Board of Directors (In Public)

Schedule	Friday 23 May 2025, 9:15 AM — 1:15 PM BST
Venue	Northgate Meeting Room, WSH
Description	A meeting of the Board of Directors in the Public domain on Friday 23rd May 2025
Organiser	Kathryn McMahon

Agenda

	AGENDA Presented by Jude Chin _WSFT Public Board Agenda - 23 May 2025.docx
9:15 AM	1. GENERAL BUSINESS Presented by Jude Chin
10:10 AM	1.1. Welcome and apologies for absence - Richard Jones, To Note - Presented by Jude Chin
	1.2. Declaration of interests for items on the agenda To Assure - Presented by Jude Chin
10:10 AM	1.3. Minutes of the previous meeting - 28th March 2025 (ATTACHED) To Approve - Presented by Jude Chin Item 1.3 - 2025 03 28 March - WSFT Public Board Minutes - DRAFT.docx
	1.4. Action log and matters arising (ATTACHED) To Review - Presented by Jude Chin Item 1.4 - Open Board Matters Arising - Complete.pdf Item 1.4 - Open Board Matters Arising - Active.pdf

10:10 AM	1.5.	Questions from Governors and the Public relating to items on the agenda To Note - Presented by Jude Chin
	1.6.	Patient story - presentation To Review - Presented by Susan Wilkinson
10:10 AM	1.7.	Chief Executive's report (ATTACHED) To inform - Presented by Ewen Cameron Item 1.7 - CEO Board report - May 2025 v2.docx
10:10 AM	2.	STRATEGY
	2.1.	WSFT Strategy (ATTACHED) Presented by Sam Tappenden Item 2.1 - Strategy Refresh Cover Paper Public Board May 2025.docx Item 2.1 - Strategy Update to Board Final May 2025.docx
10:45 AM	2.2.	Future System board report (ATTACHED) To Assure - Presented by Ewen Cameron Item 2.2 Future systems.docx
	2.3.	Suffolk System Update Report - SNEE Integrated Care Board (ICB); Wider System Collaboration (Verbal) To Assure - Presented by Peter Wightman and Clement Mawoyo
	2.4.	Digital Board Report (ATTACHED) To Assure - Presented by Nicola Cottington Item 2.4 - Trust Open Board digital report May 2025.docx
10:45 AM	Comfort Break	

	2.5.	Collaborative Oversight Group (ATTACHED) To Assure - Presented by Sam Tappenden Item 2.5 - WSFT Collaborative Oversight Group Public Board.docx
10:55 AM	3.	ASSURANCE
	3.1.	IQPR Report (ATTACHED - full IQPR under supporting Annex) To Review - Presented by Nicola Cottington Item 3.1 IQPR Cover Sheet.docx
11:10 AM	3.2.	Finance Report (ATTACHED) To Review - Presented by Jonathan Rowell Item - 3.2 Finance Report M1 Cover Sheet - Open Board.docx Item 3.2_M1 Finance board report.pptx
11:35 AM	Comfort Break	
11:50 AM	4.	PEOPLE, CULTURE AND ORGANISATIONAL DEVLEOPMENT
	4.1.	Involvement Committee Report - Chair's Key Issues from the meeting (ATTACHED) To Assure - Presented by Tracy Dowling Item 4.1 - INVOLVEMENT CKI report 16 Apr 2025 TD.doc
	4.1.1.	Staff Survey (ATTACHED) For Report - Presented by Carol Steed Item 4.2 - NHS Staff survey Board update May 2025 PL17042025 v4 (1).docx
	4.1.2.	Freedom to Speak Up (ATTACHED) For Report - Presented by Carol Steed Item 4.2.2WSFT FTSUG report Q4 2024-2025.doc

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12:15 PM 5. OPERATIONS, FINANCE AND CORPORATE RISK

12:25 PM 5.1. Insight Committee Report - Chairs key issues from the meetings (ATTACHED)
To Assure - Presented by Antoinette Jackson and Nicola Cottington

Item 5.1 - INSIGHT CKI report 19 Mar 2025 AJ.docx

Item 5.1 - INSIGHT CKI report 16 Apr 2025 AJ.docx

12:25 PM 6. QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT

6.1. Improvement Committee Report - Chairs key issues (ATTACHED)
To Assure - Presented by Susan Wilkinson

Item 6.1 - IMPROVEMENT CKI report 19 Mar 2025 RP.docx

Item 6.1 - IMPROVEMENT CKI report 16 Apr 2025 RP.docx

6.2. Quality & Nurse Staffing Report (ATTACHED)
To Assure - Presented by Susan Wilkinson

Item 6.2 - Nurse.Midwifery staffing report Mar.April 2025.docx

6.3. Maternity services report (ATTACHED)
For Approval - Presented by Susan Wilkinson and Karen Newbury

Item 6.3 - May 2025 Maternity and Neonatal quality safety and performance Board report (002) (002).docx

12:50 PM 7. GOVERNANCE

7.1. Charitable Funds CKI Committee report (ATTACHED)
For Approval - Presented by Jonathan Rowell and Richard Flatman

Item 7.1 - CFC CKI report 8Apr 2025 v2 RF.docx

7.2. Board Assurance Framework (ATTACHED)
To Note - Presented by Pooja Sharma

Item 7.2 - BAF report to Board May 25.docx

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7.3. Audit One recommendation – progress report (ATTACHED)
Presented by Pooja Sharma

Item 7.3 - AuditOne well led response - Trust Board 23 May 2025.docx

Item 7.3_ConsultOne action Plan - Apr 2025 version shared with Trust board 23 May 2025.pdf

7.4. Governance Report (ATTACHED)
For Approval - Presented by Pooja Sharma

Item 7.4 - Governance report Trust Board 23 May 2025.docx

8. OTHER ITEMS
Presented by Jude Chin

1:10 PM 8.1. Any other business
To Note - Presented by Jude Chin

8.2. Reflections on meeting
For Discussion - Presented by Jude Chin

8.3. Date of next meeting - 25th July 2025
To Note - Presented by Jude Chin

RESOLUTION
The Trust Board is invited to adopt the following resolution:
“That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest” Section 1 (2), Public Bodies (Admission to Meetings) Act 1960

9. SUPPORTING APPENDICES
To inform - Presented by Jude Chin

IQPR Full Report

To Note - Presented by Nicola Cottington

Item 3.1_IQPR Board Report March 2025.pdf

Item 7.1 Charitable Funds CKI Appendices

Item 7.4 Governance Appendices

Item 7.4_Annex C Board meeting July 2025 agenda DRAFT.docx

Item 7.4_Annex A Role spec T&C of Lead & deputy lead Gov - Constn Annex 11.doc

Item 7.4_Annex B Register of Interests summary April 2025 presented to Board May 2025.docx

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AGENDA

Presented by Jude Chin

WSFT Board of Directors – meeting in public

Date and Time	Friday, 23 May 2025 9:15 -13:15
Venue	Northgate meeting room, Quince House, West Suffolk hospital site

Time	Item	Subject	Lead	Purpose	Format
1.0 GENERAL BUSINESS					
09.15	1.1	**Welcome and apologies for absence**	Chair	Note	Verbal
	1.2	**Declarations of Interests**	All	Assure	Verbal
	1.3	**Minutes of meeting** 28 March 2025	Chair	Approve	Report
	1.4	**Action log and matters arising**	All	Review	Report
	1.5	**Questions from Governors and the public relating to items on the agenda**	Chair	Note	Verbal
	1.6	**Patient Story**	Chief Nurse	Review	Verbal/ Video
	1.7	**CEO report**	Chief Executive	Inform	Report
2.0 STRATEGY					
10.10	2.1	**WSFT Strategy**	Director of strategy and transformation		Report
	2.2	**Future system board report**	Chief Executive	Assure	Report
	2.3	**System update/Alliance report** - SNEE Integrated Care Board (ICB) - Wider system collaboration	West Suffolk Alliance Director and Director of Integrated Adult Health and Social Care	Assure	Verbal
	2.4	**Digital Board report**	Chief Operating Officer	Assure	Report
10:30 Comfort Break					
10:40	2.5	**Collaborative oversight group**	Director of strategy and transformation	Assure	Report
3.0 ASSURANCE					
10:50	3.1	**IQPR report** To consider areas for	Executive leads	Review	Report

Time	Item	Subject	Lead	Purpose	Format
		escalation *(linked to CKI reports from assurance committees)*			
	3.2	**Finance report**	Interim CFO	Review	Report
11:35 Comfort Break					
4.0 PEOPLE, CULTURE AND ORGANISATIONAL DEVELOPMENT					
11.50	4.1	**Involvement Committee report –** Chair's key issues from the meetings	NED Chair	Assure	Report
		People and OD Highlight Report - NHS Staff survey	Deputy Dir of Workforce, Organisational Development and Learning	Inform	
		- FSUP report Q4	FSUP Guardian		
5.0 OPERATIONS, FINANCE AND CORPORATE RISK					
12.15	5.1	**Insight committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
6.0 QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT					
12.25	6.1	**Improvement committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
	6.2	**Quality and nurse staffing report**	Chief Nurse	Assure	Report
	6.3	**Maternity services report** - Maternity services quality and performance report	Chief Nurse Karen Newbury Kate Croissant Simon Taylor	Approval	Report
7.0 GOVERNANCE					
12:50	7.1	**Charitable Funds Committee report** Chair's key issues from the meetings	NED Chair	Inform	Report
	7.2	**Board assurance framework**	Trust Secretary	Approval	Report
	7.3	**AuditOne recommendation – progress report**	Trust Secretary	Inform	Report
	7.4	**Governance Report**	Trust Secretary	Inform	Report
8.0 OTHER ITEMS					

Time	Item	Subject	Lead	Purpose	Format
13.10	8.1	**Any Other Business**	All	Note	Verbal
	8.2	**Reflections on meeting**	All	Discuss	Verbal
	8.3	**Date of next meeting** Board meeting on 25 July 2025	Chair	Note	Verbal
	Resolution The Trust Board is invited to adopt the following resolution: "that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicly on which would be prejudicial to the public interest" Section 1(2) Public Bodies (Admission to Meetings) Act 1960				

Supporting Annexes

Agenda item	Description
3.1	IQPR

Guidance notes

Trust Board Purpose
The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

Our Vision and Strategic Objectives			
Vision Deliver the best quality and safest care for our local community			
Ambition	First for Patients	First for Staff	First for the Future
Strategic Objectives	• Collaborate to provide seamless care at the right time and in the right place • Use feedback, learning, research and innovation to improve care and outcomes	• Build a positive, inclusive culture that fosters open and honest communication • Enhance staff wellbeing • Invest in education, training and workforce development	• Make the biggest possible contribution to prevent ill-health, increase wellbeing and reduce health inequalities • Invest in infrastructure, buildings and technology

Our Trust Values	
Fair	We value fairness and treat each other appropriately and justly.
Inclusivity	We are inclusive, appreciating the diversity and unique contribution everyone brings to the organisation.
Respectful	We respect and are kind to one another and patients. We seek to understand each other's perspectives so that we all feel able to express ourselves.
Safe	We put safety first for patients and staff. We seek to learn when things go wrong and create a culture of learning and improvement.
Teamwork	We work and communicate as a team. We support one another, collaborate and drive quality improvements across the Trust and wider local health system.

1. GENERAL BUSINESS

Presented by Jude Chin

1.1. Welcome and apologies for absence - Richard Jones,

To Note

Presented by Jude Chin

1.2. Declaration of interests for items on the agenda

To Assure

Presented by Jude Chin

1.3. Minutes of the previous meeting - 28th March 2025 (ATTACHED)

To Approve

Presented by Jude Chin

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE
Open Board meeting

Held on Friday 28 March, 2025, 09:15 – 13:30
Sudbury Community Healthcare Centre

Members:		
Name	**Job Title**	
Jude Chin	Trust Chair	JC
Ewen Cameron	Chief Executive Officer	EC
Nicola Cottington	Executive Chief Operating Officer	NC
Sue Wilkinson	Executive Chief Nurse	SW
Richard Goodwin	Executive Medical Director/Board Level Maternity and Neonatal Safety Champion	RG
Jeremy Over	Executive Director of Workforce & Communications	JMO
Jonathan Rowell	Interim Chief Finance Officer	JR
Sam Tappenden	Director of Strategy & Transformation	ST
Antoinette Jackson	Non-Executive Director/SID	AJ
Tracy Dowling	Non-Executive Director	TD
Richard Flatman	Non-Executive Director	RF
Heather Hancock	Non-Executive Director	HH
Alison Wigg	Non-Executive Director	AW
Clement Mawoyo	Director of Integrated Adult Health & Social Care West Suffolk	CM
Peter Wightman	West Suffolk Alliance Director	PW
In attendance:		
Pooja Sharma	Deputy Trust Secretary	PS
Ruth Williamson	FT Office Manager (minutes)	RW
Anna Hollis	Deputy Head of Communications	AH
Sarah Judge	Interim Chief Information Officer (Item 2.5 only)	SJ
Karen Newbury	Director of Midwifery (Item 6.4 only)	KN
Apologies: Michael Parsons, Non-Executive Director, Roger Petter, Non-Executive Director, David Weaver, Associate Non-Executive Director, Richard Jones, Trust Secretary, Greg Bowker, Head of Communications, Paul Zollinger Read, Associate Non-Executive Director.		
Governors observing: Jane Skinner, Val Dutton		
Staff:		
Members of the public: Victoria Baster		

1.0 GENERAL BUSINESS		
1.1	**Welcome and apologies for absence**	**Action**
	The Trust Chair (JC) welcomed all to the meeting and apologies for absence, detailed above, were noted.	
1.2	**Declarations of interest**	
	There were no declarations of interest for items on the agenda.	
1.3	**Minutes of the previous meeting**	
	The minutes of the previous meeting held on 31 January 2025, were accepted as a true and accurate reflection.	
1.4	**Action Log and matters arising**	
	Action Ref 3121 – IQPR Report – UEC Deep Dive - to feature at May Insight Committee on 21 May. Update to be provided at May Board meeting. Action to remain open. **Action 3122 – Finance Report – QIA process** – discussion on QIA process undertaken at Insight Committee and will be further discussed at today's Closed Board. Action closed.	
1.5	**Questions from Governors and the public relating to items on the agenda**	
	Jane Skinner (JS) referred to the Safe Nurse Staffing Report and the fact that the Care Hours Per Patient Day (CHPPD) had dropped again to 5.7 (provider value) ranking the Trust towards the bottom of the 120+ other providers in terms of benchmarking. How long could this go on for in terms of patient safety? Sue Wilkinson (SW) confirmed the Trust had seen a reduction. It was today closing the seasonal pressure ward and releasing staff. Patient safety was being maintained. Work was being undertaken with the matrons to ensure all areas are clinically safe with the current staffing ratios. The Trust was also closely monitoring patient safety incidents to ascertain if any related to reduction of staffing levels.	
1.6	**Patient Story**	
	Jemma Morris (JM), DSU Clinical Team Manager, was in attendance at the meeting to discuss the approach taken by the Day Surgery Unit in making reasonable adjustments for a patient with complex needs requiring dental surgery. Tracy Dowling (TD) complimented the department on taking a holistic approach, including the patient and family. Clement Mawoyo (CM) highlighted the fact that the application for the Mental Capacity Act had been well executed and personalised. This only served to reflect the importance of the Oliver McGowan training and asked if JM had undergone this. Noted she had and that more staff were undertaking. All teams at ground level were completing the Tier 1 e-training.	

	JC and the Board thanked JM for sharing her story, which demonstrated how staff had gone above and beyond to ensure the patient received the treatment required.	
1.7	**CEO Report**	
	Ewen Cameron, CEO (EC) presented the report. Improvement in UEC pathway. Noted a 22% increase on the previous month resulting in the Trust being ranked 8th nationally. Staff across the Trust and community were thanked for their efforts. In terms of elective performance and long waits, it was anticipated that the 65- and 78-week waits would be cleared by month end. Again thanks were offered to staff for enabling this. Noted the Trust anticipates coming out of Tier 1 Cancer Standards at the next assessment in April. The recent Putting Yourself First Awards had highlighted the impact of non-clinical staff on patient care, citing a porter who had assisted a patient with dementia. TD commended EC on the personal tone to the report and for visits to staff and how the impact of this on staff facing difficult challenges could not be underestimated. She stressed that a vital part of communication was for Board members to go out and meet staff and listen to their thoughts and ideas. Jeremy Over (JMO) highlighted the challenge in getting the balance right in terms of reflecting the distress in the organisation against its successes. As leaders there was a need to make space for staff to demonstrate how proud they were of what they do. Nicola Cottington (NC) felt this to be a step in the direction of change in culture, with a balance between celebrating what the Trust does well and holding people to account, which has driven some of the improvements made. This in turn can cause distress in the organisation. Challenges remain. Heather Hancock (HH) believed JM's presentation and EC's report had demonstrated hope which was required to underpin any change in culture. CM highlighted that community teams would also welcome visits from Board Members. Noted EC had conducted recent visits to Newmarket and Haverhill.	
2.0 STRATEGY		
2.1	**WSFT Strategy**	
	Sam Tappenden, Director of Strategy & Transformation, presented the report. JC asked whether ST and his team had the capacity to meet the July deadline. ST responded that a number of roles were being	

	onboarded to the team, which would give capacity. This was a refresh rather than a rewrite so matters were on course. NC queried staff's capacity for engagement with this refresh and asked if it would be a difficult message to sell in terms of people's priorities? ST advised that the engagement was designed to be accessible with short surveys and joining existing meetings. It was incumbent on the Board to ensure direction was understood and critical to articulate to the organisation and wider system. JMO stressed the need to protect engagement time and provide a platform for staff to express their concerns. This was about the future and not just the here and now. RG referred to the environment in the Trust when by summer, outcomes for the Trust and system may remain unknown. How would this be built in? ST advised of the need to ensure alignment and what the changes will be. There were capable and committed people within the organisation. Focus was required on things that would make a difference. The Board had a duty to set this out and be confident in its direction. EC advised that there was some uncertainty. The Sustainability Review would be completed by July. The prospective direction of travel for the local population was unlikely to be dramatically affected by the changes. The Trust needed to move on from a strategy that did not correlate with the current context. There was never a right time but a refresh was required. **Action: ST to advise due date for Engagement Plan to come to the Board.** AJ advised that reports were being received with a lack of EDI implications and suggested this should be a founding principal of the refresh. JMO advised that the Trust had a legal duty to include. **ACTION: Deputy Trust Secretary to ensure Board papers contain EDI implications going forward.**	**ST** **PS**
2.2	**Future System Board Report**	
	EC presented the report. The update was noted.	
2.3	**System Update/Alliance Report**	
	Peter Wightman presented the report. The ***Virtual Ward*** paper was taken as read and accepted as reflective of the direction of travel for the step-up provision and measures to enhance this. NC referred to the Trust retaining patients who should be under social care and the ICB. Was there an argument for money to follow the patient rather than provide support to the ICB? PW advised that money had been apportioned to the Trust, but had been retained by the ICB due to a change in forecast. Resource was being committed in 2025/2026. Further, the rate of patients with no criteria to reside has improved.	

	CM suggested this was an opportunity to look at actioning discharge in a different way. The underspend had been as a result of mental health support. The Trust was working with systems to ensure schemes were put in place. NC stated that if the money followed the patient it would come to WSFT. Failure to reside was increasing Trust costs. **Action: PW and NC to discuss outside of meeting.** RG advised that use of virtual ward was a step up in terms of frailty and a key tool for that cohort of patients in avoidance of admission. NC asked if a conversation had been had about accelerating the milestone? **Action: NC and CM to discuss outside of meeting.** Alison Wigg (AW) asked in terms of step up, how much work had been undertaken with the ambulance service? CM advised that this was an opportunity to strengthen what the Trust was currently doing with the ambulance service and Early Intervention Team (EIT). A step-up option for the ambulance service would be for EIT to refer to Virtual Ward where appropriate. More work was to be done on strengthening of pathways. Consideration was also being given to direct referral from primary care on to Virtual Ward. TD asked where and how the assurance on the detail of delivery was to be provided? EC responded that this would be via the Improvement Committee for the Board and in the meantime through the Community Performance Review Meeting.	**PW/MC** **NC/CM**
2.4	**Digital Board Report**	
	Sarah Judge, (SJ), Interim Chief Information Officer, presented the report. Noted the Intensive Care Unit (ICU) has gone live on e-Care. The last of the medications have been added, with complex medications going live at the same time as ICU. The new Patient Portal is now live, with a simpler registration process using the same login credentials as the NHS app. With the ability for patients to receive information immediately, EC asked how close the Trust was to being able to switch off paper communication? SJ advised that whilst paperless numbers were increasing, the Trust was taking a digital first approach but not a digital only approach. During the next year, the Trust would be looking at information coming in to the Trust, i.e. digital surveys, together with the outpatient process, to encourage use of the patient portal. AW asked what the digital team's thoughts were on freeing capacity for more strategic elements. SJ advised that the challenge was what could be delivered with the resources available. It was important to use current resource for standard service, upgrades and transformation. The team were prioritising and remained agile. ST advised that the strategy refresh would assist in deciding priorities.	

	NC acknowledged that it was a challenging time for digital services with the current service restructure. The digital programme had been discussed at the Management Executive Group (MEG) and will require Board support for some of the decisions made. Current finances will result in a constraint in resources.	
2.5	**Collaborative Oversight Group**	
	ST presented the report. NC suggested there would need to be difficult questions asked in terms of cost benefits of working collaboratively and at times both Trusts would need to take stock of how this is working in light of sustainability. **Action: ST to include cost benefits within report**. EC asked if the 600 patients referred to as having completed their surgery via ESEOC were all WSFT patients or a mix across SNEE. **Action: ST to confirm.**	**ST** **ST**
3.0 ASSURANCE		
3.1	**IQPR Report**	
	Nicola Cottington,Chief Operating Officer, presented the report. ***Urgent & Emergency Care (UEC)*** - noted changes have been embedded. The change in diagnostic performance has been driven by a backlog and workforce challenges. The IQPR and PRM are being redrafted as part of the accountability framework. TD stated it was good to see a step change in performance in UEC standards, together with an improvement in elective and cancer. She asked what was the level of confidence that a trend of improvement could be sustained as the Trust entered in to 2025/2026. NC advised there was a high level of confidence. Elective had sustained a period of improvement over the last 3 years, post pandemic. Priorities did shift in light of planning guidance. Focus was now on constitutional standards. In terms of UEC, this was due to marginal gains, with lots of different changes undertaken by the Trust and System to effect change. It was unlikely to sustain the high 80s for the remainder of the year, but the Trust's ability to recover is improved. There has been a significant reduction in 12 hour waits in ED. Noted most gains have been made from improving processes, holding people to account and senior support. This now needs to become automatic. SW advised that the timeliness of nutritional assessments was under review and the issue of post-partum haemorrhage was coming back to Improvement. C-diff had been presented as a deep dive at the Improvement Committee and demonstrated the use of robust audit data. JMO stated that the headline metrics from a workforce perspective remain on target, particularly turnover at 7.5%. Concern as a	

	Board is the decline in the Estates and Facilities Directorate due to sickness levels and staff turnover. Noted a leadership change is taking place. HR are struggling to support due to recruitment controls. JC asked if the Management Executive Group (MEG) was looking at potential solutions? JMO advised that this was being monitored at Improvement. A new leader of Estates and Facilities will be key. JC asked when this position was likely to be filled. Jonathan Rowell (JR) advised that further interviews were to be undertaken on 31st March, 2025. In the event a successful candidate is not identified the role will be filled by an interim. Given potential risks associated with this the leadership will need to be strengthened. EC referred to concerns regarding staff sickness in the current financial climate. The stats did not appear to be showing an impact. He asked what this suggested for the next 12 months and why the changes anticipated were not being seen. JMO could only speculate. The Trust had tried to communicate well to reassure and the wellbeing services offered were good and being accessed by staff. Measures were in place for concerns to be raised. The Trust had tried to strike a balance between reducing costs and providing core services. JMO advised that distress shown at the decisions being made was because staff cared.	
3.2	**Finance Report**	
	JR presented the report. Noted the Trust is in the process of actioning year end. Prior to any adjustments the Trust remains confident of achieving the £26.5m deficit.	
3.3	**Operational Planning Guidance**	
	JC advised that the guidance had been approved at Insight and was brought to this meeting for information. NC highlighted that the trajectory for the 52-week compliance had been amended since Insight. The trajectory submitted would allow the Trust to achieve 1% by the end of March, 2026. Noted the Trust was compliant in its submission for all operational planning targets. Risks have been flagged due to assumptions on productivity. The current financial target heightened the risk. AJ advised that at Insight the risk of not meeting the trajectory had been reported. What had informed the change? NC stated that the risk in not meeting the 63.6% for 18 weeks RTT had been highlighted at Insight and the risk remains. What has changed is that the percentage of waits over 52 weeks submitted to Insight at 3% at the end of March had been updated to 1%. The reason for 3% previously was due to local and national guidance that focus should be on 18 weeks. This guidance changed 10 days ago. It remained the case that the Trust was committed to achieve all requirements of the planning guidance.	

3.4	**Capital Planning 2025-26**	
	Noted this planning had been approved at Insight and was brought to this meeting for information only. The paper was noted and accepted.	
4.0 PEOPLE, CULTURE AND ORGANISATIONAL DEVELOPMENT		
4.1	**Involvement Committee Report**	
	The report was noted. TD congratulated Jamais Webb-Small, Organisational Development Manager and the team on the excellent examples of EDI in education and training. JMO advised that substantial assurance in this regard would be not to see any discrimination. However the Trust has processes in place with its staff networks to be able to respond.	
	People & OD Highlight Report	
	Awards noted and thanks offered to staff concerned.	
5.0 OPERATIONS, FINANE AND CORPRATE RISK		
5.1	**Insight Committee Report**	
	The report was noted and taken as read.	
6.0 QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT		
6.1	**Improvement Committee Report**	
	The report was noted and taken as read.	
6.2	**Quality and Nurse Staffing Report**	
	SW presented the report. Noted January and February had been challenging months, with high levels of sickness and requirement for additional capacity. Sickness was improving which is indicative of the end of the Flu season. Infection outbreaks on wards had had an impact on staff. Care Hours Per Patient Day (CHPPD) are also likely to improve as the seasonal pressure ward closes and sickness levels improve. Noted fill rates of shifts is 90% at day rate for Registered Nurses. Staffing levels at night are already in the lower threshold and therefore cannot be further reduced. Whilst concerned at day fill rates, mitigations are in place. Midwifery is on track to be underbudget by year end. No impact on quality indicators for pressure ulcers. JMO asked if other Trusts were recording CHPPD the same way as WSFT? Further, in the multi professional setting, were we counting hours of care from Allied Health Professionals and if not perhaps others were? SW advised that the Trust was recording nursing hours. Accurate figures were detailed in the paper and had been uploaded to the national database. These were being mitigated with peripatetic staff.	

	NC highlighted the importance of using a range of metrics. She queried where improvements might be seen from staff not being deployed to other areas. SW advised that a reduction of any escalation space would have a positive impact on nursing staff as they would be spread less thinly. EC referred to the dichotomy between CHPPD and the Safer Nursing Care Tool (SNCT). What was the more meaningful measure? SW advised that the SNCT was peer reviewed, checked and is how the Trust sets its establishment. Fill rates are informed by the SNCT. A robust review has been undertaken at the Involvement Committee. EC asked if the tool, (SNCT) sets the establishment, why is CHPPD so different and is it relevant? SW reported that CHPPD is dependent on what wards are open and patients admitted. This should be read in conjunction with other data, hence the inclusion of quality data in the report. JC asked if there was an argument for having an external validation of the use of the SNCT. SW advised that there was external training on its use and a peer-to-peer review. There was specific criteria and clear definitions. JMO reported on a national piece of work being undertaken to review and update national profiles for registered nurses. There was a risk to the Trust in terms of staffing and finance. Work is being undertaken with the national team to review the utilisation and impact of 1-1 specialling.	
6.3	**Maternity Services Report**	
	Karen Newbury, Director of Midwifery, presented the report. Noted since the introduction of the core competency framework, multi professional training is required in several areas, including paediatrics, theatres and anaesthetics. Whilst organisation of this is proving challenging, the Trust is meeting the core competency framework requirements. HH asked if this training was required to be face-to-face? KN advised that it was in order to evidence multi professional training for all elements.	
7.0 GOVERNANCE		
7.1	**Audit Committee Report**	
	The report taken as read. Following the recommendation of the Audit committee, the Board gave its approval to the following: • Scheme of Reservation and Delegation of Powers Policy – PP366 • Standing Financial Instructions Policy – PP364	

	• Policy on the engagement of the external auditor to supply non audit services.	
7.2	**Board Assurance Framework**	
	Pooja Sharma (PS), Deputy Trust Secretary, presented the report. JC asked if any major changes in the ten BAF risks had been identified. Richard Flatman (RF) referred to the need for a conversation on risk appetite by the Board, highlighted previously. AJ stated that some BAF changes had not been presented to the Board. JC requested that any change recommended to risk appetite be bought to the Board for approval, together with logic behind the request. JC referred to the finance risk, to be discussed at the next Insight Committee, with ratings included. AJ advised that actions to ensure capacity risk sat with capability or transformation. At times it was hard to gain a sense of whether the actions were being implemented. ST advised that he and PS had met to look at templates to be used for discussion at the Management Executive Group (MEG). NC stated that the current BAF format was agreed a year ago and was unsure of the ability to engage in BAF in its current format. Noted PS is looking at templates for this and will work with the executive team and the Head of Health, Safety & Risk. **Action: Update to come to May Board Meeting.**	**PS**
7.3	**Governance Report**	
	PS presented the report. NC referred to the Risk Management Policy and actions for the strategy. Should the BAF be incapsulated in the policy? JC advised that the policy and strategy were how the Trust approached risk rather than what it looked like. The policy will be reviewed at the strategy refresh stage. RF enquired as to training on risk management for the Board. Noted this had been provided prior to commencement of the new NED cohort and will be undertaken again with the strategy refresh. **The Board gave its approval to the following:** • Risk Management Policy and Strategy • Terms of reference for the Improvement, Involvement and Audit Committees • Updated Modern Slavery Statement.	

8.0 OTHER ITEMS		
8.1	**Any Other Business**	
	Noted this was JMO's last Board Meeting following his resignation from the role of Director of Workforce and Communications. JMO stated he was immensely proud to have been a part of the Board and offered his thanks to all. JC responded that JMO's assistance to the Board and to him personally had been invaluable. EC stated that JMO was leaving the organisation in a better place and would be missed.	
8.2	**Reflections on meeting**	
	• Patient story and the importance of keeping focus on quality and safety for patients. How did the Trust use learning from these to imbed in the rest of organisation? **Action: Discussion to be taken to Improvement Committee on how to spread learning.** • Oliver McGown Training – importance acknowledged, but the Trust is unable to release staff in great numbers. • Business today undertaken at pace which was not felt to be sustainable in the long term. ○ Can put pressure on those attending to present at such a pace. • It is important to remember that the majority of times staff deliver fantastic care and services to the population. Today has been uplifting.	**SW**
8.3	**Date of next meeting** 23 May, 2025.	

1.4. Action log and matters arising (ATTACHED)

To Review

Presented by Jude Chin

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3123	Open	31/1/25	6.1	**Involvement Committee** - Plan detailing actions for addressing any issues identified from Annual Staff Survey to be included with final report to the Board.	**The staff survey action plan was presented at the April meeting of the Involvement Committee, as a follow up to the initial results provided in February. A report is on today's (23.5.25) agenda.**	JMO/CS	23/05/25	Complete	23/05/2025
3128	Open	28/3/25	2.1	**WSFT Strategy** - Deputy Trust Secretary to ensure Board papers contain EDI implications going forward.	**A reminder has been sent to all authors of Board Meeting papers to complete the EDI section**	PS	23/05/25	Complete	23/05/25
3129	Open	28/3/25	2.3	**System Update/Alliance Report** - Patient Discharge - Failure to Reside - Funding. Discussion outside of meeting.	**Discussion held. No further action required.**	PW/NC	23/05/25	Complete	23/05/25
3130	Open	28/3/25	2.3	**System Update/Alliance Report** - Virtual Ward and avoidance of admission for frailty cohort. Acceleration of milestone. Discussion outside of meeting.	**Agreed to accelerate trajectory and updates to be provided through Community Performance Review Meetings.**	NC/CM	23/05/25	Complete	23/05/25
3131	Open	28/3/25	2.5	**Collaborative Oversight Group** - cost benefits to be included in future reports.	**Action to be replaced following the Sustainability Review, due to implementation of a refreshed approach to collaboration with ESNEFT.**	ST	23/05/25	Complete	23/05/25
3132	Open	28/3/25	2.5	**Collaborative Oversight Group** - confirm if 600 patients referred to in report as having completed surgery at ESEOC are all WSFT patients.	**Action to be replaced as a result of the Sustainability Review, due to implementation of a refreshed approach to collaboration with ESNEFT.**	ST	23/05/25	Complete	23/05/25
3133	Open	28/3/25	7.2	**Board Assurance Framework** - Update to May meeting on BAF templates.	**Working with the executive team to review and agree BAF template. To ensure the template remains current and effectively supports our refreshed strategy, the template will be discussed at a future board development day, aligning with our two yearly training on risk management, BAF/strategic risks and risk appetite. Added to Board development forward planner.**	PS	23/05/25	Complete	23/05/25

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3121	Open	31/1/25	3.1	**IQPR Report** - Comprehensive report on UEC to come to March Board Meeting. AJ and NC to agree on template to be used.	Insight Committee in March is focusing on the Trust's Planning Guidance submissions which need to be made before the March Board meeting. Urgent and Emergency Care is scheduled for a deep dive at the May meeting. **To feature at May Insight Committee on 21 May. Update to be provided at July Board meeting. Action to remain open.**	NC/AJ	~~28/03/2025~~ 25/07/2025	Green	
3124	Open	31/1/25	6.1	**Freedom to Speak Up** - Consider presentation of data to reflect reported concern results as a percentage of total workforce.	**Detail to be contained within May FTSU report.**	JS	23/05/25	Green	
3127	Open	28/3/25	2.1	**WSFT Strategy** - ST to advise due date for Engagement Plan to come to the Board.	**Engagement work commenced on 19 May. Update to come to July Board.**	ST	25/07/25	Green	
3134	Open	28/3/25	8.2	**Reflections on Meeting** - discussion on how to imbed learning from patient stories to be taken to Improvement Committee.	**This is being progressed via the patient experience and quality and safety teams, to confirm with Improvement Committee on how this will be captured and actioned.**	SW	23/05/25	Green	

1.5. Questions from Governors and the Public relating to items on the agenda

To Note

Presented by Jude Chin

1.6. Patient story - presentation

To Review

Presented by Susan Wilkinson

1.7. Chief Executive’s report (ATTACHED)

To inform

Presented by Ewen Cameron

WSFT Board of Directors (Open)	
Report title:	**CEO report**
Agenda item:	1.7
Date of the meeting:	23 May 2025
Sponsor/executive lead:	Dr Ewen Cameron, chief executive
Report prepared by:	Dr Ewen Cameron, chief executive Sam Green, communications manager (acting) Anna Hollis, deputy head of communications

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 headlines for May 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 Board 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
The Board is asked to note the content of the report.

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

Legal and regulatory context:	NHS Act 2026 Trust Constitution

Chief Executive Officer's 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 an enormous effort 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 4 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 78% in 2024/25 (this remains at 78% for 2025/26). The Trust's performance ranked it as the highest performing trust in the east of England, and fourth nationally. Crucially, we sustained this into April.

Over the winter period from 2024 into 2025, the Trust worked 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.

The honest reflections and subsequent changes have made a clear difference. Importantly, this means patients are getting the care they need more quickly, we're reducing long waits in the emergency department, and it is 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 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 March 2025, the position is:

- >79% of patients had cancer ruled out or confirmed within 28 days, this is a continued improvement and in line with achieving the national standard of 77% by March 2025.
- >83% 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.

2. STRATEGY

2.1. WSFT Strategy (ATTACHED)

Presented by Sam Tappenden

WSFT Board of Directors (Open)	
Report title:	Trust Strategy Refresh Update
Agenda item:	2.1
Date of the meeting:	23 May 2025
Lead:	Sam Tappenden, Executive Director of Strategy and Transformation
Report prepared by:	Sam Tappenden, Executive Director of Strategy and Transformation

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 purpose of this report is to provide an update regarding the refresh of the Trust's corporate strategy. This report will set out updated timescales for the strategy refresh, outline the proposed approach, and highlight the draft 'ambitions' to be tested with stakeholders.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
It is crucial that the Trust has a robust strategy to ensure that the organisation is fully aligned in the delivery of the organisation's key priorities.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
Deliver the engagement activities to support the strategy refresh, completion of strategic analyses, and commence the development of the strategy document itself.
Recommendation / action required
• Deliver the engagement activities as planned. • Provide updates to the Management Executive Group (MEG) to track progress. • Deliver a refreshed public strategy document to Board on 25th July for approval.

Previously considered by:	Public Board
Risk and assurance:	The strategy is being developed at pace. There is a risk of delays owing to the Trust's focus on financial and operational improvement.
Equality, diversity and inclusion:	A core tenant of the draft ambitions pertains to having an inclusive, supported, and valued workforce. The strategy will ensure EDI is incorporated as an important component of a robust organisational culture.
Sustainability:	The strategy will play a critical role in delivering the Trust's financial sustainability through aligning Trust resources on key priorities.
Legal and regulatory context:	A key role of the Board is ensuring the Trust has a robust strategy.

Strategy update to Board
Date: 14th May 2025
Author: Sam Tappenden, Executive Director of Strategy and Transformation

1. Purpose

1.1. The purpose of this report is to provide the Board with an update regarding the refresh of the Trust's strategy 'First for the Future'.

1.2. This report will set out updated timescales for the strategy refresh, outline the proposed approach, and highlight the key dependencies.

2. Context

2.1. The Trust's strategy, 'First for our patients, staff, and the future', was published in January 2022. The strategy articulates a vision, three ambitions, and five values as follows:

- **Vision:** 'To deliver the best quality and safest care for our community'.
- **Ambitions:** (1) first for patients; (2) first for staff and (3) first for the future.
- **Values:** Fairness, Inclusivity, Respect, Safety, and Teamwork.

2.2. The strategy was intended to cover the period 2021 – 2026, with annual reviews to oversee the strategy's delivery success.

2.3. As well as the corporate strategy, the Trust has several enabling strategies, including digital, quality, estates, and clinical and care.

2.4. The Trust has several gaps in its departmental-level strategies, which will be addressed through the strategy refresh process.

3. External environment

3.1. There are several material changes taking place in the Trust's external environment which will have a significant impact on the Trust's strategy:

- The highly anticipated NHS 10-Year Health Plan which is due to be published in Spring 2025.
- The government's focus on the 'three shifts' of hospital to community, 'analogue to digital', and 'treatment to prevention'.
- The sharp focus on planning guidance on financial sustainability, waiting list recovery, and productivity.
- The Suffolk and North East Essex (SNEE) Sustainability Review, which has now concluded.
- Accelerated local government devolution in Suffolk.
- The abolition of NHS England (NHSE), and considerable workforce reductions in Integrated Care Boards (ICBs).
- On-going discussions with the National Hospital Programme (NHP), regarding the development of a new West Suffolk Hospital.

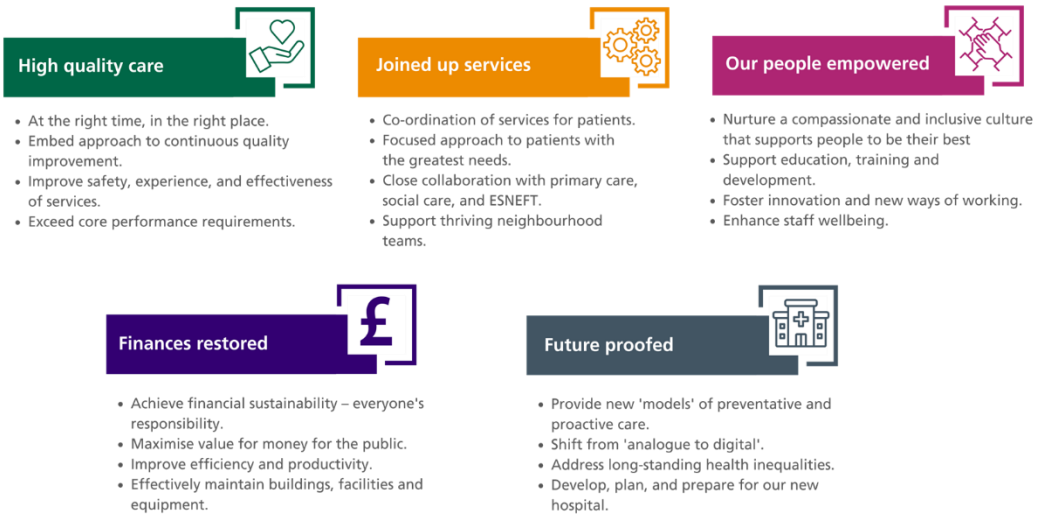
4. Our draft ambitions

4.1. The Trust has developed a high-level visual of **five draft ambitions** which we will use in our engagement materials.

4.2. The purpose of the visual is to provide stakeholders with a focal point on which to centre their feedback, a sense of the Trust's direction, and an opportunity to test key concepts.

4.3. It is likely that the visual, ambitions, and language will change significantly following feedback, and it is important to note that a considerable amount of detail will be developed under our final ambitions for the final strategy.

Figure 1: draft ambitions for testing with stakeholders



5. Communications and engagement

5.1. In October 2024 the Board agreed to a 'refresh' of the Trust's strategy to take account significant changes, challenges, and opportunities.

5.2. Significant engagement has since taken place with the Trust's Board and Senior Leadership Team (SLT), with plans to engage much more widely.

5.3. It was planned that a refreshed strategy be delivered by April 2025, however, significant external factors led to a decision to delay the refresh.

5.4. However, the Communications Team have developed a clear engagement approach to ensure we capture the views of our stakeholders.

5.5. Engagement will take the form of surveys, focus groups, and feedback from staff, as well as 1:1s with leaders in partner organisations.

5.6. The staff survey will be issued via internal channels (e.g. staff briefing), and regular meetings accessed for focus groups (e.g. medical staffing committee, non-medical clinical council, Trust council, all staff update) as well as some in person events and online events set up.

5.7. The Trust will share the survey with our patient VOICE group for feedback.

5.8. Structured interviews will be carried out with key stakeholders and relevant stakeholder forums accessed where possible.

6. Updated timescales

6.1. Engagement commenced on 19th May, and is due to continue up until the end of June to allow sufficient time for feedback.

6.2. The strategy can then be refreshed, refined, and presented to Board on the 25th July for final approval and then implementation.

7. Next steps

7.1. Deliver the engagement activities as planned.

7.2. Provide updates to Management Executive Group (MEG) to enable executives to track progress.

8. Recommendations

8.1. For a refreshed strategy to be presented to Board on 25th July.

2.2. Future System board report (ATTACHED)

To Assure

Presented by Ewen Cameron

Open Trust Board Committee	
Report title:	Future System Board Report
Agenda item:	2.2
Date of the meeting:	23 May 2025
Sponsor/executive lead:	Ewen Cameron
Report prepared by:	Gary Norgate

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 project to replace the current West Suffolk Hospital is formally a **Scheme** within the national New Hospitals **Programme** (NHP). The following report provides an overview of progress being made towards our goal to build a sustainable new hospital for West Suffolk.

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

Scheme Status

As reported last month, the project to build a new West Suffolk Hospital is within the first wave of schemes to be built with an expected commencement date in 2027/28 and a capital budget of between £1 and £1.5bn. A more precise capital figure, within this range and based on a new build space of 97k sqm has been confirmed in writing but remains commercially sensitive[1].

Royal Institute of British Architects (RIBA) Stage 2 Design:

Stage 2 designs see our new hospital drawn to the 1:200 scale and provide detail on how services will be positioned within the new hospital as well as how they interact with utilities and the fabric / grid of the building.

Since completing our RIBA2 report in December, two significant developments have occurred:

[1] The Trust and the Programme needs to retain the ability to negotiate with potential suppliers and as such the actual capital budget is being treated as commercially sensitive.

a) The national new hospital programme has continued to develop and release the details of its standard design (known as Hospital 2.0 – H2.0).
b) The capital envelope for our new hospital has been formally agreed and communicated.

These developments provide the Trust with the challenge of adjusting the scope, scale and preferences of its design to meet the allocated budget and the opportunity to benefit from increased adoption of the H2.0 standard.

In last month's update I explained how the process to reconcile these challenges and opportunities would create a short hiatus in our programme. This month I am pleased to report that work has progressed positively and that we are nearing a point where we will have an agreed and affordable schedule of accommodation that can be used to produce a set of coordinated drawings that will show how departments will function and interoperate.

The changes recommended as part of this exercise have been carefully considered against the design that we had first constructed. The functional content of each department has been reviewed "side by side" to ensure critical clinical requirements have not been downgraded or removed. In many cases functional space has increased, however, there is a greater emphasis placed upon the need to improve productivity to maximise the return on the investment in modern infrastructure and systems.

The clinical team from NHP will be visiting West Suffolk at the end of May to present the process and logic that has informed the standard design to our own clinical teams.

Project Plan

The snap-shot below highlights how we remain on track to complete our affordability review by the end of May. This will enable us to re-visit our RIBA2 drawings and produce a new layout demonstrating how departments will work together within the fabric of the building. Having agreed the revised design, we will progress to the next level of design detail (RIBA3[2]).

MAIN PROJECT HOSPITAL	1950 days?	Mon 17/02/25	Thu 20/01/33
Capital Affordability	61 days	Mon 03/03/25	Fri 30/05/25
Re-Work RIBA 2 Design	109 days	Mon 02/06/25	Fri 31/10/25
Main Contractor Procurement Via NHP Framework	195 days	Mon 17/02/25	Fri 21/11/25
RIBA Stage 3 Technical Design	211 days	Mon 22/09/25	Fri 31/07/26
Reserved Matters Planning Approval & Planning Conditions	183 days	Fri 01/05/26	Thu 28/01/27
Outline Business Case (OBC) Finalisation - Based on RIBA Stage 3	50 days	Mon 22/06/26	Fri 28/08/26
OBC Approval (NHP / NHSE / Treasury)	125 days	Fri 28/08/26	Fri 05/03/27
RIBA Stage 4 Design (Contractor Led)	314 days	Mon 03/08/26	Thu 04/11/27
Full Business Case (FBC) Finalisation	40 days	Fri 05/11/27	Thu 13/01/28

RIBA3 is a critical step in our project plan, if its date for completion slips, so does the next design phase, the completion of our final business case and, therefore our date for construction – hence it is extremely important that we commence and complete this task in line with the defined schedule.

