Agenda item:	10
Date of meeting:	20 May 2026
Report to the:	Trust Board
Title of report:	Integrated Governance and Performance Report
Report authors & Executive sponsors:	Executive Team
Recommendation:	Approve

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

1.0 Executive Summary

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

1.2 The report period relates to the period February 2026 and March 2026 and is structured into two sections:

- Feedback and escalation from each of the Assurance Committees.
- Salient Trust wide information that the Trust Board should be cognisant of, including how risks and issues are being managed.

1.3 Attached to this report are the following annexes which require the Board to consider:

- **Annex 1 - Inpatient Establishment Review:**
  The Board is asked to consider and accept the recommendations provided within the report.

- **Annex 2 – Antimicrobial Resistance Call for Review**

The Board is asked to:

1. **Note** the current antimicrobial stewardship performance and assurance position
2. **Acknowledge** the key risks, particularly digital and data limitations
3. **Approve** the identified priorities and improvement plan
4. **Support** the strategic actions required to strengthen antimicrobial stewardship

2.0 How the report supports tackling Health Inequalities

The metrics for Equality Delivery System (EDS) are being monitored for delivery by the People Participation and Equalities Committee. Implementation of the Equality Delivery System will help the Trust to meet the requirements of the Public Sector Equality Duty (section 149) set out within the Equality Act 2010. The report contains various examples of how our services are addressing health inequalities, across the different systems in which we operate.

3.0 Board Assurance Framework and Trust Risk and Issue Registers

The report assesses the strength of assurance provided in relation to the Trust's strategic risks in the Board Assurance Framework and operational risks scoring 15 and above.

4.0 Legal and Regulatory requirements

4.1 All Care Quality Commission Key Lines of Enquiry and fundamental standards of care are addressed in this report.

4.2 There was one NatPSA (National Patient Safety Alerts) received in this reporting period which was applicable to Norfolk Adults Services. See section 1.7.1 of part three of the report.

5.0 Previous consideration by Committee or Executive

Group Trust Board Integrated Governance & Performance Report, 18 March 2026

6.0 Assurance

6.1 The three Assurance Committees confirmed the following levels of assurance reported from the individual integrated governance reports:

- Luton and Bedfordshire Community Adult Services – **Substantial assurance**
- MSK Dynamic Health Services – **Substantial Assurance**
- MSK Services Norfolk – **Reasonable Assurance**
- Dental Healthcare – **Reasonable Assurance**
- iCaSH Services – **Reasonable Assurance**
- Children & Young People (CYP) Integrated Governance Report - **Reasonable Assurance**
- Norfolk Adult Services – **Partial Assurance**

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

6.3 Therefore the Executive team recommends an overall rating of **REASONABLE** assurance for the aggregated position across our entire portfolio. The rationale for this

rating is based on the combined three Service Assurance Committee assurance levels in 6.1 above. This is not an exact science but is proportionate given the detail shown in 6.1.

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

7.0 Key Matters

The key reports from the Assurance Committees (part one of this report) also include matters for the Board to note and examples of outstanding practice that were discussed at the committee meetings.

8.0 Key Risk Register:

8.1 There are no operational risks scoring 15 or above.

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

9.0 Key Issues Register:

9.1 There are 11 operational issues scoring 4 (Major) or above on the Trust's issue register. They are discussed in detail at the relevant Assurance Committees.

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

- Three relate to children and young people's services.
- Seven relate to adult services across Norfolk.
- One relates to the reduced pharmacist and pharmacy technician cover across the legacy CCS footprint and is discussed at the Quality Committee.

10.0 Forward View for 2026/27

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

- Continued spotlight on reducing waiting times
- Identifying further recurrent efficiencies for 2026/27 and beyond
- New reporting framework for service assurance committees and Board in July 2026

Annexes

Annex 1: Inpatient Establishment Review – April 2026

Annex 2: Antimicrobial Resistance Call to Action

Part One: Feedback, assurance and escalation from the service assurance committees

Key Matters and Escalation Report to the Trust Board

Name of Committee: Luton and Bedfordshire Adults & Older People Services and Ambulatory Care Service Assurance Committee
Chair: Charlotte Black, Non-Executive Director
Meeting Date: 06 May 2026

Key matters:

- Learning from Improvement, Service Redesign and Transformation Team – 2025/26
- Annual Finance Plan 2026-27
- Service Plans for 2026-27 presented for all services.

Luton and Bedfordshire Community Adult Services – Substantial assurance.

Key points:

- Services continue to deliver safe, effective and responsive care, with all core domains rated as substantial. Patient safety indicators remain strong. Staff pressures well controlled which is demonstrated by the service reporting Opel 1 or 2 almost every day during the reporting period.
- Safeguarding Adult level 3 training for Luton Adults remains below target at 86% - targeted approach being used to improve compliance.
- Sickness levels below Trust target for the first time in many years.
- Staff survey results were shared and the division performed well, outperforming the Trust in 8 of the 9 domains.
- Update on delivery of 25/26 service plan was presented as was the annual plan for 26/27.

MSK Dynamic Health Services – Substantial assurance:

- Waiting lists overall remain below average 18 weeks. However, the service has 171 patients waiting over 30 weeks – 167 in core physio and 4 in specialist service. No over 52 week waiters.
- Waiting times for urgent referrals for core physio – average of 4.3 weeks. Plan in relation to improving urgent referral times to be included in July 2026 report.
- Sickness absence levels above target (5.81%) in March 2026 – all cases being pro-actively managed. Appraisal rates 83% below Trust target, however, plans in place to get to compliance.
- Overall staff survey results positive – local improvement actions being identified.

NOW MSK Service – Reasonable assurance

- Safeguarding level 3 adults below target at 87%, plan in place to improve.

- Waiting list overall remain below average 18 weeks. No 30 week or over 52 weeks waits. Waiting times for urgent referrals for pelvic services – average of 5.7 weeks.
- AI (Artificial Intelligence) pathway for lower back pain to be rolled out in May 2026.

Dental Healthcare – Reasonable assurance

- Waiting times – Cambridgeshire and Peterborough Special Care Dentistry, average wait remains at 21 weeks. General Anaesthetic (GA) over 52 week waiters has reduced to 18 as at end March 2026. Additional capacity has been identified however access to theatre space for the service remains a challenge. Suffolk Special Care Dentistry – average wait is 7 weeks.
- Appraisal rates below target at 87% and sickness absence rate remains above trust target at 8% in March 2026. All cases being managed in line with policy.
- Staff survey results for 2025 – actions identified.

iCaSH – Reasonable assurance:

- December 2025 never event - linked to a coil fitting. Correct type of device however 10-year device fitted rather than a 5-year device. After action review has taken place and learning shared. No harm and duty of candour completed and patient content with outcome.
- UV light hand hygiene compliance below Trust target at 78% for March 2026.
- Service continues not to meet the 2 contractual key performance indicators in relation to Cambridgeshire and Peterborough women being offered access to LARC (Long-Acting Reversible Contraception) within 10 working days. Indicators being reviewed with Commissioners.
- Norfolk service continues to have a formal LARC waiting list in place – average wait 11 weeks.
- Norfolk services successfully relocated in March 2026 and started to provide their new contract from 1st April 2026.

Key escalations

No Board escalations

Key risks and issues

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

Good practice or innovation

- **Luton and Bedfordshire Adults –** staff survey results for 2025.
- **Dynamic Health –** online booking and patient portal is being rolled out at the end of April 2026, to support with triage and referral management processes.
- **iCaSH –** Outreach and prevention services have expanded reach of Chlamydia screening to McDonalds, Primark and other retail outlets.

Key Matters and Escalation Report to the Trust Board

Name of Committee: Children and Young People's Service Assurance Committee
Chair: Anna Gill
Meeting Date: Tuesday, 05 May 2026

Key matters

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

The committee received a Trust-wide Children and Young People's (CYP) report. Key points:

- Mandatory training rates are substantial, Information Governance training rates are reasonable.
- Staff sickness remains high in various services across all localities.
- Appraisal rates variable at 75-97% in different services.
- At Q4 end-Year to Date CYP services overspend £1003k
- New KPIs (Key Performance Indicators) released for HCP (Healthy Child Programme) visits and a new MHST (Mental Health Support Team)
- Benchworking framework and discussions are being held with Local Authorities about these and the local commissioning direction.
- Norfolk Healthy Child Programme (HCP) procurement plans- we will continue to manage the services while this process progresses (contracts extended until Oct 27).

Universal Services:

- Challenges continue regarding meeting KPIs for HCP mandated visits rates with only partial or reasonable assurance across all localities.
- Failure to achieve Initial Health Assessments across all localities – reasons include LA (Local Authority) issues, increased referrals, staffing capacity and sickness. Plans to improve this and to monitor delays.
- One PSIRF (Patient Safety Incident Response Framework) case review in progress.

Specialist Services:

- B&L Dietetics issues with delays resulting in moderate harm to 5 patients. Waiting list reviews now ongoing.
- Luton Audiology waits improving but still an issue - moderate harm to 2 patients. Waiting list reviews now ongoing and a mitigation plan is in place.
- Cambridgeshire Dietetics waits ongoing: 70 CYP waiting >52 weeks – bank staff recruited.

Thematic Reviews:

- Increasing complexity has resulted in increased waiting lists
- Longest waits are to see a specialist clinician (Audiologist, Dietitian, Paediatrician)

- CYP being offered support earlier in service than previously
- Additional insourcing, skill-mixing and service redesign having greatest impacts
- Improvement plans are in place for all services with long waits

Annual Reports

- Service plans and 26/27 financial plan were discussed and signed off,

Key escalations:

No escalations to Board.

Key risks and issues:

One risk rated 16: Trust risk 3751 – regarding potential harm due to NDS long waits

High scoring risks 3885 and 3685 alongside the issues 3764 , 3474 and 3568 were reviewed - A discussion to review and amalgamate NDS risks and issues was had. Lower scoring risks and issues were also discussed.

Regulatory Updates:

- Quality Control self-assessments were completed December 2025, with most self-assessing as good or outstanding. Some Requires Improvements self-assessments reflected the lack of collating evidence. Discussions were held about challenging ourselves and the need for consistency across the CYP Trust-wide services when completing self-assessments. Discussions agreed the need for triangulation of this with the targets, KPIs etc and the impact on CYP.
- Full ILACS (Inspecting Local Authority Children's Services) inspection in Luton rated as Good – teams were commended.
- Norfolk had ILACS inspection March 26- awaiting report.
- Department of Education and NHS England visited Central Bedfordshire to review progress of the Accelerated Progress Plan and gave positive feedback on partnership.

Good practice or innovation:

- In-depth work with the QI (Quality Improvement) team around NDS service redesign with workshops. The team were commended and were invited to give a staff story at a future meeting.
- Trust-wide Speech and Language therapy services presented a service at NHS Elect Improvement Collaborative event
- Norfolk and Waveney Celebration of ADHD team played an active role in supporting CYP in research. "Making Mind Wandering Visible" was conducted in collaboration with the SGDP Centre at King's College London. We enrolled 14 CYP with an additional 11 participants due to be enrolled soon.
- C&P (Cambridgeshire & Peterborough) - UNICEF infant feeding Stage 3 re-accreditation took place in March 2026.
- B&L Audiology service selected to be included in NHS Elect's Audiology Improvement Collaborative, focusing on tailored QI support, data quality and pathway redesign.

Key Matters and Escalation Report to the Trust Board

Name of Committee: Norfolk Adults Service Assurance Committee
Chair: John Kennedy, Non-Executive Director
Meeting Date: 07 May 2026

Key matters

- Overall Assurance Level: **Partial**
- Approved the IGR, Annual Service Plan, and operational and financial budgets.
- Partial assurance noted for commode audit compliance, pressure/wound care harms, community nursing pressures and out-of-hours access to end of life medicines.
- All actions in relation to Regulation 28, Prevention of Future Deaths in relation to Pressure Ulcers have been completed and signed off.

Key escalation

No formal Trust Board decision or change of course requested.

For Board awareness:

- Severe harms reported, including category 4 pressure ulcers and penile erosions
- Financial plan for 26/27 includes £2.3m efficiencies and an expected £1.5m Norfolk Adults deficit to be managed at Trust level.
- Transformation capacity is an action supporting delivery of the Annual Service Plan.

Key risks and issues

- Out-of-hours EOL (End-of-Life) medicines access added as an issue.
  Mitigation: Recent deep dive demonstrated ongoing issue - work planned to manage internal issues with issues with external partners.
- Wound care / pressure ulcer harm remains the main cause of severe harm.
  Mitigation: After-action reviews completed; PSII (Patient Safety Incident Investigation) linked to the NCH&C Regulation 28 has received executive sign-off; learning moving into Safety Action Plan.
- Community nursing and urgent care pressures: 94.9% of requests are allocated. Risk of harm, inequity, poor communication and staff pressure.
  Mitigation: transformation roadmap due July including SPOC (Single Point of Contact)/triage review, professional lines, mobile working and communication standards.
- Annual plan and finance delivery: Delivery depends on transformation, digital and service capacity.
  Mitigation: live tracker, aligned budget construct and resource requirements review.

Good practice or innovation

- Wheelchair service improvement recognised despite ongoing fragility and workforce challenges.
- Improved transparency, insight and accountability in Norfolk Adults reporting.
- Strategy and Transformation diagnostic approach using SPOC, patient cohort and cluster analysis to support targeted improvement.
- 1st Norfolk Adults Leadership meeting with >100 leads attending and positive feedback.

