OPEN Council of Governors Meeting

Schedule	Thursday 11 September 2025, 5:30 PM — 7:30 PM BST
Venue	Rooms 19a & b, Education Centre, WSFT, Hardwick Lane, Bury St. Edmunds. IP33 2QZ
Notes for Participants	Please advise of apologies in advance of the meeting to the FT Office.
Organiser	Ruth Williamson

Agenda

NHS
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6:50 PM	10.	Nominations Committee Report (enclosed) To receive the report from the Nominations Committee To Note - Presented by Jude Chin	131
		Item 10 Nominations committee report CoG 11 Sept 2025.doc	132
	11.	Membership and Engagement Committee Report (enclosed) To receive a report from the Membership and Engagement Committee To Note - Presented by Sarah Hanratty	134
		Item 11 Membership & Engagement committee report CoG 11 Sept 2025.doc	135
		Item 11a Annex 1 Governor activities 2025 - Feedback report.docx	137
	12.	Standards Committee Report (enclosed) To receive a report from the Standards Committee To Note - Presented by Jude Chin	139
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		Item 12_Annex A Governors development programme 2025 - v1.docx	144
	13.	Staff Governor Report (enclosed) To receive a report from the Staff Governors To Note	146
		Item 13 Staff Governors report CoG 11 Sept 2025.doc	147
	14.	Lead Governor Report (enclosed) To receive a report from the Lead Governor To Note - Presented by Jane Skinner	149
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AGENDA:
OPEN Council of Governors meeting
Thursday 11 September, 2025, 5.30pm
in Rooms 19a & b, Education Centre,
WSFT, Hardwick Lane, Bury St.
Edmunds. IP33 2QZ

NHS West Suffolk
NHS Foundation Trust

Council of Governors Meeting

There will be a meeting of the **COUNCIL OF GOVERNORS** of West Suffolk NHS Foundation Trust on **Thursday 11 September 2025 at 5.30pm at Education Centre, rooms 19a&b, West Suffolk Hospital site, Bury St Edmunds.**

Jude Chin, Chair

Agenda

General duties/Statutory role

(a) To hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.
(b) To represent the interests of the members of the corporation as a whole and the interests of the public.

The Council's focus in holding the Board to account is on strategy, control, accountability and culture.

GENERAL BUSINESS			
17:30	**1.**	**Welcome and introductions** To welcome governors and attendees to the meeting and request mobile phones be switched to silent	JC
	2.	**Apologies for absence** To receive any apologies for the meeting	JC
	3.	**Declaration of interests** (enclosed) To receive any declarations of interest for items on the agenda	JC
	4.	**Minutes of the previous meeting** (enclosed) To note the minutes of the meetings held on 14 May 2025	JC
	5.	**Matters arising action sheet** (enclosed) To note updates on actions not covered elsewhere on the agenda	JC
17:40	**6.**	**Introduction - newly appointed Chief Nurse** (presentation) To note an overview of the role and reflections to date	DS
18:00	**7.**	**Chair's report** (enclosed) To receive an update from the Chair	JC
18:10	**8.**	**Chief executive's report** (enclosed) To note a report on operational and strategic matters	NC

GOVERNOR BUSINESS (INC. STATUTORY DUTIES)			
18:20	**9.**	**Feedback from Board committees** (enclosed) To receive committee key issues (CKI) and observer reports from the assurance and audit committees: 9.1 Insight Committee 9.2 Improvement Committee 9.3 Involvement Committee 9.4 Audit Committee	NED chairs / Governor observers
18:50	**10.**	**Nominations Committee report** (enclosed) To receive the report from the Nomination committee	JC
	11.	**Membership and Engagement Committee report** (enclosed) To receive a report from the Membership and Engagement Committee	SH
	12.	**Standards Committee report** (enclosed) To receive a report from the Standards Committee	JC
	13.	**Staff Governors' Report** (enclosed) To receive a report from the Staff Governors	Staff Governor
	14.	**Lead Governor Report** (enclosed) To receive a report from the Lead Governor	JS
	15.	**Annual report and accounts, including auditor's letter** (enclosed) To receive the report	MP
ITEMS FOR INFORMATION			
19:20	**16.**	**Summary report for Board of Directors meetings** (enclosed) To receive the report from the Chair and Non-Executive Directors	JC / NEDs
	17.	**Dates for meetings for 2025** To note dates for meetings in 2025: • **8 October 2025 - Annual Members' Meeting** • **13 November 2025**	JC
	18.	**Reflections on meeting** To consider whether the right balance has been achieved in terms of information received and questions for assurance and the Trust's values and behaviours observed.	JC
CLOSE			

Supporting Annexes

Agenda item	Description
9	IQPR full report – May 2025

GENERAL BUSINESS

1. Welcome and Introductions

To welcome governors and attendees to the meeting & request mobile phones be switched to silent.

To Note

Presented by Jude Chin

2. Apologies for Absence

To receive any apologies for the meeting

Apologies received from:

Governors - Lisa Parish

NEDs - Paul Zollinger-Read, Tracy Dowling, Antoinette Jackson

Richard Jones

To Note

Presented by Jude Chin

3. Declaration of interests

To receive any declarations of interest for items on the agenda

To Note

Presented by Jude Chin

4. Minutes of the Previous Meeting (enclosed)

To note the minutes of the meeting held on 14 May 2025

For Approval

Presented by Jude Chin

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE COUNCIL OF GOVERNORS' MEETING - OPEN

Held on Wednesday 14 May 2025 at 17:45
At the Education Centre, West Suffolk Hospital site, Bury St Edmunds

Members:		
Name	**Job Title**	**Initials**
Jude Chin	Trust Chair	JC
Anna Conochie	Public Governor	AC
Val Dutton	Public Governor	VD
Sarah Hanratty	Public Governor	SH
Ben Lord	Public Governor – Deputy Lead Governor	BL
Jayne Neal	Public Governor	JN
Becky Poynter	Public Governor	BP
Jane Skinner	Public Governor – Lead Governor	JS
Gordon McKay	Public Governor	GMc
Robin Howe	Public Governor	RH
Louisa Honeybun	Staff Governor	LH
Andy Morris	Staff Governor	AMo
Adam Musgrove	Staff Governor (left meeting at 7.05 pm)	AMu
Diana Stroh	Staff Governor	DS
David Brandon	Partner Governor	DB
Sue Kingston	Partner Governor	SK
Lisa Parish	Partner Governor	LP
In attendance:		
Nicola Cottington	Chief Executive Officer	NC
Antoinette Jackson	Non-executive Director/Senior Independent Director	AJ
Tracy Dowling	Non-executive Director/Deputy Chair	TD
Michael Parsons	Non-executive Director	MP
Roger Petter	Non-executive Director	RP
Richard Flatman	Non-executive Director	RF
Paul Zollinger-Read	Non-executive Director	PZR
Heather Hancock	Non-executive Director	HH
Alison Wigg	Non-executive Director	AW
Jonathan Rowell	Interim Chief Finance Officer	JR
Pooja Sharma	Deputy Trust Secretary	PS
Ruth Williamson	Foundation Trust Office Manager (Minutes)	RW
Apologies: Thomas Pulimood (Partner Governor), Anna Clapton (Staff Governor), Adrian Osborne (Public Governor), Tom Murray (Public Governor) and Clare Rose (Public Governor), Ewen Cameron		

(Chief Executive Officer).
Members of the Public
Layla Cooke, WSFT staff member.

No.	Item	Action
1.	**Welcome and introductions**	
	The Chair extended a warm welcome to Robin Howe (Public Governor), upon his return to the Trust's Council of Governors. The Council formally noted the resignations of Carol Bull (Public Governor), and David Weaver (Associate Non-Executive Director). The Council expressed its sincere appreciation for their valuable contributions and conveyed best wishes to both for the future.	
2.	**Apologies for absence**	
	Apologies for absence were noted, as detailed above.	
3.	**Declaration of interests**	
	There were no declarations of interest made.	
4.	**Minutes of the previous meetings**	
	The minutes of the meeting held on 26 February 2025 were approved as a true and accurate reflection.	
5.	**Matters arising on action sheet**	
	Noted all actions completed.	
6.	**Update on Financial Position**	
	Jonathan Rowell (JR), Interim Chief Finance Officer provided an update on the financial position. Noted the Trust had recorded a £25.7m deficit for year ending 31 March, 2025, (subject to audit). Reductions in the whole time equivalent (WTE) have been made, returning the Trust to its April 2023 position. The deficit plan for this year is £20.7m. In terms of the funding settlement for this year the Trust will be required to pay for the proposed salary and employer National Insurance increases. The Trust is looking at three workstreams, non-pay, clinical productivity and corporate services. Jim Mackey, CEO, NHS England, has asked for a 50% reduction in ICB running costs. For providers, the ask is a reduction of 50% in the growth of corporate services since Covid. DB referred to people's fear that a reduction in costs will equate to a reduction in clinical services and queried the consequences of this. JR responded that the impact on patients' interaction with the Trust would remain largely unchanged and possibly improved due to the efficiencies made. The review was helpful in ascertaining what could be done to continue sustainability now that additional funds were not available.	

	WSFT was not alone in this. Whilst challenging, the review was helpful. NC advised of the Trust's need to deliver the best value for taxpayers' money, whilst at the same time improving patient care. The Emergency Department had seen an improvement, with a reduction in waiting times and, as a result, potential for harm. This also meant the Trust did not need to pay for extra contractual sessions for those waiting. Inefficiency was not good for patients. TD reported that the ICB was having to spend more on Trust services than expected and as a result this meant less funding in the community, primary care etc., essential components in keeping people away from hospital. There were things that WSFT and its counterpart ESNEFT did well and for the latter, productivity was one of them. Improved collaboration created valuable opportunities for learning. The review was not solely financial, but clinical too. AMu queried whether learning from ESNEFT could be used rather than an external consultant. JR advised that the Sustainability Review is how the Trust will look at productivity. WSFT did not want to work long term with external organisations. Due to the requirement to save £32m, the Trust did not have the appropriate capacity and needed the experience of PA Consulting's work with other NHS organisations. The process of working through the options with the ICB and region, who would ultimately sign-off, was a difficult one. The relationship with PA Consulting was being tightly managed and it was anticipated that their work would tail off in the Autumn. AC asked for clarification of the savings required for backroom operations and IT, expressing concern at the potential clash with IT savings and the third shift requirement for better Virtual Ward and e-Care. JR agreed this was a challenge and would need to be prioritised. It was recognised that corporate functions continue to add value, and while the Board is actively reviewing contracts, the team supporting this work is relatively small. NC stated that the IT department did revisit its priorities on a weekly basis giving precedence to those developments with clear benefits for clinical safety and cost savings. AMo stated that Trust staff were in Cost Improvement Programme (CIP) fatigue and were now being asked for more; what was the degree of confidence that what is agreed will be achieved? JR advised that the Trust was doing everything it could, but there was still scope for improvement. JS cited the reduction in bank and agency staff together with the freeze on recruitment and asked if there have been any reductions in management. NC advised that use of temporary staff, whilst reduced, had not been eliminated due to the need to prioritise for clinical safety reasons. It was preferable to have substantive posts. Corporate Services and operational management vacancies were not being filled as they were currently under review. Clinical posts were being prioritised.	

	JC stated that the review should also be viewed in context of the system. The ICB were also looking at back-office functions. JS asked if there was a target for reduction in whole time equivalents (WTE) for next year? JR advised that a further 200 WTE were required this year. The Corporate Service review was anticipated to provide a third of this number. PA Consulting has identified that since 2020, 1000 more staff are in the organisation, with a query on the justification for some of that number. JS asked if the proposed reduction included those applying for the Mutually Agreed Resignation Scheme (MARS). JR advised that they were not. PZR acknowledged the difficult decisions the organisation had had to take and the improvements made. It was possible to move forward and staff should be thanked for their efforts.	
7.	**Chair's Report**	
	The Chair provided a verbal update. JC referred to the dissolution of NHSE its merger into the Department of Health and Social Security, suggesting that distribution of funds to ICBs has not always been equitable, but that there were plans to address this next year. In the eastern region it is planned for the six ICBs to reduce to three. The current SNEE Chair and CEO have been appointed in the same roles, but on an interim basis, at Norfolk and Waveney, creating a Norfolk and Suffolk ICB, omitting Essex. In was noted that whilst progressing the move of services from acute to community the Alliance is undergoing cost saving measures and as a result there will be a period of uncertainty. AW asked what would happen to Colchester General Hospital? JC advised that they would remain with ESNEFT, who would now be required to deal with two commissioners. JR left the meeting at 6.45 pm.	
8.	**Chief Executive's report**	
	Nicola Cottington (NC), Chief Operating Officer, in attendance to present the report. Noted the formal opening of the Community Diagnostic Centre in Newmarket had taken place. Since opening in December 2024, in excess of 6,000 patients have been seen. In terms of elective recovery and planned operations it was reported that65 week waits had 31 patients at the end of March. NC reported that the emphasis has shifted, with the requirement for patients not to wait longer than 52 weeks and 18 weeks. Whilst slightly behind, the Trust	

	had plans to catch up. Noted the Trust was 4th in the country for Urgent and Emergency Care (UEC) in March, maintaining the standard in April. This was an outstanding achievement by all those involved. NC advised of a visit to the Trust's children's ward by students from a local primary school as an opportunity to offer ideas on how to make the ward more appealing and engage with staff. Noted clarity received on budget for the future system programme, a positive step forward and plans are being worked on. DB congratulated the Trust on the positives reported and wished to add his thanks to those of the CEO to Kirsty Millard, INT co-ordinator at Haverhill following her Putting You First Award. DB also congratulated the Trust on its nomination for "Provider Collaboration of the Year" alongside primary care and ICB partners regarding early skin cancer detection. BP asked whether the 21 patients on the waiting list for elective recovery were all within one service. Noted this was gynaecology, with urogynae under particular pressure due to staffing issues. JS referred to the improvements in cancer performance with approximately 75% having either had Cancer ruled out within 28 days or commencing treatment within 62 days. JS asked how long the remaining percentage were waiting. NC advised that the Trust tracked every patient waiting on the cancer pathway and those beyond the standard were tracked daily. JS queried whether there was any prioritisation of patients. NC responded that anybody with a suspected Cancer diagnosis was top of the priority list. JN referred to a previous meeting when staffing levels at the Community Diagnostic Hub in Newmarket was discussed and queried if this site was now fully staffed. NC advised that the Trust was actively recruiting, but sourcing of ultrasound personnel was a national issue.	
9.	**Feedback from Board Committees**	
9.1	**Insight Committee**	
	Antoinette Jackson (AJ), Non-executive Director and Chair of the Insight Committee, presented the report. SH asked if the Trust had now moved out of Tier 1 in terms of Cancer diagnostics. NC responded that due to changes taking place at NHSE, an update was yet to be received. JS raised the issue of a minimal assurance rating for diagnostics and questioned whether this applied solely to cancer diagnostics or to diagnostics in general, including services at Newmarket.	

	AJ clarified that the minimal assurance rating was in place due to performance against the 6-week diagnostic standard, which currently stands at 50%, significantly below the national target of 95%. Whilst tiering specifically applies to cancer diagnostics, overall diagnostic performance, including non-cancer pathways, contributes to the assurance rating. AJ emphasized that improvements in cancer diagnostics are critical to moving out of the minimal assurance category, but the issue is not exclusive to cancer. AJ noted that data can change between meetings and the current discussion reflects a snapshot in time. The reports from governor observers were noted and taken as read.	
9.2	**Improvement Committee**	
	Roger Petter, (RP) Non-executive Director and Chair of the Improvement Committee, presented the report. RP referred to a reduction in the number of calls to the Call 4 Concern team. Noted this is currently a work in progress and as the system imbeds, the number of calls will become appropriate. JS highlighted that in March discharge summaries were given reasonable assurance, but in April only partial and enquired as to the Trust's performance. RP responded that last year this had been a quality priority. A decision was made at the end of the year that sufficient workstreams showed that the Trust was moving in the right direction and therefore, not considered a priority, but business as usual. **Action: NC to confirm performance statistics and share with governors.** JS advised that it was difficult to understand the impediment to actioning a discharge summary. NC advised that work had been undertaken with the clinical teams to digitalise discharge summaries and make them easier. This can be a challenge for busy wards and departments. JS asked where oversight on progress would be received. Noted this is within the remit of the Improvement Committee. TD advised that the matter was discussed at the Performance Review Meetings (PRMs) as part of business as usual and was being monitored. DB advised that primary care, through interactivity with health exchange, did have access to some information on what has taken place in hospital, which can mitigate some of the risk. Quality took precedence over speed. The observer reports were noted. AMo advised of a growing sense of unease at insufficient resource to prepare for a future CQC review. NC reported that services were encouraged to escalate concerns. **Action: NC to discuss with Medical Director, Richard Goodwin. Roger Petter to raise issue at Improvement Committee.** SH referred to the March and April CKIs and the scores of 4 (minimal assurance) without escalation noted in the appropriate column. **Action:**	**NC** **NC/RP**

	Roger Petter to take forward at Improvement Committee. BL and AMu left the meeting at 7.00 pm.	**RP**
9.3	**Involvement Committee**	
	Tracy Dowling, (TD) Non-executive Director and Chair of the Involvement Committee, presented the report. Noted partial assurance on the Staff Survey Report. Actions in this regard will be reported to the Board. Governor observations noted an appreciation for the reduction in the number of papers for the last meeting.	
9.4	**Audit Committee**	
	The report was noted and taken as read.	
10.	**Nomination Committee Report**	
	JC offered thanks to governors for their NEDs' appraisal feedback. Summaries have been produced and incorporated into the appraisal templates. The deadline for completion of appraisals by the Chair is the end of June 2025.	
11.	**Membership & Engagement Committee Report**	
	The report was noted and taken as read.	
12.	**Standards Committee Report**	
	Jude Chin (JC), Chair, presented the report. ***Lead and Deputy Lead Governor Election Process 2025 and Role Specification*** – the Council were asked to vote on the options regarding the preferred term span for Lead Governor, taking in to account the arguments presented for and against. Option 1 – The term of office for the lead Governor will normally run for three years <u>until **one** year after Governor elections</u> Option 2 – The term of office for the lead Governor will normally run for three years <u>until **two years** after Governor elections</u> **Following a majority vote, the Council gave its approval to Option 2 to run until two years after governor elections. The Council also gave its approval to the Lead and Deputy Lead Governor roles specification and terms and conditions, subject to inclusion of the decision made on term of office.** **The Council of Governors noted that the approval of option 2 triggered an amendment to the Trust Constitution (Annex 11 – lead governor and deputy lead governor-role specification and terms & conditions) necessitating approval by the board of directors and this will be taken forward through the appropriate governance route.**	

13.	**Staff Governors' Report**	
	The report was noted and taken as read.	
14.	**Lead Governor Report**	
	Jane Skinner (JS), Lead Governor, presented the report. The meeting acknowledged with sadness the passing of Michael Simpkin, Public Governor. Michael's valuable contribution and dedication to the role were much appreciated and he would be greatly missed.	
15.	**Quality Accounts 2024/25**	
	Following a recommendation by the Standards Committee, the Council approved the draft of the governors' commentary for the Quality Accounts.	
16.	**Governance Report**	
	The report was noted and taken as read.	
17.	**Summary Report for Board of Directors Meetings**	
	The report was noted and taken as read.	
18.	**Any Other Business**	
	Noted an extraordinary CoG meeting will be convened to discuss the findings of the Sustainability Review. Date to be confirmed.	
19.	**Dates for meetings in 2025**	
	▪ 11 September 2025 ▪ 13 November 2025 ▪ Annual Members' Meeting - TBC	
16.	**Reflections on meeting**	
	JS remarked that the timing of the meeting had been particularly effective.	

5. Matters Arising Action Sheet (enclosed)

To note updates on actions not covered elsewhere on the agenda

To Note

Presented by Jude Chin

Council of Governors' meeting - action points

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3	Public	14/05/25	9.2	**Feedback from Board Committees - Improvement Committee - Discharge Summaries -** Confirm performance Statistics to be shared with governors**.**	**Sending the discharge summary to Primary care within 24 hours is a contractual obligation with a target of 95%. In 2023, the rate was 80-85%. Patients in ED were most likely to fail the target for several identified reasons. Human factors and IT (e-Care) factors were both important, and both have been tackled. Current rates (June 2025) are 89.1% (non-elective) and 90.1% (elective).** **Significant Progress. A new digital platform is scheduled for 1 July 2025 which is much more streamlined. Induction training, audit and work with both primary care and ED should all help. Updates will be reported to Improvement Committee on a quarterly basis.**	Nicola Cottington	11/09/2025	Complete	11/09/2025
4	Public	14/05/25	9.2	**Feedback from Board Committees - Improvement Committee - CQC Preparation Resource -** COO (now Chief Nurse) and Medical Director to discuss. Matter to also be raised at Improvement Committee.	**CQC preparation has commenced in the divisions. Following the governance and patient safety restructure, CQC prep and responsibilities are more defined. Next step is to centralise CQC preparation now that the governance structure will support a corporate approach and respective framework.**	~~NC/RG/ PZR~~ Dan Spooner/ Richard Goodwin	11/09/2025	Complete	11/09/2025

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
5	Public	14/05/25	9.2	**Feedback from Board Committees - Improvement Committee - Minimal Assurance Scoring** - Items scored at 4 are lacking comment in the escalation column. To be taken forward by Improvement Committee.	**The committee chair, together with the executive leads, has progressed this through the Improvement committee. Any areas receiving minimal assurance scores will be appropriately addressed, including clear identification of escalation routes where required. To support continued transparency and assurance to the Council of Governors, future Committee Key Issues (CKI) reports are to reflect this approach, ensuring visibility of progress and escalation where relevant.**	~~PZR~~/Dan Spooner/ Richard Green	11/09/2025	Complete	11/09/2025

Red	Due date passed and action not complete
Amber	Off trajectory - The action is behind schedule and may not be delivered
Green	On trajectory - The action is expected to be completed by the due date
Complete	Action completed

6. Introduction - newly appointed Chief Nurse (presentation)

To note an overview of the role and reflections to date

Dan Spooner in attendance

To Note

7. Chair's report (enclosed)

To receive an update from the Chair

To Note

Presented by Jude Chin

NHS
West Suffolk
NHS Foundation Trust

WSFT Council of Governors meeting (Open)	
Report title:	**Chair's report**
Agenda item:	7
Date of the meeting:	11 September 2025
Sponsor/executive lead:	Jude Chin, Trust Chair
Report prepared by:	Jude Chin, Trust Chair

Purpose of the report:			
For approval ☐	**For assurance** ☐	**For discussion** ☐	**For information** ☒
Trust strategy ambitions	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
Please indicate Trust strategy ambitions relevant to this report.	☒	☒	☒

Summary

Sustainability Review Update

Following the publication of the Sustainability Review ('SR'), both ESNEFT and WSFT were tasked with implementing the recommendations set out in the SR. A Joint Productivity Board ('JPB') has been established, comprising senior executives and a NED from both Trusts and jointly chaired by Mark Millar and myself.

The JPB has met twice and has made progress in establishing scope and priority projects. A key objective of the JPB is to foster effective collaboration between ESNEFT and WSFT, to identify barriers to cooperation and to remove or mitigate them.

A number of the initiatives set out in the SR, particularly those concerned with 'left shift' are currently being scoped and managed by the ICB; the JPB is keeping a watching brief on those initiatives. There are two initiatives concerned with clinical productivity and corporate services which are being managed by executives from the two trusts and are monitored by the JPB.

One of the recommendations in the SR was the appointment of a Joint Chair which was endorsed by the boards of both Trusts. Following the publication of the NHS 10-year plan, the Joint Chair role is being reviewed and the appointment process is currently on hold.

Strategy Refresh and NHS 10-year plan

The board took the decision to refresh the Trust strategy, and the process started prior to the publication of the NHS 10-year plan ('the Plan'). Subsequent iterations of the strategy have taken place, including reflection on the initiatives set out in the Plan.

The Board used their most recent Board Development Day to work together in confirming the key elements of the strategy. Work has continued to refine and clarify the strategy, and it is anticipated that a final draft will be presented at the board meeting at the end of the month for approval.

The hard work then begins as we launch an extensive communications exercise to share and explain the strategy with our staff and partners.

NED Appraisal and Objective setting

I would like to thank the Nominations Committee of the Council of Governors and those governors who provided feedback on NED performance. Feedback was also provided by executives and NED's. I was able to complete the appraisal and objective setting of all NED's by the deadline set by Region. I would also like to thank the Lead Governor and the Senior Independent Director for carrying out my appraisal and objective setting.

Suffolk and North East Essex Integrated Care System Chairs Group

The most recent meeting of the group was on 5 August, attended by the chairs or representatives from all providers of healthcare services in the SNEE ICS. The main item under discussion was the restructuring of the regions ICB's and the proposed changes to the executive team for our new ICB.

Plans are underway to consolidate the 6 ICB's in our East Region down to 3 ICB's. For the SNEE ICB, Suffolk will merge with Norfolk and Waveney and North East Essex will join the new Greater Essex ICB. The legal merger of the ICB's is expected to be effective from 1st April 2026, however the new ICB structure is effectively in operation now.

All ICB's have been tasked with cutting operating costs by roughly 50%; in future, ICB's will be funded on a per capita of population served, which is likely to prove challenging for the smaller ICB's (of which Norfolk and Suffolk ICB with a population of 1.7million will be one).

The restructuring of the Norfolk and Suffolk ICB will be based upon design principles set out by NHS England and will start with the appointment of a single executive team. A process has started whereby existing ICB executives have been invited to apply for one (or more) of the new ICB roles across the three ICB's in the East Region. This will be followed by consultation on the other roles within the ICB.

Recommendation
The Council of Governors is asked to note the report.

8. Chief Executive's Report (enclosed)

To note a report on operational and strategic matters

To Note

Presented by Ewen Cameron

WSFT Council of Governors Meeting (Open)	
Report title:	**CEO report**
Agenda item:	8
Date of the meeting:	11 September 2025
Sponsor/executive lead:	Dr Ewen Cameron, chief executive
Report prepared by:	Dr Ewen Cameron, chief executive Sam Green, communications manager (acting) Anna Hollis, deputy head of communications Greg Bowker, head of communications

Purpose of the report:			
For approval ☐	**For assurance** ☒	**For discussion** ☐	**For information** ☒
Trust strategy ambitions	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
Please indicate Trust strategy ambitions relevant to this report.	☒	☒	☐

Executive Summary

This report summarises the main headlines for July 2025.

Chief Executive Officer's report

The Government has recently published its 10 Year Health Plan for England; a document outlining significant changes to the way we work, which are aligned to the three shifts identified in the Darzi Report. While this may seem daunting, it outlines exactly the kind of transformation we have been making across the organisation.

As an integrated Trust, our community division is already working in lockstep with our teams in our hospitals. We have been a Global Digital Exemplar for some years now – having adopted our electronic patient record system in 2016. We are also strong advocates for prevention, with a commitment to educating our local population on topics such as sun-safe awareness, vaccinations and winter illnesses, and working with local partners to enhance the health and wellbeing of our communities.

There will be challenges in reshaping the way we work but also opportunities. We have recently evidenced our ability to adapt through the transformation work across the Trust that has helped improve our performance against key metrics, such as the 4-hour standard.

Alongside the work needed to deliver against the objectives of the 10 Year Health Plan for England, we must also stabilise our finances to live within our means (a challenge being faced by the whole NHS). Having taken some difficult decisions over the last year, I am pleased to say that we are making strong progress with our financial recovery. Against our plan for 2025/26 we have been ahead of plan for the first 4 months of the year, and I would like to thank all colleagues at every level of the organisation for helping us to make this really strong progress. While there will be larger in-month savings we need to make later in the year, we have the mechanisms and tools at our disposal, alongside the ongoing perseverance of our colleagues, to give us the best chance of delivering our financial plan.

Performance

Finance

At the end of June, our reported position in-year was a £0.9m deficit, which is £0.7m better than planned. There has been an enormous effort from colleagues to help reduce the deficit, and significant progress made so far this year, with a positive reduction in our underlying run rate.

We know the second half of the year will be more challenging. We must put in place cost-saving measures that generate larger in-month reductions from September to meet our plan. We will continue delivering against our larger CIP actions, such as the corporate and admin services reviews, workforce management such as the recruitment controls, and looking at how we can most effectively spend money and use our resources. No doubt this will be challenging, and there are further difficult decisions that we will have to make in the future, however, it is very important that we live within our means.

Industrial action

The Trust saw a further round of British Medical Association (BMA) resident doctor industrial action between 25 July and 30 July 2025. As we have done for all previous rounds, we undertook comprehensive planning in the run up to the strikes and maintained a larger number of elective procedures and outpatient appointments than we have done previously. While we rescheduled 81 procedures and 521 outpatient appointments, the vast majority of these were rescheduled very quickly to ensure our patients receive the treatment they need as soon as possible.

Over these days, our teams worked incredibly hard, and by focusing our resources on our urgent and emergency care services, namely the emergency department, patients were seen in a similar or shorter time than usual.

We did not see a larger uptake of strike action amongst our resident doctors, with it being broadly in line with previous rounds. However, the number that took strike action per day, 97 were absent from work on 25 July, 33 on 26 July, 32 on 27 July, 106 on 28 July and 114 on 29 July.

There have been no announcements about further rounds of BMA resident doctor strike action, and we await the result of the ongoing negotiations. Should there be any more strike action, our experienced teams will continue to plan comprehensively for this.

Elective recovery

The latest referral to treatment (RTT) data (June 25) confirms:

- 3 patients over 78 weeks
- 135 patients over 65 weeks
- 1,573 patients over 52 weeks
- 15,114 patients over 18 weeks with overall RTT compliance of 56.98% within the 18-week standard

For long waits (52, 65 and 78 weeks), the Trust is behind plan with more patients waiting long periods than we would like. 65-week waits are strongly affected by dermatology, however, key actions for recovery are in place, including additional weekend activity.

We are slightly behind plan (0.7%) in meeting our RTT targets. To get back on track, we are focusing on double checking our waiting lists and making better use of outpatient appointments and identifying productivity improvements.

We are currently rated as Tier 1 for how well we are doing with planned (elective) care meaning NHS England national oversight and monitoring against recovery plans.

Urgent and emergency care

Our performance against the 4-hour standard was 74.7% in July, which is below the 78% target, but remains higher than our performance in the early part of 2025. While this is a dip from March, April and May, we have seen record attendances in our emergency department, and it is both an improvement on June's performance and ahead of our planned trajectory. Following a significant transformation project to improve patient flow throughout the organisation, I am confident we have the right measures in place to sustain the improvements that have helped ensure more patients are receiving the care they need as quickly as possible.

While we continue to be significantly better than we were last year, we have to continue working hard to return to meeting the target. This is being supported by a wide-ranging transformation project aimed at improving how we work across our Trust. Some of the outcomes from this include improving how we discharge patients, bringing staff together to unblock barriers, and planning ahead to improve efficiency. All these improvements ultimately mean our patients have a better experience when they attend A&E, when they're being treated in a bed and when they get ready to return home. It also benefits our staff, both in terms of more effective patient management and increased pride in the care they provide. This will also play an important part in helping us maintain our performance during the most difficult parts of the year.

Cancer

28-day faster diagnosis standard (target 80% by March 2026):

- March – 79%
- April – 69.1%
- May – 68.3% (against trajectory of 75.4%)

31-day decision to treat standard (target 96%):

- March - 99.6%
- April - 100%
- May - 99.6%

62-day referral to treatment standard (target 75% by March 2026):

- March - 83.2%
- April - 83.7%
- May - 69.8% (against a trajectory of 72.5%)

The Trust's cancer performance has reduced due to constraints within the breast department. Waits for first appointment have extended due to workforce gaps within radiology and this has impacted the overall 28-day and 62-day performance targets. However, we are pleased to confirm we started to recover this position in June and were fully recovered for July.

We remain in Tier 2 for cancer care meaning NHS England regional oversight and monitoring against recovery plans.

Quality

Colleagues from across the Trust have been recognised for their excellence and innovation at the Suffolk and North East Essex ICS 'Can Do' Health and Care Awards 2025. I was incredibly proud to be at the ceremony to see our people and projects getting the recognition they deserve.

The diversity of service improvement projects and partnerships we had shortlisted was a testament to the innovation of our colleagues and their determination to provide excellent care for patients.

The Trust had six nominations across five categories, taking three ‘runner up’ spots as well as one ‘highly commended’ and two ‘commended’ accolades.

This year, there were over 200 nominations submitted across the 10 award categories.

Preventing Ill-health, Inequalities, and Injustice award: Helen Scharf and Andy Mizen – highly commended

Helen, a speech and language therapist, and Andy, a clinical nurse specialist, have developed and are running a head and neck surveillance clinic, providing holistic support to reduce inequalities and prevent ill-health for cancer survivors.

Technology and Innovation Award: West Suffolk NHS Foundation Trust Virtual Ward – runner up

The WSFT virtual ward enables patients who would previously have been an inpatient in hospital to be cared for at home. Working in tandem with our community teams, the virtual ward staff make use of a range of technology to help patients and families receive high quality care and support in their own environment.

Learning from Data, Evidence, Knowledge, and Intelligence Award - West Suffolk Taskforce: West Suffolk NHS Foundation Trust and Suffolk County Council – commended

The West Suffolk Taskforce undertook a comprehensive review of processes and practices driving our urgent and emergency care performance. Implementing a series of detailed recommendations and action plans – bringing together staff from across acute, community and support functions – saw the Trust place 1st regionally and 4th nationally for its 4-hour performance earlier this year.

Making Better Use of our Resources Award: WSFT Maternity Social Media – runner up

The West Suffolk maternity team have been using social media to improve women’s experiences and outcomes of pregnancy. Accessible posts around the team and services, live Q&As, and antenatal education have received positive engagement and feedback.

Partnership with the VCFSE Sector Award: Integrated health and leisure pathways – runner up

The Trust, Abbeycroft Leisure and the West Suffolk Alliance developed free, personalised exercise programmes to support patients who are frail, have respiratory issues, or musculo-skeletal problems. Over 8,000 patients were referred to the programmes, influencing primary care attendance and significantly improving patient experience.

Partnership with the VCFSE Sector Award: One Haverhill Market Place Events – commended

Coordinated by One Haverhill, Wellbeing Suffolk, WSFT, and Abbeycroft Leisure, the biannual One Haverhill Marketplace Events are a showcase for the public to engage with voluntary organisations, charities, schools, local business and services that serve Haverhill and beyond.

Workforce

It is currently a difficult time for many working across our Trust. Colleagues are dealing with wholesale change across the NHS and difficult conditions with the high temperatures, alongside the impact of operational and financial pressures. Therefore, it is important we showcase the amazing work they do - day in, day out - because they are our most precious resource.

Helen Whiting, one of our long-serving critical care nurses with 40-years of West Suffolk Hospital experience, received the Cavell Star having been nominated by her colleagues. Her work in developing the patient profile form and her unwavering commitment to enhancing the patient experience were outlined in her nomination, alongside her kind and compassionate nature. I would like to congratulate Helen on a very well-deserved award.

Recently, we were awarded the Work Experience Quality Standard Gold Award, only two years after having been awarded the Bronze Award. The team, supported by our volunteer service, do an incredible job of facilitating clinical shadowing and student volunteering opportunities, which provide young people with an incredible opportunity to find out what a career in the NHS is like. This experience helps ensure we are showing our young people that the NHS offers a rich and rewarding career, which is important if we are to maintain our workforce into the future.

Future

With the 10 Year Health Plan for England having been published, we have a much more detailed understanding of the direction of travel for the entire NHS. While above I mention that we are already doing a lot of the work aligned with the three shifts, there is much more we are going to have to do over the coming years.

Technology will play a key role in how we adapt to ensure we have a sustainable model of healthcare delivery. Whether this is our continued adoption of AI to help us achieve greater diagnostic accuracy more quickly, facilitate patients leaving hospital sooner or avoiding admission altogether thanks to our virtual ward.

Of course, we will have to adopt this change in preparation for our new hospital. This facility will take a digital first approach, caveated by ensuring the less digitally engaged patients do not face barriers to accessing healthcare. This project continues to progress, and we have recently signed the Alliance Agreement, which is another step in the right direction. This sets out how the partners involved in the project, such as the Trust and the NHS England New Hospital Programme team, will work together to deliver a new hospital for west Suffolk. It establishes clear roles and responsibilities, shared principles, and a commitment to collaborative decision-making in the best interests of the programme.

As a Trust we continue to refresh and develop an updated strategy (due for approval in September) to set the future direction of the organisation and focus on things that will make the biggest difference for patients and staff. Draft ambitions and priorities were shared with stakeholders for feedback via a short survey and focus groups, with the ambitions in the 10 Year Health Plan for England and local system strategies also being considered as part of project.

Recommendation

The Council of Governors is asked to note the report.

Previously considered by:	NA
Risk and assurance:	Failure to effectively manage risks to the Trust’s strategic objectives.
Equality, diversity and inclusion:	Decisions should be inclusive of individuals or groups with protected characteristics
Sustainability:	Sustainable organisation
Legal and regulatory context:	NHS Act 2026 Trust Constitution

GOVERNOR BUSINESS (INC. STATUTORY DUTIES)

9. Feedback from assurance committees (enclosed)

To receive committee key issues (CKI) and observers reports from the assurance and audit committees

To Note

WSFT Council of Governors meeting (Open)	
Report title:	Feedback from Board assurance committees
Agenda item:	9
Date of the meeting:	11 September 2025
Sponsor/executive lead:	Non-Executive Directors / Governor observers at the Board's assurance committees
Report prepared by:	Chairs of the assurance committees Governor Observers at the assurance committees Pooja Sharma, Deputy Trust Secretary

Purpose of the report:

For approval	For assurance	For discussion	For information
☐	☒	☒	☒
Trust strategy ambitions	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
Please indicate Trust strategy ambitions relevant to this report.	☒	☒	☒

Executive summary:

WHAT?
Summary of issue, including evaluation of the validity the data/information

Governors have the opportunity to observe board assurance committee meetings. This allows them to witness NED contribution to the conduct of the meeting and the level of challenge provided.

The Trust supports Governors to observe Board and relevant assurance committees to provide greater oversight of Board and NED activities. A guidance note for governor observers at board assurance committees sets out clear expectation of observer role for governors, chair, NEDs and Execs.

SO WHAT?
Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk

The report highlights the summary of the agenda items discussed in the Board assurance committees, chairs' key issues and respective governor observers' reports to provide an update to the Council.

Annex A of the report details the exception slide from the Trust's IQPR. This information helps to focus discussion within the assurance committees.