The procurement of a main contractor is being progressed nationally via. The Hospital 2.0 Alliance Framework which has now been launched and has attracted a wide range of capable, credible bidders (minimising the risk that schemes will not be able to find a suitable construction partner). The process for announcing successful bidders remains on track for completion in quarter three of the 25/26 financial year. This means that West Suffolk will have secured a construction partner well in advance of both the commencement of the RIBA4 design phase (allowing early engagement) and the writing of the final business case.

Commercial Progress

[2] RIBA3 is known as the spatial coordination phase and focuses on developing the concept into a more detailed coordinated design. It ensures the plans meet building regulations, prepares us for our full planning application and finalises cost information.

Having previously considered the terms and conditions that will underpin how Trust's, the Programme and the Construction Partner will work together, the outstanding matters of concern, relating to how HM Treasury will underpin any decisions that are in the best interest of the Programme rather than the Trust, have been addressed and the Board will now be asked to sign the agreement[3].

Finance

The Programme is progressing within its NHP allocated budget and is fully funded to complete the activities associated with RIBA stages 2 and 3 as well as its Outline Business Case in the 25/26 financial year.

The hiatus created by the need to conclude a design that fits within the allocated capital envelope means that the completion of the outline business case (including RIBA3) now extends beyond the current financial year, hence additional budget will be required to complete these deliverables. This funding will be sought at an appropriate point so that funding continues seamlessly between years.

Outside of capital affordability, the Trust continues to work with its ICB colleagues to assess and understand the sustainability of its current and future operational costs. Given the fact that any new hospital will increase capacity, the Future System Team are working to ensure the implications and benefits of a new hospital are fully understood and reflective of any changes to our established clinical model.

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

- Complete the affordability review with NHP and arrive at an agreed, affordable schedule of accommodation.
- Use the agreed schedule to produce revised 1:200 layouts.
- Commence RIBA3 design (September 2025).
- Transformation – continue plans for the delivery of the Clinical and Care Strategy and draft an operational readiness plan.
- Continue to work with co-production teams on the refinement of scale and layout of individual departments.

Action Required

The Board are asked to note the content of this report.

Risk and assurance:	Risk of failure to ensure that the health and care system has the capacity to respond to the changing and increasing needs of our communities
Equality, Diversity and Inclusion:	Building hospital ensuring inclusivity, equitable access to healthcare services for all communities.
Sustainability:	Implementing environmentally responsible practices and sustainable health care practices.
Legal and regulatory context	The Health and Care Act Compliance with all relevant national and local laws Trust Constitution

[3] Note: The commercially sensitive nature of the agreement has been considered in detail by the Executive Programme Board and its recommendation for signature will be put to the Board in its private session.

2.3. Suffolk System Update Report - SNEE Integrated Care Board (ICB); Wider System Collaboration (Verbal)

To Assure

Presented by Peter Wightman and Clement Mawoyo

2.4. Digital Board Report (ATTACHED)

To Assure

Presented by Nicola Cottington

WSFT Board of Directors (Open)	
Report title:	**Digital board report**
Agenda item:	2.4
Date of the meeting:	23 May 2025
Sponsor/executive lead:	Nicola Cottington, chief operating officer
Report prepared by:	Sarah Judge, interim CIO

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 digital programme for 2025/26 has been through a process of prioritisation to allow staff and resources to be focused on key areas. This has been scrutinised through the management executive group, quality impact assessment and clinical review.

Cyber security remains a focus for the Trust, with increasing activity within the Senior Information Risk Owner (SIRO) domains. This includes engagement plans for both cyber security and SIRO activities for the next year.

The new digital patients steering group was stood up in March 2025 and includes patient representation.

The annual clinical safety report has been received.

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

This is the first time such a prioritisation has occurred and allows the digital services department to focus on key areas such as compliance and cyber security, urgent patient safety requirements, major upgrades and CIP.

The digital clinical safety officer has put in place a number of processes to ensure we meet digital clinical safety requirements, but also to look at wider themes across the whole department.

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

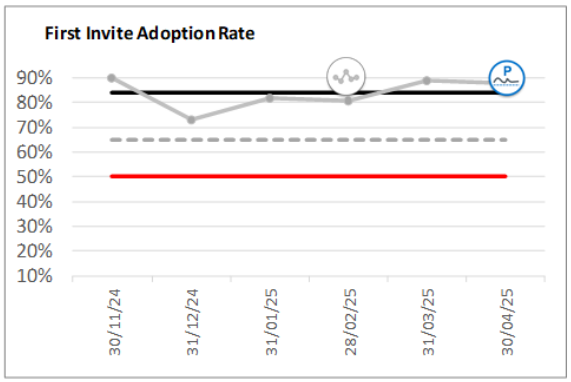
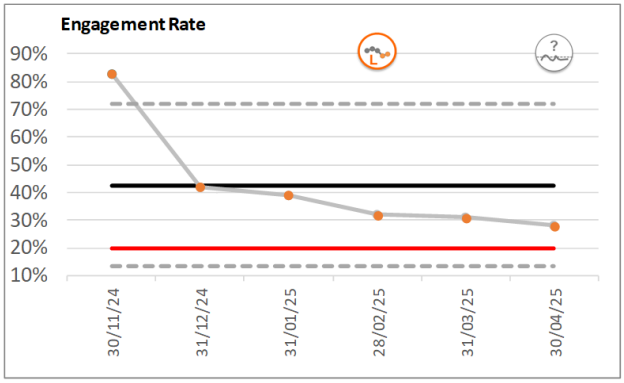
Communication regarding prioritisation of the digital programme is underway, including how staff can request digital support for projects, bring innovations to us and appeal a project that is put on hold. The

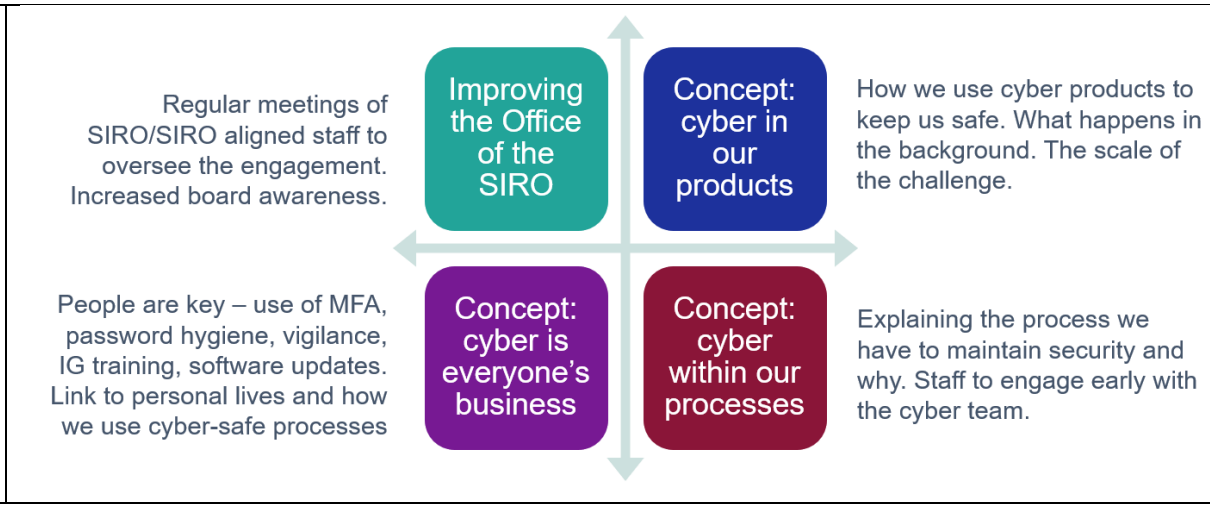
internal process are being strengthened to ensure each project has clinical or operational owners, funding, benefits owners and the relevant business cases.
Action Required
None

Risk and assurance:	The digital programme is managed through standardised project management methodologies and risk management. Risks are escalated through the appropriate steering group and through to the executive leads where appropriate. Prioritisation of the digital programme has included a quality impact assessment.
Equality, Diversity and Inclusion:	Each project will include an equalities impact assessment as per Trust process.
Sustainability:	Increasing focus on this, particularly within our infrastructure projects. Projects feed into the Green Plan where relevant.
Legal and regulatory context	External scrutiny via compliance assessments such as DSPT/CAF, DCB0160 – clinical risk management, DCB1596 secure email etc.

Digital board feedback

1.	Key areas of focus
1.1	**Prioritisation of the digital programme** has taken place. This is the first major prioritisation of the programme in several years and allows the department to focus on four key areas: • Mandatory requirements, cyber security and compliance • Urgent patient safety issues • Major system upgrades • CIP initiatives A considerable number of projects have been put on hold, with communications going out to all project owners. The 'front door' process into digital is being revised, with additional scrutiny being placed on projects that are submitted to the department to ensure clinical/operational engagement, funding and benefits owners. We have a number of major clinical system upgrades due this year including WinPath, our laboratory information management system (LIMS). The formal kick-off session for the WinPath LIMS replacement project took place on 2 May, where key stakeholders from the laboratory team, digital services and the supplier were introduced to each other and there was a high level overview of the project deliverables. The next steps are for there to be discipline specific workshops to discuss what is going to be required in more detail. Clinisys have been working with Telefonica to start creating the servers and other infrastructure for this project, and it has been reported that they are currently about two weeks ahead of schedule. The planned go live is February – March 2026, with user acceptance testing planned for September. There are several complexities in the timing of this project due to the planned code upgrade to Oracle Health (e-Care). The WinPath replacement must be in place by April 2026 as the Capita infrastructure that WinPath uses becomes unsupported at this point.

	Another success is the go live of our Targeted Lung Health Check (TLHC) in-house solution in e-Care which allows WSFT to manage lung CT scans for all patients with a history of smoking, aged between 55-74. This has started to send invites and manage patients in early May.
1.2	Our new **patient portal**, PPUK, has now been live for 6 months, providing a full integrated patient engagement portal instead of two separate solutions. Our usage data is increasing as each month goes by. Our 'first invite adoption rate' is healthy but our adoption rate is lower than at deployment in November 2024. This is not unexpected, but we continue to monitor the downwards trajectory and will put steps in place to remediate as necessary.   The new digital patient steering group met in March 2025 for the first time to bring a focus on patient-facing digital transformation, and includes patient representation.
1.3	Community colleagues are now using the **SystmOne staff app** ("Brigid") which has been well received. This app allows staff to document straightforward care plans using a mobile device instead of on their laptops.
1.4	**Clinical safety** remains a key priority and the annual report has been circulated to digital board members. NHS England issue core national standards (DCB0160) which confirm a set of requirements that promote and ensure the effective application of clinical risk management by those organisations that are responsible for the deployment, use, maintenance and/or decommissioning of health IT systems within the health and care environment. The "clinical safety management system" continues to provide a framework to review digital clinical safety cases, with our digital clinical safety officer (DCSO) approving seven new clinical systems for go live, and one for a go live 'at risk'. The DCSO works closely with the patient safety and quality manager to review incidents relating to clinical safety, and learning from patient safety events (LFPSE) are routinely scheduled with the CIO to ensure wider scrutiny of all digital services related incidents to identify potential these and areas for improvement.
1.5	The WSFT **cyber strategy** has previously been approved but an engagement plan has been drawn up to ensure that key messages are delivered across the organisation. These may include changes in culture so that cyber security is seen as not just digital, IT or IG, but everyone's business as the risk is ever increasing. The new Data Security and Protection Toolkit (DSPT) audit using the cyber assessment framework (CAF) is due to begin shortly. Meetings with the **SIRO** (Nicola Cottington) and SIRO-aligned colleagues (e.g. digital, IG, operational) are underway, ensuring that key activities for our cyber approach are aligned across multiple departments.


Regular meetings of SIRO/SIRO aligned staff to oversee the engagement. Increased board awareness.
Improving the Office of the SIRO
Concept: cyber in our products
How we use cyber products to keep us safe. What happens in the background. The scale of the challenge.
People are key – use of MFA, password hygiene, vigilance, IG training, software updates. Link to personal lives and how we use cyber-safe processes
Concept: cyber is everyone's business
Concept: cyber within our processes
Explaining the process we have to maintain security and why. Staff to engage early with the cyber team.

Comfort Break

2.5. Collaborative Oversight Group (ATTACHED)

To Assure

Presented by Sam Tappenden

WSFT Board of Directors (Open)	
Report title:	**Collaborative Oversight Group update May 2025**
Agenda item:	2.5
Date of the meeting:	23 May 2025
Sponsor/executive lead:	Sam Tappenden, Executive Director of Strategy and Transformation
Report prepared by:	Stephanie Rose, Programme Director Sam Tappenden, Executive Director of Strategy and Transformation

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 East Suffolk and North Essex NHS Foundation Trust (ESNEFT) and the West Suffolk NHS Foundation Trust (WSFT) have been developing a provider collaborative called the 'Suffolk and North Essex Provider Collaborative (SNEE PC)'. A governance structure has been established which includes the formation of a Collaborative Oversight Group (COG) to provide assurance and scrutiny. This paper provides an update on the Collaborative Oversight Group and next steps following the outputs of the SNEE Sustainability Review.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
This report assures the Board that the trust is working collaboratively with partners within the SNEE footprint to ensure we deliver better and more sustainable services for the local population.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
A review of the existing Provider Collaborative governance will take place with our colleagues at ESNEFT in response to the outputs of the Sustainability Review.
Action Required
The WSFT Board is asked to note this update.

Risk and assurance:	There is a risk that a failure to collaborate with system partners could impede the delivery of the 'future shift' and Trust transformation priorities.
Equality, Diversity and Inclusion:	The Provider Collaborative supports more efficient and productive use of resources in the system, which in turn supports the allocative efficiency of resources, particularly to those areas in SNEE that most require health and care support.

Sustainability:	Collaboration with our partners is crucial to the Trust's long-term sustainability.
Legal and regulatory context	The Trust has a legal 'duty to collaborate' with partners.

Collaborative Oversight Group update March 2025

1.	**Introduction**
1.1	The Suffolk and North Essex Provider Collaborative has an embedded governance structure which includes a Collaborative Oversight Group. The COG has met four times since inception, most recently on 4th February 2025. The role of the COG is to provide assurance and scrutiny to the SNEE PC. Following the findings of the SNEE ICB Sustainability Review, there is a need to review the SNEE PC and its governance structures which include the COG.
2.	**Background**
2.1	The 2019 NHS Long Term Plan sets out a "duty to collaborate" which was further developed in Working Together at Scale (2021), which requires NHS Providers to be part of one or more Provider Collaboratives. With finite resources, increasing demand, and the shift towards greater collaboration, the Trust has significant opportunities to collaborate with partners for patient benefit.
3.	**Detailed sections and key issues**
3.1	The WSFT Board has received the recommendations of the SNEE ICB Sustainability Review. WSFT and ESNEFT must now review the existing structures of the Provider Collaborative and consider whether they are optimal for further collaboration.
4.	**Next steps**
4.1	Work has commenced to consider options for the SNEE PC and associated governance structures, including the COG, to ensure effective governance is in place to deliver the findings of the sustainability review as well as other national, local and trust priorities.
5.	**Conclusion**
5.1	With the changing NHS landscape, enhanced collaborative working and sharing of resources and expertise across our system will be critical to deliver the required pace and scale of change. The Trust has an opportunity to work closely with ESNEFT to take stock of the Provider Collaborative, and develop new arrangements to support the implementation of the Sustainability Review recommendations.
6.	**Recommendations**
	The Board is asked to support the review of the Provider Collaborative arrangements as part of the implementation of the Sustainability Review recommendations.

3. ASSURANCE

3.1. IQPR Report (ATTACHED - full IQPR under supporting Annex)

To Review

Presented by Nicola Cottington

WSFT Board of Directors (Open)	
Report title:	**Integrated Quality and Performance Report**
Agenda item:	3.1
Date of the meeting:	23 May 2025
Sponsor/executive lead:	Sue Wilkinson, chief nurse Nicola Cottington, chief operating officer
Report prepared by:	Andrew Pollard, information analyst. Narrative provided by clinical and operational leads.

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

To update and provide assurance to the Board of Directors on performance during March 2025.

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

The Integrated Quality and Performance Report (IQPR) uses the Making Data Count methodology to report on the following aspects of key indicators:

1. The ability to reliably meet targets and standards (pass/fail)

2. Statistically significant improvement or worsening of performance over time.

Narrative is provided to explain what the data is demonstrating (what?), the drivers for performance, what the impact is (so what?) and the remedial actions being taken (what next?). Please note the IQPR will be refreshed in line with the NHS 2025/6 priorities and operational planning guidance, published 30th January 2025 for performance from April data onwards. This provides an opportunity to review the structure and format of the IQPR and board feedback is welcomed. Following feedback from the national Making Data Count team, it is planned that the narrative for the metrics will be more concise going forwards, so that the key points stand out. Consideration is also being given about how to present the information to demonstrate inter-related metrics. It is planned to include a productivity section of the IQPR. A Trust Performance and Accountability framework is also in development which will set out how performance against the key metrics is managed within the organisation.

Please refer to the assurance grid for an executive summary of performance. The following areas of performance are highlighted below for the board's attention:

- The cohort of elective patients waiting 65 weeks or more continues to reduce, down from 70 patients >65 weeks at February month end to 31 patients at the end of March 2025, however this means the standard (zero patients) was missed.
- Cancer Faster Diagnosis Standard (FDS) performance increased to achieve the 77% standard a month early in February 2025 and 62-day performance exceeded the 70% requirement at 75.2% in February 2025.
- Diagnostic performance against the 6-week standard dropped from 55.2% to 53.2% in March 2025. MRI performance improving with additional Community Diagnostic Centre capacity and expected to recover by the end of May 2025. A clear recovery plan is in place for DEXA, pending the permanent scanner delivery and ultrasound pending recruitment, and the Trust is exploring remedial actions for endoscopy.
- The Trust continues to be in 'Tier 1' nationally for cancer and diagnostic waiting times performance, 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 is expecting to exit tiering completely in the forthcoming April review of Q4 2024/25 performance.
- There was a significant improvement in all UEC metrics in March. The Trust met the 30-minute ambulance handover metric, achieving 95.75%
- The number of 12-hour length of stay breaches in March significantly reduced to 181 and 4-hour performance for March was 88.39%, which exceeded the in-month trajectory of 78% and placed the Trust top in the region and fourth in the country. It is critical to maintain these improvements.
- The impact and effectiveness of the new shortened nutritional assessment for the emergency department continue to be monitored. Initial data suggests improvement.
- We continue to monitor the threshold combination of HOHA and COHA cases of C-Difficile infections and work with community colleagues to support appropriate stewardship of anti-microbial usage. We have enhanced support for the QI programme and this continues to report into Improvement committee. We have remained under the 24/25 threshold for infection.
- We will monitor the impact the current staffing within the PALS and patient complaints team has on performance.
- Appraisal participation rates are below target and decreased slightly in month to 86.9%.
- Mandatory training completion rates are better than the 90% target, improving to 90.7%.
- Staff retention remains stable with a turnover rate (8.0%) better than the target threshold of 10%. This is also now the case for each division and corporate services, with the exception of estates and facilities (11.4%), where additionally, sickness rates remain significantly adrift from the 5% target, sitting at 8.2%.

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 Board of Directors is asked to note the Integrated Quality and Performance Report for March 2025.

Previously considered by:	Board assurance committees (May 2025) Component metrics are considered by Patient Safety and Quality Group and Patient Access Governance Group.

Risk and assurance:	**BAF risk: Capacity (Ref: 02): The Trust fails to ensure that the health and care system has the capacity to respond to the changing and increasing needs of our communities**
Equality, diversity and inclusion:	Monitoring of waiting times by deprivation score and ethnicity are monitored at ICB level. From June 2024, health inequalities metrics will be included in the IQPR.
Sustainability:	Organisational sustainability
Legal and regulatory context:	NHS Act 2006, West Suffolk NHS Foundation Trust Constitution

3.2. Finance Report (ATTACHED)

To Review

Presented by Jonathan Rowell

WSFT Board of Directors (Open)	
Report title:	Finance Report – as at April 2025 (M1)
Agenda item:	3.2
Date of the meeting:	23 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			
Please indicate Trust strategy ambitions relevant to this report.	☐	☐	☒

Executive Summary

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

The attached Finance Board Report details the financial position for Month 1 (April 2025).

Income and Expenditure position

The trust has agreed to a planned income and expenditure deficit of £20.7m for the year. As of Month 1, it is reporting a slight underspend of £145k compared to the plan.

However, several factors make it challenging to draw definitive conclusions from the Month 1 reports. These include the effects of accruals from the year-end, assumptions regarding the impact of pay awards, inflation, increased National Insurance contributions, and the ongoing development of Cost Improvement Program (CIP) plans.

The Trust is on track with plans at M1 and no concerns reported.

Efficiencies

The CIP schemes aimed to generate £32.7m for the year, including a stretch target of £5.8m. In the first month (M1), the target for the CIP was set at £1.4m, which was successfully achieved. Of this, £500k represents the full-year effect of savings from 2024/25, while an additional £400k has been recorded on the tracker.

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

Budgets are phased in line with the annual plan submitted by the end of March. Consequently, the phasing of the CIP has changed since then, requiring full reconciliation.

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

Budget phasing will be further updated in Month 2. FRG will monitor the Vacancy Control Panel, Non-Pay Control Panel, and CIP Board to achieve the agreed deficit target of £20.7 million this year.
Recommendation / action required
Review and approve this report

Previously considered by:	n/a
Risk and assurance:	Financial risk
Equality, diversity and inclusion:	n/a
Sustainability:	Financial sustainability
Legal and regulatory context:	Financial reporting

WSFT Monthly Finance Report

2025-26 – April 2025 (M1)
for Public Board
23rd May 2025

Putting you first

Executive Summary as at April 2025

NHS West Suffolk NHS Foundation Trust

Summary

The Trust has agreed a £20.7m deficit budget for the year, and at Month 1 is reporting a small underspend against plan. It is difficult to draw many conclusions from M1 reporting for a number of reasons; the impact of accruals over year end, assumptions about the impact of pay awards, inflation and increased NI, and the phasing of CIP plans which are still being developed.

The Trust are reporting a 3.26% reduction in WTE's as of April 2025 (4,953.37 WTEs) compared to April 2024 (5,120.52 WTEs), a reduction of 167.15 WTEs. A net increase of 25.7 WTE's was reported in M1, however this included the impact of c30 WTE's previously capitalised. The net impact is a 4.6WTE reduction on a like for like basis. Pay spend in M1, while within plan, was an increase on the m12 run rate, however this includes the residual impact of the escalation ward, and the impact of 'super Saturday' lists in March where the impact on income has not yet been assessed.

Budgets are phased in line with that submitted in the annual plan at the end of March; understandably since then there has been changes to CIP phasing which requires fully reconciling. This will be further updated at Month 2; however the Trust is on track with plans at M1 and no concerns reported.

Revenue

The reported Income and Expenditure (I&E) for Month 1 shows a deficit of £2.7m, compared to the planned external deficit of £2.8m. This results in a favourable year-to-date variance of £0.15m. We plan to conduct further analyses and adjust the uploaded budget in the ledger to revise the budget profile starting from Month 2.

Efficiencies

The CIP schemes aimed to deliver £32.7m for the year, including the stretch target of £5.8m. In month, the target CIP was £1.4m, and this was achieved in the month. £500k is the full year effect of 24/25 savings, with an additional £400k recorded on the tracker. There is confidence that an additional £400k has been achieved although at the time of reporting this has not been recorded fully against individual schemes. Delivery of CIP ramps up through the year and therefore M1 targets are comparatively low. Work to reconcile the annual plan submission phasing of savings (submitted in March) with the (constantly iterating) CIP tracker continues.

Capital

The Capital Plan for 2025/26 has been agreed at £25.6m. £10.5m as internally funded, with the remaining £15.1m being funded by Public Dividend Capital (PDC). YTD capital spend at month 1 is £520k. This is slightly behind the phased plan, but at this early stage we anticipate that the plan for 2025/26 will be achieved.

M1 income and expenditure position

West Suffolk NHS Foundation Trust

The Trust has agreed a planned deficit of £20.7m for the year. Our adjusted run rate for the month is £2.7m, compared to budget £2.8m, resulting in a favourable variance of £0.1m. As noted above, the impact of year end and 'bedding in' of new budgets limit the conclusions which can be drawn from M1 reporting. Pay is in line with budget, with Non-Pay showing a significant in month positive variance. As the non-pay run rate is consistent with previous months, we are reviewing the budget phasing in this area.

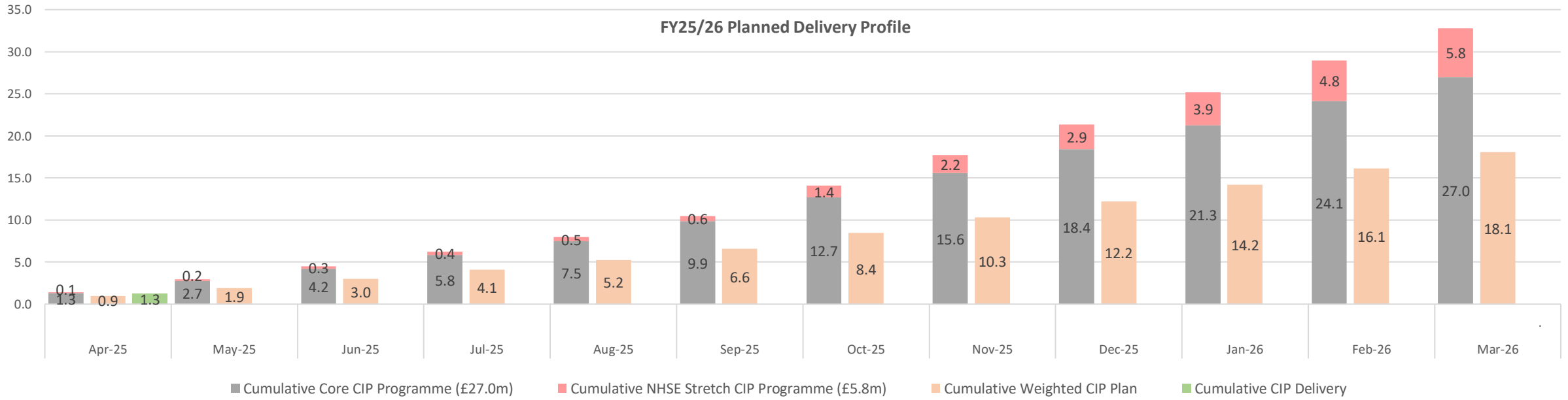
		In Month Budget £'000	In Month Actuals £'000	In Month Variance £'000 F/(A)	YTD Budget £'000	YTD Actuals £'000	YTD Variance £'000 F/(A)	Annual Budget £'000	M1 WTE Budget	M1 WTE Actual	M1 WTE Variance
Capital Charges	Capital Charges	1,893	1,938	(45)	1,893	1,938	(44)	22,721	0	0	0
Capital Charges Total		**1,893**	**1,938**	**(45)**	**1,893**	**1,938**	**(44)**	**22,721**	**0**	**0**	**0**
Income	Clinical Income	(32,057)	(32,173)	116	(32,057)	(32,173)	116	(393,941)	(7)	(10)	3
	Non Clinical Incom	(2,824)	(2,438)	(386)	(2,824)	(2,438)	(386)	(28,103)	(32)	(27)	(4)
Income Total		**(34,881)**	**(34,611)**	**(270)**	**(34,881)**	**(34,611)**	**(270)**	**(422,044)**	**(39)**	**(38)**	**(1)**
Non Pay	Clinical Non Pay	6,897	6,296	601	6,897	6,296	601	89,023	0	0	0
	Non Clinical Non P	3,538	3,718	(180)	3,538	3,718	(180)	33,820	0	0	0
Non Pay Total		**10,435**	**10,014**	**421**	**10,435**	**10,014**	**421**	**122,843**	**0**	**0**	**0**
Pay	Agency	15	147	(132)	15	147	(132)	173	2	10	(8)
	Bank	1,705	1,806	(101)	1,705	1,806	(101)	6,820	31	282	(251)
	Substantive	23,639	23,367	272	23,639	23,367	272	290,187	4,999	4,661	338
Pay Total		**25,359**	**25,321**	**38**	**25,359**	**25,321**	**38**	**297,181**	**5,032**	**4,953**	**79**
Reserves	RESERVES	0	0	0	0	0	0	0	0	0	0
Reserves Total		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Grand Total		**2,806**	**2,661**	**145**	**2,806**	**2,661**	**145**	**20,700**	**4,993**	**4,915**	**77**

25/26 CIP Progress

The FY25/26 CIP target of £32.8m is comprised of: £27.0m of core CIP; and £5.8m of 'stretch CIP. Delivery of this ramps up through the year, see graph below. The Finance team are working to reconcile the annual plan submission phasing of savings (submitted in March) with the evolving CIP tracker. As at M1, there is understandably reconciling differences between the two – and this work will be fully reconciled for M2.

As at M1, the Trust has delivered £1.3m of CIPs, against a budgeted plan of £1.4m, of which £0.1m is 'stretch' CIP, resulting in an adverse variance of £0.1m. The £1.3m delivery in M1 is comprised of £0.4m against CIPs within the detailed CIP programme, £0.5m of FYE pay CIP, and £0.4m against initiatives that have not yet been put into the CIP gateways which will be developed and more comprehensively presented as part of M2 reporting.

The £0.4m has been assured against the overall M1 financial performance of £0.15m favourable to plan.



Better Payment Practice Code (BPPC) – Month 1

West Suffolk NHS Foundation Trust

April 2025		
Better Payment Practice Code	**Total bills paid YTD Performance Number**	**Total £ paid YTD Performance £'000**
Non NHS		
Total bills paid in the year	2,925	12,971
Total bills paid within target	1,557	10,290
Percentage of bills paid within target	***53%***	***79%***
NHS		
Total bills paid in the year	80	1,899
Total bills paid within target	50	917
Percentage of bills paid within target	***63%***	***48%***
Total		
Total bills paid in the year	3,005	14,870
Total bills paid within target	1,607	11,207
Percentage of bills paid within target	**53%**	**75%**
Previous year performance	**73%**	**85%**

The table shows the Trust's performance against the Better Payment Practice Code for 2025/26. The Code measures the performance of invoices being paid within 30 days. The standard requires that 95% of invoices are paid within the 30 day target.

The performance is measured over the year and the table shows the Trust's performance at month 1. The performance has deteriorated in month 1 as we have paid a backlog of old invoices due. The performance is cash dependent, but we hope to see an improvement in the coming months.

Capital progress report

Capital Spend - 30th Apr 2025	In Month					Full Year		
Capital Scheme	M1 Original Plan	M1 Forecast	M1 Actual	Variance to Original Plan	Variance to Forecast	Full year Original Plan	*Funding Split*	
							Internal	*PDC Available*
	£000's	£000's	£000's		£000's	£000's	*£000's*	*£000's*
**New Hospital Programme	1,114	284	**284**	830	0	13,366		*13,366*
RAAC	112	50	**14**	98	36	1,340		*1,340*
Estates	504	581	**128**	376	453	5,575	*5,575*	
Digital/IT	136	136	**69**	67	67	3,138	*3,138*	
*Medical Equipment	8	20	**14**	- 6	6	550	*550*	
Radiology	85	92	**12**	73	80	1,215	*1,215*	
Net zero	-	-	**-**	-	-	420		*420*
Total Capital Schemes	1,959	1,163	**520**	**1,439**	**642**	25,604	*10,478*	*15,126*
Overspent vs Original Plan							*25,604*	
Underspent vs Original Plan								

* This includes all equipment being purchased across the Trust
** NHP budget is subject to change throughout the year and is fully funded by PDC

The Capital Plan for 2025/26 has been agreed at £25.6m. £10.5m as internally funded, with the remaining £15.1m being funded by PDC. The plan submitted to NHSE also incudes additional PDC funding of £28m for projects that have not yet been approved.

Note that the phasing of the plan was set in March, but is subject to change, particularly at the start of the financial year as projects get underway.

The capital spend as at 30 April 2025 was £520k and is below plan. At this early stage of the financial year we continue to anticipate that the Capital Plan for 2025/26 will be achieved.

Comfort Break

4. PEOPLE, CULTURE AND ORGANISATIONAL DEVLEOPMENT

4.1. Involvement Committee Report - Chair's Key Issues from the meeting (ATTACHED)

To Assure

Presented by Tracy Dowling

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

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
6.1	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

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			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

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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

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			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

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			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

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			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.

4.1.1. Staff Survey (ATTACHED)

For Report

Presented by Carol Steed

WSFT Board of Directors (Open)	
Report title:	NHS staff survey 2024 analysis and action planning
Agenda item:	6.2
Date of the meeting:	23 May 2025
Lead:	Jeremy Over, Executive director of workforce and communications
Report prepared by:	Philippa Lakins, Organisational development lead

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 NHS staff survey is conducted annually and was carried out at WSFT from 7th October to 29th November 2024. Results have declined since 2023 across most questions asked (90 out of 119 question). These results have previously been presented to this committee and are provided in summary for completeness at the start of this paper. This report outlines how this data has been triangulated with staff data from other sources, the next steps already taken, as well as plans and actions to follow. Actions are across different levels of the organisation, including at Trust wide level, as well local divisional level action planning.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
The staff survey results have been analysed and triangulated with other data sources across the Trust, resulting in 5 key priority areas: health and wellbeing; speaking up; care of patients; recommend as a place to work; and leadership and management. Actions and next steps for each of these are outlined in this report, including ways to monitor progress. It is important that these are addressed to ensure that colleague satisfaction, motivation, morale and productivity are maintained, and that sickness and turnover do not increase.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
Actions and intervention will be monitored through a number of methods, including through the engagement data collected through the pulse survey; monitoring the delivery of action plans through PRM meetings; and monitoring colleague data collected through the various colleague services e.g. HR, Freedom to speak up, staff psychology service and EAP.
Recommendation / action required
Trust Board is invited to note the themes identified and actions recommended.

Previously considered by:	Involvement Committee, Trust Council
Risk and assurance:	This work aims to reduce the risk of continual decline in staff survey results, and forms part of the mitigation work to Trust wider risks on staff engagement and morale.
Equality, diversity and inclusion:	All actions aim to be fully inclusive.
Sustainability:	N/A
Legal and regulatory context:	N/A

1. Introduction

The NHS staff survey is conducted annually and was carried out at WSFT from 7 October to 29 November 2024. The Trust uses an external company called Picker, to allow for the survey to be fully anonymous. The survey is promoted externally by Picker directly to colleagues, as well as through internal communication routes, to maximise its publicity and uptake rates. The survey questions align to the seven elements of the NHS "People Promise" as well as the themes of "engagement" and "morale". The response rate to the 2024 survey among trust colleagues was 44% (2023: 46%). The results were initially held under embargo until 13 March.

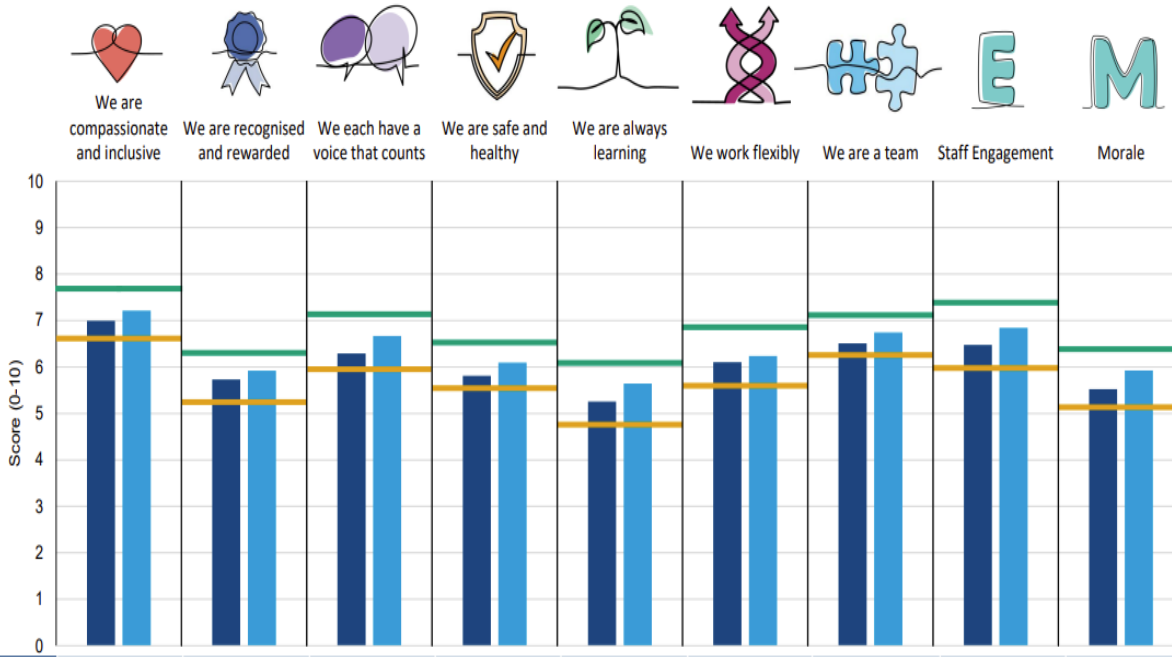
The staff survey data is available at different levels, including organisational, departmental and team levels. This paper provides an overview of key results and subsequent strategy and planning on how these results are being analysed, actioned and monitored moving forward.

2. Results

2.1. Overview of key results

For the 2024 survey the Trust utilised a mixed-mode (email/postal), full census survey of eligible colleagues. Below is the overview of topline results grouped by the seven elements of the NHS "People Promise", as well as the themes of engagement and morale, and on the following page this data is represented over the past 4 years to display the annual variations.

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	6.99	5.73	6.29	5.81	5.26	6.10	6.51	6.48	5.52
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	2369	2369	2349	2350	2260	2359	2368	2371	2372

Fig 1. People promise scores 2024

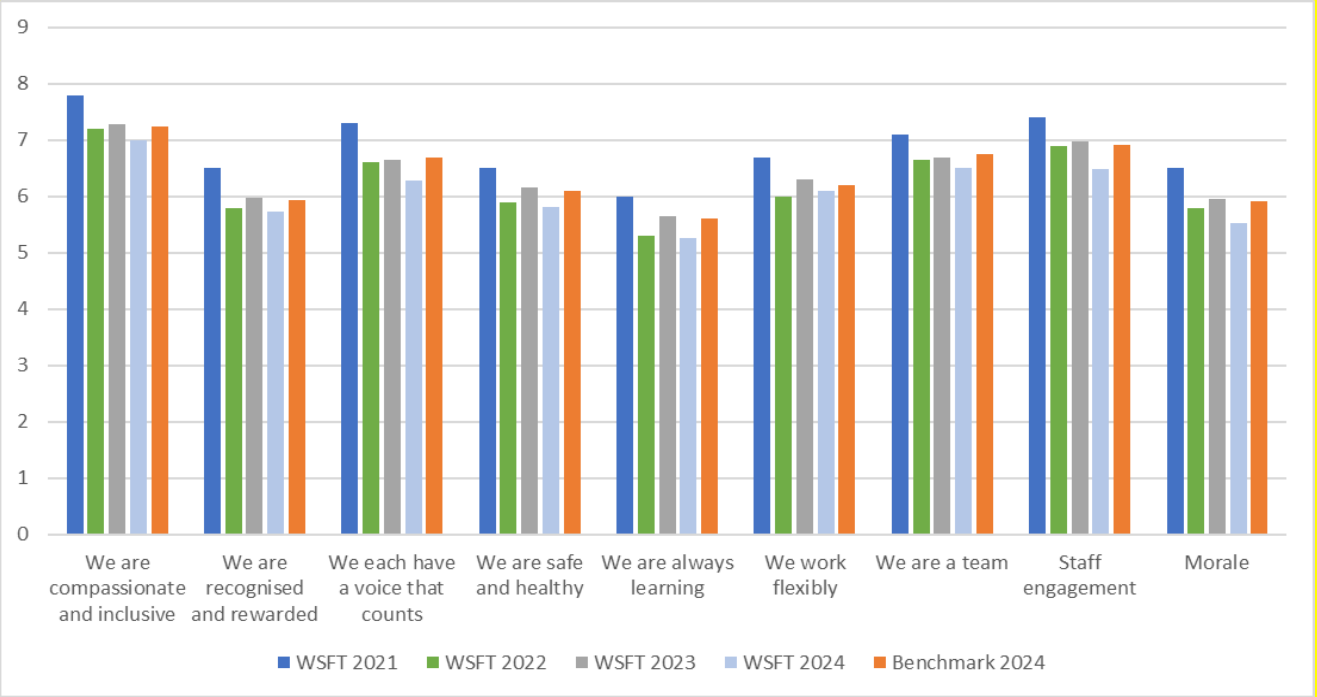


Fig 2. People promise scores 2021 - 2024

2.2. Highest five benchmarked scores (compared to average)

The following table outlines the five questions in which the Trust scored well:

Top 5 scores vs Organisation Average	Org	Picker Avg
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	74%	64%
q22. I can eat nutritious and affordable food at work	62%	56%
q23a. Received appraisal in the past 12 months	88%	84%
q11b. In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	73%	70%
q4c. Satisfied with level of pay	34%	32%

2.3. Lowest five benchmarked scores (compared to average)

The following table outlines the five questions in which the Trust scored the lowest:

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q11a. Organisation takes positive action on health and well-being	41%	55%
q25b. Organisation acts on concerns raised by patients/service users	57%	69%
q19d. Feedback given on changes made following errors/near misses /incidents	49%	60%
q24b. There are opportunities for me to develop my career in this organisation	43%	54%
q3h. Have adequate materials, supplies and equipment to do my work	47%	57%

2.4. Areas of improvement/deterioration from prior year

The table below shows where the Trust scores have improved the most:

Most improved scores	Org 2024	Org 2023
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	74%	63%
q13d. Last experience of physical violence reported	70%	67%
q11e. Not felt pressure from manager to come to work when not feeling well enough	80%	78%
q23a. Received appraisal in the past 12 months	88%	86%
q4c. Satisfied with level of pay	34%	33%

The table below shows where the Trust scores have declined the most:

Most declined scores	Org 2024	Org 2023
q11a. Organisation takes positive action on health and well-being	41%	61%
q25c. Would recommend organisation as place to work	49%	65%
q3h. Have adequate materials, supplies and equipment to do my work	47%	61%
q25a. Care of patients/service users is organisation's top priority	63%	76%
q25b. Organisation acts on concerns raised by patients/service users	57%	69%

2.5. Summary of key results

- Benchmark organisations have scored higher across most areas (WSFT is ranked 55 out of 58 for most improved scores)
- Of the 119 questions asked, (of which 113 can be compared to last year):
  - 90 questions scored lower than last year; and 68 were lower than the benchmark average
  - 17 questions scored the same as last year; and 25 were the same as the benchmark average
  - 6 questions scored higher than last year; and 26 scored higher than the benchmark average
- Little to no change in the following areas:
  - Questions about “my immediate line manager”
  - Questions about the “team”
  - Discrimination / sexual safety related questions
  - Bullying / harassment related questions
- Significant deterioration in key headline metrics related to the wider organisation:
  - Care of patients is top priority -13%
  - Recommend as place to work -15%
  - Recommend as place to receive care -9%
  - Positive action on health and wellbeing -20%

- Speak up questions worsened by c. 5-7%
- Errors / near misses questions worsened by c. 3-5%
- On balance across most questions, Community and Corporate Services generally score higher
- On balance across most questions, Estates and Facilities and Medical generally score lower

3. Data triangulation

In addition to the staff survey, there are other methods across the Trust where data is collected related to colleagues, particularly those offering different areas of colleague support. A number of them have been contacted to provide information and data that has been triangulated with the data collected through staff survey, to identify if similar themes are emerging through different support channels. HR, Freedom to speak up, Staff psychology service and EAP and have been approached and have provided information on trends of themes being reported within their respective areas. The free text comments from the staff survey have also been thematically reviewed and key themes triangulated with this data.

There was much commonality around the top themes that were reported across the different groups that support colleagues. Listed below are the main themes:

- General concerns around organisational change, topics including:
  - Consultations and how they are being handled
  - People do not feel safe when it comes to the future of their jobs
  - Concerns over workplace adjustments and flexible working being affected either directly (through jobs being put risk) or indirectly (increased pressures on teams who have lost colleagues through change activities)
  - Emotional and physical burnout, stress and anxiety
- Work related anxiety and moral distress linked to not being able to deliver required levels of care
- Behaviours – bullying and workplace unrest
- Relationships – peer to peer relationships, and manager to colleague relationships being strained and lacking communication
- Lack of equipment and tools for doing the job (particularly from Estates and facilities)
- Distress following an incident at work

Notably there has also been an increase in concerns being raised by those in administrative and clerical roles across the Trust, as well as those in other non-clinical roles involved in the corporate review, which reflects the themes that are presented here. Also notable is the fact that the prioritisation of patient care, which was one of the bottom 5 areas scoring in the staff survey, has not been a prominent theme through these feedback routes, in some instances it has not featured at all.

A number of these themes are directly or indirectly related to current CIP and organisational change activities that have been impacted the Trust for nearly a year and will continue to impact the Trust into the financial year 2025/26 as the Trust enters the “recover” period of its financial recovery plans.

Further work is planned to triangulate these findings with other key stakeholder groups, such as staff governors, staff side lead etc.

4. Action Plans

With the embargo being lifted on 13 March, there has been a greater ability to have more open discussions across the Trust about the results of the staff survey. This has included organisational level data analysis, discussions and action planning, as well as drilling into the details for specific results within divisions, department and teams.

4.1. Organisational actions

Based on the staff survey results and the data triangulation process, five key areas emerged as areas of focus for intervention from an organisational perspective:

- **Health and wellbeing** – including managing this through change, as well as reducing stress, anxiety and issues related to reasonable adjustments
- **Speaking up** – including increasing confidence of action and reducing fear of reprisal
- **Care of patients** – including being able to speak up when care is compromised
- **Recommend as a place to work** – including feeling more engaged in decision making and change processes
- **Leadership and management** – including being listened to and valued, as well as tackling poor leadership behaviours

A multi-faceted approach will be required to address these issues, with leadership from several different departments across Trust involved, from both clinical and non-clinical settings. Actions already underway have been identified to address these particular focus areas. In addition, actions within the people and culture plan 2025/26 have been cross-checked for alignment to the staff survey feedback, with actions being created accordingly to ensure that these five key areas are being addressed.

These key themes are explored further below, with a summary of agreed actions listed.

