OPEN Council of Governors Meeting

Schedule	Thursday 10 September 2026, 5:30 PM — 7:30 PM BST
Venue	Rooms 19a & b, Education Centre, WSFT, Hardwick Lane, Bury St. Edmunds. IP33 2QZ
Notes for Participants	Please advise of apologies in advance of the meeting to the FT Office.
Organiser	Ruth Williamson

Agenda

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AGENDA:

OPEN Council of Governors meeting

Thursday 10 September 2026, 5.30pm

in Rooms 19a & b, Education Centre, WSFT, Hardwick Lane, Bury St. Edmunds. IP33 2QZ

Council of Governors Meeting- OPEN

There will be a meeting of the **COUNCIL OF GOVERNORS** of West Suffolk NHS Foundation Trust on **Thursday 10 September 2026 at 17:30 in Rooms 19a & b, Education Centre, WSFT, Hardwick Lane, Bury St Edmunds. IP33 2QZ**

Jude Chin
Chair

Agenda

General duties/Statutory role
 (a) To hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. (b) To represent the interests of the members of the corporation as a whole and the interests of the public. The Council's focus in holding the Board to account is on strategy, control, accountability and culture.

GENERAL BUSINESS			
17:30	**1.**	**Welcome and introductions** To welcome governors and attendees to the meeting and request mobile phones be switched to silent	Jude Chin
	2.	**Apologies for absence –**Diana Stroh, Anna Conochie, Anna Clapton, Louisa Honeybun, Martin Robinson, Lisa Parish, Sue Kingston, Richard Jones, Pooja Sharma To receive any apologies for the meeting	Jude Chin
	3.	**Declaration of interests** (enclosed) To receive any declarations of interest for items on the agenda	Jude Chin
	4.	**Minutes of the previous meeting** (enclosed) To note the minutes of the meetings held on 19 May 2026	Jude Chin
	5.	**Matters arising action sheet** (enclosed) To note updates on actions not covered elsewhere on the agenda	Jude Chin
	6.	**Introduction to Accreditation of Care Excellence (ACE)** (presentation enclosed) To receive a presentation from the Deputy Chief Nurse	Sarah Ward
	7.	**Update on Elective Recovery** To receive an update from the chief operating officer	Nicola Cottington
	8.	**Chair's report** (enclosed) To receive an update from the Chair	Jude Chin
	9.	**Chief Executive's report** (enclosed) To note a report on operational and strategic matters	Ewen Cameron

GOVERNOR BUSINESS (INC. STATUTORY DUTIES)			
18:40	**10.**	**Feedback from Board committees** (enclosed) To receive committee key issues (CKI) and observer reports from the assurance and audit committees: 10.1 Finance and Performance Committee 10.2 Quality and Patient Safety Committee 10.3 People and Organisational Development Committee 10.4 Digital & Data Assurance Committee 10.5 Audit & Risk Committee	NED chairs / Governor observers
19:00	**11.**	**Nominations Committee report** (enclosed) To receive a report from the Nominations Committee	Jude Chin
	12.	**Membership and Engagement Committee report** (enclosed) To receive a report from the Membership and Engagement Committee	Sarah Hanratty
	13.	**Standards Committee report** (*No meeting since 21 April 2026)*	Jude Chin
	14.	**Staff Governors' report** *(No formal meeting since 13 April 2026)*	Jude Chin
	15.	**Lead Governor report** (enclosed) - To receive a report from the Lead Governor	Ben Lord
	16.	**Annual report and accounts, including auditor's letter** (enclosed) To receive the Annual Report and Accounts	MP
	17.	**Governance report** (verbal) To receive a governance update	Paul Bunn
ITEMS FOR INFORMATION			
19:20	**18.**	**Summary report for Board of Directors meetings** (enclosed) To receive a report from the Chair and Non-Executive Directors.	Jude Chin/ NEDs
	19.	**Any Other Business** (verbal) To discuss any other matters not included on the agenda.	All
	20.	**Dates for meetings for 2026** To note dates for meetings in 2026: **5.30 pm to 7.30 pm, Rooms 19a/b, Educations Centre, WSFT** • **24 September 2026 – Annual Members Meeting – Guildhall Bury St. Edmunds (4.30 pm market square, 5.30 pm. talk commences)** • **10 November 2026**	Jude Chin
	21.	**Reflections on meeting** To consider whether the right balance has been achieved in terms of information received and questions for assurance and the Trust's values and behaviours observed.	Jude Chin
CLOSE			

Supporting Annexes

Agenda item	Description
10.1	IQPR full report June

GENERAL BUSINESS

1. Welcome and Introductions

To welcome governors and attendees to the meeting & request mobile phones be switched to silent.

To Note

Presented by Jude Chin

2. Apologies for Absence

To receive any apologies for the meeting

Apologies received from:

Governors - Diana Stroh, Anna Conochie, Anna Clapton, Louisa Honeybun, Martin Robinson, Lisa Parish, Sue Kingston, Jane Skinner

Other - Richard Jones, Pooja Sharma

To Note

Presented by Jude Chin

3. Declaration of interests

To receive any declarations of interest for items on the agenda

To Note

Presented by Jude Chin

4. Minutes of the Previous Meeting (enclosed)

To note the minutes of the meeting held on 19 May 2026

For Approval

Presented by Jude Chin

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE
COUNCIL OF GOVERNORS' MEETING - OPEN

Held on Tuesday 19 May, 2026 at 17:30
In the Education Centre, West Suffolk Hospital site, Bury St Edmunds

Members:		
Name	**Job Title**	**Initials**
Jude Chin	Trust Chair	JC
Anna Conochie	Public Governor	AC
Val Dutton	Public Governor	VD
Sarah Hanratty	Public Governor	SH
Elizabeth Hodder	Public Governor	EH
Ben Lord	Public Governor – Lead Governor	BL
Gordon McKay	Public Governor	GM
Jayne Neal	Public Governor	JN
Adrian Osborne	Public Governor	AO
Becky Poynter	Public Governor	RP
Barry Probert	Public Governor	BP
Clare Rose	Public Governor	CR
Jane Skinner	Public Governor	JS
David Slater	Public Governor	DSl
Anna Clapton	Staff Governor	AC
Louisa Honeybun	Staff Governor	LH
Diana Stroh	Staff Governor	DSt
David Brandon	Partner Governor	DB
Sue Kingston	Partner Governor	SK
Lisa Parish	Partner Governor	LP
Thomas Pulimood	Partner Governor	TP
In attendance:		
Ewen Cameron	Chief Executive Officer	EC
Jonathan Rowell	Chief Finance Officer	JR
Sam Tappenden	Director of Strategy & Transformation	ST
Antoinette Jackson	Non-Executive Director	AJ
Heather Hancock	Non-Executive Director	HH
Paul Zollinger-Read	Non-Executive Director	PZR
Richard Flatman	Non-Executive Director	RF
Alison Wigg	Non-Executive Director	AW
Paul Bunn	Acting Trust Secretary	PB
Pooja Sharma	Deputy Trust Secretary	PS
Ruth Williamson	Foundation Trust Office (Minutes)	RW

Apologies: **Public Governors:** Elizabeth Hodder, Barry Probert, Anna Conochie **Staff Governor**s: Diana Stroh. **NEDs:** Michael Parsons, Mike Knapton. **Other:** Richard Jones, Trust Secretary.
Members of the Public: none in attendance.

No.	Item	Action
1.	**Welcome and introductions**	
	Jude Chin (JC), Chair welcomed all to the meeting.	
2.	**Apologies for absence**	
	Apologies for absence were noted, as detailed above. The Council noted the resignations of Adam Musgrove, Staff Governor and Robin Howe, Public Governor and recorded its sincere thanks and appreciation for their valuable contributions and commitment during their tenure.	
3.	**Declaration of interests**	
	There were no declarations of interest made.	
4.	**Minutes of the previous meetings**	
	The minutes of the meeting held on 5 March 2026 were approved as a true and accurate reflection, subject to the following amendments: • **Members** - amend reference to Lead Governor to Ben Lord. • **Item 4** , **Minutes of the previous meeting** - amend meeting date to 13 November, **2025.**	
5.	**Matters arising on action sheet**	
	Action Ref 10 – Update on Operational Performance: ED Patient Experience - the Council noted that this matter had been referred to the Quality & Patient Safety Committee, with governor observations and actions taken reflected in committee papers. Further data was expected in July and an update would be provided at a future meeting. JS noted that not all Governors attended Assurance Committee meetings or reviewed the associated papers and suggested a more effective method of communicating the outcome. JC agreed and proposed that an update be shared through the CKI report to September's meeting. This was agreed. **Action: Update on question raised to be shared with all governors, via the Quality & Patient Safety CKI at CoG in September.** **Action Ref 11 – Chief Executive's Report: Ward Cleanliness Ratings** - the Council noted that FR1 and FR2 areas are subject to different audit	**PZR**

	schedules and performance standards. Recent cleanliness audits in areas affected by norovirus achieved predominantly four and five-star ratings, providing assurance that cleanliness standards were not considered a contributory factor. **Action Ref 11 Closed.** **Action Ref 12 – Any Other Business: Phlebotomy -** the Council received an update on the requirement for blood test request forms. Challenges relating to multiple test requests, printing requirements and ICE system limitations were noted. Software solutions are being explored, but paper forms remain necessary at present. JS raised concerns regarding GP awareness of the requirement. DB confirmed that the issue remains on the WSFT Primary Care Interface Group action log and that a solution is being sought. **Action Ref 12 Closed.**	
6.	**Update on Finance**	
	Jonathan Rowell (JR), Chief Finance Officer and Sam Tappenden (ST), Director of Strategy & Transformation presented the report. The Council noted delivery of the 2025/26 financial plan, including £32.8m of CIP savings and significant reductions in temporary staffing costs, with agency expenditure reduced by 76%. A year-end deficit of £14.5m was reported following system funding adjustments and additional national support linked to delivery against plan. JR outlined the national deficit reduction trajectory, requiring the Trust to reduce its deficit by 2% of turnover annually and achieve financial balance by 2028/29. For 2026/27, the Trust is required to deliver a £12.8m deficit position supported by £29.7m of CIP savings. In response to a question from RF, JR confirmed that deficit support funding would continue subject to delivery against agreed plans. In response to a question from TP, JR advised that opportunities to increase income through repatriated activity would depend on commissioning arrangements and operational capacity. JR further advised that inflation assumptions had been incorporated into financial planning. DB thanked colleagues for the significant savings achieved and emphasised the importance of delivering genuine efficiencies within the wider system context. EC added that the priority remained delivery of current activity for the benefit of local patients. Responding to a question from BP, JR advised that workforce reductions were expected to be achieved primarily through natural turnover, with any targeted changes subject to local consultation. EC reiterated the Trust's commitment to avoiding compulsory redundancies wherever possible. In response to questions from JS, JR advised that non-NHS and private patient income remained low compared with peer organisations and any growth would utilise available capacity without disadvantaging NHS patients. Governors discussed their statutory responsibilities regarding	

	private patient income. **JC to confirm wording contained within the constitution**. DB and EC emphasised that any additional income would support the provision of NHS services and improve outcomes for NHS patients. In response to a question from CR, JR confirmed that additional activity would be agreed through the ICB and remain subject to delivery against contractual commitments. The Council noted progress against the Trust's *Recover, Renew, Reimagine* programme. In response to a question from GM regarding potential NHS reforms, ST advised that no significant changes were currently anticipated. JC noted strong early progress against the 2026/27 CIP programme and thanked ST and his team for their work.	**JC**
7.	**Chair's Report**	
	Jude Chin (JC), Chair, presented the report, which was noted and taken as read.	
8.	**Chief Executive's report**	
	Ewen Cameron (EC), Chief Executive Officer, presented his report. The Council noted that the Trust had recently been featured by *Look East* as one of the best operationally performing organisations in the region. EC highlighted improvements in patient access to services, noting that access remained the primary concern identified by the public. Whilst recent staff survey results remained below previous levels, EC reported that performance was improving, although further work was required. In response to a question from SH regarding the impact of other organisations adopting the Trust's learning, EC advised that many organisations were focused on similar operational challenges and regularly shared learning and good practice. JN highlighted the Trust's work within the fracture clinic, including the development of an app which had been shared more widely and noted the significant progress achieved locally.	
9.	**Feedback from Board Committees**	
9.1	**Finance & Performance Committee (previously Insight Committee)**	
	Antoinette Jackson (AJ), Non-Executive Director, presented the report and highlighted the Chair's Key Issues (CKIs). AJ reported improved performance in a number of areas. Challenges remained within Community Paediatrics, particularly in relation to waiting times, where increasing demand and system-wide factors required broader solutions. The Committee received substantial assurance regarding the work being undertaken to manage the waiting list. It was also noted that early discussions had commenced with the ICB regarding renewal of the community contract in September 2027. EC advised that pressures within Community Paediatrics reflected a national issue. The service was undertaking a pilot to use AI to support	

	consultation documentation, with the aim of reducing administrative time and increasing capacity for patient care. EC emphasised that the pilot was being implemented carefully and in a measured way. In response to a question from JS regarding RTT validation and patients who do not attend outpatient appointments, EC outlined the Trust's Did Not Attend (DNA) policy. LH advised that, following a first missed outpatient appointment, including diagnostic appointments, the clinician may discharge the patient. For follow-up appointments, discharge may occur after two missed appointments. Medical secretaries contact patients following non-attendance, after which the responsible clinician determines whether a further appointment is required or whether the patient should return to the waiting list. The Council noted the observer feedback. JS commented positively on the "Making Data Count" initiative.	
9.2	**Quality & Patient Safety Committee (previously Improvement Committee)**	
	Paul Zollinger-Read (PZR), Non-Executive Director, presented the report and highlighted the Chair's Key Issues (CKIs). PZR advised that the Committee had completed a restructuring and streamlined a number of its sub-groups. The Committee had also received a presentation on antimicrobial resistance and infection prevention and control. Whilst assurance had been received regarding key infection measures, concern had been raised that the Trust prescribed broad-spectrum antibiotics more frequently than peer organisations. The Committee requested a more detailed review from the Executive Team. The Committee also reviewed progress on the risk register and noted the improvements being made by the Executive Team. The Committee has requested that this work be accelerated where possible. The Council noted the observer feedback. JS suggested that Governors would benefit from a briefing session on the Board Assurance Framework (BAF) and the management of corporate and clinical risks. JC advised that work on the BAF would be presented to the Board for approval and agreed that a Governor briefing would be arranged. PS noted that the session should distinguish between clinical and corporate risks. **Action: Governor briefing on the BAF, corporate risks and clinical risks to be arranged.**	**PB**
9.3	**People & Organisational Development Committee (previously Involvement Committee)**	
	Alison Wigg (AW), Non-Executive Director, presented the report and highlighted the Chair's Key Issues (CKIs).	

	The Committee received an update on the People Programme from the Chief People Officer. The Committee also reviewed data relating to unacceptable behaviour sanctions and requested further analysis by protected characteristic, together with assurance regarding support available to affected staff. In response to a question from JS regarding staff survey results relating to staffing levels, EC advised that a community nursing workforce toolkit had been agreed to support workforce planning. Whilst some staff may perceive staffing levels as insufficient, objective measures did not always support this view. EC noted that senior nursing leaders regularly scrutinised staffing levels and were satisfied that they remained appropriate. JS highlighted the occurrence of nursing red flag events and noted that explanatory information within the report indicated that care may have been missed. PZR observed that where staffing concerns had been identified, such as within Maternity Triage, the Trust had responded by increasing staffing levels. JC noted that red flag events could occur where staffing levels were below establishment but did not necessarily indicate an immediate risk to patient safety. EC advised that the Chief Nurse would be able to provide further explanation on the interpretation of red flag events. **Action: Chief Nurse to provide a briefing on the interpretation of nursing red flag events and associated assurances.** The Council noted the observer feedback.	**DS**
9.4	**Digital & Data Assurance Committee**	
	Alison Wigg (AW), Non-Executive Director, presented the report and highlighted the Chair's Key Issues (CKIs). AW highlighted ongoing challenges relating to data and business intelligence capacity due to increased demand. Strategic measures were in place to address this, with oversight provided through the Programme Board. The Committee had also received a presentation on inclusive communications. In response to a question from SH regarding the role of artificial intelligence (AI) within the third phase of the Transformation Strategy, AW confirmed that oversight would be provided through the Digital & Data Assurance Committee. HH advised that discussions had taken place with a national clinical AI lead and that opportunities to improve documentation and patient engagement were being explored, whilst ensuring an appropriate balance between innovation and clinical standards. EC reported that colleagues had visited the Royal Devon and Exeter Hospital to review its use of AI, including the safeguards and engagement processes in place. Whilst the Trust had adopted a cautious approach, opportunities for further progress were being considered.	

	TP suggested that consideration be given to reviewing areas already using AI within the Trust. AW agreed that an audit of current AI use would be beneficial. The Council noted the observer feedback.	
9.5	**Audit & Risk Committee (previously Audit Committee)**	
	Antoinette Jackson (AJ), Non-Executive Director, presented the report, which was noted and taken as read. EC left the meeting at 6.55 pm.	
10.	**Nominations Committee Report**	
	The Council noted that no meeting of the Nominations Committee had been held since February 2025.	
11.	**Membership & Engagement Committee Report**	
	Sarah Hanratty (SH), Chair of the committee presented the report. The Committee had considered the recommendations of the Standards Committee regarding the election process and noted the current vacancies on the Membership and Engagement Committee. SH presented the revised Terms of Reference for approval. **The Terms of Reference were approved.**	
12.	**Standards Committee Report**	
	Paul Bunn (PB), Acting Trust Secretary, presented the report. The Council considered the proposed election process and timetable. SH raised concerns regarding the cost of running elections given the uncertainty surrounding the future role of Councils of Governors. JC acknowledged the uncertainty but emphasised the importance of remaining constitutionally compliant and maintaining effective community representation. He further advised that, irrespective of future legislative changes, there would remain a need for public and community engagement. CR asked whether Governors could support the development of any future engagement model. JC advised that this would be considered once greater clarity on future arrangements became available. In response to questions from JN, BP and BL, it was confirmed that any significant developments affecting the election process would be reported back to the Council. The Council also discussed communication of election costs and arrangements for induction and training of newly elected Governors. **The Council approved the proposed election process and timetable.** The Council also considered a recommendation from the Audit & Risk Committee to amend the Trust Constitution to include details of approval	

	and review dates. It was noted that the amendment was minor and did not require legal or NHS approval. **The amendment to the Trust Constitution was approved by the Council.**	
13.	**Staff Governors' Report**	
	Louisa Honeybun (LH), Staff Governor, presented the report, the contents of which were noted and taken as read.	
14.	**Lead Governor Report**	
	Ben Lord (BL), Lead Governor, presented the report, the contents of which were noted and taken as read.	
15.	**Quality Accounts 2025/6**	
	Paul Bunn (PB), Acting Trust Secretary, presented the report. PB sought the Council's approval for inclusion of the draft governor commentary in to the Quality Accounts. In response to a question from SH regarding whether the report should reference future uncertainties, PB confirmed that the document was intended as a retrospective review of performance. **The Council approved the commentary for inclusion within the Quality Account.**	
16.	**Governance Report**	
	Paul Bunn (PB), Acting Trust Secretary, presented the report. The Council was advised that PZR had been appointed as a substantive Non-Executive Director and was no longer serving as an Associate Non-Executive Director. PB also advised that two Governors had volunteered to act as readers for the Quality Account; however, additional volunteers would be welcomed. Governors interested in participating were asked to contact PS.	
17.	**Summary Report for Board of Directors Meetings**	
	Jude Chin (JC), Chair, presented the report, the contents of which were noted and taken as read.	
18.	**Any Other Business**	
	None noted.	
19.	**Dates for meetings in 2026**	
	• 10 September, 2026 • 24 September, 2026 – Guildhall, Bury St. Edmunds • 10 November, 2026	
20.	**Reflections on meeting**	
	GM reflected on personal experience of hospital services over the Christmas period, noting that the treatment received was excellent. However, it was observed that physiotherapy support, which should have	

	been arranged on discharge, was not organised by the hospital and subsequently had to be arranged through the GP. GM also reported receiving feedback from a hospital cleaner regarding frequent redeployment of cleaning staff before tasks were completed. AO advised that conversations with local residents who had recently used hospital services had generated very positive feedback regarding the care received.	

5. Matters Arising Action Sheet (enclosed)

To note updates on actions not covered elsewhere on the agenda

To Note

Presented by Jude Chin

Council of Governors' meeting - action points

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
10	Public	05/03/26	7	**Update on Operational Performance - ED Patient Experience** - further detail to be provided via the formal Governor Question process.	Update on question raised to be shared with all governors, via the Quality & Patient Safety CKI at CoG in September. **Today's QPS CKI report (10.9.26) refers.**	~~PB~~ PZR	~~19/05/2026~~ 10/09/2026	Complete	10/09/2026
13	Public	19/05/26	6	**Update on Finance - Non-NHS and Private Patient Income** - confirm wording contained within the constitution.	**Clause 3 (page 4) allows WSFT to generate income from non-health related sources. Clause 40.7 (page 21) confirms CoG approval is only needed if there is a proposal to increase the Trust's private patient income by more than 5% of its total income in any financial year. This is in accordance with the NHS Act 2006 as amended**	JC	10/09/2026	Complete	10/09/2026
14	Public	19/05/26	9.2	**Quality & Patient Safety Committee -** arrange Governor briefing on the BAF, corporate risks and clinical risks.	**Briefing booked for 27.10.26.**	PB	10/09/2026	Complete	10/09/2026
15	Public	19/05/26	9.3	**People & Organisational Development Committee** - Chief Nurse to provide a briefing on the interpretation of nursing red flag events and associated assurances.	**Deputy Chief Nurse to provide a briefing at September meeting.**	DS	10/09/2026	Complete	10/09/2026

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

6. Introduction to Accreditation of Care Excellence (presentation attached)

To receive a presentation from the Deputy Chief Nurse

To inform

Presented by Sarah Ward

Introduction to Accreditation of Care Excellence (ACE)

Council of Governors

Sarah Ward

Deputy Chief Nurse

September 2026

Compassionate care, healthier communities

What is care accreditation?

- A structured quality assurance and improvement programme designed to assess and enhance the standards of care delivered at ward/ service level.
- It provides a framework for measuring performance against agreed standards and encourages continuous improvement.
- A driver for identifying and communicating measurable improvements in patient care and safety outcomes supporting identification of areas requiring improvement and highlighting areas of excellence.

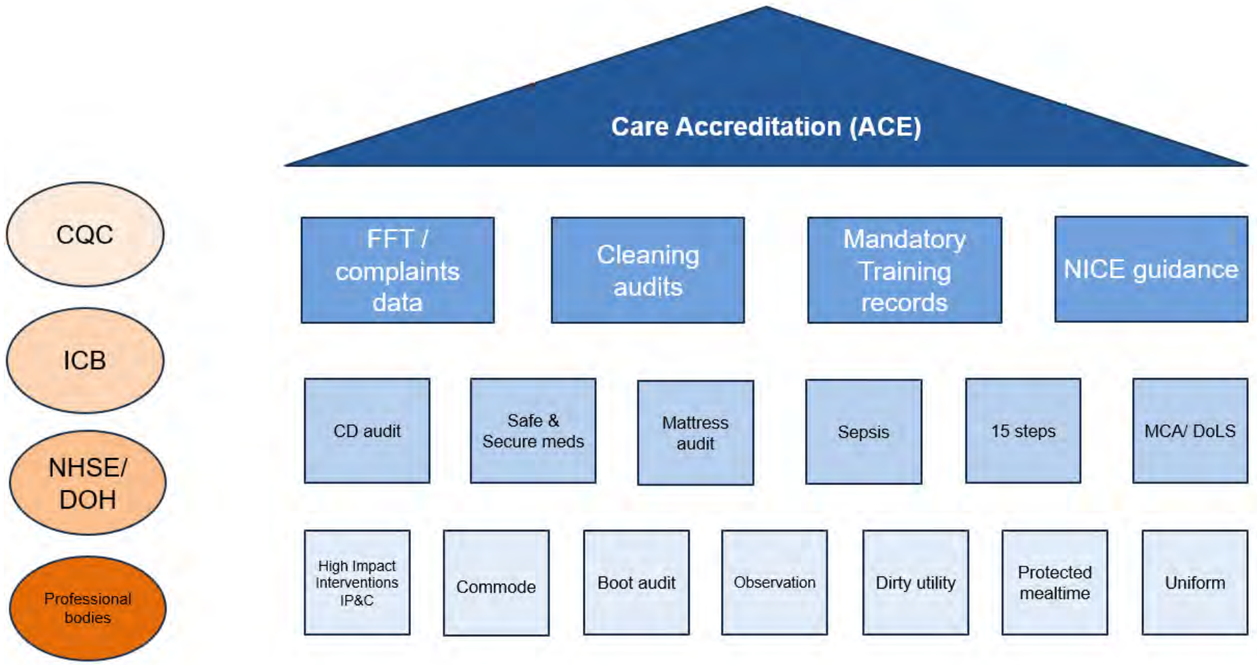
Compassionate care, healthier communities

What is care accreditation?

NHS
West Suffolk
NHS Foundation Trust

Standards

- Deteriorating patient
- Infection prevention and control
- End of life
- Safeguarding and complex care
- Medicines management
- Discharge
- Falls
- Tissue viability
- Food and hydration
- Patient experience



NB : Examples of audits which underpin the programme – there are many more !

Compassionate care, healthier communities

How?

- Scale of programme
- Underpinning audit review / testing methodology (peer/ measures)
- QI integration
- Staff engagement
- Communication
- Benefits realisation
- Ambitious goals

Year / Objective	2025	2026	2027	2028
Establish programme plan aims/ draft standards / Board approval				
Secure funding and progress digital system to enable reporting / data ownership / pace				
Audit programme review				
Comms plan/ socialise/ launch				
Trial assessments acute				
Baseline all acute inpatient hospital areas / ED and Theatres				
Scope community and develop standards				
Improve all acute inpatient / ED and Theatres				
Baseline community				
Scope outpatient departments				
Improve all acute and community				
Baseline outpatient departments				

healthier communities.

So what?

West Suffolk NHS Foundation Trust

- **Improved patient outcomes** through standardisation and accountability. Creates a culture of pride and accomplishment and supports collective leadership, personal and professional development
- **Enhanced staff morale and engagement** via recognition and structured feedback.
- **Data-driven decision-making** using metrics and audits.
- **Provides ward-to-board assurance** on the quality of care and demonstrates compliance with fundamental standards, which enables continual preparedness for external inspections.
- **Improves accountability** and encourages shared governance by enabling a focus on the key risks associated with the delivery of care as well as by identifying excellent practice
- https://www.england.nhs.uk/wp-content/uploads/2021/08/NHSI_Ward_accreditation_guidance_FINAL.pdf

Compassionate care, healthier communities

Any questions?

Compassionate care, healthier communities

7. Update on Elective Recovery

To receive an update from the Chief Operating Officer

To inform

Presented by Nicola Cottington

8. Chair's report (enclosed)

To receive an update from the Chair

To inform

Presented by Jude Chin

West Suffolk NHS Foundation Trust Council of Governors OPEN

Report information

Report title: Chair's report
Agenda item: 8
Sponsor/Executive lead: Jude Chin, chair
Report prepared by: Dr Ewen Cameron, chief executive; Greg Bowker, head of communications
This report is for: ☐Approval ☒ Assurance ☐Discussion ☒Information

This report supports the following ambitions within the organisational strategy:

☒ **High quality care** ☒ **Joined up services**
☒ **Empowered to improve** ☒ **Responsible with resources**
☒ **Fit for tomorrow**

Executive summary

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

This report summarises the main headlines from May to August 2026.

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

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

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

The items reported will be actioned through the appropriate routes.

Action required by the Council of Governors: The Council of Governors is asked to note the content of the report.

Governance and compliance

Risk and assurance: Failure to effectively manage risks to the Trust's strategic objectives.
Equality, diversity and inclusion: We have a duty to reduce inequalities.
Sustainability: Sustainable organisation
Legal and regulatory context: NHS Act 2026; Trust Constitution.

Chair's report

1. Since we last met in May, the Trust's performance has remained fairly steady, though we are currently off plan with our deficit target and there are operational targets that will require concerted effort if we are to achieve them by the end of the financial year. Nevertheless, the plans we have in place – not to mention our more favourable

relative position compared with last year's cost improvement programme (CIP) – means the Board has taken assurance we are making the necessary progress. And it is important to recognise the improvements and sustained performance in areas such as RTT, diagnostics and cancer, which means patients are waiting less time for their procedures and receiving high quality care.

2. This financial year, we have a planned deficit of £12.8m and a total CIP target of £29.7m. Our current position is detailed in the CEO's report. As was discussed in my last update to governors, we've moved away from a block contract to a model where we're able to earn money from our activity – a cost-and-volume contract. Due to industrial action and delays in a theatres refurbishment project, we have not been able to deliver the additional activity we would have planned for in the first months of this financial year. With that work now completed and an end to industrial action, we can begin in earnest to balance cost saving activity with the income we can earn from increased activity.

3. Our performance is dependent on strong leadership and I once again thank the non-executive directors (NEDs) for their commitment and contributions. As part of our Board development, we've recently conducted workshops on our risk appetite, how Board members manage disciplinary procedures effectively and equitably, and how we create a welcoming and inclusive Trust culture. The NEDs have also been active at the four assurance committees and been hearing case studies from staff about quality improvement projects and the work of one of our midwives in championing equality, diversity and inclusion. All of this activity connects to our new strategy, the Trust values, and a model of leadership I believe is needed to build on the strong foundations we've laid.

4. As governors will be aware, the Health Bill going through parliament currently proposes removing the requirement for NHS foundation trusts to have a council of governors. This change is described as being intended to give Foundation Trusts the ability to choose a dynamic approach to local engagement, tailored to the needs and structure of local communities. The passage of the Bill may see changes to this proposal but, for now, the council continues to play an important role in our governance processes and in their work holding NEDs accountable in the performance of their duties. We will continue to keep governors informed as we wait to see the detail when this becomes an Act of parliament.

5. Despite this uncertainty, we move forward with our next round of governor elections and the Annual Members' Meeting (AMM). Nominations open for the council of governors on 8 September and I hope we will attract a mix of familiar faces and a diverse group of people motivated to help shape the way we deliver our services. The AMM is being held in the Guildhall in the centre of Bury on Thursday, 24 September from 4.30pm. It will showcase our successes during the last financial year, offer a marketplace to explore a range of services and initiatives, and feature special interest talks on the theme of technology transforming healthcare.

6. We are now operating as part of the newly-created NHS Norfolk and Suffolk Integrated Care Board (ICB), led by Dr Ed Garrett. This remains a period of adjustment but continue to have strong relationships with partners across the two counties, as well as with neighbours who have moved into their new ICBs. A new accountability framework means the region now holds us accountable, with the ICB

chiefly playing a commissioning role. As part of these changes, Nick Carver has been appointed as the chair of NHS England for the East of England region. We look forward to working collaboratively with Nick and the network he will be building over the coming months.

7. Lastly, it has been a busy summer for our Future Systems Programme team. Along with signing a contract with our construction partners for the new hospital, we've seen new visuals of what this health care facility might look like once completed. It is an incredibly exciting time for our staff, patients, and the communities we serve as the construction moves ever closer and begins to feel more tangible. The next step will be the approval of the outline business case, which should be submitted later in September.

9. Chief Executive's Report (enclosed)

To note a report on operational and strategic matters

To inform

Presented by Ewen Cameron

COUNCIL OF GOVERNORS MEETING (OPEN)

Report information

Report title: Chief Executive Officer's report
Agenda item: 9
Sponsor/Executive lead: Dr Ewen Cameron, chief executive officer
Report prepared by: Dr Ewen Cameron, chief executive; Greg Bowker, head of communications; Anna Hollis, deputy head of communications; Sam Green, senior communications officer.
This report is for: ☐Approval ☒ Assurance ☐Discussion ☒Information

This report supports the following ambitions within the organisational strategy:

☒ **High quality care** ☒ **Joined up services**
☒ **Empowered to improve** ☒ **Responsible with resources**
☒ **Fit for tomorrow**

Executive summary

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

This report summarises the main headlines for June and July 2026.

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 will be actioned through the appropriate routes.

Action required by the Board: The Board is asked to note the content of the report.

Governance and compliance

Risk and assurance: Failure to effectively manage risks to the Trust's strategic objectives.
Equality, diversity and inclusion: We have a duty to reduce inequalities.

Sustainability: Sustainable organisation
Legal and regulatory context: NHS Act 2026; Trust Constitution.

