NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday 27 March 2026, 9:15 AM — 1:15 PM GMT
Venue	Northgate Room
Description	A meeting of the Board of Directors in the Public domain on Friday 27 March 2026
Organiser	Emma Whight

Agenda

9:25 AM	1.5.	Questions from Governors and the public relating to items on the agenda (verbal) To Note - Presented by Jude Chin	30
9:35 AM	1.6.	Staff story - (ATTACHED) To Review - Presented by Daniel Spooner	31
		Item 1.6 - Staff Story - EOL Lantern Presentation for board presentation.pptx	32
10:00 AM	1.7.	Chief Executive's report (ATTACHED) To inform - Presented by Ewen Cameron	38
		Item 1.7 - CEO Board report - March 2026 v2.docx	39
10:10 AM	1.8.	BAF and Risk Report (ATTACHED) To inform - Presented by Paul Bunn	45
		Item 1.8 - BAF Risk Report - Open Board Mar 2026.docx	46
10:15 AM	2.	HIGH QUALITY CARE	55
10:15 AM	2.1.	Integrated Quality & Performance Report (IQPR) (ATTACHED) To Review - Presented by Daniel Spooner, Nicola Cottington and Jonathan Rowell	56
		Item 2.1 - IQPR January 2026 (002).pptx	57
10:45 AM		COMFORT BREAK	89
10:55 AM	2.2.	Quality & Patient Safety Committee - Committee's Key Issues (ATTACHED) To Assure - Presented by Paul Zollinger-Read	90
		Item 2.2 - Quality Patient Safety Committee CKIs - January 2026.pdf	91

	2.3. Quality and Nurse staffing report - quality priorities and learning from deaths (ATTACHED) To Assure - Presented by Daniel Spooner	95
	Item 2.3- Safer NMW Staffing Jan Feb 2026.docx	96
	2.4. Maternity Services Report Presented by Karen Newbury	115
	Item 2.4 - Perinatal Quality Safety and Performance report_.docx	116
11:20 AM	3. JOINED UP SERVICES	129
	3.1. Strategic priorities update (ATTACHED) To inform - Presented by Sam Tappenden	130
	Item 3.1 - Open Board Strategy Paper March 2026.docx	131
	3.2. West Suffolk Alliance and SNEE Integrated Care Board update (ATTACHED) To Assure - Presented by Maddie Baker -Woods	137
	Item 3.2 - WSFT Board report 02_03_26 docx V2.docx	138
11:40 AM	4. EMPOWERED TO IMPROVE	144
	4.1. People & Organisational Development Committee - Committee's Key Issues (ATTACHED) To Assure - Presented by Heather Hancock	145
	Item 4.1 - People and OD Committee CKIs February 2026 - final.docx	146
	4.2. Putting You First Award (ATTACHED) To Assure - Presented by Greg Bowker	151
	Item 4.2 - PYF slides for Board Mar 2026 (002).pptx	152

	4.3. National Staff Survey Report (ATTACHED) Presented by Julie Hull	159
	Item 4.3 - Board - NHS Staff Survey 2025 results March 2026.docx	160
	Item 4.3 - NHS Staff survey overview BoD v1.2 PL 16032026.pptx	162
12:05 PM	COMFORT BREAK	181
12:15 PM	5. RESPONSIBLE WITH RESOURCES	182
1:00 PM	5.1. Finance and Performance Committee - Committee's Key Issues (ATTACHED) To Assure - Presented by Antoinette Jackson	183
	Item 5.1 - Finance and Performance CKI January 2026 FINAL.docx	184
	Item 5.1 - Finance and Performance CKI February 2026 Final.docx	192
	5.2. Finance Report (ATTACHED) To Review - Presented by Jonathan Rowell	200
	Item 5.2 - Public Board cover sheet M11 Finance Paper.docx	201
	Item 5.2 - M11 Finance Board report Final.pptx	203
	5.3. Audit Committee - Committee's Key Issues (ATTACHED) To Assure - Presented by Michael Parsons	220
	Item 5.3 - AUDIT CKI report March 2026 (002).docx	221
1:00 PM	6. FIT FOR TOMORROW	226

	6.1. Future system board report (ATTACHED) To Assure - Presented by Ewen Cameron	227
	Item 6.1 - Future System Board Report.docx	228
1:05 PM	7. GOVERNANCE	233
	7.1. Governance report (ATTACHED) To Assure - Presented by Paul Bunn	234
	Item 7.1 - Governance Report Trust Board Mar 2026.docx	235
	Item 7.1 - Quality and Patient Safety Committee Terms of Reference - Proposed amendments March 2026.docx	243
	Item 7.1 - ToR digital and data programme board_Feb26.pdf	247
	7.2. Audit Committee Terms of Reference (ATTACHED) For Approval - Presented by Paul Bunn	250
	Item 7.2 - Audit Committee Terms of Reference AC 17 Mar 2026 DRAFT v3.docx	251
	7.3. Agenda items for next meeting To Note - Presented by Jude Chin	260
1:10 PM	7.4. Reflections on meeting For Discussion - Presented by Jude Chin	261
	7.5. Date of next meeting - 5 June 2026 To Note - Presented by Jude Chin	262
	RESOLUTION The Trust Board is invited to adopt the following resolution: “That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest” Section 1 (2), Public Bodies (Admission to Meetings) Act 1960	263

AGENDA

Presented by Jude Chin

WSFT Board of Directors – meeting in public

A meeting of the committee will take place on **Friday 27 March 2026 9:15 – 13:15**.
The meeting will be held in Northgate Meeting Room, Quince House, West Suffolk Hospital site,

Agenda

The committee's responsibilities are to improve understanding and provide assurance to the Board on delivery and improvements in relation to quality, patient safety and change management. In fulfilling this role the committee will need to consider available intelligence, seek views from relevant stakeholders and oversee relevant improvements.

Time	Item	Subject	Lead	Purpose	Format
1.0 General Business					
09.15	1.1	Welcome and apologies for absence	Chair	Note	Verbal
09.20	1.2	Declarations of Interest	All	Assure	Verbal
	1.3	Minutes of previous meeting 30 January 2026	Chair	Approve	Report
	1.4	Action log and matters arising	All	Review	Report
09.25	1.5	Questions from Governors and the public relating to items on the agenda	Chair	Note	Verbal
09.35	1.6	Staff Story	Chief Nurse	Review	Verbal
10.00	1.7	CEO Report	Chief Executive	Inform	Report
10.10	1.8	BAF & Risk Report	Acting Trust Secretary	Inform	Report
	High quality care				
10.15	2.1	Integrated Quality & Performance Report (IQPR)	Director of Resources/Chief Operating Officer/Chief Nurse	Review	Report
10.45 Comfort Break – 10 mins					
10.55	2.2	Quality & Patient Safety committee - Committee's Key Issues	Committee Chair	Assure	Report
	2.3	Quality and Nurse staffing report – quality priorities and learning from deaths	Chief Nurse	Assure	Report
	2.4	Maternity Services Report	Director of Midwifery	Assure	Report
	Joined up services				
11.20	3.1	Strategic priorities update	Chief Executive /Director of Strategy & Transformation	Inform	Report
	3.2	West Suffolk Alliance and SNEE Integrated Care Board update	West Suffolk Alliance Director	Assure	Report
	Empowered to improve				
11.40	4.1	People & Organisational Development Committee – Committee's Key Issues	Committee Chair	Assure	Report
	4.2	Putting you First Award	Head of Communications	Assure	Report
	4.3	National Staff Survey Report	Director of Workforce & Communications	Review	Report
12.05 Comfort Break – 10 mins					
	Responsible with resources				
12.15	5.1	Finance & Performance Committee – Committee's Key Issues	Committee Chair	Assure	Report
	5.2	Finance Report	Chief Finance Officer	Review	Report

	5.3	Audit Committee – Committee's Key Issues	Committee Chair	Assure	Report
	Fit for tomorrow				
13.00	**6.1**	Future system board report	Chief Executive	Assure	Report
		Governance			
13.05	**7.1**	Governance report	Trust Secretary	Assure	Report
	7.2	Audit Committee Terms of Reference	Trust Secretary	Approve	Report
	7.3	Agenda items for next meeting	Chair	Note	Verbal
13.10	**7.4**	Reflections on meeting	Chair	Discuss	Verbal
	7.5	Date of next meeting – 5 June 2026	Chair	Note	Verbal

1. GENERAL BUSINESS

Presented by Jude Chin

1.1. Welcome and apologies for absence - Richard Jones, Dan Spooner,

To Note

Presented by Jude Chin

1.2. Declaration of interests for items on the agenda

To Assure

Presented by Jude Chin

1.3. Minutes of the previous meeting - 30 January 2026 (ATTACHED)

To Approve

Presented by Jude Chin

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE
Open Board meeting

Held on Friday 30 January 2026, 09:15 – 13:15
Northgate Meeting Room, Quince House, WSFT

Members:		
Name	**Job Title**	
Jude Chin	Trust Chair	JC
Ewen Cameron	Chief Executive Officer	EC
Nicola Cottington	Executive Chief Operating Officer	NC
Dan Spooner	Executive Chief Nurse	DS
Richard Goodwin	Executive Medical Director/Board Level Maternity and Neonatal Safety Champion	RG
Jonathan Rowell	Chief Finance Officer	JR
Sam Tappenden	Director of Strategy & Transformation	ST
Julie Hull	Chief People Officer	JH
Antoinette Jackson	Non-Executive Director/SID	AJ
Tracy Dowling	Non-Executive Director	TD
Heather Hancock	Non-Executive Director	HH
Richard Flatman	Non-Executive Director	RF
Alison Wigg	Non-Executive Director	AW
Michael Parsons	Non-Executive Director	MP
Paul Zollinger-Read	Non-Executive Director/ Maternity and Neonatal Safety Champion	PZR
Clement Mawoyo	Area Director, HomeFirst, Safeguarding and West Suffolk	CM
Maddie Baker-Woods	Executive Director (Designate), Primary Care and Neighbourhood Health for Suffolk	MBW
In attendance:		
Paul Bunn	Acting Trust Secretary	PB
Greg Bowker	Head of Communications	GB
Sarah Judge	Interim Chief Information Officer	SJ
Karen Newbury	Director of Midwifery (Item 6.3 only)	KN
Simon Taylor	ADO, Women & Children and Clinical Support Services (Item 6.3 only)	ST
Hayley McBride	Acting Deputy Head of Midwifery (Item 6.3 only)	HM
Ruth Williamson	FT Office (minutes)	RW
Apologies: Richard Jones, Trust Secretary.		
Governors observing: Val Dutton Jane Skinner, Anna Conochie.		
Staff: Lisamarie Jones, Emergency Nurse Practitioner, Anna Kaleva, Consultant		
Members of the public: Menekse Meech.		

1.0 GENERAL BUSINESS		
1.1	**Welcome and apologies for absence**	**Action**
	The Trust Chair (JC) welcomed attendees to the meeting. Apologies noted as detailed above.	
1.2	**Declarations of interest**	
	There were no declarations of interest for items on the agenda.	
1.3	**Minutes of the previous meeting**	
	The minutes of the previous meeting held on 28 November 2025, were accepted as a true and accurate reflection, subject to the following amendments: ***Item 1.6 – Patient Story*** – "It was noted that the value of sharing stories is now embedded in committees such as NMCC and Quality Improvement. Shared learning has been discussed, actions have been taken and a checklist **proposed** for loved ones…" ***Item 4.2 – Freedom to Speak Up Guardian Update*** – "~~Some concerns have been raised regarding the anti-racism charter although reassurances have been given via the Central Safety Charter where the high priority is for a proactive anti-racist organisation~~. Replace with "**Reassurance was provided from the Chief People Officer and the Organisational Development Manager, Equality, Diversity and Inclusion, via the Involvement Committee, that being an anti-racism organisation and fulfilling its obligations to the Anti-Racism Charter, is a high priority for the Trust".** ***Item 3.1 – IQPR Report*** - **"**TD raised a query as to whether the significant shift in improvements includes within ultrasound. MK confirmed that the data does include ultrasound and more detail will be covered within the ~~insider CKIs~~ **Quality & Patient Safety Committee CKIs**."	
1.4	**Action Log and matters arising**	
	Action Ref 3181 – Quality & Nurse Staffing Report – Community – reported to People & Organisational Development Committee and part of handover to Quality & Patient Safety Committee. Will be kept under review. **Action closed**. **Action Ref 3182 – Patient Story - Follow-up Letter –** letter has been sent. **Action closed**. **Action Ref 3183 – Patient Story – Guidance and Protocols End of Life Care –** DS reviewed the end-of-life policy and identified minor elements that did not fully support patient choice, including the expectation to move a patient to the mortuary within an hour and encouragement of relatives to view the deceased at the funeral home rather than on site. DS is discussing these points with the Mortuary Manager and noted the positive role of end-of-life champions in supporting sensitive conversations. In response to JC's query, DS confirmed the team had complied appropriately, but the policy requires amendment to strengthen patient choice. DS	

	will monitor this through the relevant group. **The action was agreed as complete.** **Action Ref 3184 – People & Organisational Development Committee (previously Involvement Committee) – Job Planning –** RG outlined the action relating to managing flow and noted the learning taken from the stroke unit. The matter has been taken forward by RG, Deputy Chief Operating Officer and Deputy Chief Nurse and is now incorporated into the delivery group's work and the ward accreditation process. A follow-up will be provided through the IQPR. It was agreed that the matter will be reported through the Finance & Operations Committee. **Action closed.** **Action Ref 3185 – Quality & Nurse Staffing Report – Reducing Demand on Non-house Bound Patient Services in the Community –** NC reported that patients who are not house-bound are to be encouraged to attend GP appointments rather than receiving home visits and confirmed that individual circumstances continue to be reviewed to support appropriate conversations and decision-making. NC, MBW and the community contract team will consider this further. ST noted that an internal group is being established for the community contract, and this issue will be incorporated into its work. **Action closed.** **Action Ref 3186 – CQC Preparedness – Business Planning & Next Steps –** scheduled for March Board Development session. **Action closed.** Completed actions noted.	
1.5	**Questions from Governors and the public relating to items on the agenda**	
	Jane Skinner (JS), Public Governor, referred to the nurse staffing report, noting concerns about registered nursing levels, amber clinical indicators and red flag events recorded since July 2025. JS asked how the Board maintained oversight and whether staffing levels were sufficient to ensure patient safety. Dan Spooner (DS) advised that recent increases in sickness levels amongst nurses and support staff had affected fill rates, which were currently around 90%. Staffing is reviewed three times daily with the senior team and Heads of Nursing, with staff redeployed, when required, to mitigate risks. DS acknowledged that redeployments created anxiety and confirmed work was underway to improve the experience for affected staff. Establishment levels were reviewed twice yearly and were considered appropriate for the coming financial year, although daily fill rates remained challenging over winter. Nurse-sensitive indicators had shown no decline in quality and DS was assured that no significant harm had occurred as a direct result of shortages. Improvement work continues. JS asked whether the continued presence of red flag events indicated a need for additional staff. DS responded that red flags were an important mechanism for identifying and addressing risks quickly. DS noted that not all incidents were linked to staffing; for example, some falls involved independently mobile patients.	

	Real-time reporting through the SafeCare module was in place, with strengthened audit arrangements. Tracy Dowling (TD) sought clarification on operational support arrangements. DS confirmed that Ward Managers managed staffing issues initially, with escalation to senior managers and matrons at the daily 8.45 a.m. meeting, attended by either the Chief Nurse or Deputy Chief Nurse. Unresolved issues were escalated to the Head of Nursing involved and/or the Chief/ Deputy Chief Nurse through established pathways. Jude Chin (JC), provided additional assurance, highlighting that operational control was supported by a robust governance framework operating alongside the Board's assurance processes.	
1.6	**Patient Story**	
	The Board heard a recording from a patient regarding their experience of visiting the Trust as a blind person. JC asked how the Trust intended to act on the issues raised. DS noted that similar themes had been identified previously, particularly the extent to which the hospital environment could feel unfamiliar and disorientating. DS emphasised the importance of reasonable adjustments and reported that a quality improvement project with MyWiSH (the Trust's charity), on adaptive cutlery was shortly to begin. Patient stories were routinely taken to the Nursing, Midwifery and Care Committee to ensure learning. Antoinette Jackson (AJ) highlighted the difference between congenital and late-onset blindness and asked what support existed across the wider system for people who had lost sight later in life. AJ stressed that day-to-day staff interactions were central to an inclusive approach to care. **Clement Mawoyo (CM) confirmed that the local council had a specialist sensory team supporting individuals in their homes and care settings and agreed to share contact details with DS**. CM noted that the Trust had made progress with learning disability and autism pathways and that similar support networks were needed for sensory needs. DS agreed that awareness of reasonable adjustments varied and confirmed ongoing discussions with families regarding cognitive and sensory needs, including the potential to expand the patient passport beyond learning disability and autism. Greg Bowker (GB) reported joint work underway with Healthwatch Suffolk on a visual impairment survey, which he believed would provide valuable insights. He confirmed that the Trust had been open to sharing the patient's experience through this route. Nicola Cottington (NC) commented on the need for practical measures to raise awareness. NC observed that personalised care should be expected regardless of disability and highlighted the contrast between the more person-centred approach in patients' homes and the task-focused nature of the acute environment, which could feel dehumanising. JC agreed that personalised care	**CM**

	required better recognition of individual needs and confirmed that further improvement work was required. Richard Goodwin (RG) spoke positively about the virtual ward model, noting that it allowed patients to remain in their own homes and benefits of same. JC asked how best to communicate this benefit to decision-makers. RG highlighted the expansion of home-based intravenous antibiotics and the work underway to avoid unnecessary hospital attendances. Alison Wigg (AW) said the virtual ward approach had clear potential and should be considered earlier for some patients. NC confirmed that the virtual ward team was developing "step-up" pathways, working with Emergency Department clinicians and families to ensure it was viewed as a viable option. Stabilisation in hospital was sometimes necessary before transfer to the virtual ward, but work continued to ensure personal needs were considered alongside medical thresholds. TD questioned whether gaps existed in staff training, noting that student nurses and healthcare assistants should receive basic instruction on supporting patients with sensory loss. TD asked whether practical learning, such as blindfold exercises, should be used and DS agreed to review student nurse training in this area, acknowledging that existing provision could be improved and that the acute environment remained task-oriented. DS noted that Matrons, Heads of Nursing and others had recently undertaken "ward weeks", providing first-hand insight into staff pressures and patient experience. TD also queried progress on personalised care initiatives, such as the patient profile work previously trialled in intensive care and asked whether staff had sufficient time to engage with patients in this way. **DS to revisit this work.** Paul Zollinger-Read (PZR) highlighted the challenge of achieving consistency across the organisation, noting that the Trust demonstrated a strong performance in dignity, kindness and compassion, but that this was not uniformly delivered. **It was agreed that JC would write to the patient to thank them for sharing their experience and to outline the actions being taken, with consideration given to the most appropriate format for a blind recipient.**	**DS** **JC**
1.7	**CEO Report**	
	Ewen Cameron (EC), Chief Executive Officer, (CEO) presented the report, which was noted and taken as read. EC expressed thanks to staff who had supported the organisation during periods of industrial action and throughout the pressures experienced in early January. He reported encouraging signs of progress in the organisation's league-table position and acknowledged the significant contributions made by staff. EC also expressed appreciation to those recognised through recent long-service awards.	

	AJ sought an update on whether the business case for the planned expansion at Newmarket (item 8.3) had been approved. EC confirmed that approval had not yet been secured and that the business case would be submitted in due course. TD welcomed EC's comments regarding staff recognition and extended thanks to EC for his leadership during what had been a difficult 18-month period. TD noted recent planning work for the coming year and reflected on improvements achieved over the past 12 months, particularly in operational performance and quality, whilst acknowledging continuing challenges. PZR thanked EC and commented that, although the organisation was not yet out of difficulty, staff had risen admirably to the challenges faced. JC noted that the organisation was now in a position to raise expectations further and emphasised the need to continue pushing targets as part of a collective effort. EC reiterated the importance of distinguishing between relative and actual performance. PZR observed that service performance sometimes improved during resident doctor strikes due to increased senior involvement and advised against establishing expectations that would be unrealistic to maintain. EC reported on related national discussions and cited Health Service Journal commentary regarding the resident doctor workforce. He noted the complexities this created, including the risk associated with relying heavily on consultant staffing and the longer-term workforce implications, as well as potential financial impact. NC raised concerns regarding elective patients in the community whose care had been deferred during periods of industrial action and emphasised the strain placed on consultants. NC stressed the need to consider the welfare of all staff and to avoid creating divisive approaches whilst strengthening senior oversight. PZR expressed ongoing reservations. RG noted that not all areas of performance had improved during strike periods and emphasised the strong relationships the organisation maintains with its residents, supported by the Guardian of Safe Working and the Freedom to Speak Up Guardian. JC reiterated the focus on continuous improvement and the opportunity to learn from other organisations. A consultant at the meeting highlighted the pressure created by operational efficiency expectations and the resulting impact on resident training. JC confirmed that discussion would continue and EC acknowledged the challenge of achieving the right balance. CM welcomed the progress seen in the heart failure pathway and the support provided to staff working in the community, describing this as a positive development.	
1.8	**Board Assurance Framework (BAF) & Risk Report**	
	Paul Bunn, (PB), Acting Trust Secretary, presented the report and confirmed that there are currently ten risks, with work ongoing to	

	strengthen mitigations. The intention is to finalise and roll out the new BAF at the start of the new financial year. EC observed that most risks have improved, even if not yet at target, but noted that two have not altered, collaboration and staff wellbeing. EC asked whether the current actions are sufficient and what further mitigation may be required. PB referenced earlier discussion at the Management Executive Group (MEG), explaining that the capacity interdependencies are being considered in full. **EC and Julie Hull (JH), Chief People Officer, to review the mitigations for the two static risks ahead of the next board development session.** Richard Flatman (RF) noted that the paper clearly outlined the work completed and highlighted the upcoming CQC preparedness work in March, emphasising the CQC's strong focus on the BAF. RF proposed bringing the outputs from the recent development session to the March Board Development Day to support consideration of the organisation's risk appetite. RF also queried the accuracy of some links between risk themes and assurance committees, noting in particular that BAF1 (patient safety) was linked to Occupational Health. **PB will ensure the committee links are correct.** JH commented on the staff wellbeing risk, stressing the importance of staff engagement and the proportion of staff recommending the organisation as a place to work. JH noted the challenges of the past 12–18 months and outlined ongoing work aligned to the strategic aim of empowering the workforce and enhancing psychological safety, with further information to be brought to the Board in due course. **JC emphasised the need to define required actions and available resources, requesting that this be brought back to the Board Development Day by mid-March and subsequently to the Board for formal approval. PB to action.**	**EC/JH** **PB** **PB**
2.0 HIGH QUALITY CARE		
2.1	**Integrated Quality & Performance Report (IQPR)**	
	Nicola Cottington (NC), Chief Operating Officer, presented the report and offered apologies for the incorrect IQPR having been circulated initially. NC reported that January had been challenging and that the trajectory for the four-hour standard would not be met, with long ambulance waits continuing. A deep dive on emergency care was received at the Finance & Performance assurance committee. Although still below trajectory, NC thanked teams for the significant improvement achieved compared to the previous year. NC confirmed a forecast of 28 patients waiting 65 weeks, with an expectation of reducing this to zero by the end of February, noting the complexity of the pathways involved. The Trust is participating in NHS England-endorsed "sprints" focusing on validation, outpatients and 52-week waits, with further work on urgent and emergency care planned for March.	

	AW asked how confident NC was in reaching zero 65-week waits by the end of February. NC explained that the numbers were low and that Performance Review Meetings with divisions this week were focusing on this area, with patient-by-patient reviews carried out. NC expressed a reasonable level of confidence but noted that long-wait cohorts often contain a small number of very complex cases. NC added that as attention moves towards the 18-week standard, it is likely a small number of long waits will persist, although teams remain fully focused. EC highlighted the balance between quality improvement and business-as-usual performance, asking how the Trust benchmarks and what additional steps may be required if it remains an outlier. DS provided an update on C.difficile, explaining that improvement plan actions were largely complete and the work had returned to business-as-usual. The Trust remains in the upper quartile due to a high trajectory linked to past outlier status. DS referred to the spike in July and confirmed that C.difficile remains a clinical priority, with further work needed on infection prevention control (IPC) practices alongside the gloves-off campaign. TD expressed concern regarding activity levels and the significant gap in the activity report. TD asked how confident the Trust could be that next year's planning would align activity, finance and performance. NC noted relative improvements in productivity but acknowledged that performance still does not align with finance. This issue is a major focus of current planning discussions and was explored at the recent Senior Leadership Team (SLT) meeting, emphasising that the response must include both cost reduction and increased activity. NC confirmed that the closed Board would receive a planning update and noted that under the new payment regime the Trust is now incentivised to increase activity, which is the right approach for patients. JR added that the Trust's cost base had reduced more than any organisation in the region and noted that weekend lists had not been run due to payment constraints. JR stressed that in order to meet RTT performance standards, the Trust could not operate in the same way as last year. TD raised the importance of monitoring waiting times from an equality, diversity and inclusion (EDI) perspective and stressed the need for Board visibility, even if this required use of ICB data. NC confirmed that Sarah Judge (SJ) is incorporating this into the refreshed IQPR and that she would like to see EDI considerations woven into all levels of performance reporting to ensure no patient group is disadvantaged. JC asked if the refreshed IQPR would be presented at the March Board. SJ confirmed she would try and JC emphasised the need for the most up-to-date information without requiring prior consideration by assurance committees. JH noted that workforce data did not fluctuate significantly month to month and that converting percentages into staff numbers provided a clearer picture. Mandatory training compliance of 88.6% equates to 70 colleagues and appraisal compliance reflects 185 staff. Presenting data this way gives a better sense of the workload for managers and JH stated that a plain-language narrative would assist further. JC supported the need to identify	

	specific staff groups and JH confirmed ongoing work to make reporting more agile. PZR raised concerns about the rising burden of mandatory training, noting that whilst the Trust expects improvement, additional requirements are continually added, making completion difficult. He asked whether the Trust had flexibility to prioritise key elements. JH confirmed that there is discretion over local programmes and that a group is reviewing this, with the aim to reduce pressure on staff. JC expressed hope this could be implemented before year-end. EC clarified that flexibility applies only to local requirements and emphasised the need to assess the value added by each element. SJ noted the importance of reviewing which mandatory training applies to which staff groups and improving how it is delivered.	
2.2	**Quality & Patient Safety Committee – Committee's Key Issues**	
	Paul Zollinger Read (PZR), Non-Executive Director, presented the report. PZR explained that clinical effectiveness processes remain challenged in providing assurance, particularly in how clinical divisions engage with the committee. Richard Goodwin (RG) has been asked to work with divisions on improving these processes, including progress on NICE guidance and audits, noting this will not be a quick fix. On transfer of care (ToC), the Trust's investment in a digital system has not delivered the anticipated improvements. PZR highlighted that the issues are as much cultural and clinical as technological and RG will be reviewing these. RG emphasised the need to win "hearts and minds", noting that doctors understand the importance of clinical effectiveness but need support in prioritising it. Work is under way to involve the wider clinical team, including exploring ward-initiated processes for doctors to sign off. JC noted the broader challenge of staff engagement, which is crucial for clinical transformation and asked whether more is needed to support the executive team in reinforcing this message. RG referred to conversations with NC about divisional organisation and leadership alignment, suggesting this is a timely opportunity to improve structures and give staff permission to prioritise this work. RG reported that Grand Rounds continue to provide valuable learning and celebrate success. He cited strong orthopaedic joint registry data and SNNAP data as examples of rigorous benchmarking and constructive challenge that clinicians value. NC noted work underway to strengthen clinical leadership, warning that current arrangements risk "othering". NC stressed the importance of harnessing clinical expertise to drive change and providing staff with the insight and support needed to act.	

	JC queried whether this represents an organisational change. NC said this is not solely structural, but also about developing leadership skills. RG noted inconsistencies in team structures. TD referred to the Clinical Effectiveness and Governance Group, which provided only partial assurance. Although the clinical lead had not given full assurance during the meeting, some positive examples were highlighted. PZR commented that whilst outcomes can be reviewed, the volume of national requirements can become overwhelming and must be made relevant locally. TD stressed the need for good outcomes for patients and robust assurance processes. EC reminded the Board that providing assurance is the group's role and whilst there is flexibility in what is demonstrated, the group's functioning needs work. RG, as Chair, is leading this improvement and noted there are other routes for demonstrating assurance. AW asked whether expectations for ToC technology had been unrealistic. RG emphasised that the technology alone cannot deliver change without improved ward culture, clear ownership of ToC letters and teamwork, noting it was a mistake to expect individual groups to resolve issues in isolation. AW asked about learning from this. EC said digital systems are sometimes treated as either the barrier or the solution, but culture and people drive change. AW sought reassurance that the same issues would not recur with future systems. EC explained this was an upgrade and that appropriate support is in place. PB confirmed that staff are in place to support clinicians. NC added that SJ has introduced a new digital front door process to ensure more rigorous assessment and benefits realisation, improving confidence whilst recognising the risk of being overwhelmed by data. Processes have now been strengthened. CM raised concerns about mental capacity assessments, noting that the safeguarding partnership is focusing on this system-wide challenge. **CM will link DS into this work**. DS reported that an MTA group is being established. This will be taken back to Quality & Patient Safety for oversight and escalated to the Board as needed.	**CM/DS**
2.3	**National Patient Survey Report**	
	Dan Spooner (DS), Chief Nurse, presented the 2024 report, confirming that it had previously been discussed at the People & Organisational Development meeting in December. DS noted that overall results were relatively stable and broadly consistent with other organisations, with stronger performance in dignity, respect, kindness and pain control. DS highlighted poorer performance in noise at night, which aligns with feedback received through the 15 Steps visits. DS described actions taken in response, including reminding staff about noise awareness through the "listening ears" initiative, with plans to monitor its impact. Whilst most scores were unchanged, both noise and cleanliness showed deterioration. DS explained that housekeeping resourcing had been challenging, although national cleaning standard audits	

	now show improvement, with posters displayed at ward entrances to demonstrate outcomes. NC observed that noise at night is a longstanding issue and questioned whether the actions being taken should already have been implemented. NC asked how the Board could retain oversight of actions and their impact. DS responded that organisational processes, including late and overnight admissions, were contributing factors and that noise will continue to be monitored through ongoing patient experience work alongside staff reminders. NC asked how operational actions such as late transfers are monitored through a quality lens. **DS and NC to discuss how reductions might be achieved.** EC noted that patient flow, particularly late-night discharges, also contributes to noise and affects all organisations, but emphasised the need to understand why performance locally is comparatively worse. TD suggested deeper engagement with patients to understand specific reasons for noise, noting that some may have straightforward solutions. PZR reminded the Board that the 2024 survey data reflects feedback that is now two years old, creating a risk of relying on out-of-date information. JC queried how more timely data could be obtained and DS and EC explained that national CQC survey data is always at least a year old, with the 2024 dataset having been collected in Autumn 2024. JC suggested exploring small-scale surveys of patients on discharge to inform more responsive action. DS confirmed that the findings are being used to guide improvement work. AJ commented that the design of the new hospital presents opportunities to build in noise reduction measures, noting that many current spaces have hard surfaces which exacerbate noise; AJ suggested considering acoustic panels. EC added that the future move to 100% single rooms will also support noise reduction.	**DS/NC**
2.4	**Quality and Nurse Staffing Report – Quality Priorities and Learning from Deaths**	
	Sarah Ward (SW), Deputy Chief Nurse, presented the report. SW reported increasing sickness levels linked to winter viruses, which are being monitored, alongside a slight reduction in staffing fill rates. DS explained that the whole time equivalent (WTE) registered nurses have moved to special cause for concern. However, vacancy rates have remained stable, indicating the reduction in headcount from the disinvestment of Glastonbury Court and the corporate restructure rather than a deterioration in the underlying vacancy position. DS confirmed that the vacancy rate itself remains consistent, as verified with HR.	
2.5	**Maternity Services Report**	
	Karen Newbury (KN), Associate Director of Midwifery and Simon Taylor (ST), Associate Director of Operations for Women &	

	Children and Clinical Support Services, attended to present the report. KN noted that three perinatal reports remained pending and confirmed that work continued on the quality assurance model. KN outlined progress with the maternity care bundle and the postnatal care tool, explaining that a full gap analysis was underway to determine how requirements would be achieved. KN reported that the service was broadly on track, with the principal challenge being meaningful engagement of all relevant stakeholders. KN confirmed that the Maternity Incentive Scheme had been signed off by the Quality and Patient Safety Committee, EC and the ICB, resulting in full compliance for Year Seven. JC observed that although the Baroness Amos review had not yet been published, early indications suggested common themes across all hospitals. JC asked whether mapping these themes onto the organisation's assurance processes would be beneficial. KN replied that the elements highlighted were already subject to reporting and scrutiny and that presenting to the Board as a triumvirate, with openness about incidents and staff feedback, strengthened assurance. KN added that increased clinical risk was being seen nationally, partly owing to rising caesarean section rates, but emphasised that the service excelled in involving families throughout investigations and care processes. EC queried compliance with the Saving Babies' Lives care bundle. KN confirmed that compliance was assessed annually, although changes frequently occurred mid-year, necessitating a multidisciplinary approach. KN stated that many requirements were already embedded and that compliance was not a concern. AJ asked about the significant drop in antenatal service user feedback. KN responded that the Friends and Family Test remained the primary tool but often produced limited qualitative data, for example, simple frustrations such as waiting times. KN noted that social media and the Maternity and Neonatal Voices Partnership provided richer feedback and PALS also contributed insights, with antenatal waiting times being a recurring theme. AJ asked about the launch of reverse mentoring and whether it would extend beyond maternity. KN hoped it would be rolled out more widely, noting that maternity was the regional pilot and that participation had already been opened to staff. PZR sought assurance regarding community midwifery, including staffing, competency breadth and the management of women choosing to deliver against medical advice. KN referred to a paper previously submitted to QPS on community home-birth services, confirming that equipment and training were in place and that skills drills were conducted in service users' homes, including joint work with the ambulance service. KN explained that most midwives held combined community and acute roles. KN highlighted that risk profiles were changing, that home-birth numbers remained small and that media attention had influenced some women's decisions. When births occurred outside guidance, midwives were	

	required to attend whilst documenting the circumstances and MDT discussions were held where appropriate to ensure decisions were supported and risks mitigated. KN emphasised the importance of supporting staff in these scenarios. MBW expressed support for strengthening links with GPs and offered assistance. TD raised concern that the growing volume of national requirements and forthcoming reports risked creating an unmanageable checklist that could distract from staff experience. KN agreed this was a challenge and noted she continued to raise the issue regionally and nationally. KN emphasised that many recommendations across reports overlapped and that the cumulative burden risked becoming disproportionate. TD asked whether this environment might deter people from working in maternity. KN acknowledged the impact of media portrayal and the potential for defensive practice. EC noted that large volumes of mandated actions had not historically improved outcomes and that this had been recognised nationally. KN added that service-user expectations were increasingly prominent in the emerging reports and that the challenge was meeting these expectations whilst ensuring actions remained achievable. JC commented on the importance of KN and colleagues' leadership in maintaining safety and doing the right things. PZR asked whether more could be done locally to demonstrate the organisation's safeguards, noting the tone of some coverage, such as a recent Women's Hour commentary. Greg Bowker (GB) reported that the department's social media account had been positively recognised and that local media reporting had tangible effects on staff, prompting a focus on supporting colleagues and highlighting good work. PB confirmed that matters were being logged with NHS Resolution and agreed to liaise with KN to feed into the relevant national reports.	
3.0 JOINED UP SERVICES		
3.1	**Strategic Priorities Update**	
	Sam Tappenden (ST), Director of Strategy & Transformation presented the report and confirmed that work continued on the development of the enabling strategy, which is due for completion in April, alongside a corresponding refresh of the Board Assurance Framework (BAF). AW asked whether staff had provided feedback. GB noted that feedback so far had been largely anecdotal, although a relevant question had been included in the PULSE survey and the results would be reported back. GB added that further work was required to strengthen visibility and ensure staff understood what the strategy meant for practice and priorities. HH queried the short timescale and asked how confident the team was that staff would have sufficient awareness to translate the strategy into action. GB replied that engagement had taken place,	

	although the level of awareness would vary across areas. ST added that whilst the suite of enabling strategies would be completed by April, embedding them across the organisation would take longer. ST confirmed that the content was being incorporated into quality and improvement training and emphasised that April was not a hard stop.	
3.2	**West Suffolk Alliance and SNEE Integrated Care Board Update**	
	Maddie Baker Woods (MBW), Executive Director (Designate), Primary Care and Neighbourhood Health for Suffolk, presented the report. AW asked about progress on the Care Management Service. NC confirmed that several expressions of interest had been received for schemes intended to reduce emergency care attendances and further cost-breakdown detail had been requested. AW asked about the timescale for implementation. MBW said work was expected to begin in April and NC emphasised that it would still require formal commissioning. MBW added that a clear business case was in place and would follow the appropriate process, noting that the programme was fundamental and would generate valuable learning. NC commented on the intention to draw on the Ipswich trailblazer experience to understand how similar approaches might work in West Suffolk. PZR queried whether the trailblazer had been run as a research project. NC confirmed it had not. PZR asked how effectiveness would be demonstrated. MBW explained that the programme was being closely monitored for its impact on length of stay and health outcomes by community and primary care colleagues. PZR observed that only one study on frailty models had been identified and stressed the importance of aligning programmes with existing research evidence. MBW noted that the approach had been developed by expert partners and tested in Ipswich. NC emphasised that the programme was developmental and could be adapted if necessary, adding that the national 10-year plan aimed to shift more care into the community. PZR expressed concern that money could be spent without firm evidence. NC acknowledged that risks existed. TD suggested engaging with Health Innovation East, which had expertise in real-world evaluation. MBW added that Norfolk ICB also had a strong research team. JR raised concerns about the deconstruction of block contract arrangements and the risk of funding services that do not deliver the expected outcomes. JR emphasised the need for clear assurance on activity levels and a financial plan that shared risk appropriately between partners. MBW confirmed that WSFT was a partner and would have regular oversight and insight. JR noted that whilst the business case was high-level, further detail would need to be reviewed locally.	
4.0 EMPOWERED TO IMPROVE		
4.1	**People & Organisational Development Committee - Committee's Key Issues**	

	Tracy Dowling (TD), Non-Executive Director, presented the report. TD outlined areas of focus relating to disability data, noting the need to improve equality of opportunity in career progression, particularly in relation to race and highlighted the need to examine the data in greater depth. TD reported that the proportion of staff declaring a disability remained very low. TD confirmed that the Organisational Development Manager (ODM) for EDI would return to a future meeting to discuss race-related work. TD commended the strong progress on sexual safety in the workplace and observed that the pace of improvement in race equality was not yet comparable. TD noted that the communications team and ODM for EDI were exploring whether learning from the sexual safety programme could help accelerate progress in this area.	
4.2	**Freedom to Speak Up Guardian**	
	Jane Sharland (JS), Freedom to Speak Up Guardian, presented the report. JS noted that the National Guardians Office disbandment had been delayed until the end of June and that an engagement plan had been issued for review with JH and AJ. The number of concerns had risen slightly, with low levels of anonymous reporting. A cluster of concerns in biomedical sciences related to a single incident involving multiple reporters. JS highlighted positive outcomes from genuine apologies in cases of incivility. JS confirmed that recruitment concerns had been managed appropriately and that targeted work on bystander support was underway following night-shift feedback, with a new framework being incorporated into mandatory conflict-resolution training. All bullying concerns had been investigated. JS reported the loss of the delirium nurse role and noted that support had been provided by the discharge team. CM confirmed that a Suffolk-wide review of the delirium pathway was being initiated with the ICB. The FTSU policy was due for review and JS invited comments, noting that links to the sexual safety policy would be added. JS and AJ were developing reflection and a planning tool for the next Board meeting. In discussion, ST queried the rise in reporting; JS attributed this to increasing confidence following appointment of a new Guardian, with staff expressing trust in speaking up without detriment. DS and JH reflected on concerns in biomedical sciences, with lessons learned from the recent incident. ST said these would be considered within administrative and transformation functions. **NC referred to patient abuse towards staff and will share anonymised enforcement data with JS for wider circulation.**	**NC/JS**
4.3	**Putting You First**	

	Greg Bower (GB), Head of Communications, presented the report and outlined work underway to improve visibility for staff receiving awards. GB noted feedback from a recipient who expressed how meaningful it was to be nominated by a colleague. The report was noted and congratulations were offered.	
5.0 RESPONSIBLE WITH RESOURCES		
5.1	**Finance & Performance Committee – Committee's Key Issues**	
	Antoinette Jackson (AJ), Non-Executive Director, presented the report. AJ highlighted two substantial assurances, noting that the impact of PA Consulting had been reviewed and confirmed the work had been well managed, with learning taken from the contract process. On Emergency Preparedness, AJ welcomed the progress made, explaining that the number of plans had reduced from 166 to 20 through a revised and more effective approach, providing a strong case study. TD asked whether other areas of work had similarly become more complex over time and could be simplified. NC agreed this had been discussed in committee, identifying digital and AI as one such area. NC noted that EPRR had previously relied on a single specialist lead, but restructuring had moved to a more distributed model that had proved successful; subject-matter expertise could sometimes limit perspective, so programmes needed built-in process checks. AJ asked whether greater rotation of staff across areas could strengthen this approach. SJ added that devolving skills had clear benefits and that linking activities to 20 core plans rather than 166 had significantly improved effectiveness.	
5.2	**Finance Report**	
	Jonathan Rowell (JR) , Chief Finance Officer, presented the report. JR confirmed a positive month with a £200k deficit and an underlying deficit of £1.5m. With three months remaining, JR advised that the Trust was on track to meet its year-end target. JR reported that issues with drawing down cash had been resolved. The Board asked when the capital plan would be met. JR confirmed that NHP capital will not be spent this year and will be moved into next year, whilst Newmarket endoscopy is expected to deliver alongside the Urgent and Emergency Care (UEC) element. JR noted strong overall performance, with system and regional discussions now taking place on a more productive and aligned basis. Although the Trust remains in an absolute deficit, its relative position and financial trajectory are positive. The Board acknowledged the significant work undertaken and expressed thanks to all involved. RF noted potential system requests for WSFT support to another Trust. JR advised that the ICB has proposed a system-level break-even position. This would involve the Trust but without	

	additional financial risk. The ICB holds bonus funding that may be shared across the system and if the Trust achieves its plan it will deliver an improved deficit position, with a cash benefit to the organisation. TD commended the progress and queried whether capital allocations for urgent care, endoscopy and diagnostics were supported by system revenue funding to ensure longer-term investment. JR explained that endoscopy carries the most significant impact and risk. A business case will come to the March Board. JR noted that CDC funding was now allocated on a fair shares basis and so needed to be affordable within the system and that the endoscopy backlog must be addressed ahead of the new hospital build. EC raised concerns about historic reliance on non-recurrent funding. JR confirmed that such funding was not expected this year and that the ICB has a well-established principle governing its use.	
5.3	**Outline of Annual Capital Programme**	
	Jonathan Rowell (JR), Chief Finance Officer, presented the report. JR confirmed that this was on the Board's forward plan and that the Trust has now received its four-year capital allocations, which will be set out in the final plan. JR outlined three elements of the programme: the nationally determined NHP allocation; an internal capital allocation and the Estates Safety Fund from which monies might be bid. JR noted that the SSD plant requires upgrading and that these allocations will support this work. The endoscopy build is expected to take longer and JR is in discussion with the central team regarding potential solutions. A full report will be submitted to the Finance & Performance Committee and subsequently to the March Board.	
5.4	**Charitable Funds Committee – Committee's Key Issues**	
	Richard Flatman (RF), Non-Executive Director, presented the report. RF confirmed that December activity focused on year-end and the accounts, with the audit progressing smoothly and all matters recommended for approval. RF reported ongoing discussions regarding the robot and noted that, due to time criticality, options had been explored; whilst supportive, the value involved required Board approval at the extraordinary meeting held in December meeting. RF advised that all work is proceeding as planned.	
5.5	**Audit Committee – Committee's Key Issues**	
	Michael Parsons (MP), Non-Executive Director, presented the report. MP noted that the deep dive into management processes had been helpful and advised that the internal auditors had issued three audit reports. Minimal assurance was provided on medical devices and partial assurance on establishment control. MP confirmed that the	

	relevant assurance committees would pursue the necessary follow-up actions.	
5.6	**Business Planning Update**	
	Sam Tappenden (ST), Director of Strategy and Transformation, presented the report. ST advised that teams were progressing service developments and business cases for consideration by the panel in February, the outcomes of which would inform forthcoming plans. Negotiations with the ICB continue. NC queried whether there was any risk that attention was concentrated on clinical divisions rather than corporate areas. ST explained that corporate teams were pursuing alternative strategies and preparing a business plan, noting that a recent restructure had already generated significant progress. The final submission would be presented to the Board in March.	
6.0 FIT FOR TOMORROW		
6.1	**Future System Board Report**	
	Jonathan Rowell (JR), Chief Finance Officer, presented the report. JR confirmed that the team is progressing the outline business case for submission in August, with a further focus session planned for the Board in July. JR noted that maternity siting requirements will necessitate design changes and that design work continues in principle. JR reported close collaboration with the central programme and highlighted that, as one of the first hospitals to proceed, the team is encountering issues earlier than others. JR advised that capital affordability remains a key factor, with the 2.0 allocation determining the design within the available capital envelope and that the national team is working with the Trust to ensure affordability. JR emphasised the importance of triggering planning permission in May. Work continues on revenue affordability and associated investments, including the impact of PDC charges, noting that expenditure between £1 billion and £1.5 billion attracts a 3.5% annual charge. JR stated that this issue is nationally recognised and must be resolved before the outline business case stage.	
7.0 GOVERNANCE		
7.1	**Governance Report**	
	Paul Bunn (PB), Acting Trust Secretary, presented the report and confirmed the amendment of the assurance committees names. PB advised that the BAF had reduced to eight risks with mitigations in place and that scoring remained aligned, noting this had been reviewed at the Management Executive Group (MEG). A discussion was held on the potential reduction in the number of open Board meetings to create time for Board development. JC commented on meeting frequency and confirmed no decision	

	would be taken today. TD expressed concern that quarterly meetings would reduce wider Board awareness of maternity issues, though acknowledged the need for development time and noted that other organisations are moving to quarterly meetings, raising questions about how public accountability is exercised. JC observed that the Board currently meets ten times a year. EC reflected on the number of observers at meetings and the balance between public accountability and development needs, noting no clear answer. PZR supported exploring a reduction but highlighted the need for a deeper analysis of the public Board's purpose. AW noted that maternity reports could be heard in private, though EC cautioned against an overreliance on private meetings. NC supported further exploration and urged consideration of the underlying problems before reaching solutions. AJ stressed the importance of transparency, particularly given the Trust's deficit and performance challenges and expressed concern about the optics whilst supporting a review of options and agenda management. ST favoured reviewing options and suggested that quarterly meetings could work if focused on quality, potentially with online elements. JH asked that benchmarking be undertaken to identify organisations that manage this well. **PB will take the comments forward for further discussion at a future Board meeting.**	**PB**
7.2	**Agenda Items for Next Meeting**	
	Jude Chair, (JC), Chair, presented the report, which was noted and taken as read.	
7.3	**Reflections on Meeting**	
	• Good to have more public in attendance. • New agenda, with some items moved around, appeared to flow well. • Good to pull out recognition piece. ***Any other business*** **<u>Deputy Chief Executive Appointment</u>** EC advised of the appointment of NC as Deputy Chief Executive.	
7.4	**Date of Next Meeting**	
	27 March, 2026.	

1.4. Action log and matters arising (ATTACHED)

To Review

Presented by Jude Chin

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3191	Open	30/01/2026	1.8	**BAF & Risk Report** - ensure all BAF committee links are correct.	**This is a work in progress as the Trust populates the 2026 BAF.**	PB	30/03/26	Green	
3196	Open	30/01/2026	7.1	**Governance Report** - **Public Board Meeting Frequency** - comments to be taken forward for discussion at future Board Meeting.	**Deferred to the June meeting as benchmarking exercise underway, but Trusts have not responded as quickly as hoped. Subcommittees have pressed on and reviewed their frequency in any event as part of the agenda setting and work programme delivery.**	PB	05/06/26	Green	

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3188	Open	30/01/2026	1.6	**Patient Story** - Chief Nurse to revisit patient profile work trialled in intensive care and time available to staff for patient engagement.	**Content has been reviewed and opinion is that this will be superseded by 'My Care Choices'. Demonstration of this is awaited in the next couple of weeks to see how it can be implemented. There is a potential element of duplication so will wait to see if patient profile supports or repeats this process.**	DS	30/03/26	Complete	30/03/2026
3189	Open	30/01/2026	1.6	**Patient Story** - Chair to write to patient, thanking them for sharing their story and confirming actions to be taken.	**Letter sent.**	JC	30/03/26	Complete	30/03/2026
3190	Open	30/01/2026	1.8	**BAF & Risk Report** - CEO & Chief People Officer to review the mitigations for the two static risks (collaboration and Staff Wellbeing) ahead of March Board Meeting.	**Both BAF risks have undergone extensive review, with additional actions and rescoring.**	EC/JH	30/03/26	Complete	30/03/2026
3192	Open	30/01/2026	1.8	**BAF & Risk Report** - Actions and resources to be defined and included in March Board Development Day and onwards to March Board for approval.	**CQC Well Led was the focus of the March Board Development day. Risk Actions from previous session were reviewed at a high level as part of that discussion, but more work to be done. This is on the agenda to look at a future development day alongside review of the Trust's risk appetite statement.**	PB	30/03/26	Complete	30/03/2026
3194	Open	30/01/2026	2.3	**National Patient Survey Report** - how to reduce late ward transfers to be discussed.	**Quality-driven improvement project in place to shift discharge profile to earlier in the day.**	NC/DS	30/03/26	Complete	30/03/2026
3195	Open	30/01/2026	4.2	**Freedom to Speak Up Guardian** - share anonymised enforcement data with guardian for wider circulation.	**Quarterly report now shared with FTSU Guardian.**	NC	30/03/26	Complete	30/03/2026

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

To Note

Presented by Jude Chin

1.6. Staff story - (ATTACHED)

To Review

Presented by Daniel Spooner

NHS
West Suffolk
NHS Foundation Trust

Our End of Life Lantern

Chloe Ames (RNA) and Alison Devlin (F7 Ward Manager)

Putting you first

What is F7?

- F7 is an acute medical short stay ward (72hrs stay)
- We cater for patients from 16 years and above with any medical or psychological complaint

F7 Environment

NHS
West Suffolk
NHS Foundation Trust

Advantages:

- A very high - energy bubbly team, who thrive on patient care and team work.
- A high turn over - On an average week, we can have up to 100 discharges or more!

Disadvantages:

- High - energy staff, who may come across loud and disrespectful
- A very busy ward with a high turn over of patients

What is the Lantern?

Patient on the ward is end of life

Patient has passed away

What is the Lantern?

- Lantern picture
- Flower stickers

End of Life Lantern

- A visible symbol of end of life
- A reminder of extra compassion, dignity and respect for a life
- A symbol to show families that their loved one is not overshadowed by the business of the ward.

1.7. Chief Executive’s report (ATTACHED)

To inform

Presented by Ewen Cameron

West Suffolk NHS Foundation Trust Board

Report information

Report title: Chief Executive Officer's report
Agenda item: 1.7
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 January 2026, February 2026, and March 2026.

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

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

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

The items reported will be actioned through the appropriate routes.

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

Governance and compliance

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

Compassionate care, healthier communities

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

Chief Executive Officer's report

1. Introduction

1.1. The end of February marked three years since I took up this post, which gives me the responsibility and privilege to work on behalf of every member of staff, and every patient and visitor. The last three years have certainly been testing for our Trust, and we have all navigated numerous challenges. Whether it's about our financial situation, our operational performance, or industrial action, I'm proud of everyone working here for their non-stop dedication and hard work. It's had a real impact on us turning a corner with our finances, and making profound service improvements which enhance the quality and safety of the care we provide. As we look to sure up our Trust so we can provide our services sustainably now, and in the future, I'm confident of our ability to negotiate difficult situations and utilise these as opportunities to make improvements.

