS providers to update their chaperone policies in line with refreshed national guidance. Our Deputy Chief Nurses are taking this review forward, which will culminate in a single policy/approach for our new organisation.

4.0 RESPONSIVE

4.1 **Summary:** Section 4.2 details the waiting list across both organisations in the Group. Waiting time initiatives have now started in all services with 52+ week waits, funded by NHSE England regional tier. 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 NDS waits make up 96% of all waits of 52+ weeks across the Group.

NCHC services at a glance:

The project to improve waiting times in the Norfolk wheelchair services continues to make good progress, as shown in the next page.

3,617 people are waiting over 52 weeks for a service to commence in the NCHC service areas. Additionally, 1,730 people are waiting between 18 and 52 weeks for a service to commence, with the vast majority in one of higher volume services, Musculo-skeletal care.

CCS services at a glance:

5,192 people are waiting over 52 weeks for a service to commence and 94% are those are in community paediatric services across multiple geographies. Additionally, 1,310 people are waiting between 18 and 52 weeks for a service to commence, with 82% of those waits in our Musculo-skeletal service.

The Board can be assured that data, oversight and focus is accurate and focused on finding solutions to our waiting times. The neuro-developmental services do not yet 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. They are developing plans to reduce the waits with includes external agencies.

4.2 **Neurodevelopment waiters update (as of December 2025)**

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.

Number of CYP waiting for their 'Initial neurodevelopmental appointment'				
	Bedfordshire & Luton	**Cambridgeshire**	**Norfolk**	**Groupwide**
0-18 weeks	322	490	228	1040
18-52 weeks	1033	816	487	2336
52-104 weeks	1804	982	1616	4402
104-156 weeks	1992	113	1511	3616
156-208 weeks			440	440
Total	5151	2401	4282	11834

4.3 **Waiting times/Waiters**

In the following tables the services with waiting times challenges based on either, or a combination of, total waiters, low RTT compliance, high levels of 18+ week waiters, 52+ week waiters for both Trusts.

4.3.1 **NCHC services with waiting times challenges:**

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	4282	98.3	N/A	206.4	4054	3567	Nov

Summary narrative:

Over the past reporting period, 206 total waiters have reduced of which 13 were 52+week waiters.

As discussed at the service transformation programme, initiatives underway include the following elements:

- Non-recurrent funding initiative commenced 8th December 2025 will show reduction of 400 longest waits (156+ weeks) in the next reporting period.
- Improved waiting well resources and self-care information on Just One Norfolk
- Implementation of a digital referral form and process
- One day assessments clinics (ODACS) for CYP under 5years old
- 'Fast Track' process for cases received from Specialist Resource Bases (SRB)
- Coproduction with wider system collaborative partners and families of a needs-led model and future neighbourhood health model
- All 18+ young people transferred at the end of October 2025 to ICB-funded adult assessment pathways
- 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	825	20.9	41.8%	133.1	480	50	Nov

Summary narrative:
The Wheelchairs Service comprises two elements, a Wheelchair Assessment service and a Wheelchair Repair service.
The Repair service receives approximately **200** referrals per month and discharges approximately the same.
There are no issues with waiters or waiting times in this element of the Wheelchairs service.

The data in the narrative below only includes data for the Wheelchair Assessment service. The overall caseload within the assessment service has reduced from **1,199** in November to **825** at the end of December (clock stops at equipment handover, not first assessment).

Of the **50** 52+week waiters (down from **82** reported in November), 49 (**98%**) have had a first assessment **27** (**51%**) have appointments booked within the next month, **40** (**75%**) have had appointments cancelled by patient or a DNA, **35** (**66%**) are awaiting equipment handover. To manage the current high caseload, the service continues to prioritise patients according to clinical need and is focusing on building resilience by adapting the skill mix and making effective use of non-registered clinicians.

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 an 18-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)	8631	8.4	89.8%	49.9	779	0	N/A
MSK Services (ECCH)	5946	9.4	90.5%	37.9	567	0	N/A

Summary narrative:
There continue to be high volumes of patients waiting across the NoW MSK service, however the overall waiting position continues to improve since September. There are currently **8,631** waiters within NCHC MSK services and **5,946** within ECCH.

