NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday 25 July 2025, 9:15 AM — 1:15 PM BST
Venue	Northgate Room
Description	A meeting of the Board of Directors in the Public domain on Friday 25 July 2025
Organiser	Emma Whight

Agenda

	1.4. Action log and matters arising (ATTACHED) To Review - Presented by Jude Chin	24
	Item 1.4 - Matters Arising - Active.pdf	25
	Item 1.4 - Matters Arising - Complete.pdf	26
10:10 AM	1.5. Questions from Governors and the Public relating to items on the agenda (verbal) To Note - Presented by Jude Chin	27
	1.6. Patient story To Review - Presented by Daniel Spooner	28
10:10 AM	1.7. Chief Executive's report (ATTACHED) To inform - Presented by Ewen Cameron	29
	Item 1.7 - CEO Board report - July 2025.docx	30
10:10 AM	2. STRATEGY	35
	2.1. WSFT Strategy (ATTACHED) For Approval - Presented by Ewen Cameron	36
	Item 2.1 - Strategy Refresh Cover Paper Public Board July 2025.docx	37
	Item 2.1 - Strategy Update to Public Board Final July 2025.docx	39
10:35 AM	2.2. Future System board report (ATTACHED) To Assure - Presented by Ewen Cameron	41
	Item 2.2 - FSP Report.docx	42

	2.3. System Update/Alliance Report - SNEE Integrated Care Board (ICB); Wider System Collaboration (ATTACHED) To Assure - Presented by Peter Wightman and Clement Mawoyo	47
	Item 2.3 - WSFT_WSA report May and JUNE 2025_ (002).docx	48
	2.4. Digital Board Report (ATTACHED) To Assure - Presented by Sarah Judge	53
	Item 2.4 - Trust Board digital report July 2025.docx	54
10:35 AM	Comfort Break	58
10:45 AM	2.5. Joint Productivity Board (ATTACHED) To Assure	59
	Item 2.5 - Productivity Board Update July 2025.docx	60
11:25 AM	3. ASSURANCE	62
	3.1. IQPR Report (ATTACHED - full IQPR under supporting Annex) To Review - Presented by Nicola Cottington	63
	Item 3.1 - IQPR Cover Sheet May.docx	64
11:55 AM	Comfort Break	67
12:10 PM	4. PEOPLE, CULTURE AND ORGANISATIONAL DEVELOPMENT	68
	4.1. Involvement Committee Report - Chair's Key Issues from the meeting (ATTACHED) To Assure - Presented by Tracy Dowling	69
	Item 4.1 - CKI Involvement Committee June 2025 draft 1.0.docx	70

	5.4. Acute Contract Signing (ATTACHED) Presented by Nick Macdonald	167
	Item 5.4 - Acute Contract Board Approval 180725 Final.docx	168
12:45 PM	6. QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT	174
	6.1. Improvement Committee Report - Chair's key issues from the meetings (ATTACHED) To Assure - Presented by Paul Zollinger-Read	175
	Item 6.1 - Improvement Cttee CKIs 18 06 25.docx	176
	Item 6.1 - Improvement Cttee CKIs 21 05 25.docx	187
	6.2. Quality & Nurse Staffing Report (ATTACHED) To Assure - Presented by Daniel Spooner	196
	Item 6.2 - Nurse.Midwifery staffing report May and June 2025.docx	197
	6.3. Maternity services report (ATTACHED) For Approval - Presented by Karen Newbury and Daniel Spooner	215
	Item 6.3 - July 2025 Maternity and Neonatal quality safety and performance Board report - final.docx	216
1:00 PM	7. GOVERNANCE	226
	7.1. Charitable Funds Committee report - Chair's key issues from the meeting (ATTACHED) To inform - Presented by Richard Flatman	227
	Item 7.1 - CFC CKI report 10 June 2025 v1 RF.docx	228

	7.2. Audit Committee - Chair's key issues from the meeting (ATTACHED) To inform - Presented by Michael Parsons	234
	Item 7.2 - AUDIT CKI report 20 June 2025.docx	235
	7.3. Board Assurance Framework (ATTACHED) For Approval - Presented by Paul Bunn	240
	Item 7.3 - BAF report to Board Jul 25.docx	241
	7.4. Governance Report (ATTACHED) To inform - Presented by Paul Bunn	248
	Item 7.4 Governance report Trust Board 25 July 2025 PS (1).docx	249
	8. OTHER ITEMS Presented by Jude Chin	253
1:10 PM	8.1. Any other business To Note - Presented by Jude Chin	254
	8.2. Reflections on meeting For Discussion - Presented by Jude Chin	255
	8.3. Date of next meeting - 26 September 2025 To Note - Presented by Jude Chin	256
	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	257

AGENDA

Presented by Jude Chin

WSFT Board of Directors – meeting in public

Date and Time	Friday, 25 July 2025 9:15 -13:15
Venue	Education Centre, 16 A&B, West Suffolk Hospital site, WSFT

Time	Item	Subject	Lead	Purpose	Format
1.0 GENERAL BUSINESS					
09.15	1.1	**Welcome and apologies for absence –** Richard Jones; Sam Tappenden; Jonathan Rowell	Chair	Note	Verbal
	1.2	**Declarations of Interests**	All	Assure	Verbal
	1.3	**Minutes of meeting** 23 May 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** (Staff member attending to present case study)	Chief Nurse	Review	Verbal
	1.7	**CEO report**	Chief Executive	Inform	Report
2.0 STRATEGY					
10.10	2.1	**WSFT Strategy**	Director of strategy and transformation	Approval	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	Report
	2.4	**Digital Board report**	Chief Information Officer	Assure	Report
10:35 Comfort Break					
10:45	2.5	Joint Productivity Board	Director of strategy and transformation	Assure	Report

Time	Item	Subject	Lead	Purpose	Format
3.0 ASSURANCE					
11.25	3.1	**IQPR report** To consider areas for escalation *(linked to CKI reports from assurance committees)*	Executive leads	Review	Report
11:55 Comfort Break					
4.0 PEOPLE, CULTURE AND ORGANISATIONAL DEVELOPMENT					
12.10	4.1	**Involvement Committee report** – Chair's key issues from the meetings **People and OD** **- FTSU Report** **- Putting You First**	NED Chair Interim Chief People Officer	Assure Inform	Report
5.0 OPERATIONS, FINANCE AND CORPORATE RISK					
12.35	5.1	**Insight committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
	5.2	**Finance report**	Interim CFO	Review	Report
	5.3	**Green Plan 2025-29**	Neil Jackson on behalf of Interim CFO	Approval	Report
	5.4	**Acute Contract Sign-off**	Interim CFO	Approval	Report
6.0 QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT					
12.45	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					
13:00	7.1	**Charitable Funds Committee report** Chair's key issues from the meetings	NED Chair	Inform	Report
	7.2	**Audit Committee** Chair's key issues from the meetings	NED Chair	Inform	Report

Time	Item	Subject	Lead	Purpose	Format
	7.3	**Board assurance framework**	Trust Solicitor	Approval	Report
	7.4	**Governance Report**	Trust Secretary	Inform	Report
8.0 OTHER ITEMS					
13.10	8.1	**Any Other Business**	All	Note	Verbal
	8.2	**Reflections on meeting**	All	Discuss	Verbal
	8.3	**Date of next meeting** 26 September 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, Sam Tappenden, Jonathan Rowell (Nick McDonald deputising), Pooja Sharma (Paul Bunn presenting)

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 - 23 May 2025 (ATTACHED)

To Approve

Presented by Jude Chin

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE
Open Board meeting

Held on Friday 23 May, 2025, 09:15 – 13:15
Northgate Meeting Room, Quince House, WSFT

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
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
Alison Wigg	Non-Executive Director	AW
Michael Parsons	Non-Executive Director	MP
Roger Petter	Non-Executive Director	RP
Paul Zollinger-Read	Non-Executive Director	PZR
Peter Wightman	West Suffolk Alliance Director	PW
In attendance:		
Pooja Sharma	Deputy Trust Secretary	PS
Ruth Williamson	FT Office Manager (minutes)	RW
Carol Steed	Deputy Director of Workforce & Communications	CS
Greg Bowker	Head of Communications	GB
Sarah Judge	Interim Chief Information Officer (Item 2.4 only)	SJ
Karen Newbury	Director of Midwifery (Item 6.3 only)	KN
Simon Taylor	ADO, Women & Children and Clinical Support Services (Item 6.3 only)	ST
Kate Croissant	Clinical Director, Women & Children (Item 6.3 only)	KC
Apologies: Richard Jones, Trust Secretary. Clement Mawoyo, Director of Integrated Adult Health & Social Care West Suffolk, Heather Hancock, non-executive director and Jeremy Over, Director of Workforce & Communications.		
Governors observing: Tom Murray, Val Dutton.		
Staff: -		
Members of the public: -		

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 on 18 March 2025, were accepted as a true and accurate reflection.	
1.4	**Action Log and matters arising**	
	Action Ref 3121 – IQPR Report – UEC Deep Dive – noted report has gone to the Insight Committee and will come to Board in July. Action to remain open. **Action 3124 – Freedom to Speak Up –** Item on today's agenda. Action closed. **Action 3127 – WSFT Strategy -** Item on today's agenda. Action closed. **Action 3134 – Reflections on Meeting – Imbedding Learning from Patient Stories** – noted robust report going to Improvement Committee and an approach to sharing has been approved. Agreed the Board has assurance on learning, which is fed through the Patient Safety and Quality Meeting. The Improvement Committee will monitor progress. Action closed. Completed actions noted.	
1.5	**Questions from Governors and the public relating to items on the agenda**	
	No questions were received.	
1.6	**Patient Story**	
	The Board listened to pre-recorded feedback from the daughter of a patient on her mother's treatment whilst at the Trust. JC asked how the Board could be assured that such an experience would not recur. Noted it was important to share the learning and it was the intention that this feature at a Grand Round. This feedback was from events that had happened two years previously, where one of the issues related to changing ward, which was one of the Trust's quality priorities. It also related to delivery of information. It was noted there was some confusion as to how much the patient was able to understand. EC advised that if a patient was being moved around the hospital and this involved a new medical team, communication would be difficult. The care model is ward-based. If the patient had	

	remained with the same consultant, no matter which ward, it was anticipated their experience would have been different. SW agreed that the Trust operates ward-based care, but it was not just about wards, but also beds, as a patient could have a different clinician if moving beds on the same ward. The Improvement Committee is looking at "Right Move, Right Time" and use of measurable metrics. RP stated it was vital for resident doctors to hear stories such as this and queried how many would attend a Grand Round. **Action: RG to speak to the Director for Post Graduate Medical Education, to ensure this learning is disseminated.** TD suggested there was much to do to engage the families and next of kin as partners in care and that this should be a priority. SW confirmed that discussions are undertaken with senior nursing staff on patient stories and inclusion of families in patient care. TD queried the process for escalating complex cases. RG advised Cambridge University Hospitals were consulted on more difficult cases. It was a matter of how to embed the structure to encourage people to share cases more generally. It made a person's practice harder if working in isolation. ST believed the impression was that the patient had to work around the Trust's structures; how did the Trust provide more personalised care? Were there specific cohorts at particular risk from being moved and if so, how did the Trust focus on their needs? SW advised that efforts were made not to move those with complex issues. However, this could prove difficult when certain bed spaces were required, with many changes occurring out of hours. AW highlighted that the patient's daughter was knowledgeable and proactive. If she was having issues, what would happen to someone who was not? Was there a more systematic way of contacting families to ensure they are involved? SW advised that the Trust did have processes in place, including a carer's package, with an identity badge and wards worked hard to ensure family members could remain with the patient. CS asked if a single point of contact could be identified at arrival stage? RG advised that consideration would need to be given to ensure such a person was able to discharge that duty. It should be the consultant and therefore getting the patient to the right ward was important. PZR acknowledged the difficult diagnosis, but stated how different the situation would have been if the communication had been right. He queried how feedback on such cases was provided. RG advised that the Trust participated in the Friends and Family Test, providing an opportunity for feedback. For doctors, the General Medical Council had a more formal arrangement.	**RG**

	PZR asked how this could be actioned in real time. RG advised that the answer was unknown at this stage. PZR stated that real time feedback was more powerful and asked that some thought be given to how this might be achieved. AJ referred to another patient story of a family unprepared for an end-of-life diagnosis and believed the issue was about recognising and informing. This was a difficult time for both family and patient and the issue did not appear to be ending. EC advised that some of the problem was about provision of feedback. Training in the context of not doing the job was ineffective; a way had to be found to provide people with insight. SW stressed the need to make staff less anxious about such conversations. PW advised of an electronic tool, produced by the system, in collaboration with the local hospice. This asks families and carers to share their experience. Examples of good conversations will be shared across the system to enable learning. Implementation is anticipated in July/August 2025. NC acknowledged that sometimes the Trust did not perform as well when there was an unusual diagnosis and queried how team reflection could be enabled, as per safety incidents. NC believed the Trust's digital strategy and priorities should reflect communication with families. This was not an immediate solution. However, through the patient portal and electronic patient record, there could be the ability to nominate another person to have access such as a family member/carer. Consideration should be given to the strategy in terms of patient records and access. **Action: CEO and Chair to use discussion on this item to consider how to progress and prioritise end of life discussions and ward moves.** The Board offered its sincere thanks to the daughter for her feedback.	**JC/EC**
1.7	**CEO Report**	
	Ewen Cameron (EC), CEO, presented the report. An improvement in Urgent and Emergency Care (UEC) performance was noted. A fantastic achievement and recognition of the significant contribution from staff. TD highlighted the impact of the Community Diagnostic Centre on reducing waiting times. TD queried the understanding on turnaround times. NC advised that not all were where the Trust wanted to be and this was an area of focus and discussed at the weekly Senior Operations Meeting, with an emphasis on diagnostic and elective performance.	

2.0 STRATEGY		
2.1	**WSFT Strategy**	
	Sam Tappenden (ST), Director of Strategy & Transformation provided an update. Staff engagement with the strategy commenced on 19 May 2025 and 60 responses have thus far been received. It is planned to use June's Board Workshop for development and the refreshed strategy to come to July's Board Meeting. JC referred to the NHS 10-year plan, which is yet to be published and queried whether this would be ready for June's development session. ST hoped the plan would be ready by then but accepted that if not it may delay the strategy development. JR suggested the Government's Spending Review, due to be published on 11 June 2025, may be more pertinent. AW expressed concern at the timescale and impact of the Sustainability Review. AW queried whether it would be more appropriate to wait until the Autumn when there would be a greater understanding of the external environment and staff would be in a better place. ST suggested it was a perennial challenge to find the right time and believed that was now. The organisation needed clarity of focus. TD shared the concerns, querying whether dialogue with stakeholders should be extended in order to allow feedback up until the July Board, with a second round prior to sign-off in September. AJ queried communication of the future direction with staff, having anticipated difficult decisions being made prior to going out to engagement. This appeared a missed opportunity. ST advised that engagement had been sought on the tone and language of the 5 high level ambitions; what the Trust was doing well and what could be improved This was an opportunity for staff to have their say. ST is in discussions with Comms regarding interim feedback received. CS suggested thought be given to a more iterative process, even if not finalised, to give people a sense of alignment. **Action: ST to take comments from meeting, including iterative approach and consider how to come together, reverting to the Board with a plan.** PS enquired whether there would be further engagement with the governors. ST advised he had met with the Lead Governor and had committed to doing so. **Action: ST and JC to develop governor engagement session.**	**ST** **ST/JC**
2.2	**Future System Board Report**	
	Ewen Cameron (EC), CEO, presented the report.	

	NC asked if the clinical and care strategy is being revised in light of suggested changes in accommodation. EC advised that this had not been fundamentally changed. RF enquired if the Trust drove selection of the contractor. EC advised that they would be procured centrally.	
2.3	**System Update/Alliance Report**	
	Peter Wightman (PW), West Suffolk Alliance Director, presented the report. Following the nationally proposed changes to the Integrated Care Board, it is anticipated that NHSE will direct on boundaries. Ed Garratt, CEO and Will Pope, Chair, of SNEE ICB, have also been appointed as interim CEO and Chair for Norfolk & Waveney ICB. Dr. Frankie Swords has been appointed as Executive Medical Director for both, replacing Andrew Kelso at SNEE. It was acknowledged that whilst this was a challenging time for staff, there were benefits from working with Norfolk & Waveney. JC asked, given the importance of the alliance, how this Trust could support PW. PW asked that focus remain on patient care and the benefits of integration. RG advised that at a meeting with general surgeons, working with Norfolk & Waveney was seen in a positive light. TD suggested it would be wise to become familiar with the ICB blueprint as there may be strategic opportunities for integrated providers to take on additional responsibilities and develop a different relationship. ST stressed the need to maintain patient focus and look at how relationships align. This was a good opportunity to take stock and look at the way the Trust works.	
2.4	**Digital Board Report**	
	Nicola Cottington (NC), Chief Operating Officer, presented the report. The department is undergoing a rigorous reprioritisation process, focussing on cyber security, patient engagement, clinical safety and management of Artificial Intelligence (AI). It was noted that the ICB has an AI strategy which the Trust is adapting for its own use. Interviews are being undertaken for the substantive appointment of the Chief Information Officer. AW referred to engagement scores for the patient portal and asked if they were of concern? NC advised that these were being looked at but was confident the Trust could improve upon people's use of the app.	

	RP requested detail on any issues with using the app, such as difficulty with logging in. NC advised that use of the app was discussed at the Digital Patient Steering Group in order to understand any barriers preventing use. PZR referred to clinical safety standards and the robust governance required for use of AI. NC advised that NHSE have a core standard setting out the requirements and the Trust ensures it is compliant with these. PZR suggested AI could be used for image reporting. NC agreed that this was something the Trust would like to do and in the current financial climate there were cost benefits in doing so. Ian Coe, Digital Clinical Safety Officer was looking at this.	
2.5	**Collaborative Oversight Group**	
	Sam Tappenden (ST), Director of Strategy & Transformation, presented the report. Noted following the Sustainability Review, the Trust was taking stock of existing provider collaborative governance arrangements. A joint productivity board is to be set up. AW asked if any learning had been gleaned from what had been achieved so far. ST advised there had been some good achievement and the Trust now has the opportunity to take stock and review arrangements to inform the future.	
3.0 ASSURANCE		
3.1	**IQPR Report**	
	Nicola Cottington (NC), Chief Operating Officer, presented the report. Learning from the Trust's successful reduction in the 12-hour length of stay and other UEC metrics is being shared with other organisations. Elective Access RTT has been reduced to 31 patients as at the end of March. Focus continues on this cohort. RP referred to annual appraisal rates, which at 87% was lower than required, advising that appraisal for doctors was mandated by the GMC and played an important part in revalidation. RP referred to the 13% without an appraisal and enquired how many fell in to the group without a legitimate reason for not engaging and asked if follow up and support were being undertaken. EC highlighted that the rates shown were for all staff and not just doctors. RG advised that doctors were able to defer appraisal for an unavoidable reason. The Revalidation Support Group identified and managed non-engagement by clinicians. It would be unusual for any issues with wellbeing to only be highlighted at appraisal stage. **Action: RG to provide detail on how many doctors included in the 13% of appraisals outstanding.** PZR asked how much of the ultrasound issue related to demand. Other trusts were reducing levels and he asked if this Trust could	**RG**

	do the same. NC stated that engagement with primary care is important, with work also able to be done internally. Some of the requirement was informed by NICE guidance. RG stated that ultrasound is under the most pressure, but was not unique to this Trust. A software tool has been rolled out that places evidence guidelines in the process request. However, evidence on effectiveness is difficult to obtain due to intellectual property rights. Nationally, the NHS is looking at how to manage gynae ultrasound. SW advised that the Patient Advice and Liaison Service was part of an ongoing consultation process and actions will be put in place to mitigate any impact.	
3.2	**Finance Report**	
	Jonathan Rowell (JR), Interim Chief Finance Officer, presented the report. Noted the Trust has agreed a planned income and expenditure deficit of £20.7m for the year and Month 1 has seen a good start. The pay position is being monitored, with no underlying issues noted. The Trust has a good understanding of its whole-time equivalents (WTE) and those posts capitalised last year are returning to revenue. Pay awards will need to be taken in to consideration. EC asked in terms of pay were accruals in line with pay awards. JR advised that the Trust had accrued 2.8% as per planning guidance. The Finance Team have been asked to calculate the risk following the increase in award. The Government's position is that it is within the NHS and no extra money will be provided. This is a potential risk. **Action: JR to update Insight Committee and July Board on pay award situation.**	**JR**
4.0 PEOPLE, CULTURE AND ORGANISATIONAL DEVELOPMENT		
4.1	**Involvement Committee Report**	
	Tracy Dowling, (TD) Non-executive Director, presented the report. Noted partial assurance on the National Staff Survey due to work required to understand results from directorates and divisions, together with ownership of actions.	
4.2	**People & OD Highlight Report**	
	Carol Steed (CS), Deputy Director of Workforce, presented the report. Noted a more central approach is being taken on the NHS Staff Survey. It was acknowledged that results had deteriorated this year. However, the National Quarterly PULSE Survey results detail a dip for other organisations too. Analysis and socialising of the final results have produced 5 key themes:	

	1. Health & Wellbeing 2. Speaking Up 3. Care of Patients 4. Recommend as a Place to Work 5. Leadership & Management Actions under each theme have been identified and taken to the Involvement and People & Culture Committees. Next steps will be to convert these in to a full action plan with ownership and timescales. Packs will be created with business partners for each division. JC asked if progress on the action plans will be monitored through the Involvement Committee. CS confirmed they would, together with the People & Culture Committee and Performance Management Reviews. NC referred to constrained resources in terms of action planning. Was the Trust aware of the areas that would have most impact? Equality Diversity and Inclusion (EDI) had performed poorly in the report. CS advised that this would take the form of what was achievable, together with impact and what the data is showing. Other items would be included as quick wins. NC highlighted that the Staff Survey Report did not mention discriminatory behaviour. TD referred to an excellent report on the EDI plan from Jamais Webb-Small received by the Involvement Committee. Noted sexual safety and associated equality issues are being looked at. TD requested a more conscious effort on the outcomes of protected characteristics. Was the Trust achieving these or demonstrating a level of bias? Noted Equality Impact Assessments were imbedded in the consultation processes being undertaken.	
4.2.2.	**Freedom to Speak Up Report Quarter 4**	
	Jane Sharland (JS), Freedom to Speak up Guardian, presented the report. The following themes were noted: • Impact of current financial constraints on staff, who suggest speaking up unlikely to change the situation. • Gender neutral toilets and changing facilities for trans and non-gender colleagues and patients. Affected colleagues advise they do not feel safe in either toilet (male or female). NC advised of a longer-term action for permanent signage. An immediate action is for the current accessible toilets to have an additional sign to designate as gender neutral.	

	RF asked if there was a full complement of FTSU Champions? JS advised that she was looking at the champion network, to increase not only numbers, but diversity. AJ asked what Board members could do to encourage speaking up? JS responded being out in the organisation, refreshing the message. JC suggested this was a suitable question to pose in 15 Step Visits to wards. JC asked if staff were aware of how to raise any concerns? JS advised that Comms had run a doorstep survey of wards in this regard and 82% advised that they would feel confident in speaking up. EC reported that executives were trying to mitigate the financial situation on a daily basis and it was not always possible to directly address all concerns raised. However, staff concerns were recognised. TD referred to the theme relating to formal consultation. Had the Trust taken the opportunity to gain feedback from the staff involved? NC advised that HR business partners were sharing learning. As a personal reflection, NC thought it was less about policy and more about how to carry out the process and the language used to ensure staff's understanding. JR referred to learning from the financial services consultation, where use of a dedicated email address for receipt of questions had been helpful.	
5.0 OPERATIONS, FINANE AND CORPRATE RISK		
5.1	**Insight Committee Report**	
	The report was taken as read.	
6.0 QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT		
6.1	**Improvement Committee Report**	
	Roger Petter, (RP) Non-executive Director presented the report. Noted for Summary Hospital-level Mortality Data (SHMI), the Trust was one of the best performers in the country and the best in region.	
6.2	**Quality and Nurse Staffing Report**	
	Sue Wilkinson, (SW) Chief Nurse, presented the report. The Trust continues to see an improvement in staff sickness and fill rates. A review of Care Hours Per Patient Day (CHPPD) data has revealed an inaccuracy over the last five months that has been corrected. The Trust remained within the lower quartile for this period. This is to be expected for the time of year, due to additional beds being open. NHSE have contacted Trusts regarding substantive posts for qualifying nursing students. Plans are already in place to enable this, with the holding of vacant posts for this cohort and those under redeployment.	

	EC referred to fill rates of 77% at night for one of the wards. SW advised that this was a small ward and only ever rostered to have two Registered General Nurses (RGN) at night. If one of these was called away for a short period of time, it would affect the fill rate. Mitigations are in place for backfill or to provide break cover. JR highlighted the national management of sickness and special leave and queried whether the Trust was looking at other leave as an area of focus? SW advised that the Nursing Deployment Group looked at rostering and there was a robust process in place. PW queried the Trust's understanding for what was driving the demand on community nursing. SW reported that this related to enhanced discharge. More complex patients were being received in to the community. EC suggested this could not have happened overnight. SW advised that a new nursing tool was being used, which will audit existing demand and nursing care hours in order to provide data on suggested nursing establishment requirements. Once this audit is complete an update will come to Board through the Quality and Nurse Staffing Report. NC queried the reduction in neonatal fill rates in April 2025. SW believed this to be an anomaly and suggested an increase in care staff may have mitigated this. **Action: SW to confirm reasons for reduction in neonatal fill rates for April.**	**SW**
6.3	**Maternity Services Report**	
	Karen Newbury, (KN) Associate Director of Midwifery, Kate Croissant, (KC) Clinical Director for Women Children and Simon Taylor, (ST) Associate Director of Operations for Women & Children and Clinical Support Services were in attendance to present the report. Noted under Section 3.2 – Maternity and Neonatal Safety Investigations (MNSI) Report – Q4 1st January 205 – 31st March 2025, the missing number of incidents reported was one. KC reported that the department was prioritising training. As part of this work, consideration was being given to ability to deliver with less impact on clinical care. PZR asked if training was mandatory. KN advised it was, forming part of the core competency framework. Efficiencies were being investigated. The intention was that all staff would be competent by year end. EC highlighted that all those detailed as red or amber were doctors and asked how the Trust could make it as easy as possible for this cohort to complete their training. KN advised that this has been reviewed and the department is trying to get as many elements completed in a day as possible. The majority of junior doctors were on rotation, but would achieve 100% of the most important training.	

	NC referred to the internationally educated midwives and issues raised, asking if there was anything the Trust needed to do as a result? KN responded that the majority of these midwives, if spoken to, would say there were difficulties. Initially there was not a culture of speaking up for this cohort. The department now has its own EDI lead to assist in making people feel comfortable and heard. This was in the initial stages. TD requested further detail on the impact of service user feedback. KN advised that this was an average response. KN felt that completion of the Friends and Family Test was often difficult for someone who had just had a baby to complete, but this was not the only form of feedback which included Healthwatch Suffolk and the National Maternity Voice Partnership (NMVP).	
7.0 GOVERNANCE		
7.1	**Charitable Funds Committee Report**	
	Jonathan Rowell (JR), Interim Chief Finance Officer and Richard Flatman (RF), Non-executive Director presented the report. Noted no matters for escalation. Further noted the appointment of the new Head of Fundraising, Joanne Landucci.	
7.2	**Board Assurance Framework**	
	Pooja Sharma, Deputy Trust Secretary, presented the report. Noted a Board Workshop will be arranged for the Autumn to look at the strategy refresh and renewed BAF template. RF queried whether the staff risk was picked up in the Involvement Committee. TD advised this was being reviewed at the July meeting. JR referred to BAF 6 (Estates) and queried whether it was appropriate for this to go to the Future System Board. Agreed this should be amended to Insight Committee in time for their next meeting. Noted Interim Head of Estates to be invited to attend. **Action: Amend Board Committee for BAF 6 to Insight Committee and invite Head of Estates to join the meeting.** PZR highlighted that cyber security had not been included specifically in the risk detail. NC advised this was covered by the term digital.	**MD/PS/AJ**
7.3	**AuditOne Recommendation – Progress Report**	
	Pooja Sharma (PS), Deputy Trust Secretary, presented the report. Noted RSM have reviewed the recommendation as part of its Well Led Audit. Following suggestions made, a column will be added to detail the check and challenge taking place at the Management Executive Group (MEG). The final report will be reviewed by the Audit Committee in June. An update on final actions will come to Board.	

	The Board were asked if a further standalone report was required, or if further updates could be provided through the CKI process. **The Board gave its agreement for further updates via the Improvement Committee, with escalation of items to Board.** AJ referred to a discussion at the March Board Meeting on impactful challenge at Board level and holding executives to account. AJ was of the understanding that a facilitated session was to be conducted on what a unitary board is. EC suggested training was not a measure of holding to account. Regrettably, the current situation meant limited time within the board development calendar to action. AJ stressed the need for some understanding of how effective the Board was other than through appraisal. AJ felt there was work to be done collectively on how the Board worked together during difficult times. NC stated that training on holding to account and exec to exec challenge was as vital as any of the Board Workshop sessions and should be prioritised. EC responded that things had changed since the review and exec-to-exec challenge had increased. **Action: JC to look at forward plan for Board Development Workshops and include session on unitary board.** **Action: Action points to be reviewed by JC, PS and TD.**	**JC** **JC/PS/TD**
7.4	**Governance Report**	
	Pooja Sharma (PS), Deputy Trust Secretary, presented the report. Following approval at the Council of Governors' Meeting on 14 May 2025, Board approval was sought for agreement to amend the Trust's Constitution to reflect a change in the term of office for the Lead Governor of three years, extending until **two years** (previously one year) after governor elections. This was in order to allow newly elected governors time to gain more experience and confidence to vote or stand for the role. The same principle will apply to the Deputy Lead Governor. Legal advice has been sought from the Trust's solicitor. **The Board gave its approval to the amendment to the Constitution, subject to receipt of legal confirmation.**	
8.0 OTHER ITEMS		
8.1	**Any Other Business**	
	Sue Wilkinson, Chief Nurse – the Board offered its sincere thanks to SW on her last Board Meeting, following her decision to retire at the end of July. It was agreed that SW had made a significant contribution to the Trust, having been an outstanding advocate for both patients and Staff. SW would be greatly missed.	

8.2	**Reflections on meeting**	
	TD – Today's patient story was very difficult to hear. The length of time spent discussing demonstrated perfectly why it should come to this meeting. The actions taken from it will ensure the impact is not lost. CS – whilst recognising the importance of hearing these stories, some advance warning of the content may be helpful.	
8.3	**Date of next meeting** 25 July, 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
3140	Open	23/5/25	2.1	**WSFT Strategy** - take comments from meeting, including iterative approach and consider how to come together, reverting to the Board with a plan.	**Strategy engagement work almost complete, survey results analysed, staff focus groups held and development of the public document has commenced. Further update to be provided at today's (25.7.25) meeting.**	ST	25/07/25	Green	
3141	Open	23/5/25	2.1	**WSFT Strategy** - Develop Governor Engagement session.	**Date being sourced via Foundation Trust Office.**	ST/JC	25/07/25	Green	
3146	Open	23/5/25	7.3	**AuditOne Recommendation - Progress Report** - JC to look at forward plan for Board Development Workshops and include session on unitary board.	**Training on unitary boards planned to be undertaken at October Board Development Workshop.**	JC/PS	25/07/25	Green	
3147	Open	23/5/25	7.3	**AuditOne Recommendation - Progress Report** - Action points to be reviewed.	**Most appropriate process for reviewing action points currently under consideration.**	JC/PS/TD	25/07/25	Green	

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. Report has gone to Insight and will come to Board in July. **UEC report has been to Insight Committee on 18 June 2025. Today's CKI report refers.**	NC/AJ	~~28/03/2025~~ 25/07/2025	Complete	25/07/2025
3138	Open	23/5/25	1.6	**Patient Story** - Contact Director for Post Graduate Medical Education, to ensure learning from patient story is disseminated.	**Patient Story being presented at Grand Round on 9 July, 2025. Repeated advertising to be undertaken and session recorded and added to Totara for those unable to attend in person.**	RG	25/07/25	Complete	25/07/2025
3139	Open	23/5/25	1.6	**Patient Story** - use discussion on this item to consider how to progress and prioritise end of life discussions and ward moves.	**Covered through Trust Quality Priorities and Ambition, outlined in the Quality Report and will be monitored via the Improvement Committee Workplan.**	JC/EC	25/07/25	Complete	25/07/2025
3142	Open	23/5/25	3.1	**IQPR Report** - Provide detail on how many doctors included in the 13% of appraisals outstanding.	**Medical appraisal rate for 24/5 was 97%.**	RG	25/07/25	Complete	25/07/2025
3143	Open	23/5/25	3.2	**Finance Report** - Interim Chief Finance Officer to update Insight Committee and July Board on pay award situation.	**Verbal update being given to Insight Committee on 16.7.25. Further verbal update to be provided at today's (25.7.25) meeting.**	JR	25/07/25	Complete	25/07/2025
3144	Open	23/5/25	6.2	**Quality and Nurse Staffing Report** - Chief Nurse to confirm reasons for reduction in neonatal fill rates for April.	**No concerns raised at Nursing & Midwifery Development Group in May. Any underfill in registered nurses is mitigated by additional nursing assistants, in keeping with Badger NET risk assessment. Staffing can flex with acuity and occupancy. Roster managers are reminded to remove shifts that are not required for filling or not required. The May fill rate is 96% for registered nurses in day, indicative of more accurate roster management**	SW/DS	25/07/25	Complete	25/07/2025
3145	Open	23/5/25	7.2	**Board Assurance Framework** - Amend Board Committee for BAF 6 to Insight Committee and invite Head of Estates to join the meeting.	**BAF Board Committee Amended. Item on Insight Agenda for meeting on 16 July. Head of Estates attending.**	MD/PS/AJ	25/07/25	Complete	25/07/2025

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

To Note

Presented by Jude Chin

1.6. Patient story

To Review

Presented by Daniel Spooner

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:	25 July 2025
Sponsor/executive lead:	Dr Ewen Cameron, chief executive
Report prepared by:	Dr Ewen Cameron, chief executive Sam Green, communications manager (acting) Anna Hollis, deputy head of communications Greg Bowker, head of communications

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

Executive Summary
WHAT? *Summary of issue, including evaluation of the validity the data/information*
This report summarises the main headlines for July 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

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

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

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

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

Performance

Finance

At the end of June, our reported position in-year was a £8.2m deficit, which is £0.6m better than planned. There has been an enormous effort from colleagues to help reduce the deficit, and significant progress made so far this year, with a positive reduction in our underlying run rate.

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

Elective recovery

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

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

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

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

We are currently rated as Tier 2 for how well we are doing with planned (elective) care meaning NHS England regional oversight and monitoring against recovery plans.

Urgent and emergency care

Our performance against the 4-hour standard was 71.4% in June, which is below the 78% target, but remains higher than our performance in the first two months of 2025. While this is a dip from March, April and May, we have seen record attendances in our emergency department. Following a significant transformation project to improve patient flow throughout the organisation, I am confident we have the right measures in place to sustain the improvements that have helped ensure more patients are receiving the care they need as quickly as possible.

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

Cancer

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

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

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

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

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

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

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

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

Quality

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Workforce

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

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

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

Future

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

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

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

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

2. STRATEGY

2.1. WSFT Strategy (ATTACHED)

For Approval

Presented by Ewen Cameron

Public Board	
Report title:	Trust Strategy Refresh Update
Agenda item:	2.1
Date of the meeting:	25th July 2025
Lead:	Sam Tappenden Executive Director of Strategy and Transformation
Report prepared by:	Sam Tappenden

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, summarise engagement to date, and outline the next steps.
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, review all feedback received, and complete the drafting and design work for the final strategy document.
Recommendation / action required
• To formally approve the refreshed strategy in September's Board. • To launch the strategy at the Annual Member's Meeting.

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 Public Board
Date: 25 July 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'.

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:

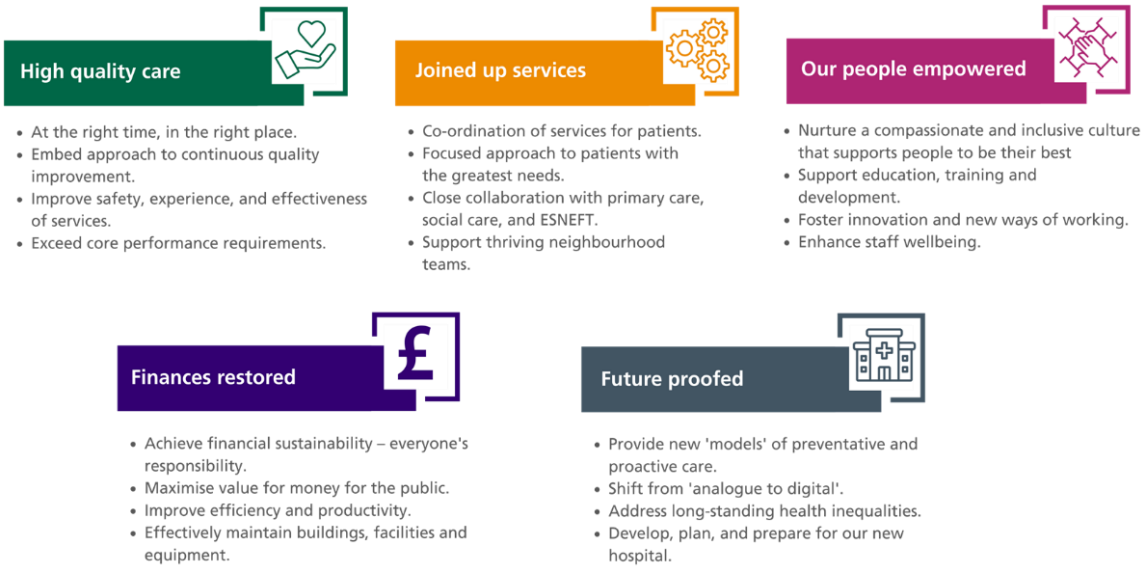
- The NHS 10-Year Health Plan which was published in July 2025.
- The sharp focus on planning guidance on financial sustainability, waiting list recovery, and productivity.
- The Suffolk and North East Essex (SNEE) Sustainability Review, which has now concluded.
- Accelerated local government devolution in Suffolk.
- The abolition of NHS England (NHSE), and considerable workforce reductions in Integrated Care Boards (ICBs), and the forthcoming merger of Suffolk's and Norfolk's 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. A high-level visual of **five draft ambitions and the priorities** that sit alongside them were distributed as part of our engagement activities.

4.2. The visual provided 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.

Figure 1: draft ambitions for testing with stakeholders



5. Engagement and development

5.1. To date the Trust has received more than 200 responses to its strategy feedback survey, held three focus groups, received feedback from staff networks and some patient groups.

5.2. The Board held a development session in June to further progress the strategy, work has started to draft the strategy document and develop the design of supporting visuals.

5.3. All feedback received is being analysed and will inform the development of the future strategy, including our vision, mission, ambitions, and priorities.

6. Updated timescales

6.1. While good progress has been made to develop the strategy, there have been delays owing to extending engagement deadlines, team capacity, and the later-than-anticipated launch of the 10-Year Plan.

6.2. We are now anticipating the strategy to be completed by the end of August, to be approved by Board in September, and be formally launched at the Annual Members Meeting.

7. Next steps

7.1. Complete all engagement work, review all feedback received, and complete draft and design of the strategy and supporting documents.

8. Recommendations

8.1. To approve the refreshed strategy in September's Board.

8.2. To launch the strategy at the Annual Member's Meeting.

2.2. Future System board report (ATTACHED)

To Assure

Presented by Ewen Cameron

Trust Board	
Report title:	Future System Board Report
Agenda item:	2.2
Date of the meeting:	July 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 previously reported, 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:

The project team have now completed two detailed design reviews with the National New Hospital Programme team:

1) **Affordability Review** – this work focussed on defining a schedule of accommodation[2] that can be delivered within the prescribed capital budget whilst complying with; the H2.0 clinical briefs,

[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.
[2] A "schedule of accommodation" refers to numbers of rooms (per type of room) required and the size of each room.

the project's demand modelling and the Trust's clinical and care strategy. This work has been completed and agreed with both the national NHP team and the Trust's Executive Programme Board. The resultant scale of the new hospital extends to 94,186k sqm with 4,645 sqm of retained estate being refurbished.

2) **Massing and Stacking Review**[3] – Having agreed a schedule; the next step was to provide a high-level set of drawings that show how the various rooms and department with be positioned and how they will interact with each other. This work has also been completed, reviewed and agreed.

- Next steps:

The clinical team from NHP will be visiting West Suffolk Hospital at the end of July to present the process and logic that has informed the standard H2.0 design to our own WSFT clinical teams.

Having agreed the massing and stacking our architects will now review our existing 1:500 level drawings and update them to reflect the latest compliant designs.

The 1:500 plans will provide a base upon which to then re-draw our 1:200 plans and re-issue a fully complaint and affordable RIBA2 report in October 2025.

Project Plan

The snap-shot project plan remains current and illustrates how we remain on track to complete the re-drawing of the RIBA 2 designs in October. Once RIBA2 is agreed, we will progress to the next level of design detail (RIBA 3[4]).

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

RIBA 3 is a key step to completing the final stage of our planning permission, known as Reserved Matters"[5] , which must start by 1st May 2026, and which will culminate with the award of full planning permission.

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 RIBA 4 design phase (allowing early engagement) and the writing of the final business case.

The East of England is unique due to being theonly region that is building seven new hospitals and a nuclear power station (Sizewell C). These projects will clearly create an unprecedented demand for skilled construction workers. With this in mind, WSFT have supported a bid by West Suffolk College to

[3] Massing and Stacking refers to a high level design that positions the rooms identified within the schedule of accommodation next to each other and maps out how the different blocks will fit together and interoperate.
[4] 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.
[5] Reserved Matters refer to specific aspects of a development proposal that were intentionally left out of our outline planning application and that are subject to a separate, later, application for full planning.

become a Construction Education Centre of Excellence. A successful bid will provide funding for the creation of new training courses and the development of the skills we need for the realisation of our plans.

Commercial Progress

Having previously considered the terms and conditions that will underpin how Trust, the Programme and the Construction Partner will work together the Board has now formally executed the H2.0 Alliance Agreement[6].

Transformation

Claire Lovett has now joined the WSFT team in the capacity of Assistant Director of Transformation. In this role Claire will be lending support to the implementation of the clinical and care strategy and target operating models upon which the new hospital design has been based.

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 RIBA 3) 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 assumption 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. The ongoing operational affordability of the new hospital (and any new hospital in the new hospital scheme) has been discussed nationally with the leaders of the recently combined NHSE / DOHSC leadership team, we await the outcome of these discussions.

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

- Use the agreed massing and stacking design to produce revised 1:200 layouts.
- Commence RIBA3 design (September 2025).
- Transformation – continue plans for the delivery of the Clinical and Care Strategy and target operating models.
- 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.

[6] Note: The commercially sensitive nature of the agreement has been considered in detail by the Executive Programme Board and WSFT are the first Trust in the Country to execute this agreement.

Previously considered by:	Public Board, Scheme Executive Programme Board
Risk and assurance:	The strategy for a new hospital is being developed in line with NHS 10-year Plan, ICB Forward Plan, NHP H2.0 design and WSFT Clinical and Care Strategy. The primary risks are associated with time, capital and operational affordability and aligning optimal design with the need to transform.
Equality, Diversity and Inclusion:	The design and assurance process has been based on an ongoing strategic principle of co-production.
Sustainability:	The design and business case reflect and support the outputs from the recent ICB sustainability review. The associated plans for transformation will ensure the target operating model of the Trust is sustainable.
Legal and regulatory context	The project is underpinned by the terms of NHP Alliance Agreement.

2.3. System Update/Alliance Report - SNEE Integrated Care Board (ICB); Wider System Collaboration (ATTACHED)

To Assure

Presented by Peter Wightman and Clement Mawoyo

Committee	
Report title:	**West Suffolk Alliance Update**
Agenda item:	2.3
Date of the meeting:	25 July 2025
Sponsor/executive lead:	Peter Wightman – Director West Suffolk Alliance
Report prepared by:	C King/M Shorter/P Wightman

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 paper provides a summary of the key items of business for West Suffolk Alliance for the Committee meetings held 13 May *and 10 June* (*nb no meeting was held in April 2025)*
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
Board members are asked to note progress identified and risks associated with the changes to the ICB
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed up (evidence impact of action)*
Actions are managed through the Alliance Committee process
Action Required
Note the report

Risk and assurance:	1. Risks due to the imminent changes to the ICB function and structure. 2. Continued higher levels of demand in Neurodiversity assessment remain above the ability to respond effectively across Children and Young Peoples' work. Designated additional funding in place to respond to the backlog
Equality, Diversity and Inclusion:	Health Inequalities is reported to the HIPPC Committee in the ICB, but programme is underway with interim evaluation to be presented to HIPPC in July. Clear links to reducing health inequalities in all programmes

Sustainability:	Sustainability Impact Assessments in place for all newly commissioned services and transformation workstreams – governance held in the ICB.
Legal and regulatory context	Governance held within the ICB, this report is for information to the Trust

West Suffolk Alliance Committee report	
1.	**Introduction**
1.1	**West Suffolk Alliance Update including Committee meetings held 13 May 2025 and 10 June 2025**
	Key themes
2.	**Start Well**
2.1	**Neuro-diversity update** - Alliance partners fed back concerns regarding access to NHS services for diagnostic of potential neuro-diverse disorders (NDD) young people. Alliance noted following updates from ICB team: - SNEE ICB has designated additional funding in 2025/26 for Autism (ASD) and attention deficit hyperactivity disorder (ADHD) to support backlog of screening to include new care coordinator roles to support Children and Young People's (CYP)/families based in provider services. ASD and ADHD procurement has gone live with contract to begin in November 2025. This will support CYP after screening has been completed, and children are awaiting assessment. - Confirmed funding agreed for new online referral system that will be developed to digitally-capture referral information thereby enabling greater access for parents to review progress/ reduce enquiries to services for update of child's progress. - Waiting times of 22 weeks at WSFT are noted although the longest wait has decreased from 93 weeks down to 58 weeks. NSFT has seen an increase in both average and long waiting times.
3.	**Be Well and Health Inequalities**
3.1	**Physical activity strategic leadership group** has enabled ICB and Councils to combine their different funding streams into a single contract for Abbeycroft, which ensures continuation of the Exercise on Referral Pathway (previously funded by WSFT). This service will also include the waiting well programme. Further discussion with Abbeycroft is to take place to adapt the programme to meet commissioner needs **Sport England project in Lakenheath was progressing well with an** outcome by September 2025 to release the final part of funding. **PHM database live again:** The Public Health management (PHM) dashboard has now been restarted following conclusion of GO collective action. This now ensures a comprehensive dataset is available across the health domains.
4	**Age Well**
4.1	**Community services contracting update** - Noted Suffolk Community health service contract for adults and children is due to reach the end of its 10-year term in October 2027. The ICB is working with partners to understand future requirements including: "future shift" ambition for proactive frailty management in the community; integration with primary care, social care and VCFSE. It is aimed to have a view by Autumn 2025 which will feed into the wider ICB on future contract direction. **Care Homes support team update -** The Committee noted the WSFT decision to build care homes support into the work of INTs rather than to operate a separate team. INTs will continue higher support/monitoring for homes where there is greatest challenge.