Health and wellbeing
The questions in relation to health and wellbeing were the most declined across the whole survey, with a reduction of 20% versus the previous year. Stakeholders also highlighted issues related to stress, anxiety and strained relationships are also impacting on colleague wellbeing. Actions and interventions to address this include:

- Internally commissioned and service specification changes of the staff psychology service to focus on work-related stress and trauma
- Promote and embed the new Employee Assistance Programme (EAP) providing independent colleague support, available 24/7, through Vivup
- Promote the new stress management policy (and risk assessment) to assist both individuals and managers to identify sources of stress and find effective ways to address them
- Enhanced communication to promote the range of wellbeing offers available to Trust colleagues. This includes digital promotions; regular stands in Time Out; presence at community locations and connecting with night shift workers
- Producing an area on the HR Information zone to highlight wellbeing resources to support managers and colleagues in times of organisational change
- Circulation of the new Occupational health referral document, that will reduce the number of referrals being delayed or discharged without action
- Continual promotion of the new workplace adjustment guide and dashboard
- A new training session as part of the management skills series called “Health and Wellbeing for Managers”, focusing on equipping managers with practical strategies to support staff wellbeing during change, while maintaining their own mental resilience
- Close collaborative working and triangulation of data across the health and wellbeing services to identified trends and to create joint solutions
- Handover and re-introduction of wellbeing and inclusion champions

- Continual monitoring of organisational feedback and trends through the Looking after our people group
- Continuation of driving the Sexual safety charter actions forward
- Engaging in listening exercises and forums, prioritising Medical and Estate and Facilities, as they had they had the most challenging scores

Speaking Up

The questions relating to speaking up have declined and analysis of the free-text comments suggest that some colleagues are not clear whether any action takes place, as they have not necessarily experienced any change, or don't have confidence that action will be taken. Actions identified here aim to promote the service and to encourage people to speak up:

- Continual encouragement of colleagues to speak up and the channels by which this can happen
- Feeding back on impacts/changes that have happened off the back of speaking up
- Communications plan, including promoting speaking up and sharing anonymised case studies to share how actions are followed through
- Increase personal outreach, including visiting both hospital and community sites
- Additional outreach sessions in Time Out
- Regular attendance during nightshift hours
- Poster campaign
- Continue to attend all new staff welcome inductions to promote FTSU
- Continue to attend the staff networks to promote FTSU and additionally as a route to increase diversity into the champion network
- Review, refresh and renew training for speak up champions

Care of patients

There was a decline in the measures around whether the Trust prioritises patient care and whether colleagues would recommend the Trust as a place to receive care. There are many inventions and actions that have been put in place or are going to be actioned to promote patient care, including:

- Discussion of staff survey results and action planning through the Experience of care and engagement committee
- Focussed attention on waiting times, including reducing ED waiting times and increasing the percentage success rate of the 4-hour target
- Publicising though internal communication patient care focussed activities e.g.
  - Focussed attention on waiting times, including reducing ED waiting times and increasing the percentage success rate of the 4-hour target
  - 18-week target – goal to see outpatient as quickly as possible e.g. a scan CT and MRI within the 6 weeks, supported in part by the opening of the new diagnostic centre in Newmarket
  - Introduction of "Super Saturdays" e.g. recent Saturday session on carpal tunnel operations
- Promotion of the increased usage of the Trust's virtual ward
- Collaboration between integrated neighbourhood teams, early intervention team and virtual ward to support care in the community and care within the patient's own home, to remove the requirement for the patient to attend hospital
- Listening to and acting on feedback, and analysing and identifying trends from patient survey data collection and communications
- Trialling the use of AI tools to find themes and trends from patient feedback is being trialled in three wards
- QIAs being conducted before organisational change activities that could affect patient care
- Monitoring of incidents reported through RADAR
- Using data and analytics collected through the patient safety framework

- Triangulation of colleague concerns about patient care being raised through other routes e.g. FTSU, Staff psychology, governors
- Regular updates of the delivery of improved patients care results through various channels, including the All staff update and Green sheet

Further action is required around identifying which staff groups are showing concerns about whether patients are the top priority, particularly identifying if this is coming from patient facing colleagues, and where the main areas of concern might be. With the focus on financial recovery over the past year, colleagues could be seeing finances as the Trust's "top priority", when in fact there are still strong foundations and frameworks in place to protect patient safety and care.

Recommend as a place to work

There was a decline in colleagues saying they would recommend the Trust as place to work, and there were key areas where this was highlighted in the free text questions including staff not feeling valued, low morale, lack of career development, lack of autonomy, and inability to contribute to decision making. Stakeholders also reported the anxiety and stress colleagues were sharing, and how this was impacting on their morale and lack of motivation at work. Colleagues reported that dis-engagement with decision making was a key factor, although their focus on care for their patients, and support for colleagues and their team were what kept them at work.

To address these themes the following actions are either underway and/or are recommended:

- A new package of career and personal development learning available on the Learning hub, with accompanying facilitator-led webinars and development coaching, run by the learning and development team
- Continuation of programmes, including Leadership and management programmes, apprenticeships, and bite-sized learning on topics of immediate demand
- A more integrated organisational design and development approach to the 'recover' and 'renew' stages of the Trust's transformation journey, which embeds a much higher level of staff engagement and decision making
- Consideration of the development of 'time to innovate' learning labs which provide opportunity for autonomy, innovation and decision making on knotty issues the Trust is facing, to be solved by a range of front-line and middle/senior level staff

Leadership and management

The question in relation to leadership and management in general terms saw a decline, although references to line managers and immediate team were generally favourable – although there was some variation on this in the free text comments. Analysis of the free text comments provided a number of underlying issue areas related to leadership and management, including there being a disconnect between senior management and front-line colleagues; the Trust being top heavy in terms of management versus front-line staff; and there is inconsistency in manager's approach around leadership activities e.g. communication, appraisals, performance management, and the way different colleagues are treated. Stakeholders also reported relationship difficulties, with some managers demonstrating poor behaviours that remained unchallenged.

These are a number of actions being implemented to address this:

- Implementation of NHS England's leadership and management framework
- Launch and embedding of a behavioural framework for the Trust, including expected leadership and management behaviours
- Continued support for team interventions focused on enhancing relationships
- Development and launch of the change and transformation programme (design funded by SNEE) with SNEE partners to ensure leader and managers are equipped with to manage organisational change

- Continue development of learning interventions and resources via the HR Information Zone and Totara to support competency in knowledge, skills and behaviours required for people management as part of the employee lifecycle support
- Facilitate and promote targeted learning opportunities for leaders and managers to develop skills in conducting supportive and effective mental health conversations
- Ensure resources are available to improve leadership and management capability in service review and planning, financial management and digital development

4.2. Divisional actions

Data for divisions, departments and teams are currently being collated and analysed, having been released after 13 March embargo. This is being led by the relevant divisional leadership teams, supported by their HRBP. Each division follows its own approach and creates its own action plans, however there are similarities to the process. At this stage there is a variation across the divisions as to progress with this work given current operational pressures. Some have started sharing initial information and results with others still at the analysis stage.
The scale, pace and extent of action planning in response to this years' survey results is likely to be less than in previous years, as teams balance this work with other priorities and pressures.

Typical activities usually include:

- Team meeting to discuss results and agree on local actions
- Listening groups around key themes
- Suggestions boxes
- Targeted intervention by relevant colleague support staff e.g. FTSU visit to listen to concerns, group coaching by L&D, team support through staff psychology
- HR support and intervention around HR related themes such as bullying or discrimination

In addition to these actions, a more targeted and strategic approach to divisional data will be completed to identify areas of high scores vs lower scores. This will allow divisional leadership and HRBPs with more challenging scores to contact other divisions to identify what they have done previously to drive a strong performance in a particular focus area by sharing best practice. The progress of action plans will be monitored through PRM meetings.

5. Risks

Change, transformation and operational challenges are likely to remain over the coming year as a result of the Trust's on-going financial recovery plan and also the wider changes that are happening across the NHS. There is a risk that this overrides all focus of attention, and that investment in plans may not be deemed as time well invested. However, the development of plans and actions that allow for adaptation and changes is essential to ensure that the Trust remains focused on the key staff indicators highlighted through times of change as well as times of stability.

Whilst every effort will be made to progress with the actions outlined in this paper, it should be noted that organisational change activities within the Trust are on-going and having significant impacts in the following areas:

- To colleagues involved in change activities e.g. through consultations and potential redundancies
- Through changes to teams, work priorities or service provisions
- Challenges to work planning for the year ahead, as teams are unsure of future resource levels and flux that can occur either through Trust or wider NHS change activities

These factors may affect the delivery of actions created.

6. Summary and next steps

The results for the Trust's NHS staff survey 2024 were lower than last year across many areas, mirroring the challenging environment being faced over the past year at the Trust. Through a deep dive analysis, along with comparing the results to other areas of colleague feedback, clear areas of focus and actions that the Trust can take to address some of the most challenging scores at an organisational level have been identified.

Initial analysis of Trust wide data was carried out and presented earlier in the year, and this has then been followed up by the more detailed Trust wide analysis within this paper. The contents of this paper, and the themes identified within this paper, have now been socialised at Involvement committee and Trust Council to gather feedback on the themes and actions, and also agreement that those identified are the correct course of action. The consensus is that these are right themes and actions to proceed with, but with an additional theme of "Communication" to be added. An action plan has now been created to monitor progress of these6 themes. This is in the process of being circulated to assign timelines and insert updates by the various action owners. In parallel, a similar approach has been taken at divisional level, with the divisional analyses being presented at Divisional boards, with localised action plans discussed and created. The progress from the divisional action plans will be updated on a monthly basis at Divisional Performance Review Meetings.

It is anticipated that the execution of both the organisational and divisional action plans will have positive effects on Trust colleagues, as well as levels of patient care.

There are a number of ways that the impact of actions will be monitored going forward, including through the engagement data collected through the pulse survey; monitoring the delivery of action plans through PRM meetings; and monitoring colleague data collected through the various colleague services e.g. HR, Freedom to speak up, Staff psychology service and EAP.

4.1.2. Freedom to Speak Up (ATTACHED)

For Report

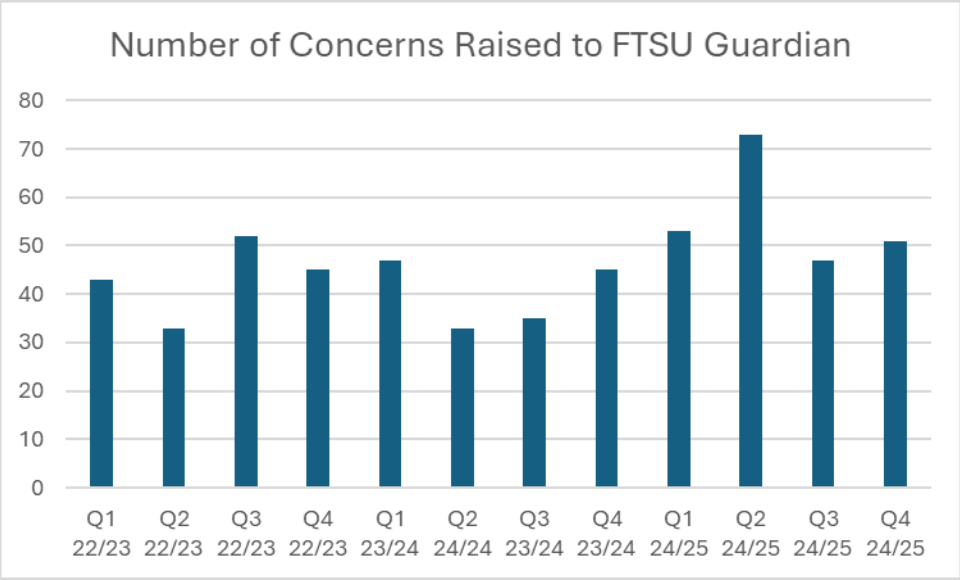
Presented by Carol Steed

Freedom to Speak Up: Guardian's Report Q4. 2024 – 2025. January, February, March 2025.

1. Data Sent to National Guardian's Office – Number of concerns

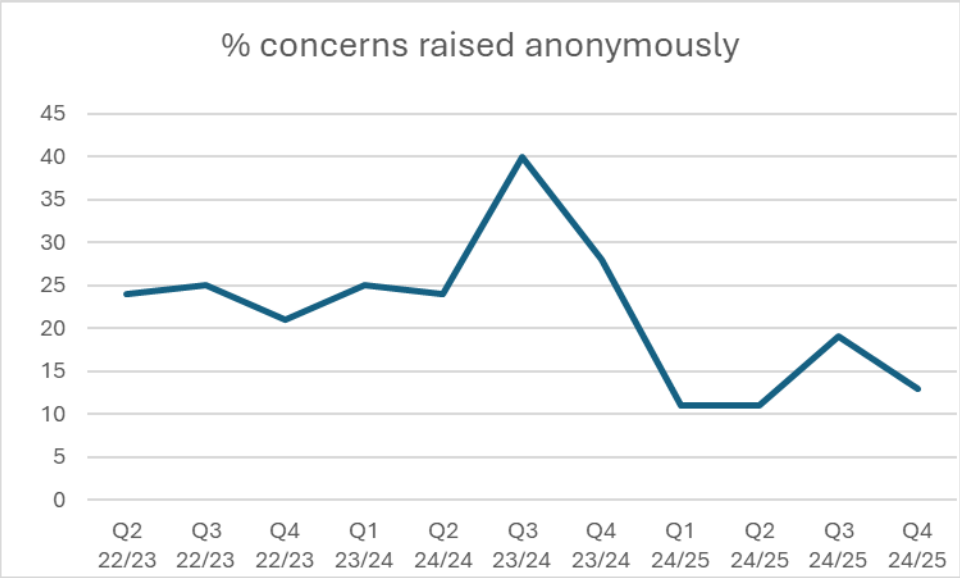
FTSU Guardian's for each organisation are required to submit data around the concerns raised to them each quarter. (NGO Guidance, 2024). This is to inform the NGO's understanding of the implementation and utilisation of the Guardian role and the themes and trends in speaking up. It is also felt that observing that the guardian actively submits data may increase workers confidence in the effectiveness of the guardian route and potentially increase confidence in choosing to speak up.

The number of concerns raised with the Guardian in Quarter 4 was 51. This is a return to the previous levels (following a spike last quarter due to concerns around reducing the staff psychology support provision).



2. Anonymous Reporting

Whilst it is important to have an option for anonymous reporting, the NGO acknowledges in its report the challenges for organisations in investigating anonymous cases due to limited information and the difficulty in providing feedback. The percentage of anonymous concerns is an indicator for how confident staff feel to speak up. In Quarter 4, there were 7 anonymous reports, with a percentage decrease from 19% last quarter, to 13%.

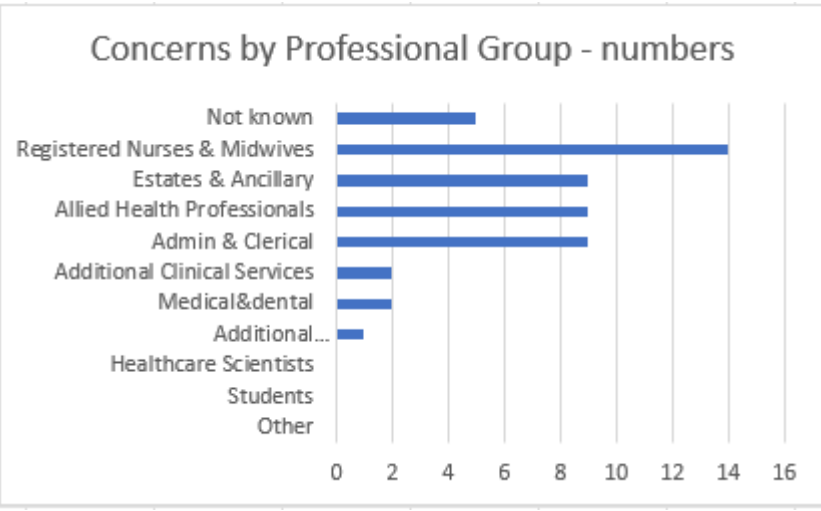


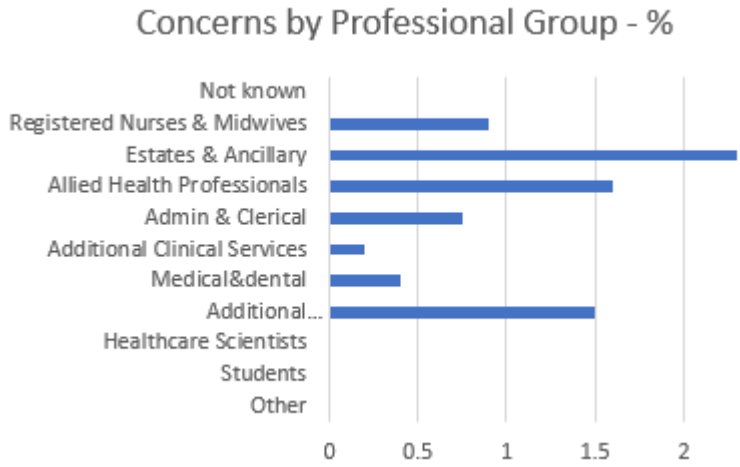
Anonymous reporting themes

The themes from anonymous reporting this quarter again included concerns over finance restrictions and consequent vacancies. Also raised anonymously were concerns over lack of written reports following appraisals, and one instance of bullying. These anonymous reports are taken seriously, and each one was investigated as far as possible.

The Guardian, working with the Trust's Speak Up champions, continues to tackle barriers to speaking up and to assure staff that detriment to those who do speak up will not be tolerated in the Trust. The Guardian is also working closely with the wellbeing team to understand barriers to speaking up highlighted in their work, and how to provide appropriate re-assurance.

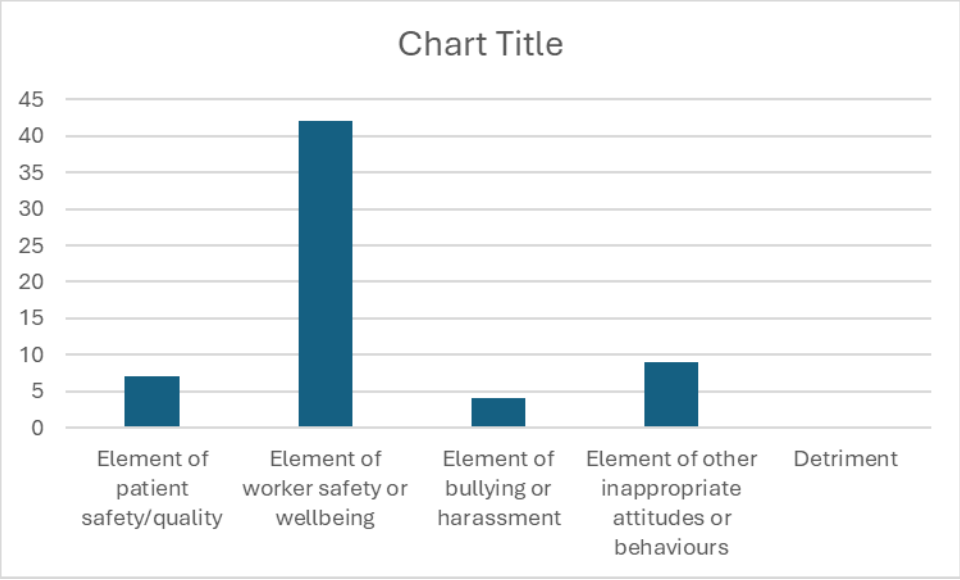
3. Who is speaking up?





As always, the most concerns were raised by registered nurses and midwives, but looking at the percentages, the greatest number of concerns were raised by Estates and Ancillary staff.

What were people speaking up about?



Many cases involve an element of staff safety or wellbeing. Patient safety concerns comprised 6 percent of concerns raised, mainly around staffing levels. The national figure is 19%. Each of these cases has been investigated and addressed individually. The Trust has a patient safety team and robust systems in place where most patient safety concerns are reported.

4. NHS Staff Survey

The results for the 2024 NHS staff survey were released in this quarter and are measured against the NHS People Promise elements.
In relation to speaking up, the People Promise states,

''We all have a voice that counts. We all feel safe and confident when expressing our views. If something concerns us, we speak up, knowing we will be listened to and supported. Our teams are safe spaces where we can work through issues that are worrying us'.

Supporting staff to feel safe to speak up can improve the experience of everyone who works in the Trust as well as improve patient safety with the focus always on promoting learning and improvement.

There are four questions, within the 'We have a voice that counts' Element, which relate to Raising Concerns.

Raising Concerns Sub-Group Score WSFT: 6.28/10 – Average: 6.41/10

Q20a – **I would feel secure raising concerns about unsafe clinical practice** WSFT 63.67% (last year 67.47%) – Average 70.44%

Q20b – **I am confident that my organisation would address my concern** WSFT 45.31% (last year 52.57%) - Average 55.91%

Q25e- **I feel safe to speak up about anything that concerns me in this organisation** 53.17% (last year 61.01%%) - Average 60.29%

Q25f - **I am confident that my organisation would address my concern –** 37.45% (last year 49.10%) Average 48.23%

These results are disappointing as they suggest a decline in colleagues feeling safe to speak up, particularly regarding non-clinical issues, and reduced confidence that their concerns will be addressed. This is in spite of efforts made to improve confidence in speaking up – see ongoing work in response to NGO guidelines in section 7 which include continual encouragement of colleagues to speak up and raising awareness of the channels by which this can happen.

Actions: Raising awareness and promoting speaking up will continue, but in addition, visits will be prioritised to departments whose NHS survey results indicate less confidence to speak up.

The NHS staff survey results are being triangulated with the Freedom to Speak Up mandatory training data. This will allow targeted intervention where there is poor compliance with this training. In particular, it is hoped to improve the management training Listen Up compliance scores, as a starting point for increasing psychological safety in teams. The Guardian will then work with managers to identify further ways of increasing confidence in speaking up.

The Communications Team undertook an internal 'doorstep survey' of awareness and confidence in the FTSU service at WSFT. There were some more encouraging results here, with, overall nearly 82% of respondents saying they would feel comfortable raising a concern to the Guardian. However, clinical staff showed a lower level of confidence in the FTSU service, with 34% saying they would have some level of discomfort raising concerns.

Analysis of the results of this survey has provided further information for targeting communication around those particular areas where there is less awareness or confidence around speaking up.

Suggestions would be welcomed from the Board regarding anything further they feel they or the Guardian could do to improve confidence in speaking up, with the aim of seeing an improvement in the response to these raising concerns questions in future surveys.

5. Themes from Q3. 2024/2025, with learning and actions

Every Freedom to Speak Up concern is dealt with on an individual basis and raised with the appropriate senior leader**.** However, the Trust continues to address broad themes raised via FTSU, and accepts the information gained as a gift to support future learning and development to help support improvements across the organisation.

Theme: The ongoing impact of current financial constraints on the organisation, staff and services, both clinical and non-clinical, especially around vacancies being held and lower staffing levels. Individual concerns have been escalated to the appropriate approval panel for their consideration.

Learning and Action: As some vacancies are still requiring to be held, with consequent reduced staffing levels, the resulting increase in demands on staff continues to impact staff wellbeing. The importance of communicating reasoning and progress in an effective and transparent continues to be addressed via the All Staff Update, including clear information on progress against targets.

The ongoing wellbeing support of our colleagues remains a priority and we need to ensure staff are aware of the services on offer. A number of staff speaking up have indicated unawareness of the Employee Assistance Programme and all its benefits and services. This has been highlighted to our Communications Team and a new ..\Resources\Wellbeing toolbox poster A4.pdf has being launched to summarise all services available to support staff.

Theme: Bullying. The percentage of concerns where an element of bullying is mentioned has reduced to 8% from 12% last quarter.

Learning and Action: The Trust's Respect for others - West Suffolk NHS Intranet policy states: 'As part of its commitment to equality and diversity, West Suffolk NHS Foundation Trust is committed to promoting and ensuring a working environment where colleagues are treated with courtesy and respect and wants to support a working environment and culture in which bullying and harassment is unacceptable'. However, bullying is still a concern for some of our colleagues.

Staff feeling able to speak up about bullying is an important step to address it. While the reduction in bullying cases appears a positive trend, we must be sure that this is not due to a reduction in reporting, and remain vigilant.

As we know from the NHS staff survey, it is likely that cases of bullying go unreported. This is an area where the ongoing work to psychological safety to report incidents is especially important.

Each case reported has been investigated and addressed, and those speaking up about it have been offered support.

Theme: Environment. Lack of provision of gender-neutral toilets and changing facilities. The recent Supreme Court ruling on gender has led to further speaking up enquiries about how the Trust will support transgender or gender non-conforming staff and patients. An executive message of support was issued via the Pride staff network.

Learning and Action: This concern was raised last quarter, but now feels more urgent. Currently all disabled toilets are gender neutral and information on their location has been shared as requested.

Theme: Formal Consultations. People have spoken up regarding formal consultations around team changes. Issues have been untimely communication, poor transparency of process, lack of or late updates, lack of support to staff undergoing consultations, and timing of communication to service leads.

Learning and Actions: Learning which has been consolidated into process includes increased transparency of communication if there is a formal process. Communicating in person as far as possible, in a compassionate way, with email used to follow up and reach any staff unable to attend in person meetings. Getting the timing right – with enough notice for staff to prepare for meetings, but without long delays which can lead to anxiety. Where timings have been unavoidably delayed, apologies have been issued. Staff have been signposted to the Organisational change policy and procedure - West Suffolk NHS Intranet and again, to the wellbeing services available, including supportive group sessions with the staff psychology service, as above.

Theme: Unacceptable behaviour by patients. Support for staff. This concern highlighted the importance of support for staff immediately and ongoing following any form of abuse by patients, whether or not the patient was deemed to lack capacity.

Learning: Generally, staff are well supported by their ward manager in these incidences, and referred to other services as appropriate. Those most at risk of lack of support (as in the case raised to FTSU) are Bank and agency workers who may not be returning to the ward for another shift and so pro-active efforts are needed to ensure follow up. This issue was raised at the NMCC and communicated to all ward managers. The Unacceptable Behaviour by patients, service users and members of the public - West Suffolk NHS Intranet incorporates a staff welfare checklist for supervisors.

6. Feedback on the Freedom to Speak Up Process

Following closure of each FTSU case, the person speaking up is sent an evaluation form to report their experience of the process. The themes emerging from the FTSU process evaluation indicated once again that it was a positive experience being able to talk to an independent and impartial person

The figures below show a summary of evaluations received in Q4.

- Three responses were received to the FTSU feedback survey for Quarter . 3 respondents said they would speak up again. None said maybe, and none said no.
- Free text comments and other feedback received verbally and via email was generally positive. Feedback taken from the form and email responses include:

  Do not be afraid to speak up

  Keep going back to be heard if you are unhappy - just discussing it can help you.

  She and myself are also thankful that you have discussed this with [our managers] and for updating us with your conversation.

  Thanks again for understanding and for being there for me.

7. The Guardian and FTSU champions are working to improve the culture of speaking up throughout WSFT. Our actions are categorised under eight key areas aligned with the National Guardian's Office guidance for leaders and managers. (New actions in bold)

Principle 1: Value Speaking Up:

For a speaking-up culture to develop across the organisation, a commitment must come from the top.

What's going well:

- Ongoing support from Board and SLT for Freedom to Speak Up
- Non-executive director for FTSU attended champion training.
- Non-executive director for FTSU to review FTSU contribution to the Trust's welcome session for new members of staff., by February 2025. Programme in place for an executive to attend each FTSU champion training and refresher training.

Principle 2: Senior leaders are role models of effective speaking up and set a health Freedom to Speak Up Culture

What's going well:

- FTSU non-executive director in post.

- CEO supporting the role of FTSU Guardian and promoting Speaking Up culture in staff briefing and public communications.
- NED and Exec walkabouts to ask colleagues for opinions, and feedback on improvements which could be made.
- Regular meetings established between FTSU NED and Guardian.

Next steps : FTSU message to be re-iterated by exec attending Trust's welcome session - ongoing

Principle 3: Ensure workers throughout the organisation have the capability, knowledge, and skills they need to speak up themselves and feel safe and encouraged to do so.

What's going well:

- FTSU continues to be promoted throughout the Trust. Training sessions by FTSU Guardian for preceptorship, new starter Welcome and student training programmes.
- FTSU guardian visiting wards and departments, including community teams, increasing awareness of FTSU and encouraging recruitment of champions as widely as possible.
- 'Speak Up' and Listen Up' mandatory training is promoted, and we have high numbers of staff completing this (94% and 91% respectively)
- Focus on inclusion and reaching those who may be less likely to speak up - Champion Gap analysis completed and active recruitment undertaken in areas lacking champions.
- All staff meeting FTSU Guardian at Welcome Session.
- FTSU Communication Plan has been developed by Guardian with support of Communications Team. . FTSU COMMS PLAN 2024 - FINAL.docx
- Many managers are promoting Speaking up and supporting their staff to Speak up; e.g. Guardian recently received very warm welcomes and offers to visit their team, eg by Procurement, Facilities and Sterile Services teams.
- **Governance framework for all champions, including recruitment and support nearing completion and sign off**

Next steps:

- **FTSU Guardian to continue to visit wards and departments including community sites – to target areas which are indicated from the NHS survey results, as discussed above.**

- Culture continues to improve to enable psychological safety in all teams. It is hoped this will be achieved through continued FTSU training and promotion, and work undertaken around values and behaviours. FTSU Guardian to work with OD Manager – Health & Wellbeing, to consolidate psychological safety training and ensure appropriate governance around champions.

Principle 4: Respond to Speaking Up; when someone speaks up they are thanked, listened to and given feedback.

What's going well:

- Increased promotion regarding Trust's stance on protecting staff who speak up and a zero-tolerance approach to detriment. Focus on psychological safety in welcome session.
- Individuals are thanked for speaking up, and told they are they are helping to identify areas of learning and improvement
- Champions offer valuable support by listening to colleagues, especially during times of pressure
- Leadership programmes are now in place which will support listening skills and promotion of Speaking Up culture as business as usual.

Next steps:

- **Guardian to undertake review of Listen Up mandatory training compliance and support areas where compliance is poor. This training focuses on responding with thanks and support to those speaking up.**
- Senior Leaders to complete 'Follow Up' training.

Principle 5: Information provided by speaking up is used to learn and improve

What's going well:

- Where possible and obvious, swift action is taken to address concerns, to learn and improve.
- Regular meetings set up to share and explore themes identified with patient safety team and PALS to support organisational learning.

Next steps:

- Continue to work closely with HR business partners, department leads and executive to ensure concerns are shared and used for learning and improvement.

Principle 6: Appointment and support of Freedom to Speak Up Guardian
Aim to support Guardian to fulfil their role in a way that meets worker's needs and NGO requirements.

What's going well:

- Full-time dedicated FTSU Guardian in post, registered with NGO and training complete.
- On-going support from Guardian Mentors and Community of Practice

Next Steps:

- FTSU Guardian enrolled on Coaching Professional apprenticeship. Started January2025

Principle 7: Barriers to speaking up are identified and tackled

What's going well:

- Regular and ongoing face to face sessions for speak up training.
- Inclusion training session offered for FTSU champions.
- EDI data collection form has been created by Guardian and OD Manager – EDI, and is now established as part of the FTSU process.
- FTSU guardian to continue to work closely with EDI lead to ensure barriers to speaking up are identified and overcome

- **Guardian to continue to attend the staff networks to promote FTSU and as a route to increase diversity into the champion network.**

Next Steps:

- **FTSU Guardian to cover further out of hours shifts including at Newmarket Community Hospital, to ensure equal visibility to OOH staff**.

Principle 8: Speaking up policies and processes are effective and constantly improved. Freedom To Speak Up is consistent throughout the health and care system

What's going well:

- FTSU policy , in line with NGO guidance, adopted and adapted to suit WSFT easily available online on the Trust's intranet, Freedom to Speak Up section.
- FTSU Guardian working closely with NGO and local area FTSU Guardian network to ensure adherence with national policies and processes.
- Working with Communications and Information Governance Team, Website and Intranet information on FTSU has been updated to reflect current contacts.

Next Steps:.

- NGO are undertaking a review of Guardian job description. WSFT will review and adopt changes as appropriate. July 2025

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References:

NGO, February 2024, Recording Cases and Reporting Data (nationalguardian.org.uk)

Wellbeing Toolkit Poster..\Resources\Wellbeing toolbox poster A4.pdf

Doorstep Survey ..\Staff survey\FTSU doorstep survey responses - analysed.docx

5. OPERATIONS, FINANCE AND CORPORATE RISK

5.1. Insight Committee Report - Chairs key issues from the meetings (ATTACHED)

To Assure

Presented by Antoinette Jackson and Nicola Cottington

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

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

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 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.	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

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

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

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

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

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

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?	***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.*

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

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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

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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

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Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
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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

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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

Originating Committee: Insight Committee			Date of meeting: 16 April 2025		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
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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

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Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
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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

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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? *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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6. QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT

6.1. Improvement Committee Report - Chairs key issues (ATTACHED)

To Assure

Presented by Susan Wilkinson

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Improvement Committee			Date of meeting: 19 March 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**	**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

Originating Committee: Improvement Committee			Date of meeting: 19 March 2025		
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		2 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 Overall compliance with level 1 & 2 training is 94% (some reduced compliance in ED medics); level 3 training 91%.	Training review paused whilst intercollegiate guidance is finalised, to ensure that we comply with correct training and frequency. 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 **PQSGG**	**<u>Safeguarding Adults</u>** Management of serious safeguarding incidents Level 3 Safeguarding training	 1 4	. Process approved and embedded. Not currently delivered outside SG team. Intercollegiate document indicates a minimum requirement for relevant registered staff	. Future meetings will present a summary of concerns, whether these were supported, and learning arising. Proposal presented to Mandatory Training Group. Delivery and impact of 8 hours of training over 3 years being scoped.	1

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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

Originating Committee: Improvement Committee			Date of meeting: 19 March 2025		
Chaired by: Roger Petter			Lead Executive Director: Susan Wilkinson, Richard Goodwin		
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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		

**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.
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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**	**Pressure Ulcer Prevention Group** 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**	**Accreditation – Haematology** **Accreditation – QPULSE** (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**	**Life cycle of a clinical audit – National Audit of Inpatient Falls**	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

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			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	**Internal Audit Q4 Assurance Report** A number of new reports issued. Those which relate to Improvement Committee: Board Assurance Framework	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?

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6.2. Quality & Nurse Staffing Report (ATTACHED)

To Assure

Presented by Susan Wilkinson

Open Trust Public Board	
Report title:	Nursing, safe staffing report: **March and April 2025**
Agenda item:	6.2
Date of the meeting:	**23 May 2025**
Sponsor/executive lead:	**Susan Wilkinson**
Report prepared by:	**Daniel Spooner: Deputy Chief Nurse**

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 reports on safe staffing, fill rates, contributory factors, and quality indicators for inpatient areas for the months of March and April 2025. It complies with national quality board (NQB) recommendations to demonstrate effective deployment and utilisation of nursing and midwifery staff. The paper identifies planned staffing levels and where unable to achieve, actions taken to mitigate where possible. The paper also demonstrates the potential resulting impact of these staffing levels. It will go onto review vacancy rates, nurse sensitive indicators, and recruitment initiatives within the sphere of nursing resource management. This paper also demonstrates how nursing directorate is supporting the Trust's financial recovery ambitions, through the nursing and midwifery deployment group.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
• Improved sickness levels in April, after a number of months >5% • Overall fill rate at 90% for all shifts in M12 and M1 • CHPPD data review reveals inaccuracy over past 5 months, now corrected. • RN vacancy increasing but maintaining <10% • Winter biannual inpatient establishment audit complete. Proposed reduction in 8 WTE within surgery supported by SNCT output. • Nurse sensitive indictors common cause variation but higher number in this period of falls and HAPU.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
To continue to embed and monitor temporary spend and achievement of CIP whilst monitoring any potential safety implications. Continued focus on recruitment and retention on nursing assistants
Action Required
For assurance around the daily mitigation of nurse and midwifery staffing and oversight of nursing and midwifery establishments. No action from board required.

Risk and assurance:	Red Risk 4724 amended to reflect surge staffing and return to BAU
Equality, Diversity and Inclusion:	Ensuring a diverse and engaged workforce improves quality patient outcomes. Safe staffing levels positively impacts engagement, retention and delivery of safe care
Sustainability:	Efficient deployment of staff and reduction in temporary staffing and improving vacancy rates contributes to financial sustainability
Legal and regulatory context	Compliance with CQC regulations for provision of safe and effective care

Nurse Staffing Report – March and April 2025

1. Introduction

1.1 This paper illustrates how WSFT's nursing and midwifery resource has been deployed for the months of March and April 2025 (M12 and M1). It evidences how planned staffing has been successfully achieved and how this is supported by nursing and midwifery recruitment and deployment. This paper also presents the impact of achieved staffing levels including nurse and midwifery sensitive indicators such as falls, pressure ulcers, complaints and compliance with nationally mandated staffing such as CNST provision in midwifery. The paper will also demonstrate initiatives underway to review staffing establishments and activities to ensure nursing and midwifery workforce is deployed in the most cost-efficient way.

2. Background

2.1 The National Quality Board (NQB 2016) recommend that monthly, actual staffing data is compared with expected staffing and reviewed alongside quality of care, patient safety, and patient and staff experience data. The trust is committed to ensuring that improvements are learned from and celebrated, and areas of emerging concern are identified and addressed promptly. This paper will identify safe staffing and actions taken in March and April 2025. The following sections identify the processes in place to demonstrate that the Trust proactively monitors and manages nurse staffing to support patient safety.

3. Key issues

3.1 **Nursing Fill Rates**

The Trust's safer staffing submission has been submitted to NHS Digital for March and April 2025. Table 1 shows the summary of overall fill rate percentages for these months and for comparison, the previous four months. Appendix 1a and 1b illustrates a ward-by-ward breakdown for these periods. Improvements have been seen in this period, most noticeable within day shift provision of registered staff, which has not achieved 90% for 6 months.

	Day		Night	
Average fill rate (planned Vs actual)	Registered	Care Staff	Registered	Care staff
November 2024	87%	85%	95%	94%
December 2024	87%	87%	94%	93%
January 2025	85%	86%	91%	94%
February 2025	86%	84%	94%	95%
March 2025	88%	88%	96%	101%
April 2025	90%	94%	99%	102%

Table 1

The total average of 'planned versus actual' staffing fill rates have moved out of special cause for concern. Likely due to improving absence rates and the closure of the winter escalation ward (WEW) at the end of March (M12),

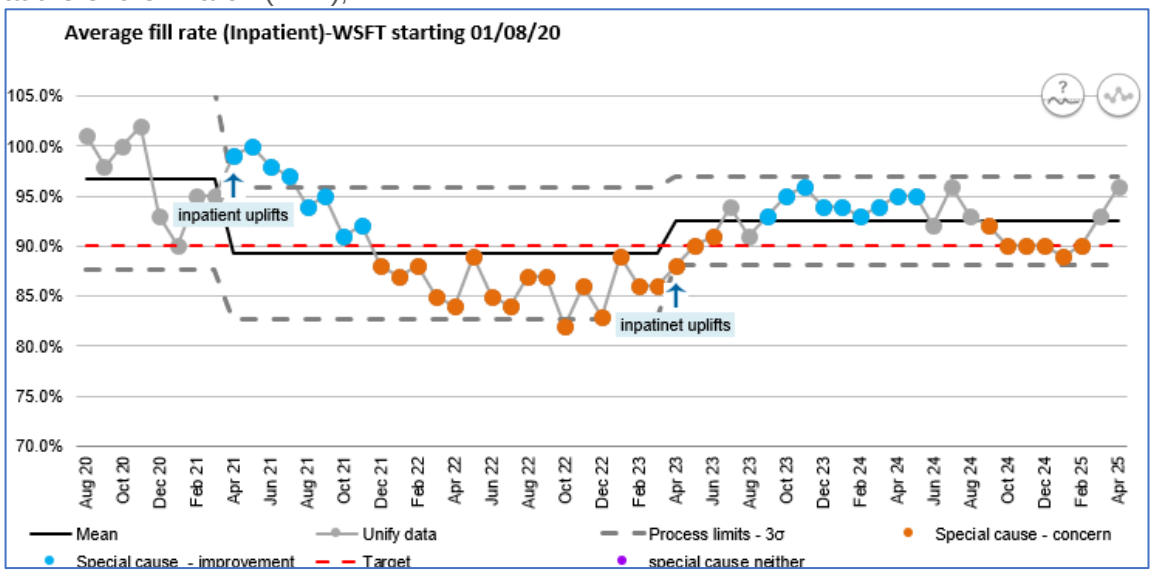


Chart 2

3.2 **Care hours per patient day**

CHPPD is a measure of workforce deployment and is reportable to NHS Digital as part of the monthly returns for safe staffing (Appendix 1a/b). CHPPD is the total number of hours worked on the roster by both Registered Nurses & Midwives and Nursing Support Staff divided by the total number of patients on the ward at 23:59 aggregated for the month. CHPPD can be affected adversely by opening additional beds either planned or emergency escalation, as the number of available nurses to occupied beds is reduced. Periods of high bed occupancy can also reduce CHPPD.

Model hospital data suggests that WSFT is in the lowest quartile nationally, when bench marking against all other organisations with inpatients beds (Appendix 2). This suggests that WSFT provides less care hours per patient than many organisations. When opening additional beds, it is expected that CHPPD will fall, this initially did not recover in April as expected. This led to a request to interrogate the data source which revealed that the data source was inaccurate for the previous 5 months. Assumptions around high sickness, low fill rates and capacity demands would be appropriate when seeing a fall in CHPPD, however this lead to challenge when the data did not recover on closure of the WEW, improving sickness and fill rate. M1's CHPPD of 7.4 is more in keeping with previous months and expectation, now that data source has been cleansed. The cleansed data set will be used going forward .

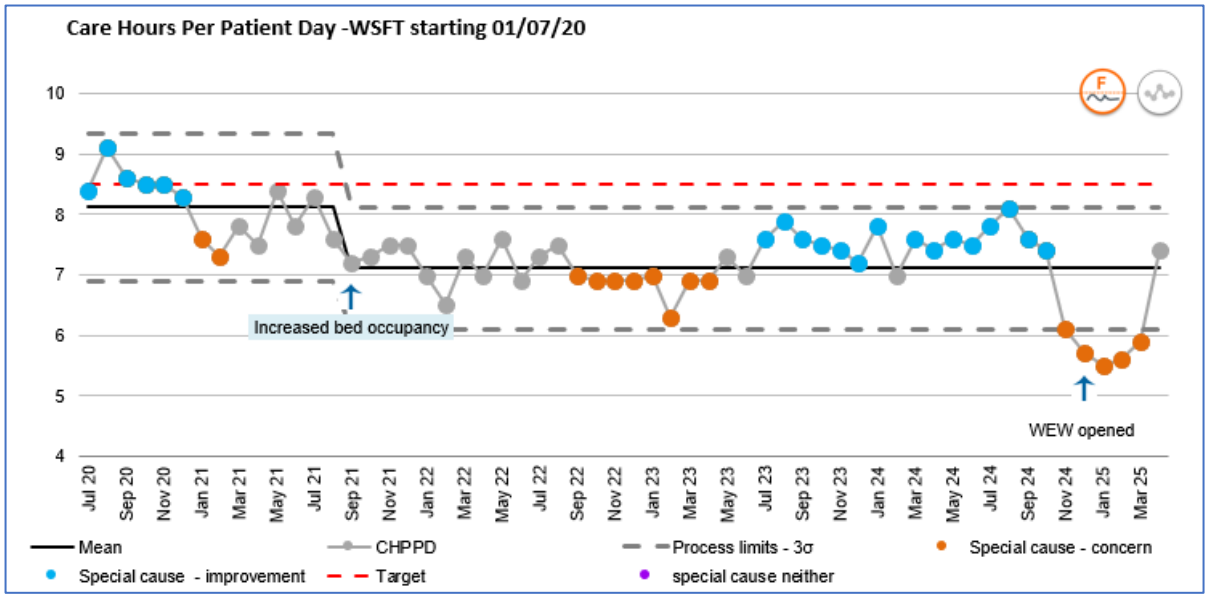


Chart 3

3.3 **Sickness**

This period saw improvements in sickness absences in the RN/RM population, falling below 5% in April. Sickness within HCSW remains higher than 5% ambition (Chart 4)

	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25
Unregistered staff (HCSW)	6.94%	7.25%	6.55%	6.61%	7.76%	6.35%	5.80%	6.12%
Registered Nurse/Midwives	3.70%	4.79%	4.90%	5.54%	5.78%	5.14%	5.01%	4.75%
Combined Registered/Unregistered	**4.71%**	**5.55%**	**5.42%**	**5.87%**	**6.41%**	**5.52%**	**5.26%**	**5.18%**

Table 4

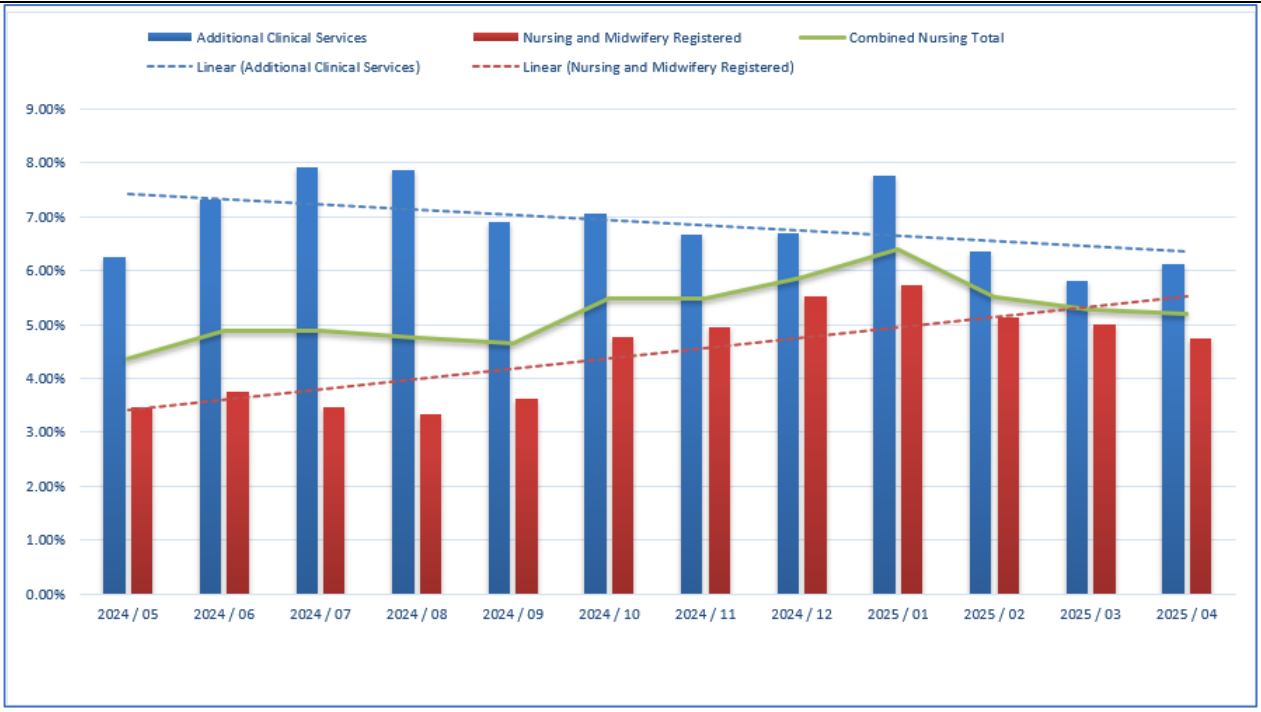


Chart 4

3.4.1 **Recruitment and Retention**

Vacancies: Registered nursing (RN/RM) and Nursing assistants (NA):

Table 5 demonstrates the total RN/RM establishment for the inpatient areas in whole time equivalents (WTE). The total number of substantive RNs has seen an improving trend, however inpatient vacancy rate has now moved into common cause variation. Full list of SPC related to vacancies and WTE can be found in appendix 2. Areas of concern remain within the non-registered staff group where vacancy percentage is higher. Vacancy rates compared with last reporting period are as follows.

