OPEN Council of Governors Meeting

Schedule	Wednesday 14 May 2025, 5:45 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

AGENDA:
OPEN Council of Governors meeting
Wednesday 14 May, 2025, 5.30pm in Rooms 19a & b, Education Centre, WSFT, Hardwick Lane, Bury St. Edmunds. IP33 2QZ

0. Agenda Open CoG meeting 14 May 2025.docx

5:45 PM 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 - Thomas Pulimood, Anna Clapton
   NEDs - David Weaver
   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 meetings held on 26 February 2025 For Approval - Presented by Jude Chin Item 4 Item 2025 02 26 February - WSFT Public CoG minutes - DRAFT.docx
	5. Matters Arising Action Sheet (enclosed) To note updates on actions not covered elsewhere on the agenda To Note - Presented by Jude Chin Item 5 CoG Action log from Open Feb 2025.docx
5:55 PM	6. Update on Financial Position (enclosed) To receive an update Jonathan Rowell, Interim Chief Finance Officer, in attendance To inform Item 6 Finance update CoG 14 May 25.docx
6:15 PM	7. Chair's report (verbal) To receive an update from the Chair To Note - Presented by Jude Chin
6:25 PM	8. Chief Executive's Report (enclosed) To note a report on operational and strategic matters To Note - Presented by Ewen Cameron Item 8 CEO CoG report - May 2025 v2.docx
	GOVERNOR BUSINESS (INC. STATUTORY DUTIES)
6:35 PM	9. Feedback from assurance committees (enclosed) To receive committee key issues (CKI) and observers reports from the assurance and audit committees To Note Item 9 Feedback from Board assurance committees CoG 14 May 2025.docx

9.1. Insight Committee

Presented by Antoinette Jackson

- Item 9.1 INSIGHT CKI report a 19 Feb 2025 AJ.docx
- Item 9.1 INSIGHT CKI report b 19 Mar 2025 AJ.docx
- Item 9.1 INSIGHT CKI report c 16 Apr 2025 AJ.docx
- Item 9.1 INSIGHT Governor observer reports.pdf

9.2. Improvement Committee

- Item 9.2 IMPROVEMENT CKI report a 19 Feb 2025 RP.docx
- Item 9.2 IMPROVEMENT CKI report b 19 Mar 2025 RP.docx
- Item 9.2 IMPROVEMENT CKI report c 16 Apr 2025 RP.docx
- Item 9.2 IMPROVEMENT Governor observer reports.pdf

9.3. Involvement Committee

Presented by Roger Petter

- Item 9.3 INVOLVEMENT CKI report a 19 Feb 2025 TD.doc
- Item 9.3 INVOLVEMENT CKI report b 16 Apr 2025 TD.doc
- Item 9.3 INVOLVEMENT Governor observer reports.pdf

9.4. Audit Committee

Presented by Michael Parsons

- Item 9.4 AUDIT CKI report 18 Mar 2025 MP.docx

7:00 PM 10. Nomination Committee Report (enclosed)

To receive the report from the Nomination Committee

To Note - Presented by Jude Chin

- Item 10 Nominations committee report CoG 14 May 2025.doc

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11. Membership and Engagement Committee Report (enclosed)
To receive a report from the Membership and Engagement Committee
To Note - Presented by Sarah Hanratty

Item 11 Membership & Engagement committee report CoG 14 May 2025.doc

Item 11_Annex A Governor activities 2025 - Feedback report.docx

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12. Standards Committee Report - (enclosed)
To Approve - Presented by Jude Chin

Item 12 Standards committee report CoG 14 May 2025.doc

Item 12_Annex A Lead and deputy lead election timetable 2025.docx

Item 12_Annex B Role spec T&C of Lead & deputy lead Gov - Constn Annex 11.doc

Item 12_Annex C Governors development programme 2025 - v1.docx

Item 12.1_Appendix 1 Lead & Deputy Lead Governor election process 2025.docx

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13. Staff Governor Report (enclosed)
To receive a report from the Staff Governors
To Note - Presented by Louisa Honeybun

Item 13 Staff Governors report CoG 14 May 2025.doc

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14. Lead Governor Report (enclosed)
To receive a report from the Lead Governor
To Note - Presented by Jane Skinner

Item 14 - Lead Gov Report May 25 - final.docx

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15. Quality Accounts 2024/25
To approve the commentary for Quality Accounts
To Approve - Presented by Pooja Sharma

Item 15 Quality accounts 2024-25 Governors commentary cover sheet.doc

Item 15_Annex A Quality accounts 2024-25 Governors commentary - FINAL DRAFT.docx

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16. Governance Report (enclosed)
To receive the Governance Report
To inform - Presented by Pooja Sharma

Item 16 Governance report CoG 14 May 2025.doc

Item 16_Appendix A_Declaration of Interests 2025.docx

Item 16_Appendix B Council of Governors sub-committees 2025-26.docx

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7:20 PM ITEMS FOR INFORMATION

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17. Summary report for Board of Directors meetings (enclosed)
To receive a report from the Chair and Non-Executive Directors
To Note - Presented by Jude Chin

Item 17 Summary Report for Board of Directors meeting CoG 14 May 2025.docx

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18. Dates for meetings for 2025:
• 11 September, 2025
• 13 November, 2025
• Annual Members' Meeting - TBC
To Note - Presented by Jude Chin

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19. 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 - February, 2025

Item 9 Annex - IQPR Board Report February 2025.pdf

AGENDA:

OPEN Council of Governors meeting

Wednesday 14 May, 2025, 5.30pm in Rooms 19a & b, Education Centre, WSFT, Hardwick Lane, Bury St. Edmunds. IP33 2QZ

Council of Governors Meeting

There will be a meeting of the **COUNCIL OF GOVERNORS** of West Suffolk NHS Foundation Trust on **Wednesday 14 May 2025 at 5.45pm 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			
17:45	**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 26 Feb 2025	JC
	5.	**Matters arising action sheet** (enclosed) To note updates on actions not covered elsewhere on the agenda	JC
17:55	**6.**	**Update on financial position** (enclosed) To receive an update	JR
18:15	**7.**	**Chair's report** (verbal) To receive an update from the Chair	JC
18:25	**8.**	**Chief executive's report** (enclosed) To note a report on operational and strategic matters	NC

GOVERNOR BUSINESS (INC. STATUTORY DUTIES)			
18:35	**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
19:00	**10.**	**Nomination 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.	**Quality Accounts 2024/25** (enclosed) To approve the commentary for quality accounts	PS
	16.	**Governance report** (enclosed) To receive the governance report	PS
ITEMS FOR INFORMATION			
19:20	**17.**	**Summary report for Board of Directors meetings** (enclosed) To receive the report the Chair and Non-Executive Directors	JC / NEDs
	18.	**Dates for meetings for 2025** To note dates for meetings in 2025: • **11 September 2025** • **13 November 2025** • **Annual Members' Meeting - TBC**	JC
	19.	**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 – February 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 - Thomas Pulimood, Anna Clapton

NEDs - David Weaver

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 meetings held on 26 February 2025

For Approval

Presented by Jude Chin

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE
COUNCIL OF GOVERNORS' MEETING - OPEN

Held on Wednesday 26 February 2025 at 17:30
At the Education Centre, West Suffolk Hospital site, Bury St Edmunds

Members:		
Name	**Job Title**	**Initials**
Jude Chin	Trust Chair	JC
Carol Bull	Public Governor	CB
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
Anna Clapton (nee Mills)	Staff Governor	AC
John-Paul (J-P) Holt	Staff Governor	JPH
Louisa Honeybun	Staff Governor	LH
Andy Morris	Staff Governor	AMo
Adam Musgrove	Staff Governor	AMu
Diana Stroh	Staff Governor	DS
David Brandon	Partner Governor	DB
Sue Kingston	Partner Governor	SK
Lisa Parish	Partner Governor	LP
In attendance:		
Ewen Cameron	Chief Executive Officer	EC
Antoinette Jackson	Non-executive Director	AJ
Michael Parsons	Non-executive Director	MP
Roger Petter	Non-executive Director	RP
Richard Flatman	Non-executive Director	RF
Paul Zollinger-Read	Associate Non-executive Director	PZR
Heather Hancock	Non-executive Director	HH
Alison Wigg	Non-executive Director	AW
Sam Tappenden	Executive Director of Strategy & Transformation	ST
Pooja Sharma	Deputy Trust Secretary	PS
Ruth Williamson	Foundation Trust Office Manager (Minutes)	RW
Apologies: Anna Conochie, Public Governor Val Dutton, Public Governor Liz Hodder, Public Governor Tom Murray, Public Governor		

Adrian Osborne, Public Governor Clare Rose, Public Governor Rowena Lindberg, Partner Governor Heike Sowa, Partner Governor Thomas Pulimood, Partner Governor Tracy Dowling, Non-executive Director David Weaver, Associate Non-executive Director
Members of the Public
None in attendance.

No.	Item	Action
1.	**Welcome and introductions**	
	The Chair welcomed to the Council two new governors, Diana Stroh (Staff Governor) and Lisa Parish (Partner Governor). Also welcomed David Brandon, a returning Partner Governor.	
2.	**Apologies for absence**	
	Apologies for absence were noted, as detailed above. The Council received the sad news of the passing of Michael Simpkin, Public Governor. MS's significant contribution to the Trust was acknowledged and condolences offered to the family.	
3.	**Declaration of interests**	
	There were no declarations of interest made.	
4.	**Minutes of the previous meetings**	
	The minutes of the meeting held on 19 November 2024 were approved as a true and accurate reflection.	
5.	**Matters arising on action sheet**	
	Minute 5 – Governor Visits to Virtual Ward Control Centre – confirmation of suggested dates in April awaited. **Closed Action Points** ***Minute 7 – Chief Executive's Report – Summary of Progress on Reported Never Events*** – Jane Skinner (JS) requested a development session on patient safety, including shared learning from Never Events. **Action: Development session to be arranged.** Ben Lord (BL) reported that more assurance was required on the process used for communicating Never Events was having the desired effect, with outcomes being discussed at assurance committees without report to governors. Jude Chin (JC) advised that these were discussed at the Improvement Committee and that the outcome of the two recent events was detailed in today's action log.	**PS**

	Andy Morris (AMo) sought clarification on a Never Event in November 2024, in an orthopaedic theatre, and if this was reported. Ewen Cameron (EC) advised that was aware of the incident referred to and was of the understanding this was a matter of human error. There was a difference in keeping the staff involved in such events informed of the learning and reporting to the Council. Roger Petter (RP) suggested a need to relook at the process to ensure learning and information is being disseminated appropriately. EC responded that it may have been. Becky Poynter (BP) stressed the importance of governors being aware of such events in order to be able to provide assurance if questioned. JS queried governor receipt of Never Event notifications. **Action: EC to ascertain reporting arrangements for the case in November and confirm overall process for reporting of Never Events to governors.**	**EC**
6.	**Update on Transformation Programme**	
	Sam Tappenden (ST), Director of Strategy and Transformation provided an update on the transformation programme. AMo referred to the requirement to agree a clear process for prioritising transformation. In terms of safety, clinical and financial, he asked what would be the process for non-executive directors (NEDs) to gain assurance? ST advised that the prioritisation process had yet to be agreed and would need to consider, in terms of quality and finance, what was feasible and cost effective. However, a vigorous process would be in place. AMo stated the process would require thought and asked if the Trust would be ready for an April timeline? ST advised that in terms of the work on sustainability, it would. AMo suggested that there would be a cross over. Would a clear process be in place by then? ST advised that this depended on the interventions agreed as a system for review. JC advised that in terms of timing, whilst the McKinsey Report was due in April, the associated initiatives would take longer to implement. EC reported that NEDs were involved in this work, with a Board session being held on 28 February, 2025 and a further in April. Tracy Dowling (TD), NED was also a member of the steering group. JC advised that any decisions would be taken collectively by the Board and NEDs would need to be comfortable with what was being asked of the Trust. JS suggested that in terms of scoping, it appeared top heavy in method of enquiry, with groups comprised of executives or the Integrated Care Board (ICB). While stakeholders, including patients and staff, were mentioned, there was no evidence of their consultation. Carol Bull (CB) asked if the Trust was looking at existing processes or how things should be and had the Board had any thoughts in this regard. JC	

	advised that this was to be discussed in item 7. The current discussion related to transformation work currently being undertaken. Paul Zollinger Read (PZR) stated that serving the frail as best we could, was key to organisational success. It was acknowledged that changes needed to be made. David Brandon (DB) highlighted that it was good to learn from best practice elsewhere. A key part of transformation was connectivity between organisations, with improvement for all, not just one. Frailty had been chosen for collective work both in and out of hospital in order to improve outcomes. Partners were stretched and it was a matter of how best to maximise use of the collective resource. Becky Poynter (BP) asked how this would link in with other organisations who were not health providers, such as Help the Aged, who had links to this cohort, in order to help people retain their independence. Loneliness was a factor that saw an increase in GP appointments. Sarah Hanratty (SH) highlighted that the previous strategy had not been refocused over the last 5 years and expressed concern at the risk of strategy overload with the 10 Year Plan etc. How would the Board choreograph this work? ST advised the intention was to make this as simple and focused as possible. The objective was to select 3-5 areas of priority to meet the needs of the Trust. By being clear on priorities, resources could be steered appropriately.	
7.	**SNEE Sustainability Review**	
	ST presented the report. The review is looking at six key areas. There are two board interventional categories; future shift from acute to community and acute collaboration between services to improve quality, productivity and sustainability. Review recommendations are anticipated in April. JC advised that whilst early on in the process, next steps will be use of the analysis to decide on interventions to provide best returns in terms of quality and finance. EC reported that the data has shown healthcare in Suffolk & North East Essex not to be sustainable. The system will need to do something different to continue to deliver services in a way the community deserves. JS asked at what stage patients and staff would become involved? ST advised the review would involve senior clinicians and leaders. Public engagement was not in scope. BP asked for assurance that the NEDs would be involved in the process regarding collaborative arrangements and report same to this meeting. She asked if NEDs would also be looking at the solutions? JC advised that upon receipt, the recommendations will go through the Trust's	

	processes to assess quality impact. EC confirmed that NEDs would be involved in any decisions made. AMo stated that whilst having some understanding of the opportunities available at the end of April, this would not deliver financial savings early on, which he understood was part of the reason for undertaking the review. EC advised that the review was against the Government's Ten-Year Plan and a multiyear issue. Therefore, it was highly unlikely that schemes identified will have an impact on 2025/2026. CB queried a formal consultation with patients. JC advised that given the scope and timeline of the review it was about what could be done as a system to be sustainable. EC reported that any formal consultation depended on the solutions found and none had been currently identified. It was accepted that patient and public involvement was to be encouraged; however, this depended on the suggestions made from the review. SH asked if the New Hospital Programme (NHP) was outside of the scope for this review? EC advised that the new hospital would not be built prior to the end of the review, but would have an impact on sustainability of the system and therefore will be considered. However, this consideration would be about financial impact rather than layout. J-P Holt (JPH) asked if the data being used was purely operational, or taken from patient surveys. ST advised that the sources of information were broad and comprehensive.	
8.	**Chair's Report**	
	The report was taken as read JS suggested the Board has been in a state of flux with a relatively new team and asked what assurances would be provided to governors that the members would be drawn together to form a unitary board. JC advised that the Board had worked hard to get to know each other and understand each other's position. Bimonthly development sessions were being held. The Board's ability to act unitarily relied on the experience of board members and this had been brought in by them from other areas. JC was pleased with the cohort and did not anticipate any great flux in NEDs in the near future. Noted the Trust was looking for executives to replace the Chief Nurse and Executive Director of Workforce and Communications.	
9.	**Chief Executive's report**	
	The report was taken as read. AMo made reference to Referral to Treatment (RTT) numbers, which appeared to differ in various papers. He advised of the impression that the over 65-week waits were not being addressed and queried the safety of those patients. Did the Trust feel more could be done to get traction on	

	RTT and was it happy with the degree of safety? EC advised that the Trust was looking at clearing the long week waits by the end of March. JS had heard that in terms of the Virtual Ward (VW), beds were underutilised and understaffed due to lack of bank staff. Had staffing now improved and what was the Trust's ambition? Would there be investment? EC advised that the decision to move VW into the community and Integrated Neighbourhood Teams was to address staffing issues and inefficiencies, thereby providing greater resilience. The number of beds served had increased. The Trust's ambition, to be built in to plans for the New Hospital, was 110 VW beds. Underutilisation was in part due to clinician confidence in using the service and therefore, until such time as use increases further, resources will not be apportioned. Noted interviews are being held on 27 February for a community geriatric lead for the service. Noted there will be limitations on investments in the coming year. DB advised that as part of the VW project, a pilot has been carried out in some care homes to directly admit to VW without the need to leave the home. The system was now looking at how VW could offer a middle ground where a patient can be admitted following a GP visit i.e. direct onboarding. AC stated that patients were appreciative of tests now being carried out in the Community Diagnostic Centre (CDC). In terms of plans to expand this work she highlighted the staffing difficulties within specialisms and suggested the recruitment process was delaying appointments and therefore required the use of existing staff. What was the plan for moving forward? EC advised of a national shortage and on site for ultrasound. Pay controls in place were due to the Double Lock which will remain until and unless the Trust is on plan by Quarter 1. The CDC was part of the Trust. AC commented on the need for the Trust to pay mileage to staff travelling to the centre and the need to recruit. AMu sought clarification from AC as to whether her query related to the prioritisation of use of staff? She confirmed that it was, whilst appreciating the need to meet CDC targets, going forward this may have a detrimental impact on inpatient services at the Trust. EC suggested this was a conversation for Ops rather than the Council. EC left the meeting.	
10.	**Feedback from Board Committees**	
10.1	**Insight Committee**	
	The CKIs were taken as read and governor observer comments noted. Antoinette Jackson (AJ) reported that the Trust was in Tier 2 in terms of regional intervention for elective and diagnostic performance. Due to progress made, it was now in Tier 1 for cancer and diagnostics.	

	JS referred to the quality impact assessment report and assurance that these assessments had been carried out and queried what the restructure of the mortuary related to and the numbers involved in the support to go home realignment. JS suggested the report could have provided more information for an observer. AJ advised that there had been a detailed discussion regarding this at the Insight Committee. The meeting had received a report on the schemes looked at by Quality Improvement in terms of changes relating to financial savings. On occasion, the description in terms of the change or service could be oblique and the committee has challenged this. It was agreed the report could not go into extreme detail about what was being considered. Insight could take assurance that there was a process looking at quality impact. This was a rounded process, as schemes were implemented. There was still work to be done on clarity and how expressed in order to provide a better understanding of the change. AC advised that the directorate aimed to stay on top of diagnostic waiting times, which was on occasion difficult and might require additional lists. She asked what assurance there was for the authorisation of these additional lists. Previous panel reviews had resulted in cancellation of some of these additions, at relatively short notice, resulting in more work to cancel and rebook. AJ reported that Insight did not get involved in operational detail for individual lists. JPH reported the demand on the cancer service and that the wait for diagnostics was causing an issue for patients. Further, the psychological support provided through McMillan was no longer able to be supplied. **Action: it was agreed that questions be raised at Insight regarding additional measures available in light of extended wait times.** JPH asked that the outcome of these questions be circulated to the Council. DB advised of the need to link with wider transformation activities in order to try and find a solution. Primary care is looking at a programme with the SNEE hub regarding cancer specialist nurses working in primary care. This was not just a matter for the Trust and work could be done in conjunction with the waiting well. SH asked if the Board was struggling to obtain an overall picture of its appetite for risk. AJ responded that the Board needs to have more understanding of the risk and its appetite for same. However, more clarify was suggested if transformation plans were part of a capability risk. The Trust Secretary is giving thought as to how to report this information, avoiding duplication to the various meetings. JC advised that when the current risk appetite was set it was by a different Board membership. This will be reviewed.	**AJ/JC**
10.2	**Involvement Committee**	
	The CKIs were taken as read and comment from governor observers noted. Noted issues raised by staff governors had been discussed and continued assurance sought via the People and Culture Committee.	

10.3	**Improvement Committee**	
	The CKIs were taken as read and comment from governor observers noted. AMo referred to comments made in the paper on MPox and requirement for PPE, but with training for its use outstanding and queried the Trust's readiness for the next pandemic. RP advised that this working group and PPE fell within the purview of the Chief Nurse and that they would be reporting into the Improvement Committee. **Action: RP to raise the issue of PPE training at next Improvement Meeting.**	**RP**
10.4	**Audit Committee**	
	CKI noted and taken as read.	
11.	**Nominations Committee Report**	
	The report was taken as read. Query raised as to process for arranging training in respect of NED appraisals for those governors not immersed in health. Noted the questions used were more about the performance of the NED. A training session recorded previously is available and can be shared. JS advised that some governors were under the misapprehension that they were acting as the appraiser. Their role was to provide feedback to the appraiser (JC) on observed performance of the NEDs. Further guidance from NHSE is awaited. Any significant changes will be notified to governors. Volunteers to act as providers of feedback were requested and expressions of interest to be sent to PS.	
12.	**Membership & Engagement Committee Report**	
	Noted the Membership & Engagement Strategy has been adopted and actions from same to be taken forward. JS advised that in respect of volunteer membership, having spoken to three other Trusts, their volunteers are automatically made members. Request made for Trust to consider same. **Action: Deputy Trust Secretary to take forward.**	**PS**
13.	**Standards Committee Report**	
	No meeting to report.	
14.	**Staff Governors' Report**	
	Noted Staff Governors are looking to improve their profile, utilising the engagement strategy. Work to be undertaken with staff networks moving into election time.	
15.	**Lead Governor Report**	
	The report was noted.	

	A welcome was extended to Lisa Parish, Diana Stroh and David Brandon, new governors and a farewell to J-P Holt, following the resignation.	
16.	**Governance Report**	
	Noted Fit and Proper Person Tests (FPPT), together with declaration of interest forms, will be circulated shortly to governors for completion. The Council agreed the approach to draft governors' commentary for the quality accounts 2024/25. Governor volunteer readers for the Quality Accounts and Annual Report to contact PS. ***Work Programme 2025***. Noted an external training session is to be arranged with NHS providers.	
17.	**Summary Report for Board of Directors Meetings**	
	Report noted and taken as read.	
18.	**Any Other Business**	
	Concerns were raised on an email about potential redundancies sent to the consultants and it was inquired if the Trust intended this and whether the NEDs had oversight regarding the numbers, quality, and equity impact. JC clarified that no decisions had been made yet. For anyone affected, a consultation process in line with employment law would be followed. It was highlighted that this situation was causing staff anxiety, which the Council and Board should be aware of. AJ advised that the matter of communication would be picked up at the Involvement Committee. JC offered thanks and those of the Council to J-P Holt, Staff Governor, upon his resignation, for JP's incredible contribution whilst in the role.	
19.	**Dates for meetings in 2024/2025**	
	▪ 14 May 2025 ▪ 11 September 2025 ▪ 13 November 2025 ▪ Annual Members' Meeting - TBC	
16.	**Reflections on meeting**	
	• Thanks offered for provision of microphones at the meeting which had greatly assisted attendees ability to hear and be heard.	

5. Matters Arising Action Sheet (enclosed)

To note updates on actions not covered elsewhere on the agenda

To Note

Presented by Jude Chin

ACTION LOG – Open Council of Governors meeting – following 26 February 2025 meeting

CLOSED ACTIONS

Minutes Ref No.	Paper/Agenda item Ref	Meeting date	Action	Lead	Progress	Target Date	RAG	Date completed
5	Matters Arising – Chief Executive's Report – Summary of Progress on Reported Never Events	26/02/2025	Ascertain reporting arrangements for the orthopaedic case in November and confirm overall process for reporting of Never Events to governors.	EC	Orthopaedic case not declared a Never Event at the time of CoG in February. Process for notification is via email to governors. An email regarding the orthopaedic case, when declared an event, was sent on 7 March, 2025.	May 2025	**Complete**	May 2025
10.1	Insight Committee	26/02/2025	Questions to be raised at Insight regarding additional measures available in light of extended wait times (diagnostics and cancer).	AJ/JC	The Chair's Key Issues reports for March and April provide details of the progress made with these two issues. The Trust has seen an improvement in elective performance which has reasonable assurance. Cancer has moved from minimal to partial assurance due to performance improvements in February and March. The Trust is hopeful it may move out of Tier 1 as a result of this.	May 2025	**Complete**	May 2025
10.3	Improvement Committee	26/02/2025	Raise issue of PPE training at Improvement.	RP	PPE training was discussed at the Improvement Committee on 19 March 2025 and assurance was received that PPE is in stock, and training for its use is in place.	May 2025	**Complete**	May 2025
12	Membership & Engagement Committee Report	26/02/2025	Automatic membership for volunteers to be taken forward	PS	Confirmation of how actioned sought from other Trusts. Follow up to be undertaken via the Membership & Engagement Committee. Added on Membership & Engagement Committee development plan. Action closed.	May 2025	**Complete**	May 2025

Minutes Ref No.	Paper/Agenda item Ref	Meeting date	Action	Lead	Progress	Target Date	RAG	Date completed
5	Matters Arising – Chief Executive's Report – Summary of Progress on Reported Never Events	26/02/2025	Development Session on Patient Safety & Quality to be arranged.	PS	Session booked.	May 2025	**Complete**	April 2025
5	AOB – Governor Visits to Virtual Ward Control Centre	02/09/2024	New Non-executive directors (NEDs) to be invited. 19/11/2024 - Visits cancelled due to operational pressures. New dates to be arranged.	RW	Invite extended. Action Closed. Following discussion with Caroline Millard, these visits are to be rescheduled for April, 2025. Dates to be confirmed. Visit booked and undertaken on 9 April, 2025. Due to current operational pressures, no additional dates available at present.	20/09/2024 May 2025	**Complete**	April 2025

RAG RATING:

Key	
Completed	
On track/On trajectory - The action is expected to be completed by the due date	
Some slippage/Off trajectory - The action is behind schedule and may not be delivered	
Serious Issues/Due date passed and action not completed	

LEAD:

Name	Initials
Ewen Cameron	EC
Roger Petter	RP
Sam Tappenden	ST
Antoinette Jackson	AJ
Ruth Williamson	RW
Jude Chin	JC

6. Update on Financial Position

(enclosed)

To receive an update

Jonathan Rowell, Interim Chief Finance Officer, in attendance

To inform

WSFT Council of Governors meeting (Open)	
Report title:	Finance update
Agenda item:	6
Date of the meeting:	14 May 2025
Lead:	Jonathan Rowell, Interim chief finance officer
Report prepared by:	Nick Macdonald, Deputy Director of Finance

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

Financial Position March 2025 (M12).

	In-Month Budget £m	In-Month Actuals £m	In-Month Variance £m F/(A)	YTD Budget £m	YTD Actuals £m	YTD Variance £m F/(A)
EBITDA						
Income						
NHS Contract Income	30.3	34.2	3.9	364.8	371.3	6.5
Other Income	3.3	3.4	0.2	39.5	38.6	-0.9
Total	**33.6**	**37.6**	**4.1**	**404.3**	**409.9**	**5.6**
Expenditure						
Pay Costs	22.7	25.4	-2.7	286.1	293.4	-7.3
Non-pay Costs	8.7	11.3	-2.6	111.5	120.4	-8.9
Total	**31.4**	**36.7**	**-5.3**	**397.6**	**413.8**	**-16.2**
EBITDA Position	**2.2**	**0.9**	**-1.2**	**6.7**	**3.9**	**-10.6**
Depreciation	**1.4**	**1.3**	**0.0**	**16.6**	**16.6**	**0.1**
Finance Costs	**0.4**	**0.4**	**0.0**	**5.2**	**5.0**	**0.2**
Impairments	**0.0**	**0.0**	**0.0**	**0.0**	**0.1**	**-0.1**
Deficit/(Surplus)	**0.4**	**0.8**	**-1.2**	**15.2**	**25.7**	**-10.5**

- The initial plan was to record a deficit of £15.2m in 2024/25. This was then revised in line with our Finance Recovery Plan (FRP) to £26.5m and agreed with the ICB.

- The Trust has reported a deficit of £25.7m for the year ending 31st March 2025 (subject to audit). 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 total agreed with the ICB due to non-recurring support from the ICB of £1.2m.

- The Trust reports 3.3% fewer WTE in March (4,953.6 WTEs) than in April 2024 (5,120.52 WTEs), a reduction of 166.94 WTEs. This reduction in staff numbers has improved the recurring run rate to £1.6m deficit, which is in line with the planned position for 2025/26 (£20.7m deficit). Due to this planned deficit, revenue support will continue to be required into 2025/26.

- Savings in many areas were seen earlier than were phased in the FRP, but this means they are not all being delivered to the depth of the FRP. As a result, our recurring position fell short of the planned £1.3m recurring monthly deficit in the FRP by around £340k to just over £1.6m deficit per month. However, this represents a huge improvement on the recurring position that was reported in Q1 of 24/25, peaking at £3.1m deficit per month.

- Our planned deficit for 25/26 (£20.7m) assumes we start the year with a monthly recurring deficit of £1.7m

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

The plan for 25/26 is for a deficit of £20.7m, which is broadly in line with the recurring deficit rate at the end of 24/25.

However, the National Planning Guidance (including a productivity target of 2%) and known cost pressures have increased our baseline deficit significantly.

Therefore, in order to achieve the planned deficit a CIP of £32.7m is required (7%). Whilst £6.1m of this relates to the full year effect of savings that began in 24/25, there remains £26.1m of new, cash releasing. cost improvements to be delivered.

In agreeing this planned deficit our system is able to plan to break even due to the ICB planning a surplus of £20.7m. However, this is due to postponing various investments in services that had been planned and they have made clear that we are still required to get to a break even position ASAP.

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

Achieving the planned CIP presents a significant risk and will require difficult decisions. We have made clear to the ICB/Region that their support is essential.

The Finance Recovery Group (FRG) meet every week, chaired by the Chief Executive.

We also have a number of groups feeding into this, particularly reviewing productivity, corporate savings and non-pay. We have support from PA consultancy and a restructured Strategy and Transformation team.

Currently around 50% of our CIP for 25/26 has been identified with a number of schemes in pipeline – being worked up and working through our internal governance processes.

In the meantime there continues to be a vacancy freeze and a Mutually Agreed Resignation Scheme (MARS) will be launched on 13th May.

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

Previously considered by:	NA
Risk and assurance:	Financial risk
Equality, diversity and inclusion:	N/A
Sustainability:	Financial sustainability
Legal and regulatory context:	NHS Act 2006, West Suffolk NHS Foundation Trust Constitution

7. Chair's report (verbal)

To receive an update from the Chair

To Note

Presented by Jude Chin

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:	14 May 2025
Sponsor/executive lead:	Dr Ewen Cameron, chief executive officer
Report prepared by:	Dr Ewen Cameron, chief executive officer Sam Green, acting communications manager Anna Hollis, deputy 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.	☒	☒	☒

With the Trust's operational pressures and challenging financial position continuing, I'm pleased to open today's report with an example of improved care and therefore outcomes for our patients.

I've been regularly reporting on the progress of the new, state-of-the-art Community Diagnostic Centre (CDC) at the Newmarket Community Hospital, which was formally opened at an event on Friday, 2 May 2025.

Taking around a year to complete in terms of construction, doors opened to its first patients on 16 December 2024. In its first 100 days, more than 6,000 patients were seen and almost 8,900 examinations completed, including MRI, CT, X-ray and ultrasound, as well as lung function and heart scans.

I was joined by our clinical and non-clinical teams involved in the project, alongside our project partners, Integrated Care Board (ICB) colleagues and the MP for West Suffolk, Nick Timothy, to formally open the facility. It is helping to significantly reduce waiting times, while also expanding the employment opportunities in the local area and reducing health inequalities by bringing the services our communities need closer to where they live.

While we have seen improvements across most of our imaging services, we have been able to halve the number of people on our CT waiting list between November and April, with waiting times down from eight weeks to four. For MRI between the same period, we reduced the number of people waiting for their scan by 37% and cut waiting times from 17 weeks to 11. This is making a massive difference for our patients, who are having their scan, getting their results and, where required, beginning treatment much more quickly, which will ultimately improve clinical outcomes.

Performance

Finance

At the end of March, our reported position in-year was a £25.3m deficit, which is £9.7m worse than planned. There has been enormous hard work from colleagues to help reduce the deficit, and significant progress made over the last seven months with a positive reduction in our underlying run rate over the course of the year.

Work continues at pace to support the Trust's financial recovery plan, and we have worked closely with the Integrated Care Board (ICB) to develop a financial plan to balance the books for the healthcare system. It outlines the scale of savings needed to become sustainable – both in the coming year and more long term – while still providing high quality care for our patients.

We are having to take difficult but necessary decisions to manage our budgets and deliver a level of productivity that matches our resources. The Trust's workforce plan identifies the overarching plan to reach by the year end of 2025/26 to meet the affordability expectations of the organisation and reducing the number of temporary and permanent staff we employ is one of the ways we'll achieve this, but every part of the Trust is contributing to make us fit for the future. Everything from clinical productivity to transformation of services to improve the quality of care for our patients is being considered.

Elective recovery

On 31 March 2024, 407 patients were waiting more than 65 weeks and 47 waiting more than 78 weeks. By the end of March 2025, this reduced to just 31 patients waiting more than 65 weeks (10 being capacity-related or the patient being medically unfit to undergo treatment) and no patients waiting more than 78 weeks.

Urgent and emergency care

Our performance against the 4-hour standard was 88.4% in March, up from 67.1% in February and against the national target of 76% in 2024/25. This increases to 78% for 2025/26. The Trust's latest performance ranked it as the highest performing trust in the east of England, and fourth nationally.

Over the winter period from 2024 into 2025, the Trust has been working incredibly hard to improve its UEC performance against the 4-hour target, rising steadily from 62.1% in December 2024, to 63.4% in January 2025 and 67.1% in February 2025 – which is always the busiest time of year. This means patients are getting the care they need more quickly, reducing long waits in the emergency department and improving patient satisfaction.

A huge thank you to every member of staff who helped the Trust to achieve such an improved UEC performance.

Cancer

For 2024/25 we have focused on the early detection of cancer and reducing waiting times for patients with cancer. Our aim was to improve our performance against the faster diagnosis standard to 77% by March 2025 - which means our patients having cancer confirmed or ruled out within 28 days, and 70% of patients beginning their cancer treatment within 62 days by March 2025.

At the end of February 2025, the position is:

- 76.7% of patients had cancer ruled out or confirmed within 28 days, this is a significant improvement and in line with our internal Trust trajectory of 76% for February.
- 75.3% of patients were treated within 62 days, this is above the national requirement for 2024/25.

Quality

Meaningful engagement with the community we serve is hugely important for the Trust, and you're never too old – or young - to help shape our services.

We recently welcomed 12 children in years 4, 5 and 6 at Hardwick Primary School to our paediatric ward at the West Suffolk Hospital as part of our Little Steps initiative. This comes from our 15 Steps initiative, which is designed to spot potential improvements we can make in different areas of our Trust from the observations made within 15 steps of entering the area. The children were asked about what changes we could make to the ward, such as whether we have enough toys and books available and how the space looks and feels. The feedback received included having more outdoor activities, such as a football goal, to photos of the staff on the walls and activities for older children.

This feedback is incredibly important, and we take it very seriously, as it helps our young patients and their families have a better experience of receiving care, which can be very stressful for those involved. I would like to thank the teams involved for their innovation when looking to improve the care we provide by engaging with our local communities.

Workforce

There's no denying it is tough for colleagues at the moment, as we navigate both our financial challenges and our work to improve the provision of care across multiple services. So, when I meet colleagues to hear about the wins, small and large, and the efforts staff are making on this journey, it puts things into perspective.

I recently met Kirsty who was nominated for a Putting You First award in recognition of her support for the Haverhill locality and hard work ensuring our patients receive the best possible care.

Kirsty's compassion, collaboration and commitment help bring together multidisciplinary teams to deliver outstanding, personalised care. Thanks to the work of Kirsty and her colleagues, more patients are safely supported at home, avoiding unnecessary hospital admissions. She's also been instrumental in creating new community connections, including helping develop Haverhill's local marketplace event, bringing together local voluntary, social and health services for the benefit of residents and healthcare professionals alike.

Kirsty and her Haverhill healthcare team colleagues are at the forefront of joining up services with local healthcare system partners, proving that collaboration in this way is key for patient outcomes and showing where we get it right, we can care well for patients closer to home rather than in the hospital setting.

Congratulations to Kirsty and thank you to all colleagues working across our hospital and community services in every type of role for your continued patience and dedication.

Future

In April, the Trust received additional clarity around the amount of funding we will receive to build a new West Suffolk Hospital - another definitive indication of the Government's commitment to our project.

This is an important positive step, our latest plans, based on our work with staff, patients and members of the community, are currently being reviewed and assured with the central New Hospital Programme team and we will share the designs once they have been agreed with our national colleagues.

The Trust has been working closely with the Suffolk and North East Essex Integrated Care Board (ICB) and the East Suffolk and North Essex NHS Foundation Trust (ESNEFT) to complete a system Sustainability Review into local NHS acute and community health services. Its aim is to help local NHS organisations, and our partners consider how to deliver a 'future shift' of resources into primary and community services while improving the clinical and financial sustainability of the system overall. It also aligns to the Government's 10-year plan expected to be published later this year, which will focus on moving from: hospital to community, analogue to digital and treatment to prevention.

