NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday 31 July 2026, 9:15 AM — 1:15 PM BST
Venue	Northgate Room, 2nd Floor Quince House
Description	A meeting of the Board of Directors in the Public domain on Friday 31st July 2026
Notes for Participants	- Asha Rajan, Ward Manager Newmarket - observer - Miguel Abreu, Operational Manager, Ophthalmology & Breast Surgery - observer - Oluwatosin Adeyemi, Clinical Specialist Physiotherapist - shadowing under mentorship program - Emma Dinnage, Student Doctor - observer
Organiser	Joanne Sanger

Agenda

9:25 AM	1.3.	Minutes of the previous meeting - 5 June 2026 (ATTACHED) To Approve - Presented by Jude Chin	7
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AGENDA

Presented by Jude Chin

WSFT Board of Directors – meeting in public

A meeting of the committee will take place on **Friday 31 July 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 5 June 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**	QI Staff Story	Sarah Thirlby / Nicola Kelly – Neonatal team	Review	Verbal
10.00	**1.7**	CEO Report	Chief Executive	Inform	Report
10.10	**1.8**	BAF & Risk Report	Acting Trust Secretary	Inform	Report
	Joined up services				
	2.1	West Suffolk Alliance, Norfolk & Suffolk ICB, NHS Essex ICB - No report this month – WSA moved to bi-monthly reporting			
	High quality care				
	3.1	Annual Review of IQPR	Chief Finance Officer/Chief Operating Officer/Chief Nurse	Review	Report
	3.2	Integrated Quality & Performance Report (IQPR)	Chief Finance Officer/Chief Operating Officer/Chief Nurse	Review	Report
10.40		**Comfort Break – 10 mins**			
10.50	**3.3**	Staff story	Chief Nurse introducing Daniela Turner, EDI Midwife	Review	Verbal
	3.4	Quality & Patient Safety Committee - Committee's Key Issues	Committee Chair	Assure	Report
	3.5	Nurse staffing report – including strategy *(after 11.30 am)*	Chief Nurse / Deputy Chief Nurse	Assure	Report
	3.6	Maternity Services Report – focus on Ockenden and Amos	Director of Midwifery	Assure	Report
	3.7	Fuller report	Chief Nurse	Assure	Report
	Empowered to improve				
11.15	**4.1**	People & Organisational Development Committee – Committee's Key Issues	Committee Chair	Assure	Report
	4.2	Organisational Culture	Chief People Officer	Assure	Report
	4.3	Putting you First Awards	Head of Communications	Assure	Report
	4.4	Lord Mann Review	Chief People Officer	Inform	Report

11.45		**Comfort Break – 10 mins**			
	Responsible with resources				
11.55	**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
	5.4	Charitable Funds Committee – Committee's Key Issues	Committee Chair	Assure	Report
	Fit for tomorrow				
12.35	**6.1**	Future system board report, to include: – - Update on build - Update on transformation - Update on digital programme	Chief Finance Officer	Assure	Report
	6.2	The Green Plan	Chief Finance Officer	Improve	Report
		Governance			
12.50	**6.3**	Governance report – to include DOI; publishing of Quality Accounts (and link for website public access); ToR F&P; ToR CFC	Trust Secretary	Assure	Report
	6.4	Agenda items for next meeting	Chair	Note	Verbal
13.10	**6.5**	Reflections on meeting	Chair	Discuss	Verbal
	6.6	Date of next meeting – **25 September 2026**	Chair	Note	Verbal

1. GENERAL BUSINESS

Presented by Jude Chin

1.1. Welcome and apologies for absence - Richard Flatman; Clement Mawoyo; Michael Parsons; Jonathan Rowell (Nick Macdonald attending); Nicola Cottington (Matt Keeling attending); Julie Hull;

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 - 5 June 2026 (ATTACHED)

To Approve

Presented by Jude Chin

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST

MINUTES OF THE
Open Board meeting

Held on Friday 5 June 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
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
Mike Knapton	Non-Executive Director	MK
Clement Mawoyo	Area Director, HomeFirst, Safeguarding and West Suffolk	CM
Maddie Baker-Woods	Executive Director, Primary Care and Neighbourhood Health for Suffolk	MBW
In attendance:		
Paul Bunn	Acting Trust Secretary	PB
Alex Royan	Director of Strategic Planning and Resilience, Digital and Intelligence, NHS Norfolk and Suffolk ICB (Item 2.4 only)	AR
Jane Sharland	Freedom To Speak Up Guardian (Item 4.2 only)	JS
Karen Newbury	Director of Midwifery (Item 3.4 only)	KN
Simon Taylor	ADO, Women & Children and Clinical Support Services (Item 3.4 only)	ST
Kate Croissant	Clinical Director – Women & Children and Clinical Support Services	KC
Melanie Osborne	Quality Improvement Manager (Item 4.5 only)	MO
Dina Manso	Critical Care Outreach Sister (Item 4.5 only)	DM
Diogo Torre	Deputy Senior Nurse for Critical Care Outreach & Resuscitation Critical Care (Item 4.5 only)	DT
Julie Head	Head of Deteriorating Patient Safety & Critical Care Services (Item 4.5 only)	JHd
Ruth Williamson	FT Office (minutes)	RW

Apologies: Richard Jones, Trust Secretary, Maddie Baker-Woods, Executive Director, Primary Care and Neighbourhood Health for Suffolk and Greg Bowker, Head of Communications.
Governors observing: Val Dutton, Anna Conochie
Staff: Eva Unwaha, FSP digital team, Emma Jones, Engagement Lead, FSP, Rachael Scicluna-Penso, INT, Elaine Wheeler, Service Manager, Jemma Morris, Day Surgery Unit
Members of the public: -

1.0 GENERAL BUSINESS		
1.1	**Welcome and apologies for absence**	**Action**
	The Trust Chair (JC) welcomed attendees to the meeting. Apologies were noted, as detailed above. The Chair welcomed Mike Knapton, newly appointed non-executive director (NED), to his first meeting of the Board.	
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 27 March, 2026 were accepted as a true and accurate reflection.	
1.4	**Action Log and matters arising**	
	Action Ref 3199 – People & Organisational Development Committee – CKI Issues – Mandatory Training – noted detailed review scheduled to come to Board on 25 September 2026. Will now be looked at by People & Organisational Development Committee (POD). **Action Closed**. The completed actions were noted.	
1.5	**Questions from Governors and the public relating to items on the agenda.**	
	Anna Conochie, Public Governor, asked about the Trust's position on using Palantir software in light of national concerns regarding patient confidentiality, contracting and product quality. SJ said the Trust is reviewing the NHS England Federated Data Platform through demonstrations and comparison with existing systems. Consideration includes value for money, contractual arrangements, and any concerns raised by patients and staff. If adopted, the Trust would remain the data controller for its own data, while NHS England is the controller for data submitted to national systems.	
1.6	**Patient Story**	
	Dan Spooner (DS), Executive Chief Nurse, introduced a patient story from the parents of sons with complex health needs. The story highlighted the importance of personalised care and making reasonable adjustments. DS noted that staff had continued regular check-ins despite the family's initial reluctance and said the	

	example demonstrated why understanding individual needs is so important. Staff have now been briefed to support any future visits. DS outlined two related workstreams. The first is the rollout of the patient flag system by September to help identify and communicate reasonable adjustments throughout a patient's healthcare journey. The second is the 'Back to the Floor' programme, through which staff have highlighted the burden of electronic records. An event held in May with nursing staff and healthcare assistants explored opportunities to reduce unnecessary administration and enable greater focus on patient care and personalised support. JC said the story had highlighted the wide spectrum of patient needs. NC reflected that patients and carers are the experts in their own experiences and emphasised the importance of listening to them as individuals, rather than focusing solely on systems or training. CM noted the value of listening to families and highlighted the need for a proactive approach to supporting people in the community, including through virtual wards. Opportunities for wider collaboration were also noted. HH commended DS and nursing staff for listening to the family and acting on their feedback. JC concluded that personalised care underpins the Trust's work but is not always considered explicitly at Board level. DS was asked to consider how greater focus could be given to this area.	
1.7	**CEO Report**	
	The Board noted the report presented by Ewen Cameron (EC), Chief Executive Officer. EC highlighted a 5% improvement in four-hour performance, noting that whilst further improvement was required, performance had become more consistent. He reported that the Trust had achieved the fifth largest reduction in elective waiting lists nationally, was the thirteenth most improved provider nationally for 18-week RTT performance, was the most improved provider nationally for patients receiving diagnostic tests within six weeks and had commenced its robotic surgery programme. In response to AW's question regarding lessons learned from focus on performance in March, NC advised that sustained performance throughout the year was the key objective. Improvement had been achieved through a concerted organisational effort, including senior support within the Emergency Department and a focus on ensuring patients received care from the most appropriate team. Sustainable improvement would require fundamental changes to patient flow across the organisation, supported by the CQI programme. CM recognised these results as a significant milestone for the Trust and asked how these achievements were being celebrated. EC advised that progress was being acknowledged through staff	

	communications and engagement opportunities, whilst maintaining focus on the further improvements required. The Board acknowledged the significant contribution of staff to the improvements achieved. **It was agreed that JC, EC and GB would consider how best to communicate the Board's thanks and recognition to staff.**	**JC/EC/GB**
1.8	**BAF & Risk Report**	
	The Board received the report presented by Paul Bunn (PB), Acting Trust Secretary. PB reported that the number of Board Assurance Framework (BAF) risks had reduced from eight to seven, reflecting significant work to refine the framework. JC noted the importance of using the BAF as a live document. PB advised that the BAF would continue to evolve through review by the Assurance Committees, enabling further scrutiny and testing. He reported that the framework contained three red-rated risks and four amber-rated risks. Further work would focus on risk appetite, alignment with corporate risks and ongoing refinement. Board members welcomed the progress made and discussed the frequency of risk reviews, alignment with the Trust's strategic pillars, and the relationship between interconnected risks. PB advised that the planned work on risk appetite may inform future review frequencies. He also confirmed that cyber risk would be reported to the closed session of the Board given its sensitive nature. In response to RF's question regarding risk scoring, PB advised that Executive Directors had reviewed the scores and that finalisation was underway. JC confirmed that time had been allocated at the forthcoming Board development session to consider the BAF further. He noted that Executive Directors would continue to review and update the framework as required, supported by oversight through the Assurance Committees.	
2.0 JOINED UP SERVICES		
2.1	**Strategic Priorities Update**	
	Sam Tappenden (ST), Director of Strategy & Transformation, presented the report. ST advised that the scorecard had been developed across the Trust's five strategic pillars to provide a strategic view of progress for the Board and external stakeholders. As this was the first iteration, reporting remained a largely manual process, with plans to develop a dashboard approach and review the scorecard three times a year. AJ welcomed the work but said the links between the scorecard, priority projects and 90-day targets were not always clear. AJ also highlighted inconsistencies in language, ownership descriptions	

	and the alignment between some ambitions and actions and suggested greater use of plain English. AW said the scorecard provided a useful starting point but could include stronger measures around communications and richer indicators of progress, rather than relying solely on upward or downward movement. AW also noted that the staff survey measure appeared to suggest deterioration when performance had remained broadly stable. JC noted that much of the information was already reviewed through the IQPR and emphasised the need to avoid duplication and ensure the scorecard focused on strategic progress. NC agreed, commenting that the IQPR and scorecard served different purposes, with the latter reflecting delivery of the Trust's strategy. PZR welcomed the progress made and suggested greater emphasis on inequalities of outcomes, organisational learning and the impact of joined-up services. JC added that the focus should be on identifying meaningful measures of strategic progress rather than relying solely on existing data. HH supported the use of lead and lag indicators and milestones to provide assurance that the Trust remained on track while retaining a high-level strategic overview. In response, ST agreed to review the consistency of the document and confirmed that future iterations would bring the scorecard and priority projects together more clearly, supported by a more digital reporting format. The Board welcomed the progress made and **agreed that a revised version would be presented to the September Board meeting**.	**ST**
2.2	**Joint Productivity Board Update**	
	Sam Tappenden (ST), Director of Strategy & Transformation, presented the report. ST advised that previous opportunities for collaboration with East Suffolk & North Essex Foundation Trust (ESNEFT) had been affected by changes in national policy and direction, resulting in a more transactional approach. Four areas for potential collaboration had been identified for further development. JC noted that, whilst the organisations had operated through a joint Board arrangement, delivery of any agreed actions would need to sit with the individual trusts. It had therefore been agreed that responsibility for identifying opportunities for collaboration would be delegated to the respective Chief Executives. JC advised that a new Chief Executive would take up post at ESNEFT in July and that discussions would take place thereafter. EC added that the focus would be on areas that delivered clear value. The Board noted the update.	

2.3	**West Suffolk Alliance and SNEE Integrated Care Board Update**	
	In Maddie Baker Wood's (MBW) absence, Clement Mawoyo (CM) presented the report, providing an update on the Primary Care Neighbourhood Committee, including work across the three unitary authorities, the community contract and discussions at the May Alliance Committee meeting, which had been positive. PZR asked for an update on progress relating to dementia and whether learning from the Better Care Fund *Die Well* programme could be rolled out more widely. CM advised that significant progress had been made through the Suffolk Strategic Dementia Group and offered to provide further highlights on local dementia care. EC noted that the Alliance Committee received regular reports and action plans on dementia and, whilst progress was not yet at the desired level, work was continuing. EC confirmed that the Alliance Committee was leading this work and that MBW would provide an update to a future Board meeting. On the *Die Well* programme, CM advised that considerable work was being undertaken through the *Live Well* framework. Whilst recognising that further improvement was required, progress was being made in embedding ageing well across localities. SJ advised that the joint app referenced in section 3.1 had been removed from the programme due to limited clinical engagement, together with information governance and clinical safety concerns, and was therefore not currently being rolled out. **NC welcomed the reported outcomes relating to end of life patients remaining at home but queried the baseline position, noting the importance of ensuring any improvement could be evidenced. CM agreed to take this point back to MBW for consideration**. CM also noted that additional end of life funding had been allocated and confirmed that a further update would be provided on the issues raised. The Board noted the update.	**CM/MBW**
2.4	**ICB Joint Forward Plan – Strategy & Population Health Improvement Plan**	
	Dr Alex Royan (AR), Director of Strategic Planning and Resilience, Digital and Intelligence, NHS Norfolk and Suffolk ICB, presented the report and thanked the Trust for its contribution to the development of the strategy. AR outlined the implications of the Darzi Review and the evolving role of Integrated Care Boards, which had informed the development of a Strategic Commissioning Framework focused on improving population health. AR highlighted the three strategic shifts, the outcomes the strategy sought to achieve and the four delivery ambitions set out within the framework. The accompanying toolkit had been developed to support commissioners in decision-making and ensure investment decisions were based on value and outcomes, as well as affordability.	

	JC asked how population needs would be assessed across different localities and whether analysis would be undertaken at a Suffolk-wide or more local level. AR advised that the intention was to use granular data and lived experience insights to understand needs at neighbourhood and place level wherever possible. NC welcomed the commissioning framework and asked about the ICB's role in supporting digital transformation, including the development of a single patient record. AR said that, whilst the ICB's direct role in digital oversight had reduced, it would continue to play a collaborative and facilitative role in major digital programmes and in developing a shared vision across the system. MK asked how the strategic commissioning approach would align with workforce planning and support changes in care delivery. AR acknowledged the importance of workforce considerations and said this would require collaboration between commissioners and providers, with providers best placed to understand workforce implications. ST asked how new payment mechanisms and relationships between the ICB and providers would develop under the emerging model. AR said that new arrangements would continue to evolve through collaborative working, including consideration of risk-sharing and alternative payment approaches. PZR welcomed the whole-life approach but questioned whether greater emphasis should be placed on early intervention and younger people, particularly those with mental health needs. AR said that the framework included targeted initiatives and outcome measures for specific population groups and would support investment decisions aimed at improving long-term outcomes. HH commented that the strategic direction was clear but sought assurance that existing successful initiatives would be built upon rather than replaced. AR explained that delivery plans and commissioning intentions would identify areas for improvement, with implementation led by provider organisations rather than the ICB. JC concluded that the framework presented both significant opportunities and challenges for the Trust.	
3.0 HIGH QUALITY CARE		
3.1	**Integrated Quality & Performance Report (IQPR)**	
	Nicola Cottington (NC), Chief Operating Officer, presented the report. The Board welcomed the continued improvement in diagnostic performance and noted the positive impact this was having on RTT performance and patient experience. NC cautioned that future targets would be more stretching and that further improvement would be required. NC also highlighted work through the CQI programme to address bed waits within the Emergency Department.	

	JH noted the increasing demands arising from mandatory training requirements, including recommendations following Lord Mann's review of antisemitism and other forms of racism in the NHS. JH emphasised the importance of ensuring training added value whilst managing the burden on staff. JH advised that a review of mandatory training requirements was underway, including consideration of the removal of some elements and the introduction of group training sessions to improve efficiency. NC highlighted positive feedback received following implementation of the Absence Management Policy within Estates. MK asked about the implications of the recent Supreme Court ruling relating to deprivation of liberty. PB advised that teams were well versed in deprivation of liberty processes and that the ruling was unlikely to have a significant operational impact. CM added that guidance was being developed, with targeted communications planned in liaison with safeguarding colleagues. AJ sought an update on Community Paediatrics. NC advised that performance challenges continued to be driven largely by autism assessment demand and that a system-wide solution was being developed. A report would be presented to the Management Executive Group (MEG). RF queried the Trust's reported position within the National Oversight Framework. EC clarified that the Trust had moved into Segment 3 under the unadjusted segmentation methodology and that an earlier reference to Segment 2 had been incorrect. JC asked when Quarter 4 results were expected. EC advised that these were anticipated the following week.	
3.2	**Quality & Patient Safety Committee – Committee's Key Issues**	
	Paul Zollinger-Read (PZR), Non-Executive Director, presented the report. PZR noted that a number of clinical policies were currently overdue for review. A plan was in place to update these policies, with completion expected by the end of August.	
3.3	**Quality and Nurse Staffing Report**	
	Dan Spooner (DS), Chief Nurse, presented the report. DS advised that March and April had been challenging months, particularly due to sickness absence. Acute staffing incidents had reduced, although a continuing trend remained within community services. DS highlighted that staffing red flags were reviewed three times daily, with mitigations recorded and action taken in real time. The transition from Radar to Allocate would further strengthen real-time oversight and response. DS outlined emerging risks relating to community nursing capacity, reflecting increasing demand and advised that work was underway to review acuity and demand alongside recruitment into Integrated Neighbourhood Teams. DS also highlighted turnover amongst	

	Healthcare Support Workers and reported targeted work with Human Resources to improve retention. **EC queried whether the common cause variation shown in the report under Falls and Pressure Ulcers had been driven by decisions relating to the closure of Glastonbury Court and requested an update in the next report to the Board.** SJ suggested that future reports should provide clearer narrative alongside metrics to indicate whether performance was improving or deteriorating. SJ also queried the critical care fill rate shown. DS explained that the figure related to a single role and did not present a risk to the Intensive Care Unit. PZR said it was difficult, from the appendices alone, to identify areas of success and asked whether staffing data was triangulated with indicators such as mortality. DS confirmed that staffing levels were reviewed where harm events occurred to assess whether staffing had been a contributory factor. EC added that patient movement across wards could make direct correlation challenging. MK asked about specialling. DS advised that robust monitoring arrangements were in place and discussed three times daily, but the detail was not currently included within the report. DS noted that over-establishment was often attributable to specialling requirements, which were not included within funded establishments. MK suggested this information would be helpful to demonstrate that high-risk patients were receiving appropriate care and support. NC acknowledged that some of these issues were difficult to identify through the data alone and noted that concerns were escalated through divisional and operational processes. Seeking assurance on staffing levels, JC asked where this was obtained. **It was agreed that DS and PZR would discuss how further assurance could be reflected in future reporting via the Quality & Patient Safety Committee.** The Board noted the report.	**DS** **DS/PZR**
3.4	**Maternity Services Report**	
	Karen Newbury (KN), Associate Director of Midwifery, Simon Taylor (ST), Associate Director of Operations for Women & Children and Clinical Support Services and Kate Croissant, Clinical Director, Women & Children, presented the report. KN advised that work was ongoing to improve the quantification of service user feedback. Whilst Friends and Family Test scores had declined, valuable qualitative feedback continued to be received through free text comments and other feedback mechanisms. The importance of ensuring SHO training was included during induction was highlighted, given the short duration of placements.	

	JC asked how Friends and Family Test feedback was shared with staff. KN confirmed that feedback was routinely shared, including through 'Take 5' sessions. NC asked how staff were informed about actions taken in response to concerns raised by Safety Champions. KN explained that individual concerns were fed back directly, whilst broader themes were shared through the 'Risky Business' communications, highlighting both issues raised and mitigating actions taken. PZR asked about postnatal support and feedback. KN explained that, following discharge, women were visited by a community midwife within 24 hours and generally remained under maternity services until Day 10, with support extended where required. Care then transferred to Health Visitors and GPs, with community teams liaising closely and escalating concerns, as necessary. KN noted that postnatal depression often emerged after discharge from maternity services and that Health Visitor capacity remained a challenge. AJ welcomed the introduction of overnight visitors following service user feedback and cited this as a positive example of the division responding to patient views. Discussing quality improvement, JC noted the number of maternity QI projects and asked what had enabled progress. KN said the division actively sought to improve services and embedded quality improvement within everyday practice. All newly qualified midwives completed a preceptorship programme that included a mandatory QI project and governance was regarded as everyone's responsibility. KN added that listening to service users remained central to improvement work. In response to a further question from JC regarding the Trust's Continuous Knowledge and Improvement ambition, KN said that quality improvement was embedded from the start of careers and supported as a lifelong approach to practice.	
4.0 EMPOWERED TO IMPROVE		
4.1	**People & Organisational Development Committee - Committee's Key Issues**	
	Alison Wigg (AW), Non-Executive Director, presented the report. AW noted that the Committee had received only partial assurance in relation to unacceptable behaviour. Whilst members were comfortable that appropriate sanctions could be enacted where required, clarification was sought as to why only partial assurance had been provided. NC explained that the rating related to behaviours and the support provided to staff. Further information had been requested, including a breakdown of incidents to better understand the nature of reported concerns, such as how many cases involved racist behaviour. EC advised that the partial assurance reflected the assurance received by the Committee. It was noted that there remained a gap	

	between the actions taken by the organisation and staff perceptions, with staff often expressing the view that no action was taken in response to concerns raised. Work was ongoing to address this disconnect and improve staff confidence in the processes in place.	
4.2	**Freedom to Speak Up Guardian**	
	Jane Sharland (JS), Freedom to Speak Up Guardian, presented the report. JS reported that the National Guardian Office had closed at the end of June. She emphasised that the Freedom to Speak Up (FTSU) function would continue, with responsibilities transitioning locally. JS was working with AJ and JH to support this process. An increase in anonymous reporting was noted, which was viewed as a positive indicator of psychological safety. Common reasons for approaching FTSU included seeking additional assurance and concerns about potential detriment from speaking up. JS noted that engagement with FTSU often gave staff greater confidence to raise concerns directly with their manager where appropriate. Key themes included support for junior staff in raising concerns, the need to undertake Equality Impact Assessments at an early stage of organisational change and the importance of communicating difficult messages compassionately. It was noted that staff affected by organisational change should feel their contribution had been recognised and valued. JS also advised that toilet facilities at the main entrance had reopened. EC referred to a recent meeting with the University of East Anglia (UEA) regarding student training and complaints processes. JS confirmed that no concerns had been raised through FTSU by medical students, although the service was available to them. An increase in referrals from resident doctors was noted as a positive sign. **RG agreed to explore including JS in student induction arrangements.** JS updated the Board on the FTSU planning tool, which was being developed with EC, JH and AJ. JC welcomed the encouraging assessment scores. The assessment had also highlighted the need for a formal evaluation of the FTSU function every two years. JS and JH confirmed that this was being considered.	**RG**
4.3	**Putting You First Award**	
	Julie Hull (JH), Chief People Officer, presented the report. JH thanked Emma Wheeler and Jemma Morris for attending the meeting as recipients of the Putting You First Award and noted the Board's appreciation of their achievements. **It was agreed that future recipients of PYF Awards would be invited to attend Board meetings.**	**JH**

	The Board noted all the award recipients, Elaine Wheeler, Jemma Morris, Ian Markham, Siobhan Johnson and Rachel Pym, and extended its congratulations.	
4.4	**National Staff Survey Action Plan**	
	Julie Hull (JH), Chief People Officer, presented the report and noted an increase in Pulse Survey responses. She advised that five priority areas had been identified, linked to staff recommender scores and the themes of work and care, with actions developed against each. SJ welcomed the report and noted that the actions were relevant to both clinical and corporate teams. MK asked how Pulse Survey results were being used to monitor progress. JH explained that, whilst the Pulse Survey does not directly align with all Staff Survey measures, recommender scores are linked and the findings provide a useful indication of organisational sentiment when considered alongside other metrics. ST asked how staff had helped shape the action plan. JH advised that staff feedback had informed divisional plans and that future engagement would place greater emphasis on collaboration with colleagues. EC reflected on previous staff survey discussions and emphasised the importance of staff engagement at all levels. JC highlighted the role of the People and Organisational Development team in supporting delivery of the actions and monitoring progress.	
4.5	**Quality Improvement**	
	Sam Tappenden (ST), Director of Strategy and Transformation, introduced Melanie Osborne (MO), Quality Improvement Manager, Dina Manso (DM), Critical Care Outreach Sister, Diogo Torre, Deputy Senior Nurse for Critical Care Outreach & Resuscitation Critical Care and Julie Head (JHd), Head of Deteriorating Patient Safety & Critical Care Services, who gave a presentation on the Trust's Quality Improvement (QI) programme and the Martha's Rule project. DS congratulated DM on her presentation and noted that her project had won the Trust's Nurses Day QI award. He also recognised the national attention received for the Trust's Martha's Rule work. JH welcomed the cultural shift towards encouraging challenge and asked how Martha's Rule supports escalation where concerns are not initially heard. DM explained that clear escalation routes and independent review processes are in place, supported by strong working relationships between the Outreach Team and clinical staff. RG commented that the credibility of the Outreach Team helped support effective challenge. NC agreed but noted the importance of remaining mindful of the power imbalance that can be experienced by patients and families.	

	NC also welcomed the structured QI approach, noting that staff had always sought to improve services but now had the skills and framework to achieve greater impact. PZR asked how QI could be spread further across the Trust. DM advised that face-to-face engagement and clear communication about the purpose of projects were key to securing support. EC asked how the success of QI activity would be measured. MO advised that this would include staff survey measures, QI dashboards and reporting against organisational priorities. ST explained that QI is a core component of the Trust's management system and should support both organisational and local priorities. In response to AW, he acknowledged that a formal process for spreading successful projects across the Trust is still being developed, although learning is shared through divisional governance arrangements and project closure processes.	
5.0 RESPONSIBLE WITH RESOURCES		
5.1	**Finance & Performance Committee – Committee's Key Issues**	
	Antoinette Jackson (AJ), Non-executive Director, presented the report which was noted and taken as read.	
5.2	**Finance Report**	
	Jonathan Rowell (JR), Chief Finance Officer, presented the report. JR reported a year-end adjustment from £20.7 million to £14.5 million, reflecting a combination of system and national bonus funding. The final position was a positive impairment adjustment of £5.7 million. This arose from the reversal of an impairment previously recognised in relation to the RAAC programme, as the expected lifespan of the affected hospital infrastructure had been extended. JR advised that the external auditors were nearing completion of their work and had not identified any matters of concern to date. Providing an update on the Month 1 financial position, JR noted that the Trust's plan for 2026/27 was to achieve a breakeven position. Performance at the start of the year had been impacted by industrial action and the extended closure of theatres for refurbishment works. Income had been slower than anticipated and had been further affected by these factors. Industrial action over the Easter period had required additional temporary staffing at enhanced rates. Whilst the Trust expected to recover the direct costs associated with industrial action, there would be no reimbursement for lost income as the activity had not taken place, despite funding being available within the ICB for cancelled activity. JR explained that the Board had approved the refurbishment of two theatres, originally scheduled for completion in April. However, the programme had been extended until July following the discovery of fire compartmentation issues concealed above ceiling spaces	

	which did not meet the required standard. As a result, the theatre closures would have a further impact on income. A recovery plan had been agreed by the MEG, although delivery was expected to take the remainder of the financial year. In response to a question from PZR regarding the variance between the original estimate and the actual duration of the theatre refurbishment works, JR explained that the initial assessment had been based on existing drawings and estate records. The previously unidentified fire compartmentation issues had only become apparent once work commenced. JR noted that, as a learning point, future theatre refurbishment projects would include detailed surveys undertaken during weekend closures before timescales were finalised. JC asked when Board members could expect to receive the Annual Report and Accounts for review, noting the 30 June audit deadline and the planned sign-off date of 23 July. JR confirmed that papers would be issued the week before sign-off. PB commented that the auditors appeared to be further advanced than anticipated and expected a draft to be available within approximately 12 days. JR acknowledged the support provided by Liana Nicholson and Ross Beard, Finance, throughout the audit process.	
5.3	**Charitable Funds Committee – Committee's Key Issues**	
	Richard Flatman (RF), Non-executive Director presented the report, advising that there were no matters requiring escalation to this Committee. RF reported on a recent visit to view the Trust's new surgical robot. The visit provided an opportunity to see the impressive technology in operation and its potential benefits for patient care and clinical practice.	
6.0 FIT FOR TOMORROW		
6.1	**Future System Board Report**	
	Jonathan Rowell (JR), Chief Finance Officer, presented the report. JR reported that Dragados had been confirmed as the Trust's construction partner for the hospital redevelopment programme. He noted that the New Hospital Programme (NHP) had undertaken effective market engagement activity, which had helped stimulate interest and competition within the sector. JR advised that work continued to address capital affordability challenges, as the current scheme did not yet fully align with the available funding envelope. The Trust was therefore working closely with Dragados and the NHP team to refine the proposals and progress the programme. JR confirmed that a stocktake meeting would take place on 15 June to review progress and consider the next steps. Submission of the Outline Business Case (OBC) remained planned for the autumn, with construction currently expected to commence in 2028.	

6.2	**Governance Report**	
	Paul Bunn (PB), Acting Trust Secretary, presented the report, advising that there were no matters requiring escalation. The report presented a proposal regarding the timing of the Public Board meeting cycle. Having considered the merits of revising the existing arrangements and for the reasons set out, it was recommended that the current cycle be retained. **The Board approved continuation of the bi-monthly Public Board meeting cycle.** PB provided an update on the next steps relating to the Council of Governors and member engagement. He advised that the approach had been refined to reflect the current landscape and to support wider engagement with governors and members. Governor elections would proceed as planned, with a key objective of broadening participation and increasing the diversity of the candidate pool. This would include engagement and presentations to a range of community and stakeholder groups. PB confirmed that the election process would commence in July.	
6.3	**Agenda Items for Next Meeting**	
	Jude Chin, (JC), Chair, presented the report, which was noted and taken as read.	
6.4	**Reflections on Meeting**	
	NC reflected that the inclusion of real-life case studies within Board discussions was valuable, noting that they were more engaging and helped bring the matters under consideration to life. PB commented on the balance of Board time spent considering both retrospective performance and future priorities. He considered that the balance was appropriate and provided a good level of strategic discussion. JC noted that, following the recent Council of Governors meeting, AJ had been confirmed as Deputy Chair.	
6.5	**Date of Next Meeting**	
	31 July, 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
3205	Open	05/06/2026	2.1	**Strategic Priorities Update -** revised version of scorecard would be presented to the September Board meeting.	**Updated paper to come to September Board.**	ST	25/09/26	Green	
3206	Open	05/06/2026	2.3	**West Suffolk Alliance and SNEE Integrated Care Board Update** - Baseline required for outcomes relating to end of life patients remaining at home to ensure any improvement can be evidenced.	**Update to come to September Board.**	CM/MBW	25/09/26	Green	
3208	Open	05/06/2026	3.3	**Quality & Nurse Staffing Report** - **Staffing Levels** - consider how further assurance could be reflected in future reporting via the Quality & Patient Safety Committee.	**Verbal update to be provided at today's (31.7.26) meeting.**	DS/PZR	31/07/26	Green	

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for	Date
3204	Open	05/06/2026	1.7	**CEO Report -** consider how best to communicate the Board's thanks and recognition to staff winning a Putting You First Award.	**Board members to be invited to offer feedback as part of the regular item on PYF winners. This will be captured by the Head of Comms or their deputy, and shared with the winner during the presentation of the Award from the CEO.**	JC/EC/GB	31/07/26	Complete	31/07/2026
3207	Open	05/06/2026	3.3	**Quality & Nurse Staffing Report** - reasons for common cause variation shown under Falls and Pressure Ulcers to be included in next report.	**Detail within today's (31 July 2026) Quality & Nurse Staffing Report.**	DS	31/07/26	Complete	31/07/2026
3209	Open	05/06/2026	4.2	**Freedom to Speak Up Guardian** - explore inclusion of Guardian in medical student induction arrangements.	**Guardian in touch with undergraduate medical education team to arrange to attend student doctor inductions**	RG	31/07/26	Complete	31/07/2026
3210	Open	05/06/2026	4.3	**Putting You First Award** - future recipients of PYF Awards to be invited to attend Board meetings.	**It has been agreed that award winners will continue to receive their awards personally from the Chief Executive, ensuring that colleagues who are based off-site are able to receive their recognition. However, all award winners are warmly invited to attend the public Board meeting, where their achievements and success will be formally reported and acknowledged.**	JH	31/07/26	Complete	31/07/2026

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

To Note

Presented by Jude Chin

1.6. QI Staff Story - Sarah Thirlby (Neonatal Governance Lead) and Nicola Kelly (Quality and Improvement Lead for Neonates)

To Review

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; Greg Bowker, head of communications; Anna Hollis, deputy head of communications; Sam Green, senior communications officer.
This report is for: ☐Approval ☒ Assurance ☐Discussion ☒Information

This report supports the following ambitions within the organisational strategy:

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

Executive summary

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

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

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

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

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

The items reported will be actioned through the appropriate routes.

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

Governance and compliance

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

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

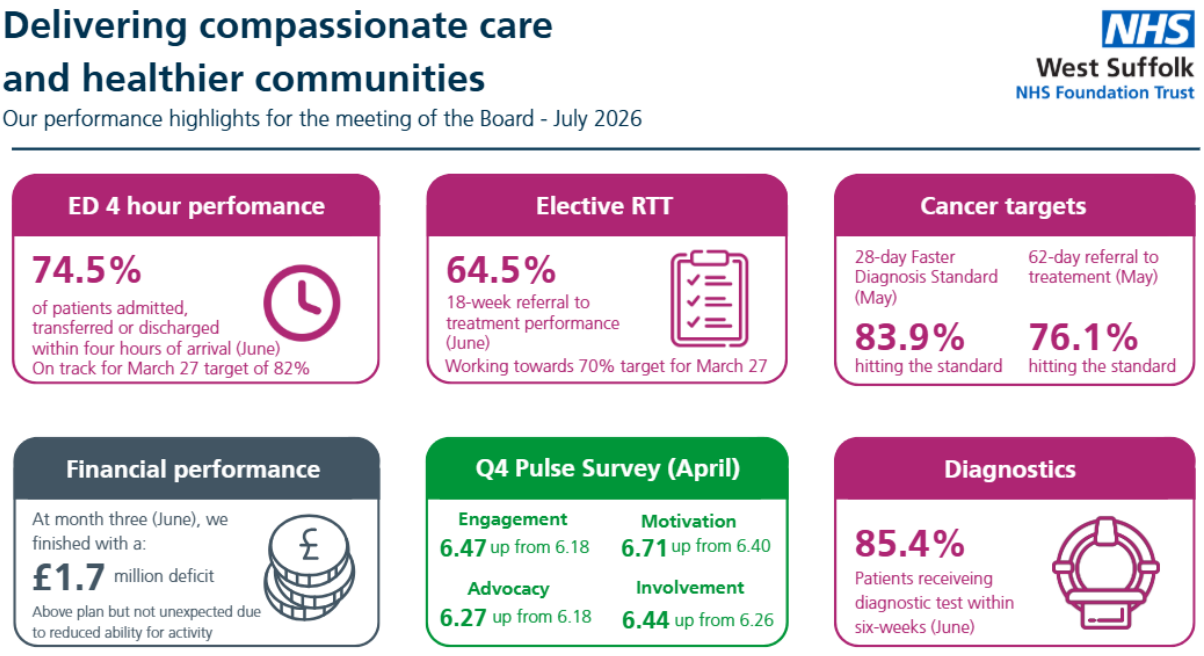
Chief Executive Officer's report

1. Introduction

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

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

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



Compassionate care, healthier communities

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

2. Financial performance

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

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

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

3. Performance

Elective recovery

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

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

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

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

Diagnostics

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

Urgent and emergency care

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

Cancer

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

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

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

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

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

4. Quality

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

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

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

5. Workforce

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

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

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

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

6. Future

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

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

1.8. BAF and Risk Report (ATTACHED)

To inform

Presented by Paul Bunn

Open Board – 31 July 2026; Risk Appetite Review

Report information

Report title: Review of BAF and associated Risk Appetite Statements
Agenda item: 1.8
Sponsor/Executive lead: Ewen Cameron, CEO
Report prepared by: Paul Bunn, Acting Trust Secretary
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?
This paper provides: (i) an update on changes to the Board Assurance Framework (BAF) since this was last reviewed in May 2026; (ii) an update following the Board development workshop on 26 June 2026 where risk appetite in relation to the revised BAF was discussed.

(i) BAF update

Given the wholescale rewrite of the entire BAF in May 2026, during the last two months we are now settling into the usual reporting cycle for each BAF risk. There have been no significant changes to mitigations, actions or assurance lines in the reporting period.

In accordance with the reporting schedule in **Appendix 1:** BAF 2, 3 and 8 have been reviewed. The highlights are:

- **BAF 2 (estates)** – F&P discussed if the BAF adequately captures the risks around extreme heat, particularly re the effects on the estate, and are mitigations enough to cope with extreme weather generally. Acknowledged heat is affecting preventative work programme and mitigations are in place. Environmental issues agreed to be captured through the risk register and feed into the estates BAF.
- **BAF 3 (Finance loss of control)** – F&P discussed whether the deadlines of October 26 for mitigations to be in place around managing weakness in business planning were appropriate. Clarification around current work programmes provided. Also looked at whether BAF needs to reflect changes from block contract to income linked to activity and this will be reflected in future reviews.

- **BAF 8 (Transformation)** – QPS and F&P noted that the previous collaboration and transformation risks had been combined into a single risk, reflecting the significant interdependencies between the two areas. Progress was reported across a number of areas, including partnership working, strategy development, governance, internal audit activity, organisational planning and the implementation of quality improvement programmes.

Escalations
The internal audit recommended that the Board should specifically be made aware of any escalations/de-escalations to the BAF. There are none to report this month.

Workplan
BAFs - 5 (workforce), 6 (quality of care) and 7 (performance) are due for review in the next reporting period.

(ii) Risk Appetite

This section of the report sets out the refreshed board appetite for the BAF throughout 2026/27, following discussion at the Board workshop on 26 June 2026.

BAF 1 – cyber will be discussed in closed Board in order to minimise the risks to cyber security, however, no change proposed to the risk appetite. This is deemed the correct balance between transparency and risk of harm to the organisation.

Table 1 below captures the current and proposed changes of risk appetite for each BAF. Future actions will be monitored through the assigned assurance committees.

The matrix in **Appendix 2** was used to facilitate the discussion and to ensure this was as objective as possible. When reviewing the risk appetite, the Board has considered both external factors including environmental, political and operational pressures specific to the healthcare sector, as well as our own culture, governance and decision-making processes. The Trust currently adopts the following risks appetite scale:-

Averse	Avoidance of the risk is the objective. Every reasonable action taken to reduce risk as far as practicably possible.
Minimal	Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls.
Cautious	Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.
Open	Willing to consider all potential options, subject to continued application and / or establishment of controls: recognising that there could be a high-risk exposure.
Hungry	Eager to be innovative and take on a very high level of risk but only in the right circumstances.

During the workshop, the Board questioned the merits of reference to the word 'hungry' within the definition. Further research confirms many Trusts and the Government guidance on risk appetite[1] adopt the definition 'Eager' rather than 'Hungry'. **The Board is invited to agree to adopt this definition in 2026/27 Risk Appetite statement,** but with no changes to the actual description.

BAF Risk	Current Score	Appetite	Proposed 2026/27 Appetite	Rationale – next steps
1. Cyber	16	Cautious (max 9)	No change	Remain at cautious for now. D&D to review if 16 is the right score and provide a recommendation re whether the risk appetite of cautious is achievable.
2. Estates – Fail to ensure the Trust estates are safe, fit for purpose while maintained to the appropriate standard so that everyone has a comfortable environment to be cared for and work in today and for the future. This includes both the main acute hospital site and community sites.	15	Open (max 12)	No change	Remain open because of move to future hospital and capital programme works planned.
3. Finance – Loss of Control 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	12	Cautious (max 9)	No change	Accepted this in on the boundary between cautious and minimal. Acknowledged Trust is running a deficit. However, workshop did not think that reflected investment decisions recently made.
5. Workforce, Staff engagement, supply chain, diversity Failing to ensure that the Trust has the necessary capability and skills to deliver high-quality, safe, and effective services risks compromising the outcomes and experiences of those we serve, including our ability to attract and develop both our current and future workforce. In addition, failing to effectively support, protect, and improve the health, wellbeing, and safety of our staff undermines our ability to sustain a resilient and engaged workforce.	12	Cautious (max 9)	Change to open	Admin review and transformation to new hospital work captures approach. POD to consider separating BAF into (i) supply chain, capability; and (ii) workplace staff experience to encompass EDI
6. Quality of care	9	Cautious (max 9)	No change	Agreed is a need to innovate with patient care to deliver left

[1] *Risk Appetite Guidance Note

There is a risk that the Trust may fail to meet the required CQC regulations and to continuously improve the quality, safety, and experience of its services. This could adversely impact patient outcomes and experience, as well as the organisation's reputation				shift, but in a balanced way with appropriate safeguards in place. QPS to revise risk appetite statement
7. Performance There is a risk that the Trust is unable to consistently deliver safe, timely and effective acute and community services, including meeting key national access and flow standards, due to sustained operational pressures, workforce constraints and increasing demand, resulting in harm to patients, regulatory intervention, financial deterioration and reputational damage.	16	New risk	Open	In transforming a service one takes appropriate and measured risks in the hope of effective delivery of service in future.
8. Transformation There is a risk that ineffective collaboration with partners, combined with insufficient organisational capacity, capability, prioritisation discipline, and commitment to change, prevents the Trust from delivering the 'Future Shift'. This may lead to failure to implement strategic transformation priorities, including the Future Systems Programme and new models of care. As a result, the Trust may be unable to meet changing demand, deliver major programmes, or secure sustainable services, resulting in increased operational pressures, deteriorating quality and outcomes, and risks to the Trust's long-term financial and organisational sustainability.	12	Open (max 12)	No change	Transformation work underway although in its infancy in some areas.

Table 1

So what?

Risk appetite provides a framework which enables the Trust to make informed management decisions. By defining the risk trajectory, the Trust clearly sets out both the target and acceptable position in the pursuit of its strategic objectives.

The benefits of adopting a risk appetite include: supporting informed decision-making; reducing uncertainty; improving consistency; supporting performance improvement; focusing on priority areas; and, informing resource prioritisation processes.

What next?

- If agreed, refresh risk appetite statements with executive leads for each BAF in accordance with reporting cycle.
- Refresh the Trust's overarching risk appetite statement – by September 2026.
- Work with senior leadership team to spread risk appetite themes into the divisions so that they can reflect thinking in business as usual and transformation projects when considering risk.

Action required by the committee:

1. Formally approve change to the risk appetite scale changing ‘hungry’ to ‘Eager’.
2. To discuss and approve the Risk Appetite approach for 2026/27 as discussed in this report and Table 1.

Governance and compliance

Risk and assurance:
Failure to effectively manage risks is a potential breach of the relevant regulations and the Trusts own objectives. Internal audit review and testing of the risk register.

Equality, diversity and inclusion:
Decisions should not disadvantage individuals or groups with protected characteristics as they apply universally throughout the Trust and comply with national standards for scoring risk.