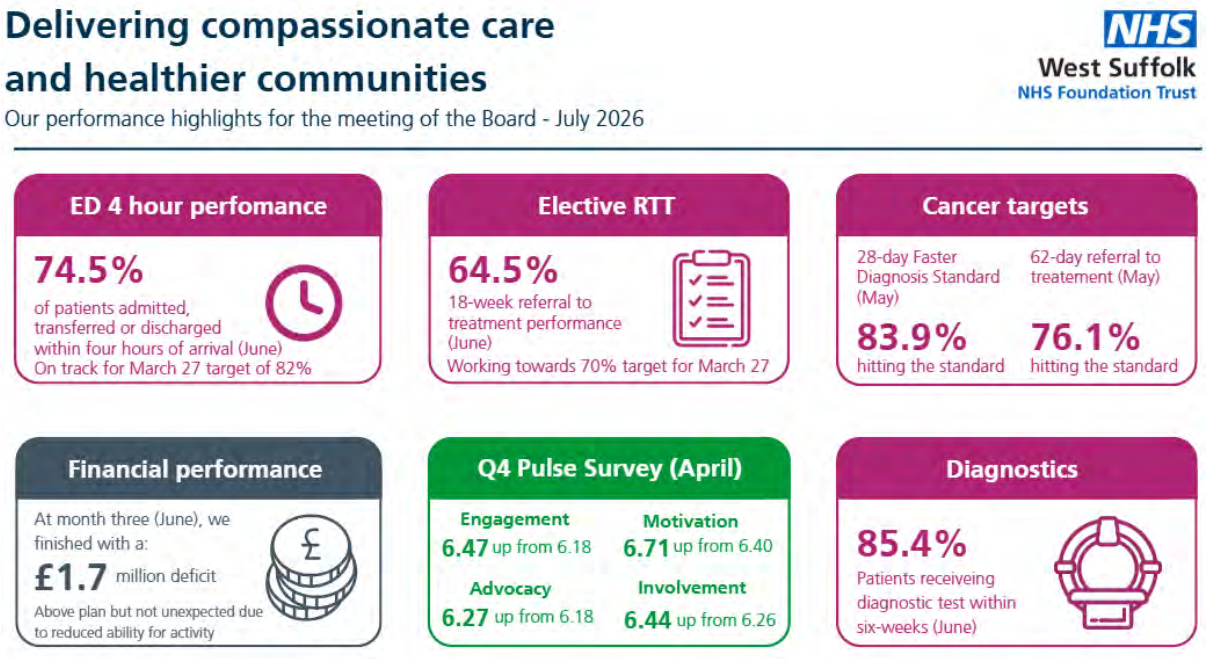
Chief Executive Officer's report

1. Introduction

1.1. We are continuing our work to meet the targets set for this year, and there has been some brilliant progress on this so far. As you may recall, a recent report from the Health Service Journal showed we were the most improved Trust for diagnostic waits from March 2025 to May 2026. Across a wide range of operational and performance targets, we have continued to make progress which benefits our patients and colleagues.

1.2. Progress has been slowed in certain areas though, primarily due to industrial action, extremely hot weather, and planned upgrades to our estate. However, we are making up lost ground. One area affected is our financial performance. We have moved to a new financial model linking activity with our income, and due to the operational challenges, this has inevitably had a small impact on our agreed deficit. We are currently working through our plan to fully recover this within the financial year.

1.3. I would like extend my huge thanks to colleagues working in challenging conditions recently, and who are delivering transformation projects to support improvements across our services.



1.4. In the past few months, a number of high-profile government-commissioned reports and NHS England directives have been published, which impact on the work of all NHS staff. These have looked at maternity care, antisemitism and other forms of racism in healthcare settings, and the unlawful access of patient records. Each of these landmark reports carries recommendations and learning opportunities for us, even if the data suggests we have a record we can be proud of across all these areas. As ever, it is important we take the opportunity to reflect on our practices and identify any potential improvements and, remain vigilant in providing high-quality care in an environment free from fear and discrimination.

2. Financial performance

2.1. We are now in month four of the 2026/27 financial year, and we are continuing to work hard to meet our financial targets for the year, as we have done previously.

2.2. This year, there is a greater emphasis on delivering more activity as we are under a contract based on payment for activity rather than a block contract. Delivering the increased activity we need to treat our patients is a critical part of our financial success this year, as well as being extremely important for patients.

2.3. While much effort has delivered success in operational performance, we have been hindered over recent months by industrial action, extreme weather, and planned theatre closures for improvement renovations. Ultimately, this means as of the end of June, we are not currently on plan, with an in-year position of £1.7m deficit against a planned £0.9m deficit. However, we have detailed plans on how we recover our position during this financial year which we are working through.

3. Performance

Elective recovery

3.1. Our performance in June against the 18-week target was 66%, meaning we continue to be on plan despite having operational pressures.

3.2. As ever, we continue to work hard to reduce the number of patients waiting 52-weeks or more. However, we are currently off plan due to the cumulative impact of improvement works to two of our theatres at the West Suffolk

Hospital (which have since reopened), the difficulties faced during the April period of industrial action, postponements made due to the suspended industrial action planned in June and, the unexpected extreme heat. This means our June 2026 performance for those patients waiting 52 weeks is off plan at 564 against our forecast of 221. We will make further improvements throughout this year to ensure patients are not waiting longer than is acceptable.

3.3. Those waiting more than 52-weeks makes up less than 1.7% of our total waiting list and, having dealt with these operational challenges we move forward with greater confidence and an improved estate, meaning we are primed to deliver more activity and recover our position.

Diagnostics

3.4. In June 2026 84.5% of patients had their diagnostic test within six weeks. This shows the significant improvement programme success continues, which helps us meet these performance targets.

Urgent and emergency care

3.5. Our emergency department performance for the 4-hour standard in June 2026 was 74.5%. While this is below the 2026/27 target of 82%, we are on plan to meet this by the end of March 2027.

Cancer

3.6. 28-day Faster Diagnosis Standard (80% target):
March 2026 – 85.1%
April 2026 – 83.1%
May 2026 – 83.9%

3.7. 31-day Diagnosis to Treatment (96% target):
March 2026 – 99.6%
April 2026 – 99.4%
May 2026 – 100%

3.8. 62-day Referral to Treatment (75% target):

March 2026 – 81.6%
April 2026 – 78.6%
May 2026 – 76.1%

3.9. Our cancer services are all above standard for the first quarter of 2026/27, which is great news and shows ongoing strong performance.

4. Quality

4.1. On 3 July, many of our teams attended the Norfolk and Suffolk Health and Care Expo in Newmarket. The event included the Health and Care Awards, which recognises teams and organisations who deliver outstanding services across the region. Many teams and individuals from our Trust were nominated across numerous categories. For the 'Analogue to Digital Award', the Virtual Bones app received runner up, with the digital transformation and waste management teams being highly commended. Additionally, the workplace adjustment team and the Disability Network were commended. For the 'Hospital to Community Award', the virtual ward team was highly commended and, for the 'Research and Innovation Award', the speech and language therapy intensive treatment unit team were highly commended, with Amanda Keighly and Shelley Lee being commended. Finally, under the 'Unsung Hero Award', the Trust was runner up as part of the collaborative Service by Emergency Response Volunteers, and the West Suffolk Blanketeers, Ehab Georgy, and Georgie Brown were all highly commended.

4.2. These teams and individuals have all demonstrated the innovation and compassionate care that defines our culture. It was a very competitive field in every category, and everyone should know they have done themselves and the Trust proud.

4.3. The training and education opportunities offered by the Trust are hugely important and underpin the quality of the care we provide. Therefore, it is great news our orthopaedic team has been awarded Training Hospital of the Year for the eastern region. A fantastic achievement, this demonstrates to current and future resident doctors we are committed to providing a great work environment, where you will receive the knowledge and skills needed to go far in your career.

5. Workforce

5.1. In early July, NHS England shared its new 'staff standards', which set out expectations and commitments to support a better, fairer, and more consistent employment experience for all staff working in the NHS. The standards focus on six domains; line management, violence reduction and prevention, tackling racism, health and wellbeing, championing sexual safety, and promoting flexible working. Each area stipulates expected actions for the employer, with compliance against the standards measured as part of the NHS Oversight Framework. We are developing our plans to meet the standards and will be communicating with colleagues to help them understand what they mean – and how they should translate into an improved experience of day-to-day work.

5.2. At the last Board meeting, I shared the positive news we've seen our quarterly Pulse survey scores improve. In the Q1 results we were above the national average in three of the four key measures (engagement, advocacy, involvement, and motivation). The Q2 Pulse survey has been running throughout July and closes today. Those results will show whether we have sustained the progress, ahead of the 2026 NHS Staff Survey launching later this year.

5.3. Of course, the quality of the care we provide is underpinned by the hard work and dedication of our colleagues, day-in, day-out. However, another aspect which is very important, is our colleagues' wealth of knowledge and expertise, which can often come from their length of service not just to the NHS, but our Trust specifically. I've been astounded by the number of people who have worked here 20, 30, or even 40 years, and it is frequently these colleagues people reference when they describe steadfast, masters of their craft. On Thursday, 2 July, one of these colleagues in our estates and facilities team, Roger Gembis, marked 50 years with us, having joined the NHS here at West Suffolk in 1976.

5.4. Roger, an engineer by trade, is an expert who does the right work in the right way to make this a safe place for all who come to our sites. What you hear most often about Roger is his know-how, and we all consider him an absolute pleasure to work with and be around. He is a shining example of everything that makes this Trust a great place to work, and I hope you join me in thanking him for all he has contributed, and all he will contribute as he continues his work here with us.

6. Future

6.1. The project to deliver a new West Suffolk Hospital is making good progress. The Trust has now been matched with its construction partner and can confirm Dragados Sociedad Anonima as the organisation who will work alongside us. This is an important milestone for the programme and another step forward in the development of our future hospital. We now look towards the coming years and have greater clarity on the timeline of this project.

6.2. Alongside this, the Trust's Board and the ICB's Board have formally approved the business case for the expansion of the Newmarket Community Diagnostic Centre. This means endoscopy services will be offered on the Newmarket Community Hospital site, reducing operational congestion at the West Suffolk Hospital and giving our patients greater flexibility in where they are treated. This collaborative project with our partners at Cambridge University Hospitals NHS Foundation Trust (CUH) means patients in west Suffolk and east Cambridgeshire get the option to attend a dedicated facility providing planned endoscopy care. This not only protects our own urgent and emergency pathways, but also offers more specialised CUH services to the communities of west Suffolk.

GOVERNOR BUSINESS (INC. STATUTORY DUTIES)

10. Feedback from assurance committees (enclosed)

To receive committee key issues (CKI) and observers reports from the assurance and audit committees

For Discussion

Presented by Jude Chin

COUNCIL OF GOVERNORS MEETING (OPEN)

Report information

Report title: Feedback Report from Board Assurance Committees and Audit & Risk Committee
Date of the meeting: 10 September 2026
Agenda item: 10
Sponsor/Executive lead: Non-Executive Directors / Governor observers at the Board's assurance committees
Report prepared by: Chairs of the assurance committees, Governor Observers at the assurance committees, Pooja Sharma, Deputy Trust Secretary, Ruth Williamson, Senior Administrator, FT Office
This report is for: ☐Approval ☒ Assurance ☒Discussion ☒Information

This report supports the following ambitions within the organisational strategy:

☒ **High quality care** ☒ **Joined up services**
☒ **Empowered to improve** ☒ **Responsible with resources**
☒ **Fit for tomorrow**

Executive summary

What?
Governors have the opportunity to observe board assurance committee meetings. This allows them to witness NED contribution to the conduct of the meeting and the level of challenge provided.

The Trust supports Governors to observe Board and relevant assurance committees to provide greater oversight of Board and NED activities. A guidance note for governor observers at board assurance committees sets out clear expectation of observer role for governors, chair, NEDs and Execs.

So what?
The report highlights the summary of the agenda items discussed in the Board assurance committees, committees' key issues and respective governor observers' reports to provide an update to the Council.

Annex A of the report details the exception slide from the Trust's IQPR. This information helps to focus discussion within the assurance committees.

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

Action required:
The Council of Governors is asked to note the feedback from Board assurance committees and audit committee.

Governance and compliance

Risk and assurance: Council of Governors unable to undertake its statutory duties.
Equality, diversity and inclusion: We have a duty to reduce inequalities.
Sustainability: Sustainable organisation
Legal and regulatory context: West Suffolk NHS Foundation Trust Constitution, Health & Social Care Act 2022, NHSE Code of Governance 2022.

BOARD ASSURANCE COMMITTEES - FEEDBACK REPORT

Finance and Performance Committee:

20 May 2026 (observed by none)

High quality care

- Operational Performance
- March 2026 IQPR and Patient Access Governance Group
- Community waiting times against 18-week target – adult and children including NDD

Joined up services
No reports

Responsible with resources
Finance

- Financial Accountability Committee
- Month 12 Reporting
- CIP Update
- QIA Panel Outcomes
- Internal Audit Report

Empowered to improve

- No reports

Fit for tomorrow

- Finance & Estates Strategies
- Green Plan – update on progress

Governance

- Review of the Work Programme/Forward Plan
- Escalations to and from other board assurance committees and board

17 June 2026 (observed by Jayne Neal)

High quality care

- Operational Performance
- April 2026 IQPR and Patient Access Governance Group
  - Community services performance follow up
- Elective Plan

Joined up services

- Stroke Services across acute and community (ESD) – how we perform and benchmark and what are the critical success factors

Responsible with resources
Finance

- Financial Accountability Committee
- Month 2 Reporting
- CIP Update
- QIA Panel Outcomes
- Internal Audit Report
- Board Assurance Framework - BAF 7 (Performance) and BAF 3 (Finance)

Empowered to improve

- No reports

Fit for tomorrow

- No reports

Governance

- Corporate Risk Governance Group
- Review of the Work Programme/Forward Plan
- Escalations to and from other board assurance committees and board

15 July 2026 (observed by none)

High quality care

- Operational Performance
- May 2026 IQPR and Patient Access Governance Group
- Elective Delivery Plan Update

Joined up services

- Community Contract – Update

Responsible with resources
Finance

- Financial Accountability Committee
- Month 3 Reporting
- CIP Update
- QIA Panel Outcomes
- National Cost Collection
- Capital Process
- Board Assurance Framework - BAF 2 (Estates) and BAF 3 (Finance)

Empowered to improve

- Access Indicators through an EDI lens – are we creating inequalities in our waiting lists? How do we address this?

Fit for tomorrow

- No reports

Governance

- Review of the Work Programme/Forward Plan
- Escalations to and from other board assurance committees and board

19 August 2026 (observed by Jayne Neal)

High quality care

- Operational Performance
- June 2026 IQPR and Patient Access Governance Group
- Elective Delivery Plan Update
- Productivity Deep Dive – Theatres and Outpatients – How are we strategically driving productivity? What do we mean by productivity? How do we benchmark and how do we monitor improvements?

Joined up services

- Community Contract Renewal Update

Responsible with resources

Finance

- Financial Accountability Committee
- Month 4 Reporting
- CIP Update
- QIA Panel Outcomes
- National Cost Collection
- Internal Audit Report
- Board Assurance Framework - BAF 7 (Performance)

Empowered to improve

- No reports

Fit for tomorrow

- No reports

Governance

- Review of the Work Programme/Forward Plan
- Escalations to and from other board assurance committees and board

Quality and Patient Safety Committee:

20 May 2026 (observed by Jane Skinner and Sue Kingston)

- Risk register
- Mortality Oversight Group update
- Reports from Clinical Services
  - Maternity and Neonatal services - Claims scorecard
- Quality Performance / KPIs
- Quality Delivery Governance Group report (formerly known as Patient Quality & Safety Governance Group)
- Clinical Effectiveness Governance Group
- IQPR, PRM packs
- Patient Safety quarterly report
- Discussion on strategic priorities for Committee
- Quality priority reporting
- Information Governance action referred from Digital and Data Assurance Committee
- Escalations to and from other board assurance committees and board

17 June 2026 (observed by Sue Kingston)

- Risk register
- Pharmacy risk: full articulation of controls and mitigations (Action 249)
- Patient experience update report
  - Patient engagement and experience – strategic approach (Action 243)
- SEND oversight
- ED long waits, to include specifically experience of care (Action 247)
- Reports from Clinical Services – no reports this month
- Quality Performance / KPIs
- Quality priorities 2026/2027
- Quality Delivery Governance Group report
- Clinical Effectiveness Governance Group

- IQPR
- PRM packs
- BAF 8 – Transformation
- Discussion on strategic priorities for Committee
- Discussion on improving communication and documentation themes across services
- Review of Committee Effectiveness - draft questionnaire

15 July 2026 (observed by Jayne Neal)

- Risk register
- General clinical risk update
- Community clinical risks deep dive
- IPC service update
- Hand hygiene update report
- Respiratory audit completion plan
- Medication safety assurance report
- Reports from Clinical Services
  - National maternity learning
- Quality Performance / KPIs
- Quality Delivery Governance Group report
- Clinical Effectiveness Governance Group
- IQPR
- PRM packs
- Reports from Clinical Services
- National maternity learning
- Discussion on strategic priorities for Committee

19 August 2026 (observed by Sue Kingston)

- Risk register
- General clinical risk update
- Quality Performance / KPIs
- Clinical Effectiveness Governance Group
- Mortality Oversight Group update
- Capturing family feedback post-review
- Mental health update – verbal
- Reports from Clinical Services - No report this month
- Quality Performance / KPIs
- Quality Delivery Governance Group report
- Clinical Effectiveness Governance Group
- IQPR
- PRM packs
- Patient Safety quarterly report
- Discussion on strategic priorities for Committee
- Review of Committee Effectiveness results

People and Organisational Development Committee:

17 June 2026 (observed by none)

Recent announcements affecting workforce – Band 5 Review, Industrial Action, Sexual Safety.

Empowered to improve
- Volunteer Service Annual Impact and Development Report 2025/26
- Mann Review
- WSFT Staff survey action plan
- BAF - Transformation
- My WiSH – maternity Services

High quality care
- Resident Doctor 10 Point Plan
- Guardian of Safe Working

Joined up services
- PRIDE Network Update

Fit for tomorrow
- Embedding a Culture of Continuous Quality Improvement (CQI)

Responsible with resources
- IQPR extract for the Committee (staff KPIs) for information

Escalations to and from other board assurance committees and board

19 August 2026 (observed by David Slater and Becky Poynter)

Recent announcements affecting workforce – Consultant Strikes, New Secretary of State for Health, Lord Mann Update, Pulse Survey.

Empowered to improve
- Update on Mandatory Learning
- Leadership & Management Framework
- Staff Standards (verbal)
- Gender, Disability & Ethnicity Pay Gap Report
- WRES/WDES Reports
- Inclusive Culture Policy

High quality care
- My WiSH – Maternity Service

Joined up services
- Parent & Carer Network Update

Fit for tomorrow
- Embedding a Culture of Continuous Quality Improvement (CQI)

Responsible with resources
- IQPR extract for the Committee (staff KPIs) for information

Escalations to and from other board assurance committees and board

Digital & Data Assurance Committee

30 July 2026 (observed by Jane Skinner)

National updates or mandates

- Cyber letter from NHS England
- Frontline productivity and national funding

Risks, governance and safety
- Risks for assurance/escalation
- Deep Dive into controls around accessing patient records
- Cyber hygiene summary report

Governance
- BAF 1 – cyber and discussion of risk appetite

Digital and data programme
- Digital and data programme board report, including items for escalation
- Delivering on our strategy
- Future System programme digital update
- Data and BI report

Audit & Risk Committee
Audit & Risk Committee's key issues report (23 June 2026) presented by the Committee Chair.

Annex A: IQPR – exception summary slide

Summaries
Finance & performance
Quality and patient safety
Workforce & OD
Appendices

Variance – are the measures being met?

June 2026	Assurance – can the target be consistently achieved? Consistently hitting target - celebrate (P)	Target not consistently achieved or failed (?)	Consistently fail target - investigate (F)	No target set – celebrate, monitor or investigate
Special cause improvement- celebrate (H) (L)		F&P 28 Day Faster Diagnosis	F&P Diagnostic Performance % within 6 weeks Total RTT 65+ Week Waits Q&PS Patient Safety Incidents (PSIs)	F&P RTT 52+ Week Waits RTT 52+ Weeks Wait as a % of Trust WL RTT <18 Week Waits (%All) RTT <18 Weeks Waits (% First OPA) Q&PS Incidents & RO
Common cause – monitor & understand		F&P Non-admitted 4 hour performance Virtual Ward Total average occupancy percentage POD Mandatory Training Turnover	F&P Ambulance Handover within 15min Incomplete 104 Day Waits	F&P 12 hour breaches 12 hour breaches as a percentage of Type 1 attendances RTT Waiting List Q&PS INT Nursing Deffered by Service Inpatient Deaths Forma Complaints Received Formal Complaints Resolved Late (>25wd) PALS Received
Special cause concerns - investigate (H) (L)	POD Staff Sickness Rolling 12months Staff Sickness	F&P Cancer 62 Days Performance	POD Appraisal	F&P Community Paediatrics RTT Overall Waiting List Community Paediatrics RTT Overall 52 Weeks Wait Q&PS SHMI

Items for escalation
Finance and performance (F&P) - Elective: Ambulance Handover within 15min, Diagnostic Performance % within 6 weeks Total, RTT 65+ Week Waits
Finance and performance (F&P) - Cancer: Incomplete 104 Day Waits, Cancer 62 Days Performance
Quality and Patient Safety (Q&PS): Patient Safety Incidents (PSIs)
People and Organisational Development (POD) - Well Led: Staff Sickness Rolling 12months, Staff Sickness, Appraisal

For noting: Trajectory in place for ED 12 hour breaches. 92% target for RTT 18 weeks still in place as well as monthly trajectory. Trajectory in place for 4 hour ED waits.

10.1. Finance & Performance Committee (previously Insight)

To Note

Presented by Antoinette Jackson

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			Date of meeting: 20 May 2026		
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	**Operational performance** The Committee noted strong year-end performance, with most key operational metrics met or exceeded, reflecting sustained effort across the year, particularly in March. Of note was the sustained improvement in diagnostic performance which is ahead of the agreed recovery trajectory. Whilst the 4-hour target in ED was met there are still significant number of 12-hour breaches. Corridor care is used on occasion to enable offload of ambulances.	**2 Reasonable**	There has been significant improvement in the range of metrics contributing to better patient care. There are 6,000 fewer people on the elective waiting list since last year.	The challenge going into 2026/27 will be sustaining improvements particularly for ED and this will require better flow throughout the hospital and appropriate community and system support	1 no escalation

Community waiting lists deep dive	The Committee noted significant performance challenges in achieving the 18-week RTT standard across community services. In **paediatric services** demand exceeds capacity, due to rapid growth in neurodevelopmental disorder (NDD) referrals, increasing SEND demand nationally and a broader rise in general paediatric workload. For **adult community services**, performance issues were more localised. Some areas (e.g. integrated neighbourhood teams) are under sustained capacity pressure. Others (e.g. pain management) are showing improvement and recovery.	**3.Partial**	Paediatric services are facing a structural challenge, needing to balance high-volume, lower acuity NDD pathways with smaller numbers of complex, high-risk children, including those with significant clinical needs. Much of the pressure in community services is system-wide and not fully within Trust control. Current block contract arrangements do not adequately reflect rising demand, and this then limits responsiveness.	Actions underway include pathway redesign and engagement with the ICB; workforce development, outsourcing, and additional diagnostic capacity; and improved triage and demand management. Whilst some actions are within the Trust's control, current performance against the 18-week target remains unsustainable without wider system change, including clearer commissioning support and better alignment of capacity to demand. The community contract renewal provides an opportunity to address these issues more strategically. The issues raised in the report will be considered by MEG.	2 Escalate to MEG

Finance Accountability Committee	**Performance month 12 of 2025/26** The Trust met its revised control total in 25/26 which, including a redistribution of central system funding resulted in a deficit of £15.0m. Capital spend for 2025/26 was below the forecast plan. **Month1 2026/27** The Trust has agreed a deficit plan of £12.8m in 2026/27 which will be funded with deficit support funding. The reported deficit for M1 is £1.0m, £545k worse than plan. This includes costs relating to industrial action and a loss of income due to the closure of two theatres for refurbishment. With regard to capital, in month 1 the Trust performed well below the in-month delivery plan of £3.8m.	**2 Reasonable**	The new tariff arrangement and a move away from a block contract means sustaining income levels is crucial. Although the start to the year was unfavourable, this reflects specific operational issues rather than systemic deterioration. The position is considered recoverable over the course of the year, subject to successful delivery of planned mitigations	It is anticipated that elective activity and associated income will be recovered later in the year, once the theatres are fully operational (Q2 onwards) and plan is being developed to achieve this. The Financial Accountability Committee will be reviewing capital control systems and reporting back to a future F&P Committee.	2.Escalate to FAC

Cost Improvement Programme	The Committee noted progress in identifying savings, with the tracker showing savings of around £19.3m (non-risk adjusted) with a remaining gap of approximately £7–8m to target. The Exec team reported improved rigour in recent weeks, with better validation and costing of schemes; increased alignment between operational and finance teams and more confidence in the reported figures.	**3.Partial**	Current progress shows around 70% of target has been identified, which is a significant improvement compared to a month ago. The remaining gap represents more complex and less easily deliverable schemes; some schemes are still underdeveloped or require further validation; and there is a need to ensure that identified savings are deliverable in practice.	A range of additional opportunities are being explored, including workforce efficiencies (particularly reducing temporary staffing), procurement savings and further divisional scheme development. Risks are being reviewed through programme boards and oversight groups. The Committee challenged whether the risk register was sufficiently focused and actively managed, rather than simply listing issues which might impede progress.	2 Escalate to MEG/FRG

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: Finance and Performance			Date of meeting: 17 June 2026			
Chaired by: Antoinette Jackson			Lead Executive Directors: Nicola Cottington and Jonathan Rowell			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**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)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
7.1	**Operational performance** The Committee noted good performance above trajectory in relation to Cancer, Diagnostics and Urgent Community response. The majority of Emergency Department (ED) indicators are still under target including 30-minute ambulance handover, overall 4-hour performance and 12 hour breaches. Occupancy of the virtual ward has also reduced.	**3 Partial**	Emergency Department (ED) attendances for April were 9131, 3.1% higher than our planned growth and 8.5% higher than April 2025	The challenge going into 2026/27 will be sustaining improvements particularly for ED and this will require better flow throughout the hospital and appropriate community and system support	Assure	1

Originating Committee: Finance and Performance			Date of meeting: 17 June 2026			
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7.2	**Elective Recovery** The deficit in elective activity is significant; this is due to the continuation of overrunning refurbishment works in main theatres. First outpatient attendances are slightly behind plan. Day case activity is only slightly behind plan.	**4 Minimal**	Delivery of the activity plan is required to meet both financial and operational performance objectives in response to the NHS Medium Term Plan, with further activity required to get the plan back on track over the course of the year.	This remains an area of risk and the lack of detailed plans to show how the Trust will get back on track limited the assurance the committee could take at this meeting. An Elective Delivery Group has been established to bring together oversight of both core and stretch activity plans. Workstreams across theatres, outpatients, diagnostics, clinical coding and system-wide initiatives will drive delivery of these. Group will monitor delivery against financial and performance objectives and will report to Finance and Performance Committee monthly.	Assure	1/2 Escalate to MEG and to Board for awareness

Originating Committee: Finance and Performance			Date of meeting: 17 June 2026			
Chaired by: Antoinette Jackson			Lead Executive Directors: Nicola Cottington and Jonathan Rowell			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**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)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
8	**Stroke Services Deep Dive** The committee undertook a deep dive into Stroke Services. The Sentinel Stroke National Audit Programme (SSNAP) is a major national healthcare quality improvement programme for stroke patients. It collects data along the patient stroke pathway, pre, during and post admission. The service consistently scored A in the previous performance regime. The new SSNAP indicators are more challenging and therefore the service's score in October – December was C on a scale of AtoE. This is the highest in the region and in the top 10 nationally.	**1 Substantial**	Quality of care has not deteriorated but the new framework measures different things and is more challenging. The service demonstrates exemplary multi-disciplinary working in identifying and delivering service improvement. Some targets remain aspirational due to limited therapy resources, in particular at weekends.	The service focus for this year was to adjust to the new SSNAP requirements and look at productivity in order to address most challenging gaps. In order to meet the weekend therapy requirement, extra staffing across Physiotherapy, Occupational Therapy and Speech and language therapy would be needed. The service will be considering what further resources are required as part of the business planning cycle.	Assure	1

Originating Committee: Finance and Performance			Date of meeting: 17 June 2026			
Chaired by: Antoinette Jackson			Lead Executive Directors: Nicola Cottington and Jonathan Rowell			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**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)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
9.2	A gap of £9.2m/£11.4m remains when considering the unweighted / weighted CIP position respectively. This represents 69% or 62% of CIPs identified against target.	**3.Partial**	The remaining gap represents more complex and less easily deliverable schemes; some schemes are still underdeveloped or require further validation; and there is a need to ensure that identified savings are deliverable in practice. This means significant risks remain in the programme.	A range of additional opportunities are being explored, including workforce efficiencies (particularly reducing temporary staffing), procurement savings and further divisional scheme development. Risks are being reviewed through programme boards and oversight groups.	Assure	1

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

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Definitions

Alert	Proactive notification of subject matter/risk that reporting committee is currently dealing with or mitigating which may require further action/decision.	**Inform**	No action required. Reporting to update on discussion within a reporting committee's TOR.
Escalate	Formally raise an issue, concern, or risk to a higher level of authority so that it can be reviewed and acted upon appropriately	**Assure**	Information to demonstrate that appropriate action is being taken within a reporting committees' TOR.
Approve	A request by the reporting committee that something meets required standards but needs higher authority permission to proceed/sign off before being implemented.		

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Finance and Performance			Date of meeting: 15 July 2026			
Chaired by: Antoinette Jackson			Lead Executive Directors: Nicola Cottington and Jonathan Rowell			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**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)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
7.1	**Operational performance** The Committee took assurance on performance above trajectory in relation to Cancer, Diagnostics and Urgent Community response. The Committee recognised continued risks relating to UEC performance and virtual ward occupancy and Elective Care. RTT performance remained above plan at 65.4% but the size of the waiting list and the number of long waits have increased. Emergency Department (ED) attendances for May were 9420, 1% higher than previous month. 7.49% of all Emergency Department (ED) attendances were 12-hour breaches	**3 Partial**	Outbreaks of Norovirus and resident doctors' industrial action were contributing factors to UEC under-performance. Theatre closures are impacting on elective recovery.	A Continuous Quality Improvement project is being set up to address UEC performance and flow taking a Trust-wide approach. The refurbished theatres are to reopen in late July.	Alert	1 No escalation

Originating Committee: Finance and Performance			Date of meeting: 15 July 2026			
Chaired by: Antoinette Jackson			Lead Executive Directors: Nicola Cottington and Jonathan Rowell			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**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)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
7.2	**Elective Recovery Plan Update** The Committee noted the newly established Elective Delivery Board (EDB) had met and was providing speciality-level oversight. The Committee noted that gaps against plan were narrowing in outpatient and day-case activity; elective inpatient activity remained significantly below plan.	**3 Partial**	Delivery of the activity plan is required to meet both financial and operational performance objectives in response to the NHS Medium Term Plan, with further activity required to get the plan back on track over the course of the year.	This remains an area of risk. The Committee acknowledged the improved governance arrangements but requested greater assurance regarding the deliverability of the speciality recovery plans.	Escalate	2. Escalate to MEG
8	**Community Contract Update** Work is continuing to identify risks and opportunities associated with future contractual arrangements. There are emerging indications that the procurement timetable may be delayed.	**2 Reasonable**	There are potential risks relating to contract scope and service transfer and loss of income related to the contract.	The Committee concluded that the overall risk remained manageable and that the Trust was well positioned for future discussions. MEG will receive regular reports on progress	Inform	1 No escalation

Originating Committee: Finance and Performance			Date of meeting: 15 July 2026			
Chaired by: Antoinette Jackson			Lead Executive Directors: Nicola Cottington and Jonathan Rowell			
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9.1 and 9.2	**Finance Month 3 report and CIP Update** The reported deficit for June 2026 is £318k, £265k worse than plan (£873k YTD). This is largely due to clinical income being behind plan, net of costs associated with reduced activity levels. The Trust is forecasting to break even in 2026/27 after receiving the agreed deficit support funding. However, there are risks to this position in relation to recovering our elective activity plan and delivering our CIP programme. .	**3.Partial**	As reported above there is currently only partial assurance that the elective recovery programme has appropriate plans in place to achieve the recovery trajectory required. The remaining gap in CIP represents more complex and less easily deliverable schemes. This means significant risks remain in the programme.	A range of additional CIP opportunities are being explored. CIP risks are being reviewed through programme boards and oversight groups.	Alert	1 No escalation

Guidance notes

The practice of scrutiny and assurance

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

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Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Finance and Performance			Date of meeting: 19 August 2026			
Chaired by: Antoinette Jackson			**Lead Executive Directors: Nicola Cottington and Jonathan Rowell**			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**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)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
7.1	**Operational performance** The Committee took assurance on performance above trajectory in relation to Cancer, Diagnostics and Urgent Community response. The Committee recognised continued risks relating to UEC performance and virtual ward occupancy and Elective Care. UEC is meeting the 4-hour plan but 12 hour waits and ambulance handover are still behind plan	**3 Partial**	A Continuous Quality Improvement (CQI) project has been set up to address UEC performance and flow taking a Trust-wide approach. An initial workshop and learning from others suggests incremental shifts can make a big difference to overall outcomes.	The refurbished theatres reopened in July. The UEC CQI project will continue. The elective recovery plan is discussed below	Alert	1 No escalation
7.2	**Elective Recovery Plan Update** The Committee looked at activity information for Month 4 and Finance performance for Month 3. Current performance shows elective inpatient activity remains significantly below the income	**3 Partial**	There are some positive indicators including improved outpatient performance, increasing theatre activity, strong benchmarking for Patient Initiated Follow-Up (PIFU)	This remains an area of risk. Recovery plans are in place across all divisions, focused particularly on General Surgery, Orthopaedics and Gynaecology.	Escalate	2. Escalate to MEG

Originating Committee: Finance and Performance			Date of meeting: 19 August 2026			
Chaired by: Antoinette Jackson			Lead Executive Directors: Nicola Cottington and Jonathan Rowell			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**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)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
	target plan at 26.3% below expected levels, while outpatient and day case activity are closer to plan. Overall elective income is £1.87m below plan at Month 3.		remote appointments and Do Not Attends (DNAs). But there remains a risk that planned elective and financial recovery trajectories will not be achieved.			
7.3	**Productivity Deep Dive** The Committee undertook a deep dive into clinical productivity across outpatient services and theatres. The Committee took some assurance that there was comprehensive governance systems and improvement programmes in place. But theatre productivity has been significantly impacted by estates issues and refurbishment projects, losing 338 theatre days between January 2024 and July 2026.	**2 Partial**	Whilst some specialties demonstrate improving utilisation, variation remains across services, creating operational and financial risks if planned productivity improvements are not sustained.	There are number of projects in place to improve productivity and to manage the operational and financial risks associated with those improvement plans.	Alert	1 No Escalation

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9.1 and 9.2	**Finance Month 3 report and CIP Update** The reported deficit for July 2026 is £319k, being £127k worse than plan (£1.0m YTD). This is largely due to clinical income being behind plan. The recurring deficit position continues to be just below £1.5m without the monthly deficit funding (of almost £1.1m per month). The Trust has identified £21.3m/£20.4m of unweighted/weighted CIP opportunities respectively against a full year target of £29.7m leaving a gap of £8.4m/£9.3m unweighted / weighted CIP. It is positive to note that 94% of those schemes identified, deliver recurrent savings.	**3.Partial**	The Trust is forecasting to break even in 2026/27 after receiving agreed deficit support funding. However, there are risks to this position in relation to delivering our CIP Plan; in particular (as discussed above) recovering our elective activity plan and achieving significant productivity improvements.	A range of additional CIP opportunities are being explored. CIP risks are being reviewed through programme boards and oversight groups.	Alert	1 No escalation

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The practice of scrutiny and assurance

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Feedback from assurance committees: Governor observer report

Board assurance committee: Finance and Performance (formerly Insight)

Meeting date: 17 June 2026

Governor observer: Jayne Neal

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• The meeting included discussions concerning Financial and Operational performance. • The IQPR discussion included Emergency Care performance, use of the Virtual Ward, diversity data on long waits in ED, community paediatrics, elective plan performance • The Finance report focussed on the Trust's month 2 position against plan and CIP targets • Deep dive presentation on stroke services in both the acute and community settings
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• The meeting was conducted throughout in line with Trust values • Good level of challenge and probing questions in order to facilitate good understanding of the subjects discussed, in particular from the committee Chair • The meeting flowed well even though it was punctuated to include the stroke services presentation

Assurance

Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.