INSIGHT COMMITTEE:

21 May 2025 (observed by Jayne Neal & Jane Skinner)

- Report from sub-committees:
  - Financial Accountability Committee including Month 1 reporting, update on CIP, update on ICB double lock process, the Green Plan for approval
  - Patient Access Governance Group including Quality Impact Assessment panel outcomes
- Urgent and Emergency Care deep dive
- IQPR - data for March 2025
- BAF 7 financial sustainability
- Corporate Risk Governance Group
- Forward Plan
- Escalations to and from other board assurance committees and board

18 June 2025 (observed by David Slater and Tom Murray)

- Report from sub-committees:
  - Financial Accountability Committee including Month 2 reporting, update on CIP
  - Patient Access Governance Group including Quality Impact Assessment panel outcomes
- Community Services deep dive
- IQPR - data for April 2025
- BAF 2 Capacity
- Corporate Risk Governance Group
- Forward Plan
- Escalations to and from other board assurance committees and board

16 July 2025 (observed by Jayne Neal, Jane Skinner & David Slater)

- Report from sub-committees:
  - Financial Accountability Committee including Month 3 reporting, update on CIP, pay award update, national cost collection, wheelchair services contract award
  - Patient Access Governance Group including Quality Impact Assessment panel outcomes
- Diagnostics deep dive
- IQPR - data for May 2025
- BAF 2 Capacity
- BAF 6 Estates
- Forward Plan
- Escalations to and from other board assurance committees and board

IMPROVEMENT COMMITTEE:

21 May 2025 (observed by Andy Morris & Jane Skinner)

- Reports from governance sub-groups: Patient Quality & Safety, Clinical Effectiveness and Transfer of Care Group report
- Quality & patient safety insight: Quality & safety datasets, IQPR, PRM packs
- Quality priorities, progress and planning - Quality priority 2 (GIRPS)
- CQC update
- QIAs – Oversight and Assurance
- Escalations to and from other board assurance committees and board

18 June 2025 (observed by Sue Kingston and Andy Morris)

- Reports from governance sub-groups: Patient Quality & Safety, Clinical Effectiveness Governance Group report
- Quality & patient safety insight: IQPR, PRM packs, Quality faculty update (EoL programme)
- Quality Priorities
- Maternity update
- Completion of Transfer of Care Summary letters (discharge letters)
- BAF 4 - Continuous improvement and Innovation
- Escalations to and from other board assurance committees and board

16 July 2025 (observed by Sue Kingston, Andy Morris & Jane Skinner)

- Reports from governance sub-groups: Patient Quality & Safety, Clinical Effectiveness Governance Group report
- Quality & patient safety insight: IQPR, PRM packs
- Quality Priorities - Diabetes care deep dive (training, medication, time working etc.)
- NatSSIPs 2 - deep dive on progress
- BAF 8 – Governance
- Escalations to and from other board assurance committees and board

INVOLVEMENT COMMITTEE:

18 June 2025 (observed by Anna Clapton)

Setting the scene: Our FIRST values and committee purpose - Fairness, Inclusivity, Respect, Safety, Teamwork

First for staff:

- Engagement Scores – Making the Trust the best place to work in the NHS
- Staff story/what can we learn
- Workforce Health and Wellbeing workplan update
- Guardian of safe working report
- Veterans update
- Statutory Mandatory Training review update

First for patients:

- Experience of Care and Engagement Committee report
- Progress of 2025/26 strategic priorities

First for the future:

- Workforce Strategy/People Plan

Governance:

- People and Culture Committee update

Other items for oversight and assurance:

- IQPR extract for Involvement Committee (staff & patient experience KPIs)
- Escalations to and from other board assurance committees and board
- Correspondence / concerns from staff governors

AUDIT COMMITTEE	
Audit Committee's key issues report (20 June 2025) presented by the Committee Chair.	
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	
The items reported through this report will be actioned through the appropriate routes.	
Action required / Recommendation:	
The Council of Governors is asked to note the feedback from Board assurance committees.	
Previously considered by:	N/A
Risk and assurance:	Council of Governors unable to undertake its statutory duties.
Equality, diversity and inclusion:	N/A
Sustainability:	N/A
Legal and regulatory context:	West Suffolk NHS Foundation Trust Constitution Health & Social Care Act 2022 NHSE Code of Governance 2022

Annex A: IQPR – exception summary slide

Assurance Grid

VARIANCE: Variation from the mean
The colours indicate the trend- positive (blue), Negative (orange), or neither (grey)

ASSURANCE: Will we reliably meet the target based?

Not Met

Performance in May 2025 [No Title]	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement	**INSIGHT** Virtual Beds Trajectory **INVOLVEMENT** Staff Sickness Rolling 12 Months	**INSIGHT** Ambulance Handover within 30min 12 Hour Breaches Non-admitted 4 hour performance % patients with no criteria to reside Cancer 62 Days Performance **INVOLVEMENT** Mandatory Training Turnover	**INSIGHT** 12 hour breaches as a percentage of attendances Incomplete 104 Day Waits RTT 78+ Week Waits	**INSIGHT** Criteria to reside – Acute RTT 65+ Week Waits RTT NDD Only Waiting List **IMPROVEMENT** SHMI
Common Cause	**INSIGHT** 4 hour breaches Urgent 2 hour response – EIT Virtual Ward Total average LOS per patient **INVOLVEMENT** Staff Sickness	**INSIGHT** Virtual Ward Total average occupancy percentage 28 Day Faster Diagnosis **IMPROVEMENT** C-Diff Hospital & Community onset, Healthcare Associated	**INSIGHT** Virtual Ward Total average occupancy number **INVOLVEMENT** Appraisal	**INSIGHT** Criteria to reside – Community Virtual Ward Total bed days RTT NDD Only 52 Waiting List RTT NDD Only 78 Waiting List **IMPROVEMENT** % of patients with Measured Weight % of patients with a MUST/PYMs assessment completed within 24 hours of admission Post Partum Haemorrhage Inpatient Deaths **INVOLVEMENT** Closed complaints % extended Count extended % Complaints responded to late Count responded to late % resolved in one week Total PALS resolved Count
Special Cause Concern Deteriorating	**INSIGHT**	**INSIGHT** Community Paediatrics RTT Overall 78 Waiting List	**INSIGHT** Diagnostic Performance - % within 6 weeks total	**INSIGHT** RTT Waiting List Community Paediatrics RTT Overall Waiting List Community Paediatrics RTT Overall 52 Waiting List Community Paediatrics RTT Overall 65 Waiting List RTT NDD Only 65 Waiting List **INVOLVEMENT** Active complaints

Items for escalation based on those indicators that are failing the target, or are worsening and therefore showing Special Cause of Concerning Nature by area:
INSIGHT - Urgent & Emergency Care: 12 hour breaches as a percentage of attendances, Virtual Ward Total average occupancy number
Cancer: Incomplete 104 Day Waits
Elective: Diagnostic Performance - % within 6 weeks total, RTT 78+ Week Waits, Community Paediatrics RTT Overall 78 Waiting List
INVOLVEMENT – Well Led: Appraisal

9.1. Insight Committee

To Note

Presented by Richard Flatman and Jude Chin

Board assurance committee - Committee Key Issues (CKI) report

NHS West Suffolk NHS Foundation Trust

Originating Committee: Insight Committee			**Date of meeting: 21 May 2025**		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:** **SO WHAT?** Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk	**WHAT NEXT?** Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
PAGG/IQPR	**Elective Recovery** The cohort of elective patients waiting 65 weeks or more continues to reduce. The March position was 31 patients waiting more than 65 weeks, of which 10 were capacity related. This meant that the Trust narrowly missed achieving the national target.	**2 Reasonable**	There is a risk of patient harm if patients are not treated in a timely way.	As a result of our improved elective position and commitment to reduce the 65 week waits by March 2025, we were removed from 'Tier 2' for Elective Recovery. In response to the Operational planning guidance the Trust is committing to delivering the 5% Referral To Treatment (RTT) improvement to 63.6% through reducing outpatient wait times and increasing activity to increase 18-week compliance. Seven specialties have been identified as those where the impact will be greatest having high volumes but low RTT performance.	1 no escalation

PAGG/IQPR	**Cancer Faster Diagnosis (FDS) Targets** Cancer FDS performance increased to 77% in February 62-day performance increased to 75.% meeting national targets.	**3 Partial**	Achieving the FDS target of 77% and a 62-day performance of 70% by March 2025 were the key objectives for cancer in 2024/25 planning.	The Trust is still in Tier 1 for the cancer pathway and hopes this improved performance will mean tiering is lifted once April quarter 4 data is available. Learning from the performance achievements in February and March 2025 will be captured to inform the detail and direction of delivery plans against NHS 2025/26 priorities and operational planning guidance. The Trust has committed to achieving the 62-day standard (75%) and Faster Diagnosis Standard (FDS) (80%) for 2025/26. Gynaecology, skin and lower gastrointestinal (LGI) are the areas of focus for transformation.	No escalation

PAGG/IQPR	**Diagnostics** Diagnostic performance against the 6-week standard dropped from 55.2% to 53.2% in March 2025. **MRI** performance is improving with additional Community Diagnostic Centre capacity and is expected to recover by the end of May 2025. With **endoscopy** priority is being given to patients on a cancer pathway. Routine performance is plateauing. **Ultrasound** performance is vulnerable because of difficulty in recruiting. Whilst bank and agency staff have been approved availability is limited. This also applies to CDC capacity. **Breast imaging** has also been impacted by staffing issues and failure to recruit to approved posts.	**4 Minimal**	Longer waiting times for diagnosis and treatment have a detrimental effect on patients. .	As a result of our worsening Cancer and Diagnostic performance we were placed in 'Tier 1' nationally. Although diagnostic performance is included in Tier 1 meetings, exit criteria will be defined by cancer performance alone. A clear recovery plan is in place for DEXA, pending the permanent scanner delivery In the longer-term Newmarket CDC will help endoscopy performance but there is currently no clear recovery plan for the service and this needs addressing. Ultrasound is forecast for recovery by October 2025 if recruitment issues can be resolved. Breast imaging is trying to fill posts temporarily whilst going back out to substantive recruitment. There will be a deep dive into the issues around diagnostic recovery at the July Insight Committee.	3.Escalate to Board

Urgent and Emergency Care deep dive	Urgent and Emergency Care (UEC) performance at WSFT remained below trajectory for majority of 2024/25. It was recognised that improvements were required to meet the 4-hour standard of 78%. In December 2024 an improvement programme was initiated through a series of cross divisional 'taskforces' aimed at diagnosing and removing barriers to flow throughout the system. These taskforces made recommendations for sustainable improvements, thereby enhancing UEC performance. A primary objective of these taskforces and the resulting transformation initiatives was to create a seamless UEC pathway and flow through out the organisation with a strong emphasis on patient safety and avoiding patient harm.	**1 Substantial**	During March the Trust achieved a 4-hour performance of 88.39%. This achievement placed WSFT 1st in region and 4th nationally for 4-hour performance. 12-hour waits as a % of attendances reduced significantly from 10.2% to 2.1% against the standard of 2% Significant improvements were seen in the non-admitted patient group. The overall performance for non-admitted patients during March was 93.12%. During March the MECU saw a 38% increase in activity compared to the average number from the previous 3 months. The 'reset' of the short stay ward (F7) facilitated appropriate selection and transfers of short stay patients. This resulted in significant improvements in discharge numbers within the short stay cohort. Ambulance handover within 30 minutes exceeded the target for the first time, and significant improvements eliminated all but meant only 3 ambulances waited over 60 minutes. The effect on staff morale was noticeable throughout the organisation, despite the need to adjust to new ways of working.	Most of the actions implemented from these workstreams did not require new funding but involved dedicated focus and change from both clinical and operational teams. Performance during April has been sustained, therefore providing an element of confidence that this improvement will continue. As of 14th April performance was 88.81% compared with 87.85% at the same point in March, with an April month end position of 81.35%. UEC performance will continue to be closely monitored against the trajectory for 2025/26. Early escalation of issues via the UEC delivery group will be used ensure strong performance continues, The NHSE improvement team has offered their support in implementing the actions from the ward taskforce, which will assist in embedding the improvements highlighted. This work will commence early May 2025. There are risks to delivery in terms of sustaining this approach as business as usual throughout the year. This is compounded by the pressures of the Trust financial system.	3 Escalate to Board to note the significant progress and learning

			The deep dive demonstrated that there is now a much greater understanding of the drivers of performance in UEC.		

Finance Accountability Committee	**Month 1 Reporting** The Trust has agreed a £20.7m deficit budget for the year, and at Month 1 is reporting a small underspend against plan. The reported Income and Expenditure (I&E) for Month 1 shows a run rate of £2.7m, compared to the planned rate of £2.8m. Pay spend in M1, whilst within plan, was an increase on the M12 run rate. This includes the residual impact of the escalation ward, and the impact of 'super Saturday' lists in March where the impact on income has not yet been assessed. In addition, funding for cancer alliance posts has not been fully reflected as this is not yet confirmed, however the costs are reflected. In month, the target CIP was £1.3m, and this was achieved in the month.	**3 Partial**	It is difficult to draw many conclusions from M1 reporting for a number of reasons; the impact of accruals over year end, assumptions about the impact of pay awards, inflation and increased National Insurance , and the phasing of CIP plans which are still being developed Whist the run rate is just below target it is still a much higher run rate than achieved in 24/25 so this needs further analysis.	There will be further analyses and adjustments to the uploaded budget in the ledger to revise the budget profile starting from Month 2. Work to reconcile the annual plan phasing of savings with the CIP tracker continues.	3.Escalate to Board

Cost Improvement Programme (CIP) delivery	The Trust has identified £28.6m/£17.8m of unweighted/weighted CIP opportunities respectively against a full year target of £32.8m. This is an improvement of £7m in unweighted CIP since April's Insight Committee. However, there remains a gap of £4.2m. Several high value schemes (e.g. corporate services) will be 'in delivery' imminently, which will significantly increase the weighted CIP position. Challenges with reconciling the baseline 25/26 corporate service budget positions with the 'to be' workforce structures has proved challenging, and has materially affected the anticipated CIP as reductions already made in 24/25 have reduced the starting position against which CIPs have been estimated.	**3** **Partial**	Whilst overall progress is positive, and it is good to see the improvement over the last month, there is still a gap of £4.2 m that needs to be addressed with additional schemes. There is a material risk that further delays, particularly in the major schemes (e.g. corporate services) could deteriorate this position further. The Finance Team is undertaking urgent work to understand the budget discrepancies. It should be noted that there is the potential for an upside, given that in some cases, the 25/26 budgets are significantly higher than the 'to be' workforce models.	Further work is on-going to develop 'stretch' CIPs; the executive team have approved several schemes to proceed, halted some due to safety risks, and continue to develop others Additional consultancy support still needs to be agreed with SNEE ICB. All CIP programme groups now have Non-Executive Director representation which helps improve both oversight and support.	3 Escalate to Board

NHS West Suffolk NHS Foundation Trust

SNEE ICB Double lock panel	The Committee considered a report from the ICB about the operation of the double lock panel process, which that had been considered at the SNEE ICB Finance Committee. The Panel reviews both pay and non-pay expenditure requests from the Trust after requests have first been approved through the Trust's own internal financial controls. Between August 24 and March 25 a total of 74% of all pay requests were supported. The total value of supported non-pay requests was £2.027m, the value of rejected requests was £140k. But the report noted that the value of retrospective requests was £1.237m.	**2 Reasonable**	The Panel expressed their concern to WSFT about the prevalence of retrospective requests and the weakness in internal controls that this suggested. Further internal analysis suggested that some of these were ongoing expenditure such as insurance cover that rolled forward. But it is recognised that there is an ongoing need to ensure the controls in place are managed tightly.	The double lock arrangements will stay in place. The Exec will continue to work with individual services to ensure the controls are fully understood.	1 No escalation

Green Plan	The committee considered a draft of the Trust's second Green Plana. This is a high-level strategy document backed up by a detailed action plan that sets out environmental and sustainability ambitions and targets for the period 2025-2029. Net zero is embedded into legislation through the Health and Care Act 2022. It is a requirement of the NHS Standard Contract for all provider Trusts to have a Green Plan. This plan will cover the period where the Trust will be delivering a new West Suffolk Hospital, with the ambition being to construct this using net zero techniques.	**1 Substantial**	In 2020 the NHS made a commitment to become the first healthcare service in the world to reach net zero. For the emissions we control directly the NHS must reach net zero by 2040, with the ambition to reach an 80% reduction by 2028-2032 from a 1990 baseline (equivalent to a 47% reduction). For the emissions we can influence the NHS must reach net zero by 2045, with an ambition to reach an 80% reduction by 2036-2039 from a 1990 baseline, (equivalent to a 73% reduction). The Green Plan demonstrates the Trust's commitment to playing a leading role in securing a healthy, sustainable Suffolk.	Following Insight Committee's endorsement of the document, the Gren Plan will be reported to Board. The plan is underpinned by action plans which will be delivered between now and 2029. Insight will monitor progress twice a year. It should be noted that the Plan has not been fully costed and new schemes will need to be considered through the Trust's usual financial and business planning processes.	3 Escalate to Board for approval

Board assurance Framework – BAF risk 7 Financial Sustainability	The Trust's Financial Sustainability strategic risk is that we fail to ensure we manage our finances effectively in order to guarantee the long-term sustainability of the Trust and secure the delivery of our vision, ambitions and values. The report updated the risk scores for this risk and the action plan for mitigation.	**3 Partial**	The Trust has a significant underlying financial deficit which, if left unaddressed, would leave the Trust in an unviable financial position. The Trust is in the process of recovering the financial position through a robust turnaround process. Whilst steps are being taken to address this risk, it cannot be completely mitigated at present. The Board Trust appetite is 9. The current risk score is 16 and the mitigated risk would still have a score of 12.	The action plan focuses on - achieving the 2025/26 financial plan within the deficit approved by the March Board. - Developing a long-term financial model and financial strategy - Delivering a training and development programme for appropriate staff (both budget holders and finance staff) to ensure a business mindset is ingrained throughout the Trust. The risk will continue to be monitored by both Insight and the Board.	3 Escalate to Board

Guidance notes

The practice of scrutiny and assurance

	Questions regarding quality of evidence…	***Further consideration…***
What?	***Validity*** *– the degree to which the evidence…* • *measures what it says it measures* • *comes from a reliable source with sound/proven methodology* • *adds to triangulated insight*	• *Good data without a strong narrative is unconvincing.* • *A strong narrative without good data is dangerous!*

Deepening ***understanding*** *of the evidence and ensuring its* ***validity***		
So what? *Increasing* ***appreciation*** *of the* ***value*** *(importance and impact) – what this means for us*	***Value*** *– the degree to which the evidence…* • *provides real intelligence and clarity to board understanding* • *provides insight that supports good quality decision making* • *supports effective assurance, provides strategic options and/or deeper awareness of culture*	• *What is most significant to explore further?* • *What will take us from good to great if we focus on it?* • *What are we curious about?* • *What needs sharpening that might be slipping?*
What next? *Exploring what should be* ***done next*** *(or not), informing* ***future*** *tactic / strategy, agreeing follow-up and future* ***evidence of impact***		• *Recommendations for action* • *What impact are we intending to have and how will we know we've achieved it?* • *How will we hold ourselves accountable?*

Assurance level

1. Substantial	*Taking account of the issues identified, the board can take substantial assurance that this issue/risk is being controlled effectively.* *There is substantial confidence that any improvement actions will be delivered.*
2. Reasonable	*Taking account of the issues identified, the board can take reasonable assurance that this issue/risk is being controlled effectively.* *Improvement action has been identified and there is reasonable confidence in delivery.*
3. Partial	*Taking account of the issues identified, the board can take partial assurance that this issue/risk is being controlled effectively.* *Further improvement action is needed to strengthen the control environment and/or further evidence to provide confidence in delivery.*
4. Minimal	*Taking account of the issues identified, the board can take minimal assurance that this issue/risk is being controlled effectively.* *Urgent action is needed to strengthen the control environment and ensure confidence in delivery.*

NHS West Suffolk NHS Foundation Trust

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			**Date of meeting: 18 June 2025**		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk	**WHAT NEXT?** Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)	**Escalation:** 1. No escalation 2. To other assurance committee /MEG **3.** Escalate to Board
Finance Accountability Committee	**Month 2 Reporting** The Trust had a deficit of £5.2m in May 2025 with a £489k underspend against plan year-to-date. There has been a further reduction in staff numbers with 159 fewer whole-time equivalents In May 2025 compared to May 2024. There has also been a reduction in bank and agency use. Year to date capital spend is £1.15m. This is slightly behind the phased plan but it is anticipated the full plan will be achieved. The CIP programme year-to-date target of £2.9 million was broadly achieved.	**3 Partial**	2025/ 26 will continue to be difficult in terms of cash and the trust is likely to require cash support for the last eight months of the financial year. The CIP programme monthly targets ramp-up significantly through the rest of the year and remains a risk.	Delivery of the CIP programme needs continued focus – see below	3.Escalate to Board

NHS West Suffolk NHS Foundation Trust

Originating Committee: Insight Committee			Date of meeting: 18 June 2025		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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Cost Improvement Programme (CIP) delivery	The Trust has identified £29.1m of unweighted CIP opportunities (£19.5m weighted). 89% of the CIP target has been identified, compared to 68% in April. So there has been further progress but a gap remains of £3.7m/£13.3m unweighted/weighted CIP respectively. Efforts are being focused on high priority schemes and getting them into delivery and developing further high value opportunities. The trust received formal approval from NHSE to contract with PA consulting for delivery support.	**3 Partial**	Further work is needed to ensure the delivery phasing matches the profile of CIP financial targets. The high value programmes where there is significant risk of delivery are corporate services; clinical productivity and commercial. The strategic risks are to do with pace because of the volume of work that is required; capacity due to the breadth and depth of work taking place across the Trust; and resourcing due to some gaps and vacancies. There is also work force risk regarding the capacity to support the large number of evaluation panels for the new job descriptions required.	Further work is on-going to develop 'stretch' CIPs; the executive team have approved several schemes to proceed, halted some due to safety risks, and continue to develop others Additional consultancy support is in place and this needs be maximised. All CIP programme groups now have Non-Executive Director representation which helps improve both oversight and support.	3 Escalate to Board

<table>
<tr><td colspan="3">Originating Committee: Insight Committee</td><td colspan="3">Date of meeting: 18 June 2025</td></tr>
<tr><td colspan="3">Chaired by: Antoinette Jackson</td><td colspan="3">Lead Executive Director: Nicola Cottington/Jonathan Rowell</td></tr>
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2. To other assurance committee /MEG
3. Escalate to Board</td></tr>
<tr><td>PAGG/IQPR</td><td>Elective Recovery

Having narrowly missed achieving the national target in March, performance declined in April. The number of elective patients waiting over 65 weeks increased to 44 and is also set to increase further in April and May.</td><td>3 Partial</td><td>There is a risk of patient harm if patients are not treated in a timely way.</td><td>In response to the Operational planning guidance the Trust is committing to delivering the 5% Referral to Treatment (RTT) improvement to 63.6% through reducing outpatient wait times and increasing activity to increase 18-week compliance. Seven specialties have been identified as those where the impact will be greatest having high volumes but low RTT performance.

Insight Committee will continue to monitor progress.</td><td>3 Escalate to Board</td></tr>
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Originating Committee: Insight Committee			Date of meeting: 18 June 2025		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
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PAGG/IQPR	**Cancer Faster Diagnosis (FDS) Targets** Cancer faster diagnosis performance increased to 79.3% to exceed the 77% standard in March 25. 62 day performance was at 84.2%, also exceeding the 70% requirement Ongoing challenges in breast cancer mean the there is a risk of not achieving the 62 day performance in April, May and June.	**3 Partial**	Achieving the FDS target of 77% and a 62-day performance of 70% by March 2025 were the key objectives for cancer in 2024/25 planning.	The Trust has been removed from Tier 1 for cancer and diagnostic waiting times performance and is now in Tier 2. The Trust has committed to achieving the 62-day standard (75%) and Faster Diagnosis Standard (FDS) (80%) for 2025/26. Gynaecology, skin and lower gastrointestinal (LGI) are the areas of focus for transformation.	1 No escalation

Originating Committee: Insight Committee			Date of meeting: 18 June 2025		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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PAGG/IQPR	**Diagnostics** Diagnostic performance has continued to decline with performance against the six week standard dropping from 53.2% to 47.9% in April 2025. All modalities except cardiology and CT are currently underperforming. MRI performance is improving with additional community diagnostic centre capacity and this is expected to recover by the end of May 25 There is a recovery plan in place for DEXA pending permanent scanner delivery There is also a plan in place in ultrasound, pending recruitment. There is no recovery plan for endoscopy.	**4 Minimal**	Longer waiting times for diagnosis and treatment have a detrimental effect on patients. The risk to further progress is the Trust's ability to recruit staff with the skills required.	As a result of our worsening Cancer and Diagnostic performance we were placed in 'Tier 1' nationally but have now been moved to Tier 2. In the longer-term, Newmarket CDC will help endoscopy performance but there is currently no clear recovery plan for the service and this has been escalated to the June Management Executive Group. There will be a deep dive into the issues around diagnostic recovery at the July Insight Committee.	3.Escalate to MEG

Originating Committee: Insight Committee			Date of meeting: 18 June 2025		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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PAGG/IQPR	**Urgent and Emergency Care** UEC exceeded trajectory for 12 hour waits for April with 12 hour waits as a percentage of attendance sustained at 2.9%. 4 hour performance was 81.35% and above trajectory The improvement in the 30 minute ambulance handover metric was maintained in April Inpatients not meeting the criteria to reside continues to decrease and performance against the urgent community response two-hour standard remains stable.	**2 Reasonable**	Not meeting urgent and emergency standards means some patients are waiting longer in the Emergency Department than they should be and being nursed in escalation areas. The improved performance means fewer patients in escalation areas making for a better patient experience.	THE UEC action plan includes Weekly performance meetings with the Emergency Department and Medical Division senior leaders/Executives. Implementation and monitoring of the cross-divisional workstreams of both the UEC and taskforce projects. Continued focus on length of stay reductions to support flow out of the Emergency Department, including the task and finish group for board rounds planned in June.	1. No escalation

NHS West Suffolk

Originating Committee: Insight Committee			Date of meeting: 18 June 2025		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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Community Services Deep Dive	The committee held a deep dive into how Community Services can enable timely discharges, prevent avoidable admissions and to manage urgent care needs. The report highlighted the key strategies in place and the progress of the shared service delivery project in delivering sustainable efficiencies and high-quality care, closer to home. WSFT has consistently delivered two hour community response above the national target of 70%. There has been a significant increase in community referral numbers especially in nursing indicating a trend of special cause concern.	**2 Reasonable**	The shared service delivery project aims to build a locally based workforce capable of managing higher acute acuity patients efficiently and responsively. One example of this is community delivered IV treatments. The development of local integrated neighbourhood teams has enabled a release of clinical time with less time spent travelling and a cost reduction in mileage claims. The committee noted an increase in integrated neighbourhood team cancelled nursing appointments and work will be undertaken to more accurately record the reasons for this as there is a risk, if demand increases, that the team will not have the capacity to respond fully.	The new Community Geriatrician and Virtual Ward clinical lead began in post at the beginning of June 2025. There is a comprehensive project plan in place to continue to develop the integrated teams. Next steps include full implementation of the workforce changes and a skills gap analysis and training plan is being developed Funding has been secured for point of care testing equipment and a task and finish group aims for a pilot site to offer the first suite of point of care tests in September 2025.	2. MEG will be considering the approach to the community contract renewal

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Originating Committee: Insight Committee			Date of meeting: 18 June 2025		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
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	Virtual ward capacity is 59 at present and average occupancy in May 25 was 55% compared to 67% in February. Average length of stay is well managed and is significantly below target.			Phase three of the virtual ward has an enhanced focus on step up (admission avoidance) to ensure the capacity is fully utilised with an agreed target of 50% step up by November 2025. The Committee noted that the Community Services contract will be up for renewal in 2027. There is a need to plan for this and ensure that the learning from the service informs future contract negotiations. MEG was asked to ensure there is an effective project plan in place for this, involving community services managers from the outset.	

<u>Guidance notes</u>

The practice of scrutiny and assurance

	Questions regarding quality of evidence…	***Further consideration…***
What? *Deepening **understanding** of the evidence and ensuring its **validity***	***Validity** – the degree to which the evidence…* • *measures what it says it measures* • *comes from a reliable source with sound/proven methodology* • *adds to triangulated insight*	• *Good data without a strong narrative is unconvincing.* • *A strong narrative without good data is dangerous!*
So what? *Increasing **appreciation** of the **value** (importance and impact) – what this means for us*	***Value** – the degree to which the evidence…* • *provides real intelligence and clarity to board understanding* • *provides insight that supports good quality decision making* • *supports effective assurance, provides strategic options and/or deeper awareness of culture*	• *What is most significant to explore further?* • *What will take us from good to great if we focus on it?* • *What are we curious about?* • *What needs sharpening that might be slipping?*
What next? *Exploring what should be **done next** (or not), informing **future** tactic / strategy, agreeing follow-up and future **evidence of impact***		• *Recommendations for action* • *What impact are we intending to have and how will we know we've achieved it?* • *How will we hold ourselves accountable?*

Assurance level

1. Substantial	*Taking account of the issues identified, the board can take substantial assurance that this issue/risk is being controlled effectively.* *There is substantial confidence that any improvement actions will be delivered.*
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Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			Date of meeting: 16 July 2025		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	***WHAT NEXT?*** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	***Escalation:*** *1. No escalation* *2. To other assurance committee /MEG* *3. Escalate to Board*
PAGG/IQPR	**Urgent and Emergency Care** Ambulance handover was maintained in May at 94.9% just under the 95% target. The number of 12 hour stay breaches was 237 in May, an improved position compared to April. Non-admitted performance showed no significant change with 86.92% achieved in May. Four-hour performance was 78.5% against the trajectory for the month of 78%.	**2 Reasonable**	Not meeting urgent and emergency standards means some patients are waiting longer in the Emergency Department than they should be and being nursed in escalation areas. The improved performance means fewer patients in escalation areas making for a better patient experience.	There is a continued focus on the UEC recovery plan which includes: Weekly performance meetings with the Emergency Department and Medical Division senior leaders/Executives. Implementation and monitoring of the cross-divisional workstreams of both the UEC and taskforce projects. Continued focus on length of stay reductions to support flow out of the Emergency Department There are also plans to trial an Ambulatory Care Unit within the emergency department footprint.	1. No escalation

PAGG/IQPR	**Elective Recovery** The number of patients over 65 weeks increased in May and is set to increase further in June and July. The Trust is above its submitted forecast for patients over 52 weeks, with 541 patients over the trajectory. The biggest contributors to this are Dermatology and Orthopaedics. 18 week waits performance in May was 55.57% against a trajectory of 57.2%.	**3 Partial**	There is a risk of patient harm if patients are not treated in a timely way. Declining performance in elective recovery against the submitted trajectories has led to the trust has been put into national tiering at Tier 2. Whilst performance is trailing the agreed trajectories this is by relatively small amount and the main issues are in the two specialities of Orthopaedics and Dermatology.	In response to the Operational planning guidance the Trust is committing to delivering the 5% Referral to Treatment (RTT) improvement to 63.6% through reducing outpatient wait times and increasing activity to increase 18-week compliance. Seven specialties have been identified as those where the impact will be greatest having high volumes but low RTT performance. Regular meetings will be held with regional NHSE to monitor the Trust's recovery plans. Insight Committee will continue to monitor progress.	3 Escalate to Board

PAGG/IQPR	**Cancer Targets** Cancer faster diagnosis performance reduced to 69.4% in April due to capacity constraints in Breast specifically. This is below Trust trajectory for April of 74.3%. 62 day performance was sustained at 83.8%.	**3 Partial**	Due to the challenges in breast there is a continued risk to the faster diagnosis standard and 62 day performance.	The Trust has been removed from Tier 1 for cancer and diagnostic waiting times performance and is now in Tier 2. The Trust has committed to achieving the 62-day standard (75%) and Faster Diagnosis Standard (FDS) (80%) for 2025/26. Gynaecology, skin and lower gastrointestinal (LGI) are the areas of focus for transformation.	3 Escalate to Board

Diagnostics Deep Dive	The committee undertook a deep dive into diagnostic performance given the continuing under-performance against targets. The IQPR showed that in May performance dropped again from 47.9% to 43.8%. All modalities except Cardiology, CT, MRI and Urology are currently underperforming. Common themes in the underperforming modalities were inability to recruit staff with the skills and qualifications required. There were also variable rates of non-attendance from patients in the different clinics Community Diagnostic Centre posts are currently only 60% filled but despite this, 15,868 examinations have been undertaken since the centre opened at the end of December.	**3 Partial**	Longer waiting times for diagnosis and treatment have a detrimental effect on patients. The risk to further progress is the Trust's ability to recruit staff with the skills required. It was also suggested that some of the Trust's temporary staffing controls have impacted on performance. There is a need to ensure we are making conscious decisions about the trade-offs between performance and financial savings	Action plans are focusing on productivity and rates of non-attendance, with a number of services now overbooking lists to address this. In NOUS the service continues to pursue international recruitment opportunities and plans to recruit and train two additional trainee sonographers. The Endoscopy action plan has includes additional weekend lists and increased overbooking of morning lists. This should enable performance to increase 34.5% to 50.79%. (Although this would still leave 630 patients waiting over 6 weeks). MEG needs to consider how we ensure there are not unintended consequences from decisions and how trade-offs are clearly articulated and accepted (or not) as part of the decision-making process.	3 Escalate to Board and MEG

Finance Accountability Committee	**Month 3 Reporting** The Trust had a deficit of £7.6m for the year to June 25 which is £0.6m better than planned and continues to forecast meeting the planned deficit of £20.7m for 25/26. This forecast assumes able to delivery of £4.5 million of CIP that has been identified but isn't yet in delivery. The capital plan for 25/26 was agreed at £25.6 million but additional allocations now takes this plan to £33.8 million. £11.5m of this is internally funded with the remaining £22.3m funded by public dividend capital (PDC). Spend to date is behind plan but it is anticipated that the full plan will be achieved with year.	**3 Partial**	Cash balances are healthy but the trust is likely to require cash support for the last eight months of the financial year. The CIP programme monthly targets ramp-up significantly through the rest of the year and remain a risk.	Delivery of the CIP programme needs continued focus – see below	3.Escalate to Board

Cost Improvement Programme (CIP) delivery	The trust has identified £30m of unweighted CIP opportunities (£23.6m weighted) against a full year target of £32.8m. This is an improvement on June and 92% of the CIP target is now identified compared with 68% in April. A gap of £2.8m/£9.2m (unweighted/weighted) CIP remains. The Executive are continuing to finalise stretch CIPs programmes to address the current gap.	**3 Partial**	Further work is needed to ensure the delivery phasing matches the profile of CIP financial targets. The Trust's CIP plans were presented to the ICB and NHSE. They acknowledged the assurance this gave regarding delivery but also recognised the continuing risks in the programme. The high value programmes where there is significant risk of delivery continue to be corporate services, clinical productivity and commercial.	Further work is on-going to develop 'stretch' CIPs; the executive team have approved several schemes to proceed, halted some due to safety risks, and continue to develop others. Any controversial schemes will need discussion with SNEE ICB.	3 Escalate to Board

Board Assurance Framework	**BAF 6 Estates** Neil Jackson, the Interim Director of Estates and Facilities provided a detailed report on the current state of the Trust's estate and the risks being managed. RAAC has been well managed to date by the Trust, but there is a significant backlog of more routine maintenance. The report suggested that there was potentially £17.6m of high-risk issues in the outstanding backlog.	**3 Partial**	Currently only 50% of maintenance tasks are being completed within the agreed service level agreement and the backlog of extra outstanding maintenance increases the likelihood of business continuity and safety incidents. Several incidents have occurred in recent months including two that were reportable under RIDDOR regulations (Reporting of Incidents, Diseases and Dangerous Occurrences).	A number of detailed actions are in train with a focus in the short term on reducing business continuity and compliance risks. More detailed risk assessments are being undertaken to ensure that risks are fully understood and mitigated wherever practical. Short term investment will be necessary to support some of this action and part of this investment will be offset by bringing high-cost maintenance activities in house. This will need ot be considered by MEG.	2/3. Escalate to Board and MEG

Guidance notes

The practice of scrutiny and assurance

	Questions regarding quality of evidence…	***Further consideration…***
What?	***Validity** – the degree to which the evidence…* • *measures what it says it measures* • *comes from a reliable source with sound/proven methodology* • *adds to triangulated insight*	• *Good data without a strong narrative is unconvincing.* • *A strong narrative without good data is dangerous!*

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NHS West Suffolk NHS Foundation Trust

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 21 May 2025
Governor observer : Jayne Neal

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Regular Finance / CIP and Operational Management / IQPR matters discussed • Deep dive into Urgent & Emergency Care (U & EC) • The Trust's Green Plan was presented and the Committee agreed and signed off the Plan
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• The meeting was conducted in line with Trust values throughout • The meeting kept to time with the Chair summing up key points and politely moving the agenda along • Good discussion and engagement on IQPR • Good and positive reflections on the progress with U & EC
Assurances *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*

- Mixed levels of assurance around all Finance / CIP matters but on the whole there is progress
- The improvements in U & EC was a highlight and much of this was down to a multi-disciplinary approach to work and improved ways of dealing with routine duties. Good level of assurance this can be continued

Governor observer Notes

Use this section to highlight any other areas for example good practice or 'even better if'

- A Travel Strategy and Plan will be developed to work alongside the Green Plan. Statutory requirements dictate all work must factor in Green / sustainable planning and implementation

Feedback from assurance committees: Governor observer report

Board assurance committee: <u>Insight</u> / Improvement / Involvement
Meeting date: 18th June 2025
Governor observer (observed by): David Slater

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Good agenda format and the meeting finished on time. • There are issues with regard to how CIP can be achieved
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• *Some of the discussions were difficult to hear, are there microphones in the meeting room. If there are perhaps they could be used?*
Assurances *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
• *The meeting was very well organised and the chair was very good at keeping the meeting on track.*
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• *Already mentioned that the chair was very good and kept the meeting on track.* • *Concerns about how CIP can be achieved.*

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Feedback from assurance committees: Governor observer report

Board assurance committee: ~~Insight~~ / Improvement / Involvement
Meeting date: 18.7.25
Governor observer (observed by): **Tom Murray via teams link**

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• As I viewed the meeting via teams it was the first time I actually heard 98% of what was said.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
Meeting as usual run in a Professional manner, some members must talk up and stop mumbling, I was able to hear everything as I was on teams and not in the actual building.
Assurances *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
• No glaring issues.
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• I am personally happy to view these meetings via teams so I can actually hear what's being said and follow long on convene

NHS West Suffolk NHS Foundation Trust

Feedback from assurance committees: Governor observer report

Board assurance committee: <u>Insight</u>
Meeting date: 16 July 2025
Governor observer (observed by): David Slater

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Good agenda format and the meeting finished on time. • There are issues with regard to how CIP can be achieved this financial year. • Risk Management needs to be monitored as to how the risks are reduced.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• *Same as previous meeting it is still difficult to hear everything which is said and discussed.* • *There are microphones in the meeting room but are not used.*
Assurances *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
• *The meeting was very well organised and the chair was very good at keeping the meeting on track.*
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*

- *Already mentioned that the chair was very good and kept the meeting on track.*
- *Concerns about how CIP can be achieved.*

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 16 July 2025
Governor observer (observed by): Jane Skinner

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• It was the turn of operations to present first. • Excellent papers, relevant data and insightful presentation on estates.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Chair ensured everyone was introduced to each other. We were invited to sit at the table. As usual the acoustics were not good for quiet speakers, a point picked up by the Committee Chair. • There were 4 observers attending the meeting; 3 Governors and a senior operations manager on a development pathway with CEO (not present). Trust Chair and 4 other NEDs present. • The majority of NEDS were proactive in their contributions to the meeting • Reflection included: positive points made, curiosity, constructive challenge, assurance sought and provided, pragmatic, flexible agenda to meet needs of presenters, active listening. My reflection is that not everyone contributed. • Thanks and appreciation was given to the Chief Nurse who is retiring.
Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*

* Concerns were expressed regarding MRI, CT and US waiting times, the latter due to a national shortage of sonographers, inability to recruit and reduction in temporary staff spend. DNA at 7%. Governors can be assured of the oversight of the situation with some processes in place for improvement. A new Dexa machine is in place so that waiting list situation (discussed at previous meetings) will improve.
* A difference in endoscopy performance between ESNEFT and WSFT was flagged as WSH is poorly performing so can something be learnt from ESNEFT? Interesting challenge and a reference to developing better collaboration.
* What effect are/will some of the CIPs implemented and outlined have on the patient experience? Governors need to have further understanding and assurance from NEDs
* In Tier 2 for waiting lists, again Governors need further understanding of what that means.
* Estates presentation highlighted many challenges, the deep dive was scheduled as estates are red on the BAF, after the presentation it was felt that the BAF did not reflect the detail of the risk. Governors can be assured by the oversight now in place and that progress will be reported back to the assurance committee.