Part Two- Themes across the organisations

1.0 SAFE

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

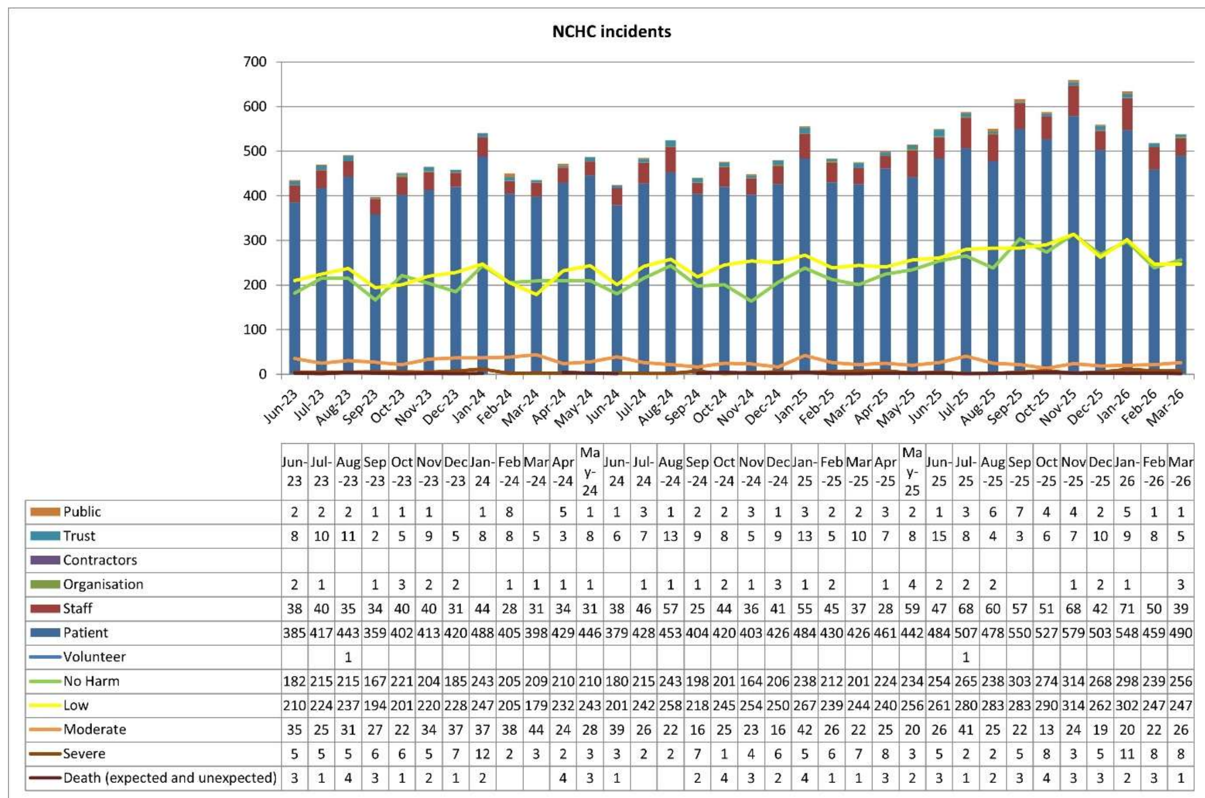
1.1 Overview of all incidents across CCS and NCHC across a 2-year period.

1.1.1 Graphs 1 and 2 demonstrate a steady profile of incident reporting. The incidents differ reflecting the type, and volume, of patient interactions across both Trusts portfolios. Two years of data is used to show clear trends.

1.1.2 Statistical process chart 1 (SPC) shows an upward trend in incident reporting across NCHC over the last twelve months, this is due to the increase in services at Willow and the Urgent Community Response teams. The harm level ratio for Norfolk adults remains consistent with the majority at no and low harm - see key escalation report for variance reporting to this.

Statistical process chart 2 (SPC) shows a stable profile across CCS and within control limits for the period.

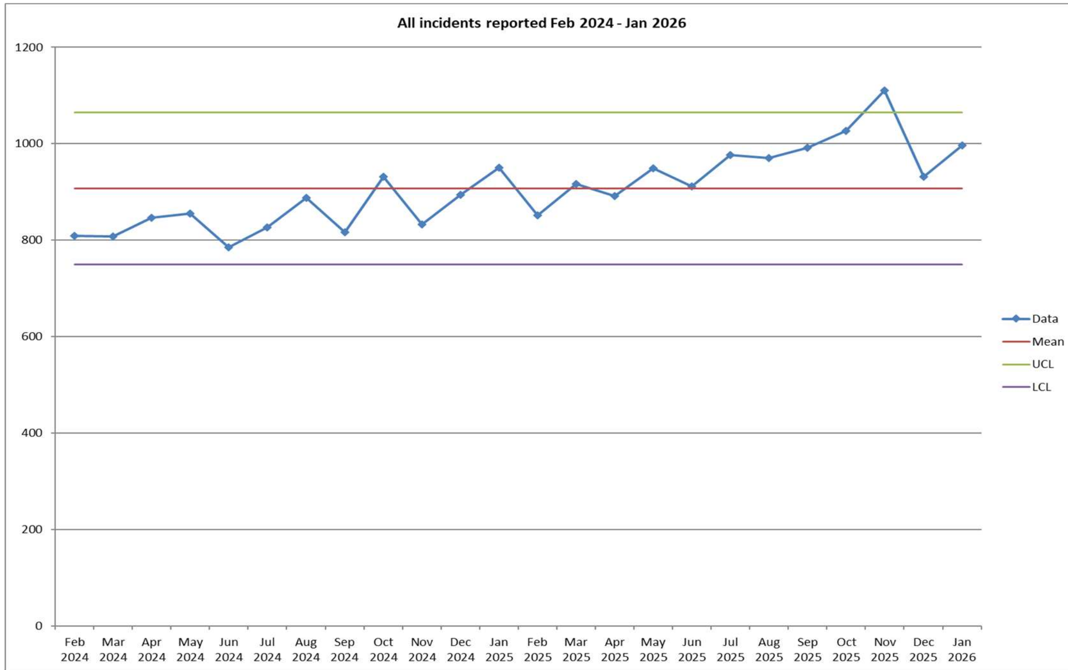
Graph 1 Norfolk Adults Incident Profile



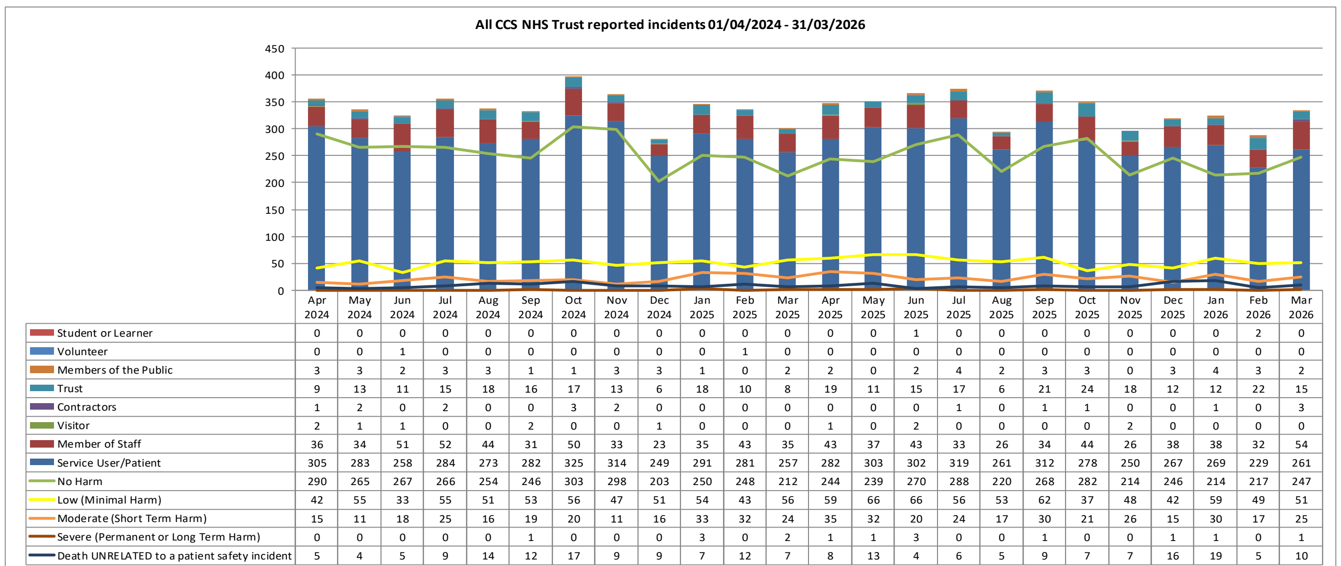
	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Public	2	2	2	1	1	1		1	8		5	1	1	3	1	2	2
Trust	8	10	11	2	5	9	5	8	8	5	3	8	6	7	13	9	8
Contractors																	
Organisation	2	1		1	3	2	2		1	1	1	1		1	1	1	2
Staff	38	40	35	34	40	40	31	44	28	31	34	31	38	46	57	25	44
Patient	385	417	443	359	402	413	420	488	405	398	429	446	379	428	453	404	420
Volunteer			1														
No Harm	182	215	215	167	221	204	185	243	205	209	210	210	180	215	243	198	201
Low	210	224	237	194	201	220	228	247	205	179	232	243	201	242	258	218	245
Moderate	35	25	31	27	22	34	37	37	38	44	24	28	39	26	22	16	25
Severe	5	5	5	6	6	5	7	12	2	3	2	3	3	2	2	7	1
Death (expected and unexpected)	3	1	4	3	1	2	1	2			4	3	1			2	4

	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Public	3	1	3	2	2	3	2	1	3	6	7	4	4	2	5	1	1
Trust	5	9	13	5	10	7	8	15	8	4	3	6	7	10	9	8	5
Contractors																	
Organisation	1	3	1	2		1	4	2	2	2			1	2	1		3
Staff	36	41	55	45	37	28	59	47	68	60	57	51	68	42	71	50	39
Patient	403	426	484	430	426	461	442	484	507	478	550	527	579	503	548	459	490
Volunteer									1								
No Harm	164	206	238	212	201	224	234	254	265	238	303	274	314	268	298	239	256
Low	254	250	267	239	244	240	256	261	280	283	283	290	314	262	302	247	247
Moderate	23	16	42	26	22	25	20	26	41	25	22	13	24	19	20	22	26
Severe	4	6	5	6	7	8	3	5	2	2	5	8	3	5	11	8	8
Death (expected and unexpected)	3	2	4	1	1	3	2	3	1	2	3	4	3	3	2	3	1

SPC 1 NCHC All reported incidents February 2024-January 2026



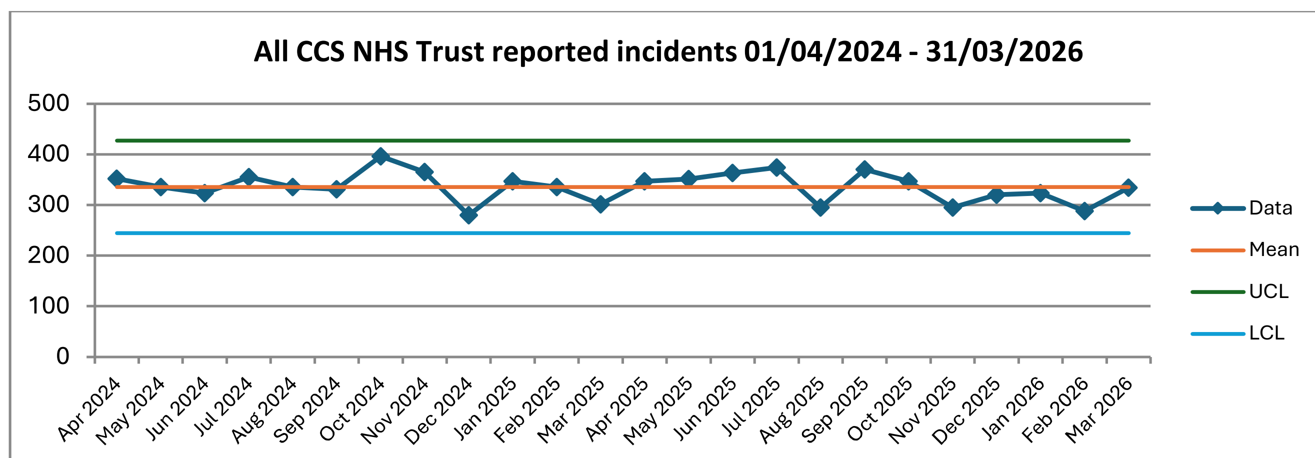
Graph 2 CCS Incident Profile



	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Student or Learner	0	0	0	0	0	0	0	0	0	0	0	0
Volunteer	0	0	1	0	0	0	0	0	0	0	1	0
Members of the Public	3	3	2	3	3	1	1	3	3	1	0	2
Trust	9	13	11	15	18	16	17	13	6	18	10	8
Contractors	1	2	0	2	0	0	3	2	0	0	0	0
Visitor	2	1	1	0	0	2	0	0	1	0	0	0
Member of Staff	36	34	51	52	44	31	50	33	23	35	43	35
Service User/Patient	305	283	258	284	273	282	325	314	249	291	281	257
No Harm	290	265	267	266	254	246	303	298	203	250	248	212
Low (Minimal Harm)	42	55	33	55	51	53	56	47	51	54	43	56
Moderate (Short Term Harm)	15	11	18	25	16	19	20	11	16	33	32	24
Severe (Permanent or Long Term Harm)	0	0	0	0	0	1	0	0	0	3	0	2
Death UNRELATED to a patient safety incident	5	4	5	9	14	12	17	9	9	7	12	7

	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Student or Learner	0	0	1	0	0	0	0	0	0	0	2	0
Volunteer	0	0	0	0	0	0	0	0	0	0	0	0
Members of the Public	2	0	2	4	2	3	3	0	3	4	3	2
Trust	19	11	15	17	6	21	24	18	12	12	22	15
Contractors	0	0	0	1	0	1	1	0	0	1	0	3
Visitor	1	0	2	0	0	0	0	2	0	0	0	0
Member of Staff	43	37	43	33	26	34	44	26	38	38	32	54
Service User/Patient	282	303	302	319	261	312	278	250	267	269	229	261
No Harm	244	239	270	288	220	268	282	214	246	214	217	247
Low (Minimal Harm)	59	66	66	56	53	62	37	48	42	59	49	51
Moderate (Short Term Harm)	35	32	20	24	17	30	21	26	15	30	17	25
Severe (Permanent or Long Term Harm)	1	1	3	0	0	1	0	0	1	1	0	1
Death UNRELATED to a patient safety incident	8	13	4	6	5	9	7	7	16	19	5	10

SPC 2 CCS All reported incidents April 2024 - March 2026



1.2 NCHC Patient Safety Incidents

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

1.2.2 Two PSII’s related to prevention of future death (Regulation 28) reports have now been signed off with learning and action plans compiled into one Norfolk Adults Safety Action Plan.

