OPEN Council of Governors Meeting

Schedule	Thursday 5 March 2026, 5:30 PM — 7:30 PM GMT
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

	AGENDA: OPEN Council of Governors meeting Thursday 5 March 2026, 5.30pm in Rooms 19a & b, Education Centre, WSFT, Hardwick Lane, Bury St. Edmunds. IP33 2QZ	1
	📄 __2026 03 05 March - Agenda Open CoG meeting.docx	2
5:30 PM	**GENERAL BUSINESS**	4
	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	5
	2. Apologies for Absence To receive any apologies for the meeting Apologies received from: Governors - Adam Musgrove, Anna Conochie, Lisa Parish, Thomas Pulimood, Barry Probert NEDs - Antoinette Jackson, Alison Wigg, Tracy Dowling Other - Richard Jones To Note - Presented by Jude Chin	6

AGENDA:

OPEN Council of Governors meeting

Thursday 5 March 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 5 March 2025 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 <u>welcome</u> governors and attendees to the meeting and <u>request</u> mobile phones be switched to silent	Jude Chin
	2.	**Apologies for absence** To <u>receive</u> any apologies for the meeting	Jude Chin
	3.	**Declaration of interests** (enclosed) To <u>receive</u> any declarations of interest for items on the agenda	Jude Chin
	4.	**Minutes of the previous meeting** (enclosed) To <u>note</u> the minutes of the meetings held on 13 November 2025	Jude Chin
	5.	**Matters arising action sheet** (enclosed) To <u>note</u> updates on actions not covered elsewhere on the agenda	Jude Chin
17:40	6.	**Stop Smoking Campaign Update** (presentation) To <u>receive</u> an update on the current campaign	Jessica Hulbert
18:00	7.	**Update on operational performance** (presentation) To <u>note</u> an overview of performance, service pressures, discharges and patient flow.	Matt Keeling
18:20	8.	**Chair's report** (enclosed) To <u>receive</u> an update from the Chair	Jude Chin
18:30	9.	**Chief Executive's report** (enclosed) To <u>note</u> a report on operational and strategic matters	Ewen Cameron

GOVERNOR BUSINESS (INC. STATUTORY DUTIES)			
18:40	**10.**	**Feedback from Board committees** (enclosed) To <u>receive</u> 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 Committee	NED chairs / Governor observers
19:00	**11.**	**Nominations Committee report** (enclosed) To <u>receive</u> the report from the Nomination Committee	Jude Chin
	12.	**Membership and Engagement Committee report** *(No meeting since Oct 2025)*	-
	13.	**Standards Committee report** (enclosed) To <u>receive</u> a report from the Standards Committee	Jude Chin
	14.	**Staff Governors' report** (enclosed) To <u>receive</u> a report from the Staff Governors	Staff Governor
	15.	**Lead Governor report** (enclosed) To <u>receive</u> a report from the Lead Governor	Ben Lord
	16.	**Governance report** (enclosed) To <u>receive</u> the governance report	Paul Bunn / Pooja Sharma
ITEMS FOR INFORMATION			
19:20	**17.**	**Summary report for Board of Directors meetings** (enclosed) To <u>receive</u> the report from the Chair and Non-Executive Directors.	Jude Chin/ NEDs
	18.	**Any Other Business** (verbal) To <u>discuss</u> any other matters not included on the agenda.	All
	19.	**Dates for meetings for 2026** To <u>note</u> dates for meetings in 2026: **5.30 pm to 7.30 pm, Rooms 19a/b, Educations Centre, WSFT** • **19 May 2026** • **10 September 2026** • **10 November 2026**	Jude Chin
	20.	**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 – November 2025

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 - Adam Musgrove, Anna Conochie, Lisa Parish, Thomas Pulimood, Barry Probert

NEDs - Antoinette Jackson, Alison Wigg, Tracy Dowling

Other - Richard Jones

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 13 November 2025

For Approval

Presented by Jude Chin

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE
COUNCIL OF GOVERNORS' MEETING - OPEN

Held on Thursday 13 November 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
Robin Howe	Public Governor	RH
Ben Lord	Public 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 – Lead Governor	JS
David Slater	Public Governor	DSI
Anna Clapton	Staff Governor	AC
Louisa Honeybun	Staff Governor	LH
Adam Musgrove	Staff Governor	AMu
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
Antoinette Jackson	Non-Executive Director	AJ
Tracy Dowling	Non-Executive Director	TD
Richard Flatman	Non-Executive Director	RF
Alison Wigg	Non-Executive Director	AW
Paul Bunn	Acting Trust Secretary	PB
Ruth Williamson	Foundation Trust Office (Minutes)	RW

	Apologies:
	Public Governors: Robin Howe, Anna Conochie, Gordon McKay, Becky Poynter
	Staff Governors: Adam Musgrove.
	Partner Governors: Lisa Parish, Rowena Lindberg.
	NEDs: Michael Parsons, Paul Zollinger-Read, Heather Hancock.
	Other: Richard Jones, Trust Secretary, Pooja Sharma, Deputy Trust Secretary.
	Members of the Public – Lisa Cunningham.

No.	Item	Action
1.	**Welcome and introductions**	
	The Chair extended a warm welcome to all.	
2.	**Apologies for absence**	
	Apologies for absence were noted, as detailed above.	
3.	**Declaration of interests**	
	There were no declarations of interest made.	
4.	**Minutes of the previous meetings**	
	The minutes of the meeting held on 11 September 2025 were approved as a true and accurate reflection.	
5.	**Matters arising on action sheet**	
	Action Ref 7 – Freedom to Speak Up (FTSU) – a presentation on FTSU to take place as part of the Governor Briefing programme. Date to be confirmed. The closed action was noted.	
6.	**Finance Update**	
	Jonathan Rowell (JR), Chief Finance Officer, presented the financial update. The Trust is reporting a £20.7m deficit, an improvement on last year's £25m deficit, reflecting delivery of a challenging financial plan. At Month 6, the position was £0.8m ahead of the planned £15.2m deficit, with further improvement in Month 7. JR confirmed the Trust is taking firm action and maintaining focus on financial sustainability. Around 70% of costs relate to pay, and staffing levels have been reviewed accordingly. Workforce numbers have reduced since April 2024, following growth during the pandemic. JR noted this has helped rebalance the position. JR reported good progress on the Cost Improvement Programme (CIP). Although not all schemes for the year are fully identified, delivery is on track, with work underway to support sustainability into 2026/27. The next six months will be challenging, but progress to date is positive.	

National funding and requirements are not yet confirmed, but further work on productivity will be needed. Maximising use of staff, resources and the cost base will be essential.

Questions:

TP queried finance costs and depreciation. JR confirmed these are standard for an organisation of this size, with assets depreciated over set timelines. Valuations are completed annually by the district valuer and reviewed by auditors.

TP asked how accuracy is assured. JR confirmed monthly reporting to Insight Committee, with detailed reports to Finance and Audit Committees. Valuations and controls are externally validated. JC confirmed auditors have raised no concerns.

TP queried scope for review. JR noted finance costs include public dividend capital at 3.5% of net assets, a national requirement. The 2023/24 revaluation, linked to RAAC, reduced asset values and informed depreciation adjustments.

DSI asked about expenditure figures. JR explained the public report shows revenue, while capital spend is £32m, mainly for the new hospital project, which is nationally funded. Capital funding is often confirmed late, creating in-year pressures.

DSI asked about drawdown of funds. JR confirmed drawdown is managed as needed and must be used within the year. System-level brokering cannot take place this year.

SH congratulated JR on his appointment and asked about robustness of financial data. JR confirmed internal audits show strong controls and consistent reporting. Occasional minor unexpected items arise, such as late invoices, but there are no concerns about completeness. JC noted auditors have confirmed the strength of processes. AJ added that CIP reporting is now more robust. TD noted that detailed responses and data provide assurance.

JS asked about the recent workforce reduction and future expectations. JR advised further changes cannot be ruled out, pending Government announcements, but efforts will focus on productivity and targeted reductions where safe. JC noted activity-based remuneration is still under discussion.

JS raised concerns about safe staffing in non-clinical areas, referencing portering. EC confirmed a review is underway, noting the issue relates to timing and deployment rather than overall numbers, and work is underway to improve alignment.

DB highlighted the need for transformation alongside workforce changes, noting historic productivity levels and current national pressures. EC added

	that staffing has increased significantly in five years, and productivity must improve.

JR confirmed a large proportion of CIP relates to clinical productivity, supported by initiatives such as patient-initiated follow-ups and corporate reviews. DB stressed the aim is sustainability. TD noted further efficiency opportunities. JC referenced analysis showing 2023/24 productivity remains below 2019/20 levels.

TP queried Emergency Department attendances where no treatment is required. DB reported this was discussed at the Alliance Board, highlighting high-frequency attenders with complex needs. JC noted NHSE action with primary care to reduce hospital attendance. DB confirmed three local pilot schemes. JC acknowledged the deficit but commended progress on CIP delivery.

JR left the meeting at 6.10pm. | |
| 7. | **Chair's Report** | |
| | The Chair confirmed the substantive appointments of Julie Hull as Chief People Officer and Jonathan Rowell as Chief Finance Officer, noting that the Trust now has a fully substantive executive team, which will support the organisation in meeting current challenges

JS referred to the recent Board Development Day and asked what actions governors could expect. JC advised that the feedback received is being worked through and that output measures will follow, with continued focus on Board effectiveness. He reminded governors that their role was to hold Non-Executive Directors to account and encouraged increased attendance at Board meetings. TD requested that finalised actions be shared privately with governors; this was agreed. **PB to action.**

DB emphasised that the Council of Governors plays a key role in supporting openness and cohesion within the Board, cautioning that excessive publicity may inhibit frank discussion. JC noted that Board development has been constrained by operational pressures but confirmed plans to allocate additional time, aiming for four days per year.

JS sought clarification on new guidance for "advanced trusts", particularly references to governor removal. JC and EC advised they had not yet reviewed the guidance but considered it unlikely to apply whilst the Trust remains in deficit. JS observed that the guidance is clear and suggested legislative change may follow next year, potentially affecting future elections. JC noted that any changes would require legislation and that current arrangements remain in place. PB advised that consultation is open until January and aims for all trusts to achieve advanced status by 2035 under a new model constitution; a briefing will be provided once more detail is available. SH encouraged governors to use this as an opportunity for strategic thinking. JS asked that consideration be given to how feedback for the consultation will be gathered. | PB |

8.	**Chief Executive's report**	
	Ewen Cameron, Chief Executive Officer, presented the report. JS raised concerns regarding surgical waiting lists, noting that women appear to wait significantly longer than men, which could indicate inequality when viewed through an EDI lens. JS asked whether the Trust has targeted work to address this. EC responded that the comparison is not valid as procedures differ in complexity, for example, hydrocele versus hysterectomy. EC acknowledged staffing challenges in urogynaecology and stated that a genuine data comparison would be required. JS maintained that discrepancies exist across gender-specific operations. AJ confirmed discussion with Nicola Cottington, Chief Operating Officer and that relevant information was available and will be shared with JS. AJ advised that the Insight Committee will undertake a deep dive into access through an EDI lens in early 2026. NC has clarified that urology and urogynaecology are separate specialties with different decision-making teams and has agreed that theatre time allocation be reviewed for potential gender bias.	
9.	**Feedback from Board Committees**	
9.1	**Insight Committee**	
	The Committee Key Issues (CKIs) were noted. Antoinette Jackson (AJ), Non-Executive Director highlighted that the September meeting included a deep dive into elective recovery, which offered limited assurance due to the lack of detailed plans, though analysis identified areas requiring focus. Reports were submitted to October's meeting, demonstrating assurance had improved to partial as more detailed plans were in place. JS noted the value of deep dives in strengthening oversight and planning. DSI observed improvements in the structure of subsequent meetings. Reports from governor observers were noted.	
9.2	**Improvement Committee**	
	The Committee Key Issues (CKIs) were noted. TD reported that themes across the three meetings included CQC preparedness, with work now underway to ensure readiness. It was noted that the September CKIs were brief and did not reflect the full discussion. TP referred to Andy Morris's feedback from 20 August, highlighting the level of challenge and asking about next steps. EC confirmed the challenge had not come from the CEO and that the actions have been incorporated into the audit process. TD added that reporting at Involvement meetings demonstrates how EIAs and QIAs are managed and their impact. JS reflected on TD chairing a meeting as the only Non-Executive Director present and questioned whether this provided sufficient assurance. TD	

	acknowledged this was not ideal; whilst executive challenge is useful, effective chairing requires more than one NED. Quoracy will be reviewed. JN commended TD but raised concern about one individual presenting multiple papers and leaving with substantial actions. JC advised that deadlines should be realistic, and TD confirmed that following the recent restructure, the individual now has a wider team to support delegation.	
	JS raised concerns about audibility, particularly for those joining via Teams, and suggested rotating meeting times to avoid end-of-day fatigue. JC agreed and noted that whilst same-day scheduling supports executives, timings will be reviewed. AJ observed that Insight Committee meetings often receive late financial information and IQPR data two months in arrears; later scheduling might improve accuracy but would affect Board preparation. It was agreed to keep this under review.	
	JN reported that staff observers at the September Insight meeting found their attendance useful for understanding decision-making and suggested including community representatives. EC confirmed the staff observers were being mentored and that meetings are not open sessions.	
	Reports from governor observers were noted.	
9.3	**Involvement Committee**	
	The Committee Key Issues (CKIs) were noted.	
	Staff stories have been introduced, including a presentation from a neurodiversity trailblazer. TD noted that staff engagement remains below the desired level, but is improving, supported by renewed focus on equality, diversity and a commitment to anti-racism. Work continues on improving complaint responses, with recommendations anticipated in February. SH commented that this offers a useful opportunity to see the Board's forward planning and encouraged early governor involvement to contribution to its developments.	
	Reports from governor observers were noted.	
9.4	**Audit Committee**	
	Antoinette Jackson, Non-Executive Director, presented the report, which was noted.	
	AJ confirmed reasonable assurance on delivery of the internal audit plan and advised that outstanding actions highlighted in the Insight committee feedback report are being actively monitored by EC and the executive team.	
	BL queried recent debt write-offs, noting earlier assurance about improved processes and asked for details on the amounts and circumstances. AJ explained that one case involved an overseas patient with a complex history, including the use of false addresses. TD added that the individual, who was not eligible for NHS-funded care, was admitted through the Emergency Department with a serious illness and their overseas status was not immediately apparent. JC noted that many such cases are historic	

	due to lengthy processes. EC confirmed the write-offs relate to this same individual, who held an NHS number but had no confirmed residency or overseas address.	
10.	**Nominations Committee Report**	
	Jude Chin, Chair, presented the report. The Committee reviewed the Non-Executive Director terms of office, agreed the Terms of Reference and forward planner and noted that discussion on NED remuneration will take place at the Closed Council of Governors' meeting.	
11.	**Membership & Engagement Committee Report**	
	Sarah Hanratty, (SH), Public Governor and meeting chair presented the report. SH confirmed that governor case studies are being gathered to demonstrate impact of the role and reminded all members to contribute.	
12.	**Standards Committee Report**	
	Paul Bunn (PB), Acting Trust Secretary, presented the report. PB confirmed that work continues on the Fit and Proper Persons Test (FPPT) and DBS checks. The engagement policy was reviewed and approved, with a minor amendment to section 3.10 regarding licence duties. Amendments to the Terms of Reference were agreed. The Deputy Lead Governor appointment will be discussed in the Closed Council of Governors' meeting. The Lead Governor vacancy is being readvertised, with a closing date of 21 November. Members were invited to contact JS or PB with any queries.	
13.	**Staff Governors' Report**	
	Di Stroh, (DSt) Staff Governor, presented the report, the contents of which were noted and taken as read.	
14.	**Lead Governor Report**	
	Jane Skinner (JS), Lead Governor, presented the report, the contents of which were noted and taken as read.	
15.	**Summary Report for Board of Directors Meetings**	
	Jude Chin (JC), Chair, presented the report, the contents of which were noted and taken as read. The Chair encouraged all Governors to attend public Board Meetings where able.	

16.	**Any Other Business**	
	Jane Skinner & Ben Lord- the end of the term of office for Jane Skinner, Lead Governor and Ben Lord, Deputy Lead Governor was formally noted. The Committee expressed its sincere thanks and appreciation for their dedication, hard work and commitment throughout their tenure, acknowledging the significant contribution they have made to the role and to the effectiveness of the Council.	
17.	**Dates for meetings in 2026**	
	• 5 March, 2026 • 19 May, 2026 • 10 September, 2026 • 10 November, 2026	
18.	**Reflections on meeting**	
	• Respectful and challenging. • Positive meeting.	

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
9	Public	13/11/25	7	**Chair's Report - Board Development Day Actions** - Finalised actions to be shared privately with Governors	**Actions shared.**	PB	05/03/2026	Complete	05/03/2026

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. Stop Smoking Campaign (presentation)
To receive an update on the current Campaign
Jessica Hulbert, Public Health Manager, in attendance
To inform

7. Update on Operational Performance (presentation)

To note an overview of performance, service pressures, discharges and patient flow

To inform

Presented by Matt Keeling

8. Chair's report (enclosed)

To receive an update from the Chair

To Note

Presented by Jude Chin

COUNCIL OF GOVERNORS MEETING (OPEN)

Report information

Report title: Chair's report
Agenda item: 8
Sponsor/Executive lead: Jude Chin, Trust Chair
Report prepared by: Jude Chin, Trust Chair
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 December 2025, January 2026, and February 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 November, we have overcome a number of significant challenges. These include the winter pressures, industrial action, increased sickness during the peak of the flu season, and other singular events. Our staff have negotiated these tough periods while upholding safe patient care, and to them I am very grateful.

2. We now have a fully established senior leadership team following the appointments of Jonathan Rowell to chief finance officer, and Julie Hull to chief people officer. Additionally, as outlined in our constitution, we will have eight non-executive directors should the council approve the recruitment of the nominated representative from the University of Cambridge. We are moving forward with greater certainty so we can deliver the changes needed to best respond to not just the operational pressures we face, but the important work of keeping our finances under control.

3. While there is more to do over the next two years to become financially sustainable, I'm pleased to say the action we have taken means we are on track to deliver the savings required this year. We have turned a corner and that is thanks not just to our finance team, but staff across the Trust. Everyone has a role to play in identifying ways we can manage our resources responsibly.

4. We are continuing to see that NHS England and the Department for Health and Social Care (DHSC) are focused on operational and financial performance. Almost every week, providers and Integrated Care Boards with deficit plans are encouraged to fix their finances as quickly as possible. The requirement to provide 92% of elective procedures within 18-weeks and reducing waiting times in our emergency department are significant targets we are being held to. This is evidenced by the move from block contracts to tariffs from 1 April 2026, which links productivity to our income. Moreover, from 1 April 2026 we will no longer be monitored on our operational and financial performance by the Integrated Care Board (ICB); instead, our NHS England regional colleagues will undertake this role. This change comes from the NHS Oversight Framework, which details NHS England's commitment to transparency and improvement and is in line with the ICB boundary changes and mergers taking place across the East of England. The aim of this is to emphasise the importance of fair and consistent rewards based on our activity and the use of league tables, such as the NHS Oversight Framework, to encourage improvements.

5. Following the launch of our refreshed strategy in October 2025, we have been working to meet the expectations set by NHS England and DHSC, not just to guarantee our income, but to provide compassionate care which ensures our communities are as healthy as possible. Our new strategy is guided by five strategic ambitions which underpin our vision and mission: high quality care, joined-up services, empowered to improve, responsible with resources, and fit for tomorrow.

6. The strategy will help us tackle the challenges the NHS faces and comes at an appropriate time following the publication of the 10- Year Health Plan for England. Setting a clear direction of travel helps us achieve our goals and makes sure we are working on the things that will bring about the greatest good for the people of west Suffolk.

7. Finally, many of you may be aware our non-executive director, Tracy Dowling, has been appointed as chair of the East Suffolk and North Essex NHS Foundation Trust. Since she joined in September 2024, Tracey has made a significant contribution – and brought all of her knowledge and experience in the NHS – to help us navigate difficult operational and financial challenges. Our partners at ESNEFT are gaining a stellar member of their Board, I hope it will strengthen our close collaboration, and I wish her all the best in her new role.

9. Chief Executive's Report (enclosed)

To note a report on operational and strategic matters

To Note

Presented by Ewen Cameron

West Suffolk NHS Foundation Trust Council of Governors

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; Sam Green, senior communications officer; Greg Bowker, head of communications; Anna Hollis, deputy 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 for December 2025, January 2026, and February 2026.

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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.

Compassionate care, healthier communities

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. The last three months have been an incredibly busy and challenging period. Alongside the expected increased demand for our services, we have been dealing with flu and norovirus. Whilst the wave of flu was not as severe as initially feared, we did see a spike in staff absences due to sickness. Thankfully, we are now seeing a decline in flu amongst our patients and a reduction in sickness-related absences. Additionally, norovirus again presented itself as a barrier to patient flow, however, our teams, are dealing with this well. I would like to reiterate that the best way to prevent the spread of flu and protect your health is to get your vaccination. Thanks to the hard work of our vaccination team, we passed the NHS England staff vaccination target on the 10 December. We will continue vaccinations until March.

1.2. We also navigated through the 14th round of British Medical Association (BMA) resident doctor industrial action in December. I would like to thank colleagues across our acute and community services for their incredibly hard work to keep our services running and patients safe. While the BMA's mandate to take industrial action has ended, we are ready to stand up our robust planning procedures should they be needed.

1.3. It's fantastic to see we have moved up in the National Oversight Framework league table for acute trusts. In December, we increased our standing from 90th to 57th – a leap of 33 places. While we remain in segment 3 due to our deficit plan, we now sit towards the top. This is really positive news and reflects the quality and safety of the care we provide our patients every day, and who we are as a Trust. There are numerous factors which are considered when calculating our league table position, so I would like to thank every member of staff for their contribution in achieving this improvement.

1.4. Furthermore, we're continuing to see our financial situation improving, showing we have turned a corner. This means the tough decisions we've made over the last 12 months are making a difference and gives us a reason to be much more positive. While we still have a way to go in achieving financial sustainability, we've earned the trust and confidence of others to decide our path. Controls remain in place to ensure we don't allow the hard-

Compassionate care, healthier communities

earned ground to be lost, but it's thanks to all colleagues and their consistent support that we are now at this point in our journey.

2. Financial performance

2.1. At the end of December, our reported position in-year was a £16.5m deficit, which is £0.8m better than planned. There has been an enormous effort from colleagues to help reduce the deficit, and significant progress has been made so far this year, with a positive reduction in our underlying run rate.

2.2. The continued favourable difference between our planned and reported position, especially after September where the planned trajectory became more difficult to achieve, means the changes we've put in place are making a difference. While we still have a way to go, it's thanks to all colleagues and their consistent support that we can start being much more positive.

2.3. While we have a deficit plan of £20.7m for 2025/2026, this is facilitated by us delivering £32.8m in savings under our cost improvement plan (CIP). I am please that at the end of January, we have continued to meet this, and have so far delivered £25.2m of savings, which is on target

3. Elective recovery

3.1. Despite British Medical Association industrial action continuing, with a further five days taking place between 17 and 22 December 2025, we continue to make good progress in reducing our waiting lists.

3.2. Our robust planning procedures mean we were able to keep appointment and procedure postponements to a minimum, and while we were under significant pressure over these days, there was very little change in the number of postponements compared to the previous round in November. Additionally, as outlined by NHS England, more than 95% of activity continued, showing the resilience and diligence of our colleagues.

3.3. Between August and the end of January 2026, the number of patients waiting 52 weeks or more decreased by 56% from 1,746 to 691. The number of patients waiting 65 weeks or more also reduced by 54% from 72 to 33 in a single month between the end of November and the end of December. While this increased to 38 by the end of January, we anticipate bringing this down to zero by the end of March.

3.4. We are also making good progress in reducing our 18-week waits, currently achieving a performance of 62.6%. Our focus is to bring the number of people waiting down, so we meet the target of 92% by the end of this Parliament.

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4. Urgent and emergency care

4.1. Our performance against the 4-hour standard was 68% in January compared to 71.2% in December. This reflects the significant pressure our urgent and emergency care services have been under, and we are doing all we can to ensure we meet the target of 78% by the end of March. We're still undertaking a number of transformation projects to improve our care pathways, with an aim of delivering more effective patient flow and admission prevention.

5. Cancer

5.1. 28-day Faster Diagnosis Standard (75% target):
October 2025 – 74.6%
November 2025– 73.3%
December – 76%

5.2. 31-day Diagnosis to Treatment (96% target):
October 2025 – 100%
November 2025 – 100%
December 2025– 99%

5.3. 62-day Referral to Treatment (85% target):
October 2025 – 84.9%
November 2025 – 81.7%
December 2025 – 82.9%

5.4. Our cancer services are achieving against their targets almost across the board, which is great news and testament to the quality of care we provide to our patients.

6. Quality

6.1. Having been in tier 1 for cancer services early last year due to staff sickness and a temporary reduction in activity within high-volume pathways, we improved to tier 2 in April 2025. We have now exited tiering for cancer altogether, and the above figures demonstrate the remarkable turnaround this service achieved in just one year, which means our patients get the high quality and timely care they deserve.

6.2. One recent example of service transformation, that helps us improve our efficiency and enhance the patient experience, is a project showing the

benefits of interdisciplinary working.

6.3. In January 2025 we trialled delivering IV Furosemide in the homes of heart failure patients, instead of them attending one of our hospitals and needing one of our beds. Following an extensive but positive trial, this was subsequently agreed as a permanent care pathway. Community nurses have been trained to deliver this treatment, working alongside the cardiac team. As this treatment is delivered, they are monitored by our virtual ward which means if they need further medical assistance we can deliver this quickly. Approximately nine patients a day require this treatment, so having patients being able to remain in their homes gives us an additional nine beds every day for those needing inpatient care, as well as being a better experience for patients. Additionally, GPs and Trust staff can refer into this service, which gives patients greater flexibility in how we deliver their care. This is an excellent project, which aligns perfectly with two of the 'three shifts' outlined in the 10-Year Health Plan for England: acute to community, and analogue to digital.

7. Workforce

7.1. Developing our staff is one of the ways we improve the quality of care we provide. I recently learned more about the great work our quality improvement team is doing to improve how we implement positive change across our Trust. Their Continuous Quality Improvement (CQI) leaders programme gives colleagues the tools to effectively embed projects to improve the safety and quality of our care. Over a six-to seven-month period, colleagues from across the organisation are supported to implement a project in their team or service so they have the tools needed for any future projects. In the most recent cohort, the projects included promoting timely interventions and discharges for elective colorectal patients, improving clinical productivity in the community dietetic service, and improving the inequality demographic data we have. This in-house programme is something I am keen to promote so we as a Trust can deliver the necessary transformation to ensure we sustainably provide timely and high quality care for years to come.

7.2. As the largest single workforce survey in the world, we know the NHS Staff Survey is an important way to gauge how our staff are feeling, and where we need to make improvements. Following an extensive campaign to encourage our staff to complete the survey, it closed on Friday, 28 November with a higher number of responses when compared to last year's survey. We expect the results to be published in full in March 2026, and we will share the results

at a future Board meeting where we will consider their impact.

7.3. In the interim, we have launched the Quarterly People Pulse survey – another tool to capture feedback from our colleagues. This shorter and simpler survey also allows us to include some bespoke questions on topics or issues we are keen to learn more about. For the January survey, these questions focus on the new organisational strategy and should provide a benchmark for awareness and key messages. We will ask these questions again after we have undertaken further communications and engagement activity, with the hope this will provide evidence that our strategy and ambitions have become more embedded.

7.4. Many working here will spend all, or the majority, of their careers within the NHS. Throughout the year, I am afforded the pleasure of writing to those who have worked for the NHS for 20 years or more and I'm always amazed at the number of people who achieve this.

7.5. As a few examples, radiographer practitioner, Nazira Ahmed, has worked for the NHS for more than 20 years, as has Tina Reynolds, one of our senior assistant technical officers in pharmacy. Nursing assistant on ward F7, Michelle Hales, and patient referral coordinator, Sarah Ramsbottom, have reached the 25-year mark. Additionally, senior contracts manager, Allen Petchey has 35 years of service to the NHS under his belt. However, in what is an incredible achievement, clinical nurse specialist, Helen Small, has hit 40 years. I would like to thank everyone I've mentioned, as well as those I haven't, for their dedication and commitment to our NHS.

8. Future

8.1. The plans for our new hospital on Hardwick Manor in Bury St Edmunds continues to make good progress. We're finalising the design with our New Hospital Programme colleagues at NHS England, and we look forward to sharing these with you soon. Furthermore, we will be going through a period of consultation with our staff and communities for the 'reserved matters' stage of the planning process. This

8.2. On 16 December 2025, the Community Diagnostic Centre (CDC) at Newmarket Community Hospital marked one year since it began seeing patients. Over the course of the year, the CDC saw almost 8,000 patients and performed 43,693 investigations. These include 5,799 MRI scans, 5,835 CT scans and nearly 11,000 X-rays. As a result of this increase in diagnostic capacity, between December 2024 and December 2025, the number of patients waiting for an MRI scan dropped by 53%, and the percentage of patients waiting six-weeks or more for their scan fell from 61.4% to 1.6%. This is an incredible improvement and shows how by developing the

Newmarket Community Hospital site we're improving the care we provide.

8.3. In another bit of exciting news, we are in the early stages of planning an expansion of our services at Newmarket Community Hospital by building an endoscopy and paediatric audiology unit next to the existing CDC. This 2,300m² two-storey facility will include four endoscopy suites, two audiology suites and a range of clinical and support spaces.

8.4. We hope to begin construction in the summer, with this planned to open in 2027. This is another brilliant project, and I look forward to providing updates on this over the course of the year.

