NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday 26 September 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 26 September 2025
Organiser	Joanne Sanger

Agenda

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RESOLUTION 240

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

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AGENDA

Presented by Jude Chin

NHS
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WSFT Board of Directors – meeting in public

Date and Time	Friday, 26 September 2025 9:15 -13:15
Venue	Northgate meeting room, second floor, Quince House, West Suffolk Hospital site, WSFT

Time	Item	Subject	Lead	Purpose	Format
1.0 GENERAL BUSINESS					
09.15	1.1	**Welcome and apologies for absence**	Chair	Note	Verbal
	1.2	**Declarations of Interests**	All	Assure	Verbal
	1.3	**Minutes of meeting** 25 July 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** Maternity prem baby	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 Social Care, Area Director	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** **- 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 chief finance officer	Review	Report
	5.3	**Winter planning 2025/26**	Chief operating officer/Deputy COO	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 Maternity Team	Approval	Report
7.0 GOVERNANCE					
13:00	7.1	**Board assurance framework**	Trust secretary	Assure	Report
	7.2	**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** 28 November 2025	Chair	Note	Verbal
	Resolution				

Time	Item	Subject	Lead	Purpose	Format
	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 (Paul Bunn attending);

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 - 25 July 2025 (ATTACHED)

To Approve

Presented by Jude Chin

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE
Open Board meeting

Held on Friday 25 July 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
Julie Hull	Interim Chief People Officer	JH
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
Paul Zollinger-Read	Non-Executive Director	PZR
Peter Wightman	West Suffolk Alliance Director	PW
Clement Mawoyo	Area Director, Homefirst, Safeguarding and West Suffolk	CM
In attendance:		
Nick Macdonald	Deputy Director of Finance	NM
Dan Spooner	Deputy Chief Nurse	DS
Paul Bunn	Trust Solicitor	PB
Greg Bowker	Head of Communications	GB
Sarah Judge	Interim Chief Information Officer	SJ
Neil Jackson	Associate Director of Estates & Facilities (Item 5.3 only)	NJ
Louise Brooks	Sustainability Officer (Item 5.3 only)	LB
Karen Newbury	Director of Midwifery (Item 6.3 only)	KN
Simon Taylor	ADO, Women & Children and Clinical Support Services (Item 6.3 only)	ST
Ruth Williamson	FT Office Manager (minutes)	RW
Apologies: Sue Wilkinson, Chief Nurse, Sam Tappenden, Director of Strategy & Transformation, Jonathan Rowell, Interim Chief Finance Officer, Richard Jones, Trust Secretary, Pooja Sharma, Deputy Trust Secretary, Clement Mawoyo, Area Director Homefirst, Safeguarding and West Suffolk, Heather Hancock, Non-Executive Director.		
Governors observing: Jane Skinner, David Slater		
Staff: - Amara Zeb, Finance Lead, Future Systems Programme		

Members of the public: none in attendance.

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 23 May 2025, were accepted as a true and accurate reflection, subject to the following amendment: **Item 1.4 – Action Ref 3134 – Reflections on Meeting – Imbedding Learning from Patient Stories** – Improvement Committee to read **Involvement** Committee.	**RW**
1.4	**Action Log and matters arising**	
	Action Ref 3140 – WSFT Strategy - Item on today's agenda. Action closed. **Action 3141 – WSFT Strategy - Governor Engagement Session** – governor comments and feedback have been received, with an opportunity to further engage in the survey and three Teams' sessions undertaken. A separate meeting is not required. Action closed. **Action 3146 – AuditOne Recommendation – Progress Report –** session to be undertaken in October will focus on Board effectiveness. Julie Hull (JH), Interim Chief People Officer, Ewen Cameron (EC), CEO and Jude Chin (JC), Chair, are working on the agenda. **Action 3147 – AuditOne Recommendation – Review of action points –** these actions will be covered in the CKIs from the Involvement Committee which come to Board. Any items for escalation will also come to Board. Matter closed. Completed actions noted.	
1.5	**Questions from Governors and the public relating to items on the agenda**	
	Jane Skinner (JS) referenced the Insight Committee's Key Issues (CKIs) and highlighted the minimal assurance rating for diagnostics, specifically endoscopy and ultrasound, with only 50% of target achieved in March 2025. JS requested clarification on the number of patients affected by waits exceeding six weeks, the duration of these delays and the nature of assurance to be provided to patients awaiting access to these diagnostic services. Nicola Cottington (NC) responded that these matters would be addressed within the Integrated Quality and Performance Report (IQPR) scheduled later in the agenda. Antoinette Jackson (AJ) noted that	

	a comprehensive review of diagnostic services had recently been undertaken by the Insight Committee. JS further enquired as to the anticipated percentage of resident doctors expected to participate in the proposed industrial action and whether the Trust would have access to this data on a daily or shift-by-shift basis. NC confirmed that an update on this matter would be provided as part of the CEO Report.	
1.6	**Patient Story**	
	Tom Walker, (TW), Clinical Lead Physiotherapist for Critical Care and Surgery attended the meeting to present a patient's rehabilitation journey. **<u>Questions</u>** EC queried whether patients experienced a culture shock when transitioning from the Intensive Therapy Unit (ITU), where rehabilitation is intensive to a general ward or home setting, where rehabilitation input may be reduced. TW responded that some patients fall under multiple specialties, making it challenging to identify a single ward capable of meeting all their needs. He noted his department provides continuity of rehabilitation services and also supports ward-based nursing teams. Additionally, the outreach critical care nursing team was commended for its effectiveness in supporting patients during this transition. AJ referred to the intensive rehabilitation support provided to the patient presented and asked how many patients typically required a similar level of input at any one time. TW responded that demand fluctuates, with higher numbers generally observed during the winter months. At any given time, there may be up to four or five patients on the follow-up list transitioning to ward-based care. TW noted that his department provides handover to ward-based physiotherapy and occupational therapy teams to ensure continuity of care. Within the ITU, there are typically three or four complex patients at any one time, in addition to others, with varying levels of acuity. All patients are assessed individually to determine their rehabilitation and care needs. JH enquired about the wellbeing of the rehabilitation team, given the demanding nature of their work and asked whether additional support from the Trust would be beneficial. TW acknowledged that whilst the work is challenging, particularly due to the multi-speciality nature of the service and the rotation of staff, it is also highly rewarding. TW noted that staff are expected to maintain a broad range of competencies, which can be demanding, especially for junior and rotational staff. Some team members have expressed concern about a perceived shift in focus from rehabilitation to discharge planning. TW emphasised the importance of finding a balance between service delivery and staff development and highlighted the role of appraisals and supervision in ensuring staff feel supported and heard. TW confirmed that learning opportunities are actively provided to help maintain morale and professional growth.	

	Tracy Dowling (TD) asked what TW, in his capacity as Clinical Lead Physiotherapist, would like the Board to take in to account in relation to long term planning. TW responded that the most significant challenge lies in the day-to-day care of patients, particularly regarding mobility and ensuring patients are assisted out of bed daily. TW noted that when patients transition to a ward setting, nursing staff, who are often extremely busy, may struggle to maintain this level of support, resulting in increased pressure on the physiotherapy team. Rehabilitation sessions can take thirty to forty-five minutes and may require more than one staff member. TW highlighted that patients are sometimes re-referred to his team after becoming dependent due to lack of mobilisation and support with basic needs such as toileting. He emphasised that reliance on bedpans, whilst expedient, can negatively impact rehabilitation outcomes. TD suggested that this issue could be considered within workforce planning and the integration of professionals under new models of care. TW stressed the importance of not overlooking patients' basic needs. Sarah Judge (SJ) asked about the patient's recovery progress. TW confirmed that the patient had regained a good range of movement, improved global strength and returned to normal lung function. Paul Zollinger-Read (PZR) enquired whether any technological tools could have supported respiratory care. TW responded that whilst further consideration is needed to answer this question, the implementation of e-Care has provided valuable IT support for problem solving. Paul Bunn (PB) asked whether the Virtual Ward model could be used. TW advised that this was not applicable in the case presented, as the patient had no on-going medical issues at the point of discharge. The Board thanked TW for his insightful presentation and commended the work of the Allied Health Professionals (AHPs), noting the evident passion and dedication of the team. Appreciation was extended to all staff involved.	
1.7	**CEO Report**	
	Ewen Cameron (EC), CEO, presented the report. It was noted that West Suffolk NHS Foundation Trust (WSFT) received six nominations at the Suffolk and North East Essex Integrated Care System "Can Do" Health and Care Awards 2025 ceremony. EC expressed pride in attending the event, alongside the nominees and witnessing both the individuals and their projects receive well deserved recognition. NC advised that, following standard procedures, strategic and operational planning began as soon as strike action was confirmed. Executive directors attend regular strategic meetings to coordinate the Trust's response. Communications have been issued to provide patients with appropriate advice. It was noted that no picket lines are expected to be formed. At present the number of	

	staff participating in the action remains unknown and it is too early to determine the full extent of involvement. It was further noted that there is no requirement for resident doctors to notify the Trust in advance of their participation. The cancellation and rescheduling of appointments began on 24 July, 2025 as part of the Trust's mitigation measures. PZR asked for an estimate of how many routine procedures might be cancelled as a result of industrial action. NC advised that the situation remains fluid and that further detail would be provided during the private Board meeting later in the afternoon. TD enquired about the level of transparency with the general public and whether the outcomes of the industrial action would be shared both locally and nationally. NC confirmed that the Trust would be submitting a return for NHS England (NHSE) for publication in line with national guidance. JC suggested it would be useful to review the rate of Did Not Attends (DNA) for elective procedures to assess the effectiveness of communications issued to patients. NC confirmed that this would be monitored.	
2.0 STRATEGY		
2.1	**WSFT Strategy**	
	Ewen Cameron (EC), CEO, provided an update on the development of the Trust's strategy. It was noted that over 200 responses had been received to the Trust's strategy feedback survey. Engagement activities have included discussions with governors, three focus groups and a Board Development session. All feedback is currently being analysed, with completion anticipated in August. The final strategy will be presented for Board approval in September, followed by a formal launch at the Annual Members' Meeting in October. Alison Wigg (AW) commented that the current draft ambitions appeared inwardly focused and lacked resonance with patients. EC responded that three of the draft ambitions, high quality care, joined up services and future proofed, were patient centred. EC emphasised the importance of empowering staff in delivering the strategy. It was noted that further discussion would take place during the private Board meeting later in the afternoon.	
2.2	**Future System Board Report**	
	Ewen Cameron (EC), CEO, presented the report. Progress on capital affordability was noted. It was further reported that Sam Tappenden (ST) now has a deputy in post, providing support for the implementation of the Clinical Care Strategy and the target operating models that underpin the design of the new hospital. TD expressed concerns about the planning timelines and priorities for the new hospital programme, pointing out that focus seemed to	

	be mainly on capital costs, without equal consideration given to revenue affordability across the NHS. TD observed that the planning process appeared disjointed. EC acknowledged that significant work is underway at a national level and confirmed that there is recognition of the issues raised. He noted that revenue implications are a consequence of capital investment and that the inclusion of the Hospital 2.0 model may increase both capital and revenue costs. EC advised that various measures are being explored to address these challenges, including identifying efficiencies to mitigate additional costs. It was noted that support from the Integrated Care Board, (ICB) will be required for the business case, along with confirmation that the proposed development is financially sustainable.	
2.3	**System Update/Alliance Report**	
	Peter Wightman (PW), West Suffolk Alliance Director, presented the report. The Board noted that changes are being implemented to the director structure of the Integrated Care Board (ICB), and is currently subject to a consultation process. It is anticipated that appointments to the revised structure will be made progressively from September through to December 2025. At the system board meeting last week, members noted a positive trend in patient satisfaction within primary care services. It was confirmed that preparations are underway for dental procurement, which will encompass services in Bury St. Edmunds and Brandon, with a strategic plan to enhance primary care dental provision in the wider area. AW queried the reasons behind the reported increase in patient satisfaction within primary care services. PW explained that the enhanced use of digital solutions has played a significant role in improving patients' access and overall experience. NC acknowledged the inspiring work on dental service provision and enquired how the system could use a similar approach in other difficult areas. PW advised that the dental commissioning team had made a concerted effort to speak to local dentists in order to gain a list willing to undertake this work. The national push in this regard had also helped. NC suggested the Neuro-Developmental Disorder (NDD) pathway was conducive to a broader commissioning approach and noted the Trust was working collaboratively with the ICB in this regard. PZR raised a query regarding the prolonged waiting times for dementia diagnosis. PW responded that work is currently underway to address this issue and confirmed that an update will be presented at the September Board Meeting. TD questioned whether the Trust should begin evaluating the skills needed to lead joint care projects with its partners, in response to the NHS 10-Year Plan and changes in ICB structures. PW advised	

	that these changes are at an early strategic stage and offer opportunities for the Trust to engage. PW noted that the role of the GP Federation is expected to become increasingly significant with integrated care arrangements. TD expressed concern about the potential uncertainty faced by ICB staff between now and April 2026 and suggested the Trust consider how it might support the ICB in providing space and capacity for strategic planning. PW proposed that implementing a few of the planned changes could help maintain momentum. EC added that clarity is likely to improve once the director appointment process is concluded. PZR referred to a recent presentation at the Improvement Committee concerning diabetes. Two key issues were highlighted: limited ICB commissioning of the Loop system (an automated insulin delivery system) and the high number of Type 2 diabetes patients attending hospital clinics, who might be more appropriately managed in primary care. EC noted that secondary care support remains essential within an integrated service model. PW stated that funding constraints are the primary challenge and that the matter is being addressed through the Clinical Interface Group. JC asked how the Board would maintain oversight of priority areas, moving forward. NC responded that this would be facilitated through the proposed Care Management Service, which will operate collaboratively and focus on targeted population health areas, including diabetes. **Action: PW to provide an update within the Alliance Report to the September Board Meeting.**	**PW**
2.4	**Digital Board Report**	
	Sarah Judge (SJ), Chief Information Officer, presented the report. SJ reported that departmental focus has been on improving access to services. A prioritisation group has been established to review initiatives, with two meetings held to assess the backlog against strategic objectives and key priorities. SJ emphasised the need to enhance communication across the organisation. The most recent implementation involved the sending of discharge summaries to GPs, developed in collaboration to meet national standards. Floor-walking support for clinicians in this regard is coming to an end. SJ advised that there is a national requirement to migrate devices to Windows 11 by the end of September. Future updates will include results from the annual digital maturity assessment, based on the "What Good Looks Like" framework. These results are currently undergoing ratification and will be accompanied by an action plan to come to a future Board meeting. PZR queried the Trust's use of cloud-based services. SJ confirmed that multiple cloud platforms are used and all procurements undergo data protection assessments and governance review to mitigate any potential risks.	

	NC asked about the benefits of code upgrades. SJ explained that major upgrades, such as the annual e-Care update, due in Autumn, enable new functionality. A current topic of interest is ambient listening during patient consultations. SJ noted that NHS England has issued guidance to pause implementation and the Trust will explore integration within clinical systems, rather than standalone applications. GB asked how prioritisation balances productivity improvements with patient safety. SJ responded that prioritisation is guided through the Management Executive Group (MEG). In April this included mandatory compliance changes, urgent cybersecurity and patient safety issues and solutions aligned with the Cost Improvement Programme (CIP). IT acts as an enabler for productivity. Improvements in data collection forms will ensure benefits are considered alongside costs. AW raised concerns about reliance on staff and cyber risks during implementations. SJ acknowledged that communication is critical and noted challenges in reaching frontline staff despite emails and ward visits. SJ committed to improving communication strategies, including clearer instructions and more proactive engagement going forward. JC observed improved control over project approvals and stressed the importance of rigorous post-implementation reviews. SJ agreed and stated that benefit realisation should be led by service users, not solely IT. A revised front-door process is being developed to identify project owners. EC added that ownership is essential to achieving benefits. NC noted that benefit identification has improved, but acknowledged that legacy projects sometimes lacked clarity. JC asked who would ensure benefits are realised. SJ confirmed that benefit tracking and lessons learned will become a standing item on the Digital Board agenda.	
2.5	**Joint Productivity Board**	
	Ewen Cameron (EC), CEO, presented the report to the Board. It was noted that at the inaugural meeting held on 14 July, the Terms of Reference (TOR) and Senior Responsible Officers (SROs) were agreed.	
3.0 ASSURANCE		
3.1	**IQPR Report**	
	Nicola Cottington (NC), Chief Operating Officer, presented the report. ***Breast Service*** NC reported ongoing challenges within the breast service, primarily due to staffing issues, including recruitment difficulties in radiology. Positive developments include the deployment of a second mobile screening unit and previous sustained achievement of national standards over a 13-month period. However, concerns remain	

	regarding long-term sustainability. A new breast consultant has been appointed and a part-time radiologist role has been filled. Discussions have been undertaken at MEG and the ICB has commissioned a review of the breast pathway. ***Dermatology*** A paper regarding dermatology services has been submitted to MEG, approving the use of an external company to triage referrals. NC noted that longer-term pathway transformation is required, aligning with the NHS 10-Year Plan. PZR queried the meaning of pathway transformation, to which NC responded that services could potentially be managed by GPs with a special interest, similar to diabetes care. Funding and strategic planning will be key. PZR highlighted that some demand may not require secondary care input. **Action: NC agreed to return with further detail on specific conditions that have seen an increase in demand.** JC asked about community-based priorities. EC suggested that AI could assist with diagnosis, enabling more conditions to be managed in primary care. TD added that specialist nurses need not be hospital-based and skill development across the team is essential. NC acknowledged that a clear plan is not yet in place and further work is required. ***Diagnostics*** A deep dive into diagnostics was conducted at the Insight Committee, with supporting papers submitted to MEG. The forecast indicates a potential recovery in diagnostics performance in 2026. As at the end of June: • 6494 patients were waiting over 6 weeks • 5231 patients were waiting under 6 weeks • 3991 patients were waiting over 13 weeks Imaging outliers, particularly MRI and CT, remain challenging. ***Ultrasound*** Workforce shortages persist nationally, with Trust reliance on temporary staff. International recruitment efforts are underway and two trainees are being supported internally. Productivity is impacted by Did Not Attends (DNA). If recruitment targets are met and DNA rates reduced an improvement in productivity is achievable. ***Endoscopy*** Job planning is complex due to dual roles of clinicians as surgeons. A structure review is ongoing. Temporary staffing is supporting additional weekend lists, generating approximately 100 extra procedures per month. Nurse Endoscopists are being utilised and overbooking is being trialled to offset DNAs. The forecast improvement is from 34% to 56% of patients seen within 6 weeks.	**NC**

	NC observed recurring themes in deep dives and acknowledged that the absence of a prior plan had contributed to minimal assurance ratings. Even with improvements, 600 patients will remain waiting over six weeks. Monthly discussions on operational performance continue. NC highlighted digital innovations, including use of AI for polyp detection. TD referred to concerns about ultrasound productivity and recruitment challenges. TD noted a lack of data demonstrating session efficiency and suggested quantifying time spent in order to improve productivity. Noted a CIP is in place for management of services. The current utilisation is 87%. **Action: NC and RG to review existing initiatives concerning demand management for ultrasound services and obtain assurance that the thresholds for referral requests are correct.** EC noted that small time savings in endoscopy, (e.g. 5/6 minutes per procedure), can accumulate significantly and present opportunities for improvement. PZR questioned whether the Trust has sufficient specialists and how this is benchmarked against patient need. **Action: NC to review and report back to Board.** RG added that referral validation is essential and guidelines may not always be helpful due to a broad scope. RG emphasised the importance of pathway-based decision making. PZR requested data on diagnostic capacity per 1,000 population. **Action: NC to investigate availability of this information.** (AW left the meeting at 11.15 am).	**NC/RG** **NC** **NC**
4.0 PEOPLE, CULTURE AND ORGANISATIONAL DEVELOPMENT		
4.1	**Involvement Committee Report**	
	Tracy Dowling, (TD) Non-executive Director, presented the report. The Board were informed of recent changes to the apprenticeship levy. As a result, the Trust's apprenticeship strategy will be reviewed and realigned to reflect the updated regulations. It was noted that the Guardian of Safe Working Hours report did not fully align with the executive summary. JH is taking forward for review and discussion at the next Involvement Committee meeting.	
4.2	**People & OD Highlight Report**	
	Freedom to Speak Up Report Quarter 4	
	Julie Hull (JH), Interim Chief People Officer, presented the report. It was noted that today's report related to **Quarter 1** and not Quarter 4 as indicated. The Board acknowledged a reduction in anonymous reports. Efforts to encourage open reporting will continue.	

	It was noted that the report included data from the launch of the Sexual Safety Charter, highlighting an encouraging trend of colleagues feeling confident to raise concerns. NC observed that whilst registered nurses and midwives were identified as the highest reporting group, the level of reporting is comparable to that of professional services and overall volumes remained low. JH emphasised that every comment is significant and although anonymous reports are investigated, feedback cannot be provided in those cases. EC queried the absence of speak-up reports from doctors. JH confirmed this was reflected in the data and highlighted the importance of encouraging engagement from staff groups. TD asked whether any current FTSU champions were members of the medical workforce. EC noted that consultants may feel more comfortable raising concerns than resident doctors and acknowledged that the FTSU role itself can sometimes be perceived as intimidating. **Action: JS to attend clinical meetings to promote the FTSU agenda and encourage recruitment of champions from the doctor and consultant cohort. An update to be provided in the report to the Board in November.** RF highlighted that most FTSU concerns relate to HR issues and queried why so few related to patient safety issues. EC noted that this reflects the national trend, with approximately 80% of concerns relating to relationships and behaviours and 20% to patient safety. AJ reported that NHS England is taking over responsibility for national support and guidance of guardians from the National Guardians Office.	**JS**
	Putting You First	
	Julie Hull, (JH) presented the report. The Board noted the recent staff awards and extended congratulations and thanks to all the recipients. It was noted that approximately 15 nominations are received each month.	
5.0 OPERATIONS, FINANE AND CORPRATE RISK		
5.1	**Insight Committee Report**	
	Antoinette Jackson (AJ), Non-executive Director, presented the report. TD expressed concern that a deep dive highlighted Virtual Ward (VW) occupancy at 55%, a level that would not be acceptable in other areas. TD queried what actions were being taken to improve this. NC responded that a range of actions had been implemented to increase occupancy, with a renewed focus on improvement. Over the last three weeks, occupancy had risen to an average of 70%-77%. NC noted the need to review the allocation of enabling resources where occupancy remains low. This issue will be further addressed through the IQPR report at Insight.	

5.2	**Finance Report**	
	Nick Macdonald, (NM), Deputy Finance Director, presented the report. In June, (Month 3) the Trust is ahead of plan, representing a significant improvement compared to the same period in the previous two years. However, it was noted that the deficit remains high in the early months of the financial year, with increasing challenges anticipated. The CIP is weighted with 30% delivery expected in the first half of the year and 70% in the second half. The current run rate of approximately £1.8m deficit per month, excluding non-recurring costs was highlighted. Efforts are on-going to reduce this. A further £4.5m in CIP savings is required to meet financial targets and some risk remains around delivery. RF raised concerns regarding the £4.5m CIP risk and referenced the budget letter to the ICB, which included additional projects requiring system-wide collaboration. RF queried whether these projects are being tracked. EC confirmed that work is ongoing in this area. PZR queried pay costs by staff group and asked whether the over 2% unallocated CIP was within an acceptable tolerance. NM responded what whilst further improvement is desirable, the current position is considered manageable. RF asked whether the CIP project list is being updated to reflect any changes. EC confirmed that all schemes are under review and efforts continue to move non-delivering schemes in to active delivery. Additional controls on recruitment were introduced in April and further actions are under consideration. These will be discussed at the Insight Committee. TD noted the cumulative forecast of £4.8m below the income level set in the budget. TD asked whether there is a realistic opportunity to increase income in-year to mitigate some of the CIP risk. NM responded that whilst there may be some reductions in marginal costs, the Trust is working to full cost delivery and expects variances to balance out. Opportunities to maximise NHS and non-NHS income are being considered.	
5.3	**Green Plan 2025-29**	
	Neil Jackson, (NJ) Associate Director of Estates & Facilities, and Louise Brooks, (LB), Sustainability Officer, presented the report. The plan, extending through to 2029, reaffirms the Trust's commitment to the sustainability strategy, recognising its importance for the health and wellbeing of both staff and patients. The updated plan aligns with the latest NHS Green Plan guidance, particularly Section 18 and places greater emphasis on the interconnection between climate change and human health. An action log has been developed to support delivery across key focus areas, identifying risks and facilitating future planning.	

	Once approved by the Board, the plan will be shared with the Communications Team and embedded on the Trust's website, allowing for ongoing updates. It has received prior approval from MEG and Insight Committee. NC commended the plan and queried the appointment of a Senior Responsible Officer for implementation. NC suggested aligning any policy decisions made as a Trust, including AI, with the net zero objectives. LB confirmed that meetings with delivery leads are underway to define actions which can be used to engage with the Digital Team. PZR stated that algorithmic AI is energy efficient. SJ raised awareness about reducing unnecessary email responses in order to save energy. NJ confirmed collaboration with the New Hospital programme on sustainability initiatives. TD praised the inclusion of food and nutrition, particularly the focus on local suppliers and emphasised the importance of health and wellbeing. PZR raised the priority of increasing digital consultations and their environmental benefits. LB will explore this further with the digital team. RG highlighted that the reduction of face-to-face consultations is a key focus area of the Productivity Board. EC emphasised the importance of engaging medical staff in discussions related to this transition. EC further advised that video consultations had been discontinued due to low use, with telephone conversations now being the preferred method of remote patient interaction. NC recommended mainstreaming environmental considerations in to decision-making processes and Trust meeting papers. Noted Communications are exploring sustainability as a holistic concept, encompassing both environmental and financial aspects. LB will monitor the impact of the plan. **The Board formally approved the Green Plan and extended its thanks to all involved for their dedication and hard work.**	
5.4	**Acute Contract Sign-Off**	
	Nick Macdonald, (NM), Deputy Finance Director, presented the report for information. The contract in question spans a three-year period and, in line with good governance practices, has been brought to the Board for oversight. As an income contract, sign-off will be required by the CEO. It was agreed that the Board should remain informed of ongoing activity and the implications of changes to contracts. **Action: MEG and Insight Committee to consider next steps.**	**JR/AJ**

6.0 QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT		
6.1	**Improvement Committee Report**	
	Paul Zollinger-Read, (PZR) Non-executive Director, presented the report. In May, a query was raised regarding assurance on the GIRFT programme; this is being progressed by NC and RG through domain-level review. In June, minimal assurance was noted for Adult Safeguarding Level 3. Actions are underway to identify individuals requiring training. VTE baseline assessments have been conducted; a question was raised regarding outcomes. An audit is proposed to ensure high-level assessments translate into minimum VTE. The National Safety Standards for Invasive Procedures (NATSSIPs) programme, aimed at preventing Never Events, is well advanced in theatres and being extended to other areas. A risk-based approach to adherence is being developed, led by RG. Regarding diabetes, the closed-loop system (pump and monitor) has limited commissioning by the ICB. Assurance is being sought, with progress to be reported back to the Committee. TD raised concern over the Public Health Strategy, noting that whilst assurance was good, the strategy is currently input-focused and lacks emphasis on improving population health outcomes. This will be reviewed by MEG and the Improvement Committee.	
6.2	**Quality and Nurse Staffing Report**	
	Dan Spooner (DS), Deputy Chief Nurse, presented the report. Vacancy rates have fallen below 10%, including support staff, though this is partly attributed to budget adjustments. Vacancies held in the last quarter to support redeployment efforts are expected to be released shortly, with confidence in effective staff placement and student allocation. Fill rates have improved. Care Hour Per Patient Day (CHPPD) data shows a lag; the Trust's low ranking is considered a data anomaly. Pressure ulcer rates are escalating and are being closely monitored via PRMs. Temporary staffing spend remains a focus. Notably, agency nursing in surgery has been eliminated. EC highlighted an apparent increase in community nursing referrals, which was confirmed as a data anomaly. DS noted continued engagement with the Community Safer Care Tool, which has recently been reinstated. Results are expected in the Q3 report alongside the summer inpatient audit.	

	TD raised concerns about nursing overspend and questioned whether staff booking bank shifts are aware of budget constraints. DS confirmed last year's underspend and noted current budget-setting does not fully account for shift coverage. Efforts to implement budget-aware processes have been challenging due to system limitations. TD emphasised the importance of financial awareness among ward staff in the context of future CIP programmes. DS acknowledged the need for improved visibility and control. JC queried the timeframe for reversing the current overspend. DS indicated a likely balance by October/November. EC reported a £1.5m underspend in substantive staffing, offset by bank staffing costs. Further analysis is underway, with expectations that temporary staffing will reduce as substantive appointments increase.	
6.3	**Maternity Services Report**	
	Karen Newbury, (KN) Associate Director of Midwifery and Simon Taylor, (ST) Associate Director of Operations for Women & Children and Clinical Support Services were in attendance to present the report. The service has adopted the Perinatal Quality Oversight model, resulting in some reports no longer being submitted to the Board. Staff engagement continues, with four workshops held in collaboration with the GMC and NMC. Key themes have emerged, and further sessions are planned. Complaints saw a slight increase in June, consistent with historical fluctuations. A thematic and methodical approach is being applied, with quarterly reporting. A Safety Champion Meeting introduced a neonatal voice champion to gather user perspectives on safety. ESNEFT's prior work in this area was noted as insightful. EC referenced increased national scrutiny of maternity services following a government investigation. Whilst concerns were raised nationally, EC confirmed these issues are not present locally and commended the Trust's strong governance. NC raised concerns regarding community team equipment. KN confirmed actions taken, including review and implementation of grab bags, ordering of automated pressure cuffs, and plans for transcutaneous bilirubin testing prior to discharge. **Action: KN to include an update on community equipment in the next report, including formal responses to key themes from the government investigation in order to demonstrate local application.** TD expressed concern over rising complaints and welcomed the exploration of alternative feedback mechanisms. An offer was	**KN**

	made for KN and the Patient Experience Team to present learning and support needs at the Improvement Committee.	
7.0 GOVERNANCE		
7.1	**Charitable Funds Committee Report**	
	Richard Flatman (RF), Non-executive Director, presented the report. No matters were identified for escalation. A presentation was received from CCLA, the Trust's investment fund managers and agreed would meet on an annual basis going forward. The business case for the robot was reconsidered and the Board reconfirmed its commitment to the initiative, including progressing fundraising efforts. JR will formally engage with the supplier regarding costings. The proposed restructure of the fundraising team has been approved.	
7.2	**Audit Committee**	
	Michael Parsons (MP), Non-executive Director presented the report. The Board noted ongoing monitoring of audit action implementation. EC is taking an increased role in oversight, with monthly reviews now incorporated in to MEG.	
7.3	**Board Assurance Framework**	
	Paul Bunn, (PB), Trust Solicitor, presented the report. Risks 4, 7 and 8 were reviewed in the last reporting cycle. The report has been updated to affirm the review process which involves executive leads, MEG and assurance committees. Work is underway to realign the assurance framework in line with the new strategy. A workshop is anticipated before Christmas to consider the number and nature of risks, with input from RSM. JC noted that there is only one Board development session scheduled before the year end, with an existing agenda. **Action: PB and JC to discuss capacity to include BAF in October agenda.** The timing and mitigation of risks is being reviewed. RF recommended further review of the risk elements and queried control assessments. PB confirmed these are documented through work programmes and reviewed during each BAF cycle. Undelivered workstreams are monitored via the assurance committees. The Audit Committee maintains a programme for oversight.	**PB/JC**

7.4	**Governance Report**	
	Paul Bunn, (PB), Trust Solicitor, presented the report for information. The Board noted the contents.	
8.0 OTHER ITEMS		
8.1	**Any Other Business**	
	None noted.	
8.2	**Reflections on meeting**	
	NC referred to patient stories coming to Board and the shift away from in-person attendance. NC highlighted the value of hearing directly from individuals, with appropriate preparation for both the patient and audience. **Action: NC and DS to discuss further, drawing on the patient story coaching training undertaken by NC. PB to speak to Charlie Firman, Acting Head of Patient Experience and Engagement.**	**NC/DS** **PB**
8.3	**Date of next meeting** 26 September 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
3155	Open	25/07/2025	3.1	**IQPR Report - Dermatology** - Provide further detail on specific conditions that have seen an increase in demand.	**An increase in Urgent Suspected Cancer referrals account for the majority of the increase in demand. Further detail can be provided verbally at the board meeting if required.**	NC	26/09/25	Green	
3159	Open	25/07/2025	4.2	**Freedom to Speak Up Report Quarter 4 -** FTSU Guardian to attend clinical meetings to promote the FTSU agenda and encourage recruitment of champions from the doctor and consultant cohort. Update to be provided to November Board.		JS	28/11/25	Green	

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3153	Open	25/07/2025	1.3	**Minutes of the Previous Meeting -** Item 1.4 – Action Ref 3134 – Reflections on Meeting – Imbedding Learning from Patient Stories – Improvement Committee to read Involvement Committee.	**Actioned.**	RW	26/09/25	Complete	26/09/2025
3154	Open	25/07/2025	2.3	**System Update/Alliance Report - Priority Area Oversight - Care Management Service** - Update in System Update/Alliance Report to September Board.	**Today's report (26.9.25) refers.**	PW	26/09/25	Complete	26/09/2025
3156	Open	25/07/2025	3.1	**IQPR Report - Diagnostics** - review existing initiatives concerning demand management for ultrasound services and obtain assurance that the thresholds for referral requests are correct	**Simon Taylor (ST) in touch with NNUH whose US performance has improved recently. ST will seek support from the imaging network to see if there are other Trusts from whom we can learn. Through the tiering meeting, the national NHSE team shared information about managing demand by working more closely with Primary Care. This will be followed up through Primary Care interface meetings**	NC/RG	26/09/25	Complete	26/09/2025
3157	Open	25/07/2025	3.1	**IQPR Report - No. specialists benchmarked against patient need** - Review to be undertaken and reported back to Board.	**This is part of GIRFT benchmarking. The approach to GIRFT was presented to Improvement Committee in September. It also forms part of demand and capacity planning for medium term business planning, presented to Insight in September.**	NC	26/09/25	Complete	26/09/2025
3158	Open	25/07/2025	3.1	**IQPR Report - Diagnostic Capacity per 1,000 population**- Availability of information to be investigated.	**This is not information that is currently made available on a routine basis. However there are current streams of work which relate including demand and capacity planning for medium term business planning and the refresh of the digital and data strategy by April 2026.**	NC	26/09/25	Complete	26/09/2025
3160	Open	25/07/2025	5.4	**Acute Contract Sign-off** - Next step consideration, by Insight Committee and MEG, of how to keep Board abreast of ongoing activity and implications of changes to contracts.	**Insight Committee discussed the issue at the July meeting. It was agreed that the Financial Accountability Committee would monitor performance and other contract issues and update Insight, as part of its regular reports to the Committee. Insight will then escalate issues to the Board as required**	JR/AJ	26/09/25	Complete	26/09/2025
3161	Open	25/07/2025	6.3	**Maternity Services Report - Community Team Equipment & National Scrutiny on Maternity Services** - update on community equipment in next report, including formal responses to key themes from the government investigation in order to demonstrate local application.	**Today's report (26.9.24) refers.**	KN	26/09/25	Complete	26/09/2025

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3163	Open	25/07/2025	7.2	**Board Assurance Framework - BAF Board Development Session** - discussion on capacity to include in October session and proposed agenda.	**Session now under consideration for February, 2026.**	PB/JC	26/09/25	Complete	26/09/2025
3164	Open	25/07/2025	8.2	**Reflections on Meeting - In Person Patient Stories:** **- COO & Chief Nurse to discuss, with focus on patient story coaching training by COO.** **- Trust Solicitor to speak to Acting Head of Patient Engagement & Experience re ability to hold inperson presentations.**	**Discussion has taken place. Exploration of potential for Board Development Session taking place.** **Patient Experience Team advise that they have a bank of patient stories recorded and ready to share both at future Board and Involvement meetings. Patient/families are offered the opportunity of 'in person' presentations, but many are reluctant to re-live the experiences in a public setting and often choose the recorded route. However, Patient Experience team will continue to promote the face to face offer and schedule this in for the Board as soon as one is identified.**	NC/DS PB/CF	26/09/25	Complete	25/09/2025

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

Trust Board, 26 September 2025

Sara's story (previously shown at Experience of Care and Engagement Committee on 4 September)

Introduction

Sara attended the birth reflections service following the premature birth of her baby at 26 weeks and was keen to record a patient story to share her experience and highlight the importance of patients being well informed about what to do if they go into preterm labour.

Actions and learning

The following statement has been provided by Lizzy Snowden Labour Suite Co-Ordinator/ Preterm Birth Lead Midwife.

Preterm birth can have a significant physical and emotional impact upon families with long term impact on the baby's health and development. There is a package of interventions/care called Periprem that we can provide during labour to help reduce the mortality/ morbidity rates for preterm babies, but timing is key. The sooner we know someone is in preterm labour, the more we can potentially offer to optimise a preterm baby's outcomes. Preterm labour does not always present in the same way that labour after 37 weeks does, so, we encourage pregnant people to contact triage ASAP with any concerns. The sooner we know about a preterm labour, the more we can offer to optimise the baby's long-term outcomes.

We will look to include more information about preterm birth given to those who are expecting – that it can happen to anyone, it's available from 16 weeks gestation, to be vigilant of symptoms, and to always contact triage with any concerns.

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

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

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

Introduction

Following the publication of the Government's 10 Year Health Plan for England, the NHS Oversight Framework was published in early-September, which is a league table of all providers in England. This is a notable document and one that will highlight how we're doing based on a range of metrics. We have digested this, reviewed our position, and are continuing plans to make sure that as the year progresses, we see an improvement in our position.

While our position is not in the top quartile, we must shine a light on the amazing work our teams do, day in, day out. We have had much reason to celebrate the achievements of our staff recently with high-ranking hip fracture care according to the National Hip Fracture Database and praise from cancer patients via the Cancer Patient Experience Survey which shows that when someone is diagnosed with cancer, the way care is provided is of a high standard. We have also performed well in the training we provide to our foundation and resident doctors, alongside retaining teaching partner status through the learning opportunities we provide through the University of Cambridge.

While there is still a long way to go in achieving our financial goals, I would like to remind everyone that they are doing a fantastic job, and that this doesn't go unrecognised or unappreciated. At the end of August (month five), we remain on track to deliver against our financial deficit plan, and thanks to the hard work of every colleague across our hospitals and in the community, we have made significant savings through our cost improvement programme (CIP). While it will become harder to stay on course as we move into the second half of the year, I'm sure we will all come together to ensure we become a sustainable healthcare provider.

Performance

Finance

At the end of August, our reported position in-year was a £12.2m deficit, which is £0.8m 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 have also remained on track due to the savings made under numerous cost improvement programme (CIP) projects across the Trust. £447,000 has been saved by purchasing cheaper/alternative drugs. £640,000 has been saved by clinical productivity improvements. £135,000 by the Trust using its estate more effectively. Additionally, we have saved £289,000 through procurement initiatives, such as product switching and the ongoing project to adopt the new national uniform.

While the second half of the year from September will be more challenging, it's important to recognise how far we have come in returning to financial sustainability. Every colleague across our Trust has made an effort to help us get this far, and we are seeing the results of this. I'd like to thank everyone for their help and encourage them to continue working with us. I am confident that once we achieve our financial goals and deliver the transformation projects that will enhance the care we provide.

Elective recovery

On 31 March 2024, 407 patients were waiting more than 65 weeks and 47 waiting more than 78 weeks.

At the end of August, our performance in reducing the number of patients waiting 65 and 78-weeks has dipped. Currently, 178 patients have been waiting 65-weeks or more, which is up from 31 at the end of March this year. Additionally, the number of patients waiting 78-weeks or more has increased from four to eight. To recover our position, we are working hard and are putting on additional lists at weekends to bring the backlog down and ensure patients get the treatment they need.

Urgent and emergency care

Our performance against the 4-hour standard was 71.4% in June, 74.6% in July, 74.3% in August. While we are close to the 78% target, we know that we aren't meeting it, despite this remaining a vastly improved position when compared to the earlier part of this year.

We are looking at ways to improve our performance here by changing the way we work and utilising our resources as efficiently and effectively as possible.

Cancer

28-day
- May – 64.3%
- June – 74.1%
- July – 80.4%

31-day
- May – 99.6%
- June 100%
- July – 99.8%

62-day
- May – 68.3%
- June – 73.6%
- July – 70%

Since 2024/25, we have been working hard to improve our performance against the faster diagnosis standard (FDS). Our aim was to ensure we achieve 77% of patients having cancer diagnosed or ruled out within 28-days by March 2025 and 70% of patients beginning their treatment within 62-days. You can see that throughout the last three months we have been largely improving. For the 28-day target there has been a significant amount of work to meet the national target, and while there has been a slight dip over the last month for the 62-day target, we are seeing us returning to consistently meeting this month-on-month.

Quality

A cancer diagnosis is very significant, and patients deserve to have high-quality and compassionate care from all the Trust teams who look after them. I am delighted that the latest results of the 2024 Cancer Patient Experience Survey show we have maintained positive responses from our patients, and these results are a tribute to the commitment of our hardworking staff.

More than 90 per cent of cancer patients have rated the experience of the care they received at the West Suffolk NHS Foundation Trust (WSFT) as very good or good.

Patients' responses to 16 of the 59 questions asked were above the expected range, and none fell below the expected range. The survey also showed a steady improvement in the responses to most questions over the past four years.

In response to a question about the way their care was given, 93% of respondents said it was very good or good.

There are always areas where we can improve, and we will be considering all that this survey tells us going forward.

Other questions where the Trust scored highly include:

- patient was always treated with respect and dignity while in hospital (99%)
- patient found it very or quite easy to contact their main contact person (91%)
- patient had confidence and trust in all of the team looking after them during their stay in hospital (90%)
- treatment options were explained in a way the patient could completely understand (89%)
- patient was always involved in decisions about their care and treatment whilst in hospital (88%).

The Trust also organises a well-attended annual cancer forum which gives patients the opportunity to reflect on their treatments and improve the experience for others in the future. The Trust's lead cancer nurse, Karen McKinnon, and her team work with the West Suffolk Cancer Patient User Group to produce recommendations for service improvement, including running a survey of our patients focused on local services.

Workforce

We received our Pulse survey results for Q2, with 1,234 responses captured from across the Trust. We score above the national average in some areas – 'we each have a voice that counts' and 'we are compassionate and inclusive' – but show a fall in the scores for the four themes we track; advocacy, engagement, involvement and motivation.

The survey also captures some of the areas staff tell us need to change or improve, with 'communication', 'resource' and 'morale' among the most frequently raised topics. I am reassured at the activity already underway to address these issues, as well as new initiatives being developed as direct result of the feedback.

While the drop in scores is part of a national trend, it is an important reminder of the work we still have to do to help our colleagues feel more empowered, valued, and able to take pride in the quality of care they deliver or enable. We will soon be asking colleagues to complete the national NHS Staff Survey, which will provide a richer picture of our strengths and areas for improvement.

We are starting to say farewell to colleagues who successfully applied to our mutually agreed resignation scheme, which closed in June. The scheme will see people leave between September and October from across our corporate and administrative & clerical teams, with their vacated positions providing redeployment opportunities for others.

Future

As part of plans to increase accountability and transparency, the Government launched its new NHS Oversight Framework in early September – a set of league tables ranking the performance of every NHS provider. It measures a range of metrics to generate a single overall score, and the

tables are then divided into segments, with the best overall performers in segment 1 and those that are struggling placed in segment 5.

West Suffolk NHS Foundation Trust ranks 90 out of 132 - around two thirds of the way down the table for acute trusts, within segment 3. As we have a deficit financial plan, we can't be placed into segment 1 or 2 but I believe we could – and should - be higher up the table. While our position is a fair reflection of the Trust's overall performance at the moment, 60% of acute trusts are also in segment 3.

This new framework captures so much of the amazing care we provide to patients in hospital and out in the community and our staff should be immensely proud of the hard work and passion they bring every day. It also highlights areas where we can improve, with action plans already in place to identify opportunities and make changes.

With the new Framework following on from the recent publication of the 10 Year Health Plan for England, the governments' priorities have become clearer, and we have a more detailed understanding of the direction of travel for the entire NHS. This provides the context for our new strategy, which will launch in October.

The refreshed Trust strategy for 2025-28 will reflect our commitment to staying responsive, forward-looking, and aligned with the broader health and care landscape. With the vision of building a healthier West Suffolk where compassionate care helps everyone to thrive, the strategy will help us successfully navigate the future by focusing on what's most important: high quality care; joining-up services; empowering our colleagues; ensuring we're responsible with resources; and making sure we're fit for tomorrow.

The timeline of our strategy won't stretch to the completion of the new hospital but, crucially, it will deliver the transformation needed to ensure the Future Systems Programme (FSP) can achieve its full potential. We know the construction of a new hospital must be complemented with new ways of working, such as adopting the three shifts, to allow us to enhance the care and support we provide in West Suffolk and beyond.

The FSP team recently visited a site in Leeds to view and experience a 'life size' mock-up of a single room. We were able to offer feedback on the design from a clinical, digital and patient experience perspective based on the team's experience, alongside the insights gleaned from patient and staff engagement and co-production.

The team also continues to work on their 1:200 designs, which they hope to be able to share in the Autumn following New Hospital Programme ratification.

2. STRATEGY

2.1. WSFT Strategy (ATTACHED)

For Approval

Presented by Ewen Cameron

Public Board	
Report title:	Strategy
Agenda item:	Strategy
Date of the meeting:	26 September 2025
Lead:	Sam Tappenden Executive Director of Strategy and Transformation
Report prepared by:	Sam Tappenden, Executive Director of Strategy and Transformation Greg Bowker, Head of Communications Anna Hollis, Deputy Head of Communications

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

Executive Summary
WHAT? *Summary of issue, including evaluation of the validity the data/information*
The Trust has been developing a refreshed strategy since April 2025. Significant engagement has included a survey, focus groups, and analysis of the Trust's challenges.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
A refreshed strategy is critical to provide the direction of the organisation to our colleagues, assurance to our stakeholders, and is a key responsibility of the Board. The refreshed strategy will ensure the Trust will effectively respond to the national direction of the 10-Year Health Plan for England, support the Trust's Future Systems Programme, and enable the Trust to make the required improvements to become a high quality and financially sustainable organisation.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
To approve the draft strategy (subject to final proof and design review), formally launch the strategy at the Annual Member's Meeting, and to embed the strategy throughout the Trust.
Recommendation / action required
• Receive final comments from Board regarding the draft strategy • Approve the draft strategy • Embed the strategy throughout the organisation

Previously considered by:	Public Board
Risk and assurance:	The refreshed strategy will enable the Trust's BAF to be updated, and in turn to ensure the organisation is addressing our strategic risks.
Equality, diversity and inclusion:	A core tenant of the ambitions pertains to having an inclusive, supported, and valued workforce. The strategy included a renewed focus on EDI.
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.

NHS
West Suffolk
NHS Foundation Trust

Our strategy 2025-2028

Compassionate care, healthier communities

By harnessing our strengths,
we genuinely believe we could be
the best in the country at what we do.

Foreword by CEO and Chair

Dr Ewen Cameron, CEO

Jude Chin, Chair

We're proud to share our strategy for 2025-28, which is driven by a collective vision to create a healthier West Suffolk where compassionate care helps everyone to thrive.

We launched our last strategy, 'First for our patients, staff and the future', in 2021. It got a lot of things right – putting patients first, putting staff at the heart of what we do, and a clear mandate to become fit for the future.

So much has changed. Nobody could have predicted the lasting impact of the covid-19 pandemic, the domestic impact from global instability, and a cost-of-living crisis that affects the whole country. At the same time, trusts are responding to the breathtaking speed and scale of changes in technology, such as artificial intelligence.

The coming years will see more change and uncertainty, and the challenges ahead are significant — rising demand, workforce wellbeing, financial pressures, and persistent health inequalities in our communities.

Yet within these challenges lie extraordinary opportunities. We have a chance to transform how we provide care; not just to meet demand but to tackle the root causes of poor health in our communities.

With structural shifts across the NHS, the publication of the 10 Year Health Plan for England and the completion of the local Sustainability Review, now is the right time for a new strategy. We have outstanding people, high quality services, and a determination to work more closely with our partners. By harnessing our strengths, we genuinely believe we could be the best in the country at what we do.

This strategy will help us successfully navigate the future by focusing on what's most important: high quality care; joining-up services; empowering our colleagues; ensuring we're responsible with resources; and making sure we're fit for tomorrow.

Whether you're a colleague, patient or partner, we want this strategy to inspire you – setting a clear direction of travel and demonstrating the energy, ambition, and passion that makes this a great place to work and receive care.

The most important message we'd want you to take away is that everyone has a role to play in our success. We can only do all of this if we work together as one — with our people, patients, and partners — for a healthier West Suffolk where compassionate care helps everyone to thrive.

Our strategy

Our strategy sets five ambitions and is powered by our FIRST values

- Fairness
- Inclusivity
- Respect
- Safety
- Teamwork

About us

280,000 catchment population

More than **5,000** staff

More than **11,900** foundation trust members

More than **2,000** babies born including 26 sets of twins

More than **101,000** attendances at the emergency department

More than **16,000** planned operations

More than **3,500** emergency operations

More than **315,000** outpatient attendances

More than **371,900** contacts with patients through community services*

*Does not include wheelchair services

Who we are

The West Suffolk NHS Foundation Trust (WSFT) provides hospital and community services to around 280,000 people spread across a largely rural area of roughly 600 square miles.

Our catchment area extends beyond Thetford in the north and Sudbury in the south, Newmarket to the west and Stowmarket to the east. We also care for patients in parts of Essex, Cambridgeshire and Norfolk.

The Trust provides a full range of acute and secondary care services from its West Suffolk Hospital base in Bury St Edmunds. This includes an emergency department, maternity and neonatal services, day surgery, eye treatment, Macmillan Unit and outpatient clinics. We have around 500 beds and are a partner teaching hospital of the University of Cambridge.

In addition, we provide community services in West Suffolk, and specialist community services across the county. Many of our adult and children's community services - including nursing, therapy, and specialist services - are provided in patients' own homes, health centres and community buildings.

Our rehabilitation services are provided through our community inpatient beds at Newmarket Community Hospital (NCH) and Hazel Court in Sudbury. And a new, state-of-the-art Community Diagnostic Centre based at NCH opened in December 2024.

Our colleagues and services are award-winning, gaining regional and national recognition for their quality, innovation, and compassion. Most importantly, WSFT has a culture that is inherently welcoming, supportive, and dedicated to the people we serve.

Delivering for our communities

Our stroke and hip fracture services are national exemplars, with our stroke team maintaining an "A" rating for over six years and our hip fracture care twice ranked as the best in England and Wales. Patient experience remains a strength, both for our inpatient services and through the Cancer Patient Experience Survey.

Teams and services have been recognised for their quality and innovation, from the virtual ward and our emergency department performance to information and support provided through our maternity social media account.

Across a range of performance measures, we are steadily improving or exceeding national targets. Some areas, however, remain challenging, such as elective care. Our performance against the 18-week Referral to Treatment standard must improve, diagnostic test results are often taking too long, and we have too many patients that have been waiting for care over 52 weeks.

We want WSFT to be a great place to work and receive care. The 2024 national NHS Staff Survey results showed a worrying drop in our scores, especially in wellbeing and advocacy, demanding a long-term response to ensure our colleagues feel included, supported, and valued.

At the same time, we must become financially sustainable. We have taken the difficult but necessary decisions to deliver against our deficit plan and, while there are challenging days ahead, together we have shown we can exercise the discipline needed to live within our means while still providing high quality care.

As we look forward, the Trust's Future System Programme is set to transform the delivery of outstanding, sustainable care through a new state-of-the-art healthcare facility. The new hospital will provide increased capacity, modern infrastructure, and technology-enabled care.

Our vision is to become a Trust that is digitally advanced, supports environmental sustainability, and delivers high-quality services to meet the needs of patients and staff.

The Future System Programme is the most ambitious programme in our history, and this strategy will prepare us for the major changes needed to transition into a new era of healthcare.

Evolving healthcare

National context

The NHS faces profound challenges. Public satisfaction has reached historic lows, driven by long waits, difficulty accessing care, and pressure on emergency services. These pressures are compounded by rising demand, workforce shortages, and changing patient needs. To meet these challenges, major transformation is underway.

The Health and Care Act 2022 marked a major shift in how health and care services are provided by putting Integrated Care Systems (ICSs) into law. The NHS's 10-Year Health Plan for England builds on this with its focus on 'three shifts': hospital to community, analogue to digital, and illness to prevention.

Structural changes within NHS England, Integrated Care Boards, and national bodies are reshaping the health and care landscape. Within local government, devolution deals are giving councils greater influence over health and care planning, reinforcing the importance of partnership. This national direction aligns strongly with our vision and, with the once-in-a-generation opportunity to build a new hospital, we are well placed to reimagine how care is delivered.

Local context

The Trust fully supports Suffolk & North East Essex Integrated Care System's (ICS) 'Future Shift' strategy to transform health and care by focusing on early intervention, prevention, and health inequalities. As active members of our ICS, we work closely with partners to improve health and care services for our communities.

The West Suffolk Alliance is one of three place-based alliances in our system and its purpose — to improve health through partnership — uses the 'live well' model to meet population needs. The Alliance has played a crucial role in developing our services, such as the integrated neighbourhood teams, as well as establishing new ways of working together for the benefit of our patients.