1.2.3 There is one Patient Safety Incident Investigation underway related to the Learning Disabilities Service

Table 1 All NCHC incidents Feb 26 - Mar 26 by degree of harm

Month	No Harm	Low	Moderate	Severe	Total
Feb 2026	239	247	22	8	970
March 2026	256	247	26	9	1006
Total	**495**	**494**	**48**	**17**	**1057**

1.2.4 Seventeen ***Severe Harm Incidents*** reported in total across February and March:

- **10** Category 4 pressure ulcer incidents were reported. These incidents are reviewed at Norfolk Place level with escalation to Pressure Ulcer Learning Group and Wound Care Group.
- **4** incidents related to skin damage secondary to long term catheter use. These incidents were reviewed through the Bladder and Bowel Improvement Group. Joint working has taken place with social care partners to improve care delivery across the integrated care pathway.
- **1** incident related to deterioration of diabetic foot wounds. Patient was well monitored, and all relevant specialists were already involved.
- **1** incident identified that on transfer to a recovery and reablement bed and removal of leg brace by visiting therapist a category 4 pressure ulcer was

noted. This incident was shared with the relevant acute hospital for further investigation.
- **1** therapy delay while on waiting list – patient noted to have fallen at home and sustained fracture. Investigation at Place level ongoing.

1.2.5 Forty-eight **moderate harm incidents** reported in February and March 24 related to development of a category 3 pressure ulcer whilst under community services. All cases were reviewed and any local learning was shared.

- **2** related to medication administration (one in community and one on inpatient ward). Immediate actions and learning shared across all inpatient areas to improve insulin storage and reduce the risk of incorrect administration.
- The remaining 9 incidents related to different individual issues covering, contractures, burns management, CDiff, access to end-of-life medication, fall with fracture. All issues identified are already part of pathway improvement work.
- 4 related to safeguarding concerns raised by Norfolk Adult Services for care delivered by other system partners.

1.3 CCS Patient Safety Incidents

1.3.1 One Patient Safety Incident Investigation (PSII) currently reviewing a young person's care who accessed the Mental Health Access Service (MHAS).

1.3.2 No 'Never Event's' were declared in the period.

1.3.3 One Patient Safety Incident Investigation remains ongoing of an incident that occurred in Bedfordshire Community Children and Young people service.

1.3.4 One Never Event review concluded and closed in Mar 26. The After-Action Review recommended changes in the process of device selection due to similar device packaging.

1.3.5 There is one action awaited from an historical PSII involving the ICB and are in relation to Cambridgeshire's Dietetic Service – Service Specification to be reviewed with the ICB

1.3.6 Seven review responses were commissioned by Safety Huddle in Feb 2026, two had a safeguarding element. Eight review responses were commissioned in March 2026, three of which had a safeguarding element.

Table 2 All CCS incidents Feb – March 2026 by degree of harm

Month	No Harm	Low	Moderate	Severe	Total
Feb 2026	99	22	8	0	129
March 2026	114	26	12	0	152
Total	**213**	**48**	**20**	**0**	**281**

1.3.7 Twenty **moderate harm incidents** reported (increase of two incidents)

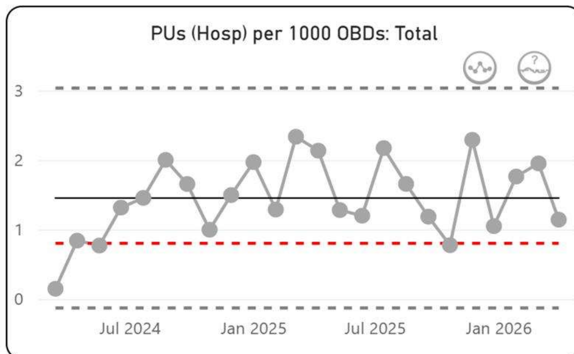
- **14** were reported related to preventable wounds (Luton Adults)
- **3** Growth/weight management (Nutrition & Dietetics)

- **2** Diagnosis – delay/failure (Audiology)
- **1** Treatment – delay/failure in recognising complications (Dental)
- **17** had the statutory Duty of Candour completed and letters sent
- **2** cases remain outstanding and are being followed up and escalated via the Safety Huddle
- **1** incident - skin deterioration at the end of life, so duty of candour not completed but a follow up family bereavement call was made

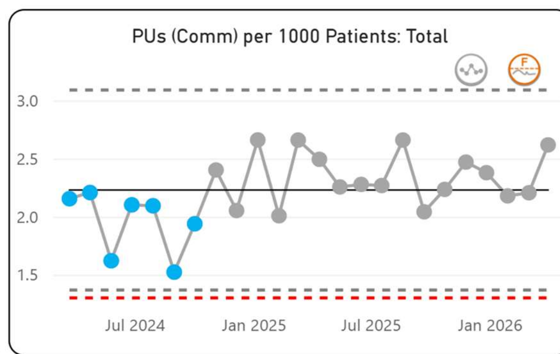
1.4 **Thematic review of specific incident categories:**

NCHC Pressure Ulcers

SPC Chart 3 NCHC Hospital Pressure Ulcers



SPC Chart 4 NCHC Community Pressure Ulcers



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

- Community acquired numbers have had a small reduction.
- All pressure ulcers have an initial review within Place, and greater complexity/harm cases are escalated to specialist forums for further scrutiny.

1.4.2 Progress with wider improvement initiatives:

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

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

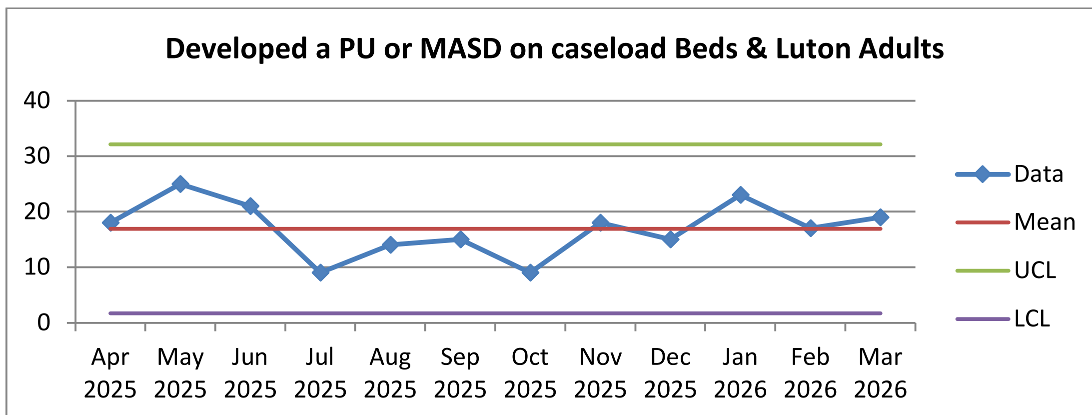
1.4.3 All Pressure Ulcers and Moisture-Associated Skin Damage are reported under the Clinical Assessment and Treatment category. 79 incidents reported as 'developed Pressure Ulcers or MASD', with 82 reported under Beds and Luton Adults Services. A further 12 incidents related to patients who 'acquired a skin tear', all of which are deemed to be off caseload and are 'happened upon' incidents.

1.4.4 Of the 79 Beds and Luton Adults incidents, 36 (46%) were deemed to have occurred whilst the patient was on the Luton Nursing caseload. Pressure Ulcer incidents reporting for those patients on caseload, shows a steady rate and is within the upper and lower control levels as per *Graph 3.*

1.4.5 The Preventable Wounds Community of Practice receive a monthly thematic

review of all grade 3 and 4 pressure ulcers to identify emerging themes and learning for wounds that are considered preventable.

- In the past 6 months we have introduced and embedded a wound care app to standardise photography and measurements. 25,854 wound assessments have been completed through the app with 451 patients currently on caseload. The median heal time is 10 weeks
    - Senior review requests completed within 24 hours
    - Identification of improving, static and deteriorating wounds
    - Photography and measurements taken at every visit
- New wound care priorities have been written and Action Plan for improvements and new work streams.
- Continued training and development of DN and TVN team.
- Monthly senior oversight of all Cat 3 and above wounds.
- Shared learning with NCHC including templates in system one; ESR based training and the positive impact of the wound care app.



1.5 Medicines Optimisation – Data from CCS and NCH&C

Overview

CCS Medication related Incidents

- Feb 26 - Mar 26: 25 medicines incidents: 20 no harm, 5 low harm.
- The majority (n=17, 68%) related to medicines administration.
- Bedfordshire Adult Services accounted for two-thirds of reports, partly reflecting proactive reporting of insulin-related events.

NCH&C Medication related Incidents

- Feb 26 - Mar 26: 245 medicine incidents: 220 no harm, 23 low harm and 2 moderate harm.
- The two moderate harm medication incidents were subject to structured review and escalation through established governance routes.

    - One community incident involving an incorrect dose of morphine administered via a syringe driver resulted in a multidisciplinary incident review. Subsequent After-Action Review focused on reinforcing staff education, compliance with existing processes, improved planning for joint care provider visits and strengthening documentation standards.

- The second incident, involving the selection of an incorrect insulin type which was then self-administered by the patient, prompted a review by inpatient ward managers.. This review identified the need to strengthen ward-level oversight and assurance arrangements for high-risk medicines. Actions are focused on reinforcing existing safety controls rather than introducing additional processes.

1.5.1 **Controlled Drugs (CDs) in NCH&C**

In response to several incidents a trial has been implemented in selected inpatient wards in Norfolk to manage CDs Schedule 4, and above, as Schedule 2 including full CD cupboard storage and record keeping. This enhanced security approach aligns with the CD policy response to incidents of this nature and is intended to address identified risks related to compliance and the potential for stock diversion.

1.5.2 **Summary Trust-Wide Actions**

- **Incident reporting:** A review of harm attribution has been initiated to improve the accuracy and consistency of incident reporting and strengthen data quality.

- **Long-Acting Reversible Contraception (LARC) safety**: Actions continue following Dec 25 Never Event regarding incorrect copper intrauterine device fitting, and a separate low-harm incident of spontaneous implant expulsion.

- **Documentation quality:** trial of the mobile application via electronic tablet devices is ongoing, assessing medication administration record accuracy, access to up-to-date information, and whether it improves communication at care transfer between providers. Relevant templates being reviewed to support integration with Bridgid app.

- **Insulin Safety**Targeted education being delivered through Oversight Groups, Huddles and MDTs.

- **Controlled drugs (CDs):** Pharmacy teams are actively engaged in identifying and supporting solutions to improve palliative care prescribing and timely access to anticipatory medications, particularly out of hours.

- **Medicines Stock management:** Digital temperature monitoring probes for medication fridges have been rolled out. Training is ongoing, and manual records are being maintained until full assurance is achieved that electronic systems can be relied upon as the sole monitoring method.

1.6 Violence Prevention and Reduction Standard

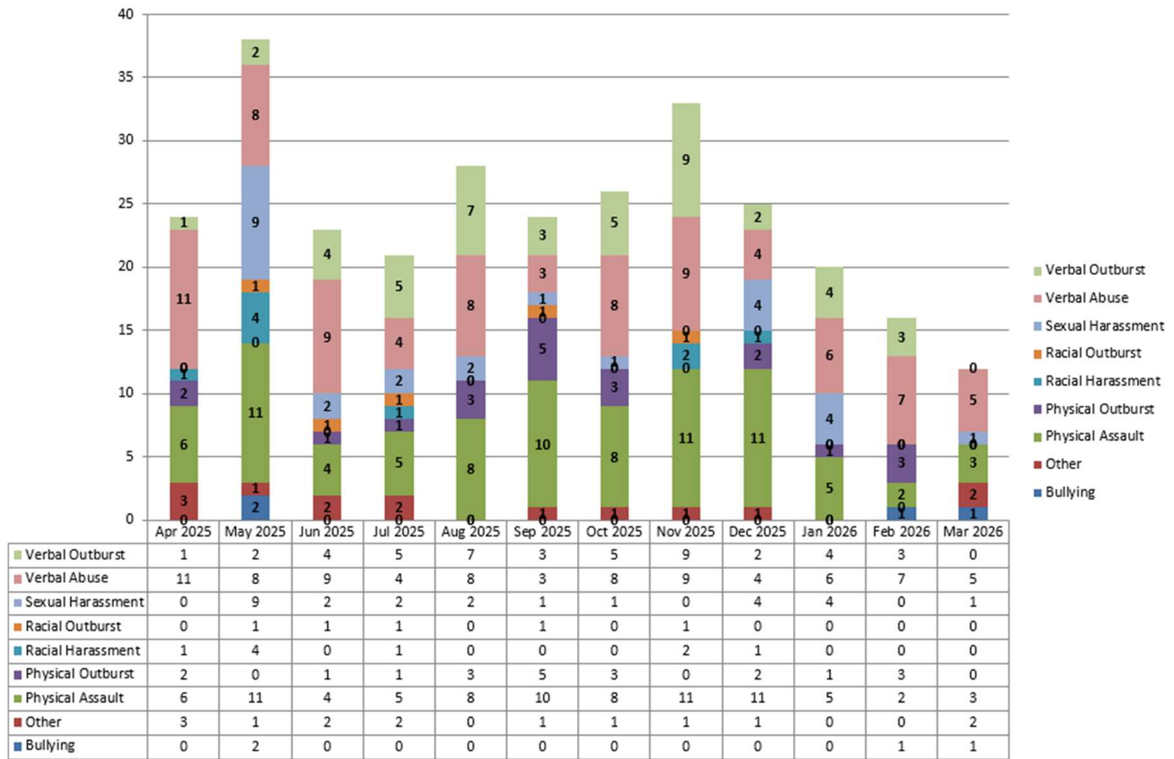
NCHC Violence and Aggression towards staff data

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

1.6.2 In the current reporting period, there were 28 incidents reported affecting staff. Incidents subtypes are presented in Graph 4.