Notes

* Good news on all ED performance targets
* A VW consultant has been appointed to facilitate step up patients
* Lots of information discussed in the delivery of finance papers of note the expected pay rise is fully funded, the Trust is (so far) on target for planned deficit. Future CIPs outlined.

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date:16 July 2025
Governor observer : Jayne Neal

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Usual Finance / CIP and Operational matters discussed • Deep dive into the performance of the Trust's diagnostic services • Review of the wheelchair services contract
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• The meeting was conducted in line with Trust values throughout • 'Active' listening prompted insightful questions and challenge around the table • Good summaries of discussions from Chair and forward actions and consultation over a couple of issues with Improvement Committee
Assurances *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*

- Mixed levels of assurance around diagnostic services; some areas performing better than others; National shortages of staff impacting in some service areas; e.g. Ultra Sound, and the CTC is still not functioning fully for these reasons.
- The Dexa scanner has now been delivered but will take time (some months) to show improved results

Governor observer Notes

Use this section to highlight any other areas for example good practice or 'even better if'

- Future business planning activities will focus on improving diagnostics by taking a broad view across all services.
- The supply of wheelchairs has been reviewed and it has been decided to continue with the current provider which will align with the Mediquip provision and gives the best value for money.

9.2. Improvement Committee

To Note

Presented by Ewen Cameron

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Improvement Committee			**Date of meeting: 21 May 2025**		
Chaired by: Roger Petter			**Lead Executive Director: Susan Wilkinson, Richard Goodwin**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
5.1 **PQSGG**	**Mortuary Services** Human Tissue Authority inspection 2024 made recommendations for refurb. Medical Examiner staffing issues (sick leave and impending vacancy). Funding shortfall.	1 2	Fridge room will be out of action for 4d during refurb. Bereavement room refurb to start July 2025. Role is a statutory requirement. Currently able to mitigate demand, and service being reviewed within funding available	. Mitigations are in place for storage of deceased patients during this time. Conversations with ICB are already in hand re funding shortfall.	1
5.1 **PQSGG**	**Temporary Escalation Spaces (corridor care)**	2	Need to minimise risks to patients and impact on staff. Significant improvement in March 2025 due to ED improvements.	Future plans for TES Group include harm reviews, incident reviews, staff survey results	1
5.1 **PQSGG**	**Hospital Transfusion Committee**				

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	Non-implementation of a closed loop system -> some ongoing risks assoc with traceability and blood sample labelling	2	System reduces error risk, which could -> sample rejection, incompatible blood transfusions or delay in blood availability.	Joint IT / Pathology paper to be submitted to MEG in May to consider alternative supplier.	1
	Decline in the closure of incident investigations within 30 days	2	MHRA standard for review and closure is 100%.	Patient safety team to review escalation times, and measures to increase attendance at HTC meetings.	
	Blood labelling competency has improved though not meeting target	2	Risk of errors, including wrong blood administration	Audit of non-compliance to be undertaken. Action plan to be discussed at next HTC.	
5.1	**Deteriorating Patient Group**				
PQSGG	Sepsis – early administration of antibiotics	2	This is a KPI. Early recognition and intervention reduce mortality. Improving, but not yet at target.	NICE guidelines have changed. eCare workflow will implement these changes in Sept 2025.	1
	BLS Compliance. Medical staff compliance up from 53% Nov 2024 to 67% April 2025. Nursing staff compliance steady at 89%	2	Interventions include additional BLS sessions, training at inductions and in the workplace, sessions on audit days. External	Continue to monitor. Medical staff compliance continues to improve.	

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			training paused to prioritise Newborn LS.		
5.1 **PQSGG**	**<u>Dementia, Delirium and Frailty</u>** Dementia Pathway near completion Least Restrictive Practice Panels being piloted in Q1 on G5 and G10. Delirium Discharge Nurse: role will end in 2025 as ICB funding discontinued. National Audit for Dementia Outputs	2 2 4 2	This will help more consistent support with continuity of care and ensuring ward-based interventions occur before specialist advice is sought. Ensure any restrictive practice is proportionate to risk of harm, and that less restrictive options have been considered. Aim to learn from incidents requiring hands-on or chemical restraint. Role supports discharge to help reduce length of stay and ensure input continues post discharge. Most scores have improved, though not all are reaching national average.	Plan to go live 19th May. Compliance to be monitored through Information Team reports. Ensure learning and good practice is shared. Will progressively be extended to other ward areas. These activities will be performed by ward team and the discharge hub. Data will be analysed to monitor impact of this. Dementia Group will monitor areas for improvement	1

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5.1 **PQSGG**	**Mortality Oversight Group** SHMI Morbidity and Mortality SOP	1	SHMI continues to show fewer than expected deaths and WSFT is performing best in East of England. This ensures clear procedures, and that data is available for audit and for WSFT mortality database.	Continue to monitor Continue to monitor. Sustained improvement seen since introduction of SOP.	1
5.2 **CEGG**	**Accreditation – Cellular Pathology**	2	Currently in year 4 (of 4) of the accreditation cycle.	Accreditation on track and achievable with some work	1
5.2 **CEGG**	**Accreditation - Anaesthetics**	3	Achievable but a number of challenges. Anaesthetic associates will need protected time for CPD, appraisal and revalidation (now regulated by GMC)	To be delivered by the service through PRMs	
5.2 **CEGG**	**Life cycle of a clinical audit – National Audit of Dementia**	2	Some aspects going well (eg delirium screen on admission 95%, driven by eCARE), others need improvement (eg initiating	Many steps already in place or development, eg Dementia Care	1

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			discharge plan in first 24 hours, carer ratings 55/100 for quality of care and 53/100 for communication)	Pathway and Least Restrictive Practice pilots. Next round of audit 2026.	
5.2 **CEGG**	**National and Local Clinical Audits**	2	WSFT involved in most national mandated audits. Has withdrawn from 4 programmes: Perioperative QIP, Adult Asthma Secondary Care, COPD Secondary Care, National Inflammatory Arthritis Audit.	Upcoming vacancies in clinical audit team likely to affect support available. Any future possibility of withdrawing from a mandatory audit will need to be discussed with CD, MD and other execs, as appropriate.	
5.2 **CEGG**	**Getting it Right First Time** No centrally reported oversight of GIRFT process	3	Aim is to improve patient care by reviewing services, benchmarking, and using data to support change. Clinical and operational aspects underlie all activity.	Strategy and Transformation team to consider coordinated framework, bearing in mind that GIRFT is just one of several lenses on quality and outcomes. Review September.	
6.3	**Patient Safety and Quality report**	2	Reporting figures remain steady.	Learning outcomes: good evidence indicating avoidance of blame language; factual	1

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	Quarterly report, Q4 2024/25 These quarterly reports now come to Improvement Committee rather than direct to Board		83% of incidents reported in Q4, and 83% of reportable occurrences, had learning outcomes completed. 96% of incidents and ROs reported in Q3 were quality controlled and closed. 554 safety actions were completed in Q4. 32 Emerging Incidents were discussed.	statements generally used; written reports generally clear and easy to read. Numerous areas for improvement identified and approved, including those measures in 7.1 GIRPS. "Let's Talk Safety" walkabouts are due to start, to help improve our safety culture.	
7.1	**<u>Quality Priorities – Getting it Right for Patients and Staff (GIRPS): Place, Service, Pathway</u>** Update 1 of 4		This was chosen as a priority at a trust-wide summit. Patient safety incidents that have been included in PSIRP are investigated to produce safety actions and areas for improvement in order to mitigate risks. Components of care that can be a focus are: inappropriate referral; safest handover; safest discharge; right patient, right time, right place; service provision.	'Safest handover' has been chosen for an initial scoping exercise. Project group to be established and will look at overall aims, change ideas, data sets, identification of areas for improvement. Project to be completed by April 2026. Update 2 in Sept 2025.	1

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7.2	**CQC Update** Improvement Committee maintains oversight of CQC preparedness. Nationally, CQC continues to evolve as part of its development process. The 34 new Quality Statements are divided into key questions: Safe; Effective; Caring; Responsive; Well-led. Core areas are divided into Acute and Community Health, as before.	2	We are informed that inspections are being undertaken on a risk basis rather than a schedule based on time of last inspection. 2 nearby trusts have had recent inspections, and we are seeking feedback from them. Relationship meetings between CQC and WSFT have restarted, the first on 8 May. Numerous discussions covered all 5 domains, but without significant concerns raised. We have had 6 contacts from CQC in 2025 requesting info on specific concerns. 32 cases of concern have been raised in last 6 months with themes including: whistleblowing concerns re culture / bullying; staff shortages; poor discharges.	Focus at specialist committee level is underway, with Infection Prevention Committee and Medication Safety Group scheduled to review relevant aspects over the next couple of months. The relationship meetings are a very positive step and will continue quarterly. All the concerns raised at the recent meeting were closed with no further information requested.	1

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

	Questions regarding quality of evidence…	Further consideration…
What? Deepening **understanding** of the evidence and ensuring its **validity**	**Validity** – the degree to which the evidence… • measures what it says it measures • comes from a reliable source with sound/proven methodology • adds to triangulated insight	• Good data without a strong narrative is unconvincing. • A strong narrative without good data is dangerous!
So what? Increasing **appreciation** of the **value** (importance and impact) – what this means for us	**Value** – the degree to which the evidence… • provides real intelligence and clarity to board understanding • provides insight that supports good quality decision making • supports effective assurance, provides strategic options and/or deeper awareness of culture	• What is most significant to explore further? • What will take us from good to great if we focus on it? • What are we curious about? • What needs sharpening that might be slipping?
What next? Exploring what should be **done next** (or not), informing **future** tactic / strategy, agreeing follow-up and future **evidence of impact**		• Recommendations for action • What impact are we intending to have and how will we know we've achieved it? • How will we hold ourselves accountable?

Assurance level

1. Substantial	Taking account of the issues identified, the board can take substantial assurance that this issue/risk is being controlled effectively. There is substantial confidence that any improvement actions will be delivered.
2. Reasonable	Taking account of the issues identified, the board can take reasonable assurance that this issue/risk is being controlled effectively. Improvement action has been identified and there is reasonable confidence in delivery.
3. Partial	Taking account of the issues identified, the board can take partial assurance that this issue/risk is being controlled effectively. Further improvement action is needed to strengthen the control environment and/or further evidence to provide confidence in delivery.
4. Minimal	Taking account of the issues identified, the board can take minimal assurance that this issue/risk is being controlled effectively. Urgent action is needed to strengthen the control environment and ensure confidence in delivery.

Board assurance committee - Committee Key Issues (CKI) report

<table>
<tr><td colspan="3">Originating Committee: Improvement Committee</td><td colspan="3">Date of meeting: 18 June 2025</td></tr>
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<tr><td>5.1

PQSGG</td><td><u>Safeguarding Children and Young People</u>

Medical photographs

Vacancy in Community CYP in July

Mandatory Training: Community services 91%, Acute Services 89%</td><td>1

1

2</td><td>Photographs now admissible in court.

Role still required and gives an opportunity to review safeguarding provision across the Trust.

Not meeting requirements</td><td>Image storage needs reviewing from a data protection perspective. Otherwise launch imminent.

Adult and CYP leads to collaborate on future service provision.

May require a similar approach to BLS training in order to improve training of medical teams</td><td>1</td></tr>
<tr><td>5.1

PQSGG</td><td><u>Adult Safeguarding</u>

No Level 3 adult safeguarding training outside the Safeguarding Team.</td><td>4

2</td><td>Not meeting requirements

Ensure patients have given consent for treatment. Restorative Safeguarding</td><td>On risk register.

Paper scheduled for Mandatory Training Steering Group June 2025.</td><td>1</td></tr>
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	Mental Capacity Act assessments may need to be improved (suggested by audit data)		Supervision Model has been offered to G3, G4, G10, to demonstrate change in these areas	Early signs of improvement in the quality of MCA assessments in these 3 areas.	
5.1 **PQSGG**	**<u>Mental Health</u>** CQC recommend that staff in acute trusts have training to increase awareness of poor MH Increased demand for MH beds Concerns over the complexity of patients with challenging behaviour	1 2 2	Training delivered to areas of greatest need: ED, AAU, F7 This results in admission to acute beds and prolonged length of stay: MH intervention tends to be delayed whilst in acute beds. The principles of least restrictive practice should be followed	Not currently mandatory. Further training being rolled out to matrons and ward managers. Mental Health Strategy being developed by MH team. Continues to be monitored through Bed Wait audit, escalation meetings, and engagement with system partners. Least restrictive practice pilots on G5 and G10, to learn from these events.	1

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5.1 **PQSGG**	**Thrombosis** VTE baseline assessments show good compliance	3	This ensures correct prophylaxis is given to reduce VTE. The challenge is to ensure that the assessments lead to appropriate prophylaxis.	Audits are planned. Not entirely clear whether or not there is an issue. The Emerging Incident Reviews will pick up cases if this is the case.	2 Further assurance has been sought from the Thrombosis Group
5.1 **PQSGG**	**Learning Disability and Autism** Oliver McGowan training compliance is low. Tier 1 for all patient facing staff completed by 260 staff across the trust, but Tier 2 for Band 7 senior staff only done by 30.	4	This training is now mandatory. ICB is currently offering Tier 2 training.	Need to ensure all Band 7s have received training before ICB offer is withdrawn. DCN to raise at PRMs and ward manager meeting. Once senior staff are trained, they can help disseminate the information.	1
5.1 **PQSGG**	**Safer Surgery Group** National Safety Standards for Invasive Procedures (NatSSIPs 2) – good compliance in theatres, but additional areas	4	Required national standard. NatSSIPs 2 now includes additional measures for more minor procedures.	A deep dive is planned and will report to Improvement Committee.	1

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	identified that may not be compliant.				
5.2 **CEGG**	**Accreditation – Biochemistry (Pathology)**	2	Surveillance visit March 2025. Year 2 of 4-year cycle.	Achievable with work: Audits and KPIs are on target	1
5.2 **CEGG**	**Accreditation – Radiology: Quality Standard in Imaging** (moved from UK Accreditation Service)	2	In Year 3 of a 3-year cycle. Date of Year 3 assessment tbc. Currently meeting all QSI standards.	Newmarket CDC will be included in future accreditation. Progress being made on Non-Medical Referrals	1
5.2 **CEGG**	**Life cycle of a clinical audit – National Emergency Laparotomy Audit**	3	Good areas include pre-op assessment and theatre presence of Consultant Surgeon and Consultant Anaesthetist for high-risk patients, and also timely arrival in theatre. Areas for improvement include increased Geriatric support, and mortality data. We are an outlier	Mortality to be discussed at Mortality Oversight Group, Surgical Clinical Governance meeting (June) and joint General Surgery and Anaesthetic meeting (Sept). Geriatric support and considering ReSPECT forms & EoL care planning will help inform the	1

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			in overall mortality (WSFT av 13.8%; National av 9.8%)	decision whether to operate or not. MD to lead a rapid review and report back to Improvement Cttee	
5.2 **CEGG**	**Life cycle of a clinical audit – National Audit of Care at the End of Life** 10% of annual deaths included in the audit	2	Areas for improvement: need earlier recognition of end of life. Survey results scored poorly in Communication, Care and Support Offered. Areas going well: good presence of palliative care team and EoL volunteers.	End of Life Group to consider. Results are shared at relevant groups (eg Mortality Oversight Group and EoL Operational Group) and are fed into the EoL Improvement Plan. Earlier recognition of EoL will help avoid unnecessary investigations and procedures.	1
5.2 **CEGG**	**Public Health: Prevention, Health Inequalities and Personalised Care Strategy** 6-monthly report. Sequential 2-year action plans.	2	Overall, we achieved a good delivery of our 2023-25 action plan, particularly given our financial constraints. Completion of 2023-25 action plan: 9 actions complete, 6 actions rated green, 1 action rated amber, 2 actions rated red	A new 2-year action plan for 2025-27 has been produced. This needs to be discussed at MEG.	1

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			(improving the accuracy of recording of protected characteristics in EPR, and doubling the number of people identified as having a learning disability)		
6.3	**<u>Quality Faculty Update – End of Life Programme:</u>** **<u>ReSPECT Quality Improvement Project</u>** (Recommended Summary Plan for Emergency Care and Treatment). This replaced DNACPR forms and is now held within eCARE. Update 1 (of 4)	2	It aims to ensure that treatments are planned in advance through discussions between a person (including CYP), their family and their health & care professionals. On admission, the CPR status should be added to eCARE. Audit shows that a ReSPECT conversation and documentation is sub-standard for 'DNACPR' patients. Project aims to Improve EoL recognition, improve family involvement, and improve communication.	Quality Group has agreed aims and process. A daily compliance report is produced which gives reporting metrics for the QIP. Future work will include timeliness (policy is within 72 hours). Aim is to improve timeliness and quality of ReSPECT by June 2026. Next update September 2025.	1

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			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
7.1	**Maternity Services Update** Neonatal Medical Workforce Planning	1	Requirement to meet set standards (part of Maternity Incentive Scheme). In the 6-month period assessed, cover of weekday neonatal sessions was 100%, and 100% of paediatric consultants had done the required 8 hours of neonatal training.	Monthly monitoring and 6-monthly reporting to continue. Escalation pathway exists for short- and long-term shortages. Ensure that recruitment and retention of staff are key priorities, and forward planning minimises the impact of vacancies	1
7.1	**Maternity Services Update** Maternity Claims Scorecard (01/04/2014-31/03/2024); Incident and Complaint Data (01/01/2024-31/03/2024) Quarterly review	2	In last 10 years, maternity claims for the Trust are approx £32.3 million, with the average claim approx £1.07 million. This is about 49% of the cost of all claims (national average about 60%). Leading causes by volume of cases are unnecessary pain, bladder damage, intraoperative problems and psychiatric injury.	Learning from cases, and the dissemination of this learning remain key focuses. Themes from incidents in Q4 include screening issues, medication errors, early care of neonates, and measuring neonatal oxygen sats at 6 hours. During Q4 there were 5 perinatal deaths and 1 maternal death in the Trust. These are notified as required, and detailed analyses	1

Originating Committee: Improvement Committee			Date of meeting: 18 June 2025		
Chaired by: Roger Petter			**Lead Executive Director: Susan Wilkinson, Richard Goodwin**		
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			Largest value causes are cerebral palsy, sepsis and cardiovascular conditions.	are undertaken to identify any learning. Any changes to practice are audited and monitored.	
7.2	**Improving the Quality and the Timely Completion of the Transfer of Care Summary Letter** This was a 2024/25 Quality Priority and numerous measures were put in place. It remains a Trust priority.	2	Sending the discharge summary to primary care within 24 hours is a contractual obligation, with a target 95%. In 2023 the rate was 80-85%. Patients in ED were most likely to fail the target, for several identified reasons. Human factors and IT (eCARE) factors were both important, and both have been tackled. Current rates are 89.1% (non-elective meetings) and 90.1% (elective).	Excellent progress. A new digital platform is scheduled for 1 July 2025, which is much more streamlined. Induction training, audit, and work with both primary care and ED should all help. Updates will be reported to Improvement Committee on a quarterly basis.	1
8.1	**BAF 4 Update**	2	Improvements are being made. Risks are being addressed.	Progress will be reported to MEG and to Improvement Committee.	1

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*See guidance notes for more detail

Guidance notes

The practice of scrutiny and assurance

	Questions regarding quality of evidence…	Further consideration…
What? Deepening **understanding** of the evidence and ensuring its **validity**	**Validity** – the degree to which the evidence… • measures what it says it measures • comes from a reliable source with sound/proven methodology • adds to triangulated insight	• Good data without a strong narrative is unconvincing. • A strong narrative without good data is dangerous!
So what? Increasing **appreciation** of the **value** (importance and impact) – what this means for us	**Value** – the degree to which the evidence… • provides real intelligence and clarity to board understanding • provides insight that supports good quality decision making • supports effective assurance, provides strategic options and/or deeper awareness of culture	• What is most significant to explore further? • What will take us from good to great if we focus on it? • What are we curious about? • What needs sharpening that might be slipping?
What next? Exploring what should be **done next** (or not), informing **future** tactic / strategy, agreeing follow-up and future **evidence of impact**		• Recommendations for action • What impact are we intending to have and how will we know we've achieved it? • How will we hold ourselves accountable?

West Suffolk NHS Foundation Trust

Assurance level

1. Substantial	Taking account of the issues identified, the board can take substantial assurance that this issue/risk is being controlled effectively. There is substantial confidence that any improvement actions will be delivered.
2. Reasonable	Taking account of the issues identified, the board can take reasonable assurance that this issue/risk is being controlled effectively. Improvement action has been identified and there is reasonable confidence in delivery.
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Board assurance committee - Committee Key Issues (CKI) report

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<tr><td>Action Log</td><td>National Laparotomy audit</td><td>3</td><td>Previous report had shown WSH was an outlier in terms of mortality.</td><td>Most recent data suggests a return to trend. Our teams are in discussion with NELA. Await next NELA report.</td><td>1. No escalation</td></tr>
<tr><td>5.1</td><td>Pressure Ulcers</td><td>3</td><td>Inconsistencies identified in reporting whether ulcers were present on admission or acquired during care. Change in assurance process has potentially increased ‘new/acquired in care’ category.</td><td>The Patient Safety team is conducting a data diligence exercise to clarify ownership and improve accuracy.
Focus on resetting baselines and identifying high-prevalence areas.</td><td>1. No escalation</td></tr>
<tr><td>5.1 3</td><td>Appropriate use and risk assessment of using bedside rails</td><td>3</td><td>Concerns raised about inappropriate use of bed rails continue despite eCare risk assessment and publication of safety alert.

Staff often use and relatives request them for perceived safety without understanding risks.</td><td>Launch a pilot ward initiative to educate staff on appropriate use.
Integrate into a QI (Quality Improvement) programme.
Include both acute and community settings for broader impact</td><td>1. No escalation</td></tr>
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5.2.4	**Compliance with National Audits**	3	WSH does not partake in all Nationally requested audits and there was uncertainty whether this was required by the standard contract	RG to determine if Nat Audits a requisite of standard contract	1. No escalation
7.1	**NatSSIPS 2**	3	**NatSSIPS 1** was introduced in **2015** to reduce 'never events'. Version 2 was broadened to include all "intervention" irrespective of location. WSH is currently not compliant	RG to develop a risk based approach and report back Oct	1. No escalation
7.2	**Diabetes**	3	The Committee could not assure compliance with HCL rollout targets.	**Workforce planning**: Need for a strategic workforce development plan (CNS review has been completed, with recommendations around strengthen workforce and future opportunities). **Primary care transition**: Interface group to explore better type 2 diabetes management in primary care. **ACTION:** Type 2 diabetes primary care management plan to be developed and discussed at the Clinical Interface Group **Follow-up**: Diabetes team to return in six months with updates on above.	1. No escalation

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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What next? Exploring what should be **done next** (or not), informing **future** tactic / strategy, agreeing follow-up and future **evidence of impact**		• Recommendations for action • What impact are we intending to have and how will we know we've achieved it? • How will we hold ourselves accountable?

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Feedback from assurance committees: Governor observer report

Board assurance committee: <u>Improvement</u>
Meeting date: May 21st 2025
Governor observer (observed by): Jane Skinner

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
Usual high standard of reports and presentations.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Well Chaired, introductions, everyone had a say, good pace. Volunteer for reflection also collated actions which are agreed at the end. Finished on time, agenda didn't seem as full as usual. • Trust values evident, listening, constructive challenge, respectful. Team work and working together a theme.
Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
• The patient safety and quality report was presented. It contained very brief outlines of incidents. I had detailed knowledge of one incident and I was surprised to read the outline as it failed to convey the serious nature of the incident. I wondered how much detail was missing from the other incidents outlined and whether a whole picture of risk was being presented. "Duty of Candour" terminology has changed is now being "open and honest". • There has been an increased focus on sepsis for the last 30 years, in 2003 the first guidelines for sepsis and septic shock were published internationally. In 2015 the sepsis care bundle became effective. It is disappointing that not all patients with

sepsis are diagnosed promptly, investigated and treated according to the latest research. Data was presented, but not discussed at the meeting, evidencing delays in recognition and initial treatment of sepsis.
Notes
• The meeting noted that the Trust has not been inspected by the CQC for some time. It is important for staff to be equipped with the right knowledge in order to answer CQC questions.

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NHS Foundation Trust

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight / **Improvement** / Involvement
Meeting date: 21/5/25 & 18/6/25 (amalgamated)
Governor observer (observed by): Andy Morris

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Delay and lack of traction in GIRFT programme as resources diverted to CIPs and potential lack of focus on quality of care. Delayed til September and currently no clinical lead. • No funding for a dementia lead now that non-recurrent funding ceased. • Concern over loss of funding for the Medical Examiner post. • Concern over mortality rates and LOS for patients in NELA audit. • 4 national audit data sets no longer being submitted: asthma, arthritis, COPD, PQIP • Quality lead asking for forcing digital prompts to improve standards of care. • Excellent PSQ report from Jenni Kerr. • Concern expressed regarding timeliness and compliance for L&D training
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Chair always welcoming to attendees and observers. Always focussed and keeps to time. Allows open and safe discussion. • Chair clearly studies the papers forensically • Good challenge and tenacity by the Chair and NEDs on matters of concern. • Chair and NEDs also acknowledge and commend high standards of care where appropriate. • The CEO is always focussed.

• Some of the Execs spend time going through emails and are less focussed.
Assurances *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
• *None*
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• Given the concerns regarding the balance between finance and safety, it would be helpful to hear more from the MD to reassure/assure.

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NHS Foundation Trust

Feedback from assurance committees: Governor observer report

Board assurance committee: Improvement
Meeting date: 18th June 2025
Governor observer (observed by): Sue Kingston

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• PQSGG • CEGG Report • Quality Faculty Update • Maternity Services Update
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• The Chair welcomed attendees and introductions were made round the table. • The meeting was polite and respectful. Attendees were all given the opportunity to speak and contribute and to feel comfortable in doing so. • The Chair was thorough and respectful in the handling of the meeting. • RA agreed to observe and reflect on the meeting. • I felt trust values were maintained.

&

Assurances

- PQSGG Report showed that Oliver McGowan training that is now mandatory in LD&A is extremely low. NED raised the question that the Oliver McGowan training is a massive commitment for any staff so not surprised with current staffing levels that the uptake has been low. However, they wanted assurances as to how this would be addressed, given that training is mandatory. Partial assurance was given that the focus going forward, will be to ensure that senior staff are trained before the ICB withdraw their current training. It was felt that senior staff could then pass down their learning to the team.

- CEGG Report highlighted that because of the NELA audit, WSFT has significantly higher mortality figures than the national or indeed regional figures. To obtain assurances, this has been referred to the Mortality oversight group to consider and the data from the audit to be discussed at the surgical clinical governance meeting in June and the joint general surgery and anaesthetic meetings in September, to facilitate the development of effective change and improvements.

- ReSPECT process. An interesting update on this process which aims to improve end of life care and refresh with three distinct components, Improve EOL recognition, Improve Family involvement and Improve communication. It's re-assuring to see a focus on this area which will create personalised recommendations for clinical treatment in any future emergency. This becomes vitally important if the patient is unable to make or express a choice at that time.

Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• Reflections on the meeting provided by RA. Comments reflected on the assurances gained, and when assurances could not be provided, the actions required going forward. RA also commented on this being the Chair's last meeting before stepping down as an acting NED. He gave thanks on behalf of the committee for his dedication to the hospital over the years and indeed acting as Chair on frequent 3i's committees. The chair was given a round of applause, which was justly deserved!

West Suffolk NHS Foundation Trust

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight / **Improvement** / Involvement
Meeting date: 16.7.25
Governor observer (observed by): Andy Morris

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Deep dive into diabetes care • Understanding pressure ulcer data • Lack of compliance with national audits and compliance with NICE guidance and implications of this (contractually and clinically) • Overall a lack of assurance around clinical effectiveness • NATSSIPS 2 plan to come to Improvement in October with a plan, a year after its launch
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Chair welcoming and will carry out a re-fresh by speaking individually with all members for their thoughts • Chair held Execs to account and very clear in what was expected with a timeline • Chair repeatedly brought relevant Execs into a conversation where appropriate • Chair had detailed knowledge of papers • Chair praised clinical outcome in IPQR and the work put into them • Strategy Exec very engaged and curious • NED very engaged, tenacious but appropriately so, pragmatic and supportive

- Some good Exec to Exec challenge and debate
- Finished just ahead of time with a good summary by the Chair
- Some people in the room distracted by emails and calendars

Assurances

Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.

- *I feel the delays around moving the clinical effectiveness agenda are growing but to offset that the Chair has now "called time" so would hope to see Improvement oversee this*

Governor observer Notes

Use this section to highlight any other areas for example good practice or 'even better if'

- The deep dive into DM was excellent and a wake-up call. Would be great to see tangible support for the team.

West Suffolk
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Feedback from assurance committees: Governor observer report

Board assurance committee: <u>Improvement</u>
Meeting date: July 16 2025
Governor observer (observed by): Jane Skinner

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
Usual high standard of reports and presentations. Agenda was delivered in the order presenters became available. Unfortunately embedded reports cannot be accessed by committee members, they should be presented as appendices to reports.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• A new NED Chair for this meeting; volunteered to give his reflection and maintained his own action log. • Both actions, timescale and ownership were made very clear to committee members. Good time keeping. • Reflections included – good input and challenge and inclusive. Well chaired with definite focus on quality and patient care/experience
Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
There was focus on gaining assurance from the committee, for example: • More work required on data collection for PUs, education on use of bed rails and patient falls to deliver assurance to the committee. I wondered how patients on the VW were assessed for PUs and falls at home.

- We heard about the complexities of Hybrid Closed Loop (HCL) monitoring, which is the proposed method of monitoring/insulin delivery in the future for all Type 1 diabetic patients; a target is mandated by NHS guideline which is not going to be reached at current transition rate; not assured
- Some audits such as for asthma and COPD are not being completed, committee not assured.

  The chair ensured that where there was no or not sufficient assurance that the issue was picked up as an action and a committee member was made responsible for bringing information on progress back to the committee.

Notes

- Next meeting the committee will receive a presentation on the Penny Dash report. This is a review into the operational effectiveness of the CQC (Oct 24) on the Gov.UK web site; Governors may find it interesting reading.
- Excellent presentation (deep dive) by the diabetes team/consultant. There are clearly staffing issues within the team making some aspects of care delivery challenging and not as timely as desirable. Discussion over moving patients with Type 2 diabetes to GP care to free up time for better management of Type1 patients. Frightening statistics on the increase of diabetes in the population.
- Having been aware of issues with the provision of discharge summaries over the last 7 years as a governor it was really good news that progress has been made and a new method of ensuring compliance instigated.
- It was suggested that a refreshed quality strategy is required.

Feedback from assurance committees: Governor observer report

Board assurance committee: Improvement
Meeting date: 16th July 2025 (observed by): Sue Kingston

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• NatSSIP's Report • Diabetes Deep Dive • PQSGG Report June 2025 • CEGG Key issues report
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• The Chair welcomed everybody and asked for introductions for the benefit of any new members. • The Chair was thorough and respectful in the handling of the meeting. • Disappointing to see that nobody volunteered to reflect on the meeting. It was then left to the Chair to do this at the end. • Trust values were maintained throughout. • Quite a few apologies for this meeting and the attendance were the smallest I have ever seen. • Meeting ran slightly different to the schedule due to staff being unavailable at their allotted times but arriving later to present.

Assurance

Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.

- Excellent Diabetes Deep Dive presentation with alarming statistics from Public Health England showing ever increasing rates of T1 & T2. Presentation also highlighted lack of knowledge/education/special interest within primary care including both GP's and nurses is causing inequality in patients having their care processes carried out annually, resulting in more cases for the hospital. Current Diabetes team under considerable pressure, staffing issues and some job vacancies on hold due to current financial restraints.
- PQASG reports on pressure ulcers, assurances being sought through requested steering group supporting targeted intervention and personal education resources being developed to support staff awareness. Update requested at next PQSGG rotation of PUPG steering group in September.
- Continuing concern over the use of bed rails. On Audit, only 50% of risk assessments that advise against use are being adopted. Despite training, staff often raise rails by default due to safety concerns, particularly when under staffing pressures. NED raised that training is not working, and it was suggested that a pilot ward be set up to provide better focused training to address this issue.

Governor observer Notes

Use this section to highlight any other areas for example good practice or 'even better if'

- The reflections of the meeting were given by the Chair. Actions agreed. Highlighted re-assurance required for Diabetes deep dive studies and to be reviewed in 6 months.
- This was the first time the new Chair had led the Improvement Committee following RP stepping down from the role. He stated his plans and expectations for the committee going forward with a request to meet with all heads of departments and to ensure that the committee became a focus for real improvement, as it names states. Also to look further into arears of possible repetition that could be happening within the various committees, sub committees, focus groups etc.
- The Chair also gave mention that this meeting was the last for the Chief Nurse who is retiring at the end of the month. He thanked her for her dedication and hard work especially within this committee and her invaluable contributions.

9.3. Involvement Committee

To Note

INVOLVEMENT COMMITTEE REPORT

Originating Committee: Involvement Committee			**Reporting to: Trust Board**		
Chaired by: Tracy Dowling Non-executive Director			**Date of meeting:18th June 2025**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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5.1	Action log: Action 44 - revisit issues raised by staff governors a number of months ago to assess progress	2. Reasonable	Issues have been considered at regular intervals in a number of oversight committees	Julie Hull to attend staff governors' development session 1st July 2025 to explore further	1. No escalation
6.0	Recent announcements affecting workforce	3. Partial	• Use of Apprenticeship Levy changing from 1 January 2026. • Job evaluation / national job profiles	• Trust will re-evaluate the apprenticeship strategy to align with new rules. • Stock take of existing practice and resource to be undertaken and a task and finish group established to take work forwards	People and Culture Leadership Group
7.0	**First for Staff**				
7.1	Engagement Scores – Making the Trust the best place to work in the NHS	3. Partial	Notable decline in staff recommending WSFT as a place to work and staff recommending WSFT as a place to receive care.	Actions to ensure improvement in these scores are prioritised; including improving staff involvement in decision making which affects them and improving	2. Share scores and priority actions with other sub committees

Originating Committee: Involvement Committee			Reporting to: Trust Board		
Chaired by: Tracy Dowling Non-executive Director			Date of meeting:18th June 2025		
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				communications with staff. The annual staff survey and quarterly pulse surveys will be used to track trends.	
7.2	Staff story – what can we learn	2. Reasonable	Jenny Gatley presented her experience of working as a volunteer at WSFT for over ten years, initially on G4 then in End-of-Life Care	Feedback regarding pressures on nursing staff were acknowledged and will be followed up. The Freedom to Speak Up Guardian asked to visit the Blanketeers group.	1. No escalation
7.3	Workforce Health and Wellbeing Update	2. Reasonable	Actions were prioritised; assurance was given that return-to-work interviews are being conducted following sickness absence.	Recommendation to empower local teams and managers to own wellbeing actions rather than rely on HR interventions. This is a day-to-day managerial responsibility.	1. No escalation
7.4	Guardian of Safe Working Hours Report	4. Minimal	The report author was not able to attend, and the executive summary did not accord with the report content.	Julie Hull to meet with leads in advance of the next meeting where this item will be considered further	2. Escalated to Director of Workforce and communications.
7.5	Veterans Update	1. Substantial	The Veterans Aware accreditation plan and actions update was shared. Work is on track.	The action plan runs to October 2025. Philippa Lakins was thanked for her work on this important item.	1. No escalation

Originating Committee: Involvement Committee			**Reporting to: Trust Board**		
Chaired by: Tracy Dowling Non-executive Director			**Date of meeting:18th June 2025**		
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7.6	Statutory Mandatory Training Review Update	3. Partial	There is a national requirement to review statutory mandatory training. The only outstanding requirement is the completion of the training needs analysis.	A new national framework is due in Autumn 2025. This will provide clear guidance on role specific training requirements and governance expectations.	2. To MEG when work complete and then back to Involvement Committee
8.0	**First for the Future**				
8.1	Workforce Strategy / People Plan	3. Partial	Assurance received from Julie Hull that the Trust is actively reviewing its workforce strategy and people plan.	On forward plan for 6 months' time	1. No escalation
9.0	**First for patients**				
9.1	Experience of Care and Engagement Committee Report	1. Substantial	Update received on work to improve patient experience and engagement including: • Patient Equity Group fully established and meeting regularly. • Engagement team visited drop-in centre in Bury for homeless people to identify	Team exploring use of AI. Team invited to join the Trust stand at the Bury St Edmunds PRIDE event on 30th August 2025.	1. No escalation

Originating Committee: Involvement Committee			Reporting to: Trust Board		
Chaired by: Tracy Dowling Non-executive Director			**Date of meeting:18th June 2025**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:** **SO WHAT?** *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To MEG / other assurance committee **3.** To Board
			with them barriers to service access		
9.2	Progress of 2025/26 Strategic Priorities	2. Reasonable	Updates received on bringing together reasonable adjustments and personalised care plan workstreams. A project is underway to use AI to translate patient letters in house.	NC to invite CF to link in with the AI group as the patient safety representative.	1. No escalation
10.0	**Governance**				
10.1	People and Culture Committee Update	3. Partial	Good and comprehensive update received however concern remains that low attendance continues from operational and clinical representatives. This is now compromising the effectiveness of this subcommittee.	NC agreed to take action to address this.	2. Escalation via NC
11	IQPR extract for Involvement Committee	2. Reasonable	Appraisal 5% below expected standard. Sickness rates within tolerance. Increase in number of complaints	Update on complaints increase and response rates to be received at next meeting.	1. No escalation

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

	Questions regarding quality of evidence…	Further consideration…
What? Deepening **understanding** of the evidence and ensuring its **validity**	**Validity** – the degree to which the evidence… • measures what it says it measures. • comes from a reliable source with sound/proven methodology. • adds to triangulated insight	• Good data without a strong narrative is unconvincing. • A strong narrative without good data is dangerous!
So what? Increasing **appreciation** of the **value** (importance and impact) – what this means for us	**Value** – the degree to which the evidence… • provides real intelligence and clarity to board understanding. • provides insight that supports good quality decision making. • supports effective assurance, provides strategic options and/or deeper awareness of culture	• What is most significant to explore further? • What will take us from good to great if we focus on it? • What are we curious about? • What needs sharpening that might be slipping?
What next? Exploring what should be **done next** (or not), informing **future** tactic / strategy, agreeing follow-up and future **evidence of impact**		• Recommendations for action • What impact are we intending to have and how will we know we've achieved it? • How will we hold ourselves accountable?