- The Committee had good assurance with regard to the Finance plan and CIP situations. The Finance Director explained the reasons why the Trust is behind plan; mainly due to clinical income shortfalls but optimistic of recovery as the year progresses.
- There are approximately £20m value of CIP schemes identified against the £29.7m target, with major schemes emerging soon which will make significant financial contributions
- The deep dive into stroke services gave high levels of assurance that this high performing sector will continue to deliver significant quality care for patients. Discussions included how the service actually works on both a day to day basis and how they are planning longer term, whilst working closely with the community colleagues

Governor observer Notes

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

- The stroke services ways of working offer opportunities across the Trust; eg their multidisciplinary teams work together to solve problems and therefore improve patient outcomes. This is a highly specialised team with low staff turnover, providing opportunities for newly qualified nurses in particular.
- The meeting was well Chaired with all attendees being able to contribute and offer their thoughts and opinions on all the agenda items

Feedback from assurance committees: Governor observer report

Board assurance committee: Finance and Performance

Meeting date: 19 August 2026

Governor observer: Jayne Neal

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• The meeting included discussions concerning Financial and Operational performance. • The June IQPR data report was presented and discussion included Emergency Care performance, elective delivery plan update, cancer pathway treatment and diagnostics activity • The Finance report focussed on the Trust's month 4 position against plan and CIP targets • Deep dive presentation on productivity re theatre use and out-patient services
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*

- The meeting was conducted throughout in line with Trust values
- Good level of challenge and debate, significant issues were covered
- The meeting was well chaired, with the Chair seeking clarification where appropriate to get a clear understanding of specific points

Assurance

Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.

- The Committee had partial assurance with regard to the Finance recovery plan and CIP. All operating theatres are now open following the refurbishment of two theatres. Therefore, there are now opportunities to provide more services and increase income in the coming months.
- The introduction of the new robot is having a positive impact (after the initial staff training period). It reduces the in-patient stay / recovery time in the hospital. A number of different work areas are keen to learn to use this equipment.
- There is still a gap in the value of CIP schemes. However, the introduction of different ways of working in some areas should mean increase in productivity which will make significant financial contributions.
- The deep dive discussions concerning out-patient services focussed on the 'did not attend' (DNA) patients and how to manage that; ie better digital / electronic reminder systems along with how best to use the capacity missed appointments generate

Governor observer Notes

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

- The meeting was well Chaired with all attendees being able to contribute and offer their thoughts and opinions on all the agenda items
- The agenda items flowed well and clearly identified the links between productivity and the financial implications for the Trust
- There were a number of observers at the meeting who are work-shadowing senior executives. They said they found the meeting interesting with comprehensive discussions

10.2. Quality & Patient Safety Committee (previously Improvement)

To Note

Presented by Paul Zollinger-Read

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Quality & Patient Safety Committee			Date of meeting: 20 May 2026		
Chaired by: Dr Paul Zollinger-Read			Lead Executive Director: Dan Spooner – Executive Chief Nurse / Dr Richard Goodwin – Executive Medical Director		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:** **SO WHAT?** *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
4.	Clinical divisional risk registers are currently unwieldy and do not clearly identify the divisions biggest risk and subsequent oversight/actions	3	Poorly developed risk registers may lead to significant risks being unidentified or unmanaged.	Divisional risk registers to be reviewed, updated by Sept. Training underway in division to better articulate risk within division	1
7.2	Currently not all Nationally mandated audits are completed by WSFT. Driven by unclear ownership and clinical capabilities	3	Failure to complete audits risks notification being sent to CQC. Unable to benchmark quality of care and service provision against national best practice	Better oversight and understanding of completion and non compliance following, patient safety team restructure. Clinical audit role in post and working well Revised TOR of CEG will provide improved oversight	1
10.	Number clinical policies are out of date, practice may be outdated and unclear governance. Limited ownership and capacity to complete reviews	3	Failure to have up to date clinical policies could lead to inadequate care, loss of reputation as is often a KLOE for regulation reviews	T&F group established to be established in M3 [IG, HONS, Patient safety group] to remove duplication, prioritise and update. Report back to QPS in August	1

Guidance notes

The practice of scrutiny and assurance

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So what? Increasing **appreciation** of the **value** (importance and impact) – what this means for us	**Value** – the degree to which the evidence… • provides real intelligence and clarity to board understanding • provides insight that supports good quality decision making • supports effective assurance, provides strategic options and/or deeper awareness of culture	• What is most significant to explore further? • What will take us from good to great if we focus on it? • What are we curious about? • What needs sharpening that might be slipping?
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Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Quality & Patient Safety Committee			Date of meeting: 17 June 2026			
Chaired by: Dr Paul Zollinger-Read			Lead Executive Director: Dan Spooner – Executive Chief Nurse / Dr Richard Goodwin – Executive Medical Director			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**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)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
4.1	Pharmacy workforce and service risk	3	Deep dive undertaken into the pharmacy workforce risk and the mitigations in place to support safe service delivery. Members noted that 3 additional pharmacy posts recently approved and recruitment activity was underway, alongside wider workforce planning aimed at improving capacity and resilience within the service. Recruitment and retention trends were reported to be improving both locally and nationally. Mitigations also confirmed focus on digital solutions and innovations including electronic prescribing and work to improve integration with community pharmacies.	1. Wider analysis of incident report themes and trends for next meeting to assure committee that risk is re staffing and not some other theme. 2. QPS to review KPIs being tracked through medications safety group	Inform	1 – QPS monitoring risk
6.1	Patient Experience update	2	Reviewed complaint numbers, noting these remained broadly stable. Improvements in complaint resolution processes welcomed, supported by the introduction of digital sign-off	Work underway to strengthen governance arrangements, improve divisional accountability	Inform	1

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			arrangements. Review of 25 day response time target. Patient Experience team will consider aligning this to national standards which better reflects complexity of some complaints and report back.	for patient experience actions, and enhance organisational learning from complaints and PALS feedback		
6.2	SEND oversight	2	First update on SEND oversight to QPS. Highlighted the continued growth in demand across Suffolk, particularly within speech and language therapy and community paediatric services. Whilst assurance was provided regarding the quality of SEND services and supporting processes, QPS noted ongoing challenges relating to rising demand, workforce capacity and waiting times.		Inform	1
6.3	ED waiting room harm	1	Deep dive into long waits within ED waiting room. QPS noted delays are closely linked to wider patient flow pressures across the hospital.		Inform	1

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			Whilst prolonged waits were recognised as carrying an inherent risk of harm, QPS was advised that reviews of incidents, complaints and harm investigations had identified limited evidence of specific harm directly attributable to waiting room delays. Assurance was provided that robust clinical triage and monitoring arrangements are in place to identify deteriorating patients and prioritise access to appropriate clinical areas.			
7.1	Quality Priorities	2	Progress against the Trust's quality priorities for 2026/27 reported. QPS noted adoption of a consistent QI approach across all priorities, supported by clear governance arrangements, defined metrics and reporting structures.	Broaden these to all 6 quality domains in 2027/28	Inform	1
7.3	National audit 100% compliance	3	Audit team confirmed WSFT eligible for 36 national mandatory audits. 28 have been confirmed and are underway. 5 are in development and 4 are not yet due but will be completed by end of 2026/27. Work is	Newly developed divisional dashboards will assist with visibility and compliance moving forward. Further review in	Inform	1

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			ongoing to ensure all relevant audits have clear ownership and oversight.	September 26.		

Guidance notes

The practice of scrutiny and assurance

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Board assurance committee - Committee Key Issues (CKI) report

Originating Committee Quality & Patient Safety Committee			Date of meeting: 15 July 2026			
Chaired by: Dr Paul Zollinger-Read			Lead Executive Director: Dan Spooner – Executive Chief Nurse / Dr Richard Goodwin – Executive Medical Director			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**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)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
6.1	**Hand Hygiene** The committee was unable to obtain reasonable assurance regarding the effectiveness of the Trust's current hand hygiene audit programme.	4	As hand hygiene is a key infection prevention and control measure this presents a risk to the Trust's ability to demonstrate compliance and effectiveness.	Work is underway to establish a robust peer audit process, with a further report on compliance, assurance and actions to address non-compliance to be presented at September QS.	Escalate	3
6.3	**Medication safety** The committee was unable to obtain reasonable assurance regarding the effectiveness of the medication safety programme. Performance	4	Crucial area of patient safety.	To return to the September QS with mitigation and improvement plan. To include defined actions, named leads, delivery milestones, target dates, escalation triggers and	Escalate	3

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	against key indicators remains below target and unchanged over several months, impacted by medicines storage infrastructure issues.			measures of success. Progress will continue to be monitored through the governance framework until sustained improvement is demonstrated.		
6.4.1.	**Maternity 10-point action plan** QS can gain partial assurance form the action plan. The team have undertaken a considerable amount of work in many of the areas. The plan identifies partial assurance in addressing inequalities. A National programme will be launched in this area towards the end of	3	National area of focus following published reports of service failures across England	The Maternity services have worked hard to develop the service to ensure it meets the needs of local woman and is safe and effective. The quality of the reports is good, however these reports require triangulation. It is important that the Board assures itself not just about the 10-point plan	Escalate	3

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	2026.The team also reported partial assurance in the implementation of the maternity care bundle; this is required to be implemented by March 2027. The team highlighted Triage as an area of focus. Changes in coverage have taken place and work is underway to relocate the service to the labour suite. This area will require close focus going forward.			but in the following areas… These are the views of PZR and not discussed in detail at QS. All too often Boards have taken reports at face value; what I outline below is a process to triangulate the data we currently receive. 1 Psychological safety and the ability of staff to speak up; how can the Board triangulate the existing data it receives? 2 Quality of multi-disciplinary working. Problems are rarely due		

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				to technical competence; difficulties in the effectiveness of teams can lead to delayed escalation, disagreement over risk, tribal behaviour, lack of shared decision making. How can the Board assure itself in this area? 3 Listening to women; how does the Board triangulate the current information it receives 4 Learning from harm; how can the Board determine that the service is both learning from incidents and		

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				implementing lessons learnt 5 Workforce capability rather than number. Are the right people on every shift, are experienced staff leaving, is supervision good, how may newly qualified staff work nights, how many consultants are present OOH, are CTG competencies current, how often are emergency drills practised. The Board needs to determine how it will measure competency		

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				6 Curiosity about weak signals. Failures usually begin with low level signals in the following areas; complaints, deteriorating culture, repeated low level incidents, increased sickness, staff leaving, families making similar comments, reluctance to report incidents. The Board needs to assure itself that it is interrogating a wide range of different data sets looking for early trend.		

Guidance notes

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Board assurance committee - Committee Key Issues (CKI) report

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Chaired by: Dr Paul Zollinger-Read			Lead Executive Director: Dan Spooner – Executive Chief Nurse / Dr Richard Goodwin – Executive Medical Director			
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6.1	**Mortality oversight group report** • Increase in Prevention of future death (PFDs) reports being issued by coroner • Need to improve completion of ReSPECT forms. 44% completion on audit • SHIMI coding data backlog.	2	PFD: WSH experiencing significant challenges from some coroners which is leading some clinicians anxiety in attending ReSPECT: As a recognised document used across acute, community and primary care settings, ReSPECT helps ensure that patient preferences are communicated, understood and respected throughout their healthcare journey, particularly if they are unable to express their wishes in the future. SHIMI: Review of all deaths accruing in care supports assurance around expected levels	ReSPECT Improvement Programme: Policy update: The timeframe for completing a ReSPECT extended from 72 hours to one week to support more meaningful patient and family engagement. eCare enhancement: Automated reminders have been introduced to prompt completion of a ReSPECT discussion and plan 7 days after a DNACPR decision. SHIMI: Not expected to see SHIMI reflect accurate coding until Dec 2026	Assure	1. No escalation

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6.2	**Mental health** learning from recent incidents suggests delays in in seeking urgent Mental health inpatient advice; this has been in children's services and maternity. No harm but learning	2.	Timely access to mental health service for inpatient ensures patients have the right intervention at the tight time. Increasing frequency and delays in CYP inpatient stay for CYP to access onward care and discharge	A series of Trust-to-Trust meeting has occurred to determine how our existing SLAs can be fully utilised. Mental health lead attends all system MH capacity meetings to ensure WSFT challenge is escalated Exec to exec discussion with NSFT to remove pathway barriers have been effective	Alert	1. No escalation
7.1	**QDG** BLs rates remain around 80% for trust compliance	3.	BLS is part of mandatory training suit to provide assurance around safe and effective services. While compliance remains below 90%. National cardiac arrest audit is favourable	Trainer vacancy now filled should improve training access and increase adhoc sessions for medical team (lowest compliance group)	Assure	2.

Guidance notes

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Feedback from assurance committees: Governor observer report

Board assurance committee Quality and Patient Safety
Meeting date:20 May 2026
Governor observer (observed by): Jane Skinner

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Emphasis on patient experience in addition to quality and safety
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Professional. • Chair gives clear directions on devolved responsibility and timescales in bringing items back. • Good discussion, overall desire to makes things better is evident from all committee members in their questioning and suggestions.
Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
• The risk register was discussed as a work in development. Risks must be owned and reviewed by divisions, be clear on the risk involved, what the consequences might be and what mitigations are in place. A timeline of September was imposed for when risk registers must be completed to the expected standard. • A really interesting report from the Mortality Oversight Group was presented. Themes from Prevention of Future Death notices were described with actions taken to strengthen mortality governance including improved family involvement.

- Observing Governors are aware, from previous reports to the Committee from CEGG, of issues with assurance that guidelines and protocols are updated, mandatory audits completed and that clinicians are fully engaged. Governance has been strengthened and work remains in progress.

Notes

Governors have expressed concerns (personal experience, letter to BFP and discussion at informal Gov/NED meeting) regarding the experience of patients waiting for admission but seated in the ED waiting areas for long periods, including overnight. In addition some patients are being cared for in escalation areas. A report was requested by the Comm' Chair and will come back to the next meeting. Governors should have some general feedback on the contents of the report, not just observers of the meeting.

Feedback from assurance committees: Governor observer report

Board assurance committee: Quality and Patient Safety
Meeting date:20th May 2026
Governor observer (observed by): Sue Kingston

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Mortality Oversight Group Update • Maternity Claims Scorecard. Quarterly Review • CEGG • Patient Safety Quality Report
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Good participation from all members • Many open discussions, providing opportunity and challenges from NED's • Chair sought actions and set timelines for those • Large agenda, good time keeping.

Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
• Mortality Governance is required to provide assurance that deaths are identified, reviewed and learned from. Assurance is required in this area as current data shows that our reviews remain inconsistent. The MPR is demonstrating accelerated learning and is working to improving system safety and supporting continuous improvement. Hopefully this in turn will lead further assurance. • Maternity review continues to provide safety information to inform and progress improvement and development of best practice This in turn should identify potential risk factors and complications and ensure that the management and treatment of mothers and babies can provide assurance to the board. Chair asked if the department felt supported and there were further challenges around how the department can ensure that care is ok. • CEGG report is again showing arears of risk due to non-compliance of Audits so much so that the trust is now on the risk register. Development of the 2026/27 organisational audit programme is under way but we are some way off any assurance in this area.
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• In his reflections, the Chair pointed out that the hospital has a duty of candour and what as a committee are we doing to improve that? What can we learn from other trusts? He reiterated that this very committee is the focus of patient quality and safety and is that happening? He wanted members to take that away and think about it.

Feedback from assurance committees: Governor observer report

Board assurance committee: Quality & Patient Safety Committee
Meeting date: 17th June 2026
Governor observer (observed by): Sue Kingston

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Pharmacy Risk Update • SEND Oversight • ED Waiting Room Long Stay
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Meeting conducted in line with trust values • Large Agenda but meeting finished on time • Good discussions, leading to respectful challenges from the NED's present

Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
• Very little assurance given to the committee in the Pharmacy update. pharmacy still remains under staffed. Pharmacy budget partially restored to previous levels to enable additional recruitment, however the risk category still remains high with significant risk to patent safety, service quality and staff wellbeing. Many challenges by the NED's and Chair asking for better systems to support pharmacy through this critical period • Excellent presentation by Clinical Lead Consultant on the potential risks of long waits in the ED waiting room. There is no formal reporting process to monitor this group of patients. As a results there was a review process put in place assessing the scale of the issue and reviewed for recorded harm and analysed patient experience data. Assurance to the board provided by the report that process are in place now to ensure quality, safety and governance for patients in ED Waiting areas.
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• Good reflections by the Chair. Three NED's present at the meeting which provided many challenges and opened good discussions. • These meetings have many attendees and Governors sit at the side of the room to observe which is completely appropriate and acceptable. However, sometimes what people are saying is completely inaudible as they talk very softly. The added issue in this particular meeting was the aircon which was absolutely necessary on a very hot day, but sadly the fan drowned out most of the speakers!

Feedback from assurance committees: Governor observer report

Board assurance committee: Quality and Patient Safety Committee

Meeting date: 15 July 2026

Governor observer : Jayne Neal

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• The Patient Quality and Safety committee included: • The Clinical Risk Register report highlighted organisational wide risks relevant to this committee. There are 7 identified risks. This meeting had in depth discussions on community and pharmacy risks. • There was a deep dive into risks associated with community services. • The infection prevention and control update focused on hand hygiene. • A medication safety assurance report was presented and discussed. • Implications for West Suffolk NHS Trust were considered following the recent national reports on maternity services by Donna Ockenden and Baroness Amos

Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• The meeting adhered to Trust principles throughout. • It was a constructive meeting with good participation from attendees and particularly from those presenting community, maternity and infection prevention and control reports. • At the conclusion of the meeting the Chair clearly stated the agreed actions to be taken forward, the future date for review of the actions and the individual responsible for responding to those work areas
Assurances *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
• The committee had good assurance on the maternity services at West Suffolk. This had recently been evidenced by independent visits from peer groups, including the ICB. A national task force will be taking the recommendations from the reviews forward which West Suffolk will study and implement. • There was very strong assurance around the mortuary service (these services had been found wanting in the Ockenden Review) • The paper on medication safety was interesting but the committee felt it did not offer solutions to some areas of concern. The continuing situation with lack of secure lockers was especially troubling . The Chair asked for a proper evaluation of the situation and a plan for resolving this by September. • There was limited assurance concerning pharmacy services but this should improve as staff vacancies

Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• The discussions focusing on infection prevention and control and maternity services were forthright and the staff presenting the reports were thanked for their openness and raising their concerns.

10.3. People & Organisational Development Committee (previously Involvement)

To Note

Presented by Heather Hancock

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: People Organisation & Development			Date of meeting: 17th June 2026			
Chaired by: Heather Hancock			**Lead Executive Director: Julie Hull**			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**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)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
4.0	**Recent announcements affecting workforce** The Trust must submit a Band 5 nursing job-evaluation plan by 31 July, completing reviews by October 2026. New sexual-safety reporting requirements are also in place, supported locally by the Trust's Sexual Safety Charter..	Partial	The Trust must review all Band 5 nursing roles by October 2026 and meet new national sexual-safety reporting requirements. Both areas carry material workforce, financial, equality, governance and confidentiality risks. Board oversight and clear accountability are required.	Template to be completed for Band 5 ahead of next POD meeting Appoint an Executive Lead for sexual safety, report required cases, and clarify data handling and confidentiality safeguards.	Alert Assure	2. SLT for action 1. Board Oversight required
5.1	**Volunteer Service Annual Impact and Development Report 2025/26** Volunteering remains a key strength, with	Substantial	Strong engagement is delivering a positive experience, but volunteers need greater consideration in service	Improve volunteer diversity, develop employment pathways, expand training and	Assure	1. No escalation

Originating Committee: People Organisation & Development			Date of meeting: 17th June 2026			
Chaired by: Heather Hancock			**Lead Executive Director: Julie Hull**			
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	most KPIs achieved and 96% of volunteers recommending the Trust..		change and workforce planning.	embed volunteering within transformation plans.		
5.2	**Mann Review** The Committee received an initial overview of the Mann Review, noting that this is early-stage work following its recent publication	Substantial	The Trust reaffirmed its commitment to a zero-tolerance approach to racism and recognised the importance of aligning the review's requirements with forthcoming NHS staff standards, mandatory training and organisational development activity.	The Committee supported planned engagement activity, including Schwartz rounds, conferences and strengthening staff networks, to better capture and respond to staff experience	Alert	2. SLT for action 3. Board Oversight required

Originating Committee: People Organisation & Development			Date of meeting: 17th June 2026			
Chaired by: Heather Hancock			Lead Executive Director: Julie Hull			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**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)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
5.3	**WSFT Staff Survey Action Plan** The Committee welcomed the revised Staff Survey Action Plan,	Substantial	Actions now embedded in existing divisional plans to strengthen ownership and reduce duplication.	Key concerns included transparency in decision-making and the perceived balance between financial priorities and patient care. Members stressed clear, consistent leadership and team-level communication, with measurable actions that demonstrably improve staff experience.	Assure	2.SLT for action 3.Board Oversight required
5.4	**BAF – Transformation** BAF Transformation is progressing well, with Board-agreed strategy, stronger system engagement and key delivery groups established.	Substantial	The programme has a clear direction,	Complete the partnerships audit, update programme tracking, and maintain delivery momentum and oversight.	Assure	1. No escalation
6.1	**Resident Doctor 10 Point Plan** Around 90% of the Resident Doctor 10-Point Plan is complete. Improvements include rest facilities,	Substantial	The Trust is performing well regionally, with a stronger platform for resident doctor	Resolve annual leave, payroll and transferable mandatory-training issues; address overnight-food	Assure	1. No escalation

Originating Committee: People Organisation & Development			Date of meeting: 17th June 2026			
Chaired by: Heather Hancock			Lead Executive Director: Julie Hull			
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	rota compliance and overnight hot food; resident doctor feedback is broadly positive.		experience and Board engagement. Some practical issues remain.	operational problems; and use the new NED role to deepen Board–resident doctor engagement.		
6.2	**Guardian of Safe Working** There were 211 exception reports, mainly late finishes in the medical division and among FY1 doctors. Actions including registrar recruitment and redesigned weekend working are improving trends.	Substantial	The new reporting system gives better visibility of safety concerns, though it has increased recorded breaches and fines. Progress has also been	Sustain workforce and rota improvements, reinvest fines in staff wellbeing, and improve consistent engagement with reporting across divisions	Inform	1. No escalation
7.1	**Pride Network Update** The Pride Network shared Pride Month activity and plans for further events, alongside a three-year strategy to increase visibility and membership. Training is planned to build	Reasonable	Limited engagement and concerns about disclosure show that staff do not yet consistently experience a safe, inclusive culture. Stronger allyship and	Improve communication and use new platforms to raise awareness; strengthen manager understanding of inclusion policies; increase volunteering; and ensure	Escalate	2. Other committee /SLT

Originating Committee: People Organisation & Development			Date of meeting: 17th June 2026			
Chaired by: Heather Hancock			Lead Executive Director: Julie Hull			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**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)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
	confidence around LGBT+ inclusion, terminology and pronouns.		consistent application of guidance are needed	transgender and non-binary staff guidance is applied consistently.		
8.1	**Embedding a Culture of Continuous Quality Improvement (CQI)** CQI foundations are in place through training and active projects, but activity is inconsistent and not yet embedded in everyday work.	Reasonable	The Trust now needs to shift from individual projects to a consistent improvement culture, supported by leadership, capability and accountability.	Integrate CQI into appraisals, induction and leadership development; establish a CQI Steering Group; use case studies and measures to evidence impact; and align governance with organisational priorities.	Escalate	2 . Other committee /SLT
9.1	**IQPR extract for Involvement Committee (staff KPIs)** Staff KPI information was shared, alongside an update that new national NOF metrics will be added to the IQPR.	Substantial	Board and committee reporting will change, including advocacy scores and additional people measures.	Incorporate the new metrics into the IQPR and ensure reporting remains aligned with national requirements	Inform	1.

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

Alert	Proactive notification of subject matter/risk that reporting committee is currently dealing with or mitigating which may require further action/decision.	**Inform**	No action required. Reporting to update on discussion within a reporting committee's TOR.
Escalate	Formally raise an issue, concern, or risk to a higher level of authority so that it can be reviewed and acted upon appropriately	**Assure**	Information to demonstrate that appropriate action is being taken within a reporting committees' TOR.
Approve	A request by the reporting committee that something meets required standards but needs higher authority permission to proceed/sign off before being implemented.		

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: People Organisation & Development			Date of meeting: 19th August 2026			
Chaired by: Heather Hancock			**Lead Executive Director: Julie Hull**			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**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)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
4.0	**Recent announcements affecting workforce National workforce and policy updates** –	Partial	Engagement with the new Secretary of State indicates, at present, no material change to current NHS plans No material change to current Trust plans. Consultant industrial action remains a potential workforce risk. Lord Mann update: Most actions have progressed. One area remains outstanding relating to the potential adoption of a formal definition of antisemitism. The Trust is awaiting further national guidance	Continue delivery of current plans Monitor industrial action and any local impact; Await national guidance on the outstanding Lord Mann action.	Assure Inform/Assure Alert /Assure	No escalation. Continue monitoring national developments and escalate only if there is a material local workforce, operational or policy impact. Board to remain sighted; final decision to return through appropriate governance route.

Originating Committee: People Organisation & Development			Date of meeting: 19th August 2026			
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Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**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)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
			before reaching a final position.			
4.4	**Staff Pulse survey** Staff pulse survey response rates and overall scores have declined compared with previous periods. Key themes include communication, workload, resourcing, recognition and simplifying processes. Awareness of the Trust strategy has improved. Further analysis of free-text feedback is underway	Partial	The downward trend in staff experience, alongside recurring concerns about workload, communication and organisational processes, requires attention. Improved understanding of Trust strategy is encouraging but has not yet translated into improved overall staff experience.	Complete analysis of staff comments, identify priority actions and accountable leads, and use the findings to inform the NHS Staff Survey response. Monitor improvement through subsequent pulse survey results.	Alert Assure	Board oversight required
5.1	**My Wish Maternity Service** Charitable investment is delivering clear additional benefit to patients and families and demonstrates effective partnership working between My WiSH, clinical teams and Quality Improvement.	Substantial	Charitable investment is delivering clear additional benefit to patients and families and demonstrates effective partnership working	Continue to strengthen impact measurement, share learning and patient stories, and ensure funding remains focused	Assure	No escalation required. Board to note the positive impact and contribution

Originating Committee: People Organisation & Development			Date of meeting: 19th August 2026			
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			between My WiSH, clinical teams and Quality Improvement.	on areas of greatest benefit.		of My WiSH and associated fundraising.
6.1	**Update on Mandatory Learning** The Trust remains compliant with current national mandatory learning requirements, with strengthened governance now in place for approving additional mandatory training. The new national framework is awaited.	Partial	The Committee received assurance that current requirements are being appropriately governed and that additional mandatory learning is subject to greater scrutiny, helping manage unnecessary training burden.	Review and implement the new national framework when published and assess any resulting changes to Trust requirements	Assure /Inform	No escalation required. Committee to oversee implementation of the new framework and escalate any material compliance or workforce impact.
5.4	**The National Leadership and Management Framework** This has been launched, introducing common standards, competencies and self-assessment for NHS leaders and managers. A Trust SLT pilot is	Partial	This provides an opportunity to strengthen leadership capability and consistency across the Trust. The key risk is that implementation becomes compliance-led rather	Complete the pilot, identify capability and development gaps, align Trust leadership and appraisal processes to the framework, and agree	Assure/ inform	No escalation Committee to oversee implementation and receive further assurance

Originating Committee: People Organisation & Development			Date of meeting: 19th August 2026			
Chaired by: Heather Hancock			**Lead Executive Director: Julie Hull**			
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	underway ahead of wider implementation by the end of Q4.		than driving meaningful development and behavioural change. Alignment with appraisal and existing leadership programmes will therefore be important	measures of impact before wider rollout.		on identified capability gaps, progress and agree measures of impact.
6.4	**Gender disability and ethnicity pay gap report** Annual Gender, Disability and Ethnicity Pay Gap Reports identify continuing disparities across the workforce. Action plans are in place, but the Committee requested greater clarity on the evidence underpinning some conclusions, particularly around recruitment outcomes and potential bias	Partial	There is clear evidence of workforce inequality, but understanding the underlying drivers is essential if the Trust is to target interventions effectively. The Committee requires assurance that actions move beyond reporting and result in measurable improvements in representation,	Strengthen the analysis, clearly distinguish evidence from interpretation, identify the principal drivers of the pay gaps, and tighten accountability and measures for the associated action plans. Report progress and impact back to Committee.	Alert/Assure	2. Committee to maintain close oversight. Further assurance required on the robustness of the analysis and effectiveness of actions; escalate if disparities persist without measurable improvement.