We also work closely with East Suffolk and North Essex NHS Foundation Trust (ESNEFT), with the successful launch of the Essex and Suffolk Elective Orthopaedic Centre a symbol of our partnership approach.

While we have strong relationships to build on, to make the 'Future Shift' a reality, we must scale-up preventative care with our partners, shift care 'closer to home' where appropriate, and embrace technology.

Ambitions

People in our communities are healthier and more independent

Patients experience services that are seamlessly integrated around their needs

Shape an inclusive culture where people are empowered to continuously improve services

Achieve the best possible value for money for taxpayers

A forward-thinking Trust with the agility to seize the opportunities of the future

Priorities

- Improve access, experience, and safety of services
- Achieve improvements in the greatest health inequalities
- Embed continuous quality improvement in everything we do.

- Provide more care closer to home through transformed hospital and community services
- Create new models of preventative care with our partners
- Work closely with our partners to create the conditions for success.

- Nurture a safe, high performing and inclusive culture
- Proactively support colleagues' health, wellbeing and development
- Strengthen leadership to foster autonomy, accountability and ensure staff feel valued.

- Achieve a long-term sustainable financial position
- Instil shared responsibility for managing all our resources wisely
- Make efficiency and productivity improvements.

- Accelerate the adoption of technology to enhance our services
- Improved access to data to enhance decision-making
- Modernise the way we work to free up time for colleagues.

Ambition: High quality care

Provide high quality care in the best place for patients and families

We are proud of our reputation for delivering high quality care and committed to protecting and strengthening it.
Our ambition means putting patients first every time — ensuring safety, dignity, and compassion are at the heart of every interaction.
We will maintain clinical excellence through evidence-based practice, listening to the lived experience of patients, families, and carers, and by acting on their feedback to provide personalised care. Central to this is the creation of a 'learning culture', where we are curious about how we can improve. It's essential we deliver care equitably so everyone receives the same high standard of care, regardless of background or circumstance.

Strategic outcome

People in our communities are healthier and more independent.

Strategic priorities

- Improve access, experience, and safety of services
- Achieve improvements in the greatest health inequalities
- Embed continuous quality improvement in everything we do.

Strategic measures

'True North' metric

Effectiveness: Increase in healthy life expectancy in the most deprived communities.

Safety:

- Summary Hospital-level Mortality Indicator
- Percentage of incidents that caused moderate harm or above.

Experience:

Friends and Family Test (FFT), including the % of patients from Core20Plus5 groups reporting positive experience.

Infection prevention:

Healthcare acquired infections:

- MRSA bacteraemia count
- C. Difficile infection count
- E. Coli bacteraemia count
- Klebsiella bacteraemia count
- Pseudomonas bacteraemia count.

CQC rating

Performance:

- 4-hour A&E standard
- Referral to Treatment (RTT) <18 weeks
- RTT <52 weeks
- RTT <65 weeks
- Cancer 28-day Faster Diagnosis Standard.

Staff survey, 'advocacy':

If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.

What does great look like for our patients and families?

- Every patient is treated with compassion, dignity, and care that makes them feel safe and valued
- We listen to patients and families, use their feedback to make care better, and follow proven medical practices
- No matter who you are or where you're from, you will get the same high standard of care.

What does great look like for our staff?

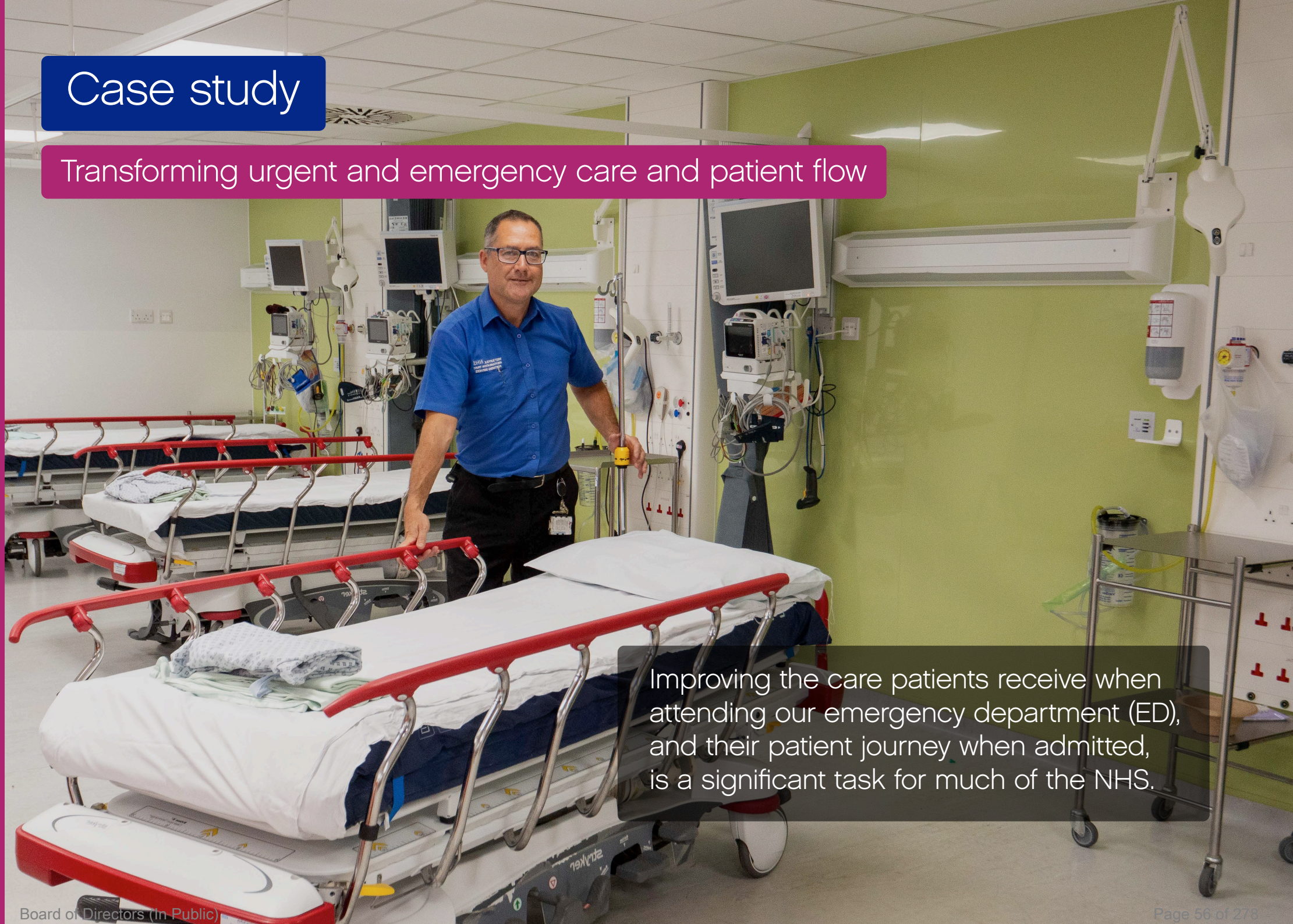
- Staff are supported to deliver care that is kind, safe, and respectful in every interaction
- Staff have the skills, support, and tools to do their jobs to the best of their abilities
- Staff work together to make sure everyone gets the same high standard of care, no matter their background.

What does great look like for our partners?

- Partners benefit from working with a team that puts patients first and delivers safe, kind, and reliable care in the right place
- Partners gain access to feedback, data, and proven approaches that help improve services and outcomes together
- Partners will feel valued because we listen to the perspectives of different professionals in the delivery of care.

Case study

Transforming urgent and emergency care and patient flow



Improving the care patients receive when attending our emergency department (ED), and their patient journey when admitted, is a significant task for much of the NHS.

What we did...

Targets such as the 4-hour standard, where 78% of patients who attend A&E are to be admitted, transferred or discharged within 4 hours, are a focus for the Trust. Much work involving multiple teams across many of our services has been undertaken to identify meaningful ways to implement changes in the ways we work to improve performance and patient experience.

A taskforce focused on empowering colleagues across every division, including social care, and consisting of clinical and non-clinical colleagues was guided by an action plan developed across seven areas identified as being able to support improvements: the emergency department; medical same day emergency care; surgical and surgical same day emergency care; paediatrics; corporate services; therapies and community; and ward processes.

The impact of the project was far reaching.

Improved patient experience within ED was achieved following a reduction in waiting times and patients receiving the care they need in the correct area under the right clinicians.

Length of stay was also reduced, and thanks to a reduction in the time it takes investigations to be conducted, care was provided sooner.

For staff, it also increased morale by reducing redeployment, waiting times, and them being able to stay in their speciality instead of being redeployed to support operational pressure.

Target

78% of patients who attend A&E to be admitted, transferred or discharged within 4 hours.

Impact

Improved patient experience achieved by reduction in waiting times and length of stay.

Impact

Increase in staff morale achieved by reducing redeployment, waiting times, and them being able to stay in their speciality.

Ambition: Joined up services

Work closely together with our partners to deliver joined-up care

We are committed to delivering care that feels connected, coordinated, and centred around the needs of the individual. Our ambition for joined-up care means breaking down silos between hospital, community, primary care, mental health, and voluntary services — designing pathways around people, not organisations — so patients experience continuity, not fragmentation. We will collaborate with partners to ensure care is equitable, accessible, and responsive, wherever people live. It's critical we develop our community health services and integrated care models at pace so that we can provide care in the best place for patients — starting the journey towards becoming an integrated neighbourhood health service.

Strategic outcome

Patients experience services that are seamlessly integrated around their needs.

Strategic priorities

- Provide more care closer to home through transformed hospital and community services
- Create new models of preventative care with our partners
- Work closely with our partners to create the conditions for success.

Strategic measures

'True North' metric

Patients reporting coordinated care across integrated pathways and services.

- Evidence that new services, delivered in partnership, are shifting care 'closer to home' for specific cohorts of our population
- Increased use of preventative and proactive services
- Proportion of workforce working in neighbourhood health services
- Reduction in bed days in target patient cohorts
- Average length of stay in target patient cohorts
- Percentage of partners reporting positive partnership working.

What does great look like for our patients and families?

- Patients won't have to repeat their story or chase different services, because everything works together smoothly
- More support is available in local communities, so people can get help where and when they need it
- Everyone gets the same high standard of care, no matter where they live or what their background is.

What does great look like for our staff?

- Staff work closely with colleagues across services, making care smoother and more coordinated for everyone
- Joined up care helps staff know who's doing what, reducing confusion and making it easier to solve problems together
- Staff can see the difference they're making — helping patients get the right care, in the right place, at the right time.

What does great look like for our partners?

- Partners are part of a trusted team working together to design and deliver care that truly meets people's needs
- Partners benefit from clearer roles, better communication, and joint planning that helps services run more smoothly
- By working closely with us, partners help bring care closer to home and reduce health inequalities — making a real difference where it matters most.

Case study

Collaboration supports community wellbeing

Colleagues in our community services are supporting awareness and engagement with wellbeing services through the ONE Haverhill Partnership, which brings together organisations and resources to make them more effective and efficient.

What we did...

The Trust's local clinical administrator Alison Barnes and integrated neighbourhood team coordinator Kirsty Millard are active members of the health and wellbeing committee, which has communication as a priority.

With Wellbeing Suffolk and Abbeycroft Leisure, they organise biannual One Haverhill marketplace events, a showcase for the public to engage with voluntary organisations, charities, schools, local business and services. With good turnout and positive feedback from stallholders and attendees, the events are attracting growing interest.

Comments from stallholders have highlighted that these are effective networking events supporting engagement with other services as well as the opportunity to promote their own.

Members of the public have described them as well-organised and fun, with a wealth of local information.

In the 2025 Suffolk & North East Essex Integrated Care Board 'Can Do' Health and Care awards, One Haverhill Market Place Events were commended in the 'Partnership with the VCFSE Sector Award' category.

Target

Join up services in Haverhill to better support patients and community.

Impact

Good turnout and positive feedback from stallholders and attendees alike.

Impact

Supporting cross service engagement and provision of local health and wellbeing information.

Ambition: Empowered to improve

Be a great place to work where people are empowered to be their best

We believe that the strength of our organisation lies in the people who work and volunteer here. Our ambition to empower our people means creating a culture of trust and respect, where every voice matters and contributions are recognised. We must ensure our staff have the time, tools, and training to grow and thrive in their roles. We will take actions to improve staff wellbeing, with a focus on psychological safety, inclusion, and recognition. We understand the importance of enabling autonomy, so staff can shape how care is delivered and lead improvements in their services. Finally, we will strengthen the relationship with our workforce through engagement and action, ensuring feedback leads to visible change and that leadership is accessible and accountable.

Strategic outcome

Shape a culture where people are empowered to continuously improve services.

Strategic priorities

- Nurture a safe, high performing and inclusive culture
- Proactively support colleagues' health, wellbeing and development
- Strengthen leadership to foster autonomy, accountability and ensure staff feel valued.

Strategic measures

'True North' metric

Staff survey, 'advocacy': I would recommend my organisation as a place to work.

- Staff survey, 'motivation': I look forward to going to work
- Workforce Disability Equality Standard: percentage of disabled staff saying their employer has made reasonable adjustments to enable them to carry out their work
- Workforce Race Equality Standard: 'staff experience': percentage of staff reporting personal experience of discrimination
- NHS Equality Diversity and Inclusion Improvement Plan: percentage of staff saying that they have not experienced harassment, bullying, or abuse from managers in the last 12 months
- Staff survey, 'involvement': I can make improvements happen in my area of work
- Staff sickness absence.

What does great look like for our patients and families?

- Patients and families feel listened to, supported, and treated with dignity in every interaction
- People will feel assured that staff are skilled, well-supported, and working in a culture that values safety, compassion, and improvement
- Feedback leads to real changes, and care keeps getting better because staff are empowered to make a difference.

What does great look like for our staff?

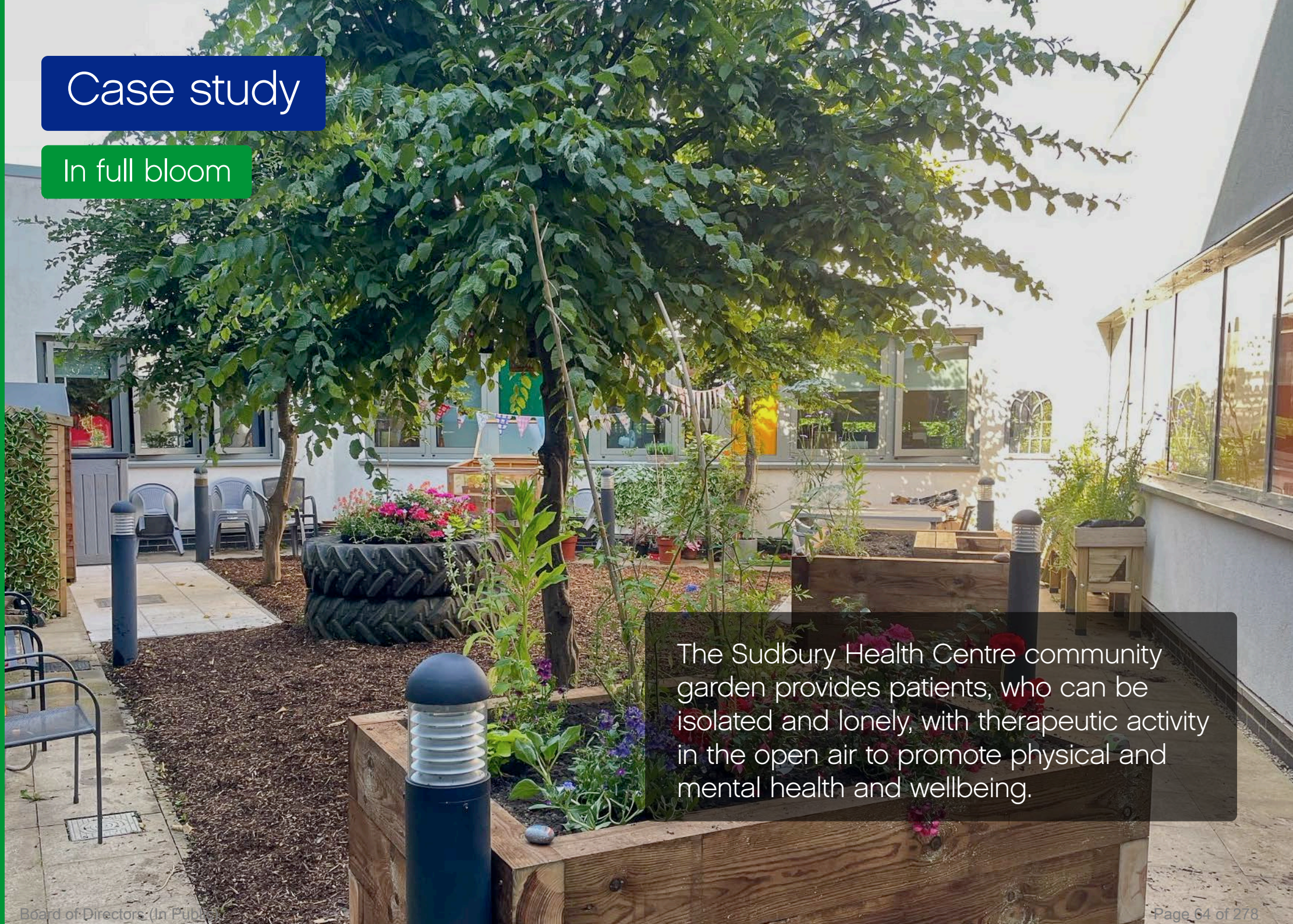
- Staff are empowered to shape how care is delivered and improve services for patients and families
- Staff are listened to, respected, and recognised for their contributions
- Staff have the time, tools, and training they need to do their jobs well and develop their careers.

What does great look like for our partners?

- Partners are welcomed into a culture of trust, respect, and shared purpose — where their contributions are valued and their voices heard
- Partners benefit from clearer communication, shared goals, and joined up working that makes it easier to deliver great care together
- By working with empowered staff, partners help shape services that improve outcomes for patients, families, and communities.

Case study

In full bloom



The Sudbury Health Centre community garden provides patients, who can be isolated and lonely, with therapeutic activity in the open air to promote physical and mental health and wellbeing.

What we did...

Lucie Johnson, Judy Kiddy and Mags Phillips are health and social care occupational therapists (OTs) with the Sudbury integrated neighbourhood team. They saw an opportunity to turn an unused patch of ground at Sudbury Community Health Centre into a therapy garden, for the benefit of their patients and colleagues.

Giving up their own time to clear the site during the winter, they set about creating a garden which could be managed by people with different physical abilities. Finances were needed to develop the scheme, so they embraced new skills to seek funds from a variety of sources.

After successfully applying for start-up funds from the Friends of the West Suffolk Hospital and My WiSH Charity; they won two awards from the Royal College of Occupational Therapy, which provided further money.

The work has developed, as has their ability to link up with local firms – such as garden centres – and charities – such as Men's Shed – to support the project. They have also shared learning and good practice with colleagues.

The garden provides patients, who can be isolated and lonely, with therapeutic activity in the open air to promote physical and mental health and wellbeing.

Clinicians see an increase in strength, mobility, dexterity and confidence, all leading to greater independence and improved quality of life.

Target

Turn an unused patch of ground at Sudbury Community Health Centre into a therapy garden, for the benefit of their patients and colleagues.

Impact

The garden provides patients, who can be isolated and lonely, with therapeutic activity in the open air to promote physical and mental health and wellbeing.

Impact

Clinicians see an increase in strength, mobility, dexterity and confidence, all leading to greater independence and improved quality of life.

Ambition: Responsible with resources

Deliver a financially responsible and sustainable organisation

We are committed to achieving financial sustainability as a foundation for delivering safe, high-quality care.
This means maximising value for money for the public, ensuring every pound spent contributes to better outcomes. It means improving efficiency and productivity, while protecting the quality and safety of care. We must maintain our assets, including buildings, equipment, and digital infrastructure, so they remain fit for purpose. It's crucial that we recognise that financial sustainability is not just the job of our finance team — it's a collective effort across the organisation. Finally, we will be transparent and fair, especially when difficult decisions are required, and support staff through change with compassion.

Strategic outcome

Achieve the best possible value for money for taxpayers.

Strategic priorities

- Achieve a long-term sustainable financial position
- Instil shared responsibility for managing all our resources wisely
- Make efficiency and productivity improvements.

Strategic measures

'True North' metric

Total cost per Weighted Activity Unit of clinical output.

- Sustainable financial position delivered
- Percentage of cost improvement plan (CIP) plan delivered
- Score in NHS Oversight Framework
- Reduction in specific spend categories including temporary staffing
- NHS reference cost score
- % of budget holders trained in financial management.

What does great look like for our patients and families?

- Every pound is spent wisely to improve care, so patients and families get the best possible value
- Buildings, equipment, and technology are kept up to date, helping ensure care is safe and fit for the future
- Even as we work more efficiently, the focus stays on delivering kind, high-quality care that meets people's needs.

What does great look like for our staff?

- Staff know the organisation is well-managed and financially stable, helping protect jobs and services
- Resources are used wisely so staff have the right tools, equipment, and training to deliver great care
- Staff are involved in changes, treated with respect, and supported through decisions that affect their work.

What does great look like for our partners?

- Partners can rely on a well-run organisation that uses public money wisely and protects the quality of care
- Clear financial planning and shared goals make it easier to work together on long-term improvements and service transformation
- Partners are engaged in open conversations about priorities, trade-offs, and how to get the best value for communities.

Case study

Producing chemotherapy in-house saves £150k

As part of the Trust's ask on all teams and colleagues to consider whether we're getting the best value for money in their area, pharmacist Terry Arnott and colleagues in the pharmacy production unit spotted the potential savings to be made by bringing the production of chemotherapy back in house rather than buying them in.

What we did...

As part of the Trust's ask on all teams and colleagues to consider whether we're getting the best value for money in their area, pharmacist Terry Arnott and colleagues in the pharmacy production unit spotted the potential savings to be made by bringing the production of chemotherapy back in house rather than buying them in.

Without enough staff for the number of patients requiring treatment, the team historically bought outsourced chemotherapy to ensure their activity complied with safety regulations. A review of their spending, however, revealed the cost of outsourcing was significantly higher than increasing the in-house resource to prepare these medicines.

Funding for two additional members of production unit staff was agreed, which will save the Trust an estimated £150,000 per year and provide new training and development opportunities within the team.

Terry, pictured left on the previous page, said: "We feel proud to have done something that not only makes a saving but also benefits the team. Our knowledge and expertise was trusted and we were given the support to make a positive change."

Target

Potential savings to be made by bringing the production of chemotherapy back in house.

Impact

Funding for two additional staff members agreed, saving the Trust an estimated £150,000 per year.

Impact

New training and development opportunities provided within the team.

Ambition: Fit for tomorrow

Deliver health and care services that are fit for the future

We are committed to building an organisation that is not only fit for today, but prepared for tomorrow. Our ambition to future proof the Trust means investing in prevention, so we reduce avoidable illness and support healthier lives. We must embrace innovation, including digital tools, data-driven care, and new models of care. It's important we build our resilience by strengthening our infrastructure, workforce, and partnerships. Given the once-in-a-generation opportunity to build a new hospital, we must prepare for major change, with the flexibility to adapt to new challenges and opportunities. Finally, we must act sustainably, so we protect our environment, our resources, and our people for the long term.

Strategic outcome

A forward-thinking Trust with the agility to seize the opportunities of the future.

Strategic priorities

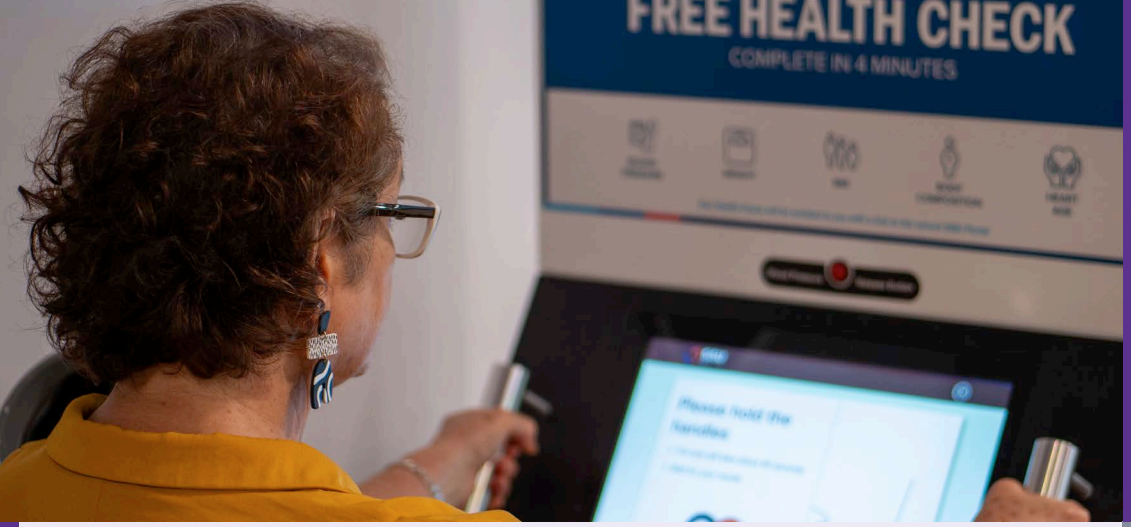
- Accelerate the adoption of technology to enhance our services
- Improved access to data to enhance decision-making
- Modernise the way we work to free up time for colleagues.

Strategic measures

'True North' metric

Improvement in the digital maturity score of the Trust.

- Hours saved through modernised working
- Patient uptake of Patient Portal
- Staff satisfaction with digital implementations
- Percentage of managers reporting that they have access to appropriate data to support decision making
- % reduction in carbon emissions delivered
- Total Gross Internal Area of estate per Worked Activity Unit.



What does great look like for our patients and families?

- New technology and better data help make care more efficient, easier to access, and tailored to individual needs
- More focus on prevention and early support means fewer avoidable illnesses and better long-term health
- Patients benefit from modern infrastructure, strong local services, and a system ready to adapt to future challenges.

What does great look like for our staff?

- Staff save time and effort through modern tools, better data, and more efficient systems
- Staff are equipped to handle change, with training, innovation, and opportunities to shape new ways of delivering care
- Staff work in a resilient organisation that invests in its people, technology, and infrastructure to be ready for tomorrow.

What does great look like for our partners?

- Partners work with a Trust that's planning, embracing innovation, and ready to meet future challenges together
- Partners benefit from better access to digital tools and information that support joint decision-making and service improvement
- Partners can collaborate on new technologies, models of care, and approaches to prevention that improve services and outcomes for patients.

Case study

Patient Portal supports patient experience

With upgrades to the Trust's Patient Portal in autumn 2024, registration now stands at nearly 60,000.

What we did...

Designed to make managing health information easier and more convenient, the portal provides an enhanced experience, allowing patients to access their health information whenever and wherever they need it.

The portal currently supports patients with:

- **appointments and messaging** including details about future appointments with option to cancel if needed, SMS appointment reminders, and any relevant health questionnaires
- **test results** including numerical laboratory results, radiology reports and pathology reports (both visible with a three-week delay)
- **health records** including allergy information, procedures, document access to clinic letters and inpatient discharge summaries (from 12 February 2018 onwards), obstetric ultrasound reports, and notes such as maternity bookings, ongoing assessment, antenatal and postnatal discharge information.

Fully integrated with both our electronic patient record, offering two-way updates to and from the patient record, and the NHS App for appointment reminders and digital questionnaire support, patients can use their NHS login account to access PPUK, as a user of this service.

Ongoing developments include expansion of digital health questionnaires, waiting list management via SMS messaging and enhanced appointment rescheduling.

Impact

The Patient Portal allows patients to access their health information whenever and wherever they need it.

Impact

The portal is fully integrated with our electronic patient record and the NHS app.

Impact

Ongoing developments include SMS waiting list management and enhanced appointment rescheduling.

Delivering our strategy

We'll take a disciplined approach to prioritisation — focusing our energy and resources on the areas that will have the greatest impact for patients, staff, and partners.

This strategy will be supported by several 'enabling' strategies — including digital, workforce, and finance. Delivering this strategy will require significant change — across services, systems, and culture.

Our approach to change will include:

- Patient, staff, and partner engagement and co-production, ensuring those closest to services shape how change happens
- Building our capacity and capability for change, including quality improvement training, tools, and support for teams leading transformation
- Ensuring that change is inclusive and compassionate, recognising the emotional impact of transformation and supporting our people through it.

Our Board will oversee the delivery of this strategy, ensuring alignment with our values, statutory duties, and our partners in the Integrated Care System.

Strategic ambitions will be embedded into Board sub-committees, with regular reporting to track progress and assess risk.

We will also develop a refreshed performance framework, linking our five strategic ambitions to measurable quality, finance, and workforce outcomes.

Our action plan

High quality care

- Deliver refreshed clinical and care strategy
- Deliver refreshed quality strategy
- Deliver national Planning Guidance requirements
- Develop delivery plan against Core20Plus5 groups
- Enhanced approach to personalised care planning, shared decision-making, and patient empowerment
- Work closely with patients, families, and carers to develop our services
- Implement approach to continuous quality improvement.

Joined up services

- Take an inclusive approach to develop services with all our partners
- Enhance and accelerate our partnership working with primary care
- Develop integrated neighbourhood health and care services with all partners, including mental health, social care, and the voluntary, community, faith and social enterprise sector
- Deliver Sustainability Review recommendations with ESNEFT and the ICB
- Develop appropriate mechanisms that enable us to improve collaboration with partners including asset sharing
- Empower our people to resolve operational barriers between organisations
- Maximise opportunities to expand our autonomy as a Foundation Trust.

Empowered to improve

- Deliver a medium-term workforce plan
- Develop an improved workforce ‘offer’ for colleagues
- Improve communication and engagement with colleagues
- Enhance divisional and service leadership structures
- Enhance the Trust’s approach to equality, diversity, and inclusion
- Implement a balanced ‘performance framework’ for colleagues
- Remove non-value-added processes to free-up staff time
- Ensure our facilities are accessible for colleagues with disabilities.

Responsible with resources

- Deliver a medium-term financial plan
- Work with commissioners to incentivise transformation
- Implement rigorous financial control processes
- All services complete a service line review of their productivity
- Review all services' contract specifications
- Embed a sustainable Trust-wide approach to CIP delivery
- Develop our commercial approach to maximise income generation
- Improve corporate systems to enhance decision-making and reporting
- Improve financial training for staff.

Fit for tomorrow

- Work closely with partners and the New Hospital Programme to prepare for our new hospital
- Deliver modernised working practices through digital transformation to improve quality, reduce costs, and free-up time, whilst being mindful of the risk of 'digital exclusion' that could affect some patients
- Deliver an enhanced approach to innovation, research, and development
- Continually improve our infrastructure including estate, environment, and equipment to provide the best possible facilities for patients
- Improve access to information to support local decision-making
- Take a system approach to planning services with our partners
- Ensure patients are empowered to take control of their health
- Deliver our Green Plan
- Develop our role as an 'anchor institution'.

Our roadmap for success

Our three-year roadmap, 'recover, renew, reimagine', outlines some of the defining activities we must start in each of the next three years of our strategy.

We will use 'recover, renew, reimagine' in our internal communications to help describe to our colleagues what we are doing, when we are doing it, and how we are progressing.

Recover

- Deliver significant improvements in quality and performance
- Deliver priority improvements for our valued colleagues
- Establish long-term change projects and launch our approach to continuous improvement
- Embed our Trust-wide approach to efficiency and productivity
- Refresh our strategies and plans.

Renew

- Launch high impact service changes for those patients with the greatest needs
- Launch services to help shift care 'closer to home'
- Accelerate adoption of digital technologies
- Develop new ways of working with our partners to enhance collaboration
- Deliver a near-balanced financial position.

Reimagine

- Scale-up new services to improve outcomes and manage demand
- Embed new ways of working with our partners
- Deliver a digitally advanced organisation with modern working practices
- Commence construction of our new hospital
- Deliver a balanced financial position.

2025 - 2026 → 2026 - 2027 → 2027 - 2028

Our values and behaviours

Our FIRST values

At the heart of WSFT are shared values that guide everything we do — for our patients, our people, and our communities.

These values are not just words; they are the foundation of our culture and the behaviours we expect from every individual across our organisation.

Fairness	We value fairness and treat eachother appropriately and justly.
Inclusivity	We are inclusive, appreciating the diversity and unique contribution everyone brings to the organisation.
Respect	We respect and are kind to one another and to patients. We seek to understand each other's perspectives so that we all feel able to express ourselves.
Safety	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.

The FIRST values are borne out of our commitments to equality, diversity, accessibility and inclusion for every person connected to the Trust. Our ambition is to truly live these values every day, in every way, and through this becoming the best place to work and receive care in the region.

Our values guide how we treat people and how we work together as one. They influence how we respond to adversity, how we learn from mistakes, and how we celebrate success. At times we may need to make difficult decisions, we may need to change direction, and we will need to respond to unexpected challenges. By championing a culture where the right behaviours are recognised and reinforced, we create the conditions for safer, more compassionate, and more effective care.

We are committed to placing values and behaviours at the centre of our strategy — not as a separate initiative, but as a golden thread running through every action and decision we take. It is through living our values every day that we will build the kind of Trust we all want to be part of for the communities we serve.

Values and behaviours framework

	How this feels	How we behave
Fairness	• We are treated equitably, not identically • We neither benefit nor suffer from favouritism • Our access to development and progression is based on merit.	• Respect differences and value diversity • Speak up to address unfair behaviours or treatment • Consider how our actions affect others.
Inclusivity	• Equality, diversity and inclusion is supported actively • We listen to and learn from colleagues lived experiences • Everyone feels valued and able to contribute fully.	• Support inclusion and a sense of belonging for all • Recognise and celebrate different perspectives • Continuously develop own understanding of bias and inclusivity.
Respect	• Civility and respectful behaviour are promoted within and across teams • Colleagues and patients feel heard • Diverse thinking and differing perspectives are welcomed.	• Treat others as they wish to be treated • Show respect and care to colleagues, patients and families • Help each other during challenging times.
Safety	• We feel pride in the care we provide • Our health and wellbeing is an organisational priority • We feel safe voicing concerns and promote a culture of improvement rather than blame.	• Work safely following guidelines and instructions • Support new ideas and ways of working, being flexible in approach • Speak up and report unsafe behaviours.
Teamwork	• We are supported and encouraged to work together • We have a shared purpose • Working with wider teams and health systems can help us achieve better outcomes.	• Support others helping those who are struggling • Value and seek input from all team members • Celebrate success and achievements and build a positive team spirit.

NHS
West Suffolk
NHS Foundation Trust

Thank you to all patients, colleagues and partners who supported the development of this strategy through a questionnaire and/or focus groups.

West Suffolk NHS Foundation Trust
Hardwick Lane
Bury St Edmunds
Suffolk IP33 2QZ

2.2. Future System board report (ATTACHED)

To Assure

Presented by Ewen Cameron

Trust Board	
Report title:	Future System Board Report
Agenda item:	Future System Board Report
Date of the meeting:	September 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, has been confirmed in writing but remains commercially sensitive[1].

Since receiving this formal notification of budget, the team have worked with NHP to develop and agree a complete schedule of accommodation (SOA) which has been massed and stacked[2] in accordance with the latest Hospital 2.0 design standards.

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

[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] The schedule of accommodation defines the sizes of each room type and how many of each type we require. The massing and stacking report defines how these room types are positioned relative to each other and, therefore, the broad mass of each department.

Having agreed the SOA, the next task has been the drawing of these services to the 1:200 level.

This activity is aided by standard departmental templates developed by the New Hospital Programme (NHP). These templates have been developed with both technical and clinical input from across the NHS and draw upon best practice from recent builds as well strategic future direction for example the NHS 10-year plan.

Whilst accelerating the overall design process, the application of these templates requires a degree of local contextualisation to reflect a hospital's unique service mix and demand profile.

West Suffolk remains a pathfinder within the NHP and has enjoyed significant support from the national team, ensuring we both learn from the first application of this design system.

This support has culminated in a number of multi-disciplinary "scrums" that have facilitated detailed debate and the prompt agreement of solutions that allow WSFT to meet its specific local needs whilst complying with the standards of the H2.0 design.

An example is provided by the design of the new Critical Care Unit.

The standard design allows for 16 bedrooms, isolation lobbies, donning and doffing space etc.

The local design requirement within the SOA identifies the need for 12 bedrooms (including 2 x isolation bedrooms), an overnight room for patient relatives, a family lounge, a seminar room etc.

The solution to provide these extra rooms whilst remaining within the budgeted space and complying with H2.0 standards is to re-purpose the 4 "extra" bedrooms.

This example is then repeated across the other standardised departments.

This design process is expected to culminate in an agreed set of RIBA2 drawings by the end of September.

As part of the design process a team, representing the clinical, communications, digital and technical workstreams of the Future System Programme visited the prototype of the single bedroom / en suite that has been established by NHP. The feedback was positive, and the visit reassured the team that the room has been designed with clinical need and the delivery of care as the primary goal. A more detailed report will be produced in the coming weeks for broader communication and discussion.

Communications and Engagement

Given our commitment to co-production as the foundation ensuring patients and staff actively contribute to the design of our new hospital, we have developed a targeted process for sharing and gathering input on the RIBA2 designs. This includes:

1) Inviting co-production leads, Trust Executives and ADOs to engage in design discussions with the NHP clinical team.
2) Securing dedicated slots at divisional boards to present proposed designs.
3) Keeping all staff informed through established internal communication channels, including the "all staff update" and GreenSheet.

While we continue to work closely with our retained co-production leads (one per department), expanding engagement through the divisional boards will help deepen and broaden awareness and participation across the organisation.

This process has driven significant reconsideration of the outpatient's department, a clear indication of its effectiveness.

Project Plan

The snap-shot below highlights:

1. The re-work of our RIBA2 designs remains on track for completion in September.

2. The RIBA3[3] design process (taking designs down to the 1:50 level) will overlap with RIBA2 to ensure we have the detailed information required for a timely and successful reserved matters (full planning) application. To preserve our outline planning permission, our reserved matters (full planning) application must commence at the beginning of May – this is critical.

3. The development of our Outline Business Case (OBC) is progressing strongly. Utilising a template provided by the national team, the FSP team have produced a detailed schedule of when specific chapters within the case will be produced and submitted for NHP approval / comment. This process of "progressive review" will maximise the likelihood of the full case being compliant whilst minimising the time required for authorisation. The project team and its NHP colleagues have already completed 8 "multi-disciplinary check-ins" (MDCI) and have 2 more are planned before December. Once these meetings are completed, the agreed content will be assembled into the final OBC and submitted for formal authorisation.

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

Commercial

The procurement of a main contractor is being progressed nationally via the Hospital 2.0 Alliance Framework which has been launched and 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 West Suffolk will have secured a construction partner significantly in advance of both the commencement of the RIBA4 design phase (allowing early engagement) and the writing of the full business case.

The procurement process is progressing strongly and the FSP team have provided two of our subject matter experts (technical and digital) to participate in the assessment of tender responses. This provides us with an early sight of applications and input into ensuring the most capable providers are selected. It also allows us to get closer to the terms and conditions of the contract which will determine the working relationship between the supplier and Trust.

To further prepare the Trust for the prompt adoption and effective management of the supply contract, legal advice has been sought from Capsticks and a Board Development Session is being scheduled during which the terms and implications of the contract will be discussed. The fact that the contract is based upon a standard New Engineering Contract (NEC) means the terms are largely tried and tested, however, there are adjustments that have been made and it is important that the Trust are fully sighted on any potential risks.

[3] 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.

The agreement dictating the relationship between the Trust and NHP has now been fully agreed and signed by the Trust.

All in all, this represents solid and constructive commercial progress and is a great example of the programmatic benefit being provided by the NHP.

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.

Outside of capital affordability, the Trust continues to work with its ICB colleagues to assess and understand the sustainability of its current and future operational costs. Given the fact that any new hospital will increase capacity, the Future System Team are working to ensure the implications and benefits of a new hospital are fully understood and reflective of any changes to our established clinical model. The issue of future affordability has been recognised by the national NHSE finance team with a resolution expected in time for the submission of our outline business case[4].

Decisions taken at Scheme Executive Programme Board

The Scheme Executive Programme Board (SEPB) is an integral part of the governance system that has been designed to provide Trust Executives and Non Executive Directors with detailed visibility of progress whilst ensuring any necessary decisions receive appropriate independent debate and scrutiny. The most recent meeting was held on 9th September and the following decisions were taken:

- The recommendation to retain the helipad in its current location and provide secondary transport via a Trust operated ambulance was accepted. All future developments of the Helipad (e.g. commencements of night flights) would be managed by the Trust as business as usual.
- The UKPN business case for the upgraded power supply necessary for the construction and operation of the new hospital was agreed by the SEPB. The case will now progress to NHP Investment committee and once agreed will ensure timely provision of essential electricity supply to the new hospital.
- The strategies, changes and measures within the Target Operating Model[5] were accepted as representing an appropriate direction of travel.

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

- Complete RIBA 2 design and report (September 2025)
- Commence RIBA3 design (September 2025).

[4] When a Trust receives capital from Government, it has to repay the money at a rate of 3.5% a year, as soon as the new asset becomes operational. The chare is known as the Public Dividend Capital (PDC) and is recycled by Government to fund other capital projects. In the case of WSFT (and every scheme in the NHP programme) a charge of 3.5% on £1.295bn would be unaffordable, hence, the 3.5% could be reduced or it could be delayed until benefits have had time to materialise.

[5] The Target Operating Model (TOM) describes the way in which the future hospital will operate. It consists of 14 strategies, a description of the planned / necessary transformation, associated enablers and measures for the success of the implementation. The TOM is aligned with the work of the Trust Transformation Team who remain accountable for overseeing its timely delivery.

- Transformation – continue plans for the delivery of the Clinical and Care Strategy and draft an operational readiness plan.

- Continue to work with co-production teams on the refinement of scale and layout of individual departments.

Action Required

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

Risk and assurance:	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 fully inclusive co-production.
Sustainability:	The design and business case reflect and support the outputs from the recent 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:	
Date of the meeting:	
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 08 July and 09 September
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
Equality, Diversity and Inclusion:	Health Inequalities is reported to the HIPPC Committee in the ICB. 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 08 July and 09 September**
2.	**START WELL**

2.1	**Neurodiversity update** **Context** • Demand remains high post-pandemic, with rising Special Educational needs and Disabilities (SEND) assessments, reduced consultant capacity (down 57%), and growing links to complex care and safeguarding. • While Barnardo's backlog is cleared, Children & Young People's (CYP) are now entering the Norfolk & Suffolk Foundation Trust (NSFT) autism spectrum disorder (ASD) queue. Preschool referrals are high, school-age rejection rates persist. The waitlist stands at 205 CYP, averaging 29.7 weeks. • It is noted that half of school-age referrals are assessed as inappropriate by providers, suggesting the need for greater clarity on the options and suitability of each path for schools, Special Educational Needs Coordinators (SENCOs) and other family facing health professionals **Improvement plans** • Right to Choose enables families to access private providers. The ICB has run a tender process for school-age Right to Choose providers which closes on 13 September. This will enable a refreshed accredited provider list, focusing on end-to-end quality. • Clarify pathway options for professionals including exploration of digital tools and a single referral route to improve access and coordination.
3	**FEEL WELL**
3.1	**Adult Attention Hyperactivity Disorder (ADHD)** • Demand has been rising - driven by public awareness and post-pandemic effects – and now significantly exceeds capacity. This is replicated nationally. • 47 GP practices are withdrawing from shared care agreements in Autumn 2025. This change is being managed through emergency prescribing via GP Federations and increased services by Care ADHD, but challenges remain, including long waits, up to three years for ADHD and 2.5 years for adult autism. • The SNEE NDD Taskforce (July–November 2025) is working to improve coordination and oversight. Priorities include implementing digital referrals, defining the Right to Choose framework, and strengthening regional collaboration.
4.	**BE WELL**
4.1	**JOY implementation** The alliance has commissioned this new digital service which enables access for residents and health and care professionals to the full range of VCFSE and statutory support offers in the community. It has been successfully evaluated in Cambridgeshire and Norfolk and is supported by all partners including Suffolk County Council. It uses AI technology to support partners to keep information up to date and report on usage levels and service gaps. The new West Suffolk service launched 4 Sept.
4.2	**High Intensity Users** The Committee gave approval for a business case for a High Intensity User (HIU) service to support a caseload of around 30 individuals who are identified as having very high levels of attendance at health and care services (e.g. analysis identified 29 individuals in West Suffolk costing £916K annually). The business case builds on national evidence supporting targeted 1:1 coaching model. In giving its approval, the Committee sought further assurance on: • Confirm inclusion of all on-costs in commissioning • Clear criteria to enter and exit the service

4.3	**Social Prescribing Strategy** The HIU service is one part of the overall pattern of social prescribing in West Suffolk including: PCNs, Citizens Advice (universal and intensive support); INT coordinators; Lifelink; Abbeycroft leisure. The ICB alliance team are working with partners to review the optimum pattern of social prescribing service and due to report November 2025.Be
5	**AGE WELL**
5.1	**Dementia Memory assessment service update** West Suffolk population access to dementia diagnosis is significantly below comparative populations. Current position: - 762 patients on the NSFT dementia diagnosis waitlist - Average of 64 referrals per month and 59 assessments per month (Jan–Aug 2025). Service delivery has been affected by staff sickness, vacancies, and onboarding delays. Progress has been made through increased staff stability and new roles have joined the team increasing capacity. Further improvement is planned by • Increasing assessment capacity to 112/month from December 2025. • Service improvements underway include: • Refreshing referral template working with GPs/LMC • Enhanced waiting list management including DNA reduction • Exploring increased efficiency including digital tools and benchmarking. • Integrating approach to frailty pathways is also under consideration.
5.2	**Suffolk Family Carers Respite on Prescription Contract Extension** The Respite on Prescription scheme commissions Suffolk Family Carers to enable essential support to unpaid carers by funding respite care to enable attendance at medical appointments. WSA has funded the scheme with £10,000 annually since 2021, supporting an average of 13 carers per year to access critical procedures. The Committee agreed to extend contract for 2 years.
6.	**STAY WELL**
6.1	**Winter Planning** The Committee approved the 2025/26 Winter Plan. The Plan was developed in alignment with NHS England's Urgent and Emergency Care priorities, the plan reflects a collaborative, system-wide approach across all Alliance partners. The Committee also supported the proposal to fund increased primary care capacity over winter months to respond to surges in demand for respiratory conditions, based on experience in previous years. It was proposed to use anticipated underspend from the Additional Roles Reimbursement Scheme
7.	**DIE WELL**
7.1	• End of year report: 2024/25: 1,158 EoL patients; 17% with ReSPECT forms. • Overnight care pilot delivered; • My Care Wishes (MCW) in use. • 2025/26 Planning: • Launch EoL Support Line • Expand overnight care to 7 days • Implement My Care Choices as an electronic platform to enable system-wide access to ReSPECT and patient and carer experience and achievement of plan. • Ensure MCC supported by local GP enhanced service contract to identify and upload end of life plans.

8.	**LOCALITY**
8.1	Haverhill Locality team update • Locality has decided to use health equity funds to create Haverhill Healthy Living Centre using old GP site. • Noted that Haverhill marketplace events had proved a very effective method for connecting and communicating local community support offers. This was commended in annual SNEE Awards • Noted direct bus route to West Suffolk Hospital has been launched and was highly valued • The team sought Committee support in promoting events, raising awareness of agency support, and engaging with PPG and VCSFE colleagues. Key actions include continuing work to improve transport links, securing café support for Health & wellbeing centre, connecting dental practices, and strengthening DWP engagement.
9.	**SYSTEM MEDICINES OPTIMISATION GOVERNANCE UPDATE**
9.1	Committee supported establishment of the Suffolk and North East Essex Integrated Medicines Optimisation Committee (SNEE IMOC) as a system-wide decision-making body across SNEE, ESNEFT, WSFT, and NSFT. Key governance changes include expanded membership with voting rights for primary care, and inclusion of consultants and a patient representative. IMOC will centralise medicines governance, replacing fragmented decision-making, and report to the ICB Financial Performance Committee for enhanced budget oversight. All submissions will require prior governance approval. Phase one of the structure has been approved, with further engagement planned with WSFT Drug Group.
10.	**Care Management Service**
10.1	The ICB is progressing the commissioning of a care management service (CMS), following the recommendations of the Sustainability Review undertaken by McKinsey. Two commissioning models are under consideration: - A single pan-Suffolk CMS led by one provider. - Multiple CMSs at the alliance level under a unified commissioning framework. The high-level draft specification sets out the following: • That the CMS is likely to be one of the first of its kind to be commissioned in the UK • The focus of the CMS on the 1% of the population (10,000 people at any given time) who use 60-70% of non-elective acute bed days • The CMS will include six types of activity: 1. Care planning 2. Care coordination 3. Frequent touchpoints 4. Rapid response 5. Discharge planning 6. Remote monitoring • It is not intended that the CMS duplicates existing services, however, this is a completely new way of identifying the target cohort, and co-ordinating and delivering interventions • The CMS will require integrated working across primary care, acute, community, mental health, social care, hospice, VCFSE • A range of suggested roles within the CMS and enablers are listed, to be determined by provider(s) and the delivery model(s)

	• Proposed benefits are outlined, including reduction of non-elective bed bays for the target cohort Provider stakeholders have been progressing a response and proposal for the delivery of the CMS with the intention that commissioning decisions and investment plans are finalised by the end of September.
4.	**Next steps**
5.	**Conclusion**
6.	**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:	
Date of the meeting:	26 September 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 and maintaining a supported technical infrastructure.

The key focus for the past two months is improving governance, standardisation of processes and optimising our workflows, as well as focusing on how we can support our staff with digital initiatives.

Following the last digital board meeting, it has been proposed to amend the purpose of the digital board to act as an assurance committee, in line with the 3 I committees with a more agile decision-making committee meeting more regularly.

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

It is essential that we continue to maintain a supported technical infrastructure in order to reduce the risk of cyber threats, maximise the up-time of our systems and maintain functionality for our staff and patients so progressing with key upgrades in our digital programme is important.

The launch of the artificial intelligence (AI) policy is a key step in providing direction and guidance for our staff who are using AI tools in the workplace.

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

Following approval of the changes to digital board, this will be finalised at digital board in October, with full implementation by the January 2026 meeting.

Action Required

The board is asked to note the update and provide approval for the changes to the digital board structure.

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. The proposal regarding the changes to digital board strengthen our assurance processes for the digital and data programme.
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 (cyber), DCB0160 clinical risk management, DCB1596 secure email etc.

Digital board feedback

1	**Key areas of focus**
1.1	**Digital programme FY25/26** During late July and August, we have completed several system upgrades which have moved them onto cloud infrastructure and the most up-to-date 'code'. This includes Totara, our online learning management system, and the fetal monitoring system used in maternity. We have secured capital and revenue funding for a major upgrade to one of our technical infrastructure systems. **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 over 92% compliance achieved.
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. The group has now reviewed the backlog of decisions and are now working in real-time. Requests for digital input into ICS and system-wide projects is also being funnelled through this process to ensure parity for all requests.
1.3	**Cyber and information security** The cyber hygiene report and SIRO (senior information risk owner) report are presented at closed board due to the sensitive nature of the contents.

	The cyber hygiene report is also reported to the information governance steering group for ongoing visibility and discussion.
1.4	**AI (artificial intelligence) policy** Digital services has led the publication of the Trust's AI policy. This has been written in conjunction with technical teams, clinical, operational, organisational development and EDI colleagues to ensure that the approach that WSFT takes to the use of AI is multifaceted. The policy establishes a clear framework for the development, implementation, and monitoring of AI systems within the Trust, including: • Protecting personal data • Upholding ethical standards • Supporting diversity and inclusivity • Mitigating potential risks It defines key areas of focus which include: • The general use of AI within the Trust (including ambient listening tools) • Developing AI products for healthcare • Using AI in clinical and operational settings • Using AI in non-clinical settings • Using AI for research • Reasonable adjustments and accessibility The aim is to give staff easy access to understand the AI solutions that are in use in the Trust, and the appropriate use cases for each of them. It is likely that this list will change regularly given the focus on AI deployments from NHS England and consideration of how we can use AI-enabled tools to enhance productivity.
1.5	**Digital accessibility and inclusion working group** A new working group has been established to lead, advise and support the Trust in improving digital and online accessibility across all our platforms and services. This is a joint piece of work between digital services, the Future System (new hospital) digital team and organisational development. The group will ensure that digital services are inclusive, usable and accessible to all users, including those with disabilities or additional access needs, in line with all legislative requirements. It is a multidisciplinary group and includes representation from external organisations that focus on this theme. It will include work to improve knowledge sharing, compliance with legislation, digital skills and confidence, procurement and design decisions. It is being chaired by Nicola Cottington (chief operating officer) or Sarah Judge (chief information officer).
1.6	**Proposal to amend the purpose of the digital board** The digital board was established as a programme board in 2014 as part of the planned Cerner Millennium electronic patient record ("e-Care") implementation. It continued its use as a programme board whilst WSFT was participating in NHS England's Global Digital Exemplar (GDE) programme. The purpose of the digital board is twofold: 1. To provide assurance to the Trust board that the digital programme is delivering on the Trust's strategic direction, to time and budget, and 2. To provide programme and project decision making at an executive level as per standardised project management methodology.