NHS
West Suffolk
NHS Foundation Trust

Feedback from assurance committees: Governor observer report

Board assurance committee: Involvement
Meeting date: 18.06.25
Governor observer (observed by): Anna Clapton

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• The matters discussed at the meeting were pertinent and respectful and meaningful discussion was had around them.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• *The meeting was conducted in a professional manner in line with the Trust values.* • *Contributors to the meeting were able to express their views with everyone actively listening. Respectful debate/deliberation was had.*
Assurances *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
• *Good levels of assurance were sought regarding the topics which were presented.*
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• *Having a volunteer talk to us about the work they do and give some insight into the Trust issues on the ground was very insightful. It was a great addition to the meeting.*

9.4. Audit Committee

To Note

Presented by Michael Parsons

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Audit Committee			**Date of meeting: 20 June 2025**		
Chaired by: Michael Parsons			**Lead Executive Director: Jonathan Rowell**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / MEG 3. Escalate to Board
Annual Report & Accounts 2024/25	Review of - Head of Internal Audit Opinion - External Audit report - Annual Report - Annual Accounts - Year-end certifications - Quality Accounts	Substantial	Positive overall Head of Internal Audit opinion – noting the progress being made on implementing the recommendations from 6 negative assurance audit reports issued during the year. Unqualified external audit opinion on the accounts – there were a few immaterial uncorrected audit misstatements which the Committee accepted and a small number of recommendations for future improvements. The standard Letter of Representation was recommended for signing. The Annual Report and Accounts were discussed and – subject only to a few minor	Board approval	3. To Board to approve Annual Report & Accounts (etc)

			textual changes – were recommended for signing. The positive working relationship between WSFT and KPMG was noted. The General Condition 6 and continuity of service certification were approved. The Quality Accounts were also approved for signing. This was KPMG's last year as auditor and they were thanked – as were the Finance and Governance Teams.		
Matters relating to Year-end 2024/25	Review of losses, special payments, and waivers	Substantial	The Committee were satisfied with the reports and the explanations.		1. No escalation
Internal Audit (RSM)	Update on delivery of internal audit plan 2024/25 and implementation of recommendations.	Reasonable	Discussed the 3 final reports issued since the last meeting which were all partial assurance opinions – and the need for recommendations to be implemented promptly. The Committee continued to express concern over some long-outstanding management	Executive to continue to address overdue audit actions.	2 -> Management Executive Group

			actions from historic audits (some dating back to 2021/22).		
Counter Fraud (RSM)	Annual report and the governance functional standard return.	Substantial	The Committee welcomed the green ratings for all areas of the annual return.		1. No escalation

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

	Questions regarding quality of evidence…	Further consideration…
What? Deepening **understanding** of the evidence and ensuring its **validity**	**Validity** – the degree to which the evidence… • measures what it says it measures • comes from a reliable source with sound/proven methodology • adds to triangulated insight	• Good data without a strong narrative is unconvincing. • A strong narrative without good data is dangerous!
So what? Increasing **appreciation** of the **value** (importance and impact) – what this means for us	**Value** – the degree to which the evidence… • provides real intelligence and clarity to board understanding • provides insight that supports good quality decision making • supports effective assurance, provides strategic options and/or deeper awareness of culture	• What is most significant to explore further? • What will take us from good to great if we focus on it? • What are we curious about? • What needs sharpening that might be slipping?
What next? Exploring what should be **done next** (or not), informing **future** tactic / strategy, agreeing follow-up and future **evidence of impact**		• Recommendations for action • What impact are we intending to have and how will we know we've achieved it? • How will we hold ourselves accountable?

Assurance level

1. Substantial	Taking account of the issues identified, the board can take substantial assurance that this issue/risk is being controlled effectively. There is substantial confidence that any improvement actions will be delivered.
2. Reasonable	Taking account of the issues identified, the board can take reasonable assurance that this issue/risk is being controlled effectively. Improvement action has been identified and there is reasonable confidence in delivery.
3. Partial	Taking account of the issues identified, the board can take partial assurance that this issue/risk is being controlled effectively. Further improvement action is needed to strengthen the control environment and/or further evidence to provide confidence in delivery.
4. Minimal	Taking account of the issues identified, the board can take minimal assurance that this issue/risk is being controlled effectively. Urgent action is needed to strengthen the control environment and ensure confidence in delivery.

10. Nominations Committee Report (enclosed)

To receive the report from the Nominations Committee

To Note

Presented by Jude Chin

WSFT Council of Governors meeting (Open)

Report title:	Nominations Committee report
Agenda item:	10
Date of the meeting:	11 September 2025
Sponsor/executive lead:	Jude Chin, Trust Chair
Report prepared by:	Pooja Sharma, Deputy Trust Secretary

Purpose of the report:

For approval	For assurance	For discussion	For information
☒	☐	☒	☐

Trust strategy ambitions	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
Please indicate Trust strategy ambitions relevant to this report.	☒	☒	☒

Executive summary:

WHAT?
Summary of issue, including evaluation of the validity the data/information

The report summarises discussions that took place at the Nominations Committee meeting on 10 July 2025.

SO WHAT?
Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk

The Committee's agenda focussed on the following areas:

NEDs Terms of Office (for noting)

The terms of office for the NEDs were reviewed and noted.

University of Cambridge nominated NED (for noting)

Discussions are ongoing with the University of Cambridge to secure a suitable nomination.

Reappointment of non-executive director - a recommendation to be considered by the Council in closed session.

WHAT NEXT?
Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)

The items reported through this report will be actioned through the appropriate routes.

Action required / Recommendation:

The Council of Governors is asked to **note** the report from the Nominations Committee.

Previously considered by:	Council of Governors' Nominations Committee (10 July 2025)

Risk and assurance:	Council of Governors unable to undertake its statutory duties.
Equality, diversity and inclusion:	Ensure inclusion and fair recruitment and staff management processes
Sustainability:	N/A
Legal and regulatory context:	West Suffolk NHS Foundation Trust Constitution Health & Social Care Act 2022 NHSE Code of Governance 2022

11. Membership and Engagement Committee Report (enclosed)

To receive a report from the Membership and Engagement Committee

To Note

Presented by Sarah Hanratty

NHS
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WSFT Council of Governors meeting (Open)

Report title:	Membership and Engagement Committee report
Agenda item:	11
Date of the meeting:	11 September 2025
Sponsor/executive lead:	Sarah Hanratty, Public Governor (Chair of Membership & Engagement Committee)
Report prepared by:	Sarah Hanratty, Public Governor Pooja Sharma, Deputy Trust Secretary Ruth Williamson, Foundation Trust Office Manager

Purpose of the report:

For approval	For assurance	For discussion	For information
☐	☒	☒	☐

Trust strategy ambitions	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
Please indicate Trust strategy ambitions relevant to this report.	☒	☒	☒

Executive summary:

WHAT?
Summary of issue, including evaluation of the validity the data/information

The report summarises the discussions that took place at the Membership and Engagement Committee meeting on 15 July 2025.

SO WHAT?
Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk

Summary/Highlights

In the meeting on 15 July, the Committee focussed on the following key areas:

- The Committee received an update on **engagement on the New Hospital Programme (NHP)**, noting continued liaison with Government representatives and oversight by NHS England and the Department of Health and Social Care. Design proposals, developed with staff and patient input, are being reviewed against the confirmed capital envelope. The Trust remains in the ratification period, progressing through RIBA Stage 2, with Stage 3 anticipated in Autumn 2025. Preparatory works are underway, including infrastructure planning. A stakeholder video has been produced and revised travel plans have been informed by Highways Authority feedback.

- The Committee received a report on the **membership and engagement strategy development plan**. The communications team continues to support Trust-wide engagement, with emphasis on growing membership and enhancing visibility. Discussion included the use of hospital engagement events and newsletters to expand member voices. Concerns were raised about the website's clarity, and suggestions were made to improve digital articulation of opportunities. The Committee also discussed the membership growth, including the need to define success beyond numerical targets. Underrepresented groups were highlighted, and the inclusion of an EDI objective was proposed. It was noted that staff remain the most diverse group. Suggestions included creating case studies and video content to promote governor roles and improve understanding of membership value.

- The Committee explored funding options for member events and proposed leveraging existing Trust hosted public events for member recruitment. Volunteer recruitment was discussed as a potential pathway to membership, with alignment between volunteering and membership & engagement strategies encouraged.

- The Committee received an update on **patient engagement and VOICE**. Work continues to improve engagement with marginalised communities, including those experiencing homelessness or addiction. The Little Steps Programme delivered on the Rainbow Ward, in collaboration with primary school children, was reported as a success, with plans to expand to high school students.

- The Committee received a report on **Governor activities** from April 2025 onwards and discussed the emerging themes from the feedback received from the observers. The activities identified a significant number of positives across these areas including our staff, environments and the focus on patients and care. The Governor activities coversheet is included for oversight for the CoG **(Annex 1**) and includes three 15-steps visits, one area observation, one environmental walkabout and one Courtyard Café engagement session. Key themes from the activity analysis were confirmed and will be considered through the Trust's Experience of Care and Engagement Committee.

- The Committee received feedback from governor observers of **VOICE** and members attending the **Experience of Care & Engagement Committee.** VOICE received a presentation on the Trust Strategy. Feedback from related committees included concerns about paediatric oncology staffing and the discontinuation of the Paediatric Virtual Ward. A video showcasing the Roald Dahl specialist nurses and physiotherapy team was commended.

- The Committee noted the **forward plan 2025.**

WHAT NEXT?
Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)

The items reported through this report will be actioned through the appropriate routes.

Action required / Recommendation:

The Council of Governors is asked to note the report from the meeting held on 15 July 2025.

Previously considered by:	Council of Governors' Membership & Engagement Committee
Risk and assurance:	Council of Governors unable to undertake its statutory duties.
Equality, diversity and inclusion:	N/A
Sustainability:	N/A
Legal and regulatory context:	West Suffolk NHS Foundation Trust Constitution Health & Social Care Act 2022 NHSE Code of Governance 2022

NHS
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NHS Foundation Trust

Council of Governors' Membership and Engagement Committee

Report title:	Governor activities 2024/25 - Feedback report
Agenda item:	8
Date of the meeting:	15 July, 2025
Sponsor/executive lead:	Richard Jones, Trust Secretary
Report prepared by:	Ruth Williamson, Foundation Trust Office Manager Pooja Sharma, Deputy Trust Secretary

Purpose of the report:			
For approval	**For assurance**	**For discussion**	**For information**
☐	☐	☒	☒

Trust strategy ambitions	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
Please indicate Trust strategy ambitions relevant to this report.	☐	☒	☒

Executive summary:

WHAT?
Summary of issue, including evaluation of the validity the data/information

This paper summarises the Governor activities from April 2025 and the emerging themes from the feedback received from the observers.

15 steps visits led by Deputy Chief Nurse (Annex A)

- 30 April 2025: G3 and MTU by Anna Conochie, (Public Governor), Sue Kingston, (Partner Governor) and Heather Hancock, (non-executive director).
- 28 May 2025: F5 & F8 by Sarah Hanratty, (Public Governor), Anna Conochie, (Public Governor) and Tracy Dowling, (non-executive director).
- 25 June 2025: G10 & ICU by Adam Musgrove, (Staff Governor), Anna Conochie, (Public Governor) and Jude Chin (Chair).

Area observations led by patient experience and engagement team (Annex B)

- 11 June 2025: Phlebotomy by Adam Musgrove, (Staff Governor)

Environmental reviews led by Estates and Facilitates

- Dates for 2025 to be confirmed following changes within the Estates & Facilities Directorate.

Courtyard Café led by FT office team

- 8 July 2025: Sue Kingston, (Partner Governor) and Val Dutton, (Public Governor).

SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
The visits are designed to support continuous improvement and are a valuable source of qualitative information that aligns patient and staff experience to collectively promote a positive experience for all and support staff to initiate local service improvement. The objective of the report is to highlight areas for improvement and extracting themes will help the Trust to take those initiatives.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
The activities identified a significant number of positives across these areas including our staff, environments and the focus on patients and care. The results will be analysed at regular intervals, ensuring area owners have been made aware of any issues, themes and trends that are identified throughout the visits and giving support to focus on improvements and sharing positive feedback. Some themes from visiting teams are identified below: **15 steps:** • Signage • Aging estate • Noise on ward **Area observations: Reports requested from PALS.** • Missed Appointments • Estate – repairs/replacement
Action required / Recommendation:
The Membership and Engagement Committee is asked to: - note the report and emerging themes - consider how these can be further tested in future governors activities –provide a short briefing of themes for governor undertaking visits / activities - consider any locations of particular focus for future visits / activities

Previously considered by:	NA
Risk and assurance:	Council of Governors is unable to undertake its statutory duties.
Equality, diversity and inclusion:	NA
Sustainability:	NA
Legal and regulatory context:	West Suffolk NHS Foundation Trust Constitution Health & Social Care Act 2022

12. Standards Committee Report (enclosed)

To receive a report from the Standards Committee

To Note

Presented by Jude Chin

NHS
West Suffolk
NHS Foundation Trust

WSFT Council of Governors meeting (Open)	
Report title:	Standards committee report
Agenda item:	12
Date of the meeting:	11 September 2025
Sponsor/executive lead:	Jude Chin, Trust Chair
Report prepared by:	Pooja Sharma, Deputy Trust Secretary

Purpose of the report:

For approval	For assurance	For discussion	For information
☐	☒	☒	☐

Trust strategy ambitions	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
Please indicate Trust strategy ambitions relevant to this report.	☒	☒	☒

Executive summary:

WHAT?
Summary of issue, including evaluation of the validity the data/information

The report summarises discussions at the Standards committee of the Council of Governors meeting held on 8 July and an extraordinary meeting held on 11 August 2025.

SO WHAT?
Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk

Summary

The committee focussed on the following key areas:

Governor attendance at Council meetings

<u>Constitutional requirement</u>

The Committee reminds Governors that it is a constitutional responsibility to attend meetings of the Council of Governors. When this is not possible, they should submit an apology to the meeting administrator in advance of the meeting.

If a Governor fails to attend <u>three successive public meetings of the council of governors</u> without good reason and prior explanation, as set out in the Constitution, this is grounds for dismissal from their office, unless the grounds for absence are deemed to be acceptable by the Council of Governors.

Governors are expected to attend for the duration of the meeting and maintain good practice with respect to the conduct of meetings and the views of their fellow council members. Governors should not conduct private conversations when a meeting is taking place.

Managing non-attendance at Council of Governors' meetings

The Committee reviewed attendance records and noted that two Public Governors had missed three consecutive public Council of Governors' meetings. In line with the Constitution, this raised the possibility of dismissal unless acceptable reasons were provided.

To assess the situation, the Committee considered each Governor's mitigation responses, overall engagement, including attendance at briefing sessions, Board and Board Assurance Committee meetings, and other governor events. It was acknowledged that both individuals had shown strong participation in these areas and had demonstrated a clear commitment to attending future Council meetings.

The Committee agreed that the Chair should meet with both Governors to emphasise the importance of attending formal Council meetings. It was confirmed that the absences were due to reasonable causes with the apologies for absence sent in advance, and the explanations provided were deemed acceptable by the Committee on behalf of the Council of Governors. As a result, no further action was required.

Following the Committee's resolution, the Chair met individually with both Governors to reinforce the importance of attending formal Council of Governors meetings. These discussions focused on how regular attendance supports the fulfilment of statutory duties and ensures Governors remain actively engaged in their role; and to gain assurance of their intention to resume attendance at future meetings.

To strengthen future attendance processes, the Foundation Trust Office has introduced a system to issue reminders to any Governor who has missed two consecutive meetings. This aims to support attendance at the third meeting and avoid triggering the constitutional clause. The Trust remains committed to offering support to Governors to help improve attendance, particularly at face-to-face meetings.

ACTION

- Note the constitutional requirement for Governor attendance
- Note the cases of non-attendance and the Committee's approach in accepting the mitigating circumstances for both Governors, allowing them to continue in their roles as Public Governors.

Compliance with the Code of Conduct

The Trust operates a just culture for managing staff conduct and it is therefore appropriate for the Council of Governors to adopt a similar approach when dealing with any allegations of conduct breaches relating to Governors. Part of the Standards Committee's remit is to review alleged breaches of the Code by Governors and advise on the procedure for managing the Governor's conduct and expected standards.

In case of any breaches in Governors' conduct, the Standards Committee is asked to note the matters of alleged breach of Code of Conduct and approve a recommendation to the Council of Governors in terms of next course of action.

Governor conduct and meeting etiquette

The Committee discussed expectations for Governor observers at assurance committee meetings. In-person attendance was encouraged, though virtual participation remains acceptable when necessary. Differing views were expressed regarding camera use during virtual meetings, with guidance to be issued. The Committee agreed that observers may sit at the meeting table if invited by the Chair or with permission. It was noted that table seating improves audibility and facilitates notetaking. A suggestion was made for chairs to introduce attendees at the start of meetings.

The Committee agreed to reaffirm expectations for in-person attendance at the board assurance committees and to issue guidance on virtual meeting etiquette. This will support consistency and clarity in governor participation across formats.

ACTION
- Note the update.

- **Standards Committee workplan**

The Committee noted the forward workplan that has been developed to ensure timely consideration of relevant issues.

- **Governors' development programme 2025**

The Committee noted the forward workplan that is developed to ensure timely consideration of relevant issues. The work programme will be maintained as a live document to reflect new issues.

An update was received on the Governor Development Programme. Governors were invited to submit further suggestions for inclusion in the work programme, with the aim of scheduling additional development sessions before year-end. The Committee noted ongoing engagement with Governors regarding the Trust Strategy, including a circulated questionnaire and workshops.

The UK Government published the 10 Year Health Plan on 3 July 2025, outlining long-term priorities for improving the health system and health outcomes in England. A suggestion was made to provide an outline of the 10-year plan and the implications for the Trust.

ACTION
- Note the Governors' development programme 2025 (Annex A)

Lead Governor Election Process 2025 – progress update

The Trust remains committed to ensuring continuity in leadership roles, including the Lead and Deputy Lead Governor positions, through a term structure that supports effective governance while allowing for new leadership opportunities.

In April, the Standards Committee received a report outlining the election process for these roles, with new post holders expected to begin their term on 1 January 2026.

In May 2025, the Council of Governors agreed the process for election and appointment. Following this, the Board approved an amendment to Annex 11 of the Trust Constitution, updating the role specification and confirming that the Lead Governor's term will normally run for three years, concluding two years after the Governor elections. This change aims to support smoother transitions and better alignment with election cycles.

In line with the agreed process, the Foundation Trust Office invited self-nominations for the Lead Governor role between 30 June and 18 July 2025. Two governors expressed interest but later withdrew due to time constraints, despite support offered.

An extraordinary meeting on 11 August was convened and the Committee agreed to rerun the election, reopening nominations and encouraging participation. Additional support was offered including shadowing opportunities and role clarity.

The rerun took place from 14 August to 2 September and despite engagement efforts, only one nomination was received. The Council of Governors will consider the appointment during the closed session of the meeting.

ACTION

- Note the update

WHAT NEXT?

Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)

The items reported through this report will be actioned through the appropriate routes.

Action required / Recommendation:

The Council of Governors is asked to **note** the report and **actions** as specified above.

Previously considered by:	Council of Governors' Standards committee (8 Jul and 11 Aug)
Risk and assurance:	Council of Governors unable to undertake its statutory duties. There is a risk of termination of tenure of office if a Governor fails to attend three successive public meetings of the council of governors.
Equality, diversity and inclusion:	N/A
Sustainability:	N/A
Legal and regulatory context:	West Suffolk NHS Foundation Trust Constitution Health & Social Care Act 2022 NHSE Code of Governance 2022 Trust Constitution- Annex 7 – standing orders for the practice and procedure of the council of governors

Governors' Development Programme 2025

Timing	Themes	Rationale	Led by
16 January 2025	Non-executive appraisals training	Interests of members and the public	Organisational Development and Learning Team
5 February 2025	Trust's strategy refresh	Interests of members and the public Interactive engagement with the governors as part of the review of the Trust's strategy and priorities	Director of Strategy and Transformation
4 March 2025	Session on Integrated Care Board introduction and provider collaboration	Interests of members and the public	ICB partners/Chair/Trust Secretary
3 April 2025	CQC single assessment framework	Interests of members and the public	Chief Nurse
17 July 2025	Patient quality and safety, incidents/never events, PSIRF	Holding the NEDs to account for the performance of the Board	Chief Nurse / others as agreed
16 September 2025	Session on Future Systems Programme	Holding the NEDs to account for the performance of the Board	Programme Director / others as agreed
21 October 2025	Session on Virtual Ward	Interests of members and the public	Senior Operational Team, Virtual Ward
TBC	Fit for the future: 10 Year Health Plan for England	Interests of members and the public	Director of Strategy and Transformation or others as agreed
TBC	Effective questioning and holding the NEDs to account for the performance of the Board	Interests of members and the public Holding the NEDs to account for the performance of the Board	NHS Providers

Timing	Themes	Rationale	Led by
	The role of the Foundation Trust Governor and practical ways to carry out the statutory roles of a governor	Item from annual skills audit – considering options for delivery to support working of the Council	

13. Staff Governor Report (enclosed)

To receive a report from the Staff Governors

To Note

NHS
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WSFT Council of Governors' Meeting (Open)			
Report title:	Staff Governors' report		
Agenda item:	13		
Date of the meeting:	11 September 2025		
Sponsor/executive lead:	Staff Governors		
Report prepared by:	Pooja Sharma, Deputy Trust Secretary Ruth Williamson, Foundation Trust Office		
Purpose of the report:			
For approval ☐	**For assurance** ☐	**For discussion** ☒	**For information** ☒
Trust strategy ambitions	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
Please indicate Trust strategy ambitions relevant to this report.	☒	☒	☒

Executive summary:

WHAT?
Summary of issue, including evaluation of the validity the data/information

The Staff Governors met on 1 July 2025. The report summarises discussions that took place.

SO WHAT?
Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk

The meeting was attended by the staff governors Diana Stroh, Adam Musgrove, Louisa Honeybun, Sue Kingston (Partner Governor), Jane Skinner (Lead Governor), Julie Hull (Interim Chief People Officer), Jane Sharland (Freedom to Speak Up Guardian), Pooja Sharma (Deputy Trust Secretary) and Ruth Williamson (Foundation Trust Office Manager).

Summary/Highlights:

Freedom to Speak Up – update on themes:

The staff governors noted an overview of themes in the Freedom to Speak Up (FTSU) update and concerns were raised about the ongoing financial constraints and impact on recruitment, Mutually Agreed Resignation Scheme, consultation process and the challenges of delivering difficult news to staff. Staff expressed uncertainty about how to respond to individuals smoking on site and it was noted that the refreshed smoke free environment policy offers clear guidance and suggested responses. The updated policy will be available on the intranet shortly.

The FTSU Guardian shared that the Government has decided to disband the National Guardian's Office. Despite this change, Guardians will continue their roles within individual trusts. Responsibility for governance, training, and data collection will be transferred to NHS England and the Department of Health.

Staff concerns

Staff governors reflected on the challenges of raising sensitive concerns, particularly when issues are brought to them directly. There was a shared desire to ensure that staff feel safe and supported when speaking up, with suggestions including the introduction of an anonymous email channel. Staff governors expressed a commitment to fostering a culture where constructive challenge is welcomed and relationships remain respectful.

Discussions also highlighted the importance of openness and governors shared personal experiences on dealing with the concerns raised. There was a strong affirmation of pride in working at the Trust. Senior leaders reiterated their openness to feedback and confirmed that staff are being listened to.

WHAT NEXT?
Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)

The items reported through this report will be actioned through the appropriate routes.

Action required / Recommendation:

The Council of Governors is asked to note the report from the meeting held on 1 July 2025.

Previously considered by:	Staff Governors
Risk and assurance:	Council of Governors unable to undertake its statutory duties.
Equality, diversity and inclusion:	N/A
Sustainability:	N/A
Legal and regulatory context:	West Suffolk NHS Foundation Trust Constitution Health & Social Care Act 2022 NHSE Code of Governance 2022

14. Lead Governor Report (enclosed)

To receive a report from the Lead Governor

To Note

Presented by Jane Skinner

WSFT Council of Governors' Meeting (Open)	
Report title:	**Lead Governor Report**
Agenda item:	14
Date of the meeting:	11 September 2025
Sponsor/executive lead:	Jane Skinner, Lead Governor
Report prepared by:	Jane Skinner, Lead Governor

Purpose of the report			
For approval ☐	**For assurance** ☐	**For discussion** ☒	**For information** ☐
Trust strategy ambitions	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
Please indicate Trust strategy ambitions relevant to this report.	☐	☐	☐

Executive Summary

WHAT?

Summary of issue, including evaluation of the validity the data/information

Brief summary of Governors' main activities over the last quarter.

SO WHAT?

Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk

The Council of Governors (CoG) sits in the accountability and governance structure of Foundation Trusts. The role is defined in both the NHS Act 2006 and the Social Care Act 2012. An addendum to these duties was published in October 2022 taking into account system working and collaboration within Integrated Care Systems (ICS).

Therefore, NHS Foundation Trust Governors have both statutory and general duties to perform:

- Representing the interests of members and the public
- Holding the Non-Executive Directors (NEDs) individually and collectively to account for the performance of the Board and therefore the Trust.
- Appoint and remove Chair/NEDS as appropriate and decide on other terms and conditions of office
- Decide the remuneration and allowances of the Chair and NEDs
- Approve the appointment of the Chief Executive
- Appoint/remove as the external auditor, as appropriate
- Receive the Annual Accounts and Auditor's report
- Approve/make changes to the Trust Constitution and recommend to the Board
- Approve defined significant transactions
- Approve applications for mergers, acquisitions and dissolutions
- Be assured that the Board has considered the consequences of decisions on other partners in the ICS and on the public at large.

WHAT NEXT?

Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)
Governors will continue to carry out activities and to develop engagement strategies, that are in line with the fulfilment of their statutory duties and responsibilities.
Recommendation
The Council of Governors is asked to note the report.

Risk and assurance:	**-**
Equality, Diversity and Inclusion:	All Governor activities are performed in line with the principles of EDI
Sustainability:	-
Legal and regulatory context	NHS Act 2006 Social Care Act 2012 WSHFT Constitution WSHFT Governors Code of Conduct

Lead Governor Report

1. Introduction

Governors who observe Board and Board Assurance meetings will be aware of the issues which continue to challenge Trust leaders. Stringent financial control and CIPs are vital to ensure the agreed year end budget deficit is not exceeded. Governors are aware that the morale of staff working in the acute Trust and community has declined (Staff Survey, 2024); recruitment pauses, restructuring and other cost improvement initiatives cause uncertainty and further affect morale. Staff Governors keep the CoG appraised of staff concerns. However, Trust staff continue to work very hard to provide safe care to patients, we see the evidence of this when we meet staff and patients on our "15 Step" visits. I am sure Governors will join me in thanking them for their efforts in such difficult times.

As representatives of the public and FT Membership, Governors are interested in patient access to and experience of, Trust services. Data is presented to the Board, which shows the Trust's achievement against numerous standards, for example diagnostic waiting times, cancer targets and ED performance. As public and staff representatives, Governors are encouraged to observe Board meetings and to question Board members for further clarity and assurance on the contents of Board papers.

Since our last meeting, the Government has published its 10 Year Health Plan for England: fit for the future. The broad principles are clear – hospital to community, analogue to digital and sickness to prevention but the detail and finance has yet to be worked through. The plan states that "FTs will no longer be required to have Governors" we shall have to wait and see how/when/if that will be implemented as our role is currently written in statute.

The Annual Members Meeting will be held on 8th October this year. Governors please note the change of venue. This an excellent opportunity to meet staff and public FT Members; please send apologies if you are unable to attend.

2.	**COG Sub-Committees**
2.1	**Membership and Engagement Committee** Members are continuing to work through the strategy action plan. They are currently reviewing membership recruitment material. The aim being to increase Foundation Trust Membership and to encourage diversity and inclusion in the lead up to the next Governor elections. Governors attend the Trust VOICE and Experience of Care Groups and provide feedback to the Committee.
2.2	**Nominations and Remuneration Committee** This Committee is currently seeking to appoint a University of Cambridge NED; a task still in progress, as following recent candidate interviews and stakeholder assessments, the interview panel was not able to appoint. NED appraisals have been completed.
2.3	**Standards Committee** It is a requirement that Governors attend public CoG meetings. If three consecutive meetings are missed by a Governor, then it is the responsibility of the Standards Committee to consider that Governor's written rationale for their absence. This process was carried out by the Committee at their last meeting, resulting in acceptance of two Governors' apologies for their absence. An extra meeting was called to address the problem of no Governors self-nominating for the Lead Governor role. It was decided to ask for nominations again and to offer additional support for the successful nominee, if required.
3.	**Board Assurance Meetings** Governors continue to observe monthly assurance meetings, their reports are submitted as agenda items to this CoG. We also have opportunity to question the Chairs of these meetings during the presentations of their KPIs to the CoG, which I encourage Governors to do. Governors are reminded that the approved Closed Board and Assurance Committees' approved minutes are available to read on Convene. Also a reminder that questions, seeking assurance from NEDs, can be submitted to the Trust office via the dedicated email address.
4.	**Governor Updates and Development** Thank you to Lucy Winstanley for her interesting presentation on Patient Safety and Quality. Congratulations to Dan Spooner who has recently taken up his role as Chief Nurse. Dan has kindly agreed to attend this CoG to introduce himself and his portfolio of responsibility and to answer our questions.
5.	**Changes to the COG** Tom Murray has recently stepped down from his Public Governor role, thank you Tom for your contribution. Welcome to David Slater and Barry Probert, new Public Governors.
6.	**Governor's activities** Governors continue to carry out monthly 15 Step visits, regularly meet visitors in the Courtyard café and Environmental Reviews have recommenced. Feedback is given to the relevant managers and any resulting action plans are implemented and reviewed.
7.	An informal meeting of Governors followed by an informal meeting of NEDs and Governors was held recently. These always provide opportunity for rich discussion, information gathering and insight.

15. Annual Report and Accounts, including Auditor's letter (enclosed)

To receive the report

To Approve

Presented by Michael Parsons

WSFT Council of Governors meeting (Open)			
Report title:	**Annual Accounts and Annual report 2024/25** **Annual Auditor's Report 2024/25**		
Agenda item:	15		
Date of the meeting:	11 September 2025		
Sponsor/executive lead:	Michael Parsons, non-executive director and audit committee chair		
Report prepared by:	Annual Auditor's Report 2024/25 (KPMG, external auditors)		
Purpose of the report:			
For approval ☐	**For assurance** ☐	**For discussion** ☐	**For information** ☒
Trust strategy ambitions	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
Please indicate Trust strategy ambitions relevant to this report.	☐	☐	☐

Executive Summary

WHAT?
Summary of issue, including evaluation of the validity the data/information

Annual Report and Accounts 2024/25

The annual accounts and report 2024/25 were approved by the Board in June. The Trust is legally required to lay the document before Parliament. This took place on Wednesday 3 September 2025.

Annual Auditor's Report 2024/25 **(Appendix A)**

The Auditor's Annual Report provides a summary of the findings and key issues arising from our 2024-25 audit of West Suffolk NHS Foundation Trust (the 'Trust'). This report has been prepared in line with the requirements set out in the Code of Audit Practice published by the National Audit Office and is required to be published by the Trust alongside the annual report and accounts.

SO WHAT?
Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk

The Council of Governors is asked to receive the annual accounts and report and annual auditors' report 2024/25 in the public session.

The full annual report is available via the link below and the auditors' report is appended to this document:

Annual report 2024-25

WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
The Board's Audit Committee will maintain oversight of issues and recommendations arising from the audit work.
Action Required
The Council of Governors is asked to receive the report.

Auditor's Annual Report 2024/25

West Suffolk NHS Foundation Trust

—

June 2025

Contents

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This report is addressed to West Suffolk NHS FT (the Trust), as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state, those matters we are required to state to them in an auditors' annual report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

We take no responsibility to any member of staff acting in their individual capacities, or to third parties.

External auditors do not act as a substitute for the audited body's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

01 Executive Summary

Executive Summary

Purpose of the Auditor's Annual Report

This Auditor's Annual Report provides a summary of the findings and key issues arising from our 2024-25 audit of West Suffolk NHS FT (the 'Trust'). This report has been prepared in line with the requirements set out in the Code of Audit Practice published by the National Audit Office and is required to be published by the Trust alongside the annual report and accounts.

Our responsibilities

The statutory responsibilities and powers of appointed auditors are set out in the Local Audit and Accountability Act 2014. In line with this we provide conclusions on the following matters:

Accounts - We provide an opinion as to whether the accounts give a true and fair view of the financial position of the Trust and of its income and expenditure during the year. We confirm whether the accounts have been prepared in line with the Group Accounting Manual prepared by the Department of Health and Social Care (DHSC).

Annual report - We assess whether the annual report is consistent with our knowledge of the Trust. We perform testing of certain figures labelled in the remuneration report.

Value for money - We assess the arrangements in place for securing economy, efficiency and effectiveness (value for money) in the Trust's use of resources and provide a summary of our findings in the commentary in this report. We are required to report if we have identified any significant weaknesses as a result of this work.

Other reporting - We may issue other reports where we determine that this is necessary in the public interest under the Local Audit and Accountability Act.

Findings

We have set out below a summary of the conclusions that we provided in respect of our responsibilities:

Accounts	We issued an unqualified opinion on the Trust's accounts on 27th June 2025. This means that we believe the accounts give a true and fair view of the financial performance and position of the Trust. We have provided further details of the key risks we identified and our response on page 7.
Annual report	We did not identify any significant inconsistencies between the content of the annual report and our knowledge of the Trust. We confirmed that the annual report has been prepared in line with the NHS Group Accounting Manual (GAM) and the Foundation Trust Annual Reporting Manual (the ARM).
Value for money	We are required to report if we identify any matters that indicate the Trust does not have sufficient arrangements to achieve value for money. We have nothing to report in this regard.
Other reporting	We did not consider it necessary to issue any other reports in the public interest.

02 Audit of the Financial Statements

Audit of the financial statements

KPMG provides an independent opinion on whether the Trust's financial statements:

- Give a true and fair view of the state of the Trust's affairs as at 31 March 2025 and of its income and expenditure for the year then ended;
- Have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2025 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2024/25; and
- Have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Audit opinion on the financial statements

We issued an unqualified opinion on the Trust's financial statements before 30 June 2025.

The full opinion is included in the Trust's Annual Report and Accounts for 2024/25 which can be obtained from the Trust's website.

Further information on our audit of the financial statements is set out overleaf.

Audit of the financial statements

The table below summarises the key risks that we identified to our audit opinion as part of our risk assessment and how we responded to these through our audit.

Risk	Procedures undertaken	Findings
Valuation of land and buildings The carrying amount of revalued Land and buildings differ materially from the fair value.	We performed the following procedures designed to specifically address the significant risk associated with the valuation: - We critically assessed the independence, objectivity and expertise of Newmark Gerald Eve, the valuers used in developing the valuation of the Trust's properties at 31 March 2025 - We inspected the instructions issued to the valuers for the valuation of land and buildings to verify they are appropriate to produce a valuation consistent with the requirements of the Group Accounting Manual - We compared the accuracy of the data provided to the valuers for the development of the valuation to underlying information, such as floor plans, and to previous valuations, challenging management where variances are identified - We evaluated the design and implementation of controls in place for management to review the valuation and the appropriateness of assumptions used. - We challenged the appropriateness of the valuation of land and buildings; including any material movements from the previous revaluations. We will challenge key assumptions within the valuation, including the use of relevant indices and assumptions of how a modern equivalent asset would be developed, as part of our judgement. - We performed inquiries of the valuers in order to verify the methodology that was used in preparing the valuation and whether it was consistent with the requirements of the RICS Red Book and the GAM - We agreed the calculations performed of the movements in value of land and buildings and verify that these have been accurately accounted for in line with the requirements of the GAM; and - We reviewed the valuation report prepared by the Trust's valuers to confirm the appropriateness of the methodology utilised; and Disclosures: - We considered the adequacy of the disclosures concerning the key judgements and degree of estimation involved in arriving at the valuation.	We identified a misstatement relating to impairment of Buildings that has not been corrected by management. Updating this would lead to a reduction in Property, Plant and Equipment and Increase in Impairment expense, however we did not consider this material. We raised a recommendation relating to Review of Valuation specialist report. We considered the estimate to be balanced based on the procedures performed.