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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

To Note

COUNCIL OF GOVERNORS MEETING (OPEN)

Report information

Report title: Board Assurance Committees - Feedback Report
Date of the meeting: 05 March 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, chairs' 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:

19 November 2025 (observed by David Slater and Jayne Neal)
- Report from sub-committees:
  - Financial Accountability Committee including Month 7 reporting, update on CIP, Business Planning Update, Patient Access Governance Group including Quality Impact Assessment panel outcomes, Financial Planning Briefing, Medium Term Planning Framework
- Virtual Ward Deep Dive
- CDC Activity and Diagnostic Recovery Deep Dive including DM01 recovery
- IQPR - data for September 2025
- BAF 7 Financial Sustainability (via FAC) and BAF 6 Estates
- Forward Plan
- Escalations to and from other board assurance committees and board

17 December 2025 (observed by David Slater)
- Report from sub-committees:
  - Financial Accountability Committee including Month 8 reporting, update on CIP, Quality Impact Assessment panel outcomes, PA Consulting Review
- IQPR - data for October 2025
- Patient Access Governance Group update
- 26/27 Planning: Medium Term Planning, 26/27 CIP Approach
- Corporate Risk Governance Group - EPRR Core Standards
- Forward Plan
- Escalations to and from other board assurance committees and board

21 January 2026 (observed by Jane Skinner and David Slater)
- Report from sub-committees:
- Financial Accountability Committee including Month 9 reporting, update on CIP, Quality Impact Assessment panel outcomes
- Operational performance
- IQPR - data for November 2025
- Patient Access Governance Group update
- UEC update - Deep Dive including our activity and performance plan for 26/27 and unbundling of UEC tariff
- Forward Plan
- Escalations to and from other board assurance committees and board

18 February 2026 (observed by Jane Skinner, Jayne Neal and David Slater)
High quality care
- Operational Performance
- December 2025 IQPR and Patient Access Governance Group
- Board Assurance Framework - BAF 2 Capacity and BAF 7 Finance
- Interim Revised IQPR

Joined up services
- No reports

Responsible with resources
Finance
- Financial Accountability Committee
- Month 10 Reporting

- CIP Update
- QIA Panel Outcomes
- Internal Audit Report
- Final Submission Plan

Empowered to improve
- No reports

Fit for tomorrow
Governance
- Review of the Work Programme/Forward Plan (attached)
- Escalations to and from other board assurance committees and board

Quality and Patient Safety Committee:

19 November 2025 (observed by Sue Kingston)
- Reports from governance sub-groups: Patient Quality & Safety
- Quality Performance / KPIs – Clinical accreditation model, PSIRP, Patient safety quarterly report, IQPR - data for September 2025, PRM packs
- Discussion on strategic priorities for Committee
- Review of Committee Effectiveness
- Risk register
- Escalations to and from other board assurance committees and board

17 December 2025 (observed by Jane Skinner and Sue Kingston)
- Reports from governance sub-groups: Patient Quality & Safety, Clinical Effectiveness Governance Group report
- Quality & patient safety insight: IQPR, PRM packs, Quality faculty update (EoL programme)
- Dermatology rapid access pathway concern update
- SHMI – Mortality rates update
- Maternity services: claims scorecard, review of pain control by ethnicity
- Quality Priorities - Quality Priority 1 – TES
- Quality faculty update (EoL programme) – Update on ReSPECT programme progress
- Quality account priorities
- BAF 4 – Continuous improvement and Innovation
- Escalations to and from other board assurance committees and board

21 January 2026 (observed by Jane Skinner)
- Reports from governance sub-groups: Patient Quality & Safety, Clinical Effectiveness Governance Group report
- Quality & patient safety insight: IQPR, PRM packs, Quality faculty update (EoL programme)
- Risk update
- NatSSIPs 2 update
- Medication safety update
- Maternity services: homebirth service review, maternity incentive scheme sign off
- Completion of Transfer of Care Summary letters (Discharge letters)
- Quality Priorities - Quality priority 2 (GIRPS)
- CQC update
- BAF 8 – Governance
- Escalations to and from other board assurance committees and board

18 February 2026 – No meeting convened

People and Organisational Development Committee:

17 December 2025 (observed by Val Dutton)
Setting the scene: Our FIRST values and committee purpose - Fairness, Inclusivity, Respect, Safety, Teamwork
Recent announcements affecting workforce - 2026/27 pay round
First for staff:
- WRES and WDES report
- Anti-racism
- Sexual safety in the workplace
- Update on nursing profiles project
- Annual nurse staffing review
- Bi-annual workforce reviews for the maternity incentive scheme
- Addressing staff engagement at WSFT

First for the future:
- Trust Strategy/Workforce Strategy/Business Plan
- Review of feeder groups and governance arrangements

First for the patients:
- Patient story (Martha's rule)
- Experience of Care and Engagement Committee Report
- Inpatient CQC results and action plan

Governance:
- AuditOne – well led response – review progress
- Staff Wellbeing BAF

Other items for information, oversight and assurance:
- IQPR extract for the Committee (staff & patient experience KPIs)
- Professional standards framework for quality assurance and improvement
- Escalations to and from other board assurance committees and board

18 February 2026 (observed by Becky Poynter)
Setting the scene: Our FIRST values and committee purpose - Fairness, Inclusivity, Respect, Safety, Teamwork
Recent announcements affecting workforce - Anti-racism
Empowered to improve
- Staff Story

High quality care
- BAF and Risk Management Update
- Staff Wellbeing BAF
- Capability BAF
- Resident Doctor 10 Point Plan
- Guardian of safe working

Joined up services
- Disability Network Update
- Mandatory Learning Update

Fit for tomorrow
- How do we join up now and tomorrow – new hospital
- Employment Rights Act
- People Strategy

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

29 January 2026 (observed by NONE)
- National updates or mandates
- Digital and data programme
    - Delivering on our strategy
    - Future System programme digital update
    - Data and BI report
    - e-Care CSP upgrade
- Risks, governance and safety
    - Risks for escalation
    - Information governance steering group report
    - Cyber hygiene summary report
- Governance
    - Approval of Terms of Reference (approval)
    - BAF 5 – digital
- Items for assurance
    - Role of the digital pharmacist
    - Digital maturity assessment – roadmap for improvements
    - Benefits tracking approach
    - DDAC forward plan

Audit Committee
Audit Committee's key issues report (16 December 2025) presented by the Committee Chair.

West Suffolk
NHS Foundation Trust

Assurance – can the target be consistently achieved?

December 2025	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** Cancer 62 Days Performance	**F&P** RTT 65+ Week Waits	**F&P** RTT 52+ Week Waits RTT 52+ Weeks Wait as % of Total WL RTT <18 Week Waits (%All)
Common cause – monitor & understand	**F&P** Urgent 2 hour response – UCR Virtual Beds Trajectory	**F&P** Ambulance Handover within 30min Non-admitted 4 hour performance % patients with no criteria to reside Virtual Ward Total average occupancy percentage 28 Day Faster Diagnosis **Q&PS** C-diff Hospital & Community onset, Healthcare Associated **W&OD** Mandatory Training Turnover	**F&P** Incomplete 104 Day Waits Diagnostic Performance % within 6weeks Total **W&OD** Appraisal	**F&P** 12 Hour Breaches 12 hour breaches as a percentage of Type 1 attendances Criteria to Reside Acute Criteria to Reside Community RTT Waiting List RTT <18 Week Waits (% First OPA) **Q&PS** % of patients with Measured weight % of patients with a MUST/PYMS assessment completed within 24 hours of admission Post Partum Haemorrhage Inpatient Deaths **W&OD** Active complaints Closed complaints % extended Count extended % Complaints responded to late Count responded to late % resolved in one week Total PALS resolved Count
Special cause concerns - investigate (H) (L)	**W&OD** Staff Sickness – Rolling 12months Staff Sickness			**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) - Cancer: Incomplete 104 Day Waits
Finance and performance (F&P) - Elective: Diagnostic Performance % within 6weeks Total, RTT 65+ Week Waits
Workforce & organisational development (O&D) - Well Led: Staff Sickness – Rolling 12months, Staff Sickness, Appraisal

Summaries / Finance & performance / Quality and patient safety / Workforce & OD / Appendices
Variance – are the measures being met?

Compassionate care, healthier communities

10.1. Finance & Performance Committee (previously Insight)

To Note

Presented by Richard Flatman

Board assurance committee - Committee Key Issues (CKI) report

NHS West Suffolk NHS Foundation Trust

Originating Committee: Insight Committee			Date of meeting: 19 November 2025		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk	*WHAT NEXT?* Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)	*Escalation:* 1. No escalation 2. To other assurance committee /MEG 3. Escalate to Board
BAF Risk 6 Estates Update	By taking a proactive approach, the Trust has made significant progress in addressing structural risks, particularly those associated with Reinforced Autoclaved Aerated Concrete (RAAC). Nonetheless, the estates maintenance backlog remains substantial. Significant progress has been achieved in addressing urgent items such as oxygen leaks, water hygiene improvements, sterilisation services plant replacements and addressing medical gas leaks.	**3 Partial**	The Trust possesses relatively good condition data for the estate at a high level, but significant areas of detailed information were incomplete. A review of all risk assessments has been completed to ensure that risks are fully understood and mitigated wherever practicable. The number of risk assessments for the directorate has increased from 45 to 197. Progress has been made across all areas of risk identified within BAF6. However, the continued challenges of recruiting suitably qualified staff means it is forecast to remain as a significant risk for the time being.	Building on the recovery work completed to date, the requirement for a more detailed survey and inspection of plant has been identified and is being procured. In the short to medium term, the focus is on reducing business continuity and compliance risks and the development of more robust Planned Preventative Maintenance schedules. Recruitment for key positions is also underway, alongside a staff development plan. Short-term investment will be necessary to support these actions and business cases are being developed for this.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 19 November 2025		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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PAGG/IQPR	**Urgent and Emergency Care** September 4-hour performance decreased to 69.7%, not meeting the in-month trajectory of 75%. 12-hour waits as a percentage of attendances increased from 4.7% in August to 8.62% in September, not meeting plan but below the comparable 2024 position**.**	**3 Partial**	Not meeting urgent and emergency standards means some patients are waiting longer in the Emergency Department than they should be.	Recovering delivery of the 4-hour performance trajectory will be the key focus for urgent and emergency care in November, with 72% needing to be achieved. 12-hour waits will also need to meet a resubmitted trajectory of 7% in October and 6% in November and December. WSFT will be required to submit performance trajectories for 2026/27 to 2028/29 in response to the publication of the Medium-Term Planning framework.	3. Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 19 November 2025		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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PAGG/IQPR	**Cancer Targets** 28-day Faster Diagnosis Standard performance remained stable at 80.4% in August. 62 day performance increased to 78.6% in August from 70% in July.	*3 Partial*	Due to the challenges in breast there is a continued risk to the faster diagnosis standard and 62-day performance.	The Trust has committed to achieving the 62-day standard (75%) and Faster Diagnosis Standard (FDS) (80%) for 2025/26. Gynaecology, skin and lower gastrointestinal (LGI) are the areas of focus for transformation. WSFT will be required to submit performance trajectories for 2026/27 to 2028/29 in response to the publication of the Medium-Term Planning framework.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 19 November 2025		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
Agenda item	WHAT? Summary of issue, including evaluation of the validity the data*	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	For 'Partial' or 'Minimal' level of assurance complete the following:		
			SO WHAT? Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk	WHAT NEXT? Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)	Escalation: 1. No escalation 2. To other assurance committee /MEG 3. Escalate to Board
PAGG/IQPR	**Elective Recovery** The total waiting list was 32,635 at the end of September, down from 33,671 at the end of August. Overall RTT compliance increased from 58.39% to 62.1% due to additional activity and validation in September. As at the end of September there were 102 patients over 65 weeks, a further reduction from August, this volume is expected to continue to reduce over the coming months with a national expectation of zero from the 21st December. The volume of 52 week waits also reduced in September to 3.3% of the total waiting list (target 1% by March 2026) but we remain off plan.	**3 Partial**	There is a risk of patient harm if patients are not treated in a timely way. As a result of the Trust's variance to plan, we were placed into 'Tier 1' for elective care, alongside diagnostics. This requires fortnightly meetings with national and regional NHS England teams. Gynaecology remains a particular area of risk and a high reliance on ultrasound is impacting their ability to recover.	The Management Executive Group (MEG) has approved an additional £424k for elective recovery and the investment will be profiled to provide the best value for money through targeting specialities which can provide high volume, accelerated recovery whilst also reducing long waits in all specialities. Trajectories for elective access standards were resubmitted as part of the NHS mid-year review process. While these allowed for a "reset" against current delivery, a concerted effort to recover is required to regain progress against original plans in Q4.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 19 November 2025		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
Agenda item	WHAT? Summary of issue, including evaluation of the validity the data*	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	For 'Partial' or 'Minimal' level of assurance complete the following:		
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Community Diagnostic Centre activity and Diagnostic Recovery Deep Dive	Current performance is being closely monitored through fortnightly Tier 1 meetings with NHSE regional and national teams. September DM01 performance fell short of plan, primarily due to ultrasound. Weekly improvements have been observed throughout October, with reductions in six-week waits and overall compliance trending positively As of 09/11/2025, weekly DM01 compliance stands at 51.32%, with a forecasted improvement to 76.22% under the current action plan by March 2026. This is underpinned by insourcing in ultrasound which has already started and planned endoscopy insourcing from January. This is a slightly later than anticipated.	3 Partial	Ongoing areas of concern are NOUS DEXA Endoscopy CDC Activity vs Plan – there was an 18% increase in imaging activity between August and September, 68% of staff recruited to CDC, 46% delivery against activity plan in September. The current forecast for the end of 25/26 is 61% of planned activity The challenge across modalities remains the recruitment of skilled staff. Mutual aid requests have not been successful.	Given the national recruitment challenges, a SNEE ICB diagnostic strategy is currently being developed. DEXA are working through the back log as planned with increased activity 5 days a week Ultrasound plans to clear the majority of the back log by the end of the financial year. This will mean less use of temporary staffing and insourcing going forward, using a pipeline of the Trust's own trainees. The proposed solution for endoscopy is CDC expansion, if the business case for this is approved. Longer term there may be technological advances, offering further solutions for some services.	3 Escalate to Board for information

Originating Committee: Insight Committee			Date of meeting: 19 November 2025		
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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
Virtual Ward Capacity	The Trust's Virtual Ward currently has capacity for 53 adults with both step down and step-up pathways in place. Capacity will be reduced to 48 beds from January 2026 aligned to the withdrawal of capacity from specialist pathways. The ward is not utilising its capacity with occupancy averaging 60-65%, therefore the Management Executive Group are recommending that investment in the Virtual Ward be reduced further. Two options are being considered subject to further work on impacts. They would result in ward with either 43 or 35 beds. It is important that the option chosen minimises the impact on UEC 4 and 12-hour performance and community services; and avoids significant risk.	3 Partial	The acute bed base and workforce planning under the Trust's Future Systems Programme has been modelled on c.100 virtual beds to be achieved by 2032 (to deliver the Target Operating Model). Reducing the Virtual Ward bed base goes against this aspiration. It is intended that capacity for future expansion will be retained. The Committee were assured the reduction made sense in the short term but were only partially assured about the direction of travel for the longer term. In particular, whether there were plans in place to affect the cultural and behaviour changes required to maximise use of the ward.	A working group is being established to identify how change will be made and a 10% reduction in the cost envelope achieved.	3 Escalate to Board for information

Originating Committee: Insight Committee		Date of meeting: 19 November 2025		
Chaired by: Antoinette Jackson		**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**	
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	*WHAT NEXT?* *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	*Escalation:* 1. *No escalation* 2. *To other assurance committee /MEG* 3. *Escalate to Board*
Finance Accountability Committee	**Month 7 Reporting** At month seven the Trust was reporting a £1.2m year to date (YTD) underspend against the plan, with a YTD deficit of £15.3m, compared to the planned deficit of £16.5m. We continue to forecast meeting our planned deficit of £20.7m for 25/26 The CIP plan is currently on plan at £14.1m YTD. However, challenging CIP targets in the second part of the year remain. YTD capital spend at month 7 is £7.8m. This is behind the phased plan, but it is anticipated that the plan for 2025/26 will be achieved, subject to final PDC funding agreements being in place.	**3 Partial**	It is positive to see the monthly run rate reducing ahead of plan as this will help the position going into 2025/26. The CIP programme monthly targets ramp-up significantly through the rest of the year and remain a risk. Cash is being rigorously monitored to ensure that the Trust remains on plan and does not fall below the £1.1m limit that must be maintained The Trust applied for £10m in cash support for November, but has only been awarded £5.7m.	Discussions are being held with NHSE to ensure that the full level of cash support is received in December. Delivery of the CIP programme needs continued focus – see below	3.Escalate to Board for information

Originating Committee: Insight Committee			Date of meeting: 19 November 2025		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
Agenda item	WHAT? Summary of issue, including evaluation of the validity the data*	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	For 'Partial' or 'Minimal' level of assurance complete the following:		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	*WHAT NEXT?* *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	*Escalation:* 1. No escalation 2. To other assurance committee /MEG 3. Escalate to Board
Cost Improvement Programme (CIP) delivery	At month 7 the Trust had identified £29.4m/£27m of unweighted/weighted CIP opportunities respectively against a full year target of £32.8m. This compares to £29.3m/£26.1m of unweighted/weighted CIP opportunities reported the previous month. A gap of £3.4m/£5.8m remains against the 25/26 CIP target when considering unweighted/weighted CIP positions respectively The overall gap in the portfolio has reduced, with 90% of the CIP target identified (82% weighted).	**3 Partial**	There are several high value schemes progressing through the change control process, which will lead to a fluctuation in some figures and not all will achieve their original targets. Those with significant risk of delivery continue to be corporate services and clinical productivity. The CIP programme only captures formal schemes not all financial changes. There will be other fortuitous savings which will help bridge the 2025/26 deficit. The Quality Impact Assessment panel continues to take a critical look at proposed schemes and not all are approved if there are risks to patient safety.	The Business Planning process will help tease out ideas for 2026/27, as well as exploring the full year effect of 2025/26 schemes.	3 Escalate to Board

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee		Date of meeting: 17 December 2025		
Chaired by: Antoinette Jackson		**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		

Agenda item	WHAT? Summary of issue, including evaluation of the validity the data*	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	For 'Partial' or 'Minimal' level of assurance complete the following:		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	*WHAT NEXT?* *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	*Escalation:* 1. *No escalation* 2. *To other assurance committee /MEG* 3. *Escalate to Board*
PAGG/IQPR	**NHS Oversight Framework** The Q2 2025/26 update of the NHS Oversight Framework was released on 28 November 2025. Although WSFT remains in overall segment 3, the unadjusted segment improved from 3 to 2, with improvements seen in scores across all domains except effectiveness and experience of care (the lower the score in each domain, the better the ranking).	**2 Reasonable**	The Trust cannot move out of segment 3 because of its financial deficit position but the Board can take assurance from the improvements seen across many domains.	The Framework will be updated quarterly.	3 To Board for information

| PAGG/IQPR | **Urgent and Emergency Care**

In urgent and emergency care October 4-hour performance was similar to September at 69.5%, missing the in-month trajectory of 72%.

12-hour waits increased again, from 8.62% in September to 9.00%, above plan but still below the comparable 2024 position. | **3 Partial** | Not meeting urgent and emergency standards means some patients are waiting longer in the Emergency Department than they should be. | Recovering delivery of the 4-hour performance trajectory will be the key focus for urgent and emergency care in November, with 72% needing to be achieved. Provisional November data indicates the trajectory for that month was exceeded by 4%.

12-hour waits will also need to meet a resubmitted trajectory of 6% in November and December.

WSFT will be required to submit performance trajectories for 2026/27 to 2028/29 in response to the publication of the Medium-Term Planning framework. | 3. Escalate to Board |

| PAGG/IQPR | **Cancer Targets**

28-day Faster Diagnosis Standard performance decreased to 74.1% in September (from 80.4% in August).

In comparison 62-day performance increased to 84.9% in September (from 78.6% in August)

Overall improvements to Cancer performance have resulted in the Trust being moved out of Tiering completely. | **2 Reasonable** | Due to the challenges in breast there is a continued risk to the faster diagnosis standard and 62-day performance.

Whilst challenges remain the Board can take assurance from the Trust's removal from the Tiering process for Cancer performance | The Trust has committed to achieving the 62-day standard (75%) and Faster Diagnosis Standard (FDS) (80%) for 2025/26. Gynaecology, skin and lower gastrointestinal (LGI) are the areas of focus for transformation.

WSFT will be required to submit performance trajectories for 2026/27 to 2028/29 in response to the publication of the Medium-Term Planning framework. | 3

Escalate to Board |

PAGG/IQPR				
	Elective Recovery The total waiting list and RTT 18-week compliance were comparatively stable from September to October, giving high confidence in meeting the March 2026 target for both. As at the end of October 2025 there were 72 patients over 65 weeks, a further reduction from 102 in September, this volume is expected to continue to reduce over the coming weeks with a national expectation of 0 from the 21st December. The volume of 52 week waits reduced further in October to 2.8% of the total waiting list (target 1% by March 2026), in line with the revised trajectory.	**2 Reasonable**	There is a risk of patient harm if patients are not treated in a timely way. Significant efforts in this area are beginning to show sustained improvement. Our regional ranking on long waits has improved from 92nd to 52nd. Regional data shows WSFT is one of only four Trusts ahead of its RTT 18-week plan; has a lower than average 65-week cohort; and has the third smallest 52 week wait cohort. WSFT has increased capped theatre utilisation but needs to catch up on waiting list validation. Given the Trust's improved performance we have been moved from Tier 1 into Tier 2 in the national support system.	Trajectories for elective access standards were resubmitted as part of the NHS mid-year review process. While these allowed for a "reset" against current delivery, a concerted effort is required to regain progress against original plans in Q4.	3 Escalate to Board

Diagnostics	September DM01 performance increased further, from 45.54% to 51.5%. Additional ultrasound activity commences in October, which will see further recovery in subsequent months and an improved forecast year performance at 76% by March 2026.	**3 Partial**	Longer waiting times for diagnosis and treatment have a detrimental effect on patients, as well as delay in achieving the diagnostic 6-week DM01 compliance standards.	Given the national recruitment challenges, a SNEE ICB diagnostic strategy is currently being developed. DEXA are working through the back log as planned with increased activity 5 days a week Ultrasound plans to clear the majority of the back log by the end of the financial year. This will mean less use of temporary staffing and insourcing going forward, using a pipeline of the Trust's own trainees. The proposed solution for endoscopy is CDC expansion, if the business case for this is approved. Longer term there may be technological advances, offering further solutions for some services.	3 Escalate to Board

Finance Accountability Committee	**Month 8 Reporting** At month eight the Trust is reporting a £1.0m year to date(YTD) underspend against the plan. There is a YTD deficit of £16.3m, compared to the planned deficit of £17.3m. We continue to forecast meeting our planned deficit of £20.7m for 25/26. The CIP plan is currently on plan at £17.7m YTD. CIP targets in the second part of the year remain challenging. Year to date capital spend at month 8 is £10.3m. This is behind the phased plan, bit it is anticipated that the plan for 2025/26 will be achieved, subject to final PDC funding agreements being in place. The Trust has been successful in its application for £14m of cash support in quarter 3 and has applied for a further £6m of cash support in quarter 4, which is in line with our plan.	**2 Reasonable**	It is positive to see the monthly run rate reducing ahead of plan as this will help the position going into 2025/26. The CIP programme monthly targets ramp-up significantly through the rest of the year and remains a risk.	Delivery of the CIP programme needs continued focus – see below	3.Escalate to Board

| Cost Improvement Programme (CIP) delivery | At Month 8, the Trust has delivered £17.7m of CIP against a budgeted plan of £17.7m.

It has identified £28.9m/£28.1m of unweighted/weighted CIP opportunities respectively against a full year target of £32.8m. This compares to £29.4m/£27.0m of unweighted/weighted CIP opportunities respectively, reported at last month's Insight.

A gap of £3.8m/£4.7m remains when considering the unweighted/weighted CIP position respectively. | **3 Partial** | There are several high value schemes progressing through the change control process, which will lead to a fluctuation in some figures and not all will achieve their original targets. Those with significant risk of delivery continue to be corporate services and clinical productivity.

The CIP programme only captures formal schemes not all financial changes. There will be other fortuitous savings which will help bridge the 2025/26 deficit.

The Quality Impact Assessment panel continues to take a critical look at proposed schemes and not all are approved if there are risks to patient safety. | The Business Planning process will help identify ideas for 2026/27, as well as exploring the full year effect of 2025/26 schemes. See report on CIP Plans for 2026/27 below | 3 Escalate to Board |

PA Consulting Deep Dive	The Trust commissioned PA consulting to support CIP delivery for 25/26. Given the scale of the CIP challenge facing the Trust at the time and the level of grip and pace required, the Board agreed that substantial temporary resources would be required to assure Board of delivery. The purpose of the deep dive was to review the effectiveness of the contract with PA Consulting in delivering the outcomes required and to establish what learning had been built into the Trust's future approach to managing CIP.	**1 Substantial**	The management of the contract was broadly successful, given the value of schemes delivered with PA support, the flexibility of the arrangement, and the incentivisation of work on priority areas. The outcomes delivered varied by work stream and by necessity evolved through the contract period. Significant learning has been captured which is directly feeding-in to planning for the 26/27 CIP programme.	Learning from the contract has fed into the plans for 26/27CIP delivery (see below) The Trust will continue to develop internal skills and capacity and address identified gaps in capability Regular updates will be provided to the Finance and Performance Committee on the 26/27 CIP approach.	3 Escalate to Board for information

CIP Planning 2026/27	The Committee considered a paper setting out the proposed approach to CIP delivery in 26/27.	**2 Reasonable**	While the Trust's approach has matured, there are opportunities to empower staff further, ensure decisions are data driven, and to clarify strategy. Given the considerable cost reductions made in 25/26, the strategy to delivering CIP will now shift more to enhancing productivity.	The Trust will identify the key opportunities for 26/27 through analysis of key information sources (e.g. NHS benchmarking), early engagement workshops with colleagues, and sharing best practice	3 Escalate to Board
	The report outlined the proposed programme management arrangements to deliver a sustainable approach to CIP delivery which will deliver of the Trust's full 26/27 CIP target by March 2027. The programme will also seek to deliver the effective management of risks to service quality and maximise alignment between organisational priorities; and support the shift to a more empowered culture.		The proposed approach has been informed by the learning from previous years. This gave the committee assurance that the Trust would start 2026/27 on a good footing, not withstanding the fact that there will be challenging targets to deliver.	Targets will be developed in December as part of the Medium-Term Planning Process. This will be supported by an action plan and roadmap which will highlight the clear interdependencies with related activities. It will also set out the key implementation milestones.	
	The Trust's approach to CIP has improved significantly in the last two years, but opportunities remain to enhance the approach.				

| Emergency Preparedness, Resilience and Response (EPPR) | NHS England (NHSE) requires the Trust to participate in the annual Emergency Preparedness, Resilience and Response (EPRR) assurance process, which is undertaken by a self-assessment against a set of national core standards. This is how NHSE obtains assurance that NHS funded organisations are sufficiently capable to respond to business as usual, business continuity, critical and major incidents.

In 2024, WSFT was assessed as 'Partially Compliant' having reached 80.65% against the standards, with 12 core standards where the Trust were not fully compliant. An action plan against all areas of non-compliance was delivered, with a particular focus on core standards relating to decontamination capability, mass casualty incident plans and business continuity management. | 1.Substantial | The approach taken in the action planning process involved a significant change in approach and simplification of key processes with the needs of the end user in mind. (For example, Business continuity plans were reduced from 166 documents to 20). It is a good case study in stepping back from how things have always been done and reimagining how they could be done differently.

As a result of the work undertaken through the action plan the Trust could demonstrate improvement to 'Substantially Compliant' in 60 out of 62 standards (96.78%). This was accepted and confirmed by Suffolk & North East Essex Integrated Care Board (SNEE ICB) who undertook an assurance visit. | There are action plans in place to achieve fully compliance on the outstanding two standards. | 3. Escalate to Board |

<u>**Guidance notes**</u>

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

Assurance level

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

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			Date of meeting: 21 January 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	**Cancer Targets** 28-day Faster Diagnosis Standard (FDS) performance increased slightly from 74.1% in September to 74.8% in October whereas 62-day performance decreased slightly from 84.9% in September to 84.1% in October. Overall improvements to Cancer performance have resulted in the Trust being moved out of Tiering completely.	**2 Reasonable**	Underperformance was mostly related to the Beast pathway where vacancies and sickness contributed to performance of 68% for FDS. Whilst challenges remain the Board can take some assurance from the Trust's removal from the Tiering process for Cancer performance	The Cancer Alliance is leading an external review of the breast service. A review of urology pathways is also underway. An additional cancer session is being run in Endoscopy to improve FDS performance.	1 no escalation

| PAGG/IQPR | **Elective Recovery**

The total waiting list and RTT 18-week compliance remained relatively stable from October to November.

At the end of November 2025 there were 55 patients over 65 weeks, a further reduction from 72 in October. This volume was expected to continue to reduce over the coming weeks but the Trust did not achieve the target of 0 by the end of December.

The volume of 52 week waits reduced in November to 2.4% of the total waiting list which was behind plan (target 1% by March 2026). The ambitious trajectory set between October and November will need to be recovered in Quarter 4. | **2 Reasonable** | There is a risk of patient harm if patients are not treated in a timely way.

Significant efforts in this area are beginning to show sustained improvement. WSFT has increased capped theatre utilisation but needs to catch up on waiting list validation.

Given the Trust's improved performance in relation to elective recovery, we have been moved from Tier 1 into Tier 2 in the national support system. | Three NHSE funded sprints are underway looking at Waiting list Validation, Outpatients and 52 week waits.

The endoscopy business plan assumes expansion at Newmarket CDC which has yet to be approved and is part of a national programme which sits with the ICB. If it is approved, this will not be built until 2028 at the earliest and there is a need to look at whether there are other structural issues within the service that need addressing e.g the approach to job planning. | 2 Escalate to MEG |

PAGG/IQPR	**Diagnostics** November DM01 performance further improved, from 51.5% to 56.7% with significant reductions in the ultrasound waiting list leading to improvements in overall performance, as ultrasound is a high volume modality.	**3 Partial**	Longer waiting times for diagnosis and treatment have a detrimental effect on patients, as well as delay in achieving the diagnostic 6-week DM01 compliance standards.		2 Escalate to MEG

| Urgent and Emergency Care Deep Dive | Despite a picture of increased attendances, the Trust has met or exceeded UEC performance trajectories on 4 hour and 12 hour waits for 6 out of the last 9 months.

WSFT continues to perform well in relation to achievement of ambulance metrics. Average hospital ambulance handover times are significantly below plan and continue a trend of year-on-year improvement.

For 2026/27 NHSE are moving away from block contracts and re-establishing a blended model of payment with a link to activity levels. Providers will receive a fixed payment, reflecting the expected UEC demand, to cover fixed costs. An activity-linked variable adjustment is applied if actual activity differs from plan. | 3 Partial | Not meeting urgent and emergency standards means some patients are waiting longer in the Emergency Department than they should be.

Achieving sustainability in performance improvement remains a key objective.

If UEC activity falls below the planned level, provider fixed payments will be reduced by 20% of the value of the activity below plan. Similarly, if UEC activity is above plan, acute provider fixed payments will be increased by 20% of the value of activity above plan. It is therefore crucial that UEC demand is planned appropriately. | Trajectories for 2026/27 have been set collaboration with stakeholders of UEC performance. These are stretching but are perceived to be achievable and are underpinned by detailed improvement plans.

Performance will be monitored via the UEC Delivery Group reporting into the West Suffolk Alliance Operational Group (WSAOG), the WSFT Productivity Programme Board, Finance & Performance Committee and Divisional PRM's.

The Trust is currently working with the ICB to confirm baseline activity levels. | 3. Escalate to Board for information |

Finance Accountability Committee	**Month 9 Reporting** At month 9 the Trust is reporting a £0.8m year to date (YTD) underspend against the plan. This is a YTD deficit of £16.5m, compared to the planned deficit of £17.3m. The M9 position includes recognition of income that was previously deferred, and this has driven an in-month deficit of only £203k. The CIP plan is currently on plan at £21.4m YTD. Year to date capital spend at month 9 is £13.3m. This is behind the phased plan, but after a detailed review of forecast spend it is anticipated that the plan for 2025/26 will be achieved, subject to final PDC funding agreements being in place.	**2 Reasonable**	The Trust is forecasting to achieve its planned deficit for the year. However, the underlying position is important in planning for 2026/27, and in December the underlying deficit has remained at £1.54m. There is a risk that some schemes funded by PDC will not be delivered due to the delay in receiving the funding from NHS England and DHSC. PDC funding will be returned where schemes are not delivered.	Delivery of the CIP programme needs continued focus – see below	3.Escalate to Board

| Cost Improvement Programme (CIP) delivery | The Trust has identified £29.9m/£29.3m of unweighted/weighted CIP opportunities respectively against a full year target of £32.8m.

As at M9, the Trust reported delivery of £21.4m of CIP against a budgeted plan of £21.4m. Work continues to ensure that all CIPs are accurately classified and reported against in delivery initiatives

A gap of £2.8m/£3.4m remains when considering the unweighted/weighted CIP position respectively. | **3 Partial** | Those schemes with significant risk of delivery continue to be corporate services and clinical productivity.

The CIP programme only captures formal schemes, not all financial changes. There will be other fortuitous savings which will help bridge the 2025/26 deficit.