Median waits have remained broadly stable (NCHC currently **8.4** weeks; ECCH currently **8.7** weeks).

RTT performance has improved, with NCHC increasing from **85.7%** to **89.8%** and ECCH increasing from **89.6%** to **90.5%**). Encouragingly, maximum waits have reduced across both services (NCHC: **51.6** to **49.9** weeks; ECCH: **51.3** to **37.9** weeks), alongside a reduction in 18+ week waiters (NCHC: **900** to **779;** ECCH: **697** to **567**).

There continue to be no 52+ week waiters.

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	579	9.9	N/A	624	118	1	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. There has been some mitigation of the Consultant absence with bank sessions from a LTFT Consultant.

Despite the volume of new referrals into the service, the number of waiters has dropped from 800 to 579 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.

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	277	7.4	80.9%	35	53	0	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).

Pulmonary Rehab update:

There are now currently no 52-week waiters (**five** 52+week waiters reported in November), and a firm plan to tackle the capacity gap. This is testament to the hard work of the team.

The recovery plan has not yet been confirmed by the ICB (A £170,000 two-year investment is planned across the Central and West teams) with the aim to increase the capacity of both teams to meet the 12-week wait time target.

Waiting times position for all NCHC services:

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 Service Assurance Committees IGRs. This is the position as of 31/12/2025.

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	4282	98.3	N/A	206.4	4054	3567
Wheelchairs	965	20.3	44.8%	133.1	533	50
Childrens Consultant Outpatients	579	9.9	N/A	624.3	118	1*
Childrens Specialist Continence	83	5.9	94.0%	63.9	5	2*
Childrens Short breaks Home Based	1	89.9	0.0%	89.9	1	1*
					Total	**3617 (61%)**

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

NCHC Service lines with patients waiting 18-52 weeks	Number of Waiters	Median Wait (Weeks)	18 Week RTT Compliance	Max Wait (Weeks)	18+ Week Waiters
MSK Services (NCHC)	8631	8.4	89.8%	49.9	779
MSK Services (ECCH)	5946	9.4	90.5%	37.9	567
Community Therapy	1767	4.0	95.9%	33.1	72
Community Nursing	1707	1.1	99.4%	34.1	11
Bladder and Bowel Routine Nursing	996	4.0	99.5%	21.1	5
Adult Speech and Language Therapy Central	577	8.1	88.6%	28.1	66
Community Dietetics	505	6.3	92.5%	30.4	38
Community Nursing Clinic	494	2.3	96.8%	47.0	16
Pulmonary Rehabilitation	277	7.4	80.9%	35.0	53
Foot Health	252	2.4	99.2%	23.4	2
Discharge to Assess (D2A)	231	1.6	99.6%	19.1	1
Specialist Nursing Neurology	227	5.0	97.4%	39.3	6
Specialist Nursing Heart Failure	210	4.3	97.6%	23.9	5

NCHC Service lines with patients waiting 18-52 weeks	Number of Waiters	Median Wait (Weeks)	18 Week RTT Compliance	Max Wait (Weeks)	18+ Week Waiters
Bladder and Bowel Routine Physiotherapy	203	5.3	99.0%	25.3	2
Lymphoedema	158	8.9	81.0%	26.4	30
Adult Speech and Language Therapy West	148	10.3	78.4%	25.4	32
Colman Centre for Specialist Rehabilitation Services	141	7.9	89.4%	32.9	15
Specialist Nursing Epilepsy	69	3.3	98.6%	18.0	1
Specialist Neurology Team	66	5.4	83.3%	38.9	11
Specialist Nursing TB Service	66	7.6	93.9%	29.4	4
SCSCYP Non NDS Childrens Occupational Therapy	60	6.4	98.3%	18.9	1
SCSCYP Non NDS Starfish	46	6.1	95.7%	38.9	2
ICES Review and Recall	32	2.3	93.8%	36.0	2
Childrens Epilepsy	29	3.9	93.1%	35.1	2
Specialist Nursing Dermatology	24	4.6	91.7%	33.3	2
Prosthetics	21	5.9	95.2%	26.0	1
Rapid Assessment Team QEH	15	3.3	80.0%	22.9	3
SCSCYP Non NDS Childrens Key Working	8	9.1	87.5%	48.4	1
				Total	**1730 (7.5%)**