- **Inpatient RN/RM** vacancy percentage at M1 is **8.3%** a 1.2% improvement from last report.
- **Total RN/RM** vacancy rate at M1 is also **8.3%** an improvement of 0.2% from last report
- **Inpatient NA** vacancy rate at M1 is 13.5% an increase of 2% from last report
- **Total NA** vacancy is **11.6%** in M1, a static position from last month

	Sum of Month 8	Sum of Month 9	Sum of Month 10	Sum of Month 11	Sum of Month 12	Sum of Month 1	WTE vacancy at 1
RN	727.2	724.7	715.4	714.0	715.9	712.1	60.7
NA	384.3	383.3	384.3	386.0	387.3	382.1	45.1

Table 5 Inpatient actual substantive staff WTE.

3.4.2 **New Starters**

Table 6 demonstrates registered and non-registered staff commencing induction within the WSFT. Induction attendance for registered nurses has declined in the last 3 months.

	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25
RN/RM	19	24	17	5	4	6	8	8
NA	11	16	16	11	15	17	8	8

Table 6: Data from HR and attendance to WSH induction program.

- In March 8 registrants attended induction; of these; 2 RN was for the acute, 5 for bank staff and 1 for community.
- In March, 8 NAs attended induction; of these; 7 NAs were for the acute Trust and 1 for midwifery

- In April 8 registrants attended induction; of these; 2 RNs were for the acute, 5 RN bank staff, 1 RN for community teams.
- In April 8 NAs attended induction; of these; 7 NAs were for the acute Trust and 1 for Midwifery.

3.4.3 **Turnover**

On a retrospective review of the last rolling twelve months, turnover for RNs continues to positively be under the ambition of 10%. RN turnover has increased slightly to 5.8%. NA turnover has increased to over 10%.

		Turnover	01/05/2024	-	30/04/2025			
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,512.00	1,326.8348	73	61.6733	89	69.2504	5.8862%	5.2192%
Additional Clinical Services	603.00	509.0820	108	99.3733	72	62.3600	11.9403%	12.2495%

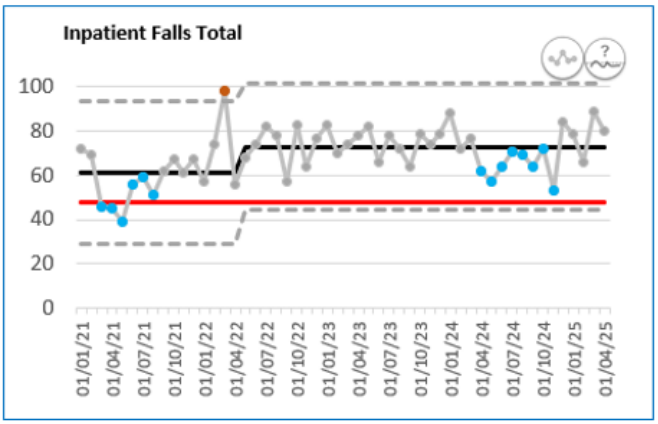
Table 7. (Data from workforce information)

3.5 **Quality Indicators**

Falls and acquired pressure ulcers.

Improvement projects and oversight of these quality indicators are reviewed through the patient quality and safety governance group (PQASG).

Fall incidents in this period where higher than expected average but remain in common cause variation. Falls per 1000 bed days has returned to levels similar to the previous improvement period and above average for this period (M12 and M1), but below national average.



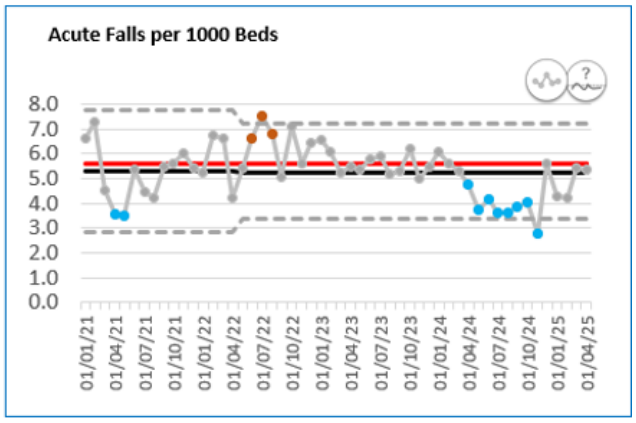
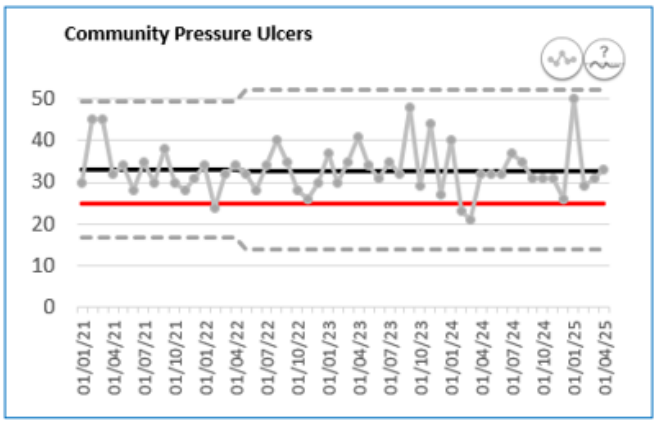


Chart 8 inpatient falls

Pressure ulcers remain in common cause variation and the spike seen in January has fallen to normal variation.



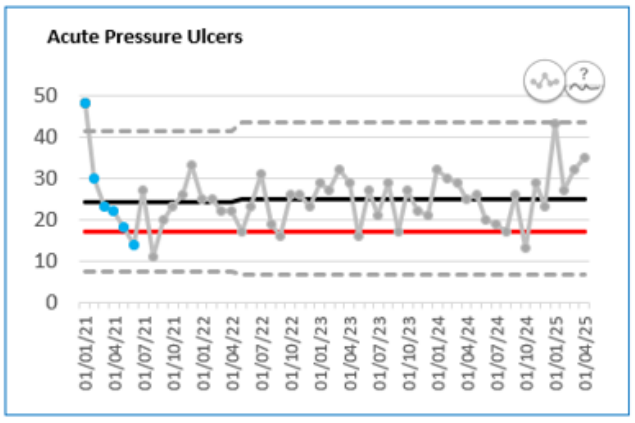


Chart 9 Pressure ulcers acquired in care.

3.6 **Compliments and complaints**

22 formal complaints were received in March. The most consistent theme this month was communication, with a total of 5 formal complaints being listed under this subject. Orthopaedics received 3 formal complaints making these the highest areas for the month.

26 formal complaints were received in April. The emergency department and F3 received the highest number of complaints this month with a total of 3 formal complaints each. The most common theme this

month was communication with 7 complaints being listed under this heading. Patient care received 6 formal complaints.

Chart 10a and 10b demonstrates the incidence of complaints and compliments for this period. The number of complaints for this period remains in common cause variation.

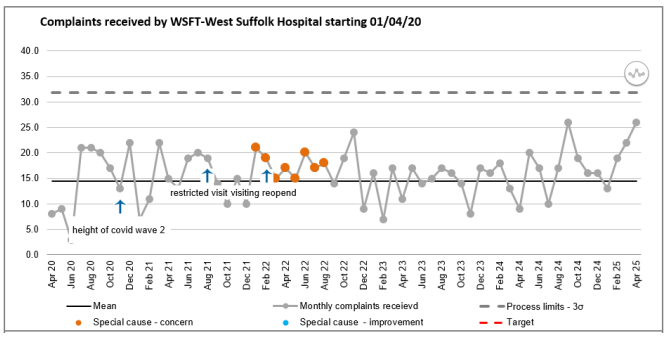


Chart 10a (complaints)

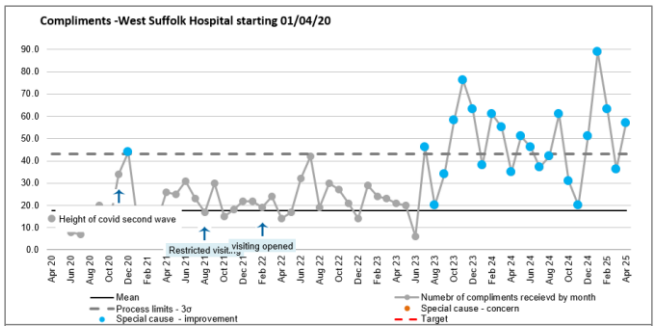


Chart 10b (compliments)

3.7 **Staffing incidents**

January (M10, 24/25)) saw the largest number of incidents in the last year (chart 11). This coincides with the grip and control of 90% fill rate ambition, reduced bank fill and escalating sickness rates since September. This suggests that during this time, the resilience of staffing was reduced. Incidents have reduced since January, with April seeing the lowest number since September 2024.

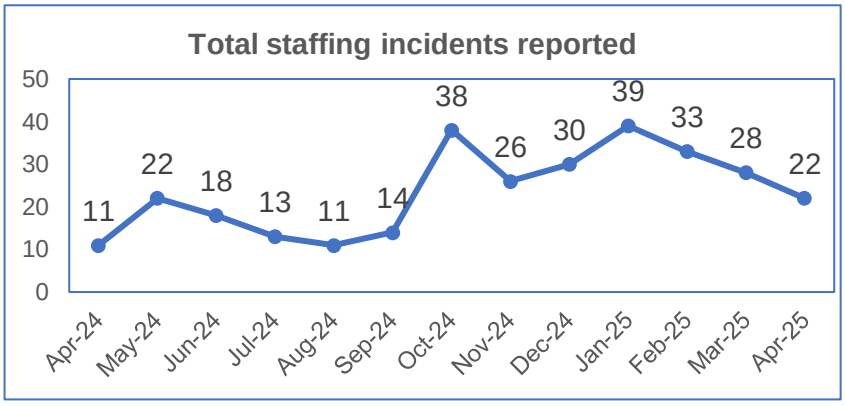


Chart 11

Red flags as per NQB (Appendix 4) are now able to be reported through RADAR from M9 (24/25) and are in (chart 11.1). The most common red flag event appears to be the inability to conduct regular intentional rounding at times of shortfall. April 2025 saw significantly less staffing incidents reported which would triangulate with improving fill rates and reduced short notice absence

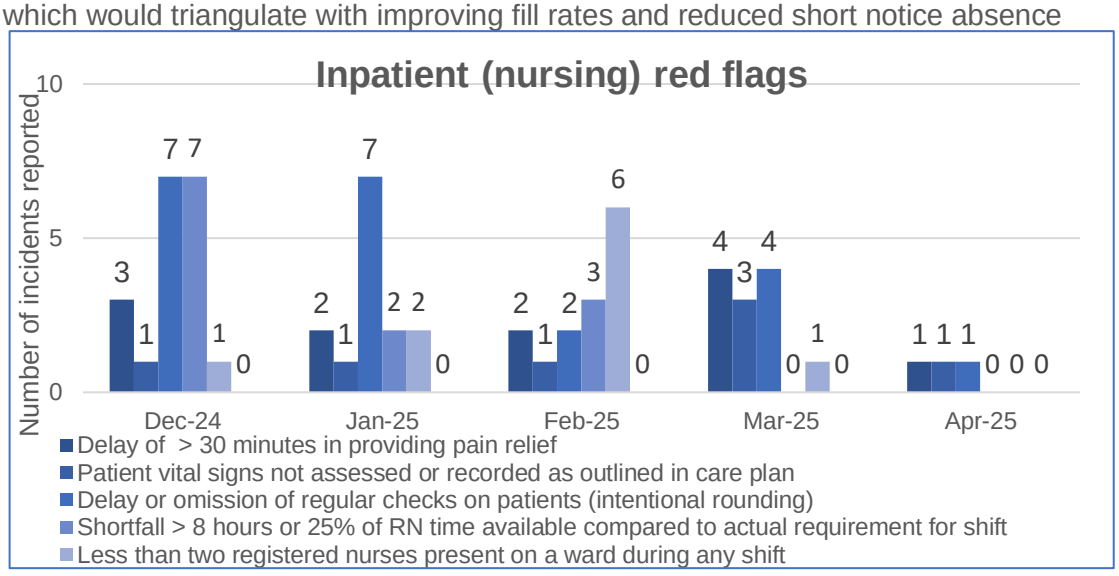


Chart 11.1

3.8 **Maternity services**

A full maternity staffing report will be attached to the maternity paper as per CNST requirements.

1:1 Care in Labour

The recommendation comes from NICE's second guideline on safe staffing in the NHS, which gives advice on midwifery safe staffing levels for women and their babies on whatever setting they choose. This recommendation is also 1 of the 10 safety actions published as part of the Maternity Incentive Scheme Year 6. Maternity services should have the capacity to provide women in established labour with supportive one-to-one care. This is because birth can be associated with serious safety issues and can help ensure that a woman has a safe experience of giving birth. Escalation plans have been developed to respond to unexpected changes in demand. In both March and April 2025 compliance against this standard was 100%.

Red Flag events

NICE Safe midwifery staffing for maternity settings 2015 defines Red Flag events as events that are immediate signs that something is wrong, and action is needed now to stop the situation getting worse. Action includes escalation to the senior midwife in charge of the service and the response include allocating additional staff to the ward or unit. Red Flags were previously captured on Datix and highlighted and mitigated as required at the daily Maternity Safety Huddle. In April 2024 the Trust introduced a new reporting system RADAR. In March 2025 one red flag event were reported, due to delay in induction of labour process. In April 2025 one red flag events were recorded due to delay in induction of labour process. No adverse outcome resulted from the occurrence.

Midwife to Birth ratio

The latest BirthRate plus review was undertaken in March 2023 and illustrated that Midwife to Birth ratio at West Suffolk NHS Foundation Trust should reduce to 1:21. The ratios are based on the Birthrate Plus® dataset, national standards with the methodology and local factors, such as % uplift for annual, sick & study leave, case mix of women birthing in hospital, provision of outpatient/day unit services, total number of women having community care irrespective of place of birth and primarily the configuration of maternity services

- March 2025 Midwife to birth ratio was 1:20.5
- April 2025 midwife to birth ratio was 1.19.7

Supernumerary status of the labour suite co-ordinator (LSC)

This is one of the Maternity Incentive Scheme Year 6 safety actions requirements and was also highlighted as a 'should' from the CQC report in January 2020. The band 7 labour suite co-ordinator should not have direct responsibility of care for women. This is to enable the co-ordinator to have situational awareness of what is occurring on the unit and is recognised not only as best but safest practice. 100% compliance against this standard was achieved in both March and April 2025.

	Standard	October	November	December	January	February	March	April
Supernumerary Status of LS Coordinator	100%	100%	100%	100%	100%	100%	100%	100%
1-1 Care in Labour	100%	100%	100%	100%	100%	100%	100%	100%
MW: Birth Ratio	1:21	1:19	1:18.3	1:20.6	1:21	1:18.4	1:20.5	1:19.7
No. Red Flags reported	NA	0	0	2	2	2	1	1

Table 12

3.9 **Community and integrated neighbourhood teams (INT)**

Sickness & Turnover

Sickness rate for the integrated community division was 4.8% in March. There are teams where sickness is much higher than the trust target, 5/6 INTS sickness rate is much higher, Bury town are at 10.88%.

Demand

The demand for community nursing services continues in special cause for concern (chart 13), this has been an increasing trend for the past 18 months.

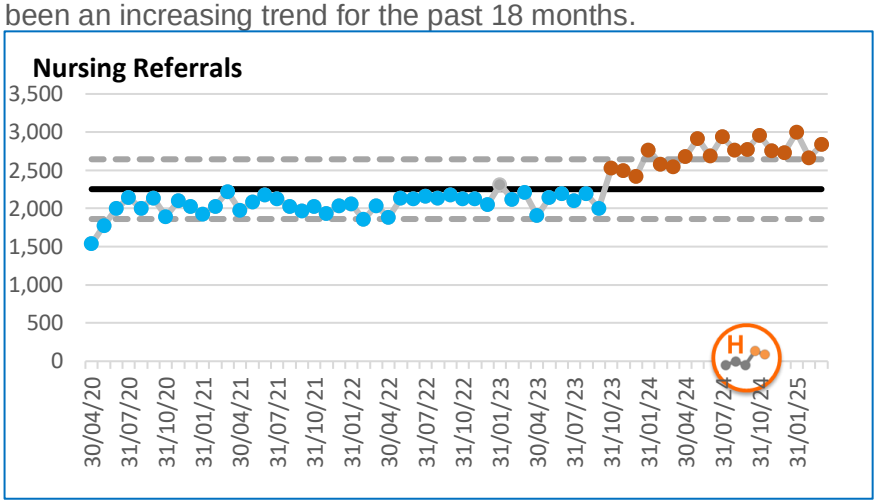


Chart 13

The division has begun to review the clinical impact of the increase in demand by measuring the number of cancelled care plan hours per week, as the clinical team's triage, defer and manage their visits (chart 14). This often involves deferring visits to the following day if the visit has been triaged as a lower priority. The harm this causes is difficult to monitor, senior matrons are completing a manual audit of some of the deferred, or cancelled care. Deferred care peaked at end of Jan/ beginning of Feb.

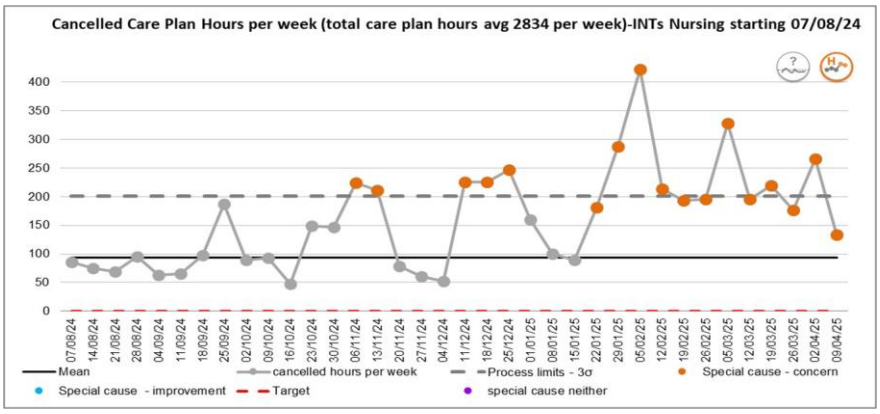


Chart 14

Community based actions

- The Community Nursing Safer Staffing Tool (CNSST)has been re-launched. The trust are signed up to this national tool to set safe staffing levels.
- The INTS , EIT and Virtual ward are involved in a shared services integration projects, the staff consultation is underway.
- INT teams continue to utilise the daily capacity dashboard use to support decision on OPEL levels and actions to mitigate risk.
- Senior matrons to continue monthly audit of deferred care. Provide feedback loop to DNs for assurance of prioritisation.

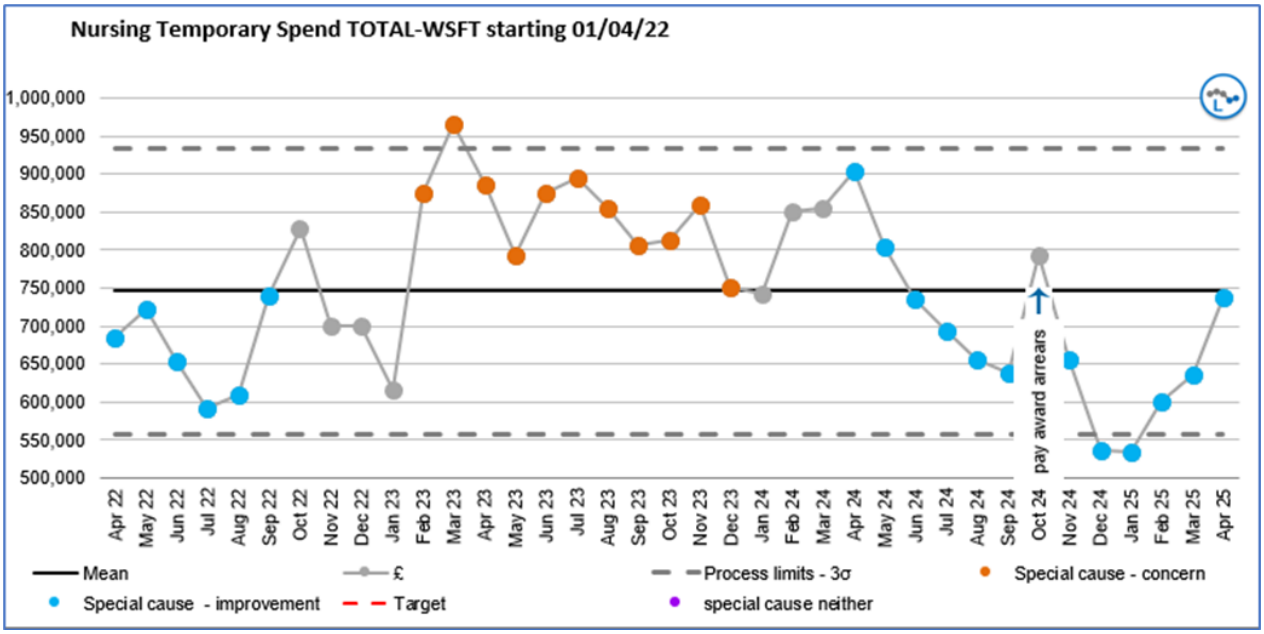
4.	**Next steps/Challenges**
4.1	**Nursing Resource oversight Group** The Nursing Deployment Group continue to meet monthly to review best practice methods of deploying staff and to reduce the temporary nursing spend. Interventions include the commencement of a better

rostering subgroup to fully utilise eRostering modules, stringent control over agency and overtime spend and reducing high-cost temporary nursing shifts.

At year end 24/25 nursing and midwifery pay spend was under budget by £2.26 million.

		Prior Month Actuals £000	In-Month Actuals £000s	In-Month Budget £000s	In-Month Variance £000s	YTD Actuals £000s	YTD Budget £000s	YTD Variance £000s
Nursing	Substantive	7,952	7,402	8,327	924	94,770	104,775	10,006
	Bank & Locum Staff	569	596	19	-576	7,470	214	-7,255
	Agency	16	24	17	-7	439	201	-238
	Overtime	16	15	2	-13	277	30	-247
	Total	8,553	8,037	8,365	328	102,955	105,220	2,265

However, M1 illustrates a large rise in temporary spend in M1 this will be explored in the NMDG following this paper submission.



		Values					
Exp-L1	Analaysis-1	In-M Bgt	In-M Act	In-M Var	WTE Bgt	WTE Act	WTE Var
Pay	Agency	0	21,856	(21,856)	0.0	3.0	(3.0)
	Bank	29,203	716,993	(687,789)	2.3	169.4	(167.1)
	Substantive	8,876,358	8,395,630	480,729	2,080.0	1,922.2	157.9
Pay Total		**8,905,562**	**9,134,479**	**(228,917)**	**2,082.3**	**2,094.6**	**(12.3)**

Table 17.

Nursing substantive spend was underbudget in M1 by £480k (table 17), however temporary spend exceeded total spend to over £228K. This rise is potentially driven due to the changes in the employers NI contributions, which has risen from 13.8% to 15%, in addition to the reduced threshold from £9,100 to £5,004.

However, this does not account for all the increase; the figure reported in month 1 is also likely to be driven by payment for work undertaken in March. For surgery particularly, there was a significant push towards generating ERF income and bank was higher in DSU to support this. An additional driver of temporary spend may be due to the vacancies pause to accommodate nursing redeployment.

Regular agency use has been all but eliminated in all areas, and sourcing high cost is managed by exception only.

4.2 **Biannual inpatient review,**

The biannual audit was completed in January and February 2025 following the usual methodology and audit program described fully at open board on 29th November 2024.

	The output (Appendix 5) has been reviewed by the Heads of Nursing. A reduction of 8.95 WTE has been proposed through surgical bed reconfiguration and this is supported by the out put of the SNCT (affecting wards F4 and F5). No further investment is required following this round of audit.
5.	**Conclusion**
5.1	Registered nurse recruitment continues positively and the trust vacancy rate for both inpatient and total nurses and midwives is consistently under 10%. Nursing assistant recruitment has remained static. Average fill rate for inpatient planned staffing is over 90% for this period with improvements in registered nursing day shifts also reaching 90% for this period. This improvement is driven by reduced sickness and the closure of the WEW The focus on temporary spend continues and nursing and midwifery pay is on track to be underbudget at year end. Continued focus on the impact of robust nursing and midwifery deployment controls will continue monitoring both activity and quality impact.
6.	**Recommendations**
	For the board to take assurance around the daily mitigation of nurse and midwifery staffing and oversight of nursing and midwifery establishments,

Appendix 1a. Fill rates for inpatient areas (March 2025) Data adapted from NHSE Unify submission.
RAG: Red <79%, Amber 80-89%, Green 90-100%, Purple >100

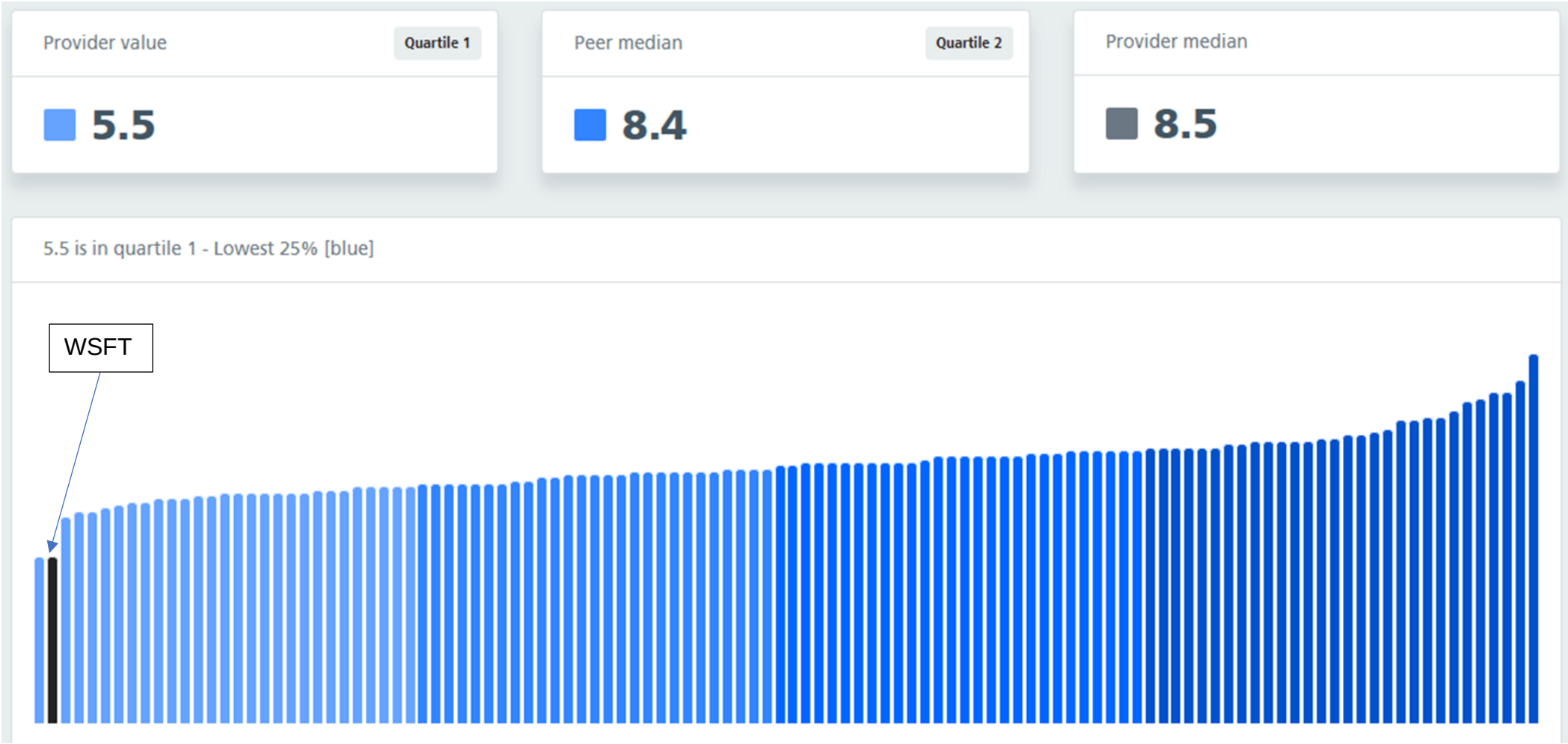
	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1428.5	1365.0833	1782.25	1670.3333	1069.5	1068	1426	1419	96%	94%	100%	100%	852	2.9	3.6	6.5
Glastonbury Court	713.5	715.5	1068.75	1051.25	713	713	542.5	543.5	100%	98%	100%	100%	560	2.6	2.8	5.4
Acute Assessment Ur	2359.75	2240.1667	2019.25	1870	1782.5	1767.5	1403	1354.75	95%	93%	99%	97%	830	4.8	3.9	8.7
Cardiac Centre	1782.5	1550	1062	796	1772.75	1679.25	711.5	663	87%	75%	95%	93%	862	3.7	1.7	5.4
G10	1779.5	1452	1783	1573	1069.5	968.5	1782.5	1718.5	82%	88%	91%	96%	1344	1.8	2.4	4.3
G9	1707	1523	1421	1340.75	1398.25	1363.75	1069.5	1046.5	89%	94%	98%	98%	1021	2.8	2.3	5.3
F12	713	637.75	356.5	308	713	621	356.5	276	89%	86%	87%	77%	369	3.4	1.6	5.0
F7	1782.5	1498	1771	1522.5	1414.5	1265	1782.5	1656	84%	86%	89%	93%	1582	1.7	2.0	3.9
G1	1329.5	998	355	314.5	713	701.5	356.5	356	75%	89%	98%	100%	458	3.7	1.5	5.2
G3	1775.5	1434	1781.5	1641.5	1069.5	1072.5	1421.5	1471.5	81%	92%	100%	104%	1092	2.3	2.9	5.1
G4	1769.5	1571.5	1770.5	1732	1069.5	1030.5	1426	1713.75	89%	98%	96%	120%	1146	2.3	3.0	5.3
G5	1772	1491.5	1782.5	1518.5	1069.5	1067	1426	1422	84%	85%	100%	100%	1240	2.1	2.4	4.5
G8	2395	1953.1667	1778.5	1493.25	1747.5	1724	1069	1122.3667	82%	84%	99%	105%	1193	3.1	2.2	5.3
F8	1777	1390.75	1758.5	1339.9167	1069.5	1023.75	1415.166667	1499.6667	78%	76%	96%	106%	1026	2.4	2.8	5.1
Critical Care	2506.75	2348.6667	150	132.5	2284.5	2240	0	10	94%	88%	98%	*	222	20.7	0.6	21.3
F3	1731.5	1569.75	1765.5	1570.6667	1069.5	1046.75	1424.5	1529.75	91%	89%	98%	107%	1130	2.3	2.7	5.1
F4	856.5	805	560.5	413.25	644	554	379.5	311	94%	74%	86%	82%	170	8.0	4.3	12.3
F5	1707	1459	1320.5	1218	1069.5	1028	1069.5	1092.5	85%	92%	96%	102%	608	4.1	3.8	7.9
F6	1587.75	1378.75	1628.5	1357.75	1069.5	1044.5	1403	1316	87%	83%	98%	94%	1430	1.7	1.9	3.7
Neonatal Unit	1579	1580.75	336	414.5	1019	1094	564	552	100%	123%	107%	98%	170	15.7	5.7	21.4
F1	2092	1836.75	713	598	1426	1412.5	0	23	88%	84%	99%	*	265	12.3	2.3	14.6
F14	367	367.5	362	350	744	744	0	0	100%	100%	100%	*	300	3.7	1.2	4.9
F10 (WEW)	1288	1054	1288	909	966	678.5	966	1085.25	82%	71%	70%	112%	217	8.0	9.2	17.2
Total	36,800.25	32,220.58	28,614.25	25,135.17	26,963.50	25,907.50	21,994.67	22,182.03	**88%**	**88%**	**96%**	**101%**	**18087**	**3.2**	**2.6**	**5.9**

* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours

Appendix 1b. Fill rates for inpatient areas (April 2025) Data adapted from Unify submission.

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1382.5	1256	1728	1668.5	1035	1029	1380	1391.5	91%	97%	99%	101%	1035	2.2	3.0	5.2
Glastonbury Court	690	690	1037.5	980.5	690	692	525	520	100%	95%	100%	99%	690	2.0	2.2	4.2
Acute Assessment Unit	2253.75	2200.25	2010.5	1942	1702	1705.666667	1345.5	1330.66667	98%	97%	100%	99%	698	5.6	4.7	10.3
Cardiac Centre	1725	1633.75	1017.25	883.5	1725	1689	690	655.5	95%	87%	98%	95%	639	5.2	2.4	7.6
G10	1724.5	1554.1667	1687.25	1540.75	1012	1025	1725	1722.5	90%	91%	101%	100%	949	2.7	3.4	6.2
G9	1672	1617	1350.5	1305	1345.5	1322.5	1035	1035	97%	97%	98%	100%	793	3.7	3.0	6.8
F12	690	674.5	339.25	295.75	690	655	338.5	281	98%	87%	95%	83%	224	5.9	2.6	8.5
F7	1598.5	1445.5	1709	1618.5	1357	1288	1702	1619.5	90%	95%	95%	95%	980	2.8	3.3	6.3
G1	1331.5	1052	345.5	322	690	690	345	356.5	79%	93%	100%	103%	358	4.9	1.9	6.8
G3	1709.5	1522.9167	1686	1614	1035	1035	1368.5	1622.5	89%	96%	100%	119%	986	2.6	3.3	5.9
G4	1720.5	1597	1727.5	1668.5	1035	1000.5	1374.5	1528	93%	97%	97%	111%	934	2.8	3.4	6.2
G5	1707.75	1580.3333	1646.5	1437.5	1023.5	1029.5	1375	1367.5	93%	87%	101%	99%	979	2.7	2.9	5.6
G8	2284	1803.5667	1725	1547.5	1667.5	1661.833333	1035	1046.5	79%	90%	100%	101%	842	4.1	3.1	7.2
F8	1725	1373.4167	1720	1535	1034.5	1008.083333	1375.5	1604	80%	89%	97%	117%	793	3.0	4.0	7.0
Critical Care	2518.5	2476.5	97.5	105.75	2355	2493.583333	0	0	98%	108%	106%	*	207	24.0	0.5	24.5
F3	1560.5	1511	1691.25	1665.25	1035	1035	1368.5	1589.5	97%	98%	100%	116%	852	3.0	3.8	7.0
F4	819	771	555.5	494	632.5	530	437	386	94%	89%	84%	88%	209	6.2	4.2	10.4
F5	1474.25	1420.5	1335	1308	1012	990	1000.5	972	96%	98%	98%	97%	320	7.5	7.1	14.7
F6	1572.5	1459	1583.25	1402	1023.5	1015	1276.5	1230	93%	89%	99%	96%	844	2.9	3.1	6.4
Neonatal Unit	1743	1372.5	360	483	1080	1036.5	720	492	79%	134%	96%	68%	291	8.3	3.4	11.6
F1	1960.75	1600.25	690	598	1380	1292.5	0	34.5	82%	87%	94%	*	165	17.5	3.8	21.4
F14	360	360	360	338	720	696	0	0	100%	100%	97%	*	90	11.7	3.8	15.5
Total	34,223.00	30,971.15	26,402.25	24,753.00	25,280.00	24,919.67	20,417.00	20,784.67	**90%**	**94%**	**99%**	**102%**	**13878**	**4.0**	**3.3**	**7.4**
* planned hours are zero																

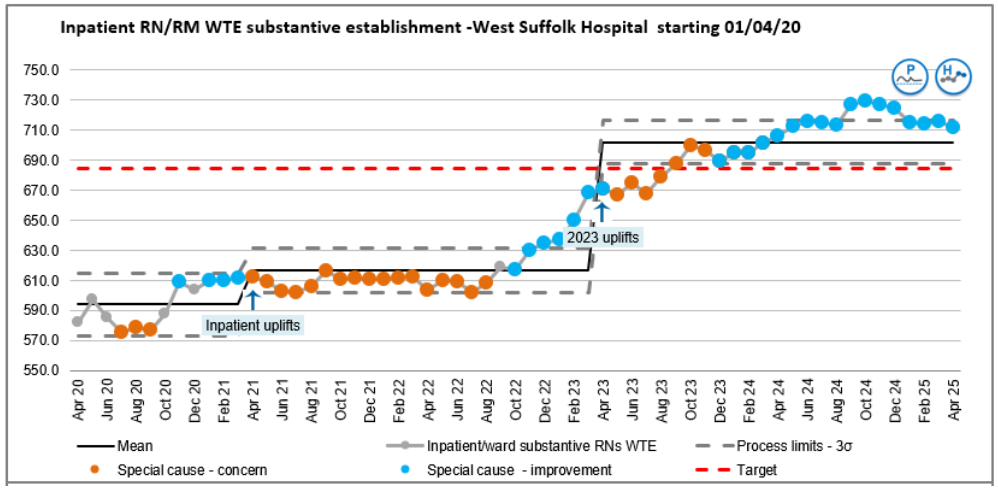
Appendix 2. CHPPD Model Hospital data (January data accessed 14.5.25



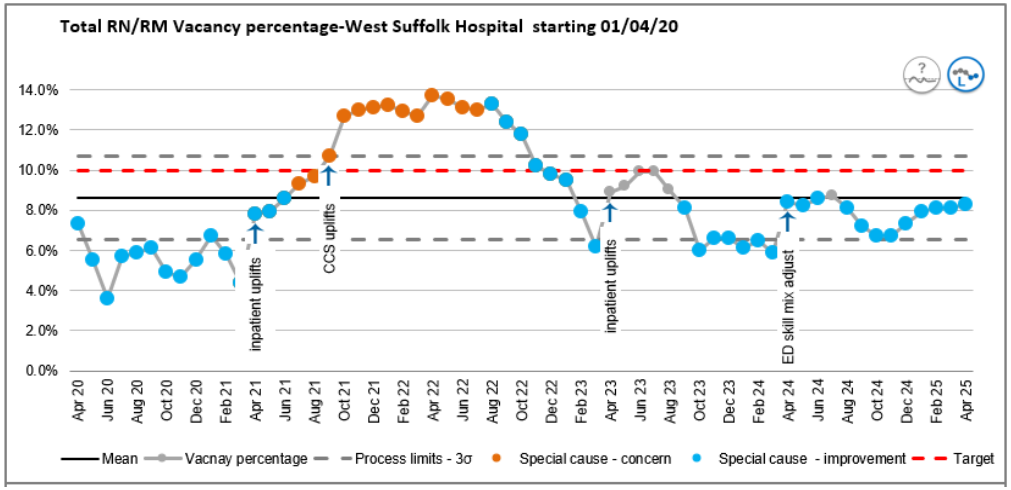
As stated in main paper this data is flawed. Most recent data on model hospital is Jan 2025 a significant lag and unlikely to demonstrate the data cleanse for a couple of months. April CHPPD is 7.4, would still fall with lower quartile compared with peers and national picture

Appendix 3 WTE and Vacancy rates.

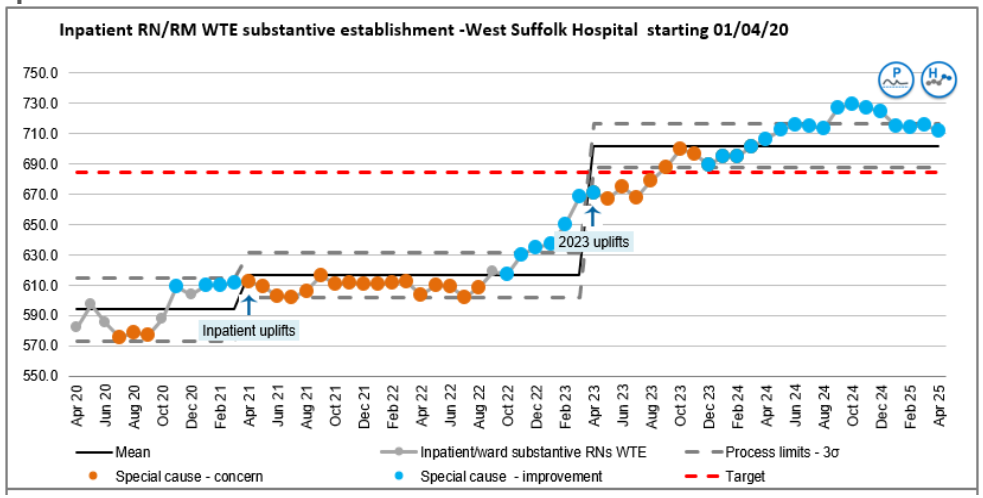
Trust Total RN/RM WTE



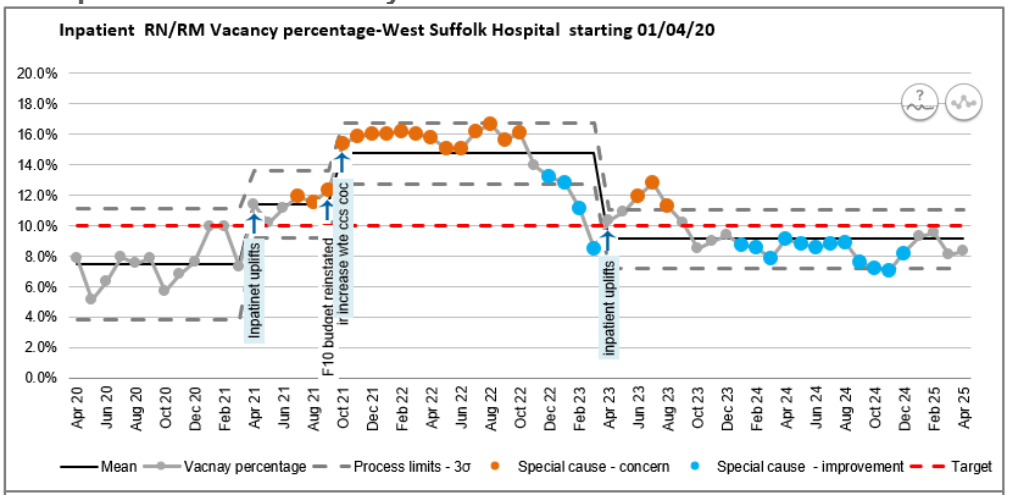
Trust Total RN/RM vacancy %



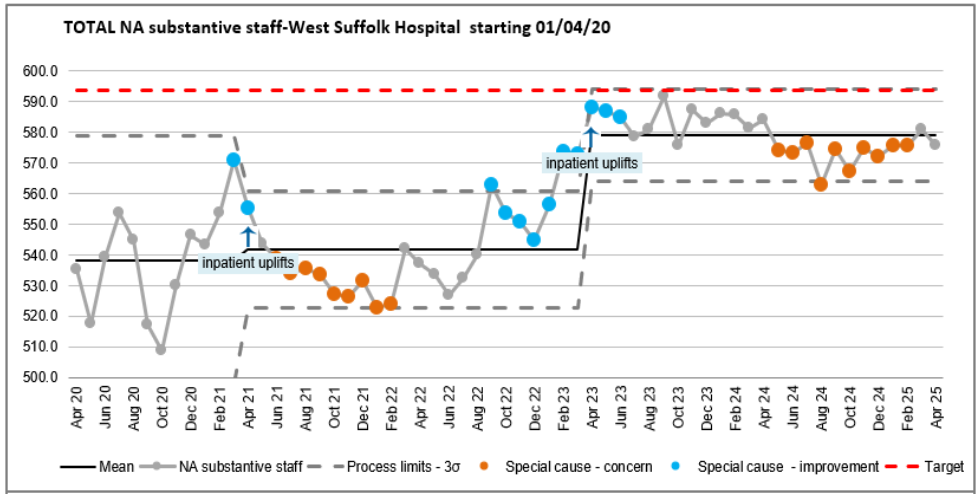
Inpatient RN/RM WTE



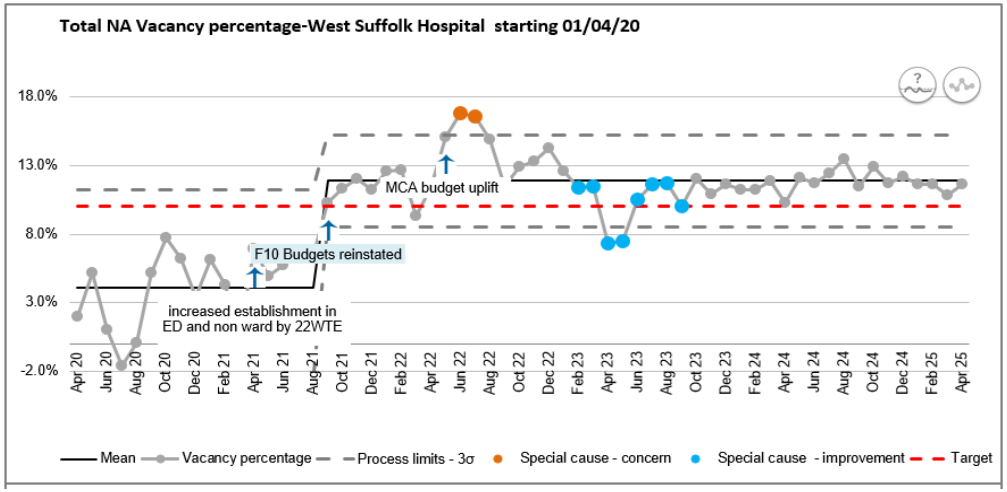
Inpatient RN/RM vacancy %



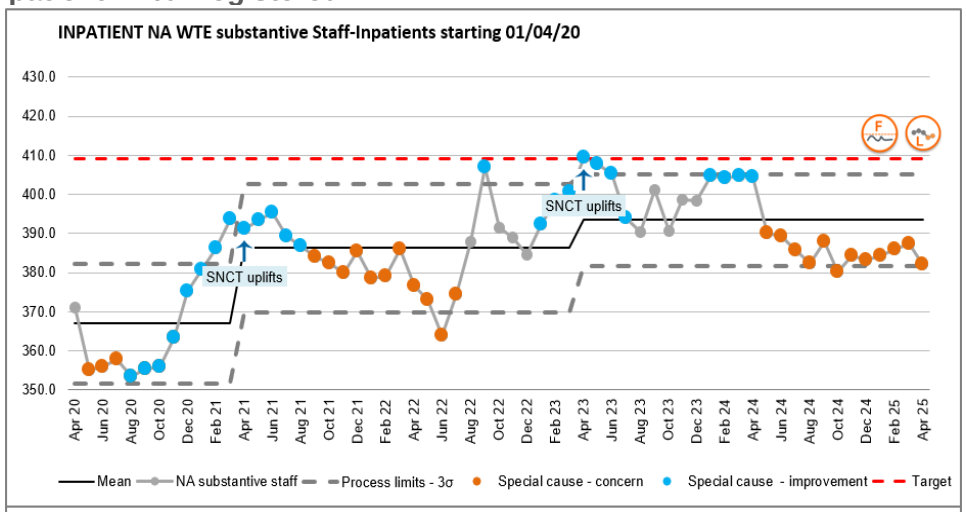
Total NA/unregistered WTE.