The final report of the Sustainability Review has been completed and handed over to the review's Steering Group for consideration. The Trust looks forward to implementing the agreed recommendations of the Sustainability Review in close collaboration with ESNEFT and the ICB.

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:	14 May 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:

19 February 2025 (observed by Jane Skinner and Adam Musgrove)

- Report from sub-committees:
  - Financial Accountability Committee including Month 10 reporting, financial recovery plan for community equipment services and wheelchair services
  - Patient Access Governance Group including Quality Impact Assessment panel outcomes
- IQPR - data for December 2024
- 25 / 26 Planning Update including CIP update
- Forward Plan
- Escalations to and from other board assurance committees and board

19 March 2025 (observed by Jayne Neal, Adam Musgrove, Diana Stroh)

- Report from sub-committees: Financial Accountability Committee and Patient Access Governance Group including Planning Update, Quality Impact Assessment Panel Outcomes, Month 11 reporting, CIP Update, 2025/26 Capital Plan
- Board Assurance Framework - BAF 7 financial sustainability (via FAC)
- IQPR – data for January 2025
- Escalations to and from other board assurance committees and board
- Review of Work Programme / Forward Plan

April 2025 (observed by Jane Skinner, Adam Musgrove and Diana Stroh)

- Report from sub-committees: Financial Accountability Committee and Patient Access Governance Group
  - Month 12 Reporting
  - 25/26 CIP Plan Development
  - Corporate Review
  - Productivity Programme Board Briefing
  - QIA Panel Outcomes
- IQPR - data for February 2025
- Board Assurance Framework - BAF 2 capacity (via Access)
- Internal Audit Report
- Escalations to and from other board assurance committees and board
- Forward Plan

IMPROVEMENT COMMITTEE:

19 February 2025 (observed by Sue Kingston and Jayne Neal)

- Reports from governance sub-groups: Patient Quality & Safety, Clinical Effectiveness and Transfer of Care Group report
- Update on Discharge Summaries
- Quality & patient safety insight: Quality & safety datasets, IQPR, PRM packs, and agree any areas requiring assurance review
- Quality priorities, progress and planning
- Maternity updates - 60 Safer Steps, Claims and incident quarterly review report
- Escalations to and from other board assurance committees and board

19 March 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: Quality & safety datasets, IQPR, PRM packs

- Quality Priorities – future topics
- Quality priorities update / Deep Dive: C-difficile
- Quality priorities update – discharge summaries
- Patient Safety Incident Framework - management and reporting incidents (quarterly report)
- Escalations to and from other board assurance committees and board

16 April 2025 (observed by Andy Morris and Jayne Neal)

- Reports from governance sub-groups: Patient Quality & Safety, Clinical Effectiveness Governance Group report
- Quality & patient safety insight: Quality & safety datasets, IQPR, PRM packs
- Quality Priorities - TES update
- CQC single assessment framework: proposed framework for review
- Maternity Update - 60 Supportive Steps
- Internal Audit Q4 assurance report
- QIAs - oversight and assurance
- 2025/26 Forward Planner
- Escalations to and from other board assurance committees and board

INVOLVEMENT COMMITTEE:

19 February 2025 (observed by Anna Clapton, Becky Poynter and Carol Bull)

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

First for staff:

- Education & Training Report
- Staff Psychology Service Specification
- National Staff Survey 2024 – early headlines

First for patients:

- Consideration of underrepresented groups in our patient experience monitoring
- Quality priorities review and 2025/26 proposed priorities
- EDS Report Summary and EDS Reporting submission

First for the future:

- Equality, Diversity and Inclusion update - EDI annual report and WRES / WDES reports and action plans

Governance:

- People and Culture Committee update – ToR sign off
- Experience of Care and Engagement Committee report
- Involvement Committee forward plan

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

16 April 2025 (observed by Anna Clapton and Becky Poynter)

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

First for staff:

- 2024 National Staff Survey Results – taking action
- Sexual Safety in the Workplace
- Band 2/3 Healthcare Support Worker Project Review

First for the future:

- Volunteer Services Strategic Plan

First for patients:

- Consideration of underrepresented groups in our patient experience monitoring

Governance:

- People and Culture Committee Update - 11 March 2025
- Experience of Care and Engagement Committee Report
- Audit one well led response
- BAFs - Patient Engagement and Staff Wellbeing
- Internal Audit Q4

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 (18 March 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)

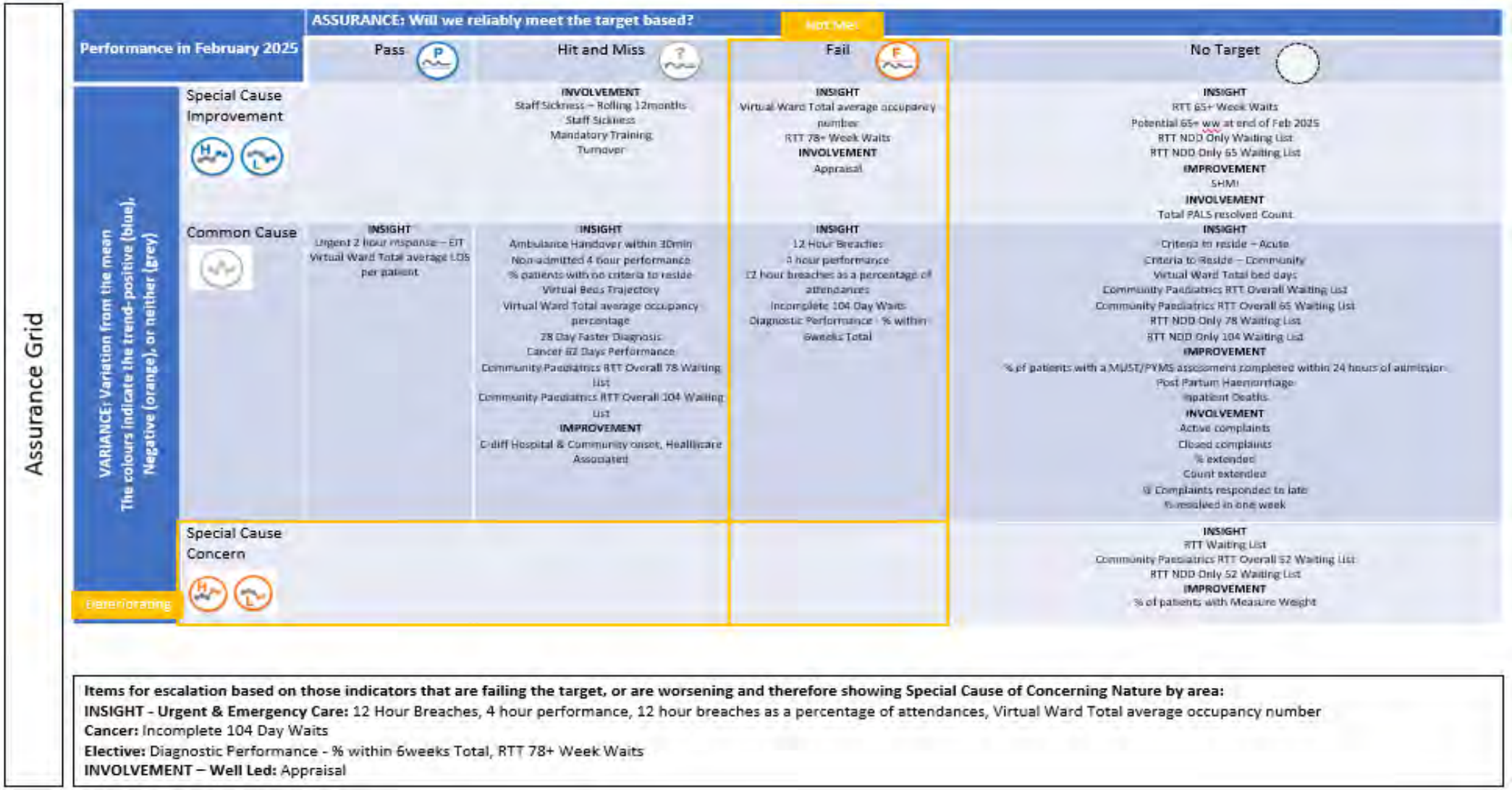
The items reported through this report will be actioned through the appropriate routes.

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



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, 4 hour performance, 12 hour breaches as a percentage of attendances, Virtual Ward Total average occupancy number
Cancer: Incomplete 104 Day Waits
Elective: Diagnostic Performance - % within 6weeks Total, RTT 78+ Week Waits
INVOLVEMENT – Well Led: Appraisal

9.1. Insight Committee

Presented by Antoinette Jackson

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			Date of meeting: 19 February 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
Finance Accountability Committee	**Month 10 Reporting** The Trust continues to make progress on its recovery trajectory and is on track for the revised control total of £23.8m. Workforce savings are being seen, with the trust reporting 168.1 fewer WTE in January than in April 2024. The controls put in place as part of the financial recovery plan remain. This exit rate for 24/25 is important in determining the start position for the 25/26 plan. The recurring deficit in January is £1.77m £165k behind the anticipated FRP trajectory. ERF remains on trajectory, although there is some risk of interruption with winter pressures and norovirus impacting on elective capacity. The combined revised CIP and FRP schemes planned to deliver £13.0m YTD,	**3 Partial**	The Trust is optimistic that it will exceed its 'likely case' outturn position as presented in the FRP and are now forecasting a deficit of £23.8m. This revised forecast remains challenging and has some risks. It is unlikely that the exit monthly run rate for the year will be in line with the original plan at £1.3m deficit per month. This exit rate for 24/25 is important in determining the start position for the 25/26 plan.	Work continues on the development of the Financial Recovery Plan for 2025/26 in the context of the new Planning Guidance and indicative financial allocations, see Operational Planning Guidance item below.	3.Escalate to Board

	with actual delivery of £16.2m YTD, a favourable variance of £3.2m YTD. The cash position remains critical and the Trust has put in an application for a further £7.9m of revenue (deficit) support for quarter 4 to match the deficit forecast.				

Quality Impact Panel Reviews	The scope of the QIA Panel is to ascertain the quality or sustainability impact of the cost improvement programmes schemes. Two schemes were reviewed by the panel in January 1. A restructure of the mortuary staffing model 2. A review of staffing in The Support To Go Home (STGH) scheme which previously received non-recurrent funding for additional reablement capacity and a responsive coordinator. As funding for these posts has now ceased the workforce is being realigned with the budget.	**1. Substantial**	The Panel's remit is to solely to focus on the quality impacts of each scheme, on patients, their families, staff and the Trust more widely based on assessment criteria. Insight Committee concluded it can give assurance that there is a robust process in place for assessing the risk of an adverse impact on quality. The actual quality outcomes of the schemes over time will be considered by the other assurance committees as part of their role in the ongoing monitoring of services	The Panel will meet fortnightly, as required, as new schemes come forward.	1 No escalation

Operational Planning Guidance	The operational planning guidance was published on the 30 January 2025, with the expectation of planning submissions to be completed by 20th February 2025. The Trust has also been notified of its indicative financial allocations for the year. This very much remains a dynamic planning environment where regular changes are being made and so the figures presented to Insight were not final. However, they suggest there is additional risk of c£16m in the Trust's financial position for 2025/26 which would give a of c£31m for the year.	**3. Partial**	The guidance outlines the performance the Trust will be expected to achieve in 2025/26. Key targets are highlighted in the operational sections below. A full summary of the targets is included in the Committee report. Given the uncertainty of the financial position the Committee agreed that all risks should be reflected in full in our submission and that a high-level deficit plan of £31m be submitted at this stage.	The financial figures will continue to be refined during March and it is likely that the final submission will improve; albeit many of the factors moving against the financial position are not likely to materially change. The ICB are aware of our risks and the uncertainty around our position. Discussions are also underway with the ICB around the assumptions and associated costs of achieving the operational standards. The Trust will need to decide what targets we want to realistically commit to and what resources will be required.	3 Escalate to Board

PAAG/IQPR	**Elective Recovery** The cohort of elective patients waiting 65 weeks or more is reducing, however the December month end position was 120 patients over 65 weeks, with a provisional January month end position of 92 patients, 68 of which are capacity breaches and a forecast position of zero over 65 weeks by the end of March 2025.	**2 Reasonable**	Elective long wait trajectories are being reforecast to deliver zero 65 week waits by the end of March 2025 at the latest. Dermatology are expected to meet this threshold by 02 March 2025, with gynaecology by 30 March 2025. The latter assumes additional theatre capacity and surgical activity of four cases per week can be delivered alongside the continuation of activity being delivered by Nuffield Health.	As a result of our improved elective position and commitment to reduce the 65 week waits by March 2025, we have been removed from 'Tier 2' for Elective Recovery.	3. Escalate to Board

PAAG/IQPR	**Diagnostics** Diagnostic performance against the 6-week standard is forecast to be c.50% in March 2025, against an expectation of 95% compliance. Although the opening of the Newmarket CDC in late 2024 has seen the modelled step change increase in imaging performance delivered, delays to the DEXA service relocation, non-obstetric ultrasound and endoscopy activity not increasing will need to be addressed to regain compliance.	**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 have now been placed in 'Tier 1' nationally, with fortnightly meetings including WSFT, SNEE ICB and the NHS England East of England regional team to agree recovery actions and trajectories for the Cancer FDS and diagnostic modalities that are driving underperformance.	3.Escalate to Board

IQPR/PAAG	**Cancer Faster Diagnosis (FDS) Targets** Cancer Faster Diagnosis Standard performance has not consistently met the 75% target in any month of 2024/25, with a further month of consecutive decline in November, projected to improve in December through recovery in both Skin and Breast services. insourcing and sickness within the photography team for the teledermatology service provided as part of the pathway.	**4 Minimal**	Achieving the FDS target of 77% and a 62-day performance of 70% by March 2025 are the key objectives for cancer in 2024/25 planning. The November performance has been largely driven by activity not keeping pace with demand in the high-volume breast and skin pathways. Breast clinic activity has reduced due to radiographer shortages and less take up of shifts from external bank staff owing to this being temporarily paused. The skin pathway has not met increases in demand across the summer, because insourcing has ceased and sickness within the photography team for the teledermatology service provided as part of the pathway. Planning guidance requires improved performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026 and improvement against performance against the 62-day cancer standard to 75% by March 2026.	As a result of our worsening Cancer and Diagnostic performance we have now been placed in 'Tier 1' nationally, with fortnightly meetings including WSFT, SNEE ICB and the NHS England East of England regional team to agree recovery actions and trajectories for the Cancer FDS and diagnostic modalities that are driving underperformance. Improving radiological support to breast cancer clinics, will be a key area of focus, alongside the plan to deliver more dermatology activity for the suspected cancer pathway alongside elective long waits. It is expected that FDS performance will increase from December with one-stop breast clinics being booked within 28 days once more.	3. Escalate to Board

PAAG/IQPR	**Urgent and Emergency Care** Ambulance handovers within 30 min and non-admitted 4-hour performance are not reliably hitting target. The overall four-hour performance trajectory was missed again in December with variance worsening – 62.1% against a plan of 75%.	**3 Partial**	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 which makes for a poor patient experience. Planning guidance shows the 4-hour target is once again 78% by March 2026. Modelling the same trajectory of performance improvement seen from 23/24 to 24/25 for 25/26 gets us to 78%, with no additional expenditure. Guidance is less precise on 12-hour waits other than we must demonstrate a reduction, as a % of overall attendances. We have included an indicative reduction of -0.5%in our submission.	Recovery against the 4-hour UEC trajectory needs to ensure improvement initiatives are delivering expected benefits, alongside robust daily management of performance expectations. The UEC delivery plan has been revised and is being supported the fortnightly UEC Delivery Group and weekly Emergency Department leadership meetings, reporting to the monthly West Suffolk Alliance Operational Group.	3 Escalate to Board

Update on Community Equipment and Wheelchair services	The Community Equipment Service (CES) and Wheelchair Service (WCS) presented a report to Insight Committee in October 2024 due to significant budget pressures within the services. Unfunded elements included no uplifts for demographic pressures and growth, inflationary pressures and changes in VAT treatment By December 2024, these unfunded pressures resulted in a £499k overspend for the 'Community' element of CES .This position significantly exceeds the growth and inflation funding provided through the Community Contract (4.2% in 23/24 and 3.9% in 24/25. Proactive financial management measures achieved £220k in cost avoidance for CES and £240k for WCS through enhanced controls and monitoring. A recent Internal Audit report provided substantial assurance that robust governance and control mechanisms are in place, using the contract mechanism to maintain performance, avoid additional cost pressures and provide value for money. The service is gatekeeping effectively and looking for all opportunities to reduce costs.	**1** **Substantial**	The paper set out, actions which are being taken as part of the service recovery plan. The service acts as a key enabler for the wider system in terms of discharges and admission avoidance, and any projects or changes to patient flow could further increase the cost to CES and this needs to be recognised in relevant business cases/decision making. Without additional funding support, there is a risk that service capacity may not continue to meet the growing system demands, potentially affecting patient flow and care quality.	The management Executive Group have agreed a series of actions to support the services and discussions continue with system partners on funding issues and risk sharing.	1. No escalation

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

Originating Committee: Insight Committee			***Date of meeting: 19 March 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*
Finance Accountability Committee	**Month 11 Reporting** The Trust continues to make progress on its recovery trajectory and is on track for the revised control total of £23.8m. In particular, workforce savings are being seen, with the trust reporting 187.7 fewer WTE in February than in April 2024. The controls put in place as part of the financial recovery plan remain, and the underlying run-rate is expected to reduce further by March but is currently £1.7m not the £1.3 originally planned. The combined revised CIP and FRP schemes planned to deliver £16.0m YTD, with actual delivery of £18.7m YTD, a favourable variance of £1.7m YTD Cash. The cash position remains critical, and the Trust has received a further £2.9m of revenue (deficit) support for March.	**2 Reasonable**	The Trust is optimistic that it will exceed its 'likely case' outturn position as presented in the FRP and is now forecasting a deficit of £23.8m. This revised forecast remains challenging and has some risks. It is unlikely that the exit monthly run rate for the year will be in line with the original plan at £1.3m deficit per month. This exit rate for 24/25 is important in determining the start position for the 25/26 plan.	Work continues on the development of the Financial Recovery Plan for 2025/26 in the context of the new Planning Guidance and indicative financial allocations. See below.	3.Escalate to Board

Originating Committee: Insight Committee			***Date of meeting: 19 March 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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Financial Planning	The Trust needs to complete its planning submission by the 22/03/2025 for submission to the ICB before national submission on the 27/03/2025. This the draft proposals for the year, show a deficit plan of £26.5m. Given that the system are close to balance, the ICB have made clear their expectations that this gap is closed. The report included some potential options which were more radical but had potential to reduce the deficit further, possibly to £20m, to allow the system to break even.	3 Partial	The Committee were asked to consider what level of deficit budget the Trust should set. Other members of the Board were also in attendance given the timing of the ICB finance meeting ahead of the planned Board meeting. To be able to close the gap further there would need to be higher assurance around CIP delivery. There would also need to be further analysis of the impact on any radical options on the delivery of the Trust's strategic objectives, which were currently under review.	There need to be further discussions on options that will have an impact on other partners and system wide objectives. The ICB needs to be supportive of the more radical options to be explored. Further discussion is needed with the full Board about whether the deficit can be further reduced from £26.5m and the risks and opportunities to deliver this. An Extraordinary Board meeting to be convened to discuss this.	3 Escalate to Board

Originating Committee: Insight Committee			***Date of meeting: 19 March 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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Operational Planning Guidance	NHS England has published the NHS priorities and operational planning guidance for 2025/26. This sets out key objectives against operational performance standards, alongside finance and quality expectations. The committee paper set out the requirements and the Trust's response to these, as part of the Suffolk and North East Essex (SNEE) submission. The Trust is committed to meeting the targets and has developed detailed trajectories to track the performance improvement required **For elective care,** 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 the 18-week compliance. Seven specialties have been identified as those	2 Reasonable	The committee supported the Trust's submission committing to the expectations in the 25/26 planning guidance, understanding the risks to delivery and the risk that the Trust will not achieve the transformational change required. Achievement of the RTT trajectory is heavily dependent on outpatient transformation, profiled to make most impact from Q3-4. Maintenance of urgent and emergency care performance will require transformational change, particularly ahead of winter 2025/26, including the development of sub-acute frailty services.	The final draft system submission will be made by the ICB to NHSE region by 20th March, with the final submission due 27th March. Performance against trajectories will be monitored at the Patient Access Governance Group and Insight Committee. A revised integrated Quality and Performance Report (IQPR) is being developed to reflect the updated standards. Productivity improvements underpinning delivery are monitored through the clinical productivity workstream.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 19 March 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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	where the impact will be greatest having high volumes but low RTT performance. **For urgent and emergency car**e, the Trust is forecasting delivery of the requirement to meet the 4-hour standard to 78% in March 2026. The Trust has also committed to a reduction in 12 hour waits and has accepted the fair shares allocation of ambulance handover delays.				

Originating Committee: Insight Committee			Date of meeting: 19 March 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 report provided an update on the development of the Trust's Cost Improvement Programmes (CIPs). It outlined the approach being taken, the governance processes, and the resources being put in place to drive delivery. Good progress has been made in improving the approach to CIP development, however, there are some gaps including a need for a more robust governance, process, and some resourcing challenges. The Trust is taking a pragmatic approach to the gateway process to ensure there is less administration for smaller schemes, but the right balance is struck between the need to deliver significant savings with proper quality and safety assessments.	**2 Partial**	The 2024 internal audit report into the Trust's CIP programme highlighted several deficiencies, including a lack of strategic approach, unclear roles and responsibilities, and a lack of resource and ownership. If the Trust is to deliver the scale of savings programmes required, it must have a clear, rigorous, and strategic approach that focuses on maximising high-value programmes rather than smaller-scale bottom-up efficiencies. The support required for the programme is being addressed by the Executive Director of Strategy and Transformation within his team and there is a proposal to commission further targeted support from PA Consulting.	A number of improvements have been put in place but further work is required to ensure the CIP tracker provides an accurate reflection of the current status of the CIP portfolio. This is recognised as crucial for both internal Board assurance and external assurance. Discussions will take place with the ICB about the approval process for additional consultancy support.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 19 March 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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PAAG/IQPR	**Elective Recovery** The cohort of elective patients waiting 65 weeks, or more is reducing, however the January month end position was 92 patients greater than 65 weeks, 68 of which are capacity breaches. The forecast position is 70 patients over 65 weeks by the end of February and zero by the end of March 2025.	**2 Reasonable**	Dermatology are expected to meet the threshold by 02 March 2025, with gynaecology by 30 March 2025. The latter assumes additional theatre capacity and surgical activity of four cases per week can be delivered alongside the continuation of activity being delivered by Nuffield Health.	As a result of our improved elective position and commitment to reduce the 65 week waits by March 2025, we have been 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 the18-week compliance. Seven specialties have been identified as those where the impact will be greatest having high volumes but low RTT performance.	3. Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 19 March 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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PAAG/IQPR	**Diagnostics** Diagnostic performance against the 6-week standard is forecast to be c.50% in March 2025, against an expectation of 95% compliance. Although the opening of the Newmarket CDC in late 2024 has seen the modelled step change increase in imaging performance delivered, delays to the DEXA service relocation, non-obstetric ultrasound and endoscopy activity will need to be addressed to regain compliance with the target. .	**4 Minimal**	Longer waiting times for diagnosis and treatment have a detrimental effect on patients. Additional activity will be required in endoscopy (which will not benefit from the CDC in the short term), DEXA (impacted by delays to bring the service back in house following cessation of external provider provision) and non-obstetric ultrasound to regain progress against 95% target.	As a result of our worsening Cancer and Diagnostic performance we were placed in 'Tier 1' nationally, with fortnightly meetings including WSFT, SNEE ICB and the NHS England East of England regional team to agree recovery actions and trajectories for the Cancer FDS and diagnostic modalities that are driving underperformance. Although diagnostic performance is included in Tier 1 meetings, exit criteria are defined by cancer performance alone.	3.Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 19 March 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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IQPR/PAAG	**Cancer Faster Diagnosis (FDS) Targets** Cancer Faster Diagnosis Standard performance has not consistently met the 75% target in any month of 2024/25, however improvement was seen in December 2024 to 72.9%, driven through recovery in both Skin and Breast services. T The forecast was due to drop in January 2025 as seen across the country to around 70%, before recovering again to around 75% in February and with focus on the national ambition to achieve 77% by the end of March 2025.	**4 Minimal**	Achieving the FDS target of 77% and a 62-day performance of 70% by March 2025 are the key objectives for cancer in 2024/25 planning. 2025/26 planning guidance requires improved performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026 and improvement against the 62-day cancer standard to 75% by March 2026.	As a result of our worsening Cancer and Diagnostic performance we were placed in 'Tier 1' nationally, with fortnightly meetings including WSFT, SNEE ICB and the NHS England East of England regional team to agree recovery actions and trajectories for the Cancer FDS and diagnostic modalities that are driving underperformance. 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 and central funding has been made available to support improvement.	3. Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 19 March 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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PAAG/IQPR	**Urgent and Emergency Care** Ambulance handovers within 30 min and non-admitted 4-hour performance are not reliably hitting target. The overall four-hour performance trajectory was missed again in January with a slight improvement from December 2024 – 63.7% against a plan of 70%.	**3 Partial**	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 which makes for a poor patient experience.	Recovery against the 4-hour UEC trajectory needs to ensure improvement initiatives are delivering expected benefits, alongside robust daily management of performance expectations. In response to the 2025/26 operational planning guidance, the Trust is forecasting delivery of the requirement to meet the 4-hour standard to 78% in March 2026. The Trust has also committed to a reduction in 12 hour waits and has accepted the fair shares allocation of ambulance handover delays.	3 Escalate to Board

Originating Committee: Insight Committee			***Date of meeting: 19 March 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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Capital programme	WSFT has developed a proposed capital programme in consultation with divisions. The funding available is £10.478m Capital Resource Limit (CRL) allocation at SNEE ICB System Level; and £1.340m Public Dividend Capital (PDC) support for the RAAC programme (yet to be confirmed by NHSE) The programme is based on an overcommitment of the CRL. Typically, capital schemes do not spend as quickly as planned or are not delivered for a variety of reasons; expenditure can be slowed down if required. There is a £400K allocation for Transformation, the scope of this is to be confirmed.	2 Reasonable	The schemes within the plan aim to make best use of funding in the context of the Future system programme.	The Committee approved the plan for submission to the Trust Board but queried whether enough detail as provided in business cases to understand the revenue consequences of schemes and any interdependencies between them. The Chief Financial Officer was asked to give further consideration to this.	3 Escalate to Board

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!*
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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?*

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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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

Originating Committee: Insight Committee			Date of meeting: 16 April 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
Finance Accountability Committee	**Month 12 Reporting** The Trust has reported a deficit of £25.7m for the year ending 31st March 2025 (subject to audit). However this has been 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. A further £1.5m that may have been available from the system to improve the deficit to £23.8m was unable to be utilised, however, a surplus at EEAST has ensured that the overall system is anticipated to break even. The 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.	**2 Reasonable**	The underlying recurring run rate of around £1.6m is in excess of the finance recovery plan (at £1.3m deficit per month). However, this is in line with the planned deficit for 2025/26. The Trust reports 3.3% fewer whole time equivalent (WTE) staff than in April 2024, a reduction of 166.94 WTEs. The cash position remains critical and cash support will continue to be required in to 2025/26 as the Trust continues to report a deficit.	The Financial Plan for 25/26 has been developed in the light of these year-end figures.	3.Escalate to Board

Cost Improvement Programme (CIP) delivery	The report provided an update on the development of the Trust's Cost Improvement schemes to be delivered in 2025/26. The total programme for target for 25/26 has increased to £32.8m which includes the recently agreed stretch target from the ICB. The total savings identified to date is £21.6m, which is 68% of the total targeted value, leaving a gap of £11.2m still to find. There are three delivery groups overseeing delivery 1. Commercial, Non-pay, Procurement and Pharmacy. 2. Clinical Productivity and Divisional Efficiencies. 3. Corporate Services. These are supported by an enabling workforce group.	**3** **Partial**	Whilst overall progress is positive, there is a considerable gap of £11.2 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 focus in coming weeks will be on developing high value schemes, and ensuring resources are focused on priority areas. Additional controls will be implemented including a vacancy freeze and a mutually agreed resignation scheme (MARS). Additional consultancy support still needs to be agreed with SNEE ICB.	3 Escalate to Board

Corporate Services Deep dive	The report provided the committee with an update regarding the corporate services review, outlined progress against benchmarking, the CIP target, and national targets, and outlined next steps to ensure delivery. Significant progress has been made to develop new workforce designs, complete benchmarking and financial modelling, and plans are in place for a large volume of staff consultations. Our corporate service functions typically benchmark in 3rd or 4th quartile for WTE/£100m (according to 23/24 Model Hospital). The Trust is currently projecting a CIP of between £2.6m - £2.9m against a target of £3.2m. Further modelling is being undertaken to gain certainty ahead of staff consultations, to avoid confusion, delays, and uncertainty for staff.	**2** **Reasonable**	The target allocated to WSFT is to reduce corporate service costs by £5.68m, with our target costs to be £19.486m. The full year 26/27 costs of the new corporate service structures are currently projected to be £19.655m so currently falling short of around ~£200k. This may be mitigated by further changes to corporate models and/or other measures. Corporate Service functions have grown significantly since 2018. We must ensure our corporate services have the right operating models to be sustainable and effective recognising that the services they support are also changing; new technologies are available and are being implemented; and opportunities for greater collaboration with system partners are emerging.	Workforce restructures will be implemented in two phases: Tranche 1: high-priority services Digital, finance, governance, workforce, and information services, with consultation targeted by the end of April Tranche 2: other services operational management, medical, nursing and communications Consultation is targeted by May at latest. These workforce changes will be the first phase on a longer-term plan to transform corporate services.	3 Escalate to Board

Productivity Programme Board	The report provided the Committee with detailed information about the programme in place to drive clinical productivity and divisional efficiencies. The aim of the programme is to maximise the use of resources and capacity to best effect, whilst treating patients safely and in the most efficient manner. There are 4 sub-groups under the Programme Board focusing on: Community & Acute Clinic Elective Delivery UEC and Ward Productivity Community Productivity. Crosscutting themes and are also being explored including Extra Contractual Work, Job Planning and moving to Patient Initiated Follow Up by default.	**2 Reasonable**	The work is being informed by detailed data analysis and benchmarking. The CIP Target is £11.7m with only 28% of risk adjusted schemes identified to date, but with another £1.7m in the pipeline. The Committee felt assured that the programme was looking at productivity issues in detail and opportunities were being effectively prioritised. The major risk going forward was seen to be cultural and ensuring that clinicians were owning the change required to drive and deliver transformation. The Committee also made links to the improvements in UEC performance noted below and how was a positive and tangible example of what services could achieve that should be promoted and celebrated.	The Programme Board will continue to deliver its work programme and Insight will track delivery through the overall CIP programme updates.	3 Escalate to Board

PAAG/IQPR	**Elective Recovery** The cohort of elective patients waiting 65 weeks or more continues to reduce, down from 92 patients longer than 65 weeks at end of January to 70 patients at the end of February. The provisional month end March position is 31 patients >65 weeks, of which 10 are capacity related. This performance narrowly missed the mandate to have zero capacity breaches but represents a significant improvement.	**2 Reasonable**	Dermatology are expected to meet the threshold by 02 March 2025, with gynaecology by 30 March 2025. The latter assumes additional theatre capacity and surgical activity of four cases per week can be delivered alongside the continuation of activity being delivered by Nuffield Health.	As a result of our improved elective position and commitment to reduce the 65 week waits by March 2025, we have been 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 the18-week compliance. Seven specialties have been identified as those where the impact will be greatest having high volumes but low RTT performance.	3. Escalate to Board

PAAG/IQPR	**Diagnostics** Diagnostic performance against the 6-week standard is forecast to be 50% in March 2025, against the national standard of 95%. February performance increased from 47.7% to 55.2%, ahead of plan. MRI performance improving with additional Community Diagnostic Centre capacity and expected to recover by the end of May 2025.	**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 are defined by cancer performance alone. A diagnostic recovery plan has been agreed for ultrasound, endoscopy, and DEXA, including the use of available Cancer Alliance funding. However, overall compliance is constrained by the volume of ultrasound patients.	3.Escalate to Board

IQPR/PAAG	**Cancer Faster Diagnosis (FDS) Targets** Cancer FDS performance dipped slightly in January to 70.6%, as expected due to patients choosing to delay investigations and appointments over Christmas. Skin and breast continue to demonstrate strong performance and support overall recovery. February and March performance forecasts are at 76.6% and 77.8% respectively against the 77% target.	**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 2025/26 Planning guidance requires improved performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026 and improvement against performance against the 62-day cancer standard to 75% by March 2026.	We are currently in Tier 1 for the cancer pathway but the Trust is hopeful we may soon be able to exit this due to the improved performance in February and March. 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 and central funding has been made available to support improvement.	3. Escalate to Board

PAAG/IQPR	**Urgent and Emergency Care** The overall four-hour performance trajectory was missed again in February but with further month on month improvement demonstrated – 67.1% against a plan of 74%. March performance across all UEC indicators was significantly improved, culminating in 4-hour performance at 88.4%. Full details will be included in next month's report.	**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 which makes for a poor patient experience.	The March figures suggest a step change in UEC performance which should be celebrated as an example of what can be chevied. How this has been achieved needs to be understood and maintained. The Trust is forecasting delivery of the requirement to meet the 4-hour standard to 78% in March 2026. The Trust has also committed reducing ambulance handover times to an average of 26 minutes, so as not to exceed WSFT's "fair share" of ambulance crew lost hours, with no handovers exceeding 45 minutes.	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.*

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight

Meeting date: 19 March 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*
• Financial updates; including month11 reporting, CIP update and Capital Planning • January IQPR Report and Financial Planning Proposals
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• All attendees demonstrated behaviours and courtesies in line with Trust values. • The meeting was well chaired by Antoinette Jackson. The Chair gave everyone an opportunity to speak and summarised key points at the end of each agenda item. • Time-keeping was good with the Chair occasionally having to politely move the conversation on. • Good challenges, particularly around strategic planning
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 Committee reviewed and approved the Capital Programme for 2025/26; therefore, good level of assurance that the backlog of carried over issues and the priority schemes identified can be achieved.
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• The Committee discussed issues which will impact on working practices at the Trust. Whilst these are high level strategic issues they were discussed with sensitivity at all times, with patient safety and staff well-being as the top priorities.

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 16 April 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*
• Month 12 finance report presented, financial issues presented and discussed early on the agenda. In order to ensure fairly apportioned time for finance and operational papers they take priority on the agenda on alternate months..
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Three Governors observing via Teams, including myself as I was away from home. I don't feel that this is the best way to observe an assurance meeting - the majority of committee members are there in person, it is difficult to hear, it is also impossible to see who is talking, I was aware that if I had my camera on that I would be a large presence on the screen and so turned it off. Non verbal communication was not visible to us. • Well chaired but really hard to hear on Teams. Subjects discussed were closed with a good summing up and action points. • NED participation and challenge, also Exec to Exec challenge. Trust behavioural values adhered to.
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 a lot of information presented relating to next year's potential cost savings plans and the corporate review. Much clearly confidential at this stage. There was assurance for Governors in that impact assessments were planned with a clear 2 tier process in place – rapid assessment, then if CIP meets set criteria to go to panel, it does – panel meets weekly.. • Good news on meeting ED targets in early part of the year with improved patient flow, this is good for patients who are safer admitted to a ward rather than waiting in ED for a bed, ambulances are also made available to attend emergencies.

Notes
• There was discussion and concern expressed as to how and when to communicate cost saving measures to staff. There was empathy and understanding expressed about how staff were feeling and recognition that delaying communication creates uncertainty. • It was observed that there is still waste in the system, waste of patient time presenting the biggest opportunity. Every single service encouraged to reduce waste and increase productivity.. • Much talk of future left shift, also outlined in the corporate review transformation strategy.