	Home First Reablement – Noted a significant reduction in care hours with 55% of individuals fully reabled and not requiring ongoing care; plus decreases Accident & Emergency attendances. The service is seen as a key contributor to the strong discharge performance in West Suffolk. **Better Care Fund – Discharge funding** A report on forecast outturn for schemes for 2024/25 and plans for 2025/26 was given. Underspends arising from delays in delivery have been used to support spot purchasing of community beds at peak times and to support SNEE ICS financial position. **The committee agreed with** the proposed schemes for 2025/26 which are primarily a continuation of services commissioned in 2024/25 based on evaluation. **Level 1 falls service –** committee approved a recommendation to end the current separate service and incorporate this into the INT service. This was based on an evaluation of the service after 12 months and strategy to consolidate community services in INT teams. **Adult Social Care** A strategic overview entitled "People at the Heart of Care" focusing on independence, quality, sustainability, and people's voices was provided. Future priorities involve redesigning the Tier 1 model, enhancing therapy-led reablement, and increasing the use of direct payments. - NSFT to link with Social Care and the Alliance in the wider context to support the Mental health beds. It was noted that positive outcomes were observed in Haverhill, specifically the joint working with the INT and Social Workers joining the Practice MDT. - An event was held in **Haverhill on 1 July** Supporting and Empowering the Carers of Elderly People 10am – 2pm coordinated by the Patient Participation Group. - Continued Alliance work is being undertaken around High Intensity Users (HIU) with social prescribers being instrumental in supporting this. Learnings are to be shared
5	**Stay Well**
	Urgent and Emergency Care - UEC performance notes some key achievements: - Accident & Emergency performance (people seen within 4 hours) achieved an annual average of 74% and 88% in March. A WSFT Case study was requested by NHSE as WSFT is 4th nationally against performance measures. West Suffolk discharge performance has been a key contribution to this. - Virtual ward average occupancy throughout 24/25 was 74% against a monthly target of 80%. - The Operational model for Emergency Village is expected to be fully established in Q1 – 25/26. - Minor Emergency Care Unit (MECU) is fully implemented **Elective Care:** - WSFT achieved 5% Patient Initiated follow-up in 2024/25 (up from 3.8%). - Diabetes 8 care processes delivery is better than the national average. - Trust reducing hospital waiting times to national target levels
4.	**Die Well**
4.1	- Virtual ward for palliative and End of Life (EoL) care is now successfully integrated and is part of business-as-usual operations for all six integrated neighbourhood teams. - The Compassionate Communities Initiative (CCI) is being developed across Suffolk with workshops planned in Haverhill and Forest Heath Primary Care Networks (PCN's). - Waveney is to be included to ensure a single charter for all of Suffolk.

	- My Care Choices is in the implementation stage for West Suffolk and will enable the system to accurately record choices for patients approaching the end of life, as well as enabling data collation to support future commissioning decisions. - Commissioning issue with Norfolk and Waveney ICB resolved with regards to Thetford population accessing St Nicholas hospice.
5.	**Workforce**
5.1	Noted a hands-on Science, Technology, Engineering Arts and Maths (STEAM) Expo event is planned for Chantry School Ipswich on 1 July includes some of the "West Schools". It's planned to work with West Suffolk College (WSC)/Eastern Education Group (EEG) to replicate the event in West Suffolk. The biggest challenge for school attendance is the cost of transport across the County.
6.	**Health Equity update**
6.1	- Bury St Edmunds – noted PCN teams has contacted residents with history of smoking resident in higher need postcodes. The Primary Care Network (PCN) noted limited impact on the standard smoking cessation services. - Public health will work with alliance partners to support the smoking cessation challenge using new national funding allocations. - Involvement work continues with residents in Haverhill to determine optimum plan to tackle variation identified in PHM data.
7	**Locality updates**
7.i	- Mildenhall & Brandon community members joined the committee and provided an update. The dispersed nature of the locality was noted as a significant challenge. - Newmarket group updated and reported progress in some target areas. - Smoking is a particular challenge in both localities and public health. Suffolk are linking to follow-up on work that has taken place around smoking cessation and low Body Mass index within parts of the community.
8	**Haverhill growth planning**
8.1	- The committee noted proposals for use of s106 funds in Great Wilsey. - Committee agreed that the resources should be used for the benefit of the whole population of Haverhill and should support the healthcare model for the area which is to concentrate resources in current locations. - Partners would consider sessional use of the community centre for some functions. A further joint partner meeting is taking place on 30 June led by the Head of Alliance Development (HOA).
9	**Primary Care Update**
9.1	**Planning for growth** ICB teams have worked successfully with practices in localities with areas of high population growth to agree plans for premises changes to accommodate future growth. This enables access to ICB funding, national funding, and s106 or CIL resources to fund expansions. Growth is across the alliance with largest areas of growth in Bury St Edmunds, villages east of BSE (e.g. Thurston) and Haverhill. **Dementia diagnosis -** GPs noted continuing concern with regards to the long waiting times for dementia diagnosis in West Suffolk. This is driving rates and the need for recovery objectives to address capacity issues. GPs often refer patients privately. The Deputy Medical Director and Deputy Alliance Director will work with NSFT colleagues to progress this and bring an update on Dementia waiting times to the September Committee meeting**.** **Heath checks -** WSA has achieved 88% of annual health checks for people with learning disabilities, surpassing the national target of 75%.
7.	**Changes to ICBs and Local Government reform**
7.1	**ICB reform**

7.2	- Noted the move to Norfolk and Suffolk ICB and smaller ICB by April 2026 as part of national changes. It is noted that SNEE CEO is now also Interim CEO of Norfolk & Waveney ICB. - The Alliance Director emphasised that a firm commitment to Place and neighbourhood is expected to continue as a basis to ensure continuation of the west suffolk alliance model. - Partners recognised that this represents a significant challenge for ICB staff going through this change process. Partners noted the importance of maintaining focus on outcomes and organisational memory. - Committee members continue to offer full support to the West Suffolk Alliance. **Local Government Reform** - Norfolk and Suffolk new strategic Mayoral authority elections are scheduled for May 2026 - Options for Unitary authorities in Suffolk are being developed and will be the subject of national Government assessment in September 2025 and consult communities with final proposals to follow and outcome expected January 2026.
8.	**Further items**
8.i	**West Suffolk Alliance Delivery Plan** - The WSA ADP Closing report and WSA Delivery plan" were approved by Committee at the May 13 Committee meeting. **Reduction of Street Drinking in Bury St Edmunds** - Approval given by Committee 13 May meeting subject to clarity around "consent" from clients for GPs to provide information, to support the project which aims to reduce costs, improve outcomes, and address gaps with the help of the Alliance. The impact of street drinking, data usage, and the need for coordinated links with mental health, housing, and primary care were noted.
9.	**Next steps**
10.	**Conclusion**
11.	**Recommendations**
	Note the report

2.4. Digital Board Report (ATTACHED)

To Assure

Presented by Sarah Judge

Trust board - open	
Report title:	**Digital board report**
Agenda item:	2.4
Date of the meeting:	25 July 2025
Sponsor/executive lead:	Nicola Cottington, chief operating officer
Report prepared by:	Sarah Judge, chief information officer

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 board meets quarterly to receive assurance and reports on the digital programme. The digital programme this year has been prioritised to focus on the most urgent of projects. The prioritisation also underwent clinical review and quality impact assessment. As a follow-up piece of work, digital services has now put in place a 'design and prioritisation group' to ensure that all requests for new projects align with the strategic objectives of the Trust, as well as full engagement from clinical and operational colleagues, a focus on benefits delivery and funding.

Despite the prioritisation and staff changes within digital services, seven projects have been completed as well as three clinical system 'go-lives' or upgrades within June and July. These move into post-implementation support.

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

The focus on delivery of projects that have meaningful impact on our staff and patients as well as tangible benefits is essential. A re-focus to these principles has been extremely valuable and allows us to put in guard-rails to ensure all our digital programme is aligned with strategic priorities.

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

Additional communication around the new requesting process is being put in place to ensure that staff are able to see where to request our services. This includes project requests from other organisations and the ICS. This will reduce the reassignment of requests.

Action Required

The board is asked to note the update.

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	**Digital programme FY25/26** The digital programme was reviewed and prioritised in March/April 2025 in order to focus delivery of projects on four main areas: • Mandatory or compliance requirements • Urgent patient safety • Essential upgrades to maintain systems • CIP delivery We have completed seven of the prioritised projects since then and have an additional ten nearing completion. The implementations completed in May and June have received post-implementation support and benefits reviews before being handed over to their operational owners.
1.2	**Digital design and prioritisation group and 'front door process'** The digital design and prioritisation group (DDPG) has been established to review all new projects ("front door requests") and includes operational, clinical and technical input. We have reviewed any open requests made since January 2025 and are working through a backlog of decisions. So far the following decisions have been made: • Four requests have been already managed as business as usual (BAU) or existing project requests • Four requests have been reassigned to other processes as they are not projects • One duplicate removed • Two requests rejected as more information required and are returning for July's meeting for review DDPG has also taken some escalations of projects that are requested to be reprioritised. The content of the request forms is being revised as well as more robust processes being put in place to manage the 'front door'. Communications will be sent out as part of the publishing of the revised process.
1.3	**Governance updates** Alignment of the steering group terms of reference is underway, including alignment with those of Digital Board as part of our annual review.

	We continue to report the cyber hygiene report to the information governance steering group.
1.4	**Key go lives and deployments** **Astraia** On 7 July 2025, WSFT successfully went live with the Astraia Obstetrics module within the Obstetrics and Gynaecology department. This milestone marks a significant step forward in digitising maternity records, supporting safer, more efficient care through improved clinical documentation, standardised data capture, and enhanced reporting capabilities. The implementation was the result of close collaboration between clinical, digital, and operational teams, with little disruption to patient care. **Discharge summary** After a temporary delay following discussions with primary care colleagues, the transition to the revised method for creating discharge summaries commenced on 15 July. This work is in support of the wider quality improvement programme to improve the quality of communications at the point of discharge and assist the trust in meeting standards and contractual requirements. Any benefits achieved as part of the wider programme will be reported through the transfer of care group directly to the Improvement Committee. The digital services clinical support team have been providing at the elbow support since the go-live. **CareAware Migration to Oracle Cloud Infrastructure (OCI)** The digital services team has successfully completed the migration of CareAware services to Oracle Cloud Infrastructure (OCI), moving all Oracle Health (OH) devices off legacy on-premise systems. This is a key foundational step in preparation for the Millenium CSP (code upgrade), which is scheduled to commence next month. Migrating to the cloud will enable enhanced performance, streamlined service delivery, and significantly improved security capabilities, including more consistent patching, encryption, and monitoring compared to previous on-premise infrastructure. The migration scope included: • BMDI (Bedside Medical Device Integration) • WA (Vitals monitoring devices) • Capacity Management This project was delivered using a sprint-based approach and was completed successfully on time and within scope. The migration means we are ready for the upcoming CSP implementation and aligns with our broader strategic shift toward cloud-first, modern healthcare infrastructure.
1.5	**Windows 11 migration** Microsoft are to cease updates and security patches from October 2025 for Windows 10, requiring all NHS providers to transition to Windows 11 to ensure the continued protection of NHS systems and patient data. Our project to deploy Windows 11 is on track to deliver against this target, with 62% compliance achieved.
1.6	**Digital maturity assessment 2025** The digital maturity assessment (DMA) is a national benchmarking exercise that assesses digital maturity against NHS England's 'what good looks like' framework. The annual digital maturity assessment (DMA) for 2025 has now completed and the results are being ratified at present. We expect our results to be broadly in line with 2024's DMA and slightly above the national average. An assessment of our scores and the onward priorities will be assessed in the coming weeks.

1.7	**10 Year Health Plan for England** Following publication of the 10 year health plan on 3 July, digital services are assessing the impact, requirements and ambitions following the key shift from analogue to digital.
2	**Recommendations**
2.1	The board is asked to note the update from the digital programme.

Comfort Break

2.5. Joint Productivity Board (ATTACHED)

To Assure

Public Board	
Report title:	**Productivity Board Update**
Agenda item:	2.5
Date of the meeting:	15th July 2025
Executive 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*
On 14th July 2025 West Suffolk NHS Foundation Trust (WSFT) and East Suffolk and North East Essex Foundation Trust (ESNEFT) held the first Productivity Board. The purpose of this report is to provide Board with an update of the meeting and agreed next steps.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
The establishment of the joint WSFT-ESNEFT Productivity Board was one of the agreed recommendations from the Suffolk and North East Essex (SNEE) Sustainability Review. The purpose of the Productivity Board is to oversee the implementation of interventions to support the sustainability of acute and community services in SNEE.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
The Productivity Board will develop a prioritised work plan based on Sustainability Review recommendations, will review the previous Provider Collaborative arrangements, and will agree Senior Responsible Owners (SROs) for joint work programmes.
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 July 2025

1.	**Introduction**
1.1	The purpose of the Productivity Board is to oversee the implementation of interventions to support the sustainability of acute and community services in SNEE. The Productivity Board is jointly chaired by the chairs of both WSFT and ESNEFT respectively.
2.	**Progress update**
2.1	In the inaugural Productivity Board meeting on 14th July, the draft Terms of Reference (ToR) for the Productivity Board were reviewed, the scope of the Board's responsibilities were discussed, and the proposed work programme was outlined for comments. The Board reviewed proposed owners for the agreed Sustainability Review initiatives, agreed to review the previous Provider Collaborative arrangements, and agreed to consider the resources required to deliver the future work plan. The Board noted the ICB's paper regarding the agreed initiatives of the Sustainability Review, and will work closely with partners to ensure alignment in the delivery of those initiatives where close working is required, such as the Care Management Service.
3.	**Next steps**
3.1	The Productivity Board will hold monthly meetings to ensure the prioritised initiatives in scope are delivered with rigor and pace, will agree SROs for the initiatives to ensure accountability for delivery, and will review the resources required for delivery of agreed work programmes.
4.	**Recommendations**
4.1	The Board is asked to note the update from the inaugural Productivity Board and support its development to ensure the delivery of the agreed Sustainability Review initiatives.

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:	25 July 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 May 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?). The IQPR has been refreshed in line with the NHS 2025/6 priorities and operational planning guidance and a productivity section will be included in future reports. 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 improvement in all UEC metrics was sustained in April.

- 4-hour performance for May was 78.5%, which exceeded the in-month trajectory of 78% .
- Virtual ward occupancy is 55% in May against a target of 80%, representing unused capacity which would enable patients to be cared for at home rather than acute hospital. An improvement trajectory is in place and the service is focussing on developing step up pathways from primary care and the Early Intervention Team (EIT).
- Cancer Faster Diagnosis Standard (FDS) performance was 69.4% in April, below trajectory of 74.3%, as forecast last month, due to challenges in the breast service. 62-day performance exceeded the target but this will reduce in future months due to the underperformance of FDS for the early part of the breast pathway. Short term recovery actions are in place, with a comprehensive recovery proposal being presented to Management Executive Group on 23rd July.
- Diagnostic performance against the 6-week standard dropped to 43.8% in May 2025. The key areas of focus are ultrasound and endoscopy, with recovery papers being presented at Management Executive Group during June.
- There were 65 patients who had waited over 65 weeks for elective care at the end of May and the Trust is already behind trajectory on patients waiting over 52 weeks. A paper on dermatology recovery is being presented to Management Executive Group in June, additional validation of the waiting list is taking place and the operational teams are undertaking a "reset" to accelerate recovery to trajectory.
- The Trust is in "tier 2" for cancer, elective and diagnostic performance, with regional support and challenge to improve performance.
- The C-Difficile improvement programme has now moved into business as usual and will be monitored through the Improvement Committee.
- 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

Comfort Break

4. PEOPLE, CULTURE AND ORGANISATIONAL DEVELOPMENT

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

To Assure

Presented by Tracy Dowling

INVOLVEMENT COMMITTEE REPORT

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

Originating Committee: Involvement Committee			Reporting to: Trust Board		
Chaired by: Tracy Dowling Non-executive Director			Date of meeting:18th June 2025		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To MEG / other assurance committee **3.** To Board
				communications with staff. The annual staff survey and quarterly pulse surveys will be used to track trends.	
7.2	Staff story – what can we learn	2. Reasonable	Jenny Gatley presented her experience of working as a volunteer at WSFT for over ten years, initially on G4 then in End-of-Life Care	Feedback regarding pressures on nursing staff were acknowledged and will be followed up. The Freedom to Speak Up Guardian asked to visit the Blanketeers group.	1. No escalation
7.3	Workforce Health and Wellbeing Update	2. Reasonable	Actions were prioritised; assurance was given that return-to-work interviews are being conducted following sickness absence.	Recommendation to empower local teams and managers to own wellbeing actions rather than rely on HR interventions. This is a day-to-day managerial responsibility.	1. No escalation
7.4	Guardian of Safe Working Hours Report	4. Minimal	The report author was not able to attend, and the executive summary did not accord with the report content.	Julie Hull to meet with leads in advance of the next meeting where this item will be considered further	2. Escalated to Director of Workforce and communications.
7.5	Veterans Update	1. Substantial	The Veterans Aware accreditation plan and actions update was shared. Work is on track.	The action plan runs to October 2025. Philippa Lakins was thanked for her work on this important item.	1. No escalation

Originating Committee: Involvement Committee			Reporting to: Trust Board		
Chaired by: Tracy Dowling Non-executive Director			Date of meeting:18th June 2025		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To MEG / other assurance committee **3.** To Board
7.6	Statutory Mandatory Training Review Update	3. Partial	There is a national requirement to review statutory mandatory training. The only outstanding requirement is the completion of the training needs analysis.	A new national framework is due in Autumn 2025. This will provide clear guidance on role specific training requirements and governance expectations.	2. To MEG when work complete and then back to Involvement Committee
8.0	**First for the Future**				
8.1	Workforce Strategy / People Plan	3. Partial	Assurance received from Julie Hull that the Trust is actively reviewing its workforce strategy and people plan.	On forward plan for 6 months' time	1. No escalation
9.0	**First for patients**				
9.1	Experience of Care and Engagement Committee Report	1. Substantial	Update received on work to improve patient experience and engagement including: • Patient Equity Group fully established and meeting regularly. • Engagement team visited drop-in centre in Bury for homeless people to identify	Team exploring use of AI. Team invited to join the Trust stand at the Bury St Edmunds PRIDE event on 30th August 2025.	1. No escalation

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

*See guidance notes for more detail

Guidance notes

The practice of scrutiny and assurance

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

Freedom To Speak Up (FTSU) Report (ATTACHED)

To inform

Presented by Julie Hull

WSFT Board of Directors (Open)	
Report title:	**Freedom to Speak Up Quarter 1 2025-26**
Agenda item:	4.1
Date of the meeting:	25th July 2025
Sponsor/executive lead:	Julie Hull, Chief People Officer
Report prepared by:	Jane Sharland, Freedom to Speak Up Guardian

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 report summarises the data regarding concerns raised to the Freedom to Speak Up Guardian in Quarter 1 2025-2026, with comparison to previous quarters, and highlights themes identified from concerns raised. The report contains: 1. Data sent to NGO 2. Anonymous reporting – percentages and themes 3. Who is speaking up – by professional group 4. Themes identified, and learning and actions 5. Feedback on the FTSU experience 6. Actions to promote a speaking up culture within the organisation.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
The report ensures Board oversight of numbers and themes of concerns being raised via the FTSU service. It also assures the Board of ongoing work to promote and support a speaking up culture across the organisation, and compliance with NGO principles.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
Actions in response to the themes are included in section 4.
Action Required
The Trust Board is invited to note the themes identified and actions that have been taken.

Risk and assurance:	This work aims to support staff to speak up about any concerns in a psychologically safe way

Equality, Diversity and Inclusion:	All work towards promoting freedom to speak up aims to be fully inclusive.
Sustainability:	N/A
Legal and regulatory context	The current NHS England standard contract (5.10) requires all Trusts to appoint a Freedom to Speak Up Guardian and comply with the requirements of the National Guardian's Office.

Freedom to Speak Up: Guardian's Report Q1. 2025-26 April May June 2025

National Guardian's Office (NGO) future.

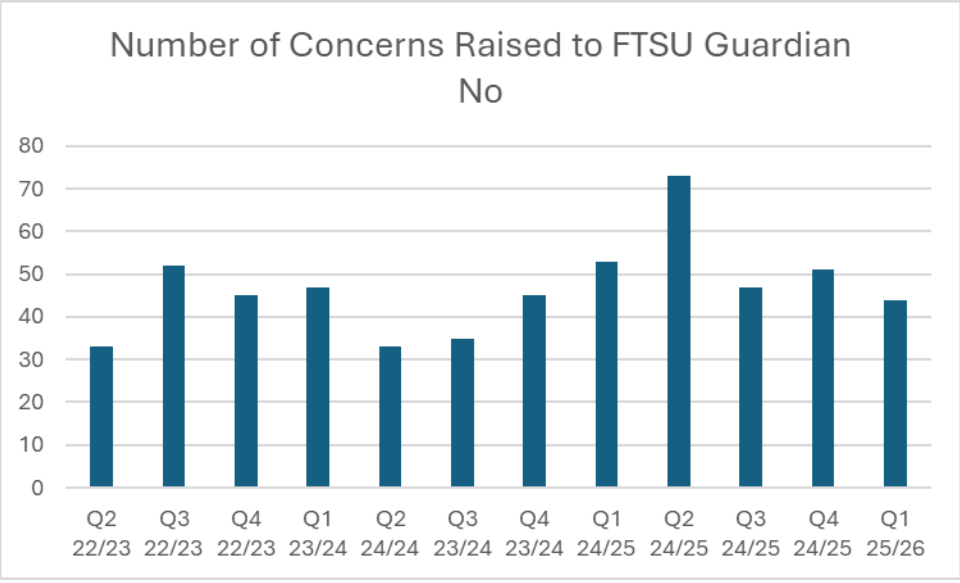
Following the announcement in the press regarding the future of the NGO, they put out the following statement:

We understand from the Department of Health and Social Care that the role of guardian will remain across the health service. It is the functions of National Guardian's Office that will be changing.
Our understanding is that the Government plans to align the functions of the National Guardian's Office with the other staff voice functions in NHS England and NHS England will take on the National Guardian's national functions. NHS England will transfer, in due course, to the Department of Health and Social Care.

Data for Quarter 1 will be submitted to the NGO portal as usual.

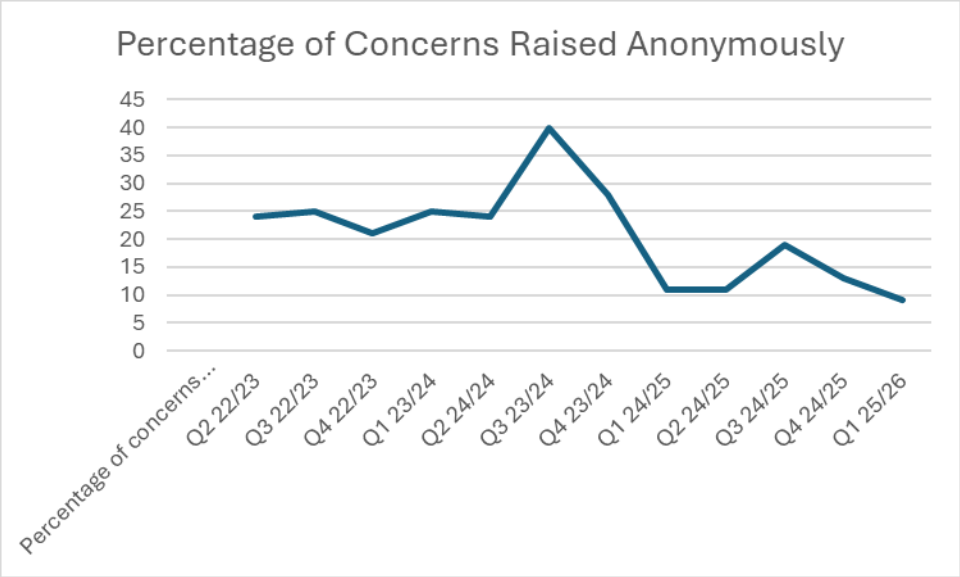
1. Data Sent to National Guardian's Office – Number of concerns

The number of concerns raised with the Guardian in Quarter 4 was 44. This is slightly below the average for the last 2 years (48).



Jane Sharland 14.5.25

2. Anonymous Reporting



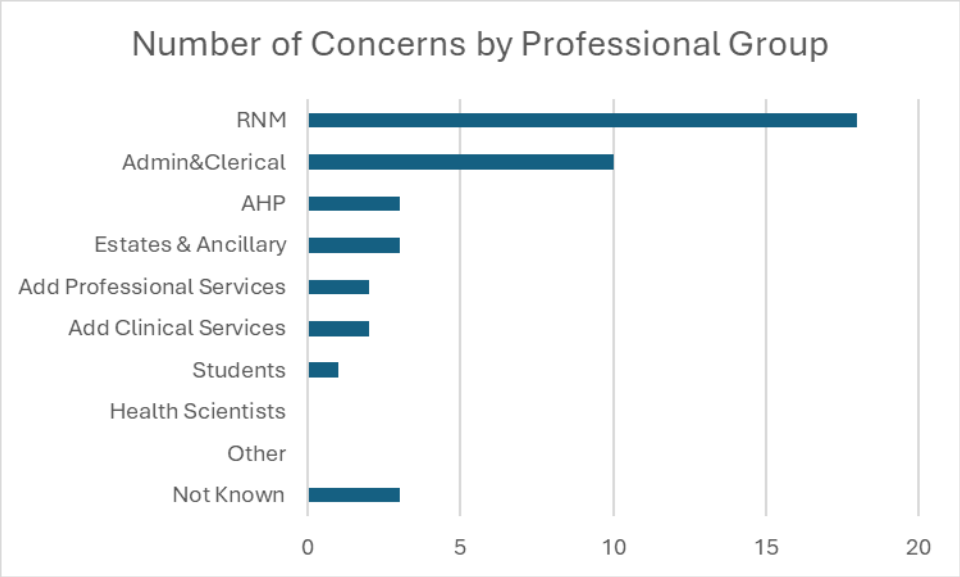
Whilst it is important to have an option for anonymous reporting, there are challenges in investigating anonymous cases due to limited information and the difficulty in providing feedback or support for those raising the concern.
A decision was made to remove the option for anonymous comments at the all staff update, but anonymous reporting option remains available via the Raising Concerns page of the Trust Intranet, or by letter to the Guardian ant the Education Centre In Quarter 1, there were 4 anonymous reports, with a percentage decrease from 13% last quarter, to 9%, showing a continuation of the relatively low level of anonymous reporting. The percentage of anonymous concerns is an indicator for how confident staff feel to speak up.

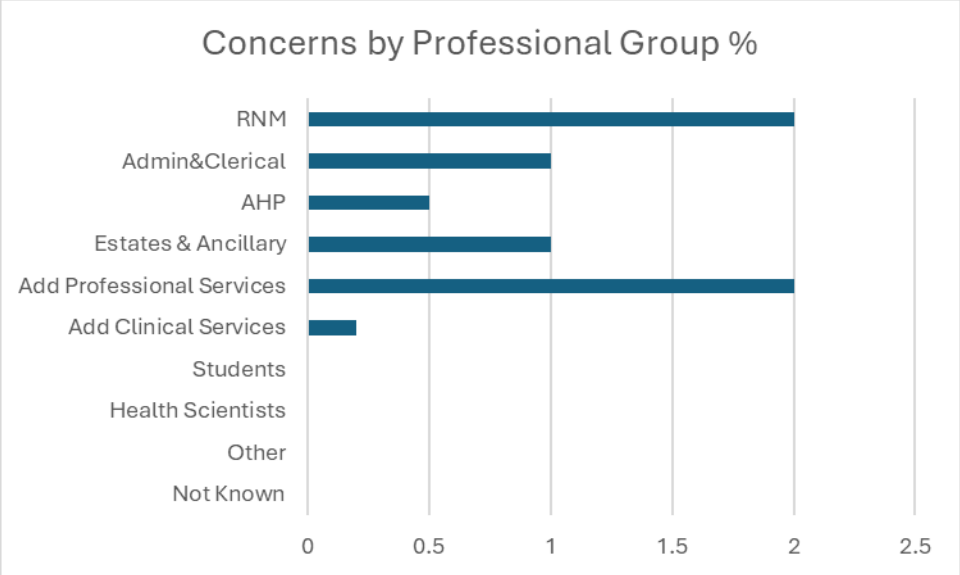
Anonymous reporting themes

These anonymous reports are taken seriously, and each one was investigated as far as possible. The subject of the 4 anonymous reports were the removal of anonymous comments from the All Staff Update, poor communication from management, concern that mandatory training still refers heavily to Covid (which could be triggering for some staff), and the increase in Patient Instigated Follow Up. (PIFU).

The Guardian, working with the Trust's Speak Up champions, continues to tackle barriers to speaking up (see Principles of FTSU below) 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 staff psychology team to understand barriers to speaking up highlighted in their work, and how to provide appropriate re-assurance.

3. Who is speaking up?

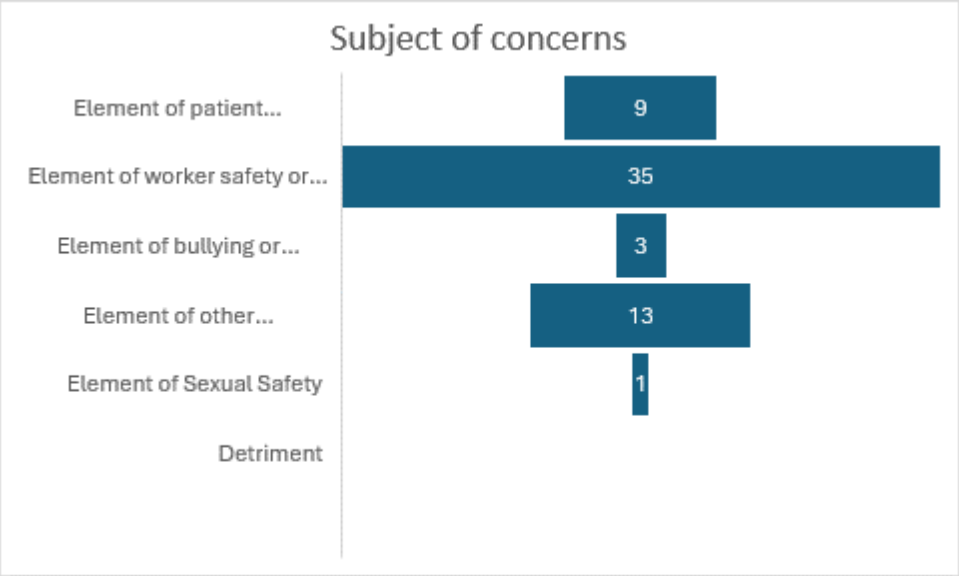




As always, the most concerns were raised by registered nurses and midwives, and looking at the percentages, this remains the highest reporting group this quarter.

What were people speaking up about?

Many cases involve an element of staff safety or wellbeing. Patient safety concerns comprised 20 percent of concerns raised, including staffing levels, PIFU, documentation and patient choice. 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. Themes from Q1. 2025/26, 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.

Sexual safety Concerns

One incidence concerning sexual safety was reported to the FTSU guardian this quarter. As part of the ongoing work of the Sexual Safety Working Group, to ensure compliance with the Sexual Safety Charter, Sexual safety - West Suffolk NHS Intranet (principle 10) all cases of a sexual nature will be collated with those raised through other routes.

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, and the effects of these demands on staff well-being. Includes concerns from Bank staff who have had their regular shifts reduced. Individual concerns have been escalated to the appropriate approval panel for their consideration.

Learning and Action: The effect of ongoing reductions in staffing on staff wellbeing is recognised.

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, as well as other wellbeing services on offer. This is being addressed by increased communications including the Wellbeing Toolkit poster.

Theme: MARS. Concerns were raised about the short timescale given for the MARS opportunity. Staff felt they were under pressure to make a decision.

Learning and Actions: Individuals were responded to personally to explain the reasoning behind the timescale i.e. to identify vacancies in a timely way that might be appropriate for re-deployment of staff whose roles were at risk following current restructures. This is opportunity could be offered again later in the year subject to regional and national approval.

Theme: Formal Consultations. People have spoken up again regarding formal consultations for re-structures. Issues this quarter that were highlighted were support for those at risk of redundancy in finding alternative roles or jobs outside the organisation, and communication via email.

Learning and Actions: Learning from previous quarters has been consolidated into improved processes especially around communication. 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. 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.

Theme: Partial Retirement. Several staff approached FTSU following their requests for partial retirement being turned down.

Learning and Actions: Staff were signposted to the Retirement Policy - West Suffolk NHS Intranet. In all cases the needs of the service and the effects of the loss of hours were taken into account when making the decision.

Theme: Smoking on Site Concerns regarding smoking on site were a frequent theme this quarter and have been in previous quarters. Smoking outside A&E and the main entrance, with smoke billowing up into wards above, and the many thousands of cigarette butts here and elsewhere on site have caused considerable distress.

Learning and Actions: In September 2024, the Trust signed the NHS Smoke Free Pledge. Following a great deal of research and discussion, the new Smoke-free - West Suffolk NHS Intranet Policy has recently been completed, approved and gone live on the Trust Intranet.

"This policy updates the previous Smoke Free Environment Policy in line with the most recent evidence, practice standards and government ambition to create a 'Smoke-free Generation' by 2030. The policy outlines how the Trust will promote and support a healthy environment free from tobacco use for all who use WSFT services, premises, or work at the Trust."

The policy includes support for staff to challenge smoking on site, providing information on where to direct smokers to off site smoking zones, or to smoking cessation support.

This policy will be followed up with the erection of strong messaging to deter smoking on site, plus communication to patients and staff via other means. The public health team will be conducting an evaluation to evidence behaviour change.

Theme: Bullying. The percentage of concerns where an element of bullying is mentioned has remained similar to last quarter at 7% (8% 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.

5. 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.

- Four responses were received to the FTSU feedback survey for Quarter 1. All respondents said they would speak up again.
- Free text comments and other feedback received verbally and via email was generally positive. Feedback taken from the form and email responses include:

"The guardian was easy to reach and was able to book me in quickly. She listened to me without judgement'

"When concerns were raised about a patient safety issue, the Freedom to Speak Up Guardian immediately took action, which was brilliant."

"The guardian was very approachable, and I felt my concerns were listened to and addressed."

6. **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.
- 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, and internal doorstep survey.**

- 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
- OOH shifts covered by FTSU Guardian in main site and Newmarket Community Hospital.

Next Steps:

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

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:.

- **We await further information from the NGO or NHS England regarding new channels for governance, data reporting and support for FTSU guardians. New processes will be adopted as required by NHSE/DHSC.**

References:

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

Putting You First (ATTACHED)

To inform

Presented by Julie Hull

NHS
West Suffolk
NHS Foundation Trust

Putting You First awards
April – July 2025 winners

Board of Directors: 25 July 2025

Putting you first

Rebecca Gildersleeves, nursing assistant, Sudbury community team

Nominated by Julie Lloyd, nursing assistant

Rebecca was on shift with me when I had a call from my husband who had had a stroke. Rebecca followed me home, took control of the situation, dealt with the paramedics and supported me through this traumatic time. She then sorted my house and dog, got essential items and then met me at the hospital after her shift. She spoke to the stroke team and supported both of us that evening. she took me home and made sure every day that we were ok and was always there whilst he remained in hospital for a week.

She is an example of kindness, compassion and keeping calm in stressful situations. She is a huge asset to the community team and west Suffolk. She gave me unwavering support when I needed it most.

Adel Khalifa, speciality doctor, cardiology

Nominated by Abigail Penn, assistant service manager

I would like to nominate Dr Adel Khalifa (Cardiology) for this award in recognition of the outstanding dedication and support he has consistently shown to the cardiology department.

He is an absolute asset to the Cardiology Department, going above and beyond to support both the service and his colleagues, particularly during challenging times. Nothing is ever too much trouble—he is always willing to step in and help in any way he can.

His professionalism, compassion, and unwavering commitment make a real difference to the team and the patients we care for. He is a powerful example of the values we should all uphold.

Louise Woolner, domestic department, Newmarket Community Hospital

Gillian Jeffrey, domestic department, Newmarket Community Hospital

Nominated by Angela Harvey, facilities officer

Louise and Gillian have put the patients first by coming in on days off and staying on past their shift in the domestics to ensure in patients on Rosemary ward here at NCH receive their evening meal.

Luke Nobbs and the WSH/NCH catering team

Nominated by Angela Harvey, facilities officer

Luke and his teams at WSH and NCH catering have ensured the patients here at NCH have received freshly cooked hot meals by cooking and preparing and making sure all is ready to serve on time at NCH.

NCH has gone down to one chef and three catering assistants and, without the two departments pulling together as they have, our patients would not have received these lovely hot meals. This is a whole team effort and the all the catering team at WSH and NCH deserves a huge well done and thank you. Great teamwork.

Sandra Austin, care certificate coordinator

Debbie Bond, care certificate support worker

Nominated by Alex Levitt-Powell, lead practice education facilitator

This week marks 10 years of the national care certificate. Unfortunately, this is not being recognised nationally, however, Sandra and Debbie have arranged for an information stand in Time Out to thank our HCSW staff at WSFT and showcase the 10-year anniversary.

They have also put together six hampers (at personal cost) to show appreciation of our HCSW staff who have completed a care certificate - either here or at another organisation - showcasing the value of our HCSW colleagues and that we are one team working together, highlighting the impact our HCSWs have on patient care.

The team has been visiting clinical areas, spreading awareness and talking with colleagues about the anniversary, and offering them the opportunity to enter a prize draw. Winners will be drawn on 4 April in Time Out, where the team will be sharing more information about the care certificate with colleagues around the Trust.

Thank you, Sandra and Debbie, for all of your hard work in putting this together!

Jessica Fuller, specialist biomedical scientist

Nominated by Marcus Milner, microbiology laboratory manager, and Janet Woolston, pathology quality manager

Over the past year Jess has acted up as the Microbiology Quality Lead whilst the substantive post holder was away on parenting leave. The Quality Lead role has been challenging as the laboratory has been through the dual challenges of a UKAS re-accreditation visit combined with the move to the new ISO15189:2022 standards.

Jess has had a stellar year where she has led the laboratory through these two challenges - the UKAS assessment team have been extremely complementary to Jess and have a very high regard to the documentation that she has written as well as the way that she has managed the quality management system.

Whilst the year has been a steep learning curve for Jess, she has met her challenges with grace and kindness to others. She has worked in such a way that she has engendered great respect from her peers at many layers of the organisation. She is a credit to our team and has been fundamental to the outcome of our UKAS Surveillance Visit where we have been recommended for retention of UKAS accreditation and move to the 2022 standards.

Putting You First (PYF) awards

- PYF awards celebrate colleagues throughout the Trust for upholding Trust values in their daily working life and putting patients and/or colleagues ‘first’.
- Nominations can be made by any member of WSFT staff at any time in the year.
- Nominations are collated by the communications team and sent to the chief people officer during the first or second week of every other month.
- These are assessed by the executive and winners selected (usually 2-3 winners per process). The citations are included in the following Trust Board report.
- Sponsors of unsuccessful nominees are signposted to our Radar ‘Star’ scheme as an alternative way of celebrating and recognising their colleague(s).

5. OPERATIONS, FINANCE AND CORPORATE RISK

5.1. Insight Committee Report - Chair's key issues from the meetings (ATTACHED)

To Assure

Presented by Antoinette Jackson

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

Originating Committee: Insight Committee			Date of meeting: 21 May 2025		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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PAGG/IQPR	**Cancer Faster Diagnosis (FDS) Targets** Cancer FDS performance increased to 77% in February 62-day performance increased to 75.% meeting national targets.	**3 Partial**	Achieving the FDS target of 77% and a 62-day performance of 70% by March 2025 were the key objectives for cancer in 2024/25 planning.	The Trust is still in Tier 1 for the cancer pathway and hopes this improved performance will mean tiering is lifted once April quarter 4 data is available. Learning from the performance achievements in February and March 2025 will be captured to inform the detail and direction of delivery plans against NHS 2025/26 priorities and operational planning guidance. The Trust has committed to achieving the 62-day standard (75%) and Faster Diagnosis Standard (FDS) (80%) for 2025/26. Gynaecology, skin and lower gastrointestinal (LGI) are the areas of focus for transformation.	No escalation

Originating Committee: Insight Committee			Date of meeting: 21 May 2025		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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PAGG/IQPR	**Diagnostics** Diagnostic performance against the 6-week standard dropped from 55.2% to 53.2% in March 2025. **MRI** performance is improving with additional Community Diagnostic Centre capacity and is expected to recover by the end of May 2025. With **endoscopy** priority is being given to patients on a cancer pathway. Routine performance is plateauing. **Ultrasound** performance is vulnerable because of difficulty in recruiting. Whilst bank and agency staff have been approved availability is limited. This also applies to CDC capacity.	**4 Minimal**	Longer waiting times for diagnosis and treatment have a detrimental effect on patients. .	As a result of our worsening Cancer and Diagnostic performance we were placed in 'Tier 1' nationally. Although diagnostic performance is included in Tier 1 meetings, exit criteria will be defined by cancer performance alone. A clear recovery plan is in place for DEXA, pending the permanent scanner delivery In the longer-term Newmarket CDC will help endoscopy performance but there is currently no clear recovery plan for the service and this needs addressing.	3.Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 21 May 2025		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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	Breast imaging has also been impacted by staffing issues and failure to recruit to approved posts.			Ultrasound is forecast for recovery by October 2025 if recruitment issues can be resolved. Breast imaging is trying to fill posts temporarily whilst going back out to substantive recruitment. There will be a deep dive into the issues around diagnostic recovery at the July Insight Committee.	

Originating Committee: Insight Committee			Date of meeting: 21 May 2025		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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Urgent and Emergency Care deep dive	Urgent and Emergency Care (UEC) performance at WSFT remained below trajectory for majority of 2024/25. It was recognised that improvements were required to meet the 4-hour standard of 78%. In December 2024 an improvement programme was initiated through a series of cross divisional 'taskforces' aimed at diagnosing and removing barriers to flow throughout the system. These taskforces made recommendations for sustainable improvements, thereby enhancing UEC performance. A primary objective of these taskforces and the resulting transformation initiatives was to create a seamless UEC pathway and flow through out the organisation with a strong emphasis on patient safety and avoiding patient harm.	**1 Substantial**	During March the Trust achieved a 4-hour performance of 88.39%. This achievement placed WSFT 1st in region and 4th nationally for 4-hour performance. 12-hour waits as a % of attendances reduced significantly from 10.2% to 2.1% against the standard of 2% Significant improvements were seen in the non-admitted patient group. The overall performance for non-admitted patients during March was 93.12%. During March the MECU saw a 38% increase in activity compared to the average number from the previous 3 months. The 'reset' of the short stay ward (F7) facilitated appropriate selection and transfers of short stay patients. This resulted in significant improvements in	Most of the actions implemented from these workstreams did not require new funding but involved dedicated focus and change from both clinical and operational teams. Performance during April has been sustained, therefore providing an element of confidence that this improvement will continue. As of 14th April performance was 88.81% compared with 87.85% at the same point in March, with an April month end position of 81.35%. UEC performance will continue to be closely monitored against the trajectory for 2025/26. Early escalation of issues via the UEC delivery group will be used ensure strong performance continues, The NHSE improvement team has offered their support in implementing the actions from the	3 Escalate to Board to note the significant progress and learning

Originating Committee: Insight Committee			Date of meeting: 21 May 2025		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
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			discharge numbers within the short stay cohort. Ambulance handover within 30 minutes exceeded the target for the first time, and significant improvements eliminated all but meant only 3 ambulances waited over 60 minutes. The effect on staff morale was noticeable throughout the organisation, despite the need to adjust to new ways of working. The deep dive demonstrated that there is now a much greater understanding of the drivers of performance in UEC.	ward taskforce, which will assist in embedding the improvements highlighted. This work will commence early May 2025. There are risks to delivery in terms of sustaining this approach as business as usual throughout the year. This is compounded by the pressures of the Trust financial system.	