NCHC Service lines with patients waiting under 18 weeks	Number of Waiters	Median Wait (Weeks)	18 Week RTT Compliance	Max Wait (Weeks)
Specialist Palliative Care Nursing	151	2.1	100.0%	16.3
SCSCYP ADHD Medication Review	119	4.0	100.0%	6.0
Cardiac Rehabilitation	60	1.3	100.0%	7.3
Rapid Response	53	0.1	100.0%	11.7
Post Covid Assessment Service	41	2.4	100.0%	10.0
Specialist Nursing Respiratory	33	2.9	100.0%	11.3
Specialist Nursing Diabetes	31	1.9	100.0%	5.4
Looked After Children	27	4.4	100.0%	14.9
Tissue Viability Service	27	1.9	100.0%	7.3
Community Access Team	24	0.1	100.0%	2.0
Urgent Community Response	23	0.1	100.0%	11.1
Early Supported Discharge Norfolk	10	0.4	100.0%	1.3
Childrens Community Nursing Team	8	4.4	100.0%	15.4
ICC Bed Management	5	0.1	100.0%	7.9
Childrens OT Non NHS	3	1.9	100.0%	5.0
Environmental Controls	3	5.0	100.0%	8.9
High Intensity Users	2	6.3	100.0%	12.3
Community IV Therapy	1	0.1	100.0%	0.1
SCSCYP Non NDS Starfish Plus	1	2.4	100.0%	2.4

4.3.2 **Five services with longest waiters in CCS** (Data as at 31/12/2025)

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	2705	93.0	N/A	171.0	2579	2103	Nov
Luton Community Paediatrics	2447	87.0	N/A	154.0	2251	1694	Nov

Summary narrative:

All Children are clinically triaged upon receipt of referral, no backlog for triage at present. The service is assured any clinical risk factors are reviewed at this stage.

Since August 2025, the longest wait has been reduced by 13 weeks. The median wait has increased slightly due to a high number of referrals accepted during early 2023.

Since November a number to measures have been introduced to reduce waiting times in the Community Paediatric Service, including:

- Validating the waiting list and has introduced of weekly patient level review meetings chaired by the Director of CYP services and Head of Service.
- Increased medical capacity through revised job plans and increased scrutiny of clinic cancellations, and changes.
- The new early awareness approach, in collaboration with the Local Authorities, is resulting in a reduction in referrals being received.
- A new Nurse and Speech and Language Therapist led diagnostic pathway for attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD). The new pathway has been successful for a small number of CYP to date and will release medical capacity to focus on children with more complex clinical presentations.
- Additional Consultant and clinical Nurse specialist posts are being advertised to further increase capacity within the service.

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	2401	47.0	N/A	136.0	1911	1095	Nov

Several 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 through the optimisation of digital dictation and job planning
- A short-term (Jan–March 2026) skill mix pilot is underway to see 200 children who have waited 104 weeks+ for an assessment. With the non-recurrent financial support of NHSE, we have engaged an independent provider to support this. We are scoping further sustainable solutions, which will require additional funding.
- 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 a 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. A Community Appointment Day is planned for East Cambridgeshire in March 2026, and families currently waiting from this area (circa 250 children) will be invited.

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 Paediatric Audiology	1083	21.0	N/A	81.0	588	99	Nov

Several 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 through the optimisation of digital dictation and job planning
- A short-term (Jan–March 2026) skill mix pilot is underway to see 200 children who have waited 104 weeks+ for an assessment. With the non-recurrent financial support of NHSE, we have engaged an independent provider to support this. We are scoping further sustainable solutions, which will require additional funding.
- 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 a cost/benefit analysis.
- Deputy Service Director working with the ICB regarding audiology capacity across the ICB.