1.2. Our refreshed strategy will guide us over the next three years as we continue the vital work of enhancing the quality of our services. The ambitions and priorities are designed to create positive health outcomes for our communities, ensure resources are used sustainably, and strengthen joint working with local community leaders as we prepare for the new hospital. We are already working with local partners to tackle health inequalities and reduce the number of people smoking and suffering from the results of this with our lung-screening programme. Therefore, our strategy reaffirms our commitment to this, as we are much stronger and effective when we work with others instead of soldiering on alone.

1.3. Having now had the opportunity to read the full set of results from the 2025 NHS Staff Survey, we see there is some progress in important areas, but of course, our staff have told us there is more we need to do. This is such an important opportunity for us to make changes which enhance how it is for our almost 5,000 members of staff to work here. They are delivering important services for our communities and are dealing with an ever expanding population, alongside making continuous improvements which benefit our patients.

1.4. As we approach the end of the financial year, I am very pleased with the progress we've made against our planned deficit. In September we started a very ambitious month-on-month performance target, and at each step of the way we've remained on plan. While we have some way to go over the next two years, we no longer have to be as aggressive in our pursuit of this goal.

2. Financial performance

2.1. At the end of January, our reported position in-year was a £14.8m 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.

3. Elective recovery

3.1. Between August and the end of January 2026, the number of patients waiting 52 weeks has continued decreasing, where at the end of February 609 patients were on this list. The number of patients waiting 65 weeks or more also reduced from 38 to 20 between the end of January and the end of February.

3.2. We are also making good progress in reducing our 18-week waits, currently achieving a performance of 62.9%. Our focus is to bring the number of people waiting down, so we meet the target of 92% by the end of this Parliament.

4. Urgent and emergency care

4.1. Our performance against the 4-hour standard was 68% in February. 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. At the time of writing, our performance is shy of this, but showing signs of improvement. 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 (80% target):
November 2025– 73.3%
December 2025 – 76%
January 2026 – 75.9%

5.2. 31-day Diagnosis to Treatment (96% target):
November 2025 – 100%
December 2025– 99%
January 2026 – 100%

5.3. 62-day Referral to Treatment (75% target):
November 2025 – 81.7%
December 2025 – 82.9%
January 2026 – 75.8%

5.4. Our cancer services are achieving against their targets almost across the board, which is great news and testament to the quality of the care we provide to our patients. While our performance under the 62-day Referral to Treatment target dropped slightly in January, this is expected and is reflected nationally, however, we are still meeting the target.

6. Quality

6.1. There's a lot we're doing to support our patients as they receive care, both in the community and in our hospitals. We're also facilitating patient groups and services which provide support as they go through treatment. In February, we launched a new cancer support group at the Newbury Community Centre in Bury St Edmunds. This drop-in space gives those living with cancer and their loved ones access to confidential, free sessions so they can share their views, learn about the support available, and to meet new people. The first of its kind in the town, this joint initiative with the charity Cancer Support Suffolk aims to help our patients and their loved ones share their experiences have dedicated support from our Macmillan Information Unit who are in attendance. With the next meeting happening at 1pm on 13 April, I encourage everyone who is affected by cancer to attend, or share this message with their friends and family.

6.2. In March, our My WiSH Charity launched a £1,000,000 appeal to fundraise for a surgical robot, which will modernise surgery for the region and improve patient experience. The robot will enable our surgeons to carry out procedures with greater precision while maintaining the same highly skilled clinical leadership patients expect. NHS England predicts that within a decade, nine in 10 keyhole surgeries will be performed using a robot, and we, and the charity, want our patients to benefit from cutting-edge surgery now. Robot-assisted surgery mean smaller incisions, which reduces discomfort and the prevalence of scar tissue, alongside faster recovery times.

7. Workforce

7.1. Having now had the opportunity to read the full set of results from the 2025 NHS Staff Survey, we see there is some progress in important areas, but of course, our staff have told us there is more we need to do. This is such an important opportunity for us to make changes which enhance how it is for our almost 5,000 members of staff to work here. They are delivering important services for our communities and are dealing with an ever expanding population, alongside making continuous improvements which benefit our patients.

7.2. Of all the 99 questions, 59 of them had improved scores, with 19 having been improved significantly. I'm pleased to see that questions relating your manager increased across the board, and there have been uplifts for questions around speaking up and how we respond to errors or near misses.

7.3. I'd like to thank every one of the more than 2,400 colleagues who completed the survey. When you submit your response, you're telling us how we're doing, so we can make informed decisions to make this Trust a great place to work.

7.4. Sunday, 8 March was International Women's Day, which is celebrated all over the world. The United Nations' theme for the day was 'Rights. Justice. Action. For ALL Women and Girls', and in honour of this, we marked the day on Friday, 6 March by hiding talks and sessions on technology and sexual harassment, resilience and wellbeing, and discussion focused on leadership. We must embody our Trust's FIRST values, so taking the opportunity to mark the day in a meaningful way, is one of many things we can do to truly be an inclusive organisation.

7.5. We are continuing to work through the transformation of our administration and clerical services. We have engaged and work with the affected teams to agree a model going forward, which aims to deliver an accessible, high quality, and effective service. This will reduce the amount of variation, complexity, inefficiencies. This will mean three hubs will be created, which will improve the experience our staff and patients have when delivering or accessing administration and clerical services. They focus on a centralised administration hub for end-to-end support for outpatient booking and referral processing, a hub for outpatient reception and health records for the front-of-house reception teams, and the centralised medical resource hub for medical workforce rota coordination and support. This is a complex set of changes, and it will be delivered in a phased approach over the next two to three years. I must stress, this does not mean dedicated administrative support is being withdrawn or specialist roles lost.

8. Future

8.1. The project to deliver a new West Suffolk Hospital is making good progress. We are agreeing the final design with our colleagues at NHS England, and are engaging with our staff and communities on this, before we submit our Reserved Matters application later this Spring.

8.2. We are also making headway on the expansion of the Community Diagnostic Centre in Newmarket. This will provide endoscopy and paediatric audiology services, and means patients in and around Newmarket have the services they need closer to where they live. Bringing the care patients need to them is a key part of the Government's 10-Year Health Plan for England, and represents the development of the Newmarket Community Hospital site. We expect to begin construction in the Summer, and have this facility seeing its first patients in 2027.

1.8. BAF and Risk Report (ATTACHED)

To inform

Presented by Paul Bunn

Open Board of Directors – 27 March 2026

Report information

Report title: BAF Update and Risk Report
Agenda item: 1.8
Sponsor/Executive lead: Ewen Cameron, CEO
Report prepared by: Paul Bunn, Acting Trust Secretary
Previously considered by: Standing Board Agenda item
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 provides the Board with the most significant changes to the Board Assurance Framework (BAF) since this was last considered in January 2026.

We continue to work on the old BAF structured around **10 strategic risks** (agreed in November 2022), until the new BAF template and themes are finalised (expected April 2026).

The process of review is that operational and executive leads review their BAF risks at a functional level. Any changes are highlighted and discussed at the Management Executive Group (MEG). Once finalised, the updated strategic risk is reported into the relevant Board assurance committee. As per accepted best practice, WSFT operates 3 levels of assurance for each strategic risk.

Q how has the BAF changed since January 2026?

- ***BAF 1 Staff capability* –** Reviewed by People & OD in February 2026. Actions(mitigations) refreshed to reflect work on implementing the People, Culture & OD strategy; continued support for learning and development and integrating the behavioural framework for leaders – all rated green. However, minimal assurance around the future hospital programme, as not joined up enough currently. Work not yet started re better integration of future planning and the development and ownership of shared actions across boundaries. Work scheduled for delivery by March 2028.
- ***BAF 2 Capacity* –** Discussed at F&P in February 2026. No significant changes. Upgraded assurances from amber to green to reflect positive BCP work and external audits. Detailed conversations had about mitigations, are they the right actions? Current actions will be delivered in March 2026, but WSFT will still not achieve risk appetite of 9, this will remain at 12. In new BAF, need to look at controls/ what more can we do, or does the Board need to revise the risk appetite around capacity?
- ***BAF 4 Continuous Improvement* –** Verbal update provided at March QPS meeting with detailed review planned in April 26. Risk previously reduced to 12 in the Autumn

25 to reflect work across the pathway has progressed. Risk currently in line with risk appetite but to reduce further WSFT needs to find capacity to change and think about partnerships and how to drive cultural change.

- ***BAF 6 Estates*** – Discussed at March F&P. Progress highlighted on a number of actions but not reduced the risk score presently as there are steps to go to ensure change embedded. Health and safety risk reduced significantly as a result of the completion of the RAAC programme. However, significant business continuity risk remains due to the condition of the estate infrastructure. NHS England independent report provides assurance in terms of ensuring that the Trust can continue to provide services in the existing environment until the new hospital is completed.
- ***BAF 7 Finance*** – Reviewed at March F&P. Score reduced from 16 to 12 (target score is 9) in November 2025, reflecting progress made in developing budgets and plans for 26/27. No changes to score at this review but progress against actions noted. Emerging assurance gap noted around regulatory oversight model – moving from system to regional control totals and the changing relationship in their strategic commissioning role. Challenges around decentralised finance highlighted in BAF together with mitigations to address that.
- ***BAF 10 Staff wellbeing*** – Reviewed February 2026 at People & OD. Partial assurance given for controls as this reflects need to change and shape culture as well as drive actions forward. Actions focus around implementing the People, Culture and OD strategy and business plan through 2026 and 2027. Progress will be defined by continued integration of organisational development expertise and interventions, not just functional HR support.

The following are due for review in April 2026:-

- BAF 2 - Capacity
- BAF 3 – Collaboration
- BAF 5 – Digital
- BAF 10 – Staff Wellbeing – currently outside risk appetite

Appendix 1 maps movement for each of the BAF risks according to the risk score for 'current' (with existing controls in place) and 'future' (with identified additional controls in place). This does not identify slippage from original trajectory.

Appendix 2 summarises and tracks the inherent, current and future risks score. Only BAF 4 and 9 are currently within risk appetite. 7 BAFs have a plan to achieve this over the coming months. As discussed above, BAF 2 poses a challenge of whether the risk appetite surrounding capacity is achievable in the current climate.

Three risks are assigned reasonable assurance and seven have partial assurance. **No** BAF risks are rated minimal assurance.

Workplan
The forward plan and reporting lines are contained within **Appendix 3:** 3 strategic risks are reviewed every 6 months; 7 are reviewed quarterly.

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

BAF 26/27

The current BAF was reviewed at the October 25 Board Development workshop. Due to other operational pressures work has not progressed on this as fast as we would have hoped. Benchmarking of templates against other organisation has been completed. The Executive team have met twice with the risk team since January 2026 to discuss the new BAF. Draft new BAFs are being populated for wider circulation and discussion. A working group has also been set up to complete a review of the associated organisational wides risks that may impact on each new BAF. Currently there is no corporate or organisational wide risk register to capture these and this is a gap.

So what?

The BAF is a tool used by the Board to manage its principal strategic risks. Focusing on each risk individually, the BAF documents the key controls in place to manage the risk, the assurances received both from within the organisation and independently as to the effectiveness of those controls and highlights for the board's attention the gaps in control and gaps in assurance that it needs to address in order to reduce the risk to the lowest achievable risk rating.

Failure to effectively identify and manage strategic risks through the BAF places the strategic objectives at risk. It is critical that the Board can maintain oversight of the strategic risks through the BAF and track progress and delivery.

What next?

To continue with the review and update of the strategic risks within the BAF including:

1. Agree and finalise new BAF template and align with the strategy. Then revise forward plan. This will also include review and assessment of the risk appetite for each risk (Q1 2026/27).
2. To arrange a Board Risk Management workshop to discuss risk appetite. (Q1 2026/27).
3. A matrix will be developed to map the interdependencies between individual BAF risks. (Q1-26/27).
4. Review and refresh longer term assessment of the mitigation and risk for each of the BAF risks to achieve the agreed risk appetite (throughout 2026/27).

Action required by the board:

1. **Note the report** and progress with the BAF review and development
2. **Approve the 'Next steps' actions**.

Governance and compliance

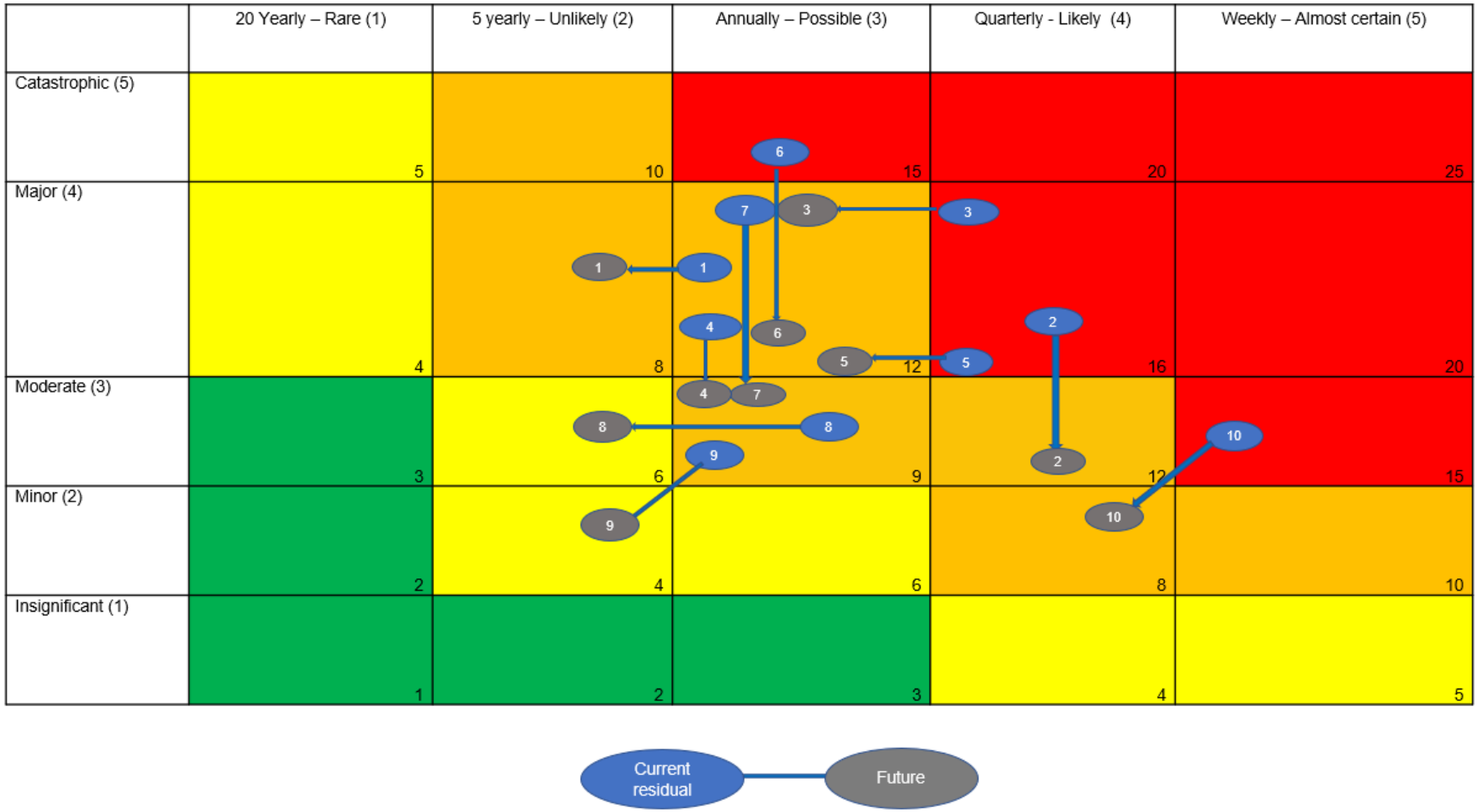
Risk and assurance: If WSFT does not have an effective risk management process in place, which includes: regular reviews of the BAF, and assessment and control of strategic risks, it will be unable to provide a positive statement within the Annual Governance Statement. This would impact its licence requirements.

Equality, diversity and inclusion: Applies universally to all. Decisions should not disadvantage individuals or groups with protected characteristics.

Sustainability: A properly managed BAF ensures WSFT will be fit for the future and able to meet the future healthcare needs of the population of West Suffolk. It will support the operational and strategic performance of WSFT. Identifying risks early and mitigating them may prevent occurrence or lesson their impact.

Legal and regulatory context: NHS Act 2006, Code of Governance. Well-led framework

Appendix 1: BAF Risk Movement



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Appendix 2: Risk themes – summary table

Risk Descriptions	Exec lead	Board comm.	Appetite Level and score	Inherent risk score	Current risk score	Future risk score (target date)	Future risk within appetite?	Assur. level
BAF 1 Fail to ensure the Trust has the capability and skills to deliver the highest quality, safe and effective services that provide the best possible outcomes and experience (Inc developing our current and future staff)	CPO	P&OD Planned for Aug 26	Cautious (9)	20	12	8 (Mar 27)	Yes	Reasonable
BAF 2 The Trust fails to ensure that the health and care system has the capacity to respond to the changing and increasing needs of our communities	COO	F&P Planned for Apr-26	Cautious (9)	20	16	12 (Mar 26)	No	Partial
BAF 3 The Trust fails to collaborate effectively with partners, causing an inability to deliver the 'Future Shift', leading to a failure to implement strategic transformation priorities, the Future Systems Programme, and/or new models of care that could improve population health outcomes, Trust sustainability, and operational performance.	DST	P&OD Planned for Apr-26	Open (12)	16	16	12 (Apr 26)	Yes	Partial
BAF 4 There is a risk that the Trust does not have the capacity, capability, or commitment to change the way it provides health and care services, which could lead to a failure to respond to changing demand pressures, unsustainable services, and/or not delivering major projects, which would worsen operational pressures, quality of care, and financial viability.	DST	PQ&S Planned for June-26	Open (12)	16	12	9 (Apr 26)	Yes	Partial

Risk Descriptions	Exec lead	Board comm.	Appetite Level and score	Inherent risk score	Current risk score	Future risk score (target date)	Future risk within appetite?	Assur. level
BAF 5 Fail to ensure the Trust implements secure, cost effective and innovative approaches that advance our digital and technological capabilities to better support the health and wellbeing of our communities	COO	Digital &Data Planned for Jul - 26	Cautious (9)	20	16	12 (Jan26)	No	Partial
BAF 6 [1] Fail to ensure the Trust estates are safe, fit for purpose while maintained to the best possible standard so that everyone has a comfortable environment to be cared for and work in today and for the future	DoR	F&P Planned for Jun - 26	Open (12)	20	15	12 (Apr 26)	Yes	Partial
BAF 7 Fail to ensure we manage our finances effectively to guarantee the long-term sustainability of the Trust and secure the delivery of our vision, ambitions, and values	DoR	F&P planned for May - 26	Cautious (9)	16	12	9 (Jun 26)	Yes	Partial
BAF 8 Good governance is about having clear responsibilities, roles, systems of accountability to manage and deliver good quality, sustainable care, treatment and support. A failure to ensure this means the Board would be unable to act on the best information when planning services, improvements or efficiency changes both locally and with system partners in line with our vision and values.	ECN	PQ&S Planned for Jul - 26	Minimal (6)	16	9	6 (Apr 26)	Yes	Reasonable
BAF 9 Trust fails to centre decision making and governance around the voices of people and communities at every stage including feeding back to them how their voice has influenced decisions, especially with marginalised groups and those affected by health inequalities, resulting in a lack of understanding of our community's health needs	ECN	Transferred to PQ&S Planned for Apr - 26	Cautious (9)	12	9	4 (Jun '26)	Yes	Reasonable

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Risk Descriptions	Exec lead	Board comm.	Appetite Level and score	Inherent risk score	Current risk score	Future risk score (target date)	Future risk within appetite?	Assur. level
BAF 10 Fail to ensure the Trust can effectively support, protect and improve the health, wellbeing and safety of our staff	HR&C	P&OD Planned for May - 26	Cautious (9)	15	15	8 (Mar 27)	No	Partial

[1] risk rating increases in future years as WSH building reaches end of effective life

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Appendix 3 – Forward Plan

	Score	Frequency	Executive lead	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-26	Apr-27	May-27	Jun-27	Jul-27	Aug-27	Sep-27	Oct-27	Nov-27	Dec-27	Jan-28
Management Executive Group																											
BAF 1-Capability and skills	12	six monthly	HR&C (Julie Hull)	X						X						X					X						X
BAF 2-Capacity	16	quarterly	COO (Nicola Cottington)			X			X			X			X			X			X			X			
BAF 3-Collaboration	16	quarterly	DST (Sam Tappenden)			X						X			X			X			X			X			
BAF 4-Continous improvement and Innovation	12	quarterly	DST (Sam Tappenden)		X			X			X			X			X			X			X				
BAF 5-Digital	16	quarterly	COO (Nicola Cottington)		X			X			X			X			X			X			X				
BAF 6-Estates	15	quarterly	DoR (Jonathan Rowell)		X			X			X			X			X			X			X				
BAF 7- Finance	12	quarterly	DoR (Jonathan Rowell)	X			X			X			X			X			X			X			X			X
BAF 8-Governance	9	six monthly	ECN (Dan Spooner)						X						X						X						X	
BAF 9-Patient Engagement	9	six monthly	ECN (Dan Spooner)			X						X						X						X				
BAF 10-Staff Wellbeing	15	quarterly	HR&C (Julie Hull)	X			X			X			X			X			X			X			X			X
Quality and Patient Safety Committee																											
BAF 4 -Continous improvement and Innovation	12	quarterly	DST (Sam Tappenden)			X			X			X			X			X			X			X			X	
BAF 8 -Governance	9	six monthly	ECN (Dan Spooner)	X						X						X						X						X
BAF 9-Patient Engagement	9	six monthly	ECN (Dan Spooner)				X					X							X						X			
Finance and Perfomance Committee																											
BAF 2-Capacity	16	quarterly	COO (Nicola Cottington)	X			X			X			X			X			X			X			X			X
BAF 6-Estates	15	quarterly	DoR (Jonathan Rowell)			X			X			X			X			X			X			X			X	
BAF 7- Finance	12	quarterly	DoR (Jonathan Rowell)		X			X			X			X			X			X			X			X		
People and Organisational Development Committee																											
BAF 1-Capability and skills	12	six monthly	HR&C (Julie Hull)		X						X						X					X						
BAF 3-Collaboration	16	quarterly	DST (Sam Tappenden)	X			X			X			X			X			X			X			X			X
BAF 10-Staff Wellbeing	15	quarterly	HR&C (Julie Hull)		X			X			X			X			X			X			X			X		
Digital and Data Committee																											
BAF 5-Digital	16	quarterly	COO (Nicola Cottington)	X			X			X			X			X			X			X			X			X

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2. HIGH QUALITY CARE

2.1. Integrated Quality & Performance Report (IQPR) (ATTACHED)

To Review

Presented by Daniel Spooner, Nicola Cottington and Jonathan Rowell

NHS
West Suffolk
NHS Foundation Trust

Integrated quality and performance report (IQPR)

January 2026 report

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Executive summary: January 2026

This report is for **Assurance.**

This reports supports the following ambitions within the organisational strategy:

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

What?

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

So what?

The Integrated Quality and Performance Report (IQPR) uses the Making Data Count (MDC) methodology to report on the following aspects of key indicators:
1. The ability to reliably meet targets and standards (pass/fail)
2. Statistically significant improvement or worsening of performance over time.

Narrative is provided to explain what the data is demonstrating (what?), the drivers for performance, what the impact is (so what?) and the remedial actions being taken (what next?). An explanation of MDC is available in the appendices.

What next?

The narrative alongside the data summarises the actions being taken to improve performance where this is not meeting standards and/or is worsening over time.
A task and finish group has been set up to review the content of the IQPR to ensure the correct metrics are being measured and monitored with regard to workforce data. The outputs from this work will become part of the IQPR. Other metrics are being reviewed in line with the new NHS National Oversight Framework (NOF) and new Trust Strategy, and to include health inequalities, digital and productivity metrics.

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

Executive summary: January 2026

Highlights this month

- **Health inequalities** data has been included for the first time in the IQPR. For emergency care, the data are showing that women, older people, and people with an ethnicity other than white are more likely to experience the longest waits compared to the distribution of these groups in the local population. However, it is important to note that the comparison is currently against local population data and from next month this will be compared to emergency department activity data.
- The trajectory for 4-hour performance was not met at **67.92%** against a plan of 72% and **971** patients spent over 12 hours in the Emergency Department - 12.39% of all patients.
- Average occupancy in the Virtual Ward in January was **79%**, an increase from 68% the previous month and just below the 80% target.
- Cancer 28-day Faster Diagnosis Standard performance was **76.5%** in December, which was an improvement from November's performance but remains below trajectory, driven by Breast service underperformance.
- However, 62-day cancer treatment performance continues to be strong in all tumour sites, at **83.3%.**
- We are ahead of the agreed recovery trajectory for 6-week diagnostic performance, with **71.32%** of patients in January receiving their tests within six weeks.
- Referral to Treatment (RTT) is ahead of plan at **62.63%** against a trajectory of 62%, with a focus on outpatient activity and validation supporting continued improvements. There were 38 patients waiting over 65 weeks, with ongoing reduction forecast during February and March.

Variance – are the measures being met?

Assurance – can the target be consistently achieved?

December 2025	Consistently hitting target - celebrate	Target not consistently achieved or failed	Consistently fail target - investigate	No target set – celebrate, monitor or investigate
Special cause improvement- celebrate			F&P Diagnostic Performance- % within 6weeks Total RTT 65+ Week Waits	F&P RTT Waiting List RTT 52+ Week Waits RTT 52+ Weeks Wait as % of Total WL RTT <18 Week Waits (% All)
Common cause – monitor & understand		F&P Ambulance Handover within 30min Non-admitted 4 hour performance Virtual Ward Total average occupancy percentage 28 Day Faster Diagnosis Cancer 62 Days Performance Q&P C-Diff Hospital & Community onset, Healthcare Associated PPH O&D Mandatory Training Turnover	F&P Incomplete 104 Day Waits O&D Appraisal	F&P 12 Hour Breaches 12 hour breaches as a percentage of Type 1 attendances RTT <18 Week Waits (% First OPA) Q&P % of patients with Measured Weight % of patients with a MUST/PYMS assessment completed within 24 hours of admission Inpatient Deaths 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	O&D Staff Sickness – Rolling 12month Staff Sickness			F&P Community Paediatrics RTT Overall Waiting List Community Paediatrics RTT Overall 52 Weeks Wait Q&P 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 12month, Staff Sickness, Appraisal

National oversight framework (NOF)

Overall segment and domain scores

Headlines	Data period	Provider value	Peer average		National value	National value method	Chart	Actions
Adjusted segment			Q2 2025/26	3	NOF Score	Provider value		
Average metric score			Q2 2025/26	2.27	NOF Score	Provider value		
Unadjusted segment			Q2 2025/26	2	NOF Score	Provider value		
Financial override	Q2 2025/26	Yes	Yes		Yes	Provider median		
Is the organisation in the Recovery Support Programme?	Q2 2025/26	No	No		No	Provider median		

Domain Scores	Data period	Provider value		Chart	Actions
Access to services domain segment	Q2 2025/26	2	NOF Score		
Effectiveness and experience of care domain segment	Q2 2025/26	2	NOF Score		
Patient safety domain segment	Q2 2025/26	3	NOF Score		
People and workforce domain segment	Q2 2025/26	3	NOF Score		
Finance and productivity domain segment	Q2 2025/26	3	NOF Score		

Q2 NOF standing (acute Trusts)

57/134

Segment

3

What?

- The National Oversight Framework (NOF) score for WSFT is 57 out of 134 Trusts for quarter 2 of 2025/26. The previous rank was 90 so this represents a significant climb in the rankings relative to other NHS providers. The unadjusted segment is 2 (higher is better), but due to the Trust's planned deficit, there is a financial override meaning WSFT cannot be ranked higher than segment 3.

So what?

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

What next?

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

Health inequalities – ED 12-hour breaches

What?

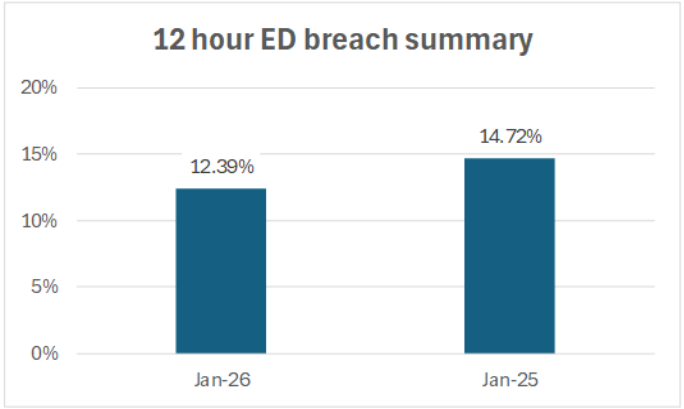
- January 2026 saw 7,385 Type 1 patients depart the Emergency Department (ED). 971 of those patients were in ED for 12 hours or more – 12.39% of all Type 1 departures. This is lower than the number for January 2025, when 1,101 (14.72%) Type 1 patients spent over 12 hours in ED
- Sex: 53.45% of patients who experienced a stay in ED of 12 hours or more were female (46.45% were male and 0.10% were unspecified). Data from the 2021 census states that 50.7% of Suffolk residents were female and 49.30% were male
- Age: 55.20% of patients who experienced a stay in ED of 12 hours or more were over 75 years old. The next highest group was of patients aged 61 to 75 years old (21.52%)
- Ethnicity: 92.28% of patients who experienced a stay in ED of 12 hours or more were white (British, Irish or other). Data from the 2021 census stated that 93.1% of Suffolk residents were white
- Data comparisons will be using WSFT data going forwards, but census data has been used this month for information.

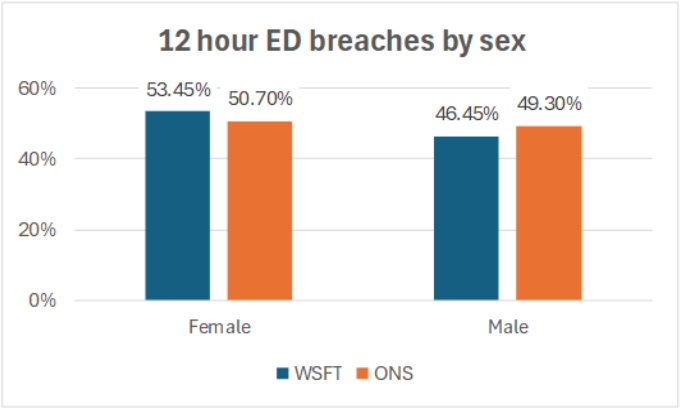
So what?

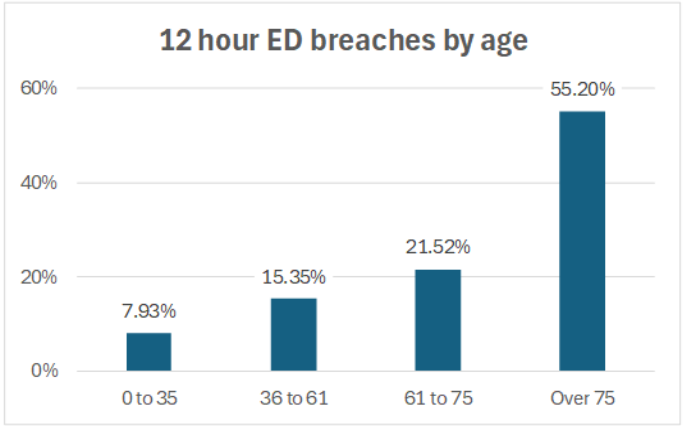
Reporting on health inequalities helps us understand potential areas for improving access and waiting times and ensuring the care we provide is equitable and fair.

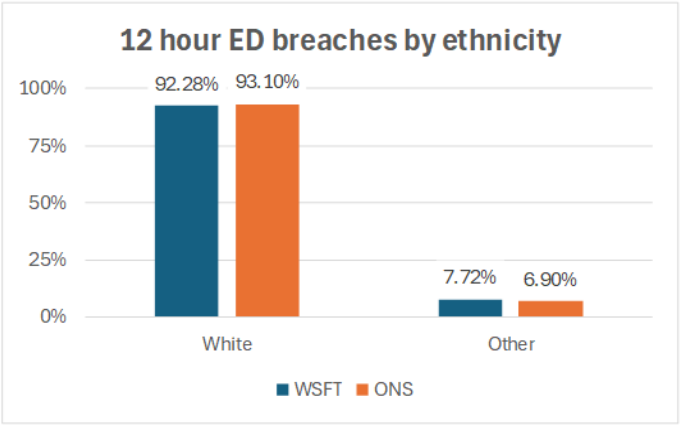
What next?

Additional reporting is being built to include at cancer 28-day targets and Referral to Treatment (RTT) total waiting list.









White - British	839	86.41%	Asian - Any Other Background	3	0.31%
Other - Not Stated	55	5.66%	Other - Not Known	2	0.21%
White - Any Other Background	52	5.36%	Mixed - White and Asian	1	0.10%
Other - Any Other Ethnic Group	6	0.62%	Mixed - Any Other Background	1	0.10%
Black - Any Other Background	5	0.51%	Mixed - White and Black African	1	0.10%
White - Irish	5	0.51%	Asian or Asian British - Indian	1	0.10%

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Finance and performance committee metrics

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Urgent & Emergency Care: ED ambulance and 4-hour performance

What?

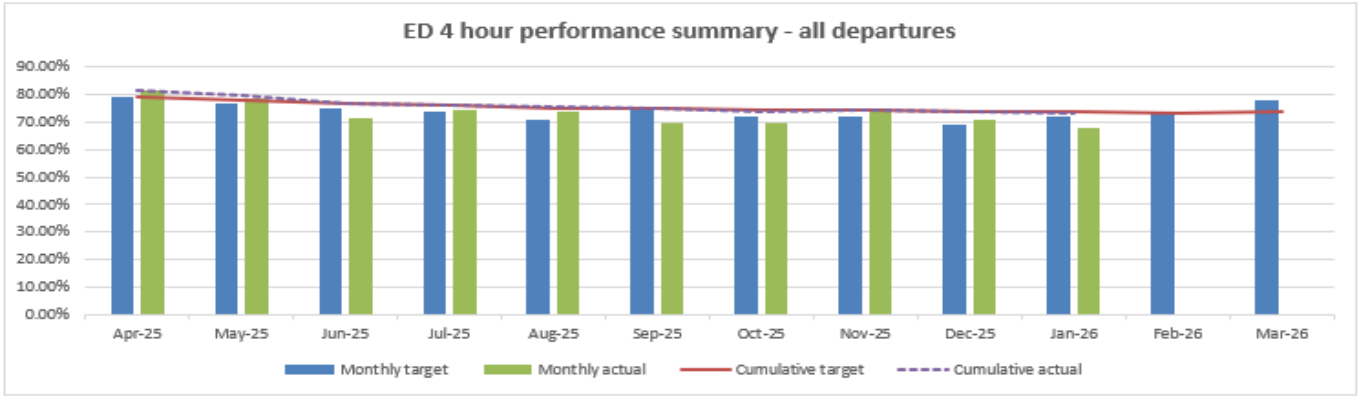
- No significant change is demonstrated in the 30-minute ambulance handover metrics. In January we achieved 70.8% against a target of 95%.
- Non-admitted 4-hour performance was 80.35% showing no significant change and missing the internal target of 85%.
- Overall, 4-hour performance was 67.92% against a trajectory of 72%.

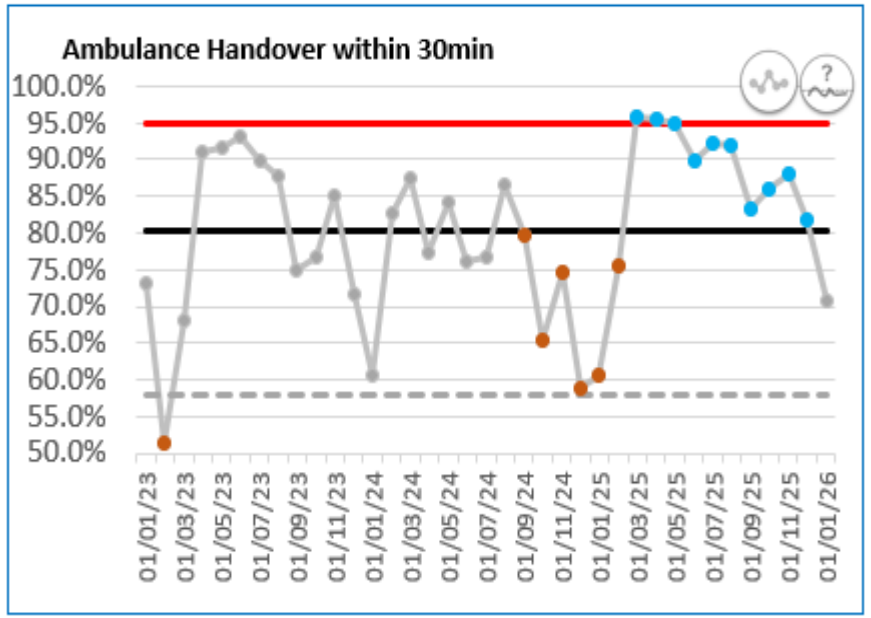
So what?

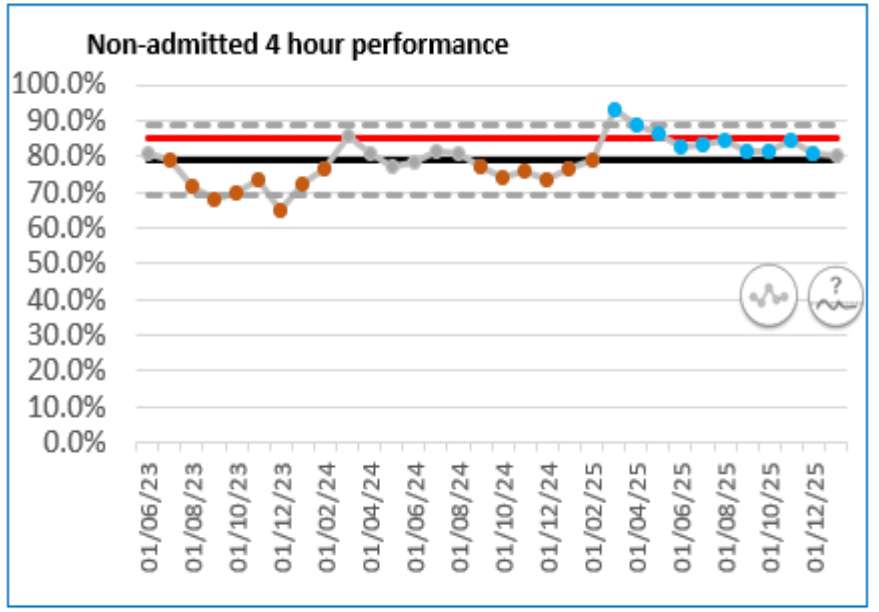
- Meeting the Urgent and Emergency Care (UEC) performance metrics means that our patients receive timely, safe care.
- Meeting the in-month trajectory for the 4-hour Emergency Department metric keeps us on track to achieve 78% by March 2026.

What next?

- Continued work to meet the monthly trajectory to achieve 78% for the Emergency Department (ED) 4hr target.
- Weekly performance meetings with Medical Division Senior Leaders and Executives.
- Continued daily support including some weekends, by senior operations and nursing teams alongside some weekend support.
- Embedding huddles throughout the day in ED – promoting focus, identifying issues and making plans.
- Same Day Emergency Care and ED GP work continues.
- Preparations for March underway
- Review of doctor and nursing cover in ED against activity in the department.







Urgent & Emergency Care: ED 12-hour performance

What?

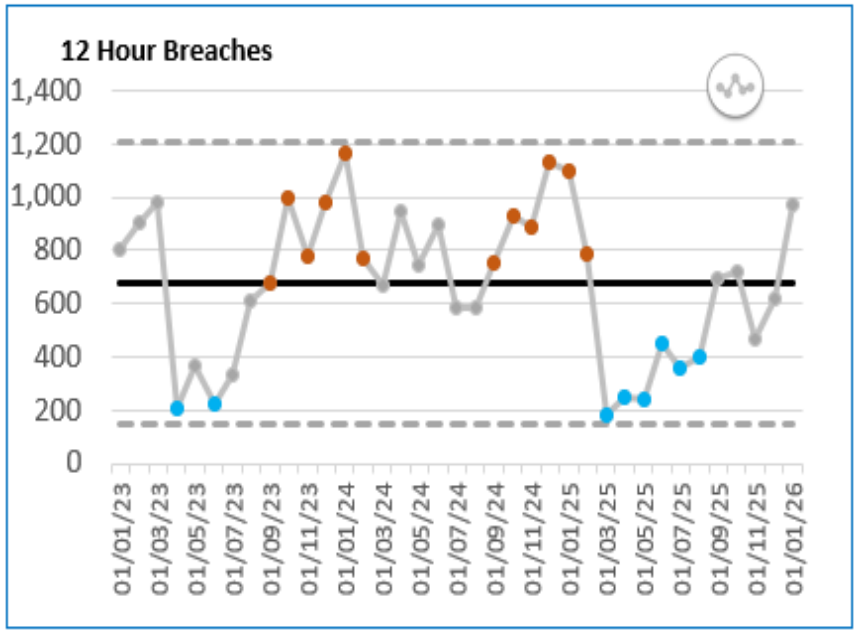
- There was an increase in the number of 12-hour length of stay breaches from 619 in December to 971 in January . This does not represent a significant change from previous performance. .
- 12.39% of ED attendances were 12-hour breaches against a monthly target of 4.04%.

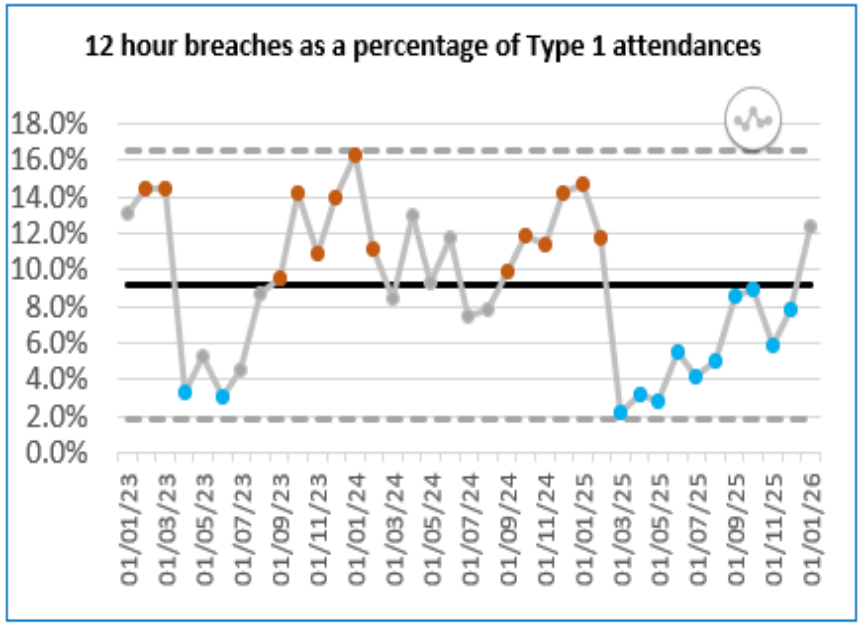
So what?

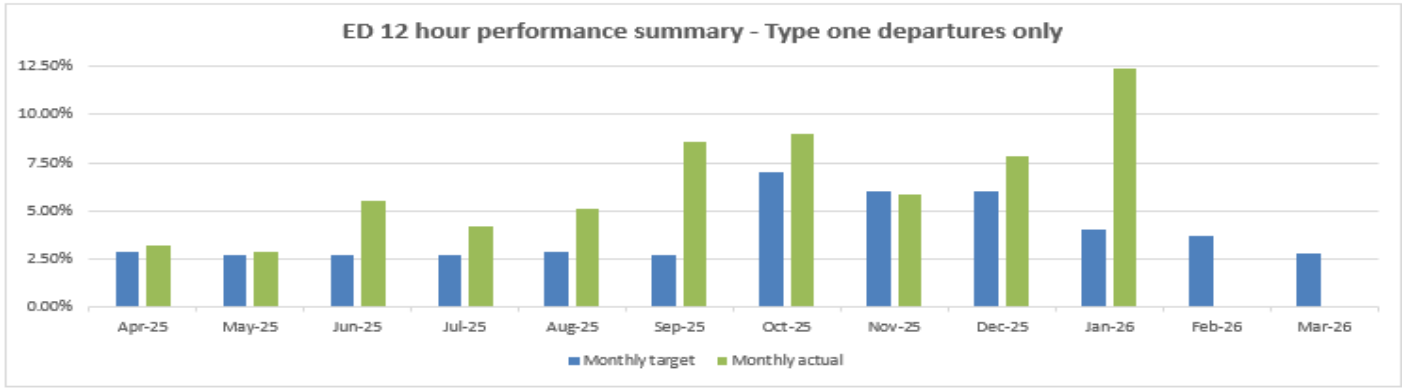
- An increased number of patients spent more than 12 hours in the Emergency Department (ED) which reflects poor patient experience.
- The impact of more 12 hours breaches in the ED is that escalation capacity is regularly used, impacting on the use they are intended for - this includes Rapid Assessment Triage (RAT) and Same Day Emergency Care, both of which impact on our ability to offload ambulances and the flow in and through the department. At times, the RAT corridor was also used as temporary escalation space.

What next?

- Continued focus on length of stay (LOS) reductions to support flow out of ED including the ongoing task and finish group for board rounds/huddles.
- Focus on ensuring right patients are placed in right specialties to support specialist needs and LOS reductions
- Working with Transformation team to process map patient discharge pathway within clinical wards to highlight any themes that are delaying discharges with aim to bring on day discharge times earlier.







Urgent & Emergency Care: Urgent Care Response (UCR)

What?

- Overall UCR response remains above target at 87.66%.
- Integrated neighbourhood teams (INT) UCR response is below the 70% target for a third month.

So what?

- Overall, patients requiring an urgent response, often to avoid hospital admission, are being seen within 2 hours in the community
- Increased cancellations within the INTs of planned care presents risk to quality of patient care and increases the workload for co-ordinators and clinicians to re-organise care, compounding capacity challenges.

What next?

- Workforce review occurs in line with National Quality Board, utilising the Community nursing safer staffing tool (CNSST).
- Working with Chief Nurse to review business case.

Team	Aug-25				Sep-25				Oct-25				Nov-25				Dec-25				Jan-26			
	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant
Total INT Nursing & Therapy	192	132	60	69%	179	131	48	73%	187	132	55	71%	212	141	71	67%	163	112	51	69%	183	123	60	67%
Total EIT*	596	539	57	90.44%	576	534	42	92.71%	677	634	43	93.65%	652	602	50	92.33%	635	580	55	91.34%	741	687	54	92.71%
Combined Total	788	671	117	85.15%	755	665	90	88.08%	864	766	98	88.66%	864	743	121	86.00%	798	692	106	86.72%	924	810	114	87.66%

Urgent & Emergency Care: virtual ward

What?

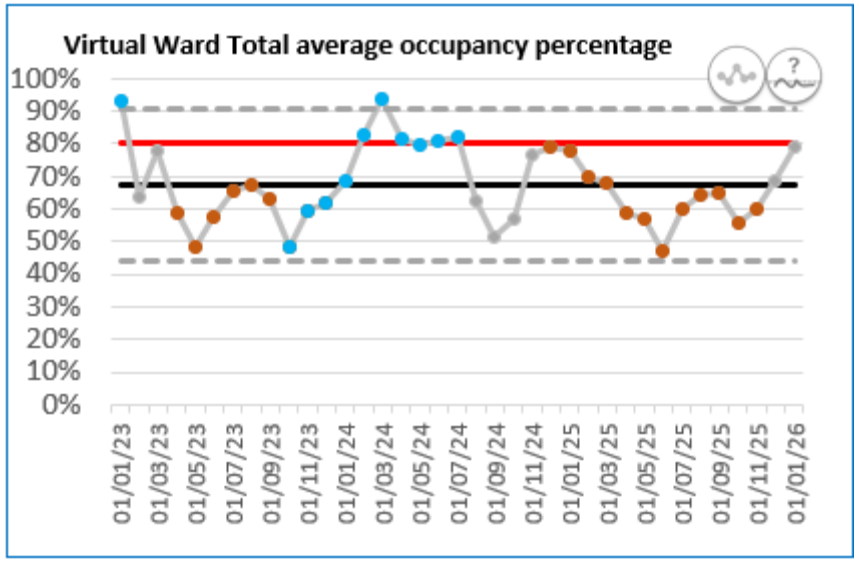
- Average occupancy in January was 79%, an increase from 68% the previous month.
- Total bed nights occupied were 1173 (increase from 1018) with a small increase in length of stay (average 8.8 days in January compared to 8.1 in December). This is consistently well managed and is significantly below the NHSE target of 14 days.

So what?

- Virtual Ward (VW) capacity is critical in ensuring adequate capacity to enable patient flow across the Trust and strategic ambition of caring for patients at or near home wherever possible.

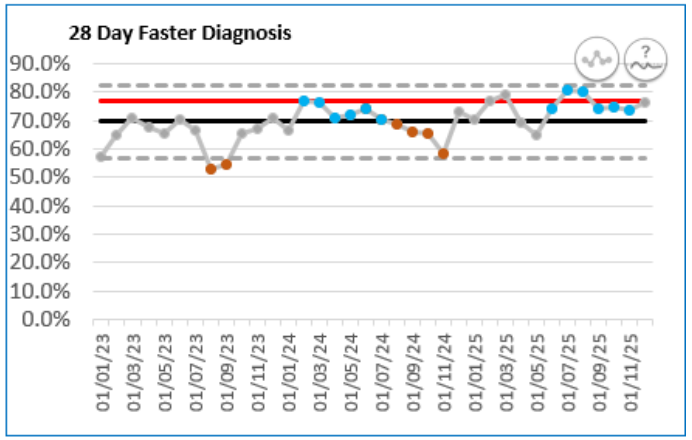
What next?

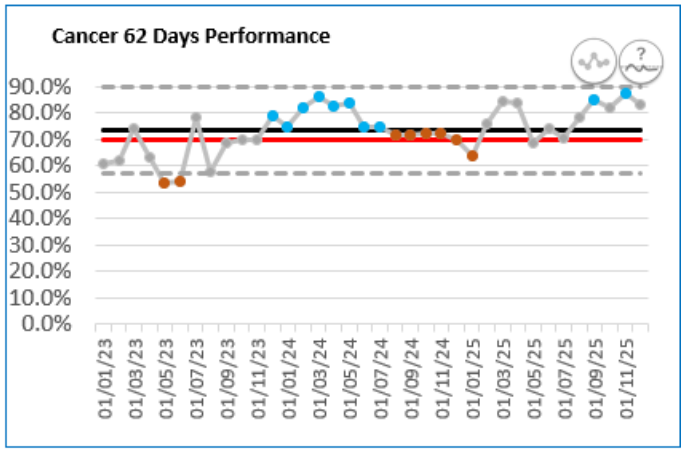
- Pilot commenced on 5 January to test long lies pathway via Cleric referrals, use of point of care testing devices and flexing of staffing across Virtual Ward and Early Intervention Team.
- Reviewing options to fill upcoming clinical lead vacancy
- Opportunity identified to reduce number of diabetes patients in inpatient beds and manage jointly by Virtual Ward/specialist diabetes team. Test and learn exercise currently being scoped to begin in April.
- Reflection and learning taken place from January's Trust-wide critical incident and increase in occupancy.

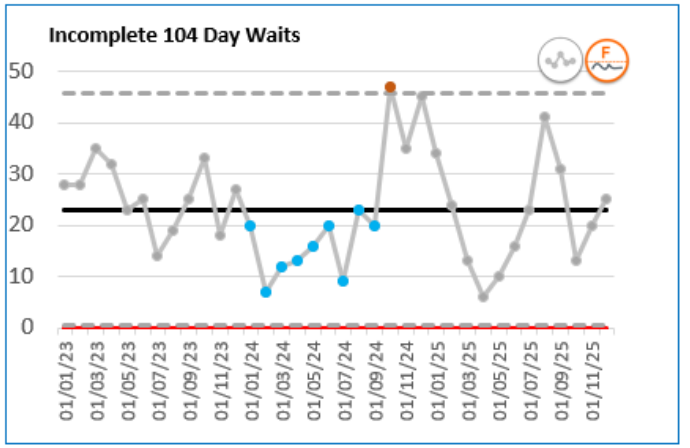


Cancer access

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	Dec 25	76.5%	77.0%			69.7%	56.9%	82.6%
Cancer 62 Days Performance	Dec 25	83.3%	70.0%			73.5%	57.2%	89.8%
Incomplete 104 Day Waits	Dec 25	25	0			23	0	46







What?

