NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday 28 November 2025, 9:15 AM — 1:15 PM GMT
Venue	Northgate Room
Description	A meeting of the Board of Directors in the Public domain on Friday 28 November 2025
Organiser	Emma Whight

Agenda

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	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	218
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AGENDA

Presented by Jude Chin

WSFT Board of Directors – meeting in public

Date and Time	Friday, 28 November 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					
	1.1	**Welcome and apologies for absence**	Chair	Note	Verbal
	1.2	**Declarations of Interests**	All	Assure	Verbal
	1.3	**Minutes of meeting** 26 September 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** EOL care	Chief nurse	Review	Verbal
	1.7	**CEO report**	Chief executive	Inform	Report
2.0 STRATEGY					
	2.1	**Update on Business Planning**	Director of strategy and transformation	Approval	Report
	2.2	**Enabling strategy re next steps to implement and deliver the new strategy**	Director of Strategy and transformation	Assure	Report
	2.3	**Future system board report**	Chief executive	Assure	Report
	2.4	**System update/Alliance report** - SNEE Integrated Care Board (ICB) - Wider system collaboration	West Suffolk Alliance Director Social Care, Area Director	Assure	Report
	2.5	**Digital Board report**	Chief information officer	Assure	Report
10:30 Comfort Break – 10 mins					
	2.6	Joint Productivity Board	Director of strategy and transformation	Assure	Report

Time	Item	Subject	Lead	Purpose	Format
3.0 ASSURANCE					
	3.1	**IQPR report** To consider areas for escalation *(linked to CKI reports from assurance committees)*	Executive leads	Review	Report
12.05 Comfort Break – 10 mins					
4.0 PEOPLE, CULTURE AND ORGANISATIONAL DEVELOPMENT					
	4.1	**Involvement Committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
	4.2	**Freedom to Speak Up (FTSU) Report**	Chief people officer	Assure	Report
	4.3	**Putting You First Report**	Chief people officer	Assure	Report
5.0 OPERATIONS, FINANCE AND CORPORATE RISK					
	5.1	**Insight committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
	5.2	**Finance report**	Chief finance officer	Review	Report
6.0 QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT					
	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	**CQC preparedness**	Chief nurse	Assure	Report
	6.4	**Maternity services report** - Maternity services quality and performance report	Chief nurse Karen Newbury Kate Croissant Simon Taylor	Approval	Report
7.0 GOVERNANCE					
	7.1	**Charitable Funds Committee report** Chair's key issues from the meetings	NED Chair	Inform	Report
	7.2	**Audit Committee** Chair's key issues from the meetings	NED Chair	Inform	Report

Time	Item	Subject	Lead	Purpose	Format
	7.3	**Governance Report**	Acting Trust secretary	Assure	Report
	7.4	**Proposed changes to Governance Structure**	Acting Trust secretary	Approval	Report
8.0 OTHER ITEMS					
	8.1	**Any Other Business**	All	Note	Verbal
	8.2	**Reflections on meeting**	All	Discuss	Verbal
	8.3	**Date of next meeting** 30 January 2026 WSFT, Quince House floor 2 Northgate Meeting Room.	Chair	Note	Verbal
	Resolution The Trust Board is invited to adopt the following resolution: "that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicly on which would be prejudicial to the public interest" Section 1(2) Public Bodies (Admission to Meetings) Act 1960				

Supporting Annexes

Agenda item	Description
3.1	IQPR

Guidance notes

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

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

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

1. GENERAL BUSINESS

Presented by Jude Chin

1.1. Welcome and apologies for absence - Richard Jones; Nicola Cottington (Matt Keeling attending); Sarah Judge; Richard Goodwin (Ravi Ayyamuthu attending); Greg Bowker (Anna Hollis 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 - 26 September 2025 (ATTACHED)

To Approve

Presented by Jude Chin

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE
Open Board meeting

Held on Friday 26 September 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
Dan Spooner	Executive Chief Nurse	DS
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
Heather Hancock	Non-Executive Director	HH
Richard Flatman	Non-Executive Director	RF
Alison Wigg	Non-Executive Director	AW
Michael Parsons	Non-Executive Director	MP
Paul Zollinger-Read	Non-Executive Director/ Maternity and Neonatal Safety Champion	PZR
Peter Wightman	West Suffolk Alliance Director	PW
Clement Mawoyo	Area Director, HomeFirst, Safeguarding and West Suffolk	CM
In attendance:		
Paul Bunn	Acting Trust Secretary	PB
Greg Bowker	Head of Communications	GB
Sarah Judge	Interim Chief Information Officer	SJ
Matt Keeling	Deputy Chief Operating Officer (Item 5.3 only)	MK
Karen Newbury	Director of Midwifery (Item 6.3 only)	KN
Simon Taylor	ADO, Women & Children and Clinical Support Services (Item 6.3 only)	ST
Kate Croissant	Clinical Director – Women & Children and Clinical Support Services (Item 6.3 only)	KC
Justyna Skonieczny	Deputy Head of Midwifery (Item 6.3 only)	JS
Ruth Williamson	FT Office (minutes)	RW
Apologies: Richard Jones, Trust Secretary, Pooja Sharma, Deputy Trust Secretary.		
Governors observing: David Slater, Val Dutton, Anna Conochie, Diana Stroh, Clare Rose		
Staff: Diana Stroh		
Members of the public: Deborah Ohara.		

1.0 GENERAL BUSINESS		
1.1	**Welcome and apologies for absence**	**Action**
	The Trust Chair (JC) welcomed attendees to the meeting. Apologies for absence, as detailed above, were noted. It was further noted that Paul Bunn was in attendance, following his appointment as Acting Trust Secretary.	
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 25 July 2025, were accepted as a true and accurate reflection.	
1.4	**Action Log and matters arising**	
	Action Ref 3155 – IQPR Report – Dermatology – The increase in urgent suspected cancer referrals, particularly dermatology, continues to drive demand pressures. PW advised that an AI platform for routine skin triage has been successfully trialled and will be rolled out at pace, as agreed this week. Engagement with the ICB is ongoing to explore moving appropriate dermatology activity to primary care. The timeline for ICB response is awaited. Patient engagement activities remain on track. An optional paper is anticipated mid-September, with presentation scheduled for early November and ICB approval expected by the end of December. JC advised that progress will be monitored through the Insight Committee. **Action closed.** **Action 3159 – Freedom to Speak Up Report Quarter 4 –** An update will come to November's Board meeting. Completed actions noted.	
1.5	**Questions from Governors and the public relating to items on the agenda** Anna Conochie (AC) raised concerns regarding the incompatibility of computer systems between WSFT and the Essex and Suffolk Elective Orthopaedic Centre (ESEOC) following a recent 15 Steps visit to the pre-assessment unit. NC advised that two different samples for transfusion are required and the laboratory IT systems at ESNEFT are only linked to WSFT via the Colchester laboratory. There is no current link between WSFT labs and the new EPIC laboratory system being introduced on 2 October at ESNEFT. Although not an immediate issue, it is anticipated to become problematic when EPIC is introduced in October. The matter has been escalated in meetings with ESNEFT. The interim solution involves analogue processing, with blood samples transported from WSFT to ESEOC so they can be processed in the Colchester laboratory. A response from ESNEFT regarding mitigation	

	measures is awaited. The issue is being escalated and is recorded on the Risk Register, as it affects WSFT patients. SJ noted that whilst the Health Information Exchange provides visibility of certain results, it does not offer clinical safety assurance for group results, which must be accessed via the laboratory system. The existing link is helpful, but does not resolve the issue.	
1.6	**Patient Story**	
	The Board viewed a pre-recorded account from a mother detailing her experience of the premature birth of her baby. TD reflected on how time can feel extended during traumatic experiences, emphasising the importance of maintaining clear and compassionate communication with patients in such moments. AW raised a point regarding the provision of triage information, noting the request for it to be delivered through various channels, written and verbal and queried whether there is any formal follow-up. DS confirmed that learning from this experience is captured in today's paper, with ongoing efforts to improve the information provided to patients, particularly in pre-term scenarios. JC discussed the pressures clinicians face during emergencies, which often limit their ability to provide detailed explanations. He questioned where the organisation stands in terms of clinical communication practices. DS responded that patient experience feedback is being used to inform improvements and that work is underway to embed shared decision-making in to clinical practice. RG added that this process is being reported to the Clinical Effectiveness Governance Group (CEGG), with training nearing completion. RG also noted that whilst the concept of shared decision-making is well understood, its application varies between elective and emergency contexts. Feedback from both a doctor and nurse were highlighted as especially impactful. HH asked whether any part of the patient pathway might expose the Trust to risk, particularly if a patient later expresses dissatisfaction. DS identified triage as a key area of learning, explaining that without proper triage, the patient might have gone directly to the Emergency Department, potentially resulting in a different outcome. PZR described the stressful situation in which numerous staff entered the room and sought assurance that roles were clearly defined and that only essential personnel were present. DS clarified that although the patient perceived a large number of people, the actual number was lower and the presence of staff in this instance was due to handover. RG acknowledged that in emergency situations it can feel overwhelming, regardless of the actual number of people present, as staff naturally gravitate towards the scene to help. TD asked whether managing such turmoil is a designated responsibility during emergencies. RG confirmed that structured roles are in place, guided by Resuscitation Council protocols, with	

	team leaders assigned for arrest, trauma and emergency caesarean procedures. RG noted that in this case, there was a rapid transition from a suspected diagnosis of IBS to the delivery of a 26-week-old baby and whilst the process is highly structured, patients may not be aware of this. RF enquired about follow-up care involving Addenbrooke's Hospital. RG explained that patients are typically discharged back to the Trust for continued care, with efforts made to ensure continuity and timely return of the baby to local services. JR highlighted the role of PaNDR, the Paediatric and Neonatal Decision Support and Retrieval Service, as a strong example of regional coordination, supporting seamless care across organisations. JC asked how the Board can be assured that learnings from such cases are being disseminated effectively to drive improvement. DS described the use of patient stories, which are shared across nursing and clinical councils and patient experience forums. Teams are encouraged to reflect on these stories in the context of their own services, particularly focusing on communication and dignity. The aim is not simply to resolve issues, but to foster meaningful reflection and service development. JC suggested that governors and the 15 Steps programme engage with clinical teams to discuss how learnings are shared and implemented, ensuring that feedback from frontline staff is captured and acted upon.	
1.7	**CEO Report**	
	Ewen Cameron (EC), CEO, presented the report, which was noted and taken as read.	
2.0 STRATEGY		
2.1	**WSFT Strategy**	
	Sam Tappenden (ST), Director of Strategy & Transformation, presented the final draft of the Strategy report, which is scheduled for launch at the Annual Members' Meeting on 8 October, 2025. ST confirmed that feedback had been received from various stakeholders and expressed confidence that the strategy provides a clear direction and set of priorities to guide the organisation through upcoming challenges. Approval and launch were recommended to the meeting, with a commitment to embed the strategy throughout the organisation. Thanks were extended to all staff and colleagues involved, with particular recognition given to the Communications team. AW commented on accessibility and clarity of language, suggesting simplification of terminology such as "True North" to ensure the document is understandable to the public, including those with neurodiverse needs. ST agreed to review the language and confirmed that the organisation would commission an accessibility review.	

	TD commended the document's ambition and its suitability for varied audiences, but noted that maternity, children's services and community paediatrics lacked sufficient prominence, given their local and national relevance. SJ highlighted the example of the patient portal, but noted it did not reflect the existence of two separate records, particularly the absence of a portal for community services. Minor wording changes were suggested to improve accuracy. NC referred to the slide, "About Us", which lacked clarity on whether statistics were annual and suggested that diversity and inclusion could be more visibly presented. DS recommended reducing the overuse of PPE imagery in the document. RF questioned the positioning of the New Hospital Programme, suggesting it should be more prominent, given its significance. He also noted that references to financial sustainability were vague. JC advised there was specific reference to return to a balanced financial position. JC acknowledged the extensive consultation, involvement and co-production that had informed the strategy. He proposed that the Board begin planning for its implementation. AJ asked how the strategy would align with the Integrated Quality and Performance Report (IQPR), particularly regarding metrics. JC noted the broader issue of identifying appropriate measures and data. NC added that the IQPR would be refreshed to reflect the strategy, the national oversight framework and the new accountability framework. ST confirmed that the rollout plan would focus on embedding the strategy through appraisals, assurance committees and visual materials, alongside updates to enabling strategies.	
2.2	**Future System Board Report**	
	Ewen Cameron (EC), Chief Executive Officer, presented the report. TD raised a query regarding the adaptability of facilities, citing the reduction of ITU beds and questioning whether operating costs had been modelled on income from the original number. EC responded that capacity modelling indicates a requirement for a smaller number of critical care beds, although both the clinical team and regional Critical Care Network advocate for more, given the lower provision per capita in the East of England. Whilst modelling suggests lower demand, flexibility remains in balancing available rooms and functional spaces, including consideration of whether seminar or training rooms within critical care could be repurposed. AW asked whether the design had considered the need to scale up during a pandemic. EC confirmed that the facility will comprise 100% single rooms, but acknowledged it is not designed specifically for extremely rare, large-scale pandemic events.	

2.3	**System Update/Alliance Report**	
	Peter Wightman (PW), West Suffolk Alliance Director, presented an update on current workstreams, including responses to the increasing national demand for neurodevelopmental disorder (NDD) services for both children and adults. The Alliance has been exploring how best to contribute, with a key focus on ensuring clarity at the point of referral regarding expected outcomes. Changes to the "Right to Choose" framework are expected to reduce the number of providers. A session on social prescribing highlighted the identification of high-intensity service users through data systems, with plans to procure a targeted service to support these individuals and optimise NHS resource use. In relation to Dementia diagnoses, challenges persist around recruitment and retention of consultant staff. Efforts are underway to increase monthly assessments, with a review scheduled for January. EC clarified that the dementia service referenced does not relate to WSFT. NC added that dementia metrics are limited and risk being overlooked. ST noted that high-intensity users often represent a distinct cohort who frequently access emergency services rather than inpatient care. Noted funding for this work falls within the social prescribing budget. **Action: PW agreed to take the issue forward, noting recent progress at NSFT following a positive CQC report. Update to come to January Board.** AJ raised the importance of visibility and capacity within the voluntary and community sector, referencing the JOY platform. PW responded that ensuring up-to-date information is key and that simplification of referral handoffs is being explored, including insights from a Cambridge GP. SJ cautioned that whilst JOY is live, it is not yet integrated with System One and awaits data processing agreements. PZR queried the prioritisation of severe autism cases, noting a rise in mild cases. PW acknowledged the challenge, stating that whilst the NHS organises services as best it can, private sector involvement under "Right to Choose" can lead to inequalities. He stressed the need for national and county-level decisions on eligibility. TD raised concerns about school-age referrals, highlighting the link between diagnosis and access to educational support. TD emphasised the need for a joint health and education approach to avoid over-medicalisation. ST noted positive developments, including West Suffolk being selected as one of 43 national neighbourhood implementation sites, with SNEE ICB having three areas included. ***Care Management System (CMS)*** NC referenced the McKinsey report, which identified ten high impact areas, aligning with findings from the sustainability review. A key concern is financial sustainability across acute and	**PW**

	community services, necessitating further exploration of both sectors, including potential implementation of a care management service. Work is ongoing to develop a provider response. NC emphasised the importance of CMS analytics, noting that patient cohorts are dynamic. The role of hospice and end of life (EOL) services requires consideration, with opportunities to apply AI for predictive modelling rather than retrospective analysis of bed usage. A small trial is underway in West Ipswich to assess service delivery models. A meeting with the ICB is scheduled to refine the specification and offer. Digital delivery presents opportunities, particularly for high use groups, such as digitally delivered health coaching. JC suggested two potential commissioning models; one focused on the recommendation of the sustainability review and another involving multiple CMSs at locality level. NC is exploring digital maturity and advanced analytics to inform delivery. JC suggested the Board may need to review strategic direction. NC advised that a report will be presented to a future Board meeting. TD highlighted the role of analytics in early intervention and offered to connect NC with health innovation networks working in this area. ST noted the opportunity is relatively small, but significant and should be pursued. PZR advised against duplicating existing efforts and recommended reviewing external examples. PZR stressed the need for robust clinical leadership, capable of operating across the system and questioned whether West Suffolk has the necessary leadership to span primary and acute care. NC confirmed delivery must be led by primary care and stated that predictive and bespoke regional examples that specifically matched this version had yet to be found. PZR cited previous work on frail elderly mobility. NC responded that such initiatives have not demonstrated reductions in acute costs. **Action: PZR and NC to continue discussions offline.** PW emphasised the importance of effective collaboration between community and GP services. The greatest overlap lies within the EOL group. NC reported that was a new area of national focus and cautioned against scope creep. ST reported positive feedback from GPs following a recent meeting, reinforcing the Trust's focus on primary care relationships. JC stated that the greatest return on sustainability efforts would be achieved through successful implementation. ***ICB Reconfiguration*** PW provided an update, noting the establishment of the Norfolk and Suffolk ICB. The process involves a reduction in the number of directors, with designates commencing on 1 October. Maggie	**PZR/NC**

	Baker-Woods will assume PW's role. PW will continue to support the ICB on dental and other workstreams. PW expressed gratitude to Board members, describing it as a privilege to serve in an open organisation, committed to its values.	
2.4	**Digital Board Report**	
	Sarah Judge (SJ), Chief Information Officer, presented the report. The Digital Board, originally established prior to the implementation of e-Care in 2016, has been led by the CEO throughout the GDE programme. At the last Digital Board Meeting discussion was held regarding the potential alignment of the Digital Board with the assurance committees, rather than maintaining it as a standalone board. It was proposed to transition the Digital Board to a quarterly schedule, with a Non-Executive Director (NED) as Chair. AW was confirmed as the responsible NED for digital matters. TD suggested that the Digital Board become a committee rather than a Board and this was agreed. JC proposed it become an assurance committee, with further work needed to determine its integration with existing committees and CKIs. JC queried the timeline for setting up the new structure. SJ confirmed that the Digital Board will convene in four weeks, at which point today's agreement will be presented, with the transition planned for January. JC raised a query regarding the group referenced in the report on digital design and prioritisation. SJ clarified that specific steering groups will undertake this work and report in to the digital committee. The DDP, a multi-disciplinary group, will manage requests for new solutions and prioritise programmes feeding in to the programme board. SJ noted that there are currently 50 live projects requiring assurance via the audit route. JC requested assurance on data governance, including visibility of accepted and rejected projects, associated benefits and monitoring mechanisms to assess effectiveness. This will be included on the Digital Board agenda. Approval was granted to establish a new assurance committee. The Board will be updated on working practices. **Action: PB and JC to draft the terms of reference and consider how the committee will link in to the Board.**	**PB/JC**
2.5	**Joint Productivity Board**	
	Sam Tappenden, Director of Strategy & Transformation presented the report to the Board. A further update will come to Board following the meeting on 29 September 2025.	
3.0 ASSURANCE		
3.1	**IQPR Report**	
	Nicola Cottington, (NC), Chief Operating Officer, presented the report.	

	JC queried areas behind target and whether improvement was evident. NC highlighted elective activity, noting progress in August across waiting list size and RTT metrics, excluding 65-week waits. Activity and RTT remain off-plan due to Tier 1 constraints and financial pressures, with cost reductions impacting delivery. The Trust's decision to straight-line recovery differed from others, and a recent stocktake with JR led to agreement at the Management Executive Group on investment to recover activity, focusing on specialties with longest waits and greatest benefit. NC emphasised the need to balance productivity and cost improvement, cautioning against removing productivity gains solely as CIP, which can lead to premium agency costs. AW queried what this meant in terms of achieving zero 65-week waits. NC confirmed confidence in delivery of this objective by the deadline of 21 December. NC acknowledged further work required on 52-week and 18-week targets, demand management, and validation. PZR raised concerns over July data showing reduced elective and day case activity. NC referenced a successful "Perfect Week" in surgery where capacity was maximised with no overruns. NC also confirmed submission of RTT reforecasts to be back on track by December. TD expressed concern over affordability of the activity plan and prioritisation variation, questioning planning process robustness. EC noted several factors influence planning, including political. NC stated achieving RTT trajectory would align with productivity goals. JR confirmed the Trust operates under a guaranteed income contract, with potential return to cost-per-volume next year. AJ referred to a deep dive on elective recovery at the September Insight Committee. AJ has requested detailed recovery action plans to come to the next meeting in order to gain assurance. JC confirmed receipt of weekly RTT data since August. UEC performance exceeded trajectory in August but is expected to fall in September due to increased long-stay patients and reopening of COVID beds. JC questioned sustainability of March improvements; NC acknowledged processes had not been embedded. Intense management input had been used in March, impacting on other duties. Recruitment of an ED manager has since occurred. RG noted summer pressures resembling winter conditions. AJ asked whether March learnings were captured and disseminated. NC confirmed a reflective exercise was undertaken and a new performance framework is being introduced. PZR raised concerns about cultural issues and accountability. NC stated the framework aims to address this, balancing performance with staff experience. EC noted performance is 10% better than two years ago and March demonstrated capability. CM acknowledged team efforts and asked about discharge focus and Virtual Ward capacity. NC confirmed community PRM discussions this week regarding discharges and how work at times of acute escalation. Virtual Ward occupancy fluctuates. A decision point is coming to MEG in early October. JC offered Board support,	

	noting the issue's significance. EC highlighted associated health, safety, and clinical quality risks. On cancer services, NC reported improved performance and confirmed an external review of the breast service is pending. Diagnostic performance remains challenged, with a deep dive planned at Insight. Endoscopy and obstetric ultrasound are key drivers, with ultrasound recruitment a national issue. NC noted financial controls affected temporary staffing and productivity in endoscopy requires greater focus and inclusion in job plans. TD expressed concern over ultrasound delays and sustainability and suggested a deep dive be undertaken at Insight to ensure wait times are as clinically appropriate as possible. NC reported success with insourcing and temporary staffing. **Action: NC to explore assurance mechanisms (deep dive) and alternative management approaches for elements of ultrasound and diagnostics.** RG suggested optimising primary care referrals and staff capacity. The waiting list issue is under national discussion and will be addressed at the national imaging board in October. DS reported a peak in C.difficile cases in July, linked to a number of teams that had been located within the same decant ward, (at different times). The ward was closed and fogged in August, addressing the potential environmental burden. JH noted metrics are stable but suggested deeper reporting to the Board, particularly around engagement, which will be addressed through Involvement.	**NC**
4.0 PEOPLE, CULTURE AND ORGANISATIONAL DEVELOPMENT		
4.1	**Involvement Committee Report**	
	Tracy Dowling, (TD) Non-executive Director, presented the report. Recent meetings included an excellent staff story from a member of staff sharing her lived experience with NDD. The Organisational Development Manager provided an update on EDI, highlighting the critical issue of limited data and advocating for a focused approach on six high-impact areas, reinforcing the organisations commitment to inclusivity and diversity. PULSE staff engagement scores will be reviewed at the next meeting in October. JH confirmed the national staff survey will launch on 29 September, alongside the flu vaccination campaign beginning on 1 October, with staff encouraged to participate in both initiatives.	
4.2	**People & OD Highlight Report**	
	Putting You First	
	Julie Hull, (JH), Interim Chief People Officer, presented the report. The Board acknowledged the recent staff awards and expressed congratulations and appreciation to all recipients.	

	GB confirmed that Putting You First (PYF) is likely to remain as a recognition initiative, with the process currently under review.	
5.0 OPERATIONS, FINANE AND CORPRATE RISK		
5.1	**Insight Committee Report**	
	Antoinette Jackson (AJ), Non-executive Director, presented the report. It was noted that July's report is missing from today's meeting pack. The July report included a diagnostic deep dive and a discussion led by Neil Jackson, Associate Director, Estates and Facilities, on the backlog of works and associate risks. These risks require active management. **Action: July Insight CKI to be circulated to board members.** In relation to finance, minimal assurance was noted around business planning. It is hoped that the medium-term strategy will provide mitigation. JR requested consideration of financial data risks due to shifting parameters. ST confirmed that work is underway as part of the medium-term planning process, placing the organisation in a stronger position. Phase two of the corporate services review is now commencing.	**EW**
5.2	**Finance Report**	
	Jonathan Rowell, (JR), Interim Chief Finance Officer, presented the report. JR confirmed that if the financial plan is met this year, current budgets will be reiterated, with broader work underway to support this. August performance was favourable, with the reduction in whole time equivalents (WTEs) and bank usage noted by Region. Activity underperformance in diagnostics and UEC was acknowledged, with targeted investment agreed at MEG. The forecast position remains on track, with strong CIP delivery, although a gap persists. Work is ongoing to close this, including a recent outpatient review. Cash performance is ahead of plan, though impacted by the pay award. Engagement with NHSE is ongoing to secure support for the deficit plan. RF highlighted the importance of the recurrent position at year-end, noting a positive position, despite a Month 5 deficit. JR confirmed this reflects genuine non-recurrent costs. JC queried when recurrent and non-recurrent run rates would be clarified; JR confirmed in October. PZR asked about unidentified CIP. JR confirmed £28.5m identified against a risk adjusted target of £24.9m, leaving approximately £4m outstanding. JC queried if the expectation was to meet £27m. JR confirmed that it was. ST noted the positive cultural shift, with teams developing schemes at pace and focusing on next year. EC added that some initiatives planned for late this year will support delivery in to the next financial period.	

5.3	**Winter Planning**	
	Matt Keeling, (MK), Deputy Chief Operating Officer, presented the report. Board approval was sought for Annex B. The winter response plan largely mirrors previous years, including command and control arrangements and use of the Operational Pressures Escalation Levels Framework (OPEL), with day-to-day responses regularly reviewed. This year's approach includes improvements from the UEC Delivery Group, which achieved performance gains in March. Current focus is on maximising Same Day Emergency Care (SDEC) and timely specialty reviews, with divisional leadership supporting care at home and patient flow. Capital funding has been incorporated earlier in to planning, with infection control measures addressing side room capacity through fogging, FIT testing and portable "ready rooms". Despite mitigations, bed modelling indicates a deficit, requiring close daily clinical and operational risk management. Assurance will be provided through performance trajectories and plans aimed at reducing variation in 4 and 12-hour waits. Regional winter preparedness was tested during Exercise Arboreous on 3 September and Exercise Pegasus will test national system-level pandemic response later this year. The Trust is in a stronger position due to extensive preparedness, though challenges remain. EC noted a decline in 4-hour performance, but sustained improvement in 12-hour breaches. NC highlighted the impact of schemes on length of stay and activity, despite an overall deficit. PZR queried primary care readiness for respiratory illnesses and flu. PW confirmed that flu vaccination is on track and additional winter resources have been allocated. JC asked about the significance of 24 GP practices participating in the plan. MK clarified this forms part of an alliance-wide plan, aimed at smoothing demand peaks rather than identifying reductions. PW noted EoL care may support this and MK referenced funding sources including the Better Care Fund and council contributions. UEC pressures are acknowledged, with management through the alliance group. AW queried confidence in Virtual Ward step-up benefits. NC confirmed high confidence, with increased step-up activity. DS asked about social care staff vaccination. CM confirmed co-ordination with primary care and public health is ongoing. TD asked whether senior manager cover during evenings and weekends is included in the plan. MK confirmed this has continued through the summer and is embedded in daily operations, though not detailed in the plan. **The Board gave its approval to the winter plan.**	

6.0 QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT		
6.1	**Improvement Committee Report**	
	Paul Zollinger-Read, (PZR) Non-executive Director, presented the report. The Board noted the prompt response to the C.difficile issue on one of the wards. In relation to PSIRF, concerns raised by some coroners about robustness in other Trusts were acknowledged. RG advised that WSFT is using more in-depth analysis and, as an early adopter, had already identified the issue and is ahead in implementing necessary changes. An in-depth review of the Trust's position regarding CQC is scheduled for next month. DS provided reassurance, noting revisions to the corporate governance structure with clear guidelines. RG confirmed the CQC has undergone significant changes and reviewed internal processes, with staff preparedness identified as a key factor. AJ raised the importance of Board member readiness and their role in the process. **Action: Detail on Trust's CQC visit preparedness to come back to future board.** A half day workshop is planned for the committee next week. The current framework was noted as overly complex, with a need for simplified data presentation and greater focus on risk.	**DS**
6.2	**Quality and Nurse Staffing Report**	
	Dan Spooner (DS), Chief Nurse, presented the report. The new Deputy Chief Nurse, Sarah Ward, has commenced in post. Nursing and support staff vacancies remain positive, under 10%, with some movement in budgets. Fill rates are at 90%, though Care Hour Per Patient Day (CHPPD) remains in the lower quartile. An increase in pressure ulcers is being investigated. All newly qualified nurses and midwives from the Trust's cohort have secured employment, either within the organisation or elsewhere, with community services attracting a number of new starters. JC queried fill rate outliers. DS confirmed safe staffing is maintained through daily reviews and staff redeployment. JC queried anomalies on particular wards. DS noted that the closure of the King's Suite at Glastonbury Court and rostering issues, where staff were not on HealthRoster, were affecting data. ST asked about early results from nursing referrals in the community. DS confirmed a requested change in reporting to address the issue, though not to a significant degree. JC queried vacancy rate comparisons with ESNEFT and Norfolk. DS noted data was not to hand, but confirmed vacancies had been held for redeployment purposes which due to timings could not be addressed.	

	AJ raised concerns about communication in community nursing, referencing the complaints analysis. TD confirmed a deep dive at Involvement is scheduled for October. AJ requested further focus on staff training and development. **Action: TD to liaise with JH and GB to explore communication in more depth, linking to staff engagement. Feedback to come to future Board meeting.**	**TD/JH/GB**
6.3	**Maternity Services Report**	
	Karen Newbury, (KN) Associate Director of Midwifery, Simon Taylor, (ST) Associate Director of Operations for Women & Children and Clinical Support Services, Kate Croissant, Clinical Director, Women & Children and Justyna Skonieczny, Deputy Head of Midwifery, were in attendance to present the report. KN highlighted the importance of civility in care, promoting the "Civility Saves Lives" initiative and listening to families and supporting staff to speak up. Data driven quality improvement is being shared across the forums and EDI efforts are focused on empowering individuals to speak up when culturally may not be comfortable in doing so. RG commended a recent visit with the community team, which provided valuable insight into pathway differences. **Action: NC suggested showcasing examples of personalised care at Involvement or Board level and proposed further discussion offline regarding assurance.** HH raised concerns about communication, referencing complaints data. KN noted issues stem from assumptions and a lack of active listening, as reflected in CQC feedback and free-text responses. Staff are being encouraged to adopt practices such as "Hello, my name is" and ending interactions with "Have I answered all your questions?" to improve communication.	**NC/DS**
7.0 GOVERNANCE		
7.1	**Board Assurance Framework**	
	Paul Bunn, (PB), Acting Trust Secretary, presented the report. Noted future iterations will provide greater assurance on whether mitigation trajectories are being met and, if not, the reasons why. The timeline of next steps has been brought forward, with consideration for inclusion in the February Board Development Day. JC noted positively that two risks have moved within appetite and encouraged executives to ensure mitigation levels are accurately reflected in risk scores. PZR raised the broader issue of proactive risk management within the NHS. PB confirmed progress in divisional reporting and clinical risk structure, with corporate mapping to follow. A more detailed discussion is planned for the November Corporate Risk Governance Meeting agenda. RF queried the use and clarity of assurance levels within the BAF and their alignment with the strategy. PB confirmed a revised	

	template is in development to improve transparency. RF suggested that visibility of risk exposure would support cross-organisational working. JC noted that risks are allocated to assurance committees for deep dives. The question was how effective these deep dives are. ST confirmed work on a revised template, aligning risks with the strategy, which will be reviewed in October workshop sessions. ST noted the need for improved forward-looking risk management, which can be incorporated into the process.	
7.2	**Governance Report**	
	Paul Bunn, (PB), Acting Trust Secretary, presented the report. The report was noted and taken as read.	
8.0 OTHER ITEMS		
8.1	**Any Other Business**	
	Peter Wightman – The Board expressed its sincere appreciation for PW's significant contribution, noting his departure would be a loss to the Board. EC commended PW's ability to manage dual responsibilities effectively. PW acknowledged the supportive environment that had enabled this. PW advised that this successor would be a valuable asset to the Trust. The Board extended its best wishes to PW for the future.	
8.2	**Reflections on meeting**	
	• TD considered the discussion on the items presented during the meeting was detailed and constructive. • AJ welcomed the continued evolution of the Trust strategy, reflecting various discussions. • HH expressed appreciation for the culture of supported challenge and encouraged its continuation.	
8.3	**Date of next meeting** 28 November 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
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.	**FTSU Guardian already invited to F1 doctors induction and to give Lunch and Learn teaching session in the first year. Guardian to actively promote champion role at these sessions.** **Introduction to FTSU at every Staff Welcome, attended by all new staff, including doctors.** **FTSU Guardian has attended the Medical Staffing Committee – going forward regular attendance quarterly to share themes. (I will liaise with Carolina Caprio).** **FTSU already attends Schwartz rounds when possible.** **FTSU guardian to give brief introduction at the Grand Round (JS will liaise with Lorna Lambert).** **RG to invite JS to give introduction to speaking up and support listening up at Senior Medical Leadership meeting. (yearly?)**	JS	28/11/25	Complete	28/11/2025
3171	Open	26/09/2025	2.3	**System Update/Alliance Report - Care Management System -** acute and emergency care, predictive and bespoke regional examples. Discussion to be continued off line.	**Care Management Service update on closed board agenda. Discussion to be continued offline.**	PZR/NC	28/11/25	Complete	28/11/2025
3172	Open	26/09/2025	2.5	**Digital Board Report** - Draft terms of reference and consider how the committee will link in to the Board	**Please see separate governance report (Item 7.4) converting digital board into an assurance committee with reporting lines into that. Draft terms of reference are with the Digital team for discussion and review.**	JC/PB	28/11/25	Complete	28/11/2025
3173	Open	26/09/2025	3.1	**IQPR** - explore assurance mechanisms (deep dive) and alternative management approaches for elements of ultrasound and diagnostics.	**Division supported through Performance, Accountability and Autonomy Framework and revised trajectory submitted to Performance Review Meeting. Deep dive being presented to November Insight Committee.**	NC	28/11/25	Complete	28/11/2025
3174	Open	26/09/2025	5.1	**Insight Committee Report** - Circulate July's CKI report to Board Members.	**Actioned.**	EW	28/11/25	Complete	28/11/2025

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3175	Open	26/09/2025	6.1	**Improvement committee Report** - Detail on Trust's CQC visit preparedness to come back to future Board	**Item 6.3 on toay's (28.11.25) agenda refers.**	DS	28/11/25	Complete	28/11/2025
3177	Open	26/09/2025	6.2	**Maternity Services Report** - discussion off line re. showcasing examples of personalised care at Involvement or Board level.	**Discussion taken place, including with Director of Midwifery. Opportunities for content under consideration for inclusion at future Board/sub-committee.**	NC/DS	28/11/25	Complete	28/11/2025

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3170	Open	26/09/2025	2.3	**System Update/Alliance Report - Dementia** - PW agreed to take the issue forward, noting recent progress at NSFT following a position CQC report. Update to come to January Board.	**Maddie Baker-Woods to take forward for action at January Board.**	~~PW~~ MBW	30/01/26	Green	
3176	Open	26/09/2025	6.2	**Quality and Nurse Staffing Report -** Explore communication in community nursing, referencing complaints analysis in more depth, linking to staff engagement. Feedback to come to future Board meeting.	**The deep dive into complaints management was completed at the October Involvement Committee and the Committee will continue to keep Complaints and PALS under review. There is further work in progress to review the effectiveness of communications through the Trust with recommendations to a future meeting.**	TD/JH/GB	28/11/25	Green	

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

To Note

Presented by Jude Chin

1.6. Patient story

To Review

Presented by Daniel Spooner

1.7. Chief Executive’s report (ATTACHED)

To inform

Presented by Ewen Cameron

WSFT Board of Directors (Open)	
Report title:	**CEO report**
Agenda item:	1.7
Date of the meeting:	Friday, 28 November 2025
Sponsor/executive lead:	Dr Ewen Cameron, chief executive
Report prepared by:	Dr Ewen Cameron, chief executive Sam Green, senior communications officer 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 October 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

As we move into the throes of winter, we have been focusing on continuing to reducing our waiting lists, making sure our staff and our communities receive their seasonal flu vaccinations, and keeping to our deficit plan.

In September, we invested significantly in our divisions to reduce the number of patients waiting long periods, as well as improving our performance against the 18-week target. While the impact of this funding is still being evaluated, it represents our commitment to not just meeting operational targets, but providing the care our patients deserve, when they need it.

The flu season has again arrived earlier than planned, and we are gearing up for a tough flu season, which is likely to be in full swing by the time this meeting occurs. NHS England have issued a 'flu jab SOS', and we have supported this by providing additional clinics on weekends to ensure those who work irregular, or unsocial shift patterns, can get the protection they need, as well as promoting the availability of clinics across Suffolk and north east Essex so our communities are protected. Through a focused effort, the east of England is above the national average for the number of staff vaccinated, and currently 44% of our staff have received their vaccination. We are using behavioural science in collaboration with our SNEE partners to encourage further uptake.

As I've said before, our deficit plan is ambitious, however, we are making significant progress, which is down to a concerted effort from colleagues in all divisions of our Trust. While there's still a lot more we need to do, we are reaping the rewards of decisive actions taken earlier in the financial year. I am grateful to our staff for their ongoing commitment to helping us push forward with this plan to achieve financial sustainability, and I invite you to join me in thanking them and encourage their ongoing support.

Performance

Finance

At the end of October, our reported position in-year was a £15.3m deficit, which is £1.2m 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. In the first six months of the financial year (25/26), savings include:

- £339k through purchasing of cheaper/alternative drugs for patient care
- £2,436k of divisional clinical productivity improvements
- £531k of staff savings through hiring controls
- £326k of savings through improved use of the Trust's estate and commercial income from rent and accommodation
- £785k of savings through procurement initiatives, including product switching, enhanced usage control and savings achieved by our buyers.

Elective recovery

Despite British Medical Association industrial action continuing, with a further five days taking place between 14 and 19 November, we are making good progress in reducing our waiting lists.

Between August and November 2025, the number of patients waiting 52 weeks or more decreased by almost 50% from 1,746 to 921. The number of patients waiting 65 weeks or more also reduced by 70% in the same period to 72. This comes following a huge push by our teams to support our patients, and I am looking forward to seeing the outcome of our investment in the surgical division in the coming weeks and months.

We are also making good progress in reducing our 18 week waits, with us currently achieving a performance of 61.9%. Our focus is to bring these figures down, so we meet the target of 92% by the end of the current Parliament.

Urgent and emergency care

Our performance against the 4-hour standard was 69.8% (target 78%) in October. This represents a drop in where we were in Spring this year, however, our teams are working very hard to transform how we provide care in our urgent and emergency care pathways.

Again, thanks to the thorough planning ahead of the most recent round of BMA industrial action, over this period we achieved performance against the 4-hour standard well over the 78% target in the lead up to and during the strike days. On Saturday, 15 November, we recorded a 93.2% compliance with the 4-hour standard as part of a week where we performed 12th best nationallyThis demonstrates how our teams come together to provide the care our patients deserve during even the most challenging times.

Cancer

28-day

- June – 74.1%
- July – 80.4%
- August – 79.9%

31-day

- June 100%
- July – 99.8%
- August – 100%

62-day

- June – 73.6%
- July – 70%
- August – 78.2%

While we are making progress in our performance against the Faster Diagnosis Standard, I am pleased that in the recent National Cancer Patient Experience Survey, 93% of respondents said our service was ‘good’ or ‘very good’. With our top scores being in areas about respect and dignity, availability, confidence in the team, and involving patients in discussions around their treatment options. The care and dedication our teams have for our patients is evident, and I’m very proud of the quality of our service for those going through difficult cancer journeys is so high.

Quality

As we continue on our journey to deliver a new West Suffolk Hospital and achieve financial and operational sustainability, there is a lot we are doing to transform the way we work. I was

delighted to learn that the improvements we've made in our urgent and emergency care (UEC) services were recognised at the recent Proud2bOps awards in the 'operational improvement – urgent and emergency care' category. The team was shortlisted for their work resetting ward F7 at the West Suffolk Hospital back to short stay, improving patient flow, and supporting how our UEC services transform their way of working. The team empowered colleagues to select the appropriate patients to be admitted to their ward and identify those who required specialist beds or who may be potential long-stay patients. The impact resulted in a 49% increase in the number of discharges and reducing long-stay patients by 50% on their ward. This is a great example of how our teams are delivering the changes we need, so our patients get the quality of care they deserve as quickly as possible.