Audit of the financial statements

The table below summarises the key risks that we identified to our audit opinion as part of our risk assessment and how we responded to these through our audit.

Risk	Procedures undertaken	Findings
Fraudulent expenditure recognition Auditing standards suggest for public sector entities a rebuttable assumption that there is a risk expenditure is recognised inappropriately. We recognised this risk over the Trust's non-payroll and non-depreciation expenditure.	– We have inspected a sample of invoices of expenditure, in the period before 31 March 2025, to determine whether expenditure has been recognised in the correct accounting period; – We have selected a sample of year end accruals and inspect evidence of the actual amount paid after year end and other supporting information in order to assess whether the accrual exists and has been accurately recorded. – We have inspected journals posted as part of the year end close procedures that increase the level of expenditure recorded in order to critically assess whether there was an appropriate basis for posting the journal and the value can be agreed to supporting evidence; – We have performed a retrospective review of prior year accruals in order to assess the existence and accuracy with which accruals had been recorded at 31 March 2024 and consider the impact on our assessment of the accruals at 31 March 2025. We will also compare the items that were accrued at 31 March 2024 to those accrued at 31 March 2025 in order to assess whether any items of expenditure accrued for the first time have been done so appropriately.	We did not identify any material misstatements relating to this risk. We raised a recommendation relating to Journals Authorisation.
Management override of controls We are required by auditing standards to recognise the risk that management may use their authority to override the usual control environment.	- In line with our methodology, we have evaluated the design and implementation of controls over journal entries and post closing adjustments. - We have assessed the appropriateness of changes compared to the prior year to the methods and underlying assumptions used to prepare accounting estimates. - We have assessed the business rationale and the appropriateness of the accounting for significant transactions that are outside the component's normal course of business, or are otherwise unusual. - We have analysed all journals through the year and focus our testing on those with a higher risk, such as journals impacting expenditure recognition posted during the final close down.	We did not identify any material misstatements relating to this risk. We raised a recommendation relating to Journals Authorisation.

03
Value for Money

Value for Money

Introduction

We are required to consider whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources or 'value for money'. We consider whether there are sufficient arrangements in place for the Trust for the following criteria, as defined by the National Audit Office (NAO) in their Code of Audit Practice:

- Financial sustainability: How the Trust plans and manages its resources to ensure it can continue to deliver its services.
- Governance: How the Trust ensures that it makes informed decisions and properly manages its risks.
- 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

Approach

We undertake risk assessment procedures in order to assess whether there are any risks that value for money is not being achieved. This is prepared by considering the findings from other regulators and auditors, records from the organisation and performing procedures to assess the design of key systems at the organisation that give assurance over value for money.

Where a significant risk is identified we perform further procedures in order to consider whether there are significant weaknesses in the processes in place to achieve value for money.

We are required to report a summary of the work undertaken and the conclusions reached against each of the afore mentioned reporting criteria in this Auditor's Annual Report. We do this as part of our commentary on VFM arrangements over the following pages.

We also make recommendations where we identify weaknesses in arrangements or other matters that require attention from the Trust.

Summary of findings

	Financial sustainability	Governance	Improving economy, efficiency and effectiveness
Commentary page reference	12-14	15-16	17-18
Identified risks of significant weakness?	Yes	No	No
Actual significant weakness identified?	No	No	No
2023-24 Findings	No significant weakness identified	No significant weakness identified	No significant weakness identified
Direction of travel	⇔	⇔	⇔

Value for Money

NATIONAL CONTEXT

Following the general election in July 2024 the Labour government commissioned reviews in order to determine the causes of challenges within the sector and where priorities were for improvement. A 10 year plan is currently being developed to set out the strategy for transforming health care services in the future.

Operational performance across the sector has continued to be significantly below constitutional standards, continuing a trend that began during the Covid-19 pandemic. In March 2025 25% of patients attending A&E waited more than the four hour target and 60% of patients awaiting planned care had a wait of more than 18 weeks. While mental health performance improved year on year in a number of areas the backlog for treatment nationally has grown by a further 11% year on year, with 1.7 million referred patients awaiting their second contact.

During the year a revised timetable was announced for the New Hospital Programme, the national capital project to build 40 new hospitals. For a number of hospitals this has meant delays to the timetable for their construction deferred to the 2030s.

Financial performance

Local NHS systems continued to face challenging financial targets in 2024-25. Budgets across the 42 integrated care systems in England had a combined £500m deficit compared to the funding that was available at the beginning of 2024-25. By February 2025 (the latest national data available when this report was drafted) the forecast performance of all systems was a £604m overspend against the agreed figures.

Each year NHS entities are delegated efficiency targets through funding allocations and contracting guidance. Across England there was a £539m shortfall in the identified efficiencies compared to those required based on the agreed levels of funding delegated to systems.

Structures

Significant changes to the structure of the health system have been announced, to be implemented between 2025 and 2027. ICBs have been set running cost targets, with many expected to pursue mergers or large restructurings in order to achieve these. Providers are expected to reverse 50% of their corporate cost growth since Covid-19. During 2025-26 all NHS entities will therefore need to reassess their structures, which can impact on management bandwidth, stability of controls and morale.

LOCAL CONTEXT

West Suffolk NHS Foundation Trust is a highly successful, award-winning trust providing hospital and community services to a population of around 280,000 people who live in west Suffolk.

The trust provides acute hospital services from our 430-bed hospital set in parkland on the outskirts of Bury St Edmunds. The hospital has an emergency department, obstetrics, maternity and neonatal services, a day surgery unit, eye unit and children's wards and provides the full range of secondary care services. Trust refers many patients who need more specialist care to Addenbrooke's Hospital in Cambridge and many of their consultants work in both hospitals.

The Trust has reported a deficit of £25.7m for the year ending 31st March 2025. However, this is adjusted centrally to £25.3m in M12 due to an adjustment of £370k related to depreciation on donated assets. This is better than the control target agreed within the Finance Recovery Plan (£26.5m deficit) due to non-recurring support from the ICB of £1.2m.

The capital spend as at 31 March 2025 was £33.4m. This is in line with the forecast spend for 2024/25 of £33.4m.

The Trust's cash balance as at 31 March 2025 was £12.6m compared to a plan of £1.1m. This was made up of £4m of cash ringfenced to be spent on capital projects and £8.6m for revenue items. The higher than planned cash is due to a combination of factors, including, the increased recovery of aged debt, the impact of the Financial Recovery Plan and the timing of the last payment run for the year.

WSFT has a comprehensive quality reporting framework that includes an array of quality indicators that are monitored and reported on monthly basis. National standards:

Ambulance handover within 30 mins – 95.7% against target of 95%

62 day combined referral to treatment wait for first treatment- 88.4% against 76%

28day faster diagnosis standard – 79.07% against 77%

No patient waiting longer than 65 weeks – 31 against target of 0

Maximum 6week wait for diagnostic procedures – 53.2% against target of 95%

Financial Sustainability

How the Trust plans and manages its resources to ensure it can continue to deliver its services.

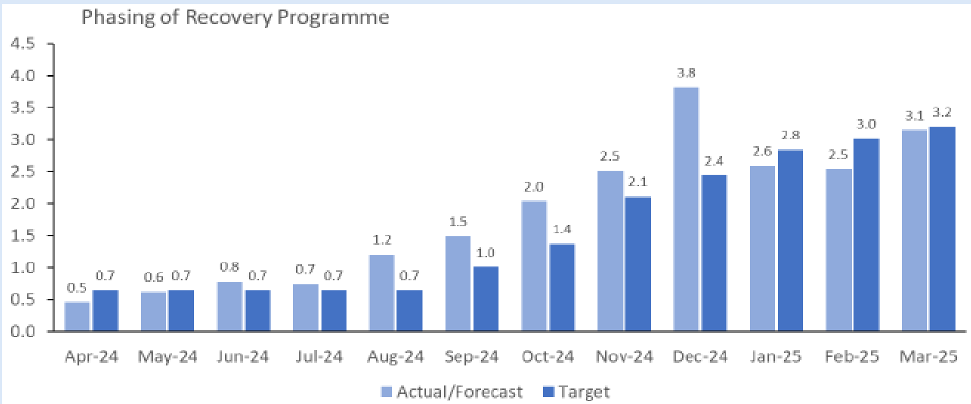
We have considered the following in our work:

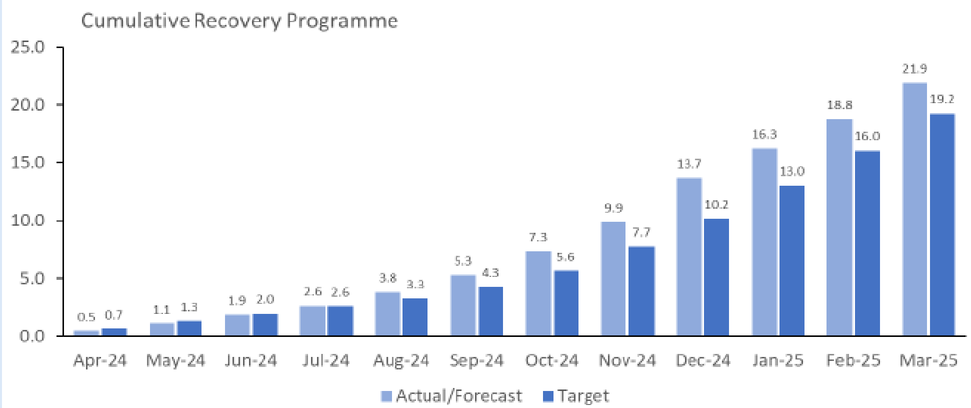
- How the Trust ensures that it identifies all the significant financial pressures that are relevant to its short and medium-term plans and builds these into them;
- How the Trust plans to bridge its funding gaps and identifies achievable savings;
- How the Trust plans finances to support the sustainable delivery of services in accordance with strategic and statutory priorities;
- How the Trust 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
- How the Trust identifies and manages risks to financial resilience, e.g. unplanned changes in demand, including challenge of the assumptions underlying its plans

- The Trust prepares guidance that brings together the financial principles to be used for the 2024/25 annual budget setting process. The guidance lists the principles that will steer the budget setting process. The process is divided into 3 phases –Phase 1 : Setting the recurrent baseline. Phase 2: Impact of commissioned service changes and Phase 3: Efficiency requirement.
- Financial performance against the budgets is assessed as part of the monthly PFR returns and Financial accountability Committee(FAC) reporting. There is continuous engagement between Finance and budget holders through individual budget holder meetings, Divisional boards, Insight committee and Financial accountability committee.
- Cost Improvement Plans (CIPs) are identified during the business planning. Finance will identify a minimum percentage saving to be made through CIPs for each division's budget. Once the annual savings have been identified each division will be required to identify where efficiencies and savings can be made. These will include divisions plan, corporate plan, procurement plan, job planning, outpatient and theatre efficiencies.
- CIP targets are allocated to divisions, and it is typically at that level efficiency schemes are developed. Support and monitoring is provided to the PMO (and delivery partner) and Finance. Divisional leads work with their PMO and Finance Lead partners to identify CIP schemes to meet their Targets. Each CIP scheme will need to be developed into a Project Initiation Document.
- The Financial Recovery Group reviews the potential savings against the financial target for the CIP Programme as the Programme is being developed in advance of the new financial year.
- The trust was facing an unmitigated forecast outturn deficit of £37.5m. A financial recovery plan was adopted to help mitigate this to a range between £28.5-£25.5m. At year-end, the Trust has reported a deficit of £25.7m for the year ending 31st March 2025. However, this is adjusted centrally to £25.3m in M12 due to an adjustment of £370k related to depreciation on donated assets. This is better than the control target agreed within the Finance Recovery Plan (£26.5m deficit) due to non-recurring support from the ICB of £1.2m. The deficit is mainly driven by the pay cost including overspending on bank and agency staff due to vacancies among permanent staff.

Financial Sustainability

- For the ease of monitoring and reporting the efficiencies from the revised CIP and FRP programmes were aggregated. These combined revised CIP and FRP schemes planned to deliver £19.2m YTD, with actual delivery of £21.7m YTD, a favourable variance of £2.7m YTD. The current overperformance is due to FRP schemes delivering earlier than anticipated in the FRP.





Key financial and performance metrics:	2024-25	2023-24
Planned surplus/(deficit)	(£15.2m)	(£2.7m)
Actual surplus/(deficit)	(£25.35m)	(£6.27m)
Planned CIP		
- Recurrent	£12.2m	£7.4m
- Non-recurrent	£4.4m	£3.3m
Actual CIP		
- Recurrent	£14.4m	£4.8m
- Non-recurrent	£2m	£3.4m
Year-end cash position	£12.7m	£9.3m

Financial Sustainability

- The trust has agreed to a planned income and expenditure deficit of £20.7m for 2025/26. The Trust's CIP target is £32.7m. This target is comprised of three elements; £6m from the full year effect of the 24/25 Financial Recovery Plan, £20.8m 25/26 CIP and £5.8m further 'stretch' CIP agreed with SNEE ICB.

Conclusion:

The trust has proactively adopted the financial recovery plan and reported a deficit of £25.3m which was better than the control target agreed with the Financial recovery plan. Based on the performance of the trust against the action plan agreed and delivery of CIP, although there is an ongoing risk related to financial sustainability as the trust has a planned deficit of £20.7m for 2025/26, we have not identified a significant weakness associated with Financial sustainability.

Governance

***How the* Trust ensures that it makes informed decisions and properly manages its risks.**

We have considered the following in our work:

- 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;
- how the Trust 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;
- how the Trust ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency; and
- how the body monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements and standards in terms of management or Board members' behaviour

- The Trust has a risk management policy that provides guidance on responsibilities and procedures to ensure risks are effectively identified, monitored and managed. A risk register is used to capture Divisional and corporate risks. Risks are rated as Red (high), Amber (Significant), Yellow (Moderate) and Green (low) based on an assessment of the likelihood and consequence (harm) of a risk materialising. This risk rating informs the escalation requirements. Monitoring arrangements are in place to ensure that risks are appropriately reviewed and agreed action taken.

- Trust's budget setting guidance for 2024/25 brings together the financial principles to be used for the 2024/25 annual budget setting process. The guidance is written to support divisions, directorates, and corporate departments in establishing budgets within a common framework across the trust. The consolidated budget feeds into the overall trust plan for approval and submission to NHSE

- The Trust has a Governance structure with objectives and performance measures that are derived from and aligned to the NHS system oversight framework. The structure flows with the Trust Board at the top and followed by Insight committee(assurance on Operations, finance and corporate risk), Involvement committee (assurance on People and organisational development) and improvement committee (assurance on Quality, patient safety and quality improvement) supported by Audit committee, charitable funds committee, Board remuneration & nomination committee, Future system scheme executive, programme board and Management executive group.

- The Board of directors ensures that WSFT remains compliant with relevant legislation. Executive Directors assess the risk against each of the conditions in the licence and no significant risks were identified in the previous reporting cycle. The Audit Committee has overarching responsibility for monitoring specific elements relating to compliance with laws.

- The Trust has anti-bribery, whistle blowing and other policies established to prevent instances of non-compliance of laws and regulations. Any breaches of law and regulation are reported to the trust Board on monthly basis. All the attendees at the board meeting are fully informed on the Trust's compliance with laws and regulations.

Governance

- Meeting minutes of all the committees and Trust Board evidence that all the key decisions, financial performance and risks are discussed and presented at the relevant committees and Trust Board. All the attendees are given an opportunity to raise questions and challenge the decisions and the same are documented in the meeting minutes along with resolution or actions for the accountable individual.

- The Trust is part of the New Hospital programme and during our risk assessment procedures in the previous year we noted a significant risk around the Governance of New Hospital Programme. Based on review of the governance structure and progress made by the Trust we concluded that this was not a significant weakness. As part of our work, we have noted that WSFT have made good progress in 2024/25. They have got their SOC approved and received funding for the development of its outline business case. WSFT is the only trust to have reached this stage which shows great progress. They have got their RIBA stage 2 considered and have made progress on the recommendations received. Based on inquiries we have noted that they are on track for their RIBA3 stage.

- WSFT are working on their proposed governance structure for NHP. Q5 performed a review of their governance structure and concluded that trust's model of governance was mature, effective and well established, however, they also made a range of recommendations. The proposed structure is based on the guidance provided by NHP and their commissioned consultants Q5. We have not noted any issues or concerns flagged as result of external reviews and WSFT is making good progress on the recommendations raised.

Conclusion:
Based on the work performed we have not identified a significant weakness associated with Governance.

	2025	2024
Control deficiencies reported in the Annual Governance Statement	None noted	None noted
Head of Internal Audit Opinion	Adequate and effective framework for risk management with further enhancements	Adequate and effective framework for risk management with further enhancements
Oversight Framework segmentation	3	3
Care Quality Commission rating	Requires improvement	Requires Improvement

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 have considered the following in our work:

- how financial and performance information has been used to assess performance to identify areas for improvement;
- how the Trust ensures effective processes and systems are in place in order to develop their cost saving efficiency saving program;
- how the Trust evaluates the services it provides to assess performance and identify areas for improvement;
- how the Trust ensures it delivers its role within significant partnerships and engages with stakeholders it has identified, in order to assess whether it is meeting its objectives; and
- where the Trust commissions or procures services, how it assesses whether it is realising the expected benefits.

- Development of CIP starts while identifying future priorities during business planning. Finance identifies a minimum percentage saving to be made through CIPs for each division's budget. Once annual saving has been identified each division will identify where efficiencies and savings can be made. This will include divisions plan, corporate plan, procurement plan, job planning, outpatient and theatre efficiencies.
- Governance and assurance of the overall Programme and schemes within the Programme is overseen through standardised reporting to the Financial Recovery Group on a weekly basis. To close the CIP Programme a final review of objectives and achievements of benefits will be undertaken at the end of the financial year by the Financial Recovery Group/ Financial Accountability Committee.
- Once a CIP idea has been approved and PMO supports this. PMO supports services from the conception of an idea to developing the project gateway progression. For larger and more complex projects a named project manager will support the delivery of the identified scheme. The Executive Director of Strategy and Transformation has overall responsibility for the development of the CIP plan and line manages the PMO resource.
- The trust had original plans to deliver £16.5m of saving in 2024/25. After the introduction of Financial recovery plan to help the trust manage its deficit the combined revised CIP and FRP schemes planned to deliver £19.2m CIP. The actual delivery of CIP was £21.7m, a favourable variance of £2.7m. This overperformance was due to Financial recovery plan schemes delivering earlier than anticipated.
- The Trust's CIP target for 2025-26 is £32.7m. This target is comprised of three elements; £6m from the full year effect of the 24/25 Financial Recovery Plan, £20.8m 25/26 CIP and £5.8m further 'stretch' CIP.
- Performance of providers or sub-contractors is monitored through meetings that take place on monthly basis with a log and tracker of actions. Contracts have differing performance requirements and these are normally outlined in the main contract documentation and form part of the monitoring meetings. In case of dispute, all agreements contain a dispute resolution process with stepped arrangements and named positions for responsibility of the parties.

Improving economy, efficiency and effectiveness

- The Trust has contracts greater than £1m with Cambridge University Hospital, Medequip and Rosscare. We have obtained the minutes of the meeting held in January with Medequip to monitor performance. The minutes provides evidence of monitoring of the performance via KPI reporting. Key Performance indicator reports are presented which provides details of each KPI and performance for each month along with compliance target. The minutes cover all the areas from performance to quality report and customer feedback. An action log is maintained and updated for any actions taken and additional actions agreed in the meeting.

- Trust has SFI's that detail the financial responsibilities and provides formal authorisation limits for awarding contracts. The procurement policy ensures transparent, fair and open competition. We have inspected the tender waiver register and noted that all waivers are approved by the appropriate approver based on the set limits.

Conclusion:

Based on the work performed we have not identified a significant weakness associated with Improving economy, efficiency and effectiveness.

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ITEMS FOR INFORMATION

16. Summary report for Board of Directors meetings (enclosed)

To receive the report from the Chair and Non-Executive Directors

To Note

Presented by Jude Chin

NHS
West Suffolk
NHS Foundation Trust

WSFT Council of Governors Meeting (Open)	
Report title:	Summary Report for Board of Directors meetings
Agenda item:	16
Date of the meeting:	11 September 2025
Sponsor/executive lead:	Jude Chin, Trust Chair
Report prepared by:	Pooja Sharma, Deputy Trust Secretary Ruth Williamson, Foundation Trust Office Manager

Purpose of the report:			
For approval ☐	**For assurance** ☐	**For discussion** ☒	**For information** ☐
Trust strategy ambitions	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
Please indicate Trust strategy ambitions relevant to this report.	☒	☒	☒

Executive summary:

WHAT?
Summary of issue, including evaluation of the validity the data/information

This report is from the Board of Directors to the Council of Governors and recognises the statutory duties of the Governors to:

- **represent the interests** of the members of the NHS foundation trust and the public
- through the NEDs **hold to account** for the performance of the Board of Directors.

SO WHAT?
Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk

The Board of Directors recognises and respects this role of the Council of Governors.

This report summaries the activities of the Board meetings and complements the reports received from the Board's assurance committees earlier on the agenda.

WHAT NEXT?
Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)

The Council of Governors to review this report in order to:

- consider any elements relating to the **performance of the Board** arising from this report which they wish to raise with the non-executive directors,

• consider any **areas of priority** identified in this report for future engagement with members and the public.	
Action required / Recommendation:	
The Council of Governors is asked to note and review the summary report.	
Previously considered by:	N/A
Risk and assurance:	If we do not provide the Council of Governors with the right level of reporting on the performance of the Board, this will not provide them with the intelligence and context against which they can effectively hold the NEDs to account for the Board's performance and information on the principal issues for which they are responsible for representing the interests of members and the public in the governance of the Trust.
Equality, diversity and inclusion:	Ensure appropriate consideration of EDI issues
Sustainability:	Be aware of the environmental impact of decision making
Legal and regulatory context:	NHS Act 2006, Health and Social Care Act 2012 Your Statutory Duties: A reference guide for NHS Foundation Trust Governors – Monitor 2013 The NHS Foundation Trust Code of Governance July 2014

Board of Director Key Issues

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Board of Director Key Issues – May 2025			
Patient Story – The Board listened to pre-recorded feedback from the daughter of a patient on her mother's treatment whilst at the Trust. Learning was to be disseminated	• To consider progression and prioritisation of end-of-life discussions and ward moves.	• Model for future care	Verbal
CEO Report – UEC performance had notably improved, highlighting staff efforts. The Community Diagnostic Centre was helping reduce waiting times. Turnaround times remained a focus, with diagnostic and elective performance reviewed weekly in Senior Operations Meetings.	• Ongoing assurance/ monitoring	-	1.7
WSFT Strategy – Staff engagement on the Trust's strategy is underway. In response to concerns about timing and external factors, an iterative approach and extended stakeholder engagement—including governors—was being considered before presenting a revised plan to the Board.	• Ongoing assurance/ monitoring	• Deliver the Trust strategy	2.1
Future System Board Report – The clinical and care strategy remained unchanged despite suggested accommodation adjustments. Contractor selection will be managed through central procurement.	• Ongoing assurance/ monitoring • Board to receive future updates	• Sustainable service improvements	2.2
West Suffolk Alliance and SNEE Integrated Care Board - Following proposed changes to the Integrated Care Board structure, senior leadership roles were shared between SNEE and Norfolk & Waveney ICBs. Whilst this presents challenges, it also offers strategic opportunities for integration and collaboration, with a continued focus on patient care and stakeholder engagement.	• Strengthened provider collaboration	• Focus on system working	2.3

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Digital Board Report – The department was reprioritising its focus on cyber security, patient engagement, clinical safety, and AI management. The Trust is adapting the ICB's AI strategy and exploring AI applications such as image reporting, with governance aligned to NHSE standards. Barriers to patient portal usage are being reviewed to improve engagement.	• Ongoing assurance/monitoring	-	2.4
Collaborative Oversight Group – Following the Sustainability Review, the Trust is reassessing its provider collaborative governance arrangements and will establish a Joint Productivity Board to support future planning and improvement.	• Strengthened provider collaboration	• Focus on system working	2.5
IQPR Report - The Trust shared its UEC success and remained focused on reducing Elective Access RTT. Work was ongoing to boost patient portal engagement and manage ultrasound demand, with AI tools under review. Appraisal compliance is monitored, with further detail sought on outstanding doctor appraisals.	• Ongoing assurance/monitoring	-	3.1
Finance Report – The Trust had agreed a planned deficit of £20.7m for the year, with a positive start in Month 1. Pay awards present a financial risk, as no additional funding is expected from the Government. The Finance Team was assessing the impact, with an update to be provided to the Insight Committee and July Board.	• Ongoing assurance/monitoring	• Financial sustainability	3.2
Involvement Committee – Partial assurance was given on the National Staff Survey, with further work needed to analyse results by directorate and ensure clear ownership of follow-up actions.	• Ongoing assurance/ monitoring	-	4.1
People & OD Highlight Report – A more centralised approach is being taken to the NHS Staff Survey following a decline in results. Five key themes had been identified, with action plans in development and oversight through relevant committees. Equality, Diversity & Inclusion and outcomes for protected characteristics were areas of particular focus.	• Recognition of staff.	-	4.2

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Freedom to Speak Up Report – Quarter 4 - Key themes from staff feedback included financial pressures, concerns around gender-neutral facilities, and the importance of encouraging speaking up. Actions are underway to improve inclusivity, expand the FTSU Champion network, and strengthen staff consultation processes, with a focus on learning and communication.	• Ongoing assurance/ monitoring	-	4.2.2
Insight Committee – the report was noted.	• Ongoing assurance/ monitoring	-	5.1
Improvement Committee – The Trust was among the top performers nationally and the best in the region for Summary Hospital-level Mortality Indicator (SHMI) outcomes.	• Ongoing assurance/ monitoring	-	6.1
Quality and Nurse Staffing Report – Staff sickness and fill rates continued to improve. Care Hour Per Patient Day (CHPPD) performance remaining within expected levels. The Trust was supporting newly qualifying nurses and using a new tool to assess community nursing demand and staffing needs.	• Ongoing assurance/ monitoring • Overseeing quality indicators	-	6.2
Maternity Services – The department was prioritising mandatory training, aiming for full staff competency by year-end. Measures were being taken to minimise impact on clinical care, with tailored approaches to support doctors in completing training efficiently.	• Ongoing assurance/ monitoring in areas of priority	-	6.3
Charitable Funds Committee – Joanne Landucci was appointed as the new Head of Fundraising.	• Board visibility and oversight	-	7.1

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Board Assurance Framework - A Board Workshop will be held in the Autumn to review the strategy refresh and updated BAF template. BAF 6 (Estates) will be reassigned to the Insight Committee, with the Interim Head of Estates invited to attend. Cyber security was covered under the broader digital risk category.	• Board Oversight	-	7.2
AuditOne Recommendation – Progress report noted	• Board visibility and oversight	-	7.3
Governance Report – An amendment to the Trust's Constitution to extend the Lead and Deputy Lead Governor terms of office to three years, allowing two years post-election for newly elected governors to gain experience to vote or stand for the role was approved, subject to legal confirmation.	• Board oversight	-	7.4
Any Other Business – Thanks were expressed to the Chief Nurse, Sue Wilkinson, at her final meeting, recognising significant contribution to the Trust and advocacy for patients and staff ahead of retirement in July.	-	-	Verbal

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Board of Director Key Issues – July 2025			
Patient Story – The Board received a presentation from the Clinical Lead Physiotherapist for Clinical Care & Surgery outlining a patient's rehabilitation journey and associated service challenges.	• To improve rehabilitation outcomes through continuity of care.	• Model for future care	Verbal
CEO Report – WSFT received six nominations at the 2025 ICS "Can Do" Awards, and discussed preparations and communications in response to upcoming industrial action, including potential impacts on routine procedures and patient appointments.	• Ongoing assurance/ monitoring	-	1.7
WSFT Strategy – Over 200 responses were received to the Trust's strategy survey; feedback is being analysed ahead of Board approval in September and formal launch in October. Concerns were raised about patient focus in the draft ambitions, with further discussion scheduled.	• Ongoing assurance/ monitoring	• Deliver the Trust strategy	2.1
Future System Board Report – Progress on capital affordability was noted, alongside concerns about disjointed planning and the need to balance capital and revenue costs in the new hospital programme. Support from the ICB will be essential to confirm financial sustainability.	• Ongoing assurance/ monitoring • Board to receive future updates	• Sustainable service improvements	2.2
West Suffolk Alliance and SNEE Integrated Care Board - Noted ongoing ICB director structure changes and a positive trend in primary care patient satisfaction, attributed to digital improvements. Preparations for dental procurement are underway, and updates on dementia diagnosis delays and diabetes service commissioning will come to a future Board meeting.	• Strengthened provider collaboration	• Focus on system working	2.3

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Digital Board Report – The Board noted ongoing efforts to improve service access and communication, including prioritisation of initiatives and the rollout of discharge summaries to GPs. Device migration to Windows 11 is underway, and benefit tracking will become a standing item on the Digital Board agenda.	• Ongoing assurance/ monitoring	-	2.4
Joint Productivity Board - the inaugural meeting took place on 14 July, at which the Terms of Reference and Senior Responsible Officers were agreed.	• Strengthened provider collaboration	• Focus on system working	2.5
IQPR Report – Ongoing challenges in breast, dermatology, diagnostics, ultrasound, and endoscopy services, driven by staffing shortages and rising demand. Key actions include pathway reviews, external triage support, international recruitment, and digital innovations. Forecasts show gradual performance recovery, with further updates and data reviews planned.	• Ongoing assurance/ monitoring	-	3.1
Involvement Committee – Changes to the apprenticeship levy have prompted a review of the Trust's apprenticeship strategy.	• Ongoing assurance/ monitoring		4.1
People & OD Highlight Report – Putting You First - Recent staff awards noted and congratulations extended to recipients.	Recognition of staff.	-	4.2
Freedom to Speak Up Guardian Report - Noted a reduction in anonymous speak-up reports together with encouraging feedback following the launch of the Sexual Safety Charter. Actions are underway to improve engagement from medical staff.	• Ongoing assurance/ monitoring	-	4.2
Insight Committee Report - Virtual Ward occupancy has risen from 55% to an average of 70–77% following targeted improvement actions. Further review of resource allocation and performance will be addressed through the IQPR report at Insight Committee.	• Ongoing assurance/monitoring	-	5.1

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Finance - Improved financial performance in Month 3, though a £1.8m monthly deficit and £4.5m CIP gap remain. Actions are underway to review and deliver CIP schemes, manage recruitment, and explore income opportunities.	• Ongoing assurance/ monitoring	• Financial sustainability	5.2
Green Plan – Approval granted to the updated Green Plan, aligned with NHS guidance and focused on the link between climate change and health.	• Ongoing assurance/ monitoring	-	5.3
Acute Contract Sign-Off - Contract noted with sign-off to be undertaken by the CEO.	• Ongoing assurance/ monitoring		5.4
Improvement Committee – ongoing assurance work across key programmes, including Getting It Right First Time (GIRFT), Venous Thromboembolism (VTE), National Safety Standards for Invasive Procedures (NATSSIPs), and diabetes commissioning. Concerns were raised about the public health strategy being input-focused and low Adult Safeguarding Level 3 compliance, with actions underway to address training gaps and improve population health outcomes.	• Ongoing assurance/ monitoring	-	6.1
Quality and Nurse Staffing Report –Vacancy rates fallen below 10%, with improved fill rates and confidence in staff placement. Pressure ulcer rates are rising and monitored via Performance Review Meetings (PRMs). Temporary staffing spend remains a focus, with agency nursing in surgery eliminated. Overspend is expected to balance by October/November.	• Ongoing assurance/ monitoring • Overseeing quality indicators	-	6.2
Maternity Services – noted adoption of the Perinatal Quality Oversight model and continued staff engagement through workshops. A slight increase in complaints is being addressed with thematic analysis. Community equipment concerns are being actioned and a neonatal voice champion has been introduced to enhance safety feedback.	• Ongoing assurance/ monitoring in areas of priority	-	6.3

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Charitable Funds Committee Report - The business case for the robot was reconfirmed, with fundraising to progress. The proposed restructure of the fundraising team was approved.	• Board visibility and oversight	-	7.1
Audit Committee - Internal Audit actions monitoring continues, with the CEO now leading monthly reviews via the Management Executive Group (MEG) to enhance governance oversight.	• Board visibility and oversight	-	7.2
Board Assurance Framework – Selected risks have been reviewed, with executive leads, MEG, and assurance committees involved in oversight. Work is underway to realign the assurance framework with the new strategy, with a workshop proposed before Christmas.	• Ongoing assurance/ monitoring	-	7.3
Governance Report - report noted.	• Board oversight	-	7.4
Any Other Business – none reported.	-	-	Verbal

17. Dates for meetings for 2025:

- 8 October, 2025 - Annual Members' Meeting
- 13 November, 2025

To Note

Presented by Jude Chin

18. Reflections on meeting

To consider whether the right balance has been achieved in terms of information received and questions for assurance and the Trust's values and behaviours observed

To Note

Presented by Jude Chin

CLOSE

SUPPORTING ANNEXES

Item 9 - IQPR full Report - May, 2025

Assurance Grid

VARIANCE: Variation from the mean
The colours indicate the trend- positive (blue), Negative (orange), or neither (grey)

ASSURANCE: Will we reliably meet the target based?

Not Met

Performance in May 2025	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement	**INSIGHT** Virtual Beds Trajectory **INVOLVEMENT** Staff Sickness Rolling 12 Months	**INSIGHT** Ambulance Handover within 30min 12 Hour Breaches Non-admitted 4 hour performance % patients with no criteria to reside Cancer 62 Days Performance **INVOLVEMENT** Mandatory Training Turnover	**INSIGHT** 12 hour breaches as a percentage of attendances Incomplete 104 Day Waits RTT 78+ Week Waits	**INSIGHT** Criteria to reside – Acute RTT 65+ Week Waits RTT NDD Only Waiting List **IMPROVEMENT** SHMI
Common Cause	**INSIGHT** 4 hour breaches Urgent 2 hour response – EIT Virtual Ward Total average LOS per patient **INVOLVEMENT** Staff Sickness	**INSIGHT** Virtual Ward Total average occupancy percentage 28 Day Faster Diagnosis **IMPROVEMENT** C-Diff Hospital & Community onset, Healthcare Associated	**INSIGHT** Virtual Ward Total average occupancy number **INVOLVEMENT** Appraisal	**INSIGHT** Criteria to reside – Community Virtual Ward Total bed days RTT NDD Only 52 Waiting List RTT NDD Only 78 Waiting List **IMPROVEMENT** % of patients with Measured Weight % of patients with a MUST/PYMs assessment completed within 24 hours of admission Post Partum Haemorrhage Inpatient Deaths **INVOLVEMENT** Closed complaints % extended Count extended % Complaints responded to late Count responded to late % resolved in one week Total PALS resolved Count
Special Cause Concern Deteriorating	**INSIGHT**	**INSIGHT** Community Paediatrics RTT Overall 78 Waiting List	**INSIGHT** Diagnostic Performance - % within 6 weeks total	**INSIGHT** RTT Waiting List Community Paediatrics RTT Overall Waiting List Community Paediatrics RTT Overall 52 Waiting List Community Paediatrics RTT Overall 65 Waiting List RTT NDD Only 65 Waiting List **INVOLVEMENT** Active complaints

Items for escalation based on those indicators that are failing the target, or are worsening and therefore showing Special Cause of Concerning Nature by area:
INSIGHT - Urgent & Emergency Care: 12 hour breaches as a percentage of attendances, Virtual Ward Total average occupancy number
Cancer: Incomplete 104 Day Waits
Elective: Diagnostic Performance - % within 6 weeks total, RTT 78+ Week Waits, Community Paediatrics RTT Overall 78 Waiting List
INVOLVEMENT – Well Led: Appraisal

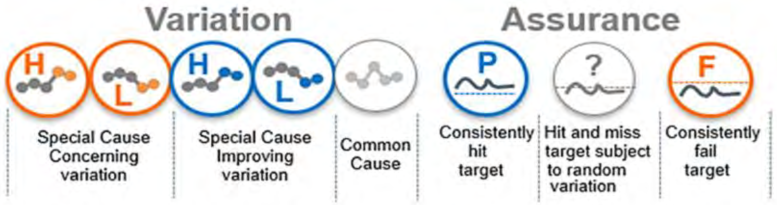
INSIGHT COMMITTEE METRICS

Urgent & Emergency Care summary

Chart Legend

Target — Mean — Measure

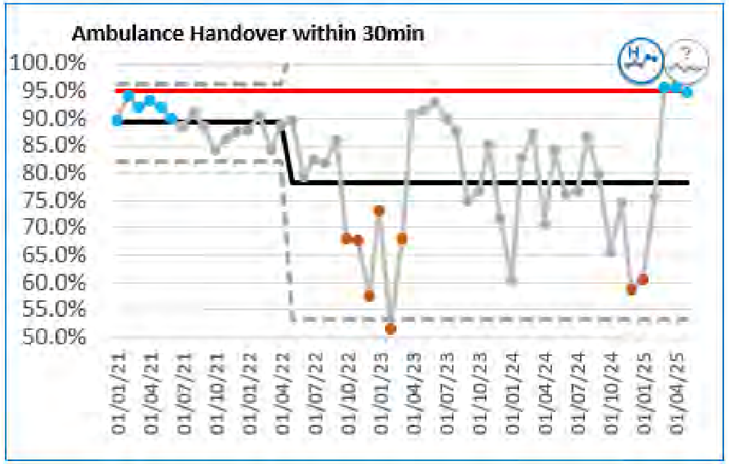
Process Limit — Lower Process Limit

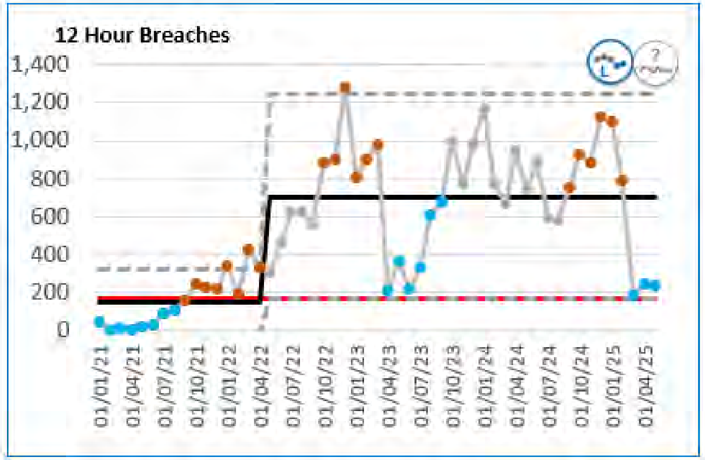


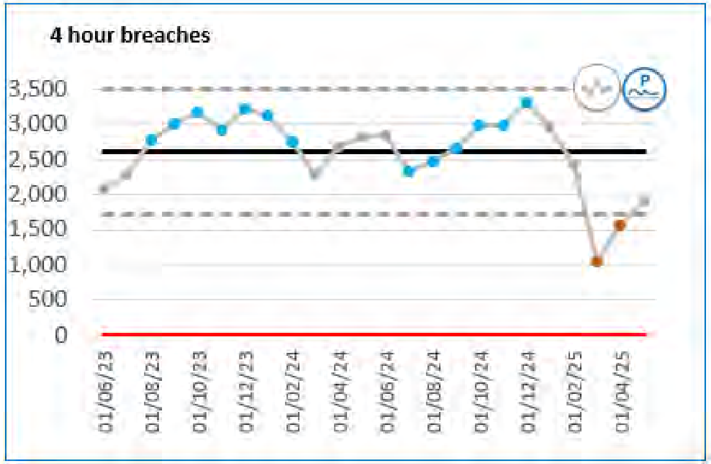
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover within 30min	May 25	94.9%	95.0%			78.2%	53.2%	103.1%
12 Hour Breaches	May 25	237	167			706	166	1245
4 hour breaches	May 25	1923	0			2613	1716	3510
Non-admitted 4 hour performance	May 25	86.5%	85.0%			77.7%	66.4%	89.0%
12 hour breaches as a percentage of attendances	May 25	2.6%	2.0%			9.0%	2.2%	15.7%
Urgent 2 hour response - EIT	May 25	94.2%	70.0%			91.0%	83.8%	98.2%
Criteria to reside (Average without reason to reside) Acute	May 25	31				53	39	68
**Criteria to reside (Average without reason to reside) Community	May 25	38				36	26	45
% patients with no criteria to reside (acute)	May 25	7.8%	10.0%			12.3%	8.3%	16.2%
Virtual Beds Trajectory	May 25	59	40			46	42	50
Virtual Ward Total average occupancy number	May 25	32.7	47.2			24.9	16.6	33.2
Virtual Ward Total average occupancy percentage	May 25	55%	80%			67%	44%	90%
Virtual Ward Total bed days	May 25	975				764	320	1208
Virtual Ward Total average LOS per patient	May 25	8.5	14.0			8.8	5.0	12.7

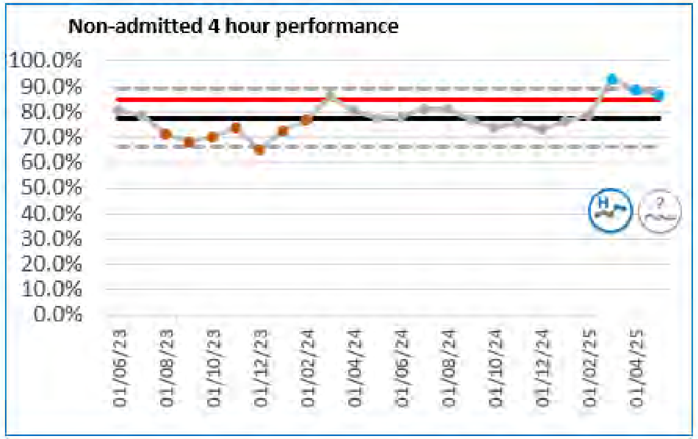
** Figures are for Glastonbury and Newmarket only, data not currently captured at Hazel Court.