- 28-day performance was 76.5% in December, which was an improvement from November's performance but remains below trajectory.
- The underperformance is mostly related to the Breast performance which was at 74.5%, which is improved from previous months but remains below expected position, Urology and Lower GI both remain challenged with diagnostic delays which remain an area of focus.
- Performance was sustained in Gynaecology, Head and Neck, Skin, and Lung.
- Despite these challenges the 62-day treatment performance increased to 83.3%, with strong performance in all tumour sites.
- The volume of 104-day waits did increase slightly in December, due to a number of complex pathways in Skin and the delays in the Breast service.

So what?

- 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.

What next?

- Weekend insourced capacity to commence in February for the Breast service to reduce the backlog and bring down the wait to first appointment. External review for breast service to be completed by Cancer Alliance.
- Urology pathway focus on result clinics, which will improve once new consultant starts in February 2026.
- Lower GI focus on scan and reporting turnaround times, which are forecast to improve following return from maternity leave consultant in radiology.
- Continue with additional cancer session in endoscopy to improve FDS performance.

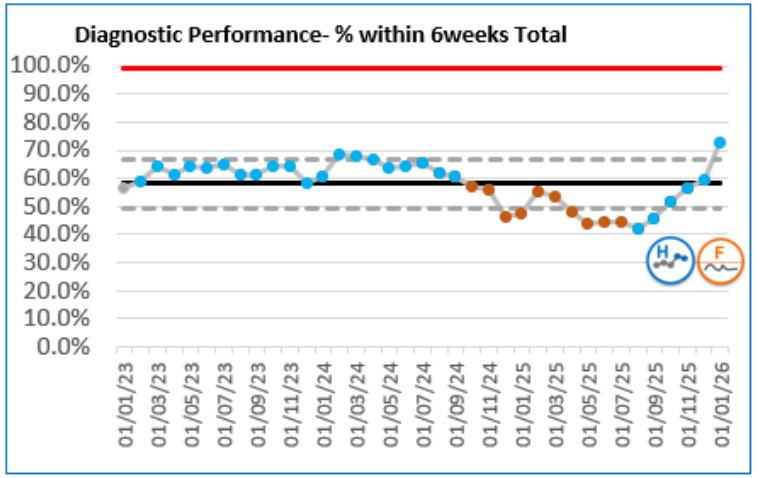
Diagnostic performance

What?

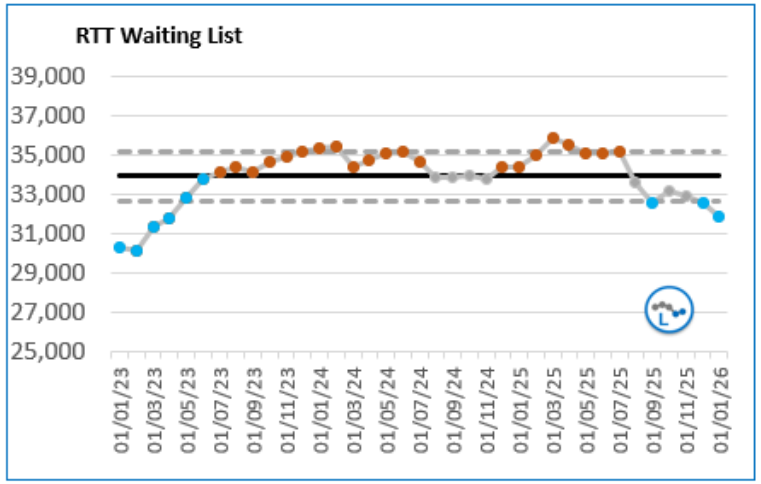
- The monthly Diagnostics Waiting Times and Activity Data (DM01) measures the number of patients waiting six weeks or more for 15 key diagnostic tests.
- WSFT is ahead of the agreed recovery trajectory, with 71.32% of patients in January receiving their tests within six weeks.
- The main areas of non-compliance are DEXA (bone density scan), endoscopy, non-obstetric ultrasound (NOUS) and audiology.

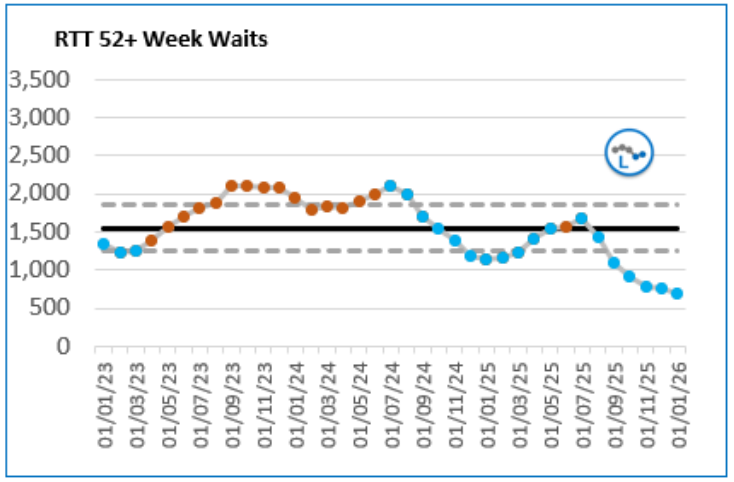
- **So what?**
- Longer waiting times for diagnosis and treatment have a detrimental effect on patients.
- Delay in achieving DM01 compliance standards and Referral to Treatment (RTT) standards.
- Reputational harm and lack of confidence in our services for our patients.

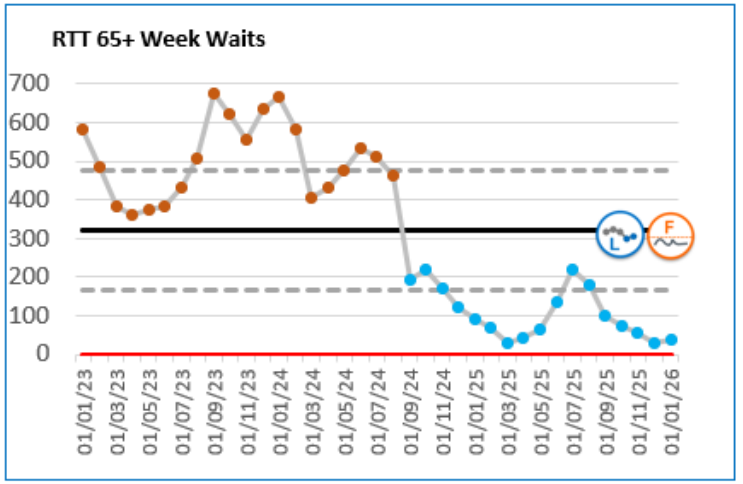
- **What next?**
- Recovery actions forecast improvement from overall position in September of 45.54% to 82% by end of March 2026 with observable week on week improvements in DM01.

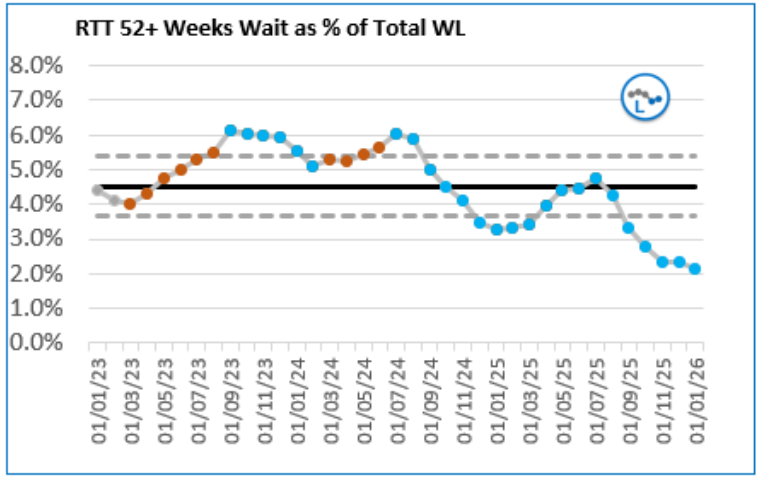


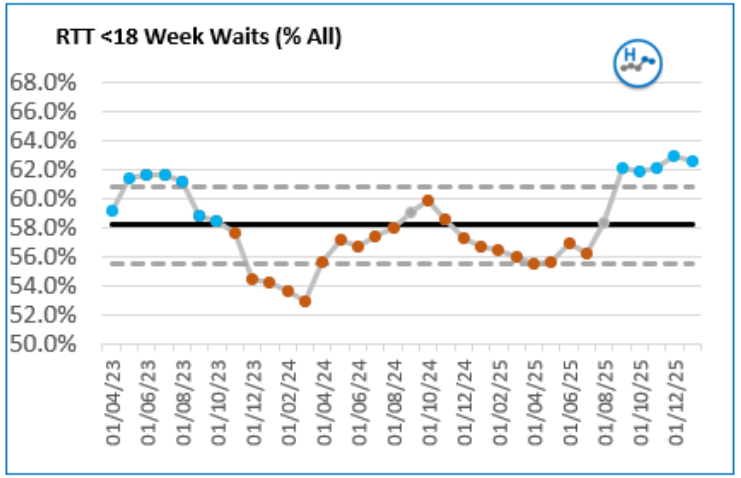
Referral to treatment (RTT) performance

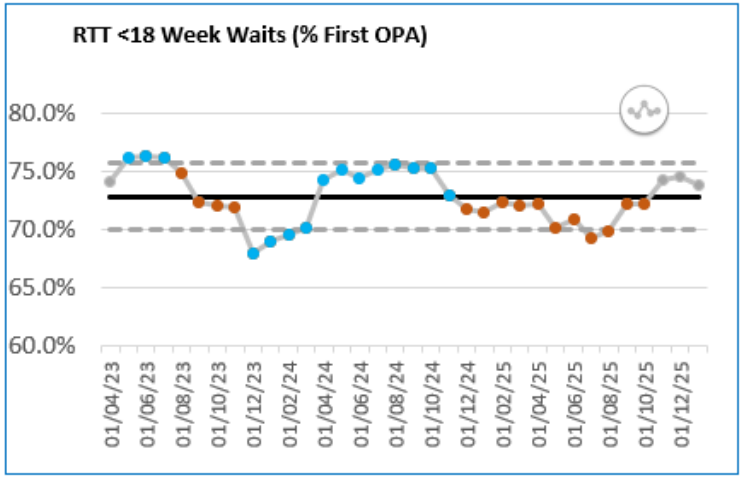












Referral to treatment (RTT) performance

Overall 18-week compliance January 2026	Patients with 65 week wait January 2026	Patients with 52 week wait January 2026	Total waiting list	% of patients being seen for first OPA within 18 weeks
62.63%	38	691	31925	73.7%

What?

- Overall RTT compliance is ahead of plan at 62.63% against a 62% requirement, with focus on outpatient activity and validation supporting continued improvements.
- The volume of patients over 65 weeks was 38 at the end of January, with this number set to reduce throughout February and reach 0 within March 2026.
- The volume of 52 week waits continues to improve, with significant focus on reducing the total cohort of 52 week waits before the end of March 2026. Additional session activity in theatres, utilisation of the independent sector, insourcing and continued focus on productivity is supporting the reduction.
- The focus on outpatient waits is supporting continued improvements in the wait time for first appointment, with WSFT as one of the higher performers in the region for this metric at 73.7%.

So what?

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.

What next?

- Continue with validation resource as part of validation sprint until March 2026.
- Focus on outpatient activity in quarter 4 in line with national expectation for outpatient sprint, for WSFT this includes additional in week and weekend sessions, as well as some insourcing for Breast, Vascular and Dermatology.
- Engage and process with 52 week wait delivery as part of quarter 4 52 week wait sprint, with additional activity agreed.

Community paediatrics

What?

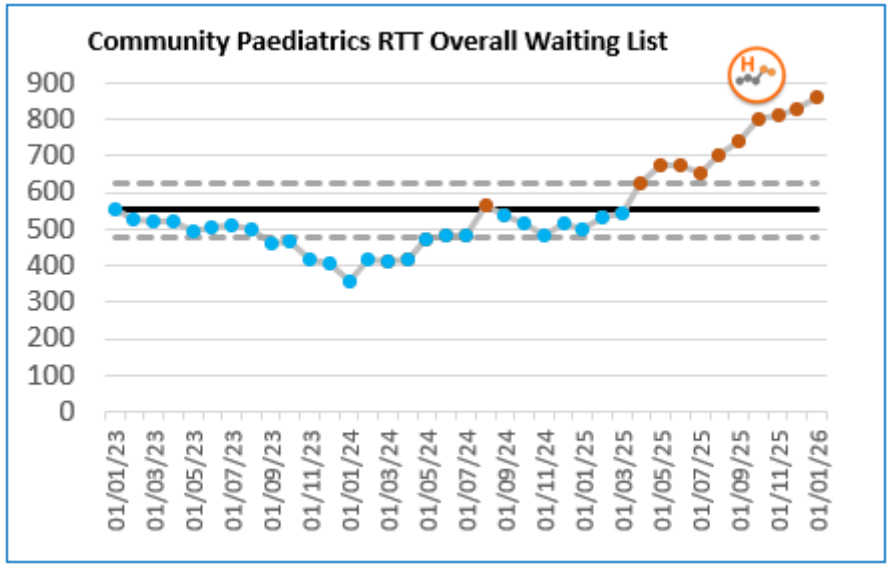
- There is sustained deterioration in waiting times for the paediatric team due to sustained level of demand and reduced capacity within the medical team.
- Longest waiting times, above 52 weeks, are associated with autism assessments although average waiting times for preschool assessments are increasing.

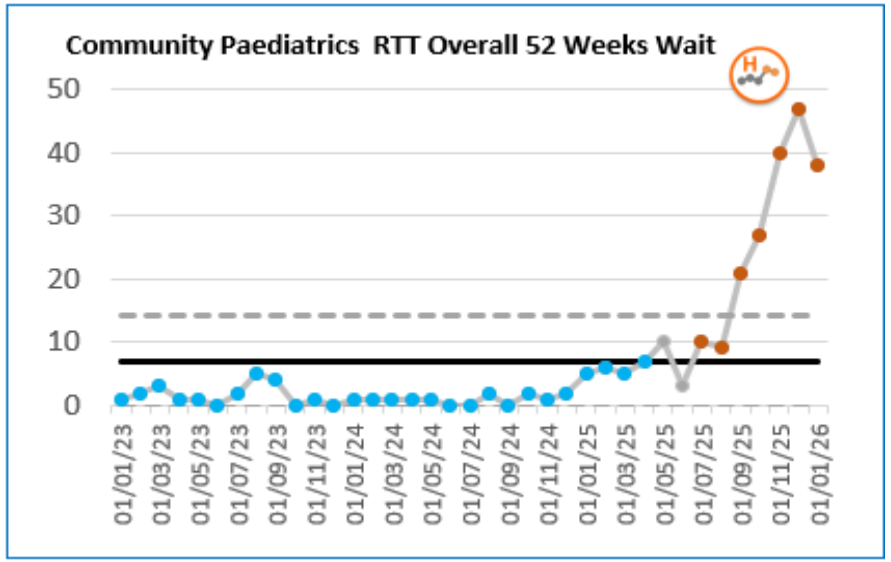
So what?

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

What next?

- Full time agency locum consultant within the east team covering vacancy – extension request for this placement to be submitted this month
- 0.7wte Consultant offered post for1wte vacancy in the west team – staring at the end of March
- Monthly monitoring of long waits continues.
- Plan enacted to reduce long waits by end of March.





KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Community Paediatrics RTT Overall Waiting List	Jan 26	861				554	480	628
Community Paediatrics RTT Overall 52 Weeks Wait	Jan 26	38				7	0	14

Elective activity plans

What?

- First outpatient attendances were behind plan in January to a similar level was seen in December at -2.4%.
- Similarly, electives were 11.0% behind compared to 13.7% the previous month, however day cases reversed the trend of being behind plan to a positive variance of 12.3%.
- Outpatient follow ups continue to grow ahead of plan, where a reduction is seen as positive for productivity – freeing up capacity for new patient appointment.

So what?

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.

What next?

- 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 'sprint' incentives for 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.

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	9,042	8,967	9,325	(283)	(3.0%)
Sep	10,914	10,529	10,950	(36)	(0.3%)
Oct	11,351	11,008	11,448	(97)	(0.8%)
Nov	10,762	9,814	10,207	555	5.4%
Dec	9,974	9,809	10,201	(227)	(2.2%)
Jan	10,327	10,172	10,579	(252)	(2.4%)
Feb		9,814	10,207		
Mar		10,893	11,328		
Total (YTD)	**103,232**	**100,382**	**104,395**	**(1,163)**	**(1.1%)**

January 2026

25/26	10,327
24/25	10,172
Plan	10,579
Var	(252)
Var %	(2.4%)

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	2,407	2,375	2,423	(16)	(0.7%)
Dec	2,332	2,315	2,362	(30)	(1.3%)
Jan	2,821	2,462	2,511	310	12.3%
Feb		2,405	2,453		
Mar		2,666	2,719		
Total (YTD)	**24,783**	**24,237**	**24,722**	**61**	**0.2%**

January 2026

25/26	2,821
24/25	2,462
Plan	2,511
Var	310
Var %	12.3%

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	23,502	23,971	22,532	970	4.3%
Sep	27,616	28,148	26,459	1,157	4.4%
Oct	28,693	29,427	27,662	1,031	3.7%
Nov	25,985	26,236	24,662	1,323	5.4%
Dec	25,635	26,221	24,648	987	4.0%
Jan	26,276	27,192	25,560	716	2.8%
Feb		26,236	24,662		
Mar		29,119	27,372		
Total (YTD)	**263,382**	**268,346**	**252,243**	**11,139**	**4.4%**

January 2026

25/26	26,276
24/25	27,192
Plan	25,560
Var	716
Var %	2.8%

Elective

Mon	25/26	24/25	Plan	Var	Var %
Apr	244	261	267	(23)	(8.5%)
May	247	268	273	(26)	(9.6%)
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	235	268	273	(38)	(14.0%)
Dec	230	261	266	(36)	(13.7%)
Jan	231	255	260	(29)	(11.0%)
Feb		268	273		
Mar		304	310		
Total (YTD)	**2,411**	**2,734**	**2,789**	**(378)**	**(13.5%)**

January 2026

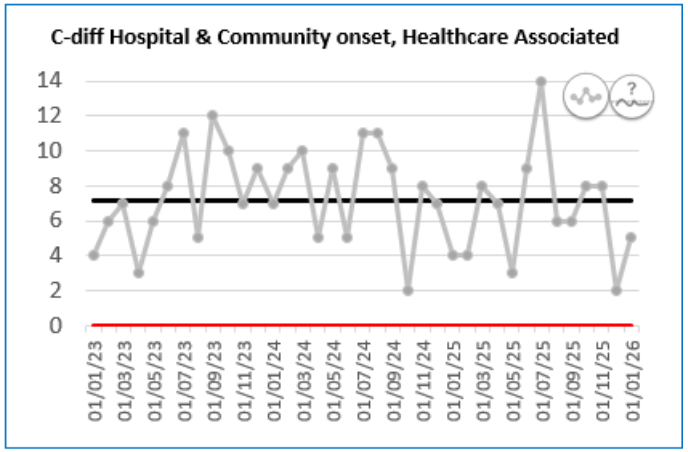
25/26	231
24/25	255
Plan	260
Var	(29)
Var %	(11.0%)

NHS
West Suffolk
NHS Foundation Trust

Quality and patient safety committee metrics

Compassionate care,
healthier communities

Quality and patient safety: C-difficile performance



What?

- January 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.
- April - January 2025/26: Trust total health care associated case rate demonstrates overall improvement compared to April-January 2024-25.

So what?

- Infection prevention and control is a key priority for all NHS providers and will form 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.

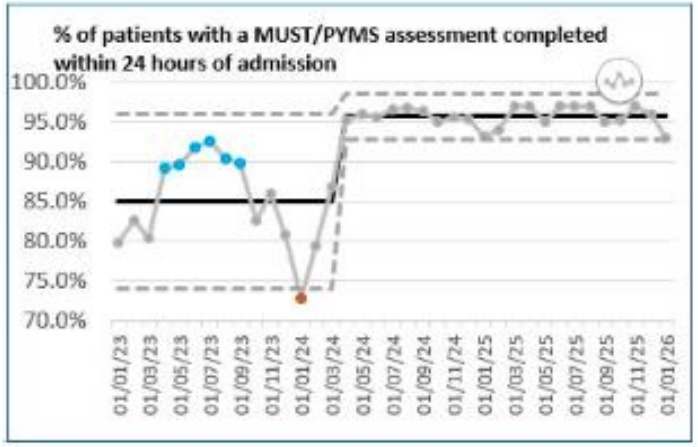
What next?

- At present, the service is on track to meet the target specific indicator despite increased cases related to the Clostridiodes difficile outbreak June/July 2025 and with focus on targeted interventions and leadership support we remain confident that performance will continue along this positive trajectory, ensuring sustained improvement across the service.
- The IPC Healthcare Associated Infection weekly review continues to be supported by an infection control doctor, (Consultant Microbiologist) which will continue as capacity allows.
- The Quality Improvement Programme continues with Clostridiodes difficile programme board re-convening 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.
- The cleaning poster is underway with aim for completion by April 2026.
- Statement of need for additional HPV fogging machines and Redirooms is completed with submission made Jan 2026, outcome awaited.
- IPN presence on the wards has been increased over the past few weeks, with bitesize training and on-the-spot discussions delivered in response to real-time observations and staff questions.
- Antimicrobial Stewardship Team engagement with the National 'Call to action' to reduce 'watch and reserve' antibiotic usage with a shift to 'access'. This work has included a submission to e-Care meds team and AMG for a community acquired pneumonia order-set which historically has high consumption of 'watch' antibiotic usage, thought to be linked to C.diff.
- Review of the IPC Board Assurance framework.

Quality and patient safety: nutritional screening

What?

- This month, we have observed a significant decrease in the proportion of patients receiving a nutritional assessment within 24 hours of admission across the Trust (90%)
- This reduction is partly attributable to increased bed waits within the Emergency Department (ED), which delay formal admission processes and therefore impact the timing of full MUST/PYMS completion.
- To safeguard patients during this period of operational pressure, ED staff are appropriately utilising the rapid nutritional screening process, ensuring that immediate nutritional risks are identified and acted upon. This provides assurance that patient safety is being maintained despite delays in full documentation.
- The current reduction appears to represent a temporary pressure-related dip, rather than a reversal of the established improvement trajectory.
- It is anticipated that this month represents a short-term fluctuation, and that Trust-wide performance will improve next month as operational flow stabilises. Performance will continue to be closely monitored to ensure early identification of any sustained deterioration.



So what?

- 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.
- Improving nutritional care continues to be a key focus for all teams, with growing recognition of the important role that good nutritional practice plays in supporting positive patient outcomes.
- While MUST scoring can be completed using estimated weights, obtaining an actual measured weight remains best practice and helps to ensure the most accurate assessment. Additional MUST training is available on Tōtara to support staff in building confidence and applying the tool consistently in everyday practice

What next?

- 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
- 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.

Quality and patient safety: post-partum haemorrhage

What?

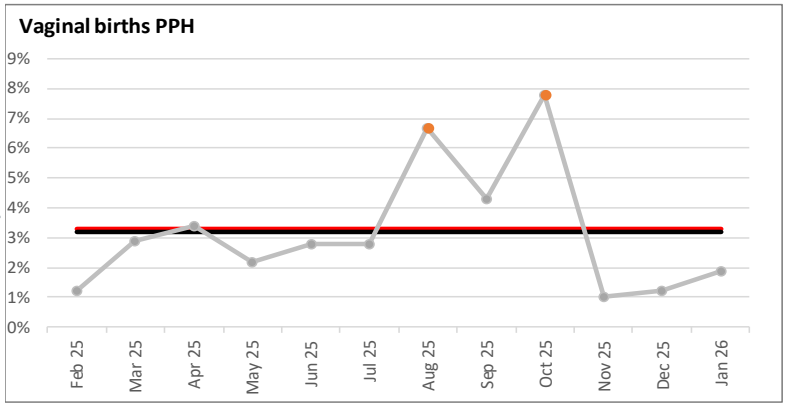
- Postpartum haemorrhage (PPH) is one of the most common obstetric emergencies and requires clinical skills, with prompt recognition of the severity of a haemorrhage and emphasis on communication and teamwork in the management of these cases. Severe bleeding after childbirth -PPH- is the leading cause of maternal mortality world-wide.
- In January 2026, five cases of significant PPH over 1500 ml were reported. None exceeded 2500ml. Of these cases: three occurred following a caesarean birth and two occurred after a vaginal birth.
- A recent case demonstrated excellent clinical practice and strong teamwork. Prompt recognition of the PPH and implementation of a comprehensive, well-coordinated management plan, ensured safe and effective care throughout. The positive learning from this case has been shared with the staff involved, reinforcing good practice and supporting ongoing quality improvement.

So what?

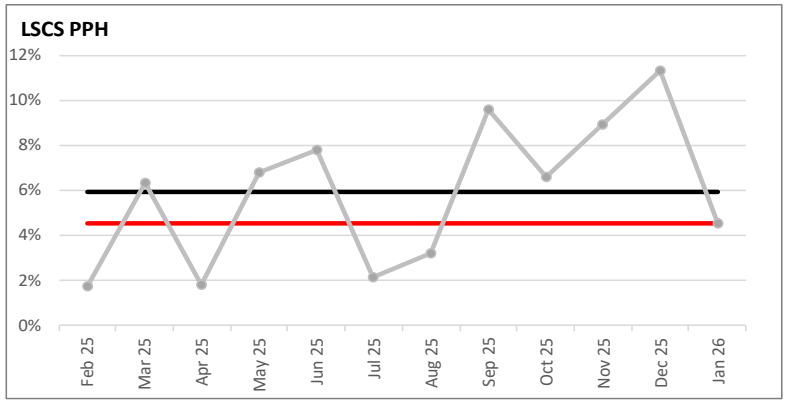
- In recent months, there has been a decline in postpartum haemorrhages following vaginal births. This improvement has occurred without major changes to clinical processes, suggesting that existing good practice, particularly early recognition and timely management, is having a positive impact. The rate of PPH following caesarean birth has been above the expected level in seven of the past twelve months. However, this month the rate has fallen and is now in line with the national rate, which is a positive development.
- An ongoing action log remains in place as we continue to embed learning, monitor outcomes, and implement further improvements to strengthen maternity safety. Multidisciplinary (MDT) simulation and skills drills will continue, with a particular focus on caesarean-related PPH and effective communication between theatre, midwifery, and obstetric teams.

What next?

- 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 caesarean.
- The Maternal Care Bundle (2026) has been launched to strengthen safety and consistency across maternity services looking at 5 elements of care. Key components include routine PPH risk assessment at all stages of care, accurate measurement of blood loss, clear escalation pathways, and timely use of evidence-based interventions. Implementation is expected to improve response times, reduce severe PPH events, and enhance overall maternal safety.
- The maternity department will meet the implementation time frame of March 2027, with full implementation of all elements of the Maternal Care Bundle, including maintaining regular MDT training and skill drills, objective blood-loss measurement across all birthing environments with a clear and rapid response for blood loss exceeding 500ml. We will maintain proactive risk assessment and individualised management plans for those at increased risk of PPH.



Quarter	Total vaginal births	PPH after vaginal birth	Total Quarterly rate
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%
3 (Oct- Dec 2025)	294	7	2.4%



Quarter	Total C. section performed	PPH at CS	Total Quarterly rate
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%
3 (Oct- Dec 2025)	225	19	8.4%

Quality and patient safety: patient safety reports

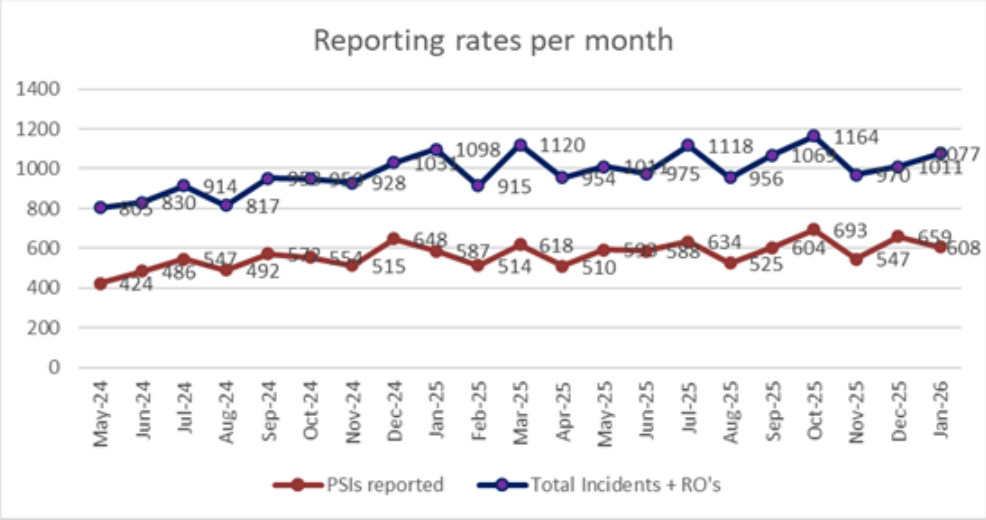
What?

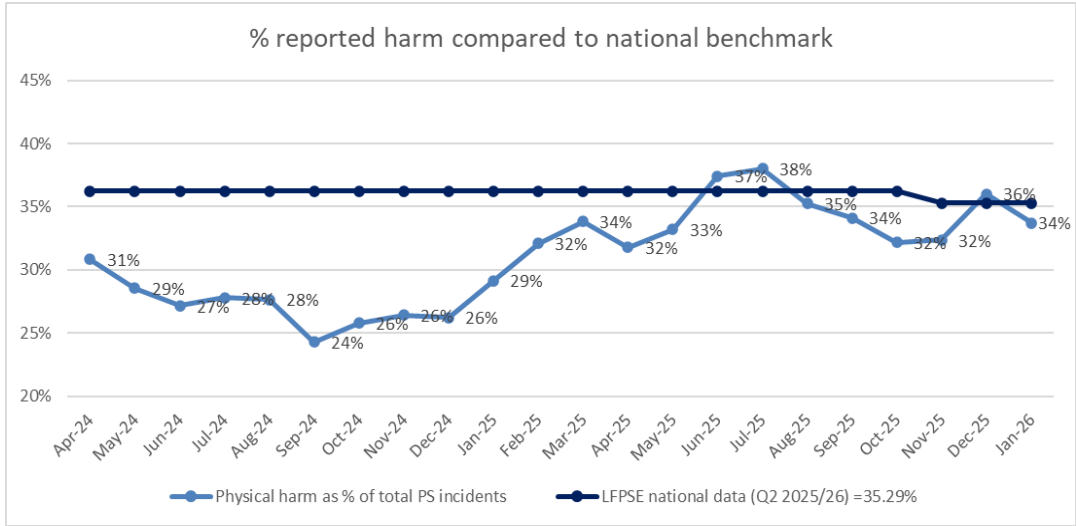
- In January, overall incident reporting showed a slight increase, while reportable occurrences experienced a minimal decrease. There were no significant changes across incident categories to note, with the total number of reported incidents and reportable occurrences differing by just 66 compared to December.
- The patient safety team continues to benchmark the monthly proportion of reported harm against national data from the Learning from Patient Safety Events (LFPSE) data set. This month, WSFT recorded a harm rate of 34% compared to 36% last month. The national average is currently recorded at 35.29%.

- **So what?**
- We continue to encourage reporting of every incident, as doing so strengthens learning and helps to drive improvement. Tracking how often incidents are reported offers valuable insight into our safety culture, while assessing the level of harm helps us understand the overall safety of our services. All patient safety incidents and reportable occurrence events are reviewed each quarter and shared with the Quality and Patient Safety committee. Incidents that lead to moderate harm are addressed within the relevant division, while those believed to have caused serious or fatal harm are escalated to the Emerging Incident Review (EIR). At the EIR, we collectively agree the most appropriate learning response, guided by our Patient Safety Incident Plan (PSIRP).

What next?

- The insights gained from this analysis, together with the outcomes of the quarterly patient safety report, will continue to be shared with divisional governance teams and speciality leads to guide focused improvement efforts. These findings also shape trust-wide safety discussions, ensuring timely escalation and action whenever harm levels or incident trends indicate the need for further scrutiny. Our trust's patient safety incident response plan (PSIRP) is currently being developed for 2026-27, and insights from our regular patient safety incident data will be incorporated into its design.





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

What?

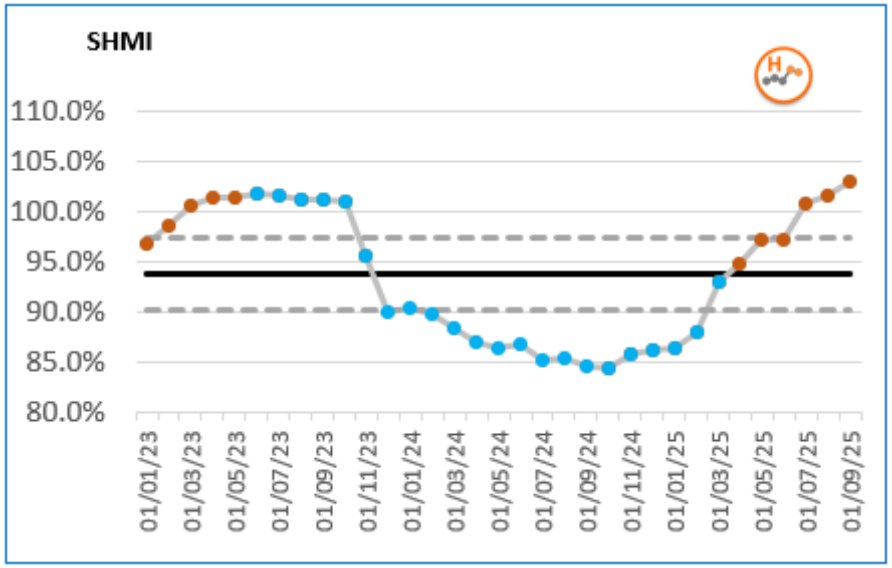
- In January 2026 there were 112 inpatient adult deaths at WSFT. This is on average with the time of year and our patient demographic. The SHMI data is showing an upward trend which we have identified as a coding anomaly starting at reporting period March 2025, where coders placed uncoded episodes into the 'invalid primary diagnosis' category. This resulted in 'invalid primary diagnosis' showing more deaths than is expected in that single category, which is why there is an upwards trend. As SHMI is reported in 6-month arrears the coding anomaly became evident in September 25 reporting.

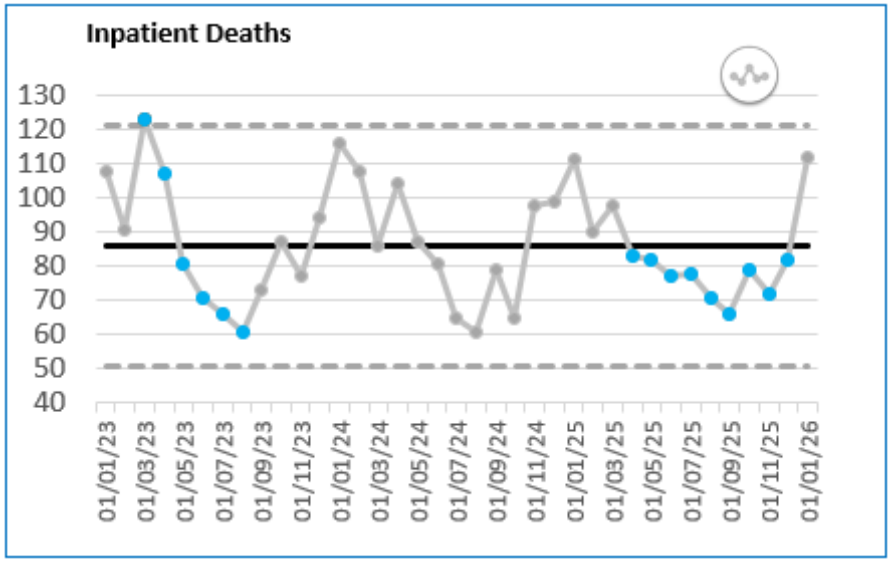
So what?

- The coders not meeting the deadline was causing the WSFT SHMI data to rise.
- The coding issue was escalated, and coders have been meeting national deadline for SHMI submission since December 2025. We predict that the WSFT SHMI data will decline again around May/June and normalise.

What next?

- We continue to analyse mortality data through the mortality oversight group and the independent medical examiner service.
- We are assured through our monthly mortality data reported in the Learning from Deaths report and National Cardiac Arrest Audit data that the Trust is performing well; with no unusual activity/data flagged.
- SHMI data is checked monthly and reported into Mortality Oversight Group.





KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SHMI	Sep 25	103.0%				93.8%	90.2%	97.4%
Inpatient Deaths	Jan 26	112				86	51	122

Quality and patient safety: complaints

What?

- Active formal complaints have risen slightly from 34 to 36 at the time of reporting however remain within the controlled limits. However volume of complaints resolved have increased from 12 in December to 19 in January.
- Complaints extended have increased further which was due to an unexpected period of sick leave within the team however the volume of complaints extended remain relatively low, with 8 extended.
- 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, remain consistent at 65%. 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.

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Active complaints	Jan 26	36	-			35	22	48
Closed complaints	Jan 26	19	-			17	3	30
% extended	Jan 26	42%	-			64%	31%	98%
Count extended	Jan 26	8	-			10	1	19
% Complaints responded to late	Jan 26	5%	-			9%	-18%	37%
Count responded to late	Jan 26	1	-			2	-4	7
% resolved in one week	Jan 26	58%	-			60%	33%	87%
Total PALS resolved Count	Jan 26	127	-			185	74	297

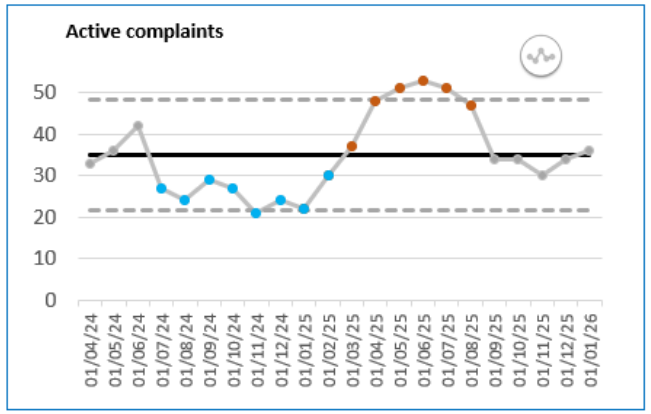
So what?

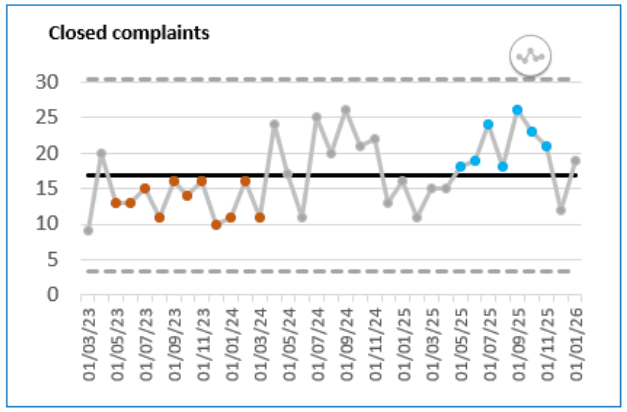
- Initial findings show that AI (copilot) is having a positive effect on the response timeframes once the investigation has been completed by clinical staff. Further results show the quality of investigation is successful with initial results currently at 95% first time resolution rate. In turn this 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. Although percentage of complaints extended have increased for January, we ensure there is a robust process in place to ensure complainants are updated throughout the investigation on any delays, investigation pathways and updates on progress.
- The majority of complainants are satisfied with the level of investigation and updates provided.

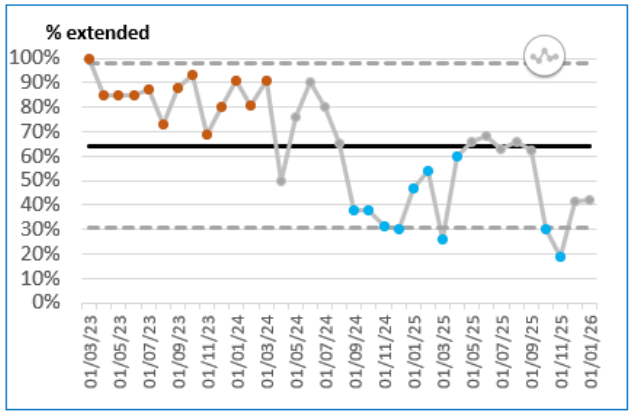
What next?

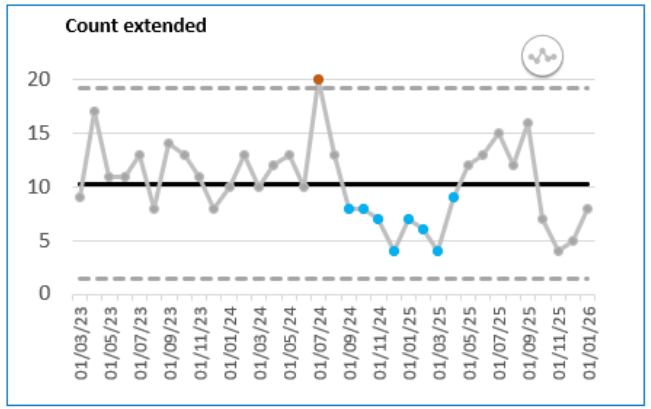
- We are working with Patient safety and the wider patient quality team to triangulate reports and reviewing divisional oversight to enhance divisional ownership. Initial discussions to trial attending more clinical/department team meetings to escalate upcoming complaints rather than oversight meetings to increase engagement and ensure we are meeting with the most appropriate staff.
- The QI project for the use of AI in complaint responses will continue until we are using this software to its full capabilities. Initial results show that it has enhanced the quality of responses, including the tone, language used and openness of our learning.

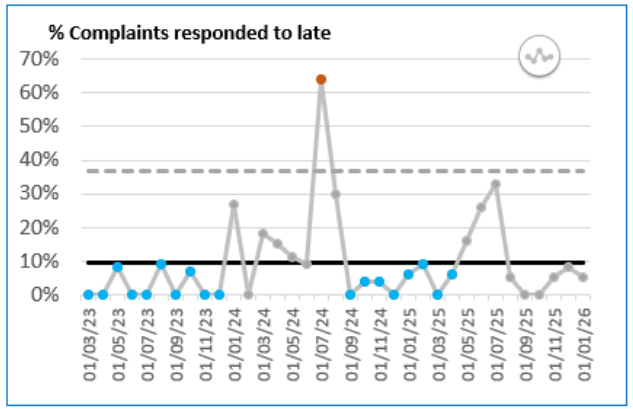
Quality and patient safety: complaints

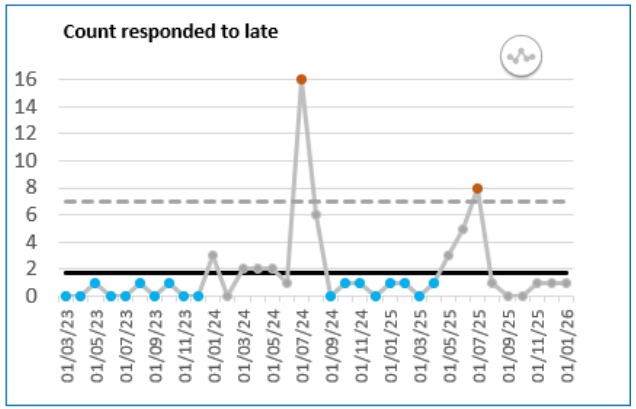


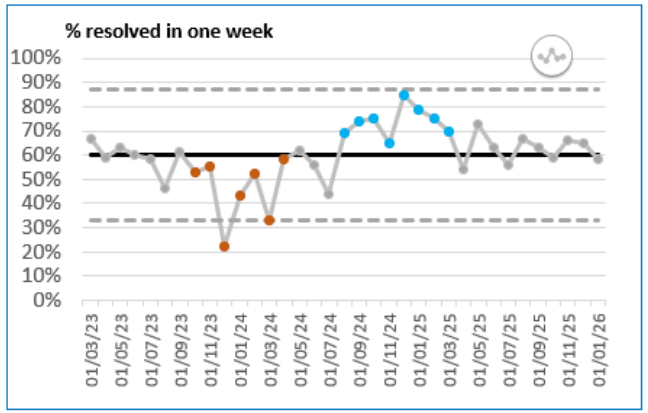


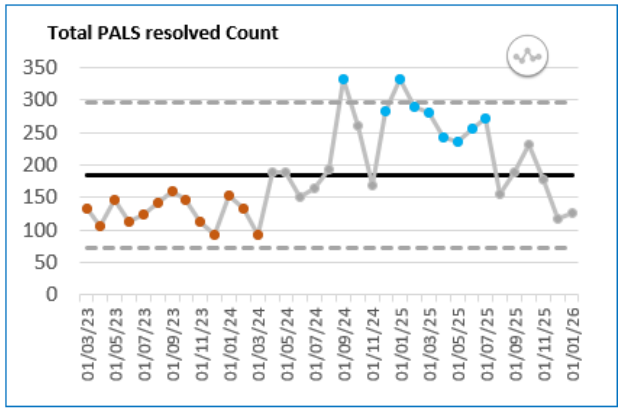












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Workforce and organisational development committee metrics

Compassionate care,
healthier communities

Workforce & organisational development metrics

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	Jan 26	4.9%	5.0%			4.8%	4.7%	4.9%
Staff Sickness - monthly	Jan 26	4.9%	5.0%			4.8%	4.7%	4.9%
Mandatory Training monthly	Jan 26	89.2%	90.0%			89.6%	88.0%	91.2%
Appraisal Rate monthly	Jan 26	85.7%	90.0%			85.7%	83.3%	88.0%
Turnover rate monthly	Jan 26	9.8%	10.0%			9.3%	8.5%	10.1%

What?

- Sickness – 4.9% 12-month rolling performance versus 5% target.
- Mandatory Training – marginally failing target this month at 89.2% versus 90% target.
- Appraisal – consistently failing target, 85.7% versus 90% target.
- Turnover – achieving target, 9.8% versus 10% target.

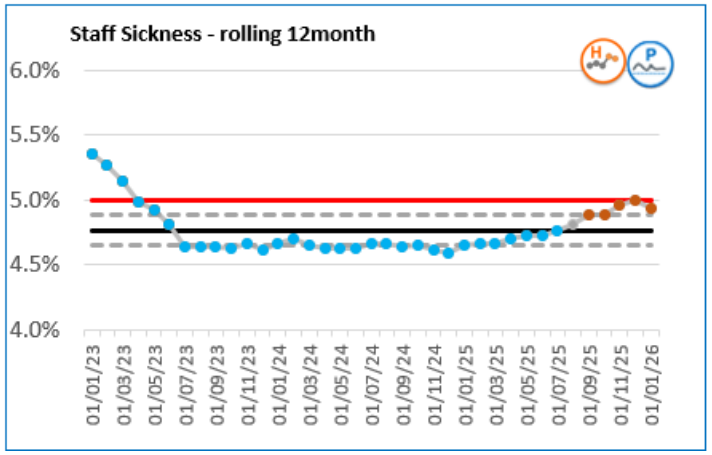
So what?

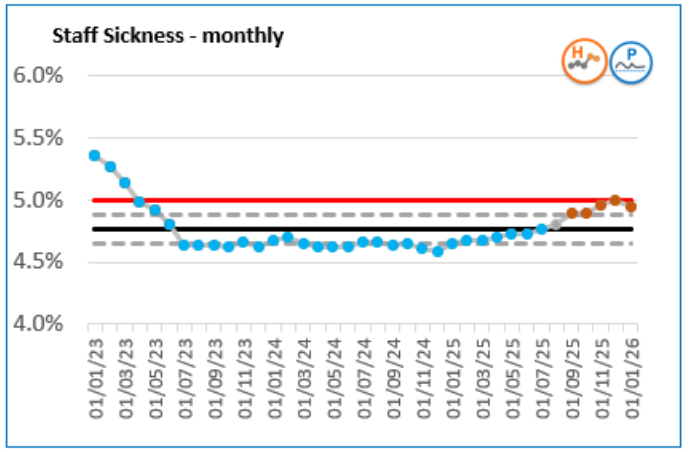
- These workforce key performance indicators directly impact on staff morale and engagement, staff retention, and therefore, patient care and safety.
- Additionally, improvements in these workforce key performance indicators will strengthen our ability to be the employer of choice for our community and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

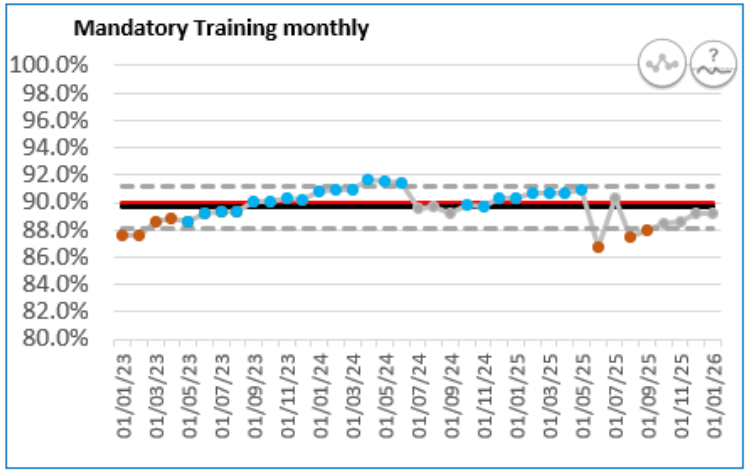
What next?