9.2. Improvement Committee

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Improvement Committee			Date of meeting: 19 February 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**	**Thrombosis Group** Consistent compliance with VTE assessments	1	This ensures that correct prophylaxis is given to reduce the risk of hospital-acquired VTEs	We have good assurance and will look at how this relates to outcomes and prophylaxis, using audit and other methods.	1
5.1 **PQSGG**	**Deteriorating Patient / Resus Group** Sepsis: improvement in taking of blood cultures; lactate results achieving target; administration of antibiotics and iv fluids in common cause variation.	2	Early sepsis recognition and treatment improves patient outcomes and shortens length of stay.	NICE sepsis guidelines have been updated and give more emphasis on high-risk patients. Internal monitoring will change (Spring 2025) due to e-Care provision. This should give more consistent assurance.	1
	BLS: Current compliance levels 80% for trust overall (88% nursing staff, 58% medical staff). We need to improve our assurance.	2	Prompt BLS is key for survival to discharge. NCAA data suggests WSFT is performing well against national average despite low compliance	Additional training starting Jan 2025 to support 90% ambition. BLS has been introduced to all inductions, and F2F training at	

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	Call for Concern (C4C): 78 calls since launch, 31% calls appropriate use of service	2	Increase in calls in Dec, possibly following cease of Clinical Helpline. Jan calls have reduced to expected levels. Use of service now being assessed, and better communication is a recurrent theme.	the place of work should improve medical compliance. C4C team working with patient experience team. If inappropriate calls remain high, this will be looked at further.	
5.1 **PQSGG**	**<u>Dementia / Delirium and Frailty Steering Group</u>** Dementia pathway in development following successful implementation of delirium pathway. Restrictive practice: panel planned for Q4 to review restrictive interventions and the legal frameworks in place.	2 2	A clear pathway will help continuity of care and also ensure that ward-based interventions are in place before specialist advice is sought. Initial focus on physical restraint but may expand to chemical restraint after pilot. Restrictive practice should be proportionate to the risk of harm.	Working group to be set up and implementation to be monitored. We have a duty to protect our staff as well as our patients. Pilot areas G5 and G10.	1

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	Delirium Discharge Nurse activity: High numbers of referrals in this quarter. Concerns regarding cessation of external funding of the role.	1	Supporting discharge of patients admitted with an associated delirium helps patient experience and also patient flow through the organisation.	Review shows a potential cost saving of 142 bed days per quarter and a positive impact on patient flow. Submission made to ICB and funding tbc.	
5.1 **PQSGG**	**<u>Mortality Oversight Group</u>** SHIMI data shows lower than expected deaths (0.85)	1	Indicative of good safe care. We are performing best in the East of England.	Good assurance. Continue monthly monitoring and reporting.	1
5.1 **PQSGG**	**<u>Human Tissue Authority / Mortuary</u>** No reportable HTA incidents in last quarter. Eden Software live since Dec 2024. Used by mortuary, bereavement and medical examiner services. Fuller Report: Pre-emptive action already taken by mortuary	1 1 1	These are serious incidents or near-misses in licensed mortuaries that may affect the dignity of the deceased. This gives better management of deceased patients' records and helps to minimise risks. Fuller Report published 2023 following unauthorised access to mortuary at Maidstone and Tunbridge Wells NHS Trust by a	Continue to monitor. Continue use. Swipe card access and CCTV installed on mortuary door.	1

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	services following phase 1 recommendations.		member of staff and subsequent criminal acts.	Working with ICB to arrange supportive peer review visits.	
5.2 CEGG	**<u>Accreditation – Point of Care Testing</u>** (POCT)	3	POCT are working through accreditation device by device, currently looking at blood gas analysers.	Expanding virtual ward is one of the challenges. Accreditation not yet applied for but believed to be achievable.	1
5.2 CEGG	**<u>Accreditation - Endoscopy</u>**	2	Accreditation looks particularly at clinical quality, patient experience, workforce and training. No outstanding action plans. Challenges include expansion of endoscopy to Newmarket in 2025/26, and endoscopy is one of the last departments to go live for Concentric.	Accreditation renewal due May 2025 and believed to be achievable. .	1

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5.2 **CEGG**	**Life Cycle of a Clinical Audit** MBRRACE (mothers and babies: reducing risk through audit and confidential enquiries)	1	National reporting and audit mechanism for analysing results. BAME over-representation in reports is recognised and analysed. JADE team and other initiatives to help.	Regularly discussed at MatNeo Safety meetings	1
5.2 **CEGG**	**Life Cycle of a Clinical Audit** SSNAP (Sentinel Stroke National Audit Programme)	3	National QI programme covering whole patient journey. WSFT has always scored very highly with an ongoing 'A' rating.	Significant update to SSNAP due to advancements in treatments and updated guidelines. Many changes will be hard to achieve with resource constraints and it is anticipated that we will score a 'C'. Meetings planned with ICB and integrated stroke delivery network to discuss.	1
5.2 **CEGG**	**Clinical Audit Programme Update** A local project in Surgical Division to increase engagement in audit	1	This is in line with the ConsultOne Well-led report regarding benefit and learning from audit.	Ongoing Trust initiatives to improve audit learning and outcomes.	1

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5.2 **CEGG**	**Getting it Right First Time** (GIRFT). A national programme to improve patient care using data-driven evidence. CEGG receives quarterly updates.	3	GIRFT has a structure in place for preparation of reviews, but no structure for coordinating the response to reviews, and no governance framework. We have limited assurance about implementing GIRFT recommendations.	Development and agreement of a governance framework.	1
6.1 6.2	**Integrated Quality and Performance Report (IQPR)** Including **Performance Review Meetings (PRM Packs)**	2	IQPR will be refreshed in line with NHS 2025/26 priorities and operational planning guidance. C diff remains in common cause variation and continues as a key priority. HCAIs pose a serious risk to patients, staff and visitors, and can increase length of stay. The new strain remains a significant threat nationally.	The narrative for metrics will be more concise in the future so that key points stand out. QI Programme ongoing, will run to at least Oct 2025. Ongoing work with community colleagues regarding anti-microbial stewardship. C diff deep dive postponed to next month.	

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			PPH – ongoing QI Programme which is monitored through various regulatory mechanisms. PPH following vaginal delivery showed special cause concern, and following LSCS showed uncontrolled variation. Nutritional Assessments within 24 hours reduced in December, partly due to patients who remained in ED over 24 hours. The MUST score was completed on admission to the ward. Patient Safety Incidents and Reportable Occurrences remain stable and within expected limits.	QI 3rd cycle launched. Ongoing work to deep dive into causes of PPH. The effectiveness of the ED short assessment will be assessed next month once more data is available. Improvements in UEC performance will enable earlier nutritional assessments. 'Food as medicine' workstreams continue.	
7.1	**Quality Priorities 2025/26: UEC Care Pressures** Under our Quality Accounts, we are required to provide a description of future areas for improvement, and describe	2	Priorities for 2024/25: -To deliver measurable improvements in safe care through implementation of our patient safety strategy. This will be measured through the quality	Progress reports for 2024/25 priorities will be provided to March meeting.	1

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	achievements against the previous year's priorities.	3	of discharge summaries, and also through the rates of HCAI C. diff infections. -To reduce inequalities in experience of care. This will be measured through various measures, including recording of information on e-Care, accessibility improvements, completion of the Equality Delivery System by March 2025. **<u>Proposed quality priorities for 2025/26</u>**: -<u>Temporary Escalation Spaces</u> Important for patient safety and experience, ability of staff to deliver care, and staff morale. Measured through audit and various data, looking at harm, incidents, experience & risk.	Improvement Committee will receive final draft of the annual report in the April meeting, following sub-group meetings to discuss this. Both proposals agreed by the committee. Progress reported to PSQGG, and quarterly updates will be provided to Improvement Committee. A TES quality group has been created to develop reporting metrics and support improvement of flow alongside operational performance.	

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			-Getting it Right for Patients and Staff: place, service, pathway. This was chosen at a trust-wide safety summit. Aim is to improve communication about the placement of patients, handovers, minimise ward moves, follow correct referral processes, and ensure the right patient is cared for in the right place	A multi-professional project group will be formed, and a programme of improvements developed using QI methodology. We need to ensure the right information is captured. This will be reported to Improvement Committee quarterly.	
7.2	**Transfer of Care Group: Update on Discharge Summaries** Need to improve quality of information as well as the %. Various workstreams in place. Improvement Cttee metrics:	2	Target for getting the letter to the GP within 24 hours is 95% and we currently achieve about 80%. Delays risk safety incidents, complaints and poor patient experience. Governance: clinical guidelines approved; performance data shared at departmental meetings.	Improvement work has been initiated to help achieve the objectives. In-patients and ED need particular efforts. Communication to be delivered throughout March via Staff Bulletin, MD bulletin, Intranet page, Resident doctors' WhatsApp group, All Staff Update.	1

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		2	Staff engagement & training: plan agreed and scheduled for promotion March 2025 e-Care: latest Oracle model provides an improved method for creating the ToC documentation. New ways of working are being explored, eg protected time for completion. Long-term opportunities: AI and Computer Assisted Design (CAD) are being explored by other organisations	Revised workflow to be demonstrable by April, and training May / June. Future possibilities	
7.3	**Response to RCN Corridor Care Priorities** RCN report is sobering reading and a carefully considered response is important, respecting the impact on both patients and staff.	2	Temporary Escalation Spaces (TES) impact patient care and safety, and also the ability of staff to deliver care and affect staff morale. RCN survey found that 67% of nursing staff respondents had delivered care in TES; >90% felt patient safety is compromised in these spaces;	WSFT regularly uses TES and we do not consider this appropriate or best practice. We have clear governance around TES use, and our SOPs and escalation plans aim to ensure that our most vulnerable patients are not nursed in TES. We	1

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			many patients have their privacy and dignity compromised. WSFT TES spaces are 3 corridor spaces in ED (regularly used over winter period); 4 spaces in AAU external corridor (used 14 times since recording commenced in Q3); and 'Arrive by 9' spaces on most inpatient wards (regularly used and important for patient flow). We discussed that >12-hour ED stays are equivalent to a TES.	addressed these issues in a deep dive in August 2024. PALS have surprisingly little data relating to TES and will add a flag so that data is more easily captured. TES Oversight Group established to audit and monitor TES use and outcomes. Mandatory reporting will occur via this group. For review in 3 months.	
7.4	**Maternity Report:** 60 Safer Steps	1	This was a regional assessment of safety and care provision. The feedback was very positive, and we were complemented on communications, governance structures, staff feedback, and student integration.	Some recommendations were made but none of them was considered a major issue.	1

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7.4	**Maternity Report:** Claims and Incident Quarterly Review	2	In the last 10 years claims for WSFT are about £32.3 million with the average claim about £1 million (30 claims). This represents 49% of the total value of claims against the Trust (a lower % than national average). Most claims are as expected and benchmarked. Cerebral palsy remains the biggest claim by value. Themes from incidents, complaints and mortalities were described in detail. How to support staff affected by these remains a high priority.	Ongoing monitoring to identify and mitigate risks. Learning points were identified from some of the events, eg the correct call cascade was an issue in multiple PPH reviews. High levels of pre-term births continue to be a problem: Trust rate is 7.8% against a national ambition of 6%. Securing testing equipment for predicting prem births has been an issue, and this will be followed up outside Improvement Committee.	1

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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.
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Board assurance committee - Committee Key Issues (CKI) report

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5.1 **PQSGG**	**Claims Activity** Internal KPIs exist for reporting claims, identifying learning opportunities, obtaining staff feedback and maintaining compliance with all deadlines	2	9 of 11 new claims since August 2024 affect female patients. 18 cases closed since August 2024, 14 resulting in a compensation payment.	A retrospective review of the sex of claims is being undertaken to ensure no one group harmed disproportionately. Will be kept under review. No cases have been to trial since last report; one case due for trial June 2025 and appropriate learning for this case (cauda equina) has been addressed.	1
5.1 **PQSGG**	**Human Factors**	1	HF Specialist Lead has completed a PGCert in Human Factors and Ergonomics. 959 staff have been trained in HF workshops since 2016.	Numerous projects are supported, and an in-depth review of HF works will be undertaken, looking at impact and effect on productivity.	1
5.1 **PQSGG**	**Safeguarding Children and Young People**	1	Clinical Photography – camera equipment purchased, and sufficient staff trained to support usage.	From 1/4/25, images taken of alleged NAI will be admissible in court.	1

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		2	Level 3 training has been done yearly, and the intention was to move to 3-yearly in line with guidance. National guidance now proposes a change to yearly training	Training review paused whilst intercollegiate guidance is finalised, to ensure that we comply with correct training and frequency.	
		2	Overall compliance with level 1 & 2 training is 94% (some reduced compliance in ED medics); level 3 training 91%.	Non-compliant staff will be contacted, and training dates emailed as appropriate. More sessions to be available. Domestic Abuse training to be part of the package	
5.1	**<u>Safeguarding Adults</u>**		.	.	1
PQSGG	Management of serious safeguarding incidents	1	Process approved and embedded.	Future meetings will present a summary of concerns, whether these were supported, and learning arising.	
	Level 3 Safeguarding training	4	Not currently delivered outside SG team. Intercollegiate document indicates a minimum requirement for relevant registered staff	Proposal presented to Mandatory Training Group. Delivery and impact of 8 hours of training over 3 years being scoped.	

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5.1 **PQSGG**	**Learning Disability and Autism** Oliver McGowan mandatory training for LD&A	3	OM training: Tier 1 is available to all patient-facing staff (186 completed). Tier 2 available to designated staff (28 completed)	We need to increase awareness in relevant staff groups to increase compliance. System training ends in Q3 2025 so alternative delivery will need to be scoped	1
5.1 **PQSGG**	**Mental Health**	1 3	Ensuring staff with the right skills in the right place at the right time are available to care for inpatients with mental health needs. Supporting the 4-hour stand within the UEC pathway, as patients awaiting mental health assessments can have protracted waits.	Funding secured from continuing health fund for 2 Adult Specialist MH nurses. 18-month fixed term contracts. Continue to monitor. Admission to an acute trust is on a case-by-case basis, and sometimes remaining in ED carries a lower risk.	1
5.1 **PQSGG**	**Safer Surgery Group** Inaugural presentation. National Safety Standards for Invasive Procedures (NatSSIPS 2)	3	NatSSIPs 2 aims to improve patient safety, team-working and efficiency in theatre suites.	SSG will report quarterly. NatSSIPs 2 has been adopted in Theatres and the aim is to extend it to all departments performing invasive procedures. Currently	1

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				unclear whether all these areas have a framework or checklist in place.	
5.2 CEGG	**<u>Accreditation – Blood Transfusion</u>**	2	MHRA inspection 2021; none since. Need a mechanism for implementing and monitoring recommendations of Serious Hazards of Transfusion (SHOT) reports	BT team has requested support in identifying who should respond to the relevant recommendations, and this is being addressed.	1
5.2 CEGG	**<u>Radiology Non-Medical Referrals</u>** (need to be either a registered medical practitioner, or acting under a specific protocol)	2	The large number of referrals (approx 5,000 per week) makes NMRs hard to monitor with current resources. Community referrals are part of the issue. NMRs can't be banned as the service and patient care would suffer. The committee received assurance that rigorous steps and existing controls are in place to address the issue and minimise risks.	Ongoing work involving IT access and restrictions, reminder comms re correct procedures, audit, IR(ME)R training updates, measures when staff move or leave.	1

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5.2 **CEGG**	**Life cycle of a clinical audit – Hip Fractures**	1	In 2023 we were top of the national league table. Still some opportunities for improvement, eg admission to orthopaedic ward < 4 hours, and mobilisation after surgery.	Some data could be collated electronically rather than via nurse practitioners, thus freeing up time and resources.	1
5.2 **CEGG**	**Public Health (PH) programme** 6-monthly report	3	Concerns include: Tobacco control plan (funding uncertainty for inpatient services and maternity pathway); Personalised care delivery plan (possible loss of hospital based social prescribing); BP health promotion campaign (risk of not achieving board objective of 50,000 people); Patient physical activity pathways are at risk (outcomes are significant for positive patient outcomes).	Ongoing discussions with SNEE ICB and Suffolk County Council re funding Options appraisal for how to progress this, as it is a mandatory requirement. Plan in place to deliver a campaign jointly with WSFT Comms Team. Planned escalation route being initiated to ensure informed decision making; start planning for pathways to cease.	1

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5.2 **CEGG**	**Quality Improvement** 154 active projects across WSFT	1	Current freeze on new QI projects whilst recruiting to vacant roles.	.	1
6.1 6.2	**Integrated Quality and Performance Report (IQPR)** Including **Performance Review Meetings (PRM Packs)** Note: IQPR will be refreshed in line with NHS 2025/26 priorities and operational planning guidance. Once fully developed, narrative will be more concise so that key points stand out. Presentation will help demonstrate inter-related metrics, and a productivity section will be included. Trust	2	Clostridium difficile cases remain in common cause variation. HCAIs are a risk to patients, staff and visitors and can increase length of stay. Nutritional Screening associated with MUST showed a decrease this month, and there was an increase in patients awaiting beds following a decision to admit. 98.92% had a MUST assessment made during admission. PPH data shows common cause variation.	Remains an organisational key priority with a QI Programme running till at least Oct 2025. Deep Dive at March 2025 Improvement Committee. 'Food as Medicine' workshops continue. As UEC performance improves, it is hoped patients will get to wards sooner and have an earlier assessment. The ED short rapid assessment continues to be embedded, and we will have data re impact next month. Ongoing work and engagement with local and regional QI Programmes.	1

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	performance against key metrics will be clearer		SHMI data continues to show that we have fewer than expected deaths for our population demographic. Inpatient deaths have increased as expected over the winter months but with no unusual trends.		
7.2	**Deep Dive – C difficile infections** Reduction in rates of hospital and community onset healthcare associated C difficile infections was a 2024/25 quality priority	2	Rates have increased over recent years, and this was chosen as a priority because WSFT was a poorly performing trust both regionally and nationally. Numerous QI initiatives helped improve performance including antibiotic use, audit, hand hygiene training, review of side room use, improved ED cleaning between patients, etc. Challenges included pharmacy	Current data (end Feb) suggests the target will be met. Weekly microbiology C diff ward rounds are about to start. The committee agreed that this quality priority has been met, and ongoing QI work can be incorporated into business as usual, reporting through existing pathways. With planned updates	1

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			capacity to perform antimicrobial audits, clinical awareness of prescribing antimicrobials, duplication of sampling, and estates (side rooms, en-suites etc)	on the forward plan for improvement committee	
7.3	**Discharge Summaries update** Discharge Summary quality and timeliness was a 2024/25 quality priority	2	This was chosen as a priority because the discharge summary provides an important record of the admission, is mandated by the NHS contract, is important for patient safety and for continuity of care. The target is that the letter should get to the GP within 24 hours in 95% of cases, but WSFT has found this hard to achieve. Numerous measures were put in place, as discussed at last month's Improvement committee	Data is available 2-3 months in arrears, so ongoing monitoring is needed to ensure we are meeting the timeliness target. Quality is being monitored by the Transfer of Care Group, & further work is planned for 2025, currently being tested at Glemsford. The committee agreed that although the requirements are not yet met, ongoing work can be	1

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				considered BAU, reporting to Improvement committee.	
7.4	**Patient Safety Incident Framework – management and reporting incidents** Quarterly report	2	Patient safety incidents reported via Radar; reviewed daily (or on Mondays after the weekend) and escalated as appropriate. Learning is a key part of this, and reporting is via the Learning From Patient Safety Events (LFPSE) database. PSIRF has changed our internal and external reporting, and we have provider control of our safety concerns, serious incidents and never events.	We will continue to maintain incident management processes, reporting as appropriate and ensuring that key learning is undertaken and shared. It was agreed that rather than reporting to closed Board (as now), we will move to quarterly reporting to Improvement committee. The reporting and learning arising will be more transparent.	1
12.1	**BAF 4 Continuous improvement and innovation** We need to have the capacity, capability and commitment to adapt to changing demands, circumstances and pressures		Various initiatives are underway, including restructuring the strategy and transformation team, developing the Trust's QI approach, refocussing the West Suffolk Alliance's priorities, progress with the SNEE Provider	We will have an open risk appetite when looking at continuous improvement and innovation.	1

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			Collaborative, and developing the "react, recover, renew" narrative		

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Board assurance committee - Committee Key Issues (CKI) report

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5.1	**Trauma**				
PQSGG	Education and Training	1	June course will have 12 attendees for Level 2 trauma-trained nurses, ensuring compliance.	Funding also approved for a second round.	1
	Major Trauma Coordinator post secured	2	This is a requirement for regional trauma peer review (TARN).	Business case in development for an additional post to meet Trauma Quality Indicators. We discussed the merits of developing business cases given our financial position.	
	24/7 CT scanning and reporting	2	How quickly patients get a CT and report following trauma is a regional problem and a requirement for TARN.	Ongoing QIP addresses key areas, and quarterly audits will monitor progress.	
	Rib fracture management	2	Review of incidents has led to updates & guidelines, enhanced analgesia, and better risk identification	Ongoing education in ED	

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	Surgical Engagement Challenges	4	Engaging general surgeons in trauma discussions (eg M&M meetings) is a requirement but remains a problem.	Plan is to attend the surgical meetings for direct engagement, and escalation through MD if issues persist	
5.1 **PQSGG**	**<u>Nutrition</u>** MUST Assessment compliance has reduced due to high ED waiting times in Dec Nutrition and Hydration Initiatives Non-compliance with NHS nutrition and hydration standards Loss of enteral feed reimbursement (approx £40k pa).	3 2 3 2	99% of patients received assessments within required timeframe post-admission. Short form assessments in ED have improved compliance to 98%. Initiatives include: recruitment of Nutrition Advocates; Digital menus; updated paed menus; improved enteral feed system. Gap analysis has identified 450 areas of non-compliance, and this is required under CQC regs. Identified need for an additional role to oversee this.	Nutrition steering group will continue to monitor As above Business case developed for a Dietitian to oversee this. Areas will be prioritised and targeted accordingly. Further discussions required with finance and procurement teams.	1

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	Reporting and Governance issues	2	The possibility of integrating this role into the new dietitian role (see above) is being explored. 60% increase in reported incidents, possibly due to more reporting via RADAR.	Efforts underway to standardise reporting within SALT	
5.1 **PQSGG**	**<u>Diabetes</u>** Inaugural report from Diabetes Governance Group. Type 1 diabetes patients are to be moved to Hybrid Closed Loop (HCL) System within next 5 years.	2 4	We have a new clinical lead for diabetes service, and awards for diabetes care. This will enhance care, but resources, increased caseload (esp gestational diabetes), limited capacity, time required for technology-supported care are all issues.	Group will present quarterly, and metrics to measure improvement are being worked on. Workforce and capacity issues have not been resolved despite meetings. Prioritising primary care diabetes management where appropriate will free up capacity in secondary care.	1
5.1 **PQSGG**	**<u>Falls</u>** Use of bed rails	2	Risk assessments being undertaken due to ongoing concerns regarding use. We	Ongoing audits, supported by staff and patient leaflets.	1

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			need to comply with a national patient safety alert regarding use		
5.1 **PQSGG**	**<u>Pressure Ulcer Prevention Group</u>** Increase in pressure ulcers reported in January	2	Increase typical of this time of year and could also relate to introduction of Purpose T, a more in-depth assessment tool, leading to increased reporting.	Continued monitoring and interpretation of data.	1
5.2 **CEGG**	**<u>Accreditation – Haematology</u>** **<u>Accreditation – QPULSE</u>** (quality management software to become unsupported)	2 3	Currently in year 1 for accreditation and this should be achievable. Will impact pathology, pharmacy and mortuary	Paper being submitted to MEG	1
5.2 **CEGG**	**<u>Life cycle of a clinical audit – National Audit of Inpatient Falls</u>**	2	Falls with serious harm are subject to an after-action review (AAR).	Falls group to consider how the falls AAR process can be widened to look at multifactorial assessment (eg medication)	1

Originating Committee: Improvement Committee			Date of meeting: 16 April 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
			Falls Group presents to PQASG		
6.1	**Integrated Quality and Performance Report (IQPR)**	2	C diff data in common cause variation, though overall rates have improved over last 8 months. Anticipated that by the end of 2024/25, rates will achieve the ICB target. Nutritional Assessments - short assessment for patients in ED >12 hours is encouraging, with 97.5% of patients having an assessment. 94.2% of patients have a nutritional assessment carried out within 24 hours of admission. The % of patients with a measured weight has improved,	Remains an organisation key priority, and the QI Programme continues. Remains a key priority and we actively support the WHO concept of 'food as medicine'. It is hoped that with UEC performance improvements, we will see further improvements in nutritional assessments. Ongoing monitoring, eg audit of re-weighing at 7 days.	1

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			though remains in common cause variation. Post Partum Haemorrhage rates are currently in common cause variation. Ongoing work. Patient Safety Incidents and Reportable Occurrences have both reduced this month SHMI data again shows lower than expected deaths.	QI 3rd cycle launched, and we continue to engage with local and regional QI programmes. We wish to encourage reporting of all incidents (incl low harm and near miss) to help improvement work to occur. This is monitored as part of the reporting schedule. Continued monitoring	
7.1	**Quality Priorities – Temporary Escalation Spaces update** The first of four updates on provision of safe care in TESs (now to be called 'Corridor Care' again)		TESs present challenges for patient safety, quality of care and resources. TES Quality Group established which will report to the PSQGG. This will develop reporting metrics, identify barriers to patient flow, evaluate outcomes, collaborate with system partners, and help to inform decisions on when TES	Quality Improvement Programmes initiated looking at: incident reporting, clinical harm, risk register analysis, audits and benchmarking against standards, flow data. Next update August 2025.	1

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			should be activated. TESs used less over last 7 weeks		
7.2	**CQC Single Assessment Framework – proposed framework for review** Providing safe care is the first priority, but CQC preparedness is also important, and where possible the two can overlap.	2	Incorporating CQC quality standards into established workstreams would give best use of resources. If individual core areas need a greater focus, then central support should be available. The CQC introduced a new assessment framework in 23/24 with 34 new Quality Statements. The CQC is reviewing this process through a series of stakeholder events.	Next update due July 2025. Comms Team is developing staff guidance, to start May/June 2025 Support available for teams wishing to review compliance against the 34 new quality statements (already done by Critical Care, EOLC, CYP). The relevant quality statements will be incorporated into specialist committee's work programmes.	1
7.3	**2025/26 Forward Planner** For approval	2	This supports good governance, focussed discussions and alignment with our ToR.	Agreed to implement	1
7.4	**Maternity Update – 60 Supportive Steps**	2	Visit provides external oversight and assurance of compliance;	Results will be shared with maternity and neonatal staff, and	1

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	Following EoE visit to WSFT on 31 Jan 2025		identifies good practice and areas for improvement; identifies good working relationships and the functioning and safety of our maternity and neonatal services. Overall findings were very positive, evidencing good multi-professional communication and a safe service. 38 areas identified for improvement (10 completed, 16 in progress, 12 not currently possible).	an action plan will be agreed and shared. A few actions are currently unachievable due to financial / estate constraints (eg 7-day rather than 5-day wardrounds on SCBU and transitional care). If mitigation is not possible then these will be added to our risk register. Some standards will be met after the new build (eg number of maternal beds on SCBU). Maternity and Neonatal Improvement Board will monitor progress with the action plan.	
8.1	**<u>Internal Audit Q4 Assurance Report</u>** A number of new reports issued. Those which relate to Improvement Committee: <u>Board Assurance Framework</u>	2	Governance Committee:	Ongoing input from the relevant governance committee	1

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	Clinical Guidelines Discharge Summaries	2 3	Corporate Risk Governance Group Corporate Risk Governance Group Patient Access Governance Group	This was considered in detail in March 2025 Improvement Cttee	

*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.

Feedback from assurance committees: Governor observer report

Board assurance committee: Improvement
Meeting date: 19 February 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*
• A) Item 7 of the agenda, (Quality priorities, improvement and assurance), included in depth discussions around the recent RCN report outlining the challenges facing hospitals with regard to 'corridor care'. West Suffolk are taking this seriously and actions are being taken to manage and address these situations to minimise disruptions and potential harms to patients. The use of Temporary Escalation Spaces (TES) will be reported quarterly to the Improvement Committee. • B) The pressures on Urgent and Emergency Care (UEC) linked to TES (point A above) was discussed and how these issues might be included as 'quality' priorities for 2025/26 • C) There was an update from the Transfer of Care Group (TOCG): specifically around Discharge summaries which do not always reach GPs in a timely manner. Actions to improve these communications to care providers beyond the hospital are being highlighted and monitored.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Observers and committee members were given a warm and polite welcome by the Chair • All attendees behaviour was in line with the Trust's values and this was echoed by the independent reviewer at the end of the meeting
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 were good levels of challenge to seek assurances, along with wider background conversations to add to understanding and links to other themes. The TOCG report showed areas of 'partial' and 'reasonable' levels of assurance across their areas of responsibility
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• Roger Petter chaired the meeting very well, giving all attendees the opportunity to raise questions and ask for points of clarification.

Feedback from assurance committees: Governor observer report

Board assurance committee: Improvement
Meeting date: 19th February 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*
• Large Agenda including the following • PQSGG report • CEGG Report • Transfer of care group report • RCN Corridor care report • Maternity updates quarterly review
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Meeting started on time, The Chair welcomed everybody and introductions were made round the table. • The meeting was polite and respectful. Attendees were all given the opportunity to speak and contribute and it felt very inclusive. • The Chair was thorough and respectful in the handling of the meeting. • The chair asked for a volunteer to reflect on the meeting, the CFO present accepted the challenge! • Trust values maintained throughout the meeting.

- The meeting finished on time

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.

- Many items on the agenda and assurances were provided by NED challenges.
- Quite a lot of discussion around the pressure on ED and the use of corridors to treat patients. Challenges and the seeking of reassurance on matters arising from an NED. Good reassurance given by Chief Nurse that systems in place to support staff when they are morally challenged treating patients under these difficult circumstances.
- good presentations giving deep analysis of subject gave assurances to the committee. The Chair asked for clarification on any points that he felt needed expanding and further NED challenges led to further discussions.

Governor observer Notes

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

- Good reflections given on the meeting by the CFO. All aspects covered and reflected to the committee.
- Once again, I felt that transparency was prioritised and apparent in the meeting.

Feedback from assurance committees: Governor observer report

Board assurance committee: Improvement
Meeting date: 19th March 2025
Governor observer (observed by): Sue Kingston and Dr 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*
• PQSGG Report • CEGG • C-Difficile • Patient Safety (Quarterly) Report
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Well chaired. Meeting started and finished on time, The Chair welcomed attendees and introductions were made round the table. We felt welcome and were offered seats at the table. • The meeting was polite and respectful. Attendees were all given the opportunity to speak and contribute. • 2 other NEDs present. • The Chair was thorough and respectful in the handling of the meeting. • The Chair asked for a volunteer to reflect on the meeting, this was accepted by TD. • Professional and Trust values maintained throughout the meeting.

Assurances

- PQSGG Report flagged several claims received by the trust showing a high proportion of female claimants. This is unusual and has prompted a retrospective review to give assurance that WSFT is not harming one group of patients disproportionately. Further re-assurance given that this will be kept under review.
- CEGG report showed issues with radiology receiving non-medical referrals. This issue is on-going but is being addressed by ensuring that access is restricted to all non-medical staff until their necessary training is complete. Further re-assurance given through auditing that is currently being carried out by radiology to monitor incorrect referrals and act accordingly.
- Level 3 Safeguarding Training not currently delivered at WSFT outside the SG Team. Level 2 is delivered and is the minimum required for all staff. But worrying that Level 3 is a minimum requirement for all registered staff. A good challenge by an NED that this needs to be addressed. OD Team looking at delivery and the impact of training over a 3yr period to address this.

- C – Difficile Deep presentation was excellent, and re-assurance was given to the meeting that many arears of infection control and compliance are now in place through the Radar Audit module. Is good to see that a real focus on the basic hand hygiene being put in place on the wards.

- Lots of round table discussion and appropriate challenge by NEDs
- Many senior staff present
- One of the NEDs was allowed to safely dissent

Governor observer Notes

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

- It was re-assuring that questions raised recently by the Governors, were also raised at this meeting by the Chair. The concerns over the visit to the Catering Department were put to the DCN, especially concerns over dirty surfaces and floors leading to possible infection/food poisoning. Staff shortages were also concerning within that department. Re-assurance to be sought from the DCN and brought back to the next meeting.
- Excellent IPC presentation on hand washing, very enthusiastic and motivated
- Never Events and the reporting of same, was another question brought up by the Chair as being raised by the Governors. CN gave re-assurance that the new Radar System of reporting events is always followed. An analysis of this system can be seen on the Patient Safety Report, from the daily reporting of incidents through to any that require escalation to divisional leadership.
- Reflections on the meeting provided by TD. It was also good to hear the actions from the meeting being captured, reflected and reiterated for re-assurance to the committee at the close
- On a personal note, as an observer, the Chair invited us to sit at the table today as he felt it was more inclusive. I do appreciate that sometimes the meeting has a lot of members, and it is not always possible to fit us in. However, for me it made such a difference to my observations. Its good to see who is talking and to be able to hear them clearly. It felt a more engaging experience.
- Not so positive: Inadequate resources to prepare for future CQC inspection coupled with uncertainty as to how the process might be changing. Concerns about EOLC and the need for review, this would also be a target area for CQC. Lack of staff compliance with safeguarding, how this might be viewed by the CQC and how staff should now be managed to ensure compliance
- Concern raised by CEO on Governors and Safety incidents and how that should change
- No divisional representation and only one AMD who had other commitments and so was not present except for his own paper
- Overall: Found it to be of great value

Feedback from assurance committees: Governor observer report

Board assurance committee: Improvement
Meeting date: 16 April 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*
• 5) Patient Quality & Safety Governance Group; areas highlighted included trauma surgical engagement challenges, nutritional assessments and diabetes • 6) IQPR; improvements in ED turnaround • 7) TES update (corridor care). This is a priority for 2025/26 and must only be used in exceptional circumstances • 7) Maternity & Neonatal Services; A visit from a group of external representatives had given very positive feedback on West Suffolk services
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• The Chair welcomed all attendees including governor observers. • The meeting was conducted in line with Trust values throughout • All attendees participated in discussions • Good level of challenge

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.*
• Minimal assurance with regard to the engagement of surgical staff in the multi-disciplinary trauma meetings. The Medical Director is confident this is improving and mechanisms are in place to ensure participation and explained time pressures are the reason surgeons find it difficult to participate • Red risks around some areas of diabetes care mainly due to higher levels of the condition in maternity patients. There will be a deep dive into this area in June • High level of assurance concerning the quality of maternity care
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• This meeting was quorate but several committee members were not in attendance. • There was a slightly narrower than usual agenda which allowed for detailed and thorough discussions with time for review and clarification

9.3. Involvement Committee

Presented by Roger Petter

Board assurance committee - Committee Key Issues (CKI) report- Draft

Originating Committee: Involvement Committee			Date of meeting: 19th February 2025		
Chaired by: Tracy Dowling – Non-executive Director			**Lead Executive Directors: Jeremy Over and Sue Wilkinson**		
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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4.3	Actions from previous meeting: Guardian of Safe Working Hours	2. Reasonable	Issue raised at Board by resident doctors raising concerns about being asked to move to work in areas different to their rota	To continue to be monitored to assess frequency and concerns regarding continuity of care and impact on staff morale, including at Trust Negotiating Committee with medical staff representatives	1. No escalation
6.0	Education and Training Report	1. Substantial	Evidence of strong multi-professional access to education and training across the organisation with clarity about areas requiring attention and areas of future innovation.	Maintain focus on paediatrics and surgical foundation training. Maintain focus on locally employed doctors as vital for clinical sustainability. Consider how to measure the output and impact of our investment in education and training. Ensure that the development of our strategic workforce plan includes full consideration of associate and extended scope of practice clinical roles; developing sustainable career pathways for these vital roles.	1. No escalation

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6.2	Staff Psychology Service Specification	2. Reasonable	It was agreed that the service is valued by staff and the draft revised service specification was noted. The next step is to re-launch the service and the Tier 1 level support available to staff.	Undertake further work to define outcome metrics and other measures of success to ensure value added from the investment in this service. Ensure clarity on complaints management for the service. Ensure clarity on patient records as through this service our staff become patients of the Trust. These areas need to accompany the service specification as an internal SLA, to be approved by MEG.	1. No escalation
6.3	National Staff Survey 2024	2. Reasonable	The initial results of the Autumn 2024 Staff Survey show a decrease in scores across most categories compared to 2023. Whilst this is regrettable, it is not surprising given the impacts of the financial recovery actions during the period of the survey. There is variance in results across the divisions with Community and Corporate	A more detailed analysis will be completed once the full report and benchmarking is released in March. However, it is clear from the interim results where actions, communications and learning need to focus. The results show what a shock the financial position and resultant actions have been to the staff of WSFT;	1. No escalation; however response to the full report will come to Trust Board for assurance

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			Divisions scoring most highly, and Medicine Division and Estates and Facilities scoring generally lower.	however, living within our means and delivering high quality care through productive service models are core requirements. There is therefore organisational development work to do to navigate the cultural change needed across large parts of the Trust.	
7.0	Equality, Diversity and Inclusion Update	1. Substantial	Jamais Webb-Small presented the EDI workforce annual report and the WRES and WDES reports. The reports identified EDI activities, priorities, achievements and challenges from 2024; and key areas of focus for 2025. It was agreed that these comprehensive reports give robust assurance of activities in progress, and clarity on future priorities whilst recognising that the data shows that disparity and discrimination are still prevalent as it is in wider	The reports have been approved for publishing internally and externally. It was agreed that we would like to see more evidence of trends over time to know that the activity in place is having positive impact. We want to see further action to address the inequity between shortlisting and appointment between white and BME applicants. We want to see improvement in disability status disclosure rates; reduction in harassment, bullying or	1. No escalation

Originating Committee: Involvement Committee			Date of meeting: 19th February 2025		
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			society. A Board level EDI development session was fully supported as a priority action.	abuse from colleagues towards those with disabilities, and improvement in the extent to which the organisation values the work of staff with disabilities.	
8.2	Quality Priorities Review and 2025/6 proposed priorities	1. Substantial	Good assurance was provided of progress made on the 2024-5 quality priorities. The quality priorities for 2025-6 were agreed.	Progress delivering the quality priorities will be reported to the Involvement Committee every 4 months. The proposed quality priorities for 2025-6 will be subject to on-going engagement with various stakeholders including VOICE to ensure they are meeting the communities needs. The priorities may be subject to change as a result of this engagement (by April 25)	1. No escalation
8.3	EDS Report Summary and EDS Reporting Submission	1. Substantial	The EDS is a system which allows NHS organisations to review and improve their performance for people with protected characteristics.	The action plan for radiology services was agreed. It was confirmed that feedback has been shared with radiology staff members.	1. No escalation

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			The Trust EDS Reporting Submission was approved. The EDS report into radiology services was considered.		
9.1	People and Culture Committee	1.Substantial	The revised terms of reference were agreed.		1. No escalation
9.2	Experience of Care and Engagement Committee Report	1. Substantial	The report was received for information.		1. No escalation
10	IQPR extract for Involvement Committee	1. Substantial	Metrics reviewed and both patient experience and human resource metrics show good performance.		1. No escalation

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

	Questions regarding quality of evidence…	Further consideration…
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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?