Originating Committee: People Organisation & Development			Date of meeting: 19th August 2026			
Chaired by: Heather Hancock			**Lead Executive Director: Julie Hull**			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**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)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
			progression, retention and staff experience.			
6.5	**WRES/WDES reports** The annual WRES and WDES reports identify continuing inequalities in staff experience. Key areas of concern include recruitment, bullying and harassment, anti-racism, disability inclusion and confidence in disability disclosure. Action plans are in place, but some WDES measures have deteriorated.	Partial	There is evidence that some staff groups continue to experience poorer outcomes and, in some areas, the position is worsening. The critical issue is whether current actions are creating meaningful behavioural and cultural change, particularly in relation to psychological safety, inclusion and confidence to raise concerns or disclose disability.	Strengthen delivery and accountability for WRES/WDES actions, with measurable outcomes focused on recruitment, bullying and harassment, disability disclosure and workplace support. Review the ethnicity narrative for evidence and context, and monitor whether staff experience improves.	Alert /Assure	1. No escalation

Originating Committee: People Organisation & Development			Date of meeting: 19th August 2026			
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6.6	**Inclusive Culture Policy** The Inclusive Culture Policy is moving into implementation, with focus on respectful behaviours, support for staff experiencing bullying, harassment or discrimination, and clearer reporting and escalation routes. Further work is also underway on communicating expected behaviours to patients, carers and visitors.	Partial	The policy is in place, but the key test is whether staff and managers can easily understand and use it in practice. Effective implementation is important to creating a safer, more respectful culture and ensuring inappropriate behaviours are addressed consistently.	Simplify practical guidance and signposting, strengthen links to reporting and support routes, communicate behavioural expectations more widely, and monitor evidence of behavioural and cultural change. Await national guidance on gender identity and facilities before changing local arrangements.	Assure/Inform	No escalation at present. Committee to retain oversight and seek evidence that implementation is improving staff confidence, consistency of response and organisational culture.
7.1	**Parent and Carer Network** A significant proportion of the workforce reports parent or wider caring responsibilities, but engagement with the Parent and Carer Network remains relatively small at around 40members. The network is developing support around flexible working, returning from maternity leave, breastfeeding and manager guidance.	Partial	Caring responsibilities potentially affect a large proportion of the workforce and may have implications for staff experience and retention. The opportunity is therefore bigger than the network itself: the Trust	Increase the network's visibility and reach, develop practical manager and return-to-work support, and use workforce and exit data to identify where caring responsibilities are contributing to retention or	Assure /inform	No escalation at present. Committee to receive further assurance on reach, identified workforce barriers and evidence that actions are

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			needs to understand whether its working practices enable staff with caring responsibilities to remain and thrive at work.	staff-experience issues. Align governance with organisational priorities.		improving the experience and retention of staff with caring responsibilities.
8.1	**Reasonable**	Reasonable	Reduced appraisal compliance limits assurance that staff are receiving regular performance, development and wellbeing conversations. Although system implementation is a contributory factor, continued deterioration would indicate a wider management and workforce risk.	Resolve ESR access issues, implement a clear recovery plan for appraisal completion and monitor progress through future IQPR reporting	Alert/Assure	1 Committee to receive further assurance on recovery actions and timescales. Escalate if ESR issues remain unresolved or appraisal compliance fails to improve.

**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, by when and how will we know we've achieved it? • How will we hold ourselves accountable?

Assurance level

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Approve	A request by the reporting committee that something meets required standards but needs higher authority permission to proceed/sign off before being implemented.		

Feedback from assurance committees: Governor observer report

Board assurance committee: People & Organisational Development
Meeting date: 19 August 2026
Governor observer (observed by): David Slater

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Good agenda format and paper were available for review a few days before the meeting. • Excellent papers, easy to follow and understand any issues.
• *The meeting covered all the items on the agenda.*
Assurances *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
• *The meeting was very well organised and run by the chair, the meeting finished earlier than planned. All agenda items discussed and reviewed with comments and ideas taken away. The chair ensured that with changes in personnel support was given to the person who stepped allowing them to do a very job at covering the presentations.*
• *Leadership and Management Framework* • *Mandatory Learning* • *My Wish presentation which was excellent*

Feedback from assurance committees: Governor observer report

Board assurance committee: Quality and Patient Safety
Meeting date:19th August 2026
Governor observer (observed by): Sue Kingston

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Review of Committee Effectiveness Results • Mortality Oversight Group • CKI report
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Smaller numbers at the meeting today, only one NED plus Chair. • Good open discussions, challenges from members met with respectful responses. • Trust Values adhered to. • Some shifting of the agenda to accommodate presenters. • Meeting finished early, a very rare occurrence, but all agenda topics covered.

Assurance

Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.

- Interesting review of the effectiveness of this committee, setting out conclusions and actions for 26/27. Overall it was concluded that the committee had delivered it responsibilities. Going forward and following participation from its members, improvements have been highlighted.
- Further update from the MOG showing positive outcomes with good assurance. However some back dated coding still remains a problem which is effecting data. This is expected to be rectified by 1st September.
- CKI report still not offering assurance on Hand Hygiene and Medication safety. Both items are scheduled to return to this committee next month with defined actions and reports to establish improvement and assurance for the board.

Governor observer Notes

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

- In his reflections, the Chair spoke of the effectiveness of the committee and changes that are being made as a result of input from members. This was a result of a workshop held last year and a questionnaire earlier this year where all members and observers gave feedback on the effectiveness of this committee.
- The Chair wishes to continue this input and a 'working together for the better' and requested that a date is put in the diary possibly in October for a further workshop. All members and observers being invited. This feels such an inclusive and positive move by the Chair who wishes for continuous improvement.

10.4. Digital & Data Assurance Committee

To Note

Presented by Alison Wigg

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Digital and data assurance committee			Date of meeting: 30 July 2026			
Chaired by: Alison Wigg			Lead Executive Director: Nicola Cottington			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**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)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
6.2	Frontline Productivity and national funding update	Reasonable	Sarah Judge presented a list of areas where the trust had been successful and unsuccessful in getting national funding.	Continue to apply for funding when available. Learn from successful funding applications.	Assure	1
7.3	Deep dive into access to patient records and information governance.	Partial	Actions to help provide assurance in this area: • Core systems now actively audited (this was not done for up to 6 months due to resource issues, but reactive investigations and targeted monitoring remained in place) • Enhanced auditing around potential targets such as VIP records, people in high profile cases, etc • Continued emphasis in staff induction, training and comms.	Continued auditing, training and comms.	Assure	1

Originating Committee: Digital and data assurance committee			Date of meeting: 30 July 2026			
Chaired by: Alison Wigg			Lead Executive Director: Nicola Cottington			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**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)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
9.4	Data and BI Report	Partial	An update was provided on BI and analytics capability. Positive developments included: • Significant reduction in turnaround times for eCare change requests. • Increased use of self-service dashboards. • Introduction of a single point of access for BI requests. • Recruitment of a senior BI manager. However, challenges remained around data warehouse implementation and overall BI maturity. Assurance was assessed as improving but not yet complete.	Provide enhanced BI assurance reporting and summary.	Assure	1

Cyber and any commercially sensitive areas are covered in a separate CKI report that is reported to the closed board.

**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, by when 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.

Definitions

Alert	Proactive notification of subject matter/risk that reporting committee is currently dealing with or mitigating which may require further action/decision.	**Inform**	No action required. Reporting to update on discussion within a reporting committee's TOR.
Escalate	Formally raise an issue, concern, or risk to a higher level of authority so that it can be reviewed and acted upon appropriately	**Assure**	Information to demonstrate that appropriate action is being taken within a reporting committees' TOR.
Approve	A request by the reporting committee that something meets required standards but needs higher authority permission to proceed/sign off before being implemented.		

10.5. Audit & Risk Committee

To Note

Presented by Michael Parsons

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Audit & Risk Committee			Date of meeting: 23 June 2026			
Chaired by: Michael Parsons			**Lead Executive Director: Jonathan Rowell**			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**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)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
5.1	Head of Internal Audit opinion & annual report 2025/26 – reported a positive opinion and good progress on implementing audit recommendations.	Reasonable	Provides assurance on internal control arrangements.	Continued implementation of audit recommendations.	Assure	2 – SLT for action on overdue recommendations
5.2	External Auditor opinion – reported unqualified opinion on accounts, with no material errors.	Substantial	Provides assurance on financial results and disclosures.	Implement external audit recommendations.	Assure	1
5.3-5.6	Annual Report and Accounts, Quality Accounts, etc. – recommended approval to Board.	Substantial			Approve	3 – Board approval
7.1	Internal Audit progress report – completion of 3 audits (including 2 negative assurance opinions: Partnership Working; Mental Capacity Act/DoLS) and progress on implementation of recommendations.	Partial	Delivery of risk-based audit plan provides assurance on internal control arrangements.	Assurance Committees to consider negative assurance opinions	Assure	2 – MCA/DoLS to Q&S Cttee 2- Partnership Working to P&OD Cttee

Originating Committee: Audit & Risk Committee			Date of meeting: 23 June 2026			
Chaired by: Michael Parsons			**Lead Executive Director: Jonathan Rowell**			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**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)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
7.2	Counter Fraud progress report – including submission of annual Functional Standard return.	Reasonable	All standards reported as Green apart from Standard 3 where the Economic Crime and Corporate Transparency Act 2025 has introduced some new requirements.	Review and strengthen controls in relation to the new Act's requirements.	Assure	1
8.1-8.3	Losses, Special Payments, Waivers, FPP annual report	Substantial	Provides assurance that SFIs, Scheme of Delegation, etc. are being followed and appropriate controls in place.	Opportunities to strengthen capital planning processes highlighted.	Assure	1
9.1	Risk Management – received an update on ongoing work to strengthen both clinical and corporate risk oversight.	Reasonable	Oversight of risk management arrangements is a key focus for the Committee.	Ongoing work on BAF and Risk Register.	Inform	1

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

1. Substantial	Taking account of the issues identified, the board can take substantial assurance that this issue/risk is being controlled effectively. There is substantial confidence that any improvement actions will be delivered.
2. Reasonable	Taking account of the issues identified, the board can take reasonable assurance that this issue/risk is being controlled effectively. Improvement action has been identified and there is reasonable confidence in delivery.
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Definitions

Alert	Proactive notification of subject matter/risk that reporting committee is currently dealing with or mitigating which may require further action/decision.	**Inform**	No action required. Reporting to update on discussion within a reporting committee's TOR.
Escalate	Formally raise an issue, concern, or risk to a higher level of authority so that it can be reviewed and acted upon appropriately	**Assure**	Information to demonstrate that appropriate action is being taken within a reporting committees' TOR.
Approve	A request by the reporting committee that something meets required standards but needs higher authority permission to proceed/sign off before being implemented.		

11. Nominations Committee Report - (enclosed)

To receive a report from the Nominations Committee

For Discussion

Presented by Jude Chin

COUNCIL OF GOVERNORS MEETING (OPEN)

Report information

Report title: Nominations Committee report
Date of the meeting: 10 September 2026
Agenda item: 11
Sponsor/Executive lead: Jude Chin, Trust Chair
Report prepared by: Pooja Sharma, Deputy Trust Secretary
This report is for: ☒Approval ☒ Assurance ☒Discussion ☒Information

This report supports the following ambitions within the organisational strategy:

☒ High quality care ☒ Joined up services
☒ Empowered to improve ☒ Responsible with resources
☒ Fit for tomorrow

Executive summary

What?
The report summarises discussions that took place at the Nominations Committee meeting on 18 May 2026, which included the following:

- **NEDs Terms of Office** (for noting)

  The terms of office for the NEDs were reviewed and noted.

- **Non-executive Directors' and Chair appraisals 2026** (for noting)

  The 360° feedback reports for Jude Chin, Alison Wigg, Antoinette Jackson, Heather Hancock, Paul Zollinger-Read, Michael Parsons, Richard Flatman, were reviewed and discussed. The Committee agreed emergent themes from stakeholder assessments, areas of strength and identified opportunities to increase impact and effectiveness, for discussion at the individual's appraisal meetings. All appraisals will be scheduled for May/June for completion before 30 June 2026. Dr Mike Knapton is excluded from the appraisal process as the term began on 1 April 2026.

So what?
The value of the Nominations committee lies in its ability to ensure a rigorous and transparent processes for the appointment of key leadership roles within the Trust. This committee plays a crucial role in establishing and managing processes for the appointment/re-appointment of the Chair and NEDs; overseeing their annual appraisals; and reviewing remuneration of the NEDs and Chair.

What next?
The items reported through this report will be actioned through the appropriate routes and progress updates supplied at future meetings of the Council of Governors.

Action required

The Council of Governors is asked to **note** the report from the Nominations Committee.

Governance and compliance

Previously considered by: Governors' Nominations committee (18 May 2026)
Risk and assurance: Council of Governors unable to undertake its statutory duties.
Equality, diversity and inclusion: Ensure inclusion and fair recruitment and staff management processes.
Sustainability: Sustainable organisation
Legal and regulatory context: West Suffolk NHS Foundation Trust Constitution, Health & Social Care Act 2022, NHSE Code of Governance 2022.

12. Membership and Engagement Committee Report

To receive a report from the Membership & Engagement Committee

For Discussion

Presented by Sarah Hanratty

COUNCIL OF GOVERNORS MEETING (OPEN)

Report information

Report title: Membership and Engagement Committee report
Date of the meeting: 10 September 2026
Agenda item: 12
Sponsor/Executive lead: Sarah Hanratty, Public Governor (Chair Membership & Engagement Committee)
Report prepared by: Sarah Hanratty, Public Governor, Pooja Sharma, Deputy Trust Secretary, Ruth Williamson, Senior Administrator, Foundation Trust Office

This report is for: ☐Approval ☒ Assurance ☒Discussion ☒Information

This report supports the following ambitions within the organisational strategy:

☒ High quality care
☒ Joined up services
☒ Empowered to improve
☒ Responsible with resources
☒ Fit for tomorrow

Executive summary

What?
The report summarises the discussions that took place at the Membership and Engagement Committee meeting on 20 July 2026.

So what?

Summary/Highlights

In the meeting on 20 July, the Membership and Engagement Committee focused on the following key areas:

- **Future Systems Programme Engagement -** The Committee received an update on progress with the Future Systems Programme, including the Reserved Matters application, development of the RIBA 3 design stage and appointment of the preferred construction partner. Governors noted that feedback from earlier engagement activity had influenced elements of the design, including accessible parking arrangements and traffic management measures. The Committee welcomed the commitment to continued engagement throughout future design stages and noted plans for a Governor briefing on the programme in September. Committee members also discussed opportunities to align future programme engagement with promotion of the 2026 Governor elections.

- **Patient Experience and VOICE -** The Committee received an update on patient engagement and experience work, including the appointment of a new Patient Engagement and Experience Officer. Members noted the development of a structured engagement approach using the Core20PLUS5 framework, ongoing work to strengthen the VOICE programme, and plans to recruit additional representatives, including a staff representative. Updates were provided on the carers' accreditation programme, implementation of the Reasonable Adjustments Flag, health inequalities work and collaboration with Public Health colleagues. The Committee also welcomed the introduction of adaptive cutlery on wards following patient feedback and noted ongoing efforts to ensure patient experience and engagement remain central to service improvement.

- **Governor Elections 2026 -** The Committee received an update on planning for the 2026 Governor elections and discussed the challenges associated with receiving interests from both Staff and Public Governors constituencies, particularly in the context of ongoing national discussions regarding the future role of governors and foundation trusts. It was agreed that the Trust should continue to promote the elections positively and maximise engagement opportunities. Discussion included increasing representation from younger people and underrepresented groups, strengthening links with local colleges and community networks, and ensuring prospective candidates receive clear and transparent information. The Committee noted that existing governors wishing to continue in role would be required to stand for election again.

- **Membership and Engagement Strategy and Development Plan -** The Committee received an update on the delivery of the Membership and Engagement Strategy and Development Plan. Ongoing engagement activity was noted, including newsletters, the Annual Members' Meeting, election communications, and community engagement events. The discussion focused on ensuring that these activities result in meaningful outcomes and increase public awareness of the role of governors and upcoming elections. It was agreed that a further update on communications and engagement activity would be presented at a future meeting, alongside a review of the Strategy to assess its effectiveness in achieving and delivering its priorities.

- **Feedback from Committees and Governor Activities -** The Committee considered feedback from the Experience of Care and Engagement Committee and recent governor activities, including **15 step visits and area observations**. Members reflected positively on the value of governor involvement in assurance committees and welcomed discussions relating to patient experience, maternity services and environmental observations. Governors were encouraged to continue participating in engagement opportunities, including 15 Steps visits and Courtyard Café sessions, to strengthen visibility and engagement with patients, staff and members. The Governor activities coversheet is included for oversight for the CoG (Annex 1) and includes three 15 steps visits, two area observation. No environmental reviews or Courtyard Café engagement sessions were held during the period. Key themes from the activity analysis were confirmed and will be considered through the Trust's Experience of Care and Engagement Committee.

- **Engagement Opportunities -** The Committee noted forthcoming engagement opportunities, including the Annual Members' Meeting and Governor election campaign.
  Governors are encouraged to actively support events and engagement initiatives over the coming months to help raise awareness of the governor role and encourage wider participation in the 2026 elections.

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

Action required

The Council of Governors is asked to:

- note the report from the meeting held on 20 July 2026
- participate in upcoming events and engagement activities to support Governor Elections 2026.

Governance and compliance

Previously considered by: NA
Risk and assurance: Council of Governors is unable to undertake its statutory duties.
Equality, diversity and inclusion: Duty to reduce inequalities.
Sustainability: An active membership is an important part of our sustained governance processes.
Legal and regulatory context: West Suffolk NHS Foundation Trust Constitution, Health & Social Care Act 2022, NHSE Code of Governance 2022

COUNCIL OF GOVERNORS' MEMBERSHIP AND ENGAGEMENT COMMITTEE

Report information

Report title:	Governor Engagement Activities
Agenda item:	9
Meeting Date:	20 July 2026
Sponsor/Executive lead:	Paul Bunn, Acting Trust Secretary
Report prepared by:	Ruth Williamson, FT Trust Office, Pooja Sharma, Deputy Trust Secretary

This report is for: ☐Approval ☐ Assurance ☒Discussion ☒information

This report supports the following ambitions within the organisational strategy:

☒ **High quality care** ☒ **Joined up services**

☒ **Empowered to improve** ☒ **Responsible with resources**

☒ **Fit for tomorrow**

Executive summary

What?

This paper summarises the Governor activities from July 2025 and the emerging themes from the feedback received from the observers.

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

- 29 April 2026: Johanna Finn Unit (Urology) & F7 by Jayne Neal (Public Governor), Sue Kingston (Partner Governor) and Richard Flatman (Non-executive director).
- 21 May 2026: Pharmacy & Eye Treatment Centre by Jane Skinner (Public Governor) and Antoinette Jackson (Non-executive director).
- 24 June 2026: F3 & Therapies by Jane Skinner (Public Governor) and Heather Hancock, (Non-executive director)

Area observations led by Patient Experience and Engagement team (Annex B)

- 23 April 2026: Breast Screening by Becky Poynter (Public Governor)
- 9 June 2026: Fracture Clinic by Clare Rose (Public Governor)

Environmental reviews led by Estates and Facilitates

- Dates for 2026 remain outstanding.

Courtyard Café led by FT office team

- No sessions undertaken since last meeting.

So what?

The visits are designed to support continuous improvement and are a valuable source of qualitative information that aligns patient and staff experience to collectively promote a positive experience for all and support staff to initiate local service improvement.

The objective of the report is to highlight areas for improvement and extracting themes will help the Trust to take those initiatives.

What next?

The activities identified a significant number of positives across these areas including our staff, environments and the focus on patients and care.

The results will be analysed at regular intervals, ensuring area owners have been made aware of any issues, themes and trends that are identified throughout the visits and giving support to focus on improvements and sharing positive feedback.

Some themes from visiting teams are identified below:

15 steps:

- Compassionate, dedicated staff delivering high-quality care.
- Positive patient experience in welcoming, calm environments.
- Strong teamwork, communication and multidisciplinary working.
- Commitment to innovation, continuous improvement and use of technology.
- Space, storage and facilities limitations affecting services.
- Workforce, recruitment, training and capacity pressures.
- Ongoing estates and infrastructure issues requiring attention.
- Need to balance growing demand with financial and resource constraints.
- Focus on patient safety, dignity, accessibility and clear communication.
- Future developments offer opportunities to address current challenges.

Area observations:

- Outdated and excessive posters create clutter and some information may no longer be relevant.
- Visible wear and tear in the environment, particularly damaged chair upholstery.
- Staff were friendly, efficient, and handled challenging situations calmly.
- Patients found it difficult to distinguish between staff nurse and sister uniforms.
- Accessibility could be improved through clearer wheelchair spaces and better furniture positioning.
- Children's facilities were valued, but access to some play equipment was obstructed.
- Positive amenities included Wi-Fi, free water, and a visible clock.
- The TV was difficult to hear when the area was busy; subtitles could improve accessibility.

Action required

The Membership and Engagement Committee is asked to:

- note the report and emerging themes
- consider any locations of particular focus for future visits / activities

Governance and compliance

Risk and assurance: Council of Governors is unable to undertake its statutory duties
Equality, diversity and inclusion: The Trust supports an inclusive governance culture
Sustainability: Supports the sustainability of effective governance structures and long-term organisational resilience across the Board.
Legal and regulatory context: West Suffolk NHS Foundation, Trust Constitution/Health & Social Care Act 2022

13. Standards Committee Report (No meeting since 21 April 2026)

To Note

Presented by Jude Chin

14. Staff Governors' Report (No formal meeting since 13 April 2026)

To Note

Presented by Jude Chin

15. Lead Governor Report (enclosed)

To receive a report from the Lead Governor

To inform

Presented by Ben Lord

Council of Governors Meeting (Open)

Report information

Report title: Lead Governor's Report
Meeting Date: 10 September 2026
Agenda item: 15
Sponsor/Executive lead: Ben Lord, Lead Governor
Report prepared by: Ben Lord, Lead Governor
This report is for: ☐Approval ☐ Assurance ☒Discussion ☒information

This report supports the following ambitions within the organisational strategy:

☐ High quality care ☒ Joined up services
☒ Empowered to improve ☒ Responsible with resources
☒ Fit for tomorrow

Executive summary

What?
Brief summary of Governors' main activities over the last quarter.

So what?
The Council of Governors (COG) sits in the accountability and governance structure of Foundation Trusts. The role is defined in both the NHS Act 2006 and the Social Care Act 2012. An addendum to these duties was published in October 2022 taking into account system working and collaboration within Integrated Care Systems (ICS).

Therefore, NHS Foundation Trust Governors have both statutory and general duties to perform:

- Representing the interests of members and the public
- Holding the Non-Executive Directors (NEDs) individually and collectively to account for the performance of the Board and therefore the Trust.
- Appoint and remove Chair/NEDS as appropriate and decide on other terms and conditions of office
- Decide the remuneration and allowances of the Chair and NEDs
- Approve the appointment of the Chief Executive
- Appoint/remove as the external auditor, as appropriate
- Receive the Annual Accounts and Auditor's report
- Approve/make changes to the Trust Constitution and recommend to the Board
- Approve defined significant transactions
- Approve applications for mergers, acquisitions and dissolutions
- Be assured that the Board has considered the consequences of decisions on other partners in the ICS and on the public at large.

What next?
Governors will continue to carry out activities and to develop engagement strategies, which are in line with the fulfilment of their statutory duties and responsibilities.

Action:
The Council is asked to note the report.

Governance and compliance

Risk and assurance: Council of Governors unable to undertake its statutory duties.
Equality, diversity and inclusion: All Governor activities are performed in line with the principles of EDI
Sustainability: Sustainable organisation and Council of Governors
Legal and regulatory context: NHS Act 2006, Social Care Act 2012, WSFT Constitution, WSFT Governors Code of Conduct

Lead Governor Report

1. Introduction

Governor elections take place later this year and current Governors are involved in promoting the Governor role to Trust staff and the public:

- Supporting information desks in various areas of the Trust, including at the Newmarket site
- Supporting an awareness stand at the Annual Members' meeting at the Guildhall, BSE, scheduled for 24 September
- Supporting an awareness stand at the MyWish Charity 'Thank You' event at the Ashlar House on 30 September.

David Slater, Deputy Lead Governor, and I continue to meet Jude Chin, Trust Chair, every month. We also meet with Paul Bunn, Acting Trust Secretary and Pooja Sharma, Deputy Trust Secretary. We are updated and provided with assurance on many areas of Trust activity.

In addition, the survey, that I had commissioned earlier, was shared with governors to gather feedback on their experiences, effectiveness, and perceptions of the governor role, is complete now. The aim was to use this insight to help shape a continued programme of improvement, development and stronger engagement in our governance arrangements. Further update on the summary of findings and areas of development will be shared in due course.

2. Council of Governors' Sub-Committees

2.1 Membership and Engagement Committee

The meeting in July discussed the governor elections and the continuing Membership & Engagement Strategy Development Plan.

2.2 Nominations Committee

Chair and NEDs appraisals were discussed in the meeting held on 18 May 2026.

2.3 Standards Committee

As the July meeting agenda was relatively light and had no time critical items requiring consideration, the Standards Committee meeting was stood down with the agreement of both the Chair and the Lead Governor. The next scheduled meeting of the Committee will take place on **20 October 2026**.

3. Board Assurance Committee Meetings

Governors continue to observe board assurance committee meetings, and their reports are submitted as agenda items to this CoG. Governors have an opportunity to question the Chairs of these meetings during the presentations of their KPIs to the CoG and are encouraged to do so.

4. Governor Updates and Development

The Governors, as part of their continuous development, received a briefing from the Freedom to Speak Up Guardian on 23 June 2026, where governors received insight on context for FTSU, new national arrangements, cases raised at WSFT, concept of anonymous reporting, themes, reflection and planning tool, future plans.

An update on the Future System Programme, by the Programme Director is scheduled for September 2026.

Slides for governors' briefings are made available on Convene.

5. Partner Governor

We note the commencement of Martin Robinson as Partner Governor (Suffolk County Councillor) and welcome to the CoG. We look forward to working with him in the future.

6. Governor's activities

Governors continue to carry out monthly 15 steps visits, regularly meet visitors in the Courtyard café and participate in Area Observations. Feedback is given to the relevant managers and any resulting action plans are implemented and reviewed. The 15 steps programme provides staff with an opportunity to showcase their ward/department and to benefit from a governor's listening ear and earnest attempts to aid in highlighting any issues.

Many thanks to all governors for their continued efforts, support and engagement around our functions and in general supporting the Trust.

16. Annual Report and Accounts, including Auditor's Letter (enclosed)

To receive the Annual Report and Accounts

For Discussion

Presented by Michael Parsons

COUNCIL OF GOVERNORS MEETING (OPEN)

Report information

Report title: Annual Report and Accounts, Annual Auditor's Report 2025/26
Date of the meeting: 10 September 2026
Agenda item: 16
Sponsor/Executive lead: Michael Parsons, Audit & Risk Committee Chair
Report prepared by: Annual Auditor's Report 2025/26 (E&Y, external auditors)
This report is for: ☐ Approval ☒ Assurance ☒Discussion ☒Information

This report supports the following ambitions within the organisational strategy:

☒ High quality care ☒ Joined up services
☒ Empowered to improve ☒ Responsible with resources
☒ Fit for tomorrow

Executive summary

What?
Annual Report and Accounts 2025/26

The annual report and accounts 2025/26 were approved by the Board in June. The Trust is legally required to lay the document before Parliament. This took place on Tuesday 14 July 2026.

Annual Auditor's Report 2025/26 **(Appendix A)**

The Auditor's Annual Report provides a summary of the findings and key issues arising from our 2025-26 audit of West Suffolk NHS Foundation Trust (the 'Trust'). This report has been prepared in line with the requirements set out in the Code of Audit Practice published by the National Audit Office and is required to be published by the Trust alongside the annual report and accounts.

So what?
The Council of Governors is asked to receive the annual accounts and report and annual auditors' report 2025/26 in the public session.

The full annual report is available via the link below and the auditors' report is appended to this document:

Annual report 2025-26

What next?
The Board's Audit & Risk Committee will maintain oversight of issues and recommendations arising from the audit work.

Action required:
The Council of Governors is asked to receive the report.

Governance and compliance

Risk and assurance: Review by the Council of Governors supports transparency and accountability and assists Governors in fulfilling their statutory duties.
Equality, diversity and inclusion: Trust's commitment to equality, diversity and inclusion to ensure that the Trust continues to promote equitable outcomes for patients, service users, staff and local communities.
Sustainability: Promotes Trust's approach to environmental, financial and organisational sustainability.

Legal and regulatory context: WSFT Constitution, Health & Social Care Act, NHSE Code of Governance, NHS FT Annual Reporting Manual and other applicable statutory and regulatory requirements.

West Suffolk NHS Foundation Trust

Auditor's Annual Report

Year ending 31 March 2026

26 June 2026

The better the question. The better the answer. The better the world works.

Shape the future with confidence

Audit and Risk Committee
West Suffolk NHS Foundation Trust
Hardwick Lane, Bury St. Edmunds
Suffolk IP33 2QZ

26 June 2026

Dear Committee Members

2025/26 Auditor's Annual Report

We are pleased to attach our Auditor's Annual Report including the commentary on the Value For Money (VFM) arrangements for West Suffolk NHS Foundation Trust. This report and commentary explains the work we have undertaken during the year and highlights any significant weaknesses identified along with recommendations for improvement. The commentary covers our findings for audit year 2025/26.

This report is intended to draw to the attention of the Trust any relevant issues arising from our work. It is not intended for, and should not be used for, any other purpose.

Yours faithfully

David Riglar

For and on behalf of Ernst & Young LLP

Enc

Contents

The contents of this report are subject to the terms and conditions of our appointment as set out in our engagement letter of 02 December 2025.

This report is made solely to the Audit and Risk Committee, Trust Board and Management of West Suffolk NHS Foundation Trust in accordance with our engagement letter. Our work has been undertaken so that we might state to the Audit and Risk Committee, Trust Board and Management of West Suffolk NHS Foundation Trust those matters we are required to state to them in this report and for no other purpose. To the fullest extent permitted by law we do not accept or assume responsibility to anyone other than the Audit and Risk Committee, Trust Board and Management of West Suffolk NHS Foundation Trust for this report or for the opinions we have formed. It should not be provided to any third-party without our prior written consent.

01 Executive Summary

Executive Summary

Purpose

The purpose of the Auditor's Annual Report is to bring together all of the auditor's work over the year and the value for money commentary, including confirmation of the opinion given on the financial statements; and, by exception, reference to any reporting by the auditor using their powers under the Local Audit and Accountability Act 2014. As set out in the Code of Audit Practice 2024 (the 2024 Code) issued by the National Audit Office (NAO) and the accompanying Auditor Guidance Note 3 (AGN 03), this commentary aims to highlight to the Trust, and the wider public, relevant issues identified during our audit. It includes the recommendations arising from our current year's audit.

Responsibilities of the appointed auditor

We have undertaken our 2025/26 audit work in accordance with the Audit Plan that we issued on 27 February 2026. We have complied with the National Audit Office's (NAO) Code of Audit Practice 2024, other guidance issued by the NAO and International Standards on Auditing (UK).

As auditors we are responsible for:

Expressing an opinion on:

- The 2025/26 financial statements;
- The parts of the remuneration and staff report to be audited;
- The consistency of other information published with the financial statements, including the Annual Report;
- Whether the consolidation schedules are consistent with the Trust's financial statements for the relevant reporting period.

Reporting by exception:

- If the Governance Statement does not comply with relevant guidance or is not consistent with our understanding of the Trust;
- To NHS England if we have concerns about the legality of transactions or decisions taken by the Trust;
- Any significant matters or written recommendations that are in the public interest; and
- If we identify a significant weakness in the Trust's arrangements in place to secure economy, efficiency and effectiveness in its use of resources.

Responsibilities of the Trust

The Trust is responsible for preparing and publishing its financial statements, Annual Report and Governance Statement. It is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Executive Summary (cont'd)

2025/26 conclusions

Financial statements	Unqualified – the financial statements give a true and fair view of the financial position of the Trust as at 31 March 2026 and of its expenditure and income for the year then ended. We issued our auditor's report on 24 June 2026.
Parts of the remuneration report and staff report subject to audit	Our work in this area identified amendments required in respect of the exit packages banding, pension benefit figures and other disclosure differences. This was corrected in the audited remuneration report. No other matters were identified.
Consistency of the other information published with the financial statements	Financial information in the Annual Report and published with the financial statements was consistent with the audited accounts. We identified minor disclosure amendments which Management agreed to correct.
Value for money (VFM)	We had no matters to report by exception on the Trust's VFM arrangements. We have included our VFM commentary in Section 03.
Consistency of the annual governance statement	We were satisfied that the Annual Governance Statement was consistent with our understanding of the Trust.
Referrals to NHS England	We made no such referrals.
Public interest report and other auditor powers	We had no reason to use our auditor powers.

Executive Summary (cont'd)

2025/26 conclusions (cont'd)

Reporting to the Trust on its consolidation schedules	We concluded that the Trust's consolidation schedules agreed, within a £1,000,000 tolerance, or £300,000 tolerance for losses and special payments, gifts and contingent liability disclosures, to the audited financial statements.
Reporting to the National Audit Office (NAO) in line with group instructions	We have reported to the NAO in line with their group instructions.
Certificate	We cannot formally conclude the audit and issue an audit certificate until the NAO, as group auditor, has confirmed that no further assurances will be required from us as component auditors of West Suffolk NHS Foundation Trust.