Sustainability:
Effective risk management and internal control will ensure systems and process are not only safe but sustainable into the future**.**

Legal and regulatory context:
The Annual Governance Statement (AGS) includes a section on the Trust’s capacity to handle risk; risk and control framework; resourcing levels; any data governance serious incidents and key controls; and overall effectiveness of internal control. This links to the CQC Well Led assessment framework and the Health & Safety at Work Act 1974

Appendix 1

	Score	Frequency	Executive lead	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
Manangement Executive Group																							
BAF 1- Cyber	16	quartely	COO (Nicola Cottington)		X		X			X			X			X			X			X	
BAF 2-Estates	15	quarterly	CFO (Jonathan Rowell)	X			X			X			X			X			X			X	
BAF 3-Finance	12	six monthly	CFO (Jonathan Rowell)	X						X						X						X	
BAF 4-TBC																							
BAF 5-Workforce	12	six monthly	CPO (Julie Hull)			X						X						X					
BAF 6-Quality of Care	9	six monthly	ECN (Dan Spooner)			X						X						X					
BAF 7- Performance	16	quarterly	COO (Nicola Cottington)		X			X			X			X			X			X			X
BAF 8- Transformation	12	six monthly	DST (Sam Tappenden)	X						X						X						X	
Quality and Patient Safety Committee																							
BAF 6 - Quality of Care	9	six monthly	ECN (Dan Spooner)				X						X						X				
BAF 8 - Transformation	12	six monthly	DST (Sam Tappenden)		X						X						X						X
Finance and Perfomance Committee																							
BAF 2-Estates	15	quarterly	CFO (Jonathan Rowell)		X			X			X			X			X			X			X
BAF 3-Finance	12	six monthly	CFO (Jonathan Rowell)		X						X						X						X
BAF 7-Performance	16	quarterly	COO (Nicola Cottington)			X			X			X			X			X			X		
People and Organisational Development Committee																							
BAF 5-Workforce	12	six monthly	CPO (Julie Hull)			X						X						X					
Digital and Data Committee																							
BAF1-Cyber	16	quartely	COO (Nicola Cottington)		X			X			X			X			X			X			

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Appendix 2

Risk Level Risk Type	Averse (score 4 and below)	Minimal (score 6 and below)	Cautious (9 and below)	Open (12 and below)	Hungry (16 and below)
Quality	Zero appetite for any decisions with a high chance of an adverse or uncertain impact on the quality of patient care and the quality of outcomes for the patient.	Appetite for taking very limited clinical risks if essential to the quality of patient care and outcomes. Such risks are properly assessed with mitigating controls in place. Avoid innovation unless established and proven to be effective.	Appetite for taking moderate clinical risks where there is a low degree of inherent risk and the possibility of improved quality of outcomes, and appropriate controls are in place.	We will pursue innovation where there is potential for significant longer-term rewards and improvement on the quality of patient outcomes.	We seek to lead the way and will prioritise new innovations, even in emerging fields. We consistently challenge current working practices in order to drive improvement in the quality of patient outcomes.
Finance	No appetite for decisions or actions which may result in financial loss.	Only prepared to accept minimal possibility of material financial impacts or losses or reporting misstatements if essential to safe and effective patient care and outcomes	Limited financial impacts or losses are accepted if they yield upside opportunities elsewhere within the Trust. Value for money is a key focus.	Prepared to invest and/or accept financial impacts or losses for the benefit of improved patient care and outcomes if appropriate controls are in place and value for money is delivered.	Proactively invest and/or accept financial impacts or losses for the benefit of patient care and outcomes, recognising that the potential for substantial gain outweighs inherent risks.
Performance	No appetite for action which may impact on operational service delivery. Focus on capability to protect services and maintain tight control.	Limited action may be taken which may impact on operational service delivery only where it is essential to deliver safe and effective patient care and outcomes. Decision making authority held by senior management.	Appetite for taking moderate risks relating to service delivery where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. Robust performance oversight processes in place.	Willing to take decisions that will impact on the business-as-usual delivery of services to deliver transformation and secure longer term quality improvement.	Appetite to take investment and transformation decisions in areas which are likely to impact on the delivery and accessibility of services in the short term in order to deliver significant improvement for the long term.
People & Culture	Avoidance of any workforce risks that threaten the delivery of safe and effective patient care and outcomes.	Only prepared to accept the possibility of very limited workforce risk impacts if essential to safe and effective patient care and outcomes. Innovation is not a priority.	Prepared to take limited risk with regards to workforce as long as this could yield opportunities elsewhere within the Trust for improvements in workforce, cultural and leadership development.	Appetite to take workforce management decisions which may have short term implications for our workforce for potential longer-term gains.	Seek to lead the way in terms of workforce and cultural innovation, accepting that this may be disruptive in the short term, but would be outweighed by the opportunity to drive improvement.
External	Zero appetite for any decisions that present risks to the Trust maintaining its CQC registration, complying with the law and its policies.	Only prepared to accept the possibility of minor regulatory observations if related actions are essential to the safe and effective patient care and outcomes.	Accept possibility of moderate regulatory observations / judgements as long as appropriate controls are in place and there is a potential for improvement outcomes.	Willing to take decisions that are likely to bring additional scrutiny to outwardly promote new ideas and innovations where potential benefits outweigh the risks.	Comfortable to take decisions that may expose the trust to significant additional scrutiny or judgement as long as there is commensurate opportunity for improvement outcomes for our stakeholders.

*Based on models produced by the Good Governance Institute 'Risk Appetite for NHS Organisations, A matrix to support better risk sensitivity in decision taking' developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU January 2012 and the Leeds Teaching Hospitals NHS Trust 'Risk Appetite second edition' March 2023 and tailored for use by WSFT.

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2. JOINED UP SERVICES

2.1. West Suffolk Alliance, Norfolk & Suffolk ICB, and NHS Essex ICB - No report this month (WSA moved to bi-monthly reporting)

Presented by Maddie Baker -Woods

3. HIGH QUALITY CARE

3.1. Annual Review of IQPR (ATTACHED)

To Assure

Presented by Nick Macdonald

Trust Board committee, 31 July 2026

Report information

Report title:	**Integrated quality and performance report update**
Agenda item:	**x.x**
Sponsor/Executive lead:	Nicola Cottington, chief operating officer and deputy chief executive (SIRO)
Report prepared by:	Sarah Judge, chief information officer Matt Keeling, deputy chief operating officer
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**
☒ **Empowered to improve**
☒ **Fit for tomorrow**
☒ **Joined up services**
☒ **Responsible with resources**

Executive summary

What?
During 2026 the Integrated Quality and Performance Report (IQPR) has been revised and updated to include new metrics and improved formatting and readability.

So what?
Visibility of the process and prioritisation of new requests is important so colleagues can have their requests reviewed by a multidisciplinary team.

What next?
There is work to be done to prioritise and apply the same rigour to the BI requesting process. We will also be reporting on our strategic measures through other governance forums.

Action required by the committee:
No action required.

Governance and compliance

Risk and assurance: The digital programme is governed through the digital governance structure and is reflected in project, steering groups and Trust wide risks and BAF assurance framework.

Equality, diversity and inclusion: EDI is considered as part of ongoing project governance.

Sustainability: Many digital initiatives support the sustainability agenda including tools to support remote working, reductions in the power and heat consumption of current technologies and cloud-based services delivered from highly energy efficient data centres.

Legal and regulatory context: Compliance with regulations such as:

- Data Security and Protection Toolkit (DSPT)
- GDPR
- DCB0160 (clinical risk management)
- DCB1596 (secure email)

Integrated quality and performance report (IQPR)

1. Introduction

1.1. The Integrated quality and performance report (IQPR) is produced monthly by the business intelligence team for presentation of key metrics to three of the board subcommittees. It is a combined report for quality and patient safety, finance and performance, and people and organisational development.

2. Detailed sections and key issues

2.1. Formatting and readability

One of the concerns raised about the previous iteration of the IQPR was that it is not visually accessible for members of the general public to view as part of our public board papers. A revision was undertaken earlier this year to improve the visual formatting and align with other reporting processes within the trust.

We also asked contributors to ensure that their narrative was concise and explained all terminology and acronyms. Guidance was also provided to them on how to best explain their data.

2.2. Making Data Count

In addition to the formatting changes, a standardised appendix has been included in all versions of the IQPR, demonstrating how to read the Making Data Count charts and formats. This is to assist committee and board attendees and members of the public in understanding the statistical process charts that are used as part of the making data counts methodology.

2.3. Standard content

In order to improve and reduce repetitive board and committee papers, a standardised summary has been included. This has now taken the format of an infographic that is used throughout our internal communications with staff in order to improve consistency of the messages around key performance indicators for the trust.

A summary of the national oversight framework position is included in each IQPR pack.

We have continued to use the ‘what?’, ‘so what?’ and ‘what next?’ approach to delivering the narrative as we have continued to receive good feedback on this approach. It also helps our contributors to focus their narrative content on what is important to share with readers.

2.4. Health inequalities

In order for the Trust to receive assurance that we are providing the best quality care for all our community, we have started to include health inequalities metrics within the IQPR. This has taken a standardised approach to date but further steps are being taken to understand where we focus our next reviews on health inequalities.

2.5. **Assurance vs reporting**

The content of the IQPR pack has also been revised throughout the year to reflect where additional assurance is required or where the standards are being met and maintained. This has allowed the IQPR pack to focus on the key areas for visibility at the board subcommittees, rather than overwhelming members with data that is continually improving or has plateaued. This does not mean that we do not celebrate where good quality care or performance is being demonstrated, it is just that the focus is on where improvements can be made or extra visibility is required

We have also focused the data on quality priorities or areas of escalation.

2.6. **Process improvement**

Small changes have been undertaken within the business intelligence service to streamline the collection of the data from other sources as well as the narrative. These changes have saved one to two working days per month and streamlined the process considerably.

3. Next steps

3.1. The IQPR will continue to be reviewed on a regular basis to ensure it is still relevant and appropriate in terms of the data and narrative that is being shared with the board and its subcommittees.

3.2. The business intelligence teams are also undertaking a review of the performance reporting packs that report quarterly to the executive team to align more closely with the IQPR.

4. Recommendations

4.1. This report is for information only.

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

To Assure

Presented by Jude Chin

NHS
West Suffolk
NHS Foundation Trust

Integrated quality and performance report (IQPR)

May 2026

Compassionate care,
healthier communities

Executive summary:

This report is for **Assurance.**

This reports supports the following ambitions within the organisational strategy:

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

What?

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

So what?

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

1. The ability to reliably meet targets and standards (pass/fail)
2. Statistically significant improvement or worsening of performance over time.

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

What next?

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

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

Executive summary: May 2026

Delivering compassionate care and healthier communities

NHS West Suffolk NHS Foundation Trust

Our performance highlights from May 2026

ED 4 hour perfomance

74.9%

of patients admitted, transferred or discharged within four hours of arrival (below target of 80%)

Elective RTT

65.4%

Referral to treatment performance (18 weeks)

Working towards 70% target for March 2027

Cancer targets

28-day Faster Diagnosis Standard (April)

82.9%

hitting the standard

62-day referral to treatement (April)

78.8%

hitting the standard

Financial performance

At month one (April), we finished with a:

£1 million deficit

Above plan but not unexpected due to reduced ability for activity

Q4 Pulse Survey (April)

Engagement
6.47 up from 6.18

Motivation
6.71 up from 6.40

Advocacy
6.27 up from 6.18

Involvement
6.44 up from 6.26

Community care

87.8%

Urgent community response performance (April)

Variance – are the measures being met?

Assurance – can the target be consistently achieved?

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

Items for escalation

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

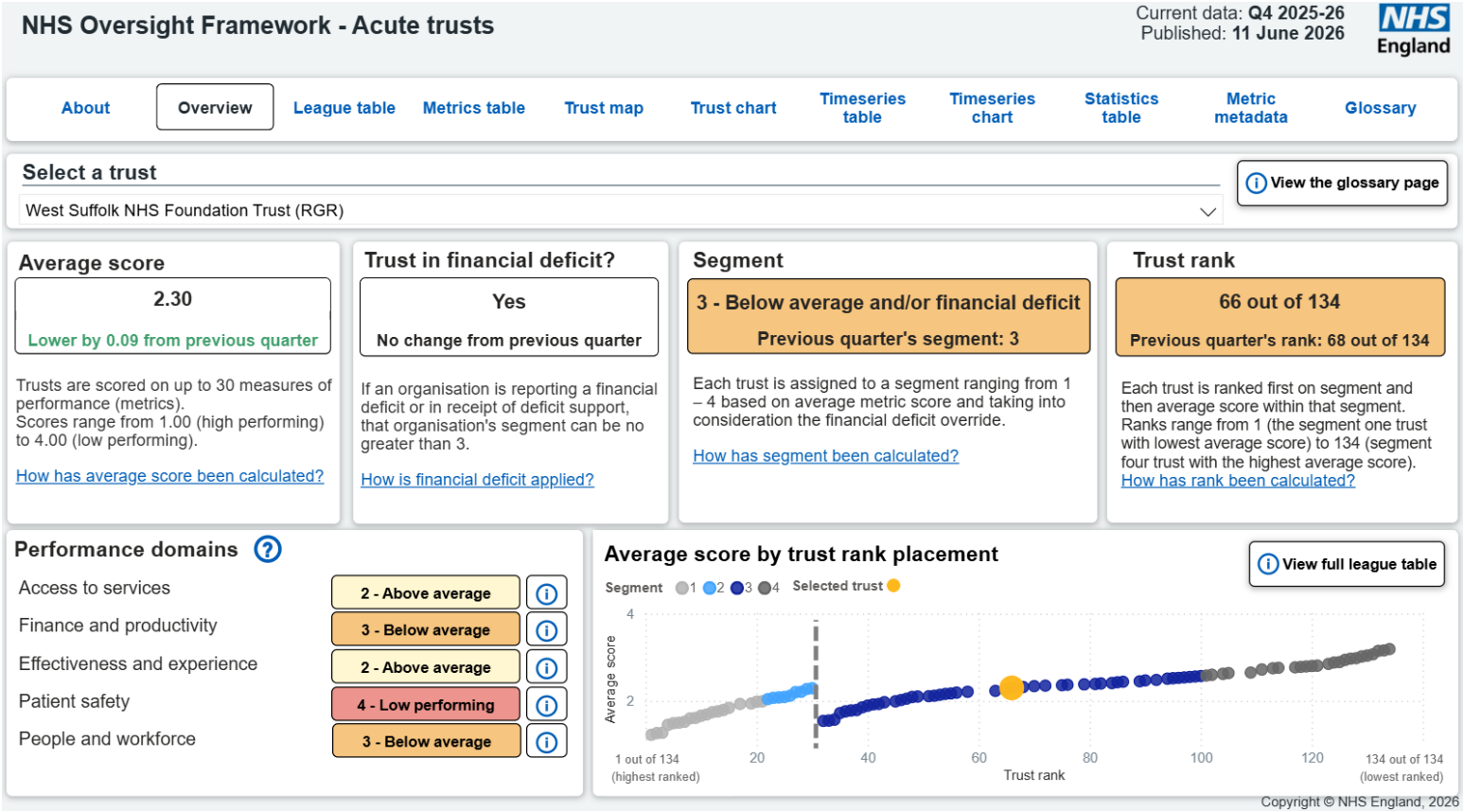
Finance and performance (F&P) - Cancer: Cancer 62 Days Performance, Incomplete 104 Day Waits

Quality and Patient Safety (Q&PS): Patient Safety Incidents with Harm

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

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

National oversight framework (NOF)



What?

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

So what?

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

What next?

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

Health inequalities – ED 12-hour breaches

What?

•May 2026 saw 8,328 Type 1 patients depart ED at West Suffolk. 624 of those patients were in ED for 12 hours or more – 7.49% of all Type 1 departures. This is slightly higher than the average for 2025/26 overall, when 6.96% of Type 1 patients spent over 12 hours in ED but is an improvement on what was seen in 2024/25 with an average of 10.36% of all Type 1 patients spending more than 12 hours in ED

•52.40% of patients who experienced a stay in ED of 12 hours or more were female (47.44% were male and 0.16% were unspecified). Trust level data shows that in 2025/26 54.59% of patients who accessed acute services at WSFT were female, 45.36% were male and 0.05% were unspecified

•54.01% 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 (21.79%)

•91.99% of patients who experienced a stay in ED of 12 hours or more were white (British, Irish or other). Data from the 2021 census stated that 83.89% of Suffolk residents were white

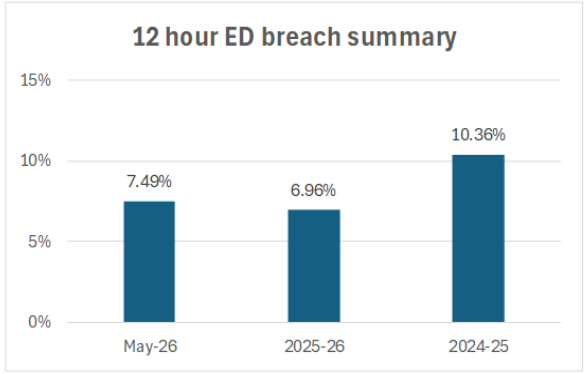
So what?

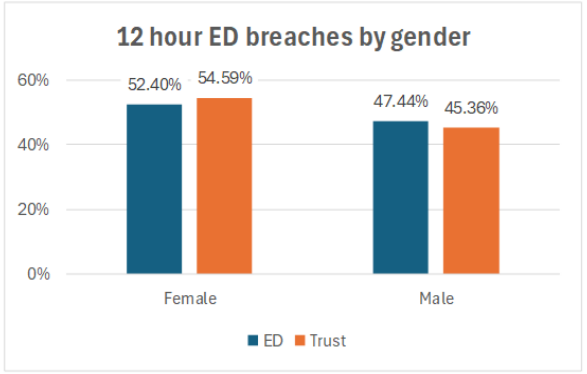
Reporting on health inequalities helps us understand potential areas for improving access and waiting times and ensuring the care we provide is equitable and fair.

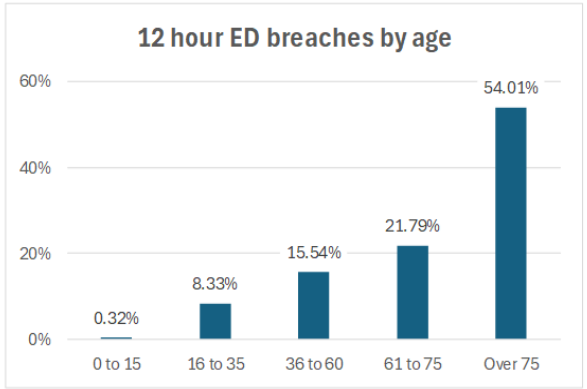
What next?

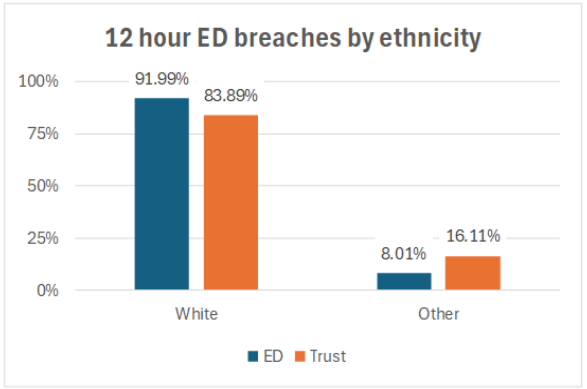
These data demonstrate that most long waits in ED are experienced by people over 75 years, and that there appears to be a disparity between ethnic groups, although ethnicity is not stated for 5.45%. We know that long waits in ED cause harm and it is critical that understand the drivers of inequalities,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

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



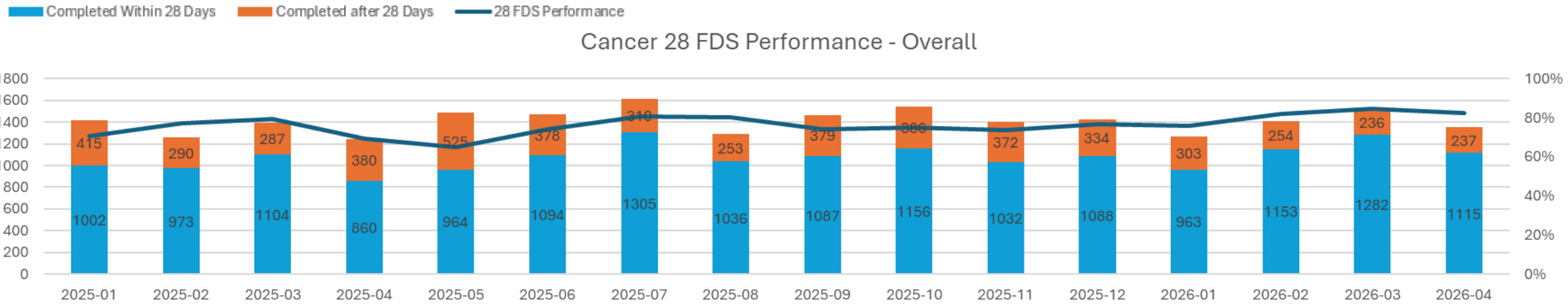


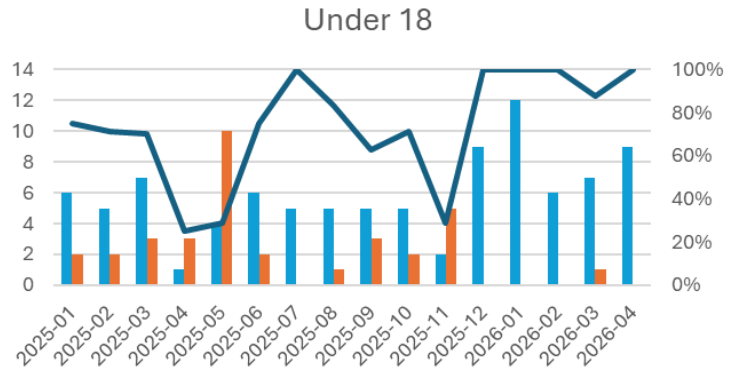


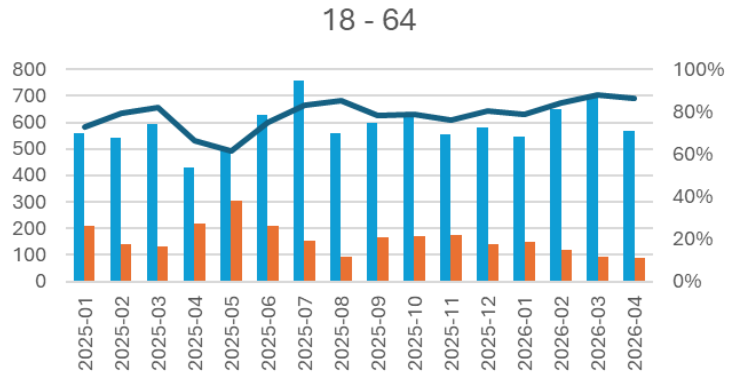


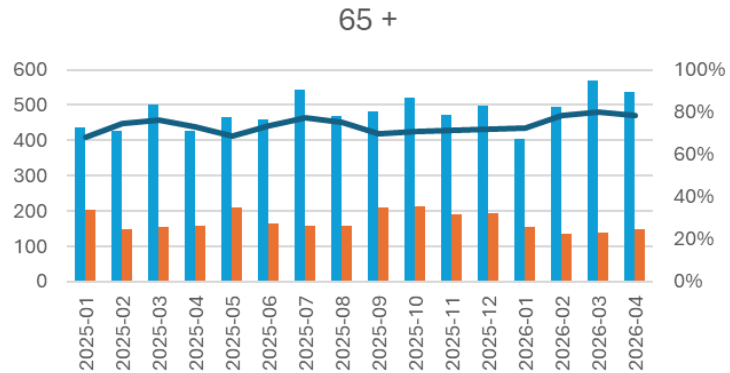
White - British	532	85.26%	Black or Black British - Caribbean	1	0.16%
White - Any Other White Background	41	6.57%	Mixed - Any Other Mixed Background	1	0.16%
Other - Not Stated	34	5.45%	White - Irish	1	0.16%
Other - Any Other Ethnic Group	5	0.80%	Mixed - White and Asian	1	0.16%
Black - Any Other Black Background	3	0.48%	Mixed - White and Black African	1	0.16%
Asian or Asian British - Indian	2	0.32%	Other - Not Known	1	0.16%
Black or Black British - African	1	0.16%			

Health inequalities – 28 days FDS performance by age group





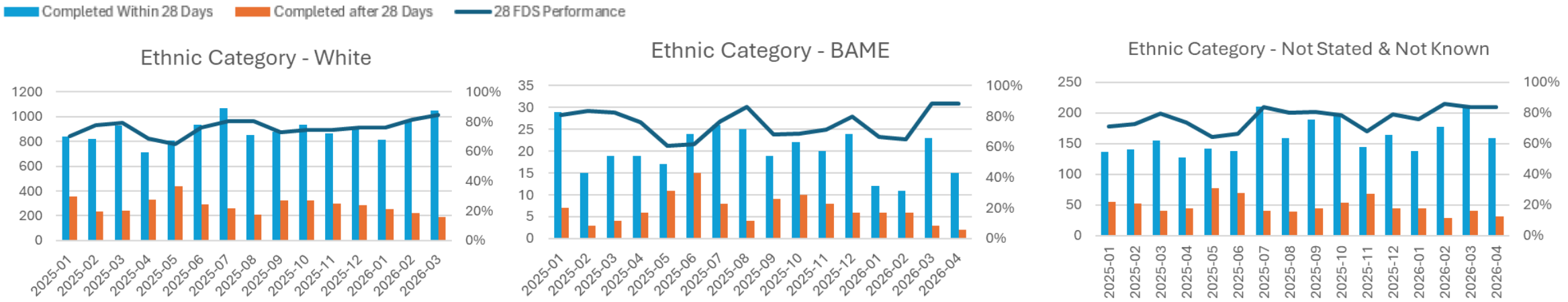




What?

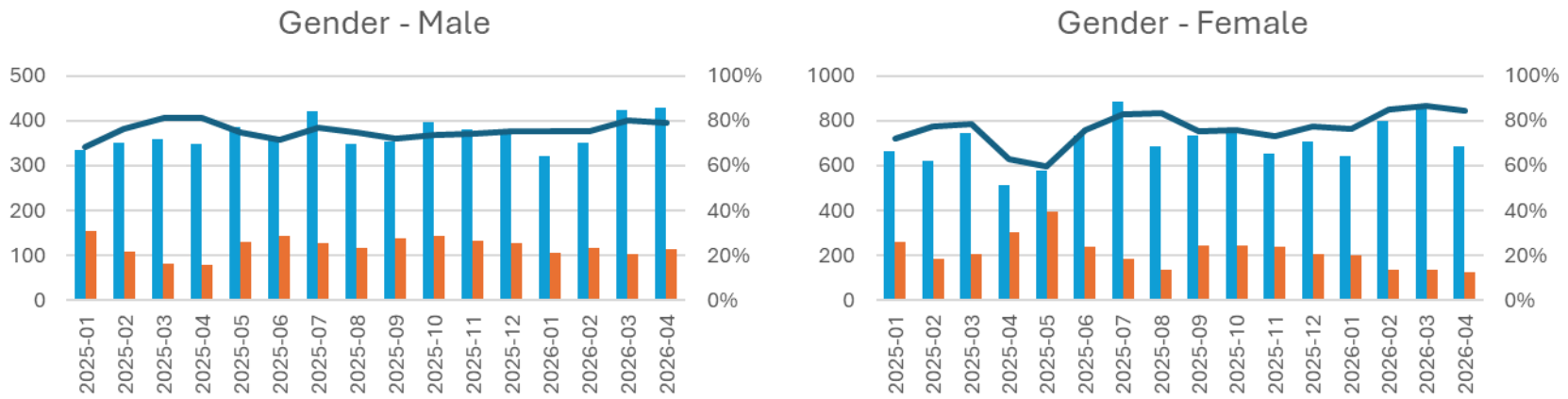
- Under 18: Performance varies due to low volumes but improves sharply, meeting or exceeding the 75% target by year-end.
- 18 - 64: Consistently strong, staying at or above the 75% target for most of the period.
- 65 +: Falls below target mid-year but steadily improves, finishing close to the 75% benchmark.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

Health inequalities – 28 days FDS performance by ethnicity and gender



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

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



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

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Finance and Performance committee metrics

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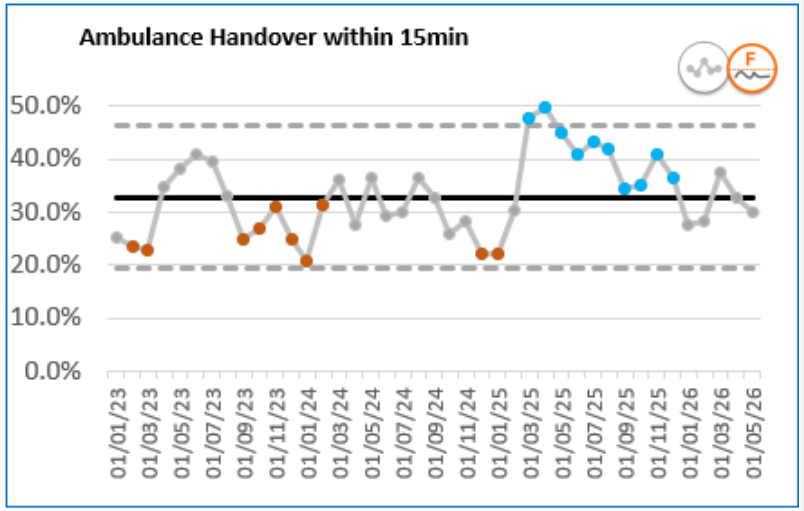
Urgent & Emergency Care: ambulance and 4-hour performance

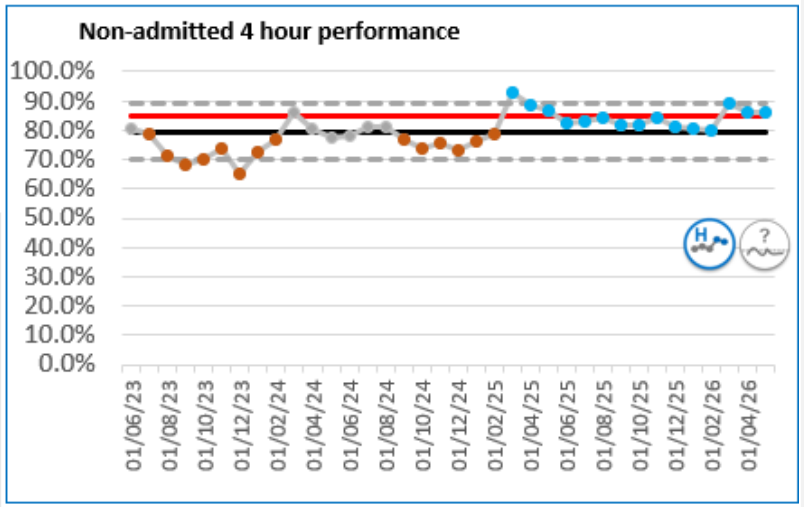
What?

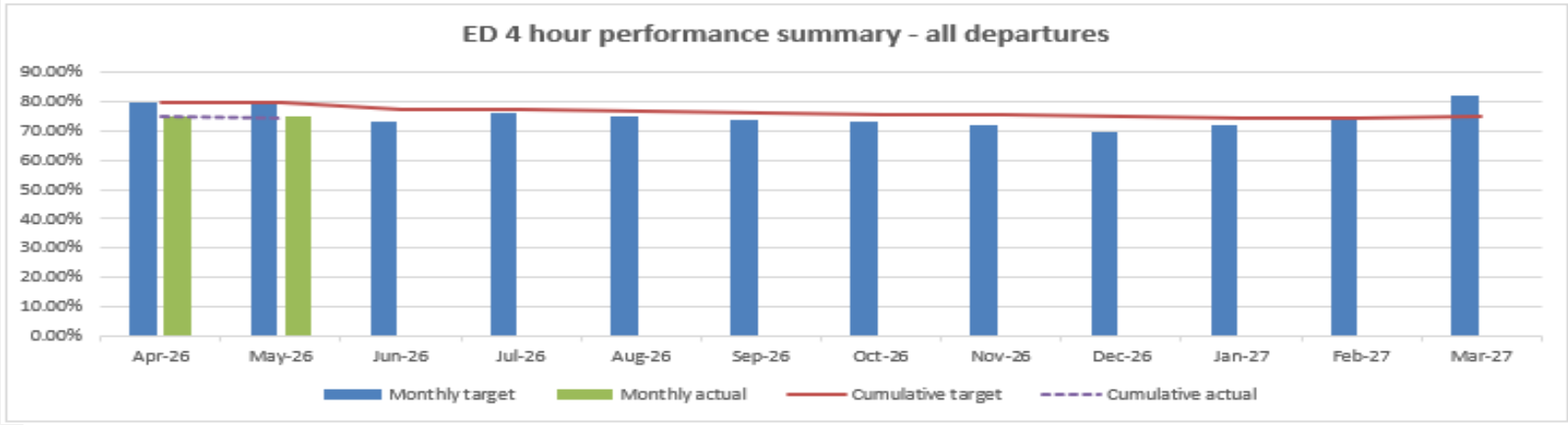
- No significant change was demonstrated in the 15-minute ambulance handover metric. In May we achieved 32.81% against a target of 65%.
- May's non-admitted 4-hour performance was 86.11%, meaning the 85% internal target was met.
- Overall, 4-hour performance for May was 74.87% meaning we didn't meet the monthly trajectory of 80%.
- To note in May:
  Emergency Department (ED) attendances for May were 9420, 1% higher than previous month.

So what?

- Meeting the Urgent and Emergency Care (UEC) performance metrics means that our patients received timely, safe care.
- Meeting the in-month trajectory for the 4-hour Emergency Department metric will keep us on track to achieve 82% by March 2027.
- **What next?**
- Weekly performance meetings ED and Medical Division Senior Leaders/Executives continue.
- Continue to allocate a registrar to the twilight minor patients whilst recruitment continues- aim to start in August.
- Extended GP hours up until midnight will commence fully from 1st June.
- Focus on the use of EDSDEC (ED Same Day Emergency Care), its purpose and improving the environment.
- Continued focus on all SDEC pathways.
- Working through focussed streams, identified in the UEC Delivery Group.
- Redesign of reception streaming desk has commenced.







Urgent & Emergency Care: ED 12-hour performance

What?

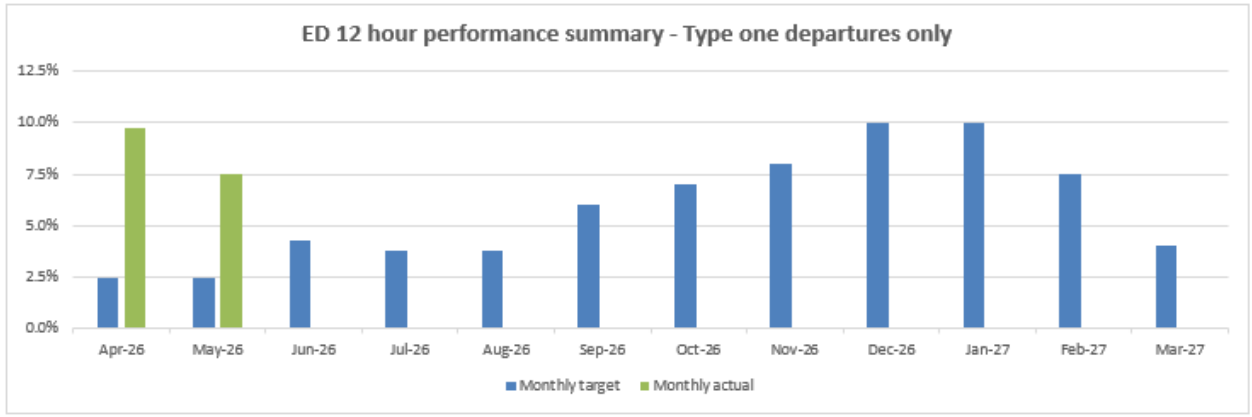
- There was a decrease in the number of 12-hour length of stay breaches in May, which were 624 compared to 793 in April. (In May 2025 there were 237 12-hour waits.)
- 7.49% of all Emergency Department (ED) attendances were 12-hour breaches.
- Outbreaks of Norovirus and doctor's industrial action, were contributing factors to this in April.

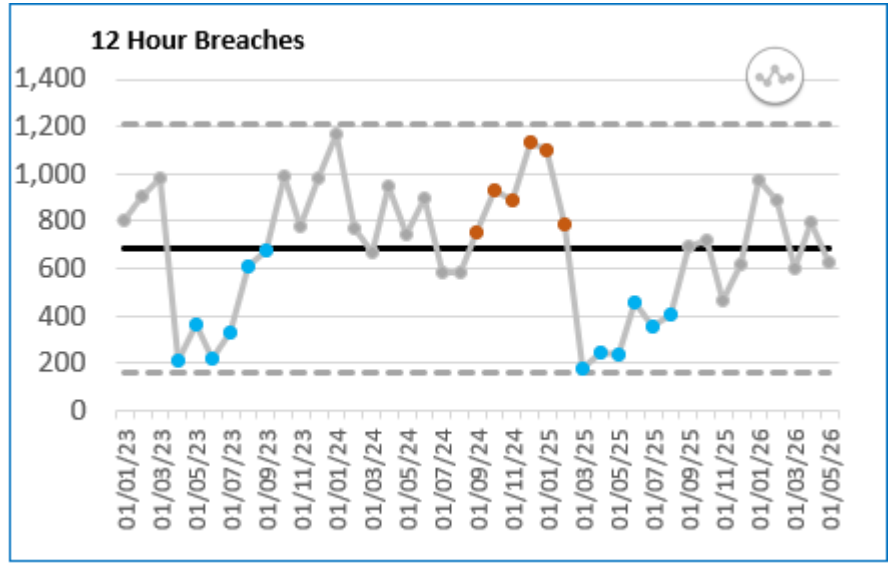
So what?

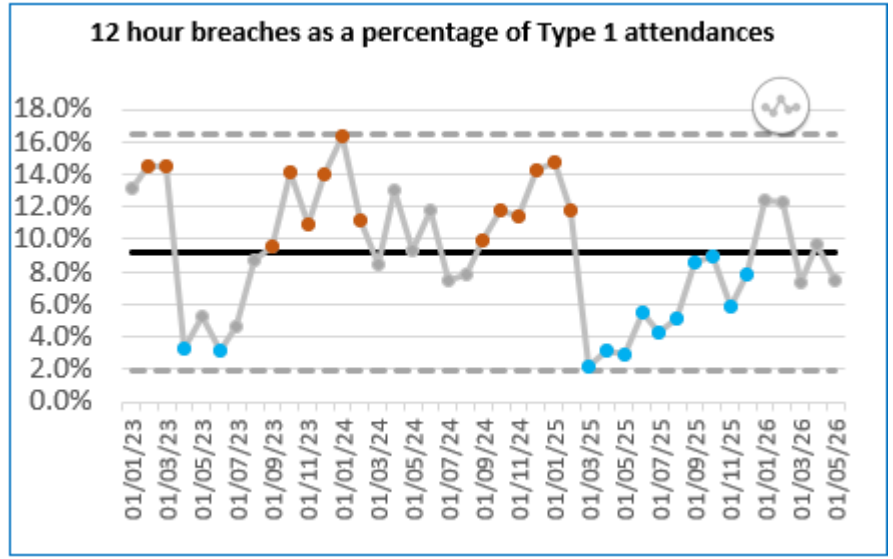
- 7.49% of ED attendances spent more than 12 hours in the department, which is a poor patient experience.
- The impact of more 12 hours breaches in the ED is that temporary escalation spaces were regularly used, including Rapid Assessment Triage (RAT) and Same Day Emergency Care, both of which impact on our ability to offload ambulances and the flow in and through the department. At times, the RAT corridor was also used to aide ambulance offloads.

What next?

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







Urgent & Emergency Care: Urgent Care Response (UCR)

What?

Urgent Community Response performance remains above target at 87 %. There are workforce pressures in the Integrated Neighbourhood Teams (INTs) which impacts on the responsiveness of those teams.

There has been a 2% improvement in April in comparison to March.

So what?

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

What next?

- Investment in community nursing agreed and recruitment started, aim to recruit 10.5 WTE by September.
- Number of deferred or cancelled visits and harm audit are monitored.
- Workforce review, utilising community Nursing Safer Staffing Tool (CNSST) completed
- Project to reduce high sickness levels sickness continues.
- New Standardised Operating Procedure for booking of therapy patients, to be embedded by end of July.

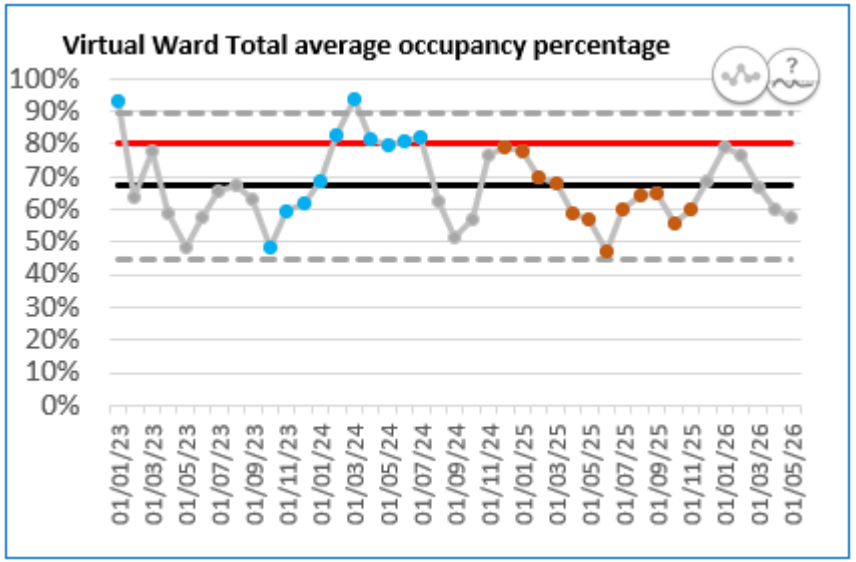
Team	Dec-25				Jan-26				Feb-26				Mar-26				Apr-26				May-26			
	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock 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	163	112	51	69%	183	123	60	67%	190	123	67	65%	199	133	66	67%	213	148	65	69%	234	167	67	71%
Total EIT*	665	609	56	91.58%	769	717	52	93.24%	700	651	49	93.00%	732	701	31	95.77%	668	625	43	93.56%	726	690	36	95.04%
Combined Total	828	721	107	87.08%	952	840	112	88.24%	890	774	116	86.97%	931	834	97	89.58%	881	773	108	87.74%	960	857	103	89.27%
*From May 26 Using DW figures backdated to Apr2024																								
EIT 2hr from UCR Dashboard - CSDS Figures	635	580	55	91.34%	741	687	54	92.71%	671	625	46	93.14%	689	660	29	95.79%	628	584	44	92.99%	680	644	36	94.71%

Urgent & Emergency Care: virtual ward

What?
Average occupancy has decreased to 57% in May.

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

What next?
- Recruitment to Consultant Clinical lead vacancy is underway, and temporary cover continues.
- Virtual ward & Early Intervention Team reviewing pilot that occurred. This identified that work needs to be done with Urgent Care Coordination Hub to enhance their awareness of the Virtual Ward.



Cancer access

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	Apr 26	82.9%	77.0%			70.9%	58.6%	83.3%
Cancer 62 Days Performance	Apr 26	78.8%	70.0%			74.3%	59.4%	89.3%
Incomplete 104 Day Waits	Apr 26	6	0			23	0	45

What?

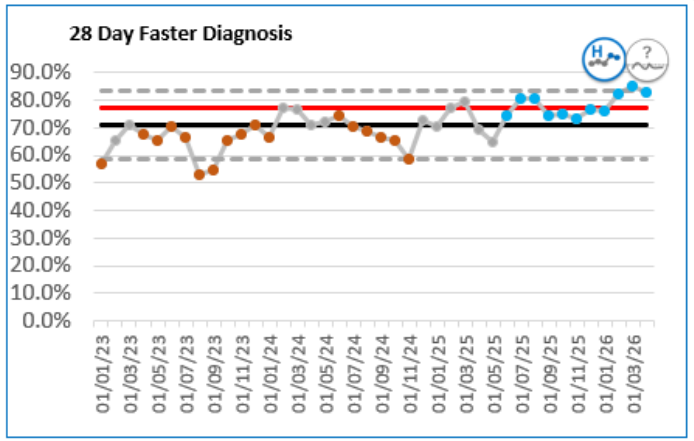
- 28 day performance was 82.9% in April, which is above trajectory and over achieving against the 80% requirement.
- Urology performance remains challenged and under trajectory whilst Breast has recovered due to the insourcing of first clinic appointments.
- Performance in Head and Neck, Skin, Gynaecology, Lung and Upper GI have been consistent throughout the year.
- 62-day performance continues to be above the 77% requirement.

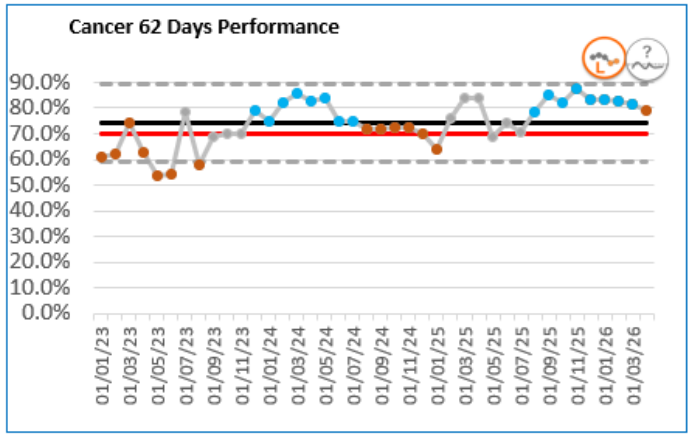
So what?