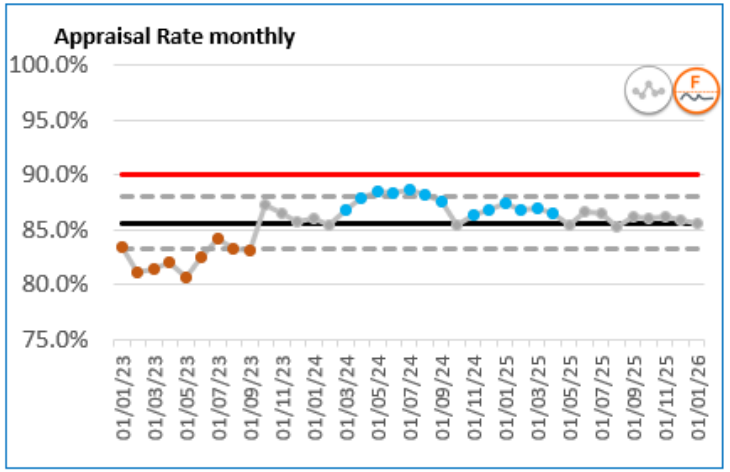
- Monitor staff attendance at department level with focus where improvement is required.
- Review compliance of mandatory training ensuring areas and staff groups are identified where further focus and support may be required.
- Continued analysis of appraisal data to support and challenge areas in need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

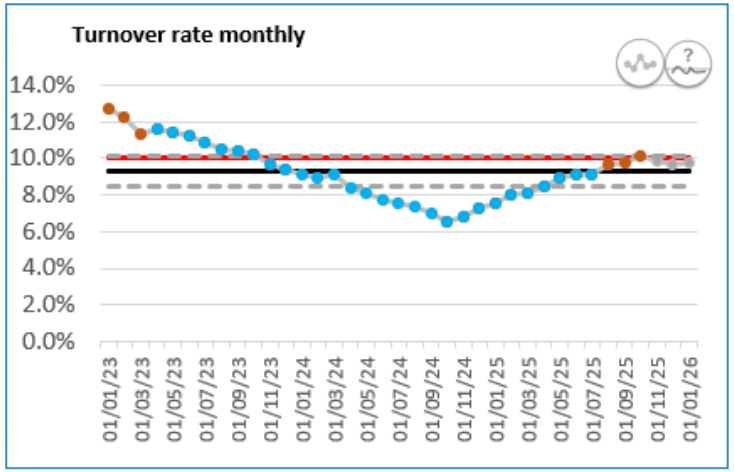
Workforce & organisational development metrics











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Appendices: understanding MDC

Compassionate care,
healthier communities

Making Data Count (MDC): understanding the charts

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

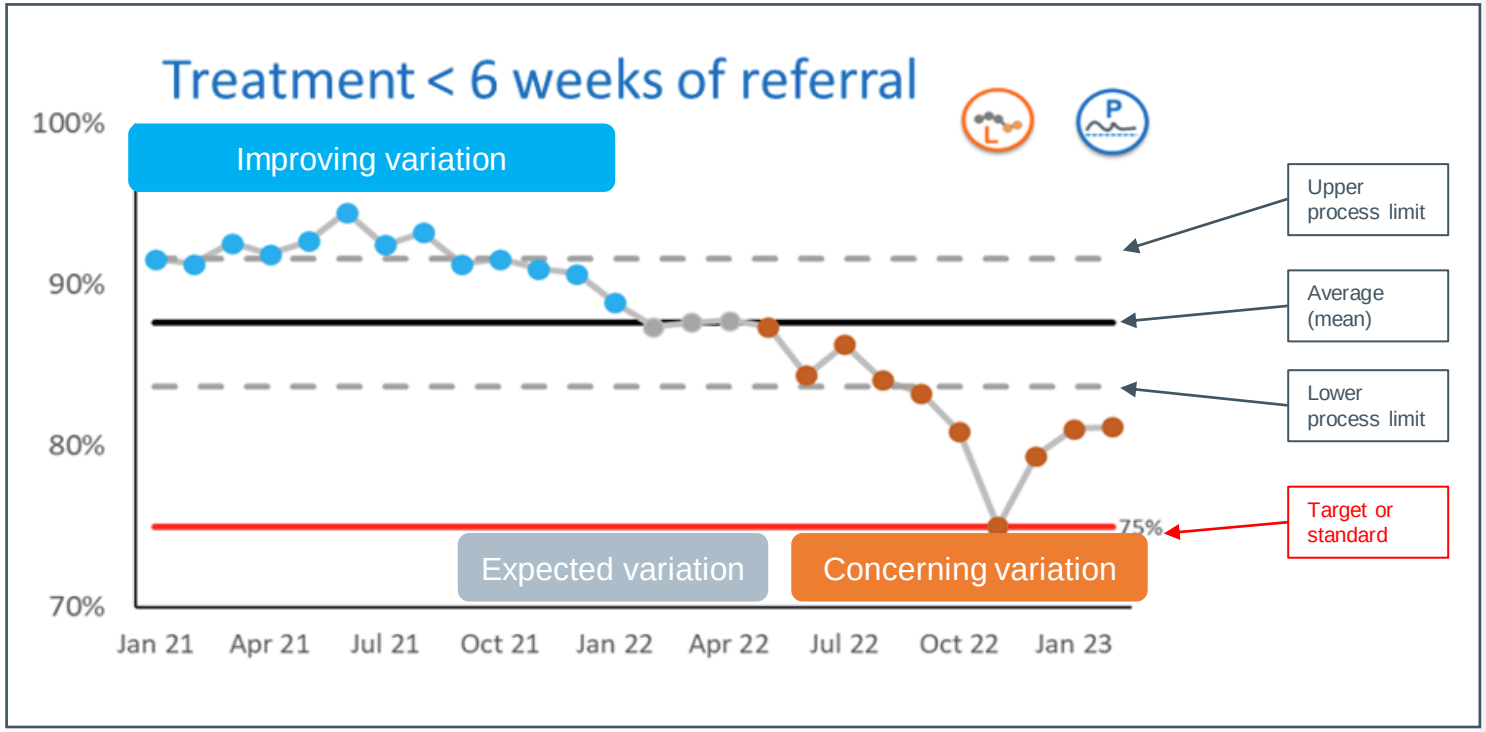
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

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

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

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

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



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

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

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

Example data only

Making Data Count (MDC): interpreting SPC icons

Icons for variation and performance

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

Icons for assurance

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

Making Data Count (MDC): reading the assurance grid

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

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

COMFORT BREAK

2.2. Quality & Patient Safety Committee - Committee's Key Issues (ATTACHED)

To Assure

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: 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:** **SO WHAT?** *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
5.2	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:**		
			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
	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

	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.

2.3. Quality and Nurse staffing report - quality priorities and learning from deaths (ATTACHED)

To Assure

Presented by Daniel Spooner

Public Board

Report information

Report title: Nursing and Midwifery safe staffing report: January and February 2026
Agenda item:
Sponsor/Executive lead: Daniel Spooner: Executive Chief Nurse
Report prepared by: Sarah Ward : Deputy Chief Nurse and Julie Wiggin: PA to DCN
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?
The report provides an overview of safe staffing levels, fill rates, contributory factors, and key quality indicators across inpatient areas for **January and February 2026.**

It complies with national quality board (NQB) recommendations to demonstrate effective deployment and utilisation of nursing and midwifery staff. It outlines planned versus actual staffing, highlights areas where staffing shortfalls occurred, and actions to mitigate where possible. The report also reviews vacancy levels, nurse-sensitive quality indicators, and recruitment activity. In addition, it sets out how nursing and midwifery workforce deployment is supporting the Trust's wider financial recovery ambitions.

So what?

- During this period, Care Hours Per Patient Day (CHPPD) have reduced and continue to sit in the lower national quartile.
- Staffing performance in the period shows reduction in combined sickness absence in both registered and unregistered staff.
- Oversight of temporary nursing spend continues through the Nursing and Midwifery Deployment Group.
- Overall fill rates remained stable at 90% overall in months 10 and 11.
- The most common Red Flag staffing incident event reported remains inpatient nurse staffing shortfall impacting on care.

What next?

- Continued oversight of temporary staffing spend controls with monitoring of any associated safety risks.
- Sustained focus on recruiting and retaining nursing assistants to strengthen the unregistered workforce.
- Use of community nursing census (Community Nursing Safer Staffing Tool, CNSST II) to progress investment business case. Analysis of January/ February 2026 inpatient Safer Nursing Care Tool (SNCT) census, including Emergency Department data.

Action required by the board: For the board to take assurance regarding the daily management and mitigation of nurse and midwifery staffing, and systematic oversight of nursing and midwifery establishments.

No action from board required.

Governance and compliance

Risk and assurance:
Red Risk 4724 amended to reflect surge staffing and return to BAU

Equality, diversity and inclusion:
Enabling a diverse and engaged workforce improves quality patient outcomes. Safe staffing levels positively impacts engagement, retention and delivery of safe care.

Sustainability:
Efficient deployment of staff, reduction in temporary staffing and improving vacancy rates contributes to financial sustainability.

Legal and regulatory context:
Compliance with CQC regulations for provision of safe and effective care.

Nurse and Midwifery safe staffing report : January and February 2026

1. Introduction

1.1.

The paper outlines how WSFT managed and deployed its nursing and midwifery workforce during January and February 2026 (M10 and M11). It reviews the impact of staffing levels on key quality indicators such as falls, pressure ulcers and complaints, and confirms compliance with national requirements, including CNST midwifery standards. It also highlights ongoing work to review establishments and strengthen cost-effective deployment of the nursing and midwifery workforce.

2. Background

2.1.

The National Quality Board (NQB 2016) recommends that monthly, actual staffing data is compared with expected staffing and reviewed alongside quality of care, patient safety, and patient and staff experience data. The trust applies this approach to ensure learning from improvements and early identification of emerging concerns.

3. Key staff indicators

3.1.

Nursing Fill Rates

The Trust's safer staffing data has been submitted to NHS Digital for January and February 2026. Table 1. summarises the overall trust fill rate percentages for these months and for comparison, the previous four months. This is monitored at ward level as illustrated in Appendix 1a and 1b. Exception reporting for low and high fill rates is monitored through the Nursing and Midwifery Deployment Group (NMDG) and the daily rhythm of divisional staffing meetings.

Average fill rate	Day		Night	
(planned vs actual)	Registered	Care Staff	Registered	Care staff
September 2025	91%	96%	96%	99%
October 2025	90%	90%	96%	100%
November 2025	90%	89%	96%	99%
December 2025	88%	87%	93%	97%
January 2026	88%	85%	94%	96%
February 2026	87%	83%	95%	97%

Table 1.

The overall average of 'planned versus actual' staffing fill rates show a stable position across January and February 2026 (Chart 1). Staffing shortfalls are mitigated

throughout the day via robust escalation processes and areas supported responsively from central teams e.g. Clinical Education.

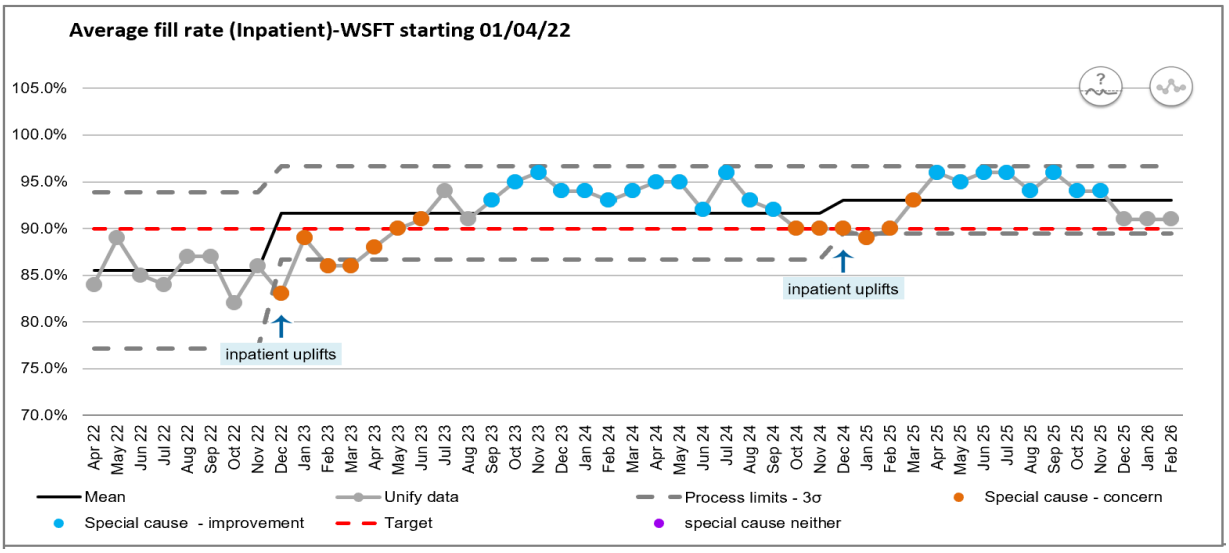


Chart 1.

3.2

Care hours per patient day (CHPPD)

Model hospital data indicates that WSFT is in the lowest quartile nationally when benchmarked against other organisations with inpatients beds (Appendix 2). This suggests that WSFT provides less care hours per patient than many organisations. There has been some improvement in this position in previous months, with a decline in January and February. Assumptions around high sickness, low fill rates and capacity demands would be appropriate when seeing a fall in CHPPD. January achieved CHPPD of 7.2 and February achieved 6.9.

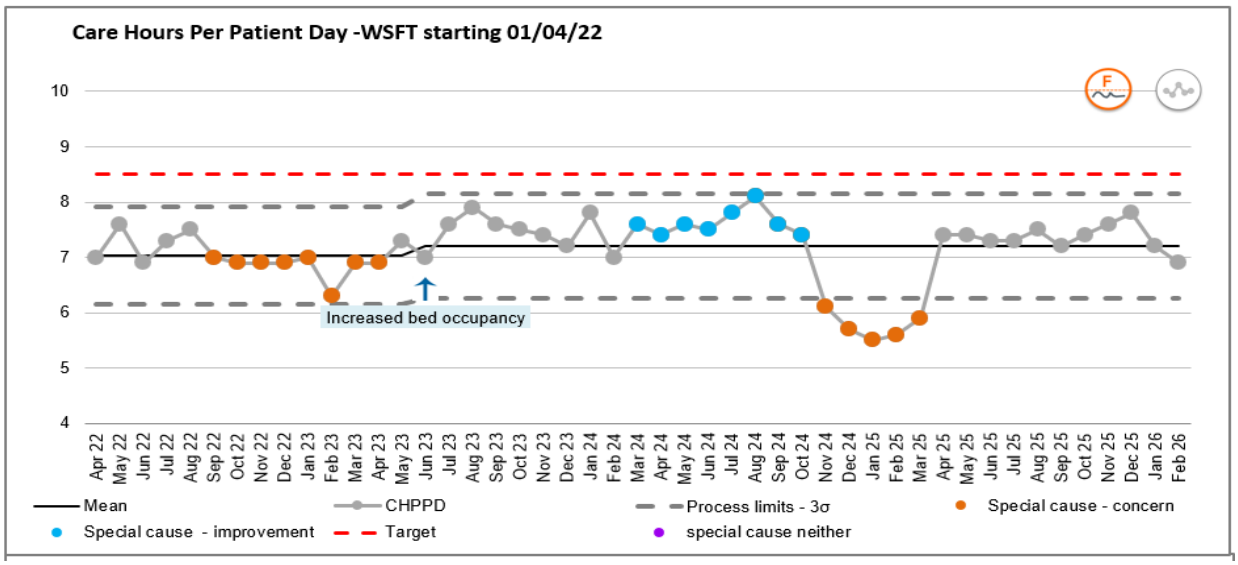


Chart 2.

3.3

Sickness

For January and February, sickness absence across the RN/RM workforce remained above 5%. For unregistered staff, absence levels continued to exceed the 5% target. Although there was a reduction in January, sickness rates increased to 7.28% in February, predominantly linked to winter viruses. (see Table 2 and Chart 3).

	July 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Unregistered staff (HCSW)	6.45%	6.66%	8.57%	6.79%	7.21%	8.24%	6.74%	7.28%
Registered Nurse/Midwives	4.32%	4.74%	4.61%	5.28%	5.42%	5.90%	5.38%	5.19%
Combined Reg/Unregistered	**5.01%**	**5.35%**	**5.87%**	**5.75%**	**5.98%**	**6.63%**	**5.81%**	**5.85%**

Table 2.

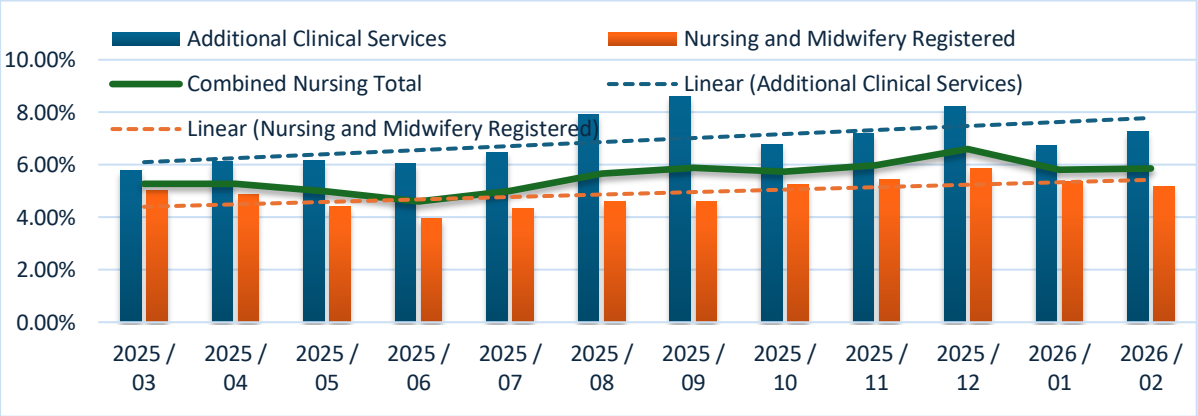


Chart 3.

3.4

Recruitment and retention

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

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

- **Inpatient RN/RM** vacancy percentage at M11 is **8.1%**
- **Total RN/RM** vacancy rate at M11 is **7.1%**
- **Inpatient NA** vacancy rate at M11 is **10%**
- **Total NA** vacancy at M11 is **9.4%**

	Sum of Month 6	Sum of month 7	Sum of month 8	Sum of month 9	Sum of month 10	Sum of month 11	WTE vacancy at M11
RN	691.9	689.8	698.6	698	691.3	689.9	61
NA	370.5	361.7	361.9	365.7	369.1	367.6	40.9

Table 3. Inpatient actual substantive staff WTE

3.5

New Starters

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

	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
RN/RM	7	4	20	12	13	9	10	6
NA	10	3	3	5	12	15	24	14

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

- **During January -** 10 registrants attended induction (3 RNs acute, 4 RN bank staff, 3 RNs community). 24 NAs attended induction (13 NAs acute, 5 NA for midwifery, 6 NA community).
- **During February -** 6 registrants attended induction (3 RN acute, 3 RN bank). 14 NAs attended induction (11 NAs acute, 1NA midwifery, 2 NAs community).

3.6

Turnover

On retrospective review of the last rolling twelve months, turnover for registered staff maintained positively under the ambition of 10%, decreasing to 8.5%. Unregistered staff turnover continues to be over 10%. Positive NA recruitment in the last quarter and analysis of turnover at individual level is in progress to reduce this gap.

		Turnover	01/03/2025	-	28/02/2026			
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,506.00	1,320.6901	76	62.3067	132	103.9291	8.7649%	7.8693%
Additional Clinical Services	592.00	502.6896	80	71.0133	121	99.5074	20.4392%	19.7950%

Table 5. Workforce information data.

4. Key quality indicators

4.1

Falls and acquired pressure ulcers

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

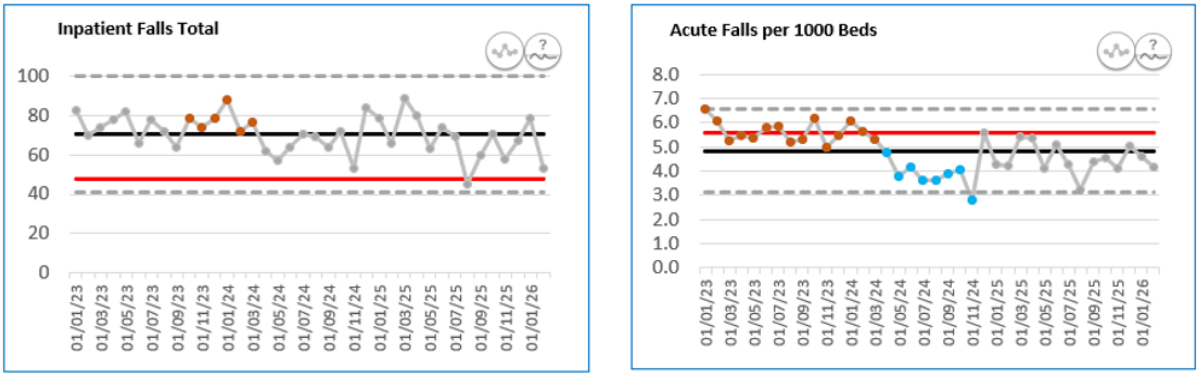


Chart 4. Inpatient falls

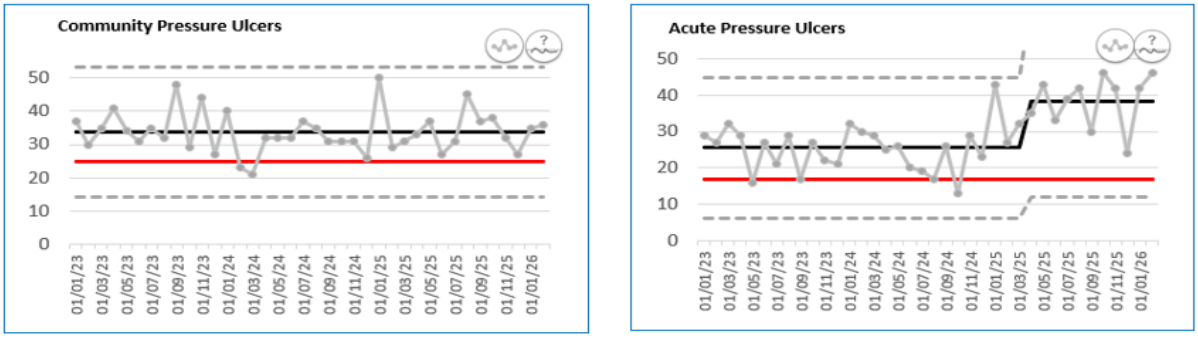


Chart 5. Pressure ulcers acquired in care

4.2

Staffing incidents

Following an increase in January, the reported incidents reduced in February, noting shorter month. This reflects previous years trend (Chart 6. below).

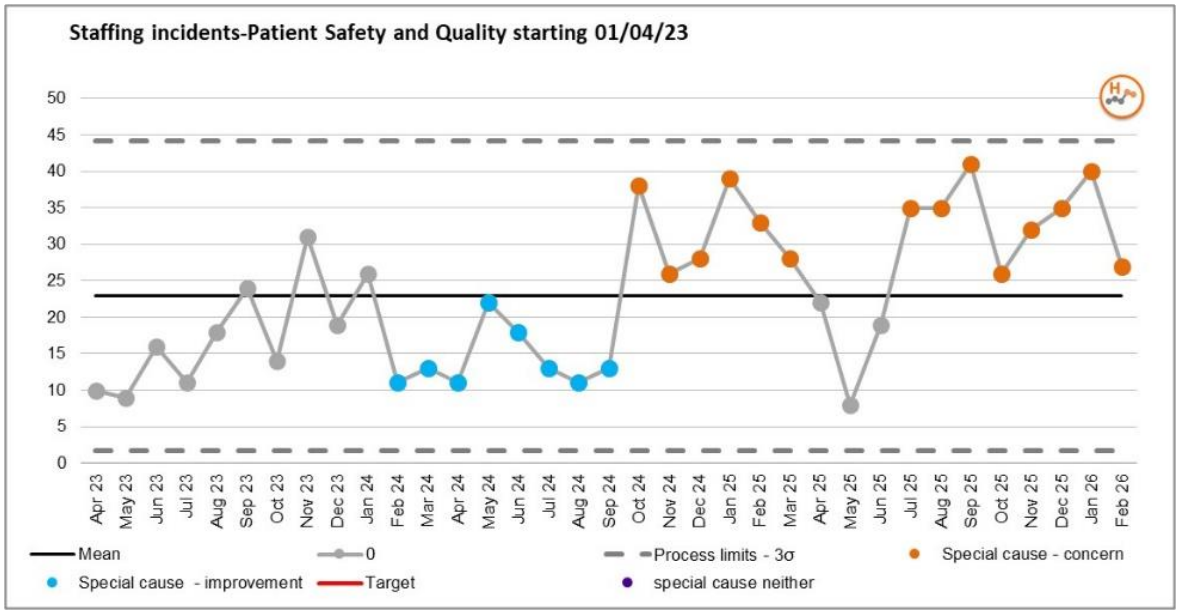


Chart 6.

Red flags as per NQB (Appendix 4) have been reported via RADAR from M9 24/25 (Chart 7). The most common Red Flag event reported remains inpatient nurse staffing shortfall impacting on care.

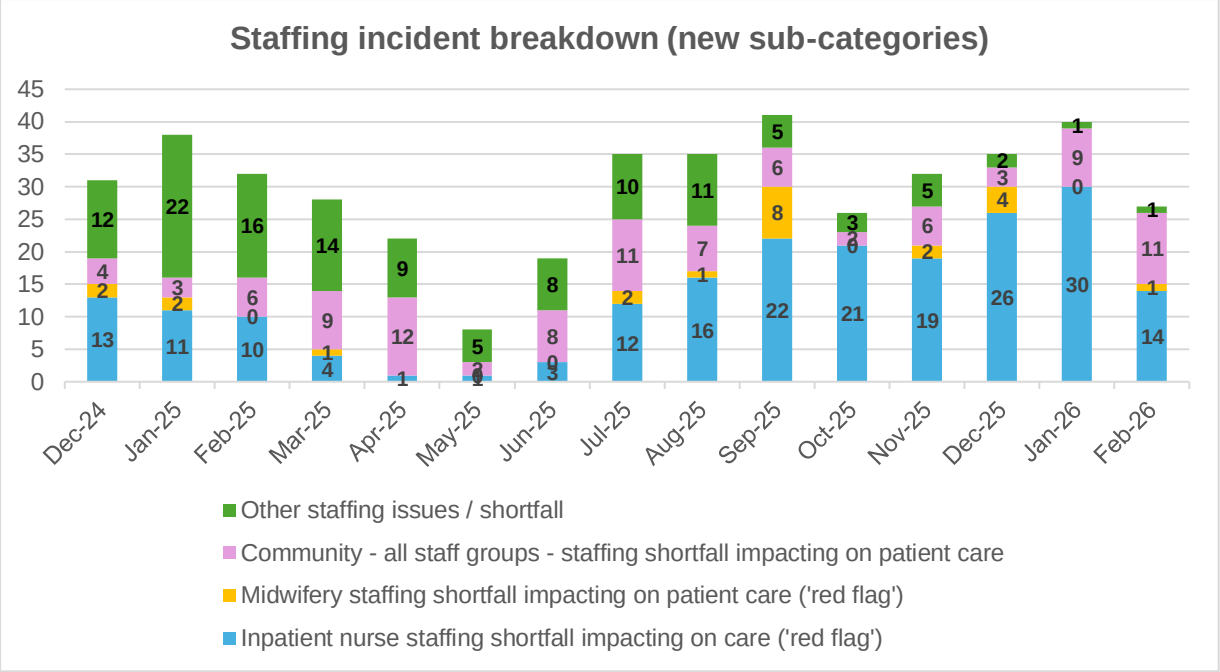


Chart 7.

4.3

Maternity services

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

1:1 Care in Labour

NICE's guidance on safe staffing recommends safe midwifery staffing levels for women, birthing people and their babies in their chosen setting. This recommendation is also one of the ten safety actions published as part of the Maternity Incentive Scheme. Maternity services should have the capacity to provide women in established labour with supportive one-to-one care as birth can be associated with serious safety issues and can help ensure a safe experience of giving birth. Escalation plans have been developed to respond to unexpected changes in demand. Midwifery 1:1 care in labour had met the required standard of 100% for both January and February 2026.

Red Flag events

NICE safe midwifery staffing for maternity settings (2015), defines Red Flag events as events that are immediate indications that something is wrong, and action is required to prevent the situation deteriorating. Action includes escalation to the senior midwife in charge of the service, and the response includes allocating additional staff to the ward or unit. All Red Flag events are recorded in RADAR and addressed during the daily Maternity Safety Huddle, where they are highlighted and mitigated as necessary. There were no Red Flag events recorded in January.

In February, one Red Flag event was reported. This related to a delay in the induction of labour, where a patient experienced a prolonged wait for continuation of the induction process. The delay was attributed to high acuity within the unit, which

affected capacity and the timeliness of care. The single event reported in February represents a significant reduction in Red Flag activity when compared with previous reporting periods.

Midwife to Birth ratio

The latest BirthRate Plus® review was undertaken in March 2023 and illustrated that Midwife demand to Birth ratio at West Suffolk NHS Foundation Trust has reduced to 1:21. The ratios are based on the Birthrate Plus® dataset, national standards with the methodology and local factors, such as percentage uplift for annual, sickness and study leave, case mix of women birthing in hospital, provision of outpatient/day unit services, total number of women having community care irrespective of place of birth and primarily the configuration of maternity services.
The maternity department has commenced the scheduled three-year review of BirthRate Plus, which will reassess the service's staffing requirements. It is anticipated that the midwife-to-birth ratio will change as a result of this work, with the outcomes of the review expected in the summer 2026.

- December 2025 In the previous reporting period, delays in IT reporting meant that the December midwife-to-birth ratio could not be provided. This data has now been included, confirming that the service remained within the target ratio at 1:21
- January 2026 Midwife to birth ratio was 1:20.7
- February 2026 a reduced number of births resulted in a Midwife to birth ratio of 1:18.

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

This is one of the Maternity Incentive Scheme Year 6 safety action requirements and highlighted as a 'should' from the CQC report in January 2020. The band 7 labour suite co-ordinator should not have direct responsibility of care for women. This is to enable the co-ordinator to have situational awareness of what is occurring on the unit and is recognised not only as best but safest practice. Labour Suite Coordinator supernumerary compliance has been maintained at **100%** for both January and February 2026 (Table 6.).

	Standard	August	September	October	November	December	January	February
Supernumerary Status of LS Coordinator	100%	100%	100%	100%	100%	100%	100%	100%
1-1 Care in Labour	100%	100%	100%	100%	100%	100%	100%	100%
MW: Birth Ratio	1:21	1:18.8	1:23	1:20	1:19	1:21	1:20.7	1:18
No. Red Flags reported	NA	1	8	3	2	4	0	1

Table 6.

4.4
Community and integrated neighbourhood teams (INT)

Sickness & Turnover

Sickness in the division is 5.3% overall. For nursing, Rosemary Ward and INT teams almost 8%. A specific quality improvement approach to address high sickness levels in the INTs has commenced. The turnover figure continues to rise and is above trust target at 12.5%.

Demand

The demand for community nursing services has been on an upward trend in 2025 and 2026. Chart 8 reflects the greater transparency of demand since the change to reporting of 2 days, 2 weeks and 18 weeks introduced in late 2023.

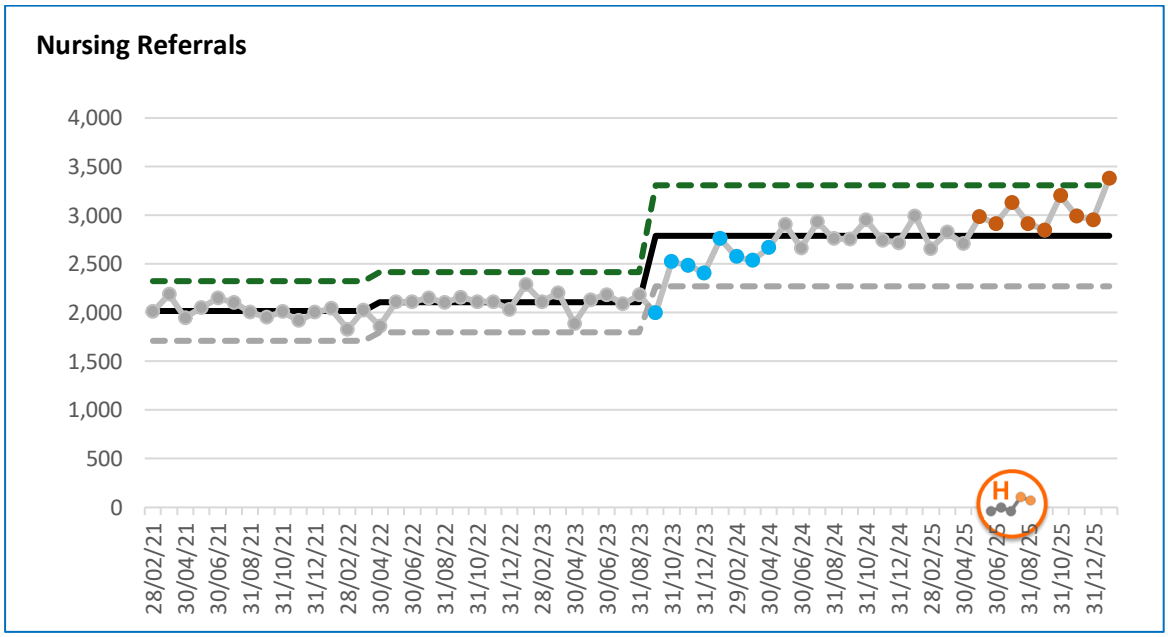


Chart 8.

The division reviews the operational impact of demand increase by measuring the number of cancelled care plan hours per week, as the clinical team's triage, defer and manage their visits. This involves deferring visits to the following day as clinically appropriate.

Deferring or cancelling care is considered the community equivalent of corridor care and is a "red flag" from the Queens Nursing Institute. This is not unique to West Suffolk as the publication of a Prevention of Future Deaths report from Norfolk coroner found failings in district nursing (Ref: 2025-0325) similar to that experienced by West Suffolk; missed visits, staff shortages and increasingly complex caseloads. Harm reviews of cancelled or deferred visits are conducted to monitor impact.

Chart 9. Demonstrates the increase over time.

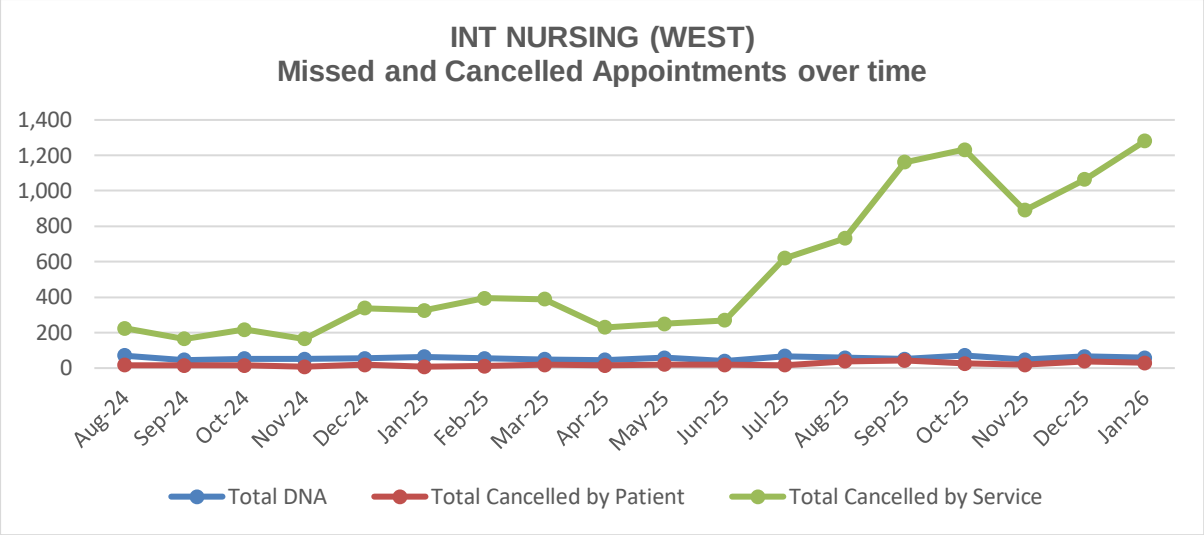


Chart 9.

CNSST II

The relaunched Community Nursing Safer Staffing Tool provided census data in July 2025 and has been repeated from 28th January 2026. The triangulation of CNSST data informed redeployment of staffing resource to mitigate risk. A business case was presented to Investment panel in February 2026.

Community based actions

- CNSST census – results being quality control audited and analysed within the tool.
- Productivity workstreams continue across all services in division.
- INT sickness project continues.
- QI project initiated to improve documentation quality.
- Business case for community nursing to investment panel.

5. Next steps / challenges

5.1
Nursing resource oversight group

The Nursing and Midwifery Deployment Group continues to meet monthly to review best practice methods of deploying staff and reduction of temporary nursing spend.

Total temporary spend is in special cause improvement (Chart 10).

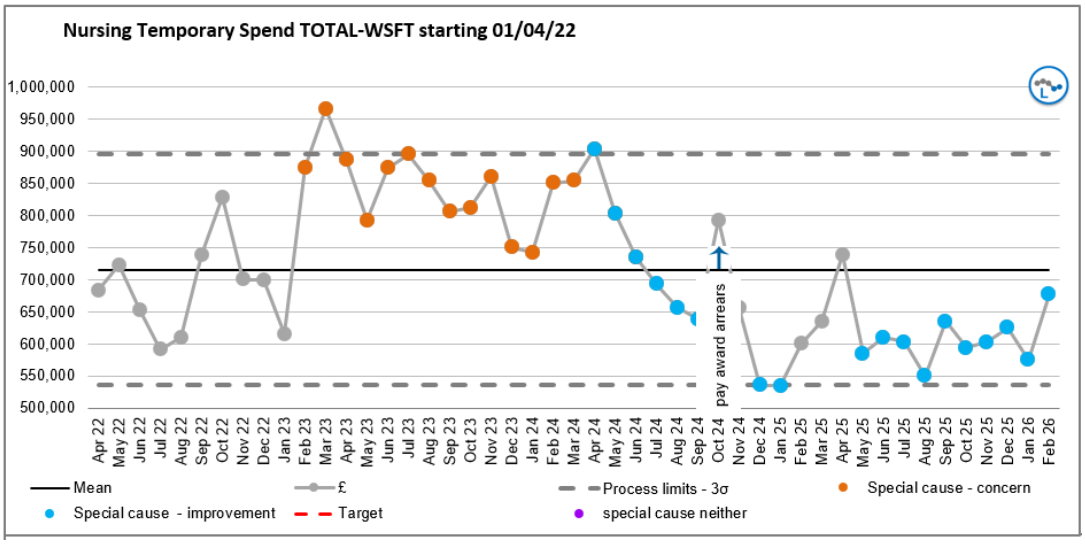


Chart 10.

5.2

SNCT Biannual inpatient review

The winter inpatient establishment census data has been collected throughout January and February which included the Emergency Department. Analysis is in progress and results are expected towards the end of March. The census data will continue to inform our assurance of nurse staffing levels and inform recommendations.

5.3

Newly registering student recruitment

We maintain our commitment to support newly registered nursing and midwifery colleagues to transition into the workforce and foster strong partnerships with educational institutions and system partners, in line with national commitments. A recruitment plan for the 2026 qualifying cohorts was agreed at PQASG in January.

6. Conclusion

6.1

The Trust continues to demonstrate a proactive and data-driven approach to nursing and midwifery workforce management.

Recruitment of registered nurses remains positive, with vacancy rates consistently below 10%, while nursing assistant recruitment shows signs of stabilisation.

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

7. Recommendations

For the board to take assurance regarding the daily management of our nurse and midwifery staffing resource and systematic oversight of nursing and midwifery establishments to ensure patient safety.

Appendix 1a. Fill rates for inpatient areas (January 2026) data adapted from NHSE Unify submission.

RAG: Red <79%, Amber 80-89%, Green 90-100%, Purple >100

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1426.75	30914.1	1786.25	1445	1069.5	1049.5	1420.5	1407.75	93%	81%	98%	99%	1060	2.2	2.7	4.9
Acute Assessment Unit	2352.5	2305.42	2097.5	1871.17	1759.5	1763.67	1425	1358.17	98%	89%	100%	95%	845	4.8	3.8	8.7
Cardiac Centre	1772.98	1531	1043.58	803.58	1782.5	1624.5	713	654.5	86%	77%	91%	92%	663	4.8	2.2	7.0
G10	1758.5	1417.25	1778.5	1415.17	1069.5	1009	1782.5	1600.5	81%	80%	94%	90%	925	2.6	3.3	5.9
G9	1746	1509.5	1426.5	1263	1380	1375.5	1069.5	1035	86%	89%	100%	97%	799	3.6	2.9	6.6
F12	710	697	356.5	297.25	713	546.5	356.5	326	98%	83%	77%	91%	234	5.3	2.7	8.0
F7	1652	1303.25	1740	1633	1391.5	1184	1782.5	1587.5	79%	94%	85%	89%	1001	2.5	3.2	5.9
G1	1072.5	807.5	355.5	293	713	711.5	356.5	316	75%	82%	100%	89%	349	4.4	1.7	6.1
G3	1722	1452.58	1773.5	1600.5	1069.5	1048.5	1426	1414	84%	90%	98%	99%	970	2.6	3.1	5.7
G4	1778.5	1459	1803	1622	1069.5	943	1426	1527	82%	90%	88%	107%	944	2.5	3.3	5.9
G5	1715.5	1424	1751	1225.5	1069.5	1040.5	1414.5	1380.75	83%	70%	97%	98%	984	2.5	2.6	5.2
G8	2353.5	1775.75	1873.5	1596.52	1643.5	1557.28	1196	1019.67	75%	85%	95%	85%	848	3.9	3.1	7.0
F8	1783.5	1468.27	1748	1531.67	1069.5	961.33	1426	1345.5	82%	88%	90%	94%	766	3.2	3.8	6.9
Critical Care	2617.34	2362.83	150	119.25	2591.5	2263.75	0	0	90%	80%	87%	-	217	21.3	0.5	21.9
F3	1644.5	1394	1753.5	1460.5	1069.5	999	1391.5	1334.5	85%	83%	93%	96%	922	2.6	3.0	5.8
F4	636.5	608.75	466	350.75	600	557	0	34.5	96%	75%	93%	-	161	7.2	2.4	9.9
F5	1641	1585.42	1398.75	1228.75	1069.5	1021.58	931.5	989	97%	88%	96%	106%	490	5.3	4.5	9.8
F6	1541.25	1292.25	1709	1312.5	1069	1070	1391.5	1236.5	84%	77%	100%	89%	910	2.6	2.8	5.6
Neonatal Unit	1650.5	1783.42	336	372	1032	1068	636	648	108%	111%	103%	102%	229	12.5	4.5	16.9
F1	2066.5	1875.5	713	695	1426	1364.25	0	23	91%	97%	96%	-	231	14.0	3.1	17.1
F14	372	384.5	372	372	744	732	0	0	103%	100%	98%	-	115	9.7	3.2	12.9
F10 (Esc)	1316	1153.83	1405.25	1026.75	713	690	1424.5	1386	88%	73%	97%	97%	198	9.3	12.2	21.6
Total	**35,329.82**	**30,914.10**	**27,836.83**	**23,534.85**	**26,114.50**	**24,580.37**	**21,569.50**	**20,623.83**	**88%**	**85%**	**94%**	**96%**	**13,861**	**4.0**	**3.2**	**7.2**

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

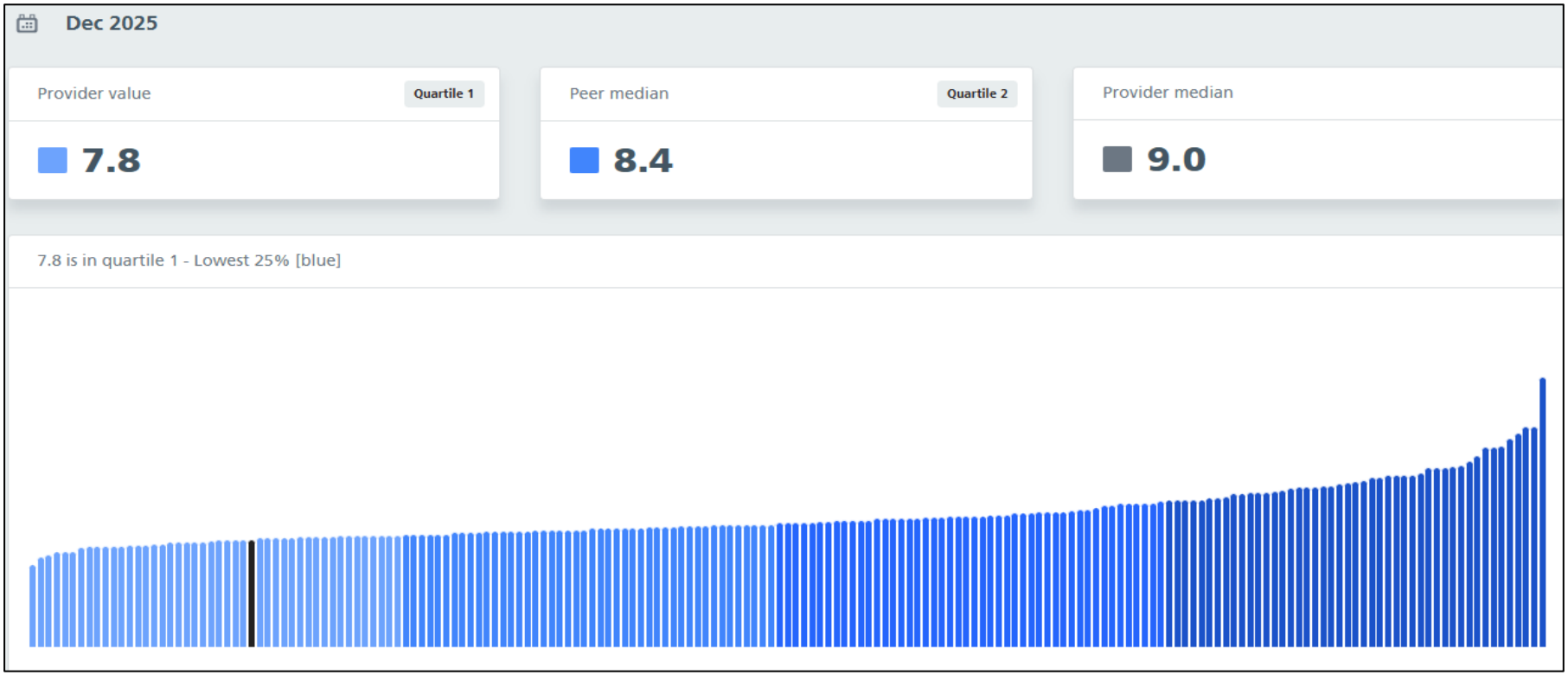
Appendix 1b. Fill rates for inpatient areas (February 2026) data adapted from Unify submission.

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1291	1235.666667	1613.25	1317.5	966	967.5	1287	1270.5	96%	82%	100%	99%	891	2.5	2.9	5.4
Acute Assessment Ur	2117.25	2038.5	1893	1488.5	1598.5	1577	1276.5	1264	96%	79%	99%	99%	807	4.5	3.4	7.9
Cardiac Centre	1610	1364.5	958.5	681	1610	1495	644	655.5	85%	71%	93%	102%	592	4.8	2.3	7.1
G10	1597	1282	1606.4833	1349.8333	966	882.5	1610	1447.6667	80%	84%	91%	90%	894	2.4	3.1	5.6
G9	1575.5	1354.5	1288.5	1128.5	1287.5	1273	954.5	953	86%	88%	99%	100%	745	3.5	2.8	6.3
F12	644	608	291.75	241	644	567	313.5	299.5	94%	83%	88%	96%	221	5.3	2.4	7.8
F7	1472	1170	1597	1441	1268	1092	1609.5	1440	79%	90%	86%	89%	939	2.4	3.1	5.5
G1	967.5	645	322	287.5	644	654.5	322	310.16667	67%	89%	102%	96%	332	3.9	1.8	5.7
G3	1580.5	1312	1597.5	1352	966	954.5	1288	1253.5	83%	85%	99%	97%	921	2.5	2.8	5.3
G4	1596.5	1340.5	1603.25	1451.5	966	803.5	1294	1409	84%	91%	83%	109%	884	2.4	3.2	5.7
G5	1550	1268.833333	1499.75	1109.5	954.5	890	1276.5	1241.5	82%	74%	93%	97%	886	2.4	2.7	5.1
G8	2121	1683.2	1627.75	1342.8	1495	1397.45	1075.5	931.18333	79%	82%	93%	87%	778	4.0	2.9	6.9
F8	1516	1243.5	1512.25	1205.5	920	839.75	1276.5	1169	82%	80%	91%	92%	744	2.8	3.2	6.0
Critical Care	2350	2086.5	112.5	106.75	2278.5	2085.166667	0	0	89%	95%	92%	-	182	22.9	0.6	23.5
F3	1541	1281.25	1598.5	1269	966	954.5	1288	1263.5	83%	79%	99%	98%	864	2.6	2.9	5.5
F4	643	660	444.5	352.83333	621	575	0	57.5	103%	79%	93%	-	226	5.5	1.8	7.3
F5	1518	1429	1230.5	1063.5	954.5	917.25	931.5	977.5	94%	86%	96%	105%	494	4.7	4.1	8.9
F6	1386.5	1131	1555	1183.75	954.5	905	1253.5	1162.5	82%	76%	95%	93%	844	2.4	2.8	5.2
Neonatal Unit	1594.5	1643.25	288	420	949	997	636	624	103%	146%	105%	98%	237	11.1	4.4	15.5
F1	1959.51667	1711.333333	644	662.5	1288	1263	0	22.25	87%	103%	98%	-	269	11.1	2.5	13.6
F14	336	336	324	299.5	672	660	0	0	100%	92%	98%	-	125	8.0	2.4	10.4
F10(WEW)	1188.5	1010.25	1263.25	866.5	644	654.5	1276.5	1217.75	85%	69%	102%	95%	211	7.9	9.9	17.8
Total	**32,155.27**	**27,834.78**	**24,871.23**	**20,620.47**	**23,613.00**	**22,405.12**	**19,613.00**	**18,969.52**	**87%**	**83%**	**95%**	**97%**	**13,086**	**3.8**	**3.0**	**6.9**

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

Appendix 2. CHPPD Model Hospital data (accessed 15.21.26)

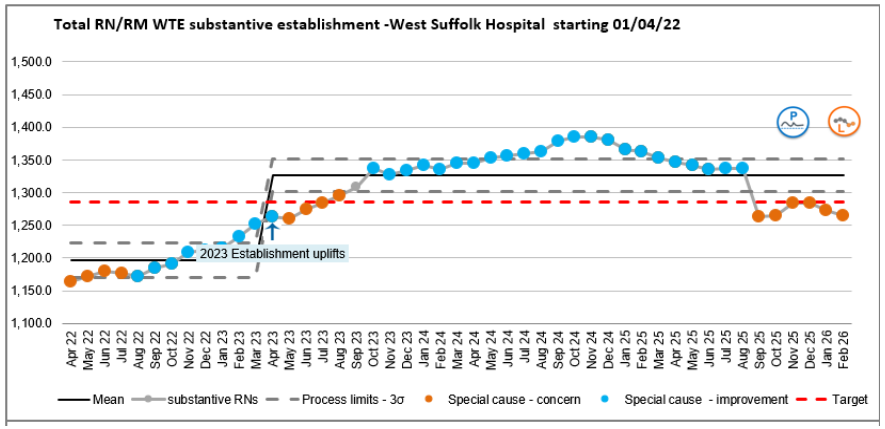
CHPPD is a measure of workforce deployment and is reportable to NHS Digital as part of the monthly returns for safe staffing (Appendix 1a/b).
CHPPD is the total number of hours worked on the roster by both Registered Nurses & Midwives and Nursing Support Staff divided by the total number of patients on the ward at 23:59 aggregated for the month. CHPPD can be affected adversely by opening additional beds either planned or emergency escalation, as the number of available nurses to occupied beds is reduced. Periods of high bed occupancy can also reduce CHPPD.



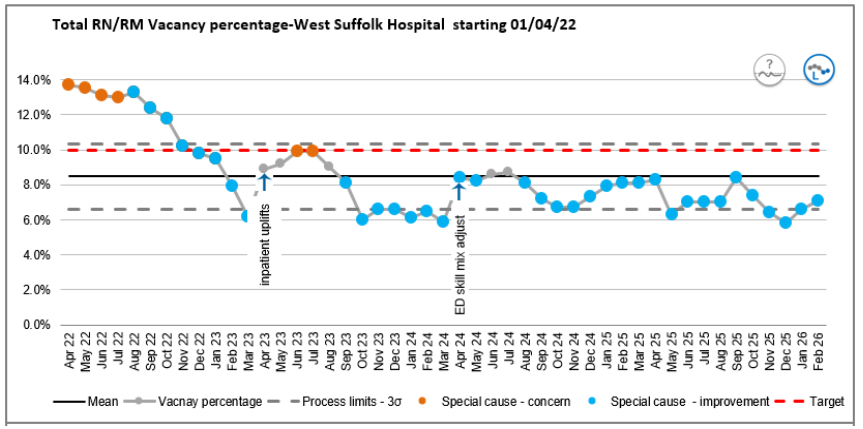
16

Appendix 3 WTE and Vacancy rates.