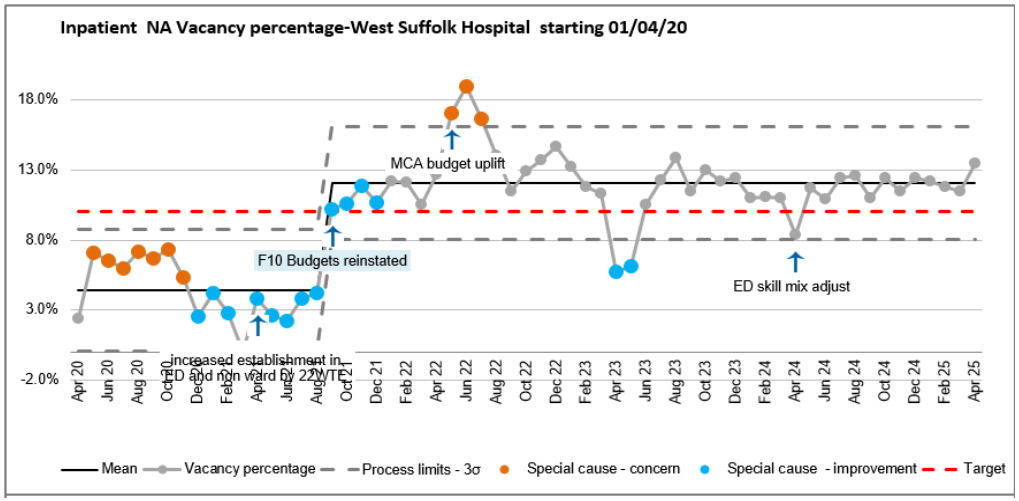
Total NA/Unregistered vacancy %



Inpatient NA/unregistered WTE



Inpatient NA/unregistered vacancy %



Appendix 4. Red Flag Events

Maternity Services

Missed medication during an admission
Delay of more than 30 minutes in providing pain relief
Delay of 30 minutes or more between presentation and triage
Delay of 60 minutes or more between delivery and commencing suturing
Full clinical examination not carried out when presenting in labour
Delay of two hours or more between admission for IOL and commencing the IOL process
Delayed recognition/ action of abnormal observations as per MEOWS
1:1 care in established labour not provided to a woman

Acute Inpatient Services

Unplanned omission in providing patient medications.
Delay of more than 30 minutes in providing pain relief
Patient vital signs not assessed or recorded as outlined in the care plan.
Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as: • pain: asking patients to describe their level of pain level using the local pain assessment tool. • personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration. • placement: making sure that the items a patient needs are within easy reach. • positioning: making sure that the patient is comfortable, and the risk of pressure ulcers is assessed and minimised.
A shortfall of more than eight hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift.
Fewer than two registered nurses present on a ward during any shift.
Unable to make home visits.

Appendix 5: SNCT output

Audit Results

Key	
	<SNCT output
	>SNCT output

Wards	WTE Budget at 2024**	January / February 2025						Difference to current budget (not including 1:1 care)	Difference to current budget if (1:1 care included)	Additional comments and outcome
		Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately		Additional Recommended				
		FTE	CHPDD	FTE	CHPDD	FTE	CHPDD			
AAU *	39.8	40.39	6.64	36.39	5.98	3.99	17.83	3.4	-0.6	No change current establishment consistently staffs escalation area within current numbers.
Cardiac / G7 *	41.2	34.74	7.14	34.42	7.07	0.32	17.21	6.8	6.5	No change. Telemetry role not captured in SNCT, requires additional staff due to remote monitiring activity within cardiac services
F12	19.7	14.49	7.60	14.40	7.55	0.10	15.68	5.3	5.2	No change
F7	50.7	49.82	6.54	49.04	6.44	0.78	20.94	1.7	0.9	No change
F8	45.4	39.52	6.16	39.20	6.11	0.32	17.21	6.2	5.9	Scope to reduce ward as lower bed base than simialr wards. Establishment will need to be protected while scoping ward reconfiguration
G1 *	20.6	25.10	8.76	24.67	8.61	0.43	23.16	-4.1	-4.5	No change. Support from MACU as required
G3	46.1	44.80	7.47	35.59	5.93	9.21	17.21	10.5	1.3	Only 5 weeks data Wk6 not submitted: therefore invalid audit
G4	46.0	58.19	7.96	44.92	6.15	13.28	17.21	1.1	-12.2	No change. Output consistent with current establishment. However high requirement for enhanced care.
G5	45.1	42.06	6.45	41.95	6.43	0.11	17.21	3.1	3.0	Only 5 weeks data Wk6 not submitted: therefore invalid audit
G8	53.3	57.23	8.22	56.44	8.10	0.78	20.94	-3.1	-3.9	No change
G9	43.8	42.15	7.23	40.20	6.89	1.95	24.09	3.6	1.7	No Change Level 2 patients within the ward flucutate and are current establishment supports this
G10	49.5	55.23	7.30	46.80	6.18	8.44	19.10	2.7	-5.7	No change, high use of 1:1 care seen, current establishment not able to consistently absorbs this
F3	48.0	52.60	6.83	52.60	6.83	0	0	-4.6	-4.6	No change
F4	27.4	17.52	4.41	17.52	4.41	0	0	9.9	9.9	reduction of 4.95 WTE NA through service redesign
F5 *	40.7	33.43	4.86	33.43	4.86	0	0	7.3	7.3	reduction of 4 WTE NA through service redesign
F6	42.5	45.28	5.80	44.86	5.74	0.43	17.21	-2.4	-2.8	No change. Acuity can be supported within the division
F14*	10.6	7.31	4.24	7.31	4.24	0	0	3.3	3.3	No change any reduction would result in lone working
F1*	23.9	20.63	5.46	19.13	5.06	1.50	17.21	4.7	3.2	No change. Ward supports CAU and UEC flow during peak activity. Any reduction would remove the ability to respond to emergency care demands

6.3. Maternity services report (ATTACHED)

For Approval

Presented by Susan Wilkinson and Karen Newbury

Open Trust Board Committee	
Report title:	Maternity & Neonatal quality, safety, and performance report
Agenda item:	6.3
Date of the meeting:	23rd May 2025
Sponsor/executive lead:	Sue Wilkinson, Executive Chief Nurse Richard Goodwin Medical Director & Executive Mat/Neo Safety Champion
Report prepared by:	Karen Newbury, Director of Midwifery Justyna Skonieczny Head of Midwifery

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?

This report presents a document to enable board scrutiny of Maternity and Neonatal services and receive assurance of ongoing compliance against key quality and safety indicators and provide an update on Maternity quality & safety initiatives in line with the NHS Perinatal quality surveillance Model (Dec 2020).

This report contains:

- Maternity improvement plan
- Safety champion feedback from walkabout
- Listening to staff
- Service user feedback
- Reporting and learning from incidents
- Training compliance for all staff groups in maternity related to the core competency framework.
- Reports approved by the Improvement Committee
- Closed Board reports, nil due this month
    - Perinatal Mortality Report Q4 January – March 2025
    - Maternity and Neonatal Safety Investigations (MNSI) Q4 January- March 2025
- Next steps

SO WHAT?

The report meets NHSE standard of perinatal surveillance by providing the Trust board a methodical review of maternity and neonatal safety and quality.

WHAT NEXT?

Action plans will be monitored, and any areas of non-completion will be escalated as appropriate.
Quarterly, bi-annual and annual reports will evidence the updates.
As applicable, reports will be shared with external stakeholders as required.

Action Required

For assurance and information.

Risk and assurance:	As below
Equality, Diversity and Inclusion:	This paper has been written with due consideration to equality, diversity, and inclusion.
Sustainability:	As per individual reports
Legal and regulatory context	The information contained within this report has been obtained through due diligence.

Maternity quality, safety, and performance report

1.	**Detailed sections and key issues**
1.1	**Maternity and Neonatal improvement plan** The Maternity and Neonatal Improvement Board (MNIB) receives the updated Maternity improvement plan monthly. This has been created through an amalgamation of the original CQC improvement plan with the wider requirements of Ockenden, Maternity and Newborn Safety Investigations, external site visits and self-assessment against other national best practice (e.g., MBRRACE, SBLCBv3, UKOSS). It has been agreed with the exit from the Maternity Safety Support Programme (MSSP) in October 2022, that NHSE regional team and ICS (Integrated Care System) will be invited to attend the MNIB monthly for additional assurance and scrutiny. NHSE regional team, Local Maternity and Neonatal System ICB members and the Lead for the Neonatal Operational Delivery Network, undertook a 60 Supportive Steps visit on the 31st of January 2025, to provide a systematic review of the Trust's maternity and neonatal service. The day's feedback was overwhelmingly positive. The final report has now been received and highlights all the good practices identified along with areas for consideration and /or further action. Due to the number of the latter (32) an action plan is under way and was presented at April's Improvement Board. The impact of all changes is being closely monitored through various channels such as the Maternity and Neonatal Improvement Board, training trackers, dashboards, clinical auditing, and analysis of clinical outcomes for specific pathways. The Trust remains dedicated to making sustained improvements in quality and safety for women and pregnant people, babies, their families, and the staff working within the teams.
1.2	**Safety Champion feedback** The Board-level safety champion undertakes a monthly walkabout in the maternity and neonatal unit. Staff can raise any safety issues with the Board level champion and if there are any immediate actions that are required, the Board level champion will address these with the relevant person at the time. Individuals or groups of staff can raise issues with the Board champion. An overview of the Walkabout content and responses is shared with all staff in the monthly governance newsletter 'Risky Business'. Roger Petter our Non-Executive Maternity and Neonatal Safety Champion visited the Gainsborough Midwifery team in Sudbury on the 11th of March 2025. Roger was able to speak with a number of staff, who had no significant issues to raise now that staffing levels have improved. Communication between the hospital and the community is generally good and they feel this may improve further if the morning handover call moves to an electronic system, which has been proposed. No safety concerns were raised affecting either service users or staff. The team reported that they have lone worker devices but admitted that these are not always used. Roger gained the impression of a well led team with good motivation, morale and job satisfaction. There was no Safety Champion walkabout conducted in April; however, two are scheduled for May 2025, focusing on the antenatal and postnatal ward F11 and the Castlehill Midwifery team in Thetford.

1.3	**Listening to Staff** The maternity and neonatal service continues to promote all staff accessing the Freedom to Speak up Guardians, Safety Champions, Professional Midwifery/Nursing Advocates, Unit Meetings and 'Safe Space'. In addition to this there are maternity and neonatal staff focus groups, and specific care assistant and support worker forum, which all provide an opportunity to listen to staff. Following the release of the National Nursing and Midwifery Retention Report in March 2022, regional efforts were initiated to analyse the data in greater depth and pinpoint areas needing enhancement. It was observed that a significant number of midwives tend to exit the profession within 2-5 years post-qualification. In response, substantial initiatives have been implemented to improve up on, with all staff members who have been qualified for less than three years being offered opportunities for further career development discussions. Currently, the turnover rate stands at 6.9%, which is lower than the peer average of 8.1% and the national average of 8.4% (NHS Model Health System, Feb 2025). Our recruitment and retention lead, along with the Legacy midwife offer group, conducts coaching sessions for all internationally educated midwives, a program that has recently been expanded to include all internationally educated nurses in both the ward and neonatal unit. These group coaching sessions have begun to gain popularity, providing a secure environment for this specific staff demographic to express their opinions. Participants have reported an increase in their confidence regarding their daily practices. The 2025 National Staff Satisfaction Survey results have just been published and in response the quadrumvirate and HR Business Partner are reviewing the findings and developing an action plan. In addition, the quadrumvirate are continuing to focus on the SCORE Culture Survey results which provided in-depth information regarding our workforce, specific to roles, teams and work settings. SCORE Culture Survey is the final component of the Perinatal Culture & Leadership Programme with the aim of nurturing a positive safety culture, enabling psychologically safe working environments, and building compassionate leadership to make work a better place to be and is included in the requirements for NHS Resolutions Maternity Incentive Scheme. All staff across Women's & Children were invited to participate in the survey with a response rate of 49%. An external culture coach then met with targeted groups to gain further understanding of the survey results. This feedback has been reviewed and the following aspirations identified. 1. Develop a strong and effective communication ethos, 2. Create a strong sense of belonging for all, across the service 3. Culture is embedded and prioritised as how we do things here. The perinatal quadrumvirate and in-house culture coaches are continuing the work regarding our safety culture and aspirations. In March and May, maternity and neonatal staff were invited to professional behaviours and patient safety sessions run jointly by the General Medical Council and Nursing & Midwifery Council. The sessions were positively received by those attending. Following both sessions the speakers will identify any themes/areas to address with the quadrumvirate. Our HR Business Partner and Freedom to Speak up Guardian were also in attendance, to action any immediate issues without impacting confidentiality.
1.4	**Service User feedback.** The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It's a quick and anonymous way to give views after receiving NHS care or treatment.

Ward/Dept	March Survey returns	% of discharged people provided feedback *	March Very good and good %	April Survey returns	April Very good and good %	% of discharged people provided feedback *
F11	32	9%	84%	36	100%	12%
Antenatal	38	NA	95%	24	88%	NA
Postnatal Community	27	NA	85%	26	92%	NA
Labour Suite	14	48%	93%	9	100%	24%
Birthing Unit	8	35%	100%	5	100%	33%
NNU	2	8%	100%	1	100%	3%
Transitional Care	6	NA	83%	9	100%	NA

*Target of ≥30%

Due to the low number of responses the maternity and neonatal team are working closely with the Patient Engagement team and the Parent Education and Patient Experience Lead Midwife to increase the number of responses.

In addition to the FFT, feedback is gained via our PALS, CQC Maternity survey and Healthwatch surveys. The maternity service has also noted increased volume of feedback received via social media. To note our Maternity and Neonatal Voice Partnership (MNVP) chair has stepped down from their position at the beginning of 2024. Since then, the MNVP has lacked both a chair and sufficient members to function effectively. The release of the Maternity and Neonatal Voices Partnership guidance in November 2023 provided our Local Maternity and Neonatal System (LMNS) with the opportunity to reassess and establish more sustainable services. In response, the new LMNS MNVP Lead has been appointed and commenced in their role in October 2024. The incoming MNVP Lead is responsible for the re-establishment of the WSFT MNVP.

In March 2025, the patient experience team at WSFT received one compliment regarding the maternity and neonatal services, specifically highlighting the care provided on Antenatal and Postnatal- Ward F11. In April 2025, two compliments were noted, focusing on the care received on the antenatal and postnatal ward F11 and Neonatal Unit.

During March 2025, the Trust recorded a total of nine PALS inquiries related to the Antenatal Clinic, ward F11, the Neonatal Unit, and community services, with the majority of inquiries pertaining to administrative issues, followed by those related to patient care and communication. In April 2025 two PALS inquiries were logged, primarily concerning the antenatal and postnatal ward F11, with the predominant topics being patient care.

In March 2025 no formal complaint was submitted and in April 2025 one formal complaint was received related to clinical treatment.

1.5 **Reporting and learning from incidents**

During March and April 2025 there was one case that met the referral criteria to the Maternity and Newborn Safety Investigations (MNSI).

The maternity service is represented at the Local Maternity and Neonatal System (LMNS) monthly safety forum, where incidents, reports and learning are shared across all three maternity units.

Quarterly reports are shared with the Trust Board to give an overview of any cases, with the learning and assurance that reporting standards have been met to MNSI/Early Notification Scheme and the Perinatal Mortality Reporting Tool (PMRT).

1.6 **Training compliance for all staff groups in maternity related to the core competency framework.**

Staff Group March 2025	Saving Babies Lives 1,2,5,6	GAP/GROW	Maternity Emergencies / PROMPT	Skills and Drills	Personalised Care	Safeguarding	Care in labour & Immediate Postnatal	Neonatal Life Support	Fetal Heart Surveillance	Newborn Feeding update
Midwives	94.61%	92.8%	97.58%	97.58%	95.18%	98.8%	95.78%	97.58%	92%	98.8%
MCA/MSW	NA	NA	100%	100%	NA	98%	97.62%	100%	NA	98%
Consultant Obstetrician	75%	87.5%	100%	100%	88.24%	85%	75%	NA	100%	NA
Obstetric Registrar	90.9%	91.6%	83.3%	83.3%	45.45%	100%	60%	NA	100%	NA
SHO/Core trainees	N/A	100%	100%	100%	N/A	100%	N/A	NA	NA	NA
Sonographer	NA	94.7%	NA	NA	NA	NA	NA	NA	NA	NA
Consultant Obstetric Anaesthetists	NA	NA	58.83%	58.83%	NA	NA	NA	NA	NA	NA
Obstetric Anaesthetists	NA	NA	93.75%	93.75%	NA	NA	NA	NA	NA	NA
Neonatal Consultants	NA	NA	NA	75%	NA	89%	NA	100%	NA	TBC
Neonatal Nurses	NA	NA	96%	96%	NA	97%	NA	100%	NA	97%
Neonatal Doctors	NA	NA	NA	TBC	NA	81%	NA	100%	NA	TBC
ANNP/PA	NA	NA	NA	TBC	NA	100%	NA	100%	NA	TBC

Staff Group April 2025	Saving Babies Lives 1,2,5,6	GAP/GROW	Maternity Emergencies / PROMPT	Skills and Drills	Personalised Care	Safeguarding	Care in labour & Immediate Postnatal	Neonatal Life Support	Fetal Heart Surveillance	Newborn Feeding update
Midwives	96.27%	96.72%	94.41%	94.41%	96.34%	96.27%	97.56%	94.41%	92%	96.27%
MCA/MSW	NA	NA	97.62%	97.62%	NA	98%	97.67%	97.62%	NA	98%
Consultant Obstetrician	75%	73.4%	100%	100%	76.47%	78%	75%	NA	97%	NA
Obstetric Registrar	100%	91%	100%	100%	50%	93%	66.67%	NA	100%	NA
SHO/Core trainees	N/A	11.1%	100%	100%	N/A	85%	N/A	NA	NA	NA
Sonographer	NA	94.7%	NA	NA	NA	NA	NA	NA	NA	NA
Consultant Obstetric Anaesthetists	NA	NA	62%	62%	NA	NA	NA	NA	NA	NA
Obstetric Anaesthetists	NA	NA	92%	92%	NA	NA	NA	NA	NA	NA
Neonatal Consultants	NA	NA	NA	75%	NA	100%	NA	93.33%	NA	TBC
Neonatal Nurses	NA	NA	97%	69%*	NA	97%	NA	97%	NA	95%
Neonatal Doctors	NA	NA	NA	TBC	NA	94%	NA	100%	NA	TBC
ANNP/PA	NA	NA	NA	TBC	NA	100%	NA	100%	NA	TBC

Key

COLOUR CODE	MEANING	ACTIONS
	>90%	Maintain
	80-90%	Identify non-attendance and rebook; monitor until >90% for 3 months
	<80%	Urgent review of non-attendance and rebook; monitor monthly until >90% or direct management if <90%
	Not applicable to that staff group	Review criteria for training as part of annual review
	New training for that staff group	Review compliance trajectory after 3 months

The reduction in consultant obstetric anaesthetist availability is attributed to their need to forgo training in order to accommodate additional theatre lists. They will be prioritised to attend the next session.

Attendance of neonatal consultants and trainee doctors at safeguarding training has improved, although efforts are ongoing to enhance compliance with skills and drills.

Currently, compliance for neonatal skills and drills stands at 69%, as attendance at the NNU study day was not mandatory last year due to NNU staff participating in a full day of PROMPT training. However, this situation is improving, and it is anticipated that compliance will reach 100% by the end of 2025.

In response to the introduction of the Six Core Competency Framework version 2, additional training sessions were initiated at the start of 2024. While compliance in these areas is on the rise, it remains

	challenging to release all staff groups for training. A comprehensive review of the current training requirements is in progress to identify more effective training delivery methods. Data collection regarding compliance is not yet fully established, measures have been implemented to address this issue; however, for certain training components, compliance is dependent on individuals providing evidence of their training from their previous Trust.
2.	**Reports**
2.1	**Reports approved by the Improvement Committee** Year 6 of the NHS Resolution Maternity Incentive Scheme was launched in April 2024 with ten key Safety Actions to be achieved and maintained by the Maternity and Neonatal Services provided by West Suffolk NHS Foundation Trust. We reported compliance against all requirements. There have been some minor changes to the safety requirements for 2025 in some of the Safety Actions, one of the key changes has been the processes and pathways for Trust committee and Board oversight. This has afforded the Trust the opportunity to optimise the reporting structures and assurance processes to ensure that each report has appropriate oversight and approval during this time. Reports to provide assurance in each Safety Action can be monthly, quarterly, six-monthly, annually or as a one-off oversight report at the end of the reporting period for sign-off prior to submission. Many of the reporting processes are embedded into business as usual for the services so are continued out with the Maternity Incentive Scheme (MIS). The updated process was agreed at the Board Meeting on the 24th of May 2024, whereby some reports will be presented and approved by the Board sub-committee, the Improvement Committee. The Improvement Committee will provide an overview and assurances to the Trust Board that reports have been approved and any concerns with safety and quality of care or issues that need escalating. Following reports were presented and approved at the Improvement Committee held on the 16th April 2025: • 60 supportive Steps visit 31.01.25 report No reports were due to be presented to the Improvement Committee held on the 19th of March 2025.
3.	**Reports for CLOSED BOARD** Due to the level of detail required for these reports and subsequently containing possible patient identifiable information, the full reports will be shared at Closed board only.
3.1	**Perinatal mortality Report Q4 1st January 2025- 31st March 2025** The Trust reported five perinatal losses to Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE) in this quarter. All cases have received bereavement support. All the timeframes for reporting to MBRRACE have been met and local and Perinatal Mortality Review Tool (PMRT) reviews are on course for completion. Two PMRT reports have been completed from previous quarters and learning has been identified and shared with the teams.
3.2	**Maternity and Neonatal Safety Investigations (MNSI) Report Q4 1st January 2025- 31st March 2025** There have been ?? incidents in the Trust that meet the reporting criteria for MNSI but not the NHS Resolution Early Notification Scheme (ENS) in this quarter and no completed MNSI reports. The Maternity and Neonatal services remain vigilant to identify any incidents that may need further external investigation and have embedded processes to review and identify learning at an early stage.
4.	**Next steps**
4.1	Reports will be shared with the external stakeholders as required. Action plans will be monitored and updated accordingly.

7. GOVERNANCE

7.1. Charitable Funds CKI Committee report (ATTACHED)

For Approval

Presented by Jonathan Rowell and Richard Flatman

Charitable Funds Committee Key Issues (CKI) report

Originating Committee: Charitable Funds Committee			Date of meeting: 27 March 2025		
Chaired by: Richard Flatman			**Lead Executive Director: Jeremy Over**		
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
1	Committee was introduced to Jo Landucci, (JL) replacing Sue Smith as our new Head of fundraising	Substantial	Committee very pleased to welcome Jo and note early progress made	Strategy and team development	No escalation
4	The investment manager CCLA had agreed to attend the March meeting but was unavailable	Reasonable	It is important that we receive regular attendance and update from the investment manager, including performance against agreed target returns	It has been agreed that CCLA will attend the June meeting	No escalation
4	The external auditors, Lovewell Blake (LB) are out of contract	Reasonable	We are close to year end and need to appoint auditors as a matter of urgency. LB are willing to continue	In compliance with procurement requirements, Finance are obtaining quotes to test the market. Reasonable assurance as we are aware that LB are willing to continue	No escalation
5	Noted summary of recent fundraising activity, legacies and upcoming priorities.	Reasonable	JL will continue to review approach	JL to present revised strategy and financial targets for 25/26 to June committee. Committee stressed the importance of	No escalation

				contextualising the strategy in terms of agreed vision and mission.	
5	Counsellors / activity co-ordinators	Partial	There was much discussion as to which posts the Charity should fund and the period of time the Charity should fund (in order to demonstrate value) before responsibility for funding moves to the Trust.	JL agreed to consult widely and bring back a policy for approval by Committee. Agreed that wider communication of the agreed policy is essential.	No escalation
5	Fundraising team	Reasonable	Change of leadership provides opportunity for review of team structure and focus	JL to consider and present proposals for future team structure and targets JL to review and amend job descriptions and advertise for new role of Corporate Manager in the team.	No escalation
5	Robot	Partial	Accounted for in capital plans. Discussed maintenance costs £120kpa and replacement costs (£250k after 8-10 years).	Significant fundraising required. Cost £1.5m+ with target 85% from major/corporate donors and grants with balance from community. Agreed to re-circulate original business case to ensure maintenance and replacement costs included. Committee to determine whether these costs can be covered and once agreed JL to review Robot funding strategy.	No escalation

6	Financial performance	Reasonable	Income behind previous year as a result of significant legacies accounted for in 23/24. Noted that close to £1m in debtors related to legacies accounted for but not yet received as pending linked to sale of properties	Finalisation of strategy and agreed targets for 25/26 (expected to be similar to actual 24/25 with growth thereafter) Regular review and follow up but should not be relied upon for funding of Robot	No escalation
7	Investment Report	Reasonable	Noted the fund value of £1.66m, which was a small increase over the 11 months from 1/4/24.	Review of performance at June Committee with a presentation from CCLA.	No escalation
8, 9	Funds closed and fund balances	Substantial	Noted fund balances and agreed closure and transfer of funds as previously approved.		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.

7.2. Board Assurance Framework (ATTACHED)

To Note

Presented by Pooja Sharma

WSFT Board of Directors (Open)	
Report title:	**Board Assurance Framework**
Agenda item:	7.2
Date of the meeting:	2025
Sponsor/executive lead:	Richard Jones, Trust Secretary
Report prepared by:	Mike Dixon, Head of Health, Safety and Risk

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 provides an update on development of the board assurance framework (BAF). The BAF remains structured around the agreed **10 strategic risks:**

1. Capability and skills
2. Capacity
3. Collaboration
4. Continuous improvement & Innovation
5. Digital
6. Estates
7. Finance
8. Governance
9. Patient Engagement
10. Staff Wellbeing

The assessment of each BAF risk continues to be developed in line with the approach approved at by Board, including review by the agreed governance group and Board assurance committee.

Annex A of this report **maps movement for each of the BAF risk** according to the risk score for 'current' (with existing controls in place) and 'future' (with identified additional controls in place).

All of the BAF risk assessments are regularly reviewed and updated. The Management Executive Group (MEG) undertake scheduled reviews of the individual risks within the BAF, this supports reporting into the Board assurance committees.

The following **summarises changes since the last report**:

- **BAF 2 Capacity** – the risk and action plan reviewed and updated by the Chief Operating Officer and presented to MEG in March and the Insight Committee in April
- **BAF 3 Collaboration** - reviewed and updated by the Executive Director of Strategy and Transformation and presented to MEG in March and to the Involvement Committee in April.
- **BAF 5 Digital** – reviewed and updated by the Interim chief information officer and presented to the Digital Board in April.
- **BAF 7 Finance –** reviewed and risk rating updated by the Executive Director Financial Recovery and presented to MEG and Insight Committee in May
- **BAF 9 Patient Engagement** – reviewed and updated by the Head of Legal Services and IG and presented to MEG in March and the Involvement Committee in April. The focus of BAF 9 has moved away from large scale substantial change eg the transfer of elective orthopaedic care, to ensuring the culture of engagement is embedded across the organisation and focuses on delivering reasonable adjustments and recording protected characteristics.

Based on the current assessments **four BAF risks will achieve the risk appetite** rating approved by the Board based on the identified additional mitigations and future risk score (Annex B). This position will form part of the review and challenge by the relevant assurance committee's of the Board for all the risks – testing the risk rating, additional controls and risk appetite.

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

The Board assurance framework is a tool used by the Board to manage its principal strategic risks. Focusing on each risk individually, the BAF documents the key controls in place to manage the risk, the assurances received both from within the organisation and independently as to the effectiveness of those controls and highlights for the board's attention the gaps in control and gaps in assurance that it needs to address in order to reduce the risk to the lowest achievable risk rating.

Failure to effectively identify and manage strategic risks through the BAF places the strategic objectives at risk. It is critical that the Board can maintain oversight of the strategic risks through the BAF and track progress and delivery.

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

To continue with the review and update of the strategic risks within the BAF including:

- Schedule **review of risks to the agreed strategy** when the strategy refresh has been undertaken. This will also include review and assessment of the risk appetite for each risk (Q2-Sep/Oct)

- To arrange a Board Risk Management workshop supported by external stakeholders in November, which will include a review of the current BAF. This will ensure the Board of Directors meets the requirements of the strategy and policy for risk management to receive specific risk management training on a two-yearly basis. (Q3-Nov)

- A matrix will be developed to **map the interdependencies** between individual BAF risks. (Q4-Jan)

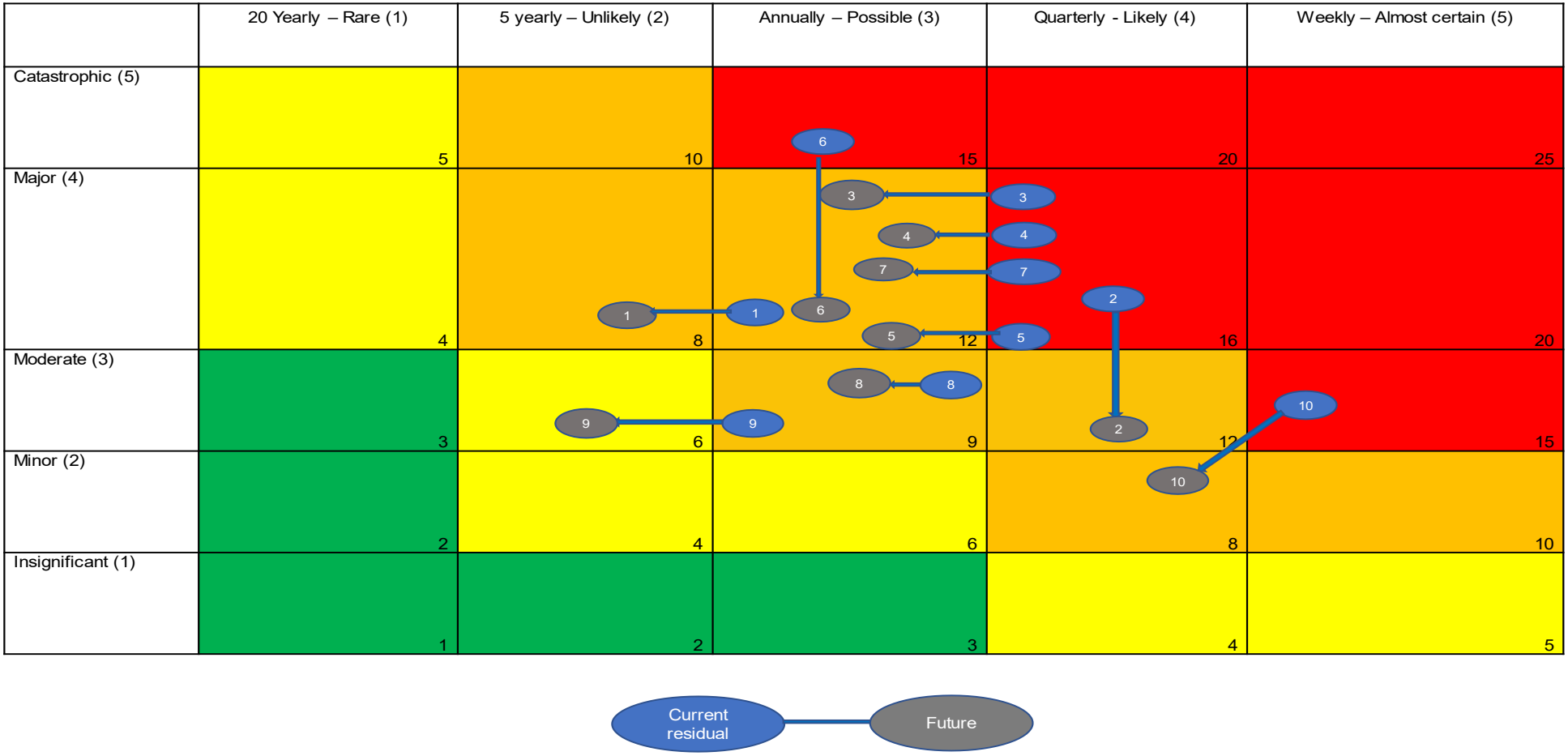
- Review and refresh **longer term assessment** of the mitigation and risk for each of the BAF risks to achieve the agreed risk appetite (Q4-Feb).

Action Required

1. **Note the report** and progress with the BAF review and development
2. **Approve the 'Next steps' actions**.

Previously considered by:	The Board of Directors
Risk and assurance:	Failure to effectively manage risks to the Trust's strategic objectives. Agreed structure for Board Assurance Framework (BAF) review with oversight by the Audit Committee. Internal Audit review and testing of the BAF.
Equality, diversity and inclusion:	Decisions should not disadvantage individuals or groups with protected characteristics
Sustainability:	Decisions should not add environmental impact
Legal and regulatory context:	NHS Act 2006, Code of Governance. Well-led framework

Annex A: BAF risk movement



1. Capability and skills
2. Capacity
3. Collaboration
4. Continuous improvement & Innovation
5. Digital
6. Estates
7. Finance
8. Governance
9. Patient Engagement
10. Staff Wellbeing

Annex B: Risk themes – summary table

Risk Descriptions	Exec lead	Board comm.	Board committee review (MEG review)	Appetite Level and score	Current risk score	Future risk score (target date)	Future risk with appetite?	Assur. level
BAF 1 Fail to ensure the Trust has the capability and skills to deliver the highest quality, safe and effective services that provide the best possible outcomes and experience (Inc developing our current and future staff)	HR&C	Involvement	Planned for Jan 26 (Jul '25)	Cautious (9)	12	8 (Mar 25)	Yes	Reasonable
BAF 2 The Trust fails to ensure that the health and care system has the capacity to respond to the changing and increasing needs of our communities	COO	Insight	Planned for Jul '25 (Jun '25)	Cautious (9)	16	12 (June 25)	No	Partial
BAF 3 The Trust fails to collaborate effectively with partners, causing an inability to deliver the 'Future Shift', leading to a failure to implement strategic transformation priorities, the Future Systems Programme, and/or new models of care that could improve population health outcomes, Trust sustainability, and operational performance.	DST	Involvement	Planned for Jul '25 (Jun '25)	Open (12)	16	12 (June 25)	No	Partial
BAF 4 There is a risk that the Trust does not have the capacity, capability, or commitment to change the way it provides health and care services, which could lead to a failure to respond to changing demand pressures, unsustainable services, and/or not delivering major projects, which would worsen operational pressures, quality of care, and financial viability.	DST	Improvement	Planned for Jun '25 (May '25)	Open (12)	16	12 (July 25)	Yes	Partial
BAF 5 Fail to ensure the Trust implements secure, cost effective and innovative approaches that advance our digital and technological capabilities to better support the health and wellbeing of our communities	COO	Digital Board	Planned for Jul '25	Cautious (9)	16	12 (Aug 25)	No	Partial
BAF 6 [1] Fail to ensure the Trust estates are safe, fit for purpose while maintained to the best possible standard so that everyone has a comfortable environment to be cared for and work in today and for the future	DoR	Future Systems Board	Planned for Jun '25 (May '25)	Open (12)	15	12 (Dec 24)	Yes	Partial

Risk Descriptions	Exec lead	Board comm.	Board committee review (MEG review)	Appetite Level and score	Current risk score	Future risk score (target date)	Future risk with appetite?	Assur. level
BAF 7 Fail to ensure we manage our finances effectively to guarantee the long-term sustainability of the Trust and secure the delivery of our vision, ambitions, and values	DoR	Insight	May '25 (May '25)	Cautious (9)	16	12 (Mar 26)	No	Partial
BAF 8 Fail to ensure the Trust has the appropriate governance structures, principles and behaviours to help us safely deliver the best quality and safest care for our local population (our vision) and ambitions (for patients, staff and the future) in the right way	ECN	Improvement	Jul '25 (Jun '25)	Minimal (6)	9	9	No	Reasonable
BAF 9 Trust fails to centre decision making and governance around the voices of people and communities at every stage including feeding back to them how their voice has influenced decisions, especially with marginalised groups and those affected by health inequalities, resulting in a lack of understanding of our community's health needs	ECN	Involvement	Planned for Oct '25 (Sep '25)	Cautious (9)	9	6 (Sep 25)	Yes	Reasonable
BAF 10 Fail to ensure the Trust can effectively support, protect and improve the health, wellbeing and safety of our staff	HR&C	Involvement	Aug '25 (Jul '25)	Cautious (9)	15	8 (Mar 26)	No	Partial

[1] risk rating increases in future years as WSH building reaches end of effective life

7.3. Audit One recommendation – progress report (ATTACHED)

Presented by Pooja Sharma

Board of Directors Meeting (Open)

Report title:	Response to AuditOne recommendations – review of progress
Agenda item:	7.3
Date of the meeting:	23 May 2025
Sponsor/executive lead:	Richard Jones, Trust Secretary & Head of Governance
Report prepared by:	Paul Bunn, Trust solicitor, Head of Legal Services and IG 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 Trust commissioned ConsultOne (the consultancy arm of AuditOne) to undertake a well led developmental review of leadership and governance at the Trust in 2023/24. The final report was issued in April 2024. In summer 2024, the 32 recommendations/actions (appendix 1) were mapped against the CQC well led quality statements and the Trust's existing work streams. The Board last received an update in September 2024. The matter has since been considered at MEG in March 2025 and Involvement Committee in April 2025. This report is an update to the Board on progress since September 2024.

The Involvement committee monitors progress against the original 32 actions and approves sign off and closure once evidence has been submitted that they are complete. 7 Actions have been signed off since the Board last met and a further update is contained within the Involvement committee CKI key issues report – no escalations required.

The Board is asked to note that the internal auditors, RSM reviewed the process during w/c 24 February 2025, the scope was defined as: "*To assess the outcome of the Well Led Review and that the Trust has addressed the recommendations from the review*."

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

Good leadership enables better care for patients, and a more sustainable health and care service.

By delivering on these actions, WSFT can show the CQC and other stakeholders that the leadership, management and governance of the organisation is effective and: ensures the delivery of sustainable high quality person-centred care, supports learning and innovation, and promotes an open and fair culture in line with our values.

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

Appendix 1 considers each of the recommendations in the context of the CQC quality statements. Of the 32 recommendations:

Progress in ***May 2025*** is as follows:

- 18 are on track
- 6 identified as deferred for future timescales
- 8 are complete

For assurance, performance/progress has continued as expected. In September 2024, only 1 action was completed. In March 25, 7 were completed and 19 on track. When there is an overdue action, reminders are sent from the Foundation Trust office who draw together actions from multiple workstreams and collate the evidence necessary for disclosure in collaboration with the functional leads.

RSM's final report is awaited, due June 2025 and this will be reveiwed by the audit committee. Initial feedback has been reviewed by the Involvement committee. 6 actions provisionally identified, none are rated high. All rated medium and go to enhancing control or improving efficiency.

In March, *MEG* considered specific actions from the initial suggestions made by RSM as part of their review and MEG agreed to:

- Develop a mechanism to review the evidence of the completed actions. To be achieved by adding a column to the action log '**evidence - check and challenge**', where action owners will provide details and the nature of the evidence available
- **Quarterly** review of the AuditOne action log by MEG. Given competing priorities and existing workplan a monthly timeframe was not achievable
- **Involvement Committee** to oversee the completion of actions/recommendations.

Involvement Committee (16 April 2025) agreed to the recommendations from MEG and noted the progress on open actions and received assurance on evidence of closure for the closed actions.

A further update on final action points/findings will be provided to MEG once the internal audit report for Well-Led review in issued by the internal auditors. Involvement Committee to continue to receive assurance and oversee the completion of actions/recommendations

Action required / Recommendation:

The Trust Board is asked to:-

- ***Note*** the update on the progress on actions in Appendix 1 alongside the assurance in the CKI report from the Involvement committee enclosed within these papers.
- ***Consider*** if further standalone reporting is required or whether further updates can be provided through the CKI reporting process (**recommended**).