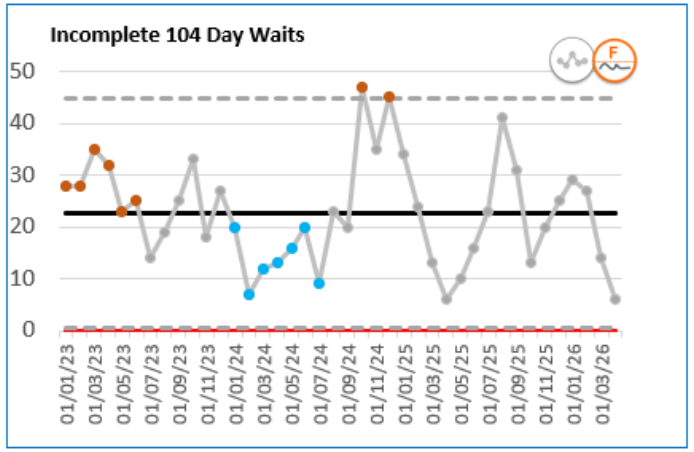
- The priorities for 26/27 this year focus on seeing, diagnosing and treating patients in line with national guidance to improve patient outcomes and maintain standards.

What next?

- Breast insourcing for first appointment will continue throughout 26/27.
- Nurse led template biopsy training due to be complete by end of Q2 allowing for independent lists.
- Continued engagement with Cancer Alliance led Breast services review.







Diagnostic performance

What?

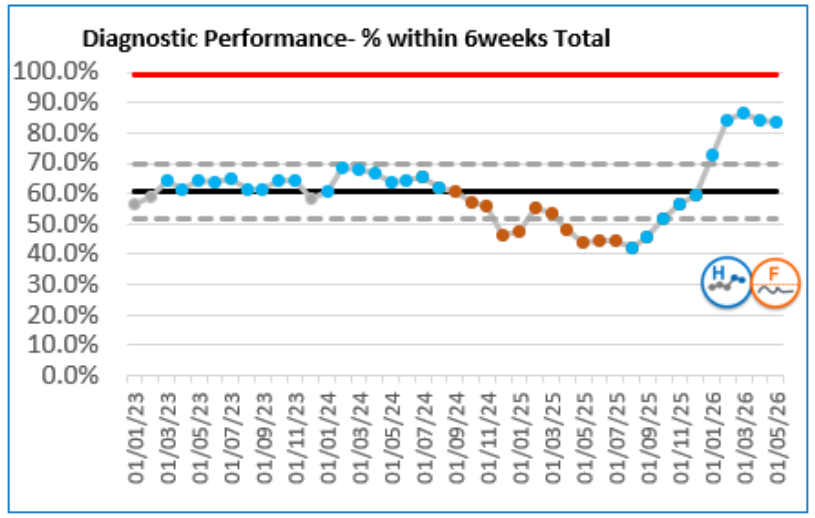
- The monthly Diagnostics Waiting Times and Activity Data (DM01) measures the number of patients waiting six weeks or more for 15 key diagnostic tests.
- WSFT is marginally behind the agreed recovery trajectory of 83.80%, with 83.37% of patients in May receiving their tests within six weeks.
- The principal areas of non-compliance are endoscopy and audiology.

So what?

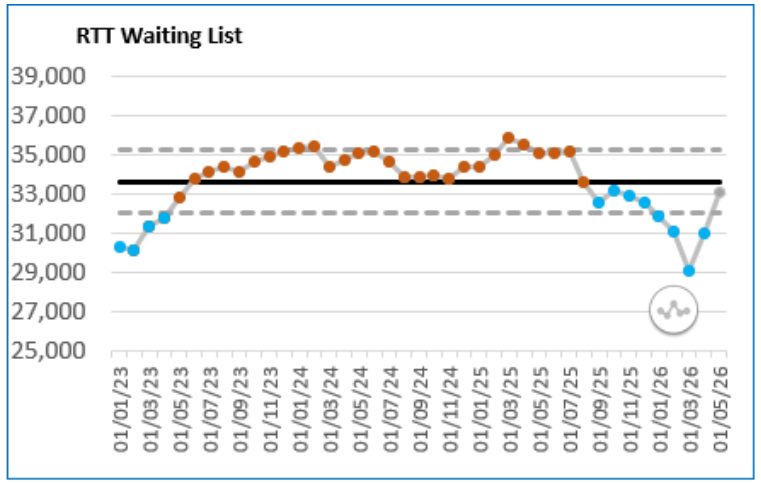
- Longer waiting times for diagnosis and treatment have a detrimental effect on patients.
- Delay in achieving DM01 compliance standards and Referral to Treatment (RTT) standards.
- Reputational harm and lack of confidence in our services for our patients.

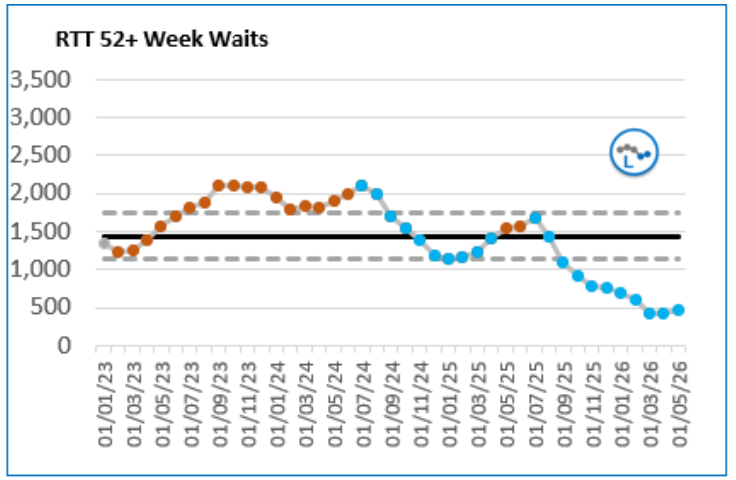
What next?

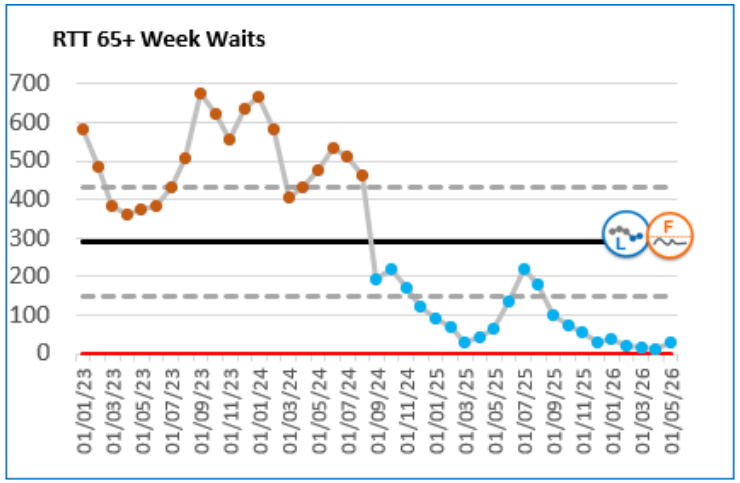
- Recovery actions forecast improvement to 88% in March 2027 in line with the agreed plan for DM01 performance.

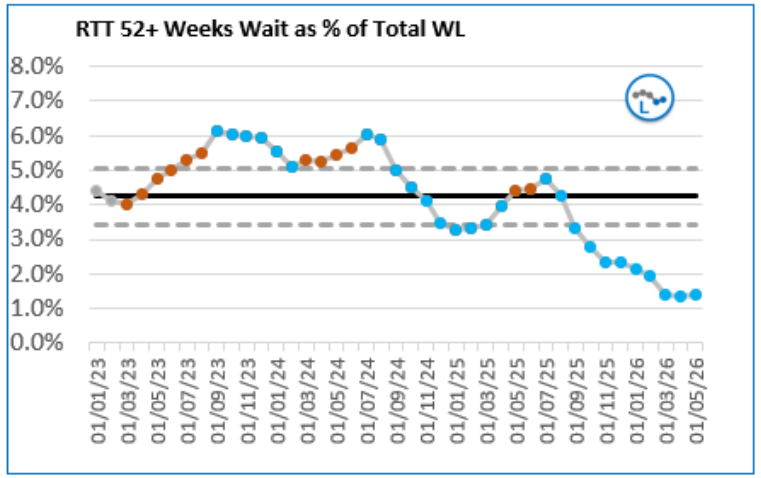


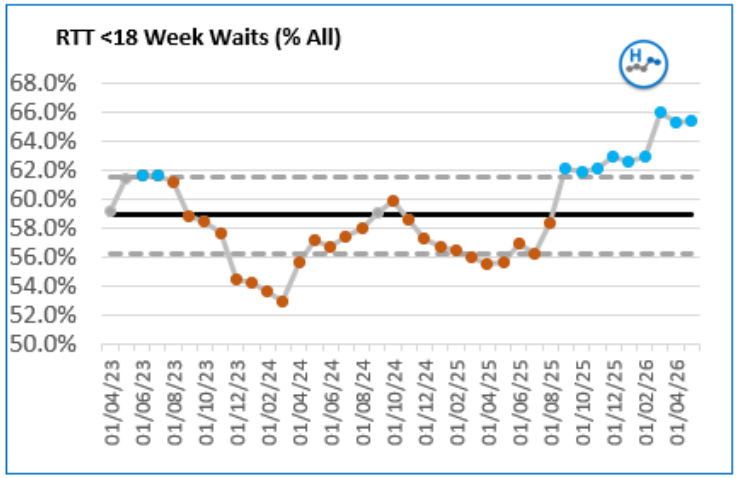
Referral to treatment (RTT) performance

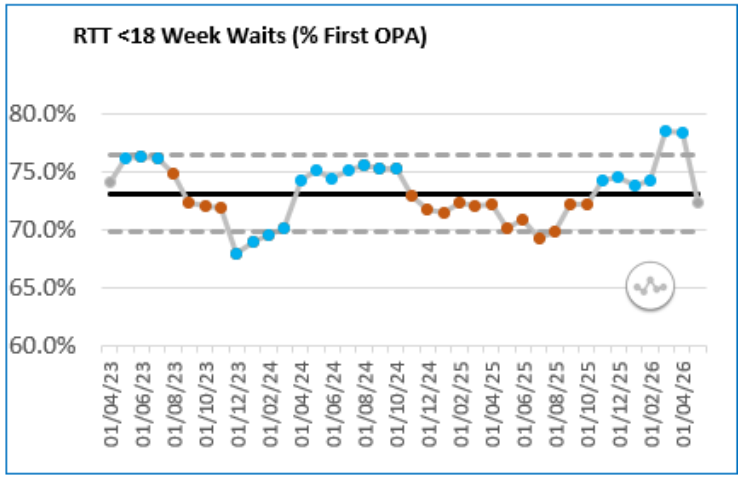












Referral to treatment (RTT) performance

Overall 18-week compliance May 2026	Patients with 65 week wait May 2026	Patients with 52 week wait May 2026	Total waiting list	% of patients being seen for first OPA within 18 weeks
65.4%	28	472	33140	72.3%

What?

- Overall RTT compliance was at 65.4%, which is above our May 2026 forecast.
- The volume of patients waiting 65 weeks increased slightly, partly due to on-going closures of Orthopaedic theatres. The volume of patients over 52 weeks is higher than trajectory at 472 and increasing, with the theatre closures impacting ability to reduce.
- The total waiting list size has now increased considerably in the past month, with reduced activity and limited data quality validation resource impacting delivery.

So what?

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

What next?

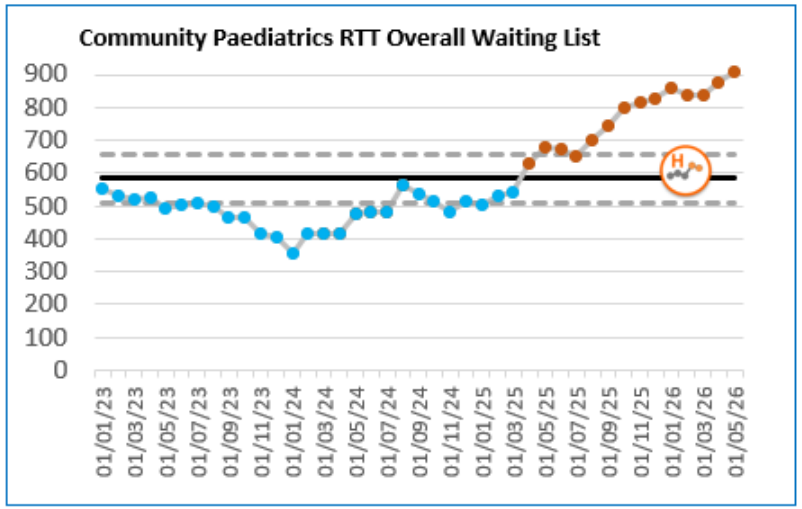
- Delivery against 26/27 activity schemes, which will be monitored via the Elective Delivery Board.
- Continue to utilise independent sector capacity to mitigate the closure of theatres during the period of refurbishment.
- External validation resource to commence 1st July, whilst internal recruitment is underway.
- Return of Orthopaedic theatres due 20th July 2026.

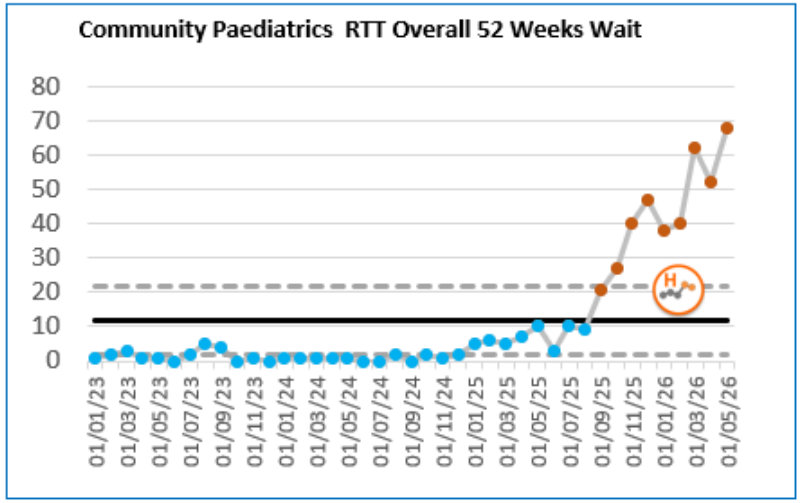
Community paediatrics

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

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

What next?
- ICB-led recommissioning of neurodevelopmental diagnostic assessment pathway is delayed whilst further provider submissions required. Implementation of new pathway now scheduled to be April 2027
- Full time agency locum consultant within the east team covering vacancy – substantive appointment made with start date in September.
- Monthly monitoring of long waits continues.
- Executive-level escalation with the aim of resolving the issues impacting on jointly-commissioned services including Speech and Language Therapy.





KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Community Paediatrics RTT Overall Waiting List	May 26	906				584	512	657
Community Paediatrics RTT Overall 52 Weeks Wait	May 26	68				12	2	22

Elective activity plans

What?

- First outpatient attendances are slightly behind plan.
- The deficit in elective activity is significant; this is due to the continuation of overrunning refurbishment works in main theatres.
- Day case activity is not affected by this and is only slightly behind plan. This, and the gap for first outpatients largely correlates with the volume of activity lost due to resident doctor industrial action.
- Outpatient follow ups are slightly above plan, whereas they need to be at or below this level. It is likely that this is due to a reduction in the plan rather than a step change increase in activity.

So what?

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

What next?

- Specialty level RTT trajectories are monitored through weekly access meetings.
- An Elective Delivery Group has been established to bring together oversight of core and stretch activity plans, monitoring delivery against financial and performance objectives.
- Workstreams across theatres, outpatients, diagnostics, clinical coding and system-wide initiatives will drive delivery of these.

Outpatient First

Mon	26/27	Plan (B)	Plan (T)	Var	Var %
Apr	9,637	9,449	9,830	(193)	(2.0%)
May	9,256	9,332	9,713	(457)	(4.7%)
Jun		10,631	11,252		
Jul		10,631	11,262		
Aug		8,855	9,591		
Sep		10,393	11,279		
Oct		10,156	11,094		
Nov		10,156	11,094		
Dec		10,160	11,133		
Jan		9,446	10,419		
Feb		9,571	10,544		
Mar		9,805	10,778		
Total (YTD)	18,893	18,781	19,543	(650)	(3.3%)

May 2026	
26/27	9,256
Plan (B)	9,332
Plan (T)	9,713
Var	(457)
Var %	(4.7%)

Daycase

Mon	26/27	Plan (B)	Plan (T)	Var	Var %
Apr	2,367	2,140	2,409	(42)	(1.7%)
May	2,175	2,115	2,384	(209)	(8.8%)
Jun		2,356	2,633		
Jul		2,409	2,722		
Aug		2,004	2,317		
Sep		2,356	2,669		
Oct		2,303	2,598		
Nov		2,304	2,599		
Dec		2,140	2,435		
Jan		2,168	2,463		
Feb		2,220	2,515		
Mar		2,356	2,651		
Total (YTD)	4,542	4,255	4,793	(251)	(5.2%)

May 2026	
26/27	2,175
Plan (B)	2,115
Plan (T)	2,384
Var	(209)
Var %	(8.8%)

Outpatient Follow Up

Mon	26/27	Plan (B)	Plan (T)	Var	Var %
Apr	26,485	24,251	24,569	1,916	7.8%
May	24,091	23,954	24,272	(181)	(0.7%)
Jun		26,682	27,035		
Jul		27,284	27,665		
Aug		22,732	23,113		
Sep		26,682	27,091		
Oct		26,069	26,531		
Nov		26,074	26,536		
Dec		24,248	24,724		
Jan		24,556	25,032		
Feb		25,168	25,644		
Mar		26,685	27,161		
Total (YTD)	50,576	48,205	48,841	1,735	3.6%

May 2026	
26/27	24,091
Plan (B)	23,954
Plan (T)	24,272
Var	(181)
Var %	(0.7%)

Elective

Mon	26/27	Plan (B)	Plan (T)	Var	Var %
Apr	156	270	314	(158)	(50.3%)
May	185	268	312	(127)	(40.6%)
Jun		299	346		
Jul		306	353		
Aug		254	301		
Sep		299	346		
Oct		290	337		
Nov		290	337		
Dec		270	317		
Jan		274	321		
Feb		279	326		
Mar		299	346		
Total (YTD)	341	538	625	(284)	(45.5%)

May 2026	
26/27	185
Plan (B)	268
Plan (T)	312
Var	(127)
Var %	(40.6%)

NHS
West Suffolk
NHS Foundation Trust

Quality and Patient Safety committee metrics

Compassionate care,
healthier communities

Community nursing: deferred care

What?

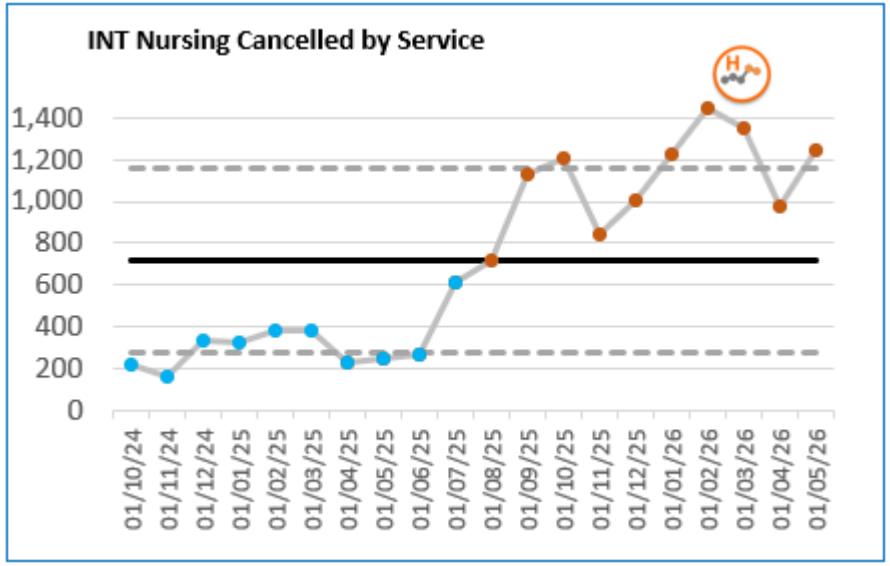
- The is a national move to ensure similar governance and reduction ambitions seen with recent focus on corridor care.
- Deferred care became a cause for concern since September 2025.
- The number of deferred or cancelled visits is beginning to reduce, 6.4% of all nursing visits were cancelled or deferred in April.

So what?

- The impact of deferred care
    - Increased administration to reorganise care
    - Poor patient experience
    - Potential for patient harm
    - Impact in staff wellbeing

What next?

- Following successful business case recruitment has begun to increase nursing capacity.
- Additional improvement work underway focussing on maintaining attendance, reducing sickness and maximising efficiency with record keeping.
- Further work being explored with the 'harm by proxy' data set of patients who have been deferred and attended Emergency Department.



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
INT Nursing Cancelled by Service	May 26	1249				716	276	1156

Quality and patient safety: post-partum haemorrhage

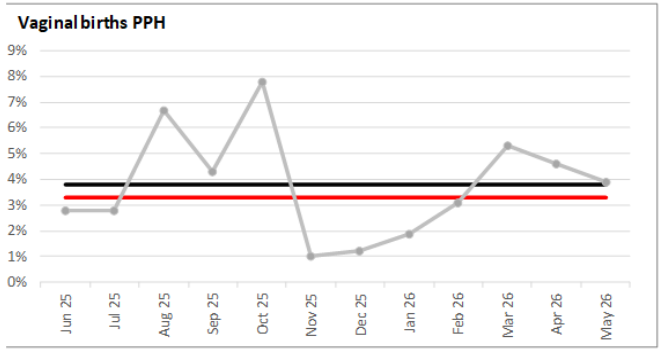
What?

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

In May 2026, seven cases of PPH with blood loss >1500 ml were reported, one of which exceeded 2500 ml:

- Three cases followed caesarean birth
- Four cases followed vaginal birth

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



4 (Jan-Mar 2025)	300	6	2%
1 (Apr-Jun 2025)	347	9	2.6%
2 (Jul-Sept 2025)	331	14	4.2%
3 (Oct-Dec 2025)	294	7	2.4%
4 (Jan-Mar 2026)	307	10	3.3%

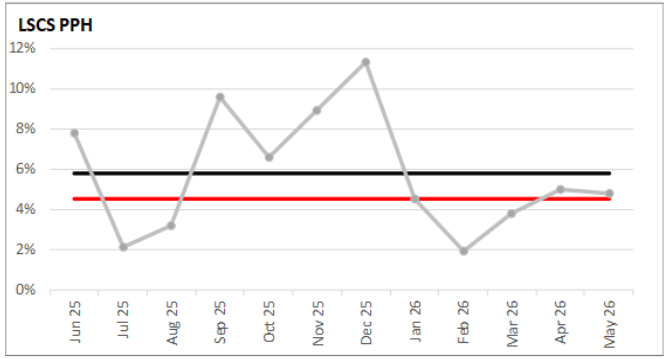
So what?

Trend analysis shows variable month-on-month PPH rates, reflecting the low overall incidence and the limitations of interpreting single-month data. In this reporting period trend analysis shows PPH rates remaining broadly stable around the regional standards. This suggests recent positive impact from targeted interventions, though variation persists.

Case reviews highlight themes around timely escalation and documentation. These themes are not new to the QI group – work will focus on communication in theatre.

Under-buttock drapes to improve blood loss estimation are in place and their use encounraged. PPH risk scoring will be displayed on ward whiteboards, and regular multidisciplinary simulation drills are led by the MDT training Matron. Carbatocin is being introduced for elective caesarean sections, this will be rolled out by end of July 2026.

Immediate post PPH huddles are being undertaken 11 PPH reviews have occurred since launch. Themat



4 (Jan-Mar 2025)	194	6	3.1%
1 (Apr-Jun 2025)	182	9	4.9%
2 (Jul-Sept 2025)	198	10	5.1%
3 (Oct-Dec 2025)	225	19	8.4%
4 (Jan-Mar 2026)	184	6	3.3%

What next?

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

Key next steps include:

- Capacity has been Identified to undertake a deep dive retrospective review, this should be undertaken in July 2026.
- Maintain oversight of new post PPH huddle – immediate learning to be shared with the wider team and inform PPH QI improvement
- Full implementation of the Maternal Care Bundle (2026), including: routine PPH risk assessment at all stages of care, accurate and cumulative measurement of blood loss, clear escalation pathways

Quality and patient safety: patient safety reports

What?

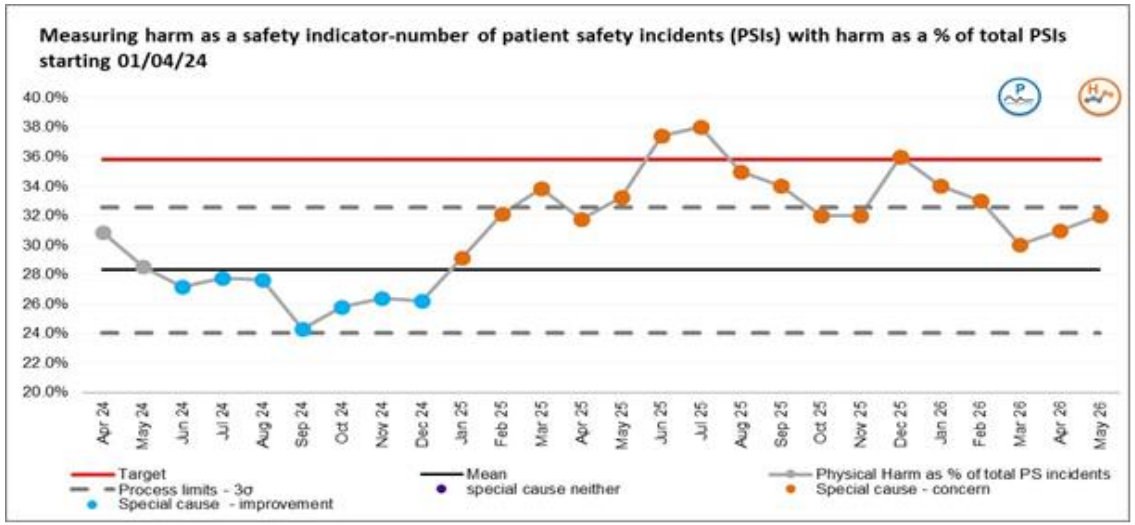
In May, the total number of reported events rose by three. The patient safety team continues to benchmark the monthly proportion of reported harm with national figures from the Learning from Patient Safety Events (LFPSE) data set. WSFT reported a 32% harm rate, a slight increase from 31% in April, and remain below the current national average stands at 35.81%. A total of 197 incidents involving physical harm were reported in May, compared with 189 in the previous month.

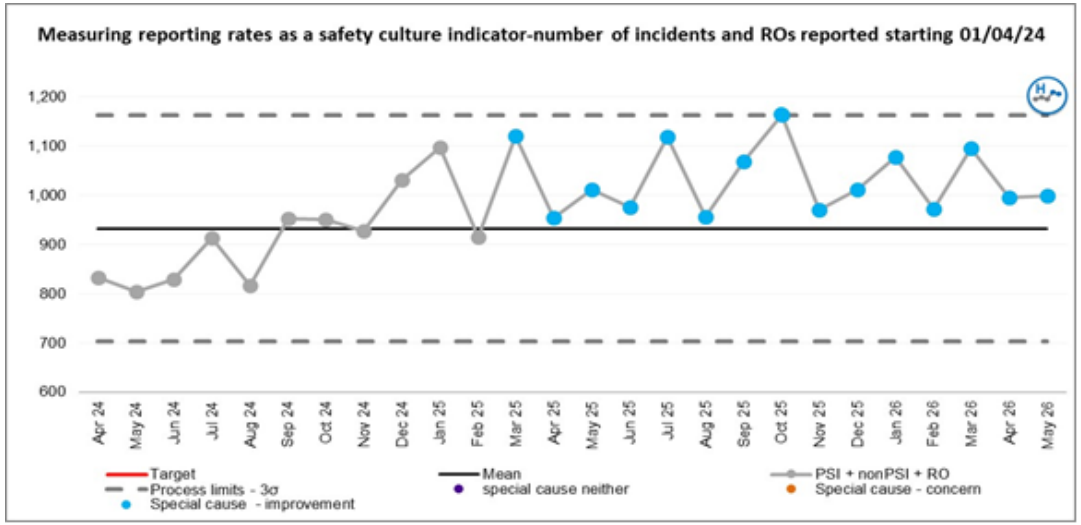
So what?

We continue to encourage reporting of all incidents, as doing so strengthens learning and helps to drive improvement. Monitoring how often incidents are reported gives us important insight into our overall 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 quarterly 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). This structured process helps ensure that learning is captured, shared, and translated into meaningful safety improvements across the organisation.

What next?

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





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

What?

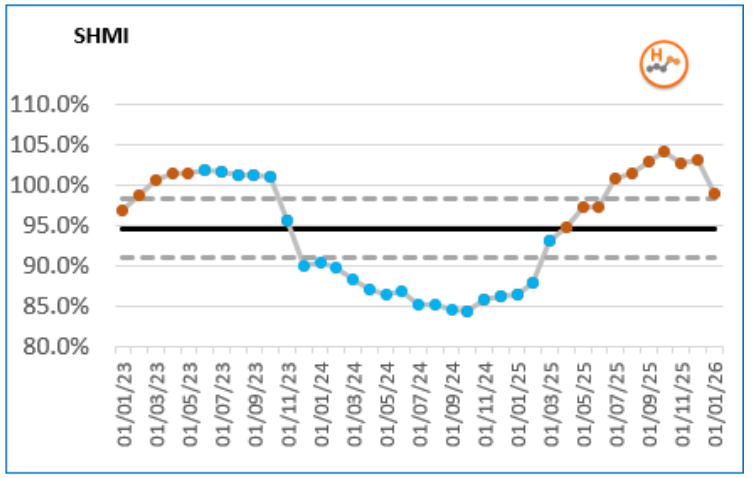
- In May 2026 there were 77 adult inpatient deaths at WSFT. The SHMI data is showing a raised trend due to a coding anomaly at reporting period March 2025 (becoming evident in September 2025), where uncoded episodes were placed into the 'invalid primary diagnosis' category. This resulted in 'invalid primary diagnosis' showing more deaths than expected in that single category, which created a sudden spike in the WSFT SHMI data.

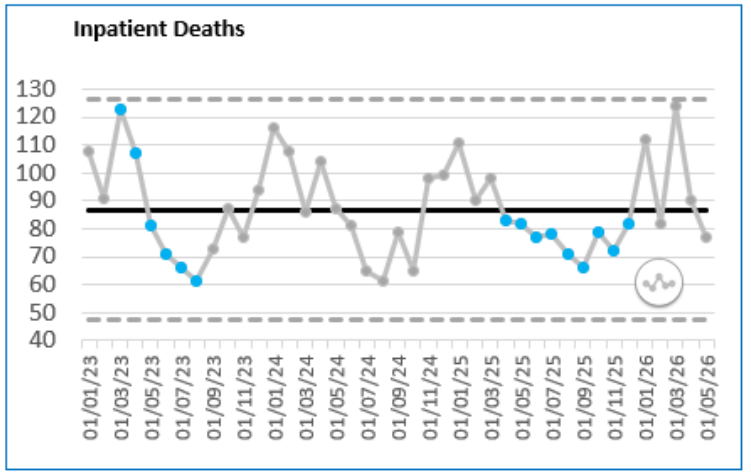
So what?

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

What next?

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





KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SHMI	Jan 26	99.1%				94.7%	91.0%	98.4%
Inpatient Deaths	May 26	77				87	47	127

Quality and patient safety: complaints

What?

- Volume of complaints resolved late have increased slightly from 8 in April to 9 in May
- During this reporting period, 17 complaints were received. The largest proportion related to clinical treatment concerns (35%), followed by access to services and communication issues (each 18%). The Medicine division accounted for 41% of complaints and the Emergency Department was the most frequently location. Recurring themes included access to services, communication with patients, unmet care needs and delays in diagnosis or treatment.

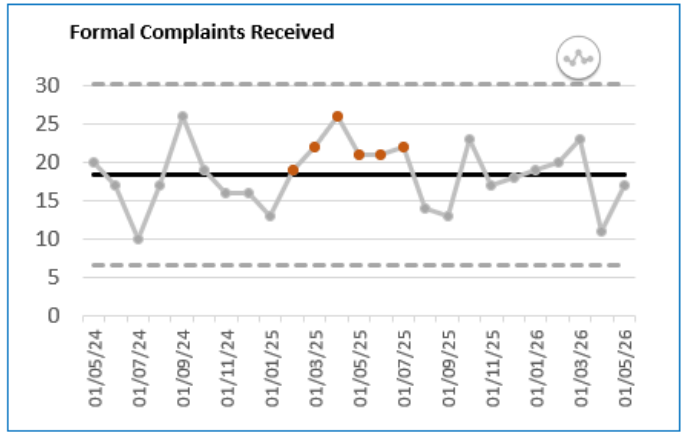
So what?

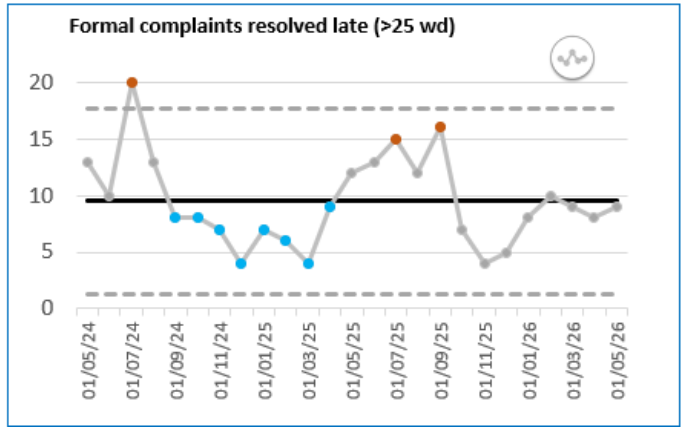
- Complaints resolved late are still high due to only one member of staff in the complaints team.
- Additional work required to ensure investigating staff provide a response in a timely manner. Although volume of complaints extended have increased for May, the percentage has decreased from 43% down to 38% due to 24 complaints responded to. 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.

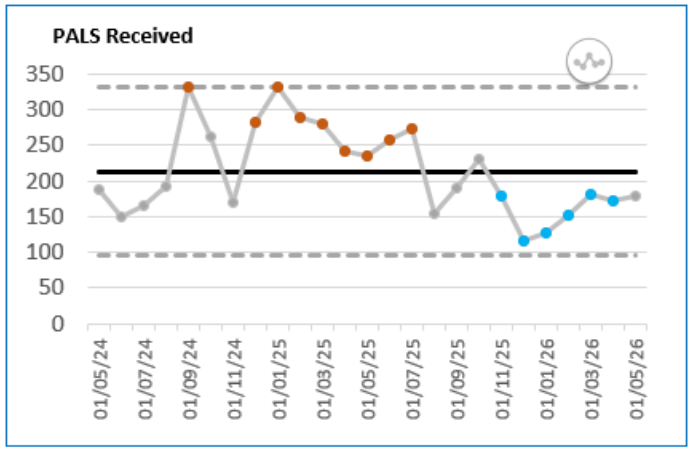
What next?

- Patient experience team are attending regular tri meetings to discuss upcoming and overdue complaints for more divisional accountability.
- New governance feedback loop process put in place with divisions to analyse themes and report back through the experience of care and engagement committee focussing on outcomes and learning.
- 2 PALS officers recruited to back fill positions lost through MARS scheme

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Formal Complaints Received	May 26	17				18	7	30
Formal complaints resolved late (>25 wd)	May 26	9				9	1	18
PALS Received	May 26	178				213	95	332







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People and Organisational Development committee metrics

Compassionate care,
healthier communities

Workforce & organisational development metrics

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	May 26	4.9%	5.0%			4.8%	4.7%	4.9%
Staff Sickness - monthly	May 26	4.9%	5.0%			4.8%	4.7%	4.9%
Mandatory Training monthly	May 26	89.9%	90.0%			89.6%	88.1%	91.2%
Appraisal Rate monthly	May 26	82.7%	90.0%			85.6%	83.2%	87.9%
Turnover rate monthly	May 26	9.1%	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 89.9% versus 90% target.
- Appraisal – consistently failing target, 82.7% versus 90% target.
- Turnover – achieving target, 9.1% versus 10% target.

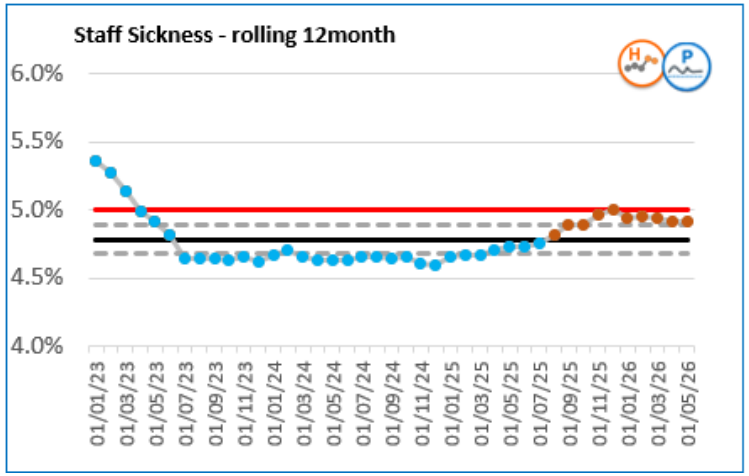
So what?

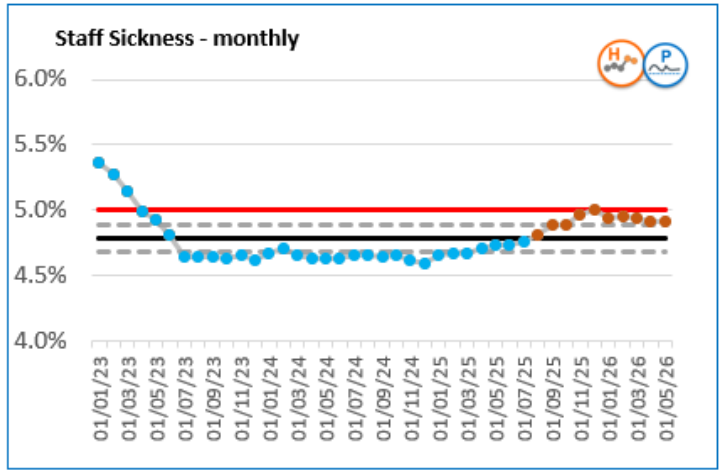
- These workforce key performance indicators directly impact on staff morale and engagement, staff retention, and therefore, patient care and safety.
- Additionally, improvements in these workforce key performance indicators will strengthen our ability to be the employer of choice for our community and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

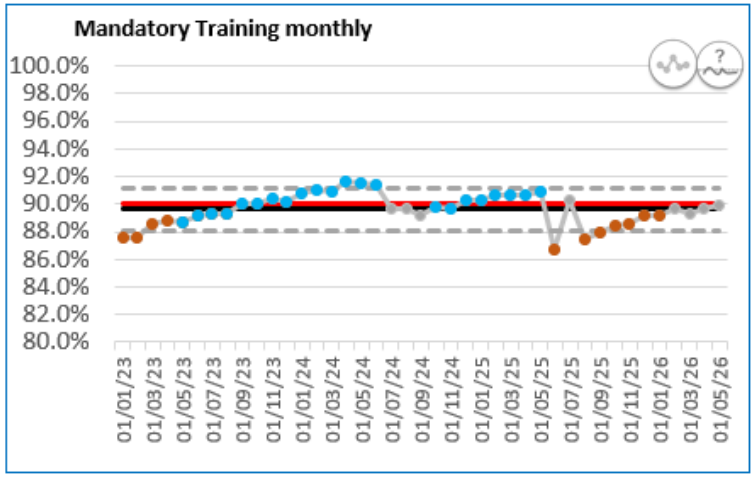
What next?

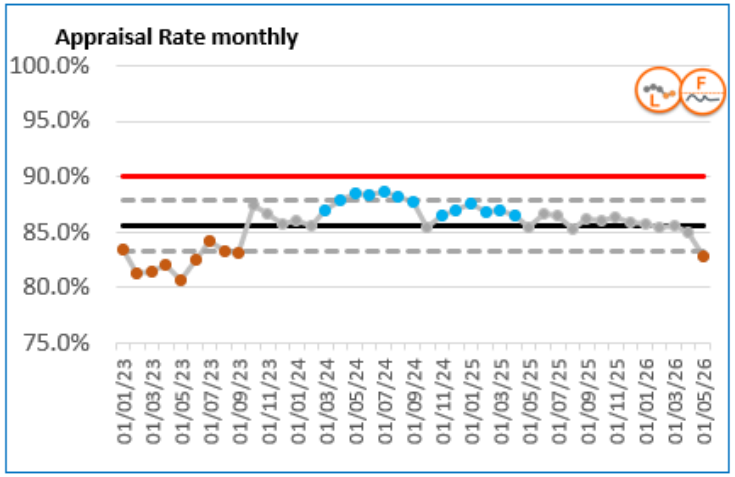
- Monitor staff attendance at department level with focus where improvement is required.
- Review compliance of mandatory training ensuring areas and staff groups are identified where further focus and support may be required.
- Continued analysis of appraisal data to support and challenge areas in need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

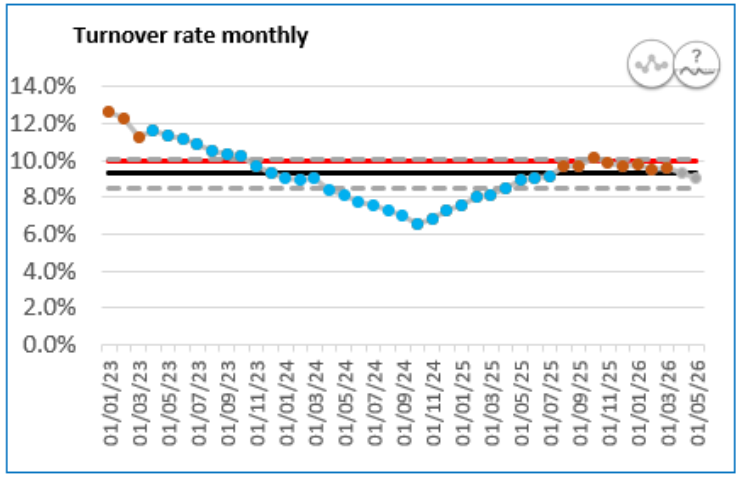
Workforce & organisational development metrics











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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.

