

Our story

Our people

Annual Report

2025/2026





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Our mission

Our values

Our objectives

- Improve the health and wellbeing of people across the diverse communities we serve.
- Honesty
- Empathy
- Respect
- Ambition
- Provide outstanding care
- Be an excellent employer
- Be collaborative
- Be sustainable

Strategic objectives	It is our ambition that by 2026:
Provide outstanding care	1. Our services are inclusive and easy to access
	2. Our services are innovative and drive improvements in outcomes for people
	3. Our services support good health and help prevent ill health
Be collaborative	4. All our services are tied into formal partnerships that improve outcomes for local people
	5. We always involve people from our local communities to help us improve our services
	6. We are leading care collaboratives in each of the systems we work within
Be an excellent employer	7. Our people feel valued and can realise their full potential
	8. Our people embrace diversity and promote an inclusive culture that challenges all forms of discrimination
	9. In meeting the needs of our services, our people can balance their work and personal commitments and are trusted to work flexibly
Be sustainable	10. We are financially resilient and support our people in developing and improving our services
	11. Our main sites have a community value and usage plan in place
	12. We take positive action to reduce the environmental impact of our services

Our services

	Bedfordshire	Cambridgeshire	Luton	Norfolk	Peterborough	Suffolk	Milton Keynes	Essex
Adult services								
District nursing/community matrons			X					
Specialist nurses/long term conditions			X					
Neurorehabilitation	X							
Specialist services								
Community dental services, dental access centres and minor oral surgery	Oral health promotion only	X		Minor oral surgery	X	(Excluding DAC)		Supervised tooth brushing in early years only
Musculoskeletal services		X			X			
Sexual health and contraception services	X	X		X	X		X	
HIV services	X	Huntingdonshire		X	X			
Children's services								
Health visiting	X	X	X	X	X			
School nursing	X	X	X	X	(from April 25)			
Therapies	X	X		Speech and language therapy				
Community nursing	X	X	X					
Audiology	X	X	X					
Community paediatricians	X	X	X					
Children's rapid response	X		X					
Family nursing partnership		X		X	(from April 25)			
Emotional health and wellbeing service		X		X	X			
Continuing care	X		X				X	

Our portfolio of services in 2025/26 was provided from the following main sites, as well as from GP surgeries and health centres, community settings such as schools, children's centres and people's own homes:



- Bedfordshire: The Child Development Centre and Kings Brook in Bedford, Grove View in Dunstable and a range of community-based facilities.
- Cambridgeshire: Brookfields in Cambridge, Doddington Hospital, Princess of Wales Hospital in Ely, North Cambridgeshire Hospital in Wisbech, Oak Tree Centre and Hinchingbrooke Hospital in Huntingdon.
- Luton: Luton Treatment Centre, Redgrave Children and Young People's Centre and a range of community-based facilities.
- Milton Keynes: South Fifth Street.
- Norfolk: Breydon Clinic in Great Yarmouth, Oak Street Clinic in Norwich, Vancouver House in King's Lynn and a range of community-based facilities.
- Peterborough: City Care Centre, Midgate and Kings Chambers and a range of community-based facilities.
- Suffolk: Nash House in Ipswich, Hillside in Bury St Edmunds, Newmarket Community Hospital and a range of community-based facilities.

Chair and Chief Executive's welcome

This Annual Report marks an important moment in our history, as it will be the final report we publish as Cambridgeshire Community Services NHS Trust (CCS). From 1 April 2026, our people and services will join with Norfolk Community Health and Care NHS Trust (NCH&C) to form the East of England Community Health and Care NHS Trust (EEC).

As we look back, we do so with real pride. Over the past year - and throughout our wider history - we have remained unwavering in our focus on compassionate, high-quality care. That same commitment will guide us as we move into the new organisation.

The most important measure of quality is always the experience of the people we serve. It is therefore extremely encouraging that once again service users have provided highly positive feedback, with 95.09% telling us they would recommend our services to a friend or family member.

Our staff feedback is equally powerful. I am pleased that our latest staff survey shows 84% of colleagues would recommend CCS to their own friends and family for care - the highest rating for a community trust nationally.

This year also saw the publication of the 10-Year Health Plan. Its ambitions - shifting from hospital to community care, from sickness to prevention and from analogue to digital - mirror our own. As leaders in community health, we see strong opportunities to support this "Fit for the Future" agenda both within our services and across the system, and we are actively developing new ways to help deliver these shifts for our communities.

Financially, the environment remains challenging across the NHS, and CCS has been no exception. Despite this, our teams have identified and delivered efficiencies that have helped us reach a positive position. We will close the year with a financial surplus of £1.656m.

This report (and our Trust websites) highlights many achievements from the past year. A few examples include:

- **Adult services:** Our rapid response and virtual ward programmes continue to expand, helping more people receive safe, effective care at home and avoid unnecessary hospital admissions.
- **Children's services:** We have supported local families through initiatives such as Baby Week, raising awareness of baby safety and early development.
- **Physiotherapy innovation:** A trial using AI has improved patient experience and significantly reduced waiting times. We have also introduced community assessment days, bringing together physiotherapists, rehab instructors and other specialists to help people manage pain and long-term conditions.
- **Sexual health services:** We welcomed new colleagues from the Terrence Higgins Trust, broadened our treatment offer and expanded outreach, enabling us to support more people across our communities.
- **Improving access:** Our services continue to meet people where they are - for example, dental teams spending time with families with additional needs to build confidence in accessing care, and physio teams working with the Islamic community in Peterborough to support health and improve access to services.



Every service has countless examples of excellent practice, and I wish I could showcase them all. I want to offer my heartfelt thanks to our staff and volunteers, whose dedication makes our services so caring, compassionate and effective.

As we transition into the new Trust, our commitment to outstanding, person-centred and continually improving care will remain at the heart of everything we do. We look forward to working closely with our patients, partners and communities as we embrace the opportunities ahead and strive to make an even greater difference for the people we serve.



Matthew Winn
Chief Executive



Lynda Thomas
Chair



Overview

This overview provides a summary of the Trust's background, service portfolio, income, aims and aspirations, as well as our approach to risk management.

We became a community NHS Trust in England on 1 April 2010 and were established under sections 25(1) and 272(7) of, and paragraph 5 of Schedule 4 of the National Health Service Act 2006 (Establishment Order 2010 no. 727). We report under the Accounts Direction determined by the Department of Health (Secretary of State) and approved by the Treasury. The Accounts Direction is made under the following legislation: National Health Service Act 2006 c. 41 Schedule 15: Preparation of annual accounts. The Trust Board is accountable to NHS England. We provide health services for people across the East of England, in people's homes and neighbourhoods, to support them to live healthier lives.

We do this in partnership with individuals, their families and carers, and with health, care and educational providers, preserving good health as well as responding to ill health. We are proud to provide outstanding quality services that meet the needs of our diverse communities in an accessible way, closer to home, giving people more choice and control over their health and wellbeing. During 2025/26, the Trust received its funding through integrated care boards (ICBs), NHS England and local authorities, which totalled £***million.

Many of our services are provided at a regional level and are focused on preventative care, funded by public health commissioners.

Our work is characterised by collaboration with other NHS and care providers, working together in integrated models of care for adult and children's services.

In line with the NHS Long Term Plan, the work we undertake supports the NHS to prevent ill health, support a growing older population, deal with the increasing level of obesity and manage the complexity of care required to support people to live independently in community settings.

This report sets out our many achievements over the last 12 months, focusing on how we have successfully improved existing services and introduced innovation, in line with our aim to deliver services that:

- Are locally accessible - provided close to or in people's own homes
- Are provided to the highest standard by skilled and compassionate staff
- Promote good health and the prevention of ill health
- Reduce inequalities and ensure equity of access
- Are integrated across health and social care boundaries
- Are focussed on maximising an individual's potential and independence.

The Trust will work with the integrated care systems and local authorities - including through upcoming changes - to support the achievement of local plans and joint forward plans.

The Trust can be affected by a variety of financial, clinical, operational and regulatory risks and uncertainties. The organisation's risk management strategy clarifies responsibility for the identification, assessment and management of risk throughout the Trust. The Board retains ultimate responsibility for the Trust's risk management framework, and a formal risk management system is in place, to identify and evaluate both internal and external risks. The Board's audit committee regularly reviews strategic risks. Service and localised risks on the risk register are reviewed by other Board subcommittees. Further information on risk management procedures is provided within the annual governance statement on page **. The narrative in the following performance report meets all the requirements and disclosures of strategic reports as required by the Companies Act 2006.

Strategic objective 1 - Provide outstanding care

High assurance - There is strong evidence that we are consistently delivering high-quality, person-centred care. This is supported by performance data, patient feedback and ongoing improvement work. While there are some differences between services, there are clear systems in place to monitor quality and keep improving.

Provide outstanding care: The context for future working

Continued change is expected across the health and care landscape. Regional and national reforms are reshaping how services are planned and delivered, and we will adapt proactively to ensure continuity and quality of care.

Key upcoming changes include:

- We will be joining with Norfolk Community Health and Care NHS Trust on 1 April 2026 to form our new Trust, East of England Community Health and Care NHS Trust. By joining together, we can strengthen our resilience, expand our skills and resources, and deliver the kind of innovative, responsive community health and care our region needs.
- Nationally, there is a focus on progressing the NHS Long Term Plan, with particular emphasis on moving care closer to home, prevention, digital innovation and workforce development. We will continue to align our strategies and service development programmes with the priorities set out in the NHS Long Term Plan and its delivery frameworks.
- Integrated Care Boards (ICBs) will be changing to reduce their number in our geography and will be shifting to become strategic commissioners with a focus on improving population health, reducing health inequalities and ensuring access to high-quality care. As these changes take effect, we will be looking to support colleagues in our health systems and understand how we can support patients and progress our shared priorities.
- Local authority restructuring will impact community services, commissioning arrangements and partnership models. We will work closely with new and existing structures to maintain strong relationships, align with shifting responsibilities and ensure services remain joined up for the people we serve.

This evolving context presents both challenges and opportunities, and we are committed to staying agile, collaborative and forward-looking to support the needs of our communities.



Our strategic priorities

From April 2026 we will begin delivery of our new Clinical and Care Strategy which has four key strategic priorities.

Priority 1: Putting people in control of their care

1. People will be able to digitally directly book, cancel and amend their appointments with us.
2. Anyone who has care provided by us will be a partner in defining their own care plan and have a digital copy of their live care plan, which can be shared with those they nominate.
3. For those expecting a home visit or attending a clinical appointment, patients will have real time information about their appointment, (including if on a waiting list, when their care will start), in a format that meets their needs.
4. All of those receiving complex care will have their own care preferences set out and include the risks they are willing to take with their own care and support.
5. Develop and implement needs identification tools for professionals and users of our services to use.
6. We will enable and use intelligent and focused remote monitoring, linked with our patient portal and patient record.
7. Patients will have outcome measures developed with them and shared in real time.
8. For people who struggle with technology, we will ensure equity of access to our services.

Priority 2: Valuing our Colleagues

1. Through expert workforce planning, we will plan for both our short term and longer-term people needs using strategic intelligence, skills and competency mapping.
2. We will create accessible, flexible career pathways and training routes to join and progress in the workforce.
3. We will strengthen the data and digital literacy of our workforce.
4. We will ensure protected time for learning for all and build upon our culture of quality improvement and research and continue to build our capability in these areas.
5. As an anchor institution, we will offer good quality jobs and support local work experience and recruitment.
6. We will extend our advanced practice roles, often in partnership with other organisations.
7. We will embed a culture of inclusiveness, ensuring a welcoming environment where everyone feels valued.
8. We will invest in the health and wellbeing of our workforce, making the Trust a place where people want to work.
9. We will improve the working environment of our teams and the equipment they use.
10. We will recognise and celebrate success across our teams.



Our priorities for the future

Our strategic priorities

Priority 3: Working in partnerships

1. Use our estate to develop community neighbourhood health campuses enabling collaboration and shared use by multiple health and care providers, supporting the shift towards community and primary care-based services.
2. In partnership with like-minded, high performing, innovative providers, develop:
 - o Electronic patient record(s) that is fit for modern day usage.
 - o Common data definitions and reporting for all service areas.
 - o Data systems that provide greater insights and intelligence about the needs of our communities and the care we provide.
3. Implement a new model for moderate or severely frail people to support them to be as healthy as possible in partnership with primary care, councils and the voluntary sector.
4. With educational, social care and voluntary sector organisations, develop a children and young people neighbourhood care and support model.
5. With council partners, develop sustainable models to optimise our approach for those supported at home on discharge from acute hospitals and reduce the use of bedded care pathways.
6. Develop a new model with hospice partners using end-of-life funding (fast track).
7. To support hospital level care at home in all geographies, we will train, recruit and rotate our clinical staff with health partners to enhance joint working and keep skills up to date for our clinicians.
8. We will work in partnership with academic institutions and industry to deliver high-quality research, education and training.

Priority 4: Innovating and transforming our organisation

1. Agree with our strategic NHS commissioners how the Trust can have greater role to lead pathways and/or population health groups (all ages).
2. Expand our quality improvement and research teams to lead changes in care delivery.
3. Implement a digital architecture that allows patients to communicate with us and manage their care with ease, supported by a single patient record and the full use of the NHS app across all our services.
4. Develop greater capabilities and experience to manage medicines and pharmacy management/ drug distribution for our services to support all of our care delivery.
5. Strengthen and modernise our electronic patient record capabilities across the organisation.
6. Develop and use data insights to ensure we can prioritise those with greatest health inequalities.
7. Create an AI and automation centre of excellence that drives rapid innovation, embeds innovative technologies into services, and empowers our workforce with the skills and tools to transform care.
8. Take greater financial risk to support investment in meeting health and care needs of the community.



Our priorities for the future

Our service priorities

We will also be focusing on four service priority areas.

1. Best start in life

School readiness

- Ensuring children reach developmental milestones by age 5.
- Early years interventions (speech and language, social/emotional development, evidence-based parenting programmes).
- Health visiting and family support services with early help and pre-school providers.
- Narrowing gaps in readiness between disadvantaged children and other children.

Adverse childhood experiences and trauma-informed care

- Early identification and intervention for children experiencing trauma, abuse, neglect or other forms of adverse childhood experience.
- Training workforce across health, education, and social care in trauma-informed approaches.
- Prevention programs targeting families at risk.

Children and young people neighbourhood care and support

- Needs identification tool available to parents, carers and teachers to promote early access to advice, guidance, self-care and further support.
- Integrated multi-agency teams organised around neighbourhood, including education, social care and voluntary sector organisations.
- Implementation of patient portal and 'request for support' technologies.
- Joined-up data to support proactive individual care and population health planning.

2. Support for children and young people with complex needs

Centre of excellence for neurodevelopmental conditions

- Improved pathways for autism and ADHD assessment and diagnosis.
- Integrated education, health and social care with specialist multidisciplinary teams.
- Reducing waiting times for neurodevelopmental assessments to below 18 weeks.

Regional centre for neuro-disability

- Specialist services for children with cerebral palsy, epilepsy, brain injuries and other neurological conditions.
- Multidisciplinary assessment and treatment in conjunction with hospital tertiary centres.
- Equipment and technology provision, including respiratory and ventilation expertise.
- Dental, visual and audiological expertise for children with complex needs.
- Transition planning to adult services.

3. Neighbourhood Care

Transform support for those living with moderate/ severe frailty

- Proactive identification using frailty indices.
- Comprehensive geriatric assessment in community settings.
- Falls prevention, medication reviews and social prescribing.
- Coordinated care planning to prevent hospital admissions in all care homes.



Our priorities for the future

3. Neighbourhood Care cont.

Proactive care for people with multiple long-term conditions

- Case finding, predictive analysis and risk stratification.
- Multidisciplinary team support with partners in primary care/ networks in neighbourhood teams.
- Personalised care plans, self-management support and health coaching, including ensuring that people living with HIV are healthy and well.

Exemplary end of life care

- Early advanced care planning conversations, digitally recorded and shared.
- Coordinated palliative care across community, primary, secondary and hospice care.
- 24/7 specialist advice and rapid response.
- Supporting more people to die in their preferred place.
- Integrate 'continuing health care' in mainstream partnerships with hospice providers.

4. Unscheduled Care

Hospital at home

- Hospital level capability delivered at home as a default for frail older people.
- Virtual wards and urgent response services working with remote digital monitoring.
- Supported by community nursing, therapy, pharmacy and medical teams.
- Use of new digital advances to facilitate home care.

Multi-agency hub in each geography

- Integrated urgent care access point.
- NHS 111, out-of-hours GP, ambulance service, mental health crisis and social care coordination.
- Flow navigation to prevent unnecessary emergency department attendance, using same-day emergency care where appropriate

In delivering our priorities and service priorities, we will be working to ensure we are maintaining financial and operational sustainability.



Our priorities for the future

We are proud that the CQC rated our services 'outstanding' in August 2019 following their inspection in spring 2019. No Trustwide inspection visits have taken place in 2025/26; however, we continue to engage and support our system partners with any inspections that are undertaken across our geography.

Cambridgeshire Community Services NHS Trust has participated in these system reviews:

- Ofsted inspection of Peterborough Children's Services in April 2025 and Central Beds Children's Services in March 2025.
- ILAC inspection in Luton in January 2026

Overall rating for this trust		Outstanding ☆
Are services safe?	Good ●	
Are services effective?	Good ●	
Are services caring?	Outstanding ☆	
Are services responsive?	Good ●	
Are services well-led?	Outstanding ☆	

Our approach to reviewing and ensuring our services are Safe, Caring, Effective, Responsive and Well Led, continues to adapt and grow. In 2025/26 we have focussed on several areas, which have included:

Safe:

- Developing our approach to manage violent and aggressive incidents against our colleagues.
- Developing a new model of safeguarding training and embedding our supervision framework.

Caring:

- Focussing on our approach to co-production and hearing the patient's voice.
- Having a continued focus on staff wellbeing.

Effective:

- Improving our audit outcomes and performance year on year.
- Developing our approach to the Accessible information Standard.

Responsive:

- Supporting individual teams to develop their own approach to reducing inequalities through engagement and service led activities.
- Reviewing our use of the Friends and Family test and adding in questions around dignity and compassion.

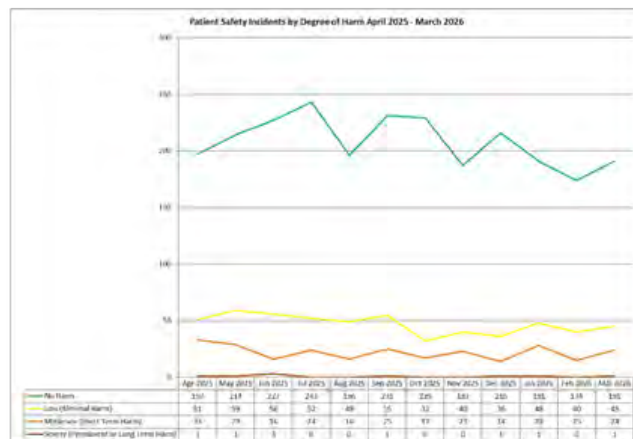
Well Led:

- Co-producing with colleagues and communities a new vision and clinical and care strategy as we move towards becoming a new organisation.
- Ensuring we have a robust freedom to speak up process, so no one is afraid to share their story.

Patient safety incidents

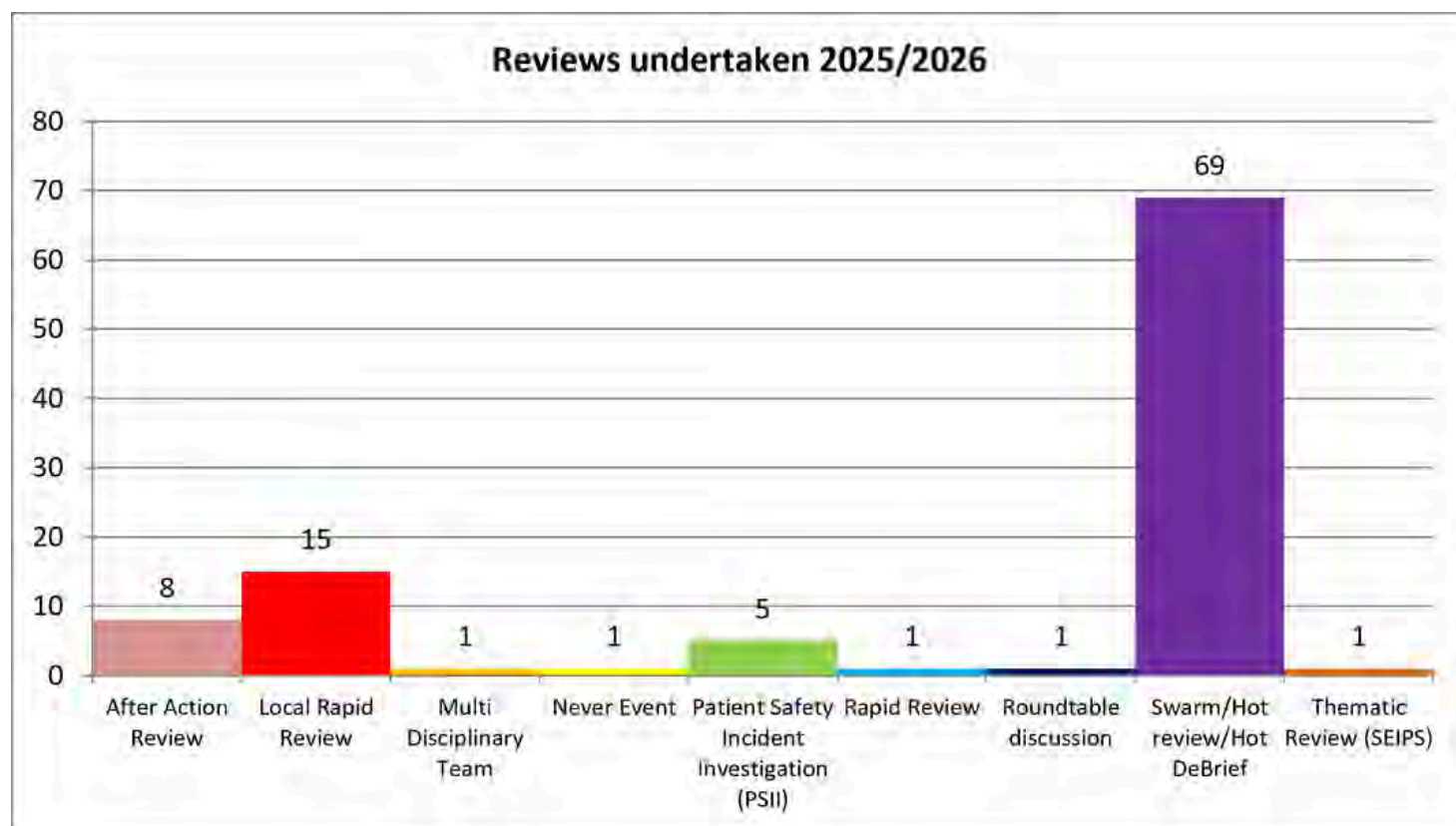
Over the year, Patient Safety Improvement Framework (PSIRF), was fully established as business as usual, shifting review processes, towards a stronger emphasis on improvement and learning.

In 2025/26, a total of 3,332 patient safety incidents and near miss events were reported, a slight decrease from 3,399 the previous year. Of these, 92% resulted in no or low harm, 7.75% resulted in moderate harm, and 0.25% (9 incidents) resulted in severe harm. Eight of these occurred off caseload - incidents identified by our staff during clinical visits that were unrelated to Trust-provided care – and one occurred on caseload, relating to a missed opportunity to provide growth monitoring for a child.



Local reviews

The services continue to undertake local reviews, which receive oversight via the weekly Safety Huddle and monthly Safety Improvement Group. Where appropriate, the reviews are linked to the ongoing Trustwide improvement plans in line with Patient Safety Incident Response Framework. During 2025/26 the Trust commissioned 102 reviews – see below for the breakdown:



Embedding PSIRF into everyday practice strengthens a just and learning culture by shifting the focus from blame to understanding system factors, enabling more meaningful and proportionate incidents responses. As a result, staff feel more psychologically safe to report concerns, improvement actions are more targeted and effective, and organisational resources are used more efficiently. Over time, this leads to higher-quality insights, clearer communication with patients and families, and more sustainable improvements in patient safety.

Improvement plans

The Trust reviews its risk profile annually and currently has five Improvement Plans in place which have been agreed by the Board. Each of these improvement plans have progressed during the year.

Improvement plan
Improving patient care through optimal treatment and improved knowledge of preventable wounds
Medication errors (including the prescribing and administration of oxygen) where CCS staff member was the administrator, leading to a patient safety incident.
Safeguarding incidents that identify escalation of care needs has not occurred or there is professional disagreement about what is required.
Supporting care of large sibling groups.
Quality improvement plan for the management of constipation.

Patient Safety Incident Investigations (PSII)

The Trust reported three Patient Safety Incident Investigations during the financial year and one Never Event.

PSII

- Missed opportunities to implement and follow the Trust’s growth monitoring process for two vulnerable children.
- A misconfiguration in the triage system (provided by external partner) led to high-risk users being incorrectly downgraded in testing, resulting in the cohort of users not being offered further testing.
- An unauthorised registrant was present at Autism Diagnostic Observational Schedule (ADOS) clinic assessments completed by staff contracted through a nursing agency.

Never event

- An intrauterine device (IUD) was fitted that differed from the procedural plan.

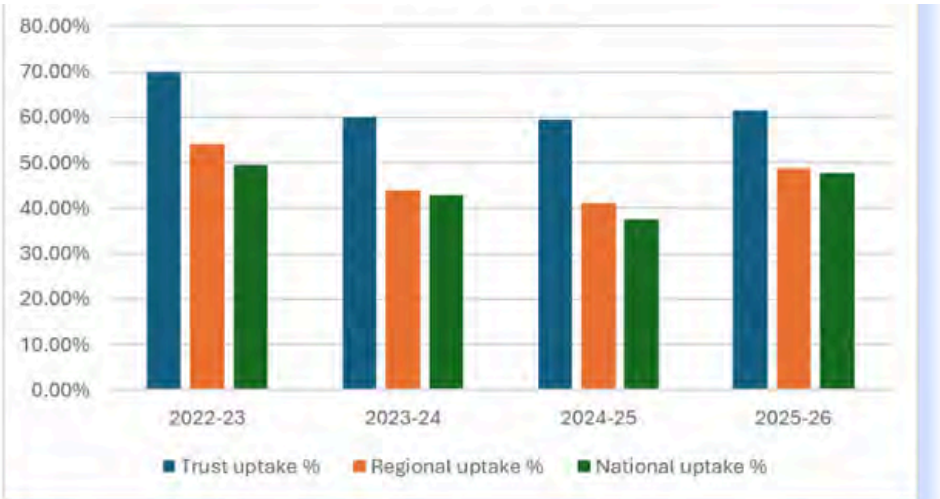
Implementation of the Duty of Candour

The Trust fulfilled 100% of its Duty of Candour obligations in line with national guidelines and timeframes and continues to ensure that the requirements of the Duty of Candour are followed and embedded into practice.

Infection prevention and control

The most complex infection prevention and control challenges over the past year have been the continued impact of respiratory viruses such as influenza, and other organisms including Whooping Cough, Measles and Mpox. Extensive infection prevention and control arrangements have been put in place to protect both staff and service users, such as cleaning audits and standard operating procedures. The assurance framework for infection prevention and control is reviewed monthly and reported to Trust board every six months.

The Trust continues to arrange for staff vaccinations through our Occupational Health contractors and inhouse. The Trust continues to promote our staff seasonal influenza campaign and is recognised as one of the best in the East of England Region for staff uptake.



There were zero cases of clostridium difficile, MRSA bacteraemia, MSSA bacteraemia or E. Coli bacteraemia across the Trust.

Safeguarding

The Trust has robust internal and external quality controls, ensuring a 'substantial' level of assurance under the NHS England Safeguarding Accountability and Assurance Framework 2024. Assurance measures include:

- Training and supervision compliance.
- Audit findings and action plan progress.
- Incident reviews and staffing levels.

External Quality Controls

- Active participation in multi-agency safeguarding arrangements, reviews, and audits, ensuring action plans and learning are embedded.
- Involvement in inspections to support system learning and accountability.
- Submission of Section 11 reports (children) and self-assessments (adults) with participation in challenge events.

Internal Quality Controls

- Operational safeguarding and clinical group meetings in each locality to ensure that there is oversight of information to cascade, and a formal route for escalation of any learning or issues identified.
- Direct reporting to the Strategic Safeguarding Group to report on safeguarding activity, identify escalations and risks and to provide assurance of good practice.
- Thematic review of all incidents through the Patient Safety Incident Response Framework, resulting in quality improvement plans and workstreams.

	% achieved 2023/24	% achieved 2024/25		% achieved 2025/26	
Level 1 - Mandatory for all staff	97%	98%	↑	98%	↔
Level 2 - Mandatory for all clinical and non-clinical staff in regular contact with parents, children and young people	97%	97.6%	↑	98%	↑
Level 3 - Mandatory for all staff predominantly working with children, young people and adults	89%	91.25%	↑	92%	↑
Level 1 - Mandatory for all staff	97%	97.8%	↑	98%	↑
Level 2 - Mandatory for all clinical and non-clinical staff in regular contact with parents, children and young people	97%	97.7%	↑	98%	↑
Level 3 - Mandatory for all staff predominantly working with children, young people and adults	86%	89%	↑	90%	↑

Training compliance target has been agreed by the Board as 90% for most of the mandatory training, with some exceptions related to national expectations such as Prevent. Robust governance is in place to support service directors to ensure compliance with safeguarding training is prioritised for all staff.

Safeguarding supervision

Safeguarding supervision ensures staff are given support with the emotional impact from indirect trauma of safeguarding children and adults.

All staff have access to advice and supervision as needed, whilst some staff groups are offered formal safeguarding supervision quarterly. Compliance with the formal supervision offer is monitored in operational safeguarding groups.