	The digital board meetings are held quarterly and so decision making may be delayed or exceptional meetings stood up for more urgent decisions. It is currently chaired by the chief executive, with executive directors and a non-executive director attending. It is proposed that the digital board moves to focussing on assurance, similar to the 3 I committees. It will continue to receive updates from the steering groups that report into it, governance updates, and reports on compliance and accreditations. It will continue to report into Trust board. It is proposed that the digital board is chaired by a non-executive director, in line with the current 3 I committees. In addition, the digital board moves to formally include the business intelligence service and become the 'digital and data board'. In addition, a new and smaller decision-making group ("digital and data programme board") will meet monthly and act in the capacity of a programme board for project escalations requiring senior decision making, with a summary of decisions being presented at the digital and data board for oversight. Attendance on this group is yet to be formalised but will be executive led and include clinical and operational decision makers. The programme board will have the ability to escalate decisions outside its control to the management executive group if appropriate. This has been discussed and proposed by the current chair (CEO), non-executive director, executive with responsibility for digital (COO) and chief information officer.
2	**Recommendations**
2.1	The board is asked to note the update from the digital programme and accept the proposal for amending the digital board: (a) Become the 'digital and data board' (b) Move to providing assurance on the digital and data programmes (c) Chaired by NED (d) Convene a 'digital and data programme board' for project escalations and decision-making.

Comfort Break

2.5. Joint Productivity Board (ATTACHED)

To Assure

Presented by Ewen Cameron

Public Board	
Report title:	**Productivity Board Update**
Agenda item:	2.5
Date of the meeting:	26th September 2025
Executive lead:	Sam Tappenden, Executive Director of Strategy and Transformation
Report prepared by:	Stephanie Rose, Programme Director Sam Tappenden, Executive Director of Strategy and Transformation

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

Executive Summary
WHAT? *Summary of issue, including evaluation of the validity the data/information*
The joint Productivity Board was established in July 2025 by West Suffolk NHS Foundation Trust (WSFT) and East Suffolk and North East Essex Foundation Trust (ESNEFT) to deliver the agreed recommendations from the Suffolk and North East Essex (SNEE) Sustainability Review. This report will provide an update on the progress of the Productivity Board.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
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 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 Productivity Board 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 recent Productivity Board meeting on 11th August, the Board confirmed that the collaborative will focus predominantly on high impact clinical productivity and corporate services collaboration respectively. Updates on other projects in the scope of the original Sustainability Review recommendations (e.g. implementation of a Care Management Service) will be provided to the Productivity Board on a regular basis. More detailed reports were presented to the Board updating on progress for these two key areas: **Clinical Sustainability** • An initial focus on four priority services determined by service sustainability and outcomes • The Board approved the establishment of four task and finish groups for the priority services (ear, nose and throat, stroke, urology, and paediatric orthopaedics) **Corporate Services Collaboration** • Terms of reference for this group will be shared with the Board • Scoping work is taking place at each respective Trust to identify opportunities for corporate services collaboration • A joint workforce dashboard is in development
3.	**Next steps**
3.1	• A reporting process is to be stood up for the sustainability review initiatives to report to the Joint Productivity Board • A live dashboard to be developed to track progress on clinical productivity and corporate services collaboration • Task and finish groups will be established for the four services and clinical leads identified to drive progress • Corporate service opportunities will be agreed and plans developed as appropriate for those areas in scope • Improving the working arrangements between the two organisations will be prioritised to ensure effective collaboration
4.	**Recommendations**
4.1	Board is asked to note the update from the Productivity Board and support its development to enable the delivery of the agreed Sustainability Review interventions.

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:	
Sponsor/executive lead:	Daniel Spooner, 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 April 2025.

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

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

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

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

Narrative is provided to explain what the data is demonstrating (what?), the drivers for performance, what the impact is (so what?) and the remedial actions being taken (what next?). Please note the IQPR will be refreshed in line with the new NHS National Oversight Framework. A new Trust Performance and Accountability framework will be launched in September which sets out how performance against the IQPR 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 total elective waiting list was 35, 220 at the end of July, against a planned position of 33,079. Overall RTT compliance was 2.19% behind plan at 56.27%.

- End of July 2025 position had 221 patients over 65 weeks, with this number increasing since March 2025. This volume is expected to start to reduce in August, with the aim to reach a 0 position by the end of September.
- Dermatology is the main driver for this continual increase with 158 breaches, due to the wait time for first appointment. However there were also breaches in Orthopaedics (18), Gynaecology (13), Plastic Surgery (9) and Paediatrics (9).
- The volume of 52 week waits continues to increase, with 1670 as at the end of June, against a submitted plan position of 835. The 52 week wait position is due to reduce from August 2025, when insourcing of Dermatology commences.
- The Trust is in tier 1 for elective and diagnostics with national and regional scrutiny of progress against recovery plans. A range of recovery actions are in place including a specific plan for dermatology including external triage support and insourced treatment capacity.
- Activity plans across elective, daycase and first outpatient attendances are not being met as at the end of July 2025, with the largest variance in elective at -24.1%, and 4.9% decrease in outpatient first attendances. The variance to plan for daycases improved slightly to -4.9%.
- Data-driven proposals for the recovery of both RTT performance and activity targets for the rest of the year will be considered by Management Executive Group in September.
- Cancer Faster Diagnosis Standard (FDS) performance has improved to 74% in June, and 62 day performance was also 74%, both driven by a recovery in breast service performance.
- Diagnostic performance against the 6-week standard was 44.5% in July 2025. Recovery actions, as previously agreed at Management Executive Group, continue to be implemented with the aim of achieving 82% compliance by March 2026.
- Urgent and emergency care (UEC) performance Improved in July and it back on trajectory at 74%.
- The C-Difficile improvement programme has now moved into business as usual and will be monitored through the Improvement Committee. Monthly data remains in common cause variation. Significant peak seen this month possibly driven by environmental burden of CDiff within decant ward affecting a number of clinical teams. Actions taken as described.
- Percentage of reportable harm is above national average for second month time. Collaboration with the patient safety team and transformation team will review if CIP program is impacting on this measure. Insights from this analysis will feature in the quarterly patient safety report.
- We will monitor the impact the current staffing within the PALS and patient complaints team has on performance. Recruitment into the new structure has commneced
- Appraisal participation rates are below target and decreased slightly in month to 86.7%.
- Mandatory training completion rates are special cause for concern dropping below target of 90% target.
- Staff retention remains stable with a turnover rate (9.1.%) better than the target threshold of 10%.

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 June 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.
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

NHS
West Suffolk
NHS Foundation Trust

COMMITTEE/SUBGROUPS REPORTING TEMPLATE

Originating Committee: Involvement Committee			**Reporting to: Trust Board Meeting September 2025**		
Chaired by: Tracy Dowling Non executive Director			**Date of meeting: 20th August 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
6.0	Recent announcements regarding changes to the apprenticeship levy	2. Reasonable	Work to address changes to the apprenticeship levy has stepped up and a new strategy to increase early career apprenticeships is underway. Work to address changes to Level 7 funding requirements is also in progress	Updates on progress, impacts and decisions necessary to come to future meetings	1. No escalation
6.0	Industrial action	2. Reasonable	Update received including notification of national work to protect the use of the title of 'nurse'.	Director of Workforce and Communications to maintain oversight of IR issues	1. No escalation
7.0	**First for Staff** Excellent Staff Story presentation from Hollie Royal and Human Factors Lead regarding how the organisation is learning to make reasonable adjustments for neurodiverse staff members.	2. Reasonable	The Disability Network has been working with Hollie Royal to learn from her experience of seeking reasonable adjustment to meet her needs, arising from neurodiversity.	An organisation wide policy is being developed and will come back to Involvement Committee; coaching is being developed for managers and other leads for staff engagement to build knowledge and expertise in identifying and supporting neurodiversity; the Occupational Health contract will be reviewed for meeting the needs of neurodiverse staff.	1. No escalation

Originating Committee: Involvement Committee			Reporting to: Trust Board Meeting September 2025		
Chaired by: Tracy Dowling Non executive Director			Date of meeting: 20th August 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
7.2	Equality Diversity and Inclusion Mid year Report Received from Jamais Webbsmall-Eghan	2. Reasonable	The mid year report showed progress in most areas of the action plan; however the Committee supported a verbal recommendation to step up activity in a small number of priority areas with an expectation of measurable impact by the time of the annual report	The Committee has asked for a review of priorities and the data sets used to indicate change. The Committee has asked that these priorities be the focus of the next 6 months; and that we have more focus on using data to measure impact and be assured of progress	3. To Board for a development session on ED&I as visible Board oversight and assurance is vital.
7.3	Connecting the QIA and EIA process	2. Reasonable	The QIA and EIA processes have been developed. A final step will be added to assure the QIA panel that EIAs are completed, quality checked, and required actions implemented.	Phase 2 of the digitised EIA process is launched on 1st Sept using a Power App. This process enables feedback on the completion and quality of EIAs	1. No escalation
7.5	Education and Training Report presented by Kaushik Bhowmick	1. Substantial	The Committee received a 6 month interval report which showed good progress and forward thinking regarding the impact of the 10 year plan on education and training across the Trust	Lots of positive assurance regarding quality of learning experience at WSFT. The report demonstrates clarity about where there are areas of concern and that actions are being taken; including	1. No escalation

Originating Committee: Involvement Committee			Reporting to: Trust Board Meeting September 2025		
Chaired by: Tracy Dowling Non executive Director			Date of meeting: 20th August 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
				where oversight of progress happens.	
7.6	Pulse Survey / Engagement Score Recent scores have been received and are under analysis. It is clear that staff are still feeling the impact of measures to control expenditure.	3. Partial	The executive team are considering different approaches to engagement and communication to improve the measures of engagement whilst the Trust continues to address the underlying financial position.	There is a need for wider discussion and engagement with staff to consider how the ongoing the issues impacting on morale can be addressed. This needs to be part of the Trust strategy refresh.	2. To MEG; will come back to Involvement with more data at the next meeting.
8.1	**First for the Future** Presentation from Julie Hull on the workforce content in the 10 year plan	2. Reasonable	Clarity on the next steps for making progress in line with the 10 year plan.	Further details on the actions will be developed once the 10-year plan delivery document is published.	1. No escalation
9.0	**First for Patients** Experience of care and engagement Committee Report	2. Reasonable	A detailed report outlining the scope of initiatives to assess patient experience and the measures implemented to address identified concerns.	Number of actions regarding access for those with disabilities. Further assurance needed regarding complaints management and PALS following impacts of the corporate review.	1. No escalation
9.2	**Paediatric CQC Survey** Survey results shared and good level of assurance received that outcomes are accepted and	2. Reasonable	Action plan developed from CQC and other feedback received about service users experience.	Future surveys will assess progress after delivering the action plan.	1. No escalation

Originating Committee: Involvement Committee			Reporting to: Trust Board Meeting September 2025		
Chaired by: Tracy Dowling Non executive Director			Date of meeting: 20th August 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
	actions in place to robustly address issues raised by feedback		Service to use AI to simplify information for paediatric patients.		
10.4	**Audit One well led action plan** Progress report received and noted	3. Partial	Concern raised that level of detail and complexity of this report is resulting an unhelpful level of complexity.	CEO to review and oversee streamlining so that we have clarity where standards are met, and where priority actions remain.	2. MEG to oversee before coming back to Involvement Committee.

**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?

People and OD - Putting You First

To inform

Presented by Julie Hull

NHS
West Suffolk
NHS Foundation Trust

Putting You First awards
July – September 2025 winners

Board of Directors: 26 September 2025

Putting you first

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. All 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 group 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).

Damian Towns, porter, WSH

Nominated by David Brooklyn, fire advisor

When I joined the Trust in January, I requested Fire wardens and staff who wished to assist me in a very challenging role by being my eyes and ears around the hospital. Damian volunteered and has been brilliant ever since.

He contacts me daily with issues he spots whilst Portering and is a constant source of information whilst maintaining his own duties.

He also (whilst I was on leave) ensured that the main hospital street near Joyce Parker remained clear [to allow] a grieving widow to collect her husband on the day of his funeral.

Damian always goes the extra mile.

Rachel Abbott, speech and language therapist, community paediatrics

Nominated by Laura Ellam, highly specialist speech and language therapist

Rachel has developed a bilingual assessment guidance manual for speech and language therapists including working with interpreters from referral to report.

Rachel has written and delivered training to the community paediatric speech and language therapy team to introduce this manual. Producing it has been a massive project for her, including information on assessment, therapy and linking theory and evidence into practice.

Rachel's work will ensure that as a team we meet the needs of bilingual children and families on our caseloads. It will also ensure that assessment and therapy is equitable and accessible. Rachel's tremendous efforts on this project will be of benefit to the whole of our community paediatric speech and language therapy team. She has also produced amazing assessment templates, guidance and information on language acquisition in multiple languages including the high-frequency languages that we see within Suffolk. Rachel is now developing a top tips therapy document, and further resources for therapy, and is planning further training in this area for the team.

The Trust values of Fairness, Inclusivity, Respect, Safety and Teamwork are evident throughout this project and Rachel's dedication, drive and passion to ensure we are meeting the needs of the bilingual children and families we work with. This project has also ensured the Suffolk paediatric speech and language therapy team is able to provide a service that reflects the Royal College of Speech and Language Therapists' guidelines and HCPC standards for working with bilingual children and families.

Thank you Rachel!

Rosie Cawston, G4 ward manager

Nominated by Louise Harper, senior matron

Rosie has faced an unexpected loss of a team member; this has sent shock waves through the team and has been a challenging time for the G4 team and wider trust. The loss of our team member has caused a great deal of distress.

Rosie stepped up to this responsibility with such compassion and devotion to her team. She ‘boxed’ her own grief to support others and ensured patient safety.

Rosie spent many hours of her own time over the weekend of the incident providing face to face support on the ward, including remote support to her team and the wider organisation.

I am in awe of Rosie. She has an amazing level of emotional intelligence and has most definitely gone above and beyond in her role, and I will be forever thankful to her.

Teresa Worley, cardiology nurse specialist, cardiac rehab team lead

Nominated by Monika Kovacic-Graham (admin support worked) and the cardiac rehab team

Teresa took over the role of cardiac rehabilitation team lead in challenging circumstances and, despite these, has led the team with clear direction and efficiency.

She has led throughout staff changes and the movement of our service into the community from the hospital for the last two summers and has been pivotal in helping us as a service to achieve accreditation with the Cardiac Rehabilitation Team National Audit.

Teresa uses both her roles as cardiology nurse specialist and cardiac rehabilitation team lead to enable us to deliver high quality care for our patients. She never turns anyone away who asks for help and goes above and beyond for our patients.

We would like to acknowledge her skills and dedication with this nomination and show our appreciation for all she does.

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

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			Date of meeting: 20th August 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 4 Reporting** At month 4 the Trust was reporting a £0.7m under spend year to date against plan. The year to date target for CIP was £6.2m million and this was broadly achieved, through withheld vacancies and other actions over and above those captured within the core CIP schemes. Most of the CIP programme is phased for later in the year and achieving the planned deficit continues to be a challenge for the organisation.	**3 Partial**	Cash balances are healthy but the trust is likely to require cash support for the last six months of the financial year. It is good to see the progress made to date. The CIP programme monthly targets ramp-up significantly through the rest of the year and remain a risk.	Delivery of the CIP programme needs continued focus – see below	3.Escalate to Board for information

Cost Improvement Programme (CIP) delivery	At month 4 the CIP programme was broadly on target but the overall gap in the portfolio has reduced to 80% of the target compared to the 92% reported to the August Committee. A gap of £9.7m of weighted CIP remains. Other savings are being pursued that are not currently on the tracker and some costs will drop out such as the end of the PA consulting contract. The material delivery risks remain as previously reported.	**3 Partial**	The high value programmes where there is significant risk of delivery continue to be corporate services, clinical productivity and commercial.	Further work is on-going to develop 'stretch' CIPs; the executive team have approved several schemes to proceed, halted some due to safety risks, and continue to develop others. Any controversial schemes will need discussion with SNEE ICB.	3 Escalate to Board

PAGG/IQPR	**Urgent and Emergency Care** In June four-hour performance decreased to 71.28% against the trajectory of 75% dropping below trajectory for the first time this year in a challenging month across urgent and emergency care. Other metrics were also below target. Ambulance handover in 30 minutes dropped to 89.74%, not meeting the 95% target. The number of 12 hour stay breaches was 452 compared to 237 in May. Non-admitted performance was 82.46% In June missing the target of 85%.	**3 Partial**	Not meeting urgent and emergency standards means some patients are waiting longer in the Emergency Department than they should be. In June patients were waiting longer than the Trust planned and more were nursed in escalation areas.	There is a continued focus on the UEC recovery plan which includes: Weekly performance meetings with the Emergency Department and Medical Division senior leaders/Executives. Implementation and monitoring of the cross-divisional workstreams of both the UEC and taskforce projects. Continued focus on length of stay reductions to support flow out of the Emergency Department There are also plans to trial an Ambulatory Care Unit within the emergency department footprint.	3. Escalate to Board for information

PAGG/IQPR	**Elective Recovery** For elective care the number of patients waiting over 65 weeks increased in June to 135. This was mainly driven by dermatology. The volume of 52 week waits also continued to increase with 1,573 as a the end of June against a submitted plan position of 835. The total waiting list was 35,129 at the end of June.	**3 Partial**	There is a risk of patient harm if patients are not treated in a timely way. Declining performance in elective recovery against the submitted trajectories has led to the trust has been put into national tiering at Tier 1.	Seven specialties have been identified as those where the impact will be greatest, having high volumes but low Referral to treatment performance. An external validation and triage process is to start in August to assess the waiting list. This will need to be discussed with primary care colleagues following concerns that this would shift activity back into the primary care community that they are then unable to deal with. There will be additional sessions to clear the backlog in plastics in July and August. Regular meetings will be held with regional NHSE to monitor the Trust's recovery plans. Insight Committee will continue to monitor progress.	3 Escalate to Board

PAGG/IQPR	**Cancer Targets** Cancer faster diagnosis standard performance dropped in April and May driven by capacity issues in the breast pathway. Breast performance was below 15% in both months due to lack of radiology support to support the one-stop clinics. 62 day performance dropped in May to 68% this was due to performance in breast and lower GI. The Executive anticipate performance will recover during July and August.	**3 Partial**	Due to the challenges in breast there is a continued risk to the faster diagnosis standard and 62 day performance.	The Trust has committed to achieving the 62-day standard (75%) and Faster Diagnosis Standard (FDS) (80%) for 2025/26. Gynaecology, skin and lower gastrointestinal (LGI) are the areas of focus for transformation.	3 Escalate to Board

Diagnostics	The IQPR showed that in June performance increased slightly to 44.6%. The Community Diagnostic CDC contract (CDC) is currently underperforming meaning a risk of ERF clawback	**3 Partial**	Longer waiting times for diagnosis and treatment have a detrimental effect on patients. The risk to further progress is the Trust's ability to recruit staff with the skills required. Under performance in diagnostics against the submitted trajectories has led to the trust has been put into national tiering at Tier 1.	The new DEXA service went live in June which should deliver a major improvement in performance. CDC funding for temporary ultrasound staffing has been approved. A report will go to MEG on activity levels and costs in the CDC and how these are balanced	3 Escalate to MEG

Winter Planning	The Committee received a detailed report outlining the plans for dealing with increased demand during the winter. The plan was developed taking account the 25/26 winter plan checklist issued by NHSE in July 2025. These plans need to be signed off with the ICB and submitted by the 30th of September 2025	**2 Reasonable**	Failing to sufficiently plan for the winter period will increase the level of clinical risk held within the Trust, leading to a greater likelihood of poor patient outcomes and potential harm. There is a clear expectation that providers will meet the headline targets of four-hour elective 52 week an 18 week performance by March 2026	Delivery will be lead, supported and monitored through the Urgent and Emergency Care delivery group. This will be reporting to the West Suffolk alliance operational group For day to day management of issues WSFT will follow the Command, Control and Co-ordination (C3) plan across all operational states: business as usual, business continuity or critical incident, and major incident. This is led at strategic and tactical level during working hours by the (Deputy) Chief Operating Officer and Head of Operations for Patient flow respectively, and by the strategic and tactical commanders out of hours or should a critical/major incident be declared.	1 No escalation

Board Assurance Framework	**BAF 7 Financial Sustainability** The Committee noted that the mitigations in relation to Business Planning were assessed as minimal assurance. They also asked that actions were developed in relation to the quality of financial data used by the Trust.	**3 Partial**	The Trust needs appropriate business planning informed by good data to minimise its risks.	The Planned Medium-Term Strategy will help mitigate part of the business planning risk. This is due in the Autumn of 2025. The CFO to consider the data quality risks that the Trust may have an update the BAF in relation to this.	2/3. Escalate to Board and MEG

Guidance notes

The practice of scrutiny and assurance

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

*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 August 2025 (M5)
Agenda item:	
Date of the meeting:	26th September 2025
Lead:	Jonathan Rowell
Report prepared by:	Nick Macdonald

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 5 (August 2025). <u>Income and Expenditure position</u> The Trust has reported a deficit of £12.2m for the year to August 2025, which is £0.8m 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 £3.9m 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

	[Insert report title]
1.	**Introduction**
1.1	
2.	**Background**
2.1	
2.2	
2.3	
3.	**Detailed sections and key issues**
3.1	
3.2	
4.	**Next steps**
4.1	
4.2	
5.	**Conclusion**
5.1	
6.	**Recommendations**
	[Insert same wording you have on your cover sheet]

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?

WSFT Monthly Finance Report

2025-26 – August 2025 (M5)
for WSFT Public Board
26th September 2025

Putting you first

Executive Summary as at August 2025

West Suffolk NHS Foundation Trust

Summary
The Trust has agreed a £20.7m deficit budget for the year, and at month five is reporting a £0.8m 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 August 2025 (4,818 WTEs) compared to August 2024 (5,100 WTEs), a reduction of 282 WTEs. WTEs are 218.7 below the annual workforce plan as at month five, with reductions seen in both substantive and bank. Agency usage continues to be low. Since April 2024 we have reduced our staffing levels by 283 WTES (5.5%)

Revenue
The reported Income and Expenditure (I&E) for month five shows a YTD deficit of £12.2m, compared to the planned deficit of £12.9m. This results in a favourable year-to-date variance of £0.8m. The estimated impact of the pay award is reflected in both income and expenditure. Pay before pay awards continues to reduce, reflecting the reductions seen in WTE. 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 £8.0m, and this was broadly achieved with held vacancies and other actions over and above those captured within the core CIP reporting contributing to the position. Delivery of CIP ramps up through the year and therefore month five targets are comparatively low. Work to de-risk future CIP continues, with vacancy and non-pay controls remaining in place.

Cash
The cash balance as at 31 August 2025 was £11m compared to a plan of £1.1m. The remainder of 2025/26 is forecast to be difficult in terms of cash, with the forecast showing cash becoming low in October and the Trust going overdrawn in November. The Trust will require cash support for the last 5 months of the financial year.

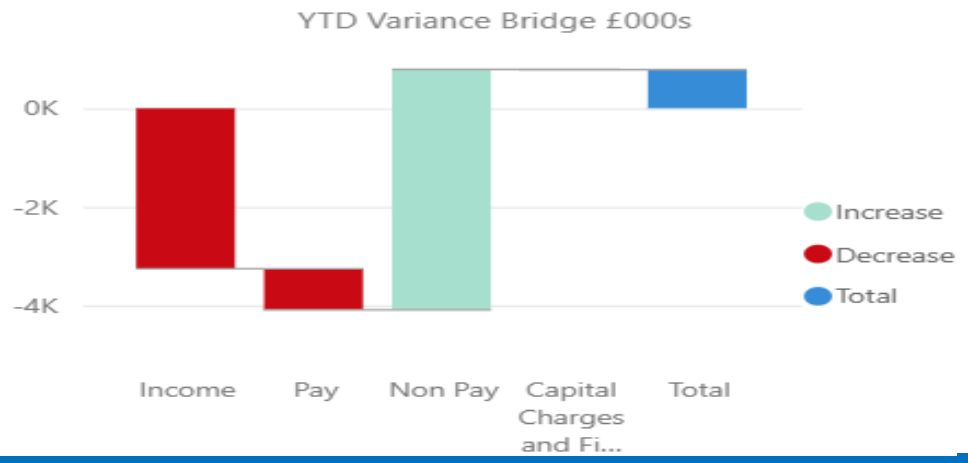
Capital
The Capital Plan for 2025/26 was agreed at £25.6m. An additional £1m of CDEL and £7.2m of PDC was awarded to the Trust in the first quarter. In month 5, PDC adjustment for the New Hospital Programme has resulted in a Capital Plan for 2025/26 of £34.6m. £11.5m of this is internally funded, with the remaining £23.1m being funded by Public Dividend Capital (PDC). Year to date capital spend at month 5 is £3.8m. This is behind the phased plan, but at this stage we anticipate that the plan for 2025/26 will be achieved.

M5 position

We are slightly ahead of plan as at M5, due largely due to reduced expenditure in line with reduced activity.

	In-Month Budget £m	In-Month Actuals £m	In-Month Variance £m F/(A)	YTD Budget £m	YTD Actuals £m	YTD Variance £m F/(A)	Annual Budget £m	Forecast £m	Forecast Variance £m F/(A)
EBITDA									
Income									
NHS Contract Income	32.1	31.9	-0.2	159.9	157.7	-2.3	385.3	385.3	0.0
Other Income	3.4	2.7	-0.6	16.5	15.5	-1.0	39.6	39.6	0.0
Total	**35.4**	**34.6**	**-0.8**	**176.5**	**173.2**	**-3.3**	**424.9**	**424.9**	**0.0**
Expenditure									
Pay Costs	25.9	24.3	1.7	128.9	125.4	3.5	310.5	310.5	0.0
Non-pay Costs	10.0	10.7	-0.8	51.0	50.4	0.5	112.1	112.1	0.0
Total	**35.9**	**35.0**	**0.9**	**179.9**	**175.8**	**4.0**	**422.6**	**422.6**	**0.0**
EBITDA Position	**0.5**	**0.4**	**0.1**	**3.4**	**2.6**	**0.8**	**2.3**	**2.3**	**0.0**
Depreciation	**1.5**	**1.5**	**0.0**	**7.4**	**7.3**	**0.1**	**17.8**	**17.8**	**0.0**
Finance Costs	**0.4**	**0.4**	**0.0**	**2.1**	**2.2**	**-0.1**	**5.2**	**5.2**	**0.0**
Impairments									
Deficit/(Surplus)	**2.4**	**2.3**	**0.1**	**12.9**	**12.2**	**0.8**	**20.7**	**20.7**	**0.0**

Deficit YTD £	**12.2M**	
Variance against plan YTD £	**0.8M**	**Favourable**
Movement in month against plan £	**0.1M**	**Favourable**
EBITDA Postion YTD £	**-2.6M**	**Adverse**
EBITDA margin YTD	**-2%**	**Adverse**
Cash at bank	**£11.0M**	



Income and Expenditure Summary – August 2025

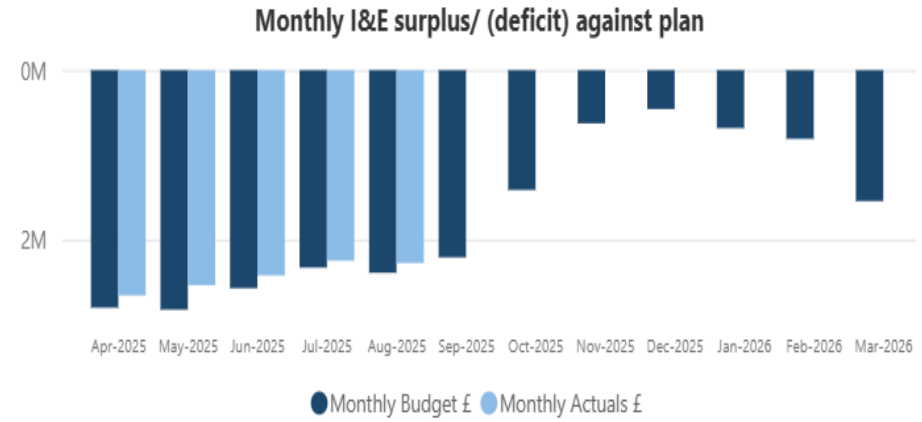
The favourable variance was £0.1m in August, £0.8m YTD. As our CIP target increases month on month this favourable variance will become harder to achieve

Board Report Item	Original Plan/ Target £000s	Actual/ Forecast £000s	Variance to Plan £000s F/(A)	
In month surplus/ (deficit)	-2,394	-2,278	116	↑
YTD surplus/ (deficit)	-12,940	-12,155	785	↑
Clinical Income YTD	159,931	157,666	-2,265	↓
Non-Clinical Income YTD	16,523	15,533	-990	↓
Pay YTD	128,893	125,366	3,527	↑
Non-Pay YTD	50,963	50,445	518	↑
EBITDA YTD	-3,401	-2,612	789	↑
EBITDA %	-1.9	-1.5	0.4	↑

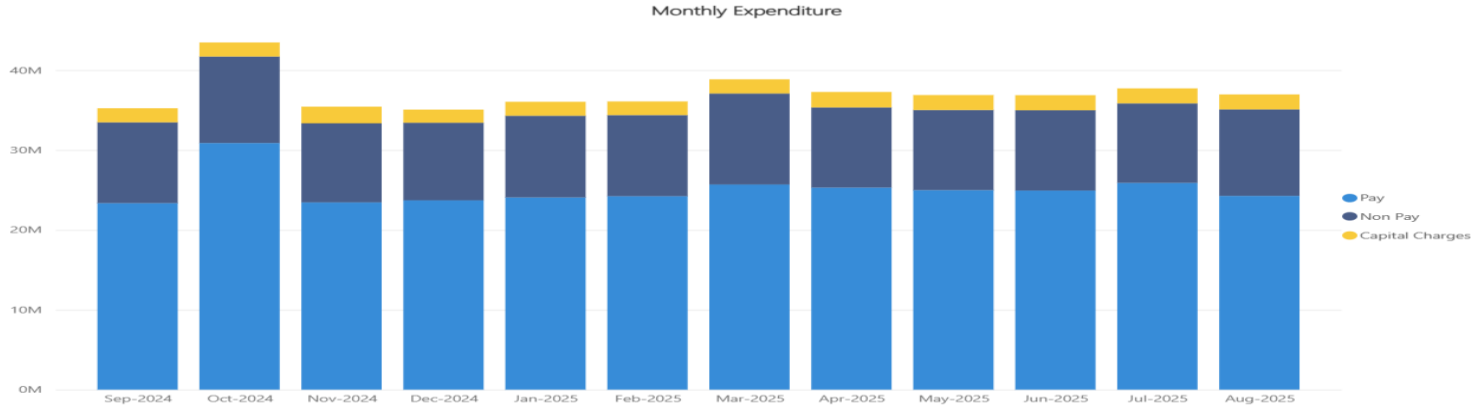
Adverse variance > 1% ↓

Adverse variance within 1% →

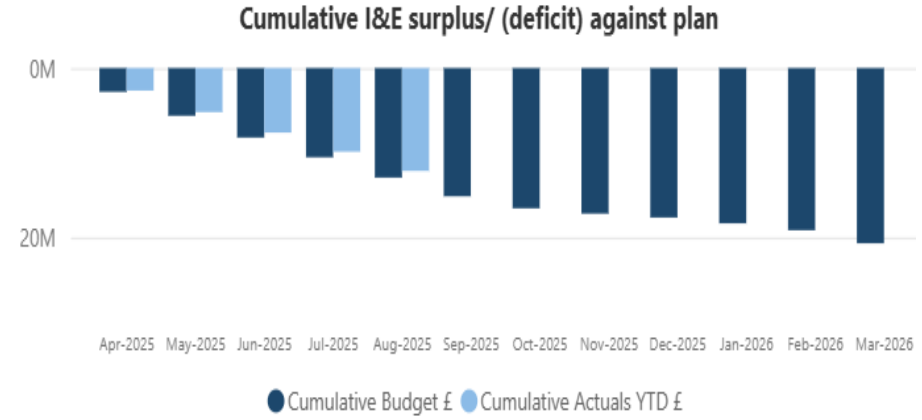
On plan or favourable variance ↑



The chart below shows the monthly expenditure over a rolling 12 months (including the impacts of pay awards and inflation)



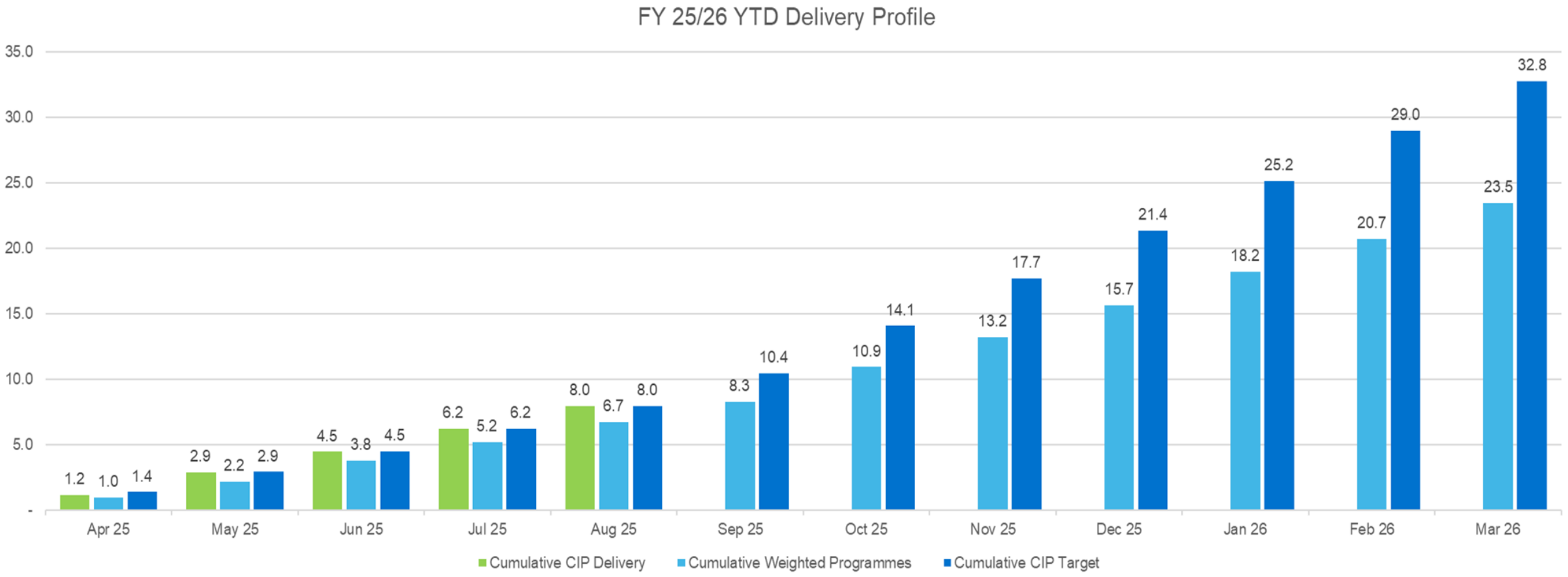
Excludes impairments and centrally funded pension contributions



25/26 CIP Progress

The FY25/26 CIP target is £32.8m. Delivery of this ramps up through the year, see graph below (H1: 32%, H2 68%).

As at M4, the Trust has delivered £8.0m of CIPs, against a budgeted plan of £8.0m, resulting in delivery to plan YTD. All reported numbers are now recorded on the CIP Tracker.



Divisional Financial Performance

Note that all of Clinical Income is held within the Corporate division. Therefore the savings associated with lower than planned activity levels are reflected in the Divisions position whilst the income underperformance is reflected within the Corporate position.

Division	In-Month Budget £000s	In-Month Actuals £000s	In-Month Variance £000s	YTD Budget £000s	YTD Actuals £000s	YTD Variance £000s	Full Year Budget £000s
Medical Services	**7,294**	**8,260**	**-966**	**39,751**	**40,939**	**-1,188**	**94,635**
Income	-363	-358	-5	-2,133	-2,090	-43	-5,089
Pay	5,542	6,294	-752	31,151	31,851	-700	73,835
Non Pay	2,069	2,278	-210	10,499	10,948	-449	25,327
Capital Charges	47	46	1	234	231	3	562
Surgical Services	**5,804**	**6,070**	**-266**	**30,436**	**30,080**	**356**	**72,438**
Income	-379	-363	-17	-1,885	-1,884	-1	-4,639
Pay	4,749	4,949	-199	24,801	24,924	-123	59,138
Non Pay	1,406	1,459	-54	7,380	6,913	467	17,602
Capital Charges	28	25	4	141	127	13	337
Women and Children Services	**2,047**	**2,031**	**16**	**11,102**	**11,177**	**-74**	**26,400**
Income	-244	-446	202	-1,218	-1,524	306	-2,924
Pay	2,129	2,334	-205	11,513	11,977	-463	27,295
Non Pay	160	142	17	798	718	79	2,007
Capital Charges	2	0	2	10	6	4	23
Clinical Support	**3,421**	**3,882**	**-461**	**19,154**	**19,607**	**-453**	**44,275**
Income	-768	-664	-104	-3,453	-2,404	-1,049	-9,726
Pay	2,881	3,204	-323	15,808	15,228	580	37,530
Non Pay	1,305	1,339	-34	6,784	6,768	16	16,436
Capital Charges	3	3	0	14	14	0	35
Community Services	**4,756**	**5,071**	**-316**	**26,314**	**26,031**	**283**	**62,143**
Income	-610	-577	-33	-2,769	-2,726	-43	-6,568
Pay	3,707	3,909	-202	20,523	20,327	196	49,040
Non Pay	1,598	1,690	-92	8,255	8,147	107	18,940
Capital Charges	61	50	11	305	282	23	731
Facilities	**1,905**	**1,696**	**209**	**9,267**	**9,052**	**216**	**22,601**
Income	-425	-365	-60	-2,174	-1,982	-191	-5,148
Pay	1,349	1,176	173	6,477	6,399	79	15,922
Non Pay	980	884	96	4,962	4,634	328	11,824
Capital Charges	0	0	0	1	1	0	3
Contract Income & Corporate	**-22,831**	**-24,732**	**1,901**	**-123,085**	**-124,731**	**1,646**	**-301,792**
Income	-32,698	-31,913	-785	-163,204	-160,944	-2,260	-391,626
Pay	4,476	2,401	2,075	14,257	14,660	-403	36,287
Non Pay	2,532	3,028	-496	12,738	12,759	-21	21,045
Reserves	1,107	0	1,107	4,362	0	4,362	11,472
Capital Charges	1,752	1,752	0	8,762	8,795	-32	21,030
Deficit/(Surplus)	**2,394**	**2,278**	**116**	**12,940**	**12,155**	**785**	**20,700**

Pay Costs by Staff Type

Note that pay costs are £1.6m lower than July due to a release of over accruals relating to the pay award which was paid in August (£423k). July was also exceptionally high due to back dated pay awards that were accrued (£1.1m).

		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	6,258	5,829	6,509	680	29,855	32,598	2,744
	Nursing	8,664	8,197	8,957	760	41,981	44,756	2,775
	Sci & Professional	1,240	1,165	1,262	98	5,874	6,318	444
	A&C	3,780	3,616	3,893	277	18,411	18,931	521
	AHP	2,520	2,438	2,694	256	12,363	13,420	1,056
	Prof & Tech	247	242	266	25	1,207	1,302	95
	Support Staff	948	783	936	154	4,345	4,531	186
	Other	501	195	601	406	2,527	2,969	442
	Unallocated central funding	0	0	291	291	0	1,446	1,446
	Total	24,158	22,463	25,410	2,947	116,563	126,271	9,708
Additional Medical Sessions	Medical Staff	284	343	177	-166	1,415	887	-528
	Total	284	343	177	-166	1,415	887	-528
Bank & Locum Staff	Medical Staff	420	487	164	-323	2,117	814	-1,303
	Nursing	579	527	27	-500	2,966	135	-2,831
	Sci & Professional	18	18	2	-16	96	11	-85
	A&C	31	39	8	-31	204	30	-174
	AHP	12	9	1	-8	65	5	-60
	Prof & Tech	0	1	1	0	3	4	1
	Support Staff	187	143	142	-2	878	702	-176
	Total	1,246	1,224	344	-879	6,328	1,700	-4,628
Agency	Medical Staff	102	156	0	-156	589	0	-589
	Nursing	0	0	0	0	24	0	-24
	Sci & Professional	0	0	0	0	0	0	0
	A&C	6	7	0	-8	15	-2	-16
	Prof & Tech	19	27	0	-27	116	0	-116
	Support Staff	0	0	-2E-5	-2E-5	-8	0	8
	Total	128	190	0	-190	735	-2	-737
Overtime	Nursing	24	23	1	-22	97	3	-94
	Sci & Professional	6	7	0	-7	39	0	-39
	A&C	8	-12	7	19	32	33	1
	AHP	23	16	0	-16	97	0	-97
	Prof & Tech	11	13	0	-13	61	0	-61
	Total	72	47	8	-39	326	37	-289
Total		25,889	24,267	25,940	1,672	125,366	128,893	3,527

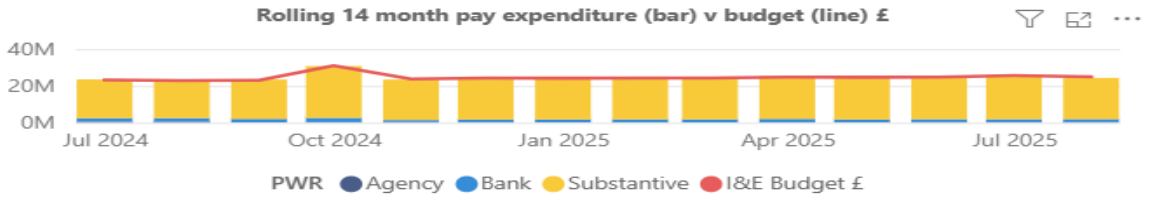
Pay Costs (by Staff Group)

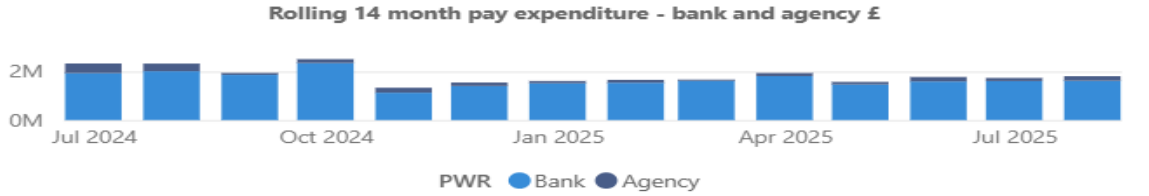
		Prior Month Actuals £000	In-Month Actuals £000s	In-Month Budget £000s	In-Month Variance £000s	YTD Actuals £000s	YTD Budget £000s	YTD Variance £000s
Medical Staff	Substantive	6,258	5,829	6,509	680	29,855	32,598	2,744
	Additional Medical Sessions	284	343	177	-166	1,415	887	-528
	Bank & Locum Staff	420	487	164	-323	2,117	814	-1,303
	Agency	102	156	0	-156	589	0	-589
	Total	7,065	6,815	6,850	35	33,975	34,298	324
Nursing	Substantive	8,664	8,197	8,957	760	41,981	44,756	2,775
	Bank & Locum Staff	579	527	27	-500	2,966	135	-2,831
	Agency	0	0	0	0	24	0	-24
	Overtime	24	23	1	-22	97	3	-94
	Total	9,267	8,747	8,985	239	45,067	44,894	-173
Sci & Professional	Substantive	1,240	1,165	1,262	98	5,874	6,318	444
	Bank & Locum Staff	18	18	2	-16	96	11	-85
	Agency	0	0	0	0	0	0	0
	Overtime	6	7	0	-7	39	0	-39
	Total	1,264	1,189	1,265	75	6,008	6,329	320
A&C	Substantive	3,780	3,616	3,893	277	18,411	18,931	521
	Bank & Locum Staff	31	39	8	-31	204	30	-174
	Agency	6	7	0	-8	15	-2	-16
	Overtime	8	-12	7	19	32	33	1
	Total	3,826	3,650	3,907	257	18,661	18,993	332
AHP	Substantive	2,520	2,438	2,694	256	12,363	13,420	1,056
	Bank & Locum Staff	12	9	1	-8	65	5	-60
	Overtime	23	16	0	-16	97	0	-97
	Total	2,554	2,463	2,695	231	12,526	13,425	899
Prof & Tech	Substantive	247	242	266	25	1,207	1,302	95
	Bank & Locum Staff	0	1	1	0	3	4	1
	Agency	19	27	0	-27	116	0	-116
	Overtime	11	13	0	-13	61	0	-61
	Total	278	282	267	-15	1,386	1,306	-80
Support Staff	Substantive	948	783	936	154	4,345	4,531	186
	Bank & Locum Staff	187	143	142	-2	878	702	-176
	Agency	0	0	-2E-5	-2E-5	-8	0	8
	Total	1,135	926	1,078	152	5,215	5,233	18
Other	Substantive	501	195	601	406	2,527	2,969	442
	Total	501	195	601	406	2,527	2,969	442
Unallocated central funding	Substantive	0	0	291	291	0	1,446	1,446
	Total	0	0	291	291	0	1,446	1,446
Total		25,889	24,267	25,940	1,672	125,366	128,893	3,527

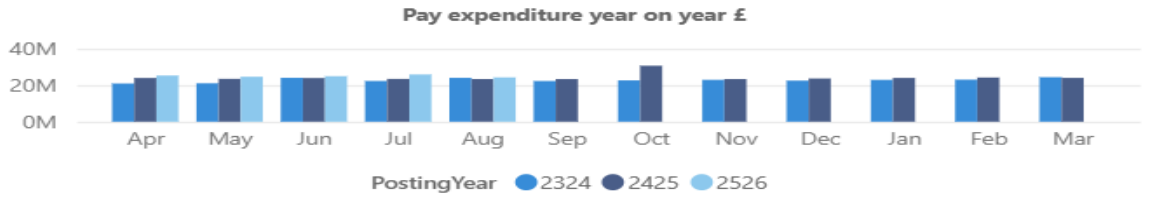
Pay Costs (trends)

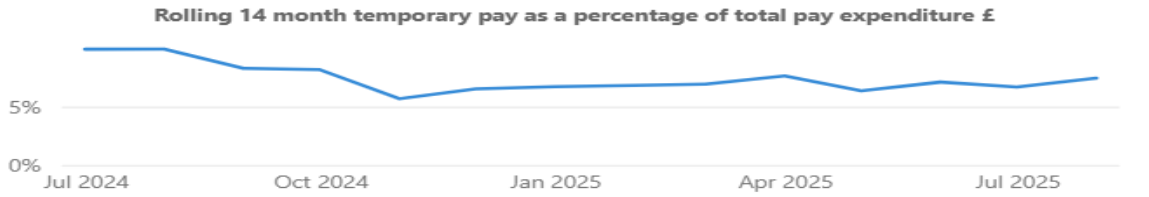
West Suffolk NHS Foundation Trust

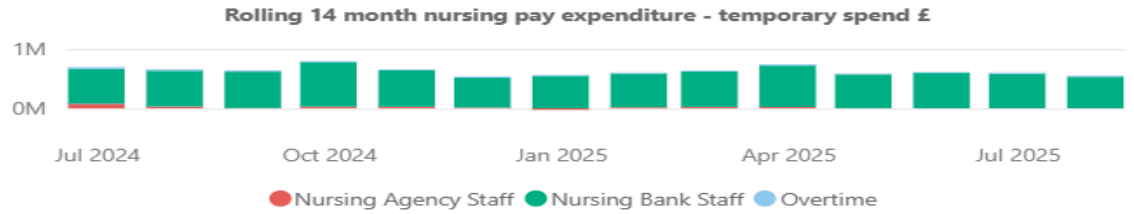
5 | 2025/26

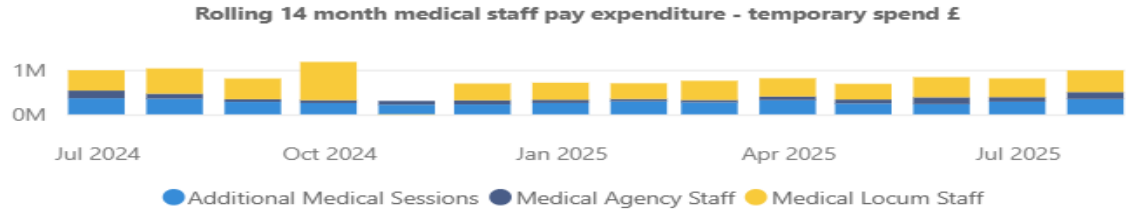


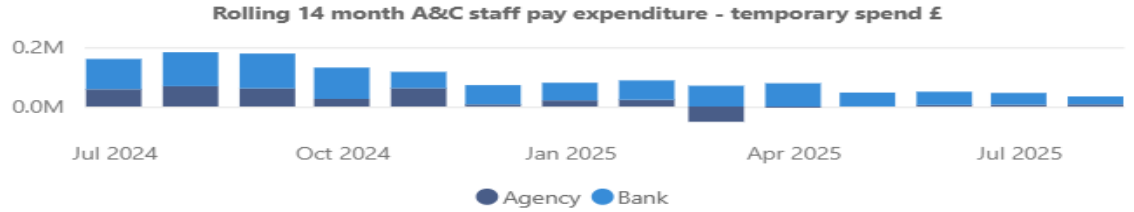












Workforce – WTEs by Staff Type

Substantive staff have decreased by 23.3 WTEs in month, primarily in Nursing (21.6) whilst there has been an increase in Medical Staff (10.2).
Temporary staffing has increased by 8.2 WTEs, mainly in Bank - Medical Staff and A&C

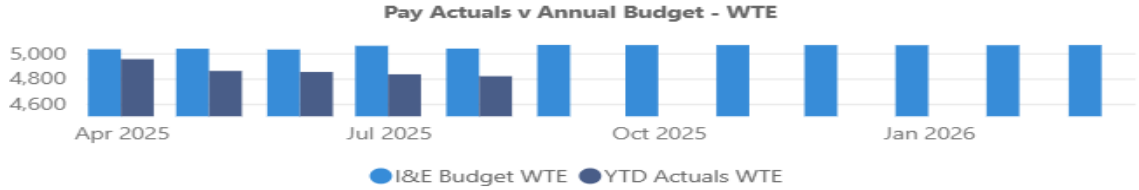
		Prior Month Actuals WTE	Prior Yr Same Period Actuals WTE	In-Month Actuals WTE	In-Month Budget WTE	In-Month Variance WTE	YTD Actuals Average WTE	YTD Budget Average WTE	YTD Variance Average WTE
Substantive	Nursing	1,909.3	1,925.1	1,887.7	2,073.7	186.1	1,910.9	2,077.6	166.7
	A&C	921.8	985.4	918.9	999.0	80.1	928.5	994.7	66.2
	AHP	539.6	546.3	536.7	601.3	64.6	545.1	600.0	55.0
	Medical Staff	587.2	595.9	597.4	645.6	48.2	586.4	646.1	59.6
	Support Staff	281.5	286.5	277.8	301.4	23.6	280.5	292.4	12.0
	Other	52.5	75.0	48.6	68.9	20.3	54.0	65.6	11.6
	Sci & Professional	276.2	273.5	277.6	295.2	17.5	273.6	292.1	18.5
	Prof & Tech	48.1	50.3	48.1	55.8	7.7	49.2	54.4	5.3
	Unallocated central funding	0.0	0.0	0.0	-24.6	-24.6	0.0	-7.2	-7.2
	Total	4,616.2	4,738.0	4,592.9	5,016.2	423.3	4,628.0	5,015.7	387.6
Additional Medical Sessions	Medical Staff	8.0	20.3	9.0	4.6	-4.4	9.1	4.7	-4.4
	Total	8.0	20.3	9.0	4.6	-4.4	9.1	4.7	-4.4
Agency	Nursing	0.0	4.0	0.0	0.0	0.0	1.1	0.0	-1.1
	Sci & Professional	0.0	4.5	0.0	0.0	0.0	0.2	0.0	-0.2
	Support Staff	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	A&C	0.9	8.8	0.9	0.0	-0.9	0.5	0.0	-0.5
	Prof & Tech	2.4	11.0	1.8	0.0	-1.8	3.3	0.4	-2.9
	Medical Staff	4.7	8.3	6.5	0.0	-6.5	4.6	0.0	-4.6
	Total	8.0	36.6	9.1	0.0	-9.1	9.7	0.4	-9.3
Overtime	A&C	1.6	5.4	0.6	0.8	0.2	1.7	0.9	-0.9
	Sci & Professional	0.9	2.0	1.1	0.0	-1.1	1.2	0.0	-1.2
	AHP	4.5	2.1	3.3	0.0	-3.3	3.9	0.0	-3.9
	Prof & Tech	2.9	5.4	3.7	0.0	-3.7	3.2	0.0	-3.2
	Nursing	5.3	5.9	5.8	0.3	-5.5	4.8	0.4	-4.4
	Total	15.2	20.7	14.5	1.1	-13.4	14.8	1.3	-13.4
Bank & Locum Staff	Prof & Tech	0.1	0.2	0.2	0.3	0.0	0.2	0.3	0.1
	Other		0.2						
	AHP	1.9	5.2	1.6	0.0	-1.6	2.3	0.1	-2.2
	Sci & Professional	4.9	8.2	5.9	0.3	-5.6	5.6	1.2	-4.4
	A&C	8.8	29.6	12.2	2.1	-10.0	12.5	3.1	-9.5
	Support Staff	14.0	40.1	12.8	1.0	-11.9	16.9	1.2	-15.7
	Medical Staff	30.3	47.9	33.3	8.8	-24.5	29.0	8.9	-20.2
	Nursing	125.3	152.6	126.1	1.8	-124.2	134.5	1.3	-133.2
	Total	185.3	284.0	192.1	14.3	-177.8	201.1	16.1	-185.0
Total		4,832.7	5,099.5	4,817.6	5,036.2	218.7	4,862.7	5,038.1	175.4