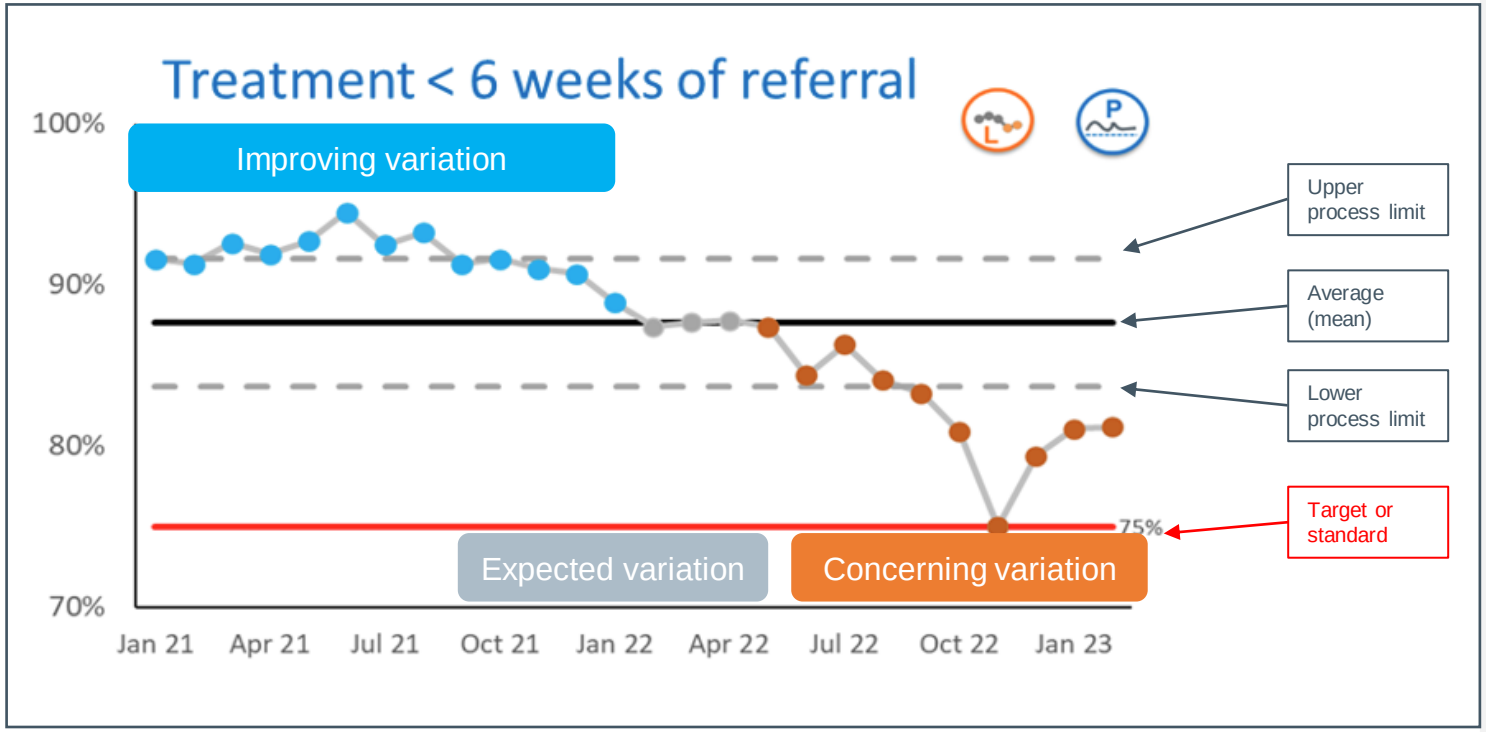
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

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 (10 mins)

3.3. Staff story - Daniela Turner, EDI Midwife

To Assure

Presented by Daniel Spooner

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

Originating Committee Quality & Patient Safety Committee			Date of meeting: 15 July 2026			
Chaired by: Dr Paul Zollinger-Read			Lead Executive Director: Dan Spooner – Executive Chief Nurse / Dr Richard Goodwin – Executive Medical Director			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**SO WHAT?** *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
	against key indicators remains below target and unchanged over several months, impacted by medicines storage infrastructure issues.			measures of success. Progress will continue to be monitored through the governance framework until sustained improvement is demonstrated.		
6.4.1.	**Maternity 10-point action plan** QS can gain partial assurance form the action plan. The team have undertaken a considerable amount of work in many of the areas. The plan identifies partial assurance in addressing inequalities. A National programme will be launched in this area towards the end of	3	National area of focus following published reports of service failures across England	The Maternity services have worked hard to develop the service to ensure it meets the needs of local woman and is safe and effective. The quality of the reports is good, however these reports require triangulation. It is important that the Board assures itself not just about the 10-point plan	Escalate	3

Originating Committee Quality & Patient Safety Committee			Date of meeting: 15 July 2026			
Chaired by: Dr Paul Zollinger-Read			Lead Executive Director: Dan Spooner – Executive Chief Nurse / Dr Richard Goodwin – Executive Medical Director			
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	2026.The team also reported partial assurance in the implementation of the maternity care bundle; this is required to be implemented by March 2027. The team highlighted Triage as an area of focus. Changes in coverage have taken place and work is underway to relocate the service to the labour suite. This area will require close focus going forward.			but in the following areas… These are the views of PZR and not discussed in detail at QS. All too often Boards have taken reports at face value; what I outline below is a process to triangulate the data we currently receive. 1 Psychological safety and the ability of staff to speak up; how can the Board triangulate the existing data it receives? 2 Quality of multi-disciplinary working. Problems are rarely due		

Originating Committee Quality & Patient Safety Committee			Date of meeting: 15 July 2026			
Chaired by: Dr Paul Zollinger-Read			Lead Executive Director: Dan Spooner – Executive Chief Nurse / Dr Richard Goodwin – Executive Medical Director			
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				to technical competence; difficulties in the effectiveness of teams can lead to delayed escalation, disagreement over risk, tribal behaviour, lack of shared decision making. How can the Board assure itself in this area? 3 Listening to women; how does the Board triangulate the current information it receives 4 Learning from harm; how can the Board determine that the service is both learning from incidents and		

Originating Committee Quality & Patient Safety Committee			Date of meeting: 15 July 2026			
Chaired by: Dr Paul Zollinger-Read			Lead Executive Director: Dan Spooner – Executive Chief Nurse / Dr Richard Goodwin – Executive Medical Director			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**SO WHAT?** *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
				implementing lessons learnt 5 Workforce capability rather than number. Are the right people on every shift, are experienced staff leaving, is supervision good, how may newly qualified staff work nights, how many consultants are present OOH, are CTG competencies current, how often are emergency drills practised. The Board needs to determine how it will measure competency		

Originating Committee Quality & Patient Safety Committee			Date of meeting: 15 July 2026			
Chaired by: Dr Paul Zollinger-Read			Lead Executive Director: Dan Spooner – Executive Chief Nurse / Dr Richard Goodwin – Executive Medical Director			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**SO WHAT?** *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
				6 Curiosity about weak signals. Failures usually begin with low level signals in the following areas; complaints, deteriorating culture, repeated low level incidents, increased sickness, staff leaving, families making similar comments, reluctance to report incidents. The Board needs to assure itself that it is interrogating a wide range of different data sets looking for early trend.		

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

Definitions

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

3.5. Nursing staffing report - including strategy (ATTACHED)

To Assure

Presented by Daniel Spooner and Sarah Ward

Public Board

Report information

Report title: Nursing and Midwifery safe staffing report: May and June 2026 review
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 a retrospective overview of safe staffing levels, fill rates and key quality indicators across inpatient areas for May and June 2026.

It complies with national quality board (NQB) recommendations by demonstrating 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. It describes how nursing and midwifery workforce deployment is supporting the Trust's wider financial sustainability ambitions while maintaining a focus on patient safety and care quality.

So what?

- Care Hours Per Patient Day (CHPPD) remains in the lower national quartile (Model Hospital data March 2026), indicating need for continued triangulation with quality, acuity and professional judgement.
- Sickness absence has reduced, supporting improved workforce availability, although unregistered workforce resilience remains a risk.
- Robust oversight of temporary nursing spend continues through the Nursing and Midwifery Deployment Group.
- Overall fill rates at 92% and 91% in May and June respectively.

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.
- Continue recruitment linked to the approved community nursing investment business case, with progress monitored through divisional and nursing governance routes.

Action required by the board:
The Board is asked to receive assurance that nursing and midwifery staffing is actively monitored and mitigated through daily operational oversight, establishment review and governance routes, while noting the residual risks relating to community capacity, nursing assistant workforce resilience and lower CHPPD benchmarking.

Governance and compliance

Risk and assurance:
Robust systems are in place to assure safe nurse / midwifery staffing, including daily escalation, data triangulation and oversight through established governance forums. Mitigations are in place and actively monitored. Overall, risk remains controlled but requires continued oversight.

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

Sustainability:
The Trust continues to balance safe staffing with financial sustainability through:

- Reduction in temporary staffing spend
- Improved rostering and deployment efficiency
- Ongoing review of workforce establishments (SNCT, CNSST)

Workforce investment, particularly in community services, supports long-term service sustainability and aligns with system priorities to shift care closer to home.

Legal and regulatory context:
This report supports compliance with:

- CQC Fundamental Standards, particularly Regulation 12 (Safe care and treatment) and Regulation 18 (Staffing)
- National Quality Board (NQB) safe staffing guidance
- CNST maternity safety requirements

The Trust continues to demonstrate compliance with expectations for the provision of safe, effective, and well-governed care, supported by regular review of staffing, quality indicators, and escalation processes.

Nursing and Midwifery safe staffing report : May and June 2026

1. Introduction

The paper provides the Board with a retrospective assessment of nurse and midwifery staffing levels, fill rates and key quality indicators across inpatient areas for May and June 2026. The Trust continues to maintain safe nursing and midwifery staffing overall, with stable quality indicators and full compliance with maternity safety standards.
There are no immediate patient safety concerns directly attributable to staffing levels. However, there are emerging and ongoing risks relating to:

- Community service capacity and care deferrals
- Lower care hours per patient day (CHPPD) compared to peers
- Sustained workforce gaps in nursing assistants (NAs)

Robust systems for daily staffing oversight, escalation, and mitigation remain effective, and targeted actions are in place to address these risks.

2. Background

The National Quality Board (2016) identifies three expectations (Table 1.) that form a triangulated approach to staffing decisions. This approach supports staffing decisions based on patients' needs, acuity and risk, monitored from "ward to board".
NHS provider Boards are required to ensure proactive, robust and consistent approaches to safe staffing.

Expectation 1	Expectation 2	Expectation 3
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Table. 1 NQB safe sustainable and productive staffing

3. Right staff, right skills, right place and time

The Trust conducts nurse comprehensive establishment reviews using the full suite of licenced Safer Nursing Care Tools (SNCT) twice per year across acute settings, the Community Nursing Safer Staffing Tool (CNSST II) across community settings and Birthrate Plus for Maternity services.
The Nursing and Midwifery Deployment Group (NMDG) provides monthly oversight of nursing and midwifery workforce deployment, reviewing staffing levels, acuity, fill rates, workforce risks and temporary staffing controls. The group enables assurance that staffing decisions are clinically led, data-informed and aligned to safe, effective care, while also contributing to financial sustainability through oversight of temporary staffing use.

On a daily basis, acuity and dependency are reviewed three times per day formally during staffing meetings, with a RAG rated score included in Trust wide capacity report.

3.1 Nursing Fill Rates

The Trust's safer staffing data has been submitted to NHS Digital for May and June 2026. This is monitored at ward level (Appendix 1a and 1b). Overall fill rates remain stable (Table 2, Chart 1.) with no deterioration in harm indicators.

Average fill rate (planned vs actual)	Day		Night	
	Registered	Care Staff	Registered	Care staff
February 2026	87%	83%	95%	97%
March 2026	88%	83%	95%	95%
April 2026	87%	80%	92%	92%
May 2026	90%	85%	96%	97%
June 2026	87%	84%	94%	100%

Table 2. Summary of overall trust fill rate percentages for M2 and M3 (previous three months for comparison).

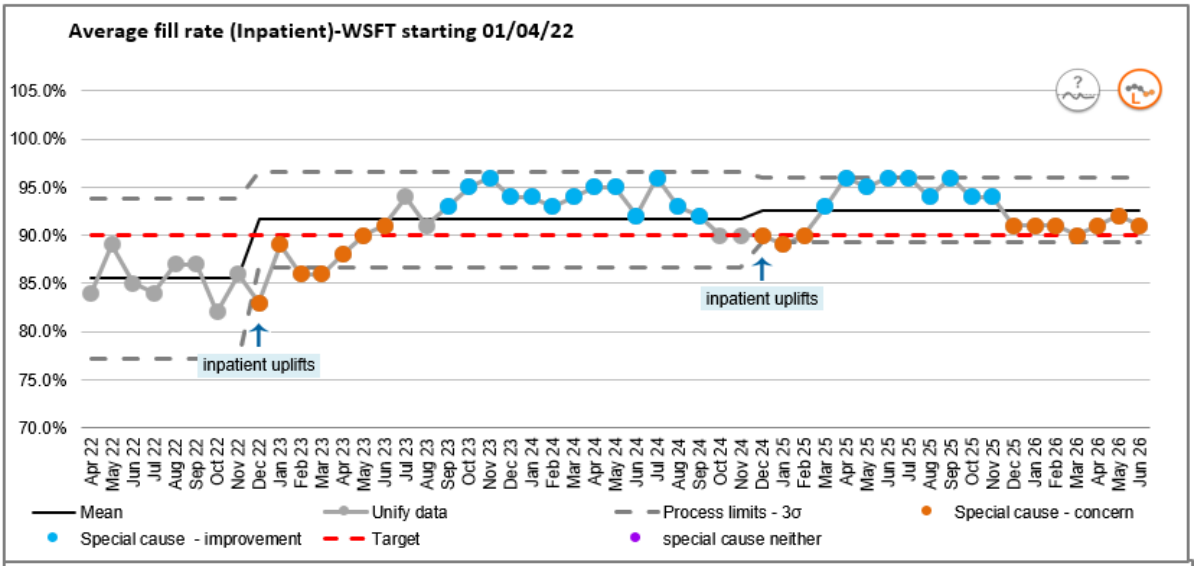


Chart 1. Overall nursing fill rates registered / non registered combined day/ night shifts

3.2 Care hours per patient day (CHPPD)

Model Hospital data (Appendix 2.) demonstrates that WSFT remains in the lower national quartile for CHPPD, recorded at 7.2 in May and 7.3 in June 2026. Although there is a small improvement between months, the benchmarked position indicates ongoing workforce pressure and continues to be triangulated with fill rates, acuity and dependency, quality indicators and professional judgement to support safe staffing assurance.

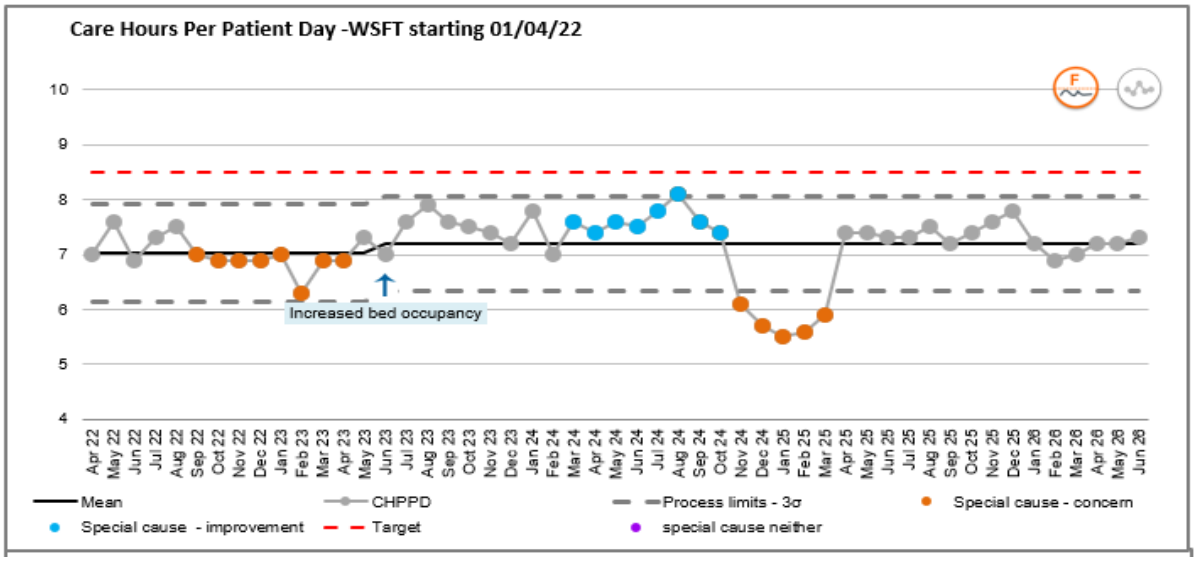


Chart 2. Care Hours Per Patient Day

3.3 Mandatory training

Mandatory training compliance for registered nurses, midwives and nursing assistants remains above the Trust target of 90%, providing assurance that staff have the core skills required to support safe care. While some training is postponed in times of operational demand, this is considered in context during daily staffing meetings.

Staff group	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Additional Clinical Services	92%	92%	93%	93%	93%	93%
Nursing and Midwifery Registered	91%	91%	91%	91%	91%	91%

Table 3. Mandatory training for last 6 months, registered and unregistered care staff

3.4 Recruitment and retention

Vacancies: The registered nursing and midwifery workforce remains broadly stable, with an overall RN/RM vacancy rate of **8.4%.** The principal workforce risk remains within the unregistered workforce, where the NA vacancy rate is **10.6%**. Inpatient substantive WTE data shows a month 3 vacancy position of 42 WTE for registered nurses and 23.1 WTE for nursing assistants. Although NA substantive staffing levels have remained relatively stable over the reporting period, the higher vacancy rate and continued turnover indicate an ongoing risk to workforce resilience.

Table 4. demonstrates the total RN/RM establishment for the inpatient areas in whole time equivalents (WTE). Full suite of SPC charts related to vacancies and WTE can be found in Appendix 3.

	Sum of month 10	Sum of month 11	Sum of Month 12	Sum of Month 1	Sum of Month 2	Sum of Month 3	WTE vacancy at M3
RN	691.3	689.9	703.3	685.4	578.9	574.1	42
NA	369.1	367.6	368.6	363.6	362.7	367.7	23.1

Table 4. Inpatient actual substantive staff and vacancies at month 3 in WTE

New starters: Recruitment and retention actions remain focused on strengthening the unregistered workforce, while maintaining oversight of RN/RM vacancy trends through the Nursing and Midwifery Deployment Group and associated workforce governance routes.

Table 5. 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.

	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	June 26
RN/RM	13	9	10	6	24	-	11	5
NA	12	15	24	14	14	13	6	11

Table 5: Data from HR for attendance at WSFT induction program.

During May
- 11 registrants attended induction (6 RNs acute, 3 RN bank staff, 2 RNs community).
- 6 NAs attended induction (5 NAs acute, 1NAs community)

During June
- 5 registrants attended induction (3 RNs acute, 2 RNs bank staff)
- 11 NAs attended induction (10 NAs acute, 1 NAs community).

Turnover: On retrospective review of the rolling twelve-month position, registered nurse and midwife turnover has remained stable and below the Trust ambition of 10%, reducing to **8.5%**. This provides assurance regarding registered workforce stability.
Turnover within the unregistered workforce remains above **10%** and continues to represent a workforce resilience risk. Although nursing assistant recruitment has been positive during the last quarter, this has not yet been sufficient to fully offset turnover. Individual-level analysis is informing targeted retention actions to reduce the gap and strengthen the unregistered workforce.

3.5 Sickness

Table 6. demonstrates an overall improvement in nursing and midwifery sickness absence since the winter peak, with combined registered and unregistered absence reducing from 6.60% in December 2025 to 5.28% in June 2026.
Unregistered staff continue to have the highest absence rates, although this has improved to 5.93% in June. Registered nurse and midwife sickness remains comparatively lower in June just below 5%. Focus continues on attendance improvement, particularly within the unregistered workforce, remains important to support safe staffing.

	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	June 26
Unregistered staff (HCSW)	7.19%	8.20%	6.74%	7.31%	6.24%	6.90%	6.34%	5.93%
Registered Nurse/Midwives	5.43%	5.87%	5.44%	5.21%	4.25%	4.29%	4.47%	4.97%
Combined Reg/Unregistered	**5.98%**	**6.60%**	**5.85%**	**5.88%**	**4.88%**	**5.12%**	**5.07%**	**5.28%**

Table 6. sickness absence as a % across registered and unregistered nursing/ midwifery staff

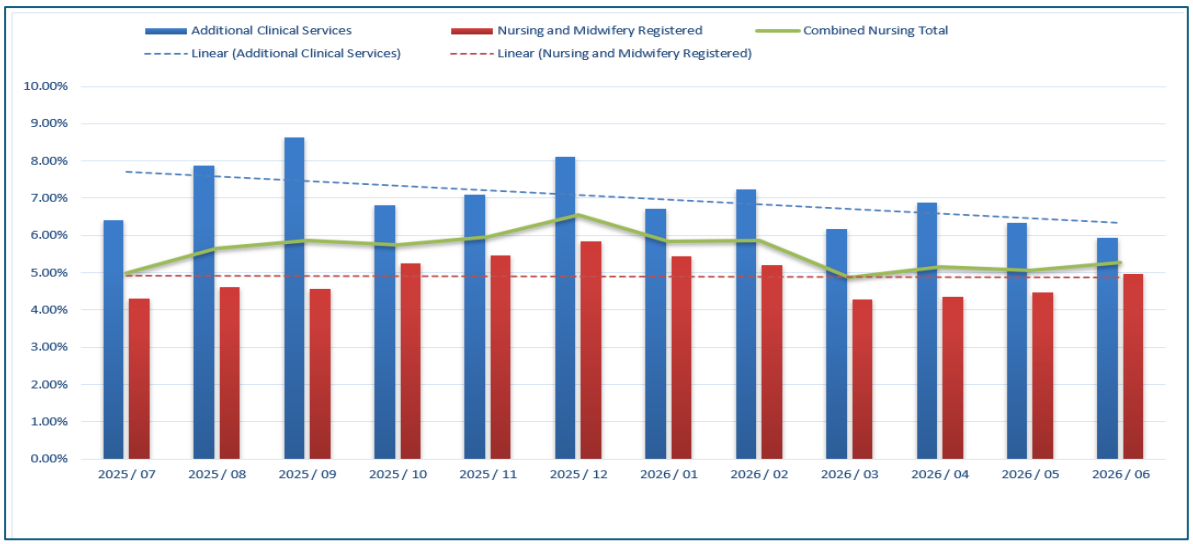


Chart 3. Nursing and midwifery sickness absence by staff group, November 2025 to June 2026.

4. Quality and Safety

4.1 Falls and acquired pressure ulcers

Improvement projects and oversight of these quality indicators are reviewed through the Quality Delivery Governance Group (QDGG). Fall incidents in this period remain in common cause variation as do falls per 1000 bed days.

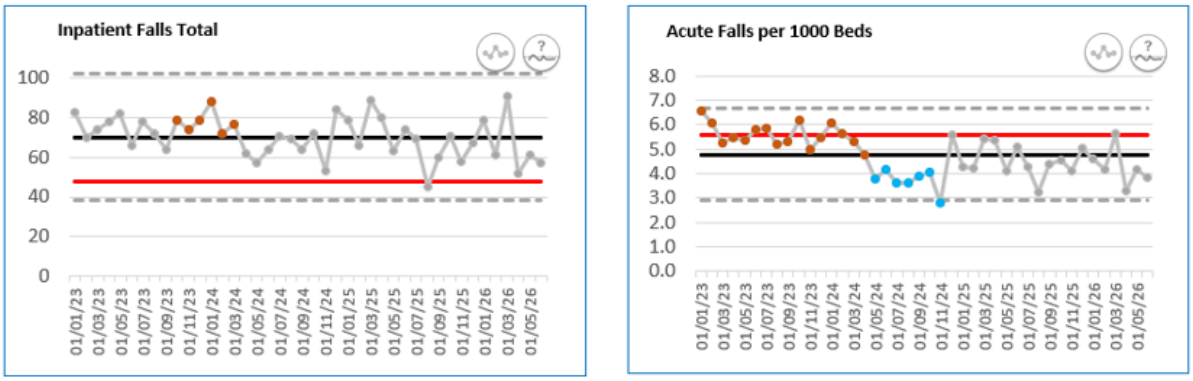


Chart 4. Inpatient falls total and per 1000 bed days

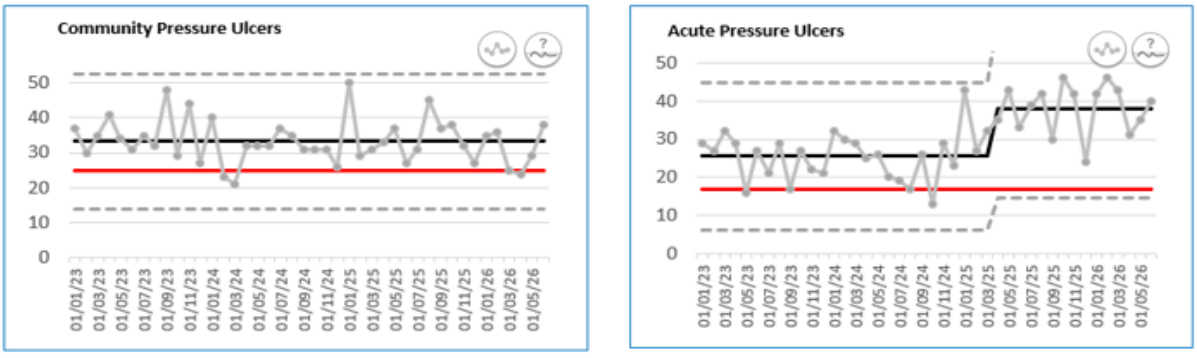


Chart 5. Pressure ulcers acquired in care, community and acute

4.2 Staffing incidents

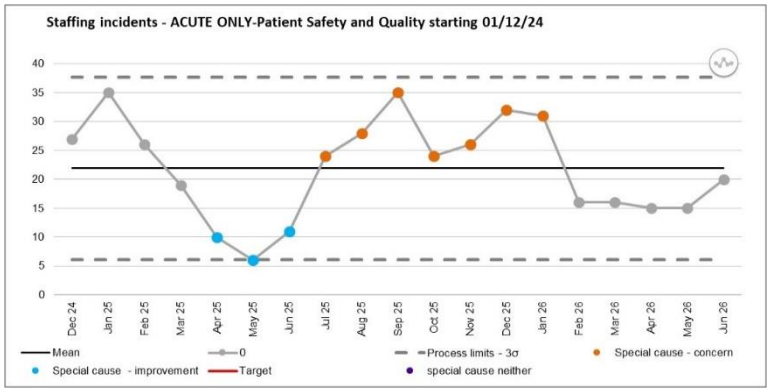


Chart 6. Acute only reported staffing incidents.

All incidents relating to staffing (Acute only) remain below the mean.

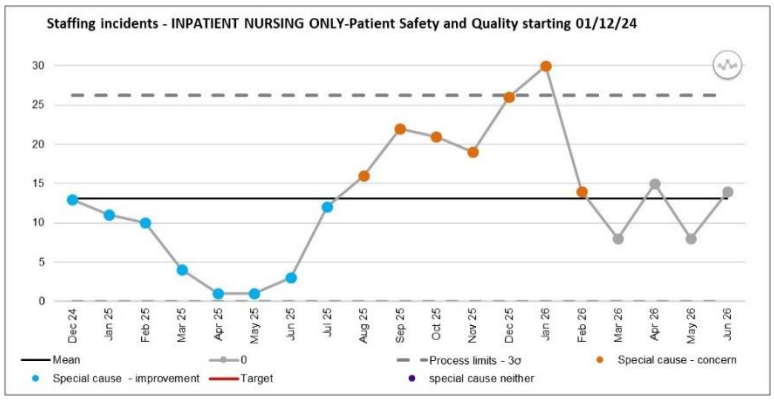


Chart 7. Inpatient only reported staffing incidents.

For inpatient nursing recovery to or below the mean indicate mitigating actions are effective and the system is stabilising.

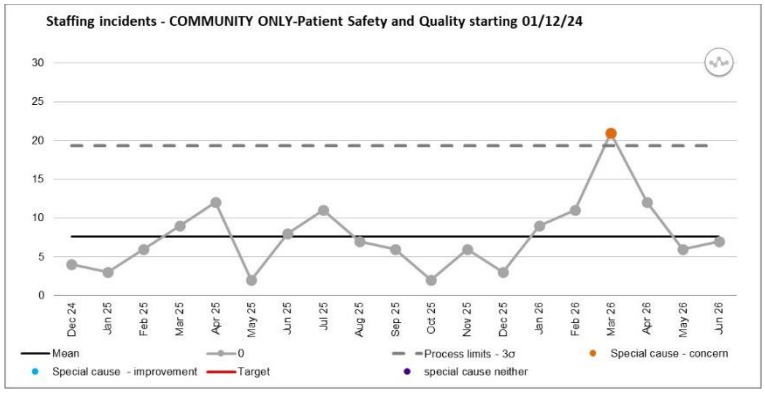


Chart 8. Community only reported staffing incidents.

Community staffing incidents have remained largely within expected variation, with spike in March 2026 aligned to rising demand and care deferrals.

4.3 Red Flags

Red flags as per NQB guidance (Appendix 4) have been reported via RADAR from M9 24/25 (Chart 9). The most common Red Flag event reported remains inpatient nurse staffing shortfall impacting on care. Red flags are mitigated through the rhythm of staffing meeting throughout the day.

To enhance assurance, a refreshed proposal to report red flags contemporaneously and mitigate against acuity and dependency on SafeCare is under review.

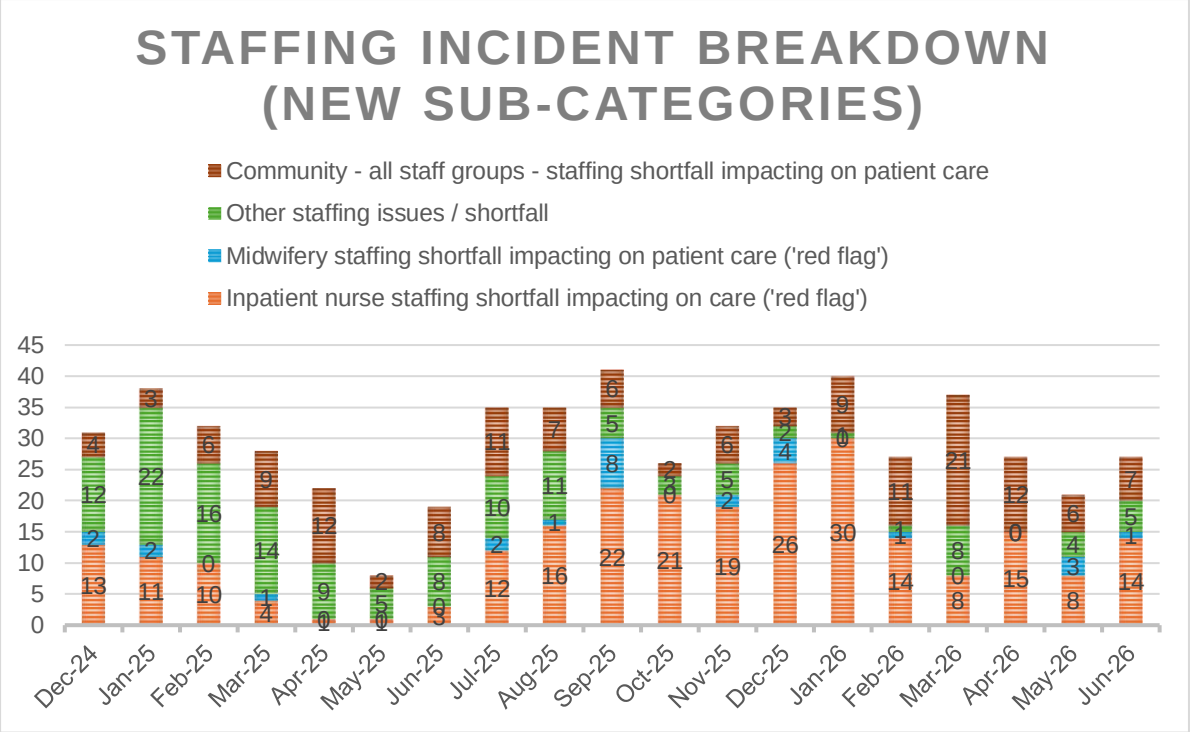


Chart 9.Red flag reported by month and category.

5. Maternity services

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

5.1. One to one care in labour

NICE 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 May and June 2026. Furthermore, this standard has been achieved through the financial year, demonstrating high quality midwifery care.

5.2 Maternity 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 3 Red Flag events recorded in May and 1 in June 2026. These incidents related to delays in commencing induction of labour due to reduced staffing levels. No patient harm occurred. Risk is mitigated through regular oversight huddles to prioritise higher-risk women, with six-hourly updates provided by the Duty Manager to keep patients informed of any delays.

5.3 Midwife to Birth ratio

The midwife-to-birth ratio is no longer considered an accurate standalone measure of safe staffing; all other maternity staffing metrics remain in place.

5.4 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 May and June 2026 (Table 7).

	Standard	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Supernumerary Status of LS Coordinator	**100%**	100%	100%	100%	100%	100%	100%	100%	100%
1-1 Care in Labour	**100%**	100%	100%	100%	100%	100%	100%	100%	100%
MW: Birth Ratio	**1:21**	1:19	1:21	1:20.7	1:18	1:18	1:19	NA	
No. Red Flags reported	**NA**	2	4	0	1	0	0	3	1

Table 7.Maternity Incentive Scheme safety actions key metrics

6. Community and integrated neighbourhood teams (INT)

6.1 Workforce

Sickness Adults: 6.24% rate continues to improve, with a further reduction of 39.89 days lost compared to last month. Over the past four months, this has resulted in a total of 883.44 days regained across the service.

Sickness Therapies: 5.78% rate has increased this month. Action plan commenced to improve sickness across the service.

Turnover: rates have reduced since last month and stand at 10.8%.

Non registered vacancy at Rosemary ward remains an area of focus. While the risk is being mitigated, a Trust wide HCSW summit to has established key strategies to support this workforce group.

Fragility of small services

The recent impact of sickness within the nutritional nursing team has reinforced the fragility of small specialist services. Existing risk assessments have been reviewed, and the learning has highlighted the need to strengthen business continuity arrangements for small specialist teams.

6.2 Demand and capacity

Demand for community nursing services remains sustained and has been on an upward trend throughout 2025 and 2026. Chart 10 demonstrates increase in demand over this period.

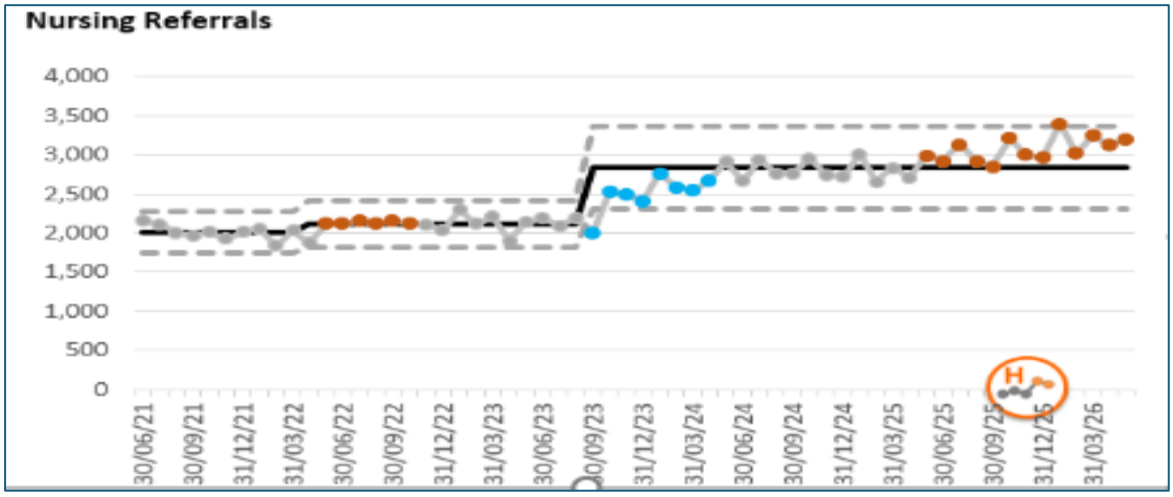


Chart 10. Community nursing referrals

The main method to manage rising demand is to risk assess visits and postpone the least urgent. Deferral or cancelling care and is considered the community equivalent of corridor care.

Deferred care is reducing from a peak in February where over 10% of visits were being cancelled, down to 7.64% in May. Our senior nursing team have presented the robust governance for deferred visits regionally and are contributing to the national review in support of consistent reporting and guidance. Active recruitment is in place against the community staffing investment, together with sickness reductions CQI programme to support deferral reduction.

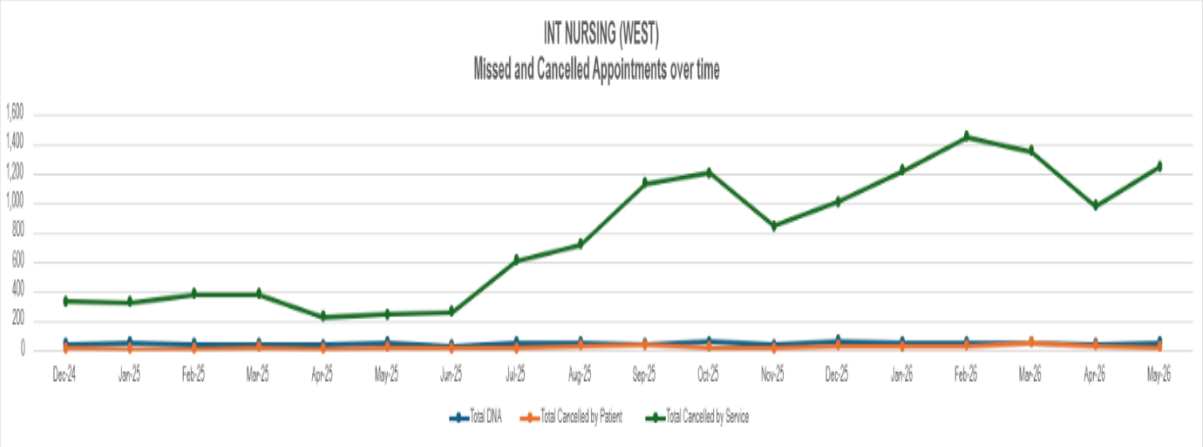


Chart 11. Deferral and missed visits increase over time.

6.3 CNSST II

The combination of CNSST findings, workforce metrics, quality indicators and professional judgement provides reasonable assurance that community staffing resources are being deployed safely and effectively, but with residual risk due to increasing demand, deferred care and the time required to realise the benefits of planned investment (approx. 20% in post, 40% awaiting start date).

The division is conscious that while NHSE has recommended demand and capacity tools for community nursing they do not exist for AHPs in the hospital or community, we are aware that NHSE has commissioned academic research on this, expected to be published end of next year.

Recommendations from CNSST

- Improved data collection method to record triage hours.
- Collect CNSST data digitally via a MS Team form, then saved directly into SharePoint
- Compare with regional group and sharing via NHS futures.

7. Next steps / challenges

7.1 Nursing resource oversight group

The Nursing and Midwifery Deployment Group meets monthly to review best practice methods of deploying staff alongside use of temporary workers (Bank).

Total temporary spend is in special cause improvement providing assurance that temporary staffing controls and deployment oversight are having a positive impact while maintaining safe staffing oversight (Chart 12).

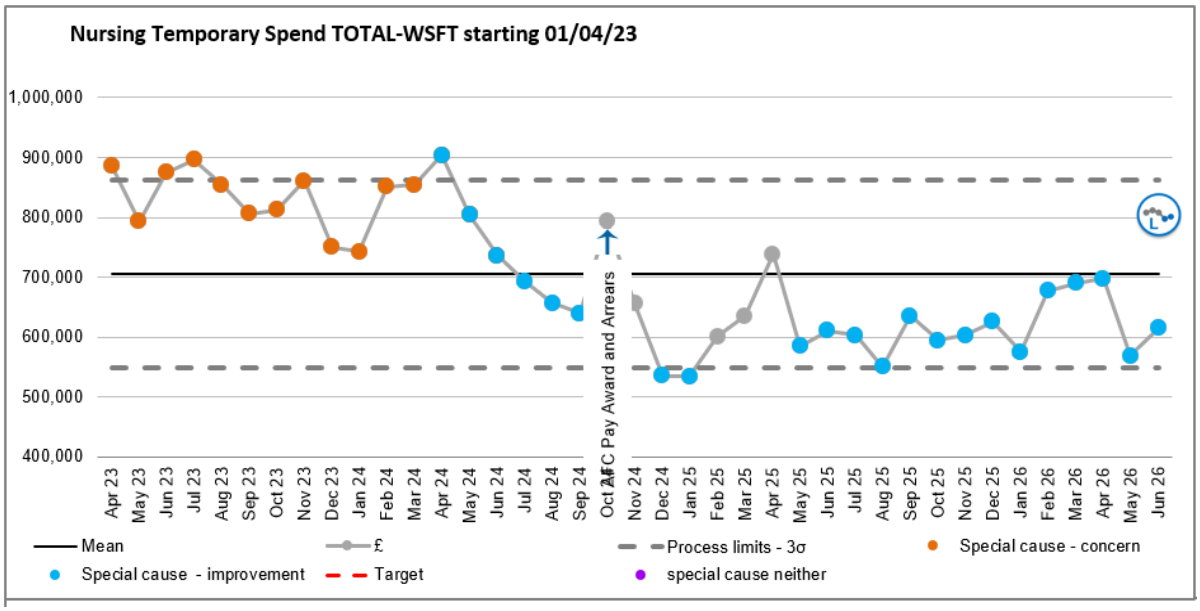


Chart 12. Total temporary spend, nursing.

7.2 SNCT Biannual inpatient review

The summer inpatient establishment census data collection commences throughout July and August and will include the Emergency Department. Analysis will continue to inform our assurance of nurse staffing levels and inform recommendations. The census will be repeated in the winter.

7.3 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 is progressing with all adult nursing applicants securing a post.

8. Conclusion

The Trust continues to demonstrate a proactive and data-driven approach to nursing and midwifery workforce management, supported by strong governance, sustained improvements in registered workforce stability, and consistent quality outcomes.
The Board is asked to note ongoing residual risks in community capacity, unregistered workforce resilience and CHPPD benchmarking.

9. Recommendations

For the Board to:

- take assurance that safe staffing systems are robust and effective.
- to note ongoing residual risks in community capacity, unregistered workforce resilience and CHPPD benchmarking.

Appendix 1a. Fill rates for inpatient areas (May 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	1430.75	1422	1743	1341.25	1069.5	1057.666667	1426	1390.5	99%	77%	99%	98%	983	2.5	2.8	5.3
Acute Assessment Unit	2331	2301.5	2052	1593.4167	1782.5	1739.75	1418.5	1380.5	99%	78%	98%	97%	849	4.8	3.5	8.4
Cardiac Centre	1782.5	1598.5	1069.5	870	1782.5	1667.5	713	712	90%	81%	94%	100%	677	4.8	2.3	7.2
G10	1784.25	1531.25	1796.5	1657.75	1069.5	1013.416667	1781.75	1774.25	86%	92%	95%	100%	984	2.6	3.5	6.1
G9	1773	1507	1428.5	1315	1426	1390	1069.5	1058	85%	92%	97%	99%	821	3.5	2.9	6.6
F12	713	665	356.5	315	713	652.5	356.5	287.5	93%	88%	92%	81%	241	5.4	2.5	8.0
F7	1575.5	1356	1779.5	1611.75	1378.5	1233	1783.5	1638.5	86%	91%	89%	92%	1019	2.5	3.2	6.0
G1	1066.5	900	358	213.5	713	711	356.5	325	84%	60%	100%	91%	371	4.3	1.5	5.8
G3	1638.5	1460.5	1776.5	1547	1069.5	1058	1420.5	1344	89%	87%	99%	95%	1012	2.5	2.9	5.5
G4	1755.5	1531	1774.5	1595	1069.5	1012	1426	1425	87%	90%	95%	100%	989	2.6	3.1	5.6
G5	1764.75	1421	1770.5	1334	1069	1077	1414.5	1566	81%	75%	101%	111%	1016	2.5	2.9	5.4
G8	2295.75	1836	1866.5	1567.5833	1587	1579.083333	1266.333333	979.83333	80%	84%	100%	77%	880	3.9	2.9	6.9
F8	1755	1537.5	1746	1466.75	1069.5	977	1426	1220.8333	88%	84%	91%	86%	0			
Critical Care	2317.25	1976.5	97.5	0	2315	1998.916667	0	0	85%	*	86%	*	159	25.0	0.0	25.0
F3	1770.5	1503.75	1768.5	1431.5	1069.5	1033.25	1299.5	1379.5	85%	81%	97%	106%	941	2.7	3.0	5.7
F4	694.75	856.25	418.75	243.08333	667	609.5	0	67.5	123%	58%	91%	*	233	6.3	1.3	7.8
F5	1413	1423	1362	1129	1069.5	1047.5	954.5	961.25	101%	83%	98%	101%	521	4.7	4.0	8.8
F6	1692	1432.5	1705.5	1457.75	1012	963.5	1405	1347	85%	85%	95%	96%	873	2.7	3.2	6.1
Neonatal Unit	1579.5	1733.333333	272.5	380.5	1054.5	1176.5	552	540.5	110%	140%	112%	98%	290	10.0	3.2	13.2
F1	2063.5	1879	713	747.5	1426	1334	0	134.5	91%	105%	94%	*	272	11.8	3.2	15.1
F14	362	362.5	372.5	352	744	744	0	0	100%	94%	100%	*	140	7.9	2.5	10.4
Total	**33,558.50**	**30,234.08**	**26,227.75**	**22,169.33**	**25,156.50**	**24,075.08**	**20,069.58**	**19,532.17**	**90%**	**85%**	**96%**	**97%**	**13,271**	**4.1**	**3.1**	**7.2**

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

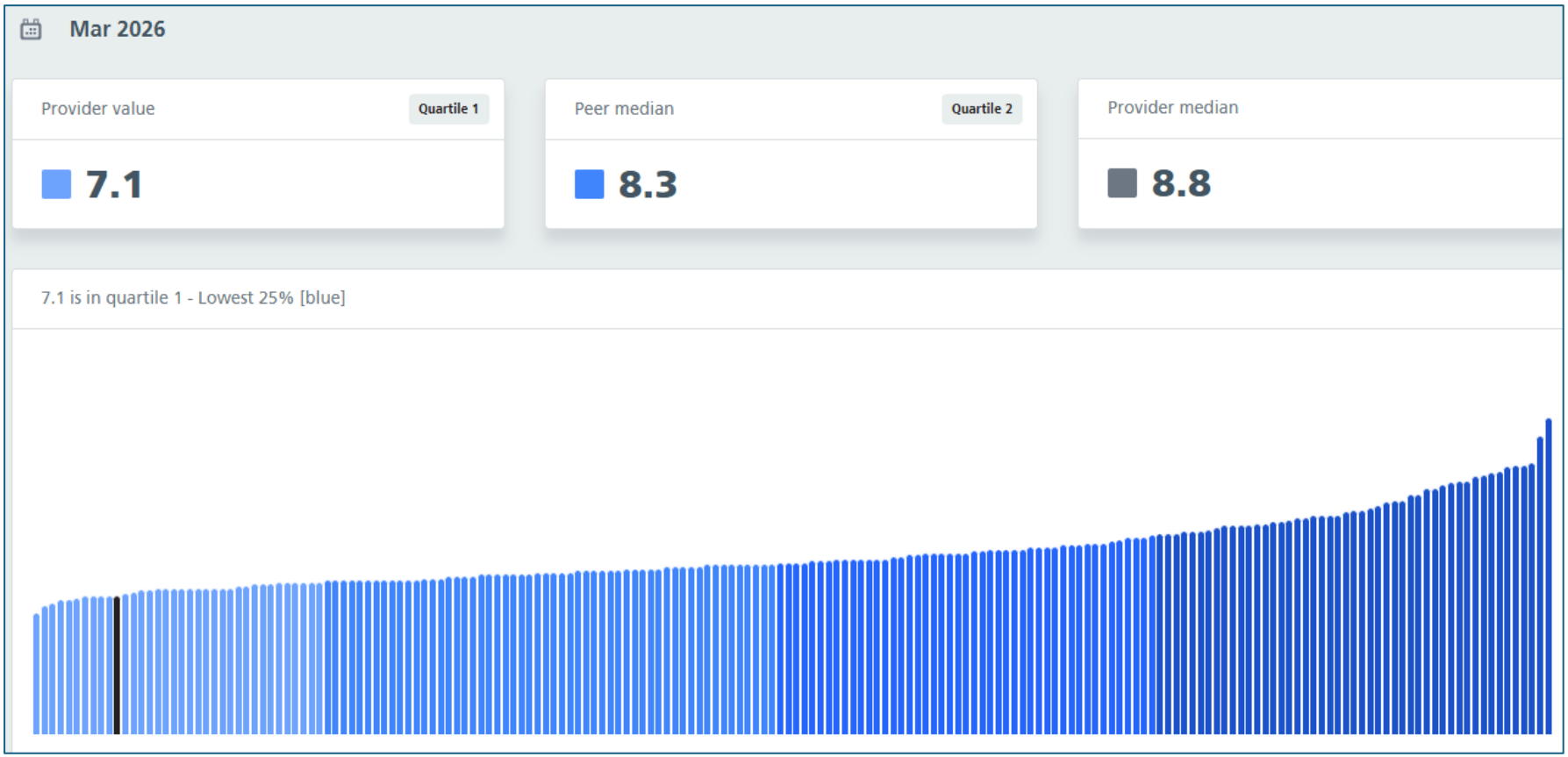
Appendix 1b. Fill rates for inpatient areas (June 2026) data adapted from Unify submission.