Originating Committee: Insight Committee			Date of meeting: 21 May 2025		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
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Finance Accountability Committee	**Month 1 Reporting** The Trust has agreed a £20.7m deficit budget for the year, and at Month 1 is reporting a small underspend against plan. The reported Income and Expenditure (I&E) for Month 1 shows a run rate of £2.7m, compared to the planned rate of £2.8m. Pay spend in M1, whilst within plan, was an increase on the M12 run rate. This includes the residual impact of the escalation ward, and the impact of 'super Saturday' lists in March where the impact on income has not yet been assessed. In addition, funding for cancer alliance posts has not been fully reflected as this is not yet confirmed, however the costs are reflected. In month, the target CIP was £1.3m, and this was achieved in the month.	**3 Partial**	It is difficult to draw many conclusions from M1 reporting for a number of reasons; the impact of accruals over year end, assumptions about the impact of pay awards, inflation and increased National Insurance , and the phasing of CIP plans which are still being developed Whist the run rate is just below target it is still a much higher run rate than achieved in 24/25 so this needs further analysis.	There will be further analyses and adjustments to the uploaded budget in the ledger to revise the budget profile starting from Month 2. Work to reconcile the annual plan phasing of savings with the CIP tracker continues.	3.Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 21 May 2025		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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Cost Improvement Programme (CIP) delivery	The Trust has identified £28.6m/£17.8m of unweighted/weighted CIP opportunities respectively against a full year target of £32.8m. This is an improvement of £7m in unweighted CIP since April's Insight Committee. However, there remains a gap of £4.2m. Several high value schemes (e.g. corporate services) will be 'in delivery' imminently, which will significantly increase the weighted CIP position. Challenges with reconciling the baseline 25/26 corporate service budget positions with the 'to be' workforce structures has proved challenging, and has materially affected the anticipated CIP as reductions already made in 24/25 have reduced the starting position against which CIPs have been estimated.	**3** **Partial**	Whilst overall progress is positive, and it is good to see the improvement over the last month, there is still a gap of £4.2 m that needs to be addressed with additional schemes. There is a material risk that further delays, particularly in the major schemes (e.g. corporate services) could deteriorate this position further. The Finance Team is undertaking urgent work to understand the budget discrepancies. It should be noted that there is the potential for an upside, given that in some cases, the 25/26 budgets are significantly higher than the 'to be' workforce models.	Further work is on-going to develop 'stretch' CIPs; the executive team have approved several schemes to proceed, halted some due to safety risks, and continue to develop others Additional consultancy support still needs to be agreed with SNEE ICB. All CIP programme groups now have Non-Executive Director representation which helps improve both oversight and support.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 21 May 2025		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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SNEE ICB Double lock panel	The Committee considered a report from the ICB about the operation of the double lock panel process, which that had been considered at the SNEE ICB Finance Committee. The Panel reviews both pay and non-pay expenditure requests from the Trust after requests have first been approved through the Trust's own internal financial controls. Between August 24 and March 25 a total of 74% of all pay requests were supported. The total value of supported non-pay requests was £2.027m, the value of rejected requests was £140k. But the report noted that the value of retrospective requests was £1.237m.	**2 Reasonable**	The Panel expressed their concern to WSFT about the prevalence of retrospective requests and the weakness in internal controls that this suggested. Further internal analysis suggested that some of these were ongoing expenditure such as insurance cover that rolled forward. But it is recognised that there is an ongoing need to ensure the controls in place are managed tightly.	The double lock arrangements will stay in place. The Exec will continue to work with individual services to ensure the controls are fully understood.	1 No escalation

Originating Committee: Insight Committee			Date of meeting: 21 May 2025		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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Green Plan	The committee considered a draft of the Trust's second Green Plana. This is a high-level strategy document backed up by a detailed action plan that sets out environmental and sustainability ambitions and targets for the period 2025-2029. Net zero is embedded into legislation through the Health and Care Act 2022. It is a requirement of the NHS Standard Contract for all provider Trusts to have a Green Plan. This plan will cover the period where the Trust will be delivering a new West Suffolk Hospital, with the ambition being to construct this using net zero techniques.	**1 Substantial**	In 2020 the NHS made a commitment to become the first healthcare service in the world to reach net zero. For the emissions we control directly the NHS must reach net zero by 2040, with the ambition to reach an 80% reduction by 2028-2032 from a 1990 baseline (equivalent to a 47% reduction). For the emissions we can influence the NHS must reach net zero by 2045, with an ambition to reach an 80% reduction by 2036-2039 from a 1990 baseline, (equivalent to a 73% reduction). The Green Plan demonstrates the Trust's commitment to playing a leading role in securing a healthy, sustainable Suffolk.	Following Insight Committee's endorsement of the document, the Gren Plan will be reported to Board. The plan is underpinned by action plans which will be delivered between now and 2029. Insight will monitor progress twice a year. It should be noted that the Plan has not been fully costed and new schemes will need to be considered through the Trust's usual financial and business planning processes.	3 Escalate to Board for approval

Originating Committee: Insight Committee			Date of meeting: 21 May 2025		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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Board assurance Framework – BAF risk 7 Financial Sustainability	The Trust's Financial Sustainability strategic risk is that we fail to ensure we manage our finances effectively in order to guarantee the long-term sustainability of the Trust and secure the delivery of our vision, ambitions and values. The report updated the risk scores for this risk and the action plan for mitigation.	**3 Partial**	The Trust has a significant underlying financial deficit which, if left unaddressed, would leave the Trust in an unviable financial position. The Trust is in the process of recovering the financial position through a robust turnaround process. Whilst steps are being taken to address this risk, it cannot be completely mitigated at present. The Board Trust appetite is 9. The current risk score is 16 and the mitigated risk would still have a score of 12.	The action plan focuses on - achieving the 2025/26 financial plan within the deficit approved by the March Board. - Developing a long-term financial model and financial strategy - Delivering a training and development programme for appropriate staff (both budget holders and finance staff) to ensure a business mindset is ingrained throughout the Trust. The risk will continue to be monitored by both Insight and the Board.	3 Escalate to Board

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

Board assurance committee - Committee Key Issues (CKI) report

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

Cost Improvement Programme (CIP) delivery	The Trust has identified £29.1m of unweighted CIP opportunities (£19.5m weighted). 89% of the CIP target has been identified, compared to 68% in April. So there has been further progress but a gap remains of £3.7m/£13.3m unweighted/weighted CIP respectively. Efforts are being focused on high priority schemes and getting them into delivery and developing further high value opportunities. The trust received formal approval from NHSE to contract with PA consulting for delivery support.	**3 Partial**	Further work is needed to ensure the delivery phasing matches the profile of CIP financial targets. The high value programmes where there is significant risk of delivery are corporate services; clinical productivity and commercial. The strategic risks are to do with pace because of the volume of work that is required; capacity due to the breadth and depth of work taking place across the Trust; and resourcing due to some gaps and vacancies. There is also work force risk regarding the capacity to support the large number of evaluation panels for the new job descriptions required.	Further work is on-going to develop 'stretch' CIPs; the executive team have approved several schemes to proceed, halted some due to safety risks, and continue to develop others Additional consultancy support is in place and this needs be maximised. All CIP programme groups now have Non-Executive Director representation which helps improve both oversight and support.	3 Escalate to Board

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

PAGG/IQPR	**Cancer Faster Diagnosis (FDS) Targets** Cancer faster diagnosis performance increased to 79.3% to exceed the 77% standard in March 25. 62 day performance was at 84.2%, also exceeding the 70% requirement Ongoing challenges in breast cancer mean the there is a risk of not achieving the 62 day performance in April, May and June.	**3 Partial**	Achieving the FDS target of 77% and a 62-day performance of 70% by March 2025 were the key objectives for cancer in 2024/25 planning.	The Trust has been removed from Tier 1 for cancer and diagnostic waiting times performance and is now in Tier 2. The Trust has committed to achieving the 62-day standard (75%) and Faster Diagnosis Standard (FDS) (80%) for 2025/26. Gynaecology, skin and lower gastrointestinal (LGI) are the areas of focus for transformation.	1 No escalation

PAGG/IQPR	**Diagnostics** Diagnostic performance has continued to decline with performance against the six week standard dropping from 53.2% to 47.9% in April 2025. All modalities except cardiology and CT are currently underperforming. MRI performance is improving with additional community diagnostic centre capacity and this is expected to recover by the end of May 25 There is a recovery plan in place for DEXA pending permanent scanner delivery There is also a plan in place in ultrasound, pending recruitment. There is no recovery plan for endoscopy.	**4 Minimal**	Longer waiting times for diagnosis and treatment have a detrimental effect on patients. The risk to further progress is the Trust's ability to recruit staff with the skills required.	As a result of our worsening Cancer and Diagnostic performance we were placed in 'Tier 1' nationally but have now been moved to Tier 2. In the longer-term, Newmarket CDC will help endoscopy performance but there is currently no clear recovery plan for the service and this has been escalated to the June Management Executive Group. There will be a deep dive into the issues around diagnostic recovery at the July Insight Committee.	3.Escalate to MEG

PAGG/IQPR	**Urgent and Emergency Care** UEC exceeded trajectory for 12 hour waits for April with 12 hour waits as a percentage of attendance sustained at 2.9%. 4 hour performance was 81.35% and above trajectory The improvement in the 30 minute ambulance handover metric was maintained in April Inpatients not meeting the criteria to reside continues to decrease and performance against the urgent community response two-hour standard remains stable.	**2 Reasonable**	Not meeting urgent and emergency standards means some patients are waiting longer in the Emergency Department than they should be and being nursed in escalation areas. The improved performance means fewer patients in escalation areas making for a better patient experience.	THE UEC action plan includes Weekly performance meetings with the Emergency Department and Medical Division senior leaders/Executives. Implementation and monitoring of the cross-divisional workstreams of both the UEC and taskforce projects. Continued focus on length of stay reductions to support flow out of the Emergency Department, including the task and finish group for board rounds planned in June.	1. No escalation

Community Services Deep Dive	The committee held a deep dive into how Community Services can enable timely discharges, prevent avoidable admissions and to manage urgent care needs. The report highlighted the key strategies in place and the progress of the shared service delivery project in delivering sustainable efficiencies and high-quality care, closer to home. WSFT has consistently delivered two hour community response above the national target of 70%. There has been a significant increase in community referral numbers especially in nursing indicating a trend of special cause concern. Virtual ward capacity is 59 at present and average occupancy in May 25 was 55% compared to 67% in February. Average length of stay is well managed and is significantly below target.	**2 Reasonable**	The shared service delivery project aims to build a locally based workforce capable of managing higher acute acuity patients efficiently and responsively. One example of this is community delivered IV treatments. The development of local integrated neighbourhood teams has enabled a release of clinical time with less time spent travelling and a cost reduction in mileage claims. The committee noted an increase in integrated neighbourhood team cancelled nursing appointments and work will be undertaken to more accurately record the reasons for this as there is a risk, if demand increases, that the team will not have the capacity to respond fully.	The new Community Geriatrician and Virtual Ward clinical lead began in post at the beginning of June 2025. There is a comprehensive project plan in place to continue to develop the integrated teams. Next steps include full implementation of the workforce changes and a skills gap analysis and training plan is being developed Funding has been secured for point of care testing equipment and a task and finish group aims for a pilot site to offer the first suite of point of care tests in September 2025. Phase three of the virtual ward has an enhanced focus on step up (admission avoidance) to ensure the capacity is fully utilised with an agreed target of 50% step up by November 2025. The Committee noted that the Community Services contract will be up for renewal in 2027. There is a need to plan for this and ensure that the learning from the service informs future contract negotiations. MEG was asked to ensure there is an effective project plan in place for	2. MEG will be considering the approach to the community contract renewal

				this, involving community services managers from the outset.	

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.*

5.2. Finance Report (ATTACHED)

To Review

Presented by Nick Macdonald

WSFT Board of Directors (Open)	
Report title:	Finance Report – as at June 2025 (M3)
Agenda item:	5.2
Date of the meeting:	25 July 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 3 (June 2025). <u>Income and Expenditure position</u> The Trust has reported a deficit of £7.6m for the year to June 2025, which is £0.6m better than planned. We continue to forecast meeting our planned deficit of £20.7m for 25/26 <u>Efficiencies</u> The CIP plan is broadly on track, but work is ongoing to meet the increased challenge that our CIP profile requires. Our forecast assumes we are able to deliver £4.5m of CIP that has been identified but isn't yet in delivery. <u>Cash</u> The cash position is healthy but will need support in line with our deficit over the second part of the year.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
The reported position is in line with the planned deficit for 2025/26.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
We continue to develop our 25/26 cost improvement programme in order to deliver the CIP that is phased later in the 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 – June 2025 (M3)
for Public Board
25th July 2025

West Suffolk NHS Foundation Trust

Putting you first

Executive Summary as at June 2025

NHS West Suffolk NHS Foundation Trust

Summary
The Trust has agreed a £20.7m deficit budget for the year, and at month three is reporting a £586k year to date underspend against the plan. Reductions in pay through held vacancies, reduced activity levels and non-pay controls contribute to this favourable variance. Most of the CIP programme is phased for later in the year and achieving the planned deficit is still expected to be a challenge.

Workforce
The Trust are reporting a further reduction in WTEs as of June 2025 (4,851 WTEs) compared to June 2024 (5,091 WTEs), a reduction of 240 WTEs. WTEs are 176.8 below the annual workforce plan as at month three, with reductions seen in both substantive and bank. Agency usage continues to be low. Since April 2024 we have reduced our staffing levels by 269 WTES (5.3%)

Revenue
The reported Income and Expenditure (I&E) for month three shows a YTD adjusted deficit of £7.6m, compared to the planned deficit of £8.2m. This results in a favourable year-to-date variance of £0.6m. Pay expenditure reduced in comparison to May by £50k reflecting the WTE reduction of 6.5 WTEs month on month (16.4 WTE substantive). Non-pay continues to fluctuate with activity demands and is expected to vary month-on-month.

Efficiencies
The CIP schemes aimed to deliver £32.7m for the year. The year-to-date target CIP was £4.5m, and this was broadly achieved with further work underway to collect the detailed impact of held vacancies and other actions over and above those captured within the core CIP reporting. Delivery of CIP ramps up through the year and therefore month three targets are comparatively low. Work to de-risk future CIP continues, with vacancy and non-pay controls remaining in place.

Cash
The Trust's cash balance as at 30 June 2025 was £12.3m compared to a plan of £1.1m. 2025/26 continues to remain difficult in terms of cash, with the forecast showing the Trust going overdrawn towards the end of August. The Trust will require cash support for the last 8 months of the financial year.

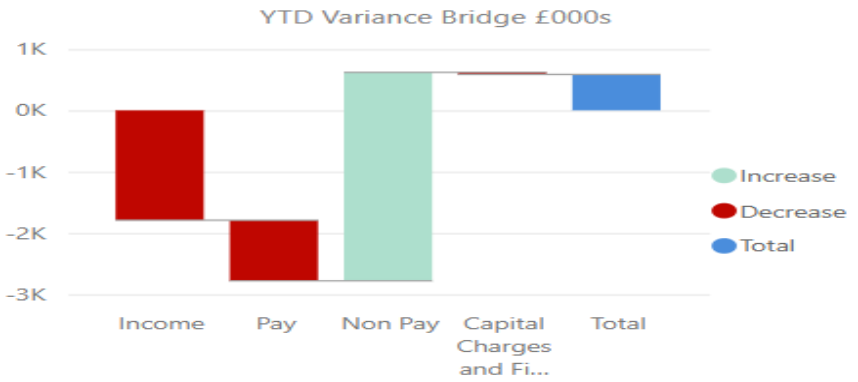
Capital
The Capital Plan for 2025/26 has been agreed at £25.6m. In month 2 an additional £1m of CDEL was awarded to the Trust, and in month 3 additional PDC was awarded of £7.2m taking the Capital Plan to £33.8m. £11.5m of this is internally funded, with the remaining £22.3m being funded by Public Dividend Capital (PDC). Year to date capital spend at month 3 is £1.95m. This is behind the phased plan, but at this early stage we anticipate that the plan for 2025/26 will be achieved.

M3 position

We are slightly ahead of plan as at M3, due largely due to reduced expenditure in line with reduced activity.
The monthly variance on pay relates to a YTD adjustment of funding between pay and non-pay

	In-Month Budget £000s	In-Month Actuals £000s	In-Month Variance £000s	YTD Budget £000s	YTD Actuals £000s	YTD Variance £000s F/(A)	Annual Budget £000s	Forecast £000s	Forecast Variance £000s F/(A)
Depreciation	**1,484**	**1,480**	**3**	**4,451**	**4,415**	**36**	**17,805**	**17,594**	**211**
EBITDA									
Expenditure									
Pay Costs	24,821	24,931	-111	76,572	75,210	1,362	307,307	312,339	-5,033
Non-pay Costs	10,926	9,959	967	30,895	29,845	1,049	112,027	114,681	-2,654
Total	**35,746**	**34,890**	**856**	**107,467**	**105,056**	**2,411**	**419,334**	**427,021**	**-7,687**
Income									
NHS Contract Income	31,786	30,977	-809	95,178	93,666	-1,513	382,860	378,563	-4,297
Other Income	3,292	3,402	111	9,793	9,515	-279	38,731	38,157	-574
Total	**35,078**	**34,380**	**-698**	**104,972**	**103,180**	**-1,791**	**421,590**	**416,719**	**-4,871**
EBITDA Position	**669**	**510**	**159**	**2,495**	**1,875**	**620**	**2,257**	**10,301**	**-12,558**
Finance Costs	**424**	**434**	**-10**	**1,266**	**1,336**	**-70**	**5,152**	**5,122**	**29**
Impairments									
Deficit/(Surplus)	**2,576**	**2,425**	**152**	**8,212**	**7,626**	**586**	**20,700**	**33,018**	**-12,318**

Deficit YTD £	**7.6M**	
Variance against plan YTD £	**0.6M**	**Favourable**
Movement in month against plan £	**0.2M**	**Favourable**
EBITDA Postion YTD £	**-1.9M**	**Adverse**
EBITDA margin YTD	**-2%**	**Adverse**
Cash at bank	**£12.3M**	



Income and Expenditure Summary – June 2025

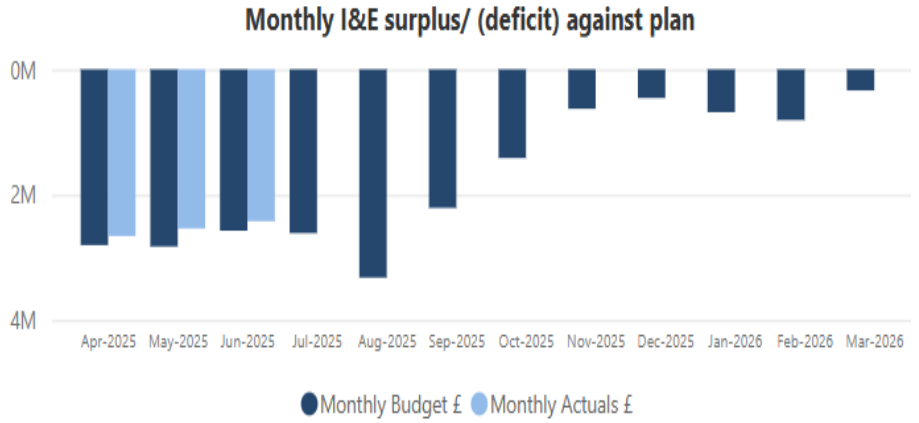
The favourable variance was £0.2m in June, £0.6m YTD. As our CIP target increases month on month this favourable variance will become harder to achieve.

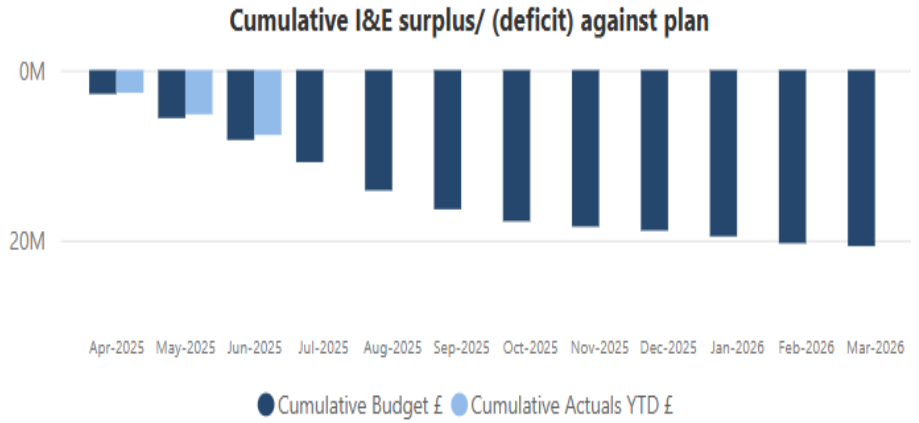
Board Report Item	Original Plan/ Target £000s	Actual/ Forecast £000s	Variance to Plan £000s F/(A)	
In month surplus/ (deficit)	-2,576	-2,425	152	↑
YTD surplus/ (deficit)	-8,212	-7,626	586	↑
Clinical Income YTD	95,178	93,666	-1,513	↓
Non-Clinical Income YTD	9,793	9,515	-279	↓
Pay YTD	76,572	75,210	1,362	↑
Non-Pay YTD	30,895	29,845	1,049	↑
EBITDA YTD	-2,495	-1,875	620	↑
EBITDA %	-2.4	-1.8	0.6	↑

Adverse variance > 1% ↓

Adverse variance within 1% →

On plan or favourable variance ↑



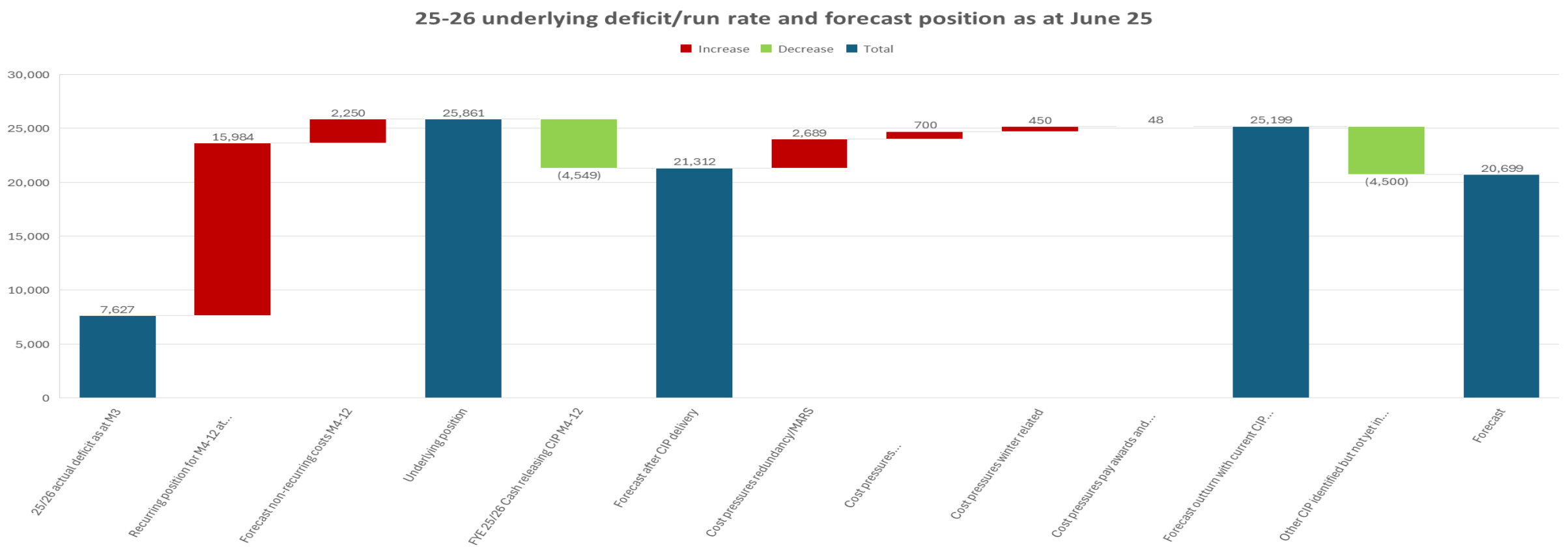


25/26 Underlying Position and Forecast

The FY25/26 plan is to deliver a deficit of £20.7m, after achieving a CIP of £32.8m

As at M3 the forecast continues to be to deliver the plan as below, assuming that the recurring position is currently broadly £1.8m deficit per month, and that CIP delivery increases over the second part of the year, as well as seasonal and activity related costs varying throughout the year. Redundancy and external support costs are also phased into this forecast.

However, this forecast is contingent on delivering around £4.5m of CIP that has been identified but not yet in delivery.

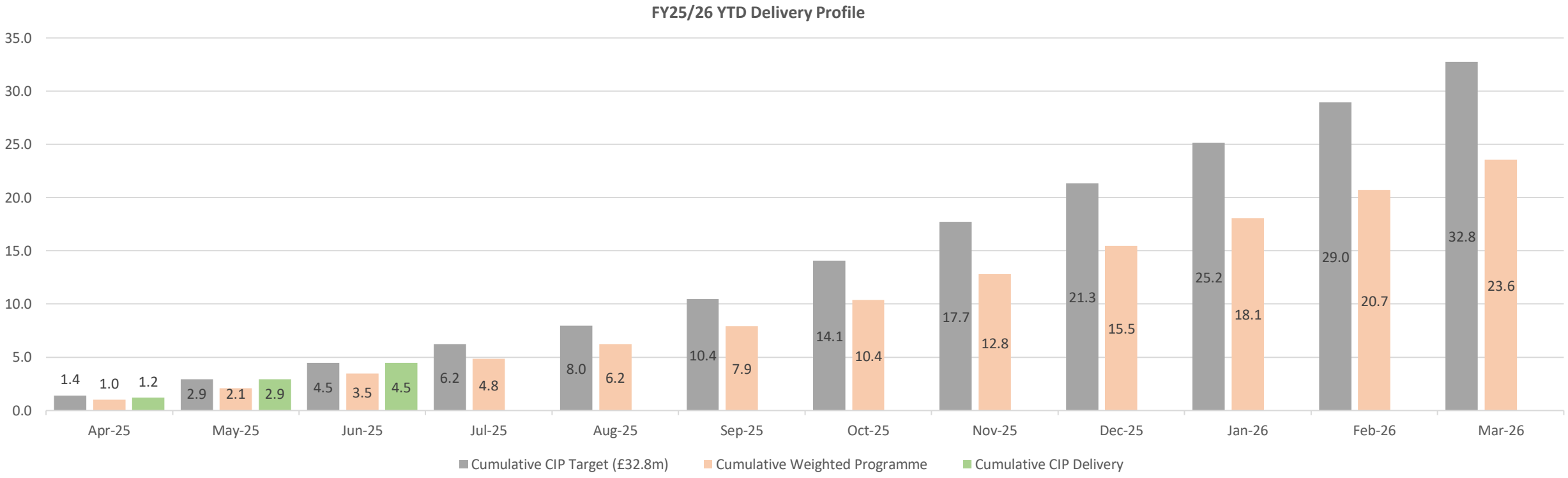


25/26 CIP Progress

The FY25/26 CIP target is £32.8m. Delivery of this ramps up through the year, see graph below.

As at M3, the Trust has delivered £4.5m of CIPs, against a budgeted plan of £4.5m, resulting in delivery to plan YTD. The £4.5m delivery is comprised of £3.6m against CIPs within the detailed CIP programme (including £1.5m of FYE pay CIP), and £0.9m against initiatives that are currently being developed for inclusion within the CIP tracker or non-recurrent initiatives (a reduction of £0.2m from last month as in development initiatives have moved into delivery.

Note: The Weighted CIP Plan (£26.3m) is as per the CIP Tracker on 4 July 2025.



Pay Costs by Staff Type

Note that the monthly financial variance does not align with the WTEs variance in June due to a YTD budget adjustment that is not reflected in the monthly budgeted WTEs

		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
Substantive	Medical Staff	5,892	5,896	6,390	494	17,767	19,242	1,475
	Nursing	8,359	8,366	8,854	487	25,120	26,641	1,521
	Sci & Professional	1,155	1,151	1,251	100	3,469	3,753	283
	A&C	3,631	3,674	3,720	46	11,014	11,184	170
	AHP	2,457	2,450	2,668	218	7,406	7,994	588
	Prof & Tech	241	230	264	34	718	763	45
	Support Staff	870	877	877	1	2,615	2,642	27
	Other	809	518	585	67	1,831	1,756	-75
	Unallocated CIP	0	0	-316	-316	0	-1,312	-1,312
	Total	23,413	23,161	24,294	1,133	69,941	72,663	2,723
Additional Medical Sessions	Medical Staff	242	229	161	-68	788	532	-256
	Total	242	229	161	-68	788	532	-256
Bank & Locum Staff	Medical Staff	352	451	163	-288	1,210	487	-723
	Nursing	568	594	25	-569	1,860	74	-1,786
	Sci & Professional	21	12	2	-10	60	7	-54
	A&C	38	35	1	-34	134	17	-116
	AHP	17	13	1	-12	45	3	-42
	Prof & Tech	1	0	1	0	2	2	1
	Support Staff	164	185	141	-44	548	417	-131
	Total	1,159	1,291	334	-957	3,858	1,007	-2,851
Agency	Medical Staff	92	154	0	-154	330	0	-330
	Nursing	2	0	0	0	24	0	-24
	Sci & Professional	-4	0	0	0	0	0	0
	A&C	0	5	0	-6	1	-1	-2
	Prof & Tech	24	27	0	-27	70	0	-70
	Support Staff	-8	0	-2E-5	-2E-5	-8	-6E-5	8
	Total	106	185	0	-185	417	-1	-418
Overtime	Nursing	15	16	1	-15	50	1	-49
	Sci & Professional	8	7	0	-7	26	0	-26
	A&C	9	10	7	-3	36	20	-16
	AHP	18	16	0	-16	58	0	-58
	Prof & Tech	10	16	0	-16	36	0	-36
	Total	60	65	8	-58	207	21	-186
Total		24,981	24,931	24,795	-136	75,210	74,222	-988

Pay Costs (by Staff Group)

Note that the monthly financial variance does not align with the WTEs variance in June due to a YTD budget adjustment that is not reflected in the monthly budgeted WTEs

		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
Medical Staff	Substantive	5,892	5,896	6,390	494	17,767	19,242	1,475
	Additional Medical Sessions	242	229	161	-68	788	532	-256
	Bank & Locum Staff	352	451	163	-288	1,210	487	-723
	Agency	92	154	0	-154	330	0	-330
	Total	6,578	6,729	6,713	-16	20,095	20,261	166
Nursing	Substantive	8,359	8,366	8,854	487	25,120	26,641	1,521
	Bank & Locum Staff	568	594	25	-569	1,860	74	-1,786
	Agency	2	0	0	0	24	0	-24
	Overtime	15	16	1	-15	50	1	-49
	Total	8,943	8,976	8,880	-96	27,054	26,717	-338
Sci & Professional	Substantive	1,155	1,151	1,251	100	3,469	3,753	283
	Bank & Locum Staff	21	12	2	-10	60	7	-54
	Agency	-4	0	0	0	0	0	0
	Overtime	8	7	0	-7	26	0	-26
	Total	1,179	1,170	1,253	83	3,555	3,759	204
A&C	Substantive	3,631	3,674	3,720	46	11,014	11,184	170
	Bank & Locum Staff	38	35	1	-34	134	17	-116
	Agency	0	5	0	-6	1	-1	-2
	Overtime	9	10	7	-3	36	20	-16
	Total	3,678	3,723	3,727	4	11,185	11,220	35
AHP	Substantive	2,457	2,450	2,668	218	7,406	7,994	588
	Bank & Locum Staff	17	13	1	-12	45	3	-42
	Overtime	18	16	0	-16	58	0	-58
	Total	2,492	2,479	2,669	190	7,509	7,997	488
Prof & Tech	Substantive	241	230	264	34	718	763	45
	Bank & Locum Staff	1	0	1	0	2	2	1
	Agency	24	27	0	-27	70	0	-70
	Overtime	10	16	0	-16	36	0	-36
	Total	276	273	265	-8	826	765	-61
Support Staff	Substantive	870	877	877	1	2,615	2,642	27
	Bank & Locum Staff	164	185	141	-44	548	417	-131
	Agency	-8	0	-2E-5	-2E-5	-8	-6E-5	8
	Total	1,026	1,062	1,018	-43	3,155	3,058	-97
Other	Substantive	809	518	585	67	1,831	1,756	-75
	Total	809	518	585	67	1,831	1,756	-75
Unallocated CIP	Substantive	0	0	-316	-316	0	-1,312	-1,312
	Total	0	0	-316	-316	0	-1,312	-1,312
Total		24,981	24,931	24,795	-136	75,210	74,222	-988

Workforce – WTEs by Staff Type

Substantive staff have decreased by 16.5 WTEs in month, primarily in Nursing, Medical and Support Staff.
Temporary staffing has increased by 8.4 WTEs, mainly in Bank Nursing

NHS West Suffolk NHS Foundation Trust

		Prior Month Actuals WTE	Prior Yr Same Period Actuals WTE	In-Month Actuals WTE	In-Month Budget WTE	In-Month Variance WTE	YTD Actuals Average WTE	YTD Budget Average WTE	YTD Variance Average WTE
Substantive	Nursing	1,921.0	1,929.0	1,914.4	2,077.2	162.9	1,919.2	2,080.1	160.9
	Medical Staff	581.0	575.9	576.9	645.4	68.5	582.5	646.2	63.7
	A&C	931.5	977.6	932.5	993.7	61.2	933.9	990.3	56.5
	AHP	548.3	544.6	549.1	603.5	54.4	549.7	601.1	51.5
	Sci & Professional	271.5	275.1	270.9	292.6	21.8	271.3	289.8	18.4
	Other	53.2	75.4	55.6	63.4	7.8	56.3	63.8	7.5
	Prof & Tech	50.4	48.8	47.3	53.8	6.5	49.9	53.5	3.7
	Support Staff	286.5	281.4	280.4	286.4	6.0	281.0	286.7	5.7
	Unallocated CIP	0.0	0.0	0.0	-7.0	-7.0	0.0	-3.8	-3.8
	Total	4,643.4	4,707.7	4,626.9	5,009.0	382.1	4,643.7	5,007.7	364.0
Additional Medical Sessions	Medical Staff	8.6	17.4	7.7	4.6	-3.1	9.5	4.7	-4.8
	Total	8.6	17.4	7.7	4.6	-3.1	9.5	4.7	-4.8
Agency	Nursing	2.3	11.2	0.0	0.0	0.0	1.8	0.0	-1.8
	Sci & Professional	0.0	5.8	0.0	0.0	0.0	0.3	0.0	-0.3
	Support Staff	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	A&C	0.0	6.8	0.8	0.0	-0.8	0.3	0.0	-0.3
	Prof & Tech	4.2	12.5	4.5	0.0	-4.5	4.1	0.7	-3.4
	Medical Staff	3.3	7.5	6.1	0.0	-6.1	4.0	0.0	-4.0
	Total	9.8	43.7	11.3	0.0	-11.3	10.5	0.7	-9.8
Overtime	A&C	1.5	5.6	1.6	0.8	-0.8	2.1	0.9	-1.2
	Sci & Professional	1.1	3.6	1.1	0.0	-1.1	1.3	0.0	-1.3
	AHP	3.6	2.3	3.1	0.0	-3.1	3.9	0.1	-3.8
	Nursing	3.7	6.0	4.1	0.2	-3.8	4.2	0.5	-3.7
	Prof & Tech	2.7	5.2	4.2	0.0	-4.2	3.2	0.0	-3.2
	Total	12.5	22.6	14.0	1.0	-13.0	14.7	1.5	-13.2
Bank & Locum Staff	Prof & Tech	0.3	0.2	0.1	0.3	0.1	0.2	0.3	0.1
	Other		0.0						
	AHP	3.0	4.1	2.3	0.0	-2.3	2.7	0.2	-2.4
	Sci & Professional	6.2	7.6	3.7	0.3	-3.4	5.7	1.8	-3.9
	A&C	11.6	29.2	10.5	2.2	-8.3	13.9	3.5	-10.4
	Support Staff	15.1	39.7	17.1	1.0	-16.1	19.2	1.3	-17.9
	Medical Staff	23.4	54.4	26.1	8.8	-17.3	27.2	8.9	-18.2
	Nursing	125.5	164.3	131.3	0.9	-130.4	140.4	0.9	-139.5
	Total	185.0	299.5	191.2	13.4	-177.7	209.3	17.0	-192.3
Total		4,859.3	5,090.9	4,851.2	5,028.0	176.8	4,887.7	5,031.5	143.8

Workforce - WTE (by Staff Group)

We are reporting a reduction of 239.7 WTEs when comparing June 2024 with June 2025 (4.7%).
There has been a reduction of 8.1 WTEs in month and 269.3 WTEs since April 2024.
The favourable variance against establishment is 176.8 WTEs in June 2025
This equates to broadly £916k in month favourable variance, based on average costs per WTE (£5,179 per month in June).

		Prior Month Actuals WTE	Prior Yr Same Period Actuals WTE	In-Month Actuals WTE	In-Month Budget WTE	In-Month Variance WTE	YTD Actuals Average WTE	YTD Budget Average WTE	YTD Variance Average WTE
Medical Staff	Substantive	581.0	575.9	576.9	645.4	68.5	582.5	646.2	63.7
	Additional Medical Sessions	8.6	17.4	7.7	4.6	-3.1	9.5	4.7	-4.8
	Bank & Locum Staff	23.4	54.4	26.1	8.8	-17.3	27.2	8.9	-18.2
	Agency	3.3	7.5	6.1	0.0	-6.1	4.0	0.0	-4.0
	Total	616.3	655.2	616.8	658.7	41.9	623.2	659.8	36.6
Nursing	Substantive	1,921.0	1,929.0	1,914.4	2,077.2	162.9	1,919.2	2,080.1	160.9
	Bank & Locum Staff	125.5	164.3	131.3	0.9	-130.4	140.4	0.9	-139.5
	Agency	2.3	11.2	0.0	0.0	0.0	1.8	0.0	-1.8
	Overtime	3.7	6.0	4.1	0.2	-3.8	4.2	0.5	-3.7
	Total	2,052.5	2,110.4	2,049.7	2,078.4	28.6	2,065.6	2,081.5	15.9
Sci & Professional	Substantive	271.5	275.1	270.9	292.6	21.8	271.3	289.8	18.4
	Bank & Locum Staff	6.2	7.6	3.7	0.3	-3.4	5.7	1.8	-3.9
	Agency	0.0	5.8	0.0	0.0	0.0	0.3	0.0	-0.3
	Overtime	1.1	3.6	1.1	0.0	-1.1	1.3	0.0	-1.3
	Total	278.7	292.1	275.6	292.9	17.3	278.7	291.6	13.0
A&C	Substantive	931.5	977.6	932.5	993.7	61.2	933.9	990.3	56.5
	Bank & Locum Staff	11.6	29.2	10.5	2.2	-8.3	13.9	3.5	-10.4
	Agency	0.0	6.8	0.8	0.0	-0.8	0.3	0.0	-0.3
	Overtime	1.5	5.6	1.6	0.8	-0.8	2.1	0.9	-1.2
	Total	944.5	1,019.1	945.4	996.7	51.3	950.2	994.7	44.5
AHP	Substantive	548.3	544.6	549.1	603.5	54.4	549.7	601.1	51.5
	Bank & Locum Staff	3.0	4.1	2.3	0.0	-2.3	2.7	0.2	-2.4
	Overtime	3.6	2.3	3.1	0.0	-3.1	3.9	0.1	-3.8
	Total	554.8	551.0	554.6	603.5	49.0	556.2	601.4	45.2
Prof & Tech	Substantive	50.4	48.8	47.3	53.8	6.5	49.9	53.5	3.7
	Bank & Locum Staff	0.3	0.2	0.1	0.3	0.1	0.2	0.3	0.1
	Agency	4.2	12.5	4.5	0.0	-4.5	4.1	0.7	-3.4
	Overtime	2.7	5.2	4.2	0.0	-4.2	3.2	0.0	-3.2
	Total	57.5	66.7	56.1	54.0	-2.1	57.3	54.4	-2.9
Support Staff	Substantive	286.5	281.4	280.4	286.4	6.0	281.0	286.7	5.7
	Bank & Locum Staff	15.1	39.7	17.1	1.0	-16.1	19.2	1.3	-17.9
	Agency	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total	301.7	321.0	297.4	287.4	-10.1	300.2	288.0	-12.2
Other	Substantive	53.2	75.4	55.6	63.4	7.8	56.3	63.8	7.5
	Total	53.2	75.4	55.6	63.4	7.8	56.3	63.8	7.5
Other	Bank & Locum Staff		0.0						
	Total		0.0						
Unallocated CIP		0.0	0.0	0.0	-7.0	-7.0	0.0	-3.8	-3.8
Total		4,859.3	5,090.9	4,851.2	5,028.0	176.8	4,887.7	5,031.5	143.8

Statement of Financial Position – 30 June 2025

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2025	Plan 31 March 2026	Plan YTD 30 June 2025	Actual at 30 June 2025	Variance YTD 30 June 2025
	£000	£000	£000	£000	£000
Intangible assets	54,005	44,573	49,452	52,429	2,977
Property, plant and equipment	146,062	200,307	165,949	145,655	(20,294)
Right of use assets	9,807	7,544	9,020	9,334	314
Trade and other receivables	7,162	7,158	7,158	7,162	4
Total non-current assets	**217,036**	**259,582**	**231,579**	**214,580**	**(16,999)**
Inventories	5,128	5,000	5,000	4,911	(89)
Trade and other receivables	18,989	21,668	20,668	19,006	(1,662)
Non-current assets for sale	490	490	490	490	0
Cash and cash equivalents	12,659	1,107	1,107	12,330	11,223
Total current assets	**37,266**	**28,265**	**27,265**	**36,737**	**9,472**
Trade and other payables	(41,296)	(28,250)	(33,210)	(44,951)	(11,741)
Borrowing repayable within 1 year	(4,510)	(4,627)	(4,627)	(4,438)	189
Current Provisions	(2,524)	(70)	(70)	(2,500)	(2,430)
Other liabilities	(938)	(2,685)	(2,685)	(2,596)	89
Total current liabilities	**(49,268)**	**(35,632)**	**(40,592)**	**(54,485)**	**(13,893)**
Total assets less current liabilities	**205,034**	**252,215**	**218,252**	**196,832**	**(21,420)**
Borrowings	(39,716)	(34,656)	(38,693)	(39,137)	(444)
Provisions	(385)	(400)	(400)	(385)	15
Total non-current liabilities	**(40,101)**	**(35,056)**	**(39,093)**	**(39,522)**	**(429)**
Total assets employed	**164,933**	**217,159**	**179,159**	**157,310**	**(21,849)**
Financed by					
Public dividend capital	326,166	390,273	340,058	326,165	(13,893)
Revaluation reserve	12,319	11,941	11,941	12,319	378
Income and expenditure reserve	(173,551)	(185,055)	(172,840)	(181,174)	(8,334)
Total taxpayers' and others' equity	**164,934**	**217,159**	**179,159**	**157,310**	**(21,849)**

The table shows the year-to-date Statement of Financial Position as at 30 June 2025.

The variance to plan of property, plant and equipment is due to the plan not taking into account the reduction in the value of property, plant & equipment as at 1 April 2025. This is due to the timing of the production of the plan and the completion of the year end valuation for the 2024/25 accounts. The plan also included an assumption that £25m would be spent at Newmarket, the funding of which has not yet come to fruition. The capital spend to date is also slightly below plan, impacting on this variance.

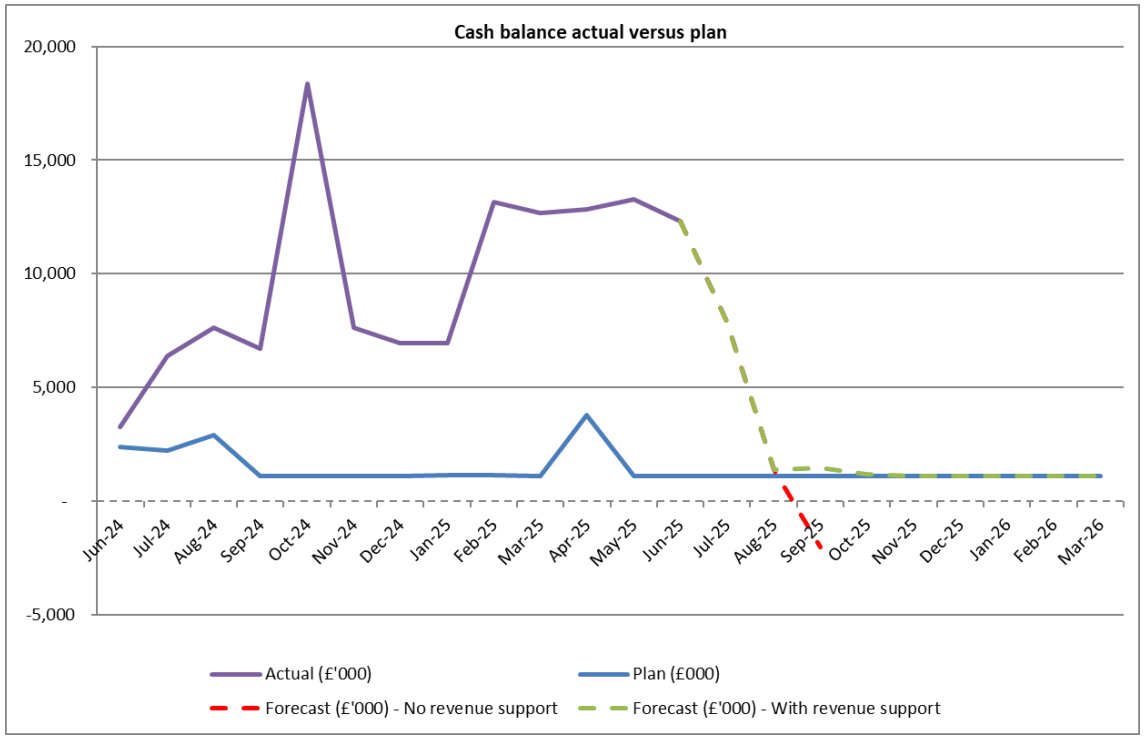
Cash is above plan, but is also linked to the fact that trade and other payables had increased, due to a backlog of invoices not being matched and receipted against a valid purchase order. Although trade and other payables appears to have increased significantly against plan, it has not increased as much compared to the month 12 outturn position.

Provisions has increased due to the redundancy provision which was created in month 12 of 2024/25. Again, this is not reflected in the plan due to timing. Note that this expected cost was previously included within trade and other payables.

Public dividend capital (PDC) is not as high as expected due to the fact that we have not required revenue support during 2025/26 so far and have not yet drawn down any PDC for capital projects.

Cash balance for the year

The graph below illustrates the cash trajectory since June 2024. The Trust is required to keep a minimum balance of £1.1m.



The Trust's cash balance as at 30 June 2025 was £12.3m compared to a plan of £1.1m. The cash position is relatively healthy compared to plan due partly to the pay award not yet being actioned and our favourable cash position at month 12 which has continued to support us through the early part of 2025/26.

However, 2025/26 continues to remain difficult in terms of cash, with the forecast showing the Trust going overdrawn towards the end of August. The Trust will require cash support for the last 8 months of the financial year.

The cash support regime for 2025/26 has been revised by NHSE and, as we are in a system that is forecasting to break even, it is envisaged that the system will be required to support the Trust with the cash required, so long as the Trust remains on plan. We are waiting for confirmation from NHSE of this process.

Better Payment Practice Code (BPPC) – Month 3

West Suffolk NHS Foundation Trust

June 2025		
Better Payment Practice Code	**Total bills paid YTD Performance Number**	**Total £ paid YTD Performance £'000**
Non NHS		
Total bills paid in the year	9,588	39,002
Total bills paid within target	6,572	34,018
Percentage of bills paid within target	***69%***	***87%***
NHS		
Total bills paid in the year	508	6,480
Total bills paid within target	197	3,245
Percentage of bills paid within target	***39%***	***50%***
Total		
Total bills paid in the year	10,096	45,482
Total bills paid within target	6,769	37,263
Percentage of bills paid within target	**67%**	**82%**
Previous month performance	**66%**	**83%**

The table shows the Trust's current performance against the Better Payment Practice Code. 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 3. The performance remains stable as we continue to have a more favourable cash position.

Capital progress report

West Suffolk NHS Foundation Trust

Capital Spend - 30th June 2025	Year to Date - Month 3			Full Year		
	YTD Forecast	YTD Actual	Variance to Forecast	Full year Forecast	Funding Split	
Capital Scheme					Internal	PDC Available
	£000's	£000's		£000's	£000's	£000's
**New Hospital Programme	1,434	963	471	13,366		13,366
RAAC	150	170	-20	600		1,340
Estates	1,349	360	989	6,500	5,575	
Digital/IT	428	42	386	3,138	3,138	
*Medical Equipment	159	-8	168	1,275	550	
Radiology	276	430	-153	1,305	1,215	
Newmarket Endoscopy	-	-	-	2,500		2,500
Other UEC Schemes	-	-	-	4,654	1,000	4,654
Net zero	-	-	-	420		420
Total Capital Schemes	3,796	1,956	1,841	33,758	11,478	22,280
Overspent vs Plan					33,758	
Underspent vs 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
*** Figures aligned to submitted PFR

The Capital Plan for 2025/26 has been agreed at £25.6m. In month 2 an additional £1m of CDEL was awarded to the Trust, and in month 3 additional PDC was awarded of £7.2m taking the Capital Plan to £33.8m. £11.5m of this is internally funded, with the remaining £22.3m being funded by Public Dividend Capital (PDC).

Year to date capital spend at month 3 is £1.95m. This is slightly behind the phased plan, but at this early stage we anticipate that the plan for 2025/26 will be achieved.

Given on-going concerns over cash and the impact of our capital expenditure on our future I&E position (depreciation and PDC), we are continually reviewing our Capital Programme.

5.3. Green Plan 2025-29 (ATTACHED)

Neil Jackson attending

For Approval

Board Meeting	
Report title:	West Suffolk NHS Foundation Trusts Green Plan 2025-2029
Agenda item:	5.3
Date of the meeting:	25/07/2025
Lead:	Simon Taylor
Report prepared by:	Louise Brooks

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 Trusts current Green Plan runs from 2021-2025, this new version is written in line with NHS guidance and requires sign off by the Board.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
Net zero is embedded into legislation through the Health and Care Act 2022. It is a requirement of The NHS Standard Contract for all provider Trusts to have a Green Plan and for it to be updated.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
Sign off required by the Trust Board ready for publication on the trust website in August 2025. Continual annual monitoring of targets via the Sustainability Net Zero Steering Group (SNZSG).
Recommendation / action required
Approval and sign off (content only) The communications team will be designing the document in line with new accessibility requirements and embedding it into the Green Plan section on the new website. Infographics and photos will be included in the design. A PDF version will be printed and given to the Greener NHS team to ensure compliance.

Previously considered by:	
Risk and assurance:	Yes
Equality, diversity and inclusion:	Yes
Sustainability:	Yes
Legal and regulatory context:	No

West Suffolk NHS Foundation Trusts Green Plan

2025-2029

Contents

Foreword

Welcome to our updated Green Plan!

West Suffolk NHS Foundation Trust's (WSFT) Green Plan continues to represent pivotal steps towards a sustainable future for healthcare and our commitment to patients, staff and the wider community.