The Quality Impact Assessment panel continues to take a critical look at proposed schemes and not all are approved if there are risks to patient safety. | The Business Planning process will help identify ideas for 2026/27, as well as exploring the full year effect of 2025/26 schemes. | 3 Escalate to Board |

Guidance notes

The practice of scrutiny and assurance

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

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

Assurance level

1. Substantial	*Taking account of the issues identified, the board can take substantial assurance that this issue/risk is being controlled effectively.* *There is substantial confidence that any improvement actions will be delivered.*
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Board assurance committee - Committee Key Issues (CKI) report

NHS West Suffolk NHS Foundation Trust

Originating Committee: Insight Committee			Date of meeting: 18 February 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	**Cancer Targets** For cancer, 28-day Faster Diagnosis Standard (FDS) performance continues to be challenged. The most significant area of underperformance is Breast. Whilst the position mostly recovered in July and August, FDS performance has dropped since with November to 56%. 62-day performance continues to be strong with 86.4% performance in November 2025.	**3 Partial**	Sickness is impacting the ability to recover the position in the Breast Pathway.	The Cancer Alliance is leading an external review of the breast service. A review of urology pathways is also underway. Sprints funded by NHSE include cancer FDS performance and the breast pathway and will take place in Q4	1 no escalation

Originating Committee: Insight Committee			Date of meeting: 18 February 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	**Elective Recovery** In December RTT compliance exceeded trajectory at 62.88%, with the percentage of patients receiving a first appointment within 18 weeks improving to 74.5%, which is the highest compliance in the region (excluding a specialist provider). The current total waiting list size at the end of December was 32542, a small reduction from November 2025. Long waits continue to reduce - 33 patients over 65 weeks and 761 over 52 weeks.	**2 Reasonable**	There is a risk of patient harm if patients are not treated in a timely way. Whilst long waits are reducing, the deadline to clear 65 week waits was missed– daily scrutiny will be required to eliminate these by the end of February with the largest cohorts in Orthopaedics (8) and Plastics (7).	Three NHSE funded sprints are underway looking at Waiting list Validation, Outpatients and 52 week waits.	1 Escalate to MEG

Originating Committee: Insight Committee			Date of meeting: 18 February 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	**Diagnostics** December diagnostic DM01 performance further improved, from 56.7% to 59.3% with further reductions in the ultrasound waiting list leading to improvements in overall performance, as ultrasound is a high-volume modality. As a result, the year end forecast position has been lifted to 82%, doubling performance from August.	**3 Partial**	Longer waiting times for diagnosis and treatment have a detrimental effect on patients, as well as delay in achieving the diagnostic 6-week DM01 compliance standards.	Additional ultrasound activity will support a reduction in diagnostic waiting times, whilst substantive recruitment takes place. Further work, including additional activity, is required on endoscopy waiting times to contribute to overall diagnostic waiting times recovery.	3 Escalate to MEG

Originating Committee: Insight Committee			Date of meeting: 18 February 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	**Urgent and Emergency Care** 4-hour performance exceeded the in-month trajectory of 69% in December, achieving 70.63%. No significant change was demonstrated for ambulance handovers within 30 minutes, achieving 81.7% on a target of 95%. There was an increase in the number of 12-hour length of stay breaches from 464 in November to 619 in December. As a percentage of attendances this was 7.8% against a monthly trajectory of 6%.	**3 Partial**	Not meeting urgent and emergency standards means some patients are waiting longer in the Emergency Department than they should be and being nursed in escalation areas which makes for a poor patient experience.	The Urgent and Emergency Care Delivery Group has rationalised its focus to increasing timely discharges and maximising alternative non-admitted pathways, with additional "sprint" actions planned for March.	1 No escalation

Originating Committee: Insight Committee			Date of meeting: 18 February 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
Finance Accountability Committee	**Month 9 Reporting** The Trust has agreed a forecast deficit budget of £17.8m for the year. Income and Expenditure (I&E) for month ten shows a year-to date deficit of £14.8m, compared to the planned deficit of £18m giving an underspend of £3.2m against plan. The cash balance at 31 January 2026 was £8.2m compared to a plan of £1.1m. Cash is higher than plan due to the timing of a creditors payment run. The balance also includes cash that is earmarked specifically for spend on capital projects. The Trust will receive further cash support of £2m in February. An application for a further £4m has been submitted for March. Year to date capital spend at M10 is £15.7m. The forecast plan is expected to be achieved	**2 Reasonable**	The month ten position includes £0.9m in income from industrial action (exceeding related costs) and £2m in Revenue Incentive Funding from the ICB, resulting in an in-month surplus of £1.7m. The cash support funding received is in line with the Trust's plan The Trust is currently forecasting to be £2.9m ahead of the planned deficit for the year, by year end. The underlying position is important in planning for 2026/27. In M10 the underlying deficit has marginally improved to £1.48m. from the previous month's £1.54m.	Delivery of the CIP programme needs continued focus – see below	3.Escalate to Board for information

Originating Committee: Insight Committee			Date of meeting: 18 February 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
Cost Improvement Programme (CIP) delivery	The Trust's CIP schemes aimed to deliver £32.8m for the year. The year-to-date target in M10 was £25.2m, and this was achieved. A gap of £1.8m/£2.1m remains when considering the unweighted/weighted CIP position respectively.	3 Partial	Those schemes with significant risk of delivery continue to be corporate services and clinical productivity. The CIP programme only captures formal schemes, not all financial changes. There will be other fortuitous savings which will help bridge the 2025/26 deficit. The Quality Impact Assessment panel continues to take a critical look at proposed schemes and not all are approved if there are risks to patient safety.	Work to de-risk future CIP continues, with vacancy and non-pay controls remaining in place The Business Planning process will help identify ideas for 2026/27, as well as exploring the full year effect of 2025/26 schemes.	3 Escalate to Board for information

**Guidance notes**

**The practice of scrutiny and assurance**

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

Assurance level

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

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight

Meeting date: 19 November 2025

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 routine discussions concerning Financial and Operational performance.
- Deep dives into the Virtual Ward and Diagnostic Recovery
- The BAF discussions included a detailed report on Estates issues

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

- The order of papers on the agenda had been changed; ie matters often discussed towards the end of the meeting were earlier on the agenda which increased focus on these areas.

- Good time-keeping, which was especially important as a late paper had been added to the agenda

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.

- Overall the Committee was assured that the plan to embed the Virtual Ward into the routine work culture would ensure it will be working at full capacity in time. It must become part of the business norm. Currently the Stroke and Community teams make good use of the Ward but other areas less so. This is consistent across the wider NHS.

- The CDC is not working to full capacity as the recruitment, pay and some out-dated grading challenges continue. However, the deep dive gave partial reassurance that this would improve with the up-skilling of current staff.

- Higher level of assurance now than 12 months ago, concerning financial management and sustainability of the Trust. Whilst some challenges continue, better training of budget holders and managers is improving the performance of the organisation

Governor observer Notes

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

- On this occasion the Chair did not ask one individual to review the meeting but asked for the collective thoughts of all attendees.

- Throughout the meeting the Chair regularly asked colleagues for their thoughts and opinions on the subjects discussed and for their confidence on the levels of progress and assurance around all agenda items

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 19 November 2025
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 the meeting finished early due to the new way of running the meeting by the Chair.   - By adopting the principle of the papers being already read by the attendees provided more time for questions. This was a far better way of conducting the meeting than the Lead taking the committee through the cover sheet and then moving onto the detailed paper.   - Excellent papers
Meeting conduct
Any issues to highlight in terms of how the meeting was conducted or behaviours
Some of the discussions were difficult to hear.   *The meeting ran very well with the Chairs new way of running the meeting.*
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 the chair.

Governor observer Notes

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

- *Questions asked about Estates budget underspend and what will happen if it is not spent.*

- *Detailed discussions on the Virtual Ward and how it will operate in the future.*

- *Discussions on CDC covering areas of concern which will require action by the operational leads.*

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 17 December 2025
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.   - By adopting the principle of the papers being already read by the attendees provided more time for questions. This was a far better way of conducting the meeting than the Lead taking the committee through the cover sheet and then moving onto the detailed paper.   - Excellent papers, easy to follow and understand any issues.

Meeting conduct
Any issues to highlight in terms of how the meeting was conducted or behaviours
Some of the discussions were difficult to hear, are there microphones in the meeting room.   *The meeting ran very well continuing to use a format of papers assumed to be read and then questions rather than wasting time reading points from the paper before discussions.*

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 the chair.

Governor observer Notes

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

- *Questions asked about Finance and the expected any of year results.*
- *CIP – gap in closing and ideas for the next financial year are coming are discussed.*
- *IPQR – improving in all areas*
- *PA Consulting – detailed discussions on how the contract worked, lessons learnt and ways of working in the future.*
- *Plans for 2026/27 submitted and how NEDs could help supporting the plan.*
- *EPRR – improved over last year, assurances required every year.*

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 21 January 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

- New agenda format works well and paper were available for review.
- By adopting the principle of the papers being already read by the attendees provided more time for questions. This was a far better way of conducting the meeting than the Lead taking the committee through the cover sheet and then moving onto the detailed paper.
- Papers were good, easy to follow and understand any issues and concerns.

Meeting conduct
Any issues to highlight in terms of how the meeting was conducted or behaviours

- *Some of the discussions were difficult to hear, are there microphones in the meeting room.*
- *The meeting ran very well continuing to use a format of papers assumed to be read.*

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 the chair.*

Governor observer Notes

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

- *Questions asked about Finance and the expected any of year results which look to be on target.*
- *Capital - spend is in line with for the current year budget but is under review to ensure no funding is not reduced. This includes funding for the new hospital.*
- *CIP – gap in closing and proposals for the next financial year are coming forward for review and to greet if they should go ahead.*
- *IPQR – improving in all areas*
- *Deep Dive - for this year to be agreed and list will be reviewed at the next meeting.*
- *Plans for 2026/27 – have been submitted and agree ment on how NEDs can help in the future.*

Feedback from assurance committees: Governor observer report

Board assurance committee: Finance and Performance
Meeting date: Jan 21st 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*
- Deep dive into Urgent and Emergency Care Performance presented.   - The name of this meeting has changed from Insight Committee to Finance and Performance Committee, not sure why.
Meeting conduct   *Any issues to highlight in terms of how the meeting was conducted or behaviours*
- Chair welcomed guests to the meeting and introductions were made. A committee member was attending via Teams but it was difficult to make out everything he said as the sound was distorted.   - Five NEDs present   - General reflection, month 9 financial report demonstrates financial control. Comments on the high standard of reports, answers to possible questions were covered in the reports.   - Meeting finished early. The conduct of the meeting was as always in line with Trust values. Constructive feedback given to a guest presenter.
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.*
- Data shows progress in the reduction of patients waiting 65 weeks for treatment   - Elective and diagnostics de-escalated from tier 1 and no tiering for cancer

Notes
Data presented in the deep dive into UEC showed increased (double) ED attendance over the last 4 years It concentrated on ambulance handover, 4 and 12 hour metrics. Actions to achieve/improve performance were outlined. The experience and numbers of patients waiting in escalation areas of ED was not captured. How many patients were either on "fit to sit" chairs or in corridor beds and for how long? If patients were not seen within 4 hours how long were they waiting? I felt that the qualitative aspect of UEC was not covered or captured. Quality Impact Assessment (QIA) panel outcome paper was once again lacking in any description of the schemes listed, therefore it was not possible to deduce what the scheme was that was approved, or not, by the panel.

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 18 February 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 papers were available for review
- Excellent papers, easy to follow and understand any issues

Meeting conduct
Any issues to highlight in terms of how the meeting was conducted or behaviours

- *It was easier to hear, possible due to fewer attendees and the video screen not being used*

- *The meeting ran very well continuing to use a format of papers easy to read and then questions ms challenges in a respectful manner*

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, it finished earlier than planned.*

- *All agenda items were discussed and challenged as required*

Governor observer Notes

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

- *Questions asked about Finance and the expected any of year results which look to be better than target result for 2025/26*

- *Capital - spend is in line with for the current year budget but is under review to ensure no funding is retained. This includes funding for the new hospital.*

- *CIP – gap in closing and proposals for the next financial year are coming forward for review and to greet if they should go ahead*

- *IPQR – improving in all areas but needs to include Finance and detailed reports made available*

- *Deep Dives to be agreed for the rest of the year*

- *Plans for 2026/27 – have been submitted and agree ment on how NEDs can help in the future*

- *There is a potential issue with the admission of private patients and how beds would be made available ensuring NHS patients are not penalised. This needs to be discussed urgently and these discussions need to involve the Governors at some point*

Feedback from assurance committees: Governor observer report

Board assurance committee: Finance and Performance
Meeting date: Feb 18th 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*
• Updated agenda format makes clear the category in which various papers sit
Meeting conduct   *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• General reflection on meeting rather than volunteer   • Thoughtful chairing, all made welcome, introductions as appropriate
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.*
• Hope to not have any patients waiting over 52 weeks for procedures by end March   • One of top 5 of most improved trusts for emergency care   • US recovery on track   • Finance on track – Governors will need assurances that planned increase in private patient activity will not negatively impact NHS patients, there are Gov rules to follow for NHS Trusts

Notes
Changes to IQPR, work in progress, change to narrative, and finance to be included – positive reflection on this Budget holders to receive training! Administrative and Corporate services are undergoing "transformation" plus "new ways of working" lots of CIP information presented with work commenced on plans for 26/27

Feedback from assurance committees: Governor observer report

Board assurance committee: Finance and Performance (formerly Insight)

Meeting date: 18 February 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 routine discussions concerning Financial and Operational performance. • The IQPR discussion included information on the NHS Cancer Plan, launched on 4 February 2026. It outlines the ambitions and commitments required to deliver improved waiting, diagnosis and treatment for cancer patients • The new style IQPR was presented and discussed • The BAF discussions focussed on the risks associated with Trust capacity to deliver 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 probing questions in order to facilitate good understanding of the subjects discussed • 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.

- The Committee had partial assurance with regard to the delivery risks detailed in the BAF report as many factors are beyond the direct control of the Trust.

- There have been successful bids for additional funding (known as 'Sprint' funds) to support elective orthopaedic work, for breast cancer treatment and for community paediatric services, therefore, some assurance gained to reduce waiting times and treatments.

- Workforce challenges continue. Up-skilling staff, in particular for ultrasound and breast cancer, is ongoing but training is not always available locally with some staff having to travel further afield; eg London and Manchester

- Continued increased level of assurance concerning financial management and sustainability of the Trust. Whilst some challenges continue, the processes around better training of newly promoted individuals in their budget management responsibilities will improve the performance of the organisation

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

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 (formerly known as the Improvement Committee)			Date of meeting: 19 November 2025		
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
7.1	An analysis of this data shows a spike in our SHMI for the reporting periods of March 25 and April 25. This has been identified as a result of an issue with coding.	3.	Uncoded episodes are not identified as such and instead are placed in the SHMI sub-group 'Invalid primary diagnosis'. As a result of this a significant group of patients who have died have had their deaths placed into this category and this has adversely affected our overall SHMI as this is counted in just the same way as clinical diagnosis groups. As SHMI is reported in arrears we will continue to see an upward trend until the coding issue is resolved. There is now a "flag" on our data nationally and of note there are now many other Trusts with the same flag which was not the case when we had a coding issue previously.	Ongoing monitoring of mortality data through LFD group to identify any evidence of increased observed v expected deaths.	1. No escalation

Originating Committee: Quality & Patient Safety Committee (formerly known as the Improvement Committee)			Date of meeting: 19 November 2025		
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
			There is a risk with uncoded deaths that we could miss an increase in deaths from other causes. However, the LFD group monitors all causes of death on a monthly basis, including age and location and it is reassuring that there has been no change in what we expect to observe and what has been recorded during the period with the coding anomalies.		
7.1	The consistency of reporting from the sub groups at PQASG is variable with many leads focussed on delivering operational and performance metrics rather than quality data. This was evidenced in the Dementia, delirium and frailty report to PQASG and acts as the catalyst for review.	2.	The chair and deputy chair of PQASG, realise the potential for change and are working through a process of supportive conversations with speciality leads to reshape the the narrative and subsequent data reported and discussed at PQASG. This will take place over Q4 due to the reporting structure of PQASG.	By April 2026 there will be refreshed templates for speciality leads to complete which easily identify quality data, to include clinical audit and trends for assurance and opportunities for improvement. There will also be a heighten awareness of risk.	1. No escalation

Originating Committee: Quality & Patient Safety Committee (formerly known as the Improvement Committee)			Date of meeting: 19 November 2025		
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
9	Update paper received on WSFT's risk register and risk assessment process. Describing work underway to articulate the Trust's top rated risks for further review and alignment with the Board Assurance Framework. There are currently 144 open risks across the Clinical Divisions and 13 for the notional Corporate Division. 15 risks in total are rated as red risks, the scores are being reviewed as only 1 has a risk assessment in place which enables mitigations to be captured and check and challenge provided. Only 24 risk assessments exist for all 144 entries on the risk register.	4.	Part of the CQC well led inspection is to be able to demonstrate that the Trust has clear processes, robust data and suitable information systems to effectively identify, manage, escalate and sustainably mitigate current and future risks.	By January 26:- *1. All top red risks reviewed to ensure they are scored properly;* *2 Ensure mitigation through risk assessments for all red risks is in place;* *3 Establish an exec risk oversight group;* *4 Start to answer the question 'what are our top risks?'* *5. Develop plan for reviewing amber and green rated risks with Divisions.*	2 Escalation to SLT

Originating Committee: Quality & Patient Safety Committee (formerly known as the Improvement Committee)			Date of meeting: 19 November 2025			
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
	Issues also highlighted regarding uptake of risk training.					

See guidance notes for more detail

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

1. Substantial	Taking account of the issues identified, the board can take substantial assurance that this issue/risk is being controlled effectively.

There is substantial confidence that any improvement actions will be delivered. |
| 2. Reasonable | Taking account of the issues identified, the board can take reasonable assurance that this issue/risk is being controlled effectively.

Improvement action has been identified and there is reasonable confidence in delivery. |
| 3. Partial | Taking account of the issues identified, the board can take partial assurance that this issue/risk is being controlled effectively.

Further improvement action is needed to strengthen the control environment and/or further evidence to provide confidence in delivery. |
| 4. Minimal | Taking account of the issues identified, the board can take minimal assurance that this issue/risk is being controlled effectively.

Urgent action is needed to strengthen the control environment and ensure confidence in delivery. |

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Quality & Patient Safety Committee (formerly known as the Improvement Committee)			Date of meeting: 17 December 2025		
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
6.1	Lack of confidence in addressing gaps in legal compliance and safeguarding assurance under the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), especially in community settings, uncertainty whether or not these concerns also apply to inpatient care.	3	Risk of failure to comply with safeguarding regulations	DS / SW To bring a detailed update in March 2026, including process, compliance, and audit findings	1
6.2	Concern was expressed that the Clinical Effectiveness Governance Group (CEGG) is struggling to gain traction on its core responsibilities, with many objectives still marked as 'in development' or 'requiring further progress.'	3	Risk of ineffective clinical effectiveness function	To arrange a meeting in January with key stakeholders (Dr Richard Goodwin, Dan Spooner, Nicola Cottington, Paul Bunn, Dr Paul Zollinger-Read) to agree improvements and clarify responsibilities.	1

Originating Committee: Quality & Patient Safety Committee (formerly known as the Improvement Committee)			Date of meeting: 17 December 2025		
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:		
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See guidance notes for more detail

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

Originating Committee: Quality & Patient Safety Committee (formerly known as the Improvement Committee)			Date of meeting: 21 January 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:		
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5.2	Two issues recognised as quality priorities by the Medication Safety Group: • **Security of medicines at the bedside**: Concerns about broken or inadequate lockers used for storing patient medications. • **Critical medications – missed or delayed doses**: Focus on reducing incidents of missed or delayed administration of essential drugs.	3	Immediate mitigation is needed to ensure safe practice while awaiting locker replacements. • Review current practice on wards where lockers are broken. • Ensure medicines are stored safely in line with policy. • Explore how to measure and report on this risk effectively to understand the scale of the issue – may require some replacement.	Nicola Cottington to scope out extent of broken / inadequate lockers and appropriate action to replace/fix them. Report back in February 2026. Dan Spooner to review with ward managers the process for bedside storage.	1. No escalation
7.1	Current clinical effectiveness processes unable to provide assurance on Implementation of	4	Clinical effectiveness function is no longer able to provide assurance on compliance against mandated external	Dr Richard Goodwin to work with divisions on restoring an effective clinical effectiveness function.	1. No escalation

Originating Committee: Quality & Patient Safety Committee (formerly known as the Improvement Committee)			Date of meeting: 21 January 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:		
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	National audits and NICE guidance		audits, National guidance and NICE guidance ; there is limited engagement from clinical divisions.	Reporting back to Committee in April 2026.	
7.2	Failure of transfer of care processes to achieve target levels of completion	3	Limited improvement in transfer of care documentation following implementation of digital solution; failure to achieve this risks poor communication to Primary and community care re patient management.	Dr Richard Goodwin to work through the clinical divisions and PRM process to ensure that transfer of care communication is implemented in line with guidance across all clinical disciplines. Compliance to be added to PRM assurance	1. No escalation

*See guidance notes for more detail

Guidance notes

The practice of scrutiny and assurance

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What next? Exploring what should be **done next** (or not), informing **future** tactic / strategy, agreeing follow-up and future **evidence of impact**		• Recommendations for action • What impact are we intending to have and how will we know we've achieved it? • How will we hold ourselves accountable?

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Feedback from assurance committees: Governor observer report

Board assurance committee: Quality &Patient Safety Committee (formerly known as the Improvement Committee)
Meeting date: 19th November 2025
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
- Care Accreditation Model   - PSQ Quarterly Report   - PSIRF in Response to Coroners Concerns   - Risk Register Report

Meeting conduct
Any issues to highlight in terms of how the meeting was conducted or behaviours
- Well Chaired meeting. Chair always has a good understanding of the papers and is not afraid to hold Execs to account.   - Good challenges by NED present.   - Good open discussions, engagement and focus.   - Clear actions and timelines sought.   - Reflections on the meeting gave indication that it was conducted in line with Trust Values, people were engaging, non-judgemental and respectful. Actions required were also reflected on.

Assurances

- Excellent presentation of the Care and Accreditation Plan. NED questioned the four-year time frame to roll this out and how this could possibly be reduced.

- Little assurance given on some of the topics raised in the PSQ report. Challenges by Chair and NED around learning outcomes and how the quality is measured.

- Risk register report highlights some worrying arears of concern with no assurance given. The Chair, NED and CEO both made many challenges, many items are flagged for better outcomes in January 2026, and these will all be re-visited.

Governor observer Notes

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

There was no report or update from the CEGG due to the cancellation of their meeting earlier in the month.

Feedback from assurance committees: Governor observer report

Board assurance committee: Quality &Patient Safety Committee (formerly known as the Improvement Committee)
Meeting date: 17th December 2025
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

- SHMI Data
- PSQ Group Report
- NCAA
- CEGG report

Meeting conduct
Any issues to highlight in terms of how the meeting was conducted or behaviours

- Well Chaired meeting.
- Many challenges not only by NED's but Exec's challenging and questioning each other.
- Engagement and focus leading to good open discussions within the committee
- Clear actions sought by the chair and many requests for timelines to be adhered to.
- Reflections on the meeting, giving a good summary of roles and deadlines.

Assurances
 • Partial re-assurance on SHMI data but further assurance required. Temporary staffing and national shortage of coders remains an issue. • Limited re-assurance on several topics covered in the PSQ group report, resource limitation, operational pressures and governance impact are often highlighted as being factors. • Progress is slow in providing assurance in the CEGG report. National Audits remain a problem. NICE clinical guidelines and completion of Gap analyses still in development. • No assurance on SDM training compliance

Governor observer Notes
Use this section to highlight any other areas for example good practice or 'even better if'
• As this was the last meeting of the year the chair gave thanks to the members for their continued support and to all staff for their hard work and effort during a very difficult year.

Feedback from assurance committees: Governor observer report

Board assurance committee Quality and Patient Safety
Meeting date: Jan 21st 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
This meeting was called the Improvement Committee and is now the Quality and Patient Safety Committee. Patient experience will now be captured by this Committee and not Involvement.

Meeting conduct
Any issues to highlight in terms of how the meeting was conducted or behaviours
- Chair was welcoming, very focused and clear in his direction and stated expectation of committee members with agreed timelines for reporting back on actions.   - No reflection by Committee, but good discussion and questioning.

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.
- Maternity – in response to a prevention of future death report, maternity services in England were asked to assure their Boards of the safety and governance of home births. The report and presentation to the Committee assured that maternity services could evidence safety and quality in the home birth service.   - Problems with Clinical Effectiveness Governance Group were outlined by its clinical Chair. Lack of assurance reported re clinical buy-in to the committee and to ensuring clinical guidelines and practice are updated in line with latest research and guidance eg NICE. Mandatory and other audits are not all being conducted.

- Completion of timely discharge summaries was discussed. It is mandated that these are provided within 24 hours of discharge by NHS contract in order to prevent patient harm. A new easy to use digital platform has been provided, however completion remains around 81 – 88%, further work required.

Notes

Risk register presented, still needs work, I wondered if other Governors should have sight of this? I wondered why some of the concerns discussed at the meeting such as late discharge summaries and CEGG concerns were not on the register.

10.3. People & Organisational Development Committee (previously Involvement)

To Note

Presented by Heather Hancock

COMMITTEE/SUBGROUPS REPORT

Originating Committee: Involvement Committee			Reporting to: Trust Board Meeting		
Chaired by: Tracy Dowling Non-executive Director			Date of meeting: 17th December 2025		
Agenda item	WHAT? *Summary of issue, including evaluation of the validity the data**	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	Escalation: 1. No escalation 2. To MEG / other assurance committee 3. To Board
6.0	Recent announcement affecting workforce 26/27 pay round – Unison letter	2.0 Reasonable	Julie Hull shared perspectives on the informative letter received from Unison	Concern regarding potential further staff dissatisfaction leading to industrial action regarding the 26-7 pay round	1. No escalation
7.0 7.1	**First for Staff** WRES and WDES Report	3.0 Partial	Areas for improvement highlighted in both reports; with focus specifically on opportunities for career progression in our global majority workforce, and improvement in declaration of disability status to enable meaningful action for staff with disabilities	Consider data regarding potential discrimination and division / department level to identify areas where support is required. Focus action plans on areas where we need to see change happen. Review learning from Sexual Safety work and see how we can impact on progress with race equality using similar methods	2. To MEG for continued focus through the organisation
7.2	Anti-racism	3. Partial	Update on progress since Oct 25 meeting in two priority areas; 1) Increasing visibility of our anti-racism commitment and 2) enhancing literacy and understanding of anti-racism across our organisation	Two written articles to be published, one re-affirming the Trust commitment and the other setting out what colleagues can do to become anti-racist. Communications plan to be developed for anti-racism campaign	2. To MEG for continued focus through the organisation

Originating Committee: Involvement Committee			Reporting to: Trust Board Meeting		
Chaired by: Tracy Dowling Non-executive Director			Date of meeting: 17th December 2025		
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7.3	Sexual Safety in the Workplace	2. Reasonable	Progress update since least reported April 25. Full communications plan implemented; development sessions being delivered; 67% actions achieved and 33% in progress	Self assessment against the Charter due Spring 2026. Workplan being updated to prioritise outstanding actions	1. No escalation
7.4	Update on Nursing Profiles Project	3 Partial	Significant Project to evaluate all nursing and midwifery posts against the new national job profiles – with refreshed and aligned job descriptions.	Project team established; detailed project plan in development with anticipated timescales of January – September 2026. Risks relate to impact on staff and finances if current roles undertaken do not reflect the bandings in the new profiles	1. No escalation
7.5	Annual Nurse Staffing Review	1. Substantial	Assurance received that adult inpatient establishments meet the Developing Workforce Standards (2018) and CQC regulatory compliance	Bi-annual review to be a regular item to this Committee. Arrangements in place for Emergency Department and Theatres staffing to be aligned / included in future reports.	1. No escalation
7.6	Bi-annual workforce reviews for the Maternity Incentive Scheme: • Midwifery • Obstetric	1. Substantial	Detailed reports received in relation Maternity Incentive Scheme Workforce. Compliance noted in all four areas.	Actions detailed to keep under review; particular focus on staff being able to attend multi-disciplinary training. Future neonatal standards for medical	2. Escalate to MEG consideration of future standards for neonatal medical workforce levels.

Originating Committee: Involvement Committee			Reporting to: Trust Board Meeting		
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	• Neonatal Medical Workforce • Anaesthetic staffing to maternity services			workforce are not met and will be considered as part of 2026-6 business planning	
7.7	Addressing staff engagement at WSFT	2. Reasonable	Update received on progress with gaining insight and progressing actions identified from the staff survey in 2024.	Continue implementation of 'Each Person'; review findings from 2025 staff survey; Managers training and support materials for launch early 2026	1. No escalation
8.0 8.1	**First for the Future** Trust workforce strategy and business plan	2.Reasonable	Julie Hull set out plans progressing development of the People, Culture and OD strategy aligned to the Trust strategy and 10 Yr Health Plan.	Progress developing the 2026-7 business plan for delivery of Year 1 of the People, Culture and OD Strategy is also in progress. Sign off of both documents expected March 2026	1. No escalation
8.2	Review of feeder groups and governance arrangements	2. Reasonable	Approval was given to streamline the four workforce groups that report to the People and Culture Committee to two.	Workforce Planning and Development Group to be established; Workforce wellbeing and Inclusion Group to be established. Review of the People	1. No escalation

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				and Culture Committee to be undertaken	
9.0 9.1	**First for Patients** Patient story – Martha's rule	1. Substantial	Julie Head presented an overview of the arrangements in place to implement Martha's rule with patient stories and data to illustrate how well this has been established	Continue to review data and patient / carer experience. Continue to share our learning to support other organisations with their implementation.	1. No escalation
9.2	Experience of care and engagement committee report	2. Reasonable	Report received shows good breadth of work to consider the experience of our patients to improve services. Reduced staffing levels as we reorganise to 'live within our means' has led to change in how activities are undertaken	Impact of staff changes and processes regarding PALS and complaints handling will remain under review.	1. No escalation
9.3	Inpatient CQC results and action plan	2. Reasonable	Report received regarding work undertaken in response to 2024 CQC inpatient survey results. Areas being addressed include noise at night; access to food outside of mealtimes and access to help with eating	Actions and escalations to be overseen by the Experience of Care and Engagement Committee	1. No escalation

Originating Committee: Involvement Committee			Reporting to: Trust Board Meeting		
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10	**Governance** Audit One Well led response update	3. Partial	Following a detailed review MEG now received monthly updates on actions with assurance that progress is being made.	Continue to be reviewed by MEG with 15 outstanding actions	1. No escalation
10.2	Staff Wellbeing BAF	3. Partial	The updated BAF was agreed with actions noted.	Continue to prioritise staff wellbeing as part of work to improve staff engagement at WSFT	1. No escalation
11.0	**Items for Information IQPR extract Professional standards framework for quality assurance and information**		Items for information received for information		

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Guidance notes

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COMMITTEE/SUBGROUPS REPORT

Originating Committee: Involvement Committee		Reporting to: Council of Governors Meeting		
Chaired by: Tracy Dowling Non-executive Director		**Date of meeting: 18th February 2026**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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3.0	Matters Arising	2.0 Reasonable	EDS for workforce completed WRES and WDES publications on Trust website	To be circulated to committee members for information	1. No escalation
4.0	Recent announcements affecting workforce	2.0 Reasonable	Julie Hull shared perspectives on the annual pay award of 3.3%, to be paid from April; anti-racism activities and the Band 5 nursing job profiles review	Concern regarding potential further staff dissatisfaction with the pay award Colleagues to be asked to update their staff profile as part of 'My Profile Counts'.	1. No escalation
5.1	Staff Story	2.0 Reasonable	Michelle Westcott shared her experience regarding reasonable adjustments following a life changing traumatic injury.	Follow up regarding documentation of reasonable adjustments so that they become part of the formal working arrangements for a staff member. Conformed that new policies are about supporting attendance – Bradford Score not part of policy now	1. No escalation
6.1	BAF and risk management update	3.0 Partial	Update from Paul Bunn regarding progress with the development of the use of the	Once work to thoroughly review the risk register, and to refine the BAF is complete a greater level of	1. No escalation

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			risk register through the organisation	assurance is expected. Work is progressing at a good pace.	
6.2	Staff Wellbeing BAF	2.0 Reasonable	Activities to support staff wellbeing are established in the BAF – however limitations with the current BAF structure and nature or assessing risk appetite and dynamic risk assessment were discussed	Planned BAF development will address the deficiencies of the current BAF structure and process	1. No escalation
6.3	Capability BAF	3.0 Partial	Many areas of positive assurance, however minimal assurance that we are aligning the capability and skills we will need for the New Hospital programme with current service transformation and workforce planning	Actions to address this identified risk are being developed. Suggested that service transformation also reports through the People and Organisation Development Committee in future to ensure this risk is actively managed.	2. To MEG for agreement of actions to address this risk
6.4	Resident Doctor 10 Point Plan	1.0 Substantial	Dr Roopa Balasundarum presented a report showing a high level of assurance (87%) against the 10 point plan.	Further actions in progress to improve further (additional vending machines for hot food at night). Consideration given to how self rostering might work for resident doctors.	1. No escalation

Originating Committee: Involvement Committee			Reporting to: Council of Governors Meeting		
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6.5	Guardian of Safe Working Report	2.0 Reasonable	Dr Roopa Balasundarum presented her first report at GOSW. Improvements seen in exception reporting and reductions in overtime claims. Issues remain in medicine division.	There is a need to ensure that the current regulations are fully understood all options reflected in the proposed business cases. Need DoF oversight.	2. To MEG as part of business planning
7.1	Disability Network Update	1.0 Substantial	Ceiridwen Walker updated on the development of the disability network which she has led for the last three years.	Succession planning in progress for new leadership of the network is in place; the need to provide clarity for staff to report disability status on My Profile was emphasised	1.0 No escalation
7.2	Mandatory Learning Update	3.0 Partial	Rachel Austin presented work underway to review statutory and mandatory training	Further update required in 6 months time as there I still much to complete to define what training is mandatory for which staff groups; and the most productive and effective way of delivering this training	1.0 No escalation
8.1	How we join up workforce planning now and for the future with the new hospital programme	4.0 Minimal	Michelle Warwick joined as Workforce lead for the New Hospital Programmme	The People and Organisational Development Committee agreed that there is an important work programme to link current workforce planning and service	1.0 No escalation

Originating Committee: Involvement Committee			Reporting to: Council of Governors Meeting		
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				transformation with planning for the New Hospital Programme	
8.2	Employment Rights Act	2.0 Reasonable	Laura Lynas, Union representative shared the joint work that staff side have undertaken with HR colleagues to prepare for the impact of the Employment Rights Act	Laura conformed that much work is complete, and the areas for further development are later elements of the Act with longer lead times. It was agreed that it is vital that line managers understand the Act and how this needs to be reflected in management practice.	1.0 No escalation
8.3	People Strategy	2.0 Reasonable	Julie Hull invited feedback on the People Strategy. This is developing well and should be ready for sign off by the end of March	Revise the strategy to: • Reduce duplication • Ensure reflects impact that frontline clinical staff can expect to experience • Reduce volume of priorities so focus is clear	2.0 MEG for final checks prior to Board for sign off
9.1	**Items for Information IQPR extract**		Items for information received for information		

See guidance notes for more detail

Guidance notes

The practice of scrutiny and assurance

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

Feedback from assurance committees: Governor observer report

Board assurance committee: Involvement Committee
Meeting date: 17 December 2025
Governor observer (observed by): Val Dutton

Agenda: scope and coverage
Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place
• The agenda items were in line with providing assurance to the Board on delivery of quality and safety which is inclusive and engaging of our staff, patients and stakeholders.
Meeting conduct
Any issues to highlight in terms of how the meeting was conducted or behaviours
• Despite it being a full meeting with a large attendance and agenda, everyone was included and opportunities were given for all those attending to participate in what were often in-depth discussions of the agenda items.   • All participants behaved in a respectful and polite manner.   • Everyone was included in the discussions and given time to speak.
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.
• Assurance was pained by in depth discussions and polite appropriate challenges for clarification of then information being provided.   • There was a pre-recorded patient presentation which everyone found interesting. It was followed by raised concerns and an in-depth discussion relating to the issues raised in the presentation.   • It was acknowledged there were some ongoing large projects and pieces of work being undertaken and implemented into the organisation and the committee, in its future title of People and Organization Committee.