Executive Summary (cont'd)

Value for money scope

Under the 2024 Code, we are required to consider whether the West Suffolk NHS Foundation Trust has put in place 'proper arrangements' to secure economy, efficiency and effectiveness in its use of resources. The Code requires the auditor to design their work to provide them with sufficient assurance to enable them to report to the West Suffolk NHS Foundation Trust a commentary against specified reporting criteria (see below) on the arrangements the West Suffolk NHS Foundation Trust has in place to secure value for money through economic, efficient and effective use of its resources for the relevant period.

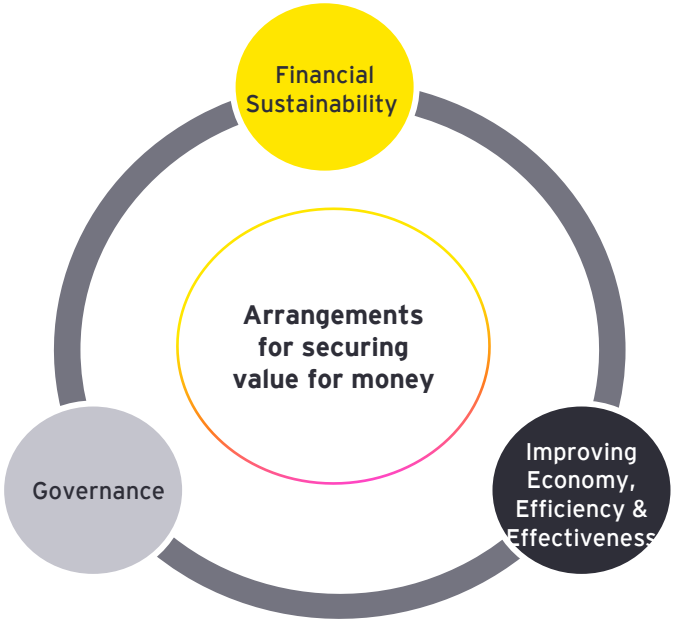
We do not issue a 'conclusion' or 'opinion', but where significant weaknesses are identified we will report by exception in the auditor's opinion on the financial statements.

The specified reporting criteria are:

- Financial sustainability - How the Trust plans and manages its resources to ensure it can continue to deliver its services.
- Governance - How the Trust ensures that it makes informed decisions and properly manages its risks.
- Improving economy, efficiency and effectiveness - How the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

In undertaking our procedures to understand the body's arrangements against the specified reporting criteria, we identify whether there are risks of significant weakness which require us to complete additional risk-based procedures. AGN 03 sets out considerations for auditors in completing and documenting their work and includes consideration of:

- our cumulative audit knowledge and experience as your auditor;
- reports from Internal Audit which may provide an indication of arrangements that are not operating effectively;
- our review of Trust committee reports;
- meetings with the officers of the Trust;
- information from external sources; and
- evaluation of associated documentation through our regular engagement with Trust management and the finance team.



Executive Summary (cont'd)

Reporting

Our commentary for 2025/26 is set out in Section 03. The commentary on these pages summarises our understanding of the arrangements at the Trust based on our evaluation of the evidence obtained in relation to the three reporting criteria (see table below) throughout 2025/26.

In accordance with the 2024 Code, we are required to report a commentary against the three specified reporting criteria. The table below sets out the three reporting criteria, whether we identified a risk of significant weakness as part of our planning procedures, and whether, at the time of this report, we have concluded that there is a significant weakness in the body's arrangements.

Reporting criteria	Risks of significant weaknesses in arrangements identified?	Actual significant weaknesses in arrangements identified?
Financial sustainability: How the Trust plans and manages its resources to ensure it can continue to deliver its services	One significant risk identified: Trust's Financial planning, including delivery of cost improvement programme (CIP)	No significant weakness identified
Governance: How the Trust ensures that it makes informed decisions and properly manages its risks	No significant risks identified	No significant weakness identified
Improving economy, efficiency and effectiveness: How the Trust uses information about its costs and performance to improve the way it manages and delivers its services	No significant risks identified	No significant weakness identified

Executive Summary (cont'd)

Independence

The FRC Ethical Standard requires that we provide details of all relationships between Ernst & Young (EY) and the Trust, and its members and senior management and its affiliates, including all services provided by us and our network to the Trust, its members and senior management and its affiliates, and other services provided to other known connected parties that we consider may reasonably be thought to bear on our integrity or objectivity, including those that could compromise independence and the related safeguards that are in place and why they address the threats.

There are no relationships from 1 April 2025 to the date of this report, which we consider may reasonably be thought to bear on our independence and objectivity.

EY Transparency Report 2025

Ernst & Young (EY) has policies and procedures that instil professional values as part of firm culture and ensure that the highest standards of objectivity, independence and integrity are maintained.

Details of the key policies and processes in place within EY for maintaining objectivity and independence can be found in our annual Transparency Report which the firm is required to publish by law. The most recent version of this Report is for the year end 30 June 2025:

EY UK 2025 Transparency Report | EY - UK

02 Audit of financial statements

Audit of financial statements

Key findings

The Annual Report and Accounts is an important tool for the Trust to show how it has used public money and how it can demonstrate its financial management and financial health.

On 24 June 2026, we issued an unqualified opinion on the financial statements. We reported our audit scope, risks identified and detailed findings to the 23 June 2026 Audit and Risk Committee meeting in our Audit Results Report. We outline below the key issues identified as part of our audit. We reported three internal control recommendations and areas for improvement in the control environment in our Audit Results Report. See Appendix A for further details.

Financial statement risks

Risks/Area of Focus	Conclusion
Misstatements due to fraud or error – Management override of controls	We have not identified any instances of inappropriate judgements or estimates being applied. Our work did not identify any other transactions during our audit which appeared unusual or outside the Trust's normal course of business.
Inappropriate capitalisation of revenue expenditure	We have raised a recommendation for the Trust to improve arrangements for monitoring and maintaining evidence to support appropriate capitalisation of these costs.
Risk of fraud in revenue and expenditure recognition - completeness of non-NHS manual accruals	We have not identified matters to report.
Valuation of land and buildings (including dwellings)	We have not identified matters to report.
Valuation of right of use assets	We have not identified matters to report.
Remuneration report disclosures	We have identified disclosure amendments, which Management agreed to address in the final version of financial statements. We have raised a recommendation on the timeliness of provision of the Remuneration Report and Annual report, along with the working papers.

03 Value for money commentary

Value for Money Commentary

Financial sustainability: How the Trust plans and manages its resources to ensure it can continue to deliver its services

No significant weakness identified

The Trust maintains a structured and integrated approach to financial planning, aligned to its strategic objectives, statutory obligations, and the delivery of sustainable, high-quality services. Financial planning is centred on stabilising the Trust's financial position, ensuring compliance with NHS regulatory requirements, and supporting long-term clinical sustainability. In line with national NHS financial rules, the Trust operates within an agreed control total, and publishes required statutory reports, including the annual accounts, governance statement, and quality report.

Planning is undertaken through a collaborative and inclusive process, bringing together finance, operational leaders and senior management to identify pressures at an early stage. These include demand growth, workforce challenges, and regulatory changes. The Trust has established a Medium-Term Financial Strategy (MTFS) covering a three- to five-year period, which incorporates key assumptions such as inflation, pay awards, borrowing costs and demographic changes. This supports alignment of resources with strategic priorities and provides a framework for financial sustainability.

The financial planning framework is fully integrated with workforce, capital, and operational planning. Workforce assumptions are embedded within the budget-setting process, with associated risks monitored through the business planning cycle. Capital investment decisions are prioritised based on strategic alignment, patient safety, and affordability, and are subject to review and oversight. The operational plan is developed alongside the financial plan to ensure deliverability, supported by close collaboration between finance, clinical, and corporate teams. The Trust also participates in system-wide planning through engagement with the ICB, NHSE and local partners to ensure alignment of priorities and effective use of resources across the wider system.

Our risk assessment identified the following risk of significant weakness in arrangements in respect of securing financial sustainability:

Risk of significant weakness: Trust's Financial planning, including delivery of cost improvement programme (CIP)

The Trust continues to operate in a challenging financial environment and has implemented a range of measures to support financial recovery and sustainability. A board-led recovery approach is in place, supported by strengthened financial controls and oversight of expenditure. The Trust has implemented a comprehensive CIP, focusing on key areas such as reducing reliance on temporary staffing, improving productivity, optimising medicines usage, and reviewing commercial contracts.

For 2025/26, the Trust remains in a deficit position, with a £15 million outturn deficit. It also forecasts a deficit of £12.85 million in 2026/27 and continues to rely, in part, on non-recurrent CIP delivery. We recognise that there is therefore a risk that financial sustainability could represent a significant weakness. However, the Trust has established financial recovery plans and continues to receive deficit support funding from NHS England to support improvement. For instance, the Trust planned to deliver £32.8 million of savings through its CIP and achieved £31.158 million at year-end, representing delivery broadly in line with the original plan. These actions have contributed to a reduction in the underlying deficit and demonstrate progress in financial recovery.

Value for Money Commentary

Financial sustainability: How the Trust plans and manages its resources to ensure it can continue to deliver its services (cont'd)

No significant weakness identified

The Trust continues to develop forward-looking recovery initiatives aimed at reducing the underlying run rate and improving operational efficiency. Future plans include delivery of additional CIP savings, including a target of £21.9 million for 2026/27, with schemes developed collaboratively to support deliverability. These are complemented by initiatives to strengthen workforce sustainability and better align staffing models with service demand.

The Trust has established structured arrangements to identify, monitor and manage financial sustainability risks. These are embedded within wider governance and risk management processes, including oversight by the Board and relevant committees. Financial risks and uncertainties—including funding volatility, demand pressures and operational disruption—are regularly assessed as part of financial planning and forecasting processes to ensure plans remain responsive and robust. A key strategic risk relates to system capacity to meet increasing demand, which is currently assessed as exceeding the Trust's risk appetite. Mitigating actions are in place, including capacity planning and operational escalation measures. The Board maintains oversight of the risk appetite and effectiveness of mitigating actions through regular reporting and review.

Routine monitoring of revenue and capital positions, supported by in-year forecasting, enables early identification of adverse variances and informs timely management action. Governance arrangements, including review by the Finance and Performance Committee, provide scrutiny of financial and operational performance against plan. In addition, the incorporation of national demand pressures into local planning assumptions supports a proactive approach to risk management. The Trust also reviews its capital programme regularly through a capital strategy group, ensuring compliance with NHS funding requirements while considering longer-term affordability, including maintenance, depreciation and Public Dividend Capital implications.

As the Trust remains in a deficit position and continues to rely in part on non-recurrent and challenging CIP delivery, we recognise there is a risk that financial sustainability could represent a significant weakness. However, the Trust has identified these risks and is monitoring them through established governance arrangements, including Board reporting and oversight and financial recovery actions. On this basis, we are satisfied that appropriate arrangements are in place and therefore have not identified a significant weakness in financial sustainability.

Conclusion: Based on the work performed, the Trust had proper arrangements in place in 2025/26 to enable it to plan and manage its resources to ensure that it can continue to deliver its services.

Value for Money Commentary (cont'd)

Governance: How the Trust ensures that it makes informed decisions and properly manages its risks

No significant weakness identified

The Trust has established a comprehensive governance framework to support informed and transparent decision-making, underpinned by statutory requirements, defined accountability structures, and independent assurance. The Trust's Annual Governance Statement shows a comprehensive list of arrangements that are in place within the Trust that shows it has a robust system of internal control. The Board of Directors retains overall responsibility for the effectiveness of governance and internal control arrangements and formally approves key documents, including the Scheme of Delegation and Schedule of Matters Reserved.

The Board is supported by a structured committee framework, which provides oversight and scrutiny across key areas including financial performance, risk, workforce, and quality. Committees report regularly to the Board, highlighting key risks, areas of concern and matters requiring escalation. The Audit and Risk Committee plays a central role by providing independent and objective assurance over the effectiveness of governance, risk management and internal control arrangements, including oversight of financial reporting and internal audit activity.

These arrangements are complemented by additional assurance committees, which undertake detailed reviews of key areas such as operational delivery, financial control, organisational risk and quality, providing depth of scrutiny and supporting the Board in its decision-making processes.

Risk management arrangements:

The Trust has embedded structured risk management processes, supported by a formal risk management policy which assigns responsibility for risk identification and management across all levels of the organisation. Strategic risks are captured within the Board Assurance Framework (BAF), which is aligned to the Trust's strategic objectives and is regularly reviewed and updated. Each principal risk is owned by an Executive Director and subject to ongoing review and challenge. Risks are scrutinised at committee level before escalation to the Board, ensuring appropriate oversight and accountability. The Audit and Risk Committee retains overarching responsibility for reviewing the effectiveness of the risk management framework and gaining assurance that material risks are appropriately identified and mitigated.

Independent assurance is provided through an internal audit programme approved annually by the Audit and Risk Committee, alongside external audit review. In addition, arrangements to prevent and detect fraud are in place through the Trust's Anti-Fraud, Bribery and Corruption Policy, supported by a Local Counter Fraud Specialist who operates in line with national standards and reports regularly to senior management and the Audit and Risk Committee.

The Head of Internal Audit Opinion (HoIA) for 2025/26 concluded that the Trust has an 'adequate and effective framework for risk management, governance, and internal control'. The HoIA issued four partial assurance opinions and one minimal assurance opinion as part of the delivery of the 2025/26 Internal Audit Plan. Whilst actions for follow up were raised on areas such as Medical Devices, Establishment Control, Decentralised Financial Processes, Partnership Working, and Mental Capacity Act and Deprivation of Liberty Standards, the HoIA is satisfied with the Trust's overall progress, including the positive assurance outcomes and good progress in implementing agreed actions, with a number of items not yet due.

Value for Money Commentary (cont'd)

Governance: How the Trust ensures that it makes informed decisions and properly manages its risks (cont'd)

No significant weakness identified

Decision-making, performance and financial governance:

The Trust supports effective decision-making through robust financial governance and performance management arrangements. A structured annual budget-setting process is in place, aligned with national planning guidance and supported by a formal timetable. This process incorporates assessment of financial pressures, service requirements and savings opportunities, including the development of CIPs. Final plans are subject to Board approval, ensuring appropriate oversight.

Performance against plan is monitored throughout the year through regular reporting and challenge. Budget holders are supported through routine review of variances, with monthly divisional performance meetings and detailed financial reporting enabling early identification of issues and timely corrective action. Governance oversight is provided through established forums, including the Finance and Performance Committee and Financial Accountability Committee, which receive regular updates on financial and operational performance. A Financial Recovery Group is also in place to address emerging financial pressures and support delivery of recovery plans.

These arrangements are supported by the use of timely and reliable management information, covering both financial and non-financial metrics. Workforce indicators, patient flow, waiting times and quality measures are regularly reported and considered alongside financial performance, enabling a holistic assessment of organisational performance and supporting informed decision-making.

In 2020, the Trust was announced as one of the 40 new hospitals to be built by 2030 as part of the Government Health Infrastructure Plan, representing a significant opportunity to replace the ageing estate. A clear governance structure is in place, supported by defined committees, and active risk management through the Risk, Assumption, Issue and Dependency (RAID) log and Board Assurance Framework. In 2025/26, the Trust signed an Alliance Agreement with key partners to promote collaborative delivery and shared decision-making on the New Hospital Programme.

Capital spend is being closely monitored and remains aligned to the phased progression of the programme. For 2025/26, the Trust forecast capital spend of £13.36 million, with actual spend of £12.24 million. The underspend reflects the phasing of the New Hospital Programme project rather than any underlying issue. The scheme has made steady progress to date, including key planning milestones and movement into detailed design, with appropriate arrangements in place to support delivery in line with the agreed timeline.

Value for Money Commentary (cont'd)

Governance: How the Trust ensures that it makes informed decisions and properly manages its risks (cont'd)

No significant weakness identified

Regulatory compliance, transparency and assurance:

The Trust operates within a robust regulatory framework, supporting transparency, accountability and compliance with statutory requirements. The Board provides oversight of compliance with the NHS Provider Licence and confirms this through annual self-certification. As a Care Quality Commission (CQC) registered provider, the Trust ensures compliance with relevant legislation, with assurance provided through the Quality and Patient Safety Committee and escalated to the Board where appropriate.

Following the 2020 CQC inspection, which resulted in an overall rating of 'Requires Improvement', the Trust implemented a comprehensive improvement plan to address the identified weaknesses. Since then, it has made good progress in strengthening governance, leadership and safety arrangements, with all required actions now completed and enhanced assurance processes embedded. The Trust remains compliant with regulatory requirements and is not subject to additional oversight measures. It is now awaiting its next inspection to demonstrate sustained improvement and support a progression to a 'Good' rating.

Governance is further strengthened through arrangements to manage conflicts of interest, including maintenance of comprehensive registers and mandatory declarations. External assurance is provided through internal audit, external audit and regulatory oversight, while public reporting through published accounts, governance statements and quality reports supports openness and stakeholder scrutiny. The Council of Governors provides additional independent challenge, representing the interests of patients, staff and the public, and contributing to transparency and accountability.

Conclusion: Based on the work performed, the Trust had proper arrangements in place in 2025/26 to make informed decisions and properly manage its risks.

Value for Money Commentary (cont'd)

Improving economy, efficiency and effectiveness: How the Trust uses information about its costs and performance to improve the way it manages and delivers its services

No significant weakness identified

The Trust uses financial and performance information systematically to monitor service delivery, identify risks, and drive continuous improvement. This information is embedded within Board oversight, operational management, and strategic planning, enabling informed decision-making and effective use of resources. A formal performance management framework supports regular reporting to the Board and its committees, incorporating key performance indicators (KPIs) across quality, finance, workforce and operations. This is complemented by trend analysis to identify areas of deterioration or improvement. The Trust's annual Quality Accounts further strengthen this approach by comparing performance against agreed priorities, assessing delivery of strategic objectives, and monitoring actions taken to improve performance and inform next steps.

The Trust operates a structured and multi-layered framework to review performance and quality, integrating financial, operational, and clinical information. This includes reporting through Integrated Quality and Performance Report (IQPR) and established performance forums such as Performance Review Meeting (PRM), Financial Recovery Group (FRG) and productivity boards, alongside clinical quality assurance processes, incident reporting systems, and feedback from staff and patients. These arrangements provide a comprehensive view of service delivery, supporting identification of emerging risks and areas requiring improvement.

Financial performance and cost management are closely monitored through established governance forums, including PRM, FRG, the Investment Panel and CIP-related boards. Particular focus is placed on addressing the Trust's deficit through programmes such as React, Recover, Renew, and reducing workforce-related financial pressures. The Finance and Performance Committee provides additional oversight by reviewing performance, identifying key issues and ensuring that actions and recovery plans are implemented and monitored.

Insights generated through these processes are actively used to improve efficiency and effectiveness. The Trust uses this intelligence to design and deliver CIPs, optimise resource allocation, and redesign care pathways, including elective recovery and Emergency Department flow. Operational and quality metrics, such as performance against the four-hour standard and management of long elective waits, are used to target interventions and support service improvement.

The Trust also operates within a wider system context, using shared data and partnership working to improve outcomes and value for money. Performance, financial and quality information is integrated into governance processes across the Suffolk and North East Essex (SNEE) Integrated Care System, supporting alignment with system priorities and enabling coordinated responses to demand and capacity pressures. Where performance falls short, issues are escalated through established governance routes, with clear recovery actions and improvement plans implemented and tracked.

In addition, the Trust ensures that commissioning and procurement activities deliver value for money through structured contract management and monitoring arrangements. Performance against agreed service specifications and KPIs is routinely reviewed, supported by engagement with providers and stakeholders to drive continuous improvement. Compliance with procurement legislation and internal policies ensures that resources are used efficiently and transparently.

Conclusion: Based on the work performed, the Trust had proper arrangements in place in 2025/26 to enable it to use information about its costs and performance to improve the way it manages and delivers its services.

04 Appendices

Appendix A – Recommendations

Recommendations from 2025/26

The table below sets out the recommendations arising from the financial statements work for the year 2025/26. All recommendations have been agreed by Management.

Issue	Recommendation	Management response
Signed Contracts Our testing of the Trust's commissioning contract income identified that the main contract between the Trust and two ICBs and NHS England was not signed by both parties. Under NHS Standard Contract 2025/26 Technical Guidance (April 2025), the commissioning of services from providers should be underpinned by a signed contract between the ICBs and the providers.	We recommend that going forward, the Trust should ensure that signed contracts (including variation contracts) are in place in line with NHS Standard Contract Guidance.	Responsible officer: Allan Petchey, Senior Contracts Manager We will work with associated parties to ensure that NHS contracts are signed on a timely basis.
Capitalisation of staff costs We identified that during the year the Trust capitalised a total of £0.92 million of Digital/IT staff costs which was allocated to various projects. The Trust was unable to provide sufficient evidence to support the accounting treatment of these costs in accordance with IAS 16 Property, Plant and Equipment, particularly in relation to the underlying rationale for the extent of staff costs capitalised.	We recommend the Trust improve arrangements for monitoring and maintaining evidence to support appropriate capitalisation of these costs.	Responsible officer: Liana Nicholson, Assistant Director of Finance We will implement a control to ensure that any staff costs that are to be capitalised are accompanied by appropriate evidence (e.g. timesheet) before being approved as capital expenditure.
Remuneration Report and Annual Report As part of the NHS provider accounts timetable for 2025/26, NHS England suggested deadlines for Trusts to submit the draft remuneration and annual reports (including supporting working papers) to auditors. Whilst providers can continue to agree different timings with their auditors, the timetable establishes an expected baseline to support timely audit completion. Adherence to these suggested deadlines is therefore important to minimise the risk of delays in meeting the overall accounts sign-off deadline. The Trust provided the reports and supporting working papers between the 22 May and 1 June, after the deadline suggested by NHSE of 27 April and 6 May for Remuneration Report and Annual Report, respectively.	The Trust should meet the suggested deadlines indicated in the year-end accounts timetable to ensure sufficient time for review by the Audit and Risk Committee and avoid delays in the audit so that reporting deadlines are met.	Responsible officer: Liana Nicholson, Assistant Director of Finance Paul Bunn, Trust Secretary We will work with the Auditors to ensure that these documents are received by the deadline set. Internally, we will ensure that timetables are revisited to achieve the deadline.

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UKC-038566 (UK) 03/25. Creative UK.
ED None

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17. Governance Report (verbal)

To receive a governance report

To Note

Presented by Paul Bunn

ITEMS FOR INFORMATION

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

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

To inform

Presented by Jude Chin

COUNCIL OF GOVERNORS MEETING (OPEN)

Report information

Report title: Summary Report for Board of Directors Meetings
Date of the meeting: 10 September 2026
Agenda item: 18
Sponsor/Executive lead: Jude Chin, Trust Chair
Report prepared by: Ruth Williamson, Senior Administrator, FT Office, Pooja Sharma, Deputy Trust Secretary,
This report is for: ☐Approval ☐ Assurance ☒Discussion ☒information

This report supports the following ambitions within the organisational strategy:

☒ High quality care
☒ Joined up services
☒ Empowered to improve
☒ Responsible with resources
☒ Fit for tomorrow

Executive summary

What?
This report is from the Board of Directors to the Council of Governors and recognises the statutory duties of the Governors to:

- **represent the interests** of the members of the NHS foundation trust and the public
- through the NEDs **hold to account** for the performance of the Board of Directors.

So what?
The Board of Directors recognises and respects this role of the Council of Governors.

This report summaries the activities of the Board meetings and complements the reports received from the Board's assurance committees earlier on the agenda.

What next?
The Council of Governors to review this report in order to consider any elements relating to the **performance of the Board** arising from this report which they wish to raise with the non-executive directors, consider any **areas of priority** identified in this report for future engagement with members and the public.

Action required by the Council of Governors:
The Council of Governors is asked to note and review the summary report.

Governance and compliance

Risk and assurance: If we do not provide the Council of Governors with the right level of reporting on the performance of the Board, this will not provide them with the intelligence and context against which they can effectively hold the NEDs to account for the Board's performance and information on the principal issues for which they are responsible for representing the interests of members and the public in the governance of the Trust.
Equality, diversity and inclusion: Ensure appropriate consideration of EDI issues
Sustainability: Be aware of the environmental impact of decision making
Legal and regulatory context: NHS Act 2006, Health and Social Care Act 2012
Your Statutory Duties: A reference guide for NHS Foundation Trust Governors – Monitor 2013, The NHS Foundation Trust Code of Governance July 2014

Board of Director Key Issues

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Board of Director Key Issues – 31 July 2026			
Quality Improvement (QI) Staff Story - The Board received an inspiring presentation from the Neonatal Team on a quality improvement project to undertake intravenous cannulation at the baby's cot side rather than away from parents. The project has reduced separation between mothers and babies, supported family-centred care, improved staff engagement and increased the use of electronic documentation. Members praised the team's work and highlighted the importance of embedding continuous quality improvement as part of everyday practice.	• To note learnings.	-	Verbal
CEO Report - The Chief Executive highlighted a number of achievements across the organisation, including national recognition for medical education and training. The Board also discussed the impact of recent hot weather on services and infrastructure, noting increased demand, pressure on emergency care services and challenges associated with the estate. Members recognised the need for year-round resilience planning across the wider health and care system.	• Ongoing assurance/ monitoring	-	1.7
BAF & Risk Report – The Board approved updates to the Board Assurance Framework and Risk Appetite Statements. No significant risk escalations were reported.	• Ongoing assurance/ monitoring		1.8
West Suffolk Alliance, Norfolk & Suffolk ICB and NHS Essex ICB - Reporting arrangements have moved to a bi-monthly cycle. The next formal update on partnership and system working will be presented to the September Board meeting.	• Strengthened provider collaboration	Focus on system working	2.1
Annual Review of IQPR - The annual review confirmed that the Integrated Quality and Performance Report remains a key source of public assurance. Improvements have been made to data quality and reporting, with an increased focus on health inequalities. The Board also discussed future opportunities for digital reporting and accessibility.	• Ongoing assurance/monitoring	-	3.1

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
IQPR Report - Cancer performance continues to meet national standards, although urgent and emergency care performance remains challenging. The Board discussed plans to recover elective activity lost earlier in the year and reviewed progress in areas such as virtual wards and community services. A quality improvement programme aimed at improving urgent care performance is due to commence in August.	• Ongoing assurance/monitoring	-	3.2
Staff Story – EDI Midwife - The Board heard how maternity services are working to reduce inequalities and improve personalised care. Initiatives include improved support for people experiencing language barriers, deprivation, transport difficulties and neurodiversity-related challenges. Practical changes such as communication tools, interpreter support and reasonable adjustments are helping improve access to services and patient experience. Members commended the impact of this work and encouraged the learning to be shared more widely.	• To note learnings	-	Verbal
Quality & Patient Safety Committee Report – The Committee reported partial assurance in a number of areas, including maternity and mortuary services. Further work is underway to strengthen hand hygiene auditing and medication safety oversight. Board members discussed the importance of triangulating quality and safety information to ensure assurance processes are robust and effective.	• Ongoing assurance/ monitoring	-	3.4
Nursing Staffing Report – The Board received assurance regarding nursing workforce planning, recruitment and safe staffing arrangements. New initiatives are supporting workforce development and improving redeployment processes. Staffing levels continue to be reviewed against patient acuity and dependency to ensure safe and effective care.	• Ongoing assurance/ monitoring • Overseeing quality indicators	-	3.5
Maternity Services – Progress continues against recommendations arising from national maternity reviews, including Ockenden and Amos. Members were advised that an independent review by regional and ICB teams had been positive. Ongoing work focuses on staff engagement, communication, accessibility and the exploration of technological solutions to improve language support and personalised care.	• Ongoing assurance/ monitoring in areas of priority	-	3.6

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Fuller Report - The Board reviewed progress against actions arising from the Fuller review. Most actions have now been completed, with a small number of estates-related actions remaining. The Board approved the required assurance statement for submission to NHS England.	• Ongoing assurance/ monitoring in areas of priority	-	3.7
People & Organisational Development Committee – The Committee highlighted work relating to staff wellbeing, sexual safety, workforce culture and support for resident doctors. Staff survey findings identified opportunities to improve communication, transparency and staff involvement in decision-making. The Trust also reaffirmed its zero-tolerance approach to discrimination and inappropriate behaviour.	• Ongoing assurance/ monitoring	-	4.1
Organisational Culture - The Board received an update on work underway to strengthen organisational culture following a recent Board workshop. Further work and discussion will be brought back to future meetings	• Ongoing assurance/ monitoring •	-	4.2
Putting You First – congratulations were offered to those staff receiving awards.	• Ongoing assurance/ monitoring	-	4.3
Lord Mann Review - The Board considered the recommendations arising from the Lord Mann review and broadly supported the proposed actions. Further advice is being sought regarding aspects of the recommendations before final adoption.	• Ongoing assurance/ monitoring	-	4.4
Finance & Performance Committee – CKIs – The Board noted the key matters discussed by the Finance and Performance Committee, including the ongoing focus on performance recovery and financial sustainability.	• Ongoing assurance/ monitoring	-	5.1
Finance Report - The Trust reported a financial deficit against plan during the first quarter but continues to forecast delivery of its year-end financial target. This remains dependent on successful elective recovery, increased activity levels and delivery of cost improvement programmes. Work continues to identify additional savings opportunities and close the remaining gap in the cost improvement programme.	• Ongoing assurance/monitoring	Financial sustainability	5.2

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Audit & Risk Committee – The Board noted that the Annual Report and Accounts had been approved and submitted. No significant concerns were escalated by the Committee.	• Board visibility and oversight	-	5.3
Charitable Funds Committee - The Board received an update on charitable fundraising activity, including progress towards funding a surgical robot. Further updates will be provided through future reports.	• Board visibility and oversight	-	5.4
Future System Board Report – The Trust reached a significant milestone in the New Hospital Programme, with the contract signed with the preferred construction partner. This represents an important step in progressing plans for future healthcare facilities in West Suffolk.	• Ongoing assurance/ monitoring • Board to receive future updates	Sustainable service improvements	6.1
Green Plan - The Board noted progress made against the Trust's Green Plan and sustainability objectives, including ongoing work to reduce environmental impact and support long-term resilience.	• Board oversight	-	6.2
Governance Report – Members were advised that there were no governance concerns requiring escalation and that statutory compliance requirements continue to be met. The Board formally approved the Terms of Reference for the Finance and Performance Committee and was reminded to review declarations of interest.	• Board oversight	-	6.3

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Board of Director Key Issues – 5 June 2026			
Patient Story - The Board heard a powerful patient story from the parents of adult children with complex health needs, highlighting the importance of personalised care and reasonable adjustments. The discussion reinforced the need to listen to patients and carers as experts in their own experiences. Members noted work to introduce a patient flag system to identify reasonable adjustments and support personalised care throughout the patient journey. The Board agreed that personalised care should continue to receive greater focus across the organisation.	• To note learnings.	-	Verbal
CEO Report - The Chief Executive reported significant performance improvements across several areas. Emergency Department four-hour performance had improved by 5%, while the Trust achieved one of the largest reductions in elective waiting lists nationally. Diagnostic performance and 18-week referral-to-treatment performance also improved considerably, and the Trust launched its robotic surgery programme. The Board recognised the significant contribution made by staff and agreed that ways of formally thanking and recognising teams should be explored.	• Ongoing assurance/ monitoring	-	1.7
BAF & Risk Report – The Board reviewed the refreshed Board Assurance Framework and noted a reduction in principal risks from eight to seven. Continued work is underway to refine risk appetite, strengthen links between strategic and operational risks and ensure the framework remains a live tool for assurance and decision-making. Members welcomed the progress made and agreed further discussion at an upcoming Board development session.	• Ongoing assurance/ monitoring	-	1.8
Strategic Priorities Update - The Board received the first iteration of a new strategic scorecard designed to monitor progress against the Trust's five strategic pillars. Members welcomed the development but requested greater clarity on measures, ownership, outcomes and links to priority projects. Future versions will include improved alignment between strategic priorities and delivery plans, with a revised scorecard to be presented in September.	• Ongoing assurance/ monitoring	-	2.1

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Joint Productivity Board Update - An update was provided on collaborative opportunities between the Trust and East Suffolk and North Essex Foundation Trust. National policy changes have altered the approach to joint working, with future collaboration focusing on areas that provide clear benefits and value. Discussions will continue with the incoming Chief Executive at ESNEFT to identify future opportunities.	•		2.2
West Suffolk Alliance, Norfolk & Suffolk ICB and NHS Essex ICB - The Board received an update on work across the West Suffolk Alliance, including developments relating to community services, dementia care and end of life care. Members welcomed positive outcomes being achieved and requested clearer baseline measures to demonstrate improvements. Further updates on dementia services and end of life care performance will be brought to future meetings.	• Strengthened provider collaboration	Focus on system working	2.3
ICB Joint Forward Plan – Strategy & Population Health Improvement Plan - Representatives from the Integrated Care Board presented a new strategic commissioning framework focused on population health improvement and reducing inequalities. The Board discussed the importance of neighbourhood-level data, workforce planning, digital transformation and preventative approaches to care. Members recognised the opportunities presented by the strategy; alongside the challenges it may create for providers across the health system.	• Ongoing assurance/monitoring	-	2.4
IQPR Report - The Board noted continued improvements in diagnostic services and waiting time performance, which are contributing positively to patient experience. However, members acknowledged that future targets will be more demanding and that continued improvement will be required. Work is also underway through the Continuous Quality Improvement programme to improve patient flow and reduce waits within the Emergency Department.	• Ongoing assurance/monitoring	-	3.1
Quality & Patient Safety Committee Report – The Committee highlighted progress in addressing overdue clinical policies, with a plan in place to ensure all outstanding policy reviews are completed by the end of August.	• Ongoing assurance/ monitoring	-	3.2