Assurance level

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Board assurance committee - Committee Key Issues (CKI) report- Draft

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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
6.1	National Staff Survey Report – Taking Action Presented by Philippa Lakins	3. Partial	The Staff survey results showed significant deterioration compared to previous recent years. The results have been analysed and compared to other data sources and five areas of priority for action have been identified: • Health and wellbeing • Speaking Up • Care of patients • Recommend as a place to work • Management and Leadership Actions, next steps and monitoring arrangements were set out in the	Data for divisions, departments and teams is currently being analysed and collated. Typical approaches to local responses include team meetings to discuss the outcomes and agree actions, suggestion boxes, listening groups around key themes and targeted intervention by specific specialist support where necessary (e.g. staff psychology service, HR business partners, F2SUp guardian) Specific approaches with directorates / departments with especially low scores are also being planned; and learning from teams and divisions with the highest scores also analysed to see what learning can be shared across the Trust. Assurance level is 'partial' because the	3. Escalate to Trust Board given vital nature of staff survey

Originating Committee: Involvement Committee			Date of meeting: 16th April 2025		
Chaired by: Tracy Dowling - Non executive Director			Lead Executive Directors: Jeremy Over and Sue Wilkinson		
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
			report and supported by the Committee. The Committee approved on-going monitoring through the year and reporting through the PRM meetings, and to the People and Culture Committee. The quarterly Pulse surveys are a key element of monitoring colleague satisfaction, morale and motivation.	actions need to be owned and delivered across all parts of the organisation and especially in teams and departments with strong leadership from the directorate leadership teams. The financial pressures that significantly contributed to the fall in the staff survey scores continue to exist and significant organisational change to return to a sustainable position will continue to impact staff.	
6.2	Sexual Safety in the Workplace	2. Reasonable	Progress update from Deputy Director of Workforce, organisation development and Learning. Good initial progress; Sexual Safety working group meeting regularly; action plan developed with owners assigned; national policy adapted to include patients and visitors as well as staff; guidelines drafted; next steps agreed and in progress	Communications plan and posters being developed for discussion at May meeting Staff development needs and support options to be considered in May meeting Work planned on reporting and escalation routes; data capture and reporting; staff training	1. No escalation

Originating Committee: Involvement Committee			Date of meeting: 16th April 2025		
Chaired by: Tracy Dowling - Non executive Director			Lead Executive Directors: Jeremy Over and Sue Wilkinson		
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
6.3	Band 2/3 Healthcare Support Worker project outcomes and learning Presented by Lou Bland	2. Reasonable	The outcomes of the review of band 2 / 3 healthcare support worker roles and responsibilities was presented. The review was undertaken March – May 2024. 639 staff were deemed in scope and their individual pay journeys were assessed to assess any need for retrospective reimbursement. This was completed and any back pay owed to staff has been paid.	The committee asked for an assessment of the project outcomes from the perspective of protected characteristics to assess whether there was any learning from this regarding the equity of the process undertaken and the outcomes reached. The Committee asked to see these results in a future meeting.	1. No escalation
7.1	Volunteeer Service Strategic Plan Presented by Lee Ranson	1. Substantial	The volunteer service strategy has been updated to reflect priorities and ambitions over the next three years. This has been co-produced and is designed to be flexible, to be focussed on impacts, with structured reviews built in to ensure	Key reporting metrics and deliverables are defined; with clear mechanisms to ensure the strategy stays on track. The newly formed Volunteer Forum will oversee progress, and report to the People and Culture Committee and	1. No escalation

Originating Committee: Involvement Committee			Date of meeting: 16th April 2025		
Chaired by: Tracy Dowling - Non executive Director			Lead Executive Directors: Jeremy Over and Sue Wilkinson		
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
			on-going relevance.	Involvement Committee	
8.1	Consideration of under-represented groups in patient experience monitoring	1. Substantial	Update received on actions taken to ensure engagement with under-represented groups in patient experience monitoring. Excellent progress has been made to grow the VOICE network	Work continues to adapt and develop means of engaging with under-represented groups and to ensure that through their feedback we address health inequalities	1. No escalation
9.2	Experience of care and engagement committee	1. Substantial	Report of items considered at the last Experience of Care and Engagement Committee		1. No escalation
9.3	Audit One Well led review	1. Substantial	Actions for Involvement Committee reviewed; Involvement Committee approved the recommendation to close Line 25 'the Trust should ensure that it has parity of reporting between quantitative and qualitative data from ward to Board and in particular ensure that patient	The RSM internal audit report assessing the Trust response to the Well Led review will be received in June. There may be actions for the Involvement Committee following this.	1. No escalation

Originating Committee: Involvement Committee			Date of meeting: 16th April 2025		
Chaired by: Tracy Dowling - Non executive Director			Lead Executive Directors: Jeremy Over and Sue Wilkinson		
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
			feedback is used more effectively to help improve and reshape services.'		
9.4	BAF review Patient Engagement BAF Risk 9	2. Reasonable	The revisions and updates to BAF 9 since December 2024 were agreed	Work to consider how BAF9 and BAF 3 (Collaboration) should link up and work on the risk appetite is planned over summer 2025	1. No escalation
10.1	IQPR	1. Substantial	All metrics within range; recent variation in complaints responses was explained and assurance received.		1. No escalation
11.1	Any Other Business	3. Partial	The identification of the Estates and Facilities Directorate as a cause for concern was raised. This directorate is an outlier in the staff survey, some IQPR metrics and therefore the Chair asked the executive to review a need for escalation following the next PRM		2. To SLT

Originating Committee: Involvement Committee			Date of meeting: 16th April 2025		
Chaired by: Tracy Dowling - Non executive Director			Lead Executive Directors: Jeremy Over and Sue Wilkinson		
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
			with Estates and Facilities		

**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.

Feedback from assurance committees: Governor observer report

Board assurance committee: Involvement
Meeting date: 19th February 2025
Governor observer (observed by): Becky Poynter

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• The agenda was extensive and associated documents amounted to 303 pages. Apart from the amount of time this takes to prepare/read and digest it was inevitable that the meeting would either overrun or discussion be curtailed in the 1hr 50mins timeslot. This issue was discussed at the end of the meeting and the points raised - this committee meets every two months (where the other "I" committees meet monthly) - every item was timed for 10 minutes - executive officers gave detailed introductions to their documents which impacted discussion time
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• The Chair reminded members of the committee's remit and Trust values and asked that these be at the forefront of discussions. As always members were respectful and professional in their conduct throughout the meeting.
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 Chair made an excellent attempt at trying to cover all items on the agenda but, as already alluded to, the number of items and nature of some of the discussion made this extremely challenging.

Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• Within the time constraints the expertise of the non-executive directors was evident through their questioning and contributions. Staff are also confident in their areas of work and provide highly detailed and content rich reports which were acknowledged as such by the committee members. • Perhaps consideration could be given to prioritising agenda items to make better use of the time available rather than allocating 10 mins to each item. • The committee members appeared to be well prepared for the meeting so maybe verbal executive summaries could be shorter to allow more time for discussion. • there was debate between executive members about the contents of documentation being presented which may have been better addressed at MEG, before being presented to the committee.

Feedback from assurance committees: Governor observer report

Board assurance committee: Involvement
Meeting date:19 February 2025
Governor observer (observed by): CAROL BULL

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
Again too much on the agenda and the last item had to be rolled forward to the next meeting. *When a discussion drifted into looking at the "bigger picture" on one particular topic the Chair was quick to bring the discussion back to the paper in hand.* The agenda items and subsequent discussions raised a number of further issues to follow up and to come back to the committee.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
Welcomed to meeting and made to feel included and invited to sit at table. Introductions were made and all members were reminded of remit of the committee and of the trust values. Meeting started with a positive good feeling. *Chair at the conclusion of each agenda item summarised the discussions doublechecking everyone was in agreement with any action required.* *Time was tight as always with such large agendas and Chair moved things forward whilst allowing members to have their say.* *All those bringing reports to the table were thanked appropriately and towards the end when time was short and a paper had to be taken as read the presenters were given enough time for a quick summary. The final item though had to be carried forward to the next meeting rather than be rushed through.* *Questioning and subsequent discussions were conducted in an inclusive and open manner at times with humour and certainly with consideration to all.*

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 were three NEDs including the Chair and whilst they contributed to discussions I think the only assurance sought was in relation to how staff were being informed and supported with all the current uncertainties because of the financial situation. In fact at the end of the meeting one of the NEDs commented that she did nor feel that enough assurance in general had been sought and that they had got into too much management detail.
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• *As always no allowance for those with hearing difficulties – this disability does not seem to be recognised in any of the committees I have attended.*

Feedback from assurance committees: Governor observer report

Board assurance committee: Involvement
Meeting date: 19.02.1984
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 agenda covered a number of really important topics. There was much discussion around the items which was necessary, but it did mean items at the end of the agenda were either not covered or had a short period of time which made them feel a little rushed.*
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• *The meeting was conducted in accordance with the Trust values.* • *Respectful and polite challenge was given.* • *The meeting was well chaired, ensuring all that wanted to contribute did.*
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.*
• *Much of the information presented was for discussion or to note. Assurance was sought on many of the items.* • *Many points or challenges raised were bigger questions that need consideration at further meetings and or given more time for discussion so assurance around some issues is still to be sought.*
Governor observer Notes

Use this section to highlight any other areas for example good practice or 'even better if'
• *The Staff Psychology Support Service specification and the Quality Priorities for 25/26 were aiming for approval to be granted to proceed with their plans. Challenge was raised with some aspects of these requiring further clarification which may affect the time frame. The challenges and implications for implementing these works were dealt with in a respectful manner with suggestions for progress put forward, but I can understand the concern of the impact on implementation.* • *There was a theme across many items around measuring outcomes/impact. There are many great pieces of work and projects going on with in the Trust which were celebrated, but metrics to demonstrate their success help in the continued support of these. It was interesting to consider this and I feel as a member of staff, an important consideration with any project. The Trust Quality Improvement team do a great job of helping support the development of such metrics.*

9.4. Audit Committee

Presented by Michael Parsons

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Audit Committee			**Date of meeting: 18 March 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 Governance Statement (AGS)	Review of AGS including internal control issues.	Substantial	The Committee agreed that the (1) building structure, (2) performance and patient access, and (3) financial control and sustainability remain relevant as significant internal control matters for this year's AGS. In addition, MEG should consider including in the AGS any other significant issues from internal audits with negative assurance opinions.	Consideration while drafting the AGS.	2. To MEG to finalise AGS
Code of Governance 2022	Self-assessment was undertaken to evaluate the Trust's compliance with the expectations set out in the new Code.	Substantial	The internal review demonstrates that the Trust is largely compliant with the Code of Governance, with the one area for improvement identified being progressed.	The gap identified is being addressed through the development of a new policy for Board approval on 'purchase of non-audit services from its external auditor'.	3 -> Board approval where required **SEE SEPARATE PAPER REQUESTING APPROVAL**

Originating Committee: Audit Committee			Date of meeting: 18 March 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
Matters relating to Year-end 2024/25	Updates to governance documents (standing financial instructions, standing orders, scheme of delegation).	Substantial	Proposed amendments (SFIs and SoD) were approved by the Committee noting no amendments needed to Standing Orders.		3 -> Board approval where required **SEE SEPARATE PAPER REQUESTING APPROVAL**
Terms of reference	Annual review of the terms of reference was undertaken.	Substantial	Minor amendments were approved by the Committee.		3 -> Board approval where required **SEE SEPARATE PAPER REQUESTING APPROVAL**
Internal Audit (RSM)	Approval of Internal Audit Plan for 2025/26. Update on delivery of internal audit plan 2024/25 and implementation of recommendations.	Reasonable	The Committee approved the Internal Audit Plan for 2025/26, subject to further consideration by Executive in relation to coverage of productivity issues. Discussed progress with delivering the 2024/25 audit plan, and expressed concern at	Executive to consider the approach to productivity issues within the audit plan (and other assurance activity). Executive to review protocol and escalation approach to ensure 2025/26 IA plan is not backloaded.	2 -> Management Executive Group

Originating Committee: Audit Committee			Date of meeting: 18 March 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
			delays in concluding audits, resulting in a significant back-loading of the plan. Three audits awaited sign-off and a further two audits are still in progress: Governance - Well Led and Future Systems Programme - Clinical and Care Strategy. The draft Head of Internal Audit Opinion was discussed – noting that it may change in light of the assurance opinions in the final audits and any further information supplied by the Trust in response to audit recommendations. The Committee also reviewed progress with implementation of outstanding management actions.	Executive to continue to address overdue audit actions.	

Originating Committee: Audit Committee			Date of meeting: 18 March 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
Counter Fraud (RSM)	Approval of workplan for 2025/26. Update on counter-fraud activity.	Substantial	The Committee approved the workplan for 2025/26 and noted actions on awareness and training. Case studies on fraud were noted with information on prevention measures. Discussed RSM analysis emerging areas of risk, including increasing levels of regulation, technology resilience, access to markets, technology fraud, shifts in business culture and potential for an epidemic.	Benchmarking data will be considered at a future meeting.	1. No escalation
External Audit (KPMG)	Approval of audit plan and planning for upcoming audit.	Substantial	The Committee approved the audit plan and noted key points. The good working relationship between the external auditors and the trust finance team was welcomed; timeliness of		1. No escalation

Originating Committee: Audit Committee			Date of meeting: 18 March 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
			information provision and responsiveness to queries during the audit will be essential to achieve timelines.		
Fit & Proper Persons Annual Report	Review of Fit and Proper Persons annual report.	Substantial	The Fit and Proper Persons annual report was noted and approved, with minor amendments.		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. Nomination Committee Report (enclosed)

To receive the report from the Nomination 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:	14 May 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			
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 7 May 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.

NEDs and Chair appraisals (for noting)

The 360° feedback reports for Jude Chin, Alison Wigg, Antoinette Jackson, Heather Hancock, Paul Zollinger-Read, Michael Parsons, Richard Flatman, Roger Petter and Tracy Dowling were reviewed and discussed. The Committee agreed emergent themes from stakeholder assessments, areas of strength and identified opportunities to increase impact and effectiveness, for discussion at the individual's appraisal meetings. All appraisals will be scheduled for May/June for completion before 30 June 2025.

NHS England (NHSE) - new board member appraisal guidance (for noting)

The **new board member appraisal framework** was published on 1 April 2025. The framework incorporates the 6 domains of the leadership competency framework into a single approach for all executive and non-executive roles and aligns with the fit and proper person test (FPPT) framework. Key updates were noted by the Committee.

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 and take actions as recommended in the report.

Previously considered by:	Council of Governors' Nominations Committee (7 May 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

WSFT Council of Governors meeting (Open)	
Report title:	Membership and Engagement Committee report
Agenda item:	11
Date of the meeting:	14 May 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 29 April 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 29 April, the Committee focussed on the following key areas:

- The Committee noted the revised membership of the committee with three new members joining - Robin Howe, Diana Stroh and Lisa Parish.

- The Committee received an update on **Patient Engagement and VOICE**, highlighting patient engagement activities and various projects. Feedback indicated a need for better visibility on actions taken from member input. A proposal for a formal Patient VOICE Partner role was introduced to involve volunteers in structured work, including representation at key meetings, involvement in Equality Impact Assessments (EIAs), and contributing to service design. Current members can continue in informal roles. A presentation was also received on Suffolk Family Carers and ongoing work in the region on protected characteristics. The Committee will be updated on project progress.

- The Head of Communications attended the meeting and advised that discussions had been undertaken within the Comms department on how best to support governors going forward. Confirmation of suggestions to be provided in writing for consideration by the committee with an offer to organise a dedicated session to discuss further, including a review of promotional material.

- The Committee received a report on **Governor activities** from January 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 two 15-steps visits, two area observations, two environmental walkabouts and three Courtyard Café engagement sessions. Key themes from the activity analysis were confirmed and will be considered through the Trust's Experience of Care and Engagement Committee.

- **Membership and Engagement Strategy Development Plan** this was shared with the Committee and updates on actions discussed. The Phase I actions are in progress and the Committee noted that there is a lot to achieve. Briefing packs for governors and updated leaflets are being prepared with the comms team to facilitate member engagement and new sign ups to the Trust membership. The development plan is a live document to be reviewed, developed and monitored by the Committee. An interim annual review of the strategy will be undertaken by the Membership and Engagement Committee with periodical reviews of the development plan. The Committee will also review progress against the objectives of this strategy reporting back on progress at the Council of Governors through an update from the Committee chair.

- The Committee received feedback from governor observers of **VOICE** and members attending the **Experience of Care & Engagement Committee.**

- 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 29 April 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

Council of Governors' Membership and Engagement Committee	
Report title:	Governor activities 2024/25 - Feedback report
Agenda item:	-
Date of the meeting:	29 April, 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			
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 January 2025 and the emerging themes from the feedback received from the observers.

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

- 26 February, 2025: Catering & G8 by Jane Skinner, (Public Governor), Jayne Neal, (Public Governor) and Richard Flatman, (non-executive director).
- 26 March, 2025: F6 & F7 by Louisa Honeybun, (Staff Governor), Sue Kingston, (Partner Governor) and Alison Wigg, (non-executive director).

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

- 13 February, 2025: Pharmacy by Adam Musgrove, (Staff Governor) – **(no formal report)**
- 8 April, 2025: Chapel by Louisa Honeybun, (Staff Governor)

Environmental reviews led by Estates and Facilitates (Annex C)

- 5 February, 2025: MacMillan Unit by Adam Musgrove (Staff Governor)
- 5 March, 2025: Fracture Clinic by Jayne Neal (public governor).
- Dates for 2025 to be confirmed following changes within the Estates & Facilities Directorate.

Courtyard Café led by FT office team

- 9 January, 2025: Sue Kingston, (Partner Governor) and Michael Simpkin, (Public Governor)
- 11 February, 2025: Session cancelled due to Norovirus outbreak
- 13 March, 2025: Adam Musgrove, (Staff Governor) and Anna Clapton (Staff 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:

- Hygiene
- Aging estate
- Noise at night on ward
- Lack of TV
- Denotation of Uniform

Area observations: Reports requested from PALS.

- Lone working concerns (chaplaincy)
- Estate - repairs

Environmental reviews:

- Appropriate fixing of pictures/notices
- Loss of chairs to other departments

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 Approve

Presented by Jude Chin

WSFT Council of Governors meeting (Open)	
Report title:	Standards committee report
Agenda item:	12
Date of the meeting:	14 May 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 held on 8 April 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:

- **Quality accounts 2024-25 Governors commentary (FOR APPROVAL agenda item 15)**

The Standards committee considered the draft commentary for discussion and recommendation to the Council of Governors for inclusion in the quality accounts 2024/25. This is covered under a separate agenda item.

- **Fit and Proper Persons Test checks**

The committee noted the update on FPPT checks. The committee will review progress at its next meeting for the outstanding self-attestation forms.

ACTION
- Note the update.

- **Governor attendance at Council meetings**

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 three successive public meetings of the council of governors 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.

The 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.

Attendance at Governors' sub-committees was also considered by the committee, and it was agreed that each committee should maintain oversight of attendance to support individuals to attend meetings and maintain the effective working of the sub-committees. The Standards committee will maintain oversight of this issue and concerns regarding non-attendance highlighted.

ACTION
- Note the update

- **Cases/concerns regarding 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. No breaches were reported between October 2024 to March 2025.

ACTION
- Note that there have been no concerns or incidents raised relating to breach of Code of Conduct by the Governors that trigger review or escalation to the committee for the period.

- **Standards Committee Workplan**

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

ACTION
- Note the workplan.

- **Recommendations from Committee's Annual Effectiveness Review 2024 (FOR NOTING)**

An update on the progress of the recommendations from the committee's annual effectiveness review was provided. The committee reviewed the areas identified in the 2024-25 self-effectiveness review report, including the consideration of mandatory training for governors similar to that provided to other staff and volunteers. It was noted that a volunteer training module could be beneficial and offered for governors, although optional. However, certain important modules, such as Equality, Diversity and Inclusion, and Information Governance, could be mandated during the governors' induction. The committee discussed incorporating these themes into the induction process. However, the organisational development and learning team, who oversee the induction modules, have not yet been informed. Therefore, the practicalities of delivering this training, whether through eLearning

modules or other formats, are still to be determined. The committee will receive a progress update at the next meeting.

ACTION
- Note the update.

- **Governors' Development Programme 2025**

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

ACTION
- Note the Governors development programme 2025 (Annex C)

- **Skills Audit - Proposal**

The Trust conducts a skills audit for its Council of Governors to identify potential areas for development. The purpose of these audits is to assess each governor's knowledge in key functional areas necessary to perform their statutory and general duties and governors are expected to attend relevant sessions offered as an outcome of this gap analysis. A skills audit was conducted in 2022 with the previous Council and again in 2024 with the new Council in post. The results of this work informed the content of training and development for the year 2024, with some themes carried forward into the 2025 programme.

The committee discussed whether another skills audit in 2025 would be valuable or if different timing would be more appropriate. It was agreed to conduct the audit six months after the new Council of Governors (CoG) starts. The committee suggested revisiting the audit to identify areas where governors require additional training and to focus on gaps in their knowledge. This involves reviewing the questionnaire and title, with the timing set for six months from the new governors' start date. Governors can communicate their support needs, learning gaps or topics of interest through informal meetings or other preferred methods to the Lead Governor or Foundation Trust Office. These topics will be considered by the committee for inclusion in future governors' work programme.

ACTION
- Note the update and timing of the next skills audit/gap analysis, scheduled for six months after the new Council of Governors start in 2026 (May/June 2027).

- Note that Governors can communicate their support needs or topics of interest through informal meetings or other preferred methods to the Lead Governor or Foundation Trust Office for consideration by the Standards Committee for inclusion in future work programmes.

- **Lead and Deputy Lead Governor Election Process 2025 and Role Specification**

The Trust is committed to maintaining continuity in leadership roles, including the Lead and Deputy Lead Governor, with a term structure that balances effective governance with opportunities for new leadership. The Standards Committee received the report that outlined the process for the Lead and Deputy Lead Governor election within the Trust. The posts are due for election in 2025 for new post holders to begin their term from 1 January 2026.

On 2 May 2023, the Council of Governors approved the term of Lead Governor to run until 31 December 2025. It was also decided that, in accordance with the Trust Constitution, future lead governor terms of office will conclude one year after CoG elections. **The term of the new lead governor will span from 1 January 2026 until 31 December 2027, and the subsequent lead**

governor's term will run from 1 Jan 2028 - 31 Dec 2030, establishing a three-year term. The amendment to the term structure was designed to return to a cycle where the Lead Governor's term ends one year after Governor elections, aligning with the CoG election cycle and ensuring effective governance transitions. The Council of Governors also approved that the same principle applies to the Deputy Lead Governor role and therefore the same term applies.

The Standards Committee noted and agreed in general the following:

- process for the Lead and Deputy Lead Governor election within the Trust **(Appendix 1)**
- Lead and Deputy Lead Governor election timetable 2025 **(Annex A)**
- Lead and Deputy Lead Governor role specification and terms & conditions **(Annex B)**

Term of Office

Current WSFT Constitutional provision:
As per the Trust Constitution, the term of office for the lead Governor will normally run for three years until one year after Governor elections* *(The timing of the Lead Governor term aims to avoid appointment to the role being held immediately after Governor elections. This is because at this point a new governing body has been formed who will need to work together to understand their role and get to know each other. It is recognised that on occasions election of the Lead Governor may be necessary at this time, but the approach tries to minimise this occurrence).*

The committee reviewed the upcoming and future election cycles (terms) for both Lead and Deputy Lead Governors, considering the input of the committee members. There were differing opinions on whether the term of office should end one year or two years after Governor elections. The committee unanimously decided to present this matter to the Council for a final decision, recommending a vote on the preferred term span based on the arguments presented.

Summary of comments on term of office:

OPTION 1

The term of office for the lead Governor will normally run for three years until **one** year after Governor elections

Arguments in support:

- flexibility with the new council to elect a new lead governor
- provides an opportunity for other governors to take on leadership roles within a shorter timeframe
- increased awareness and understanding of the lead governor role at the beginning of the term as a governor can help feel more prepared and enable confidence sooner to step into the position within a year
- strikes a balance between gaining experience and providing opportunities for others
- some believed that a one-year term is sufficient for governors to become effective in their roles.

Concerns:

- there is a concern that new governors may not have enough experience within a year to effectively perform their duties as lead governor.

OPTION 2

The term of office for the lead Governor will normally run for three years until **two** years after Governor elections

Arguments in support:

- governors have more time to gain experience and confidence in standing for lead governor role

- allows lead governor more time with the new council to develop a relationship and effectively perform their duties.

Concerns:
- two years after elections may limit the opportunities for other governors to take on leadership roles
- the Council may need to accept the previous incumbent for the next two years, despite not having voted for them, which could have an impact on overall functioning of the council.

Based on the above, the Council of Governors present in the meeting are asked to vote by a show of hands for or against the following two proposed recommendations:

- Term runs until **one** year after the Governor elections (as per existing provisions of the Trust Constitution)
- Term runs until **two** years after the Governor elections.

The length of term of office for that election for Lead Governor will remain as three years in both the circumstances. If the Council votes in favour of Option B, the change will trigger 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. Legal advice will be sought on proposed amendments to the Constitution. This is to ensure that any changes to not undermine the Constitution as a legal instrument. Please note same principles apply to the deputy lead governor role.

ACTION

NOTE
- the process for the Lead and Deputy Lead Governor election within the Trust
- the election timetable 2025

APPROVE
- the lead and deputy lead Governor role specification and terms & conditions (subject to the decision made on the term of office)
- three-year term of office for any particular lead governor election:

  o Option 1 - runs until one year after the Governor elections

  OR

  o Option 2 - runs until two years after the Governor elections

Enclosures for Lead and Deputy Lead Governor election:

Appendix 1 - Standards Committee report and process for the Lead and Deputy Lead Governor election within the Trust (as approved by the CoG in May 2023)
Annex A - Lead and Deputy Lead Governor election timetable 2025
Annex B - Lead and Deputy Lead Governor role specification and terms & conditions

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, including

approval of Lead and deputy lead governor election process 2025.	
Previously considered by:	Council of Governors' Standards 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 Trust Constitution- Annex 7 – standing orders for the practice and procedure of the council of governors 3.24 Voting - every question at a meeting shall be determined by either a majority of the votes of the Governors present, qualified to vote on the issue and voting on the question unless the Constitution requires otherwise. In the case of the number of votes for and against a Motion being equal, the Chair of the meeting, or the person presiding over that issue if the Chair is absent, shall have a second or casting vote. 3.25 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands, unless at the discretion of the Chair, a vote is held by postal or e-mail vote, or by way of written resolution. A paper ballot may also be used if a majority of the Governors present so request. At all times, no Governor may vote by proxy.

Annex A – TIMETABLE 2025

Lead governor

Lead governor election stage	Timeline
Email **inviting nominations** - all governors (public, staff and partner) *(Role specification, terms & conditions and nomination form)*	**w/c 1 Jul**
Nominations **closing date**	**18 Jul**
Nominations and supporting statements **to be received by**	**18 Jul**
Single candidate/nomination – **results declared** **PROCESS CLOSED**	**11 Sep**
More than one candidate – **summary of candidates and voting slips by email**	**w/c 4 Aug**
Ballot at face-to-face meeting (Preferred option) **(subject to approval by the Standards Committee)** - ballot of governors (face to face) - Ballots will be collected at the meeting, counted and results announced **PROCESS CLOSED**	 **11 Sep**
In case of email ballot - Email votes to be returned to the FT Office - Results announced **PROCESS CLOSED**	**w/c 4 Aug** **15 Aug** **11 Sep**

Deputy lead governor *(to be started after the appointment of Lead Governor)*

Deputy lead governor election stage	Timeline
Email **inviting nominations** - all governors (public, staff and partner) *(Role specification, terms & conditions and nomination form)*	**w/c 15 Sep**
Nominations **closing date**	**w/c 29 Sep**
Nominations and supporting statements **to be received by**	**w/c 29 Sep Oct**
Single candidate/nomination – **results declared** **PROCESS CLOSED**	**13 Nov**
More than one candidate – **summary of candidates and voting slips by email**	**w/c 6 Oct**
Ballot at face-to-face meeting ballot of governors (face to face) - Ballots will be collected at the meeting, counted and results announced **PROCESS CLOSED**	**13 Nov**
In case of email ballot (Preferred option) **(subject to approval by the Standards Committee)** (For the avoidance of doubt, this email vote will form the only method of voting and no meeting will be held) - Email votes to be returned to the FT Office - Results announced **PROCESS CLOSED**	**w/c 6 Oct** **w/c 20 Oct** **13 Nov**

Trust Constitution
Annex 11 – LEAD GOVERNOR AND DEPUTY LEAD GOVERNOR

Lead Governor role specification

The roles and responsibilities set out in the document can also be read as the responsibilities of the Deputy Lead Governor whilst undertaking their role.

1. Introduction

The lead governor of West Suffolk NHS Foundation Trust (WSFT) will be appointed to carry out the role described in Appendix B of NHS England's Code of Governance for NHS provider trusts (published on 27 October, 2022) or any subsequent amendments.

NHS England (NHSE) requires only that the lead governor act as a point of contact between NHSE and the council when needed. Directors and Governors should always remember that the Council of Governors as a whole has responsibilities and powers in statute, and not individual governors. Further guidance on NHSE's expectation of the role is provided as an annex to this role description.

This role description will be kept under review and is subject to approval by the Council of Governors.

Public, Staff and Governors appointed by partners are eligible for the role of Lead Governor.

2. Key working relationships

Trust Chair, Council of Governors, Trust Secretary, Deputy Trust Secretary, FT Office Manager, Senior Independent Director and NHS England (NHSE).

3. Role description

3.1 To act as the point of contact between the Governors and NHSE in circumstances where it would not be appropriate for the Chair of the Board of Directors, Senior Independent Director (SID) or the Trust Secretary to deal with a particular matter to contact NHSE directly, or vice versa

3.2 To work with the Chair to facilitate effective relations between the Board of Directors and the Council of Governors. This could include joint meetings/workshops with the Board of Directors and attendance of Non-Executive Directors at Council of Governors meetings

3.3 To sit on the Nominations and Remuneration Committee for the purpose of appointing the Chair and other Non-Executive Directors and discussing remuneration including allowances and other terms of office

3.4 To contribute to the Chair's annual appraisal by the Senior Independent Director, including receiving comments from Governors not directly involved in the appraisal process

3.5 To contribute to the appraisal of the non-executive directors (NEDs) by the Chair

3.6 To meet with the Chair to help plan and prepare for Council of Governors meetings

3.7 To chair meetings of the Council of Governors which cannot be chaired by the Trust Chair, Deputy Chair or other non-executive director due to a conflict of interest. These occasions are likely to be infrequent

3.8 Chair informal Governor-only meetings, if required

3.9 To ensure a process is in place to understand the views of all Governors

3.10 To help ensure a process is in place to support new Governors and to support the induction process for any newly appointed governor.

3.11 To help ensure that Governors comply with the Council's Code of Conduct.

4. Person Specification

To be able to fulfil this role effectively, the Lead Governor should ideally have some or all of the following attributes:

4.1 Have the confidence of Governor colleagues and of members of the Board of Directors

4.2 Ability to commit the necessary time to the role

4.3 Ability to influence and negotiate at different levels

4.4 Ability to present a well-reasoned view on complex issues

4.5 Committed to the success of the Foundation Trust

4.6 Demonstrate an understanding of the Trust's constitution and how the Trust is influenced by other organisations.

5. Terms and conditions

5.1 The Lead Governor will be a governor who is currently in their elected term of office and will not be eligible to continue in this role if they are not re-elected

5.2 Any Governor wishing to stand as Lead Governor will be required to relinquish other responsibilities e.g. committee chair

5.3 The term of office for the lead Governor will normally run for three years until one year after Governor elections *

5.4 A Governor will not be eligible to stand for election during their final eligible term of office as a Governor

5.5 The role specification of the Lead Governor will be reviewed by Standards Committee of the Council of Governors following engagement with the Board of Directors and the Council of Governors and will include the relevant provisions of Appendix B of the NHS Foundation Trust Code of Governance

5.6 If the Lead Governor leaves the role then the Deputy Lead Governor will take up the role until a further Lead Governor election takes place.

* *The timing of the Lead Governor term aims to avoid appointment to the role being held immediately after Governor elections. This is because at this point a new governing body has been formed who will need to work together to understand their role and get to know each other. It is recognised that on occasions election of the Lead Governor may be necessary at this time, but the approach tries to minimise this occurrence.*

Deputy Lead Governor role specification:

The Council of Governors may also elect a Deputy Lead Governor from among the governors to meet the demands of the increasing level of responsibility. The Deputy Lead Governor will deputise in the absence of the Lead Governor and will support the Lead Governor in all the duties as specified.

In general, the Deputy Lead Governor is a discretionary role and has no specific powers or responsibilities other than to deputise in the absence of the Lead Governor (with the advance agreement of the Lead Governor). This provides additional resilience and support for the Lead Governor and the smooth running of the Council.

Removal of Lead Governor/Deputy Lead Governor

Removal of the Lead or Deputy Lead Governor before their term of office is over will require approval by the majority of Governors at a meeting of the Council of Governors

NHS England expectations of lead governor role (Appendix B of Code of Governance 2022)

Lead governor

The lead governor has a role in facilitating direct communication between NHS England and the NHS foundation trust's council of governors. This will be in a limited number of circumstances and, in particular, where it may not be appropriate to communicate through the normal channels, which in most cases will be via the chair or the trust secretary, if one is appointed.

It is not anticipated that there will be regular direct contact between NHS England and the council of governors in the ordinary course of business. Where this is necessary, it is important that it happens quickly and in an effective manner. To this end, a lead governor should be nominated and contact details provided to NHS England, and then updated as required. Any of the governors may be the lead governor.

The main circumstances where NHS England will contact a lead governor are where we have concerns about the board leadership provided to an NHS foundation trust, and those concerns may in time lead to our use of our formal powers to remove the chair or non-executive directors. The council of governors appoints the chair and non-executive directors, and it will usually be the case that we will wish to understand the views of the governors as to the capacity and capability of these individuals to lead the trust, and to rectify successfully any issues, and also for the governors to understand our concerns.

NHS England does not, however, envisage direct communication with the governors until such time as there is a real risk that an NHS foundation trust may be in breach of its licence. Once there is a risk that this may be the case, and the likely issue is one of board leadership, we will often wish to have direct contact with the NHS foundation trust's governors, but quickly and through one established point of contact, the trust's nominated lead governor. The lead governor should take steps to understand our role, the available guidance and the basis on which we may take regulatory action. The lead governor will then be able to communicate more widely with other governors. Similarly, where individual governors wish to contact us, this would be expected to be through the lead governor.

The other circumstance where NHS England may wish to contact a lead governor is where, as the regulator, we have been made aware that the process for the appointment of the chair or other members of the board, or elections for governors or other material decisions, may not have complied with the NHS foundation trust's constitution, or alternatively, while complying with the trust's constitution, may be inappropriate. In such circumstances, where the chair, other members of the board of directors or the trust secretary may have been involved in the process by which these appointments or other decisions were made, a lead governor may provide us with a point of contact.

Governors' Work 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
TBC	Effective questioning and holding the NEDs to account for the performance of the Board The role of the Foundation Trust Governor and practical ways to carry out the statutory roles of a governor	Interests of members and the public Holding the NEDs to account for the performance of the Board Item from annual skills audit – considering options for delivery to support working of the Council	NHS Providers
TBC	Patient quality and safety, incidents/never events, PSIRF	Holding the NEDs to account for the performance of the Board	Chief Nurse / others as agreed
TBC - Oct 2025	Session on Future Systems Programme	Holding the NEDs to account for the performance of the Board	Chief Executive / Programme Director / others as agreed

WSFT Council of Governors' Standards Committee	
Report title:	Lead and deputy lead governor election process 2025
Agenda item:	6
Date of the meeting:	8 April 2025
Sponsor/executive lead:	Richard Jones, Trust Secretary
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 Trust is committed to maintaining continuity in leadership roles, including the Lead and Deputy Lead Governor, with a term structure that balances effective governance with opportunities for new leadership.

This report outlines the process for the Lead and Deputy Lead Governor election within the Trust.

The **current term for the lead and deputy lead Governor is from 1 January 2023 to 31 December 2025**. The new Lead Governor and deputy lead Governor term should run from 1 January 2026 to 31 December 2027, and future term will align accordingly with CoG elections.