Previously considered by:	Involvement Committee (16 April 2025) MEG (26 March 2025) Improvement Committee (18 September 2024) Trust Board (27 September 2024)
Risk and assurance:	CQC regulations FT Code of Governance
Equality, diversity and inclusion:	Recommendation in report
Sustainability:	Recommendation in report
Legal and regulatory context:	NHS Act 2006, West Suffolk NHS Foundation Trust Constitution

Ongoing progression of ConsultOne recommendations

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

CQC Quality statement	Relevant ConsultOne recommendation (reference)	Sept 2024 Status	Sept24 update	Exec. lead	Other named leads	Document containing actions	Action due dates (mentioned in narrative)	Updated action due date	Jan25 update narrative	March 2025 progress Status	'evidence document for completed actions - check and challenge'	RSM Information - would recommend adding in updated action due date to be able to track slippage.
1. Shared direction and culture	The Trust should revisit its strategy and ensure that it has fully explored and received assurances over the clinical, workforce and financial sustainability of its vision including the new hospital build (5)	1.Within existing plan - BAF 4 Improvement (Mar '25)	At the Trust's MEG on 14th August 2024 it was agreed, in principle, to conduct a rewrite of the Trust's strategy to ensure it provides the organisation with clear direction for the foreseeable future. Aiming to have a refreshed strategy by January 2025. (specified action within BAF 4)	Sam Tappenden		BAF4	Jan-25	Jul-25	Significant progress has been made in exploring the Trust's current strategy with Board, executives, governors, and our Senior Leadership Team, through engagement events, meetings, and workshops. However, due to the Sustainability Review being undertaken across SNEE, it would be premature to implement a new strategy ahead of the review's recommendations. Therefore, it is proposed that engagement work can continue during this period, but that the strategy will not be completed until the review's conclusion, currently scheduled for June 2025.	Amber		The date within this action would require changing
1. Shared direction and culture	The Trust should oversee finalisation of the overarching strategic framework ensuring interconnectivity of enabling strategies and then ensure that regular oversight of delivery is in place at Board level. (7)	1.Within existing plan - BAF 4 Improvement (Mar '25)	A review and/or refresh/development of enabling strategies would take place after the corporate strategy review, and aim to be completed by April 2025. (specified action within BAF 4)	Sam Tappenden		BAF4	Apr-25	Jul-25	As per the update above, the enabling strategies would need to be completed within four months of the corporate strategy being refreshed.	Amber		The date within this action would require changing
1. Shared direction and culture	The Trust should ensure that its suite of strategies translate into divisional business plans and BAU activities and are subject to regular oversight of delivery. (8)	1.Within existing plan – Business planning refresh (Mar '25)	We are in the process of refreshing our approach to business planning and ensuring we have the mechanisms to drive alignment within the divisions. MEG approved a refreshed approach to business planning in September 2024 which will delivery plans by March 2025.	Sam Tappenden		Business planning refresh	Mar-25	Jul-25	The Trust has implemented a 'minimalistic' approach to business planning this year, in anticipation of tighter operational planning guidance. A workshop will be held in April 2025 to assess the effectiveness of this approach, and to ensure clarity of roles and responsibilities for the planning process in 25/26. The Trust's business planning process continues to iterate, but further work is required to ensure the Trust has a clear and embedded business cycle which is fully understood by all colleagues. Some progress; evaluation required.	Amber		The date within this action would require changing
2. Capable, compassionate and inclusive leaders	The Trust should consider implementing a clinical leadership model, including the establishment of a clinical senate and a review of existing divisional triumvirate responsibilities. (1)	3.Defer – revisit as part of 2025-26 objectives	This will be revisited when the newly appointment medical director has had time to familiarise themselves with the organisation.	Richard Goodwin		N/A	Jul-25		This is under active consideration by the medical director with a target date for completing the action by 30 Jun 2025 (to consider implementation)	Green		The date within this action would require changing
2. Capable, compassionate and inclusive leaders	The Board should ensure that challenge is more impactful and holds executives to account for delivery of the Trust's objectives and targets (2)	1.Within existing plan – Board development plan (Oct '24) **Within existing 2025 NEDs appraisals 360 feedback**	The Board development plan includes a facilitated session on the working of the unitary Board. This is scheduled for October 2024 when the newly appointed NEDs are in post. **The change of approach to address this recommendation to use the NEDs' 360 appraisal, instead of a facilitated session, provides a more ongoing and personalised way to hold executives to account. This method provides regular, actionable feedback, ensuring that NEDs can directly influence the delivery of the Trust's objectives and hold executives to account.**	Jude Chin / Ewen Cameron		Board development plan	Oct-24	May-25	**This action will be taken forward through NED 360 appraisals 2025. The NED 360 appraisal template is based on NHSE leadership competency framework and designed to capture feedback from Board colleagues to gain assurance that Non-Executive Directors (NEDs) engage in strategic debate, offer robust support for decisions and assess the quality of assurance provided. This includes scrutinising risk evidence, monitoring risks effectively and ensuring the voice of staff, patients and stakeholders is heard to improve quality.** **Through the NED 360 appraisal, NEDs, Exec colleagues and other stakeholder (Governors) reflect on their individual and collective strengths, using their expertise to hold executives accountable for performance, thereby contributing to strong governance and ensuring delivery of the Trust's objectives and targets. This will be measured through overall rating received by the NED for this domain.**	Amber		This action has no information in to state if completed or on-going - Pooja made Danny aware of this prior to testing
2. Capable, compassionate and inclusive leaders	The Trust should review its current leadership development offer with a view to expanding this to all levels of management and equipping them for more devolved ways of working (3)	1.Within existing plan - People and Culture plan (Mar '25)	All leadership and management provision reviewed with 3 leadership programmes already available and bite-sized targeted learning for leaders and managers (clinical and non-clinical) at all levels available. (Linked to BAF 1)	Jeremy Over	Carol Steed	People and Culture plan	Complete		269 managers completed Trust leadership programmes, which are open to all levels of management and all staff groups. Wider portfolio of development also available e.g. management essentials webinars, coaching and mentoring. New HR Information Zone about to be launched to support managers access information and policies on people management.	Complete		
2. Capable, compassionate and inclusive leaders	The Trust should review its approach to succession planning and either reinforce it if necessary or raise its profile so that it is more widely socialised (31)	1.Within existing plan - People and Culture plan (Mar '25)	Career development and succession planning project just started and is being progressed (Linked to BAF 1)	Jeremy Over	Carol Steed	People and Culture plan	Mar-26		Eight step approach to succession planning developed. Outline paper submitted to People and Culture Leadership Group in September 2024. Pace slowed in order to prioritise other more urgent actions e.g. Veteran aware accreditation and staff survey analysis. On track, albeit to a slightly slower timeline	Green		
2. Capable, compassionate and inclusive leaders	The Board needs to ensure that it has sufficient senior leadership capacity to deliver the Trust's forward agenda (4)	4. Complete	Appointments now made for permanent medical director (Richard Goodwin) and director of strategy and transformation (Sam Tappenden). Additional resource also in place to support financial recovery (Jonathan Rowell). New NED appointments made, including associate.	Jude Chin / Ewen Cameron		N/A	complete			Complete		
2. Capable, compassionate and inclusive leaders	Trust executives should continue to take every opportunity to increase visibility, particularly informal, smaller group engagement with staff (25)	4. Complete	Integrated as part of the executive and board development programme is a focus for learning directly from patients and staff. Listening sessions have been held in Time Out and executives are encouraged to undertake walkabouts and shadowing with Trust teams. This is now an established programme of work for the hospital and community services. This will be developed to capture feedback.	Jeremy Over		N/A	complete			Complete		
2. Capable, compassionate and inclusive leaders	The Trust should continue to develop and roll out a wider suite of leadership development programmes to build management capacity and capability to deliver the forward agenda (30)	1.Within existing plan - People and Culture plan (Mar '25)	All leadership and management provision reviewed with 3 leadership programmes already available and bite-sized targeted learning for leaders and managers (clinical and non-clinical) at all levels available (Linked to BAF 1).	Jeremy Over	Carol Steed	People and Culture plan	On-going	Dec-25	(Also see action 1) All 3 leadership programmes now fully rolled out. Strategic leadership programme on hold due to lack of funding for external partner. Change and transformation programme in development with SNEE funding secured for SNEE wide scoping. Collaboration with ESNEFT and system partners in discussion. On track, although vulnerable to any potential resourcing changes	Green		No defined date
3. Freedom to speak up	The Trust should consider opportunities to provide further assurance on robustness of FTSU arrangements and build confidence in staff of the use of it (10)	1.Within existing plan – FTSU report to Involvement Committee (Mar '25)	Already in place at time of ConsultOne review (FTSU guardian new in post at time of review): The FTSU guardian and FTSU NED ad hoc meeting to discuss themes arising, cases if required and ongoing activities to promote speaking up in the Trust. Quarterly report to the Board, which includes data as reported to the NGO, themes and work being done to address issues. Also reports on the ongoing development of a Speaking Up culture, under the headings of the National Guardian's Office (NGO) Principles of Speaking Up for leaders and managers. NGO data sent directly to Workforce Director and FTSU NED for their info. Feedback survey sent to people who have raised concerns, regarding their speaking up experience. Robust FTSU policy in line with NGO guidelines. outreach to all wards and department including community teams. FTSU Guardian visits/ talk to teams, Communication by various media, including Green Sheet updates New actions / work programmes: (oversight by Involvement Committee and Board) - The next test of confidence will be the results from the 2024 NHS staff survey especially the 4 FTSU questions - FTSU guardian and FTSU NED now scheduled to meet regularly each month - Number of anonymous complaints now analysed and reported - Executives are undertaking staff listening events in time out. Themes arising from these to be triangulated with concerns raised directly to FTSU. Executive presence at new staff Welcome programme now	Jeremy Over	Jane Sharland / Antoinette Jackson	FTSU report	Mar-2025 May-2025		All actions from Sep 24 in place. FTSU Communications Plan now complete and published with Q3 Board Report. Comms team to 'doorstep' teams to identify if any gaps in awareness (Feb 25). **COMPLETE** Anonymised FTSU Case studies to be published in Green Sheet to raise confidence in process (Mar 25) **REVISED DATE MAY 2025**	Green	FTSU Comms plan	
4. Workforce equality, diversity and inclusion	The Trust should forensically identify existing pockets of poor culture and ensure that these are dealt with appropriately. (11)	1.Within existing plan - Assurance and monitoring reports on issues and actions received by Involvement Committee via subcommittees (Mar '25)	Trust staff survey data has been reviewed by HR business partners and action plans are in place to improve cultural and other metrics. WRES, WDES and other data have also been analysed with priority areas for focus identified and actions to address developed. A range of interventions are in place and in plan to support leaders and managers with equality, diversity and inclusion, e.g. launch of new approach and process to workplace adjustments; a focus on inclusive recruitment; manager training launched on 'Addressing bias, recognising privilege and becoming a proactive ally'	Jeremy Over	Carol Steed / Claire Sorenson	Assurance and monitoring reports on issues and actions received by Involvement Committee via subcommittees	Mar-26		Staff survey actions have been implemented. 2024 data will determine further actions needed. Addressing bias training being rolled out – open courses and for specific teams. Sexual safety charter signed, working group established and action plan in place. Workplace adjustments being delivered. Inclusive recruitment work slightly delayed due to other priorities.	Green		
5. Governance, management and sustainability	The Trust should review how it uses both the CKI reports and source documents such as the IQPR, Finance Report and quality assurance papers to triangulate assurances at Board and committee level (12)	1.Within existing plan - BAF 8 Governance (Mar '25)	IQPR to be part of main body of Board papers from September 2024 board to enable greater visibility and scrutiny of integrated performance. Each assurance committee has completed annual review. The Governance BAF risk (8) includes an action which addresses this requirement in terms of triangulation of assurances.	Nicola Cottington	Richard Jones	BAF8	Sep-24		Completed Sep 24	Complete		
5. Governance, management and sustainability	The Trust should set out more clearly the role of divisional management and develop and implement consistent divisional governance arrangements which fulfil that role (13)	1.Within existing plan - BAF 8 Governance (Mar '25)	The Governance BAF risk (8) includes an action to 'Review and development divisional governance structures'. The scope for this review was reported to Improvement in August with a timescale for delivery by January 2025.	Sue Wilkinson	Richard Jones	BAF8	Jan -25	Jul-25	The Clinical Divisional Governance review is ongoing, with notable actions to improve and strengthen governance. Significant progress has been made in drafting templates for the agenda and Terms of Reference (ToR) for the divisional boards (DB). Roll out of templates is scheduled for Feb aiming implementation for March DB meetings. Efforts continue to develop a comprehensive divisional governance framework document that aligns divisional infrastructure with our organisational governance framework and structure.	Green		
5. Governance, management and sustainability	The Trust should ensure that it has effective assurance flows from ward to board that link strategic priorities with delivery, risk and assurance. (14)	1.Within existing plan - BAF 4 Improvement (Mar '25)	The strategy will be embedded across the organisation, including in induction processes, performance reviews, in training etc. This will be an on-going process, starting from February 2025 (specified action within BAF 4).	Sam Tappenden		BAF4	Feb-25	Jul-25	This action will be implemented upon completion of the refresh of the Trust's strategy.	Amber		

5. Governance, management and sustainability	The Trust should seek to increase its grip and control through exercising greater performance management including a focus on improvement trajectories, agreed timelines and ownership of actions. (15)	1.Within existing plan - BAF 2 Capacity (Apr '25)	Linked to BAF Risk 2 (Capacity). Trust is constructing a performance and accountability framework which will enable exercise of greater oversight of Performance Review Meetings.	Nicola Cottington	Matt Keeling	BAF2	In progress	Jun-25	Draft to be shared at MEG by end of Feb 25. First draft complete. To be launched Q1 25/26 in line with planning guidance	Green			Need to update the date
5. Governance, management and sustainability	The Trust needs to urgently review its approach to risk management including the profile of risk, the risk culture, resourcing of the risk management function and risk reporting and training. (16)	1.Within existing plan - BAF 8 Governance (Jan '25)	The Governance BAF risk (8) includes an action to 'Review effective implementation of Radar to support risk management (C3), including embedded BAF and risk culture, reporting and training'. This risk along with all other BAF risks is reviewed by the allocated assurance committee. The scope for this review will be reported to Improvement in September with a timescale for delivery by January 2025.	Sue Wilkinson	Richard Jones	BAF8	Apr-25		Risk register within Radar in place for clinical divisions. Roll out planned for corporate directorates	Green			
5. Governance, management and sustainability	The Trust should ensure that it its Business Continuity Plans are up to date and that the Trust complies with the requirements of the annual EPRR return. (17)	1.Within existing plan - Corporate Risk Governance Group overseen by Insight (Dec '24)	Internal audit plan and part of work programme reporting to Corporate Risk Governance Group (Q3) with oversight by Insight	Nicola Cottington	Barry Moss	Corporate Risk Governance Group plan	Feb-25		Compliance with Core Standards monitored by Corporate Risk Oversight Group. % compliance with BCP completion to be available end of Feb 25	Green			
5. Governance, management and sustainability	The Trust should review the appropriateness of profile of the digital voice at Board and committee level. (18)	1.Within existing plan - Digital Maturity Matrix annual assessment to Digital Board (Mar '25)	Digital Maturity Matrix - annual assessment will monitor this and outcomes reviewed at digital board as part of its existing workplan which is reported to the Insight Committee.	Nicola Cottington	Liam McLaughlin	Digital Maturity Matrix annual assessment to Digital Board	Complete		Renumeration committee agreed proposal for CIO attendance at board from new appointment	Complete			
5. Governance, management and sustainability	The Trust should review its BI capacity with a view to better supporting operational staff with their day-to-day information requirements. (19)	1.Within existing plan - financial recovery oversight (Mar '25)	A corporate review is scheduled for later in the year 2024/25 managed by DSTP (Sam T). This will be reported as part of financial recovery oversight arrangements.	Nicola Cottington	Nickie Yates	financial recovery oversight	In progress	Ju-25	Corporate review in progress.	Green			No defined date
5. Governance, management and sustainability	The Trust should ensure that it leverages the benefits of the data warehouse investment alongside BI business partnering arrangements to produce data led insightful reports which look to triangulate information to provide improved assurance. (20)	3.Defer – revisit as part of 2025-26 objectives	Data Warehouse in testing phase. Reviewing BI support to Divisions, specific plan to be identified. Also reflects risks regarding phase 2 rollout. Confirm timescale.	Nicola Cottington	Nickie Yates	N/A	In progress	Jun-25	Predicting completion of automation and optimisation by June 2025- during that period some automated feeds will become available	Green			Need to update the date
5. Governance, management and sustainability	The Trust should ensure that it has parity of reporting between quantitative and qualitative data from ward to Board and in particular ensure that the patient feedback is used more effectively to help improve and reshape services (21)	1.Within existing plan - experience of care strategy oversight by the Involvement Committee (Mar '25)	The delivery plan for the experience of care strategy supports this recommendation with oversight by the Involvement Committee. Includes divisional governance review and development of the experience of care committee.	Sue Wilkinson	Paul Bunn / Charlie Firman	experience of care strategy	Mar-25		The Patient Equity Oversight Group has been set up and had its first meeting (December 2024). TOR have been agreed and a work programme is being established. Patient feedback, captured by patient stories, is now a regular and embedded feature in Board and committee meetings. Patient stories are now on Totara for ongoing staff learning and development. Comments from the Trust's inpatient survey are downloaded on a monthly basis and are sent to ward managers who have signed up to this. The Patient Experience and Engagement Team are monitoring actions arising from this feedback. Staff have undertaken NHSE making Data count training which looks at ways to capture qualitative data effectively as well as quantitative data via SPC charts and this will be worked into future reports. Internal divisional governance review is led by Deputy Trust Secretary, Senior Matron and Head of Patient Safety. Standard Agenda items have been agreed and now work is moving to embed practice Trust-wide and showcase pockets of good practice.	Complete	Patient Equity Group minutes confirm group is meeting and fulfilling its TOR. Divisional board agenda template now live as of April 2025 and has a focused patient experience agenda item for all divisions. Trust office can provide template when needed. Experience of care agenda for 2025/26 focuses on ensuring feedback is obtained from underrepresented groups and that the culture of engagement is embedded throughout the organisation. BAF risk 9 also revised to reflect change of focus away from large scale involvement works to making sure engagement is embedded as part of WSFT culture, so it is seen as part of the process for change and not a check at the end of the process. Although parity in reporting is not evidenced this is a challenge in any climate, least of all the current one with the financial pressures facing the Trust.	
5. Governance, management and sustainability	The Trust should explore ways in which it can increase operational buy-in and ownership of complaints including active engagement in learning from these (27)	1.Within existing plan - experience of care strategy oversight by the Involvement Committee (Mar '25)	The delivery plan for the experience of care strategy supports this recommendation with oversight by the Involvement Committee.. Experience of care committee, divisional reporting and oversight by the Involvement Committee which reports to Board through CKIs.	Sue Wilkinson	Paul Bunn / Charlie Firman	experience of care strategy	In progress	Jun-25	The Trust is currently working with Radar (Risk Management System) to look at creating internal dashboards which can be used by Divisions to assess internal performance on a variety of factors, including complaints. This is a detailed piece of work involving IT, external parties and will be worked up throughout 2025/26. Throughout Q3 and into Q4, the complaints team (monitored by Involvement Committee) have implemented a QI test and learn project. The aim is to address complaints through early resolution meetings, as opposed to written responses. The QI project will end in March 2025 and performance will be reviewed again at the Involvement Committee. Early indications suggest meetings are successful with support from an Exec lead. To support divisional oversight, Complaints team have adapted the sign off process to ensure divisional leads and service managers have input into the draft responses prior to going for exec sign off. This appears to be working well with good engagement at this stage of the process. A task group has also been established to look at high level data the board receives and that it is triangulated with other sources as per CQC recommendations	Green			Need to update the date
5. Governance, management and sustainability	The Trust should ensure that it is maximising the benefit and learning from its clinical audit programme (28)	1.Within existing plan - BAF 8 Governance (Apr '25)	The Governance BAF risk (8) includes an action to review the clinical audit programme. The scope for this review to be developed and overseen by CEGG with a timescale for delivery by March 2025.	Richard Goodwin	Rebecca Gibson	BAF8	Mar-25	Sep-25	Surgical Division undertaking a pilot of improving Clinical audit ownership (as part of an apprenticeship programme project). Delay due to staffing vacancies. **REVISED DATE SEP 2025**	Amber			
6. Partnerships and communities	The Trust should ensure that the benefits from integration of services is maximised including closer links with primary care (6)	1.Within existing plan - Links to BAF 3 - Collaboration. (April '25)	A series of Board development workshops are planned to explore our strategic approach to collaboration, including with primary care. The intention will be to have a partnership strategy agreed by April 2025. More tactically, the EDoST has regular interface meetings with primary care and is actively exploring opportunities for greater collaboration (e.g. estate sharing). Links to BAF 3 - collaboration.	Sam Tappenden		BAF3	Apr-25	Jul-25	The Board held a strategy development workshop in October which explored these areas. The Board will hold a further session on 28th February to specifically explore 'future shift' and our tactical approach to this, including working with our partners. Our strategic approach to partnership will need to be developed upon completion of the corporate strategy refresh.	Amber			
6. Partnerships and communities	The Trust should review its engagement activities to ensure that there are effective feedback loops in place to provide those inputting an understanding of impact. (22)	1.Within existing plan - experience of care strategy oversight by the Involvement Committee (Mar '25)	The delivery plan for the experience of care strategy supports this recommendation with oversight by the Involvement Committee.	Sue Wilkinson	Paul Bunn / Charlie Firman	experience of care strategy	In progress	Jun-25	Involvement Committee regularly reviews CQC survey data from patients. Results of surveys and projects communicated back via the VOICE network. The updated patient and public involvement guidance and establishment of more structured co-production partners will mean that locality engagement exercises will be undertaken more robustly when projects/ service changes are proposed. 'You said, we did' – the Patient Experience and Engagement Team will work with the Communications Team to promote the changes that have been made as a result of service user feedback. Feedback shared from the VOICE network is recorded; actions and learning are then reported on and VOICE members involved where possible. Ongoing work with the Future Systems Team will ensure collaboration with regards to dialogue and discussion with third party stakeholders. Board and wider staff body have gained experience from significant capital projects recently involving the Dame Clare Marx Building. Those shared experiences have helped shape the culture and organisational wide learning to be carried forward into future projects.	Green			No defined date
6. Partnerships and communities	The Trust should continue to focus on gaining an appropriate balance between staff and patient/families focus at Involvement Committee (23)	1.Within existing plan – Involvement development plan (Mar '25)	This is being addressed through a refocusing of the Involvement Comments forward plan including the response to the committee's effectiveness review for 2024	Jeremy Over	Paul Bunn / Charlie Firman / Claire Sorenson	Involvement development plan	Completed		This is now reflected in the shape of the agenda for each meeting. The shift in focus and the balance of the Involvement Committee work between staffing and patient experience, first recognised in Feb 2024, is now well established. Future workplans recognise the need for patient engagement to be an equal partner in discussions. Standing Agendas items help focus on this through the FIRST for patients vision. In one recent example, the December 24 Involvement Committee dedicated (Agenda set aside 50 minutes) almost half the meeting to talk about patient and public engagement. Additional subcommittees such as the establishment of the Patient Equity Oversight Group help further strengthen engagement and partnership working and the Involvement committee is the means to escalate any emerging issues.	Complete			
6. Partnerships and communities	The Trust should seek to understand its relationship with ICS partners and reframe it where necessary so that trust and understanding is central to any relationship (24)	1.Within existing plan - Links to BAF 3 Collaboration - collaboration. (April '25)	A series of Board development workshops are planned to explore our strategic approach to collaboration, including with primary care. The intention will be to have a partnership strategy agreed by April 2025. More tactically, the EDoST has regular interface meetings with primary care and is actively exploring opportunities for greater collaboration (e.g. estate sharing). Links to BAF 3 - collaboration.	Sam Tappenden		BAF3	Apr-25		As per above, plus, we have developed a more strategic approach to managing our key stakeholders, which will now be finalised and agreed with Board members in February.	Green			
7. Learning, improvement and innovation	The Trust should finalise its QI Strategy and develop an implementation plan which includes identifying and rolling out a Trust-wide QI methodology. QI projects should explicitly link with the Clinical Care Strategy and Trust Priorities. (26)	1.Within existing plan – Strategic priority 1 (Mar '25)	The Trust will have an agreed approach to Quality Improvement by April 2025. We will concurrently develop our approach to an integrated Quality Management System, ensuring that all four elements of quality are driven. All QI projects will be linked to our strategic objectives, and focused on agreed priority themes. Links to strategic priority which describes a range of measures to test whether the CQI approach is embedded	Sam Tappenden	Natasha Rivers	Strategic priority 1	Apr-25		Good progress has been made with developing our approach to QI: (1) we have restructured the QI team; (2) development workshops have been held to explore our future approach to QI as part of a wider Quality Management System (QMS) and (3) a proposal is being developed to implement a coherent approach to QI across the Trust. We are still planning to have an approach agreed to QI in April, as part of the 'recovery' aspect of our narrative.	Green			
7. Learning, improvement and innovation	The Trust should review its current management and oversight of **research** and innovation and ensure that the profile and management of this is commensurate with the Trust ambition in this area (29)	1.Within existing plan: R&D CEGG work plan (Jan '25)	CEGG's reporting schedule includes a suitable reporting on R&D, A refresh of the report content will ensure this is suitably robust (including annual report).	Richard Goodwin	Margaret Moody	CEGG work plan	Complete		R&D reported to December CEGG using full CEGG template. Included in report to Improvement. On six-monthly update timetable.	Complete			Evidence received -CEGG forward planner
7. Learning, improvement and innovation	The Trust should review its current management and oversight of research and **innovation** and ensure that the profile and management of this is commensurate with the Trust ambition in this area (29)	1.Within existing plan: innovation - BAF 4 (Jan '25)	Innovation changes link to BAF risk 4 - the refresh of Trust's strategy includes identifying innovation as a strategic priority for the Trust	Sam Tappenden		BAF4			Innovation will be explored as a key part of our future refreshed corporate strategy. How we manage innovation will also be incorporated into our corporate services review work. In progress	Green			No defined date

8. Environmental sustainability – sustainable development	The Trust should ensure that it retains appropriate oversight over its green sustainability strategy and plans (B)	1.Within existing plan - Links to BAF 4 Improvement (Mar '25)	As part of our strategic refresh we will explore whether we have the appropriate governance mechanisms in place to review the progress of delivery of all our strategies, including green sustainability. This will result in recommendations being agreed by January 2025. Linked to BAF 4. The Trust has a green plan, overseen by the Sustainability Group (chaired by Simon Taylor) and reported to Trust Board via the annual report, ICB via regular reporting. It's multidisciplinary, involving waste, catering, anaesthetics, digital, service delivery etc. The sustainability officer manages the actions and the programmes (such as green champions) which we are in the process of implementing.	Sam Tappenden	Chris Todd	BAF4	Jan-25	May-25	The second paragraph is the update from last time. We are in the process of refreshing the Green Plan, with the aim of approval at Trust Board May 2025. This will be a more concise document with SMART actions to aid effective delivery. Progress on the 2021 Plan is included in the annual report.	Green		Need to update the date

7.4. Governance Report (ATTACHED)

For Approval

Presented by Pooja Sharma

WSFT Board of Directors (Open)	
Report title:	**Governance report**
Agenda item:	7.4
Date of the meeting:	23 May 2025
Sponsor/executive lead:	Richard Jones, Trust Secretary
Report prepared by:	Richard Jones, Trust Secretary 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 report summarises the main governance headlines for May 2025, as follows:

- Senior Leadership Team
- Management Executive Group
- Council of Governors
- Proposed developments to Constitution (for approval)
- Register of interests
- Board development session – summary
- Urgent decisions by the Board
- Use of Trust's seal
- Agenda items for next meeting

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 Board 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

The Board is asked to note the content of report as outlined above and to approve the following:

- amendment to the **Trust's Constitution**

Previously considered by:	NA
Risk and assurance:	Failure to effectively manage risks to the Trust's strategic objectives.
Equality, diversity and inclusion:	Decisions should ensure inclusivity for individuals or groups with protected characteristics
Sustainability:	Decisions should not add environmental impact
Legal and regulatory context:	NHS Act 2006, Health and Social Care Act 2013

Governance Report

1. Senior Leadership Team report

There was no meeting in April 2025.

2. Management Executive Group

The Management Executive Group is established as the most senior executive forum within the Trust. Meeting takes place at least three times in a month, including corporate performance review meetings.

3. Council of Governors report

The Council of Governors met on 14 May 2025.

The Council of Governors received an **update on finance** by the interim chief finance officer and an overview of Trust's financial position was provided.

The Council of Governors received the **feedback reports from chairs of the board assurance committees** and governor observers. A summary of the agenda items was received with the committee's key issues and respective governor observers' reports providing highlight updates for the Council. The Council of Governors also received the audit committee's key issues report.

The Governors noted the report from **Nomination Committee** which highlighted that the 360° feedback reports for non-executive directors were reviewed and discussed. The terms of office for the NEDs were noted. The committee also noted 'new NHSE board member appraisal framework' that was published on 1 April 2025.

The Council of Governors received a report from the **membership and engagement committee** to draw attention to VOICE meetings and initiatives around patient engagement and governor activities. An update was also provided on the membership and engagement strategy development plan which is evolving, 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, among other steps taken to deliver the priorities as set out in the foundation trust membership and engagement strategy.

The Council of Governors received a report from the **Standards Committee** to note the update on Fit and Proper Persons Test, committee's work plan, Governors' Development Programme and timing of the next skills audit/gap analysis. The Governors also noted the areas identified for improvement in the 2024-25 self-effectiveness review and considered incorporating Equality, Diversity and Inclusion and Information Governance as mandatory modules in the governors' induction programme.

The Standards Committee recommended one amendment to the Trust's Constitution for consideration by the Council relating to the duration of terms and conditions for a lead / deputy governor election. **The Council of Governors approved proposed amendment to the Trust Constitution** which is considered in more detail under item 4 below.

The Council of Governors approved the **Governors commentary for inclusion in the quality accounts 2024-25** and identified Governor readers for the draft annual report (including quality accounts).

The Council of Governors noted the **governance report** including Governors' register of interests and composition / membership of the sub-committees.

4. Proposed developments to Constitution

The Council of Governors approved following amendments to the Trust's Constitution at its meeting in May.

The Constitution currently makes provision for the lead governor's term of office to normally run for three years until one year after Governor elections.

It was proposed to amend the 'terms and conditions' in Annex 11 of the Constitution, to ensure that a lead governor elected for a three-year term remains in office until two years after the Governor elections. The rationale behind this amendment is to allow newly elected governors to gain more experience and confidence before considering standing for the lead governor role. Same principle will apply for deputy lead governor.

The following summarises the changes and the full Annex 11 of the Constitution is providing in the supporting annexes (Annex A)

Legal advice is being sought on proposed amendment to the Constitution and a response is awaited. Board will be updated accordingly at the meeting before requesting for approval. This is to ensure that any changes do not undermine the Constitution as a legal instrument.

The Board is asked to approve the proposed change which, with the existing Council approval, will then come into effect immediately.

a) Change to the term of lead governor

Change description	Reference
Trust Constitution - lead governor and deputy lead governor 5.3 The term of office for the lead Governor will normally run for three years until **two years** 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).*	Annex 11 Clause 5 Terms and conditions sub-clause 5.3

5. Register of interests

It is a Constitutional requirement that appointed board Directors have a duty to avoid conflicts of interest with the Trust.

To ensure full openness and transparency, the register of directors' interests is formally reviewed and updated on an annual basis. At each Board meeting declarations are also received for items to be considered.

The Board is asked to note the summary of the register of directors' interests (Annex B).

6. Board development session

On 25 April, the Board held a development session covering Digital Boards (NHS Providers digital team) and Sustainability review (McKinsey). The session was well-received, with valuable discussions and contributions.

Digital Boards: The session was aimed:

- to ensure the whole board understands the need to take
- collective and individual ownership of the Trust's digital transformation
- to help the board understand the conditions for successful transformation, and how to build a successful digital delivery culture
- to share insights from other sectors about why digital transformation programmes have succeeded or failed
- to identify where digital can best support and enable the strategic themes at West Suffolk NHS Foundation Trust

The board was asked to discuss two strategic themes in detail, specifically discussing what actions the board could take to best support digital as an enabler to meeting those outcomes.

Sustainability Review: The Board received an update from McKinsey with the brief recap of project plan and where we were with the review, projection of SNEE financial position based on modelled initiatives and discussion on options for near and long-term organisational arrangements.

There was consensus that the session had been valuable with good contributions and the Trust will continue to develop and refine plans in the coming weeks to align with the board's development needs.

7. Urgent decisions by the Board

None to report.

8. Use of Trust Seal

None to report.

9. Agenda Items for the Next Meeting (Annex C)

The annex provides a summary of scheduled items for the next meeting and is drawn from the Board reporting matrix, forward plan and action points. The final agenda will be drawn-up and approved by the Chair.

8. OTHER ITEMS

Presented by Jude Chin

8.1. Any other business

To Note

Presented by Jude Chin

8.2. Reflections on meeting

For Discussion

Presented by Jude Chin

8.3. Date of next meeting - 25th July 2025

To Note

Presented by Jude Chin

RESOLUTION

The Trust Board is invited to adopt the following resolution:

“That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest” Section 1 (2), Public Bodies (Admission to Meetings) Act 1960

9. SUPPORTING APPENDICES

To inform

Presented by Jude Chin

IQPR Full Report

To Note

Presented by Nicola Cottington

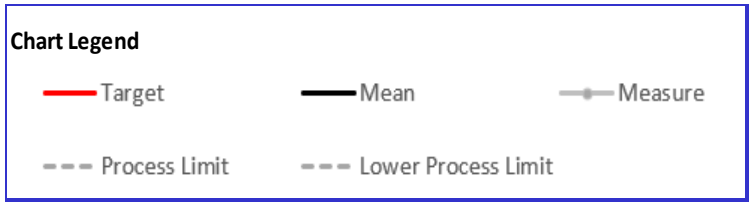
Assurance Grid

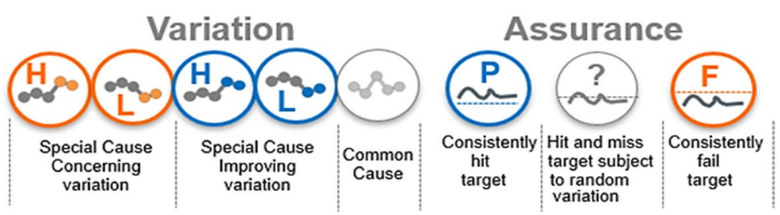
Performance in March 2025		ASSURANCE: Will we reliably meet the target based? Pass (P)	Hit and Miss (?)	Not Met — Fail (F)	No Target
VARIANCE: Variation from the mean. The colours indicate the trend- positive (blue), Negative (orange), or neither (grey)	Special Cause Improvement (H / L)		**INSIGHT**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

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

INSIGHT COMMITTEE METRICS

Urgent & Emergency Care summary

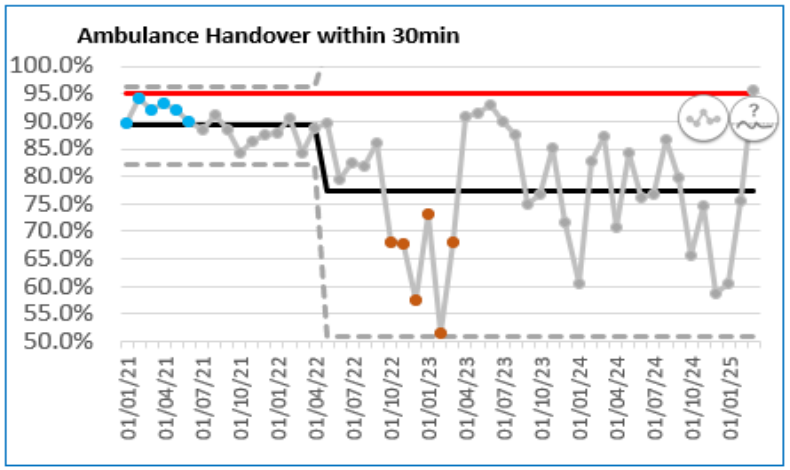


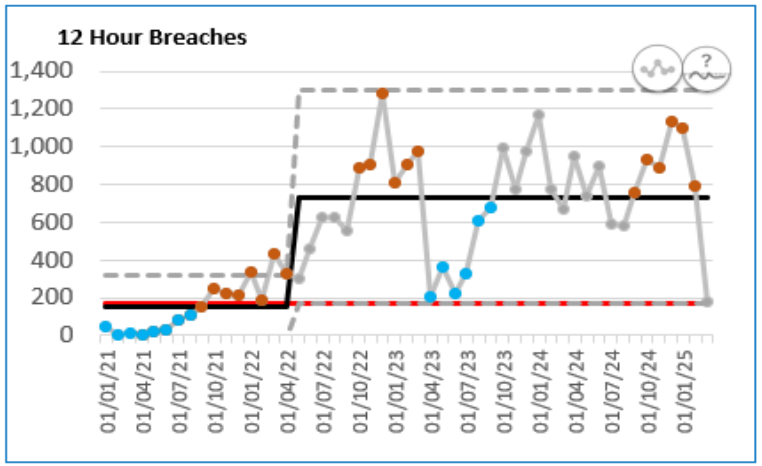


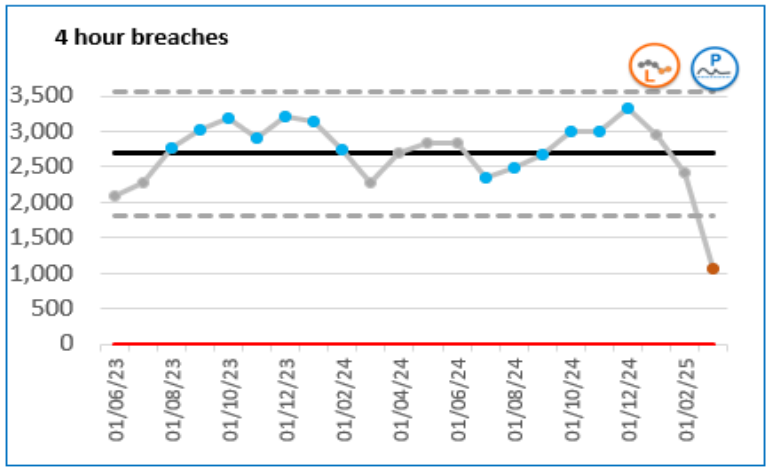
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover within 30min	Mar 25	95.7%	95.0%			77.2%	50.8%	103.6%
12 Hour Breaches	Mar 25	181	167			732	167	1298
4 hour breaches	Mar 25	1055	0			2692	1820	3564
Non-admitted 4 hour performance	Mar 25	93.1%	85.0%			76.8%	65.2%	88.4%
12 hour breaches as a percentage of attendances	Mar 25	2.1%	2.0%			9.3%	2.3%	16.4%
Urgent 2 hour response - EIT	Mar 25	91.8%	70.0%			90.8%	83.4%	98.3%
Criteria to reside (Average without reason to reside) Acute	Mar 25	41				55	40	69
**Criteria to reside (Average without reason to reside) Community	Mar 25	36				35	24	47
% patients with no criteria to reside (acute)	Mar 25	9.8%	10.0%			12.6%	8.5%	16.6%
Virtual Beds Trajectory	Mar 25	59	40			44	39	49
Virtual Ward Total average occupancy number	Mar 25	38.7	47.2			24.3	16.0	32.6
Virtual Ward Total average occupancy percentage	Mar 25	66%	80%			68%	44%	91%
Virtual Ward Total bed days	Mar 25	1226				746	295	1197
Virtual Ward Total average LOS per patient	Mar 25	8.2	14.0			8.9	4.9	12.9

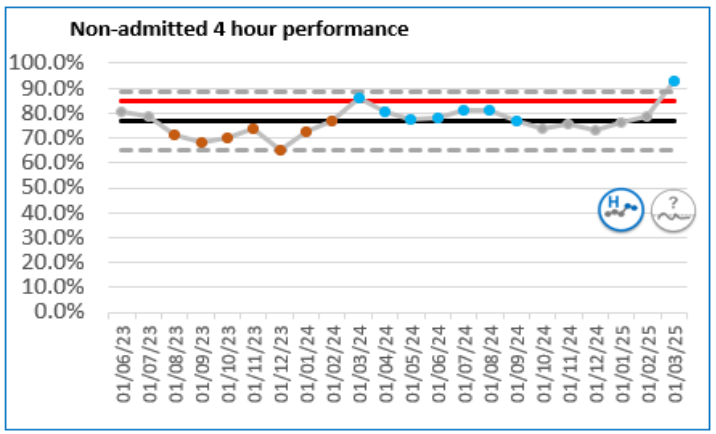
** Figures are for Glastonbury and Newmarket only, data not currently captured at Hazel Court.

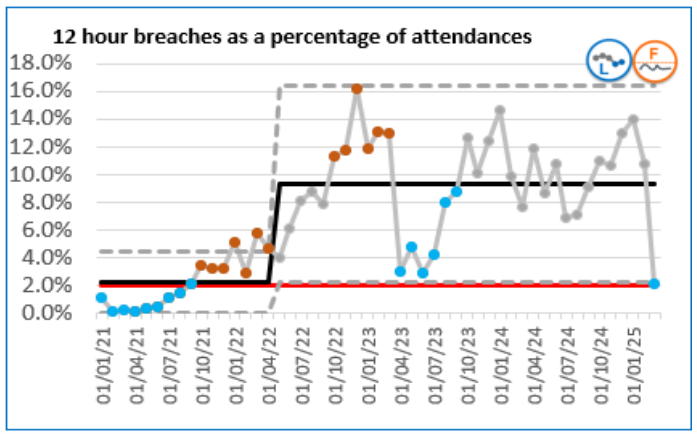
Urgent & Emergency Care: ED 4 Hour Performance

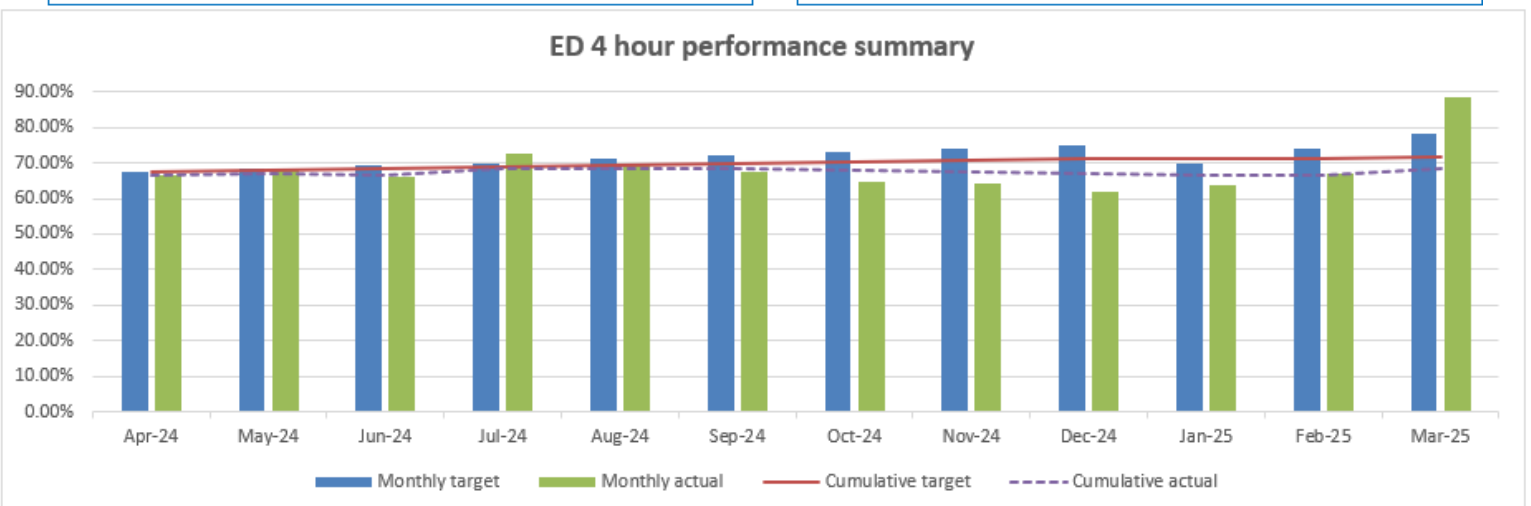












Urgent & Emergency Care

What	So What?	What Next?
30 minute ambulance handover metric, demonstrates a significant change. In that we met the target of 95% in March, achieving 95.75% The number of 12 hour length of stay breaches in March significantly reduced to 181. Numbers of 12 hour breaches as a percentage of attendances showed a significant reduction, down to 2%. Non-admitted performance showed a significant improvement with 93.12% achieved for March. The Emergency Department 4 hour performance for March was 88.39%, which exceeded the in-month trajectory of 78%.	Meeting the Urgent and Emergency Care (UEC) performance metrics in March, means that our patients received timely, safe care. Achieving the ambulance handover metrics and the 78% 4 hour Emergency Department standard means we met the national targets in March. Achieving the monthly trajectory will kept us on track to achieve and exceed 78% in March for the 4 hour standard. In March significantly less patients waited longer in the Emergency Department than they should have, and fewer patients were nursed in escalation areas, making for a better patient experience.	The Urgent and Emergency Care delivery group continues, with new workstreams and leads being identified. A new trajectory has been developed to achieve 78% 4hr Emergency Department target by March '26. Weekly performance meetings with the Emergency Department and Medical Division Senior Leaders/Executives continue. **Plans/Projects in March/April'25** • Detailed review of March performance to ascertain what can be replicated going forwards, to include: Continued senior manager presence supporting performance initially Mon-Fri 9-5pm with a plan to increase to evening cover in the future. Continuing the work to increase the number of patients taken to ambulatory areas such as Same Day Emergency Care/ ambulatory units. Emergency Intervention Team (EIT) plan to base one team member in ED. Working towards an additional Clinical Support Practitioner (CSP) in ED to ensure tests are carried out promptly. Implementing actions from the Acute Ward taskforce. • The Minor Emergency Care Unit (MECU) moved to outpatients D area on April 11th, work continues to ensure all See and Treat patients are streamed there. • Pre booked next day returner Emergency Nurse Practitioner slots to support minor injuries and Front Door Rapid Assessment (FRAT) continues. • Interviews for the Service Manager in the Emergency Department take place on April 28th. The role will be focused on performance. • A paper reflecting March performance and what helped us to achieve this will be presented at the Management Executive Group in April. **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.

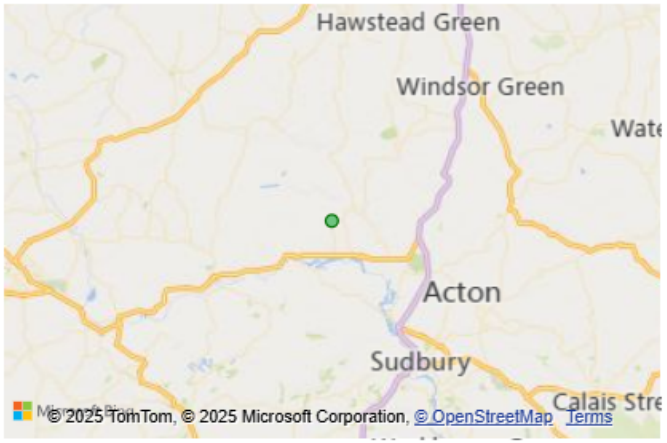
Community Access Glemsford Surgery

Practice Appointments

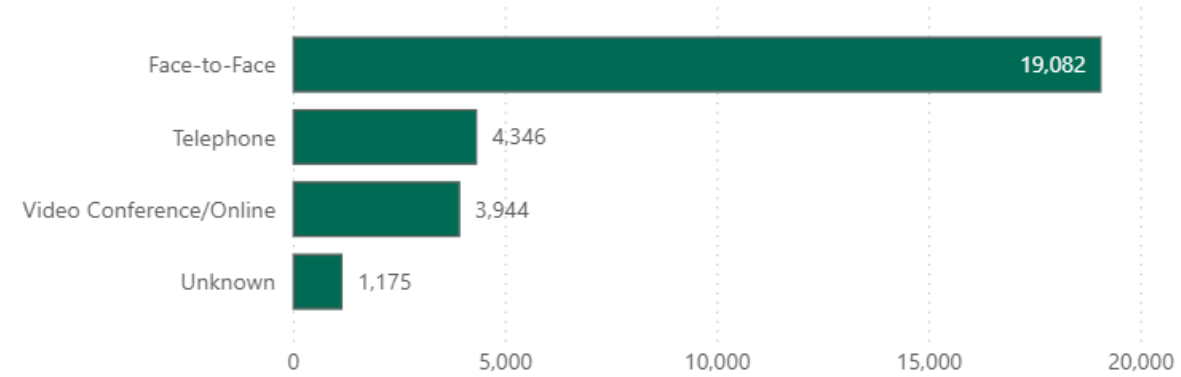
Refreshed on 15/01/2025, Data coverage up to 01/11/2024

Suffolk and North East Essex Integrated Care Board

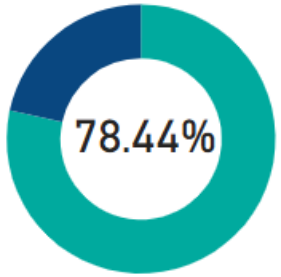
Alliance: All | **PCN**: All | **Practice**: Glemsford



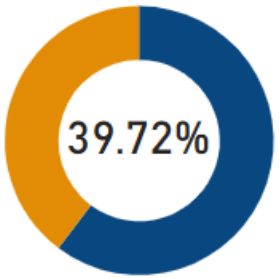
Practice appointments by contact mode



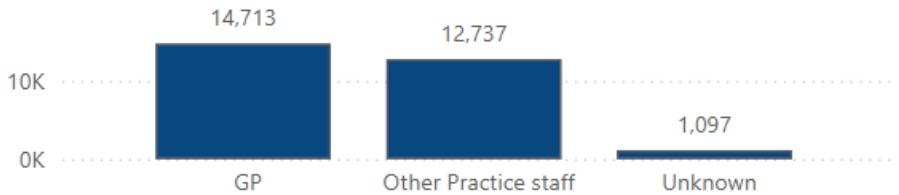
Seen within 2 weeks



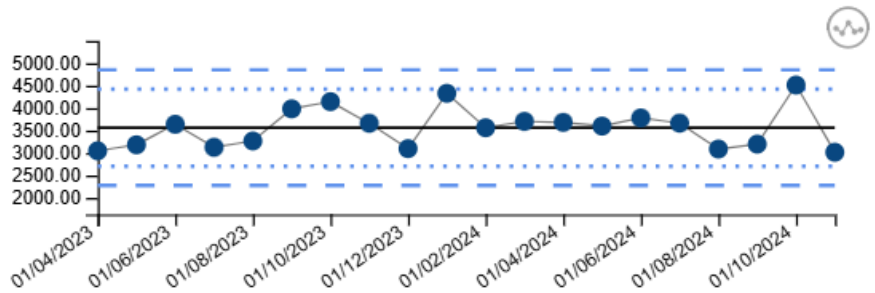
Seen within 48 hours



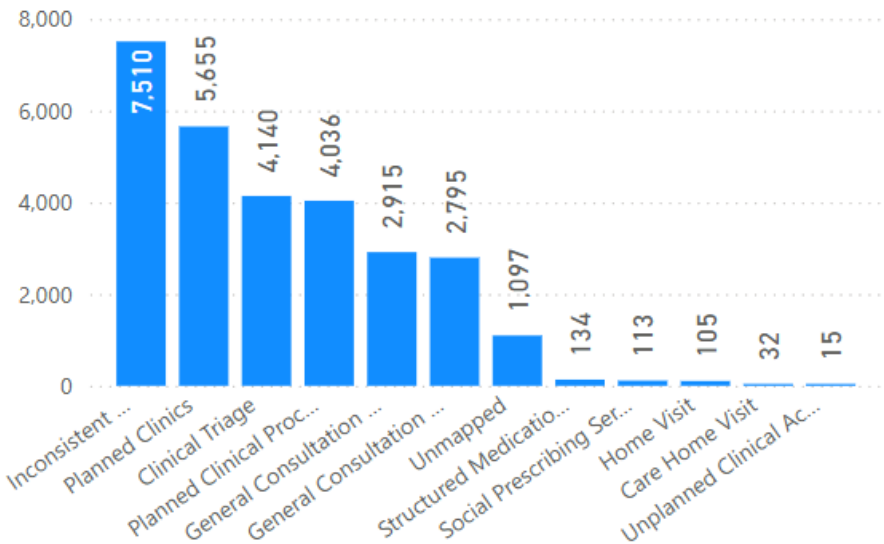
Practice appointments by health care professional type



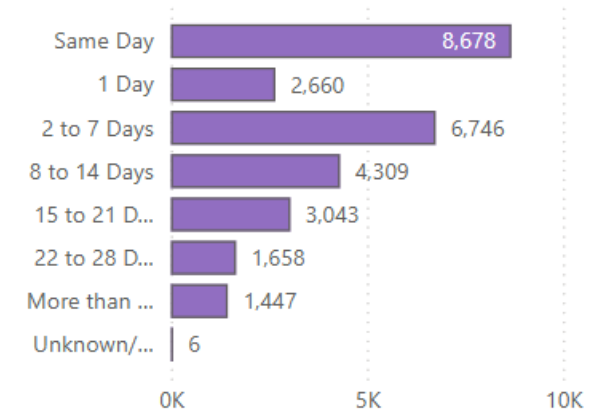
Total appointments by month



Sum of Total Appointments by National Category

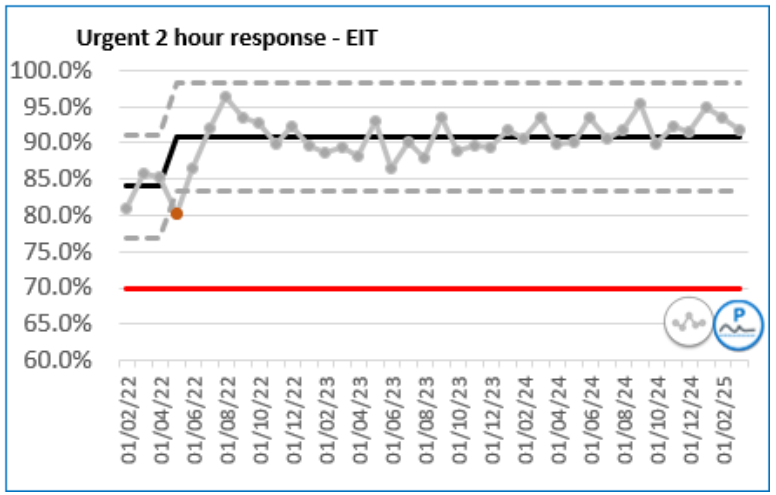


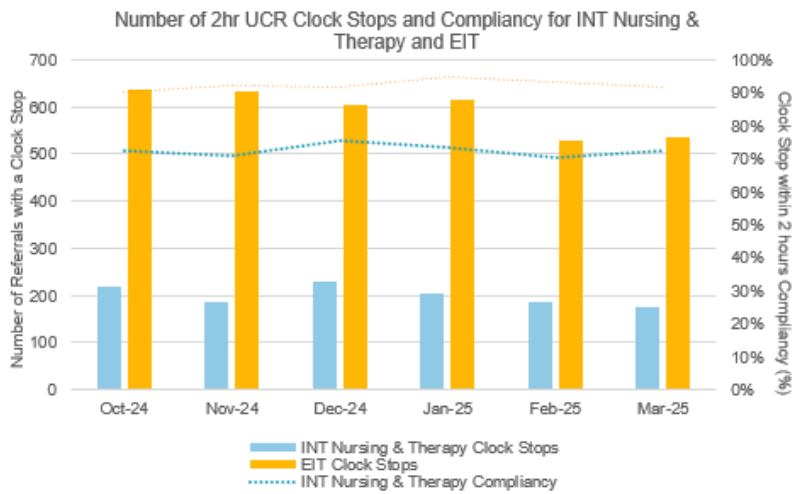
Appointments by wait time

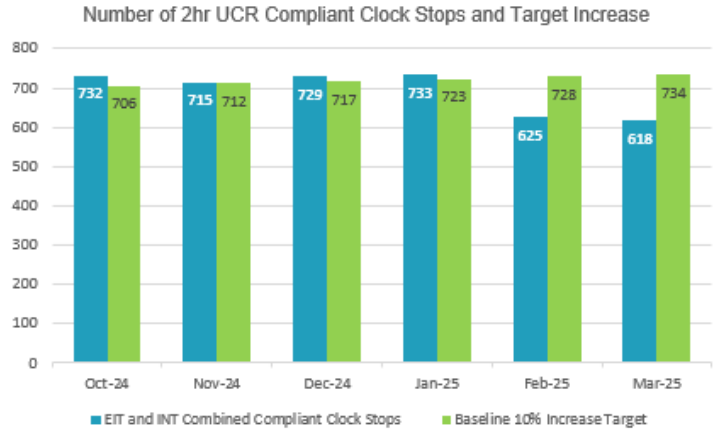


Produced by ICB

Urgent & Emergency Care: UCR







Team	Oct-24				Nov-24				Dec-24				Jan-25				Feb-25				Mar-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	220	159	61	72%	186	132	54	71%	231	175	56	76%	203	149	54	73%	186	131	55	70%	174	126	48	72%
Total EIT*	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%	536	492	44	91.79%
Combined Total	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%	710	618	92	87.04%

What

2hr Urgent Care Response no significant change at 91.79%

- Integrated Neighbourhood team (INT's) supported early Intervention Team (EIT) community therapy referrals during March, so EIT could focus on Emergency Dept (ED).