Additionally, we are fortunate to be supported by our two incredible charities: My WiSH and the Friends of West Suffolk Hospital. Every year, the 'friends' – as we call them – offer grants to our teams to enhance the care they provide, whether that is new equipment or additional specialist training for colleagues. Recently, the friends' grants totalled almost £72,000, with our critical care outreach team receiving nearly £18,000 for five Airvo machines which deliver humidified oxygen to patients nasally. This means patients can receive the support they need and still eat, drink, talk and move around more easily, without having to wear a mask.

Our My WiSH charity have also been very busy fundraising, with their second 'Grow Your Dough' campaign generating £27,000. These funds will be used to fund additional services and support departments and appeals, which includes the WiSH Upon a Star Children's Appeal.

I hope you join me in thanking those working, volunteering, and fundraising for these charities.

Workforce

We know the NHS Staff Survey, the largest single workforce survey in the world, is a key way for us to gauge how our staff are feeling, and where we need to make improvements. Following an extensive campaign to encourage our staff to complete the survey, it closes on Friday, 28 November.

We expect the results to be published in full in March 2026, and we will share the results at a future Board meeting where we will consider their impact.

Future

We are at an exciting point in our journey to deliver a new hospital in Bury St Edmunds. In collaboration with our New Hospital Programme colleagues, we have agreed 1:200 designs, which we are currently sharing with our staff. As we enter RIBA stage 3 of the planning framework, this gives our colleagues much more clarity about how our teams will be working and where they will be based. We are considering the feedback we've received and will be sharing these designs with the public and local stakeholders in the near future.

We are also developing our plans for an expansion of the Community Diagnostic Centre at Newmarket Community Hospital. The proposed design of the CDC expansion has been shared with our staff, patients and local residents, and we are taking feedback on board.

The proposed expansion will provide additional endoscopy and paediatric audiology services in Newmarket, giving us more capacity to bring down waiting lists and help patients avoid lengthy journeys to receive their care. While we are still finalising the details of how this facility will look, we are making good progress and planning the construction phase. I look forward to providing future updates on this project.

2. STRATEGY

2.1. Update on Business Planning (ATTACHED)

For Approval

Presented by Sam Tappenden

Public Board	
Report title:	WSFT Business Planning process update
Agenda item:	WSFT Business Planning process update
Date of the meeting:	28th November 2025
Lead:	Sam Tappenden Executive Director of Strategy and Transformation
Report prepared by:	Renu Mandal Head of Business Management

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 is in the process of developing its Medium Term Plan (MTP) in line with national requirements.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
It is crucial that the Trust has a structured, robust approach to planning that delivers financial sustainability, performance improvement, which maximises alignment across teams, and which is compliant with national requirements.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
• Continue Medium Term Plan development, internal engagement with stakeholders, and external engagement with the ICB. • Testing of the draft plans through 'triangulation' sessions, Management Executive Group, and in an 'exceptional' Board ahead of the first submission on 17th December.
Recommendation / action required
• Board to note progress to date.

Previously considered by:	Management Executive Group
Risk and assurance:	Failure to design and develop a structured, repeatable business planning process could result in misalignment of national and local delivery trajectories.
Equality, diversity and inclusion:	Developing plans that are robust and triangulated improves patient outcomes and reduces health inequalities.
Sustainability:	Developing a standardised approach with tools will contribute to a structured, repeatable business planning process for the Trust.

Legal and regulatory context:	NHS Contract NHS 2025/26 priorities and operational planning guidance NHSE Planning Framework for the NHS in England

Medium Term Planning update
Date: 28th November 2025
Author: Sam Tappenden, Executive Director of Strategy and Transformation, and Renu Mandal, Head of Business Management

1. Purpose

1.1. The purpose of this report is to provide an update on progress to date with the Trust's Business Planning (BP) process and submission of the Medium-Term Plan (MTP).

2. Executive summary

2.1. The business planning process and development of the MTP is underway.

2.2. The Trust is required to deliver its first submission by noon on the 17th of December. The submission will include quantitative activity, finance, and workforce plans, Board assurance statements, and narrative.

2.3. Considerable work is underway to bring all this together into a coherent plan to be ready for scrutiny by the Management Executive Group, and in an 'exceptional' Board soon after, ahead of submission.

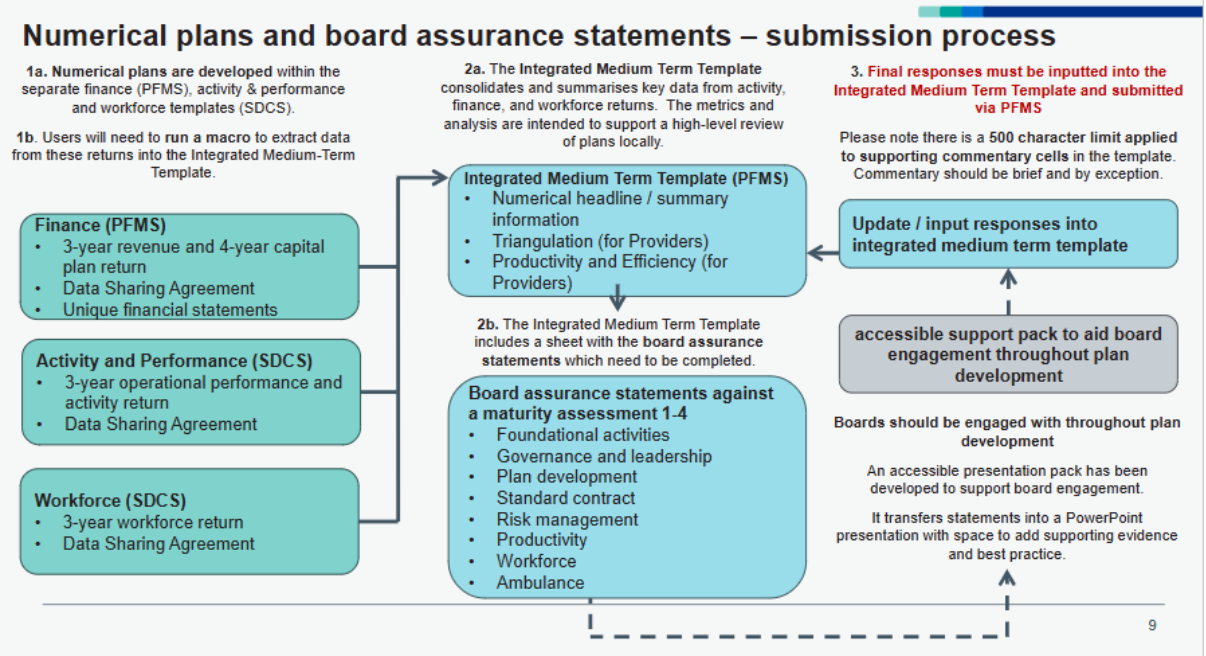
3. Planning requirements

3.1. As a reminder, to deliver the 10-Year Plan the planning framework sets out requirements of NHS bodies to develop medium-term plans for 2026/27 – 2030/31. This involves the development of:

a. **Five-year commissioning plans (Integrated Care Boards):** describing how, as a strategic commissioner, an ICB will improve population health and access to consistently high-quality services.
b. **Five-year integrated delivery plans (NHS Trusts):** demonstrating how the organisation will deliver national and local priorities.
c. **Neighbourhood health plans (local partners):** These will be drawn up by local government, the NHS and its partners at single or upper tier authority level under the leadership of the Health and Wellbeing Board, incorporating a breadth of partners.

3.2. We are now in 'phase 2' of the described approach, whereby providers are required to develop a credible, integrated organisational 5-year plan that demonstrates how national and local priorities will be delivered, including securing financial sustainability. Plans should triangulate activity, workforce, finance, and quality.

Figure 1: submission process



4. WSFT progress to date

4.1. A multi-disciplinary steering group chaired by the Executive Director of Strategy and Transformation has been set up to oversee delivery of the medium-term plan and the business planning process.

4.2. The group aims to ensure that the medium-term plan is both developed 'bottom up' and with clear corporate expectations for completion, whilst aligning development between our divisional and corporate teams.

4.3. A set of assumptions have been built into the business planning process to enable divisions to move forward at pace. These include activity targets; a financial baseline which includes a CIP target; and workforce assumptions which reconcile the electronic staff record and ledger where possible.

4.4. Divisions are completing their workbooks setting out their divisions' strategic priorities and service development plans, their delivery timelines, and any support resources that are required.

4.5. Alongside divisional activity plans, this workbook will be used as a tool to facilitate discussion for formal 'triangulation' sessions to identify impact and risk relating to interdependencies.

4.6. Triangulation sessions are planned for late November to ensure that financial affordability, operational feasibility, and workforce capability are all aligned in one integrated plan.

5. Outputs required

5.1. The key outputs required for the submission is the 'Integrated Medium Term Planning Template'. The full template has not been published yet, but this is likely to include:

- Triangulated quantitative finance, workforce, and activity plans
- Qualitative narrative for key areas including:
  - Service plans
  - Workforce plans

    - Digital plans
- Board assurance statements that require a 'maturity' rating, as well as narrative, if the rating is not 'full assurance'

Figure 2: summary of requirements for different submissions

Submission	Requirement
First submission	• 2-year finance plans and 4-year capital plan return • 2-year workforce plan • 2-year activity and performance plan • Integrated medium-term plan template giving commentary on areas of non-compliance and board assurance statements.
Full plan submission	• 3-year finance plans and 4-year capital plan • 3-year workforce plan • 3-year activity and performance plans • Integrated medium-term plan giving commentary on areas of non-compliance and board assurance statements. • 5-year narrative plans (Trust delivery plan) • Board assurance statements confirming oversight and endorsement of the totality of the plans
Plan acceptance	• Final plans will be accepted from 12 March. This should be completed by the end of March, and all plans ready for implementation by 1 April.

6. Interdependencies

6.1. The Trust attends the Norfolk and Suffolk ICB MTP Provider Co-ordination group encompassing all providers within the ICB footprint. The group has been set up to generate shared understanding and co-ordinate how best to produce integrated plans.

6.2. Providers have been asked to feedback on the draft population health needs assessment and draft ICB Commissioning Strategy. Feedback has been received from within the Trust and submitted to N&S ICB.

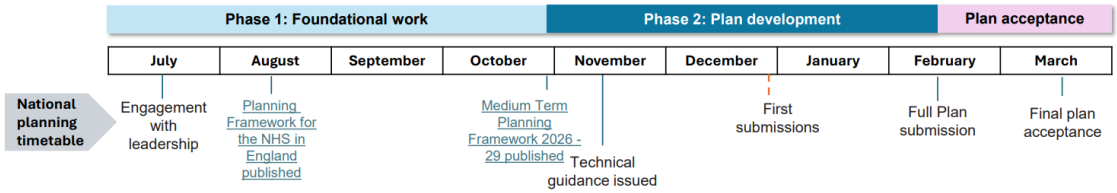
6.3. The next stage of the process is for the ICB to develop Norfolk and Suffolk Delivery plans which will include integrated delivery plans for provider trusts and the relevant county wide neighbourhood delivery plan.

6.4. It is anticipated that the ICB's commissioning intentions will be made available late November, which will form the basis of the ICB's Population Health Improvement Plan, due in January 2026.

7. Governance

7.1. It is proposed that the first draft submission, which will be required for the 17th of December, is approved at an exceptional Board meeting following Management Executive Group (MEG) in early December.

Figure 3: summary of process timescales



Key process steps and dates:

- ❖ Planning framework for the NHS shared with NHS in August, published 8 September (setting out *how* planning will work, including roles and key tasks)
- ❖ MTP Planning framework (setting out targets and guidance) published 24 October 25, technical guidance and 2-year allocations on 17 November (year 3 allocations will follow)
- ❖ First plan submission – 17 December
- ❖ Full plan submission – 12 February
- ❖ Plan acceptance – 12 March

Event	Date	Content
First submission	17 December 25 (12 noon deadline)	• 2 year finance plans (4 year for capital) • 2 year workforce plans • 2 year activity and performance plans • Integrated medium term plan template giving commentary of areas of non-compliance and board assurance statements • 2 year ambulance operational plans
Full submission	12 February 26 (12 noon deadline)	• 3 year finance plans (4 year for capital) • 3 year workforce plans • 3 year activity and performance plans • Integrated medium-term plan template giving commentary of areas of non-compliance and board assurance statements • 5 year plans (Trust delivery plan or ICB Strategic commissioning plan / PHIP) • 3 year ambulance operational plans
Plan acceptance	12 March 26 onwards	Final plans will be accepted from 12 March. This should be completed by the end of March, and all plans ready for implementation by 1st April.

8. Next steps

8.1. Continue business plan development, internal engagement with stakeholders, and external engagement with the ICB.

8.2. Testing of the draft plans through triangulation sessions, MEG, and in an 'exceptional' Board ahead of the submission date of 17th December.

2.2. Enabling strategy re next steps to implement and deliver the new strategy (ATTACHED)

To Assure

Presented by Sam Tappenden

Open Board

Report title:	Embedding the Trust strategy – compassionate care, healthier communities
Agenda item:	
Date of meeting:	28 November 2025
Executive lead/sponsor:	Samuel Tappenden, Executive Director of Strategy and Transformation
Report prepared by:	Anna Hollis, Deputy Head of Communications Greg Bowker, Head of Communications
Purpose of report:	To provide an overview of plans to embed the Trust's strategy

For approval ☐	For assurance ☒	For discussion ☐	For information ☒		
Trust ambitions	High quality care	Joined-up services	Empowered to improve	Responsible with resources	Fit for tomorrow
Ambitions relevant to this report:	☒	☒	☒	☒	☒

Executive summary
WHAT? *Summary of issue, including evaluation of the validity the data/information*
The Trust strategy 2025-2028 – compassionate care, healthier communities – has been launched. Regular communications and engagement with internal and external stakeholders are required to embed the strategy and to ensure stakeholders understand it, its purpose, the future direction of the organisation, and how they can play a role in its success.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
The refreshed Trust strategy is critical in helping the organisation successfully navigate the future by focusing on what's most important. It gives direction to colleagues, assurance to stakeholders, and will build confidence in the patients and communities we serve. The strategy will help ensure the Trust effectively responds to the national direction of the 10-Year Health Plan for England, support our Future Systems Programme, and enable the Trust to make the changes required 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)*
This paper sets out the key parts of our implementation plan to ensure that the strategy is effectively embedded across the organisation and wider health and care system.

ACTION REQUIRED
• Provide any feedback • Help embed the strategy throughout the organisation • Endorse the outline implementation approach.

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.

1. Purpose

1.1. The purpose of this report is to provide the Board with an outline approach for sharing, implementing, and embedding the Trust's refreshed strategy – compassionate care, healthier communities – so that Trust stakeholders understand the new corporate strategy, its purpose and future direction and how they can play a role in its success.

2. Strategic context

2.1. The Trust's new strategy, 'compassionate care, healthier communities', was approved at Board in September 2025.

2.2. Significant work has started to raise awareness of the strategy with internal and external stakeholders.

2.3. For example, the strategy was presented at the Trust's Annual Member's Meeting and has been launched in the All Staff Update.

2.4. However, considerable work is required to cascade and embed the strategy throughout our organisation, and with our external stakeholders.

2.5. Embedding the strategy throughout our organisation is critical to ensure staff understand our direction, our ambitions, and what they can do to support it.

3. Objectives

3.1. We have three objectives for this work:

- Improve awareness of the Trust's strategy internally and externally
- Embed the strategy into organisational processes
- Ensure the 'cultural' adoption of the strategy by colleagues

3.2. We will measure our success against these objectives through:

- Adding bespoke questions to quarterly pulse surveys to check colleagues awareness of key elements (e.g. ambitions).
- Using monitoring data from existing systems (e.g. readership of strategy intranet pages).
- Testing whether the strategy is cascading through organisational processes (e.g. whether the strategy is embedded in service plans).
- Ultimately, whether the key metrics in the corporate and future enabling strategies are delivering as intended.

4. Approach to embedding the strategy

4.1. Outlined below is a proposed four-phased cascade approach to successfully embed the strategy across the organisation and beyond.

4.2. Beyond the initial 'launch' phase, it is likely that embedding the strategy will take considerable time and will require sustained effort.

Phase 1: launch

- **Roadmap stage:** 'recover'
- **Timescales:** October 2025 – February 2026
- **Focus:** awareness of internal and external stakeholders
- **Key activities:**
  - Internal launch at All Staff Update (ASU), with follow-up through staff briefing emails and posts to staff Facebook page
  - External launch at Annual Members Meeting and through media
  - Strategy uploaded to intranet, website, and briefing emails
  - Development of all digital and physical assets
  - Presenting overviews at key meetings (e.g. Senior Leadership Team, divisional boards, staff networks, VOICE, Council of Governors, patient engagement events, and stakeholder briefings)
  - Start distribution of materials to all acute and community services.

Phase 2: spread

- **Roadmap stage:** 'renew'
- **Timescales:** February 2026 – June 2026
- **Focus:** integration into strategic processes
- **Key activities:**
  - Digital briefing and briefing packs for teams to cascade
  - Launch the complete strategic framework (i.e. enabling strategies)
  - Embed in planning, decision-making, and governance (e.g. committees, procurement processes, contracts etc.)
  - Build into Trust-wide induction programme
  - Support for enabling activities (e.g. launch of CQI approach)
  - Continued distribution of materials.

Phase 3: embed

- **Roadmap stage:** 'renew'
- **Timescales:** July 2026 – December 2026
- **Focus:** behavioural and cultural adoption
- **Key activities:**
  - Incorporate into organisational BAU processes:

        - Appraisals, objective setting, leadership programmes
        - Complementary launch of values and behaviours framework
        - Continuous Quality Improvement approach
        - Operational governance (e.g. divisional boards).

Phase 4: sustain

- **Roadmap stage:** 'reimagine'
- **Timescales:** January 2027 and beyond
- **Focus:** continuous activities to sustain awareness and engagement
- **Key activities:**
    - On-going activities to sustain engagement include:
        - Regular staff communications (e.g. ASU)
        - Embedding the strategy in Trust events.

5. Responsibilities

5.1. Support will be required from different teams across the Trust to ensure this plan is successful, including:

- On-going support from the communications team, specifically for the development of materials, briefings, and All Staff Updates.
- Support from the workforce teams to embed the strategy into key Human Resources processes (e.g. appraisals).
- Support from service managers to cascade the strategy through briefing packs to team members.

5.2. The more detailed implementation plan will set out the needs from different colleagues and ensure this is factored into future work plans.

6. Governance and reporting

6.1. It is proposed that quarterly updates are provided to the Public Board which provide an update regarding progress against the implementation plan. These updates will include information regarding each of the phases (e.g. how many briefings delivered) to provide Board with assurance regarding implementation.

7. Next steps

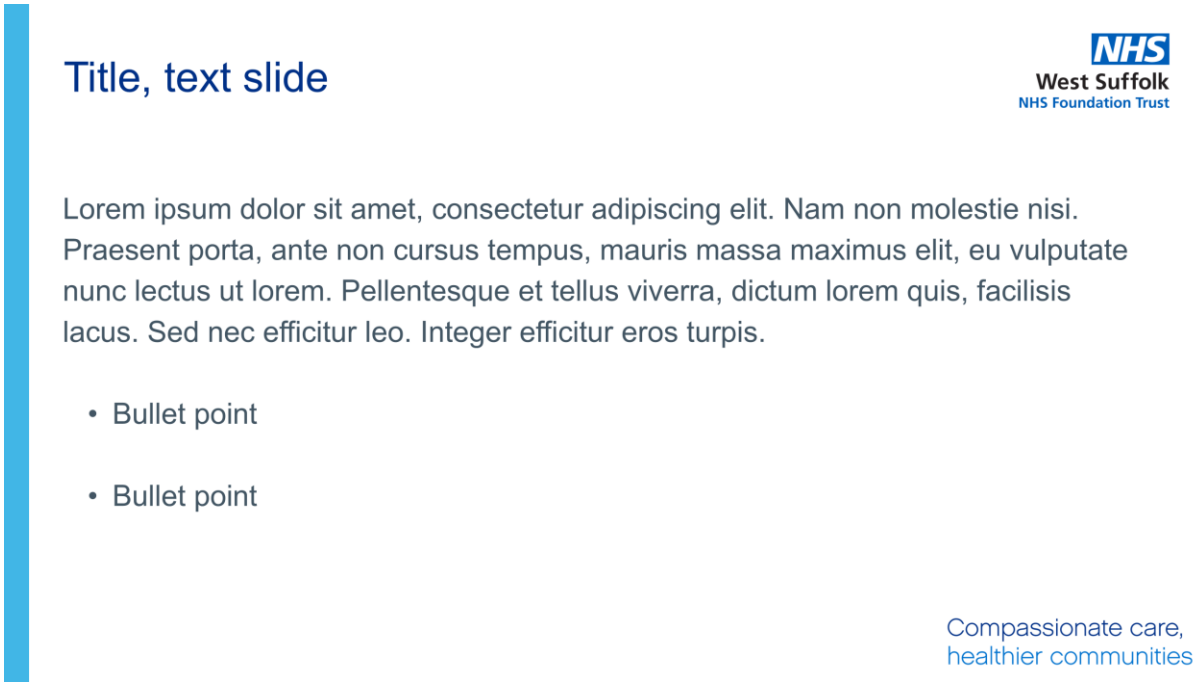
7.1. Discuss the proposed approach at Board.
7.2. Finalise the detailed plans for the phasing.
7.3. Implement the proposed approach and commence monitoring.

Appendix one: design examples

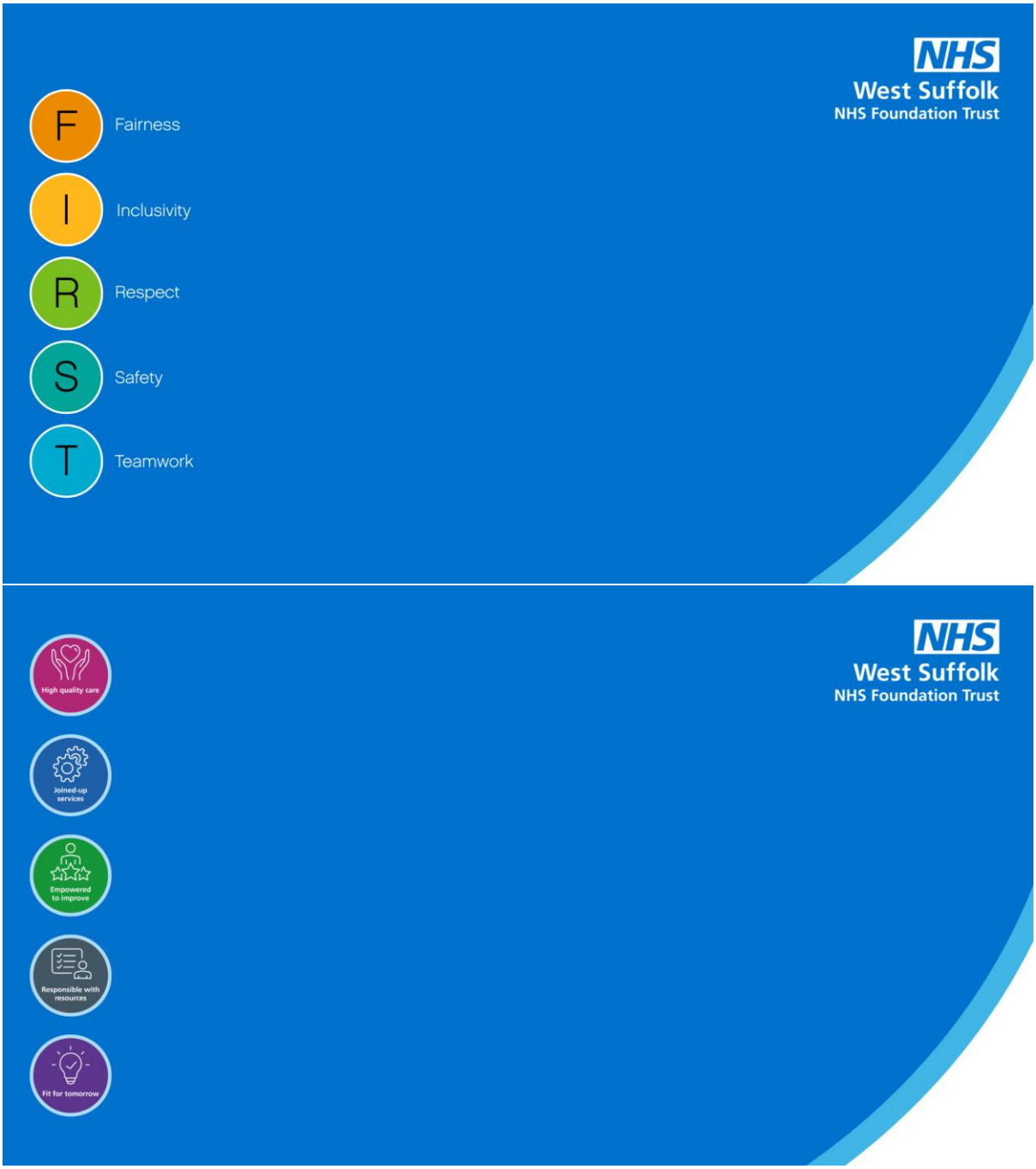
1. PowerPoint template presentation

Cover:

Internal slide:



2. Teams background



3. Strategy at a glance poster

NHS
West Suffolk
NHS Foundation Trust

Our strategy 2025-2028

Compassionate care, healthier communities

High quality care

Outcome
People in our communities are healthier and more independent

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

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

Joined-up services

Outcome
Patients experience services that are centred around their needs

Lead metric
Patients reporting coordinated care across integrated pathways and services

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.

Empowered to improve

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

Lead metric
Patients reporting coordinated care across integrated pathways and services

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.

Responsible with resources

Outcome
Achieve the best possible value for money for taxpayers

Lead metric
Patients reporting coordinated care across integrated pathways and services

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

Fit for tomorrow

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

Lead metric
Patients reporting coordinated care across integrated pathways and services

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.

2.3. Future system board report (ATTACHED)

To Assure

Presented by Ewen Cameron

Trust Board	
Report title:	Programme Director's Update
Agenda item:	Future System Project
Date of the meeting:	November 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

Executive Summary

The project to build a replacement West Suffolk Hospital is within the first wave of schemes to be built with an expected construction commencement date in 2027/28 and a capital budget of between £1.2 and £1.5bn based on a new build space of c. 100k sqm.

Since our last meeting the following progress has been made:

- **RIBA2[1] Design** has made significant progress following the completion of multiple multi-disciplinary "scrums". Drawings at a 1:200 level and a full RIBA2 report have now been completed for the new hospital and work has now commenced on the RIBA3 design phase while the designs are being socialised across the Trust and stakeholders.

[1] The Royal Institute of British Architects (RIBA) prescribe a series of phases to help steer the development and realisation of construction projects. Stage 0 refers to the strategic definition of a project, whereas Stage 7 refers to the use of the final building. The WSFT project has just completed Stage 2 (the concept design) and is commencing Stage 3 (spatial coordination).

- **Capital Affordability –** Although the detailed design process has resulted in an increase of the forecast cost of realising the new hospital, this is expected at this stage in the design process.

- **Outline Business Case (OBC) production** – the team remains on track to complete and submit a full and compliant OBC by August 2026. Content has been substantially "progressively assured" by NHP and NHSE. The outstanding element will be the comprehensive investment review which is dependent upon the completion of RIBA3 designs. Once complete, the case will be presented to the Executive Programme Board, Trust Board, ICB and NHSE before formal submission.

- **Planning Permission** – The timely completion of RIBA3 designs will enable us to trigger the reserved matters planning process that will ensure we protect our outline planning permission and secure full planning (process must be triggered on or before May 2026).

- **Power Provision –** following agreement by the Trust Board, the case for the provision of the power infrastructure required by the new hospital was agreed by the New Hospital Programme (NHP) investment committee and is now progressing.

- **Operational Affordability –** A working group to solve the issue created by the capital charges associated with building a new hospital has been established by NHSE and aims to recommend a solution in time for the submission of our OBC.

Scheme Status

The project is currently developing its Outline Business Case through a process of "progressive assurance" with experts from NHP and remains on track to be submitted in August 2026 (with the date being driven by the completion of our RIBA3 design stage).

1:200 designs were agreed on 3rd October in the final "scrum" with NHP and their advisors. The designsprovides a solid basis for the timely commencement of the RIBA 3 (1:50) design phase which remains a critical task as it underpins our application for full planning permission (reserved matters) which must start on or before 3rd May 2026.

Upon agreement of the RIBA2 designs, a full communications and engagement strategy has been launched ensuring operational and clinical colleagues have the opportunity to view and comment on their respective departments before they get drawn to the next level of detail.

The plan encompasses three phases; phase 1 centres on working with our primary care, community colleagues and co-production leads, those who have assisted with the design to date, ensuring clinical compliance; phase 2 widens our reach to all WSFT staff utilising existing communication channels, face to face stands in staff areas and online briefings before we commence phase 3 at the end of November where we share our plans with the wider community and patients.

To ensure we progress with a design that reflects an optimised infection prevention and control (IPC) strategy, it has been agreed that the Future System Project (FSP) team will fund a specialist practitioner who will work alongside our IPC team in a way that allows them to focus on operational priorities whilst ensuring future requirements are appropriately represented within the finer details of our design. Recruitment is expected to be complete before the end of December.

Commercial Progress

The process through which construction partners will be selected is progressing strongly in line with national plans. Ther FSP team have provided two people to play a role in the assessment of tenders, an activity which has now been completed. The selection and announcement of successful bidders is expected to be announced by February 2026. The terms of the framework under which partners will be

contracted (the H2.0 Alliance Call-off Contract) are based upon the standard NEC4[2] contract, however, it is important that Trusts are familiar and comfortable with the bespoke elements that have been included to maximise market participation. A separate paper and accompanying advice from Capsticks (The Trust's legal advisors), has been discussed in detail by members of the Scheme Executive Programme Board and will also be discussed at the private part of the Trust's Board meeting.

Operational Affordability

The future submission of an affordable, supported OBC for the WSFT scheme remains challenging due to the capital charges that stem from the "loan" of the capital fee.

However, there are signs of a national solution:

1) A National workshop was held on 22nd September involving senior leaders from across the NHS and resulted in the creation of a senior working group that has been asked to draw up recommendations for how the issue of Capital Charges can be best addressed.
2) The specification of the Hospital 2.0 design was reviewed at a Programme level with the Joint Investment Committee (JIC) on 15th October.
3) It has been confirmed that the impact of depreciation will be managed centrally.

Communications and Engagement

As discussed above, the conclusion of the 1:200 drawings triggered the start of a comprehensive communications and engagement plan. Complimenting this plan are a series of external events that will allow our clinicians to meet the subject matter experts from NHP and peers from other new hospital schemes. The plan will include presentations to established operational fora, direct presentations and dissemination of departmental layouts via our co-production workstream leads and direct sharing of departmental layouts via email.

The phases approach has been described in the above scheme status section.

Finance

The Programme is progressing within its NHP allocated development budget and is fully funded to deliver RIBA stages 2 and 3 as well as its Outline Business Case. Funding for the 26/27 year has been submitted and is being progressed with a view to being fully secured in time for the start of the new financial year.

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

- Share RIBA 2 drawings / report – from October 25
- Gain NHP sign off of RIBA2 21st November 25
- Agree principles of the H2.0 Alliance Call-off Contract – November 25
- Commence RIBA 3 design – October 25 to August 26
- Formal Full Planning Application submitted – 3 May 26
- OBC Submission – 28th August 2026

Action Required

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

[2] NEC4 refers to the New Engineering Contract 4th Edition which is a suite of collaborative contracts used in the construction , engineering and supply industries to manage projects effectively.

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 and is based upon robust Demand and Capacity modelling which has been approved by the Trust Board and assured by NHSE. 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.	

2.4. System Update/Alliance Report - SNEE Integrated Care Board (ICB); Wider System Collaboration (ATTACHED) (Maddie Baker-Woods)

To Assure

Committee	
Report title:	**West Suffolk Alliance Health and Wellbeing Committee reports**
Agenda item:	**2.4**
Date of the meeting:	**14 October and 11 November 2025**
Sponsor/executive lead:	**Maddie Baker-Woods - Alliance Executive Director**
Report prepared by:	**C King / M Shorter**

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 10 October and 11 November	
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*	
Board members are asked to note progress identified and risks associated with the changes to the ICB	
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed up (evidence impact of action)*	
Actions are managed through the Alliance Committee process	
Action Required	
Note the report	
Risk and assurance:	1. Risks due to the imminent changes to the ICB function and structure 2. Risk raised that the redesigned integrated weight management and complex obesity service model serviced may become overwhelmed
Equality, Diversity and Inclusion:	Health Inequalities is reported to the HIPPC Committee in the ICB. Clear links to reducing health inequalities are contained in all programmes
Sustainability:	Sustainability Impact Assessments are 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 HEALTH & WELLBEING COMMITTEE REPORT	
1.	**Introduction**
1.1	**West Suffolk Alliance Update including Committee meetings held 14 October '25 and 11 November '25**
2.	**National Neighbourhood Health Improvement Plan**
2.1	**SNEE ICB Pilot Programme Summary** SNEE ICB has secured three pilot sites in the first wave, focusing on individuals with long-term conditions and rising needs. The programme seeks to improve care outcomes, enhance collaboration, reduce health inequalities, and increase value through better resource use. Diabetes has been identified as an early target cohort, with potential system-wide benefits through improved health and wellbeing. • A leadership team has been established, and work is underway to appoint local improvement coaches, define target cohorts, and set 6- and 12-month goals. The first regional workshop took place on the **23 October** • Scalable local funding models are required and learning from other areas encouraged. • Critical evaluation framework will be established to demonstrate progress towards agreed KPI's and outcomes. **A Decision** was agreed to proceed with implementation planning. **Actions in train** • Appointment of local improvement coach • Confirm target cohort (diabetes) • Agree 6- and 12-month goals • Convene neighbourhood teams • Develop evaluation framework and funding model • Ensure alignment with alliance priorities and interdependencies
3.	**ICB strategy**
3.1	In advance of creating the new cluster organisation in April 26, work has started on Norfolk and Suffolk ICB developing a strategy to improve health outcomes and access to care, supporting the merger of regional ICBs and aligning with national plans. • The next steps focus on reviewing the Integrated Needs Assessment and includes gathering evidence across finance, quality, performance, and workforce, • Engaging stakeholders for feedback and using data-driven insights to address local variation and guide future commissioning, especially in areas like frailty, dementia waits, and diabetes. Planned return to WSA Committee in January 2026
4.	**Integrated Weight Management & Obesity Service**
4.1	A new, integrated service has launched in Suffolk and North East Essex and includes: • Single point of access for all referrals • AI-driven risk assessment and clinical validation to direct patients to the right care pathway • Integrated support: dietary advice, medications, and bariatric surgery • Repatriation of patients previously treated elsewhere • Ongoing lifestyle support via Feel Good Suffolk • Minimum assessment period before treatment to ensure appropriate care. • Committee discussed the importance of a whole system approach which understood individuals holistic needs at different points in their weight management journey. A follow up will be presented to the Alliance Committee in April 2026.
5	**Digital Transformation**

5.1	A digital transformation is planned to integrate health and social care systems within the INT's, addressing issues like siloed platforms and duplicated data. • The recommended first step is to synchronise data between System 1 and Liquidlogic LAS, with a long-term goal of a unified platform. • While the proposal has initial support and funding, full approval depends on securing primary care support. • Next steps include obtaining formal sign-off from primary care representatives before moving forward. • Completion of a risk assessment to be undertaken West Suffolk Adult Social Care Lead advised that this is currently paused (11/11/25)
6.	**Domain/enabler discussion points and action:**
6.1	• **Start Well:** Increase midwifery continuity, reduce wait times for children's services, and lower asthma admissions. Improve data tools and public communication. • **Digital and Data:** Train staff on the JOY platform, enhance digital interoperability, and address risks through engagement. • **Estates:** Reduce unused space and expand partnerships with local colleges and universities
7.	**Community Contract**
7.i	• Commissioning principles agreed; workshops held. • Public engagement underway. • Principles agreed including why not community, why not now, why not integrated? • Commissioning priorities focused on neighbourhood based, integrated and outcome driven services. • **Most current KPIs met -** some areas need improvement. **Next steps:** Enhance engagement, review KPIs, develop frameworks. **Timeline:** toolkit (Oct–Dec) with launch (Jan). Analysis (Feb–Mar), ongoing co-design from April 2026
8.	**Frailty Action Plan**
8.i	West Suffolk Alliance's Frailty Action Plan, led by the Age Well Steering Group, focuses on timely, integrated care for people with frailty. • Key workstreams cover prevention, training, falls, dementia, and end-of-life support. • Progress is tracked annually by frailty severity • Overall, the plan represents a coordinated, multi-agency approach focused on prevention, integrated care, and continuous improvement. • **Committee suggested priorities:** Clear impact evidence, timelines, and baseline data. • **Key actions:** Frailty/dementia awareness, virtual wards, care home support; training still in planning with consideration to staff capacity. • **Focus areas:** Midlife targeting, behavioural science, pilot falls clinic, build on existing resources.
9.	**Locality update: - Sudbury**
9.i	• Quarterly meetings relaunched with broad community involvement and new funding (£10K + Health Equity funds). • Priorities: youth mental health, family support, transport, and tackling isolation. • Health Equity Project focuses on perinatal health, chronic conditions, and service access. • Suggested funded projects: youth mental health programs, subsidised counselling, transport vouchers. • **Forward plans**: Upcoming events and 2026 meetings will support local health and wellbeing.
10.	**Better Care Fund (BCF) update**

10.i	• Health and social care budgets pooled between local authorities and ICBs. • Governed by Suffolk Health and Wellbeing Board; aligned with NHS England. • Focus on shifting care to home, prevention, and independent living. • Must meet four conditions: plan, implementation, funding rules, oversight. • Progress tracked by emergency admissions (65+), discharge delays, and care home admissions. • **Committee focus:** Align BCF plan with system planning; improve governance and evaluation frameworks. • **Key points:** Link BCF to ICB sustainability review; deployment of the Disabled Facilities Grant (DFG) through collaboration and transparency. • **Priorities:** Clear impact metrics, address barriers, concentrate resources on effective initiatives. • **For return to** Committee January 2026 following a local sub group meeting.
11	**Personalised Care Service**
11.i	West Suffolk Alliance will launch a personalised care service for adults with complex needs in West Suffolk, integrating Social Prescribing and High Intensity User (HIU) support. • **Service Model:** Intensive coaching for frequent users, specialist case management, and universal support to improve health outcomes. • **KPIs:** Patient numbers, response times, reduced service usage, and patient-reported outcomes. **Committee Priorities** • Ensure robust outcome measures and thorough evaluation for value for money. • Avoid duplication and achieve system-wide coordination between HIU and older adult case management. • Establish clear accountability, effective information sharing, and appropriate staffing. • Ongoing refinement of governance for long-term impact. **Key Concerns** • HIU investment questioned given limited funding for older adult case management, despite a 25% reduction in service use during the pilot. • HIU targets mid-life adults, while case management focuses on those over 70, raising sustainability and resource allocation issues. • The committee agreed to seek further assurance from the Strategic Commissioning Group and Richard Watson before final approval recognising it is a pilot. Robust outcome measures are essential to confirm whether this is the best use of funds.
12	**Financial Position (Month 6):** The Alliance reports a £0.1m year-to-date underspend and forecasts a £0.5m underspend for the full year. Overall, the Alliance expects to finish the year with a modest underspend.
13	**Suffolk Public health – mental health prevention**
	Members were invited to join a county-wide initiative featuring: • Webinars on workforce wellbeing and mental health (using Five Ways to Wellbeing and CHIME). • Strategies to boost income, physical activity, and tackle digital exclusion. • Support for community resources and engagement. **Discussion Highlights:** • Concerns about digital exclusion and need for social connection. • Webinars focus on workforce development with plans for broader community engagement. Topics included physical activity, resourcing for community groups, and collaboration via platforms like LET's Talk SNEE
14	**Next steps**
	• Focus on forward strategy and plan for 25/26. • At pace progression of the national neighbourhood implementation of work.