All safeguarding teams have access to restorative supervision to support the emotional nature of the work they are dealing with on a day-to-day basis.

Audits

- Annual audit plan includes **safeguarding node use, quality of referrals, and escalations**.
- **Mental Capacity Act** assessment audit has been repeated by the services and will include development of individual action plans to improve uptake, quality and oversight.

Incident Reviews and Staffing Levels

A **quarterly learning paper** summarises safeguarding reviews, incidents, and governance insights. This is cascaded through operational meetings, added to the intranet, and shared with the executive team for oversight.

Staff across NCH&C and CCS safeguarding teams aligned as a group model from 1 January 2025, with heads of safeguarding for adults and children's services appointed to support transition to one organisation from April 2026.

Resilience arrangements, including Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Management (BCM)

The Trust demonstrated continued readiness and preparedness throughout 2025/26. Key highlights include:

- Through established incident response frameworks, the Trust responded to 70 incidents, and the strategic on-call team answered 41 calls. Response often included the provision of mutual aid to other organisations and included opportunity for debriefing and the identification of and learning from lessons.
- Seventeen CCS colleagues attended 37 training opportunities. There has been an increase in the reporting of training opportunities identified. Thirty-six colleagues participated in 44 exercises across all systems in which we operate.
- The Trust was assessed as 'substantially compliant' against the NHS England EPRR Core Standards in 2025. Work will continue to build upon this achievement within the coming financial year.
- Co-development of key workstreams with Norfolk Community Health and Care NHS Trust (NCH&C) counterparts commenced to ensure that a robust and seamless approach is maintained across the newly established organisation. Work on this will continue into 2026/27.
- The Trust maintained its virtual and physical Incident Coordination Centres (ICC), which support the Incident Management Team (IMT) when responding to any Trustwide, Regional or National incidents.
- The Trust's Accountable Emergency Officer and the Trust's Resilience Team attended Local Health Resilience Partnership (LHRP) meetings across all Trust localities at their respective levels of delegated responsibility.
- Collaboration across Integrated Care Systems continued to be a focus for the Resilience Team in 2025/26.

During 2026/27 key workstreams will include the integration of resilience arrangements and the continued implementation of the annual workplan.

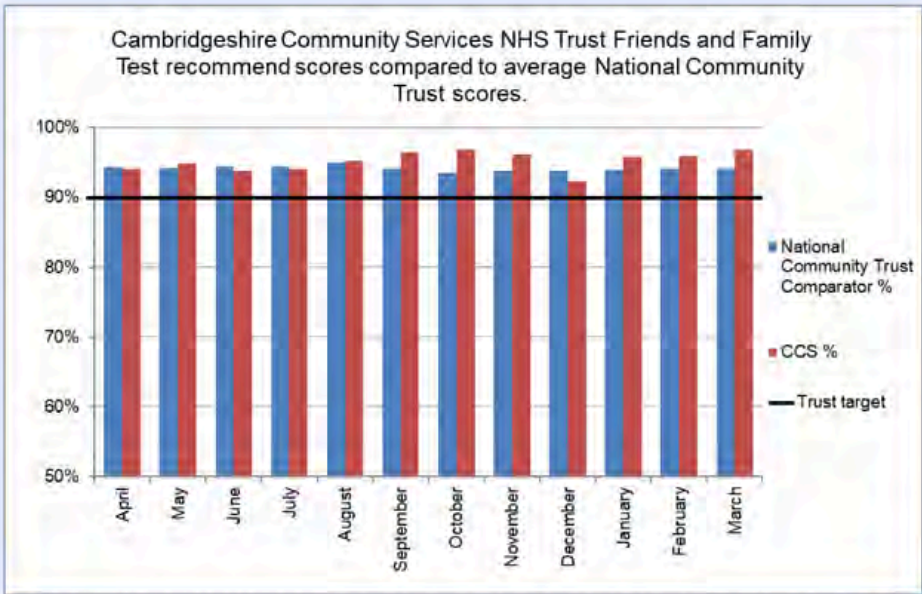
Patient experience and people participation

The involvement of service users and their carers support the Trust to improve the things that matter most, to those we serve. We want to hear from people who use our services to ensure they are involved in shared decision making and co-production projects.

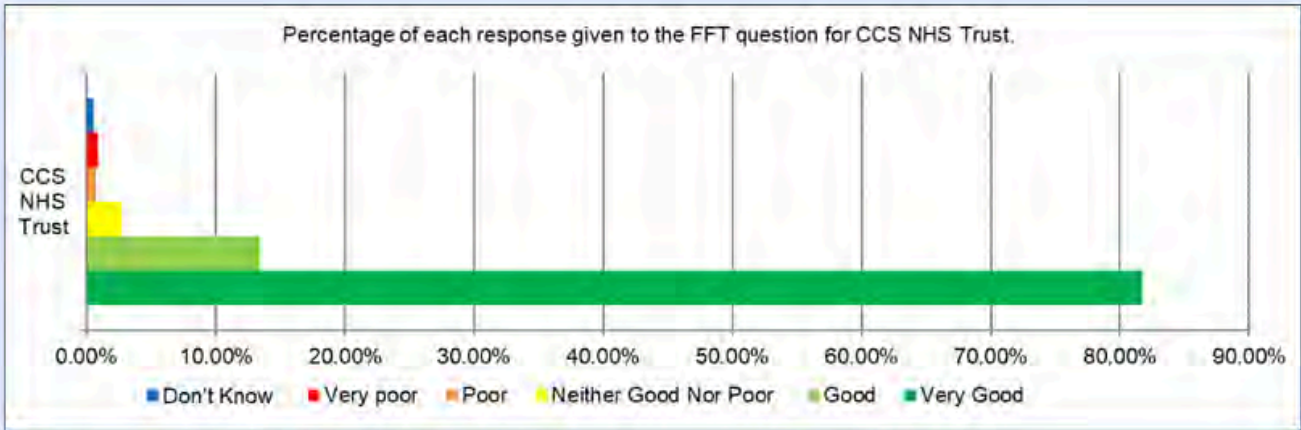
Service user feedback

Service users and carers are routinely asked to provide feedback via the Friends and Family Test (FFT). This was incredibly positive in 2025/26 with 95.09% of the 28,902 people who answered the Family and Friends Test (FFT) question saying the service provided was very good or good.

The chart below shows how the Trust compares to the average score for Community Trusts across the country.



The chart below shows a breakdown of the responses received by their rating:



Compliments

40,948 positive comments and compliments were received by services during the year. We received over 88 positive comments for every formal and informal complaint received.

Improving services using service user feedback: You Said, We Did

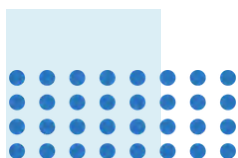
We use service user feedback to improve the services we provide. Below are a few examples of improvements we have made in response to feedback:

Beds and Luton Adults	
I prefer not to sign the visitors book it takes up time and the need to bring glasses to read the information.	A poster is now displayed in reception that advises patients that they do not need to sign the visitors' book.
I believed I had booked an online course, checked messages the evening before and had seen that the education was in person and no time to arrange lunch etc.	The team has amended the booking confirmation; it now states that the course is face to face. All patients receive a telephone call one week in advance from a volunteer to confirm their attendance and this includes information on the venue.
Beds and Luton Children's	
The clinic location was confusing, especially as it was on the same road as a GP surgery. Parking was also very limited.	We have stopped using this venue and now offer appointments in the local Midwife Hub, which has clearer access and available parking.
Cambridgeshire Children's	
It would be better if you didn't have to wait for the list of all options to be read out before being able to select the one you need.	Removed the need to listen to all options before being able to select.
Have clinics [Early Support Neurodevelopmental assessment clinic] available on other days rather than just a Tuesday.	Clinics have started on other days of the week.
[Paediatric Physiotherapist] didn't seem to understand that our child was autistic, she hadn't read his notes.	The team discussed the need to ensure clinicians are prepared for appointments (including reading notes beforehand) and the importance of creating the right atmosphere.



Patient experience and people participation

Dental	
I drove mum 50 min journey to her appointment to be told that she should not have taken her blood thinning medication before her tooth had been removed.	Staff were reminded to tell people not to take blood thinning medication before treatment.
Wrong postcode sent with address and as there are so many different departments and doors, the whole area is a maze and no signage to direct you. Using what3words would be a great improvement.	What3words directions was added to correspondence.
Update me regarding my waiting time.	A notice has now been added in waiting rooms to ask patients to speak to reception if they have been waiting longer than 15 minutes.
DynamicHealth	
The wait for an appointment is too long.	Have employed an additional physiotherapist.
Communication outside of appointments can be difficult.	Administration capacity is being increased. Telephone call answering across all three localities is being trialled to improve call waiting times.
iCaSH	
I was asked to do a urine sample and was given a see-through bag to put my bottle of urine in to sit in the waiting room. A very uncomfortable experience when already there is a big stigma of going into a sexual health clinic.	All areas ordered brown paper bags to put urine sample inside.
Another patient in the waiting room clearly and audibly on a video call.	New posters are being designed and will be displayed in all clinic waiting areas asking people not to record or make video calls whilst on the premises.
Norfolk and Waveney Children's Services	
There is a real issue with parking and parking in the school car park. This causes tension with other partner agency colleagues and families are finding themselves getting blocked in the car park.	Created a pre-set message on SystmOne records to be sent to families attending Diss development checks to highlight the limited parking.



Patient Stories

Patient stories provide insight to the Trust Board into how service users experience our services, identifying excellence and most importantly areas where we can make improvements. This feedback is incredibly powerful, and recommendations are identified by the Board to further improve the overall service user experience.

Patient stories this year included:

- A service user who was supported by the Pulmonary Rehabilitation team before and after a lung transplant. The team provided breathing techniques and tools to support the service user to ensure that a transplant was possible. The service user and family still use the tools and techniques and believe they ensured a successful outcome.
- A service user of the DynamicHealth service in Wisbech shared his story of seeking help and how his treatment meant he could get back to doing the things he loved.
- The Dental Working Together Group, made up of service users, their family and carers across Cambridgeshire, Peterborough and Suffolk, spoke about a film they created about their work. The aim was to let the wider Dental Healthcare service know about the work the group have been doing and encourage more staff to bring ideas for service improvement. This film was created for the Dental Healthcare symposium and resulted in two staff members coming forward with new ideas.

People Participation (Patient and Public Engagement)

Our co-production leads support services to regularly seek involvement and participation from those who use our services, and people from our local communities, to improve service delivery. Below is a summary of some of the activities undertaken throughout the last year.

Bedfordshire and Luton Children's Services

The health inclusion team, co-production team and Gypsy, Roma and Traveller (GRT) community worked with the NHS England immunisations team to produce audio-based educational materials and an animated film on immunisations, addressing cultural and literacy challenges. These are accessed via the service website.

Materials and resources for the Early Language Support for Every Child (ELSEC) programme have been co-produced with a parent who acts as a bridge between the programme and the wider community. An online focus group was held to engage with parents and carers of pre-school children. The group discussed future parent groups to encourage more families to get involved in the ELSEC offer.

The Bedfordshire and Luton Youth Participation Group met in December and March bringing together six young people aged between 14 and 18. The establishment of the group was a joint initiative led by the research and co-production teams following the successful award of a grant from the National Institute for Health and Care Research East of England Regional Research Delivery Network. The aim of the group is to create meaningful opportunities for young people to contribute to health research activity and co-production across the service.

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Cambridgeshire and Peterborough Children's Services

The Healthy Child Programme's "Getting Ready for Change" project held an in-person engagement event with young people at Ely College in October 2025, to gather feedback on the newly updated questionnaire following previous engagement. The project team used this information to make changes to the questionnaire and information.

The Peterborough mental health support team have continued with their co-production focused Working Together Group. The group completed filming and production of a video to support secondary school teachers in understanding the challenges that young people face when asking for help with their emotional wellbeing and mental health.

Norfolk Children and Young People's Health Services

Norfolk Healthy Child Services Parent and Carers Working Together Group was set up bringing together parents, and service leads to establish a collaborative forum for sharing experiences and shaping service improvements. Key topics included group expectations, terms of reference, service overviews, and the value of partnership working. The group agreed to meet regularly and ensure flexible, inclusive participation.

Parents shared personal experiences of the service, highlighted support received as new parents and as their children grow, SEND services and additional needs support and the reassurance provided by the Just One Norfolk website. The group have discussed the Clinical and Care strategy and were introduced to the Trustwide review of the complaint's procedure as NCH&C and CCS become one Trust.

As part of the 5 to 19 service development a sexual health and relationship focus group was held at a secondary school. Thirteen young people, aged 13 and 14 were asked about their understanding of the school nurse role and where they would go for advice and support regarding sexual health and relationships. The young people were asked what they felt should be on offer for health support and advice and how the service can promote and ensure young people are able to access the service in the future.

The young people's responses and key findings will support the development of the Norfolk Healthy Child Service offer and resources. Work continues with the co-design and co-production of the 5-19 service and the development of resources and materials.

Ambulatory Care

iCaSH co-produced 'know before you go' films with a young person for all sites and these are now available on the website. The videos give a service user's perspective and show how to access the clinic, what the clinic and appointment look and feel like. This is to help reduce anxiety service users may feel before coming to their appointment. This project received the Staff Award for co-production.

The Dental Working Together Group co-produced a 'know before you go' film for the Wisbech Clinic. It shows young service users what an inhalation sedation appointment might look like. It was filmed by a Lived Experience Partner with a young service user and their parent. The Working Together Group reviewed the footage and collaborated on the editing. The film is available on the service website and is sent to young people and their families before their appointment.

DynamicHealth held a focus group that included service users who attended a Community Appointment Day and those who followed the normal physiotherapy pathway to review how the event could be improved. As a result of the feedback the patient passport has been redesigned, including a section for the patient's baseline health data, additional information was added to the website about the community appointment days and what to expect, and at future events additional seating and bottled water was provided.

Bedfordshire and Luton Adult Services

Involvement Partners at the Bedfordshire and Luton Adult Services Working Together Group discussed the Integrated Care Board's (ICB) 'Case for Change' priorities. The Case for Change describes proposals to transform community and mental health services to reduce variations in patient access, care, experience, and outcomes across Bedfordshire, Luton and Milton Keynes. Key points from the discussion were: Access to GPs and the value of being empowered but still requiring support to navigate the healthcare system. The ICB used these themes to add more detail to their priorities for action.

Patient information resources used by the Tissue Viability Nursing Service aimed at preventing pressure ulcers and preventing skin tears have been reviewed by the Working Together Group. The Group suggested that leaflets explicitly describe risk groups and include images to support people to identify if the leaflet is relevant to them. It was also identified that the skin tear leaflet was not mobile phone friendly. It was also suggested that complicated content should be rewritten to be shorter, with supplementary information kept on subsidiary pages.

Working Together Groups continue to contribute by supporting the communications team and services to develop patient information.



Patient Advice & Liaison Service (PALS) and formal and informal complaints

The table below summarises the total number of complaints (informal and formal) and PALS enquiries received in 2025/26 compared to previous years.

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Formal complaints	100	96	49	83	99	93	83	96
Informal complaints	397	319	245	408	323	320	281	368
PALS Enquiries and Signposting	602	645	969	1274	871	1048	1010	953

Patient Advice and Liaison Service (PALS)

In 2025/26 PALS received and satisfactorily resolved 1471 contacts. These include enquiries, informal and formal complaints.

Informal complaints

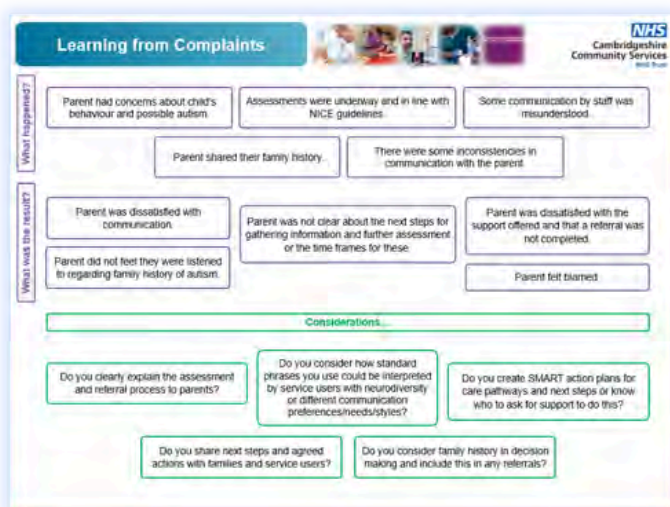
Complaints are managed informally if they can be resolved quickly through local resolution processes. This is either within the clinical setting or by the Patient Advice and Liaison Service (PALS). Local resolution is achieved through discussion by telephone and sometimes a letter from the service manager. Our services resolved 368 informal complaints this year.

Formal complaints

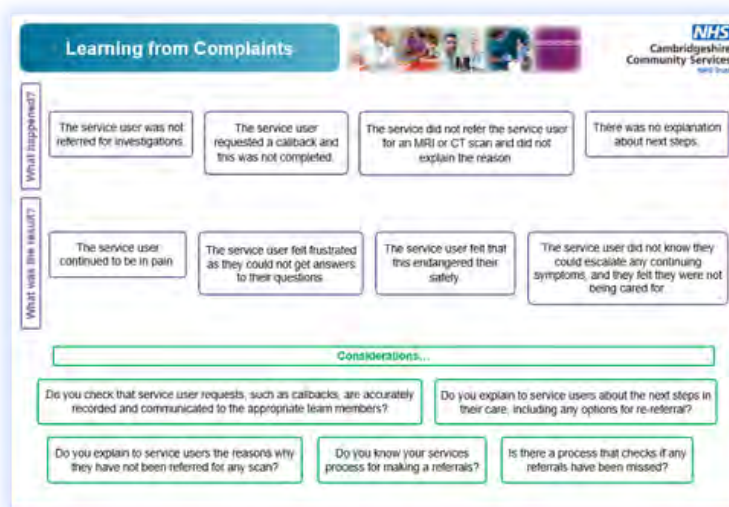
The Trust received 96 formal complaints in 2025/26. All formal complaints are investigated, and the complainant receives a formal letter of response from the Trust. The letter details the outcome of the investigation, areas of learning and actions taken by the Trust. In certain circumstances Trust representatives arrange to meet with the complainant or their representatives.

Sharing Learning from Complaints

Children's Services



Adults Services



Parliamentary and Health Services Ombudsman (PHSO)

There were no referrals to the PHSO and no recommendations received in 2025/26.

Volunteering

The Trust recognises that volunteering benefits the people who access our services, our volunteers, our staff and the wider community. Our volunteer service has grown significantly this year, with over 100 volunteers contributing more than 4500 hours of volunteering to the Trust, an increase of over 1000 hours compared to last year. This is the largest our volunteer team has ever been - thank you to all our volunteers who give us the gift of their time and make such a difference.

We welcome volunteers from all sections of the community, promoting opportunities both locally and nationally via the NHS Volunteering platform.

This year, our breastfeeding buddies in Bedfordshire have continued to provide early breastfeeding support on the maternity wards in Luton and Dunstable Hospital and Bedford Hospital, thanks to partnership working between the Trust and Bedfordshire Hospitals NHS Foundation Trust. The buddies help parents get feeding off to a great start and provide support in our community breastfeeding support and social groups, once they have been discharged from hospital.

We have been delighted to welcome volunteers to new roles to support services across the Trust. In Bedfordshire and Luton, this included Children's Community Eye Service volunteers, a role created in response to feedback about how patient experience could be enhanced, Newborn Hearing Screening volunteers and a Complementary Therapy volunteer who provides gentle massage to patients being cared for by the Heart Failure Service. In Cambridgeshire, we welcomed a volunteer to support our Down Syndrome Clinic as part of our Community Paediatrics Service, and in Norfolk, our Infant Feeding Peer Support volunteers commenced their roles within the local community.

Valuing our volunteers

The Trust's quarterly Valuing our Volunteers Award, where volunteers are nominated by staff, other volunteers, people who access our services and members of the public, was won this year by Bev Evans, a volunteer gardener, Lenuta Papadopol, Rosie Phillips and Laura Thew, all Breastfeeding Buddies. They were all nominated by members of staff who value and appreciate the contribution that volunteers make.



Our annual Trust awards shortlisted two volunteers recognised for the difference they make, demonstrating dedication, commitment and enthusiasm for the time they contribute to the Trust - the winner Carol Warden, a Speech & Language Therapy Volunteer in Bedfordshire, and Linda Collison, a Reception/Welcomer Volunteer in Cambridgeshire.

Carol pictured with her award, alongside Karen Fell, Volunteer Lead for the Trust, and Rachel Hadfield, Speech and Language Therapist - Carol's volunteer line manager.



Volunteering

In June, we celebrated National Volunteers' Week with handwritten thank you cards sent to our volunteers, a social media campaign highlighting the contribution they make, as well as tea and cake events across our region.



Volunteers at the Princess of Wales Hospital in Ely alongside Jo Oakey and Tracy Tillett from the estates team, who support them in their role, and Karen Fell, volunteer lead.

Our annual volunteer survey provided us with overwhelmingly positive feedback. This word cloud was created from three words each volunteer gave us to describe their experience of volunteering with us.



This has been a fantastic year for the volunteering service. Over the coming year, we will continue to promote and create volunteering opportunities within our services, aiming to enhance patient experience and ensure that volunteers have a positive experience of volunteering for the Trust.

Equality, Diversity and Inclusion - Patient Experience

The Trust procured a new provider for interpretation and translation services. This has proved to be largely positive. All incidents logged about the service by our clinical services are reviewed and actions taken to make improvements. A project to gather service user feedback on their experience of the interpretation and translation service is planned for 2026/27.

Equality delivery system

The Equality Delivery System (EDS) is a national framework that supports NHS organisations to improve the quality and equality of services provided to local communities, and to create fair, inclusive, and supportive working environments for staff. It helps organisations address discrimination and inequality while meeting the requirements of the Equality Act 2010.

The EDS was developed by the NHS, for the NHS, and was first launched in November 2011, drawing on established good practice across the health sector.

Implementation of the EDS supports the Trust in meeting its obligations under the Public Sector Equality Duty (Section 149 of the Equality Act 2010). This duty requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between people who share protected characteristics and those who do not.

The EDS is a practical improvement tool for patients, staff, and leaders. It enables NHS organisations in England to work in partnership with patients, the public, staff, staff networks, community groups, and trade unions. Through meaningful engagement and the use of data, evidence, and insight, the EDS supports organisations to review and strengthen their approach to tackling health inequalities and workforce inequalities across three domains:

- Services
- Workforce
- Leadership

The Trust's most recent EDS implementation, including its grading and narrative assessment, is set out in the Equality Delivery System Report. This report is [published on the Trust's website](#) and supports transparency, accountability, and learning.

The objectives planned for 2026/27 are set out below and align with the EDS domains, ensuring a coordinated and measurable approach to advancing equality and tackling health inequalities across services, workforce, and leadership.

Domain 1: Commissioned or provided services

Gain a comprehensive understanding of patients' communication needs and their experiences of using interpretation and translation services, enabling the service to identify barriers, improve equity of access, and co-design patient focused solutions.

Build greater consistency in Equality Diversity and Inclusion practice across the Trust by understanding and addressing variation in practice. Ensure that all services are equipped to embed shared good practice and deliver equitable, personalised care that meets the health needs of every patient.

To enhance the Trust's capability to collect, monitor, and interpret demographic data to identify who is and is not accessing our services, enabling targeted action to address health inequalities and ensure that individual patient health needs are met equitably.

Co-produce a new, Trustwide Learning Disability and Learning Difficulty – Inclusion and Accessibility Strategy by working collaboratively across the newly formed Trust.

To understand whether patients with protected characteristics experience different safety outcomes by strengthening the capture, analysis, and use of demographic data within DATIX. This will enable the Trust to identify potential inequalities in incidents and harm, inform targeted service improvements, and support the delivery of equitable, harm free care for all service users.

To enhance the Trust's ability to use patient feedback as a meaningful driver of service improvement by strengthening how feedback is collected, analysed, and acted upon. This includes understanding the experiences of diverse patient groups, identifying themes and inequalities, and ensuring insights directly inform changes that improve the quality, accessibility, and experience of care.

Equality, diversity and inclusion

Domain 2: Workforce health and wellbeing

When at work, staff are provided with support to manage obesity, diabetes, asthma, Chronic Obstructive Pulmonary Disease (COPD) and mental health conditions.

When at work, staff are free from abuse, harassment, bullying and physical violence from any source.

Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source.

Staff recommend the organisation as a place to work and receive treatment.

Domain 3: Inclusive Leadership

During 2026 and 2027, roll out to all leaders (team lead and above), our approach to Leading with Cultural Intelligence.

All Board members to commit to a personal inclusion pledge.

To strengthen our diversity mentoring and coaching offer to all staff.



Using data to improve patient experience and reduce inequalities

This year, our Intelligence Hub (iHub) has become a central part of how we understand our communities and shape the care we provide. What began as a way to bring together national benchmarking, public health data and local insight has grown into a resource that is changing conversations across the Trust.

The shift is simple but powerful: instead of looking at data in isolation, teams can now see the full picture. iHub helps them understand who is using services, who isn't, and why. It highlights variation, unmet need and opportunities to improve care - often revealing stories that would otherwise remain hidden.

One of the clearest examples is the Population Health app. By combining public health, demographic and service data, it allows teams to segment and stratify local populations. For many services, this has been the first time they could see, at a glance, which groups are at risk of poorer access or outcomes. It has helped teams plan proactively, redesign pathways and focus attention where it matters most.

This year, Cambridgeshire and Peterborough healthy child services used iHub to explore inequalities in mandated health-visiting checks. Working alongside local authority colleagues, they examined deprivation, family size, ethnicity and other protected characteristics. What emerged was a clearer understanding of which families were missing out - and why. This insight is now shaping targeted interventions, ensuring support reaches those who need it most.

Our role as host organisation for the NHS Benchmarking Network has strengthened this work. National benchmarking allows us to compare our services with peers and understand how well we reflect the needs of our communities. In district nursing, for example, analysis of the 2025 dataset revealed differences between the ethnicity profile of our caseload and both local population demographics and national comparators. Because our data completeness is strong, we can act with confidence - identifying underserved groups and directing improvement activity accordingly.

At our Trust, research is a vital part of how we improve care for our patients, families, and communities. Every study we support helps us learn more, treat better, and understand what matters most to the people we serve.

This year has again been very successful; we recruited 376 people, over seven studies, into the National Institute for Health Research (NIHR) Portfolio studies — three times more than last year. Because of these recruitment numbers, we've once again been awarded NIHR Research Capability Funding, which helps us build even more research opportunities for the future. There were an additional 407 recruits to a non-portfolio study.

Building a strong research culture

We want research to be something everyone can be part of. More staff than ever are weaving research into their everyday clinical roles - whether that's testing if a new idea is possible, helping to recruit people into studies, presenting at national and international meetings, or leading research as a Principal Investigator (PI).

To support this, we encourage staff to apply for national research funding. This year:

- Two colleagues completed prestigious Impact Applied Research Collaboration Fellowships — one in the research team and one in adult physiotherapy.
- A Speech and Language Therapist has applied for a Doctoral Clinical and Practitioner Academic Fellowship, which would fully fund a PhD.

We're also supported by the Regional Research Delivery Network (RRDN), who help fund research staff and clinicians interested in becoming involved in NIHR studies. Two of our consultants also hold regional research leadership roles, helping to strengthen research across the East of England.

We were pleased to receive another RRDN Patient and Public Involvement and Engagement grant, allowing a research facilitator to expand work with children and young people - ensuring their voices shape future studies.

Our Research Champions Programme continues to inspire staff to take their first steps into research. Many graduates of the programme now help deliver NIHR studies, support patient recruitment, or even take part as participants themselves.

Supporting students and new professionals

We offer a short but inspiring introduction to research for nursing students and newly qualified staff, helping them learn how research thrives in a community healthcare setting. We also welcome external students who are carrying out research projects, including trainee psychologists and a PhD student now working with our physiotherapy team.

Research opportunities for patients

Patients and families are at the heart of all our research. There are many ways to get involved, such as:

- Giving feedback through the PRES Survey.
- Reading our easy-to-understand research summaries.
- Commenting on early-stage research ideas.
- Developing our Youth Health and Research Group.
- Supporting the International Clinical Trials Day Events.

Your voice helps shape the questions we ask and the care we improve.



Working together

We collaborate closely with the RRDN, other NHS Trusts, local universities, and Integrated Care Boards. These partnerships ensure that research in our Trust is innovative, high-quality, and connected to wider healthcare improvement.



Pop up research stall for the International Clinical Trials Events



Pop up research stall for the International Clinical Trials Events



Children and Young People Group workshop



Research pop-up at a public Health Fair, Luton



Our clinical orthoptist presenting at the International Orthoptic Congress in Brisbane, on how to succeed in adopting NIHR Portfolio Studies Research

Strategic objective 2 - Be an excellent employer

High assurance - We are performing strongly as an employer, with staff survey results and workforce measures among the best in the country. Staff report a positive experience, supported by a focus on wellbeing, inclusion and development. Ongoing improvement work reflects our ambition to maintain these high standards and keep improving.