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

Next lead and deputy lead Governor term and election process

Key considerations that emerged from the lead and deputy governor elections 2022 included:

1. Separating the lead and deputy lead governor elections so that they don't run concurrently, but that the deputy elections are held separately after the lead governor is appointed

2. Ensuring, wherever possible, prior to opening the nominations, CoG receives the proposal at a face-to-face meeting so that there is clarity and transparency in the process

3. Defining a step-by-step process around communication and timing of the election. (Appendix 1 appended to this report)

On 2 May 2023, the Council of Governors approved the term of Lead Governor to run until 31 December 2025. In accordance with the Trust Constitution future lead governor terms of office will end one year after elections. **The term of new lead governor will be from 1 January 2026 until 31 December 2027.**

The amendment to the term structure was designed to return to a cycle where the Lead Governor's term ends one year after Governor elections, aligning with the CoG election cycle and ensuring effective governance transitions.

The Council of Governors also approved that the same principle applies to the deputy lead governor role and therefore the same term applies.

Further, the Council reviewed and approved proposed Lead and Deputy Lead Governor election process **(Appendix 1 appended to this report)**

The lead and deputy lead Governor role specification was also reviewed in accordance with the NHS Foundation Trust Code of Governance 2022 **(Annex B)**

Excerpts from Annex 11 of Trust Constitution - role spec and terms and conditions
Terms and conditions

- The Lead Governor will be a governor who is currently in their elected term of office and will not be eligible to continue in this role if they are not re-elected
- Any Governor wishing to stand as Lead Governor will be required to relinquish other responsibilities e.g. committee chair
- The term of office for the lead Governor will normally run for three years until one year after Governor elections
- A Governor will not be eligible to stand for election during their final eligible term of office as a Governor
- The role specification of the Lead Governor will be reviewed by Standards Committee of the Council of Governors following engagement with the Board of Directors and the Council of Governors and will include the relevant provisions of the NHS Foundation Trust Code of Governance
- If the Lead Governor leaves the role then the Deputy Lead Governor will take up the role until a further Lead Governor election takes place.

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

Actions and timeline

The new term for the Lead Governor will run from 1 January 2026 to 31 December 2027, ensuring the position aligns with the CoG election cycle. The same term will apply to the Deputy Lead Governor.

Lead/Deputy Lead Governor Election Process

Lead Governor Election Process

Step wise process for appointment of Lead Governor:

1. The election for the lead governor will take place first, followed by the election for the deputy lead governor (where applicable) **month of July**

2. In accordance with the role specification and terms & conditions of the lead governor role, it is proposed that nominations be invited from all governors. **w/c 1 July**

- An email inviting nominations to stand for lead governor to be sent to all governors with the role specification, terms & conditions and nomination form. **w/c 1 July**

- Any governor who is interested in standing can contact the following for further information: the current Lead and/or Deputy Lead Governor; Trust Chair; Senior Independent Director; Trust Secretary or Deputy Trust Secretary. **1-18 July**

3. Nominations and supporting statements for lead governor to be received by agreed deadline. Nominations closes on **18 July**

4. If there is a single candidate for the lead governor that candidate takes-up the role as lead governor without the need for an election.

5. If there is more than one candidate for the lead governor role a ballot of governors will take place by either:

   (a) Ballot at face-to-face meeting (preferred option) (FOR APPROVAL)

   (i) Nomination and voting slips to be sent out to the governors by email **w/c 4 August**
   (ii) Ballots will be collected at the meeting, counted and the results announced **September CoG meeting**

   (b) Email ballot

   (iii) Nomination and voting slips to be sent out to the governors as an email ballot in accordance with the Trust's constitution (for the avoidance of doubt, this email vote will form the only method of voting and no meeting will be held) **w/c 4 August**
   (iv) Email votes to be returned to the Trust Secretary/ Foundation Trust Office ***two-week window***

6. The ballot result will be based on the 'first past the post' voting system in which the governor with the most votes is appointed.

7. In case there is a tied vote, in accordance with the Constitution the Chair of the meeting, or the person presiding over that issue if the Chair is absent, shall have a second or casting vote.

Deputy Governor Election Process (to take place after Lead Governor election results are announced)

Step wise process for appointment of deputy lead governor:

1. The election of the deputy lead governor will take place after the appointment of the lead governor (where applicable) **September 2025**

2. In accordance with the role specification and terms & conditions of the lead governor role, it is proposed that nominations be invited from all governors. **w/c 15 September**

- Email inviting nominations for deputy lead governor to be sent to governors with role specification, terms & conditions and nomination form.

- Any governor who is interested in standing can contact the following for further information: the current Lead and/or Deputy Lead Governor; Trust Chair; Senior Independent Director; Trust Secretary or Deputy Trust Secretary. **w/c 15 - 29 Sep**

3. Nominations and supporting statements for deputy lead governor to be received by agreed deadline. Nominations closes in **w/c 29 Sep**

4. If there is a single candidate for the deputy lead governor role, that candidate takes-up the role as deputy lead governor without the need for an election

5. If there is more than one candidate for the deputy lead governor role, ballot of governors will take place by either:

   (a) Ballot at face-to-face meeting

   (i) Nomination and voting slips to be sent out to the governors by email **w/c 6 Oct**
   (ii) Ballots will be collected at the meeting, counted and the results announced **13 Nov**

   (b) Email ballot (preferred option) (FOR APPROVAL)

   (iii) Nomination and voting slips to be sent out to the governors as an email ballot in accordance with the Trust's constitution (for the avoidance of doubt, this email vote will form the only method of voting and no meeting will be held) **w/c 6 Oct**
   (iv) Email votes to be returned to the Trust Secretary/Foundation Trust Office **w/c 20 Oct *two-week window***

6. The ballot result will be based on the 'first past the post' voting system in which the governor with the most votes is appointed.

7. In case there is a tied vote, in accordance with the Constitution the Chair of the meeting, or the person presiding over that issue if the Chair is absent, shall have a second or casting vote.

Future Cycle:

Future elections for lead and deputy lead governor will follow the revised term structure. The next Lead Governor term will span from 1 Jan 2026 to 31 Dec 2027, followed by a three-year term for subsequent role holders from 1 Jan 2028 to 31 Dec 2030.

Action required / Recommendation:
The Standards Committee is asked to: • to review and agree on the proposed Lead & Deputy Lead Governor election process and timetable **(Annex A)** • to consider and approve the preferred ballot option for: - lead governor - Ballot at face-to-face meeting - deputy lead governor - Email ballot • to review and agree on the lead and deputy lead Governor role specification **(Annex B – also part of the Constitution – Annex 11)** • to note future election cycle (terms) for Lead and Deputy Lead Governor: - 1 Jan 2026 - 31 Dec 2027 two-year term (CoG election and new CoG from Dec 2026) - 1 Jan 2028 - 31 Dec 2030 three-year term (CoG election and new CoG from Dec 2029) - 1 Jan 2031 - 31 Dec 2033 three-year term (CoG election and new CoG from Dec 2032)

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

Appendix 1 (APPROVED by the CoG in May 2023)

Step by step process around communication and timing of the election

In accordance with a process agreed by the Council of Governors, the Trust Secretary will administer nomination and election procedure that will require:

- Submission of an expression of interest with a statement for support of no more than 250 words supporting candidature (from candidates)
- Election be by ballot of governors either at a face-to-face meeting or by email; individual voting choices will remain confidential.

Wherever possible, prior to opening the nominations, a report setting out the proposed election process will be received at a face-to-face meeting of the Council of Governors so that there is clarity and transparency on the process.

Lead Governor Election Process

Step wise process for appointment of Lead Governor:

1. The election for the lead governor will take place first, followed by the election for the deputy lead governor (where applicable)

2. In accordance with the role specification and terms & conditions of the lead governor role (Annex 1) it is proposed that nominations be invited from all governors.

3. An email inviting nominations to stand for lead governor to be sent to all governors with the role specification, terms & conditions and nomination form.

4. Any governor who is interested in standing can contact the following for further information: the current Lead and/or Deputy Lead Governor; Trust Chair; Senior Independent Director; Trust Secretary or Deputy Trust Secretary.

5. Nominations and supporting statements for lead governor to be received by agreed deadline.

6. If there is a single candidate for the lead governor that candidate takes-up the role as lead governor without the need for an election.

7. If there is more than one candidate for the lead governor role a ballot of governors will take place by either:

   (c) Ballot at face-to-face meeting (preferred option)

   (i) Nomination and voting slips to be sent out to the governors by email
   (ii) Ballots will be collected at the meeting, counted and the results announced

   (d) Email ballot

   (iii) Nomination and voting slips to be sent out to the governors as an email ballot in accordance with the Trust's constitution (for the avoidance of doubt, this email vote will form the only method of voting and no meeting will be held)
   (iv) Email votes to be returned to the Trust Secretary

Lead/Deputy Lead Governor Election Process

8. The ballot result will be based on the 'first past the post' voting system in which the governor with the most votes is appointed.

9. In case there is a tied vote, in accordance with the Constitution the Chair of the meeting, or the person presiding over that issue if the Chair is absent, shall have a second or casting vote.

Deputy Governor Election Process (to take place after Lead Governor election)

Step wise process for appointment of deputy lead governor:

8. The election of the deputy lead governor will take place after the appointment of the lead governor (where applicable)

9. In accordance with the role specification and terms & conditions of the lead governor role (Annex 1) it is proposed that nominations be invited from all governors.

10. Email inviting nominations for deputy lead governor to be sent to governors with role specification, terms & conditions and nomination form.

11. Any governor who is interested in standing can contact the following for further information: the current Lead and/or Deputy Lead Governor; Trust Chair; Senior Independent Director; Trust Secretary or Deputy Trust Secretary.

12. Nominations and supporting statements for deputy lead governor to be received by agreed deadline.

13. If there is a single candidate for the deputy lead governor role, that candidate takes-up the role as deputy lead governor without the need for an election

14. If there is more than one candidate for the deputy lead governor role, ballot of governors will take place by either:

    (a) Ballot at face-to-face meeting (preferred option)

    (i) Nomination and voting slips to be sent out to the governors by email
    (ii) Ballots will be collected at the meeting, counted and the results announced

    (b) Email ballot

    (iii) Nomination and voting slips to be sent out to the governors as an email ballot in accordance with the Trust's constitution (for the avoidance of doubt, this email vote will form the only method of voting and no meeting will be held)
    (iv) Email votes to be returned to the Trust Secretary

15. The ballot result will be based on the 'first past the post' voting system in which the governor with the most votes is appointed.

16. In case there is a tied vote, in accordance with the Constitution the Chair of the meeting, or the person presiding over that issue if the Chair is absent, shall have a second or casting vote.

13. Staff Governor Report (enclosed)

To receive a report from the Staff Governors

To Note

Presented by Louisa Honeybun

WSFT Council of Governors meeting (Open)	
Report title:	Staff Governors' report
Agenda item:	13
Date of the meeting:	14 May 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			
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 April 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 Anna Clapton, Diana Stroh, Adam Musgrove, Louisa Honeybun, Sue Kingston (Partner Governor), Carol Steed (Deputy Director of Workforce, Organisational Development and Learning), Anna Hollis (Deputy Head of Communications), Jane Sharland (Freedom to Speak Up Guardian) and Pooja Sharma (Deputy Trust secretary).

Summary/Highlights:

Staff Governor Engagement – raising the governor profile:

The communications update focused on various activities for governors to engage with staff and patients, including the suggestions to improve the visibility of governor activities. There was a discussion on ensuring clarity in the role of governors, particularly around attending events and the objective of these engagements. The need for governors to avoid duplication of efforts and focus on clear outcomes was emphasised. Also, the importance of including staff governors' work in Trust communications to raise awareness was highlighted, with suggestions to increase engagement and strengthen the profile of staff governors.

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 current financial constraints and the challenges of delivering difficult news to staff. Staff survey results showed a decline in responses related to FTSU, indicating a need for improvement in communication and outreach.

Staff concerns

The issues were raised around staff expressing anxiety and concerns about how potential changes were communicated. Questions were raised about the transparency of the process for changes and the availability of support. It was noted that appropriate support mechanisms are in place to address these concerns and should be made more accessible to staff to increase their awareness of available options, including resources such as HR Zone.

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 April 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:	14 May 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			
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 which are in line with the achievement of their Statutory duties and responsibilities.
Action Required
To note

Risk and assurance:	-
Equality, Diversity and Inclusion:	-
Sustainability:	-
Legal and regulatory context	NHS Act 2006 Social Care Act 2012 WSHFT Constitution WSHFT Governors Code of Conduct

Lead Governor Report

1. Introduction

It was with shock and sadness, that we heard Public Governor, Michael Simpkin, had died after an unexpected and short illness in February. I would like to acknowledge Michael's contribution to the CoG. He was enthusiastically committed to the role; one of his greatest strengths being his ability to communicate effectively with people from every walk of life. Michael was well known in his home town of Haverhill, where he gave many hours as a volunteer, including serving as a Trustee and volunteer for the local Citizens Advice office. We will miss him on the Council, a note of condolence was sent on behalf of Governors to his family.

Governors have been kept informed regarding the financial situation of the Trust and subsequent recovery plan. We are grateful to Jonathan Rowell, Interim Finance Director, for his presentations to the CoG.

A major challenge and priority for this Trust, like many others nationally, is to balance the budget (to an agreed deficit) whilst protecting patient safety, meeting quality targets and reducing waiting list numbers and waiting times. In line with the NHS Long Term Plan (2019) and the NHS Long Term Workforce Plan (2023) Governors witnessed local expansion of the workforce, including international recruitment. Conversely, current financial controls include cut back on agency, locum and bank staff spending, vacancy controls and pause, service restructuring and redundancies. All divisions and departments must achieve CIPs.

It is the Statutory duty of Governors to hold Non-Executive Directors to account for the performance of the Board. We must take every opportunity to seek assurance that the Trust values of fairness, inclusivity, respect, safety and teamwork are upheld by those involved in overseeing, reconfiguring and restructuring services. As representatives of staff and service users it is our duty to question and seek assurance on the quality and safety of care and seek understanding of what changes to services means for staff and patients.

Governors, observing Board and Board Assurance meetings are assured that the conduct of these meetings is in line with Trust values. Difficult decisions are not made lightly but are discussed fully and with transparency and are subject to challenge from Executive and Non-Executive Committee members.

	The ICB instructed Sustainability Review is to be presented to a joint ESNEFT and WSFT CoG meeting prior to this public CoG.
2.	**COG Sub-Committees**
2.1	**Membership and Engagement Committee** One meeting has been held since the previous CoG. 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.
2.2	**Nominations and Remuneration Committee** This Committee is currently ensuring NED appraisals are carried out according to the agreed process and in accordance with Governors' statutory duties.
2.3	**Standards Committee** One meeting has taken place since the previous CoG. The process for electing the next Lead Governor and Deputy Lead Governor was discussed.
4.	**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 minutes and Assurance Committees approved minutes are available to read on Convene. Also a reminder that Governors are encouraged to observe Board meetings and take the opportunity to ask questions as an agenda item. Questions seeking assurance can also be submitted to the Trust office via the dedicated email address.
5.	**Governor Updates and Development** Thank you to Sue Wilkinson, Chief Nurse, for her briefing session on the CQC Inspection Framework. Thank you to Richard Watson from SNEE ICB for his briefing session on the Integrated Care Board. Governors were also invited to visit the Virtual Ward hub, a session which was very positively reviewed.
6.	**Changes to the COG** Welcome to Robin Howe who has joined to CoG as a public Governor. Robin is an experienced Governor having served two previous terms. We welcome a new Staff Governor, Diana Stroh, who is a community-based staff member.
7.	**Conclusion** Governors recognise that this is a very difficult and uncertain time for staff, we thank them for their continued hard work and acknowledge their achievements, for example, improved ED standards and running "Super Saturdays," where all pull together to ensure extra patients receive their surgery.

15. Quality Accounts 2024/25

To approve the commentary for Quality Accounts

To Approve

Presented by Pooja Sharma

WSFT Council of Governors meeting (Open)	
Report title:	Quality accounts 2024-25 Governors commentary
Agenda item:	15
Date of the meeting:	14 May 2025
Sponsor/executive lead:	Richard Jones, Trust Secretary & Head of Governance
Report prepared by:	Pooja Sharma, Deputy Trust Secretary

Purpose of the report:			
For approval ☒	**For assurance** ☐	**For discussion** ☒	**For information** ☐
Trust strategy ambitions			
Please indicate Trust strategy ambitions relevant to this report.	☒	☒	☒

Executive summary:

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

The Council of Governors provides commentary for inclusion in the annual quality 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 in the meeting on 26 February 2025 asked the Standards Committee to develop the draft governors' commentary. To support this a draft commentary was prepared with the lead governor, based on the content of last year's report and updating this to ensure it was relevant for 2024/25.

The Standards Committee received the updated draft for discussion and approval.

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

The Standards Committee considered the draft commentary **(Annex A)** for discussion and made a recommendation to the Council of Governos to approve the draft for inclusion in the quality accounts 2024/25.

Action required / Recommendation:

The Council of Governors is asked to:

1. **Approve** the draft of the Governor commentary for the quality accounts (Annex A).
2. Seek **nominations** from governors to act as readers of the quality accounts.

Previously considered by:	Standards Committee (8 April 2025)
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 C: Comments from third parties

WSFT Council of Governors

The Council of Governors (CoG), with support from the Board and Trust colleagues, continues to embrace its role to represent both the interests of the Trust as a whole and the interests of the population that it serves. The Governors recognise and fully support the Board of Directors' commitment to improving the high standard of care for our patients.

The Governors are keen to harness the power of our local community and collaborate with health and care partners as part of the Suffolk and North East Essex Integrated Care System (ICS). We also collaborate with West Suffolk Alliance and regional partners.

The Governors recognise the importance of the West Suffolk Alliance in the delivery of health and care services in the west of Suffolk as well as collaboration with our wider system partners as part of the ICS.

The Lead Governor and Deputy Lead Governor work with the Chair to facilitate effective relations between the Board of Directors and the CoG. This includes joint meetings/workshops with the Board of Directors and attendance of Non-Executive Directors (NEDs) at CoG meetings.

There are three sub-committees of the CoG – the Membership and Engagement Committee, Standards Committee and Nominations Committee.

- **Engagement with members and public:**
    - Governors, in collaboration with Trust staff such as clinical teams, the Trust's engagement team, Future System team and My WiSH Charity, participate in various public engagement activities and events
    - Whilst carrying out engagement activities they encourage members of the public to take interest in Trust services by becoming members of the Foundation Trust. Friends, relatives and acquaintances are also encouraged to join.
    - Members receive regular information about the Trust via a newsletter. They can meet the experts to find out more about modern treatments and how to prevent ill health by attending the 'Medicine for Members' events. Members have voting rights in Governor elections and can stand for election themselves. They are invited to attend the Annual Members' Meeting (AMM) where they can meet and question the Trust Chair, Chief Executive Officer and Governors.
    - The AMM was held in the Apex in September 2024. West Suffolk Hospital landmarked 50-year anniversary and the event focussed on initiatives in diagnostic imaging with a presentation from WSFT research and development team, highlighting some of the innovative research that is being undertaken to support and advance patient care. Governors and Board members attended. In addition to service updates from the CEO and Trust Chair and a review of Governor activities delivered by the Lead Governor
    - Governors join the VOICE meetings as observers
    - Governors are invited to attend as members of the Committee and have a representation on Experience of Care and Engagement meetings a.

- **Governor Engagement Activities:**

    - Governors participate in regular “15 Steps” visits to clinical and non-clinical areas. This is a national initiative from NHS England. Governors, a Non-Executive Director and clinical staff visit a department in order to look at the care provided and the environment as if through the eyes of a patient or visitor. Feedback is given to the department staff
    - Under the guidance of the patient experience team Governors act as ‘secret shoppers’, by positioning themselves in various waiting areas in order to observe the patient experience. Feedback is provided to the department manager
    - Governors join the estates and facilities team to carry out environmental reviews. Department staff and the accompanying estates manager compile action plans with the aim of improving the department environment
    - Governors meet visitors in the Courtyard café and the Newmarket site café in order to conduct a short patient experience questionnaire. The opportunity is taken to have a conversation with the visitor about their experience of the Trust and to encourage them to join as a member.

Working with the Board:

The respective powers and roles of the Trust Board and CoG are set out in their standing orders and Trust Constitution.

- Governors receive the bi-monthly Board meeting agenda and papers. Governors and members of the public have an open invitation to attend these meetings as observers. Questions relating to the agenda may be asked at the appropriate time on the agenda
- Governors do not attend the closed Board meeting where matters of a confidential nature are discussed. However, Governors do have access to the meeting agenda and approved minutes
- An interactive engagement session was organised with the Director of Strategy & Transformation to gather input from Governors on updating the Trust's strategy. The Governors had the opportunity to contribute and found the session very helpful
- Governors volunteer to observe three Board assurance committee meetings (improvement, insight and involvement), on a rota basis. They complete reports on the meetings which, are submitted to the CoG. All Governors will have access to the agenda for these meetings and to the approved minutes. Attendance at these meetings provides insights into the working of the Trust and supports Governors in their role
- The CEO attends CoG meetings and presents a report on which, Governors have opportunity to ask questions
- Executive Directors also attend CoG meetings when they have a specific topic to present, for example, the Executive Director of Strategy and Transformation recently presented the update on transformational programmes and the sustainability review commissioned by SNEE ICB and the Chief Finance Officer provides financial updates
- Governors can request, via the Chair, that specific items are added to a CoG agenda.
- Working with the NEDs has allowed sharing of information to triangulate areas for further consideration and/or improvement
- Governors, through effective questioning, hold the NEDs to account for the performance of the Board
- Governors provide feedback to inform the appraisals of the Chair and all NEDs to a schedule. The Lead Governor and Senior Independent NED (SID) conduct the annual appraisal of the Trust Chair.
- The Lead and Deputy Lead Governors meet with the Trust Chair and Trust and Deputy Trust Secretary monthly

- **Development of knowledge and skills:**

    - A training and development programme was provided for Governors, including a session on how to undertake appraisals for NEDs, and an externally facilitated induction day. The induction day was attended by both Governors and NEDs
    - A recent briefing session was delivered by the Deputy Chief Executive and Director of Strategy and Transformation, Suffolk and North East Essex Integrated Care System to give an overview on SNEE Integrated Care Board and composition, ICB responsibilities, Alliance projects, ICS Strategy and Joint Forward Plan.
    - Governors also received a briefing session on CQC Single Assessment Framework, delivered by Executive Chief Nurse
    - Governors may suggest subjects, they would like to understand better by receiving a brief, to the Trust Secretary or Chair
    - Informal Governors' meetings and joint Governor and NED meetings, facilitated by the Lead Governor, enhance effective working relationships.

The Governors recognise the contribution made by the staff and volunteers and would like to thank them for their dedication and hard work during continued challenging times. We will continue to develop opportunities for engagement with the public and our members over the next year. The feedback we receive helps us understand people's experiences and priorities.

16. Governance Report (enclosed)

To receive the Governance Report

To inform

Presented by Pooja Sharma

NHS
West Suffolk
NHS Foundation Trust

WSFT Council of Governors meeting (Open)	
Report title:	Governance report
Agenda item:	16
Date of the meeting:	14 May 2025
Sponsor/executive lead:	Richard Jones, Trust Secretary & Head of Governance
Report prepared by:	Pooja Sharma, Deputy Trust Secretary Ruth Williamson, FT office manager

Purpose of the report:

For approval ☐	For assurance ☒	For discussion ☐	For information ☒
Trust strategy ambitions			
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 summarises the main governance headlines for May 2025, as follows:

- Register of Interest
- Council of Governors sub-committees 2025

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

This report supports the Council of Governors in maintaining oversight of key activities and developments relating to organisational governance.

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 set out in the body of the report.

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

Governance Report

1. Register of Governors' Interests

The Register of Governors' Interests is reviewed and updated on an annual basis. At each Council of Governors (CoG) meeting declarations are also received for items to be considered as part of the agenda.

Individual Governors are reminded of their responsibility to inform the Chair or Trust Secretary of any changes to their declared interests.

ACTION

The Council of Governors is asked to:

- **receive** and **note** the report and updated Register of Governors' Interests (Appendix A)

2. Council of Governors sub-committees 2025

The Council of Governors has constituted committees to support the council in a range of tasks as follows:

- FT Governors' Nominations Committee
- FT Governors' Membership and Engagement Committee
- FT Governors' Standards Committee
- Staff Governors' Group

Appendix B summarises the membership of these sub-committees.

ACTION

- Note the membership of Council of Governors' sub-committees (Appendix B)

REGISTER OF GOVERNORS' INTERESTS SUMMARY

The register of governors' interests is constructed and maintained pursuant to the National Health Service Act 2006. All governors should declare relevant and material interests. Any changes in interests should be declared at the next Council of Governors meeting following the change occurring.

Signed copies of individual governor's declarations are held by the Foundation Trust office.

Interests which should be regarded as "relevant and material" are:

1. Directorships, including Non-Executive Directorships held in private companies or public limited companies (including dormant companies).
2. Ownership, part-ownership or Directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
3. Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
4. A position of trust in a charity or voluntary organisation in the field of health and social care
5. Any connection with a voluntary or other organisation contracting for NHS services
6. To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the NHS Foundation Trust, including but not limited to, lenders or banks.
7. Any other commercial interest in the decision before the meeting

Supplementary Information: In the case of spouses and cohabiting partners the interest of the spouse/partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

	Declared Interest	Date Reviewed
Trust Chair		
Jude Chin	▪ Director of SSAT (The Schools Network) Ltd ▪ Shareholder of SSAT (The Schools Network) Ltd	30/04/2025

Staff Governors		
Anna Clapton (nee Mills)	▪ None	04/04/2025
John-Paul Holt **(Resigned 26.2.25)**	▪ None	12/12/2023
Louisa Honeybun	▪ Director of Gedunk Ltd – food services company	12/03/2025
Andy Morris	▪ None	13/03/2025
Adam Musgrove	▪ None	13/03/2025
Diana Stroh **(Commenced 11.2.25)**	▪ None	17/03/2025
Nominated Partner Governors		
Dr David Brandon **(Resigned 20.6.24. Rejoined 7.1.25)**	▪ Deputy Medical Director, SNEE ICB ▪ Clinical Director of Unity Healthcare (GP practice) ▪ National Medical Directorate Lead for Gender Incongruence, NHS England	25/03/2025
Sue Jane Kingston	▪ None	27/03/2025
Elspeth Lees **(Resigned 15.10.24)**	▪ None	02/04/2024
Cllr Rowena Lindberg	▪ Sits on Health and Wellbeing Board, Suffolk County Council	07/05/2025
Lisa Parish **(Commenced 27.1.25)**	▪ Group Assistant Principal, West Suffolk College (WSFT is a partner provider of apprenticeships receiving payments from the college)	25/03/2025
Dr Thomas Pulimood	▪ Chair of the Friends of Vellore UK (supporting Christian medical college)	13/03/2025
Cllr Heike Sowa	▪ Director of Richpicks Ltd ▪ Nurse, working for Cambridge University Hospital	12/12/2023
Public Governors		
Carol Bull	▪ West Suffolk Council – District Councillor	25/03/2025
Anna Conochie	▪ None	12/03/2025

Val Dutton	▪ None	27/03/2025
Sarah Hanratty	▪ Sole Director of Footwork Reflexology Ltd – Company Number 15228384	26/.03/2025
Elizabeth Hodder	▪ None	16/03/2025
Robin Howe **(Joined 3.4.25)**	▪ None	11/04/2025
Ben Lord	▪ Director, Speedbird Promotions Ltd ▪ Director, Speedbird Supplies Ltd ▪ Director, Speedbird Concorde Ltd ▪ Director Finn Associates Ltd	26/03/2025
Gordon McKay	▪ None	27/03/2025
Tom Murray	▪ None	13/03/2025
Jayne Neal	▪ Volunteer on Patient Participation Group at GP practice, Market Cross Mildenhall.	19/03/2025
Adrian Osbourne	▪ District Councillor – Babergh District Council	03/04/2025
Rebecca Poynter	▪ Company Secretary – Belchamp Consulting Services Ltd	19/03/2025
Clare Rose	▪ Account Manager for Crown Commercial Service, supporting customers in the East of England with non-clinical health procurement. West Suffolk Hospital and SNEE are current customers. Role does not contract or commission services but does support those that do. ▪ Partner, Michael Woodroof, has 50% share of a local electrical business (PP Electrics). They have previously completed work at West Suffolk Hospital, both as the primary and secondary contractors	07/05/2025
Michael Simpkin **(deceased 27.2.2025)**	▪ Trustee of the Memories Are Golden organisation, which specialises in offering day care services to individuals with long term challenges and conditions ▪ Volunteer for Citizens Advice West Suffolk ▪ Involved with the following organisations, as a member of the public; WSFT Virtual Wards Haverhill Locality Group	22/12/2023

	Suffolk Pharmacy	
Jane Skinner	▪ Volunteer on reception at West Suffolk Hospital	18/03/2025

Council of Governors sub-committees May 2025

FT COUNCIL OF GOVERNORS' NOMINATIONS COMMITTEE

Committee Members	Title
Carol Bull	Public Governor
Jude Chin	Trust Chair (committee chair)
Ben Lord	Public Governor (deputy lead governor)
Andy Morris	Staff Governor
Jayne Neal	Public Governor
Adrian Osborne	Public Governor
Thomas Pulimood	Partner Governor
Jane Skinner	Public Governor (lead governor)
Heike Sowa	Partner Governor

FT COUNCIL OF GOVERNORS' MEMBERSHIP & ENGAGEMENT COMMITTEE

Committee Members	Title
Sarah Hanratty	Public Governor (committee chair)
Liz Hodder	Public Governor
Robin Howe	Public Governor
Lisa Parish	Partner Governor
Becky Poynter	Public Governor
Diana Stroh	Staff Governor
Jane Skinner	Public Governor (lead governor)

FT COUNCIL OF GOVERNORS' STANDARDS COMMITTEE

Committee Members	Title
Carol Bull	Public Governor
Jude Chin	Trust Chair (committee chair)
Liz Hodder	Public Governor
Anna Mills	Staff Governor
Jane Skinner	Public Governor (lead governor)
VACANCY	Partner Governor

FT STAFF GOVERNORS' GROUP

Staff Governors	Title
Anna Clapton (nee Mills)	Staff Governor
Diana Stroh	Staff Governor
Louisa Honeybun	Staff Governor
Sue Kingston	Partner Governor (Trust & Friends volunteers)
Andy Morris	Staff Governor
Adam Musgrove	Staff Governor

ITEMS FOR INFORMATION

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

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

To Note

Presented by Jude Chin

WSFT Council of Governors Meeting (Open)	
Report title:	Summary Report for Board of Directors meetings
Agenda item:	17
Date of the meeting:	14 May 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 – March 2025			
Patient Story – The Board heard of the approach undertaken by the Day Surgery Unit in making reasonable adjustments for a patient with complex needs requiring dental surgery.	• To demonstrate reasonable adjustments for patients with complex needs.	• Model for future care	Verbal
CEO Report – 65 and 78 week waits anticipated to be cleared by end of March. Board encouraged to visit staff and listen to their thoughts and ideas.	-	-	
WSFT Strategy – work on the strategy being undertaken and will align with the Sustainability Review.	• Ongoing assurance/monitoring	• Deliver the Trust strategy	
Future System Board Report – Updated report received and noted.	• Ongoing assurance/monitoring • Board to receive future updates	• Sustainable service improvements	
West Suffolk Alliance and SNEE Integrated Care Board: ***Virtual Ward*** – paper reflective of direction of travel for step-up provision and measures to enhance this.	• Strengthened provider collaboration	• Focus on system working	
Digital Board Report – new Patient Portal is now live, using simpler registration via the NHS app. Digital services face a challenging time in terms of resource and therefore are identifying priorities.	• Ongoing assurance/monitoring	-	
Collaborative Oversight Group – Trusts to take stock of how collaboration is working in light of the Sustainability Review.	• Strengthened provider collaboration	• Focus on system working	

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
IQPR Report – Urgent & Emergency Care. Noted a step change in performance, with an improvement in elective and cancer. Nutritional assessments under review and issue of post-partum haemorrhage coming back to Improvement Committee. A deep dive at Improvement of C-difficile has demonstrated use of robust audit data. Concern regarding sickness levels and staff turnover within the Estates and Facilities directorate. A leadership change is taking place. No impact on overall sickness levels identified within the current financial climate. Wellbeing services are being offered to staff.	• Ongoing assurance/monitoring	-	
Finance Report – Trust in process of actioning year end and remains confident of achieving the £26.5m deficit.	• Ongoing assurance/monitoring	• Financial sustainability	
Operational Planning Guidance – guidance approved at Insight Committee and brought to Board for information. Trust is compliant in its submission for all operational planning targets.	• Ongoing assurance/monitoring	-	
Capital Planning 2025-26 – approved at Insight Committee and brought to Board for information.	• Ongoing assurance/monitoring	-	
Involvement Committee – congratulations offered to Jamais Webb Small, Organisational Development Manager and her team for excellent examples of EDI in education and training.	• Ongoing assurance/monitoring	-	
People & OD Highlight Report – awards noted and thanks offered to staff concerned.	• Recognition of staff.	-	
Insight Committee – report noted.	• Ongoing assurance/monitoring	-	

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Improvement Committee – report noted.	• Ongoing assurance/monitoring	-	
Quality and Nurse Staffing Report – January and February challenging in terms of sickness levels and requirement for additional capacity. This is now improving, indicative of the end of the Flu season. Mitigations in place for day fill rates. Trust working with national team on review and update of national profiles for registered nurses and utilisation and impact of 1:1 specialling.	• Ongoing assurance/monitoring • Overseeing quality indicators	-	
Maternity Services – challenge presented in meeting the core competency framework requirement for multi professional training, which is required to be face to face. However, core competency framework requirements are being met.	• Ongoing assurance/monitoring in areas of priority	-	
Audit Committee – reported noted and update to policies approved.	• Board visibility and oversight	-	
Governance Report - reported noted and update to policies approved.	• Board oversight	-	
Any Other Business – The Board gave its thanks to Jeremy Over, following his resignation from the role of Executive Director of Workforce & Communications.	-	-	Verbal

18. Dates for meetings for 2025:

- 11 September, 2025
- 13 November, 2025
- Annual Members' Meeting - TBC

To Note

Presented by Jude Chin

19. 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 - February, 2025

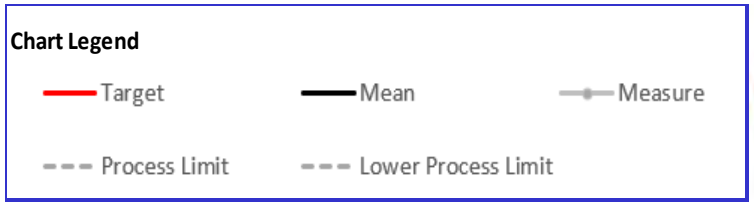
Assurance Grid

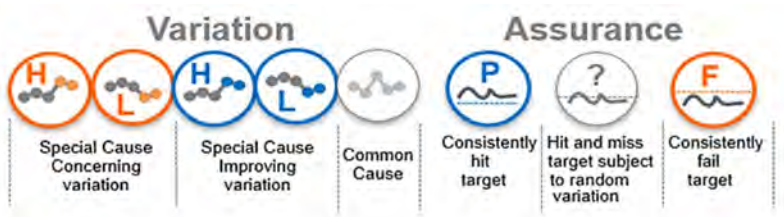
Performance in February 2025	ASSURANCE: Will we reliably meet the target based?		Not Met	
	Pass	Hit and Miss	Fail	No Target
VARIANCE: Variation from the mean The colours indicate the trend- positive (blue), Negative (orange), or neither (grey) — Special Cause Improvement		**INVOLVEMENT** Staff Sickness – Rolling 12months Staff Sickness Mandatory Training Turnover	**INSIGHT** Virtual Ward Total average occupancy number RTT 78+ Week Waits **INVOLVEMENT** Appraisal	**INSIGHT** RTT 65+ Week Waits Potential 65+ ww at end of Feb 2025 RTT NDD Only Waiting List RTT NDD Only 65 Waiting List **IMPROVEMENT** SHMI **INVOLVEMENT** Total PALS resolved Count
Common Cause	**INSIGHT** Urgent 2 hour response – EIT Virtual Ward Total average LOS per patient	**INSIGHT** Ambulance Handover within 30min Non-admitted 4 hour performance % patients with no criteria to reside Virtual Beds Trajectory Virtual Ward Total average occupancy percentage 28 Day Faster Diagnosis Cancer 62 Days Performance Community Paediatrics RTT Overall 78 Waiting List Community Paediatrics RTT Overall 104 Waiting List **IMPROVEMENT** C-diff Hospital & Community onset, Healthcare Associated	**INSIGHT** 12 Hour Breaches 4 hour performance 12 hour breaches as a percentage of attendances Incomplete 104 Day Waits Diagnostic Performance - % within 6weeks Total	**INSIGHT** Criteria to reside – Acute Criteria to Reside – Community Virtual Ward Total bed days Community Paediatrics RTT Overall Waiting List Community Paediatrics RTT Overall 65 Waiting List RTT NDD Only 78 Waiting List RTT NDD Only 104 Waiting List **IMPROVEMENT** % of patients with a MUST/PYMS assessment completed within 24 hours of admission Post Partum Haemorrhage Inpatient Deaths **INVOLVEMENT** Active complaints Closed complaints % extended Count extended % Complaints responded to late % resolved in one week
Special Cause Concern				**INSIGHT** RTT Waiting List Community Paediatrics RTT Overall 52 Waiting List RTT NDD Only 52 Waiting List **IMPROVEMENT** % of patients with Measure Weight