	• Focus resilience and capacity of primary and community services across the winter period
15.	**Conclusion**
	WSA continues as a strong integrated partnership with well attended Committee meetings and focus on the delivery of its plan.
16.	**Recommendations**
	[Insert same wording you have on your cover sheet]

2.5. Digital Board Report (ATTACHED)

To Assure

Presented by Sarah Judge

Trust board - open	
Report title:	**Digital board report**
Agenda item:	**2.5**
Date of the meeting:	28 November 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 last digital board of the current structure met on 22 October 2025. We have continued to put structures and process in place to support both the digital programme and the 'business as usual' of the Trust during a period of consolidation. There have been no major escalations and current planned work is on track. The revision of the digital and data strategy is underway, in alignment with the other enabling strategies as part of the strategy and transformation work.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
We continue to make progress on planned work for 2025-26 and the 2026-27 programme is being defined at present. This will ensure that funding opportunities are considered, as well as capacity of the service and our support of the Cost Improvement Programme. The digital and data strategy will ensure that we align the digital programme to the delivery of the corporate strategy. Roadmaps for the each of the services will follow the publication of the strategy.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
The revised Digital and Data strategy will be brought for Trust Board approval at the appropriate time.
Action Required
The board is asked to note the update.

Risk and assurance:	The digital programme is managed through standardised project management methodologies and risk management. Risks are escalated through the

	appropriate steering group and through to the executive leads where appropriate. Prioritisation of the digital programme has included a quality impact assessment. 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** Since the last Trust board meeting, the programme continues on its current projects, with assurance provided through the digital steering group structure. • The Windows 11 migration was completed on time and to budget during October, with less than ten extended support licenses required to support some specialist computers. • The code upgrade to our Oracle Health electronic patient record (e-Care) is the primary focus for our clinical systems teams; this is due before the end of 2025 and will put us on the latest code release in order to support an upgrade in early 2026 to the latest authentication software required by NHS England. • We continue to plan for our move to a WSFT-supported provision for SystmOne, our community electronic patient record, which is due to go live in February 2026. • Following the review of the overall programme in March 2025, 39 projects were deprioritized and reviewed again recently. Only three of these will be reviewed or progressed as part of the digital programme in order to ensure that projects or new work delivered within digital services are aligned to the Trust strategy. The steering groups continue to improve in their effectiveness, with project exception reporting returning for decision making at these groups.
1.2	**Amendments to the governance structure** As agreed at the trust board meeting in September 2025, the revised governance structure for the digital programme will be enacted from January 2026. It has been agreed that Alison Wigg (NED) will chair the new digital and data assurance committee, with Heather Hancock (NED) joining the committee.
1.3	**Technical and legacy debt** The service has begun a piece of work to understand the level and detail of our technical debt within digital services.

	Legacy systems and products are defined as: • those considered as end-of-life products. • being out of support with the supplier • impossible to update thereby having security vulnerabilities. • not being cost effective to run • where technical complexity requires extensive specialist skills to support interoperability and integration • where internal knowledge and skills lies with a few specialists leading to single points of failure. Technical debt is the overall impact of legacy systems and products on the organisation and includes the cost of maintaining these systems versus the cost of replacement. Our systems will be risk assessed in order to understand where key pieces of work will need to be undertaken and how we plan that into the digital roadmaps. There will be a focus on assessment of critical systems in conjunction with our Emergency Preparedness, Resilience and Response team. 1. Defined list of digital applications and systems in use by the organisation 2. Risk assessment of all applications and systems 3. Cost of maintaining or replacing all red-rated systems
2	**Digital services**
2.1	The previous trust digital strategy (2022-2026) is due for renewal as part of the enabling strategies work that supports the new corporate strategy. The revision to this is underway and will also include business intelligence services to bring these together as a singular Digital and Data strategy.
2.2	Following the organisational changes during 2025 under the wider corporate review, we have appointed into the last two leadership positions, and these colleagues are due to start working in these roles from the beginning of December.

2.6. Joint Productivity Board (ATTACHED)

To Assure

Presented by Sam Tappenden

Public Board	
Report title:	Update on Joint Productivity Board
Agenda item:	Joint Productivity Board
Date of the meeting:	28th November 2025
Lead:	Sam Tappenden Executive Director of Strategy and Transformation
Report prepared by:	Sam Tappenden

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

Executive Summary
WHAT? *Summary of issue, including evaluation of the validity the data/information*
The 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 continue developing and delivering the agreed initiatives, and will review governance arrangements in the New Year to ensure they are fit for purpose.
Recommendation / action required
Board to note progress to date.

Previously considered by:	Public Board
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 all 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.

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 17th November, the Board received updates on the major 'initiatives' agreed as part of the Sustainability Review, including: • The co-development of a Care Management Service (CMS) between system partners, of which a business case is under development for consideration. • The development of plans for the agreed priority service areas of stroke, ear nose and throat, urology, and paediatric services. • Exploring opportunities through the East of England Provider Collaborative to improve services for patients with severe asthma. • Identification of further opportunities for productivity improvements through working closely with the Integrated Care Board (ICB) to review the latest productivity data. The Board also discussed that, following the findings of the Sustainability Review, which was published in May 2025, there has been an unprecedented scale of change to the national, regional, and local landscape which includes: • Launch of the NHS 10-Year Plan • The requirement for medium-term planning submissions • Structural reform with changes in NHSE, ICBs, and regulatory bodies • The new NHS Oversight Framework • Phasing out of deficit support and shifting away from financial system controls Furthermore, both ESNEFT and WSFT are undergoing major changes which are driving a greater focus on internal improvement. This has led both organisations to re-consider whether a Joint Productivity Board is currently the optimal arrangement for both providers to drive improvements. The Board agreed to continue progressing agreed initiatives, and review arrangements in the New Year
3.	**Next steps**
3.1	• Continue progressing the agreed initiatives to deliver improved productivity, financial sustainability, and service improvement. • Review the Joint Productivity Board arrangements in the New Year to ensure they reflect on-going requirements of the Trusts and the patients we serve.
4.	**Recommendations**
4.1	Board is asked to note the update from the Productivity Board.

Comfort Break

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 Julie Hull, interim chief people 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	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
Please indicate Trust strategy ambitions relevant to this report.	☒	☒	☒

Executive summary:

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

To update and provide assurance to the Board of Directors on performance during September 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 is being refreshed in line with the new NHS National Oversight Framework (NOF) and new Trust Strategy, and to include health inequalities, digital and productivity metrics.

Please refer to the assurance grid for an executive summary of performance. The format of this is also being refreshed to provide an at a glance summary based on the NOF metrics. The following areas of performance are highlighted below for the board's attention:

- At the end of September 2025 position there 102 patients waiting over 65 weeks for elective care, which is a reduction from August, this volume is expected to continue to reduce over the coming months with a national expectation for 0 by 21st December.
- The total waiting list reduced in September to 32625, with the 18-week compliance at 62.07%, which is a significant improvement from the previous month. The increased data quality validation has supported this improvement in addition to the insourced Dermatology activity.
- There is sustained deterioration in waiting times for the paediatric team due to the level of demand and reduced capacity within the clinical team. The longest waits are within the neurodevelopmental delay (NDD) pathway. Consultant interviews will take place in December and the service are engaged in an ICB-led review of the NDD pathway.
- Activity plans across elective and first outpatient attendances are not being met as at the end of September 2025 with the gap in elective activity widened to 16.7%., however day case activity exceeded plan for a second consecutive month and the gap in outpatient first is narrowing.
- As shared previously, targeted investment enables the Trust to return to planned performance for 65 weeks, 52 weeks and 18 weeks RTT by December and achieve the required targets by March 2026.
- Cancer Faster Diagnosis Standard (FDS) performance sustained the improvement with 80.4% in August which is ahead of trajectory. 62-day performance recovered to 78.6% against a 70% trajectory.
- Diagnostic performance against the 6-week standard improved to 45.5% in September 2025. Recovery actions forecast improvement from current overall DM01 position to 74% by end of March 2026.
- The Trust continues to perform comparatively well on ambulance handover metrics, with 83.4% of handovers happening within 30 minutes.
- The Emergency Department (ED) 4-hour performance was 69.66% which meant we failed to meet the in-month trajectory of 75%, and 8.6% of patients spent more than 12 hours in the department.
- There are Executive-led weekly ED performance meetings to monitor progress and the Urgent and Emergency Care (UEC) Delivery Group workstreams have been revised, including continued ward length of stay reductions, “Basics Done Brilliantly” week in ED and maximising Same Day Emergency Care (SDEC). There is also collaborative working with the GP Federation to maximise the utilisation of GP streaming.
- 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. Two consecutive months under expected average. Improved picture month to date compared with 24/25 rates
- Percentage of reportable harm returning to under the national average for consecutive month
- PPH for vaginal births now in cause for concern. All cases are reviewed individually
- SHMI three months of special cause concern attributed to coding back log. Recovery plan to address back log has been agreed at MEG. Not correlating with actual inpatient deaths which has been below average for past 5 data points
- We will monitor the impact the current staffing within the PALS and patient complaints team has on performance. Recruitment into the new structure has commenced.
- 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.

A task and finish group has been set up to review the content of the IQPR to ensure the correct metrics are being measured and monitored with regard to workforce data. The outputs from this work will become part of the IQPR. Other metrics are being reviewed in line with the new NHS National Oversight Framework (NOF) and new Trust Strategy, and to include health inequalities, digital and productivity metrics.
Action required / Recommendation:
The Board of Directors is asked to note the Integrated Quality and Performance Report for August 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. The Trust is reviewing how to routinely include EDI metrics in a wider range of reports.
Sustainability:	Organisational sustainability
Legal and regulatory context:	NHS Act 2006, West Suffolk NHS Foundation Trust Constitution

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 28th November 2025**		
Chaired by: Tracy Dowling Non executive Director			**Date of meeting: 15th October 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 affecting our workforce Nurse Job Evaluation Process	2. Reasonable	Verbal update from Claire Sorenson setting out national guidance for the process to be followed		1. No escalation
7.0 7.2	**First for Patients** Experience of Care and Engagement Committee Report	2. Reasonable	Report received outlining engagement with Maternity and Neonatal Voices Partnership; community engagement and IQPR data regarding complaints and PALS	Discussion regarding how more evidence of the impact of patient engagement activity is collated and presented to the Committee. Suggest an annual report of change initiated by patient engagement.	1. No escalation
7.3	Complaints Timeframe Analysis	2. Reasonable	An in depth analysis of Trust complaint performance was received following concerns raised about outstanding complaint long response times.	Recommendations to improve complaints management agreed. Further report to Committee expected in February 2026 recommending Policy change.	1. No escalation
7.4	10 Year Plan – Impact on Patient Experience	2. Reasonable	Verbal report from Charlie Firman on content of 10 year plan regarding patient experience	Update to Committee once 10 year Plan delivery of the recommendations is clear	1. No escalation
7.5	Patient Experience Strategic Quality Priorities Update	3. Partial	Second update of in-year progress on our priority to reduce inequalities in healthcare	Delivery currently at risk but actions are in train to bring this back on track, including finalising the	1. No escalation

Originating Committee: Involvement Committee			Reporting to: Trust Board Meeting 28th November 2025		
Chaired by: Tracy Dowling Non executive Director			Date of meeting: 15th October 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
			for service users; and to utilise feedback and engagement activity to drive change. Strong performance on engagement and feedback with service users and especially under-represented groups	Reasonable Adjustments Policy, to pilot roll out prior to trust wide implementation with an amended timeframe of Q4. Second element regarding personalised care plan on e-care postponed until RA work progressed.	
8.0	**First for the Future**				
8.2	Future of Leadership and Management in the NHS	2. Reasonable	Presentation of progress with national work to improve standards and competence of leadership and management in the NHS. This aims to ensure access to development for managers, defined national Code of Practice and standards and potentially professional registration of leaders and managers across the NHS	There are Trust wide development programmes for managers and leaders, however currently engagement across divisions is variable. As national guidance develops, Trust programmes will align to these standards and competencies. The Committee wants to see evidence that management development results in improved service delivery and organisational health.	1. No escalation

Originating Committee: Involvement Committee			Reporting to: Trust Board Meeting 28th November 2025		
Chaired by: Tracy Dowling Non executive Director			Date of meeting: 15th October 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
9.0 9.1	**First for Staff** Addressing Staff Engagement and West Suffolk FT	3. Partial	Report identifying significant drops in staff engagement scores over recent quarters. Review of other trusts has identified areas for improvement. Suggested actions were agreed but further diagnostic analysis needs to be undertaken with impactful actions before the Committee can be assured.	In depth discussion about how effective communications and good and empowered management is vital. Acceptance that this requires sustained activity through the organisation. Progress report to December meeting.	2. To MEG for ongoing oversight as these actions develop
9.2	Anti Racism Charter	3. Partial	Verbal u[date from Jamais Webbsmall-Eghan regarding areas of significant progress and areas for renewed focus.	Agreement that more publicity through the Trust regarding our commitment to being Anti Racist is needed. To return to December meeting as this is a current priority given the socio-political context and impact of this on our workforce.	1. No escalation
9.3	Pay Gap Reports Ethnicity Pay Gap	2. Reasonable	WSFT has a negative ethnicity pay gap – both when including medical consultants and when excluding them.	There is a disparity when looking across A4C pay bands indicating that there are barriers to career progression from Band 5 to Band 6 for global majority colleagues. Actions were agreed to support	1. No escalation

Originating Committee: Involvement Committee			Reporting to: Trust Board Meeting 28th November 2025		
Chaired by: Tracy Dowling Non executive Director			Date of meeting: 15th October 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
				more inclusive recruitment and selection.	
	Disability Pay Gap Report	2. Reasonable	The report shows a disability pay gap however data quality is poor due to low disclosure rates.	There are high non-disclosure rates on ESR so data is incomplete. There are multiple options on ESR so prevents accurate interpretation of data. Actions to address these were agreed.	1. No escalation
	Gender Pay Gap Report	2. Reasonable	WSFT has a mean gender pay gap of 21.95% and a median gender pay gap of 7.56%. This will be uploaded to the Government website. This means on average, women earn less than men across the full range of jobs and salaries. It is NOT about equal pay for work of equal value.	The GPG is because there are proportionately more men in senior higher paying roles than women in comparison to the overall workforce demographic. The supporting paper listed a number of actions in place to close the GPG which were all supported.	1. No escalation
9.5	Estates and Facilities Staff Experience Update – Neill Jackson	2. Reasonable	Detailed presentation of work to address findings of 2024 staff survey. Evidence of strong leadership and management and	Continue to address concerns of colleagues and develop more proactive approaches to maintenance issues of estate and	1. No escalation

Originating Committee: Involvement Committee			Reporting to: Trust Board Meeting 28th November 2025		
Chaired by: Tracy Dowling Non executive Director			Date of meeting: 15th October 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
			efforts to engage staff and have honest conversations about their workplace.	succession planning for our workforce	Good case study for learning throughout the organisation
10.0 10.1	**Governance** People and Culture Committee Update	2. Reasonable	Verbal update from Deputy Director of Workforce on items discussed and priorities agreed		1. No escalation
10.2	Internal Audit Assurance Committee Report	2. Reasonable	Update showing improved closure of actions arising from Internal Audit Reports	Reports in future to clarify which audits each sub committee is accountable for	
11.0	Items for Information IQPR Sexual Safety Data	2. Reasonable	Sexual safety data identifies a number of areas which are being addressed through the sexual safety action plan	Report for next meeting on Sexual Safety date specifically any sectors of our workforce where we need focussed action	1. No escalation

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

4.2. Freedom to Speak Up (FTSU) Report (ATTACHED)

To Assure

Presented by Julie Hull

Freedom to Speak Up: Guardian's Report Q2. 2025-26 July, August, September 2025

News from the National Guardians Office (NGO)

National Guardian Jayne Chidgey-Clarke has retired from her role following 4 years of service. While the National Guardian role will not be replaced, Beth Carter, National Lead for Guardian Support, will oversee the running of the National Guardian's Office as Interim Director, ensuring continuity during this transitional period.

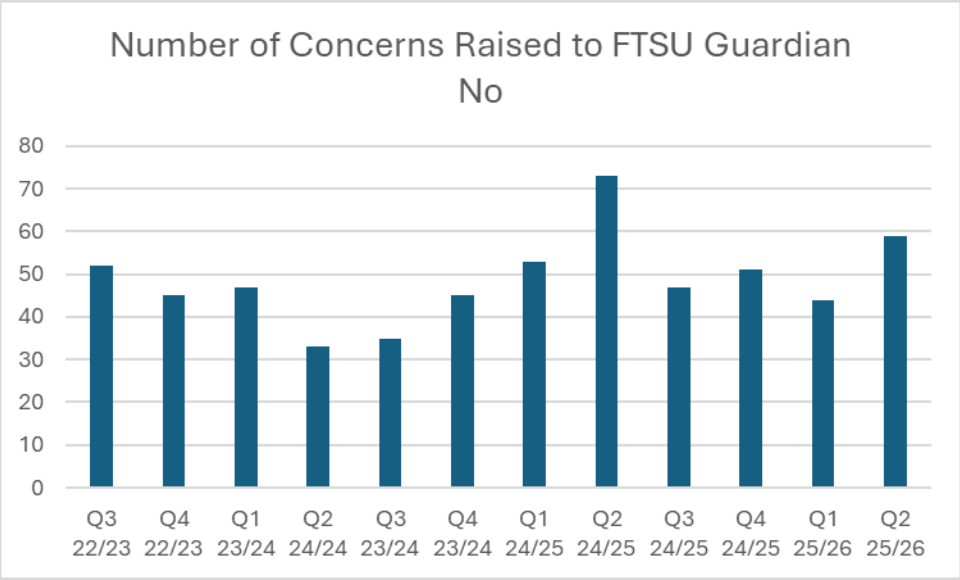
Closure Project Board established

A dedicated Closure Project Board now meets twice monthly, bringing together DHSC, NHS England, CQC and the NGO. This board provides robust governance overseeing the required changes to meet the Dash review recommendations and the commitments of the10 Year Health Plan.

Data for Quarter 2 has been submitted to the NGO portal as usual. This will continue for Quarters 3 and 4 and Guardians have been told they will be informed by NHS England where data is to be submitted after that.

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

The number of concerns raised with the Guardian in Quarter 2 was 59. This is an increase in the average for the last 3 years (49).

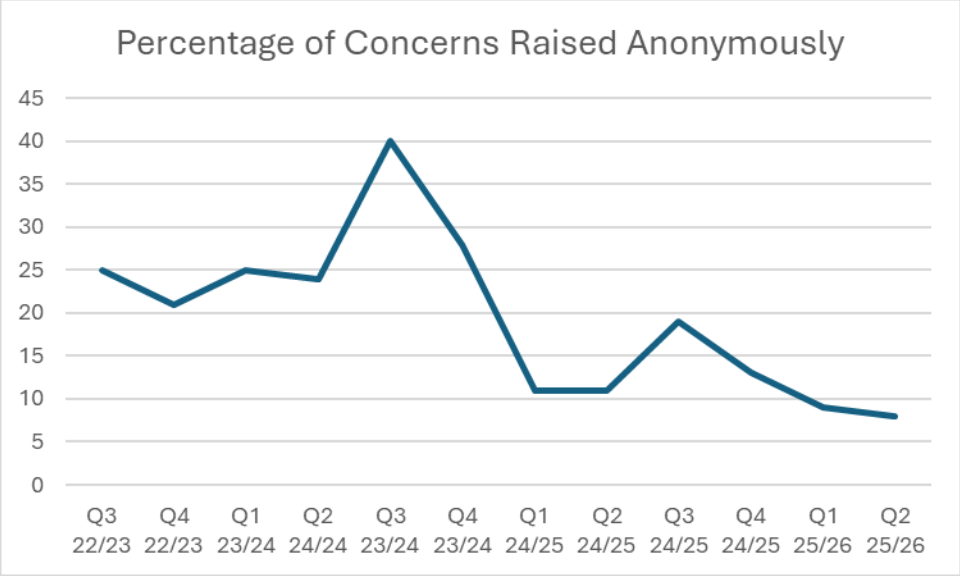


2. Anonymous Reporting

Whilst it is important to have an option for anonymous reporting, there are challenges in investigating anonymous cases due to limited information and the difficulty in providing feedback or support for those raising the concern.

Anonymous reporting option is available via the Raising Concerns page of the Trust Intranet, or by letter to the Guardian at the Education Centre In Quarter 2, there were 5 anonymous

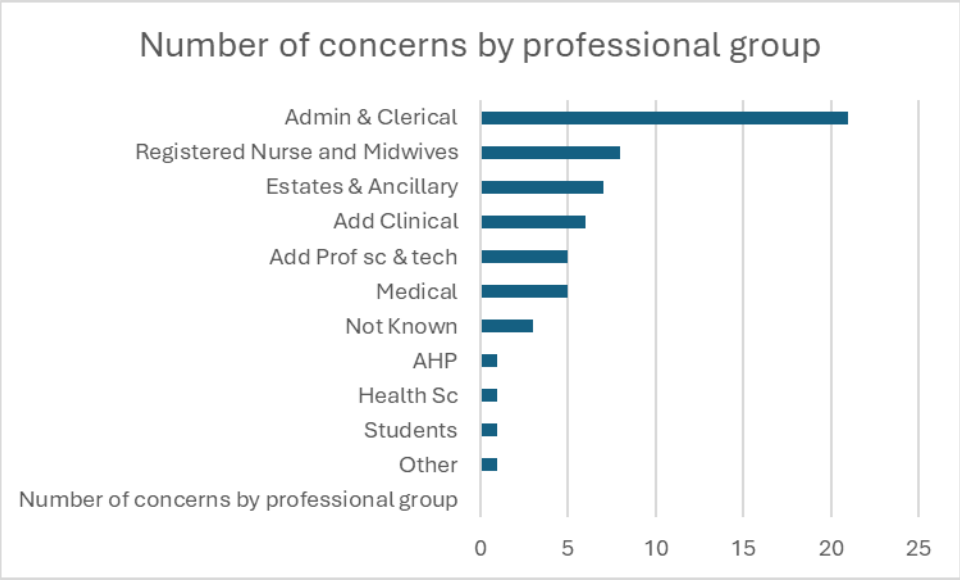
reports, 8%, showing a continuation of the relatively low level of anonymous reporting. The national figure is 11%. The percentage of anonymous concerns is an indicator for how confident staff feel to speak up, so it is positive to see the overall trend for anonymous reporting declining.

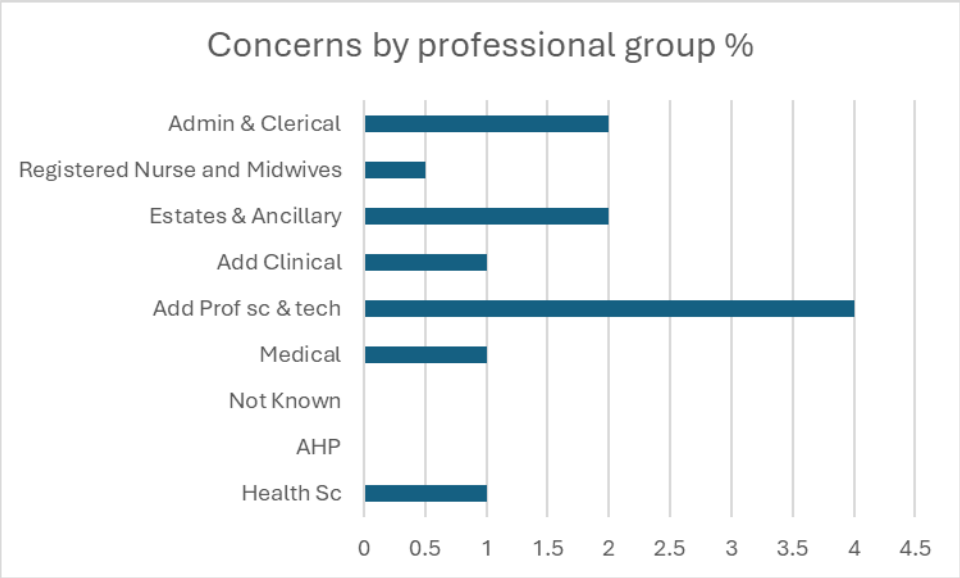


Anonymous reporting themes

These anonymous reports are taken seriously, and each one was investigated as far as possible. The subject of the 5 anonymous reports were : concern re scope of practice, fairness in recruitment processes, delay in employment review process, incivility by senior staff member, unprofessional behaviour.
The Guardian, working with the Trust's Speak Up champions, continues to tackle barriers to speaking up (see Principles of FTSU below) and to assure staff that detriment to those who do speak up will not be tolerated in the Trust.

3. Who is speaking up?

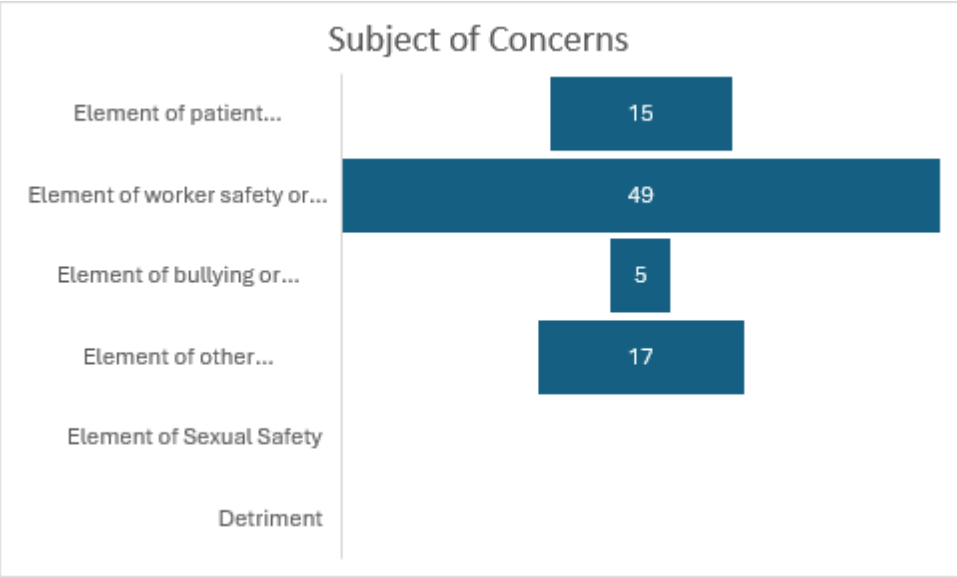




This quarter, the highest number of concerns were from admin and clerical staff, and percentage wise this was also joint second with estates. The highest reporting group this quarter from a percentage view was additional professional scientific and technical.

4. What were people speaking up about?

Most cases involve an element of staff safety or wellbeing. Patient safety concerns comprised 25 percent of concerns raised, involving safeguarding escalation, Infection Prevention and Control (IPC), patient care, Mental Capacity Assessments and staffing levels. The national figure is 19%. Each of these cases has been investigated and addressed individually. The Trust has a patient safety team and robust systems in place where most patient safety concerns are reported.



5. Themes from Q2. 2025/26, with learning and actions

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

Sexual safety Concerns

No incidences concerning sexual safety were reported to the FTSU guardian this quarter. As part of the ongoing work of the Sexual Safety Working Group, to ensure compliance with the Sexual Safety Charter, Sexual safety - West Suffolk NHS Intranet (principle 10) all cases of a sexual nature will be collated with those raised through other routes.

Theme: Formal Consultations This quarter concerns continued to be raised around the emotional and psychological effects of staff undergoing consultations. There were concerns around the length of time some reviews were taking. Concerns were raised about changes in shift patterns and working practices.

Learning and Actions The stress on staff whose services are undergoing review is recognised by the Trust. Where the reviews have taken longer than originally planned, the difficulties this has caused have been acknowledged and this has been communicated. Staff have been encouraged to make use of the wellbeing services available, including the Employee Assistance Programme.

Managers and HR were made aware of concerns raised around changes and have increased communication around rationale and re-iterated their intention to review effectiveness and effects on staff wellbeing after a period of time.

Theme: Anti-Racism Charter Concerns were raised that whilst the high-profile work around the Sexual Safety Charter was welcomed, there had been less communication and visibility around the Trust's signing of the Anti-Racism Charter and work being done to ensure adherence to this.

Learning and Actions The EDI annual report last year states *Further areas of focus for 2025 are around ensuring clear and visible allyship and commitment to anti-racism from senior leaders and scheduling regular communication and updates on the progress of this important work.*

EDI workforce annual report 2024

Reassurance was provided from the Chief People Officer and the Organisational Development Manager-Equality, Diversity and Inclusion, that being an anti-racism organisation and fulfilling our obligations to the Anti-Racism Charter, is a high priority for the Trust.

During the Involvement Committee Meeting on Wednesday 15th October 2025, the Organisational Development Manager-Equality, Diversity and Inclusion provided a verbal update on the progress of actions from the Anti-Racism Charter. Out of 20 actions within the Charter, 9 have made substantial progress. This includes areas of work such as:

- The development and implementation of the Trust's **Equality Impact Assessment process**
- **Ethnicity pay gap reporting**: the first report was run in 2024 and analysis of the data is included in the EDI workforce annual report 2024 , and the 2025 report will be published shortly after it was approved by the Involvement Committee on 15th October 2025.

- **Workforce ethnicity reporting**: the full 2024 report can be read here, and the 2025 report will be published shortly. This report includes **data on HR cases by race** (and other protected characteristics) to highlight if there are any disparities in the number of HR cases of White colleagues and Global Majority colleagues.

- **"Addressing bias, recognising privilege and becoming a proactive ally" training** being delivered since April 2024. Over 120 colleagues have participated in the full training session, in addition to many other teams who have had part of the training delivered within team meetings and away days. The content of the training focusses on: implicit bias, race, racism, white privilege, white fragility, allyship and being an active bystander. It has been designed and delivered by Organisational Development Manager-EDI, it was also co-delivered alongside the new Chief Nurse to senior nurses and midwives on six occasions.

- Establishing recruitment processes that are robust enough to identify inequity and areas of potential discrimination at shortlisting and appointment stages of our recruitment processes. To address this the Head of Resourcing and the Organisational Development Manager- EDI are implementing a number of actions that will look at tackling bias and increasing inclusive practices within the recruitment process.

Next steps: During the discussion at Involvement Committee, it was agreed that the next steps/next key priority is to increase visibility of the Trust's anti-racism commitment through trust-wide communications.

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

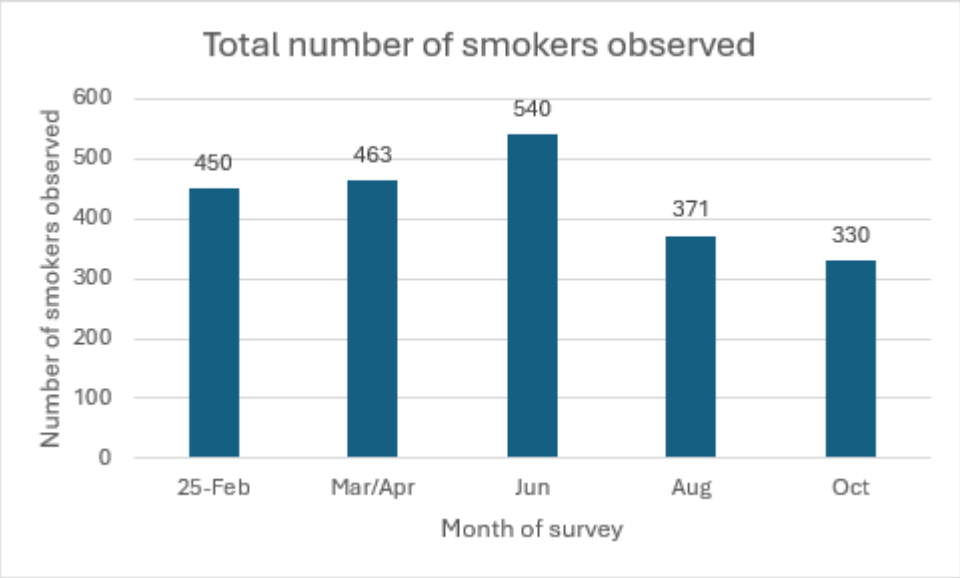
Learning and Actions: In September 2024, the Trust signed the NHS Smoke Free Pledge. The Smoke-free - West Suffolk NHS Intranet Policy is now live on the Trust Intranet.

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

The policy includes support for staff, see Quit smoking with these staff offers - West Suffolk NHS Intranet and patients, to quit smoking How to refer a patient to the tobacco dependence team. - West Suffolk NHS Intranet. The team continue to expand and have now established the service in many outpatient services as well as ED, along with a more structured approach to MECC (Making Every Contact Count) for smoking cessation.

The new signage with strong messaging has now been approved and should be in place by the end of the year.

Work has been ongoing with communication to patients, visitors and staff and smoking levels outside the front of the hospital monitored. There has been a small reduction so far, but it is hoped this will further decrease with the new signage.



Regarding cigarette litter options are being explored with estates team for an industrial clean, and litter picking occurs regularly.

Theme: Bullying The percentage of concerns where an element of bullying is mentioned has remained steady at 8%. This is a relatively low level (the NGO reports an average of 18%) but we need to consider that cases of bullying often go unreported.

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

Staff feeling able to speak up about bullying is an important step to address it. This is an area where encouraging the reporting of incidents is a key way to build a psychologically safe workplace..
Each case reported has been investigated and addressed, and those speaking up about it have been offered support.

Theme Communication by some managers. Examples include lack of face-to-face communication regarding procedural changes, poor listening and incivility.

Learning and Action The importance of effective communication continues to be a learning point. The importance of civility, and the Trust value of 'respect' needs to be reiterated throughout all levels of leadership. Each case has been investigated and addressed and ongoing leadership training aims to support communication skills and strategies across the Trust. The CQI leaders programme being offered to colleagues will include training on how to support a psychologically safe environment. The Values based Behaviour Framework - Behaviour framework launched in November will support the understanding of behaviours and attitudes required by all WSFT colleagues.

6. Feedback on the Freedom to Speak Up Process

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

The figures below show a summary of evaluations received in Q2.

- Only two responses were received to the FTSU feedback survey for Quarter 2. Both respondents said they would speak up again.
- Free text comments and other feedback received verbally and via email was generally positive. Feedback taken from the form and email responses include:

Overall a positive outcome, a shame it has to take all of this to make something so fundamental to happen. Many thanks for all your help. Very much appreciated.

Thank you for listening to my concerns. I have felt supported and feel less anxious about the concerns highlighted.

There has been some improvement – we've got a way to go still but I think our concerns must have been heard.

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

Principle 1: Value Speaking Up:

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

What's going well:

- Ongoing support from Board and SLT for Freedom to Speak Up
- Non-executive director for FTSU attended champion training.
- Programme in place for an executive to attend each FTSU champion training and refresher training.

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

What's going well:

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

- Regular meetings established between FTSU NED and Guardian.

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

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

What's going well:

- FTSU continues to be promoted throughout the Trust. Training sessions by FTSU Guardian for preceptorship, new starter Welcome and student training programmes.
- FTSU guardian visiting wards and departments, including community teams, increasing awareness of FTSU and encouraging recruitment of champions as widely as possible.
- 'Speak Up' and Listen Up' mandatory training is promoted, and we have high numbers of staff completing this (88% and 86% respectively)
- Focus on inclusion and reaching those who may be less likely to speak up - Champion Gap analysis completed and active recruitment undertaken in areas lacking champions.
- FTSU Communication Plan has been developed by Guardian with support of Communications Team. FTSU COMMS PLAN 2024 - FINAL.docx
- **Speaking up is not just about FTSU – it should be business as usual through the regular channels. Access to HR support and wellbeing services has been simplified by the addition of the HR Information Zone : HRzone - 1 empowering staff to navigate support for themselves.**

Next steps:

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

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

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

What's going well:

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

Next steps:

- Senior Leaders to complete 'Follow Up' training.

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

What's going well:

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

Next steps:

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

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

What's going well:

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

Next Steps:

- FTSU Guardian enrolled on Coaching Professional apprenticeship. Started January 2025

Principle 7: Barriers to speaking up are identified and tackled

What's going well:

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

Next Steps:

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

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

What's going well:

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

Next Steps:.

- **FTSU policy requires update December 2025 – this to be undertaken by FTSU guardian and HRBP for policy, and brought to policy governance group**

References/links:

Behaviour Framework - Behaviour framework

HRzone - 1

Smoke-free - West Suffolk NHS Intranet

4.3. Putting You First Report (ATTACHED)

To Assure

Presented by Julie Hull

West Suffolk
NHS Foundation Trust

Putting You First awards

September – November 2025 winners

Board of Directors: 28 November 2025

Compassionate care,
healthier communities

Putting You First (PYF) awards

West Suffolk
NHS Foundation Trust

PYF awards celebrate colleagues throughout the Trust for modelling Trust values in their daily working life and inspiring patients and/or colleagues with their approach.

Nominations can be made by any member of WSFT staff at any time in the year. 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.

The nominees are reviewed by members of the executive group and winners selected (usually 2-4 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).

Compassionate care,
healthier communities

Lisa Shepherd, consultant radiographer - radiography

Nominated by Sarah James, breast screening sister, and Alice Ablewhite, trainee consultant radiographer

While working in the assessment clinic, Lisa encountered a particularly distressing situation involving a patient who had previously been treated for cancer. The patient had been recalled following an abnormality detected on her annual mammogram, which understandably caused her significant anxiety and emotional distress.

Throughout this challenging interaction, Lisa demonstrated exceptional professionalism, empathy, and composure. She approached the situation with calm reassurance, taking the time to listen to the patient's concerns and provide clear, compassionate support. Her ability to remain composed while offering genuine care helped ease the patient's fear and uncertainty, transforming a moment of intense distress into one of understanding and comfort.

This was an incredibly difficult situation that required sensitivity, emotional intelligence, and strong communication skills — all of which Lisa displayed effortlessly. Her actions not only provided immediate comfort to the patient but also reflected the highest standards of patient-centred care.

Lisa is an outstanding member of the team and a wonderful ambassador for West Suffolk Hospital. Her compassion, professionalism, and dedication to patient well-being exemplify the values of the organisation. I strongly believe she deserves recognition for her exceptional work and the positive impact she has on both patients and colleagues.

Robert Smith, senior systems engineer, and Graham Mason, infrastructure engineer - digital services

Nominated by Nicola Cottington, chief operating officer

The Trust recently experienced severe Outlook email issues during a server transition. This had a significant impact on many staff and there were also potential patient safety issues. Robert and Graham worked tirelessly over this period to get emails working again for the Trust. They worked day and night through their own initiative, without complaint, evidence of their commitment to the staff and patients we serve.

Experts in their field, they both worked long hours and said it was a team effort. This was truly over and above the call of duty and evidence of how much we all rely on the often unseen, heroic efforts of our digital services team to keep services running for staff and patients.

Jabay Nkhwazi, audiovisual specialist - digital and data IT operations

Nominated by Gina Shaw, learning and development lead

Jabay is fantastic, nothing is too much trouble. He always responds to support questions quickly and graciously, regardless of how busy he is. He is prompt, efficient, and helpful, and always smiling. Very professional and hardworking. He is a real star and deserves to be recognised for how he conducts himself and performs his role. He is a true role model.

Eden Wingrave, OT – Sudbury Integrated Neighbourhood Team (INT)

Nominated by Victoria Teager, INT co-ordinator

Eden was involved with a very complex discharge from hospital. This particular patient was not fully engaging with services and care. Eden went above and beyond to firstly ensure that all possible services were involved in providing care for the patient, and regularly chased this up. She then slowly gained complete trust from the patient, with her professional, caring and individualised person-centred approach.

With this approach the patient then engaged with care and was then able to improve areas in his life by taking control of his own care needs, where sometimes others had failed. She always shows complete compassion and understanding for all the patients she sees and is an asset to her team and the Trust.

Matthew Youngman, lead antimicrobial pharmacist

Nominated by Amy Clarke, OPAT CNS

Matt has gone above and beyond to support the OPAT CNS Team, whilst we undergo significant changes within our service. Matt and his colleague Danni Gallally (OPAT Pharmacist), have been a constant source of support, both practically and emotionally to ensure the safety of our patients and the teams wellbeing.

Matt and Danni always go the extra mile for the patients, to ensure that any concerns or changes in treatment are dealt with in a swift and timely manner. They are both highly thought of within the OPAT Team and wider OPAT MDT.