	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	1378.25	1301.75	1734.5	1367.5	1035	1022.5	1381	1297	94%	79%	99%	94%	957	2.4	2.8	5.2
Acute Assessment Unit	2311.5	2231.75	2011	1538.5167	1725	1731.5	1375	1352.5	97%	77%	100%	98%	826	4.8	3.5	8.4
Cardiac Centre	1707.5	1477	1035	859.5	1712.5	1525.5	698.5	705.5	87%	83%	89%	101%	659	406.0	2.4	6.9
G10	1712.25	1420.333333	1720.5	1522	1035	915	1725	1651.1667	83%	88%	88%	96%	664	3.5	4.8	8.3
G9	1725.5	1527	1375.75	1258.75	1380	1336	1035	1048.5	88%	91%	97%	101%	786	3.6	2.9	6.6
F12	690	683.5	335.5	277.5	690	649.5	336.5	281.58333	99%	83%	94%	84%	235	5.7	2.4	8.1
F7	1615	1376	1704.5	1549	1299.5	1097.5	1725	1599.75	85%	91%	84%	93%	1005	2.5	3.1	5.8
G1	1017	752	344	286.5	690	679.5	345	335.5	74%	83%	98%	97%	353	4.1	1.8	5.8
G3	1549.5	1365	1704.5	1528.5	1035	1026.5	1378.5	1388	88%	90%	99%	101%	956	2.5	3.1	5.7
G4	1682	1430.5	1702.75	1495.25	1035	951	1380	1417	85%	88%	92%	103%	948	2.5	3.1	5.6
G5	1679	1422.5	1657	1248.5	1023.5	1009	1368.5	1470.5	85%	75%	99%	107%	985	2.5	2.8	5.2
G8	2384.5	1768.583333	1722.25	1442.9833	1667.5	1542.666667	1092.5	1000.45	74%	84%	93%	92%	862	3.8	2.8	6.7
F8	1721.75	1414.25	1696.5	1359.4167	1030	944.25	1366	1322.5	82%	80%	92%	97%	238	9.9	11.3	21.2
Critical Care	2586.25	1919.75	165	4.5	2484	2115.25	0	8	74%	3%	85%	*	195	20.7	0.1	20.8
F3	1696.5	1392.5	1709	1398	1023.5	1015	1376	1355.5	82%	82%	99%	99%	855	2.8	3.2	6.0
F4	688	868.5	487.66667	210.25	660.5	493.5	0	133.5	126%	43%	75%	*	188	7.2	1.8	9.1
F5	1379.75	1360	1368	1260.5	1035	989	977.5	1046.5	99%	92%	96%	107%	498	4.7	4.6	9.3
F6	1653.5	1333.5	1647.75	1389	1012	952	1357	1268.5	81%	84%	94%	93%	873	2.6	3.0	5.8
Neonatal Unit	1602	1705.5	324	444	984	1044	612	612	106%	137%	106%	100%	250	11.0	4.2	15.2
F1	2155.9	1813.5	690	540.5	1380	1331.25	0	149	84%	78%	96%	*	213	14.8	3.2	18.0
F14	360	348	360	357.5	720	720	0	0	97%	99%	100%	*	127	8.4	2.8	11.2
Total	**33,295.65**	**28,911.42**	**25,495.17**	**21,338.17**	**24,657.00**	**23,090.42**	**19,529.00**	**19,442.95**	**87%**	**84%**	**94%**	**100%**	**12,673**	**4.1**	**3.2**	**7.3**

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

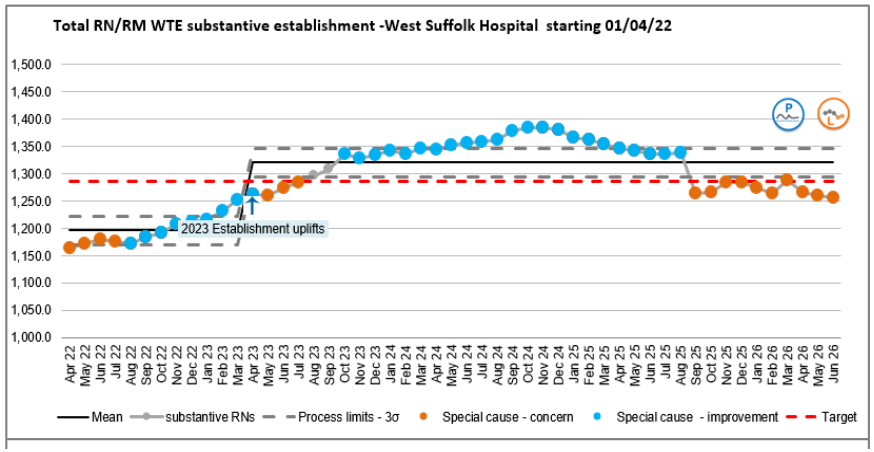
Appendix 2. CHPPD Model Hospital data (accessed 12.5.26)

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.

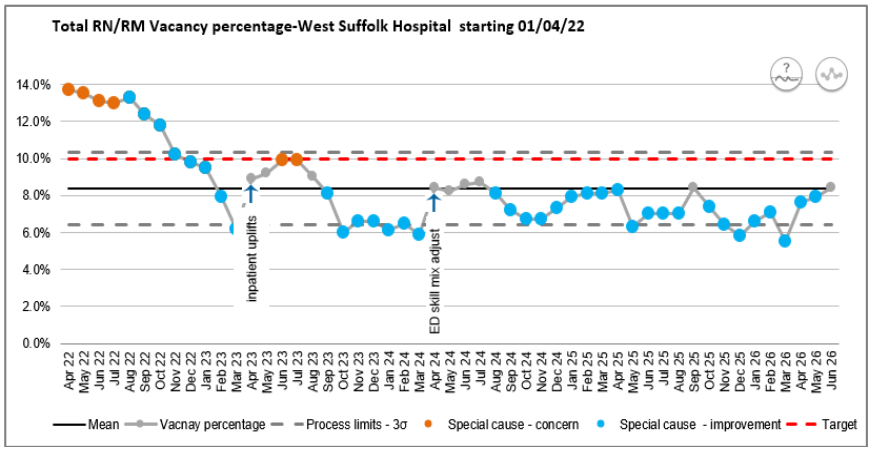


Appendix 3 WTE and Vacancy rates.

A) Trust Total RN/RM WTE

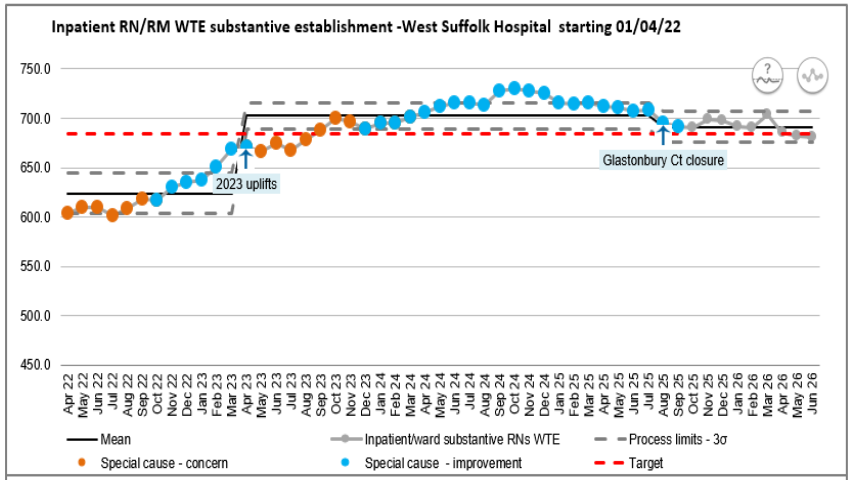


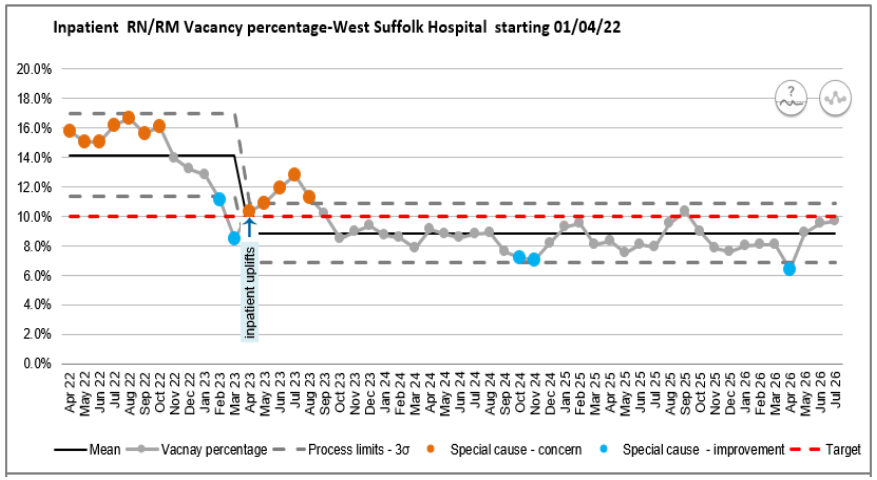
B) Trust Total RN/RM vacancy %



C) Inpatient RN/RM WTE

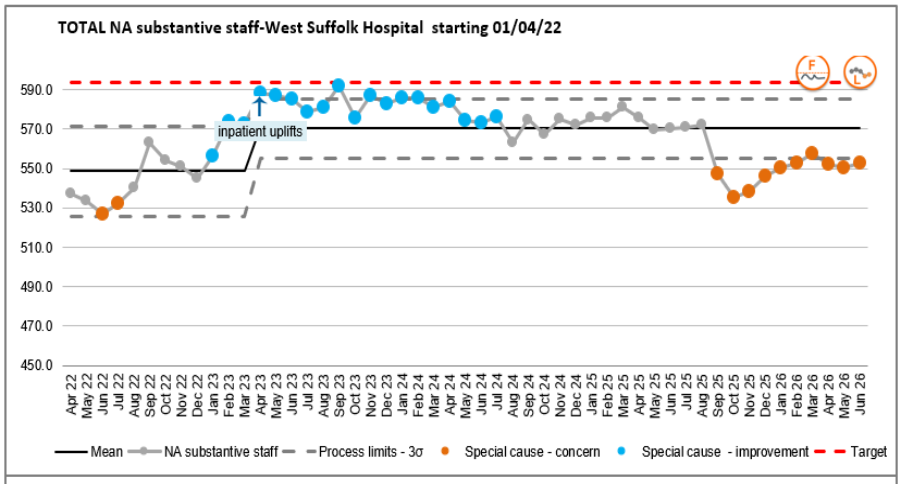
D) Inpatient RN/RM vacancy %

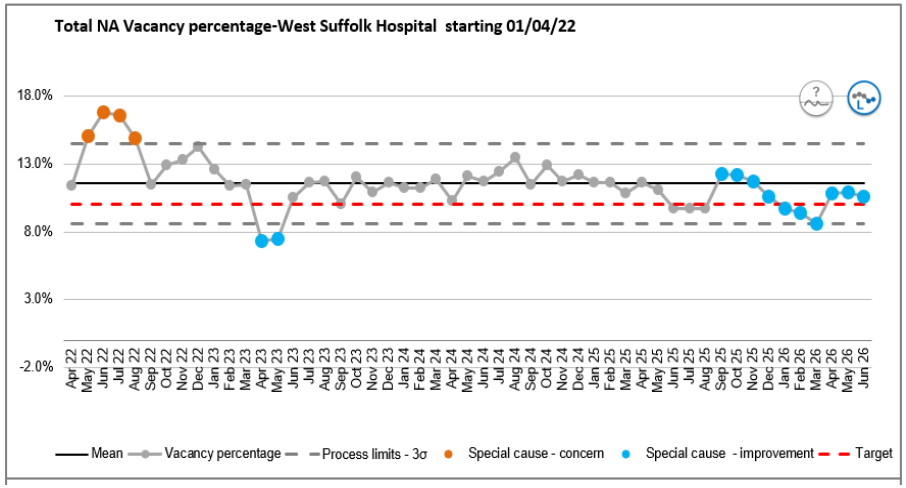




E) Total NA/unregistered WTE.

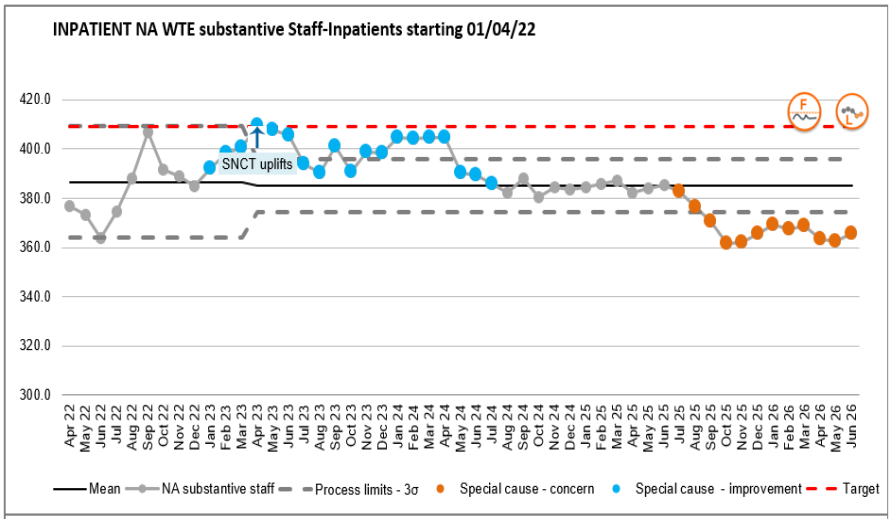
F) Total NA/Unregistered vacancy %

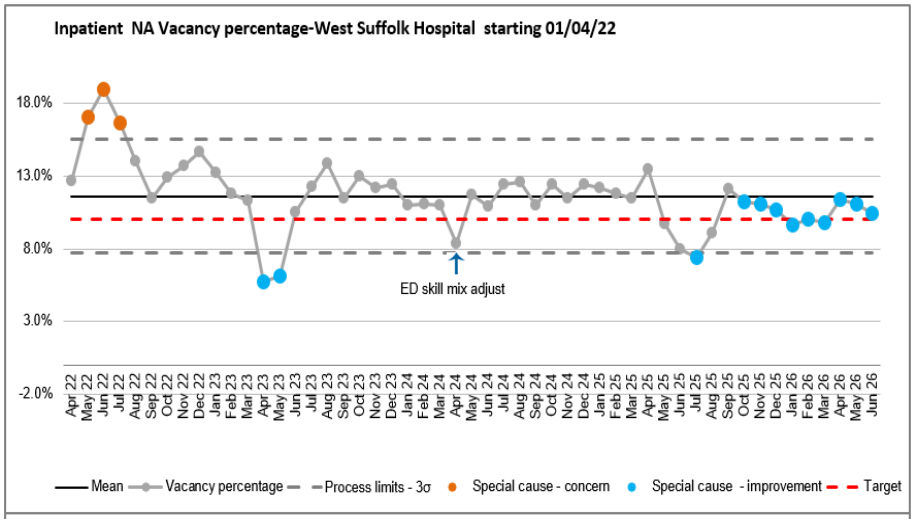




G) Inpatient NA/unregistered WTE

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.

3.6. Maternity Services Report (ATTACHED)

To Assure

Presented by Karen Newbury

Meeting/committee title: Trust Board 29th July 2026

Report information

Report title: Perinatal Quality, Safety and Performance report
Agenda item: Maternity and Neonatal services –Trust 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 Karen Green, 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) – including an overview of the Sixty Supportive Steps visit by the NHSE regional Perinatal team and ICB
- 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 8 progress

- Reports presented to Trust Board sub committees
    - Maternity Claims Scorecard, incident and complaint data Quarterly Review Q4 25/26
    - Ockenden (Nottingham) Review and Amos Review – Implications for West Suffolk NHS Foundation Trust
- Closed Board reports;

  Maternity Quality and Safety Themes and Learning Report: Claims, Incidents and Complaints (Q1 2026-2027)
- 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 Champions. The PQOM supports trusts, Integrated Care Boards (ICBs) and Regional

Teams in this duty, while providing a mechanism for escalation of any emerging risks, trends or issues that cannot be resolved at local level or would benefit from wider sharing.

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

On the 29th of June 2026 NHS England Perinatal Team and the Director of Midwifery and Maternity and Neonatal Voice Partnership Lead from the ICB visited our maternity and neonatal services for the annual Sixty Supportive Steps v4 visit. The visit is intended to provide support to perinatal services so that the Trust can feel confident that their perinatal services are improving safety outcomes, experiences for women and birthing people as well as improving staff experience. The feedback on the day was overwhelmingly positive and this has been reflected in the draft report, which is being checked for factual accuracies and then will be shared with the board.

1.2 Safety Champion feedback

Board-level Safety Champions have been able to undertake their scheduled monthly walkabout within the maternity and neonatal units. For those not able to meet them, information regarding the Perinatal Safety Champions, including contact details, remains clearly displayed across all clinical areas to support accessibility and engagement.

A few issues have been identified through established reporting routes, including:

- A required increase in Allied Health support on the Neonatal Unit due to the increase of High dependency care.
- The value of Neonatal governance as a stand-alone forum verses how to fully integrate it into paediatric and maternity/gynaecology governance forums.
- Current perinatal mental health provision due to staffing issues and variation of service delivered.
- Suitability of using a phone App for lone working with the preferred option being that of a separate device that could be activated more easily.

These issues are being actively managed, with actions and timeframes monitored through appropriate governance structures.

Board Safety Champions continue to meet with the Perinatal Leadership Team and the Maternity and Neonatal Voices Partnership (MNVP) Lead from the ICB at least bi-monthly to review progress, triangulate intelligence, and assess whether additional Trust Board support is required. Any escalations are formally recorded within the Safety Champion Action Log and are systematically monitored through the monthly Maternity and Neonatal Safety Champion meeting, ensuring robust oversight and accountability.

Role	**Meeting attended;**	
	12/05/26	**09/06/26**
Board level Safety Champion (Executive)	✓	✓
Board level Safety Champion (Non-Executive)	Apologies	✓
Perinatal Obstetric Lead/Safety champion	✓	✓
Perinatal midwifery Lead/ Safety Champion	Apologies	✓
Perinatal neonatal lead/ Safety Champion	✓	Apologies
Perinatal management lead	Apologies	✓

MNVP lead	✓	✓

Following a review of the Perinatal Safety Champions Terms of Reference in line with the updated Maternity Incentive Scheme safety actions, the Perinatal Anaesthetic Lead/Safety Champion has been removed as a quorate member. However, they continue to be invited to attend the meetings and retain full access to the meeting agendas and supporting papers, ensuring continued engagement and clinical input.

1.3 Listening to Staff

The maternity and neonatal service continues to promote a culture where staff feel listened to, supported, and empowered to speak up. Staff have access to a range of formal and informal feedback mechanisms, including Freedom to Speak Up Guardians, Safety Champions, Professional Midwifery and Nursing Advocates, staff forums, and dedicated focus groups. Themes and concerns raised are reviewed and acted upon, with feedback shared openly across teams.

In early 2025, the service completed a SCORE Culture Survey as part of Wave One of the Perinatal Culture and Leadership Programme, which supports the development of a positive safety culture, psychologically safe workplaces, and compassionate leadership. The survey achieved a 49% response rate across Women's and Children's Services. Findings were subsequently explored through targeted staff engagement sessions facilitated by an external culture coach to inform ongoing improvement work.

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

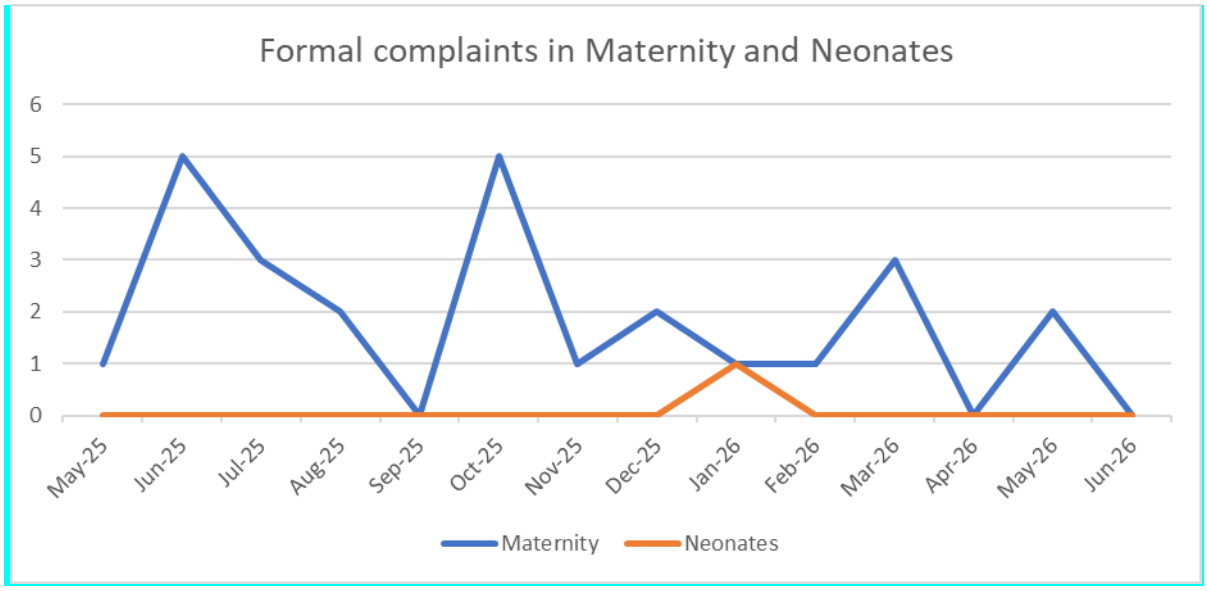
The Perinatal Quadrumvirate, supported by the Trust's in-house Culture Coaches, continues to lead improvements in safety culture and progress these aspirations. Examples of work underway include:

- 'Civility Saves Lives' and 'Active Bystander' conversations with staff undertaken by the Perinatal Quadrumvirate.
- All staff update regarding the Amos National Maternity Review and Ockenden (Nottingham) report publication, to give an overview of the reports, immediate action to be taken and where staff can access support due to the nature of the reports and subsequent targeted social media posts.
- Unfortunately, due to data protection processes there has been no further traction on the Introductory of the ImproveWell app, (supported and funded by Health Innovation East). The application is designed to enable staff to provide real-time feedback on the safety and quality of care delivered during their shift, offering a contemporaneous "sense check" of service performance.
- 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 the summer of 2026. This initiative aims to foster inclusive leadership, enhance understanding of diverse experiences, and support career development across the workforce. Due to low numbers of uptake, this is in the process of being reconfigured to meet the desired objectives whilst being financially viable.

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 by enhancing care standards, improving patient experience and driving innovation. When patients share their experiences, they highlight strengths and reveal gaps in service that may otherwise go unnoticed.

Formal complaints are a strong driver for change. Time and resources across the organisation are invested in robust investigation. During May 2026, two complaints were received. No complaints were received during June 2026.



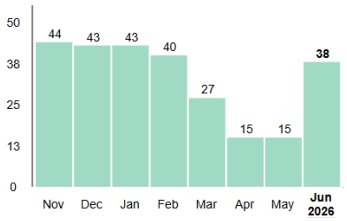
All complaints had been fully investigated and closed at the time of reporting. One complaint was upheld, and one was partially upheld. The complaints related to aspects of clinical care, communication, patient experience, and documentation. Owing to the small numbers of complaints thematic analysis cannot apply. However, aspects of care that fell below the expected standard reflected the service user not always feeling adequately listened to, supported, or informed throughout their care journey. Furthermore, it identified the need to improve the timeliness, accuracy and completeness of clinical documentation and visible senior support during care delivery.

There has been a reduction in complaints compared with previous reporting periods and provides assurance that concerns are being investigated and responded to in a timely manner, with learning identified and shared to support service improvement.

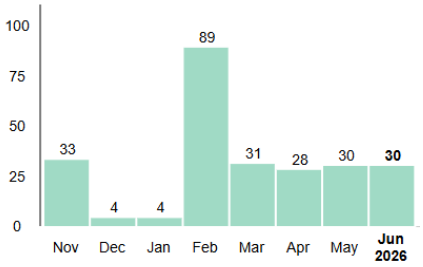
Friends and Family Test (FFT)

FFT responses continue to be monitored across all maternity and neonatal services; however, achieving consistent response rates remains challenging.

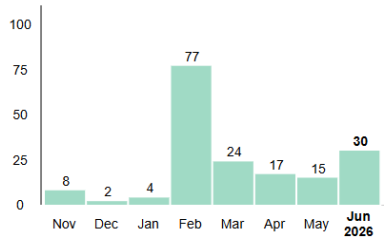
Inpatient Maternity



Community Antenatal



Community Postnatal



Patient Experience Reported by Service Users

Ward/Dept	May- All completed	May Positive Response	June – All completed	June - Positive Response
Inpatient Maternity	15	100%	39	100%
Community Antenatal	30	93%	30	80%
Community Postnatal	15	93%	30	90%

Friends and Family Test feedback for May and June 2026 remained overwhelmingly positive, with most women and families describing maternity care as compassionate, professional and supportive. Across community, intrapartum and postnatal services, respondents frequently reported feeling safe, listened to, well informed and reassured by staff.

Many respondents highlighted the positive impact individual midwives had on their experience, particularly during labour and birth. Staff were described as "kind", "attentive",

"supportive" and as "going above and beyond" to meet both physical and emotional needs. Several women specifically praised the support received during complex or changing birth journeys, including inductions, emergency caesarean births and breastfeeding challenges.

Whilst feedback was predominantly positive, several areas for improvement were identified. The most common themes related to communication, continuity and consistency of care. Some women described difficulties associated with seeing multiple clinicians during pregnancy, resulting in concerns regarding continuity of care, missed follow-up actions and inconsistent information. Others reported receiving insufficient information before procedures, such as planned caesarean births, or felt that discussions about their care lacked sensitivity, particularly when communicating scan results or changes to birth plans.

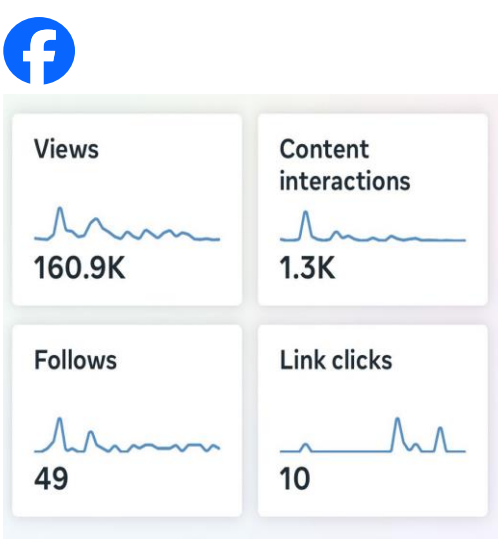
A small number of respondents felt their individual preferences and choices were not always fully recognised. This included concerns that care could at times feel "one-size-fits-all" and that significant self-advocacy was required to ensure birth preferences were considered. There were also isolated reports of women feeling unsupported during postnatal feeding difficulties or feeling that their concerns were not listened to as fully as expected.

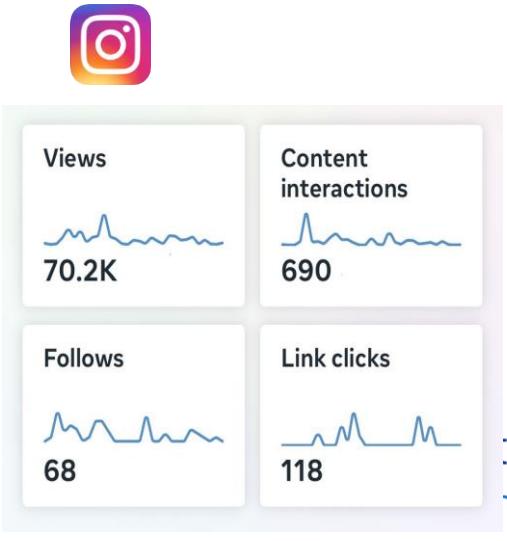
Operational pressures were reflected within some feedback. Examples included delays to induction of labour, transfer to the labour ward, planned caesarean births, discharge processes and access to pain relief. One respondent described requesting pain relief several times before receiving support, whilst others commented on lengthy waits for induction or surgery. Environmental feedback predominantly related to facilities for birth partners, including requests for improved sleeping arrangements and access to refreshments during inpatient stays.

Overall, FFT feedback provides reassurance that women and families continue to receive high-quality, compassionate care from maternity teams. Staff professionalism, kindness and personalised support were consistently recognised as key strengths. The feedback also identifies opportunities to strengthen continuity of care, improve communication and information sharing, and reduce the impact of operational delays on patient experience.

Social Media

Social media continues to provide an additional source of patient engagement and insight. Whilst feedback cannot be captured systematically through these platforms, engagement between maternity and neonatal services and service users remains strong.





e care,
munities

Data demonstrates over 200,000 interactions with service-related posts during May alone. These posts provided advice and information relating to health, education, labour and birth, and wider maternity and neonatal topics

Birth Reflections

The Birth Reflections Service continues to provide valuable insight into women's experiences of maternity care and supports organisational learning through a greater understanding of how care is experienced by women and families.

During this reporting period, 36 women attended appointments with the Birth Reflections Service, representing full utilisation of all available appointments. The service is maintained through two dedicated senior midwives who facilitate all appointments.

A recent patient experience highlighted that, whilst clinical concerns were appropriately recognised and escalated by staff, the family did not feel their concerns had been acknowledged because they were unaware of the actions being taken on their behalf. This has reinforced the importance of actively acknowledging concerns, maintaining open communication and keeping women and families informed throughout escalation and decision-making processes.

Themes identified through Birth Reflections are consistent with wider patient experience feedback and include frustration with delays within the induction of labour pathway, concerns regarding pain management during induction and the latent phase of labour, and a desire for greater involvement in decision-making. Women seeking reflection following prolonged or complex labours frequently report that understanding the reasons behind events provides reassurance and supports closure.

Overall, feedback from women accessing the service remains predominantly positive. Birth Reflections continues to provide an important opportunity to identify improvements in communication, expectation-setting and personalised care, whilst also recognising the high standard of clinical care and support provided by maternity teams.

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.

	May 26	June 26
No. of MNSI referrals	0	0
No. of Patient safety incidents	118	101

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 has previously been represented at the Local Maternity and Neonatal System (LMNS) monthly safety forum, where incidents, reports and learning were shared across all three maternity units. With the new ICB structure taking place from April 26 onwards the LMNS has ceased, however the perinatal safety forums will continue across the new ICB commencing in September 2026.

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

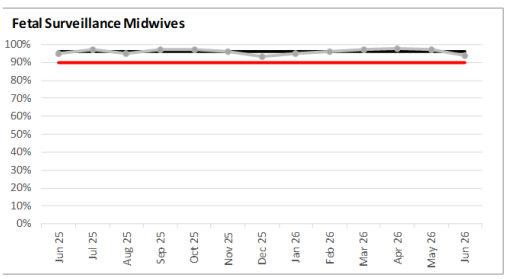
SPC charts demonstrate sustained compliance with the key elements of the Core Competency Framework, despite ongoing changes to national training requirements. Compliance is closely monitored, with any gaps addressed promptly through targeted training and development opportunities.

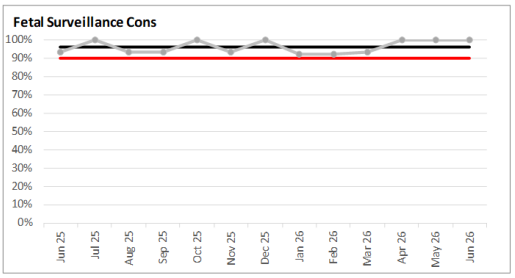
Maintaining full compliance can be particularly challenging within smaller professional groups and rotational medical staffing cohorts, where non-compliance often relates to a small number of individuals. Monitoring arrangements are in place to minimise training lapses and support timely completion.

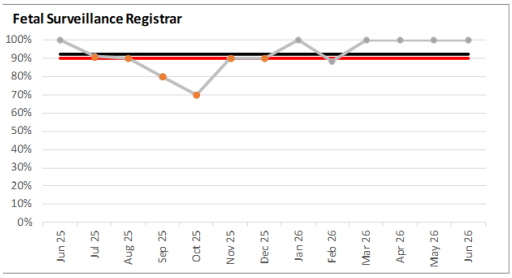
Historically, compliance levels peaked towards the end of the Maternity Incentive Scheme reporting year. Current focus is on achieving and maintaining consistent compliance throughout the year, supported by strengthened oversight and governance processes.

Data collection remains complex due to the combination of internal, external and self-directed learning requirements. While processes to improve assurance and evidence capture have been strengthened, some elements continue to rely on individuals providing confirmation of completed training.

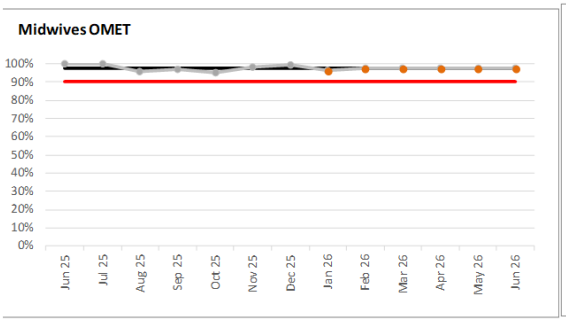
Fetal monitoring training

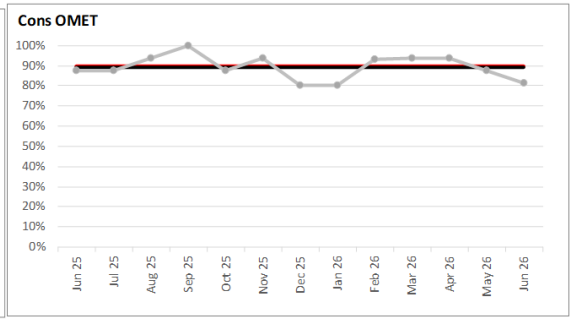


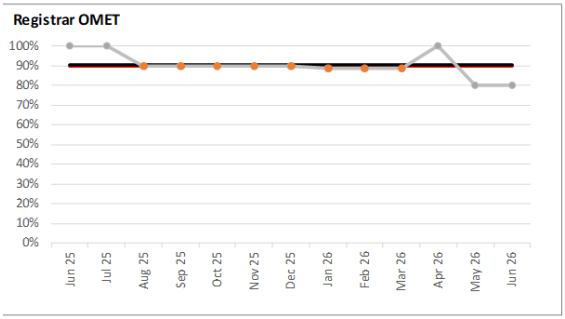


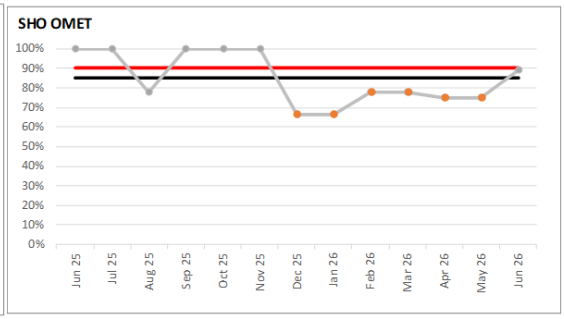


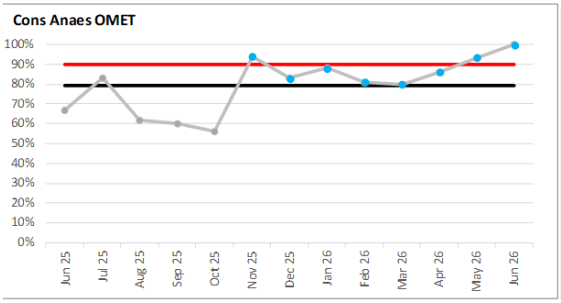
Multi-professional maternity emergency training (OMET)

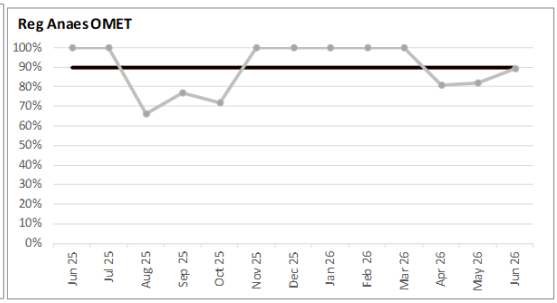


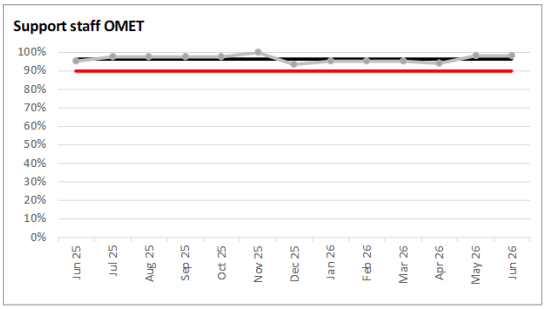




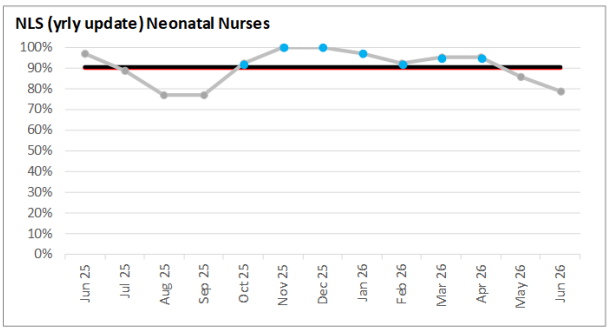


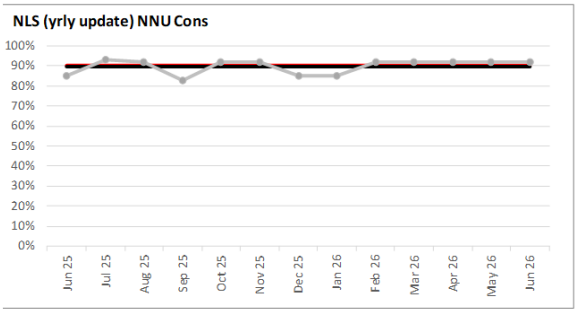


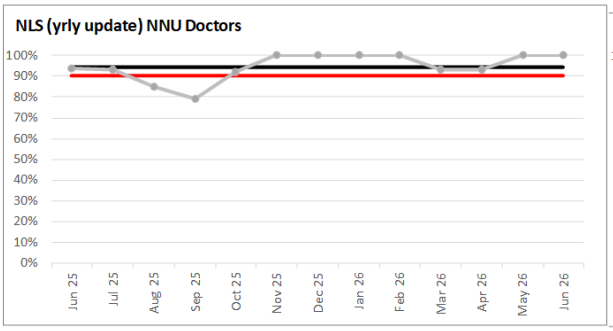


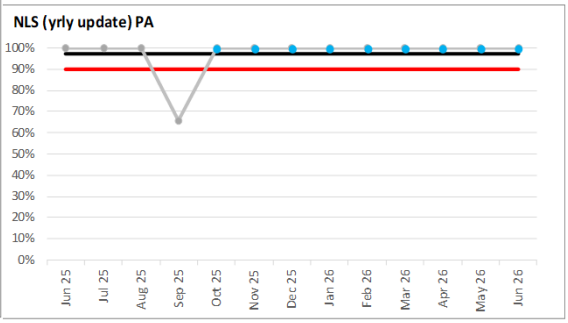


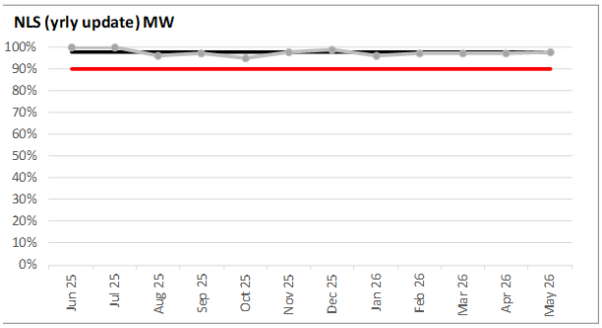
Neonatal resuscitation training (NLS)











1.7 NHS Resolution (NHSR) Maternity Incentive Scheme (MIS) Year 8 progress

Now in its eighth year of operation, NHS Resolution's Maternity (Perinatal) Incentive Scheme (MIS) continues to support safer maternity and perinatal care and reduce avoidable harm.

Year 8 of the scheme was launched in April 2026, with the reporting period 1st April until 30th November 2026, for submission by the 2nd March 2027. This year the number of safety actions have reduced to six, however it requires whole-system engagement from Board to frontline, with increasing scrutiny on credible evidence, culture, and demonstrable improvement rather than compliance alone.

The new safety actions are as follows.

Safety Action	Description	Number of domains in each safety action

A	Workforce and capacity	7
B	Training	5
C	Learning from reviews and investigations	6
D	Service-user voice and equity	2
E	Care bundles (Saving babies lives & maternal)	3
F	Board oversight, governance, culture and leadership	4

The service is actively implementing the new requirements and is on track to achieve full compliance with all six safety actions.

2. Reports

2.1 Reports approved by the Trust Board sub-committees

NHS Resolution's revised Maternity Incentive Scheme (MIS) requirements introduced changes to Trust governance and assurance arrangements in 2024. This has provided an opportunity to streamline reporting structures and strengthen oversight, ensuring that each safety action receives appropriate scrutiny and approval through the relevant governance forums.

Assurance reporting is undertaken at defined intervals throughout the year, ranging from monthly to annual reviews, with many processes embedded within routine service governance arrangements. This supports continuous monitoring and improvement beyond the annual MIS reporting cycle.

The revised governance framework, approved by the Trust Board in May 2024, includes delegated oversight and approval of specific reports through Board sub-committees, providing robust assurance while maintaining clear accountability for compliance with MIS requirements.

Reports presented and approved at the Quality and Patient Safety Committee held on;

20th May 2026: Maternity Claims Scorecard, incident and complaint data Quarterly Review Q4 25/26

This report provided a summary of the maternity claim's scorecard from 01/04/2015-31/03/2025 alongside incident and complaint data from the 01/01/2026-31/03/26, identifying common themes and subsequent learning.

17th June 2026: No reports were due to be presented.

15th July 2026: **Ockenden (Nottingham) Review and Amos Review – Implications for West Suffolk NHS Foundation Trust.**

The National Maternity Learning: Ockenden (Nottingham) Review and Amos Review – Implications for West Suffolk NHS Foundation Trust outlines the key findings from two major national maternity reviews published in June 2026, both of which identify recurring concerns across maternity and neonatal services relating to culture, leadership, governance, workforce sustainability, multidisciplinary working, inequalities in care, and the need to better listen to women and families. The report highlights that these themes mirror those identified in previous national enquiries, reinforcing the importance of sustained organisational focus on patient

safety and quality improvement. It provides assurance that many of the recommendations are already reflected in existing improvement programmes within West Suffolk NHS Foundation Trust, including strengthened governance arrangements, safety culture initiatives, workforce development, multidisciplinary training, and engagement with women and families. The report emphasises the need for ongoing Board oversight of maternity and neonatal services, continued delivery of the NHS England ten-point improvement plan, and a proactive approach to learning and improvement to ensure safe, equitable and compassionate care for women, babies and families.

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.