2025 national NHS staff survey

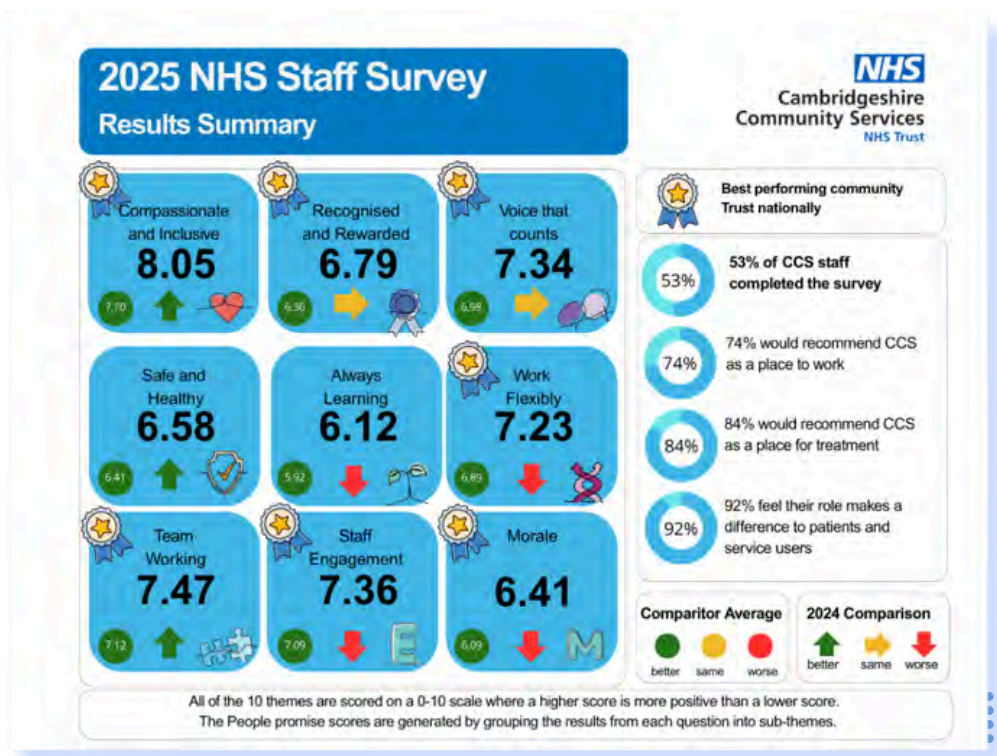
This year, 1,467 colleagues (53% of our workforce) shared their views. The findings, benchmarked against 13 community trusts nationally are grouped under the seven People Promise themes, along with staff engagement and staff morale. Together, they give us a clear picture of how people are feeling and where we can go further.

We are the best performing community Trust nationally for:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We work flexibly
- We are a team
- Staff engagement
- Morale

We were above average and very close to best performing for the remaining two themes:

- We are safe and healthy
- We are always learning



Workforce diversity and inclusion group

The CCS Workforce Diversity and Inclusion Group, chaired by the Deputy Director of Workforce, meets quarterly to oversee delivery of the Diversity and Inclusion for All programme within the People Strategy. Actions are owned by leaders across the organisation.

Membership includes staff from protected characteristic groups, cultural ambassadors, staff network advocates, the staff-side chair, workforce colleagues, and the Assistant Director of Corporate Governance as Trust lead for diversity and inclusion.

The group's work aligns with several overlapping programmes, including the staff opinion survey, staff health and wellbeing, and Health and Safety Committee work on violence, aggression, and sexual misconduct.

As a public sector employer, the Trust must meet the Public Sector Equality Duties to:

- Eliminate unlawful discrimination.
- Advance equality of opportunity.
- Foster good relations between people with and without protected characteristics.

People strategy and diversity and inclusion

Workforce diversity and inclusion is embedded in the People Strategy 2023-26 and its Diversity and Inclusion for All programme. The 2025/26 implementation plan included actions to:

- Review the Group Model and agree how learning from the Cultural Inclusion Programme will be rolled out,
- Co-produce and deliver the year-3 anti-racism plan.
- Deliver the updated No More Tick Boxes recruitment de-biasing plan.
- Agree the Inclusion Plan.
- Continue culturally diverse career and learning conversations.
- Provide interview questions in advance.

In addition, annual plans were in place for:

- Workforce Race Equality Scheme (WRES).
- Workforce Disability Equality Scheme (WDES).
- Gender Pay Gap.
- Equality Delivery System (EDS).
- Anti-Racism Plan.
- De-biasing Recruitment.
- Staff Opinion Survey.

Implementation plan progress

- Cultural Inclusion Programme

CCS has begun embedding learning from the Cultural Inclusion Programme, including a new session within the Chrysalis leadership programme. The Training and Development Manager completed Above Difference training in October 2025, and planning is underway to raise awareness among team leaders and above in the new organisation from April 2026. Full roll-out is expected to take 12–24 months to embed cultural change.

- Anti-Racism Plan

The 2025/26 anti-racism plan was co-produced with the Cultural Diversity Staff Network. Workforce actions are overseen by the Workforce Diversity and Inclusion Group, with representation from all staff networks and departments. Actions are detailed in a separate paper.

Workforce	
Objective	Progress Update
To arrange a meeting at least annually to explore working interculturally across all staff networks.	The network advocates met and jointly planned the celebrations of the national staff networks day, which took place on 14 May 2025. They have combined to build on this co-production and both advocates and network members attend and contribute to other network meetings promoting intersectionality. In addition, networks are beginning to work together with their counterparts in NCH&C to plan how they will come together in the new organisation post April 2026.
To evaluate the effectiveness of culturally diverse recruitment panels and further implement actions to make recruitment inclusive.	We continue the rollout of sharing interview questions prior to interviews. The impact of such innovations is not always easy to measure, as this is a culture shift supporting applicants to recognise CCS as an inclusive employer even if they are not successful at interview. It also removes possible opportunities for unconscious bias and level the playing field for applicants. However, to date this is being received well by both interviewers and applicants.
To promote the role of the Cultural Diversity Staff Network through allyship, volunteers and involvement partners.	The network continues to be promoted to all new staff during induction and should be discussed at management supervision. It has steady attendance from Allies.
To evaluate the effectiveness of the Diversity Mentoring Scheme.	We receive positive feedback from both mentors and mentees. We will be widening the offer and number of culturally diverse mentors we have so this offer can be more widely accessed in the new organisation.

Inclusive Leadership	
Objective	Progress Update
To develop a Cultural Intelligence Workshop, as part of the Chrysalis Leadership Development Programme to cultivate inclusive leaders.	Cultural intelligence is part of Chrysalis workshop 5. It has been agreed to adopt an updated version of Chrysalis as the Leadership Programme in the new organisation and to roll out leading with cultural intelligence development to all leaders over a 12–24 month period. An in-house trainer has undertaken training with “Above Difference” and will use this learning in the programme.
To continue to build a network of diversity mentors to enable Diversity Mentoring to be rolled out to more staff members.	We will be widening the offer and number of culturally diverse mentors we have so this offer can be more widely accessed in the new organisation.
Staff with a Diversity Mentor to feedback to their mentor, how their cultural intelligence mentoring has improved their inclusive leadership.	Ongoing.

- **No More Tick Boxes – De-biasing Recruitment and Advance Interview Questions**

Following the 2024/25 refresh of the No More Tick Boxes action plan and the successful introduction of mandatory cultural diversity at all recruitment stages, we are now implementing the practice of providing interview questions in advance to all shortlisted candidates.

This adjustment supports more thoughtful responses, enables candidates to demonstrate their understanding of the role and the Trust, and helps level the playing field - particularly for candidates with anxiety or who are neurodivergent, while benefiting all applicants. Research shows that advance questions improve fairness and inclusivity in recruitment.

To support managers, we are phasing the roll-out and have updated training to strengthen skills in using follow-up questions and complementary selection methods. Early feedback from panels and applicants has been positive, and this approach is now embedded in recruitment planning.

- **Inclusion Plan**

During development of the 2025 Anti-Racism Plan, staff raised concerns that focusing on a single protected characteristic could unintentionally exclude others. Building on learning from Above Difference training, it was agreed that a broader Inclusion Plan would be developed.

This work will now be taken forward by the new Trust after April 2026, using the existing NCH&C Inclusion Plan template. A draft will be presented to People Participation and Equalities Committee (PPEC) in July 2026.

- **Culturally Diverse Career and Learning Conversations**

Following the 2022 Staff Survey and WRES findings showing poorer career-progression experiences for culturally diverse staff, we introduced confidential career conversations for those who wanted them. This has contributed to improved survey results in 2023 and 2024.

This offer is now a permanent part of the appraisal process and will be extended to disabled staff. Uptake is being monitored, and we will expand the pool of trained facilitators if needed.

Other workforce diversity and inclusion activities

Workforce EDI post-April 2026

EDI leads from CCS and NCH&C met in October 2025 to plan post-integration priorities, including:

- Applying for the Employers Network for Equality and Inclusion Award.
- Merging staff networks and agreeing a transition plan.
- Developing an annual inclusion events calendar.
- Rolling out Cultural Ambassadors and diverse interview panels.
- Developing workforce elements of anti-racism and inclusion plans.
- Aligning support for Adjustment Passports.
- Rolling out Leading with Cultural Intelligence.
- Reviewing staff support offers.

Sexual Misconduct

Following the introduction of sexual misconduct legislation in 2024, the Trust adopted the national policy to ensure robust protection for staff. This builds on the NHS Charter signed earlier in 2024, already embedded in policies supporting staff experiencing inappropriate sexual behaviour from the public or colleagues.

Awareness has increased through senior leader engagement, and the harmonised post-April policy will include links to the relevant e-learning.



Targeted Development Opportunities: Stepping Up, Ready Now, Springboard

Working with the Integrated Care Board, we have commissioned development programmes for under-represented groups to support career progression.

Springboard, aimed at women, focuses on confidence building and features role-model input. Demand remains high, with a waiting list already in place through the Training Needs Analysis.

These programmes represent positive action to remove barriers and create fairer opportunities for all staff.

High Impact Diversity Targets

The Trust continues to align with all six national High Impact Diversity Targets. Annual self-assessments will be shared with regional EDI teams to identify where support or best-practice learning is needed. We believe we have met all but one target.

Charter for Employers Positive About Mental Health - Mindful Employer

We have renewed our commitment to the Charter for Employers Positive About Mental Health, remaining signatories until 8 December 2026. The new organisation will reapply for this and other positive-action charters. We will continue to promote available support and highlight this commitment in recruitment materials.

Cultural Ambassadors (CAs)

New Cultural Ambassadors have been recruited, and RCN-led training for CCS and NCH&C ambassadors has been agreed. In 2026, the CA model will be extended across the former NCH&C footprint ahead of becoming a Trustwide approach.

CAs support people-management processes involving culturally diverse staff to identify and prevent cultural bias. Previous challenges with CA availability led to temporary policy flexibilities, though these have rarely been needed. With additional CAs in the new Trust, we aim to remove these contingencies.

Staff Networks

In May 2025, CCS and NCH&C jointly celebrated National Staff Network Day, promoting network achievements and encouraging wider participation. Collaboration has continued, placing us in a strong position to merge networks in the new organisation.

Open conversations continue to support culturally diverse staff during periods of heightened racial tension linked to national or international events.

2025 Workforce Race Equality Scheme (WRES) and Workforce Disability Equality Scheme (WDES)

The Trust published its 2025 WRES and WDES data in May 2025, with action plans approved by the committee in July 2025.

We will take positive actions to achieve the objectives in the table on pages 34 and 35 following publication of our 2024/25 WRES data.

In 2024/25 the WRES data showed an improvement in all but one indicator and that one remained the same as in the previous year.

The actions for 2025/26 therefore focus on building on and sustaining that improvement.

We will take positive actions to achieve the objectives in the table on page 36 to address the disparity highlighted between staff with a disability and their non-disabled colleagues as seen in our WDES data published in 2025.

Objective	Current position	Action and outcomes	Timescale	Lead	Update January 2026
Grow our number of Cultural Ambassadors (CA) and our feedback process following cases, as well as supporting their peer support network. We will also build in a contingency for rare cases where a CA is not available to seek to guard against any bias in our process application.	Due to turnover and lack of training from the RCN we only have 3 CA's, and this can cause capacity pressures. Due to falling numbers and staff absences, the peer support groups have become less active.	1) Align a named HR business partner to support CA's peer support group and take feedback following any intervention. 2) Review all feedback and make any process, policy or practice changes required. 3) Seek to train more CA's and work with a local Trust who have CA's for resource sharing if possible. 4) Consult with Union and CA colleagues on an amendment to our CA Policy for emergency situations, which ensures decision making will involve someone from a culturally diverse background even if a trained CA is not available.	By June 2026	Head of HR, Recruitment and Retention, HR Team, Current and new Cultural Ambassadors	1) Completed. 2) Ongoing and Business As Usual (BAU). 3) Completed (training agreed with the RCN and dates to be agreed after NCH&C cultural ambassadors recruited post April 2026). 4) Completed (amendments agreed).
Continue our focus on the prevention of violence and aggression from members of the public towards our staff (small improvement of 0.1%).	Actions are ongoing.	1) Continue to implement actions to Violence and Aggression Standards. 2) Review and widely publicise the all-staff EDI objective to raise awareness of their responsibility and discuss regularly with their line manager. 3) Work with network advocates to promote allyship and recommend that ALL staff who manage others attend at least one Cultural Diversity Network meeting annually to learn from the lived experience of colleagues to support them with their allyship role.	By June 2026	1) Director of Finance, Chief Nursing and AHP Officer 2) CPO and Workforce Team 3) CPO, Workforce Team and Directors of Service	Ongoing and BAU. Ongoing and BAU. Ongoing and BAU.

2025 WRES proposed action plan

Objective	Current position	Action and outcomes	Timescale	Lead	Update January 2026
Build on our existing offer by embedding the offer of additional career conversations to culturally diverse staff into our Appraisal Policy to support staff progression into higher banded roles as part of our ongoing improvement of representation in roles banded at 5 and above.		1) We will include this offer into annual appraisal and Personal Development Plan (PDP) paperwork. 2) We will review and themes and feedback to improve our support for career progression. 3) We will continue to offer career support and interview preparation to all internal applicants.	By June 2026	1) Training and Development Manager 2) Workforce Team 3) Head of HR and Retention Manager	Completed. BAU. BAU.
Continue to act on the staff related actions of our Anti- Racism Plan 2025/26.		We will act as detailed in the Anti-Racism Plan.		Deputy Director of Workforce, Company Secretary (Trust EDI Lead) and Network Advocates	Completed

Objective	Current position	Action and outcomes	Timescale	Lead	Update January 2026
Take actions learned from the NHS Disability Summit.	Staff Side Chair and Disability and Long Term Conditions (LTC) Network Advocate attended the Disability Summit and will recommend actions that CCS can adopt.	TBC	To have begun by October 2025 and completed by June 2026	Head of HR and Staff Side Chair and Disability and LTC Network Advocate	Completed.
Take steps to support career progression for those interested and remove anything which may limit opportunities based on disability.	Disability discrimination is illegal, and the Trust seeks to remove any barriers to progression, which may disproportionately impact on any protected group. Career conversations embedded in appraisal and PDP process and additional support available from the workforce teams.	1)To mirror the additional career conversation support areas available to culturally diverse staff and offer this to disabled staff. 2)To embed this in the Appraisal Policy. 3)To complete the roll out of interview questions shared with applicants prior to interviews.	Jun 2026	1 and 2 - Training and Development Manager and members of the workforce team 3 - Retention Lead	1 and 2 - Completed, embedded in appraisal paperwork and offered to anyone who identifies as: ·Culturally diverse. ·Has a long-term conditions/disability. ·Is a member of the LGBTQI+ community. ·Is a carer. 3 - Roll out ongoing.
To seek to understand why staff feel pressured to attend work when unwell.		Seek feedback from Staff Networks and agree actions based on feedback.	June 2026	Head of HR and Network Advocates	Ongoing work to ensure that the managing of attendance at work can run alongside supporting staff who are absent due to ill health, recognising attendance should be managed in a supportive manner.

This section explains how the Trust supports all staff to speak up safely, why this matters, and the routes available to raise concerns or suggestions.

Speaking up is essential to maintaining high-quality care and a positive working environment. It includes raising concerns about anything that gets in the way of providing safe, effective care or that negatively affects an employee's working life. When things go wrong, speaking up helps the Trust learn lessons and make improvements. Equally, when staff identify risks early or suggest ways to make good services even better, speaking up helps prevent harm and drives continuous improvement.

The Trust is committed to creating and sustaining a positive culture where all staff feel safe, confident, and supported to speak up. Staff should be assured that their voices will be listened to, their concerns taken seriously, and their suggestions considered as opportunities for learning and improvement. The principles of "speak up, listen up and follow up" are a core part of the Trust's culture.

The Trust provides multiple routes for staff to raise concerns or ideas. In addition to speaking with line managers or Human Resources, staff may choose to raise matters directly with the Freedom to Speak Up Guardian or through the network of trained Freedom to Speak Up Champions, who are volunteers from across different services and teams.

The Trust currently has 29 Freedom to Speak Up Champions. Each has expressed an interest in supporting colleagues and has received training to carry out the role. The Champions are supported by the Freedom to Speak Up Guardian, who is the Company Secretary, and act as visible, approachable advocates for staff who wish to speak up.

The Freedom to Speak Up work is supported at executive level by the Chief People Officer. Independent support may also be provided by the Non-Executive Director, if required. The Freedom to Speak Up Guardian, Champions, and Chief People Officer meet annually to review themes and learning from concerns raised, and to agree actions that will strengthen the speaking up culture over the coming year.

On a quarterly basis, the Trust reports all concerns raised through the Freedom to Speak Up route to the National Guardian's Office. The Office leads, trains, and supports the national network of Freedom to Speak Up Guardians and undertakes speaking up reviews to identify learning and promote improvement across the healthcare sector.

The Trust also uses the annual NHS Staff Survey as an important way for staff to share feedback and raise issues. A key theme of the NHS People Promise is that "we each have a voice that counts." The Trust consistently performs well in this domain demonstrating strong staff confidence in speaking up.



All staff are required to complete mandatory Speak Up training on joining the Trust. This core training explains what speaking up is, why it matters, how to raise concerns, and what staff can expect once they do so. Ongoing training and awareness activity help reinforce these messages and ensure staff feel supported to speak up at any time.

The Trust also contributes to system-wide improvement by supporting other organisations to strengthen their Freedom to Speak Up arrangements. The Freedom to Speak Up Guardian is supported regionally through the East of England community of practice, enabling shared learning, peer support, and the spread of good practice.



- **HSJ Awards success** - The Trust, in partnership with Flok Health, was delighted to be recognised for three national awards for its innovative AI-powered physiotherapy service. The collaboration won Primary and Community Care Project of the Year and was shortlisted in Best Contribution to Improving the Efficiency of NHS Services at the HSJ Partnership Awards 2026. It was also shortlisted for the Driving Change through AI and Automation Award at the HSJ Digital Awards 2026.
- **Bedfordshire eye service** – Our innovative workforce development initiative was designed to address service backlogs in the service by upskilling two Orthoptic Support Workers (OSWs) to Band 4 roles. It demonstrates how targeted workforce development can enhance patient care, improve efficiency, and support professional growth, aligning with national Allied Health workforce priorities. This project won the Service Improvement and Innovation Award 2025 in the BIOS Awards and the National Advancing Healthcare UK awards.
- **Shortlisted for HSJ Award 2025** - Delighted to be shortlisted for an award recognising staff wellbeing, for developing an open supportive culture where everyone can belong and thrive. From Trustwide initiatives to local leadership, from reward and recognition to support and inclusion, our mission is to create an environment where all people feel seen, heard, involved and supported.
- **Gold Award recognises outstanding support for Armed Forces community** - This top-tier recognition from the Defence Employer Recognition Scheme (ERS) celebrates the positive impact made by the Trust in ensuring members of the military community – including veterans, reservists, cadet instructors, and military families – are supported, valued, and treated fairly in the workplace.
- **HSJ's Top 50 Chief Executives for 2025** - Matthew Winn, Joint Chief Executive, received this recognition for his outstanding leadership and his commitment to person centred community healthcare, delivered by the brilliant teams at Cambridgeshire Community Services NHS Trust and Norfolk Community Health and Care NHS Trust.
- **Queens Nurses** - We welcomed 10 new Queen's Nurses to the Trust. Queen's Nurses serve as leaders and role models in community nursing, delivering high-quality healthcare across the country. The application and assessment process to become a Queen's Nurse is rigorous and requires clear commitment to improving care for patients, their families, and carers.
- **Staff survey success** – We were the best performing community trust nationally for seven of the nine survey themes; we are compassionate and inclusive, we are recognised and rewarded, we each have a voice that counts, we work flexibly, we are a team, staff engagement and morale. We were above average and very close to best performing for the remaining two themes; we are safe and healthy and we are always learning.
- **Shine a Light** - Every month we celebrate our people through our Shine a Light awards, with nominations by colleagues and service users. Winners have included a community staff nurse, a school nurse, our safeguarding team, a specialist paediatric dietitian and many more.
- **Valuing our volunteers award** – Each quarter we celebrate our volunteers across the Trust. Winners this year include breastfeeding buddies and a volunteer gardener.
- **Staff awards and long service** – We received 126 nominations in total across 14 categories; a fantastic way to celebrate our staff, along with staff who completed apprenticeships and those who have achieved long service milestones, totalling more than 3,011 years of dedicated service to the NHS.



Looking forward into 2026/27 the new Trust will consolidate best practice in attracting and retaining staff into our new strategic workforce plans and associated activities. This includes our approach to apprenticeships, staff development, both clinical and skills based, and staff health and wellbeing support. We will also consolidate our approach to supporting young people to consider careers in the NHS and widen our input into schools and colleges and in offering work experience placements.

Strategic objective 3 - Be collaborative

Moderate to high assurance - We work well with partners across the health and care system, with good examples of joint working and integrated care. Some partnerships are more developed than others, and we are focusing on strengthening relationships through better engagement, shared goals and leadership. More consistent results across all partnerships will improve assurance further.

Collaboration has been a core priority for the Trust over the last year. The organisation is a full member in integrated care systems across Bedfordshire, Luton and Milton Keynes (BLMK), Cambridgeshire and Peterborough, as well as being an active member on Norfolk's Children's Services Board and Norfolk Alliance.

Examples of collaborative initiatives that our services played a key role in include the following:

Trustwide

- **Partnership campaigns:** The Trust's communications team is engaged with all three integrated care systems in developing campaigns to promote messages to make best use of NHS services and resources, vaccination programmes and public health messaging.
- **Co-production:** We have worked with service users, patients, local communities, staff and partner organisations to shape and improve future service provision, enhancing accessibility and ensuring our services reflect the diverse populations we serve.

Bedfordshire, Luton and Milton Keynes (BLMK)

- Collaboration between CCS and the wider partnership, including Family Hubs and Children's Centres supports a robust and effective infant feeding service for families. Some examples of this are:
 - Unified early-support pathways, including coordinated early feeding phone calls and aligned postnatal contact schedules.
 - Collaboration with leisure centres, restaurants, universities and employers to promote breastfeeding-friendly environments.
 - Joint development of the Infant Feeding Strategy, bringing together multiple agencies with a shared vision and aligned priorities.
- Collaborated with Family Hubs, Children's Centres and the early years system as part of the focused work on improving good levels of development for children and the reach of the 2 – 2.5 year mandated review.
- The Early Language Support for Every Child (ELSEC) programme in Luton brings together NHS, education, and local authority services to improve early identification and support for children with speech, language and communication needs. The programme emphasises joined-up, preventative working, strengthening partnerships across services to reduce demand on specialist provision and improve outcomes for children and families.
- Through improved partnership working with Central Beds and Bedford Borough Councils, we have joint commissioning arrangements for Link Speech and Language Therapists in all schools, resulting in a consistent, locality-based model of support that strengthens collaboration between health, education and the local authority.
- We are an active member of the Bedfordshire Care Alliance, which is focused on driving improvements in hospital admissions and discharge rates.



Strategic objective 3 - Be collaborative

- We have continued to develop the Bedfordshire wide hospital avoidance model, which includes the following three elements:
 - Unscheduled care hub - acting as a co-ordinating hub for unscheduled care across Bedfordshire.
 - Urgent Care Response - teams provide urgent assessment, treatment and support (within two-hours) to people (over the age of 18) in their own home who are experiencing a health or social care crisis and who might otherwise be admitted to hospital.
 - Virtual wards - Part of a system-wide project to deliver the virtual ward programme, working in partnership with Bedfordshire Hospitals NHS Foundation Trust and East London NHS Foundation Trust and delivering alongside our remote monitoring partner Doccla. Virtual wards allow patients to get the care they need at the place they call home, safely and conveniently, rather than being in hospital.

Cambridgeshire and Peterborough

- Collaborated across the early years system to launch the 'Baby week' initiative <https://babyweek.co.uk/>
- We have delivered some universal routine 2.5 year development reviews in collaboration with Child & Family Centres and adapted to support the OHID requirements to improve good levels of development and school readiness.
- We have collaborated with the Family Hubs in Peterborough to improve the infant feeding offer to support families to make healthy choices.
- We have worked in collaboration with the Family Hub in Peterborough to test and evaluate a community-based parent infant relationship resource.
- We have collaborated with the children's school age immunisation service to co-attend immunisation sessions to have a focus on sexual health promotion, healthy relationships, consent, coercions and prevention of STIs and pregnancy.
- The 5-19 team worked with the education inclusion family advisor to develop a series of webinars to support public health messages at times of transition.
- Developed an early concerns pilot, including a community appointment day with partners in the integrated neighbourhood team in East Cambridgeshire to support parents whilst their children are waiting for a neurodevelopmental assessment.

Norfolk and Waveney

- Our Norfolk Healthy Child Service works within Family Hubs alongside core partners Early Childhood and Family Service (ECFS) and Norfolk County Council Community & Partnership teams. Together we provide a seamless and timely response to families requesting support. We also participate in the workstream around parenting support, infant feeding, parent and infant relationships and adults with learning needs.
- Working with our partners, we launched the Norfolk and Waveney Advice, Support and Access Children and Young People's Mental Health Services. Providers in Norfolk worked together to create a single access route for 0-25-year-olds, simplifying access and helping people access support and advice more quickly.

Dental services

- In January 2025 we were delighted to start a new partnership with Essex County Council to provide supervised toothbrushing in South Essex early years settings. The programme will help thousands of children aged between 3 and 5 years old to develop positive brushing habits. The national scheme is also in collaboration with Colgate-Palmolive, which is providing free Colgate toothbrushes, toothpaste and educational materials to help families continue good work at home.
- Our teams run the My Smile programme, which is a quality mark awarded to early years settings. To be accredited, nurseries, receptions and pre-schools are supported to run daily toothbrushing sessions to show children how to brush their teeth properly and make it fun, make sure snacks and drinks are tooth friendly and encourage families to visit the dentist regularly. In Cambridgeshire and Peterborough, the scheme has been extended to include family hubs who have been awarded the My Smile Quality Mark.
- We have worked in partnership with Suffolk and North East Essex ICB for people with autism, learning disabilities and dementia to access our services in Suffolk.



Strategic objective 3 - Be collaborative

iCaSH Services

- iCaSH are working with the acute Trusts and ICBs in Bedfordshire, Peterborough, Huntingdon and Norwich as part of the research grant funded Emergency Department blood-borne virus screening pilot.
- Community appointment days with DynamicHealth (see below)
- We have also started working with McDonalds and Primark in some areas to increase access to chlamydia screening packs.

DynamicHealth

- Held three successful Community Appointment Days that brought together health professionals, specialties, community groups and health organisations under one roof in non-medical environments in the community, as an alternative to the normal physiotherapy pathway. Service user feedback saw the patient passport redesigned, and additional information added to the website on what to expect from the day.
- Partnership with Flok Health to pilot an AI-powered physiotherapy clinic. CCS was the first NHS organisation in England to deploy the AI clinic across community healthcare settings, providing same day personalised back pain assessment and treatment through a smartphone app.

Cambridgeshire and Peterborough integrated care system's four priorities:

Priority 1: Ensure our children are ready to enter education and exit, prepared for the next phase of their lives

We want to help local children get the best out of their education during their formative years. This includes making sure that every child is ready to start going to school, when they reach the right age to do so, and supporting children's physical and mental wellbeing so they can have a positive experience whilst in school.

We want to reduce the number of young people aged 16 and 17 who are not in education, employment or training. We are also working to reduce inequalities for children – giving every child the best possible start in life, regardless of their personal circumstances or background.

Priority 2: Create an environment to give people the opportunity to be as healthy as they can be

We know there are lots of different factors that will impact a person's health during their lives. This includes health behaviours such as diet, infrastructure including access to public transport, socio-economic factors like wealth and level of education, and availability of green spaces and clean air. Together, these factors make up the environment that affects a person's ability to live a healthy, happy life.

As a partnership of Voluntary, Community and Social Enterprise organisations, local authorities, and NHS partners, we want to improve both opportunities for better health that the NHS provides and wider factors that impact health.

Priority 3: reduce poverty through better employment, skills and housing

Poverty has a severe negative impact on people's ability to live as healthy and happy a life as possible. That's why we're committed to reducing poverty, through better employment, skills and housing.

Together, our partnership as an ICS employs thousands of people across the local area. As a group of large employers, we recognise that we have a direct role to play to treat our staff well. We are also working with wider partner organisations on the economy, housing, employment, and health.

Priority 4: Promote early intervention and prevention measures to improve mental health and wellbeing

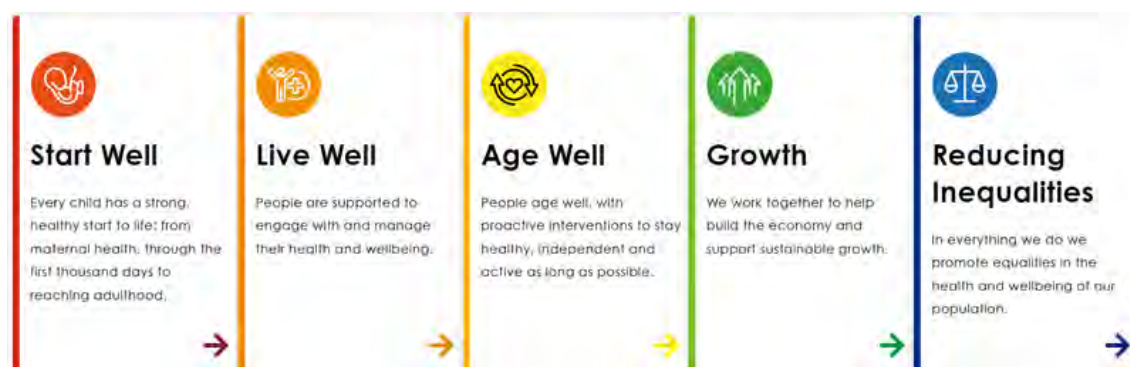
The mental health and wellbeing of our local people is as important to us, as their physical wellbeing. That's why we've committed to promoting early intervention and prevention measures to improve the mental health of local communities. By focusing on early intervention and prevention, we can help people improve their mental wellbeing before their mental ill health becomes more severe.