15min ED

- March pilot, took more proactive approach to therapy cover in ED and did not wait for referral.
- **INT -UCR** response is continued to be maintained through clinical triage and prioritisation of care, some planned non-urgent care is cancelled to safely manage the demand this may adversely impact the quality of planned and proactive delivered care.

So What?

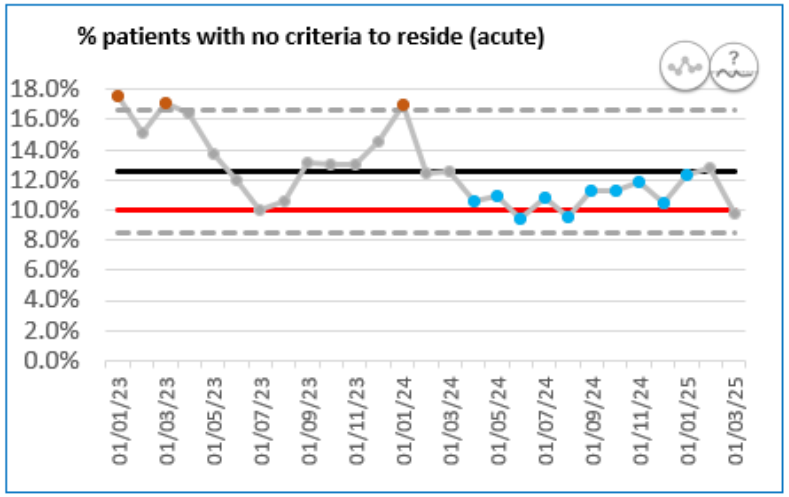
Important to meet Urgent Care Response as timeliness of urgent care is critical for good outcome and patient experience.

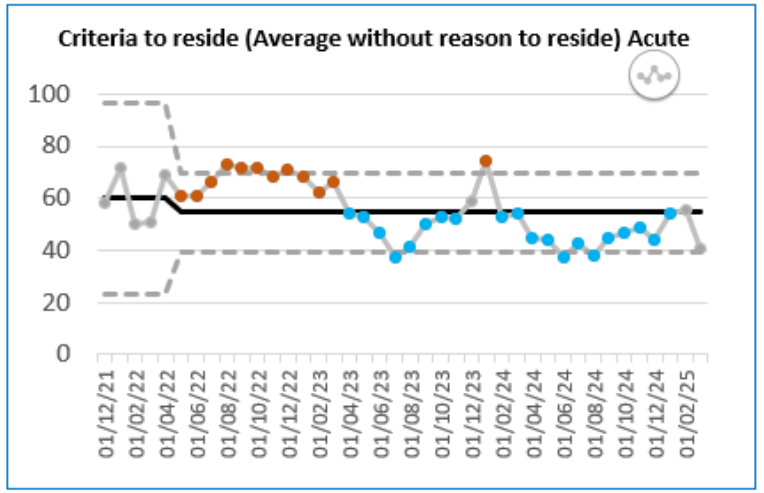
What Next?

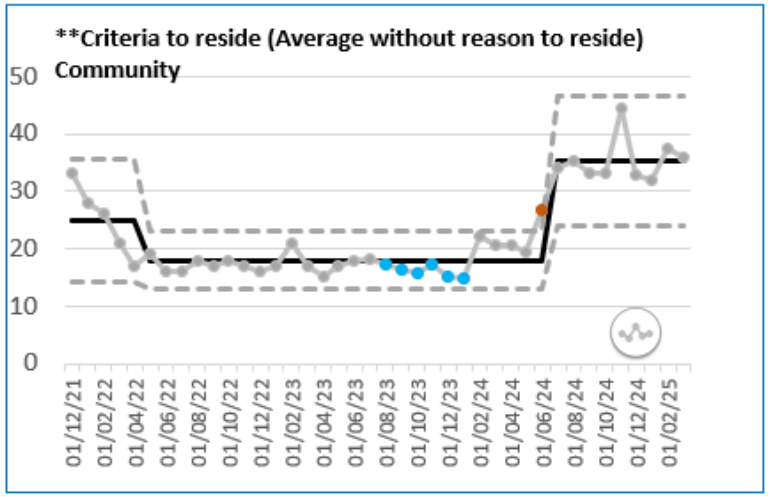
- Need to redesign data capture to highlight proactive work
- Continue to support ED with one therapist based in ED after successful pilot during March

To continue monitoring of delayed care; Senior Matrons / Leads review through incident reports and deep dives into cancelled / postponed care

Urgent & Emergency Care: Criteria to reside

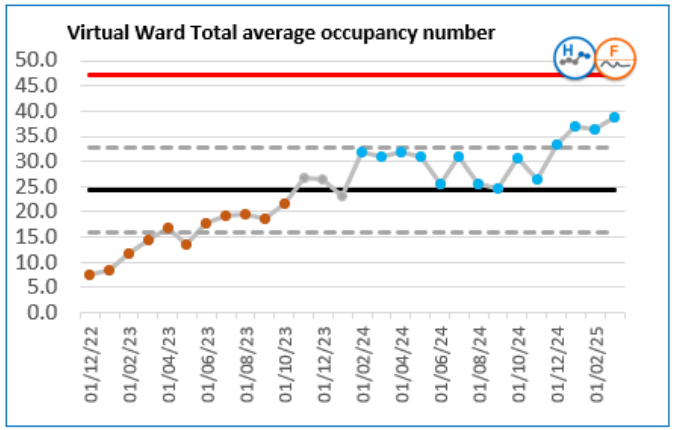


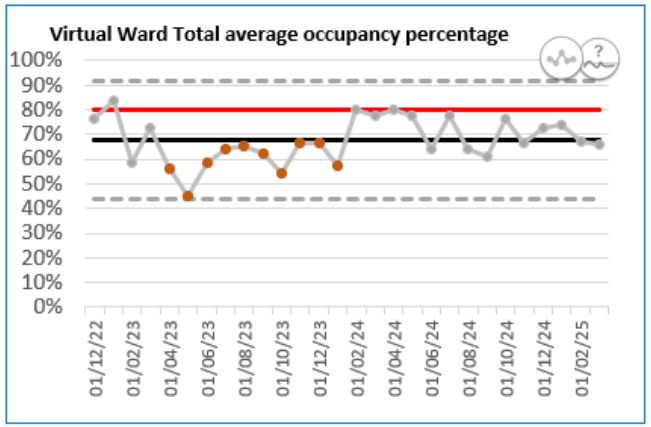


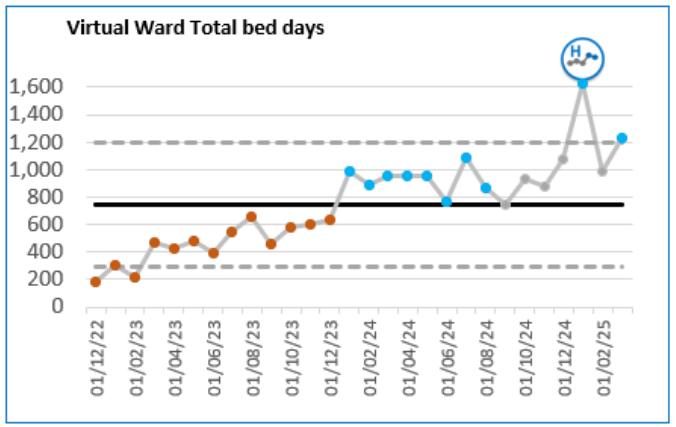


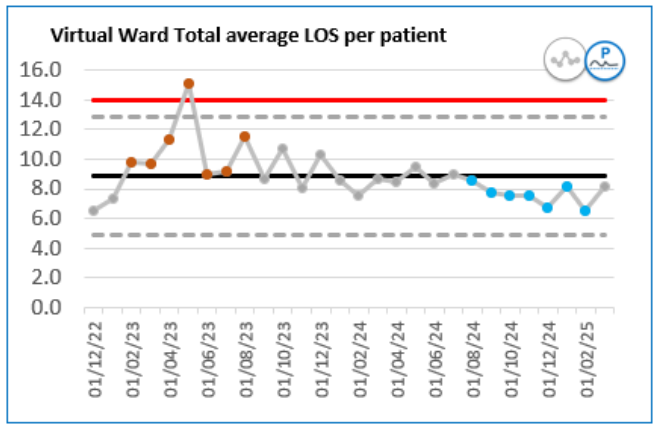
What	So What?	What Next?
There has been no significant change in the reports on percentage of no criteria to reside performance this month. Acute figures demonstrate a reduction to pre-Christmas figures whilst community figures remain static. There was additional data collection throughout March 2025 when Taskforce recommendations were implemented – this data demonstrates that whilst criteria to reside % was maintained an increase in patient flow through Community Assessment Beds (CAB) was seen with reduced length of stay for CAB patients and increased CAB admissions and discharges.	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.	Embedding of Taskforce recommendations of red2green board rounds, digitally enabled communication and use of templates to aid documentation to support the continuation of improved patient flow through CAB. Review of data and 2nd modelling of discharge pathway provision to support the reduction of acute criteria to reside The Out of County Discharge Planning Practitioner role is to provide support to all three community assessment bed settings from end of April.

Urgent & Emergency Care (TRUST – Virtual Ward)

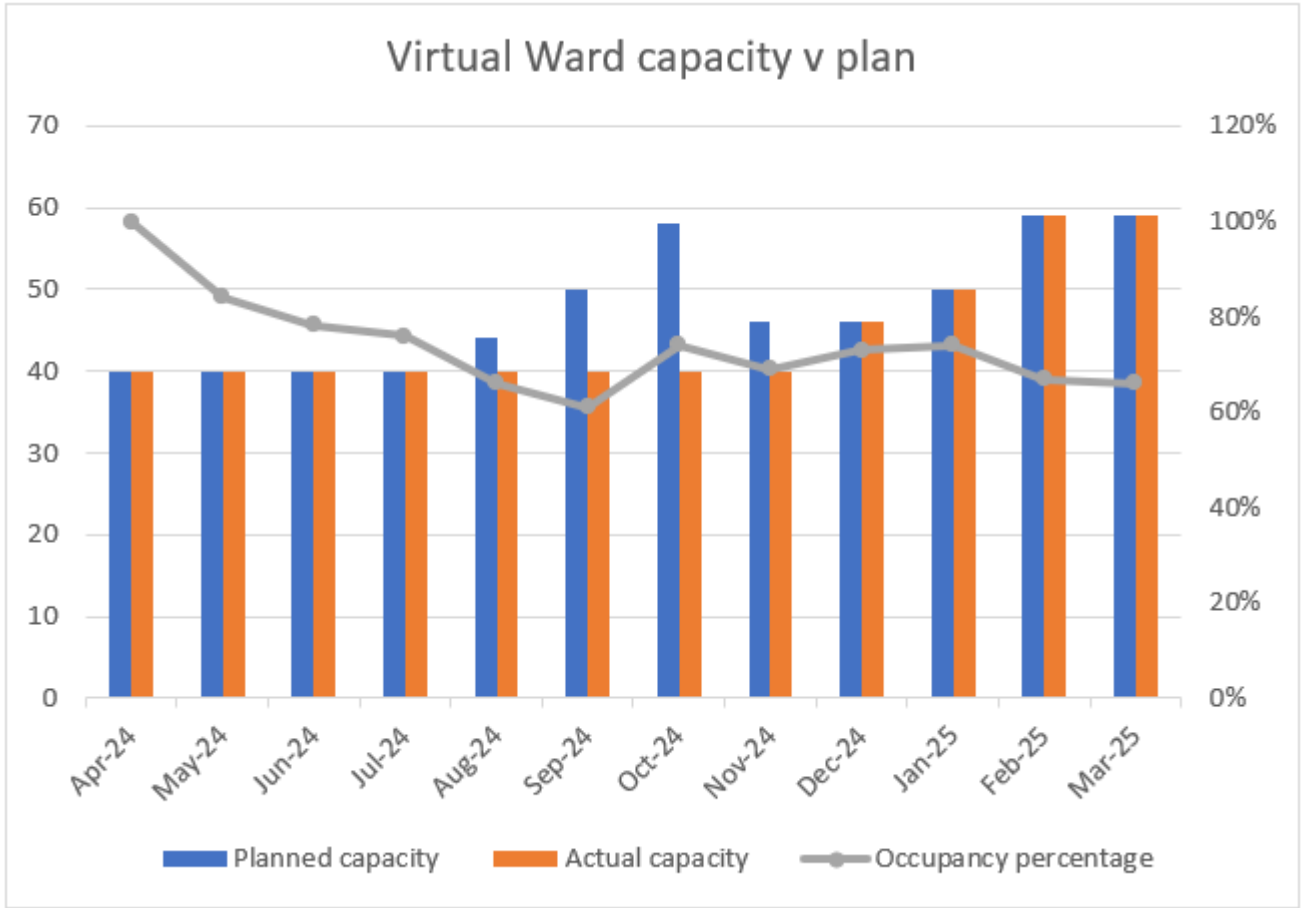






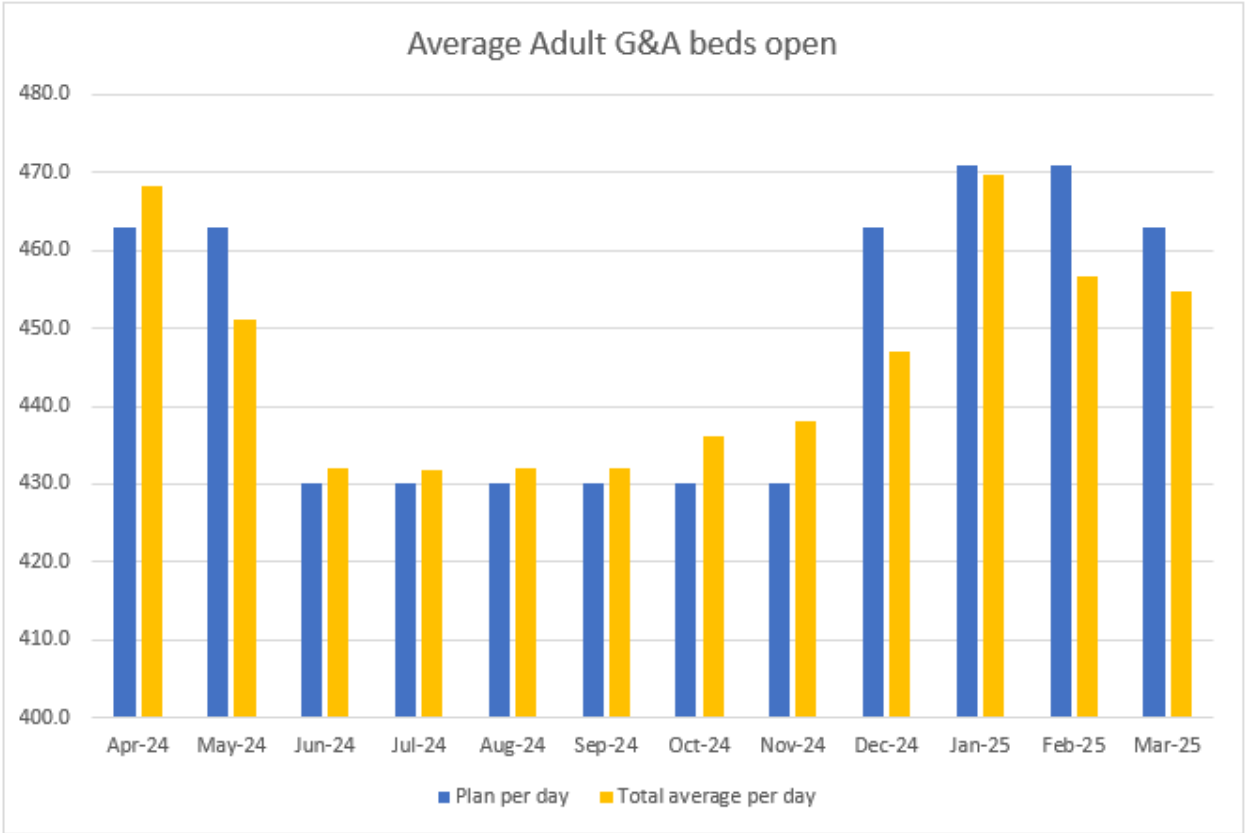


What	So What?	What Next?
The numbers being treated by virtual ward continues on an upwards trend, this is both for numbers and total bed days. Length of stay was on a downward trend , but not for March.	Virtual Ward (VW)capacity is crucial in ensuring adequate capacity to enable patient flow across the 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.	On 1st April virtual ward went live with stepping up patients directly from their home with 4 primary care practices. EIT started carrying remote monitoring kits , so that they can step patients up directly too.



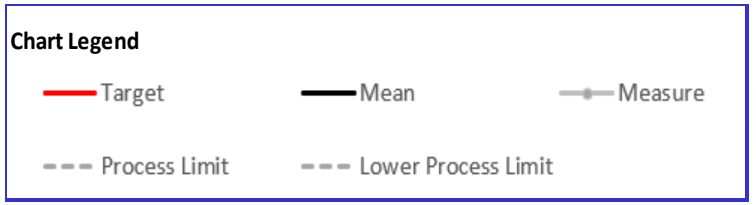
What	So What?	What Next?
Capacity was maintained at 59 beds in March.	Virtual Ward capacity is crucial in ensuring adequate capacity to enable patient flow across the Trust and strategic ambition of caring for patients at or near wherever possible.	New consultant , which will be joint virtual ward and community geriatrician has been appointed to start in June 2025. Staff consultation to integrate with nursing in the integrated neighbourhood teams is underway and will be completed end of May.

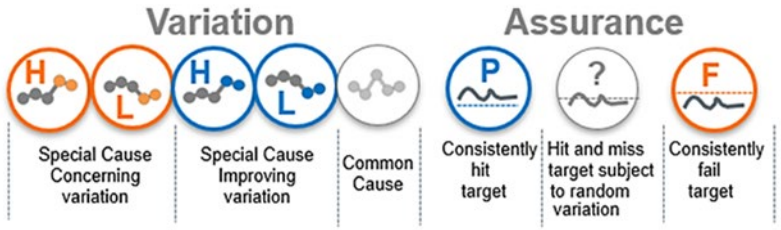
Urgent & Emergency Care: Beds



What	So What?	What Next?
March 2025 saw the average core beds reduce slightly in line with closure of the winter escalation ward by month end. Use of escalation beds decreased further to their lowest since August 2024 as discharges increased and length of stay reduced as a result of the ward-based task force in place as part of the March UEC Delivery 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. Using less core and escalation beds than planned from December to March provides the opportunity to rationalise inpatient capacity, options are being worked up through the UEC Delivery Group and Productivity Programme Board.

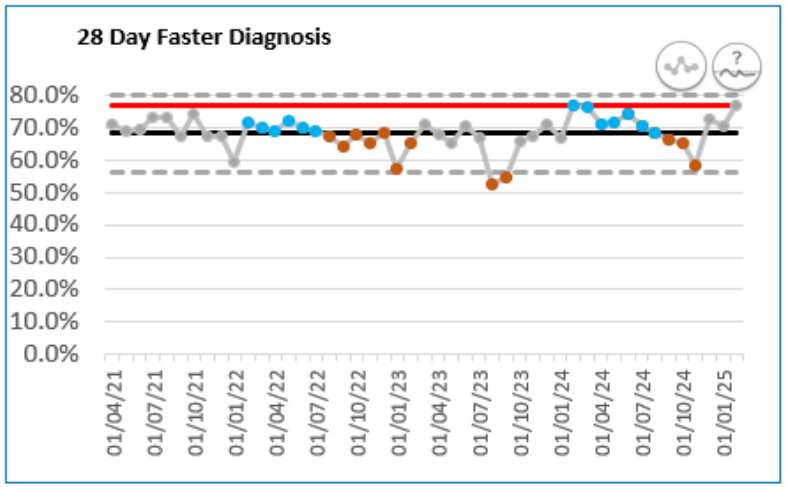
Cancer Access Summary

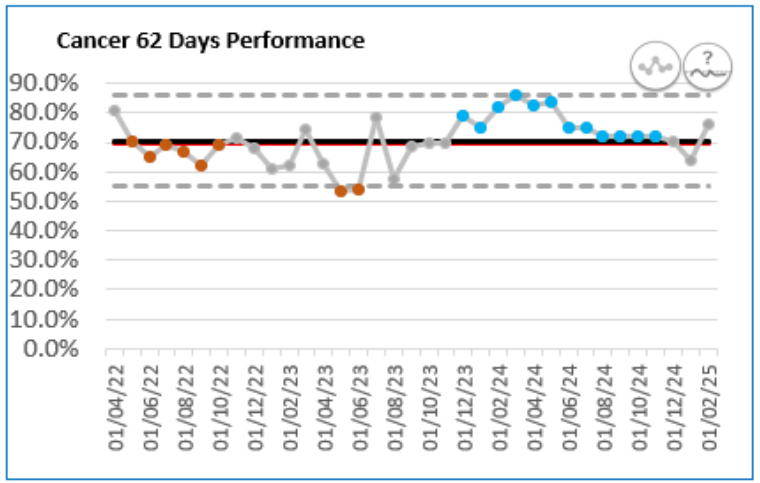


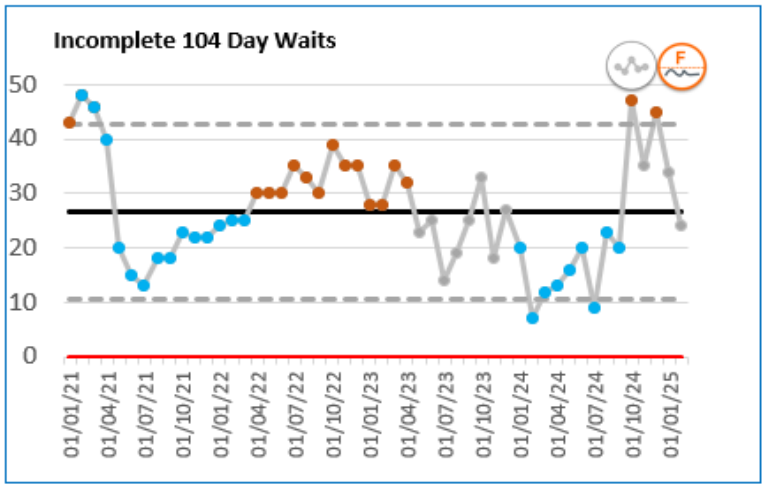


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	Feb 25	77.0%	77.0%			68.3%	56.5%	80.1%
Cancer 62 Days Performance	Feb 25	75.9%	70.0%			70.6%	55.0%	86.3%
Incomplete 104 Day Waits	Feb 25	24	0			27	11	43

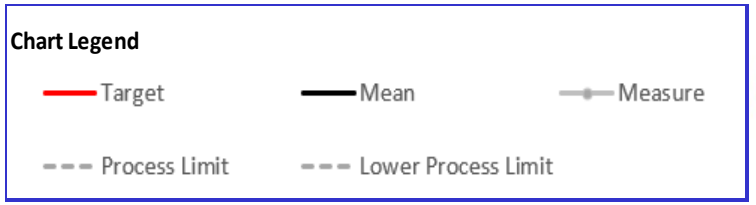
Cancer Access (Month Behind)

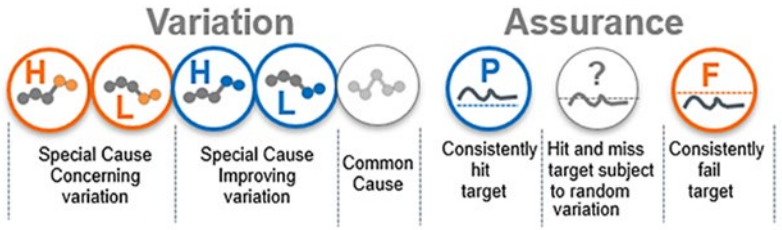






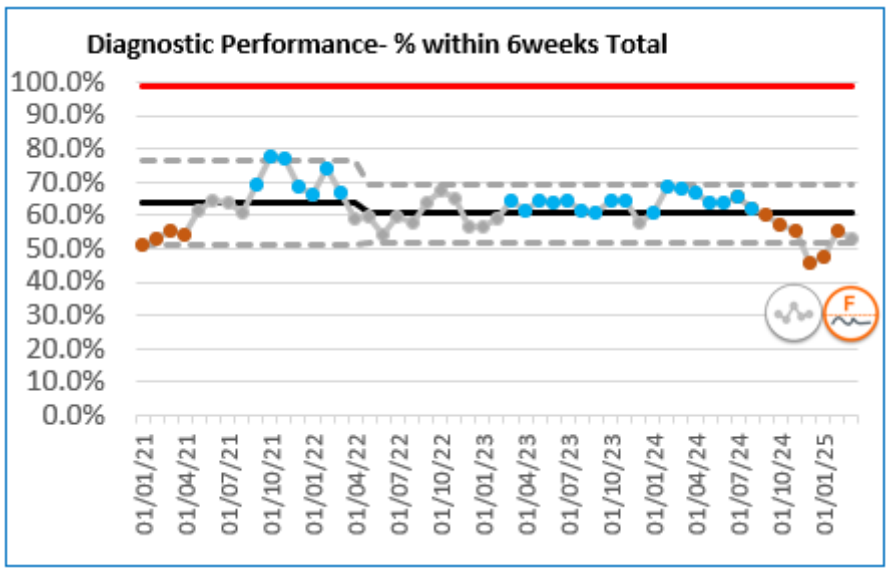
What	So What?	What Next?
Increase in February 2025 faster diagnosis with early achievement of national standard at 77%. March performance is expected to exceed to 79%. 62 Day performance improved to 75%, exceeding the national standard of 70%.	Recovering the cancer standards is key to the operational 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 25/26. Continue with FDS steering groups in Skin, Colorectal, Breast and Gynae to monitor performance and required transformational changes as guided by the Best Practice Timed Pathway (BPTP) audits. Breast meeting to take place 02/05/2025 to discuss longer term sustainability of service.





KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Diagnostic Performance- % within 6weeks Total	Mar 25	53.2%	99.0%			60.7%	52.0%	69.3%
RTT Waiting List	Mar 25	35880				33132	31830	34435
RTT 65+ Week Waits	Mar 25	31				406	231	580
RTT 78+ Week Waits	Mar 25	4	0			130	71	188
Actual 65+ ww at end of March 2025	Mar 25	31				482	-270	1233
Community Paediatrics RTT Overall Waiting List	Mar 25	544	-			506	449	563
Community Paediatrics RTT Overall 52 Weeks Wait	Mar 25	5	-			2	-2	5
Community Paediatrics RTT Overall 65 Weeks Wait	Mar 25	0	-			0	0	0
Community Paediatrics RTT Overall 78 Weeks Wait	Mar 25	0	0			0	0	0
Community Paediatrics RTT Overall 104 Weeks Wait	Mar 25	0	0			0	0	0
RTT NDD Only Waiting List	Mar 25	3	-			43	16	71
RTT NDD Only 52 Weeks Wait	Mar 25	2	-			1	0	3
RTT NDD Only 65 Weeks Wait	Mar 25	0	-			0	0	0
RTT NDD Only 78 Weeks Wait	Mar 25	0	-			0	0	1
RTT NDD Only 104 Weeks Wait	Mar 25	0	-			0	0	0

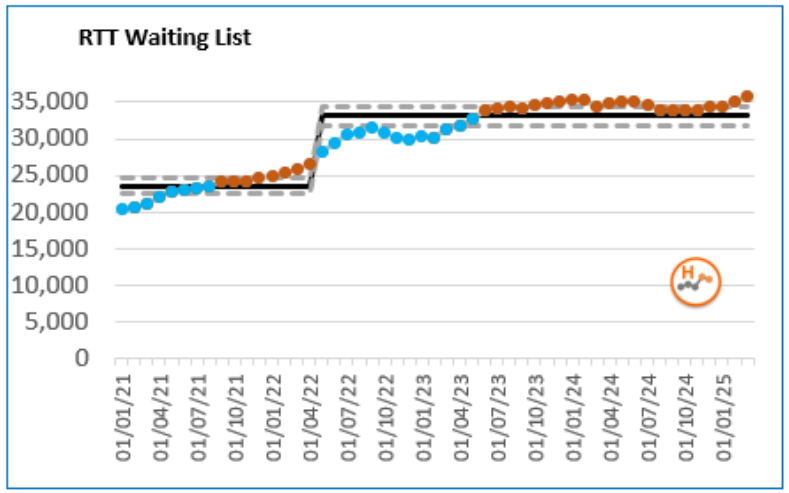
Elective Access

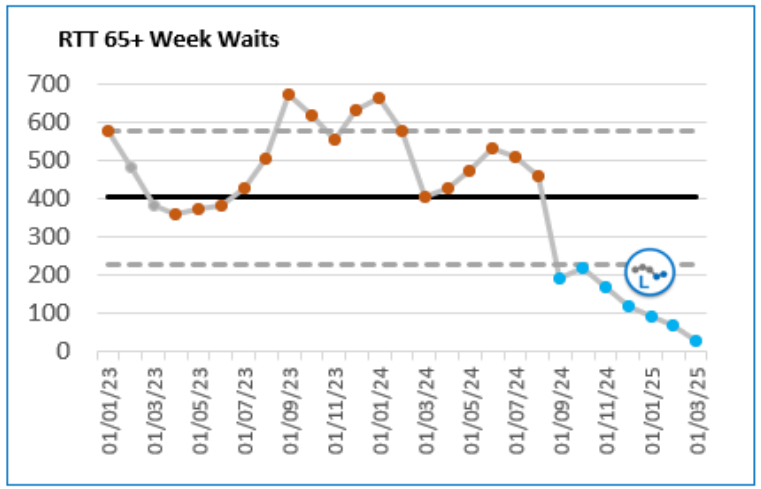


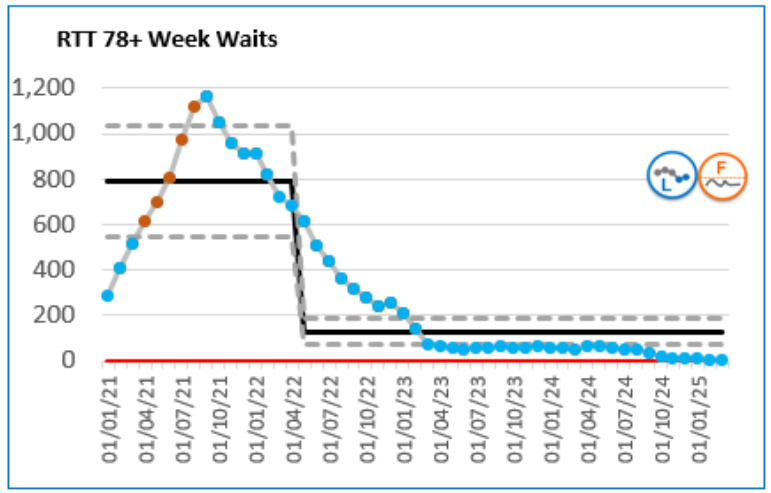
Diagnostics

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. **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. 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 supporting the 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, recent interviews were unable to appoint and will re-advertise the role. All surgical DM01 modalities have remained static in month with the exception of Urodynamics, which has seen an 8.9% improvement. Audiology continues to validate its PTL and is working on a plan to support community audiology which will, in the short-term result in further performance deterioration, taking 40 new patients to date. Urodynamics have been prioritised in month, CS resource now embedded in team to support sustainable improvement. Cystoscopy has remained static; capacity being flexed across all urological diagnostics to ensure TP biopsies and those most clinically urgent are prioritised. Tri one operational coordinator commences 5th May so will focus on DM01 and tracking.	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. Instatement of Tri one operational coordinator, supporting validation and DM01/RTT compliance.

Elective Access: RTT

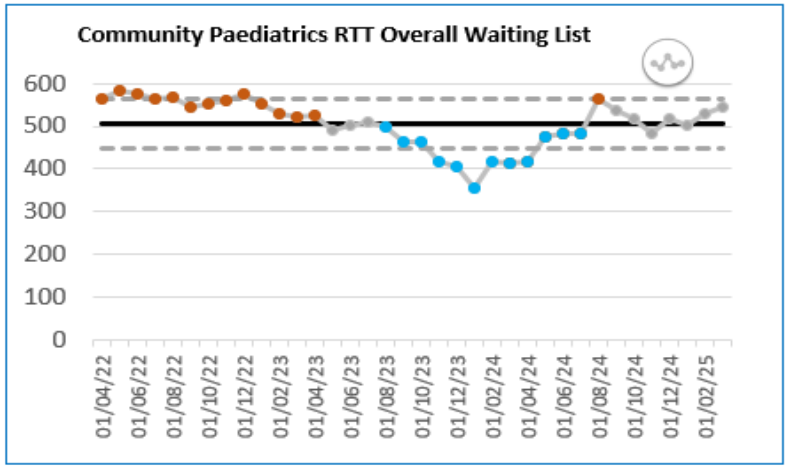


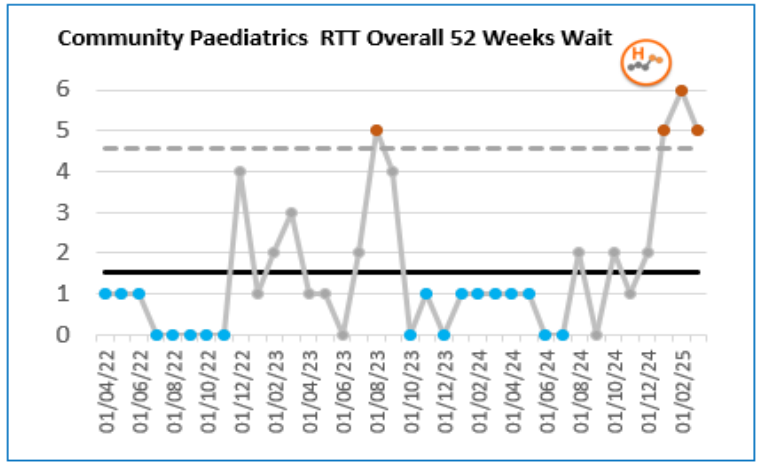


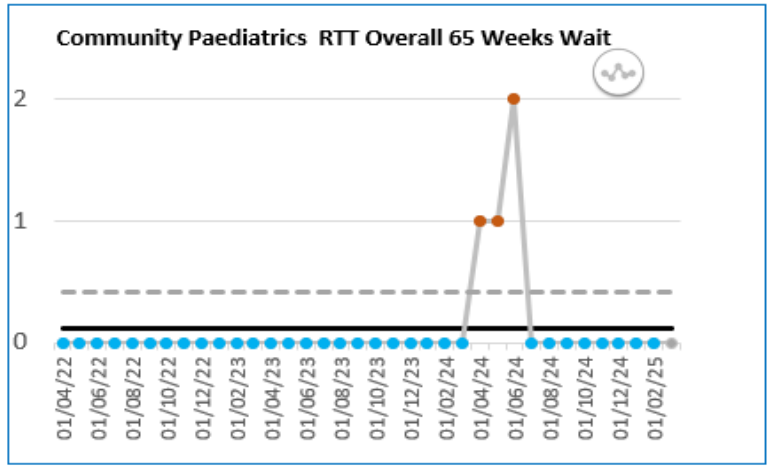


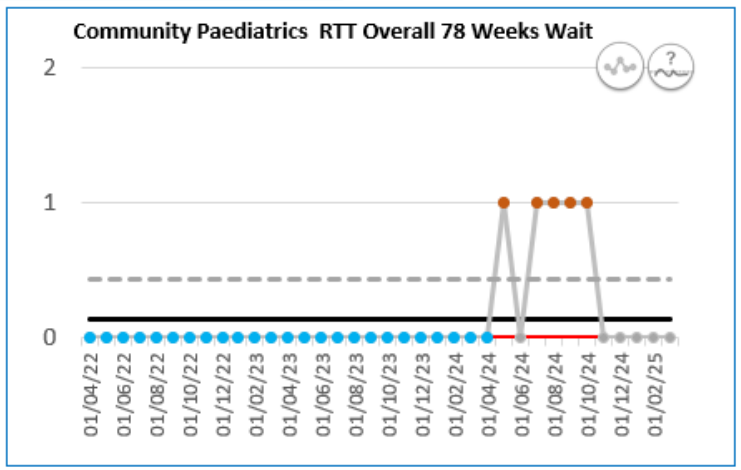
What	So What?	What Next?
The 78 week wait position for the end of March was 4 patients, which is a further reduction. The number of 65 week waits reduced to 31 patients at the end of March, with 10 of these related to capacity constraints.	Delivering the objective of no patients waiting over 65 weeks 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.	Continued focus on reducing 65ww by the end of Q1 25/26 in line with national ambition. Re-focus on plans to align to 52ww reduction in line with 25/26 operational planning guidance. Review of Dermatology options to be developed and presented.

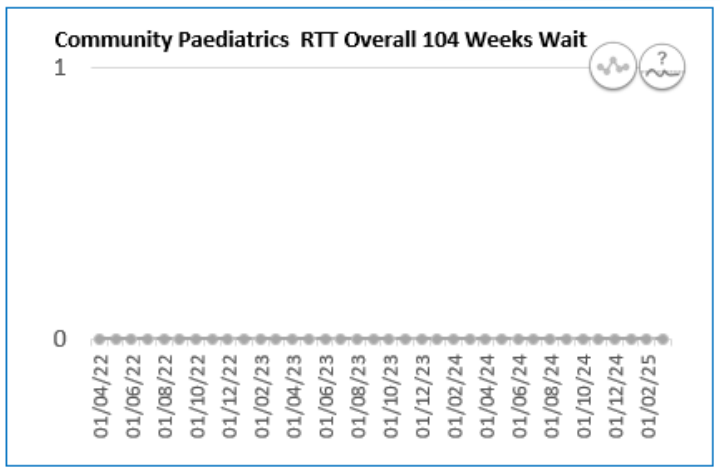
Elective Access (Community Paediatrics)











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 has reduced further from April 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 one substantive post successful but will not commence in post until Aug/September. Securing agency locum cover is being prioritised as previous cover ended contract early. Specialist Nurse vacancy appointed to, will start in 2-3months. Support for additional funding from the ICB is being considered to aid service recovery/response to school age autism assessment demand unlikely to 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	10,888	(2.8%)
Feb	9,206	9,966	9,399	(5.7%)
Mar	9,365	10,138	9,941	(1.9%)
Total (YTD)	**114,976**	**124,468**	**120,330**	**(3.3%)**

March 2025

23/24	9,365
ERF	10,138
24/25	9,941
Var	(197)
Var %	(1.9%)

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	2,534	4.4%
Total (YTD)	**27,040**	**29,288**	**29,186**	**(0.3%)**

March 2025

23/24	2,241
ERF	2,428
24/25	2,534
Var	106
Var %	4.4%

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	27,967	(4.6%)
Feb	24,452	26,086	24,380	(6.5%)
Mar	24,876	26,537	24,109	(9.2%)
Total (YTD)	**305,40**	**325,805**	**318,527**	**(2.2%)**

March 2025

23/24	24,876
ERF	26,537
24/25	24,109
Var	(2,428)
Var %	(9.2%)

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	290	10.0%
Total (YTD)	**3,085**	**3,336**	**3,303**	**10.0%**

March 2025

23/24	244
ERF	264
24/25	290
Var	26
Var %	10.0%

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

All

All

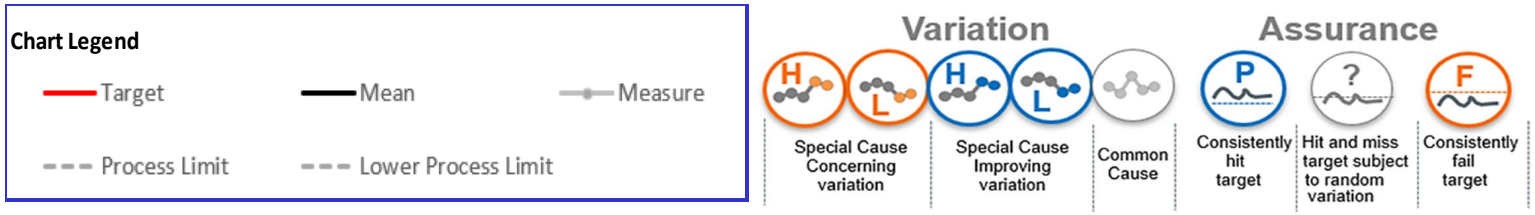
Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
23/24	38.2%	37.2%	37.0%	38.2%	38.5%	38.5%	36.6%	35.7%	37.4%	36.6%	38.2%	38.6%	**37.5%**
24/25	40.2%	39.3%	39.9%	40.9%	42.5%	39.7%	39.8%	39.3%	40.2%				**40.2%**

Target	46.0%
Month	40.9%
YTD	40.2%

Elective Access: Activity

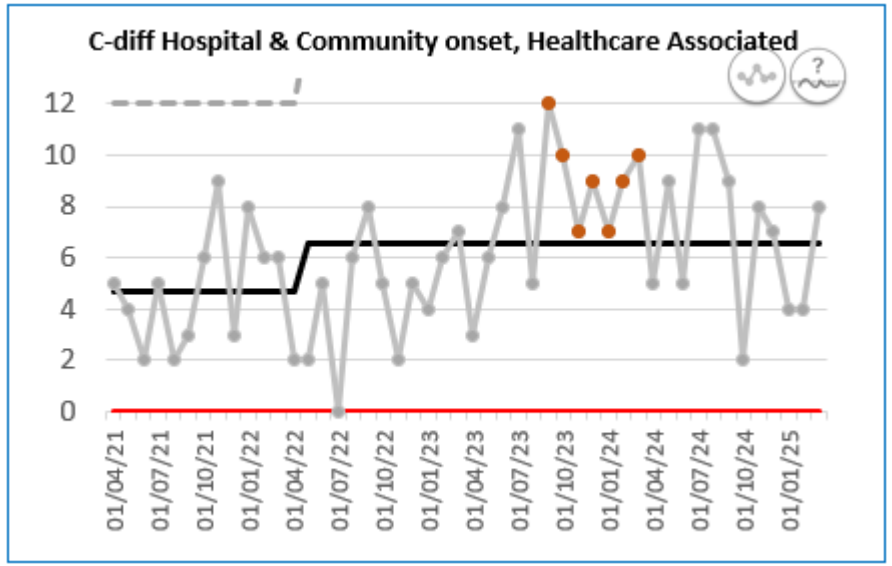
What	So What?	What Next?
Day case and elective activity exhibited a strong recovery in March, at 4.4% and 10.0% ahead of plan respectively. Full year delivery across both these points of delivery fell just short of plan. Outpatient first attendances narrowed the gap between plan and delivery in March, however across the year only met the plan in June and finished the year 3.3% below. Outpatient follow-ups, which should be reducing compared to 2019/20 levels showed their biggest negative variance in March at -9.2%, -2.2% for the year. 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 31 March 2025. 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.	Activity plans by specialty and point of delivery have been developed in response to the 2025/26 NHS operational priorities and planning guidance, reflecting the fixed clinical income element of our contract with the ICB. With the shift in focus from eliminating long elective waits, to a 5% improvement in patients actively waiting less than 18 weeks, greater emphasis will be put on the delivery of outpatient first attendances at or above plan to reduce overall waiting times, given 80% of Referral to Treatment pathways have their clock stopped without admitted or day case procedures.