This is our second Green Plan, which continues to be a high-level strategy document backed up by a detailed action plan that sets out our ambitions and targets from 2025-2029. This plan is will also cover the period where will be delivering a new West Suffolk Hospital, with the ambition being to construct this using net zero techniques.

At WSFT our vision is to lead by example by integrating sustainable practices into all aspects of how we deliver our services. This collaborative approach will not only help us protect our planet but also enhance the quality of care we provide.

"Sustainable development is development that meets the needs of the present without compromising the ability of future generations to meet their own needs." (Brundtland Report, 1987)

Through great leadership, dedication and collaborative working we will contribute towards making a significant difference.

The Trust will strive to provide sustainable healthcare by working within our available resources, to protect and improve health, now and for future generations. We believe this definition is not just compatible with the Trust's ambitions – first for our patients, first for our staff and first for the future – but also underpins them.

This Green Plan demonstrates our commitment to playing a leading role in securing a healthy, sustainable Suffolk.

(insert name and job title of the owner of the foreword, or rewrite if not appropriate)

Introduction

West Suffolk NHS Foundation Trust provides healthcare to a population of around 280,000 within a geographical area of around six hundred square miles in a range of different healthcare settings. The main catchment area for the Trust extends to Sudbury in the south and Newmarket to the west . Whilst serving the population of Suffolk, WSFT also provides care for those living in the neighbouring counties of Essex, Cambridgeshire, and Norfolk.

As part of this we provide community health services in the west of Suffolk, and some specialist community services across the county. This includes the delivery of care in a variety of settings including people's homes, care homes, community hospital inpatient units and clinics, day centres, schools, GP surgeries, and health centres.

The Trust is one of the largest employers in Suffolk, employing around 5,500 staff.

The Trusts vision is to deliver the best quality and safest care for our community.

Our sustainability development mission statement is:

"West Suffolk NHS Foundation Trust will distinguish itself by making sustainability a part of all we do. In partnership with patients, staff and the local community, our plan captures the social, environmental, and economic impact of our actions".

A Net Zero NHS

In 2020 the NHS made a commitment to become the first healthcare service in the world to reach net zero. From this, the 'For a greener NHS programme' was launched to build on the great work that trusts across the country were already doing and to encourage shared learning on how to reduce the impact on public health and the environment. In 2022 the NHS became the first health system to embed net zero into legislation through the Health and Care Act 2022.

The NHS is the UK's largest public sector organisation and estimated to be the 6th largest employer in the world *(nhs confed.org*). In 2019 The NHS's carbon footprint was around 25 million tonnes of carbon dioxide equivalent (CO2e) a year (around 4% of the UK's total carbon emissions). As a health service, the NHS must reduce its carbon footprint, helping to reduce the threat to humanity posed by climate change.

There are two clear targets the NHS must achieve as part of their net zero commitment, we as an NHS Trust support these targets and demonstrate our commitment through this Green Plan.

- **For the emissions we control directly** (the NHS carbon footprint): The NHS must reach net zero by 2040, with the ambition to reach an 80% reduction by 2028-2032 from a 1990 baseline, equivalent to a 47% reduction.

- **For the emissions we can influence** (our NHS carbon footprint plus): The NHS must reach net zero by 2045, with an ambition to reach an 80% reduction by 2036-2039 from a 1990 baseline, equivalent to a 73% reduction.

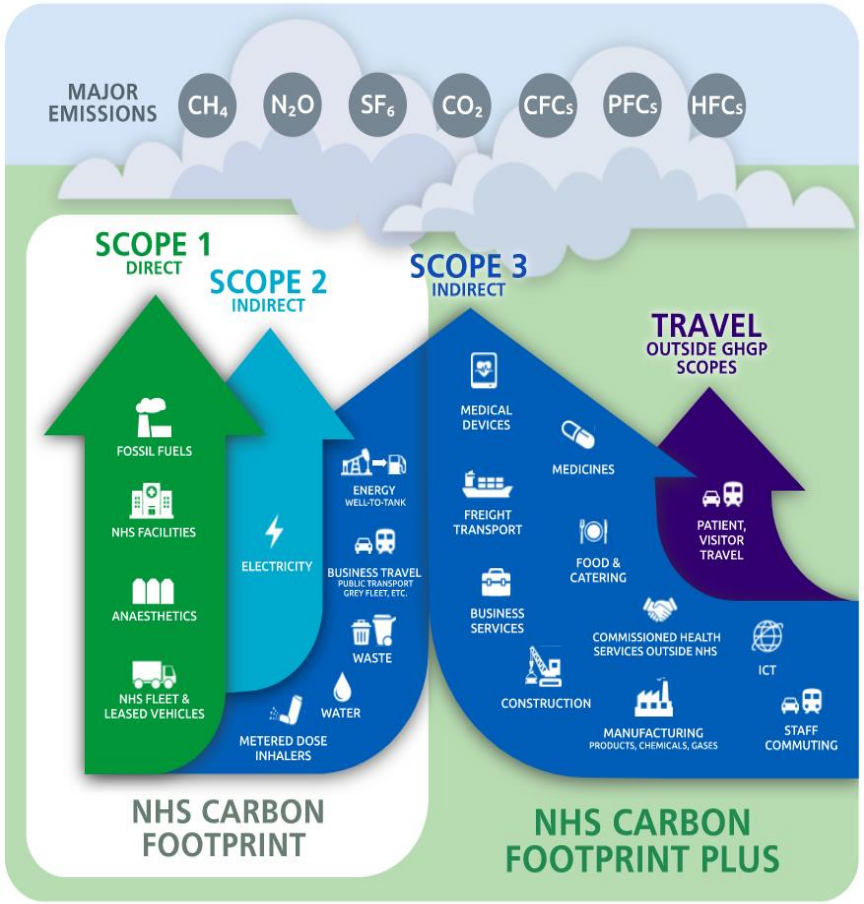


Figure 1: Graphic from Delivering a 'Net Zero' National Health Service

Drivers for change

Drivers for change help us to take accountability for our actions, they help propel and motivate us to ensure we constantly improve and are working towards a more sustainable future for healthcare. Our drivers for change will be updated with each edition of our Green Plan, to reflect how we are working with any new guidance and legislation.

Legislative

Climate Change Act 2008

Public Services (Social Values) Act 2012

Health and Social Care Act 2022

Environment Act 2021

Procurement Act 2023

Mandatory Biodiversity Net Gain 2024

Statutory Guidance

Delivering a ‘Net Zero’ National Health Service Report

CQC Well Led Framework – Sustainable development Quality Statement

NHS Estates Strategy

Green Plan guidance

Drivers for change

There are also non-legislative and non-mandatory drivers which encourage the creation of a net zero world, such as the United Nations Sustainable Development Goals. We will use these and incorporate them into future Green Plans as appropriate.

Figure 2: The United Nations Sustainability Goals

Climate Change and Human Health

The World Health Organisation (WHO) states that climate change is directly contributing to humanitarian emergencies from heatwaves, wildfires, floods, tropical storms and hurricanes and they are increasing in scale, frequency, and intensity. In the UK we are experiencing an increase in severe flooding, heat waves and wildfires which have the potential to impact our health system.

Mitigating the effects of climate change and adapting our estate is crucial for the Trust to maintain our ability to provide high quality and safe care, protect vulnerable people in the community and ensure the resilience of our healthcare system.

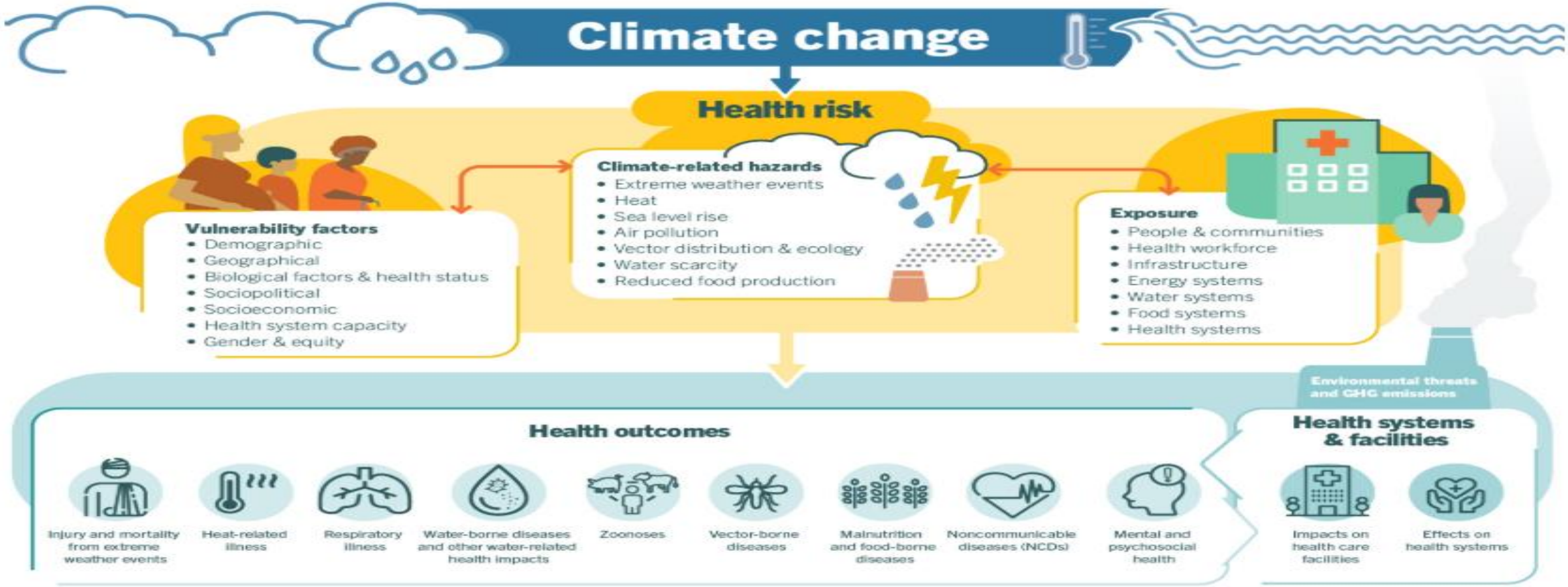


Figure 3: WHO, An overview of climate-sensitive health risk, their exposure pathways and vulnerability factors.

Sustainable Approach to Delivering Healthcare

To deliver this Green Plan we continue to work collaboratively with our staff, patients, communities and external stakeholders. The Trust is part of an Integrated Care System (ICS) and the West Suffolk Alliance which is comprised of other local public sector organisations. The integrated Care Board (ICB) within the ICS aim to focus on the Centre for Sustainable Healthcare's 'Principles of Sustainable Healthcare'.
Applying these principles ensures the Trust delivers actions in line with the ICB and underpins the '3 up 3 down' approach:

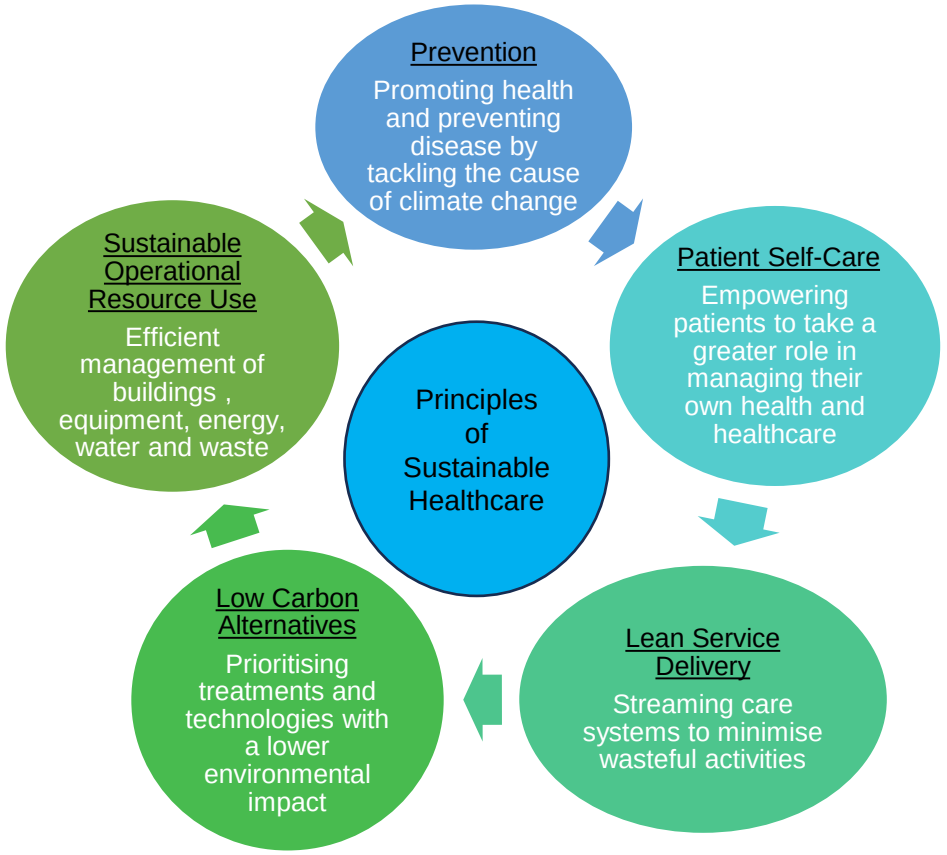


Figure 4: The Centre for Sustainable Healthcare's Principles of Sustainable Healthcare

3 up to increase

- **Green Spaces and Biodiversity**
- **Climate resilience**
- **Social value**

3 down to reduce

- **Carbon emissions**
- **Air pollution**
- **Waste**

Governance, Monitoring and Reporting

The key focus areas that continue to feature in our Green Plan are essential to us delivering a sustainable healthcare system for our patients, staff and the wider community. Providing a sustainable health service means a 'systems thinking' approach to the environmental, social and economic aspect of everything we do. The strategic priorities within the Green Plan will aim to support the Principles of Sustainable Value and The Principles of Sustainable Healthcare.

$$\text{Sustainable Value} = \frac{\text{Outcomes for patients and populations}}{\text{Environmental + Social+ Financial Impacts}}$$

To ensure we deliver the actions in our Green Plan we must maintain good governance, monitoring and reporting through the following channels:

Trust Board - The Net Zero Board Lead is responsible for the delivery of the Green Plan and along with other members of the Board, provides strategic oversight and support where necessary.

Sustainability Net Zero Steering Group (SNZSG) – The Sustainability Net Zero Steering Group meet monthly to ensure the Green Plan actions are being implemented. They report bi-annually to the Insight Committee and annually to the Board.

Net Zero Delivery Groups - The Net Zero Delivery Groups are the stakeholders (often the heads of departments) who are responsible for the individual focus areas. They will look to ensure that sustainability is embedded across their departments, provide Key Performance Indicator (KPI) measurements and report back to the SNZSG.

Green Champions - The Green Champions play a pivotal role in our Green Plan by promoting, encouraging and facilitating sustainability initiatives across the Trust. The champions report up to the SNZSG through the Sustainability Officer.

The Trust reports quarterly and annually to the Greener NHS to ensure we are contributing to the wider NHS net zero targets.

Workforce and System Leadership

Net Zero Delivery Group Lead - Executive Director of Workforce and Communications

Workforce and leadership ensures that sustainability initiatives are effectively implemented and supported across the entire organisation. A workforce that has the tools to deliver sustainable practices day-to-day both clinically and non-clinically will help us meet the ambitions set out in the Green Plan.

Strategic actions achieved so far

- Appointed a designated board-level net zero lead
- Sustainability is included in all job descriptions throughout the Trust
- Leadership management and coaching programmes in place to support staff development
- Launched a Green Champion Group to promote and deliver sustainability initiatives across the Trust, champions commit to completing the 'Building a Net Zero NHS' training
- Collaborated with the Royal Society for the Protection of Birds (RSPB) to introduce a nature at work programme to support staff health and wellbeing by encouraging nature connectedness and encouraging pro environmental behaviours
- Outdoor courtyard space at the main hospital site used for patient recovery from strokes. The courtyard is specifically designed to aid in rehabilitation.
- Introduced a Sustainability Officer apprenticeship role with level 4 training to become a Corporate Responsibility and Sustainability Practitioner

Strategic priorities for 2025-2029

- Integrating sustainability into our culture and values
- Engaging the workforce through green skills training and education
- Promoting patient and public engagement
- Embedding sustainability in decision making processes

Sustainable Models of Care

Net Zero Delivery Group Lead- Executive Chief Operating Officer

Sustainable models of care are vital for ensuring the long-term resilience and efficiency of our healthcare service. By integrating environmental, social and economic sustainability, these models will help to improve the quality of care we provide through preventative measures, holistic approaches and community-based solutions, leading to a reduction in health inequality while reducing costs.

Strategic actions achieved

- Integrated neighbourhood team have introduced route optimisation to minimise unnecessary travel between patient visits; reducing carbon emissions
- Occupational therapists have created a therapeutic garden space at Sudbury Community Health Centre to deliver clinical interventions in a green space
- Virtual ward uses digital platforms and technology to monitor patients and care for people that would otherwise be in hospital

Strategic priorities for 2025-2029

- Move towards preventative and community-based care
- Sustainable use of resources in our healthcare delivery
- Working with the clinical teams to look at the high carbon intensive departments
- Implement quality improvement projects in clinical areas that aim to reduce CO2e emissions

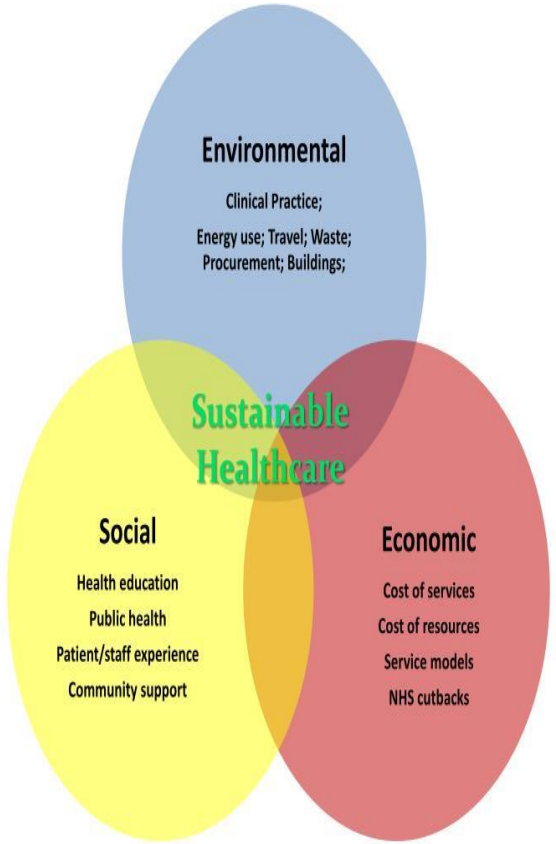


Figure 5 : The Centre for Sustainable Healthcare

Digital Transformation

Net Zero Delivery Group Lead- Head of Digital Transformation

Digital transformation is crucial to our Green Plan for both staff and patients. It will help improve the efficiency and accessibility of the care we provide. Developing digital tools will also help to break down barriers to care, reducing health inequalities.

Strategic actions achieved

- Reduction of email attachments from the community integrated neighbourhood team by transitioning to an online platform
- Infrastructure in place to move to low power thin client devices running a virtualised desktop
- A 'cloud first service strategy' in place where appropriate and work with suppliers who support this approach
- Virtual consultations, remote monitoring, digital dictation, and secure clinical messaging are all in place. Staff can work remotely using Microsoft Teams and Office365
- Installed a single combined portal for patients attending the main hospital site to access digital appointments, clinical correspondence, and questionnaires. This system fully integrates with the national NHS App
- Development of the staff platform 'Totara' which provides easier access to online training and wellbeing opportunities. It also provides online learning for schools which helps to reduce the number of visits for paediatric clinicians.
- Ensuring the delivery of digital contracts supports sustainability through social value KPI's

Strategic priorities for 2025-2029

- Expand the use of virtual service provision for patients and staff
- Move to digital health records and paperless systems
- Evaluating digital tools such as AI to streamline our services
- Optimising energy use with digital solutions and consider circular and low carbon approaches

Travel and Transport

Net Zero Delivery Group Lead- Business Manager

Travel and transport is essential to the service we provide from transporting patients, ensuring accessible routes to our healthcare sites to the delivery of goods and medical supplies to teams working out in the community. Having a well thought out travel and transport plan is crucial to us reducing our CO2 emissions, improving air quality and ensuring the timely delivery of the goods and services needed.

Strategic actions achieved

- Collaborated with Suffolk County Council to increase bus routes to the main hospital site
- Travel Plan reviewed annually, and staff encouraged to take part in a travel survey
- The Trust only lease cars that are ultra-low emission vehicles (ULEZ) or zero emission vehicles (ZEV)
- Patient transport contracts for taxis and ambulances include a no engine idling requirement
- Cycle to work and car sharing scheme implemented

Strategic priorities for 2025-2029

- Reducing air pollution through all Trust vehicles ,salary sacrifice, lease and some onsite hire cars to be zero emission vehicles (ZEVS)
- Develop a sustainable travel plan to be incorporated into the green plan by December 2026
- Encouraging sustainable travel for patients through the implementation of the travel, transport and access plan
- Sustainable delivery and logistics
- Collaboration with local and national authorities

Travel and Transport

The delivery of our net zero targets in this focus area will be guided by the NHS Net Zero Travel and Transport Road Map

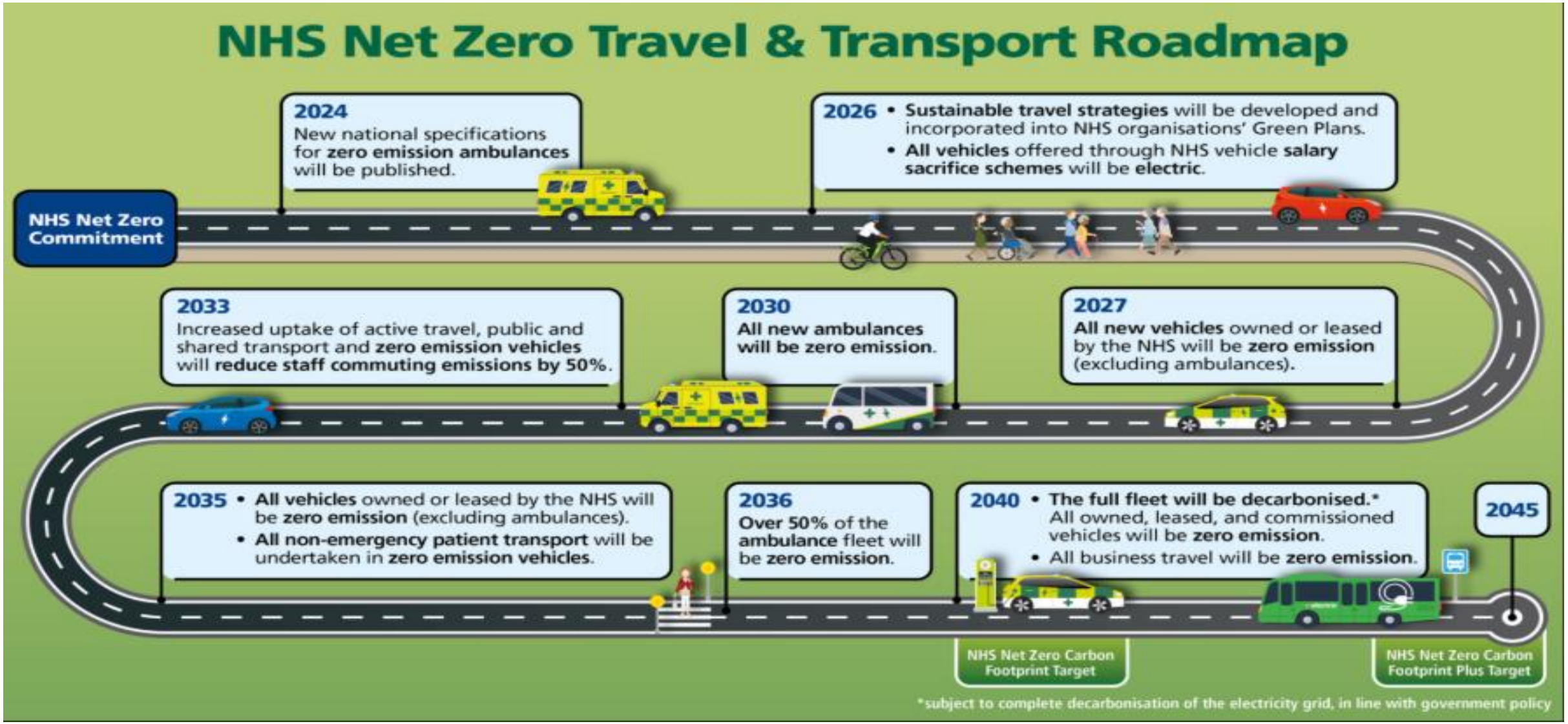


Figure 6 The NHS Travel and Transport Roadmap

Estates and Facilities

Net Zero Delivery Group Leads - Head of Estates/ Head of Facilities

Estates and facilities will continue to be at the forefront of us achieving our Net Zero targets. We will continue to reduce our carbon emissions by adopting sustainable building practices, retrofitting our existing estate, decarbonising our heating and transport systems and improving our green spaces. These all contribute to mitigating the effects of climate change on human health .
The delivery of our net zero targets in this focus area will be guided by the NHS Estates 'Net Zero' Carbon Delivery Plan .

Strategic actions achieved

- Introduced reusable cleaning equipment to reduce single use items such as mop heads and cleaning cloths
- Built a Nearly Net Zero Build (NZEB) Community Diagnostic Centre (CDC) at Newmarket Community Hospital that saved 238 tonnes of carbon in the construction. It has PV and heat pump technology contributing to 45% of the building energy requirements. Hot water at the CDC is provided solely by air source heat pumps. 10% biodiversity net gain included in this build
- Increased our electric vehicle (EV) chargers, we now have seventeen charging spaces ,a mix of single and double 22kw fast chargers
- Installed energy metering at building level that provide real-time monitoring and control of energy use

Strategic priorities for 2025-2029

- Improve energy efficiency and security
- Decarbonising our estate through the development of a heat decarbonisation plan (HDP)
- Water conservation
- Sustainable design and infrastructure through the NHS Net Zero Building Standards
- Climate resilience and adaptation

Green Space and Biodiversity

Net Zero Delivery Group Leads - Head of Estates/ Sustainability Officer

Green spaces on our healthcare sites contribute to both environmental sustainability and health and wellbeing for staff and patients. Preserving our green spaces could help to reduce the effects of climate change such as air pollution, flooding and extreme heat .

Strategic actions achieved

- Corporate volunteers helping to maintain the hospital site courtyard gardens increasing their own organisations social value
- Introduced bird boxes and bug hotels to our various green spaces
- 10% biodiversity net gain introduced as mandatory for capital development projects to help protect green space
- Carried out an ecological survey of the new hospital site and successfully relocated a rare species of fungi
- The Trust participates in 'no mow may' leaving designated areas for wildlife

Strategic priorities for 2025-2029

- Improve our connection to nature through sustainability and environmental education
- Increase greenspace availability
- Pollinator-friendly initiatives
- Therapeutic garden spaces
- Green space accessibility and inclusivity

Waste and Circular Economy

Net Zero Delivery Group Leads - Head of Estates/ Energy and Waste Manager

Waste management and circular economy are essential for our contributions towards net zero. Incorporating waste reduction and circular economy principles will help us to reduce our carbon emissions , optimise resource use and supports innovation.

Strategic actions achieved

- Introduction of offensive waste stream, resulting in fewer carbon emissions produced when being incinerated
- Over the past 4 years we have focused on implementing the waste hierarchy through the correct segregation of waste ,the overall recycling rate at WSH from 2019-2024 was 22% and 11% at Newmarket Community Hospital
- 2 silver awards achieved from the NHS's Awards for Excellence in Waste Management for the biggest reduction of carbon emissions and the best reduction of clinical waste for the year (2024)
- Development of the Exchange Hub, an internal reuse network for non-clinical items such as desks, chairs and cabinets
- Repurposing used food containers into battery bins
- Introduction of a pallet reuse scheme
- Expanded recycling streams to include rigid plastic, non-confidential paper and card, soft plastics, aluminium, and infectious metals
- Continued provision of reusable sharps containers instead of single-use at both WSH and Newmarket Community Hospital
- The Trust is the second contract in the UK to be connected to the 'Tell Us Once' service, this will further increase the opportunities for the return and reuse of community equipment.

Strategic priorities for 2025-2029

- Reducing the overall amount of waste created across the Trust, developing metrics that allow this to be tracked whilst accounting for growth
- Moving from waste to resource, through application of circular economy principles
- Further application of the waste hierarchy

Medicines

Net Zero Delivery Group Lead- Chief Pharmacist

Medicines are an important area of focus for the Trust and a key component in delivering healthcare to our patients. From the production to the disposal process, medicines are the second biggest contributor to scope 3 emissions and account for 25% of emissions produced by the NHS .

Strategic actions achieved

- Eliminated Desflurane anaesthetic gas in our theatres, only allowing exceptional use
- Reuse of patients own medication on admission
- Avoidance of dispensing on discharge if patients have sufficient supply at home
- Return and reuse of stock and temporary stock items issued to clinical areas where storage conditions are appropriate
- Regular review of stock holding in pharmacy with the aim to hold no more than 20 days of stock
- Ensure appropriate stock management to prevent waste from expiry dates
- Removed plastic carrier bags for medication and replaced with paper where appropriate
- Use of pharmacy ‘reuseable green bags’ to transfer medicines form pharmacy to wards
- Received funding from NHSE, decommissioned our nitrous oxide manifold and moved to a leaner portable supply to mitigate the waste from a harmful greenhouse gas
- Medicines wholesalers delivering in reusable plastic tote bags or recyclable carboard boxes and bulk fluid delivery on reusable pallets

Strategic priorities for 2025-2029

- Reduce the use of nitrous oxide from the medical gas pipeline system
- Low carbon alternative inhalers where appropriate
- Reducing pharmaceutical packaging
- Medicines optimisation

Supply Chain and Procurement

Net Zero Delivery Group Lead- Head of Procurement

Supply chain and procurement directly influence both our environmental sustainability and operational efficiency and are responsible for scope 3 emissions. We will be working with suppliers to promote ethical sourcing, minimising waste and supporting local economies. This will help improve health outcomes, contribute to system change and generate long-term cost savings.
The delivery of our net zero targets in this focus area will be guided by the NHS Net Zero Supplier Roadmap.

Strategic actions achieved

- Embedded 10% social values into all tenders
- Created KPI templates for ongoing monitoring of social value
- Embedded carbon reduction plans on all procurements over £5 million
- Recycling contracts in place for plastics, cooking oil, food waste, paper, metal, wood, cardboard, furniture, textiles and WEEE
- The Trust procures 100% renewable electricity from the grid and has installed 5 solar PV systems at the main hospital site and between 2023-2024 generated 50,157 kwh of energy

Strategic priorities for 2025-2029

- Sustainable sourcing and supplier engagement
- Collaboration and partnership with other NHS Trusts and suppliers
- Carbon footprint reduction
- Looking into more reusable items over single use

Food and Nutrition

Net Zero Delivery Group Lead- Head of Facilities

Food and nutrition play a crucial role in supporting the health and wellbeing of our patients and staff but also in driving environmental sustainability improvements. Sustainable food practices reduce carbon emissions, waste and can also have a cost saving.

Strategic actions achieved

- Regularly review and adapt menus to ensure they are healthy
- Installed an electronic meal ordering system at Newmarket Community hospital , plans in place to install this at WSH
- We hold the food for life bronze award
- Our meals are prepared and cooked fresh on site by our catering team
- We measure our food waste via our plated meal service
- We purchase our produce locally where possible e.g. our meat supplier is 10 minutes away from our main hospital site and our fresh fruit and vegetables are from Norfolk offering a seasonal choice and reducing the need for higher carbon out of season produce
- All our fish is sustainably sourced
- All our meat is red tractor certified

Strategic priorities for 2025-2029

- Reduce food waste across the organisation
- Installing digital technology to streamline ordering
- Provide lower carbon meal options

Adaptation

Net Zero Delivery Group Lead- Emergency Planning and Business Continuity Manager & Head of Development

Climate adaptation is the process we will go through to adjust our systems, practices and policies to minimise the negative effects of climate change. Adaptation is an essential strategy for the Trust to help maintain the quality and resilience of our healthcare service. Protecting patient and staff health, improving infrastructure and optimizing operational efficiency will help to support our sustainability goals, reducing risk and cost, allowing us to contribute positively to public health and climate resilience.

Strategic actions achieved

- The Trust has a named adaptation lead

Strategic priorities for 2025-2029

- Climate risk assessment and monitoring
- Building climate resilient infrastructure

The Net Zero Estate

Lead- Future Systems Team & Head of Development

The Trust's strategy for all new build and refurbishment construction projects , including the replacement net zero hospital in Bury St Edmunds , shall question and challenge standard approaches by exploring the art of the possible , through :

Construction

Net Zero Carbon ,Why Can't we? ……

Be Lean- Use less energy

It is anticipated that the thermal envelope performances, will follow the Passivhaus standards, which are informed by detailed thermal analysis, optimising this approach with the energy strategy.

Be Clean- Supply energy efficiency

The energy supply to all Trust owned buildings will be through electrification and the continued use of decarbonised grid electricity replicating the national drive for all future designs to be fully electric.

Be Green- Low or zero carbon energy sources

An all-electric strategy using a combination of air and ground source heat pumps and onsite generation of electricity, will greatly reduce CO2 emissions. With electricity in the UK significantly decarbonised already and projected to continue decarbonising so that it is close to or net zero carbon in the future, constructing and refurbishing the WSFT estate to 100% electric servicing strategies are a futureproof solution.

Strategic priorities for 2025-2029

- In compliance with UK law , all developments will have set targets for biodiversity net gain as a fundamental aspect of the design and construction. Mitigation strategies will be developed to minimise loss of biodiversity.
- The landscape strategies set out the Trust's ambition to create therapeutic inspired patient gardens. Existing landscapes will be utilised, and new habitats will be provided.
- All build projects will follow the procedures defined in the NHS Net Zero Building Standard to achieve a reduced carbon footprint in the materials used for construction.

5.4. Acute Contract Signing (ATTACHED)

Presented by Nick Macdonald

WSFT Board of Directors (Open)	
Report title:	**Acute Contract Approval**
Agenda item:	
Date of the meeting:	
Sponsor/executive lead:	Jonathan Rowell
Report prepared by:	Allan Petchey, Senior Contracts Manager – Contracts & Commissioning

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

Completion of the 3-year contract document with SNEE ICB running from 1st April 2025 to 31st March 2028

The NHS Contract is the mandated NHS Contract that is fixed for the three year period. Financial uplifts will be mandated by the Department of Health & Social Care based on inflationary uplifts and cost improvement targets that are set annually. This is a very large document so has not been included within this paper, although it is available for review upon request.

Although there are an unspecified number of wording changes between this version of the contract and previous versions, plus confirmation of previously agreed changes such as the COVID 19 vaccination not being mandatory. The main headline is outlined below around the growing importance of the Indicative Activity Plan e.g. commissioners will not be obliged to pay over the notified payment limit. Other changes of note are:

Commissioners can apply notified payment limits for activity-based services;

More flexibility in aggregating payments across services;

Investment in GP contracts nationally to include more advice and guidance;

New duties around staff attendance, retention, and sexual safety policies;

Enhanced obligations around stakeholder engagement and health literacy;

Providers must support medicines optimisation initiatives; and

Expanded use of Child Protection Information Sharing Service (CP-IS) across more care settings.

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

This is the main income contract for the Trust. Total 2025/26 value: £267,224,387 (SNEE only) and it is agreed on a block basis (except CDC, where under performance could be clawed back).

With the previous contract being 3 years old, the contract wording has been reviewed and updated in line with current practices and service provision. Where applicable, service leads have reviewed and approved sections relating to their services.

The Indicative Activity Plan represents the affordable levels of activity that can be achieved within the funding envelope the commissioner has received in their allocation. This therefore means system wide service redesign and productivity improvements are required to be able to deliver the national targets around RTT. The following assumptions have therefore been made to increase activity levels above those within the IAP without requiring an increase in resource.

- Advice & Guidance – a 45% increase in diversions with the doubling of the current uptake in the number of advice and guidance requests once the new primary care incentive scheme is introduced nationally. This would lead to a 3,800 reduction in clock starts.

- Waiting List Validation – a reduction in active patients on the waiting list by undertaking periodic validation sprints as per the national programme. It is anticipated this will remove 900 patients from the waiting list.

- Daycase/Elective - a 2% increase in productivity to deliver more cases per list and to fully utilise theatre capacity.

- Outpatient First Attendance – a 4% increase in outpatient first attendances. This will be undertaken by improving productivity, reducing DNAs and resource creating with the reduction in follow up attendances.

- Outpatients Follow Up Attendances – a 6% reduction in outpatient follow up attendances. This will be achieved by reviewing and moving more patients onto PIFU (Patient Initiated Follow Ups) and increasing productivity. The resource created will be used to see more first attendances and deal with the increased workload from the uptake of advice and guidance requests.

Both parties will monitor performance against the activity levels agreed in the IAP and the increased numbers required to achieve the nationally set RTT targets.

Both Parties have agreed that service developments will be managed within the Expected Annual Contract Value unless ringfenced funding is made available. If ring fenced funding is available and the Commissioner prepares a Contract Variation this shall be clear on the objectives of the service and clearly set out exit arrangements following the end of any non-recurrent schemes: this is designed to prevent or deter one year funding turning into a following year cost pressure.

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

The Acute Contract is managed and monitored via the monthly Contract Management Meetings held between the ICB and the Trust. Further monitoring of contract performance is undertaken internally.

Action Required

Signing off of the Contract by the Chief Executive Officer.

Risk and assurance:	**Failure to deliver the Contract and in particular activity can result in Financial Loss in later years.**

Equality, Diversity and Inclusion:	**Under the NHS Act 2006 (as amended by the Health and Care Act 2022), Acute Trusts must consider how their decisions and services reduce inequalities in access, experience, and outcomes. Trusts are required to appoint a named executive lead for health inequalities and embed accountability at board level**
Sustainability:	**Every Acute Trust must produce a board-approved Green Plan aligned with NHS England's guidance. These plans outline how the Trust will reduce emissions, improve resilience to climate impacts, and support sustainable healthcare delivery over a 3-year cycle. It is a key area noted as part of the Acute Contract.**
Legal and regulatory context	**ICBs contract with Provider Trusts as the statutory bodies responsible for planning, funding, and overseeing most NHS services in England formalised under the Health and Care Act 2022.**

Acute Contract Approval

1. Introduction

1.1 The Contract between SNEE, Associate Commissioners and WSFT cover a period between 1st April 2025 and 31st March 2028. This is the main income contract for the Trust. Total 2025/26 value: £267,224,387 (SNEE only). It is a "block" contract for all areas outside of the CDC.

The over-riding agreement with WSFT relating to the Lead Commissioner's Activity is to continue a Guaranteed Income Contract (GIC: our block) which stabilises (a) the costs to commissioners, and (b) the income to the Provider, at the levels agreed in the financial plan for the whole year. The GIC value is based on affordability values rather than priced activity quantum. There are no thresholds associated with over/under-performance against the activity/financial plan.

As the GIC value is set on affordability rather than using national tariff rules, there will be no adjustments to the GIC value for contract penalties. Similarly, there will be no addition to the GIC value for CQUIN payments. It is assumed that both these are within the GIC value as set out in this contract.

Contract Schedule
WEST SUFFOLK NHS FOUNDATION TRUST
2025/26

Item	Acute £	Acute - Pathology £	Acute - Other Income (System Top Up) £
Opening Contract Value	186,761,458	5,156,998	35,301,362
Initial Inflation	7,750,602	214,015	1,465,006
Initial Efficiency	(3,735,229)	(103,140)	(706,028)
Growth - Elective activity - RTT 2025/26	0	0	0
Growth - Elective activity - non-RTT 2025/26	88,591	108,297	0
Growth - Non Elective activity 2025/26	3,279,141	0	0
Growth - A&E Activity 2025/26	420,829	0	0
Growth - Maternity Activity 2025/26	193,456	0	0
Growth - Drugs (primary & excluded secondary) 2025/	98,892	0	0
Convergence	(538,791)	(14,955)	(102,131)
ERF	10,038,081	0	0
ERF (provisional capped value)	3,133,784	0	0
CNST	607,397	0	0
UEC Bed Capacity	3,436,037	0	0
UEC Capacity	1,382,972	0	0
Covid Testing	397,917	0	0
Maternity SDF (Ockenden)	226,807	0	0
Medical Examiners	283,645	0	0
Non Recurrent Support for NHS Providers Non NHS Incc	283,207	0	0
Depreciation funding	3,622,000	0	0
CDC Funding - Newmarket	7,401,167	0	0
IFRS 16	773,000	0	0
		0	0
	225,904,963	5,361,215	35,958,209

	The total payment includes contributions from Associate Commissioners such as Norfolk & Waveney ICB who are the largest and most significant contributor at £29,029,265 which includes a Community Contribution of £510,058. During the period of the contract there are a number of changes being proposed by the Government that may impact the total value and require changes to the main contract as key assumptions around the construction of the Block are challenged and will eventually be evolved. Overall, the contract is part of the reset of the Financial Governance Framework and that there will likely be an update for 26/27 – we will update the Board of these changes in due course.
2.	**Background**
2.1	The contract enables SNEE ICB to commission acute care services, such as emergency treatment, surgery, and inpatient care from WSFT to meet the needs of the local population. It outlines the specific services to be provided, performance expectations, quality standards, and reporting requirements. This ensures consistency and accountability in care delivery. The contract sets out payment mechanisms, including activity-based payments or block contracts, aligned with the NHS Payment Scheme. It helps manage budgets and ensures financial transparency between the parties. Whilst supporting the broader goals of the Integrated Care System (ICS), the contract encourages collaboration between providers to improve population health, reduce inequalities, and enhance value for money. In order to provide Oversight and Governance the contract provides a framework for monitoring performance, resolving disputes, and ensuring compliance with national priorities and local strategies.
3.	**Detailed sections and key issues**
3.1	This year, the Indicative Activity Plan (IAP) is especially important because of major changes in NHS contracting and financial planning that directly affect how services are delivered and funded.
3.2	Mandatory for Activity-Based Services - Under the 2025/26 NHS Standard Contract, IAPs must now be agreed for all services paid on an activity basis (excluding block contracts). Budget Pressures & Planning Certainty is essential with tighter budgets and a push for cost-efficiency, IAPs help commissioners and providers align expectations around service volumes, ensuring resources are used wisely and transparently. The IAP sets a baseline for expected activity. While it's not a rigid cap, it helps avoid disputes over payments for over- or under-delivery. New escalation procedures have been introduced to resolve disagreements if commissioners don't follow proper guidance. To help supports System-Wide Coordination, IAPs are now part of broader efforts to improve collaboration across Integrated Care Systems (ICSs), helping balance demand, capacity, and performance across regions. Protecting Patient Choice, although commissioners can set IAPs, they must consider patient safety, experience, and equality impacts. Plans must not restrict legal rights of patients to choose providers. In short, the IAP is no longer just a planning tool, it is a strategic lever for managing NHS activity, finances, and patient access in a year of significant reform. IAPs are emerging as a key operational lever for delivering both the Fit for the Future: 10 Year Health Plan for England and the Neighbourhood Health Guidelines 2025/26. The IAP helps translate the three major shifts in the 10-Year Plan from hospital to community, analogue to digital and sickness to prevention using measurable service volumes. By setting expectations for activity, it ensures providers are resourced to deliver care in new settings like Neighbourhood Health Centres and virtual wards. The IAP will support in future:

- the Neighbourhood Health Service model by forecasting demand for community-based services, such as rehab, diagnostics, and mental health support. This allows the emerging ICBs to commission care that's proactive, personalised, and closer to home;

- financial discipline and Value-Based Care with the NHS shifting toward value-based outcomes, the IAP ensures that activity-based payments reflect strategic priorities; not just volume. This helps rebalance spending away from acute hospitals and toward community and preventative services;

- provides a baseline for monitoring delivery against national and local goals. It's a tool for both performance management and dispute resolution, especially as new contracts and service frameworks are introduced under the 10-Year Plan; and

- can impact patient choice, safety, and equality. This aligns with the Plan's commitment to reducing health inequalities and expanding access in underserved areas.

The Indicative Activity Plan for this Contract, covering the full year April 2025 to March 2026 can be found in the document embedded below.

WSFT - SNEE 2526 IAP Final.xlsx

4. Next steps

4.1 Ensure awareness of contractual signing and evolution is shared within the Trust and prioritise the key requirements as outlined above.

5. Conclusion

5.1 The IAP is no longer just a technical requirement — it's a strategic enabler. It helps operationalise the ambitions of the 10-Year Plan and Neighbourhood Health Guidance by:

Strategic Goal	IAP Contribution
Shift care into communities	Forecasts activity for Neighbourhood Health Centres
Improve population health	Supports preventative and personalised care models
Reduce inequalities	Prioritises services in deprived areas4
Enhance system collaboration	Aligns providers under shared activity expectations
Deliver financial sustainability	Links payments to strategic priorities and efficiency

Failure to deliver the Contract and in particular the activity plan can result in the risk of Financial Loss in later years alongside the Risk of lost opportunity caused by poor organisational engagement with required strategic change. These two Risks can be compounded by poor monitoring of activity and a reliance placed on data that is created too late to change direction resulting in:

- Surges in demand (e.g. seasonal spikes) won't be addressed in time, leading to resource strain;

- Staffing shortage or deployment alongside equipment failures could persist longer than necessary;

- Planning based on outdated trends may result in misallocation of resources;

- Surgical scheduling could be mismatched with actual capacity or patient needs;

	• Budgeting and procurement decisions may be based on obsolete or inaccurate activity levels; • Failure to meet waiting time targets or other KPIs are not flagged promptly enough to initiate change; • Missed opportunities to triage or reprioritize cases based on real-time need; and • Patients on the waiting list deteriorate leading to more complex expensive procedures. The contract is designed to assist with driving the change agenda. This will require tighter reporting of data with real-time monitoring and trend analysis assisting improved decision making to achieve the IAP.
6.	**Recommendations**
	Signing off of the Contract by the Chief Executive Officer.

6. QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT

6.1. Improvement Committee Report - Chair's key issues from the meetings (ATTACHED)

To Assure

Presented by Paul Zollinger-Read

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Improvement Committee			Date of meeting: 18 June 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**	**Safeguarding Children and Young People** Medical photographs Vacancy in Community CYP in July Mandatory Training: Community services 91%, Acute Services 89%	1 1 2	Photographs now admissible in court. Role still required and gives an opportunity to review safeguarding provision across the Trust. Not meeting requirements	Image storage needs reviewing from a data protection perspective. Otherwise launch imminent. Adult and CYP leads to collaborate on future service provision. May require a similar approach to BLS training in order to improve training of medical teams	1
5.1 **PQSGG**	**Adult Safeguarding** No Level 3 adult safeguarding training outside the Safeguarding Team.	4 2	Not meeting requirements Ensure patients have given consent for treatment. Restorative Safeguarding	On risk register. Paper scheduled for Mandatory Training Steering Group June 2025.	1

Originating Committee: Improvement Committee			Date of meeting: 18 June 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
	Mental Capacity Act assessments may need to be improved (suggested by audit data)		Supervision Model has been offered to G3, G4, G10, to demonstrate change in these areas	Early signs of improvement in the quality of MCA assessments in these 3 areas.	
5.1 **PQSGG**	**<u>Mental Health</u>** CQC recommend that staff in acute trusts have training to increase awareness of poor MH Increased demand for MH beds Concerns over the complexity of patients with challenging behaviour	 1 2 2	 Training delivered to areas of greatest need: ED, AAU, F7 This results in admission to acute beds and prolonged length of stay: MH intervention tends to be delayed whilst in acute beds. The principles of least restrictive practice should be followed	 Not currently mandatory. Further training being rolled out to matrons and ward managers. Mental Health Strategy being developed by MH team. Continues to be monitored through Bed Wait audit, escalation meetings, and engagement with system partners. Least restrictive practice pilots on G5 and G10, to learn from these events.	 1

Originating Committee: Improvement Committee			**Date of meeting: 18 June 2025**		
Chaired by: Roger Petter			**Lead Executive Director: Susan Wilkinson, Richard Goodwin**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
5.1 **PQSGG**	**Thrombosis** VTE baseline assessments show good compliance	3	This ensures correct prophylaxis is given to reduce VTE. The challenge is to ensure that the assessments lead to appropriate prophylaxis.	Audits are planned. Not entirely clear whether or not there is an issue. The Emerging Incident Reviews will pick up cases if this is the case.	2 Further assurance has been sought from the Thrombosis Group
5.1 **PQSGG**	**Learning Disability and Autism** Oliver McGowan training compliance is low. Tier 1 for all patient facing staff completed by 260 staff across the trust, but Tier 2 for Band 7 senior staff only done by 30.	4	This training is now mandatory. ICB is currently offering Tier 2 training.	Need to ensure all Band 7s have received training before ICB offer is withdrawn. DCN to raise at PRMs and ward manager meeting. Once senior staff are trained, they can help disseminate the information.	1
5.1 **PQSGG**	**Safer Surgery Group** National Safety Standards for Invasive Procedures (NatSSIPs 2) – good compliance in theatres, but additional areas	4	Required national standard. NatSSIPs 2 now includes additional measures for more minor procedures.	A deep dive is planned and will report to Improvement Committee.	1

Originating Committee: Improvement Committee			Date of meeting: 18 June 2025		
Chaired by: Roger Petter			Lead Executive Director: Susan Wilkinson, Richard Goodwin		
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			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
	identified that may not be compliant.				
5.2 **CEGG**	**Accreditation – Biochemistry (Pathology)**	2	Surveillance visit March 2025. Year 2 of 4-year cycle.	Achievable with work: Audits and KPIs are on target	1
5.2 **CEGG**	**Accreditation – Radiology: Quality Standard in Imaging** (moved from UK Accreditation Service)	2	In Year 3 of a 3-year cycle. Date of Year 3 assessment tbc. Currently meeting all QSI standards.	Newmarket CDC will be included in future accreditation. Progress being made on Non-Medical Referrals	1
5.2 **CEGG**	**Life cycle of a clinical audit – National Emergency Laparotomy Audit**	3	Good areas include pre-op assessment and theatre presence of Consultant Surgeon and Consultant Anaesthetist for high-risk patients, and also timely arrival in theatre. Areas for improvement include increased Geriatric support, and mortality data. We are an outlier	Mortality to be discussed at Mortality Oversight Group, Surgical Clinical Governance meeting (June) and joint General Surgery and Anaesthetic meeting (Sept). Geriatric support and considering ReSPECT forms & EoL care planning will help inform the	1

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

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

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7.1	**Maternity Services Update** Neonatal Medical Workforce Planning	1	Requirement to meet set standards (part of Maternity Incentive Scheme). In the 6-month period assessed, cover of weekday neonatal sessions was 100%, and 100% of paediatric consultants had done the required 8 hours of neonatal training.	Monthly monitoring and 6-monthly reporting to continue. Escalation pathway exists for short- and long-term shortages. Ensure that recruitment and retention of staff are key priorities, and forward planning minimises the impact of vacancies	1
7.1	**Maternity Services Update** Maternity Claims Scorecard (01/04/2014-31/03/2024): Incident and Complaint Data (01/01/2024-31/03/2024) Quarterly review	2	In last 10 years, maternity claims for the Trust are approx £32.3 million, with the average claim approx £1.07 million. This is about 49% of the cost of all claims (national average about 60%). Leading causes by volume of cases are unnecessary pain, bladder damage, intraoperative problems and psychiatric injury.	Learning from cases, and the dissemination of this learning remain key focuses. Themes from incidents in Q4 include screening issues, medication errors, early care of neonates, and measuring neonatal oxygen sats at 6 hours. During Q4 there were 5 perinatal deaths and 1 maternal death in the Trust. These are notified as required, and detailed analyses	1

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

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**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

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5.1 **PQSGG**	**Mortuary Services** Human Tissue Authority inspection 2024 made recommendations for refurb. Medical Examiner staffing issues (sick leave and impending vacancy). Funding shortfall.	1 2	Fridge room will be out of action for 4d during refurb. Bereavement room refurb to start July 2025. Role is a statutory requirement. Currently able to mitigate demand, and service being reviewed within funding available	. Mitigations are in place for storage of deceased patients during this time. Conversations with ICB are already in hand re funding shortfall.	1
5.1 **PQSGG**	**Temporary Escalation Spaces (corridor care)**	2	Need to minimise risks to patients and impact on staff. Significant improvement in March 2025 due to ED improvements.	Future plans for TES Group include harm reviews, incident reviews, staff survey results	1
5.1 **PQSGG**	**Hospital Transfusion Committee**				

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

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

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

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

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

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

**See guidance notes for more detail*

Guidance notes

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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 Daniel Spooner

Public Board	
Report title:	Nursing, safe staffing report: **May and June 2025**
Agenda item:	6.2
Date of the meeting:	**25 July 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 May and June 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 Registered Nurse (RN) sickness levels continue in May and June after a number of months >5%. However HCSW sickness remains above 6% • Overall fill rate at 90% for all shifts in M2 and M3 • CHPPD data review reveals inaccuracy over past 5 months, now corrected. • RN vacancy increasing but maintaining <10% • 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 – May and June 2025

1. Introduction

1.1 This paper illustrates how WSFT's nursing and midwifery resource has been deployed for the months of May and June 2025 (M2 and M3). 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 May and June 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 **May and June 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 achieved 90% for 3 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%
May 2025	90%	92%	98%	98%
June 2025	92%	94%	97%	99%

Table 1

The total average of 'planned versus actual' staffing fill rates are showing an improving variation having 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),

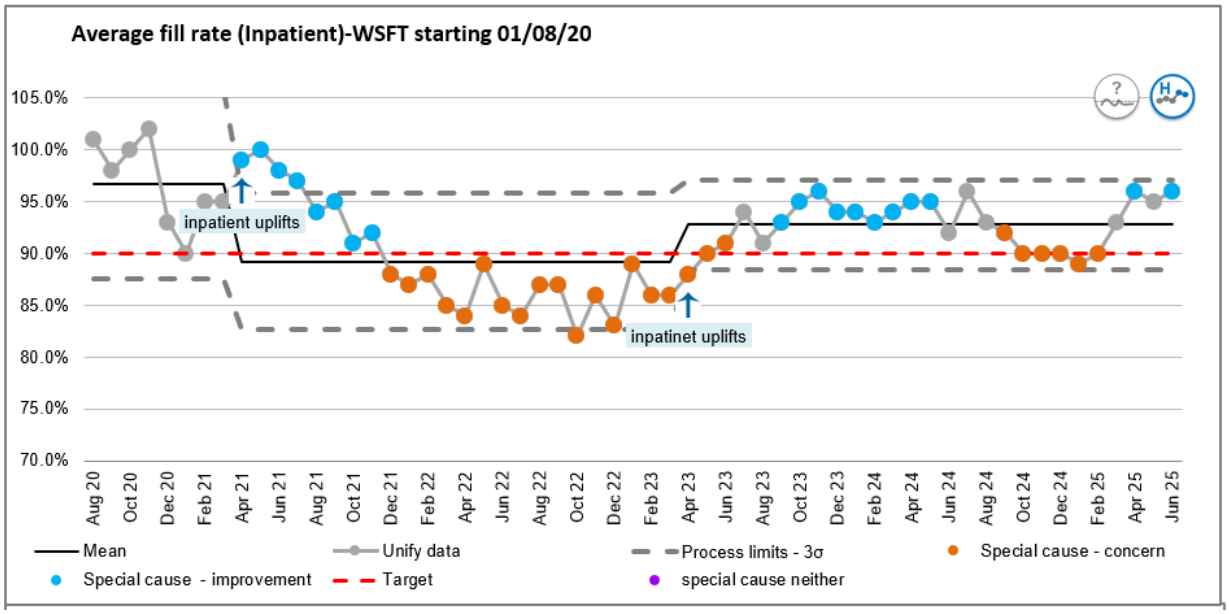


Chart 2

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. As reported in the last report this did not recover in April as expected. Following a request to interrogate the data source it was 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. May achieved CHPPD of 7.4 and June achieved 7.3.

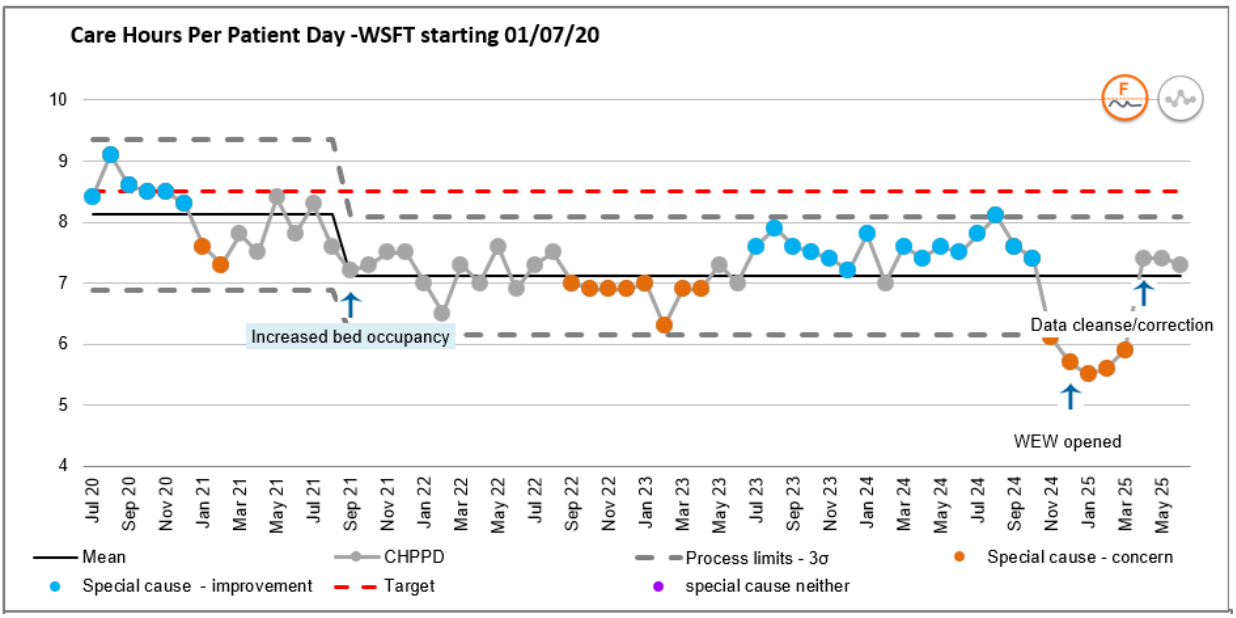


Chart 3

3.3 **Sickness**

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

	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	June 25
Unregistered staff (HCSW)	6.55%	6.61%	7.76%	6.35%	5.80%	6.12%	6.62%	6.77%
Registered Nurse/Midwives	4.90%	5.54%	5.78%	5.14%	5.01%	4.75%	4.43%	4.57%
Combined Registered/Unregistered	**5.42%**	**5.87%**	**6.41%**	**5.52%**	**5.26%**	**5.18%**	**5.12%**	**5.26%**

Table 4

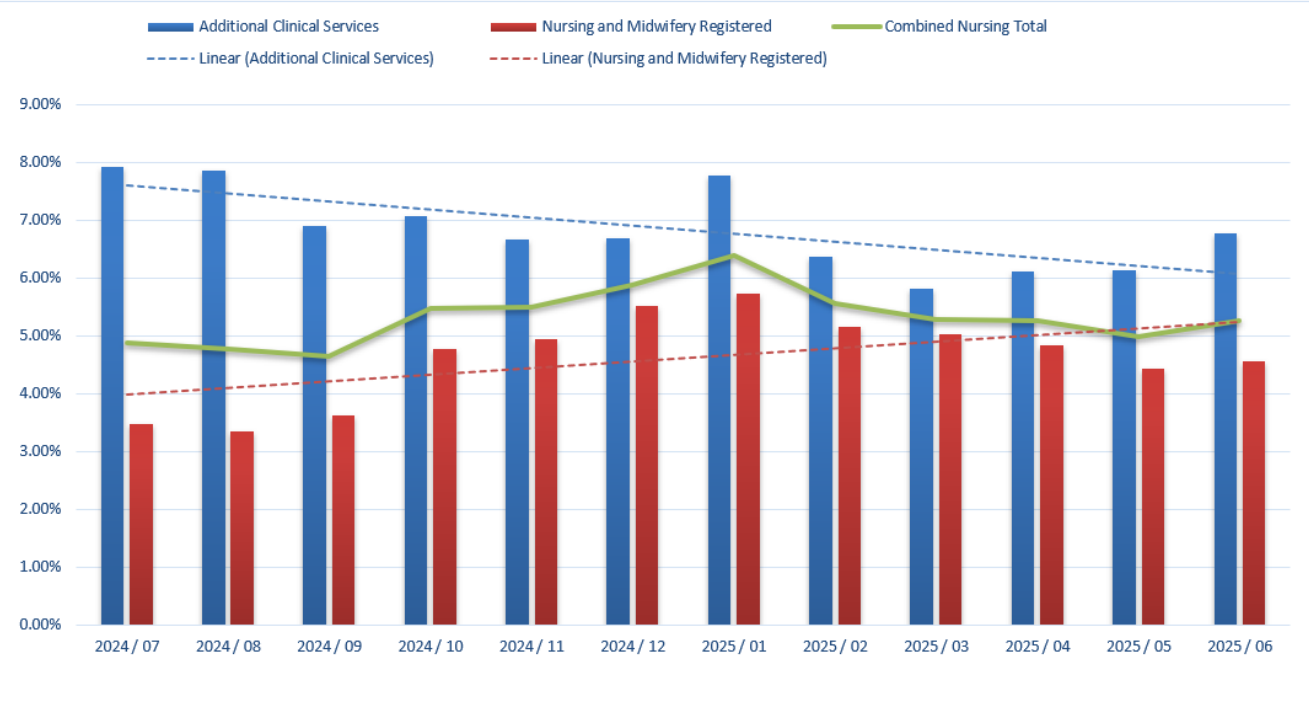


Chart 4

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 3. 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 M3 is **8.1%** a 0.2% improvement from last report.
- **Total RN/RM** vacancy rate at M3 is also **7%** an improvement of 1.3% from last report.
- **Inpatient NA** vacancy rate at M3 is 8% an improvement of 5.5% from last report.
- **Total NA** vacancy is **9**.7**%** in M3, an improvement of 1.4% from last report.

	Sum of Month 10	Sum of Month 11	Sum of Month 12	Sum of Month 1	Sum of Month 2	Sum of Month 3	WTE vacancy at 3
RN	715.4	714.0	715.9	712.1	711.0	707.6	62.8
NA	384.3	386.0	387.3	382.1	383.8	385.5	33.5

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 increased in the last 2 months.

	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	June 25
RN/RM	17	5	4	6	8	8	13	10
NA	16	11	15	17	8	8	11	12

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

- In May 13 registrants attended induction; of these; 3 RN were for the acute, 5 for bank staff, 4 for midwifery and 1 for community.
- In May, 11 NAs attended induction; of these; 8 NAs were for the acute Trust, 2 for bank staff and 1 for midwifery.

- In June 10 registrants attended induction; of these; 2 RNs were for the acute, 5 RN bank staff, 1 RN for Midwifery and 2 for community teams.
- In June 12 NAs attended induction; of these; 12 NAs were for the acute Trust.

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 6.9%. NA turnover has increased to over 10%.

		Turnover	01/07/2024	-	30/06/2025			
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	1,324.0571	77	64.9867	105	79.7157	6.9444%	6.0206%
Additional Clinical Services	597.50	503.8413	97	89.2000	75	65.1200	12.5523%	12.9247%

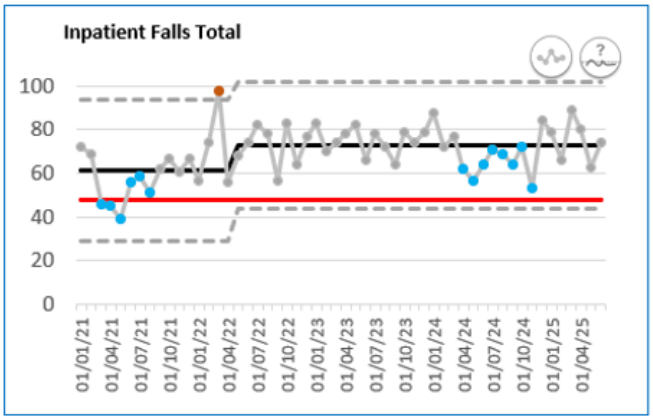
Table 7. (Data from workforce information)

3.5 **Quality Indicators**

<u>Falls and acquired pressure ulcers.</u>

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

Fall incidents in this period remain in common cause variation as do falls per 1000 bed days.



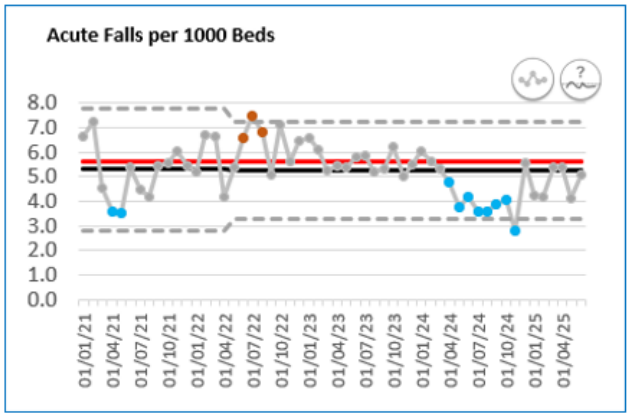
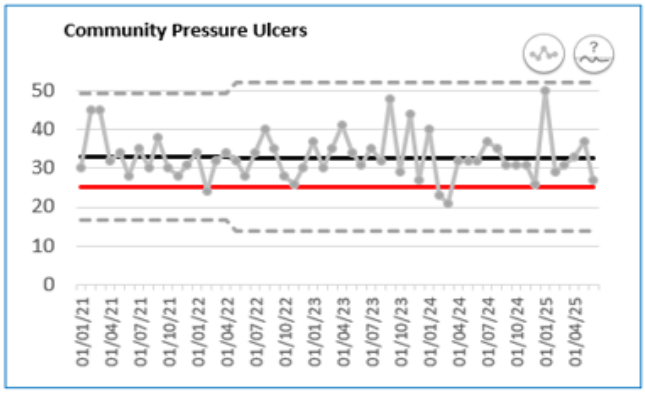


Chart 8 inpatient falls

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



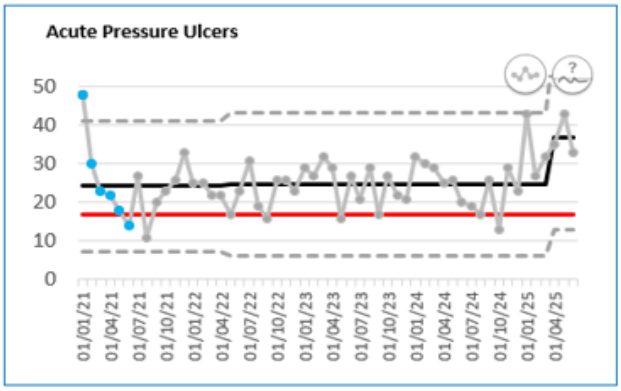
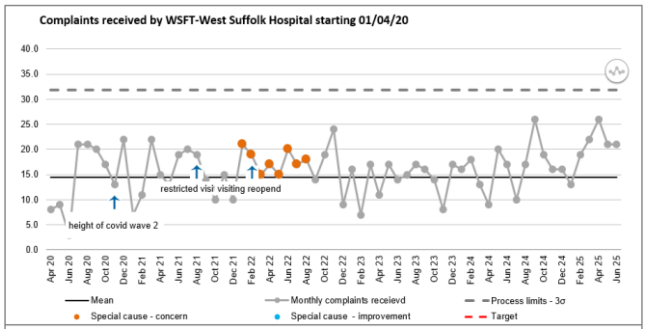
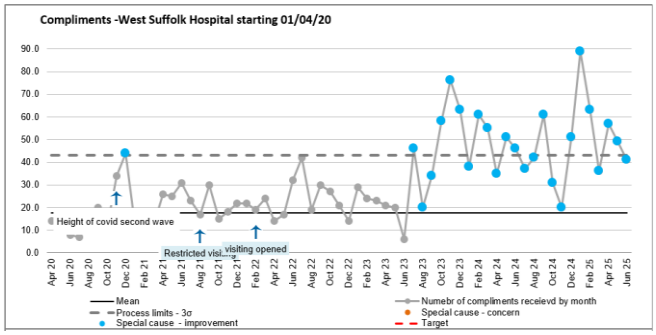
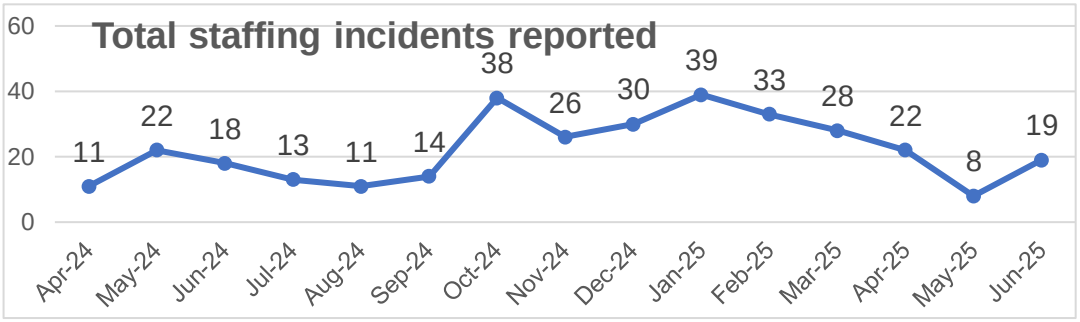


Chart 9 Pressure ulcers acquired in care.

3.6	**Compliments and complaints** 21 formal complaints were received in May. The most consistent theme this month was patient care, with a total of 6 formal complaints being listed under this subject. ED, G10 and ENT all received 2 formal complaints making these the highest areas for the month. 21 formal complaints were received in June. Labour Suite received 4 complaints and ED received 3 complaints making these the highest areas for the month. The most common theme this month was clinical treatment in obstetrics and gynaecology and communications with 4 complaints being listed under each of these subjects. 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** Staffing incidents have reduced since January, dropping to its lowest number in May, although this slightly increased in June.  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). May/June 2025 saw significantly fewer staffing incidents reported which would triangulate with improving fill rates and reduced short notice absence. The most common Red Flag event a shortfall of RN time available during a shift.

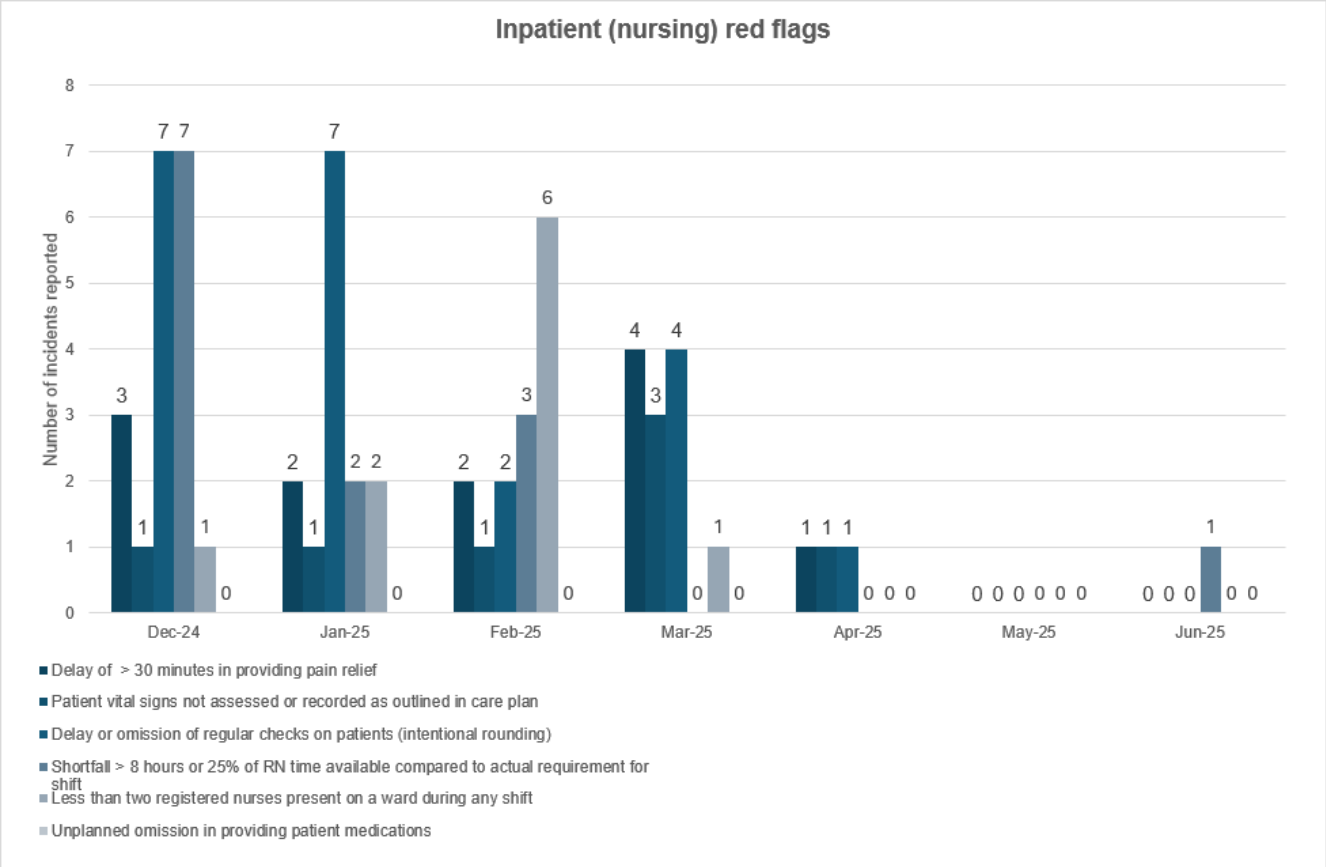


Chart 11.1

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 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 May and June 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. Notably, no Red Flag events were reported in May or June 2025.

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 has reduced 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

- May 2025 Midwife to birth ratio was 1:23 exceeding the recommended 1:20 reflecting a surge in activity and the busiest month of the year to date.

- June 2025 midwife to birth ratio improved to 1.19.

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 May and June 2025.

	Standard	December	January	February	March	April	May	June
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	1:20.6	1:21	1:18.4	1:20.5	1:19.7	1:23	1:19
No. Red Flags reported	NA	2	2	2	1	1	0	0

Table 12

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

Sickness & Turnover
Sickness rate for the integrated community division was 5% in May and 5.02% in June.

The turnover figure for the division has been rising and is above the trust target and is currently at 10.63%. This is partly because of organisational changes.

Demand
The demand for community nursing services continues in special cause for concern (chart 13), this has been an increasing trend for the past 2 years. Referrals to INT therapy has shown more variation, however, has seen rising demand in past 6 moths. With referral rate above average and other factors such as the length of time to recruit means Integrated Neighbourhood teams (INTS) are working at capacity.

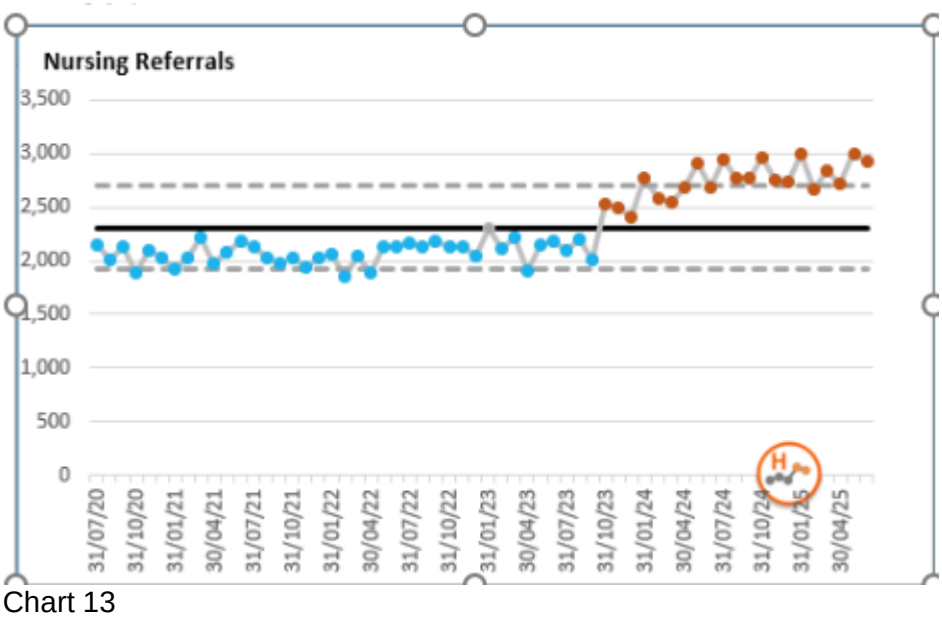


Chart 13

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 approx. 10% of the deferred, or cancelled care. Some incidents of harm from deferring care in May include deterioration in wounds.

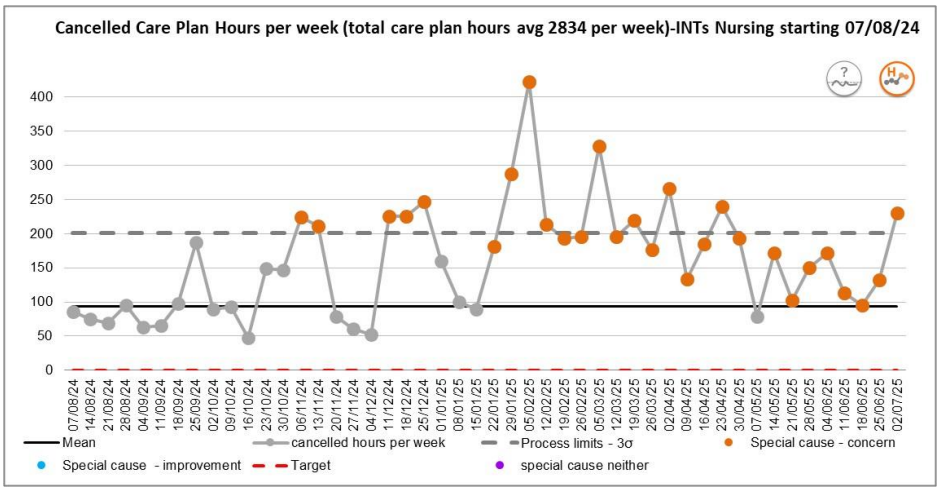


Chart 14

Community based actions

- The Community Nursing Safer Staffing Tool (CNSST) census is underway. Results will be analysed in August alongside professional judgement and quality data.
- The INTS , EIT and Virtual ward are involved in a shared services integration projects, the staff consultation is underway. This was presented at last Insight committee
- 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. Feedback will be provided to District Nurses for assurance of prioritisation.

4. Next steps/Challenges

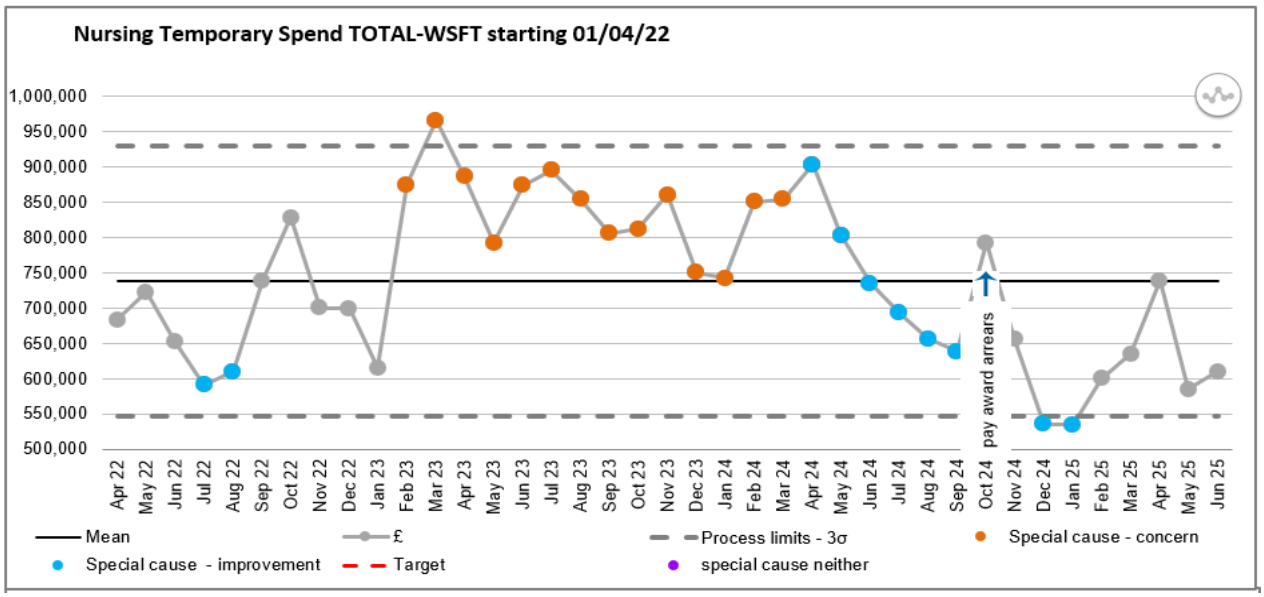
4.1 **Nursing Resource oversight Group**

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 which has now reduced in M2/3.



		Values								
Exp-L1	Analaysis-1	In-M Bgt	In-M Act	In-M Var	YTD Bgt	YTD Act	YTD Var	WTE Bgt	WTE Act	WTE Var
⊟ Pay	Agency	0	(222)	222	0	23,501	(23,501)	-	-	-
	Bank	26,417	610,461	(584,044)	75,393	1,910,353	(1,834,960)	1.16	135.39	- 134.23
	Substantive	8,853,603	8,366,114	487,489	26,641,279	25,120,429	1,520,850	2,077.22	1,914.35	162.87
Pay Total		**8,880,020**	**8,976,353**	**(96,333)**	**26,716,672**	**27,054,283**	**(337,611)**	**2,078.38**	**2,049.74**	**28.64**
Grand Total		**8,880,020**	**8,976,353**	**(96,333)**	**26,716,672**	**27,054,283**	**(337,611)**	**2,078.38**	**2,049.74**	**28.64**

Table 17.

Nursing substantive spend was underbudget in M3 by £487k (table 17), however total spend exceeded in month budget by £96k due to temporary staff usage.

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 last 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.

We are now completing the summer audit and the results will be reported once data has been collated and relevant professional judgement and review has been undertaken.

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. 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 (May 2025) Data adapted from NHSE Unify submission.
RAG: Red <79%, Amber 80-89%, Green 90-100%, Purple >100

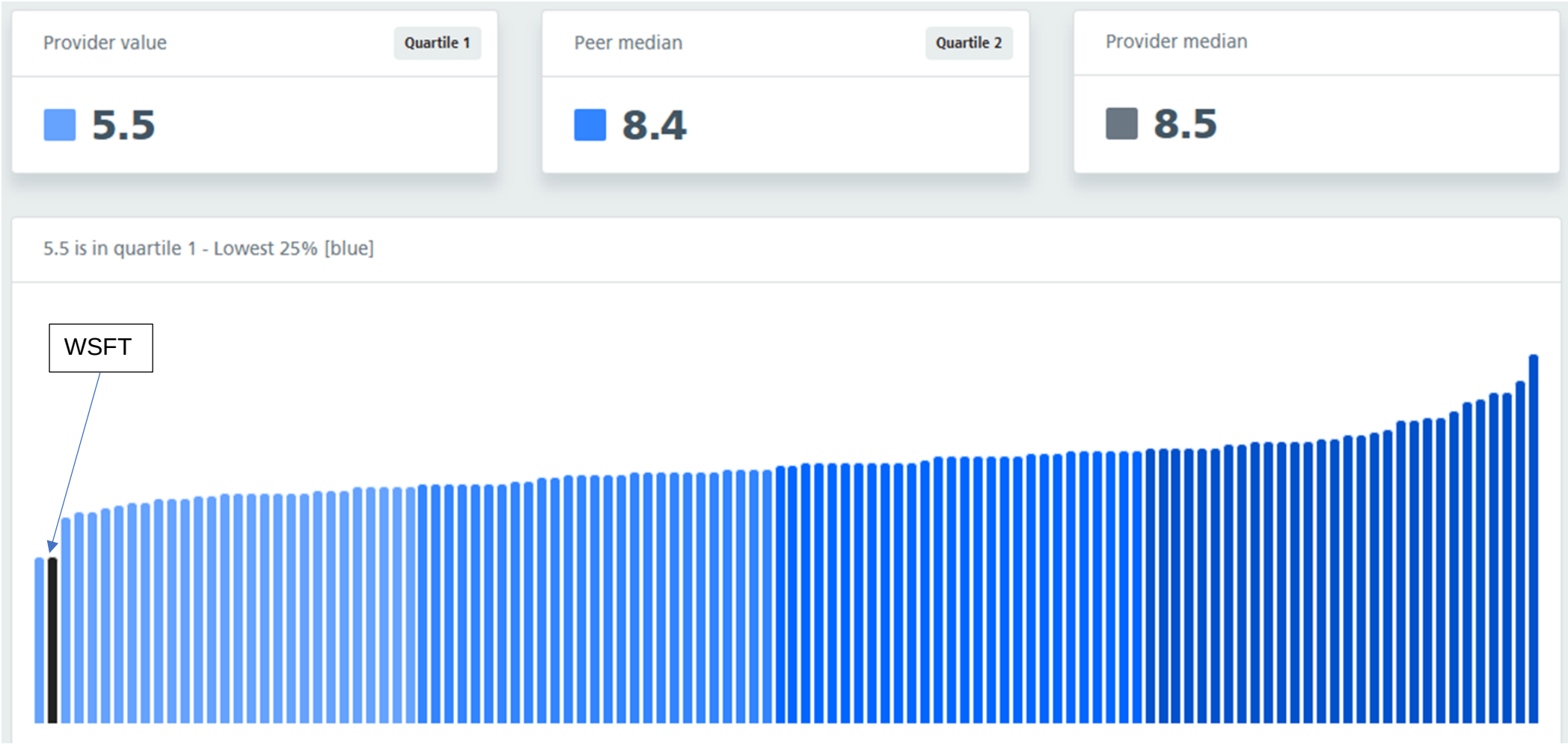
	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned 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	1425.75	1250	1788.75	1645.75	1069.5	1035.5	1426	1426	88%	92%	97%	100%	877	2.6	3.5	6.1
Glastonbury Court	713.5	714.5	1062.5	1046.5	713	713	542.5	543.5	100%	98%	100%	100%	540	2.6	2.9	5.6
Acute Assessment Unit	2254.5	2195	1950	1885.75	1702	1695	1380	1345.5	97%	97%	100%	98%	706	5.5	4.6	10.1
Cardiac Centre	1782.5	1598.5	1065.5	866.166667	1770.5	1725.5	713	667	90%	81%	97%	94%	668	5.0	2.3	7.3
G10	1778.5	1653.3333	1774.5	1618	1069.5	1066	1782.5	1672.66667	93%	91%	100%	94%	967	2.8	3.4	6.2
G9	1736.5	1667.5	1419	1362.25	1380	1403	1069.5	1081	96%	96%	102%	101%	826	3.7	3.0	6.8
F12	708.5	680.5	356.5	297	713	654	356.5	294.5	96%	83%	92%	83%	235	5.7	2.5	8.2
F7	1679	1531.5	1783.5	1669.5	1379	1263.75	1782.5	1666.5	91%	94%	92%	93%	1003	2.8	3.3	6.3
G1	1427	1124.5	356.5	342.5	713	713	356.5	356.5	79%	96%	100%	100%	362	5.1	1.9	7.0
G3	1782.5	1577	1770.5	1706.5	1069.5	1069.5	1426	1624.5	88%	96%	100%	114%	1013	2.6	3.3	5.9
G4	1784.5	1610.5	1779.25	1624.5	1069.5	1075	1425	1449	90%	91%	101%	102%	971	2.8	3.2	5.9
G5	1782.5	1613.25	1751	1561.16667	1069.5	1066.75	1426	1431	91%	89%	100%	100%	1013	2.6	3.0	5.6
G8	2403	1921.1667	1777.5	1644.7	1621.5	1614.083333	1069.5	1050	80%	93%	100%	98%	846	4.2	3.2	7.4
F8	1460.5	1406.0833	1765	1583	1066	1031.25	1414.5	1464.5	96%	90%	97%	104%	824	3.0	3.7	6.7
Critical Care	2582.5	2395.75	112.5	107	2420.75	2423.5	0	0	93%	95%	100%	*	200	24.1	0.5	24.6
F3	1754.5	1636.5	1765	1720.5	1069.5	1066.5	1426	1474	93%	97%	100%	103%	877	3.1	3.6	6.8
F4	842	790.75	587.5	551	621	554	358	270	94%	94%	89%	75%	181	7.4	4.5	12.3
F5	1633	1403.75	1411	1275	1069.5	1063	1069.5	1038	86%	90%	99%	97%	384	6.4	6.0	12.4
F6	1575.5	1518.5	1691.5	1399.75	1068	1056.5	1426	1363.5	96%	83%	99%	96%	887	2.9	3.1	6.3
Neonatal Unit	1542.5	1480	372	464.5	1116	1081	720	576	96%	125%	97%	80%	269	9.5	3.9	13.4
F1	2175.5	1670.75	713	621	1426	1372.75	0	0	77%	87%	96%	*	215	14.2	2.9	17.0
F14	372	372	353	348	744	744	0	0	100%	100%	100%	*	111	10.1	3.1	13.2
Total	35,196.25	31,811.33	27,405.50	25,340.03	25,940.25	25,486.58	21,169.50	20,793.67	**90%**	**92%**	**98%**	**98%**	**13975**	**4.1**	**3.3**	**7.4**

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

Appendix 1b. Fill rates for inpatient areas (June 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	1306.5	1721.25	1550.75	1035	989	1378.5	1360	95%	90%	96%	99%	857	2.7	3.4	6.1
Glastonbury Court	690	687	1030	997.5	690	692	525	495.5	100%	97%	100%	94%	524	2.6	2.8	5.5
Acute Assessment Unit	2147.5	2139.75	1773	1710.58333	1633	1659.5	1322.5	1316.5	100%	96%	102%	100%	795	4.8	3.8	8.6
Cardiac Centre	1714.25	1545.75	1001.2	866.2	1722	1584	683.25	648.75	90%	87%	92%	95%	649	4.8	2.3	7.2
G10	1718.5	1397.5	1686	1613	1035	1000.5	1720.5	1642.5	81%	96%	97%	95%	950	2.5	3.4	6.0
G9	1721	1552.5	1357	1385.5	1380	1369.5	1023.5	1055.5	90%	102%	99%	103%	785	3.7	3.1	6.8
F12	691	690.25	340.5	292.75	679.5	599.5	338.5	292.5	100%	86%	88%	86%	225	5.7	2.6	8.3
F7	1544	1419	1667	1567	1288	1150	1713.5	1641.5	92%	94%	89%	96%	971	2.6	3.3	6.1
G1	1354	1108.25	344	349	690	690	345	376	82%	101%	100%	109%	358	5.0	2.0	7.0
G3	1709.5	1463.75	1704	1594.75	1035	1011.833333	1368.5	1391.5	86%	94%	98%	102%	1613	1.5	1.9	3.4
G4	1718.5	1567	1694	1631.5	1035	1023	1369	1461	91%	96%	99%	107%	953	2.7	3.2	6.0
G5	1099.5	1057.25	1137	1010.75	994.5	870.75	920	875	96%	89%	88%	95%	599	3.2	3.1	6.4
G8	2251	1771.5	1721	1550.25	1598.5	1535.95	1035	1013.5	79%	90%	96%	98%	840	3.9	3.1	7.0
F8	1565.5	1550.4667	1701.25	1594.25	1035	1011.166667	1380	1396.5	99%	94%	98%	101%	255	10.0	11.7	21.8
Critical Care	2541.5	2457.0833	130.75	125.25	2392	2445	0	0	97%	96%	102%	*	206	23.8	0.6	24.4
F3	1718	1468.9167	1716	1587.25	1029.5	1005	1380	1463.5	86%	92%	98%	106%	875	2.8	3.5	6.3
F4	800.5	789	511.5	440	582	524.5	191	178	99%	86%	90%	93%	156	8.4	4.0	12.5
F5	1380	1350	1349	1280.75	1023.5	1022.5	1012	1021	98%	95%	100%	101%	446	5.3	5.2	10.5
F6	1658	1510.25	1648.5	1486.25	1012	991.5	1380	1303.25	91%	90%	98%	94%	921	2.7	3.0	5.8
Neonatal Unit	1631.25	1615.25	348	470	1080	1068	643	547	99%	135%	99%	85%	269	10.0	3.8	13.8
F1	1929	1699.5	678.5	530.5	1276.5	1210	0	11.5	88%	78%	95%	*	206	14.1	2.6	16.8
F14	360	360	360	324	720	720	0	0	100%	90%	100%	*	107	10.1	3.0	13.1
Total	33,324.50	30,506.47	25,619.45	23,957.78	24,966.00	24,173.20	19,728.75	19,490.50	**92%**	**94%**	**97%**	**99%**	**13,560**	**4.0**	**3.2**	**7.3**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

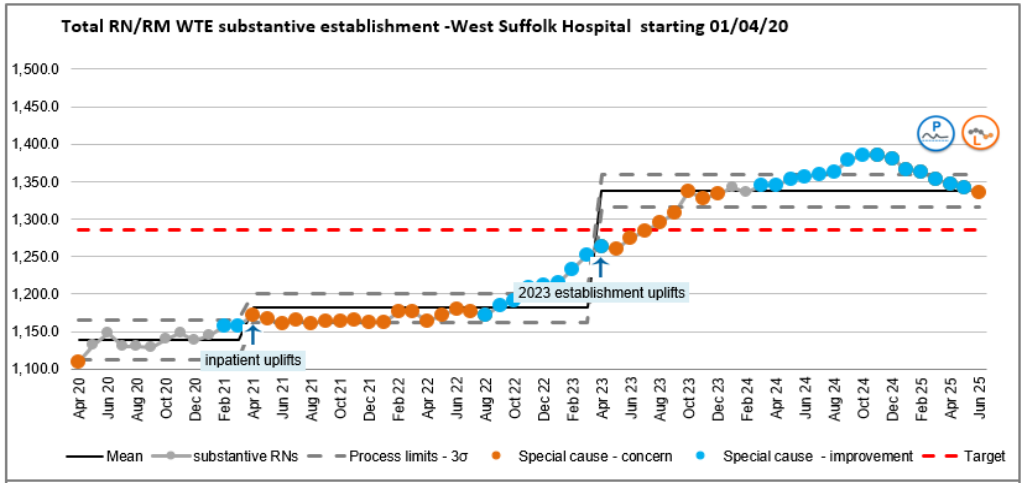
Appendix 2. CHPPD Model Hospital data (January data accessed 14.5.25



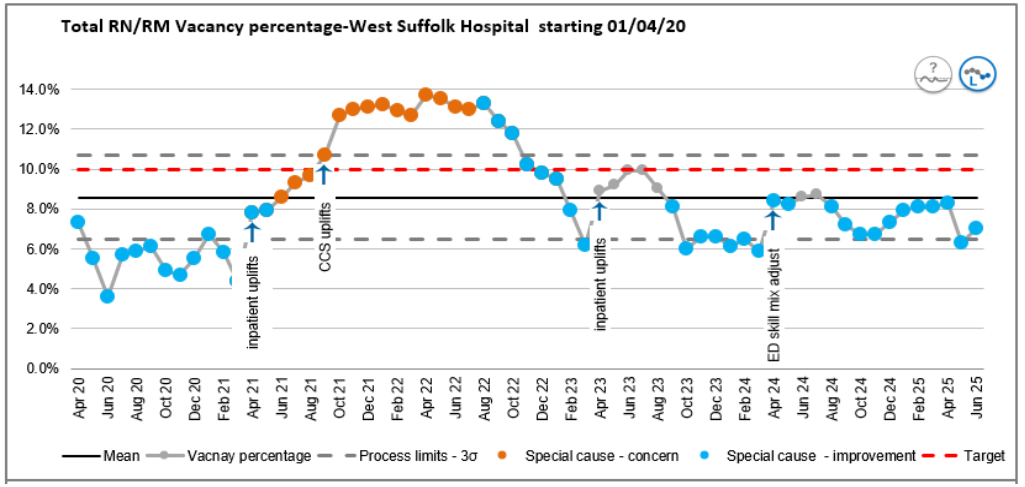
As stated in main paper this data is flawed. Most recent data on model hospital is Jan 2025 a significant lag and unlikely to demonstrate the data cleanse for a couple of months. April CHPPD is 7.4, would still fall with lower quartile compared with peers and national picture

Appendix 3 WTE and Vacancy rates.