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	288	37	38.9%	146.0	176	71	Nov

Since November, we have undertaken several initiatives to reduce our waiters:

- Obtained an additional three theatre lists in December, which allowed us to close a further nine waiters.
- Completed a data cleansing exercise and provided refresher training to admin staff on waitlist management.
- Negotiating additional theatre lists with NWAFT to secure midweek and weekend sessions where resourcing and theatre space allow, and we have a bi-weekly touchpoint with NWAFT to secure any spare theatre lists identified.
- Our longest waiter has reduced from 152 weeks to 146 weeks; however, our longest waiters are not always the most clinically urgent.
- We have benchmarked our productivity against a similar community service dental model, and our throughput is in line with theirs.
- We have also established that neighbouring private hospitals are not able to provide the facilities we need for this patient group.

Looking forward, a proposal has been submitted to the ICB for funding to secure additional theatre lists and workforce, which is being considered at their governance board in late January. This includes a proposal to reduce referrals into the service, which would reduce the number of patients converting to GA.

Waiting times position for all CCS services:

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 Service Assurance Committees IGRs. This is the position as of 31/12/2025.

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 Adult Dietetics	491	17	51.7%	85	237	47
Beds Community Paediatrics	2705	93	N/A	171	2579	2103
Beds Eye Service	379	10	73.1%	57	102	4
Beds Paed SaLT	890	8	84.3%	56	140	1
Cambs Community Paediatrics	2401	47	N/A	136	1911	1095
Cambs Dental GA (Cambridge)	49	18	57.1%	73.0	21	1
Cambs Dental GA (Peterborough)	288	37	38.9%	146.0	176	71
Cambs Dental SCD and DOM	1497	22	41.6%	53.0	874	4
Cambs Paed Dietetics	563	16	56.1%	82	247	72
Luton Community Paediatrics	2447	87	N/A	154	2251	1694
Luton Paed Audiology	1083	21	N/A	81	588	99
Norfolk Paed SaLT	879	7	91.1%	74	78	1
					Total	**5192 (38%**

CCS Service lines with patients waiting 18- 52 weeks	Number of Waiters	Median Wait (Weeks)	18 Week RTT Compliance	Max Wait (Weeks)	18+ Week Waiters
Beds Paed Occupational Therapy	38	10	71.1%	34	11
Beds Paed Dietetics	328	14	64.6%	46	116
Cambs Dental MOS	860	7	97.8%	28.0	19
Cambs Dynamic Health (Physio and Pelvic Health)	9640	9	88.9%	42	1073
Cambs Dynamic Health (Specialist)	2632	6	98.8%	33	32
Cambs Paed Audiology	276	7	N/A	31	20
Cambs Paed Occupational Therapy	161	7	97.5%	29	4
Cambs Paed Physiotherapy	47	3	91.5%	20	4
Suffolk Dental MOS	535	8.0	94.6%	31.0	29
Suffolk Dental SCD and DOM	278	4.0	99.3%	20.0	2
				Total	**1310 (9%)**

CCS Service lines with patients waiting under 18 weeks	Number of Waiters	Median Wait (Weeks)	18 Week RTT Compliance	Max Wait (Weeks)
Beds ABI	8	3.5	100.0%	4
Beds Neuro Rehab	28	5	100.0%	13
Cambs ME/CFS	10	4	100.0%	10
Cambs Paed SaLT	438	5	100.0%	16

CCS Service lines with patients waiting under 18 weeks	Number of Waiters	Median Wait (Weeks)	18 Week RTT Compliance	Max Wait (Weeks)
Luton Heart Failure Service	14	2	100.0%	11
Luton Integrated Community Diabetes Service	59	0	100.0%	16
Luton Pulmonary Rehab	26	2	100.0%	10
Luton Respiratory Service	16	5	100.0%	9
Luton Tissue Viability Service	9	1	100.0%	11
Suffolk Dental GA	31	8.0	100.0%	16.0