> Maternity Quality and Safety Themes and Learning Report: Claims, Incidents and Complaints (Q1 2026-2027)

Maternity and Neonatal services continue to maintain robust vigilance in identifying incidents that warrant external review. Established governance processes ensure early review, timely escalation and reporting, 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- Maternity Quality and Safety Themes and Learning Report: Claims, Incidents and Complaints
2. Findings of review of all cases eligible for referral to MNSI	Quarterly	Closed board- Maternity Quality and Safety Themes and Learning Report: Claims, Incidents and Complaints
Report on: 2a. The number of patient safety incidents logged and what actions are being taken	Quarterly	Closed Board - Maternity Quality and Safety Themes and Learning Report: Claims, Incidents and Complaints
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	People and Organisational Development Committee – overarching perinatal services workforce paper.
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- Maternity Quality and Safety Themes and Learning Report: Claims, Incidents and Complaints
6.Coroner Reg 28 made directly to Trust	As applicable	Closed board- Maternity Quality and Safety Themes and Learning Report: Claims, Incidents and Complaints
7.Progress in achievement of Maternity Incentive Scheme 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

3.7. Fuller Report (ATTACHED)

To Assure

Presented by Daniel Spooner

Fuller Inquiry Phase 2 recommendations : West Suffolk Hospital July 2026

Rec number	Recommendation	Current Status / Assurance	Actions
1	All NHS trusts with mortuaries and/or body stores should commission a specialist strategic review of the systems in place to protect deceased people, which should include a detailed risk assessment of the potential breaches of security that could occur. The review should include an assessment of: • the systems in place to identify any unauthorised access to the facility; • the strength and effectiveness of barriers to prevent unauthorised access to the facilities; • the systems in place to identify any access to deceased people for unauthorised purposes; and • how CCTV is used, including its monitoring and any audits undertaken.	No specialist strategic review has been undertaken. There is a risk assessment in place. The HTA inspected in 2024 and all shortfalls relating to security were addressed, link to HTA report HTA-TEM-017 Post Mortem inspection report template. CCTV access to the mortuary and a review of staff who have access is audited monthly. This is carried out by the Mortuary Manager/DI	Peer reviews planned between WSNHSFT and James Paget mortuary services. Workload and staffing pressures have delayed these reviews. In conjunction with James Paget Hospital, plan to complete by the end of Q4 2026/27.
2	All NHS trusts should install CCTV inside the mortuary, with cameras facing all doors and access points, the reception area and the doors of body fridges, while maintaining the security and dignity of deceased people by implementing the appropriate safeguards. Where double-ended fridges also open into the post-mortem room, NHS trusts should install CCTV cameras inside the post-mortem room that focus on the doors to the fridges	CCTV on all fridge doors and entrances, except for post mortem fridge doors (in the post mortem room) and internal lobby.	Planning in progress with security to install cameras on the post mortem fridge doors in the post mortem room and lobby. Exploring the use of 360 cameras. Completion by end of October 2026.
3	All NHS trusts should routinely audit the access data of all facilities used to store deceased people.	A monthly security audit is undertaken by the Mortuary Manager/DI; this reviews CCTV footage, access records and a list of staff with access.	Complete – no further action required
4	The practice of using shared electronic swipe cards for specific staff groups should cease immediately.	This practice does not happen. All access is for individual staff. Any request for mortuary access must be approved by the Mortuary Manager.	Complete – no further action required

5	All NHS trusts should consider putting in place systemic operational barriers that prevent the security and dignity of deceased people being compromised. An example of this would be implementation of a rule that prevents electronic devices such as phones or cameras being taken into a mortuary, other than for approved reasons.	There are no physical barriers. All visitors are always supervised. Cameras are only used for approved reasons, such as part of a post mortem examination and authorised by the Coroner.	Add mortuary specific information to the Trust Security Policy. Work with Security Manager, completion date end of September 2026.
6	All NHS trusts should take every breach of security in a mortuary or body store extremely seriously. Each security incident should be reviewed by a security expert who is able to identify any systemic security issues associated with the incident. A detailed action plan should be developed for each security breach, no matter how minor trusts regard such breaches to be. All security breaches occurring in mortuaries should be incorporated into security reports provided to trust boards or relevant subcommittees, in line with security breaches in other vulnerable areas.	Any security breaches either picked up by the monthly audit or as an incident will be reported on RADAR and as a Human Tissue Authority Reportable Incident. Any HTARIs are raised at Mortality Oversight Group and through Patient Safety Review Panel.	Security Manager to raise the inclusion of any security breaches to the Health and Safety Committee – awaiting response. This will feed into Corporate Risk and Quality and Risk Committees.
7	The NHS should ensure that the security standards required for body stores are the same as those required for facilities licensed by the Human Tissue Authority.	Licensed and inspected by the Human Tissue Authority.	Complete – no further action required
8	All NHS trusts should consider the installation of ‘swipe to exit’ for mortuary facilities. This would allow trusts to monitor and audit entry and exit, as well as time spent in the mortuary.	Swipe to exit by ID card is in place on the main mortuary entrance/exit. Hand swipe only on exit on side door (used for viewings), ID card required to swipe to enter.	Complete – no further action required
9	All NHS trusts should monitor the number of staff with access to the mortuary or body store and keep this under routine review.	This is reviewed monthly as part of the security audit. All staff with access to mortuary is reviewed and access revoked, if necessary.	Complete – no further action required
10	NHS trusts should ensure that Designated Individuals have enough time and resource to fulfil their responsibilities, including time for learning and development.	DI is a member of the national DI forum and has recently attended the HTA public board meeting. Limited budget and time for external training due to current staffing.	More time will become available when staffing level is improved. Request for some training funds in the budget for FY 2027/28. Refer any specific requests for training funding to ADO for support for current FY 2026/27

11	NHS trusts should ensure that senior managers, including the Chief Executive, have a clear understanding of the role of the Designated Individual, their lines of accountability, and the individual legal responsibility associated with being a Designated Individual.	Chief Operating Officer is Corporate License Holder and is included in all email correspondence between the HTA and DI. DI reports to sub-committees of the trust board.	Complete – no further action required
12	NHS trusts should ensure that Designated Individuals attend the correct governance forums. This would allow them to escalate issues and risks, as well as reporting upwards when required.	The DI attends Divisional Governance and Mortality Oversight Group.	Complete – no further action required
13	A professional background in the field of mortuary services should be made a prerequisite for the post of Mortuary Manager.	The mortuary manager has been a diploma qualified APT since 2009 and is a fellow of the association of anatomical pathology technology. Being an APT is essential criteria in the person specification of the mortuary manager job description.	Complete – no further action required
14	NHS trusts should assure themselves that the Mortuary Manager has adequate resources and support to perform their role effectively, including meeting any reporting requirements.	Funding constraints have now been resolved. Any future requests for resources will be raised via the usual Trust processes in a timely manner.	Identify any pay or non-pay resource requirements through annual business planning and budget setting cycle
15	All NHS trusts should establish a routine reporting system for matters relating to mortuaries and body stores. This reporting system should include the presentation of a formal report, by the accountable executive director, to the trust board on a routine basis. The accountable executive director should prepare and present to the trust board a formal annual report, similar to the annual safeguarding report. The report should include: • staffing matters; • security incidents; • all serious incidents; • Human Tissue Authority reports (where applicable); and • all security audits, including audits of access and any access breaches.	A quarterly report was submitted to PQASG by the Mortuary Manager/DI, however due to the review of this meeting a monthly report is now presented at MOG. The first of these reports will be presented at the August meeting.	Agree annual board reporting requirements with the accountable executive.

16	Trust boards should assure themselves that the recommendations in this Report have been implemented		Trust Board to respond
17	Trust boards should ensure that these recommendations and governance arrangements are applied to any temporary facilities used by trusts for the storage and care of deceased people.	No temporary facilities currently in use. Should the need arise to use temporary facilities, a report will be prepared for the Board.	No further action required at this time.
18	Trust boards should take note of the fact that mortuary services are subject to statutory regulation and should be treated with equivalent regard to other regulated activities within trust governance arrangements.	Reporting monthly to MOG, upwards to Q&PSC.	Trust Board to respond
19	NHS trust boards should ensure that the security and dignity of deceased people are included in safeguarding training, policies and assurance.	Security and dignity are included in mortuary SOPs and relevant Trust policies. Safeguarding training under review in response to national changes and will expand to explicitly cover care after death. Care accreditation standard for end of life and safeguarding to include this requirement.	Safeguarding training to explicitly include care after death, completion date by end October 2026.Care accreditation standards to explicitly review for cyclical assurance.
20	The remit of the Chief Nurse in NHS trusts should explicitly include executive responsibility for safeguarding the security and dignity of deceased people in NHS mortuaries and body stores.	Mortuary services report into the Quality and Patient Safety Committee.	Executive responsibility for mortuary services formally agreed as Chief Nurses Office.
21	NHS England should formally incorporate the safeguarding of deceased people into its safeguarding framework for NHS trusts. NHS England or the body that subsumes its		NHSE action.

Trust Board

Report information

Report title: Fuller Inquiry Phase 2 recommendations: Board assurance statement
Agenda item:
Sponsor/Executive lead: Dan Spooner, Executive Chief Nurse
Report prepared by: Tracey Green, Mortuary, bereavement and Medical Examiner Services Manager. HTA Designated Individual
Previously considered by: Quality and Patient Safety Committee
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 Fuller Inquiry Phase 1 report presented findings and recommendations into how David Fuller was able to carry out inappropriate and unlawful actions in the mortuary of Maidstone and Tunbridge Wells NHS Trust.

The Phase 2 report presents the findings of the inquiry's ongoing investigations, which have looked at the broader national picture, and considered if procedures and practices in other hospital and non-hospital settings, where deceased people are kept, safeguard the security and dignity of the deceased.

Further instances of unacceptable care of the deceased were also identified among the distressing findings of Donna Ockenden's review of Maternity services at Nottingham University Hospitals NHS Trust.

So what?
Boards are responsible for maintaining clear oversight of mortuaries, related storage areas and any other areas where people who have died are cared for, and for ensuring dignity, security and post-death care are central to local planning, governance and delivery.

Boards are asked to ensure compliance and that they are rigorously reviewing mortuary departments on a regular basis, including consideration of 'what you really know about the culture of your services, and the values and behaviours of your staff?'.

Assurance against Phase 2 recommendations was presented and approved at Quality and Patient Safety Committee on 15 July 2026. The committee acknowledged the Human Tissue

Authority (HTA) 2024 report at WSHFT, and all actions completed in 2025 (next inspection due 2027), together with the positive 15 steps review February 2026 (**Full copy in Appendix 1**)

What next?

Following review and approval by the Quality and Patient Safety Committee, the Board is asked to formally approve the assurance statement for onward submission to NHS England by 31 July 2026 and maintain oversight of any emerging risks.

Ongoing assurance will be maintained through the established Quality and Patient Safety governance route. Any emerging risks, gaps against national requirements or delays in estates-related assurance will be escalated to the relevant executive lead and Board committee with time-limited actions.

Action required by the board:

- Note the assurance received through Quality and Patient Safety Committee on 15 July 2026, including completion of actions from the 2024 Human Tissue Authority inspection, the positive 15 steps review in February 2026 and the next planned HTA inspection in 2027.
- Approve the Board Assurance Statement at **Appendix 2** for submission to NHS England by 31 July 2026, confirming the Trust's position against the required assurance standards.
- To formally note the Executive responsibility for mortuary services through the Chief Nurses office.
- Confirm that Board oversight will remain in place for mortuary services, related storage areas and post-death care, with clear executive leadership – led by the Chief Nurse, defined roles and responsibilities, and continued review through the established quality and patient safety governance route.
- Request that any gaps, emerging risks or changes to national requirements are escalated promptly to the relevant executive lead and Board committee, with time-limited actions where further assurance is required.

Appendix 1 : 15 steps NED/ Governor Mortuary services review February 2026

MORTUARY

- Small team with a strong, complementary skill mix; each member brings different strengths.
- High level of care shown towards patients and relatives; very impressive and heartfelt.
- Department often works "under the radar" but is vital to the community.
- Staff compassion and dedication clearly evident during the visit.
- Emma and Sarah highlighted as highly knowledgeable and engaging.
- Bereavement room to be reinstated, with project work beginning in March.
- Concern raised about families being charged for car parking when visiting; seen as unfair. **Action: Darren Cooksey agreed that department can issue parking permits to visitors. Tracey Green to confirm monthly requirements to Darren Cooksey.**
- Funeral director visits handled sensitively, using discreet signals to maintain privacy and respect.
- High level of dignity shown to the deceased.
- Corridor condition not ideal due to cages and equipment. Cages also causing issues for CT. **Action: Darren Cooksey to speak to John Earnshaw regarding corridor/cage storage issues.**
- Boiler leak caused white residue on corridor flooring. **Action: Darren Cooksey to investigate removal.**
- Entrance area for family viewing described as underwhelming; suggestion to repaint and improve appearance. Consideration of fold-down chairs for waiting outside of the mortuary, but these must remain compliant with fire route rules and infection control. **Action: Explore bid for chairs and discuss with Mike Dixon regarding fire regulations.**
- Fire exits need testing not only for emergencies but also to ensure staff know safe routes in situations involving distressed or angry families.
- Team looking forward to improvements expected with the new hospital.

Issue	Action	Lead	Due date
Free Car Parking for bereaved visitors to the mortuary	Agreed that department can issue parking permits to visitors. Tracey Green to confirm monthly requirements to Darren Cooksey.	Tracey Green/Darren Cooksey	
Corridor/cage storage issues	Darren Cooksey to speak to John Earnshaw.	Darren Cooksey/John Earnshaw	
Outside Waiting Area Seating	Explore bid for chairs and discuss with Mike Dixon regarding fire regulations.	Tracey Green/Mike Dixon	

General reflections of the morning visits

Observers wished to formally note that Maxine Shipp and Tracey Green were a credit to their departments and that their enthusiasm for their roles clearly inspires and influences their teams.

Appendix 2

Nottingham maternity review findings on post-death care and key actions required following the Fuller Inquiry

Board Assurance Statement for NHS Provider Trusts

Assurance Statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.	Yes	Care after death policy PP484 in place Audits as described in action plan
The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.	Yes	21/29 relevant to our scope of practice as detailed in the action plan
In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.	Yes	Chief Nurse has this responsibility added to their portfolio
The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency.	Yes	Clear governance oversight processes in place feeding into quality delivery group and into Quality and Patient Safety board
For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current	Yes	See action plan

window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.		

Trust name	Trust CEO/AO name	Date	Trust chair name	Date
West Suffolk NHS Foundation Trust	Ewen Cameron	31.07.2026	Jude Chin	31.07.2026

4. EMPOWERED TO IMPROVE

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

To Assure

Presented by Heather Hancock

Board assurance committee - Committee Key Issues (CKI) report

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

Originating Committee: People Organisation & Development			Date of meeting: 17th June 2026			
Chaired by: Heather Hancock			Lead Executive Director: Julie Hull			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**SO WHAT?** *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
	most KPIs achieved and 96% of volunteers recommending the Trust..		change and workforce planning.	embed volunteering within transformation plans.		
5.2	**Mann Review** The Committee received an initial overview of the Mann Review, noting that this is early-stage work following its recent publication	Substantial	The Trust reaffirmed its commitment to a zero-tolerance approach to racism and recognised the importance of aligning the review's requirements with forthcoming NHS staff standards, mandatory training and organisational development activity.	The Committee supported planned engagement activity, including Schwartz rounds, conferences and strengthening staff networks, to better capture and respond to staff experience	Alert	2. SLT for action 3. Board Oversight required

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

Originating Committee: People Organisation & Development			Date of meeting: 17th June 2026			
Chaired by: Heather Hancock			Lead Executive Director: Julie Hull			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**SO WHAT?** *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
	rota compliance and overnight hot food; resident doctor feedback is broadly positive.		experience and Board engagement. Some practical issues remain.	operational problems; and use the new NED role to deepen Board–resident doctor engagement.		
6.2	**Guardian of Safe Working** There were 211 exception reports, mainly late finishes in the medical division and among FY1 doctors. Actions including registrar recruitment and redesigned weekend working are improving trends**.**	Substantial	The new reporting system gives better visibility of safety concerns, though it has increased recorded breaches and fines. Progress has also been	Sustain workforce and rota improvements, reinvest fines in staff wellbeing, and improve consistent engagement with reporting across divisions	Inform	1. No escalation
7.1	**Pride Network Update** The Pride Network shared Pride Month activity and plans for further events, alongside a three-year strategy to increase visibility and membership. Training is planned to build	Reasonable	Limited engagement and concerns about disclosure show that staff do not yet consistently experience a safe, inclusive culture. Stronger allyship and	Improve communication and use new platforms to raise awareness; strengthen manager understanding of inclusion policies; increase volunteering; and ensure	Escalate	2. Other committee /SLT

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

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

Definitions

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

4.2. Organisational Culture - VERBAL

To inform

Presented by Julie Hull

4.3. Putting You First Awards (ATTACHED)

To Assure

Presented by Greg Bowker

West Suffolk
NHS Foundation Trust

Putting You First awards

May – July 2026 winners

Trust Board 31 July 2026

Compassionate care,
healthier communities

Putting You First (PYF) awards

NHS
West Suffolk
NHS Foundation Trust

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

Nominations can be made by any member of WSFT staff at any time in the year. All nominations are collated by the communications team and the list of nominees is reviewed by members of the executive group.

The winners are selected and notified, as well as being offered the opportunity for the chief executive to present the award and hear any feedback from Board members. The citations are included in the following Trust Board report.

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

Compassionate care,
healthier communities

Melanie Henry, administrator, and Eve Hedley, OT

Nominated by Philippa Sharp, local area team manager

An elderly gentleman was sitting in a broken down car during a heatwave near to a busy roundabout. The gentleman was given an ice cream and water and catered for by Mel, who made a sign for his broken down car (reducing the hazard). Mel suggested he waited out of the car and she sat him in the shade and breeze whilst he waited for his recovery (he walked with a three wheeled walker so needed assistance to the side of the path).

Mel is so kind and really went up and above to make sure he was ok. Gratitude also to the Newmarket Hospital reception staff. Thanks and well done Mel for going up and above to make sure the elderly man got home after his x-ray at the CDC.

He was eventually picked up by Manchetts but the recovery men would only drop him at the garage not at his home. The gentleman was over 80 and had very restricted mobility and was alone.

Eve lived in the village where the car was being taken to and on her way from work offered to drop this elderly vulnerable man (it was during a heatwave day) at his home in Burwell!

The gentleman had no support other than the INT staff and Newmarket reception staff who offered lifts, ice creams and water!

Daniela Turner, EDI lead midwife

Nominated by Lauren Rowley, patient engagement officer, and Anna Wilson, patient engagement and equalities manager

Daniela is doing an incredible job as our EDI Lead Midwife and is making a real difference to the experience of our patients.

Daniela has created Adapted Communication Cards for Maternity Triage to help support patients in communicating their needs more effectively. She has also developed and published a 'Tools to Help Read Maternity Information Online' guide, providing access to translation and accessibility tools to better support our diverse patient population.

Through the support of our My WiSH Charity, Daniela has also helped secure noise-cancelling headphones and fantastic emoji keyrings, giving patients additional ways to express their feelings and communicate with their midwives and caregivers.

Daniela is constantly thinking of innovative ways to support our patients while also identifying opportunities to improve and review existing processes. Her commitment to inclusion, accessibility and patient-centred care shines through in everything she does. Daniela is always approachable, helpful and smiling, and her passion for making a positive difference is truly inspiring.

Anna and I would like to nominate Daniela for a Putting You First Award in recognition of the way she consistently goes above and beyond for our patients. She demonstrates compassion, empathy and understanding in all that she does, always keeping the needs and experiences of our patients at the heart of her work.

Keep going, Daniela, you are fantastic!

Rose Ulanowski, midwife

Nominated by Carly Brien, lead midwife

Rose works in the Jade team, supporting vulnerable women and their families. The team liaises with 3rd sector agencies including the Moses Project, referring and signposting families to support supplementary to their antenatal care.

Rose recognised the growing impact on the Moses Project as more and more families are referred to them, that she replicated the service, at her local church, in Sudbury, supporting families in the Sudbury and Haverhill areas. Rose has been pivotal in establishing the baby bank, without her, it would not have been thought of.

Olawatosin Ibisola, theatre practitioner

Nominated by Jason Walker, senior theatre practitioner

For thinking of a solution to a complex incident that arose during a surgical procedure. Tosin came up with a solution for removing a broken guide wire from a patients hip fracture during the procedure.

It truly was a stroke of genius and the consultant surgeon praised her thinking and commented that without her idea we would have struggled to remove the wire and the operation would have taken considerably longer.

She should be proud of her ability to think in this way, and the remarkable difference she made to this case should not be underestimated. Well done, Tosin!

Compassionate care,
healthier communities

Dr Jane Hermanowski, consultant anaesthetist

Nominated by Nestor Brady, senior staff nurse recovery

I have worked with Dr. Jane Hermanowski for many years, and she has always been friendly, approachable, and compassionate, especially toward her patients. Yesterday, June 1, 2026, she once again demonstrated her dedication and professionalism. She stayed with us for over an hour until she was confident that our 2-year-old patient was safe following his operation.

During a critical event when the patient's airway became compromised, Dr. Hermanowski remained calm, focused, and reassuring. She guided us through the situation with confidence and taught us new techniques that will be extremely valuable in our roles as recovery nurses.

Despite the pressure of the situation, she consistently embodied our organization's values. She treated everyone fairly, promoted inclusivity and respect, maintained the highest standards of patient safety, and demonstrated the importance of teamwork.

Dr. Hermanowski is an exceptional clinician, leader, and role model. Her dedication to her patients and colleagues is truly inspiring, and we are fortunate to work alongside her.

Compassionate care,
healthier communities

Garry Sharp, facilities manager for community

Nominated by Angela Harvey, facilities officer

Garry, has been doing the portering role as well as trying to fit in his own job, working long hours to cover the service. Garry has gone above and beyond to ensure in patients receive the hot locks to the ward.

He has ensured that all waste has been removed, dirty laundry, restocking linen and everything else the portering team do at NCH. He has had the support from domestic services who have also assisted with Hot locks rubbish and laundry.

Myself and the domestic staff have worked with him however Garry has risen to the challenge and has ensured as much as the service as possible has been covered. Garry has lead the team with strength and determination and has shown us what a great manager and a team member he is.

Thank you Garry for all you do for Newmarket and the community sites.

Compassionate care,
healthier communities

4.4. Lord Mann Review (ATTACHED)

To inform

Presented by Julie Hull

Open Board 31st July 2026

Report information

Report title: Lord Mann Review
Agenda item:
Sponsor/Executive lead: Julie Hull, Chief People Officer
Report prepared by: Julie Hull, Chief People Officer
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?

Lord Mann review of antisemitism and other forms of racism in the NHS and healthcare regulatory system published on 4 June 2026 Lord Mann review of antisemitism and other forms of racism in the NHS and healthcare regulatory system - GOV.UK.

So what?

The review sets out recommendations for the Department of Health and Social Care, NHS England, NHS organisations and leaders as well as arm's length-bodies (ALBs) and regulators which aim to:

- strengthen leadership and accountability.
- improve understanding and capability through training and development.
- set clear expectations regarding political identifiers and inclusive practice.
- improve and standardise support and protection for NHS colleagues who experience racism.
- improve the consistency, quality and application of data relating to racism.

What next?

- sign-up to the NHS Race and Health Observatory Seven Anti-Racism Principles.
- ensure implementation of the Violence Prevention and Reduction Standard.
- implement the forthcoming NHS Staff Standards.
- ensure all colleagues complete the NHS Core Skills Framework module on Equality, Diversity and Human Rights.
- ensure all colleagues complete new bitesize module co-created with faith leaders in the NHS when it becomes available.
- ensure Board agreement to undertake new anti-racism training when it becomes available.
- ensure the Board and relevant committees fully understand staff survey data on the experience of racism at the Trust and are taking appropriate action.
- confirm adoption of the IHRA definition of antisemitism and the Government definition of anti-Muslim hostility by 31 July 2026 – on hold awaiting further advice following legal challenge
- ensure colleagues, staff representatives, patients and communities are aware of actions through internal and external communications channels and are appropriately engaged in further developments to address antisemitism and all forms of racism locally.

Action required by the board: Sign up to and monitor adoption of the Lord Mann Review recommendations where appropriate

Governance and compliance

Risk and assurance: This will be and monitored by the Board.
Equality, diversity and inclusion: Complies with our anti-racism commitment as a provider of health care and significant public sector employer in West Suffolk.
Sustainability: N/A
Legal and regulatory context: Aligned with our Public Sector Equality Duties and role as anchor institution in our communities.

Lord Mann review

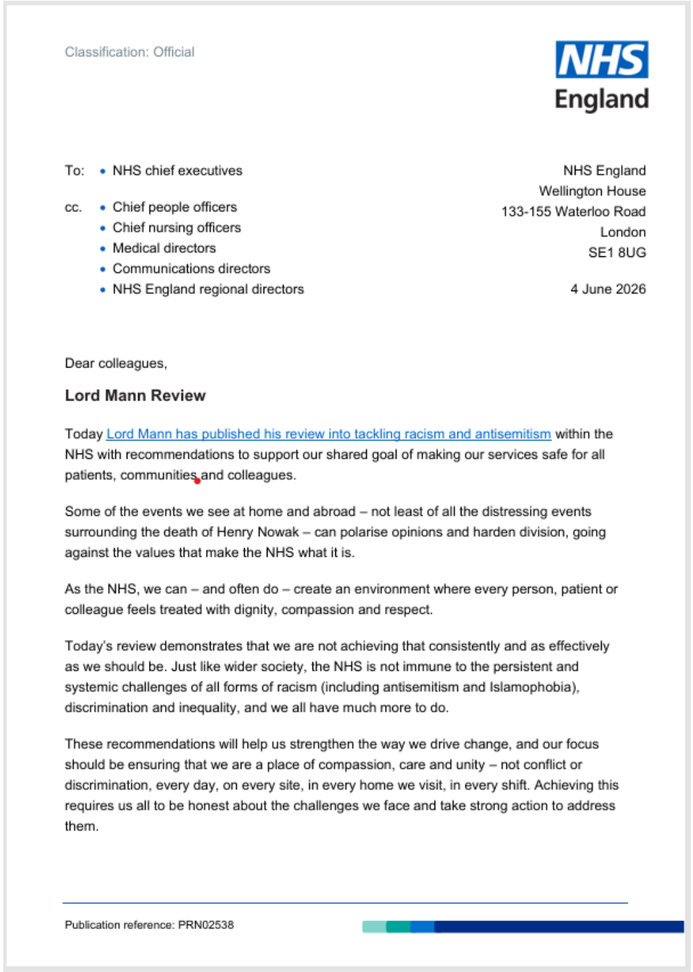
West Suffolk
NHS Foundation Trust

Compassionate care,
healthier communities

Lord Mann review/NHS England letter

- Lord Mann review of antisemitism and other forms of racism in the NHS and healthcare regulatory system published on 4 June 2026 Lord Mann review of antisemitism and other forms of racism in the NHS and healthcare regulatory system - GOV.UK.

- NHS England letter dated 4 June 2026 from Sir Jim Mackey, Chief Executive and Danny Mortimer, Director General for People describing commitment to action and immediate asks of provider organisations.



Classification: Official

NHS England

To:
- NHS chief executives

cc.
- Chief people officers
- Chief nursing officers
- Medical directors
- Communications directors
- NHS England regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

4 June 2026

Dear colleagues,

Lord Mann Review

Today Lord Mann has published his review into tackling racism and antisemitism within the NHS with recommendations to support our shared goal of making our services safe for all patients, communities and colleagues.

Some of the events we see at home and abroad – not least of all the distressing events surrounding the death of Henry Nowak – can polarise opinions and harden division, going against the values that make the NHS what it is.

As the NHS, we can – and often do – create an environment where every person, patient or colleague feels treated with dignity, compassion and respect.

Today's review demonstrates that we are not achieving that consistently and as effectively as we should be. Just like wider society, the NHS is not immune to the persistent and systemic challenges of all forms of racism (including antisemitism and Islamophobia), discrimination and inequality, and we all have much more to do.

These recommendations will help us strengthen the way we drive change, and our focus should be ensuring that we are a place of compassion, care and unity – not conflict or discrimination, every day, on every site, in every home we visit, in every shift. Achieving this requires us all to be honest about the challenges we face and take strong action to address them.

Publication reference: PRN02538

Compassionate care, healthier communities

Mann Review headlines

The review sets out recommendations for the Department of Health and Social Care, NHS England, NHS organisations and leaders as well as arm's length-bodies (ALBs) and regulators which aim to:

- strengthen leadership and accountability.
- improve understanding and capability through training and development.
- set clear expectations regarding political identifiers and inclusive practice.
- improve and standardise support and protection for NHS colleagues who experience racism.
- improve the consistency, quality and application of data relating to racism.

NHS England is committed to an immediate set of actions:

- sign-up to the NHS Race and Health Observatory Seven Anti-Racism Principles.
- set clear Staff Standards relating to experience of racism.
- support NHS improvement and assurance through the NHS Oversight Framework.
- strengthen accountability for racial inclusion through our appraisals.
- consult on adding Jewish and Sikh to NHS protected characteristic datasets.
- develop bespoke eLearning for NHS PALS and complaints handlers.
- ensure all NHS boards and system leaders complete regular anti-racism training.
- complete an engagement exercise and publish national uniform guidance including the display of politicised badges and symbols.

Trust actions

- sign-up to the NHS Race and Health Observatory Seven Anti-Racism Principles.
- ensure implementation of the Violence Prevention and Reduction Standard (including data capture) and use to target improvement with impacted groups (to be monitored via the NHS Oversight Framework).
- implement the forthcoming NHS Staff Standards.
- ensure all colleagues complete the NHS Core Skills Framework module on Equality, Diversity and Human Rights (EDHR) which includes content on antisemitism and Islamophobia.
- ensure all colleagues complete new bitesize module co-created with faith leaders in the NHS when it becomes available (with the exception of those who have completed EDHR mandatory training in the last 6 months).
- ensure Board agreement to undertake new anti-racism training when it becomes available.
- ensure the Board and relevant committees fully understand staff survey data on the experience of racism at the Trust and are taking appropriate action on key problem areas related to this issue and monitoring progress.
- by 31 July 2026 confirm adoption of the IHRA definition of antisemitism and the Government definition of anti-Muslim hostility On hold - awaiting further guidance following legal challenge
- ensure colleagues, staff representatives, patients and communities are aware of actions through internal and external communications channels and are appropriately engaged in further developments to address antisemitism and all forms of racism locally.

Compassionate care, healthier communities

Appendix A definitions

NHS Race and Health Observatory anti-racism principles

- Demonstrate knowledge by naming racism
- Understand and acknowledge
- Meaningfully involve racially minoritised individuals/communities
- Collect and publish data
- Identify racial bias
- Apply a race critical lens
- Evaluate and reflect

Seven Anti-Racism Principles and Briefings - NHS – Race and Health Observatory

Compassionate care, healthier communities

Equality Act 2010 :

Racism = prejudice, bias, stereotyping, hostility, or unfair treatment towards a person or group because of their race, ethnicity, nationality, colour, or national origin. It can occur at different levels, including:

Individual or interpersonal racism (racist attitudes, assumptions, stereotypes, comments, or behaviours towards individuals or groups)

Organisational or systemic racism (policies, practices or processes that disadvantage people from certain racial or ethnic groups)

Race discrimination = a legal term. It refers to treating a person unfairly, disadvantaging them, harassing them, or victimising them because of their race. Under the Equality Act 2010, race (which includes colour, nationality and ethnic or national group) is a protected characteristic, meaning that it is unlawful to discriminate against someone because of their race.

International Holocaust Remembrance Alliance (IHRA) definition of antisemitism

- In May 2026, the IHRA adopted the following non-legally binding working definition of antisemitism:

- "Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities."

What is antisemitism? | IHRA working definition

Compassionate care, healthier communities

Government anti-Muslim hostility definition

- Anti-Muslim hostility is intentionally engaging in, assisting or encouraging criminal acts – including acts of violence, vandalism, harassment, or intimidation, whether physical, verbal, written or electronically communicated – that are directed at Muslims because of their religion or at those who are perceived to be Muslim, including where that perception is based on assumptions about ethnicity, race or appearance.

- It is also the prejudicial stereotyping of Muslims, or people perceived to be Muslim including because of their ethnic or racial backgrounds or their appearance and treating them as a collective group defined by fixed and negative characteristics, with the intention of encouraging hatred against them, irrespective of their actual opinions, beliefs or actions as individuals.

- It is engaging in unlawful discrimination where the relevant conduct including the creation or use of practices and biases within institutions is intended to disadvantage Muslims in public and economic life.

A Definition of Anti-Muslim Hostility - GOV.UKA Definition of Anti-Muslim Hostility - GOV.UK

COMFORT BREAK (10 mins)

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

Originating Committee: Finance and Performance			Date of meeting: 17 June 2026			
Chaired by: Antoinette Jackson			Lead Executive Directors: Nicola Cottington and Jonathan Rowell			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**SO WHAT?** *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
7.2	**Elective Recovery** The deficit in elective activity is significant; this is due to the continuation of overrunning refurbishment works in main theatres. First outpatient attendances are slightly behind plan. Day case activity is only slightly behind plan.	**4 Minimal**	Delivery of the activity plan is required to meet both financial and operational performance objectives in response to the NHS Medium Term Plan, with further activity required to get the plan back on track over the course of the year.	This remains an area of risk and the lack of detailed plans to show how the Trust will get back on track limited the assurance the committee could take at this meeting. An Elective Delivery Group has been established to bring together oversight of both core and stretch activity plans. Workstreams across theatres, outpatients, diagnostics, clinical coding and system-wide initiatives will drive delivery of these. Group will monitor delivery against financial and performance objectives and will report to Finance and Performance Committee monthly.	Assure	1/2 Escalate to MEG and to Board for awareness

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

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

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

Definitions

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

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			Date of meeting: 20 May 2026		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	***WHAT NEXT?*** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	***Escalation:*** *1. No escalation* *2. To other assurance committee /MEG* ***3.** Escalate to Board*
PAGG/IQPR	**Operational performance** The Committee noted strong year-end performance, with most key operational metrics met or exceeded, reflecting sustained effort across the year, particularly in March. Of note was the sustained improvement in diagnostic performance which is ahead of the agreed recovery trajectory. Whilst the 4-hour target in ED was met there are still significant number of 12-hour breaches. Corridor care is used on occasion to enable offload of ambulances.	**2 Reasonable**	There has been significant improvement in the range of metrics contributing to better patient care. There are 6,000 fewer people on the elective waiting list since last year.	The challenge going into 2026/27 will be sustaining improvements particularly for ED and this will require better flow throughout the hospital and appropriate community and system support	1 no escalation

Originating Committee: Insight Committee			Date of meeting: 20 May 2026		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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Community waiting lists deep dive	The Committee noted significant performance challenges in achieving the 18-week RTT standard across community services. In **paediatric services** demand exceeds capacity, due to rapid growth in neurodevelopmental disorder (NDD) referrals, increasing SEND demand nationally and a broader rise in general paediatric workload. For **adult community services**, performance issues were more localised. Some areas (e.g. integrated neighbourhood teams) are under sustained capacity pressure. Others (e.g. pain management) are showing improvement and recovery.	**3.Partial**	Paediatric services are facing a structural challenge, needing to balance high-volume, lower acuity NDD pathways with smaller numbers of complex, high-risk children, including those with significant clinical needs. Much of the pressure in community services is system-wide and not fully within Trust control. Current block contract arrangements do not adequately reflect rising demand, and this then limits responsiveness.	Actions underway include pathway redesign and engagement with the ICB; workforce development, outsourcing, and additional diagnostic capacity; and improved triage and demand management. Whilst some actions are within the Trust's control, current performance against the 18-week target remains unsustainable without wider system change, including clearer commissioning support and better alignment of capacity to demand. The community contract renewal provides an opportunity to address these issues more strategically. The issues raised in the report will be considered by MEG.	2 Escalate to MEG

Originating Committee: Insight Committee			Date of meeting: 20 May 2026		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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Finance Accountability Committee	**Performance month 12 of 2025/26** The Trust met its revised control total in 25/26 which, including a redistribution of central system funding resulted in a deficit of £15.0m. Capital spend for 2025/26 was below the forecast plan. **Month1 2026/27** The Trust has agreed a deficit plan of £12.8m in 2026/27 which will be funded with deficit support funding. The reported deficit for M1 is £1.0m, £545k worse than plan. This includes costs relating to industrial action and a loss of income due to the closure of two theatres for refurbishment. With regard to capital, in month 1 the Trust performed well below the in-month delivery plan of £3.8m.	**2 Reasonable**	The new tariff arrangement and a move away from a block contract means sustaining income levels is crucial. Although the start to the year was unfavourable, this reflects specific operational issues rather than systemic deterioration. The position is considered recoverable over the course of the year, subject to successful delivery of planned mitigations	It is anticipated that elective activity and associated income will be recovered later in the year, once the theatres are fully operational (Q2 onwards) and plan is being developed to achieve this. The Financial Accountability Committee will be reviewing capital control systems and reporting back to a future F&P Committee.	2.Escalate to FAC

Originating Committee: Insight Committee			Date of meeting: 20 May 2026		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	***WHAT NEXT?*** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	***Escalation:*** *1. No escalation* *2. To other assurance committee /MEG* ***3.** Escalate to Board*
Cost Improvement Programme	The Committee noted progress in identifying savings, with the tracker showing savings of around £19.3m (non-risk adjusted) with a remaining gap of approximately £7–8m to target. The Exec team reported improved rigour in recent weeks, with better validation and costing of schemes; increased alignment between operational and finance teams and more confidence in the reported figures.	**3.Partial**	Current progress shows around 70% of target has been identified, which is a significant improvement compared to a month ago. The remaining gap represents more complex and less easily deliverable schemes; some schemes are still underdeveloped or require further validation; and there is a need to ensure that identified savings are deliverable in practice.	A range of additional opportunities are being explored, including workforce efficiencies (particularly reducing temporary staffing), procurement savings and further divisional scheme development. Risks are being reviewed through programme boards and oversight groups. The Committee challenged whether the risk register was sufficiently focused and actively managed, rather than simply listing issues which might impede progress.	2 Escalate to MEG/FRG

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

5.2. Finance Report (ATTACHED)

To Review

Presented by Nick Macdonald

Meeting/committee title: Public Board Meeting

Report information

Report title: Finance Report – as at 30 June 2026 (M3)
Agenda item:
Sponsor/Executive lead: Jonathan Rowell (Chief Finance Officer)
Report prepared by: Nick Macdonald (Director of Operational 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 3 of 2026/27 (May 2026).

Summary

We have agreed a deficit plan of £12.8m in 2026/27 which will be funded with deficit support funding.

The reported deficit for June 2026 is £318k, being £265k worse than plan (£873k YTD). This is largely due to clinical income being behind plan, net of costs associated with reduced activity levels. It is anticipated that this activity and associated income will be recovered later in the year, once the theatres are fully operational (Q2 onwards). This is linked to our CIP underperformance where the CIP programme includes a productivity margin on RTT .

Underlying Position and Forecast

Our recurring deficit position continues to be just below £1.5m without the monthly deficit funding (of almost £1.1m per month).

Since we are now earning much of our income on an activity basis it is more difficult to ascertain our overall deficit run rate due to some of our costs being fixed and some variable in line with activity (and income) levels. This can be further complicated by timing differences between when costs are incurred and when income is recognised (eg temporary pay claims, consumable stock usage and coding delays). However, since our staffing numbers and costs are the primary driver of our underlying position we are clear that this has not worsened over Q1.

The Trust is forecasting to break even in 2026/27 after receiving the agreed deficit support funding. However, there are risks to this position in relation to recovering our activity plan and delivering our CIP programme.

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

2026-27– June 2026
for Board
31st July 2026

Putting you first

Executive Summary

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The Trust is forecasting to break even in 2026/27 after receiving the agreed deficit support funding. However, there are risks to this position in relation to recovering our activity plan and delivering our CIP programme.

Workforce
Since April 2024, we have reduced our overall staffing levels by 334 WTEs (6.5%), including a number of additional posts that have been externally funded.

Cash
The cash balance as at 30 June 2026 remains healthy at £24m and still includes £3.5m of capital cash that has not yet been spent due to the capital creditors not being paid by the end of April. The strong position in March is continuing into the new financial year. Cash continues to be rigorously monitored to ensure that the Trust remains on plan and does not fall below the £1.1m enforced by NHS England.

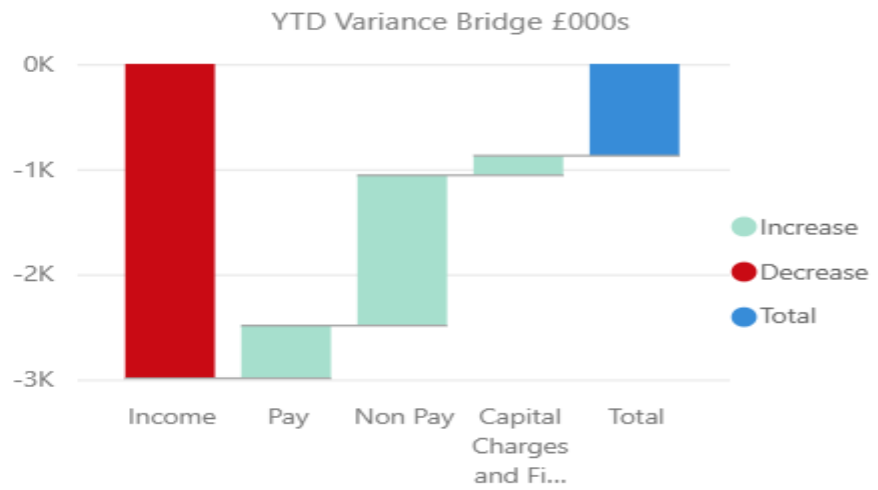
Capital
The Capital Plan for 2026/27 was agreed at £47m. During the first quarter of 2026/27, RAAC funding was also approved of £1.24m, taking the plan to £48.3m for the year. At month 3 (year to date) the Trust has spent £3m against a plan of £11m. The plan included year to date spend on the return to constitutional standards projects, the funding for which has not yet been formally approved. The Trust is still forecasting to achieve the plan set for 2026/27.

26/27 M3 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)
Income									
Clinical Income	35.7	34.5	-1.2	106.6	103.5	-3.1	426.9	426.9	0.0
Non Clinical Income	2.4	2.7	0.3	7.1	7.3	0.1	28.4	28.4	0.0
Total	**38.1**	**37.2**	**-0.9**	**113.7**	**110.8**	**-2.9**	**455.2**	**455.2**	**0.0**
Pay									
Substantive	-25.1	-23.7	1.4	-75.6	-71.2	4.5	-298.9	-298.9	0.0
Bank	-0.5	-1.6	-1.1	-1.6	-5.3	-3.7	-6.0	-6.0	0.0
Agency	0.0	-0.1	-0.1	0.0	-0.3	-0.3	0.0	0.0	0.0
Total	**-25.7**	**-25.5**	**0.2**	**-77.2**	**-76.7**	**0.5**	**-304.9**	**-304.9**	**0.0**
Non Pay									
Clinical Non Pay	-6.6	-6.5	0.2	-19.6	-19.1	0.5	-77.5	-77.5	0.0
Non Clinical Non Pay	-3.0	-3.6	-0.6	-9.6	-10.8	-1.2	-36.8	-36.8	0.0
Total	**-9.6**	**-10.1**	**-0.4**	**-29.2**	**-29.9**	**-0.7**	**-114.3**	**-114.3**	**0.0**
Capital Charges	**-2.0**	**-2.0**	**0.0**	**-6.0**	**-5.9**	**0.0**	**-23.9**	**-23.9**	**0.0**
Reserves	**-0.8**	**0.0**	**0.8**	**-2.2**	**0.0**	**2.2**	**-12.4**	**-12.4**	**0.0**
Total	**-0.1**	**-0.3**	**-0.3**	**-0.9**	**-1.7**	**-0.9**	**-0.3**	**-0.3**	**0.0**

Deficit YTD £	**1.7M**	
Variance against plan YTD £	**-0.9M**	**Adverse**
Movement in month against plan £	**-0.3M**	**Adverse**
EBITDA Postion YTD £	**4.1M**	**Favourable**
EBITDA margin YTD	**4%**	**Favourable**
Cash at bank	**£24.3M**	



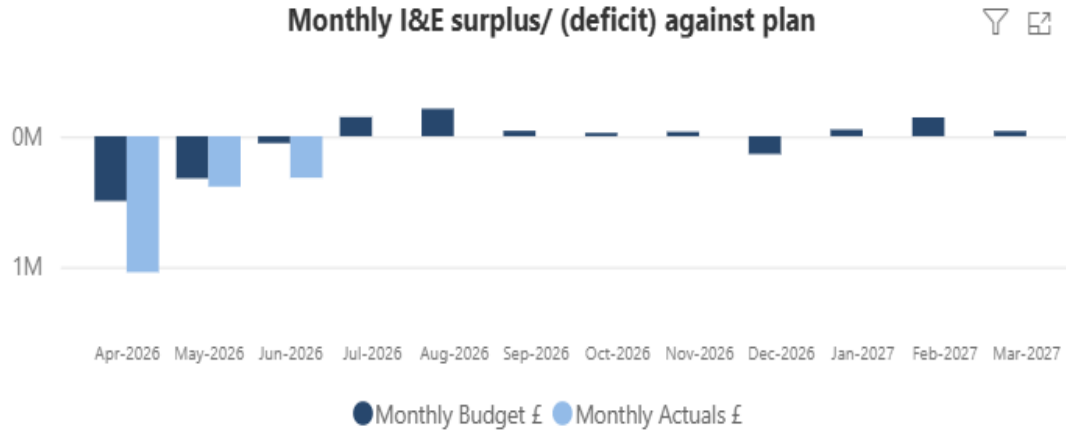
Income and Expenditure Summary – June 2026

NHS West Suffolk NHS Foundation Trust

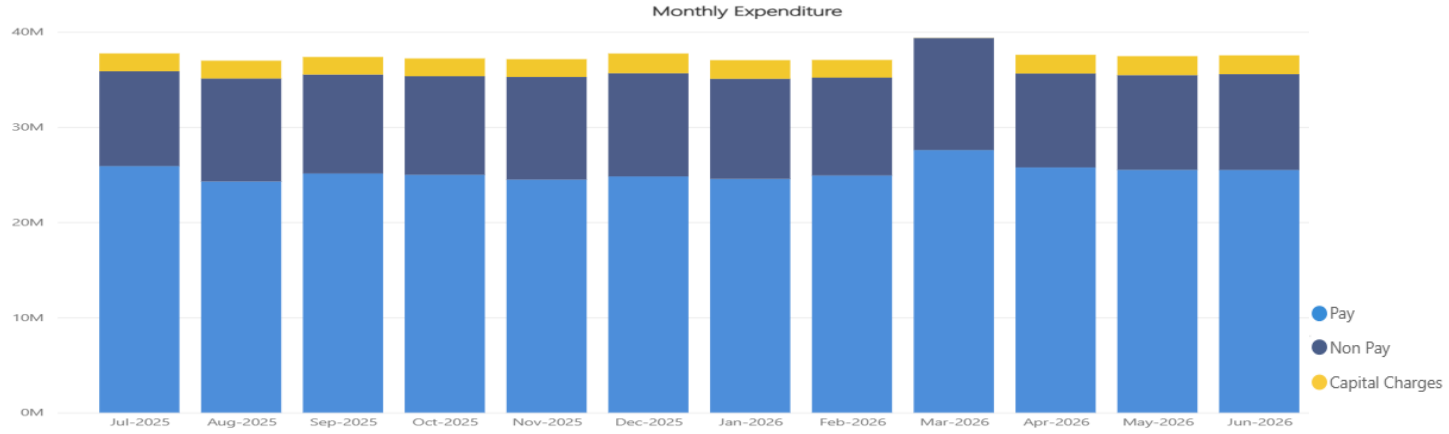
An adverse variance of £265k was reported in June, largely relating to activity related shortfall in income.