Governor observer Notes
Use this section to highlight any other areas for example good practice or 'even better if'
• The meeting was very open and informative, covering some very large , important and on-going pieces of work.

Feedback from assurance committees: Governor observer report

Board assurance committee:
Finance & Performance (Insight)/Quality & Patient Safety (Improvement)/<mark>People & Organisational Development</mark> (Involvement)
Meeting date: 18ᵗʰ February 2026
 Governor observer (observed by): Becky Poynter

Agenda: scope and coverage
Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place
As always there was a packed agenda for this committee but an item which it appears all members value is hearing directly from staff. A member of the speech therapy team shared her experiences of coming to terms with her disability after surgery resulting in chronic pain and the adaptations required to enable her to return to work. Whilst there were many positives there were also several key learning points for the Trust to consider around communication of entitlement and support for staff having to make such adjustments. However, her feedback was taken seriously and with compassion from both the NEDs and Executive. There was no defensiveness and assurances that further discussion could take place to enable her experiences to positively impact organisational practice.
Meeting conduct
Any issues to highlight in terms of how the meeting was conducted or behaviours
These meetings are always conducted with respect and professionalism, but the length of the agendas does sometimes mean that discussion has to be curtailed to cover all the business.
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 papers provided for the meeting were as always detailed. Matters arising provided an opportunity to show progress against previous discussions and areas of concern raised by the committee. The executive were open about continuing challenges and also alerted the committee to the potential of future concerns some of which are beyond the Trust's control involving National issues. NEDs sought reassurance on planning for these changes and asked challenging questions around mitigating risk.

Governor observer Notes
• This was the last meeting with Tracy Dowling as Chair before she takes up her role as Chair of ESNEFT in March. She was an exceptional Chair; knowledgeable, considered and professional whilst keeping a sense of humour and perspective. It has been a privilege to watch her in action.

10.4. Digital & Data Assurance Committee

To Note

Board assurance committee - Committee Key Issues (CKI) report
Public (open) Trust board report

Originating Committee: Digital and data assurance committee			Date of meeting: 29 January 2026		
Chaired by: Alison Wigg			Lead Executive Director: Nicola Cottington		
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 for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
7.1	Delivering on our strategy: Digital strategy update	Substantial			
7.2	Future System Programme digital update	Reasonable			
7.3	Data and BI report	Partial	There is a huge demand for analytics and data insights across the trust. There are delays in fully realising the benefits of the new data warehouse, with some areas such as community data being behind schedule.	Need to establish key Business intelligence milestones to increase assurance	1. No escalation, for information
7.4	e-Care CSP upgrade	Reasonable			

Originating Committee: Digital and data assurance committee			Date of meeting: 29 January 2026		
Chaired by: Alison Wigg			Lead Executive Director: Nicola Cottington		
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 for action: 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
8.2	Information governance steering group report	Reasonable			
10.1	Role of the digital pharmacist	Substantial			
10.2	Digital maturity assessment – roadmap for improvements	Substantial			
10.3	Benefits tracking approach	Substantial			
10.4	DDAC forward plan	Reasonable			

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.

10.5. Audit Committee

To Note

Presented by Michael Parsons

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Audit Committee			Date of meeting: 16 December 2025		
Chaired by: Michael Parsons			**Lead Executive Director: Jonathan Rowell**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / MEG 3. Escalate to Board
Internal Audit (RSM)	Update on delivery of internal audit plan 2025/26 and implementation of recommendations.	Partial	Discussed the 3 reports issued since the last meeting: • **Medical devices**: minimal assurance • **Establishment control**: partial assurance • **Investment Panel**: substantial assurance The Committee welcomed the reported effectiveness of the Investment Panel, but was concerned about the risks identified in relation to medical devices. The importance of HR and Finance having a shared picture of the staffing establishment was stressed.	Executive to continue to address audit actions in a timely way; a long-outstanding action on payroll was identified for priority attention.	2. Relevant Assurance Committee to consider negative assurance reports on Medical devices (minimal) and Establishment control (partial). 2. MEG to continue to progress outstanding actions.

1

Counter Fraud (RSM)	Progress report and benchmarking.	Substantial	Continuing good engagement on counter fraud across WSFT. Benchmarking reports on **cyber assessment** and **single tender waivers** didn't raise any specific concerns.		1. No escalation required.
Risk Management	Deep dive into risk management processes	Reasonable	Welcomed the comprehensive review and analysis of current processes and the identification of improvement opportunities.	Will return to AC during 2026.	2. Executive Oversight Panel being established – will aid consistency of scoring and effective mitigations.
Charitable Funds	Approval of Year-End Annual Report & Accounts (ARA).	Substantial	Following approval by Charitable Finds Committee, AC approved CF ARA.		1. No escalation required.
Committee Effectiveness	Review of progress on previous actions.	Reasonable	Discussed progress on improvement actions previously identified.	Improvement plan for 2026 focus to be developed.	1. No escalation required.

See guidance notes for more detail

Guidance notes

The practice of scrutiny and assurance

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

3

Assurance level

| 1. Substantial | Taking account of the issues identified, the board can take substantial assurance that this issue/risk is being controlled effectively.

There is substantial confidence that any improvement actions will be delivered. |
| 2. Reasonable | Taking account of the issues identified, the board can take reasonable assurance that this issue/risk is being controlled effectively.

Improvement action has been identified and there is reasonable confidence in delivery. |
| 3. Partial | Taking account of the issues identified, the board can take partial assurance that this issue/risk is being controlled effectively.

Further improvement action is needed to strengthen the control environment and/or further evidence to provide confidence in delivery. |
| 4. Minimal | Taking account of the issues identified, the board can take minimal assurance that this issue/risk is being controlled effectively.

Urgent action is needed to strengthen the control environment and ensure confidence in delivery. |

4

11. Nominations Committee Report (enclosed)

To receive the 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: 05 March 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 14 January 2026 and 25 February 2026, which included the following:

- **NEDs Terms of Office** (for noting)
- **Non-executive Directors' and Chair appraisal process 2026** (for approval)
- **Nomination Committee forward planner** (for noting)
- **Reappointment of Non-Executive Director and University of Cambridge nominated NED** (for approval) - a recommendation to be considered by the Council in closed session.
- **Chair's Term of Office / Reappointment of Chair** (for approval) a recommendation to be considered by the Council in closed session

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 the annual appraisal of the Chair and NEDs; 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:
1. **Note** the report from the Nominations Committee
2. **Note** the actions assigned to the closed COG
3. **Approve** the appraisal process and timeframes proposed.

Governance and compliance

Previously considered by: Governors' Nominations committee (14 Jan and 25 Feb 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.

NOMINATIONS COMMITTEE

The Committee's agenda focussed on the following areas since we last met:

1. **NEDs Terms of Office** (for noting)

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

2. **Non-executive Directors' and Chair appraisal process 2026** (for approval)

The Nominations Committee oversees the approach and appraisal process for NEDs on behalf of the Council of Governors, supporting the Governors' responsibility to hold the Chair and NEDs to account.

In 2024, the Council adopted the new NHSE framework for Chair appraisals. The 2025 Chair's appraisal followed the same national process. A new appraisal framework for all Board members was introduced on 1 April 2025. This framework includes the Leadership Competency Framework (LCF), appraisal ratings, SMART objectives, and Fit and Proper Person Test requirements.

For 2026, Chair and NED appraisals will continue to follow the national approach, including self-assessment and discussion of the LCF. The Trust will also adopt national templates while retaining relevant bespoke elements from previous years, such as reflections on strengths, development areas, and participation in NED activities. The process will include:

- Use of the **board member appraisal summary template**
- Multi-source feedback using the **board member multisource assessment template,** that includes review against LCF domains
- Agreement of **SMART** objectives, including an **Equality, Diversity and Inclusion** (EDI) objective
- Assessment and declaration under the NHS England **FPPT** Framework

This approach ensures compliance with national expectations and consistency in standards while maintaining local relevance.

It is proposed to include all the NEDs (including Chair) in the appraisal process. NEDs whose tenure starts after the appraisal process has begun, or ends/leave the Trust before it commences, will be excluded from the 2026 appraisals cycle. A brief appraisal may be scheduled for new NEDs within 6 months of their start date.

As required by the new framework, the Chair's appraisal document will be submitted to the Regional Director via the senior appointments and assessment team (SAAT).

The appraisal process includes board, governor and for the chair, external observers. The process is described in more detail in **Annex A** but the key components include:

- Multi source appraisal forms circulated: March 2026
- Chair-NED and Chair-SID & Lead Governor appraisal meetings: May–June 2026
- Chair appraisal document submitted to the Regional Director: before 30 June 2026
- Reporting to Council of Governors: September 2026.

ACTION

The Council of Governors is asked to:
- Approve the proposed approach to Chair/NED appraisal and seek nominations from Governors to act as observers (appraisers) using the appraisal questionnaires

---

-	Note the timescale for the appraisal process (Annex A)

3. **Nomination Committee forward planner** (for noting)

The Committee noted the forward plan.

4. **Reappointment of Non-Executive Director/University of Cambridge NED** (for approval) – A recommendation to be considered by the Council in closed session.

5. **Chair's Term of Office / Reappointment of Chair** (for approval) – An additional meeting of the Nominations Committee took place on 25 February 2026 to consider the Chair's term of office and the available options regarding the Chair's appointment. A recommendation arising from this discussion will be presented to the Council for consideration in its closed session.

Annex A

Chair and NED appraisal process 2026

1. NEDs' appraisal process

In accordance with the Code of Governance 2022 Section C: there should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. *For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair.*

Proposal - Chair and Non-Executive Director appraisal process

(a) The proposed observer groups and numbers for Chair and NED appraisal are described in tables 1a and 1b respectively.

Table 1a - Chair - Observers

Stakeholder group	Feedback from
Non-Executive Directors	All NEDs **– Six**
Chair	Self-appraisal
Executive Directors	All EDs including Chief Executive **- Seven**
Governors	Lead Governor plus **four** Governors **- Five**
External Stakeholders	To be nominated by Chair **- Four**
Regional Director	**One**

Table 1b - NEDs - Observers

Stakeholder group	Feedback from
Non-Executive Directors	**Seven** NEDs, including Chair
Executive Directors	All EDs including Chief Executive **- Seven**
Governors	Governors **- Five**

(b) A group of at least five Governors who volunteer to participate in this process will be assigned as observers (appraisers) for the Chair and the NEDs.

(c) Feedback from the Chair's and NEDs' observer (appraiser) questionnaires will be summarised and reported at a meeting of the Nominations Committee. This will be used to identify areas for focus in the appraisal meetings for each individual. The purpose of this will be to identify themes and issues to be considered at the appraisal meetings.

(d) Appraisal for the Chair will be undertaken by the Lead Governor and Senior Independent Director.

(e) Appraisals of the NEDs will be undertaken by the Chair.

(f) An overall summary of the Chair's and NEDs' appraisal process will be reported to the Council of Governors meeting following completion.

Table 2: Proposed Chair and NED appraisal schedule 2026

Task	Action	Date
Volunteers to undertake appraisals to be identified at CoG meeting in March 2026	**Deputy Trust Secretary**	5 March 2026
Circulate forms to appraisers and appraisees for completion and return to FT Office	**FT Office**	mid-March 2026
Completed forms to be returned to FT Office	**FT Office**	mid April 2026
Forms to be analysed and summarised	**FT Office**	late April 2026
Senior independent director to meet with non-executive directors to appraise the Chair's performance	**FT Office**	late April to early May 2026 (prior to Nominations Committee meeting)
Nominations Committee meeting to discuss results of observer questionnaires and approve the identified themes/concerns	**Nominations Committee**	12 May 2026
Lead Governor and SID to undertake Chair's appraisal	**Lead Governor / SID / Chair**	early June 2026
Chair to undertake NEDs' appraisals	**Chair / NEDs**	late May to mid Jun 2026
Submission of Chair's appraisal to RD	**Deputy Trust Secretary**	end of June 2026
Report to CoG meeting	**Chair**	10 September 2026

12. Membership and Engagement Committee Report - no meeting since October 2025

To Note

13. Standards Committee Report (enclosed)

To receive a report from the Standards Committee

For Discussion

Presented by Jude Chin

COUNCIL OF GOVERNORS MEETING (OPEN)

Report information

Report title: Standards Committee report
Date of the meeting: 05 March 2026
Agenda item: 13
Sponsor/Executive lead: Jude Chin, Trust Chair
Report prepared by: Paul Bunn, Acting Trust Secretary, Pooja Sharma, Deputy Trust Secretary, Ruth Williamson, Senior Administrator
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 at the Standards Committee of the Council of Governors meeting held on 27 January 2026. The Committee focussed on the following key areas:

- Code of conduct and managing governor conduct and standards (for approval)
- Proposal to hold Staff Governor vacancy (for approval) - a recommendation to be considered by the Council for approval
- Fit and Proper Persons Test and Disclosure and Barring Service checks (for noting)
- Governor attendance at Council meetings (for noting) – no breaches noted
- Governor attendance at Governors' sub-committees 2025/26 (for noting) - no breaches noted
- Cases/concerns regarding compliance with the Code of Conduct (for noting) - no breaches noted
- Governors' development programme 2026 (for noting) – suggestions for 2026 topics

So what?

The Council of Governors (CoG) play a critical statutory role in ensuring that NHS Foundation Trusts remain accountable, transparent and aligned with the needs of the communities they serve. As a body representing patients, the public, staff and partner organisations, the CoG strengthens governance by providing independent oversight, acting as a vital link between the Trust and its stakeholders.

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 and **actions** as specified in the body of the report, including approval of Appendix 1 and 2.
<u>Enclosures:</u>
Appendix 1 - Code of Conduct
Appendix 2 - Procedure for Managing Governor Conduct and Expected Standard
Appendix 3 – Governors' Work Programme 2026

Governance and compliance

Previously considered by: Governors' Standards committee (27 January 2026)
Risk and assurance: Council of Governors unable to undertake its statutory duties.
Equality, diversity and inclusion: 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, Trust Constitution- Annex 7 – standing orders for the practice and procedure of the council of governors

STANDARDS COMMITTEE REPORT

1. Code of conduct and managing governor conduct and standards

The Committee reviewed the Code of Conduct **(Appendix 1)** and Procedure for Managing Governor Conduct and Expected Standards **(Appendix 2)**. The final documents subject to minor amendments were recommended to the Council of Governors for approval.

Amendments are highlighted:

Code of Conduct (Appendix 1)
- 2.2 – Added - *including removing or deleting any Trust related information held on personal devices*
- 5.1.6 – Management of Violence and Aggression Policy renamed as *'Unacceptable behaviour by patients, service users and members of the public policy'*
- 8.1.14 – Added in the end *'of the Trust Constitution'*

Procedure for Managing Governor Conduct and Expected Standards (Appendix 2)
- Page 1 – Title Director of Workforce changed to *'Chief People Officer'.*

> **ACTION**
>
> - **Note** and **approve** the Code of conduct and managing governor conduct and standards

2. Proposal to hold Staff Governor vacancy

Following recent changes, the Council of Governors currently has one staff governor vacancy arising from a retirement from the NHS. This gap has been widened by another staff governor's unforeseen absence. This leaves only three serving staff governors out of the five allocated seats, and no eligible reserve candidates from the previous elections, as the next two highest polled candidates have since left the Trust.

The Council has always emphasised the importance of ensuring appropriate staff representation. Given the timing within the election cycle and the constitutional provisions, the Committee was asked to consider how best to proceed. The Committee supported the proposal to hold the current staff governor vacancy until the next elections in 2026. This approach recognises the limited time left in the term, reduces administrative costs and fairness for future candidates and ensures compliance with constitutional requirements.

> **ACTION**
>
> - **Approve** the recommendation from the Standards Committee that the current Staff Governor vacancy be **held vacant until the next elections.**

3. Fit and Proper Persons Test and Disclosure and Barring Service checks

The Committee noted the update on FPPT and DBS (standard) checks. The Committee will review progress at its next meeting.

> **ACTION**
>
> - **Note** the update on Fit and Proper Persons Test and Disclosure and Barring Service checks.

4. Governor attendance at Council meetings

Constitutional requirement

The Committee reminds Governors that it is a constitutional responsibility to attend meetings of the Council of Governors. When this is not possible, they should submit an apology to the meeting administrator in advance of the meeting.

If a Governor fails to attend three successive public meetings of the council of governors without good reason and prior explanation, as set out in the Constitution, this is grounds for dismissal from their office, unless the grounds for absence are deemed to be acceptable by the Council of Governors.

Governors are expected to attend for the duration of the meeting and maintain good practice with respect to the conduct of meetings and the views of their fellow council members. Governors should not conduct private conversations when a meeting is taking place.

There were no breaches of the constitutional attendance requirements between November 2025 to January 2026.

> **ACTION**
>
> - **Note** the constitutional requirement for Governor attendance and no breaches were reported.

Governor attendance at Governors' sub-committees 2025/26

The Standards Committee oversees the attendance at subcommittees to support individuals and the effective working of the committees. The Committee maintains oversight of this issue and concerns regarding non-attendance highlighted for any sub-committee. Attendance at the governors' committee meetings is not a statutory requirement, but it is important for the smooth functioning and valuable feedback from governor members, ensuring the effective working of the committees.

The Committee reviewed sub-committee attendance to identify governors with low engagement. The Foundation Trust Office has contacted the governor to inform them of this attendance gap and request their participation at upcoming committee meetings, offering support where needed.

All meetings remained quorate. Reminders will be issued to these governors to support compliance with the attendance requirements.

> **ACTION**
>
> - **Note** the attendance at governors' sub-committee meetings.

5. Cases/concerns regarding compliance with the Code of Conduct

The Trust operates a just culture for managing staff conduct and it is therefore appropriate for the Council of Governors to adopt a similar approach when dealing with any allegations of conduct breaches relating to Governors. Part of the Standards Committee's remit is to review alleged breaches of the Code by Governors and advise on the procedure for managing the Governor's conduct and expected standards.

In case of any breaches in Governors' conduct, the Standards Committee is asked to note the matters of alleged breach of Code of Conduct and approve a recommendation to the Council of Governors in terms of next course of action. No breaches were reported between November 2025 to January 2026.

> **ACTION**
>
> - **Note** that there have been no concerns or incidents raised relating to breach

6. **Governors' development programme 2026**

The Committee reviewed the development workplan, which is designed to support timely consideration of key issues throughout the year. The workplan will remain a live document and will be updated regularly to reflect emerging priorities.

The FT Team invited governors to propose areas where they would welcome further development or additional insight during 2026. The following suggestions were received:

- Progress on planning and financing for the new hospital, and how it fits within England's evolving healthcare framework. *(this topic could be incorporated into future updates on the New Hospital Programme)*

- An overview of the Board Assurance Framework, briefly covering how the framework operates, how risk scores are interpreted and the key risks currently captured on the Risk Register.

ACTION

- Note the Governors' development programme 2026 **Appendix 3**
- Agree or suggest additional topics for 2026 workplan.

Appendix 1

ANNEX 6 - CODE OF CONDUCT FOR GOVERNORS

1. Introduction

1.1 The NHS Act 2012 sets out the powers of and obligations upon, governors of NHS Foundation Trusts, details of which form part of the Constitution. If Governors operate outside the powers assigned to them or fail to adhere to the obligations of public office, the NHS Act gives the Foundation Trust the power, through its Constitution, to remove them from office.

1.2 This Code seeks to outline appropriate conduct for Governors and addresses both the requirements of office and their personal behaviour. Ideally any penalties for non-compliance would never need to be applied, however, a Code is considered an essential guide for Governors, particularly those who are newly elected.

1.3 The West Suffolk NHS Foundation Trust operates a just and learning culture, with an emphasis on learning from mistakes rather than blaming individuals. We expect high standards of conduct from our elected and appointed governors and we expect them to take responsibility and be accountable when they fall short. Any investigation into code breaches, as well as establishing the facts, will also seek to understand the reasons for the breach, with a view to remediation rather than punishment.

1.4 The Code seeks to expand on or complement the Constitution. Copies will be made available for the information of all Governors and for those considering seeking election to the Council of Governors.

1.5 This Code of Conduct does not limit or invalidate the right of the Governors or the Trust to act under the Constitution.

1.6 The Code applies to all forms of communication and interaction, including:

1.6.1 at face-to-face meetings

1.6.2 at online or telephone meetings

1.6.3 in written communication

1.6.4 in verbal communication

1.6.5 in non-verbal communication

1.6.6 in electronic and social media communication, posts, statements and comments.

2. Qualifications for office

2.1 Members of the Council of Governors must continue to comply with the qualifications required to hold elected office throughout their period of tenure as defined in the Constitution. The Trust Secretary should be advised of any changes in circumstances, which disqualify the Governor from continuing in office. An example of this would be a public Governor becoming an employee of the Trust, given that the number of employees sitting on the Trust's elected bodies is limited.

2.2 Where a Governor has resigned from office, that governor must promptly return to the Trust Secretary any Trust property or confidential paperwork relating to the Trust and the work of the Council of Governors as the Governor may have in their possession, including removing or deleting any Trust related information held on personal devices and continue to comply with the requirements of the Constitution, this Code and Standing Orders for the Council of Governors until such time as this resignation takes effect.

Appendix 1

3.   General Principles

3.1   Governors should at all times:

  3.1.1   adhere to the Trust's values and supporting behaviours; rules and policies; and support the agreed vision and aims of the Trust in developing a successful Trust for the people of West Suffolk.

  3.1.2   act in the best interests of the Trust at all times and in accordance with the Constitution, the Standing Orders for the Council of Governors and this Code.

  3.1.3   contribute to the workings of their Council of Governors in order for it to fulfil its role and functions.

  3.1.4   recognise that the Council of Governors exercises collective decision-making on behalf of local people, stakeholders and staff and abide by such decisions as are made within that forum.

  3.1.5   acknowledge that, other than when attending meetings and events as a Governor, Governors will have no rights or privileges over any other Member of the Trust.

  3.1.6   recognise that the Council of Governors has no managerial role within the Trust and that the roles and responsibilities of a governor are not of a managerial or executive nature.

  3.1.7   conduct themselves in a manner that reflects positively on the Trust, and act as an ambassador for the Trust.

4.   Confidentiality

4.1   Governors will receive confidential information during the conduct of their duties and will be expected to respect the confidentiality of that information. Governors are required not to disclose information given to them in confidence by anyone, or information acquired by them which they believe or ought reasonably to be aware, is of a confidential nature.

4.2   Matters discussed in closed meetings of the Council of Governors and any meetings relating to disciplinary or code of conduct matters must be assumed to be confidential and not discussed or disclosed to anyone outside the meeting.

5.   Trust Policies

5.1   The Governors shall comply with the following Trust policies (revised Trust policies will be notified to the Governors from time to time):

  5.1.1   Internet and Intranet Policy

  5.1.2   Respect for Others Policy

  5.1.3   Equal opportunities and developing an inclusive culture

  5.1.4   Freedom to Speak up

  5.1.5   Data Protection Policy

  5.1.6   Unacceptable behaviour by patients, service users and members of the public policy

Appendix 1

5.1.7   Such other reasonable Trust policies as are notified to the Governors in writing from time to time.

6.   Conflict of interests

6.1   Governors should act with the utmost integrity and objectivity and in the best interests of the Trust in performing their duties. They should not use their position for personal advantage or seek to gain preferential treatment. Any Governor who has a material interest in a matter as defined by the Constitution, shall declare such interest to the Council of Governors and:

6.1.1   shall not vote on any such matters.

6.1.2   shall not be present except with the permission of the Council of Governors in any discussion of the matter.

6.2   If in any doubt they should seek advice from the Trust Secretary. It is important that conflicts of interest are addressed and are seen to be actioned in the interests of the Trust and all individuals concerned.

7.   Conduct in meetings

7.1   Governors should at all times:

7.1.1   be aware that they have a responsibility to attend meetings of the Council of Governors. When this is not possible, they should submit an apology to the meeting administrator in advance of the meeting.

7.1.2   be aware that failure to attend three successive public meetings of the Council of Governors without good reason and prior explanation as set out in the constitution is ground for dismissal from their office, unless the grounds for absence are deemed to be acceptable by the council of governors.

7.1.3   be aware that they are expected to attend for the duration of the meeting.

7.1.4   maintain good practice with respect to the conduct of meetings and respect the views of their fellow council members. Governors should not conduct private conversations when a meeting is taking place.

7.1.5   respect the integrity of the decision-making process in meetings of the Council of Governors and its committees and not undermine that process by their actions outside those meetings.

7.1.6   respect the confidentiality of matters discussed at closed meetings and not reveal details of information received, discussions, outcomes or individual voting decisions of those present at those meetings without their permission and/or outside due process.

7.1.7   comply with Standing Orders of the Council of Governors and draw the Trust Secretary's attention to any perceived breaches of the Standing Orders.

8.   Personal conduct

8.1   Governors are required to adhere to the highest standards of conduct in the performance of their duties as holders of public office.

8.1   Governors must, whilst carrying out their role of Governor:

8.1.1   acknowledge that the Trust is an apolitical organisation.

Appendix 1

    8.1.2   adhere to good practice in respect of the conduct of meetings and respect the views of their fellow elected governors.

    8.1.3   recognise that it is not acceptable or appropriate to represent any trade union, political party or other organisation of which they are a member or represent their views whilst conducting themselves as governor.

    8.1.4   be honest and act with integrity and probity at all times.

    8.1.5   accept responsibility for their actions.

    8.1.6   show their commitment to working as a team member by working with colleagues in the NHS and wider community.

    8.1.7   share collective responsibility for all Council decisions regardless of personal opinion.

    8.1.8   be mindful of conduct which could be deemed to be unfair or discriminatory and support inclusivity.

    8.1.9   treat other governors, members of the public, Directors (executive and non-executive) and other employees with respect and in accordance with the Trust's policy against bullying and harassment.

    8.1.10 not intimidate or attempt to intimidate any person who is or is likely to be involved in the administration of any investigation or proceedings in relation to an allegation that a governor has failed to comply with this code of conduct.

    8.1.11 recognise that the Council of Governors, the Board of Directors and management have a common purpose, i.e. promote the success of the Trust, and adopt a team approach and support inclusivity

    8.1.12 act appropriately in all engagement with the media and, where appropriate, act in accordance with the guidance for governors on dealing with the media.

    8.1.13 conduct themselves in such a manner as to reflect positively on the Trust. When attending external meetings or any other events at which they are present, it is important for Governors to be ambassadors for the Trust.

    8.1.14 uphold the seven principles of public life as detailed by the Nolan Committee as set out in Annex 9 of the Trust Constitution.

9   Accountability

9.1   Governors are accountable to the membership and should demonstrate this by attending members' meetings and other key events, which provide opportunities to interface with their electorate in order to best understand their views.

9.2   Governors are also accountable to NHS England for their conduct.

10.   Induction and development

10.1   Training is essential for Governors, in respect of the effective performance of their current role. Governors are required to adhere to the Trust's policies in all respects and undertake identified training and develop to allow them to effectively undertake their role.

10.2   Governors must participate in the Trust's induction programme for Governors.

11.   Visits to Trust Premises

Where Governors wish to visit the premises of the Trust in a formal capacity as opposed to individuals in a personal capacity, the Council of Governors should liaise with the Trust Secretary to make the necessary arrangements.

12.   Non-compliance with the Code of Conduct

Governors should be aware that non-compliance with the code of conduct, any other action which may be detrimental to the Trust or breach of any other condition for qualification as stated in the Constitution will be dealt with in accordance with the procedure for Managing Governor conduct and expected standards.

Procedure for Managing Governor Conduct and Expected Standards

Introduction

The procedure for Managing Governor Conduct and Expected Standards is based on the principles of a 'Just Culture', where we will look to ask 'What went wrong' rather than placing blame on the individual. The aim of this procedure is to ensure that conduct concerns are properly assessed to ensure a full and thorough understanding of the issues raised. The process is also designed to help and encourage all governors to achieve and maintain acceptable standards of conduct.

The West Suffolk NHS Foundation Trust supports a culture of fairness, openness and learning and this procedure is designed to ensure governors feel confident to speak up when things go wrong, rather than fearing blame. An objective and prompt examination of the issues and circumstances should be carried out to establish whether there are grounds for a formal investigation and/or for formal action. Where support, guidance or informal management would be a more appropriate and productive outcome, this should be pursued. Mediation should always be considered for early resolution, where appropriate.

It is the intention of this procedure to ensure that all governor conduct issues are dealt with compassionately and appropriately. The Trust will seek restorative action wherever possible, rather than seeking to blame individuals or issue punitive sanctions.

Standards Committee

A Standards Committee (the committee) have been established as a standing committee of the Council of Governors to review the Code of Conduct for the Council of Governors, the procedure for managing governor conduct and expected standards and to ensure that the procedure is followed when it is alleged that a governor's conduct has not been in accordance with the code and expected standards. In cases where a formal investigation is required, it shall also form the panel to hear the outcome of that investigation, unless there is a conflict of interest, in which case a conflicted member will be replaced by another governor from the same constituency.

Membership of the committee shall comprise the following:

Trust Chair
Lead Governor
One Public Governor
One Staff Governor
One Partner Governor

The committee will be advised by the Trust Secretary, with further support from the Chief People Officer or a member of the HR team for cases where formal action may be necessary.

Arrangements relating to Staff Governors

If the allegation involves a staff governor, consideration should be given as to whether its scope falls within the staff policy and procedure for managing conduct and expected standards and appropriate advice sought from the Chief People Officer and the HR team.

Referrals to the Standards Committee

All allegations relating to the conduct of a governor or governors will be reported to an extraordinary meeting of the committee, which will determine whether it should be dealt with under an informal or formal process. If the allegation is made by or against a member of the committee, they shall recuse themselves from the committee for that decision and consideration to be given to inviting another member from the same constituency in their place.

In most cases, governors may continue to hold office and attend meetings while any allegations against them are investigated. However, depending on the nature of the alleged breach or the alleged circumstances giving rise to it, this may not be appropriate, in which case, the committee may, in consultation with the Chair and the Lead Governor recommend one or more of the following actions:

- Exclude the governor concerned from the whole or any part of any or all Council of Governor meetings
- Suspend the governor concerned from office pending conclusion of the matter
- Take such other action as they consider appropriate

Where the committee considers that any such action as referred to above is required, they shall notify the governor concerned in writing as soon as reasonably practicable and explain the next stage in addressing the matter.