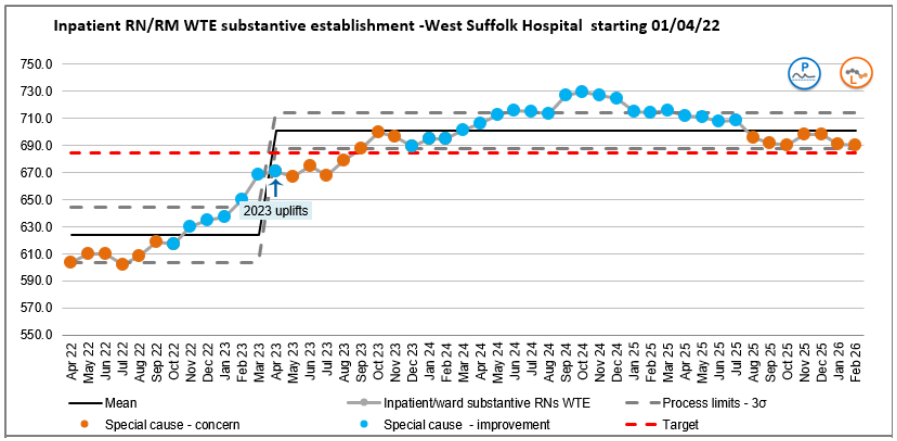
A) Trust Total RN/RM WTE



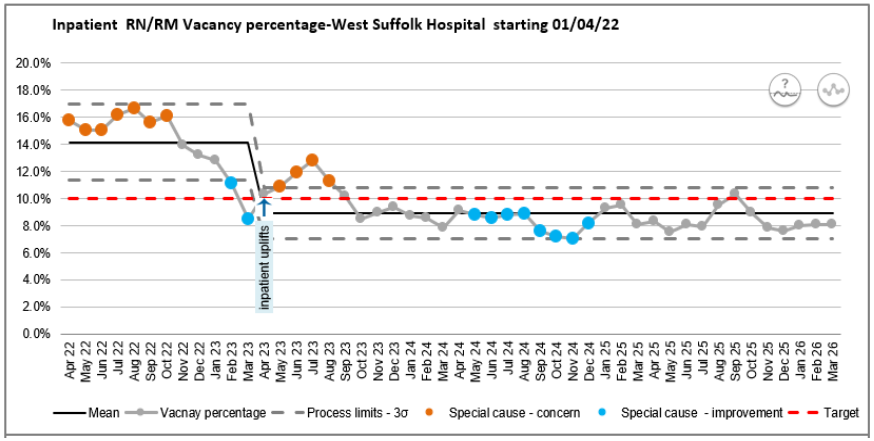
B) Trust Total RN/RM vacancy %



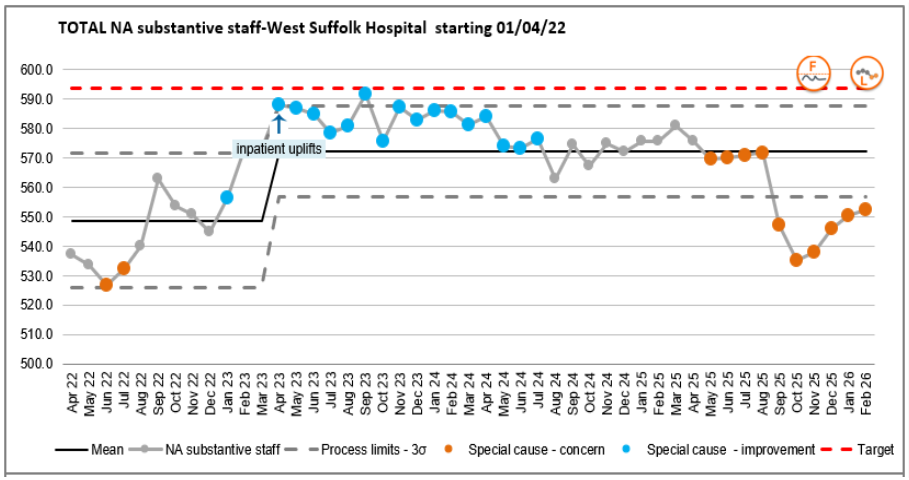
C) Inpatient RN/RM WTE



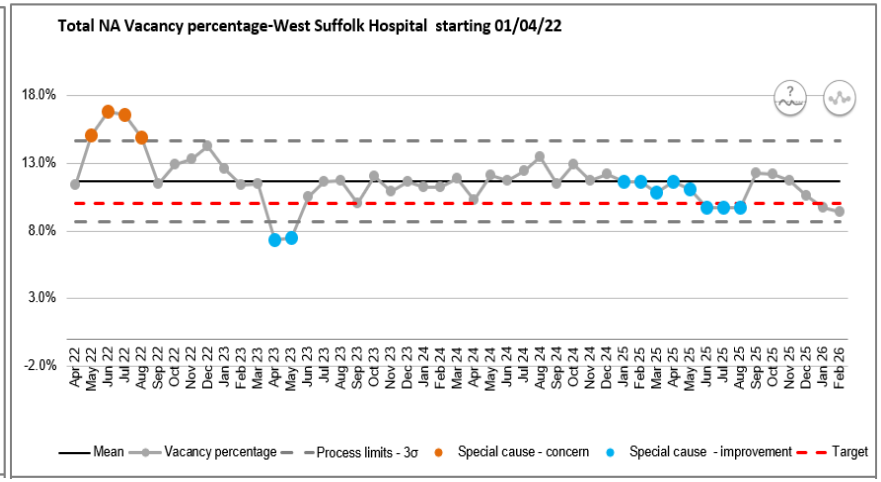
D) Inpatient RN/RM vacancy %



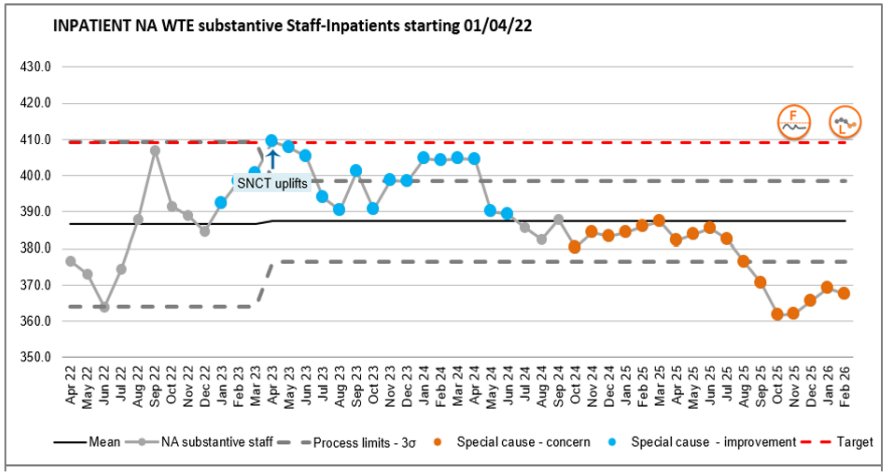
E) Total NA/unregistered WTE.



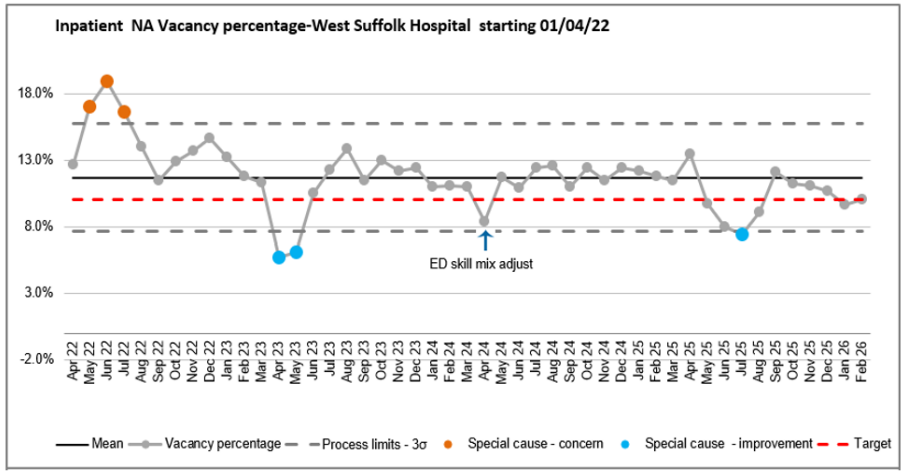
F) Total NA/Unregistered vacancy %



G) Inpatient NA/unregistered WTE



H) Inpatient NA/unregistered vacancy %



Appendix 4. Red Flag Events

Maternity Services

Missed medication during an admission
Delay of more than 30 minutes in providing pain relief
Delay of 30 minutes or more between presentation and triage
Delay of 60 minutes or more between delivery and commencing suturing
Full clinical examination not carried out when presenting in labour
Delay of two hours or more between admission for IOL and commencing the IOL process
Delayed recognition/ action of abnormal observations as per MEOWS
1:1 care in established labour not provided to a woman

Acute Inpatient Services

Unplanned omission in providing patient medications.
Delay of more than 30 minutes in providing pain relief
Patient vital signs not assessed or recorded as outlined in the care plan.
Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as: • pain: asking patients to describe their level of pain level using the local pain assessment tool. • personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration. • placement: making sure that the items a patient needs are within easy reach. • positioning: making sure that the patient is comfortable, and the risk of pressure ulcers is assessed and minimised.
A shortfall of more than eight hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift.
Fewer than two registered nurses present on a ward during any shift.
Unable to make home visits.

2.4. Maternity Services Report

Presented by Karen Newbury

Meeting/committee title: Open Board 27th March 2026

Report information

Report title: Perinatal Quality, Safety and Performance report
Agenda item: Maternity and Neonatal services – Open Board
Sponsor/Executive lead: Richard Goodwin, Medical Director & Maternity and Neonatal Safety Champion and Dan Spooner, Chief Nurse
Report prepared by: Karen Newbury, Director of Midwifery / Nursing and Hayley McBride, Acting Head of Midwifery / Nursing
Previously considered by: N/A
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 presents a document to enable board scrutiny of Maternity and Neonatal services and receive assurance of ongoing compliance against key quality and safety indicators and provide an update on quality & safety initiatives in line with the NHS Perinatal Quality Oversight Model (June 2025).

This report contains:

- Perinatal Quality Oversight Model (Annex A)
- Maternity and Neonatal Safety champion feedback
- Listening to staff
- Service user feedback
- Incident reporting and learning from incidents
- Training compliance for all staff groups in maternity related to the core competency framework.
- NHS Resolution (NHSR) Maternity Incentive Scheme (MIS) Year 7 progress
- Reports approved by the Trust Board sub committees

- Closed Board reports;

  Perinatal mortality Report Q3, 1st October 2025- 31st December 2025

  Maternity and Neonatal Safety Investigations (MNSI) Report Q3, 1st October 2025- 31st December 2025

- Next steps

So what? The report meets NHSE standard of perinatal oversight by providing the Trust board a methodical review of maternity and neonatal safety and quality.

What next? Action plans will be monitored, and any areas of non-completion will be escalated as appropriate.

Quarterly, bi-annual and annual reports will evidence the updates.

As applicable, reports will be shared with external stakeholders as required.

Action required by the board: For assurance and information.
Risk and assurance: To provide a systematic approach to the oversight of perinatal services.
Equality, diversity and inclusion: This paper has been written with due consideration to equality, diversity, and inclusion.
Sustainability: As per individual reports.
Legal and regulatory context: The information contained within this report has been obtained through due diligence.

Perinatal Quality, Safety and Performance report

1. Introduction

1.1 Perinatal Quality Oversight Model

The Perinatal Quality Oversight model (PQOM) was established in response to the need to proactively identify trusts that require support before serious issues arise, seeking to provide a consistent and methodical oversight of NHS perinatal services. The model has also been developed to gather ongoing learning and insight, to inform improvements in the delivery of perinatal services. In recognition that neonatal services are interdependent with maternity services, the PQOM refer to maternity and neonatal in terms of ‘perinatal’. The trust and its board ultimately remain responsible for the quality of the services provided and for ongoing improvement. The board is supported in this by the perinatal leadership team and the Board Safety Champion. The PQOM supports trusts and Integrated Care Boards (ICBs) in this duty, while providing a mechanism for escalation of any emerging risks, trends or issues that cannot be resolved at local level or would benefit from wider sharing.

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

1.2 Safety Champion feedback

The Board-level safety champion undertakes a monthly walkabout in the maternity and neonatal unit. Staff can raise any safety issues with the Board level champion and if there are any immediate actions that are required, the Board level champion will address these with the relevant person at the time.

Individuals or groups of staff can raise issues with the Board champion. An overview of the Walkabout content and responses is shared with all staff in the monthly governance newsletter 'Risky Business'.

Date	Board level Safety Champion	Location	Feedback raised	Comments, actions and progress
19/01/26	NED P Z-R	Community Midwifery team - Jade	Community connectivity	Engineering team testing devices at present to address this issue
			Thermometer availability	Resolved – equipment checklist in place
			Request more training time	With competency framework and mandatory training this already exceeds current headroom. Staffing review underway, including headroom review.
			Standard of interpretation service for non-elective work.	Raised with the patient experience team to feedback to the interpretation provider.
06/02/26	Exec R G	Obstetric theatres	Midwifery staffing shortfalls impacting elective work	On review of red flags and incident reporting this is a rare occurrence, however all efforts at the time are taken to support elective work but one to one care in labour must take priority.
			Absence of an obstetric High Dependency Units (HDU) on Labour suite	Due to required skills and experience current practice is for care to be received in main HDU which is accepted as the safest place for care for a unit of our size.
			Availability of a 2nd theatre in emergencies	Since Elective sections are now undertaken in a separate theatre the requirement to open a 2nd theatre has significantly reduced. When incidents relating to this do happen a full review is undertaken and learning/outcomes shared with staff.

			Dedicated obstetric theatre team	There is a dedicated team for obstetrics however due to the workload they sit within the main theatre team.

Board Safety Champions meet with the perinatal leadership team and Maternity and Neonatal Voice Partnership lead for the ICB at least bi-monthly to review progress and determine whether additional Trust Board support is required. Any escalations are formally recorded in the Safety Champion Action Log and monitored through the monthly Maternity/Neonatal Safety Champion meeting.

Role	**Meeting attended;**	
	13/01/26	**10/02/26**
Board level Safety Champion (Executive)	✓	✓
Board level Safety Champion (Non-Executive)	✓	✓
Perinatal Obstetric Lead/Safety champion	Apologies	✓
Perinatal midwifery Lead/ Safety Champion	✓	✓
Perinatal neonatal lead/ Safety Champion	✓	✓
Perinatal anaesthetic lead/ Safety Champion	Apologies	Apologies
Perinatal management lead	✓	✓
MNVP lead	✓	✓

1.3 Listening to Staff

The maternity and neonatal service continues to prioritise creating a culture in which staff feel heard, supported, and able to speak up. Colleagues are actively encouraged to access a range of supportive mechanisms, including the Freedom to Speak Up Guardians, Safety Champions, Professional Midwifery and Nursing Advocates, unit meetings, and the 'Safe Space' forum. In addition, dedicated maternity and neonatal staff focus groups provide regular opportunities to listen to staff views and experiences. Issues raised through these routes are responded to promptly, with feedback shared transparently with teams.

In early 2025, the service undertook a SCORE Culture Survey as the final element of Wave One of the Perinatal Culture & Leadership Programme. This programme aims to nurture a positive safety culture, promote psychologically safe working environments, and embed compassionate leadership—key requirements within the NHS Resolution Maternity Incentive Scheme. All staff across Women's and Children's Services were invited to participate, achieving a 49% response rate. Following this, an external culture coach engaged with targeted groups to gain deeper insight into the results.

As a result of this work, three core cultural aspirations have been identified:

The Perinatal Quadrumvirate, supported by the Trust's in-house Culture Coaches, continues to lead improvements in safety culture and progress these aspirations. Examples of work underway include:

Coaching Culture Development: With support from Health Innovation East, two "Enabling a Coaching Culture" workshops were delivered in November and December 2025. These sessions were open to all perinatal staff and provided practical tools to strengthen communication and support the development of a coaching mindset across teams.

Inclusive Multidisciplinary Working: An inclusive, multidisciplinary approach remains embedded across perinatal services. Routine audits demonstrate strong engagement from all staff groups, reflected in consistent participation in safety huddles and high levels of compliance with mandatory training.

Reverse Mentoring and Sponsorship: In collaboration with the Trust's Learning and Development team, preparations are underway to launch a Reverse Mentoring and Sponsorship Programme in spring 2026. This initiative aims to foster inclusive leadership, enhance understanding of diverse experiences, and support career development across the workforce.

1.4 Service user feedback

Service user feedback plays a vital role in healthcare by offering direct insight into the quality of care received. It enables providers to make meaningful improvements—not only by enhancing care standards, but also by enriching patient experience and driving innovation. When patients share their experiences, they highlight strengths and reveal gaps in service that might otherwise go unnoticed.

To support this, the NHS introduced the Friends and Family Test (FFT). This simple, anonymous tool helps service providers and commissioners gauge patient satisfaction and identify where changes are needed. It offers an accessible way for patients to share feedback after receiving NHS care or treatment.

Ward/Dept	January Survey Responses	January Very good and good %	February Survey Responses	February Very good and good %
F11	38	97%	37	97%
Labour Suite	2	100%	2	93%
Birthing Unit	1	100%	0	-
Maternity Triage	20	97%	1	100%
NNU	9	78%	20	92%
Antenatal Community	4	100%	89	88%
Postnatal Community	4	75%	77	84%

Due to the limited volume of feedback received, the maternity and neonatal team is working in close collaboration with the Patient Engagement Team, as well as the Parent Education and Patient Experience Lead Midwife, to improve response rates. Across maternity and neonatal services, work continues to focus on improving the volume and consistency of patient feedback captured through surveys. While some months demonstrate stronger response rates than others, it remains essential that we achieve sustained and representative feedback from all parts of our population to support meaningful service improvement. Recent internal review has identified inaccuracies in how feedback data has been reported across different areas, leading to inconsistencies in monthly returns. These issues have now been recognised and will be corrected to ensure future reports present accurate, reliable, and comparable patient experience data.

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

The publication of updated Maternal and Neonatal Voices Partnership (MNVP) guidance in November 2023 enabled our Local Maternity and Neonatal System (LMNS) to evaluate and establish a more sustainable approach to ensuring patient voices are heard throughout perinatal services. As a result, a new LMNS MNVP Lead was appointed and began their role in October 2024, with responsibility for re-establishing the WSFT MNVP. As the LMNS structure changes, there will be a need to establish a revised framework that ensures continued co-production, service user involvement, and clear lines of collaboration with the MNVP to maintain strong patient-voice representation within maternity and neonatal

improvement work. Our current MNVP representative will continue their role within the Norfolk and Suffolk ICB, and this organisational shift means our existing arrangements and communication pathways will need to be reconsidered.

postnatal care. A notable area of improvement relates to birthing partner access, where the department recorded one of its most significant increases in positive responses. This improvement aligns with targeted engagement work on Ward F11, including the introduction of 24 hour visiting, enabling birthing partners to remain throughout the inpatient stay. An action plan has been co-produced with our MNVP lead to address areas where further enhancement is required, including feeding support contact, particularly during nights and weekends and reducing delays in discharge, ensuring timely transitions from hospital to home. A full review will be shared with the Quality and Patient Safety Committee in due course.

Compliments, PALS enquiries and Complaints.

Measure	January 2026	February 2026	Trend / Narrative Summary
Compliments	Nil via PALS, however several captured via social media posts.	Nil via PALS, however several captured via social media posts.	The response to perinatal posts on social media generates a lot of positive feedback and compliments regarding their care.
PALS Enquiries	1 enquiry received: relating to unmet needs regarding care preferences	6 enquiries received: relating to tone of communication, clinical care and documentation accuracy	The overall number of PALS enquiries remains unchanged compared to the previous reporting period
Formal Complaints	1 complaint received, relating to psychological support, reasonable adjustments and inconsistencies in clinical oversight	1 complaint received, whereby the person felt they were not listened to.	Numbers appear on trend; however, it is important to note that not all complaints are upheld. Themes align with listening, communication and patient experience.

While patient feedback, both positive and negative, plays an essential role in service improvement, the service recognises the need for ongoing immediate and structured action in response to the feedback received.

1.5 Incident reporting and learning from incidents

The table below demonstrates referrals to the Maternity and Neonatal Safety Investigation (MNSI) programme and the number of reported patient safety incidents.

	January 26	February 26
No. of MNSI referrals	1	0
No. of Patient safety incidents	84	88

It is important to note that not all reported incidents reflect adverse outcomes or omissions in care delivery. National and regional guidance actively promotes the reporting of maternity triggers to strengthen transparency and standardisation in safety monitoring. Ongoing surveillance continues to identify any emerging themes and ensure timely action is taken to mitigate potential risks.

The maternity service is represented at the Local Maternity and Neonatal System (LMNS) monthly safety forum, where incidents, reports and learning are shared across all three maternity units. With the new ICB structure taking place from April 26 onwards the LMNS will cease however the plan is to continue a monthly perinatal safety forum across the ICB.

Quarterly reports are shared with the Trust Board to give an overview of any cases, with the learning and assurance that reporting standards have been met to MNSI/Early Notification Scheme and the Perinatal Mortality Reporting Tool (PMRT).

1.6 Training compliance for all staff group in maternity related to the core competency framework

End of month data Jan 2026	Saving Babies Lives E-Learning Module	GAP/GROW	Maternity Emergencies / OMET	Skills and Drills	CO Monitor	Safeguarding	Neonatal Life Support Yearly	4 Yearly NLS update	Fetal Heart Surveillance	Newborn Feeding update 3 yearly	SDM
Midwives	90.5%	93.2%	96.2%	96.2%	98.5%	99.3%	96.2%	N/A		85%	94.4%
MCA/MSW	N/A	N/A	95.2%	95.2%	96.5%	96.1%	95.2%	N/A	N/A	88%	N/A
Consultant Obstetrician	75%	100%	80%	80%	100%	95%	N/A	N/A		N/A	100%
Obstetric Registrar	88%	87.5%	88.9%	88.9%	100%	91%	N/A	N/A		N/A	100%
SHO/Core trainees	88%	87.5%	66.67%	66.67%	100%	86%	N/A	N/A	N/A	N/A	87.5%
Sonographer	N/A	83.4%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Consultant Anaesthetist (obs)	N/A	N/A	88.3%	88.3%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Obstetric Anaesthetists	N/A	N/A	100%	100%	N/A	N/A	/A	N/A	N/A	N/A	N/A
Neonatal Consultants	N/A	N/A	N/A	Self Cert	N/A		85.6%	85.6%	N/A	80%	94%
Neonatal Nurses	N/A	N/A	N/A	93%	N/A	97%	97%	100%	N/A	98%	100%
Neonatal Doctors	N/A	N/A	N/A	Self Cert	N/A		100%	100%	N/A	76%	No data
PA	N/A	N/A	N/A	Self Cert	N/A		100%	100%	N/A	100%	No data

End of month data Feb 2026	Saving Babies Lives E-Learning Module	GAP/GROW	Maternity Emergencies / OMET	Skills and Drills	CO Monitor	Safeguarding	Neonatal Life Support Yearly	4 Yearly NLS update	Fetal Heart Surveillance	Newborn Feeding update 3 yearly	SDM
Midwives	90.7%	90.6%	97.4%	97.4%	98.5%	99.3%	97.4%	N/A	96%	86.7%	98%
MCA/MSW	N/A	N/A	95.3%	95.3%	96.5%	98.1%	95.3%	N/A	N/A	84.1%	N/A
Consultant Obstetrician	75%	100%	93.3%	93.3%	100%	95%	N/A	N/A	92%	N/A	100%
Obstetric Registrar	100%	75%	88.8%	88.8%	100%	91%	N/A	N/A	88%	N/A	100%
SHO/Core trainees	87.5%	87.5%	77.7%	77.7%	100%	86%	N/A	N/A	N/A	N/A	100%
Sonographer	N/A	88.9%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Consultant Anaesthetist (obs)	N/A	N/A	81.2%	81.2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Obstetric Anaesthetists	N/A	N/A	100%	100%	N/A	N/A	/A	N/A	N/A	N/A	N/A
Neonatal Consultants	N/A	N/A	N/A	Self Cert	N/A	Awaiting data	92%	92%	N/A	87%	88%
Neonatal Nurses	N/A	N/A	N/A	86%	N/A	92%	92%	92%	N/A	98%	100%
Neonatal Doctors	N/A	N/A	N/A	Self Cert	N/A	87.5%	100%	100%	N/A	76%	70.6%
PA	N/A	N/A	N/A	Self Cert	N/A	100%	100%	100%	N/A	100%	100%

To note; new SHO/core trainees started with the organisation on the 7/12/25.

Historically the organisation had aligned full compliance with the Maternity Incentive Scheme end date, hence full compliance in November. It has now been recognised that there needs to be consistent compliance throughout the year, which the service is working towards.

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

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

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

Now in its seventh year of operation, NHS Resolution's Maternity (Perinatal) Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50%

before the end of 2025. The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST).

Year 7 of the scheme was launched in April 2025 for the reporting period 1st December 2024 - 30th November 2025. The nature of the ten safety actions remains largely unchanged from previous years covering ongoing reporting and monitoring of mortality and morbidity, compliance with national frameworks, standards of care, reporting criteria and timeframes, education and training, workforce standards, involving service users in the safety and improvement work and quality and sharing of learning. Whilst there are still areas where the maternity and neonatal services can continue to develop and improve, maintenance and monitoring of standards is a key part of everyday working within the maternity and neonatal units.

The chart below reflects our full compliance with Year 7 safety actions that has now been submitted to NHS Resolutions..

Overview of progress on MIS year 7 safety action requirements

*Mandated Safety Action Requirements:

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

Key:

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

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

Next steps: The MIS year 8 is due to be launched in April 2026.

2. Reports

2.1 Reports approved by the Trust Board sub-committees

The NHS Resolution Maternity Incentive Scheme (MIS) introduced a change in

the processes and pathways for Trust committee and Board oversight in 2024. This has afforded the Trust the opportunity to optimise the reporting structures and assurance processes to ensure that each report has appropriate oversight and approval during this time.

Reports to provide assurance in each Safety Action can be monthly, quarterly, six-monthly, annually or as a one-off oversight report at the end of the reporting period for sign-off prior to submission. Many of the reporting processes are embedded into business as usual for the service so are continued outside the MIS timeframe.

The updated process was agreed at the Board Meeting on the 24th of May 2024, whereby some reports will be presented and approved by the Board sub-committees.

Reports presented and approved at the Quality and Patient Safety Committee held on; The **21st January 2026**:

- **Homebirth service review**
- **Maternity Incentive Scheme – Year 7 declaration of full compliance**.
-

No reports were due to be presented to any of the sub-committees held in February 2026.

2.2 Reports for CLOSED BOARD

Due to the level of detail required for these reports and subsequently containing possible patient identifiable information, the full reports will be shared at Closed board only.

Perinatal mortality Report Q3, 1st October 2025- 31st December 2025

The Trust reported <5 perinatal losses to Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE) in this quarter.

All cases have received bereavement support.

All the timeframes for reporting to MBRRACE have been met and local and Perinatal Mortality Review Tool (PMRT) reviews are on course for completion. Two PMRT reports have been completed from previous quarters and learning has been identified and shared with the teams.

Maternity and Neonatal Safety Investigations (MNSI) Report Q3, 1st October 2025- 31st December 2025

During the reporting period, one incident initially met the criteria for reporting to the Maternity and Neonatal Safety Incidents (MNSI) programme; however, following further review, this case was subsequently rejected and therefore did not progress. The incident also did not meet the threshold for referral to the NHS Resolution Early Notification Scheme (ENS).

No completed MNSI reports were received during this quarter.

Maternity and Neonatal services continue to maintain robust vigilance in identifying incidents that may warrant external scrutiny. Established governance processes ensure early review, timely escalation, and prompt identification of learning to support ongoing improvements in safety and quality of care

3. Next steps

Reports will be shared with the external stakeholders as required.

Action plans will be monitored and updated accordingly.

4. Conclusion

The Board can be assured that it continues to receive appropriate and comprehensive oversight of perinatal services in accordance with the national Perinatal Quality Oversight Model. The governance structures, reporting mechanisms, and quality assurance processes in place provide the Board with clear visibility of performance, risks, and improvement activity. Collectively, these arrangements offer the required assurance that our perinatal services remain safe, well-governed, and focused on delivering high-quality care for women, babies, and families.

5. Recommendations

It is recommended that the Board note the content of this report and support the continued application of the established governance and oversight processes for perinatal services.

Annex A
Perinatal Quality Oversight Model Data Measures

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

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

3. JOINED UP SERVICES

3.1. Strategic priorities update (ATTACHED)

To inform

Presented by Sam Tappenden

Open Board

Report information

Report title: update on progress to embed the Trust's corporate strategy
Agenda item:
Executive lead: Sam Tappenden, Executive Director of Strategy and Transformation
Report prepared by: Sam Tappenden
Previously considered by: Closed Board
This report is for: ☐Approval ☒ Assurance ☒Discussion ☐information

This report supports the following ambitions:

☒ **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*

The Trust strategy 2025-2028 – compassionate care, healthier communities – has been launched. Considerable work is required to improve colleagues' and stakeholders' awareness of the strategy, embedding it throughout the organisation, and completing the Trust's suite of strategies and plans.

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

The refreshed Trust strategy is critical in helping the organisation successfully navigate the future by focusing on what's most important. It gives direction to colleagues, assurance to stakeholders, and will build confidence in the patients and communities we serve. The strategy will help ensure the Trust effectively responds to the national direction of the 10-Year Health Plan for England, support our Future Systems Programme, and enable the Trust to make the changes required to become a high quality and financially sustainable organisation.

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

The Trust will continue to embed the refreshed corporate strategy throughout the organisation, complete the Trust's 'enabling' strategies, and implement a new approach to the oversight of strategy and transformation.

Action required by the board:

- Support to embed the strategy throughout the Trust.

Compassionate care, healthier communities

Governance and compliance

Risk and assurance: The refreshed strategy will enable the Trust's BAF to be updated, and in turn to ensure the organisation is addressing our strategic risks.

Equality, diversity and inclusion: A core tenant of the ambitions pertains to having an inclusive, supported, and valued workforce. The strategy included a renewed focus on EDI. An accessible 'easy read' version of the strategy document has been developed.

Sustainability: The strategy will play a critical role in delivering the Trust's financial sustainability through aligning Trust resources on key priorities.

Legal and regulatory context: A key role of the Board is ensuring the Trust has a robust strategy.

Update on embedding the Trust's corporate strategy

1. Purpose

2.1. The purpose of this paper is to update the Board on the wide range of activities being undertaken to embed the strategy across the Trust.

2. Progress embedding the strategy

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

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

2.3. Initial results are encouraging. The most recent Trust Pulse survey, which included three strategy related questions for the first time, suggests that most of our colleagues are aware of the ambitions and how their teams contribute to the delivery of the strategy.

2.4. Considering the strategy was agreed in late September, and the Pulse survey was held in January, this is positive, and is a testament to the work of colleagues, particularly in the communications team.

2.5. A divisional analysis can be found in **Appendix A** which provides greater granularity of awareness of the strategy by divisional areas. This analysis will be used to inform more targeted engagement activity.

Table one: strategy questions in the recent Pulse survey[1]

Question	Positive	Neutral	Negative
I am aware of our strategy 2025-2028 - Compassionate care, healthier communities	44.1%	26.3%	29.6%

[1] 1045 responses were received in the Pulse survey.

I am aware of the five ambitions that sit within our Trust strategy	63.8%	19.1%	17.0%
I am aware of how my role/team contributes to the delivery of the Trust strategy	52.8%	26.4%	20.8%

2.6. These responses are the baseline indication of how well our strategy has been embedded across the Trust, and these questions will be repeated in six months' time.

2.7. Continued work is well underway to embed the strategy with internal and external stakeholders, aligned with our phased approach, as summarised in table two below:

Table two: summary of strategy roll-out phases and progress

Phase	Roadmap	Timescales	Focus	Activities	Status
One: launch	'Recover'	Oct '25 – Feb' 26	Awareness of internal and external stakeholders	General communication through key channels (e.g. All Staff Update), development of key materials (e.g. posters), and case study collation.	Complete
Two: spread	'Renew'	Feb '26 – Jun '26	Integration into strategic processes	Digital briefing and briefing packs for teams to cascade Launch the complete strategic framework (i.e. enabling strategies) • Embed in planning, decision-making, and governance (e.g. committees, procurement processes, contracts etc.)	In progress
Three: embed	'Renew'	Jul '26 – Dec '26	Behavioural and cultural adoption	Incorporate into organisational BAU processes: • Appraisals, objective setting, leadership programmes • Complementary launch of values and behaviours framework • Continuous Quality Improvement approach • Operational governance (e.g. divisional boards).	Planning
Four: sustain	'Reimagine'	Jan '27 and beyond	Continuous activities to sustain awareness	On-going activities to sustain engagement include: • Regular staff communications (e.g. ASU) • Embedding the strategy in Trust events.	Not started

3. Enabling strategy development

3.1. Strong progress is being made regarding the development of the Trust's 'enabling' strategies which are being developed jointly amongst corporate leads to maximise alignment.

3.2. We are on track to have the suite of enabling strategies completed in April as planned. Engagement from corporate teams to develop their strategies has been excellent.

3.3. The integrated clinical and quality strategy will require a slightly different approach to the other strategies, given its relative breadth, significant previous engagement, and its criticality to the FSP. This may mean that this strategy will take slightly longer to complete.

3.4. The integrated clinical and quality strategy is being co-led by the Executive Medical Director and Chief Nurse respectively, with the support of the strategy and transformation team.

4. Governance of strategy and transformation

4.1. The strategy and transformation team is aggregating all the change programmes and projects that have been identified following development of:

- Divisional service developments through planning
- Intended CIP plans for 26/27
- Corporate 'enabling' strategies and business plans
- West Suffolk Alliance plans
- Existing service or team level quality improvement projects
- Future Systems Programme (FSP)
- Likely areas of focus of commissioning activity
- Joint projects with partners

4.2. These projects will be pulled into an integrated transformation portfolio. The purpose of this portfolio is to:

- Improve visibility of the change taking place across the Trust
- Enable leaders to better manage challenges, issues, and risks
- Prioritise those projects with the greatest impact
- Ensure alignment across the Trust's services and teams
- Ensure congruency with Trust strategies and plans

4.3. Furthermore, a proposed approach to improving the governance of strategy and transformation has been developed, and will shortly be taken to MEG for discussion. The draft approach includes:

- Establishment of an integrated transformation portfolio
- Management oversight through MEG
- Assurance committees having oversight of those strategies and transformation programmes within their respective scopes.

4.4. In summary, the plan is to complete the following in April: enabling strategies, the first draft of the integrated transformation portfolio, a refreshed approach to governing strategy and transformation, the quarterly strategy dashboard including KPIs, and a refreshed BAF.

5. Board Assurance Framework

5.1. Following the recent Board development session on managing Trust risks, the BAF is in the process of being refreshed.

5.2. The current proposal, which is subject to change, is that the refresh of the BAF would see five strategic risks – reflecting each of the Trust's five ambitions.

5.3. Each BAF risk could incorporate the three priority corporate risks, reflecting those being escalated up through the organisation.

5.4. This approach would ensure strong alignment in the management of risk and the delivery of the strategy, encourage join-up between responsible executives, and provide a clear framework for action.

6. Summary and next steps

6.1. Good progress is being made to embed our strategy, maximise alignment between our teams, and develop a change portfolio.

6.2. Initial results suggest that most staff are aware of the strategic ambitions and how their roles contribute to the strategy.

6.3. In April the Board will have a refreshed approach to strategy and transformation that will enable a robust approach to the delivery, measurement, and oversight of our strategy.

Appendix A – divisional awareness of the Trust's strategy

Question 1: I am aware of our strategy 2025-2028 - compassionate care, healthier communities				
Division	**Positive (%)**	**Neutral (%)**	**Negative (%)**	**No. of respondents**
Clinical Support	38.4	26.4	35.2	159
Community	46.2	21.4	32.4	173
Corporate services	60.3	23	16.7	174
Estates and Facilities	37.5	33.9	28.6	56
Medical	37.7	24.5	37.7	106
Surgical	31.6	31.6	36.4	114
Women and Children	43.3	35	21.7	60
Prefer not to say	45.8	28.8	25.4	59

Question 2: I am aware of the five ambitions that sit within our Trust strategy.				
Division	**Positive (%)**	**Neutral (%)**	**Negative (%)**	**No. of respondents**
Clinical Support	67.1	19	13.9	158
Community	67.1	15.6	17.3	172
Corporate services	64.4	17.8	17.8	174
Estates and Facilities	57.1	26.8	16.1	56
Medical	61.3	17.9	20.8	106
Surgical	53.5	24.6	21.9	114
Women and Children	76.7	15	8.3	60
Prefer not to say	59.3	23.7	16.9	59

Question 3: I am aware of how my role/team contributes to the delivery of the Trust strategy				
Division	**Positive (%)**	**Neutral (%)**	**Negative (%)**	**No. of respondents**
Clinical Support	53.8	23.4	22.8	158
Community	54.7	23.8	21.5	172
Corporate services	52.3	26.4	21.3	174
Estates and Facilities	58.9	25	16.1	56
Medical	52.8	23.6	23.6	106
Surgical	49.1	28.1	22.8	114
Women and Children	51.7	35	13.3	60
Prefer not to say	49.2	33.9	16.9	59

3.2. West Suffolk Alliance and SNEE Integrated Care Board update (ATTACHED)

To Assure

Presented by Maddie Baker -Woods

Meeting/committee title: Open board

Report information

Report title: West Suffolk Alliance reports Feb' and Mar' 2026 meetings
Agenda item: Item 3.2
Sponsor/Executive lead: M Baker-Woods - Executive Director (Designate), Primary Care and Neighbourhood Health for Suffolk

Report prepared by: C King/M Shorter
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? *The attached paper provides a summary of the key items of business for West Suffolk Alliance for the Committee meetings held 10 February and 10 March 2026*

So what? *Board members are asked to note progress identified and risks associated with the changes to the ICB.*
What next? *Actions are managed through the Alliance Committee process*
Action required by the board: to note the report

Governance and compliance

Add explainer for each of the below.
Risk and assurance: Risks noted due to the imminent changes to the ICB function and structure
Equality, diversity and inclusion: Health Inequalities are reported to the Health inequalities Prevention Programme Committee (HIPPC) in the ICB. Clear links to reducing health inequalities are contained in all programmes
Sustainability: All programmes have internal assurance and governance through the ICB for sustainability with each programme completing an Impact Assessment
Legal and regulatory context: Governance is held within the ICB. This reports if for information to the Trust

West Suffolk Alliance Committee reports

1. Introduction

1.1. West Suffolk Alliance Committee meeting reports of the February and March Health & Wellbeing Committee meetings

2. Background.

3. Detailed sections and key issues

3.1 Joy update	• The Joy platform relaunch is progressing well, with rising activity, refreshed communications and ongoing Norfolk–Suffolk integration, including System One access and joint contract discussions. • Adult Social Care (ASC) will join the contract in April, enabling all Ipswich & East Suffolk referral options. • West Suffolk Foundation Trust are yet to mobilise on community System 1 modules • Referrals continue to grow across mental health, finance, high body weight and Long-Term Conditions (LTCs) with major flows to Citizens Advice, talking therapies and Feel-Good Suffolk. • Immediate priorities include increasing clinician uptake, resolving Trust access issues, confirming key pathways (including weight management), strengthening proactive comms and supporting grassroots providers through Community Action Suffolk. • Wider requirements such as Single Point of Access (SPA) clarity, pathway rationalisation, self-referral tracking and automated InfoLink transfers remain in train. **Next steps focus on: -** • Finalising Norfolk–Suffolk integration requirements • Progressing a potential joint contract • Launching refreshed public communications • Onboarding ASC teams • Issuing Community Action Suffolk (CAS) materials with support sessions.
3.2 Alliance updated and Governance transition	**Alliance update and governance transition:** The new Norfolk & Suffolk Integrated Care Board (ICB) structure goes live on **1 April**, with delegated place-based responsibilities. • A new Suffolk wide assurance committee will strengthen governance across the system, providing oversight of performance, quality and financial delivery while supporting pan Alliance working and shared learning; membership is still to be confirmed. • The West Suffolk Alliance (WSA) Terms of Reference will remain largely unchanged, though clarity is still needed on how this aligns with the Health and Wellbeing Board. Final staffing structures were issued on 13 February, retaining place based alliance teams and establishing pan Norfolk and Suffolk primary care and governance functions. • Alliances to continue with stable governance, maintaining assurance on strategy, spending and NHS targets, with joint Norfolk–Suffolk working still a priority. • Meetings - April 14th will follow usual format. Joint Ipswich & East and West meeting to be held May 12th in Stowmarket. • ICB Recruitment – progressing including ongoing leadership and clinical appointments. • Waking Nights service ending, with Continuing Health Care / District Nurses supporting families for assurance. It is expected that reinvestment will go back into End-of-Life pathways and with voluntary sector providers.
3.3 Community Services contract update	**Community services contract update** • Adult Community services are performing well overall and continue to meet key targets, including the 2-hour response times. • Paediatric services and the Care Coordination Centre remain under pressure due to workforce gaps, rising demand, and inconsistent data. It was recognised that these were national as well as local pressures.

	• Committee emphasised the need for recovery plans in Paediatrics, with strong governance and costing plans. • Also to strengthen workforce capacity, enhance digital readiness and provide consistency across Suffolk.
3.4 National Neighbourhood Health Implementation Plan update	**National Neighbourhood Health Implementation Plan update** The programme is progressing well, with diabetes confirmed as the target cohort and an integrated diabetes service specification being co-produced. • ICB funding has been applied for and is to be progressed through a business case. • The local coach has been recruited and partner workshops underway. **Next Steps** • National Senior Responsible Officer visit was virtual on **23 Feb** • Finalise the business case and NHSE metrics by **Mid-March** • Deliver workshop to begin Integrated Diabetes Service (IDS) implementation and early Plan Do Study Act (PDSA) cycles.
3.5 UEC & Elective Care update	**UEC & Elective Care update** • Q3 saw continued Urgent Emergency Care performance improvement with reductions in 12-hour waits, ambulance handovers and stronger referral pathways into virtual wards through the step-up programme, as well the direct pathway into Same Day Emergency Care from 999. • Elective care progress saw an extension of the Third Space service into PSA and a system wide dermatology review completed. • Over 900 patients diverted from outpatient appointments through advice and guidance performance • West Suffolk interface working continued to progress very positively and the Trust was thanked for their part in this. This had resulted in several process changes and support offers for primary care. • Celebrated collaborative work in this space. **52-week waits remain a strategic risk**
3.6 Workforce update	**Workforce update** • Q3 progress included stronger health-and-work initiatives through collaboration with the University of Essex and Norfolk colleagues to deliver a careers expo event • Films created and going through final editing to support employers hiring people with health conditions • Secured Not in Education Employment or Training funding to work in partnership with Lofty Heights and East Suffolk North Essex Foundation Trust (ESNEFT) to support young people into health and care careers • Launch of the West Suffolk **Apprenticeship Charter;** partners were invited to sign up to 'Think Apprenticeship First' for all relevant employment opportunities.
3.7 Advisory Dementia Pathway update	**Advisory Dementia Pathway update** The pathway includes a simplified primary care pathway, diagnostic process map and advanced dementia toolkit to support diagnosis and post diagnostic care. The new pathway aims to enable timely diagnosis and reduce inappropriate referrals to memory assessment. **Feedback:** Committee supported the model but raised issues around early diagnosis capacity, co-occurring condition pathways, and supporting both early and advanced diagnoses – **Endorsement given** but relies on following actions: **Actions** • Finalise and share timelines on the development of the pathway alongside the expected impact

	• Progress implementation steps including Local Medical Council (LMC) - 19 Feb meeting; Older Adults Group alignment, GP education, and exploring hospital toolkit use. • Monitor diagnosis activity, DiaDeM use, and time to diagnosis. Committee received a revised update (disseminated with Committee papers): - at the 10 March meeting noting: • Stepwise prompt for primary care to rule out learning disability, short-term symptoms, mental/physical health causes, alcohol-related issues, and advanced dementia before referring into Memory Assessment Service (MATS) • Support available via Shaftesbury Memory & Dementia Service and specialist mental health teams for assessment, behavioural symptoms, and ongoing guidance.
3. 8 Better Care Fund (BCF) update –	**Better Care Fund (BCF) update and recommendations for continued funding**. Inflationary uplifts and final allocations are still to be confirmed. **Successes** • Most BCF schemes performed strongly against Key Performance Indicators • The focus for 2026/27 is on strengthening prevention and independent living, with funding realignments reflecting where alternative funding sources now exist. • Governance remains strong: BCF oversight has improved, metrics are on track, and work is progressing on both the 2026/27 plan and the transition to the Integrated Care Funding Framework, with neighbourhood based delivery at the centre. • 2026/2027 will act as an interim stabilisation period, with four intermediate care areas, minimal financial changes, a modest £100–£200k return, and a clear emphasis on reducing duplication, aligning schemes and testing/refining approaches before larger shifts are made. **Key challenges** raised included • Static voluntary sector funding despite rising pressures. • The need for early clarity on management cost reallocations, and handling inflation once national allocations are confirmed. • The recommended changes include stopping funding for Total Mobile, with all other services continuing from the West Suffolk allocation. **Decision -** The committee **approved the recommendations for the approach** to the 26/27 plan at the 10 March meeting subject to final adjustments linked to alternative funding sources and inflationary impacts, stressing the importance of avoiding unintended impacts, maintaining clarity across initiatives and limiting simultaneous changes to preserve system stability.
3.9 Third Space – item for endorsement	**Third Space – item for endorsement** • The service continues to deliver Monoclonal Gammopathy of Undetermined Significance (MGUS) monitoring and left shift benefits, though Prostate Specific Antigen (PSA) activity remains limited by staffing gaps, referral issues and inconsistent data • A Suffolk wide business case is being developed to expand the model, including potential application to other long-term conditions, with risks highlighted around loss of monitoring capacity and weakened interface working if the service were discontinued. • Model has eased pressure across primary and secondary care. • Relaunch of PSA pathway required to encourage referrals and improve data capture.

	Decision - Committee **endorsed** creating a business case for a Suffolk-wide service, with potential expansion to other long-term conditions, noting the need to evidence impact and rebuild PSA confidence.
3.10 Offer of Community Wellbeing and Health Space for Services – Bury Leisure Centre	**Offer of Community Wellbeing and Health Space for Services – Bury Leisure Centre** **Summary** • Seven new non-clinical rooms will be available in the newly refurbished leisure centre, which can support community-based services such as physio, health promotion, and family support. • Suggestions include maternity and children's services, with a review of access routes / privacy / accessibility and potential midwifery use. • Could be used for clinical outreach but would require certain specifications to be implemented • Committee members were invited to consider this opportunity and contact Abbeycroft directly.
3.11 Workwell – purpose to identify opportunities for integration Workwell into Neighbourhoods	**Workwell** to identify opportunities for integrating into Neighbourhoods • WorkWell is a 3year, £6m early intervention employment programme offering assessment, coaching and multiple referral routes for people with health needs. • Demand is driven by mild–moderate mental health needs, requiring strong links with primary care to deliver fit note changes. • Year 1 planning starts April, with delivery from November, informed by Kick Start learning, closer ties to Talking Therapies and emerging place-based capacity (including the 2027 Skills & Innovation Centre). **Actions:** • Ongoing collaboration with potential for a task and finish group • Direct liaison with Primary Care required. • Ensure the Workwell programme is aligned with Connect to Work to avoid duplication.
3.12 Family hubs/Mental Health hubs - Purpose: to agree coordination of focus groups to collaborate and progress	• £1.5bn Best Start in Life will unify early years and family services, aiming for 75% Good Level of Development (GLD) by 2028 through universal Family Hubs; Suffolk receives an April 2026 development grant. • Norfolk & Suffolk Foundation Trust (NSFT) has submitted a bid for seven Neighbourhood Mental Health Centres (£1.5m each), offering walk-in, community-based support with MDTs and strong GP/Voluntary Sector links; Lowestoft and King's Lynn are first priorities for 2026/27. • Family Hubs will provide integrated early years, perinatal, community and health support under national branding, aligned with NSFT's planned Neighbourhood Mental Health Centres to avoid duplication. • Estate constraints limit hub options, so stronger coordination using estate mapping is needed to maximise colocation and community assets, especially rurally, and improve early years/Special Education Needs & Disabilities pathways. **Next steps** • Coordinate obesity and hub development, aligning with Public Health and ensuring Family Hubs and Neighbourhood Mental Health Centres are planned together to avoid duplication. • Strengthen governance and coproduction, clarifying which services can safely collocate and building shared purpose despite estate and cultural constraints. • Use estate mapping and ongoing engagement to identify viable locations, supported by regular NSFT updates to maintain progress and shared learning.

3.13 Final Quality report from WSA	• Final update showed strong assurance work and a move to a new quality framework, with actions improving key outcomes. • From 1 April, quality shifts into strategic commissioning under a Juran based-, collaborative culture.
3.14 Lakenheath full Award – Mid & Babergh universal bid - Sport England update	Lakenheath Full Award invests in children, young people and community health through a place-based approach, with strong evaluation • Further detail on projects has been requested by Sport England ahead of May decisions on investment. • Sudbury's £475k Universal Offer is a test and learn model to strengthen prevention and reduce inequalities. • The need for a more coordinated childhood obesity approach was highlighted; an existing strategy is in place with Public Health ahead of the May Sport England meeting. **Action:** - An offline discussion between Adult Social Care and St Nicholas Hospice representatives to be convened on piloting strength and balance classes in care homes to reduce falls.

3. Conclusion

3.1. Content - Any questions, concerns or comments to be shared with West Suffolk Alliance

4. Recommendations

All actions and recommendations are contained within each programme specific section in this report.

4. EMPOWERED TO IMPROVE

4.1. People & Organisational Development Committee - Committee's Key Issues (ATTACHED)

To Assure

Presented by Heather Hancock

NHS
West Suffolk
NHS Foundation Trust

COMMITTEE/SUBGROUPS REPORT

Originating Committee: People & Organisational Development Committee			**Reporting to: Trust Board 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:**		
			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
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. Issues with use of the Bradford Score were also identified for review	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 risk register through the organisation	Once work to thoroughly review the risk register, and to refine the BAF is complete a greater level of assurance is expected. Work is progressing at a good pace.	1. No escalation

Originating Committee: People & Organisational Development Committee			Reporting to: Trust Board 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:**		
			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
6.2	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
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	There is a need to ensure that the current regulations are fully understood all options reflected in	2. To MEG as part of business planning

Originating Committee: People & Organisational Development Committee			Reporting to: Trust Board 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:**		
			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
			reductions in overtime claims. Issues remain in medicine division.	the proposed business cases. Need DoF oversight.	
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 transformation with planning for the New Hospital Programme	1.0 No escalation

Originating Committee: People & Organisational Development Committee			Reporting to: Trust Board 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:**		
			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
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?

4.2. Putting You First Award (ATTACHED)

To Assure

Presented by Greg Bowker

West Suffolk
NHS Foundation Trust

Putting You First awards

January 2025 – March 2026 winners

Board of Directors: 27 March 2026

Compassionate care,
healthier communities

Putting You First (PYF) awards

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

Nominations can be made by any member of WSFT staff at any time in the year. All nominations are collated by the communications team and sent to the chief people officer during the first or second week of every other month.

The nominees are reviewed by members of the executive group and winners selected. The citations are included in the following Trust Board report.

Sponsors of unsuccessful nominees are signposted to our Radar ‘Star’ scheme as an alternative way of celebrating and recognising their colleague(s).

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

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Lee Ranson, Michelle Boor, and Rachel Grimwood - volunteer services lead, placements coordinator, and academies coordinator (respectively)

Nominated by the Council of Governors

The Volunteer Services Team, small but amazing, has consistently shown outstanding dedication in supporting volunteers, patients, visitors and staff. The office door is always open to volunteers who receive immediate attention to concerns, support and a friendly chat. They manage student placement and over 300 volunteers, including continuous recruitment processes. They are the first port of call for patients and relatives seeking PALS advice, as PALS no longer staffs the office in the reception area.

Lee Ranson, the voluntary services Lead, has liaised with the PALS manager to ensure processes are in place to support those needing contact with PALS. Most recently the volunteer services staff have been on the frontline, by virtue of their position behind the reception desk, in dealing with the numerous issues arising as a result of new car parking arrangements. Once again, Lee has negotiated processes to ensure car park users can be supported by volunteer reception staff most effectively.

All estate issues within the reception area, tend to be reported to the volunteer office where appropriate action is taken. They also manage any lost property found on the premises. Lee has established improved communication with and between volunteers by writing a monthly newsletter, running regular forums and ensuring every volunteer receives the Trust's Green Sheet. In addition, volunteers feel appreciated by receiving frequent thanks from the team and by being invited to an annual tea party where long service rewards are presented.