Compassionate care,
healthier communities

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: 17th September 2025		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	***WHAT NEXT?*** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	***Escalation:*** *1. No escalation* *2. To other assurance committee /MEG* ***3.** Escalate to Board*
PAGG/IQPR	**Urgent and Emergency Care** In July 4-hour performance increased to 74.37% against a trajectory of 74% and 12-hour waits as a % of attendances decreased to 4% of attendances, down from 5.5% in June, and below the comparable 2024 position.	**3 Partial**	Not meeting urgent and emergency standards means some patients are waiting longer in the Emergency Department than they should be.	There is a continued focus on the UEC Delivery Group recovery plan	3. Escalate to Board for information

PAGG/IQPR	**Cancer Targets** 28-day Faster Diagnosis Standard performance improved in June to 74% from 64% in May. 62-day performance increased in June to 74% from 68% in May, bringing the position back on trajectory.	**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	July DM01 performance was similar to June at 44.5%.	**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 being put into national tiering at Tier 1.	Additional endoscopy activity began towards the end of the month and a preferred supplier for additional ultrasound activity was engaged in August. This should contribute towards a planned improvement in performance from September.	3 Escalate to Board for information

Deep Dive – Elective Recovery	The Committee undertook a deep dive into elective recovery and received detailed analysis of the performance in each speciality. The current total waiting list size is 34,524. The number of patients over 65 weeks increased further in July, to 221, the majority of these were in Dermatology. The volume of 52 week waits continues to increase, with 1670 as at the end of July, against a submitted plan position of 835. RTT 18-week performance also remains off trajectory. Specialities with the highest number of patients over 18 weeks are: • Orthopaedics –2115 • Dermatology –1952 • Gynaecology –1441 • Ear, Nose and Throat -1347 • Ophthalmology –1091	**4 Minimal**	There is a risk of patient harm if patients are not treated in a timely way. As a result of the Trust's variance to plan we have been placed into 'Tier 1' for elective care, alongside diagnostics. This requires fortnightly meetings with national and regional NHS England teams. It is unlikely that the Trust will achieve the target of 0 patients over 65 weeks by the end of September. Gynaecology remains a particular area of risk and a high reliance on ultrasound is impacting their ability to recover.	The additional validation of the waiting list which began on 1st September, is expected to have a positive impact on the total waiting list size. The deep dive gave significant analysis about the underlying issues in each service area but the Committee could only take minimal assurance from the report, as the detailed plans to address underperformance were still in development. These were due to be considered by MEG and will be reported back to the next Insight meeting.	3 Escalate to MEG and Board

Finance Accountability Committee	**Month 5 Reporting** At month 5 the Trust was reporting a £0.8m under spend year to date against plan and continues to forecast meeting the planned deficit of £20.7m. This will require delivering £3.9m of CIP that has been identified but is not yet in delivery. 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. The report also highlighted the national exercise to identify the degree of contract funding which is not directly attributable to tariff funding. The initial assessment is that the Trust could be overfunded. The longer-term implications are unclear but are not expected to impact until 26/27.	**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. There is a risk the national tariff funding exercise will reallocate funding away from WSFT.	*Delivery of the CIP programme needs continued focus – see below*	3.Escalate to Board for information

Cost Improvement Programme (CIP) delivery	At month 5 the CIP programme was broadly on target with further schemes identified. 86% of the CIP target has been identified but a gap of £8.4m of weighted CIP remains. Handover is underway with PA consulting.	**3 Partial**	The high value programmes where there is significant risk of delivery continue to be corporate services, clinical productivity and commercial. The Quality Impact Assessment panel continues to take a critical look at schemes and not all are approved if there are risks to patient safety.	Further work is on-going to develop 'stretch' CIPs.	3 Escalate to Board

Medium Term Planning	NHS England (NHSE) has published a Planning Framework which is designed to inform the development of five-year plans covering the period from 2026/27 to 2030/31. The framework outlines clear roles and responsibilities for planning in the context of the new NHS operating model and describes the core planning activities to be completed by NHSE, Integrated Care Boards (ICBs) and providers. Phase one focuses on building a robust evidence base by the end of September. Phase two will involve working with the ICB on final plans for assurance and sign off by the Board in December.	**2 Reasonable**	Development of a 5-year integrated plan is an important requirement for delivery of the Trust's strategy. It needs to meet statutory and regulatory requirements, and also ensure the Trust provides high quality, sustainable services. There are current unknowns that will have a material impact upon the Trust's financial modelling. These include contracting arrangements for 2026/27 and whether there will be the ability to earn additional income; the level of tariff to be applied in 2026/27; and the national efficiency requirement. It is hoped these will be available in national guidance to be issued in October.	A working group is being established to oversee for delivery of the following components of the Medium Term Plan: Service plans Workforce plans Quality improvement plans Digital plans Financial plans Infrastructure and capital plans. The Plan will come to the Board for sign off in December.	3 Escalate to Board for information

Guidance notes

The practice of scrutiny and assurance

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

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

Assurance level

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

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			Date of meeting: 15th October 2025		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	***WHAT NEXT?*** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	***Escalation:*** *1. No escalation* *2. To other assurance committee /MEG* ***3.** Escalate to Board*
PAGG/IQPR	**Urgent and Emergency Care** August 4-hour performance was 73.93% meeting the in-month trajectory of 71%. Twelve-hour waits as a % of attendances demonstrated no significant change although increased slightly from 4% in July to 4.7% in August. This is still below the comparable 2024 position.	**3 Partial**	Not meeting urgent and emergency standards means some patients are waiting longer in the Emergency Department than they should be.	Maintaining delivery of the 4-hour performance trajectory will be the key focus for urgent and emergency care in October with 72% needing to be achieved.	3. Escalate to Board for information

Originating Committee: Insight Committee			Date of meeting: 15th October 2025		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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PAGG/IQPR	**Cancer Targets** 28-day Faster Diagnosis Standard performance improved in July to 80.08%, which is ahead of trajectory. However, 62-day performance dropped to 70% in July against a 74% trajectory.	**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

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PAGG/IQPR	**Diagnostics** July DM01 performance was similar to June at 44.5% but dropped further in August to 42.3%,	**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 being put into national tiering at Tier 1.	Endoscopy performance remains a concern however plans for an additional 3000 ultrasound scans are due to begin from 11 October 2025. Endoscopy priority has been given to patients on a cancer pathway requiring a rebalancing of capacity to support this. September performance will form the basis of WSFT's next published quarterly ratings against the new NHS Oversight Framework, which sees providers placed into segments from 1 (best performing) to 4 (worst performing), with segment 4 providers considered for special support as part of a segment 5 category. WSFT is currently in segment 3.	3 Escalate to Board for information

Originating Committee: Insight Committee			Date of meeting: 15th October 2025		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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PAGG/IQPR	**Elective Recovery** The total waiting list was 33,671 at the end of August, against a planned position of 31,808. Overall RTT compliance was 1.25% behind plan at 58.39%. At month end there were 178 patients over 65 weeks, which is a reduction from July. This volume is expected to continue to reduce over the coming months with a national expectation for 0 by 21 December 2025. The volume of 52 week waits reduced in August to 1,430 against a planned position of 765. As the Trust is currently not achieving the planned trajectories for RTT, it was required to submit revised forecasts to return to plan by December 2025. An update report following last month's deep dive outlined the detailed plans by speciality.	**3 Partial**	There is a risk of patient harm if patients are not treated in a timely way. As a result of the Trust's variance to plan we have been placed into 'Tier 1' for elective care, alongside diagnostics. This requires fortnightly meetings with national and regional NHS England teams.	The additional validation of the waiting list which began on 1st September, is expected to have a positive impact on the total waiting list size. The Management Executive Group (MEG) has approved an additional £424k for elective recovery and the investment will be profiled to provide the best value for money through targeting specialities which can provide high volume, accelerated recovery whilst also reducing long waits in all specialities. This investment informed the detailed action plans considered by the committee. Gynaecology remains a particular area of risk and a high reliance on ultrasound is impacting their ability to recover.	3 Escalate to Board

Originating Committee: Insight Committee			**Date of meeting: 15th October 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 6 Reporting** At month 6 the Trust has reported a deficit of £14.4m for the year to September 2025, which is £0.81m better than planned. We continue to forecast meeting our planned deficit of £20.7m for 25/26 The CIP plan currently shows a favourable variance of £0.1 million year-to-date. However, challenging CIP targets in the second part of the year remain. Our forecast assumes we are able to deliver £3.3m of CIP that has been identified but isn't yet in delivery. Since April 2024, the Trust has reduced staffing levels by 297 WTEs (6%). Capital spend is £5.8m behind the phased plan, but it is anticipated that the plan for 2025/26 will be achieved.	**3 Partial**	It is positive to see the monthly run rate reducing ahead of plan as this will help the position going into 2025/26. The Trust's cash balance as at 30 September 2025 was £1.8m compared to a plan of £1.1m. This has reduced from the previous healthy cash balance due to the payment of pay awards in full. The CIP programme monthly targets ramp-up significantly through the rest of the year and remain a risk.	In line with plan, the Trust will require cash support for the last 5 months of the financial year and an application for revenue support to be received in November has been submitted to NHSE Delivery of the CIP programme needs continued focus – see below	3.Escalate to Board for information

Originating Committee: Insight Committee			Date of meeting: 15th October 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*
Cost Improvement Programme (CIP) delivery	At month 6 the Trust had identified £29.1m/£25.9m of unweighted/weighted CIP opportunities respectively against a full year target of £32.8m. This compares to the September reported position of £28.2m/£24.4m A gap of £3.7m/£6.7m remains against the 25/26 CIP target when considering unweighted/weighted CIP positions respectively. The overall gap in the portfolio has reduced significantly, with 89% of the CIP target identified (79% weighted).	**3 Partial**	The high value programmes where there is significant risk of delivery continue to be corporate services, clinical productivity and commercial. The Quality Impact Assessment panel continues to take a critical look at schemes and not all are approved if there are risks to patient safety.	Further work is on-going to develop 'stretch' CIPs. Learning from the PA contract will be reported to Insight Committee in December.	3 Escalate to Board

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

5.2. Finance Report (ATTACHED)

To Review

Presented by Jonathan Rowell

WSFT Board of Directors (Open)	
Report title:	Finance Report – as at October 2025 (M7)
Agenda item:	5.2
Date of the meeting:	28th November 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 7 (October 2025).

Income and Expenditure position
The Trust has agreed a £20.7m deficit budget for the year, and at month seven is reporting a £1.2m year to date underspend against the plan. The reported Income and Expenditure (I&E) for month seven shows a YTD deficit of £15.3m, compared to the planned deficit of £16.5m. We continue to forecast meeting our planned deficit of £20.7m for 25/26

Efficiencies
The CIP plan is currently on plan at £14.1m YTD. However, we are still working to meet the challenges posed by our CIP targets in the second part of the year. Our forecast assumes we are able to deliver £2.3m of CIP that has been identified but isn't yet in delivery.

Cash
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 – October 2025 (M7)
for WSFT Public Board
28th November 2025

Putting you first

Executive Summary as at October 2025

Summary

The Trust has agreed a £20.7m deficit budget for the year, and at month seven is reporting a £1.2m year to date underspend against the plan. The reported Income and Expenditure (I&E) for month seven shows a YTD deficit of £15.3m, compared to the planned deficit of £16.5m. Reductions in pay through held vacancies, reduced activity levels and non-pay controls contribute to this favourable variance.

Forecast and underlying position

The Trust is forecasting to achieve its planned deficit for the year. However, the underlying position is important in planning for 2026/27, and in October the underlying deficit has improved by £50k to £1.585m, due to reductions in staffing.

Workforce

The Trust are reporting a further reduction in WTEs as of October 2025 (4,784 WTEs) compared to October 2024 (5,031 WTEs), a reduction of 247 WTEs. WTEs are 257.5 below the annual workforce plan as of month seven, with reductions in Substantive Nursing and A&C staff as well as Bank Nursing. We continue to have zero Agency Nursing. Since April 2024, we have reduced our staffing levels by 336 WTEs (6.6%).

Efficiencies

The CIP schemes were aimed at delivering £32.8m for the year. The year-to-date target was £14.1m, and this has been delivered. Delivery of CIP increases in the second part of the year and is £1.2m in October. Work to de-risk future CIP continues, with vacancy and non-pay controls remaining in place.

Cash

The cash balance as at 31 October 2025 was £4.9m compared to a plan of £1.1m. Cash is slightly higher than plan due to the timing of a creditors payment run. Cash is being rigorously monitored to ensure that the Trust remains on plan and does not fall below the £1.1m limit that must be maintained and is enforced by NHS England. The Trust applied for £10m in cash support for November, but has only been awarded £5.7m. Discussions are being held with NHSE to ensure that the full level of cash support is received in December.

Capital

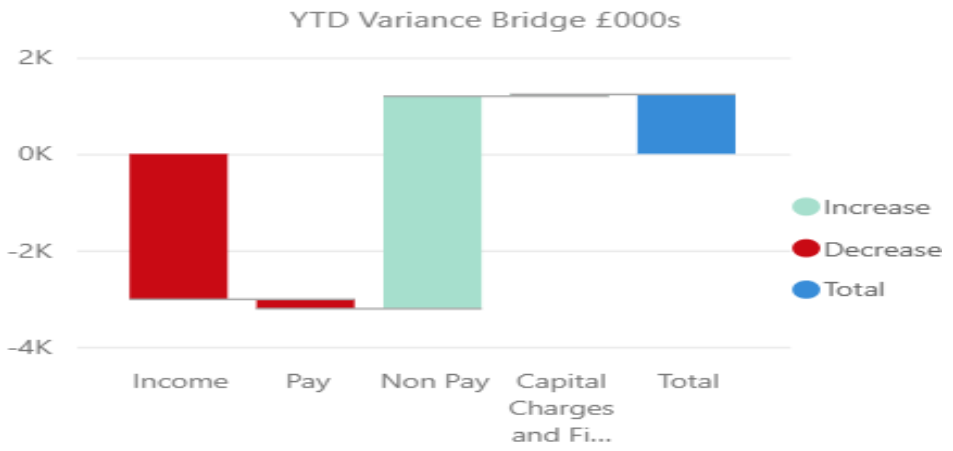
The Capital Plan for 2025/26 was agreed at £25.6m. An additional £1m of CDEL and £7.2m of PDC was awarded to the Trust in the first quarter. Further adjustments to PDC has resulted in a Capital Plan for 2025/26 of £34.9m. £11.5m of this is internally funded, with the remaining £23.4m being funded by Public Dividend Capital (PDC). Year to date capital spend at month 7 is £7.8m. This is behind the phased plan, but after a detail review of forecast spend we anticipate that the plan for 2025/26 will be achieved, subject to final PDC funding agreements being in place.

M7 position

NHS
West Suffolk
NHS Foundation Trust

	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	32.3	32.1	-0.2	224.3	221.4	-2.9	385.3	385.3	0.0
Other Income	3.4	4.2	0.8	23.2	23.1	-0.1	39.8	39.8	0.0
Total	**35.6**	**36.2**	**0.6**	**247.5**	**244.5**	**-3.0**	**425.1**	**425.1**	**0.0**
Expenditure									
Pay Costs	26.2	25.0	1.3	181.3	175.4	5.9	310.4	310.4	0.0
Non-pay Costs	8.8	10.3	-1.4	69.4	71.0	-1.7	112.4	112.4	0.0
Total	**35.1**	**35.2**	**-0.2**	**250.7**	**246.5**	**4.2**	**422.8**	**422.8**	**0.0**
EBITDA Position	**0.6**	**1.0**	**0.4**	**3.1**	**1.9**	**1.2**	**2.3**	**2.3**	**0.0**
Depreciation	**1.5**	**1.5**	**0.0**	**10.4**	**10.3**	**0.1**	**17.8**	**17.8**	**0.0**
Finance Costs	**0.4**	**0.5**	**0.0**	**3.0**	**3.1**	**-0.1**	**5.2**	**5.2**	**0.0**
Impairments									
Deficit/(Surplus)	**1.4**	**0.9**	**0.4**	**16.5**	**15.3**	**1.2**	**20.7**	**20.7**	**0.0**

Deficit YTD £	**15.3M**	
Variance against plan YTD £	**1.2M**	**Favourable**
Movement in month against plan £	**0.4M**	**Favourable**
EBITDA Postion YTD £	**-1.9M**	**Adverse**
EBITDA margin YTD	**-1%**	**Adverse**
Cash at bank	**£4.9M**	

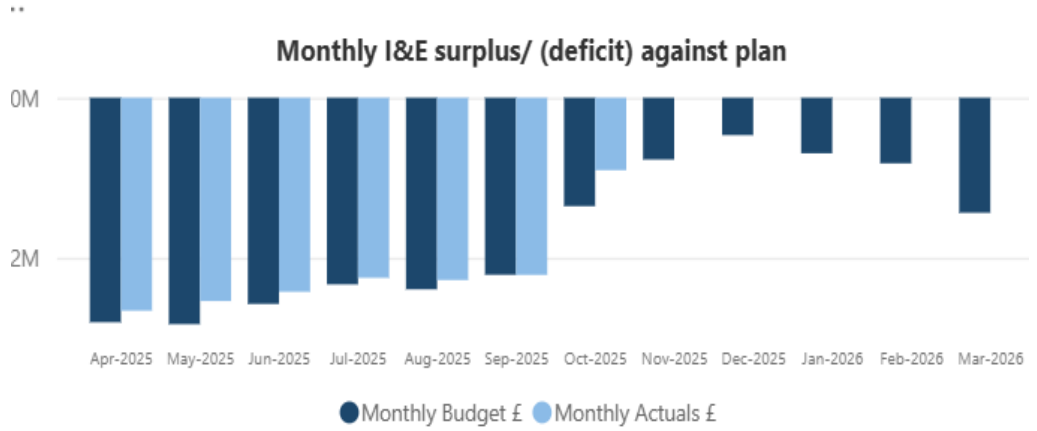


Income and Expenditure Summary – October 2025

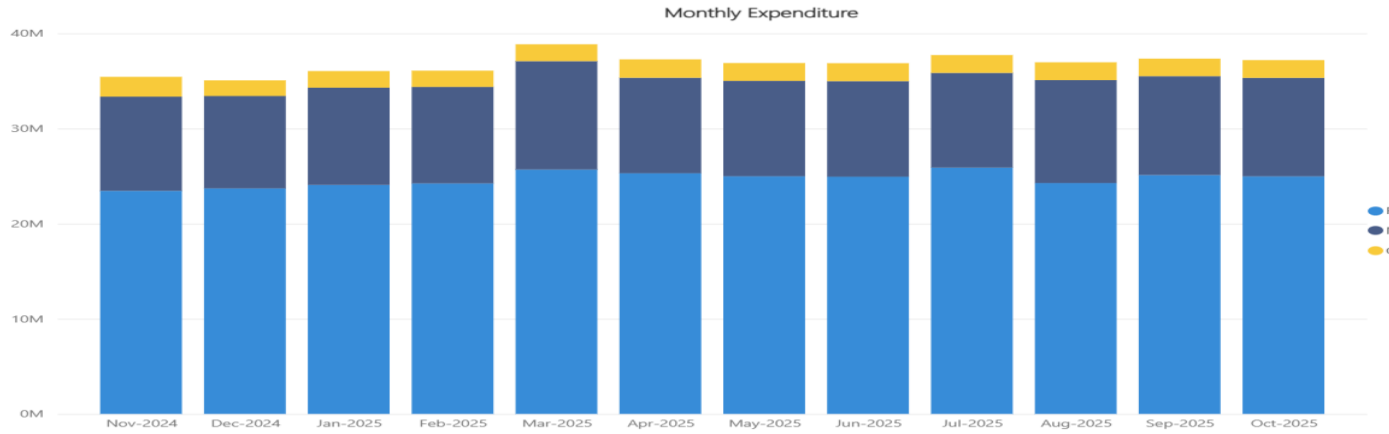
The favourable variance was £449k in October, being £1.2m YTD. The monthly position includes backdated income from Health Education England.

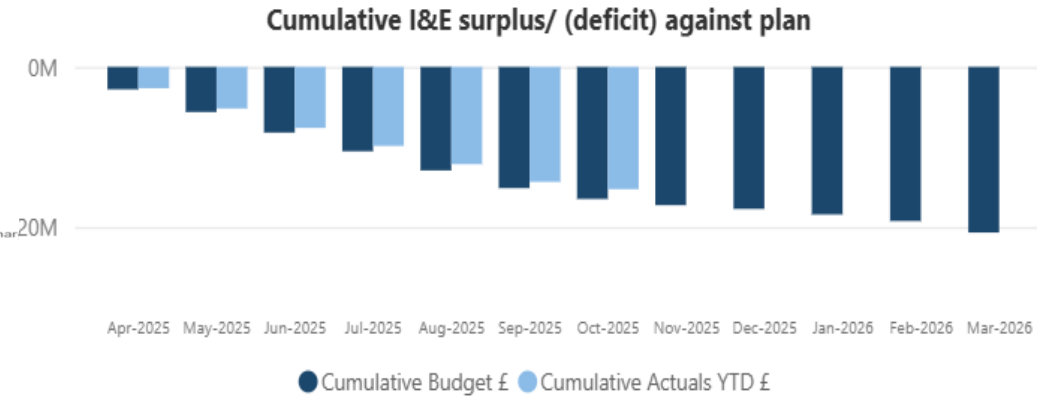
Board Report Item	Original Plan/ Target £000s	Actual/ Forecast £000s	Variance to Plan £000s F/(A)	
In month surplus/ (deficit)	-1,355	-906	449	↑
YTD surplus/ (deficit)	-16,507	-15,274	1,233	↑
Clinical Income YTD	224,331	221,428	-2,904	↓
Non-Clinical Income YTD	23,202	23,090	-112	→
Pay YTD	181,313	175,447	5,866	↑
Non-Pay YTD	69,359	71,014	-1,655	↓
EBITDA YTD	-3,139	-1,944	1,196	↑
EBITDA %	-1.3	-0.8	0.5	↑

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)



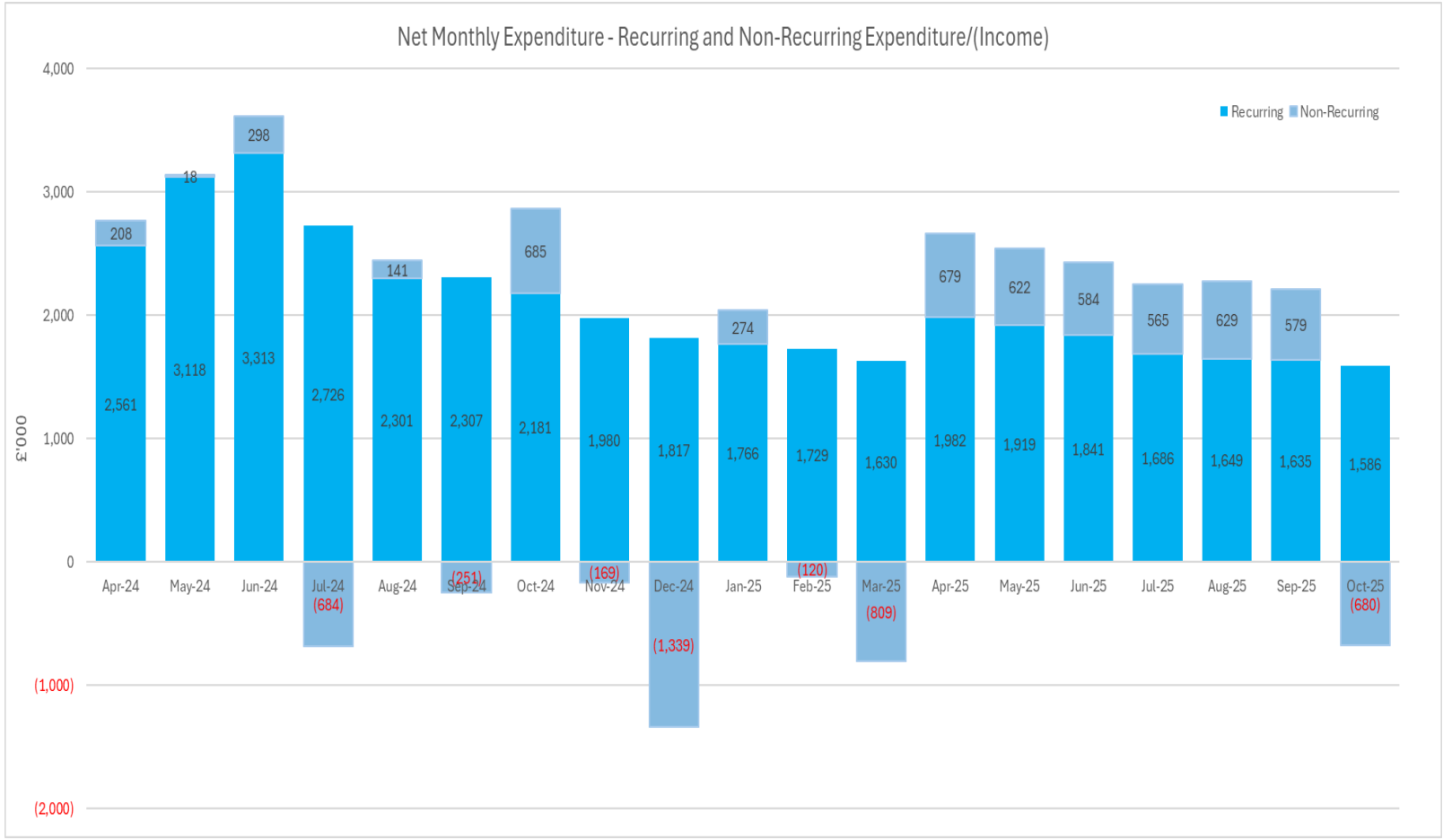


M7 recurring position

There has been a steady decrease in our recurring monthly costs since June 2024 (other than the pay awards that came into effect in April 2025).

This position includes actual achievement of CDC income on a cost and volume basis, which is underperforming. Should that be maximised there could be a contribution towards the Trusts position.

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Net Expenditure	**2,661**	**2,541**	**2,425**	**2,251**	**2,278**	**2,214**	**906**
Recurring	**1,982**	**1,919**	**1,841**	**1,686**	**1,649**	**1,635**	**1,586**
Non-Recurring							
Income adjustment	200	250	416	336	0	0	
HEE income							(670)
Private patient income				(37)	(200)		
Staff recharges			(136)				
Pay arrears	49	350		(22)	(423)	148	
Industrial Action					154		
Consumables	178	(178)					
Rent arrears	53					4	
Ecare accrual					300		
Utilities			(51)			78	
External Support	300	300	330	330	330	201	
VAT refund reversed					439		
Other	(101)	(100)	25	(42)	29	148	(10)
Non-Recurring	**679**	**622**	**584**	**565**	**629**	**579**	**(680)**

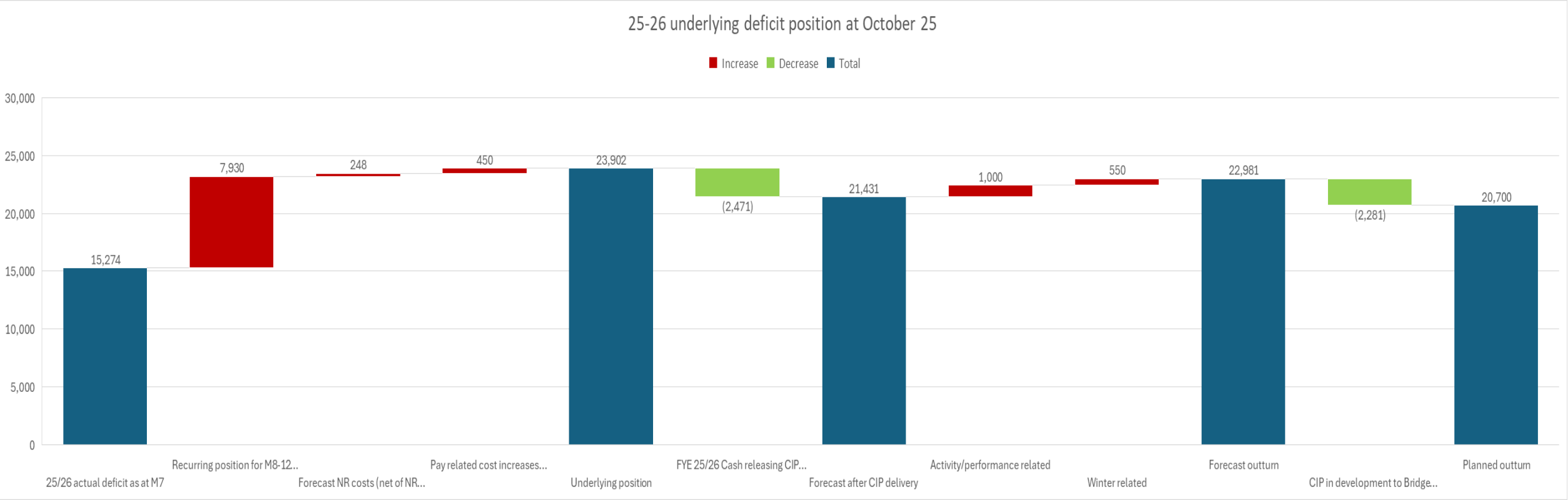


25/26 Underlying Position and Forecast

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

As at M7 the forecast continues to be to deliver the plan as below, assuming that the recurring position is currently broadly £1.58m deficit per month, and that CIP delivery increases over the second part of the year, as well as seasonal and activity related costs varying throughout the year. Redundancy costs and any associated CIP are included in this forecast.

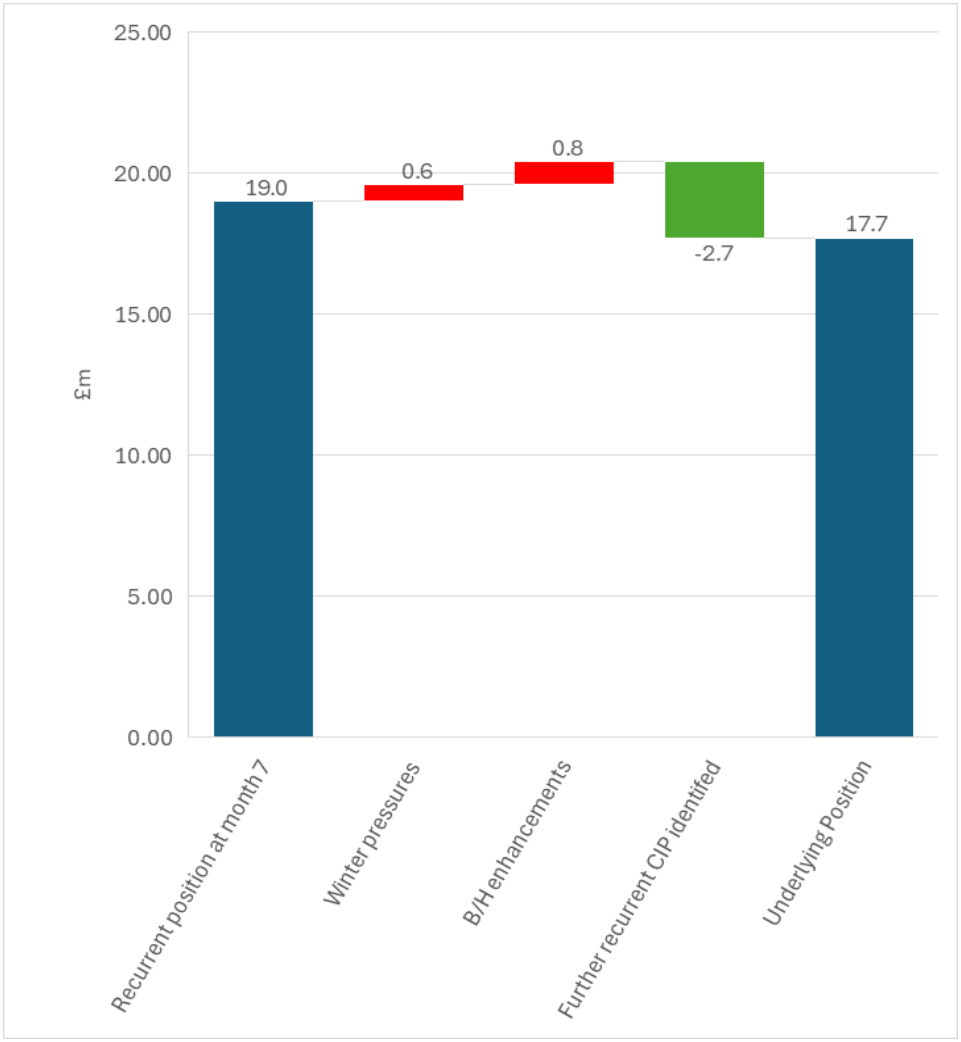
However, this forecast is contingent on delivering around £2.3m of CIP that has been identified but not yet in delivery, a reduction of £1.0m since month 6. Should the activity at the CDC increase without any significant increase in costs this gap will be covered by CDC related income



Underlying position

- The 2025/26 exit underlying position is now collected nationally by NHS England and will serve as the foundation for NHS organisations' medium-term plans (MTPs), and a robust and consistent assessment of this financial metric is essential for responding to the three-year revenue settlement.
- This bridge shows the recurrent month 7 position extrapolated to 12 months, adjusted for seasonal pressures and further net recurrent CIP to give an underlying position of £17.7m, which is a small improvement from last month.
- This is the underlying 2025/26 position and does not reflect any further pressures that may occur in 2026/27. National planning guidance has not yet been published, which could include material changes to the Trust's income, including moving more activity to a cost and volume basis and deconstructing block payments. Similarly, the table below reconciles the current position to the underlying position:

	£m
Recurrent month 7 position	1.59
Recurrent position at month 7	19.0
Winter pressures	0.6
B/H enhancements	0.8
Further recurrent CIP identifed	- 2.7
Underlying Position	**17.7**



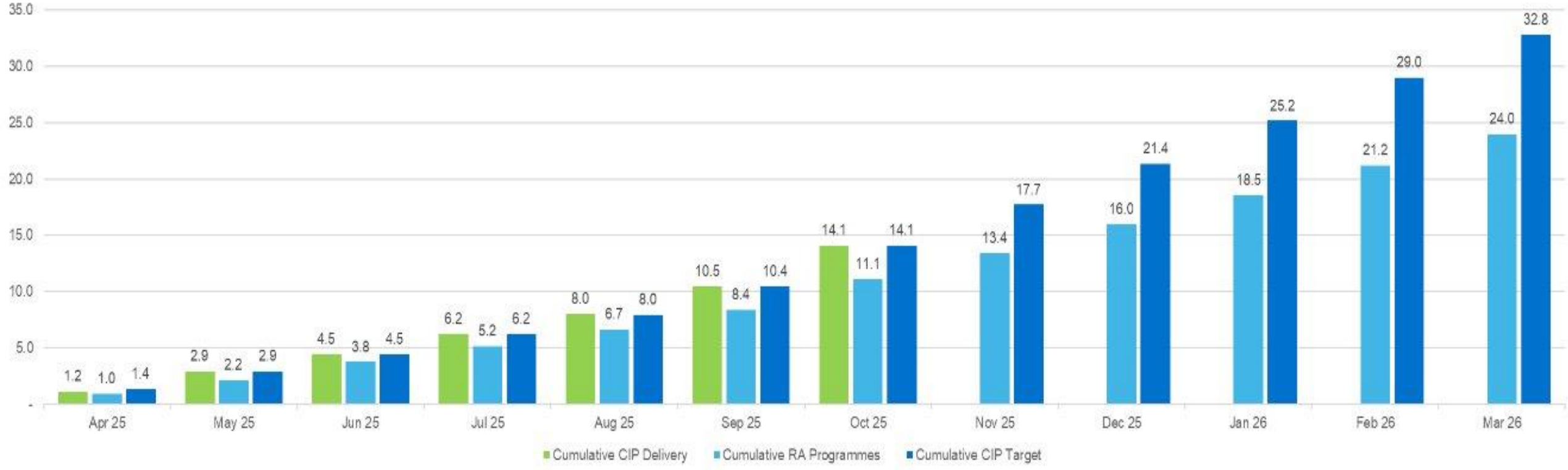
25/26 CIP Progress

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 M7, the Trust has delivered £14.1m of CIPs, against a budgeted plan of £14.1m, resulting in delivery to plan YTD.

All reported numbers are now recorded on the CIP Tracker.

FY 25/26 YTD Delivery Profile.



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	**7,907**	**7,976**	**-69**	**55,583**	**57,217**	**-1,634**	**94,611**
Income	-422	-692	269	-2,978	-3,352	374	-5,089
Pay	6,039	6,496	-457	43,348	44,873	-1,525	73,835
Non Pay	2,243	2,126	117	14,885	15,373	-488	25,303
Capital Charges	47	46	1	328	323	5	562
Surgical Services	**6,058**	**6,085**	**-26**	**42,586**	**42,329**	**257**	**72,383**
Income	-399	-588	189	-2,674	-2,870	196	-4,666
Pay	4,891	4,933	-42	34,645	34,981	-336	59,164
Non Pay	1,539	1,716	-178	10,418	10,043	375	17,547
Capital Charges	28	23	5	197	175	22	337
Women and Children Services	**2,176**	**2,318**	**-141**	**15,486**	**15,809**	**-323**	**26,397**
Income	-244	-261	17	-1,706	-2,073	367	-2,924
Pay	2,252	2,406	-155	16,077	16,833	-755	27,339
Non Pay	166	172	-6	1,101	1,043	58	1,960
Capital Charges	2	0	2	13	6	8	23
Clinical Support	**3,556**	**4,011**	**-455**	**26,383**	**27,835**	**-1,452**	**44,308**
Income	-955	-735	-221	-5,261	-3,711	-1,550	-9,726
Pay	3,096	3,110	-14	22,050	21,451	599	37,530
Non Pay	1,413	1,633	-220	9,573	10,075	-501	16,469
Capital Charges	3	3	0	20	20	0	35
Community Services	**5,166**	**4,986**	**180**	**36,661**	**36,054**	**607**	**62,190**
Income	-561	-574	12	-3,878	-3,836	-42	-6,585
Pay	4,065	3,896	169	28,748	28,213	536	49,019
Non Pay	1,601	1,613	-12	11,364	11,296	68	19,025
Capital Charges	61	50	11	427	381	45	731
Facilities	**1,817**	**1,627**	**189**	**12,465**	**11,988**	**477**	**21,548**
Income	-479	-456	-24	-3,033	-2,794	-239	-5,239
Pay	1,299	1,152	147	8,610	8,308	303	14,997
Non Pay	996	931	65	6,885	6,474	412	11,787
Capital Charges	0	0	0	2	1	1	3
Contract Income & Corporate	**-25,325**	**-26,097**	**772**	**-172,658**	**-175,959**	**3,301**	**-300,738**
Income	-32,640	-32,982	342	-228,525	-226,340	-2,184	-391,716
Pay	3,969	2,978	991	21,772	20,789	983	37,203
Non Pay	971	2,162	-1,192	15,766	17,329	-1,562	21,409
Reserves	623	0	623	6,061	0	6,061	11,337
Capital Charges	1,752	1,746	7	12,267	12,263	4	21,030
Deficit/(Surplus)	**1,355**	**906**	**449**	**16,507**	**15,274**	**1,233**	**20,700**

Pay Costs by Staff Type

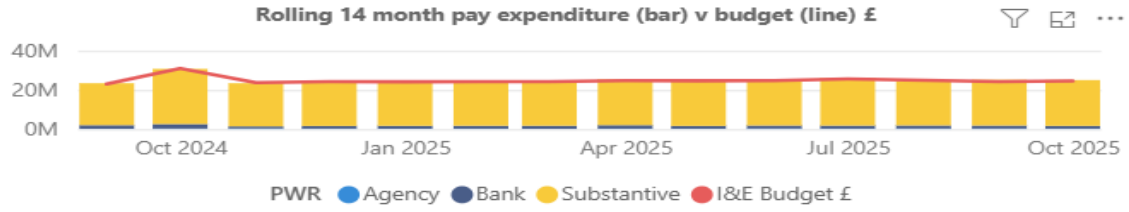
Note that pay costs in October include Redundancy and MARS payments made in month. However, these had previously been included in our position. They total £1.1m YTD.