As part of this work, we're working to improve the mental health of children and young people – reducing the number of young people in our area who need to be referred to mental health services. We're also working to improve people's understanding of the things they can do to support their own mental health and wellbeing, and increase awareness of how and where people can get help when they need it.



Strategic objective 3 - Be collaborative

Bedfordshire, Luton and Milton Keynes integrated care system's five priorities:



Norfolk and Waveney integrated care system's three goals:



Strategic objective 4 - Be sustainable

Moderate to high assurance - We have plans in place to support long-term sustainability and a strong track record of managing our resources well. However, continued pressures such as rising demand, workforce challenges and funding constraints mean some risks remain.

Sustainable development

Our green champions continue to increase awareness of environmental impacts, and this work has increased the regional and national profile of the work from some of our team. Our dedicated webpage on our staff intranet and the service specific messages and advice continue to share good practice and ideas.

We are committed to reducing the need for patients to travel, with increased digital functionality through our digital platforms, enhancing self-care advice and information and, where possible, we continue to explore opportunities to increase the social inclusion of our premises and deliver clinics as close as possible to people's homes.

Alongside delivering the key objectives included in the final year of the Trust's Green Plan, during 2025/26 we jointly developed with NCH&C a further 3-year Green Plan, focussing on key improvement initiatives and opportunities to continue to enhance the awareness across our people and service users.

Our new plan will include programmes of work with a focus on carbon reduction and:

- Workforce and leadership
- Net zero clinical transformation
- Suggested clinical focus areas
- Digital transformation
- Medicines
- Travel and transport
- Estates and facilities
- Supply chain procurement
- Food and nutrition
- Adaptation

The Green Plan was agreed by the Group Board and is available on the Trust's website.

Development of services provided

Group model

During 2025/26, the group model has created opportunities to align contracts and procurement approaches across CCS and NCH&C. Throughout the year, both teams have reviewed the support provided to operational leads for commissioned services, ensuring all key income agreements are fully covered. As part of this work, the teams have continued to review key suppliers to identify efficiencies, innovation, and service improvements.

When the Trusts merge to form East of England Community Health and Care NHS Trust on 1 April 2026, all existing contracts will transfer to the new organisation.

Key partnerships and alliances

- Bedfordshire Care Alliance: The Trust continues to remain a key partner in the Bedfordshire and Luton system playing a significant role in the development of programmes across end of life and leading on unscheduled care and the development of the Bedfordshire Unscheduled Community Care Hub.
- Children's and Maternity Accountable Business Unit (ABU): The ABU was stood down with strategic partnerships being sustained through other system forums and through the North and South Care partnerships.
- Norfolk children and young people's strategic alliance: Implementation of the Flourish strategy has continued through 2025/26, and a refresh of the strategy has just been agreed with contributions from all system partners.
- The Trust will be supporting the newly formed ICBs Central East and Norfolk & Suffolk.



Contracts overview

Income Agreements

The Trust enters the financial year with a planned turnover of £376 million. Several commissioners have renewed agreements under the Provider Selection Regime (PSR), with key contracts including:

Contract	Award/Extension
Cambridgeshire and Peterborough ICB community specialist children's and musculoskeletal services	Extended to March 2027
Bedfordshire, Luton and Milton Keynes ICB 0-19 and children's community services	Awarded for seven years (April 2025 - March 2032, with extension options to 2034)
Bedfordshire, Luton and Milton Keynes ICB Adult community service	Extended to March 2028
Minor oral surgery	Extended across Cambridgeshire, Peterborough, Norfolk, Waveney, and Suffolk to March 2027, with the option to extend for a further year to March 2028
Special care dentistry and general anaesthetic services	Have devolved into the Cambridgeshire and Peterborough ICB community contract, and as such is aligned with the end date of March 2027
First Contact Practitioners	Agreements with 11 Cambridgeshire and Peterborough Primary Care Networks extended to March 2027
Local Authority Agreements	Cambridgeshire occupational therapy extended to March 2027, albeit with a 10% reduction applied as an efficiency saving
	Norfolk and Waveney speech and language therapy to extend for a further three years to August 2029, pending a review of funding to address cost pressures
iCaSH services	Milton Keynes extension agreed until 31 October 2027
	Bedfordshire agreement in place until 17 December 2028
	Norfolk agreement in the process of being consolidated, following direct award under PSR, with a 10-year term to 2036
	Cambridgeshire agreement signed 1 April 2025 with a six-year term to 1 April 2031, and break points at 1 April 2029 and 1 April 2030
	Peterborough agreement signed 1 April 2025 with a six-year term to 1 April 2031, and break points at 1 April 2029 and 1 April 2030
Cambridgeshire and Peterborough healthy child programme services - commissioned separately by Cambridgeshire County Council and Peterborough City Council.	Have a term of six years to March 2032

Tenders

- The Norfolk Healthy Child Programme agreement: Expires September 2026 and will be tendered by Norfolk County Council (NCC) as NCC 0-5 Health Visiting Service and the NCC Single Point of Access (SPOA) and Digital Health Provision (DHP). We responded to both market engagement questionnaires and are awaiting feedback as to the route to market NCC propose to take.
- Oral Health Promotion (OHP): A 3-year contract with North Northamptonshire Council starting 1 April 2026.

Purchase Agreements

Our key supply chain agreements support the delivery of our commissioned services and ensure we deliver our broader statutory obligations.

Of the Electronic Patient Records (EPRs) in place:

- Lilie, our sexual health services EPR, is in the process of renewal with a proposed three-year term to March 2029.
- Dentally, our dental EPR, expires August 2026.
- SystemOne, our main community services EPR, expires July 2026 with the option to extend for a further two years to July 2028.

Other contracts of note include:

- Strategic estates management: CBRE (Hard FM) and OCS (Soft FM) contracts extended to April 2030 and April 2029, respectively.
- Pharmacy services: Fairview Pharmacy awarded contract under PSR for three years (April 2025– 2028), extendable to 2031.
- Logistics: GSG contract extended to September 2026.
- ICT services: NHS SBS/Sopra Steria contract continues until October 2029.
- Pathology services: awarded to HSL under PSR direct award route C, initially three years (March 2028), extendable to March 2030.
- CCS partnered with Flok Health to pilot an AI-powered physiotherapy clinic enabling more than 2,500 patients with back pain to use an AI-supported rehabilitation programme. Waiting times reduced by 44%, back pain waiting lists fell by 55% and hundreds of hours of clinician time were freed up to support patients with more complex needs. Plans are now underway to expand the programme further.



2025/26 was again a challenging year financially for the Trust and across the whole of the health sector but we have managed to successfully deliver a £1.656m (£53k 2025/26) surplus. Please note this final position was delivered following the receipt of redistributed additional £1.638m funding from NHS England. The continued impact of increasing activity levels and pay and non-pay cost inflation have been a real pressure to achieving this, but despite these challenges, the Trust's strong governance and financial management regime has enabled it to deliver its portfolio and maintain financial balance.

Key messages for the year are set out below:

- The Trust maintained its high level of financial governance, recognised by the internal auditors giving an opinion of 'reasonable assurance' over the Trust's financial systems, budget control and financial improvement.
- The Trust has a responsibility to pay its suppliers in line with the payment terms agreed at the time of purchase. Failure to do this harm the reputation of the Trust and the wider NHS, as well as damages supply sources and strains relationships with suppliers.
- The Trust is required to pay its non-NHS and NHS trade payables in accordance with the Confederation of British Industry Better Payment Practice Code. This requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The Trust is assessed as compliant with the Code if it meets this requirement 95% of the time. The Trust paid 92% (90% in 2024/25) of non-NHS invoices within 30 days of receipt of a valid invoice and therefore met the target. Seventy seven per cent of NHS invoices were paid within 30 days of receipt of a valid invoice, compared to 78% in 2024/25.
- The Trust's 2025/26 accounts have been externally audited by Bishop Fleming LLP. External audit fees for 2025/26 were agreed as £119,000 excluding VAT (2024/25 fees with Bishop Fleming LLP £113,350 excluding VAT).
- The Freedom of Information Act (FOIA) gives individuals the right to ask any public sector organisation for the recorded information they have on any subject. Most requests are free but, in some cases, individuals may be asked to pay a small amount for photocopies or postage. The Trust has complied with Treasury's guidance on setting charges for information.
- So far as the directors are aware, there is no relevant audit information of which the auditors are unaware. Directors have taken all the steps they ought to have taken in order to make themselves aware of any relevant audit information, and to establish that the auditors are aware of that information.
- The directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. It is expected that 2026/27 will be a greater financial challenge to previous years, however revenue and cash flow forecasts support the conclusion that the Trust is a 'going concern.' For this reason, directors continue to adopt the 'going concern' basis in preparing the accounts.

To obtain further detail of our financial performance, please write to: Chief Finance & Resources Officer, East of England Community Health and Care NHE Trust, Unit 7 & 8, Meadow Lane, St Ives, PE27 4LG.

Our full audited accounts will be available on our website at www.eastofenglandcommunityhealthandcare.nhs.uk

Contracts for services

Our contracts for services are with commissioners covering Bedfordshire, Cambridgeshire, Luton, Milton Keynes, Norfolk, Peterborough and Suffolk and set out ambitious objectives and targets for the coming year. We have every expectation of achieving our contract targets, ensuring that local people can access services that promote healthier lives closer to home.



Financial outlook

The financial plan for East of England Community Health and Care NHS Trust has been informed by the NHS financial framework for 2026/27, the allocation and agreement of resource distribution within the Cambridgeshire and Peterborough (C&P) system and agreed contracted income from other NHS and non-NHS Commissioners.

The financial regime for 2026/27 continues to include commissioning via contracted values to inform direct allocations from NHS commissioners and the continuation of services provided to Local Authority Public Health commissioners. System allocations have been informed by a combination of the block contract funding, a reduction in and removal of non-recurrent allocations received during 2025/26, adjustments for movement to capitation-based funding, and uplifts in cost and funding for forecast growth and inflation.

The Trust's service portfolio for 2026/ 27 will not change materially and the overall initial expenditure budget totals £376 million. On 18 March 2026, the Board approved a balanced plan for 2026/27, with a requirement to deliver a 4% efficiency target. This plan could be subject to additional funding opportunities emerging during the financial year.

The Trust has a core capital plan of £11 million for 2026/27.

Signed:



Matthew Winn, Chief Executive

Accountability report

Corporate Governance report

Directors' report 2025/26

The Trust's Board, comprising executive and non-executive directors, is responsible for setting the Trust's strategic direction and for ensuring compliance with all governance, probity and assurance requirements.

Details of the Trust's Chair, Chief Executive, executive directors and non-executive directors are provided later in the Governance Statement on page [\[TBC\]](#). This section also includes information on Board membership and the Trust's sub-committees.

Information relating to personal data-related incidents that have been formally reported to the Information Commissioner's Office is included in the Performance Report on page [\[TBC\]](#).

Compliance statement

The Trust has taken appropriate steps to ensure that each director has confirmed that, to the best of their knowledge, there is no relevant audit information of which the Trust's auditors are unaware. Each director has also confirmed that they have taken all reasonable steps to make themselves aware of any relevant audit information and to ensure that the Trust's auditors are aware of that information. In addition, the Trust undertakes annual Fit and Proper Person checks for all directors.

Statement of the chief executive's responsibilities as the accountable officer of the trust

The Chief Executive of NHS England has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the trust
- the expenditure and income of the trust have been applied to the purposes intended by Parliament and conform to the authorities which govern them
- effective and sound financial management systems are in place and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

As far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed:



Matthew Winn, Chief Executive

6 May 2026

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Statement of directors' responsibilities in respect of the accounts

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Trust's performance, business model and strategy.

By order of the Board



Matthew Winn
Chief Executive
6 May 2026



Mark Robbins
Director of Finance
6 May 2026



Annual governance statement

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Cambridgeshire Community Services NHS Trust to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Cambridgeshire Community Services NHS Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.



Capacity to handle risk

The Board of Directors (the Board) has overall responsibility for ensuring that effective systems of risk management and internal control are in place and operating throughout the Trust. The Board provides strategic leadership and oversight, setting the tone for good governance and ensuring that risks to the delivery of the Trust's objectives are identified, assessed, and managed appropriately.

In discharging this responsibility, the Board:

Sets the strategic direction, vision, and Trust objectives, ensuring that these are aligned with the Trust's purpose and values. In doing so, the Board considers the internal and external risks that may affect the achievement of the strategy and establishes a clear risk appetite to guide decision-making.

Ensures accountability for delivery of the strategy and organisational performance, holding executive management to account through regular performance reports, risk reports, and assurance processes. This includes oversight of financial sustainability, quality and safety, workforce capacity, and operational performance, ensuring that appropriate controls and mitigations are in place.

Oversees the effectiveness of the system of internal control, including arrangements for risk management, financial control, clinical and operational governance, and compliance with statutory and regulatory obligations. The Board receives assurance from its committees, including the Audit and Risk Committee, and from internal and external audit.

Promotes a positive culture of openness, integrity, and continuous improvement, fostering behaviours that support effective risk management and high-quality decision-making. The Board seeks to ensure that the Trust's culture encourages the early identification and escalation of risks, learning from incidents, and constructive challenge at all levels of the organisation.

Delegates specific responsibilities to Board committees, while retaining overall accountability. The Board regularly reviews committee effectiveness to ensure they provide robust scrutiny and assurance in relation to risk, control, and governance.

Through these arrangements, the Board gains reasonable assurance that the Trust's systems of governance, risk management, and internal control are effective in supporting the achievement of its objectives and in safeguarding public resources.

The risk and control framework

The Trust is not required to comply with the UK Corporate Governance Code. However, the Board considers strong corporate governance to be fundamental to the effective leadership and control of the organisation. Accordingly, the Trust reports on its corporate governance arrangements by drawing on recognised best practice, including those elements of the UK Corporate Governance Code that are considered relevant and proportionate to an NHS Provider Trust.

The Board operates in accordance with the Code of Governance for NHS Provider Trusts, supported by Standing Orders, Standing Financial Instructions and a Scheme of Reservation and Delegation. It demonstrates this through:

- Operating as a unitary Board with collective responsibility for the performance and governance of the Trust.
- Maintaining a strong focus on Board and committee effectiveness, supported by regular reviews of Board composition and skills, annual effectiveness evaluations, and delivery of actions arising from the well-led improvement plan.
- Providing transparency by openly considering Trust performance, quality, and risk in public Board meetings.
- Having a formal and transparent process for setting executive remuneration, in line with national guidance, overseen by a Remuneration committee.
- Effectively managing relationships with key stakeholders, including patients, staff, partners, regulators, and system colleagues.



NHS Provider Licence

The Board is satisfied that the Trust’s governance arrangements are effective and meet the requirements of Section 4 of the NHS provider licence, providing appropriate leadership, oversight and accountability in support of the Trust’s strategic objectives.

The Company Secretary provides ongoing advice to the Board on governance developments and emerging requirements.

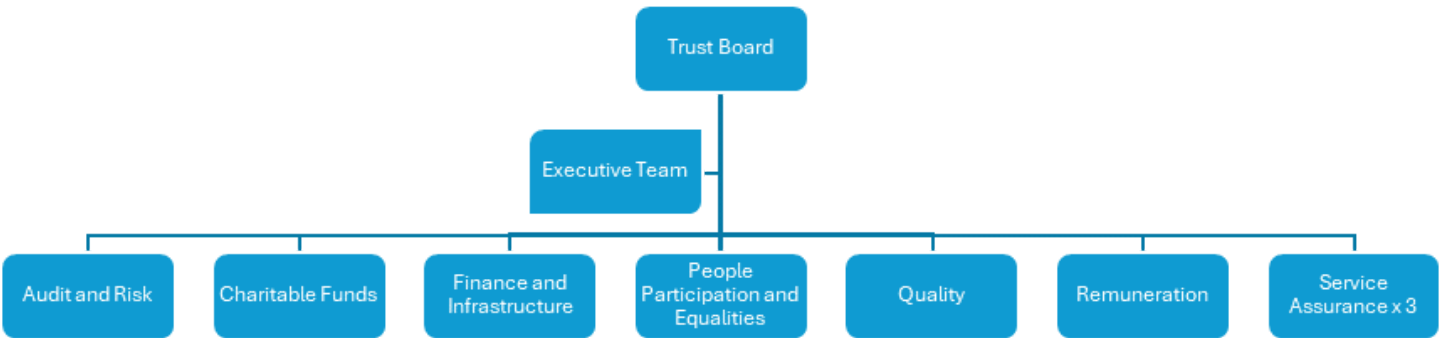
Executive leadership is co-ordinated through the Executive Team, ensuring alignment between operational delivery and Board assurance.

Reporting Lines and Accountability

The Trust operates a unitary Board, collectively responsible for strategy, performance, quality, risk and financial sustainability. The Board is supported by a formal committee structure, including **Audit and Risk, Charitable Funds, Quality, People Participation and Equalities, Finance and Performance, and Remuneration.**

Each committee operates under Board-approved terms of reference, reviewed annually, and provides assurance and escalation to the Board as appropriate.

The Trust also operates three **Service Assurance Committees**, through which clear reporting lines from operational, clinical and corporate functions into the Board’s committees are established and routinely monitored.



Trust Board

During the year, the Trust Board met seven times in public session. In line with the Trust's commitment to openness and transparency, members of the public were able to submit questions in advance of meetings via the Trust's website and social media channels.

All Board meetings were appropriately constituted and quorate. Agendas and minutes of meetings were published and made publicly available on the Trust's website.

Attendance by individual directors at Trust Board and Board Committee meetings is set out in Annex 1 (page number TBC) of this Annual Governance Statement and demonstrates appropriate engagement and participation throughout the year.

The Board comprises the Chair, the Senior Independent Director and six other Non-Executive Directors, together with the Chief Executive and seven Executive Directors.

All Directors are required to meet the requirements of the Fit and Proper Person Test Framework, both on appointment and on an ongoing basis. The Trust has processes in place to provide assurance of continued compliance. Details of each Director's skills, experience and expertise are published on the Trust's public website:

www.eastofenglandcommunityhealthandcare.nhs.uk/about-us/our-board/

The Board was satisfied that it operated effectively during the year and discharged its responsibilities in accordance with its Standing Orders and governance arrangements.

Trust Board Development

Theme	Areas of Focus
Patient experience and engagement	- Briefing for Non-Executive Directors on the Patient Safety Incident Investigation process and learning - Application of the 15 Steps challenge approach by Non-Executive Directors to assess care quality and patient experience
Staff experience and engagement	- Freedom to Speak Up Guardian annual report and self-assessment - Board discussion of staff experience metrics and workforce culture indicators
Strategic issues	- Review of the Trust Strategy 2023-26 and the five supporting strategies and strategic ambitions - Overview of clinical services across the Group - Development of the Clinical and Care Strategy and Organisational Development Plan for the new merged Trust (with effect from 1 April 2026), including mission and values, and the full business case - Agreed parameters for business development and service growth - Financial strategy, efficiency plans and medium-term financial outlook for 2025/26 and future years - Collaborative working arrangements - Integrated Care System priorities and system-level developments - Group Model and Building Trust programme development - Review of risk appetite and strategic risks contained within the Board Assurance Framework - Consideration of emerging risks through the Board's risk radar - Well-led governance and leadership assurance - Digital transformation, including developments in artificial intelligence and cyber security - Review of its own effectiveness

The Audit and Risk Committee is an independent committee of the Board and provides assurance that the organisation has effective governance, risk management and internal control arrangements in place. The committee supports the Board in discharging its statutory duties by reviewing the comprehensiveness, reliability and integrity of assurances on the effectiveness of these systems.

The committee maintains oversight of the organisation's principal risks, including clinical, strategic, financial and emerging risks, and risks arising from delivery of the integrated business plan. It oversees the Board Assurance Framework, ensuring that risks are clearly articulated, aligned to strategic objectives and supported by appropriate controls and mitigating actions.

In fulfilling its role, the committee reviews the effectiveness of risk management and internal control processes, drawing assurance from the internal audit programme and from management representations. It monitors progress against agreed internal audit recommendations and reviews the adequacy of actions taken to address identified weaknesses.

The committee is constituted in accordance with the NHS Audit Committee Handbook. During 2025/26, the committee oversaw the audit of the 2025/26 financial statements and reviewed the Annual Governance Statement prior to submission to the Board. It approved and monitored delivery of the internal and external audit plans and reviewed the effectiveness of controls across the organisation, including arrangements for counter fraud.

The committee met four times during the year. It reviewed reports from all internal audit assignments completed in accordance with the agreed 2025/26 audit plan. Based on the work undertaken, the committee was satisfied that it obtained appropriate assurance to inform the Board's assessment of the effectiveness of governance, risk management and internal control during the year.

Head of Internal Audit Opinion



Internal audit provided an overall adequate level of assurance. The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

Counter Fraud, Anti-Bribery and Corruption

The Trust has established counter fraud, anti-bribery and corruption arrangements that are designed to prevent, detect and respond to fraud and bribery, and takes a zero-tolerance approach to such activity. These arrangements are aligned with the requirements and guidance of the NHS Counter Fraud Authority.

The Trust has a designated Local Counter Fraud Specialist and appropriate counter fraud resources in place to support the investigation and prevention of fraud, bribery and corruption. An anti-fraud and bribery policy is in place, supported by procedures that set out responsibilities, reporting mechanisms and standards of conduct.

Awareness-raising and preventative activity forms a key element of the Trust's counter fraud arrangements. During the year, targeted awareness sessions were delivered, including sessions for senior leaders, to reinforce staff responsibilities and promote a culture of vigilance and timely reporting.

All allegations of potential fraud or wrongdoing are treated seriously and are investigated in line with national guidance. Where appropriate, the Trust applies the full range of disciplinary, civil, regulatory and criminal sanctions, including seeking financial recovery.

These arrangements provide the Board with assurance that proportionate and effective systems are in place to manage the risk of fraud, bribery and corruption as part of the Trust's overall system of internal control.

Counter fraud activity and outcomes are reported to the Audit and Risk Committee for oversight and assurance.

Charitable Funds

Cambridgeshire Community Services NHS Trust acts as the corporate trustee of its charitable funds. The Board, acting on behalf of the Trust as corporate trustee, is responsible for ensuring that charitable funds are managed, invested and applied effectively and in accordance with the Charities Act, Charity Commission guidance, NHS charity regulations and the specific wishes of donors.

The committee provides oversight of the governance arrangements for charitable funds, as delegated by the Board. This includes oversight of the management, investment and disbursement of charitable funds, and ensuring that appropriate systems of internal control and accountability are in place to support compliance with all relevant legal and regulatory requirements.

The committee met twice during the year and, through the work undertaken, provided assurance to the Board that the charitable funds were managed appropriately and in line with their stated objectives and donor intentions.

Finance and Infrastructure

The Finance and Infrastructure Committee is a joint committee of the Board and provides assurance that effective arrangements are in place to support the delivery of the Trust's financial, estates and digital strategies. The committee supports the Board by overseeing the development and implementation of these strategies and by ensuring that robust systems and structures are in place to support the delivery of high-quality and safe patient services.

The committee advises the Board on compliance with relevant legal and regulatory requirements and best practice, including health and safety, infection prevention and control, data protection, information security and sustainability. It also provides a formal route for reporting, escalation and engagement on finance, estates and digital matters between key operational groups, the Trust and commissioners.

The committee oversees finance, estates and digital risks, including risks on the strategic risk register and those captured within the Board Assurance Framework that fall within its remit. It also reviews the estates and digital risk registers to ensure that risks are appropriately identified, mitigated and escalated.

The committee was satisfied that it received appropriate assurance to inform the Board's oversight of finance, estates and digital matters.

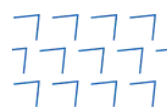
The committee met on six occasions during the year.

People Participation and Equalities

The People Participation and Equalities Committee is a joint committee of the Board and provides assurance on the Trust's arrangements for people participation and equalities. The committee oversees the Trust's approach to engaging with service users, carers, communities and staff, and seeks assurance that this engagement informs service design, delivery and improvement.

The committee also provides oversight of the Trust's equality, diversity and inclusion arrangements, supporting the Board in understanding how the Trust promotes fairness, addresses inequalities and fosters an inclusive and 'speak-up' culture. Through its work, the committee supports continuous improvement driven by meaningful engagement and feedback.

The committee met twice during the year and provided assurance to the Board that appropriate arrangements are in place to support people participation and equalities within the Trust's overall governance framework. This includes assurance on compliance with relevant equality legislation and NHS guidance.



Quality

The Quality Committee is a committee of the Board and provides assurance on the effectiveness of the Trust's arrangements for quality, patient safety and clinical governance. The committee supports the Board in fostering a culture of continuous improvement, with patient safety at the heart of service delivery.

The committee oversees the systems and structures that support the delivery of high-quality, safe and effective care and provides assurance that the Trust meets its duties and responsibilities to patients, service users and staff. This includes oversight of quality standards, clinical risk management, research governance and learning from incidents and feedback.

The committee advises the Board on compliance with quality-related regulatory and accreditation requirements and contributes to the development of key clinical and quality strategies, monitoring progress against agreed objectives.

The committee also oversees arrangements to protect the health, safety and wellbeing of staff, and reviews and approves the annual clinical audit programme, ensuring that learning from audit is embedded and informs service improvement.

The committee met five times during the year and considered a range of quality improvement themes. Through its work, the committee provided assurance to the Board on the effectiveness of quality governance and the Trust's arrangements for patient safety and continuous improvement.

The committee monitored learning from incidents, complaints and patient experience to support improvement and transparency.

Remuneration Committee

The Remuneration Committee is a committee of the Board and provides assurance that the Trust's arrangements for remuneration at executive level are fair, equitable and applied consistently. The committee also supports the Board in relation to executive succession planning and appointments.

During the year, the committee met once to discharge its responsibilities. Matters considered included the review of executive remuneration, consideration of executive appointments and succession planning arrangements, and assurance that Fit and Proper Persons Test checks had been completed for all directors.

The committee also considered workforce change matters falling within its remit, including redundancies, ensuring that these were managed appropriately and in line with relevant policies and legal requirements.

Through its work, the committee provided assurance to the Board that remuneration and associated governance arrangements were applied appropriately and in accordance with best practice.

No issues of non-compliance with remuneration regulations or Fit and Proper Persons requirements were identified.



Service Assurance Committees

The following Service Assurance Committees were in place during the year:

- Norfolk Adult Services
- Children and Young People's Services
- Luton and Bedfordshire Adult and Older People's Services, and Ambulatory Care

The Service Assurance Committees are joint committees that provide service-level assurance to the Board. Each committee met six times during the year and supports the Board through integrated analysis of performance and intelligence across quality, safety and patient experience, workforce wellbeing and morale, and key risks and operational issues.

The committees identify areas of concern requiring Board attention or action and provide a structured route for escalation of exceptions, risks and issues. In addition, they support a culture of learning and continuous improvement by sharing, disseminating and recognising good and outstanding practice across services.

Through this role, the Service Assurance Committees provide the Board with assurance that robust oversight mechanisms are in place at service level and that emerging issues are identified, managed and escalated appropriately.

This consistent approach to service-level assurance supports the Board's oversight across all places and care groups.

Risk Management and Internal Control

The Board is responsible for the delivery of the Trust's objectives and for ensuring that effective systems of risk management and internal control are in place. This includes oversight of risk management, counter-fraud and bribery arrangements, internal and external audit, and internal financial control.

During the year, progress has been made to strengthen risk management arrangements across the group. Key developments include the implementation of a joint Board Assurance Framework, incorporating a defined risk appetite and an emerging risk radar. The Trust also received reasonable assurance from its internal audit review of risk maturity, which confirmed there were reasonable and effective risk management, control and governance processes in place. The Trust operates a group-wide risk and issue management policy, revised in December 2025. The policy sets out the approach to identifying, assessing, recording, escalating and managing risks and issues, and reinforces the open and transparent culture expected by the Board. Standardised assessment of likelihood and consequence is applied consistently.

The Board and its committees receive regular integrated reports covering risk, quality, finance and performance, including progress against actions to mitigate principal risks. The Board Assurance Framework sets out the principal risks and issues affecting delivery of each Trust's objectives, identifies key controls and sources of assurance, and highlights gaps where further action is required. As part of its well-led improvement priorities, the Trust continues to strengthen the effectiveness and clarity of the Board Assurance Framework.

Executive leads are identified for all principal risks and are responsible for ensuring appropriate controls and mitigations are in place. The strategic risk and issue register is reviewed bi-monthly by the Board. In line with the escalation framework, all risks rated 15 or above and issues rated 5 are escalated to the Board, with lower-rated risks and issues subject to regular review through Board aligned committees.

Risks relating to fraud, bribery and corruption are managed through dedicated policies and oversight arrangements, with assurance provided to the Board via the Audit and Risk Committee.

Risk is assessed at all levels of the organisation and recorded on a single, organisation-wide electronic risk register, enabling effective identification and escalation of both operational and strategic risks. Key sources of assurance include integrated performance reporting, committee oversight, internal and external audit, regulatory reviews and other external assurance mechanisms.

The principal strategic risks for 2025/26 are set out in the table below, as of 31 March 2026.