IMPROVEMENT COMMITTEE METRICS



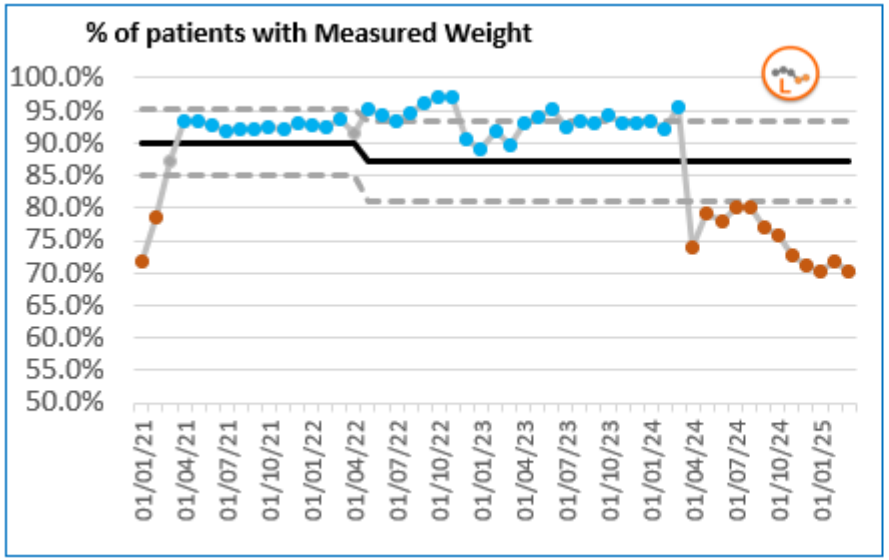
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
C-diff Hospital & Community onset, Healthcare Associated	Mar 25	8	0			7	-2	15
% of patients with Measured Weight	Mar 25	70.2%				87.2%	81.1%	93.3%
% of patients with a MUST/PYMS assessment completed within 24 hours of admission	Mar 25	97.0%				95.6%	93.0%	98.3%
Post Partum Haemorrhage	Mar 25	6				7	-1	15

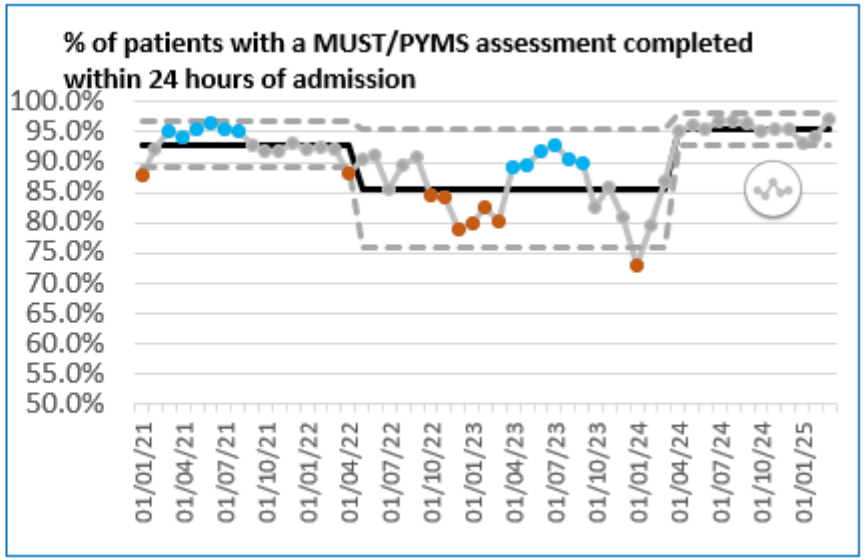
Safe



What	So What?	What Next?
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. However the last two month indicates Cdiff infection under the expected average. The threshold set combines hospital onset & community onset, healthcare associated cases (HOHA/COHA) which provides the organisations measure for national/regional data and better demonstrates the impact on our patient group. It is recognised Nationally that the rates of *Clostridioides difficile* have increased significantly over the last two reporting years. At year end incident rates over the past year have not exceeded the ceiling trajectory set by the ICB. WSFT has met the local target of 83 cases against a threshold set of 91.	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 NHS Standard Contract 2024/25: Minimising *Clostridioides difficile* sets a threshold for WSH of 91 HOHA/COHA cases 2024-25.	The situation remains complex and multifaceted. Despite this, Attendance was received at the March 2025 Improvement Committee and whilst *C.difficile* remains an organisational priority, escalation and monitoring will be via Patient Quality & Safety Group. The Quality Improvement Programme work will continue as 'business as usual' in the main. QI update: • Review of isolation signage – for IPCC 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 May 2025. • Gloves off campaign in conjunction with the waste management/sustainability team – May 2025 • Ecare documentation development in progress in the form of # - June 2025

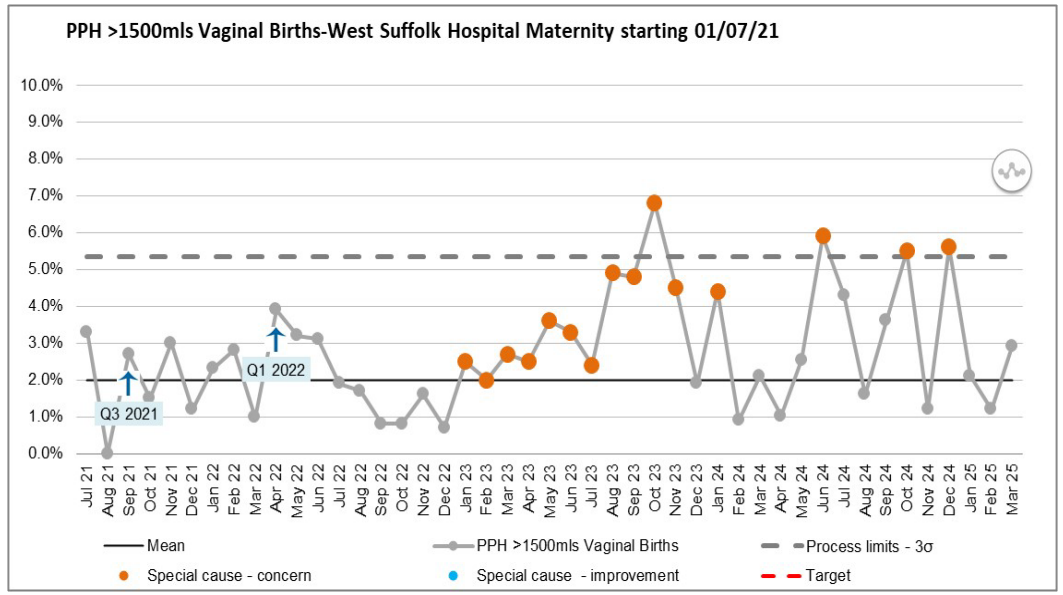
Safe

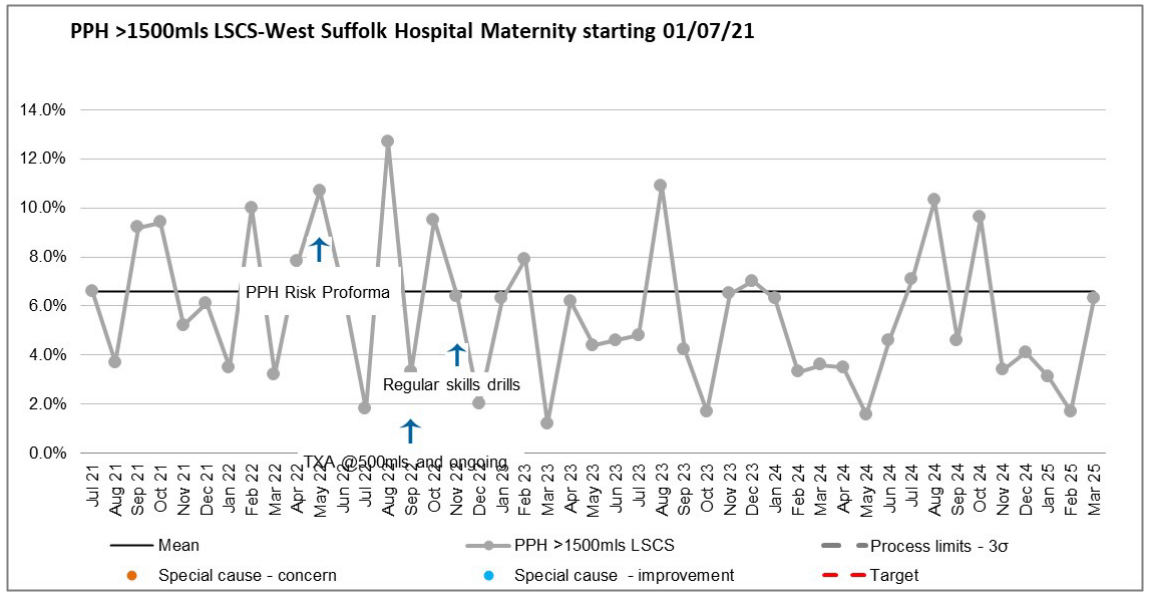




What	So What?	What Next?
Nutritional assessment (MUST) within 24hrs – 97% **Measured weight at 24 hrs – 70.2 %** Nutritional assessment remains high and has improved. 97% of patients are having a MUST score completed within 24 hours of admission to the ward 70.2% of patients are weighed within 24hours of admission and is in special cause for concern. However additional assurances can be taken that this is achieved during their inpatient stay 93.65 percent are having a measure weight undertaken during the period of their admission. This is a slight decrease from the previous month. Output from the introduction of the rapid assessment for ED is continuing, 48% percent of patients exceeding a stay of 13 hours have had a quick assessment completed.	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 world health organisation agrees and from 2016 -2025 they have collectively acknowledged the concept of 'food as medicine' The trust has been engaged with running food as medicine workshop, which has developed 4 key areas, assessment, planning, patient flow and support when eating, these are being looked at individually. All direct patient facing staff are aware of the importance of appropriate nutrition, they are cognisant of the need for assessment and reassessment in line with the change in the patient's condition and progression of their admission. Effective MUST scoring can be achieved with estimated weights, however actual measured weights is best practice	• Liaise with Dieticians to monitor impact of any delayed assessments and shared learning from this. • To build stronger working relationships with Dieticians on the ward, Ward Managers to co-ordinate. • Improvements in UEC flow has shown that we still need to act on the delays in weighing of patient at 24 hours. To discuss and review this data at performance meetings and the nutritional steering group. • The data has been reviewed and amended in the last two months; this is now allowing for a target approach to areas of noncompliance. The Heads of Nursing are now working on developing a trajectory of improvements. • Continue focus on the importance of Nutrition, reviewing protected mealtime audit data, looking at conducting peer reviews between wards.

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 March 2025, there were six reported cases of PPH over 1500 mls, with three occurring after a vaginal birth and three following Lower segment Caesarean Section (LSCS).

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.

PPH is one of the most common obstetric emergencies and requires clinical skills, with prompt recognition of the severity of a haemorrhage and emphasise communication and teamwork in the management of these cases. Severe bleeding after childbirth - postpartum haemorrhage (PPH) - is the leading cause of maternal mortality world-wide. Each year, about 14 million women experience PPH resulting in about 70,000 maternal deaths globally (WHO 2023)

As 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.

So What?

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

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

Exposure of psychological trauma to patients and our staff.

What Next?

Quality Improvement project in progress.

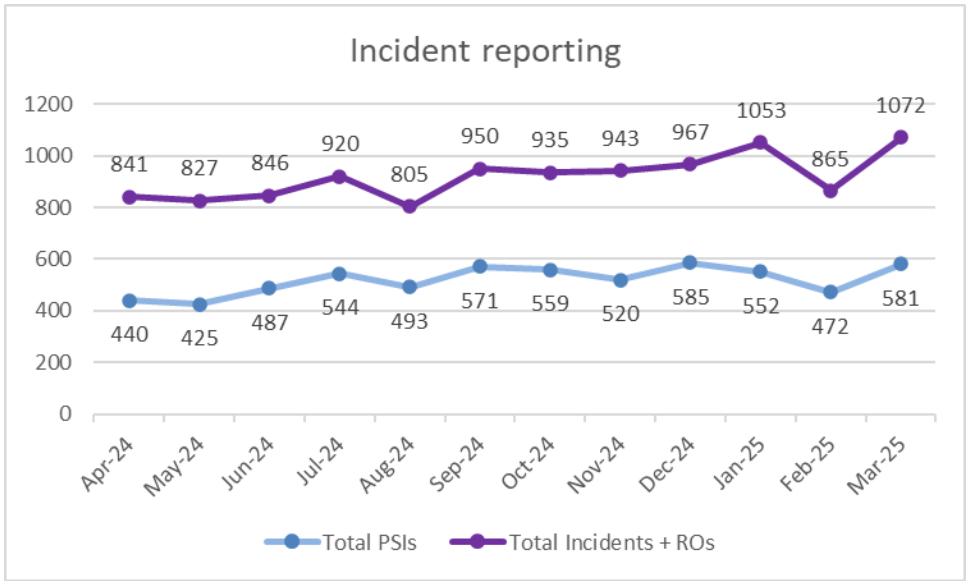
Ongoing reviews of all PPH and thematic reviews are required to continue, to truly understand the factors causing the variation and subsequent solutions to be found.

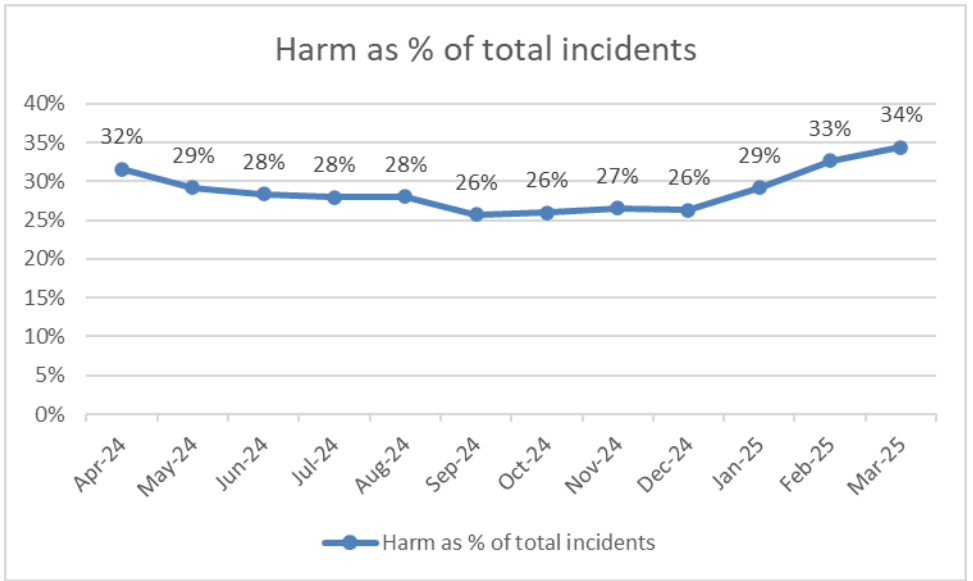
Engagement with local, LMNS (Local Maternity & Neonatal System) and regional QI programmes has shown some improvements these are not constantly sustained. Ongoing work continues to deep dive into the reasons for our PPH >1.5L.

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.

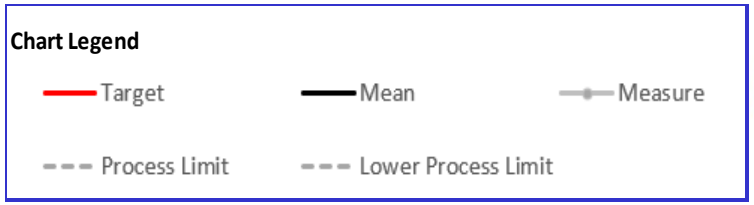
Safe

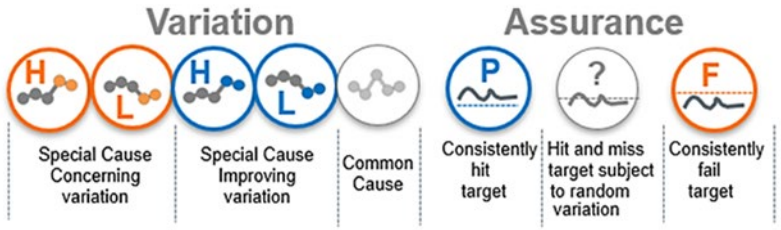




What	So What?	What Next?
There has been rise in the number of Patient Safety Incidents (PSI) and reported occurrences (RO's) following special cause variation last month. Harm as a % of total incidents continues to rise and we have seen an increase in the total amount of discharge, clinical care and treatment, medication incidents and slips, trips and falls in the last month. The national Learn from Patient Safety Events service (LFPSE) have released first official statistics since the service was introduced to replace the National reporting and learning system (NRLS). Q3 data measuring harm as a percentage of PSI is at 36%.	We are just under the national average of harm as a percentage of total PSI and will be able to use this as a benchmark moving forwards. Future publications, next due on the 15th May 2025 will include organisational level data.	Although we are under the national average we want to continue to strive to reduce harm for our patients when they are utilising our healthcare services. We will continue to collate the quarterly patent safety report which will be presented to the Improvement committee and continue to work with specialist and divisional leads to learn from reported patient safety incidents. Where there are rises in incidents reported we will work with the specialist leads and committees to ensure improvement opportunities are realised to prevent future occurrence of harm. An example is the medication safety group who have responded to a rise in missed medication incidents and are prioritising a quality improvement project (QIP) aiming to improve safest handover.

Mortality Summary

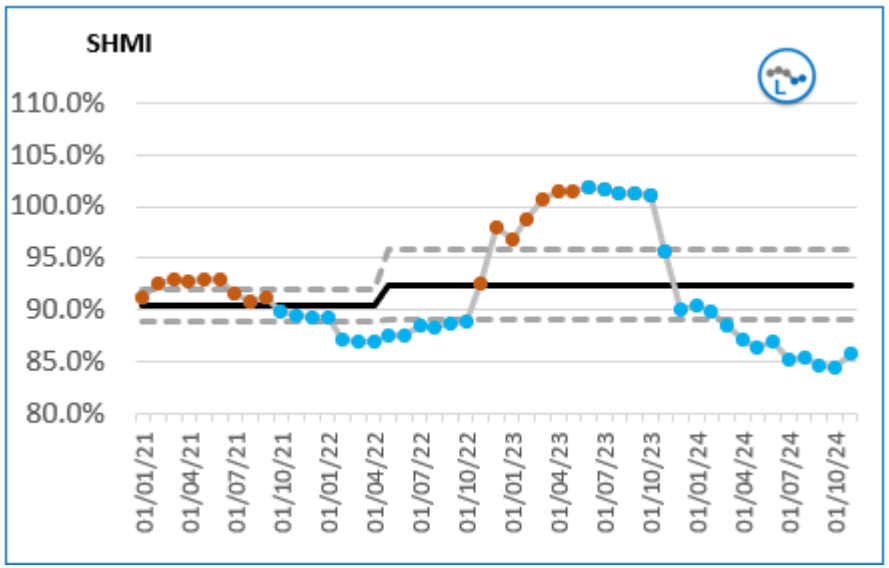


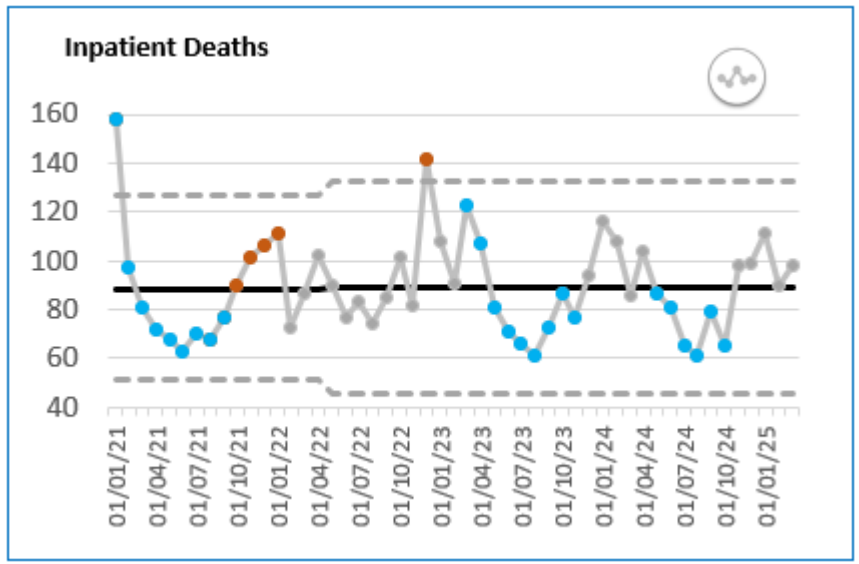


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SHMI	Nov 24	85.8%				92.5%	89.1%	95.9%
Inpatient Deaths	Mar 25	98				89	46	132

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

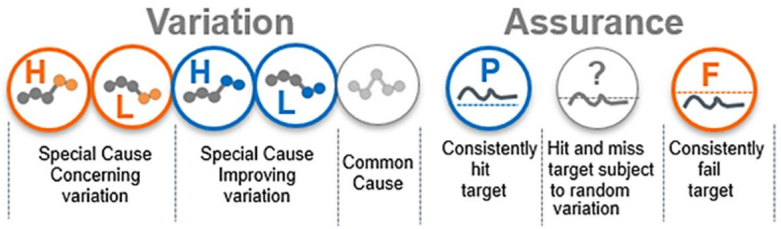
Mortality





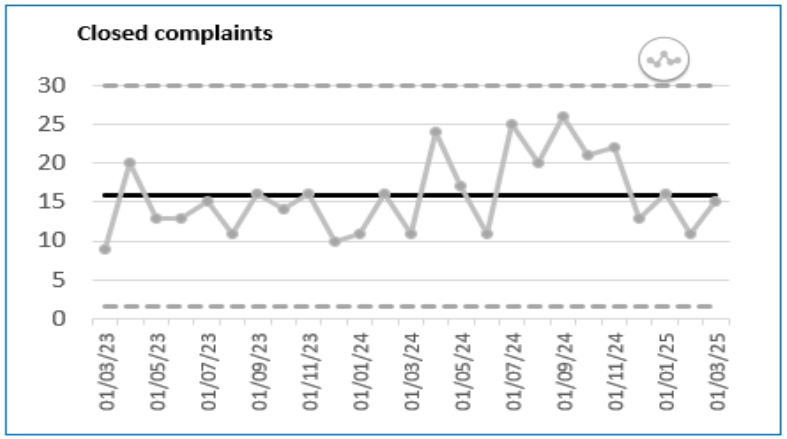
What	So What?	What Next?
An analysis of the data shows us that there has been no significant change with performance. The WSFT inpatient deaths are lower than expected with no unusual trends observed.	WSFT continues to provide a good patient care with overall higher than expected patient survival to discharge This demonstrates that WSFT is performing well against comparable Trusts	Looking forward we expect our SHMI data to remain slightly lower than expected. Inpatient deaths will continue to be scrutinised through learning from deaths programme and medical examiner service reporting to the mortality oversight group.

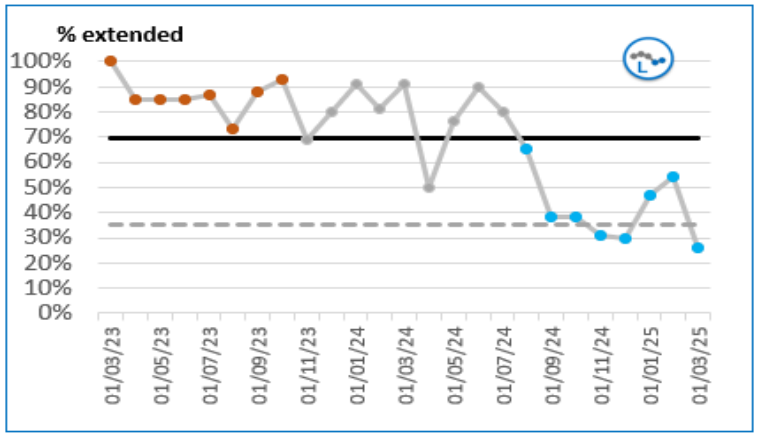
INVOLVEMENT COMMITTEE METRICS



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Active complaints	Mar 25	37	-			29	15	44
Closed complaints	Mar 25	15	-			16	2	30
% extended	Mar 25	26%	-	L		69%	35%	104%
Count extended	Mar 25	4	-			10	2	19
% Complaints responded to late	Mar 25	0%	-			9%	-22%	39%
Count responded to late	Mar 25	0	-			2	-4	7
% resolved in one week	Mar 25	70%	-			59%	31%	88%
Total PALS resolved Count	Mar 25	281	-	H		179	66	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
01/01/24
01/03/24
01/05/24
01/07/24
01/09/24
01/11/24
01/01/25
01/03/25


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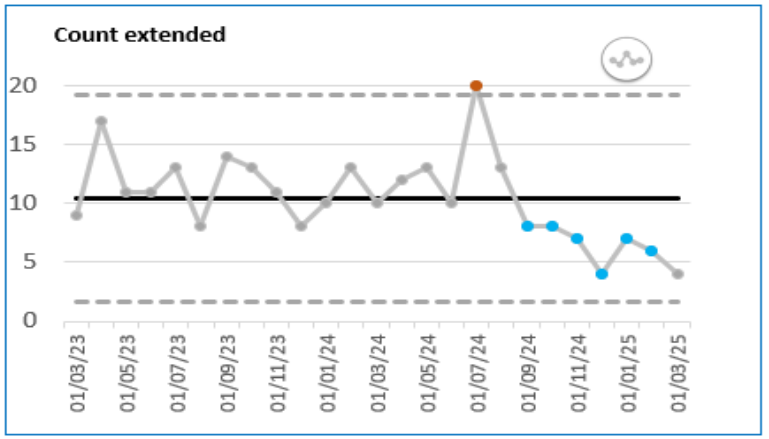
01/03/25


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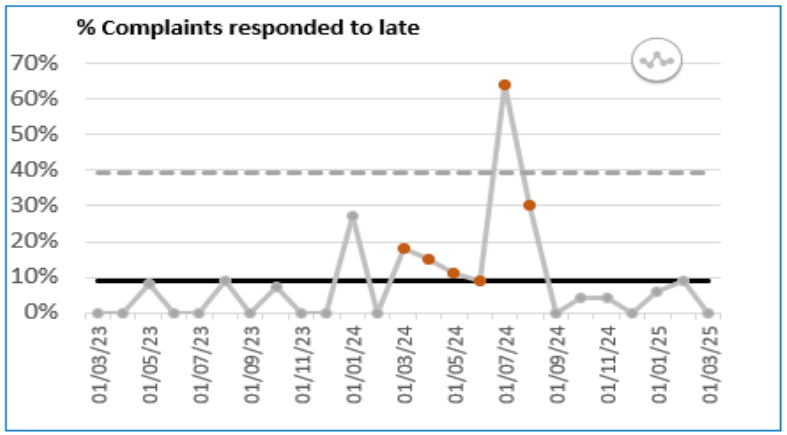
01/11/24
01/01/25
01/03/25


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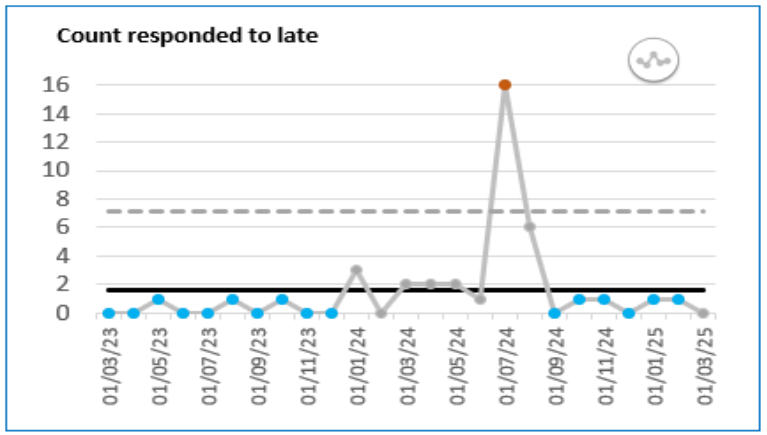
01/01/25
01/03/25


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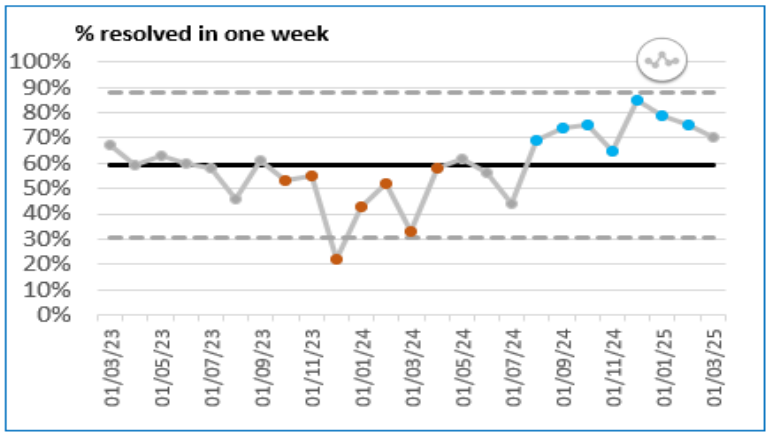
01/01/25
01/03/25


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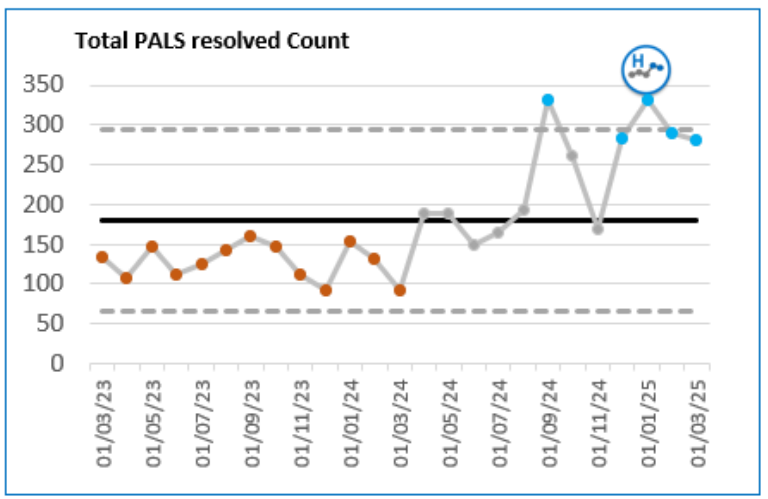
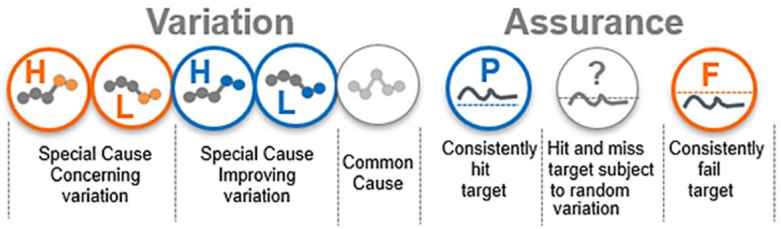
01/01/25
01/03/25


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

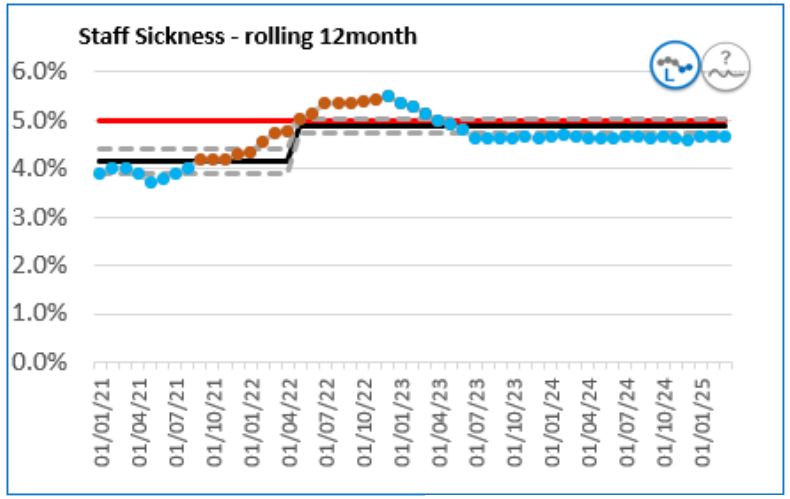
Safe

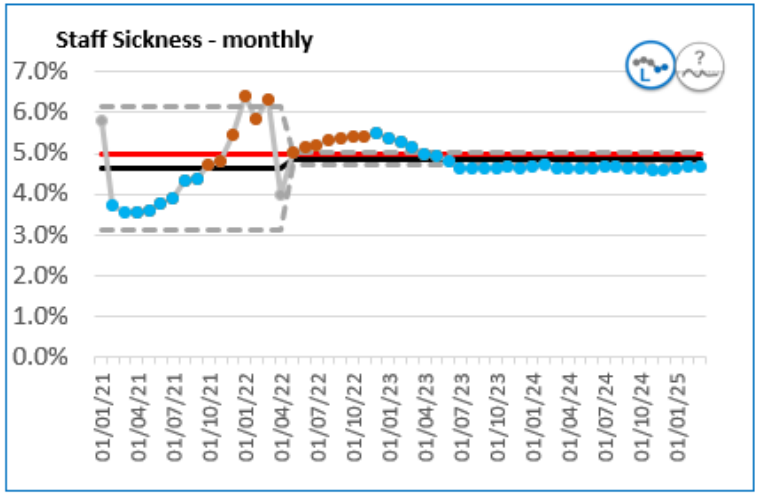
What	So What?	What Next?
Active complaints have increased from 30 to 37 however we have recently seen below average figures for this metric with lows of 19 active complaints open. Between 30-40 active complaints is a reasonable amount to achieve acceptable service levels with our current resourcing. This remains within the controlled data limits. Percentage of complaints extended has reduced significantly from 54% down to 26% however part of this was due to the reduction in complaints resolved in March. Nevertheless, this is still a positive trend and is now well below the lower controlled limit. The complaints team resolved 15 complaints in March which were all responded to within the given timeframe. This reflects 0 (Zero) complaints responded to late. PALS have seen a reduction in resource and therefore the volume of PALS cases have reduced slightly to 281 from 290. This is not a significant decrease and there are some variabilities given the service is a reactive service. The percentage resolved in one week SLA has reduced to 70%. This has been due to receiving a higher number of complex cases which have required additional investigation. Whilst this is a reduction, the data remains within the controlled limits and is a common variation.	Whilst formal complaints have increased, we ensure there is a robust process in place to ensure complainants are updated throughout the investigation on any delays, investigation pathways and updates on progress. The team have been working hard to ensure the complaints policy timeframe of 25 working days is adhered to however some cases required additional review such as going through the incident triage meeting and then on to EIR which can cause delays. This does however provide reassurance to complainants that we are taking their concerns seriously.	The 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. Performance management measures will be implemented from May to maintain service levels. 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.

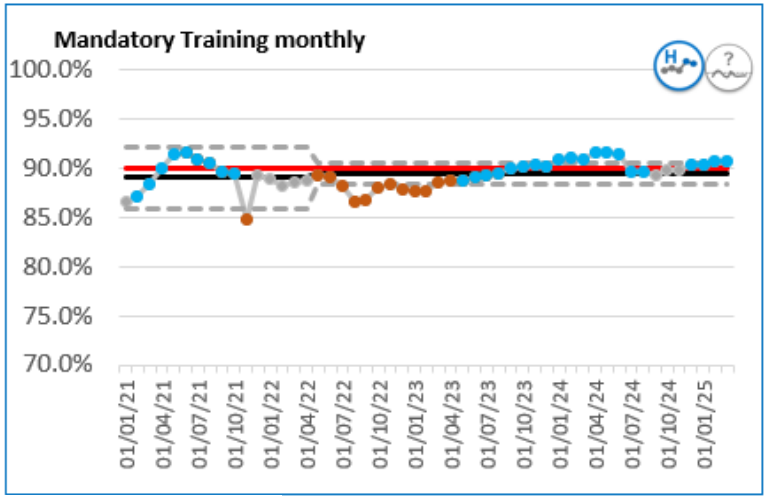


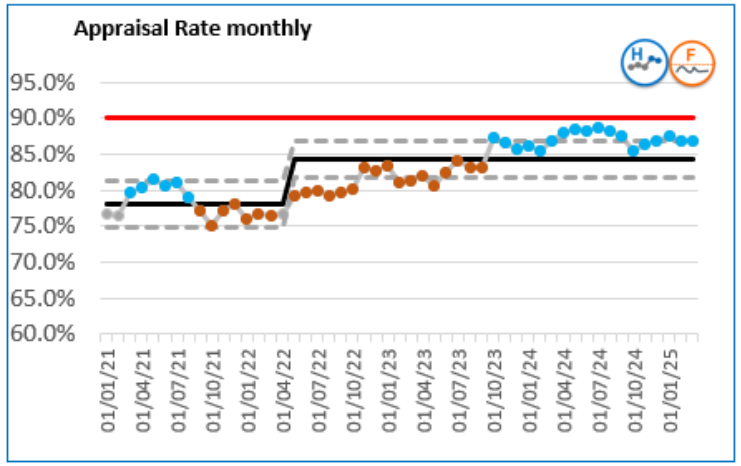
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	Mar 25	4.7%	5.0%	L	?	4.9%	4.7%	5.0%
Staff Sickness - monthly	Mar 25	4.7%	5.0%	L	?	4.9%	4.7%	5.0%
Mandatory Training monthly	Mar 25	90.7%	90.0%	H	?	89.5%	88.4%	90.6%
Appraisal Rate monthly	Mar 25	86.9%	90.0%	H	F	84.4%	81.9%	86.9%
Turnover rate monthly	Mar 25	8.2%	10.0%	L	?	10.1%	9.3%	11.0%

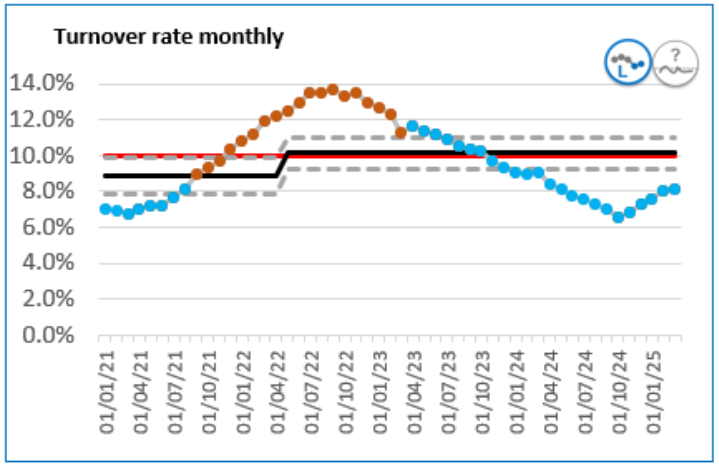
Well Led











What	So What?	What Next?
All four of our key performance indicators continue to record an improving variation, with three out of four achieving target. Sickness – achieving target at 4.7% versus 5% target. Mandatory training – achieving target at 90.7%. 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.

Item 7.1 Charitable Funds CKI Appendices

Item 7.4 Governance Appendices

Annex C: Scheduled draft agenda items for next meeting – 25 July 2025

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
Patient/staff story	✓	✓	Verbal	Matrix	DS / CS / JH
Chief Executive's report	✓		Written	Matrix	EC
Trust Strategy – Draft for approval	✓		Written	Matrix	EC
Green Plan - Draft for approval	✓		Written	Matrix	JR
System update: - West Suffolk Alliance and SNEE Integrated Care Board (ICB) - Wider system collaboration - Collaborative oversight group	✓		Written	Matrix	 PW / CM ST ST
Future System Board Report	✓		Written	Matrix	EC
Digital Board report	✓		Written	Matrix	NC
Insight Committee - committee key issues (CKI) report - Finance report	✓		Written	Matrix	AJ / NC / JR
Involvement Committee – committee key issues (CKI) report - People and OD Highlight Report o Putting you First award o FSUP Guardian	✓		Written	Matrix	TD / CS / JH
Improvement Committee – committee key issues (CKI) report - Maternity services quality and performance report - Nurse staffing report - Quality and learning report, including mortality and quality priorities	✓		Written	Matrix	RP / DS
Audit committee – committee key issues (CKI) report	✓		Written	Matrix	MP
Charitable funds committee report	✓		Written	Matrix	RF
Governance report	✓		Written	Matrix	RJ
Confidential staffing matters		✓	Written	Matrix – by exception	JH / CS
Board assurance framework report	✓		Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)	✓	✓	Verbal	Matrix	JC
Annexes to Board pack: - Integrated quality & performance report (IQPR) – annex to Board pack - Others as required					

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 two years 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.

NHS West Suffolk NHS Foundation Trust

REGISTER OF DIRECTORS' INTERESTS

The Codes of Conduct and Accountability for NHS Trusts requires all Trusts to draw up and maintain a register of director's interests. This register consequently lists all interests, defined by the Codes as relevant and material for all its Board and non-Board directors.

The definition of interests is as follows:

- Directorships held in private companies or plcs.
- Ownership or part ownership of private companies, businesses or consultancies, likely or possibly seeking to do business with the NHS.
- Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
- A position of authority in a charity or a voluntary body in the field of health and social care.
- Any connection with a voluntary or other body contracting for NHS services.

	Declared Interest	Date Reviewed / Amended
Trust Chair		
Jude Chin	Director of SSAT (The Schools Network) Ltd Shareholder of SSAT (The Schools Network) Ltd	30 April 2025
Non-Executive Directors		
Antoinette Jackson	Director and chair of Trustees in Arthur Rank Hospice Charity Director in Arthur Rank Limited	23 April 2025
Tracy Dowling **(Started on 1 Nov 2022. Term paused for 9 months from 20 November 2023, restarted 1 August 2024).**	Chair of Eastern Academic Health Science Network (trading as Health Innovation East) – a company limited by guarantee, which supports adoption and spread of innovation across the NHS in the East of England. As such, Health Innovation East could potentially do business with West Suffolk NHS Foundation Trust.	12 May, 2025
Dr John Roger Petter	Volunteer First Mate for the Ellen MacArthur Cancer Trust Charity	11 April 2025

	Declared Interest	Date Reviewed / Amended
Michael Parsons	Bursar - Christ's College Cambridge (registered charity) Director & Company Secretary – Christ's College Enterprises Ltd Director & Company Secretary – Christ's College Trading Ltd Non-Executive Director - University of Cambridge – Property Board Non-Executive Director - Parliamentary and Health Services Ombudsman (PHSO) Member of Chartered Institute of Public Finance & Accountancy (CIPFA) (Professional Body)	3 April 2025
Richard Flatman	Non-Executive Director, South West London & St. George's Mental Health Trust Co-opted member of Audit Committee of the British Accreditation Council Trustee British Society of Gastrointestinal and Abdominal Radiology	28 January 2025
Heather Hancock	Director - DigitalFutureway Ltd, consultancy specialising in executive coaching and change Management. No NHS contracts Volunteer – Arthur Rank Hospice	12 May 2025
Alison Wigg	Trustee of Suffolk Libraries (until 1 June, 2025) and then Trustee of Community Connections.	14 May 2025
Paul Zollinger-Read (Associate NED)	Director – VHI DAC Health Insurance, Ireland	1 April 2025
David Weaver (Associate NED) **Resigned 1 May 2025**	Chair – Orbit Group	26 September 2024
Louisa Pepper **Resigned 30 August, 2024**	Elected Parish Councillor for the village of Thorpe Morieux	17 April 2024
Geraldine O'Sullivan **Resigned 30 April, 2024**	Non-executive director at BPHA (Housing Association)	26 March 2024
Krishna Yergol **Resigned 30 April, 2024**	Director Shashikala Properties Ltd Director Shashikala Digital Ltd Director SP Norfolk Electricals Ltd	27 March, 2024

	Declared Interest	Date Reviewed / Amended
Executive Directors		
Ewen Cameron	Nil	1 April, 2025
Nicola Cottington	Nil	10 April 2025
Jeremy Over	Nil	30 April, 2025
Susan Wilkinson	Nil	2 April 2025
Richard Goodwin	Director of RWMH Ltd, Company number 07172203 (private medical services) Consultant to Radnet Management Inc., a subsidiary of Radnet Inc of which DeepHealth is also a subsidiary. DeepHealth provide Saige Lung, Saige Brain and Saige Prostate AI tools. Radnet Inc are also majority shareholders of HeartLungHealth, a teleradiology provider to the NHS.	1 April 2025
Craig Black **Left 26 September, 2024**	Helena Jopling, Associate Medical Director (Future System) is live-in partner	17 April 2024
Paul Molyneux **Stepped Down 3 November 2024**	Director of a private company, PD Molyneux Neurology Consultancy Ltd. This company offers private neurology consultancy work at the BMI Bury St Edmunds. Spouse employed in the Trust (bank vaccination nurse) - no line management responsibilities for the vaccination team and no direct or indirect interactions in work capacity.	27 March 2024
Other attendees		
Clement Mawoyo	Nil	9 May 2025
Peter Wightman	Nil	1 April 2025
Richard Jones **(To be confirmed)**	Director of Friars 699 Limited (which changed its name to "The Pathology Partnership Limited"), dissolved via voluntary strike-off on 20/4/2021.	17 April, 2024
Jonathan Rowell	Nil	2 April 2025