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 October and November and NCHC achieved 96% 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 November 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	115,213	114,268	(945)	173,361	170,643	(2,718)	
Pay	(84,919)	(85,850)	(931)	(126,674)	(128,011)	(1,337)	
Non-Pay	(31,022)	(29,720)	1,302	(46,662)	(43,600)	3,062	
Non-operating	(589)	19	608	(959)	(18)	941	
Accounting surplus / (deficit)	**(1,317)**	**(1,284)**	**33**	**(934)**	**(986)**	**(52)**	
Accounting performance adjustments	648	692	44	934	986	52	
Adjusted financial surplus / (deficit)	**(669)**	**(591)**	**77**	**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	(808)	(269)	539	(1,222)	(504)	718	Yes
Bank spend	(2,939)	(3,876)	(937)	(4,443)	(5,818)	(1,375)	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	118,245	120,572	2,327	177,366	179,862	2,496	
Pay	(83,840)	(84,397)	(557)	(125,760)	(126,602)	(842)	
Non-Pay	(32,253)	(34,388)	(2,135)	(48,378)	(50,641)	(2,263)	
Non-operating	(2,152)	(1,746)	406	(3,228)	(2,619)	609	
Accounting surplus / (deficit)	-	-	**41**	-	-	-	
Accounting performance adjustments	-	-	-	-	-	-	
Adjusted financial surplus / (deficit)	-	-	41	-	-	-	Yes
Efficiencies							
Recurrent	3,836	4,098	262	6,180	5,057	(1,123)	
Non-Recurrent	1,616	1,716	100	2,420	3,543	1,123	
Total Efficiencies			362			-	Yes
Temporary staffing expenditure							
Agency spend	1,040	672	368	1,560	1,010	(550)	Yes
Bank spend	968	1,006	(38)	1,452	1,510	58	Yes

Commentary

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

5.2.2 The cash balance position on 30 November was:

- NCHC had £42.0m of cash. This is £1.2m above plan and represents 3.1 months of operating cash outflows.

- CCS had £3.1m of cash. This is £4.0m below plan and represents one week of operating cash outflows. This is predominately due to timing of receipts, with £6m received at the beginning of December which has brought back the cash balance into plan. 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 £0.5m (67%) and CCS by £0.4m (35%). However, staff bank expenditure is above plan in NCHC by £0.9m (32%). 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: £2.4m, which is £2.8m behind plan due to delay in the Rackheath lease (Community nursing relocation), this is expected to be signed before year end.
- CCS: £2.6m, which is £1.6m behind plan. The two leases originally planned for signing (both Norfolk sites) are now unlikely to proceed as intended, with a shorter term preferred while estate opportunities with NCHC sites is underway.

5.3 The Group efficiency target for 2025/26 totals £17.4m (NCHC £8.8m and CCS £8.6m), with £10.9m delivered to end of November (63%). 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.

Financial Plan - Key Risks at 30 November 2025

Rating	BAF Risk	Risk description	Mitigations
High	3708	A low cash balance in CCS of £3.1m. This is £4m below plan and represents one week of operating cash outflows.	£6m received within 5 days on month end. Creditor payments are being managed, with changes to the age at which an invoice is paid. BPPC performance is at 82%. Focused efforts continue to recover aged debt including from local authority contracts.
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.	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 £0.9m (32%).	No mitigations being taken on bank spend. Focus has been on reducing agency expenditure, which is £0.5m below plan. NHS England has confirmed that overspends on bank staffing will not be penalised provided the overall financial plan is delivered.

National Cost Collection

5.4 NHS England has released the 2024/25 National Cost Collection results. The main measure used is the National Cost Collection Index (NCCI), which compares provider costs nationally (average = 100). Costs are adjusted using the Market Forces Factor to reflect regional cost differences.

5.5 For 2024/25:

- **NCHC scored 101** (up from 96 in 2023/24), indicating costs broadly in line with the national average.

- **CCS scored 112** (up from 93 in 2023/24), moving from below- to above-average cost levels. The results were influenced by missing activity and larger national cost reductions, while Audiology's score fell from 162 to 94 due to corrected cost allocations, and non-consultant led outpatients rose from 36 to 96 following correction of an inaccurate prior-year figure. In addition, significant CCS activity (including iCaSH and community dentistry) is excluded from the NCCI, making the cost base look higher.

5.6 Because community services have only had four years of mandatory reporting, data quality and comparability still require national improvement. As part of the Trust merger, both organisations will work to align their reporting methods for activity and cost.