Deteriorating

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, 4 hour performance, 12 hour breaches as a percentage of attendances, Virtual Ward Total average occupancy number
Cancer: Incomplete 104 Day Waits
Elective: Diagnostic Performance - % within 6weeks Total, RTT 78+ Week Waits
INVOLVEMENT – Well Led: Appraisal

INSIGHT COMMITTEE METRICS

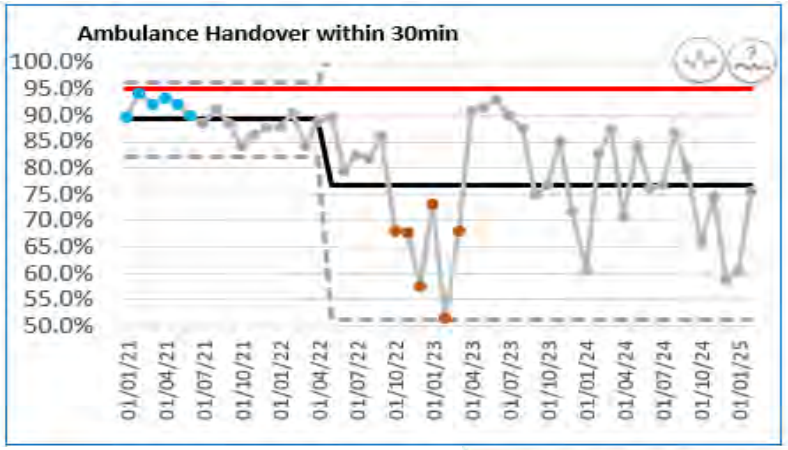


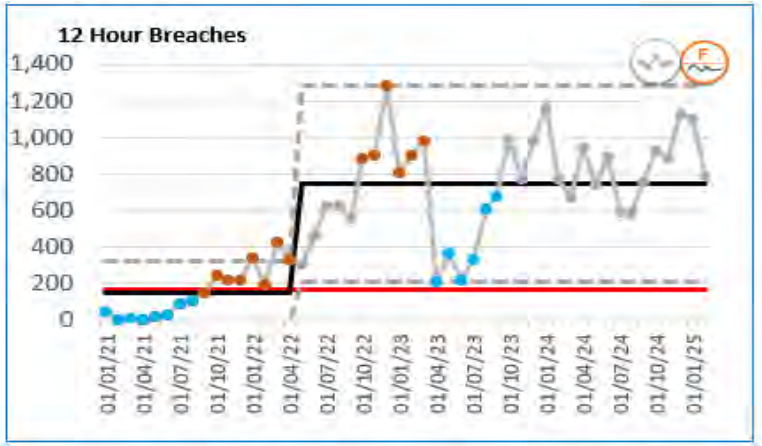


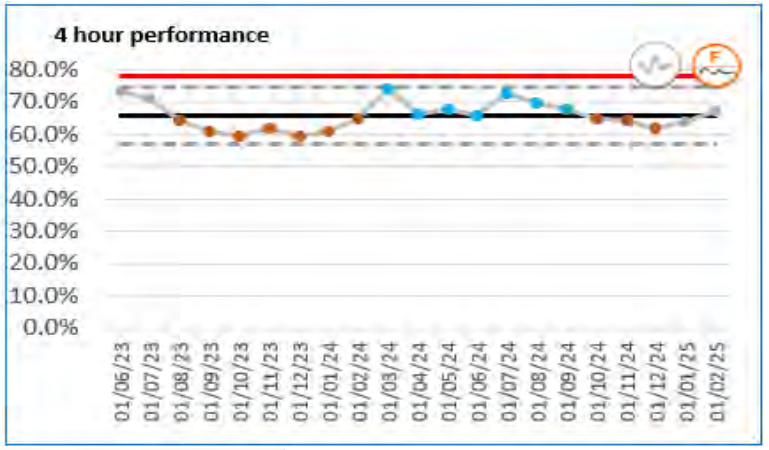
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover within 30min	Feb 25	75.7%	95.0%			76.7%	51.1%	102.2%
12 Hour Breaches	Feb 25	789	167		F	749	215	1282
4 hour performance	Feb 25	67.1%	78.0%		F	65.8%	57.0%	74.6%
Non-admitted 4 hour performance	Feb 25	78.8%	85.0%			76.0%	65.8%	86.3%
12 hour breaches as a percentage of attendances	Feb 25	10.7%	2.0%		F	9.5%	2.9%	16.1%
Urgent 2 hour response - EIT	Feb 25	93.4%	70.0%		P	90.8%	83.3%	98.3%
Criteria to reside (Average without reason to reside) Acute	Feb 25	55				55	41	69
**Criteria to reside (Average without reason to reside) Community	Feb 25	38				35	23	48
% patients with no criteria to reside (acute)	Feb 25	12.8%	10.0%			12.7%	8.8%	16.5%
Virtual Beds Trajectory	Feb 25	44	40			42	38	46
Virtual Ward Total average occupancy number	Feb 25	36.3	47.2	H	F	23.8	15.4	32.1
Virtual Ward Total average occupancy percentage	Feb 25	67%	80%			68%	43%	92%
Virtual Ward Total bed days	Feb 25	982				728	284	1172
Virtual Ward Total average LOS per patient	Feb 25	6.5	14.0		P	8.9	4.9	12.9

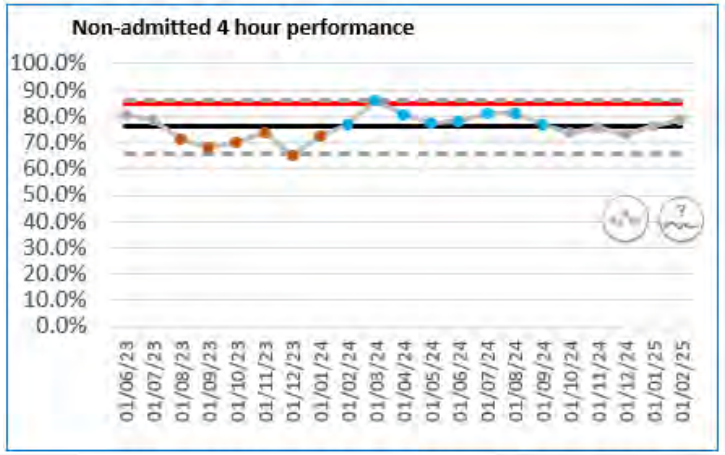
** Figures are for Glastonbury and Newmarket only, data not currently captured at Hazel Court.

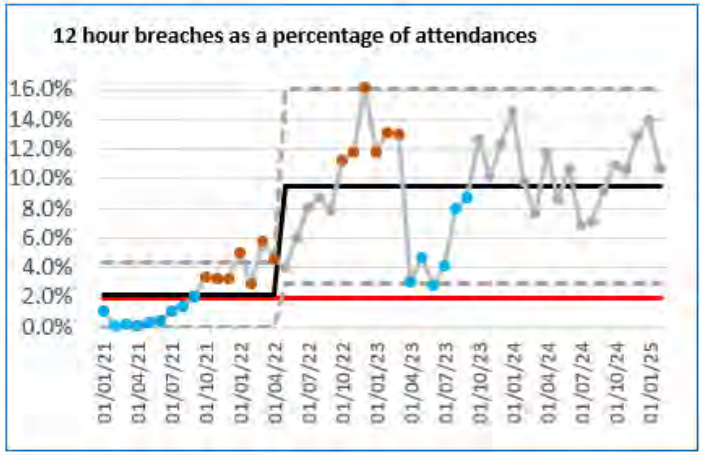
Urgent & Emergency Care: ED 4 Hour Performance

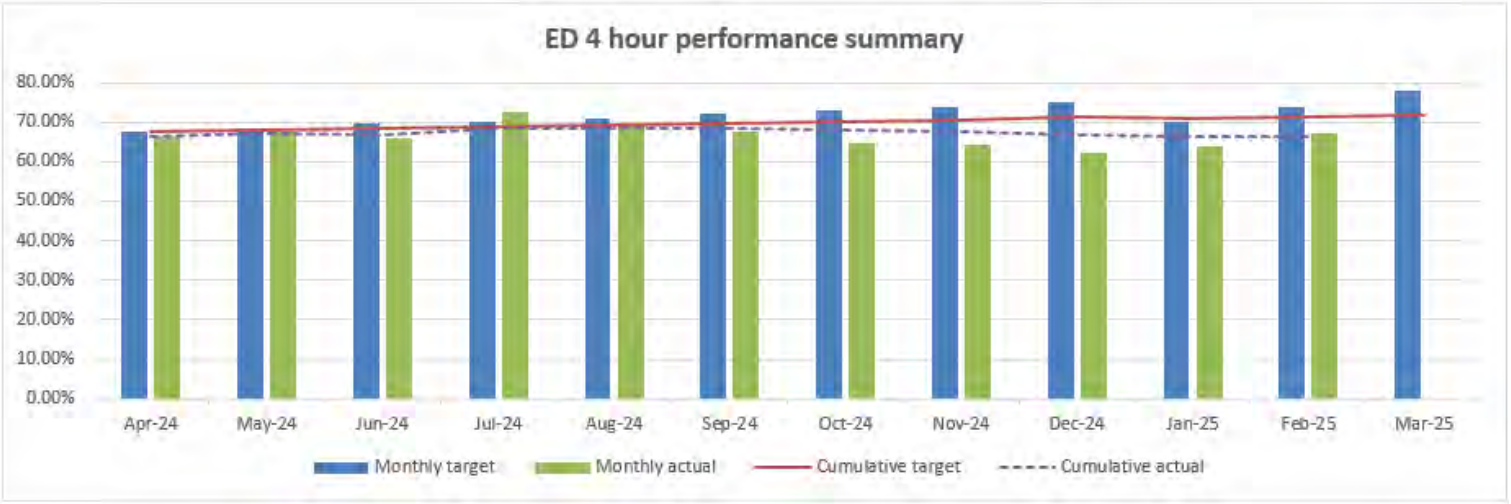












Urgent & Emergency Care

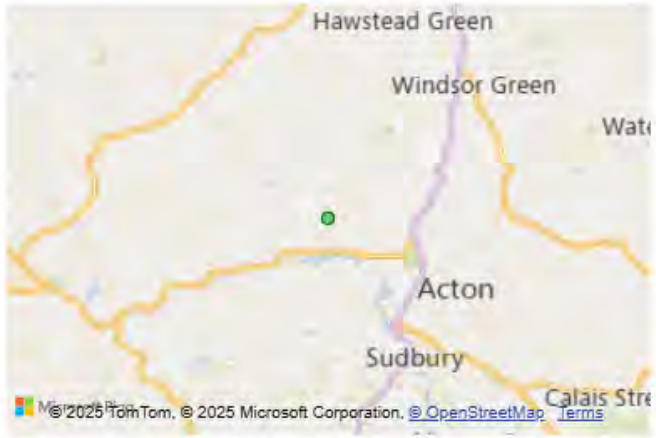
What	So What?	What Next?
30 minute ambulance handover metric, demonstrates no significant change. The main cause being high numbers of patients waiting a bed in the Emergency Department, resulting in the need to use additional cohorting areas. 12 hour length of stay breaches in January continued to show a failing picture. Numbers of 12 hour breaches as a percentage of attendances remains high and a cause for concern. Non-admitted performance shows no significant change with 78.8% achieved for February. The Emergency Department 4 hour performance for January was 67.1%, which was below the in-month trajectory of 70%.	Meeting the Urgent and Emergency Care (UEC) performance metrics is key to ensuring that our patients receive timely, safe care. Achieving the ambulance handover metrics and the 78% 4 hour Emergency Department standard will meet national targets. Achieving the monthly trajectory will keep us on track to achieve 78% by March for the 4 hour standard. Patients are waiting longer in the Emergency Department than they should be and being nursed in escalation areas, making for a poorer patient experience.	An internal Urgent and Emergency Care delivery group with workstream leads is in operation., continuing to working through a condensed action plan in order to achieve 78% 4hr Emergency Department target by March '25. Weekly performance meetings with the Emergency Department and Medical Division Senior Leaders/Executives continues. **Plans/Projects March'25** • March Focus Action Plan developed, key areas include: Increased senior manager presence supporting performance at weekends and 5-9pm as an extension of current daily rota. Additional porter during key times to ensure smooth transfer of patients. Extended hours of MECU until midnight to support the minor injury/illness patients. Increased presence of surgical registrars in the Emergency department, Working to increase the number of patients taken to ambulatory areas such as Same Day Emergency Care/ ambulatory units. Emergency Intervention Team (EIT) based in ED in March. Focus on short stay work on Ward F7. • Currently as of 25th March '25 our month to date performance stands at 87.24% • Work is underway to determine what has made a difference in March and what we can replicate to ensure our performance is maintained. **Other Projects** • Relocation of MECU to outpatient D is being planned with the aim to move there on the 11th April. • Pre booked next day returner Emergency Nurse Practitioner slots to support minor injuries attending after 10pm continues. **Longer term** Focus of the division in 2025 is Frailty transformation with an emphasis on Frailty being embedded within the community, this will include exploring a Frailty Hub being located away from the acute side to release UEC pressure.

Community Access Glemsford Surgery

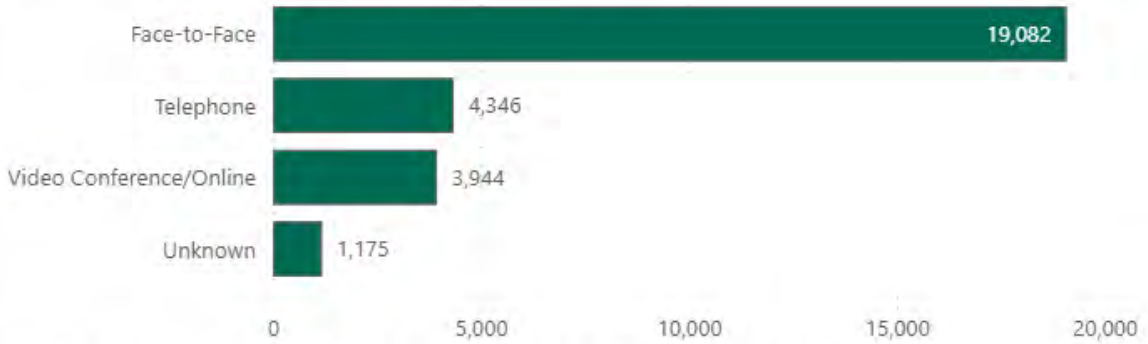
Practice Appointments

Refreshed on 15/01/2025, Data coverage up to 01/11/2024

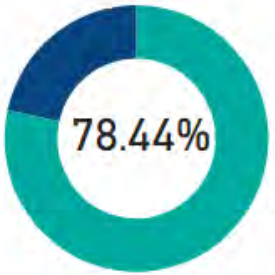
Alliance All | **PCN** All | **Practice** Glemsford



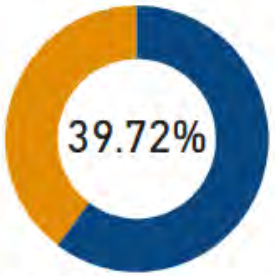
Practice appointments by contact mode



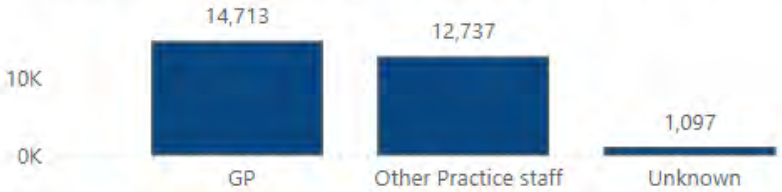
Seen within 2 weeks



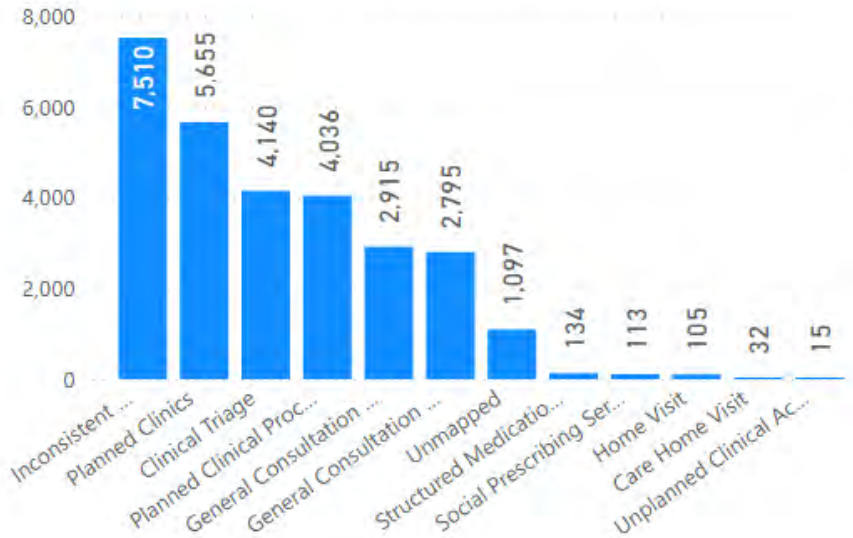
Seen within 48 hours



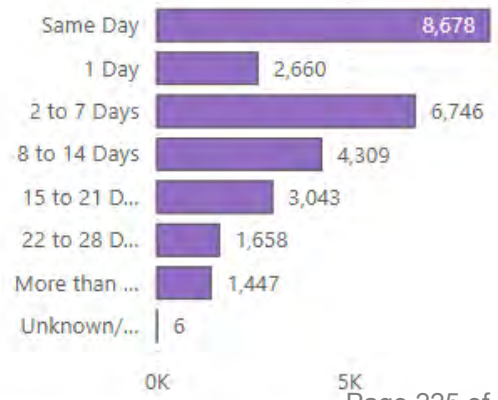
Practice appointments by health care professional type



Sum of Total Appointments by National Category



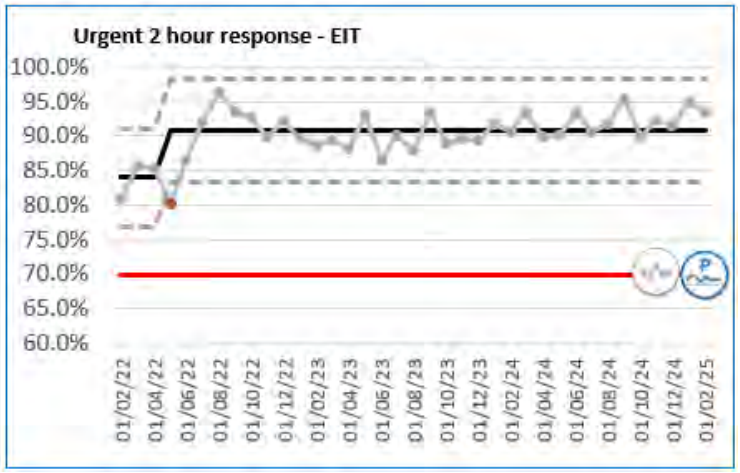
Appointments by wait time

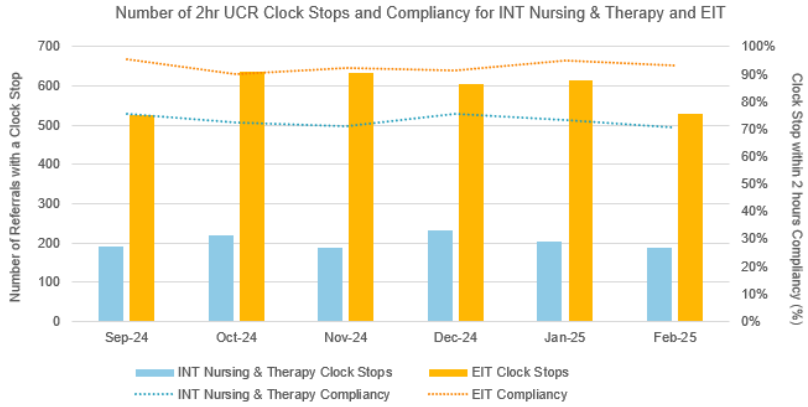


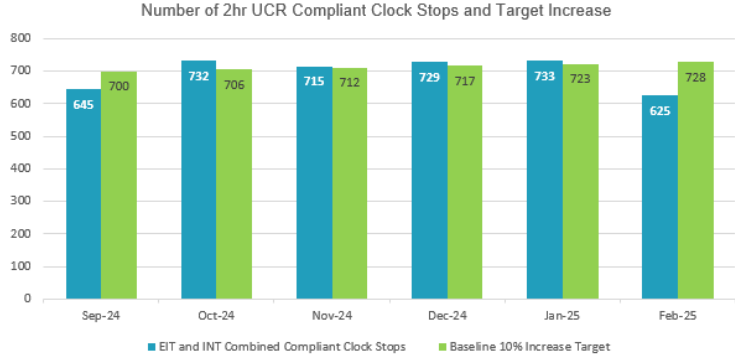
Total appointments by month

Invalid settings provided for all observations! First error:

Assurance icons require an alternative target and a non-neutral improvement direction







Team	Sep-24				Oct-24				Nov-24				Dec-24				Jan-25				Feb-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	191	144	47	75%	220	159	61	72%	186	132	54	71%	231	175	56	76%	203	149	54	73%	186	131	55	70%
Total EIT*	525	501	24	95.43%	637	573	64	89.95%	632	583	49	92.25%	605	554	51	91.57%	615	584	31	94.96%	529	494	35	93.38%
Combined Total	716	645	71	90.08%	857	732	125	85.41%	818	715	103	87.41%	836	729	107	87.20%	818	733	85	89.61%	715	625	90	87.41%

What

There has been no significant change with urgent 2 hour response at 93.38%. The number of referrals decreased; 529 patients had a clock stopped in February compared to 615 in January. This indicates that EIT will continue to achieve the target.

ED performance has increased from 56.6% in January to 61.2% in February. Referrals stayed consistent with 166 in January & 165 in February. This indicates that Early Intervention Team (EIT) will not achieve the 70% target without change.

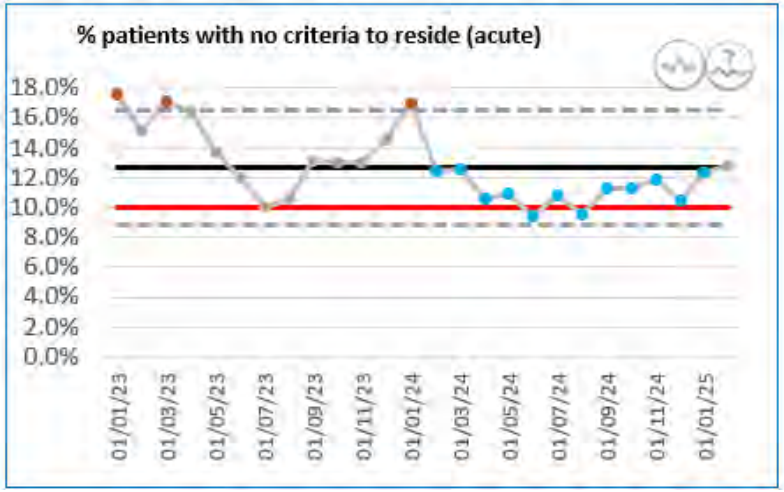
So What?

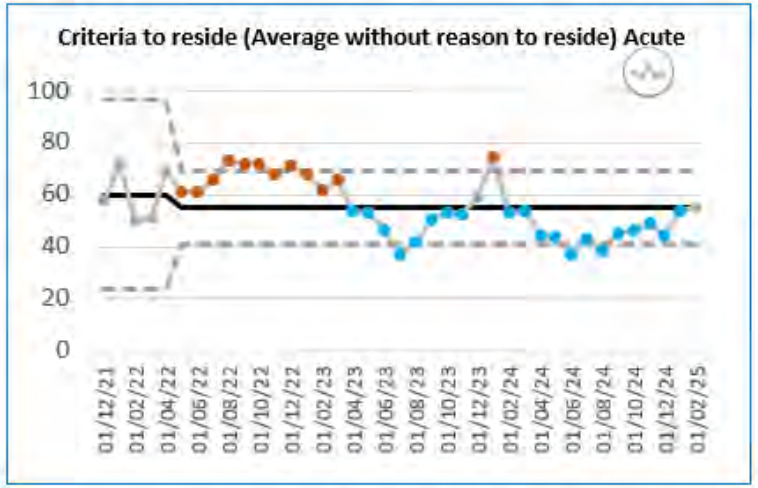
EIT continues to prioritise CCC community referrals, ED and AAU. This impacts capacity to support cleric ambulance referrals.

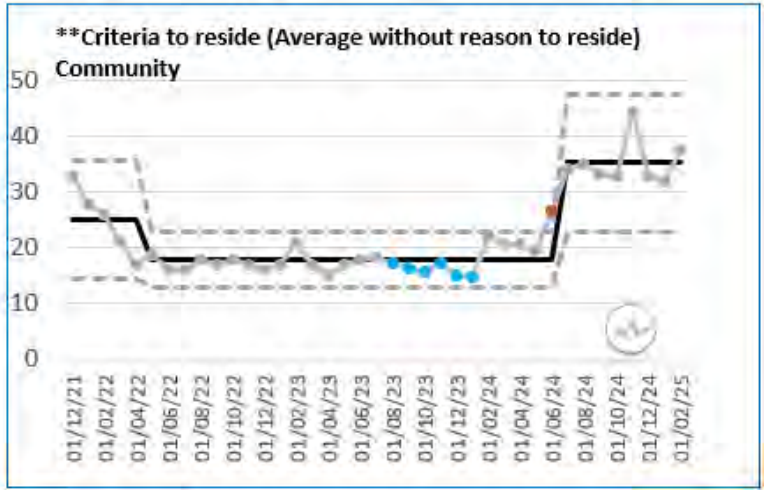
Current staffing model has limited scope to improve ED response time. Not meeting the 15 minute response time could have a negative impact on wait time within ED.

What Next?

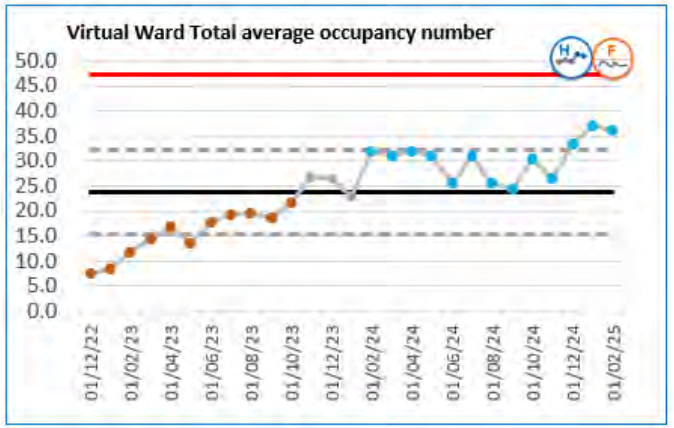
EIT have temporarily increased therapy staffing in ED with support from the acute therapy teams and are basing themselves in ED for a trial period during March. The community INT therapy teams are prioritising referrals that were previously EIT Reflections and learning from the pilot will inform the future service delivery model for front door EIT provision.

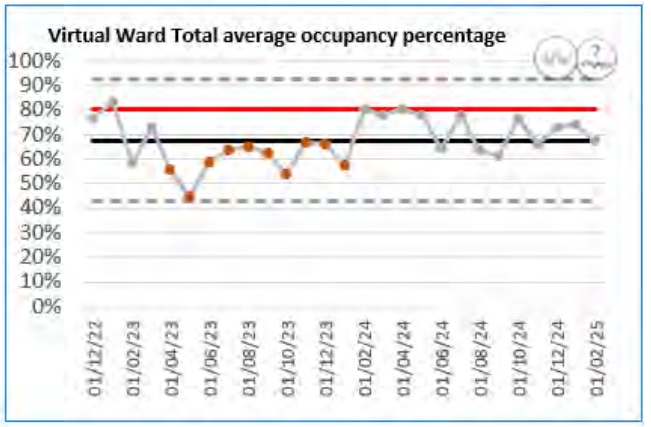


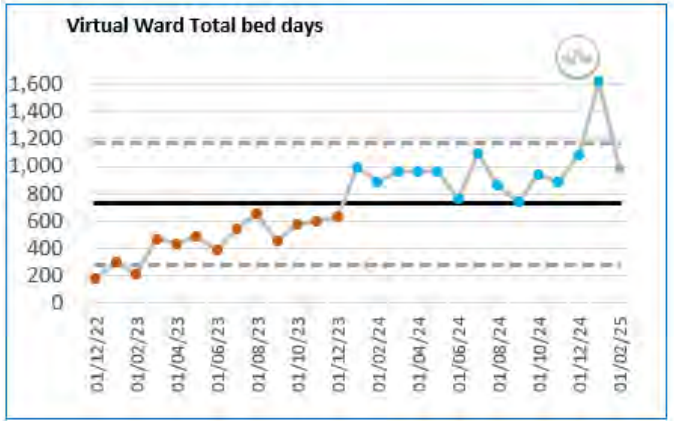


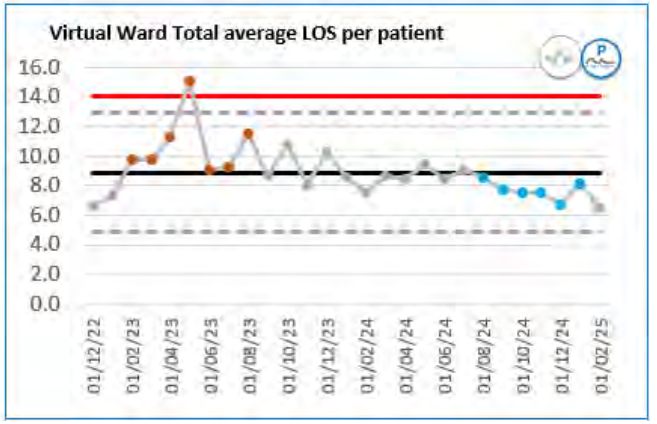


What	So What?	What Next?
There has been no significant change with no criteria to reside performance this month in both acute and community figures. February saw discharges and NCTR challenged by infection prevention issues with a number of pathway 2, pathway 3 and returning care home residents remaining in hospital due to being on closed wards with norovirus, covid and flu.	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.	Implementation of the Community Taskforce priority recommendations with the aim to support early identification of possible discharge delays, identification of alternative pathways and reduction in numbers of patients with no criteria to reside >24 hours. Work to increase the scope of the Out of County Discharge Planning Practitioner role is underway to widen support to all three community assessment bed settings.



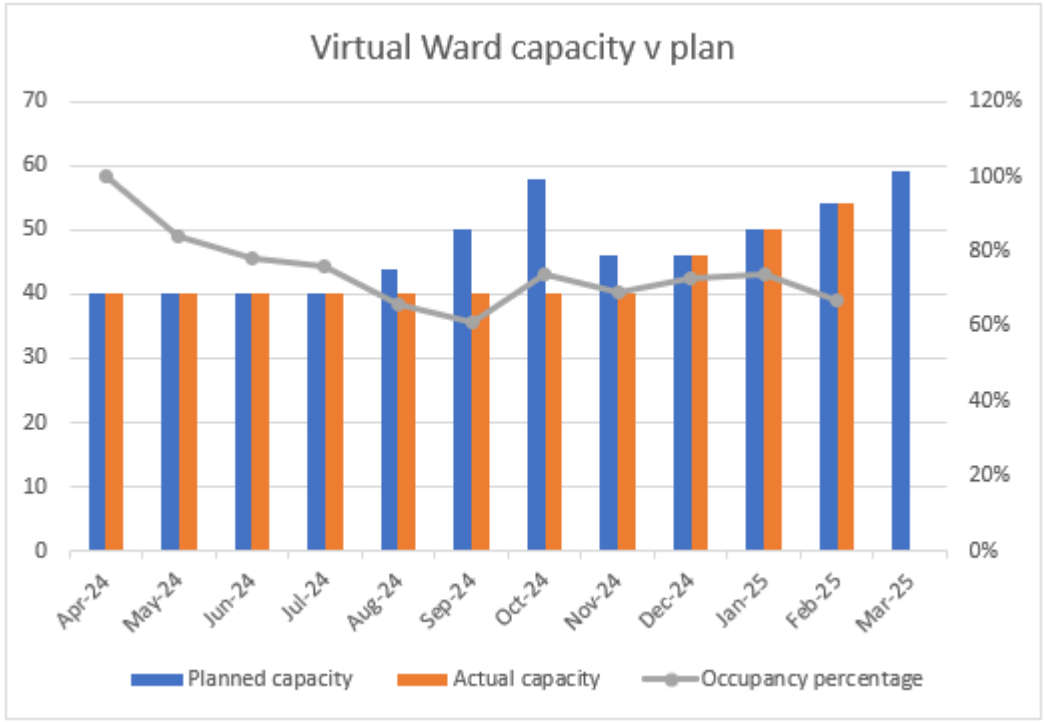






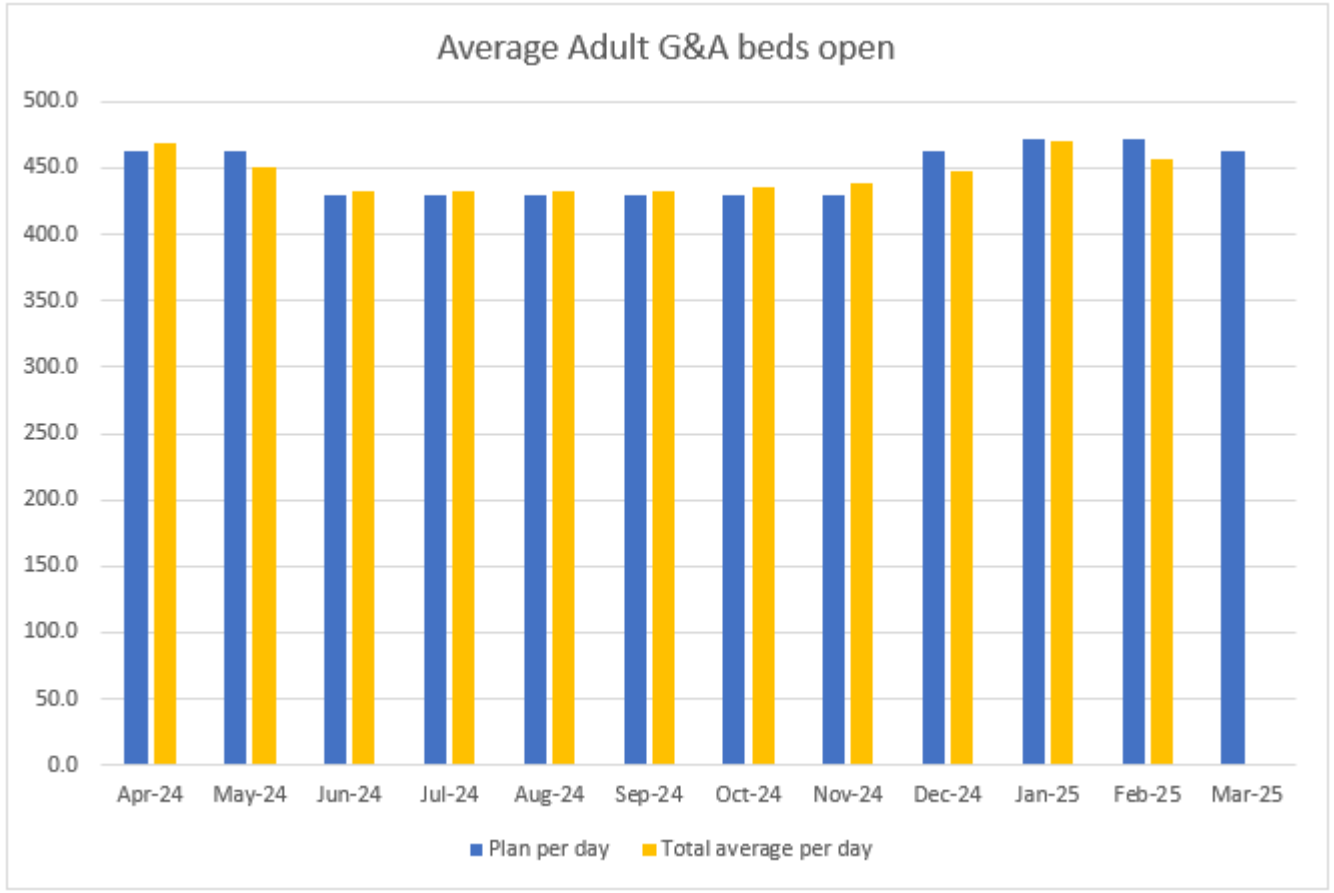
What	So What?	What Next?
The average number of acute patients cared for virtually during the month of February was 36.3 (compared to 37 during January). Average utilisation rate was 67% (representing a decrease compared to January's performance of 74%). When considering average utilisation for the month it should be noted that virtual capacity increased from 50 to 54 during this period, and that average length of stay reduced from 8.0 days to 6.5 days.	Virtual Ward (VW)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.	Pilot with four primary care practices to step up directly from primary care to virtual care (on frailty pathway) to go live on 1 April 2025. Position paper submitted to Public Board during March outlining plans to enhance step up admissions to virtual ward.. Pilot of paediatric virtual ward concluded with evaluation going to Investment Panel during April.