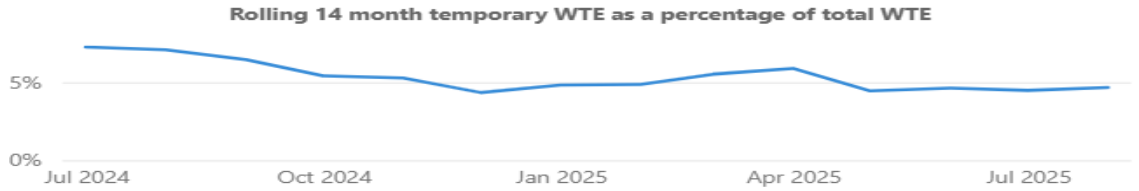
Workforce - WTE (by Staff Group)

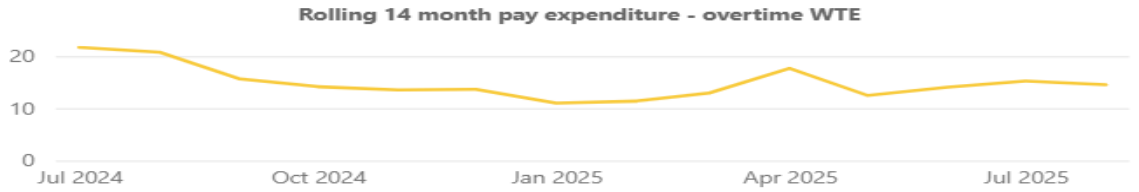
We are reporting a reduction of 281.9 WTEs when comparing August 2024 with August 2025 (5.5%).
There has been a reduction of 15.1 WTEs in month and 283 WTEs since April 2024.
The favourable variance against establishment is 218.7 WTEs in August 2025

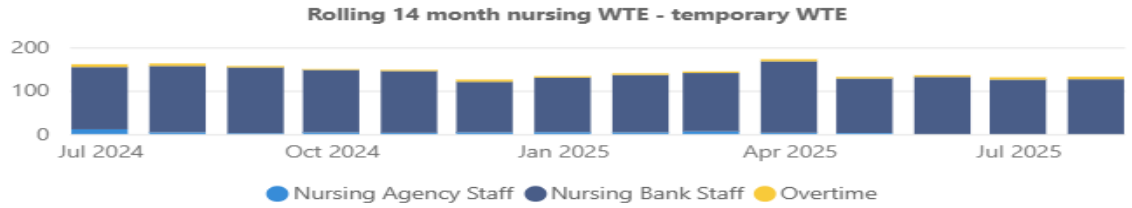
		Prior Month Actuals WTE	Prior Yr Same Period Actuals WTE	In-Month Actuals WTE	In-Month Budget WTE	In-Month Variance WTE	YTD Actuals Average WTE	YTD Budget Average WTE	YTD Variance Average WTE
Medical Staff	Substantive	587.2	595.9	597.4	645.6	48.2	586.4	646.1	59.6
	Additional Medical Sessions	8.0	20.3	9.0	4.6	-4.4	9.1	4.7	-4.4
	Bank & Locum Staff	30.3	47.9	33.3	8.8	-24.5	29.0	8.9	-20.2
	Agency	4.7	8.3	6.5	0.0	-6.5	4.6	0.0	-4.6
	Total	630.3	672.4	646.2	659.0	12.8	629.2	659.6	30.4
Nursing	Substantive	1,909.3	1,925.1	1,887.7	2,073.7	186.1	1,910.9	2,077.6	166.7
	Bank & Locum Staff	125.3	152.6	126.1	1.8	-124.2	134.5	1.3	-133.2
	Agency	0.0	4.0	0.0	0.0	0.0	1.1	0.0	-1.1
	Overtime	5.3	5.9	5.8	0.3	-5.5	4.8	0.4	-4.4
	Total	2,039.9	2,087.6	2,019.5	2,075.9	56.4	2,051.3	2,079.3	28.0
Sci & Professional	Substantive	276.2	273.5	277.6	295.2	17.5	273.6	292.1	18.5
	Bank & Locum Staff	4.9	8.2	5.9	0.3	-5.6	5.6	1.2	-4.4
	Agency	0.0	4.5	0.0	0.0	0.0	0.2	0.0	-0.2
	Overtime	0.9	2.0	1.1	0.0	-1.1	1.2	0.0	-1.2
	Total	281.9	288.2	284.7	295.5	10.8	280.5	293.3	12.8
A&C	Substantive	921.8	985.4	918.9	999.0	80.1	928.5	994.7	66.2
	Bank & Locum Staff	8.8	29.6	12.2	2.1	-10.0	12.5	3.1	-9.5
	Agency	0.9	8.8	0.9	0.0	-0.9	0.5	0.0	-0.5
	Overtime	1.6	5.4	0.6	0.8	0.2	1.7	0.9	-0.9
	Total	933.1	1,029.2	932.5	1,001.9	69.4	943.2	998.6	55.4
AHP	Substantive	539.6	546.3	536.7	601.3	64.6	545.1	600.0	55.0
	Bank & Locum Staff	1.9	5.2	1.6	0.0	-1.6	2.3	0.1	-2.2
	Overtime	4.5	2.1	3.3	0.0	-3.3	3.9	0.0	-3.9
	Total	546.0	553.5	541.6	601.3	59.7	551.3	600.2	49.0
Prof & Tech	Substantive	48.1	50.3	48.1	55.8	7.7	49.2	54.4	5.3
	Bank & Locum Staff	0.1	0.2	0.2	0.3	0.0	0.2	0.3	0.1
	Agency	2.4	11.0	1.8	0.0	-1.8	3.3	0.4	-2.9
	Overtime	2.9	5.4	3.7	0.0	-3.7	3.2	0.0	-3.2
	Total	53.5	66.9	53.8	56.0	2.2	55.8	55.1	-0.8
Support Staff	Substantive	281.5	286.5	277.8	301.4	23.6	280.5	292.4	12.0
	Bank & Locum Staff	14.0	40.1	12.8	1.0	-11.9	16.9	1.2	-15.7
	Agency	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total	295.5	326.6	290.6	302.3	11.7	297.4	293.6	-3.8
Other	Substantive	52.5	75.0	48.6	68.9	20.3	54.0	65.6	11.6
	Total	52.5	75.0	48.6	68.9	20.3	54.0	65.6	11.6
Other	Bank & Locum Staff		0.2						
	Total		0.2						
Unallocated central funding	Substantive	0.0	0.0	0.0	-24.6	-24.6	0.0	-7.2	-7.2
	Total	0.0	0.0	0.0	-24.6	-24.6	0.0	-7.2	-7.2
Total		4,832.7	5,099.5	4,817.6	5,036.2	218.7	4,862.7	5,038.1	175.4

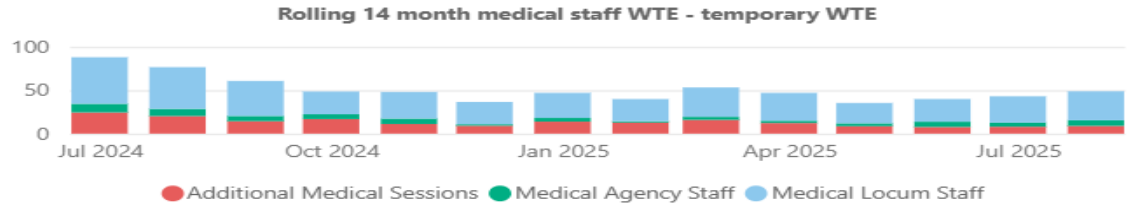
Workforce - WTE (trends)

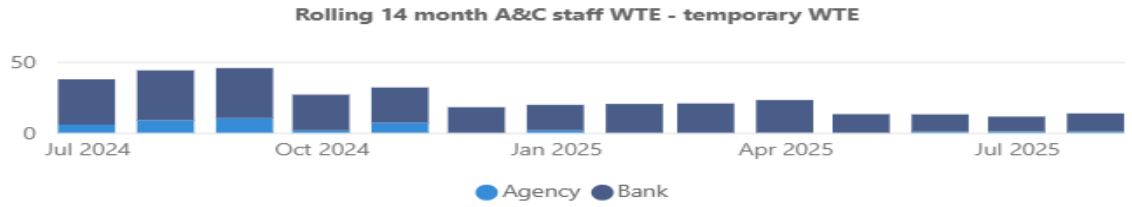


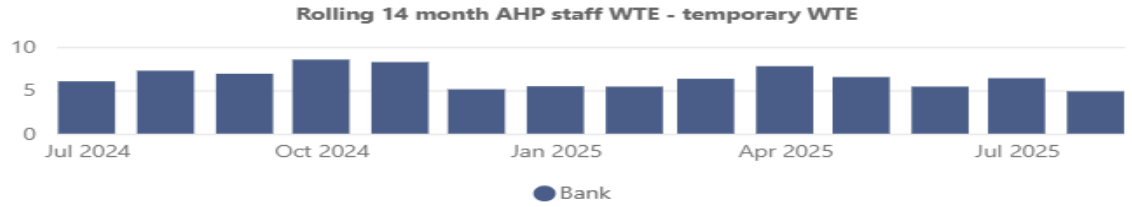












Statement of Financial Position – 31 August 2025

West Suffolk NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2025	Plan 31 March 2026	Plan YTD 31 August 2025	Actual at 31 August 2025	Variance YTD 31 August 2025
	£000	£000	£000	£000	£000
Intangible assets	54,005	44,573	48,368	51,307	2,939
Property, plant and equipment	146,062	200,307	174,728	145,942	(28,786)
Right of use assets	9,807	7,544	8,692	9,050	358
Trade and other receivables	7,162	7,158	7,158	7,162	4
Total non-current assets	**217,036**	**259,582**	**238,946**	**213,461**	**(25,485)**
Inventories	5,128	5,000	5,000	4,992	(8)
Trade and other receivables	18,989	21,668	20,668	20,652	(16)
Non-current assets for sale	490	490	490	490	0
Cash and cash equivalents	12,659	1,107	1,107	10,994	9,887
Total current assets	**37,266**	**28,265**	**27,265**	**37,128**	**9,863**
Trade and other payables	(41,296)	(28,250)	(32,379)	(47,385)	(15,006)
Borrowing repayable within 1 year	(4,510)	(4,627)	(4,627)	(4,345)	282
Current Provisions	(2,524)	(70)	(70)	(1,866)	(1,796)
Other liabilities	(938)	(2,685)	(2,685)	(4,256)	(1,571)
Total current liabilities	**(49,268)**	**(35,632)**	**(39,761)**	**(57,852)**	**(18,091)**
Total assets less current liabilities	**205,034**	**252,215**	**226,450**	**192,737**	**(33,713)**
Borrowings	(39,716)	(34,656)	(37,490)	(38,072)	(582)
Provisions	(385)	(400)	(400)	(385)	15
Total non-current liabilities	**(40,101)**	**(35,056)**	**(37,890)**	**(38,457)**	**(567)**
Total assets employed	**164,933**	**217,159**	**188,560**	**154,280**	**(34,280)**
Financed by					
Public dividend capital	326,166	390,273	355,390	327,665	(27,725)
Revaluation reserve	12,319	11,941	11,941	12,319	378
Income and expenditure reserve	(173,551)	(185,055)	(178,771)	(185,704)	(6,933)
Total taxpayers' and others' equity	**164,934**	**217,159**	**188,560**	**154,280**	**(34,280)**

The table shows the year-to-date Statement of Financial Position as at 31 August 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.

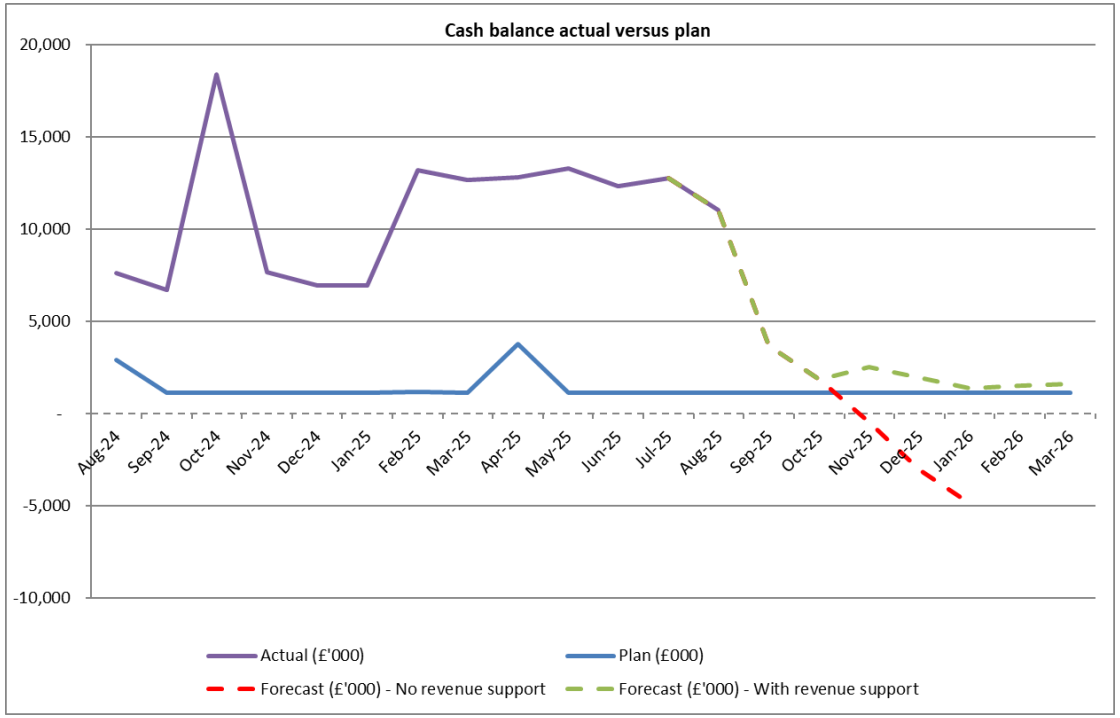
Cash is above plan, linked to the fact that trade and other payables has increased, in part due to a backlog of invoices not being matched and receipted against a valid purchase order. Although trade and other payables appears to have increased significantly against plan, the increase since the 2024/25 month 12 outturn position is much smaller at £6m, £2.8m of which relates to trade creditors, with the remainder an increase in accrued payables.

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 as at month 5 had not yet drawn down PDC for capital projects in line with the plan.

Cash balance for the year

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



The Trust's cash balance as at 31 August 2025 was £11m compared to a plan of £1.1m. The cash position has been relatively healthy compared to plan due partly to the pay award not being actioned until month 5 and our favourable cash position at month 12 which has continued to support us through the early part of 2025/26.

However, the forecast is showing cash becoming low in October and going overdrawn in November. The Trust will require cash support for the last 5 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 in discussions with the NHSE Regional Team on our cash requirements and the support that we will require from month 8.

Better Payment Practice Code (BPPC) – Month 5

August 2025		
Better Payment Practice Code	**Total bills paid YTD Performance Number**	**Total £ paid YTD Performance £'000**
Non NHS		
Total bills paid in the year	16,275	65,400
Total bills paid within target	12,031	57,470
Percentage of bills paid within target	***74%***	***88%***
NHS		
Total bills paid in the year	757	9,972
Total bills paid within target	323	5,841
Percentage of bills paid within target	***43%***	***59%***
Total		
Total bills paid in the year	17,032	75,372
Total bills paid within target	12,354	63,311
Percentage of bills paid within target	**73%**	**84%**
Previous month performance	**69%**	**82%**

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 5. The performance shows a slight improvement as we continue to have a more favourable cash position.

Capital progress report

Capital Spend - 31st August 2025	Year to Date - Month 5			Full Year		
	YTD Forecast	YTD Actual	Variance to Forecast	Full year Forecast	Funding Split	
					Internal	PDC Available
Capital Scheme	£000's	£000's		£000's	£000's	£000's
**New Hospital Programme	4,034	1,844	2,190	14,529		14,529
RAAC	250	244	6	600		1,340
Estates	2,833	654	2,178	6,500	5,575	
Digital/IT	1,296	177	1,119	3,138	3,138	
*Medical Equipment	733	216	516	1,275	550	
Radiology	660	583	78	1,305	1,215	
Newmarket Endoscopy	-	31	- 31	2,133		2,133
Other UEC Schemes	-	-	-	3,646	1,000	3,646
Net zero	-	19	- 19	509		509
Diagnostics RTC	-	-	-	572		572
Elective RTC	-	-	-	436		436
Total Capital Schemes	9,806	3,768	6,038	34,643	11,478	23,165
Overspent vs Plan					34,643	
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 was 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. In months 4 and 5 adjustments to the PDC for the New Hospital Programme has occurred resulting in the Capital Plan now being £34.6m. £11.5m of this is internally funded, with the remaining £23.1m being funded by Public Dividend Capital (PDC).

Year to date capital spend at month 5 is £3.8m. 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. Winter Planning 2025/26 (ATTACHED)

For Approval

Presented by Matt Keeling

Report to WSFT Public Board	
Report title:	**Winter Planning 2025/26**
Agenda item:	5.3
Date of the meeting:	26 September 2025
Sponsor/executive lead:	Matt Keeling, Deputy Chief Operating Officer
Report prepared by:	Matt Keeling, Deputy Chief Operating Officer Roisin Broad, Transformation Project Manager, West Suffolk Alliance Lucy Webb, Senior Transformation Lead, West Suffolk Alliance

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

Alongside delivery of objectives set out in the NHS 2025/26 priorities and operational planning guidance, all providers have been asked to complete Board Assurance Statements referencing a 2025/26 Winter Plan checklist issued in July 2025. The deadline for completion and sign off of these is 30 September 2025. This is also the deadline for Integrated Care Board (ICB) plans to be signed off, with the Suffolk and North East Essex ICB asking each of its three place-based alliances to complete their own plans. This has provided an opportunity to bring together winter improvement and resilience initiatives taking place within WSFT and the wider alliance space, alongside reviewing our daily management of operational pressures.

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

Failing to sufficiently plan for the winter period will increase the level of clinical risk held within the organisation, leading to greater likelihood of poorer patient outcomes and potential harm. This is measured by the standards set out in the operational planning guidance and also reported in the forthcoming NHS Oversight Framework. It has been made very clear that providers will be managed against the delivery of their monthly performance against plan, noting that the headline targets of Emergency Department 4-hour and elective 52 week and 18 week performance must be met as of March 2026.

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

Subject to plans being approved, delivery will be led, supported and monitored through the Urgent and Emergency Care Delivery Group reporting into the West Suffolk Alliance Operational Group. Delivery against operational standards is reported to the Insight Committee, with any safety and quality concerns able to be escalated to the Improvement Committee, both reporting into WSFT's Board.

Action Required

The board is asked to note the content of this report and to discuss and agree the approach to:

- Sustained delivery of the winter plan checklist and board assurance statements.
- Meeting the planning guidance trajectories for ED 4-hour, 12-hour and ambulance handover waits, noting the need to recover and maintain progress against the elective activity plans to reduce 52 week waits alongside a 5% improvement in patients waiting under 18 weeks.
- Identifying and managing delivery through the West Suffolk Alliance Operational Group and associated governance structure.
- Day to day management of operational pressures using the C3 plan and Tactical Patient Flow Escalation Plan, including the use of escalation space.

Risk and assurance:	Board Assurance Framework: 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:	All WSFT services need to be delivered in a way that reduces health inequalities. Health inequalities data within access standards will be monitored through the Insight Committee. Both Quality and Equality Impact Assessments have been included within this paper.
Sustainability:	Services need to be delivered in a way that ensure the financial and environmental sustainability of the organisation, contributing to the financial recovery plan and net zero ambitions.
Previously considered by:	WSFT Urgent and Emergency Care Delivery Group WSFT Management Executive Group WSFT Insight Committee
Legal and regulatory context	• NHS England letter "Winter Board Assurance Statements" • NHS 2025/26 priorities and operational planning guidance

Winter Planning 2025/26

1.	**Introduction**
1.1	As in previous years the NHS 2025/26 priorities and operational planning guidance sets out the key priorities that NHS providers must deliver by March 2026, including through the winter period. These include timely access to urgent and emergency care (UEC) alongside further reducing waiting times for elective and cancer care. Although responding to operational pressures is a year-round activity, the winter period still represents the peak period for high demand, severity of illness, increased propensity to admit into inpatient beds and reductions in discharges from the same. Ensuring that our operational response through the Command, Control and Co-ordination (C3) structure is effective and aligned to improvement plans and development opportunities will be key to increasing our resilience and delivering our 2025/26 operational plans.
2.	**Background**
2.1	WSFT in conjunction with the West Suffolk Alliance have jointly developed a response to the Suffolk and North East Essex Integrated Care Board (SNEE ICB) winter planning template, which is included as Annex A. Separately, NHS England have asked providers to complete Board Assurance Statements referencing a 2025/26 Winter Plan checklist, included as Annex B. In responding to these WSFT has drawn together relevant workstreams and processes across: 1. Daily identification and management of operational pressures across business as usual, business continuity/critical incident and major incident statuses, using the Integrated operational pressures escalation levels (OPEL) framework and internal Tactical Patient Flow Escalation Plan. 2. The UEC Delivery Group plan which supports delivery of both operational standards and productivity schemes.

3. Relevant divisional and service-led improvement initiatives outside of the UEC Delivery Group plan.
4. Relevant capital funding schemes where these have been approved by SNEE ICB pending submission of a Programme of Works Business Case.

Points 2-4 are detailed within Annex A, alongside partner organisations plans across the Alliance. Projected costs highlighted in yellow are directly attributable to WSFT, representing the capital schemes set out in 3.4, a £70K revenue cost pressure to deliver the required 5% increase in staff vaccination (previously considered by Management Executive Group), the 8-week winter escalation ward opening as is currently planned, and internal reallocation of community assessment bed funding to support reductions in pathway 2 discharges.

A completed Quality Impact Assessment is included as Annex C and an Equality Impact Assessment as Annex D.

The additional demands of winter, coupled with potential for increased sickness absence rates are likely to lead to WSFT's workforce feeling additional pressure. Good line manager relationships, access to wellbeing services and ensuring colleagues are signposted to other sources of support will be vitally important to ensure a healthy and resilient workforce during this time.

3. Detailed sections and key issues

3.1 Daily monitoring and response

As in previous years, WSFT will follow the Command, Control and Co-ordination (C3) plan across all operational states: business as usual, business continuity or critical incident, and major incident. This is led at strategic and tactical level during working hours by the (Deputy) Chief Operating Officer and Head of Operations for Patient flow respectively, and by the strategic and tactical commanders out of hours or should a critical/major incident be declared.

The Tactical Patient Flow Escalation Plan sets out the organisational response to operational pressures as defined by the OPEL framework and measured every 15 minutes during upload to the SNEE-wide e-Shrewd resilience platform. Annex D of the plan sets out the order and criteria for utilisation of temporary escalation capacity as follows:

OPEL Status	Clinical Risk	Description	Escalation Areas
OPEL 1	Low	ED flowing well, no delays to offload or transfer out	No escalation areas required.
OPEL 2	Medium	ED not able to offload all ambulances within 30 mins. Extended length of stays beginning to build.	ED escalation areas to open including reverse cohorting.
OPEL 3	High	ED escalation areas full. No flow through department Extended length of stays.	F8 extra bed DWA overnight SDEC (Medical and Surgical) RAT overnight
OPEL 4	Very High	All other options acted on	G5 closed beds/AAU corridor when G5 reopens

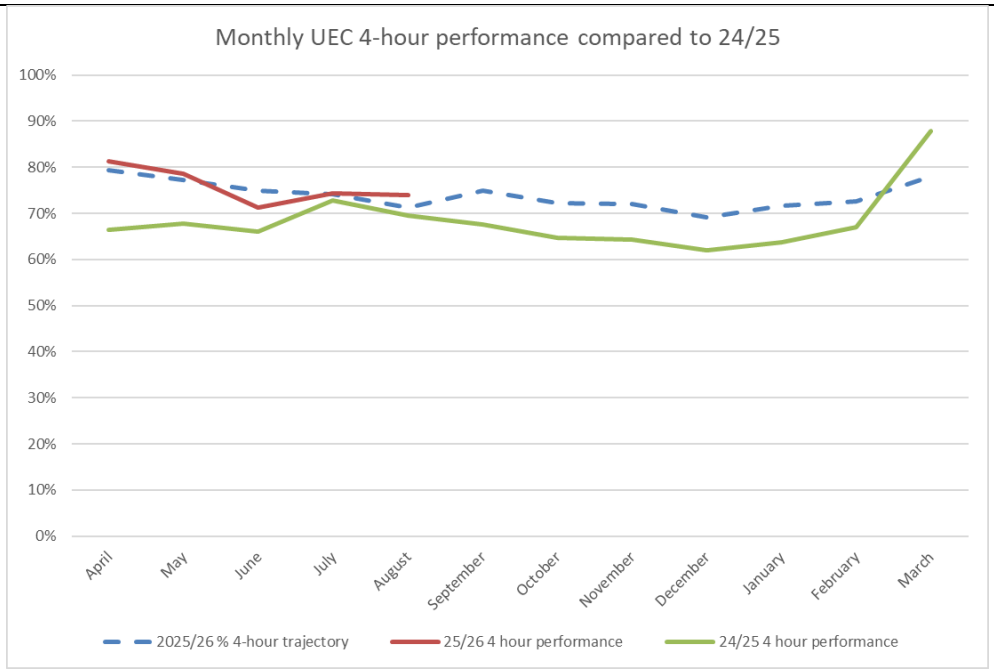
In preparation for the forthcoming Emergency Planning Response and Resilience Core Standards review in November 2025 we will be delivering training for tactical and strategic commanders against the minimum operational standards alongside an internal exercise. WSFT will also be taking part in

	a SNEE-wide winter exercise on 03 September 2025 and in Exercise Pegasus between September and November, a national pandemic preparedness exercise. The SNEE exercise tested the three operational states referenced by the assurance checklist: base, moderate and extreme pressure. In response, WSFT translated this into and deployed the corresponding actions from the Tactical Patient Flow Escalation Plan – OPEL 1 and 2 reflecting base pressure, 3 as moderate and 4 as extreme. It was noted during the exercise that there can be a material difference between definitions of pressure in an individual organisation and the wider system, which will be managed through the standing up of additional system strategic calls during the winter period, including weekends.
3.2	<u>UEC Delivery Group plan</u> The UEC Delivery Group Plan workstreams developed in Q1 will continue through the winter period with delivery monitored at fortnightly meetings through a suite of monthly and weekly metrics. The workstreams can be summarised as: • Length of stay reduction in inpatient medical wards – e.g. through implementation of standardised board rounds. • Flexible inpatient medical bed capacity: temporary closure of 15 beds on G5 during June – October 2025, and potential 8 week period of further capacity through a winter escalation ward January – February 2026. • Specialty reviews and pathways: ensuring internal professional standards are adhered to and that suitable alternative non-ED pathways are fully utilised, e.g. SDECs. • Increasing pre-noon discharges – through nurse led discharge and enhancing DWA pathways. • MECU sustainability, increasing activity in line with overall ED attendances. The winter checklist as part of the board assurance statements asks providers to ensure bed modelling has been updated and aligned to plans, the most recent update demonstrates there can be zero tolerance to non-delivery of schemes to reduce demand:

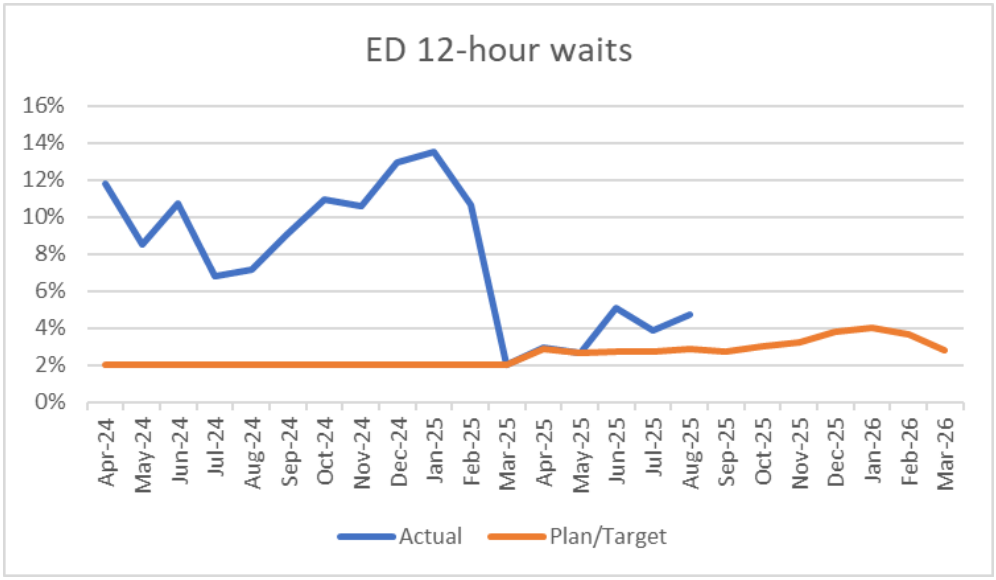
ADULT NON-ELECTIVES	**97%**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**
New forecast from bed model with latest data 1st July		411	416	422	415	443	454	457	444
NEL beds required		**424**	**429**	**435**	**428**	**457**	**468**	**472**	**458**
Virtual ward benefit from step ups	Beds	2.3	3.1	3.0	3.9	4.2	4.2	4.6	4.2
Community beds - Glastonbury impact	Beds								
Total beds impact		**2**	**3**	**3**	**4**	**4**	**4**	**5**	**4**
Core NEL beds with DWA		405	405	405	405	405	405	405	405
Winter ward		0	0	0	0	0	**26**	**26**	0
Escalation beds (SDEC's)		6	6	6	6	6	6	6	6
Total beds available		**411**	**411**	**411**	**411**	**411**	**437**	**437**	**411**
Bed balance		**-11**	**-15**	**-21**	**-13**	**-42**	**-27**	**-30**	**-43**
Schemes/impacts	**Beds**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**
Move F8 to F9	Beds	6	6	6	6	6	6	6	6
Reduce acute LOS on 6 medicine wards	Beds	15	15	15	15	15	15	15	15
Bed base reduction options	Beds	-15	-15						
Bed balance		**-5**	**-9**	**0**	**8**	**-21**	**-6**	**-9**	**-22**

Even with demand mitigations applied, there will need to be additional effort to reduce length of stay and increase flow from December 2025 to March 2026, given a bed deficit is forecast throughout this period. It is proposed to mitigate this through daily deployment of our C3 structure and response to reduce bed demand, knowing that our capacity is finite and cannot be increased and actions to smooth daily peaks and troughs in demand will need to be managed dynamically. These will typically

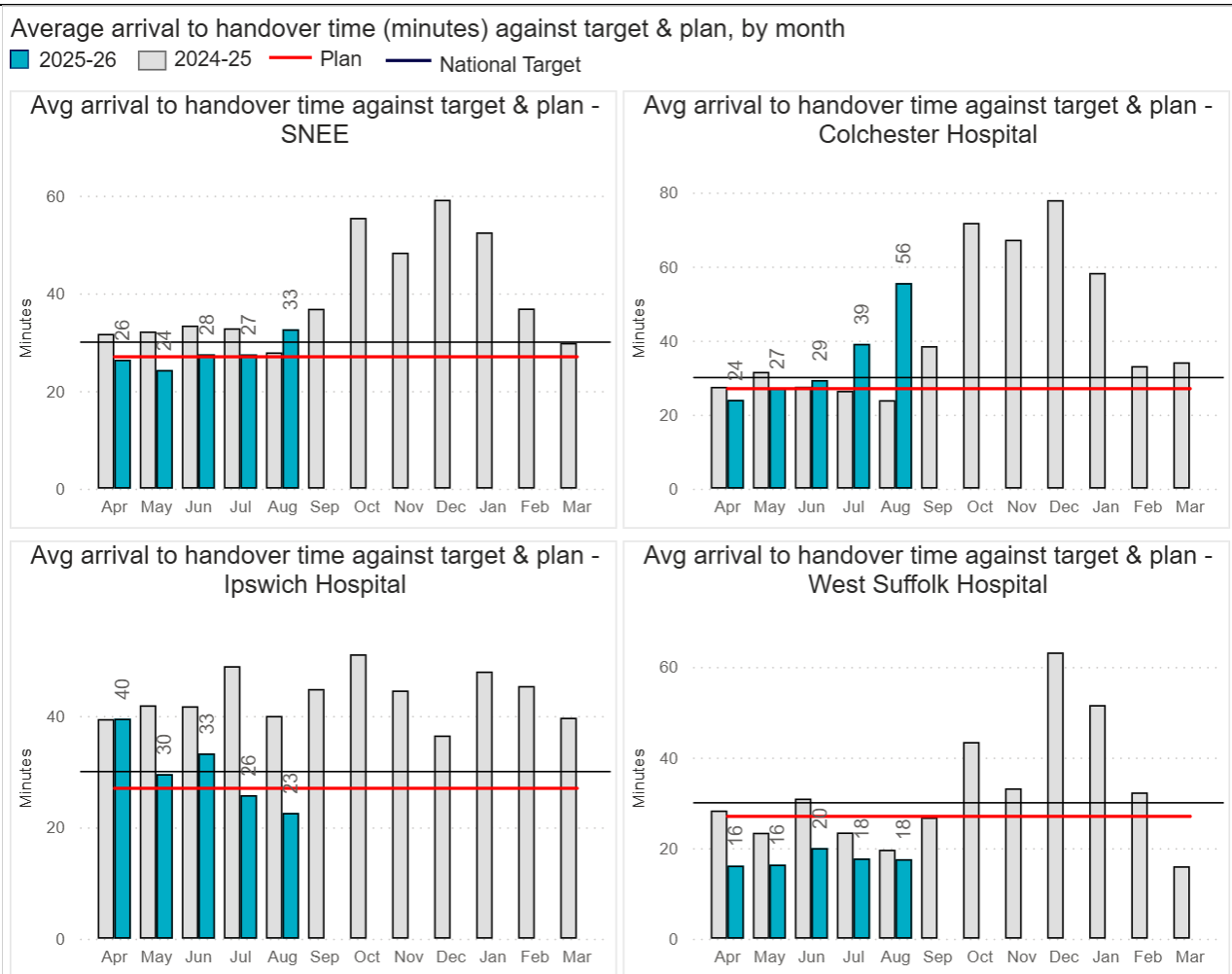
	be centred around senior review prior to admission, increased frequency of patient reviews and board rounds, balancing outliers, increasing discharge pathway capacity, etc.
3.3	Locally led improvement initiatives Outside of the UEC Delivery Group, locally led initiatives that will have a positive impact on winter resilience include: • Early intervention team (EIT) meeting the 15 minute response timeframe for requests from the Emergency Department, supported with a Monday to Friday presence. • Discharge pathways: P2-P1 conversion to allow for P2 reduction and pathway redesign allowing organisational sustainability and home is best approach. • Virtual Ward meeting step up capacity and occupancy targets. • Vaccination team delivering at least a 5% increase in staff vaccination rates. These are detailed in the plan alongside initiatives from primary care, adult social care (including continuation of Better Care Fund schemes), West Suffolk Council, St. Nicholas Hospice and Suffolk County Council public health.
3.4	Capital Funding Schemes In May 2025 bids were invited against the ICB's annual capital allocation where these could demonstrate the enabling of delivery of constitutional standards. Those that support UEC and have been accepted in principle by the ICB are as follows: • HPV fogging machines purchased to reduce IP&C (specifically C.Diff) • Purchase of 4 x 'Redirooms', including maintenance & servicing (portable bed isolation units) • Purchase of 2 x portacount machines used for FIT testing for FFP3 respiratory masks • Equipment for enhancement of ENT pathways • Equipment for enhancement of Surgical SDEC • Point Of Care Testing deployment within integrated community team through the Shared Service Delivery Model • Fibreoptic Endoscopic Evaluation of Swallowing equipment to support ED and community dysphagia reviews • Additional funding for Cassius platform and devices such as falls detectors, epilepsy sensors etc. Programme of Works business cases are currently being developed which after internal sign off will need approval by the ICB before funds can be drawn down.
3.5	Assurance of delivery Delivery of safe and effective urgent and emergency care through the winter period will be demonstrated through meeting planning trajectories submitted as part of 2025/26 planning against the 4-hour standard, 12-hour waits in ED and ambulance handovers. The plan against the 4-hour standard has been met or exceeded in 3 of 4 months in 2025/26 and is currently at 74.43% against a plan of 71%:



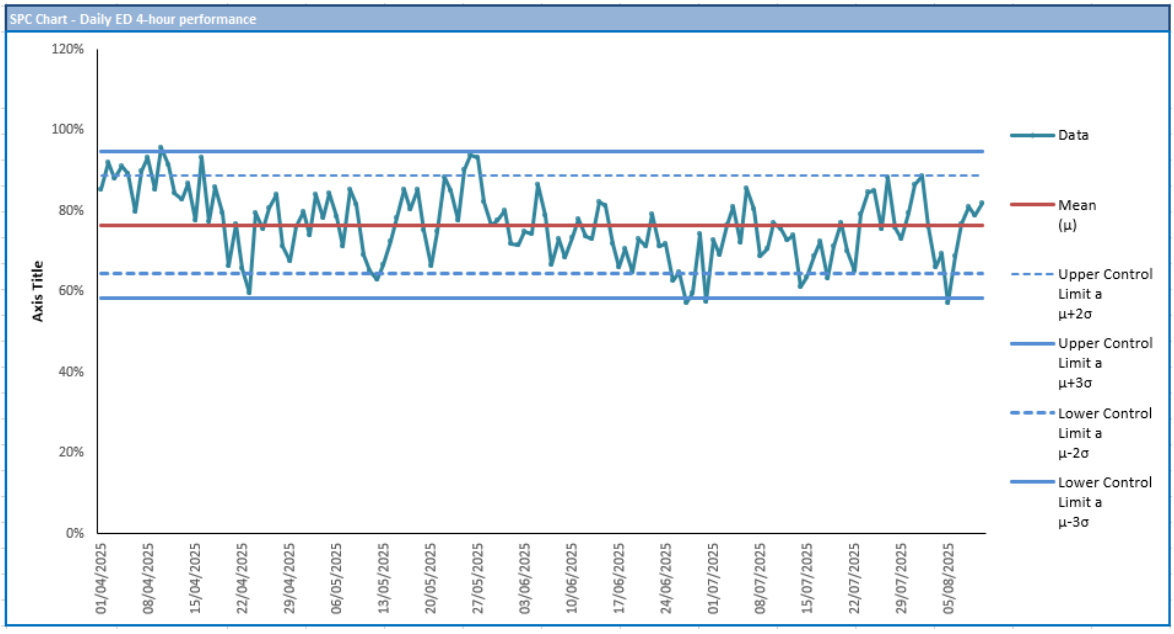
12-hour waits although not meeting plan are significantly improved from 2024's position, and it is acknowledged that WSFT were tasked with delivering a plan based on March 2025's exceptionally strong position:



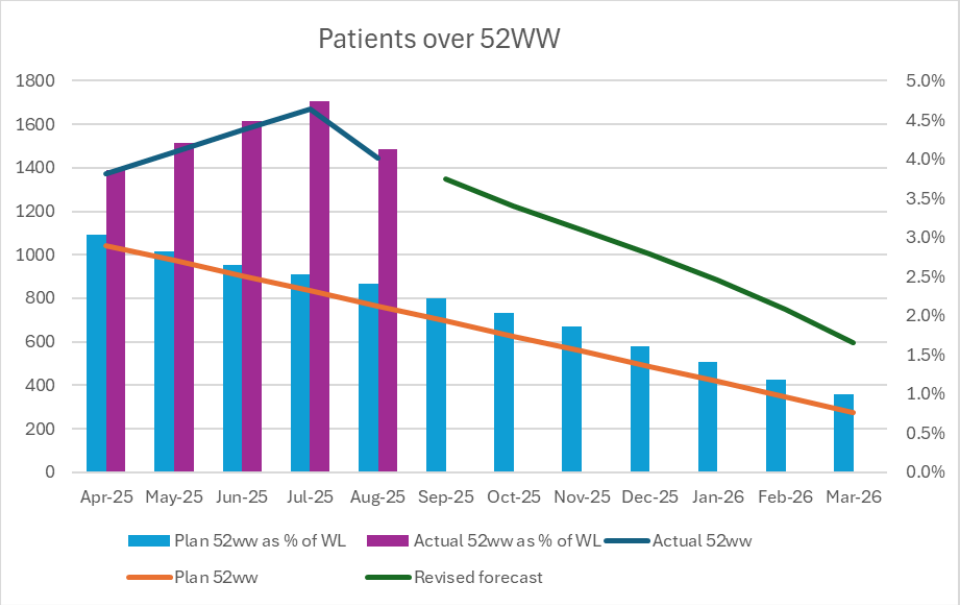
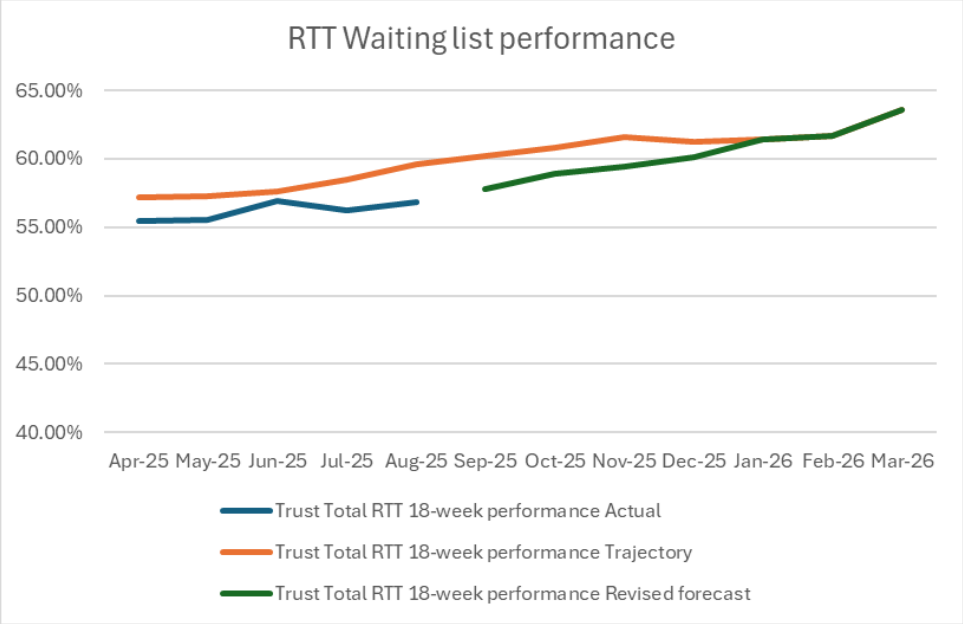
WSFT continues to deliver strong performance against ambulance handover trajectories:



Reducing variation in timely urgent and emergency care is also critical for assurance that winter plans are sufficiently robust, given that 300 plus patient per day move through the ED footprint and will all be exposed to the increase in risk that comes from extended waits. Negative variation on daily 4-hour performance outside of statistical control limits will need to be avoided to provide that assurance:



WSFT's headline operational performance planning commitments will be incorporated into the NHS Oversight Framework from September 2025. This will include elective care, against which WSFT are some way off plan, particularly on long waits of 52 weeks or more. Although performance trajectories

	have factored in a period of stasis over winter where we do not expect to make significant performance gains, ensuring performance does not deteriorate will be key to avoid an unsustainable and unachievable 'sprint' in Q4. Additional activity to recover the plan will need to be phased so as to not coincide with predicted periods of peak UEC pressure, i.e. will need to be delivered before January – these plans are currently being developed and will be reviewed for approval by the Management Executive Group on 24 September 2025. Current performance against plans for elective access is as below:  
4.	**Next steps**
4.1	Urgent and Emergency Care improvement work will continue to be led through the West Suffolk Alliance Operational Group, taking reports from organisation-led initiatives and reporting into the SNEE ICB UEC Committee. Weekly UEC performance teams with the ED leadership triumvirate will continue to have attendance from the COO or DCOO, to triangulate delivery of trajectories to recovery plans and to identify additional actions that may be required. Day to day management of operational pressures, in line with frameworks and plans, will continue through the C3 structure and Tactical Control Centre.

5.	Conclusion
5.1	Although likely to be challenging, patient safety, quality and timely access to services should be able to be consistently delivered through the winter period through the combination of thorough and joined-up improvement plans, alongside robust day to day planning and decision making. The learning from 2024/25 has been embedded into this approach, and the importance of using evidence to assess benefits from improvement initiatives and external sources of funding will be applied to ensure they maximise the impact to our financial position, alongside quality and delivery of performance expectations.
6.	**Recommendations**
	The board is asked to note the content of this report and to discuss and agree the approach to: • Sustained delivery of the winter plan checklist and board assurance statements. • Meeting the planning guidance trajectories for ED 4-hour, 12-hour and ambulance handover waits, noting the need to recover and maintain progress against the elective activity plans to reduce 52 week waits alongside a 5% improvement in patients waiting under 18 weeks. • Identifying and managing delivery through the West Suffolk Alliance Operational Group and associated governance structure. • Day to day management of operational pressures using the C3 plan and Tactical Patient Flow Escalation Plan, including the use of escalation space.

SNEE ICB
Winter Planning

The purpose of the seasonal plan is to bring together all relevant activities across Suffolk and North East Essex (SNEE) health and social care which relates to planning for winter 2025/26 ensuring robust readiness across the system.

Alliance:	West Suffolk Alliance
Return Date:	Aug-25

Area	Seasonal Variation Plan (list of schemes)	Cost	Funding Source	Trigger point* (if relevant) or start date
Acute				
UEC Capital Funding - Infection Prevention and Control	**HPV fogging machines purchased to reduce IP&C (specifically C.Diff)**	£23,230	Approved capital funding	As required, followed confirmed outbreak
UEC Capital Funding - Infection Prevention and Control	**Purchase of 4 x 'Redirooms', including maintenance & servicing. Portable bed isolation units**	£156,350	Approved capital funding	As required, followed confirmed outbreak and side room capacity full
UEC Capital Funding - Infection Prevention and Control	**Purchase of 2 x portacount machines used for FIT testing for FFP3 respiratory masks**	£26,910	Approved capital funding	Procurement in September 2025
UEC Capital Funding - Surgery	**Enhancement to ENT pathways**	£105,700	Approved capital funding	Procurement in September 2025
UEC Capital Funding - Surgery	**Enhancement to Surgical SDEC**	£37,410	Approved capital funding	Procurement in September 2025
UEC Delivery Group Workstream	**Maximisation of MECU**	In budget	Internal WSFT	Activity monitored on a monthly basis
UEC Delivery Group Workstream	**Pre-noon discharges workstream**	In budget	Internal WSFT	Performance trajectory in place
UEC Delivery Group Workstream	**Speciality reviews and pathways workstream**	In budget	Internal WSFT	Revised pathways and documentation in place by September 2025
UEC Delivery Group Workstream	**Revisit bed demand and capacity modelling throughout run up to Winter period**	In budget	Internal WSFT	Complete
UEC Delivery Group Workstream	**Deliver on Ward Level LoS trajectories**	In budget	Internal WSFT	Delivery monitored on a monthly basis
UEC Delivery Group Workstream	**Winter Escalation ward - x26 beds to open**	£750,000	Internal WSFT	27th December 2025
Early Intervention Team (EIT) - internal actions	**EIT- ED 15 minute response target**	In budget	Internal WSFT	01/10/2025
Early Intervention Team (EIT) - internal actions	**EIT located within ED Monday-Friday**	In budget	Internal WSFT	01/11/2025
Community				
Community productivity scheme	**P2-P1 conversion to allow for P2 reduction and pathway redesign allowing organisational sustaiability and home is best approach.**	£480,000	Internal use of CAB funding	01/10/2025
Virtual Ward - internal actions	**VW Step up capacity and occupancy targets**	In budget	Internal WSFT	01/10/2025

UEC Capital Funding - Community	**Point Of Care Testing deployment within integrated community team through the Shared Service Delivery Model**	£74,230	Approved capital funding	
UEC Capital Funding - Community	**Fibreoptic Endoscopic Evaluation of Swallowing equipment to support ED and community dysphagia reviews**	£35,000	Approved capital funding	Procurement in September 2025
Vaccinations				
Vaccination team	**AW25-6 Staff flu**	£70,000	Internal & surplus	1st October
Vaccination team	**External C-19 & flu**	In budget	IoS & fixed funding	1st October
Primary Care				
Primary Care proposal - subject to ICB approval	**Commission Primary Care Networks (PCNs) via an Enhanced Service (ES) to provide additional capacity during the peak respiratory activity from 1st December 2025 to 28th February 2026 flexed between preventative and on the day needs**	£390,120	Not funded (SNEE wide)	01/12/2025
Primary Care proposal - subject to ICB approval	**ES to early identify pats with COPD and support preventatively and proactively.**	£25,000	Not funded (West Suffolk only)	20/12/2025
Primary Care proposal - subject to ICB approval	**Commission GP Fed to run a Home visiting service to support general practice**	£100,000	Not funded (Suffolk wide)	01/12/2025
Adult Social Care				
UEC Capital Funding - Community/ASC	**Additional funding for Cassius platform and devices such as falls detectors, epilepsy sensors etc.**	£144,000	Approved capital funding	
Better Care Fund (BCF)	**15x Nursing/Residential beds**	£426,000	BCF funding	Oct-25
Better Care Fund (BCF)	**SPOT purchasing beds**	£80,000	BCF funding	Oct-25
Better Care Fund (BCF)	**x8 external reablement lots with providers across West Suffolk now working to supplement HomeFirst**	£383,250	BCF funding	In place
District Council				
District Council scheme	**Homeless pods which can support discharge**	£70,000	Council funding	Oct-25
Borough Councils				
Hospice				
St Nicholas Hospice	**Additional overnight out of hours SPEoLC provision integrated within EIT.**	£226,000	Part funding by West BCF monies. No additional funding sourced - WSA business case under development	Funding approved.
St Nicholas Hospice	**Pre-planned/unplanned respite bed provision *1**	N/A	Partially funding through core hospice grant and BCF monies.	N/A
St Nicholas Hospice	**Additional bed capacity - up to 12 bed inpatient unit.**	N/A	Partially funding through core hospice grant and BCF monies.	N/A
Voluntary, Community, Faith, and Social Enterprise (insert)				

Public Health				
Suffolk County Council - public health work programme	**Vaccine Maximisation** • Provide behavioural insights advice regarding accessible/action orientated communication materials • Supporting ICB community outreach (e.g. VCFSE) via trusted local voices • Use co-production to understand barriers to vaccinations and build trust (e.g. digital inclusion, mistrust issues) • Support frontline staff vaccine communications			Commencing September 2025, planning Summer 2025
Suffolk County Council - public health work programme	**Respiratory Health Prevention & Support** • Support targeting and potential evaluation of community spirometry screening (Tidal Sense) • Targeted smoking cessation campaigns to support winter health • Promotion of the Asthma Friendly Schools initiative (ensuring all schools have an asthma friendly policy, campaign and know what to do in an emergency) • Raise awareness of the impacts of wider determinants on respiratory conditions (housing conditions)			Ongoing through 2025
Suffolk County Council - public health work programme	**Mental Health & Wellbeing Support** • Enhanced suicide prevention awareness • Ensure coordinated system pathways and strengthen partnership working between FGS and Suffolk Wellbeing			
Suffolk County Council - public health work programme	**Smoking Cessation & Tobacco Control** • coSTED smoking cessation model in emergency departments • Tobacco Dependency Treatment Programme • Pharmacy pathway for prescription medication • Swap to Stop in hospital settings • Increase VBA training amongst medical professionals and trusted support organisations eg VCFSE • Vaping cessation pathway development • Reviewing of current NRT services uptake • Use of Smoke Free Generation Funding to fund SMI stop smoking nurse, dedicated smoking advisors within Feel Good Suffolk. • Varenicline provision through pharmacies • Postal NRT and Varenicline for FGS clients. • Place based approach (Felixstowe) to addressing smoking prevelence • Routine and Manual workers post, working within workplaces targeting high prevelance target groups.			
Suffolk County Council - public health work programme	**CVD Prevention & Early Detection** • Feel Good Suffolk (FGS) service winter promotion • Explore seasonal/themed campaigns/materials with Comms for CVD awareness by mirroring national campaigns ie “Heart Health Month, Know your numbers month • Health checks quality monitoring. • SiSU machines in 5 locations linked to FGS			

Suffolk County Council - public health work programme	**Frailty** • Supporting Age friendly communities • Promotion of activities during falls prevention week • Promote group activities i.e. strength and balance and active travel using a variety of comms methods • Support frality prevention, mobility, and strength-building programmes to address frailty in an ageing population. • Raising awareness of support available from the Fire service.			
Suffolk County Council - public health work programme	**Health & Housing** • Warm handover referral scheme (explore direct pathway between health and housing services) • Development of indoor air quality education materials • PHM data analysis to aid housing-related health risk identification • Warm Homes offer for people to access funds to modify their home • Household Support Fund - providing additional funds to those needing it most • Low Income Family Tracker - highlighting potential areas in need of additional support			
Other: (insert)				

Expected impact	Lead name / organisation responsible for mobilising scheme	*Organisations to inform when scheme mobilised (if relevant)	Comments
Prevention of outbreaks and reducing likelihood of ward closures that impact UEC flow	WSFT - Amanda Devereux		
Create flexible sideroom capacity and reduction in ED delays for admission where siderooms are required.	WSFT - Amanda Devereux		
Increase in FIT testing compliance and ability to place patients with suspected or confirmed infection	WSFT - Amanda Devereux		
Reduced admissions and diagnostic delays	WSFT - Moira Welham		
Supporting hospital flow	WSFT - Moira Welham		
Supporting ED performance	WSFT - Jane Allen		
Supporting hospital flow	WSFT - Hannah English / Liz Cotton		
Reduction in waits for diagnostic intervention	WSFT - Matt Keeling / Richard Goodwin		
Ensure bed modelling is accurate with seasonal variation	WSFT		
Reduction in LoS of patients with complex discharges	WSFT - Sarah Watson / Annemie Waaning		
Additional bed capacity to support predicted winter pressure point	WSFT		
Support ED performance	Gareth Blissett		Risk that EIT is already reaching capacity and may be unable to improve performance.
Support ED performance	Gareth Blissett		
provision of P1 flow to allow additional 23-40 patients/month	Kevin McGinness/Annemie Waaning		
Provision of Step up capacity	Caroline Millard		

Community based testing for patients supporting right care in the right place at the right time	Kevin McGinness		
Reduction in hospital admissions for dysphagia / aspiration pneumonia	WSFT		
Reduction in sickness absence	Michael Round		
Reduction in front door presentation through improved uptake	Michael Round		
Fewer ED admissions for respiratory	Rachel Seago	24 GP Practices across West Suffolk	This scheme needs 6 weeks to mobilise.
Reduce unplanned admissions for patients with COPD	Rachel Seago	24 GP Practices across West Suffolk	This scheme needs 6 weeks to mobilise.
Less utilisation of GP time	Rachel Seago	24 GP Practices across West Suffolk	This would need 2 months to mobilise
	Rob Kirkpatrick		
Maintaining flow from WSH	Adult Social Care		Significant focus is placed on ensuring flow from these beds. Average LoS is 23.5 days – our aim is to achieve 18 days. - supported by dedicted SW resouces and wrap around therapy . To clarify these are these funding figures - up until Oct 25 that we are basing are plannining on, both D2A and spot
Additional bed capacity to support flow where required	Adult Social Care		
Maintaining P1 flow	Adult Social Care		*This is not winter pressure specific funding but it contributes some of the funding to the overal yearly cost of external reablement. There is also opportunity to increase overtime of staff but this would require additional temporary funding.
supporting discharge into housing services			
Reduced number of emergency admissions to ED and additional support to discharge EOL patients to their preferred place of Care/Death PPoC/D.	Sharon Basson / Daisy Jacobs - St Nicholas Hospice		Funding would be required to mobilise additional capacity to be a 7DPW service.
Reduction in number of double admissions for the cared for and carer	Sharon Basson / Pippa Wilding - St Nicholas Hospice		Capacity permitting.
Increased number of discharges from acute and opportunity to direct refer through from community services and EEAST/ED.	Sharon Basson / Pippa Wilding - St Nicholas Hospice		Capacity permitting - taking into consideration that LoS does vary but currently this is Ave. 13 days.