Graph 4 Number of incidents by abuse type in NCHC services

Staff Abuse Incidents @ Prompt



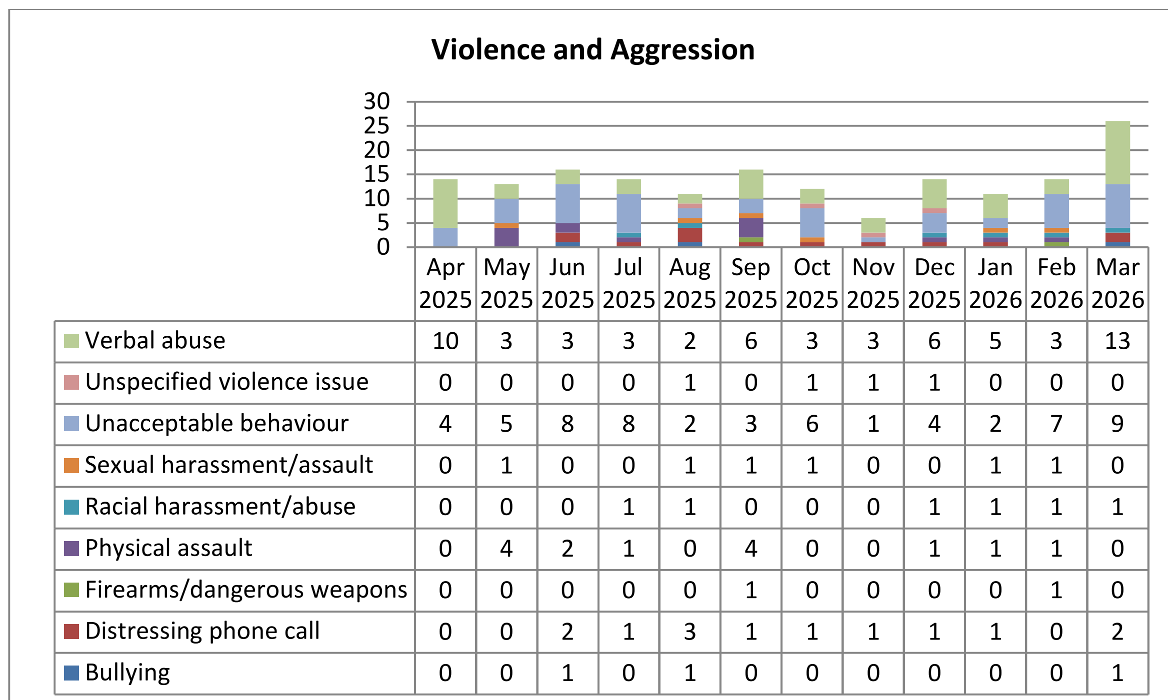
	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Verbal Outburst	1	2	4	5	7	3	5	9	2	4	3	0
Verbal Abuse	11	8	9	4	8	3	8	9	4	6	7	5
Sexual Harassment	0	9	2	2	2	1	1	0	4	4	0	1
Racial Outburst	0	1	1	1	0	1	0	1	0	0	0	0
Racial Harassment	1	4	0	1	0	0	0	2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

1.6.3 The Health and safety team attend multidisciplinary team meetings regarding specific patients, where an incident has or could occur, to provide advice guidance to teams locally. Individuals are also emailed post incident to ensure bespoke support is offered to them / the team.

CCS NHS Trust Violence and Aggression towards Staff Incidents

1.6.4 Graph 5 below shows reporting themes for the last twelve months including Feb and March 2026 and Jan 26 when 40 incidents were reported.

Graph 5 CCS Violence and aggression towards staff by category



	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Verbal abuse	10	3	3	3	2	6	3	3	6	5	3	13
Unspecified violence issue	0	0	0	0	1	0	1	1	1	0	0	0
Unacceptable behaviour	4	5	8	8	2	3	6	1	4	2	7	9
Sexual harassment/assault	0	1	0	0	1	1	1	0	0	1	1	0
Racial harassment/abuse	0	0	0	1	1	0	0	0	1	1	1	1
Physical assault	0	4	2	1	0	4	0	0	1	1	1	0
Firearms/dangerous weapons	0	0	0	0	0	1	0	0	0	0	1	0
Distressing phone call	0	0	2	1	3	1	1	1	1	1	0	2
Bullying	0	0	1	0	1	0	0	0	0	0	0	1

1.7 National Patient Safety Alerts (NatPSA)

One NatPSA/2026/002/MHRA - Recall of Quetiapine Oral Suspension (unlicensed medicine), manufactured by Eaststone Limited due to a potential for overdosing was relevant to Norfolk Adults. This alert was reviewed at the Medicines Optimisation Working Group and a check of our inpatient stock cupboards was completed, and no affected batches were identified. We will remain vigilant when admitting patients in case any are currently prescribed this medication. No further action required at this time

1.8 Safer Staffing

Annual Safer Staffing Declaration

Regular safer staffing, and annual staffing reviews, were carried out across CCS and NCHC under the remit of the Chief Nurse. Data was reviewed at Service Assurance Committees and at Board on a bimonthly basis. Monitoring of safer staffing is a core part of daily service delivery.

NCHC Safer Staffing: Inpatient Units

1.8.1 Care Hours Per Patient Per Day (CHPPD) indicates the difference between patient demand (from acuity and dependency) and the available staffing in the inpatient teams. NCHC uses the accredited Safer Nursing Care Tool on the Safe care platform to promote a consistent approach to assessing staffing levels and dependable scoring outputs (table 3 and 4).

1.8.2 Actual CHPPD is generally higher in the specialist units and the Willow rehabilitation unit, reflecting higher staff to patient ratios set in establishments. During February and March, wards experienced a greater challenge in

maintaining required CHPPD due to higher fluctuations in demand, including for enhanced care needs. When reviewed against other data such as shift fill rate (reviewed through the Quality Committee Safer Staffing Report, February 2026) assurance is provided through effective fill rates, and teams safely met patients care requirements.

1.8.3 CHPPD does not comprehensively articulate safe staffing when viewed in isolation. An example in practice that highlights this is where a group of patients requiring enhanced observations increase the required CHPPD, but a ward team may cohort them safely in a bay and require minimal additional staffing. This mitigation is not captured in CHPPD data alone. Direct review confirms that registered nurse ratios have remained satisfactory, and appropriate mitigations have ensured patient safety on the wards highlighted as red in Tables 3 and 4 during the reporting period.

There were no incidents raised during this period correlating to impacts of staffing shortfalls due to this mitigation approach.

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

1.8.5 The Norfolk Safer Staffing Escalation Group assess and prioritise staffing daily to minimise impact of staffing shortalls by effective utilisation of staff across all units, helping ensure the maintenance of safe staffing levels and reducing temporary staffing costs. Mitigation plans are put in place with staffing issues. The fact that the general rehabilitation wards are operating below the required care hours per patient day, does not mean that they were unsafe in staffing levels and care to patients was compromised.

1.8.6 Table 3 a show the CHPPD scoring for the past two months.

Table 3: February 2026

Unit	Actual CHPPD	Required CHPPD	Actual RN to Patient Ratio	Actual CHPPD	Required CHPPD	Actual RN to Patient Ratio
Generalist Wards – February 2026				**March 2026**		
Alder Ward	5.84	6.05	1:9	6.71	7.77	1:10
Foxley Ward	5.74	8.05	1:10	6.77	8.09	1:9
North Walsham	5.53	7.01	1:10	5.77	7.13	1:9
Ogden Court	5.98	10.15	1:8	6.50	9.86	1:8
Pineheath Ward	6.36	7.64	1:9	6.28	7.50	1:8
Swaffham Hospital	5.51	6.75	1:10	5.64	5.35	1:9
Willow Nursing (Forest)	5.70	7.36	1:11	6.34	5.69	1:9
Willow Nursing (Garden)	5.98	6.02	1:9	5.56	5.80	1:8
Specialist Wards						

Beech Ward	6.61	6.61	1:8	7.17	7.56	1:6
Caroline House	8.09	9.11	1:9	8.92	9.66	1:7
PBL	7.74	4.62	1:7	6.97	4.97	1:7
Pine Cottage	8.87	7.60	1:6	8.42	7.37	1:6

CCS Safer Staffing

Luton Adults

1.8.7 The service continues to evidence improved resilience; the OPEL (Integrated operational pressures escalation levels) score was 1 and 2 for 98.3% of the reporting period. This means that, for services to be safely staffed and care delivered, minor mitigations may be actioned such as workload reallocated, but priority functions are covered.

1.8.8 The daily SitRep RAG ratings add further assurance to the OPEL scores as 91.7% of shifts were on green or amber status for District Nursing. District Nursing clinical activity was deferred on two occasions: other mitigations taken included workforce being re-allocated and temporary staffing being deployed.

1.8.9 For Rapid Response (days), only 1.69% of shifts triggered a red status; clinical activity was deferred on one occasion to mitigate staffing pressures.

1.8.10 All shifts were green or amber for palliative care services.

1.9 CCS and NCHC Safeguarding

1.9.1 'Substantial' assurance is given against the NHS England Safeguarding Accountability & Assurance Framework 2026 that the Group Model have effective safeguarding arrangements in place which seek to protect children and adults from harm caused by abuse or neglect. The Safeguarding Accountability & Assurance Framework 2026 states that, all health providers are legally required to have strong leadership, governance, and operational arrangements to safeguard and promote the welfare of children, adults at risk, and children in care across all services.

1.9.2 The contractual requirements as laid out in Schedule 32 of the NHS Standard Contract are:

Domain	Compliance
Identification of a named nurse, named doctor and named midwife for safeguarding children	In place
Identification of a named nurse and named doctor for children in care	In place
Identification of a named lead for adult safeguarding and a Mental Capacity Act (MCA) lead; this role should include the management of adult safeguarding allegations against staff. This could be a named professional from any relevant professional background	In place
Safe recruitment practices and arrangements for dealing with allegations against staff	In place a full suite of processes and support are available.
Provision of an executive lead for safeguarding children, adults at risk and Prevent - In place	In place - Chief Nursing and AHP Officer.

An annual report for safeguarding children, adults and children in care to be submitted to the Trust board	On Board planner for 26/27.
A suite of safeguarding policies and procedures that support local multi-agency safeguarding procedures -	In place- some merged, some separate to reflect legacy organisations. Will be merged in year
Policies, arrangements and records, to ensure consent to care and treatment is obtained in line with legislation and guidance	In place.
Effective training of all staff commensurate with their role and in accordance with the recommended intercollegiate safeguarding competencies. Where services are provided across the young people and young adult age ranges, that staff are competent in both child and adult safeguarding	In place with all levels of training compliant with the exception of level 3 safeguarding, which is on an upward trajectory
Safeguarding must be included in induction programmes for all staff and volunteers	Plans in place to increase the detail at central induction - in place
Providing effective safeguarding supervision arrangements for staff, commensurate to their role and function (including for named professionals)	In place – there is good coverage in adults services, and a plan in place to fully replicate the children's offer.
Developing an organisational culture where all staff are aware of their personal responsibilities for safeguarding and information sharing, developing and promoting a learning culture to ensure continuous improvement	In place evidenced through supervision, local safeguarding groups, training, education sessions, on call outcomes

1.9.3 Substantial' assurance is given against this framework that the Group Model have effective safeguarding arrangements in place which seek to protect children and adults from harm caused by abuse or neglect

1.9.4 Safeguarding children supervision in CCS compliance is below target at 85%. NCHC safeguarding children supervision compliance is below target at 84%. This could be attributed to the changes in supervision model but also impacted by staff absence and staff capacity to attend. Alignment of teams across the Group means some adjustment to the delivery model is required to ensure that robust support to staff is not disrupted significantly.

1.9.5 Prevent, Safeguarding People and Safeguarding Supervision policies were written jointly across our new Organisation were launched on 1st April 2026.

1.9.6 Current work is being undertaken to launch a new Trust Model single safeguarding duty number for all safeguarding advice and guidance.

1.9.7 CCS audit of MCA has been completed. A robust action plan has been devised, and shared with operational colleagues, and a date has been set for re-audit. NCHC MCA audit action plan is progressing.

1.10 Infection Prevention and Control (IPaC)

The National Infection Prevention and Control (IPaC) board assurance framework (BAF) is issued by NHS England for use by organisations to enable them to respond using an evidence-based approach to maintain the safety of patients, services users, staff and others. The Board can take assurance that both legacy organisations regularly update and monitor via the huddles and at infection control committee with input from all relevant subject matter experts. As of April 1, 2026 a single integrated version of the IPaC Board assurance framework is in place and underpins the work of infection prevention and control services across the Trust.