No	Risk Description	Score
3655	There is a risk that the non-executive and executive and wider senior leadership capacity and expertise required to deliver the transaction to support the move to a new/single organisation will result in failure to deliver the current quality, operational, workforce and financial performance and plans.	9
3656	If stakeholders withdraw their support, there is a risk that the group model programme and transaction could not be delivered and therefore impact the performance and delivery of the existing services of the Trust and sustainability in the future.	6
3653	There is a risk that clinical quality and patient safety could be compromised if the following areas are not managed/mitigated: gaps in staffing/staff morale, group model planning, financial pressures and cost efficiencies and compliance with regulatory bodies. The impact of this potential risk could lead to an increase in level of 'harm', a reduction in clinical quality/safety across services and an increase in patient dissatisfaction.	12
3699	There is a risk that staff morale and engagement may be adversely affected whilst we culturally align our two organisations.	8
3691	There is a risk that due to increasing inflationary pressures and a challenging efficiency target, the Trust may not deliver a balanced financial plan for 2025/26 which could impact on the delivery of services.	12
3709	If we do not address cybersecurity threats (such as data breaches and patient privacy, ransomware, operational disruption, insider threats and third-party risks) then there is an increase likelihood of a major service disruption and possible compromise to patient care.	16
3837	There is a risk that if suppliers integrate AI (Artificial Intelligence) components or subcontract to third-party AI providers without disclosure or adequate contractual controls, then the organisation will have no visibility or assurance over how patient or operational data is processed and how AI influences clinical or business decisions, leading to potential patient harm, regulatory breaches (GDPR / DSPT), financial penalties, and reputational damage to the Group.	12
3708	If NCH&C and CCS cannot secure recurrent and long-term efficiencies and/or additional resources, it may not be able to fund increasing demand for services in future years.	12
3751	Long waits for children for diagnostic assessment from our neurodevelopmental services	16
3770	There is a risk that fraudulent activity could result in significant loss to the Trust	9

Compliance with the Developing Workforce Safeguards Recommendations

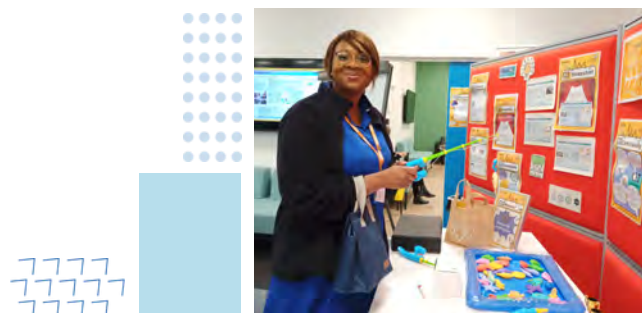
The Trust is committed to ensuring safe, effective, and sustainable staffing arrangements and has embedded the principles of the Developing Workforce Safeguards into its governance, planning, and operational processes. The Board recognises that effective workforce safeguards are critical to the delivery of high-quality, safe patient care and to the wellbeing of staff.

Board Oversight and Accountability

The Board maintains clear oversight of workforce risks and safeguards through regular reporting on workforce performance, capacity, and capability. Workforce metrics, including staffing levels, turnover, sickness absence, use of temporary staffing, and staff wellbeing indicators, are routinely reviewed by the Board and its committees. Workforce risks are explicitly reflected within the Board Assurance Framework and Trust Risk Register, ensuring that strategic and operational workforce risks are identified, mitigated, and subject to appropriate assurance.

Safe and Effective Workforce Planning

Workforce plans are developed using evidence-based tools and methodologies, including professional judgement and national guidance, to ensure that staffing models support safe care and reflect current and anticipated service need. These plans are regularly reviewed and updated to remain responsive to changes in demand, workforce availability, and system priorities.



Escalation and Mitigation of Staffing Risks

Clear processes are in place to identify, escalate, and manage staffing risks at team/ward, departmental, and organisational levels. Where staffing shortfalls arise, mitigation actions, such as redeployment, adjusted skill mix, temporary staffing, or revised service arrangements, are implemented in line with agreed escalation policies. These arrangements ensure that risks to patient safety and staff wellbeing are promptly addressed and that learning is captured to reduce future recurrence.



Workforce Capability, Wellbeing, and Culture

Consistent with the Developing Workforce Safeguards recommendations, the Trust places strong emphasis on workforce capability, training, and wellbeing. The Trust invests in education, professional development, and leadership capability to ensure staff are competent, supported, and able to deliver safe care. Initiatives to promote health and wellbeing, equality, diversity, and inclusion, and freedom to speak up are embedded across the organisation, supporting a positive culture in which staff feel empowered to raise concerns about safety or staffing without fear of detriment.

Use of Temporary Staffing

The Trust has appropriate controls in place to manage the use of temporary staffing, ensuring that agency and bank staff are used safely, effectively, and as a last resort. Governance arrangements ensure value for money, continuity of care, and maintenance of quality standards, with regular monitoring and reporting of temporary workforce usage to support assurance.

Continuous Improvement and Assurance

The Trust undertakes regular reviews of workforce safeguards through internal audit, committee scrutiny, and triangulation of data from quality, workforce, and finance sources. Learning from incidents, feedback from staff, and outcomes from national surveys inform continuous improvement of workforce planning and safeguards. Compliance is kept under ongoing review to ensure arrangements remain effective, proportionate, and aligned with national expectations.

Through these measures, the Trust can provide assurance that workforce safeguards are embedded within its governance arrangements and that workforce risks are actively managed in support of safe, high-quality patient care.

Care Quality Commission

The Quality Committee provides assurance on clinical governance, patient safety and quality improvement arrangements. The Trust is fully compliant with the registration requirements of the Care Quality Commission.

Managing Conflicts of Interest

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

Visit www.eastofenglandcommunityhealthandcare.nhs.uk/about-us/our-board/ for the register.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with, including the completion of quality and equality impact assessments.

Green Plan

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.



Review of economy, efficiency and effectiveness of the use of resources

During a period of continued and significant challenge across the health sector, the Trust achieved a breakeven financial position. This outcome reflects the effectiveness of the Trust's robust financial governance arrangements and disciplined financial management, which have enabled the delivery of operational priorities while maintaining financial balance.

Key messages for the year

The Trust maintained financial governance, over the operation of financial systems, budgetary control, and financial improvement arrangements.

The Trust recognises its responsibility to pay suppliers in accordance with agreed payment terms. Timely payment is essential to maintaining the Trust's reputation, supporting supplier sustainability, and ensuring value for money across the wider NHS.

The Trust continues to operate in line with the NHS Better Payment Practice Code, which sets a target for at least 95% of trade payables to be settled within 30 days of receipt of a valid invoice or delivery of goods, unless alternative terms have been agreed.

During the year, the Trust's performance against this target improved for both NHS and non-NHS trade payables. Detailed performance information is set out in note TBC to the annual accounts.

The Trust will continue to focus on strengthening its financial control environment, monitoring performance against national payment standards, and embedding continuous improvement to support sustainable financial management in future years.

Information Governance

The Trust has not experienced any serious information governance incidents, including data loss or confidentiality breaches, that required reporting to the Information Commissioner's Office or the Department of Health and Social Care via the Data Security Incident Reporting Tool.

Data quality and governance

The Trust has established arrangements to support the accuracy and quality of clinical and performance data. Oversight is provided through the Data Quality Group, which reviews data quality assurance and reports to the Trust Board. In addition, a records management clinical audit is undertaken annually to provide assurance on compliance with records management standards.

Clinical data is subject to validation, with routine data quality reports provided to service directors and service leads. Where issues are identified, actions for improvement are agreed and monitored through the Data Quality Group.

The Trust does not provide elective services and therefore does not hold elective waiting time data. Other relevant waiting time data is monitored on a monthly basis, with exception reports provided to service leads to support review, escalation and corrective action where required.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Conclusion

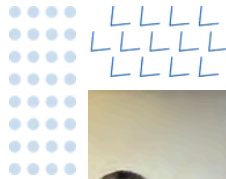
Following an incident of fraud in one service, a review identified weaknesses in the controls of cash and card payment processes. Whilst policies and procedures are in place for cash, card and petty cash processing, further work is required to strengthen and consistently embed the control framework to ensure it operates effectively and as intended across the organisation.

An action plan has been developed and is implementing targeted actions to address the weaknesses identified. This includes strengthening the design of key controls, clarifying roles and responsibilities to reinforce appropriate segregation of duties, and embedding more consistent management review and assurance processes. The internal audit plan will be followed-up in this year's audit cycle to provide an independent view that actions have been effectively implemented, and that the control framework is operating as intended.

Signed



Matthew Winn
Chief Executive
6 May 2026



Modern slavery act

We fully support the Government's objectives to eradicate modern slavery and human trafficking and recognise the important role NHS Trusts play in preventing exploitation and supporting individuals who may be affected.

We are committed to acting ethically and with integrity in all our activities and to ensuring that our employment practices, procurement arrangements and supply chains uphold high ethical and labour standards.

As an NHS Trust, we take a risk-based approach to identifying, assessing and managing the potential risk of modern slavery and human trafficking, with consideration given to higher risk areas such as workforce supply, estates and facilities services, and external contractors. Our procurement and contract management processes align with NHS Standard Contract requirements and relevant national guidance, and we expect our suppliers to share our commitment to ethical working practices.

We promote awareness of modern slavery through safeguarding arrangements and relevant staff training, and we have clear processes in place to escalate and respond to concerns. Where potential victims are identified, we work in partnership with local safeguarding teams and other statutory agencies to ensure appropriate support and referral pathways are followed.

Our Slavery and Human Trafficking Statement for 2025/26 has been approved by the Trust Board on 21 May 2025 and is [published on our website](#) as part of our commitment to transparency and continuous improvement.

Trust Accounts Consolidation (TAC) Summarisation Schedules for Cambridgeshire Community Services NHS Trust

Summarisation schedules numbers TAC01 to TAC34 and accompanying WGA sheets for 2025/26 have been completed and this certificate accompanies them.

Chief Finance & Resources Officer Certificate

1. I certify that the TAC schedules have been compiled and are in accordance with:
 - the financial records maintained by the NHS Trust
 - accounting standards and policies which comply with the *Department of Health and Social Care's Group Accounting Manual* and
 - the template NHS provider accounting policies issued by NHS England, or any deviation from these policies has been fully explained in the Confirmation questions in the TAC schedules.
2. I certify that the TAC schedules are internally consistent and that there are no validation errors.
3. I certify that the information in the TAC schedules is consistent with the financial statements of the NHS Trust



Angela Moodie
Chief Finance & Resources Officer
15 June 2026

Chief Executive Certificate

1. I acknowledge the accompanying TAC schedules, which have been prepared and certified by the Chief Finance & Resources Officer, as the TAC schedules which the Trust is required to submit to NHS England.
2. I have reviewed the schedules and agree the statements made by the Chief Finance & Resources Officer above.



Matthew Winn
Chief Executive
15 June 2026



The table below sets out the number of meetings attended by each Board member during 2025/26. Where membership of Board committees changed during the year, these are reflected in the attendance levels shown below indicating that individuals may not have been members of committees for the full year, or where directors attended meetings on an ad-hoc basis as 'ex-officio' members.

Name and Position	Board Meetings in public	Audit & Risk	Charitable Funds	Finance & Infrastructure	People Participation & Equalities	Quality	Remuneration	Children & Young People Service Assurance	Luton & Bedfordshire Adults, and Ambulatory Service Assurance	Norfolk Adults Service Assurance
Lynda Thomas (Trust Chair)	7 (7)	-	2 (2)	1*	-	1*	1 (1)	1*	1*	1*
Charlotte Black (Non-Executive Director) from 1 September 2025	4 (4) **	-	-		-	2 (2)	-	-	4 (4) **	-
Sarah Buchan (Chief Information Officer)	7 (7)	-	-	6 (6)	-	-	-	-	-	-
Laura Clear (Director of Strategy and Transformation)	6 (7)	-	-	5 (6)	-	-	-	5 (6)	-	-
David Crawford (Non-Executive Director)	5 (7)	4 (4)	-	5 (6)	-	-	-	-	5 (6)	-
Steve Crowe (Non-Executive Director) until 21 May 2025	0 (1)	-	-	1 (1) **	-	-	-	0 (1) **	-	-
Anna Gill (Non-Executive Director and Vice Chair)	6 (7)	2 (2) **	-	-	1 (2)	5 (5)	1 (1)	6 (6)	3 (3) **	3 (3) **
Rachel Hawkins (Director of Corporate Affairs)	6 (7)	4 (4)	1 (2)	-	-	-	-	-	-	-
Kate Howard (Chief Nursing and Allied Health Professions Officer)	7 (7)	-	-	-	1 (2)	5 (5)	-		3 (6)	4 (6)
Dr Caroline Kavanagh (Chief Medical Officer)	6 (7)	-	-		-	4 (5)	-	6 (6)	-	5 (6)
John Kennedy (Non-Executive Director; Senior Independent Director from 15 October 2025)	7 (7)	4 (4)	2 (2)	2 (3) **	-	-	-	-	-	-

Name and Position	Board Meetings in public	Audit & Risk	Charitable Funds	Finance & Infrastructure	People Participation & Equalities	Quality	Remuneration	Children & Young People Service Assurance	Luton & Bedfordshire Adults, and Ambulatory Service Assurance	Norfolk Adults Service Assurance
Angela Moodie (Chief Finance and Resources Officer) from 21 July 2025	4 (4) **	3 (4) **	1 (1) **	4 (4) **	-	-	-	-	-	-
Graham Nice (Non-Executive Director, Vice Chair and Senior Independent Director) until 14 October 2025	4 (4) **	1(2) **	-	-	-	4 (4) **	-	-	-	2 (3) **
Anita Pisani (Chief People Officer and Deputy Chief Executive)	5 (7)	-	-	-	2 (2)	5 (5)	1 (1)	-	6 (6)	-
Jayne Sharma (Associate Non-Executive Director) from 1 October 2025	2 (3) **	-	-	3 (3) **	-	-	-	-	-	3 (3) **
Mani Sharma (Non-Executive Director) from 1 September 2025	2 (4) **	-	-	4 (4) **	-	-	-	4 (4) **	-	-
Matthew Winn (Chief Executive Officer)	7 (7)	-	-	-	-	-	1 (1)	-	-	5 (6)
Njoki Yaxley (Non-Executive Director)	7 (7)	-	-	-	2 (2)	3 (5)	1 (1)	-	-	6 (6)

Figures in brackets show total number of meetings members could have attended in year.

* Denotes attendance to observe only.

** Denotes appointment or committee membership either ended or started during the financial year.

Names	Title	Committee members (* Indicates Chairs of that committee)
Lynda Thomas	Trust Chair	Charitable Funds Committee; Remuneration Committee.
Charlotte Black	Non-Executive Director	Quality Committee; Luton & Bedfordshire Adults, and Ambulatory Service Assurance Committee* (both from 1 September 2025 as Associate Non-Executive Director, then as Non-Executive Director from 15 October 2025).
Sarah Buchan	Chief Information Officer	Finance & Infrastructure Committee.
Laura Clear	Director of Strategy and Transformation	Finance & Infrastructure Committee; Children & Young People's Service Assurance Committee.
David Crawford	Non-Executive Director	Finance & Infrastructure Committee; Audit & Risk Committee; Luton & Bedfordshire Adults, and Ambulatory Service Assurance Committee.
Steve Crowe	Non-Executive Director	Finance & Infrastructure Committee*; Children & Young People's Service Assurance Committee (both until 21 May 2025).
Anna Gill	Non-Executive Director and Vice Chair	Quality Committee*; Children & Young People's Service Assurance Committee*; Norfolk Adults Service Assurance Committee* (from 15 October 2025); Luton & Bedfordshire Adults, and Ambulatory Service Assurance Committee* (from 1 April 2025 to 14 October 2025); Audit & Risk Committee (from 15 October 2025); People Participation & Equalities Committee; Remuneration Committee.
Rachel Hawkins	Director of Corporate Affairs	Audit & Risk Committee; Charitable Funds Committee.
Kate Howard	Chief Nursing and Allied Health Professions Officer	Quality Committee; Norfolk Adults Service Assurance Committee; Luton & Bedfordshire Adults, and Ambulatory Service Assurance Committee; People Participation & Equalities Committee.

Names	Title	Committee member (* Indicates Chairs of that committee)
Dr Caroline Kavanagh	Chief Medical Officer	Quality Committee, Children & Young People's Service Assurance Committee; Norfolk Adults Service Assurance Committee.
John Kennedy	Non-Executive Director and Senior Independent Director	Audit & Risk Committee*; Finance & Infrastructure Committee (from 1 April 2025 to 31 August 2025); Charitable Funds Committee*.
Angela Moodie	Chief Finance & Resources Officer	Audit & Risk Committee; Finance & Infrastructure Committee; Charitable Funds Committee (all from 21 July 2025)
Graham Nice	Non-Executive Director and Vice Chair	Audit & Risk Committee; Quality Committee*; Norfolk Adults Service Assurance Committee* (all up to 14 October 2025);
Anita Pisani	Chief People Officer and Deputy Chief Executive	Quality Committee; People Participation & Equalities Committee; Luton & Bedfordshire Adults, and Ambulatory Service Assurance Committee.
Jayne Sharma	Associate Non-Executive Director	Finance & Infrastructure Committee; Norfolk Adults Service Assurance Committee (both from 1 October 2025).
Mani Sharma	Non-Executive Director	Finance & Infrastructure Committee*; Children & Young People's Service Assurance Committee (both from 1 September 2025)
Matthew Winn	Chief Executive	Norfolk Adults Service Assurance Committee.
Njoki Yaxley	Non-Executive Director	People Participation & Equalities Committee*; Remuneration Committee; Quality Committee; Norfolk Adults Service Assurance Committee.

Membership of the remuneration, terms of service and nominations committee (not subject to audit)

Name	Position
Anna Gill	Non-Executive Director Chair of Committee
Njoki Yaxley	Non-Executive Director
John Kennedy	Non-Executive Director
Lydia Thomas	Chair of the Board

In attendance for relevant discussions only:

Matthew Winn Chief Executive Officer(in attendance for relevant discussions only)
Anita Pisani Chief People Officer and Deputy Chief Executive (in attendance for relevant discussions only)
Sarah Feal Company Secretary and Freedom to Speak Up Guardian (in attendance for relevant discussions only)

Policy on the remuneration of senior managers

For the purposes of the remuneration report, the Chief Executive considers the executive directors of the Trust to be 'senior managers'.

Remuneration payments made to the non-executive directors are set nationally by the Secretary of State. The remuneration of executive directors is set by the remuneration committee. The committee considers comparative salary data, benchmarking information for similar organisations and labour market conditions in arriving at its final decision. All executive directors are employed on permanent contracts with the Trust.

No remuneration was waived by members and no compensation was paid for loss of office during the financial year ended 31 March 2026. No payments were made to co-opted members and no payments were made for golden hellos. The Trust does not have any staff members on performance related pay systems.

Where national review bodies govern salaries, then the national rates of increase have been applied. Where national review bodies do not cover staff, then increases have been in line with the percentage notified by the NHS chief executive and approved by the remuneration committee.

The remuneration committee takes the financial circumstances of the organisation into consideration in making pay awards, as well as advance letters of advice from the Department of Health. All uplifts were discussed with and decided by the remuneration committee, which is supported by a human resources professional.

Policy on performance conditions

The Trust's annual objectives are set through the annual business planning cycle. The Trust's Chair then agrees these objectives with the Chief Executive whose performance is monitored via monthly one-to-one meetings. The Chief Executive agrees his objectives with the Trust's executive directors and holds similar monthly one-to-ones to manage their performance. The Chair also holds bi-monthly performance meetings with each of the executive directors.

Policy on duration of contracts, notice periods and termination payments

Executive directors' contracts are subject to three months' contractual notice. Termination payments are made in accordance with NHS policy.

Remuneration 2025/2026 (subject to audit)

Details of remuneration payable to the senior managers of Cambridgeshire Community Services NHS Trust in respect of their services for the year ended 31 March 2026 are given in the tables on the following two pages.

Name	Title	2025/26					
		Salary (Bands of £5,000)	Expense Payments - Taxable (to nearest £100)	Performance Pay & Bonuses (Bands of £5,000)	Long-term Performance Pay & Bonuses (Bands of £5,000)	All Pension-Related Benefits (Bands of £2,500)	TOTAL (Bands of £5,000)
Charlotte Black	Non-Executive Director *	5-10	100	-	-	-	5-10
Sarah Buchan	Chief Information Officer	65-70	400	-	-	30-32.5	100-105
Laura Clear	Director of Strategy & Transformation	55-60	500	-	-	5-7.5	60-65
David Crawford	Non-Executive Director *	5-10	-	-	-	-	5-10
Steven Crowe	Non-Executive Director *	0-5	-	-	-	-	0-5
Anna Gill	Non-Executive Director *	5-10	300	-	-	-	10-15
Rachel Hawkins	Director of Governance	45-50	-	-	-	55-57.5	105-110
Lydia Howard	Chief Nurse	70-75	300	-	-	142.5-145	215-220
Caroline Kavanagh	Medical Director	85-90	200	-	-	137.5-140	225-230
John Kennedy	Non-Executive Director *	5-10	100	-	-	-	5-10
Angela Moodie	Chief Finance & Resource Officer (from 21st July 2026)	50-55	500	-	-	17.5-20	70-75
Graham Nice	Non-Executive Director *	5-10	200	-	-	-	5-10
Anita Pisani	Chief People Officer / Deputy Chief Executive	80-85	400	-	-	152.5-155	235-240
Mark Robbins	Director of Finance and Resources (until 31st July 2025)	40-45	-	-	-	15-17.5	60-65
Jayne Sharma	Associate Non-Executive Director *	5-10	-	-	-	-	5-10
Muneesh Sharma	Non-Executive Director *	5-10	-	-	-	-	5-10
Lynda Thomas	Chair *	25-30	300	-	-	-	25-30
Matthew Winn	Chief Executive	100-105	200	-	-	130-132.5	230-235
Njoki Yaxley	Non-Executive Director *	5-10	-	-	-	-	5-10

* The Chairman & Non-executive Directors do not receive pensionable remuneration, therefore there are no entries in respect of pensions.



Name	Position	2024/25				
		Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100 ****	Bonus payments (Bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
Mary Elford	Chair	40 - 45	300	0	0	40 - 45
Aliyyah-Begum Nasser	Non Executive Director	10 - 15	0	0	0	10 - 15
Gary Tubb	Non Executive Director	10 - 15	0	0	0	10 - 15
Anna Gill	Non Executive Director	10 - 15	400	0	0	15 - 20
Fazilet Hadi	Non Executive Director	10 - 15	0	0	0	10 - 15
Catherine Dugmore	Non Executive Director	15 - 20	0	0	0	15 - 20
Richard Iles	Non Executive Director	10 - 15	100	0	0	10 - 15
Matthew Winn	Chief Executive * & ***	90 - 95	200	10 - 15	82.5 - 85	185 - 190
David Vickers	Medical Director **	95 - 100	0	0	0	95 - 100
Caroline Kavanagh	Medical Director (from 1st July 2024) **	80 - 85	0	0	215 - 217.5	280 - 285
Mark Robbins	Director of Finance and Resources ***	125 - 130	700	0	7.5 - 10	135 - 140
Anita Pisani	Deputy Chief Executive & Director of Workforce and Transformation ***	150 - 155	400	0	20 - 22.5	180 - 185
Kate Howard	Chief Nurse	125 - 130	100	0	20 - 22.5	145 - 150
Rachel Hawkins	Director of Governance and Service Redesign	90 - 95	600	0	0	90 - 95
Steve Bush	Director of Children and Young People's Services	120 - 125	0	0	10 - 12.5	130 - 135

Matthew Winn and Caroline Kavanagh's posts are shared 50/50 with Cambridgeshire Community Services NHS Trust. Caroline Kavanagh commenced in post with both organisations on the 1st of July 2024. Total remuneration in 2024-25 across both Trusts was £185,000 - £190,000 for Matthew Winn and £125,000 - £130,000 for Caroline Kavanagh.

** David Vickers was employed as both a paediatric consultant and Medical Director at the Trust, until 31 October 2024, when he ceased his Medical Director post. His salary includes his role as a paediatric consultant (£95,000 - £100,000). He is not covered by the pension arrangements during the reporting year.

*** On 1 April 2015, the government made changes to public service pensions schemes which treated members differently based on their age. The public service pensions remedy puts this right and removes the age discrimination for the remedy period, between 1 April 2015 and 31 March 2022. Part 1 of the remedy closed the 1995/2008 Scheme on 31 March 2022, with active members becoming members of the 2015 Scheme on 1 April 2022. For Part 2 of the remedy, eligible members had their membership during the remedy period in the 2015 Scheme moved back into the 1995/2008 Scheme on 1 October 2023. This is called rollback.

The Trust does not make any payments to directors based on the financial performance of the Trust.

Salary and other remuneration exclude the employer's pension contributions and is gross of pay charges to other NHS Trusts.

Fair Pay: Subject to audit

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director / member in Cambridgeshire Community Services NHS Trust in the financial year 2025-25 was £102,500 (2024-25, £157,500). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

This represents a 34.92% decrease on salary and on salary including allowances and bonuses. The decrease is due to Cambridgeshire Community Services forming a group structure with Norfolk Community Health and Care and the remuneration of directors being split 50/50 between the organisations. In 2024-25, only the remuneration of the Chief Executive and Medical Director was split 50/50. The average salary of the employees of the entity for 2025-26 was £42,335 (2024-25 £39,955). This represents a 5.96% increase in average salary. The relationship to the remuneration of the organisation's workforce is disclosed in the below table. Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director and the median remuneration of the organisation's workforce.

2025 to 2026	25th percentile	Median	75th percentile
Total remuneration (£)	30,162	39,212	50,272
Salary component of total remuneration (£)	28,891	37,798	48,464
Remuneration ratio information	1 to 3.4	1 to 2.61	1 to 2.04
Salary ratio information	1 to 3.55	1 to 2.71	1 to 2.11
2024 to 2025	25th percentile	Median	75th percentile
Total remuneration (£)	28,492	37,077	47,092
Salary component of total remuneration (£)	28,492	37,077	47,092
Remuneration ratio information	1 to 5.53	1 to 4.25	1 to 3.33
Salary ratio information	1 to 5.53	1 to 4.25	1 to 3.33

The ratios have reduced in 2025-26 due to the Trust being part of the group structure and the costs of directors being split 50/50 between both organisations, The employee remuneration has increased in the comparative years, due to the 3.6% agenda for change pay increase in 2025-26.

Total remuneration includes salary, non-consolidated performance-related pay, benefits in kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

No payments were made in respect of 'golden hellos' or compensation for loss of office.

No compensation payments were made to a third party for the services of an executive director or non-executive director.



Review of tax arrangements of public sector appointees (not subject to audit)

For all off-payroll engagements as of 31 March 2026, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2026	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

For all off-payroll engagements between 1 April 2025 and 31 March 2026, for more than £245 per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2025 and 31 March 2026	0
Of which...	
No. not subject to off-payroll legislation	0
No. subject to off-payroll legislation and determined as in-scope of IR35	0
No. subject to off-payroll legislation and determined as out of scope of IR35	0
the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026:

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure must include both on payroll and off-payroll engagements	19



Exit packages

The Trust has had seventeen exit packages in 2025/2026 which were all payments made through a Mutually Agreed Resignation Scheme (2024/25 comparator one exit package).

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	*Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	0	0	3	20,961	3	20,961	0	0
£10,000 - £25,000	0	0	8	128,001	8	128,001	0	0
£25,001 - £50,000	0	0	4	125,656	4	125,656	0	0
£50,001 - £100,000	0	0	2	103,741	2	103,741	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	0	0	17	378,379	17	378,379	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS pension scheme. Exit costs in this note are the full cost of departures agreed in the year. Where it has agreed early retirements, the additional costs are met by Cambridgeshire Community Services NHS Trust and not by the NHS pension scheme. Ill health retirement costs met by the NHS pension scheme are not included in the table.

Type of other departures	Agreements	Total value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	17	378
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice*	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring DHSC or HM Treasury approval**	0	0
Total	17	378

No non-contractual payments were made to individuals where the payment value was more than 12 months of their annual salary. The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report

Signed:



Matthew Winn, Chief Executive, 15th June 2026

Pension Benefits – 2025/2026 (subject to audit)

2025/26		Real increase during the reporting year in pension at pension age (bands of £2,500)	Real increase during the reporting year in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2026 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2025 (to nearest £1,000)	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2026 (to nearest £1,000)
Name	Title	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Sarah Buchan	Chief Information Officer	0-2.5		10-15	0-5	154	21	195
Laura Clear**	Director of Strategy & Transformation	0-2.5		65-70	175-180	132	25	173
Rachel Hawkins	Director of Governance	2.5-5	2.5-5	45-50	120-125	1,082	71	1,164
Lydia Howard	Chief Nurse	5-7.5	12.5-15	50-55	125-130	967	144	1,145
Caroline Kavanagh	Medical Director	5-7.5	10-12.5	80-85	200-205	1,761	167	1,981
Angela Moodie***	Chief Finance & Resource Officer	0-2.5		0-5	0-5		3	24
Anita Pisaní	Chief People Officer / Deputy Chief Executive	7.5-10	12.5-15	70-75	175-180	1,441	177	1,683
Mark Robbins****	Director of Finance and Resources	0-2.5	0-2.5	55-60	140-145	1,241	21	1,342
Matthew Winn	Chief Executive	5-7.5	10-12.5	70-75	165-170	1,394	142	1,585

*The above table discloses their full pension values.

** Laura Clear is National Retirement Age, therefore a CETV calculation is not required.

*** There are no preceding period figures, balances, or transactions to report alongside current figure, due to the in-year transfer from the Scottish Public Pension Agency.

**** Post holder was in place until 31st July, real increases are time apportioned for the period in post.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual. Further to the above, entities considering it informative to expand upon the reasons as to why significant variation is found between pension related benefits calculated, may wish to insert a paragraph similar to the following but including only pertinent factors for their entity:

Factors determining the variation in the values recorded between individuals include, but is not limited to:

- A change in role with a resulting change in pay and impact on pension benefits
- A change in the pension scheme itself
- Changes in the contribution rates
- Changes in the wider remuneration package of an individual

Staff report (subject to audit)

This staff report is based on the average number of staff in post throughout 2025/26 i.e., 2,700 whole time equivalents, including staff employed across Bedfordshire, Cambridgeshire, Luton, Milton Keynes, Peterborough, Norfolk and Waveney, and Suffolk.