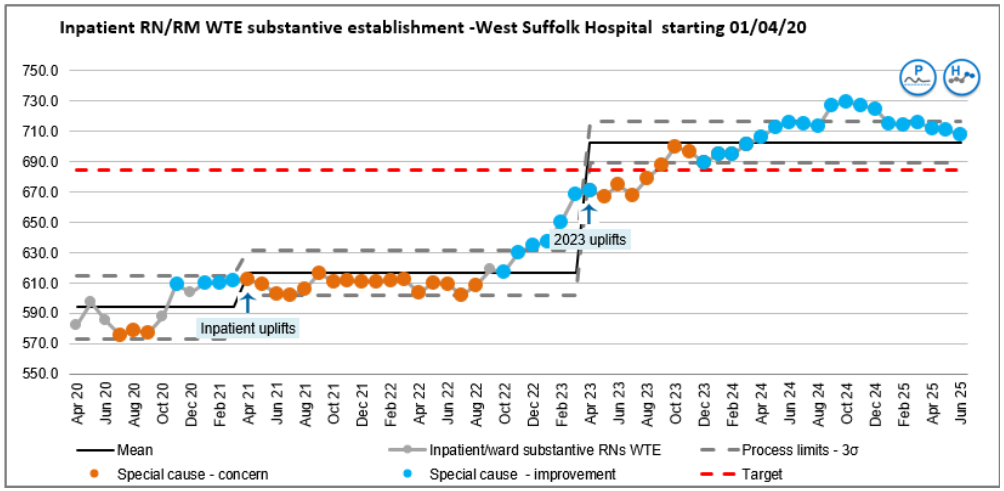
A) Trust Total RN/RM WTE



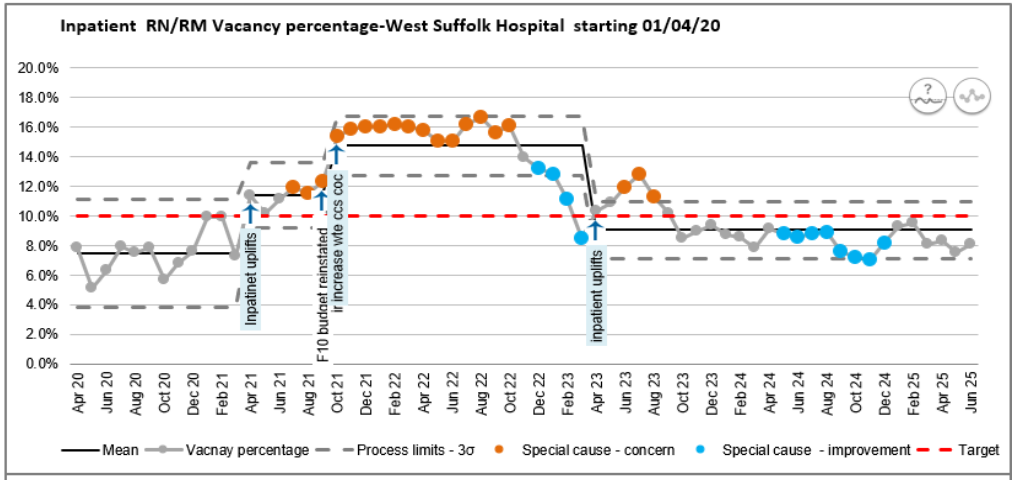
B) Trust Total RN/RM vacancy %



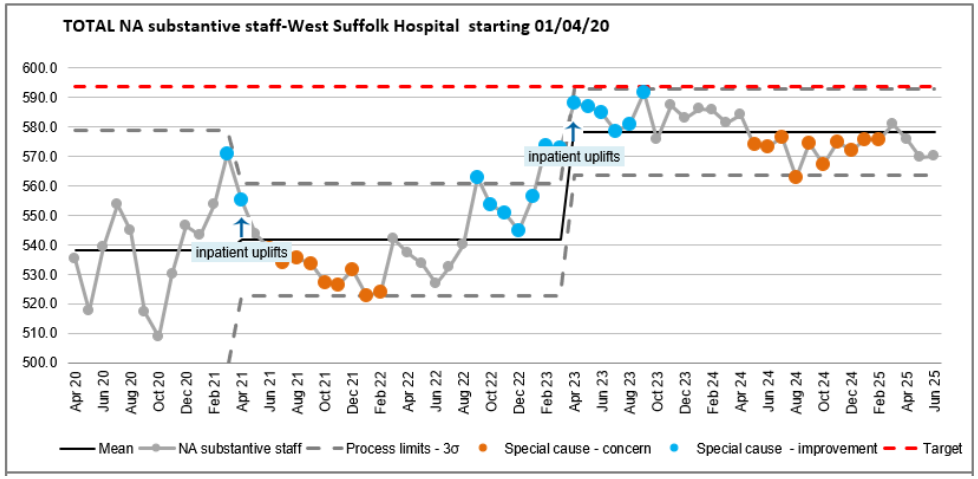
C) Inpatient RN/RM WTE



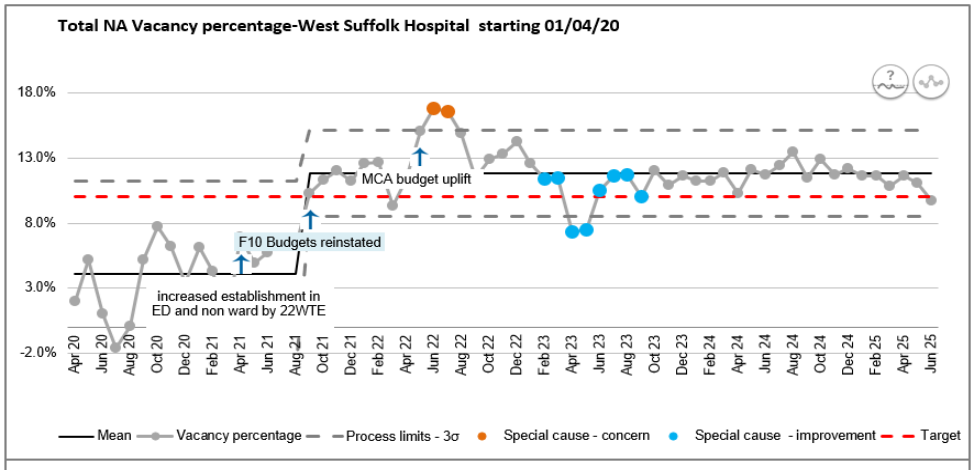
D) Inpatient RN/RM vacancy %



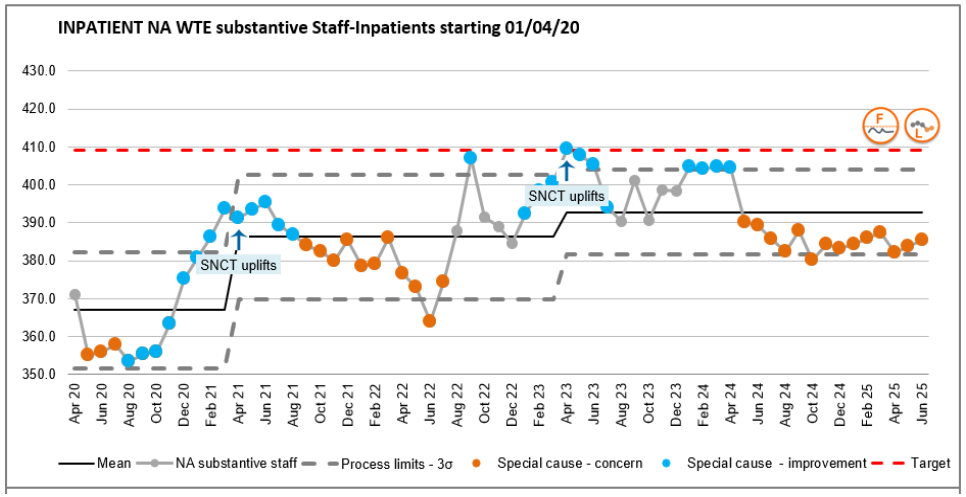
E) Total NA/unregistered WTE.



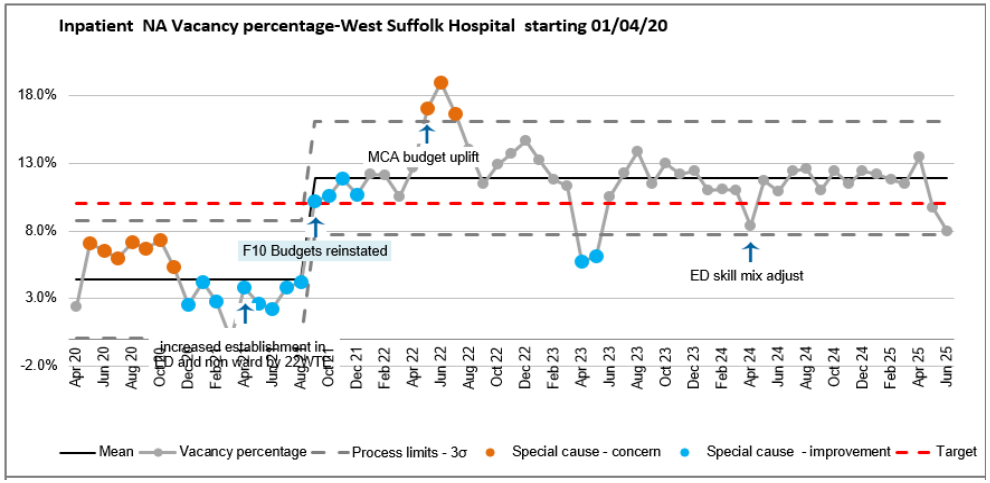
F) Total NA/Unregistered vacancy %



G) Inpatient NA/unregistered WTE



H) 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.

6.3. Maternity services report (ATTACHED)

For Approval

Presented by Karen Newbury and Daniel Spooner

Open Trust Board	
Report title:	Perinatal quality, safety, and performance report
Agenda item:	Maternity and Neonatal services
Date of the meeting:	25th July 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 quality & safety initiatives in line with the NHS Perinatal Quality Oversight Model (June 2025).

This report contains:

- Perinatal Quality Oversight Model (Annex A)
- Maternity and Neonatal 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.
- NHS Resolution (NHSR) Maternity Incentive Scheme (MIS) Year 7 progress
- Reports approved by the Improvement Committee
- Closed Board reports, nil due this month
- Next steps

SO WHAT?

The report meets NHSE standard of perinatal oversight 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 Perinatal Quality Surveillance Model (PQSM)

The Perinatal Quality Surveillance Model (PQSM) was published in December 2020 and Trusts and systems were expected to implement the actions with immediate effect. Following revision to bring it up to date, this document is now being re-published as the Perinatal Quality Oversight model (PQOM). In recognition that neonatal services are interdependent with maternity services, they refer to maternity and neonatal in terms of 'perinatal'. The NHS is currently going through a period of transition to enable delivery of the new government mandate and the 10 Year Health Plan. Whilst they are keen to provide clarity for systems and Trusts on perinatal governance, it is also important to recognise that there may be further changes to ensure alignment with new ways of working and therefore this model will be reviewed again following publication of the 10-Year Health Plan and related documents.
The PQOM was established in response to the need to proactively identify trusts that require support before serious issues arise, seeking to provide a consistent and methodical oversight of NHS perinatal services. The model has also been developed to gather ongoing learning and insight, to inform improvements in the delivery of perinatal services. The provider trust and its board ultimately remain responsible for the quality of the services provided and for ongoing improvement. The board is supported in this by the perinatal leadership team and the Board Safety Champion. The PQOM supports trusts and Integrated Care Boards (ICBs) in this duty, while providing a mechanism for escalation of any emerging risks, trends or issues that cannot be resolved at local level or would benefit from wider sharing.

An overview of the individual components of the PQOM is available in Annex A.

1.2 **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 highlighted 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 in place 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.
1.3	**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'. Drs Richard Goodwin (Medical Director & Executive Maternity and Neonatal Safety Champion) and Roger Petter (Non-executive Maternity and Neonatal Safety Champion) visited ward F11 (antenatal/postnatal ward) on the 14th May 2025. On this joint visit, they were able to speak with differing staff groups. The feedback obtained was positive and many staff reflected on good teamwork, job satisfaction and the motivation to provide high quality care. Overall, morale appeared to be good, although this can be affected by staffing levels, sickness, as well as the impact of some recent challenging clinical scenarios. The support within teams was highlighted as essential for staff to feel valued and is generally good. This is important at all levels and the significance of senior support is appreciated and should not be underestimated. The workload is inevitably a concern for many due to the nature of the work. Staff can feel drawn away from what they feel to be the clinical core of their job by IT issues. Whilst the importance of this record is understood (including for legal reasons), some staff feel this time could be better spent on patient care. They can be demoralised if they feel admonished for "not ticking a box" so the way in which such feedback is given is important. This is particularly the case after a long or difficult shift, when it can reduce morale at a time when they should feel proud of providing good care. Concerns about referrals from different departments was raised. It was felt that in order to help patient flow, female service users are sometimes referred on to obs / gynae without an adequate assessment being made first. As a result, such referrals may be inappropriate, and better managed by a different specialty. Several staff were very positive in their comments. A student midwife was very complimentary about the input and experience they were receiving. Another member of staff felt that the care provided was very positive compared to personal experience from elsewhere. In response to this the concerns regarding referrals from other departments has been raised with the relevant leads. Ongoing work continues regarding a positive safety culture within the service, including communication. Roger then visited the Castle Hill Community midwifery team in Thetford on the 19th May 2025 and met with a number of community midwives who generally expressed satisfaction with their working situation. Morale appeared good, staffing levels are currently all right and he observed healthy teamwork. Communication with the hospital is good, particularly now that there is an electronic patient record. The main concern is that equipment levels are sub-optimal. Currently they share equipment that could impact their ability to complete observations resulting in the need to do a repeat visit. This is obviously inefficient and they are concerned that this could impact patient safety. This has been raised with the community leads who are reviewing what is required to make the community more streamlined however some items of equipment are in excess of £6000 each. There appeared to be miscommunication regarding the use of pools cars which has now been resolved. Staff reported they have lone worker devices but admit these are not always used. The team leads are working with staff to work through the obstacles that are inhibiting their use.

	Otherwise, no concerns were raised. Dr Richard Goodwin visited the labour suite on the 20th June 2025 whereby staff reported that they felt supported and that there was good morale on the unit with a good culture of improvement and learning. When staffing was an issue the flexibility of staff in moving shifts at short notice meant that resources could be balanced reasonably well. Sometimes students achieving their target delivery numbers could be a challenge, but the team worked together to accomplish this. It was felt that the experience of deliveries in theatre would be improved with a dedicated obstetric theatre team rather than teams that are differently constituted day to day, albeit there was an understanding that resourcing that would be challenging. The fourth walkabout occurred in the Jade community midwifery team by Roger on the 24th June 2025. The team wanted to raise how the use of interpreters could be improved. The community midwives use mobile phones, which enables them to access an approved interpretation app for immediate interpretation. It was recommended that the triage phoneline within the hospital also have access to this app. This idea will be shared with the lead for triage for further exploration. Transport problems can affect the ability of some vulnerable patients to attend hospital for scans and other appointments. In Haverhill, Mildenhall and Newmarket there is support from the local bus company for the Bump and Baby Bus Pass scheme. This is not available in Thetford, Sudbury and Brandon which means that vulnerable service users in these areas are potentially disadvantaged. Community leads are liaising with alternative bus companies to see whether the scheme can be extended to these areas. Depending on the geographical area there are often problems with Wi-Fi connectivity. Even with dongles being in place, connectivity can freeze or drop out, which is frustrating, leads to poor time management, but also means the community team cannot access the patient records to read the plan of care etc. Currently the only solution is to access the home/venue Wi-Fi, however not everyone is happy to share their Wi-fi password or know where to find it. Overall, the Jade Team are motivated and committed to providing the best possible care. They are well led and clearly communicate well and work effectively as a team.
1.4	**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 this, with all staff members who have been qualified for longer than a year being offered opportunities for further career development discussions. Currently, the turnover rate stands at 5.4%, 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, 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 have reviewed the findings. The most challenging results related to the questions around "Your health, wellbeing and safety at work", with the following topics in the red;

	• Working additional hours – both paid and unpaid • Feeling unwell due to work related stress • Finding work emotionally exhausting • Feeling burnout • Exhausted about the thought of going to work • Finding work tiring • Facing harassment, bullying or abuse at work (from patients, service users, colleagues and managers) • I eat nutritious and affordable food at work In response to the above an action plan has been developed primarily focusing on staff health and wellbeing including signposting staff to available support. 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 this year, 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 have identified 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.
1.5	**Service User feedback** Service user feedback plays a vital role in healthcare by offering direct insight into the quality of care received. It enables providers to make meaningful improvements—not only by enhancing care standards, but also by enriching patient experience and driving innovation. When patients share their experiences, they highlight strengths and reveal gaps in service that might otherwise go unnoticed. To support this, the NHS introduced the Friends and Family Test (FFT). This simple, anonymous tool helps service providers and commissioners gauge patient satisfaction and identify where changes are needed. It offers an accessible way for patients to share feedback after receiving NHS care or treatment.

Ward/Dept	May Survey returns	% of discharged people provided feedback *	May Very good and good %	June Survey returns	June Very good and good %	% of discharged people provided feedback *
F11	31	7%	94%	25	100%	5%
Antenatal	43	NA	95%	24	88%	NA
Postnatal Community	30	NA	93%	26	92%	NA
Labour Suite	11	37%	100%	4	100%	12%
Birthing Unit	11	65%	100%	9	100%	48%
NNU	4	8%	100%	1	88%	3%
Transitional Care	5	NA	100%	5	85%	NA

*Target of ≥30%

Due to the limited volume of feedback received, the maternity and neonatal team is working in close collaboration with the Patient Engagement Team, as well as the Parent Education and Patient Experience Lead Midwife, to improve response rates.

In addition to the Friends and Family Test (FFT), further feedback is gathered through PALS, the CQC Maternity Survey, and Healthwatch surveys. Notably, the service has observed a rise in feedback shared via social media platforms.

It is important to highlight that the Chair of the Maternity and Neonatal Voices Partnership (MNVP) stepped down at the beginning of 2024. Since then, the MNVP has been without a Chair and has faced challenges due to insufficient membership, limiting its ability to operate effectively. The publication of updated MNVP guidance in November 2023 enabled our Local Maternity and Neonatal System (LMNS) to evaluate and establish a more sustainable approach. As a result, a new LMNS MNVP Lead was appointed and began their role in October 2024, with responsibility for re-establishing the WSFT MNVP.

In terms of patient experience, WSFT received no compliments relating to maternity and neonatal services in May 2025. However, in June 2025, one compliment was shared regarding the Antenatal Clinic.

In May 2025, one PALS enquiry was submitted concerning communication on the Neonatal Unit. This increased to five enquiries in June 2025, covering issues related to patient care, communication, and values and behaviours.

One formal complaint was received in May 2025 regarding values and behaviours. In June 2025, this rose to five formal complaints, primarily focused on clinical treatment and communication. The recent rise in formal complaints concerning maternity and neonatal services is acknowledged with due seriousness. While patient feedback, both positive and negative, plays an essential role in service improvement, the service recognises the need for immediate and structured action in response to this upward trend. A thematic review of complaints is shared with the Improvement Board on a quarterly basis.

1.6 **Reporting and learning from incidents**

May and June 2025 number of referrals to the Maternity and Neonatal Safety Investigation (MNSI) programme and overall patient safety incidents.

	May 25	June 25
No. of MNSI referrals	0	0
No. of Patient safety incidents	90	75

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).

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

Staff Group May 2025	Saving Babies Lives 1,2,5,6	GAP/GROW	Maternity Emergencies / OMET	Skills and Drills	Personalised Care	Safeguarding	Care in labour & Immediate Postnatal	Neonatal Life Support	Fetal Heart Surveillance	Newborn Feeding update
Midwives	92.55%	92.6%	96.41%	96.41%	96.25%	99.39%	93.25%	96.41%	95%	99.39%
MCA/MSW	NA	NA	92.68%	92.68%	NA	100%	95.45%	92.68%	NA	100%
Consultant Obstetrician	68.75%	73.4%	93.33%	93.33%	70.59%	85%	62.5%	NA	93%	NA
Obstetric Registrar	100%	100%	100%	100%	55.56%	93%	75%	NA	100%	NA
SHO/Core trainees	N/A	44.44%	100%	100%	N/A	78%	N/A	NA	NA	NA
Sonographer	NA	95%	NA	NA	NA	NA	NA	NA	NA	NA
Consultant Obstetric Anaesthetists	NA	NA	67%	67%	NA	NA	NA	NA	NA	NA
Obstetric Anaesthetists	NA	NA	100%	100%	NA	NA	NA	NA	NA	NA
Neonatal Consultants	NA	NA	NA	75%	NA	95%	NA	93%	NA	No Data
Neonatal Nurses	NA	NA	N/A	97%	NA	98%	NA	93%	NA	98%
Neonatal Doctors	NA	NA	NA	No Data	NA	94%	NA	100%	NA	73%
ANNP/PA	NA	NA	NA	No Data	NA	100%	NA	100%	NA	No Data

Staff Group June 2025	Saving Babies Lives E-Learning	GAP/GROW	Maternity Emergencies / OMET	Skills and Drills	CO Monitor	Safeguarding	Neonatal Life Support	Fetal Heart Surveillance	Newborn Feeding update
Midwives	98.1%	96.96%	100%	100%	84.4%	97.58%	100%	95%	97.58%
MCA/MSW	NA	NA	95.1%	95.1%	92.6%	100%	95.1%	NA	100%
Consultant Obstetrician	93.3%	60%	87.5%	87.5%	86.6%	95%	NA	93%	NA
Obstetric Registrar	100%	88.89%	100%	100%	100%	93%	NA	100%	NA
SHO/Core trainees	66.66%	77.78%	100%	100%	100%	78%	NA	NA	NA
Sonographer	NA	87.5%	NA	NA	NA	NA	NA	NA	NA
Consultant Obstetric Anaesthetists	NA	NA	67%	67%	NA	NA	NA	NA	NA
Obstetric Anaesthetists	NA	NA	100%	100%	NA	NA	NA	NA	NA
Neonatal Consultants	NA	NA	NA	75%	NA	95%	85.71%	NA	65%
Neonatal Nurses	NA	NA	N/A	67%	NA	98%	97%	NA	93%
Neonatal Doctors	NA	NA	NA	No Data	NA	100%	94.74%	NA	67%

ANNP/PA	NA	NA	NA	No Data	NA	100%	100%	NA	100%

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

In response to the introduction of the Perinatal Core Competency Framework version 2, additional training sessions were initiated at the start of 2024. While compliance in these areas was on the rise, it remained challenging to release all staff groups for training. A comprehensive review of the current training requirements has taken place to identify more effective training delivery methods, unfortunately in addtion to this, further mandatory trainng has been introduced to meet National and local standards. With exception of the midwifery and nursing workforce the remaining staff groups are excepitonally small teams and therefore non-compliance relates to one or two staff members. Compliance is monitoried closely by the leadership team and whereby individual staff members training expires, they are scheduled for the next availble training. An example of this is the obstetric consultant obstetric emergency training compliance; the training has now taken place resulting in >90% complinance for this staff group.

Data collection regarding compliance is another challenging area due to internal, external and self-directed learning for some topices, measures have been implemented to address this issue; however, for certain training components, compliance is dependent on individuals providing evidence of their training.

1.8 **NHS Resolution (NHSR) Maternity Incentive Scheme (MIS) Year 7 progress**

Now in its seventh year of operation, NHS Resolution's Maternity (Perinatal) Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025. The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST).
Year 7 of the scheme was launched in April 2025 for the reporting period 1st December 2024- 30th November 2025. The nature of the ten safety actions remains largely unchanged from previous years covering ongoing reporting of and monitoring of mortality and morbidity, compliance with national frameworks, standards of care, reporting criteria and timeframes, education and training, workforce standards, involving service users in the safety and improvement work and quality and sharing of learning. Whilst there are still areas where the maternity and neonatal services can continue to develop and improve, maintenance and monitoring of standards is a key part of everyday working within the maternity and neonatal units. The Trust is currently on track to be able to submit full compliance with all ten safety actions by the submission date 3rd March 2026.

2. Reports

2.1 **Reports approved by the Improvement Committee**

The NHS Resolution Maternity Incentive Scheme (MIS) introduced a change in
the processes and pathways for Trust committee and Board oversight, last year. 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 service so are continued outside the MIS timeframe.

	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 18th June 2025: • Maternity Claims scorecard Q4 24/25 • Neonatal Medical workforce report Oct 24-March 25 No reports were due to be presented to the Improvement Committee held in May 2025.
3.	**Reports for CLOSED BOARD** There are no reports due for Closed board.
4.	**Next steps**
4.1	Reports will be shared with the external stakeholders as required. Action plans will be monitored and updated accordingly.

Annex A

Perinatal Quality Oversight Model Data Measures

Metric	Frequency to be shared with board	Where evidence will be presented
1.Findings of review of all perinatal deaths using the real time data monitoring tool	Quarterly	Closed board- Perinatal Mortality Report, Early Notification Scheme and Maternity and Neonatal Safety Investigation reports.
2. Findings of review of all cases eligible for referral to MNSI	Quarterly	Closed board- Maternity and Neonatal Safety Investigation reports.
Report on: 2a. The number of patient safety incidents logged and what actions are being taken	Quarterly	Improvement board – Triangulation of legal claims, complaints and incidents
2b. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training (%)	Bi-monthly	Open board- Perinatal Quality and Safety paper
2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	Bi-annual	Improvement board – separate midwifery and obstetric workforce papers.
3.Service User Voice Feedback - Themes	Bi-monthly	Open board- Perinatal Quality and Safety paper
4.Staff feedback from frontline champion and walk-abouts – themes	Bi-monthly	Open board- Perinatal Quality and Safety paper

5.MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	As applicable	Closed board- Perinatal Mortality Report, Early Notification Scheme and Maternity and Neonatal Safety Investigation reports.
6.Coroner Reg 28 made directly to Trust	As applicable	Closed board- Perinatal Mortality Report, Early Notification Scheme and Maternity and Neonatal Safety Investigation reports.
7.Progress in achievement of CNST 10 Safety actions	Bi-monthly	Open board- Perinatal Quality and Safety paper
8.Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	Annual	Open board- Perinatal Quality and Safety paper
9.Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours (Reported annually)	Annual	Open board- Perinatal Quality and Safety paper

7. GOVERNANCE

7.1. Charitable Funds Committee report - Chair's key issues from the meeting (ATTACHED)

To inform

Presented by Richard Flatman

Charitable Funds Committee Key Issues (CKI) report

Originating Committee: Charitable Funds Committee			Date of meeting: 10 June 2025		
Chaired by: Richard Flatman			**Lead Executive Director: Julie Hull**		
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 welcomed Julie Hull to her first meeting as Interim Chief of People and lead Executive Director for Charitable Funds	Substantial	Committee very pleased to welcome Julie		No escalation
2	The Client Investment Directors from CCLA attended to give a presentation on fund performance and a review of the markets.	Reasonable	It is important that we receive regular attendance and update from the investment manager, including performance against agreed target returns. Despite recent market volatility due to global events, long-term performance remains strong and exceeds benchmarks. Earnings are accumulated in the fund rather than withdrawn and the risk profile is considered medium.	The presentation was positively received, and there was a consensus that CCLA should attend and present at least annually. Some key control actions were agreed including regular/ periodic reviews of: • Fund type / allocation • Income accumulation or withdrawal • MyWish future cashflow needs and whether to invest more or withdraw (which may impact risk	No escalation

				profile of the fund given current volatility).	
3	Committee received a fundraising report summarising progress in each of the income streams	Reasonable	There was positive feedback about the new report structure Committee noted the progress made, including a new grant application for £245k.	Accelerated progress will be linked to the appointment of the new Corporate Manager (see 5.3)	No escalation
4	Robot	Reasonable	The Committee revisited the original business case and confirmed that it covered ongoing maintenance and replacement costs as appropriate. Committee reconfirmed the business case, the need to push ahead with some urgency and that any capital shortfall and the ongoing maintenance and replacement costs would be covered by the Trust.	Early meeting to confirm current process with the Robot manufacturer Launch fundraising campaign at the earliest opportunity Engage more formally with the supplier in 6 months when more certainty on fundraising position.	No escalation
5.1	Charitable Funds policy and Procedure	Reasonable	Committee reviewed an updated policies and procedure document for the Charitable Funds	JL to circulate final version for approval.	No escalation

			Agreed that further changes required. Not approved and members asked to submit changes by email.		
5.2	MyWish team structure	Reasonable	Recent change of leadership provides the opportunity for review of team structure and focus Committee reviewed costed proposals and revised planned team structure Revised team structure agreed in principle although final proposal and costings to come back to committee for approval	Final costings to be agreed including any redundancy costs and assumed inflationary increases. Agreed ongoing level of support required from finance Team and cost of that support Final proposal and costings to come back to Committee for approval.	No escalation
5.3	New Corporate Manager role	Reasonable	Committee reviewed and approved the business case to appoint a new corporate Manager role with performance linked to delivery against agreed targets (£100k in YR1 and £240k pa after YR1).	JH to consider and advise on fixed term or permanent with probationary period. Agreed on the need to push ahead at earliest opportunity and start raising money.	No escalation
6	Disposal of Etna Road properties	Reasonable	Bequeathed to MyWish from the estate of T Clarke. Approved at recent extraordinary meeting to sell at auction with reserve of £100k.	Close of auction end July. An update will be provided at the next meeting.	No escalation
6	Financial performance	Reasonable	Finances in line with expectations. Reduction in	Ongoing financial review.	No escalation

			bank balance linked to payment of creditors.		
7	Investment Report	Reasonable	Covered in detail under CCLA presentation (item 2). Noted the fund value of £1.66m, which was a small increase over the 11 months from 1/4/24.	Review of position at next meeting.	No escalation
8, 9	Funds closed and fund balances	Substantial	Noted fund balances. No funds closed.		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. Audit Committee - Chair's key issues from the meeting (ATTACHED)

To inform

Presented by Michael Parsons

Board assurance committee - Committee Key Issues (CKI) report

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

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

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

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

7.3. Board Assurance Framework (ATTACHED)

For Approval

Presented by Paul Bunn

WSFT Board of Directors (Open)	
Report title:	**Board Assurance Framework**
Agenda item:	7.3
Date of the meeting:	July 2025
Sponsor/executive lead:	Richard Jones, Trust Secretary
Report prepared by:	Paul Bunn (Trust Solicitor)/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

The purpose of this paper is to provide the Board with assurance regarding the processes in place to make sure the Board Assurance Framework (BAF) is kept under active review. This paper provides an overview of the latest summary of the BAF for the Board to review. The BAF remains structured around **10 strategic risks** (agreed in November 2022)**:**

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 process of review is that operational and nominated executive leads review their BAF risks at a functional level. Any changes to the cause, effect and mitigations are highlighted and discussed at the Management Executive Group (MEG). Once finalised, the updated strategic risk is reported into the relevant Board assurance committee.

Annex A **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).

The following **summarises changes since the last report in May 2025**:

- **BAF 3 Collaboration** - reviewed and updated by the Executive Director of Strategy and Transformation presented to MEG in June and to the Involvement Committee in July.

- **BAF 4 Improvement** – reviewed and risk rating updated by the Executive Director of Strategy and Transformation and was presented to MEG in May and to the Improvement Committee in June.
- **BAF 7 Finance –** reviewed and risk rating updated by the Executive Director Financial Recovery and will be presented to MEG in July and Insight Committee in August.
- **BAF 8 Governance** – reviewed and updated by the Head of Legal Services and IG and presented to MEG in June and the Improvement Committee in July.

The future workplan and reporting lines are contained within **Annex C:** 4 strategic risks are reviewed every 6 months; 6 are reviewed quarterly.

WSFT operates 3 levels of assurance for each strategic risk:

- Level 1 – Operational (Management) – our first line of defence
- Level 2 – Oversight functions (Committees) – our second line of defence
- Level 3 – Independent (Audits / Reviews / Inspections etc.) – our third line of defence

Based on current assessments, **four BAF risks achieve the risk appetite** (no change from the last report) rating approved by the Board after appropriate mitigations put in place. ***Annex B*** tracks the current and predicted future risks scores once mitigation work is complete.

The current BAF will need to be extensively reviewed once the Trust's revised strategy is finalised. A Board Workshop is scheduled for December 2025 to enable discussion about what the future major strategic risks are that could prevent delivery of the new strategy this will including benchmarking against industry and NHS organisations.

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:

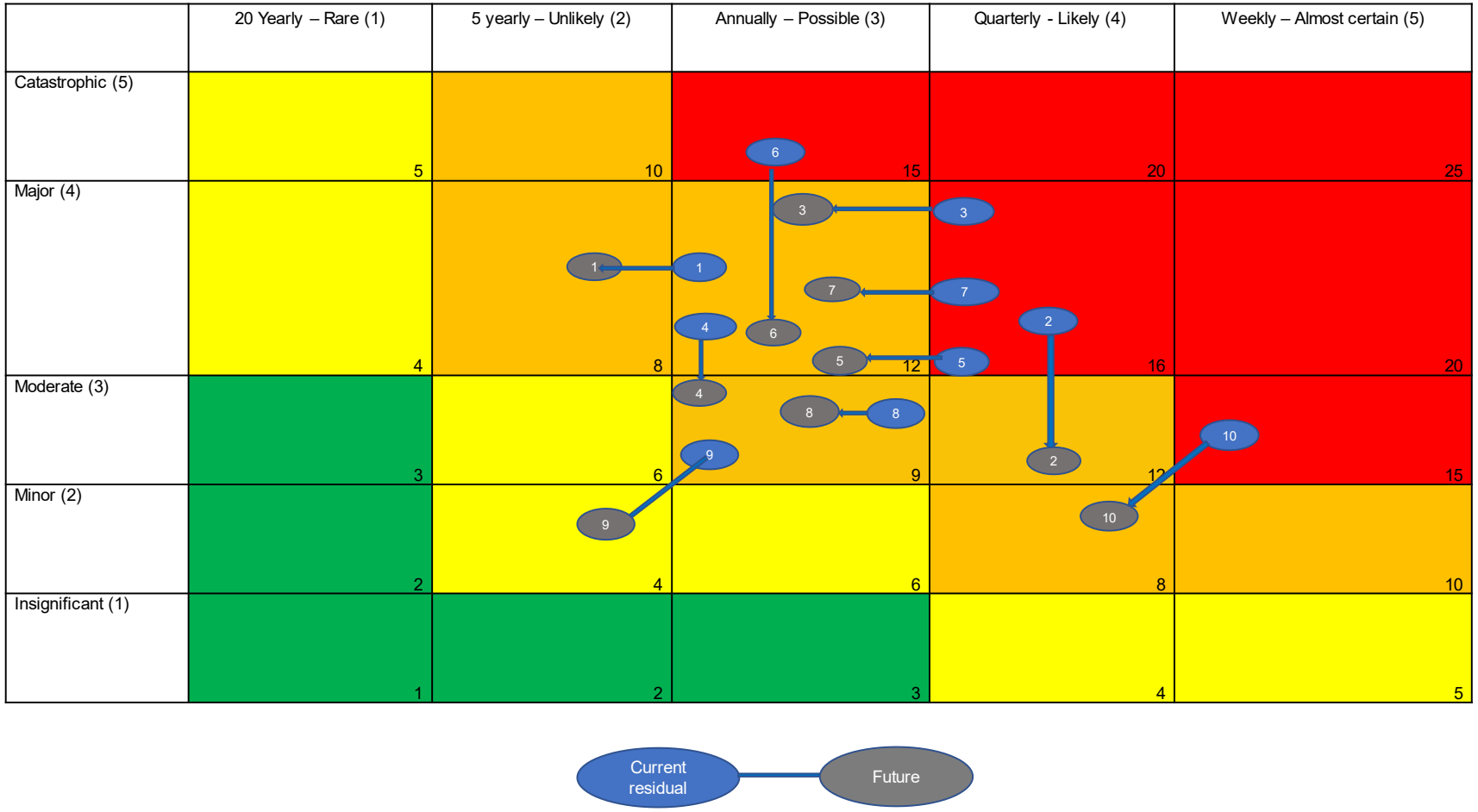
- Schedule **review of risks to the agreed strategy** when the strategy refresh has been undertaken. This will also include review and assessment of the risk appetite for each risk (Q3-Dec)
- To arrange a Board Risk Management workshop supported by external stakeholders in December, which will include 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-Dec)
- A matrix will be developed to **map the interdependencies** between individual BAF risks after the strategy refresh . (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 Aug 25 (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 Oct '25 (Sept '25)	Cautious (9)	16	12 (Mar 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 Oct '25 (Sept '25)	Open (12)	16	12 (Aug 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 Sept '25 (Aug '25)	Open (12)	12	9 (Aug 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 Oct '25 (Sept '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	Insight	Planned for Sept '25 (Aug '25)	Open (12)	15	12 (Sep 25)	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	Aug '25 (Jul '25)	Cautious (9)	16	12 (Sep 25)	No	Partial
BAF 8 Good governance is about having clear responsibilities, roles, systems of accountability to manage and deliver good quality, sustainable care, treatment and support. A failure to ensure this means the Board would be unable to act on the best information when planning services, improvements or efficiency changes both locally and with system partners in line with our vision and values.	ECN	Improvement	Jan '26 (Dec '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	4 (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

Annex 3 – Current Workplan 2025/26

	Score	Frequency	Executive lead	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Management Executive Group																			
BAF 1-Capability and skills	12	six monthly	HR&C (Jeremy Over)				X						X						X
BAF 2-Capacity	16	quarterly	COO (Nicola Cottington)			X			X			X			X			X	
BAF 3-Collaboration	16	quarterly	DST (Sam Tappenden)			X			X			X			X			X	
BAF 4-Continous improvement and Innovation	16	quarterly	DST (Sam Tappenden)		X			X			X			X			X		
BAF 5-Digital	16	quarterly	COO (Nicola Cottington)			X			X		X			X			X		
BAF 6-Estates	15	quarterly	DoR (Jonathan Rowell)		X			X			X			X			X		
BAF 7- Finance	16	quarterly	DoR (Jonathan Rowell)	X			X			X			X			X			
BAF 8-Governance	9	six monthly	ECN (Sue Wilkinson)			X						X						X	
BAF 9-Patient Engagement	9	six monthly	ECN (Sue Wilkinson)						X						X				
BAF 10-Staff Wellbeing	10	six monthly	HR&C (Jeremy Over)				X			X			X						
Improvement																			
BAF 4 -Continous improvement and Innovation	16	quarterly	DST (Sam Tappenden)			X			X			X			X			X	
BAF 8 -Governance	9	six monthly	ECN (Sue Wilkinson)				X						X						X
Insight																			
BAF 2-Capacity	16	quarterly	COO (Nicola Cottington)	X			X			X			X			X			X
BAF 6-Estates	15	quarterly	DoR (Jonathan Rowell)			X			X			X			X			X	
BAF 7- Finance	16	quarterly	DoR (Jonathan Rowell)		X			X			X			X			X		
Involvement																			
BAF 1-Capability and skills	12	six monthly	HR&C (Jeremy Over)					X						X					
BAF 3-Collaboration	16	quarterly	DST (Sam Tappenden)	X			X			X			X			X			X
BAF 9-Patient Engagement	9	six monthly	ECN (Sue Wilkinson)	X						X						X			
BAF 10-Staff Wellbeing	10	six monthly	HR&C (Jeremy Over)					X			X								
Digital Board																			
BAF 5-Digital	16	quarterly	COO (Nicola Cottington)	X			X			X			X			X			X

7.4. Governance Report (ATTACHED)

To inform

Presented by Paul Bunn

WSFT Board of Directors (Open)	
Report title:	**Governance report**
Agenda item:	7.4
Date of the meeting:	25 July 2025
Sponsor/executive lead:	Richard Jones, Trust Secretary
Report prepared by:	Pooja Sharma, Deputy Trust Secretary

Purpose of the report:			
For approval ☐	**For assurance** ☒	**For discussion** ☐	**For information** ☒
Trust strategy ambitions			
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 July 2025, as follows: • Senior Leadership Team • Management Executive Group • Remuneration Committee report • 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 the report as outlined above.

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

The Senior Leadership Team met on 16 June 2025 that featured a workshop on Digital Boards aimed to ensure the whole senior leadership understands the need to take collective and individual ownership of the Trust's digital transformation, to help 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.

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. Remuneration Committee report

The remuneration committee met on 25 June 2025 for MAR scheme agreement sign off with PA Consulting and to consider recruitment for the executive chief finance officer.

The committee also noted the change in role and job title of the Director of Integrated Adult Health and Social Care who will transition into the new role of Social Care, Area Director. Agreement was also given to the Social Care, Area Director continues being a regular attendee of the Board as a non-voting board member, to provide visibility and link to strategic leadership between ASC and WSFT that aims to enhance service delivery, improve patient outcomes and optimise resources.

4. Board development session

On 27 June, the Board held a workshop on Trust strategy development and Safeguarding training. The session was well-received, with valuable discussions and contributions.

The Board was asked to, specifically discuss, vision, mission and values, ambitions and priorities, strategic choices what actions the board could take to best support and deliver Trust's strategy. The workshop included a task to identify major uncertainties that could impact the Trust's strategy and assessed each scenario to determine the future outcome and discussed what strategic adjustments might be needed. They also considered backup plans and mitigations to stay on track if circumstances changed unexpectedly and prepare the board for future challenges by encouraging flexible thinking and forward planning.

Safeguarding training: The Board received training on safeguarding that helped board members understand how to protect adults from harm, including recognising signs of abuse and neglect, learned how to share important information and refer cases safely, while also grasping the roles and responsibilities across different organisations. The training highlighted how serious mistakes like gross negligence, can affect adult safety. It also focused on strong leadership, safe hiring practices and making sure staff are supported, trained and able to raise concerns confidently, both for the wellbeing of staff and the people being cared for.

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.

5. Urgent decisions by the Board

None to report.

6. Use of Trust Seal

None to report.

7. Agenda Items for the Next Meeting (Annex A)

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 - 26 September 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

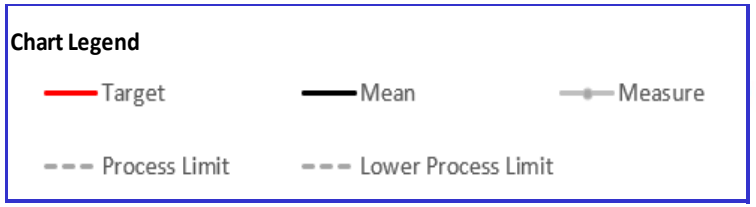
Assurance Grid

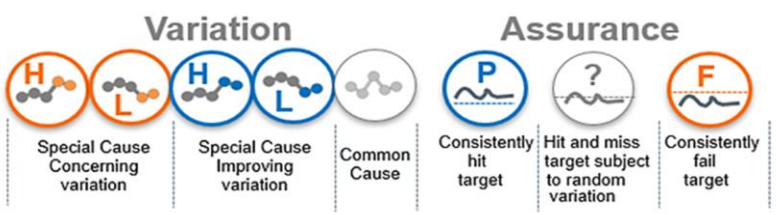
Performance in May 2025	ASSURANCE: Will we reliably meet the target based?		Not Met	
	Pass	Hit and Miss	Fail	No Target
VARIANCE: Variation from the mean The colours indicate the trend- positive (blue), Negative (orange), or neither (grey) Deteriorating	**Special Cause Improvement**  **INSIGHT** Virtual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

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

INSIGHT COMMITTEE METRICS

Urgent & Emergency Care summary

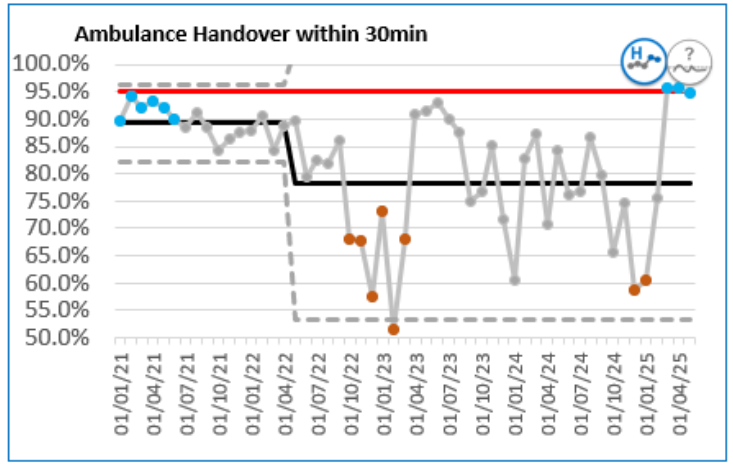


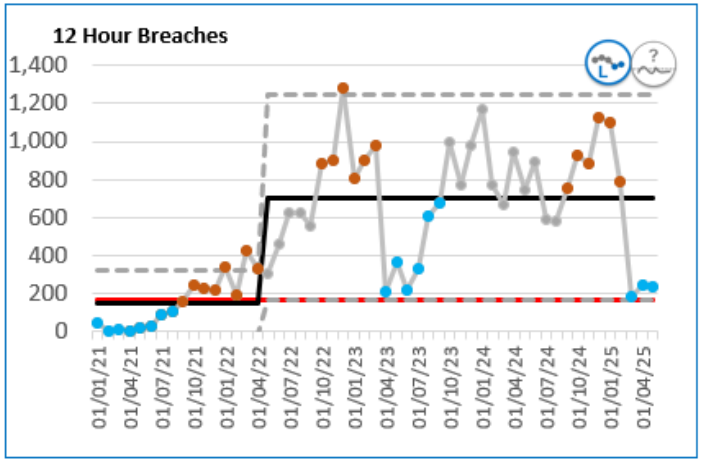


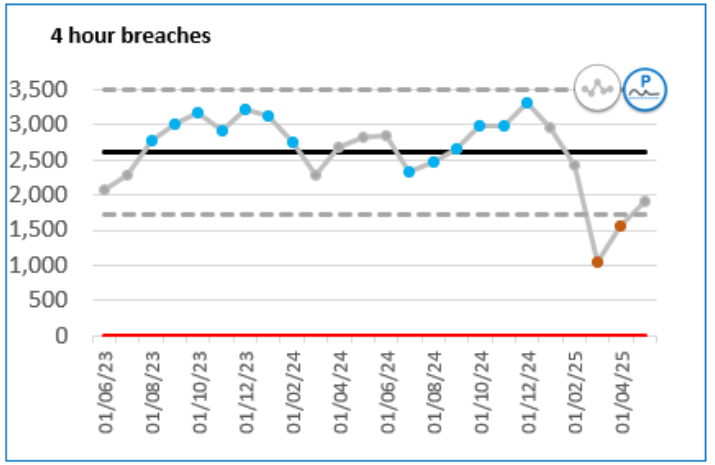
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover within 30min	May 25	94.9%	95.0%			78.2%	53.2%	103.1%
12 Hour Breaches	May 25	237	167			706	166	1245
4 hour breaches	May 25	1923	0			2613	1716	3510
Non-admitted 4 hour performance	May 25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

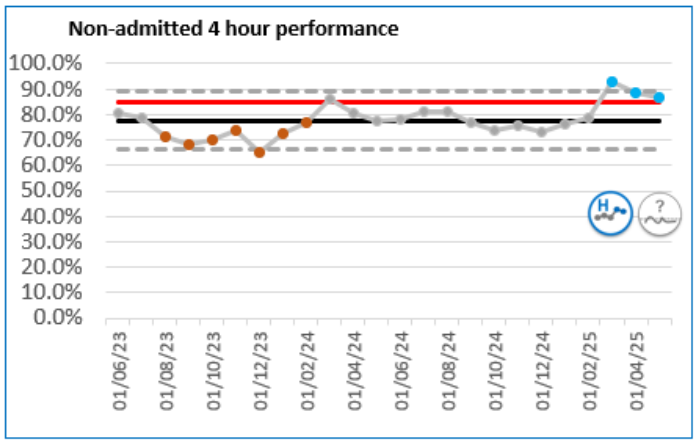
** Figures are for Glastonbury and Newmarket only, data not currently captured at Hazel Court.