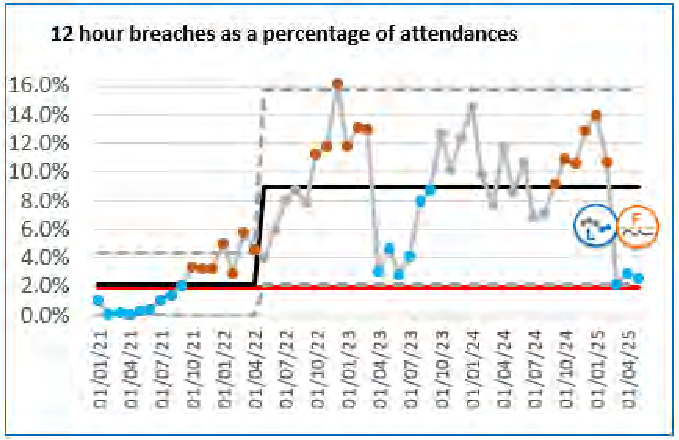
Urgent & Emergency Care: ED 4 Hour Performance

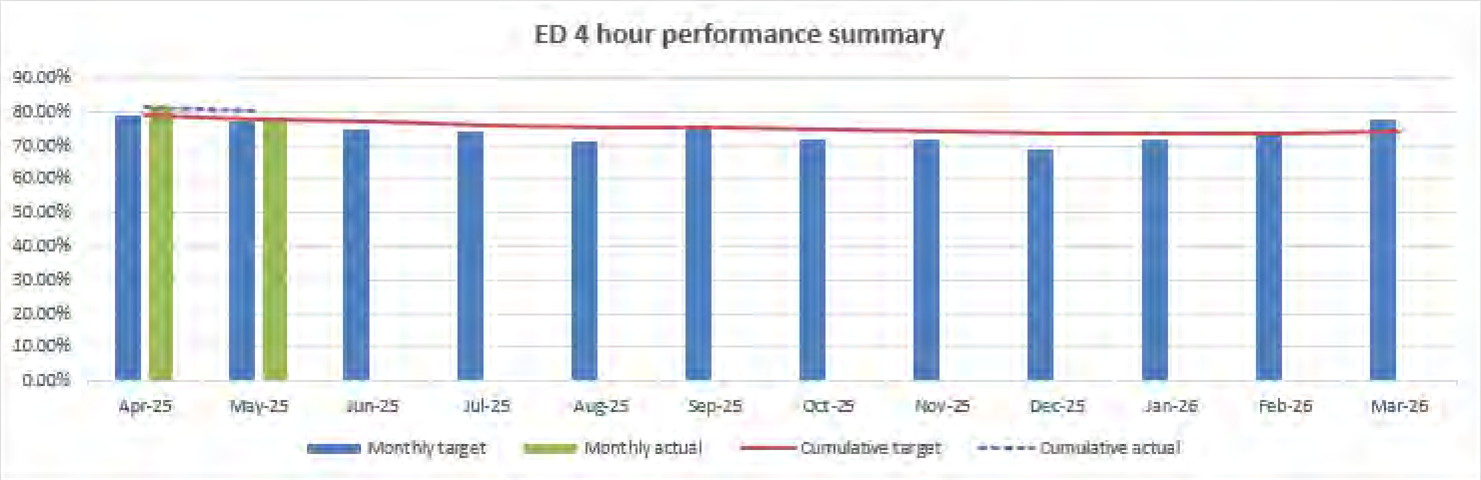












Urgent & Emergency Care

What	So What?	What Next?
The improvement in the 30 minute ambulance handover metric was maintained in May, achieving 94.9% narrowly missing the target of 95%. The number of 12 hour length of stay breaches in May was 237 representing a maintained reduction from March and an improved position compared to April. Numbers of 12 hour breaches as a percentage of attendances shows a failing picture although significant improvement continues to be maintained following on from March. Non-admitted performance shows no significant change, with 86.92% achieved for May. The Emergency Department 4 hour performance for May was 78.5%, against the in-month trajectory of 78%.	Meeting the Urgent and Emergency Care (UEC) performance metrics means that our patients receive timely, safe care. Achieving the ambulance handover metrics and the 78% 4 hour Emergency Department standard means we meet the national targets. Achieving the monthly trajectory will keep us on track to achieve 78% in March '26 for the 4 hour standard. In May the number of patients waiting longer in the Emergency Department remained lower than in previous months meaning fewer patients were nursed in escalation areas, making for a better patient experience.	• Continued work to meet monthly trajectory to achieve 78% 4hr Emergency Department target by March '26. • Weekly performance meetings with the Emergency Department and Medical Division senior leaders/Executives continue. • Continue to work through recruitment to the post of Service Manager in the Emergency Department. • Continue to implement and monitor the cross-divisional workstreams of both the UEC and taskforce projects. • Continued focus on length of stay reductions to support flow out of the Emergency Department, including the task and finish group for board rounds planned in June. • Visit from the National Urgent and Emergency Care Team on 5th June to showcase our improvements and impact on 12 hour breach reductions. • Focus on planning a trial of an Ambulatory Care Unit within the ED footprint.

Community Access Glemsford Surgery

SNEE Business Intelligence

Practice Appointments

Refreshed on 29/04/2025, Data coverage up to 01/03/2025

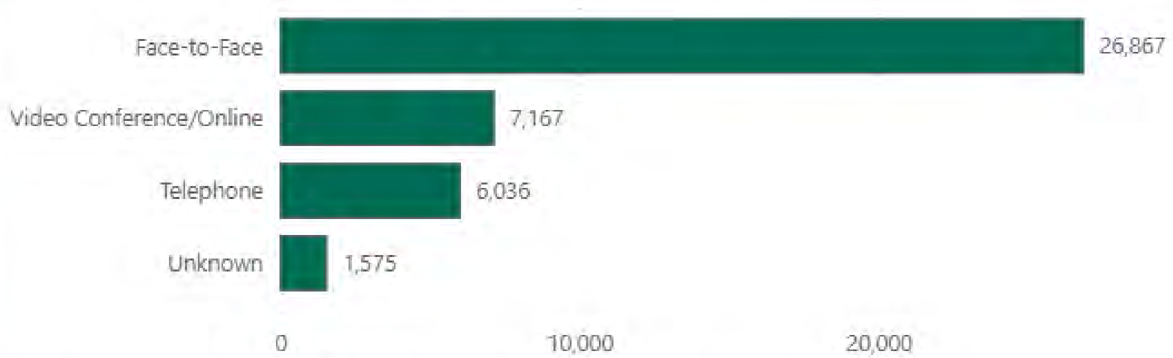
NHS Suffolk and North East Essex Integrated Care Board

Alliance All

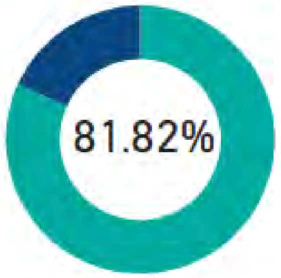
PCN All

Practice Glemsford

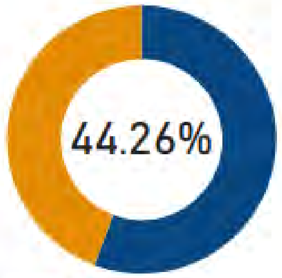
Practice appointments by contact mode



Seen within 2 weeks

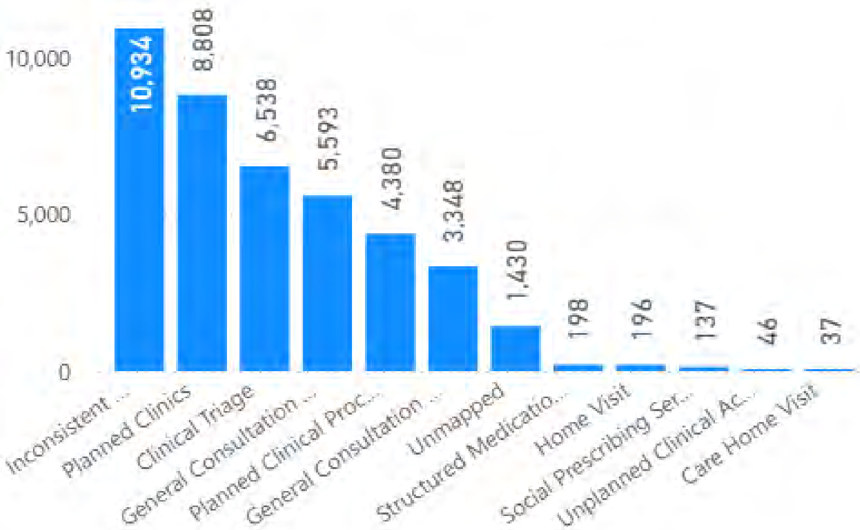


Seen within 48 hours

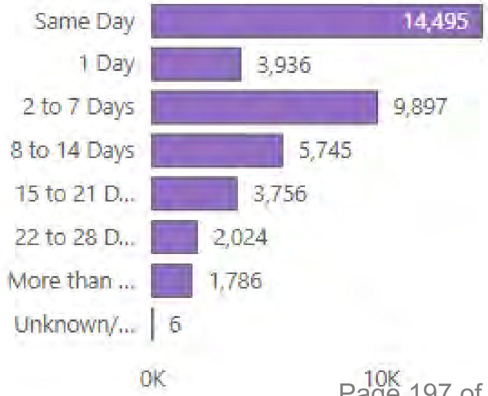


Practice appointments by health care professional type

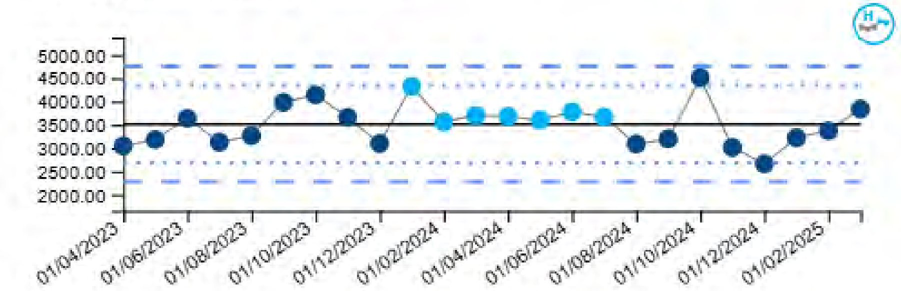
Sum of Total Appointments by National Category



Appointments by wait time

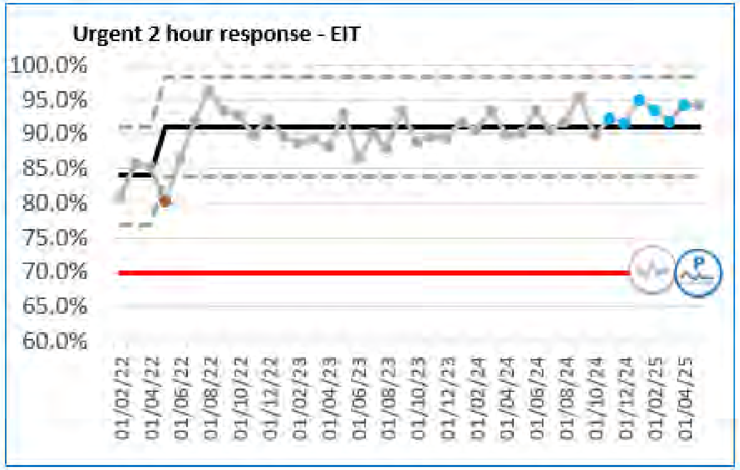


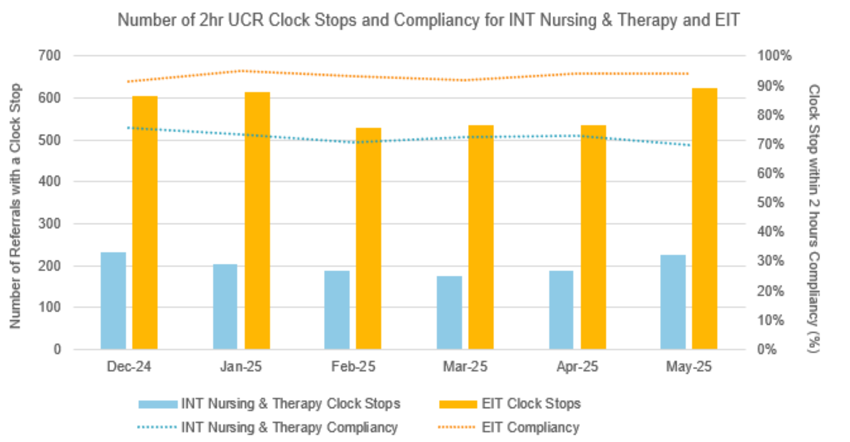
Total appointments by month

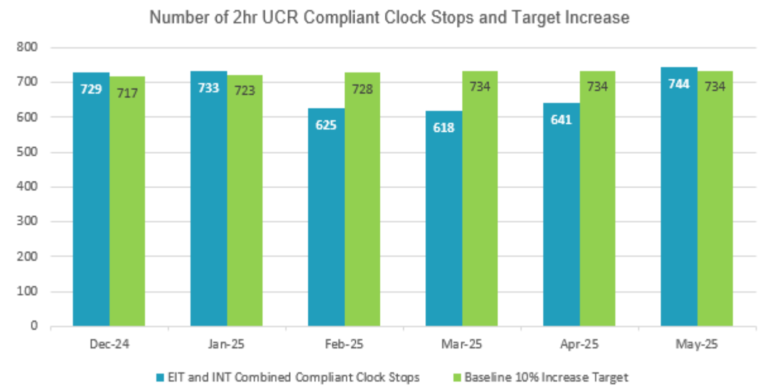


Produced by ICB

Urgent & Emergency Care: UCR







Team	Dec-24				Jan-25				Feb-25				Mar-25				Apr-25				May-25			
	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant
Total INT Nursing & Therapy	231	175	56	76%	203	149	54	73%	186	131	55	70%	174	126	48	72%	189	138	51	73%	225	157	68	70%
Total EIT*	605	554	51	91.57%	615	584	31	94.96%	529	494	35	93.38%	536	492	44	91.79%	534	503	31	94.19%	623	587	36	94.22%
Combined Total	836	729	107	87.20%	818	733	85	89.61%	715	625	90	87.41%	710	618	92	87.04%	723	641	82	88.66%	848	744	104	87.74%

What

There has been no significant change with 2-hour Early Intervention team (EIT) community performance.

Increase in nursing 2 hours referrals in the INT teams, referral compliancy has fallen as result.

54% breaches had reason for breach added with the majority being due to capacity issues.

Newmarket and Rural therapy 18 week compliancy is low for 18 week but high across all therapy teams for 2 days

So What?

Continue to exceed national UCR target.
Cleric referrals only accepted where there is capacity.

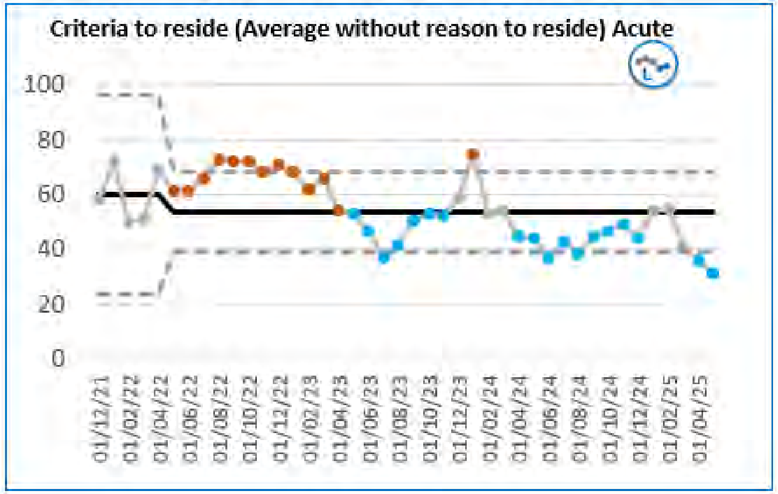
Showing that urgent response and 2 day referrals are being prioritised above routine work, in INT.

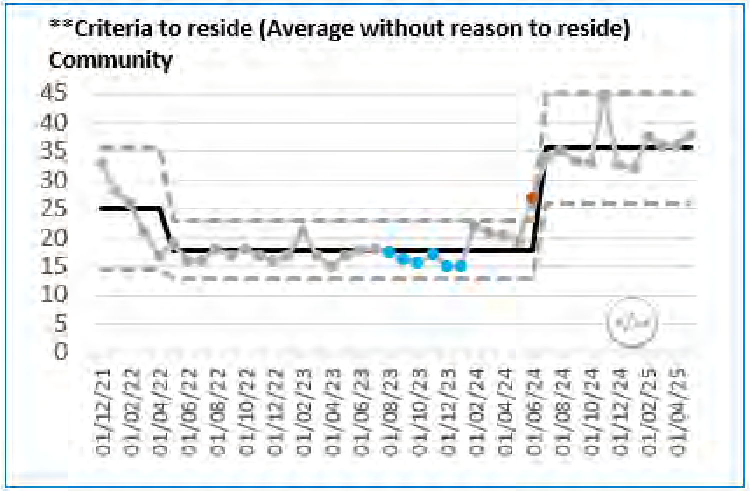
What Next?

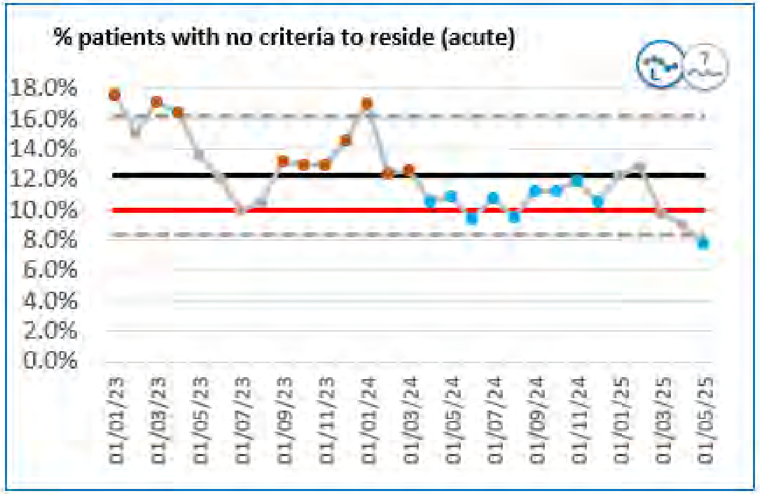
EIT - Continuing to trial one person based in ED.
Using bank staff to bring night care service to full staffing to test what current demand and capacity is to support increase in pathway 1 and reduction in pathway 2. Aim to increase night care capacity by completing single visits, vs double up visits, where safe.
Advanced Care Practitioners starting project for shared service delivery collaboration with virtual ward and Integrated Neighbourhood Teams (INT).

Initial period of formal cross cover for therapy clinical duties in Town, Rural, Mildenhall and Newmarket due to reduced staffing and skill mix challenges (resulting from blanket INT recruitment freeze) to be reviewed in 3 months, as productivity is above national benchmark.
Review and identify actions from therapy staffing PA modelling for in next 2 weeks

Urgent & Emergency Care: Criteria to reside

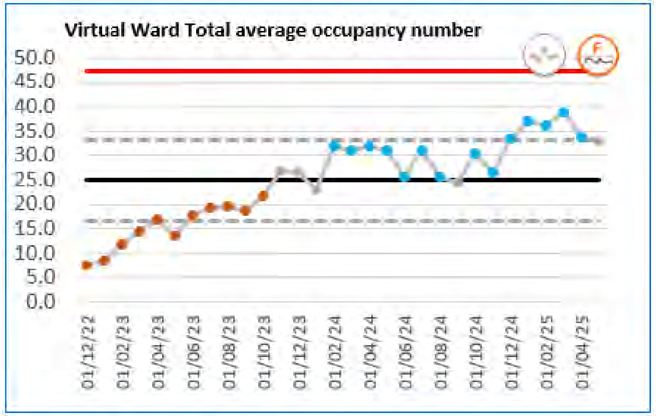


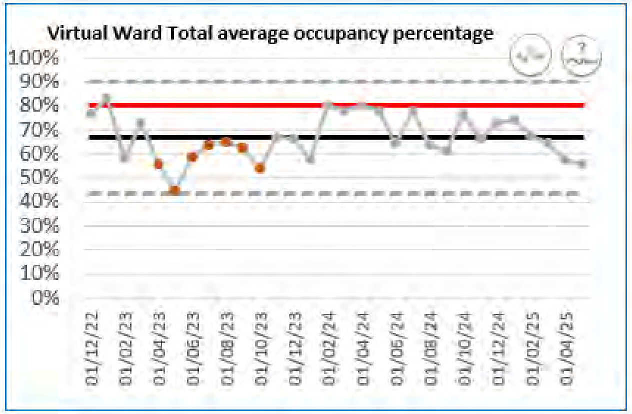


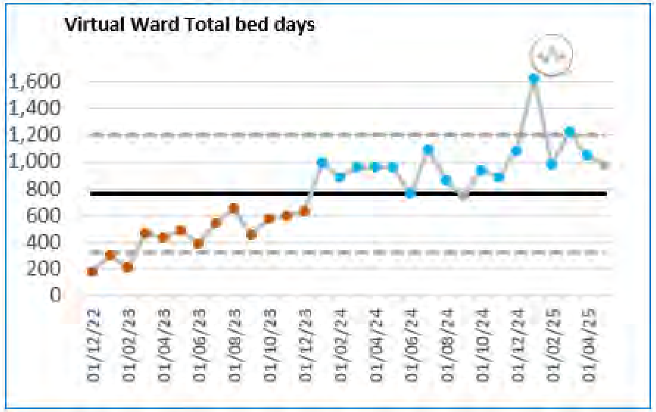


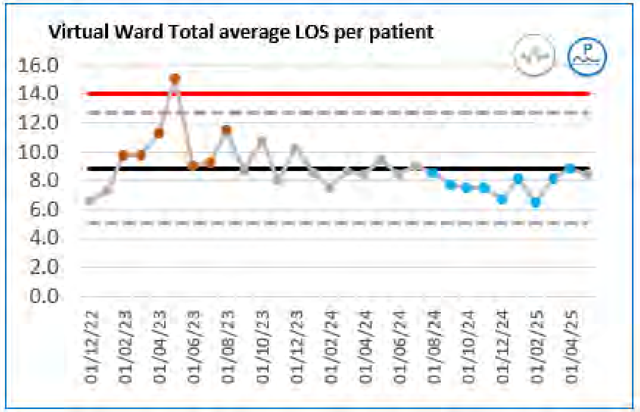
What	So What?	What Next?
May has seen a further reduction in the number of acute patients without criteria to reside with an average of 7.8% - the lowest figure recorded to date. Continue to transfer non-traditional patients into Community Assessment Beds (CAB) which may be a contributing factor however this has not had a significant impact on the Community No Criteria To Reside figures	Patients remaining in hospital longer without criteria to reside directly impacts on bed capacity and patient flow within the Trust. Longer length of stay leads to greater deconditioning and loss of independence.	Changes to the Transfer Of Care Hospital (TOCH) Discharge Planning Dashboard to support improved accountability and transparency of actions are being taken to the Change Board on 25th June 2025 for approval. If approved education needs to be undertaken with TOCH teams with the aim to have the system live by July 2025. TOCH teams continue to support workstreams to further enhance Pathway 1 discharges and reduce numbers of Out of County patients moved to CAB with the planned reduction in pathway 2 capacity from August. Work to explore mitigations from a community perspective for the removal of the delirium discharge nurse role have commenced with an acute workstream also needing to be established.

Urgent & Emergency Care (TRUST – Virtual Ward)









What

There was a slight reduction in average occupancy in May: average occupancy of 32.7 patients compared to 33.8 patients in April. This is reflected in a reduction of bed days occupied (975 in May compared to 1952 in April).

Patient flow is supported by effective length of stay which is well managed at average 8.5 days in May (slight reduction from 8.8 days in April). This is significantly below the NHSE target of 14 days . VW audit indicates that this is achieved whilst maintaining appropriate acuity.

So What?

Virtual Ward capacity is crucial in ensuring adequate capacity to enable patient flow across the Trust and strategic ambition of caring for patients at or near wherever possible.

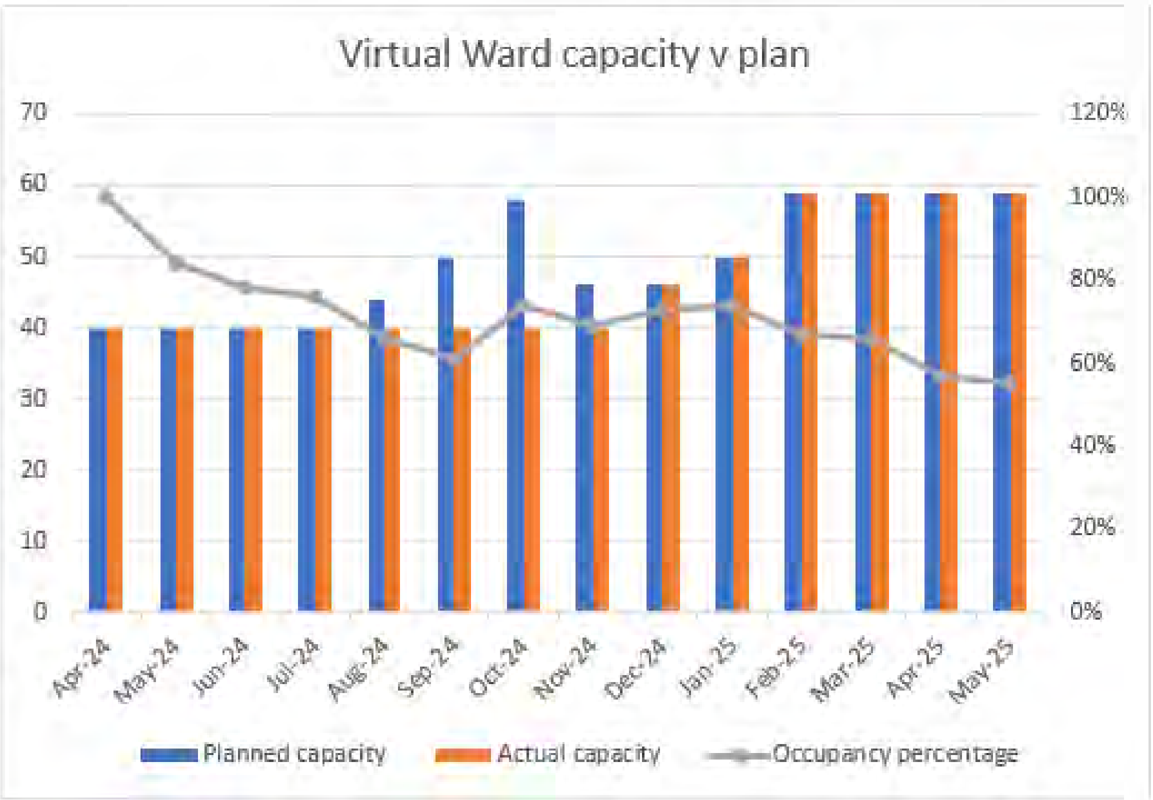
Appropriate length of stay is important to facilitate effective patient flow and ensure that value for money is achieved in relation to the investment in virtual care.

What Next?

Step ups - consultant now in post enabling further development of step ups to virtual care. Plan in place to achieve 50% target by October 2025. Monthly trajectory agreed and will be reported to PRM from July. Primary care pilot completed (Frailty pathway); next steps are (I) extension of hours (ii) expansion to 3 further GP practices and (iii) inclusion of heart failure pathway. EIT step ups enabled. Extend to community matron.

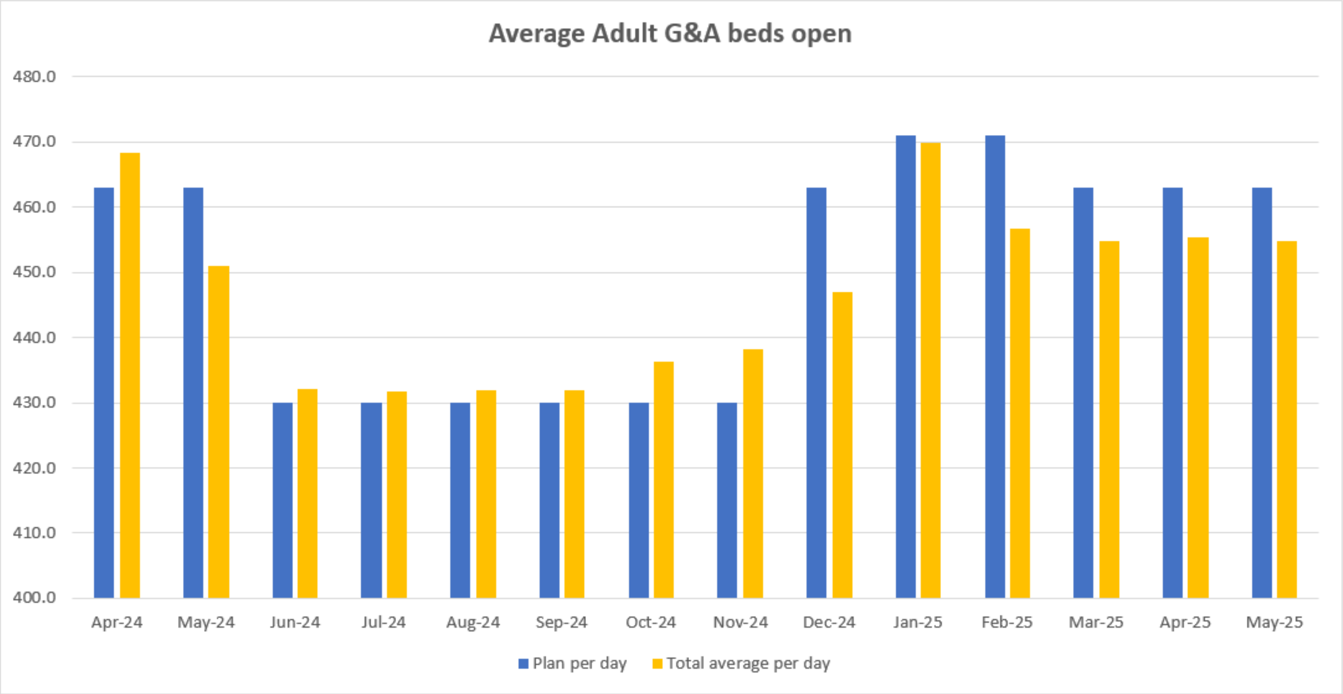
Shared Service Delivery programme - remaining VW nursing activities will be integrated into community teams in October 2025 releasing further efficiencies especially around travel time and cost.

Urgent & Emergency Care (TRUST – Virtual Ward)



What	So What?	What Next?
Average pathway occupancy during May 2025 have declined a little overall, numbers for those on respiratory pathway have declined the greatest.	Virtual Ward capacity is crucial in ensuring adequate capacity to enable patient flow across the Trust and strategic ambition of caring for patients at or near wherever possible.	Occupancy on virtual ward will be improved through stepping up patients directly from their homes. New Monthly trajectory agreed and will be reported to PRM from July.

Urgent & Emergency Care: Beds



What

May 2025 saw the average core beds maintained in line with closure of the winter escalation ward during March. Use of escalation beds decreased slightly, but still representing the 6 medical Same Day Emergency Care (SDEC) beds used to mitigate patient flow pressures and maintain timely departures from the Emergency Department.

NB – higher core beds open compared to summer 2024 represents inclusion of Discharge Waiting Area into reporting, following dataset specification being clarified.

So What?

Maintaining core beds open as per plan is a key requirement of the NHS operational priorities and planning guidance. Delivering the plan maximises patient flow and reduces extended waits for admission from the Emergency department, contributing to reduced 12-hour waits and improved 4-hour performance.

However, using escalation beds impacts on the ability of those areas being used to fulfil their primary purpose and uses unbudgeted staffing resources.

What Next?

Use of all escalation area is monitored through the daily capacity meetings in conjunction with divisional leadership teams to ensure it is in line with the Tactical Patient Flow Escalation Plan.

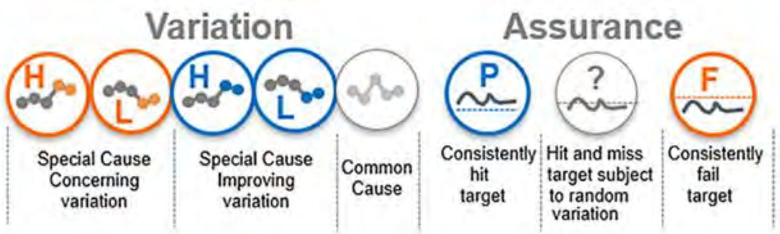
Using less core and escalation beds than planned from December to March provides the opportunity to rationalise inpatient capacity, with a plan to implement the first of these schemes in June.