Informal Stage

Where at all possible, and where appropriate, allegations where expected standards have not been met should be dealt with informally by the Chair and Trust Secretary, who will meet with the person reporting the allegation to get a thorough understanding about what has happened. This will be followed up by a meeting with the governor to establish their version of events. Once the facts of the situation are understood, restorative action should be taken to ensure conduct does not fall below expected standards again, and also to address any organisational processes that may have led to the incident occurring in the first place.

A file note of the informal action will be reported to the Standards Committee for information and a copy held on the governor's file.

Formal Procedure

There may be situations where informal action has not brought the required improvement, where expected standards are repeatedly not met, or where the nature of the allegation is so serious it can't be considered for informal action. In these circumstances, it may be appropriate for the formal procedure to be implemented. This should only be considered where all appropriate informal action has been explored and there are still concerns regarding a governor's conduct. Where it is decided that further investigation and/or formal action is appropriate, this must be approved by the committee.

Formal action must only be taken where there is no other alternative, and this will be continuously reviewed throughout any formal process. In the event of formal action being deemed necessary, it is essential that affected governors are treated with dignity, kindness and compassion, regardless of the circumstances of the case.

Investigation

Where the committee considers an investigation is appropriate, it shall notify the investigated governor in writing no later than 5 working days after the decision, of the:

- Alleged breach of the code

- Grounds giving rise to the allegation and the provisions of the code which are alleged to have been breached

- The terms of reference and timeframe for the investigation

The Chair and Trust Secretary will appoint an independent investigator to investigate the allegations. This may be an individual employed by the Trust who is not a witness or a close colleague of those affected by the matters under investigation or somebody who is external to the Trust.

Once an investigator has been appointed, the committee shall notify the investigated governor of the contact details of the investigator and a request to the governor to comply with all reasonable requests relating to the matter being investigated.

The investigator shall be asked to provide a written report to the committee at the conclusion of the investigation setting out:

- The findings of the investigation in relation to the alleged breach

- Whether there is a case to answer and any recommendations as to any further investigation or steps which should be undertaken by the committee

The committee chair shall ensure that a copy of the investigator's report is sent to the investigated governor as soon as reasonably practicable after receipt.

Following receipt of the investigator's report, the committee shall call a meeting to determine whether any further action is needed before it meets to hear and determine the issue in a panel hearing.

Panel Hearing

Upon receipt of the investigator's report, the committee shall convene a panel hearing meeting and inform the investigated governor of the same. The date for the panel hearing shall be not less than 15 working days from the date of notice.

The notice must include the following:

- The date, time and location of the panel hearing

- The members of the panel

- The date by which the investigated governor must submit to the panel any written representations they would like the panel to consider and/or any objection to a panel member

- Confirmation as to whether the investigated governor can have legal or other representation at the panel hearing

- Confirmation as to whether the investigator or any other third party will be present at the panel hearing

- Confirmation as to whether the investigated governor will be permitted to address the panel and/or post questions to the investigator or any other third party who is present

- Such other information as the panel considers it appropriate to provide

The panel hearing shall be chaired by the person nominated to chair it by the other panel members.

At the relevant stage in the process, the chair shall dismiss the investigated governor, the investigator and any third parties whilst the panel retires to consider their decision.

The chair shall ensure that the investigated governor receives:

- A copy of the decision of the panel (including the details of any sanctions the panel has voted to impose and the lifting or otherwise of any interim sanctions)

- A copy of the minutes of the panel hearing; and

- Confirmation of the appeal process within 10 working days of the panel hearing

Appeal

Where a panel has determined that a governor has been found to have breached the Code of Conduct, the investigated governor may submit an appeal to the Appeal Panel no later than 15 working days after receipt of the written decision. This must include the governor's stated grounds for appeal. The appeal panel will comprise of members who were not on the Panel for the first hearing and who are not conflicted in relation to the matter. Membership will be as follows:

Non-Executive Director

4 Governors (2 x public governors, 1 x staff, 1 x partner)

Where an appeal is submitted, it shall be acknowledged within 3 working days of the date of receipt by the Trust Secretary and referred to the Chair.

The appeal panel will determine whether to accept the appeal and will notify the Chair, who shall confirm to the investigated governor within 5 working days whether the appeal has been accepted and, if it has, shall provide notice of:

- The date, time and location for the Appeal Panel meeting which shall hear the appeal

- The process for the appeal hearing

- What, if any, further information is required from the investigated governor

Support for the Governor

Being investigated for an alleged breach of the code of conduct can be very upsetting and stressful for any affected governors. If the governor wishes to nominate a third party to support them through the process, or request such support from the Trust, they may do so, through the Senior Independent Director. Clear, regular and confidential communication can help make sure governors are kept informed of what is happening, have the opportunity to ask questions and can avoid stress and other mental health issues.

Sanctions

Where the panel determines that an investigated governor has breached the Code of Conduct it may impose such sanctions as it considers appropriate, including, but not limited to:

- Issuing a written warning as to future conduct. This shall remain on the governor's record for the remainder of their term of office

- Requiring the investigated governor to provide written undertakings as to future conduct

- Withholding the payment of expenses, if the breach related to the wrongful claiming of expenses

- Removal from office as a governor and removal as a member of the Trust

Dismissal

A decision by the panel to remove a governor from office requires a resolution to the Council of Governors approved by not less than two-thirds of the governors present and voting at a general meeting of the Council of Governors which is closed to the public. Where the committee is recommending dismissal, the Standards Committee shall report a summary of the alleged breach, the process followed and the outcome, with a recommendation to the Council of Governors to dismiss.

Governors' Development Programme 2026

Timing	Themes	Rationale	Led by
16 January 2025	Non-executive appraisals training	Interests of members and the public	Organisational Development and Learning Team
5 February 2025	Trust's strategy refresh	Interests of members and the public Interactive engagement with the governors as part of the review of the Trust's strategy and priorities	Director of Strategy and Transformation
4 March 2025	Session on Integrated Care Board introduction and provider collaboration	Interests of members and the public	ICB partners/Chair/Trust Secretary
3 April 2025	CQC single assessment framework	Interests of members and the public	Chief Nurse
17 July 2025	Patient quality and safety, incidents/never events, PSIRF	Holding the NEDs to account for the performance of the Board	Chief Nurse / others as agreed
16 September 2025	Session on Future Systems Programme	Holding the NEDs to account for the performance of the Board	Programme Director / others as agreed
21 October 2025	Session on Virtual Ward	Interests of members and the public	Senior Operational Team, Virtual Ward
24 February 2026	Effective questioning and holding the NEDs to account for the performance of the Board	Interests of members and the public Holding the NEDs to account for the performance of the Board	NHS Providers

Timing	Themes	Rationale	Led by
	The role of the Foundation Trust Governor and practical ways to carry out the statutory roles of a governor	Item from annual skills audit – considering options for delivery to support working of the Council	
3 March 2026	Session on Future Systems Programme (Reserved matters pre-application planning engagement)	Holding the NEDs to account for the performance of the Board	Programme Director / others as agreed
28 April 2026	Fit for the future: 10 Year Health Plan for England, including an overview of how the Trust is developing its plans to deliver the NHS 10 Year plan	Interests of members and the public	Director of Strategy and Transformation or others as agreed
TBC	Freedom to Speak Up	Interests of members and the public Holding the NEDs to account for the performance of the Board	FSUP Guardian or others as agreed

Timing	Themes	Rationale	Led by
TBC	Session on Future Systems Programme	Holding the NEDs to account for the performance of the Board	Programme Director / others as agreed
TBC	Freedom to Speak Up	Interests of members and the public Holding the NEDs to account for the performance of the Board	FSUP Guardian or others as agreed

14. Staff Governors' Report (enclosed)

To receive a report from the Staff Governors

For Discussion

Presented by Louisa Honeybun

COUNCIL OF GOVERNORS MEETING (OPEN)

Report information

Report title: Staff Governors' report
Date of the meeting: 05 March 2026
Agenda item: 14
Sponsor/Executive lead: Paul Bunn, Acting Trust Secretary
Report prepared by: Pooja Sharma, Deputy Trust Secretary, Ruth Williamson, Senior Administrator
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 Staff Governors met on 8 January 2026. The report summarises discussions from the meeting.

So what?
The meeting was attended by the staff governors, Anna Clapton, Diana Stroh, Louisa Honeybun, Ben Lord (Lead Governor), Jane Sharland (Freedom to Speak Up Guardian), Paul Bunn (Acting Trust Secretary) and Ruth Williamson (Senior Administrator, FT Office).

Summary:

Freedom to Speak Up – update on themes:
Staff Governors received an update from the FTSU Guardian. The National Guardian's Office is expected to close at the end of the financial year, though its work will continue until June. After that, responsibility for governance and data collection will transfer to NHS England. Freedom to Speak Up roles within the Trust will remain in place and promotion of the service continues.

The Trust currently has 74 registered Freedom to Speak Up Champions. Representation within Estates and Facilities remains limited, and further recruitment will be encouraged.

Key themes raised through Freedom to Speak Up include:

- Colleague relationships / incivility: Work is underway through Learning and Development to support culture and behaviour improvements
- Estates & Facilities issues: External lighting continues to be raised as a concern. Repairs have started, including arrangements for equipment needed to complete the work
- Abuse towards staff: Training is available to help teams feel confident in supporting colleagues
- Managerial communication: Leadership development work is ongoing to address this gap. Governors can signpost staff to the Trust's Values and Behaviours Framework
- Recruitment & redeployment: Staff were reminded to seek advice from HR where needed, particularly as employment legislation changes.

QIAs and EIAs:
Concerns were raised about the visibility and communication of Quality and Equality Impact Assessments linked to decision making processes. Following changes within HR, there is reduced availability of HR support, which has caused concern, especially for newer managers or more sensitive cases. Clarification on governance and approval processes has been requested. Questions were also raised about how QIAs are being shared with affected staff and how decisions are being assessed for impact. These queries have been passed on for clarification.

Industrial Action:
The latest period of industrial action was described as more challenging, partly due to timing and reduced preparation. Feedback has been sought.

Smoking on Site:
Smoking and vape odours continue to affect some areas. Updated signage for designated smoking areas is awaited, and further clarification on expectations for patients will be sought. It was noted that smoking management is a challenge across several sites, not just locally.

Administrative Review:
An update on the ongoing administrative review is expected soon.

Emergency Preparedness:
Business continuity documents were recently updated following a review, and the Trust is now compliant.

Staff Member Concern:
A staff member raised concerns about their patient experience. They were signposted to the appropriate formal channels for review and support.

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 8 January 2026.

Governance and compliance

Previously considered by: Staff Governors meeting (8 January 2026)
Risk and assurance: Council of Governors unable to undertake its statutory duties.
Equality, diversity and inclusion: 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.

15. Lead Governor Report (enclosed)

To receive a report from the Lead Governor

For Discussion

Presented by Ben Lord

Council of Governors Meeting (Open)

Report information

Report title:	**Lead Governor's Report**
Meeting Date:	**5 March, 2026**
Agenda item:	**15**
Sponsor/Executive lead:	**Ben Lord, Lead Governor**
Report prepared by:	**Ben Lord, Lead Governor**
Previously considered by:	**-**

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:

- o Representing the interests of members and the public
- o Holding the Non-Executive Directors (NEDs) individually and collectively to account for the performance of the Board and therefore the Trust.
- o Appoint and remove Chair/NEDS as appropriate and decide on other terms and conditions of office
- o Decide the remuneration and allowances of the Chair and NEDs
- o Approve the appointment of the Chief Executive
- o Appoint/remove as the external auditor, as appropriate
- o Receive the Annual Accounts and Auditor's report
- o Approve/make changes to the Trust Constitution and recommend to the Board
- o Approve defined significant transactions
- o Approve applications for mergers, acquisitions and dissolutions
- o 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, that are in line with the fulfilment of their statutory duties and responsibilities.

Action required by the Council of Governors:

The Council is asked to note the report.

Governance and compliance

Risk and assurance:	-
Equality, diversity and inclusion:	All Governor activities are performed in line with the principles of EDI
Sustainability:	-
Legal and regulatory context:	NHS Act 2006, Social Care Act 2012, WSHFT Constitution, WSHFT Governors Code of Conduct

Lead Governor Report

1.   Introduction

Since starting in post in January, I have been working closely with David Slater as my deputy as we begin to look at some of the salient priorities that the Council of Governors will be focusing on, in addition to its routine and statutory duties in the course of this year. Naturally governors remain curious as to the continuation of the role in foundation trusts following the NHS 10-year plan that was presented last summer. We continue to take soundings and consider what this will mean for our Trust in light of governor elections, which are scheduled at the end of the year. We continue to observe closely any developments that may appear around the joint chair matter that has been in the background since last summer despite the revocation of support for this by ESNEFT. Finally we have been closely monitoring matters around the continuation of the Chair's tenure.

2.   COG Sub-Committees

2.1   Membership and Engagement Committee
The next meeting will take place in April.

2.2   Nominations and Remuneration Committee
Recommendations have been made by the Committee regarding the reappointment of a Non-executive Director, appointment of the UEC nominated NED and the Chair's term office, which will be discussed in closed session.

2.3   Standards Committee
The Staff Governor vacancy was discussed at January's meeting and a recommendation made to this meeting for consideration.

3.   Board Assurance Meetings
Governors continue to observe monthly assurance 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
A development session took place on 24 February, 2026 run by NHS Providers on Effective Questioning and Challenge which those attending found to be beneficial.

An update on the new hospital will be provided on 3 March 2026 from Emma Jones, Engagement & Comms lead, prior to the pre-application planning engagement to be launched from 10 March.

Slides for both events will be made available on Convene.

5.   Non-Executive Directors
We note the resignation of Tracy Dowling, NED, who joins ESNEFT at the beginning of March in the role of Chair and wish her well for the future. However, it was disappointing that governors were not made aware of this appointment by the Trust prior to the public announcement.

6.   Governor's activities
Governors continue to carry out monthly 15 Step 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.

As always I am keen and interested to support governors and chat anything through in the context of our work. If any colleagues would like to talk or meet with me at any point, please feel free to get in contact without hesitation.

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

16. Governance Report (enclosed)

To receive the governance report

To Note

Presented by Paul Bunn and Pooja Sharma

COUNCIL OF GOVERNORS MEETING (OPEN)

Report information

Report title: Governance report
Date of the meeting: 05 March 2026
Agenda item: 16
Sponsor/Executive lead: Paul Bunn, Acting Trust Secretary
Report prepared by: Pooja Sharma, Deputy Trust Secretary, Ruth Williamson, Senior Administrator
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 summarises the main governance headlines for February 2025, as follows:

- Fit and Proper Persons Test and Register of Interest (DoI/G&H) – *Annual process for FPPT and DoIs/G&H returns to begin in March 2026*
- Readers for Quality Accounts and Annual Report - *Identify up to four Governors as readers for the draft annual report (including quality accounts).*
- Governor commentary for the Quality Accounts – *Note approach to drafting Governors' commentary for inclusion in the quality accounts.*
- Council of Governors sub-committees 2025 – *Note membership of the sub-committees and invite Governors to nominate themselves for vacant positions on the sub-committees.*
- Governor forward planner 2026 – *For noting*

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

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 and actions set out in the body of the report.

Governance and compliance

Risk and assurance: Council of Governors role in holding NEDS to account is vital for maintaining transparency and accountability within the governance structure.
Equality, diversity and inclusion: All election and appointment process are open to all, are fair and transparent. The COG represents all members of the community and wider population of WSFT.
Sustainability: Oversight of replacement of governor vacancies and workplan ensures work is spread out across the COG, with no single points of failure; knowledge and expertise is also shared.
Legal and regulatory context: WSFT Constitution, Health & Social Care Act 2022, NHSE Code of Governance 2022.

GOVERNANCE REPORT

1. Fit and Proper Persons Test and Register of interests and Gift & Hospitality

The NHSE Code of Governance (2022) for NHS provider trusts, section C 4.1 states that directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence.

The implementation of Fit and Proper Persons Test (FPPT) was introduced as a regulatory requirement of the Code of Governance 2022, as an annual self-attestation process and standardised template was adopted in line with the new FPPT framework.

At each Council of Governors (CoG) meeting declarations are also received for items to be considered as part of the agenda. The FPPT declarations and declaration of interests of governors was received from the governors as part of their induction documentation.

The Register of Governors' Interests should be formally reviewed and updated on an annual basis. For accuracy and completeness of our register of interests, we will be sending out the declaration of interest forms to all the governors to capture any relevant interests or relationships. Updates from governors will be requested in March and the updated register of interests will be presented to the Council of Governors at the May meeting.

As part of this annual process, we will contact the Governors for filling in FPPT and DoIs/G&H forms and return to the FT office.

> **ACTION**
>
> - The 'Fit and Proper Person Test' annual self-attestation and declaration of interests and G&H forms to be circulated to the Council of Governors in March 2026.

2. Readers for Quality Accounts and Annual Report

The Trust's timetable for final submissions of annual report and accounts 2025-26 is the end of June. This impacts on the preparation of the quality accounts as the information for these documents does overlap. **It is proposed that up to four Governors are identified as readers for the draft Annual Report and associated Quality Accounts.** This will be to ensure that the report, while complying with the requirements of national guidance, remains accessible for the public in terms of language.

Readers will receive the draft Annual Report and Quality Accounts for comment in May. The document is likely to be approximately 125 pages in length and it would be expected that comments will be received within two weeks to allow the submission of the final report to the Board.

> **ACTION**
>
> - Identify up to four Governors as readers for the draft annual report (including quality accounts).

3. Governor commentary for the Quality Accounts

The Council of Governors provides commentary for inclusion in the annual Quality Accounts. The Standards Committee will review and draft this commentary with the lead governor. The updated draft commentary will be presented to the CoG in May for discussion and approval for inclusion in the Quality Accounts.

> **ACTION**
>
> - Note approach to drafting Governors' commentary for inclusion in the quality accounts.

4. Council of Governors sub-committees 2026

The Council of Governors has constituted committees to support the council in a range of tasks as follows:

- FT Governors' Nominations Committee
- FT Governors' Membership and Engagement Committee
- FT Governors' Standards Committee
- Staff Governors' Group

The Standards Committee oversees the attendance at subcommittees to support individuals and the effective working of the committees. The Committee maintains oversight of this issue and concerns regarding non-attendance highlighted for any sub-committee.

ACTION

- Note sub-committees' membership 2026 and vacancies **(Appendix A)**
- Invite Governors to nominate themselves for vacant positions on the sub-committees.

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5. Council of Governors' forward planner 2026

The draft forward planner for the CoG meetings is attached for discussion **(Appendix B).** The forward planner is a live document that will be frequently reviewed and is not an exhaustive list of items.

ACTION

- Note and comment on the Governors' forward planner.

Council of Governors sub-committees February 2026

FT COUNCIL OF GOVERNORS' NOMINATIONS COMMITTEE

Committee Members	Title
Jude Chin	Trust Chair (committee chair)
Ben Lord	Public Governor (lead governor)
Jayne Neal	Public Governor
Adrian Osborne	Public Governor
Thomas Pulimood	Partner Governor
Jane Skinner	Public Governor
VACANT	Partner Governor
VACANT	Staff Governor

FT COUNCIL OF GOVERNORS' MEMBERSHIP & ENGAGEMENT COMMITTEE

Committee Members	Title
Sarah Hanratty	Public Governor (committee chair)
Liz Hodder	Public Governor
Robin Howe	Public Governor
Lisa Parish	Partner Governor
Becky Poynter	Public Governor
David Slater	Public Governor (deputy lead governor)
Diana Stroh	Staff Governor

FT COUNCIL OF GOVERNORS' STANDARDS COMMITTEE

Committee Members	Title
Jude Chin	Trust Chair (committee chair)
Anna Clapton	Staff Governor
Val Dutton	Public Governor
Liz Hodder	Public Governor
Sue Kingston	Partner Governor
Ben Lord	Public Governor (lead governor)
Jane Skinner	Public Governor

FT STAFF GOVERNORS' GROUP

Staff Governors	Title
Anna Clapton (nee Mills)	Staff Governor
Louisa Honeybun	Staff Governor
Sue Kingston	Partner Governor (Trust & Friends volunteers)
Adam Musgrove	Staff Governor
Diana Stroh	Staff Governor
VACANCY	Staff Governor

Forward planner 2026

WSFT COUNCIL OF GOVERNORS' FORWARD PLANNER 2026

Item	Lead	May'26	Sept	Nov	Feb'27	Notes
Date		**19/05/26**	**10/09/26**	**10/11/26**	**TBC**	
Venue		WSH site	WSH site	WSH site	WSH site	
Paper circulation (min 5 working days before the meeting)		12/05/26	03/09/26	03/11/26	TBC	
Standing Items						
Minutes	Chair	Y	Y	Y	Y	For approval
Chair's report	Chair	Y	Y	Y	Y	For information
Chief executive's report	CEO	Y	Y	Y	Y	For information
Feedback on assurance committees	3i Chairs/Governor observers	Y	Y	Y	Y	For information
Lead Governor Report	Lead Governor	Y	Y	Y	Y	For information
Summary report for Board of Directors meetings	Chair/NEDs/TS	Y	Y	Y	Y	For information
Reflections on meeting	Chair	Y	Y	Y	Y	For noting
Recurring Items						
Report from Governors' Nomination & Remuneration Committee to include recruitments of NEDs and appraisals	Committee Chair	Y	Y	Y	Y	For information
Membership & Engagement Committee report	Committee Chair	Y	Y	Y	Y	For information
Standards Committee report	Committee Chair	Y	Y	Y	Y	For information
Staff Governors' Report	Staff Governor	Y	Y	Y	Y	For information
Future System update	CEO			Y		For information
Review of Governors' sub-committees - membership and composition	TS	Y				For discussion/approval
Annual Items						
Strategic planning and priorities	CEO	Y				For discussion
Membership and Engagement Strategy	TS		Y			For approval
Forward Plan including briefing & development sessions	TS			Y	Y	For discussion/approval
Quality Accounts – commentary from Governors	TS/CN	Y			Y	For information/approval
Annual report and accounts, including Independent Auditor's report	AC chair/TS/Auditors		Y			For information
Fit and Proper Persons Test	TS	Y				For information
Other / As Required						
Changes to the Constitution	TS					For approval
Audit and effectiveness as recommended by the Standards Committee	TS					
Any items requested by Executives/Governors	TS					

Notes:										

ITEMS FOR INFORMATION

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

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

For Discussion

Presented by Jude Chin

COUNCIL OF GOVERNORS MEETING (OPEN)

Report information

Report title: Summary Report for Board of Directors Meetings
Date of the meeting: 05 March 2026
Agenda item: 17
Sponsor/Executive lead: Jude Chin, Trust Chair
Report prepared by: 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?

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 – 28 November 2025			
Patient Story – the story highlighted the need for clearer, compassionate end-of-life communication and enhanced support for relatives. Guidance to be reviewed.	• To note learnings.	-	Verbal
CEO Report – Trust's UEC performance achieved a ranking of 4th out of 134 acute trusts. Despite fluctuations, recent industrial action saw smooth flow and staff were thanked for their work during this period. Staff survey completion is slightly below the acute trust average.	• Ongoing assurance/ monitoring	-	1.7
Update on Business Planning – the service plan is on track, though concerns were raised that the national process is overly acute-focused. Assurance was given that extensive preparation since June leaves the organisation well placed.	• Ongoing assurance/ monitoring		2.1
Strategy – Next Steps to Implement and Delivery – four phases each have their own rollout plans. As metrics are not yet in place, a combined set of measures linked to the IQPR will be developed, supported by staff-survey communications and an easy-read version on the intranet.	• Ongoing assurance/ monitoring	• Deliver the Trust strategy	2.2
Future System Board Report – the Outline Business Case is progressing through "progressive assurance" and remains anticipated for submission in August, 2026. The Royal Colleges are contributing to the new hospital template, with any concerns being addressed as planning continues.	• Ongoing assurance/ monitoring • Board to receive future updates	• Sustainable service improvements	2.3
West Suffolk Alliance and SNEE Integrated Care Board - current priorities include diabetes improvement, community needs in Sudbury and frailty work covering falls, dementia and an upcoming end-of-life strategy.	• Strengthened provider collaboration	• Focus on system working	2.4

2

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Digital Board Report – Windows 11 upgrades are complete and current digital work is focused on ensuring ageing infrastructure is safe and supported, aligned with continuity planning. The first Digital & Data Committee meeting is set for 29 January 2026.	• Ongoing assurance/monitoring	-	2.5
Joint Productivity Board – discussion highlighted concerns over the productivity figures in the sustainability review. It was proposed that the Director for Strategy and Healthcare Intelligence at the ICB be invited to a future meeting to discuss.	• Strengthened provider collaboration	• Focus on system working	2.6
IQPR Report - steady progress in elective recovery and strong diagnostic improvement. Recent pressures in UEC performance were viewed as a one-off difficult month rather than a trend. Discussions continue around recommissioning neurodevelopmental services.	• Ongoing assurance/monitoring	-	3.1
Involvement Committee – the committee reviewed patient experience work, noting that complaint responses need strengthening despite recent AI-driven improvements. Leadership and management capability were highlighted as key areas for development, with plans to mandate a management framework and improve performance oversight.	• Ongoing assurance/ monitoring	-	4.1
Freedom to Speak Up –the upcoming closure of the National Guardian's Office was noted, together with the small rise in concerns reported, demonstrating increased confidence in speaking up. Staffing reviews are causing concern, but communication support and new reporting channels, such as QR codes and the HR Information Zone, are helping. Smoking on site remains an issue. **Putting You First –** congratulations were offered to those staff receiving awards.	• Ongoing assurance/ monitoring • Recognition of Staff	-	4.2
Insight Committee – Elective recovery was off track in September but gained partial assurance in October after new plans and investment, with December forecasts submitted with Board support. Diagnostic progress is dependent upon recruiting skilled staff.	• Ongoing assurance/ monitoring	-	5.1

3

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Finance Report – Month 7 showed a positive financial performance with the underlying position improving and results continuing to exceed plan each month. Although CIP requirements rise sharply for the rest of 2025 and future challenges and winter pressures remain, the Trust is maintaining a prudent approach. The significant progress made was acknowledged and thanks offered to staff across the organisation.	• Ongoing assurance/monitoring	Financial sustainability	5.2
Quality & Patient Safety Committee Report (previously Improvement Committee) – maternity services are performing well with ongoing learning. Recent mortality data concerns relate to coding issues which are being addressed. Coroners have highlighted concerns regarding the national investigation process, but the Trust's own parallel system provides comprehensive information. RESPECT form completion is improving and further progress is expected via support from a new system.	• Ongoing assurance/ monitoring	-	6.1
Quality and Nurse Staffing Report – fall rates remained stable. Care Hour Per Patient Day (CHPPD) improved but remained in the lower quartile. A drop in whole-time staffing equivalents will be reviewed. The demand on non-housebound community nursing services to be explored.	• Ongoing assurance/ monitoring • Overseeing quality indicators	-	6.2
CQC Preparedness - an increase in the likelihood of a CQC visit was noted and readiness has been strengthened through a structured framework, improved governance and ongoing monitoring. Targeted support is being provided to staff in respect of inspection preparation. Preparedness work will be embedded in the care accreditation model and upcoming changes to the CQC inspection approach highlight the need for organisation-wide readiness.	• Ongoing assurance/ monitoring		6.3
Maternity Services – NHS expectations are being addressed, culture work and staff recognition continue and a reverse mentorship trial will begin. Maternity incentive scheme progress remains strong, vacancy rates are low, and future planning includes home birth reporting, new hospital development and upcoming CQC survey results. The service is focused on stronger user engagement and continuity of care and the team reports feeling well supported by the Board.	• Ongoing assurance/ monitoring in areas of priority	-	6.4

4

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Charitable Funds Committee - noted the recent appointment of a new corporate fundraising manager, progress towards finalising the 2024/25 accounts alongside emerging ideas to enhance fundraising and the need for further work on due diligence and governance to be picked up at the next meeting. Work also continues on selecting a supplier and developing a funding strategy for a high-cost robotic device.	• Board visibility and oversight	-	7.1
Audit Committee - strong progress noted in the audit programme, with recommendations actively followed up. Recent audits of extra-contractual sessions provided partial assurance, while financial planning and governance achieved substantial assurance. The cyber assessment confirmed solid organisational competence and counter-fraud arrangements received positive feedback following the annual strategic risk review.	Board visibility and oversight	-	7.2
Board Assurance Framework – the meeting noted recent work by the sub-committees and the Council of Governors. Focus on BAF risks noted.	• Board Oversight	-	7.3
Governance Report - The Board received an update on proposed committee name changes and the creation of a new digital and data assurance committee. The main structural shift is that patient experience will move into the refreshed Quality and Patient Safety Committee. Further adjustments to the terms of reference, committee remits, workload balance and the placement of estates and experience-of-care functions will be reviewed with committee chairs. The Board approved the new committee names, noting that additional refinement of responsibilities will follow.	• Board visibility and oversight	-	7.4

5

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Board of Director Key Issues – 30 January 2026			
Patient Story – A patient shared their experience of navigating the hospital as a blind person, prompting discussion on the need for better awareness of sensory needs, more consistent reasonable adjustments and stronger personalised care. Noted current initiatives such as adaptive-cutlery, quality improvement work, collaboration with sensory support teams and virtual ward pathways, while agreeing that staff training, consistency of approach and clearer communication all require further review. A letter of thanks will be sent to the patient, outlining planned actions.	• To note learnings.	-	Verbal
CEO Report - noted organisational progress amid recent operational pressures, with appreciation expressed for staff efforts and long-service contributions. Discussion covered improving performance indicators, ongoing quality initiatives and forthcoming business cases. Attendees reflected on recent challenges, the need to balance senior oversight with staff welfare during industrial action and the longer-term impact on care models and training.	• Ongoing assurance/ monitoring	-	1.7
BAF & Risk Report – noted ongoing work to refine the risk framework, with updated mitigations being developed and an updated version expected for the new financial year. Most risks show improvement, though further action is required on collaboration and staff wellbeing.	• Board Oversight	-	1.8
IQPR - January performance remained challenging. Deep dive in to emergency care to take place at relevant assurance committee. Concern regarding alignment of future activity with finance plans, supporting staff through mandatory training demands and ensuring data better reflects operational reality.	• Ongoing assurance/ monitoring	-	2.1

6

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Quality & Patient Safety Committee - clinical effectiveness processes are challenged in providing assurance, requiring greater alignment between clinical divisions and governance structures. Work is under way to clarify leadership roles, strengthen engagement and ensure teams prioritise quality improvement, supported by grand rounds and national benchmarking. Digital systems are seen as enablers rather than solutions, with a renewed focus on culture, ward ownership and structured benefits realisation.	• Ongoing assurance/ monitoring	-	2.2
National Patient Survey Report - largely stable patient-experience results, with strengths in dignity, respect and pain control, but continued issues with night-time noise and cleanliness linked to late-hour activity and housekeeping pressures. Actions include staff awareness measures, ongoing monitoring and improved cleaning audits, though concerns were raised about reliance on outdated national survey data and the need for more immediate feedback.	• Ongoing assurance/ monitoring	-	2.3
Quality and Nurse Staffing Report – Quality Priorities and Learning from Deaths – noted increase in staff sickness levels due to winter viruses. The situation is being monitored. Vacancies were highlighted as a concern due to whole-time-equivalent changes following the loss of Glastonbury Court and corporate restructuring, though overall vacancy levels remain stable and have been verified with HR.	• Ongoing assurance/ monitoring • Overseeing quality indicators	-	2.4
Maternity Services – antenatal feedback mainly related to waiting times. Community midwifery safety and staffing were reviewed. Concerns were raised about the volume of national requirements and negative media coverage affecting staff, with continued efforts to strengthen local communication and assurance.	• Ongoing assurance/ monitoring in areas of priority	-	2.5

7

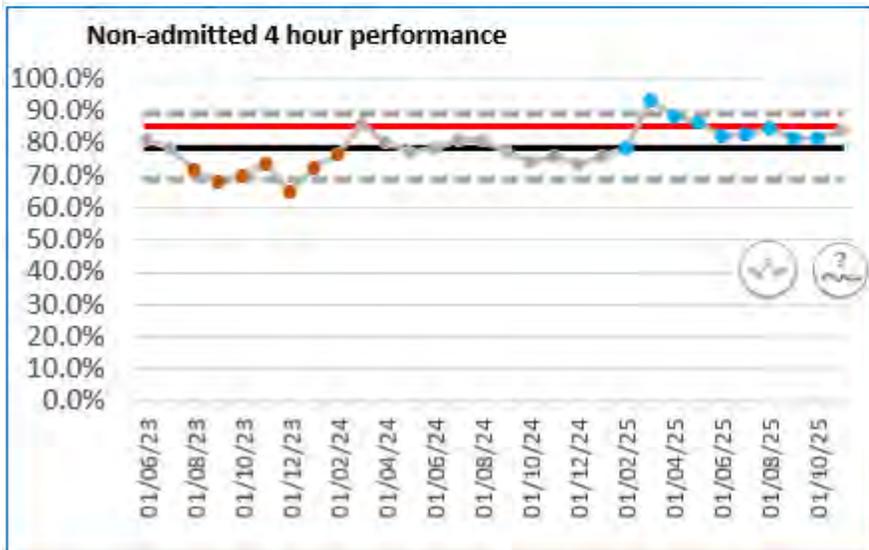| Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Strategic Priorities Update - the enabling strategy is due for completion in April, with the BAF to be refreshed afterwards. Feedback so far has been anecdotal, with further insight expected through PULSE. Work remains on visibility and practical application. Concerns were raised about the short timeline and varying levels of awareness across teams, though engagement has been positive and embedding the strategy will continue beyond April through training and improvement work.	• Ongoing assurance/ monitoring	Deliver the Trust strategy	3.1
West Suffolk Alliance & SNEE Integrated Care Board - Dementia diagnosis pressures continue to rise despite active recovery work. Discussions covered demand reduction, Better Care Fund priorities and emerging schemes aimed at easing acute pressures, though questions remain around evidence, costs, commissioning timelines and contractual assurances. The trailblazer program learning from Ipswich is informing wider plans, with ongoing monitoring and oversight expected as business cases progress.	• Strengthened provider collaboration	Focus on system working	3.2
People & Organisational Development Committee – focus on disability data and quality of opportunity for career progression. Strong progress has been made on sexual safety in the workplace and work is underway to apply learning from the sexual safety programme to accelerate progress.	• Ongoing assurance/ monitoring	-	4.1
Freedom to Speak - Work continues on promoting civility, strengthening bystander support, and ensuring appropriate responses to recruitment and redeployment issues.	• Ongoing assurance/ monitoring	-	4.2
Finance & Performance Committee – CKIs - strong assurance that the contract process had been well managed and generated useful learning. Emergency Preparedness work had shown significant improvement, with plans reduced through a more streamlined approach. Discussion highlighted that other areas, including digital and AI, could also be simplified, noting the benefits seen when responsibilities are devolved rather than concentrated in specialist roles. It was observed that rotating people across different areas can bring fresh perspectives, and that the revised, more connected planning model has proved more effective.	• Ongoing assurance/ monitoring	-	5.1

8

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Finance Report - a strong month with three months remaining and a strong possibility of meeting the year-end target. Cash drawdown issues are resolved, and while the NHP capital allocation will slip into next year, Newmarket endoscopy remains on track.	• Ongoing assurance/monitoring	Financial sustainability	5.2
Outline of Annual Capital Programme – additional funding bid from the Estate Safety Fund will help support essential SSD plant upgrades.	• Ongoing assurance/ monitoring	Financial sustainability	5.3
Charitable Funds Committee – all items approved, following the year end audit. Pharmacy robot options explored and discussed at Board level.	• Board visibility and oversight	-	5.4
Audit Committee – helpful deep dive in to management processes. Assurance committees to follow up on internal audit report.	• Board visibility and oversight	-	5.5
Business Planning Update – teams finalising service developments and business cases to shape future plans.	• Ongoing assurance/ monitoring	-	5.6
Future System Board Report – work continues on the outline business case for August submission.	• Ongoing assurance/ monitoring • Board to receive future updates	Sustainable service improvements	6.1
Governance Report – The Assurance Committees have been renamed. Options will be discussed at a future meeting regarding the possibility of reducing the number of public Board meetings, in order to create more opportunity for development work.	• Board oversight	-	7.1

9

18. Any Other Business (verbal)

To discuss any other matters not included on the agenda

Presented by Jude Chin

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

- 19 May 2026
- 10 September 2026
- 10 November 2026

To Note

Presented by Jude Chin

20. 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 - November, 2025

Assurance Grid

Performance in November 2025

ASSURANCE: Will we reliably meet the target based?