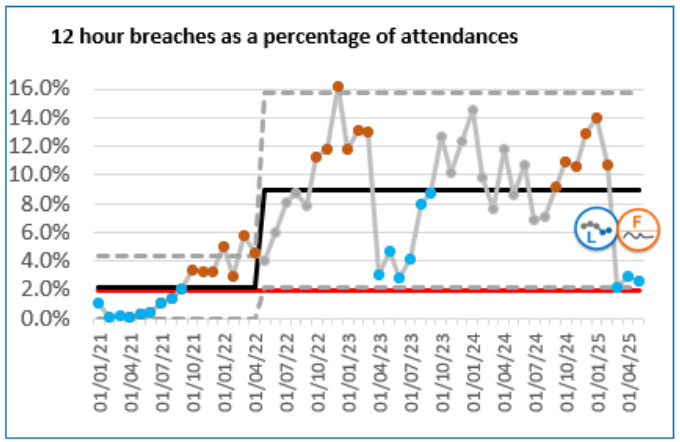
Urgent & Emergency Care: ED 4 Hour Performance

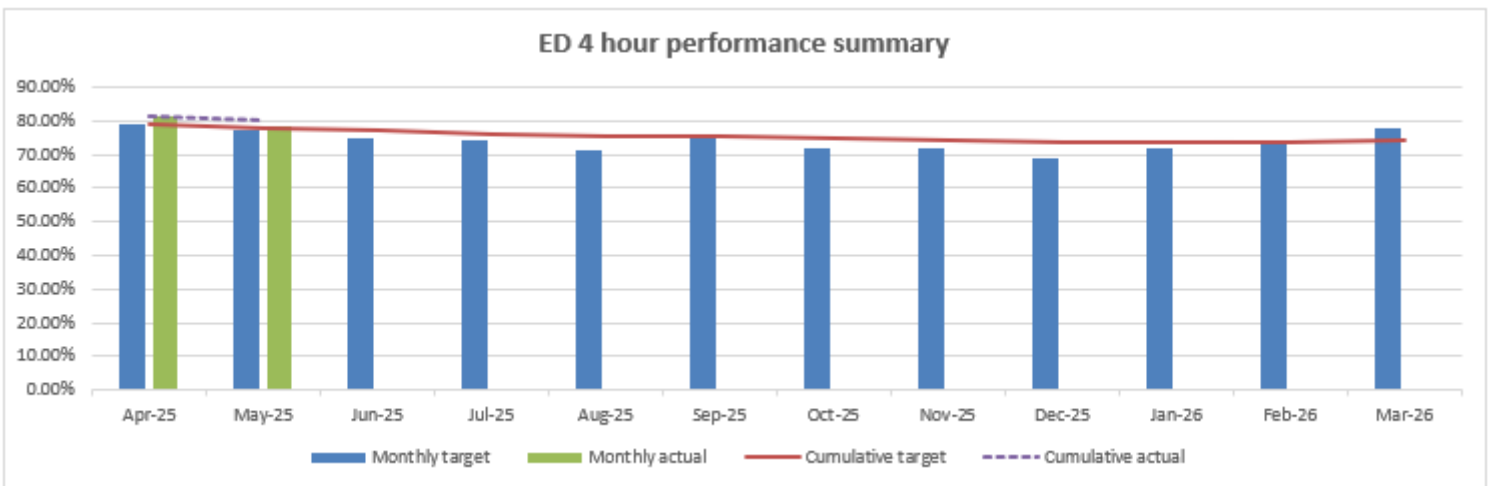












Urgent & Emergency Care

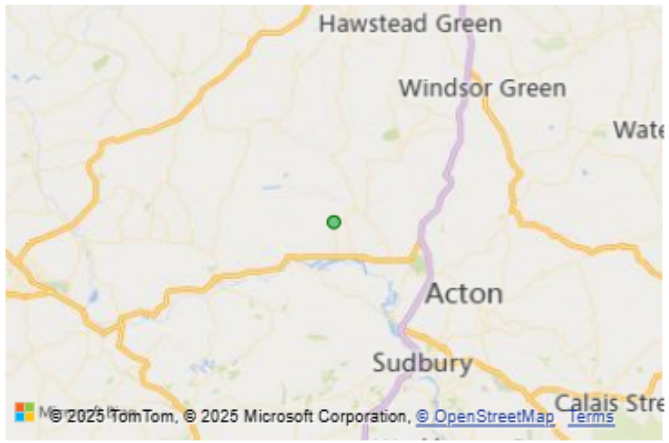
What	So What?	What Next?
The improvement in the 30 minute ambulance handover metric was maintained in May, achieving 94.9% narrowly missing the target of 95%. The number of 12 hour length of stay breaches in May was 237 representing a maintained reduction from March and an improved position compared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

Community Access Glemsford Surgery

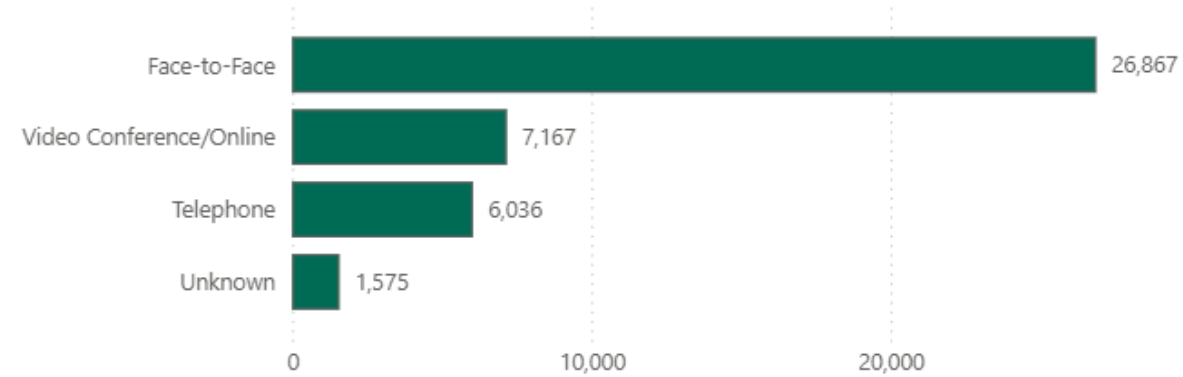
Practice Appointments

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

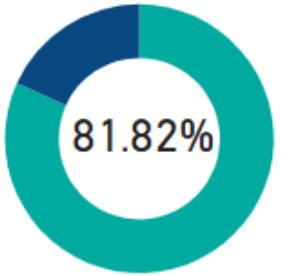
Alliance All | **PCN** All | **Practice** Glemsford



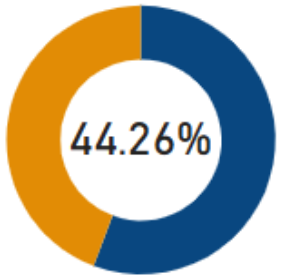
Practice appointments by contact mode



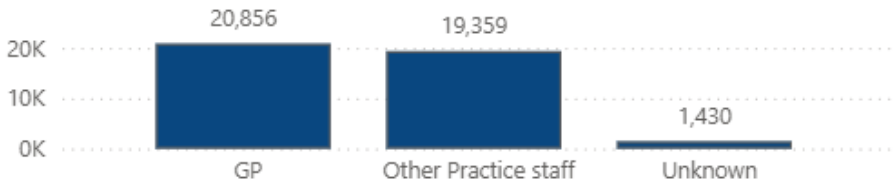
Seen within 2 weeks



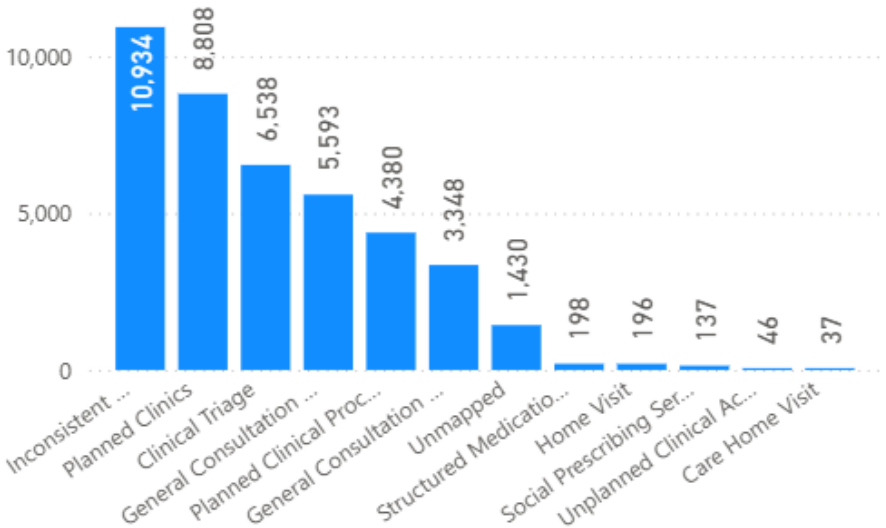
Seen within 48 hours



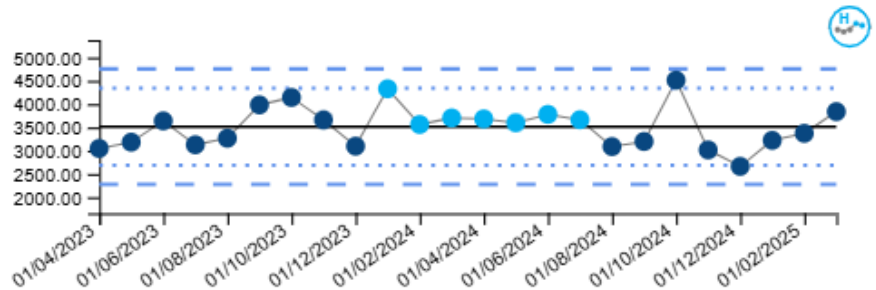
Practice appointments by health care professional type



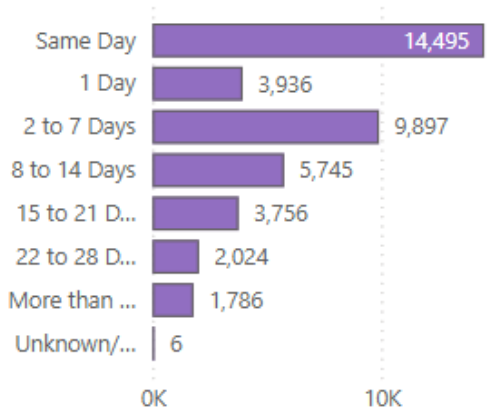
Sum of Total Appointments by National Category



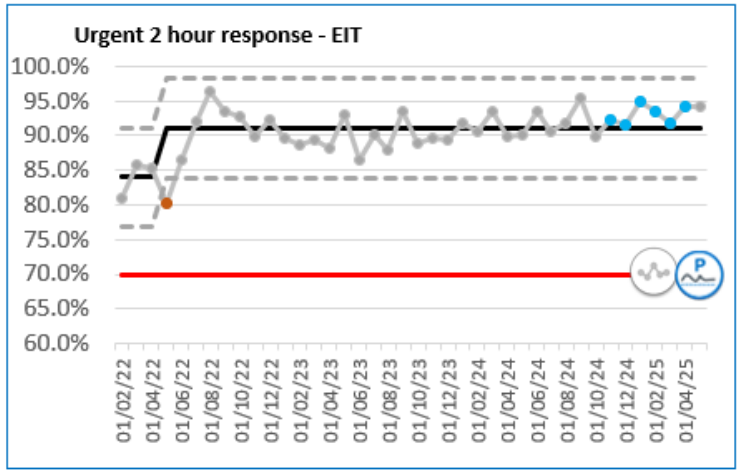
Total appointments by month

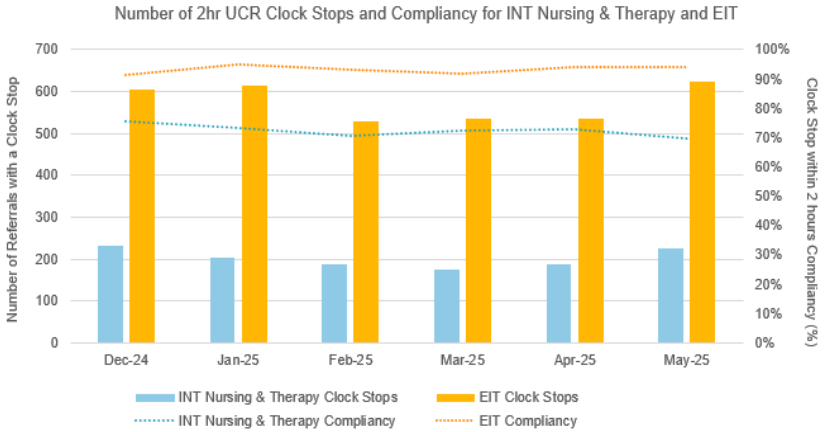


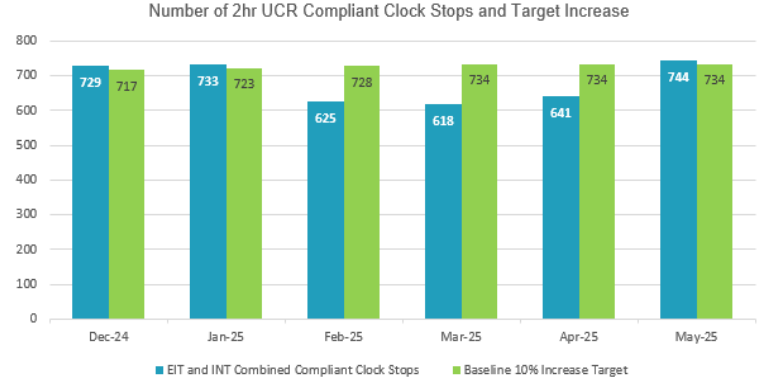
Appointments by wait time



Produced by ICB







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

What

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

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

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

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

So What?

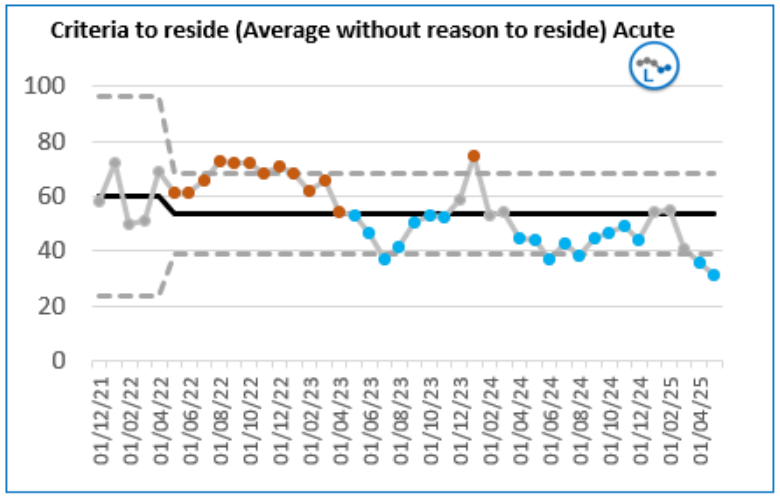
Continue to exceed national UCR target.
Cleric referrals only accepted where there is capacity.

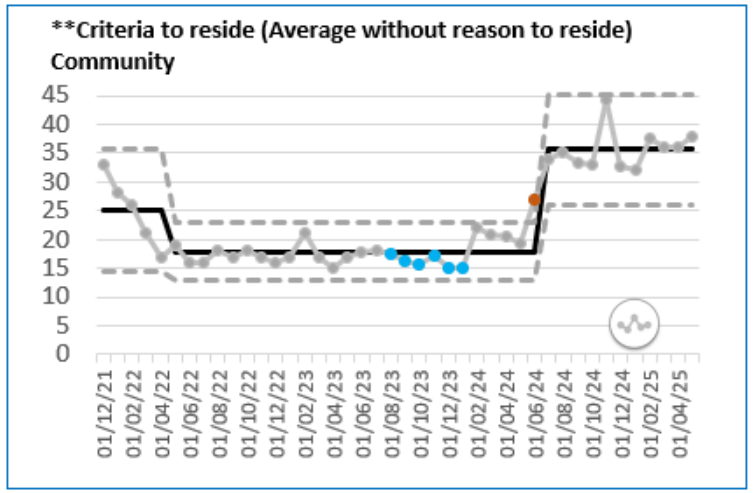
Showing that urgent response and 2 day referrals are being prioritised above routine work, in INT.

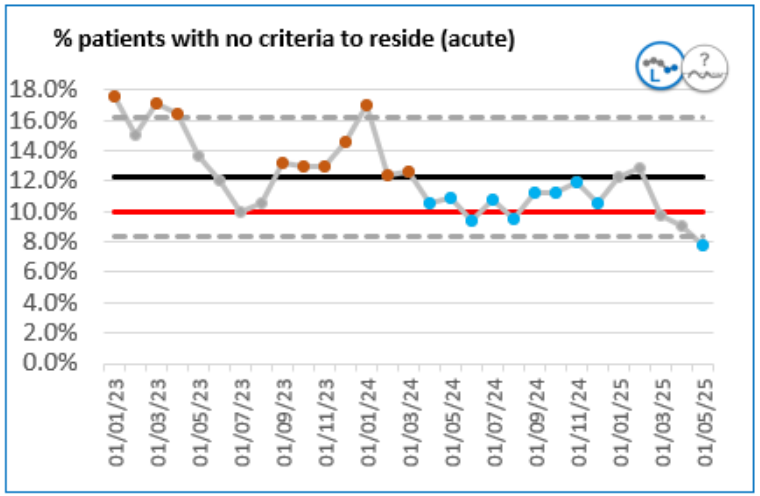
What Next?

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

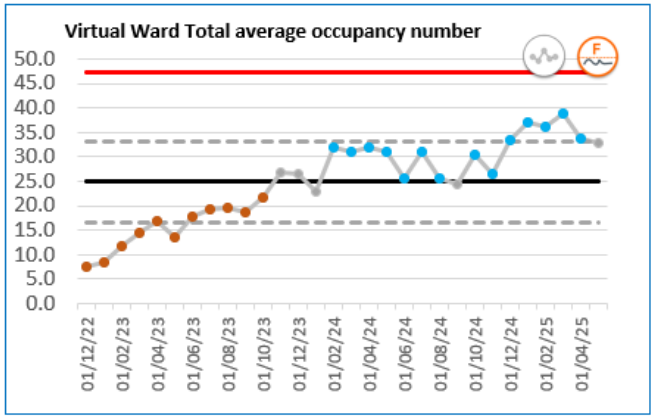
Initial period of formal cross cover for therapy clinical duties in Town, Rural, Mildenhall and Newmarket due to reduced staffing and skill mix challenges (resulting from blanket INT recruitment freeze) to be reviewed in 3 months, as productivity is above national benchmark.
Review and identify actions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

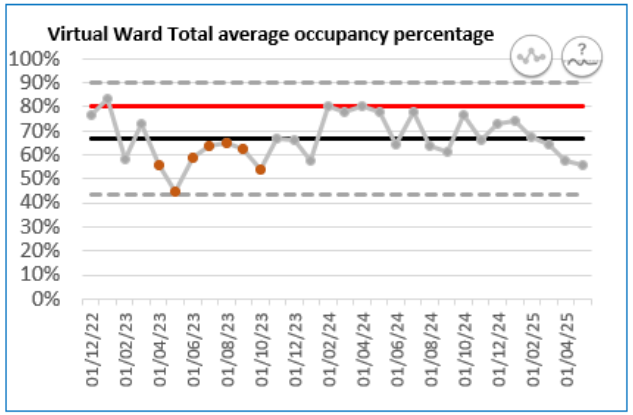


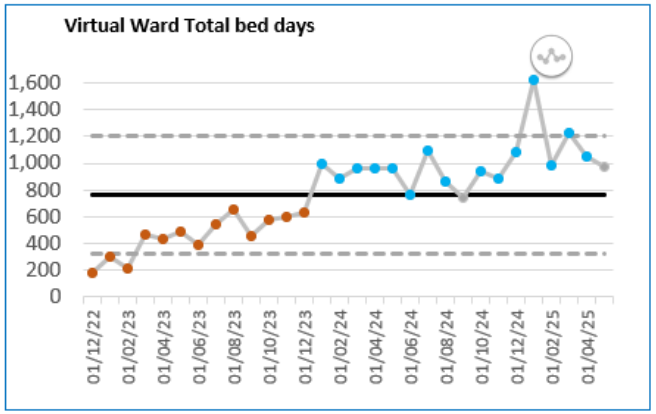


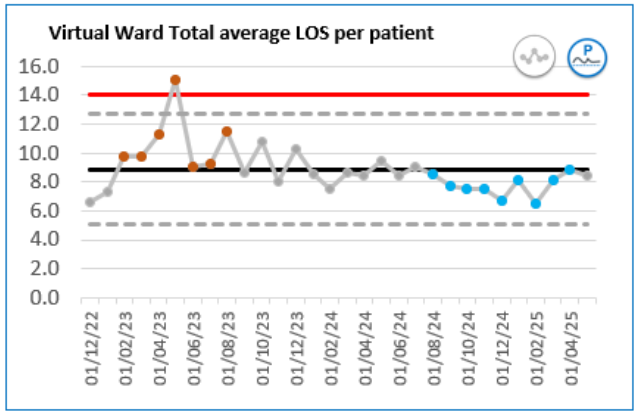


What	So What?	What Next?
May has seen a further reduction in the number of acute patients without criteria to reside with an average of 7.8% - the lowest figure recorded to date. Continue to transfer non-traditional patients into Community Assessment Beds (CAB) which may be a contributing factor however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

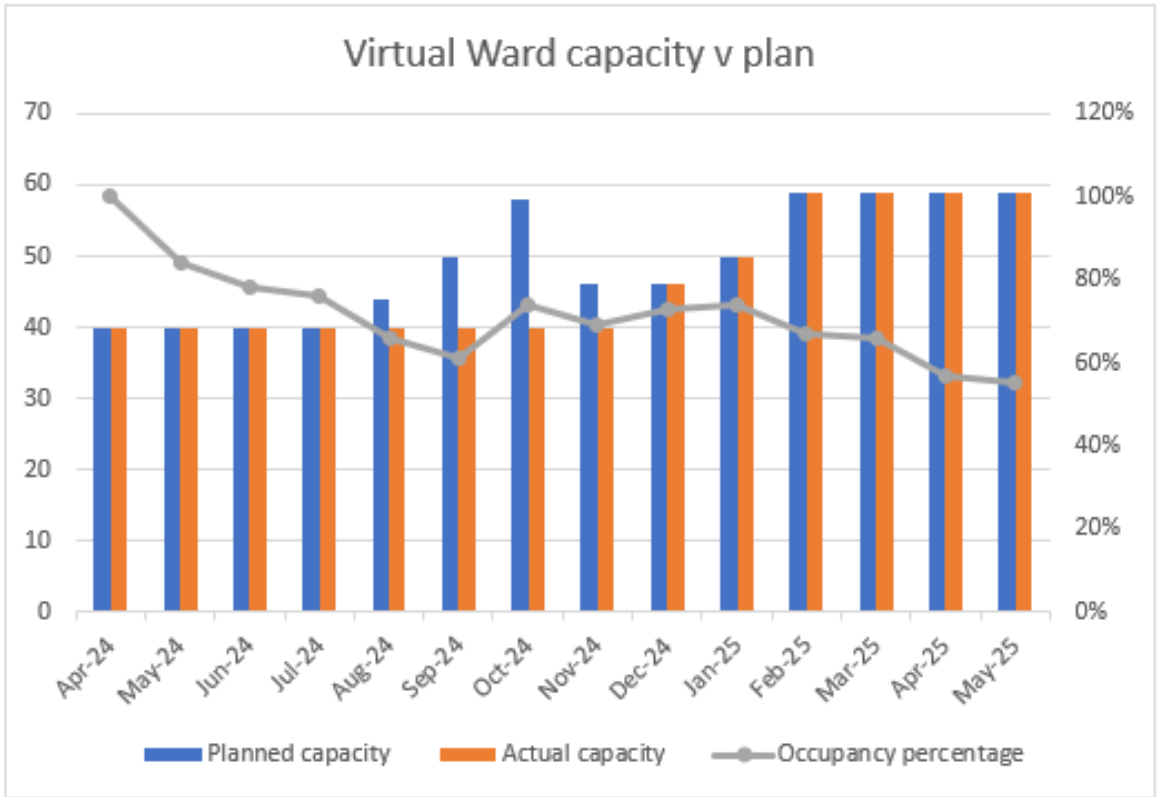






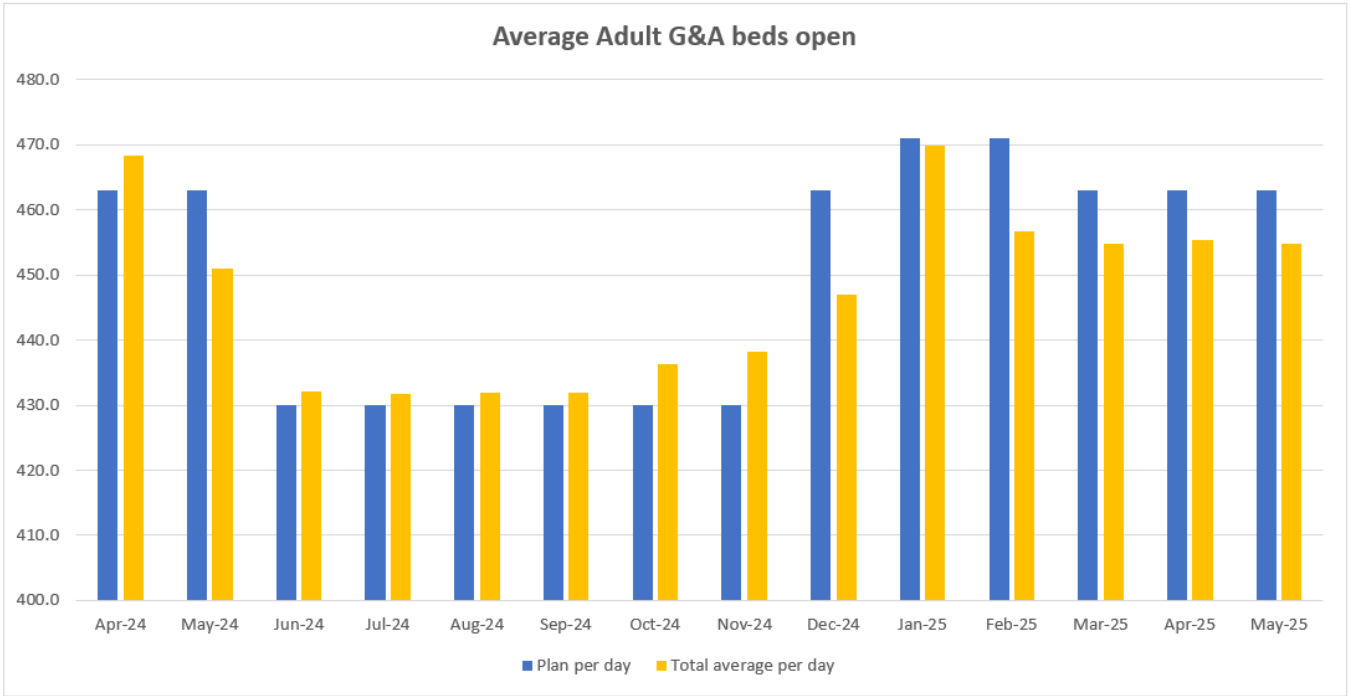


What	So What?	What Next?
There was a slight reduction in average occupancy in May: average occupancy of 32.7 patients compared to 33.8 patients in April. This is reflected in a reduction of bed days occupied (975 in May compared to 1952 in April). Patient flow is supported by effective length of stay which is well managed at average 8.5 days in May (slight reduction from 8.8 days in April). This is significantly below the NHSE target of 14 days . VW audit indicates that this is achieved whilst maintaining appropriate acuity.	Virtual Ward capacity is crucial in ensuring adequate capacity to enable patient flow across the Trust and strategic ambition of caring for patients at or near wherever possible. Appropriate length of stay is important to facilitate effective patient flow and ensure that value for money is achieved in relation to the investment in virtual care.	Step ups - consultant now in post enabling further development of step ups to virtual care. Plan in place to achieve 50% target by October 2025. Monthly trajectory agreed and will be reported to PRM from July. Primary care pilot completed (Frailty pathway); next steps are (I) extension of hours (ii) expansion to 3 further GP practices and (iii) inclusion of heart failure pathway. EIT step ups enabled. Extend to community matron. Shared Service Delivery programme - remaining VW nursing activities will be integrated into community teams in October 2025 releasing further efficiencies especially around travel time and cost.



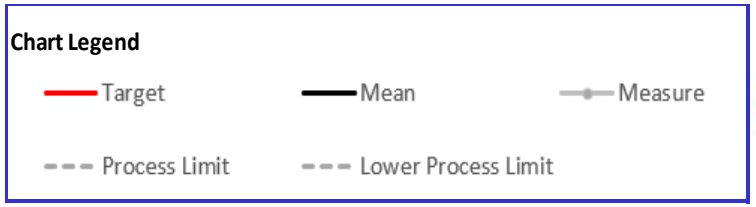
What	So What?	What Next?
Average pathway occupancy during May 2025 have declined a little overall, numbers for those on respiratory pathway have declined the greatest.	Virtual Ward capacity is crucial in ensuring adequate capacity to enable patient flow across the Trust and strategic ambition of caring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

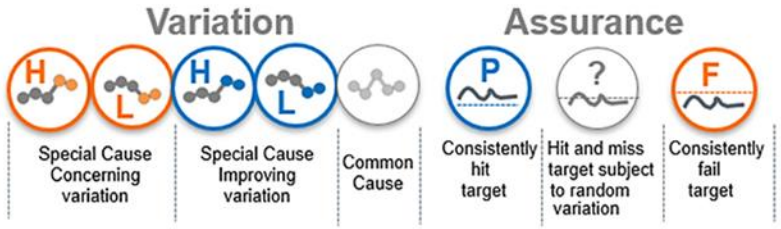
Urgent & Emergency Care: Beds



What	So What?	What Next?
May 2025 saw the average core beds maintained in line with closure of the winter escalation ward during March. Use of escalation beds decreased slightly, but still representing the 6 medical Same Day Emergency Care (SDEC) beds used to mitigate patient flow pressures and maintain timely departures from the Emergency Department. NB – higher core beds open compared to summer 2024 represents inclusion of Discharge Waiting Area into reporting, following dataset specification being clarified.	Maintaining core beds open as per plan is a key requirement of the NHS operational priorities and planning guidance. Delivering the plan maximises patient flow and reduces extended waits for admission from the Emergency department, contributing to reduced 12-hour waits and improved 4-hour performance. However, using escalation beds impacts on the ability of those areas being used to fulfil their primary purpose and uses unbudgeted staffing resources.	Use of all escalation area is monitored through the daily capacity meetings in conjunction with divisional leadership teams to ensure it is in line with the Tactical Patient Flow Escalation Plan. Using less core and escalation beds than planned from December to March provides the opportunity to rationalise inpatient capacity, with a plan to implement the first of these schemes in June.

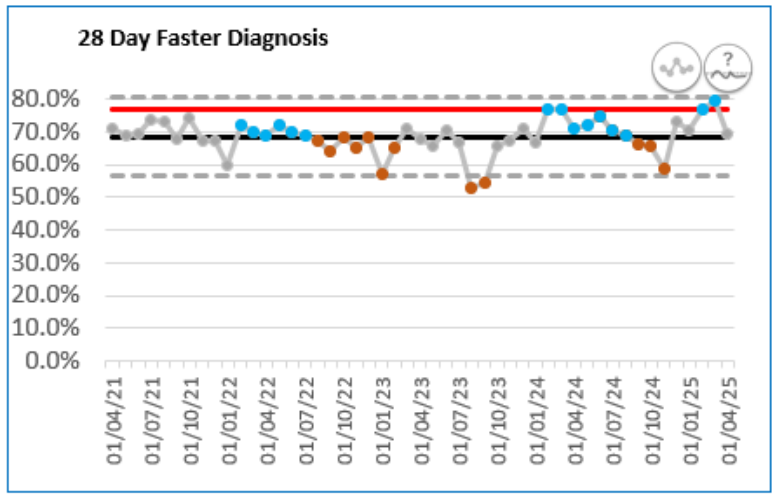
Cancer Access Summary

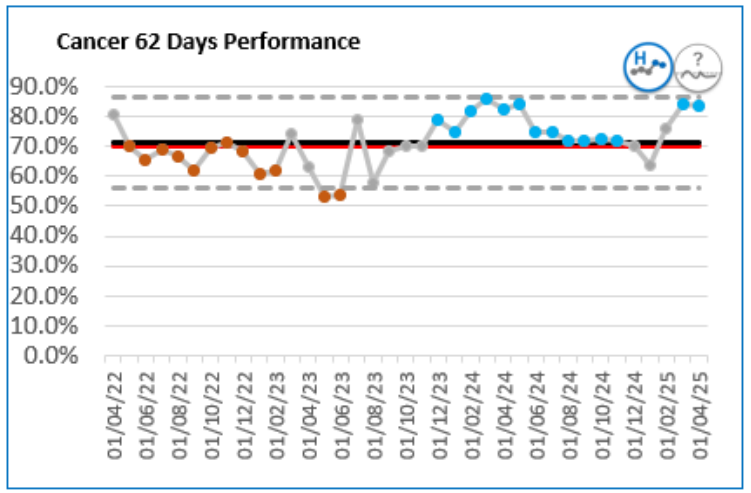


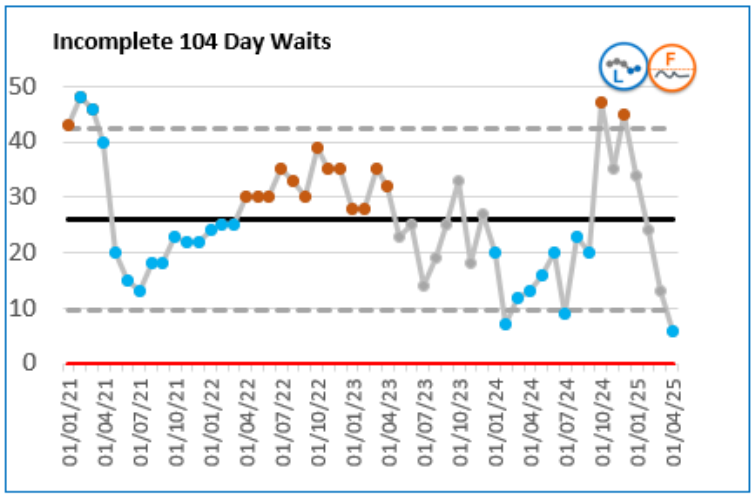


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	Apr 25	69.4%	77.0%		?	68.5%	56.5%	80.5%
Cancer 62 Days Performance	Apr 25	83.8%	70.0%	H	?	71.4%	55.9%	86.8%
Incomplete 104 Day Waits	Apr 25	6	0	L	F	26	10	42

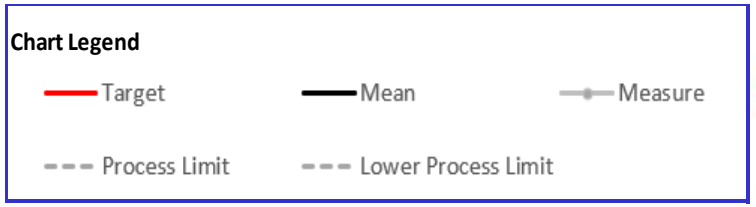
Cancer Access (Month Behind)

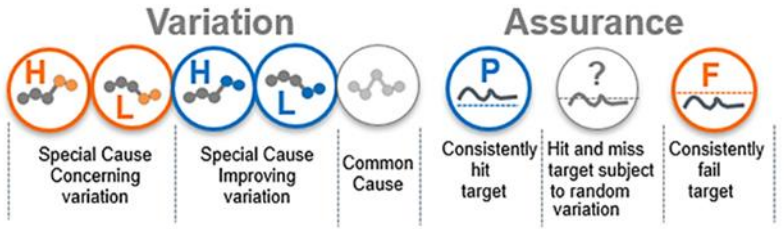






What	So What?	What Next?
Drop in faster diagnosis performance to 69.4%, against a planned position of 74.3%. This is due to significant underperformance in Breast, which was at 19% against a planned position on 92.1%. Urology, Upper GI, Skin, Head and Neck and Gynaecology all exceeded their forecast position. The Breast underperformance is due to extended waits to first appointment, driven by a shortage of radiological support to the clinics. 62 day performance exceeded national standard.	Recovering the cancer standards is key to the operational planning guidance 25/26 The priorities for this year focus on seeing, diagnosing and treating patients in line with national guidance to improve patient outcomes and maintain standards.	Task and finish group established for Skin pathway including community teledermatology provision, with a view for revised pathway to be in place by Q3 25/26. Continue with FDS steering groups in Skin, Colorectal, Breast and Gynae to monitor performance and required transformational changes as guided by the Best Practice Timed Pathway (BPTP) audits. Continue with additional clinics within Breast, interviews for consultant radiologist to take place 11th July. Cross divisional short-, medium- and long-term plan paper to be presented to executives on the 23rd July

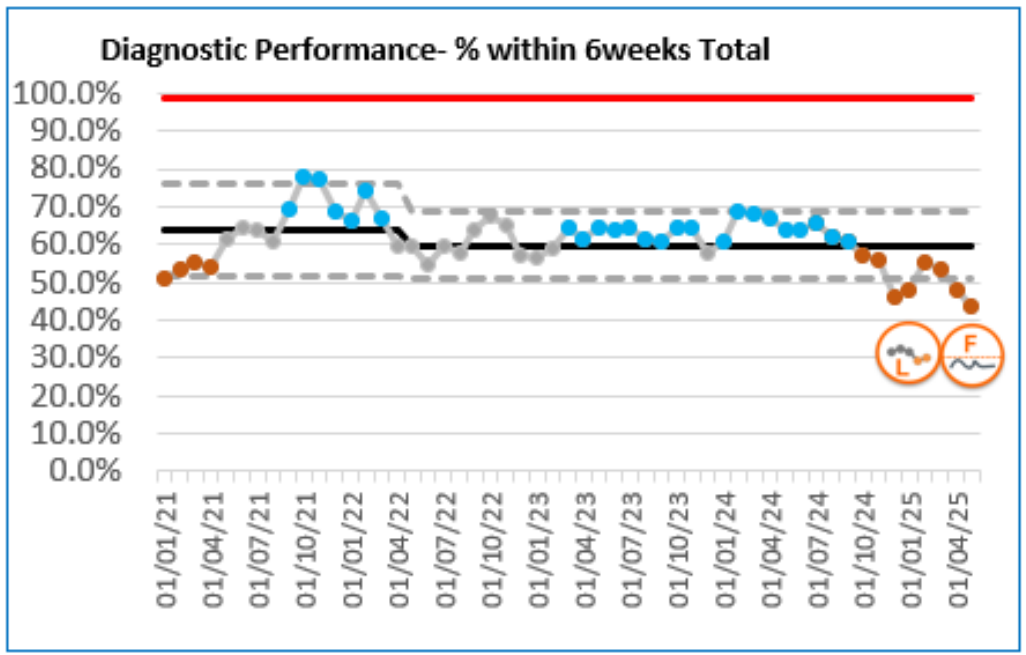




KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Diagnostic Performance- % within 6weeks Total	May 25	43.8%	99.0%			59.9%	51.0%	68.7%
RTT Waiting List	May 25	35089				33251	31963	34539
RTT 65+ Week Waits	May 25	65				381	216	547
RTT 78+ Week Waits	May 25	4	0			123	67	178
Actual 65+ ww at end of Month	May 25	65				387	-189	962

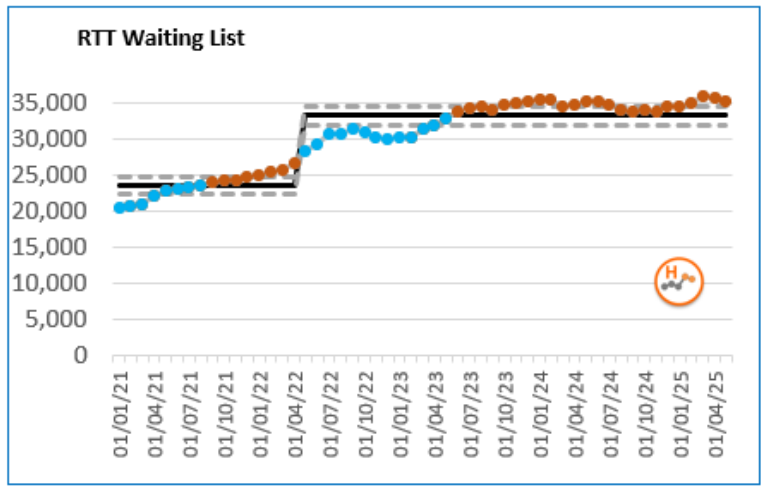
Community Paediatrics RTT Overall Waiting List	May 25	677	-			513	450	577
Community Paediatrics RTT Overall 52 Weeks Wait	May 25	10	-			2	-1	5
Community Paediatrics RTT Overall 65 Weeks Wait	May 25	3	-			0	0	1
Community Paediatrics RTT Overall 78 Weeks Wait	May 25	1	0			0	0	1
RTT NDD Only Waiting List	May 25	2	-			38	14	61
RTT NDD Only 52 Weeks Wait	May 25	0	-			1	-1	3
RTT NDD Only 65 Weeks Wait	May 25	1	-			0	0	1
RTT NDD Only 78 Weeks Wait	May 25	0	-			0	0	0