Cancer Access Summary

Chart Legend

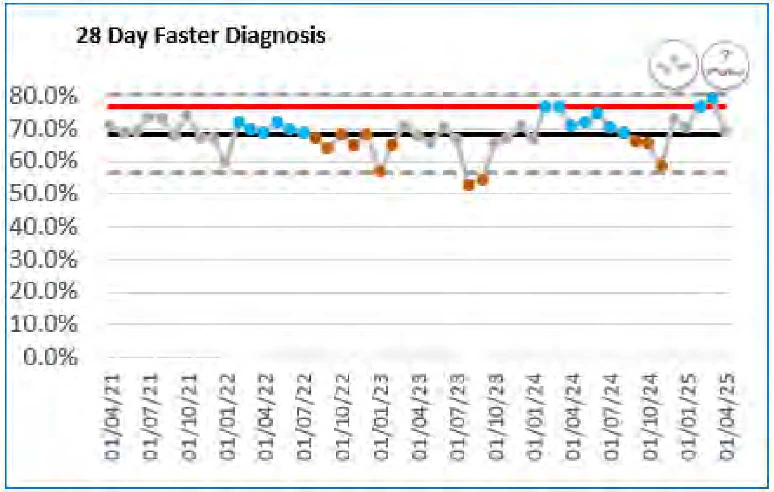
Target | Mean | Measure

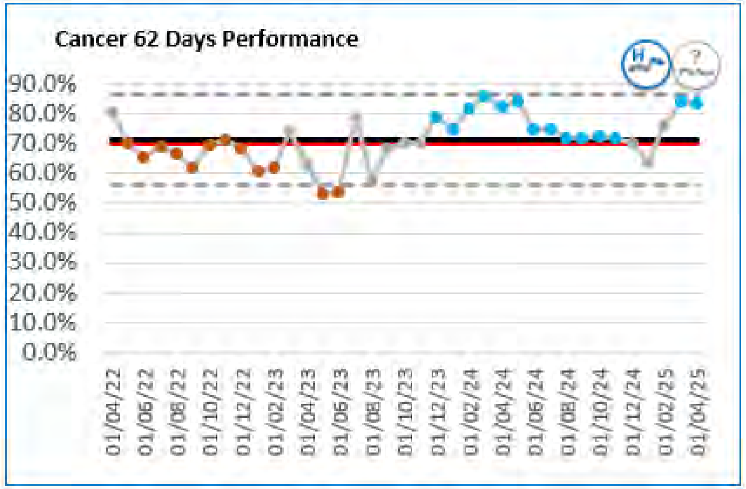
Process Limit | Lower Process Limit

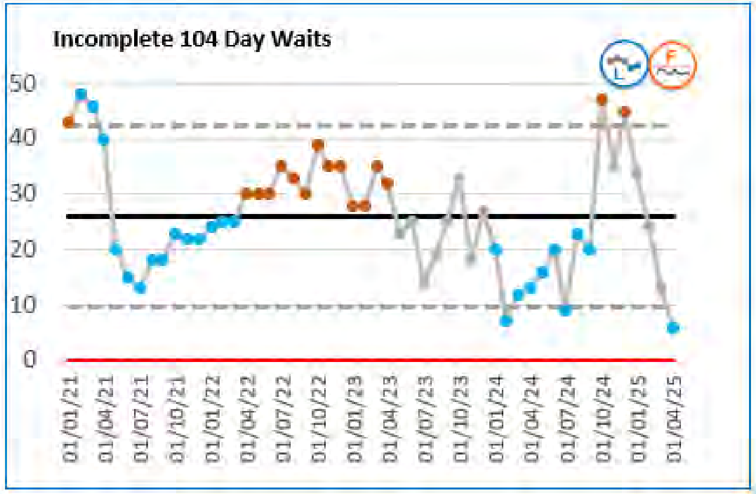


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	Apr 25	69.4%	77.0%			68.5%	56.5%	80.5%
Cancer 62 Days Performance	Apr 25	83.8%	70.0%			71.4%	55.9%	86.8%
Incomplete 104 Day Waits	Apr 25	6	0			26	10	42

Cancer Access (Month Behind)







What

Drop in faster diagnosis performance to 69.4%, against a planned position of 74.3%. This is due to significant underperformance in Breast, which was at 19% against a planned position on 92.1%. Urology, Upper GI, Skin, Head and Neck and Gynaecology all exceeded their forecast position.

The Breast underperformance is due to extended waits to first appointment, driven by a shortage of radiological support to the clinics.

62 day performance exceeded national standard.

So What?

Recovering the cancer standards is key to the operational planning guidance 25/26

The priorities for this year focus on seeing, diagnosing and treating patients in line with national guidance to improve patient outcomes and maintain standards.

What Next?

Task and finish group established for Skin pathway including community teledermatology provision, with a view for revised pathway to be in place by Q3 25/26.

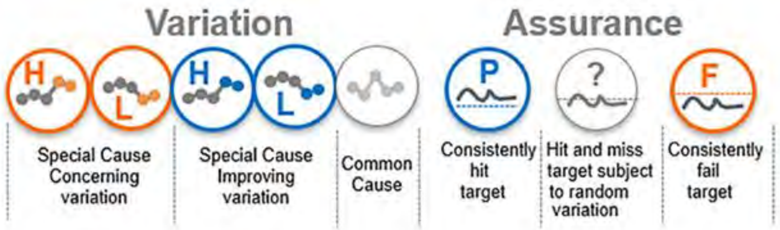
Continue with FDS steering groups in Skin, Colorectal, Breast and Gynae to monitor performance and required transformational changes as guided by the Best Practice Timed Pathway (BPTP) audits.

Continue with additional clinics within Breast, interviews for consultant radiologist to take place 11th July. Cross divisional short-, medium- and long-term plan paper to be presented to executives on the 23rd July

Elective Access: Summary

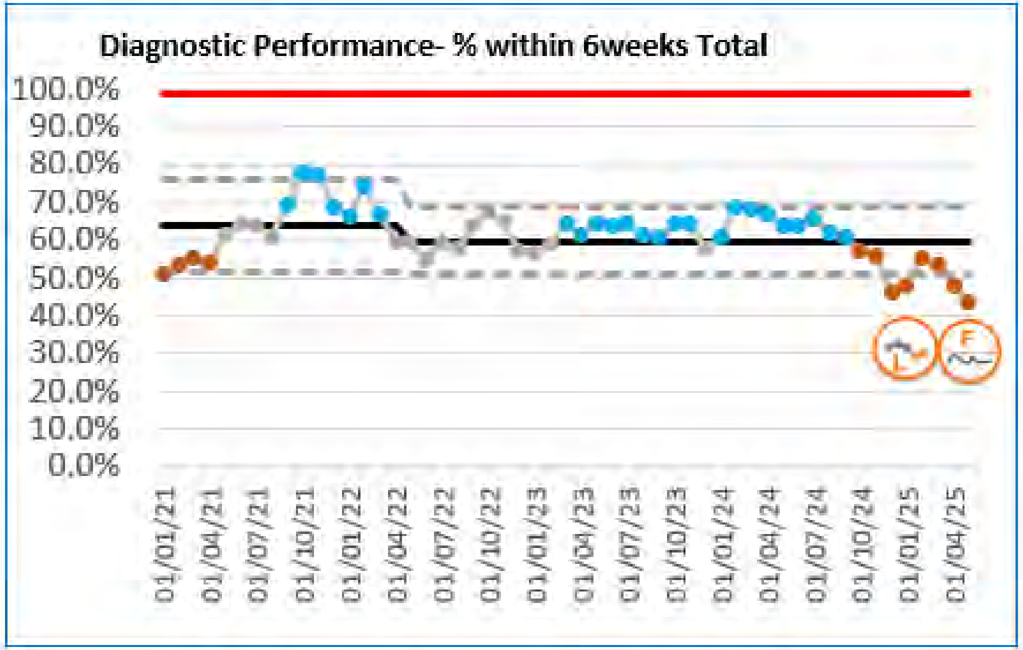
Chart Legend

- Target
- Mean
- Measure
- Process Limit
- Lower Process Limit



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Diagnostic Performance- % within 6weeks Total	May 25	43.8%	99.0%			59.9%	51.0%	68.7%
RTT Waiting List	May 25	35089				33251	31963	34539
RTT 65+ Week Waits	May 25	65				381	216	547
RTT 78+ Week Waits	May 25	4	0			123	67	178
Actual 65+ ww at end of Month	May 25	65				387	-189	962
Community Paediatrics RTT Overall Waiting List	May 25	677	-			513	450	577
Community Paediatrics RTT Overall 52 Weeks Wait	May 25	10	-			2	-1	5
Community Paediatrics RTT Overall 65 Weeks Wait	May 25	3	-			0	0	1
Community Paediatrics RTT Overall 78 Weeks Wait	May 25	1	0			0	0	1
RTT NDD Only Waiting List	May 25	2	-			38	14	61
RTT NDD Only 52 Weeks Wait	May 25	0	-			1	-1	3
RTT NDD Only 65 Weeks Wait	May 25	1	-			0	0	1
RTT NDD Only 78 Weeks Wait	May 25	0	-			0	0	0

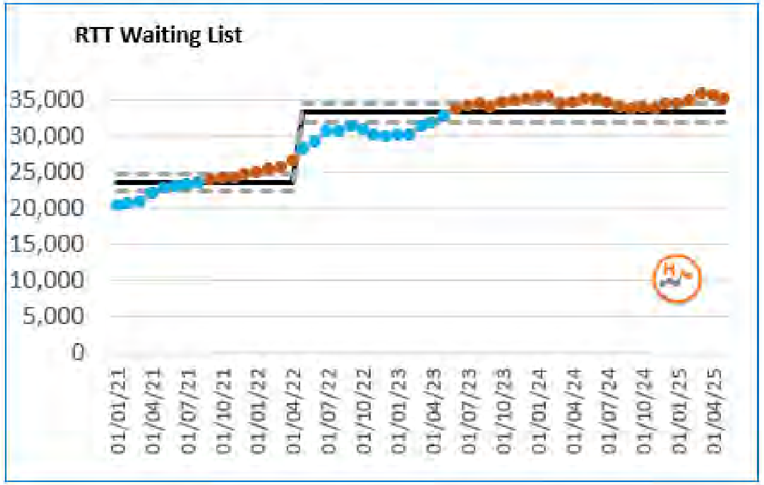
Elective Access

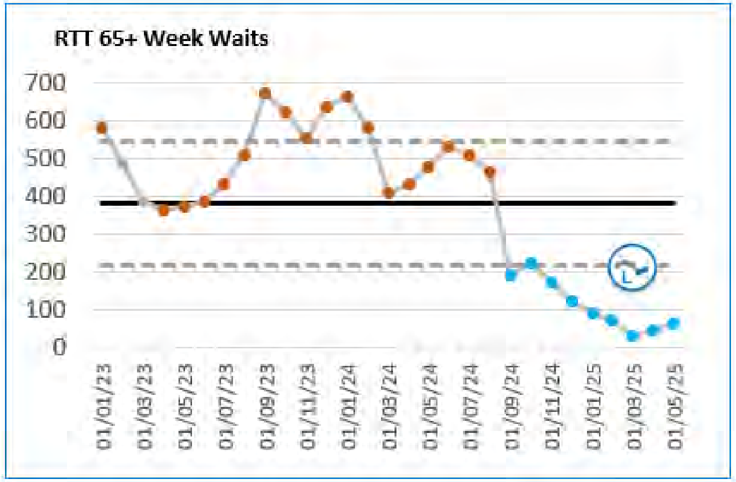


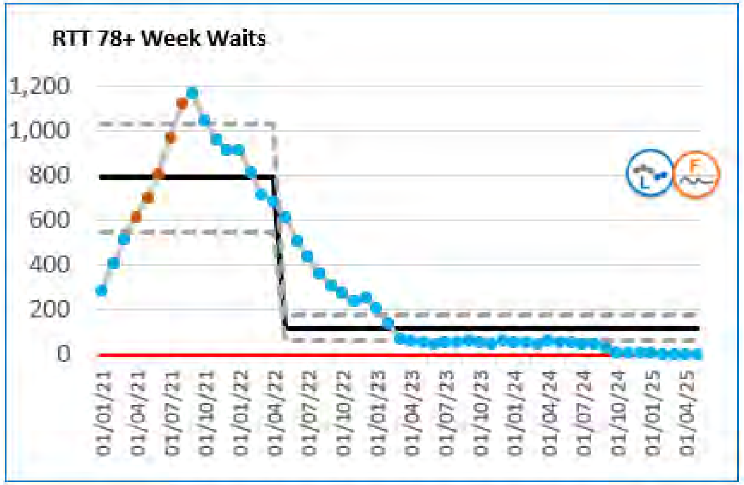
Diagnostics

What	So What?	What Next?
MRI - Common cause consistently failing target. Legacy impacts of MRI 2 replacement programme and financial constraints. Increase in working hours to CDC 08:00-20:00 5 days a week commenced on 20/01/25. With current additional activity within CDC and planned levels of activity DM01 compliance is anticipated by end of June 2025 but is slightly behind compliance at 95.86% as of 15/06/2025 **CT** –Marginally under DM01 compliance target at 98.6% in month. US – With varying factors DM01 attainment prediction is difficult to describe. Temporary staffing controls are compounded by recruitment challenges within the team. Bank and agency support has been enabled for US, but the availability of agency staff is limited. Further resignations have resulted in a 25% vacancy rate in the service. Performance remains vulnerable until recruitment improves, including capacity at the CDC. International recruitment is being pursued with support from regional colleagues. **DEXA** –Anticipated go live now end of June 2025. Scanner has now been delivered and is being installed Recovery likely by Q4 25/26 without additional investment. **Endoscopy** – Priority has been given to patients on a cancer pathway requiring a rebalancing of capacity to support. Cohort of low complexity, low risk patients suitable for outsourcing and nurse endoscopists (NE) has been exhausted with limited scope for flexing of the criteria with outsourced provider. This has led to a compound effect and a deterioration of DM01 performance. Impact of financial recovery is being seen on DM01 target compliance. A successful bid for cancer funding for 25/26 is supporting the stabilisation of the endoscopy cancer demand but routine endoscopy performance will continue to decline. Options appraisal to be submitted to MEG on the 25/07/2025 for potential recovery and alignment to JAG requirements. Seed funding for Newmarket Endoscopy CDC extension business case delivery has been allocated and is being drawn down. **Breast Imaging** - Staffing issues have and will continue to impact the delivery of the screening service and overall cancer performance. This has been compounded by sickness absence in the breast radiologist team. Temporary staffing support has been agreed and deployed to stabilise the service, but the situation remains vulnerable to availability. Approval was given to recruit a substantive Consultant Breast Radiographer to the service, recent interviews were unable to appoint, and this budget has been converted to Consultant Breast Radiologist PA's where response to current advert to replace a leaver has been more favourable and may give opportunity for fixed term appointment of a part time radiologist to the service. Interviews scheduled for 11th of July 2025. Four super Saturdays are planned throughout June to reduce wait times in conjunction with the Surgical Division.	Longer waiting times for diagnosis and treatment have a detrimental effect on patients. Delay in achieving DM01 compliance standards.	**MRI** – return to compliance anticipated. **CT** – return to compliance anticipated. **US** –Staffing issues remain unresolved, and CDC capacity will not be realised until recruitment picture improves. Temporary staffing options have been approved for a three-month period by TSCP and ICB DL Panel while recruitment is ongoing. **DEXA** – Once open the new service will increase DEXA capacity from 3 days per month to 3 days per week once staff are trained and the service is up and running fully. **Endoscopy** – longer term CDC endoscopy expansion at Newmarket will address demand. **Breast Imaging** - Short term, requests for bank / agency to fill gaps and ensure service provision continue to be sought via the TSCP and ICB double lock panel, implementation of Super Saturdays throughout June. Longer term training plan for in house Consultant Breast Radiographer will complete in 2029.

Elective Access: RTT

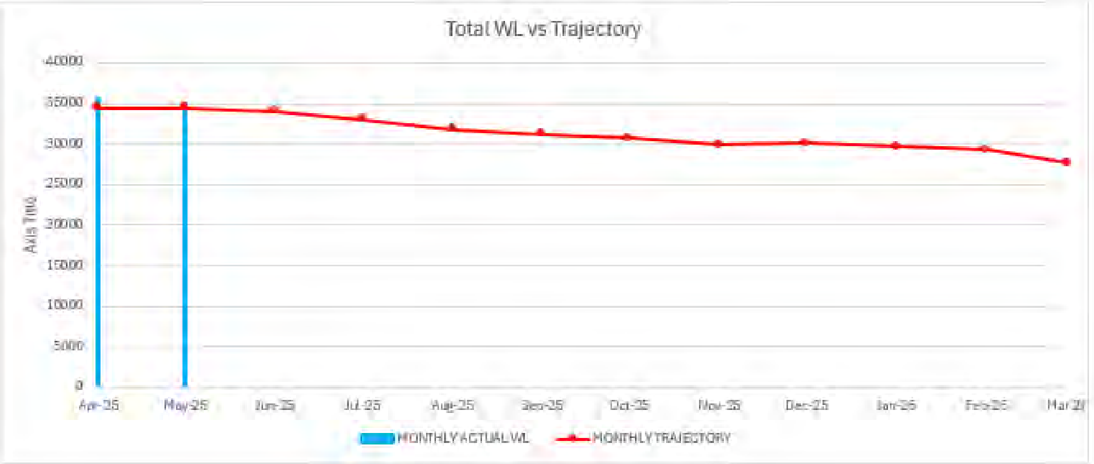


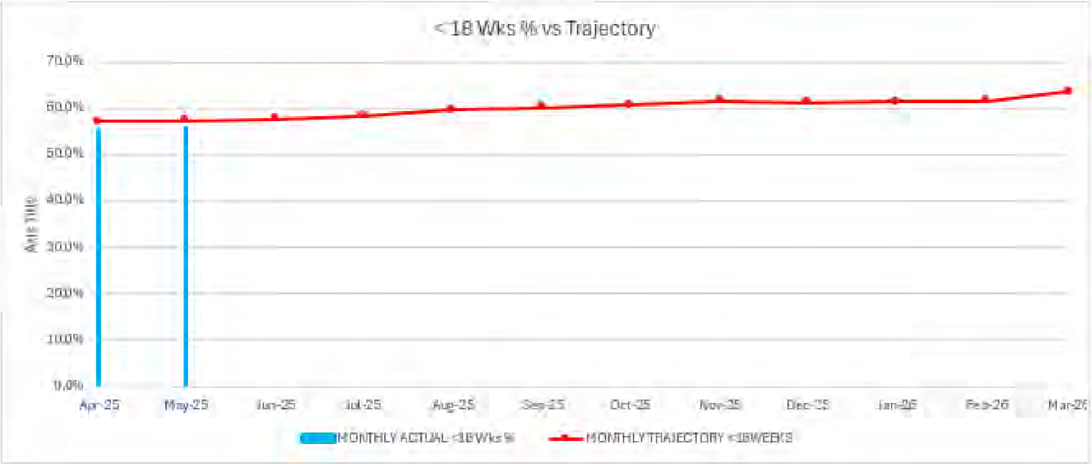


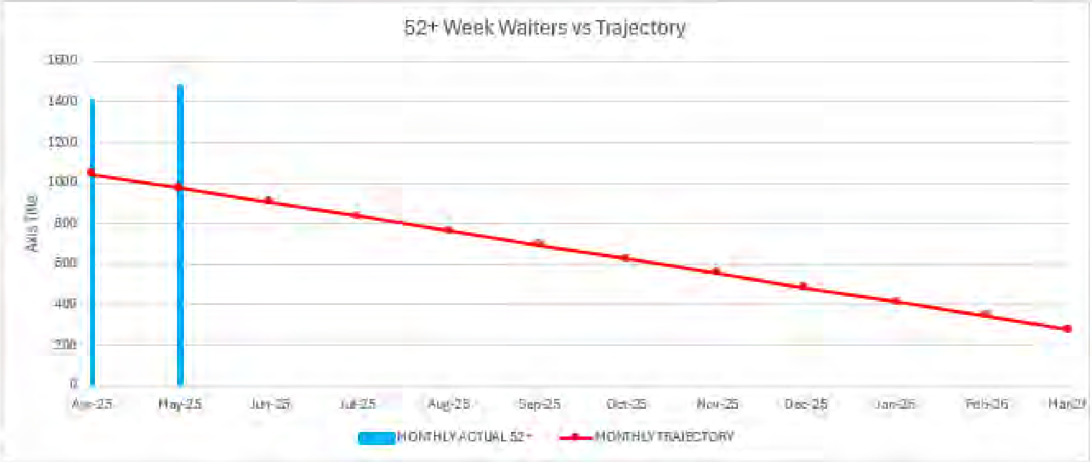


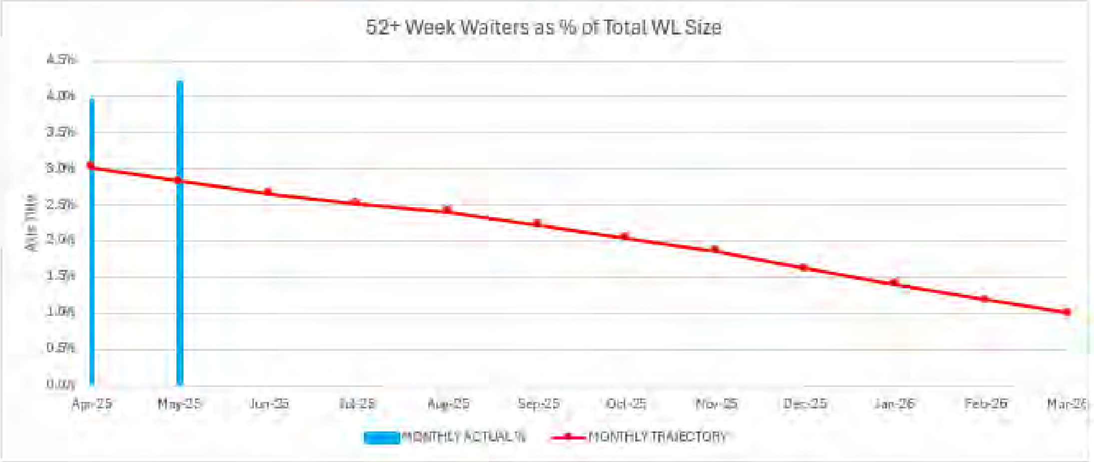
What	So What?	What Next?
The 78 week wait position for the end of May increased to 4 patients. The number of 65 week waits increased again to 65 patients, with further increases in Dermatology, Plastics, Orthopaedics and Pain management. The number of patients over 52 weeks is over the planned trajectory of 974 at 1538. The wait time for first appointment in high volume specialities such as Dermatology is placing significant challenges on reducing the 52 week waits, with Dermatology 241 over trajectory.	Delivering the objective of reducing the volume of patients over 52 weeks to 1% of the total waiting list size and no patients waiting over 65 weeks by June 2025 is a central focus of 2025/26 planning, delivering an improved set of outcomes and experience for our patients – as patients are at increased risk of harm and/or deteriorating the longer they wait. This increases demand on primary and urgent and emergency care services as patients seek help for their condition.	Options for recovery in Dermatology to be presented to management executive group on 25th June 2025. Options to increase validation to support RTT compliance to be completed in June 2025.

Elective Access: RTT





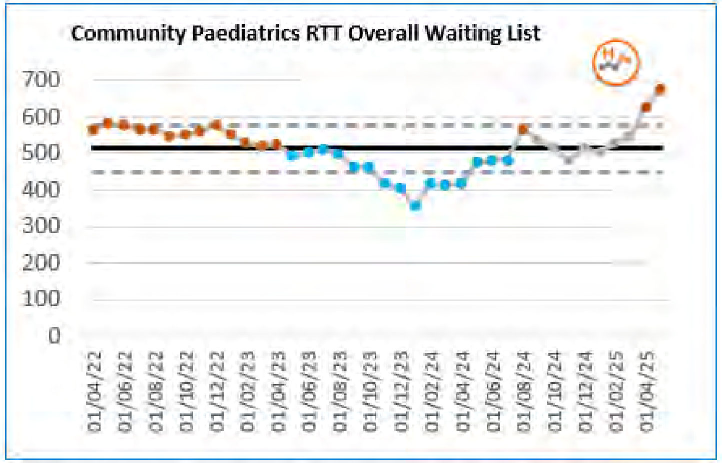


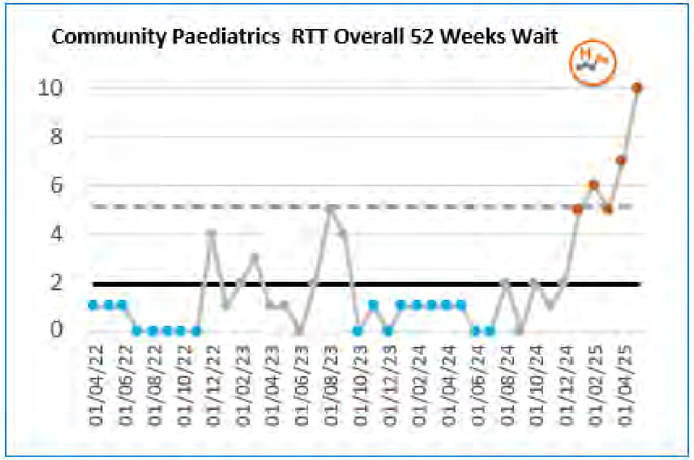


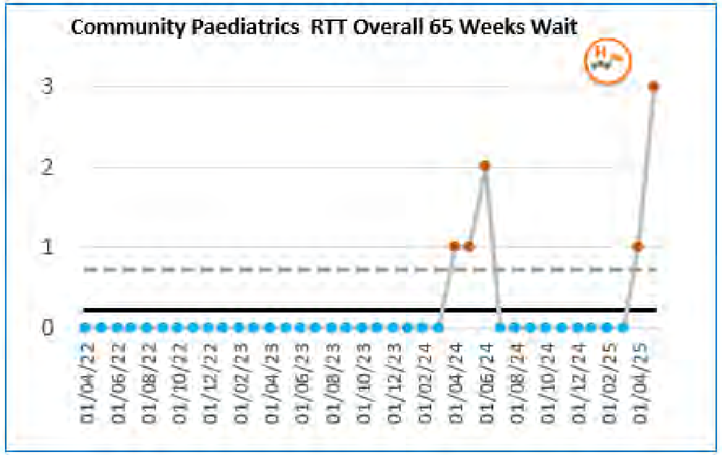
Elective Access: Activity

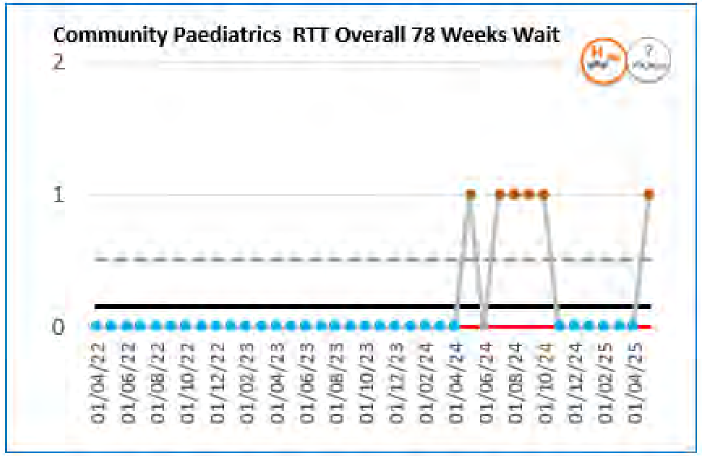
What	So What?	What Next?
We continue to be over our submitted forecast each month for patients over 52 weeks, with 541 patients over trajectory. The biggest contributor to this is within Dermatology who were 221 over plan, followed by Orthopaedics at 72 over plan. Within Dermatology, the waiting time for first appointment is currently in excess of 65 weeks, with outpatient activity currently being utilised for urgent suspected cancer patients. In Orthopaedics, closure of a theatre due to an estates issue has impact the ability to deliver all activity, as much as possible has been moved to ESEOC to accommodate. For overall RTT compliance against plan, for May our performance was 55.57% against a planned position of 57.2%. The RTT compliance is not related to any one speciality but is attributed to a reduction in validated pathways and diagnostic waiting times, specifically for DEXA, Non-Obstetric Ultrasound and Endoscopy.	Delivering the objective of reducing the volume of patients over 52 weeks to 1% of the total waiting list size and no patients waiting over 65 weeks by June 2025 is a central focus of 2025/26 planning, delivering an improved set of outcomes and experience for our patients – as patients are at increased risk of harm and/or deteriorating the longer they wait. This increases demand on primary and urgent and emergency care services as patients seek help for their condition.	Dermatology recovery options to Management executive group 2nd July. In additional existing referral form for Dermatology has been updated and patients will be turned around with advice to GP where first line treatment has not been undertaken. Increase validation resource from mid-July during national validation sprint to increase clock stops, reduce total waiting list size and improve RTT compliance. Additional NOUS activity June – September and commencing of DEXA scanning in July will support overall compliance and waiting list size. Endoscopy recovery options to be reviewed and decision to be made on additional activity. Clinic template reviews to be undertaken reporting into the productivity board to increase volume of new patients.

Elective Access (Community Paediatrics)









What	So What?	What Next?
There is a deterioration in waiting times for the paediatric team due to sustained level of demand and reduced capacity within the clinical team	Children within the school age autism assessment pathway, particularly those 8-11yrs will be waiting longer for assessment as the team respond to clinical need and complex care management. Waiting times in the preschool pathway are also deteriorating due to increased demand.	Agency locum started mid June which will support team capacity but will not deal with overall shortfall in staffing required. 1wte Specialist Nurse appointed to cover vacancy, starting in July. Attempt made to skill mix medical vacancy with another Specialist Nurse role has been delayed due to trust recruitment controls and proposed clinical nurse specialist review

Elective Access: Activity

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NHS England - 25/26 (Monthly - IQPR)

** Outpatient weekly data only includes e-care records (no Cardiology Diagnostics or Radiology)*

West Suffolk NHS
NHS Foundation Trust

All

All

Outpatient First

Mon	25/26	24/25	Plan	Var	Var %
Apr	9,722	9,572	9,955	(233)	(2.3%)
May	10,101	9,814	10,207	(106)	(1.0%)
Jun		10,051	10,453		
Jul		10,645	11,070		
Aug		8,967	9,325		
Sep		10,529	10,950		
Oct		11,008	11,448		
Nov		9,814	10,207		
Dec		9,809	10,201		
Jan		10,172	10,579		
Feb		9,814	10,207		
Mar		10,893	11,328		
Total (YTD)	**19,823**	**19,387**	**20,162**	**(339)**	**(1.7%)**

May 2025

25/26	10,101
24/25	9,814
Plan	10,207
Var	(106)
Var %	(1.0%)

Daycase

Mon	25/26	24/25	Plan	Var	Var %
Apr	2,291	2,317	2,363	(72)	(3.1%)
May	2,408	2,405	2,453	(45)	(1.8%)
Jun		2,433	2,481		
Jul		2,606	2,658		
Aug		2,170	2,214		
Sep		2,549	2,599		
Oct		2,606	2,658		
Nov		2,375	2,423		
Dec		2,315	2,362		
Jan		2,462	2,511		
Feb		2,405	2,453		
Mar		2,666	2,719		
Total (YTD)	**4,699**	**4,722**	**4,816**	**(117)**	**(2.4%)**

May 2025

25/26	2,408
24/25	2,405
Plan	2,453
Var	(45)
Var %	(1.8%)

Outpatient Follow Up

Mon	25/26	24/25	Plan	Var	Var %
Apr	26,154	25,589	24,054	2,100	8.7%
May	25,633	26,236	24,662	971	3.9%
Jun		26,868	25,256		
Jul		28,456	26,749		
Aug		23,971	22,532		
Sep		28,148	26,459		
Oct		29,427	27,662		
Nov		26,236	24,662		
Dec		26,221	24,648		
Jan		27,192	25,560		
Feb		26,236	24,662		
Mar		29,119	27,372		
Total (YTD)	**51,787**	**51,825**	**48,716**	**3,071**	**6.3%**

May 2025

25/26	25,633
24/25	26,236
Plan	24,662
Var	971
Var %	3.9%

Elective

Mon	25/26	24/25	Plan	Var	Var %
Apr	244	261	267	(23)	(8.5%)
May	246	268	273	(27)	(10.0%)
Jun		278	283		
Jul		301	307		
Aug		251	256		
Sep		291	297		
Oct		301	307		
Nov		268	273		
Dec		261	266		
Jan		255	260		
Feb		268	273		
Mar		304	310		
Total (YTD)	**490**	**529**	**540**	**(50)**	**(9.2%)**

May 2025

25/26	246
24/25	268
Plan	273
Var	(27)
Var %	(10.0%)

Elective Access: Activity

What	So What?	What Next?
Activity plans across elective, daycase and first outpatient attendances are not being met as at the end of May 2025, with the largest variance in elective at -10.0%, a worsening of 1.5%. However, the variance to plan improved for first outpatient attendances and daycases.	From 2025/26, ICB's and providers must agree an Indicative Activity Plan (IAP), failure of which to deliver can result in contractual penalties. Delivery of increased activity levels is also required to meet improvements in Referral to Treatment (RTT): 5% improvement in the number of patients waiting 18 weeks or less and less than 1% of people waiting 52 weeks or more.	Specialty level RTT trajectories have been produced – it is likely that for most specialties the activity required to deliver these will exceed the Indicative Activity Plan totals. Specific plans as to how to deliver the additional activity required that is at present effectively unfunded, will be managed fortnightly through the Senior Ops Forum, alongside diagnostic and cancer waiting times performance. Delivery of productivity initiatives across theatres and outpatients is supported through the Productivity Programme Board.

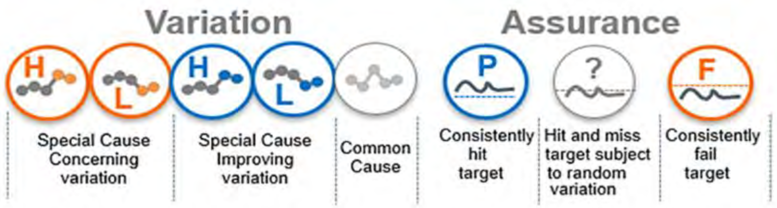
IMPROVEMENT COMMITTEE METRICS

Safe- Summary

Chart Legend

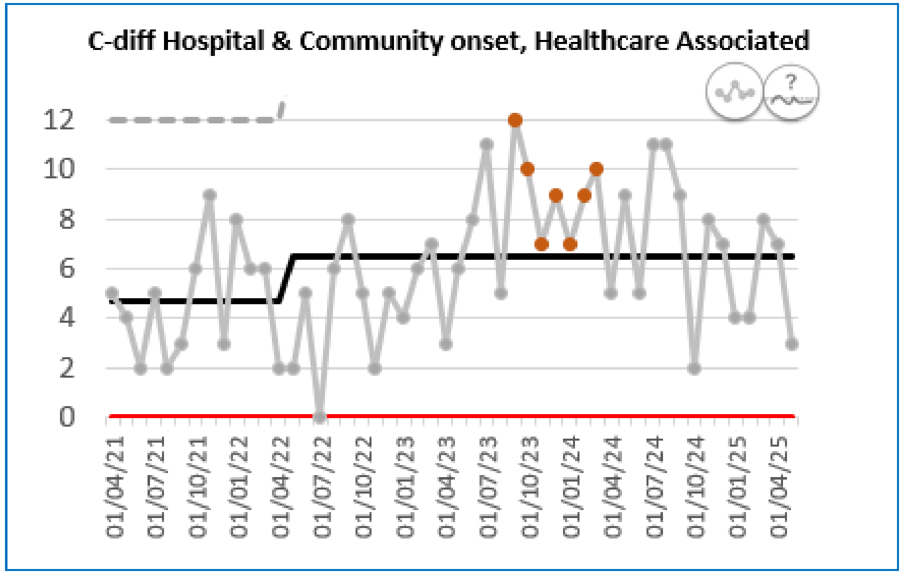
Target · Mean · Measure

Process Limit · Lower Process Limit



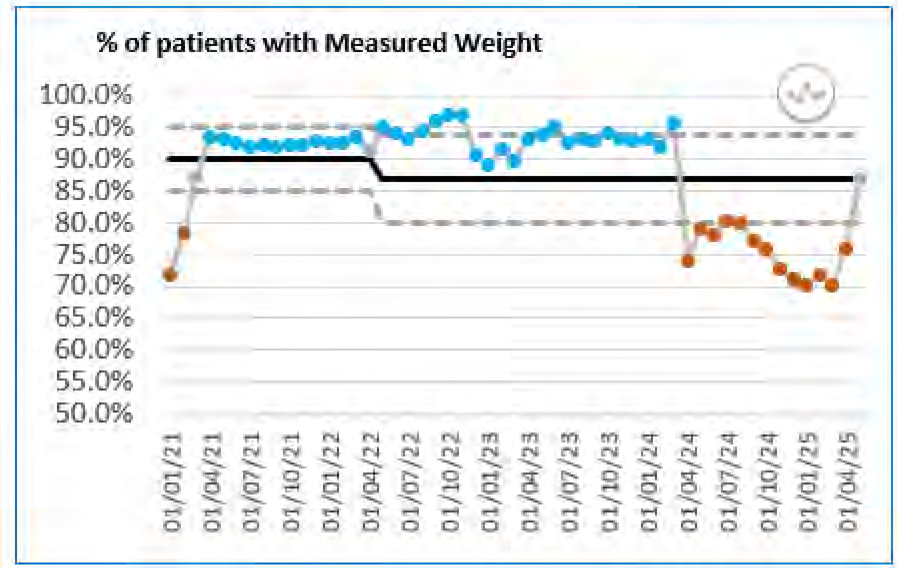
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
C-diff Hospital & Community onset, Healthcare Associated	May 25	3	0			6	-2	15
% of patients with Measured Weight	May 25	87.0%				86.9%	79.9%	93.9%
% of patients with a MUST/PYMS assessment completed within 24 hours of admission	May 25	95.0%				95.7%	93.0%	98.3%
Post Partum Haemorrhage	May 25	7				7	-1	15

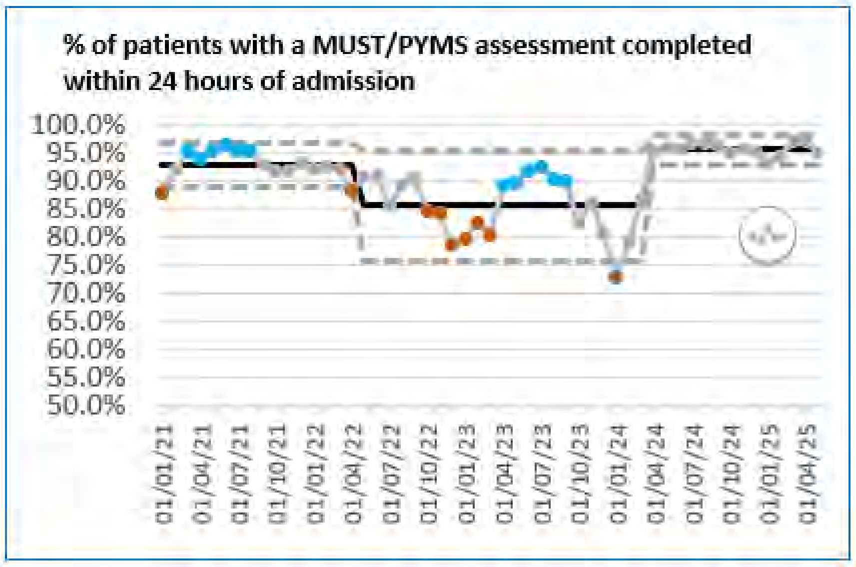
Safe



What	So What?	What Next?
Despite the recent reduction of *Clostridioides difficile* infection rates over the last eight data points, May data continues to illustrate common cause variation, with limited assurance of sustained improvement at this point. The service met the threshold set for hospital & community onset, healthcare associated cases (HOHA/COHA) 2024-25 with a total of 83 cases against a threshold of 91. NHS England 'Standard contract for Minimising *Clostridiodes difficile* and Gram-negative bloodstream infections' 2025-26 is now published. The threshold which provides the organisational measure for national/regional data and better demonstrates the impact on our patient group, is set at 81 for this reporting year. It is recognised Nationally that the rates of *Clostridioides difficile* have increased significantly over the last reporting years and is a national priority.	Infection prevention and control is a key priority for all NHS providers. Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. They can pose a serious risk to patients, staff and visitors, can increase length of stay due to illness or prevent discharges particularly to care home settings. A new strain of *Clostridioides difficile* has been identified which has been linked with outbreak scenarios within the UK. *Clostridioides difficile* are bacteria found in the bowel, usually causing no harm. This bacteria can cause diarrhoea, especially in older persons, those who have been in contact with a contaminated environment, have undergone bowel procedures or in people who have been or are being treated with certain antibiotics. Data suggests that West Suffolk has a higher-than-average age population.	The Quality Improvement Programme is ongoing, running as business as usual, for at least another five months - October 2025. A full update was provided at March 2025 improvement board. QI update: • Review of investigation process when a C.diff case is identified – including review of RADAR completion, accountability and actions after a case, (templates currently in the test phase of RADAR) review has commenced June-July 2025. • Review of isolation signage and Trust roll out; June-July 2025 • Cleaning poster development and roll out; June-July 2025 • Review & launch of 'isolation prioritisation matrix'; June-July 2025 • Review of stool specimen form browser data & form browser content/questions • Explore options within Ecare for mandating reviewed questions on the stool specimen form browser – August 2025 • Explore options within Ecare to reduce the number of specimen duplications sent to the laboratory – August 2025

Safe





What

Nutritional assessment (MUST) within 24hrs – 97%
97% patients have a must score complete in 24 hours. This remains in common cause variation and has achieved standard of >95%

Measured weight at 24 hrs – 76 %
We have seen an increase by 6 percent in month for patients with a measured weight withing 24 hours of decision to admit. This increased result will allow for accurate assessment of their health status and will also allow for proper medication dosage, also to monitor treatment effectiveness.