NCHC IPAC Board Assurance Framework

1.10.1 Areas of partial compliance:

The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals. Annual report will be in place post-merger. In the interim service specific reports are presented at adult service assurance committee

Ensure Anti-Microbial Stewardship is included in mandatory training - Some training in place but not consistent across all services. This training is being reviewed.

Provision of information to the public - Reviewing the availability of braille

Identified staff are fit-tested as per HSE requirements - staff groups identified for compliance with program of fit testing underway against an agreed staff list of applicable services.

1.10.2 Areas of non-compliance:

Maintain oversight of KPI's for prescribing - Gaps in services where there are no electronic prescribing records, this is on the Trust risk register

CCS IPAC Board Assurance Framework

1.10.3 There are currently two compliance criteria assessed as partially compliant. It is anticipated that progress will be made towards full compliance by the end of quarter four, noting that one area is dependent on external factors outside of the Trust's direct control. The areas of partial compliance are:

- There has been a drop in compliance of staff identified as requiring fit testing within the Luton Adult teams. Staff have been identified and will begin fit testing by the end of quarter 1.
- An external factor is that the UKHSA Laboratory service in Cambridge has confirmed that their application for accreditation was submitted in December. It is hoped that the assessors will be able to attend the department in the next couple of months. No date has been confirmed by the assessing team.

National Mandatory Surveillance

1.10.4 As part of the national mandatory surveillance, both CCS and NCHC supports all relevant local investigations to identify if staff have had any involvement with patients who have tested positive for the following:

- MRSA (Methicillin-Resistant Staphylococcus Aureus) bacteraemia.
- MSSA (Methicillin-Sensitive Staphylococcus Aureus) bacteraemia.
- Extended Spectrum Beta – Lactamase (ESBL) bacteraemia.
- Clostridioides difficile (previously identified as Clostridium Difficile) infections.

This is so we can learn lessons and share best practice across the system.

NCHC report 14 C.diff toxins for 2025-26. All cases are discussed at a Post Infection Review (PIR) meeting. Four cases were found to have learning for EEC staff (Themes and trends across the four cases were:

- Timely taking of a specimen
- Timely isolation
- All learning is fed back to clinical staff via Governance meetings and ward huddles.

CCS reports 0 cases of any of those listed above.

Antimicrobial Resistance Framework

1.10.5 A presentation was given to Board on 22.04.2026 about the requirements of provider organisations regarding tackling antimicrobial resistance. The Chief Nurse leads this work the IPAC Committee, The Chief Pharmacist and the wider pharmacy team and the Chief Medical officer.

Three priority areas of focus have been identified for 26/27:

- The use of intravenous antibiotics in the Virtual Ward and Hospital at Home Services
- The use of fluoroquinolone antibiotics- appropriate choices and counselling
- The training of Doctors and Non-medical Prescribers in antibiotic use.

1.10.6 Annex 2 includes the current antimicrobial stewardship performance and assurance position; the key risks, particularly digital and data limitations, our identified priorities and improvement plan and the strategic actions required to strengthen antimicrobial stewardship.

1.11 **Staff Influenza Vaccination Programme**

The staff seasonal influenza vaccination programme commenced on 1 October 2025 and concluded on 31 March 2026. The national uptake data was reported on 16 April 2026 is summarised in table 5 below and shows uptake rates among clinical facing (frontline) staff. NHS England required all Trusts to work towards a minimum 5% improvement on the previous year’s vaccination uptake (the national “stretch target”).

Table 5 Seasonal flu vaccination uptake data

Organisation	% of frontline Healthcare workers vaccinated	Stretch Target
National	47.7%	
East of England	48.8%	
NCHC	60.1%	54.5%
CCS	61.5%	63.3%

2.0 CARING

2.1 NCHC Patient Experience

Friends and Family Test (FFT)

2.1.1 The Trust received 241 responses in Feb 26 and 414 in Mar 2026. The increase in March is thought to be due to increased promotion, training and local team support with the new FFT platform. The Lived Experience team continue to support services as FFT responses are still very low to ensure adequate patent feedback is received .

Table 7 summarises total responses since Aug 2025.

Table 6 Friends and Family Test (FFT)

	% Positive	% Negative	Total FFT Responses	Contacts	Response Rate
Children and Young People's	95.65%	0.00%	23	3457	0.67%
Intermediate Care and Urgent Community Response	97.55%	0.61%	163	4518	3.61%
North	96.88%	3.13%	32	7685	0.42%
Norwich	99.20%	0.80%	125	9261	1.35%
South	96.83%	1.59%	126	10728	1.17%
West	97.56%	0.54%	186	11175	1.66%
Trust wide	**97.56%**	**0.92%**	**655**	**47464**	**1.38%**

Table 7 Trajectory for Friends and Family Test (FFT)

	Aug	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
Trust Overall	312	392	396	328	183	274	241	414	2540

2.1.2 The feedback highlights friendly, approachable staff who explain care and treatment well, are knowledgeable, professional and efficient. Patients and carers frequently comment on feeling well cared for, listened to and treated as an individual involved in decision making and care planning.

2.1.3 Themes from negative feedback relate to delays in answering call bells in some of our Intermediate Care units, waiting times for Neurodevelopmental Service (NDS), lack of communication/expectation of community Occupational Therapy or Physiotherapy following discharge from hospital and feelings of being discharged too early from Virtual ward. However, whilst negative comments are made this is often balanced with very positive feedback on the clinical care once the patient has been seen. There were fewer negative comments about food in this period. All feedback is reviewed and acted upon within Place alongside other feedback for quality improvement. Examples of "you said, we did" are shared and updated in clinical areas.

2.1.4 All surveys with the FFT question ask to what extent the service user felt they were treated with respect and dignity. In February and March 664 service users

answered and scoring for each directorate is shown below. This number is higher than total FFT responses as some patients have chosen not to answer the FFT question but have answered the respect and dignity question.

Table 8 Friends and Family Test (FFT) Respect and Dignity Question

	Respect and Dignity Score
Children and Young Peoples	96.59%
Infection Prevention and Control	95.37%
Intermediate Care and Urgent Community Response	97.06%
North	94.03%
Norwich	99.61%
South	98.38%
West	96.88%
Trust wide	**96.59%**

Compliments

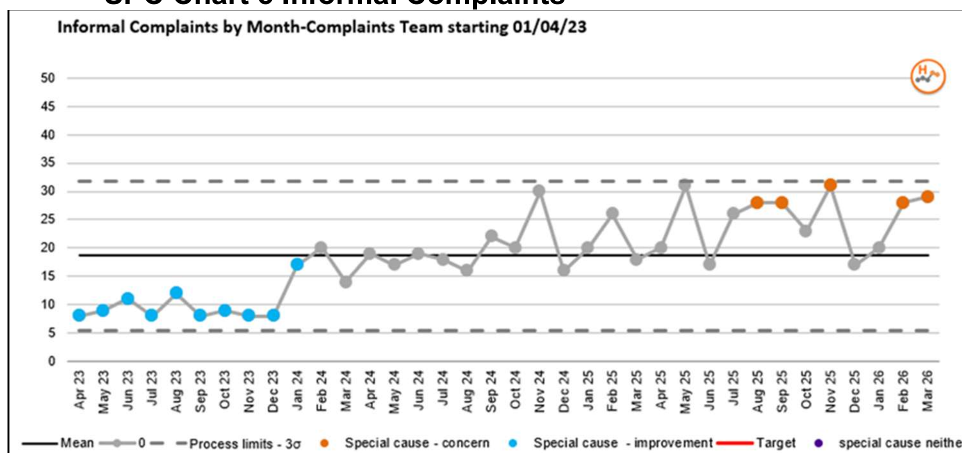
2.1.5 There were 220 compliments received in the reporting period, a slight increase from the previous period, and they were spread across all Places. West Place received and logged the highest number. There are many detailing heartfelt thanks, particularly for palliative care, urgent community response and community nursing teams for their professionalism, compassion and care at significant times of need.

Complaints

Informal Complaints received

2.1.6 The Trust received 57 informal/locally resolved complaints in this reporting period: 28 in February and 29 in March. This is a significant rise from previous reporting period but as shown in chart 3 it is within the expected variation. The increase was due to a rise in patients raising concerns about deferred or delayed appointments in community nursing. There were 47,464 contacts equating to one informal complaint for every 833 contacts.

SPC Chart 5 Informal Complaints



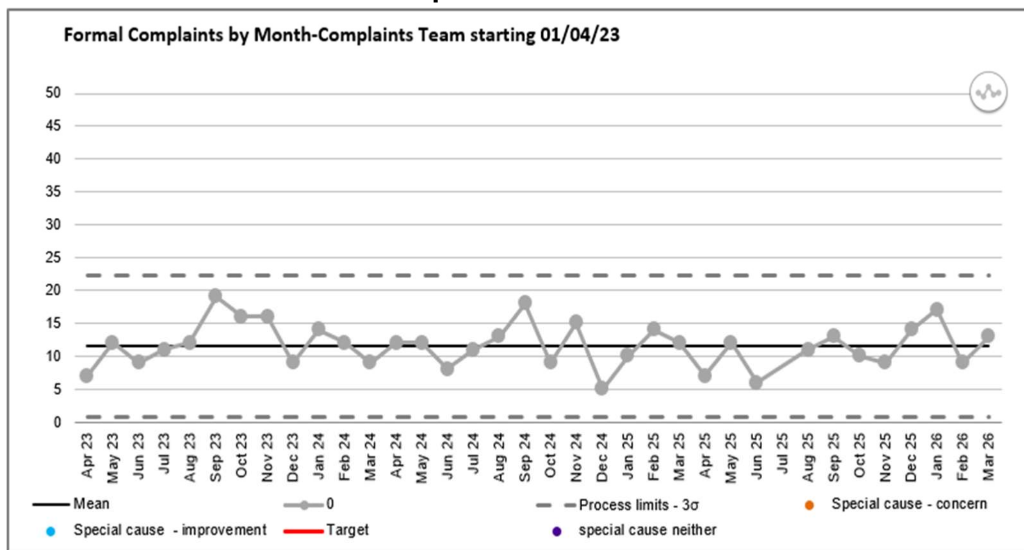
2.1.7 The prominent themes from informal complaints identified are:

- Timeliness of appointments across both months: A key theme, with 15 complaints specifically linked to patient or family concerns about timings of community nursing visits including delay to complete bladder/catheter wash-outs and leg wound care.
- Staff attitude: 4 complaints, with 3 relating to communication/lack of communication around appointment cancellations/deferred visits in community nursing. Learning/feedback has been provided to the staff involved.
- Standard of care: 16 complaints including 5concerns relating to inpatient care, 3 regarding clinical care and 2 regarding discharge. There were 4 relating to Community Nursing where patients or their family were concerned about catheter care, delay in care or for one patient discomfort experienced with dressing change as did not know when nurse would arrive. The remainder were spread across all Places.

Formal Complaints received

2.1.8 The Trust received 22 formal complaints in this data period, nine in February and 13 in March. There were 47,464 contacts which equates to one formal complaint for every 2,157 contacts.

SPC Chart 6 Formal Complaints NCHC



Themes from formal complaints received in February and March

2.1.9 Children and Young People Services (CYP): 9 complaints were received, 2 relating to the Neurodevelopmental Service (NDS), focusing on assessment and waiting times. 5 were for Community Paediatricians relating to waiting times, decline of referral and communication about assessment outcome.

2.1.10 Community Nursing: 5 complaints, 3 of these related to deferred visits or inconsistent care for wound dressings.

2.1.11 Of the remaining formal complaints, 2 were for Therapy - 1 regarding therapy in a care home and 1 regarding staff attitude in the community. 2 were for Podiatry regarding assessment and treatment including transport to appointments.

Member of Parliament (MP) Contacts

2.1.12 There was one MP contact within the reporting period, a drop from last reporting period and no MP complaints in February.

2.1.13 In March, one complaint was received via an MP and recorded and categorised as Level 2. The complaint was within Children and Young People's services, focused on concerns raised by a mother on waiting time for assessment for her son in NDS.

2.2 CCS Patient Experience

Friends and Family Test (FFT)

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

2.2.2 The Trust received 2087 responses in February and 2081 in March. This is 100 more than the previous two-month period. Below is a summary since August 2025.

Table 9 Trajectory for Friends and Family Test (FFT

	Aug	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**	**Total**
Trust Overall	2316	2122	2361	2203	2070	1979	2087	2081	**17219**

2.2.3 The overall Trust FFT positive feedback was 96.38%, with a 1.80% negative feedback percentage.

2.2.4 Any comments related to the poor and very poor scores are reviewed and followed up with the services each month by the Co-production Lead.

2.2.5 Norfolk MSK Continence/Pelvic Health services are now included on IQVIA and feedback is reported under Ambulatory Care.

Table 10 Friends and Family Test (FFT)

	% Positive	% Negative	Total FFT Responses	Contacts	Response Rate
Ambulatory Care	96.89% ↓	1.89% ↑	2217 ↑	37896	5.85% ↑
Bedfordshire and Luton Children and Young People's Service	97.82% ↑	0.99% ↓	505 ↓	37854	1.33% ↓
Bedfordshire and Luton Adults Community Service	96.92% ↑	0.77% ↓	390 ↑	22062	1.77% ↑
Cambridgeshire and Peterborough Children and Young People's Service	95.34% ↑	3.03% ↑	429 ↓	29761	1.44% ↓
Norfolk and Waveney Children and Young People's Service	93.78% ↑	1.91% ↓	627 ↑	31242	2.01% ↑
Trustwide	**96.38% ↑**	**1.80% ↑**	**4168 ↑**	**158815**	**2.62% ↑**

2.2.6 All surveys with the FFT question also ask to what extent the service user felt that they were treated with respect and dignity. In February and March 4402 service users answered this question and a score for each directorate is shown below.