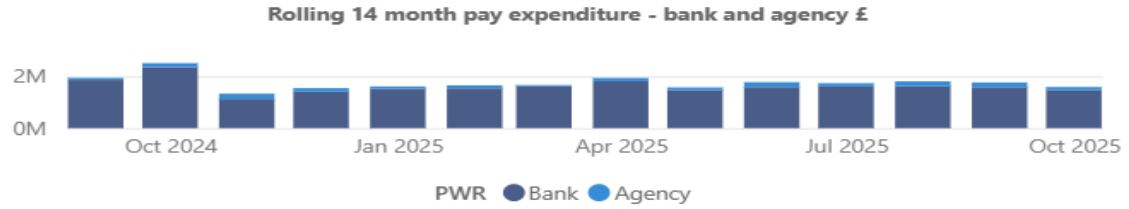
		Prior Month Actuals £000	In-Month Actuals £000s	In-Month Budget £000s	In-Month Variance £000s	YTD Actuals £000s	YTD Budget £000s	YTD Variance £000s
Substantive	Medical Staff	6,123	6,080	6,503	423	42,058	45,597	3,540
	Nursing	8,378	8,211	8,749	538	58,570	62,364	3,794
	Sci & Professional	1,197	1,166	1,284	118	8,237	8,867	630
	A&C	3,574	3,479	3,787	308	25,464	26,507	1,043
	AHP	2,460	2,425	2,851	425	17,249	19,095	1,846
	Prof & Tech	246	280	266	-14	1,733	1,834	101
	Support Staff	908	880	945	65	6,133	6,408	275
	Other	465	866	1,627	761	3,858	6,222	2,364
	Unallocated central funding	0	0	-286	-286	0	775	775
	Total	23,350	23,388	25,726	2,338	163,301	177,669	14,368
Additional Medical Sessions	Medical Staff	251	265	156	-110	1,931	1,206	-725
	Total	251	265	156	-110	1,931	1,206	-725
Bank & Locum Staff	Medical Staff	382	316	165	-151	2,815	1,140	-1,675
	Nursing	602	562	28	-534	4,130	190	-3,940
	Sci & Professional	19	16	2	-14	131	15	-115
	A&C	43	52	6	-45	299	42	-256
	AHP	11	11	1	-10	88	7	-81
	Prof & Tech	0	1	1	0	4	5	2
	Support Staff	193	160	142	-18	1,231	985	-245
	Total	1,251	1,117	345	-772	8,696	2,386	-6,311
Agency	Medical Staff	154	92	0	-92	835	0	-835
	Nursing	0	0	0	0	24	0	-24
	Sci & Professional	4	6	0	-6	9	0	-9
	A&C	6	13	0	-13	34	0	-34
	Prof & Tech	16	16	0	-16	148	0	-148
	Support Staff	0	0	-2E-5	-2E-5	-8	0	8
	Total	180	126	-5E-5	-126	1,041	0	-1,041
Overtime	Nursing	33	32	1	-31	162	6	-156
	Sci & Professional	6	6	0	-6	51	0	-51
	A&C	7	7	7	-1	47	47	0
	AHP	20	17	0	-17	135	0	-135
	Prof & Tech	11	12	0	-12	84	0	-84
	Total	77	75	8	-67	478	53	-425
Total		25,109	24,972	26,234	1,262	175,447	181,313	5,866

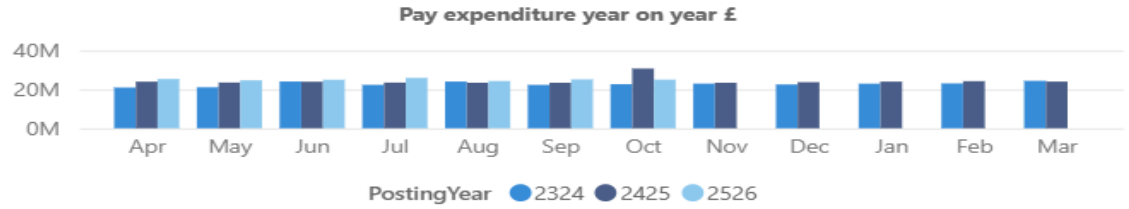
Pay Costs (by Staff Group)

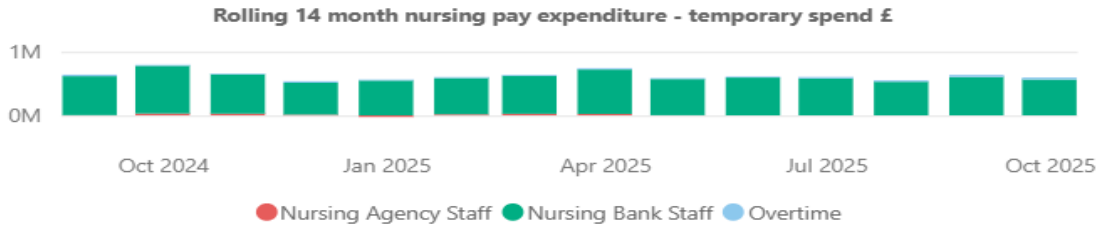
		Prior Month Actuals £000	In-Month Actuals £000s	In-Month Budget £000s	In-Month Variance £000s	YTD Actuals £000s	YTD Budget £000s	YTD Variance £000s
Medical Staff	Substantive	6,123	6,080	6,503	423	42,058	45,597	3,540
	Additional Medical Sessions	251	265	156	-110	1,931	1,206	-725
	Bank & Locum Staff	382	316	165	-151	2,815	1,140	-1,675
	Agency	154	92	0	-92	835	0	-835
	Total	6,909	6,754	6,823	70	47,638	47,943	305
Nursing	Substantive	8,378	8,211	8,749	538	58,570	62,364	3,794
	Bank & Locum Staff	602	562	28	-534	4,130	190	-3,940
	Agency	0	0	0	0	24	0	-24
	Overtime	33	32	1	-31	162	6	-156
	Total	9,013	8,805	8,778	-27	62,885	62,560	-325
Sci & Professional	Substantive	1,197	1,166	1,284	118	8,237	8,867	630
	Bank & Locum Staff	19	16	2	-14	131	15	-115
	Agency	4	6	0	-6	9	0	-9
	Overtime	6	6	0	-6	51	0	-51
	Total	1,225	1,194	1,286	92	8,428	8,882	455
A&C	Substantive	3,574	3,479	3,787	308	25,464	26,507	1,043
	Bank & Locum Staff	43	52	6	-45	299	42	-256
	Agency	6	13	0	-13	34	0	-34
	Overtime	7	7	7	-1	47	47	0
	Total	3,631	3,552	3,800	249	25,844	26,597	753
AHP	Substantive	2,460	2,425	2,851	425	17,249	19,095	1,846
	Bank & Locum Staff	11	11	1	-10	88	7	-81
	Overtime	20	17	0	-17	135	0	-135
	Total	2,492	2,453	2,852	398	17,471	19,102	1,631
Prof & Tech	Substantive	246	280	266	-14	1,733	1,834	101
	Bank & Locum Staff	0	1	1	0	4	5	2
	Agency	16	16	0	-16	148	0	-148
	Overtime	11	12	0	-12	84	0	-84
	Total	274	309	267	-42	1,968	1,840	-129
Support Staff	Substantive	908	880	945	65	6,133	6,408	275
	Bank & Locum Staff	193	160	142	-18	1,231	985	-245
	Agency	0	0	-2E-5	-2E-5	-8	0	8
	Total	1,101	1,039	1,087	47	7,355	7,393	38
Other	Substantive	465	866	1,627	761	3,858	6,222	2,364
	Total	465	866	1,627	761	3,858	6,222	2,364
Unallocated central funding	Substantive	0	0	-286	-286	0	775	775
	Total	0	0	-286	-286	0	775	775
Total		25,109	24,972	26,234	1,262	175,447	181,313	5,866

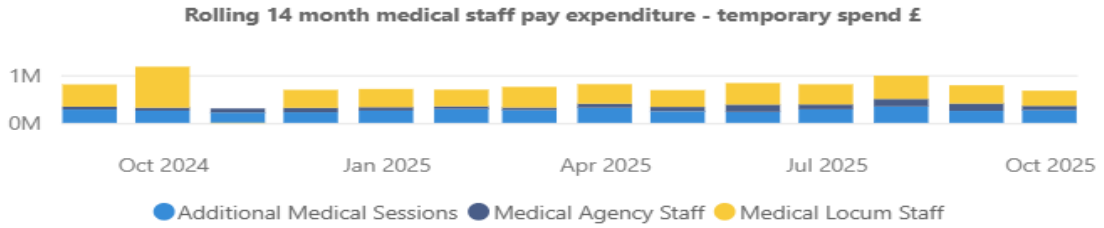
Pay Costs (trends)

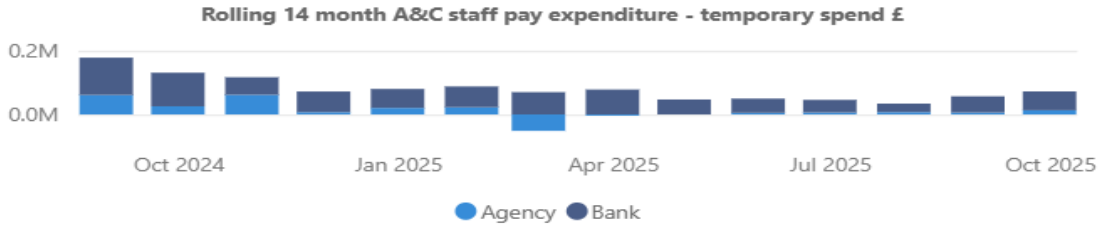












Workforce – WTEs by Staff Type

Substantive staff have decreased by 28.8 WTEs in month, primarily in Nursing (11 WTEs) and A&C staff (23.9 WTEs) whilst there has been an increase in Medical Staff (2.2 WTEs).
Temporary staffing has decreased by 10.8 WTEs, mainly in Bank Nursing (7.8 WTEs) and Bank Medical Staff (7.9 WTEs) with an increase in Bank A&C (2.9 WTEs) and Agency Medical Staff (3.2 WTEs)

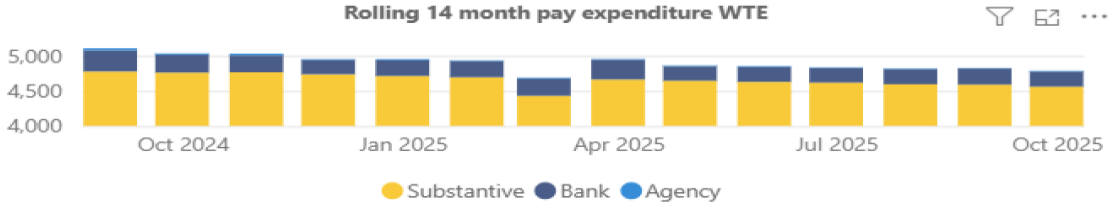
		Prior Month Actuals WTE	Prior Yr Same Period Actuals WTE	In-Month Actuals WTE	In-Month Budget WTE	In-Month Variance WTE	YTD Actuals Average WTE	YTD Budget Average WTE	YTD Variance Average WTE
Substantive	Nursing	1,883.5	1,953.3	1,872.5	2,057.9	185.5	1,901.5	2,075.7	174.2
	A&C	907.5	978.3	883.6	998.3	114.8	919.1	995.9	76.9
	AHP	536.6	556.4	533.2	602.7	69.4	542.2	600.0	57.9
	Medical Staff	606.7	586.3	608.9	649.0	40.1	592.5	646.8	54.2
	Sci & Professional	277.9	275.2	274.7	296.7	22.0	274.4	293.2	18.8
	Support Staff	280.8	290.9	281.7	301.4	19.7	280.7	295.0	14.3
	Other	46.1	68.6	53.4	68.9	15.5	52.8	66.6	13.8
	Prof & Tech	48.9	49.8	51.1	55.8	4.7	49.4	54.8	5.4
	Unallocated central funding	0.0	0.0	0.0	-7.4	-7.4	0.0	-7.2	-7.2
	Total	4,587.9	4,758.8	4,559.1	5,023.3	464.2	4,612.5	5,020.7	408.3
Additional Medical Sessions	Medical Staff	7.7	16.9	7.7	2.9	-4.8	8.7	4.2	-4.6
	Total	7.7	16.9	7.7	2.9	-4.8	8.7	4.2	-4.6
Agency	Nursing	0.0	3.8	0.0	0.0	0.0	0.8	0.0	-0.8
	Support Staff	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Sci & Professional	0.5	0.8	0.7	0.0	-0.7	0.3	0.0	-0.3
	A&C	0.7	1.6	1.5	0.0	-1.5	0.7	0.0	-0.7
	Prof & Tech	1.6	7.3	1.7	0.0	-1.7	2.8	0.3	-2.5
	Medical Staff	3.5	5.5	6.7	0.0	-6.7	4.8	0.0	-4.8
	Total	6.2	19.1	10.6	0.0	-10.6	9.3	0.3	-9.1
Overtime	A&C	0.7	2.8	0.8	0.8	0.0	1.4	0.8	-0.6
	Sci & Professional	0.9	1.2	0.9	0.0	-0.9	1.1	0.0	-1.1
	Prof & Tech	2.9	4.1	3.3	0.0	-3.3	3.2	0.0	-3.2
	AHP	4.1	3.9	3.3	0.0	-3.3	3.9	0.0	-3.8
	Nursing	7.4	2.1	7.2	0.3	-7.0	5.5	0.4	-5.1
	Total	16.0	14.1	15.6	1.1	-14.5	15.1	1.2	-13.8
Bank & Locum Staff	Prof & Tech	0.1	0.3	0.2	0.3	0.1	0.2	0.3	0.1
	Other		0.0						
	AHP	2.1	4.7	1.9	0.0	-1.9	2.2	0.1	-2.1
	Sci & Professional	5.8	8.0	5.1	0.3	-4.8	5.5	1.0	-4.6
	A&C	13.0	22.3	15.9	2.2	-13.8	13.1	2.8	-10.3
	Support Staff	15.6	17.5	14.7	1.0	-13.8	16.4	1.1	-15.3
	Medical Staff	36.9	26.2	29.0	8.9	-20.1	30.2	8.9	-21.3
	Nursing	132.3	143.8	124.5	2.0	-122.6	132.8	1.5	-131.3
	Total	205.7	222.7	191.3	14.6	-176.8	200.3	15.6	-184.8
Total		4,823.6	5,031.5	4,784.3	5,041.9	257.5	4,845.9	5,042.0	196.1

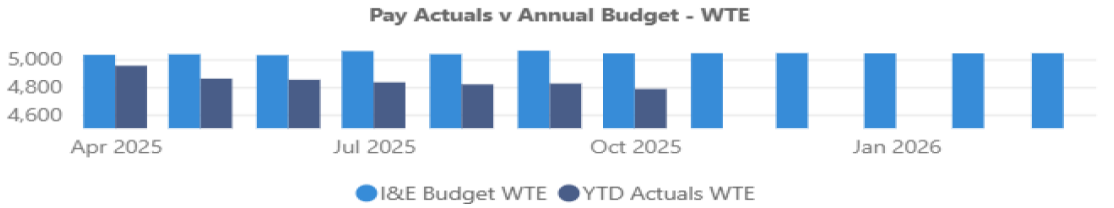
Workforce - WTE (by Staff Group)

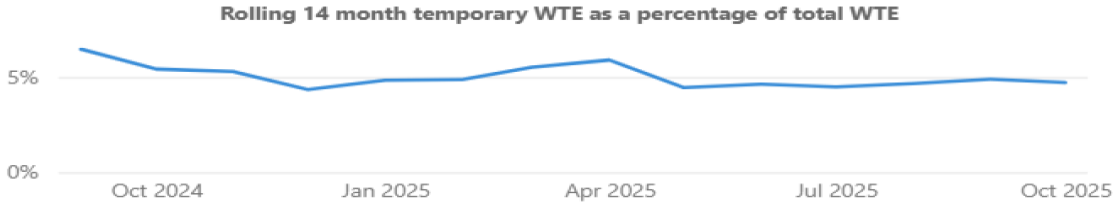
In October 2025 we are reporting a reduction of 39.3 WTEs compared with September 2025, and a reduction of 247.2 WTEs when comparing with October 2024 (4.9%).There has been a reduction of 336.2 WTEs since April 2024 (5,120.5 WTEs) (6.6%).
The favourable variance against establishment is 257.5 WTEs in October 2025

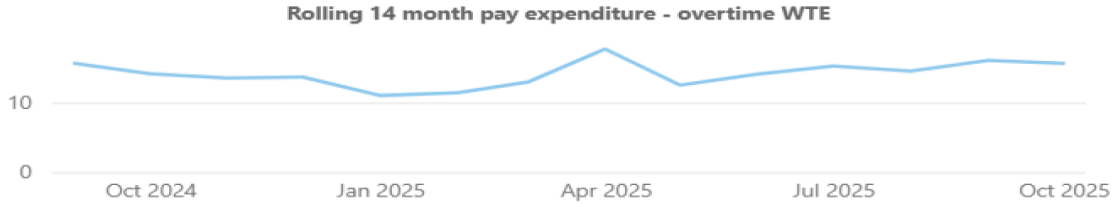
		Prior Month Actuals WTE	Prior Yr Same Period Actuals WTE	In-Month Actuals WTE	In-Month Budget WTE	In-Month Variance WTE	YTD Actuals Average WTE	YTD Budget Average WTE	YTD Variance Average WTE
Medical Staff	Substantive	606.7	586.3	608.9	649.0	40.1	592.5	646.8	54.2
	Additional Medical Sessions	7.7	16.9	7.7	2.9	-4.8	8.7	4.2	-4.6
	Bank & Locum Staff	36.9	26.2	29.0	8.9	-20.1	30.2	8.9	-21.3
	Agency	3.5	5.5	6.7	0.0	-6.7	4.8	0.0	-4.8
	Total	654.8	634.8	652.4	660.8	8.4	636.2	659.8	23.6
Nursing	Substantive	1,883.5	1,953.3	1,872.5	2,057.9	185.5	1,901.5	2,075.7	174.2
	Bank & Locum Staff	132.3	143.8	124.5	2.0	-122.6	132.8	1.5	-131.3
	Agency	0.0	3.8	0.0	0.0	0.0	0.8	0.0	-0.8
	Overtime	7.4	2.1	7.2	0.3	-7.0	5.5	0.4	-5.1
	Total	2,023.2	2,103.0	2,004.2	2,060.2	56.0	2,040.5	2,077.6	37.0
Sci & Professional	Substantive	277.9	275.2	274.7	296.7	22.0	274.4	293.2	18.8
	Bank & Locum Staff	5.8	8.0	5.1	0.3	-4.8	5.5	1.0	-4.6
	Agency	0.5	0.8	0.7	0.0	-0.7	0.3	0.0	-0.3
	Overtime	0.9	1.2	0.9	0.0	-0.9	1.1	0.0	-1.1
	Total	285.1	285.2	281.4	297.0	15.7	281.3	294.1	12.9
A&C	Substantive	907.5	978.3	883.6	998.3	114.8	919.1	995.9	76.9
	Bank & Locum Staff	13.0	22.3	15.9	2.2	-13.8	13.1	2.8	-10.3
	Agency	0.7	1.6	1.5	0.0	-1.5	0.7	0.0	-0.7
	Overtime	0.7	2.8	0.8	0.8	0.0	1.4	0.8	-0.6
	Total	921.8	1,005.1	901.8	1,001.3	99.5	934.3	999.6	65.3
AHP	Substantive	536.6	556.4	533.2	602.7	69.4	542.2	600.0	57.9
	Bank & Locum Staff	2.1	4.7	1.9	0.0	-1.9	2.2	0.1	-2.1
	Overtime	4.1	3.9	3.3	0.0	-3.3	3.9	0.0	-3.8
	Total	542.8	565.0	538.4	602.7	64.2	548.2	600.2	51.9
Prof & Tech	Substantive	48.9	49.8	51.1	55.8	4.7	49.4	54.8	5.4
	Bank & Locum Staff	0.1	0.3	0.2	0.3	0.1	0.2	0.3	0.1
	Agency	1.6	7.3	1.7	0.0	-1.7	2.8	0.3	-2.5
	Overtime	2.9	4.1	3.3	0.0	-3.3	3.2	0.0	-3.2
	Total	53.5	61.5	56.3	56.0	-0.2	55.6	55.3	-0.2
Support Staff	Substantive	280.8	290.9	281.7	301.4	19.7	280.7	295.0	14.3
	Bank & Locum Staff	15.6	17.5	14.7	1.0	-13.8	16.4	1.1	-15.3
	Agency	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total	296.4	308.4	296.5	302.4	5.9	297.1	296.1	-1.0
Other	Substantive	46.1	68.6	53.4	68.9	15.5	52.8	66.6	13.8
	Total	46.1	68.6	53.4	68.9	15.5	52.8	66.6	13.8
Other	Bank & Locum Staff		0.0						
	Total		0.0						
Unallocated central funding	Substantive	0.0	0.0	0.0	-7.4	-7.4	0.0	-7.2	-7.2
	Total	0.0	0.0	0.0	-7.4	-7.4	0.0	-7.2	-7.2
Total		4,823.6	5,031.5	4,784.3	5,041.9	257.5	4,845.9	5,042.0	196.1

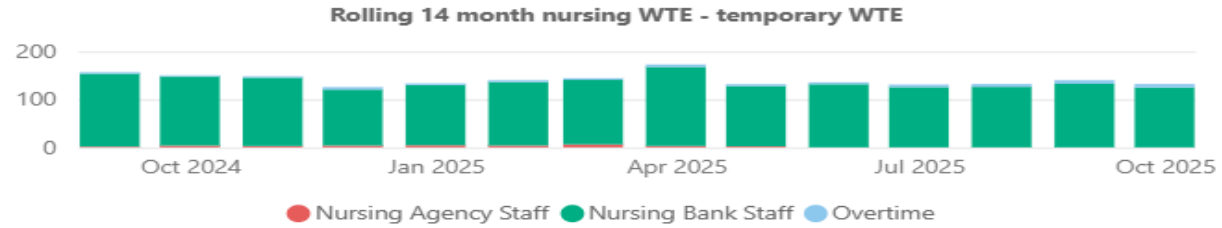
Workforce - WTE (trends)

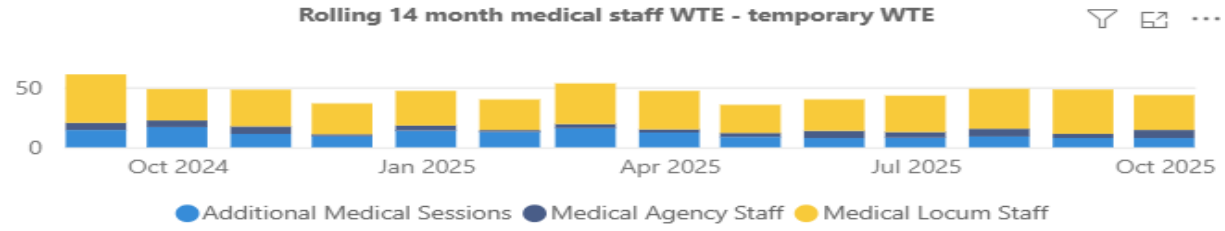


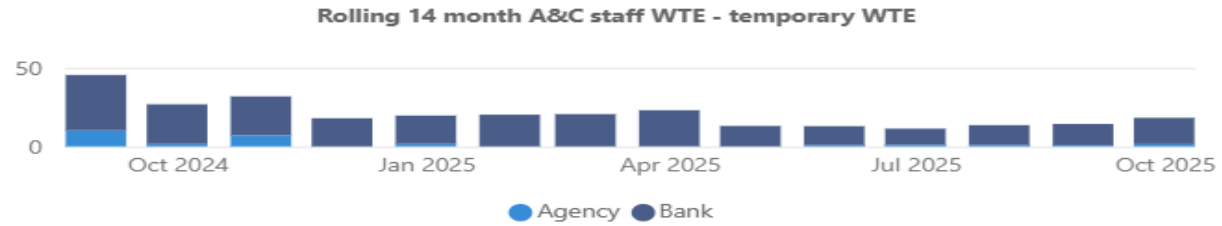


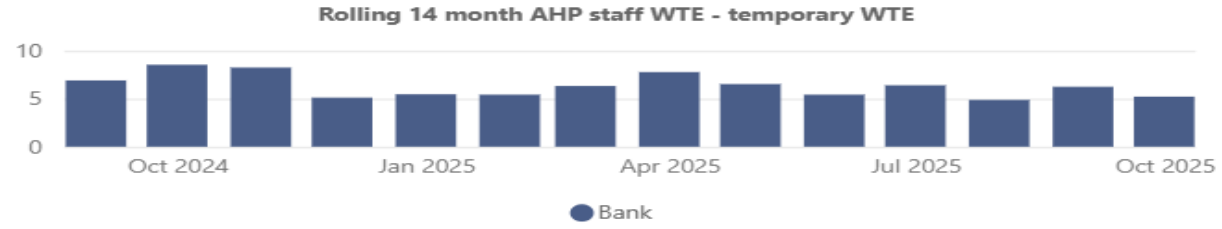












Statement of Financial Position – 31 October 2025

West Suffolk NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2025	Plan 31 March 2026	Plan YTD 31 October 2025	Actual at 31 October 2025	Variance YTD 31 October 2025
	£000	£000	£000	£000	£000
Intangible assets	54,005	44,573	47,283	50,180	2,897
Property, plant and equipment	146,062	200,307	183,096	148,508	(34,588)
Right of use assets	9,807	7,544	8,364	8,768	404
Trade and other receivables	7,162	7,158	7,158	7,162	4
Total non-current assets	**217,036**	**259,582**	**245,901**	**214,618**	**(31,283)**
Inventories	5,128	5,000	5,000	5,248	248
Trade and other receivables	18,989	21,668	21,668	22,764	1,096
Non-current assets for sale	490	490	490	490	0
Cash and cash equivalents	12,659	1,107	1,107	4,919	3,812
Total current assets	**37,266**	**28,265**	**28,265**	**33,421**	**5,156**
Trade and other payables	(41,296)	(28,250)	(31,520)	(45,777)	(14,257)
Borrowing repayable within 1 year	(4,510)	(4,627)	(4,627)	(4,305)	322
Current Provisions	(2,524)	(70)	(70)	(1,310)	(1,240)
Other liabilities	(938)	(2,685)	(2,685)	(7,501)	(4,816)
Total current liabilities	**(49,268)**	**(35,632)**	**(38,902)**	**(58,893)**	**(19,991)**
Total assets less current liabilities	**205,034**	**252,215**	**235,264**	**189,146**	**(46,118)**
Borrowings	(39,716)	(34,656)	(36,712)	(37,566)	(854)
Provisions	(385)	(400)	(400)	(418)	(18)
Total non-current liabilities	**(40,101)**	**(35,056)**	**(37,112)**	**(37,984)**	**(872)**
Total assets employed	**164,933**	**217,159**	**198,152**	**151,162**	**(46,990)**
Financed by					
Public dividend capital	326,166	390,273	368,600	327,665	(40,935)
Revaluation reserve	12,319	11,941	11,941	12,319	378
Income and expenditure reserve	(173,551)	(185,055)	(182,388)	(188,822)	(6,434)
Total taxpayers' and others' equity	**164,934**	**217,159**	**198,152**	**151,162**	**(46,990)**

The table shows the year-to-date Statement of Financial Position as at 31 October 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 slightly higher than plan due to the timing of a creditors payment run. Cash is being rigorously monitored to ensure that the Trust remains on plan and does not fall below the £1.1m limit that must be maintained and is enforced by NHS England. The Trust applied for £10m in cash support for November, but has only been awarded £5.7m. Discussions are being held with NHSE to understand why our application was rejected. The Trust has submitted an application for £8.3m of cash support in December, which includes the shortfall of support not received in November.

Trade and other payables appears to have increased significantly against plan, however the increase since the 2024/25 month 12 outturn position is much smaller at £4.5m.

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 7 had not drawn down PDC for capital projects in line with the plan.

Better Payment Practice Code (BPPC) – Month 7

October 2025		
Better Payment Practice Code	**Total bills paid YTD Performance Number**	**Total £ paid YTD Performance £'000**
Non NHS		
Total bills paid in the year	20,762	91,441
Total bills paid within target	15,593	80,412
Percentage of bills paid within target	***75%***	***88%***
NHS		
Total bills paid in the year	1,007	13,540
Total bills paid within target	430	8,174
Percentage of bills paid within target	***43%***	***60%***
Total		
Total bills paid in the year	21,769	104,981
Total bills paid within target	16,023	88,586
Percentage of bills paid within target	**74%**	**84%**
Previous month performance	**74%**	**84%**

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 7. The performance has remained stable, however we may see this performance decline as our cash balance decreases.

Capital progress report

Capital Spend - 31st October 2025	Year to Date - Month 7			Full Year		
	YTD Forecast	YTD Actual	Variance to Forecast	Full year Forecast	*Funding Split*	
Capital Scheme					*Internal*	*PDC Available*
	£000's	£000's		£000's	*£000's*	*£000's*
**New Hospital Programme	3,814	3,173	642	11,958		*14,599*
RAAC	486	536	- 50	1,340		*1,340*
Estates	3,120	1,283	1,837	6,913	*5,575*	
Digital/IT	763	1,451	- 688	3,138	*3,138*	
*Medical Equipment	248	471	- 223	619	*550*	*69*
Radiology	518	717	- 199	877	*1,215*	
Newmarket Endoscopy	777	184	593	2,133		*2,133*
Net zero	27	28	- 1	509		*509*
UEC (ED)	-	-	-	-	*1,000*	
UEC RtCS	-	-	-	3,646		*3,646*
Diagnostics RtCS	315	-	315	572		*572*
Elective RtCS	65	-	65	436		*436*
CDC Pathway	-	-	-	131		*131*
Total Capital Schemes	10,133	7,842	2,291	32,272	*11,478*	*23,435*
Capital Schemes excluding NHP	6,319	4,669	1,650	20,314	*11,478*	*8,836*
Overspent vs Plan					*34,913*	
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. Further adjustments to PDC has occurred resulting in the Capital Plan now being £34.9m. £11.5m of this is internally funded, with the remaining £23.4m being funded by Public Dividend Capital (PDC).

Year to date capital spend at month 7 is £7.8m. This is behind the phased plan.

A detailed review of the forecast capital spend for 2025/26 has been completed. All of the internally funded schemes are on track to be delivered by 31 March 2026.

For some of the other Urgent and Emergency Care (UEC) schemes, the Trust is still waiting for confirmation of funding from DHSC for £3.3m, which includes a project at Newmarket Hospital for the frailty hub, the Minor Emergency Care Unit (MECU) at West Suffolk, along with some other equipment. Due to the timing of the funding not yet being approved there is a risk that these schemes will not be delivered by 31 March 2026. All funding awarded during 2025/26 must be spent by 31 March otherwise it has to be returned to DHSC; it cannot be carried over to future years.

Some of the uncertainties around achieving the capital programme has been around the funding approval process through NHSE. For 2026/27, Estates, Finance and individual Directorates will be working much closely to ensure that the funding bids that have been submitted are achievable within the set timeframe. Bids will only be submitted for schemes that have already been designed to RIBA stage 4. This design work will be factored into the capital budget for 2026/27.

Comfort Break

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			Reporting to: Trust Board Meeting - 28th November 2025		
Chaired by: Tracy Dowling Non executive Director			Date of meeting: 15th October 2025		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To MEG / other assurance committee **3.** To Board
5.1	Patient Quality, Safety Governance Group	3. Partial	Detailed update on training ED/CCOT nurses to L2 trauma standard. Concerns regarding attendance at trauma committee. Medication safety group not assured regarding storage of patients own medicines. Partial assurance regarding use of bed rails for confused / agitated patients.	Briefing update prior to Trauma Peer Review visit to be provided. Risk assessment required of patient lockers for medicines storage to understand the size of the issue– may require some replacement. Falls lead is launching a cultural QIP for bed rail use including use of a revised risk assessment prior to use of bedrails. Overall increased use of risk assessments to guide decision making in patients' best interests.	1. No escalation
5.1.1	Nutrition performance and oversight deep dive	3. Partial	Presentation from Lucy Winstanley, and Liz Cotton. Wide ranging scope of activity to address nutrition and hydration with lots of good practice; but also identification of areas for improvement.	Presentation to be circulated as lots of detail not covered. Priority areas for action and assurance identified and Committee expects that progress will be seen in future updates to PQSG	1. No escalation

Originating Committee: Improvement Committee			Reporting to: Trust Board Meeting - 28th November 2025		
Chaired by: Tracy Dowling Non executive Director			Date of meeting: 15th October 2025		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To MEG / other assurance committee **3.** To Board
5.2	Clinical Effectiveness Governance Group	3. Partial	Summary of accreditation and audits reviewed with no escalations. Successful re-accreditation of blood transfusion services. Good progress on re-accreditation of haematology services.	Committee expects progress reports over next 2-4 months regarding national audits and national best practice.	1. No escalation
5.2.1	Research and Development annual service update	2. Reasonable	Presented by Dr Margaret Moody and Claire Barwick. 43 active studies recruiting across 14 specialties. Included 2 commercial studies.	Continue to develop research capacity. Continue to build breadth of research across trust including more patients in research activity and pursuit of more commercial studies.	1. No escalation
6.0	Quality and Safety Insight • IQPR • PRMs	2. Reasonable	No escalations		1. No escalation
7.0	Quality Priorities, Improvement and Assurance CQC Preparedness Plan	3. Partial	Jenni Kerr presented an assessment of Trust preparedness. There is good engagement from ward managers and an active improvement culture; however there is work to do to compile a repository of evidence for inspection and to ensure all colleagues appreciate what is	Gaps in preparedness assessment include a clear approach on adoption of the new Single Assessment Framework; need for a centralised evidence repository and a need for staff training on expectations. Actions to address the above in immediate and short term were approved.	2. To MEG for continued oversight

Originating Committee: Improvement Committee			Reporting to: Trust Board Meeting - 28th November 2025		
Chaired by: Tracy Dowling Non executive Director			Date of meeting: 15th October 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
			required under the Single Assessment Framework. Learning from Chief Nurses of trusts recently inspected has been shared.		
7.2	Maternity Services Update				
	Maternity Claims Scorecard	2. Reasonable	Report received detailing learning from complaints and informal patient feedback, low or no harm incidents and perinatal deaths in Q1. Actions to work with staff to continue to improve communications and compassionate care are in progress. Complaint rate 1.3%. Claims scorecard was reviewed.	Triangulation of Q1 mortality data with patient complaints has identified opportunities for improvement during periods of high clinical activity; limitations in preparedness and inconsistencies in communication and clinical decision making. There is increased oversight in neonatal care; intended to ensure proactive actions to improve safety and quality. An objective and learning culture was evident through this report. The Committee asked for review of pain control by ethnicity to investigate whether there is an ethnicity pain control gap.	3. To Board

Originating Committee: Improvement Committee			**Reporting to: Trust Board Meeting - 28th November 2025**		
Chaired by: Tracy Dowling Non executive Director			**Date of meeting: 15th October 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
	Neonatal Staffing Report	3. Partial	Report to evidence progress in meeting the neonatal nurse staffing standards. The report demonstrates some staff deficits due to inability to recruit B6 neonatal QIS nurses but Band 5 staff are being trained to B6 competence.	The action plan makes the Trust compliant with MIS safety action 4. There is a need to keep neonatal staffing and review of progress with the action plan under review. Increase use of allocate functionality to better demonstrate in charge role and QIS competency	3. To Board for final approval
	Stillbirth and Neonatal death incidence August 2024 to August 2025	2.Reasonable	A detailed review was undertaken building on previous work in prior years	No areas of concern were identified; however the evaluation of JADE and MMBRACE data will further inform.	1. No escalation
7.3	Completion of Transfer of Care Summary letters (Discharge Letters)	2. Partial	Update on progress implementing optimised approach to completing discharge summary letters within 24 hours. Performance improved from 71% to 77%	Clear and comprehensive actions to progress steady and sustained improvement. Any on-going failures will be addressed through use of data.	1. No escalation

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

6.2. Quality & Nurse Staffing Report (ATTACHED)

To Assure

Presented by Daniel Spooner

Public Board	
Report title:	**Nursing, safe staffing report: September and October 2025**
Agenda item:	
Date of the meeting:	**28.11.2025**
Sponsor/executive lead:	**Daniel Spooner: Executive Chief Nurse**
Report prepared by:	**Sarah Ward: Deputy Chief Nurse 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 September and October 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 demonstrates the potential resulting impact of these staffing levels, reviewing vacancy rates, nurse sensitive indicators, and recruitment initiatives across nursing resource management. This paper also demonstrates the nursing directorate impact on 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

- Reducing unregistered staff sickness absence level in October after a peak above 8% in September. Registered Nurse (RN) sickness absence increase in October >5%
- Overall fill rate at 90% for all shifts in M6 and M7
- CHPPD consistently improving although remain in lower quartile (model hospital)
- Successful onboarding 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 track temporary spend management and achievement of CIP whilst monitoring any potential safety implications.
Continued focus on recruitment and retention of nursing assistants.
Repeat census of community nursing using of Community Nursing Safer Staffing Tool (CNSST II)

Action Required

For assurance around the daily management and 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 : September and October 2025

1. Introduction

1.1 This paper illustrates how WSFT's nursing and midwifery resource has been managed and deployed for the months of September and October 2025 (M6 and M7). This paper presents the impact of achieved staffing levels including nurse and midwifery sensitive indicators such as falls, pressure ulcers, complaints, alongside 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) recommends 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 September and October 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 data has been submitted to NHS Digital for September and October 2025. Table 1. shows the summary of overall trust fill rate percentages for these months and for comparison, the previous four months. This is monitored at ward level as illustrated in Appendix 1a and 1b.

	Day		Night	
Average fill rate (planned Vs actual)	Registered	Care Staff	Registered	Care staff
May 2025	90%	92%	98%	98%
June 2025	92%	94%	97%	99%
July 2025	91%	96%	96%	99%
August 2025	89%	92%	95%	99%
September 2025	91%	96%	96%	99%
October 2025	90%	90%	96%	100%

Table 1.

The overall average of 'planned versus actual' staffing fill rates show a stable position across September and October (Chart 1).

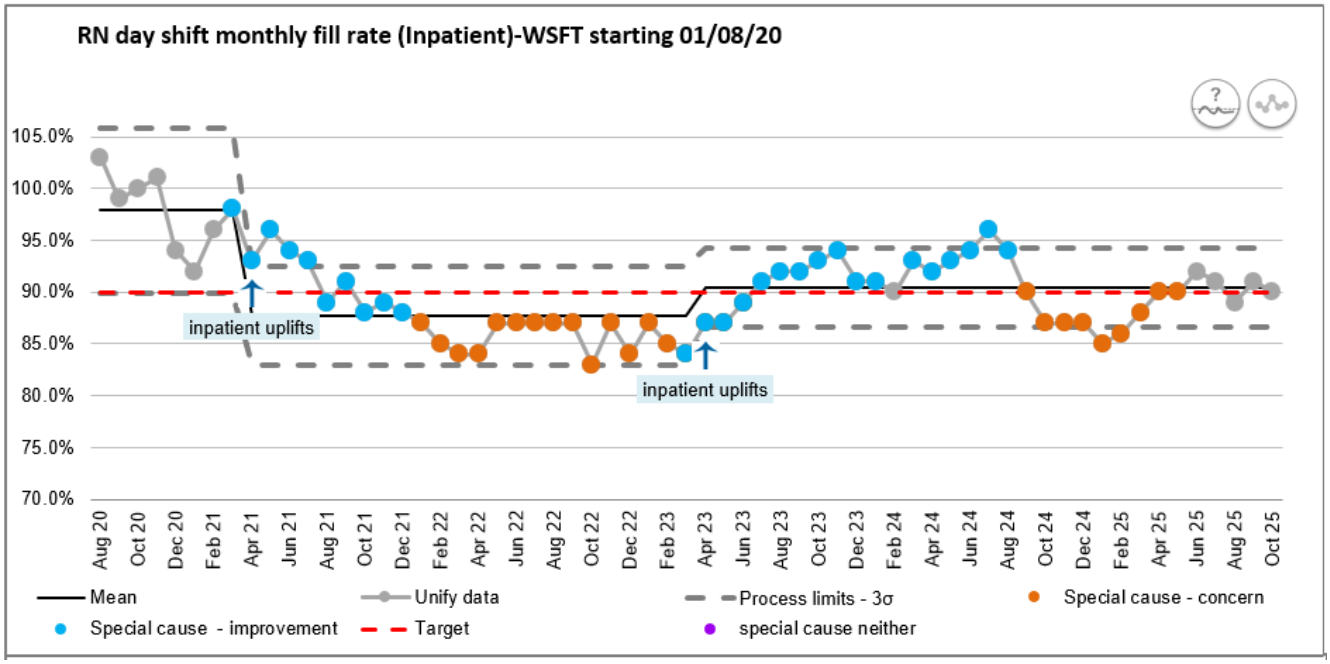


Chart 1.

3.2 **Care hours per patient day**

Model hospital data suggests that WSFT is in the lowest quartile nationally when benchmarked against 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. There has been some improvement in this position with a six place positive position change. Assumptions around high sickness, low fill rates and capacity demands would be appropriate when seeing a fall in CHPPD. September achieved CHPPD of 7.2 and October achieved 7.4.