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Quality & Nurse Staffing Report – The Board received assurance regarding nursing workforce and staffing arrangements. Staffing challenges remain within some services, particularly community nursing, due to increasing demand and capacity pressures. Robust real-time monitoring arrangements remain in place and staffing indicators are reviewed alongside patient safety outcomes. Members requested further assurance within future reports to better demonstrate links between staffing levels and patient care outcomes.	• Ongoing assurance/ monitoring • Overseeing quality indicators	-	3.3
Maternity Services – The Board heard that maternity services continue to embed quality improvement into everyday practice. Work is ongoing to strengthen how patient feedback is measured and understood, while service user views have directly influenced improvements such as the introduction of overnight visitors. Members welcomed the strong culture of continuous improvement and the emphasis on listening to women and families to shape service developments.	• Ongoing assurance/ monitoring in areas of priority	-	3.4
People & Organisational Development Committee – The Committee highlighted work relating to staff wellbeing, sexual safety, workforce culture and support for resident doctors. Staff survey findings identified opportunities to improve communication, transparency and staff involvement in decision-making. The Trust also reaffirmed its zero-tolerance approach to discrimination and inappropriate behaviour.	• Ongoing assurance/ monitoring	-	4.1
Freedom to Speak Up Guardian - The Freedom to Speak Up Guardian reported increasing levels of anonymous reporting, which was viewed positively as evidence of psychological safety across the organisation. Key themes included support for junior staff, equality impact assessments and compassionate communication during organisational change. The Board welcomed positive assessment findings and supported ongoing development of the Freedom to Speak Up function.	• Ongoing assurance/ monitoring	-	4.2

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Putting You First Award - The Board congratulated all recipients of the Putting You First Awards and thanked them for their contribution to patient care and service improvement. Members agreed that future award winners should be invited to attend Board meetings to further celebrate and recognise staff achievements.	• Ongoing assurance/ monitoring	-	4.3
National Staff Survey Action Plan - An action plan was presented in response to staff survey findings. Five priority areas have been identified, focusing on staff experience, engagement and organisational culture. The Board welcomed the increased use of Pulse Surveys and emphasised the importance of involving staff in shaping future improvement actions.	• Ongoing assurance/ monitoring	-	4.4
Quality Improvement - The Board received an update on the Trust's Quality Improvement programme, including nationally recognised work implementing Martha's Rule. Members heard how quality improvement methods are helping staff improve services, strengthen patient safety and support cultural change. The Board welcomed the growth of quality improvement capability across the organisation and recognised its importance in delivering the Trust's strategic objectives	• Ongoing assurance/ monitoring	-	4.5
Finance & Performance Committee – The Board noted the key issues discussed by the Finance and Performance Committee and ongoing oversight of financial and operational performance.	• Ongoing assurance/ monitoring	-	5.1
Finance Report - The Board reviewed the Trust's financial position for 2026/27. Performance has been affected by industrial action and delays to theatre refurbishment works, which have reduced activity levels and income. A recovery plan is in place and is expected to support restoration of performance over the remainder of the financial year. The Board also noted the successful completion of the annual accounts process, with no significant concerns raised by auditors.	• Ongoing assurance/monitoring	Financial sustainability	5.2

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Charitable Funds Committee – The Committee reported no issues requiring escalation. Members welcomed the introduction of the Trust's new surgical robot and recognised the benefits that robotic-assisted surgery will bring for patient care and clinical practice.	• Board visibility and oversight	-	5.3
Future System Board Report – A major milestone was reached in the New Hospital Programme with confirmation of Dragados as the Trust's construction partner. Work is continuing to ensure the scheme remains affordable while progressing plans towards submission of the Outline Business Case. Construction remains scheduled to begin in 2028.	• Ongoing assurance/ monitoring • Board to receive future updates	Sustainable service improvements	6.1
Governance Report – The Board approved continuation of the existing bi-monthly Public Board meeting cycle. Members also received an update on plans to strengthen governor and member engagement, including upcoming governor elections and initiatives to improve diversity within the candidate pool.	• Board oversight	-	6.2

19. Any Other Business (verbal)

To discuss any other matters not included on the agenda

For Discussion

Presented by Jude Chin

20. Dates for meetings for 2026:
5.30 pm to 7.30 pm, Rooms 19a/b, Educations Centre, WSFT

- 24 September 2026 - Annual Members' Meeting - The Guildhall, Bury St. Edmunds
- 10 November 2026

To Note

Presented by Jude Chin

21. Reflections on meeting

To consider whether the right balance has been achieved in terms of information received and questions for assurance and the Trust's values and behaviours observed

To Note

Presented by Jude Chin

CLOSE

SUPPORTING ANNEXES

Item 10.1- IQPR Full Report - June 2026

NHS
West Suffolk
NHS Foundation Trust

Integrated quality and performance report (IQPR)

June 2026

Compassionate care,
healthier communities

Executive summary:

This report is for **Assurance.**

This reports supports the following ambitions within the organisational strategy:

- High quality care
- Joined up services
- Empowered to improve
- Responsible with resources
- Fit for tomorrow

What?

The purpose of this report is to provide information and analysis relating to key performance indicators for quality, safety, operational standards and workforce during May 2026. This enables Trust Board to scrutinise performance and engage in an assurance process which supports continuous improvement and learning. The performance metrics are allocated to assurance committees as part of this process.

So what?

The Integrated Quality and Performance Report (IQPR) uses the Making Data Count (MDC) 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?). An explanation of MDC is available in the appendices.

What next?

The narrative alongside the data summarises the actions being taken to improve performance where this is not meeting standards and/or is worsening over time.

Executive lead: Daniel Spooner, chief nurse. Nicola Cottington, chief operating officer and deputy chief executive and Julie Hull, chief people officer
Report prepared by: Andrew Pollard, information analyst. Narrative provided by clinical and operational leads.

Delivering compassionate care and healthier communities

Our performance highlights - June 2026

NHS West Suffolk NHS Foundation Trust

ED 4 hour perfomance

74.5%

of patients admitted, transferred or discharged within four hours of arrival (June)

On track for March 27 target of 82%

Elective RTT

64.5%

18-week referral to treatment performance (June)

Working towards 70% target for March 27

Cancer targets

28-day Faster Diagnosis Standard (May)

83.9%

hitting the standard

62-day referral to treatement (May)

76.1%

hitting the standard

Financial performance

At month three (June), we finished with a:

£1.7 million deficit

Above plan but not unexpected due to reduced ability for activity

Q4 Pulse Survey (April)

Engagement

6.47 up from 6.18

Motivation

6.71 up from 6.40

Advocacy

6.27 up from 6.18

Involvement

6.44 up from 6.26

Diagnostics

85.4%

Patients receiveing diagnostic test within six-weeks (June)

Variance – are the measures being met?

Assurance – can the target be consistently achieved?

June 2026	Consistently hitting target - celebrate	Target not consistently achieved or failed	Consistently fail target - investigate	No target set – celebrate, monitor or investigate
Special cause improvement- celebrate		**F&P** 28 Day Faster Diagnosis	**F&P** Diagnostic Performance % within 6 weeks Total RTT 65+ Week Waits **Q&PS** Patient Safety Incidents (PSIs)	**F&P** RTT 52+ Week Waits RTT 52+ Weeks Wait as a % of Trust WL RTT <18 Week Waits (%All) RTT <18 Weeks Waits (% First OPA) **Q&PS** Incidents & RO
Common cause – monitor & understand		**F&P** Non-admitted 4 hour performance Virtual Ward Total average occupancy percentage **POD** Mandatory Training Turnover	**F&P** Ambulance Handover within 15min Incomplete 104 Day Waits	**F&P** 12 hour breaches 12 hour breaches as a percentage of Type 1 attendances RTT Waiting List **Q&PS** INT Nursing Deffered by Service Inpatient Deaths Forma Complaints Received Formal Complaints Resolved Late (>25wd) PALS Received
Special cause concerns - investigate	**POD** Staff Sickness Rolling 12months Staff Sickness	**F&P** Cancer 62 Days Performance	**POD** Appraisal	**F&P** Community Paediatrics RTT Overall Waiting List Community Paediatrics RTT Overall 52 Weeks Wait **Q&PS** SHMI

Items for escalation

Finance and performance (F&P) - Elective: Ambulance Handover within 15min, Diagnostic Performance % within 6 weeks Total, RTT 65+ Week Waits

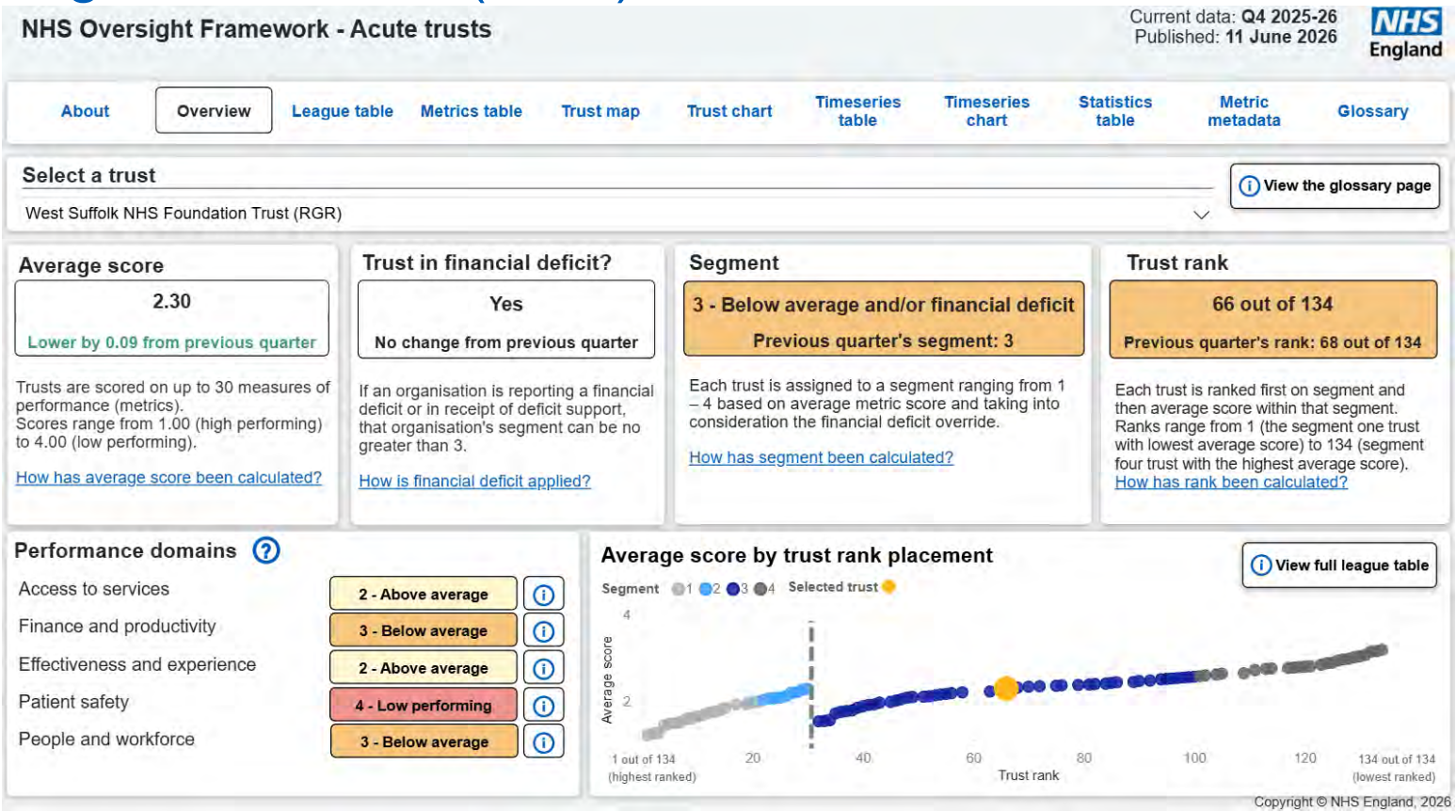
Finance and performance (F&P) - Cancer: Incomplete 104 Day Waits, Cancer 62 Days Performance

Quality and Patient Safety (Q&PS): Patient Safety Incidents (PSIs)

People and Organisational Development (POD) - Well Led: Staff Sickness Rolling 12months, Staff Sickness, Appraisal

For noting: Trajectory in place for ED 12 hour breaches. 92% target for RTT 18 weeks still in place as well as monthly trajectory. Trajectory in place for 4 hour ED waits.

National oversight framework (NOF)



What?

- The National Oversight Framework (NOF) score for WSFT is 66 out of 134 Trusts for quarter 4 of 2025/26. The previous rank was 68. The segment remains unchanged at 3.

So what?

- The NOF is a consistent and transparent approach to assessing integrated care boards (ICBs) and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement.

What next?

- NOF domains are reflected in other metrics so we can monitor changes and improvements. Financial recovery continues, in order that the financial override can be overcome once the Trust is in financial balance.

Health inequalities – ED 12-hour breaches

What?

- June 2026 saw 8,293 Type 1 patients depart ED at West Suffolk. 664 of those patients were in ED for 12 hours or more – 8.01% of all Type 1 departures. This is slightly higher than the average for 2025/26 overall, when 6.96% of Type 1 patients spent over 12 hours in ED but is an improvement on what was seen in 2024/25 with an average of 10.36% of all Type 1 patients spending more than 12 hours in ED
- 50.60% of patients who experienced a stay in ED of 12 hours or more were female (49.25% were male and 0.15% were unspecified). Trust level data shows that in 2025/26 54.59% of patients who accessed acute services at WSFT were female, 45.36% were male and 0.05% were unspecified
- 54.65% of patients who experienced a stay in ED of 12 hours or more were over 75 years old. The next highest group was of patients aged 61 to 75 years old (21.96%)
- 89.16% of patients who experienced a stay in ED of 12 hours or more were white (British, Irish or other). Data from the 2021 census stated that 83.89% of Suffolk residents were white

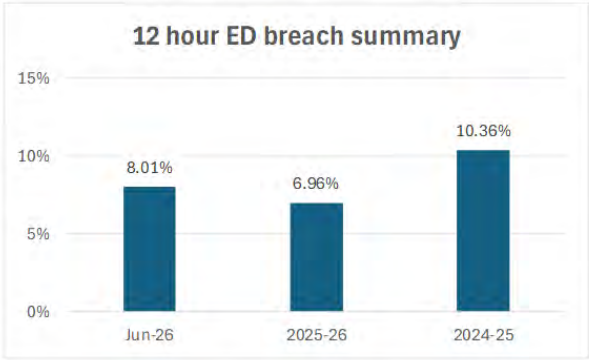
So what?

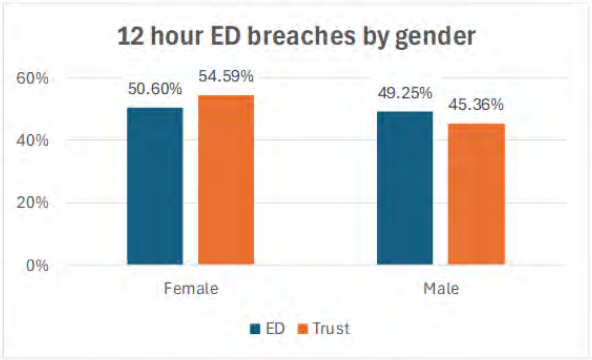
Reporting on health inequalities helps us understand potential areas for improving access and waiting times and ensuring the care we provide is equitable and fair.

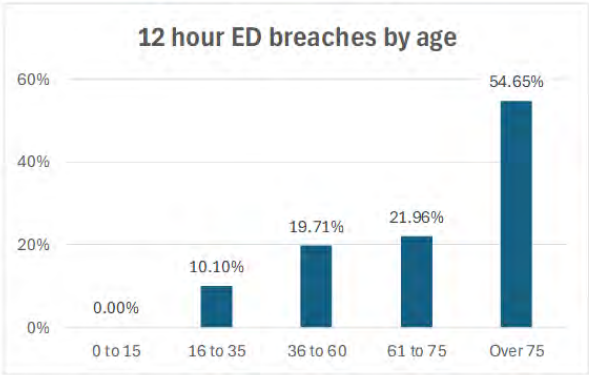
What next?

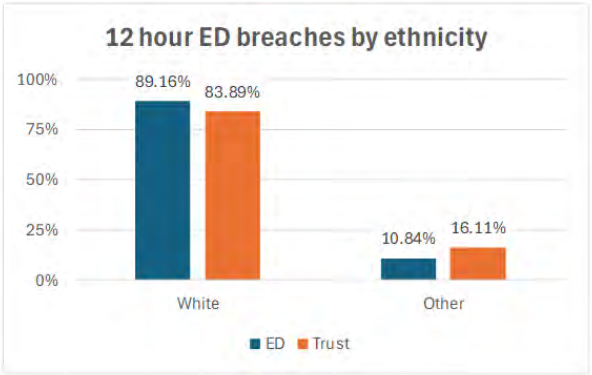
These data demonstrate that most long waits in ED are experienced by people over 75 years, and that there appears to be a disparity between ethnic groups, although ethnicity is not stated for 5.45%. We know that long waits in ED cause harm and it is critical that understand the drivers of inequalities, and that we design and deliver services that better care for older people, including avoiding ED attendance wherever possible.

Additional reporting is being built for the Referral to Treatment (RTT) total waiting list.



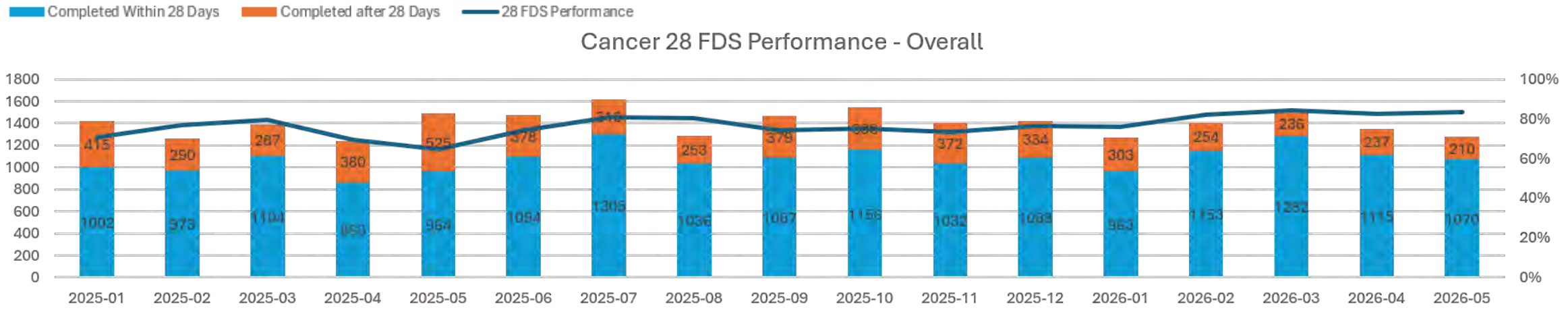


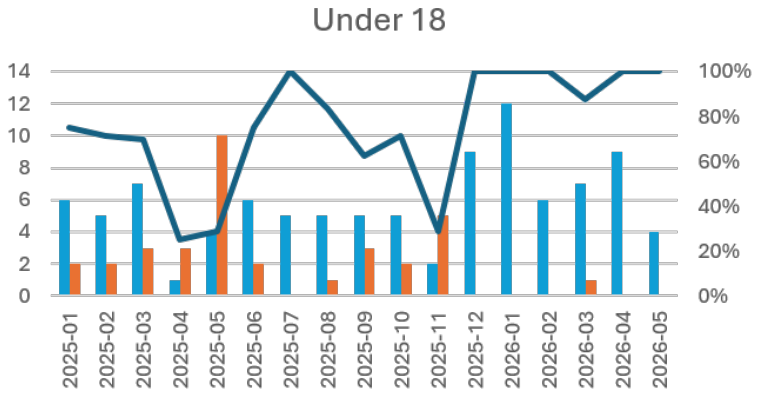


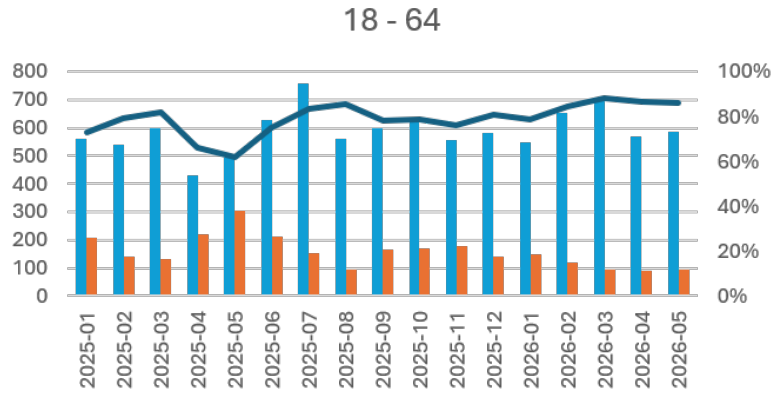


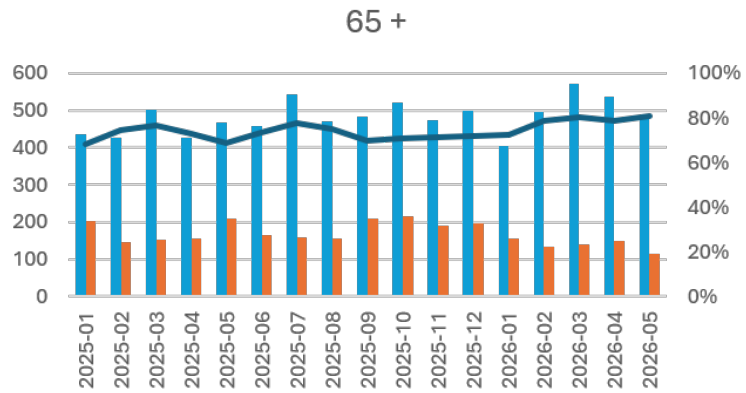
White - British	551	82.98%	Black or Black British - Caribbean	2	0.30%
Other - Not Stated	60	9.04%	Black - Any Other Black Background	2	0.30%
White - Any Other White Background	39	5.87%	Mixed - White and Black African	1	0.15%
Other - Any Other Ethnic Group	5	0.75%	Asian - Any Other Asian Background	1	0.15%
White - Irish	2	0.30%	Other - Not Known	1	0.15%

Health inequalities – 28 days FDS performance by age group





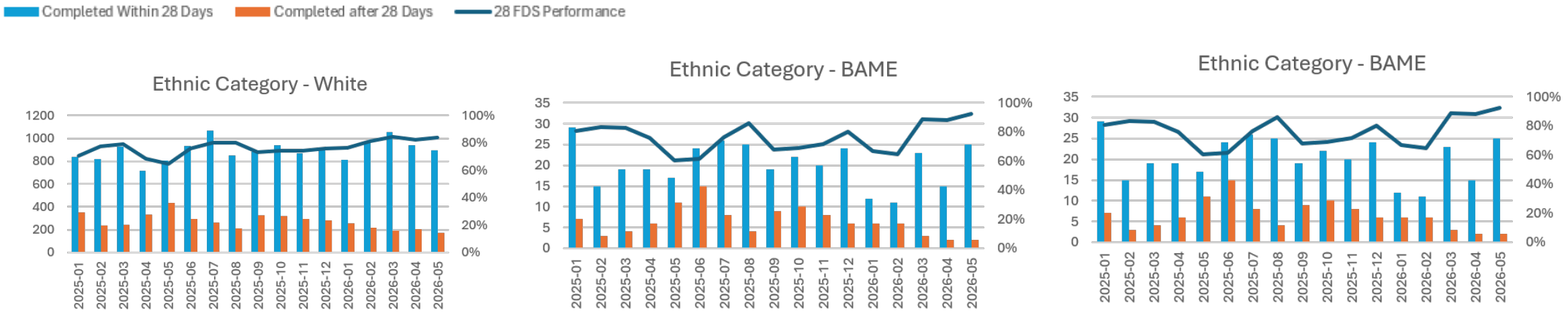




What?

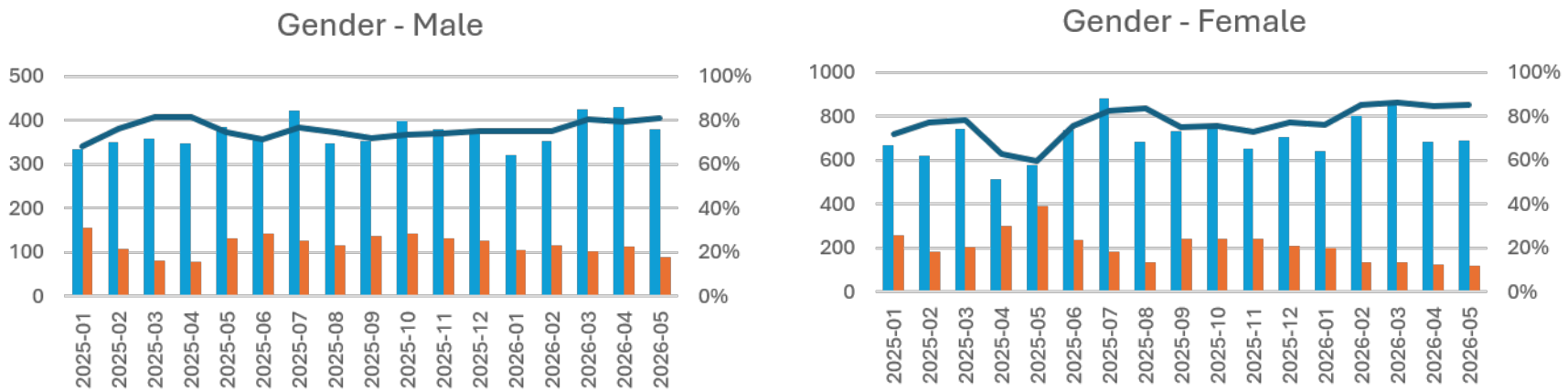
- Under 18: Performance varies due to low volumes but improves sharply, meeting or exceeding the 75% target by year-end.
- 18 - 64: Consistently strong, staying at or above the 75% target for most of the period.
- 65 +: Falls below target mid-year but steadily improves, finishing close to the 75% benchmark.
- Overall: Differences in performance across age groups are primarily due to pathway complexity (older patients) and external provider dependencies (Under 18), not unequal access. The system performs broadly around the 75% target once these age-specific factors are accounted for.

Health inequalities – 28 days FDS performance by ethnicity and gender



Performance across groups sits around the 75% target; month-to-month dips align with operational factors (case-mix, capacity, coordination).

Focus actions on faster booking, shared diagnostic slots for cross-site referrals, proactive management of complex pathways and improved ethnicity recording.



Both male and female groups track close to the 75% target, with similar mid-year dips that align with wider system pressures, not differences in access. Unfortunately, data volumes were too low to publicly report performance for genders outside male and female. This limits interpretation but does not indicate poorer access.

NHS
West Suffolk
NHS Foundation Trust

Finance and Performance committee metrics

Compassionate care,
healthier communities

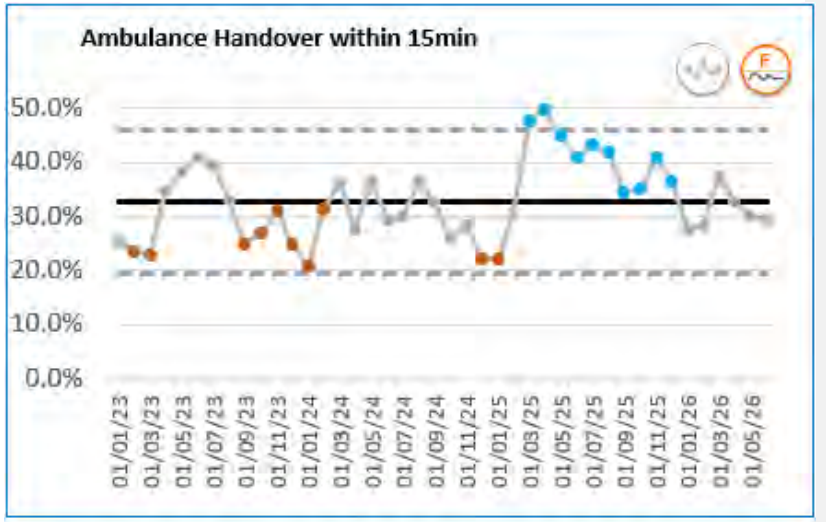
Urgent & Emergency Care: ambulance and 4-hour performance

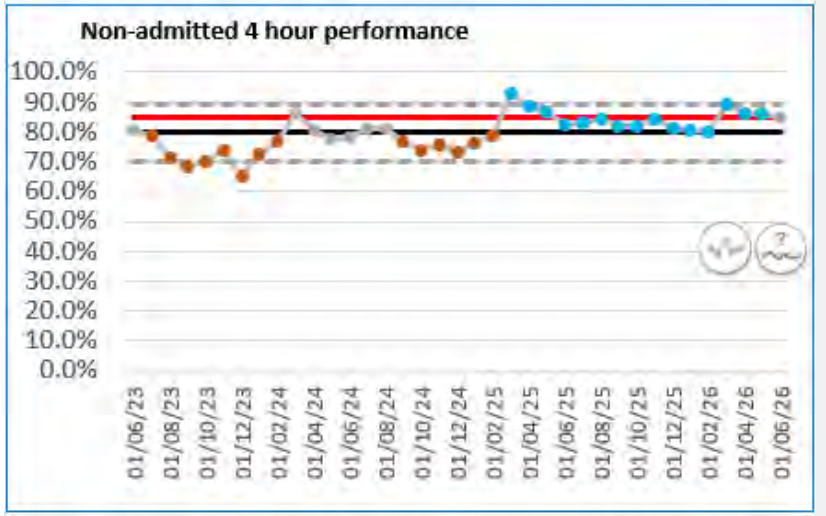
What?

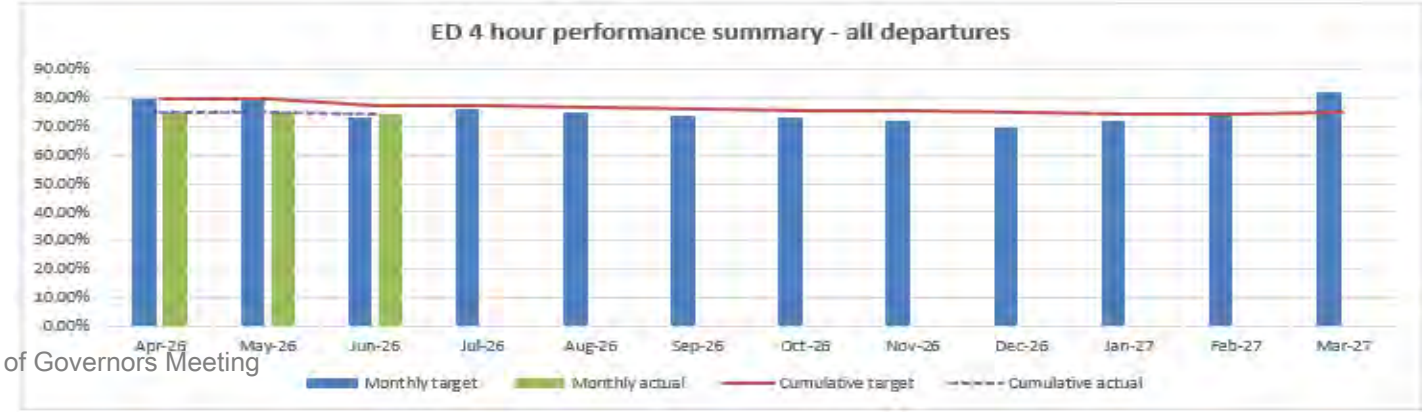
- In June 29.12% of our ambulance handovers were achieved within 15 minutes, against a target of 65%. No significant change was demonstrated in this metric.
- June's non-admitted 4-hour performance was 84.55%, meaning the 85% internal target was narrowly missed.
- Overall, 4-hour performance for June was 74.45% which means we met the monthly trajectory of 73%.

So what?

- Meeting the Urgent and Emergency Care (UEC) performance metrics means that our patients received timely, safe care.
- Meeting the in-month trajectory for the 4-hour Emergency Department metric will keep us on track to achieve 82% by March 2027.
- **What next?**
- Weekly performance meetings ED and Medical Division Senior Leaders/Executives continue.
- Continue to allocate a registrar to the twilight minor patients whilst recruitment continues- aim to start in August.
- Extended GP hours up until midnight have now commenced.
- Focus on the use of EDSDEC (ED Same Day Emergency Care), its purpose and improving the environment continues.
- FRAT (Front Door Rapid Assessment and Triage) – relaunched model with increased consultant input. FRAT consultant can now stream direct to EDSDEC following review if appropriate.
- Continued focus on all SDEC pathways.
- Working through focussed streams, identified in the UEC Delivery Group.
- Redesign of reception/streaming desk completed in line with new acuity tool pathway.