Urgent & Emergency Care (TRUST – Virtual Ward)



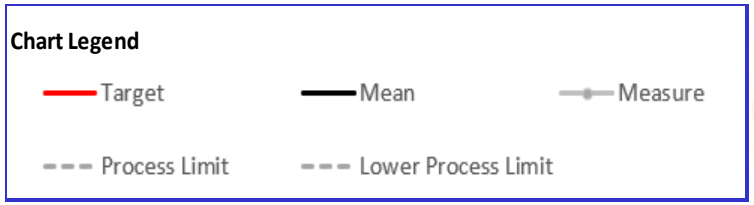
What	So What?	What Next?
Capacity to care for patients on our virtual ward has increased monthly this quarter in line with the trajectory agreed with MEG on 13 Nov 2024 (Dec 46, Jan 50, Feb 54).	Virtual Ward capacity is crucial in ensuring adequate capacity to enable patient flow across the Trust and 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.	New Consultant appointed as a joint Virtual Ward Consultant/Community Geriatrician to provide clinical leadership and support further integration along with increase in step up activity. Process improvements identified at recent review implemented alongside staff consultation to relocate core VW nursing and therapy teams into Bury Town and Bury Rural INTs as part of Shared Services Delivery programme.

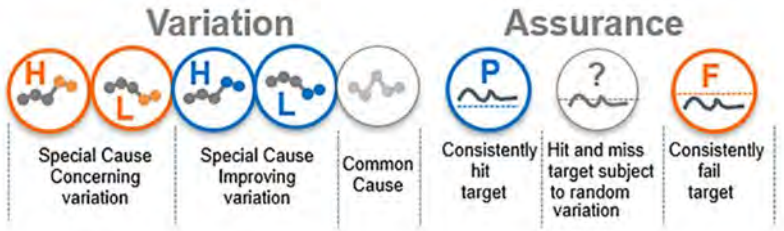
Urgent & Emergency Care: Beds



What	So What?	What Next?
February 2025 saw the average core beds open remain constant in line with the use of the winter escalation ward throughout Q4. Use of escalation beds decreased further, though are above the annual average given their increased in response to operational pressures alongside other escalation spaces in line with our Tactical Patient Flow Escalation Plan.	Maintaining core beds open as per plan is a key requirement of the NHS 2024/25 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.	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. Given current numbers of patients waiting >12 hours and for admission in the Emergency Department, it is likely that the increase in bed capacity through the winter escalation ward will be required through March 2025. A taskforce led by Medicine and Community and Integrated Therapies is reviewing ward processes in March to expedite discharge, reduce length of stay and enable the winter escalation ward to safely close.

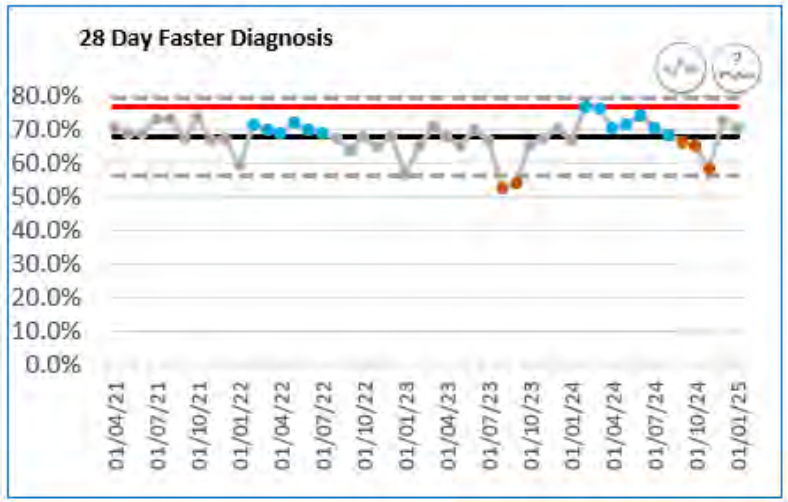
Cancer Access Summary

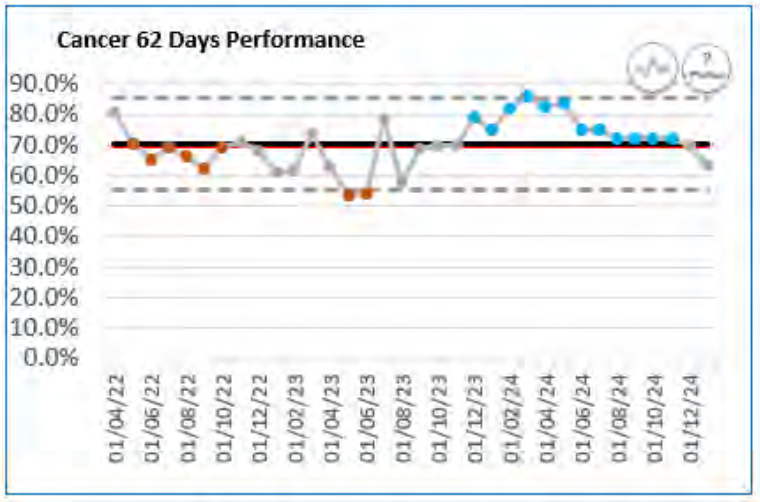


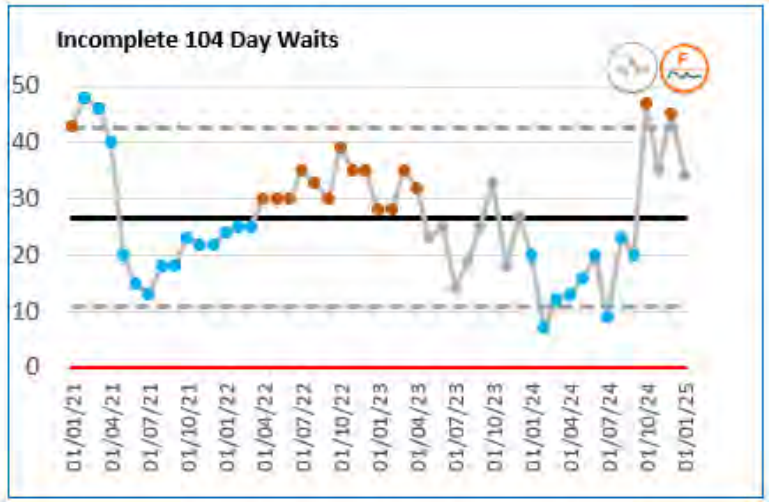


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	Jan 25	70.6%	77.0%			68.1%	56.4%	79.7%
Cancer 62 Days Performance	Jan 25	63.7%	70.0%			70.5%	55.3%	85.7%
Incomplete 104 Day Waits	Jan 25	34	0			27	11	42

Cancer Access (Month Behind)

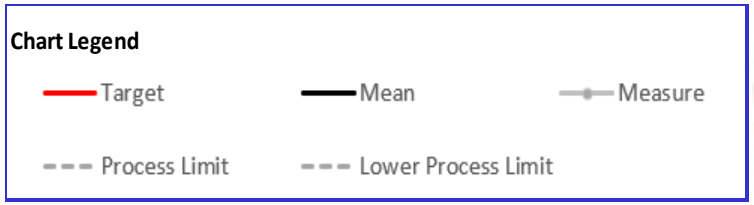


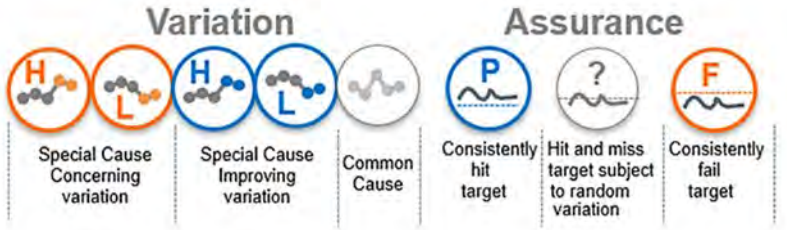




What	So What?	What Next?
Slight dip in faster diagnosis performance for January at 70%, however this drop is in line with national expectations. Skin performance continued to improve at 86% and Breast sustained at 76%. February faster diagnosis performance is set to improve, with the ambition to achieve 77% by March 2025. 62 Day performance did drop to 63.7% in January, again this is expected and in line with normal trends. Skin was the main driver here with performance at 22%. However improvements are being seen in the February and March booking data, as the front end of the pathway continues to improve and the overall 62 day backlog reduces.	Recovering the cancer standards is key to the operational planning guidance 24/25 The priorities for this year focus on seeing, diagnosing and treating patients in line with national guidance to improve patient outcomes and maintain standards.	Task and finish group established for Skin pathway including community teledermatology provision, with a view for revised pathway to be in place by Q3. 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. For Lower GI, allocation of surgical cases is a focus with an agreement now in place to review 62-day breach dates when allocating cases in MDT. Submit planning trajectories, alongside the cancer operational delivery plan for 25/26.

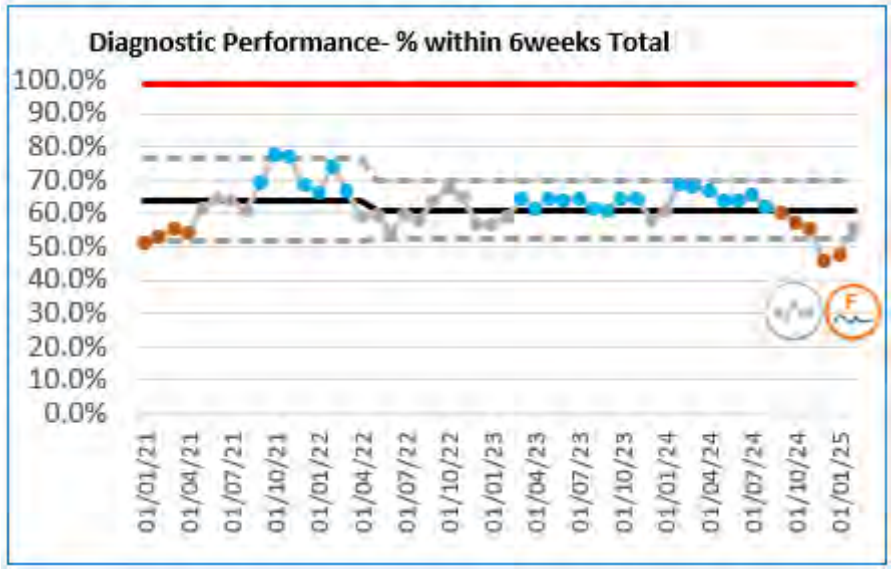
Elective Access: Summary





KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Diagnostic Performance- % within 6weeks Total	Feb 25	55.2%	99.0%		F	60.9%	52.1%	69.6%
RTT Waiting List	Feb 25	35017		H		33052	31779	34324
RTT 65+ Week Waits	Feb 25	70		L		420	243	597
RTT 78+ Week Waits	Feb 25	8	0	L	F	133	73	193
Potential 65+ ww at end of Feb 2025	Feb 25	70		L		557	-325	1438
Community Paediatrics RTT Overall Waiting List	Feb 25	530	-			505	447	562
Community Paediatrics RTT Overall 52 Weeks Wait	Feb 25	6	-	H		1	-2	4
Community Paediatrics RTT Overall 65 Weeks Wait	Feb 25	0	-			0	0	0
Community Paediatrics RTT Overall 78 Weeks Wait	Feb 25	0	0		?	0	0	0
Community Paediatrics RTT Overall 104 Weeks Wait	Feb 25	0	0		?	0	0	0
RTT NDD Only Waiting List	Feb 25	6	-	L		47	18	76
RTT NDD Only 52 Weeks Wait	Feb 25	4	-	H		1	0	2
RTT NDD Only 65 Weeks Wait	Feb 25	0	-	L		0	0	1
RTT NDD Only 78 Weeks Wait	Feb 25	0	-			0	0	1
RTT NDD Only 104 Weeks Wait	Feb 25	0	-			0	0	0

Elective Access

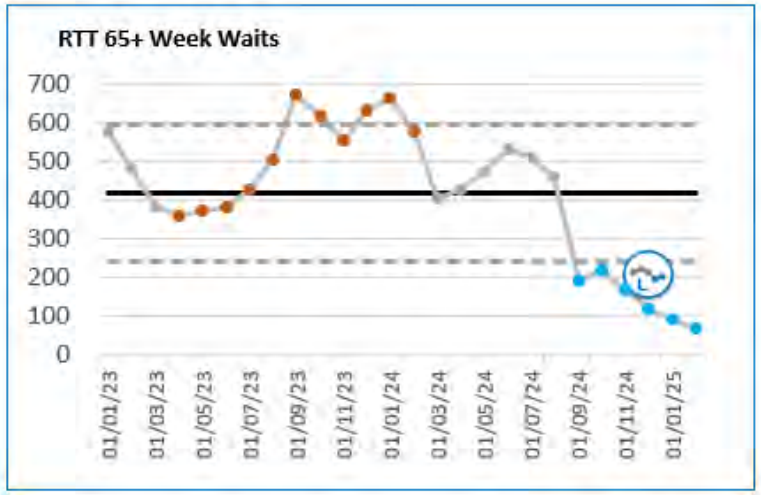


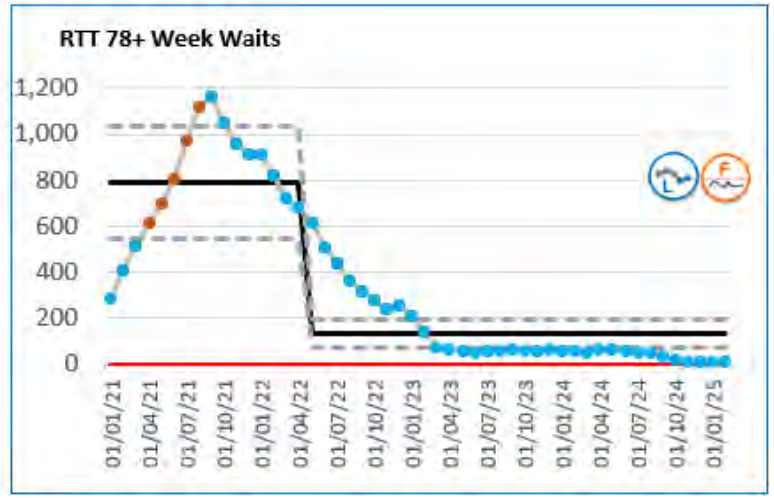
Diagnostics

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 May 2025. **CT** – Currently meeting DM01 compliance target. **A diagnostic recovery plan has been agreed for US, endoscopy, and DEXA, including the use of available Cancer Alliance funding. However, overall DM01 compliance is constrained by the volume of US patients.** **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. Performance remains vulnerable until recruitment improves, including capacity at the CDC. MSK US injections remain challenged despite trying to secure temporary staffing , performing only about five injection examinations per week. With the current demand, patients are expected to wait an average of 30 weeks as of PTL on 09/03/2025. With additional lists and growing activity numbers within CDC, a steady increase in DM01 performance can be observed and forecast recovery by October 2025. **DEXA** – Anticipated go live now end of June 2025. all element of the project on track but scanner suppler now in production difficulties due to a Field Service Notice. A loan scanner is being sought free of charge from the supplier due to the delays and confirmation is expected imminently. 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 plateauing of DM01 performance. Impact of financial recovery is being seen on DM01 target compliance. A successful bid for cancer funding for 25/26 is anticipated which would support stabilisation of the endoscopy cancer demand but routine endoscopy performance will plateau. **Breast Imaging** - Staffing issues have and will continue to impact the delivery of the screening service and overall cancer performance. To mitigate the risk to the service the department was employing two full time agency mammographers to help support the running of the screening and symptomatic services. However, due to financial restraints across the Trust this was reduced to one mammographer. 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 Radiographer to the service the outcome of recent interviews is pending.	Longer waiting times for diagnosis and treatment have a detrimental effect on patients. Delay in achieving DM01 compliance standards.	**MRI** – The delivery of the CDC will see MRI reaching DM01 compliance in May 2025. **CT** – Compliant. **US** – Staffing issues remain unresolved, and CDC capacity will not be realised until recruitment picture improves. Management team continue to review recruitment options aligned to CDC and cognisant of the workforce controls in place around financial recovery. Forecast recovery by October 2025 **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** - Investment panel ,MEG and ICB Double Lock Panel have approved the request for recruitment of a permanent Consultant Breast Radiographer. Short term, requests for bank / agency to fill gaps and ensure service provision is being sought via the TSCP.

Diagnostics

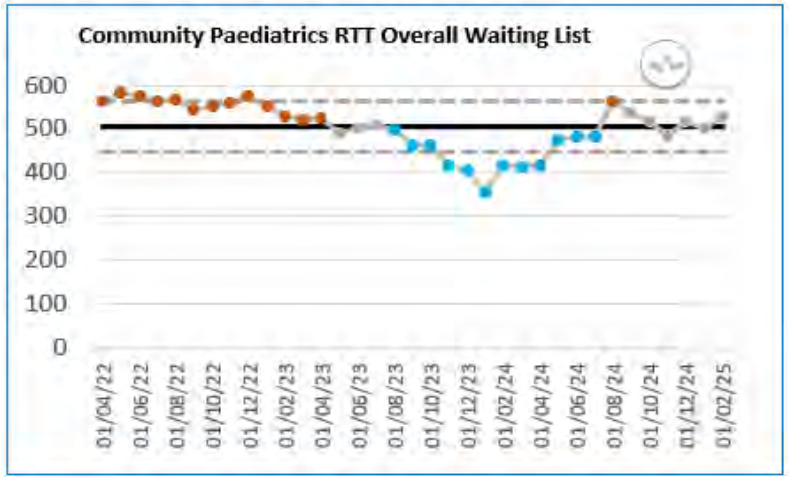
What	So What?	What Next?
AUDIOLOGY- Audiology DM01 saw a 9.3% improvement in February, at **58.2%.** This improvement is driven by validation, noting the team cannot achieve diagnostic target attainment without the provision of another soundproof booth, this facilitated via the Newmarket estates work programme. The acute audiology team are collaborating with community paediatric audiology to support community recovery and as such this will further impact on DM01 in the next 3-6 months as the intention is to take patients from referral, this increasing the overall acute waiting list. **CYSTOSCOPY-**Modality remains on an upward trend, although there has been a reduction in performance over the last 4 months, this driven by staffing absence and the need to prioritise TP biopsy provision to support delivery of the 28 day faster diagnostic standard. February performance at **86.6%.** A new urology CNS is now embedded in the team so this has released consultant resource to support increased delivery. The division has gained approval to run two additional TP biopsy sessions, this enabling in-week focus on cystoscopy. **URODYNAMICS-** Modality remains on an upward trend overall, although has seen reduction following two months of 100% compliance from October 2024. This is driven by staffing changes and the recruitment interregnum, equipment failure, the urodynamics probe breaking and the need to prioritise TP biopsies as detailed above. February performance at **62.5%.** Urological cancer referrals have increased month on month for the last 5 months and therefore cystoscopy, as part of a 2ww pathway has taken priority, this being reflected in performance.	We continue to prioritise diagnostic activity for those most clinically urgent, using the space and staffing resource we have available as flexibly as possible. We continue to seek ways to improve the care we provide, enabling improved performance.	**AUDIOLOGY-** Tri-two's operational coordinator is now focusing on DM01 compliance, supporting validation. **CYSTOSCOPY-** rebasing of trajectory as although modality hit target this has proven inconsistent due to demand fluctuation. Tri-one operational coordinator has been recruited, this enabling increased diagnostic PTL monitoring. **URODYNAMICS-** rebasing of trajectory as although modality hit target this has proven inconsistent due to demand fluctuation. Tri-one operational coordinator has been recruited, this enabling increased diagnostic PTL monitoring. 2 additional TP biopsy clinics have been instated to release medical resource to support cystoscopy delivery.

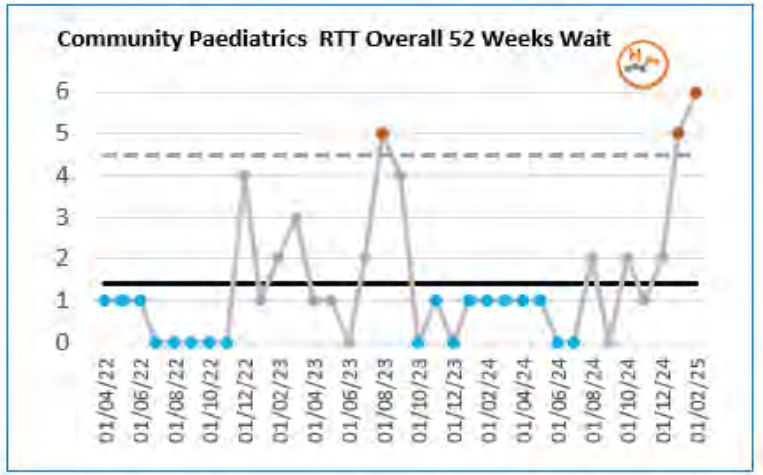


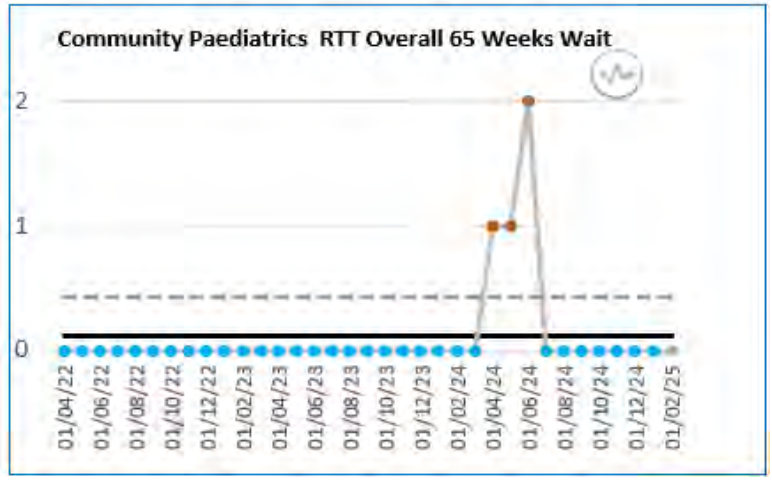


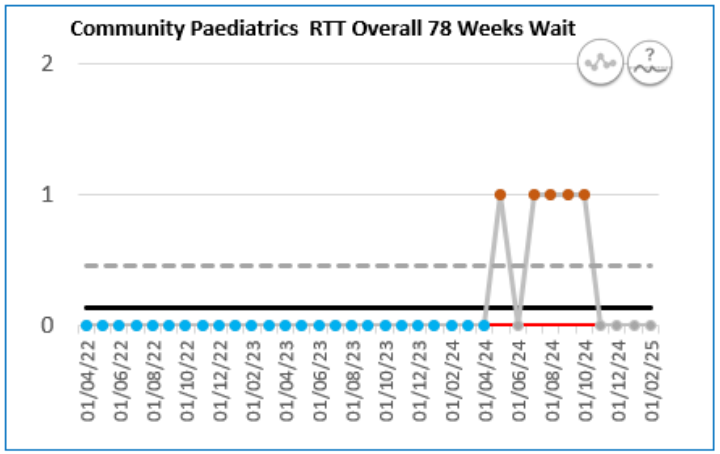
What	So What?	What Next?
The 78 week wait position for the end of February was 8 patients, which is a further reduction. The number of patients in both the actual 65ww and 65ww cohort are continuing to decrease, with the February 65ww position at 70 patients. It is forecast that this will now continue to reduce and the ambition remains to clear 65 weeks by the end of March 2025, excluding choice, unfit and grafts.	Delivering the objective of no patients waiting over 65 weeks by March 2025 is a central focus of 2024/25 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.	Continue to re-allocate theatre lists appropriately to increase Gynaecology theatre capacity to reach a sustained position. Additional sessions to continue for Dermatology. Daily focus on the 65ww patients.

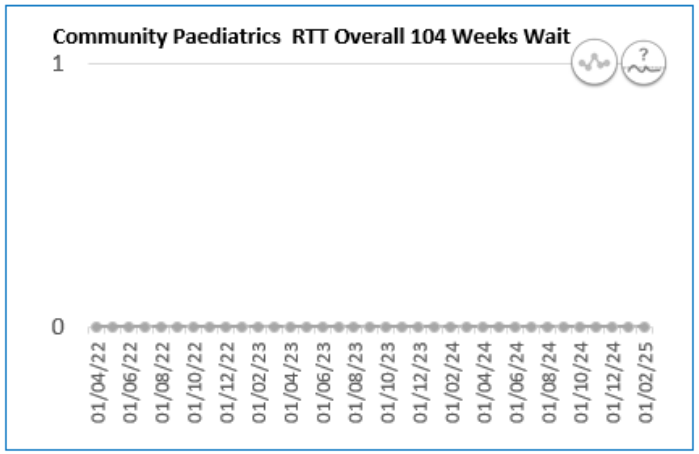
Elective Access (Community Paediatrics)











What	So What?	What Next?
There is an increase in the number of children waiting over 52weeks for initial assessment. This impacts primarily on school age children waiting for socio-communication assessment (possible autism) up to the age of 11yrs. The reduction in performance relates to sustained high level of referral demand and high service caseload numbers.	Level of current demand is above the available clinical capacity within the paediatric medical team. Capacity will reduce further in March as a result of clinician retirements. The team is prioritising response to preschool referrals and to support children with complex medical needs to minimise clinical risk. The team is also maintaining service response to vulnerable children (safeguarding and children in care assessments). Waiting times impacts on children accessing diagnosis but should be supported by the wider system (education etc)	In view of further staff reductions, the focus is on maintaining capacity to manage clinical risk. Recruitment to substantive posts is underway. Securing agency locum cover is being prioritised (1wte secured in March). Support for additional funding from the ICB is being considered to aid service recovery/response to school age autism assessment demand but may not be supported and therefore it is anticipated that waiting times will increase within the service

Elective Recovery Fund (ERF) threshold achievement

NHS England - 24/25 (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	23/24	ERF	24/25	Var %
Apr	9,545	10,333	10,285	(0.5%)
May	9,660	10,458	10,328	(1.2%)
Jun	9,090	9,841	9,891	0.5%
Jul	10,165	11,004	10,721	(2.6%)
Aug	8,967	9,708	9,280	(4.4%)
Sep	9,545	10,333	9,878	(4.4%)
Oct	10,454	11,317	10,684	(5.6%)
Nov	9,891	10,708	10,182	(4.9%)
Dec	8,744	9,466	8,853	(6.5%)
Jan	10,345	11,200	10,891	(2.8%)
Feb	9,206	9,966	9,390	(5.8%)
Mar	9,365	10,138		
Total (YTD)	105,611	114,330	110,383	(3.5%)

February 2025

23/24	9,206
ERF	9,966
24/25	9,390
Var	(576)
Var %	(5.8%)

Daycase

Mon	23/24	ERF	24/25	Var %
Apr	2,191	2,373	2,434	2.6%
May	2,245	2,431	2,568	5.6%
Jun	2,084	2,257	2,264	0.3%
Jul	2,364	2,560	2,613	2.1%
Aug	2,109	2,284	2,331	2.0%
Sep	2,245	2,431	2,423	(0.3%)
Oct	2,459	2,663	2,515	(5.6%)
Nov	2,408	2,608	2,510	(3.8%)
Dec	2,056	2,227	2,101	(5.7%)
Jan	2,420	2,621	2,520	(3.8%)
Feb	2,219	2,404	2,373	(1.3%)
Mar	2,241	2,428		
Total (YTD)	24,799	26,860	26,652	(0.8%)

February 2025

23/24	2,219
ERF	2,404
24/25	2,373
Var	(31)
Var %	(1.3%)

Outpatient Follow Up

Mon	23/24	ERF	24/25	Var %
Apr	25,353	27,046	27,943	3.3%
May	25,659	27,373	28,151	2.8%
Jun	24,145	25,758	26,717	3.7%
Jul	27,001	28,804	28,290	(1.8%)
Aug	23,819	25,411	25,452	0.2%
Sep	25,353	27,046	26,354	(2.6%)
Oct	27,767	29,622	28,006	(5.5%)
Nov	26,273	28,028	26,972	(3.8%)
Dec	23,225	24,777	24,186	(2.4%)
Jan	27,480	29,316	27,443	(6.4%)
Feb	24,452	26,086	23,835	(8.6%)
Mar	24,876	26,537		
Total (YTD)	280,528	299,268	293,349	(2.0%)

February 2025

23/24	24,452
ERF	26,086
24/25	23,835
Var	(2,251)
Var %	(8.6%)

Elective

Mon	23/24	ERF	24/25	Var %
Apr	256	277	270	(2.5%)
May	267	289	293	1.5%
Jun	247	267	233	(12.8%)
Jul	280	303	276	(9.0%)
Aug	256	277	277	0.0%
Sep	256	277	286	3.3%
Oct	284	307	337	9.9%
Nov	268	290	286	(1.5%)
Dec	249	269	253	(5.9%)
Jan	234	253	251	(0.9%)
Feb	244	264	251	(4.8%)
Mar	244	264		
Total (YTD)	2,841	3,072	3,013	(4.8%)

February 2025

23/24	244
ERF	264
24/25	251
Var	(13)
Var %	(4.8%)

Outpatient attendances that are a first attendance or with a procedure (one month in arrears – target 46.0%)

All

All

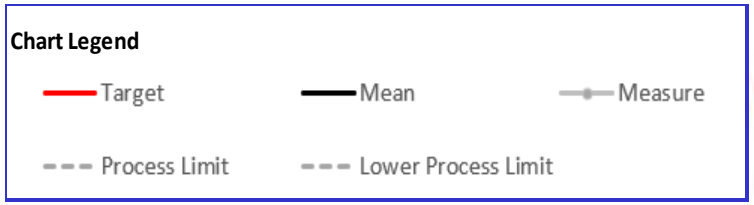
Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
23/24	38.2%	37.2%	37.0%	38.2%	38.5%	38.5%	36.6%	35.7%	37.4%	36.6%	38.2%	38.6%	**37.5%**
24/25	40.2%	39.3%	39.9%	40.9%	42.5%	39.7%	39.8%	39.3%	40.2%				**40.2%**

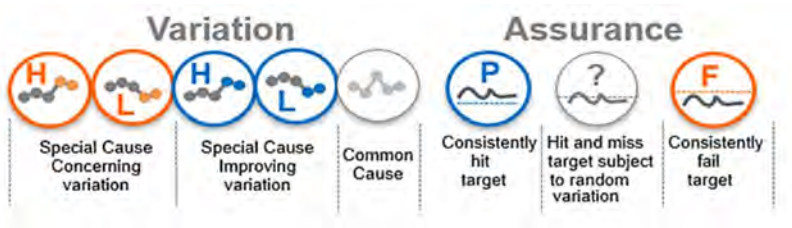
Target	46.0%
Month	40.9%
YTD	40.2%

Elective Access: Activity

What	So What?	What Next?
None of the activity across day cases, electives and first outpatient appointments is meeting the 2024/25 target of 108.09% of 2019/20 activity year to date or in month, with only day cases showing month on month improvement from January to February. Outpatient follow-ups, which should be reducing compared to 2019/20 levels showed their biggest negative variance in February at -8.6%, -2.0% year to date. Outpatient attendances that are a first attendance or with a procedure have increased by 2.7% year on year, although are not meeting the 46.0% target.	Increasing activity eligible for Elective Recovery Fund income is required as part of our Financial Recovery Plan and deliver on the objective to eliminate waits of >65 weeks by 22 December 2024. Although there is no specific requirement to deliver a reduction in outpatient follow ups this year, doing so will support delivery of the other modalities on which the Elective Recovery Fund threshold is based and will support the new ambition of 46.2% of outpatients to either be first attendances or with procedures.	All divisions to focus on delivery of activity in Q4 in line with financial recovery plans and to meet operational performance expectations for cancer Faster Diagnosis Standard and zero 65 week elective waits. Activity plans being developed in response to the 2026/26 NHS planning guidance and financial model, to be finalised in March 2025.

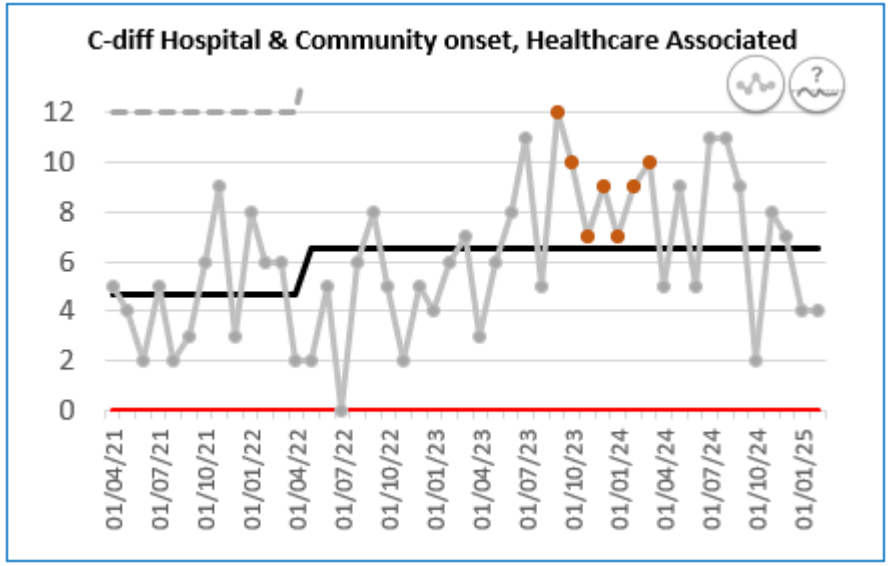
IMPROVEMENT COMMITTEE METRICS





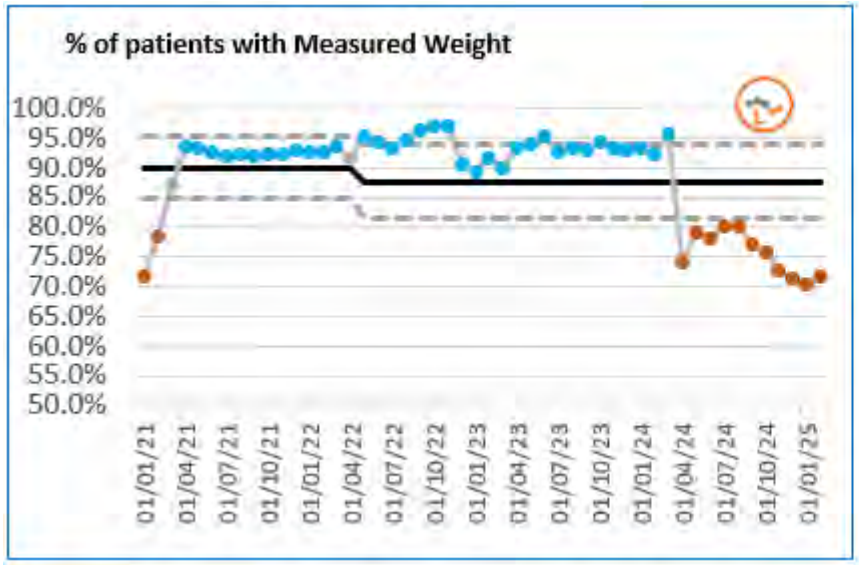
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
C-diff Hospital & Community onset, Healthcare Associated	Feb 25	4	0			7	-2	15
% of patients with Measured Weight	Feb 25	71.8%				87.7%	81.5%	93.9%
% of patients with a MUST/PYMS assessment completed within 24 hours of admission	Feb 25	71.8%				75.1%	68.7%	81.5%
Post Partum Haemorrhage	Feb 25	2				7	-1	15

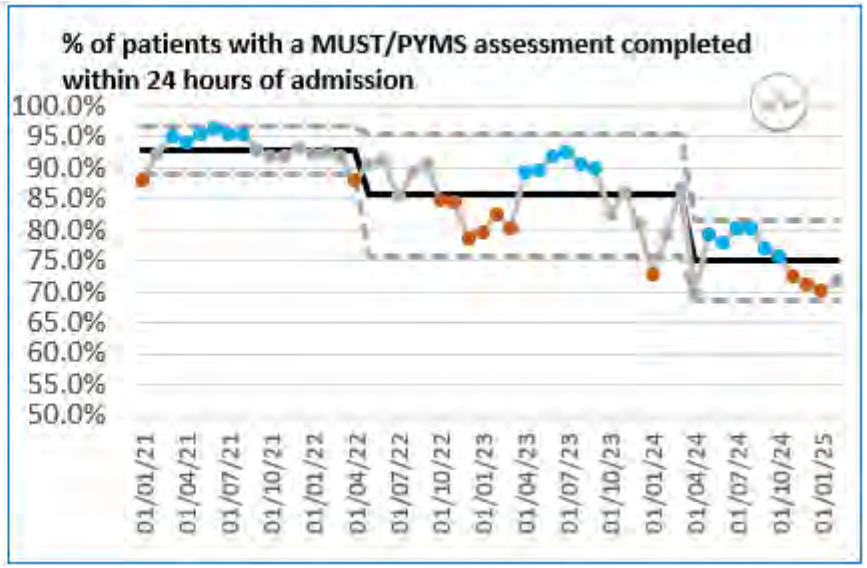
Safe



What	So What?	What Next?
We have seen a trending improvement of rates over the last eight data points with the exclusion of October cases as an anomaly. The month of October however represents the best performing month since July 2022. Whilst there is a reduction in *Clostridioides difficile* infection over this timeframe, the data continues to illustrate common cause variation, with limited assurance of sustained improvement at this point. It is anticipated by the end of 24/25 WSFT will have not reached the trust hold target (n=91) from the ICB which is positive *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. It is recognised Nationally that the rates of *Clostridioides difficile* have increased significantly over the last two reporting years.	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 extensive outbreak scenarios within the UK.	The situation remains complex and multifaceted. Despite this, the service is on track with the agreed threshold to achieve the target by the end of March 2025, however, it was set significantly higher the previous year based on performance and remains an organisational key priority with escalations via patient quality & safety group and attendance at the improvement committee March, October 2024 and again March 2025. The Quality Improvement Programme continues Full update to be provided at March 2025 improvement board QI update: • Review of isolation signage and Trust roll out; March - April 2025 • Review of investigation process when a C.diff case is identified – including review of RADAR completion, accountability and actions after a case, review has commenced April 2025. • Alternate week planned catch up meetings between domestic services and IPC; March-April 2025 • Streamline the programme of infection prevention within the RadarAudit module allowing focus on hand hygiene and providing trust-wide standards for analysis against the infection prevention and control manual for England.