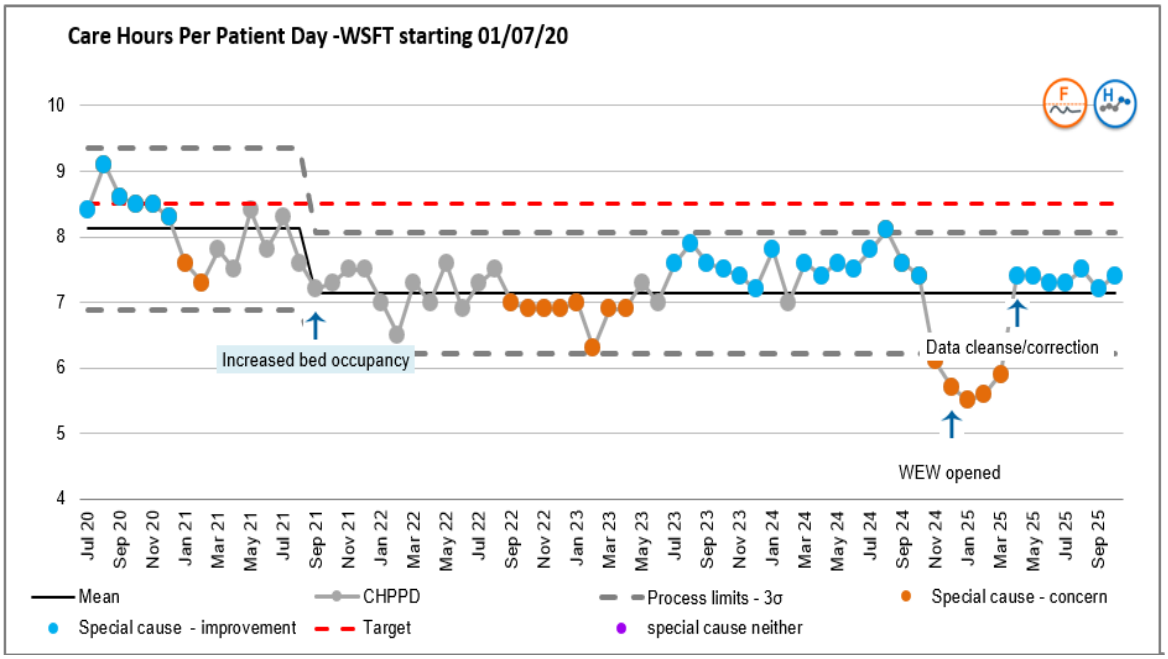


Chart 2.

3.3 **Sickness**

This period saw sickness absence in the RN/RM population remaining below 5% in September, increasing to over 5% in October. Sickness within unregistered staff remains higher than the 5% ambition, increasing to at peak of 8.57% in September, reducing to 6.79% in October (Table 2/ Chart 3).

	Mar 25	Apr 25	May 25	June 25	July 25	Aug 25	Sep 25	Oct 25
Unregistered staff (HCSW)	5.80%	6.12%	6.62%	6.77%	6.45%	6.66%	8.57%	6.79%
Registered Nurse/Midwives	5.01%	4.75%	4.43%	4.57%	4.32%	4.74%	4.61%	5.28%
Combined Registered/Unregistered	**5.26%**	**5.18%**	**5.12%**	**5.26%**	**5.01%**	**5.35%**	**5.87%**	**5.75%**

Table 2.

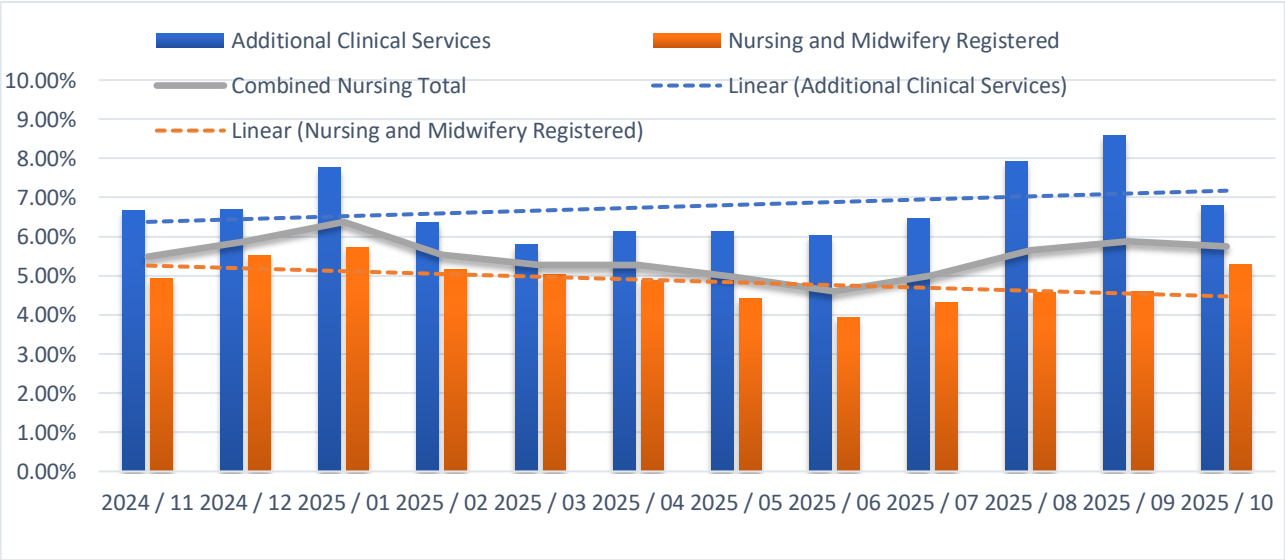


Chart 3.

3.4.1 **Recruitment and Retention**

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

Table 3 demonstrates the total RN/RM establishment for the inpatient areas in whole time equivalents (WTE). Full suite of SPC related to vacancies and WTE can be found in Appendix 3.

- **Inpatient RN/RM** vacancy percentage at M7 is **9%**
- **Total RN/RM** vacancy rate at M7 is **7.4%**
- **Inpatient NA** vacancy rate at M7 is **11.2%**
- **Total NA** vacancy at M7 is **12.2%**

	Sum of Month 2	Sum of Month 3	Sum of Month 4	Sum of Month 5	Sum of Month 6	Sum of month 7	WTE vacancy at M7
RN	711.0	707.6	706.2	695.5	691.9	689.8	79.3
NA	383.8	385.5	385.5	376.2	370.5	361.7	51.1

Table 3. Inpatient actual substantive staff WTE

3.4.2 **New Starters**

Table 4. demonstrates registered and non-registered staff commencing induction at WSFT. Induction attendance for registered nurses has increased in the last 2 months, in line with newly qualified cohorts.

	Mar 25	Apr 25	May 25	June 25	July 25	Aug 25	Sept 25	Oct 25
RN/RM	8	8	13	10	7	4	20	12
NA	8	8	11	12	10	3	3	5

Table 4: Data from HR and attendance at WSFT induction program.

- During September, 20 registrants attended induction over two dates; of these; 13 RN were for the acute and 7 for community
- During September, 3 NAs attended induction; of these; 2 NAs were for the acute Trust and 1 for community
- During October, 12 registrants attended induction; of these; 5 RNs were for the acute, 4 RN bank staff, 3 RNs for the community
- During October, 5 NAs attended induction; of these; 5 NAs were for the acute Trust

3.4.3 **Turnover**

On retrospective review of the last rolling twelve months, turnover for RNs continues to positively be under the ambition of 10%, increasing slightly to 8.8%. NA turnover continues to be over 10%.

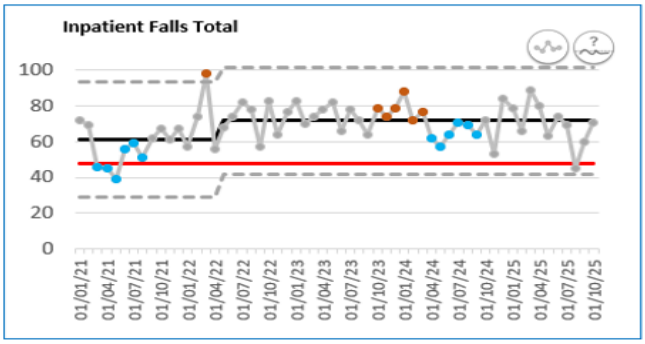
		Turnover	01/11/2024	-	31/10/2025			
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,522.00	1,335.4948	60	49.3733	135	103.9157	8.8699%	7.7811%
Additional Clinical Services	583.50	494.8746	85	77.0800	119	99.7786	20.3942%	20.1624%

Table 5. (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.



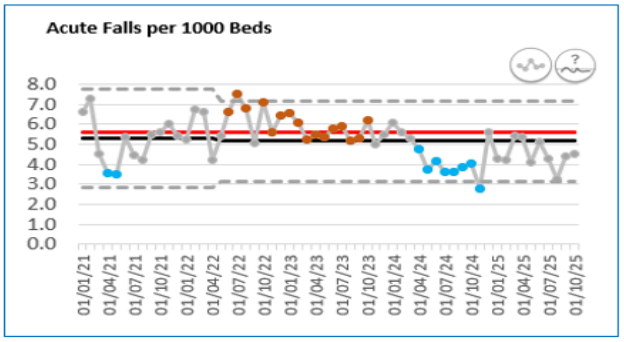
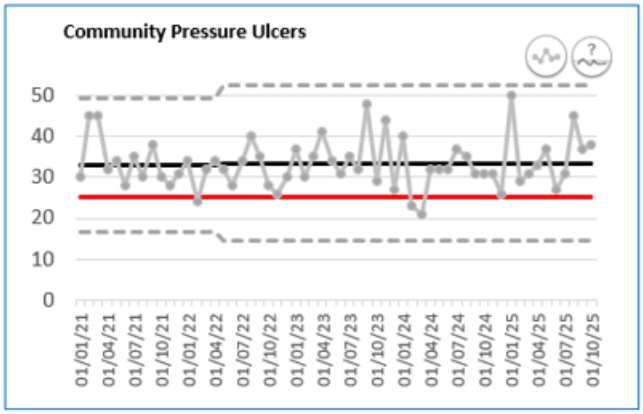


Chart 4. inpatient falls

Pressure ulcers remain in common cause variation and the spike seen in January 2025 has fallen to normal variation. A change in the validation of new pressure ulcers may be driving the increase seen in recent months.



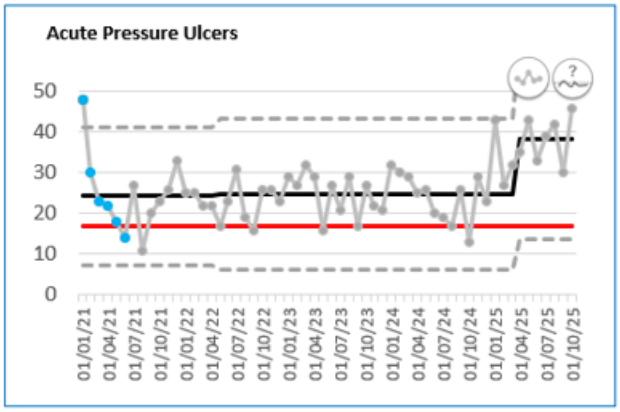


Chart 5. Pressure ulcers acquired in care

3.6 **Staffing incidents**

From the lowest point in May, staffing incidents peaked in September, with a reduction in October. (Chart 6.below).

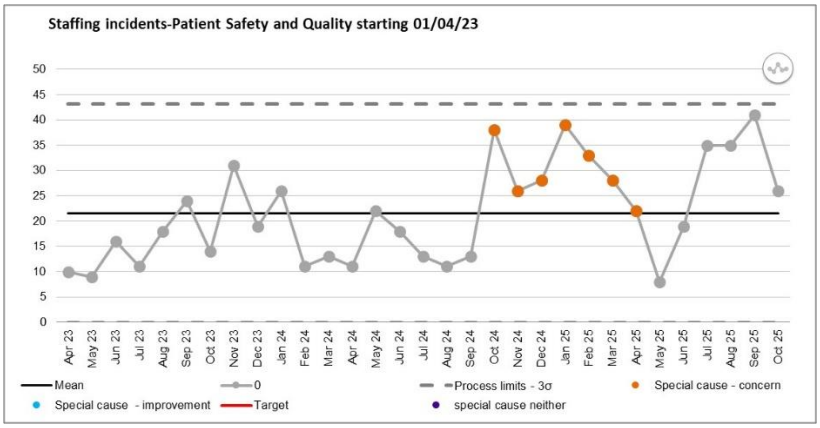


Chart 6.

Red flags as per NQB (Appendix 4) have been reported via RADAR from M9 24/25 Chart 7. September/October 2025 saw significantly more staffing incidents reported. The most common Red Flag event reported was a delay or omission of regular checks on patients in September and patient vital signs not assessed or recorded as outlined in care plans in October.

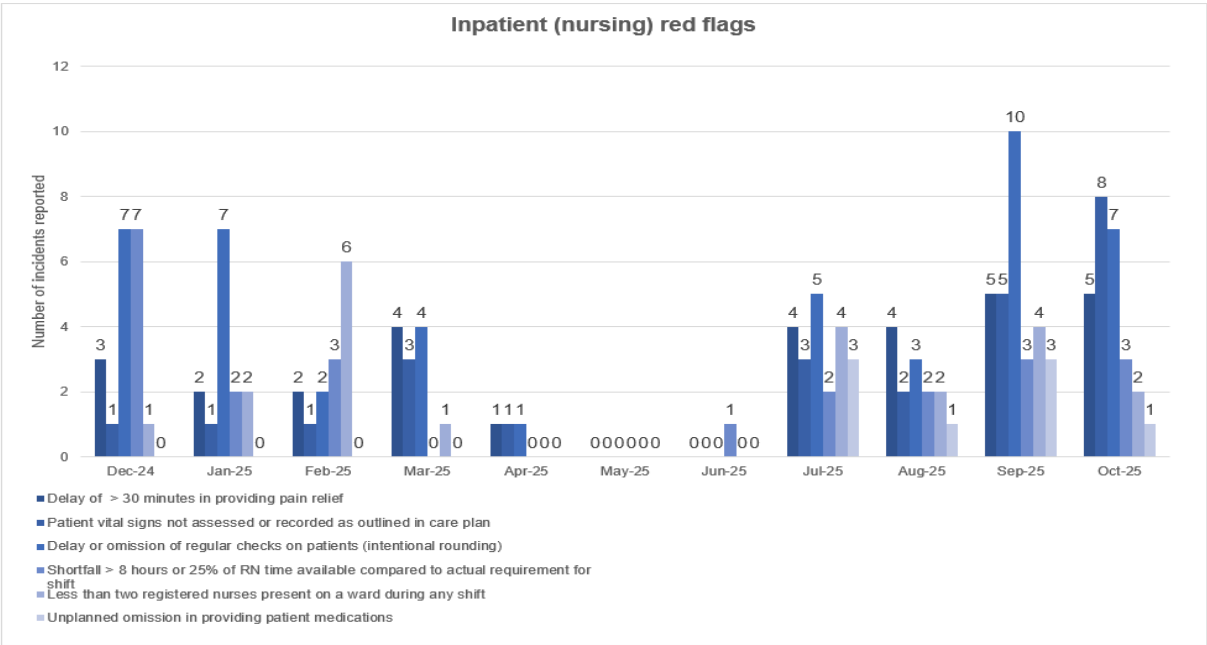


Chart 8.

3.7 **Maternity services**

A full maternity staffing report will be included in the maternity paper as per CNST requirements.

1:1 Care in Labour

NICE's guidance on safe staffing recommends safe midwifery staffing levels for women, birthing people and their babies in their chosen setting. This recommendation is also one of the ten 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 as birth can be associated with serious safety issues and can help ensure a safe experience of giving birth.

Escalation plans have been developed to respond to unexpected changes in demand. Despite September 2025 experiencing high activity, 1:1 care in labour met the required standard of 100%. This was also achieved in October 2025.

Red Flag events

NICE safe midwifery staffing for maternity settings (2015), defines Red Flag events as events that are immediate indications that something is wrong, and action is required to prevent the situation deteriorating. Action includes escalation to the senior midwife in charge of the service and the response includes allocating additional staff to the ward or unit. All Red Flag events are recorded in RADAR and addressed during the daily Maternity Safety Huddle, where they are highlighted and mitigated as necessary. **Eight** Red Flags were reported in September 2025 related to delays with induction of labour and initial assessment in Maternity Triage, **three** were reported in October 2025, all related to delay during induction of labour process and medication administration.

Midwife to Birth ratio

The latest BirthRate Plus® review was undertaken in March 2023 and illustrated that Midwife demand 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 percentage uplift for annual, sickness and 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.

- September 2025 Midwife to birth ratio demand rose to 1:23, exceeding the recommended standard. This coincided with a period of high acuity, as 206 babies were born, significantly above the monthly average of 175. Staffing sickness during this time affected care provision and contributed to the increased ratio. This did not result in any adverse outcomes.
- October 2025 midwife to birth ratio demand decreased to 1:20.

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

This is one of the Maternity Incentive Scheme Year 6 safety action 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. Labour Suite Coordinator supernumerary compliance has been maintained at 100% during this period.

	Standard	April	May	June	July	August	September	October
Supernumerary Status of LS Coordinator	100%	100%	100%	100%	100%	100%	100%	100%
1-1 Care in Labour	100%	100%	100%	100%	100%	100%	100%	100%
MW: Birth Ratio	1:21	1:19.7	1:23	1:19	1:18	1:18.8	1:23	1:20
No. Red Flags reported	NA	1	0	0	2	1	8	3

Table 6.

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

Sickness & Turnover

Sickness rate for the integrated community division remains around 5% overall in September and October. However, there are areas of high sickness above the trust target (Rosemary Ward and INT teams).

The turnover figure for the division has been rising and is above the trust target at 12% . The consultations and organisational change have impacted the high turnover, partly due to closure of Kings Suite at end of August.

Demand

The demand for community nursing services continues in special cause for concern (Chart 9). This reflects the greater transparency of demand since the change to reporting of 2 days, 2 weeks and 18 weeks was introduced in late 2023. This is the case for nursing and therapy services within INTs, and with a more or lesser degree to other integrated therapy or community services.

This demand is the same experienced nationally as the ageing population rises, the complexity of care increases and the 10-year plan priority shifts care closer to home. Nationally investment in community nursing has declined, while adult nursing in hospitals has increased by 43% in the same period. Between 2009/10 and 2023/24, there was an estimated 24% increase in the need for district nursing due to the increasing and ageing population. At current contact rates per age group, demand will increase by 34% in the next 15 years according to Nuffield trust *.

**Nuffield Trust - District nursing Research report October 2025 District nursing: Understanding the decline and mapping the future Dr Billy Palmer, Emma Dodsworth and Sophie Julia. October 2025*

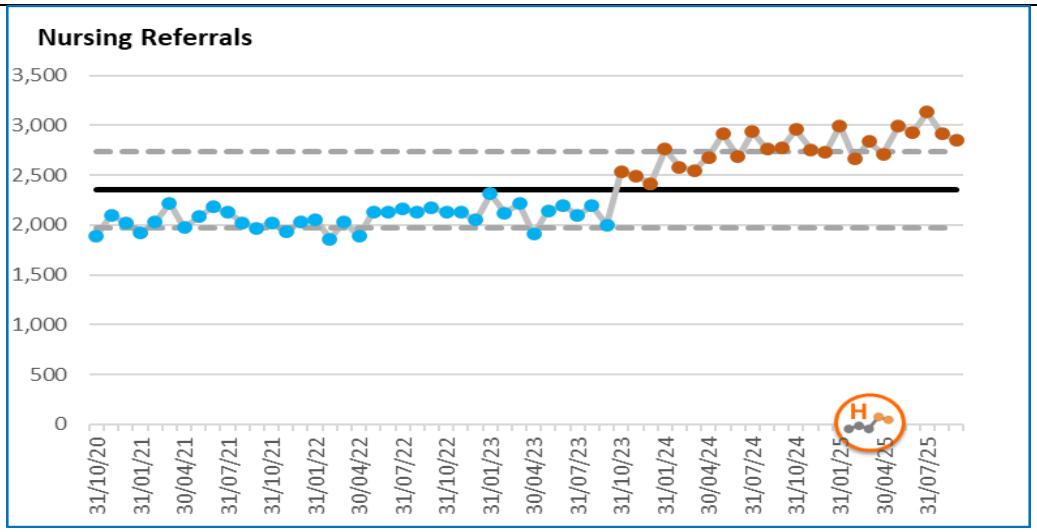


Chart 9.

The division is reviewing 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 10). 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 which shows that there is a low level of harm associated with deferring most visits. An after-action review for one patient who developed a Category 4 pressure ulcer, found deferred care could have been a contributory factor.

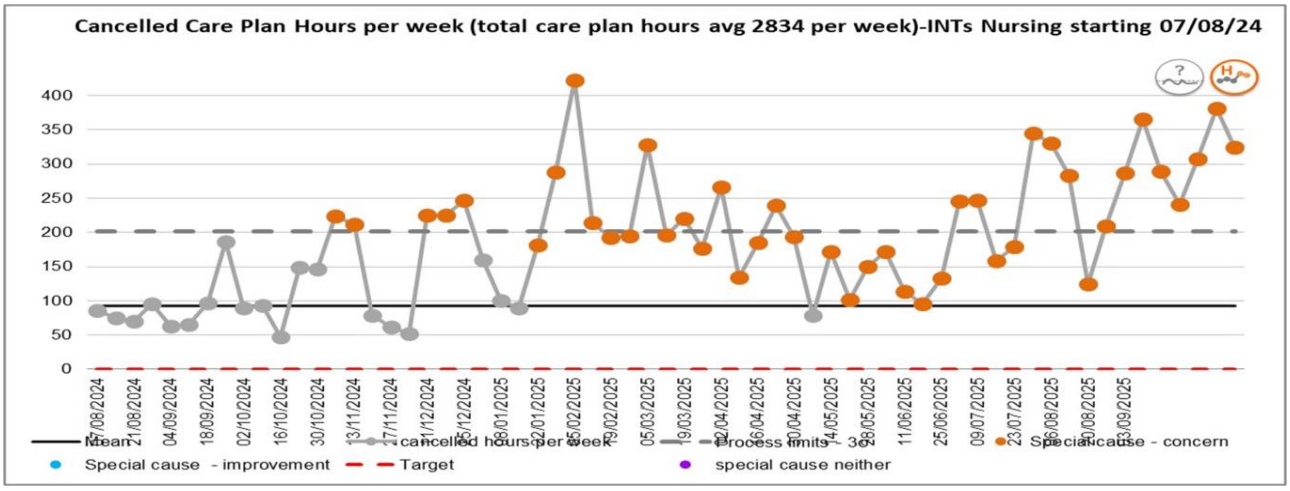


Chart 10.

CNSST II

The Community Nursing Safer Staffing Tool was relaunched this year. The recommendations are detailed below (Chart 11). Three INT teams are showing a deficit overall, and 5/5 are showing there is a deficit of unregistered staff.

The CNSST captured all activity, which at the time included 4/6 INTs carrying out virtual ward (VW) care. A paper was taken to MEG in (October 202) to consider the benefits realisation of VW investment. Exact value of budget reduction is being worked through, however any disinvestment in VW has the capacity to challenge nursing resource in the INTs through Shared Service Delivery. The results are part of the triangulation, which includes a review of quality and performance data alongside professional judgement. The outcome highlights the risk to the capacity of community nursing which was also demonstrated in the analysis from PA, and the high caseload to WTE ratio in NHS benchmarking.

	Registered Practitioners			Unregistered			Total (per Team)		
Team	Funded	Recommended	Variance	Funded	Recommended	Variance	Funded	Recommended	Variance
Bury Rural	11.76	12.89	-1.13	4.35	4.3	0.05	16.11	17.19	-1.08
Bury Town	25.27	27.51	-2.24	5.8	9.17	-3.37	31.07	36.68	-5.61
Haverhill	19.39	12.64	6.75	1.76	4.21	-2.45	21.15	16.85	4.3
Newmarket	10.03	12.14	-2.11	3	4.05	-1.05	13.58	16.19	-3.16
Mildenhall	19.76	18.52	1.24	4.88	6.17	-1.29	24.64	24.69	-0.05
Sudbury	27.15	23.87	3.28	7.5	7.96	-0.46	34.65	31.83	2.82
						Total (all INTs)	141.2	143.43	-2.78

Chart 11.

Community based actions

- Use data to reallocate resource to areas of greatest need by end of November 2025.
- Planning to repeat the Community Nursing Safer Staffing Tool (CNSSTII) in winter.
- Project to support sickness absence reduction commenced early November.
- QIA to further reduce therapist in INTs by 2.5% is being updated. There is risk, but data is limited to express impact on quality of care.
- INT teams continue to utilise daily capacity dashboard to support decision on OPEL levels and actions to mitigate risk.
- To present paper to divisional governance committee November 18th outlining safer deferral of care to be approved locally and adopted across the 6 INTS
- Work on business planning need for uplift for community nursing 2025/26.

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 (Chart 11).

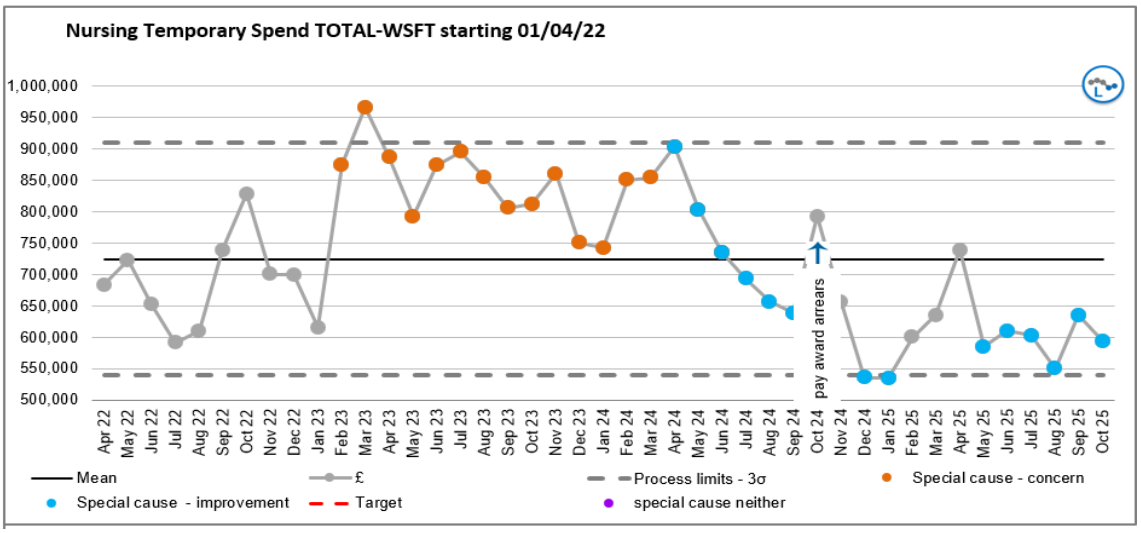


Chart 11.

4.2 **Biannual inpatient review**

The summer inpatient establishment census data is currently under review. The census data will continue to inform our assurance of nurse staffing levels .

4.3 **Qualifying Student recruitment**

During September and October WSFT welcomed newly registered nursing and midwifery colleagues as part of our ongoing commitment to support their transition into the workforce and maintain strong partnerships with educational institutions and system partners.

	This is in line with national commitments. We note the current position predicts significantly reduced cohorts for training places in the new year.
5.	**Conclusion**
5.1	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 (September 2025) Data adapted from NHSE Unify submission.
RAG: Red <79%, Amber 80-89%, Green 90-100%, Purple >100

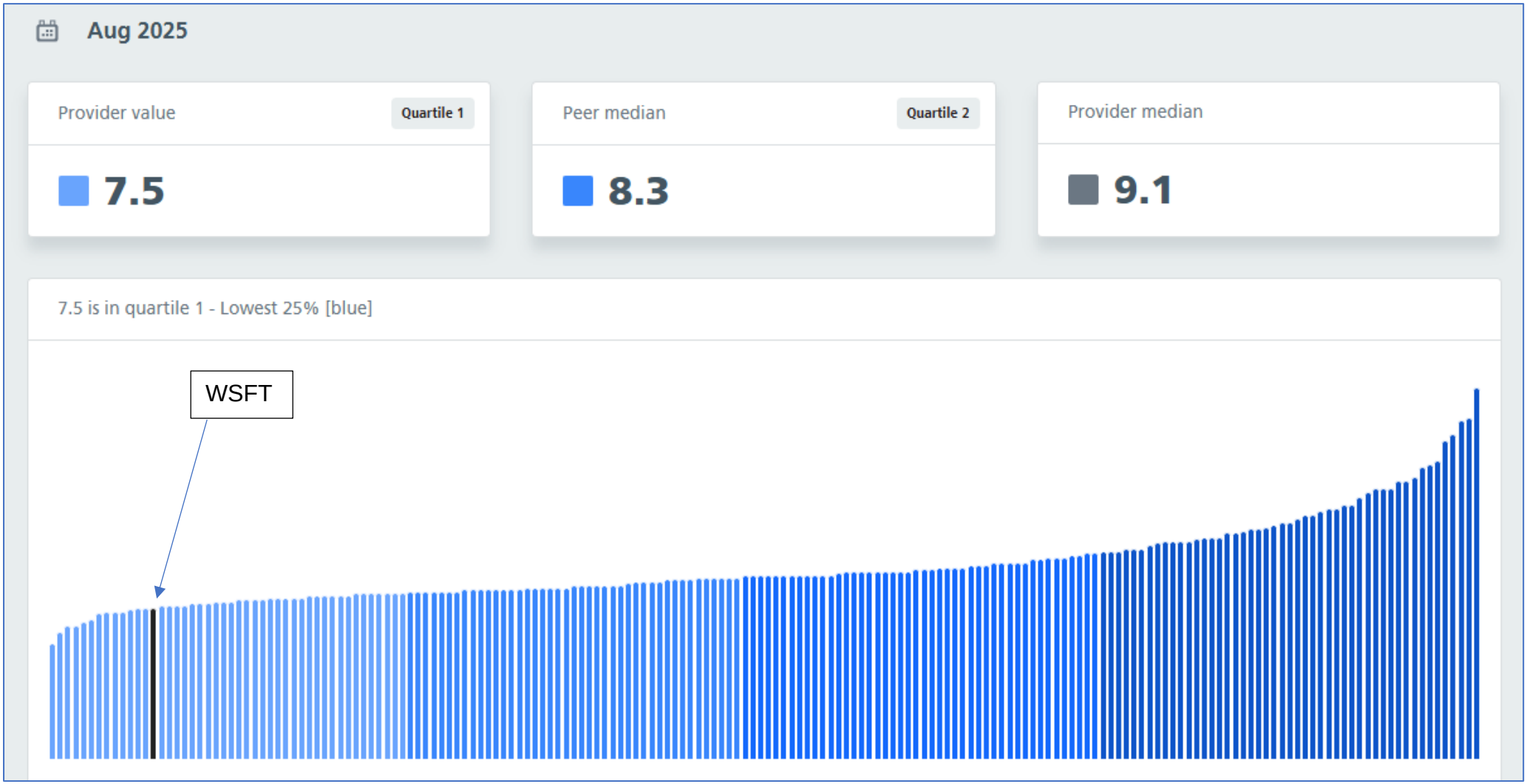
	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned 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	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1380	1317.7	1783.25	1599	1069.5	1068	1426	1389	95%	90%	100%	97%	891	2.7	3.4	6.1
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	1681.9	1337.5	1338.8	98%	98%	98%	100%	679	5.8	4.7	10.5
Cardiac Centre	1782.5	1551.8	1057.5	914.5	1782.5	1666	710	684.5	87%	86%	93%	96%	637	5.1	2.5	7.6
G10	1772.8	1482.4	1782	1687.8	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	6.5
F12	713	706.8	356.5	349.8	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	6.0
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	1452.8	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	939.3	1046.5	897.5	793.5	812.5	99%	87%	86%	102%	585	3.4	3.0	6.4
G8	2317.8	1847.8	1783	1526.3	1713.5	1686.4	1069.5	1058.2	80%	86%	98%	99%	865	4.1	3.0	7.1
F8	1674	1547.3	1761	1560	1068	1011.5	1426	1406	92%	89%	95%	99%	0	-	-	-
Critical Care	2314.7	2279.8	145.75	144.3	2302.5	2179.3	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	839.9	598	531.5	655.5	561	368	258.75	90%	89%	86%	70%	173	8.1	4.6	12.7
F5	1426	1450.9	1400	1386.8	1069.5	1078.5	1069.5	1208	102%	99%	101%	113%	510	5.0	5.1	10.0
F6	1587.5	1523.5	1647.75	1530.8	1068	1065.5	1390	1371.5	96%	93%	100%	99%	961	2.7	3.0	5.7
Neonatal Unit	1799.5	1728	372	436.5	1116	1142	647	539	96%	117%	102%	83%	346	8.3	2.8	11.1
F1	1998.3	1683.3	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	12.7
Total	33,760.10	30,575.60	26,650.25	25,115.10	25,941.50	24,947.60	20,397.50	20,491.25	**91%**	**96%**	**96%**	**99%**	**14,070**	**3.9**	**3.2**	**7.2**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

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

	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	1438.5	1311.833333	1782.25	1517	1067	1068.5	1426	1328	91%	85%	100%	93%	956	2.5	3.0	5.5
Acute Assessment Unit	2388	2311	2099.5	1872.5	1782.5	1756	1409	1414.8333	97%	89%	99%	100%	870	4.7	3.8	8.5
Cardiac Centre	1771	1563.5	1066.5	832.5	1782.5	1656	701.5	644	88%	78%	93%	92%	656	4.9	2.3	7.2
G10	1780.5	1483.583333	1783	1607.167	1069.5	1045	1782.5	1600	83%	90%	98%	90%	981	2.6	3.3	5.8
G9	1782.5	1640	1421	1305	1426	1357	1069.5	1058	92%	92%	95%	99%	825	3.6	2.9	6.5
F12	714	720.9166667	356.5	318.5	713	696.333333	356.5	321.5	101%	89%	98%	90%	236	6.0	2.7	8.7
F7	1686.5	1421.5	1766.5	1581.667	1366.5	1176	1777.5	1644.5	84%	90%	86%	93%	1041	2.5	3.1	5.6
G1	965.5	723.5	356.5	322	713	701.5	356.5	348.5	75%	90%	98%	98%	369	3.9	1.8	5.7
G3	1725	1449	1779	1841	1069.5	1069.5	1422	1594	84%	103%	100%	112%	1012	2.5	3.4	5.9
G4	1778	1517.5	1782.5	1623	1069.5	989	1426	1488	85%	91%	92%	104%	983	2.5	3.2	5.7
G5	1492	1435.5	1758	1511	1069.5	1006	1437.5	1514.75	96%	86%	94%	105%	985	2.5	3.1	5.6
G8	2280.5	1741.833333	1845.75	1558.283	1759.5	1627.58333	1069.5	1131.7167	76%	84%	93%	106%	867	3.9	3.1	7.0
F8	1781	1466.416667	1782.5	1548	1069.5	1021.5	1426	1448.5	82%	87%	96%	102%	0	-	-	-
Critical Care	2688.5	2501.25	112.5	110.25	2576	2558.41667	0	34.5	93%	98%	99%	*	263	19.2	0.6	19.8
F3	1778	1514.5	1771	1581.5	1069.5	1059.5	1426	1383	85%	89%	99%	97%	981	2.6	3.0	5.6
F4	705.5	923.5	529	422.25	713	690	0	23	131%	80%	97%	*	219	7.4	2.0	9.4
F5	1423.25	1383	1378.25	1284.75	1058	1013.33333	1069.5	1054.5	97%	93%	96%	99%	478	5.0	4.9	9.9
F6	1608	1439.5	1639	1466.25	1063	1017.83333	1403	1357.5	90%	89%	96%	97%	951	2.6	3.0	5.6
Neonatal Unit	1639.5	1669	330	479.5	1099.5	992.5	408	615.5	102%	145%	90%	151%	267	10.0	4.1	14.1
F1	2233.5	1938.75	713	684.5	1426	1382	0	52.75	87%	96%	97%	*	284	11.7	2.6	14.3
F14	372	366.5	372	373	744	741.5	0	0	99%	100%	100%	*	114	9.7	3.3	13.0
Total	34,031.25	30,522.08	26,424.25	23,839.62	25,706.50	24,625.00	19,966.50	20,057.05	**90%**	**90%**	**96%**	**100%**	**13,338**	**4.1**	**3.3**	**7.4**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

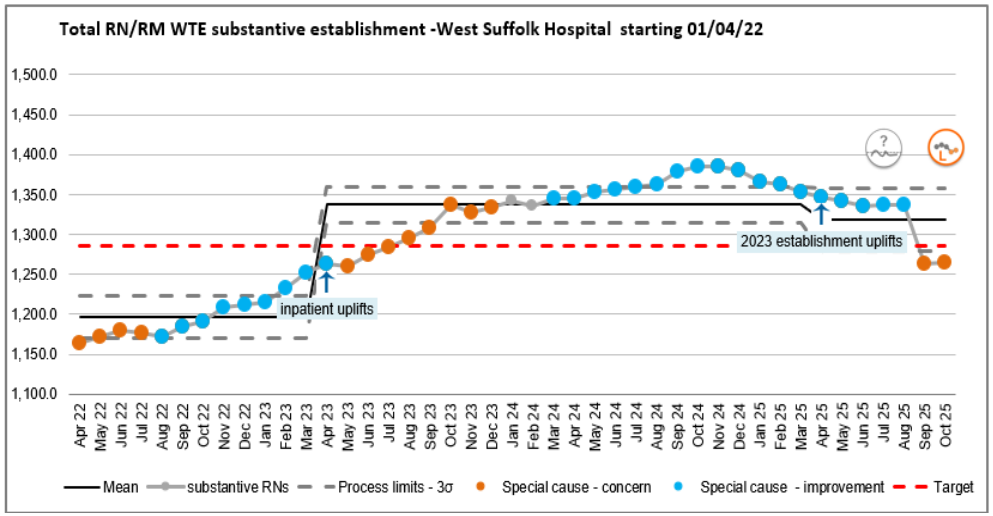
Appendix 2. CHPPD Model Hospital data (August data accessed 14.11.25)

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.

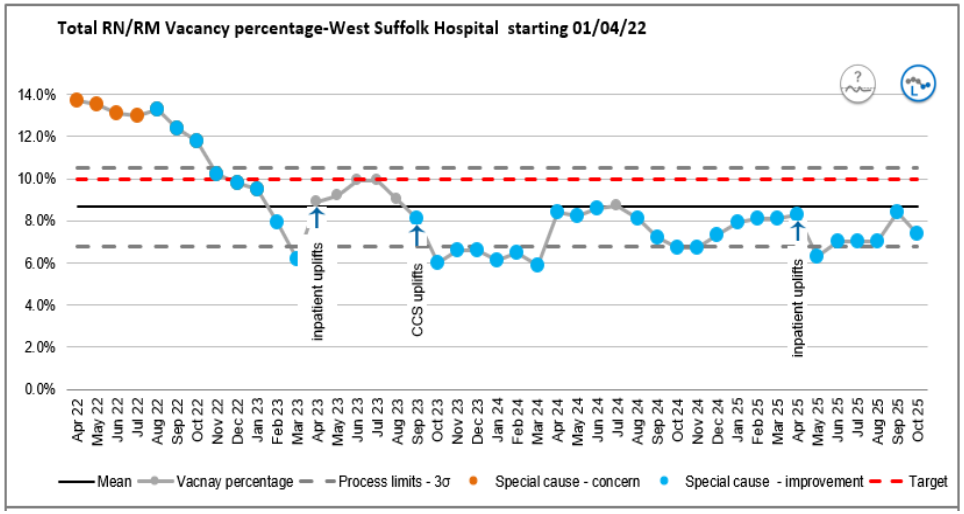


Appendix 3 WTE and Vacancy rates.