Not Met

		Pass (P)	Hit and Miss (?)	Fail (F)	No Target
VARIANCE: Variation from the mean. The colours indicate the trend- positive (blue), Negative (orange), or neither (grey)	**Special Cause Improvement** (H / L)	**FINANCE & PERFORMANCE** Virtual Beds Trajectory		**FINANCE & PERFORMANCE** RTT 65+ Week Waits	**FINANCE & PERFORMANCE** RTT 52+ Week Waits RTT 52+ Weeks Wait as % of Total WL RTT <18 Week Waits (%All) **PEOPLE & ORGANISATIONAL DEVELOPMENT** % extended
	Common Cause	**FINANCE & PERFORMANCE** Urgent 2 hour response – UCR **PEOPLE & ORGANISATIONAL DEVELOPMENT** Staff Sickness Rolling 12months Staff Sickness	**FINANCE & PERFORMANCE** Ambulance Handover within 30min Non-admitted 4 hour performance % patients with no criteria to reside Virtual Ward Total average occupancy percentage 28 Day Faster Diagnosis Cancer 62 Days Performance **QUALITY & PATIENT SAFETY COMMITTEE** C-Diff Hospital & Community onset, Healthcare Associated **PEOPLE & ORGANISATIONAL DEVELOPMENT** Mandatory Training Turnover	**FINANCE & PERFORMANCE** Incomplete 104 Day Waits Diagnostic Performance - % within 6 weeks Total **PEOPLE & ORGANISATIONAL DEVELOPMENT** Appraisal	**FINANCE & PERFORMANCE** 12 Hour Breaches 12 hour breaches as a percentage of Type 1 attendances Criteria to reside – Acute Criteria to reside – Community RTT Waiting List RTT <18 Week Waits (% First OPA) **QUALITY & PATIENT SAFETY COMMITTEE** % of patients with Measured Weight % of patients with a MUST/PYMS assessment completed within 24 hours of admission Post Partum Haemorrhage Inpatients Deaths **PEOPLE & ORGANISATIONAL DEVELOPMENT** Active Complaints Closed Complaints Count Extended % Complaints responded to late Count responded to late % resolved in one week Total PALS resolved Count
	Special Cause Concern (H / L) **Deteriorating**				**FINANCE & PERFORMANCE** Community Paediatrics RTT Overall Waiting List Community Paediatrics RTT Overall 52 Weeks Wait **QUALITY & PATIENT SAFETY COMMITTEE** SHMI

Items for escalation based on those indicators that are failing the target, or are worsening and therefore showing Special Cause of Concerning Nature by area:

FINANCE & PERFORMANCE - Cancer: Incomplete 104 Day Waits

Elective: Diagnostic Performance - % within 6 weeks Total, RTT 65+ Week Waits

PEOPLE & ORGANISATIONAL DEVELOPMENT – Well Led: Appraisal

FINANCE & PERFORMANCE COMMITTEE METRICS
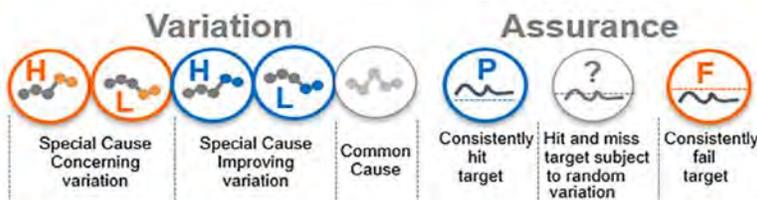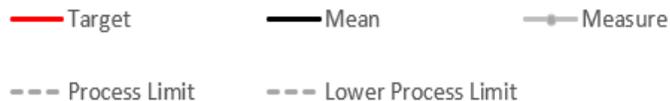
Chart Legend

— Target   — Mean   — Measure

--- Process Limit   --- Lower Process Limit

Variation

Special Cause Concerning variation | Special Cause Improving variation | Common Cause

Assurance

Consistently hit target | Hit and miss target subject to random variation | Consistently fail target

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover within 30min	Nov 25	88.1%	95.0%	Common Cause	Hit and miss	79.8%	57.9%	101.7%
12 Hour Breaches	Nov 25	464		Common Cause		679	157	1201
Non-admitted 4 hour performance	Nov 25	84.3%	85.0%	Common Cause	Hit and miss	78.7%	68.6%	88.8%
12 hour breaches as a percentage of Type 1 attendances	Nov 25	5.9%		Common Cause		7.4%	1.6%	13.3%
Urgent 2 hour response - UCR	Nov 25	92.3%	70.0%	Common Cause	Consistently hit	91.3%	84.5%	98.0%
Criteria to reside (Average without reason to reside) Acute	Nov 25	46		Common Cause		51	37	65
**Criteria to reside (Average without reason to reside) Community	Nov 25	32		Common Cause		33	31	34
% patients with no criteria to reside (acute)	Nov 25	11.0%	10.0%	Common Cause	Hit and miss	11.8%	8.1%	15.4%
Virtual Beds Trajectory	Nov 25	53	40	Special Cause Improving (H)	Consistently hit	49	46	53
Virtual Ward Total average occupancy percentage	Nov 25	60%	80%	Common Cause	Hit and miss	67%	42%	92%

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

ED 4 hour performance summary - all departures

ED 12 hour performance summary - Type one departures only

	What	So What?	What Next?
Urgent & Emergency Care	No significant change demonstrated for 30 min Ambulance handover metric. In November we achieved 88.1% on a target of 95%. Numbers of 12 hour length of stay breaches were reduced going from 723 in October to 464 in November. Numbers of 12 hour breaches as a percentage of attendances demonstrated no significant change although reduced from 8.27% in October to 5.2% in November. Non-admitted performance for November was 84.3% narrowly missing our target of 85%. In November, we met and exceeded our in month trajectory of 72% achieving 75.16%.	Meeting the Urgent and Emergency Care (UEC) performance metrics means that our patients receive timely, safe care. Achieving the ambulance handover metrics and the 78% 4-hour Emergency Department standard will meet the national targets. Meeting the in month trajectory for the 4 hour Emergency Department metric will keep us on track to achieve 78% by March 2026.	• Continued work to meet monthly trajectory to achieve 78% 4hr Emergency Department target by March '26. • Weekly performance meetings with the Emergency Department and Medical Division senior leaders/Executives continue. • Senior operations/nursing team continued daily support to ED. • The new Service Manager for the Emergency Department took up post from the 1st December. • Continued focus on the workstreams of the UEC Delivery Group. • Continued focus on length of stay reductions to support flow out of the Emergency Department, including the task and finish group for board rounds/huddles. • Reintroduction of huddles throughout the day within the Emergency Department, with Senior ED team present enabling time to focus, identify issues and plan. • Straight to Same Day Emergency Care" (SDEC) work continues with a cross divisional meeting planned for December. • Focus work on the minor non-admitted stream of patients during the twilight hours continues with a registrar allocated to this group. • Have been working with the Suffolk GP Federation (SFED) service to expand the criteria of patients seen by the Emergency Department General Practitioner. This work has been very successful and further support is being given to the Streaming team by SFED to increase confidence in referring with the new criteria. This should be demonstrated by a rise in utilisation of slots for December.
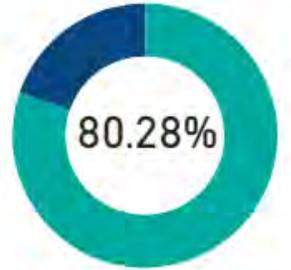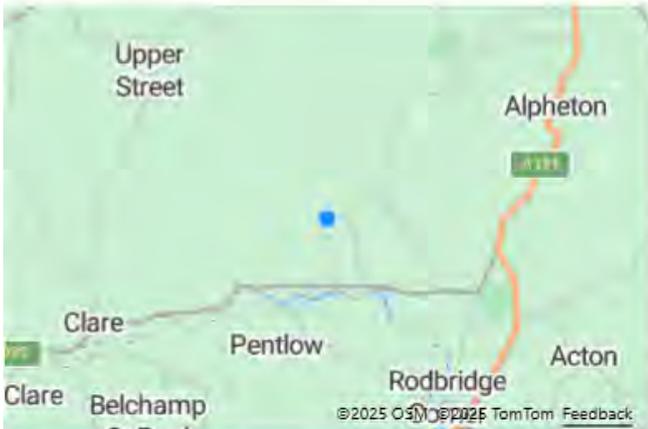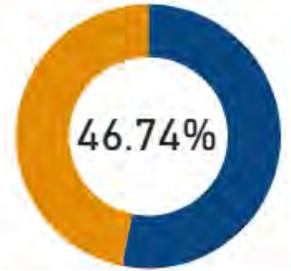
Practice Appointments

Produced by ICB

Urgent 2 hour response – UCR

Number of 2hr UCR Clock Stops and Compliancy for INT Nursing & Therapy and EIT
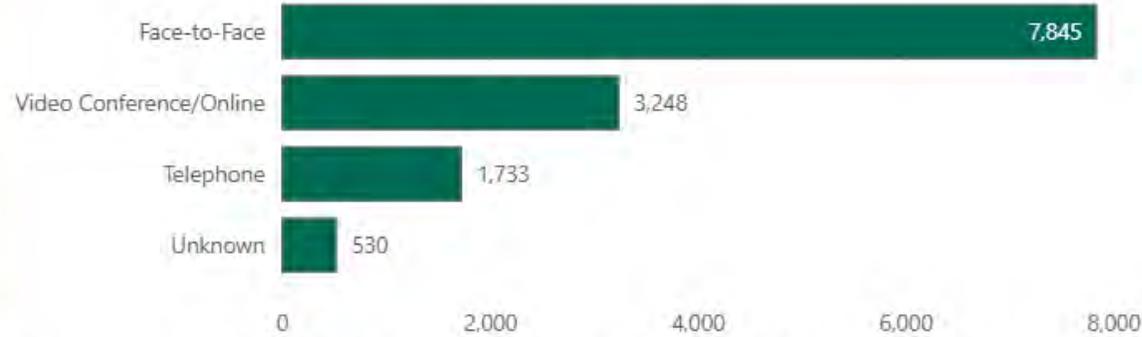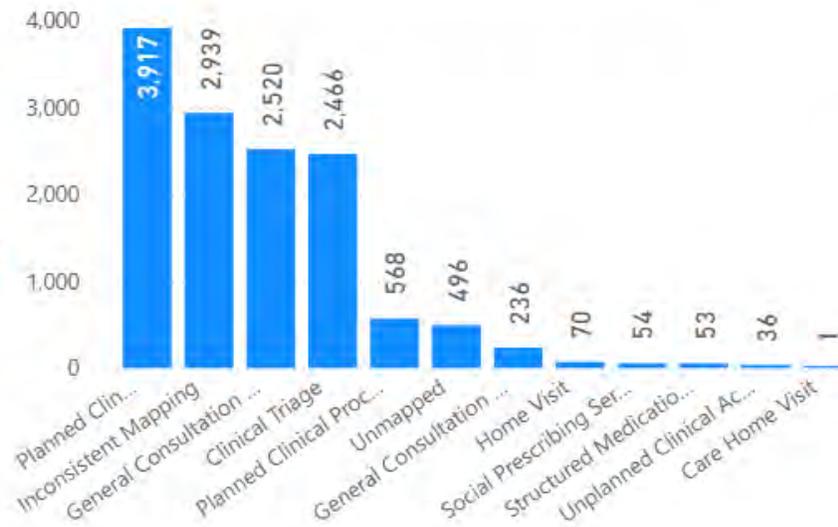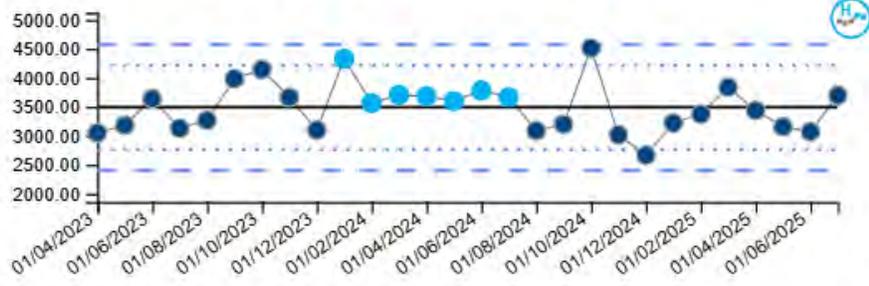
Number of 2hr UCR Compliant Clock Stops and Target Increase
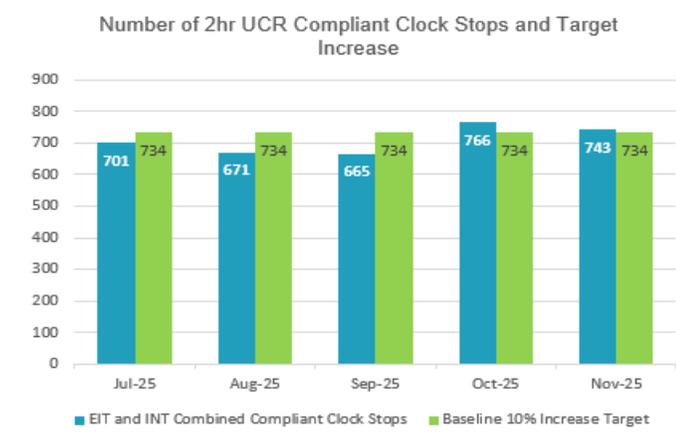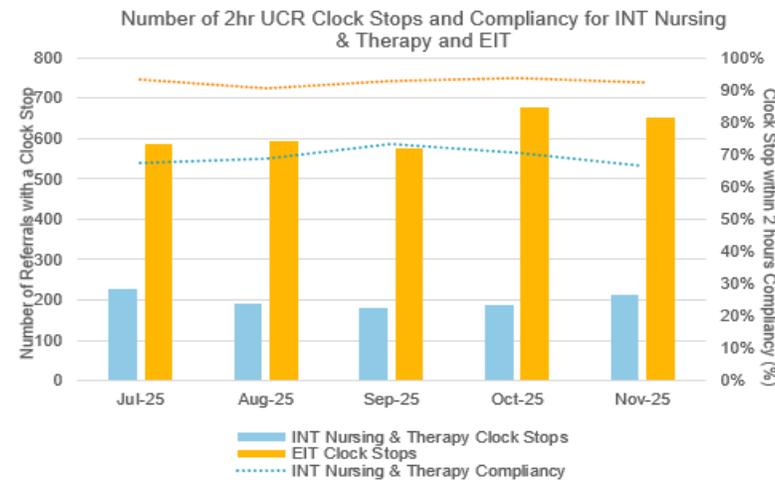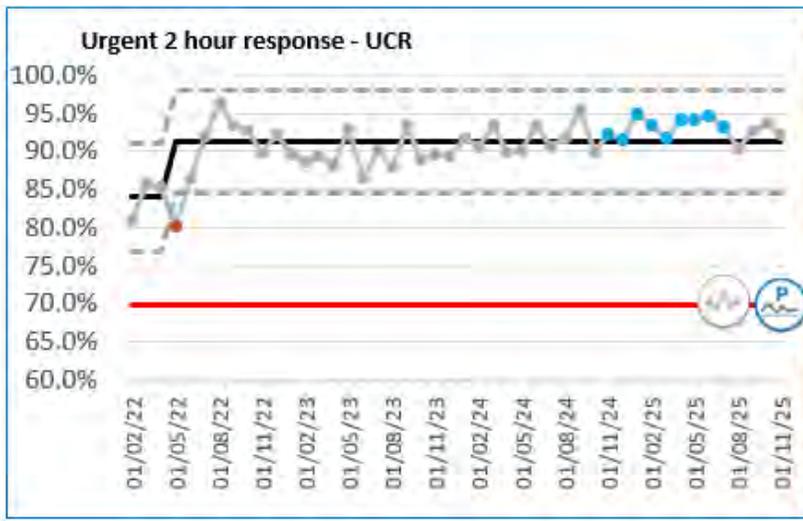
Team	Jun-25				Jul-25				Aug-25				Sep-25				Oct-25				Nov-25			
	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant
Total INT Nursing & Therapy	215	155	60	72%	227	153	74	67%	192	132	60	69%	179	131	48	73%	187	132	55	71%	212	141	71	67%
Total UCR*	591	560	31	94.75%	587	548	39	93.36%	596	539	57	90.44%	576	534	42	92.71%	677	634	43	93.65%	652	602	50	92.33%
Combined Total	806	715	91	88.71%	814	701	113	86.12%	788	671	117	85.15%	755	665	90	88.08%	864	766	98	88.66%	864	743	121	86.00%

What

UCR 2-hour performance remains above target at 88%. Community Urgent Care Response (UCR) 2 hour response is at 67% in Integrated Neighbourhood Teams (INTs) under the 70% target. UCR requires clinical prioritisation with current workforce capacity. In October (November data unavailable) an average of 27 patient treatments a day were reported as cancelled to manage capacity and prioritise urgent work.

So What?

Increased cancellations of planned care presents risk to quality of patient care and increases the workload for co-ordinators and clinicians to re-organise care.

What Next?

Working with INTs to take on more UCR therapy work during the daytime, to free up Early Intervention Team (EIT) therapy staff to focus on Emergency Dept/ Acute Assessment Unit to support performance. Aim to pilot from mid-January. Will need to monitor effect on other INT Referral To treatment performance indicators.

Urgent & Emergency Care: Criteria to reside

What	So What?	What Next?
The monthly average acute no criteria to reside (NCTR) has increased to 11.0% the highest this year since February. In comparison the NCTR for November 2024 was 11.9%. Transfer of Care Hub (TOCH) teams have had staffing challenges due to long and short term, planned and unplanned sickness. Community no criteria to reside figures have increased this month. We continue to utilise beds for delayed patients who transfer over with no criteria to reside.	Patients remaining in hospital longer without criteria to reside directly impacts on bed capacity and patient flow within the Trust. Longer length of stay leads to greater deconditioning and loss of independence.	Provisional data set for the delayed transfers to Community Assessment Beds (CAB) and reasons has been produced by the information team – the data is being cleansed, and a summary overview will be part of next month's PRM pack. Conversations continue with Adult Social Care management re. additional support for the hospital team and developing escalation triggers to avoid bottle necks when referral numbers increase.

Virtual Ward Total average occupancy percentage

What	So What?	What Next?
Average occupancy in November was 60%, an increase from 55% the previous month. Total bed nights occupied were 954 (increase from 911). Patient flow is supported by effective length of stay which is well managed at average 8.3 in November (decrease from 8.7 the previous month). This is significantly below the NHSE target of 14 days . Virtual Ward (WV) audit indicates that this is achieved whilst maintaining appropriate acuity.	Virtual Ward capacity is crucial in ensuring adequate capacity to enable patient flow across the Trust and strategic ambition of caring for patients at or near home wherever possible. Appropriate length of stay is important to facilitate effective patient flow and ensure that value for money is achieved in relation to the investment in virtual care	Key service developments to further increase the number of patients cared for on Virtual Ward are: 5 January – start of pilot of (I) long lies pathway via Cleric referrals and flexing of staffing across VW and EIT. Further discussions re onboarding out of hours and joint pilot with GP Federation. POCT pilot in "grab bags" and expand to weekends by end January. Also in January: implementation of integrated referral portal for community IV patients and use of elastomeric pumps to expand availability of pathway. Ongoing engagement with primary care and other community services to maximise step up patients to VW

Cancer Access Summary
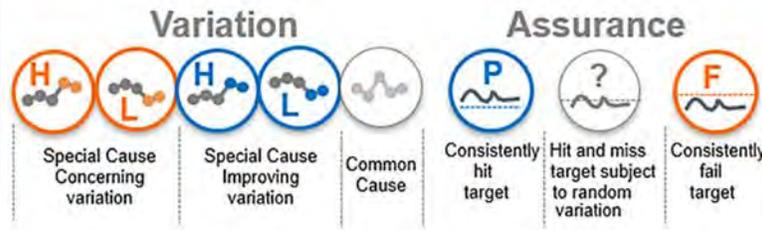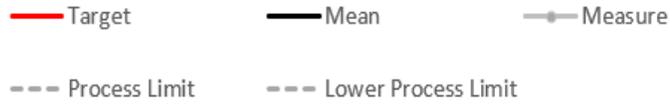
Target ——— Mean ——— Measure

- - - Process Limit - - - Lower Process Limit

Variation

Special Cause Concerning variation	Special Cause Improving variation	Common Cause

Assurance

Consistently hit target	Hit and miss target subject to random variation	Consistently fail target

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	Oct 25	74.8%	77.0%	(common cause)	(?)	69.2%	57.2%	81.2%
Cancer 62 Days Performance	Oct 25	81.9%	70.0%	(common cause)	(?)	72.1%	56.2%	87.9%
Incomplete 104 Day Waits	Oct 25	13	0	(common cause)	(F)	26	8	43

Cancer Access (Month Behind)

What	So What?	What Next?
28-day performance was 74.8% for October 2025. The under performance is mostly related to the Breast performance which was at 68%. This was due to vacancies and sickness within all staff groups. Performance is expected to improve in November and December but sickness is still having an impact.

Performance was sustained in Gynaecology, Head and Neck, Skin, Lung and Upper GI with focus required in Lower GI and Urology.

Despite these challenges the 62 day treatment performance increased to 81%, with strong performance in all tumour sites.

The volume of patients over 104 days reduced significantly following the clearance of the patients in the Skin upgrade backlog. | Recovering the cancer standards is key to the operational planning guidance 25/26.

The priorities for this year focus on seeing, diagnosing and treating patients in line with national guidance to improve patient outcomes and maintain standards. | External review for breast service to be completed by Cancer Alliance.

Urology pathway reviews underway, faster diagnosis steering group recommenced with several key actions in place including revising the bladder pathway and a focus on reporting – new pathway due to commence in January 2026.

Continue with additional cancer session in endoscopy to improve FDS performance. |

Chart Legend
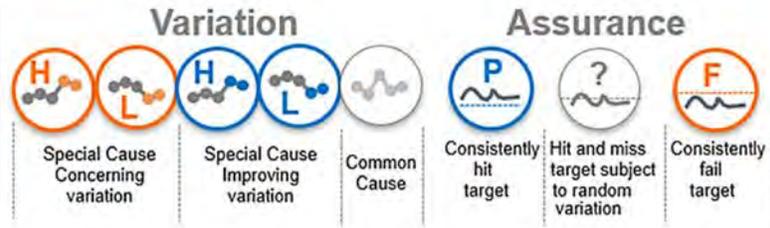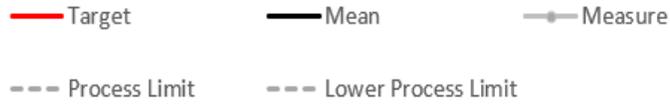
— Target   — Mean   —•— Measure

--- Process Limit   --- Lower Process Limit

Variation

Special Cause Concerning variation	Special Cause Improving variation	Common Cause

Assurance

Consistently hit target	Hit and miss target subject to random variation	Consistently fail target

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Diagnostic Performance- % within 6weeks Total	Nov 25	56.7%	99.0%	(Common Cause)	(F)	58.1%	49.4%	66.8%
RTT Waiting List	Nov 25	32931	-	(Common Cause)		33327	31997	34657
RTT 52+ Week Waits	Nov 25	776	-	(Special Cause Improving L)		1597	1316	1879
RTT 65+ Week Waits	Nov 25	55	0	(Special Cause Improving L)	(F)	338	177	499
RTT 52+ Weeks Wait as % of Total WL	Nov 25	2.4%	-	(Special Cause Improving L)		6.3%	5.1%	7.5%
RTT <18 Week Waits (% All)	Nov 25	62.1%	-	(Special Cause Improving H)		57.9%	55.2%	60.6%
RTT <18 Week Waits (% First OPA)	Nov 25	74.2%	-	(Common Cause)		72.7%	69.8%	75.7%