Table 11 Friends and Family Test (FFT) Respect and Dignity Question

	Respect and Dignity Score
Ambulatory Care	96.86%
Bedfordshire and Luton Children and Young People's Service	97.77%
Bedfordshire and Luton Adults Community Service	95.27%
Cambridgeshire and Peterborough Children and Young People's Service	96.81%
Norfolk and Waveney Children and Young People's Service	93.88%

Comments/Compliments

2.2.7 In February and March, the services we provide received 5811 positive comments across the Trust, this is over 750 fewer than the last reporting period. We received over 77 positive comments for every formal and informal complaint received.

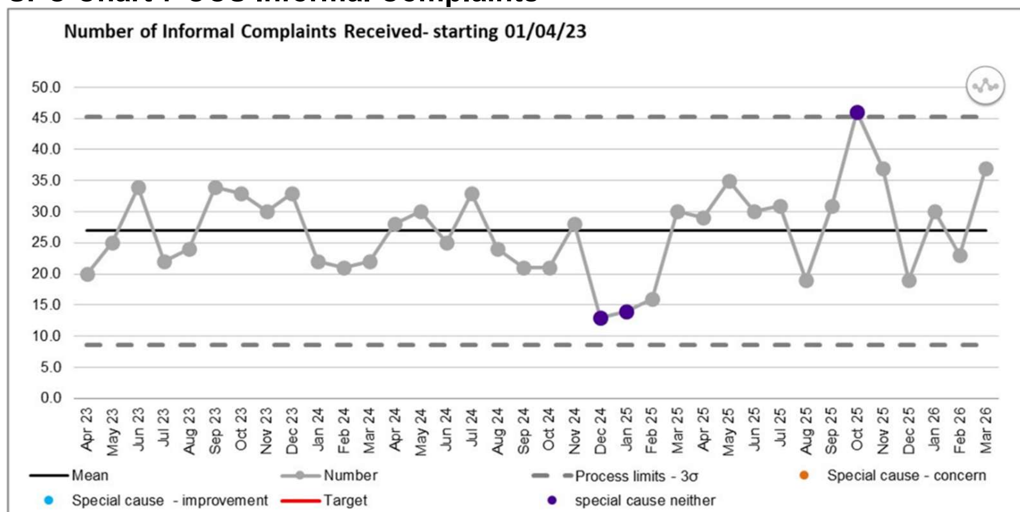
Complaints

2.2.8 There were 60 informal complaints, and 15 formal complaints received in February and March. There were 158,815 contacts which equates to one formal complaint for every 10,588 contacts and one informal for every 2,647 contacts, this is fewer for both informal and formal than in the previous reporting period.

Informal complaints received

2.2.9 The Trust received 60 informal complaints in this data period: 23 in February and 37 in March. Both months were within the expected variation.

SPC Chart 7 CCS Informal Complaints



2.2.10 Fifty eight of the 60 complainants were contacted within four working days to discuss resolution of their concerns. In one case there was a delay in the

service forwarding the informal complaint to PALS and one was delayed due to the original email not being actioned.

Themes from informal complaints closed in February and March 2026

2.2.11 Sixty informal complaints were resolved and closed in February and March with 68 subject issues identified.

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

- Delays (31)
- Clinical Care (16)
- Communication and Information (9)

2.2.13 Ten of the 31 issues related to Delays, were about Bedfordshire and Luton Community Paediatrics and five Cambridgeshire Community Paediatrics, they were related to waiting times to be seen.

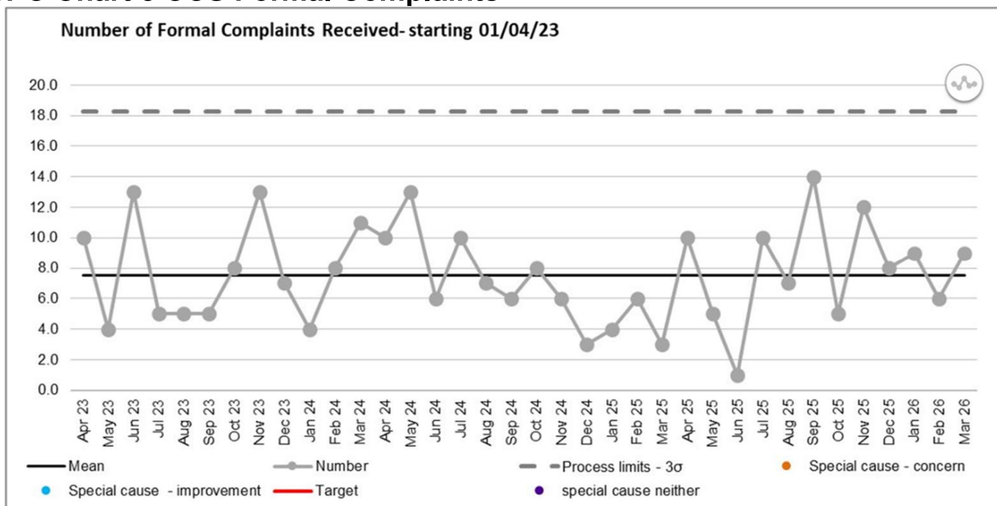
2.2.14 Five of the issues about Clinical Care related to Bedfordshire and Luton Children's Specialist Services, three Community Paediatrics and two Speech and Language Therapy.

2.2.15 There were no themes in the services identified in informal complaints about Communication and Information.

Formal Complaints Received

2.2.16 The Trust received 15 formal complaints in this data period, six in February and nine in March. As shown below, this is within the expected variation.

SPC Chart 8 CCS Formal Complaints



NB It is impossible to have fewer than 0 complaints in a month, so the lower process limit is not shown on the graph above.

Themes from formal complaints closed in February and March 2026

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

- Clinical Care was the most frequently occurring subject with 12 raised through complaints.

- Staff Attitude was the second most frequently occurring with eleven raised through complaints.

- Three of the complaints about Clinical Care were about DynamicHealth Services and related to dissatisfaction with treatment or inadequate or insufficient care being provided, none of the clinical care elements of these complaints were upheld.

- Three of the complaints were about Staff Attitude were about Dental Services. None of these were upheld.

2.2.18 Seventeen different services were named in the formal complaints responded to in February and March, four in DynamicHealth and four Dental. The remaining nine were spread across seven services.

Formal Complaint Response Times

2.2.19 In this data period, 20 formal complaints were responded to, seven in February and 13 in March. A summary of the response times is shown below.

Table 11 Formal Complaint Response Times

	December	January	February	March
Number of standard complaint responses sent within a 35-day timeframe.	1/2	6/11	5/5	6/11
Percentage of standard complaint responses sent within the 35-day timeframe.	50%	55%	100%	55%
Number of complex complaint responses sent within the 40-day timeframe.	0/0	0/0	0/2	0/2
Percentage of complex complaint responses sent within the 40-day timeframe.	N/A	N/A	0%	0%
Average number of working days to respond to standard complaints.	36	35	34	36
Average number of working days to respond to complex complaints.	N/A	N/A	49	49

2.2.20 The average number of days to respond remained similar to the previous reporting period. No complex complaint responses were sent within the 40 working day timeframe, the average number of days taken was 49 days in February and March.

Member of Parliament (MP) Contacts

2.2.21 In this period there were seven contacts received via an MP, all were enquiries. Four related to the Trust were about Community Paediatric Services and included questions about post diagnosis support and waiting time for assessment. Three were not related to the Trust and were directed to the correct Trust.

Supporting Services with Correspondence with Service Users

2.2.22 The Patient Experience Team supported services in writing five letters to service users in February and March. Four were letters of expectation, two for Bedfordshire and Luton Speech and Language Therapy and two iCaSH Peterborough. One was a letter in response to concerns raised about a Subject Access Request.

3.0 EFFECTIVE

3.1 **Sickness rates across the workforce:**

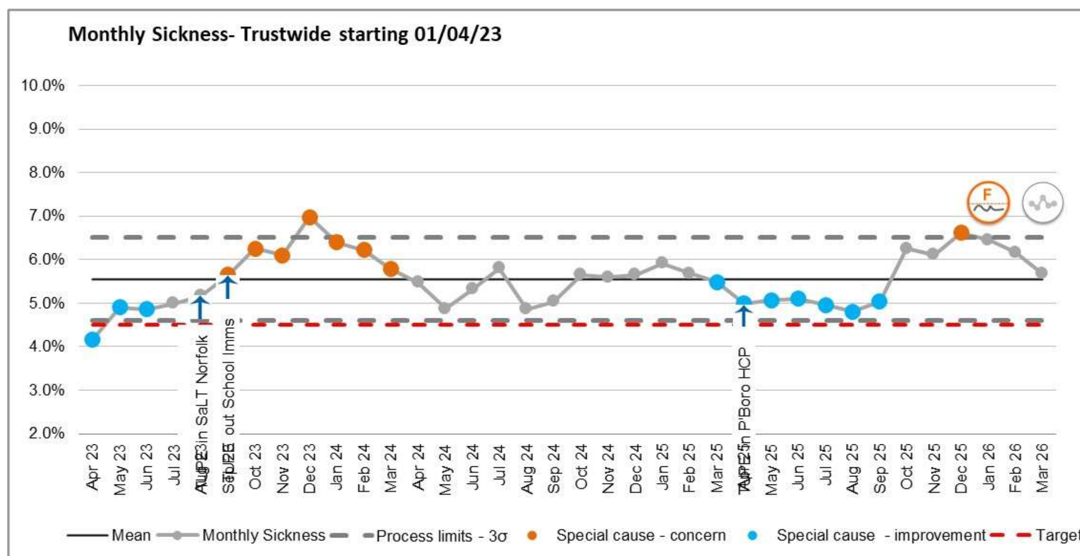
CCS

3.1.1 The 12-month cumulative rolling rate (February 2026 – 5.58%, March 2026 – 5.60%) remains above the Trust rolling target of 4.5%.

3.1.2 Monthly Trust wide rate for February 2026 was 6.16% and for March 2026 was 5.67%.

3.1.3 The Trust wide sickness rate has 3.44% was attributed to long term sickness and 2.24 % short term sickness absence. Cambridgeshire, Peterborough & Norfolk Children's had the highest sickness rate (6.74%) and Support Services the lowest (2.12%). The top reason Cold, Cough, Flu - Influenza (21.11%).

3.1.4 The Trust monthly sickness rate is above the January 2026 benchmark reported for NHS Community Trusts (source: NHS Digital Workforce Statistics) which was 6.3 %.

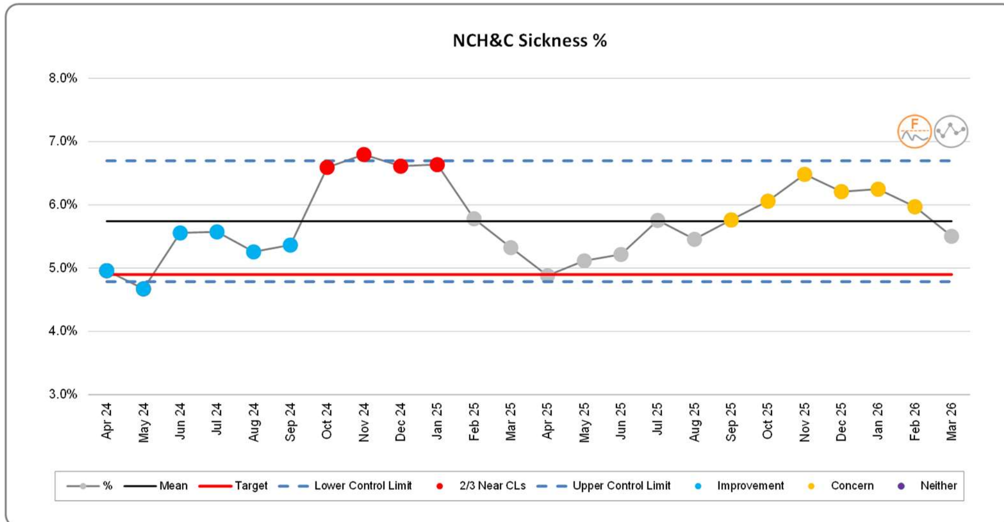


NCHC

3.1.5 The 12-month rolling rate (February 2026 – 5.70%, March 2026 – 5.72%) remains above the Trust target of 4.9%.

3.1.6 Monthly Trust wide rate for February 2026 was 5.97% and for March 2026 was 5.5%.

3.1.7 The Trust wide sickness rate has 3.48% attributed to long term sickness and 2.24 % short term sickness. In March 2026 Norwich Place had the highest sickness rate (7.83%) and Corporate Services the lowest (2.53%). The reason of ***Anxiety/stress/depression/other psychiatric illnesses*** continues to be the highest reason for absence and accounts for 34% of time lost.