While best practice is always to use a measured weight in real time, effective MUST scoring can be achieved with an estimated weight

So What?

Good nutrition is an integral component of patient care. Not only does eating correctly provide substantial physical benefits, but it also ensures psychological comfort though a patient's admission.

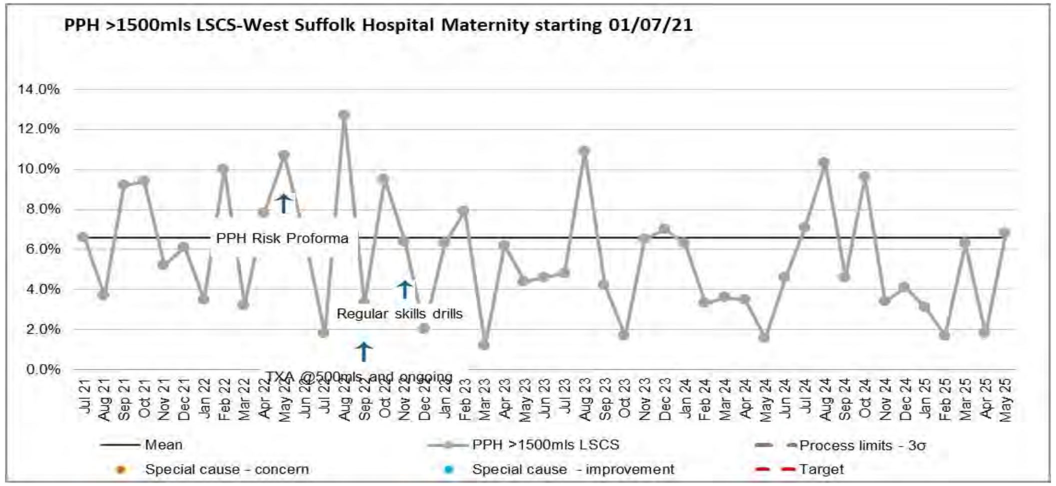
Every healthcare organisation has a responsibility to provide the highest level of care possible for their patients, staff and visitors. This includes the quality, nutritional value and the sustainable aspects of the food and drink that is served, as well as the overall experience and environment in which it is eaten (NHSE 2022)

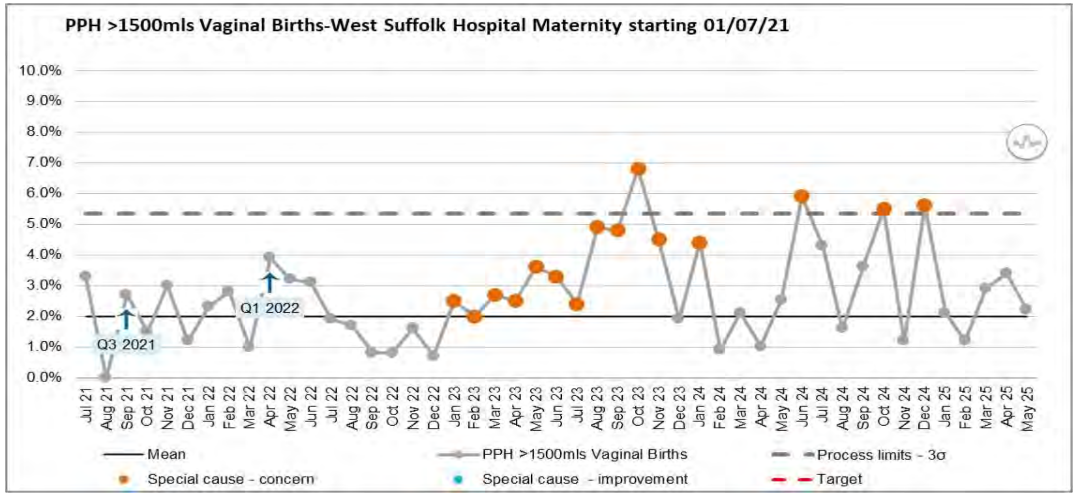
CQC Regulation 14: Meeting nutritional and hydration needs

What Next?

- Liaise with Dieticians to monitor impact of any delayed assessments and impact to the patients, reviewing all RADARS associated with this.
- Following last month's nutritional steering group, it was asked for the dieticians to have a regular slot at the monthly ward managers meeting, this has been achieved in surgery and is pending in medicine.
- Heads of Nursing still working together to utilise the new reports to look at areas that may need a more targeted approach.
- Ward and unit managers to make sure staff understand the importance of accurate MUST scoring, monitored through divisional quality board
- To focus on the importance of the protected mealtimes audit

Safe





Quarter	Total Caesareans Performed	PPH at CS	Total Quarterly Rate
1 (Apr-Jun 2023)	181	9	5.0%
2 (Jul-Sept 2023)	169	10	5.9%
3 (Oct-Dec 2023)	183	8	4.4%
4 (Jan-Mar 2024)	207	8	3.9%
1 (Apr-Jun 2024)	205	9	4.4%
2 (Jul-Sept 2024)	191	12	6.3%
3 (Oct-Dec 2024)	213	11	5.2%
4 (Jan-Mar 2025)	194	6	3.1%

What

PPH is one of the most common obstetric emergencies and requires clinical skills, with prompt recognition of the severity of a haemorrhage and emphasise communication and teamwork in the management of these cases. Severe bleeding after childbirth - postpartum haemorrhage (PPH) - is the leading cause of maternal mortality world-wide.

In May 2025, there were four reported case of PPH over 1500 mls following Lower segment Caesarean Section (LSCS) and three occurring after a vaginal birth, showing common cause variation.

Although previous target set by the NMPA (National Maternity and Perinatal Audit)using 2022 data has been removed due to significant changes in practice (increased induction of labour and elective caesarean births) regional team is working on reporting tool to support benchmark opportunity.

So What?

Following a PPH there is the potential increase of length of stay, additional treatment and financial implications for the organisation and family.

Following a PPH there is an increased risk of psychological impact, exacerbation of mental health issues, as well as affecting family bonding time, which can have irreversible consequences.

Exposure of psychological trauma to patients and our staff.

What Next?

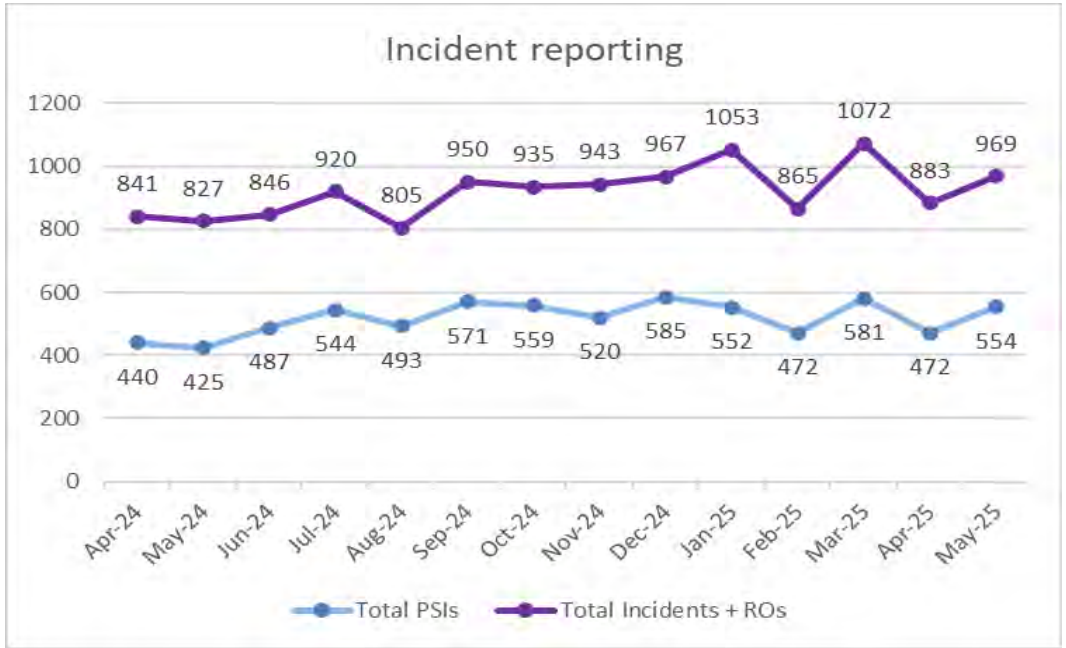
Quality Improvement project in progress focusing on three workstream:

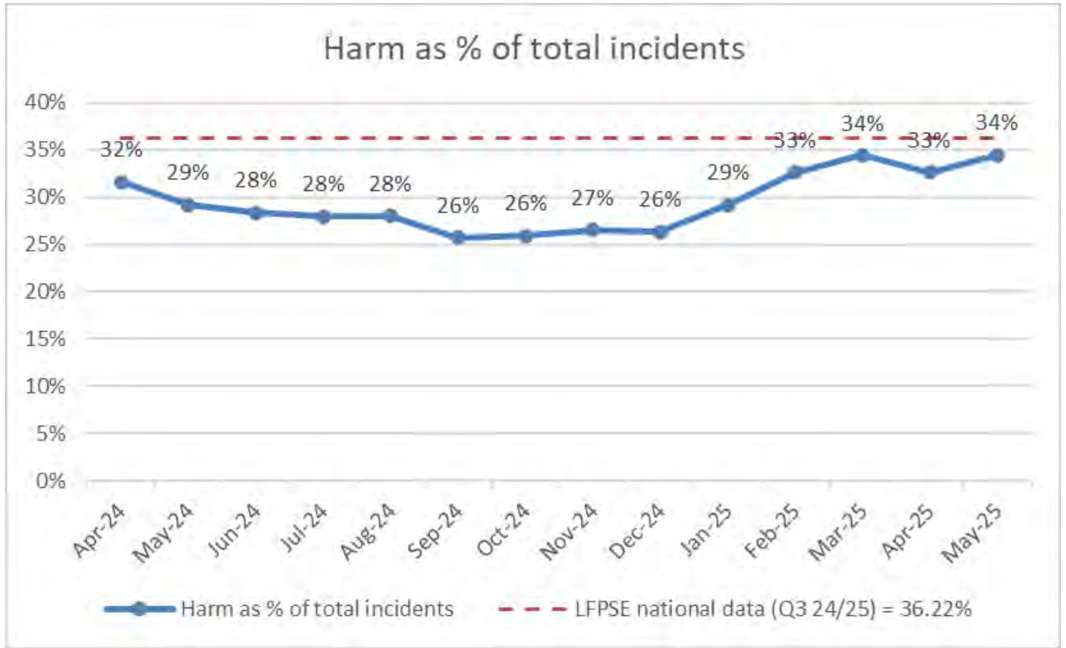
- Training and awareness
- Risk management
- Medication and timely management of PPH

Ongoing reviews of all PPH and thematic reviews are required to continue, to truly understand the factors causing the variation and subsequent solutions to be found.

With the removal of nationally set targets, performance is being monitored and is in line with maternity units across the region.

Safe





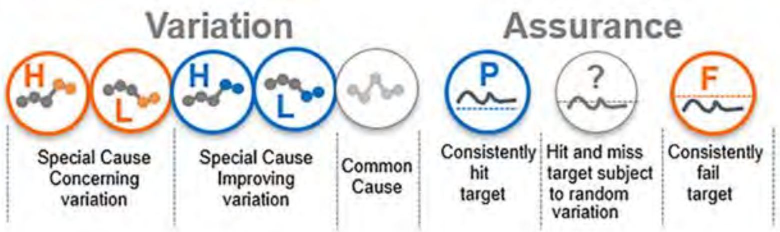
What	So What?	What Next?
This month saw a slight increase in both reported patient safety incidents and RO (reportable occurrence) events. The proportion of incidents resulting in harm rose by 1%, reaching 34%. While this represents an upward trend, the data points remain within control limits, supporting the conclusion that the increase reflects normal variation. A further review of WSFT incident data from December 2024 to May 2025 indicates that the increase in harm is not attributable to any single category or clinical area. Key observations this month include: • The number of clinical care and treatment incidents have remained steady over the review period. • Slips, trips and falls incidents and pressure ulcer RO events have shown stability with occasional fluctuations. • Medication and transfer of care incidents have shown a slight rise this month. • Incidents related to staff challenges spiked in early 2025 but have shown a consistent decline in April and May.	We want to promote reporting of all incidents, including low and no harm, to support insight into our improvement work and prevent future physical and psychological harm to patients. Our harm rate stands below the national average of 36%. We will continue to use the LFPSE data as our benchmark moving forward.	The team continue to engage with specialist leads and committees to identify opportunities for improvement. In response to the gradual increase in medication incidents this quarter, the medication safety group remain vigilant, actively monitoring trends and taking appropriate action. The patient safety will continue to link in with the Transfer of Care improvement programme. Ongoing monitoring of incidents and RO's through our Patient Safety quarterly report supports the team to detect emerging issues early and this work will continue. The quarterly report was presented to the Improvement Committee in Q3 and will now be shared on a regular basis.

Mortality Summary

Chart Legend

Target — Mean — Measure

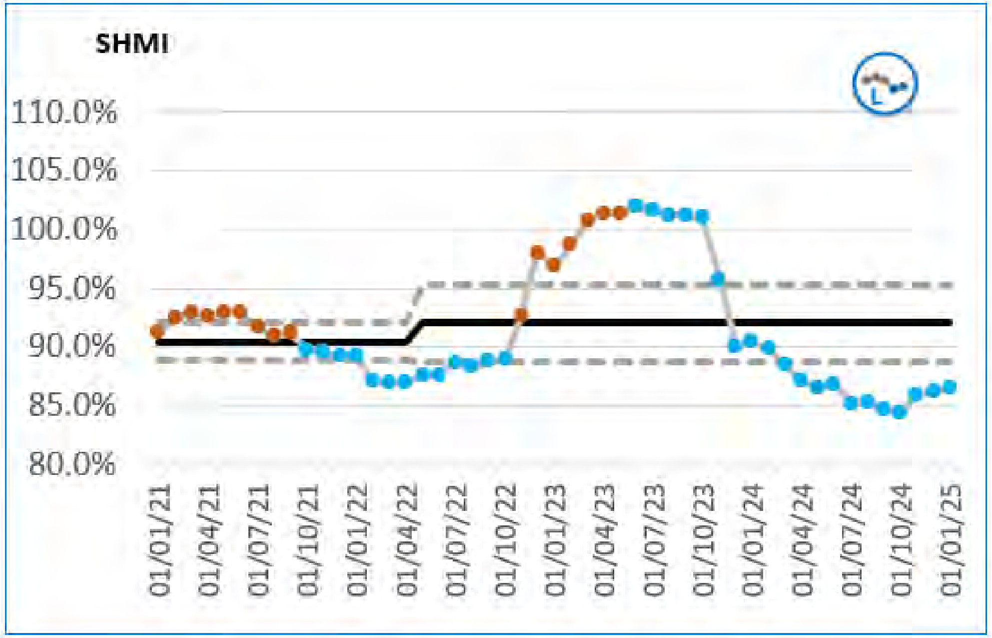
Process Limit — Lower Process Limit

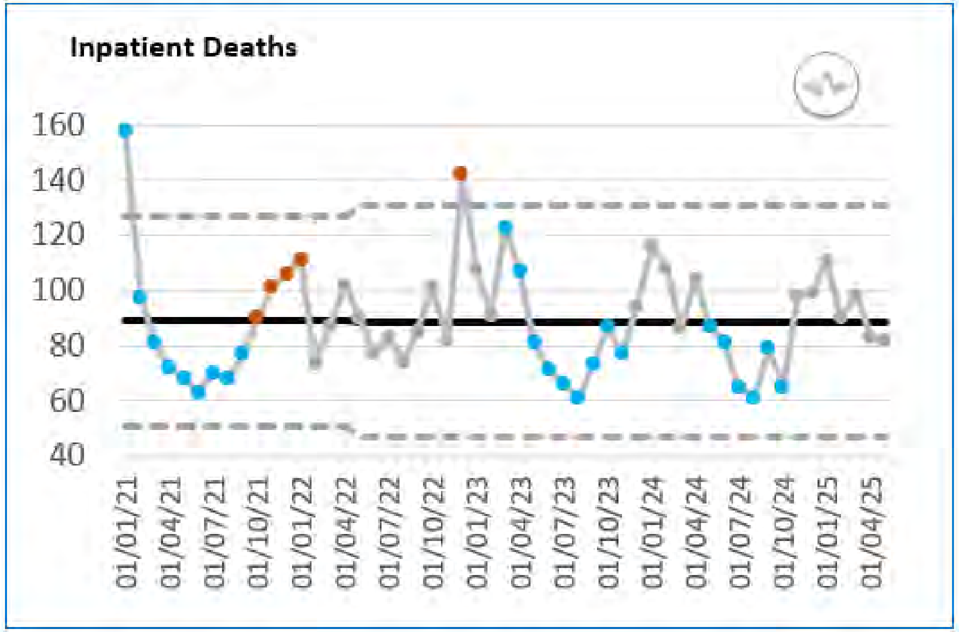


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SHMI	Jan 25	86.5%				92.1%	88.9%	95.3%
Inpatient Deaths	May 25	82				89	47	131

These will be updated once the SHMI data has been published and the Deaths have been agreed

Mortality

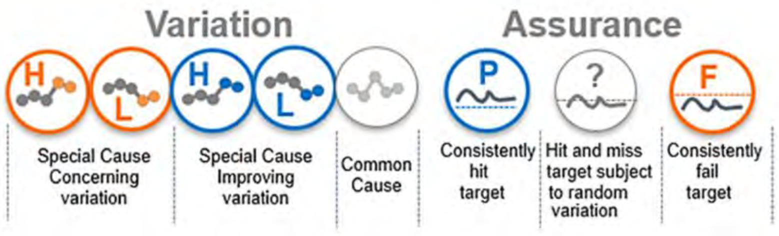




What	So What?	What Next?
An analysis of the what the data shows us that West Suffolk Foundation Trust (WSFT) is categorised on the lower end of 'as expected' deaths banding. This means that given the WSFT patient demographic that the expected number of patients have died in our care or within 30 days of discharge, than is statistically expected.	It is important to have a good oversight of inpatient mortality through a mortality indicator to help assess patient safety. The data provides comparative mortality information to other Trusts which have a similar patient demographic.	We anticipate that the WSFT SHMI will remain in the 'as expected' deaths banding. We will continue to monitor the WSFT SHMI data trend for anomalies or indication for deeper investigation through the mortality oversight group.

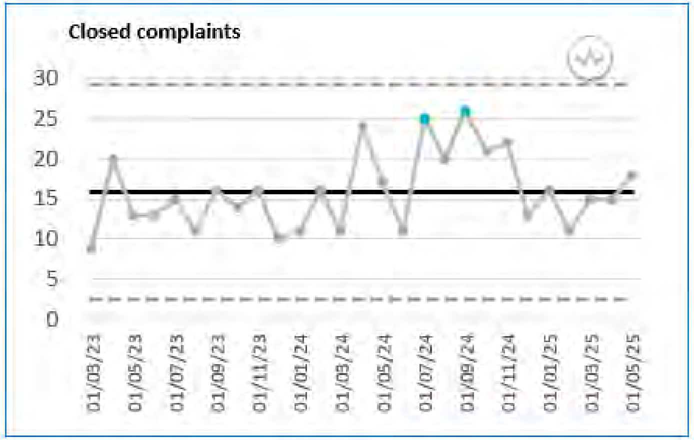
INVOLVEMENT COMMITTEE METRICS

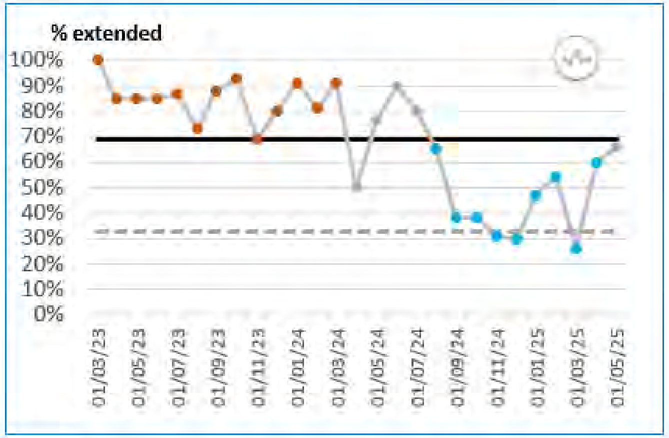
Well Led Summary

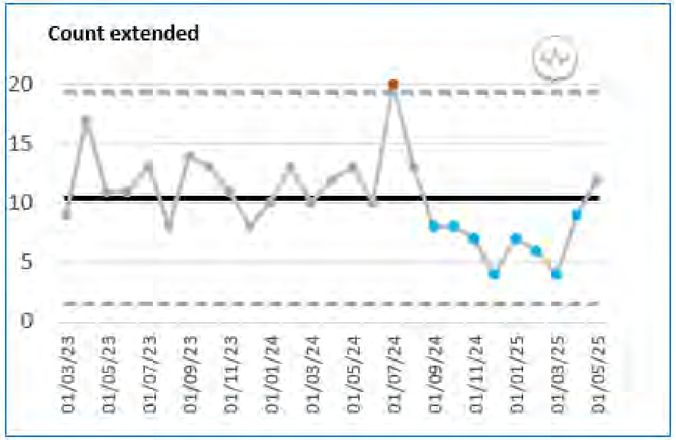


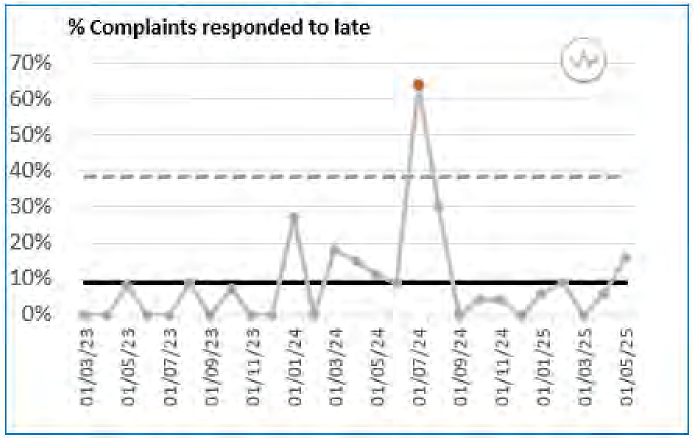
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Active complaints	May 25	51	-			32	17	47
Closed complaints	May 25	18	-			16	2	29
% extended	May 25	66%	-			69%	33%	105%
Count extended	May 25	12	-			10	2	19
% Complaints responded to late	May 25	16%	-			9%	-21%	39%
Count responded to late	May 25	3	-			2	-4	7
% resolved in one week	May 25	73%	-			60%	30%	90%
Total PALS resolved Count	May 25	235	-			184	74	294

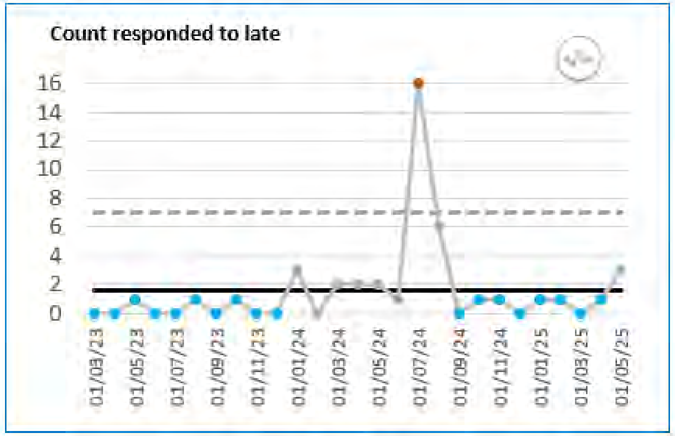
Safe

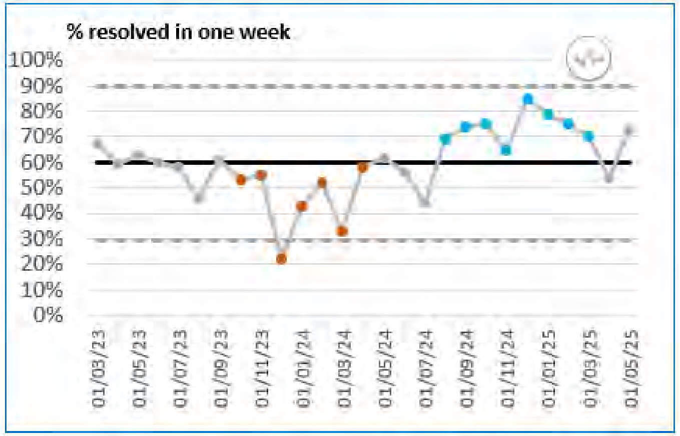

Closed complaints
30
25
20
15
10
5
0
01/03/23 01/05/23 01/07/23 01/09/23 01/11/23 01/01/24 01/03/24 01/05/24 01/07/24 01/09/24 01/11/24 01/01/25 01/03/25 01/05/25

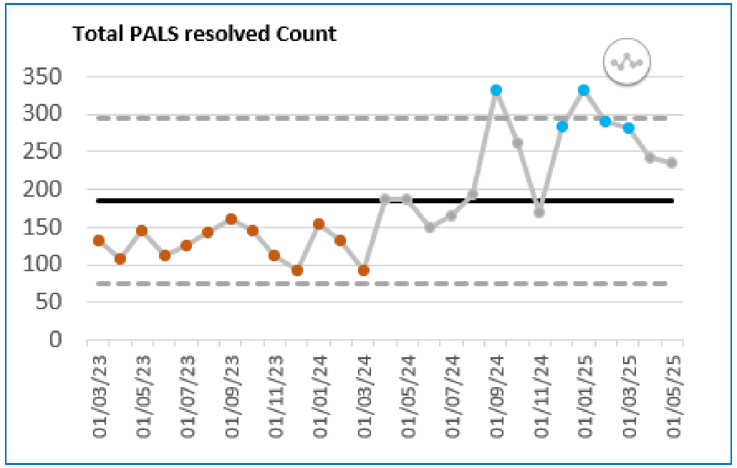

% extended
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
01/03/23 01/05/23 01/07/23 01/09/23 01/11/23 01/01/24 01/03/24 01/05/24 01/07/24 01/09/24 01/11/24 01/01/25 01/03/25 01/05/25


Count extended
20
15
10
5
0
01/03/23 01/05/23 01/07/23 01/09/23 01/11/23 01/01/24 01/03/24 01/05/24 01/07/24 01/09/24 01/11/24 01/01/25 01/03/25 01/05/25


% Complaints responded to late
70%
60%
50%
40%
30%
20%
10%
0%
01/03/23 01/05/23 01/07/23 01/09/23 01/11/23 01/01/24 01/03/24 01/05/24 01/07/24 01/09/24 01/11/24 01/01/25 01/03/25 01/05/25

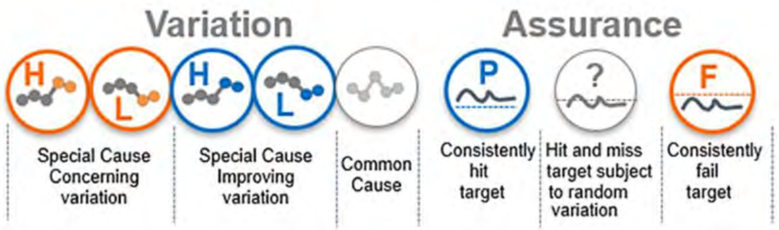

Count responded to late
16
14
12
10
8
6
4
2
0
01/03/23 01/05/23 01/07/23 01/09/23 01/11/23 01/01/24 01/03/24 01/05/24 01/07/24 01/09/24 01/11/24 01/01/25 01/03/25 01/05/25


% resolved in one week
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
01/03/23 01/05/23 01/07/23 01/09/23 01/11/23 01/01/24 01/03/24 01/05/24 01/07/24 01/09/24 01/11/24 01/01/25 01/03/25 01/05/25


Total PALS resolved Count
350
300
250
200
150
100
50
0
01/03/23 01/05/23 01/07/23 01/09/23 01/11/23 01/01/24 01/03/24 01/05/24 01/07/24 01/09/24 01/11/24 01/01/25 01/03/25 01/05/25

Safe

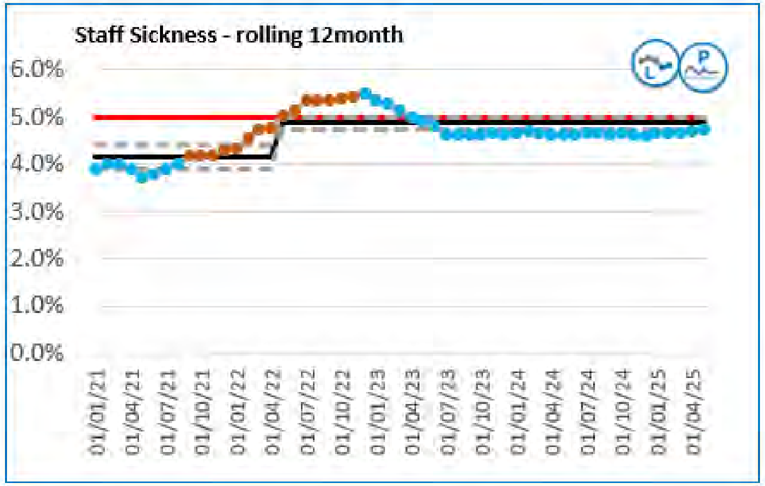
What	So What?	What Next?
Active formal complaints have increased slightly from 48 to 51 which is a concerning variation and increased trend that we have seen since February this year which now falls outside of the controlled limits. The initial impact is that we have seen an increased volume of new formal complaints received which require triaging, logging and in some cases discussion at incident triage panels for patient safety reviews. These initial administration tasks are necessary at the start of the complaints journey to ensure we get it right first time. This has had an impact on the complaints extended as time is taken to complete the necessary administration tasks rather than on completing complaint responses. Whilst percentage of complaints responded to late have increased, the count remains low and is within the controlled limits. This is a common variation depending on complainant outcomes and acceptance of any extended deadline. PALS cases logged have reduced due to a reduction in staffing and therefore the team are finding a balance between providing early resolution and logging full enquiries. Positively, the PALS cases responded to in 1 week has increased and is on track to meet the KPI of 75% resolved.	Whilst formal complaints have increased, we ensure there is a robust process in place to ensure complainants are updated throughout the investigation on any delays, investigation pathways and updates on progress. The majority of complainants are satisfied with the level of investigation and updates provided. The team have been working hard to ensure the complaints policy timeframe of 25 working days is adhered to however some cases required additional review such as going through the incident triage meeting and then on to EIR which can cause delays. This does however provide reassurance to complainants that we are taking their concerns seriously. The PALS team have introduced new working methods to ensure time is taken to accurately record PALS activity which doesn't require full investigation. The team are constantly providing support, advice, information and guidance to patients and their loved ones on a daily basis which doesn't always require investigation, however, can take a considerable amount of time.	We are monitoring the volume of open complaints and will review our current resource and working methods to meet our SLA's. The priority is ensuring complainants receive a timely investigation report or an update on progress. Trials are taking place within PALS to prevent cases escalating to formal complaints and there are benchmarking exercises happening to review and increase productivity across both PALS and Complaint teams to work more effectively. Due to staff leaving within the PALS team a review is taking place on what tasks can be shared across the wider patient experience team. This is to try and maintain an acceptable service level to our patients and their loved ones.

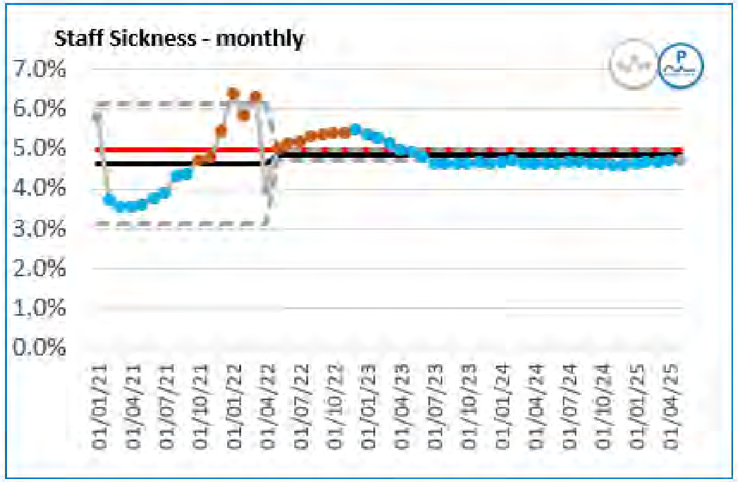


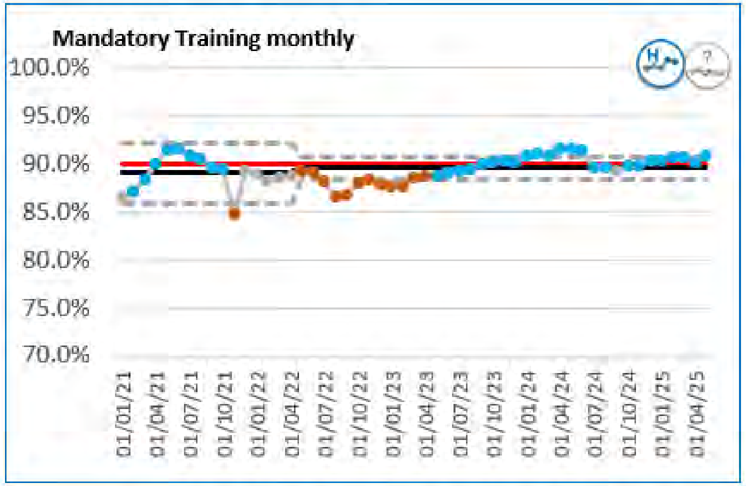
Well Led Summary

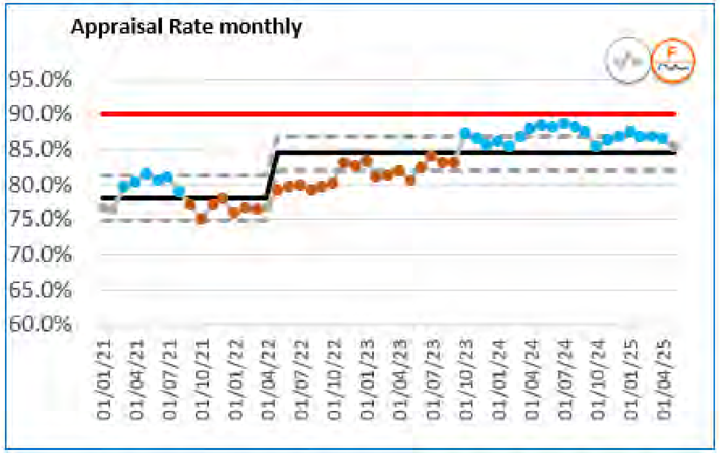
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	May 25	4.7%	5.0%			4.9%	4.7%	5.0%
Staff Sickness - monthly	May 25	4.7%	5.0%			4.9%	4.7%	5.0%
Mandatory Training monthly	May 25	90.9%	90.0%			89.5%	88.4%	90.7%
Appraisal Rate monthly	May 25	85.4%	90.0%			84.5%	82.0%	87.0%
Turnover rate monthly	May 25	9.0%	10.0%			10.1%	9.2%	11.0%

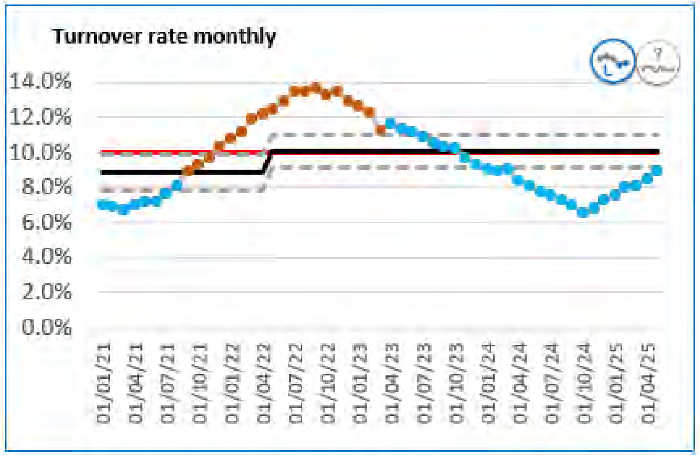
Well Led











What	So What?	What Next?
All four of our key performance indicators continue to record an improving variation, with three out of four achieving target. Sickness – achieving target at 4.7% versus 5% target. Mandatory training – achieving target at 90.9%. Appraisal – consistently failing target, 85.4% versus 90% target. Turnover – achieving target, 9% versus 10% target.	These workforce key performance indicators directly impact on staff morale, staff retention, and therefore, patient care and safety. Additionally, improvements in these workforce key performance indicators will strengthen our ability to be the employer of choice for our community and the recognition as a great place to work.	Maintain improvements in staff attendance and continue to monitor at department level. Maintain the target compliance of mandatory training ensuring areas and staff groups are identified where further focus and support may be required. Continued analysis of appraisal data to support and challenge areas in need of action and improvement. Maintain focus on the delivery of our people and culture plan and priorities.