Diagnostic Performance- % within 6weeks Total

Diagnostics
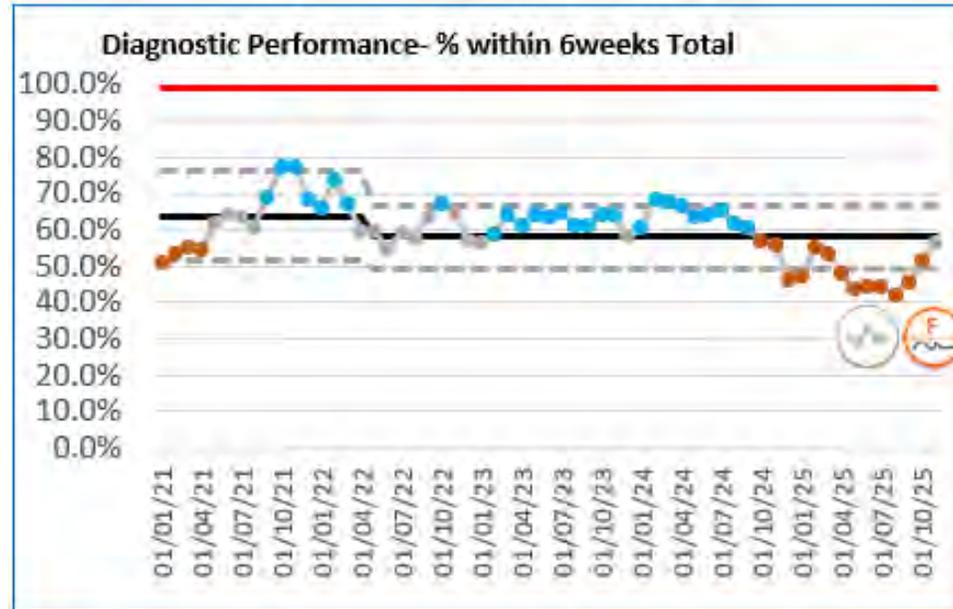
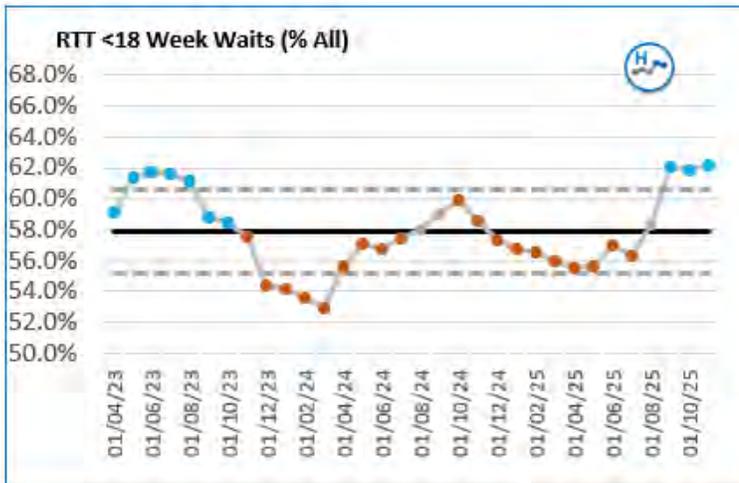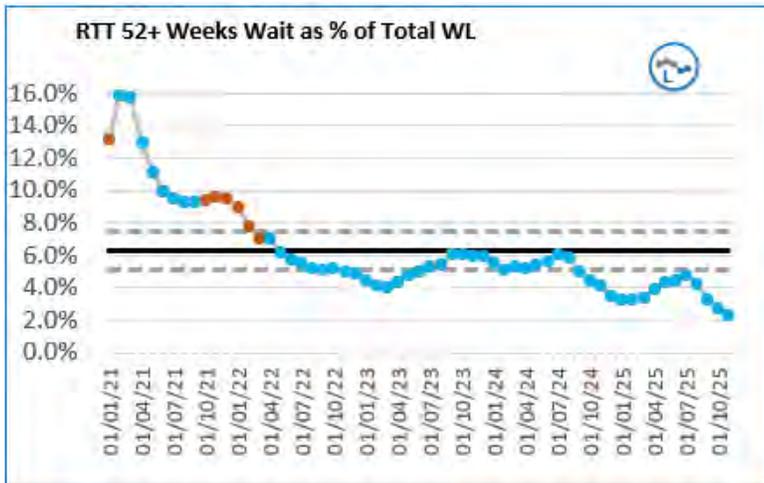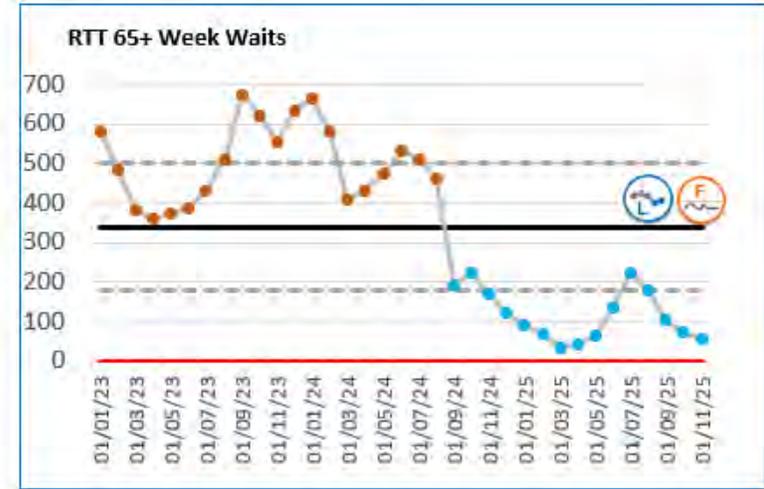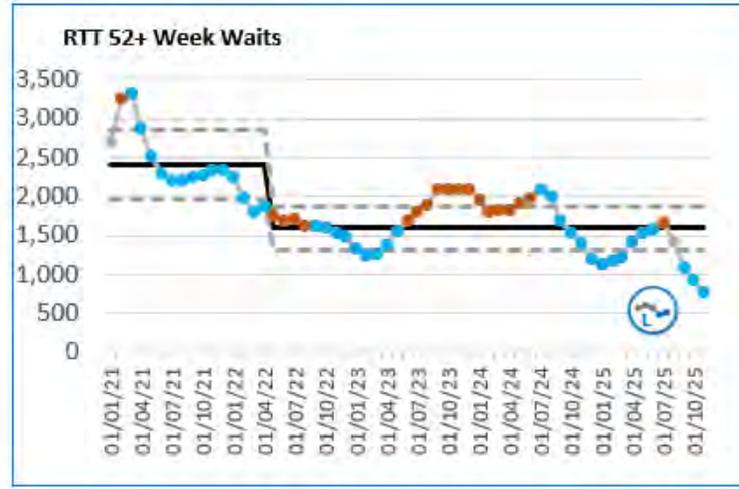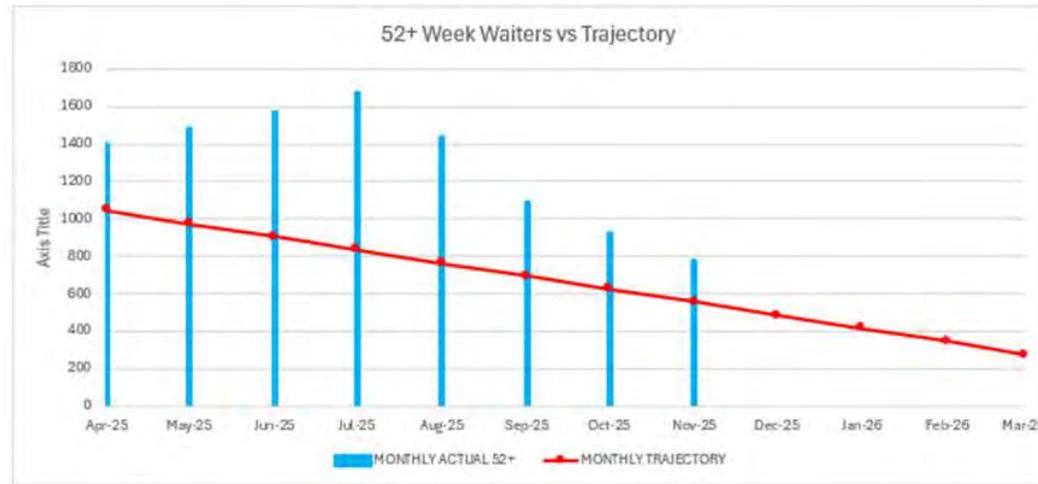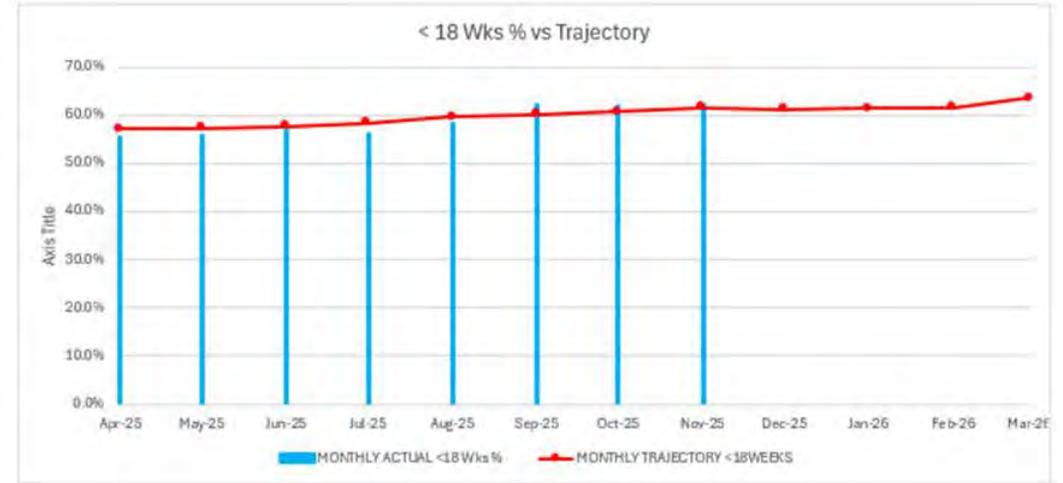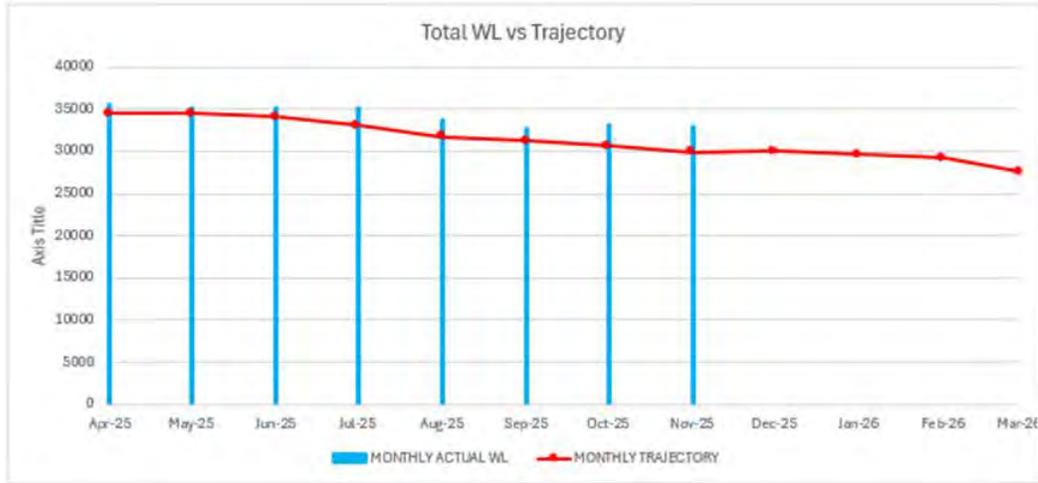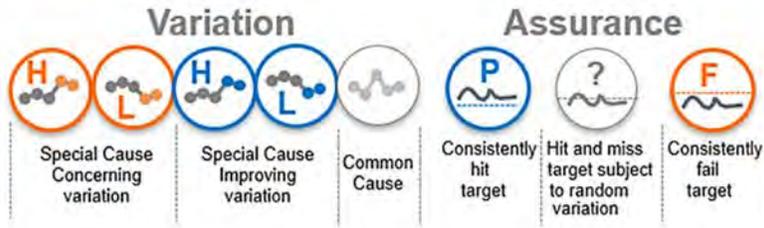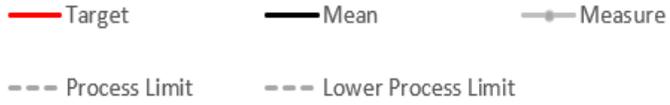| What	So What?	What Next?
MRI - Marginally under DM01 target at 98.4% in month. **CT** –compliant with DM01 target at 99.5% in month. **US** – The total waiting list size continues to reduce and DM01 has started to improve as a result of the weekend insourcing lists and additional in week capacity. Current weekly DM01 44.28% with a total waiting list size of 3900 as at 16/11. **DEXA** – Service went live in June 2025. Phased increase in activity planned which will see forecast improving to 89% by March 2026. Current DM01 25.30% with total waiting list size 1320 as at 16/11 **Endoscopy –** Priority being given to patients on a cancer pathway requiring a rebalancing of capacity to support. A successful bid for cancer funding for 25/26 is supporting the stabilisation of the endoscopy cancer demand but routine endoscopy performance is vulnerable. Options appraisal approved at MEG for recovery and alignment to JAG requirements. Seed funding for Newmarket Endoscopy Community Diagnostic Centre (CDC) extension business case delivery has been allocated and is being drawn down, business case progressing. Initial forecast position impacted by sickness within the nursing team, which has increased cancellations. Weekend lists are continuing as part of the recovery of endoscopy services, but this is partly just mitigating the in-week cancelations driven by the staffing pressures. The team continue to work to secure agency nursing during this increased level of sickness, and insourced lists supported by approved CDC underspend are being sourced to mitigate forecast position. The procurement process has completed, and a tender awarded with a go live date of very early January 2025 anticipated, and improving the DM01 forecast position to 58.10% by end of March 2026. **CDC Activity** – A continued focus remains on achieving the full activity plan for the Newmarket CDC, which faces sustained recruitment challenges across several key modalities. In September, CDC activity reached 46% of the planned level, with 68% of staff recruited. Notably, imaging activity increased by 18% between August and September. The current trajectory suggests 61% of the activity plan will be delivered. **AUDIOLOGY** – continuing on upward trajectory at 81.1%, A 5.2% improvement since October. Continuing to prioritise DM01 patients, ongoing validation supporting improvement. Physical capacity modelling indicates an inability to hot target due to soundproof booth capacity, a service review planned for January 2026. **URODYNAMICS**- 77.8%, improvement of 7.4% since October; urodynamic performance fluctuates as patients requiring TP biopsy and cystoscopy are prioritised as suspected cancer pathways. TP biopsy capacity has increased by 7% compared to 2024 so further eroding capacity. Training of a urology clinical nurse specialist is ongoing. Consultant interviews 18/12/25, successfully appointed. **CYSTOSCOPY** -Cystoscopy deterioration (89.8%) is driven by consultant absence and increased TP biopsy demand; capacity being flexed to deliver maximum activity across all modalities. SpR is picking up in-week capacity to mitigate resource loss but unable to deliver as many points, haem/flexi capacity reduced by 30% across a 6-week period due to planned absence, the loss of consultant disenabling planned backfill.	Longer waiting times for diagnosis and treatment have a detrimental effect on patients. Delay in achieving DM01 compliance standards.	**MRI** – return to compliance anticipated. **CT** – return to compliance anticipated. **US** –Staffing issues remain unresolved, and CDC capacity will not be realised until recruitment picture improves. Insourcing mobilised following procurement process. **DEXA** – Recovering as forecast. Activity increased to 5 days a week from the 15th October 2025 ahead of plan. **Endoscopy** – longer term CDC endoscopy expansion at Newmarket will address demand. Ongoing insourcing and temporary capacity will be required in the interim period and is being addressed via 2026/27 business planning to ensure a positive trajectory of recovery is maintained to meet DM01 standard. DM01 and CDC recovery plans presented to Insight Committee in November. **Recovery actions forecast improvement from current overall DM01 position in September of 45.5% to 76% by end of March 2026.** **AUDIOLOGY-** service review planned for January 2026 **URODYNAMICS-** service review planned for 26/27 **CYSTOSCOPY-** successful consultant recruitment, PTL validation ongoing.

Elective Access: RTT

| What	So What?	What Next?
End of November 2025 saw a further reduction in patients waiting over 65 weeks with 55 patients reported this month, with the ambition to continue to reduce to 0, with patient choice and clinical breaches forecast there will be a further reduction in December. The total waiting list size remained stable and there was a slight improvement in the 18 week compliance performance at just over 62%, this was slightly behind our forecast of 63%. The volume of 52 week waits continues to reduce, however is above the revised forecast. The main driver for this due to an inability to fully staff all approved additional sessions, particularly for General Surgery and Orthopaedic theatre lists and ENT outpatients' sessions. The percentage of patients waiting less than 18 weeks for a first appointment has improved as a result of the Dermatology insourcing, transformation and productivity gains in outpatients.	Patients are at increased risk of harm and/or deteriorating the longer they wait. This increases demand on primary and urgent and emergency care services as patients seek help for their condition.	Additional validation resource to commence again for sprint 4 in January 2026. Focus on outpatient activity and engage with outpatient productivity sprint. Continue with previously agreed additional sessions as part of elective recovery plan.

Elective Access: Activity

Elective Access: Summary

— Target   — Mean   —•— Measure

--- Process Limit   --- Lower Process Limit

Variation

H ●● / ●
L

Special Cause Concerning variation

H ●●●
L ●●

Special Cause Improving variation

Common Cause

Assurance

P

Consistently hit target

?

Hit and miss target subject to random variation

F

Consistently fail target

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Community Paediatrics RTT Overall Waiting List	Nov 25	813		(H↗)		543	477	609
Community Paediatrics RTT Overall 52 Weeks Wait	Nov 25	40		(H↗)		4	-1	10

Community Paediatrics RTT Overall Waiting List

Community Paediatrics RTT Overall 52 Weeks Wait
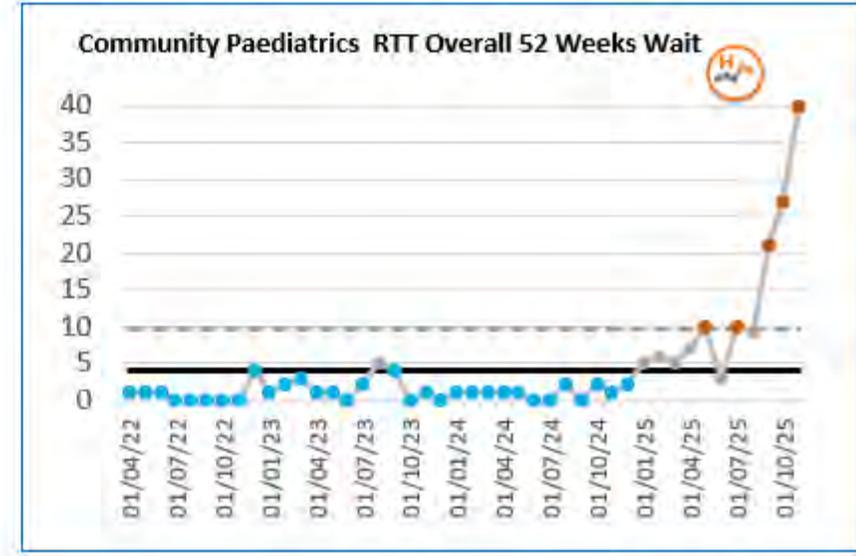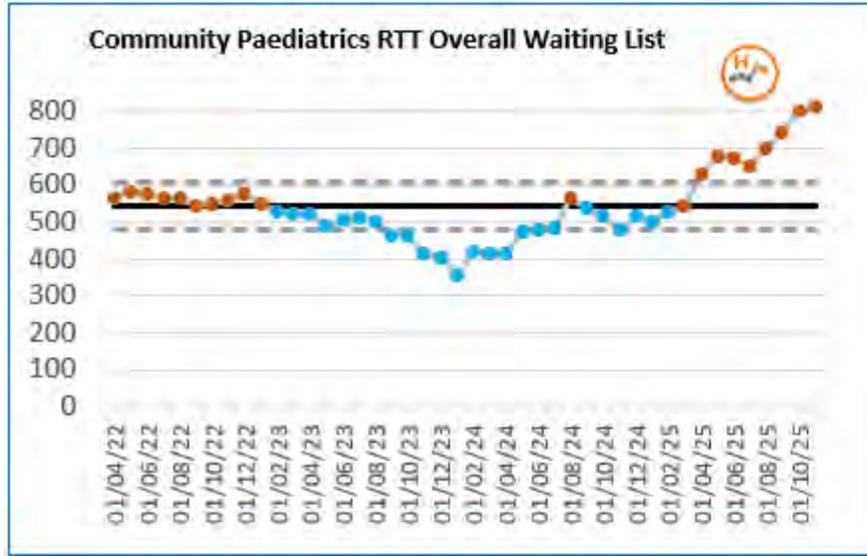
What	So What?	W
There is sustained deterioration in waiting times for the paediatric team due to sustained level of demand and reduced capacity within the medical team. Longest wait associated with a child who moved into area with a long waiting clock ticking from another county (school age NDD). Longest waiting times, above 52wks are associated with autism assessments.		Full t exte 1 pa in ne Mon .

NHS England - 25/26 (Monthly - IQPR)
Outpatient weekly data only includes e-care records (no Cardiology Diagnostics or Radiology)

West Suffolk NHS
NHS Foundation Trust

Elective Access: Activity

| All | ⌄ |
| All | ⌄ |

Outpatient First

Mon	25/26	24/25	Plan	Var	Var %
Apr	9,740	9,572	9,955	(215)	(2.2%)
May	10,146	9,814	10,207	(61)	(0.6%)
Jun	10,442	10,051	10,453	(11)	(0.1%)
Jul	10,534	10,645	11,070	(536)	(4.8%)
Aug	9,023	8,967	9,325	(302)	(3.2%)
Sep	10,901	10,529	10,950	(49)	(0.5%)
Oct	11,320	11,008	11,448	(128)	(1.1%)
Nov	10,730	9,814	10,207	523	5.1%
Dec		9,809	10,201		
Jan		10,172	10,579		
Feb		9,814	10,207		
Mar		10,893	11,328		
Total (YTD)	82,836	80,401	83,616	(780)	(0.9%)

November 2025

25/26	10,730
24/25	9,814
Plan	10,207
Var	523
Var %	5.1%

Daycase

Mon	25/26	24/25	Plan	Var	Var %
Apr	2,291	2,317	2,363	(72)	(3.1%)
May	2,410	2,405	2,453	(43)	(1.7%)
Jun	2,320	2,433	2,481	(161)	(6.5%)
Jul	2,528	2,606	2,658	(130)	(4.9%)
Aug	2,319	2,170	2,214	105	4.8%
Sep	2,615	2,549	2,599	16	0.6%
Oct	2,740	2,606	2,658	82	3.1%
Nov	2,403	2,375	2,423	(20)	(0.8%)
Dec		2,315	2,362		
Jan		2,462	2,511		
Feb		2,405	2,453		
Mar		2,666	2,719		
Total (YTD)	19,626	19,460	19,849	(223)	(1.1%)

November 2025

25/26	2,403
24/25	2,375
Plan	2,423
Var	(20)
Var %	(0.8%)

Outpatient Follow Up

Mon	25/26	24/25	Plan	Var	Var %
Apr	26,245	25,589	24,054	2,191	9.1%
May	25,863	26,236	24,662	1,201	4.9%
Jun	26,234	26,868	25,256	978	3.9%
Jul	27,333	28,456	26,749	584	2.2%
Aug	23,473	23,971	22,532	941	4.2%
Sep	27,560	28,148	26,459	1,101	4.2%
Oct	28,457	29,427	27,662	795	2.9%
Nov	24,460	26,236	24,662	(202)	(0.8%)
Dec		26,221	24,648		
Jan		27,192	25,560		
Feb		26,236	24,662		
Mar		29,119	27,372		
Total (YTD)	209,625	214,932	202,035	7,590	3.8%

November 2025

25/26	24,460
24/25	26,236
Plan	24,662
Var	(202)
Var %	(0.8%)

Elective

Mon	25/26	24/25	Plan	Var	Var %
Apr	244	261	267	(23)	(8.5%)
May	246	268	273	(27)	(10.0%)
Jun	215	278	283	(68)	(24.1%)
Jul	232	301	307	(75)	(24.3%)
Aug	252	251	256	(4)	(1.7%)
Sep	247	291	297	(50)	(16.7%)
Oct	278	301	307	(29)	(9.3%)
Nov	236	268	273	(37)	(13.7%)
Dec		261	266		
Jan		255	260		
Feb		268	273		
Mar		304	310		
Total (YTD)	1,950	2,218	2,263	(313)	(13.8%)

November 2025

25/26	236
24/25	268
Plan	273
Var	(37)
Var %	(13.7%)

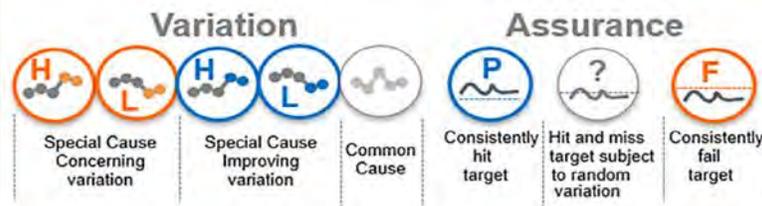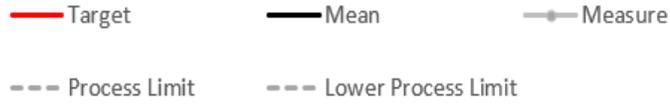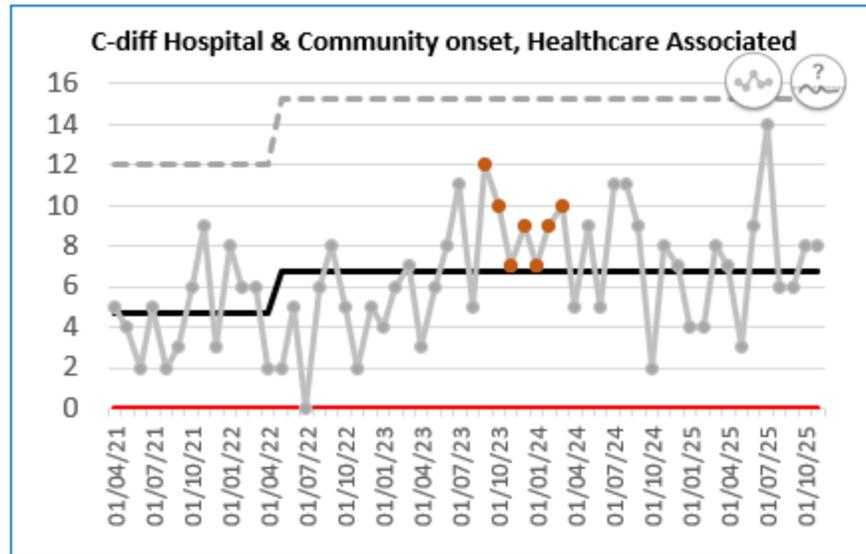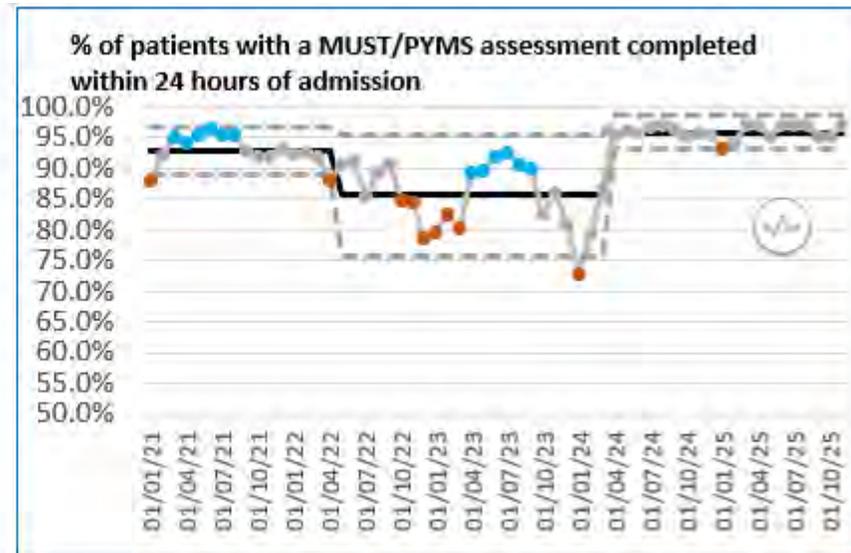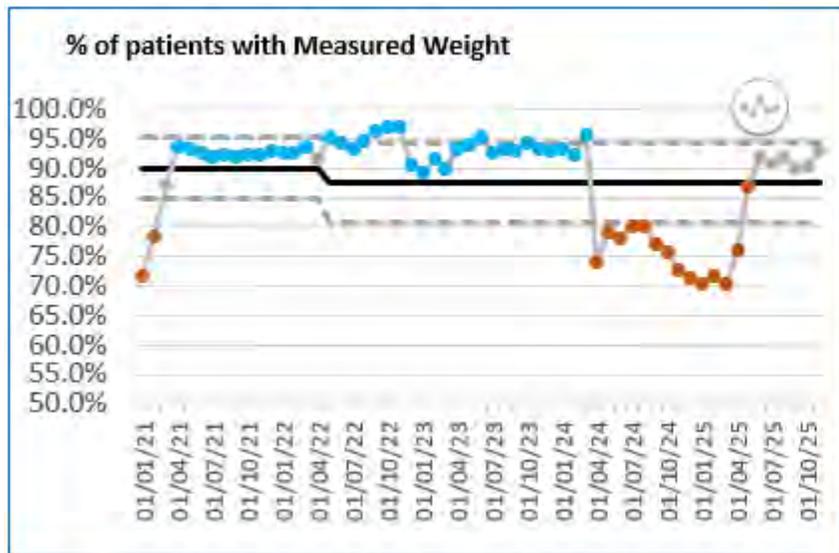| What	So What?	What Next?
Activity plans for first outpatient attendances were met for the first time this year in November 2025 but with the gap in elective activity widening once again to -13.7%. Day case activity fell behind plan, having been ahead for the previous three months. Outpatient follow ups being behind plan and the 2024/25 position is generally seen as a positive, as this reduces the new to follow up ratio and creates more new patient capacity	From 2025/26, ICB's and providers must agree an Indicative Activity Plan (IAP), failure of which to deliver can result in contractual penalties. Delivery of increased activity levels is also required to meet improvements in Referral to Treatment (RTT): 5% improvement in the number of patients waiting 18 weeks or less and less than 1% of people waiting 52 weeks or more.	Specialty level RTT trajectories are monitored through weekly access meetings – for most specialties the activity required to deliver these will exceed the Indicative Activity Plan totals. Spending is being reviewed against the £440K allocation from Management Executive Group to identify opportunities to go further, as well as responding to national initiatives to incentivise 52 week wait reduction and additional new outpatient activity in Q4. Delivery of productivity initiatives across theatres and outpatients is supported through the Productivity Programme Board.

QUALITY & PATIENT SAFETY COMMITTEE METRICS

Chart Legend

— Target   — Mean   —•— Measure

--- Process Limit   --- Lower Process Limit

Variation

| Special Cause Concerning variation | Special Cause Improving variation | Common Cause |

Assurance

| Consistently hit target | Hit and miss target subject to random variation | Consistently fail target |

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
C-diff Hospital & Community onset, Healthcare Associated	Nov 25	8	0	⟳	?	7	-2	15
% of patients with Measured Weight	Nov 25	93.0%		⟳		87.5%	80.7%	94.3%
% of patients with a MUST/PYMS assessment completed within 24 hours of admission	Nov 25	97.0%		⟳		95.9%	93.2%	98.6%
Post Partum Haemorrhage	Nov 25	6		⟳		7	-1	15

C-diff Hospital & Community onset, Healthcare Associated

Safe

What	So What?	What Next?
November data continues to illustrate common cause variation with hit and miss target subject to random variation, with limited assurance of sustained improvement at this point. Trust case rate comparison April - November 2024/25 to April - November 2025/26 shows a total number case rate that is comparable.	Infection prevention and control is a key priority for all NHS providers and will part of the NHS oversight framework. Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. They can pose a serious risk to patients, staff and visitors, *Clostridioides difficile* are bacteria found in the bowel, usually causing no harm. This bacteria can cause diarrhoea, especially in older persons, those who have been in contact with a contaminated environment, have undergone bowel procedures or in people who have been or are being treated with certain antibiotics. Data suggests that West Suffolk has a higher-than-average age population. NHS England 'Standard contract for Minimising *Clostridiodes difficile* and Gram-negative bloodstream infections' 2025/26 sets a threshold based on previous year's performance. For 2025/26 reporting year the trust threshold is 81, a reduction of a count of two from the previous reporting year.	At present, the service remains above trajectory to meet the specified indicator following the increase cases related to the *Clostridiodes difficile* outbreak June/July. However, targeted interventions have and are taking place, and we remain confident that with continued focus and leadership support, performance will improve and progress toward the indicator will be accelerated. The IPC Healthcare Associated Infection weekly review has recently been supported by an infection control doctor, (Consultant Microbiologist) which will continue as capacity allows. The Quality Improvement Programme continues with *Clostridiodes difficile* programme, the programme board has re-convened with Deputy Chief Nurse support as chair, monthly meetings are now in place for the next year to gain and maintain momentum. This co-insides with the organisation of the 'gloves off' campaign, also supported by the Deputy Chief Nurse and the Patient Safety & Quality clinical support team, engaging a broad range of staff, with an initial focus on reinforcement & education surrounding correct use of standard precaution personal protective equipment (PPE).