The Trust's 12-month rolling turnover figure was 9.82%.

The following table shows an analysis of the average whole time equivalent staff split between staff groups, showing both permanently employed and other groups, for 2025/26 and 2024/25 for the prior year.

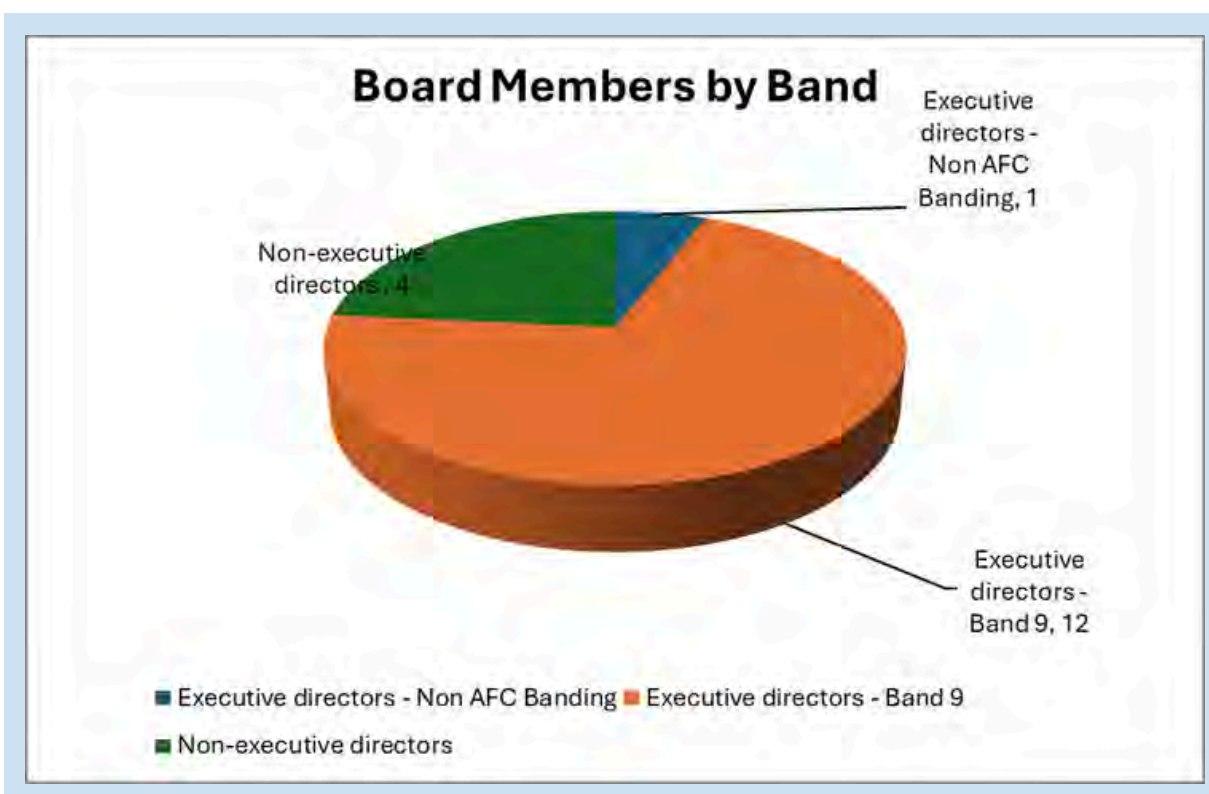
Average Staff Numbers	Total Current Year	Permanently Employed	Other	Total Prior Year	Permanently Employed	Other
Medical and dental	98	88	10	95	85	10
Ambulance staff	0	0	0	0	0	0
Administration and estates	637	616	21	663	627	37
Healthcare assistants and other support staff	683	622	62	668	597	71
Nursing, midwifery and health visiting staff	870	866	4	830	822	8
Nursing, midwifery and health visiting learners	26	8	17	27	8	19
Scientific, therapeutic and technical staff	446	435	11	449	436	13
Healthcare science staff	7	7	0	5	5	0
Total average numbers	2767	2642	125	2737	2580	158
Staff engaged on capital projects (included above)				0	0	0

Remuneration and staff report 2025/26

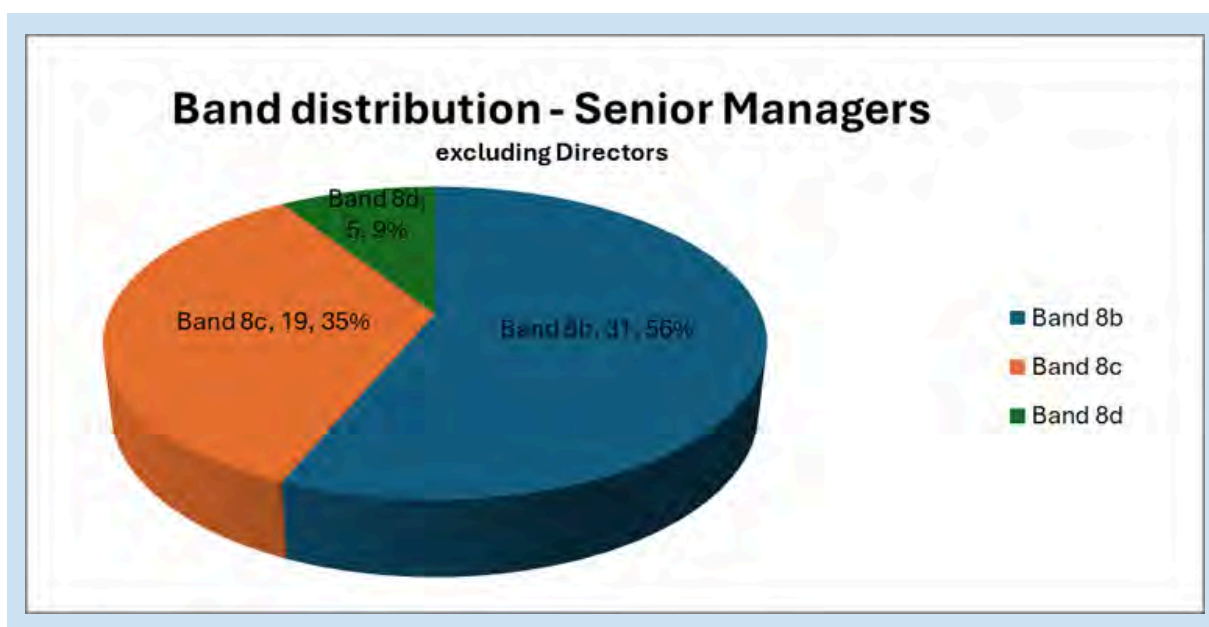
The following table shows an analysis of pay costs for 2025/2026 split between permanently employed and other.

Employee Benefits Current Year - Gross Expenditure	2025-26		
	Total	Permanently Employed	Other
	£000s	£000s	£000s
Salaries and wages	99,293	98,239	1,054
Social security costs	12,797	12,797	0
Apprenticeship levy	484	484	0
Employer Contributions to NHS pension scheme	21,717	21,717	0
Termination benefits	378	378	0
Total employee benefits	134,669	133,615	1,054

The following chart provides an analysis of the number of Board members within the Trust by national pay band.



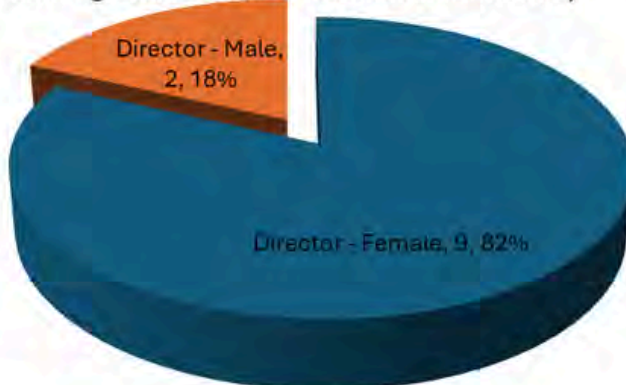
The following chart provides an analysis of the number of senior managers within the Trust by band.



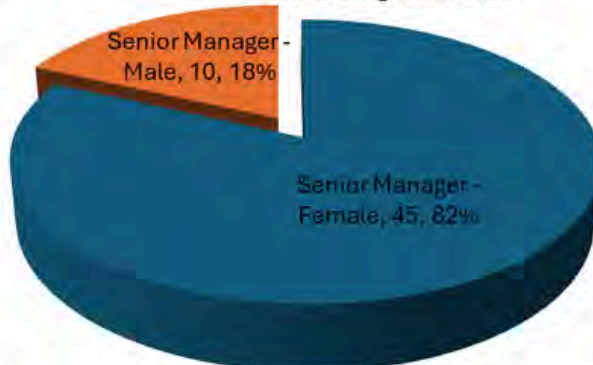
Analysis of gender distribution within our workforce

The following charts set out the gender distribution across the Trust. Whilst Trusts are required to report on workforce gender, the national staff record system (ESR) from which the data informing the following pie charts is taken, currently only asks staff to identify their biological sex. We will continue to seek amendments to the ESR system so that both sex and gender can be reported in future.

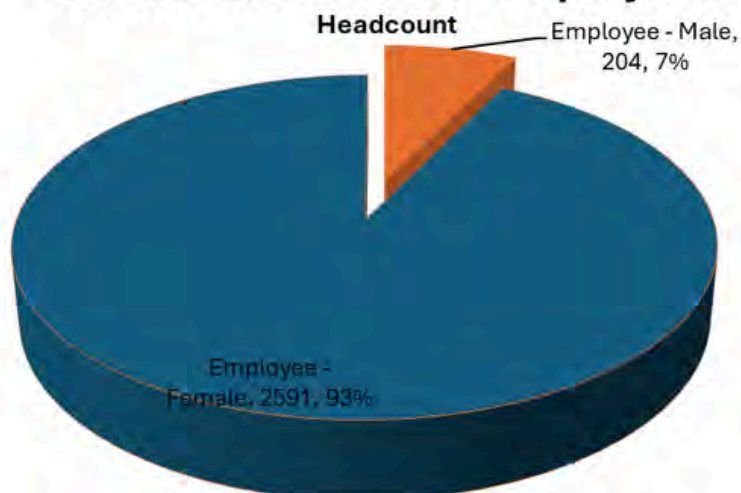
Gender distribution - Directors
(including Executive & non-Executive Directors)



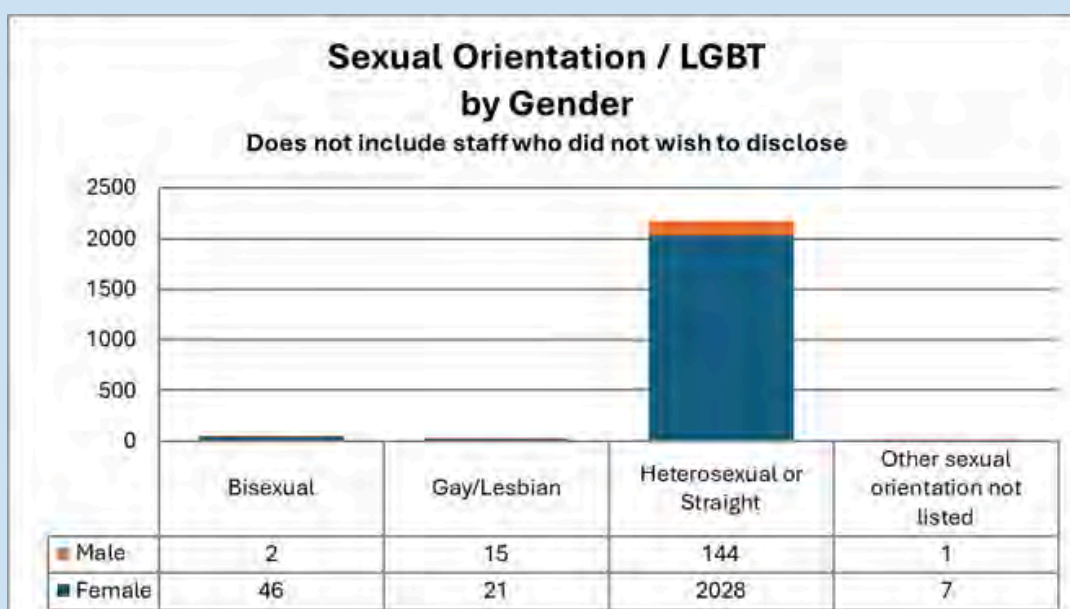
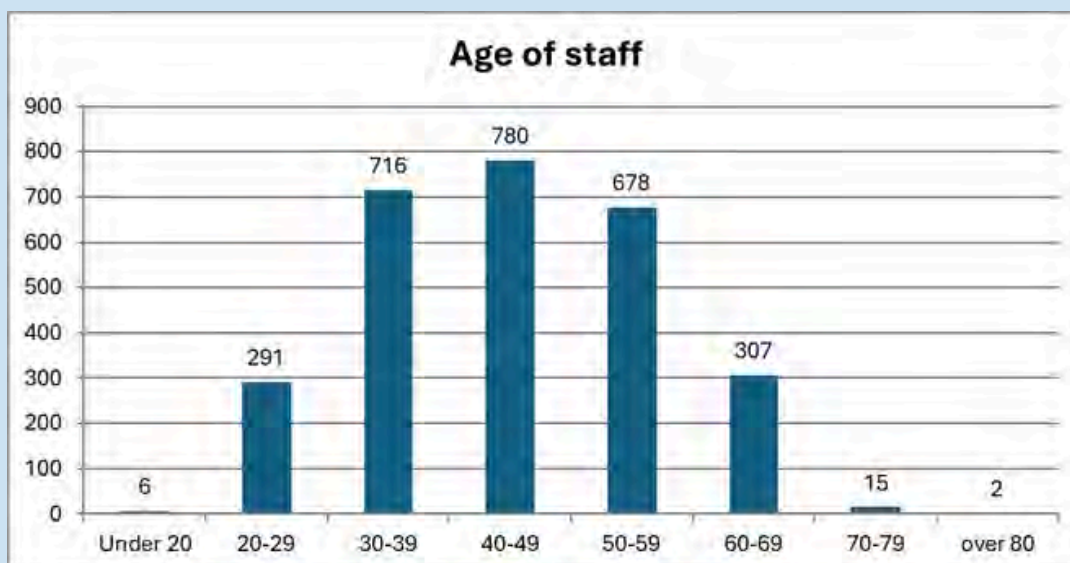
Gender distribution - Senior Managers
excluding Directors

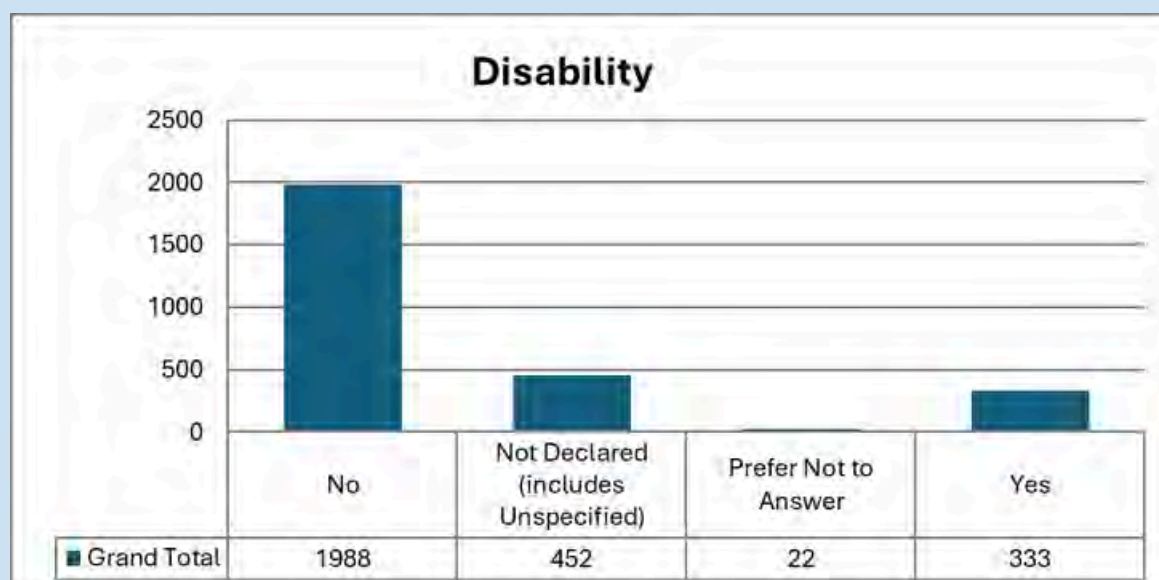
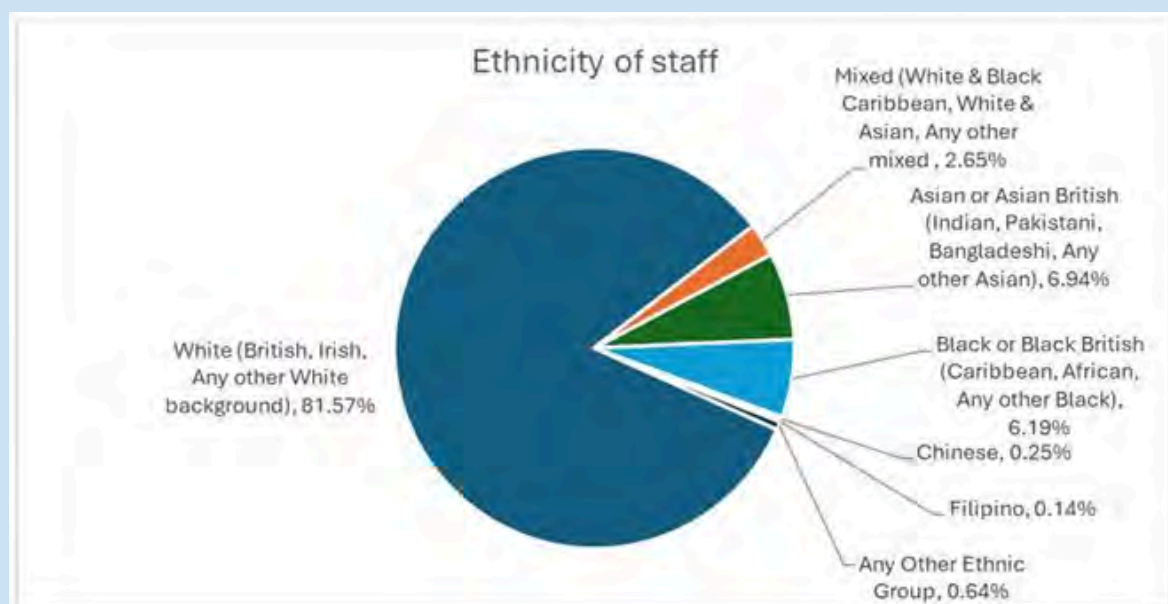
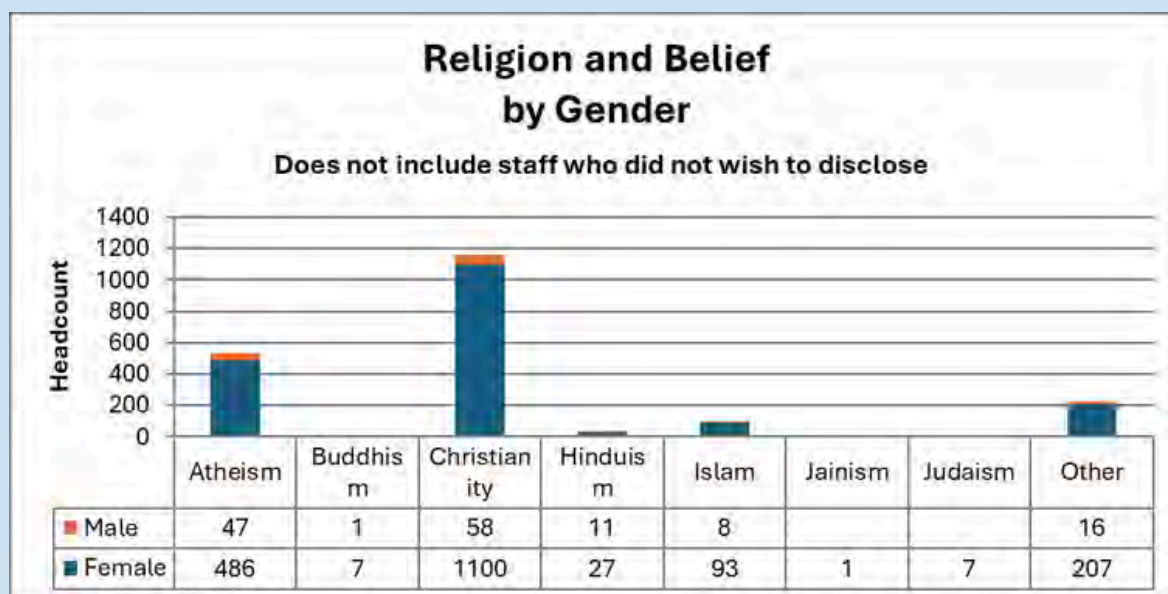


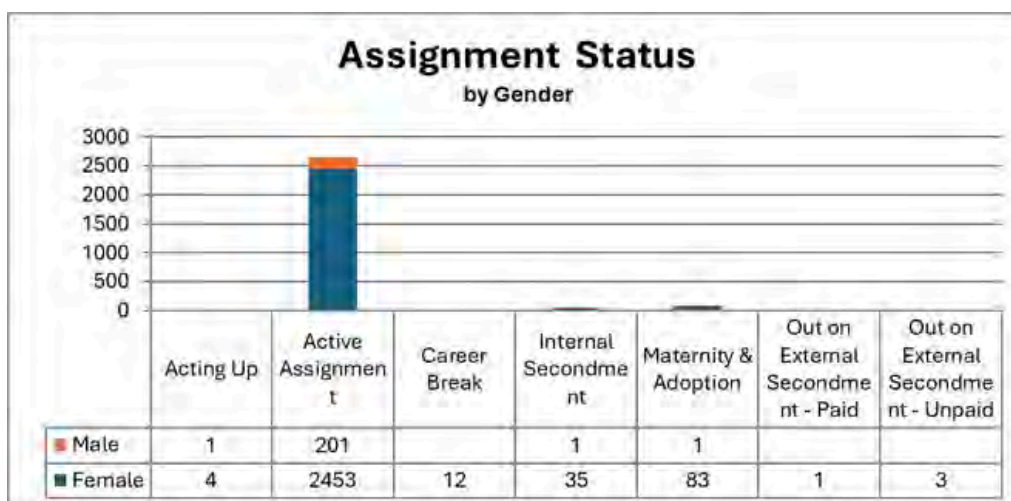
Gender distribution - Employees



As part of the Trust's commitment to promoting and ensuring inclusion and diversity across our workforce, we analyse workforce data against eight of the nine protected characteristics set out in the Equality Act 2010. The gender distribution charts/tables set out below relating to age, marriage and civil partnership, sexual orientation, religion and belief, ethnicity and disability reflect this analysis and support our programme of work to promote inclusion and diversity across the Trust.







Looking Forward to 2026/27 and Live Life Well

The Trust continues to prioritise staff health and wellbeing through extensive support, underpinned by line management, occupational health and counselling services. There are also plans for a staff wellbeing festival in June 2026, which will offer the chance to:

- discover support
- try something new
- take a fresh look at wellbeing
- connect with colleagues across the Trust

Staff wellbeing is central to our commitment to our staff, with a strong focus on tackling health inequalities. Key support includes:

Occupational health services: pre-employment checks, management, and self-referrals.

Reducing health inequalities

- Health risk assessments
- Work-related stress assessments and policy

Psychological wellbeing services

- 24/7 counselling, apps and family support
- Therapy options from brief intervention to high-intensity counselling
- Manager training
- Mindfulness support
- Bespoke services, including support for staff affected by racial violence

Rapid access MSK/physiotherapy: Self-referral for advice, guidance and treatment.

Employee assistance programme: 24/7 helpline, six free counselling sessions, self-help resources, podcasts, blogs and apps.

Health and wellbeing intranet pages: will be grouped into the following sections to support finding the right information faster:

- Emergency
- Physical wellbeing
- Mental wellbeing
- Financial support
- Social wellbeing.

This comprehensive approach ensures staff have the resources they need to live and work well.

Remuneration and staff report 2025/26

The following table provides information on the Trust's sickness absence rates:

Based on Calendar year														
Data category	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Average WTE*	2964	2924	2854	1952.79	1762.75	1713.34	1970.27	2016.66	2066.44	2197.5	2338.24	2338.24	2299.41	2312.14
Average monthly sickness rate	4.79%	4.90%	4.73%	4.38%	4.67%	4.45%	5.21%	4.96%	4.33%	5.31%	5.83%	5.83%	5.56%	5.50%
WTE days lost	52,158	52,321	49,993	31427.01	30110.73	20794.69	37430	36538.96	32746.13	42638.68	49731.12	49731.12	46751.58	46415.8
WTE days available	1,085,981	1,068,674	1,042,141	700,107.26	645,165.81	466,911.36	719,565.55	736,041.20	756,331.74	802,924.80	853,384.88	853,384.88	841,539.10	843,922.95
Cumulative sickness rate - based on yearly totals	4.80%	4.90%	4.80%	4.49%	4.67%	4.59%	5.20%	4.51%	4.34%	5.42%	5.83%	5.83%	5.56%	5.50%

Notes:

*WTE refers to whole time equivalent (e.g. a full time post equivalent to 37.5 hours per week)

Figures in the table on the previous page have been rounded up/down to the nearest decimal point.

Note: The table reflects data from our internal monitoring process based on a full calendar year of 365 days. As such, the sickness rates included within the Trust's annual accounts, which are based on Department of Health and Social Care estimated figures over 225 days per year (a year excluding weekends and bank holidays) will not correlate with the above.

We have submitted trade union facility time data every year.

Staff policies

The Trust is committed to ensuring that no employee or job applicant receives less favorable treatment because of their race, skin colour and nationality, ethnic or national origin or on the grounds of gender, marital status, disability, age, sexual orientation or religion; or is disadvantaged by conditions or requirements which are not justified by the job.

The Trust's workforce diversity and inclusion policy, alongside all our other employment related policies, procedures and actions supports this commitment.

During 2025/26, the Trust continued to receive accreditation to use the disability confident symbol for employers (for meeting a range of commitments towards disabled people) and mindful employer (which increases awareness of mental health in the workplace).

Developing workforce safeguards 2025/26

The Trust remains dedicated to maintaining safe staffing levels and strong workforce governance across all clinical services. It continues to embed the NHS England Developing Workforce Safeguards (DWS), demonstrating an ongoing commitment to both patient safety and a sustainable workforce. In alignment with the National Quality Board (NQB) 2016 standards, the Trust is strengthening its workforce assurance framework to ensure that safe staffing consistently remains a central priority.

Key elements of the Trust's staffing governance arrangements include:

- Clear Board oversight: The Board receives detailed staffing reports every two months, enabling informed decision-making and effective monitoring of workforce risks, trends, and mitigation actions.
- Regular performance monitoring: Staffing indicators are reviewed as part of bi-monthly divisional and organisational performance meetings, supporting continuous visibility and scrutiny across all levels of the Trust.
- Structured escalation and risk management: Established escalation pathways ensure staffing concerns are addressed promptly. Directorate and site-based teams oversee safe staffing in real time, taking swift action when needed to protect service delivery and maintain safety.



Consultancy expenditure

Consultancy service expenditure for 2025/2026 was £49,000.

Off payroll arrangements

The Trust had 0 off payroll engagements during 2025/2026.

Exit packages

The Trust made seventeen exit packages in 2025/2026 (subject to audit).

Signed:

A handwritten signature in dark ink, appearing to read 'M Winn', followed by a long horizontal flourish.

Matthew Winn, Chief Executive



Auditor's Annual Report

Cambridgeshire Community Services NHS Trust

For the year ended 31 March 2026



Ref: PLCA109194/CS/MB
Date: 24 June 2026

The Board of East of England Community and Health Care NHS Trust
Unit 7/8
Meadow Lane
St Ives
Cambridgeshire
PE27 4LG

Dear Sirs and Madams

Cambridgeshire Community Services NHS Trust – Auditor's Annual Report

We are pleased to attach our Auditor's Annual Report. This report, which is designed to be the basis of discussion when we meet, summarises our audit conclusions and highlights the key findings arising from our value for money work.

We have initially discussed the contents of our report with management and have incorporated their comments where relevant.

This report is intended to be solely for the information and use of the Directors and those charged with governance of the Trust and should not be shared with anyone beyond the Trust without our prior approval.

We would like to take this opportunity to thank the Trust's officers for the co-operation and assistance afforded to us during the course of the audit.

Yours faithfully

A handwritten signature in dark ink that reads "Bishop Fleming Audit Limited". The script is cursive and elegant, with the words flowing together.

BISHOP FLEMING AUDIT LIMITED

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- 4. Value for Money 5
- 5. Financial sustainability 6
- 6. Governance 8
- 7. Improving efficiency, economy and effectiveness 8
- 8. Recommendations 11

1. Introduction

Our Auditor's Annual Report (AAR) summarises the work that we **completed for Cambridgeshire Community Services NHS Trust (the Trust) for the year ended 31 March 2026.**

The Trust is responsible for keeping proper accounts and proper records in relation to the accounts and for maintaining an appropriate system of internal control. The Trust is responsible for the preparation of annual accounts for each financial year. Such accounts must present a true and fair view and comply with the requirements of enactments that apply to them.

The Trust is also responsible putting in place appropriate arrangements to secure the economy, efficiency and effectiveness in its use of resources and to maintain an effective system of internal control that supports the achievement of their policies, aims and objectives whilst safeguarding and securing value for money from the public funds at their disposal.