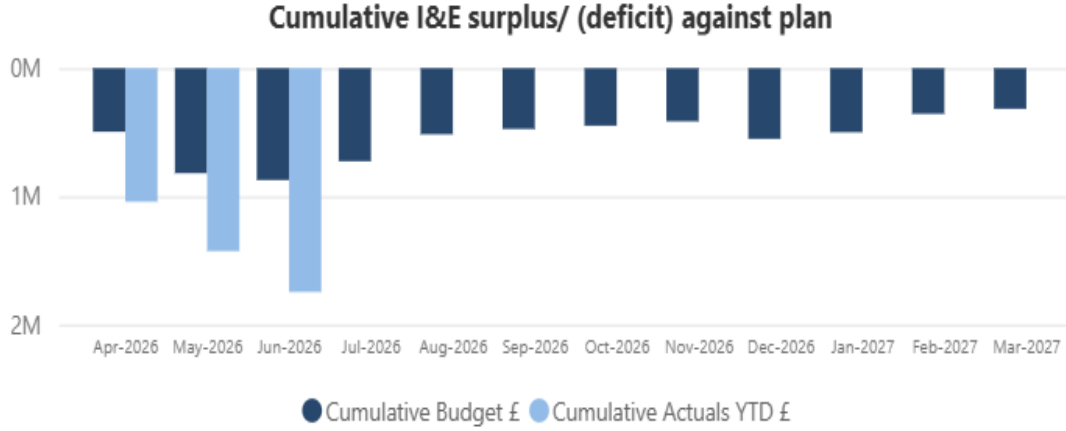
Board Report Item	Original Plan/ Target £000s	Actual/ Forecast £000s	Variance to Plan £000s F/(A)	
In month surplus/ (deficit)	-53	-318	-265	↓
YTD surplus/ (deficit)	-873	-1,746	-873	↓
Clinical Income YTD	106,576	103,518	-3,058	↓
Non-Clinical Income YTD	7,119	7,264	145	↑
Pay YTD	77,221	76,719	501	↑
Non-Pay YTD	29,172	29,873	-701	↓
EBITDA YTD	5,141	4,081	-1,059	↓
EBITDA %	4.5	3.7	-0.8	↓

↓ 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). Note that March includes the impact of impairments and centrally funded pension contributions





Divisional Financial Performance M3 26/27

In the June position we have reported YTD variances against planned clinical income within each Division. This aligns with the expenditure savings associated with lower than planned activity levels which are reflected in the Divisions expenditure positions.

Division	In-Month Budget £000s	In-Month Actuals £000s	In-Month Variance £000s	YTD Budget £000s	YTD Actuals £000s	YTD Variance £000s
Medical Services	**8,415**	**9,088**	**-674**	**25,157**	**26,860**	**-1,702**
Income	-465	-206	-259	-1,393	-775	-618
Pay	6,618	6,740	-121	19,777	20,388	-611
Non Pay	2,216	2,509	-293	6,635	7,108	-473
Capital Charges	46	46	0	138	138	0
Surgical Services	**6,259**	**6,304**	**-45**	**18,631**	**19,008**	**-378**
Income	-410	46	-455	-1,229	-35	-1,194
Pay	5,259	4,885	374	15,787	15,018	768
Non Pay	1,392	1,359	33	4,009	3,975	34
Capital Charges	18	15	3	63	49	14
Women & Children Services	**2,394**	**2,539**	**-144**	**7,105**	**7,823**	**-718**
Income	-244	-188	-56	-732	-173	-559
Pay	2,439	2,535	-96	7,267	7,610	-343
Non Pay	200	192	7	568	386	182
Capital Charges	0	0	0	2	0	2
Clinical Support	**3,933**	**3,742**	**190**	**11,706**	**12,173**	**-466**
Income	-717	-883	166	-2,150	-2,017	-133
Pay	3,198	3,262	-64	9,579	9,789	-210
Non Pay	1,451	1,363	88	4,274	4,400	-126
Capital Charges	0	0	0	3	0	3
Community Services	**5,303**	**5,148**	**155**	**15,886**	**15,358**	**528**
Income	-699	-689	-10	-1,766	-1,792	26
Pay	4,255	4,153	102	12,593	12,156	437
Non Pay	1,697	1,634	63	4,912	4,845	67
Capital Charges	50	50	0	148	149	-1
Facilities	**1,702**	**1,656**	**46**	**5,221**	**4,941**	**280**
Income	-457	-486	29	-1,377	-1,463	86
Pay	1,276	1,268	8	3,827	3,687	140
Non Pay	884	874	9	2,771	2,716	54
Capital Charges	8E-5	0	8E-5	0	0	0
Contract Income & Corporate	**-27,953**	**-28,160**	**207**	**-82,834**	**-84,417**	**1,583**
Income	-35,067	-34,794	-273	-105,049	-104,528	-520
Pay	2,614	2,639	-25	8,391	8,071	321
Non Pay	1,783	2,129	-346	6,003	6,442	-439
Reserves	835	0	835	2,202	0	2,202
Capital Charges	1,883	1,866	16	5,619	5,599	20
Deficit/(Surplus)	**53**	**318**	**-265**	**873**	**1,746**	**-873**

Pay Costs by Staff Type June 2026

West Suffolk NHS Foundation Trust

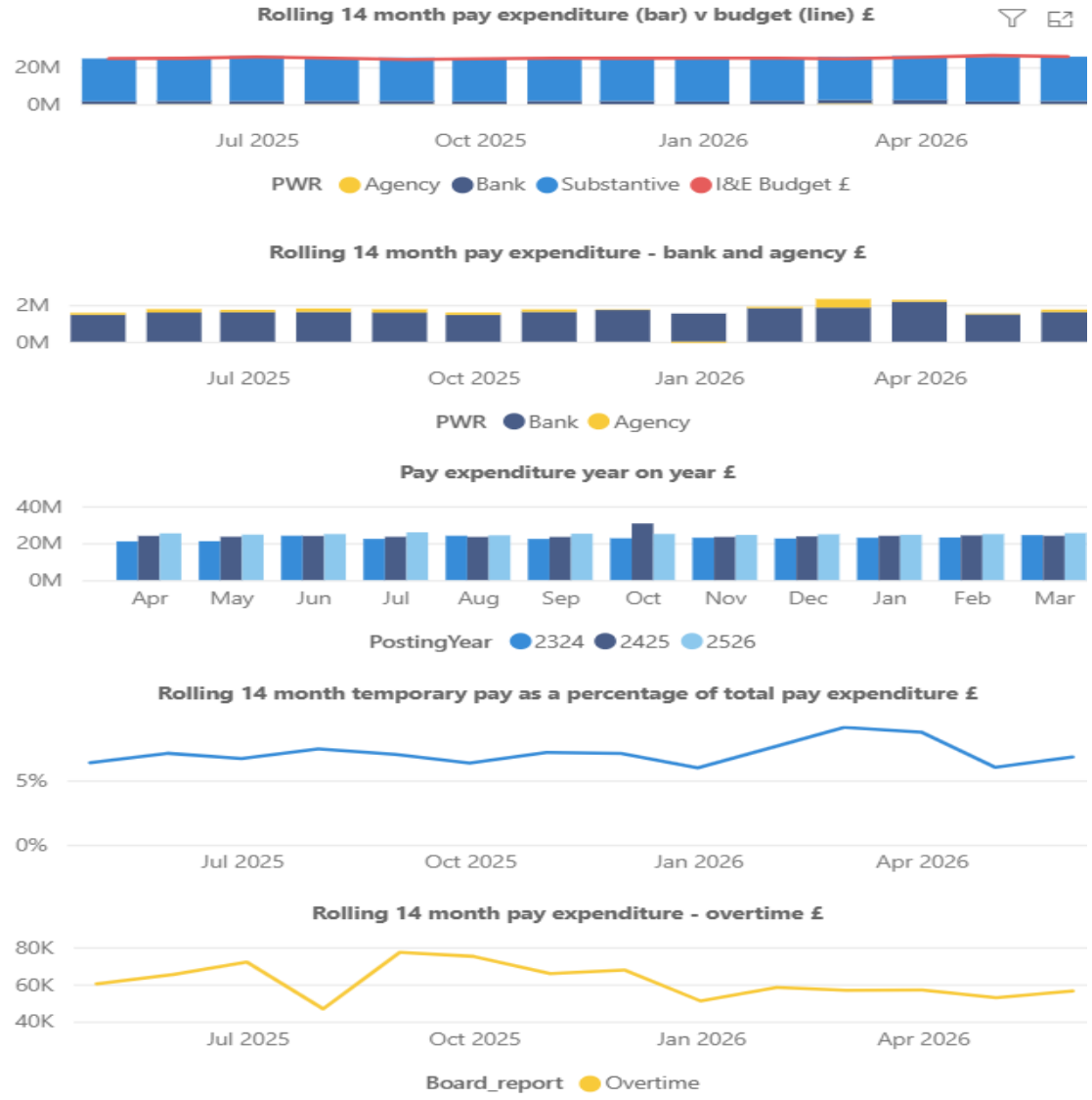
		Prior Month Actuals £000	In-Month Actuals £000s	In-Month Budget £000s	In-Month Variance £000s	YTD Actuals £000s	YTD Budget £000s	YTD Variance £000s
Substantive	Medical Staff	6,293	5,933	6,757	824	18,089	20,199	2,110
	Nursing	8,663	8,752	9,461	708	26,031	28,335	2,304
	Sci & Professional	1,237	1,245	1,417	172	3,736	4,253	517
	A&C	3,519	3,559	3,928	369	10,612	11,694	1,083
	AHP	2,564	2,643	2,792	149	7,765	8,389	625
	Prof & Tech	296	259	282	23	847	848	0
	Support Staff	904	923	962	40	2,725	2,861	136
	Other	482	427	-24	-452	1,375	-72	-1,446
	Unallocated central funding	0	0	401	401	0	1,342	1,342
	Total	23,959	23,742	25,976	2,235	71,179	77,850	6,671
Additional Medical Sessions	Medical Staff	202	275	192	-83	966	567	-399
	Total	202	275	192	-83	966	567	-399
Bank & Locum Staff	Medical Staff	425	390	146	-244	1,477	468	-1,008
	Nursing	556	615	15	-600	1,844	42	-1,802
	Sci & Professional	10	11	4	-6	30	13	-17
	A&C	60	52	1	-51	185	9	-176
	AHP	16	17	0	-17	50	0	-50
	Prof & Tech	1	1	1	0	3	2	-1
	Support Staff	165	190	137	-52	538	412	-126
	Other	0	0	0	0	1	0	-1
	Total	1,231	1,275	304	-971	4,127	945	-3,182
Agency	Medical Staff	29	110	0	-110	223	0	-223
	Sci & Professional	0	0	0	0	0	0	0
	A&C	0	0	0	0	2	0	-2
	Prof & Tech	17	22	0	-22	56	0	-56
	Total	45	132	0	-132	281	0	-281
Overtime	Nursing	16	20	2	-18	54	4	-50
	Sci & Professional	7	7	0	-7	24	0	-24
	A&C	7	6	8	1	24	23	-1
	AHP	7	7	0	-7	21	0	-21
	Prof & Tech	15	16	11	-4	43	34	-9
	Total	53	57	20	-36	166	60	-106
Total		25,490	25,480	26,493	1,013	76,719	79,423	2,703

Pay Costs (by Staff Group) June 2026

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
Medical Staff	Substantive	6,293	5,933	6,757	824	18,089	20,199	2,110
	Additional Medical Sessions	202	275	192	-83	966	567	-399
	Bank & Locum Staff	425	390	146	-244	1,477	468	-1,008
	Agency	29	110	0	-110	223	0	-223
	Total	6,949	6,708	7,095	387	20,754	21,234	480
Nursing	Substantive	8,663	8,752	9,461	708	26,031	28,335	2,304
	Bank & Locum Staff	556	615	15	-600	1,844	42	-1,802
	Overtime	16	20	2	-18	54	4	-50
	Total	9,235	9,387	9,477	90	27,929	28,381	451
Sci & Professional	Substantive	1,237	1,245	1,417	172	3,736	4,253	517
	Bank & Locum Staff	10	11	4	-6	30	13	-17
	Agency	0	0	0	0	0	0	0
	Overtime	7	7	0	-7	24	0	-24
	Total	1,254	1,263	1,422	159	3,791	4,266	475
A&C	Substantive	3,519	3,559	3,928	369	10,612	11,694	1,083
	Bank & Locum Staff	60	52	1	-51	185	9	-176
	Agency	0	0	0	0	2	0	-2
	Overtime	7	6	8	1	24	23	-1
	Total	3,586	3,618	3,937	320	10,822	11,726	903
AHP	Substantive	2,564	2,643	2,792	149	7,765	8,389	625
	Bank & Locum Staff	16	17	0	-17	50	0	-50
	Overtime	7	7	0	-7	21	0	-21
	Total	2,587	2,668	2,792	124	7,836	8,389	553
Prof & Tech	Substantive	296	259	282	23	847	848	0
	Bank & Locum Staff	1	1	1	0	3	2	-1
	Agency	17	22	0	-22	56	0	-56
	Overtime	15	16	11	-4	43	34	-9
	Total	329	297	294	-4	949	883	-65
Support Staff	Substantive	904	923	962	40	2,725	2,861	136
	Bank & Locum Staff	165	190	137	-52	538	412	-126
	Total	1,070	1,112	1,100	-13	3,263	3,274	11
Other	Substantive	482	427	-24	-452	1,375	-72	-1,446
	Total	482	427	-24	-452	1,375	-72	-1,446
Other	Bank & Locum Staff	0	0	0	0	1	0	-1
	Total	0	0	0	0	1	0	-1
Unallocated central funding	Substantive	0	0	401	401	0	1,342	1,342
	Total	0	0	401	401	0	1,342	1,342
Total		25,490	25,480	26,493	1,013	76,719	79,423	2,703

Pay Costs (trends)



Workforce – WTEs by Staff Type June 26

West Suffolk NHS Foundation Trust

This month, there was an overall increase of 26.5 WTEs. The overall net increase is due to externally funded well being staff (20 WTEs) within Community services.

Substantive staff increased by 4.4 WTEs, Agency by 5.5 WTEs, ECW by the equivalent of 12.1 WTEs and there was a reduction of 2.9 WTEs in Bank staff 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	1,882.2	1,914.4	1,887.8	2,066.7	178.9	1,885.6	2,063.8	178.1
	A&C	850.5	920.8	856.5	961.3	104.8	853.1	954.9	101.8
	Medical Staff	601.1	576.9	583.3	657.1	73.8	594.5	656.9	62.4
	AHP	541.2	549.1	552.0	599.7	47.7	543.7	599.0	55.2
	Sci & Professional	279.9	270.9	278.0	320.6	42.6	279.8	321.0	41.2
	Support Staff	278.2	280.4	286.5	297.4	10.9	281.2	294.9	13.7
	Prof & Tech	57.0	47.3	50.9	55.2	4.3	55.0	55.8	0.8
	Unallocated central funding	0.0	0.0	0.0	-26.3	-26.3	0.0	-28.4	-28.4
	Other	50.8	55.6	50.2	-21.0	-71.3	50.7	-21.0	-71.8
	Total	4,540.8	4,615.2	4,545.2	4,910.7	365.5	4,543.7	4,896.8	353.1
Agency	Sci & Professional	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	A&C	0.0	0.8	0.0	0.0	0.0	0.4	0.0	-0.4
	Nursing		0.0						
	Support Staff		0.0						
	Prof & Tech	1.2	4.5	2.6	0.0	-2.6	2.8	0.0	-2.8
	Medical Staff	4.1	6.1	8.2	0.0	-8.2	5.8	0.0	-5.8
	Total	5.3	11.3	10.8	0.0	-10.8	9.0	0.0	-9.0
Overtime	A&C	0.8	1.6	1.1	0.8	-0.3	1.2	0.8	-0.4
	AHP	1.2	3.1	2.2	0.0	-2.2	1.5	0.0	-1.5
	Sci & Professional	1.0	1.1	2.3	0.0	-2.3	1.6	0.0	-1.6
	Prof & Tech	4.0	4.2	6.1	3.2	-3.0	4.5	3.2	-1.3
	Nursing	3.5	4.1	6.2	0.8	-5.4	4.6	0.4	-4.2
	Total	10.5	14.0	17.8	4.7	-13.1	13.4	4.4	-9.0
Additional Medical Sessions	Medical Staff	8.2	7.7	20.3	0.5	-19.8	14.0	0.5	-13.5
	Total	8.2	7.7	20.3	0.5	-19.8	14.0	0.5	-13.5
Bank & Locum Staff	Prof & Tech	0.2	0.1	0.2	0.2	0.0	0.2	0.2	0.0
	Other	0.0	0.0	0.0	0.0	0.0	0.1	0.0	-0.1
	Sci & Professional	2.5	3.7	2.5	1.1	-1.4	2.6	1.1	-1.5
	AHP	2.2	2.3	3.2	0.0	-3.2	2.9	0.0	-2.9
	Support Staff	12.5	17.1	12.7	1.8	-10.9	13.9	1.8	-12.1
	A&C	17.1	10.5	15.4	0.6	-14.9	17.5	0.5	-17.0
	Medical Staff	44.0	26.1	29.2	8.3	-20.9	35.5	8.9	-26.6
	Nursing	116.7	131.3	129.0	3.9	-125.2	134.4	3.8	-130.5
	Total	195.1	191.2	192.2	15.7	-176.5	207.0	16.3	-190.7
Total		4,759.9	4,839.4	4,786.4	4,931.7	145.3	4,787.1	4,918.0	130.9

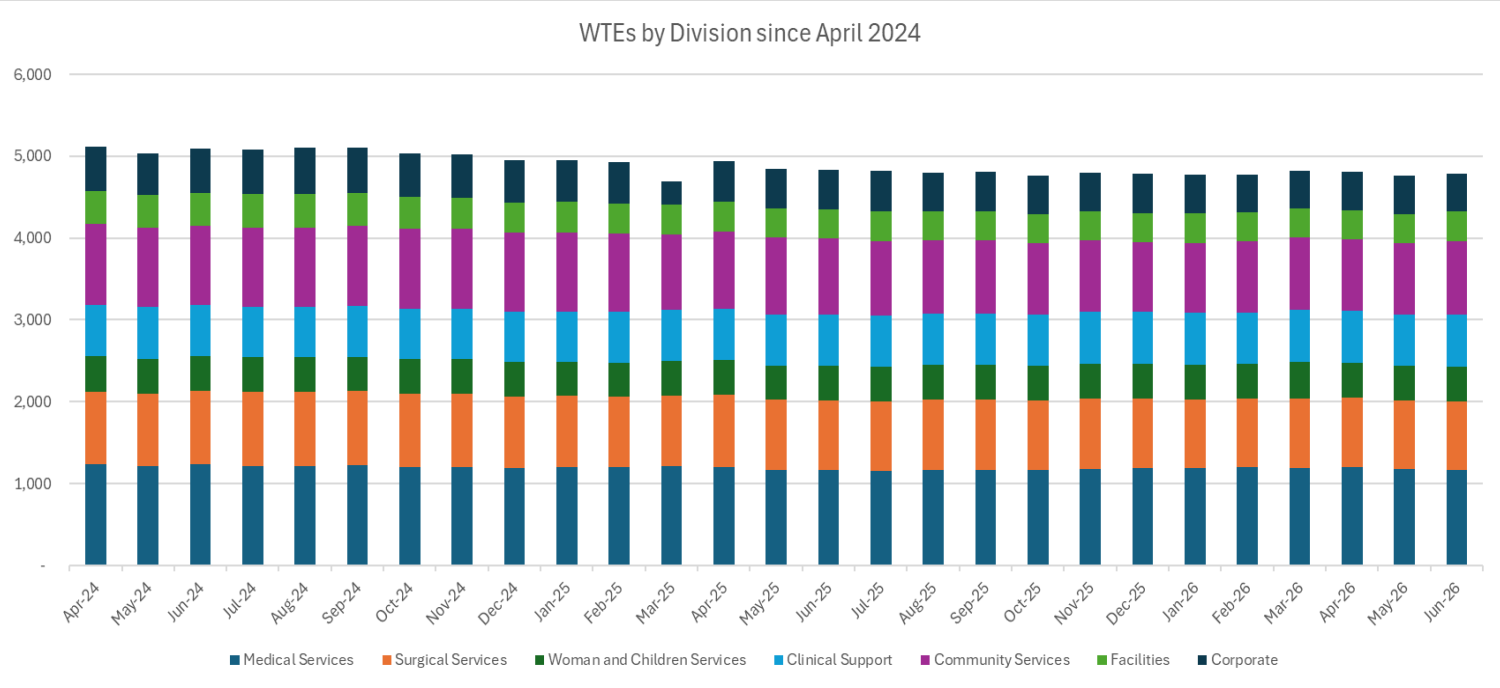
Workforce - WTE (by Staff Group) June 2026

In June 2026 we report a decrease of 53 WTEs compared to June 2025, including the increases relating to externally funded staff.

NHS West Suffolk NHS Foundation Trust

		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	601.1	576.9	583.3	657.1	73.8	594.5	656.9	62.4
	Additional Medical Sessions	8.2	7.7	20.3	0.5	-19.8	14.0	0.5	-13.5
	Bank & Locum Staff	44.0	26.1	29.2	8.3	-20.9	35.5	8.9	-26.6
	Agency	4.1	6.1	8.2	0.0	-8.2	5.8	0.0	-5.8
	Total	657.4	616.8	641.1	665.9	24.9	649.8	666.4	16.5
Nursing	Substantive	1,882.2	1,914.4	1,887.8	2,066.7	178.9	1,885.6	2,063.8	178.1
	Bank & Locum Staff	116.7	131.3	129.0	3.9	-125.2	134.4	3.8	-130.5
	Agency		0.0						
	Overtime	3.5	4.1	6.2	0.8	-5.4	4.6	0.4	-4.2
	Total	2,002.4	2,049.7	2,023.0	2,071.3	48.4	2,024.6	2,068.0	43.4
Sci & Professional	Substantive	279.9	270.9	278.0	320.6	42.6	279.8	321.0	41.2
	Bank & Locum Staff	2.5	3.7	2.5	1.1	-1.4	2.6	1.1	-1.5
	Agency	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Overtime	1.0	1.1	2.3	0.0	-2.3	1.6	0.0	-1.6
	Total	283.4	275.6	282.7	321.7	38.9	284.0	322.0	38.1
A&C	Substantive	850.5	920.8	856.5	961.3	104.8	853.1	954.9	101.8
	Bank & Locum Staff	17.1	10.5	15.4	0.6	-14.9	17.5	0.5	-17.0
	Agency	0.0	0.8	0.0	0.0	0.0	0.4	0.0	-0.4
	Overtime	0.8	1.6	1.1	0.8	-0.3	1.2	0.8	-0.4
	Total	868.3	933.6	873.1	962.7	89.6	872.3	956.2	83.9
AHP	Substantive	541.2	549.1	552.0	599.7	47.7	543.7	599.0	55.2
	Bank & Locum Staff	2.2	2.3	3.2	0.0	-3.2	2.9	0.0	-2.9
	Overtime	1.2	3.1	2.2	0.0	-2.2	1.5	0.0	-1.5
	Total	544.6	554.6	557.4	599.7	42.3	548.1	599.0	50.9
Prof & Tech	Substantive	57.0	47.3	50.9	55.2	4.3	55.0	55.8	0.8
	Bank & Locum Staff	0.2	0.1	0.2	0.2	0.0	0.2	0.2	0.0
	Agency	1.2	4.5	2.6	0.0	-2.6	2.8	0.0	-2.8
	Overtime	4.0	4.2	6.1	3.2	-3.0	4.5	3.2	-1.3
	Total	62.4	56.1	59.8	58.6	-1.2	62.5	59.1	-3.4
Support Staff	Substantive	278.2	280.4	286.5	297.4	10.9	281.2	294.9	13.7
	Bank & Locum Staff	12.5	17.1	12.7	1.8	-10.9	13.9	1.8	-12.1
	Agency		0.0						
	Total	290.7	297.4	299.2	299.1	0.0	295.1	296.7	1.6
Other	Substantive	50.8	55.6	50.2	-21.0	-71.3	50.7	-21.0	-71.8
	Total	50.8	55.6	50.2	-21.0	-71.3	50.7	-21.0	-71.8
Other	Bank & Locum Staff	0.0	0.0	0.0	0.0	0.0	0.1	0.0	-0.1
	Total	0.0	0.0	0.0	0.0	0.0	0.1	0.0	-0.1
Unallocated central funding	Substantive	0.0	0.0	0.0	-26.3	-26.3	0.0	-28.4	-28.4
	Total	0.0	0.0	0.0	-26.3	-26.3	0.0	-28.4	-28.4
Total		4,759.9	4,839.4	4,786.4	4,931.7	145.3	4,787.1	4,918.0	130.9

WTEs by Division



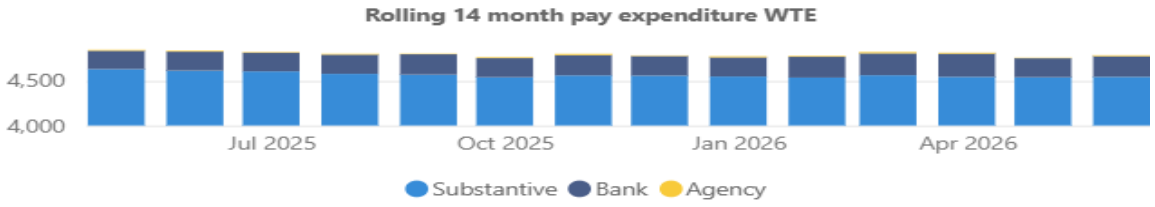
Overall, there was a net increase in staffing of 27.0 WTEs during June, 20.0 WTEs relating to well being staff within Community services that have been funded separately.

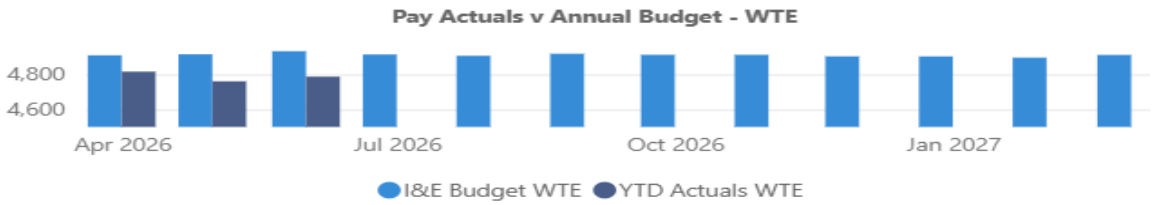
It is important that we fully understand the pipeline for recruitment to ensure that.changes in establishment are seen early and understood so that appropriate action can be taken quickly if required.

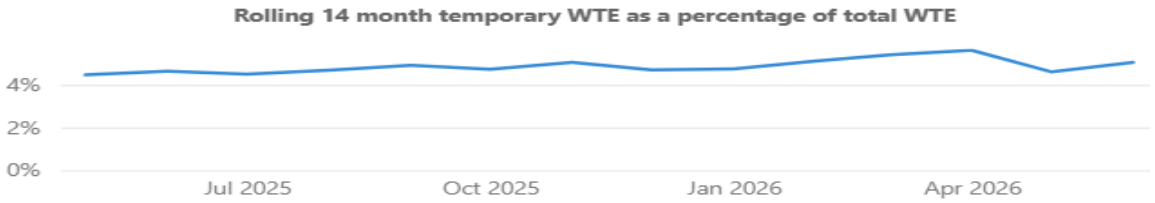
Division (excl Capitalisation)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	June 26 vs Apr 24	Month on month
Medical Services	1,231	1,217	1,237	1,218	1,215	1,225	1,197	1,197	1,188	1,206	1,207	1,209	1,203	1,169	1,165	1,154	1,161	1,165	1,162	1,179	1,186	1,187	1,199	1,194	1,204	1,176	1,171	95.1%	99.5%
Surgical Services	889	886	895	906	904	904	904	899	878	862	859	870	883	855	854	850	867	864	856	857	852	841	838	850	843	835	832	93.5%	99.7%
Woman and Children Services	433	424	428	426	428	417	421	421	417	416	412	416	418	420	418	420	419	419	421	433	428	427	423	441	427	428	425	98.1%	99.2%
Clinical Support	635	633	623	612	617	625	619	617	612	621	621	627	630	625	626	627	632	631	625	630	629	630	632	644	644	631	638	100.5%	101.2%
Community Services	982	969	969	968	963	985	976	982	971	966	959	917	945	933	929	915	895	891	877	872	853	858	865	875	868	871	896	91.3%	102.9%
Facilities	403	394	396	408	409	396	384	374	373	368	364	366	363	362	361	358	353	354	355	355	359	360	354	354	353	350	360	89.2%	102.7%
Corporate	548	509	544	543	563	554	532	539	513	513	510	283	499	483	486	500	476	482	470	477	478	475	470	465	477	470	465	84.9%	99.0%
Grand Total	**5,121**	**5,033**	**5,091**	**5,081**	**5,100**	**5,105**	**5,031**	**5,029**	**4,952**	**4,952**	**4,933**	**4,687**	**4,941**	**4,848**	**4,839**	**4,823**	**4,803**	**4,806**	**4,766**	**4,801**	**4,784**	**4,776**	**4,781**	**4,823**	**4,815**	**4,760**	**4,786**	**93.5%**	100.6%
Movement since April 2024 (decrease)		(88)	(30)	(40)	(21)	(16)	(89)	(92)	(168)	(168)	(188)	(433)	(180)	(273)	(281)	(297)	(317)	(315)	(354)	(319)	(337)	(344)	(340)	(297)	(305)	(361)	(334)		
Month on month increase/(decrease)		(88)	58	(10)	19	5	(73)	(3)	(76)	0	(20)	(246)	254	(93)	(8)	(16)	(20)	3	(40)	35	(18)	(7)	4	43	(8)	(55)	27		

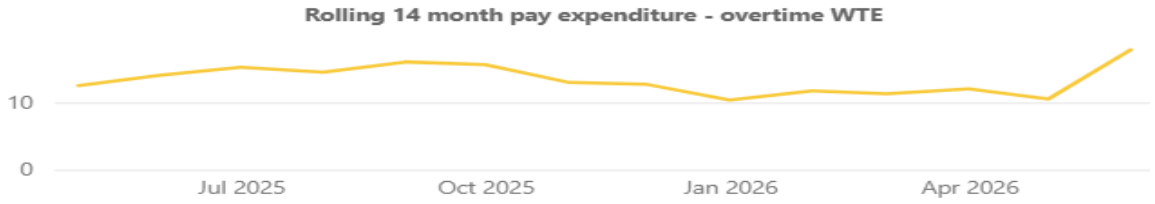
Workforce - WTE (trends)

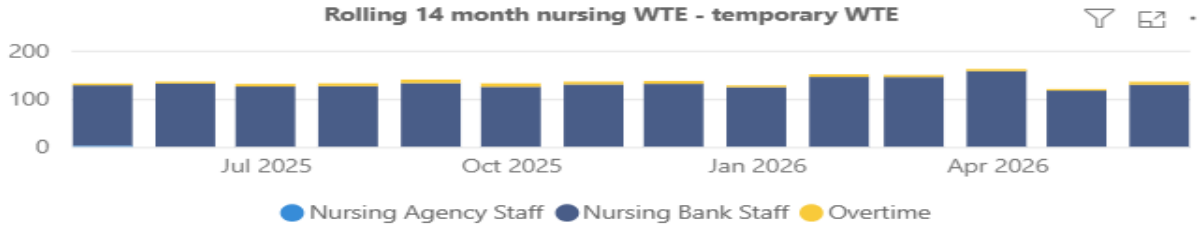
West Suffolk NHS Foundation Trust

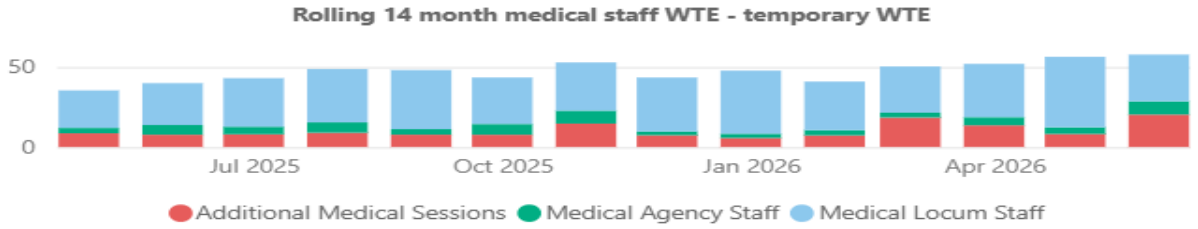


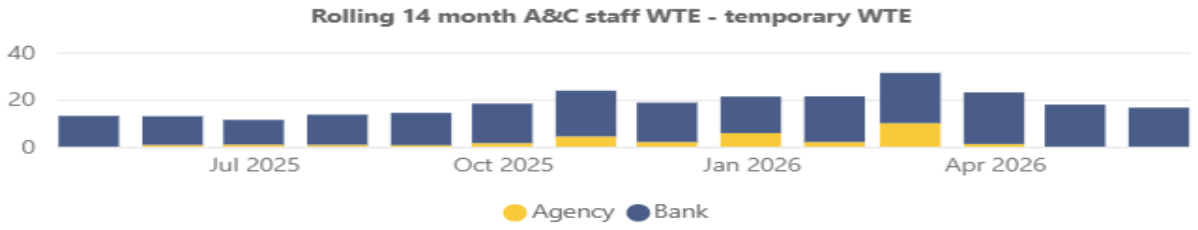


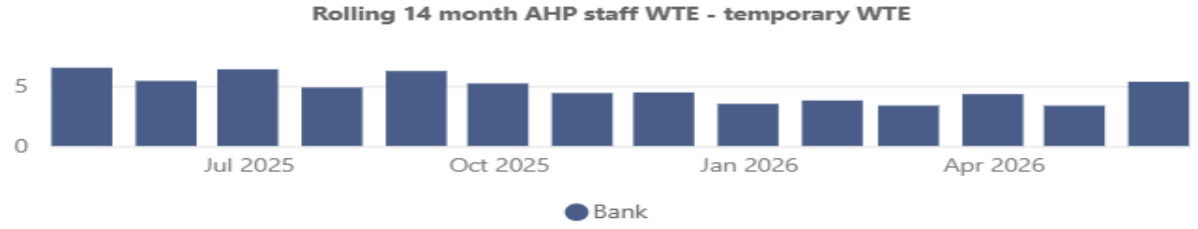












Statement of Financial Position – 30 June 2026

West Suffolk NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2026	Plan 31 March 2027	Plan YTD 30 June 2026	Actual at 30 June 2026	Variance YTD 30 June 2026
	£000	£000	£000	£000	£000
Intangible assets	47,648	37,985	42,926	46,751	3,825
Property, plant and equipment	172,171	205,945	180,575	171,870	(8,705)
Right of use assets	8,088	10,097	8,585	7,696	(889)
Trade and other receivables	5,890	7,162	7,162	5,890	(1,272)
Total non-current assets	**233,797**	**261,189**	**239,248**	**232,207**	**(7,041)**
Inventories	7,243	5,000	5,000	7,235	2,235
Trade and other receivables	23,307	16,418	19,418	21,031	1,613
Non-current assets for sale	983	490	490	983	493
Cash and cash equivalents	16,744	3,228	6,228	24,329	18,101
Total current assets	**48,277**	**25,136**	**31,136**	**53,578**	**22,442**
Trade and other payables	(40,276)	(41,666)	(38,925)	(45,779)	(6,854)
Borrowing repayable within 1 year	(4,238)	(4,609)	(4,609)	(4,356)	253
Current Provisions	(2,356)	(2,500)	(2,500)	(2,290)	210
Other liabilities	(537)	(2,685)	(2,685)	(897)	1,788
Total current liabilities	**(47,407)**	**(51,460)**	**(48,719)**	**(53,322)**	**(4,603)**
Total assets less current liabilities	**234,667**	**234,865**	**221,665**	**232,463**	**10,798**
Borrowings	(35,539)	(34,324)	(35,513)	(35,040)	473
Provisions	(326)	(385)	(385)	(367)	18
Total non-current liabilities	**(35,865)**	**(34,709)**	**(35,898)**	**(35,407)**	**491**
Total assets employed	**198,802**	**200,156**	**185,767**	**197,056**	**11,289**
Financed by					
Public dividend capital	363,968	394,933	371,928	363,967	(7,961)
Revaluation reserve	14,052	12,319	12,319	14,051	1,732
Income and expenditure reserve	(179,218)	(207,096)	(198,480)	(180,962)	17,518
Total taxpayers' and others' equity	**198,802**	**200,156**	**185,767**	**197,056**	**11,289**

The table shows the Statement of Financial Position as at 30 June 2026.

The plan was set in March and before the year end position, which included some valuations to fixed assets. As a result there are some variances to plan.

Cash is higher than plan, but includes £3.5m of PDC cash specifically allocated to capital projects and has carried over from the prior year. The cash position is still strong from the end of 2025/26. The timing of the final payment run for the month has also caused a higher variance.

The income and expenditure reserve has a lower balance than was anticipated in the plan. This is because an £8m impairment reversal was accounted for at 31 March, along with the improved deficit position. These items were not included in the planned reserve figure, causing this variation.

Better Payment Practice Code (BPPC) – Month 3

West Suffolk NHS Foundation Trust

June 2026		
Better Payment Practice Code	**Total bills paid YTD Performance Number**	**Total £ paid YTD Performance £'000**
Non NHS		
Total bills paid in the year	6,467	29,688
Total bills paid within target	5,113	27,082
Percentage of bills paid within target	***79%***	***91%***
NHS		
Total bills paid in the year	402	4,686
Total bills paid within target	183	2,623
Percentage of bills paid within target	***46%***	***56%***
Total		
Total bills paid in the year	6,869	34,374
Total bills paid within target	5,296	29,705
Percentage of bills paid within target	**77%**	**86%**
Previous year performance	**69%**	**84%**

The table shows the Trust's performance to date for 2026/27 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 3. The performance is linked to our cash position and performance over recent months has shown an improvement.

Capital progress report - Month 3

Capital Spend - 30 June 2026	Year to Date		Full Year			
Capital Scheme	YTD Original Plan £000's	YTD Actual £000's	Funding Split: Internal £000's	Funding Split: PDC Available £000's	Full Year Forecast to 31st Mar 2027 £000's	Total Full Year Variance Available Funds vs Actual Spend £000's
**New Hospital Programme	3,126	640		12,867	12,247	12,227
***Estates	2,115	1,627	8,462	1,239	6,104	8,074
Digital/IT	999	82	4,000		3,189	3,918
*Medical Equipment incl Radiology	375	199	1,500		1,172	1,301
Estates Safety Fund	453	-		1,813	-	1,813
RtCS Diagnostics Schemes	57	-		233	2,133	233
RtCS UEC Schemes	1,875	21		7,500	509	7,479
RtCS Community Schemes	774	-		3,100	-	3,100
Newmarket Endoscopy	1,290	461		5,157	406	4,696
Leases	35	-	2,454		312	2,454
Total Capital Schemes	11,099	3,030	16,416	31,909	26,072	45,295
Capital Schemes excluding NHP	7,973	2,390	16,416	19,042	13,825	33,068
Overspent vs Original Plan			48,325			
Underspent vs Original 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
*** Estates includes costs associated with RAAC works

The Capital Plan for 2026/27 was agreed at £47m. During the first quarter of 2026/27, RAAC funding was also approved of £1.24m, taking the plan to £48.3m for the year. For month 3 the Trust has spent £3m against a year-to-date plan of £11m. The variance is due to the phasing of the plan, particularly with the New Hospital Programme and the delays with the Theatre Project. The plan also assumes spend on return to constitutional standards projects, the funding for which has not yet been formally approved.

As the capital bids and approvals for 2026/27 are agreed, our Capital Plan for 2026/27 may change.

The Trust is forecasting to achieve it's Capital Plan for 2026/27.

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

To Assure

Board assurance committee - Committee Key Issues (CKI) report

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

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

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

Definitions

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

5.4. Charitable Funds Committee - Committee's Key Issues (ATTACHED)

To Assure

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Charitable Funds			Date of meeting: 11 June 2026			
Chaired by: Richard Flatman			**Lead Executive Director: Julie Hull**			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**SO WHAT?** *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
2.1	Annual presentation by CCLA (Fund Investment Manager) and review of performance. There has been recent volatility given world events but long term performance is good	Reasonable	It is important that we regularly review performance against agreed target returns, risk profile and ethical investment considerations.	CCLA have been our investment managers for many years. Notwithstanding the performance track record it was agreed that we should bring a paper to the next meeting setting out proposals and a timeline for market testing.	Inform	No escalation
3	Fundraising activity and performance	Reasonable	Committee was updated on a wide range of ongoing fundraising activity	Ongoing activity as planned	Inform	No escalation
4.1	NHS Charities together Lottery Committee received a proposal to seek approval for the MyWish Charity to join the NHS Charities Joint Lottery initiative (BIG Lotto for Health	Partial	This represents a low risk fundraising opportunity that aligns with sector best practice and which would	Committee agreed to express an interest but that formal approval would require further due	Inform	No escalation

Originating Committee: Charitable Funds			Date of meeting: 11 June 2026			
Chaired by: Richard Flatman			Lead Executive Director: Julie Hull			
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity of the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**SO WHAT?** *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Alert, Inform, Assure, Escalate, Approve**	**Escalation for action:** 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
	Charities), delivered in partnership with Starvale as external lottery manager.		support the long term financial sustainability of the charity	diligence on Starvale and detailed consideration of procurement and draft contract terms. To come back for final approval		
7	Finance reports	Reasonable	Month 1 figures reported and financial performance in line with expectation.	Ongoing monitoring and reporting	Inform	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, by when and how will we know we've achieved it? • How will we hold ourselves accountable?

Assurance level

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

Definitions

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

6. FIT FOR TOMORROW

6.1. Future system board report (ATTACHED)

To Assure

Presented by Nick Macdonald

Meeting/committee title: WSFT Trust Public Board

Report information

Report title: Future System Trust Board Report
Agenda item: Program Directors Update
Sponsor/Executive lead: Jonathan Rowell
Report prepared by: Gary Norgate
Previously considered by: Executive Programme Board
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. The key points to note since the last meeting are:

- An Executive "Stock Take" meeting has resulted in a clear agreement to proceed with the Outline Business Case (OBC). Consequently, the production and assurance of the said case is on track for submission in mid-September with formal consideration by the New Hospital Programme (NHP) in October.
-
- Central to this agreement was the Future System Team proving it could meet several conditions relating to cost, technical design and operational flow.
- These conditions have all been satisfied
- Contracts covering the first phase of our work with our construction partner, Dragados, have been prepared, checked and are ready for signature for the end of July.
- We have now completed the RIBA3[1] stage of the design process. A cost report for this design is due on 31st July. The latest costs will then be loaded into the OBC ready for its submission.