• Increased vaccination uptake in high-risk groups (e.g. flu, rates for health care workers) • Reduced hospital admissions during winter peak • Improved health literacy around vaccination benefits • Enhanced community confidence in vaccination programmes	Robert Perrement - Project Manager – HCPH – ICB, Policy and Pathways		
• Reduced COPD exacerbations and emergency admissions • Improved early detection of respiratory conditions • Enhanced smoking cessation support • Better management of housing-related respiratory risks	Robert Perrement - Project Manager – HCPH – ICB, Policy and Pathways		
• Monthly suicide prevention webinar programme • Safety planning resource development • Community mental health awareness events • VCFSE sector engagement • Reduced winter mental health crises	Emma Regan - Healthcare Public Health Project Manager (Mental Health & Health Literacy)		
• Smoking significantly increases respiratory infection risk and complications • Smokers have higher rates of winter hospital admissions • Cold weather can worsen respiratory conditions in smokers • Emergency departments see increased smoking-related presentations in winter	Deborah Cah - Project Manager - Tobacco Control Working Age & Older People team		
• Reduced winter cardiac events • Improved hypertension management • Enhanced awareness of CVD risk factors • Better health check uptake	Nowreen Azim - Project Manager – CVD, Respiratory and Cancer		

• Improve movement and mood as a result of meeting with others and keeping active • Middle age and older age groups have a better understanding and knowledge on how to join group activities and what is available locally to them • Production of resources with advice on conversation prompts and practical tools to initiate small and meaningful conversations with service users to increase daily movement, imrpove confidence and mood, and slow decline in function • Health professionals have a better understanding of how to refer to Fire service for a home visit.	Claudia Parrino - HCPH- Older Age, Frailty, Multi-morbidity Project Manager		
• Cold, damp housing directly contributes to respiratory problems and COPD exacerbations • Poor housing conditions worsen cardiovascular health during winter • Fuel poverty affects medication storage and health management • Housing quality impacts mental health during darker winter months • Low Income Family Tracker database can provide an overview of those who may be likely to attend ED	Robert Perrement - Project Manager – HCPH – ICB, Policy and Pathways		

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	West Suffolk NHS Foundation Trust

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	Produced by UEC Delivery Group, reviewed and approved by Management Executive Group, Insight (Finance and Performance) Committee and Trust Board
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	QIA and EIA included with above plan
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	Compiled by the West Suffolk Alliance
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	ICB Winter Exercise took place on 03 September 2025. NHSE Regional Winter Exercise on 08 September 2025 stood down.
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Executive Chief Operating Officer will be the Accountable Executive Officer for winter. Monthly reporting through Insight Committee with any kore urgent concerns raised at weekly Management Executive Group.
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	

Provider:	West Suffolk NHS Foundation Trust

The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	Yes	

Provider CEO name	Date	Provider Chair name	Date
Dr Ewen Cameron	26 September 2025	Jude Chin	26 September 2025

Section B: 25/26 Winter Plan checklist

Checklist		Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention			
1.	There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	Proposal agreed at Management Executive Group 23 July 2025
Capacity			
2.	The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	Bed modelling updated to reflect demand projections and mitigations. Extreme surges to be managed in line with Tactical Patient Flow Escalation Plan, linked to OPEL status.
3.	Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	Covered within existing rotas. Additional senior medical capacity through diversion of clinical activity may be considered in response to extremes of pressure, e.g., business continuity incident.
4.	Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	Pathway delays for P1-P3 reviewed daily with strategic escalation as required.
5.	Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	Included within 2025/26 planning trajectories. Q4 sprint required to mitigate and deliver March 2026 positions.
Infection Prevention and Control (IPC)			

6.	IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	IP&C schemes included as part of capital plans.
7.	Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Yes	Sufficient stocks of PPE and the ability to record fit testing results on ESR confirmed, with additional fit testing equipment purchased.
8.	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Yes	Managed through dynamic risk assessment and open communication channels. IP&C attendance at daily 13:00 capacity meeting. Core Resilience Team (CRT) stood up in the event of any outbreak to lead multi-disciplinary response.
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	Strategic and Tactical Commander rotas in place.
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	OPEL score updated every 15 minutes to the system wide e-Shrewd resilience platform.
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	N/A	Not applicable
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	N/A	Not applicable

QUALITY IMPACT ASSESSMENT

Scheme ID	N/A
Scheme Title	Winter Planning 2025/26

QIA Rapid Assessment Criteria

Schemes are sent to the QIA panel (which includes the Directors of Nursing and Medicine) if:
- It has a **risk weighting score of 15 or more**
- it involves **a change in clinical staffing change of 1 Whole Time Equivalent (WTE) or more**
- It has a **value of £100k or more**.

If the scheme does not meet the criteria above, the QIA is completed as normal and saved in this document as normal for audit purposes. A random sample of these sub-threshold Impact Assessments will be selected for review by QIA panel to ensure the process is robust. The Strategy & Transformation team updates the progress of the scheme through the CIP tracker and updates the Senior Accountable Officers (SAOs) - Executive leads for the CIP programme.

IMPACT	LIKELIHOOD				
Critical	5	10	15	20	25
High	4	8	12	16	20
Moderate	3	6	9	12	15
Minor	2	4	6	8	10
Minimal	1	3	3	4	5
	Rare	Unlikely	Possible	Likely	Almost Certain

				Pre-Mitigation Risk Score				Post -Mitigation Risk Score		
Sustainability or Quality	Category	Area of Impact	Description	Likelihood	Consequence	Overall	Relevant Mitigations	Likelihood	Consequence	Overall
Quality	Risk	Patient Safety	Surge capacity may not be sufficient to meet demand, should supporting demand management schemes deliver less impact than forecast.	3	4	12	Modelling of demand matched to planned increases in inpatient bed capacity, with these being tested by an ICB wide exercise in September. C3 plan provides structure for escalating the response to extremes of operational pressure including business continuity and critical incident providing additional internal and external support.	3	3	9
Quality	Risk	Clinical Quality and Effectiveness	Potential disruption to clinical workflows or delays in diagnostics and treatment could occur if the use of surge capacity is not clearly documented or communciated.	2	2	4	Using clear strategic and tactical objectives and ensuring these are documented within planning documents inclusing weekend plans will ensure the escalation and de-escalation of additional capacity is documented and communicated.	1	2	2
Sustainability	Risk	Workforce	Risk of increased sickness absence during winter period leading to stretched workforce responding to incrreased demand.	2	2	4	Delivery of the 5% incrrease in vaccination uptake as required by the winter board assurance statements. Increased access to line maneger and wellbeing support during winter period alongside divisioanlly led monirotng and response to increases in sickness rates.	1	2	2
Quality	Risk	Patient Experience	Risk that patients with different demographic characteristics experience variance in waits for care.	2	4	8	Patients treated in order of clinical urgency and then length of wait. Analysis undertaken by WSFT public health faculty looking at demographic factors driving increased UEC attendance ensures staffing and actions to reduce waits for emergency care can respond to this.	1	3	3
Sustainability	Risk	Resource efficiency	UEC capital schemes cost may exceed planned amounts.	2	2	4	Programme of Works business case required to be completed and accepted by WSFT and SNEE ICB, including detailed breakdown of costs.	1	2	2
Sustainability	Risk	Workforce	The current level of medical staffing experience burnout due to planned net increase of escalation beds, over and above current workload.	2	2	4	Medical workforce capacity review undertaken to assure change is in line with existing bed base ratios across other medical wards. Promoted access to staff wellbeing services.	1	2	2
Quality	Risk	Patient Safety	Paediatric capacity may not be sufficient to meet demand, should supporting demand management schemes deliver less impact than forecast. Winter 2024 as supported by virtual ward VW) pathway resulting risk score being significantly lower however VW pathways are not in place for winter 2025 due to funding constraints.	5	4	20	Paediatric escalation plan and associated actions in place to mitigate peaks in demand. Support management scheme relates solely to a plan to convert teenage room on ward F1 to increase chair assessment capacity by 4 if required.	3	3	9
Quality	Risk	Clinical Quality and Effectiveness	At peak times, the need to facilitiate early discharge with safety netting will be required, resulting in increased re-admissions.	4	2	8	Where possible, discharges to be clinically considered based on clinical presentation and not service capacity and consultnat led.	2	3	6
Quality	Risk	Patient Experience	Risk that all patients experience variance in waits for care.	2	4	8	Patients treated in order of clinical urgency and then length of wait in line with trust policy and procedures.	2	2	4
Sustainability	Risk	Resource efficiency	Cost for planned mitigation to enable support management scheme to convert teenage room at times of need could be required from Trust resource if bid unsuccessful.	2	4	8	Programme of Works business case required to be completed and accepted by WSFT and SNEE ICB, including detailed breakdown of costs.	2	4	8
Sustainability	Risk	Workforce	The current level of medical and ward/nurse staffing experience burnout due to unplanned but predicted increase in service demand over and above current workload. Risk of increased sickness absence during winter period leading to stretched workforce responding to increased demand.	2	4	8	Increased access to line manager and wellbeing support during winter period alongside divisioanlly led monirotng and response to increases in sickness rates. Senior staff to support across all modalities and cancellation of non-acute activity to be undertaken where required.	1	4	4

Risk Monitoring Strategy	Ward governance meetings, UEC delivery group to monitor UEC performance, NMDG to monitor impact on workforce, divisional board meetings

EIA Assessment template

There may be intersectionality between characteristics e.g. an older (age) disabled (disability) Black (race) woman (sex) with caring responsibilities (socially excluded), so try to consider how people with intersectional characteristics may be affected.

Protected characteristic and socially excluded groups	**Potential positive impact(s) or no impact** Will this change be good for people? Think about positive elements it will bring to people within the protected characteristic groups	**Potential negative impact(s)** How could certain groups be negatively impacted? Will it be more difficult for older people? Will it create potential barriers for people with disabilities? Will it be more difficult for people living in poverty?	**Mitigating actions to address identified negative impact(s)** What can we do to reduce the likelihood of negative impacts? How will we monitor this?	**Person responsible for implementing mitigating action(s)**	**Timeline**	**Opportunity for further equity?** Is there anything we can do to improve equity? Any ideas about what could be done in an ideal world?
Age		Patients may need to access Urgent and Emergency Care (UEC) services at different times of the day and week through age related factors such as increased dependence on public transport or people of working age being more likely to attend during evenings and weekends.	Ensuring all services are available 24/7 and that available workforce matches Emergency Department demand profiles to ensure extended waits are not correlated to particular time periods.	ED Leadership Team	September 2025	
Disability includes physical ill health, long-term health conditions, mental ill health and learning disabilities. Mental ill health includes, but is not limited to anxiety, stress, depression, bipolar, eating disorders, OCD, PTSD). Also includes neurodiversity which includes, but is not limited to dyslexia, dyspraxia, ADHD and autism		People with mental health presentations and diagnoses are more at risk of extended waits for urgent and emergency care. Patients who are neurodiverse, those with dementia and anxiety who struggle with busy, noisy environments may need extra support in cases where there are extended wait times	Proactive escalation of any patient experiencing extended waits for specialist mental health services and close liaison with mental health provider to ensure capacity is available through the winter period. Training for staff around supporting these patients	Head of Nursing for Mental Health, linking in with Norfolk and Suffolk NHS Foundation Trust ED Manager and Matron	September 2025	
Gender reassignment including trans, non-binary and gender non-conforming people		Potential risk that patients feel they cannot comfortably present for a problem that is not commonly found in their particular gender.	Ensuring urgent and emergency care pathways are able to assess, diagnose and treat all patients equally regardless	All UEC Leadership Teams	August 2025	

			of gender reassignment, ensuring a positive patient experience.			
Marriage and civil partnership (assessment only required for issues affecting employment/workforce)		Potential for assumptions to be made/role stereotyping around main income earner for people who are married/within a partnership when allocating additional shifts during winter period.	Line management incorporating reasonable requests for working patterns that take into consideration an individuals status.	All UEC Leadership Teams	August 2025	
Pregnancy and maternity		Risk that pregnancy/maternity related presentations and diagnoses are more at risk of extended waits for urgent and emergency care due to insufficient capacity over the winter period.	Ensuring capacity is planned to match known changes in demand profile and that robust escalation processes are in place. Consider whether referral to maternity assessment unit is appropriate?	Women's & Children's Divisional Leadership Team	September 2025	
Race		Patients for whom English isn't their first language may struggle with extended waits and potential lack of communication	Ensure availability of Language Line device on wheels in order to communicate via video interpreter	ED Manager and Matron		
Religion and belief		Patients observing religious events may need to schedule seeking non-life threatening urgent care around event days.	Ensuring all services are available 24/7 and that available workforce matches Emergency Department demand profiles to ensure extended waits are not correlated to particular time periods.	ED Leadership Team	September 2025	
Sex		Risk that sex-specific related presentations and diagnoses are more at risk of extended waits for urgent and emergency care due to insufficient capacity over the	Ensuring capacity is planned to match known changes in demand profile and that robust escalation processes are in place.	All UEC Leadership Teams	August 2025	

		winter period, for example the gynaecology assessment unit has a single assessment space				
Sexual orientation		Evidence suggests that compared to completely heterosexuals, mostly heterosexual and bisexual adults are more likely to report emergency departments as a usual source of care. Sexual minorities (mostly heterosexual, bisexual, gay/lesbian) are also more likely than completely heterosexuals to delay seeking care for reasons of not wanting to bother a healthcare provider, bad prior healthcare experiences, and being unable to get an appointment.	Monitoring waiting times and access to care (both planned and unplanned) by sexual orientation to ensure that disparities in waiting times are not causing to people to defer seeking care to a UEC setting. Patient experience data should be similarly correlated.	Deputy Chief Operating Officer	October 2025	
Caring responsibilities (unpaid)		Patients who are carers may need to access Urgent and Emergency Care (UEC) services at different times of the day and week to fit in with their carer responsibilities.	Ensuring all services are available 24/7 and that available workforce matches Emergency Department demand profiles to ensure extended waits are not correlated to particular time periods.	ED Leadership Team	September 2025	
Socio-economic background people living on low income, no or low paying occupation/minimal or no education and deprived social background		Patients may need to access Urgent and Emergency Care (UEC) services at different times of the day and week through socio-economic related factors such as increased dependence on public transport or people of working age being more likely to attend during evenings and	Ensuring all services are available 24/7 and that available workforce matches Emergency Department demand profiles to ensure extended waits are not correlated to particular time periods.	ED/Discharge Leadership Team	September 2025	

		weekends. Patients on lower incomes may have reduced access to informal care networks who can support with care upon discharge.				
Health inclusion groups and socially excluded populations rural and isolated communities, homeless people, Gypsy, Roma, and Traveller communities, people in contact with the justice system, migrants and sex workers. **See the EIA guidance for a full list of factors to consider within this section**		Patients may need to access Urgent and Emergency Care (UEC) services at different times of the day and week through social exclusion related factors such as increased dependence on public transport or people of working age being more likely to attend during evenings and weekends.	Ensuring all services are available 24/7 and that available workforce matches Emergency Department demand profiles to ensure extended waits are not correlated to particular time periods.	All UEC Leadership Teams	August 2025	

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: 20 August 2025		
Chaired by: Dr Paul Zollinger-Read			Lead Executive Director: Dan Spooner / Dr 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
5.2	VTE outcome audit:	3	We score well on VTE assessment, however we have not followed up with a detailed outcome audit until now. Audit suggested appropriate prescription 80%. 20% unclear if this is omitted intentionally.	New resident Doctors to undertake audit of outcomes to determine if VTE assessment is followed through by appropriate management.	1
5.2	Drs BLS Training to achieve 90%	3	Currently Doctors: 67% (up from 53%).	Dr Richard Goodwin to review and ensure processes in place to achieve 90% by Jan 2026	1
6.2	Long waiting times for community speech and language and paediatric services which could lead to harm	4	Currently not able to confirm degree of harm caused by long waiting times.	Nicola Cottington to report back Sept 2025 with an assessment of degree of harm.	1
7.1	Some Trusts have reported that the PSIRF investigation process is not adequate for coroners' investigations	2	The mortality oversight group has assessed this issue and currently have a more comprehensive process in place	Lucy Winstanley / Dr Patricia Mills to submit paper around assurances back in October on the Mortality oversight group's	1

Originating Committee: Improvement Committee			Date of meeting: 20 August 2025		
Chaired by: Dr Paul Zollinger-Read			Lead Executive Director: Dan Spooner / Dr 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
			for investigation following deaths.	actions and interface with PSIRF process.	
7.2	Currently unable to assess CQC preparedness	4	The committee requires an assessment of CQC preparedness.	Dan Spooner and Lucy Winstanley to report back in October with CQC preparedness plan.	1

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

6.2. Quality & Nurse Staffing Report (ATTACHED)

To Assure

Presented by Daniel Spooner

Public Board	
Report title:	Nursing, safe staffing report: July and August 2025
Agenda item:	
Date of the meeting:	
Sponsor/executive lead:	**Daniel Spooner: Executive Chief Nurse**
Report prepared by:	**Daniel Spooner and Julie Wiggin (PA to DCN)**

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 July and August 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 July and August after a number of months >5%. However HCSW sickness remains above 6%
- Overall fill rate at 90% for all shifts in M4 and M5
- CHPPD now consistently improving although remain in lower quartile (model hospital)
- Vacancy rates for inpatient registered nurses decreased to 7.7%, and nursing assistant vacancies dropped to 6.4%,
- Successful recruitment of qualifying nursing/midwifery nursing students into employment
- Temporary nursing spend reducing and managed through Nursing and midwifery deployment group

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 – July and August 2025

1. Introduction

1.1 This paper illustrates how WSFT's nursing and midwifery resource has been deployed for the months of July and August 2025 (M4 and M5). 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 July and August 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 July and August 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. There is a slight decrease in day shift provision of registered staff, which has dropped to 89% in August 2025.

	Day		Night	
Average fill rate (planned Vs actual)	Registered	Care Staff	Registered	Care staff
March 2025	88%	88%	96%	101%
April 2025	90%	94%	99%	102%
May 2025	90%	92%	98%	98%
June 2025	92%	94%	97%	99%
July 2025	91%	96%	96%	99%
August 2025	89%	92%	95%	99%

Table 1

The total average of 'planned versus actual' staffing fill rates have shown a slight decrease during August but remains in special cause improvement.

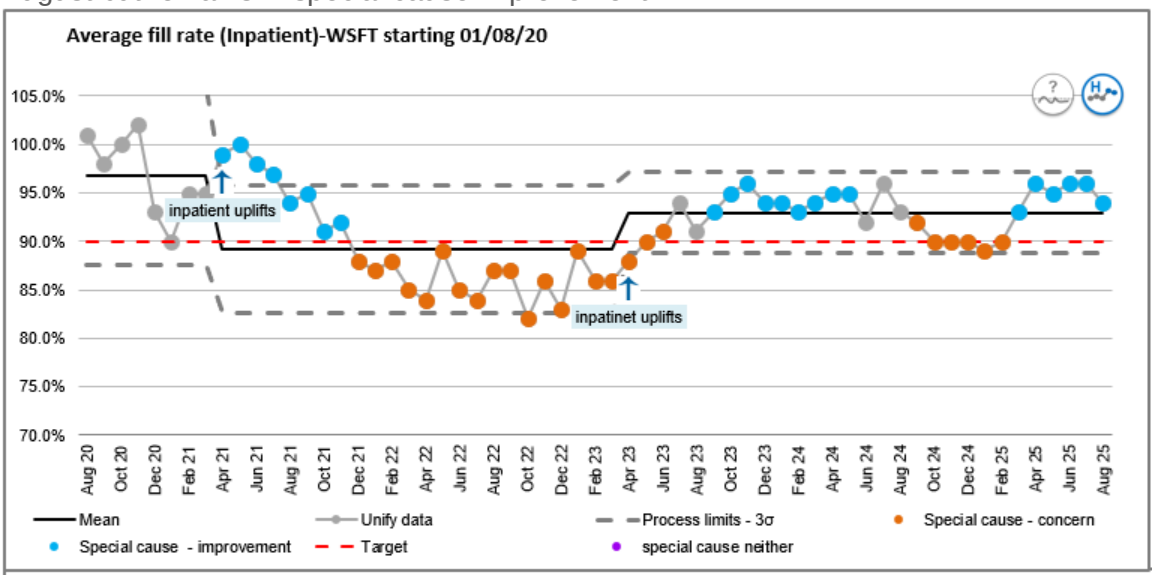


Chart 2

3.2 **Care hours per patient day**

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 d3ta did not recover on closure of the WEW, improving sickness and fill rate. July achieved CHPPD of 7.4 and August achieved 7.5.

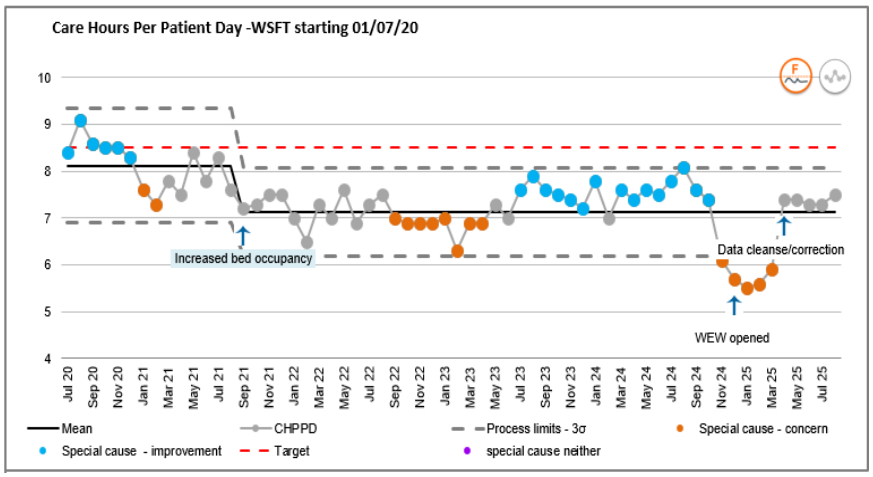


Chart 3

3.3 **Sickness**

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

	Jan 25	Feb 25	Mar 25	Apr 25	May 25	June 25	July 25	Aug 25
Unregistered staff (HCSW)	7.76%	6.35%	5.80%	6.12%	6.62%	6.77%	6.45%	6.66%
Registered Nurse/Midwives	5.78%	5.14%	5.01%	4.75%	4.43%	4.57%	4.32%	4.74%
Combined Registered/Unregistered	**6.41%**	**5.52%**	**5.26%**	**5.18%**	**5.12%**	**5.26%**	**5.01%**	**5.35%**

Table 4

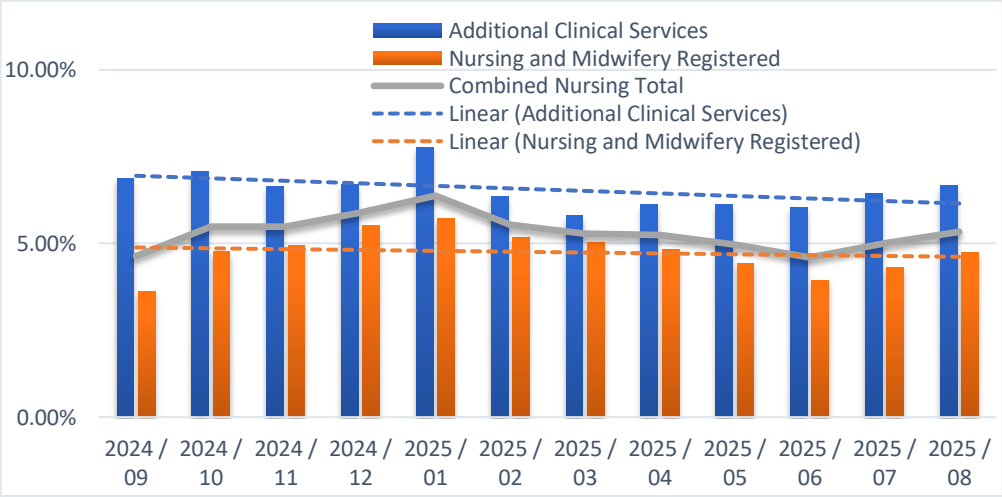


Chart 4

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 M5 is **7.7%** improved from 8.1%.
- **Total RN/RM** vacancy rate at M5 is also **7%** has remained the same.
- **Inpatient NA** vacancy rate at M5 is **6.4%** improved from 8%
- **Total NA** vacancy is **9.7%** in M5, remained the same

	Sum of Month 12	Sum of Month 1	Sum of Month 2	Sum of Month 3	Sum of Month 4	Sum of Month 5	WTE vacancy at 3
RN	715.9	712.1	711.0	707.6	706.2	695.5	73.2
NA	387.3	382.1	383.8	385.5	385.5	376.2	37.7

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.

	Jan 25	Feb 25	Mar 25	Apr 25	May 25	June 25	July 25	Aug 25
RN/RM	4	6	8	8	13	10	7	4
NA	15	17	8	8	11	12	10	3

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

- During July, 7 registrants attended induction; of these; 3 RN were for the acute, 1 for bank staff, 1 for midwifery and 2 for community.
- During July, 10 NAs attended induction; of these; 8 NAs were for the acute Trust and 2 for community.

- During August, 4 registrants attended induction; of these; 1 RNs were for the acute, 2 RN bank staff, 1 RN for Midwifery.
- In During August, 3 NAs attended induction; of these; 3 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 8.3%. NA turnover continues to be over 10%.

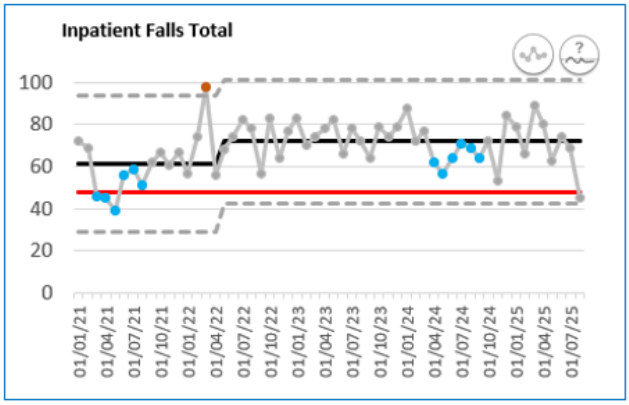
		Turnover	01/09/2024	-	31/08/2025			
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,503.00	1,315.5908	71	59.2933	125	97.2557	8.3167%	7.3926%
Additional Clinical Services	588.50	496.3973	91	83.4933	94	81.5600	15.9728%	16.4304%

Table 7. (Data from workforce information)

3.5 **Quality Indicators**

Falls and acquired pressure ulcers.

Improvement projects and oversight of these quality indicators are reviewed through the patient quality and safety governance group (PQASG). Fall incidents in this period remain in common cause variation as do falls per 1000 bed days.



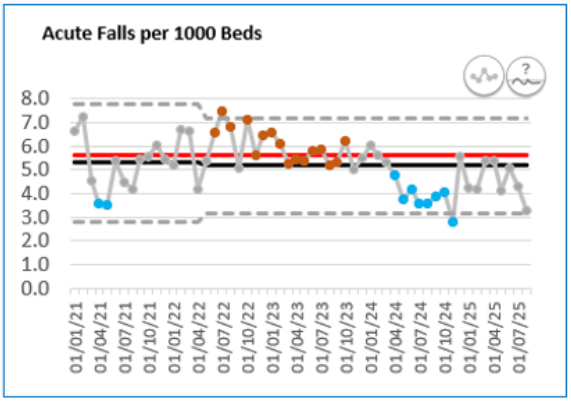
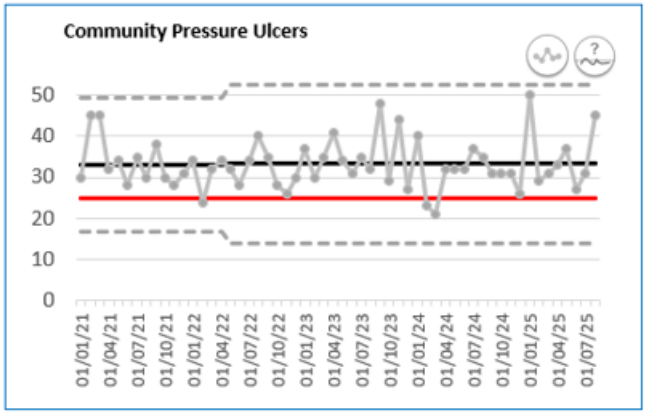


Chart 8 inpatient falls

Pressure ulcers remain in common cause variation and the spike seen in January has fallen to normal variation. A change in the validation of new pressure ulcers may be driving the increase seen in recent months. Incidents within medicine and surgery have been identified as an area of focus through division PRMs in august.



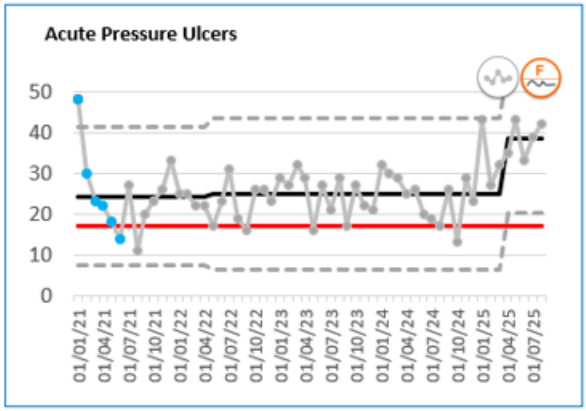


Chart 9 Pressure ulcers acquired in care.

3.6 **Compliments and complaints**

22 formal complaints were received in July. The most consistent theme this month was communication, with a total of 6 formal complaints being listed under this subject. ED and Gynaecology Outpatients both received 3 formal complaints making these the highest areas for the month.

14 formal complaints were received in August. ETC received 2 complaints making this the highest area to receive the most complaints this month. The most common theme this month was communication with a total of 4 complaints being listed under each this subject.

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.

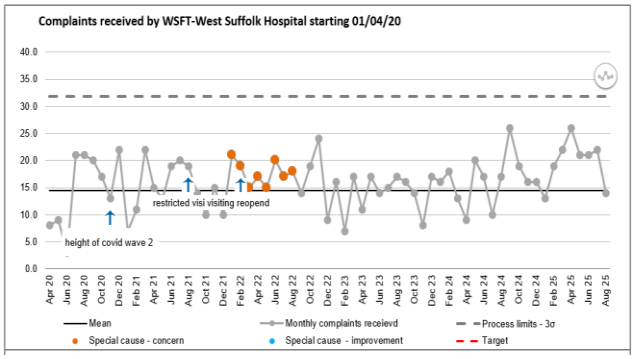


Chart 10a (complaints)

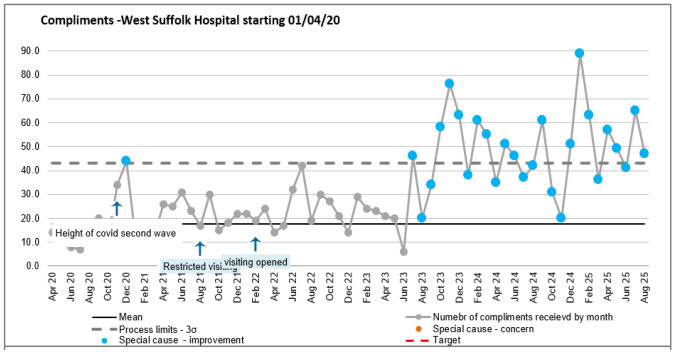


Chart 10b (compliments)

3.7 **Staffing incidents**

Staffing incidents have reduced since January, dropping to its lowest number in May, although this has increased for July and August (Chart 11 below).

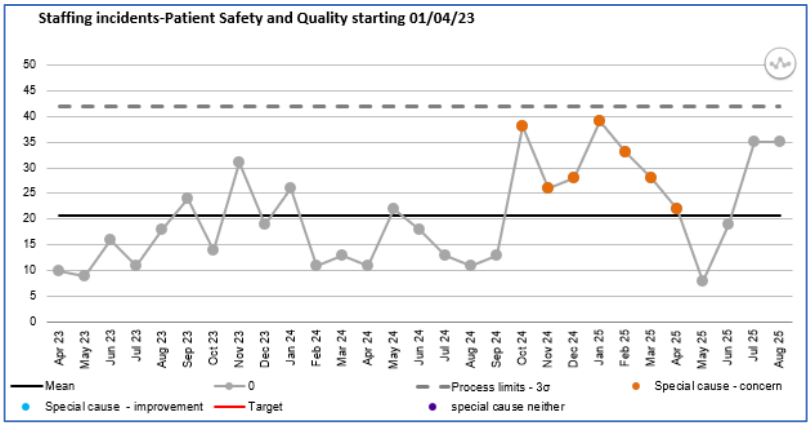


Chart 11

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). July/August 2025 saw significantly more staffing incidents reported which would triangulate with improving fill rates and reduced short notice absence. The most common Red Flag event a Delay or omission of regular checks on patients in July and Delay of >30 mins in providing pain relief in August.

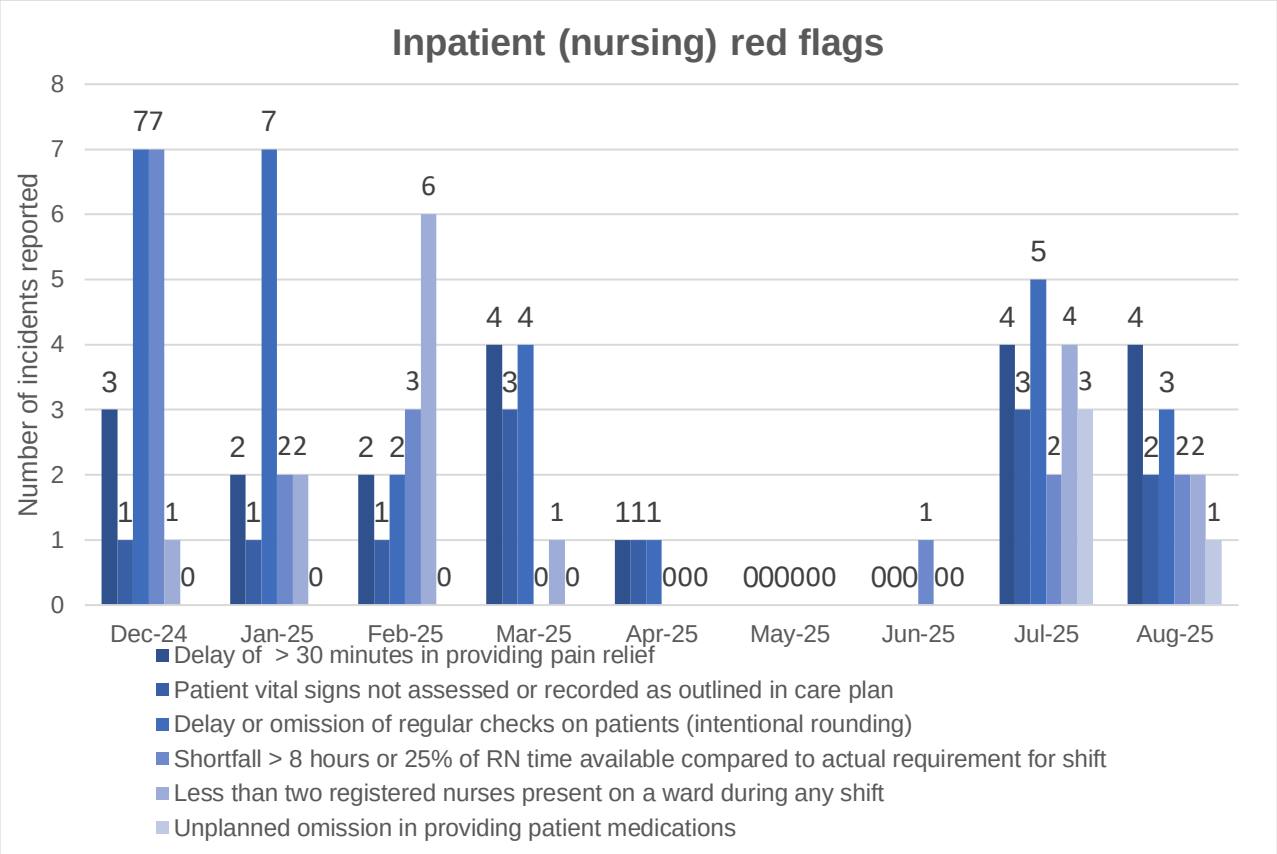


Chart 11.1

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 July and August 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. Two Red Flags were reported in July 2025 related to delays with induction of labour, this decreased to one in August 2025 also related to delay during induction of labour process.

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

- July 2025 Midwife to birth ratio decreased to 1:18
- August 2025 midwife to birth ratio increased to 1.18.8

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 July however, data for August was not available at the time this report was finalised.

	Standard	February	March	April	May	June	July	August
Supernumerary Status of LS Coordinator	100%	100%	100%	100%	100%	100%	100%	TBC
1-1 Care in Labour	100%	100%	100%	100%	100%	100%	100%	100%
MW: Birth Ratio	1:21	1:18.4	1:20.5	1:19.7	1:23	1:19	1:18	1:18.8
No. Red Flags reported	NA	2	1	1	0	0	2	1

Table 12

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

Sickness & Turnover
Sickness rate for the integrated community division was 5% in July and 4.8% in August.
The turnover figure for the division has been rising and is above the trust target and is currently at 12%. This is partly because of organisational changes such as the closure of King Suite in August.

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 7 months. There has been a change in reporting which is yet to be reflected in the SPC chart. PA consulting modelling has led to 5% reduction in therapy capacity by removing vacancies from the establishment, a further 2.5% reduction is under review in 3 months.

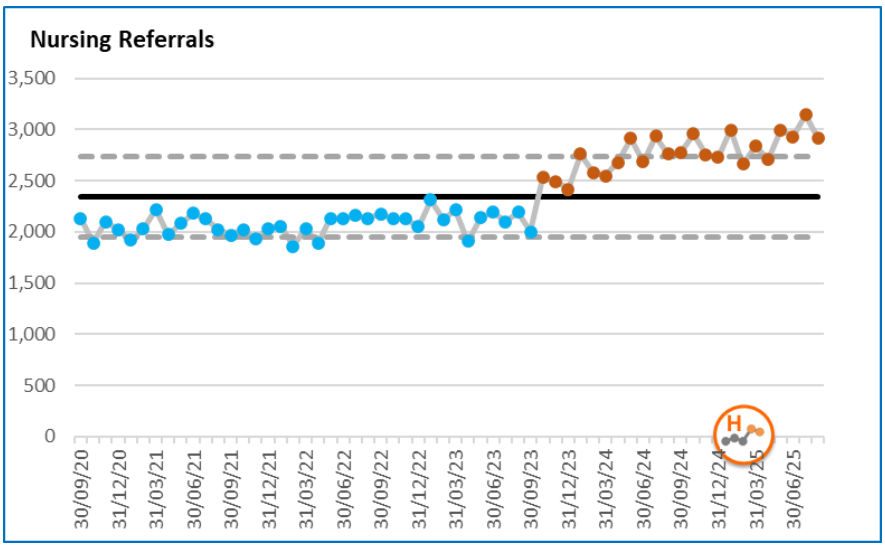


Chart 13

The division has begun to review the clinical impact of the increase in demand by measuring the number of cancelled care plan hours per week, as the clinical team's triage, defer and manage their visits (chart 14). This often involves deferring visits to the following day if the visit has been triaged as a lower priority.

The harm this causes is difficult to monitor, senior matrons are completing a manual audit of approx. 10% of the deferred, or cancelled care. To date most months, show either no harm or minor harm to approx. 5-10% of those who's care is deferred.

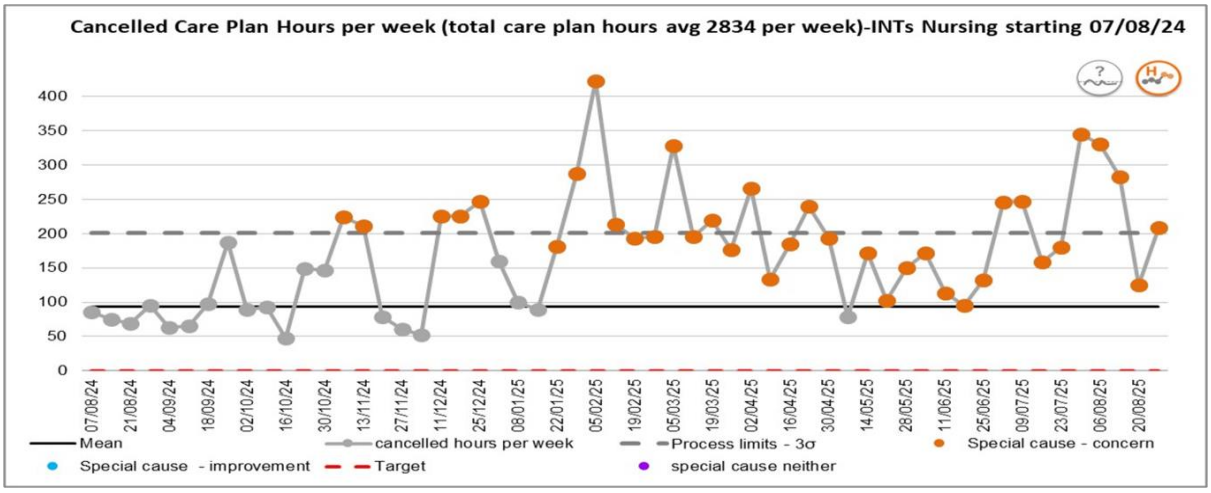


Chart 14

Community based actions

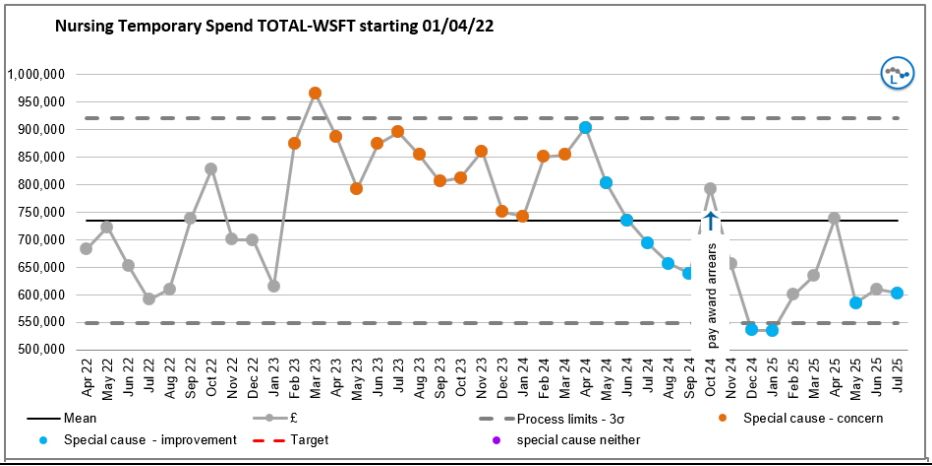
- The Community Nursing Safer Staffing Tool (CNSST) census is complete. Results are being interpreted.
- Therapy reduction in the INTs coupled with the new VAFs approved through savings made from Kings Suite closing has resulted in some internal movement required to balance therapy staffing across the 6 INTs.
- The INTS and Virtual ward are working on a shared services integration projects, the staff consultation end at the end of September.
- INT teams continue to utilise the daily capacity dashboard use to support decision on OPEL levels and actions to mitigate risk.

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

Total temporary spend is in special cause improvement.



		Values								
Exp-L1	Analaysis-1	In-M Bgt	In-M Act	In-M Var	YTD Bgt	YTD Act	YTD Var	FY Bgt	FY Act/FC	FY Var
Pay	Agency	0	0	0	0	23,501	(23,501)	0	26,102	(26,102)
	Bank	28,631	549,890	(521,259)	138,655	3,062,695	(2,924,040)	329,272	7,368,892	(7,039,620)
	Substantive	8,956,601	8,196,765	759,836	44,755,767	41,981,250	2,774,517	106,673,865	100,326,284	6,347,581
Pay Total		**8,985,231**	**8,746,655**	**238,577**	**44,894,422**	**45,067,446**	**(173,024)**	**107,003,137**	**107,721,279**	**(718,141)**
Grand Total		**8,985,231**	**8,746,655**	**238,577**	**44,894,422**	**45,067,446**	**(173,024)**	**107,003,137**	**107,721,279**	**(718,141)**

Table 17.

Month 5 (M5) reported an underspend of £238k; however, the year-to-date (YTD) position reflects an overall overspend of £173k. It is important to note that the budgets for FY25/26 have been implemented based on assumptions rather than full funding. These assumptions include projected vacancy rates and partial shift coverage (i.e., not all shifts are expected to be filled consistently).

This approach presents greater challenges in achieving budgetary targets compared to previous years, particularly as fill rates and staff sickness levels improve. Despite these constraints, the senior nursing team remains committed to operating within allocated resources, as evidenced by recent improvements in the management and control of temporary staffing expenditure

4.2 **Biannual inpatient review,**

The summer inpatient establishment review was completed in this period. The results are being review and will be presented next month to provide assurance around nursing staffing levels

Qualifying Student recruitment

There is growing national attention on the challenges faced by newly qualified nurses and midwives in securing employment following registration. Despite a generally positive vacancy position across many NHS trusts, service reviews and sustainability pressures have led to difficulties in offering substantive roles to students who have trained within clinical environments. West Suffolk NHS Foundation Trust has not been exempt from these challenges.

In particular, the need to hold vacancies to mitigate the risk of redundancy for staff affected by service redesign and consultation processes has further constrained recruitment opportunities. However, through a proactive and creative approach to recruitment, the Trust has successfully supported all members of the qualifying cohort into employment either within the organisation or in neighbouring trusts.

All adult nursing students seeking employment at West Suffolk have been recruited. While placement of paediatric nursing students presented more complexity, suitable roles have been secured. Additionally, the Trust has accessed national funding to support the employment of newly qualified midwives into vacant maternity care assistant (MCA) roles, ensuring no additional cost burden to the organisation.

This outcome reflects the Trust's commitment to supporting the transition of newly qualified professionals into the workforce and maintaining strong partnerships with educational institutions and system partners.

5. Conclusion

5.1 In summary, the Trust continues to demonstrate a proactive and data-driven approach to nursing and midwifery workforce management. Recruitment of registered nurses remains positive, with vacancy rates consistently below 10%, while nursing assistant recruitment shows signs of stabilisation.

Improvements in fill rates and reductions in sickness absence have contributed to enhanced staffing resilience, particularly in inpatient areas.

The Trust's commitment to financial sustainability is evident through ongoing efforts to reduce temporary staffing spend and optimise deployment. Continued focus on quality indicators, safe staffing compliance, and strategic workforce planning will be essential to maintaining high standards of patient care and supporting the Trust's recovery ambitions.