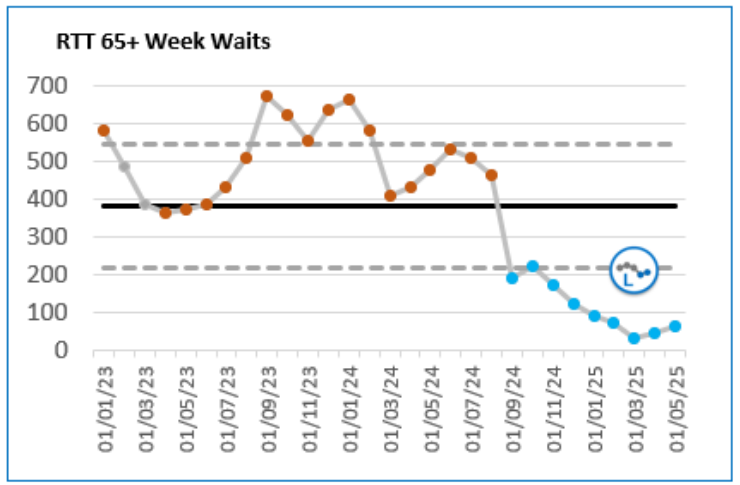
Elective Access

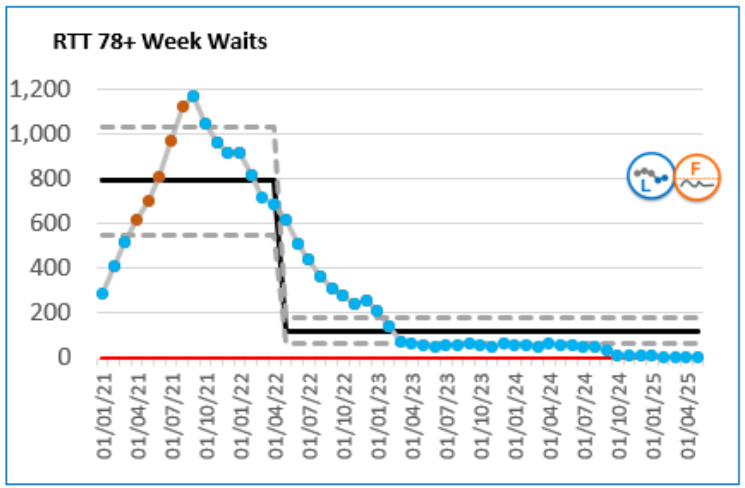


Diagnostics

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

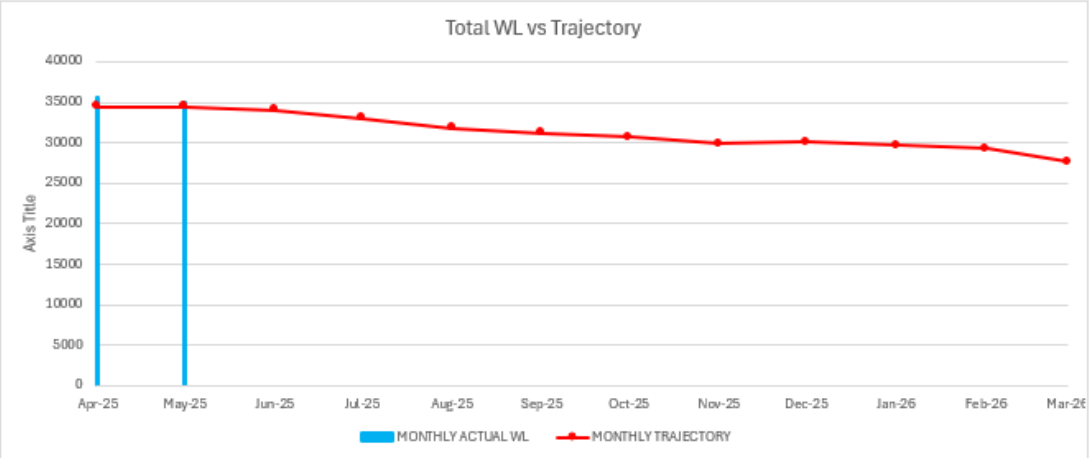


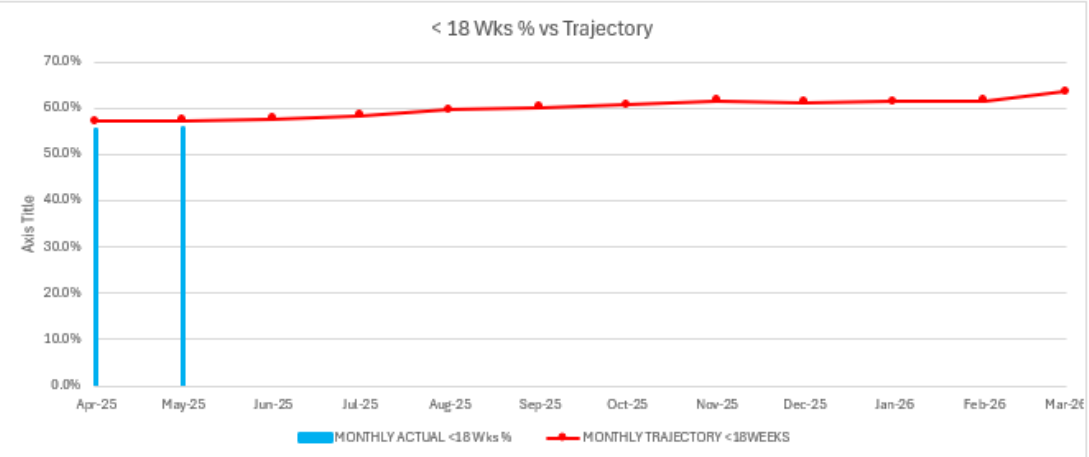


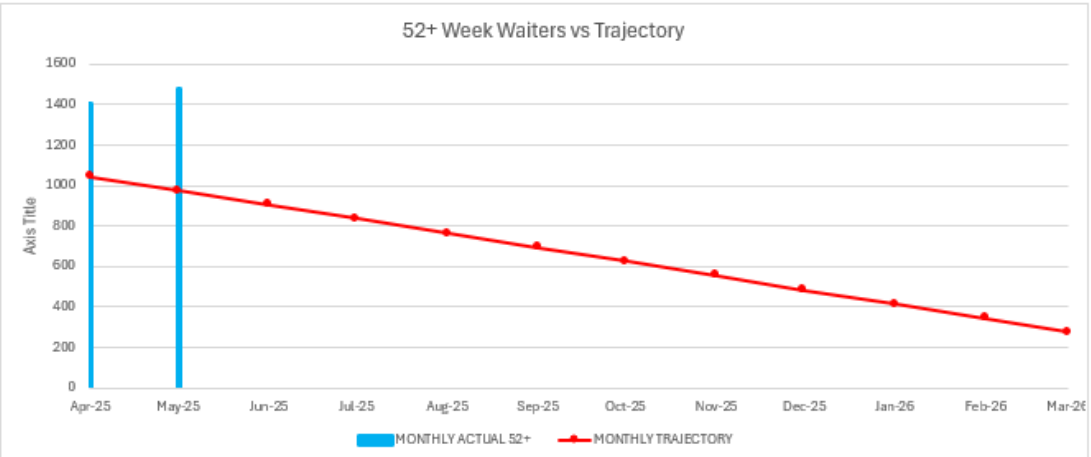


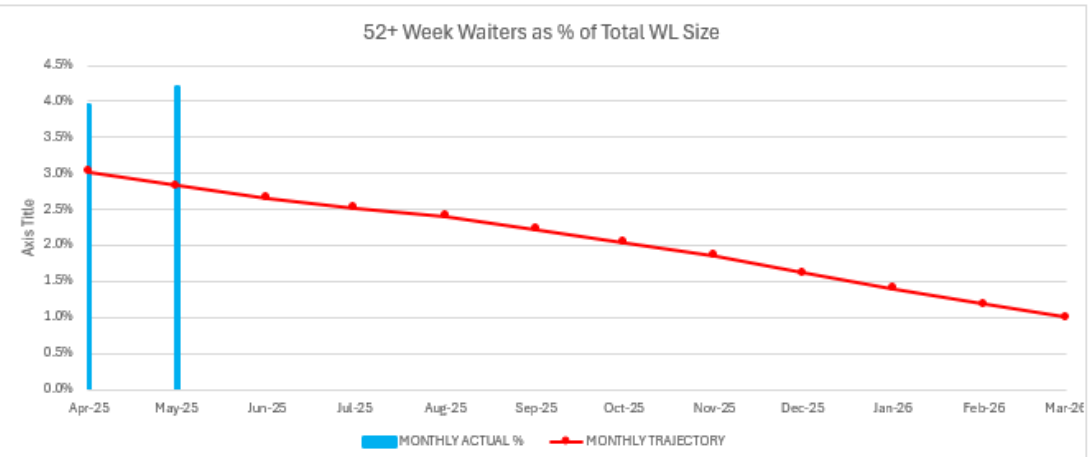
What	So What?	What Next?
The 78 week wait position for the end of May increased to 4 patients. The number of 65 week waits increased again to 65 patients, with further increases in Dermatology, Plastics, Orthopaedics and Pain management. The number of patients over 52 weeks is over the planned trajectory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

Elective Access: RTT





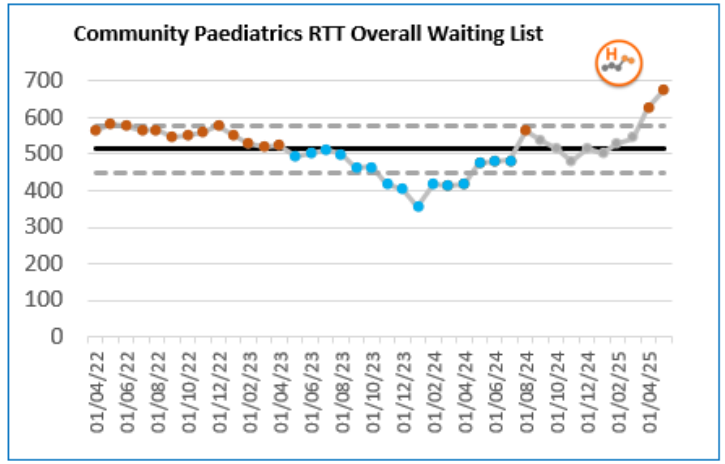


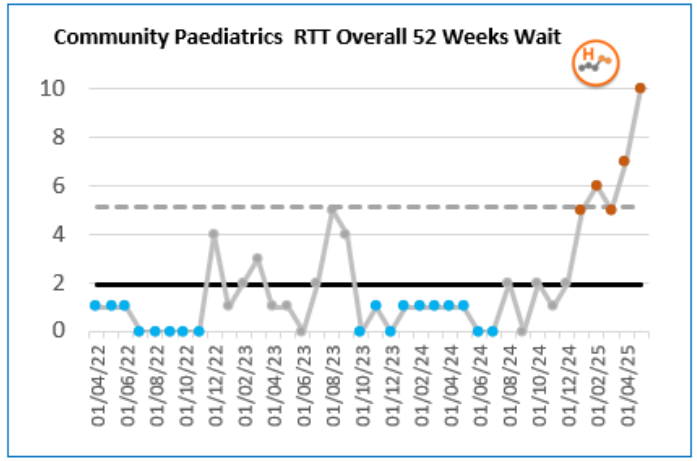


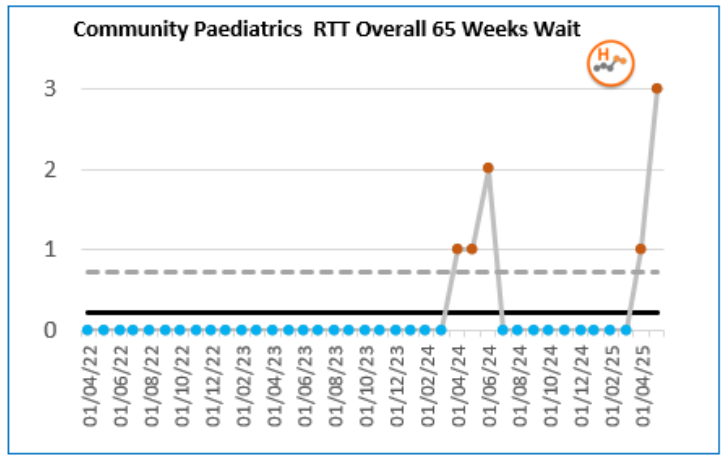
Elective Access: Activity

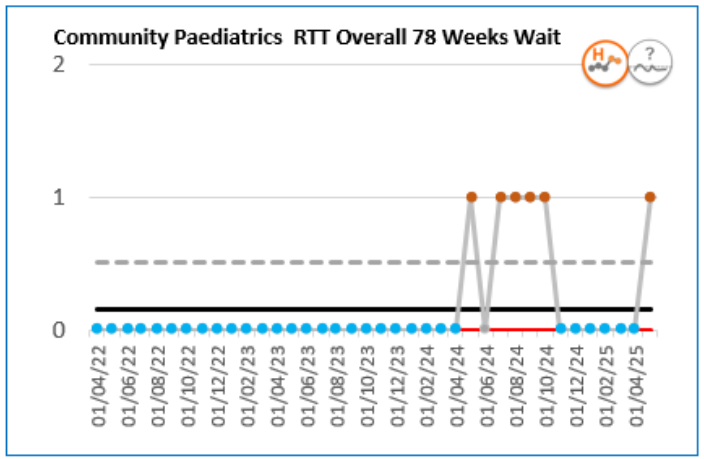
What	So What?	What Next?
We continue to be over our submitted forecast each month for patients over 52 weeks, with 541 patients over trajectory. The biggest contributor to this is within Dermatology who were 221 over plan, followed by Orthopaedics at 72 over plan. Within Dermatology, the waiting time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

Elective Access (Community Paediatrics)









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

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NHS England - 25/26 (Monthly - IQPR)

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

West Suffolk NHS
NHS Foundation Trust

All

All

Outpatient First

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

May 2025	
25/26	10,101
24/25	9,814
Plan	10,207
Var	(106)
Var %	(1.0%)

Daycase

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

May 2025	
25/26	2,408
24/25	2,405
Plan	2,453
Var	(45)
Var %	(1.8%)

Outpatient Follow Up

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

May 2025	
25/26	25,633
24/25	26,236
Plan	24,662
Var	971
Var %	3.9%

Elective

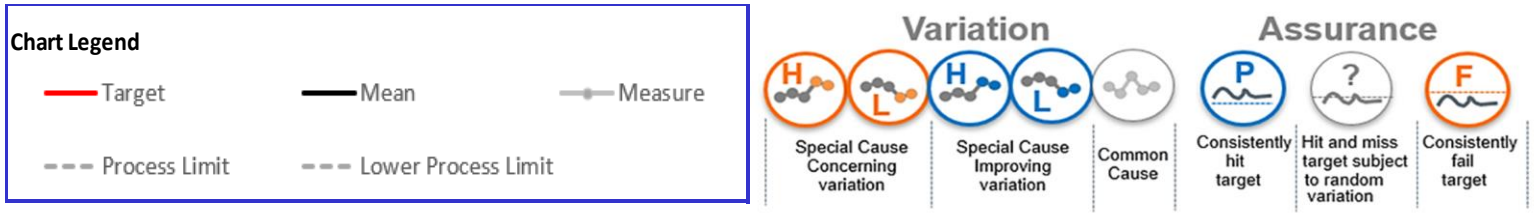
Mon	25/26	24/25	Plan	Var	Var %
Apr	244	261	267	(23)	(8.5%)
May	246	268	273	(27)	(10.0%)
Jun		278	283		
Jul		301	307		
Aug		251	256		
Sep		291	297		
Oct		301	307		
Nov		268	273		
Dec		261	266		
Jan		255	260		
Feb		268	273		
Mar		304	310		
Total (YTD)	**490**	**529**	**540**	**(50)**	**(9.2%)**

May 2025	
25/26	246
24/25	268
Plan	273
Var	(27)
Var %	(10.0%)

Elective Access: Activity

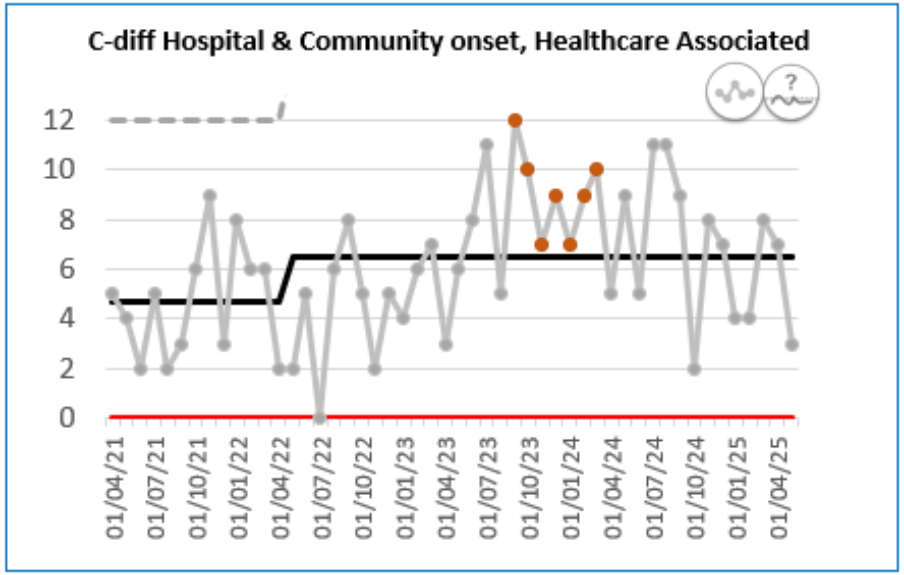
What	So What?	What Next?
Activity plans across elective, daycase and first outpatient attendances are not being met as at the end of May 2025, with the largest variance in elective at -10.0%, a worsening of 1.5%. However, the variance to plan improved for first outpatient attendances and daycases.	From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

IMPROVEMENT COMMITTEE METRICS



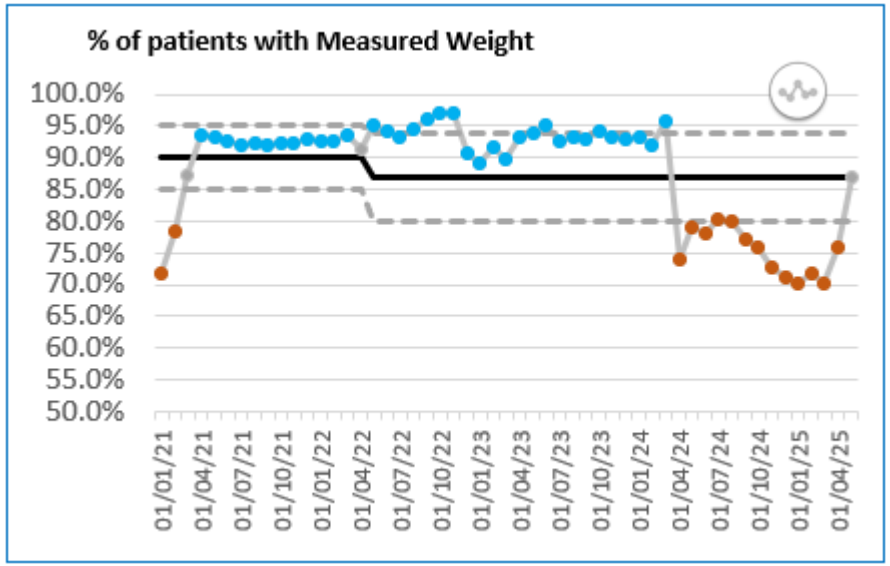
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
C-diff Hospital & Community onset, Healthcare Associated	May 25	3	0			6	-2	15
% of patients with Measured Weight	May 25	87.0%				86.9%	79.9%	93.9%
% of patients with a MUST/PYMS assessment completed within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

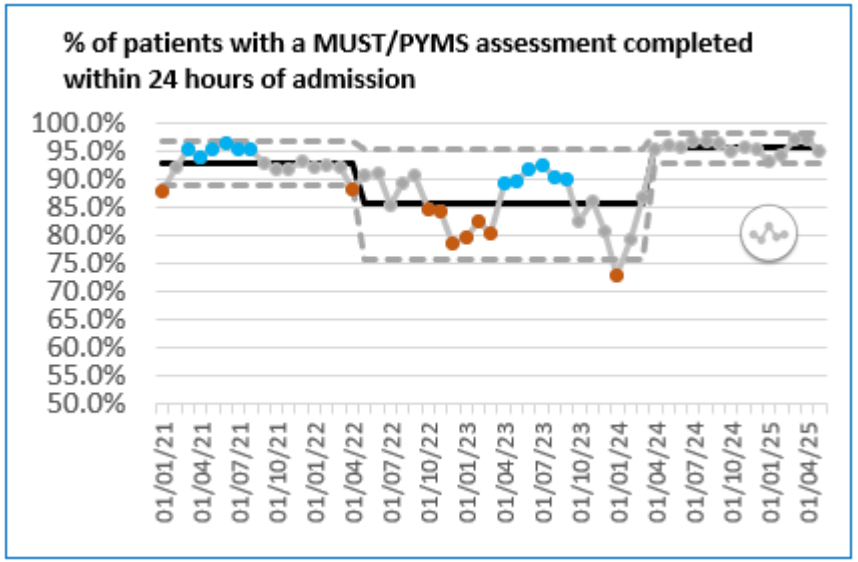
Safe



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

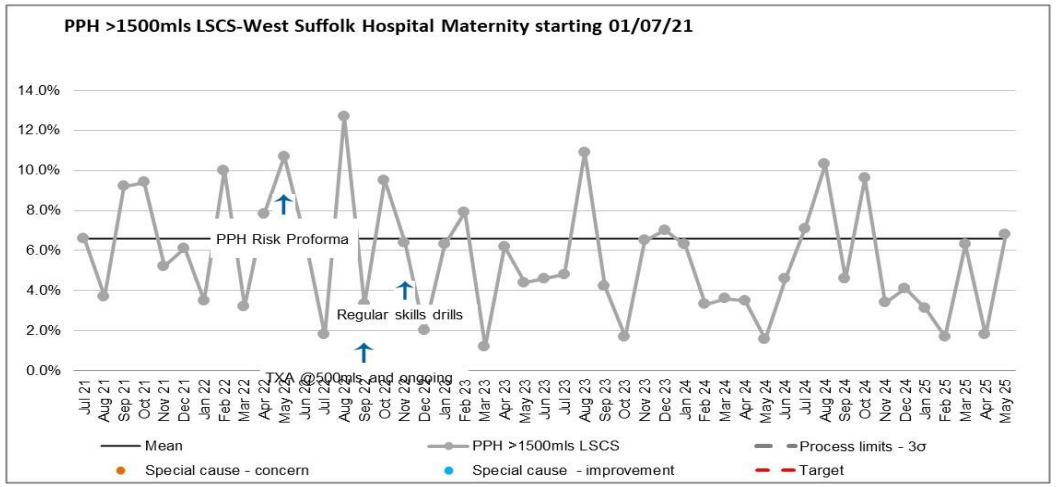
Safe

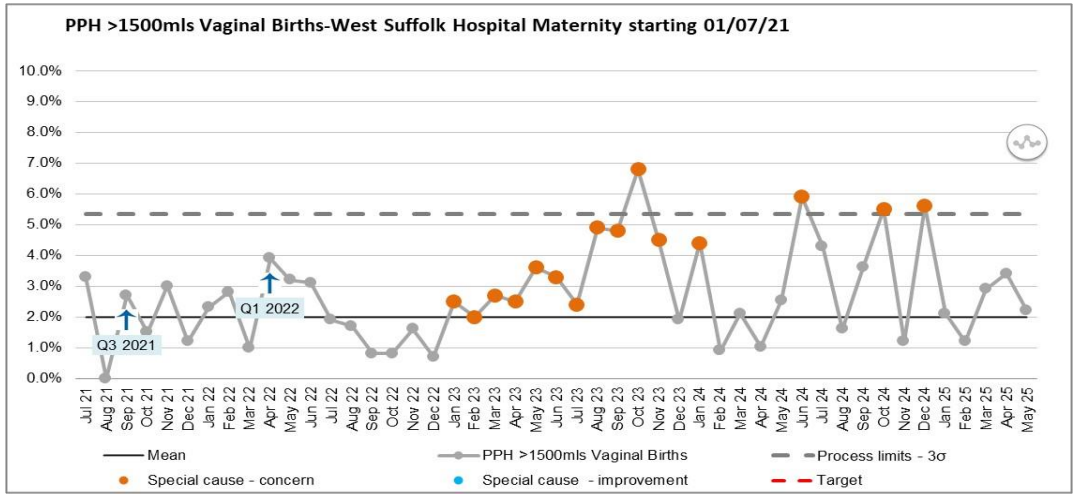




What	So What?	What Next?
Nutritional assessment (MUST) within 24hrs – 97% 97% patients have a must score complete in 24 hours. This remains in common cause variation and has achieved standard of >95% **Measured weight at 24 hrs – 76 %** We have seen an increase by 6 percent in month for patients with a measured weight withing 24 hours of decision to admit. This increased result will allow for accurate assessment of their health status and will also allow for proper medication dosage, also to monitor treatment effectiveness. While best practice is always to use a measured weight in real time, effective MUST scoring can be achieved with an estimated weight	Good nutrition is an integral component of patient care. Not only does eating correctly provide substantial physical benefits, but it also ensures psychological comfort though a patient's admission. *Every healthcare organisation has a responsibility to provide the highest level of care possible for their patients, staff and visitors. This includes the quality, nutritional value and the sustainable aspects of the food and drink that is served, as well as the overall experience and environment in which it is eaten (NHSE 2022)* *CQC Regulation 14: Meeting nutritional and hydration needs*	• Liaise with Dieticians to monitor impact of any delayed assessments and impact to the patients, reviewing all RADARS associated with this. • Following last month's nutritional steering group, it was asked for the dieticians to have a regular slot at the monthly ward managers meeting, this has been achieved in surgery and is pending in medicine. • Heads of Nursing still working together to utilise the new reports to look at areas that may need a more targeted approach. • Ward and unit managers to make sure staff understand the importance of accurate MUST scoring, monitored through divisional quality board • To focus on the importance of the protected mealtimes audit

Safe





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

What

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

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

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

So What?

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

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

Exposure of psychological trauma to patients and our staff.

What Next?

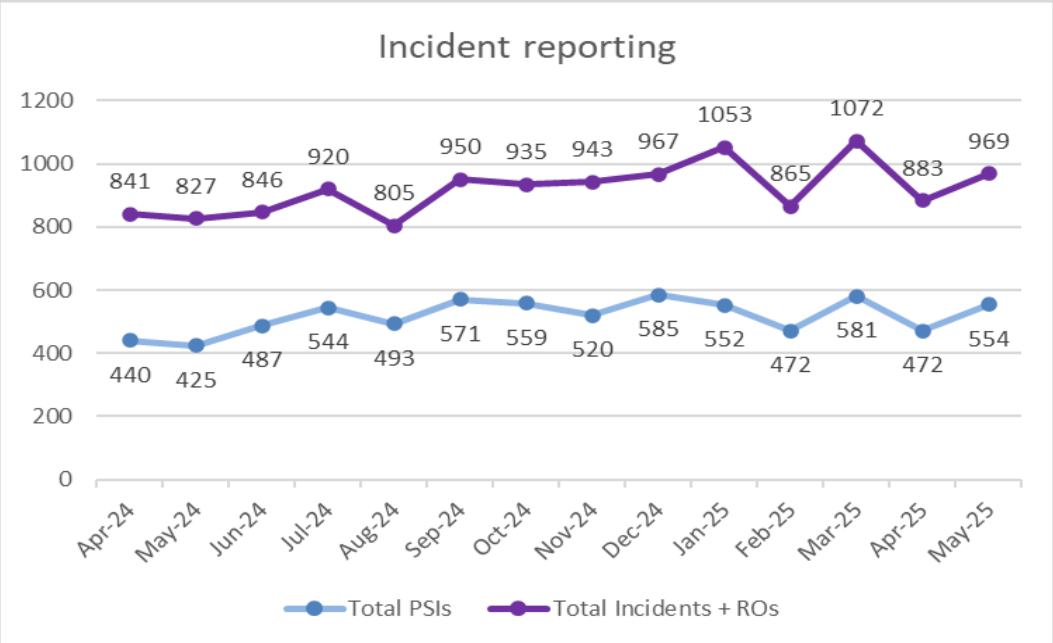
Quality Improvement project in progress focusing on three workstream:

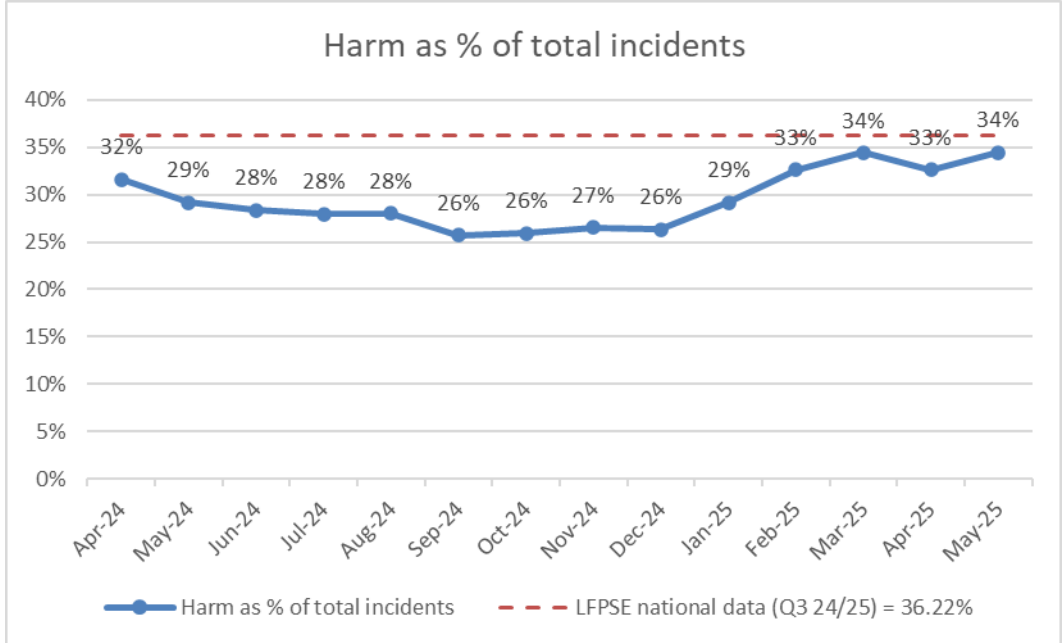
- Training and awareness
- Risk management
- Medication and timely management of PPH

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

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

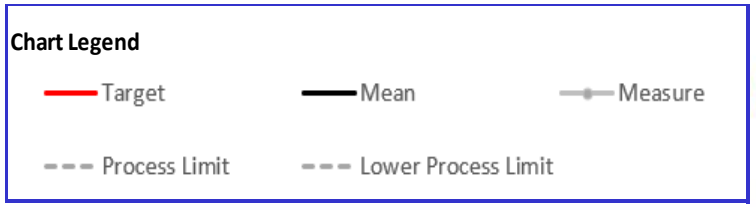
Safe

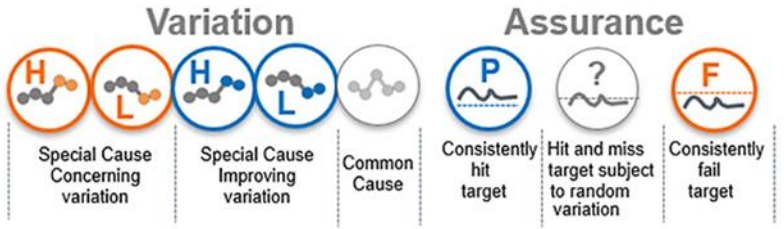




What	So What?	What Next?
This month saw a slight increase in both reported patient safety incidents and RO (reportable occurrence) events. The proportion of incidents resulting in harm rose by 1%, reaching 34%. While this represents an upward trend, the data points remain within control limits, supporting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

Mortality Summary

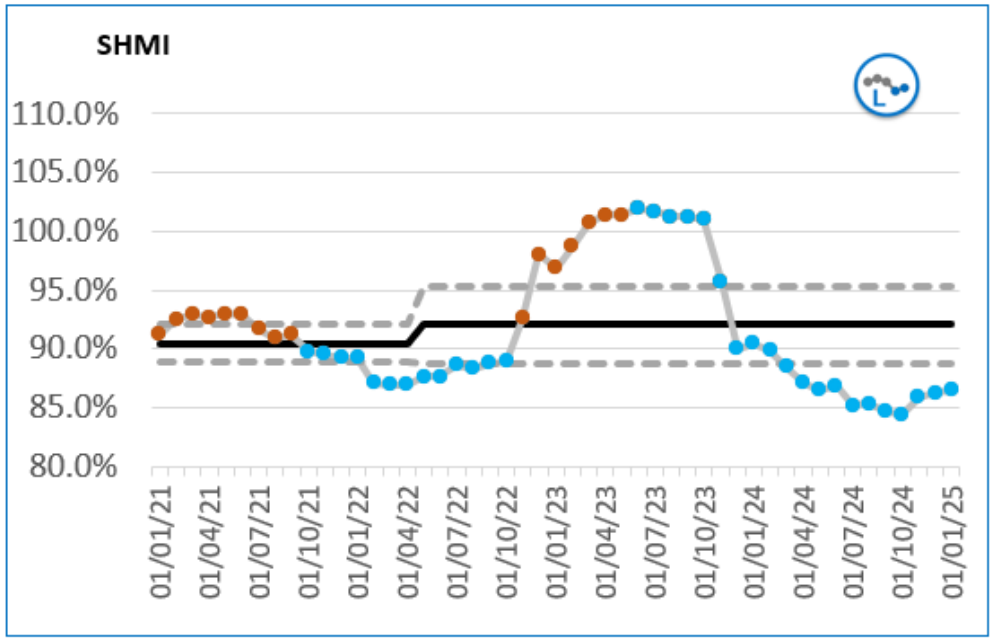


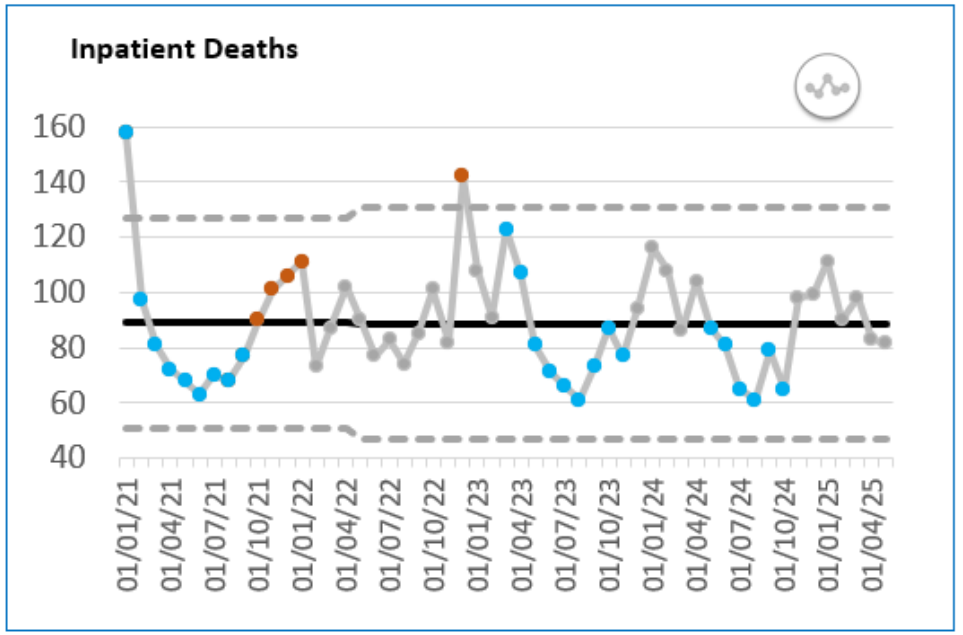


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SHMI	Jan 25	86.5%				92.1%	88.9%	95.3%
Inpatient Deaths	May 25	82				89	47	131

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

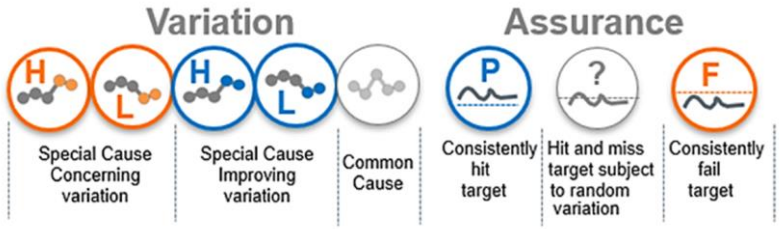
Mortality





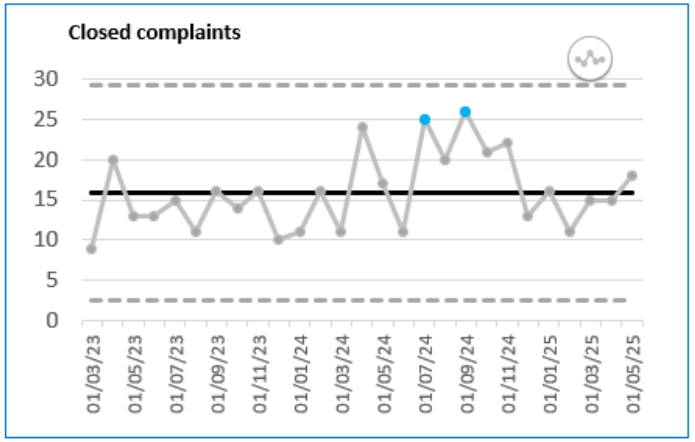
What	So What?	What Next?
An analysis of the what the data shows us that West Suffolk Foundation Trust (WSFT) is categorised on the lower end of 'as expected' deaths banding. This means that given the WSFT patient demographic that the expected number of patients have died in our care or within 30 days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

INVOLVEMENT COMMITTEE METRICS



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

Safe


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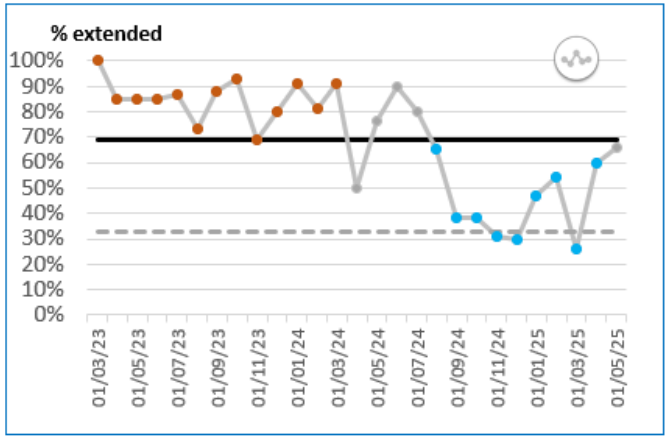
01/07/24
01/09/24
01/11/24
01/01/25
01/03/25
01/05/25


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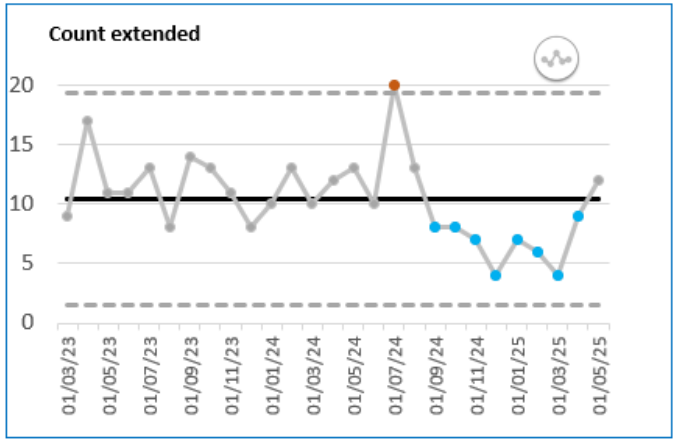
01/03/25
01/05/25


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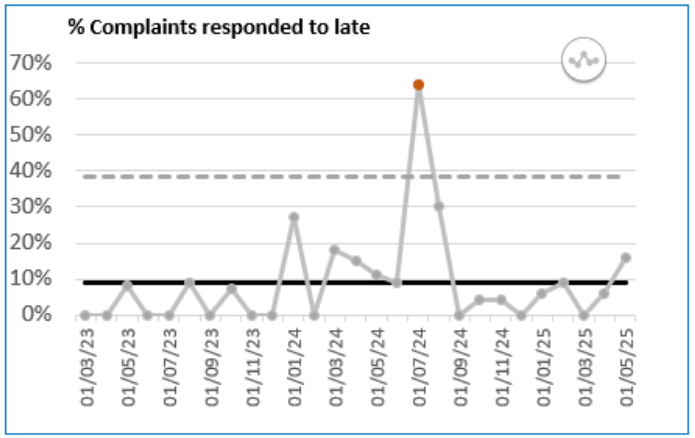
01/03/25
01/05/25


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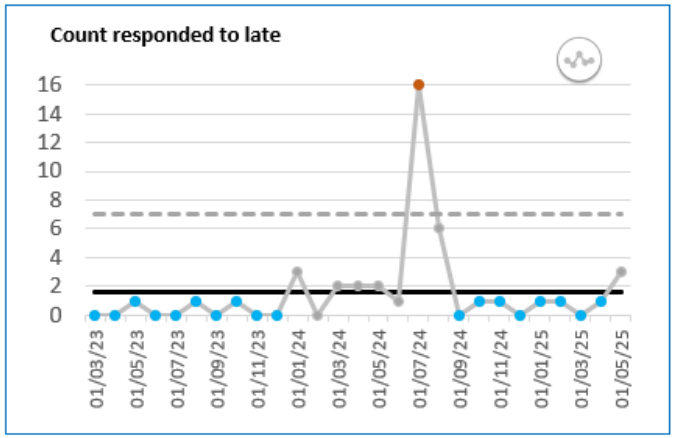
01/07/24
01/09/24
01/11/24
01/01/25
01/03/25
01/05/25


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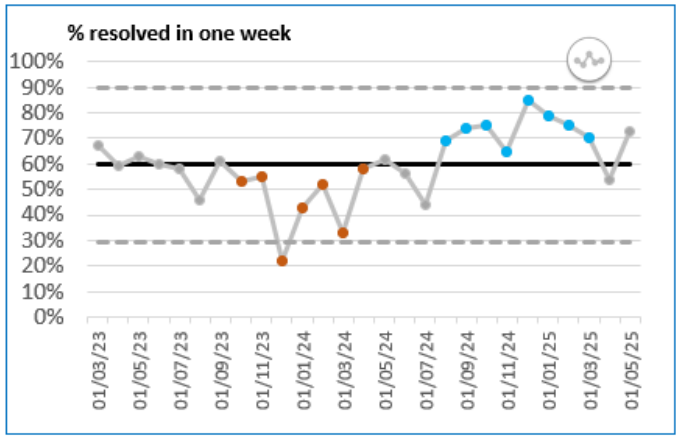
01/05/25


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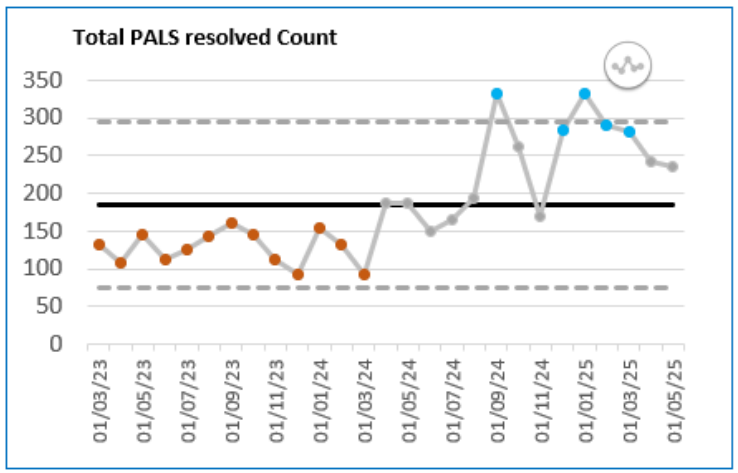
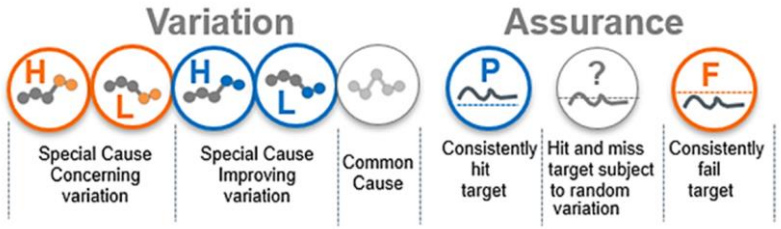
01/05/25


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

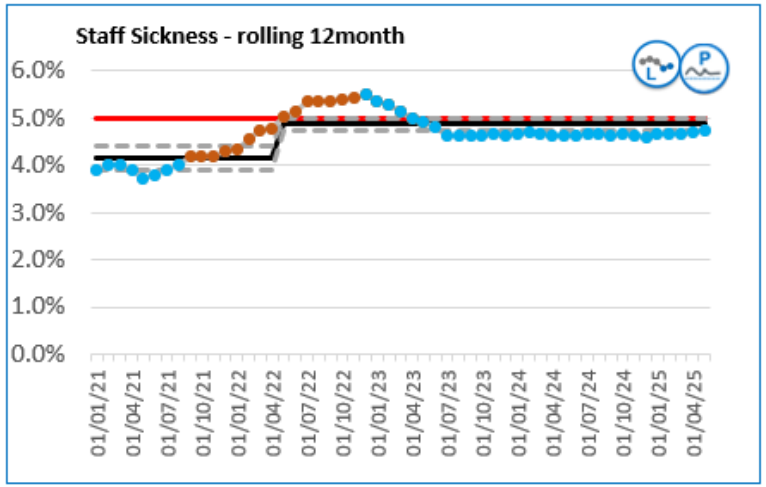
Safe

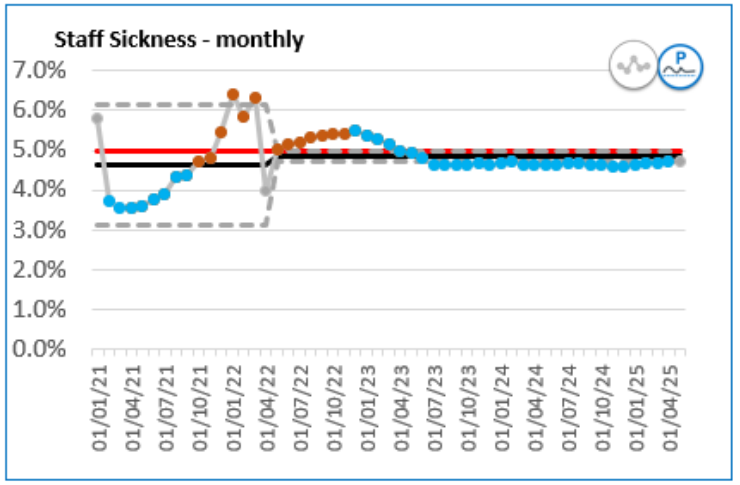
What	So What?	What Next?
Active formal complaints have increased slightly from 48 to 51 which is a concerning variation and increased trend that we have seen since February this year which now falls outside of the controlled limits. The initial impact is that we have seen an increased volume of new formal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

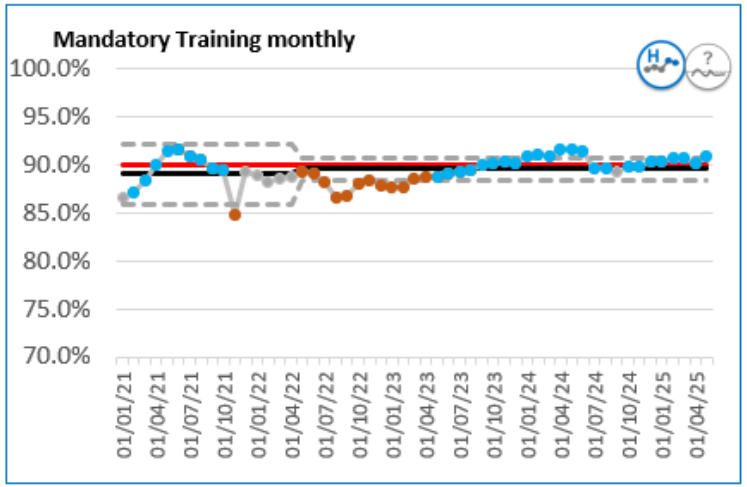


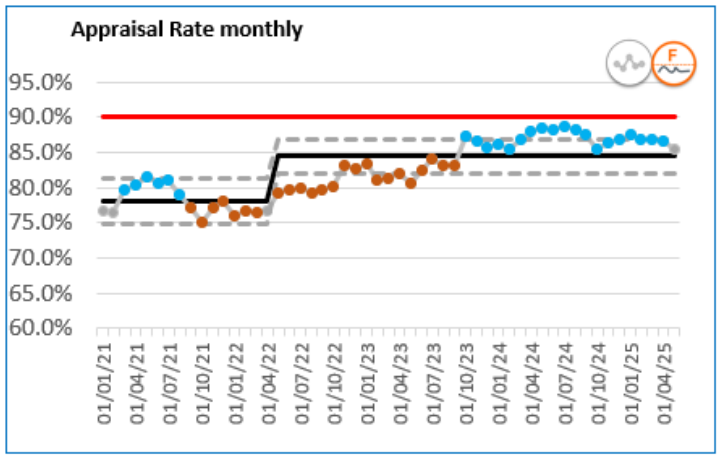
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	May 25	4.7%	5.0%	L	P	4.9%	4.7%	5.0%
Staff Sickness - monthly	May 25	4.7%	5.0%		P	4.9%	4.7%	5.0%
Mandatory Training monthly	May 25	90.9%	90.0%	H	?	89.5%	88.4%	90.7%
Appraisal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

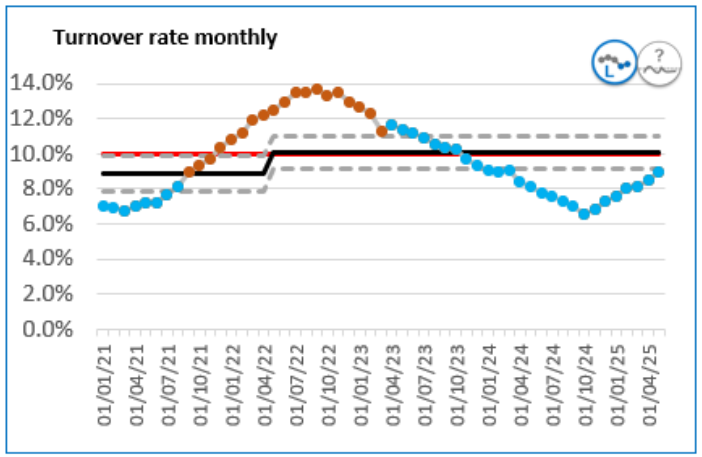
Well Led











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

Item 7.4 Governance Appendices

Annex A: Scheduled draft agenda items for next meeting – 26 September 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
System update: - West Suffolk Alliance and SNEE Integrated Care Board (ICB) - Wider system collaboration - Joint productivity board	✓		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
SIRO report		✓	Written		NC
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					