On behalf of Governors we would like to request that the volunteer services team, Lee, Rachel and Michelle, receive a Putting You First Award. This is in recognition of not only managing volunteers with support and good humour but for taking on all the extra responsibilities which, fall to them by virtue of their office position in the reception area.

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Joshua Hammond, Darren Stobart, Callum Brown, Mark Hinde, technicians, estates team

Nominated by Nicola Cottington, chief operations officer

The team went over and above the call of duty when the West Suffolk Hospital site experienced a power cut which led to multiple issues which needed to be addressed. Although the generator kicked in, there were many problems for Josh and Darren to deal with overnight in order that we could continue to provide the best quality patient care.

I am aware they were on site until at least 0230, maybe later. Callum Brown and Mark Hinde took up the reins in the morning. There were issues with the boilers leaking which disrupted heating and hot water to several patient areas. The leaks took some time to fix and then there were a number of air locks to be resolved before the heating and hot water were working again. This is an inspiring example of how our estates team are integral to the delivery of care and how they showcase the WSFT values.

Darren Stobbart, senior team leader electrical

Nominated by Ady Powell, estates operations maintenance manager

Darren has worked for the Trust for nearly 20 years always in Estates. During the last 12 months estates have experienced unprecedented demand and staffing shortages. Following the departure of the Mechanical Senior team lead Darren helped me to cover that vacancy for nearly a year taking on additional work. His knowledge of the site is exceptional and given the number of significant failures we have experienced this year that has proved invaluable. His flexibility to his role is another of his strengths and he is willing to drop everything, even on a day off, and help his colleagues to resolve major issues.

Darren holds a number of AP roles and is the electrical lead. Following the departure of Luke Goldfinch he assumed even more responsibility in this area. Darren is a cheerful individual who leads by example and has been instrumental in dealing with a number of significant and delicate HR issues in the past 12 months. Not all heros wear capes and Darren doesn't need one. A dedicated individual who puts the Trust first to ensure our patients are able to get the best care possible in the best environment

Michael Jones, chaplaincy and spiritual care

Nominated by Sarah Ward, deputy chief nurse

Michael is a much-valued member of the spiritual care team and most recently during a period of staff absence within the Chaplaincy department, has demonstrated exceptional commitment and flexibility to ensure continuity of support to patients, their families and the Chaplaincy leadership.

We experience Michael as a deeply modest, humble team member, who epitomises our Trust values. This is just a small recognition of our appreciation of what he brings to the organisation. We also wanted to acknowledge that he recently celebrated a significant birthday (80th) and celebrate him as a colleague.

Ehab Georgy, team lead, early supported discharge (ESD) service

Darren Evans, rehabilitation assistant practitioner

A relatively new member of the team attended for an initial assessment. The property was found to be dilapidated with broken windows and a loud barking dog could be heard on arrival. The therapist felt unsafe and called Ehab, his response, "I'm on my way".

Ehab attended and completed a double up visit with the therapist. The therapist felt supported and the visit went well even though Ehab nearly fell through the floorboards in the property. A true example of leading from the front, well done Ehab.

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Charlotte Hughes, Harriet Ziegler, Patricia Chilton, Amy Stokes, Charlotte Poole and Lise Catchpole, community SALT

Nominated by Madeleine Howden, speech and language therapist

I would like to nominate this team of six therapists for a Putting You First Award in recognition of their creativity, commitment, and impact on children with Developmental Language Disorder (DLD).

The team identified a gap in provision for children who needed practical, accessible strategies to support their language difficulties and responded by designing and delivering an innovative training programme: SLIC5 (Skills for language in the classroom). SLIC5 is a five-week group intervention created to empower children with DLD. The team collaboratively developed engaging, child-centred sessions that focused on practical strategies children could understand and use with confidence. They successfully piloted the group, demonstrating not only clinical expertise but also a willingness to evaluate, and refine practice for the benefit of service users.

Feedback from both children and school staff has been amazing! Children reported that they loved attending the sessions (and were sad when they ended!), and school staff observed increases in confidence and self-advocacy. This reflects the team's strong commitment to inclusivity and fairness, ensuring that children with communication needs are supported in a way that values their strengths and voices.

The team's work embodies our Trust values. Respect and safety in the way sessions were designed to be supportive and empowering.

Teamwork was central throughout, with all six therapists contributing ideas, sharing responsibilities, and supporting one another to deliver a high-quality programme. Their dedication has resulted in meaningful, lasting benefits for children and schools, making them truly deserving of this award.

Chloe Ames, registered nurse associate

Nominated by Gill Cooksey, practical education facilitator

West Suffolk NHS Foundation Trust

During a recent NMCC meeting Chloe delivered a presentation around the use of a lantern on F7 and the impact this was having on colleagues, relatives and patients at the end of life. Her simple idea held enormous impact for these groups and showed compassionate, person-centred care and its importance in care.

The idea has been well received across the Trust and many areas are looking to adopt the idea and implement in their own departments to improve care for this group of patients. It is a commendable innovation to care that has had great impact. What I noticed during the meeting was Chloe's professionalism and excellence in delivering her idea/project to senior leaders across the Trust, the (virtual) room fell silent. It was this impact that took us all back to why we work in care and why we chose a career helping others.

The 2nd line impact of this supports our patients, through innovation, education and reinforced the fundamental aspects of care. Thank you for sharing your idea and thank you for delivering an excellent presentation to share this with others to bring about change.

Compassionate care, healthier communities

4.3. National Staff Survey Report (ATTACHED)

Presented by Julie Hull

Trust Board

Report information

Report title: 2025 NHS Staff Survey results
Agenda item: 4.3
Sponsor/Executive lead: Julie Hull
Report prepared by: Philippa Lakins, organisational development manager; Greg Bowker, head of communications
Previously considered by: Management Executive Group
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 NHS Staff Survey is one of the largest workforce surveys in the world, carried out every year to help Trusts understand the experiences and views of their staff.

The survey captures scores across nine key themes that encompass the people promise; we are compassionate and inclusive, we are recognised and rewarded, we each have a voice that counts, we are safe and healthy, we are always learning, we work flexibly, we are a team, staff engagement, and morale.

The full results for the 2025 survey – as well as those for other Trusts – are available online at nhsstaffsurveys.com.

So what?
In recent years, West Suffolk NHS Foundation Trust has seen a decline in its scores. The results of the 2025 NHS Staff Survey were published on 12th March 2026 and this paper provides the headlines from our results, along with next steps as we develop our action plan in response.

The Trust's survey results are an important indicator of staff motivation, involvement, engagement, and advocacy. Since the 2024 results were published, several teams have been undertaking dedicated action to both improve our scores and show that we act on the issues our colleagues raise.

The 2025 results are an opportunity to report the impact of this activity, identify progress, and acknowledge areas where targeted action is needed. We know staff want to hear about the staff survey results and how their views will be used to shape the actions we take.

What next?

The Trust's scores have been analysed and a summary of the results is provided. These have also been discussed at Management Executive Group to recognise progress and help identify areas of targeted action.

In the coming weeks, our action plan will be developed. This will involve teams across the Trust working together and taking deliberate action to improve the experience of colleagues in areas identified as concerning. Our focus will be on the recommender scores: "recommend as a place to work" and "Care of patients/service users a top priority".

The Board is invited to review the 2025 results and reflect on the priority areas we have so far identified for the action plan.

As with previous years, the finalised action plan will be brought to the People and Organisational Development Committee, which is where the delivery will be monitored.

Action required:

The Board is asked to note the headlines from the Trust's 2025 NHS Staff Survey results and areas of focus for the coming year.

Governance and compliance

Risk and assurance: Organisational risk arising from a failure to act in response to survey results. These scores impact on NOF and other ratings, as well as public perception. Staff survey results are also used as metrics for delivery against the new organisational strategy.
Equality, diversity and inclusion: All colleagues should feel able to share their views through staff engagement exercises, knowing those views will be acted upon. The NHS Staff Survey provides and annual opportunity to identify the differences in experience between colleagues working in the Trust, helping us to develop plans that address any issues.
Sustainability: N/A
Legal and regulatory context: Compliance with national requirements

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NHS Foundation Trust

2025 NHS staff survey results, analysis and action plan

March 2026

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Survey completion summary

NHS
West Suffolk
NHS Foundation Trust

Organisation details

Survey Coordination Centre NHS

West Suffolk NHS Foundation Trust

2025 NHS Staff Survey

Organisation details

Completed questionnaires	2438
2025 response rate	45%

This organisation is benchmarked against:

Acute and Acute & Community Trusts

Survey details

Survey mode	Mixed

2025 benchmarking group details

Organisations in group: 121

Median response rate: 47%

No. of completed questionnaires: 524528

For more information on benchmarking group definitions please see the Technical Guide.

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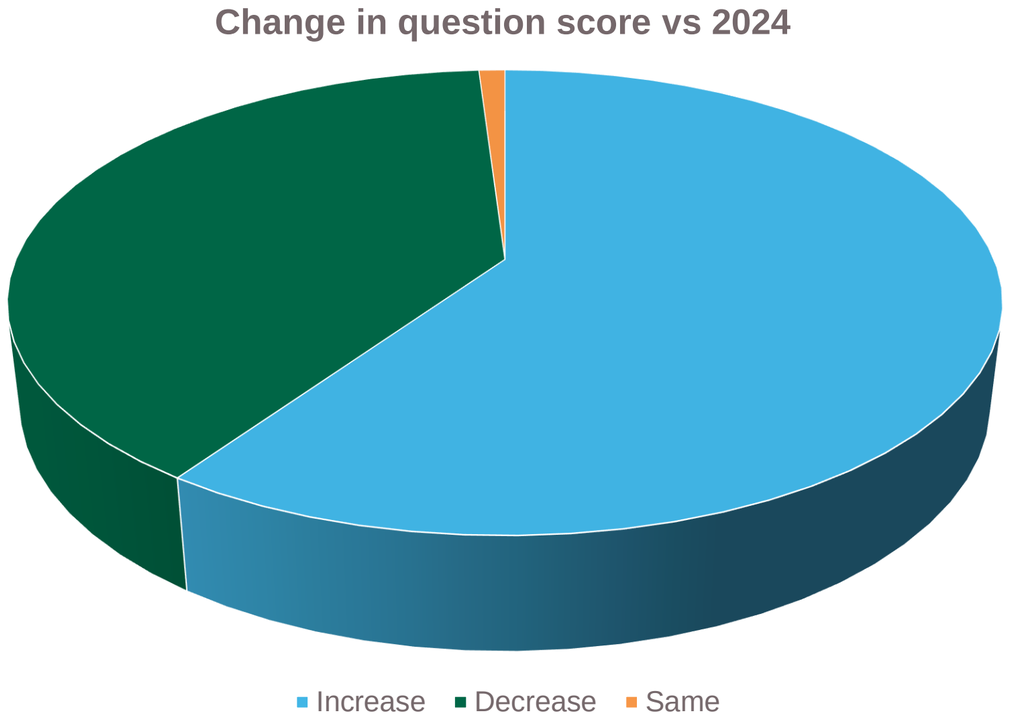
Results

In 2024, the Trust experienced a significant drop in scores throughout the survey. However, in 2025 the Trust has **improved in 59 out of 99 questions vs 2024** (that can be compared to last year and positively scored; 19 of these significantly). While there is still considerable progress to be made before the Trust reaches a stronger overall position, these early signs indicate a degree of stability from which further improvements can now build.



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Most improved and most declined scores

Most improved scores	Org 2025	Org 2024
q11a. Organisation takes positive action on health and well-being	46%	41%
q9g. Immediate manager listens to challenges I face	73%	68%
q9c. Immediate manager asks for my opinion before making decisions that affect my work	60%	56%
q19d. Feedback given on changes made following errors/near misses/incidents	53%	49%
q19a. Staff involved in an error/near miss/incident treated fairly	57%	53%

Most declined scores	Org 2025	Org 2024
q3i. Enough staff at organisation to do my job properly	21%	27%
q3h. Have adequate materials, supplies and equipment to do my work	43%	47%
q25a. Care of patients/service users is organisation's top priority	59%	63%
q12f. Never/rarely feel every working hour is tiring	47%	51%
q13a. Not experienced physical violence from patients/service users, their relatives or other members of the public	85%	88%

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Increases and improvements

- Key areas targeted in last year's action plan showing improvements:
  - Organisation takes positive action on **Health and wellbeing**, increased from 41.3% - 45.9% - the highest increased score from the survey
  - All 9 measures in relation to the questions related to "**Your Manager**" increased, with some questions showing the highest scores for the 5 years of records, showing positive impacts of the Leaderships and Manager interventions by L&D
  - Improvements in the questions in relation to **retention** e.g. "I am not planning on leaving the organisation" and "I don't often think about leaving the organisations"
  - Improvements in relation to questions relating to **Speaking Up** and **errors/near misses**
  - 3 out of 9 **engagement** measures (including all involvement scores) have improved vs 2024 staff survey; however, all 9 have improved since the most recent results in Q2 2025 Pulse survey.

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Opportunities and areas of focus

NHS West Suffolk NHS Foundation Trust

- Areas of decline / potential focus for 2026:
  - Questions in relation to **burnout** and **exhaustion**
  - Questions in relation to **career development and progression**
  - Questions around enthusiasm for job and **looking forward to going to work**
  - "**Care of patient/service users a top priority**" declined from 62.8% to 59.5% vs 2024 staff survey but has shown a considerable increase on the July Pulse survey when it was 45.5%. The highest it has been in the past 5 years was 2021 - 77.6%
  - "**Recommend as a place to work**" **–** stayed static 49.4% - 49.1% vs 2024 staff survey but has shown a considerable increase on the July Pulse survey when it measured 28.6%. The highest that it has been in the past 5 years was in 2021 when it was 65.1%

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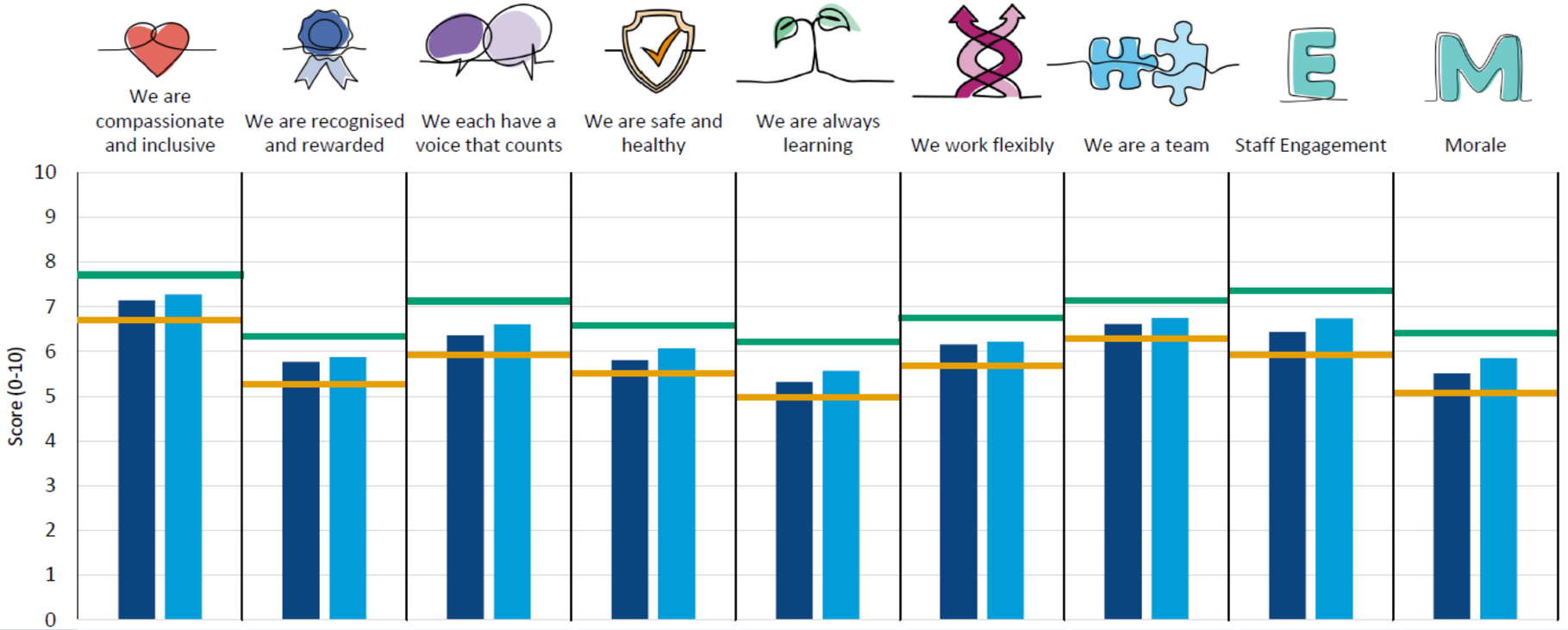
People promise elements and themes

West Suffolk NHS Foundation Trust

People Promise elements and themes: Overview

Survey Coordination Centre NHS

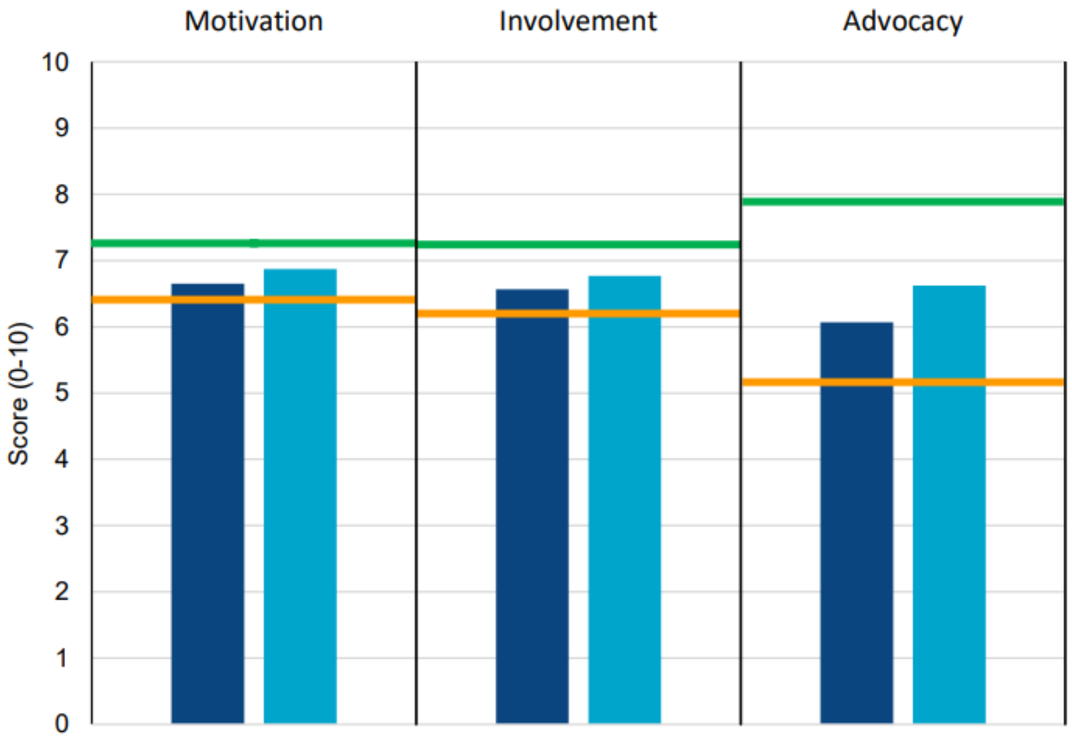
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.15	5.77	6.36	5.80	5.32	6.16	6.61	6.43	5.51
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	2434	2429	2416	2417	2309	2423	2428	2432	2432

Engagement scores

Theme: Staff engagement



	Motivation	Involvement	Advocacy
Your org	6.65	6.57	6.07
Best result	7.26	7.24	7.89
Average result	6.87	6.77	6.63
Worst result	6.41	6.20	5.17
Responses	2417	2430	2424

Both WSFT and the benchmark average showed a slight decline in overall engagement score vs 2024. WSFT's score was 6.43 vs the benchmark of 6.74 but the rate of decline was comparable.

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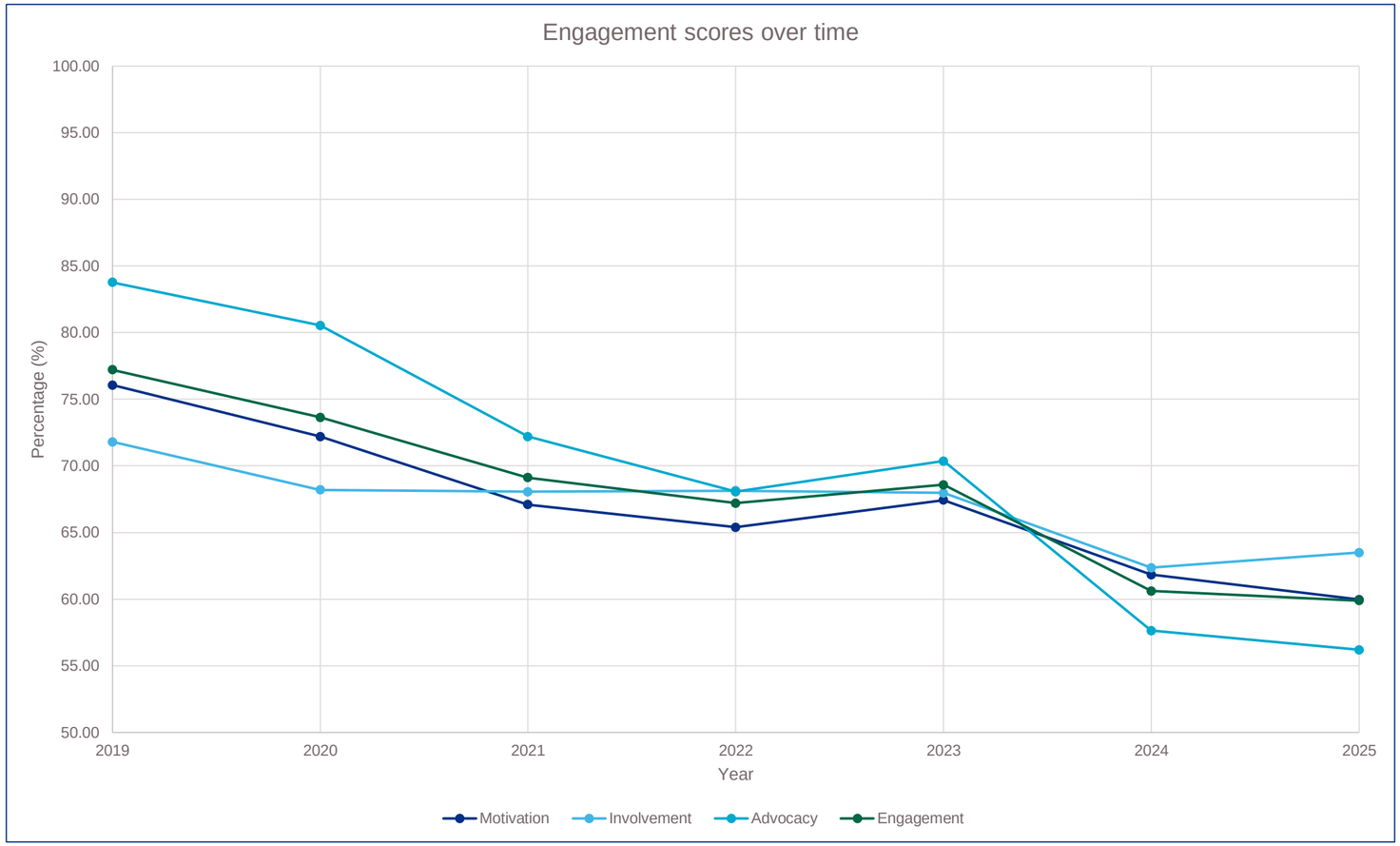
WSFT Engagement scores over time



	2019	2020	2021	2022	2023	2024	2025
Motivation	76.07	72.20	67.10	65.40	67.43	61.83	59.97
Involvement	71.80	68.20	68.07	68.13	67.97	62.37	63.50
Advocacy	83.77	80.53	72.20	68.07	70.37	57.63	56.20
Engagement	77.21	73.64	69.12	67.20	68.59	60.61	59.89

The graph shows a steady decline in engagement scores that is now beginning to level off. These declines are being reflected across the benchmark and national picture too – likely a result of financial pressures and significant change programmes.

The one engagement component that has *not* plateaued is advocacy, which continues to fall. This decline is largely driven by low scores for *"care of patients/service users is a top priority"* and *"recommend as a place to work."*

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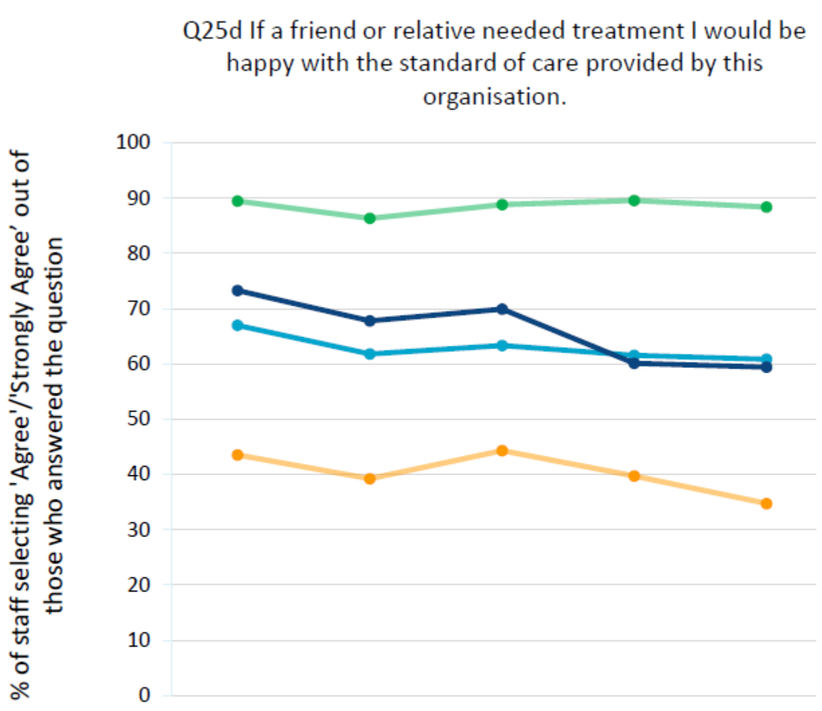
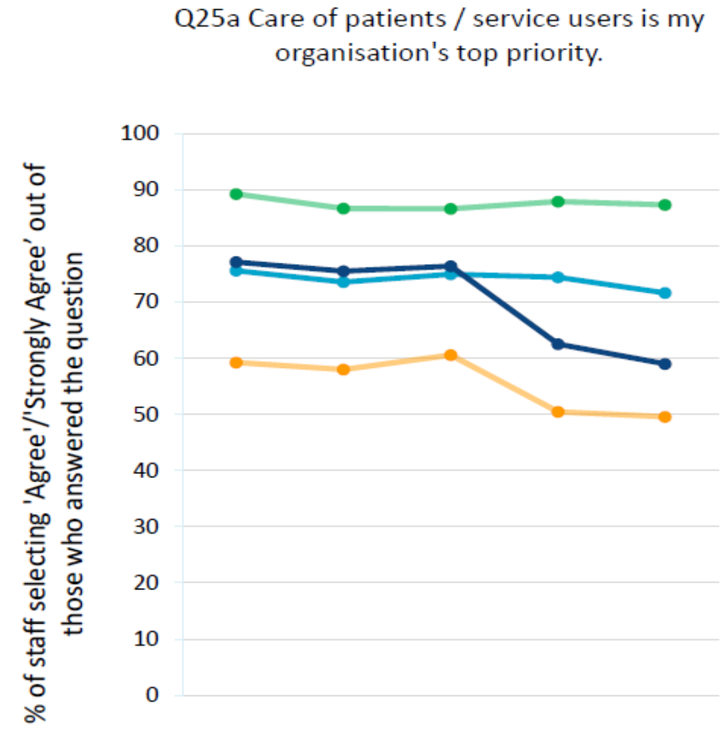
Care of patients



	2021	2022	2023	2024	2025
Your org	73.29%	67.76%	69.91%	60.11%	59.41%
Best result	89.49%	86.33%	88.81%	89.58%	88.41%
Average result	66.97%	61.78%	63.32%	61.55%	60.83%
Worst result	43.50%	39.20%	44.30%	39.68%	34.73%
Responses	1930	1978	2403	2357	2423



	2021	2022	2023	2024	2025
Your org	77.12%	75.51%	76.38%	62.53%	59.01%
Best result	89.24%	86.64%	86.62%	87.88%	87.31%
Average result	75.58%	73.58%	74.95%	74.42%	71.63%
Worst result	59.25%	57.99%	60.58%	50.48%	49.59%
Responses	1928	1973	2407	2359	2425

Scores for *"Care of patients/service users is my organisation's top priority"* sit below the benchmark average and have declined from 2024. In contrast, responses to *"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"* remain broadly in line with the benchmark.

This suggests that, while some do not feel patient care is prioritised at an organisational level, the actual standard of care delivered is still regarded as good. This prompts consideration of how the Trust can positively frame the quality-of-care narrative within our programmes of change and improvement.

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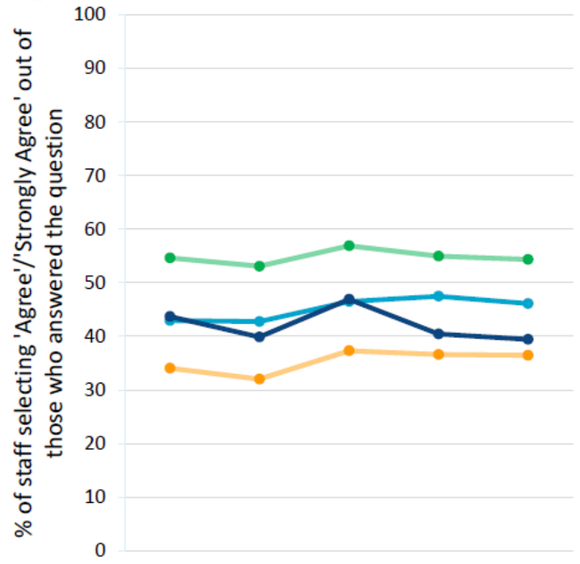
Financial pressures on work demands, resources and staffing levels

West Suffolk NHS Foundation Trust

People Promise elements and theme results – We are safe and healthy: Health and safety climate

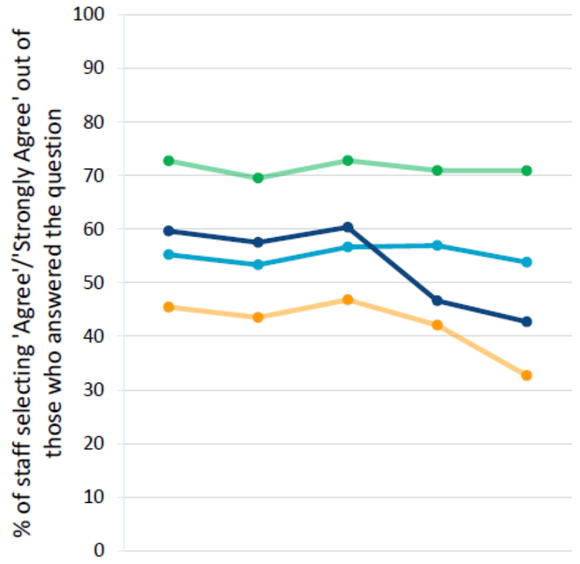
Survey Coordination Centre

Q3g I am able to meet all the conflicting demands on my time at work.



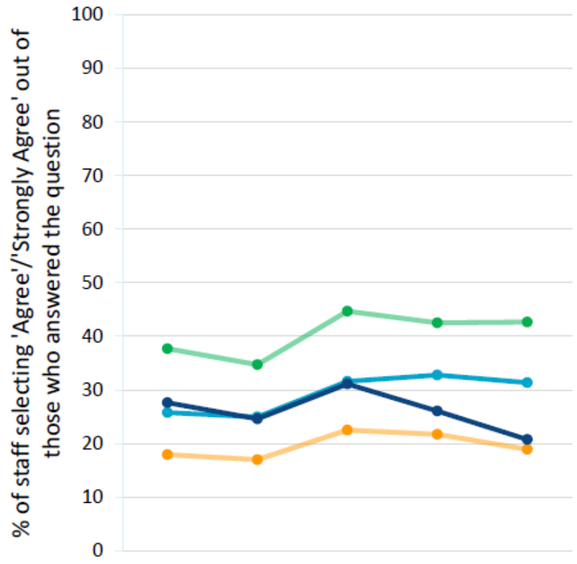
	2021	2022	2023	2024	2025
Your org	43.69%	39.88%	46.91%	40.43%	39.43%
Best result	54.61%	53.09%	56.89%	54.99%	54.34%
Average result	42.96%	42.76%	46.52%	47.47%	46.14%
Worst result	34.06%	32.02%	37.31%	36.63%	36.45%
Responses	1986	1980	2410	2363	2427

Q3h I have adequate materials, supplies and equipment to do my work.



	2021	2022	2023	2024	2025
Your org	59.64%	57.50%	60.36%	46.62%	42.73%
Best result	72.77%	69.52%	72.79%	70.96%	70.92%
Average result	55.26%	53.34%	56.68%	56.94%	53.84%
Worst result	45.45%	43.54%	46.82%	42.11%	32.70%
Responses	1989	1981	2415	2367	2429

Q3i There are enough staff at this organisation for me to do my job properly.



	2021	2022	2023	2024	2025
Your org	27.61%	24.60%	31.12%	26.08%	20.76%
Best result	37.72%	34.72%	44.68%	42.50%	42.65%
Average result	25.79%	24.95%	31.62%	32.78%	31.34%
Worst result	17.94%	17.00%	22.52%	21.73%	18.91%
Responses	1993	1981	2416	2366	2429

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EDI Results – Race

- The results show that global majority colleagues scored higher in 63 out of 101 questions asked compared to white colleagues (improved from 50 out of 101 in 2024), with the following areas coming out particularly strongly in questions relating to:
    - Manager support
    - Organisation take positive action on health and wellbeing
    - Occurrence and quality of appraisals; and access to personal/professional/career development opportunities
    - Having clear expectations, understanding responsibilities and being able to cope with demand pressures
    - More likely to recommend as a place to work than their white colleagues (65.2% v 46.3%)
    - More likely to say that care of patients is the organisations top priority than their white colleagues (71.3% v 57.4%)

- Opportunities and areas of focus:
    - Global majority colleagues experienced higher levels of discrimination from patients/service users
    - More likely to have “strained” relationships with their colleagues, less likely to “enjoy” working with their colleagues, and to “have a strong attachment” to their team
    - They are more likely to work extra unpaid hours and less likely to work extra paid hours than their white colleagues

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EDI Results - Disability

NHS
West Suffolk
NHS Foundation Trust

- The results show that colleagues who have a disability scored lower in all but 4 questions asked compared to colleagues who do not state that they have a disability, indicating that they are not having as positive experience in the workplace here.

- 71.9% of colleagues with a disability stated that the “organisation made reasonable adjustment(s) to enable me to carry out my work”

- 572 of the 2438 respondents stated that they have a disability, equating to 23.4% of the respondents. This figure is considerably higher than the numbers registered through ESR, which is approx. 6.5%. Understanding and identifying who these colleagues are and giving them the confidence to come forward and declare their disability, should allow their managers/the organisation to explore options to support them better. The “Make the most of your profile” campaign currently running aims to encourage disclosure.

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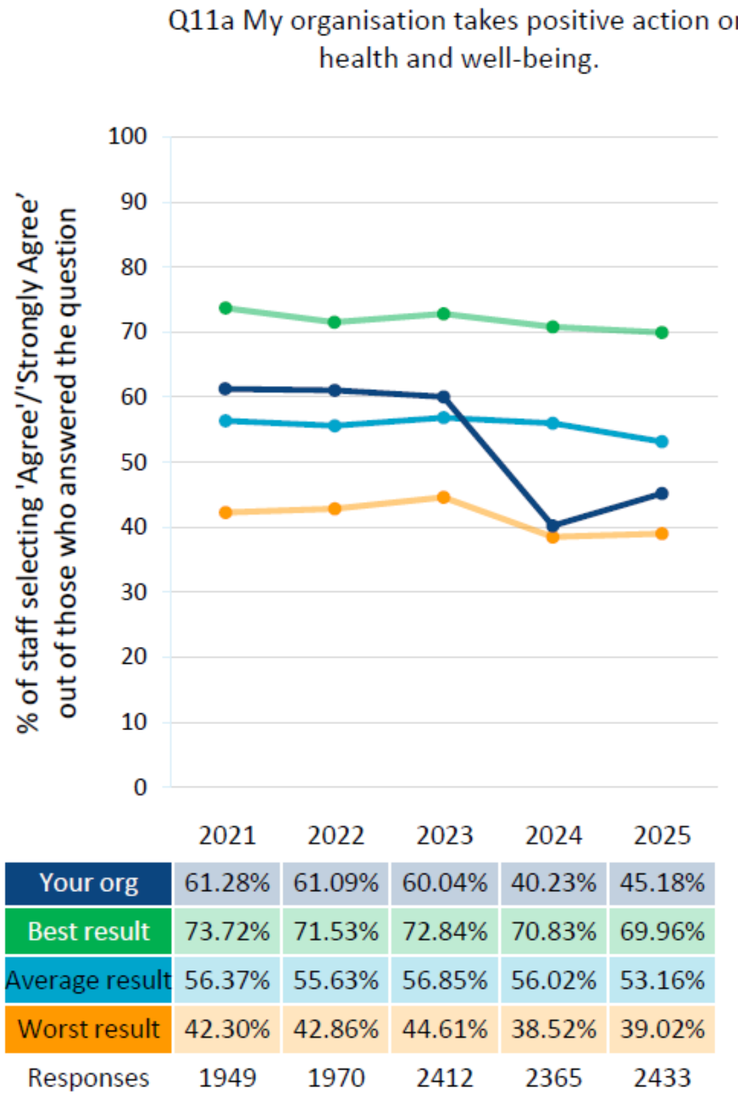
Health and wellbeing



	2021	2022	2023	2024	2025
Your org	61.28%	61.09%	60.04%	40.23%	45.18%
Best result	73.72%	71.53%	72.84%	70.83%	69.96%
Average result	56.37%	55.63%	56.85%	56.02%	53.16%
Worst result	42.30%	42.86%	44.61%	38.52%	39.02%
Responses	1949	1970	2412	2365	2433

There was a large decline of approximately 20% in 2024 to the question "*My organisation takes positive action on health and wellbeing*".

In 2025, this question has increased by 5%, a marked improvement but still a long way behind our peak.

The main areas of concern raised are:

- Work related stress, exhaustion and burnout
- Increase in physical violence and sexual harassment from patients/service user

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Open question – results

There was a considerable response to the open questions posed in the survey, of which the first two were additional questions added by the Trust:

1. “What support would make the most difference to your health and wellbeing at this time?" – 806 comments

2. “What suggestions do you have on how the organisation can improve its communications with colleagues?” – 657 comments

3. “If you have any additional comments about working in this organisation, please write them below” – 586 comments

A full thematic review is being undertaken on the free text comments and the Executive group will be required to identify at least 3 actions coming directly from these questions.

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Next steps

NHS West Suffolk NHS Foundation Trust

Areas for focus from initial Trust results

- Advocacy measures
  - Recommend as a place to work
  - Care of patients is a top priority
- Health and wellbeing – stress and burnout
- Career development and progression
- Flexible working – one of the big asks from the free text
- Enthusiasm about being at work – motivation, reward and recognition
- EDI – disability support and inclusion
- Communication – on-going

These areas will be included in the Trust's organisational level action plan

- Areas of focus have been discussed by MEG with the request of a full action plan to follow
- Owners for each topic of the action plan will be assigned and will use their areas of expertise to create suggestions for actions and areas of improvement, the action plan has been started in some areas but will require additions and completion by the relevant lead stakeholders. This will return to MEG shortly.
- Monitoring and assurance will be provided through People and Organisational Development Committee

Free text thematic review

- A full thematic review of free text answers is underway to identify actions, and add context and rigour to survey answers

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Next steps

NHS West Suffolk NHS Foundation Trust

Local distribution and analysis

- Completion of comparative analysis amongst directorates to identify areas of higher and lower scores, and local priorities and actions
- Creation of local action plans – teams, department and directorate, monitored through PRM

Communications to the organisation

- Our headline results have been shared with colleagues and will be discussed again in the April All Staff Update
- BAU comms on action being taken in response to Staff Survey results, as well as connecting this action to the new strategy
- 'You said, we did' - for example, launching the Each Person platform in April
- Action plan will align with the Comms & Engagement enabling strategy

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Staff survey links to the strategy

The strategic ambition 'empowered to improve' sets a lead metric as the response to the NHS staff survey question 'I would recommend my organisation as a place to work'.

Across the five ambitions, the delivery of several objectives will be measured partly by tracking our NHS staff survey results:

- Improve access, experience, and safety of services
- Embed a culture of CQI
- Nurture a safe and inclusive culture
- Promote staff health, wellbeing and development
- Strengthen leadership

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Draft action plan to address areas of concern

Issue	Trust score	Benchmark average	So what?	What next?
Q25a. Care of patients/service users is organisation's top priority	59.01%	71.63%	Concerns being raised were explained further in the open questions, stating that decisions within the organisation were being driven by finances rather than patient care, and that was having a detriment on the level of care that was being provided.	
Q25b. My organisation acts on concerns raised by patients/ service users	55.29%	68.11%		
Engagement score	6.43 (scored on 1-10 scale)	6.74	The engagement scores have continued to decline, driven by “advocacy” and “motivation” scores and with the questions “recommend as place to work” and “patients/service users are a top priority” the biggest drivers of the decline.	• Launch of the Each Person platform in May 2026 to drive recognition and motivation
Health and wellbeing	45.18%	53.16%	The main areas of concern raised were: • Work related stress, exhaustion and burnout • Increase in physical violence and sexual harassment from patients/service user	
Career development	40.10%	50.39%	Lack of career development opportunities can lead to demotivation of staff and increased turnover as staff search for these opportunities elsewhere at other organisations.	• New succession planning tool and process, currently being piloted and will be rolled out fully in 2026 • Admin review and subsequent development support
EDI	All but 4 questions lower for colleagues with a disability.		A widening disparity of experience between disabled staff and non-disabled staff.	

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COMFORT BREAK

5. RESPONSIBLE WITH RESOURCES

5.1. Finance and Performance Committee - Committee's Key Issues (ATTACHED)

To Assure

Presented by Antoinette Jackson

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Finance and Performance 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

Originating Committee: Finance and Performance 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:**		
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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

Originating Committee: Finance and Performance 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:**		
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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.	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.	2 Escalate to MEG

Originating Committee: Finance and Performance 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:**		
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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

Originating Committee: Finance and Performance 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:**		
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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

Originating Committee: Finance and Performance 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:**		
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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? *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: Finance and Performance 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

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

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

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

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

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

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

Assurance level

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

5.2. Finance Report (ATTACHED)

To Review

Presented by Jonathan Rowell

Meeting/committee title: Trust Board

Report information

Report title: Finance Report – as at 28 February 2026 (M11)
Agenda item: 5.2
Sponsor/Executive lead: Jonathan Rowell (Chief Finance Officer)
Report prepared by: Nick Macdonald (Deputy Director of Finance)
Previously considered by: N/A
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

The attached Finance Board Report details the financial position for Month 11 (February 2026).

Income and Expenditure position

The Trust has agreed a forecast deficit budget of £17.8m for the year. At month eleven, there is a year to date underspend of £2.7m against plan. Income and Expenditure (I&E) for month eleven shows a year-to-date deficit of £16.1m, compared to the planned deficit of £18.8m.

The month eleven YTD position includes £0.9m in income from industrial action and £2m in Revenue Incentive Funding from the ICB, resulting in an improvement to our forecast of £2.9m, to a deficit of £17.8m for 2025/26.

Efficiencies

The CIP plan is currently on plan at £29.0m YTD. We are now focussing on developing and implementing the 2026/27 Cost Improvement Programme (£21.8m)

The reported position is in line with the planned revised forecast deficit for 2025/26.

We continue to develop our 26/27 cost improvement programme in order to deliver our planned deficit of £12.8m in 2026/27.

Year end

We also request that the Trust Board approves the 2025/26 Annual Accounts being prepared on a going concern basis. The basis of this being that there are no plans for the Trust to demise or cease services and funding from NHSE/DHSC will be forthcoming in 2026/27 and future years.

Action required by the board: The Committee is asked to review and approve this report.

Governance and compliance

Add explainer for each of the below.
Risk and assurance: Financial risk.
Equality, diversity and inclusion: N/A
Sustainability: Financial sustainability.
Legal and regulatory context: Financial reporting.

WSFT Monthly Finance Report

2025-26 – February 2026 (M11)
Trust Board
27 March 2026

Putting you first

Executive Summary as at February 2026

West Suffolk NHS Foundation Trust

Summary
The Trust has agreed a revised forecast deficit of £17.8m. This is as a result of £2.9m Non recurrent extra funding being allocated to the Trust to enable the ICS to report a balanced position. The reported Income and Expenditure (I&E) position for M11 shows a year to date (YTD) deficit of £16.1m, compared to the planned deficit of £18.8m, showing an underspend of £2.7m. We report an in-month deficit of £1.3m.

Forecast and underlying position
The Trust is forecasting to be £2.9m ahead of the planned deficit for the year. In M11 the underlying deficit had marginally improved from £1.48m to £1.46m.

Workforce
The Trust is reporting a decrease in Whole Time Equivalents (WTEs) in February 2026 (4,780.7 WTEs) compared to February 2025 (4,932.8 WTEs), a reduction of 152.1 WTEs. The reductions relate to Nursing (39.8 WTEs), AHPs (22.2 WTEs) and A&C staff (107.9 WTEs) with an increase in Medical Staff of 20.1 WTEs. WTEs are 250.7 below the annual workforce plan as at M11 and we continue to spend zero on Agency Nursing. Since April 2024, we have reduced our staffing levels by 340.0 WTEs (6.6%).

Efficiencies
The CIP schemes were aimed at delivering £32.8m for the year. The year-to-date target was £29.0m, and this has been achieved. Delivery of CIP increases in the second part of the year and is £3.8m in February. Work to de-risk future CIP continues, with vacancy and non-pay controls remaining in place.

Cash
The cash balance as at 28 February 2026 was £9.7m compared to a plan of £1.1m. The cash balance also includes cash that is earmarked specifically for spend on capital projects. Cash is being rigorously monitored to ensure that the Trust remains on plan and does not fall below the £1.1m enforced by NHS England. The Trust has been successful in its application for further cash support in quarter 4, receiving £2m in February, and will receive a further £4m in March. The revenue support funding received is in line with our plan.

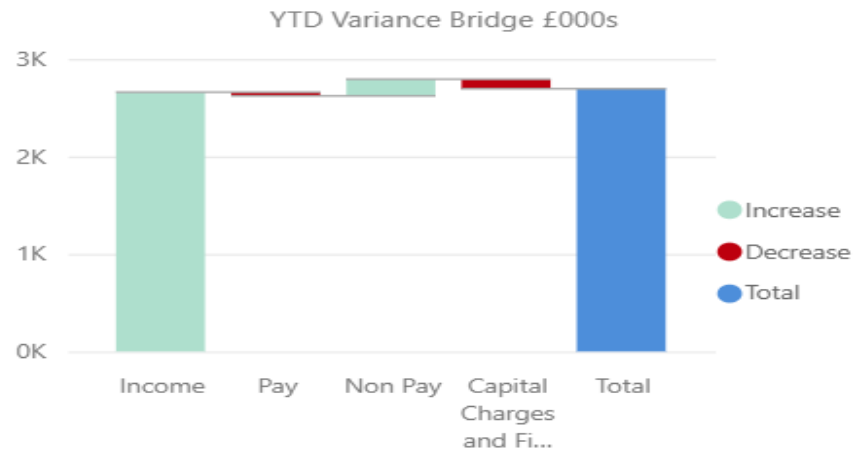
Capital
The Capital Plan for 2025/26 was agreed at £25.6m. Adjustments have been made to the plan throughout the year and at M11, capital spend was forecast to be £29.3m. £11.5m of this is internally funded, with the remaining £17.8m being funded by Public Dividend Capital (PDC). Year to date capital spend at M11 is £20m. The forecast plan is expected to be achieved.

M11 position

West Suffolk NHS Foundation Trust

	In-Month Budget £m	In-Month Actuals £m	In-Month Variance £m F/(A)	YTD Budget £m	YTD Actuals £m	YTD Variance £m F/(A)	Annual Budget £m	Forecast £m	Forecast Variance £m F/(A)
EBITDA									
Income									
NHS Contract Income	32.2	32.1	0.0	353.2	355.0	1.8	385.4	387.5	2.1
Other Income	3.3	3.5	0.2	36.5	37.4	0.9	39.8	40.7	0.9
Total	**35.5**	**35.7**	**0.2**	**389.7**	**392.4**	**2.7**	**425.2**	**428.2**	**3.0**
Expenditure									
Pay Costs	25.7	24.9	0.8	282.5	274.2	8.4	309.3	300.3	9.0
Non-pay Costs	8.6	10.2	-1.5	105.0	113.2	-8.2	113.7	122.7	-9.0
Total	**34.4**	**35.1**	**-0.7**	**387.5**	**387.3**	**0.1**	**422.9**	**423.0**	**0.0**
EBITDA Position	**1.1**	**0.6**	**-0.5**	**2.3**	**5.1**	**2.8**	**2.3**	**5.3**	**3.0**
Depreciation	**1.5**	**1.4**	**0.0**	**16.3**	**16.1**	**0.3**	**17.8**	**17.5**	**0.3**
Finance Costs	**0.4**	**0.4**	**0.0**	**4.7**	**4.9**	**-0.1**	**5.2**	**5.3**	**-0.1**
Impairments	**0.0**	**0.0**	**0.0**	**0.0**	**0.2**	**-0.2**	**0.0**	**0.2**	**-0.2**
Deficit/(Surplus)	**0.8**	**1.3**	**-0.5**	**18.8**	**16.1**	**2.7**	**20.7**	**17.8**	**2.9**

Deficit YTD £	**16.1M**	
Variance against plan YTD £	**2.7M**	**Favourable**
Movement in month against plan £	**-0.5M**	**Adverse**
EBITDA Postion YTD £	**5.1M**	**Favourable**
EBITDA margin YTD	**1%**	**Favourable**
Cash at bank	**£9.7M**	



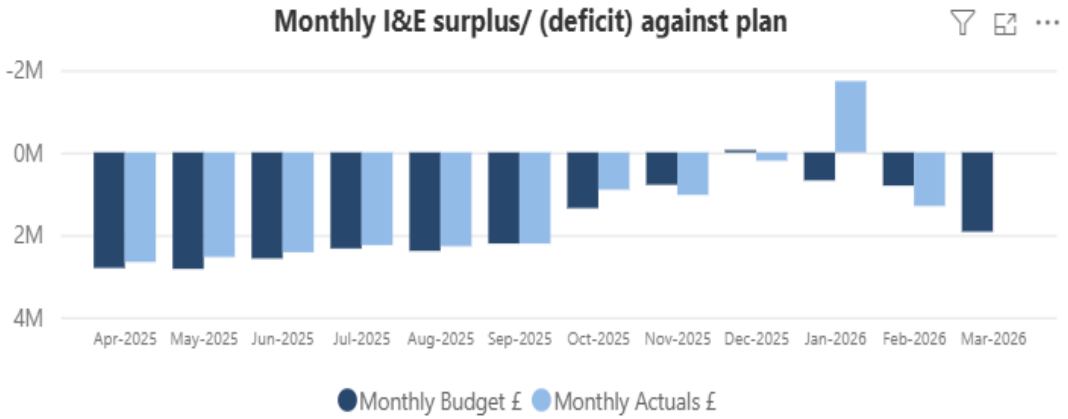
Income and Expenditure Summary – February 2026

West Suffolk NHS Foundation Trust

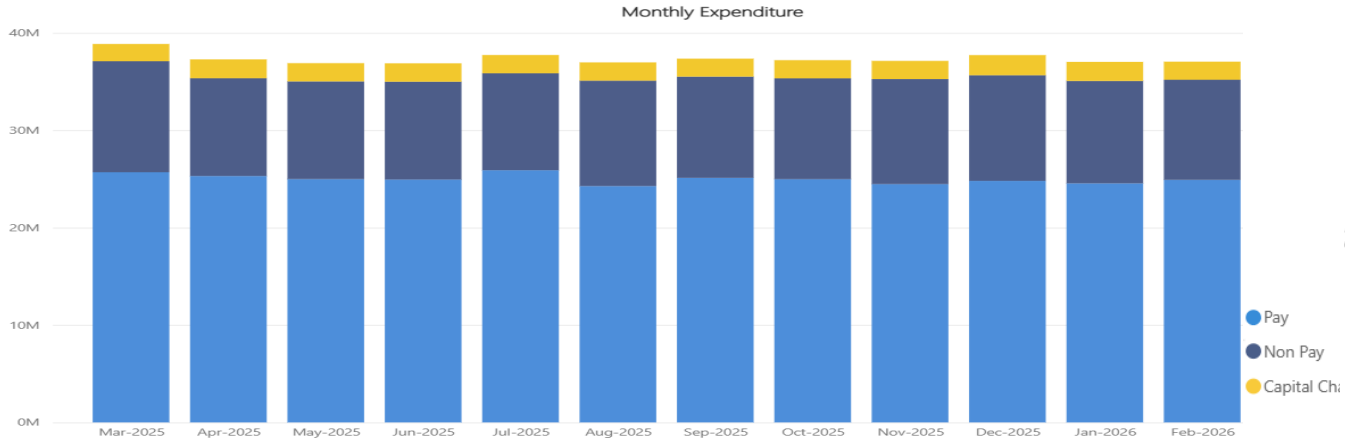
A favourable variance of £2.4m was reported in January, being £3.2m favourable YTD.