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

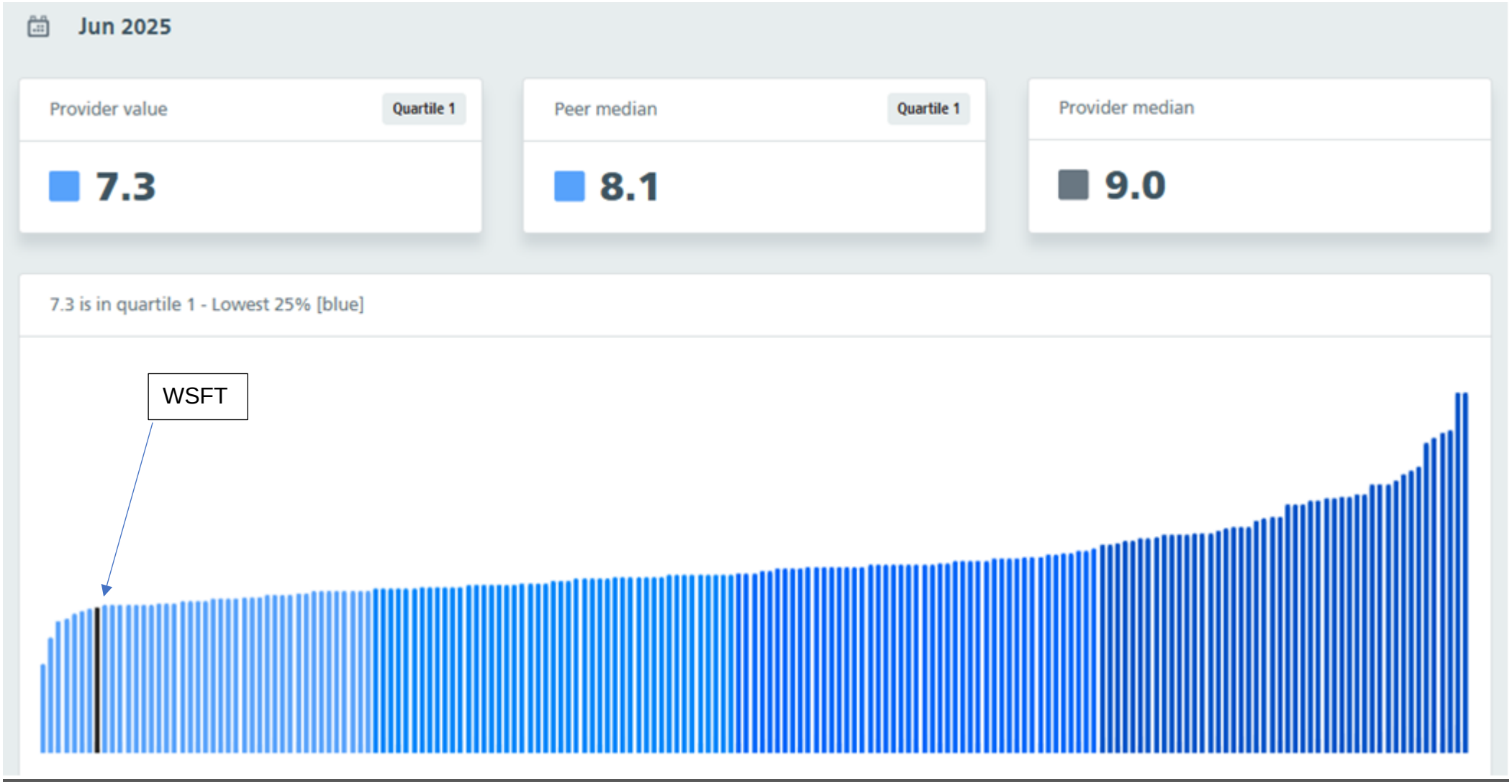
	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned 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	1380	1317.667	1783.25	1599	1069.5	1068	1426	1389	95%	90%	100%	97%	891	2.7	3.4	6.0
Glastonbury Court	715	717	1066.5	1022	713	714	535.5	538.5	100%	96%	100%	101%	541	2.6	2.9	5.5
Acute Assessment Ur	2308	2272	1895.25	1855.5	1713.5	1681.91667	1337.5	1338.8333	98%	98%	98%	100%	679	5.8	4.7	10.5
Cardiac Centre	1782.5	1551.75	1057.5	914.5	1782.5	1666	710	684.5	87%	86%	93%	96%	637	5.1	2.5	7.6
G10	1772.75	1482.417	1782	1687.75	1069.5	1046	1782.5	1754	84%	95%	98%	98%	972	2.6	3.5	6.1
G9	1709.5	1502.5	1400	1315.5	1403	1404	1069	1069.5	88%	94%	100%	100%	817	3.6	2.9	6.6
F12	713	706.75	356.5	349.75	714	642	356.5	333.5	99%	98%	90%	94%	236	5.7	2.9	8.6
F7	1686.5	1493.5	1763.5	1633	1345.5	1168.5	1782.5	1694	89%	93%	87%	95%	990	2.7	3.4	6.2
G1	1069.5	733.5	356.5	409.5	713	701.5	356.5	442.5	69%	115%	98%	124%	359	4.0	2.4	6.4
G3	1721.5	1452.75	1771	1770	1069.5	1057.5	1426	1599.5	84%	100%	99%	112%	1998	1.3	1.7	2.9
G4	1705	1528	1771.5	1649.5	1069.5	1031.5	1426	1395	90%	93%	96%	98%	982	2.6	3.1	5.7
G5	1100.5	1084	1076.75	939.25	1046.5	897.5	793.5	812.5	99%	87%	86%	102%	585	3.4	3.0	6.4
G8	2317.75	1847.833	1783	1526.333	1713.5	1686.41667	1069.5	1058.1667	80%	86%	98%	99%	865	4.1	3.0	7.1
F8	1674	1547.25	1761	1560	1068	1011.5	1426	1406	92%	89%	95%	99%	0	-	-	-
Critical Care	2314.6667	2279.833	145.75	144.25	2302.5	2179.33333	0	0	98%	99%	95%	*	233	19.1	0.6	19.8
F3	1679	1464.1	1777.5	1733	1069.5	1056.5	1426	1414.5	87%	97%	99%	99%	920	2.7	3.4	6.2
F4	931.5	839.9167	598	531.5	655.5	561	368	258.75	90%	89%	86%	70%	173	8.1	4.6	12.7
F5	1426	1450.917	1400	1386.75	1069.5	1078.5	1069.5	1208	102%	99%	101%	113%	510	5.0	5.1	10.1
F6	1587.5	1523.5	1647.75	1530.75	1068	1065.5	1390.01667	1371.5	96%	93%	100%	99%	961	2.7	3.0	5.9
Neonatal Unit	1799.5	1728	372	436.5	1116	1142	647	539	96%	117%	102%	83%	346	8.3	2.8	11.1
F1	1998.25	1683.25	713	748.5	1426	1368.5	0	184	84%	105%	96%	*	260	11.7	3.6	15.3
F14	368	369	372	372	744	720	0	0	100%	100%	97%	*	115	9.5	3.2	12.8
Total	33,759.92	30,575.43	26,650.25	25,114.83	25,941.50	24,947.67	20,397.52	20,491.25	**91%**	**96%**	**96%**	**99%**	**14,070**	**4.0**	**3.2**	**7.3**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

Appendix 1b. Fill rates for inpatient areas (August 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	1424.75	1291.8	1782.25	1487.5	1069.5	1056	1426	1379.5	91%	83%	99%	97%	876	2.7	3.3	6.0
Glastonbury Court	678.5	517.5	813	548	644	460	320.5	180.5	76%	67%	71%	56%	213	4.6	3.4	8.0
Acute Assessment Uni	2343.5	2214.083333	1986.733333	1856.483333	1771	1761.5	1409	1348	94%	93%	99%	96%	737	5.4	4.3	9.8
Cardiac Centre	1782.5	1589	1054.666667	893.1166667	1782.5	1726.5	713	629.5	89%	85%	97%	88%	649	5.1	2.3	7.5
G10	1782.25	1461.583333	1772.233333	1689.233333	1069.5	1020.66667	1782.5	1792.833333	82%	95%	95%	101%	974	2.5	3.6	6.1
G9	1679	1542	1414.5	1438	1391.5	1358	1069.5	1081	92%	102%	98%	101%	822	3.5	3.1	6.7
F12	713	720.5	356.5	255.5	710.5166667	658	356.5	393.5	101%	72%	93%	110%	233	5.9	2.8	8.7
F7	1593	1325.5	1782.5	1646.5	1357	1146	1782.5	1656	83%	92%	84%	93%	1005	2.5	3.3	6.0
G1	1066.25	719.75	355.5	361	713	713.5	356.5	368	68%	102%	100%	103%	368	3.9	2.0	5.9
G3	1782.5	1537.5	1778	1795.5	1069.5	1070	1426	1666	86%	101%	100%	117%	1942	1.3	1.8	3.1
G4	1736.5	1570.75	1773	1701.5	1069.5	1023.5	1426	1492.5	90%	96%	96%	105%	965	2.7	3.3	6.0
G5	1069.5	1006.25	1092.5	1005.5	943	814.5	1069.5	1031	94%	92%	86%	96%	549	3.3	3.7	7.0
G8	2346	1831.833333	1774.333333	1631.433333	1690.5	1649.16667	1069.5	1042	78%	92%	98%	97%	844	4.1	3.2	7.3
F8	1631	1464.683333	1699	1522.75	1069.5	978.333333	1374	1369.5	90%	90%	91%	100%	0	*	*	*
Critical Care	2660.25	2554.666667	82.5	77.75	2514.483333	2506.23333	0	11.5	96%	94%	100%	*	228	22.2	0.4	22.6
F3	1673	1534.25	1770	1586.5	1069.5	1012	1426	1423.5	92%	90%	95%	100%	830	3.1	3.6	6.8
F4	862.5	909.1666667	494.5	448.5833333	678.5	564.5	230	232	105%	91%	83%	101%	223	6.6	3.1	9.7
F5	1414.5	1395.583333	1401.5	1373.75	1058	989.5	1054	1012	99%	98%	94%	96%	366	6.5	6.5	13.1
F6	1621.5	1493.5	1668.5	1496.5	1069.5	1053.5	1374.51667	1312	92%	90%	99%	95%	912	2.8	3.1	6.1
Neonatal Unit	1639.5	1464.75	372	481	1116	1178.5	480	444	89%	129%	106%	93%	346	7.6	2.7	10.3
F1	2068.5	1642.833333	713	633.25	1426	1299.5	0	92	79%	89%	91%	*	167	17.6	4.3	22.0
F14	372	360	372	359	744	744	0	0	97%	97%	100%	*	100	11.0	3.6	14.6
Total	**33,940.00**	**30,147.48**	**26,308.72**	**24,288.35**	**26,026.50**	**24,783.40**	**20,145.52**	**19,956.83**	**89%**	**92%**	**95%**	**99%**	**13,349**	**4.1**	**3.3**	**7.5**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

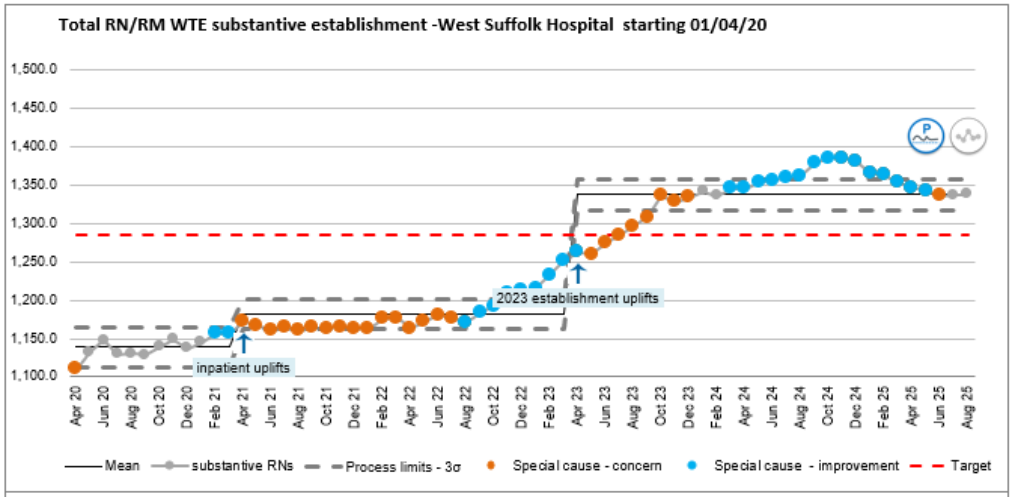
Appendix 2. CHPPD Model Hospital data (January data accessed 15.9.25

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.

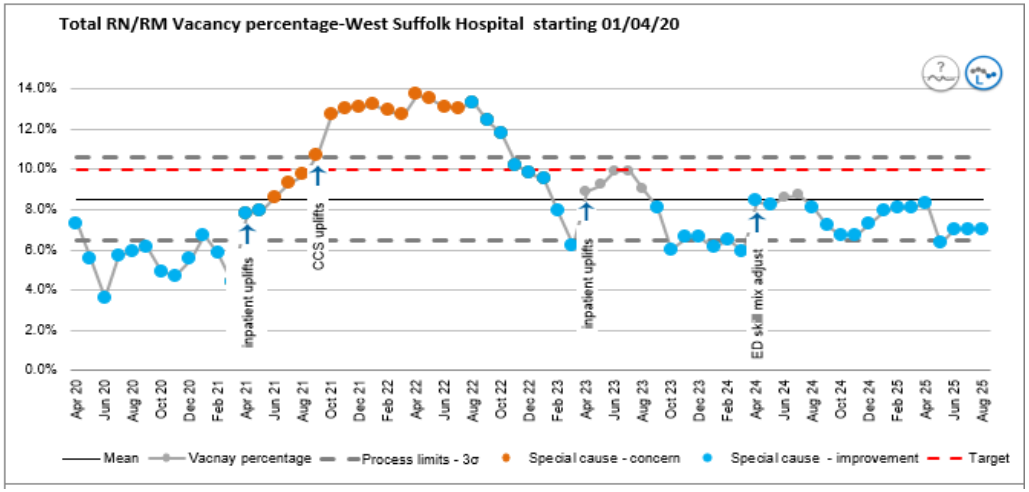


Appendix 3 WTE and Vacancy rates.

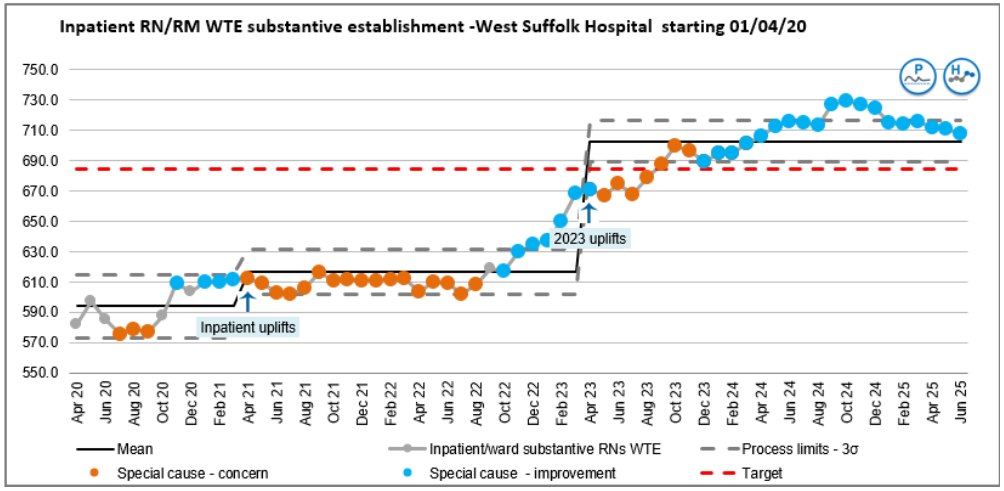
A) Trust Total RN/RM WTE



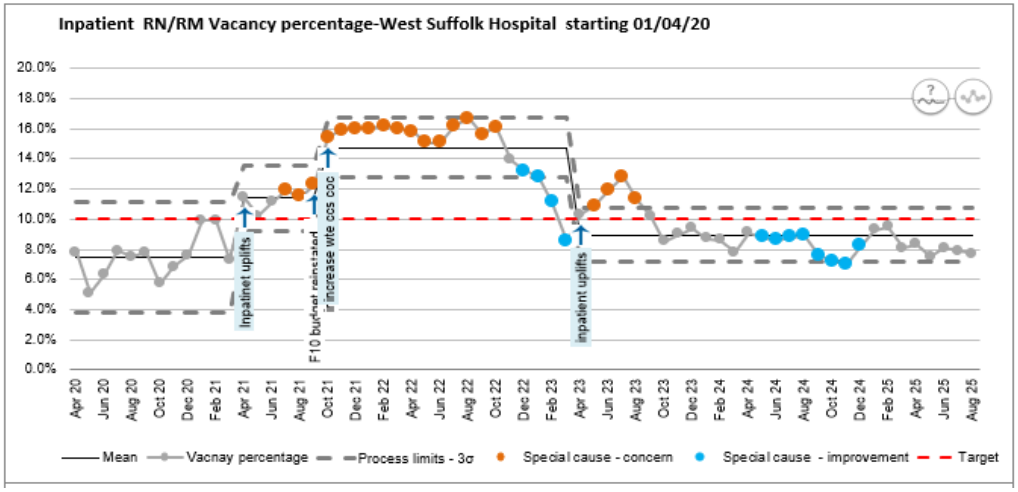
B) Trust Total RN/RM vacancy %



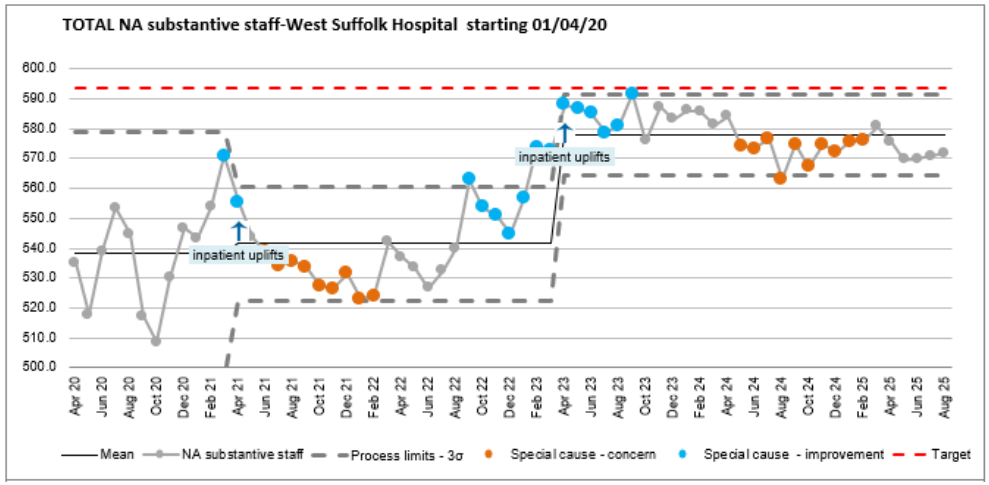
C) Inpatient RN/RM WTE



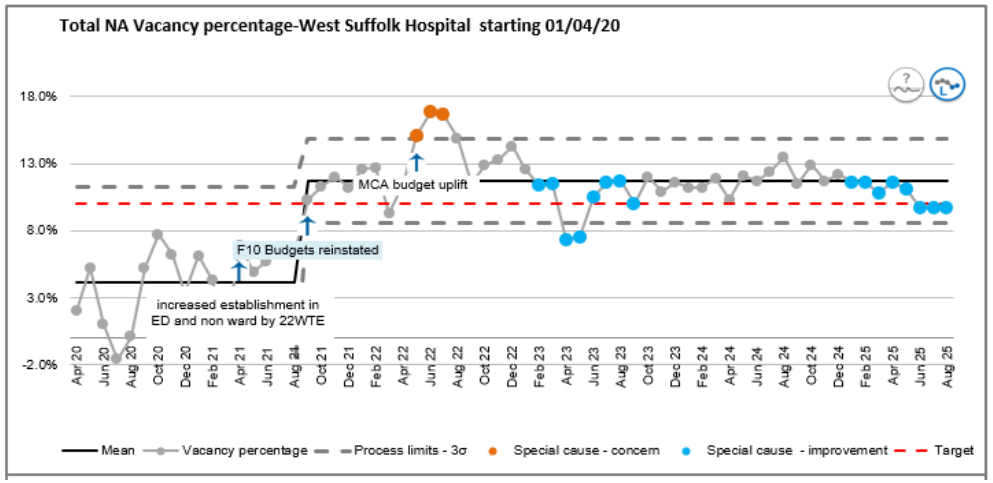
D) Inpatient RN/RM vacancy %



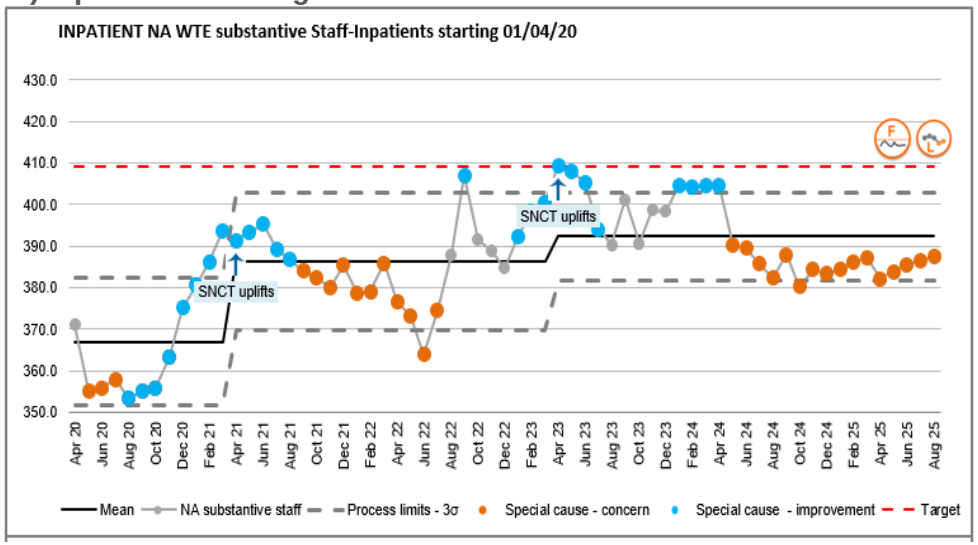
E) Total NA/unregistered WTE.



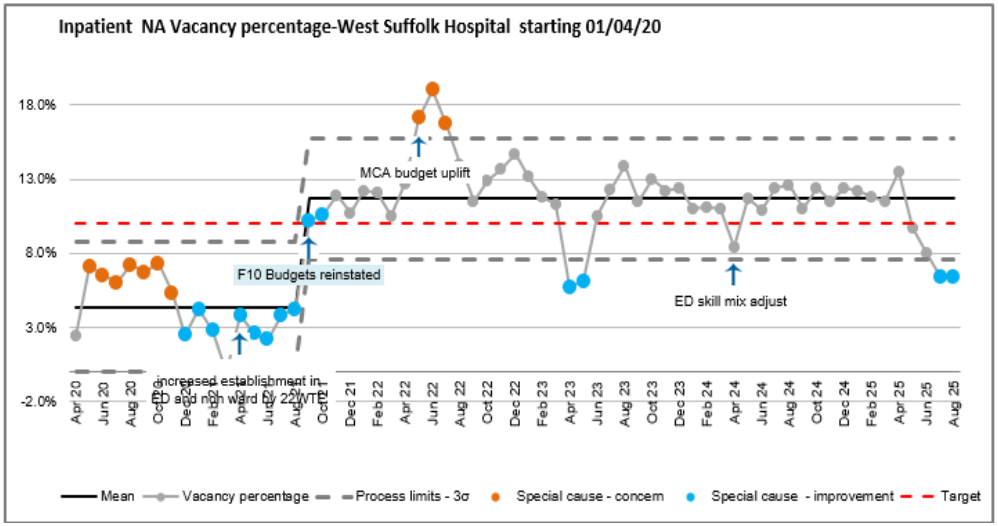
F) Total NA/Unregistered vacancy %



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:	26th September 2025
Sponsor/executive lead:	Dan Spooner, 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;
    - Perinatal Mortality Report Q1 April – March 2025
    - Maternity and Neonatal Safety Investigations (MNSI) Q1April- June 2025
- 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 Oversight Model

The Perinatal Quality Oversight model (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. In recognition that neonatal services are interdependent with maternity services, the PQOM refer to maternity and neonatal in terms of 'perinatal'. The 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 Trust level components of the PQOM is available in Annex A.

On the 23rd June 2025, NHS England announced a rapid independent investigation into maternity and neonatal services. In addition to the PQOM Trust boards were asked to focus on the five key areas relating to maternity and neonatal care. The West Suffolk perinatal service acknowledges the importance of the directives outlined and is committed to ensuring that our maternity and neonatal services are safe, compassionate, and equitable. We are pleased to report that the following actions are either in place or actively being progressed:

1. **Addressing Poor Behaviour and Team Culture**
   The Trust has clear policies and procedures for identifying and addressing poor behaviours and team cultures. We are rigorous in our approach, ensuring that concerns are escalated and managed without delay. Staff who demonstrate repeated failures in compassion or quality of care are managed through robust HR and professional standards processes. Leadership teams are supported to foster respectful and inclusive environments.

2. **Listening to Families and Supporting Staff to Speak Up**
   We have strengthened our mechanisms for listening directly to families at the point concerns are raised. This includes structured debriefs, a designated point of contact for each family and improved complaint handling pathway. We are also embedding a culture of psychological safety for staff, encouraging openness and learning from mistakes.

3. **Setting the Right Culture Through Coproduction**
   The service is actively working with our Maternity and Neonatal Voices Partnership (MNVP) and local families to co-design services. Regular engagement sessions, feedback loops, and joint improvement initiatives are in place to ensure that the voices of women and families shape our care delivery.

4. **Data-Driven Quality Improvement**

We have enhanced our data review processes, with regular board-level scrutiny of maternity and neonatal outcomes and experiences. This includes dashboards tracking key metrics, incident reviews, and patient experience data. These insights are used to drive targeted improvements and ensure accountability.

5. **Tackling Inequalities, Discrimination and Racism**
   The Trust maintains a strong focus on equity. The Trust has implemented an anti-discrimination programme by training leadership teams to improve culture and practice. We are also developing plans to deliver enhanced continuity of care in our most deprived communities, ensuring additional support is provided to women who need it most. Our data systems now allow us to track variation and target interventions more effectively.

The maternity and neonatal service remains fully committed to delivering safe, high-quality, and equitable maternity and neonatal services. We will continue to monitor progress closely and ensure that our actions reflect the values and expectations of the communities we serve.

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 Maternity and Newborn Safety Investigations, external site visits and self-assessment against other national best practice (e.g., MBRRACE, SBLCBv3). It has been agreed with the exit from the Maternity Safety Support Programme (MSSP) in October 2022, that NHSE regional team and ICB (Integrated Care Board) 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'.

Due to the Non-executive director (NED) safety champion departing at the end of June no walkabout took place in July. Paul Zollinger-Read has kindly taken on the interim NED role until a substantive replacement is appointed.

Dr Richard Goodwin (Medical Director & Executive Maternity and Neonatal Safety Champion) visited the Neonatal unit on the 13th August 2025 with the following feedback;

- Busy level 1 unit fed by the surrounding level 2 and 3 units
- Committed and dedicated workforce with a sense of identity and cohesion
- Passionate advocates for their service including parent groups and the physiotherapist service
- Clear sense of roles and responsibilities within the multi-disciplinary team
- Recent change in medical leadership is welcome
- Some concerns about staffing but an acknowledgement that people are flexible to cover gaps
- At peak times staff were called away from their 'day jobs' to support the unit, although this was understood as being necessary from time to time.
- Concerns about loss of pay if people are moved from night to daytime shifts to cover absences

	• Some concerns about the plans for the new hospital following the latest NHP Hospital 2.0 designs with discussions planned with our FSP team. Dr Richard Goodwin then visited Maple House on the 19th august 2025, hearing all about the work of the Abbeygate community team with the following themes: • A really dedicated team working in a very different but no less challenging environment to the core WSH team • Rising caseload with increasing complexity means that each staff member is getting towards the upper limit of numbers, but they appreciated the efforts made to recruit into vacancies • Stowmarket numbers are around 50% higher than had been expected when we took the work on. Seemingly mothers are choosing Stowmarket from as far away as Eye and Woodbridge • Challenges with the interfaces with neighbouring maternity units for the Stowmarket and Haverhill areas respectively. • An inevitable sense of distance between the core and community teams but ensuring community presence at the MDT and secondments have helped with that. • The secondments from the core team have been good but unless they are for a long time it's hard to give secondees their own caseload. • Maple House is not well suited to clinical care although there are some concerns about the forthcoming move to the Disability Resource Centre. There's a meeting planned for further discussion. • The Abbeygate team have enough bilirubinometers for their team, helped by arrangements for signing them in and out. No lack of equipment issues was reported.
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, which 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 and raising concerns. 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 and additional sessions are due to be planned for later this year. In addition to this our culture coaches are working with all staff groups to introduce MOMENTS (**M**eanings, c**O**mpetencies and **M**aterials in **E**veryday (**N**) **T**eam, **S**afety)

WHAT	A set of resources (website, animation, reflection guide and good practice guide) to support leaders and clinical teams to better understand and nurture their local safety culture by understanding how the work is done rather than focusing on what is done.
WHY	Spark discussion and deliberation, to encourage reflection and curiosity, and to allow staff to understand how their team's local safety culture plays out in their daily practices and to reflect on how it could be improved.
HOW	The act of participation itself impacts positively on culture, allowing teams to build relationships and reflect together

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	July Survey Responses	July Very good and good %	% of discharged people provided feedback*	August Survey Responses	August Very good and good %	% of discharged people provided feedback*

F11	57	95%	18%	56	98%	17%
Labour Suite	9	100%	23%	12	92%	48%
Birthing Unit	6	100%	100%	7	100%	58%
NNU	0	-	0%	2	100%	5%
Antenatal	22	100%		35	71%	
Postnatal Community	33	94%		16	88%	

*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. The strategy has been established to reintroduce the MNVP group, and the members of this group will be recruited by the LMNS MNVP Lead throughout Autumn 2025.

In terms of patient experience, WSFT received four compliments relating to maternity and neonatal services in July 2025. However, in August 2025, this decreased to one compliment regarding the Labour Suite.

In July 2025, three PALS enquiry were submitted concerning patient care, clinical treatment, privacy, dignity and wellbeing on the antenatal/ postnatal ward F11. In August 2025 also three enquiries were received, covering issues related to care needs, admission and discharges.

Two formal complaints were received in July 2025 regarding the communication and clinical treatment on the Labour Suite. In August 2025, one formal complaint was received, primarily focused on communication and follow up. While patient feedback, both positive and negative, plays an essential role in service improvement, the service recognises the need for ongoing immediate and structured action in response to the feedback received.

1.6 **Reporting and learning from incidents**

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

	July 25	August 25
No. of MNSI referrals	0	0
No. of Patient safety incidents	83	92

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.**

Aug 2025	Saving Babies Lives E-Learning Module	GAP/GROW	Maternity Emergencies / OMET	Skills and Drills	CO Monitor	Safeguarding	Neonatal Life Support	Fetal Heart Surveillance	Newborn Feeding update
Midwives	98.8%	93.34%	95.71%	95.71%	76.78%	97.56%	95.71%	95%	85%
MCA/MSW	N/A	N/A	97.62%	97.62%	61.2%	100%	97.62%	N/A	88%
Consultant Obstetrician	93.75%	68.75%	93.75%	93.75%	56.25%	95%	N/A	93%	N/A
Obstetric Registrar	80%	44.45%	90%	90%	40%	81%	N/A	90%	N/A
Obstetric Resident Doctors	66.66%	66.66%	77.78%	77.78%	55.56%	75%	N/A	N/A	N/A
Sonographer	N/A	90%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Consultant Anaesthetist (obs)	N/A	N/A	62.5%	62.5%	N/A	N/A	N/A	N/A	N/A
Obstetric Anaesthetists	N/A	N/A	66.67%	66.67%	N/A	N/A	N/A	N/A	N/A
Neonatal Consultants	N/A	N/A	N/A	75%	N/A	94%	92.9%	N/A	65%
Neonatal Nurses	N/A	N/A	N/A	69%	N/A	92%	77%	N/A	89%
Neonatal Reg & Resident Drs	N/A	N/A	N/A	No Data	N/A	100%	85.8%	N/A	71%
ANNP/PA	N/A	N/A	N/A	No Data	N/A	100%	100%	N/A	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.
The method of Carbon Dioxide (CO) training, changed in July hence lower than expected figures.
To note; new registrars and resident doctors joined the Trust in August, explaining the lower than expected figures for these staff groups.
The low compliance for GAP/GROW (antenatal fetal growth survielance) has been addressed with a targeted approach taking place in September.
The Neonatal nurse low compliance is due to new starters, which will all attend the training by the end of 2025.

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.

Overview of progress on MIS year 7 safety action requirements

*Mandated Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	7	0	0	7
2	0	2	0	0	2
3	0	1	5	0	6
4	0	19	0	0	19
5	0	12	0	0	12
6	0	9	0	0	9
7	0	3	1	0	4
8	0	21	0	0	21
9	0	3	6	0	9
10	0	9	0	0	9
Total	0	86	12	0	98

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

*Non-mandated sctions will not be included in this table.

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.
No reports were due to be presented to the Improvement Committee held in July 2025.

Following reports were presented and approved at the Improvement Committee held on the 20th August 2025:

	• Midwifery workforce report Oct 24-March 25 • Obstetric Anaesthetic workforce report Oct 24-March 25 There were no reports due to be presented at September's Improvement board.
3.	**Reports for CLOSED BOARD** Due to the level of detail required for these reports and subsequently containing possible patient identifiable information, the full reports will be shared at Closed board only.
3.1	**Perinatal mortality Report Q1, 1st April 2025- 30th June 2025** The Trust reported <5 perinatal losses to Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE) in this quarter. All cases have received bereavement support. All the timeframes for reporting to MBRRACE have been met and local and Perinatal Mortality Review Tool (PMRT) reviews are on course for completion. Two PMRT reports have been completed from previous quarters and learning has been identified and shared with the teams.
3.2	**Maternity and Neonatal Safety Investigations (MNSI) Report Q1, 1st April 2025- 30th June 2025** There have been no incidents in the Trust that met the reporting criteria for MNSI nor the NHS Resolution Early Notification Scheme (ENS) in this quarter and no completed MNSI reports. The Maternity and Neonatal services remain vigilant to identify any incidents that may need further external investigation and have embedded processes to review and identify learning at an early stage.
4.	**Next steps**
4.1	Reports will be shared with the external stakeholders as required. Action plans will be monitored and updated accordingly.

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. 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:	26 September 2025
Sponsor/executive lead:	Richard Jones, Trust Secretary
Report prepared by:	Paul Bunn (Trust Solicitor)/Mike Dixon, Health, Safety & Risk Manager

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

Executive Summary

WHAT?

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

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 summarises the review work since July 2025.

The BAF remains structured around **10 strategic risks** (agreed in November 2022). 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. 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

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

- **BAF 1 Capability** - This is within risk appetite. Reviewed and presented to MEG in July and Involvement in August.
- **BAF 4 Continuous Improvement & Innovation** – This is within risk appetite. Reviewed and presented to Improvement September 2025.
- **BAF 5** – This is outside risk appetite, but mitigation action plan in place to achieve risk appetite in future. Progress monitored through Digital Board, last reviewed in July. This is a standing Agenda item for Digital Board.

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

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. Acting Trust Secretary to work with BAF leads in future to map progress and ensure we are meeting mitigations by due date.

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

Escalations
The internal audit recommended that the Board should be made specifically aware of any escalations or de escalations to the BAF, there are none to report this month and this will be kept under review.

BAF 26/27
The current BAF will need to be extensively reviewed once the Trust's revised strategy is finalised. A Board Workshop is scheduled for February 2026 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:

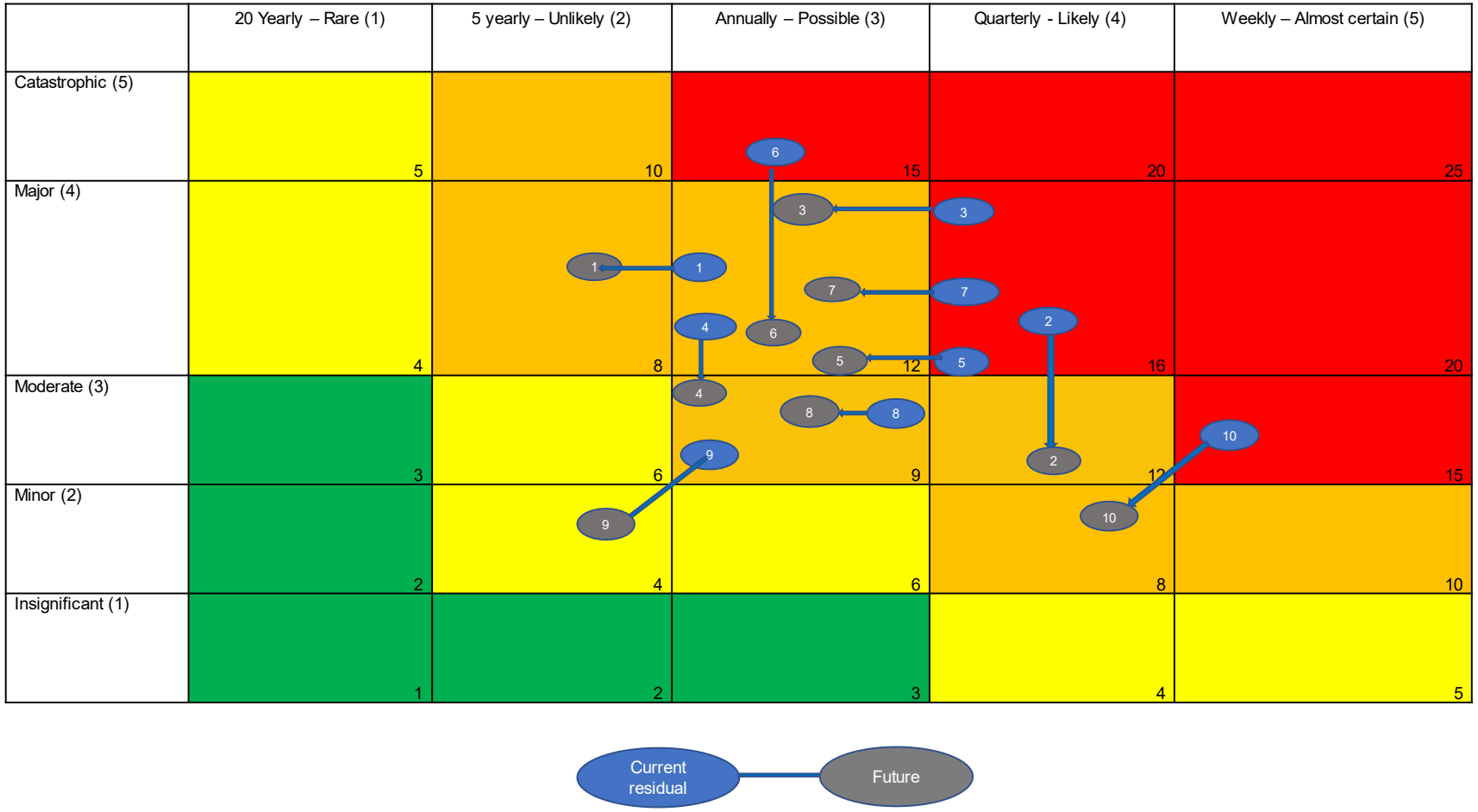
- Schedule **review of risks to the agreed strategy** when the strategy refresh has been undertaken. This will also include review and assessment of the risk appetite for each risk (Q4-Feb 26)
- To arrange a Board Risk Management workshop supported by external stakeholders in December, which will include 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. (Q4-Feb 26)
- A matrix will be developed to **map the interdependencies** between individual BAF risks after the strategy refresh . (Q1-26/27)
- Review and refresh **longer term assessment** of the mitigation and risk for each of the BAF risks to achieve the agreed risk appetite (Q1- 26/27).

Action Required

1. **Note the report** and progress with the BAF review and development
2. **Approve the 'Next steps' actions**.
3. **Consider reporting frequency of BAF to Board**-should this move to quarterly

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.	Appetite Level and score	Inherent risk 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 Feb 26 (MEG-Jan 26)	Cautious (9)	20	12	8 (Oct 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 (MEG-Sept '25)	Cautious (9)	20	16	12 (Oct 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 (MEG-Sept '25)	Open (12)	16	16	12 (Dec 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 (MEG-Aug '25)	Open (12)	16	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	Cautious (9)	20	16	12 (Nov 25)	No	Partial

Risk Descriptions	Exec lead	Board comm.	Appetite Level and score	Inherent risk score	Current risk score	Future risk score (target date)	Future risk with appetite?	Assur. level
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 MEG-Aug '25)	Open (12)	20	15	12 (Sep 25)	Yes	Partial
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 planned Nov 25 (MEG-Oct)	Cautious (9)	16	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 Planned for Jan '26 (MEG-Dec '25)	Minimal (6)	20	9	9 (at score)	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 (MEG-Sep '25)	Cautious (9)	12	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 Planned for Nov '25 (MEG-Oct '25)	Cautious (9)	15	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

7.2. Governance Report (ATTACHED)

To inform

Presented by Paul Bunn

WSFT Board of Directors (Open)	
Report title:	**Governance report**
Agenda item:	
Date of the meeting:	26 September 2025
Sponsor/executive lead:	Paul Bunn, Acting Trust Secretary
Report prepared by:	Paul Bunn, Acting Trust Secretary Pooja Sharma, Deputy Trust Secretary

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

Executive Summary
WHAT? *Summary of issue, including evaluation of the validity the data/information*
This report summarises the main governance headlines for September 2025, as follows: • Senior Leadership Team • Management Executive Group • Council of Governors' report • Remuneration Committee report • Board development session • 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 (SLT) met on 18 August to collectively discuss the strategy refresh and receive input on the progress. The SLT was also briefed on the Month 4 financial position, including income and expenditure summary, underlying position and forecast, CIP progress.

The SLT meeting on 15 September 2025 featured the launch of Performance, Accountability and Autonomy framework. The framework is an accountability mechanism, aims to hold divisions and services to account, to improve performance for patients and population and describe how accountability interacts with autonomy. The framework standardises mechanisms and culture to improve accountability and performance across multiple organisational domains (safety, quality, operational performance, finance, workforce).

2. Management Executive Group

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

3. Council of Governors report

The Council of Governors met on 11 September 2025.

The Council of Governors received an introductory presentation from the newly appointed Chief Nurse, Daniel Spooner, which included a summary of key achievements since joining the Trust, along with a brief outline of current priorities and future opportunities.

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

The Governors noted the report from **Nomination Committee** which highlighted the terms of office for the NED, along with update on University of Cambridge NED nomination.

The Council of Governors received a report from the **membership and engagement committee** to draw attention to VOICE meetings and initiatives around patient engagement and governor activities. An update was also provided on the engagement initiatives on the New Hospital Programme, membership and engagement strategy development plan and governor activities during the quarter.

The Council of Governors received a report from the **Standards Committee** to note the update on compliance with the code of conduct, committee's work plan, Governors' Development Programme and progress update on lead governor election process 2025.

The Council of Governors also noted the reports from **staff governors** and **lead governor**.

The Council in the closed meeting approved the recommendation from the nominations committee to extend the term for non-executive director and senior independent director.

The Council of Governors approved the appointment of lead governor. Single nomination was received and the Council unanimously agreed to appoint Andy Morris (staff governor) to start their term w.e.f. 1 January 2026.

4. Remuneration Committee report

The remuneration committee met on 2 September 2025 to discuss the VSM arrangements and remuneration. The Committee also noted an update on the recruitment to substantive executive roles for chief finance officer and chief people officer was provided. Remuneration policy was reviewed in line with the new guidance from the national body. The terms of reference of the committee were reviewed and are scheduled for presentation to the board for approval in the next meeting.

5. Board development session

The next board development session is scheduled for October 2025.

6. Urgent decisions by the Board

None to report.

7. Use of Trust Seal

None to report.

8. 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.

Annex A: Scheduled draft agenda items for next meeting – 28 November 2025

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
Patient/staff story	✓	✓	Verbal	Matrix	CN / CPO
Chief Executive's report	✓		Written	Matrix	CEP
System update: - West Suffolk Alliance and SNEE Integrated Care Board (ICB) - Wider system collaboration - Joint productivity board	✓		Written	Matrix	 WSA Dir / Area Dir DoST DoST
Future System Board Report	✓		Written	Matrix	CEO
Digital Board report	✓		Written	Matrix	COO / CIO
EPRR core standards submission report		✓	Written	Matrix	COO
Insight Committee - committee key issues (CKI) report - Finance report	✓		Written	Matrix	NED chair / COO / CFO
Involvement Committee – committee key issues (CKI) report - People and OD Highlight Report o Putting you First award o FSUP Guardian	✓		Written	Matrix	NED chair / CPO
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	NED chair / CN
Audit committee – committee key issues (CKI) report	✓		Written	Matrix	NED chair
Charitable funds committee report	✓		Written	Matrix	NED chair
Governance report	✓		Written	Matrix	(A)TS
Confidential staffing matters		✓	Written	Matrix – by exception	CPO
SIRO report		✓	Written		COO
Board assurance framework report	✓		Written	Matrix	(A)TS
Reflections on the meetings (open and closed meetings)	✓	✓	Verbal	Matrix	Chair
Annexes to Board pack: - Integrated quality & performance report (IQPR) – annex to Board pack - Others as required					

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 - 28 November 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

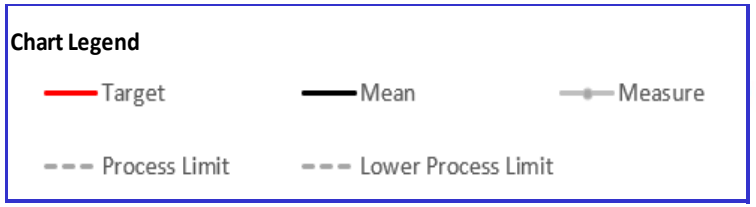
Assurance Grid

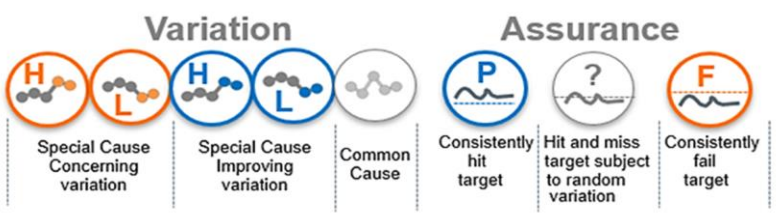
Performance in July 2025	ASSURANCE: Will we reliably meet the target based?		Not Met	
	Pass (P)	Hit and Miss (?)	Fail (F)	No Target
VARIANCE: Variation from the mean. The colours indicate the trend- positive (blue), Negative (orange), or neither (grey) — Special Cause Improvement (H / L)	**INSIGHT** Virtual Beds Trajectory **INVOLVEMENT** Staff Sickness	**INSIGHT** % patients with no criteria to reside	**INSIGHT** Virtual Ward Total average occupancy number RTT 78+ Week Waits **INVOLVEMENT** Appraisal	**INSIGHT** Criteria to reside Acute RTT 52+ Weeks Wait as % of Total WL
Common Cause	**INSIGHT** 4 hour breaches Urgent 2 hour response – EIT Virtual Ward Total average LOS per patient **INVOLVEMENT** Staff Sickness – rolling 12month	**INSIGHT** Ambulance Handover within 30min 12 Hour Breaches Non-admitted 4 hour performance 12 hour breaches as a percentage of attendances Virtual Ward Total average occupancy percentage 28 Day Faster Diagnosis Cancer 62 Days Performance Community Paediatrics RTT Overall 78 Waiting List **IMPROVEMENT** C-diff Hospital & Community onset, Healthcare Associated **INVOLVEMENT** Mandatory Training	**INSIGHT** Incomplete 104 Day Waits RTT 65+ Week Waits	**INSIGHT** Criteria to reside Community Virtual Ward Total bed days RTT <18 Week Waits (% All) **IMPROVEMENT** % of patients with measured weight % of patients with a MUST/PYMS assessment completed within 24hours of admission Post Partum Haemorrhage Inpatient Deaths **INVOLVEMENT** Closed complaints % extended Count extended % Complaints responded to late % resolved in one week Total PALS resolved Count
Special Cause Concern (H / L) — Deteriorating		**INVOLVEMENT** Turnover	**INSIGHT** Diagnostic Performance - % within 6weeks Total	**INSIGHT** RTT Waiting List RTT <18 Wek Waits (% First OPA) Community Paediatrics RTT Overall Waiting List Community Paediatrics RTT Overall 52 Waiting List Community Paediatrics RTT Overall 65 Waiting List **IMPROVEMENT** SHMI **INVOLVEMENT** Active complaints Count responded to late

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: Virtual Ward Total average occupancy number
Cancer: Incomplete 104 Day Waits
Elective: Diagnostic Performance - % within 6weeks Total, RTT 65+ Week Waits, RTT 78+ Week Waits
INVOLVEMENT – Well Led: Appraisal, Turnover

INSIGHT COMMITTEE METRICS

Urgent & Emergency Care summary

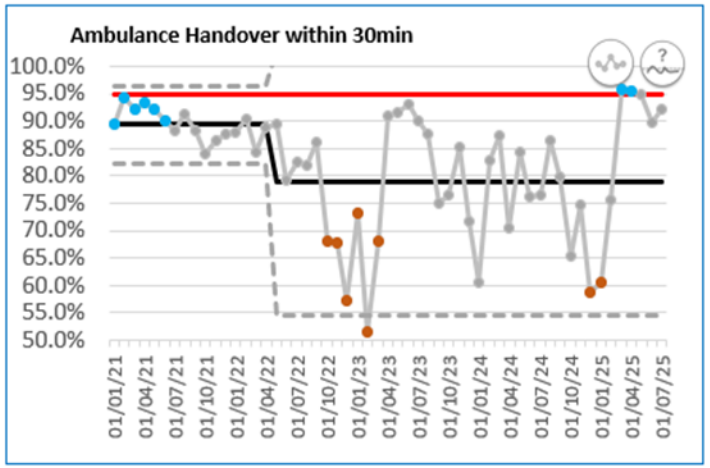


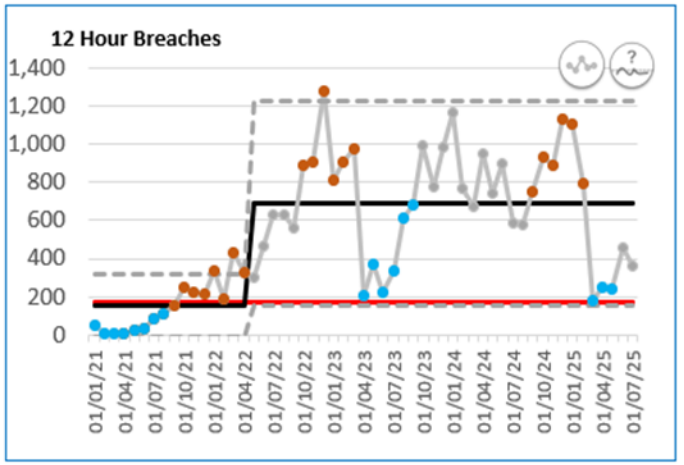


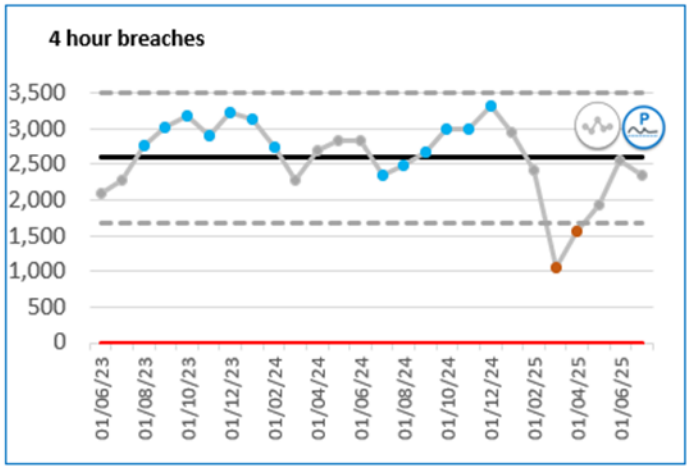
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover within 30min	Jul 25	96.3%	95.0%			78.9%	54.5%	103.4%
12 Hour Breaches	Jul 25	357	167			690	157	1223
4 hour breaches	Jul 25	2348	0		P	2600	1688	3513
Non-admitted 4 hour performance	Jul 25	83.0%	85.0%			78.1%	67.2%	89.0%
12 hour breaches as a percentage of attendances	Jul 25	4.1%	2.0%			6.8%	1.5%	12.2%
Urgent 2 hour response - EIT	Jul 25	93.4%	70.0%		P	91.2%	84.2%	98.1%
Criteria to reside (Average without reason to reside) Acute	Jul 25	34		L		52	38	67
**Criteria to reside (Average without reason to reside) Community	Jul 25	43				37	27	46
% patients with no criteria to reside (acute)	Jul 25	8.5%	10.0%	L		12.0%	8.3%	15.8%
Virtual Beds Trajectory	Jul 25	53	40	H	P	47	43	52
Virtual Ward Total average occupancy number	Jul 25	32.4	47.2	H	F	25.2	16.6	33.8
Virtual Ward Total average occupancy percentage	Jul 25	61%	80%			66%	42%	90%
Virtual Ward Total bed days	Jul 25	962				774	344	1204
Virtual Ward Total average LOS per patient	Jul 25	5.6	14.0		P	8.7	4.9	12.5

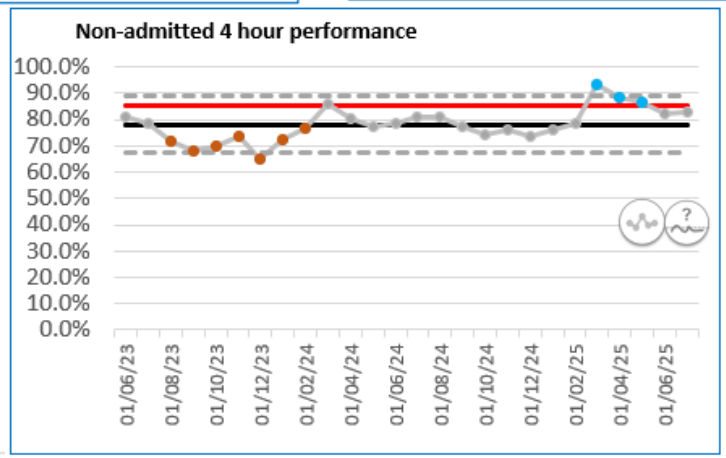
** Figures are for Glastonbury and Newmarket only, data not currently captured at Hazel Court.