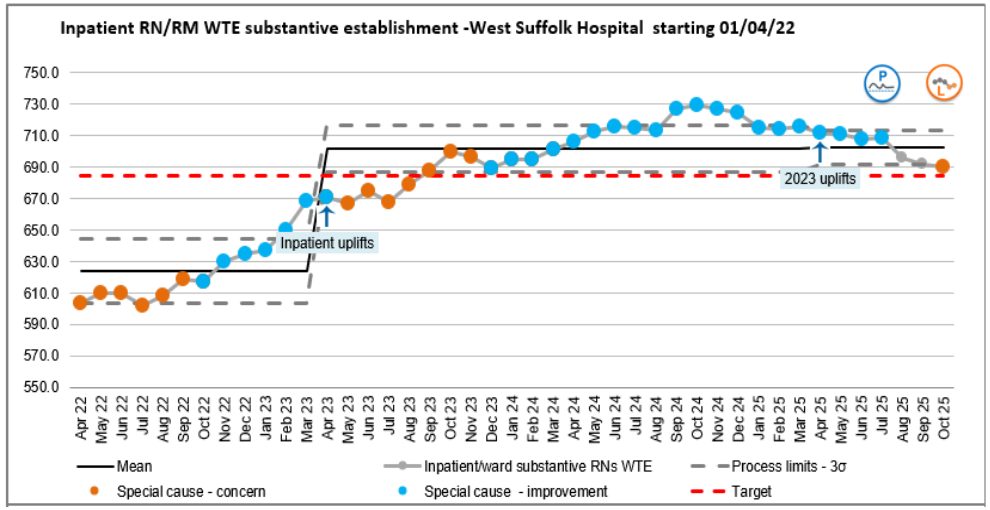
A) Trust Total RN/RM WTE



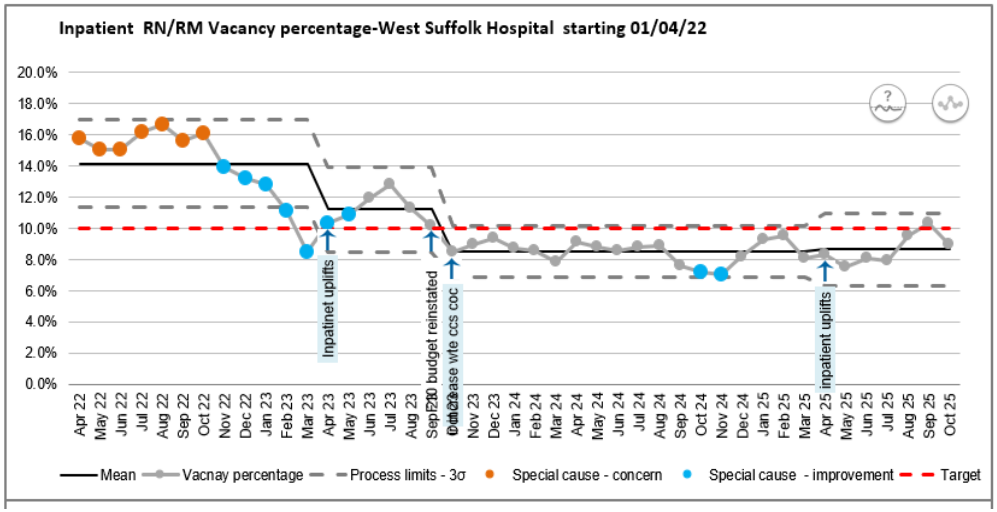
B) Trust Total RN/RM vacancy %



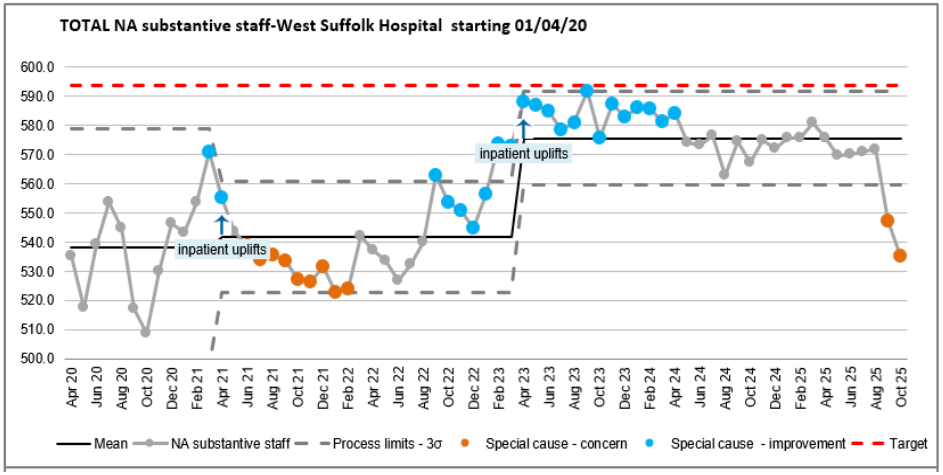
C) Inpatient RN/RM WTE



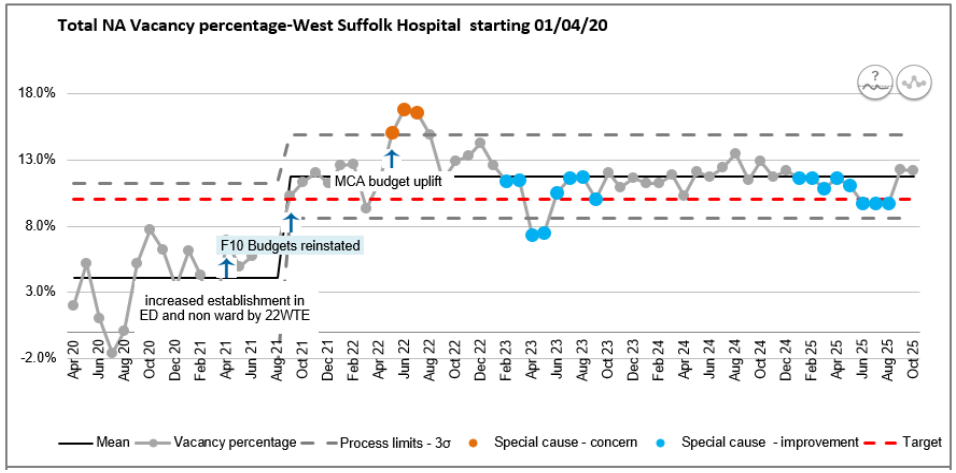
D) Inpatient RN/RM vacancy %



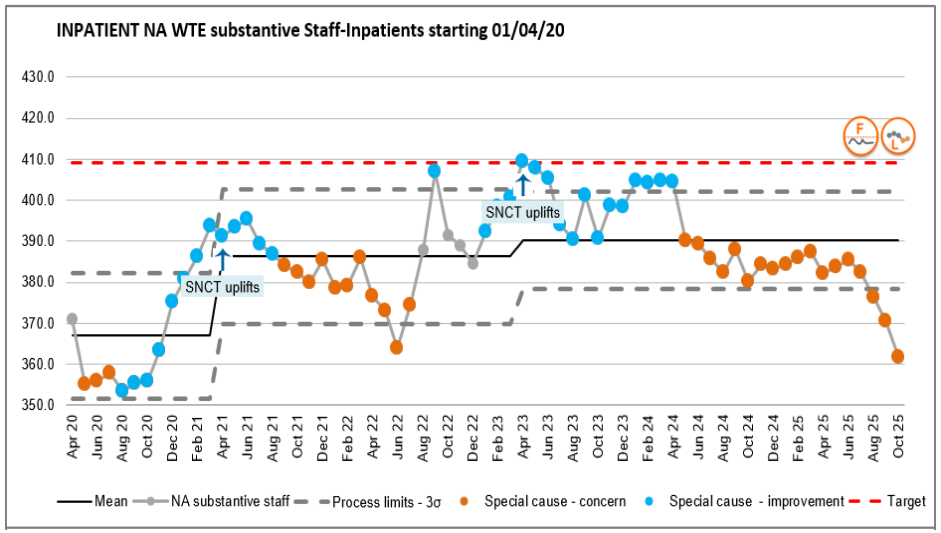
E) Total NA/unregistered WTE.



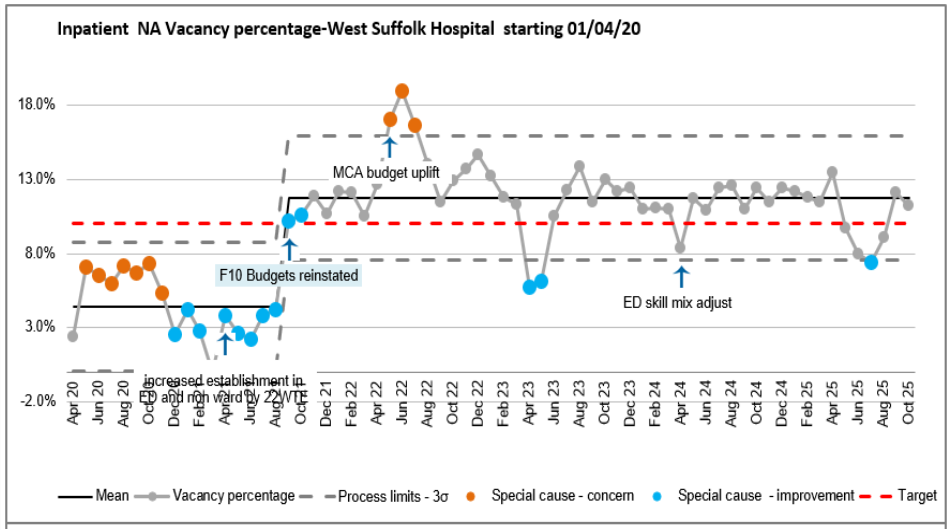
F) Total NA/Unregistered vacancy %



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. CQC preparedness (ATTACHED)

To Assure

Presented by Daniel Spooner

Committee/Group	
Report title:	CQC preparedness update
Agenda item:	TBC
Date of the meeting:	TBC
Lead:	Daniel Spooner, Executive Chief Nurse
Report prepared by:	Jenni Kerr, Corporate Quality Lead

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

Executive Summary
WHAT? *Summary of issue, including evaluation of the validity the data/information*
The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. Intelligence indicates a high likelihood of an inspection. A CQC preparedness framework is in place and implementation has commenced.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
Findings highlight both strengths and gaps in our current readiness. Addressing these gaps is critical to our regulatory compliance, maintaining patient safety, and protecting the Trust's reputation.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
Immediate actions include: • Full rollout of the CQC preparedness framework and evidence repository. • Targeted staff engagement and confidence building measures. • Ongoing monitoring through PRM meetings and quarterly Board updates. • Review and adapt processes following the CQC consultation outcome in December 2025.
Recommendation / action required
The Board is asked to note progress, endorse the proposed actions, and seek assurance through future updates.

Previously considered by:	Improvement Committee, October 2025
Risk and assurance:	Failure to address identified gaps could result in regulatory non-compliance, and reputational damage.
Equality, diversity and inclusion:	All actions within the preparedness framework apply consistently across staff groups.
Sustainability:	Embedding preparedness into routine governance processes ensures long-term sustainability of standards beyond the inspection cycle.
Legal and regulatory context:	CQC Single Assessment Framework (www.cqc.org.uk)

	CQC preparedness update
1.	**Introduction**
1.1	The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. The trust must demonstrate services meet fundamental standards. This report provides an update on regulatory preparedness and assurance activities in anticipation of a potential inspection. The report outlines insights gained from peer reviews, external feedback, as well as the actions underway to strengthen compliance and readiness across the trust.
2.	**CQC activity**
2.1	Local intelligence suggests a high likelihood of inspection following recent visits to ESNEFT and Princess Alexandra (Harlow). Insights from ESNEFT have been cascaded to nursing teams, highlighting key compliance priorities: • Documented cleaning of drug trolleys • Evidence of fridge temperature monitoring • Verification of drug expiry dates • Regular checks of resuscitation trolleys • Clear evidence of SOP adherence and risk assessment compliance Engagement meetings with CQC recommenced in Q3, strengthening relationships post-restructure. CQC remains on track to publish 9,000 assessment reports by September 2026, signalling sustained regulatory activity.
3.	**Peer review findings and themes**
3.1	All divisions have been completing bespoke programs of reviews and peer assurance visits Recent internal reviews identified three strategic themes: Knowledge and training • Variable understanding of MCA and DoLS; targeted education required. • Additional training on siderail safety protocols. Operational standards • Inconsistent completion of safety crosses; proposal to transition to quality dashboards. • Sharps bins left open; excessive posters requiring rationalisation. • Observation machines without wipes; wet floor signage left out unnecessarily. Culture and confidence • Many leaders within clinical areas have never experienced a CQC inspection/visit Confidence in engaging with inspectors varies; newer teams require support.
4.	**Next steps**
4.1	A CQC preparedness framework has been implemented to support WSFT readiness, and implementation is underway. The WSFT framework provides clear, step-by-step guidance for staff on interpreting the CQC Single Assessment Framework (SAF), evidencing compliance, and identifying any gaps and areas for improvement. On 10th November, the Executive Chief

	Nurse, Head of Patient Quality, and Corporate Quality Lead met with all Heads of Nursing to agree a consistent approach and explain details regarding the central evidence repository. The implementation of this framework has commenced with good engagement from senior team. Regular reviews through the corporate nursing forum will assess progress and keep momentum. A dedicated SharePoint site has been established by the Corporate Quality Lead for senior nursing leads initially, with plans to extend access trust-wide as part of a broader communications strategy. Readiness and learning will be monitored through PRM meetings going forward. The communications team is developing an engagement plan covering pre, during, and post-inspection phases, with messaging expected to commence in January. Additionally, a concise staff handbook is being prepared to support ongoing preparedness and build confidence for staff in knowing what will be expected during a visit. Regulatory horizon scanning will continue, and the preparedness framework along with supporting materials will be updated to reflect any anticipated changes. Opportunities for a longer term plan, for sustained CQC preparedness, will dovetail with the roll out of the care accreditation program that is currently being scoped and piloted within a number of clinical areas, led by the deputy chief nurse.
5.	**Conclusion**
5.1	The trust has taken proactive steps to enhance inspection readiness, including implementing a structured CQC preparedness framework, strengthening governance oversight. While peer reviews have highlighted areas requiring further attention, plans are in place on a divisional level to address these gaps. Continued monitoring through PRM meetings, a dedicated evidence repository, and a comprehensive communications strategy will ensure sustained progress. The trust remains committed to achieving compliance with the CQC Single Assessment Framework and maintaining high standards of patient safety and quality.
6.	**Recommendations**
	The Board is asked to note progress, endorse the proposed actions, and seek assurance through future updates.

Appendix A

Snapshot of WSFT CQC Preparedness framework

Contents

Overview of the CQC Single Assessment Framework

The CQC Single Assessment Framework is structured around five key questions that will be used to assess the care delivered for patients across our organisation.

These questions are designed to evaluate whether we are:

- Safe
- Effective
- Caring
- Responsive to people's needs
- Well-led

Each of these questions is supported by a set of **quality statements** within the framework. These statements serve as the criteria against which our responses will be assessed and represent the standards we are expected to uphold. They are articulated as "I" and "we" statements in the framework to reflect the behaviours and practices required to deliver high-quality, person-centred care.

Snapshot of WSFT assessment template

DEPARTMENT OR SPECIALITY GROUP	[DEPT NAME]	LAST REVIEWED	REVIEWER/ROLE	NOTE: Please see instruction tab for information on how to fill in this form.
		[DATE]	[REVIEWER/ROLE]	

KEY QUESTION:	SAFE									
	SECTION A - ASSESSMENT FRAMEWORK - DEFINITION OF CRITERIA (REFERENCE ONLY)				SECTION B - EVIDENCE - (REQUIRES YOUR INPUT)				NEXT STEPS - (REQUIRES YOUR INPUT)	
	SF1									
	LEARNING CULTURE									
CONSIDERATIONS	QUALITY STATEMENT :		We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.	EVIDENCE CATEGORIES		WHAT ARE OUR SOURCES OF EVIDENCE?	LINK TO AN INTERNAL DOCUMENT (if applicable) - Please note there is an evidence folder next to this form if needed	IS QUALITY STATEMENT MET Please Select from the drop down menus	ACTION	RESPONSIBILITY
I STATEMENTS										
1 I feel safe and am supported to understand and manage any risks.	tement means	1	Safety is a top priority that involves everyone, including staff as well as people using the service. There is a culture of safety and learning. This is based on openness, transparency and learning from events that have either put people and staff at risk of harm, or that have caused them harm.	1	People's experience	Assessed before/during inspection				
				2	Feedback from staff & leaders	Assessed before/during inspection				
				3	Processes					
2 I can get information and advice about my health, care and support and how I can be as well as possible - physically, mentally and emotionally.		2	Risks are not overlooked or ignored. They are dealt with willingly as an opportunity to put things right, learn and improve.	1	People's experience	Assessed before/during inspection				
				2	Feedback from staff & leaders	Assessed before/during inspection				
				3	Processes					
			People and staff are encouraged and supported to raise concerns, they feel confident	1	People's experience	Assessed before/during inspection				

6.4. 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:	28th November 2025
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	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
Please indicate Trust strategy ambitions relevant to this report.	☒	☒	☒

Executive Summary

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

This report 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 Q2 July – September 2025
  - Maternity and Neonatal Safety Investigations (MNSI) Q2 July – September 2025
- Next steps

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

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

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.

Recommendation / action required

For assurance and information.

Risk and assurance:	To provide a systematic approach to the oversight of perinatal services
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.

Perinatal 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.

In October 2025, NHS England wrote to all Trusts with Maternity services to outline the next steps to support going further and faster to improve maternity and neonatal care by;

1. Perinatal Equity and Anti-Discrimination Programme: this will give perinatal teams the skills and tools they need to improve the experiences and outcomes of ethnic minority groups and those from deprived communities, and to improve the working lives of staff from these groups. The programme's focus is on effecting the behavioural, cultural and organisational changes needed to tackle inequalities and sustain change. The programme will be phased intakes, rolled out over the next 18 months. To date we have not heard when our onboarding will take place.

2. Submit a Perinatal Event Notification service (SPEN): this portal streamlines the administrative time required by frontline staff to notify perinatal safety events to MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries Across the UK); Maternity and Newborn Safety Investigations; and NHS Resolution Early Notification Scheme. SPEN is now live and being utilised at our trust.

3. Maternity and Neonatal Performance Dashboard: This set of metrics will be used to monitor performance in maternity and neonatal services in all parts of the system, supporting trusts and integrated care boards to monitor and have insight into their own progress. The dashboard represents a balanced scorecard of operational, outcome and patient experience measures. This data is already shared with NHSE regional team, whilst a national digital format is being processed.

4. Maternity and Neonatal Improvement Support Team: will replace the current Maternity Safety Support Programme (MSSP) and will have the additional focus of neonatal,
as well as maternity, expertise. The team will support trusts to develop diagnostic, and improvement plans for their maternity services, including a focus on tackling inequalities. It will also be supported by lived experience experts to ensure trusts are able to hear and respond to service user feedback effectively. The team will work in partnership with regional teams, neonatal operational delivery networks aligning with

	improvement teams in other areas, to provide more timely diagnostics and bespoke improvement plans supporting trusts in leading and sustaining their own change efforts. This is for maternity and neonatal services that meet the criteria for additional support. WSFT maternity services exited the MSSP in October 2022.
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 (60SS) visit on the 31st of January 2025, to provide a systematic review of the Trust's maternity and neonatal service. We are awaiting the regional team to launch an updated version of 60SS before being notified of our next visit. 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'. Paul Zollinger-Read (Non-Executive Director, Mat/Neo Safety Champion) visited the Birthing unit and Labour Suite on the 21st October 2025 and spoke with a range of staff, where the only concern raised was regarding the covering of staff sickness in the current financial climate without agency staff. Safe staffing is always a Trust priority and in regard to those specific staffing shortfalls, backfill has been met without the need of agency staff. Richard Goodwin (Medical Director and Executive Mat/Neo Safety Champion) has undertaken ad hoc staff engagement events over September and October, to incorporate all areas relating to maternity and neonatal services. Questions were asked regarding a specific case, which are being addressed in a confidential way, adhering to Trust values and processes. Board Safety Champions meet with the perinatal leadership team at least bi-monthly to review progress and determine whether additional Trust Board support is required. Any escalations are formally recorded in the Safety Champion Action Log and monitored through the monthly Maternity/Neonatal Safety Champion meeting. The leadership

	team have raised their ongoing concerns regarding the plans for the new hospital, specifically in relation to perinatal services. These concerns are being actively reviewed and escalated accordingly.
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. The 2024 National Staff Satisfaction Survey identified 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. The 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, supported by our in-house Culture Coaches, continues to drive improvements in safety culture and deliver on our aspirations across the service in relation to the above aspirations by; With ongoing support from Health Innovation East, two 'Enabling a Coaching Culture' workshops have been scheduled for November and December 2025. These sessions are open to all staff within the perinatal service and will provide practical tools to strengthen communication and embed a coaching mindset In September, we launched the Perinatal Award Ceremony nominations (previously focused solely on midwifery) to reinforce that every member of the perinatal team is a

valued contributor. The ceremony took place on 14 November, celebrating outstanding achievements across all areas and disciplines within the service.

In collaboration with the Trust's Learning and Development team, we are preparing to launch a Reverse Mentoring and Sponsorship Programme in the new year. This initiative aims to foster inclusive leadership, broaden perspectives, and support career development across the workforce

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	September Survey Responses	September Very good and good %	% of discharged people provided feedback*	October Survey Responses	October Very good and good %	% of discharged people provided feedback*
F11	44	97%	11%	22	91%	6%
Labour Suite	15	100%	70%	1	100%	4%
Birthing Unit	6	83%	33%	3	100%	14%
NNU	0	-	0%	0	-	0%
Antenatal	24	88%		35	94%	
Postnatal Community	18	94%		28	86%	

*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 compliments, complaints, 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. The first MNVP meeting was held in September 2025, and the follow-up is planned for November 2025.

	In terms of patient experience, WSFT received three compliments relating to maternity and neonatal services in September 2025. However, in October 2025, this decreased to one compliment regarding the antenatal and postnatal ward F11. In September 2025, three PALS enquiry were submitted concerning patient care, clinical treatment, and communication on Labour Suite and ward F11. In October 2025 two enquiries were received, covering issues related to patient care. No formal complaints were received in September 2025. However, this increased to five in October 2025, primarily focused on patient care, treatment and access to medication. 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** The table below demonstrates referrals to the Maternity and Neonatal Safety Investigation (MNSI) programme and the number of overall patient safety incidents.

	September 25	October 25
No. of MNSI referrals	0	0
No. of Patient safety incidents	117	73

A detailed review has been undertaken following the increase in reported safety incidents during September. While birth activity was higher in this period, the rise in incident reports is not considered proportionate to activity levels. It is important to note that not all reported incidents reflect adverse outcomes or deficiencies in care delivery. National and regional guidance actively promotes the reporting of maternity triggers to strengthen transparency and standardisation in safety monitoring. The overall increase is primarily attributable to a higher number of 'maternity-triggered incidents' rather than a rise in harm-related events. Ongoing surveillance will continue to identify any emerging themes and ensure timely action is taken to mitigate potential risks.

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.**

Oct 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 3 yearly	Shared Decision Making
Midwives	99.6%	91.7%	94.97%	94.97%	97%	100%	94.97%	96.8%	85%	90%
MCA/MSW	N/A	N/A	97.6%	97.6%	92.2%	100%	97.6%	N/A	88%	N/A
Consultant Obstetrician	93.75%	87.5%	87.5%	87.5%	87.5%	99%	N/A	100%	N/A	100%
Obstetric Registrar	90%	90%	90%	90%	100%	89%	N/A	70%	N/A	100%
SHO/Core trainees	88.9%	88.9%	100%	100%	100%	92%	N/A	N/A	N/A	88.8%
Sonographer	N/A	84.3%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Consultant Anaesthetist (obs)	N/A	N/A	58.6%	58.6%	N/A	N/A	N/A	N/A	N/A	N/A
Obstetric Anaesthetists	N/A	N/A	72%	72%	N/A	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	67%	
Neonatal Nurses	N/A	N/A	N/A	74%	N/A	86.5%	92%	N/A	89%	
Neonatal Doctors	N/A	N/A	N/A	No Data	N/A	100%	92.9%	N/A	47%	
ANNP/PA	N/A	N/A	N/A	No Data	N/A	100%	100%	N/A	100%	

RAG	Standard	Actions
	Above 90%	Maintain
	80-90%	Identify non-attendance and rebook; monitor until >90% for 3 months
	Below 80%	Urgent review 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

- **NB SBL ESR Module will now be yearly so 3 month changeover period will commence next moth so figures will vary**

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.

In relation to the maternity incentive scheme, the service has to meet ≥90% compliance for all applicable staff groups in; Fetal monitoring and surveilance, maternity emergencies and neonatal life support by the 30th November 2025. The service is currently on track to achieve this.

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

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

Now in its seventh year of operation, NHS Resolution's Maternity (Perinatal) Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025. The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST).

Year 7 of the scheme was launched in April 2025 for the reporting period 1st December 2024- 30th November 2025. The nature of the ten safety actions remains largely

unchanged from previous years covering ongoing reporting of and monitoring of mortality and morbidity, compliance with national frameworks, standards of care, reporting criteria and timeframes, education and training, workforce standards, involving service users in the safety and improvement work and quality and sharing of learning. Whilst there are still areas where the maternity and neonatal services can continue to develop and improve, maintenance and monitoring of standards is a key part of everyday working within the maternity and neonatal units.

The chart below reflects our current MIS compliance position as of the end of October. The limited presence of green and blue indicators is attributable to the compliance deadline of 30 November 2025. The service remains confident that full compliance will be achieved within the required timeframe.

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	0	0	2	2
3	0	0	6	0	6
4	0	18	0	1	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	82	13	3	98

Key:

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

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 September 2025. Following reports were presented and approved at the Improvement Committee held on the15th October 2025: • Maternity Claims scorecard Q1 25/26 • Neonatal Nursing workforce report (1st July 2024- 30th June 2025)
3.	**Reports for CLOSED Board** Due to the level of detail required for these reports and subsequently containing possible patient identifiable information, the full reports will be shared at Closed board only.
3.1	**Perinatal mortality Report Q2, 1st July 2025- 30th September 2025** The Trust reported <10 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. Parental involvement continues to play a very important part in making improvements to safety and quality.
3.2	**Maternity and Neonatal Safety Investigations (MNSI) Report Q2, 1st July 2025- 30th September 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 one 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	Quality and Patient Safety committee (previously known as the 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, Safety and Performance 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	Involvement board – separate midwifery and obstetric workforce papers.
3.Service User Voice Feedback - Themes	Bi-monthly	Open board- Perinatal Quality, Safety and Performance paper
4.Staff feedback from frontline champion and walk-abouts – themes	Bi-monthly	Open board- Perinatal Quality, Safety and Performance 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, Safety and Performance 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, Safety and Performance 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, Safety and Performance paper

7. GOVERNANCE

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

To inform

Presented by Richard Flatman

Charitable Funds Committee Key Issues (CKI) report

Originating Committee: Charitable Funds Committee			Date of meeting: 30 September 2025		
Chaired by: Richard Flatman			**Lead Executive Director: Julie Hull**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / MEG 3. Escalate to Board
1	***Welcome and apologies*** Committee welcomed George Chilvers to his first meeting as Corporate Fundraising Manager for the Charitable Funds	Substantial	Committee very pleased to welcome George Chilvers		No escalation
2	***Integrated pain management system*** Committee received a presentation on the planned purchase of a portable ultrasound machine for £27k.	Reasonable	The proposal came to the committee as it exceeded the £25k threshold. The committee reviewed funding options and confirmed that the acquisition aligned with the funds' charitable goals.	Purchase was approved subject to first going through the normal capital process. The need for training and post acquisition benefits tracking was also emphasised	No escalation

3	***Fundraising report*** Committee received a fundraising report summarising progress and priorities for the next few months	Reasonable	The team highlighted the key activities and the focus for the next 3 months. Committee also thanked Ewen for his recent marathon runs which raised over £6k for the CFs	Priorities include a range of ongoing fundraising activity, management of various legacies, continued focus on the team restructure, year end audit and production of the annual report.	No escalation
4.1a	***Octopus legacy free wills programme*** Committee received a proposal whereby for an annual cost of £2k to the Charitable funds, supporters, staff and general members of the public could have their will written or amended for free (worth up to £150)	Partial	The charity would advertise the offer as part of a thank you from My WiSH, to all their supporters.	Approval was granted contingent on completing several actions, including due diligence on Octopus and assessing if the scheme could cover lasting powers of attorney. A key consideration will be the process for launch/ communication which needs to be done with sensitivity.	No escalation
4.1b	***Make a Smile Lottery*** Committee received a proposal for the charitable funds to enter into a 6 year contract with Make a Smile lottery (owned and operated by St Helena Hospice in Colchester)	Partial	We would promote the lottery at WSFT with all profits going to the Charitable Funds.	The principle of potentially running a lottery was agreed and a more formal proposal will be presented to the December meeting having completed the necessary market testing, due diligence and EIA. It was additionally resolved that, upon subsequent approval, thorough attention must be paid to matters of location and implementation.	No escalation

4.2	***Strategy*** JL presented an outline strategy/plan for the two years to 2027 for comment/approval including a draft updated vision and mission	Reasonable	With recent changes to the Team and increased funding demand, it is important to review and update the strategy	It was agreed that further work was required to develop separate strategy and operational plan documents and that the strategy should be checked for alignment with both the agreed charitable objectives of the Funds and the new Trust strategy. Updated documents to be presented to the December meeting.	No escalation
5	***Charitable Funds policy and Procedure***	Reasonable	Committee reviewed an updated policies and procedure document for the Charitable Funds Financial authority approval levels were reviewed and agreed. No changes required. It was agreed that further changes are required to the wider policy/procedures document and to the forms included therein. Not approved and members asked to submit changes by email.	JL to circulate final version for approval. Agreed that any key actions/decisions between meetings should be by extraordinary meeting whenever possible.	No escalation
6.1	***Disposal of Etna Road properties***	Substantial	Bequeathed to MyWish from the estate of T Clarke. Approved at extraordinary meeting in June to sell at auction with reserve of £100k.	Confirmed that Etna Road properties had been sold at auction for £133k, with half of that going to Woodgreen animal shelter, with the same buyer buying both cottages. No further action required.	No escalation

6.2	***Robot funding plan***	Partial	Committee has previously reconfirmed the business case, the need to push ahead with some urgency and that any capital shortfall and the ongoing maintenance and replacement costs would be covered by the Trust.	A meeting at the end October with the supplier to discuss in detail the potential acquisition, timing and purchase price Further consideration will then be given to the structure of the funding route, including the likely mix of fundraising, Trust capital plan support and/or use of charitable fund reserves as appropriate and in order of priority.	No escalation
7.1	***Financial performance***	Reasonable	Finances in line with expectations.	Ongoing financial review.	No escalation
7.2	***Investment Report***	Reasonable	Noted the fund value of £1.6m. We had a previous deep dive on investment performance at the June meeting.	Review of position at next meeting.	No escalation
7.3 & 7.4	***Funds closed and fund balances***	Substantial	Noted fund balances. No funds closed.		No escalation

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

7.2. Audit Committee - Chair's key issues from the meetings (ATTACHED)

To inform

Presented by Michael Parsons

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Audit Committee			Date of meeting: 25 September 2025		
Chaired by: Michael Parsons			**Lead Executive Director: Jonathan Rowell**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / MEG 3. Escalate to Board
Internal Audit (RSM)	Update on delivery of internal audit plan 2025/26 and implementation of recommendations.	Reasonable	Discussed the 3 reports issued since the last meeting: • Extra contractual sessions: partial assurance • Financial planning & governance: substantial assurance • Cyber assessment framework: high risk, but good competence level The Committee welcomed the improved processes introduced by Chief Exec for ensuring recommendations were actioned by Exec.	Executive to continue to address audit actions in a timely way.	2. Relevant Assurance Committee to consider partial assurance report on extra contractual sessions.

Counter Fraud (RSM)	Progress report and benchmarking.	Substantial	Continuing good engagement on counter fraud across WSFT, and benchmarking report didn't raise any specific concerns. Explored "emerging risk radar" and noted that it might be useful tool when Board reviews BAF.		1. No escalation required.
Supply chain Risk	Annual report on risk within supply chain.	Substantial	Welcomed the thoughtful analysis of systemic risk within commercial relationships.		1. No escalation required.
Debt write-off	Request to agree write-offs.	Substantial	Agreed write-off of two debts relating to one overseas patient; received assurance on processes and systems and use of flags in systems to reduce risk of repeat incident.		1. No escalation required.
Auditor performance	Confidential discussion without auditors to discuss their performance.	Reasonable	Discussed need to ensure audit testing was robust and to increase on-site presence during audits.		2. CFO to feedback to RSM

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

7.3. Governance Report (ATTACHED)

To Assure

Presented by Paul Bunn

WSFT Board of Directors (Open)	
Report title:	**Governance report – General Update**
Agenda item:	7.3
Date of the meeting:	28 November 2025
Sponsor/executive lead:	Jude Chin, Chair/Ewen Cameron, CEO
Report prepared by:	Paul Bunn, Acting Trust Secretary

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

Executive Summary

WHAT?

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

This paper provides the Trust Board with an update on governance arrangements for the period September to November 2025.

The Trust continues to operate within its statutory and regulatory framework and no issues of escalation need to be raised. This paper consolidates governance updates from subcommittees including: Senior Leadership Team; Management Executive Group, as well as providing updates from the Council of Governors; and highlights from the Board development session. In summary:-

- No urgent decisions have been made between board meetings.
- 1 use of the Trust seal in relation to executing a Deed of Surender relating to premises at Newmarket Hospital occupied by St John's Ambulance.
- Board Development session focused on risk and developing the board's culture.
- By way of assurance and to demonstrate effective decision-making, MEG has met regularly and discussed a wide portfolio of work. The Council of Governors continues to fulfil its statutory obligations, with no issues to escalate.

Risk – a summary of the Trust's 144 clinical and 13 operational risks are provided with a flag to next steps to develop this line of assurance, to include:

- Complete a 'stock take' of risks currently recorded on the risk register, ensuring all those captured are: (i) properly scored and (ii) have corresponding risk assessments in place so that mitigations are identified.
- Improve risk training.
- Establish and Exec oversight group.

SO WHAT?

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

The Board is accountable for the quality of care, financial stewardship, and compliance with NHS England and CQC standards. 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 Governance team will:-

1. Further develop the BAF with the Execs as joint owners and NED support
2. Work with NEDS re agendas for assurance committees with a view to risk being reviewed at beginning and end to assess for changes.
3. Benchmark against other organisations to see how they report and manage the governance of risk.
4. Work with Divisions to improve risk training, scoring and use of risk assessments to capture risk mitigations.

ACTION REQUIRED

The Board is asked to discuss and note the content of the report as outlined above.

Previously considered by:	Standing agenda item to open Board
Risk and assurance:	BAF 8 Governance; 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) has not met since 15 September 2025 when the Performance, Accountability and Autonomy framework was discussed. October's meeting was cancelled due to half term. The meeting scheduled for 17 November 2025 was an opportunity for all those on the strategic tactical commander's rota to undertake the necessary training exercise to remain compliant.

The SLT membership has been emailed to look for topics and themes to cover during 2026 and forward plan will then be developed.

2. Management Executive Group (MEG)

The Management Executive Group has met every Wednesday except in Board assurance committee week. This provides a forum for discussion of strategic and operational matters as well escalation of emerging themes. A snapshot of the non-commercially sensitive matters reviewed include: the business planning process, staff engagement, adult safeguarding training, staff learning development opportunities, progress on the management actions from the internal audit and enabling strategy to support the new corporate strategy.

3. Council of Governors report

3.1 The Council of Governors met on 13 November 2025.

The Council of Governors received a presentation on the current financial position from Jonathan Rowel, newly appointed substantive CFO which showed the position up to the end of month 6 (September).

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 Council of Governors received the following reports:

- **Nomination Committee** held on 22 October 2025 which highlighted the terms of office for the NEDs. Terms of Reference were also reviewed and approved with minor amends noted and the forward plan considered with no changes.
- **Membership and engagement committee** held on 14 October 2025 highlighting governor activities, including 15 steps visits and observations. These continue to highlight positive themes around staff, care and the hospital environment. Feedback was noted, including discussions on environmental improvements such as the Butterfly Garden. The Committee reflected on the influence governors have through their activities, such as 15 Steps visits and informal conversations with staff and patients. Feedback was also reviewed on engagement at the Annual Members' Meeting (AMM). Whilst attendance was strong, it was observed that most attendees at AMM were staff, with fewer members of the public present.
- **Standards Committee** held on 28 October 2025 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. TOR were also reviewed and updated with minor changes, as well as the policy for engagement where additional detail was provided about the Trust's provider licence obligations.
- **staff governors** and **lead governor** reports also noted and received.

3.2 Closed COG
NED remuneration was discussed by the Council in the closed meeting and the recommendations from the Nomination committee were approved.

David Slater was also approved as the new Deputy Lead Governor and will take up post on 1 January 2026.

The Council noted the resignation of Andy Morris from the Trust and agreed to recommence new lead governor elections to find a successor, the process is underway. If no one steps forward the Deputy will temporarily step up until a successor is found.

4. Board development session

The board development session in October was in two parts. Part 1 focused on discussing and developing the culture of the Board supported by The Blooming People Partnership. A number of models were discussed to review the culture of our Board and a discussion around whether the Board had the right balance between task, process and climate. Risks of becoming too task focus and thus transactional were discussed, followed by an analysis of pre workshop questionnaires looking at the making up of the Board. In breakout groups the Board explored the themes in more detail resolving too focus on: a commitment to look at risk differently, develop more succinct papers, and to support coaching and feedback outwith the board for development. 5 actions were agreed:

- Review risk
- Look at feedback from meetings adopting an “even better if” approach
- Visibility of the board
- Develop a buddy system for NEDS and Execs
- Look at how we have challenging conversations successfully

The afternoon session was a focus on the current Board Assurance Framework (BAF) and whether it was aligned to Trust’s new strategy. After an initial session focus on emerging risks and mapping those against strengths, opportunities and threats over the next 36 months the Board agreed to consolidate the existing BAF into the following broad themes/risks which are to be developed further outside the session:

1. Cyber
2. Estates
3. Finance – loss of control
4. Preparedness and resilience – single point of failure
5. Workforce: Staff engagement; supply chain; diversity
6. Quality of care
7. Performance
8. Transformation of care – change and preparing for the new hospital

5. Risk

The risk register has been rolled out to all the clinical divisions. There are currently 144 risks captured across the clinical Divisions. The new process of having a separate risk assessment repository and risk register is still not fully imbedded across the Trust. For every risk register entry there should also be a risk assessment, this is not always the case. Currently only 24 divisional risk assessments exist for the 144 active risks. The situation is better for corporate division where 12 of 13 risks have corresponding risk assessments.

Summary of all open Clinical Division risks:

	Red	Amber	Yellow	Green
Residual (based on existing controls)	15	105	20	4

Corporate Divisional risks are:

	Red	**Amber**	**Yellow**	**Green**
Residual (based on existing controls)	0	12	1	0

6. Urgent decisions by the Board

No urgent decisions have been required.

7. Use of Trust Seal

The Trust seal has been used on one occasion – on 29 October 2025 it was used to execute a Deed of surrender relating to premises at Newmarket Hospital, between WSFT and St John's ambulance – This was sealed by CEO and CFO.

7.4. Proposed changes to Governance Structure (ATTACHED)

For Approval

Presented by Paul Bunn

Open Board of Directors Meeting	
Report title:	**Proposal to change the Trust's Governance structure**
Agenda item:	7.4
Date of the meeting:	28 November 2025
Lead:	Ewen Cameron, CEO, Jude Chin, Chair
Report prepared by:	Paul Bunn, Acting 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

In answering the well led question the CQC expects: "*The trust regularly reflects on and reviews its governance and leadership across the organisation to ensure continuous improvement and development …"*

WSFT operates a cycle of reviewing its assurance committees effectiveness internally every two years. This was last completed in 2024. However, following a change of chair of the ***Improvement*** committee, a workshop to review its effectiveness was completed on 6 October 2025. The consensus view from that meeting was that there is merit in discussing the rebranding of the 3I's assurance committees of the Board in order to:

1. Better fulfil the assigned assurance functions;
2. More accurately reflect the work programmes and portfolios of the committees now and into the future; and,
3. Align Patient Experience and Engagement with Improvement (currently in Involvement). This better reflects NHSE's definition of quality, which says one should focus on patient safety, effectiveness of care and patient experience together.

This also provides an opportunity to review assurance committees more widely as the Digital Board is converting to an assurance committee in its own right as per previous board discussions.

Appendix 1 shows the current 3I's structure and its associated subcommittees.

Appendix 2 has the proposed new structure. This proposes the following name changes:

- Improvement – Quality and Patient Safety
- Insight – Finance and Performance
- Involvement – Workforce and Organisational Development

- Digital Board – Digital & Data Assurance

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

Good governance ensures that when planning services, improvements or efficiency changes, WSFT understands the impact of decisions on its workforce, quality of care, and financial sustainability, including for the wider health and care system. Furthermore, regular reviews of our governance structures enable WSFT to assess the well led question, namely that for governance, management and sustainability we can show that board members meet their obligations in respect of: quality of care outcomes for patients; workforce; and operational and financial performance.