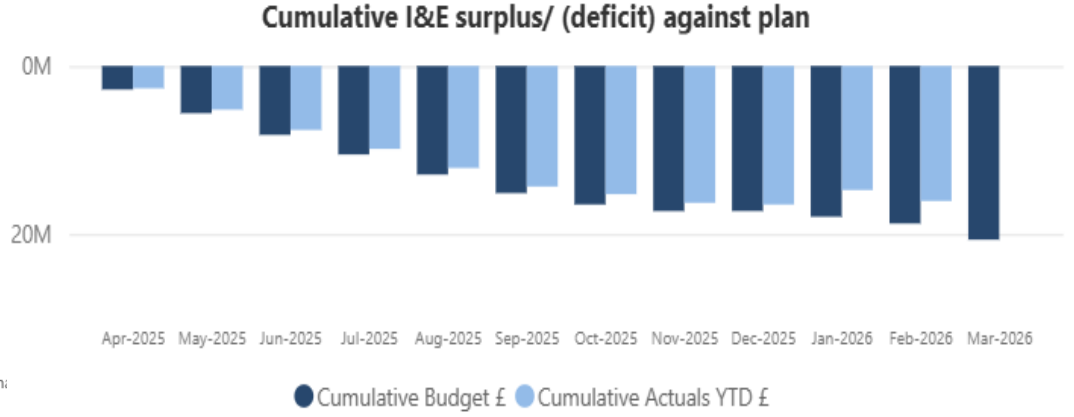
Board Report Item	Original Plan/ Target £000s	Actual/ Forecast £000s	Variance to Plan £000s F/(A)	
In month surplus/ (deficit)	-807	-1,301	-494	↓
YTD surplus/ (deficit)	-18,775	-16,081	2,694	↑
Clinical Income YTD	353,226	354,995	1,769	↑
Non-Clinical Income YTD	36,507	37,397	889	↑
Pay YTD	282,517	274,153	8,364	↑
Non-Pay YTD	104,953	113,184	-8,231	↓
EBITDA YTD	2,263	5,055	2,792	↑
EBITDA %	0.6	1.3	0.7	↑

Adverse variance > 1% ↓
Adverse variance within 1% →
On plan or favourable variance ↑



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

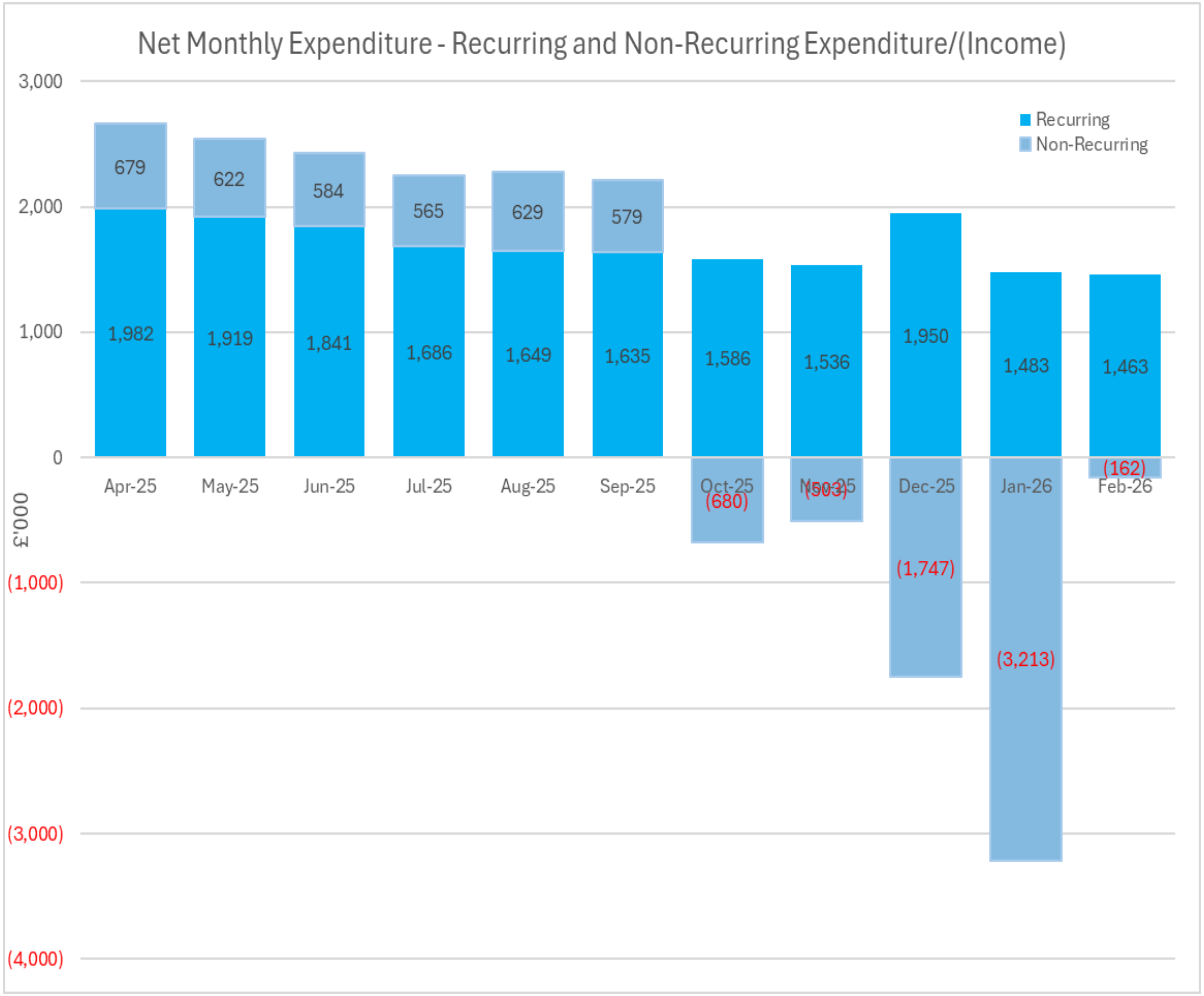




M11 recurring position

Our monthly recurring costs have reduced since June 2024 (except for the pay awards that came into effect in April 2025). Over the last five months, recurring costs have steadily improved, with a small improvement in M11.

	Apr-25 £'000	May-25 £'000	Jun-25 £'000	Jul-25 £'000	Aug-25 £'000	Sep-25 £'000	Oct-25 £'000	Nov-25 £'000	Dec-25 £'000	Jan-26 £'000	Feb-26 £'000
Net Expenditure	**2,661**	**2,541**	**2,425**	**2,251**	**2,278**	**2,214**	**906**	**1,033**	**203**	**(1,730)**	**1,301**
Recurring	**1,982**	**1,919**	**1,841**	**1,686**	**1,649**	**1,635**	**1,586**	**1,536**	**1,950**	**1,483**	**1,463**
Non-Recurring											
Income adjustment	200	250	416	336	0	0	0	(172)	(2,582)	(2,952)	(80)
HEE/ HIE income	0	0	0	0	0	0	(670)	0	0	(35)	0
Private patient income	0	0	0	(37)	(200)	0	0	(180)	0	(83)	0
Staff recharges	0	0	(136)	0	0	0	0	0	0	0	(30)
RTT recovery	0	0	0	0	0	0	0	102	74	0	0
Pay arrears / Accruals	49	350	0	(22)	(423)	148	0	110	(38)	(119)	(46)
Capitalisation arrears	0	0	0	0	0	0	0	(551)	0	0	0
Industrial Action	0	0	0	0	154	0	0	182	173	0	0
Consumables	178	(178)	0	0	0	0	0	0	0	0	0
Glemsford	0	0	0	0	0	0	0	0	580	0	0
DBS charges	0	0	0	0	0	0	0	0	0	0	90
Rent arrears	53	0	0	0	0	4	0	0	0	0	(63)
Ecare accrual	0	0	0	0	300	0	0	0	0	0	0
Utilities	0	0	(51)	0	0	78	0	0	50	0	0
External Support	300	300	330	330	330	201	0	0	0	0	0
VAT refund reversed	0	0	0	0	439	0	0	0	0	0	0
Other	(101)	(100)	25	(42)	29	148	(10)	6	(4)	(24)	(33)
Non-Recurring	**679**	**622**	**584**	**565**	**629**	**579**	**(680)**	**(503)**	**(1,747)**	**(3,213)**	**(162)**

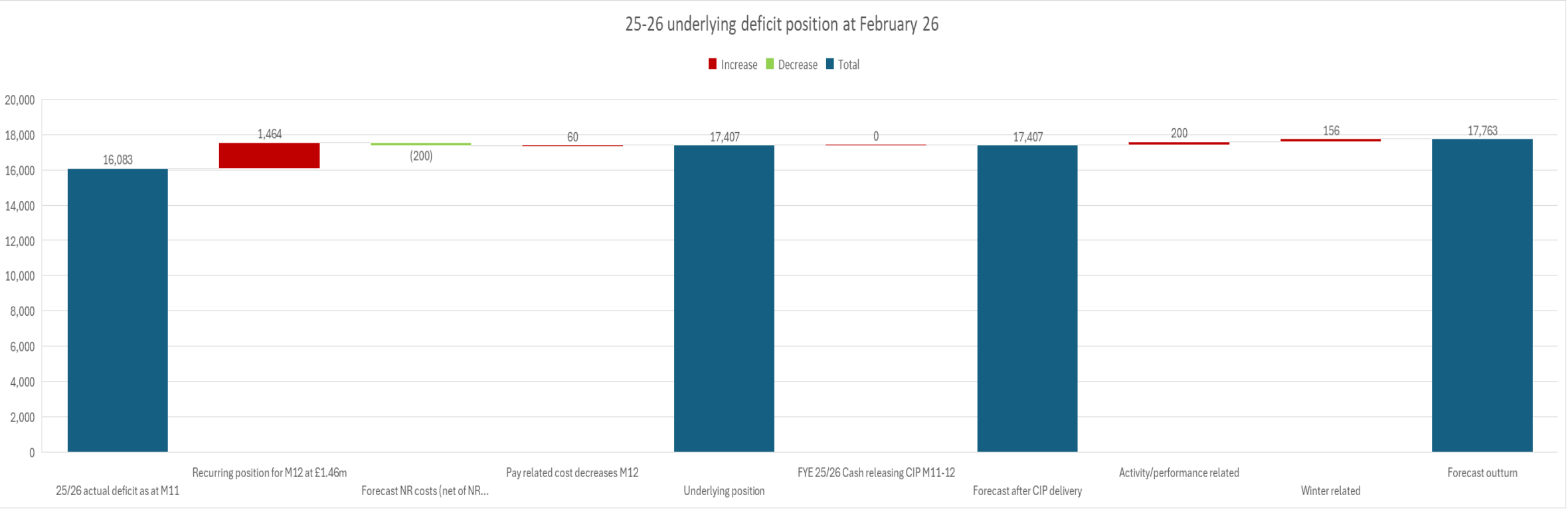


25/26 Underlying Position and Forecast

The FY25/26 plan is to deliver a deficit of £17.8m, after achieving a CIP of £32.8m

As at M11 the forecast continues to be to deliver the plan as below, assuming that the recurring position is currently broadly £1.46m deficit per month, and that CIP deliver on plan, as well as seasonal and activity related costs that we may incur during March.

The current trajectory supports delivery of the revised forecast deficit, although some adjustments to both income and expenditure are anticipated due to several RTT recovery initiatives that are expected to attract associated funding.

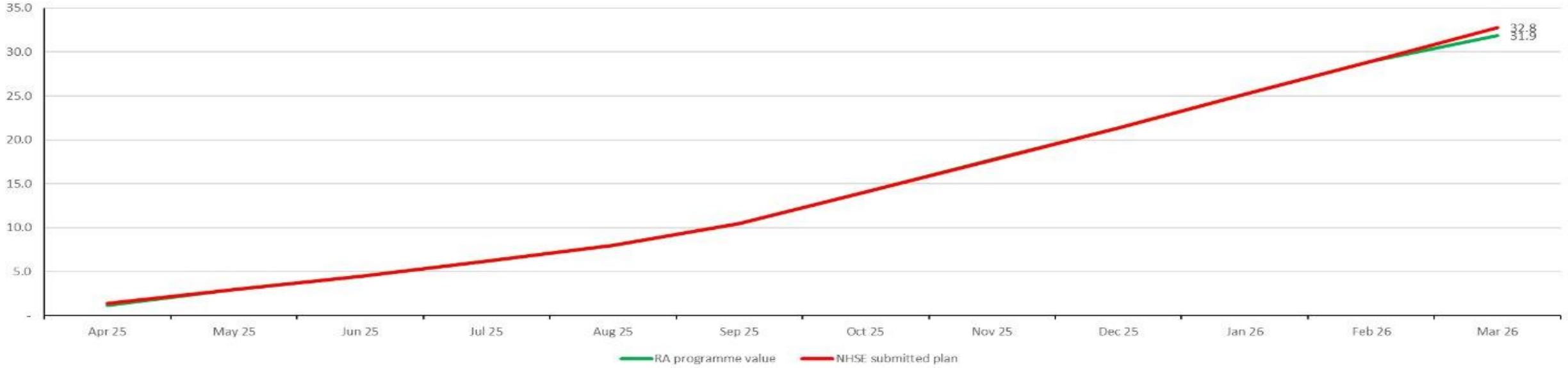


25/26 CIP Progress

YTD actual + remaining RA plan increased by £1,204k in the month (£31,862k vs £30,658k at M10), driven by:

- £1,195k performing above M11 plan.
- £10k of Risk Adjusted plan value increase.
- Remaining Risk Adjusted gap to target of £0.9m.

M11 reporting had no major operational issues.



Board	Full Year Target	M11 YTD Actuals	M12 to M12 remaining RA plans					Total Remaining Plan	Full Year Impact	Share of Target Identified	Gap
			Pipeline	Gateway 1	Gateway 2	Gateway 3	In delivery				
Corporate Services	4,200	2,016	-	73	-	-	209	282	2,298	55%	(1,902)
Clinical Productivity	11,785	6,175	1	10	1	7	867	884	7,059	60%	(4,726)
Commercial, Non-Pay, Procurement	9,079	6,965	-	0	30	57	1,123	1,210	8,175	90%	(904)
Other CIP	7,700	13,823	-	-	-	-	508	508	14,331	186%	6,631
	32,764	28,978	1	83	31	64	2,707	2,884	31,862	97%	(902)

All figures in £k, figures as at 09/03/26

Divisional Financial Performance

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

Division	In-Month Budget £000s	In-Month Actuals £000s	In-Month Variance £000s	YTD Budget £000s	YTD Actuals £000s	YTD Variance £000s	Full Year Budget £000s	Ledger Forecast £000s	Year Forecast Variance £000s
Medical Services	**7,884**	**8,291**	**-407**	**87,196**	**90,341**	**-3,146**	**94,853**	**98,476**	**-3,623**
Income	-422	-484	61	-4,667	-5,447	780	-5,089	-5,888	799
Pay	6,154	6,588	-434	67,905	70,710	-2,804	73,953	77,036	-3,083
Non Pay	2,105	2,140	-35	23,442	24,572	-1,130	25,427	26,775	-1,348
Capital Charges	47	46	1	515	507	8	562	553	9
Surgical Services	**5,881**	**5,797**	**84**	**66,299**	**65,947**	**352**	**72,383**	**71,985**	**398**
Income	-402	-475	72	-4,264	-4,707	443	-4,666	-5,306	640
Pay	4,928	4,846	82	54,237	54,833	-596	59,164	59,827	-663
Non Pay	1,327	1,408	-80	16,017	15,569	448	17,547	17,189	358
Capital Charges	28	18	10	309	252	57	337	275	63
Women and Children Services	**2,178**	**2,302**	**-125**	**24,228**	**24,940**	**-711**	**26,397**	**27,277**	**-880**
Income	-244	-419	176	-2,681	-3,458	777	-2,924	-3,721	797
Pay	2,251	2,500	-249	25,083	26,670	-1,587	27,339	29,116	-1,777
Non Pay	168	222	-54	1,805	1,722	83	1,960	1,877	83
Capital Charges	2	0	2	21	6	15	23	6	17
Clinical Support	**3,596**	**4,131**	**-535**	**40,712**	**44,963**	**-4,251**	**44,308**	**48,837**	**-4,529**
Income	-881	-693	-188	-8,844	-6,214	-2,631	-9,726	-6,945	-2,780
Pay	3,095	3,211	-116	34,433	33,844	589	37,530	36,917	613
Non Pay	1,379	1,610	-230	15,092	17,301	-2,209	16,469	18,831	-2,361
Capital Charges	3	3	0	32	32	0	35	35	0
Community Services	**5,136**	**4,891**	**244**	**57,385**	**56,539**	**846**	**62,580**	**61,594**	**986**
Income	-526	-556	30	-6,107	-6,139	32	-6,586	-6,660	74
Pay	4,006	3,849	157	45,032	43,804	1,228	49,034	47,722	1,312
Non Pay	1,594	1,549	45	17,789	18,294	-505	19,400	19,898	-498
Capital Charges	61	50	11	670	580	91	731	633	98
Facilities	**1,817**	**1,794**	**22**	**19,732**	**18,987**	**745**	**21,548**	**20,757**	**791**
Income	-441	-375	-67	-4,798	-4,305	-493	-5,239	-4,698	-541
Pay	1,277	1,181	96	13,720	13,040	680	14,997	14,275	722
Non Pay	980	988	-8	10,807	10,251	556	11,787	11,179	609
Capital Charges	0	0	0	3	1	2	3	1	2
Contract Income & Corporate	**-25,684**	**-25,906**	**222**	**-276,776**	**-285,636**	**8,860**	**-301,370**	**-311,155**	**9,785**
Income	-32,637	-32,734	98	-359,159	-362,782	3,623	-391,797	-395,715	3,918
Pay	3,056	2,724	332	33,706	31,253	2,452	37,453	33,946	3,507
Non Pay	1,185	2,364	-1,179	20,997	26,344	-5,346	22,154	27,893	-5,740
Reserves	960	0	960	8,402	0	8,402	9,791	1,428	8,363
Capital Charges	1,752	1,741	12	19,277	19,550	-272	21,030	21,293	-263
Deficit/(Surplus)	**807**	**1,301**	**-494**	**18,775**	**16,081**	**2,694**	**20,700**	**17,772**	**2,928**

Pay Costs by Staff Type

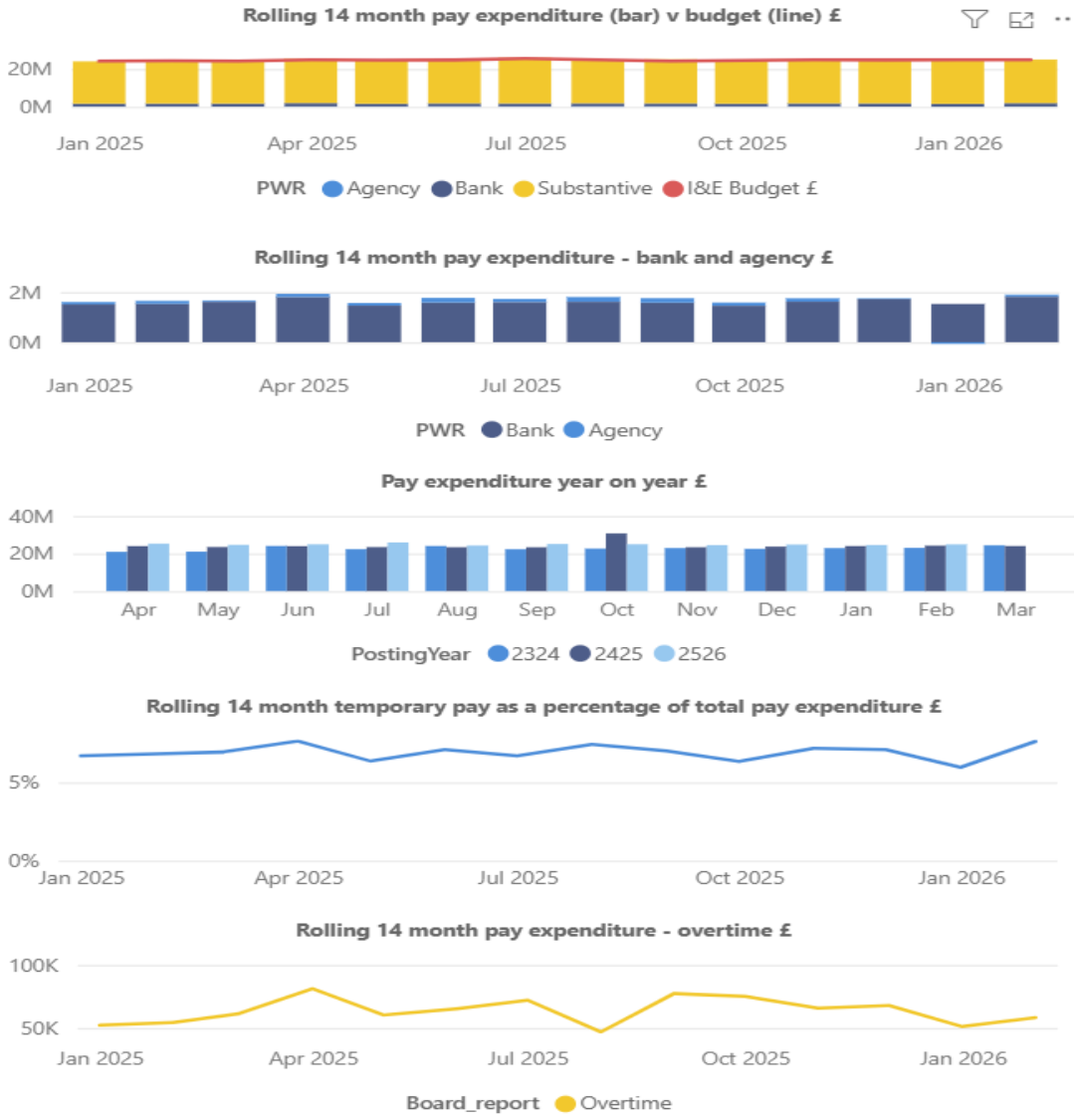
NHS West Suffolk NHS Foundation Trust

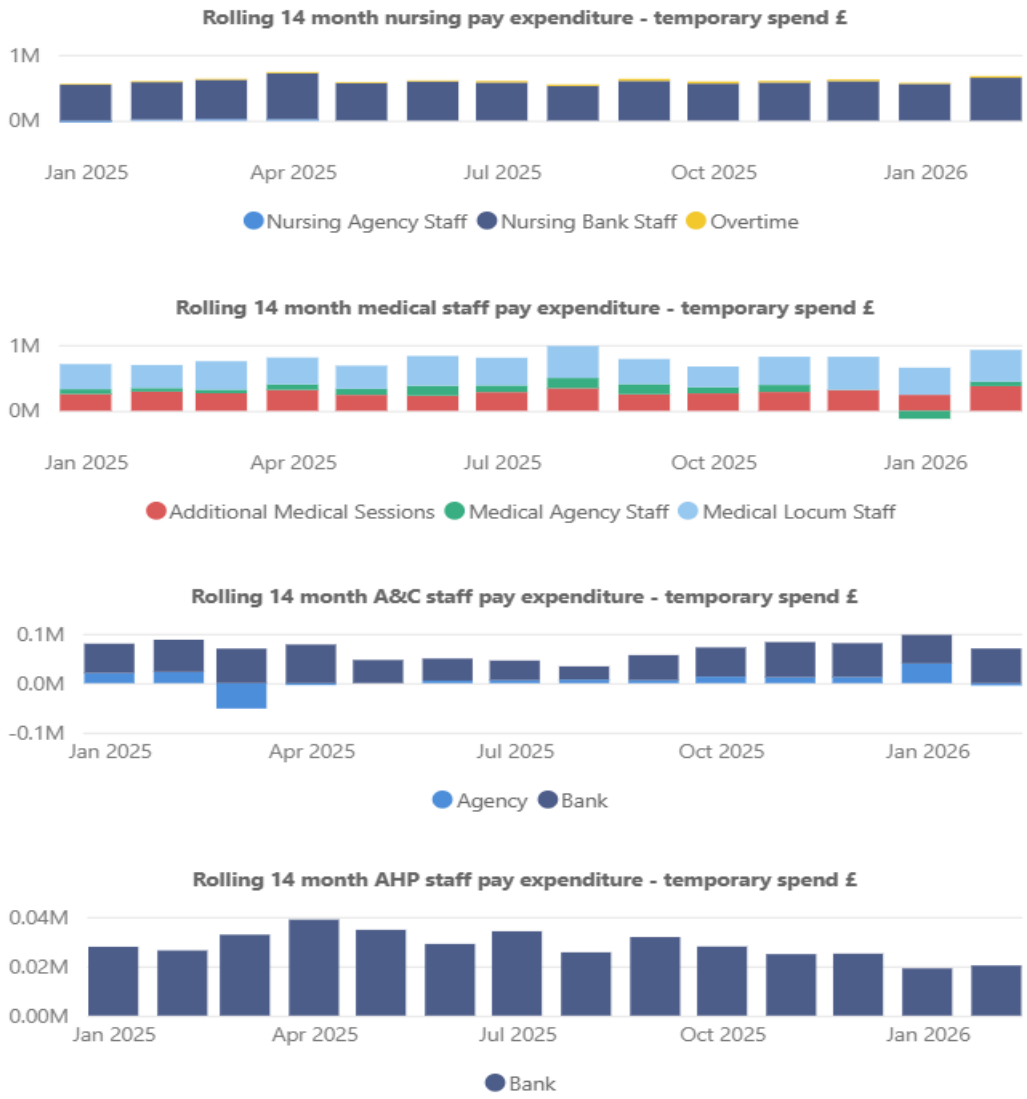
		Prior Month Actuals £000	In-Month Actuals £000s	In-Month Budget £000s	In-Month Variance £000s	YTD Actuals £000s	YTD Budget £000s	YTD Variance £000s
Substantive	Medical Staff	5,960	5,964	6,470	506	66,239	71,551	5,312
	Nursing	8,451	8,402	8,846	445	92,174	97,694	5,519
	Sci & Professional	1,180	1,185	1,267	82	12,968	13,921	953
	A&C	3,398	3,415	3,752	338	38,623	41,572	2,948
	AHP	2,444	2,412	2,791	379	26,977	30,385	3,408
	Prof & Tech	274	273	263	-10	2,805	2,892	86
	Support Staff	895	875	942	67	9,643	10,180	537
	Other	477	478	601	123	5,707	8,626	2,919
	Unallocated central funding	0	0	261	261	0	-144	-144
	Total	23,079	23,003	25,194	2,191	255,137	276,676	21,539
Additional Medical Sessions	Medical Staff	243	375	154	-221	3,149	1,872	-1,277
	Total	243	375	154	-221	3,149	1,872	-1,277
Bank & Locum Staff	Medical Staff	412	482	191	-291	4,638	1,908	-2,729
	Nursing	556	650	27	-624	6,514	304	-6,210
	Sci & Professional	12	9	2	-6	177	24	-153
	A&C	47	58	8	-50	521	77	-445
	AHP	12	15	1	-14	138	11	-127
	Prof & Tech	2	1	1	0	10	8	-2
	Support Staff	191	169	142	-27	1,925	1,553	-372
	Other	1	1	0	-1	2	0	-2
	Total	1,234	1,385	371	-1,014	13,925	3,885	-10,040
Agency	Medical Staff	-122	68	0	-68	892	0	-892
	Nursing	2	0	0	0	25	0	-25
	Sci & Professional	6	-6	0	6	10	0	-10
	A&C	40	-5	0	5	93	0	-93
	Prof & Tech	9	21	0	-21	209	0	-209
	Support Staff	0	0	-2E-5	-2E-5	-8	0	8
	Total	-66	78	-5E-5	-78	1,222	0	-1,222
Overtime	Nursing	17	27	2	-25	257	10	-246
	Sci & Professional	4	4	0	-4	70	0	-70
	A&C	11	12	7	-6	92	74	-19
	AHP	7	5	0	-5	174	0	-174
	Prof & Tech	12	10	0	-10	128	0	-128
	Total	51	58	9	-49	721	84	-637
Total		24,541	24,900	25,728	829	274,153	282,517	8,364

Pay Costs (by Staff Group)

		Prior Month Actuals £000	In-Month Actuals £000s	In-Month Budget £000s	In-Month Variance £000s	YTD Actuals £000s	YTD Budget £000s	YTD Variance £000s
Medical Staff	Substantive	5,960	5,964	6,470	506	66,239	71,551	5,312
	Additional Medical Sessions	243	375	154	-221	3,149	1,872	-1,277
	Bank & Locum Staff	412	482	191	-291	4,638	1,908	-2,729
	Agency	-122	68	0	-68	892	0	-892
	Total	6,493	6,888	6,815	-74	74,918	75,331	413
Nursing	Substantive	8,451	8,402	8,846	445	92,174	97,694	5,519
	Bank & Locum Staff	556	650	27	-624	6,514	304	-6,210
	Agency	2	0	0	0	25	0	-25
	Overtime	17	27	2	-25	257	10	-246
	Total	9,026	9,079	8,875	-204	98,970	98,008	-962
Sci & Professional	Substantive	1,180	1,185	1,267	82	12,968	13,921	953
	Bank & Locum Staff	12	9	2	-6	177	24	-153
	Agency	6	-6	0	6	10	0	-10
	Overtime	4	4	0	-4	70	0	-70
	Total	1,202	1,191	1,269	78	13,225	13,946	720
A&C	Substantive	3,398	3,415	3,752	338	38,623	41,572	2,948
	Bank & Locum Staff	47	58	8	-50	521	77	-445
	Agency	40	-5	0	5	93	0	-93
	Overtime	11	12	7	-6	92	74	-19
	Total	3,496	3,480	3,767	287	39,330	41,722	2,391
AHP	Substantive	2,444	2,412	2,791	379	26,977	30,385	3,408
	Bank & Locum Staff	12	15	1	-14	138	11	-127
	Overtime	7	5	0	-5	174	0	-174
	Total	2,463	2,432	2,792	360	27,289	30,396	3,107
Prof & Tech	Substantive	274	273	263	-10	2,805	2,892	86
	Bank & Locum Staff	2	1	1	0	10	8	-2
	Agency	9	21	0	-21	209	0	-209
	Overtime	12	10	0	-10	128	0	-128
	Total	298	305	264	-41	3,152	2,900	-253
Support Staff	Substantive	895	875	942	67	9,643	10,180	537
	Bank & Locum Staff	191	169	142	-27	1,925	1,553	-372
	Agency	0	0	-2E-5	-2E-5	-8	0	8
	Total	1,086	1,044	1,084	40	11,559	11,732	173
Other	Substantive	477	478	601	123	5,707	8,626	2,919
	Total	477	478	601	123	5,707	8,626	2,919
Other	Bank & Locum Staff	1	1	0	-1	2	0	-2
	Total	1	1	0	-1	2	0	-2
Unallocated central funding	Substantive	0	0	261	261	0	-144	-144
	Total	0	0	261	261	0	-144	-144
Total		24,541	24,900	25,728	829	274,153	282,517	8,364

Pay Costs (trends)





Workforce – WTEs by Staff Type

This month, substantive staff decreased by 13.0 WTEs. Nursing staff declined by 6.8 WTEs, Medical staff by 3.6 WTEs, and Support Staff 4.0 WTEs. However, Temporary staff increased by 17.2 WTEs, primarily relating to Bank Nursing (21.4 WTEs). Extra contracted sessions increased by 1.6 WTEs, while nursing overtime rose by 2.0 WTEs. However, Medical locum staff decreased by 9.1 WTEs and A&C agency staff fell by 3.8 WTEs, but this was negated by an increase in A&C bank of 3.6 WTEs.

		Prior Month Actuals WTE	Prior Yr Same Period Actuals WTE	In-Month Actuals WTE	In-Month Budget WTE	In-Month Variance WTE	YTD Actuals Average WTE	YTD Budget Average WTE	YTD Variance Average WTE
Substantive	Nursing	1,894.9	1,938.9	1,888.1	2,053.2	165.1	1,898.8	2,068.8	169.9
	A&C	853.7	961.8	852.7	988.2	135.5	887.0	994.0	107.0
	AHP	530.9	552.9	532.4	597.0	64.5	538.0	599.5	61.5
	Medical Staff	604.3	581.7	600.7	645.2	44.5	597.6	646.7	49.1
	Support Staff	284.0	275.7	280.0	303.2	23.2	281.5	297.7	16.2
	Sci & Professional	273.3	267.9	274.1	295.5	21.4	274.5	294.3	19.7
	Other	54.0	62.5	54.0	70.9	16.9	53.3	68.0	14.7
	Unallocated central funding	0.0	0.0	0.0	4.3	4.3	0.0	-4.3	-4.3
	Prof & Tech	55.0	51.4	55.1	54.9	-0.2	51.0	54.9	3.9
	Total	4,550.1	4,692.7	4,537.1	5,012.4	475.3	4,581.9	5,019.5	437.7
Additional Medical Sessions	Medical Staff	5.7	12.8	7.3	2.9	-4.4	8.7	3.7	-5.0
	Total	5.7	12.8	7.3	2.9	-4.4	8.7	3.7	-5.0
Agency	Support Staff	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Nursing	0.2	4.0	0.0	0.0	0.0	0.5	0.0	-0.5
	Sci & Professional	1.5	1.0	1.5	0.0	-1.5	0.5	0.0	-0.5
	A&C	5.8	0.0	2.0	0.0	-2.0	1.7	0.0	-1.7
	Medical Staff	2.7	1.6	3.3	0.0	-3.3	4.5	0.0	-4.5
	Prof & Tech	2.0	3.0	3.3	0.0	-3.3	2.6	0.2	-2.5
	Total	12.1	9.5	10.1	0.0	-10.1	9.9	0.2	-9.7
Overtime	Sci & Professional	0.7	1.7	0.6	0.0	-0.6	1.0	0.0	-1.0
	AHP	1.3	2.1	0.9	0.0	-0.9	3.1	0.0	-3.1
	A&C	1.3	1.6	1.7	0.8	-0.9	1.3	0.8	-0.5
	Prof & Tech	3.3	2.3	2.7	0.0	-2.7	3.1	0.0	-3.1
	Nursing	3.8	3.7	5.8	0.5	-5.3	5.4	0.3	-5.1
	Total	10.3	11.4	11.7	1.3	-10.4	13.9	1.2	-12.7
Bank & Locum Staff	Prof & Tech	0.6	0.2	0.3	0.3	-0.1	0.3	0.3	0.0
	Other	0.2	0.0	0.2	0.0	-0.2	0.0	0.0	0.0
	Sci & Professional	3.8	8.7	2.8	0.3	-2.5	4.9	0.7	-4.1
	AHP	2.2	3.3	2.9	0.0	-2.9	2.2	0.1	-2.2
	Support Staff	14.2	18.0	15.3	1.0	-14.3	15.5	1.1	-14.4
	A&C	14.2	18.6	17.6	2.7	-14.9	14.4	2.8	-11.5
	Medical Staff	39.4	25.5	30.3	8.7	-21.6	31.3	8.8	-22.5
	Nursing	123.6	132.1	145.0	1.8	-143.2	132.6	1.7	-130.8
	Total	198.2	206.5	214.5	14.7	-199.8	201.1	15.5	-185.6
Total		4,776.5	4,932.8	4,780.7	5,031.3	250.7	4,815.5	5,040.1	224.5

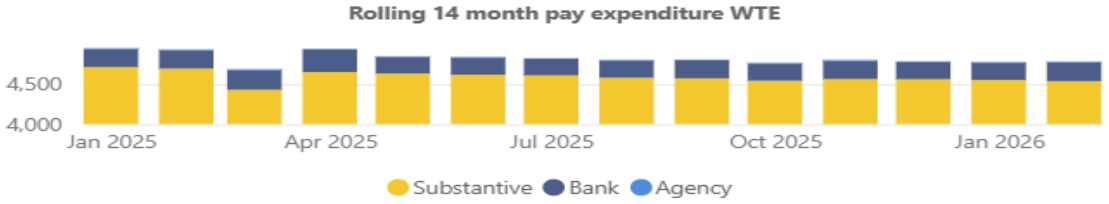
Workforce - WTE (by Staff Group)

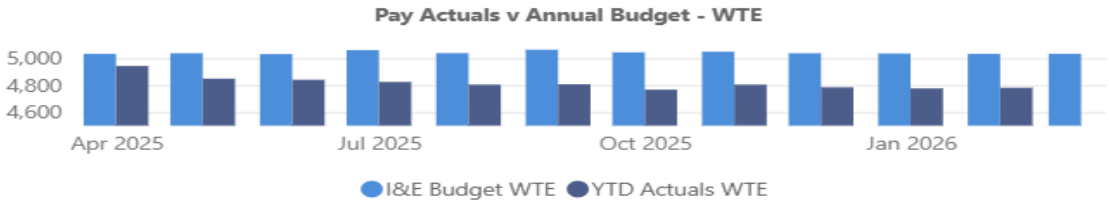
West Suffolk NHS Foundation Trust

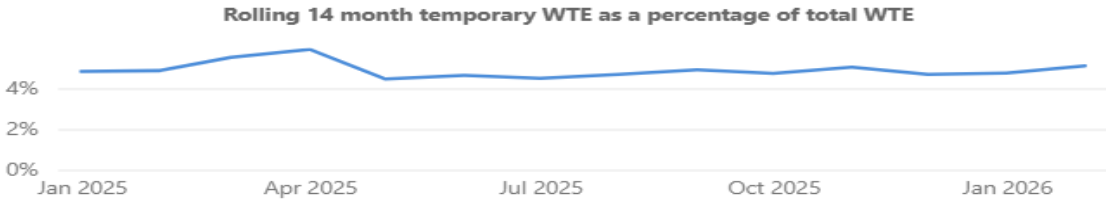
In February 2026, we report an increase of 12.0 WTEs compared to January 2026, and a decrease of 152.1 WTEs, or 3.1%, compared to February 2026. Since April 2024, there has been a total reduction of 340.0 WTEs, representing a 6.6% decrease from 5,120.5 WTEs. Medical staff increased by 20.1 WTEs over the past year, whilst nursing has dropped by 39.8 WTEs (largely relating to the closure of Glastonbury Court). The favourable variance against establishment in February 2026 is 250.7 WTEs.

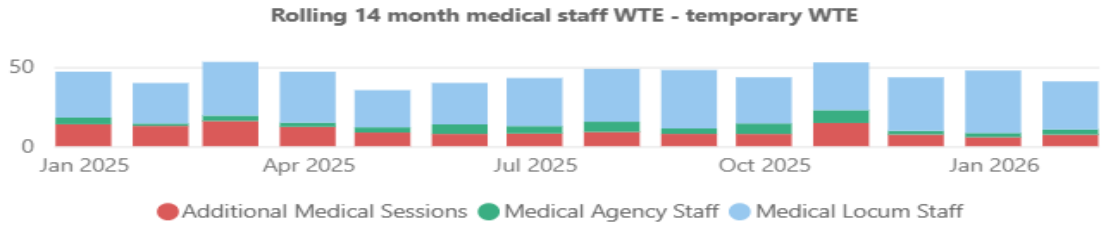
		Prior Month Actuals WTE	Prior Yr Same Period Actuals WTE	In-Month Actuals WTE	In-Month Budget WTE	In-Month Variance WTE	YTD Actuals Average WTE	YTD Budget Average WTE	YTD Variance Average WTE
Medical Staff	Substantive	604.3	581.7	600.7	645.2	44.5	597.6	646.7	49.1
	Additional Medical Sessions	5.7	12.8	7.3	2.9	-4.4	8.7	3.7	-5.0
	Bank & Locum Staff	39.4	25.5	30.3	8.7	-21.6	31.3	8.8	-22.5
	Agency	2.7	1.6	3.3	0.0	-3.3	4.5	0.0	-4.5
	Total	652.0	621.5	641.6	656.8	15.3	642.2	659.2	17.0
Nursing	Substantive	1,894.9	1,938.9	1,888.1	2,053.2	165.1	1,898.8	2,068.8	169.9
	Bank & Locum Staff	123.6	132.1	145.0	1.8	-143.2	132.6	1.7	-130.8
	Agency	0.2	4.0	0.0	0.0	0.0	0.5	0.0	-0.5
	Overtime	3.8	3.7	5.8	0.5	-5.3	5.4	0.3	-5.1
	Total	2,022.5	2,078.7	2,038.9	2,055.5	16.6	2,037.4	2,070.8	33.4
Sci & Professional	Substantive	273.3	267.9	274.1	295.5	21.4	274.5	294.3	19.7
	Bank & Locum Staff	3.8	8.7	2.8	0.3	-2.5	4.9	0.7	-4.1
	Agency	1.5	1.0	1.5	0.0	-1.5	0.5	0.0	-0.5
	Overtime	0.7	1.7	0.6	0.0	-0.6	1.0	0.0	-1.0
	Total	279.2	279.3	279.0	295.8	16.8	280.9	295.0	14.1
A&C	Substantive	853.7	961.8	852.7	988.2	135.5	887.0	994.0	107.0
	Bank & Locum Staff	14.2	18.6	17.6	2.7	-14.9	14.4	2.8	-11.5
	Agency	5.8	0.0	2.0	0.0	-2.0	1.7	0.0	-1.7
	Overtime	1.3	1.6	1.7	0.8	-0.9	1.3	0.8	-0.5
	Total	875.0	982.0	874.1	991.7	117.6	904.5	997.7	93.2
AHP	Substantive	530.9	552.9	532.4	597.0	64.5	538.0	599.5	61.5
	Bank & Locum Staff	2.2	3.3	2.9	0.0	-2.9	2.2	0.1	-2.2
	Overtime	1.3	2.1	0.9	0.0	-0.9	3.1	0.0	-3.1
	Total	534.4	558.4	536.2	597.0	60.8	543.4	599.6	56.2
Prof & Tech	Substantive	55.0	51.4	55.1	54.9	-0.2	51.0	54.9	3.9
	Bank & Locum Staff	0.6	0.2	0.3	0.3	-0.1	0.3	0.3	0.0
	Agency	2.0	3.0	3.3	0.0	-3.3	2.6	0.2	-2.5
	Overtime	3.3	2.3	2.7	0.0	-2.7	3.1	0.0	-3.1
	Total	60.9	56.8	61.4	55.1	-6.3	57.0	55.3	-1.7
Support Staff	Substantive	284.0	275.7	280.0	303.2	23.2	281.5	297.7	16.2
	Bank & Locum Staff	14.2	18.0	15.3	1.0	-14.3	15.5	1.1	-14.4
	Agency	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total	298.3	293.6	295.3	304.2	8.9	296.9	298.8	1.8
Other	Substantive	54.0	62.5	54.0	70.9	16.9	53.3	68.0	14.7
	Total	54.0	62.5	54.0	70.9	16.9	53.3	68.0	14.7
Other	Bank & Locum Staff	0.2	0.0	0.2	0.0	-0.2	0.0	0.0	0.0
	Total	0.2	0.0	0.2	0.0	-0.2	0.0	0.0	0.0
Unallocated central funding	Substantive	0.0	0.0	0.0	4.3	4.3	0.0	-4.3	-4.3
	Total	0.0	0.0	0.0	4.3	4.3	0.0	-4.3	-4.3
Total		4,776.5	4,932.8	4,780.7	5,031.3	250.7	4,815.5	5,040.1	224.5

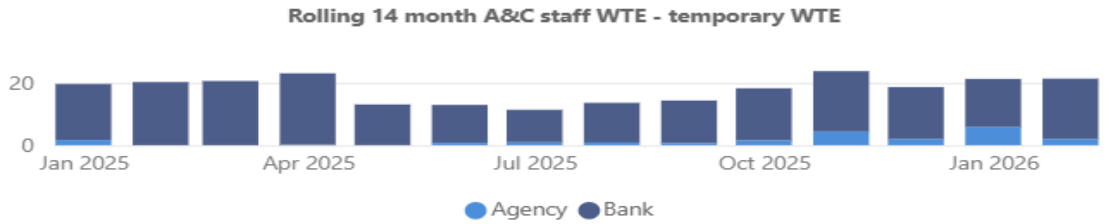
Workforce - WTE (trends)

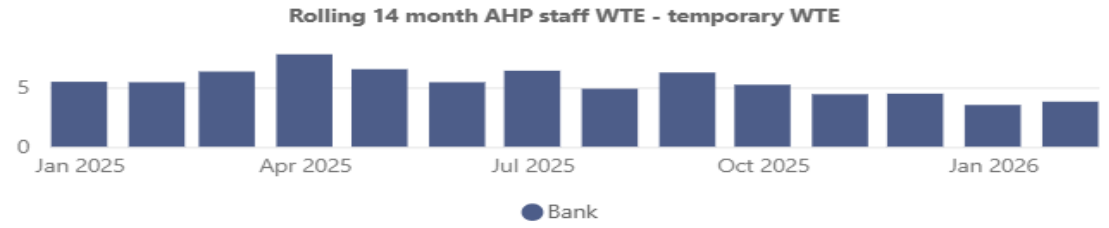












Statement of Financial Position – 28 February 2026

West Suffolk NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2025	Plan 31 March 2026	Plan YTD 28 February 2026	Actual at 28 February 2026	Variance YTD 28 February 2026
	£000	£000	£000	£000	£000
Intangible assets	54,005	44,573	45,115	47,779	2,664
Property, plant and equipment	146,062	200,307	197,012	157,831	(39,181)
Right of use assets	9,807	7,544	7,708	8,223	515
Trade and other receivables	7,162	7,158	7,158	7,162	4
Total non-current assets	**217,036**	**259,582**	**256,993**	**220,995**	**(35,998)**
Inventories	5,128	5,000	5,000	5,921	921
Trade and other receivables	18,989	21,668	21,668	24,773	3,105
Non-current assets for sale	490	490	490	490	0
Cash and cash equivalents	12,659	1,107	1,107	9,715	8,608
Total current assets	**37,266**	**28,265**	**28,265**	**40,899**	**12,634**
Trade and other payables	(41,296)	(28,250)	(28,419)	(42,423)	(14,004)
Borrowing repayable within 1 year	(4,510)	(4,627)	(4,627)	(4,399)	228
Current Provisions	(2,524)	(70)	(70)	(1,259)	(1,189)
Other liabilities	(938)	(2,685)	(2,685)	(5,818)	(3,133)
Total current liabilities	**(49,268)**	**(35,632)**	**(35,801)**	**(53,899)**	**(18,098)**
Total assets less current liabilities	**205,034**	**252,215**	**249,457**	**207,995**	**(41,461)**
Borrowings	(39,716)	(34,656)	(35,189)	(35,986)	(797)
Provisions	(385)	(400)	(400)	(101)	299
Total non-current liabilities	**(40,101)**	**(35,056)**	**(35,589)**	**(36,087)**	**(498)**
Total assets employed	**164,933**	**217,159**	**213,868**	**171,908**	**(41,960)**
Financed by					
Public dividend capital	326,166	390,273	386,663	349,218	(37,445)
Revaluation reserve	12,319	11,941	11,941	12,319	378
Income and expenditure reserve	(173,551)	(185,055)	(184,736)	(189,629)	(4,893)
Total taxpayers' and others' equity	**164,934**	**217,159**	**213,868**	**171,908**	**(41,960)**

The table shows the year-to-date Statement of Financial Position as at 28 February 2026.

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

Cash is higher than plan, but also includes cash that is earmarked specifically for spend on capital projects. Cash is being rigorously monitored to ensure that the Trust remains on plan and does not fall below the £1.1m enforced by NHS England. The Trust has been successful in its application for further cash support in quarter 4, receiving £2m in February, and will receive a further £4m in March. The revenue support funding received is in line with our plan.

Trade and other payables appears to have increased against plan, however the movement since the 2024/25 month 12 outturn position is much smaller, with an increase of £1.1m.

Public dividend capital (PDC) is not as high as expected due to the fact that we have not drawn down PDC for capital projects in line with the plan. The original plan also included £25m of PDC funding for Newmarket noted above, which will not be received during 2025/26.

Better Payment Practice Code (BPPC) – Month 11

February 2026		
Better Payment Practice Code	**Total bills paid YTD Performance Number**	**Total £ paid YTD Performance £'000**
Non NHS		
Total bills paid in the year	32,948	153,181
Total bills paid within target	22,931	131,011
Percentage of bills paid within target	***70%***	***86%***
NHS		
Total bills paid in the year	1,530	21,452
Total bills paid within target	651	13,434
Percentage of bills paid within target	***43%***	***63%***
Total		
Total bills paid in the year	34,478	174,633
Total bills paid within target	23,582	144,445
Percentage of bills paid within target	**68%**	**83%**
Previous month performance	**68%**	**82%**

The table shows the Trust's current performance against the Better Payment Practice Code. The Code measures the performance of invoices being paid within 30 days. The standard requires that 95% of invoices are paid within the 30 day target.

The performance is measured over the year and the table shows the Trust's performance at month 11. The performance has remained stable over the period which is linked to our cash position stabilising.

Capital progress report - Month 11

Capital Spend - 28th February 2026	Year to Date - Month 11			Full Year		
Capital Scheme	YTD Forecast	YTD Actual	Variance to Forecast	Full year Forecast	Funding Split	
					Internal	PDC Available
	£000's	£000's		£000's	£000's	£000's
**New Hospital Programme	9,665	9,788	- 123	12,247		12,247
RAAC	1,238	1,135	104	1,340		1,340
Estates	4,129	2,457	1,673	6,104	5,575	
Digital/IT	2,849	3,189	- 339	3,189	3,138	
*Medical Equipment	125	965	- 839	1,172	550	202
Radiology	566	921	- 355	1,215	1,215	
Newmarket Endoscopy	1,424	662	762	2,133		2,133
Net zero	411	157	254	509		509
UEC (ED)	-	-	-	-	1,000	
UEC RtCS	- 211	-	- 211	406		406
Diagnostics RtCS	389	312	77	312		312
Elective RtCS	139	318	- 179	523		523
CDC Pathway	-	117	- 117	131		131
Total Capital Schemes	20,725	20,018	823	29,281	11,478	17,803
Capital Schemes excluding NHP	11,060	10,231	829	17,034	11,478	5,556
Overspent vs Plan					29,281	
Underspent vs Plan						

* This includes all equipment being purchased across the Trust
** NHP budget is subject to change throughout the year and is fully funded by PDC
*** Figures aligned to submitted PFR

The Capital Plan for 2025/26 was agreed at £25.6m. In month 2 an additional £1m of CDEL was awarded to the Trust, and in month 3 additional Public Dividend Capital (PDC) was awarded of £7.2m taking the Capital Plan to £33.8m. Further adjustments to PDC has occurred resulting in the Capital Plan now being £29.3m. £11.5m of this is internally funded, with the remaining £17.8m being funded by PDC.