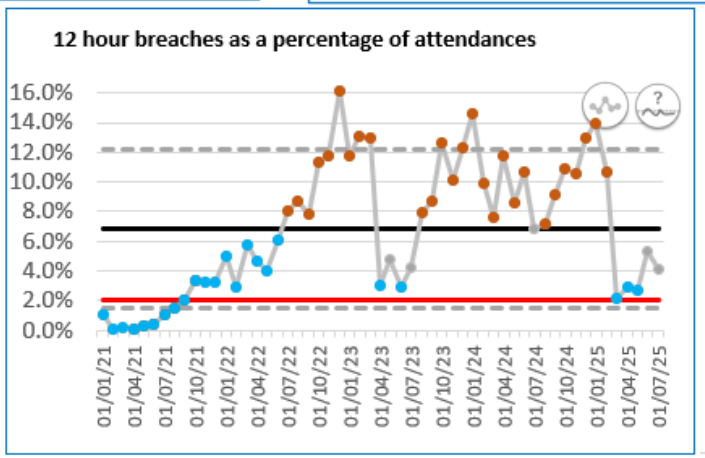
Urgent & Emergency Care: ED 4 Hour Performance

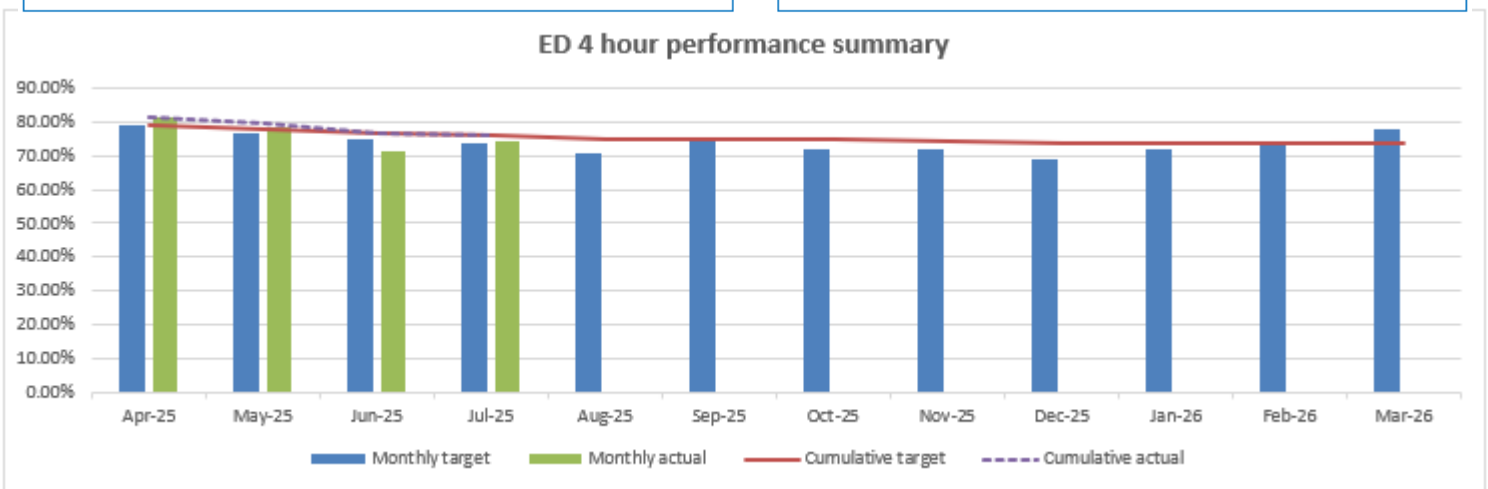












Urgent & Emergency Care

What	So What?	What Next?
In July, 30 minute ambulance handovers demonstrated no significant change, achieving 92.23% on a target of 95%. During July, at times Rapid Assessment and Treatment (RAT) area was unable to function as it was used as an escalation area for patients waiting beds. The number of 12 hour length of stay breaches decreased in July and was 357 compared to 452 in June, although representing no significant change. Numbers of 12 hour breaches as a percentage of attendances were 4% for July. Non-admitted performance shows no significant change, with 83.03% achieved in July, missing the target of 85%. The Emergency Department 4 hour performance in July was 74.37 % meeting our in month trajectory of 74%.	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 will meet the national targets. Meeting the in month trajectory for the 4 hour Emergency Department metric will keep us on track to achieve 78% by March 2026.	• 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. • Senior operations/nursing team continued daily support to ED. • The post of Service Manager in the Emergency Department is now recruited to and going through recruitment checks. A likely start date of November 2025. • 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 - further roll out planned for August. • Trial of an Ambulatory Care Unit within the ED footprint to commence in August.

Community Access Glemsford Surgery

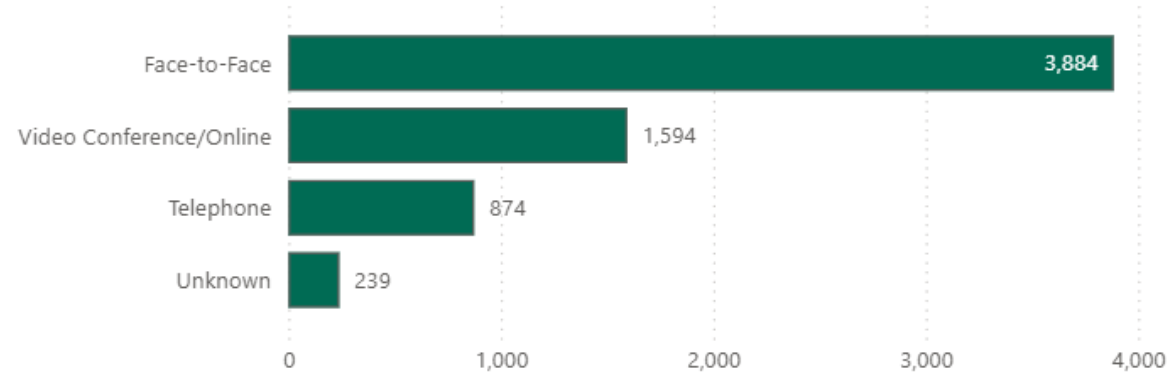
Practice Appointments

SNEE Business Intelligence

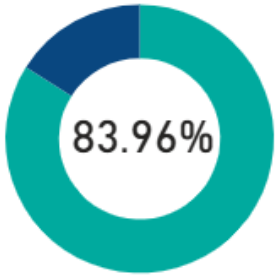
NHS Suffolk and North East Essex Integrated Care Board

Alliance: All | **PCN**: All | **Practice**: Glemsford | **Financial Year**: 2025/26

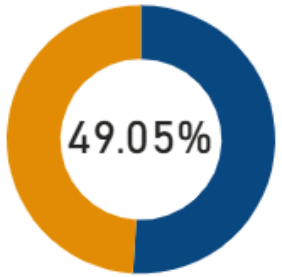
Practice appointments by contact mode



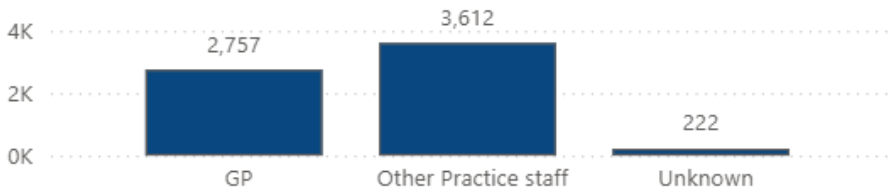
Seen within 2 weeks



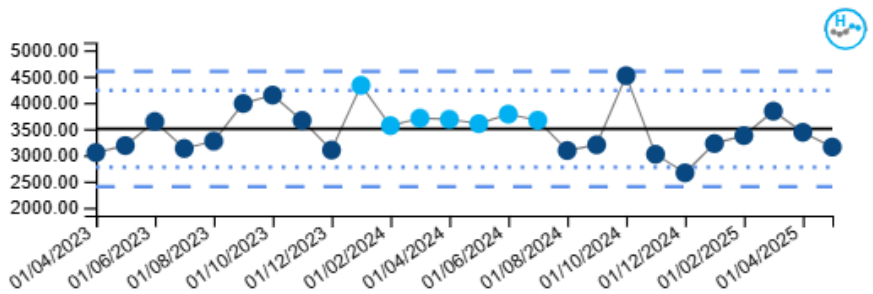
Seen within 48 hours



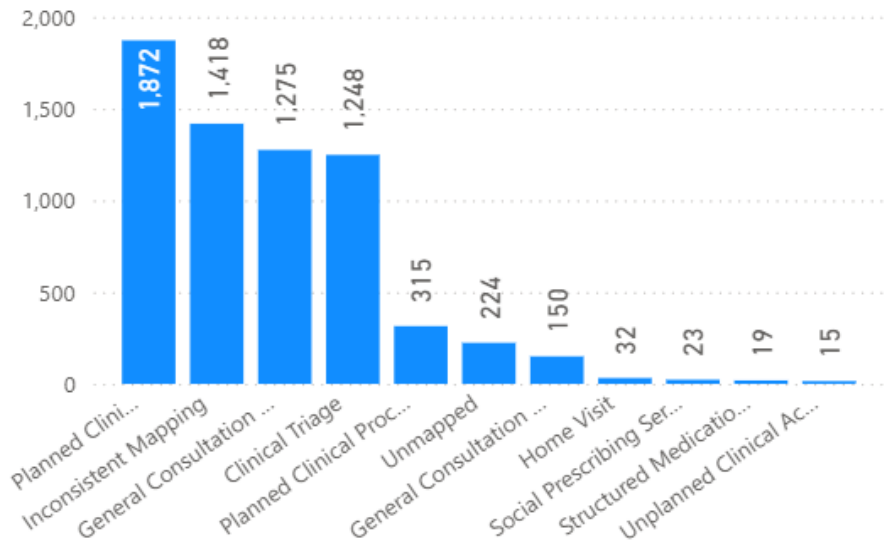
Practice appointments by health care professional type



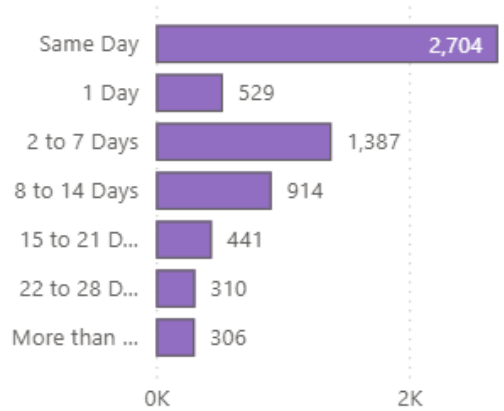
Total appointments by month



Sum of Total Appointments by National Category

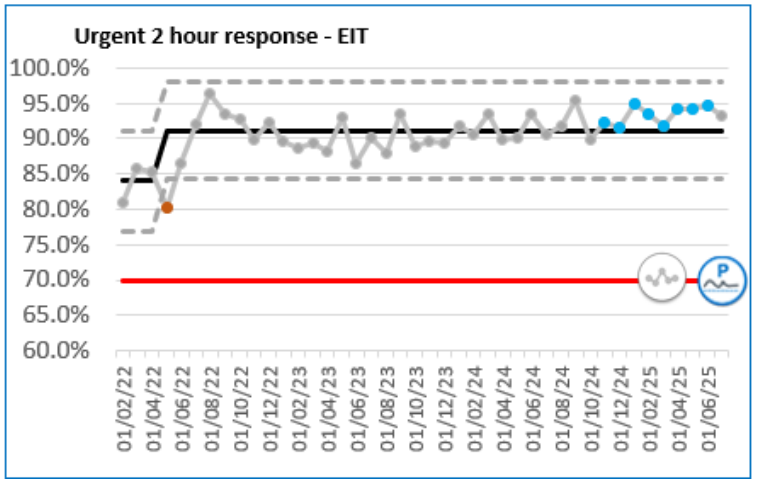


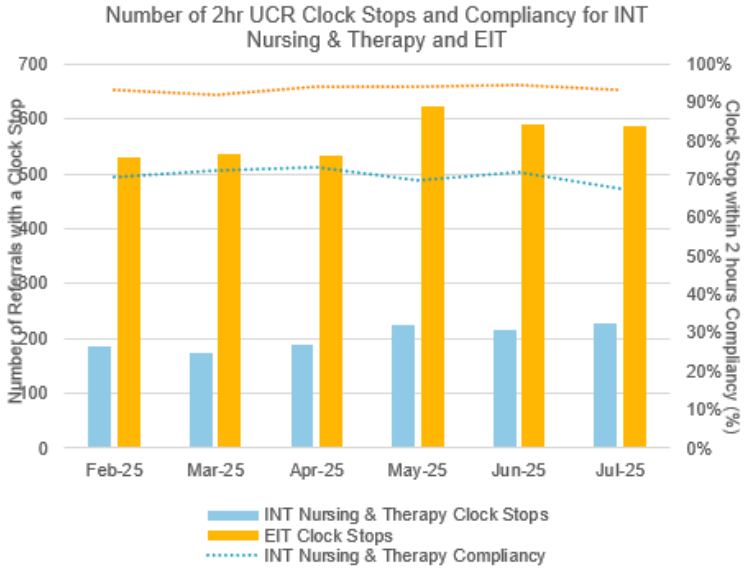
Appointments by wait time

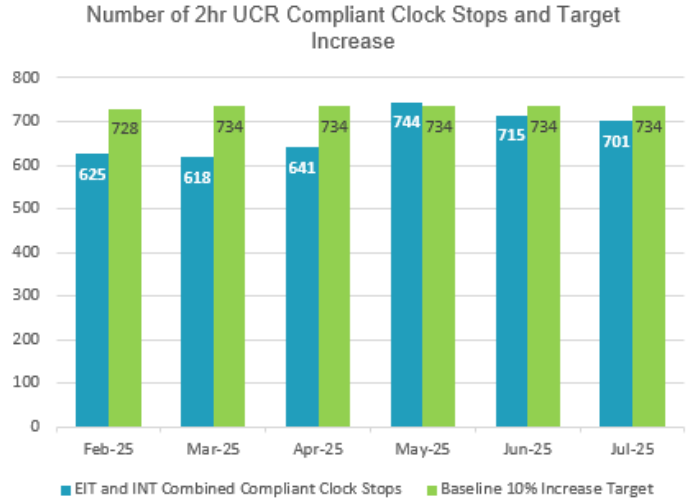


Produced by ICB

Urgent & Emergency Care: UCR







Team	Feb-25				Mar-25				Apr-25				May-25				Jun-25				Jul-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	186	131	55	70%	174	126	48	72%	189	138	51	73%	225	157	68	70%	215	155	60	72%	227	153	74	67%
Total EIT*	529	494	35	93.38%	536	492	44	91.79%	534	503	31	94.19%	623	587	36	94.22%	591	560	31	94.75%	587	548	39	93.36%
Combined Total	715	625	90	87.41%	710	618	92	87.04%	723	641	82	88.66%	848	744	104	87.74%	806	715	91	88.71%	814	701	113	86.12%

What

Early Intervention team (EIT) and Integrated Neighbourhood teams (INTs) continues to meet target of 70% urgent care response.

July saw an increase in OPEL 3 reporting for some of the nursing INT teams – this has been mitigated through INT escalation processes .

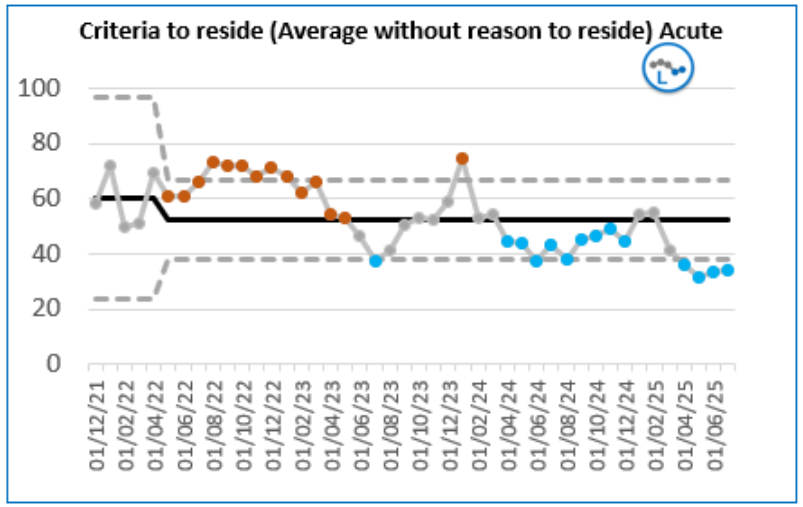
So What?

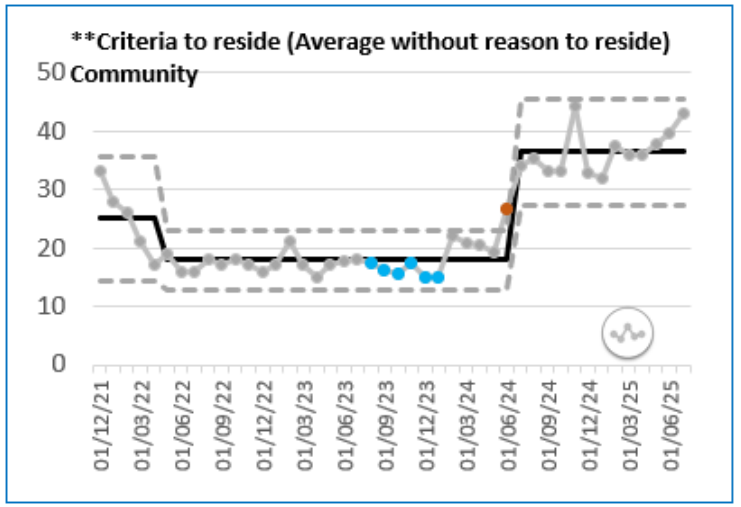
70% of urgent work referred to the INTs has been covered through clinical prioritisation of demand – in June there was 715 cancelled appointments / visits to accommodate the more urgent work.

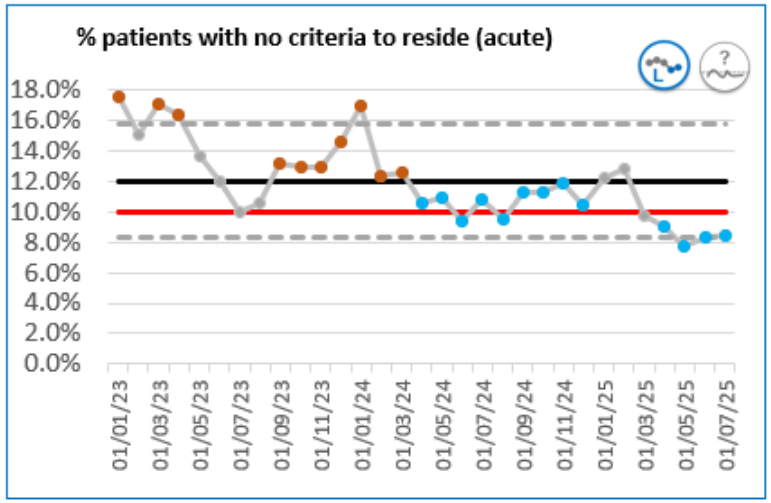
What Next?

Monitoring of the patient impact of delayed care to continue through monthly Quality meetings with INTs and Divisional Governance Steering group, and reported to nursing deployment meeting. Safe staffing establishments are being reviewed through the community nursing Safer Staffing tool (CNSST). Results to be reviewed in September.

Urgent & Emergency Care: Criteria to reside

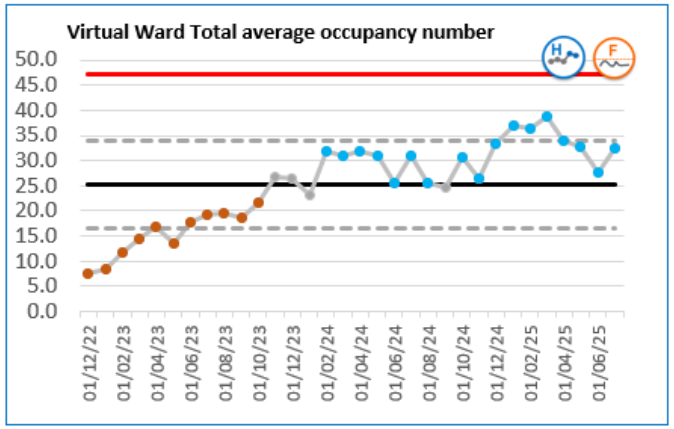


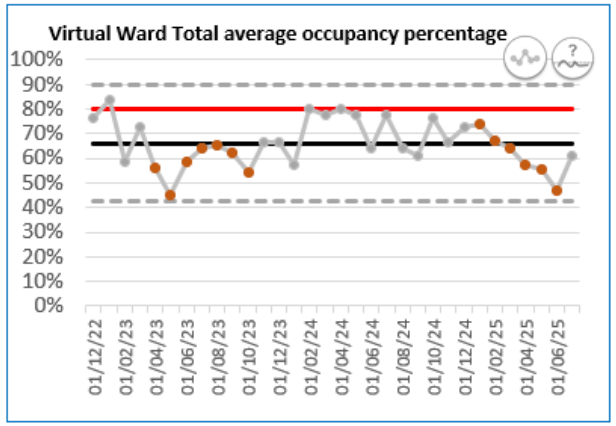


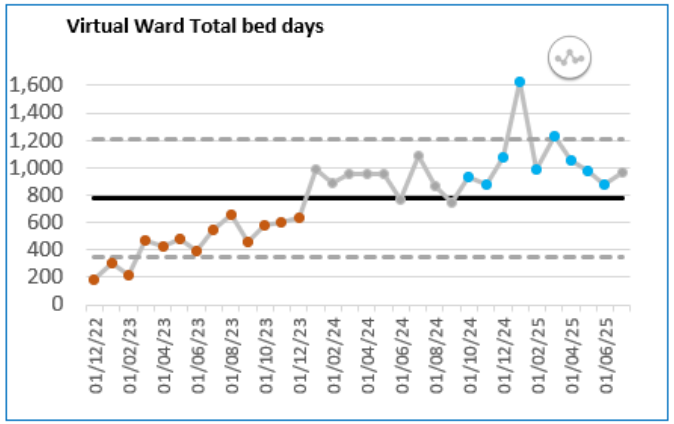


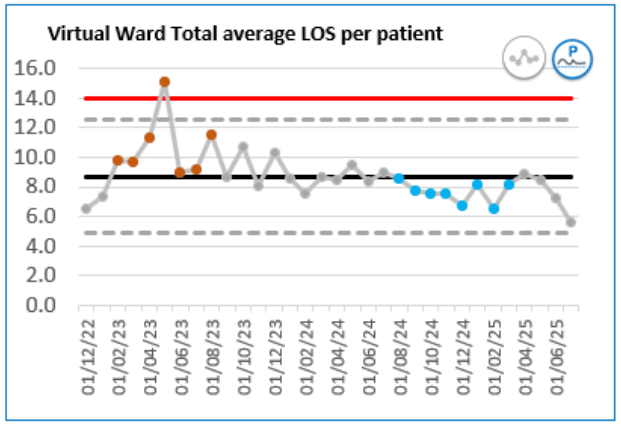
What	So What?	What Next?
The monthly average of 8.5% in July continues the positive trend for acute No Criteria To Reside (NCTR) There has been a significant increase in the transfer of delayed non-traditional patients to Community Assessment Beds (CAB) since March, due to the ongoing tightening of CAB criteria. This has certainly been a contributing factor to the lower acute NCTR figures. This has caused a resultant increase in the CAB NCTR figures in both June and July.	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. With planned bed reductions in CAB, we will no longer be able to transfer such high numbers of non traditional patients to CAB, so there is a risk of NCTR figures deteriorating as a result	1.Agree method for data collection for non-traditional CAB transfers with the information team and Transfer of Care Hub to develop more robust, accurate recording mechanisms for NCTR transfers to CAB 2. Complete audit of 150 non-traditional transfers, to analyse reasons for delays/need for non-traditional transfer to establish trends and areas for focused work/improvement ahead of the winter. 3. Embed and share changes to the TOCH/discharge planning dashboard which were launched on 21st July 2025. During morning review meetings daily actions are allocated and recorded to individual teams for ownership and responsibility . Date/time stamping allows delays to be monitored and escalated as required. Easy oversight for other colleagues of live actions to progress discharges.

Urgent & Emergency Care (TRUST – Virtual Ward)



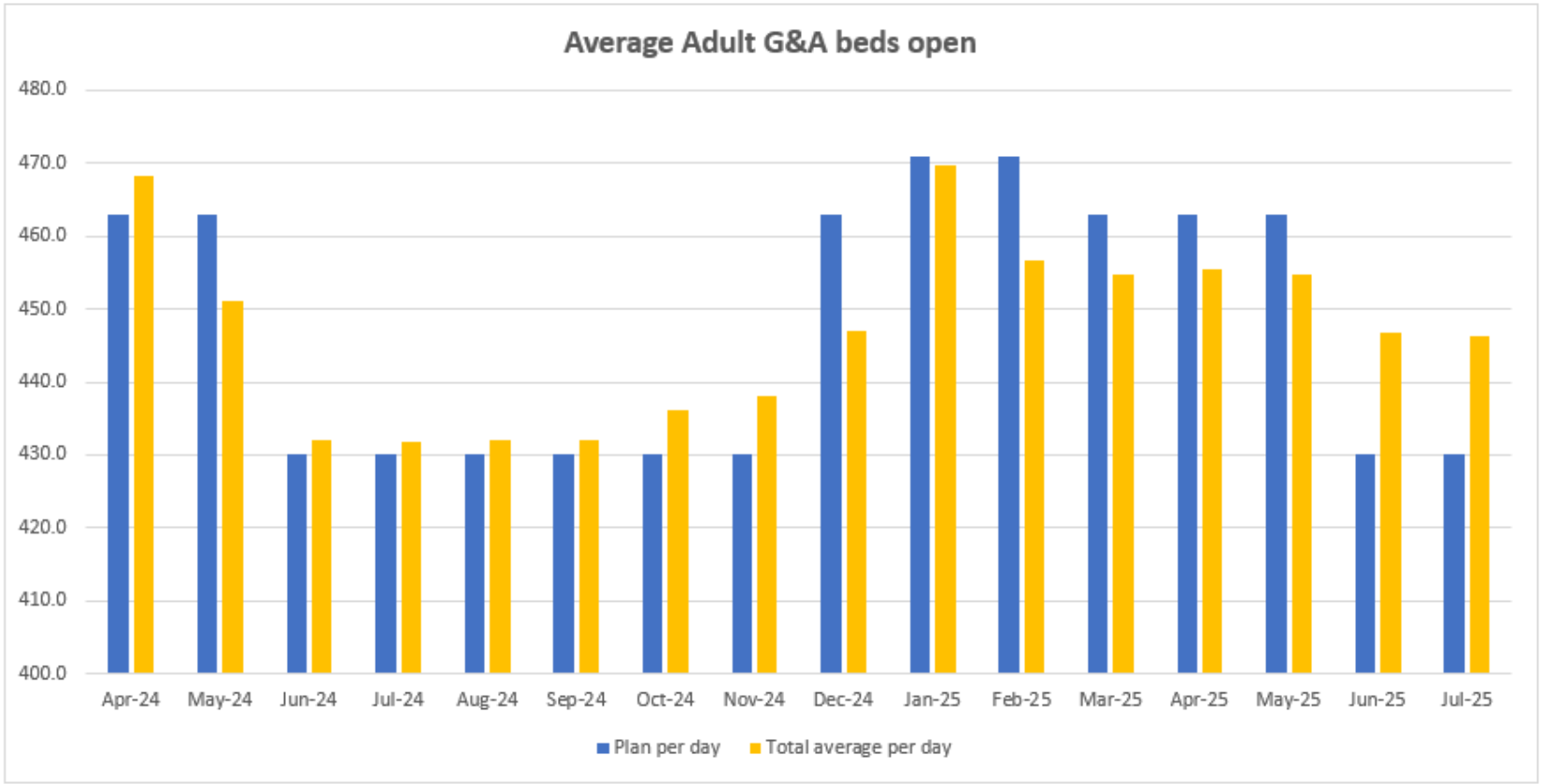






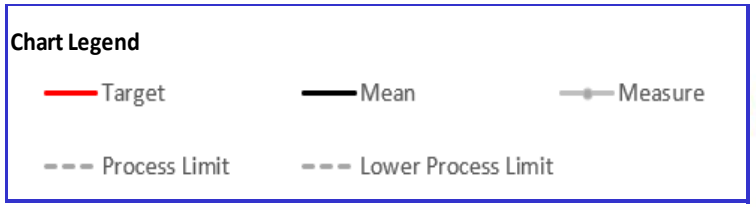
Average occupancy in July was 61%. There was significant variance during the month with **occupancy of 72% during the second half of the month** compared to 49% during the first half. This is due to transition from continuous digital monitoring to patient driven observation monitoring model .Patient flow is supported by effective length of stay which is well managed at average 5.6 days in July **(significant reduction from 8.5 days in May).** This is significantly below the NHSE target of 14 days . VW audit indicates that this is achieved whilst maintaining appropriate acuity. NB: capacity has been reduced from 59 to 53 beds during July due to removal of funding in paediatric pathway.	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 - Plan in place to achieve 50% target by October 2025. Monthly target of 30% step up patients during July was exceeded; with achievement of 46% largely due to realignment of reporting ED/AAU onboardings as step up in line with national practice. Direct referrals from all primary care practices, Early Intervention Team, community matrons and district nurses enabled. Discussions planned for August with EEAST and admission avoidance hotline. Direct referral pathway being rolled out to care homes on Top 20 conveyers list. Shared Service Delivery programme - remaining Virtual Ward nursing activities will be integrated into community teams in October 2025 releasing further efficiencies especially around travel time and cost.

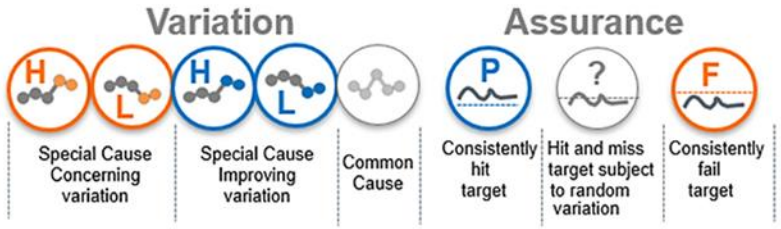
Urgent & Emergency Care: Beds



What	So What?	What Next?
July 2025 planned and actual bed capacity is similar to June, following the average core beds reduction in line with the G5 planned closure. Use of escalation beds reduced slightly, 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, and occasional use of surgical SDEC.	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. Options to reduce the number of winter escalation beds and/or extending the G5 partial closure are being reviewed through updated bed modelling as a productivity opportunity via the Urgent and Emergency Care Delivery Group.

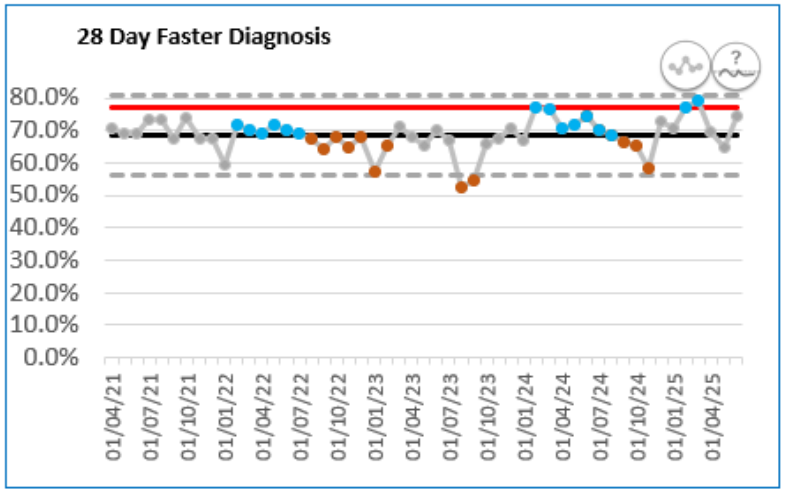
Cancer Access Summary

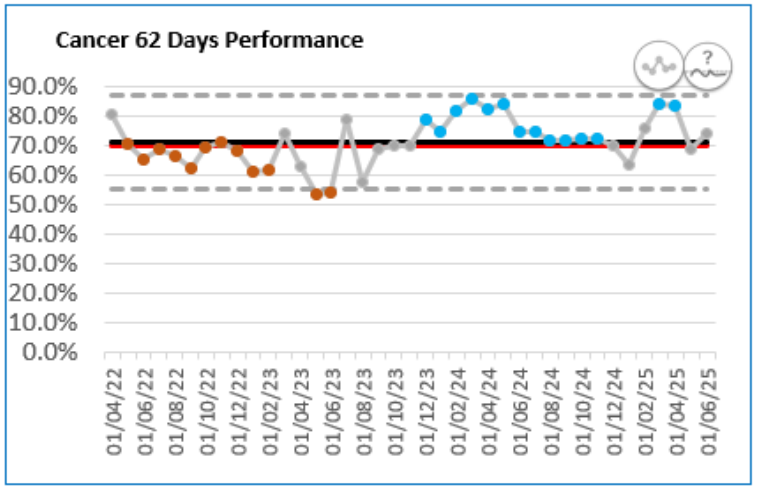


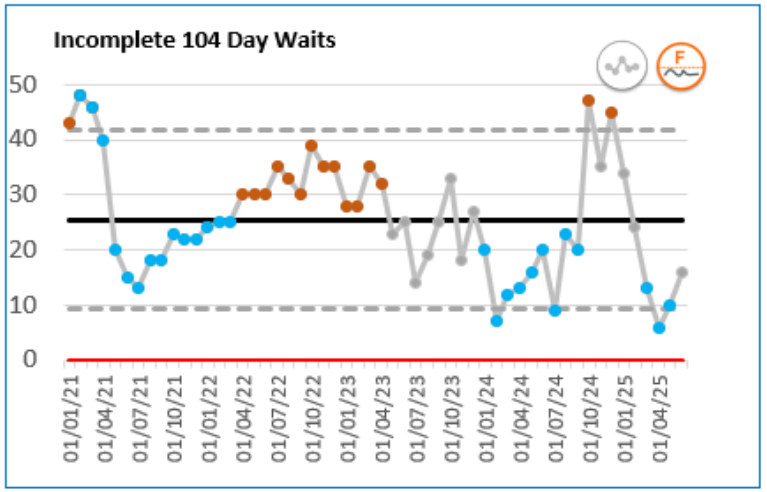


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	Jun 25	74.3%	77.0%			68.5%	56.3%	80.8%
Cancer 62 Days Performance	Jun 25	74.0%	70.0%			71.4%	55.3%	87.4%
Incomplete 104 Day Waits	Jun 25	16	0			25	9	42

Cancer Access (Month Behind)

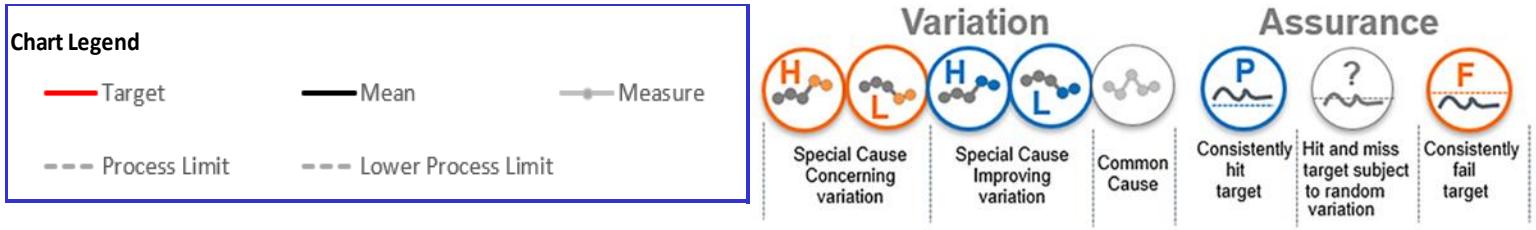






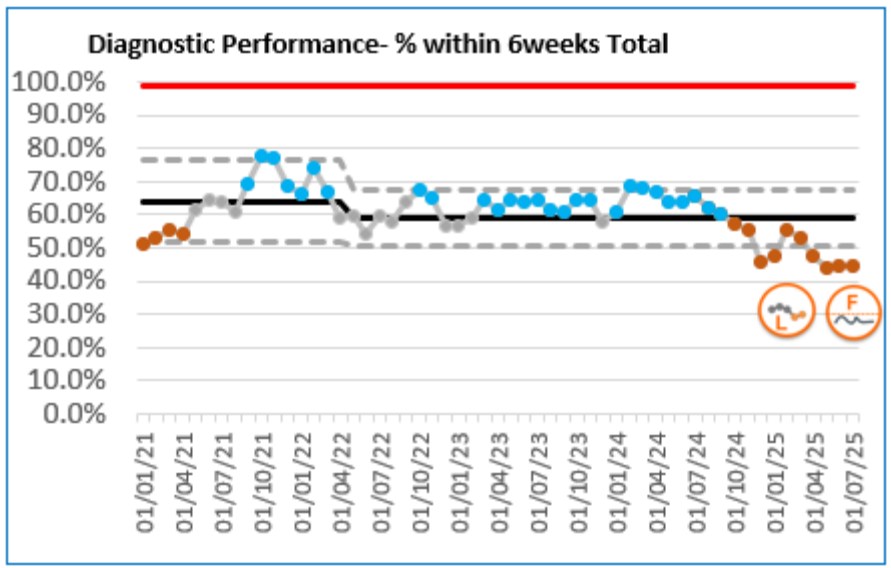
What	So What?	What Next?
28-day performance improved in June to 74% from 64% in May. This is due to the Breast performance increasing to 65.8% in June from a 12% position in May. Urology performance has dipped in June to 56% against a 67% trajectory, with all other tumour sites exceeding their trajectories, with particularly high performance seen in Skin and Gynaecology. July performance is expected to be 80%, which exceeds trajectory and achieves the 25/26 requirement of 80% performance by March 2026. 62 day performance increased in June to 74% from 68% in May, bringing the position back on trajectory. Whilst Breast performance remained at 44% and therefore still behind trajectory, the volume of patients treated was higher as the backlog was being cleared. Skin saw an improved position to 70% and Urology performance well at 77% with the highest volumes of treatments at 34.	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.	Breast Radiologist and Breast consultant surgeon recruitment successful, potential start dates in September. Continue with Friday radiology cover from CUH for Breast service. External review for breast service to be completed by Cancer Alliance. Focus on Urology – particularly bladder pathway, with best practice timed pathway audit complete and actions to be agreed. Commence direct access ultrasound pathway for post menopausal bleeding patients in Gynaecology to reduce urgent suspected cancer demand – September.

Elective Access: Summary



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Diagnostic Performance- % within 6weeks Total	Jul 25	44.5%	99.0%	L	F	59.1%	50.6%	67.5%
RTT Waiting List	Jul 25	35220	-	H		33350	32120	34579
RTT 65+ Week Waits	Jul 25	221	0		F	368	200	536
RTT 78+ Week Waits	Jul 25	1	0	L	F	117	64	170
RTT 52+ Weeks Wait as % of Total WL	Jul 25	4.7%	-	L		6.5%	5.4%	7.7%
RTT <18 Week Waits (% All)	Jul 25	56.3%	-			57.4%	54.9%	60.0%
RTT <18 Week Waits (% First OPA)	Jul 25	69.3%	-	L		72.8%	69.9%	75.7%

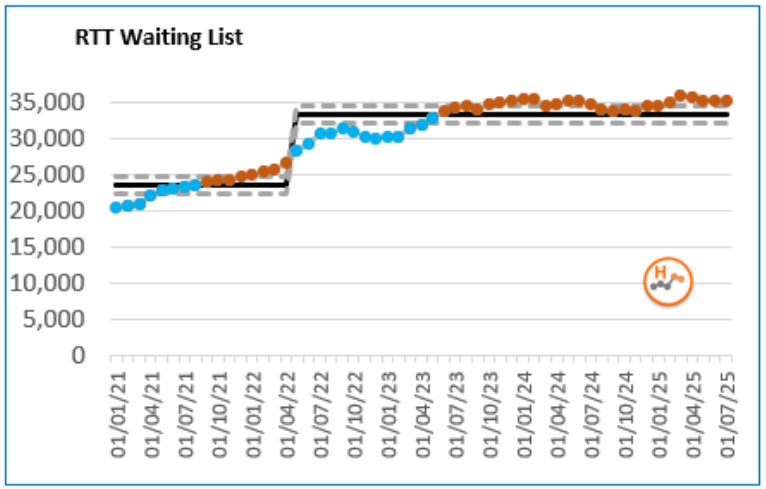
Elective Access

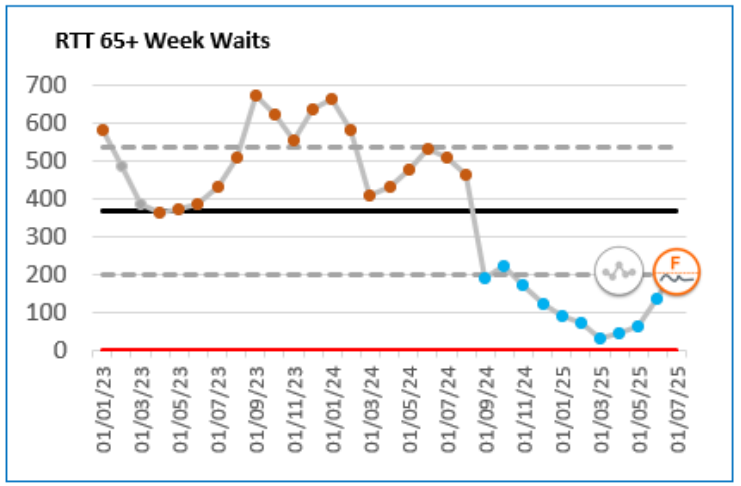


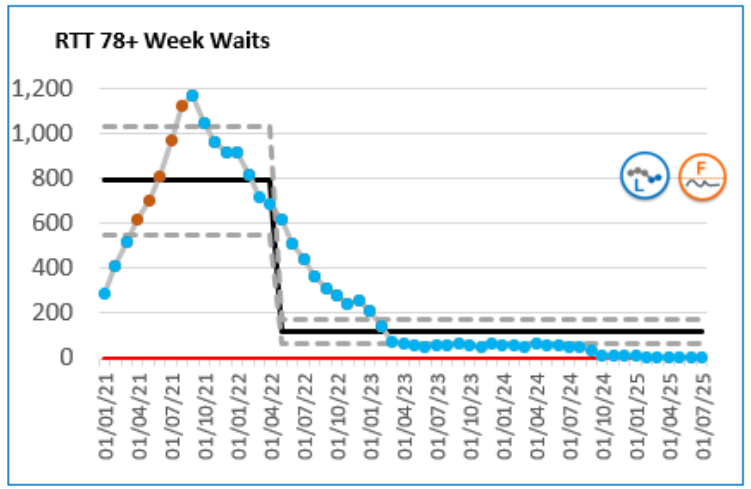
Diagnostics

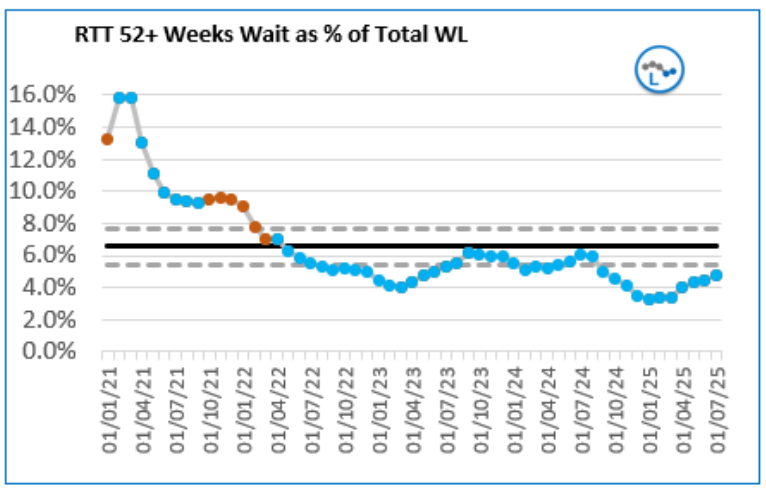
What	So What?	What Next?
MRI - Marginally under DM01 compliance target at 98.66% in June, performance impeded by temperature control issues in CDC MRI in July now resolved, July performance at 93.5% and will recover in August. **CT** –Compliant with DM01 target at 99.2% in month. **US** –Temporary staffing 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. Options to support service using CDC budget include the deployment of insourced capacity, 12 responses to tender which closed 2/08/2025 now being evaluated to deliver 3000 scans. **DEXA** – Service went live in June. Phased increase in activity planned which will see compliance with DM01 standard by end of March 2026 with options being reviewed to bring this forward now the service is established. **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 is vulnerable. Options appraisal approved at MEG for recovery and alignment to JAG requirements. Seed funding for Newmarket Endoscopy CDC extension business case delivery has been allocated and is being drawn down, business case progressing. Weekend activity commenced 26th July; however overall performance impacted by staff sickness. Number of patients over 6 weeks is expected to drop to around 1200 in August but will remain off trajectory. **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. Consultant Breast Radiologist interviews were successful with the appointed candidate due to start in September. A further opportunity remains for a fixed term appointment of a part time radiologist to the service. An assurance paper was presented to MEG and supported pending confirmation of associated cost and run rate impact assessment.	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** – Compliant **US** –Staffing issues remain unresolved, and CDC capacity will not be realised until recruitment picture improves. Temporary staffing options have been approved by TSCP and ICB DL Panel while recruitment is ongoing. Insourcing to be mobilised following procurement process. **DEXA** – Recovering as forecast. Ability to move to 4 days of scanning commenced earlier than planned in August. Performance expected to reach 20% for August 2025, with 1240 patients over 6 weeks. **Endoscopy** – longer term CDC endoscopy expansion at Newmarket will address demand. Additional measures approved by MEG including weekend lists (108 additional procedures per month) give an aggregated impact on DM01 performance increasing from 34.05% to 50.79% by end of March 2026. **Breast Imaging -** Short term, requests for bank / agency to fill gaps and ensure service provision continue to be sought via the TSCP and ICB double lock panel, implementation of Super Saturdays throughout June. Longer term training plan for in house Consultant Breast Radiographer will complete in 2029.

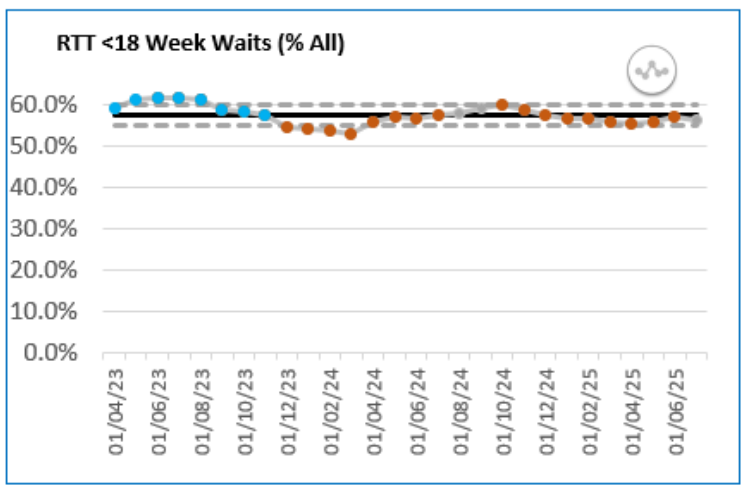
Elective Access: RTT

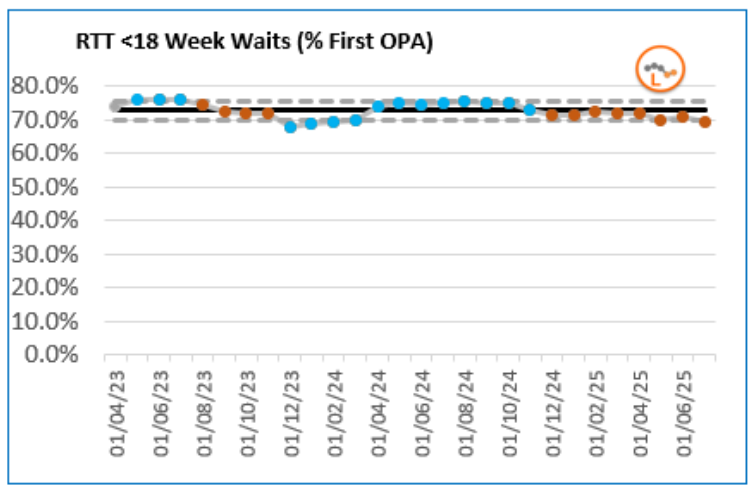




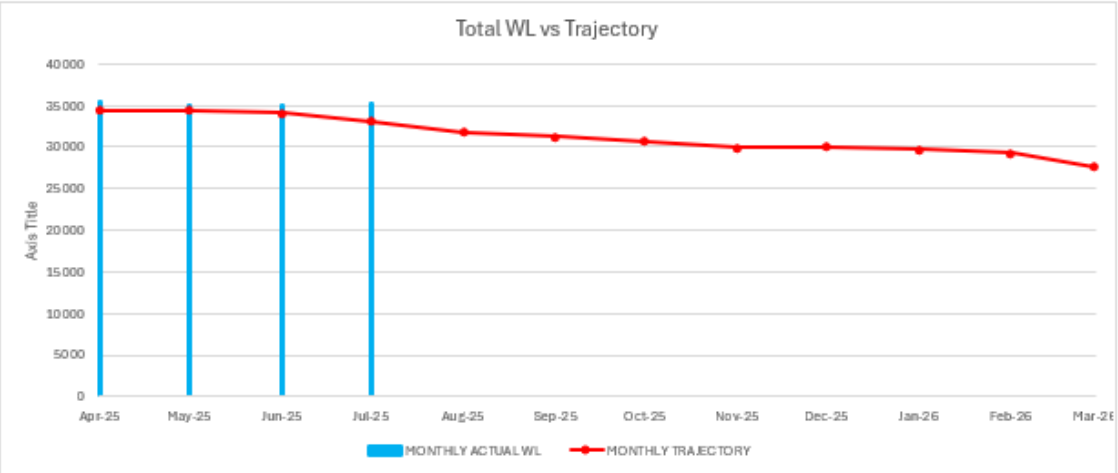


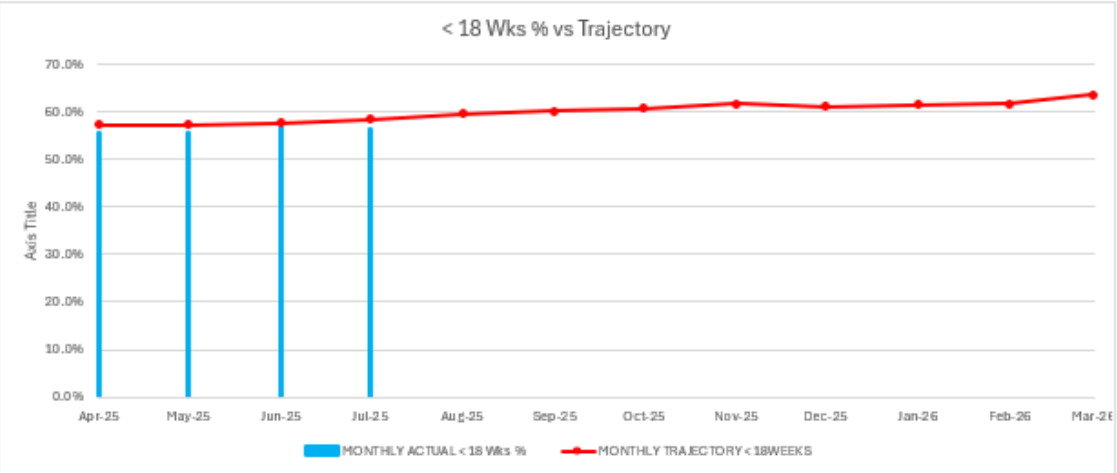


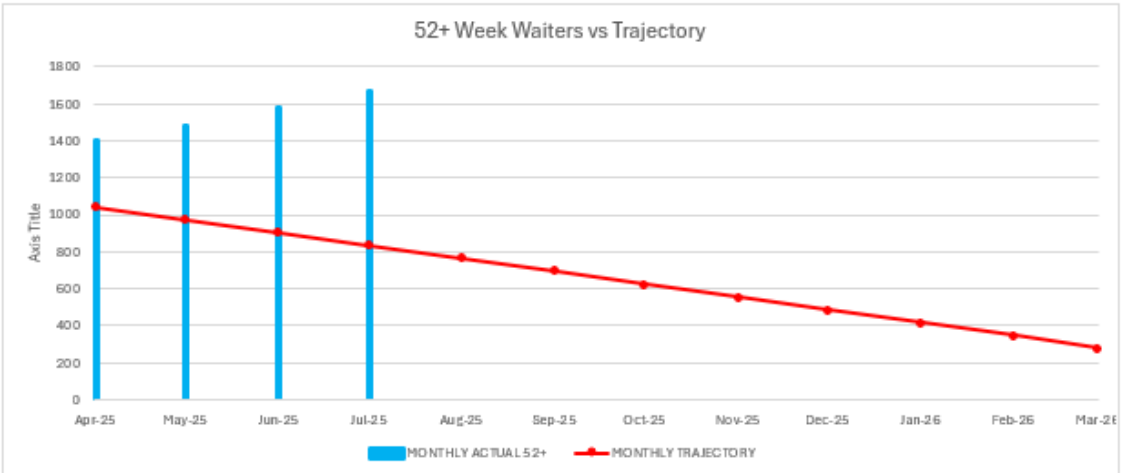


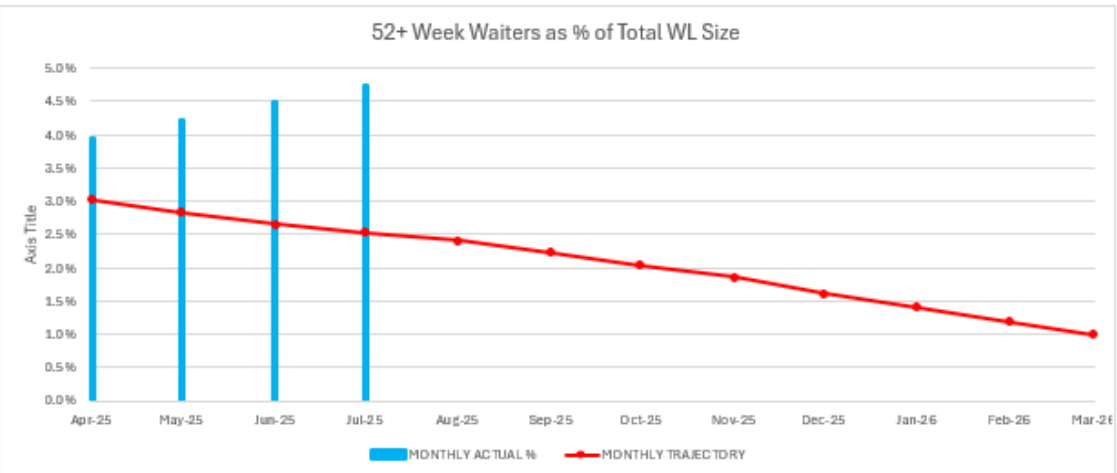


Elective Access: RTT



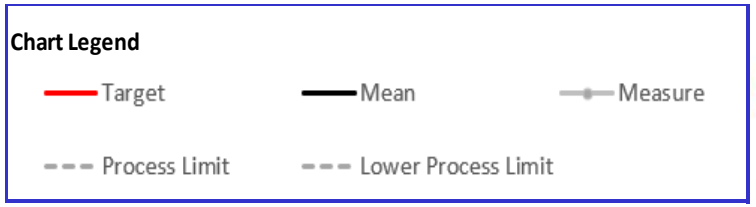


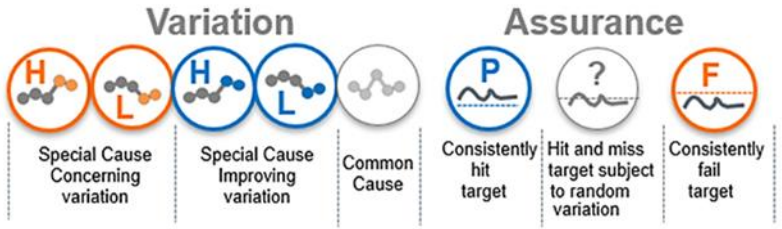




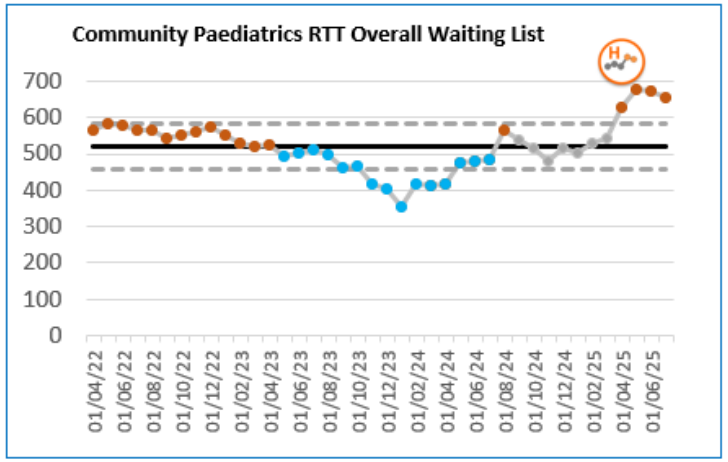
Elective Access: Activity

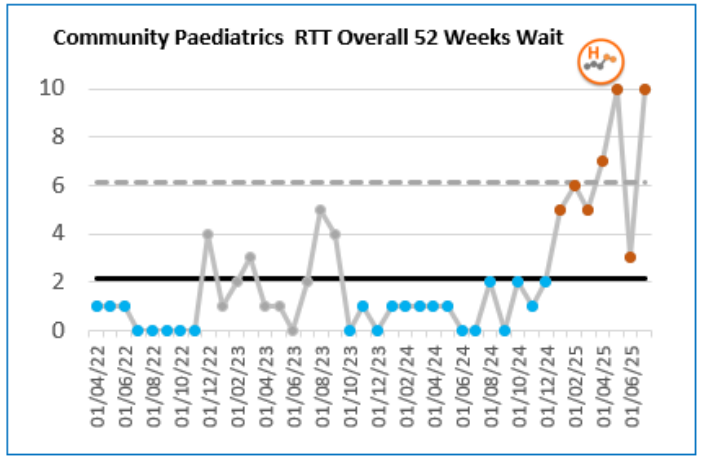
What	So What?	What Next?
End of July 2025 position had 221 patients over 65 weeks, with this number increasing since March 2025. This volume is expected to start to reduce in August, with the aim to reach a 0 position by the end of September. Dermatology is the main driver for this continual increase with 158 breaches, due to the wait time for first appointment. However there were also breaches in Orthopaedics (18), Gynaecology (13), Plastic Surgery (9) and Paediatrics (9). The total waiting list was 35,220 at the end of July, against a planned position of 33,079. Overall RTT compliance was 2.19% behind plan at 56.27%. The area's most significantly behind plan for a RTT compliance point of view are General Surgery, Ophthalmology, Plastics, Gynaecology and Pain Management. With Urology, ENT, Gastroenterology and Vascular all achieving their in-month trajectory. The volume of 52 week waits continues to increase, with 1670 as at the end of June, against a submitted plan position of 835. The 52 week wait position is due to reduce from August 2025, when insourcing of Dermatology commences. Dermatology has the biggest cohort of patients over 52 weeks at 475, followed by Orthopaedics at 238, ENT at 155, Plastics at 145 and Gynaecology at 141.	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.	Specific plan in for Dermatology, insourcing of outpatient activity to start 16th August for 8 week period to clear backlog and reduce waiting time to first appointment. Additional validation resource to commence in September, which is expected to enable both waiting list reduction and RTT compliance improvement. Dermatology actions as described previously will positively impact the overall 52ww position. Service level recovery plans are in development and expected to be completed by the end of September.