Urgent & Emergency Care: ED 12-hour performance

What?

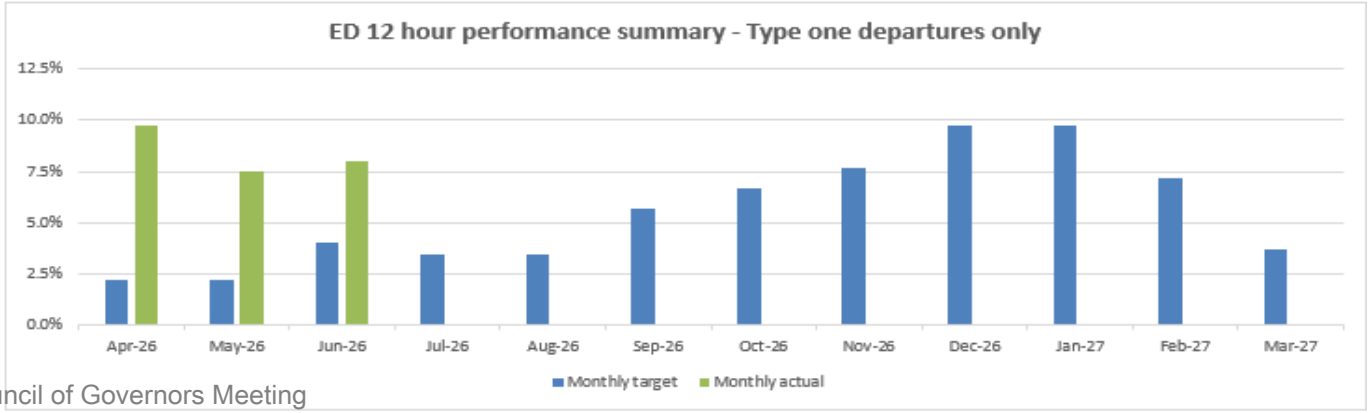
- The number of 12-hour length of stay breaches in June was 664.
- 7.49% of all Emergency Department (ED) attendances were 12-hour breaches.

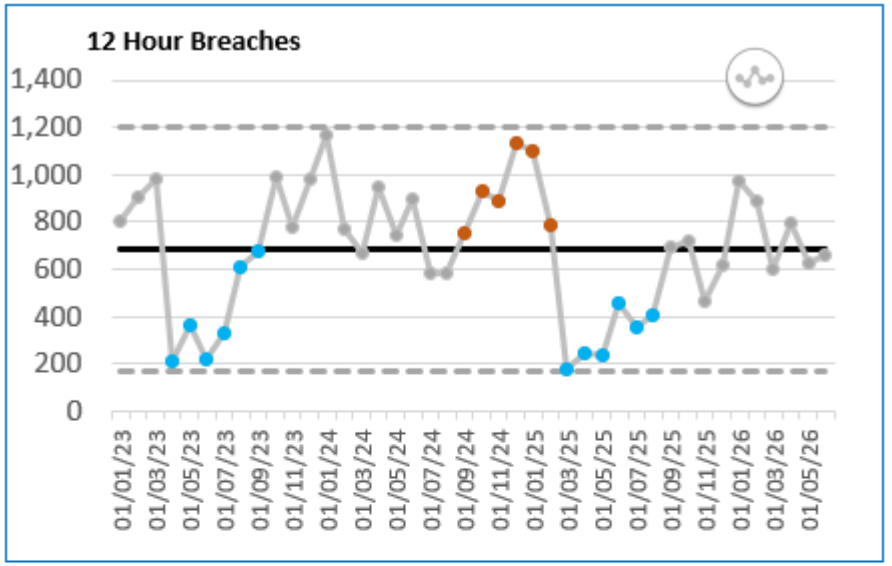
So what?

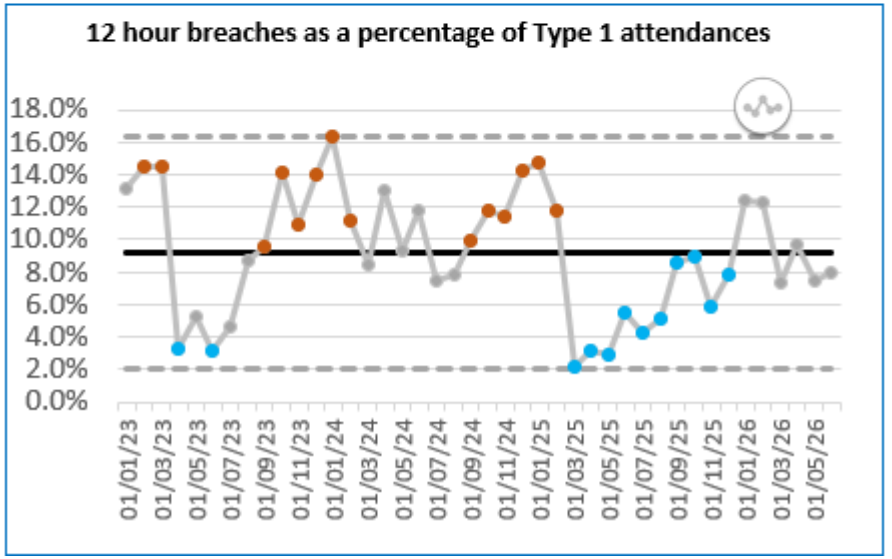
- 7.49% of patients attending ED spent more than 12 hours in the department, which is a poor patient experience.
- We did not meet our monthly trajectory of 2.74% for 12-hour LOS in ED
- The impact of more 12 hours breaches in the ED is that temporary escalation spaces were regularly used, including Rapid Assessment Triage (RAT) and Same Day Emergency Care, both of which impact on our ability to offload ambulances and the flow in and through the department. At times, the RAT corridor was also used to support ambulance offloads.

What next?

- Continued focus on length of stay (LOS) reductions to support flow out of ED including the ongoing task and finish group for board rounds/huddles.
- Focus on right patients being placed in correct speciality, supporting specialist needs & LOS reductions.
- Working with Transformation team to process map patient discharge pathway within clinical wards to highlight any themes that are delaying discharges with aim to bring on day discharge times earlier.
- Project for criteria led discharge in planning stage – funding has been agreed.







Urgent & Emergency Care: Urgent Community Response (UCR)

What?

- The data for Integrated Neighbourhood Teams and Early Intervention Team being combined for UCR has resulted in a sligh reduction in performance for past 2 months.

So what?

- Whist the performance is above target there is an impact on patient safety , increased deferrals, or cancellations of visits in community nursing teams presents risk to quality of patient care and impacts on staff well-being.

What next?

- Investment in community nursing agreed , vacancies are at 26% of registered nurses , while lower bandings are being filled the band 7 role is more challenging.
- Number of deferred or cancelled visits and harm audit are monitored.
- Workforce review, utilising community Nursing Safer Staffing Tool (CNSST) completed
- Project to reduce high sickness levels sickness continues.
- New Standardised Operating Procedure for booking of therapy patients, to be embedded by end of July.

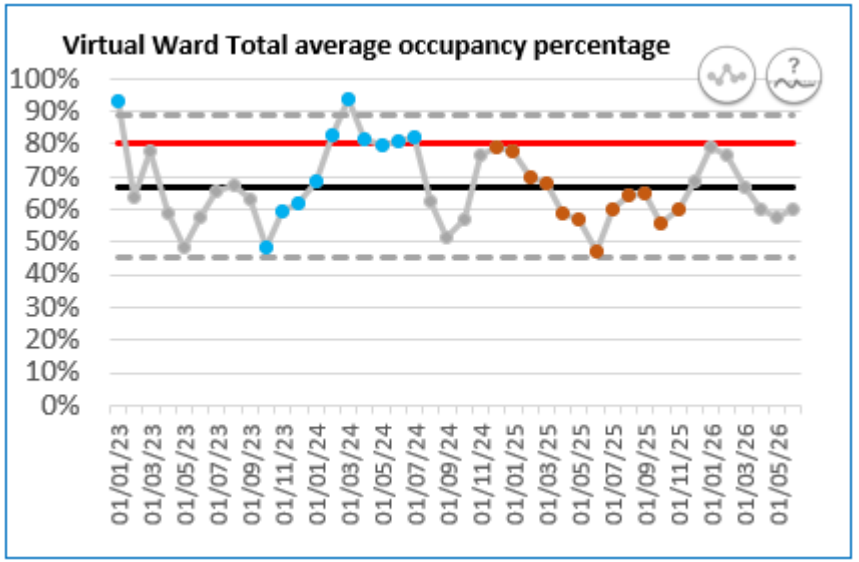
Team	Jan-26				Feb-26				Mar-26				Apr-26				May-26				Jun-26			
	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant
Total INT Nursing & Therapy	183	123	60	67%	190	123	67	65%	199	133	66	67%	213	148	65	69%	234	167	67	71%	186	147	39	79%
Total EIT*	769	717	52	93.24%	700	651	49	93.00%	732	701	31	95.77%	668	625	43	93.56%	726	690	36	95.04%	630	582	48	92.38%
Combined Total	952	840	112	88.24%	890	774	116	86.97%	931	834	97	89.58%	881	773	108	87.74%	960	857	103	89.27%	816	729	87	89.34%
*From May 26 Using DW figures backdated to Apr2024																								
EIT 2hr from UCR Dashboard - CSDS Figures	741	687	54	92.71%	671	625	46	93.14%	689	660	29	95.79%	628	584	44	92.99%	680	644	36	94.71%	583	539	44	92.45%

Urgent & Emergency Care: virtual ward

What?
Average occupancy increased slightly to 60% in June.
Total bed nights were 863.

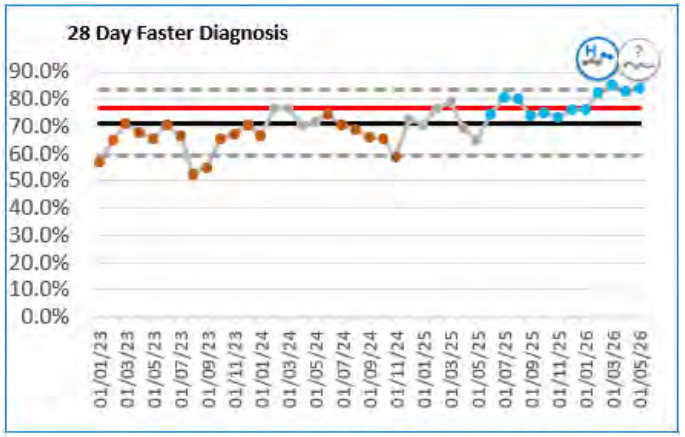
So what?
Virtual ward capacity is crucial in ensuring patient flow across the Trust and ensuring the strategic ambition of caring for patients at home whenever possible.

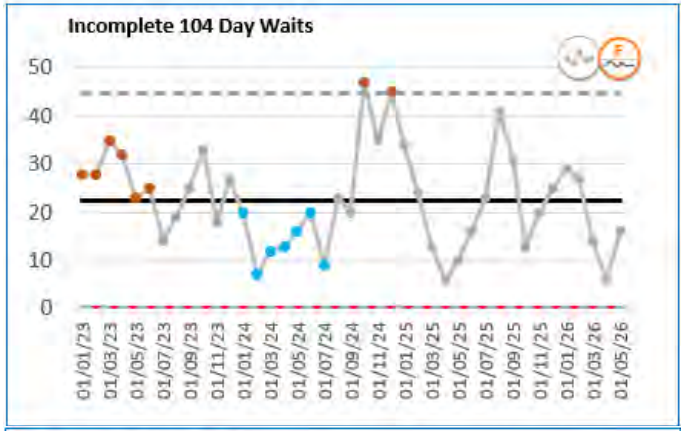
What next?
- Virtual ward Consultant post is vacant, temporary cover continues. Meeting planned with medical director on 04 August.
- Centralised triage of Cleric referrals via Unscheduled Care Coordination Hub (UCCH) went live on 13 July. Work done with UCCH to ensure they are confident with VW as well as UCR capability and capacity. Ongoing engagement and collaboration with UCCH leads.

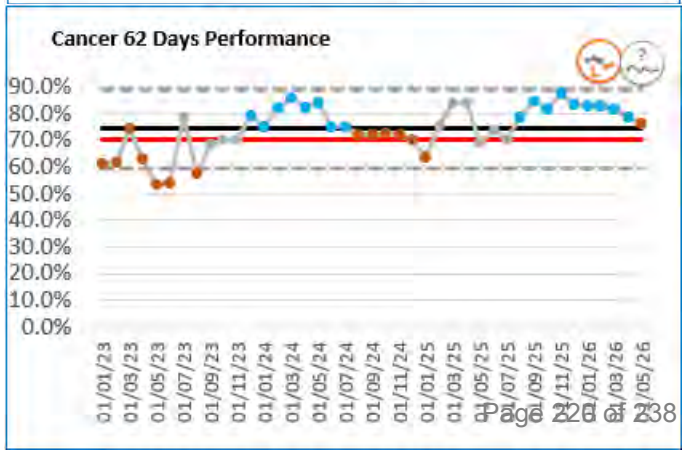


Cancer access

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	May 26	84.2%	77.0%			71.2%	59.1%	83.3%
Cancer 62 Days Performance	May 26	76.1%	70.0%			74.4%	59.6%	89.1%
Incomplete 104 Day Waits	May 26	16	0			22	0	45







What?

- 28 day performance was 84.2% in May, which is above trajectory and over achieving against the 80% requirement.
- Urology performance remains challenged and under trajectory whilst Breast has recovered due to the insourcing of first clinic appointments.
- Performance in Head and Neck, Skin, Gynaecology, Lung and Upper GI have been consistent throughout the year.
- 62-day performance has dropped slightly, due to pathway challenges in Urology and Breast.

So what?

- The priorities for 2026/27 this year focus on seeing, diagnosing and treating patients in line with national guidance to improve patient outcomes and maintain standards.

What next?

- Breast insourcing for first appointment will continue throughout 2026/27.
- Nurse led template biopsy training due to be complete by end of Q2 allowing for independent lists.
- Additional theatre activity in place for Breast throughout July to allow return to trajectory from August for 62-day performance
- Continued engagement with Cancer Alliance led Breast services review.

Diagnostic performance

What?

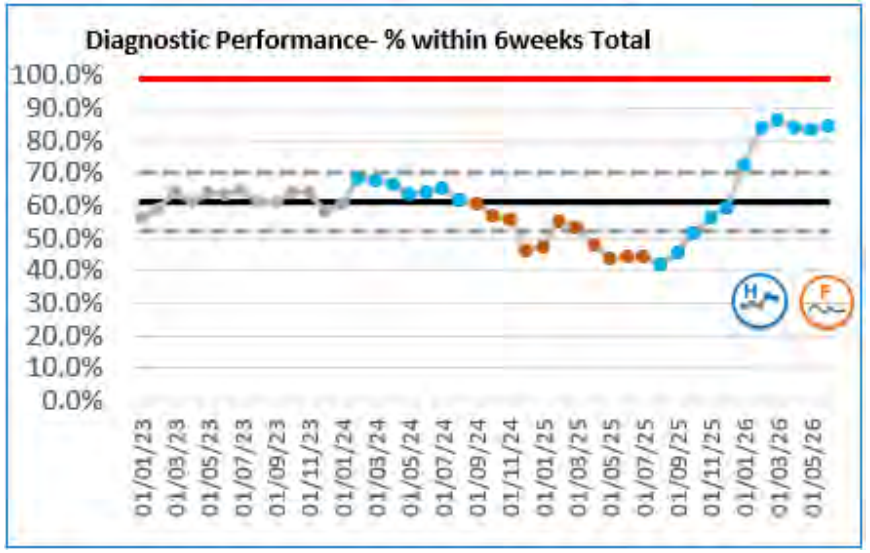
- The monthly Diagnostics Waiting Times and Activity Data (DM01) measures the number of patients waiting six weeks or more for 15 key diagnostic tests.
- WSFT is marginally behind the agreed recovery trajectory of 84.90%, with 83.76% of patients in June receiving their tests within six weeks.
- The principal areas of non-compliance are endoscopy and audiology.

So what?

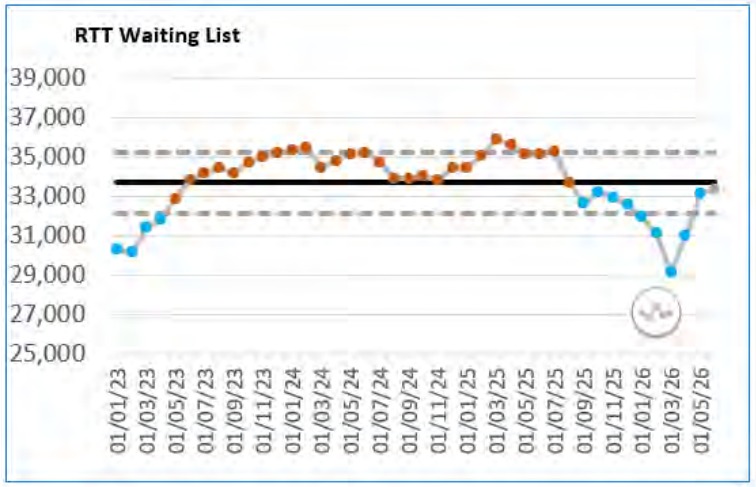
- Longer waiting times for diagnosis and treatment have a detrimental effect on patients.
- Delay in achieving DM01 compliance standards and Referral to Treatment (RTT) standards.
- Reputational harm and lack of confidence in our services for our patients.

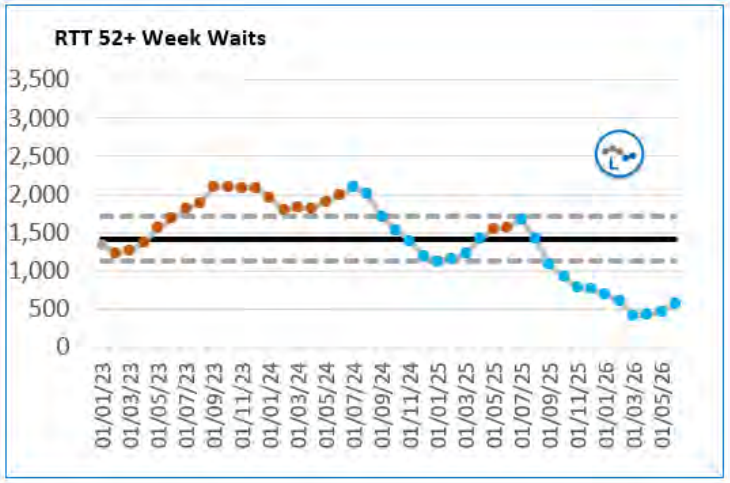
What next?

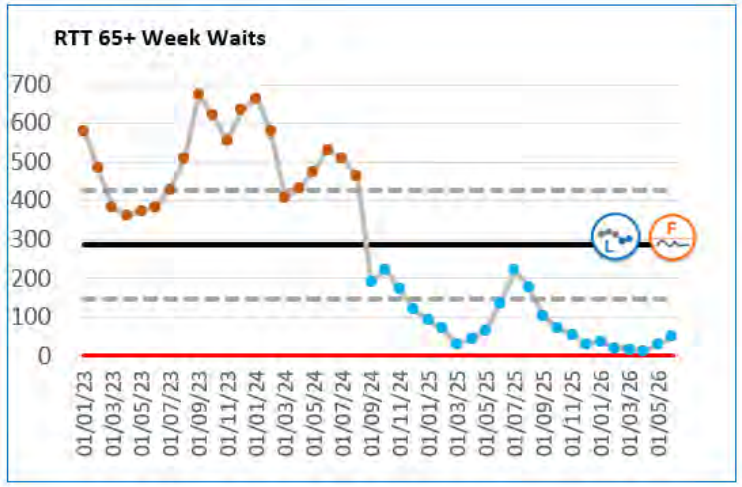
- Recovery actions forecast improvement to 88% in March 2027 in line with the agreed plan for DM01 performance.

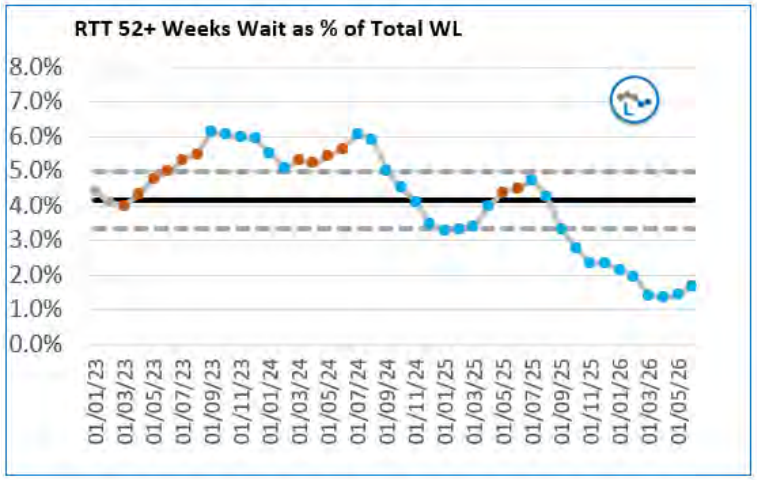


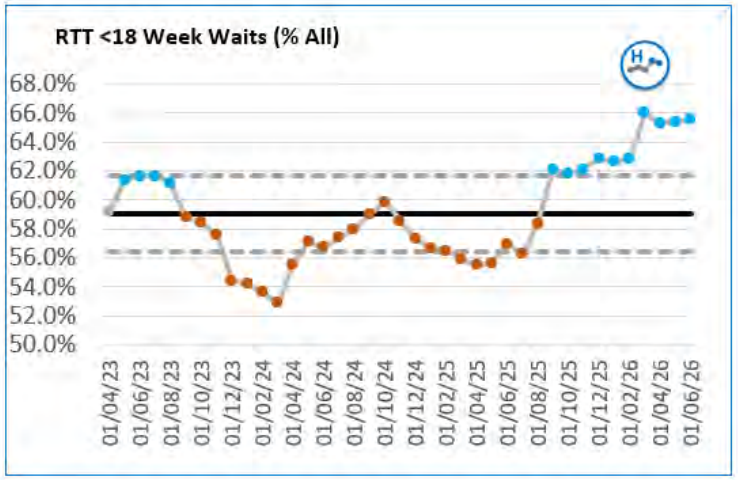
Referral to treatment (RTT) performance

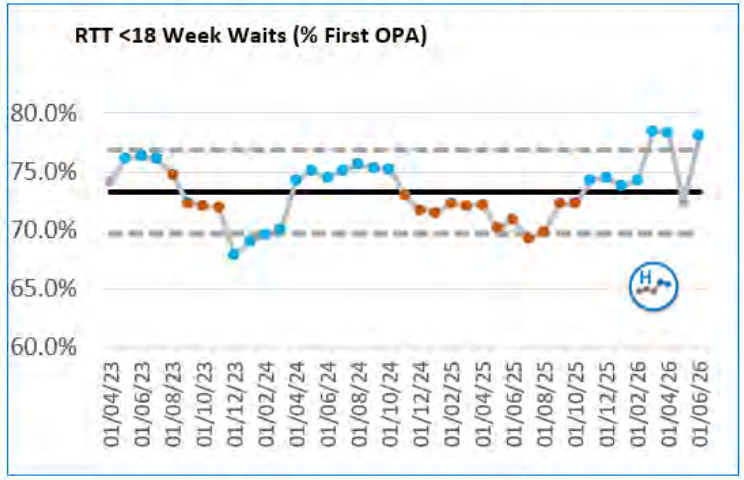












Referral to treatment (RTT) performance

Overall 18-week compliance June 2026	Patients with 65 week wait June 2026	Patients with 52 week wait June 2026	Total waiting list	% of patients being seen for first OPA within 18 weeks
65.6%	49	564	33330	78.1%

What?

- Overall RTT compliance was at 65.6%, which is above our June 2026 forecast, this was supported by additional data quality validation.
- The volume of patients waiting 65 weeks increased, partly due to on-going closures of Orthopaedic theatres and the impact of theatre cancellations due to the heat wave in June. The volume of patients over 52 weeks is higher than trajectory at 564 and increasing.
- The areas with the highest cohort of 52 weeks are Gynaecology, Orthopaedics and Vascular.
- The total waiting list size stabilised following increases in April and May, however remains above plan.

So what?

- Patients are at increased risk of harm and/or deteriorating the longer they wait. This increases the demand on primary and urgent and emergency care services as patients seek help for their condition.

What next?

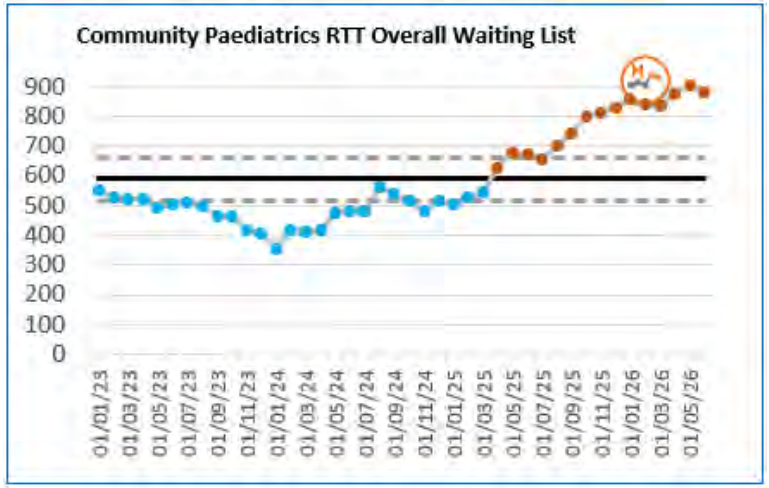
- Delivery against 2026/27 activity schemes, which will be monitored via the Elective Delivery Board.
- Continue to utilise independent sector capacity to mitigate the closure of theatres during the period of refurbishment.
- External validation resource to commence 1st July, whilst internal recruitment is underway.
- Insourcing of Vascular activity expected to commence in August 2026.
- Return of Orthopaedic theatres due 20th July 2026.

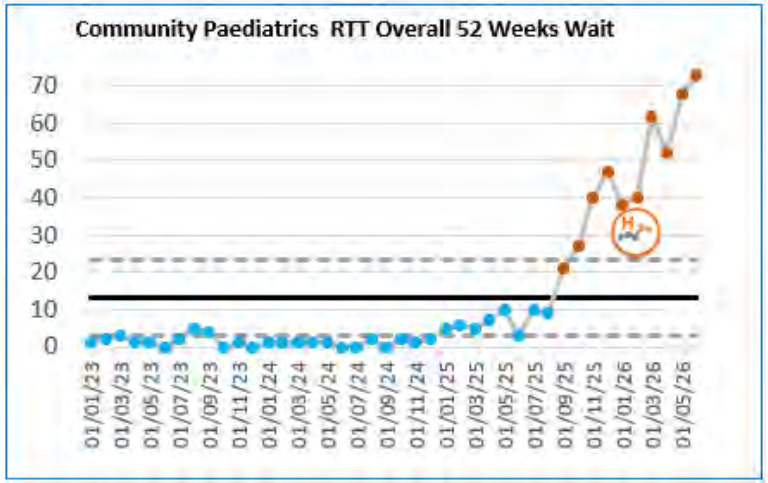
Community paediatrics

What?
- There is sustained deterioration in waiting times for the paediatric team due to sustained level of demand above the available capacity within the medical team.
- Longest waiting times, above 52 weeks, are primarily associated with autism assessments although average waiting times for preschool assessments are increasing.

So what?
- Children are waiting longer for autism assessments in the school age pathway.
- There are increasing waiting times in preschool pathway as the service responds to high demand alongside the requirement to manage children with complex care needs/reviews and prioritise clinician time.

What next?
- ICB-led recommissioning of neurodevelopmental diagnostic assessment pathway is delayed whilst further provider submissions required. Implementation of new pathway now scheduled to be April 2027
- Full time consultant vacancy covered by agency locum consultant (full time hours not covered) within the east team – substantive appointment made with start date in September.
- Monthly monitoring of long waits continues.
- Outsourcing of autism assessments for longest waiters in progress





KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Community Paediatrics RTT Overall Waiting List	Jun 26	879				591	519	664
Community Paediatrics RTT Overall 52 Weeks Wait	Jun 26	73				13	3	23

Elective activity plans

What?

- First outpatient attendances are behind plan, with greatest variance seen in May.
- The deficit in elective activity is significant; this is due to the continuation of overrunning refurbishment works in main theatres which concluded on 20 July 2026.
- Day case activity is not affected by this although is behind plan, with the June deficit recovering from the May position.
- Outpatient follow ups are above plan, whereas they need to be at or below this level. It is likely that this is due to a reduction in the plan rather than a step change increase in activity.

So what?

Delivery of our activity plan is required to meet both financial and operational performance objectives in response to the NHS Medium Term Plan, with further activity required that has been identified as part of the 2026/27 Cost Improvement Plan.

What next?

- Specialty level RTT trajectories are monitored through weekly access meetings.
- The Elective Delivery Board oversees specialty level recovery plans which identify when and where additional activity will take place to recover the running deficit.
- Workstreams across theatres, outpatients, diagnostics, clinical coding and system-wide initiatives will drive delivery of these.

Outpatient First

Mon	26/27	Plan (B)	Plan (T)	Var	Var %
Apr	9,662	9,449	9,830	(168)	(1.7%)
May	9,276	9,332	9,713	(437)	(4.5%)
Jun	11,076	10,631	11,252	(176)	(1.6%)
Jul		10,631	11,262		
Aug		8,855	9,591		
Sep		10,393	11,279		
Oct		10,156	11,094		
Nov		10,156	11,094		
Dec		10,160	11,133		
Jan		9,446	10,419		
Feb		9,571	10,544		
Mar		9,805	10,778		
Total (YTD)	**30,014**	**29,412**	**30,795**	**(781)**	**(2.5%)**

June 2026	
26/27	11,076
Plan (B)	10,631
Plan (T)	11,252
Var	(176)
Var %	(1.6%)

Daycase

Mon	26/27	Plan (B)	Plan (T)	Var	Var %
Apr	2,386	2,140	2,409	(23)	(1.0%)
May	2,187	2,115	2,384	(197)	(8.3%)
Jun	2,599	2,356	2,633	(34)	(1.3%)
Jul		2,409	2,722		
Aug		2,004	2,317		
Sep		2,356	2,669		
Oct		2,303	2,598		
Nov		2,304	2,599		
Dec		2,140	2,435		
Jan		2,168	2,463		
Feb		2,220	2,515		
Mar		2,356	2,651		
Total (YTD)	**7,172**	**6,611**	**7,426**	**(254)**	**(3.4%)**

June 2026	
26/27	2,599
Plan (B)	2,356
Plan (T)	2,633
Var	(34)
Var %	(1.3%)

Outpatient Follow Up

Mon	26/27	Plan (B)	Plan (T)	Var	Var %
Apr	26,545	24,251	24,569	1,976	8.0%
May	25,115	23,954	24,272	843	3.5%
Jun	28,037	26,682	27,035	1,002	3.7%
Jul		27,284	27,665		
Aug		22,732	23,113		
Sep		26,682	27,091		
Oct		26,069	26,531		
Nov		26,074	26,536		
Dec		24,248	24,724		
Jan		24,556	25,032		
Feb		25,168	25,644		
Mar		26,685	27,161		
Total (YTD)	**79,697**	**74,887**	**75,876**	**3,821**	**5.0%**

June 2026	
26/27	28,037
Plan (B)	26,682
Plan (T)	27,035
Var	1,002
Var %	3.7%

Elective

Mon	26/27	Plan (B)	Plan (T)	Var	Var %
Apr	183	270	314	(131)	(41.6%)
May	215	268	312	(97)	(31.0%)
Jun	218	299	346	(128)	(36.9%)
Jul		306	353		
Aug		254	301		
Sep		299	346		
Oct		290	337		
Nov		290	337		
Dec		270	317		
Jan		274	321		
Feb		279	326		
Mar		299	346		
Total (YTD)	**616**	**837**	**971**	**(355)**	**(36.5%)**

June 2026	
26/27	218
Plan (B)	299
Plan (T)	346
Var	(128)
Var %	(36.9%)

NHS
West Suffolk
NHS Foundation Trust

Quality and Patient Safety committee metrics

Compassionate care,
healthier communities

Community nursing: deferred care

What?