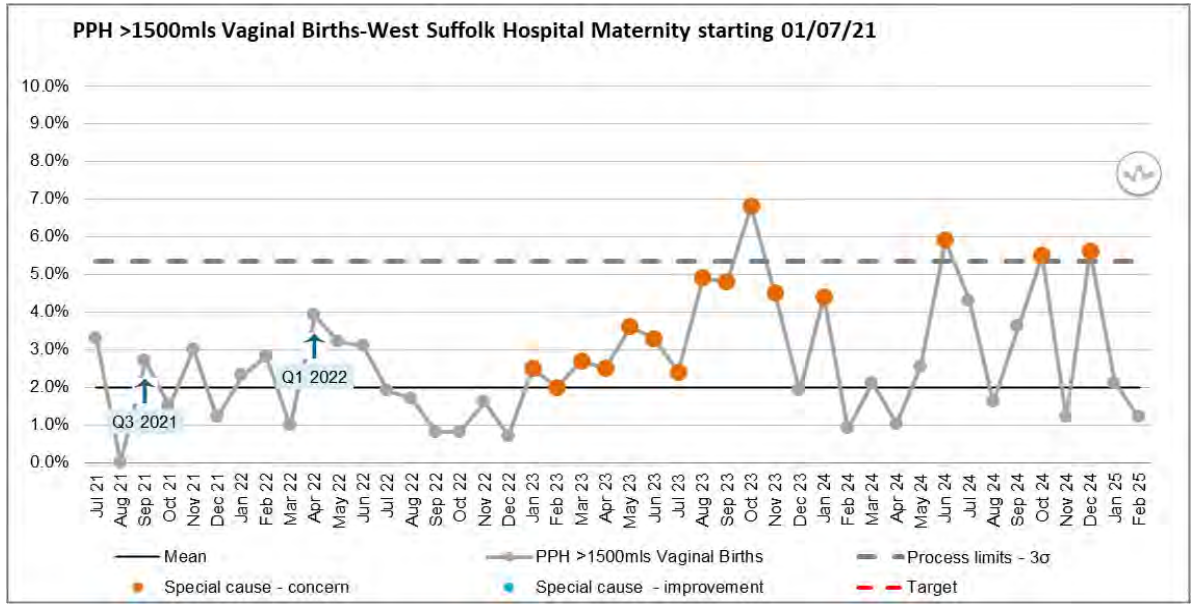
Safe

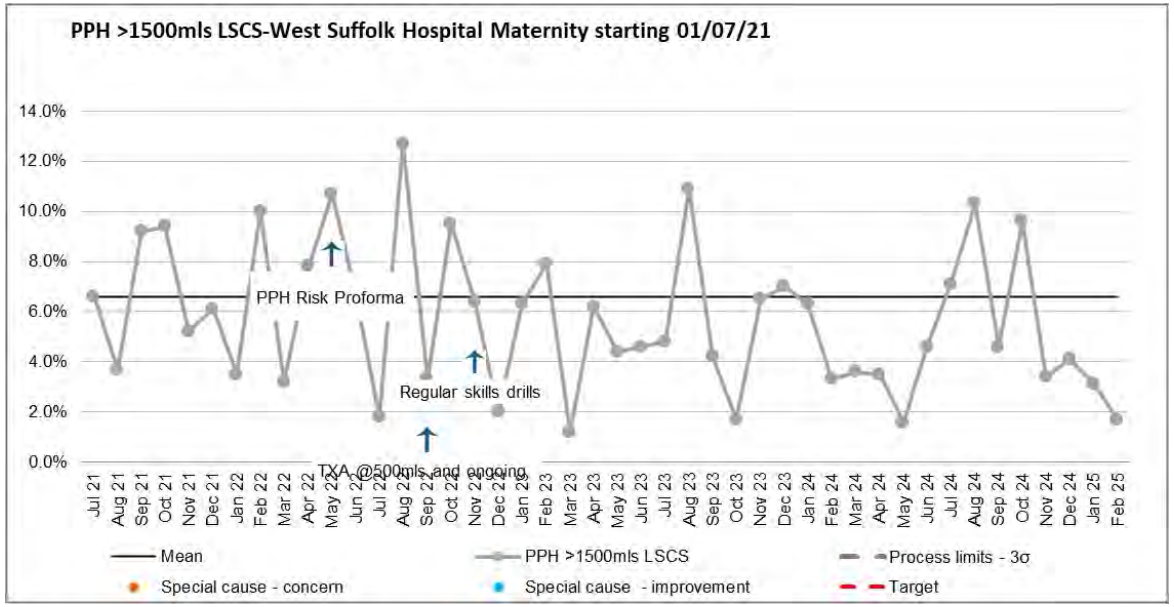




What	So What?	What Next?
The Trust has now produced the short assessment data, for patients who are in ED longer than 12 hours, the results are encouraging. Although we strive to not hold patients in ED any longer than possible, 97.56 percent of patients who are in ED over 12 hours have a nutritional assessment carried out. Nutritional assessment are a priority of the Trust, and this can be seen by the encouraging results of assessment carried out at the point of decision to admit. It is also reassuring to see that 94.2 percent of patients have a nutritional assessment carried out in the first 24 hours of admission. This metric remains in common cause variation. The percentage of patients with a measured weight has increased this month which is a positive sign, however this is a matrix which still requires improvements and remains in common cause variation. It is hoped that with the improvement in the UEC targets in March this will have a positive impact on this figure.	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. The importance of nutritional screening cannot be underestimated, using a validated tool to assess patients on admission and 7 days later, is vital to make sure no nutritional needs are overlooked. The world health organisation agrees and from 2016 -2025 they have collectively acknowledged the concept of 'food as medicine' which is something the trust is actively supporting with food as medicine workshops. With the advent on the rapid assessment in ED it now helps the inpatient areas focus on areas that need improvements. Patient facing staff have an awareness to make sure patients are assessed and have the necessary input required for their nutritional needs.	• Improvement with the UEC performance will result in patients getting to the wards earlier and having a full assessment carried out in a timely manner. It is hoped that with the improvements in March we will see a difference • Monitor and review any complaints/ incidets regarding nutritional aspects and make sure shared learning is fed back to all patient facing staff. This is also discussed at the monthly nutritional steering group. It is important that this group has wide cohort of expertise including the MDT team. • The food as medicine work streams continue and are in the final stages. • Monitor patients to make sure that they are re weighed at 7 days This is reviewed using the documentation Radar audit which is completed in ward areas weekly, and any changes are escalated as required. • Nutritional aspect of patient care are discussed at monthly governance 1:1 with the Matrons and Heads of Nursing.

Safe





What

This month data of Post-partum Haemorrhages (PPH) exceeding 1500 mls for Vaginal and lower section caesarean sections (LSCS) births shows common cause variation. A comprehensive review of all cases was conducted in line with the internal governance procedures.
In February 2025, there were two reported cases of PPH over 1500 mls, with one occurring after a vaginal birth and one following Lower segment Caesarean Section (LSCS). This was the lowest number of PPH since May 2024. The primary cause of PPH identified during the review was a combination of tone and trauma.

s noted in the Birth Trauma report from May 2024, individuals giving birth and their support partners often find PPH to be a traumatic experience, and actions for improvement have been identified through a "so what" review process.

Previous targets were set by The NMPA (National Maternity and Perinatal Audit)using 2022 data. Due to significant changes in practice (increased induction of labour and elective caesarean births) these targets have been removed as they are no longer relatable to the service.

Severe bleeding after childbirth - postpartum haemorrhage (PPH) - is the leading cause of maternal mortality world-wide. Each year, about 14 million women experience PPH resulting in about 70,000 maternal deaths globally (WHO 2023)

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.

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.

What Next?

Quality Improvement 3rd cycle launched

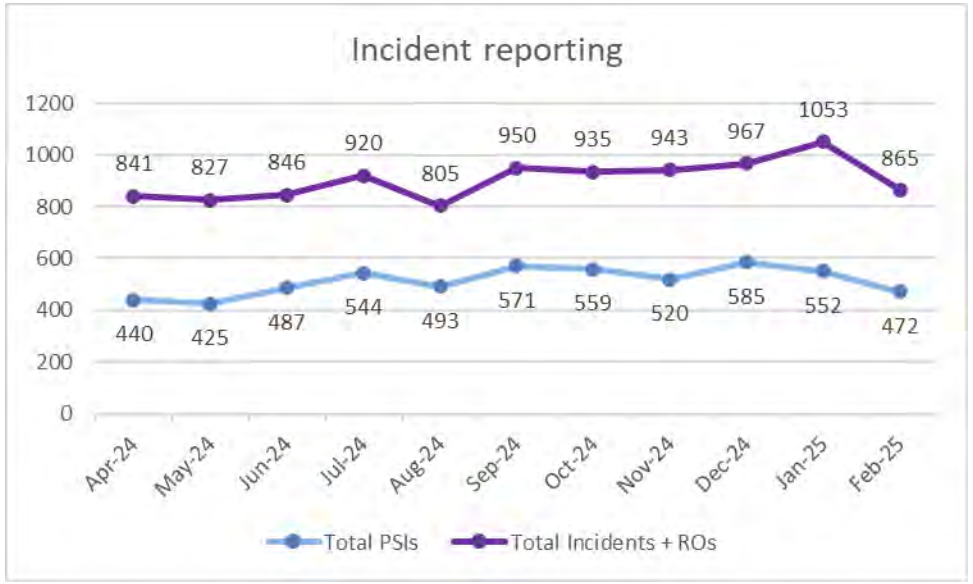
Engagement with local, LMNS (Local Maternity & Neonatal System) and regional QI programmes has shown some improvements these are not constantly sustained. Ongoing work continues to deep dive into the reasons for our PPH >1.5L.

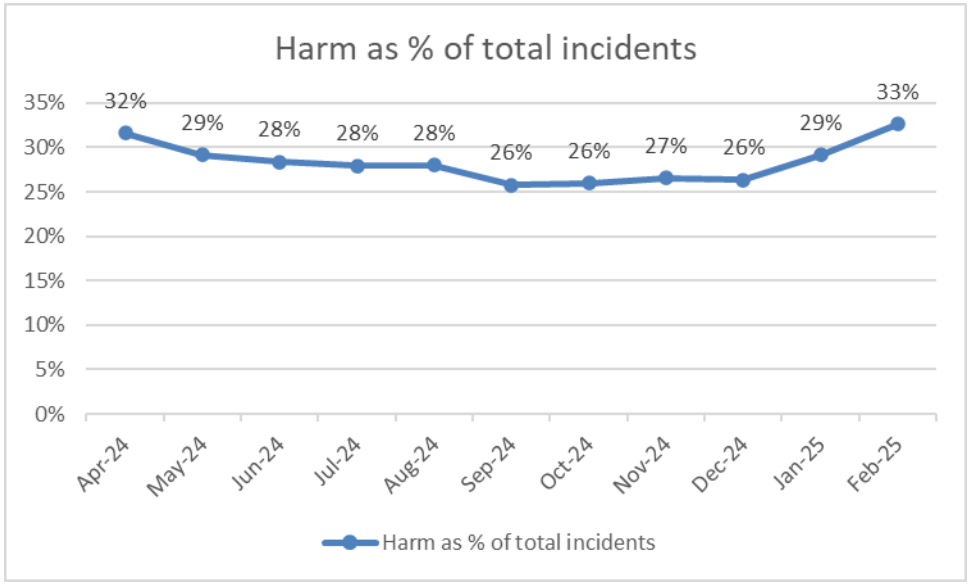
A review of the "So what" initiative was undertaken in relation to PPH and subsequently presented to the WSFT Improvement Committee and the LMNS Safety Forum in November 2024. The feedback from service users highlighted the need for enhanced support for both parents following PPH, and the methods for implementing these improvements are currently under evaluation.

With the removal of nationally set targets, to monitor performance in line with maternity units across the region.

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.

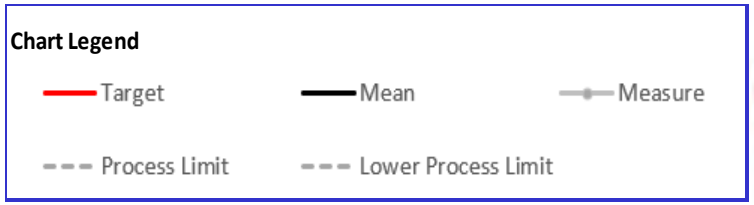
Safe

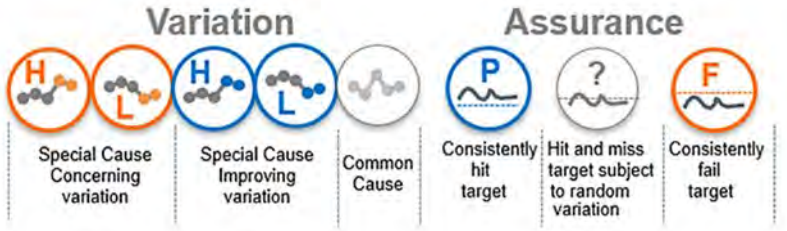




What	So What?	What Next?
This month there has been a reduction in the amount of patient safety incidents (PSI) and reportable occurrences (RO's) reported, with a notable reduction in pressure ulcers, however overall, this has returned to baseline, indicating last month there was an unexpected variance. Other reported RO's – safeguarding, infections, RPI and other are within usual limits. There was a general reduction across all categories for reporting PSI's. Harm as a % of total incidents has risen which can be contributed to consistent reporting of clinical care and treatment incidents.	We want to encourage reporting of all incidents, including low harm and near miss to enable improvement work to take place without patients coming to harm. This is key safety insight. The committees which oversee safety data including incidents and RO's use reporting data to monitor trends over time which prioritise improvement work. The pressure ulcer prevention group have reviewed the data alongside improvement opportunities and specifically the application of the PurposeT tool and visual skin check reminders. Handheld mirrors for visual skin checks have been distributed to health support workers to support this task.	Safety and quality committees report to patient safety and quality governance group (PSQGG) and improvement work is monitored as part of the reporting schedule. An analysis of the incidents which are submitted under clinical care and treatment form part of our quarterly analysis report, which has been shared widely and will be reported on a quarterly basis to Improvement committee. It provides an opportunity to ascertain if a focus of improvement needs to be changed or introduced.

Mortality Summary

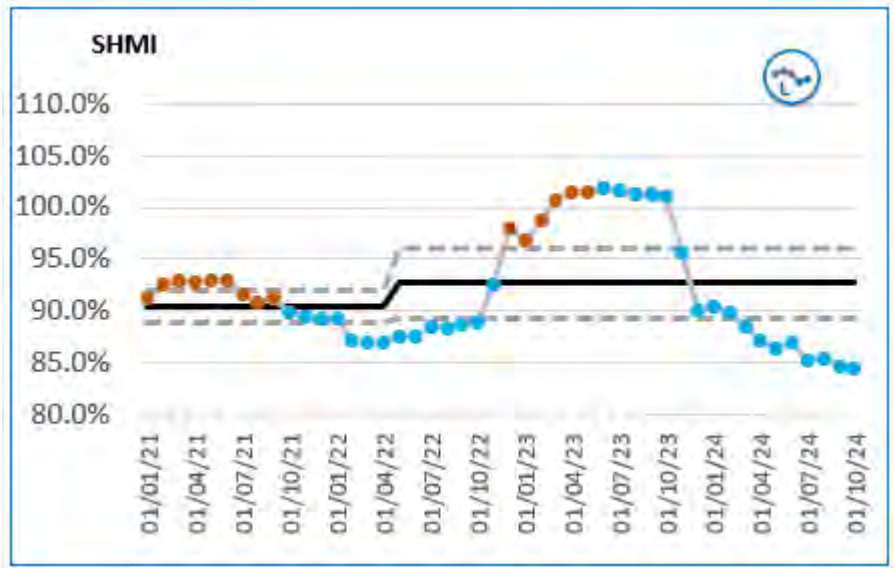


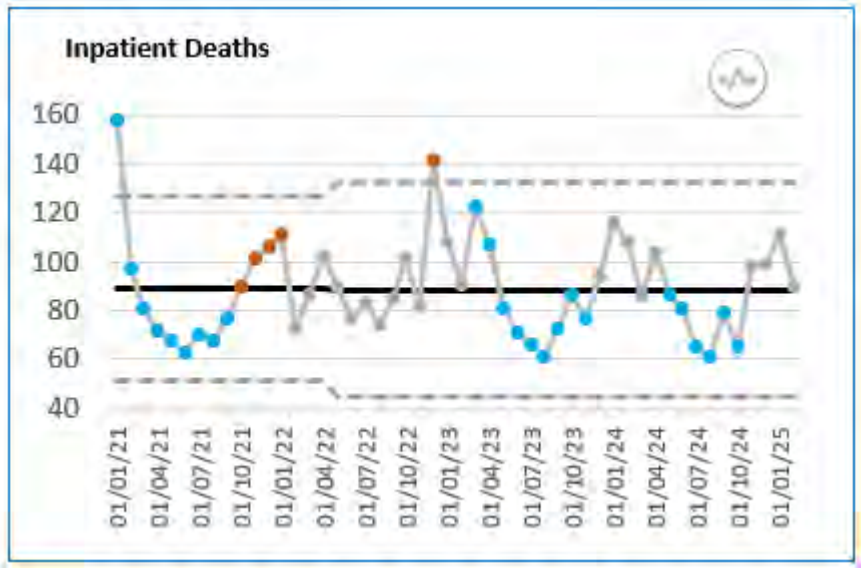


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SHMI	Oct 24	84.4%				92.7%	89.3%	96.1%
Inpatient Deaths	Feb 25	90				89	45	133

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

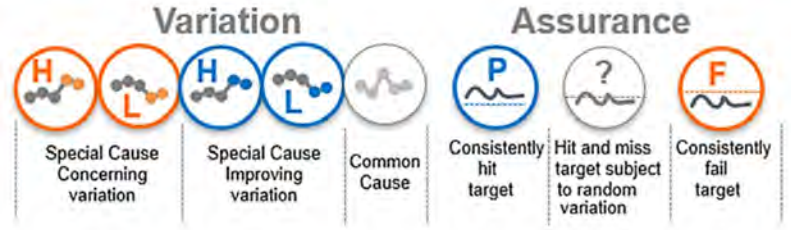
Mortality





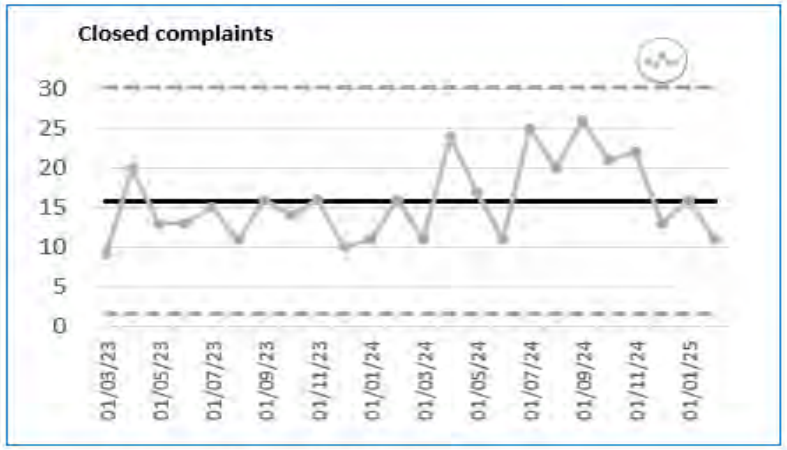
What	So What?	What Next?
The SHMI data shows that we have lower than expected deaths when analysed by demographic and disease coding. As part of our mortality oversight we observe numbers and causes of death to ensure there are no unusual trends or anomalies.	It is important to have a comparison to Trusts in similar size and demographic to establish how we are performing as an organisation. Our SHMI data demonstrates that more than expected patients are surviving in our care to discharge.	We will continue to observe data for inpatient deaths as well as causes of death for trends. As we are currently performing well no action is required, except for monitoring through the mortality oversight group.

INVOLVEMENT COMMITTEE METRICS



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Active complaints	Feb 25	30	-			29	15	43
Closed complaints	Feb 25	11	-			16	2	30
% extended	Feb 25	54%	-			71%	39%	104%
Count extended	Feb 25	6	-			11	2	20
% Complaints responded to late	Feb 25	9%	-			9%	-21%	40%
Count responded to late	Feb 25	1	-			2	-4	7
% resolved in one week	Feb 25	75%	-			59%	30%	88%
Total PALS resolved Count	Feb 25	290	-	H		175	57	293

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
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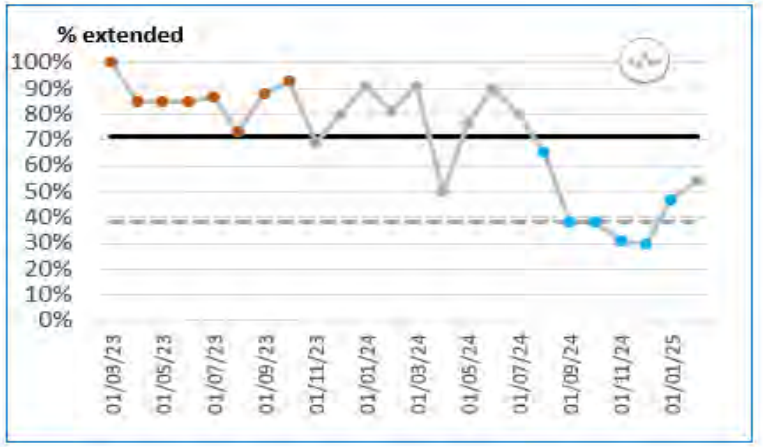
01/03/24
01/05/24
01/07/24
01/09/24
01/11/24
01/01/25


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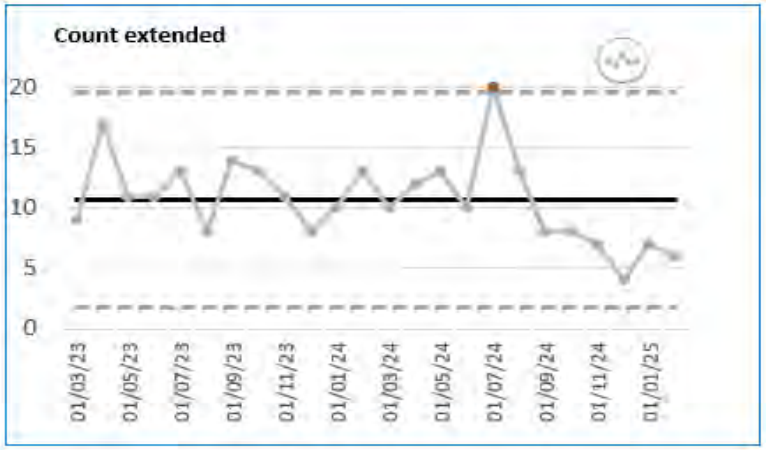
01/01/25


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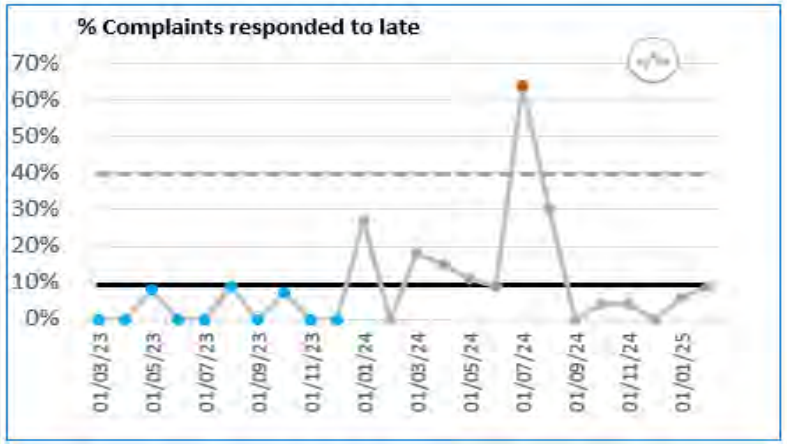
01/01/25


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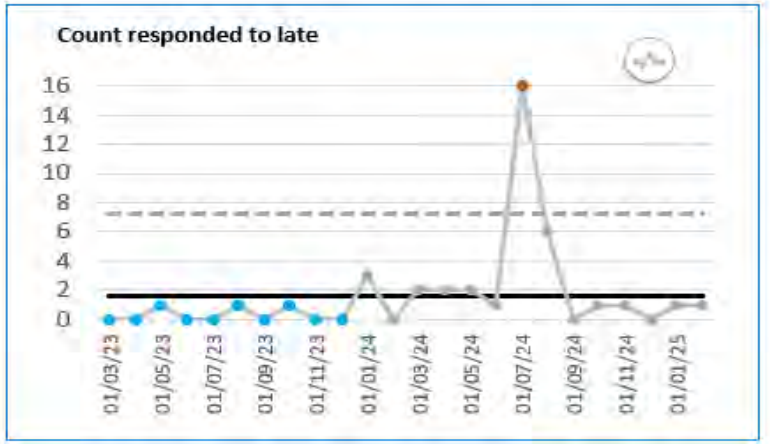
01/01/24
01/03/24
01/05/24
01/07/24
01/09/24
01/11/24
01/01/25


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
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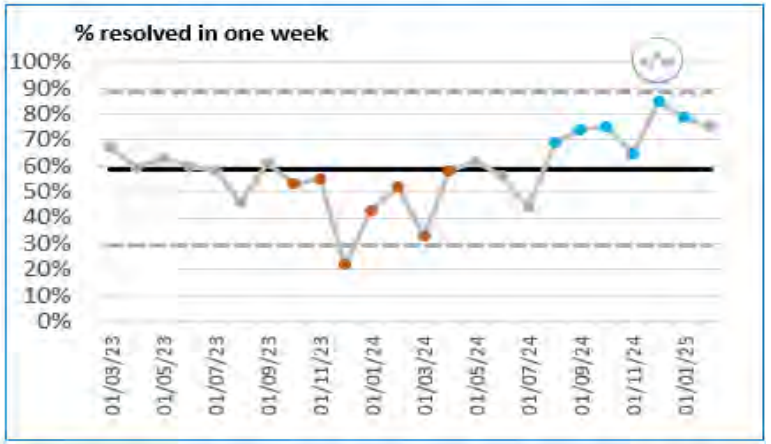
01/03/24
01/05/24
01/07/24
01/09/24
01/11/24
01/01/25


% 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
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01/03/24
01/05/24
01/07/24
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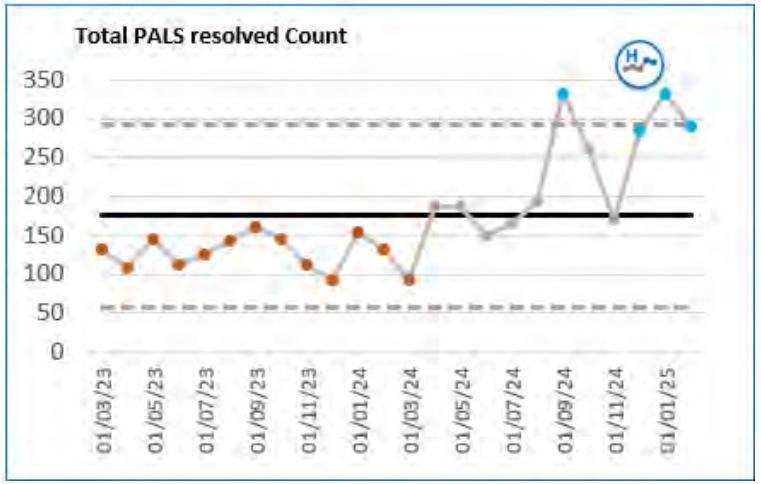
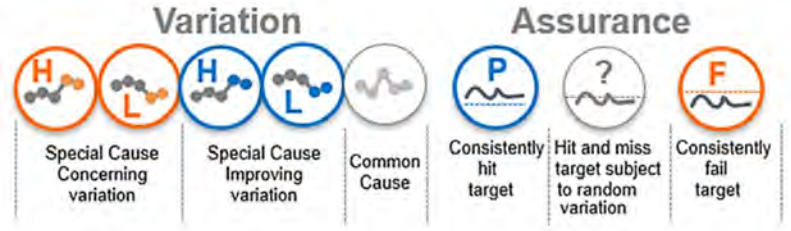
01/01/25


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

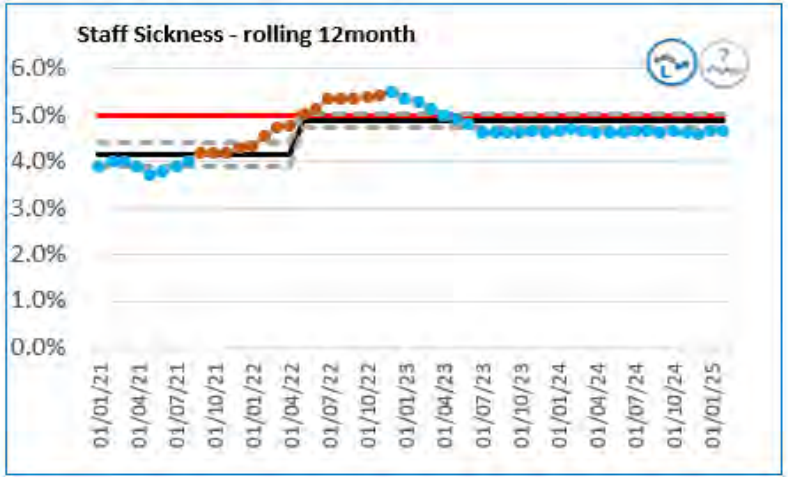
Safe

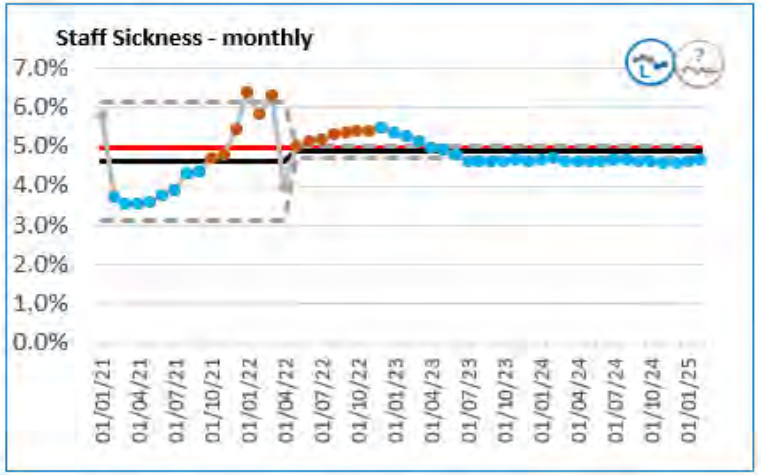
What	So What?	What Next?
There was a reduction in formal complaints that were responded to due to increased complexity and multiple pathways being explored. A number of cases have gone through the incident triage process and subsequently on to EIR for further review. Furthermore, we received 6 more complaints than February which involves more administrative tasks. However this metric remains within the controlled limits. The % of complaints extended has increased however the due to fewer complaints responded to, the actual number of complaints extended has decreased from 7 to 6. A similar trend is shown with the % of complaints that were responded to late. The % has increased from 6% to 9% however the actual count remains the same with only 1 complaint responded to late. This was due to delays in obtaining staff responses. Despite a small reduction, PALS have still achieved their target of resolving a minimum of 75% of cases within 1 week. Similarly a slight reduction in total cases resolved from 332 in January to 290 in February. This was mainly due to absence within the team. All metrics continue to be within the controlled limits.	The incident triage process is a vital part of the triage process to identify potential incidents that form part of a complaint and to confirm the correct learning pathway. Whilst this is not a requirement for all complaints, this can cause delays which subsequently requires timescales to be extended. However, all complainants are kept updated with any delays and are provided with details on what the review meetings entail. This provides greater reassurance to complainants that we are taking their concerns seriously. The data reflects that the PALS team are handling more concerns and enquiries that come in to the patient experience team, which is promoting early resolution and minimal numbers are being escalated to a formal complaint.	The target remains for the PALS team to reach a minimum of 75% of cases resolved within one week. There has been a change in direct line management for PALS and support is being given to PALS to ensure this metric reaches the target and is maintained. 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. Furthermore, a benchmarking exercise is being conducted across the regional Trusts for complaints and PALS performance including WTE/structure, resolution times and volume of complaints. Following this we will review processes and triaging if required. We have met with heads of departments to increase staff engagement with providing responses to complaints in a timely manner, including setting up weekly meetings to discuss any outstanding and overdue complaints that require escalation.

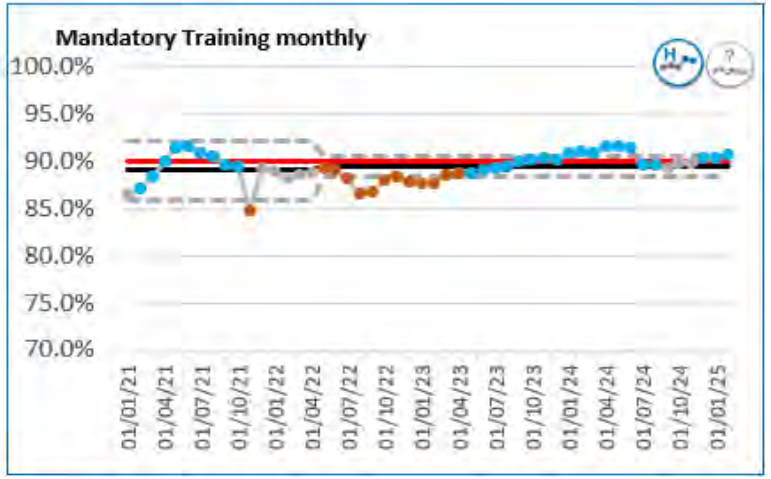


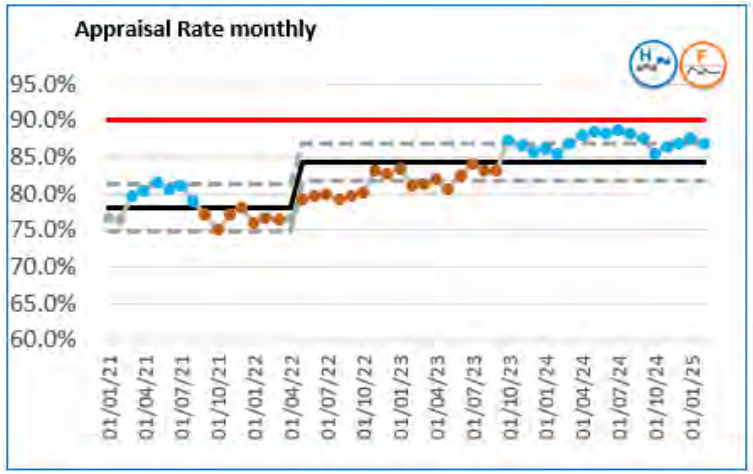
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	Feb 25	4.7%	5.0%	L	?	4.9%	4.7%	5.0%
Staff Sickness - monthly	Feb 25	4.7%	5.0%	L	?	4.9%	4.7%	5.0%
Mandatory Training monthly	Feb 25	90.7%	90.0%	H	?	89.4%	88.3%	90.6%
Appraisal Rate monthly	Feb 25	86.9%	90.0%	H	F	84.3%	81.7%	86.9%
Turnover rate monthly	Feb 25	8.0%	10.0%	L	?	10.2%	9.3%	11.1%

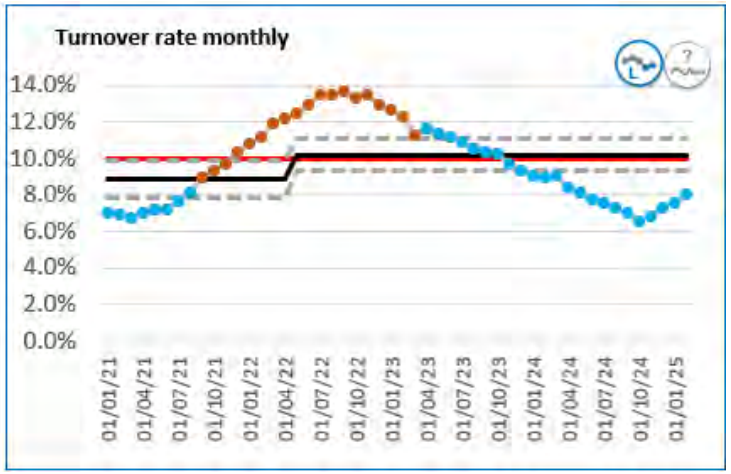
Well Led











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 90.7%. Appraisal – consistently failing target, 86.9% versus 90% target. Turnover – achieving target, sustained improvement since November 2022.	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.