% of patients with Measured Weight

% of patients with a MUST/PYMS assessment completed within 24 hours of admission

Safe

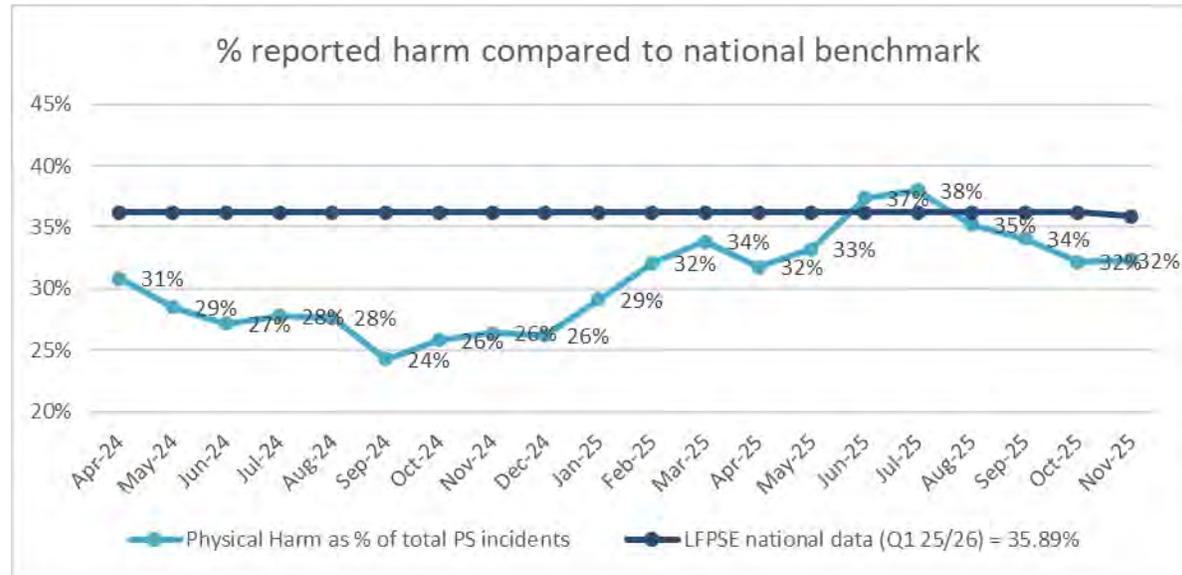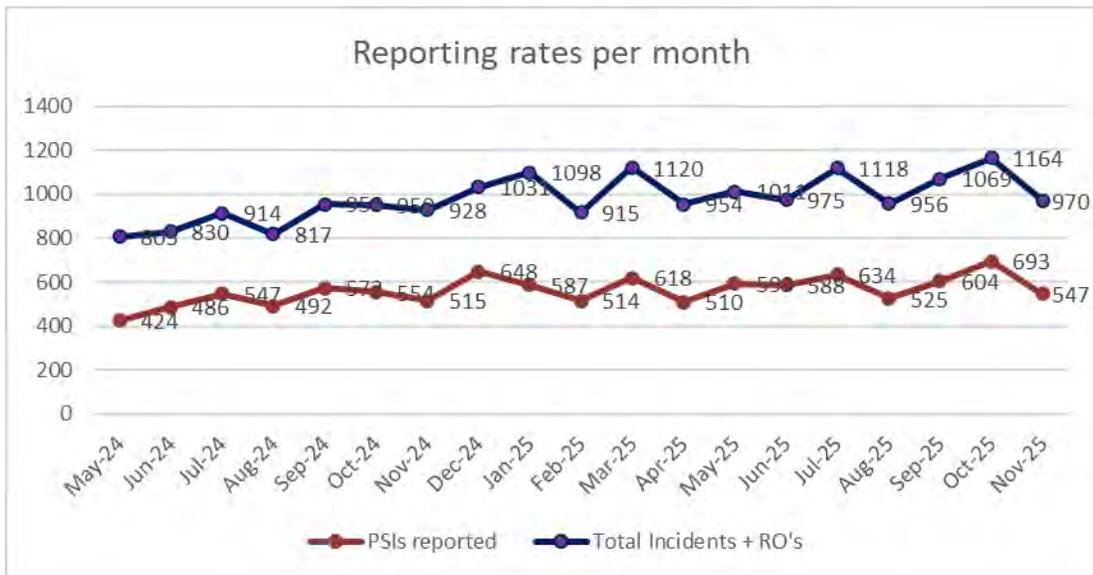| What	So What?	What Next?
Nutritional assessment (MUST) within 24hrs – 97.0% **% of Patients with a measured weights – 93.0%** The measured weights metric is currently exhibiting common cause variation above established mean. This positive shift reflects the impact of our ability to drill down to ward-level data, which has enabled a more targeted and responsive improvement approach. Progress and key outcomes are now routinely monitored through monthly performance meetings, ensuring that actions remain aligned with wider quality, safety. This structure supports sustained improvement and early identification of any emerging issues. The MUST results continue to demonstrate expected natural (common-cause) variation, indicating a stable and reliable process. Performance remains consistently high, supporting the delivery of high-quality nutritional care for our patients. The strengthened collaboration between dietitians and nursing teams is contributing to this positive performance, reflected in sustained compliance and improved patient outcomes	Good nutrition is an integral component of patient care. Eating well not only provides significant physical benefits but also contributes to a patient's psychological comfort and overall experience during their admission. Adequate nutrition strengthens the immune response and reduces vulnerability to hospital-acquired infections, supporting safer and more effective recovery. The World Health Organization has also recognised the importance of nutrition, and between 2016–2025 has promoted the broader concept of "food as medicine", emphasising the essential role diet plays in health and healing. Improving nutritional care remains a key focus for all teams, and there is growing awareness that strong nutritional practice is central to achieving positive patient outcomes. While effective MUST scoring can be completed using estimated weights, obtaining an actual measured weight remains best practice and supports more accurate assessments. Additional MUST training is available within Tōtara to ensure staff feel confident and competent in applying the tool consistently.	• Liaise with Dieticians to monitor impact of any delayed assessments and shared learning from this. • To build stronger working relationships with Dieticians on the ward, scheduled slot on the medical and surgical ward managers meeting. This relationship improvement is now impacting the data • Weights on admission is maintaining at a high level, to be further reviewed in January • Targeted approach continues, with wards now owning their own data and acting on this as required, this is then reviewed at monthly performance. • Continue focus on the importance of Nutrition, reviewing protected mealtime audit data, looking at conducting peer reviews between wards, this is on hold currently due to IT issues. A fix is now being developed and hopefully should go live in the new year. • Charitable funding now being resourced for plate guards and adaptive cutlery • Re launch of the protected mealtimes audit and the importance of this
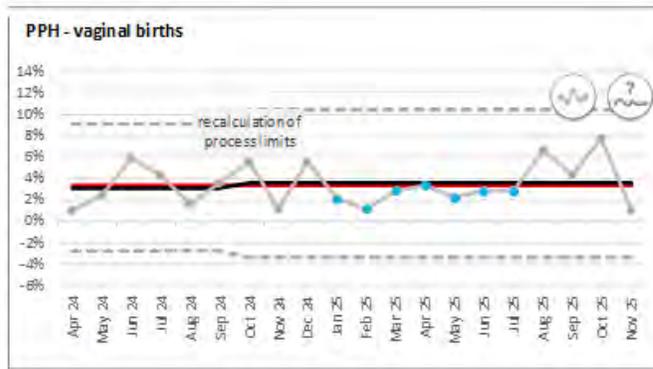
PPH - vaginal births

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

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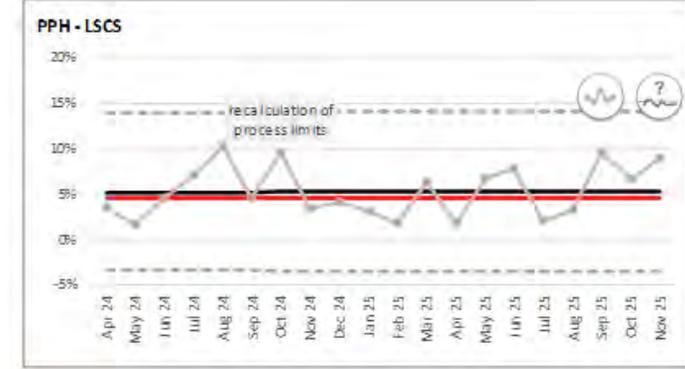
Quarter	Total C. section performed	PPH at CS	Total Quarterly rate
1 (Apr- Jun 2024)	205	9	4.40%
2 (Jul- Sept 2024)	191	12	6.30%
3 (Oct- Dec 2024)	213	11	5.20%
4 (Jan- Mar 2025)	194	6	3.10%
1 (Apr- June 2025)	182	9	4.90%
2 (Jul- Sept 2025)	198	10	5.10%

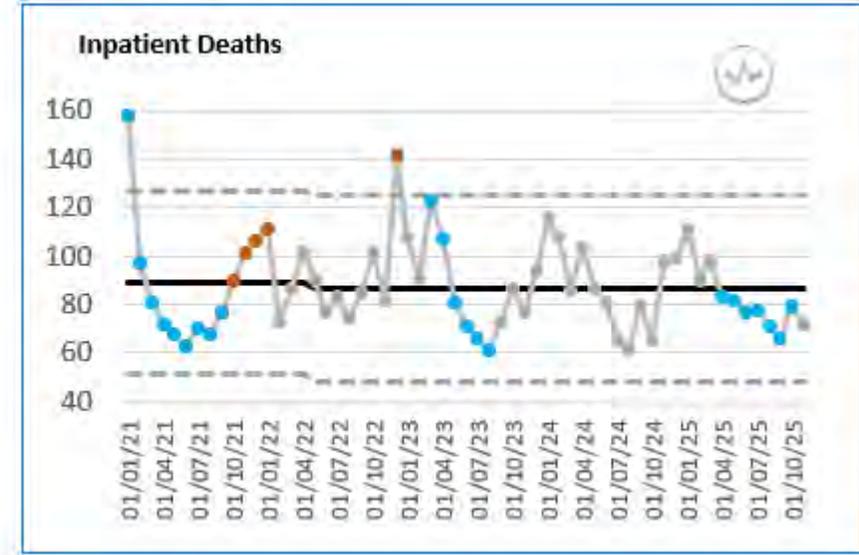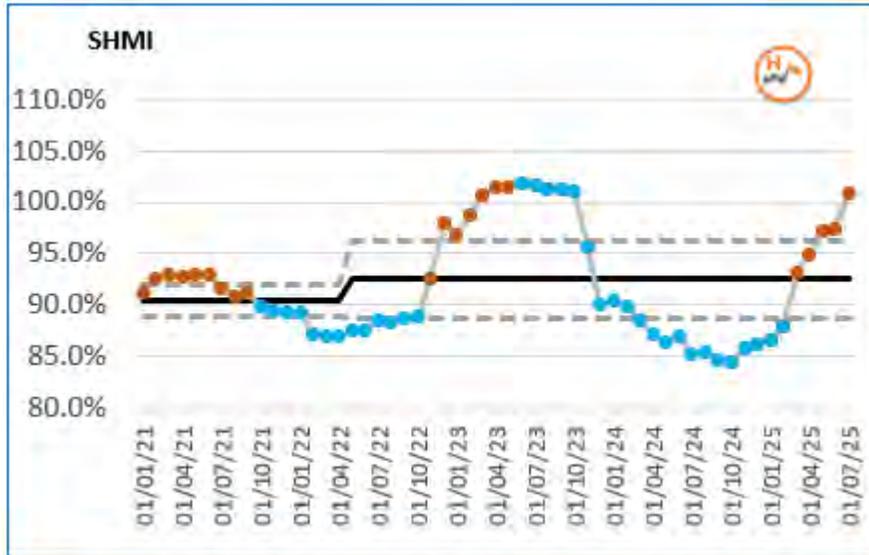| What	So What?	What Next?
PPH is one of the most common obstetric emergencies and requires clinical skills, with prompt recognition of the severity of a haemorrhage and emphasis on communication and teamwork in the management of these cases. Severe bleeding after childbirth - postpartum haemorrhage (PPH) - is the leading cause of maternal mortality world-wide. In November 2025, there were six reported post partum haemorrhages (PPH) over 1500 ml, of which: Five occurred following Lower segment Caesarean Section (LSCS) One occurring after a vaginal birth The most significant PPH of 4L was following an emergency LSCS. This case required a return to theatre for further management and was effectively managed through coordinated multidisciplinary team (MDT) response.	A further review has recently been undertaken from all deliveries from August 2024-July 2025. In this period, there were 71 PPH >1500 from 2079 births (3.4% PPH rate). While the number of PPHs is small, each case contributes significantly to clinical workload, resource utilisation and patient safety risk, reinforcing the need for continuous monitoring and assurance that preventive measures, early recognition, and prompt management are consistently delivered. The higher concentration of severe PPH following LSCS highlights an ongoing clinical risk associated with operative births, particularly in emergency settings where patients may present with complex risk factors or time-sensitive decision-making. The 4L PPH case reflects both the seriousness of potential haemorrhage and the strength of current escalation pathways, as the MDT response ensured appropriate intervention, preventing further morbidity.	The maternity department will continue to monitor PPH rates monthly, with board level visibility on any upward trends. Ongoing reviews of all PPH and thematic reviews are required to continue, to identify patterns, contributory factors, and opportunities to improve anticipatory risk management particularly for emergency LSCS. Learning dissemination; to share the positive learning from the well managed 4L PPH case, to reinforce effective teamwork and highlight clinical decisions that contributed to a safe outcome. Continue to invest in MDT simulation and skills drills, focusing on LSCS-related PPH, and effective communication between theatre and midwifery/obstetric teams.

Reporting rates per month

% reported harm compared to national benchmark

|	What	So What?	What Next?
	In November, there was a decline in reporting rates for incidents and reportable occurrences. Incidents related to bed capacity, information governance, discharge, transfer and follow up, clinical care and treatment, as well as slips, trips and falls, all showed reductions. In contrast, there was a slight increase in incidents associated with staffing difficulties. The patient safety team continues to benchmark the monthly percentage of reported harm against national figures provided by the Learning from Patient Safety Events (LFPSE) dataset. At the start of the quarter, the WSFT harm rate was 38%, slightly above the national average of 35.29%, before reducing to 34% in September.	We aim to promote the reporting of all incidents, including those causing little or no harm, as this supports learning and improvement efforts and helps prevent future physical and psychological harm to our patients. Tracking reporting rates provides insight into our safety culture, while measuring harm reflects the overall safety of our care. All patient safety incidents and reportable occurrences are reviewed quarterly and presented to the Quality and Safety committee. Incidents resulting in moderate harm are managed at divisional level, whereas those perceived to have caused severe or fatal harm are escalated for review at the Emerging Incident Review (EIR).	In addition to national comparisons, we also benchmark locally through the regional ICS led Patient Safety Collaborative with the objective to share and learn and improve safety for patients. There were no significant reductions observed in any category, which aligns with the variable reporting trend. Insights from this analysis, along with findings from the quarterly patient safety report, will continue to be shared with divisional governance and speciality leads across the trust to inform targeted improvement efforts.
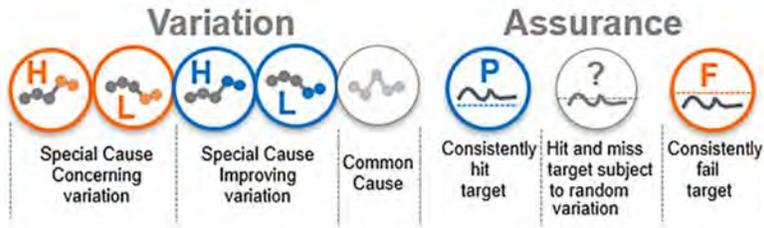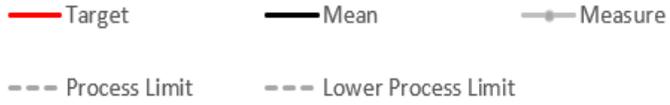
Safe

Mortality Summary

Variation

Assurance

Special Cause Concerning variation	Special Cause Improving variation	Common Cause	Consistently hit target	Hit and miss target subject to random variation	Consistently fail target

Chart Legend

— Target   — Mean   — Measure

--- Process Limit   --- Lower Process Limit

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SHMI	Jul 25	100.9%				92.6%	88.9%	96.3%
Inpatient Deaths	Nov 25	72				87	48	125

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

SHMI

Inpatient Deaths

| What	So What?	What Next?
This data is showing us that the West Suffolk Foundation Trust (WSFT) SHMI data has had a sudden incline starting in March 2025. SHMI is currently sitting as expected (1.0) The sudden incline appears to be down to a coding error in which there has been a period of uncoded episodes. These have been placed in 'invalid primary diagnosis' group. This shows that we are expected to have 95 (expected) deaths in this category but currently have 235 (observed)	SHMI website does advise to interpret Trust SHMI data with caution due to its vulnerability to coding anomalies. Although the current WSFT SHMI data trend could make it more difficult to interpret the Trust data. We are confident through other Trust intel that this is purely coding error. The NCAA (National Cardiac Arrest Audit data) puts us at national average with no identified increase in in-hospital arrests. Our number of monthly deaths and top 10 causes are as expected.	We predict the WSFT SHMI data will remain elevated for the next 4-6 months due to the arrears in reporting (6 months) if the coding issue is now rectified. We continue to monitor mortality activity through other means such as NCAA data and through monthly reporting to Mortality Oversight Group.

PEOPLE & ORGANISATIONAL DEVELOPMENT COMMITTEE METRICS
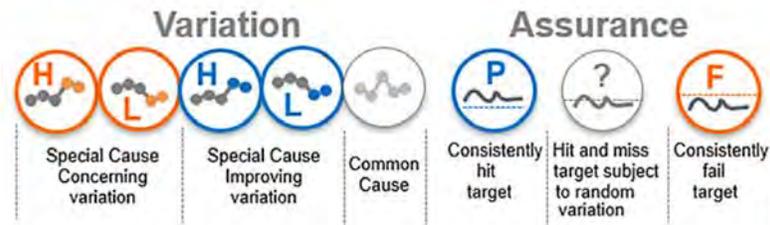
Well Led Summary

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Active complaints	Nov 25	30	-	(common cause)		35	21	49
Closed complaints	Nov 25	21	-	(common cause)		17	4	30
% extended	Nov 25	19%	-	(special cause improving)		66%	32%	99%
Count extended	Nov 25	4	-	(common cause)		11	1	20
% Complaints responded to late	Nov 25	5%	-	(common cause)		9%	-19%	38%
Count responded to late	Nov 25	1	-	(common cause)		2	-4	7
% resolved in one week	Nov 25	66%	-	(common cause)		60%	32%	88%
Total PALS resolved Count	Nov 25	178	-	(common cause)		189	76	302

Safe
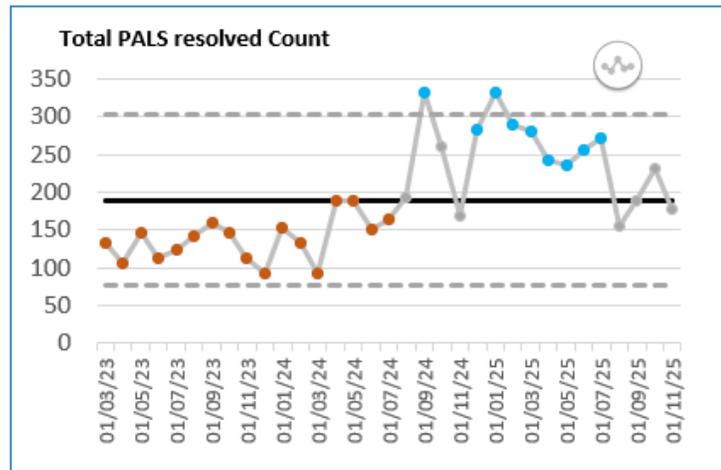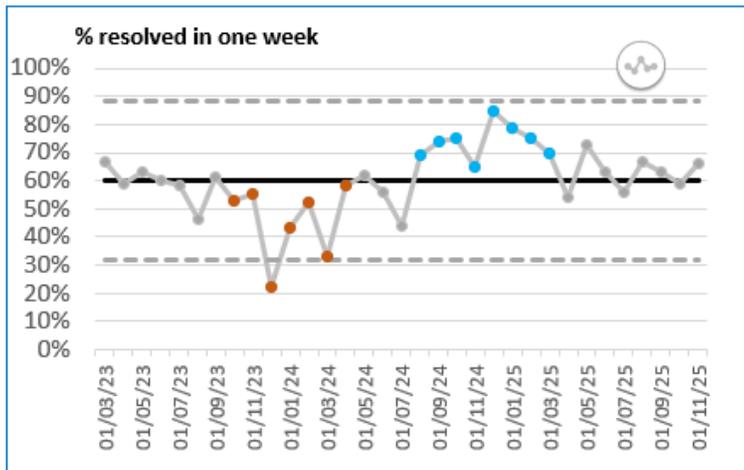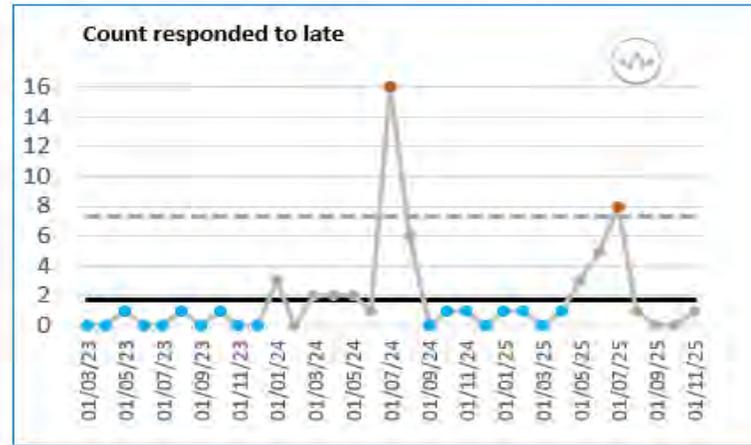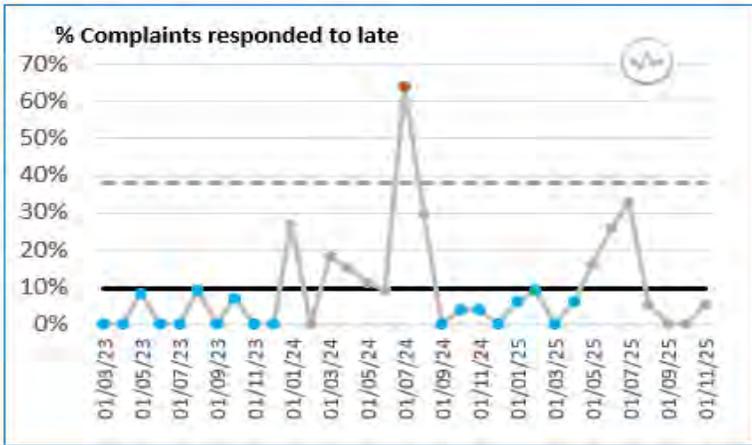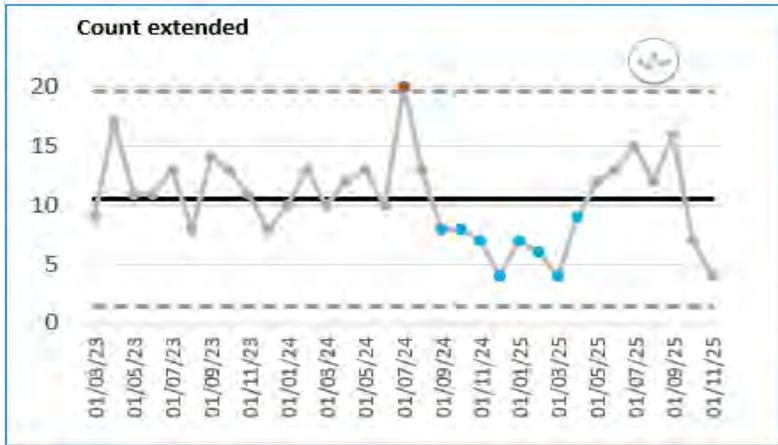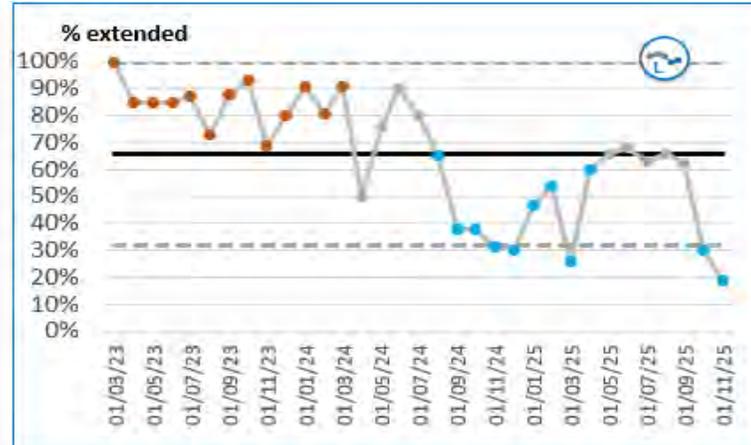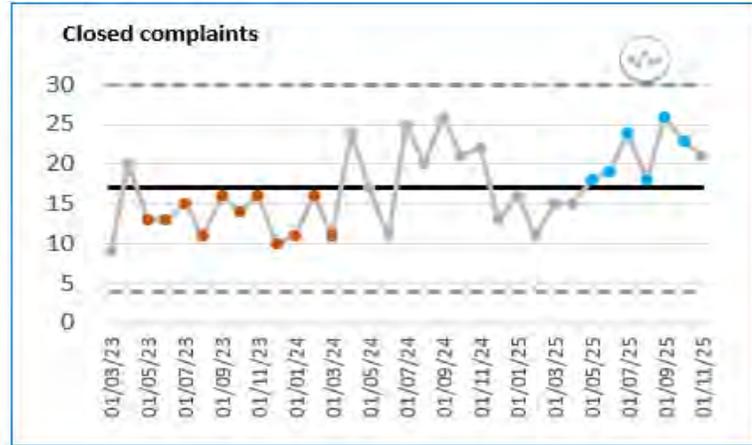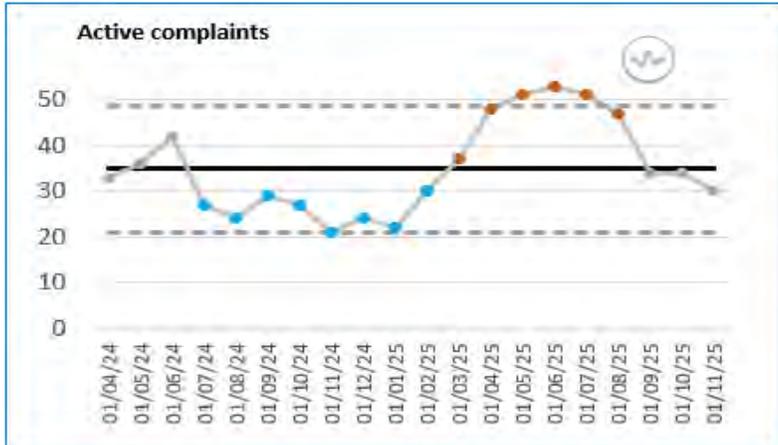
| What	So What?	What Next?
Active formal complaints have reduced further with 30 open at the time of reporting whilst the number of resolved complaints reduced slightly, we were able to reduce the current open volume. This is a positive trend and is due to a reduction in new formal complaints received into the Trust with an average of 17 per month compared to an average of 23 from Q1 of 2025. Extended complaints have reduced significantly from 30% to 19% for November. This is a positive trend and is our lowest volume of complaints recorded although is subject to common variation month on month with contributing factors which effect performance. A further positive trend with overdue/late complaints remain low (1) for November. PALS cases logged have decreased due to a member of staff on bank temporarily leaving the team due to personal reasons. The team are finding a balance between providing early resolution and logging full enquiries. However, percentage of PALS cases resolved within one week, has increased to 66%. A number of factors affecting this however predominant factors include staff sickness and reduced capacity due to upskilling and training the temporary member of staff.	Initial findings show that AI (copilot) is having a positive effect on the response timeframes once the investigation has been completed by clinical staff. Further results show the quality of investigation is successful with initial results currently at 95% first time resolution rate. In turn this reduces the volume of complaints extended and complaints that are late. There is however some additional work required to ensure investigating staff provide a response in a timely manner. In regard to the 19% of complaints (4), a robust process in place to ensure complainants are updated throughout the investigation on any delays, investigation pathways and updates on progress, of which all complainants were satisfied with the level of investigation and updates provided. The team have been working hard to ensure the complaints policy timeframe of 25 working days is adhered to however some cases required additional review such as going through the incident triage meeting and then on to EIR which can cause delays. This does however provide reassurance to complainants that we are taking their concerns seriously.	The QI project for the use of AI in complaint responses will continue until we are using this software to it's full capabilities. Initial results show that it has enhanced the quality of responses, including the tone, language used and openness of our learning. We are working with Patient safety and the wider patient quality team to triangulate reports and reviewing divisional oversight to enhance divisional ownership. Initial discussions to trial attending more clinical/department team meetings to escalate upcoming complaints rather than oversight meetings to increase engagement and ensure we are meeting with the most appropriate staff. We have also changed the way formal complaints are reviewed and signed. We have worked with the Trust office and the CEO to improve the timeliness of complaint letters being reviewed, signed and formatted back to the complaints office. This already has shown to improve turn around times for signing letters and reduces paper wastage. The project on AI has helped the complaints officer to reduce the time taken once all of the responses have been received. Additional work and engagement is required with clinical staff to ensure they provide timely responses. We will do this by building better relationships, providing different options for staff to issue their responses and attending locality/department meetings for escalation. Additionally, a training package is being created to help break down barriers for staff providing a response.
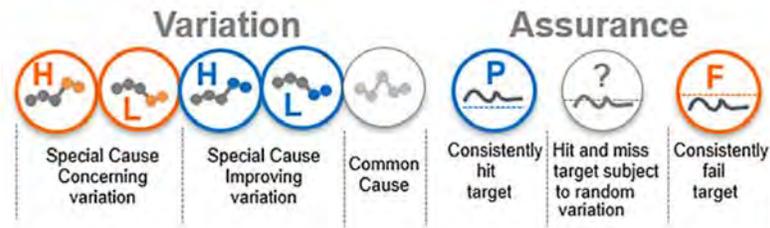
Safe

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	Nov 25	5.0%	5.0%			4.9%	4.7%	5.0%
Staff Sickness - monthly	Nov 25	5.0%	5.0%			4.9%	4.7%	5.0%
Mandatory Training monthly	Nov 25	88.6%	90.0%			89.4%	87.7%	91.0%
Appraisal Rate monthly	Nov 25	86.3%	90.0%			84.7%	82.3%	87.1%
Turnover rate monthly	Nov 25	9.9%	10.0%			10.0%	9.1%	10.9%

Well Led Summary

Well Led
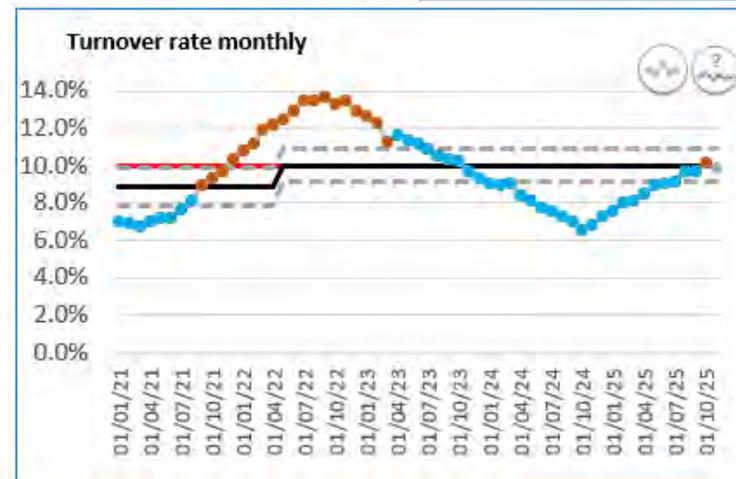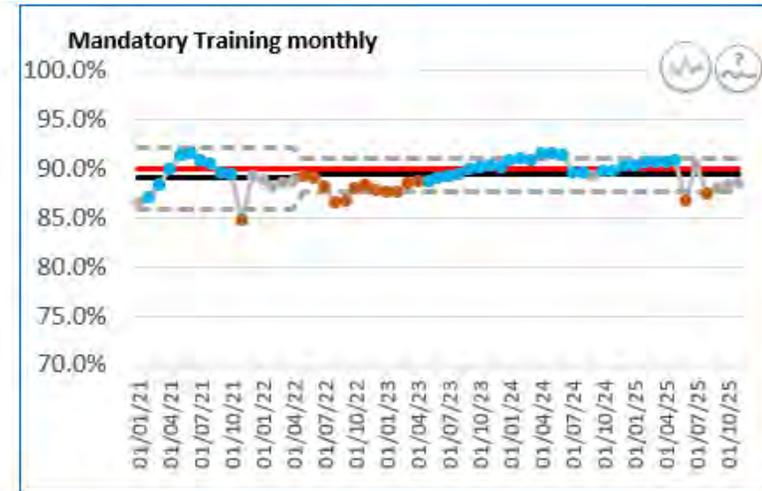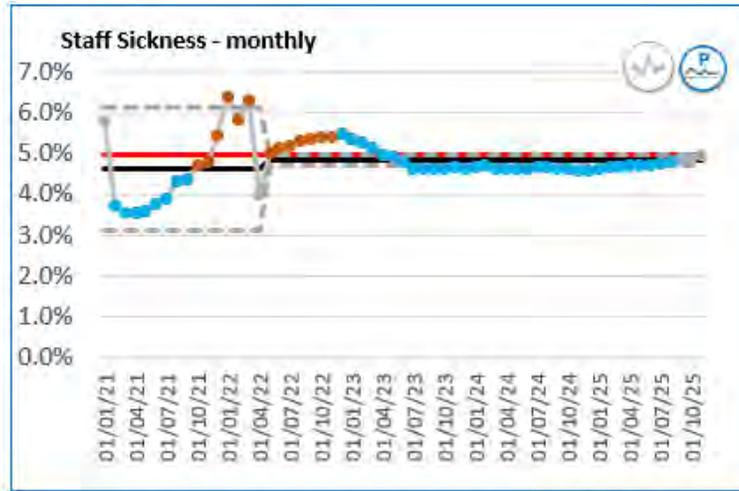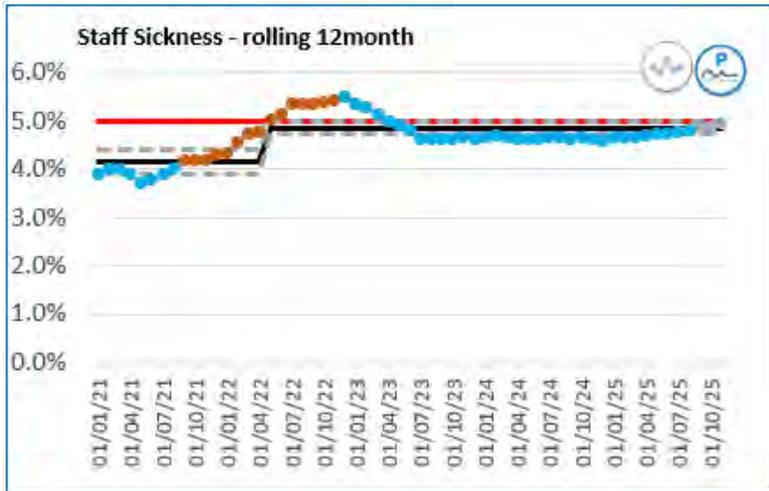
What

Sickness – 5% 12-month rolling performance versus 5% target.

Mandatory Training – failing target this month at 88.6% versus 90% target.

Appraisal – consistently failing target, 86.3% versus 90% target.

Turnover –   achieving target, 9.9% 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.