Year to date capital spend at month 11 is £20m. This is slightly behind the phased plan.

A detailed review of the forecast capital spend for 2025/26 has been completed and all remaining schemes are expected to be delivered by the end of March, achieving the forecast plan of £29.3m.

5.3. Audit Committee - Committee's Key Issues (ATTACHED)

To Assure

Presented by Michael Parsons

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Audit Committee			Date of meeting: 17 March 2026		
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. Approval of Internal Audit Plan for 2026/27.	Partial	Discussed the 3 reports issued since the last meeting: • **Decentralised Finance Processes**: partial assurance • **Payroll and Organisational Change Policy**: reasonable assurance • **Key Financial Controls – Treasury Management**: substantial assurance The Committee welcomed the reported effectiveness of Treasury Management and commented on the payroll and organisational change findings (see later for workforce assurance and pay integrity programme), but the Committee was concerned	Executive to continue to address audit actions in a timely way.	2. Relevant Assurance Committee to consider negative assurance report on Decentralised Finance Processes (partial). 2. MEG to continue to progress outstanding actions.

			about the issues identified in relation to decentralised finance processes. The importance of skills development for the Finance Team and for Budget Holders was stressed – especially with the significant changes coming this year in relation to finance processes. A multi-year schedule of audit coverage was presented which gave a helpful overview of audits in recent years and when the topics might next be reviewed. With this as context, the Internal Audit Plan for 2026/27 was agreed.		
Counter Fraud (RSM)	Progress report. Approval of Counter Fraud Workplan for 2026/27.	Substantial	Continuing good engagement on counter fraud across WSFT. 2026/27 Workplan approved.		1. No escalation required.
Establishment Control & Payroll	Deep dive into workforce assurance and pay integrity programme.	Reasonable	Welcomed the comprehensive review and the analysis of current situation. The review has the potential to deliver significant transformation and much improved assurance.	Will return to AC in due course.	1. No escalation required.
Annual Governance Statement	Review of significant internal control issues.	Reasonable	Agreed the significant internal control issues for inclusion in the AGS would remain as for	Annual Report & Accounts to be presented to next meeting.	1. No escalation required.

			2024/25 (with updated wording).		
Code of Governance	Self-assessment for 2026.	Reasonable	Agreed the self-assessment, with some minor changes.		1. No escalation required.
Committee Terms of Reference	Review of Audit Committee ToR.	Substantial	Agreed to recommend minor changes; and proposed changing name to “Audit & Risk Assurance Committee (ARAC)” to better reflect current remit.	For Board to consider/approve.	3. Escalate to Board
Year-end matters	External Audit plan. Year-end consideration of significant accounting estimates and other matters. Progress with External Audit recommendations from previous years.	Substantial	External Auditors (EY) presented workplan and were very positive about early engagement with WSFT Finance. Committee had no concerns about any of the standard year-end matters. Update on previous years’ recommendations showed all had been addressed.	Annual Report & Accounts to be presented to next meeting.	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?

Assurance level

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

6. FIT FOR TOMORROW

6.1. Future system board report (ATTACHED)

To Assure

Presented by Ewen Cameron

Meeting/committee title: Open Board

Report information

Report title: Future System Board Report
Agenda item: 6.1
Sponsor/Executive lead: Jonathan Rowell
Report prepared by: Gary Norgate
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? *Summary of issue, including evaluation of the validity the data/information*
The project to replace the current West Suffolk Hospital is formally a **Scheme** within the national New Hospitals **Programme** (NHP). The following report provides an overview of progress being made towards our goal to build a sustainable new hospital for West Suffolk.

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

Scheme Status

As previously reported, the project to build a new West Suffolk Hospital is within the first wave of schemes to be built with an expected commencement date in 2027/28 and a capital budget of between £1 and £1.5bn. A more precise capital figure, within this range and based on a new build space of c. 100k sqm has been confirmed in writing but remains commercially sensitive[1].

My last report listed the following next steps:

- Resolve issues with regards to capital budget.

[1] The Trust and the Programme needs to retain the ability to negotiate with potential suppliers and as such the actual capital budget is being treated as commercially sensitive.

- Resolve final design issues
- Commence RIBA 3 design – October 25 to August 26
- Reserved Matters Planning Application submitted – Spring 26
- OBC Submission – Summer 2026

The following progress has been made:

- **Capital Affordability –** The WSFT project team has worked with national colleagues from NHP and their technical advisors to complete a full appraisal of costs associated with our completed RIBA2 designs. This work has identified marginal savings through design "tweaks", the application of the latest cost benchmarks and the forecast of the "value engineering"[2] expected to occur during the next phase of the design. In addition, several variations to the assumptions that created the capital budget have been suggested to NHP and will be sought through a formal change control request. To ensure every option for the improvement of design and cost has been considered, the team are now analysing an "alternative geometry" which retains clinical content but alters the way in which the various wings and technical blocks connect in order to reduce the "core" (e.g. the corridors) of the hospital and save on external façade. This work is expected to be complete by the end of the month and will inform a decision on whether taking the necessary time and risk associated with the adoption of this geometry is outweighed by the costs it saves and the improvements it brings.

- **Resolution of design issues** – The existing drawn design has been clinically agreed, is compliant with H2.0 and is capable of reflecting the feedback provided by our own clinicians.
- **RIBA3[3] Design** – although the aforementioned capital affordability challenges mean that we are unable to formally commence RIBA3 designs until such time as change control has been approved (and until we have completed the analysis of the alternative geometry), we have been working on those tasks that are essential for our reserved matters planning application. Consequently, delays are, at this point in time, minimised.
- **Formal Full Planning Application** – We are on track to submit our reserved matters planning application by May. This application, termed reserved

[2] Value engineering is the process through which a construction partner analyses materials, systems and processes during the design phase to remove unnecessary expense without compromising quality.
[3] Royal Institute of British Architects Stage 3 – the stage at which designs reach the 1:50 level and start to coordinate clinical layouts with utilities.

matters, focuses on the detailed design of the hospital within the approved outline planning principles.

- **Outline Business Case (OBC) production** – the team remains on track to complete and submit a full and compliant OBC by August 2026. Content has been substantially "progressively assured" [4] with by NHP and NHSE. The outstanding element will be the comprehensive investment review which is dependent upon the completion of RIBA3 designs. Once complete, the case will be presented to the Executive Programme Board, Trust Board, ICB and NHSE before formal submission. In recent weeks, the strategic case, commercial case and management case have been completed and submitted for review. A draft "comprehensive investment appraisal" has been completed, however, adoption of an alternative geometry could push back the submission of the OBC.
- **Operational Affordability –** A working group to solve the issue created by the capital charges[5] associated with building a new hospital has been established by NHS England and aims to recommend a solution in time for the submission of our OBC. In recent weeks Jonathan Rowell (CFO) has requested an update directly from NHS England financial leadership.

Commercial Progress

In addition to the updates above, the most significant development has been the work undertaken to appraise and allocate a construction partner. At a national level NHP have successfully run a process through which prospective construction partners have "bid" to join the H2.0 Alliance. This work has resulted in the selection of 10 contractors that are all deemed capable of building the hospitals within the program. Reaching this point has involved extensive appraisal of capability and experience and the West Suffolk Team have had two people engaged throughout. Since the announcement of the successful bidders, a number of events have occurred during with the WSFT team (and their counterparts from across the Program) have had opportunity to meet with each of the companies. Following these meetings, partners were asked to state those schemes that are of high and medium interest. Of the 10 contractors, seven expressed an intertest in the WSFT scheme, four of which expressed "high" interest. This is a highly positive outcome. The next step is a series of one-to-one meetings (middle of April) during which detailed

[4] Progressive assurance aims to present subject matter experts with chapters of the business case in advance of submission. The process should mean that the eventual case is largely "pre-approved".
[5] Capital Charges refer to the cost of the "loan" provided by the Government for the building of the new hospital.

discussions will take place between the scheme and potential partners. The outcome of these meetings will inform the allocation of partners to schemes, meaning that we should know our construction partner by the end of April.

Communications and Engagement

Work has commenced on the “pre-planning application” engagement process – ensuring we can evidence public engagement in the design of our hospital and the submission of our reserved matters planning application. Engagement has been high and feedback positive, although, the need for sufficient car parking and traffic concerns prevails.

Finance

The Programme is progressing within its NHP allocated development budget and is fully funded to deliver RIBA stages 2 and 3 as well as its Outline Business Case. Funding for the 26/27 year has now been agreed and the necessary “memorandums of understanding” will be in place in time for the start of the new financial year.

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

- Resolve issues with regards to capital budget.
- Progress RIBA 3 design – October 25 to August 26
- Construction partner allocation –April 2026
- Reserved Matters Planning Application submitted – Spring 2026
- OBC Submission – Summer 2026

Clearly, the outcome of the first bullet could cause significantly change the overall plan.

Action required by the board: The Board are asked to note the content of this report.

Governance and compliance

Add explainer for each of the below.

Risk and assurance: The strategy for a new hospital is being developed in line with NHS 10 year Plan, ICB Forward Plan, NHP H2.0 design and WSFT Clinical and Care Strategy. The primary risks are associated with time, capital and operational affordability and aligning

optimal design with the need to transform.

Equality, diversity and inclusion: The design and assurance process has been based on an ongoing strategic principle of fully inclusive co-production.

Sustainability: The design and business case reflect and support the outputs from the recent sustainability review. The associated plans for transformation will ensure the target operating model of the Trust is sustainable.

Legal and regulatory context: The project is underpinned by the terms of NHP Alliance Agreement.

7. GOVERNANCE

7.1. Governance report (ATTACHED)

To Assure

Presented by Paul Bunn

Open Board of Directors – 27 March 2026

Report information

Report title: Governance report – General Update: February – March 2026
Agenda item: 7.1
Sponsor/Executive lead: Jude Chin, Chair/Ewen Cameron, CEO
Report prepared by: Paul Bunn, Acting Trust Secretary
Previously considered by: Standing Board Agenda item
This report is for: ☒Approval ☒ Assurance ☒Discussion ☐information

This report supports the following ambitions within the organisational strategy:

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

Executive summary

What?
This paper provides the Trust Board with an update on governance arrangements for the period February – March 2026 as well as referencing future work.

The Trust continues to operate within its statutory and regulatory framework and no issues of escalation need to be raised. This paper consolidates governance updates from subcommittees including: Senior Leadership Team; Management Executive Group, as well as providing updates from the Council of Governors; and highlights from the Board development session. It supplements the information provided from the CKI's from the four Assurance Committees and the audit committee.

In summary:-

- No urgent decisions have been made between board meetings.
- The reorganisation of the assurance committees has proceeded smoothly. Work on the subcommittees that feed into the assurance committees is underway:
    - **Appendix 1** has the Trust current structure and reporting lines for reference
    - TOR reference for: QPS, D&D and the AC are attached for formal ratification.
    - The Board is asked to consider if the AC should change its name to the Audit & Risk committee given the commitment and focus.
- The Trust's seal has not been used.
- **Appendix 2** contains the Board development dates scheduled for the rest of 2026/27.
- By way of assurance and to demonstrate effective decision-making:
    - MEG has met regularly and discussed a wide portfolio of work.
    - SLT has met once to focus on: anti-racism; digital accessibility and veteran awareness.

    - The Council of Governors continues to fulfil its statutory obligations, with no issues to escalate.
- Work continues to develop the risk register and define the top risks. Divisions have articulated their top risks. Executive team now working on defining the organisational wide top risks which will feed into the BAF.

So what?

The Board is accountable for the quality of care, financial stewardship, and compliance with NHS England and CQC standards. This report supports the Board in maintaining oversight of key activities and developments relating to organisational governance.

What next?

1. Continue work with subcommittee chairs that feed into the assurance committees to ensure reporting lines and committees remain effective – to report to each assurance committee
2. Work with Communications team to refine the subcommittee reporting templates based on initial feedback and with an even greater focus on meeting accessible information standards – to be approved through MEG.
3. Develop an organisational wide (corporate) risk register via an Executive working group.
4. Finalise the revised BAF to align with new strategy – MEG and Trust Board
5. Continue to liaise with Council of Governors over its future and discuss possible options for the future once formulated – Trust Board/COG
6. Work with Strategy and Transformation team to ensure any new partnerships and ways of working have governance embedded and appropriate accountability.
7. Refresh the Board reporting Matrix (last reviewed Jan 2024) to align with the new strategy and enable future agenda setting.

Action required by the board:

The Board is asked to discuss and note the content of the report, particularly:-

1. Formally ***approve*** the TOR proposed by the subcommittees – QPS, D&D, AC
2. ***Discuss*** and note the contents of this report.

Governance and compliance

Risk and assurance: Effective risk management processes support the operational and strategic performance of the trust by identifying risks and mitigating them effectively. Links to BAF 8 Governance.
Equality, diversity and inclusion: No EDI issues have been idtefied specifically arising from this goervnace report. It reports on other workstreams that have their EDI assessments where applicable.
Sustainability: Decisions should not add environmental impact, oversight of workforce should help succession planning.
Legal and regulatory context: NHS Act 2006, Health and Social Care Act 2013, NHS Code of Governance, WSFT Constitution.

Governance report – General Update: December - January 2026

1. Organisational Structure

1.1 Following the renaming of the Board Assurance committees, work is underway to review the subcommittee structures that feed into the four assurance committees, to ensure what happens on the ground is reflected in the structure; which is set out in ***Appendix 1*** for reference. This is a work in progress, but a summary of the work undertaken to date includes:

QPS

1.2 *QPS* has reviewed its portfolio of work and decided to keep the monthly meeting schedule given the volume of work it has to look at and the stage of development of areas like clinical effectiveness. Experience of care and Engagement has transferred over from People and OD and the first reports were presented in March 2026. A challenge arose at the last meeting to ensure the merging of subgroups and themes does not result in any loss of assurance. That additional check and challenge is underway with the committee chair. QPS has reviewed and approved its terms of reference. **Board is asked to review and formally approve those**.

POD

1.3 *People, and OD* are planning on rationalising its 4 sub committees into 2 as these were essentially operational meetings between HR and were not delivering the desired impact. Transformation work will be brought into this committee and discussions underway between the Committee Chair and Director of Strategy and Transformation re how best to capture that in the work programme from April 2026.

F&P

1.4 *Finance & Performance* – have not proposed any structural changes to its assurance committees. Although this review has revealed that the Patient Access Governance Group is still on the organogram but it has not met for some time after F&P approved for it to be stood down given the information, actions and decisions were entirely replicated across other meetings. The team have found that a more flexible approach of targeted intervention has been more effective, evidenced by the Trust's elective performance improvement. Work now underway to capture reporting lines of Elective Access and West Suffolk Alliance Operational group meetings.

D&D

1.5 Digital and Data underwent its review prior to becoming an assurance committee and no further changes are proposed currently it is now settling into its work programme. Its TOR have been approved and **the Board is asked to review and formally approve those**.

AC

1.6 *Audit committee* (AC)– has reviewed and approved its terms of reference subject to the Board discussing if there is any merit in changing the name of the AC to the Audit and Risk Committee. Benchmarking shows:

Norfolk & Waveney University Hospital Group (NNUH, JPUH, QEHKL) all have independent Audit and Risk committees. ESNEFT uses the title Audit and Risk Committee, while CUH has an Audit Committee. Risk features as a part of the AC and the Corporate Governance Group which reports to F&P. Does the Board feel this change of name would help show the importance and priority it has on risk? The **Board is asked to review and formally approve the TOR once the name change has been discussed**.

1.7 A revised organogram setting out the finalised changes will be shared at the next meting after it has been through MEG and the assurance committees.

2. Future Board Meetings

We continue to review the frequency of Board meetings as per the January 2026 update and discussion. We will reply with the action point once the benchmarking is complete and quality impact assessment has been complete. So far Norfolk and Waveney University Hospital Group meet bimonthly, as does ENSEFT. CUH meets quarterly.

3. Senior Leadership Team report

The Senior Leadership Team (SLT) has met once (due to February half term) since the last report:

- *16 March 2026* – in person session focusing on anti-racism; digital accessibility and veteran awareness.

A small task group involving the Director of Transformation, Chief Operating Officer, Chief People Officer, Acting Trust Secretary, and Head of Communications have discussed revising the SLT terms of reference and forward plan. Proposed changes, which are still in development, seek to better align the workings of the SLT with the revised Trust strategy and enable a portfolio of work to be set up and then delivered for 2026 and beyond.

4. Management Executive Group (MEG)

The Management Executive Group has met every Wednesday except in Board assurance committee week. This provides a forum for discussion of strategic and operational matters as well escalation of emerging themes. A snapshot of the non-commercially sensitive matters reviewed include:

- the business planning process, theatre refurbishment, 2026/27 internal audit plan review, UEC performance, admin transformation, Trust's approach to GIRFT, private patients' policy review; and workforce and staff survey reviews.

5. Council of Governors report

The Council of Governors (COG) met on 5 and 18 March 2026.

The COG has agreed to a second term of office for Michael Parsons; the appointment of Mike Knapton as University of Cambridge NED, commencing 1.4.2026; and an extension of the Chairs term of office until July 2027. COG also approved the NED appraisal process (no change from 2025 process).

Future of the COG

With Governor elections due later in the year (around July 2026), governors remain anxious to seek clarity around the government proposal in the NHS 10 year plan to abolish council of governors and to ascertain what the future holds. We still await national briefings/guidance and will share a plan once further guidance is received around next steps. In the meantime plans to hold elections are being developed so we are in a position to continue as normal with these if required in the summer.

6. Board development

The February Board Development took place on 13 March 2026. This focused on further developing the culture of the Board through the Well-Led lens. Specialist topic

in the afternoon session focused on how the Board leads on EDI. The working draft Board Development plan is at **Appendix 2** for noting and further discussion.

7. Risk

The Executive team have met and discussed top risks twice since the January 2026 Board and looked at example templates for the new BAF. WSFT now has a clear picture of what the divisions feel are the top risks which will be managed through the divisional governance and PRM process. A small working group has been established to develop the Trust corporate (organisation wide) risks as there are none listed on Radar, with the exception of the Digital risks. It is anticipated this group will establish 8-10 organisational wide risks around: the ageing estate, capacity and demand, cyber risks, crowded ED, FTSU culture, timeliness of care, discharge and deferred visit in the community.

8. Urgent decisions by the Board

No urgent decisions have been requested.

9. Use of Trust Seal

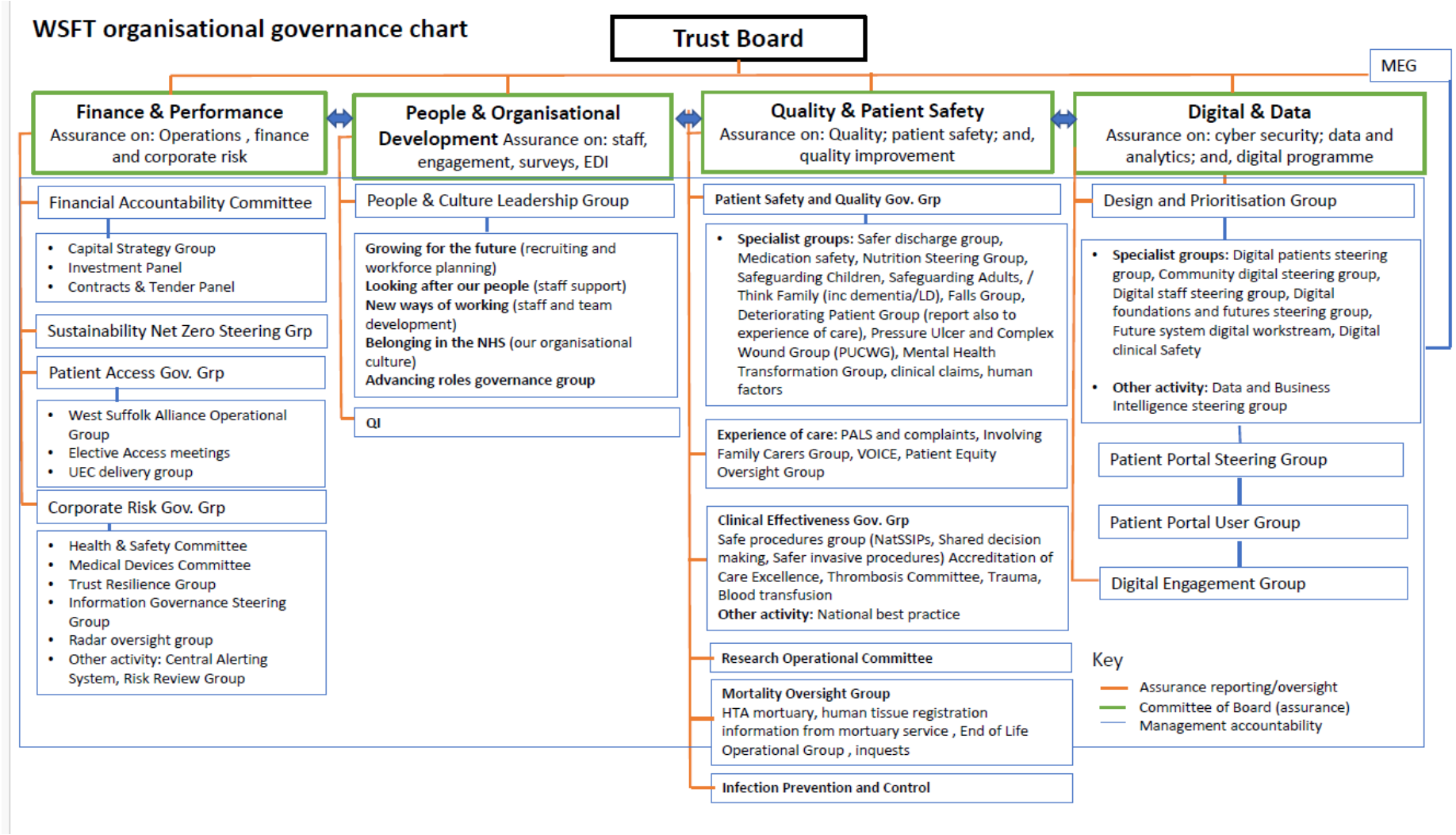
The Trust seal has not been used since January 2026.

10. Agenda Items for the Next Meeting

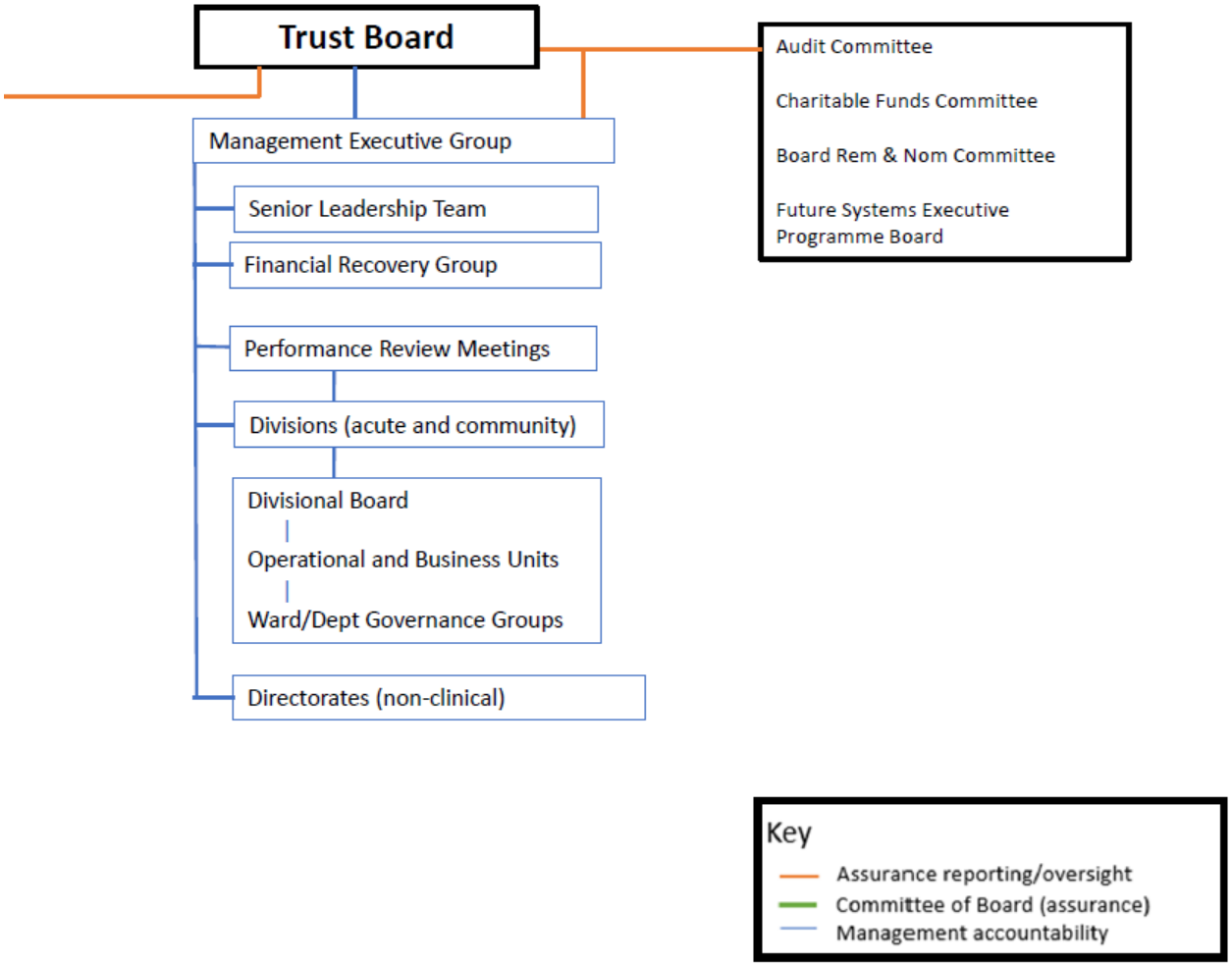
Work is underway to refresh and update the Board forward plan to align that with the new strategy. This will be shared at the next Board for review. The final agenda for each meeting will be drawn up and approved by the Chair after discussions with the Executive team.

NHS
West Suffolk
NHS Foundation Trust

Appendix 1 – Trust current structure under review



Compassionate care,
healthier communities



Compassionate care,
healthier communities

Appendix 2 – Board Development Forward Plan

Forward Plan		*Team & Knowledge development*	*Specialist Subject Focus*
Feb - (moved to 13.3. 26)		- Behaviour in the Boardroom through the well led lens, cascading the message.	How to lead on Equality Diversity and Inclusion
April -17.4.26		What it really takes to adopt a culture of continuous improvement – Amar Shah	CQC Prep (Well Led)
June – 26.6.26		How do you define what is a high performing board? - Is that something we want to aspire to? - Given where we are, what is the gap, change and stepping stones to achieve that.	Risk Appetite
Aug – 28.6.26			
Oct – 16.10.26			
Shortlist of topics to pick from:			- EDI focus - SEND - Partnership and System Leadership

Compassionate care,
healthier communities

QUALITY AND PATIENT SAFETY COMMITTEE

Terms of Reference

1. Purpose of the Committee

1.1. The Trust Board hereby resolves to establish an assurance committee to be known as the Quality and Patient Safety Committee (the committee). The committee has no executive powers other than those specifically delegated in these terms of reference. The scope of this assurance committee will focus on quality, patient safety and change management.

1.2. In line with the CQC single assessment framework (SAF) and the NHS Impact, the committee is authorised to provide the board with assurance that there is a culture of high quality, sustainable care and robust systems for learning, continuous improvement and innovation.

1.3. The committee will consider all relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the committee, as part of reporting requirements, and to report any areas of significant concern to the board as appropriate. The committee will also recommend changes to the BAF relating to emerging risks and existing entries within its remit for the executives to consider.

2. Level of Authority

2.1. The committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to request any information from any employee and all employees are directed to cooperate with any request made by the committee. The committee is authorised by the Trust Board to obtain legal advice and to secure the attendance of experts and external representatives or persons with relevant experience/expertise if it considers it necessary.

2.2. The committee has authority to make decisions on behalf of the Board but in accordance with the Trust's Standing Financial Instructions and Scheme of Delegation.

2.3. The committee may establish sub-groups/committees reporting to it. The committee shall remain accountable to the Board for the work of any group reporting to it.

3. Duties and responsibilities

3.1. The key responsibilities of the committee shall be to provide assurance to the board in relation to:

- The effectiveness of the Trust's systems and processes for ensuring clinical governance, quality governance and patient safety is embedded from ward to board.
- The Trust's compliance with statutory and regulatory standards, particularly in relation to the Care Quality Commission, Clinical Negligence Scheme for Trusts and the well-led framework.
- Oversight of the delivery of statutory and mandatory requirements relating to Quality and Safety of care.

- The provision of a platform and forum for the sharing of best practice and improvement learning throughout the Trust.
- Trust performance in relation to patient safety outcomes and effectiveness with particular focus on providing assurance to the Board on actions taken to address any major performance variations.
- Reports on significant concerns or adverse findings highlighted by external bodies in relation to clinical quality and safety and the actions being taken by management to address them.
- The systems and processes in place in the Trust in relation to infection control and to review progress against identified risks to reducing hospital acquired infections.
- Reports on actions to address trends relating to adverse events (including serious incidents), claims and litigation.
- Key strategic risks relating to quality and patient safety and consider plans for mitigation as appropriate.
- Ensuring that lessons are learnt and implemented across the Trust from patient feedback, including patient safety data and trends, compliments, complaints, patient surveys, national audits/confidential enquiries and learning from the wider NHS community.
- Systems within the Trust for obtaining and maintaining licences and accreditations relevant to clinical activity, receiving such reports as required.
- Review significant risks including those in the BAF and are relevant to the scope of the committee as allocated by the Board.
- Receive reports on Clinical Effectiveness, including: Clinical audit; QI, NICE, National best practice; public health; GIRFT and accreditation.

4. Membership

4.1. Membership of the committee will comprise:

Executive Leads:

- Executive Chief Nurse
- Executive Medical Director

Other Members

- At least two non-executive directors, one of whom will chair the meeting
- Director of strategy and transformation
- Chief Operating Officer
- Executive Director of Workforce and Communications

The Chair, other Non-executive directors and Chief Executive have an open invitation to attend meetings of the committee.

Others in attendance by invitation would be:

- Head of Patient Quality
- Director of Midwifery
- Chair of Patient Quality and Safety Governance Group – Deputy Chief Nurse
- Chair of Clinical Effectiveness governance group – Associate Medical Director
- Clinical directors as required
- Associate Medical Directors
- Trust Secretary

- Governor observers.

**Board assurance committees are not public meetings and, occasionally, matters discussed may be confidential within the Trust. Governor observers and other regular attendees must maintain confidentiality about what is discussed.*

4.2. The committee may invite members of staff, other key stakeholders and advisors to attend meetings as appropriate.

4.3. The committee may ask any other officials of the organisation or representatives of external partners to attend to assist it with its discussions on any particular matter. The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters

4.4. Attendance at meetings is essential. In exceptional circumstances when an executive member cannot attend they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf. Members will be required to attend as a minimum 75% of the meetings per year.

5. Quorum

5.1. The quorum necessary for the transaction of business shall be four members of whom at least one must be a non-executive director. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised, by the committee.

5.2. Members are requested to send a deputy with the appropriate skills and knowledge to represent them if they are unable to attend a meeting. Deputies will be counted for the purposes of the quorum.

5.3. Virtual attendance will count towards the quorum.

6. Frequency of meetings

6.1. The committee shall operate as follows:

- The committee will meet monthly until agreed otherwise
- Items for the agenda should be submitted to the committee secretary a minimum of 6 working days prior to the meeting. Papers on other matters will be put on the agenda only with the prior agreement of the chair.
- Papers will be sent out by the committee secretary at least 4 days before each meeting.
- Membership and terms of reference will only be changed with the approval of the committee and ultimately the board.

7. Sub Committees

7.1. The committee shall receive regular reports from the Patient Quality and Safety Governance Group, Clinical Effectiveness Governance Group, Experience of Care and Engagement Committee, Research Operational Committee, Mortality Oversight Group and the Infection Prevention and Control Committee.

8. Arrangements for meetings and circulation of minutes/administrative support

8.1. The committee shall be supported by Trust office with regard to arrangements for meetings and circulation of minutes/administrative support.

8.2. Minutes will be prepared after each meeting of the committee within 5 working days and circulated to members of the committee and others as necessary once confirmed by the Chair of the committee. Once the committee has approved the full minutes, a copy will be available, for information, to the board at its next meeting.

9. Accountability and reporting arrangements

9.1. The committee shall be directly accountable to the Board.

9.2. There should be a formal report from the committee to the next meeting of the Board of Directors. The chair of the committee shall draw to the attention of the Trust Board, in private or public as appropriate, any issues that require disclosure to the Board or require executive action. The speed of communication should be proportionate to the seriousness and likely impact of the issue.

9.3. The key issues of the committee will be included in the Board of Directors' meeting agenda and papers.

10. Monitoring effectiveness and compliance with Terms of reference

10.1. In order to support the continual improvement of governance standards, this committee is required to complete a self-assessment of effectiveness every two years and advise the Trust Board of any suggested amendments to these terms of reference which would improve the trust governance arrangements.

11. Ratification of terms of reference and review arrangements

11.1. The Terms of Reference shall be reviewed annually and submitted to the Board for approval.

Date approved by the Quality and Patient Safety Committee: January 2025
Date approved by the Board of Directors: 28 November 2025 (new name approved)
Next review date: March 2026

Digital and Data Programme Board
Terms of Reference

1 Purpose of the Digital and Data Programme Board

1.1 The Digital and Data Programme Board ("the programme board") is established as a subcommittee of the Digital and Data Assurance Committee. The programme board has no powers other than those specifically delegated in these terms of reference. The scope of this programme board will focus on assurance and decision making of the digital and data programmes, as well as ensuring that the programmes are on track.

1.2 The programme board will provide direction, make decisions, remove obstacles and ensure programme viability.

1.3 The programme board will consider all relevant risks within projects and the corporate risk register as they relate to the remit of the progmme board, as part of reporting requirements, and to report any areas of significant concern to the digital and data assurance committee as appropriate.

1.4 The programme board will monitor delivery of the Management Executive Group (MEG)-approved digital and data programmes.

2 Level of Authority

2.1 The programme board may establish sub-groups/committees reporting to it. The programme board shall remain accountable to the digital and data assurance committee for the work of any group reporting to it.

2.2 An operational escalation route to MEG is in place and should be used where decision making exceeds the remit of this group.

3 Duties and responsibilities

3.1 The programme board shall undertake the following:

- Receive assurance on the delivery of the digital and data programmes, ensuring alignment to Trust strategy and the digital and data strategy.
- To scrutinise the performance of the digital steering groups relating to the delivery of the benefits expected of the digital and data programme
- To drive and maximise clinical, operational and management buy in and ownership
- To receive reports from digital and data steering groups.
- To receive and make decisions on escalations on project delivery and risk from the digital and data steering groups
- Defines the tolerances for cost, quality, time and risk against which the digital and data steering groups will manage the overall digital services and data programmes
- To escalate to the digital and data assurance committee as necessary.

4 Membership

4.1 Membership of the committee will comprise:

- Chief operating officer (chair)
- Chief information officer
- All steering group delivery leads
- Deputy chief operating officer
- Chief medical information officer
- Chief nursing information officer

- Chief pharmacy information officer
- Senior business intelligence manager

Others in attendance by invitation would be:
Attendees who are not members of the committee but who will be reporting to the programme board on risks and escalations within their remit include the following:

- Future System Digital Programme Lead
- Data Protection Officer for WSFT
- Project managers

4.2 The programme board may invite members of staff, other key stakeholders and advisors to attend meetings as appropriate.

4.3 The programme board may ask any other officials of the organisation or representatives of external partners to attend to assist it with its discussions on any particular matter. The programme board may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

4.4 Attendance at meetings is essential. Where a member cannot attend, they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf. Members will be required to attend as a minimum 75% of the meetings per year.

5 Quorum

5.1 The quorum necessary for the transaction of business shall be six members of whom at least one must be a clinician, and one must be an operational lead. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised, by the programme board.

5.2 Members are requested to send a deputy with the appropriate skills and knowledge to represent them if they are unable to attend a meeting. Deputies will be counted for the purposes of the quorum.

5.3 Virtual attendance will count towards the quorum.

6 Frequency of meetings

6.1 The programme board will meet monthly until agreed otherwise

6.2 Items for the agenda should be submitted to the digital project management office team a minimum of 6 working days prior to the meeting. Papers on other matters will be put on the agenda only with the prior agreement of the chair.

6.3 Papers will be sent out by the digital project management office team at least 4 working days before each meeting.

7 Subgroups

7.1 The programme board shall receive reports as required from the steering groups, with items for escalation decided within the steering group meeting.

- Digital staff steering group
- Digital patient steering group
- Community digital steering group
- Digital foundations and futures steering group
- Data and BI steering group (when convened)
- Digital Design and prioritisation Group

7.2 Items for escalation will fall in the following categories:

(a) Highlight reports, adopt a rotation schedule so that, each month, two steering groups (including digital design and prioritisation group and BI & Data steering group) submit their highlight reports to the Digital and Data Programme Board.

(b) Escalation of risk (project, programme or corporate)
(c) Exception reports where additional decision making is required outside the scope of the steering group. This may be due to progress, finance, benefits, delays or other deviations from plan.

8 Arrangements for meetings, circulation of minutes and administrative support

8.1 The committee shall be supported by the digital project management officer with regard to arrangements for meetings and circulation of minutes/administrative support.

8.2 Exception reports can be submitted using the documents previously submitted to the relevant steering group. This document contains a record of decision making and/or escalations that have already taken place.

8.2 Minutes will be prepared after each meeting of the programme board within 5 working days and circulated to members of the programme board and others as necessary once confirmed by the Chair of the programme board. Once the programme board has approved the full minutes, a copy will be available, for information, to the board at its next meeting.

8.3 The digital PMO will share the decision documentation with the relevant project managers or steering group leads for recording keeping and audit purposes.

9 Accountability and reporting arrangements

9.1 The committee shall be directly accountable to the Digital and Data Assurance Committee.

9.2 There should be a formal report from the committee to the next meeting of the Digital and Data Assurance Committee.

10 Monitoring effectiveness and compliance with the terms of reference

10.1 In order to support the continuous improvement of governance standards, this committee is required to complete a self-assessment of effectiveness every two years and advise the Digital and Data Assurance Committee of any suggested amendments to these terms of reference which would improve the trust governance arrangements.

10.2 Membership and terms of reference will only be changed with the approval of the programme board and the digital and data assurance committee.

11 Ratification of terms of reference and review arrangements

11.1 The Terms of Reference shall be reviewed annually and submitted to the Digital and Data Assurance Committee for approval.

11.2 **Date approved by the Digital and Data Programme Board:** 3 February 2026
Date approved by the Digital and Data Assurance Committee: Due 30 April 2026
Next review date: February 2027

7.2. Audit Committee Terms of Reference (ATTACHED)

For Approval

Presented by Paul Bunn

AUDIT COMMITTEE

Terms of Reference

1. Purpose of the Committee

1.1. The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Audit Committee (the Committee). The Committee is a non-executive Committee of the Board of Directors and has no executive powers, other than those specifically delegated in these Terms of Reference.

1.2. The Committee will provide an independent and objective view of the Trust's internal control environment and the systems and processes by which the Trust leads, directs and controls its functions in order to achieve organisational objectives, safety, and quality of services, and in which they relate to the wider community and partner organisations.

1.3. The Committee will consider all relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the committee, as part of reporting requirements, and to report any areas of significant concern to the board as appropriate. The Committee will also recommend changes to the BAF relating to emerging risks and existing entries within its remit for the executive to consider.

1.4. The committee is responsible for assuring the Board on all governance related matters, including: financial and corporate governance and clinical and non-clinical audit.

2. Level of Authority

2.1. The Committee has overarching responsibility for monitoring specific elements of the systems and processes relating to governance, including financial systems, records and controls; financial information; compliance with law, guidance and codes of conduct; independence of internal and external audit; and the control environment (including measures to prevent and detect fraud). The Committee is responsible for providing an opinion as the adequacy of the integrated governance arrangements and Board Assurance Framework.

2.2. The Board of Directors authorises the Committee to investigate any activity within its duties (as detailed below) and grants to the Committee complete freedom of access to the Trust's records, documentation and employees. This authority does not extend, other than in exceptional circumstances, to confidential patient information.

2.3. The Committee may seek any information (excluding confidential patient information, other than in exceptional circumstances) or explanation it requires from the Trust's employees who are directed to co-operate with any request made by the Committee.

2.4. The Trust Board authorises the Committee to obtain external professional advice or expertise if the Committee considers this necessary.

2.5. The Committee has a statutory role in respect of assurance, controls, compliance, data and probity. The aim is to ensure complete coverage while

avoiding duplication by close liaison and cross-representation between the board assurance committees.

2.6. The Committee has authority to make decisions on behalf of the Board but in compliance with the Trust's Standing Financial Instructions and Scheme of Delegation.

2.7. The Committee may establish sub-groups/committees reporting to it. It shall remain accountable to the Board for the work of any group reporting to it.

3. Duties and responsibilities

The key duties and responsibilities of the Committee are as follows:

3.1 Governance, Risk Management and Assurance

3.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. The Audit Committee will look to the Trust's other Board Assurance Committees for assurance on items of clinical quality and corporate risk, including but not limited to: health & safety, research and information governance.

In particular, the Committee shall independently monitor and review:

3.1.1.1 the Annual Governance Statement (AGS) and the assurance system for all other external disclosure statements such as declarations of compliance with the Care Quality Commission registration, and any formal announcements relating to the Trust's financial performance, together with any accompanying Head of Internal Audit opinion, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors in order to advise (when requested by the Board or as the Committee deems appropriate) on whether such disclosures taken as a whole are fair, balanced and understandable.

3.1.1.2 the effectiveness of systems of internal financial and budgetary control and the integrity of reporting statements.

3.1.1.3 the effectiveness of systems for ensuring the optimum collection of income.

3.1.1.4 the effectiveness of risk management systems.

3.1.1.5 the effectiveness of the Board Assurance Framework (BAF).

3.1.1.6 The Committee will use a programme of 'deep dive' reviews to test the BAF and its priority areas as part of an assurance programme. The Committee's assessment of the effectiveness of the BAF should be included in the Committee's Annual Report to the Board of Directors.

3.1.1.7 the Quality Report assurance and review alongside the annual report and accounts.

3.1.1.8 the systems for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements, including the NHS Constitution, as set out in relevant guidance.

3.1.1.9 the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority.

3.1.1.10 the adequacy and security of arrangements by which staff or contractors may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters, ensuring that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

3.1.2 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

3.1.3 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

3.1.4 The Committee will receive the minutes from the Trust's other Board Assurance Committees for the purpose of ensuring: that there is no duplication of effort between the two Committees; that no area of assurance is missed and; as part of its responsibility for reviewing the Annual Governance Statement prior to submission to the Board of Directors.

3.1.5 The Audit Committee shall ensure that there is a system for reviewing the findings of other significant assurance functions, both internal and external to the organisation and consider the implications to the governance of the organisation. These will include, but will not be limited to, NHS England, any reviews by The Department of Health and Social Care or arm's length bodies, regulators/inspectors (CQC, NHS Resolution etc) and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc.)

3.1.6 In addition, the Committee will review the work of other Board Assurance Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include items in relation to quality, risk, governance and assurance. The conclusion of this review should be

referred to specifically in the Committee's self-effectiveness report to the Board of Directors.

3.1.7 The Committee will consider how its work integrates with wider performance management and standards compliance and include this within the report to the Board of Directors.

3.1.8 In reviewing the work of other Board Assurance Committees and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance that these Board Assurance Committees gain from the clinical audit function.

3.1.9 The Audit Committee will receive assurance on the arrangements for clinical audit within the Trust, including the process by which clinical audits are selected and agreed actions implemented.

3.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and the Board of Directors. An Internal Audit Charter will be agreed annually which will include objectives, responsibilities and reporting lines. This will be achieved by:

3.2.1 considering the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal.

3.2.2 the review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework.

3.2.3 consideration of the major findings of internal audit investigations, the effectiveness of the management's response and ensuring co-ordination between the Internal and External Auditors to optimise audit resources.

This will include exception reports of management action beyond deadline and consideration of the findings of Internal Audit "testing" of completed actions.

3.2.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust.

3.2.5 assessing the quality of internal audit work on an annual basis.

3.2.6 Ensuring any material objection to the completion of an assignment which has not been resolved through negotiation is brought to the Committee by the Chief Executive Officer or Chief Finance Officer with a proposed solution for a decision.

3.3 Counter Fraud

The Committee shall ensure that there is an effective counter fraud function established by management that meets the Standards set out by the NHS

Counter Fraud Authority and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

3.3.1 consideration of the provision of the Counter Fraud service, the cost of the audit and any questions of resignation and dismissal.

3.3.2 consideration of the major findings of counter fraud work (and management's response).

3.3.3 ensuring that the Counter Fraud function is adequately resourced and has appropriate standing within the organisation.

3.3.4 receiving an annual review of the work undertaken by the counter fraud function.

3.4 External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work.

3.4.1 Consideration of the appointment, performance and cost effectiveness of the External Auditor, making a recommendation to the Council of Governors on appointment of External Audit.

3.4.2 To ensure that the External Auditor remains independent in its relationship and dealings with the Trust and to review the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements;

3.4.3 To review the annual audit plan and to discuss with the External Auditor, before the audit commences, the nature and scope of the audit.

3.4.4 As part of the audit plan, discuss with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

3.4.5 To review External Audit reports, including value for money reports and management letters, together with the management response.

3.4.6 Ensuring that there is in place a clear policy for the engagement of External Auditors to supply non-audit services, including the pre-approval by the Committee of any non-audit work to be provided by the Trust's External Auditors.

3.4.7 To assess the quality of External Audit work on an annual basis.

3.5 Financial Reporting

3.5.1 The Audit Committee shall review the Annual Report and Financial Statements of the Trust and its Charitable funds before submission to the Board, to determine their completeness, objectivity integrity and accuracy. This review will cover but is not limited to:

- the wording in the Annual Governance Statement (AGS) and other disclosures relevant to the Terms of Reference of the Committee;
- changes in, and compliance with, accounting policies and practices;
- explanation of estimates and provisions having material effect;
- unadjusted misstatements in the financial statements;
- major judgemental areas;
- the schedule of losses and special payments; and
- significant adjustments resulting from the audit.

3.5.2 The Committee also has a delegated authority from the Trust Board to review and approve, on its behalf, the Charitable Funds Annual Report and Financial Statements of the Trust, prior to their submission to the Charity Commission

3.6 Key Trust Documents

3.6.1 Review proposed changes to Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved to the Board for approval by the Board of Directors.

3.6.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

3.7 Other

3.7.1 Review compliance with Standing Orders and Standing Financial Instructions through a schedule of waivers.

3.7.2 Review schedules of losses and compensations.

3.7.3 Monitor the process to ensure that Supply Chain Risk is identified and appropriate actions have been taken.

3.7.4 Entries recorded in the gifts and hospitality register would be considered on an exception basis as reported by the panel considering the entries made.

3.7.5 The Committee shall at its discretion request and review reports, evidence and assurances from Directors and Managers on the overall arrangements for governance, risk management and internal control.

4. Membership

Membership of the Committee will comprise:

4.1. The Committee shall be appointed by the Board of Directors from amongst the Non-Executive Directors of the Trust and shall consist of no fewer than three members, one of whom has recent and relevant finance experience. One of the members will be appointed Chair of the Committee by the Board of Directors.

4.2. At least one member will have a formally recognised professional accountancy qualification and/or a level of relevant financial experience assessed as being

appropriate to the role by the Nominations Committee, on behalf of the Board of Directors.

4.3. The Trust Chair will ensure that there is cross-representation by non-executive directors on the Audit Committee and any of the Trust's other Board Assurance Committees.

4.4. The Chair of the Trust shall not be a member of the Committee.

4.5. The Committee may invite members of staff, other key stakeholders and advisors to attend meetings as appropriate.

4.6. The Committee may ask any other officials of the organisation or representatives of external partners to attend to assist it with its discussions on any particular matter. The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

4.7. The Head of Internal Audit and representative of External Audit have a right of direct access to the Chair of the Committee.

In attendance:

4.8. The Chief Executive, Chief Finance Officer and the Trust Secretary will normally attend all Committee meetings.

4.9. The Head of Internal Audit, the Counter Fraud Specialist and a representative of the Trust's External Auditors will attend as necessary.

4.10. Other members of the Board of Directors to attend the Audit Committee by invitation.

4.11. All other attendances will be at the specific invitation of the Committee.

4.12. The Committee will have the over-riding authority to restrict attendance under specific circumstances.

4.13. The Committee will meet with the External and Internal Auditors, without any other Board Director present at least once a year.

4.14. Attendance at meetings will be recorded as part of the normal process of the meeting. A record of attendance will be reported as part of the Committee's self-effectiveness report.

5. Quorum

5.1. The quorum necessary for the transaction of business shall be two members. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised, by the committee.

5.2. Members are requested to send a deputy with the appropriate skills and knowledge to represent them if they are unable to attend a meeting. Deputies will be counted for the purposes of the quorum.

5.3. 'Virtual' attendance will count towards the quorum.

6. Frequency of meetings

6.1. The Committee shall operate as follows:

- Meetings will normally be held at least on a quarterly basis at appropriate times in the reporting and audit cycle and otherwise as required
- Special meetings may be convened by the Board of Directors or the Chair of the Committee
- The External Auditors or Internal Auditors may request a meeting if they consider that one is necessary

7. Sub Committees

7.1. The Committee shall receive regular reports as appropriate from the sub-groups and speciality committees in place.

8. Arrangements for meetings and circulation of minutes/Administrative support

8.1. The Minutes of Audit Committee meetings shall be formally recorded and a summary of the discussions, which includes a report of the Committee's activities and key issues, is submitted to the Board of Directors no less often than three times a year. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action. Once the committee has approved the full minutes, a copy will be available, for information, to the board at its next meeting.

8.2. The Committee shall be supported by the Trust office.

9. Accountability and reporting arrangements

9.1. The Committee shall be directly accountable to the Board.

9.2. There should be a formal report from the committee to the next meeting of the Board of Directors. The Chair of the committee shall draw to the attention of the Trust Board, in private or public as appropriate, any issues that require disclosure to the Board or require executive action. The speed of communication should be proportionate to the seriousness and likely impact of the issue.

9.3. Minutes will be prepared after each meeting of the committee within 5 working days and circulated to members of the committee and others as necessary once confirmed by the Chair of the committee. Once the Committee has approved the full minutes, a copy will be available, for information, to the board at its next meeting.

9.4. The key issues of the Committee will be included in the Board of Directors' agenda and papers.

9.5. A separate section of the Trust's Annual Report will describe the work of the Committee in discharging its responsibilities.

9.6. The Committee will report to the Board planned future workload and priorities for approval.

9.7. The Committee will agree on an annual basis a reporting framework for all areas of it terms of reference. This determines standing items for the agenda and items for regular reporting.

9.8. Maintain and monitor performance against the agreed reporting framework.

9.9. Follow-up agreed actions to ensure these are implemented in a timely and effective manner.

10. Monitoring effectiveness and compliance with Terms of reference

10.1. In order to support the continual improvement of governance standards, the Audit Committee shall carry out a self-assessment in relation to its own performance no less than once every two years, reporting the results to the Board of Directors and advise the Trust Board of any suggested amendments to these terms of reference which would improve the trust governance arrangements.

11. Ratification of terms of reference and review arrangements

11.1. The terms of reference shall be reviewed annually and submitted to the Board for approval.

Date approved by the Audit Committee:
Date approved by the Board of Directors: TBC
Next review date: March 2027

7.3. Agenda items for next meeting

To Note

Presented by Jude Chin

7.4. Reflections on meeting

For Discussion

Presented by Jude Chin

7.5. Date of next meeting - 5 June 2026

To Note

Presented by Jude Chin

RESOLUTION

The Trust Board is invited to adopt the following resolution:

“That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest” Section 1 (2), Public Bodies (Admission to Meetings) Act 1960

8. SUPPORTING APPENDICES

To inform

Presented by Jude Chin

IQPR Full Report

To Note

Presented by Nicola Cottington