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

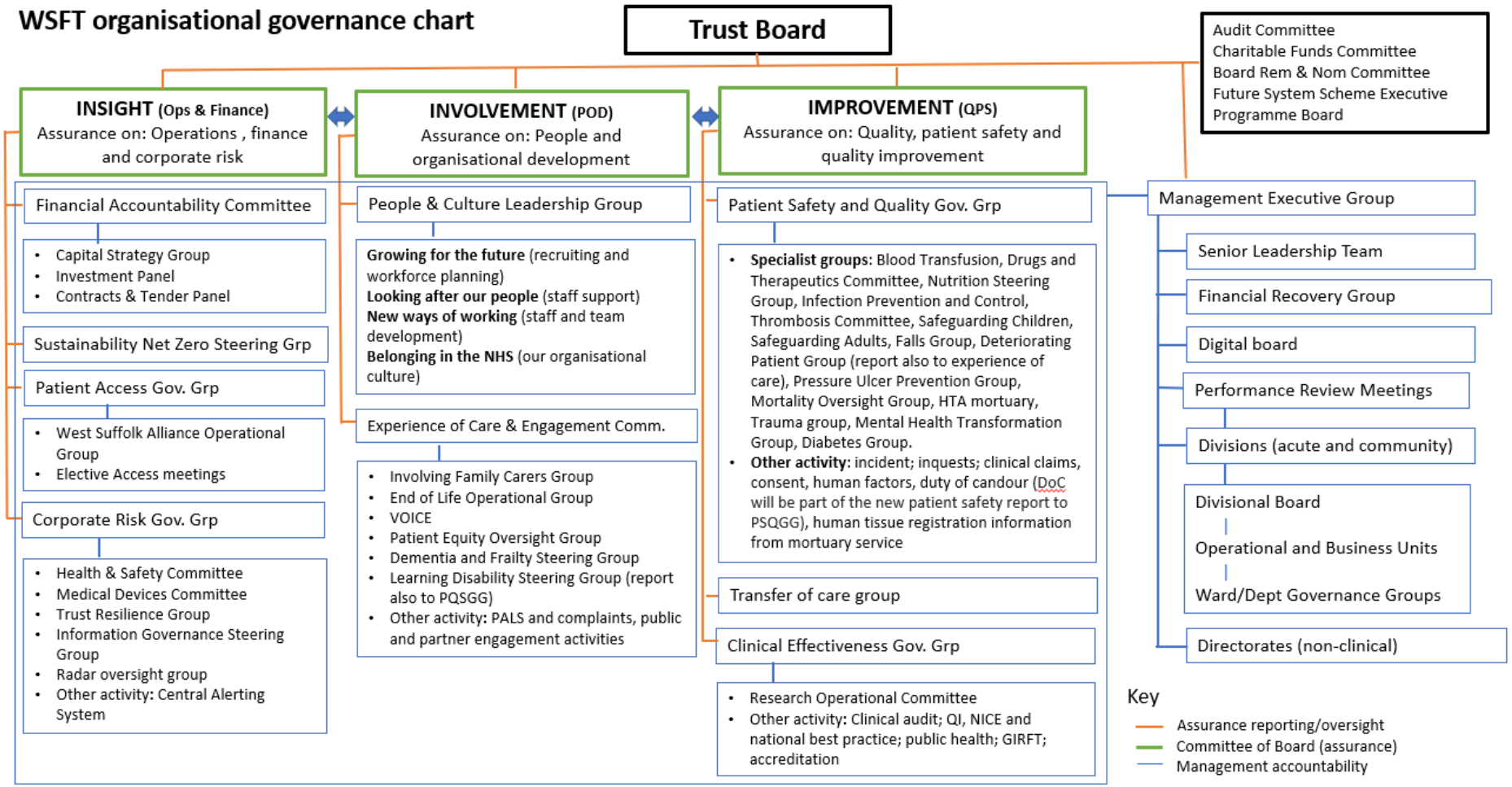
- Discuss the merits of changing the assurance committee as proposed above and in App 2
- If agreed, amend TOR for the assurance committees, workplans and communicate reporting lines across the trust
- Align policies to new committee structure
- Assurance committees to review reporting of sub committees that feed into it.

Action Required

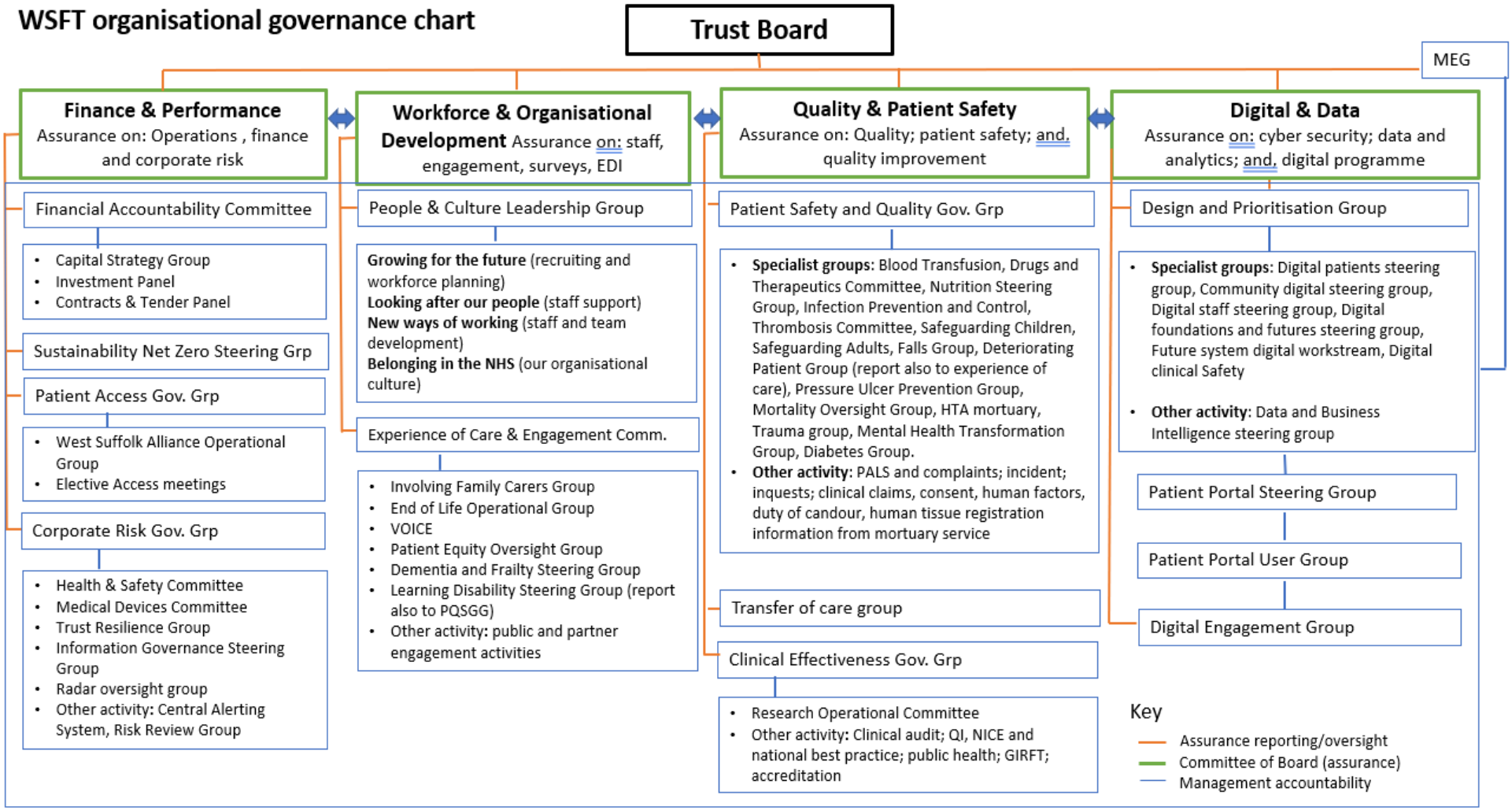
The board are asked to discuss and agree the proposed changes to the governance structure

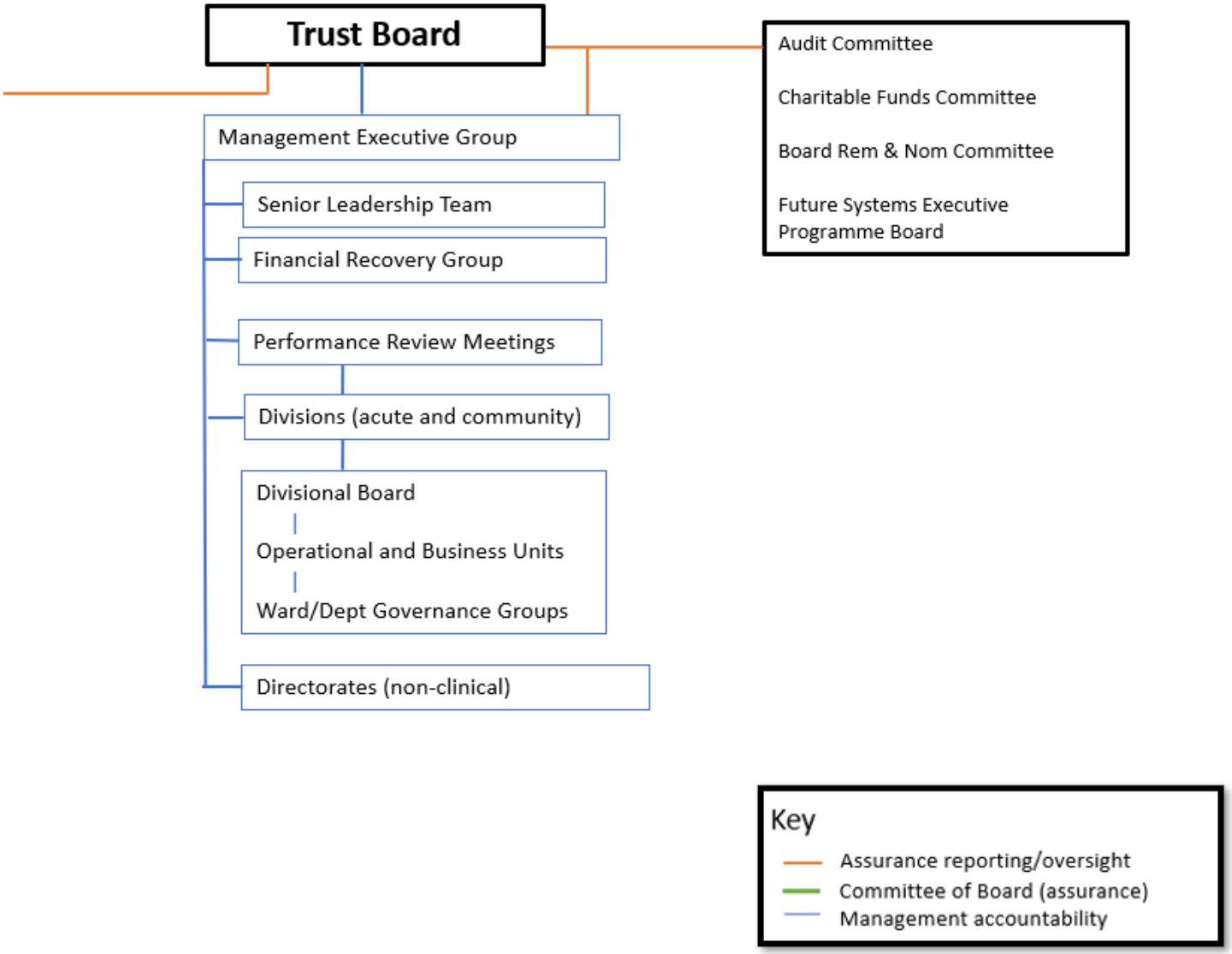
Previously considered by:	New report but is part of Boards continuous self-reflection and development
Risk and assurance:	BAF 8 (Governance) - A failure to ensure this means the Board would be unable to act on the best information when planning services, improvements or efficiency changes both locally and with system partners in line with our vision and values.
Equality, diversity and inclusion:	Not affected, streamlining of reporting should aid and improve analysis and triangulation of data.
Sustainability:	Decisions should not add environmental impact
Legal and regulatory context:	CQC Well Led Regulation 17: Good Governance Code of Governance for NHS Provider Trusts, 23 February 2023

Appendix 1 – Current WSFT Structure



Appendix 2 - Proposed new Structure




Trust Board
Audit Committee
Charitable Funds Committee
Board Rem & Nom Committee
Future Systems Executive Programme Board
Management Executive Group
Senior Leadership Team
Financial Recovery Group
Performance Review Meetings
Divisions (acute and community)
Divisional Board
Operational and Business Units
Ward/Dept Governance Groups
Directorates (non-clinical)
Key
Assurance reporting/oversight
Committee of Board (assurance)
Management accountability

8. OTHER ITEMS

To Note

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 - 30 January 2026

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

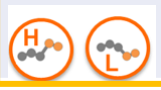
Presented by Jude Chin

IQPR Full Report

To Note

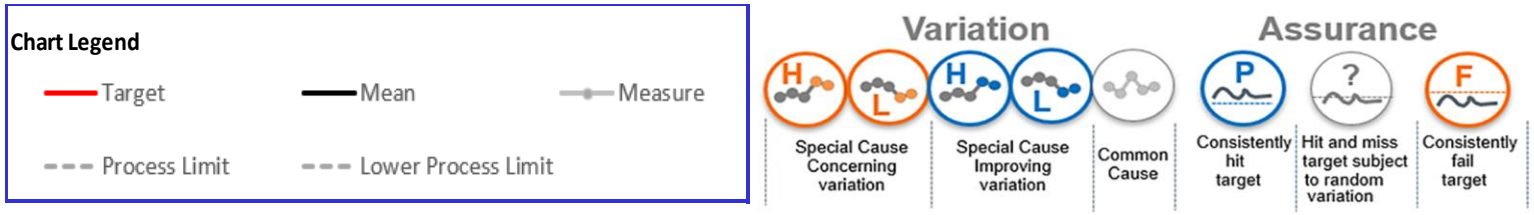
Presented by Nicola Cottington

Assurance Grid

Performance in September 2025		ASSURANCE: Will we reliably meet the target based?		Not Met	
		Pass 	Hit and Miss 	Fail 	No Target 
VARIANCE: Variation from the mean The colours indicate the trend- positive (blue), Negative (orange), or neither (grey)	Special Cause Improvement 	**INSIGHT** Virtual Beds Trajectory	**INSIGHT** 28 Day Faster Diagnosis	**INSIGHT** Virtual Ward Total average occupancy number RTT 65+ Weeks Waits RTT 78+ Weeks Waits	**INSIGHT** Criteria to reside – Acute Criteria to reside – Community Virtual Ward Total bed days RTT 52+ Weeks Wait as % of Total WL RTT <18 Week Waits (% All)
	Common Cause 	**INSIGHT** Urgent 2 hour response – EIT Virtual Ward Total average LOS per patient **INVOLVEMENT** Staff Sickness – Rolling 12 months Staff Sickness	**INSIGHT** Ambulance Handover within 30min Non-admitted 4 hour performance % patients with no criteria to reside Virtual Ward Total average occupancy percentage Cancer 62 Days Performance **IMPROVEMENT** C-Diff Hospital & Community onset, Healthcare Associated **INVOLVEMENT** Mandatory Training	**INSIGHT** Incomplete 104 Day Waits **INVOLVEMENT** Appraisal	**INSIGHT** 12 Hour Breaches 4 hour breaches 12 hour breaches as a percentage of Type 1 attendances Virtual Ward Total bed days RTT Waiting List RTT <18 Week Waits (% First OPA) **IMPROVEMENT** Post Partum Haemorrhage Inpatient Deaths % of patients with Measured Weight % of patients with a MUST/PYMS assessment completed within 24hours of admission **INVOLVEMENT** Active complaints Closed complaints % extended Count extended % Complaints responded to late Count responded to late % resolved in one week Total PALS resolved Count
Deteriorating	Special Cause Concern 		**INSIGHT** Community Paediatrics RTT Overall 78 Waiting List **INVOLVEMENT** Turnover	**INSIGHT** Diagnostic Performance - % within 6weeks Total	**INSIGHT** Community Paediatrics RTT Overall Waiting List Community Paediatrics RTT Overall 52 Waiting List Community Paediatrics RTT Overall 65 Waiting List **IMPROVEMENT** SHMI

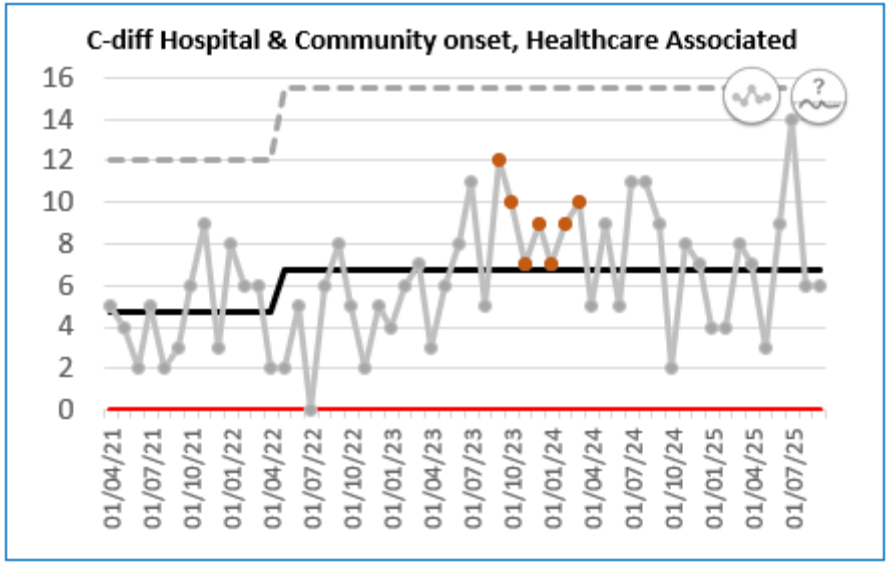
Items for escalation based on those indicators that are failing the target, or are worsening and therefore showing Special Cause of Concerning Nature by area:
INSIGHT - Urgent & Emergency Care: Virtual Ward Total average occupancy number
Cancer: Incomplete 104 Day Waits
Elective: Diagnostic Performance - % within 6weeks Total, RTT 65+ Weeks Waits, RTT 78+ Weeks Waits, Community Paediatrics RTT Overall 78 Waiting List
INVOLVEMENT – Well Led: Appraisal, Turnover

IMPROVEMENT COMMITTEE METRICS



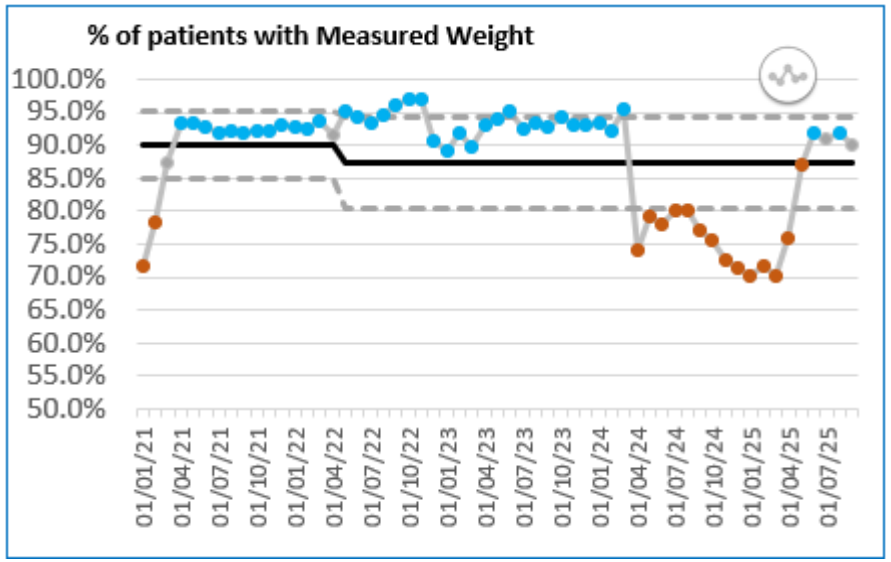
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
C-diff Hospital & Community onset, Healthcare Associated	Sep 25	6	0			7	-2	15
% of patients with Measured Weight	Sep 25	90.0%				87.3%	80.4%	94.2%
% of patients with a MUST/PYMS assessment completed within 24 hours of admission	Sep 25	95.0%				95.9%	93.2%	98.5%
Post Partum Haemorrhage	Sep 25	12				7	-1	15

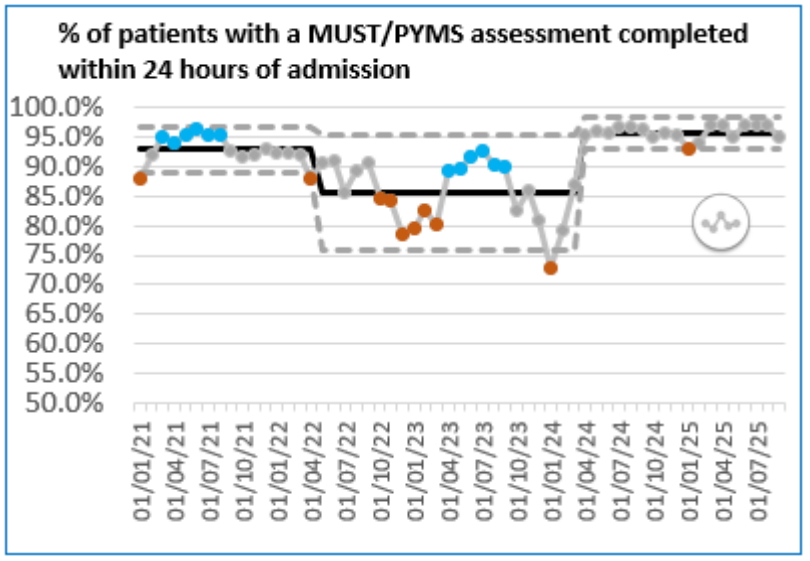
Safe



What	So What?	What Next?
September data continues to illustrate common cause variation with hit and miss target subject to random variation, with limited assurance of sustained improvement at this point. As expected, following the increased cases in July driven by an 'outbreak' of *Clostridiodes difficile* infection during June/July, the number of cases have plateaued with resolution of the outbreak following significant actions. Trust case rate comparison September 2024/25 to September 2025/26 shows a decreased total number of HOHA/COHA cases by a count of five.	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, *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. 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.	At present, the service remains above trajectory to meet the specified indicator following the increase cases related to the *Clostridiodes difficile* outbreak June/July. However, targeted interventions have taken place, and we remain confident that with continued focus and leadership support, performance will improve and progress toward the indicator will be accelerated. The Quality Improvement Programme continues with *Clostridiodes difficile* programme board due to re-convene now the chair and newly appointed deputy chief nurse is in post. The interventions presented as outbreak Incident Management Team actions continue as per the plan. This includes the completion of roll out of the new and improved Isolation poster, focus on sluice rooms by matrons in collaboration with ward staff. Implementation of new ways of working for domestic services separating cleaning and beverage provision as well as increase visibility within ward areas of the infection prevention (IP) nurses. The IPT continue to spot check sluices feeding back findings to ward managers/matrons.

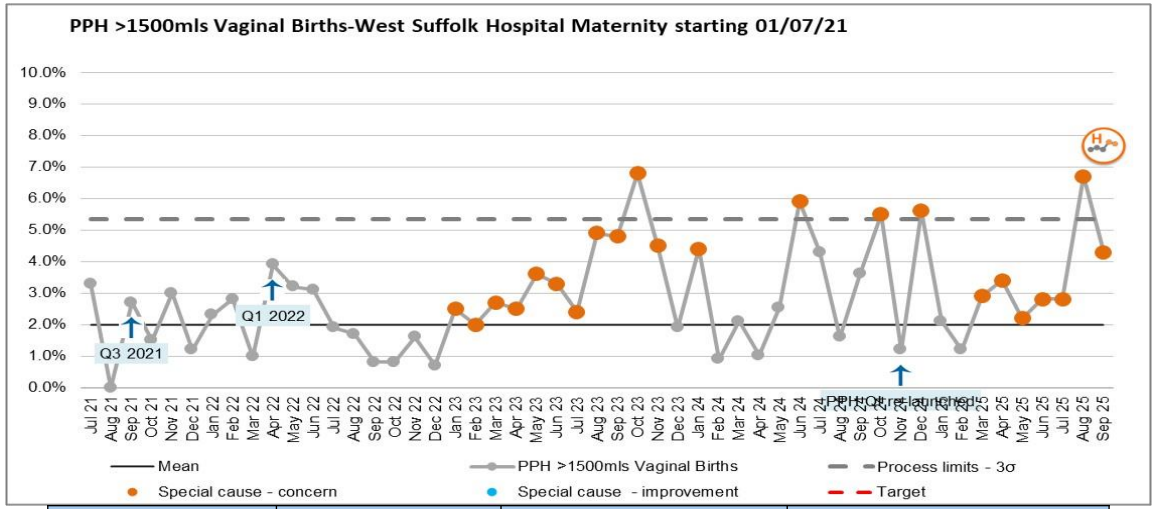
Safe



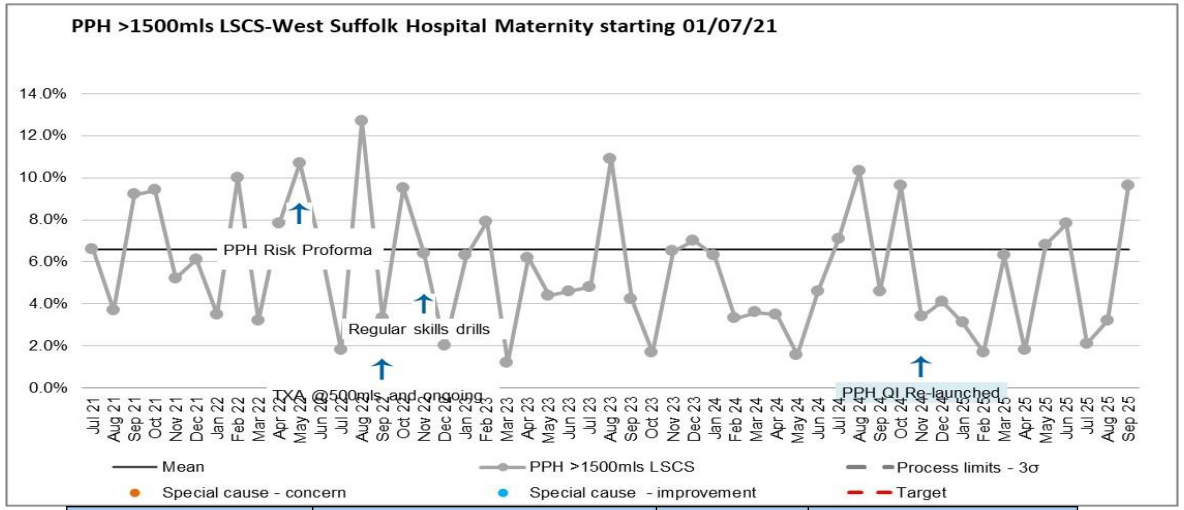


What	So What?	What Next?
Nutritional assessment (MUST) within 24hrs – 95% **% of Patients with a measured weights – 90%** We have now seen 4 data points above expected average with measured weights on admission which is encouraging, with the continued focus the wards are now making this business as usual. This in turn is positive for our patients and will enable targeted nutritional care Inpatient areas across the Trust have continued to deliver high percentage of risk assessment completed in 24 hours. By enabling wards to take ownership of their performance data and implement responsive actions on a monthly basis. The Trust has strengthened accountability and fostered a culture of continuous improvement. Progress and key outcomes are routinely reviewed through the monthly performance meetings, ensuring alignment with broader quality and governance objectives	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. Proper nutrition strengths immune response, reduces vulnerability to hospital acquired infections. The world health organisation agrees and from 2016 -2025 they have collectively acknowledged the concept of 'food as medicine' 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, this is still showing improvements and will be reviews in January 2026 • 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. A fix is now being developed and hopefully should go live in the new year.

Safe



Quarter	Total vaginal births	PPH after vaginal birth	Total Quarterly rate
1 (Apr- Jun 2024)	338	10	3.00%
2 (Jul- Sept 2024)	374	11	2.90%
3 (Oct- Dec 2024)	284	11	3.90%
4 (Jan- Mar 2025)	300	6	2.00%
1 (Apr- June 2025)	347	9	2.60%
2 (Jul- Sept 2025)	331	14	4.20%



Quarter	Total C. section performed	PPH at CS	Total Quarterly rate
1 (Apr- Jun 2024)	205	9	4.40%
2 (Jul- Sept 2024)	191	12	6.30%
3 (Oct- Dec 2024)	213	11	5.20%
4 (Jan- Mar 2025)	194	6	3.10%
1 (Apr- June 2025)	182	9	4.90%
2 (Jul- Sept 2025)	198	10	5.10%

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 September 2025, there were seven reported case of PPH over 1500 mls following Lower segment Caesarean Section (LSCS) and five occurring after a vaginal birth. These findings reveal a special cause for concern with a rising rate of postpartum haemorrhage after vaginal delivery in the last two months and increase number of PPH following LSCS last month, suggesting an atypical increase in cases that requires investigation to determine underlying factors.

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.

Quarterly rate data for the last seventeen-month has been shared to offer a comprehensive overview of WSH's status regarding postpartum haemorrhage (PPH) in both vaginal and LSCS births. The data for the last quarter reflects a PPH rate of 4.2% for vaginal births and 5.1% for LSCS.

The National Maternity and Perinatal Audit (NMPA) published in September 2025 highlights that postpartum haemorrhage remains a significant clinical concern, with notable increase confirming the changing trends in maternity care and outcomes.

What Next?

Quality Improvement project in progress focusing on three workstream:

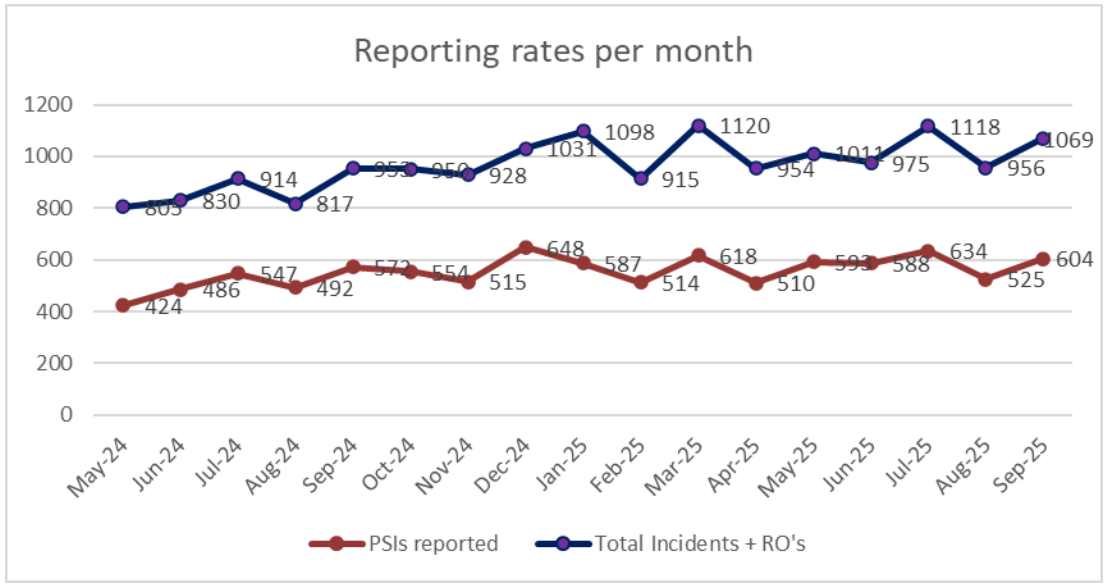
- Training and awareness
- Risk management
- Medication and timely management of PPH

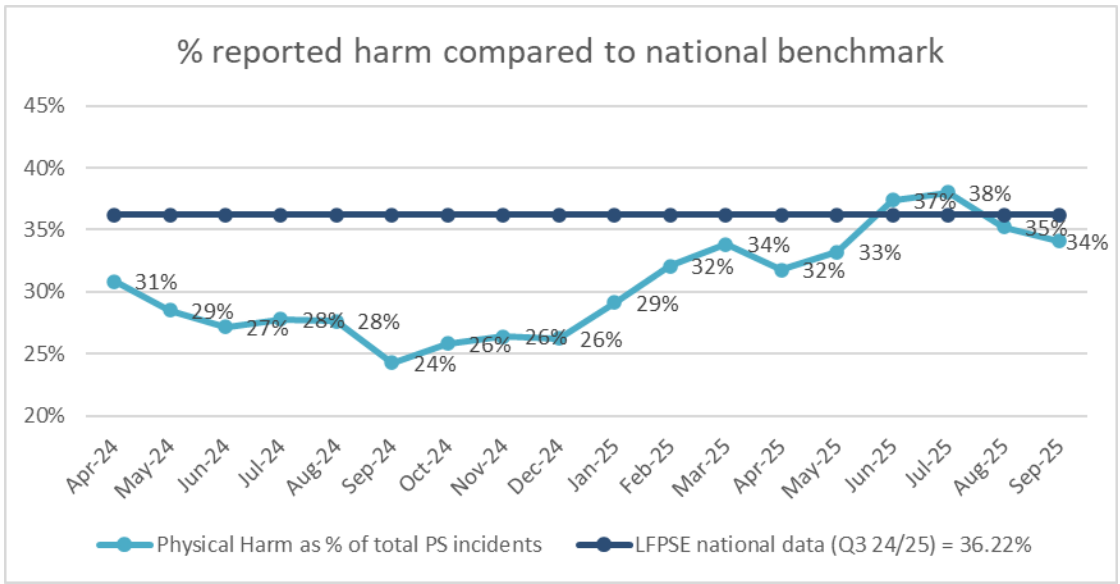
Ongoing reviews of all PPH and thematic reviews are required to continue, to truly understand the factors causing the variation and subsequent solutions to be found.

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

Conduct a comprehensive analysis of September's PPH cases in response to the observed increase.

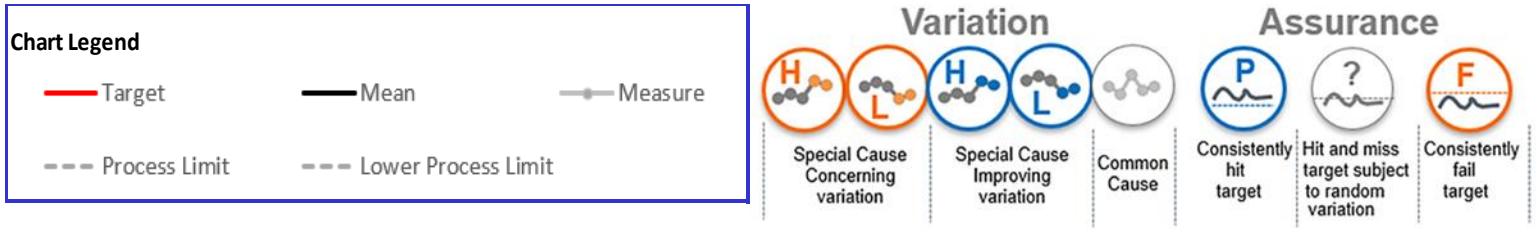
Safe





What	So What?	What Next?
In September, we observed a slight increase in reporting. This marks the fourth consecutive month of using the updated data set, introduced to ensure consistency. Incident increases were noted in clinical care and treatment, patient clinical records, security and slips, trips and falls. Moderate harm incidents also rose during this period. 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. WSFT's harm rate decreased again this month to 34%, with the national average sitting at 36.22%.	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. Measuring reporting rates helps us to measure our safety culture and measuring harm as a percentage of incidents reported indicates how safe our care is. All patient safety incidents and RO's reported are analysed on a quarterly basis and presented to the Improvement committee. Moderate harm incidents are managed at divisional level, whilst incidents which have been perceived to cause severe or fatal harm are presented to the emerging incident review (EIR).	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 ICS led Patient Safety Collaborative with the objective to share and learn and improve safety for patients. Insights from this analysis, along with findings from the quarterly patient safety report, will continue to be shared with divisional governance and speciality leads across the trust to inform targeted improvement efforts.

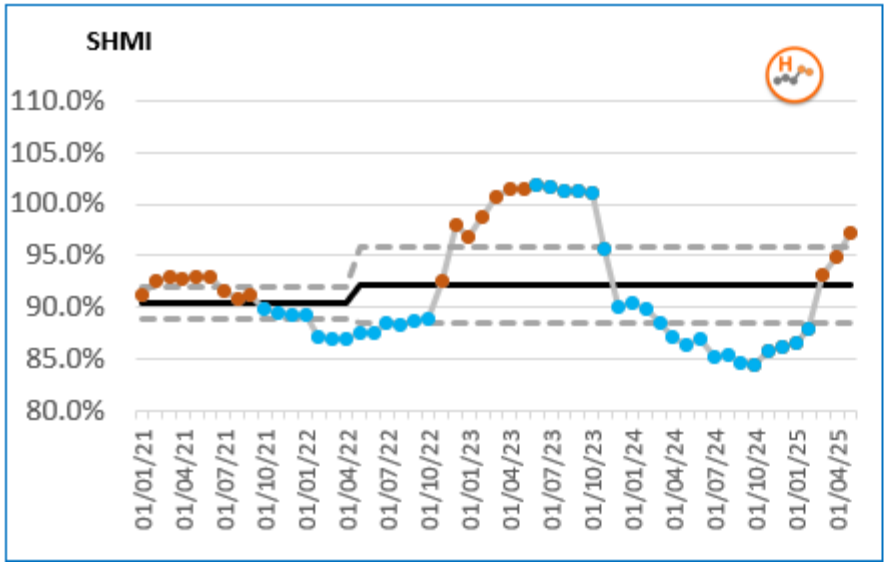
Mortality Summary

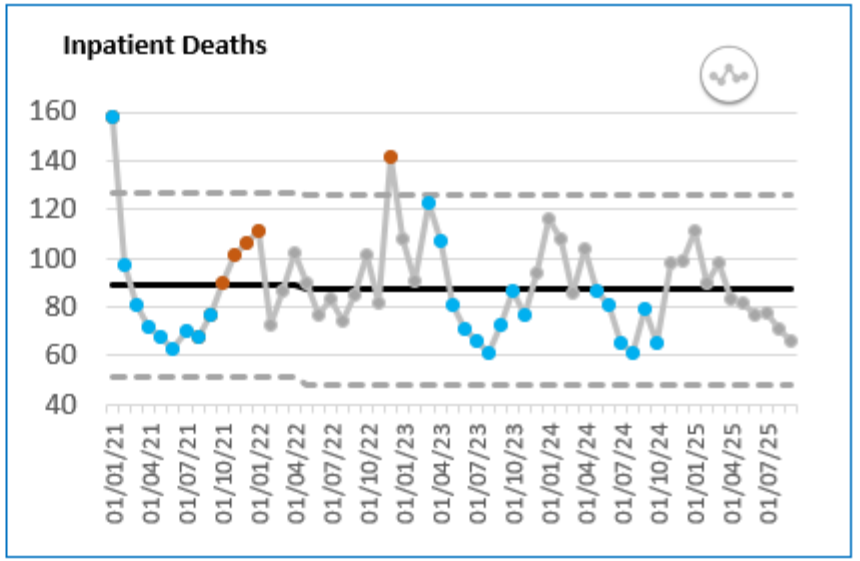


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SHMI	May 25	97.3%				92.2%	88.6%	95.9%
Inpatient Deaths	Sep 25	66				87	48	126

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

Mortality





What	So What?	What Next?
SHMI is reported 6 months in arrears. Current SHMI data reported is from (May 24- April 25) WSFT data shows as expected deaths (0.94). This means that given the WSFT patient demographic that the expected number of patients have died in our care or within 30 days of discharge, as statistically expected. There has, however, been anomaly in the WSFT SHMI data starting at March 2025. As this was not in keeping with the local mortality data, a dive into this showed a coding issue which is causing a spike in data.	The diagnosis group 'Invalid primary diagnosis' showed a large spike of observed deaths (170) against expected deaths (70). Invalid primary diagnosis is where uncoded episodes are placed. A shortage of coders is the reported reason for the data deadlines not having been met for the WSFT SHMI data. Although we are confident this is a coding issue which is causing the data spike, it does mean that other diagnosis groups are inaccurate (as they have not been coded). This also means that the monthly SHMI data will require heavier scrutiny as the anomaly could make areas that could raise concern less noticeable.	The coding issue has been raised at MOG , with the coders and the PQAS group. The coders have reported that this has been raised at an executive level and was placed on the risk register? NHS England Digital have added a flag to the WSFT SHMI data informing that it should be treated with caution. There is a similar flag on other organisations too. Local mortality and SHMI data will require scrutiny to ensure the uncoded episodes causing the anomaly are not smoke screening any areas for concern. We will also have to assume that some of the other diagnosis groups are underscored. For example, any that are 'as expected' will need closer observation as they could be 'higher than expected'.