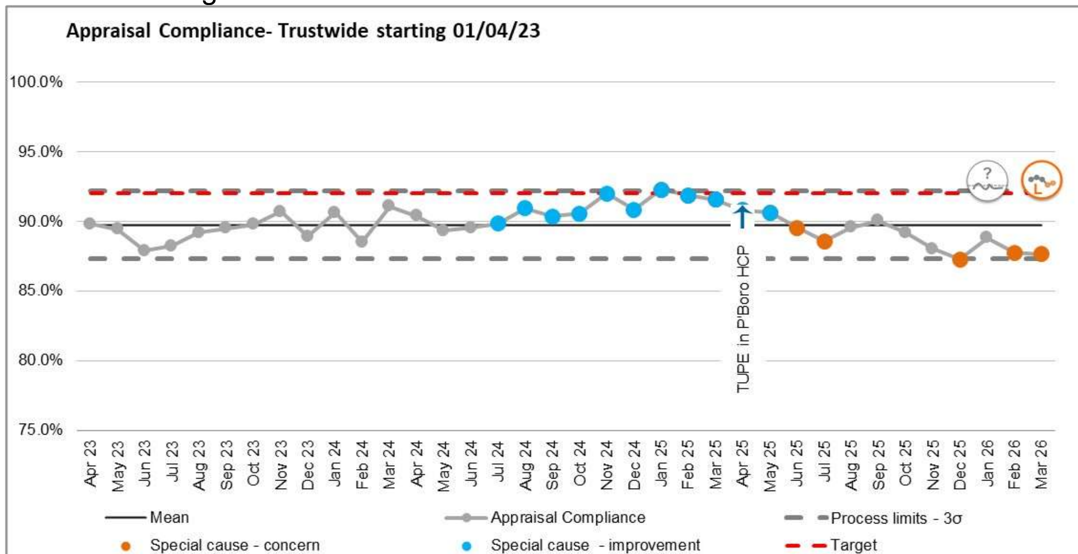
3.2 Appraisal rates across the workforce

CCS

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

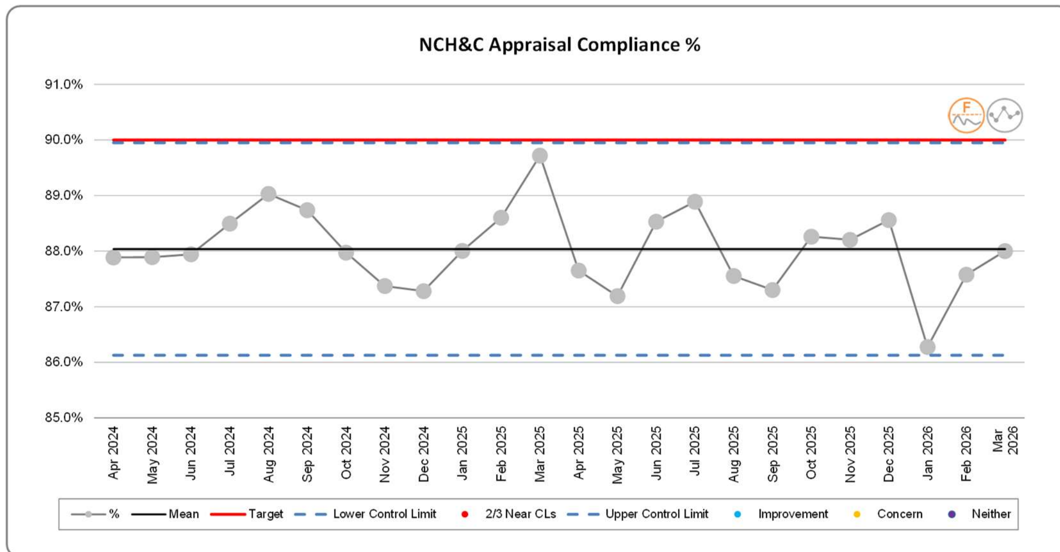
3.2.2 The Trust wide Appraisal rate decreased in February 2026 – 87.74% and March 2026 – 87.64%, has reached target of 92% for 2025/26.

3.2.3 Support Services has the lowest rate (64.25%), however, this is expected to be a data reporting issue and is currently being looked into. Bedford & Luton Adults have the highest rate (94.39%). Employees, for whom a non-compliant date is held in ESR, are sent a reminder and this will continue to be done on a regular basis.



NCHC

3.2.4 The following chart shows the percentage of eligible staff who have completed an appraisal within the last 12 months of services. Staff on Long term sickness, maternity and internal secondments are included. Staff on career break, suspension and new starters within their first 12 months of services are excluded.



The Trust wide Appraisal rate has been variable over recent months but is still falling short of target. February 2026 87.58%, March 2026 88%.

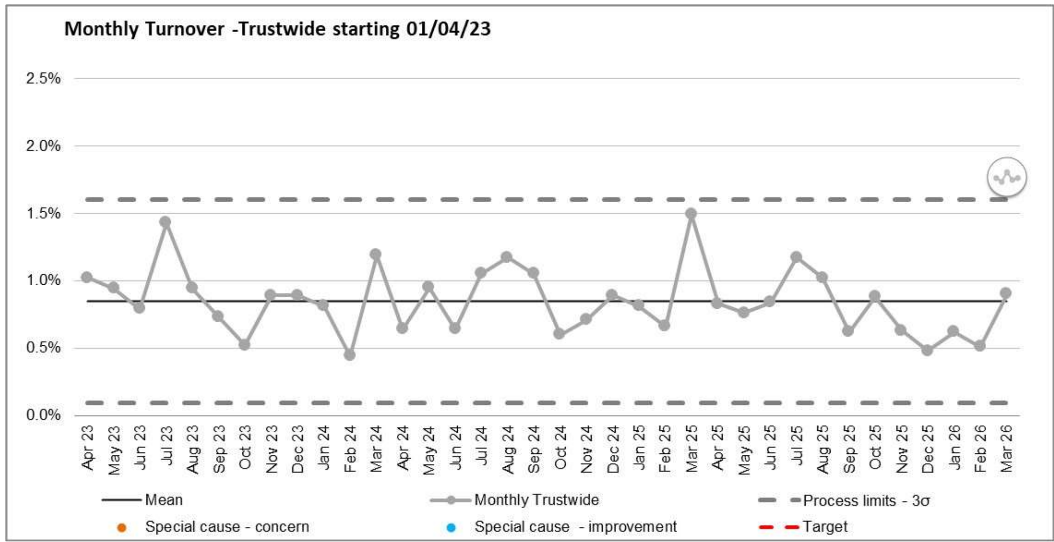
3.3 Turnover rates across the workforce

CCS

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

3.3.2 The Trust’s Rolling Year Turnover Rate is currently 9.38% (February 2026 – 9.82%, March 2026 – 9.38%) compared to an annual average Leaver rate for Community Provider Trusts of 9.6% (Source: NHS Digital Workforce Statistics – January 2026, based on “all Leavers” and “total Workforce”).

3.3.3. Ambulatory Care currently has the highest Rolling Year turnover rate at 12.82%, with Cambs, Peterborough & Norfolk Children’s having the lowest

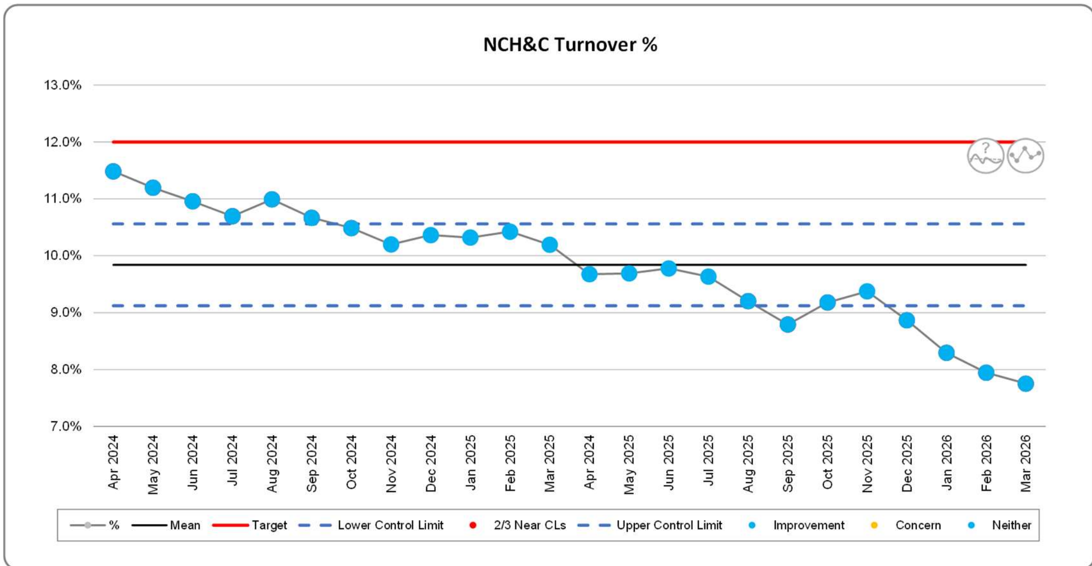


NCHC

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

3.3.5 The Trust's Rolling 12 month Turnover Rate is currently 7.75%, which sits below our Trust wide target of 12% and slightly below the tolerance of +/- 4 %.

3.3.6 Children's and Young Persons Services has the highest rate at 11.10%, with North Place having the lowest at 5.87%.



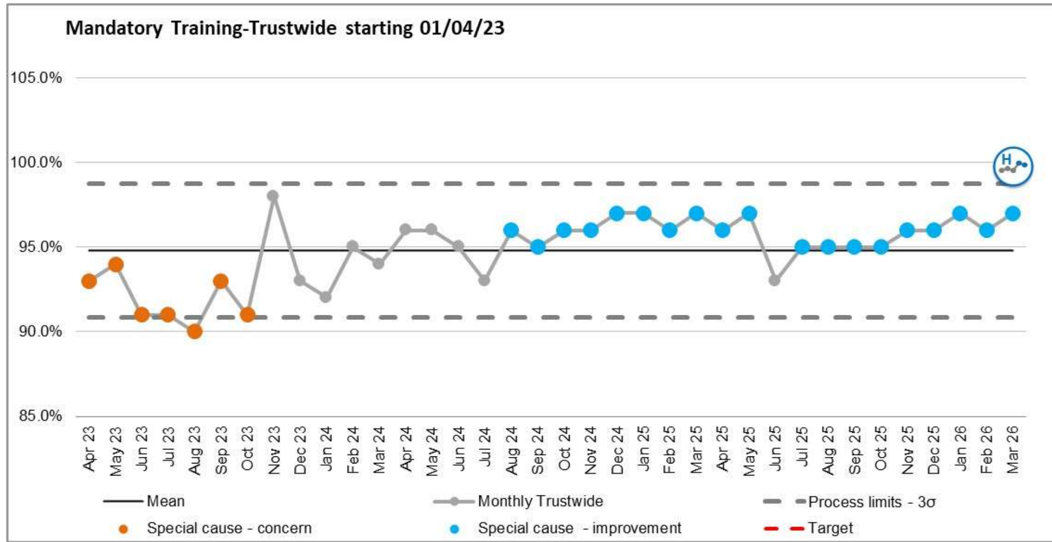
3.4 Overall Mandatory Training levels across the workforce

CCS

3.4.1 The following chart shows monthly Mandatory Training rates for the Trust which are based on the "Permanent" workforce (i.e., those employed via Fixed Term

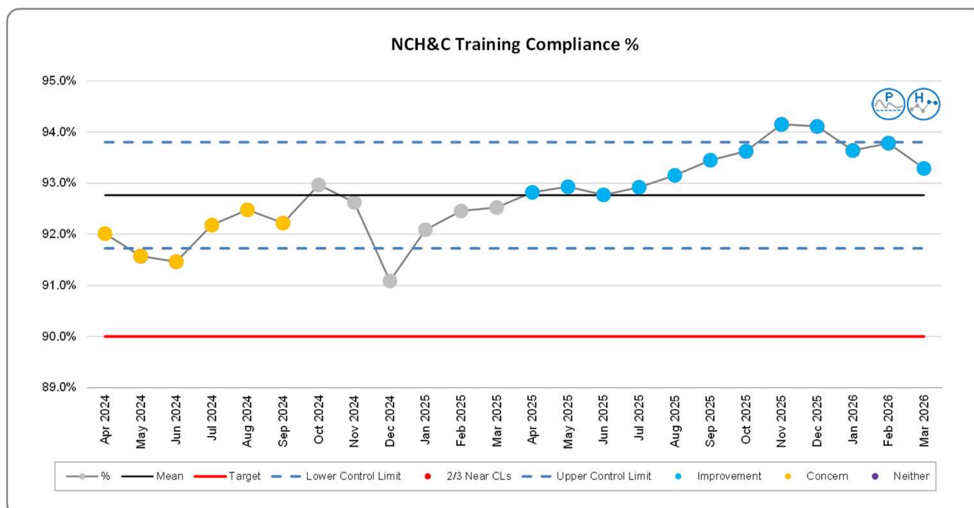
Contracts, Bank, Internal Secondment and Permanent). Staff who are within their first 3 months of employment are excluded along with staff on sickness, Maternity or Paternal leave.

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



NCHC

3.4.3 The following chart shows the training compliance rate for the 12 Core Mandatory training subjects for our substantive workforce. Staff on Long term sickness, maternity, internal secondments are included.



3.4.4 The training rate has remained consistently above the 90% target threshold. February 2026 93.78%, March 2026 93.29%.