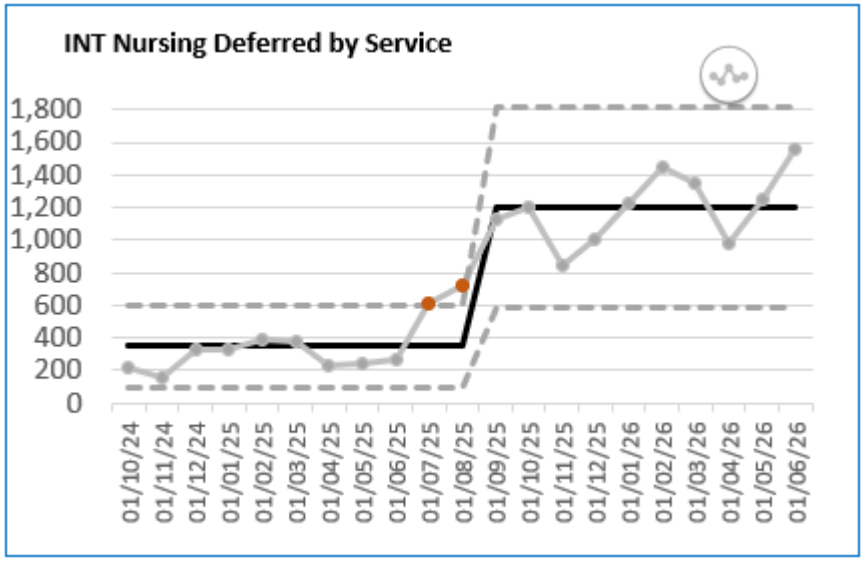
- From September 2025 there is evidence of a sustained shift in the process, with deferred patients increasing substantially above the previous mean. A new centre line was calculated in accordance with SPC rules after the process demonstrated a stable pattern at a higher level.
- In June 2026 this represents 10% of all nursing visits being cancelled or deferred.

So what?

- The impact of deferred care demonstrates a system under sustained pressure .
- It is a patient safety and quality issue.

What next?

- Recruit to nursing uplift following business case approval in June. Anticipated impact Q3/4
- Additional improvement work underway focussing on maintaining attendance, reducing sickness and maximising efficiency with record keeping.
- The number and impact of deferrals and cancellations is monitored through a harm audit.



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
INT Nursing Deferred by Service	Jun 26	1562				1200	583	1818

Quality and patient safety: post-partum haemorrhage

What?

Post-partum haemorrhage (PPH) is a common obstetric emergency requiring prompt recognition, effective clinical decision-making, and strong multidisciplinary communication. Severe PPH remains the leading cause of maternal mortality globally and is therefore a critical quality and safety priority for maternity services.

In June 2026, three cases of PPH with blood loss >1500 ml were reported, none of which exceeded 2500 ml:

- **Three cases followed caesarean birth**
- **Cases followed vaginal birth - None**

These cases have been reviewed in line with the maternity service's established incident review and governance processes.as critical to achieving continued improvement in maternal safety outcomes

So what?

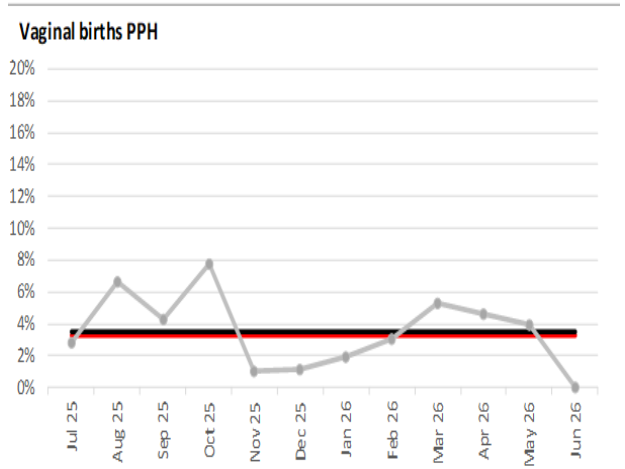
June's position sits within a wider improving trend. Vaginal birth PPH rates have remained low, with no cases reported this month, while the LSCS PPH SPC chart demonstrates a sustained run of data points below the historical mean since January 2026, representing a special cause improvement signal. Case reviews continue to demonstrate effective multidisciplinary management, timely escalation and appropriate use of the Massive Haemorrhage Protocol. Collectively, the data provide assurance that quality improvement initiatives and multidisciplinary learning processes are supporting improved and sustained maternal safety outcomes

What next?

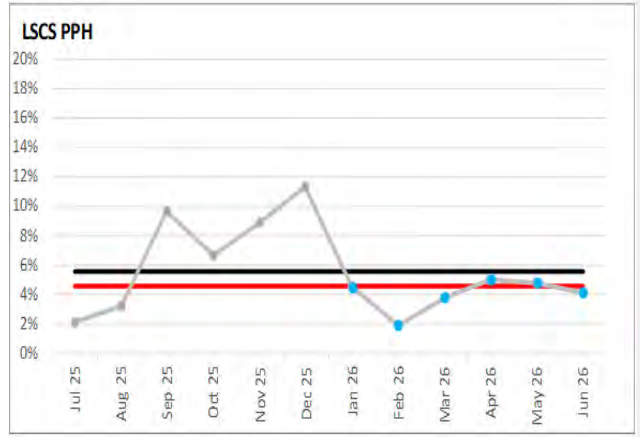
The maternity service will continue monthly monitoring of PPH rates, with board-level visibility of any upward trends or emerging risks. Quarterly analysis will remain the primary mechanism for assurance against regional standards.

Key next steps include:

- The departmental PPH QI continue with the support of the Trust QI Team.
- Communications to continue across the department supporting the routine use of the Massive Haemhorrage Protocol at 1500ml
- Full implementation of the Maternal Care Bundle (2026), including: routine PPH risk assessment at all stages of care, accurate and cumulative measurement of blood loss, clear escalation pathways



2 (Jul-Sept 2025)	331	14	4.2%
3 (Oct-Dec 2025)	294	7	2.4%
4 (Jan-Mar 2026)	307	10	3.3%
1 (Apr-Jun 2026)	307	8	2.6%



2 (Jul-Sept 2025)	198	10	5.1%
3 (Oct-Dec 2025)	225	19	8.4%
4 (Jan-Mar 2026)	184	6	3.3%
1 (Apr-Jun 2026)	214	9	4.2%

Quality and patient safety: patient safety reports

What?

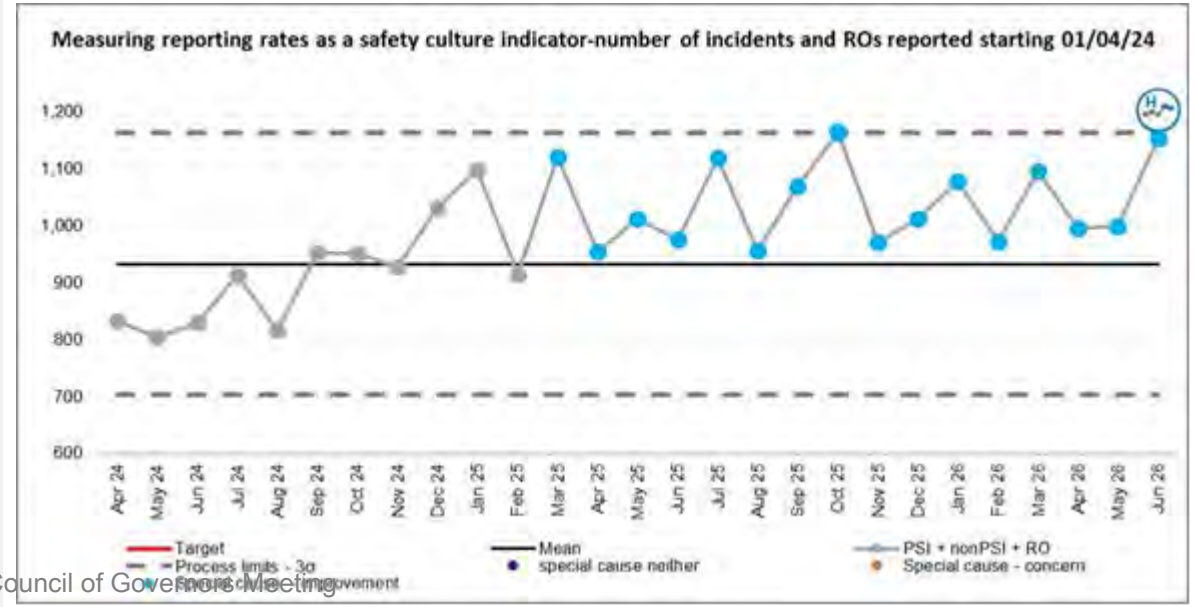
In June, the total number of reported events increased by 153 compared with the previous month, demonstrating continued staff engagement with incident reporting. The patient safety team continues to benchmark the monthly proportion of reported harm with national figures from the Learning from Patient Safety Events (LFPSE) data set. WSFT reported a 34% harm rate, a small increase from 32% in May, but remains below the current national average of 36.01%. The number of incidents involving physical harm remained stable, with 196 reported in June compared with 197 in May. An increase was observed in health and safety incidents, with 32 more events than the previous month, representing the highest monthly total recorded this year to date. Reportable occurrences for RPI were also higher, with an increase of 43 events.

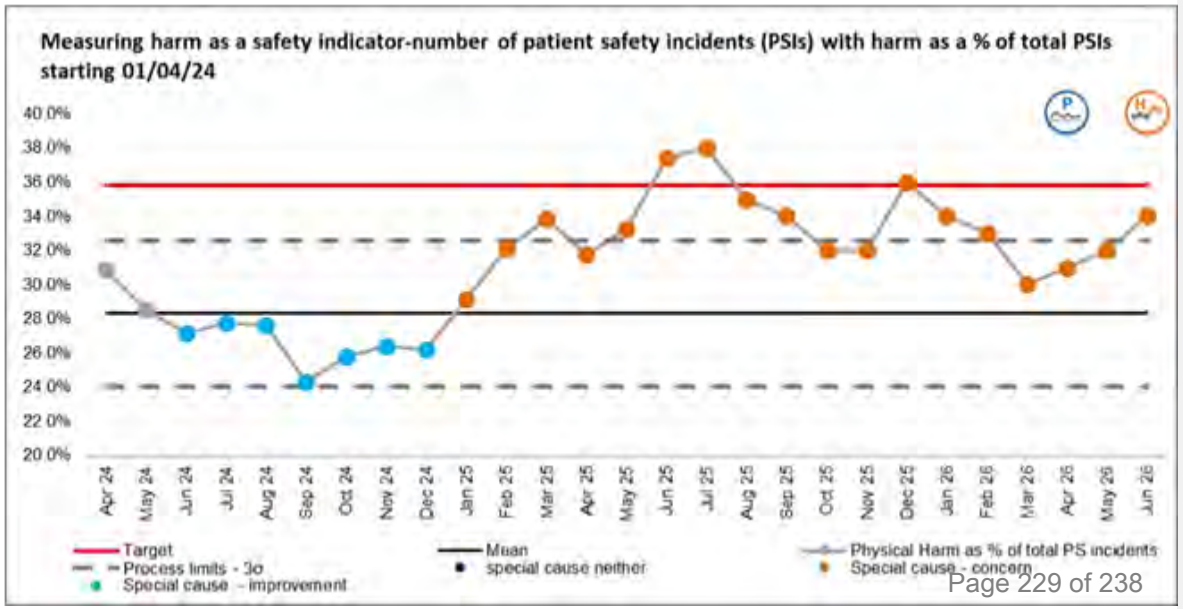
So what?

We continue to encourage the reporting of all incidents, recognising that effective reporting supports organisational learning and drives improvement. Reporting rates provide valuable insight into our safety culture, while harm data helps us assess the safety of our services. Patient safety incidents and reportable occurrence events are reviewed quarterly and reported to the Quality and Patient Safety Committee. Incidents resulting in moderate harm are managed within divisions, while those involving potential serious or fatal harm are escalated to the Emerging Incident Review (EIR). Through EIR, the most appropriate learning response is agreed in line with the Patient Safety Incident Response Plan (PSIRP), ensuring learning is identified, shared and translated into meaningful safety improvements across the organisation.

What next?

The insights gained from this analysis, together with the outcomes of the quarterly patient safety report, will continue to be shared with divisional governance teams and speciality leads to support targeted improvement activity. These findings also shape trust-wide safety discussions, ensuring prompt escalation and action whenever harm levels or incident trends indicate the need for further scrutiny.





Quality and patient safety: Summary Hospital-level Mortality Indicator (SHMI)

What?

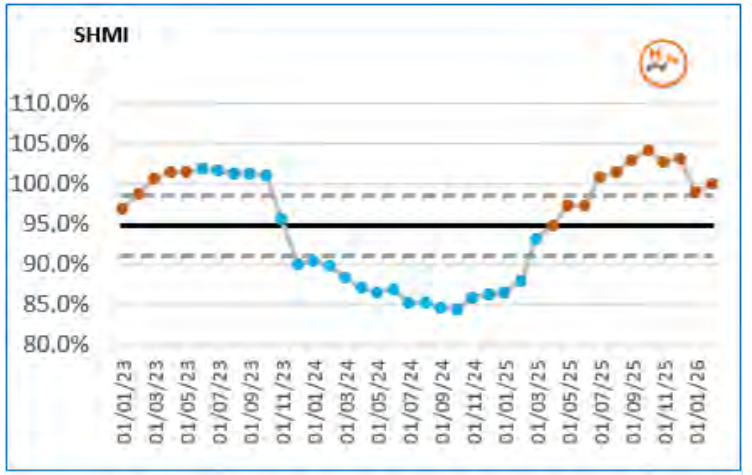
- In June 2026 there were 92 adult inpatient deaths at WSFT. The SHMI data is showing a raised trend due to a coding anomaly at reporting period March 2025 (becoming evident in September 2025), where uncoded episodes were placed into the 'invalid primary diagnosis' category. This resulted in 'invalid primary diagnosis' showing more deaths than expected in that single category, which created a sudden spike in the WSFT SHMI data.

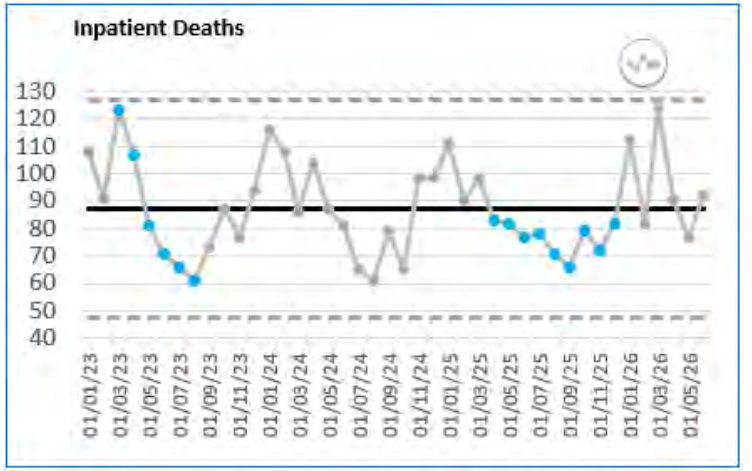
So what?

- The increase in WSFT SHMI data was caused by a coding backlog, with coders being unable to meet submission deadline.
- The issue was escalated, and since December 2025 coders have consistently met the national SHMI submission deadlines for live coding.
- As of 18 June 2026, all deaths from December 2025 and January 2026 have been coded. The remaining backlog (February–April 2026) is scheduled to be completed by August 2026, at which point all deaths will be fully coded and up to date.
- As a result, SHMI data will remain unstable with marginal decline. By December 2026, the backlog-related anomaly will have been fully resolved, and WSFT SHMI data should reflect normal, unaffected performance.

What next?

- We continue to analyse mortality data through the Mortality Oversight Group and the independent Medical Examiner Service.
- We are assured through our monthly mortality data reported in the Learning from Deaths report and National Cardiac Arrest Audit data that the Trust is performing well; with no unusual activity/data flagged.





KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SHMI	Feb 26	100.1%				94.9%	91.2%	98.6%
Inpatient Deaths	Jun 26	92				87	47	127

Quality and patient safety: complaints

What?

- Volume of complaints resolved late have decreased from 9 in May down to 4 in June
- During this reporting period, 16 complaints were received. The largest proportion related to patient care concerns (31%), with a subcategory of ' care needs not adequately met'. The Medicine division accounted for 56% of complaints however there was no trend with identifying a common location. Recurring themes included access to services, communication with patients, unmet care needs and delays in diagnosis or treatment.

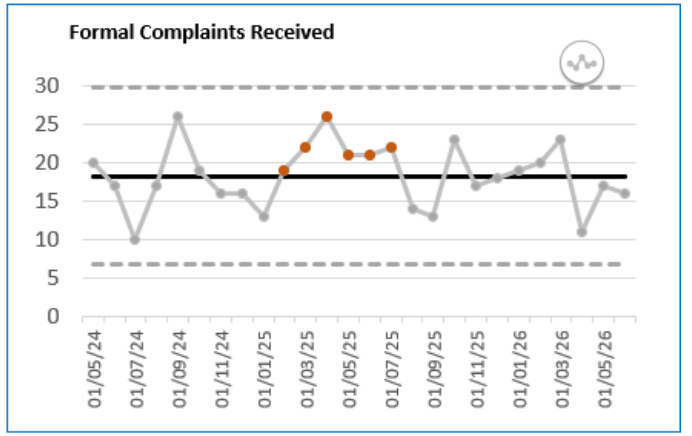
So what?

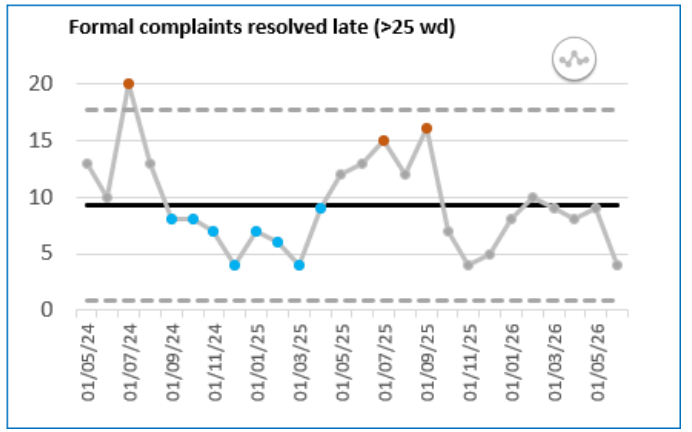
- Whilst complaints resolved late have reduced to only 4, we have not yet established an improvement trend
- PALS are logging all concerns following from a refresher session with the team and amendments made with RADAR to ensure compliance.

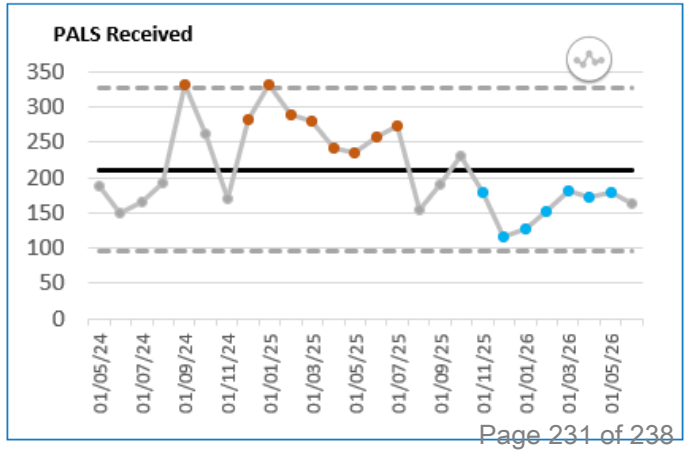
What next?

- Patient experience team are attending regular tri meetings to discuss upcoming and overdue complaints for more divisional accountability.
- New governance feedback loop process put in place with divisions to analyse themes and report back through the experience of care and engagement committee focussing on outcomes and learning.
- 2 PALS officers recruited commencing in August that will support and improve response and presnece within the service

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Formal Complaints Received	Jun 26	16				18	7	30
Formal complaints resolved late (>25 wd)	Jun 26	4				9	1	18
PALS Received	Jun 26	164				211	97	326







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People and Organisational Development committee metrics

Compassionate care, healthier communities

Workforce & organisational development metrics

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	Jun 26	4.9%	5.0%			4.8%	4.7%	4.9%
Staff Sickness - monthly	Jun 26	4.9%	5.0%			4.8%	4.7%	4.9%
Mandatory Training monthly	Jun 26	89.7%	90.0%			89.6%	88.1%	91.2%
Appraisal Rate monthly	Jun 26	81.9%	90.0%			85.5%	83.2%	87.8%
Turnover rate monthly	Jun 26	9.0%	10.0%			9.3%	8.5%	10.1%

What?

- Sickness – 4.9% 12-month rolling performance versus 5% target.
- Mandatory Training – marginally failing target this month at 89.7% versus 90% target.
- Appraisal – consistently failing target, 81.9% versus 90% target.
- Turnover – achieving target, 9% versus 10% target.

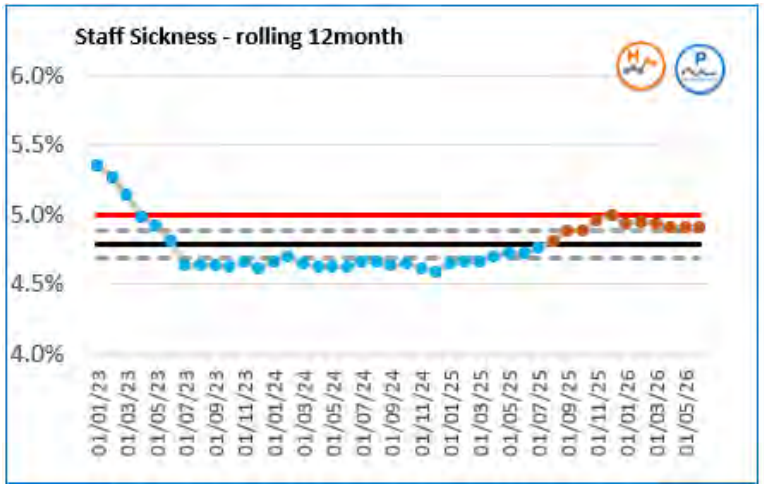
So what?

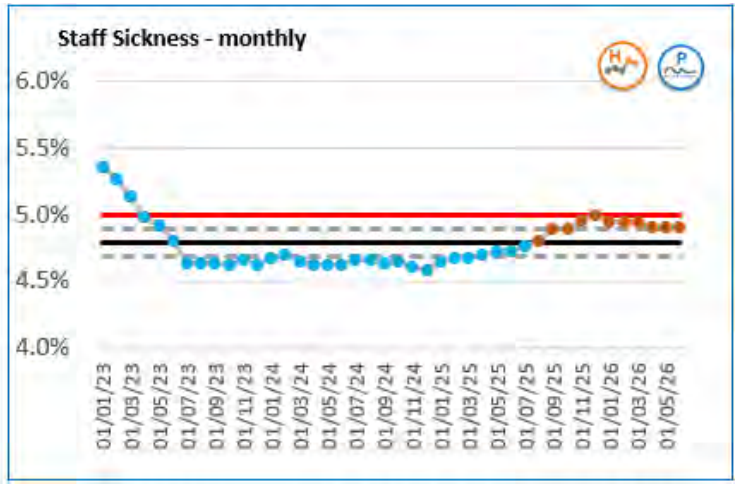
- These workforce key performance indicators directly impact on staff morale and engagement, staff retention, and therefore, patient care and safety.
- Additionally, improvements in these workforce key performance indicators will strengthen our ability to be the employer of choice for our community and the recognition as a great place to work.

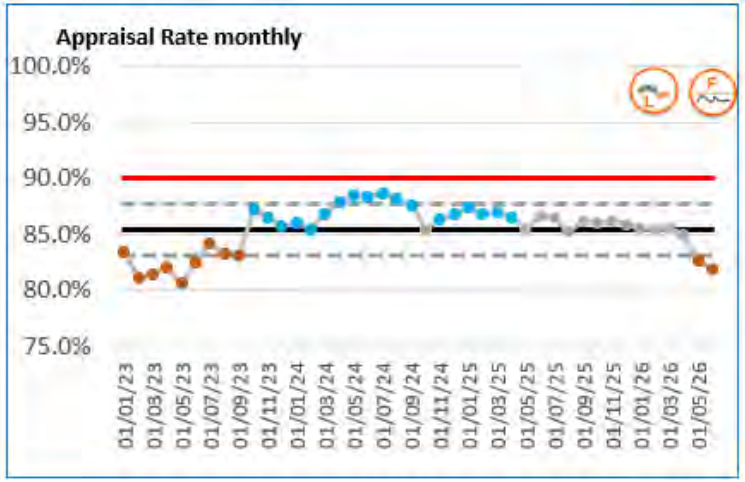
What next?

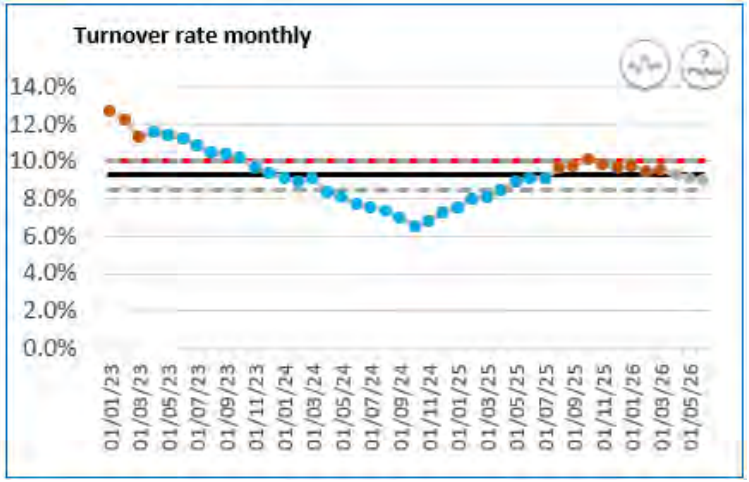
- Monitor staff attendance at department level with focus where improvement is required.
- Review compliance of mandatory training ensuring areas and staff groups are identified where further focus and support may be required.
- Continued analysis of appraisal data to support and challenge areas in need of action and improvement.
- Maintain focus on the delivery of our people and culture plan and priorities.

Workforce & organisational development metrics









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Appendices: understanding MDC

Compassionate care,
healthier communities

Making Data Count (MDC): understanding the charts

NHS England's 'Making Data Count' programme uses statistical process control charts to provide an 'at a glance' method of understanding performance.

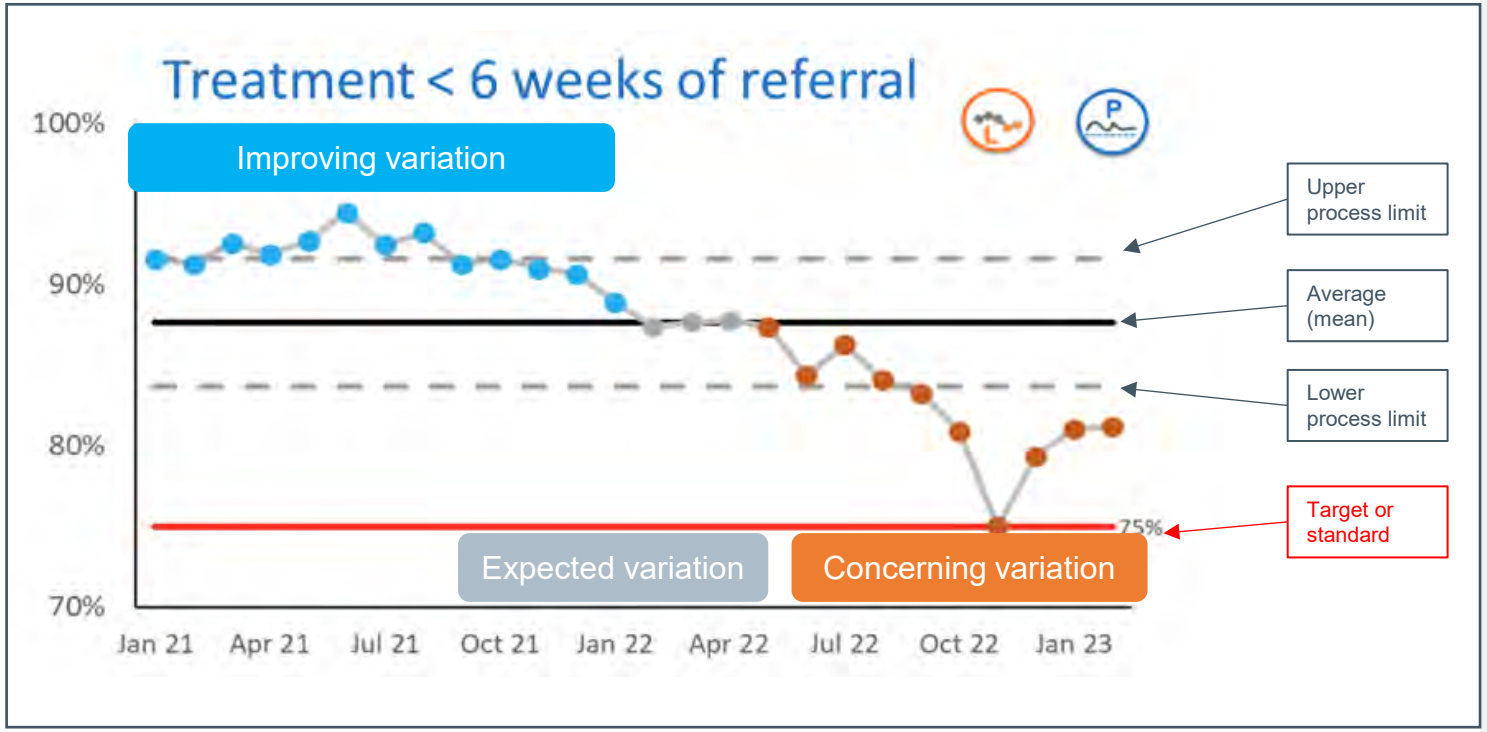
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

The following colour convention identifies important patterns evident within the SPC charts in this report.

Orange – there is a concerning pattern of data which needs to be investigated, and improvement actions implemented.

Blue – there is a pattern of improvement which should be learnt from.

Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable.



The dotted lines on SPC charts (upper and lower process limits) describe the range of variation that can be expected.
Process limits are very helpful in understanding whether a target or standard (the red line) can be achieved always, never (as in this example) or sometimes. SPC charts therefore describe not only the type of variation in data, but also provide an indication of the likelihood of achieving target.

Summary icons have been developed to provide an at-a glance view. These are described on the following page.

Concerning and improving variation are statistically significant patterns in data which may require investigation, including:
- Trend: 6 or more consecutive points trending upwards or downwards
- Shift: 7 or more consecutive points above or below the mean
- Outside control limits: One or more data points are beyond the upper or lower control limits

Example data only

Making Data Count (MDC): interpreting SPC icons

Icons for variation and performance

Icon	Description	What does this mean?	What do we do next?
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is currently not changing significantly. It shows the level of natural variation you can expect from the process or system itself.	Consider if the level/range of variation is acceptable. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature.	Something's going on! Something, a one-off or a continued trend or shift of numbers in the wrong direction.	Investigate to find out what is happening / has happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature.	Something good is happening! Something, a one-off or a continued trend or shift of numbers in the right direction.	Find out what is happening / has happened. Celebrate the improvement or success. Is there learning that can be shared to other areas?
	Special cause variation where neither high nor low is good.	Something's going on!	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something

Icons for assurance

Icon	Description	What does this mean?	What do we do next?
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies within those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	If a target lies outside of those limits in the wrong direction then you know that the target cannot be achieved.	You need to change something in the system or process if you want to meet the target. The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	If a target lies outside of those limits in the right direction then you know that the target can consistently be achieved.	Celebrate the achievement. Understand whether this is by design and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Making Data Count (MDC): reading the assurance grid

The assurance grid provides an overview of performance, summarising where our metrics are landing and what action is suggested.

Variance – are the measures being met?	Assurance – can the target be consistently achieved?			
	Consistently hitting target 	Target not consistently achieved or failed 	Consistently fail target 	No target set
Special cause improvement 	**Excellent** Consistently achieving the target and metric is improving **Celebrate and learn**	**Good** Target will not be consistently achieved but metric is improving **Celebrate and understand**	**Concerning** Metric is improving but target is consistently failing and won't be achieved without change **Celebrate but take action**	**Excellent** Metric is improving, no target has been set **Celebrate**
Common cause 	**Good** Consistently achieving the target and metric is not changing significantly **Celebrate and understand**	**Average** Target will not be consistently achieved, and metric is not changing significantly **Investigate and understand**	**Concerning** Metric not changing significantly, but target is consistently failing and won't be achieved without change **Investigate and take action**	**Average** Metric is not changing significantly and shows levels of natural variation that is expected, no target has been set **Understand**
Special cause concerns 	**Concerning** Target is being achieved but metric is deteriorating **Investigate and understand**	**Concerning** Metric not consistently achieved and metric is deteriorating **Investigate and take action**	**Very concerning** Metric is deteriorating and target won't be achieved without change of process **Investigate and take action**	**Concerning** Metric is deteriorating, no target set **Investigate**