The scope of our work is set in accordance with the National Audit Office's Code of Audit Practice (the Code) and the International Standards on Auditing (ISAs) (UK). Our work is planned to provide a focused and robust audit. We are responsible for and are required to provide an independent opinion as to whether the financial statements:

- give a true and fair view of the financial position of the Trust at the year end and of the Trust's expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care's Group Accounting Manual; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We are also responsible for:

- reviewing the Annual Governance Statement to ensure it complies with the guidance issued;
- ensuring the parts of the Remuneration and Staff Report to be audited have been properly prepared; and
- reviewing the Trust's arrangements in place to secure economy, efficiency and effectiveness in its use of resources. The Code requires us to report on the Trust's arrangements under three specified reporting criteria:
 - o Financial sustainability – how the Trust plans and manages its resources to ensure it can continue to deliver its services;
 - o Governance – how the Trust ensures it makes informed decisions and properly manages its risks; and
 - o Improving economy, efficiency and effectiveness – how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We carried out our work in accordance with our Audit Plan that we issued to the Trust in November 2025.

2. Executive summary

Results from the audit of the financial statements

We completed our audit of the financial statements and issued our unmodified audit opinion on 24 June 2026. See section 3 for more details.

We also completed component auditor procedures, in line with the National Audit Office group auditor instructions. We had no matters to report from this work.

Results on our work on other matters and the Annual Governance Statement

We completed our review of other matters and the Annual Governance Statement in line with our issuing of the audit opinion on 24 June 2026. We have nothing to report on these matters.

Results from our work on VFM arrangements

Under the Code, we are required to consider whether the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

Our conclusions are summarised below. See sections 4-8 for more details.

Criterion	2024/25 rating	2025/26 rating	Findings
Financial sustainability			We did not identify any significant weaknesses in the Trust's arrangements for financial sustainability. We have not made any recommendations.
Governance			We did not identify any significant weaknesses in the Trust's governance arrangements. We have not made any recommendations.
Improving economy, efficiency and effectiveness			We did not identify any significant weaknesses in the Trust's arrangements for improving economy, efficiency and effectiveness. We have not made any recommendations.

Key:

	Green: No significant weaknesses in arrangements identified and no recommendations made
	Amber: No significant weaknesses in arrangements identified but recommendations for improvements made
	Red: Significant weaknesses in arrangements identified and key recommendations made

3. Audit of the financial statements

Audit opinion on the financial statements

The scope of our work is set in accordance with the Code and the International Standards on Auditing (ISAs) (UK). We are required to provide an independent opinion as to whether the financial statements:

- give a true and fair view of the financial position of the Trust at the year end and of the Trust's expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care's Group Accounting Manual; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We gave an unqualified opinion on the Trust's financial statements on 24 June 2026.

Other matters

We are required to give an opinion on whether the other information published in the Annual Report is materially inconsistent with the financial statements or the knowledge obtained by us in the course of our audit.

We have no issues to bring to your attention.

We are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit.

We have nothing to report in this regard.

We are required to give our opinion on whether the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006.

We issued an unmodified opinion in this regard on 24 June 2026. However, amendments were required to the Remuneration and Staff Report to comply with the requirements of the Group Accounting Manual, with amendments required to all areas subject to audit with the exception of the pensions table.

More detailed findings can be found in our Audit Completion Report which was reported to the Audit and Risk Committee on 15 June 2026.

Audit certificate

At the end of the audit, we are required to certify the completion of the audit. The effect of this certificate is to close the audit and marks the point when the auditor's responsibilities in respect of the audit of the period covered by the certificate have been discharged.

We cannot formally conclude the audit and issue an audit certificate for Cambridgeshire Community Services NHS Trust for the year ended 31 March 2026 in accordance with the requirements of Local Audit and Accountability Act 2014 and the Code, until we have confirmation from the NAO that no additional work will be required in respect of the Consolidated NHS Provider Accounts exercise.

More detailed findings can be found in our Audit Completion Report, which was reported to the Audit and Risk Committee on 15 June 2026.

4. Value for Money

Under the Code, we are required to consider whether the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

The Code requires us to report our commentary on the Trust's arrangements under three specified reporting criteria:

- Financial sustainability – how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance – how the Trust ensures it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness – how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

The National Audit Office has issued guidance for auditors to report against each of the three specified reporting criteria. The guidance also includes a number of further areas for review within each criterion for the auditor to assess those arrangements.

Our risk assessment did not identify any potential risks of significant weakness.

We asked management to complete an evidenced self-assessment of the Trust's arrangements. We then reviewed the evidence provided and carried out follow up work as appropriate to consider whether there were any significant weaknesses in the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Our commentary on the Trust's arrangements in each of these three areas is set out in sections 5, 6 and 7 of the report. Our recommendations for improvement are included in section 8.

5. Financial sustainability

We considered how the Trust plans and manages its resources to ensure it can continue to deliver its services, including how the Trust:

- ensures that it identifies all the significant financial pressures that are relevant to its short and medium-term plans and builds these into them;
- plans to bridge its funding gaps and identifies achievable savings;
- plans finances to support the sustainable delivery of services in accordance with strategic and statutory priorities;
- ensures that its financial plan is consistent with other plans such as workforce, capital, investment, and other operational planning which may include working with other local public bodies as part of a wider system; and
- identifies and manages risks to financial resilience, e.g. unplanned changes in demand, including challenge of the assumptions underlying its plans.

Overview and 2025/26 outturn

The Trust's financial statements show a deficit of £2.26m on the Statement of Comprehensive Income, the deficit being due to impairment of asset values following the revaluation exercise. As impairments are not included within expenditure for reporting on a control total basis, the adjusted financial performance was a surplus of £1,656k, with the Trust achieving its breakeven duty in the year. This compares to a surplus of £53k in 2024/25.

Financial planning and monitoring

In line with NHS England guidance, the Trust has processes and procedures in place to review its financial forecast position throughout the year and keeps this under review to reflect changing circumstances. This includes submitting monthly monitoring reports in line with guidance and requirements.

The Trust's Medium Term Plan for 2026/27, submitted in February 2026 includes the relevant financial data, linking back to the plans submitted to NHS England along with key actions for the year in line with the Trust's strategic objectives.

The Trust's capital plans for 2026/27 identify the relevant forecast allocations. Capital schemes are documented in line with NHS England guidance within the Trust's Financial Planning Return.

Alongside the financial plans, the Trust completes workforce planning returns and cashflow forecasting. There is a reconciliation exercise to ensure that planning implications are captured in both financial and workforce plans and that a consistent approach is delivered.

The financial reporting to the Board is within the Integrated Governance Report (IGR). Individual Clinical Operational Boards (COB) consider the detailed financial position for their areas. The financial reporting to the Board via the IGR is high level with more detailed scrutiny taking place at the Finance and Infrastructure Committee, which oversees financial performance, estates, digital, and infrastructure across the Trust. It monitors risks and performance and escalates key issues to the Board.

Achieving efficiency savings

The (IGR to the Board in May 2026 reported delivery of the efficiency programme target of £8.6m, with £8.57m delivered to the end of March (99.7%)

Whilst overall delivery was on plan, there remains a £3.5m shortfall in recurrent savings, representing approximately 40% of the total efficiency requirement, indicating that a significant proportion of savings are not sustainable on a recurring basis.

A significant proportion of non-recurrent savings are attributable to workforce related savings such as vacancy management. Within the risk reporting, it highlights that a higher proportion of non-recurrent delivery is shifting financial pressure into future years and delaying progress towards financial sustainability. In common with other NHS bodies, the Trust continues to face a challenging efficiency requirement.

The Trust's policy for CIP schemes requires a savings initiation document to be completed and submitted to the finance lead. For transformational CIPs or where the value is greater than £250k, a Quality Impact Assessment is required. These must

be reviewed by a number of stakeholder groups to ensure a wide range of perspectives have been considered. These then go before the Quality Impact Review Panel for approval including the Chief Nurse, Finance Director and Medical Director. All CIPs are subject to post-implementation reviews at 6 and 12 months post implementation.

Looking forward – 2026/27 financial planning

The Medium Term Plan was submitted for the new Trust, which shows a breakeven adjusted financial performance position in 2026/27. However, in order to achieve a balanced position, the efficiencies required in the year are £15.5m (4% of gross expenditure). The report to the May 2026 Finance and Infrastructure Committee sets out the status of savings with 3.5m of the efficiencies (22%) currently unallocated and at risk.

The Trust has incorporated workforce planning within the financial plan, with clear triangulation between pay costs, workforce WTE assumptions and productivity. The plan includes a quantified workforce impact from efficiency schemes.

The Medium Term Plan submitted in February 2026 shows a breakeven position for 2026/27 to 2028/29. In addition to the efficiency savings of £15.5m in 2026/27, the plan sets out required efficiencies of £7.7m in 2027/28 and £6m in 2028/29.

Risks are appropriately reflected within the financial planning process. The MTP is reliant on delivering significant efficiency savings. Sensitivity analysis also identifies potential downside risks relating to cost pressures, workforce assumptions and income variations. The Trust and wider system financial plans explicitly incorporate these risks and assumptions, with mitigations identified and ongoing monitoring required through governance processes to ensure delivery of the financial plan.

Based on the work carried out, we were satisfied that there are no significant weaknesses in the Trust's financial sustainability arrangements.

6. Governance

We considered how the Trust ensures that it makes informed decisions and properly manages its risks, including how the Trust:

- monitors and assesses risk and how the body gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud;
- approaches and carries out its annual budget setting process;
- ensures effective processes and systems are in place to ensure budgetary control; to communicate relevant, accurate and timely management information (including non-financial information where appropriate); supports its statutory financial reporting requirements; and ensures corrective action is taken where needed, including in relation to significant partnerships;
- ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency. This includes arrangements for effective challenge from those charged with governance/audit committee; and
- monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements and standards in terms of officer or member behaviour (such as gifts and hospitality or declarations/conflicts of interests), and for example where it procures or commissions services.

Overview

The Trust moved into the Group operating model with Norfolk Community Health and Care Trust from 1 April 2025, with governance arrangements fully implemented through the establishment of a Group Trust Board as a statutory joint committee.

During the year the Group Trust Board was authorised to exercise joint functions and make binding decisions on behalf of both organisations, while each Trust Board retains ultimate statutory accountability for its functions. This model was supported by a Group Governance Manual, which sets out the framework for governance, delegation, and decision-making, including the various committee structures. From 1 April 2026 the arrangements moved into one Board for the new East of England Community and Health Care NHS Trust.

Risk management

The Risk and Issue Management Policy (approved December 2025) defines the framework for the identification, escalation, and reporting of risks to the Board and is formally reviewed on an annual basis by the Audit and Risk Committee. Risk oversight is maintained as a standing agenda item across all committee meetings. The IGR presented at every public Board meeting, provides assurance on strategic risks and operational risks assessed with a score of 15 or above.

The Board Assurance Framework (BAF) addresses relevant strategic risks, identifying the designated executive lead, the accountable committee, and the associated corporate objective. For each risk, the BAF sets out the current RAG rating, the trajectory of the risk score over time, key challenges, gaps in control and assurance, future opportunities, and the actions in place to manage identified challenges. The BAF is reported to the Trust Board at each public Board meeting, with Audit Committee receiving the BAF at every meeting. All risks, including strategic risks, scoring 12 and above are also reported to Sub Committees.

The Trust's detailed risk register operates beneath the BAF and outlines the process for escalating risks that exceed the organisation's defined risk appetite. This structure ensures the Board remains focused on the Trust's most significant and strategically important risks.

The Trust operated within a fully established Group governance model with Norfolk Community Health and Care NHS Trust, formalised through the creation of a Group Trust Board as a statutory joint committee from 1 April 2025. This includes core Committees (Audit and Risk, Finance and Infrastructure, Quality, Remuneration, People Participation and Equalities, and Charitable Funds) together with three Service Assurance Committees, each with clearly defined terms of reference, delegated authority and reporting arrangements, each of which is chaired by a Non-Executive Director (NED). This allows for direct channels of communication between the sub-committees and the main board in order to report any risks.

Given the Trust's delivery of services across multiple geographies and its formal partnership arrangements, the governance model supports effective oversight of system-wide developments, emerging risks and service pressures, with risks escalated through committees to the Group Trust Board in a structured and consistent manner.

Internal control

Internal Audit is provided by RSM. The Audit and Risk Committee approve the Annual Internal Audit Plan and receives regular progress updates against delivery as well as reviews the internal audit reports.

Our review of Internal Audit reports, together with an examination of Audit and Risk Committee minutes and supporting documentation, has not identified any significant gaps in the assurance received by the Trust. The Audit and Risk Committee continues to maintain oversight of audit activity and implementation of recommendations.

In 2025/26, Internal Audit completed five reviews, with no reviews receiving a minimal assurance opinion. One area was assessed as partial assurance, with control weaknesses identified and management actions agreed to strengthen controls.

Internal Audit completed their work for the 2025/26 financial year. The Head of Internal Audit's opinion concluded that the Trust has reasonable and generally effective risk management, governance and internal control arrangements, while recognising that further enhancements are required in some areas to maintain effectiveness.

The Local Counter Fraud Service (LCFS) is also provided by a RSM, with a nominated Counter Fraud lead attending Audit and Risk Committee meetings and reporting progress against the approved workplan. The Committee also approves the annual LCFS plan and receives regular updates.

The Audit and Risk Committee has a key role in ensuring the overall effectiveness of internal controls and continues to discharge this responsibility appropriately through review of audit outputs, monitoring of actions, and appropriate challenge to management on internal and external audit findings.

Budget setting and budgetary control

NHS financial planning arrangements changed in for 2026/27, with Trust's required to submit a MTP covering the 2026/27 to 2028/29 period rather than a one year plan submitted in previous years. The plan was submitted for the new merged Trust and demonstrates a break-even position in every year across the three-year period, subject to the delivery of planned efficiency savings.

For 2026/27, the financial plan includes an initial deficit position of £15.5m before efficiencies, which is offset through a combination of identified and unidentified savings. However, a significant proportion of these efficiencies (£3.5m) remains unidentified, representing a key risk to delivery and requiring continued development of detailed plans.

Budgets continue to be developed at a service level, informed by central NHS planning assumptions and aligned to agreed commissioning arrangements. The MTP confirms that income assumptions have been developed in conjunction with key commissioners.

Financial management arrangements remain embedded at an operational level, with Clinical Operations Boards (COBs) retaining ownership of budgets for their respective areas, supported by access to financial reporting and monitoring information.

The Trust has established a clear link between financial planning and strategy, with the MTP integrating financial, workforce and activity assumptions, although it acknowledges that further work is required to align and refine these elements as system planning progresses.

Our review of Board and Committee papers confirms that financial performance continues to be reported regularly through the IGR, supported by non-financial information to provide context for performance and variance analysis.

The introduction of the Finance and Infrastructure Committee during the year represents a significant strengthening of governance compared to the prior period, addressing the previous absence of a dedicated finance committee. The Board received bi-monthly updates on performance and financial information with clear evidence of regular monitoring, challenge and escalation.

Decision making

Board and Committee papers include a standard cover sheet outlining purpose, recommendations and required actions, and are supported by agendas and timely circulation of information to enable informed decision-making. Reports summarise key issues, including links to strategic objectives, risks and previous discussions, in line with the Trust's formal governance and decision-making framework.

The Standing Orders and Scheme of Delegation define responsibilities and ensure decisions are taken at the appropriate level, with matters reserved to the Board subject to formal scrutiny. There is evidence of appropriate challenge and debate, with the Board supported by information and advice. Clinical involvement in decision-making is consistent, supported by established governance structures.

Partnership working remains well embedded, with governance arrangements in place to oversee system-wide activity and collaboration. From our attendance, we can confirm that the Audit and Risk Committee continue to provide independent assurance and effective challenge over governance, risk management and internal control.

Ensuring appropriate standards

We are not aware of any instances of significant non-compliance with standards during the year. The Quality Committee monitors issues that may impact compliance across the organisation.

The Trust's Standing Orders are subject to regular review and periodic full revision in line with legislative requirements, with Standing Financial Instructions available to staff via the intranet.

There are clearly defined executive responsibilities for maintaining compliance, including the Chief Finance and Resources Officer, Director of Finance, Director of Corporate Affairs and the Trust Secretary. These roles ensure governance frameworks, policies and procedures remain current, accessible and aligned with statutory and regulatory requirements. The Trust has a suite of policies to support high standards of conduct, including the updated Standards of Conduct and Employment Practice Policy (2025) and the Conflicts, Hospitality, Gifts and Commercial Sponsorship Policy, which set clear expectations on integrity, ethical behaviour, and the appropriate management of conflicts of interest.

Arrangements are in place for the identification, declaration and management of interests. Board members are required to complete annual declarations, with additional declarations made at the start of all Board and Committee meetings. A Register of Interests is maintained and updated and is published in line with transparency requirements.

The Trust's policies reinforce expectations around openness, accountability and proper use of public funds, aligned to the Nolan Principles, with clear processes for managing breaches, including escalation and investigation where required. We are satisfied that the Trust has robust and effective arrangements in place to promote, monitor and maintain compliance with legislative and regulatory standards.

Based on the work carried out, we were satisfied that there are no significant weaknesses in the Trust's governance arrangements.

7. Improving efficiency, economy and effectiveness

Assessing performance and evaluating service delivery

The Trust reports performance against its strategic objectives through the IGR, presented regularly to the Board. This provides an assessment of performance across key indicators or the strategic priorities, incorporating financial, operational and workforce metrics, and oversight across the Integrated Care System (ICS) areas that the Trust operates within. Evidence shows monitoring of areas such as staff development, cost improvement opportunities and patient waiting times, alongside analysis of performance trends and drivers. Divisional performance is monitored through reporting to three Service Assurance Committees, ensuring that both strategic and operational performance is reviewed at an appropriate level.

There is historical evidence of the Trust taking appropriate action in response to performance and value considerations, including prior decisions not to pursue contracts where financial or delivery risks were identified.

There is strong evidence of collaboration across systems, including increased integration and joint working following organisational changes, as reflected in Board and Committee discussions.

The Well-Led Improvement Plan is Board-owned, with priorities refreshed annually and progress reviewed regularly. This demonstrates a structured approach to continuous improvement, with actions aligned to the Well-Led Framework and supported by Board development activity.

The Trust's CIP framework sets out processes for identifying, approving and monitoring savings. Schemes, particularly those of higher value or transformational nature, are subject to Quality Impact Assessments, attempting to ensure that financial improvements do not adversely affect quality or patient outcomes. The policy has been updated during the year to reflect internal and external audit recommendations.

There is continued evidence that the Trust acts on both internal and external audit recommendations, embedding learning and strengthening arrangements for performance management and service delivery.

Partnership working

The Trust operated in 2025/26 within a fully established single NHS group model with Norfolk Community Health and Care Trust. This has resulted in the full integration of governance arrangements, with Committees combined across the group and operating as a unified structure under Board oversight.

The Trust continues to work closely with partners across its ICSs, with performance and activity reported through the IGR. This provides a view of system-wide working, including shared priorities, delivery of services and collaborative initiatives across partner organisations.

The Trust engages and consults with key stakeholders to determine local priorities for resources, as demonstrated by the co-production of the Clinical and Care Strategy (2026–2031), which incorporated input from 7,000 staff, over 100 service users, and system partners including local authorities. This engagement directly informed the Trust's priority service areas and strategic focus, ensuring resources are aligned to local needs and priorities, with ongoing stakeholder involvement supporting continuous improvement and efficiency.

Commissioning and procuring services

Although the Trust does not have a standalone procurement strategy, it continues to utilise the East of England NHS collaborative procurement hub to support compliant and effective procurement activity.

The Trust's Standing Financial Instructions (SFIs) provide clear guidance on procurement processes, including thresholds, tendering requirements and delegated authority. There is no evidence to suggest procurement is not conducted fairly or in line with requirements.

The Trust has arrangements in place to monitor supplier and subcontractor performance, including regular KPI reporting, audits and monthly reviews of key contractors.

Where issues arise, there is evidence of timely identification and resolution, with corrective actions and engagement with the supply chain to address performance concerns. The Trust also assesses whether expected benefits are being realised, through financial monitoring, delivery outputs and value-for-money measures reported to the Board and committees.

Based on the work carried out, we were satisfied that there are no significant weaknesses in the Trust's arrangements for improving economy, efficiency and effectiveness.

8. Recommendations

KEY:



Recommendations that refer to issues that have resulted in a significant weakness in the Trust's arrangements



Recommendations that should improve the arrangements in place at the Trust, but are not as a result of identifying a significant weakness.

Prior-Year Issues – resolved

Cost Improvement Plans (CIPs) Reporting, monitoring and delivery	
Internal Audit's review of Key Financial Controls – CIPS was given a partial assurance rating and identified a number of issues, which included weaknesses in • Reporting arrangements • Policies and Procedures • Record • Planning • Design of the control framework • Compliance with Policies and Procedures The report resulted in a number of actions for the Trust to address. The Internal audit was carried out in June/July 2024 and the Trust appointed a CIPs Project Manager in July 2024, with significant work having been undertaken to address the audit findings. All high-priority actions have been implemented. The Trust has a challenging target of achieving efficiency savings of £8.6m in 2025/26. At the end of May 2025 it had identified schemes totalling £2.9m. The updated position at 17 June 2025 shows that the Trust has identified schemes totalling £6.9m, with only £0.3m overall rated as high risk. This demonstrates good progress since the plan was submitted in what will be a significant challenge for the Trust in 2025/26. <u>2025/26 follow up</u> The Trust has embedded its Efficiency Programme approach in 2025/26. The Trust achieved its £8.6m target for efficiencies in 2025/26, although a larger proportion were non-recurrent that had been planned.	<u>2024/25 Recommendation</u> The Trust must ensure that it implements the outstanding recommendations from the Internal Audit review of CIPs and embeds the changes within the Trust. The Trust must urgently identify plans for the remaining unallocated CIPs. Reporting in May 2025 showed £2.9m of schemes had been identified out of a target of £8.6m. As at the date of writing this report the values of schemes identified had increased to £6.9m. Identifying schemes for the remainder of the target and delivery of the plans is a significant challenge and a risk to the Trust achieving its breakeven plan position in 2025/26. <u>2024/25 Management comment</u> As at 17.6.25 schemes identified to date total £6.9m (80%) of the target with £2m of schemes potentially also provided for. The Trust has now embedded an Efficiency Programme approach across the Group, monitoring and delivering various programmes with oversight from the Group Finance and Infrastructure Committee.

Financial reporting to the Board	
	
The financial reporting to the Board in the Integrated Governance Report (IGR) is at a summarised high level. A detailed Trust wide position is not being considered at any other Committee, as the Trust do not have a Finance Committee. CIP savings were reported in the May IGR to have been achieved in line with the target set by "a combination of planned and unplanned delivery of recurrent and non-recurrent schemes". In fact, 95% of the savings were delivered non-recurrently with most of this being via underspends rather than planned schemes. <u>2023/24 Follow Up</u> The financial reporting to the Board in the IGR continues to be at a summarised high level, with the format largely unchanged from last year. The reporting of the CIP savings concentrated on the savings delivered without setting the context and impact of the under delivery of plans against the target for the year. <u>2024/25 Follow up</u> The level of financial reporting to the Board remained largely unchanged during 2024/25. We also noted that the reporting of the CIP savings in the IGR to the May 2025 Board referred to a target of £5.3m. The previous IGRs during the year had been against a target of £5.9m, although no reference is made to a change in the target. In April 2025 the Trust had its first Finance and Infrastructure Committees in common with Norfolk Community Health and Care Trust. The Committee received separate reports on the Trust's 2024/25 outturn position, the 2025/26 budget and a report detailing the Cost Improvement Programme for 2024/25 and 2025/26. The new Committee fills what we considered to be a gap in the Trust's arrangements. <u>2025/26 Follow up</u> The financial reporting to the Finance and Infrastructure Committee in 2025/26 complements the high level reporting to the Board in the IGR and has filled what we considered to be a gap in the Trust's arrangements. This issue has been resolved.	<u>2022/23 Recommendation</u> The financial reporting to the Board should include more detail and ensure that there is increased transparency over areas of challenge. The financial reporting to the Board should be improved, in line with the recommendations from the Well Led review of Integrated Governance Reporting and our previous recommendation. This should include more detail and ensure that there is increased transparency over areas of challenge such as the delivery of CIP savings (recurrent/non-recurrent, planned/unplanned) against the target. <u>2022/23 Management comment</u> Management had been in agreement with the Board that the content of the Sustainability Section of the Trust's Integrated Governance Report should be extended with greater detail of Trust wide financial performance and issues / forecast challenges for the Trust's finances, but also to include reference to the finances of the systems the Trust provides services and supports. <u>2023/24 Follow-up</u> The recommendations above remain in place to improve the financial reporting to the Board. <u>2023/24 Management Response</u> Management will build on the Board Development programmes delivered during 23/24, targeting productivity, finance and efficiency and there will be focus on reporting to the Board the emerging multi-year Cost Improvement Plans. These programmes will provide focus at a greater level of detail and including insight into the areas of particular challenge and opportunity. <u>2024/25 Follow-Up</u> Following the introducing of the Finance and Infrastructure Committee, the Trust should now consider the appropriate level of financial reporting to the Board to support effective oversight and decision-making. The Trust should ensure reporting identifies if targets change between reports during the year. <u>2024/25 Management Response</u> The Trust is currently developing its approach to a revised Integrated Governance Report, establishing an Assurance Matrix and escalation criteria which incorporates performance reported to the Service Assurance Committees and the Finance and Infrastructure Committee. The first report is due to the Board in July and the IGR will develop and evolve during the year.



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ICAEW
CHARTERED
ACCOUNTANTS



Cambridgeshire Community Services NHS Trust

Annual accounts for the year ended 31 March 2026

Statement of Comprehensive Income

		2025/26	2024/25
	Note	£000	£000
Operating income from patient care activities	3	184,734	172,263
Other operating income	4	8,719	7,838
Operating expenses	6.1	(193,274)	(182,186)
Operating surplus/(deficit) from continuing operations		179	(2,085)
Finance income	10	318	-
Finance expenses	11.1	(272)	(274)
PDC dividends payable		(2,488)	(2,648)
Net finance costs		(2,442)	(2,922)
Other gains / (losses)		-	-
(Deficit)/surplus for the year		(2,263)	(5,007)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(590)	(12,311)
Revaluations	13.3	1,590	2,683
Total comprehensive income / (expense) for the period		(1,263)	(14,635)
Adjusted financial performance (control total basis):			
(Deficit)/surplus for the period		(2,263)	(5,007)
Remove net impairments not scoring to the Departmental expenditure limit		3,919	5,060
Adjusted financial performance surplus / (deficit)		1,656	53

Statement of Financial Position

		31 March 2026 £000	31 March 2025 £000
	Note		
Non-current assets			
Intangible assets	12	754	312
Property, plant and equipment	13	72,444	76,125
Right of use assets	14	19,904	22,131
Receivables	15	10	9
Total non-current assets		93,112	98,577
Current assets			
Inventories		56	56
Receivables	15	15,906	13,230
Non-current assets for sale and assets in disposal groups	16	899	-
Cash and cash equivalents	17	8,461	6,577
Total current assets		25,322	19,863
Current liabilities			
Trade and other payables	18	(16,496)	(15,477)
Borrowings	20	(2,434)	(2,693)
Provisions	22	(866)	(94)
Other liabilities	19	(912)	-
Total current liabilities		(20,708)	(18,264)
Total assets less current liabilities		97,726	100,176
Non-current liabilities			
Borrowings	20	(17,862)	(19,732)
Provisions	22	(1,014)	(922)
Total non-current liabilities		(18,876)	(20,654)
Total assets employed		78,850	79,522
Financed by			
Public dividend capital		30,261	29,670
Revaluation reserve		15,570	14,570
Other reserves		(1,653)	(1,653)
Income and expenditure reserve		34,672	36,935
Total taxpayers' equity		78,850	79,522

The notes on pages 7 to 38 form part of these accounts.

Signed

Name

Position

Date



Matthew Winn

Chief Executive Officer

15th June 2026

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2025 - brought forward	29,670	14,570	(1,653)	36,935	79,522
Surplus/(deficit) for the year	-	-	-	(2,263)	(2,263)
Impairments	-	(590)	-	-	(590)
Revaluations	-	1,590	-	-	1,590
Public dividend capital received	591	-	-	-	591
Taxpayers' equity at 31 March 2026	30,261	15,570	(1,653)	34,672	78,850

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2025

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2024 - brought forward	25,431	24,198	(1,653)	41,942	89,918
Surplus/(deficit) for the year	-	-	-	(5,007)	(5,007)
Impairments	-	(12,311)	-	-	(12,311)
Revaluations	-	2,683	-	-	2,683
Public dividend capital received	4,239	-	-	-	4,239
Taxpayers' equity at 31 March 2025	29,670	14,570	(1,653)	36,935	79,522

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Financial assets reserve

This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

Other reserves

In line with Department of Health accounting instructions in the 2010-11 Manual for Accounts the net assets (£1,653,000) of the Trust's predecessor or Autonomous Provider Organisation (APO) were acquired by the Trust upon establishment. The transaction resulted in the Trust making a payment to NHS Cambridgeshire, returning the reserves associated with these assets to them. This created a merger reserve in the Trust's 2010/11 accounts.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

		2025/26	2024/25
	Note	£000	£000
Cash flows from operating activities			
Operating surplus / (deficit)		179	(2,085)
Non-cash income and expense:			
Depreciation and amortisation	6.1	6,565	6,660
Net impairments	7	3,919	5,060
(Increase) / decrease in receivables and other assets		(2,763)	5,911
Increase / (decrease) in payables and other liabilities		2,146	(4,703)
Increase / (decrease) in provisions		865	(138)
Net cash flows from / (used in) operating activities		10,911	10,705
Cash flows from investing activities			
Interest received		318	-
Purchase of intangible assets		(476)	(278)
Purchase of PPE and investment property		(4,019)	(13,746)
Net cash flows from / (used in) investing activities		(4,177)	(14,024)
Cash flows from financing activities			
Public dividend capital received		591	4,239
Capital element of lease rental payments		(2,766)	(2,782)
Interest paid on lease liability repayments		(273)	(275)
PDC dividend (paid) / refunded		(2,402)	(2,845)
Net cash flows from / (used in) financing activities		(4,850)	(1,663)
Increase / (decrease) in cash and cash equivalents		1,884	(4,982)
Cash and cash equivalents at 1 April - brought forward		6,577	11,559
Cash and cash equivalents at 31 March	17	8,461	6,577

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.2 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.3 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

On 1 April 2026, Cambridgeshire Community Services NHS Trust's assets, liabilities and operations merged into Norfolk Community Health and Care NHS Trust, which was then renamed to East of England Community Health and Care NHS Trust. Cambridgeshire Community Services NHS Trust was then dissolved.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Note 1.5 Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

Note 1.5 Revenue from NHS contracts continued

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under the scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Note 1.6 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.7 Patient care revenue from non-NHS contracts

A large proportion of the Trust's income comes from Local Authorities for Public Health commissioned services. This is in the form of fixed payments to fund an agreed level of service provision.