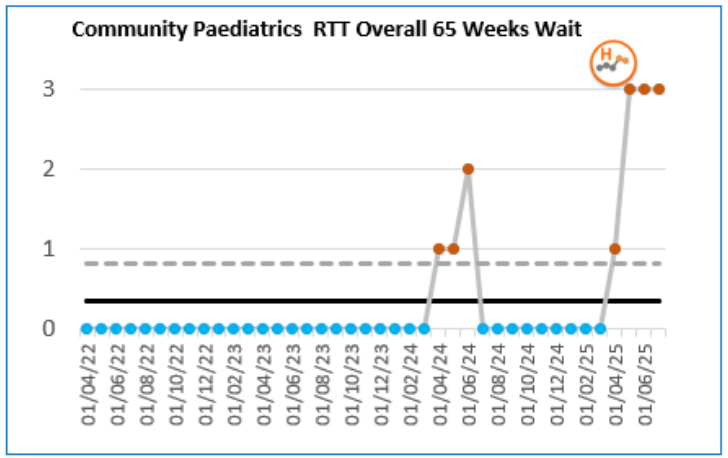


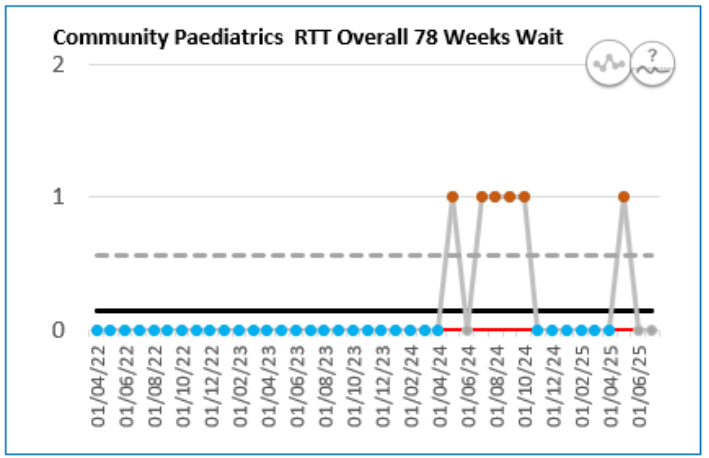


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Community Paediatrics RTT Overall Waiting List	Jul 25	653				521	459	583
Community Paediatrics RTT Overall 52 Weeks Wait	Jul 25	10				2	-2	6
Community Paediatrics RTT Overall 65 Weeks Wait	Jul 25	3				0	0	1
Community Paediatrics RTT Overall 78 Weeks Wait	Jul 25	0	0			0	0	1









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. Increasing parental frustration with waiting times.	1wte agency locum consultant in post will support team capacity but will not deal with overall shortfall in staffing required. 1wte Specialist Nurse appointed to cover vacancy, started mid July. Skill mix of medical vacancy with another Specialist Nurse role approved – interviews on 3rd Sept. Planning to readvertise substantive vacancies for approval and service will submit a request for further locum consultant cover for the west locality to cover core capacity in the meantime

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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	9,740	9,572	9,955	(215)	(2.2%)
May	10,135	9,814	10,207	(72)	(0.7%)
Jun	10,420	10,051	10,453	(33)	(0.3%)
Jul	10,500	10,645	11,070	(570)	(5.2%)
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)	**40,795**	**40,082**	**41,685**	**(890)**	**(2.1%)**

July 2025

25/26	10,500
24/25	10,645
Plan	11,070
Var	(570)
Var %	(5.2%)

Daycase

Mon	25/26	24/25	Plan	Var	Var %
Apr	2,291	2,317	2,363	(72)	(3.1%)
May	2,411	2,405	2,453	(42)	(1.7%)
Jun	2,320	2,433	2,481	(161)	(6.5%)
Jul	2,528	2,606	2,658	(130)	(4.9%)
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)	**9,550**	**9,760**	**9,955**	**(405)**	**(4.1%)**

July 2025

25/26	2,528
24/25	2,606
Plan	2,658
Var	(130)
Var %	(4.9%)

Outpatient Follow Up

Mon	25/26	24/25	Plan	Var	Var %
Apr	26,245	25,589	24,054	2,191	9.1%
May	25,850	26,236	24,662	1,188	4.8%
Jun	26,212	26,868	25,256	956	3.8%
Jul	26,996	28,456	26,749	247	0.9%
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)	**105,303**	**107,150**	**100,721**	**4,582**	**4.5%**

July 2025

25/26	26,996
24/25	28,456
Plan	26,749
Var	247
Var %	0.9%

Elective

Mon	25/26	24/25	Plan	Var	Var %
Apr	244	261	267	(23)	(8.5%)
May	246	268	273	(27)	(10.0%)
Jun	215	278	283	(68)	(24.1%)
Jul	232	301	307	(75)	(24.3%)
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)	**937**	**1,108**	**1,130**	**(193)**	**(17.1%)**

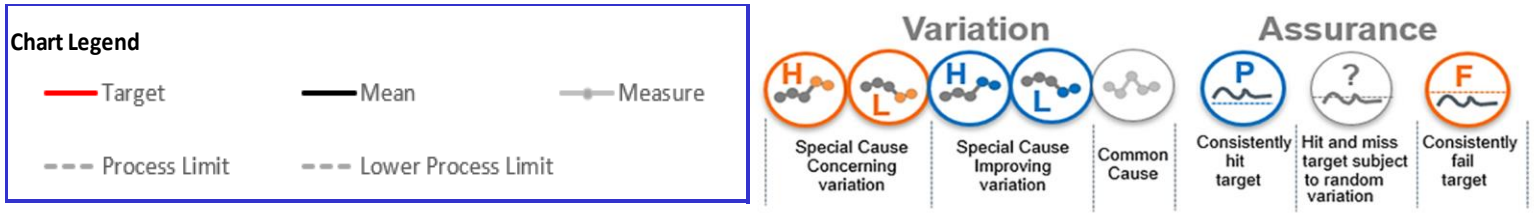
July 2025

25/26	232
24/25	301
Plan	307
Var	(75)
Var %	(24.3%)

Elective Access: Activity

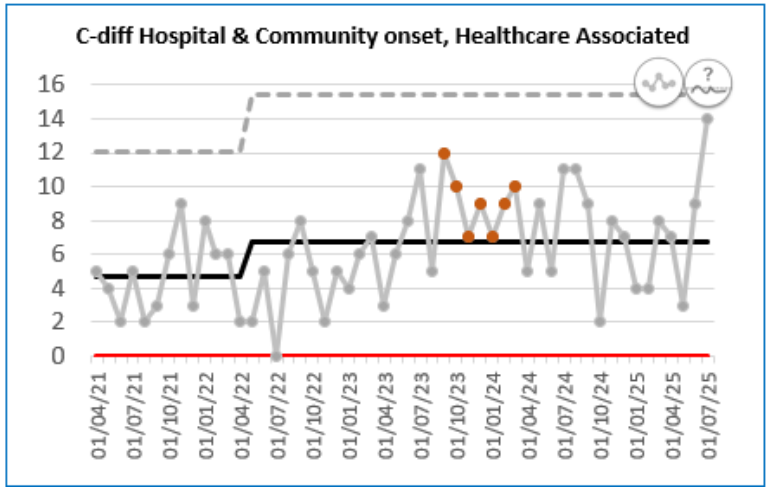
What	So What?	What Next?
Activity plans across elective, daycase and first outpatient attendances are not being met as at the end of July 2025, with the largest variance in elective at -24.1%, and 4.9% decrease in outpatient first attendances. The variance to plan for daycases improved slightly to -4.9%.	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 are monitored through weekly access meetings – it is likely that for most specialties the activity required to deliver these will exceed the Indicative Activity Plan totals. Specialty level plans as to how to deliver the additional activity required that is at present effectively unfunded, are being managed through COO/DCOO led discussions. 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	Jul 25	14	0			7	-2	15
% of patients with Measured Weight	Jul 25	91.0%				87.1%	80.0%	94.2%
% of patients with a MUST/PYMS assessment completed within 24 hours of admission	Jul 25	97.0%				95.9%	93.2%	98.5%
Post Partum Haemorrhage	Jul 25	4				7	-1	15

Safe



What

Despite the recent trending improvement of *Clostridioides difficile* infection, July's data illustrates common cause variation with hit and miss target subject to random variation, with limited assurance of sustained improvement at this point.

This month we saw a peak in cases in the month of July. This has been driven by an 'outbreak' of *Clostridiodes difficile* infection during June/July associated to a single medical ward, with six cases having ward exposure prior to symptom onset and one known case transferred into the ward, posing risk of increase *Clostridiodes difficile* burden within this ward environment.

The ward potentially has a high C.diff environmental 'burden'. It has been used as a decant ward recently with periods of increased incidence located or linked to this area as previous ward teams have decanted and rotated through.

So What?

Infection prevention and control is a key priority for all NHS providers and will part of the NHS oversight framework.

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,

NHS England 'Standard contract for Minimising *Clostridiodes difficile* and Gram-negative bloodstream infections' 2025/26 sets a threshold based on previous year's performance. For 2025/26 reporting year the trust threshold is 81.

Clostridioides difficile are bacteria found in the bowel, usually causing no harm. This bacteria can cause diarrhoea, especially in older persons, those who have been in contact with a contaminated environment, have undergone bowel procedures or in people who have been or are being treated with certain antibiotics. Data suggests that West Suffolk has a higher-than-average age population.

It is recognised Nationally that the rates of *Clostridioides difficile* have increased significantly over the last reporting years and is a national priority.

What Next?

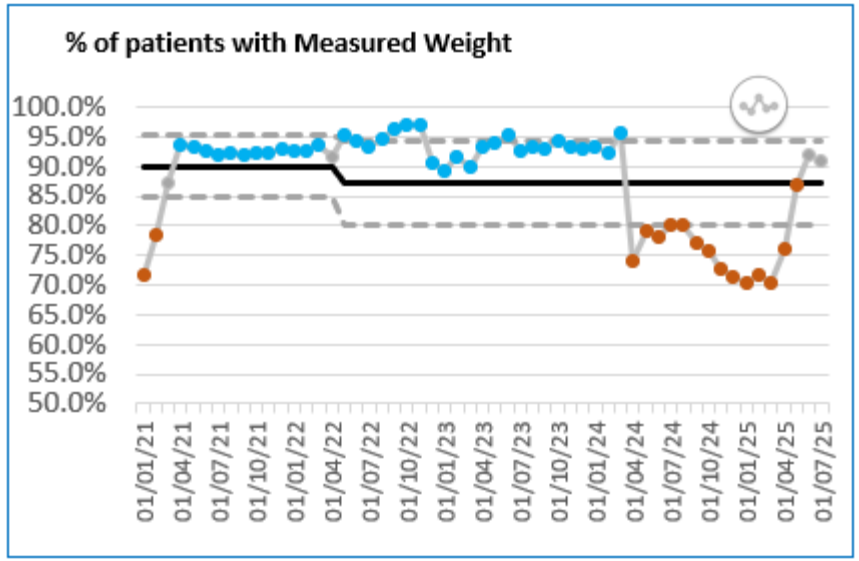
The situation remains complex and multifaceted and continues as a business-as-usual organisational priority with escalations via patient quality & safety group.

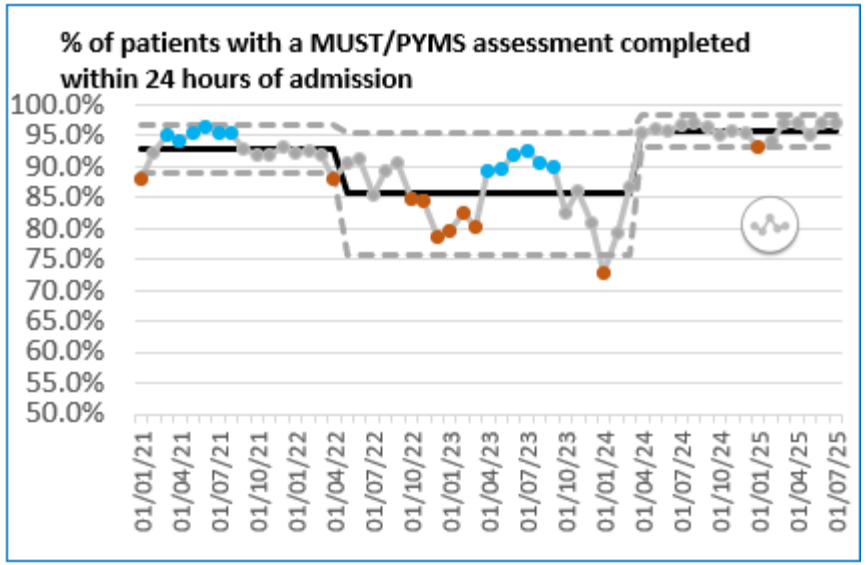
The ward outbreak has and continues to be managed via an incident management team with following actions;

- Ward closure to admissions temporarily (current admissions remain) – Re opened in early August
- Enhanced clean and vapourised hydrogen peroxide fogging of the complete ward including the shared kitchen (excluding the main ward corridor due to patient habitation) - August 2025
- Increased dilution of hypochlorite solution used for cleaning commodes, side rooms & bathrooms - August 2025
- Increase focus on cleaning and disinfection of shared equipment
- Bi-weekly antibiotic audits - August 2025
- Routine monitoring/surveillance continues to early identify further cases associated.

The Quality Improvement Programme continues with *Clostridiodes difficile* programme board due to re-convene September 2025

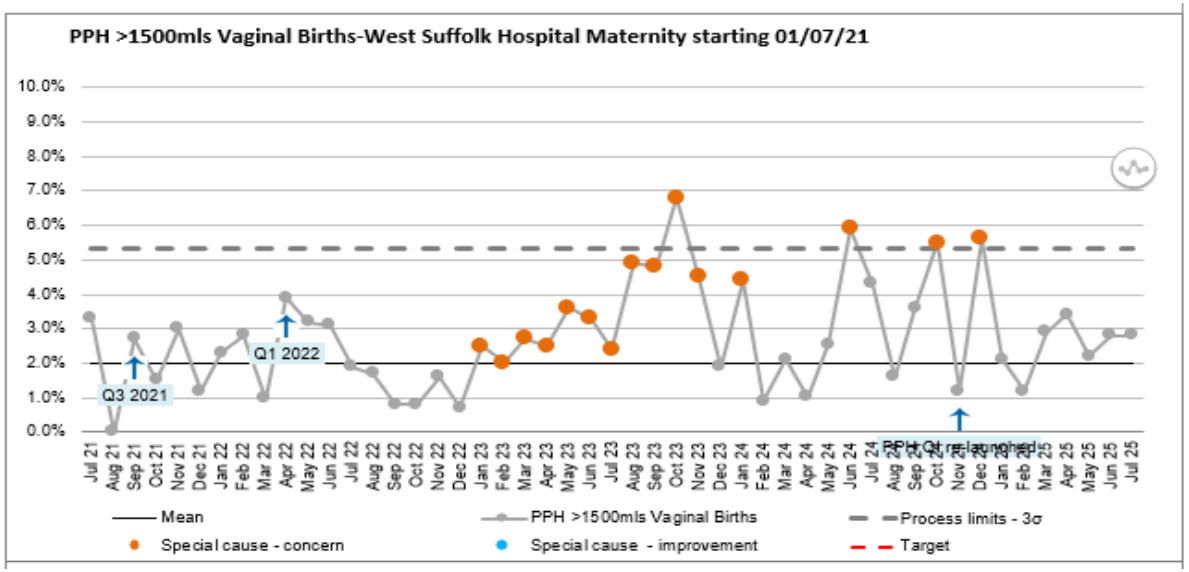
Safe

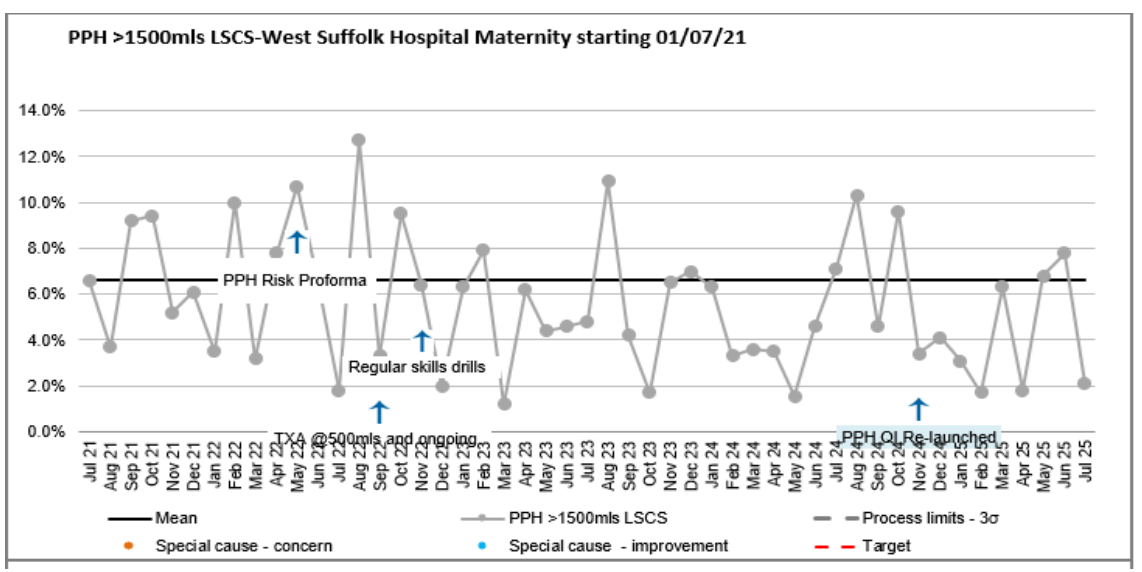




What	So What?	What Next?
Nutritional assessment (MUST) within 24hrs – 97% **Weight Within 24 hours of Admission – 91%** Nutritional assessments within 24 hours remains stable in common cause variation. It can be noted that all areas in the trust have shown improvement with their record keeping with nutrition and this is from a more targeted approach, wards have been able to identify their own data and act on it monthly as required. This is also discussed during monthly performance meetings Looking at the data, we have had 3 points of improvement regarding measured weights on admission; it is too early to tell if this will be a sustained improvement, but we will review again in another 3 months.	Good nutrition is an integral component of patient care. Not only does eating correctly provide substantial physical benefits, but it also ensures psychological comfort though a patient's admission. The world health organisation agrees and from 2016 -2025 they have collectively acknowledged the concept of 'food as medicine' The trust has been engaged with running food as medicine workshop, which has developed 4 key areas, assessment, planning, patient flow and support when eating, these are being looked at individually. Overall, this is an area of focus and improvement for all the teams and there is improved awareness that this will underpin a positive experience and outcome for the patients in our care. Effective MUST scoring can be achieved with estimated weights, however actual measured weights is best practice, MUST additional training is available within Totora.	• Liaise with Dieticians to monitor impact of any delayed assessments and shared learning from this. • To build stronger working relationships with Dieticians on the ward, scheduled slot on the medical and surgical ward managers meeting. • Review weights on admission data in October 2025 • Targeted approach continues, with wards now owning their own data and acting on this as required, this is then reviewed at monthly performance. • Continue focus on the importance of Nutrition, reviewing protected mealtime audit data, looking at conducting peer reviews between wards, this is on hold currently due to IT issues.

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%
1 (Apr-Jun 2025)	165	9	5.5%

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 July 2025, there was one 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?

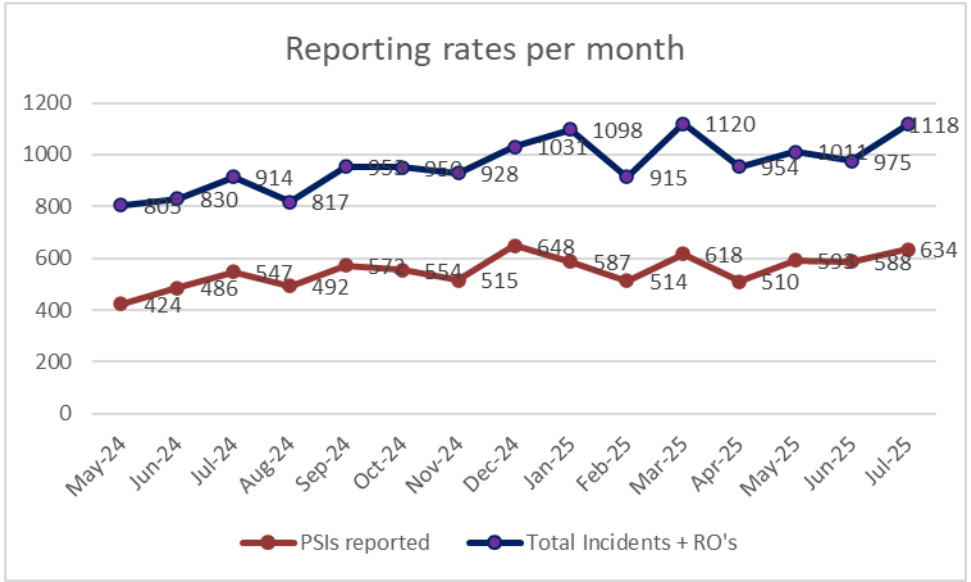
Quality Improvement project in progress focusing on three workstream:

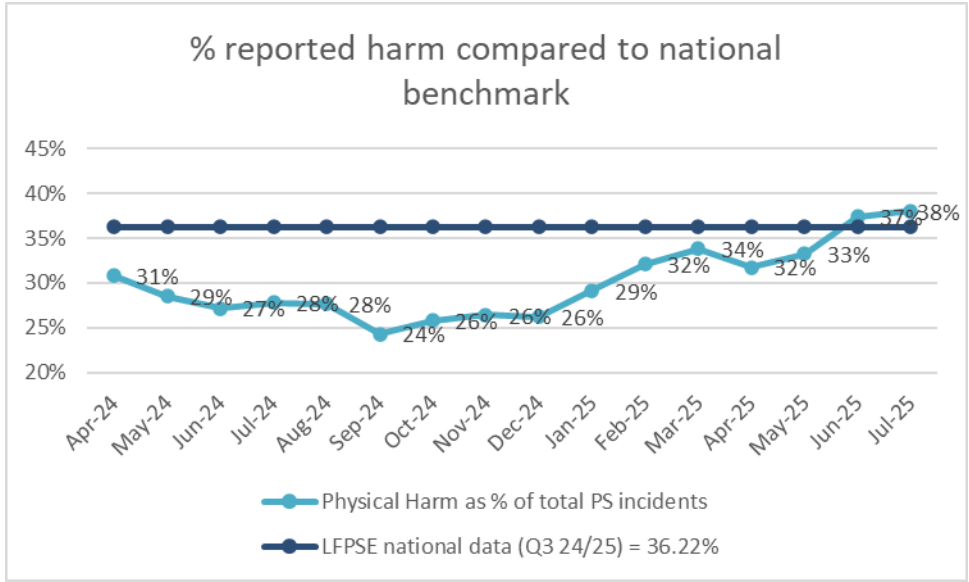
- Training and awareness
- Risk management
- Medication and timely management of PPH

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 monitor and is in line with maternity units across the region.

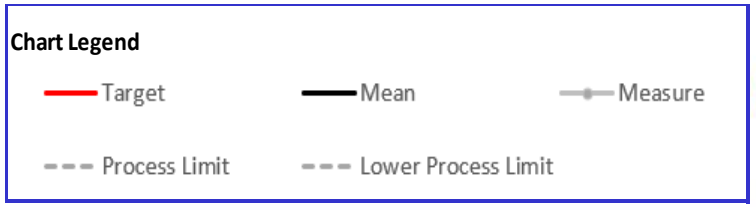
Safe

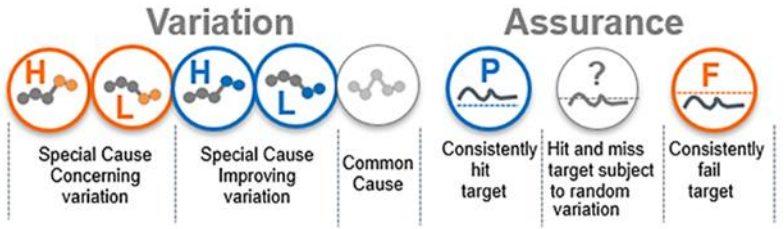




What	So What?	What Next?
This is the second consecutive month in which the team has reported using the updated data set above, introduced to ensure consistency and accuracy in monthly reporting. As outlined in the previous IQPR, we have adopted a standardised approach to address variability associated with the previous method, supporting a more reliable reflection. In July, we observed an uplift in reporting rates for both incidents and ROs, reflecting increased engagement with the reporting process. The patient safety team benchmarks the monthly percentage of reported harm against the national figures from the Learning from Patient Safety Events (LFPSE) data set. For the second consecutive month, our harm rate has exceeded the national average of 36%, reaching 38%.	We want to encourage 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. 'No harm' incidents continue to be the most frequently reported. However, there was another slight increase in low harm incidents reported in July, while moderate and severe incidents showed a decline. Low harm incidents rose in relation to discharge, transfer and follow arrangements, falls and medication. Notably, falls incidents have also experienced a slight increase in moderate harm cases.	The team will continue to extract this data set using the 'created date', ensuring a consistent and stable monthly representation of reported incidents. It is important to note that the current national benchmark is based on the initial iteration of data released by NHS England. We await subsequent updates, which will be incorporated into future benchmarking. In addition to national comparisons, we also benchmark locally through the regional Patient Safety Collaborative. Insights from this analysis, along with findings from the quarterly patient safety report, will continue to be shared with divisional governance and speciality groups across the trust to inform targeted improvement efforts. Beginning in September, the team will collaborate with the strategy and transformation team to align the observed increase in incidents involving harm with the trust's CIP programme. This partnership will support the monitoring of the impact on patient safety.

Mortality Summary

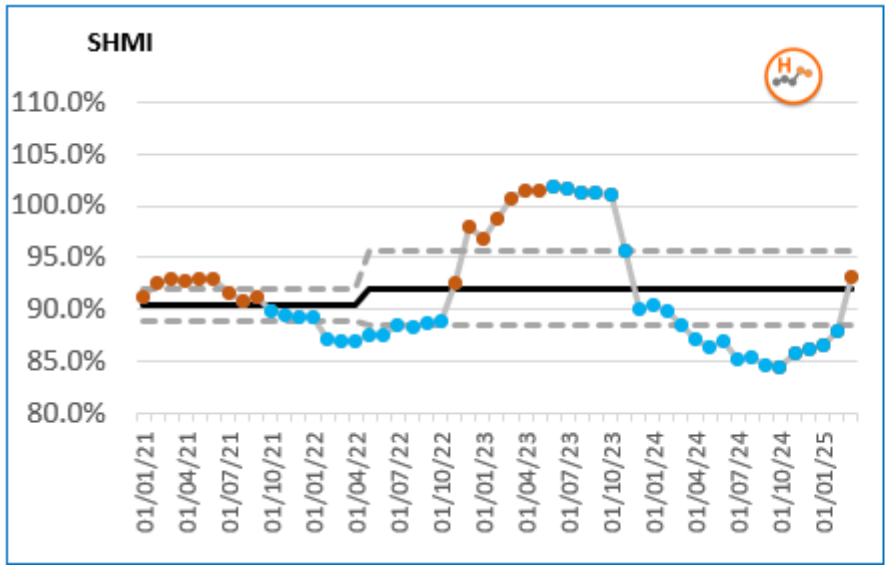


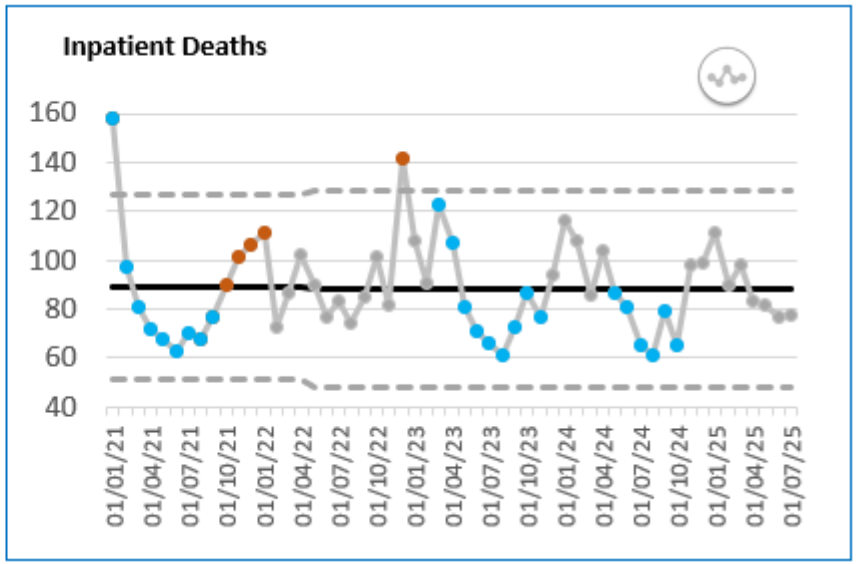


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SHMI	Mar 25	93.1%				92.0%	88.5%	95.6%
Inpatient Deaths	Jul 25	78				88	48	128

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

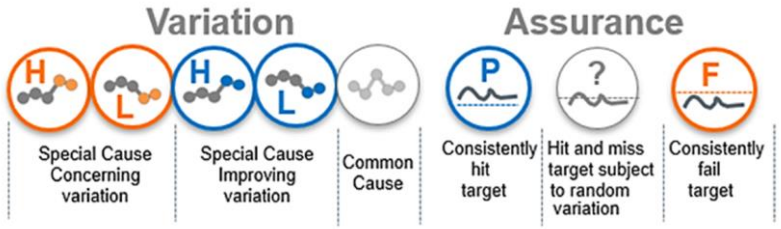
Mortality





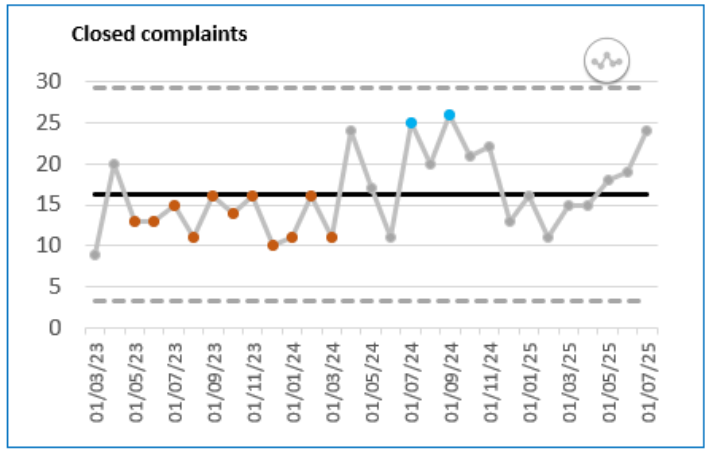
What	So What?	What Next?
An analysis of the what the data is showing us that there is a sudden spike in the SHMI.	The SHMI data is a ratio of the observed number of deaths to the expected number of deaths, which is reported in 144 categories. The spike in SHMI ratio is likely an intermittent anomaly from coding.	To investigate the rise in SHMI data with the coding department and to rule out any other reasons for the spike in data. Continue to monitor the SHMI data through our mortality oversight group.

INVOLVEMENT COMMITTEE METRICS



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Active complaints	Jul 25	51	-	H		35	21	49
Closed complaints	Jul 25	24	-			16	3	29
% extended	Jul 25	63%	-			69%	35%	103%
Count extended	Jul 25	15	-			11	2	19
% Complaints responded to late	Jul 25	33%	-			10%	-19%	40%
Count responded to late	Jul 25	8	-	H		2	-4	7
% resolved in one week	Jul 25	56%	-			60%	30%	89%
Total PALS resolved Count	Jul 25	273	-			189	84	295

Safe


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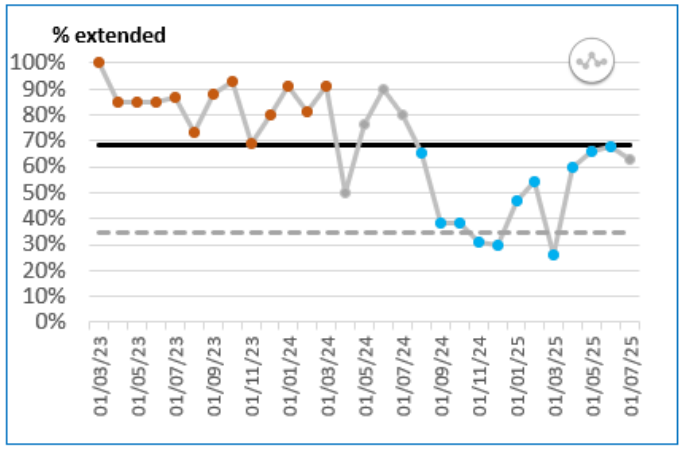
01/05/25
01/07/25


% extended
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
01/03/23
01/05/23
01/07/23
01/09/23
01/11/23
01/01/24
01/03/24
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01/01/25
01/03/25
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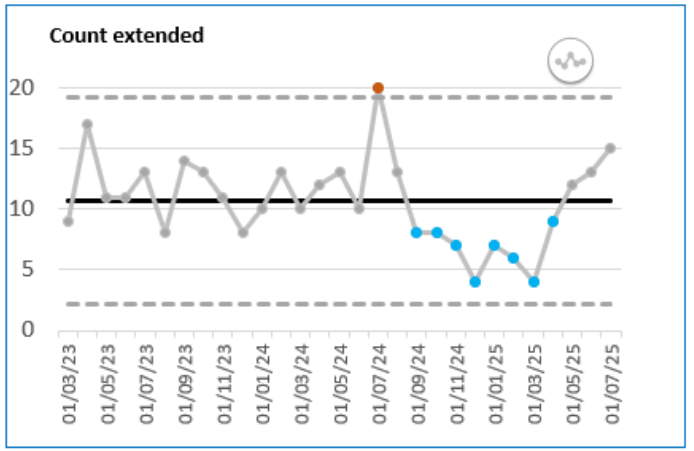
Count extended
20
15
10
5
0
01/03/23
01/05/23
01/07/23
01/09/23
01/11/23
01/01/24
01/03/24
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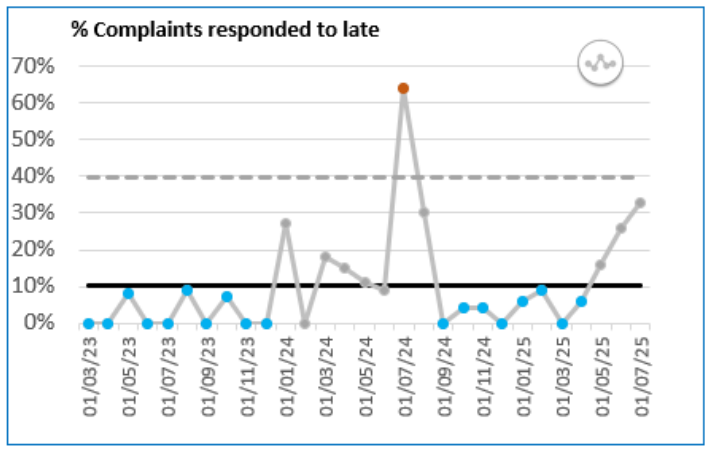
01/01/25
01/03/25
01/05/25
01/07/25


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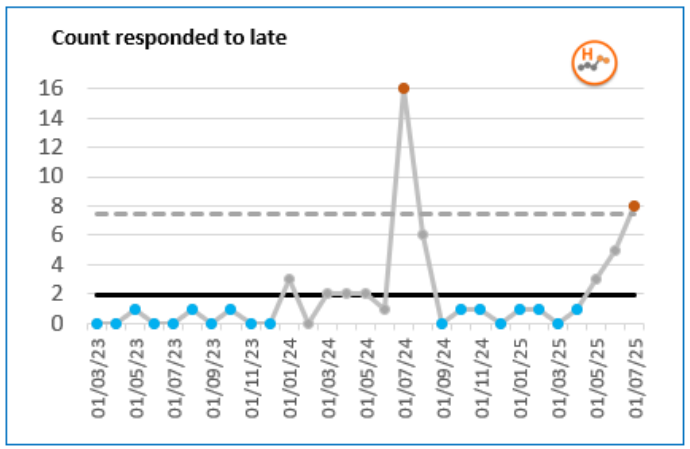
01/01/25
01/03/25
01/05/25
01/07/25


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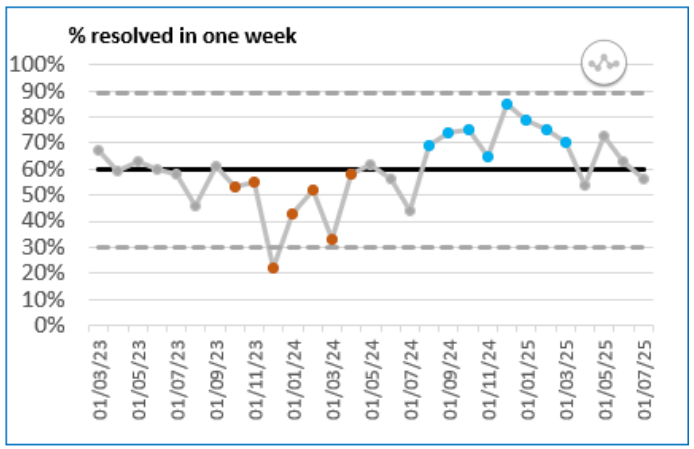
01/01/25
01/03/25
01/05/25
01/07/25


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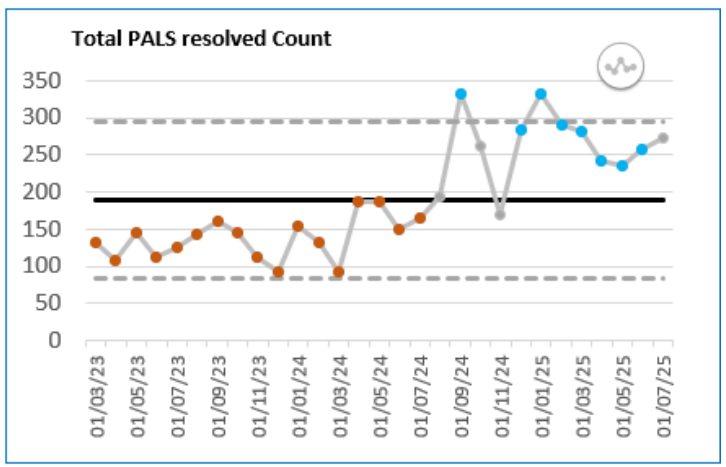
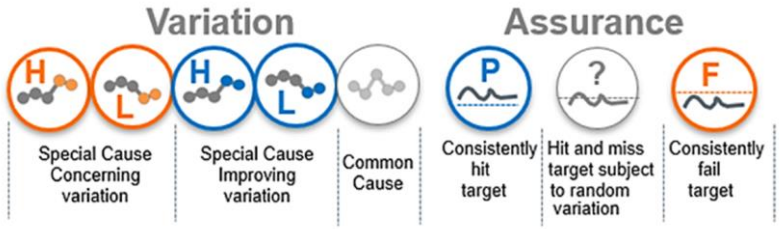
01/01/25
01/03/25
01/05/25
01/07/25


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
01/07/25

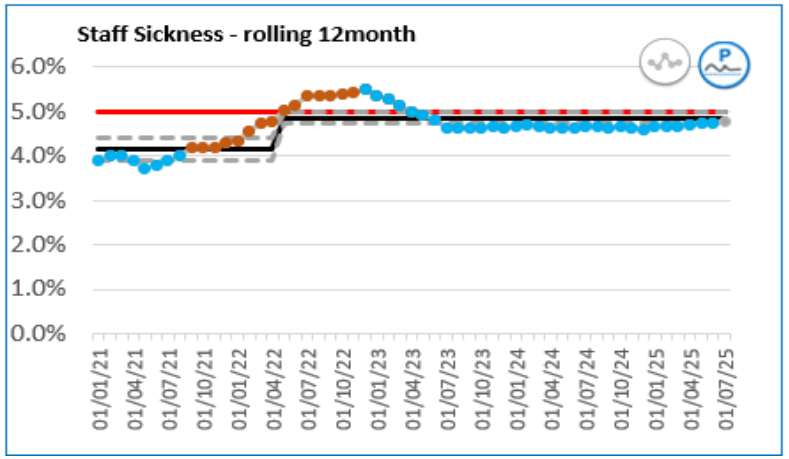
Safe

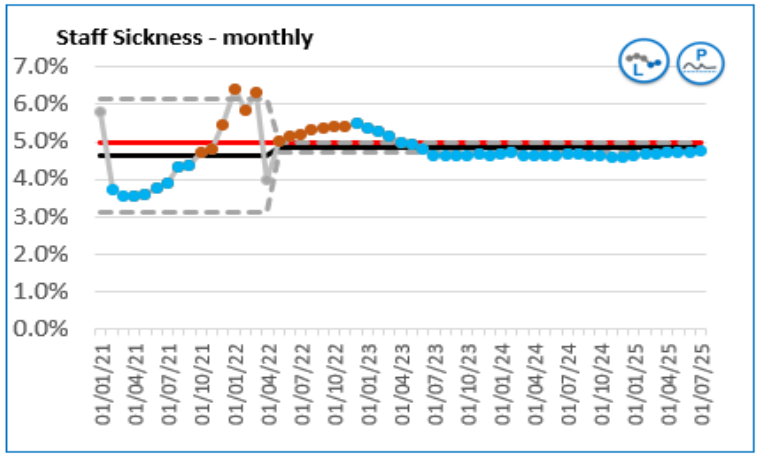
What	So What?	What Next?
Active formal complaints have decreased slightly from 53 to 51 which is still a high variation and increased trend that we have seen since February this year which now falls outside of the controlled limits. The initial impact is that we have seen an increased volume of new formal complaints received which require triaging, logging and in some cases discussion at incident triage panels for patient safety reviews. Over the last 5 months we have received 109 formal complaints compared to 5 months previous where we received 90 formal complaints (17% increase). 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. Percentage of complaints responded to late have increased and in line with this the count responded to late has subsequently increased and has fallen outside of the controlled limits. This is a common variation depending on complainant outcomes and acceptance of any extended deadline. 3 out of the 8 complaints that were overdue were not extended, 4 were waiting for SJR's or patient safety investigations and one other complainant was not satisfied with an extension. PALS cases logged have increased slightly however are still down from previous months due to a reduction in staffing and therefore the team are finding a balance between providing early resolution and logging full enquiries.	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.	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. A reminder has been sent to the team to ensure that complainants receive an update email with an extension to avoid reporting of overdue/late complaints and we have put additional measures in place to ensure every complainant that falls outside of the local policy timeframe, receives an extension. Some responsibilities which were previously part of the complaints team have been shared with other teams and departments to help with workloads such as consultants appraisals are now completed by the revalidation/appraisal team. Staff compliments and translator requests are now completed by administration services within the team along with the engagement team. Following the corporate review, the new structure will be able to offer more support in regards to administration and complaint support from the wider Patient Safety and Quality team. We are completing a benchmarking exercise across the system and other national Trusts in regards to complaint response timeframes, with a view to changing local policy timeframes to reflect severity of the complaint.

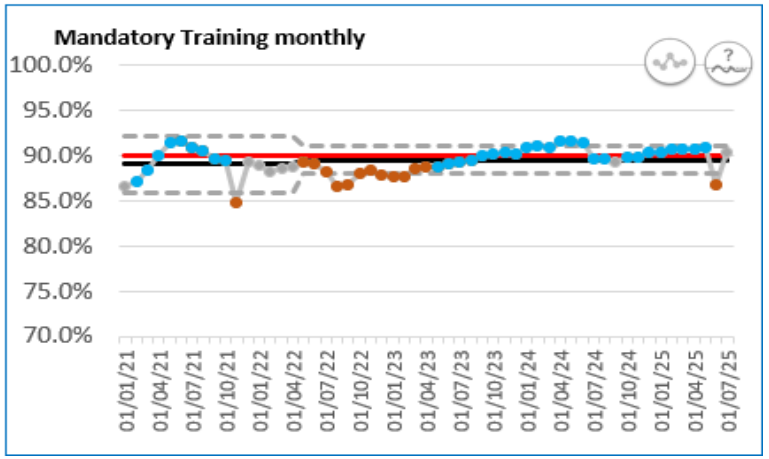


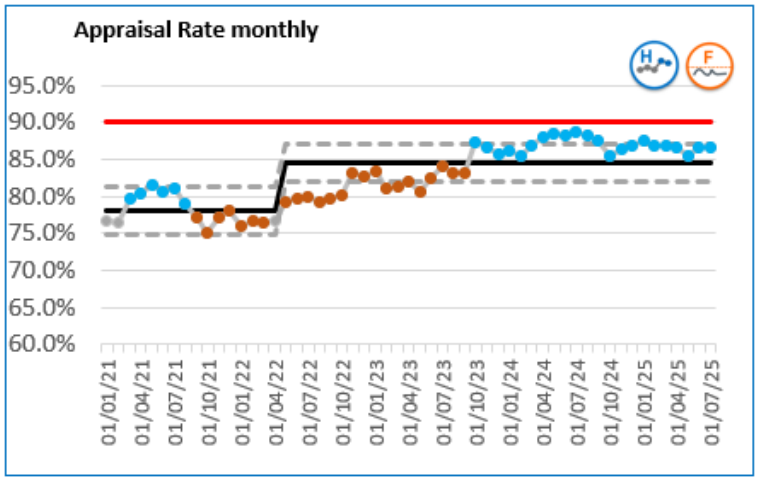
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	Jul 25	4.8%	5.0%		P	4.9%	4.7%	5.0%
Staff Sickness - monthly	Jul 25	4.8%	5.0%	L	P	4.9%	4.7%	5.0%
Mandatory Training monthly	Jul 25	90.3%	90.0%		?	89.5%	87.9%	91.0%
Appraisal Rate monthly	Jul 25	86.6%	90.0%	H	F	84.6%	82.1%	87.0%
Turnover rate monthly	Jul 25	9.2%	10.0%	H	?	10.0%	9.2%	10.9%

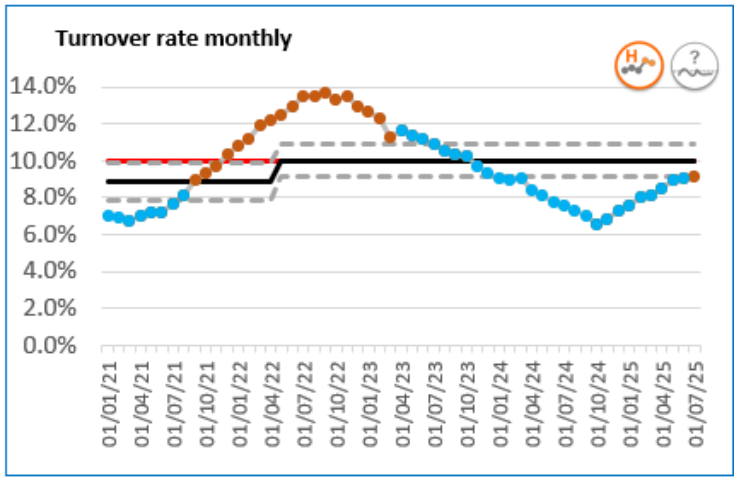
Well Led











What	So What?	What Next?
Two of our key performance indicators continue to record an improving variation. Sickness – achieving target at 4.8% versus 5% target. Mandatory Training – achieving target this month at 90.3% versus 90% target Appraisal – consistently failing target, 86.6% versus 90% target. Turnover – achieving target, 9.2% versus 10% target.	These workforce key performance indicators directly impact on staff morale and engagement, 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.	Monitor staff attendance at department level with focus where improvement is required. Review 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.