4.0 RESPONSIVE

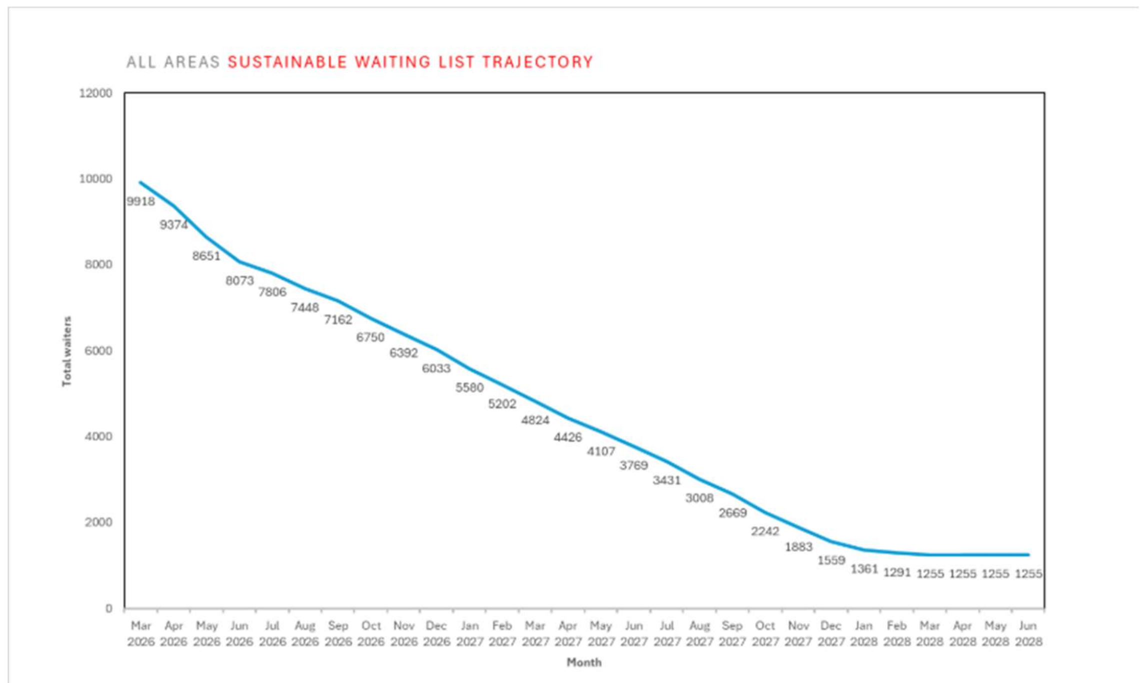
4.1 This section provides an overview of waiting times across the Trust.

- The focus in our services is to make targeted improvements for all services with patients waiting over 52 weeks for an appointment.
- The most significant challenge remains within Neurodevelopmental Services (NDS), where the Board approved plan to deliver a reduction in waiting times and achieve the national 18-week standard within the Parliamentary cycle is active. The work includes a focus on capacity, pathway redesign and improved productivity.
- The Board (in an earlier meeting) heard and can be assured that there is robust oversight, improving data quality, and a clear trajectory for recovery, with operational and strategic focus aligned to reducing long waits and improving timely access to care.

4.2 **Trust wide Neurodevelopmental Services (NDS) – Primary Pressure**

4.2.1 As of 31 March 2026, 9,918 children are awaiting an initial NDS assessment. Of these, 8,884 have waited over 18 weeks and 6,989 over 52 weeks. This is a reduction of 2,064 total waiters since October 2025, as a result of detailed improvement work with the extra funding being made available from NHS England in the final quarter of the financial year.

4.2.2 The Board-approved improvement trajectory to achieve <18-week waits by April 2028 is expected to materialise in the improvement trajectory below.



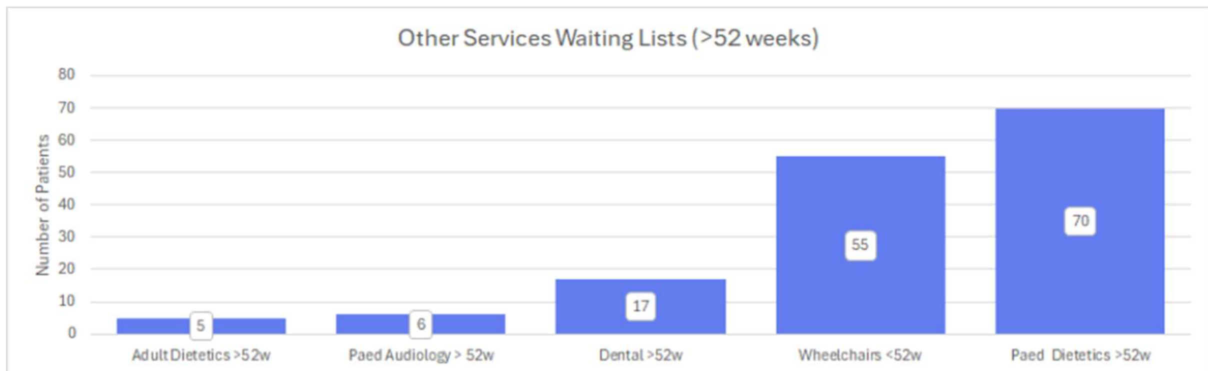
4.2.3 The current activity includes pathway standardisation, expanded skill mix, and productivity improvements. Digital enablers, including Automated Voice Technology, are being implemented to support demand management and efficiency. A supporting data and financial model is in development to track trajectory delivery. The trajectory indicates that recovery has now moved from planning into delivery, with early evidence that backlog reduction is being achieved at pace;

4.2.4 The current run-rate reduction will need to be sustained and further accelerated to meet the 2028 target, with performance and improvement being closely monitored.

4.2.5 There are risks associated with meeting the cost of the waiting list reduction. At time of writing, the Trust has had to go at risk to fund the extra capacity, as neither Integrated Care Board have been able to confirm non recurrent funding to support meeting the 18-week pathway achievement. This issue and risk are articulated on the Board assurance framework (BAF Risk 3751 / Operational issue 3568) and **the Board are asked to support the actions underway to mitigate the impact of the issue and risk materialising.**

4.2.6 The Board oversight of the improvements will be achieved through close monitoring by the executive team at monthly reviews; detailed provided at the bi-monthly children and young people service assurance committee and reporting into the public Board integrated governance report.

4.3 **Other Services – Residual long waits**



There are low levels of >52-week waits in five other service areas as shown above and detailed below.

- **Bedfordshire & Luton Audiology:** Sustained improvement has been achieved with 6 children now waiting over 52 weeks, supported by increased capacity and improved booking processes. All children waiting are risk assessed and prioritised accordingly.

- **Cambridgeshire Dietetics (Children):** 70 long waiters, with workforce challenges being mitigated through bank staff recruitment.

- **Adult Dietetics (Bedfordshire):** 5 long waiters, with trajectory to eliminate >52-week waits in the next reporting period.

- **Cambridge and Peterborough Special Care Dentistry:**
    - 2 patients >52 weeks (expected to be cleared within 2 months due to new dentist starting).
    - 18 patients awaiting General anaesthetic procedures. We are dependent on acute theatre capacity and are working with Peterborough hospital team to improve procedures. Similar work with the West Suffolk Hospital team has reduced the waits to below 52 weeks for children and young people.

- **Wheelchair services (Norfolk):** 55 waiters over 52 weeks. Recovery actions are focussed on earlier assessment booking and streamlined pathways, alongside using additional funding to enable more patients to receive wheelchairs at first appointment, reducing repeat visits. Being supported by targeted workforce improvements in repairs and closer procurement management.

5.0 WELL LED

5.1 **Ability to raise concerns:**

Freedom to Speak Up Mandatory Training

- All staff complete 'Speak Up' Mandatory Training when they join each Trust. Core training is essential for all employees and covers what speaking up is and why it matters. It helps our workforce understand how to speak up and what to expect when they do. The annual target is 90% and CCS achieved 99% compliance in February and March 2026 and NCHC achieved 96% compliance, respectively.

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

5.2 **Finance**

NCHC

5.2.1 The Trust finished the financial year ahead of plan, delivering a surplus of £1.6m. It met the requirements for the year-end Support Funding incentive, which was appropriately reflected in the bottom line.

5.2.2 The £8.8m efficiency target for 25/26 was achieved, with 33% delivered on a recurring basis (against a planned 53%), offset by non-recurrent efficiencies exceeding plan by £1.7m.

5.2.3 Agency spend was £0.8m (68%) below plan, reflecting the impact of targeted reduction measures, while bank spend was £1.3m (30%) above plan.

5.2.4 The Trust closed the year with a cash balance of £40.1m, equivalent to 2.5 months of operating expenditure.

5.2.5 Capital spend against CDEL totalled £11.0m, £3.3m ahead of plan due to additional in-year funding.

5.2.6 BPPC performance achieved the 95% value target and was marginally below the quantity target by 0.3%.

Statement of comprehensive income March 2026	Plan	Actual	Variance	On plan?
£'000	Full year	Full year	Full year	Full year
Statement of comprehensive income				
Income	173,361	181,069	7,708	
Pay	(126,674)	(132,098)	(5,424)	
Non-Pay	(46,662)	(48,215)	(1,552)	
Non-operating	(959)	(79)	880	
Accounting surplus / (deficit)	**(934)**	**677**	**1,611**	
Accounting performance adjustments	934	965	31	
Adjusted financial surplus / (deficit)	**0**	**1,642**	**1,642**	Yes
Efficiencies				
Recurrent	4,692	2,940	(1,752)	
Non-Recurrent	4,131	5,883	1,752	
Total Efficiencies	8,823	8,823	-	Yes
Agency expenditure				
Agency spend	(1,212)	(386)	826	Yes
Bank spend	(4,408)	(5,719)	(1,311)	No

Balance sheet March 2026	Plan	Actual	Variance	On plan?
£'000	Full Year	Full Year	Full Year	Full year
Statement of Financial Position				
Non-current assets	109,068	101,137	(7,931)	
Current assets	48,868	53,396	4,528	
Current liabilities	(29,432)	(33,857)	(4,425)	
Non-current liabilities	(6,577)	(6,887)	(310)	
Total net assets employed (equity)	**121,927**	**113,789**	**(8,138)**	
Operating cashflow				
Cash at bank	41,804	40,054	(1,750)	Yes
Number of months of operating cash cover	3.1	2.5	(1)	
Capital expenditure				
Total capital expenditure	8,034	11,278	3,244	Yes
System capital limit (CDEL) spend	7,757	11,062	3,305	Yes
Aged Debt				
Debt over 90 days		643		
Bad debt provision		653		
BPPC				
By Number	95.0%	94.7%	-0.3%	No
By Value	95.0%	96.9%	1.9%	Yes

CCS

5.2.7 The Trust delivered a surplus position of £1.6m, which like NCHC was due to the receipt of the year-end Support Funding incentive, which was appropriately reflected in the bottom line.

5.2.8 Efficiency savings in were broadly on target at £8.6m, with £4.9m (55%) being found recurrently.

5.2.9 Temporary staffing costs (agency and bank) totalled £2.5m, which was 18% below plan.

5.2.10 The Cash balance as at 31 March 2026 was £9.6m, which was 36% above the plan position of £7.1m. Outstanding Local authority receivables have reduced over the period to improve the cash position.

5.2.11 The Multi-Storey Car Park at The Princess of Wales Hospital in Ely was subject to valuation by the Trust's external valuers during the year, resulting in an impairment charge of £3.9m, reflecting the difference between the asset's value in use and its construction cost.

Statement of comprehensive income MONTH YEAR	Plan	Actual	Variance
£'000	YTD	YTD	YTD
Statement of comprehensive income			
Income	185,941	193,453	7,512
Pay	(134,335)	(134,669)	(334)
Non-Pay	(48,378)	(58,605)	(10,227)
Non-operating	(3,228)	(2,442)	786
Accounting surplus / (deficit)	**-**	**-**	**(2,263)**
Accounting performance adjustments	-	3,919	3,919
Adjusted financial surplus / (deficit)	-	-	1,656
Efficiencies			
Recurrent	6,180	4,907	(1,273)
Non-Recurrent	2,420	3,664	1,244
Total Efficiencies			(29)
Temporary staffing expenditure			
Agency spend	1,560	1,054	506
Bank spend	1,452	1,418	34

Balance sheet MONTH YEAR	Plan	Actual	Variance
£'000	Month end	Month end	Month end
Statement of Financial Position			
Non-current assets	112,757	93,480	(19,277)
Current assets	21,922	24,954	3,032
Current liabilities	(19,285)	(20,708)	(1,423)
Non-current liabilities	(21,970)	(18,876)	3,094
Total net assets employed (equity)	**93,424**	**78,850**	**(14,574)**
Operating cashflow			
Cash at bank	7,053	9,600	2,547
Number of months of operating cash cover	0.5	0.6	0
Capital expenditure			
Total capital expenditure	4,393	4,326	(67)
System capital limit (CDEL) spend	4,393	4,326	(67)
Aged Debt			
Debt over 90 days		2,925	
Bad debt provision		1,425	
BPPC (YTD)			
By Number	95.0%	91.1%	-3.9%
By Value	95.0%	90.8%	-4.2%

Financial Plan - Key Risks at 31 March 2026

Rating	BAF Risk	Risk description	Mitigations
Medium	3708	A higher proportion of savings will be delivered non-recurrently, shifting the financial pressure into future years and delaying progress toward sustainability.	There is a focus on identifying a higher proportion of recurring savings for 26/27 onwards.
Medium	3911	Continuing overspends in NCHC inpatient units, predominately in bank and agenda staff spend, represent a risk to delivery of the full year plan. Forecast full year overspend is £1.2m (3%).	Forecast underspends and reserves will be used to offset the overspends. The inpatient service model is under review and being benchmarked against other trusts to support development of a sustainable, recurring model.
Medium	3911 NEW	Deconstruction of block funding and shift to activity based funding from April 2027 could reduce the Trust's overall funding envelope, requiring cost reductions and potentially impacting the quality and breadth of services provided to patients.	Analysis is underway; however, we are awaiting the detailed guidance, scope and parameters from NHS England to enable a full assessment of the impact on the Trust.
Medium	3751	There is no identified funding source to address long waits for children's neurodevelopment services (NDS). If no additional funding is identified, this may require cost reductions elsewhere or could result in a slowdown or cessation of backlog clearance.	We are exploring funding options with the ICB, NHS England, and from our own resources, including cash balances, to identify ring-fenced funding. While we are currently operating at risk, this is lower early in the year but will need close review as the risk increases over time.