Note 1.8 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

The NHS Pension scheme is the only scheme the Trust operates.

Note 1.9 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.10 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current value in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Note 1.10 Property, plant and equipment continued

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	15	50
Plant & machinery	10	25
Transport equipment	5	5
Information technology	5	5
Furniture & fittings	10	10

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.13 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

Note 1.13 Leases continued

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 22.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at <https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts>.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £67m as at 31 March 2026.

Note 1.18 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.19 Critical judgements in applying accounting policies

The need for application of management judgement within the Trust's accounts is limited by the nature of its transactions.

Under the provisions of IFRS10 Consolidated Financial Statements those Charitable Funds that fall under the common control of NHS bodies are consolidated within the entity's financial statements. The Trust has determined that consolidation of its related Charitable Fund is not required as the Charitable Fund is not material in the context of the Trust's accounts. Consolidated financial statements have therefore not been presented for the current or previous period.

Note 1.20 Sources of estimation uncertainty

There are a number of areas in which management have exercised judgement in order to estimate Trust liabilities. Management do not consider that any of these constitute a risk of material misstatement of the Trust's financial statements, however more information on these risks is detailed below.

The Trust's provision for the impairment of receivables

The Trust adopts the simplified approach to impairment, in accordance with IFRS9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses.

There are a number of long standing debts owed to the Trust from non NHS bodies. Management have reviewed all debts past their due date and formed a judgement on each one's recoverability. This provision represents the sum of all those debts that management consider to be at significant risk. Resolution on these outstanding debts is expected within the next financial year.

Accruals and provisions

In line with the framework set out by International Financial Reporting Standards, the Trust has made expenditure accruals and provisions for transactions (and other events) that relate to 2025/26 where cash has not been paid and no invoice has been received.

In some cases, this has resulted in estimates being made by management for transactions or events that have already occurred but whose costs are not known exactly. In such cases management have exercised judgement in calculating an estimate for the costs and do not expect that to differ significantly to those finally incurred on payment. The liabilities will be settled during the normal course of the Trust's business.

Asset valuation, Asset lives, impairment and depreciation methodology

The valuation of land and buildings is a key accounting estimate which is sensitive to changes in assumptions and market conditions.

In line with IAS 16, Property, Plant and Equipment (PPE), the Trust depreciates its PPE in line with the assets' useful economic lives. The Trust's management team believe that the economic benefits associated with such assets are broadly consumed on a straight line basis in line with the useful economic lives contained within the property, plant and equipment accounting note.

Note 2 Operating Segments

IFRS 8 requires income and expenditure to be broken down into the operating segments reported to the Chief Operating Decision Maker. The Trust considers the Board to be the Chief Operating Decision Maker because it is responsible for approving its budget and hence responsible for allocating resources to operating segments and assessing their performance. For 2025-26 the Trust has five Divisions: Ambulatory Care Services, providing a diverse range of primary care services including sexual health, musculoskeletal services, and dental services; Bedfordshire Community Unit providing Children's and Young Peoples Services (including Health Visiting, School Nursing and Speech Therapies services within Bedfordshire); Children's and Young Peoples Services (including Health Visiting, School Nursing and Speech Therapies services within Cambridgeshire); Luton Community Unit, providing a range of community nursing, therapy and hospital based services for both Adults and Children throughout Luton; and Other Services which includes Corporate Costs, Contracted income and other indirect costs. The Trust's operating segments reflect the services that it provides across Bedfordshire, Cambridgeshire, Luton, Milton Keynes, Peterborough, Suffolk and Norfolk. Expenditure is reported to the Board on a regular basis by Division.

The Statement of Financial Position is reported to the Board on a Trust wide basis only.

2025/26	Income	Pay	Non-Pay	Net Total
Division Level	£'000	£'000	£'000	£'000
Ambulatory Care Services	24,464	(22,078)	(12,752)	(10,366)
Bedfordshire Community Unit	3,296	(18,965)	(3,160)	(18,829)
Childrens & Younger Peoples Services	47,053	(46,232)	(10,166)	(9,345)
Luton Community Unit	11,001	(25,359)	(8,308)	(22,666)
Other Services	99,384	(13,751)	(26,691)	58,942
*9.4% additional pension contributions paid by NHSE on providers behalf	8,575	(8,575)	-	-
CCS Total 2025/26	193,773	(134,960)	(61,077)	(2,264)

2024/25	Income	Pay	Non-Pay	Net Total
Division Level	£'000	£'000	£'000	£'000
Ambulatory Care Services	2,781	(21,234)	(9,064)	(27,517)
Bedfordshire Community Unit	3,566	(17,705)	(2,669)	(16,808)
Childrens & Younger Peoples Services	13,018	(41,795)	(5,127)	(33,904)
Luton Community Unit	2,469	(25,320)	(7,403)	(30,254)
Other Services	150,135	(13,721)	(33,913)	102,501
*9.4% additional pension contributions paid by NHSE on providers behalf	8,131	(8,131)	-	-
CCS Total 2024/25	180,100	(127,906)	(58,176)	(5,982)

	2025-26	2024-25
	£000	£000
Revenue from patient care activities	184,734	172,263
Other operating revenue	8,719	7,838
Operating expenses	(193,274)	(182,186)
Operating (deficit)/surplus	179	(2,085)
Finance income	318	-
Finance expenses	(272)	(274)
Public dividend capital dividends payable	(2,488)	(2,648)
Retained (deficit)/surplus for the financial year	(2,263)	(5,007)
Add back all I&E impairments / (reversals)	3,919	5,060
Adjusted financial performance surplus	1,656	53

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.5

Note 3.1 Income from patient care activities (by nature)	2025/26	2024/25
	£000	£000
High cost drugs income from commissioners	6,447	6,155
Income from commissioners under API contracts*	81,790	75,454
Income from other sources (e.g. local authorities)	76,359	71,574
National pay award central funding***	-	23
Additional pension contribution central funding**	8,575	8,131
Other clinical income	11,563	10,926
Total income from activities	184,734	172,263

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.

<https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income from patient care activities (by source)

	2025/26	2024/25
Income from patient care activities received from:	£000	£000
NHS England	14,827	14,361
Integrated care boards	83,512	76,948
Department of Health and Social Care	20	35
Other NHS providers	5,637	6,477
Local authorities	70,702	65,062
Injury cost recovery scheme	3	7
Non NHS: other	10,033	9,373
Total income from activities	184,734	172,263

Note 4 Other operating income

	2025/26			2024/25		
	Contract	Non-contract	Total	Contract	Non-contract	Total
	income	income		income	income	
	£000	£000	£000	£000	£000	£000
Research and development	8	-	8	3	-	3
Education and training	3,243	357	3,600	2,794	-	2,794
Income in respect of employee benefits accounted on a gross basis	45	-	45	50	-	50
Charitable and other contributions to expenditure	-	1	1	-	21	21
Revenue from operating leases	-	4,284	4,284	-	4,268	4,268
Other income	781	-	781	702	-	702
Total other operating income	4,077	4,642	8,719	3,549	4,289	7,838

Note 5 Operating leases - Cambridgeshire Community Services NHS Trust as lessor

This note discloses income generated in operating lease agreements where Cambridgeshire Community Services NHS Trust is the lessor.

The lease agreements are managed through lease contracts and Memoranda of Occupation with both NHS and Non-NHS organisations. The properties are either freeholds of the Trust or properties where the Trust holds the head lease.

Note 5.1 Operating lease income

	2025/26 £000	2024/25 £000
Lease receipts recognised as income in year:		
Minimum lease receipts	4,284	4,268
Total in-year operating lease income	4,284	4,268

Note 5.2 Future lease receipts

	31 March 2026 £000	31 March 2025 £000
Future minimum lease receipts due in:		
- not later than one year	5,712	4,268
- later than one year and not later than two years	12	12
- later than two years and not later than three years	12	12
- later than three years and not later than four years	12	12
- later than four years and not later than five years	5	4
- later than five years	-	-
Total	5,753	4,308

Note 6.1 Operating expenses

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,185	3,168
Purchase of healthcare from non-NHS and non-DHSC bodies	3,845	3,735
Staff and executive directors costs	134,669	127,365
Remuneration of non-executive directors	123	133
Supplies and services - clinical (excluding drugs costs)	5,737	4,182
Supplies and services - general	3,742	3,511
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	7,707	7,310
Consultancy costs	49	44
Establishment	2,392	2,497
Premises	14,961	13,257
Transport (including patient travel)	2,017	2,041
Depreciation on property, plant and equipment	6,531	6,588
Amortisation on intangible assets	34	72
Net impairments	3,919	5,060
Movement in credit loss allowance: contract receivables / contract assets	617	43
Change in provisions discount rate(s)	51	34
Fees payable to the external auditor for statutory audit	119	113
Internal audit costs	126	104
Clinical negligence	652	554
Education and training	1,036	805
Other *	2,762	1,570
Total	193,274	182,186

* Costs have increased in 2025/26 due to a VAT provision for the Trust's partial exemption resulting from VAT case law developments (£778k).

Note 6.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2024/25: £1m).

Note 7 Impairment of assets

	2025/26	2024/25
	£000	£000
from:		
Changes in market price	3,919	5,060
Total net impairments charged to operating surplus / deficit	3,919	5,060
Impairments charged to the revaluation reserve	590	12,311
Total net impairments	4,509	17,371

Impairments are as a result of a professional valuation of the Trust's owned estate carried out in 2025/26 by Montagu Evans LLP.

The valuation of the Trust's estates may result in the impairments or reversals of previous year's impairments compared to the carrying values, which are required to be recognised in the Statement of Comprehensive Income (SOI).

Where there is no revaluation reserve balance, or the value of the impairment exceeds the balance in the revaluation reserve, this may lead to an in-year charge. For the year ended 31 March 2026, a net charge of £3,919k is recognised (2024/25: £5,060k).

In addition, there has been a net increase to the revaluation reserve resulting from the valuation of £1,000k (2024/25: (£9,628k)).

	Land	Buildings	Total
	£000s	£000s	£000s
Charged to revaluation reserve			
Revaluation increase	211	1,379	1,590
Impairment	-	(590)	(590)
Net increase/(decrease) to revaluation reserve	211	789	1,000

	Land	Buildings	Total
	£000s	£000s	£000s
Charged to income and expenditure reserve			
Revaluation increase	-	-	-
Impairment	-	(3,919)	(3,919)
Net increase/(decrease) to income and expenditure reserve	-	(3,919)	(3,919)

Note 8 Employee benefits

	2025/26	2024/25
	Total	Total
	£000	£000
Salaries and wages	98,240	94,779
Social security costs	12,797	9,680
Apprenticeship levy	484	465
Employer's contributions to NHS pensions	21,716	20,574
Termination benefits	378	40
Temporary staff (including agency)	1,054	1,827
Total gross staff costs	134,669	127,365
Recoveries in respect of seconded staff	-	-
Total staff costs	134,669	127,365
Of which		
Costs capitalised as part of assets	-	-

Note 8.1 Retirements due to ill-health

During 2025/26 there were 6 early retirements from the trust agreed on the grounds of ill-health (5 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £1,004k (£364k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2025/26	2024/25
	£000	£000
Interest on bank accounts	318	-
Total finance income	318	-

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on lease obligations	273	275
Total interest expense	273	275
Unwinding of discount on provisions	(1)	(1)
Total finance costs	272	274

Note 12.1 Intangible assets - 2025/26

	Software licences £000	Development expenditure £000	Websites £000	Intangible assets under construction £000	Total £000
Cost at 1 April 2025 - brought forward *	12	358	21	278	669
Additions	-	-	-	476	476
Cost at 31 March 2026	12	358	21	754	1,145
Amortisation at 1 April 2025 - brought forward	12	324	21	-	357
Provided during the year	-	34	-	-	34
Amortisation at 31 March 2026	12	358	21	-	391
Net book value at 31 March 2026	-	-	-	754	754
Net book value at 1 April 2025	-	34	-	278	312

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 12.2 Intangible assets - 2024/25

	Software licences £000	Development expenditure £000	Websites £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2024 - as previously stated	12	358	21	-	391
Additions	-	-	-	278	278
Valuation / gross cost at 31 March 2025	12	358	21	278	669
Amortisation at 1 April 2024 - as previously stated	12	252	21	-	285
Provided during the year	-	72	-	-	72
Amortisation at 31 March 2025	12	324	21	-	357
Net book value at 31 March 2025	-	34	-	278	312
Net book value at 1 April 2024	-	106	-	-	106

Note 13.1 Property, plant and equipment - 2025/26

	Land £000	Buildings excluding dwellings £000	Lease Improvements £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2025 - brought forward	11,710	47,508	8,670	11,432	1,139	1	5,533	1,451	87,444
Additions	-	158	155	2,700	666	-	125	-	3,804
Impairments	-	(5,467)	-	-	-	-	-	-	(5,467)
Revaluations	211	1,379	-	-	-	-	-	-	1,590
Reclassifications	91	12,577	-	(12,668)	-	(1)	1	-	-
Transfers to / from assets held for sale	(487)	(412)	-	-	-	-	-	-	(899)
Valuation/gross cost at 31 March 2026	11,525	55,743	8,825	1,464	1,805	-	5,659	1,451	86,472
Accumulated depreciation at 1 April 2025 - brought forward	-	50	4,877	-	816	-	4,690	886	11,319
Provided during the year	-	2,469	443	-	78	-	564	113	3,667
Impairments	-	(958)	-	-	-	-	-	-	(958)
Accumulated depreciation at 31 March 2026	-	1,561	5,320	-	894	-	5,254	999	14,028
Net book value at 31 March 2026	11,525	54,182	3,505	1,464	911	-	405	452	72,444
Net book value at 1 April 2025	11,710	47,458	3,793	11,432	323	1	843	565	76,125

Note 13.2 Property, plant and equipment - 2024/25

	Land £000	Buildings excluding dwellings £000	Lease Improvements £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2024 - as previously stated	12,030	35,625	8,439	30,414	1,094	1	5,395	1,364	94,362
Prior period adjustments *	-	-	(232)	232	-	-	-	-	-
Valuation / gross cost at 1 April 2024 - restated	12,030	35,625	8,207	30,646	1,094	1	5,395	1,364	94,362
Additions	-	1,394	231	8,179	45	-	138	87	10,074
Impairments	(1,743)	(17,932)	-	-	-	-	-	-	(19,675)
Revaluations	1,423	1,260	-	-	-	-	-	-	2,683
Reclassifications *	-	27,161	232	(27,393)	-	-	-	-	-
Valuation/gross cost at 31 March 2025	11,710	47,508	8,670	11,432	1,139	1	5,533	1,451	87,444
Accumulated depreciation at 1 April 2024 - as previously stated	-	29	4,449	-	724	-	3,945	770	9,917
Provided during the year	-	2,325	428	-	92	-	745	116	3,706
Impairments	-	(2,304)	-	-	-	-	-	-	(2,304)
Accumulated depreciation at 31 March 2025	-	50	4,877	-	816	-	4,690	886	11,319
Net book value at 31 March 2025	11,710	47,458	3,793	11,432	323	1	843	565	76,125
Net book value at 1 April 2024	12,030	35,596	3,758	30,646	370	1	1,450	594	84,445

* An asset was previously stated as a Lease Improvement, when it should have been stated as an Asset Under Construction. This had no impact on the depreciation charge in either financial year

Note 13.3 Revaluations of property, plant and equipment

The valuation of land and buildings is a key accounting estimate which is sensitive to changes in assumptions and market conditions.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the Statement to Financial Position date. In practice the Trust will ensure there is a full quinquennial valuation and an interim calculation in the third year of each quinquennial cycle. In any intervening year the Trust will carry out a review of movements in appropriate land and building indices and where material fluctuations occur, will engage the services of a professional valuer to determine appropriate adjustments to the valuations of assets to ensure that the book values reflect fair values.

A desktop revaluation was performed at 31 March 2026 following a full revaluation at 31 March 2025. Land and buildings held by the Trust were revalued and building useful economic lives were reviewed. The valuation and useful economic lives review were undertaken by the Trust's property valuer in accordance with the requirements of the RICS Valuation – Global Standards 2021, effective from 31st January 2022) and the accounting framework. Significant judgements are used in determining the fair value of land and buildings. For assets valued at depreciated replacement cost, key judgements include remaining and total useful lives, construction costs and professional fees, unit costs, optimisation, and the Trust's required service potential from assets.

Fair values are determined as follows:

The valuation of each property was on the basis of fair value, subject to the assumption that all property would be sold as part of continuing enterprise occupation.

The valuers opinion of the market value was primarily derived using comparable recent market transactions on arms length terms.

The depreciated replacement cost method of valuation as the specialised nature of the asset means that there is no market transaction of this type except as part of the enterprise in occupation and is subject to the prospect and viability of the continued occupation and use.

Note 14 Right of use assets - 2025/26

	Property (land and buildings)	Total	Of which: leased from DHSC group bodies
	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	30,618	30,618	2,461
Remeasurements of the lease liability	637	637	-
Valuation/gross cost at 31 March 2026	31,255	31,255	2,461
Accumulated depreciation at 1 April 2025 - brought forward	8,487	8,487	468
Provided during the year	2,864	2,864	168
Accumulated depreciation at 31 March 2026	11,351	11,351	636
Net book value at 31 March 2026	19,904	19,904	1,825
Net book value at 1 April 2025	22,131	22,131	1,993
Net book value of right of use assets leased from other NHS providers			1,206
Net book value of right of use assets leased from other DHSC group bodies			619

Note 14.1 Right of use assets - 2024/25

	Property (land and buildings)	Total	Of which: leased from DHSC group bodies
	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	30,341	30,341	2,531
Remeasurements of the lease liability	277	277	(70)
Valuation/gross cost at 31 March 2025	30,618	30,618	2,461
Accumulated depreciation at 1 April 2024 - brought forward	5,605	5,605	305
Provided during the year	2,882	2,882	163
Accumulated depreciation at 31 March 2025	8,487	8,487	468
Net book value at 31 March 2025	22,131	22,131	1,993
Net book value at 1 April 2024	24,736	24,736	2,226
Net book value of right of use assets leased from other NHS providers			1,275
Net book value of right of use assets leased from other DHSC group bodies			718

Note 14.2 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 20.

	2025/26	2024/25
	£000	£000
Carrying value at 1 April	22,425	24,930
Lease liability remeasurements	637	277
Interest charge arising in year	273	275
Lease payments (cash outflows)	(3,039)	(3,057)
Carrying value at 31 March	20,296	22,425

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Income generated from subleasing right of use assets is £1,107k and is included within revenue from operating leases in note 4.

Note 14.3 Maturity analysis of future lease payments

	Of which leased from DHSC group bodies:		Of which leased from DHSC group bodies:	
	Total		Total	
	31 March	31 March	31 March	31 March
	2026	2026	2025	2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	2,679	185	2,940	200
- later than one year and not later than five years;	9,476	742	9,666	742
- later than five years.	9,696	1,528	11,499	1,714
Total gross future lease payments	21,851	2,455	24,105	2,656
Finance charges allocated to future periods	(1,555)	(572)	(1,680)	(623)
Net lease liabilities at 31 March 2026	20,296	1,883	22,425	2,033
Of which:				
Leased from other NHS providers		1,262		1,314
Leased from other DHSC group bodies		621		719

Note 15.1 Receivables

	31 March 2026	31 March 2025
	£000	£000
Current		
Contract receivables	14,237	11,435
Allowance for impaired contract receivables / assets	(1,425)	(808)
Prepayments (non-PFI)	2,871	2,076
PDC dividend receivable	161	247
VAT receivable	62	280
Total current receivables	15,906	13,230
Non-current		
Other receivables	10	9
Total non-current receivables	10	9
Of which receivable from NHS and DHSC group bodies:		
Current	4,703	4,699
Non-current	10	9

Note 15.2 Allowances for credit losses

	31 March 2026	31 March 2025
	Contract	Contract
	receivables and	receivables and
	contract assets	contract assets
	£000	£000
Allowances as at 1 April - brought forward	808	765
New allowances arising	87	194
Changes in existing allowances	596	-
Reversals of allowances	(66)	(151)
Allowances as at 31 Mar 2026	1,425	808

Note 16 Non-current assets held for sale and assets in disposal groups

	2025/26	2024/25
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	-	-
Assets classified as available for sale in the year	899	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	899	-

The Trust is selling St Ives Clinic, which is a wholly owned freehold land and building, and a section of land at Princess of Wales Hospital, Ely. Both are surplus to requirements and currently being actively marketed for sale

Note 17 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	31 March 2026	31 March 2025
	£000	£000
At 1 April	6,577	11,559
Net change in year	1,884	(4,982)
At 31 March	8,461	6,577
Broken down into:		
Cash at commercial banks and in hand	2	2
Cash with the Government Banking Service	8,459	6,575
Total cash and cash equivalents as in SoCF	8,461	6,577

Note 18 Trade and other payables

	31 March 2026 £000	31 March 2025 £000
Current		
Trade payables	4,321	6,709
Capital payables	437	652
Accruals	7,383	4,100
Receipts in advance and payments on account	-	86
Social security costs	1,392	1,129
Other taxes payable	1,124	1,090
Pension contributions payable	1,839	1,711
Total current trade and other payables	16,496	15,477
Of which payables from NHS and DHSC group bodies:		
Current	1,833	2,309
Non-current	-	-

Note 19 Other liabilities

	31 March 2026 £000	31 March 2025 £000
Current		
Other deferred income	912	-
Total other current liabilities	912	-

Note 20 Borrowings

	31 March 2026 £000	31 March 2025 £000
Current		
Lease liabilities	2,434	2,693
Total current borrowings	2,434	2,693
Non-current		
Lease liabilities	17,862	19,732
Total non-current borrowings	17,862	19,732

Note 21 Reconciliation of liabilities arising from financing activities

	31 March 2026	31 March 2025
	Lease Liabilities £000	Lease Liabilities £000
Carrying value at 1 April 2025	22,425	24,930
Cash movements:		
Financing cash flows - payments and receipts of principal	(2,766)	(2,782)
Financing cash flows - payments of interest	(273)	(275)
Non-cash movements:		
Lease liability remeasurements	637	277
Application of effective interest rate	273	275
Carrying value at 31 March 2026	<u>20,296</u>	<u>22,425</u>

Note 22.1 Provisions for liabilities and charges analysis

	Other £000	Total £000
At 1 April 2025	1,016	1,016
Transfers by absorption	-	-
Change in the discount rate	51	51
Arising during the year	836	836
Utilised during the year	-	-
Reclassified to liabilities held in disposal groups	-	-
Reversed unused	(23)	(23)
Unwinding of discount	-	-
At 31 March 2026	1,880	1,880
Expected timing of cash flows:		
- not later than one year;	866	866
- later than one year and not later than five years;	211	211
- later than five years.	803	803
Total	1,880	1,880

Other: Dilapidations

The Trust occupies a number of properties on short term leasehold agreements. There are a number of lease covenants requiring that during and on expiry of the leases, the properties need to be maintained in a good condition and state of repair, which usually requires a level of reinstatement, repair or decoration. As such, it is deemed appropriate to create a provision to ensure that leased properties can be maintained and vacated in correct condition. The Trust has used historical knowledge of actual costs incurred.

Note 22.2 Clinical negligence liabilities

At 31 March 2026, £1,150k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Cambridgeshire Community Services NHS Trust (31 March 2025: £914k).

Note 23 Financial instruments

Note 23.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship the Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by commercial business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the DHSC (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures at 31 March 2026 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with ICB's, NHSE and Local Authorities, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 23.2 Carrying values of financial assets

	2026	2025
	Held at amortised cost £000	Held at amortised cost £000
Carrying values of financial assets as at 31 March 2026		
Trade and other receivables excluding non financial assets	12,820	10,610
Cash and cash equivalents	8,461	6,577
Total at 31 March 2026	21,281	17,187

Note 23.3 Carrying values of financial liabilities

	2026 Held at amortised cost £000	2025 Held at amortised cost £000
Carrying values of financial liabilities as at 31 March 2026		
Obligations under leases	20,296	22,425
Trade and other payables excluding non financial liabilities	10,004	10,946
Total at 31 March 2026	30,300	33,371

Note 23.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2026 £000	31 March 2025 £000
In one year or less	12,957	13,886
In more than one year but not more than five years	9,476	9,666
In more than five years	9,696	11,499
Total	32,129	35,051

Note 24 Related parties

The DHSC is the Trust's parent entity and also regarded as a related party. During the year Cambridgeshire Community Services NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is also regarded as the parent Department. The Trust also had transactions with other government bodies which are regarded as related parties. These entities are:

Cambridgeshire County Council
Bedford Unitary Authority
Central Bedfordshire Unitary Authority
Luton Borough Council
Norfolk County Council
Suffolk County Council
HM Revenue and Customs

DHSC Related Parties:

NHS Bedfordshire, Luton and Milton Keynes ICB
NHS Cambridgeshire and Peterborough ICB
NHS Norfolk and Waveney ICB
NHS England - Core
NHS England - Central Specialised Commissioning Hub
East of England Regional Office
Health Education England
DHSC
Bedfordshire Hospitals NHS Foundation Trust
Cambridge University Hospitals NHS Foundation Trust
Cambridgeshire and Peterborough NHS Foundation Trust
East London NHS Foundation Trust
North West Anglia NHS Foundation Trust
The Queen Elizabeth Hospital King's Lynn NHS Foundation
NHS Resolution
Care Quality Commission
NHS Property Services
NHS Pension Scheme

Transactions with the NHS Pension Scheme comprise the employer contribution disclosed in note 8. No contributions were owed at the start or end of the financial year. The Scheme is administered by the NHS Business Services Authority.

There have been transactions in the ordinary course of the Trust's business with an organisation with which Directors of the Trust are connected. The Chief Executive is also Chief Executive of Norfolk Community Health and Care NHS Trust.

Details of directors' and senior managers remuneration are given in the Remuneration Report included in the Trust's Annual Report.

The Trust is corporate Trustee for the children's charity Dreamdrops and the Community Services fund. These have not been consolidated within the Trust's accounts on the grounds of materiality, with the unaudited results for 2025/26 being £39k and £98k respectively of income generation and resources expended of £21k and £26k respectively and a closing fund balance of £565k and £937k respectively.

Note 25 Events after the reporting date

On 1 April 2026, Cambridgeshire Community Services NHS Trust's assets, liabilities and operations merged into Norfolk Community Health and Care NHS Trust, which was then renamed to East of England Community Health and Care NHS Trust. The merger was treated as an absorption transfer of Cambridgeshire Community Services NHS Trust into Norfolk Community Health and Care NHS Trust. Cambridgeshire Community Services NHS Trust was then dissolved.

As the two Trusts apply the same accounting policies, no adjustments are required to the values of assets and liabilities on transfer from Cambridgeshire Community Services into the newly named Trust.

Note 26 Final period of operation as a trust providing NHS healthcare

As referred to in Note 25, all assets and liabilities are to be transferred to Norfolk Community Health and Care NHS Trust on 1 April 2026. The following table shows the values of assets and liabilities that will transfer into the new Trust from Cambridgeshire Community Services NHS Trust:

	£'000
Non current assets	93,112
Current assets	25,322
Current liabilities	(20,708)
Non current liabilities	(18,876)
Equity	78,850

Note 27 Better Payment Practice code

	2025/26 Number	2025/26 £000	2024/25 Number	2024/25 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	12,561	80,756	12,869	82,021
Total non-NHS trade invoices paid within target	11,537	74,233	11,617	76,134
Percentage of non-NHS trade invoices paid within target	91.8%	91.9%	90.3%	92.8%
NHS Payables				
Total NHS trade invoices paid in the year	672	6,606	571	4,156
Total NHS trade invoices paid within target	514	5,220	445	3,213
Percentage of NHS trade invoices paid within target	76.5%	79.0%	77.9%	77.3%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

Note 28 Capital Resource Limit

	2025/26 £000	2024/25 £000
Gross capital expenditure	4,917	10,629
Charge against Capital Resource Limit	4,917	10,629
Capital Resource Limit	4,917	10,629
Under / (over) spend against CRL	-	-

Note 29 Adjusted financial performance

	2025/26 £000	2024/25 £000
Surplus / (deficit) for the period per SOCI	(2,263)	(5,007)
Remove net impairments not scoring to the departmental expenditure limit	3,919	5,060
Adjusted financial performance surplus / (deficit)	1,656	53

Note 30 Breakeven duty financial performance

	2025/26 £000
Adjusted financial performance surplus / (deficit)	1,656
Breakeven duty financial performance surplus / (deficit)	1,656

Note 31 Breakeven duty rolling assessment

	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	-	(1,633)	446	17	53	1,656
Breakeven duty cumulative position	15,948	14,315	14,761	14,778	14,831	16,487
Operating income	153,002	172,446	180,124	176,953	180,101	193,453
Cumulative breakeven position as a percentage of operating income	10.4%	8.3%	8.2%	8.4%	8.2%	8.5%

The Trust has achieved financial balance in 2025/26, as can be seen in the table above. The table also sets out the previous four years of breakeven information.