[1] RIBA3 refers to the Royal Institute of British Architects framework for construction projects. Stage 3 specifically deals with the coordination of physical and service designs to ensure everything works together. It produces detailed drawings at the 1:50 level and is known as the Spatial Coordination stage.

- The National Infrastructure and Service Transformation Authority (NISTA) are scheduled to conduct a three-day assurance review of the project in Mid-September.
- A detailed plan of stakeholder familiarisation and assurance is underway to ensure all internal signoffs and letters of support are completed before the planned OBC submission date of 16th September.

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

This update demonstrates that the project to build a new West Suffolk Hospital is has made significant progress in the last month and remains on track in terms of its schedule and budget. There are no significant challenges to escalate to the board at this time.

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

- RIBA3 cost report (31st July)
- Contract Signature end of July)
- Submit OBC – 16th September
- OBC Heard by NHP Investment Committee – 13th October

Action required by the board:

The Board are asked to note the contents of this report and to support the timely assurance of the OBC.

Governance and compliance

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.

Programme Directors Update

1. Introduction

1.1. The following report provides an overview of progress being made towards our goal to build a sustainable new hospital for West Suffolk.

2. Background

2.1. The project to replace the current West Suffolk Hospital is formally a Scheme within the national New Hospitals Programme (NHP).

3. Detailed sections and key issues

3.1 Stock Take Meeting

Matthew Coats (CEO West Herts) has been seconded to the New Hospital Programme (NHP) to aid a "pivot" in focus from preparation to delivery. He requested "stock take" meetings with the foremost schemes to identify anything blocking progress and to agree the way forward. The meeting with West Suffolk was attended by Ewen Cameron, Jonathan Rowell, Ed Garrett, Simon Wood, Matthew Coats, Natalie Forrest (NHP Chief Delivery Officer) and Charlotte Taylor (DHSC Sponsor). The meeting was proceeded by a letter outlining a number of "conditions" that would need to be met by WSFT before an Outline Business Case could be considered. These conditions included a small number of design questions (vertical transport strategy, length of corridor / flow, positioning of energy centre) and a challenge for the Scheme to reduce its forecast capital cost. The key points of the discussion are summarised below:

Key points of discussion

The Trust stressed how the introduction of Dragados and collaborative working between alliance partners had resulted in significant progress, specifically:

- Clinical and operational flows had been assessed by both Deloitte and NHP / Trust teams.
- Mechanical Electrical Plumbing (MEP) designs had been collectively reviewed, and a detailed report had been provided to NHP, effectively addressing the final questions and conditions in the area.
- The Trust's vertical transport strategies (lifts) had been independently reviewed.
- It was explained how the energy centre would be made external to the main hospital.
- Bed numbers had been collectively reviewed and the option to "shell and core"[2] a ward had been identified (this would be reviewed against real data as the scheme progresses).
- The cost saving challenge contained in the conditions letter had been addressed.

In response to these points, NHP, ICB and NHSE East of England all expressed support for the West Suffolk scheme.

Whilst recognising the tight timescales, all parties agreed to work towards the hearing of the OBC by NHP Investment Committee on 13th October 2026.

[2] Shelling is a construction technique that allows the construction of a building without fully fitting it out. In this context we would reduce capital and operational cost by providing one ward (32 beds) as a shell and fitting it out once demand is both irrefutable and irresistible.

In order to make this happen, it was recognised that we will need to work progressively on the internal assurance of the case (Trust, System, Region and NHP) ensuring that there are no surprises (open book approach) and that challenges are resolved in real time.

A discussion of operational costs and benefits highlighted that the current financial case presented a "balanced" position (as required by the business case process).

Regional colleagues agreed to work to with the Department for Health and Social Care (DHSC) Capital and Cash team to ensure they are comfortable with the case ahead of submission.

NHP will continue to push for a resolution to the challenge of capital charges[3].

Although NHP are supportive of progressing the RIBA4 design once Investment Committee have granted their approval, they will continue to work with the Cabinet Office and Treasury to formalise this approach.

This represents a significant step forward for both Programme and Scheme and provides us with the basis upon which to progress to contract.

3.2 Commercial Progress

Following the Board's agreement, we have been progressing the formal signature of the NHP Alliance Agreement and Call-off contract with Dragados for the end of July. Having received and considered final "engrossed[4]" contract documents, the team have compiled a small number of minor comments and returned the documents to NHP's legal team. These adjustments will be made, and we expect to be able to request formal signature of the contracts comfortably in time for the end of July. Communications activity is being coordinated across the East of England schemes, while enabling each programme to target communications to its local audiences.

3.3 OBC Progress

The Outline Business Case is materially complete. The finance case (covering the affordability of the project) has been through an initial assessment by NHP subject matter experts and presented to ICS finance colleagues. Given the importance of the finance case, Deloitte have been engaged to create a Board level summary presentation and ensure all associated risks and challenges are fully understood (as a consequence of its commercial sensitivity, this presentation is being delivered today to Trust Board in the closed session). The familiarisation of the OBC is underway with ICB, NHS Regional teams, WSFT Non-Executives and Governors, Trust Board and their subject matter experts. The plan can be summarised thus:

[3] Capital Charges refer to the dividend payable by the Trust on any capital spent. On a project of this size, the normal application of capital charges would create a significant affordability issue. This is an issue that applies to all schemes in the Programme.
[4] Engrossment refers to the full and executable version of a contract.

The next key deliverables are the completion of the RIBA3 cost plan, the update of the finances with RIBA3 costs and the submission of the OBC.

3.4 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” have been received.

4. Next steps

- RIBA3 cost report
- Contract Signature
- Refresh Finance and Economic case in light of RIBA3 Costs.
- Submit OBC
- OBC Heard by NHP Investment Committee

5. Conclusion

This update demonstrates that the project to build a new West Suffolk Hospital is has made significant progress in the last month and remains on track in terms of its schedule and budget. There are no significant challenges to escalate to the board this month, and the Board and our stakeholders will be progressively introduced to the contents of the OBC, ensuring its confident and timely sign-off prior to submission.

6. Recommendations

The Board is asked to note the contents of this report and to support the timely assurance of the OBC.

6.2. The Green Plan (ATTACHED)

To inform

Presented by Nick Macdonald

Finance and Performance Committee

Report information

Report title: Green Plan Progress
Agenda item: Item 12
Sponsor/Executive lead: Executive Director of Finance and Information
Report prepared by: Sustainability Officer
Previously considered by: Net Zero Steering 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?

This report provides a six-monthly update on delivery of the Trust's Green Plan 2025–2029, summarising progress across agreed focus areas, alignment with statutory and regulatory requirements, and emerging risks, opportunities, and priorities.

So what?

Delivery of the Green Plan supports statutory compliance, future financial resilience, service continuity and value for money. Progress to date demonstrates strong delivery momentum, with tangible benefits across estates, medicines, waste, procurement, and workforce engagement. However, climate-related risks and emerging reporting requirements require continued executive oversight.

What next?

The next six months will focus on priority actions to strengthen compliance (including climate risk and adaptation planning), accelerate delivery in key carbon hotspots, and embed sustainability more consistently within operational and financial planning.

Action required by the board:

The Committee is asked to note progress, consider the risks and mitigations set out, and support priorities and enablers for the next reporting period.

Governance and compliance

Risk and assurance:

The Green Plan provides the primary framework for demonstrating compliance with legal, regulatory and assurance responsibilities in relation to climate change. The Trust's net zero board lead holds executive accountability for the delivery of the Green Plan, whilst the sustainability lead provides operational oversight through established governance arrangements. The net zero steering group provides oversight, challenge and assurance on progress, risks and compliance. Key sustainability risks will be reviewed regularly, escalated where appropriate, and alignment with wider Trust risk management processes will be strengthened.

Equality, diversity and inclusion:

The Green Plan supports the Trust's equality, diversity and inclusion objectives by prioritising actions that reduce health inequalities and protect vulnerable groups who are disproportionately affected by climate change, poor air quality and environmental degradation. Initiatives such as sustainable models of care, active travel, green space, and workforce wellbeing contribute positively to inclusive access, staff experience and population health.

Sustainability:

This report directly addresses environmental sustainability through progress against the Trust's Green Plan, while also demonstrating links to financial sustainability, service resilience and long-term value for money. Actions within the Green Plan support carbon reduction, resource efficiency, climate adaptation and social value, aligning environmental sustainability with operational and financial priorities.

Legal and regulatory context:

The Trust has a statutory duty to have regard to climate change adaptation under the Climate Change Act 2008 and must comply with NHS England sustainability and reporting requirements. This includes maintaining an up-to-date Green Plan, contributing to NHS net zero targets, and progressing towards Task Force on Climate-Related Financial Disclosures (TCFD) under the Annual Reporting Manual. The Trust's approach ensures compliance with current requirements while preparing for future regulatory and assurance expectations.

Green Plan Progress

1. Introduction

This paper provides an overview of Green Plan progress, emerging risks, opportunities, and priorities for the next six months, reflecting discussions at the net zero steering group.

2. Background

In July 2025, the Trust Board approved an updated Green Plan setting out its approach to delivering sustainable healthcare, reducing carbon emissions, improving resilience to climate change and enhancing social value. Sustainability is increasingly embedded within governance, estates planning, quality improvement and procurement processes.

3. Detailed sections and key issues

The Trust continues to make strong progress against its Green Plan, delivering environmental, financial and social benefits. Key achievements include expanded on-site renewable energy generation, completion of the nitrous oxide reduction project, strengthened recycling and circular economy initiatives, and increased workforce capability through sustainability training and apprenticeships.

3.1. Alignment against statutory and system requirements

- Green Plan aligned to NHS England and ICB requirements.
- Progressive alignment with CQC Well-Led Framework relating to environmental sustainability and governance.
- Progressive alignment with TCFD-aligned disclosure requirements, with further work planned to strengthen climate risk identification and integration.

3.2. Progress against Green Plan focus areas

Workforce and system leadership:

Two of the Trust's Green Champions are undertaking the level 4 corporate responsibility and sustainability apprenticeship. This programme is supporting the development of internal capability, by upskilling existing members of the workforce to embed sustainability principles into everyday decision-making and operational practice across the organisation.

In relation to assessing our current and future workforce, the Trust's sustainability lead will host work experience students on three of more occasions each year. Students will spend a full day gaining insight into sustainability and the importance of it in all job roles within the NHS, with the aim of increasing awareness of sustainability as a viable and rewarding career pathway, inspiring local students to consider this as a future option.

In addition, the Trust continues to work in partnership with the Royal Society for the Protection of Birds (RSPB) to deliver the staff nature at work programme, which supports staff wellbeing through increased connection with nature while also encouraging

pro-environmental behaviours in the workplace. The programme promotes positive behaviour change, helps staff build an understanding of the links between health and the natural environment, and supports wider workforce wellbeing and retention objectives.

Sustainable models of care:

Sustainability has now been formally embedded within the Continuous Quality Improvement (CQI) process. All staff undertaking CQI projects are required to consider and assess the environmental impact of proposed changes and to measure outcomes across the triple bottom line (people, planet and profit). Sustainability principles are now also included within CQI training, ensuring that all participants develop a baseline understanding of sustainable improvement methodologies.

Targeted work is underway with teams in high-carbon clinical areas, including A&E. There are currently four CQI projects with a specific sustainability focus: reducing unnecessary cannulation, minimising medication waste, switching from intravenous to oral pain relief where clinically appropriate, and reviewing the use of a blood thinner to reduce environmental impact.

In addition, the Trust is working in partnership with the RSPB to introduce green social prescribing using nature-based prescriptions, supporting both patient wellbeing and environmental outcomes.

Estates and facilities:

Nine dual electric vehicle chargers have been installed at the Newmarket Community Hospital providing a total of 18 Electric vehicle (EV) parking spaces. The Newmarket Community Diagnostic Centre is on target to receive excellence status from The Building Research Establishment Environmental Assessment Method (BREEAM) due to its sustainable building design.

Installation of 325 additional solar photovoltaic panels at West Suffolk Hospital has commenced and installation of a further 252 panels are planned for NCH. Producing on site energy will reduce reliance on the national grid.

The Trust now procures 100% zero-carbon electricity sourced from a combination of renewable and nuclear power generation.

Medicines:

The Trust has completed its nitrous oxide reduction programme, transitioning to a portable supply model. This has delivered significant environmental and financial benefits, including an estimated annual reduction of 132 tonnes of carbon dioxide emissions (CO_2e), equivalent to the weight of approximately 11 double-decker buses, by avoiding the release of around 252,000 litres of nitrous oxide per year. The initiative also supports improved air quality for patients, staff and visitors, alongside minimum annual cost savings of £2,700.

A review of pharmacy ordering practices reduced monthly orders from an average of 950 to 500, delivering £32,000 in savings on delivery charges. The reduction in deliveries has also lowered the number of vehicles required, resulting in a reduction in CO2e emissions.

Waste and circular economy:

As part of its waste reduction and circular economy objectives, the Trust has expanded the use of furniture repair and reupholster services. Since April 2025, this approach has delivered financial savings of £6,302, reduced waste disposal costs and avoided an estimated 40kg CO_2e emissions per item repaired, supporting both environmental and financial sustainability. During 2025–2026, the Trust continued to expand and refine its recycling infrastructure across both acute and community sites.

Supply chain and procurement:

Recognising that approximately 62% of NHS emissions arise from procurement and supply chains, the Trust has approved a one-year contract with CO2 Analysis to develop a robust Scope 3 carbon baseline. This work will identify high emission procurement hotspots and prioritise practical carbon reduction opportunities, supporting evidence-based action on the Trust's largest and most complex emissions source.

The Trust continues to embed sustainability and social value within its procurement activity. Social value considerations are now applied across all procurement, with high value tenders requiring suppliers to provide a published Carbon Reduction Plan, supporting alignment with national NHS requirements. The Trust is also working in partnership with the Norfolk and Suffolk Integrated Care Board to support the development and implementation of a supplier roadmap, strengthening engagement with the supply chain on carbon reduction.

Operational initiatives have reduced reliance on single-use consumables, including tourniquets, toner cartridges and stationery, alongside the recycling of staff uniforms and plastic clinical tubing in theatres and day surgery. Further progress has been made through the rollout of plastic free wipes across Trust and community services, supporting waste reduction, circular economy principles and value for money.

Food and nutrition:

The Trust is taking further steps to improve the sustainability of its catering services. From May 2026, food waste will be separated and measured in line with simpler recycling requirements, supporting improved monitoring and waste reduction.
Approximately 50% of patient meals are now being ordered through a digital meal ordering system, with further roll out underway, helping to improve ordering accuracy and reduce waste.

Menu changes have also reduced the environmental impact of catering, including reduced beef content and the introduction of meat-free main meals on Monday evenings, delivering an estimated 20% reduction in meat use across the week.

Green space and biodiversity:

Partnership working has supported both patient outcomes and environmental improvement. Collaboration with the Green Light Trust has enabled the maintenance and enhancement of a therapeutic green space supporting stroke rehabilitation on G8 ward, while also increasing biodiversity on the hospital site through the introduction of native planting. The partnership is mutually beneficial, with the Green Light Trust participants also benefiting from the delivery of their wellbeing sessions within the Trust's gardens, supporting improved mental wellbeing and connection with nature.

3.3 Key risks and mitigations

Risks:

- Financial exposure from climate driven cost pressures.
- Disruption to clinical and operational performance from climate related events.
- Noncompliance with statutory and regulatory sustainability requirements.

Mitigations:

- Progressing energy efficiency, expanding on-site renewables, and embedding climate resilient estate planning within capital strategy.
- Development of a Trust wide climate adaptation plan.
- Strengthening governance, embedding sustainability into business cases.

3.4 Opportunity and enablers

- Capital investment in renewables and energy infrastructure for retained estate.
- Embedding sustainability into decision-making processes.
- Workforce engagement and skills development.
- System wide partnership working.

4. Next steps

- Develop a Trust wide sustainable travel plan.
- Develop a Trust wide climate adaptation plan.
- Proceed analysing scope three emission baseline and prioritise carbon hotspots.
- Strengthen integration of sustainability into all decision-making processes, through the development of a sustainability impact assessment (SIA).
- Expand sustainability training across clinical and corporate teams.

5. Conclusion

The Trust is making strong and credible progress in delivering its Green Plan and meeting statutory sustainability expectations. Continued executive oversight and targeted investment will be essential to manage emerging climate-related risks and maximise opportunities for long-term resilience and value for money.

6. Recommendations

The Finance and Performance Committee is asked to:

- Note progress against the Green Plan.
- Acknowledge key risks and proposed mitigations.
- Support the proposed priorities for the next six months.

GOVERNANCE

6.3. Governance report (ATTACHED)

To Assure

Presented by Paul Bunn

Open Board of Directors – 31 July 2026

Report information

Report title: Governance report – General Update: June – July 2026
Agenda item: 6.3
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 June-July 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 Trust's seal has been used on one occasion for a land transaction.
- WSFT Annual Accounts and Quality report have been submitted to NSHE and laid before Parliament.
- Annual review of the register of interest has been completed and ready for publication- **Appendix 1**.
- FPPT checks have been completed and submissions made to NHSE.
- CKI reports have been aligned following work with committee chairs to increase consistency of reporting and assurance.
- F&P TOR are attached for approval, with minor amends to membership.
- Update on WSFT's 7 organisational risks and Divisional Risks is provided – **Appendix 2**

  - QPS is monitoring the alignment of top clinical risks across the divisions with the current risk register.
  - The Executive team continue to have monthly oversight of all risks through the Executive Risk Oversight Group.
- **Appendix 3** contains the Board matrix and forward plan 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 FSP and Clinical Care Strategy.
  - The Council of Governors continues to fulfil its statutory obligations, with no issues to escalate.

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. Finalise the Agenda for August Board Workshop.
2. Work with subcommittees chairs that report to F&P and POD to ensure reporting lines of assurance are correctly mapped out – November 2026.
3. Continue work to develop the organisational wide (corporate) risk register – September 2026.
4. Work with POD chair and Director of Strategy and Transformation to ensure any new partnerships and ways of working have governance embedded and appropriate accountability - September 2026.
5. Define the overarching risk appetite statement post BAF review and disseminate that to Divisions – November 2026.
6. Continue to liaise with Council of Governors over its future as we proceed through the election process and report on updates - April 2027.

Action required by the board:

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

1. ***Approve*** the F&P TOR.
2. ***Discuss*** and note the contents of this report, specifically the Board forward plan.

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 the entire BAF.
Equality, diversity and inclusion: No EDI issues have been identified specifically arising from this governance report. It reports on other workstreams that have undertaken 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: June - July 2026

1. Governance update

The annual report and quality accounts were submitted ahead of deadline to NHS England on 25 June 2026. These have been approved and laid before parliament on 14 July 2026. These can now be published on the Trust's website and will be formally presented at the Annual Members Meeting on 24 September 2026.

A revised CKI template has been developed to strengthen the assurance processes and improve consistency for reporting escalations to Board.

Following completion of the annual Fit and Proper Person (FPPT) checks performed by HR, the appropriate declarations have been submitted to NHSE on 30 June 2026, with no issue or concerns to note.

The Register of Interests for the Board of Directors has been updated and is attached as **Appendix 1**. The Board is asked to note the declarations recorded prior to publication on the Trust's website.

- The declaration of interest process was subject to internal audit in May 2026. 4 management actions were recorded: 1 medium and 3 low priority. All have been actioned and agreed for closure by RSM.

Chair of the People & Organisational Development committee has met with senior execs and acting trust secretary to review work programme and future aspirations of committee moving forward - this will focus on people, culture and transformation and better align work programme to Trust's 5 strategic ambitions. This is a work in progress and revised TOR will follow in September 2026 once development work is completed.

F&P approved its amended TOR several months ago, but this has not had Board approval. A copy are attached and the Board is asked to note the minor change was to:-

- Reflect Director of Strategy and Transformation's role has been added to the membership.

2. Senior Leadership Team (SLT)

The Senior Leadership Team (SLT) has met once since the last report. June's SLT was cancelled as it coincided with the industrial action. In July 2026, SLT looked at:

- Clinical Care Strategy.
- Future System programme update

A small task and finish group is looking at the membership of the SLT to see how this can link into the Trust succession planning and enabling works to deliver the strategy and other key projects. Once this is agreed it is hoped that the SLT can then agree a portfolio of work which can then be delivered for the next 18 months.

3. 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 as a forum for escalating emerging themes. A snapshot of the non-commercially sensitive matters reviewed include:

- Accreditation for care excellence update; analysis of the NHS staff survey results; review of exceptional pay; assess progress delivering the internal audit management actions;

theatre recovery plan to recover lost activity; estates paper on utilisation of the wider estate; update on Lord Mann review; discussion on the digital and data strategy metrics; assessment on mitigations for temperature on the wards and estates response to extreme weather events; and, review of the clinical care strategy.

4. Council of Governors report

The Council of Governors (COG) last met on 19 May 2026. No matters are referred or escalated to the Board. The governor election process is underway and a timetable has been agreed with COG to ensure elections are complete by 1 December 2026.

There have been no further updates on the future of the COG. The Health Bill continues to make its way through Parliament.

A questionnaire was sent to all governors asking them to look at what is working well and what can be improved. The results have been received and analysed. A draft action plan is with the lead governor for consideration. This will be presented to COG in September 2026 and will help form the basis of future inductions of governors.

5. Board development

On 26 June 2026 the Board Development session focused in the morning on developing the culture we need at WSFT and defining that into a statement and principles linked to the strategy.

In the afternoon, the Board built on the earlier BAF work and looked at risk appetite for each strategic BAF risk, which is reported separately on the agenda.

Work is underway to complete the agenda for the August 2026 Board development session. It is likely this session will focus on:

- follow up work on developing our culture further
- Worksop on managing disciplinary hearings
- CQC preparation

6. Risk

Organisational risks - There are currently 7 organisational wide risks (**Appendix 2**). 3 new risks have been added since May 2026, 4 additional risks will be added and are currently going through the governance process. 3 have been closed/downgraded during the review process and reasons have been discussed at QPS.

Divisional risks – there are 47 divisional risks captured on the risks register (including 5 corporate risks). This is a stable position as in May 2026 there were 44 risks.

Divisional risks can be broken down as follows: 0 red risk (score 15 +), 45 amber risks (score 12+) and 2 amber risks (score 8+). 3 red risks have been reviewed and closed/downgraded as mitigations have enabled risk score to be reduced. Risks have been/are being reviewed at QPS and the Audit Committee will have a deep dive into risk later in the year.

There is an even spread of risks across the Divisions. The PRM process which discusses these risks is starting to show alignment with organisational wide risks. However, the

description and scoring of risk remains inconsistent across the Trust and will take time to change.

7. Urgent decisions by the Board

No urgent decisions have been requested.

8. Use of Trust Seal

The Trust seal has been used on one occasion (28 May 2026) in respect of a Land Registry transaction around the assignment of premisses used by the Disability Resource Centre.

9. Agenda Items for the Next Meeting

Appendix 3 – is the refreshed and revised Board Matrix and forward plan for 2026/27. This has been benchmarked against other Trusts and aligns with the work programmes of the respective assurance committees and new Trust strategy. The final agenda for each meeting will be drawn up from this matrix and approved by the Chair after discussions with the Executive team.

Appendix 1 – Register of Interests, Trust Board

Appendix 2 – Organisational wide risks

Item 4.1 - APPENDIX 1 - Org Risk Register

Compassionate care,
healthier communities

Appendix 3 – Board Development Forward Plan

Annual Board reporting schedule 26/27		Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar	
		O	C	O	C	O	C	O	C	O	C	O	C	O	C	O	C	O	C	O	C	O	C	O	C
GENERAL BUSINESS																									
Declaration of interests	Chair			R	R			R	R			R	R			R	R			R	R			R	R
Minutes	Chair			R	R			R	R			R	R			R	R			R	R			R	R
Action log and matters arising	Trust Secretary			R	R			R	R			R	R			R	R			R	R			R	R
Questions from public relating to items on the agenda	Chair			R				R				R				R				R				R	
Patient or Staff story	Chief Nurse			R				R				R				R				R				R	
Chief Executives report	Chief Executive			R				R				R				R				R				R	
Board Assurance Framework (BAF)	Trust Secretary			R				R				R				R				R				R	
JOINED UP SERVICES																									
Strategic priorities update report	Director of Strategy & Transformation			R				R				R				R				R				R	
West Suffolk Alliance and SNEE Integrated Care Board	WSA Director			R				R				R				R				R				R	
Joint Productivity Board - suspended until further notice	Director of Strategy & Transformation																								
ICB Joint Forward Plan - to include an update from Alex Royan on Strategy and Population Health Improvement Plan	Alex Royan, Director of Strategic Planning and Resilience, Digital and Intelligence, NHS Norfolk and Suffolk ICB			A																					
Medium Term Planning (MTP)	Chief Executive/COO			A																				R	
HIGH QUALITY CARE																									
Review of IQPR	Chief Finance Officer/COO			A																					
Integrated Quality & Performance Report (IQPR)	CN/COO/Chief Finance Officer			R				R				R				R				R				R	
Quality and Patient Safety																									
Quality and Patient Safety Committee - committee's key issues report	Committee Chair			R				R				R				R				R				R	
Annual review of quality improvement strategy	Director of Strategy & Transformation															A									
Nurse staffing report including strategy	Chief Nurse			R				R				R				R				R				R	
R&D annual report	Medical Director							A																	
Maternity Services Report	Director of Midwifery			R				R				R				R				R				R	
Annual complaint report (for annual report)	Chief Nurse							A																	
National inpatient survey report	Chief Nurse																			A					
National Annual CQC urgent and emergency care survey	Chief Nurse															A									
EMPOWERED TO IMPROVE																									
People and Organisational Development																									
People and Organisational Development Committee - committee's key issues report	Committee Chair			R				R				R				R				R				R	
National staff survey report	Chief People Officer			X																				A	
Freedom to speak up Guardian (Qrtly)	FTSU Guardian			Q				Q								Q				Q					
Organisational Development Strategy / People and Culture plan	Chief People Officer							A																	
"Putting you first award"	Head of Comms			R				R				R				R				R				R	
Confidential staffing matters	Chief People Officer				R				R				R				R				R				R
RESPONSIBLE WITH RESOURCES																									
Finance and Performance																									
Finance and Performance Committee - committee's key issues report	Committee Chair			R				R				R				R				R				R	
Finance Report	Chief Finance Officer			R				R				R				R				R				R	
Budget setting	Chief Finance Officer																							A	
Capital programme	Chief Finance Officer																							A	
Approval of annual capital programme	Chief Finance Officer																			R					A
Estates strategy (master plan)	Chief Finance Officer															A									
Winter Planning	COO											A													
Annual Car Park Review	Chief Finance Officer																				A				
Audit Committee - committee's key issues report	Committee Chair			R				R								R				R				R	
Charitable Funds Committee - committee's key issues report .	Committee Chair			R				R				R												R	
Digital & Data Committee - committee's key issues report	Chief Operating Officer				R								R				R								R
Standing Orders and Schemes of Reservation/Delegation - 3 yearly. Next due 2028	Chief Finance Officer																							X	
FIT FOR TOMORROW																									
Future system board to include updates on: the build; transformation; and, digital programme	Chief Finance Officer			R				R				R				R				R				R	
The Green Plan	Chief Finance Officer							R																	
Other assurance by exception																									
Annual report and accounts	Trust Secretary						A																		
Annual Health & Safety Report (inc fire, incidents, complaints & claims) inc review of modern slavery statement	Chief Finance Officer																								
Quality Accounts	Chief Nurse						A																		
Annual review of governance arrangements	Chair			A																					
Executive Director Remuneration Policy (via remun eration committee)	Chair											A													
GOVERNANCE																									
Governance report, including: SLT; Management Executive meeting; CoG meeting; Use of Trust seal	Trust Secretary			R				R				R				R				R				R	
- Remuneration Committee																									
Board development programme				R								R								R					
Annual Board skills review	Chief People Officer											A													
Future Board meeting dates and times	Trust Secretary											A													
Review of annual reporting schedule	Trust Secretary							A																	
Risk overview report	Trust Secretary			R				R				R				R				R				R	
Annual review of register of interests	Trust Secretary			A																					
Federated Data Platform	Chief Information Officer				X																				
SIRO/Cyber Security/Cyber Hygiene Report	Chief Information Officer				R								R								R				
OTHER ITEMS																									
Business cases	*As required*																								
Agenda items for next meeting	Chair			R				R				R				R				R				R	
Reflections on meeting	Chair			R	R			R	R			R	R			R	R			R	R			R	R
Agenda items from forward programme (separate document)	Trust Secretary			R				R				R				R				R				R	

Key

R = Report
A = Annual report
S = Strategy, programme or plan
I = Implementation plan (including progress report)
X = Exception report (as required)

Compassionate care,
healthier communities

6.4. Agenda items for next meeting

To Note

Presented by Jude Chin

6.5. Reflections on meeting

For Discussion

Presented by Jude Chin

6.6. Date of next meeting - 25 September 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

7. SUPPORTING APPENDICES

To inform

Presented by Jude Chin

Item 6.3 - Governance

To Note

Presented by Paul Bunn

Risk Register List report

Reference	Created by	Title	Description	Impact of risk	Owner	Last review	Next review	Inherent score	Current score	Target score	Target date	Controls outstanding	Controls implemented	Risk identified
RSK-224	Mike Dixon	Risk of harm and regulatory risk and financial risk of elective/ diagnostic waits	There is a risk that patients experience harm, and the Trust is subject to regulatory and financial risk, due to sustained delays in elective care and diagnostic pathways, driven by demand exceeding capacity, workforce constraints, pathway inefficiencies and system-wide flow challenges.	Patient harm due to delays in diagnosis or treatment (including deterioration and poorer outcomes) •Failure to meet national standards (RTT, cancer, diagnostics) leading to regulatory intervention •Financial impact from lost income, inefficiencies and cost of recovery actions •Reputational damage and loss of public confidence •Increased complaints, incidents and clinical risk	NC	02-Jul-2026	30-Sep-2026	20	16	12		Enhanced grip and governance on long-wait cohorts, Delivery of sustainable elective recovery plans with reduced reliance on non-recurrent capacity, Alignment of financial plans with realistic delivery assumptions, Further pathway redesign to improve productivity and reduce delays (e.g. straight-to-test, digital validation, PIFU optimisation), Strengthen	Elective Delivery Board overseeing recovery trajectories and delivery(02-Jul-2026), Diagnostic and elective performance monitoring through Performance Review Meetings and Board reporting(02-Jul-2026), Waiting list validation and clinical prioritisation processes(02-Jul-2026), Targeted insourcing, outsourcing and waiting list initiatives(02-Jul-2026), Demand and capacity planning through annual planning process and divisional business plans(02-Jul-2026), Clinical productivity programmes and pathway improvement workstreams(02-Jul-2026), System working with Integrated Care Board and partners to manage demand and capacity(02-Jul-2026), scalation frameworks and oversight of long waits (e.g. 52+ week / cancer breaches)(02-Jul-2026), Financial planning aligned to activity and recovery trajectories(02-Jul-2026)	02-Jul-2026
RSK-216	Mike Dixon	Risk to the ability to deliver care due to failure of multiple legacy systems	The Trust runs a number of clinical and technical systems which run on outdated, unsupported hardware, or which are not cybersecurity compliant, or the system cannot be upgraded. This is known as 'technical and legacy debt'. This has been assessed and the individual systems/components that have been identified as 'red rated' through this specialised assessment have been added to Radar separately. This risk articulates the collective risk.	Interruptions to patient care for some specialist services. Severe disruption to corporate services. Lack of linking between clinical systems so searching of patients, ensuring accuracy of patient records would be affected.	NC	02-Jul-2026	31-Dec-2026	12	9	6	31-Mar-2027		Monitoring of systems on a regular basis(19-Jun-2026), Each of the identified systems has individual risk assessment completed, and the chance of these happening at the same time is less.(19-Jun-2026), Back-up procedures are in place(19-Jun-2026), Business continuity processes are in place.(19-Jun-2026)	18-Jun-2026
RSK-214	Lucy Winstanley	Capacity for side room isolation in the event of potential transmission of Candidozyma auris	Patients who are identified as location contacts of Candidozyma auris stepping down from ITU require a side room of which there is limited availability. As a result of side room limitations a risk assessment using the isolation matrix of current patients in side rooms will take place to identify the lowest risk patients that can be de-isolated. Potential risk to ITU capacity.	Potential for infectious patients to be moved to bay areas.	DS	02-Jul-2026	31-Dec-2026	15	10	10	30-Jun-2026		Infection prevention practices following national IPC manual to include PPE, hand decontamination, waste management, water and waste water management, linen and care of the environment and equipment.(04-Jun-2026)	04-Jun-2026

RSK-213	Mike Dixon	Industrial Action Across NHS Workforce Impacting Service Delivery	Risk of ongoing and/or escalating industrial action across multiple NHS staff groups (including resident doctors, consultants, nursing, and allied health professionals), leading to disruption to elective and urgent care services, reduced workforce availability, and potential deterioration in performance, patient outcomes, and access standards.	•Sustained reduction or cessation of patient flow from Emergency Department through to discharge •Deterioration in condition of inpatients due to delays in assessment, treatment, and discharge •Increased risk to safe delivery of urgent and emergency care and inpatient services due to reduced and/or redeployed workforce operating outside usual areas of practice •Disruption to elective pathways, including outpatient, diagnostic, and planned surgical activity •Increased length of stay driven by delays in clinical decision-making, investigations, and discharge processes •Growth in waiting lists and backlogs resulting from cancelled or deferred outpatient and elective activity •Adverse impact on elective recovery trajectories and delivery of performance standards •Financial impact associated with reduced activity, recovery requirements, and additional staffing costs (including TOIL) •Extended recovery period required to return to normal levels of activity following industrial	JH	02-Jul-2026	31-Dec-2026	12	8	8		Operational Planning and Clinical Prioritisation •Pre-emptive service planning to maximise patient flow and reduce inpatient occupancy ahead of periods of industrial action •Continuation of clinically prioritised activity, including urgent cancer pathways, P1/P2 elective procedures, and time-critical services (e.g. maternity, paediatrics, renal, chemotherapy, trauma, stroke thrombolysis) •Maintenance of essential emergency and urgent services, including emergency theatres, diagnostics, endoscopy, and specialist on-call services •Dynamic review and prioritisation of activity to align with available workforce and clinical risk(04-Jun-2026), Workforce Management and Cover •Redeployment and coordination of available workforce to maintain safe staffing levels across urgent and inpatient services •Enhanced senior clinical (e.g. consultant and equivalent) presence to support decision-making and patient flow •Central oversight of staffing and attendance through rota coordination and rostering systems •Clear identification of on-call and emergency cover arrangements across all specialties(04-Jun-2026), Command, Control and Escalation •Activation of organisational command and control structures (e.g. tactical/strategic coordination hubs) during industrial action periods •Operational response aligned to established escalation frameworks (e.g. OPEL levels and Patient Flow Escalation Plans) •Designated clinical and operational coordinators to provide real-	04-Jun-2026
RSK-187	Mike Dixon	Keeping staff and visitors safe from Healthcare acquired infection (HCAI)	To keep patients, staff and visitors safe by having systems to ensure that the risk of healthcare associated infection (HCAI) to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year in year reductions in HCAI , including MRSA and MSSA bacteraemia and Clostridium Difficile (CDT) infections.	Potential for acquisition of serious infection by patients, staff, visitors and contractors. Service closure/restriction. Litigation costs. Increased cost of services due to impact of incidents (e.g., increased LOS, surgery, investigation. Staff absence from work. Increased insurance premiums. Contractual penalties if ceiling not achieved. Potential HSE prosecution and fines. Adverse publicity.	DS	02-Jul-2026	31-Jul-2026	12	12	12		Trust compliance with standards contained within Code of Practice on Healthcare Associated Infections 2008 (Hygiene Code), National manual for Infection Control in England and any relevant up to date guidance.(23-Sep-2025), Designated leads for infection prevention and control at board and clinical level.(23-Sep-2025), Clear strategy and procedures for management infection prevention and control (including infection prevention and control team and committee).(23-Sep-2025), Infection prevention and control activity and programmes are reported to the board on annual basis and progress monitored by the Clinical Safety & Effectiveness Committee.(23-Sep-2025), Infection prevention and control activity reported to clinical areas, includes monthly ward and consultant statistics and reports to Directorate Clinical Governance Steering Groups.(23-Sep-2025), Action plans for specific infections are developed and in place.(23-Sep-2025), Policies and procedures developed for the prevention and control of infections, which reflect legislation and published guidance, including aseptic technique.(23-Sep-2025), Infection prevention and control team established with microbiology laboratory support.(23-Sep-2025), Programme for infection prevention and control training and education delivered to all staff and attendance monitored (including staff induction and mandatory training).(23-Sep-2025), Monitor rates of healthcare acquired infection (including MRSA, MSSA, ESBL & CDT), using comparative data where this is	25-Jun-2025
RSK-099	Mike Dixon	Medication Storage	Trust policy states that all medication must be stored in locked medication cupboards or drug rooms. In the majority of clinical areas medication is stored in locked medication cupboards. In a limited number of clinical areas (Critical Care, F2 and F14) the ward drug storage is on open shelves in a secure drug room. In these areas the drug room door should be closed at all times that the drug room is not occupied.	Loss of medication stored in insecure drug room Risk of harm to patient if delay in accessing required medication in an emergency situation	DS	02-Jul-2026	31-Oct-2026	16	12	12		All staff working in the clinical areas with medication stored on open shelves in secure drug rooms are aware of the need for the drug room door to be closed and secure at all times that the drug room is not in use.(07-Jan-2025)	18-Nov-2024

RSK-070	Mike Dixon	Potential impact on quality and safety of patients within the emergency department	As a result of the overall capacity within the trust, patients are being held within the Emergency Department following the decision that they are clinically fit to proceed to a ward for on-going care and treatment. The department is unable to transfer patients to the appropriate clinical areas for on-going care. This may increase the risk of a poor patient experience and there is a risk the staff will be unable to meet the patient's care needs. The department is balancing the needs of patients requiring ward based care and trying to maintain the ability to assess new patients entering the department. The higher volume of patients within the department is impacting on the ability for the ambulance service to transfer patients from the ambulance within the expected 15 minute handover time. This scenario creates a potential risk within the community. The staffing level template within the department has been created based on an assessment model and not a ward based model. This may impact on the ability for staff to provide the expected level of clinical care: such as medication rounds; personal care; and to provide an environment that supports the patient to relax and rest.	1) Increase in Sickness absence 2) Increase in accidents 3) Increase in clinical errors 4) Increase in complaints 5) Decline in Morale 6) Personal safety at risk 7) Increase in litigation 8) Breach of Health & Safety & Work Act 1974 9) Breach Workplace Health, Safety and Welfare Regs 1992 10) Compensation 11) Improvement Notice from HSE 12) Due to a slip: Potential for musculoskeletal injury or sprain due to a slip. Potential for “minor injury” (bruise, laceration) to “specified injury” (fracture or dislocation). Specified injury (reportable to HSE under RIDDOR 2013 if due to health and safety reason for slip). Litigation and associated costs, local media publicity and potential visit from the HSE. 13) Due to Trip: Potential for “minor injury” (bruise, laceration) to “specified injury” (fracture or dislocation). Specified injury (reportable to HSE under RIDDOR 2013 if due to health and safety reason for trip), litigation and associate costs. Local media publicity and potential visit from the HSE.	NC	02-Jul-2026	31-Oct-2026	15	12	12		Staffing levels reviewed three times a day with senior clinical team to support increased staffing when required.(23-Oct-2024), ED Matron completed a staffing review with SNCT tool. This has informed the required templated staffing against our acuity levels. The new staffing template is currently being recruited to.(23-Oct-2024), Capacity is reviewed throughout the day to support the movement of patients out of the department.(23-Oct-2024), Early escalation to external parties to support with ambulance attendance and community capacity.(23-Oct-2024), Implementation of cohorting when department is at capacity. Partial secured resource of paramedics (agency 24/7). Arrive by 9am in place(23-Oct-2024), Consultants are regularly assessing patients within ambulances and initiate investigations and to prioritise order of acuity(23-Oct-2024), Harm reviews undertaken for delayed ambulance offloads and increased LOS within department(23-Oct-2024), Additional medical consultant post take ward rounds and daily reviews to support tasks with long stay patients(23-Oct-2024), GP streaming 7 days a week to support walk in patients which supports reduction of patients within department(23-Oct-2024), SDEC model continues to evolve and increase patient pathways.(23-Oct-2024), Senior nursing and Operational oversight established and in place(23-Oct-2024), Daily review of additional consulting areas to alleviate space constraints and times of overcrowding (fracture clinic)(23-Oct-	09-Nov-2022

NHS
West Suffolk
NHS Foundation Trust

REGISTER OF DIRECTORS' INTERESTS

The Codes of Conduct and Accountability for NHS Trusts requires all Trusts to draw up and maintain a register of director's interests. This register consequently lists all interests, defined by the Codes as relevant and material for all its Board and non-Board directors.

The definition of interests is as follows:

- Directorships held in private companies or plcs.
- Ownership or part ownership of private companies, businesses or consultancies, likely or possibly seeking to do business with the NHS.
- Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
- A position of authority in a charity or a voluntary body in the field of health and social care.
- Any connection with a voluntary or other body contracting for NHS services.

	Declared Interest	Date Reviewed / Amended
Trust Chair		
Jude Chin	Director of SSAT (The Schools Network) Ltd Director of Woodbridge School Enterprises Limited Shareholder of SSAT (The Schools Network) Ltd	14 April 2026
Non-Executive Directors		
Antoinette Jackson	Director and chair of Trustees in Arthur Rank Hospice Charity Director in Arthur Rank Limited	30 March 2026
Mike Knapton	Non-executive Director, Cambridge and Peterborough NHS Foundation Trust Director, The Old Dairy (Kelling), Residents Association Trustee Addenbrooke's Charitable Trust Chairman of Cambridge Community Nursing Trust	15 April 2026
Michael Parsons	Nil	17 March 2026
Richard Flatman	Trustee British Society of Gastrointestinal and Abdominal Radiology Trustee of the British Accreditation Council, Treasurer & Chair of Audit Committee	20 March 2026
Heather Hancock	Director - DigitalFutureway Ltd, consultancy specialising in executive coaching and change Management. No NHS contracts	26 March 2026

	Declared Interest	Date Reviewed / Amended
Alison Wigg	Trustee of Suffolk Together (charity)	14 April 2026
Paul Zollinger-Read (Associate NED- Appointed as NED from **1 July 2025**)	Director – White Rabbit Health Care Ltd	23 March 2026
Tracy Dowling (**until 28 Feb 2026**)	Chair of Eastern Academic Health Science Network (trading as Health Innovation East) – a company limited by guarantee, which supports adoption and spread of innovation across the NHS in the East of England. As such, Health Innovation East could potentially do business with West Suffolk NHS Foundation Trust.	16 April 2026
Dr John Roger Petter **Resigned 30 June 2025**	Volunteer First Mate for the Ellen MacArthur Cancer Trust Charity	11 April 2025
David Weaver (Associate NED) **Resigned 1 May 2025**	Chair – Orbit Group	26 September 2024
Executive Directors		
Ewen Cameron	Nil	17 March 2026
Nicola Cottington	Trustee and Director, Restore (WA) (Bury St. Edmunds Women's Aid Centre)	26 March 2026
Jonathan Rowell	Nil	14 April 2026
Sam Tappenden	Nil	14 April 2026
Julie Hull	Nil	26 March 2026
Dan Spooner **(appointed as chief Nurse from Aug 2025)**	Nil	10 April 2026

	Declared Interest	Date Reviewed / Amended
Richard Goodwin	Director of RWMH Ltd, Company number 07172203 (private medical services) Consultant to Radnet Management Inc., a subsidiary of Radnet Inc of which DeepHealth is also a subsidiary. DeepHealth provide Saige Lung, Saige Brain and Saige Prostate AI tools. Radnet Inc are also majority shareholders of HeartLungHealth, a teleradiology provider to the NHS.	27 April 2026
Jeremy Over **(Resigned 30 May 2025)**	Nil	30 April, 2025
Susan Wilkinson **(Resigned 31 July 2025)**	Nil	2 April 2025
Other attendees		
Clement Mawoyo Area Director, Homefirst, Safeguarding & West Suffolk	Nil	19 March 2026
Peter Wightman Executive Director, West Suffolk Alliance (until September 2025)	Nil	1 April 2025
Maddie Baker-Woods Executive Director (Designate), Primary Care and Neighbourhood Health for Suffolk **(November 2025)**	Trustee Suffolk ArtLink	22 March 2026
Sarah Judge Chief Information Officer	Nil	2 April 2026

	Declared Interest	Date Reviewed / Amended
Richard Jones Trust Secretary **(on long term absence since 24.1.25)**	Director of Friars 699 Limited (which changed its name to "The Pathology Partnership Limited"), dissolved via voluntary strike-off on 20/4/2021.	17 April, 2024
Paul Bunn Acting Trust Secretary	Committee Member – Garboldisham Cricket Club Practising Solicitor – Law Society & Solicitors Regulatory Authority Trustee – Acorn Learning Alliance Honorary Lecturer – University of East Anglia Parent Committee Forum Member – Diss High School Chief Executive Officer (Accountable Officer) – Co-Operative Education East	16 September 2025

CHARITABLE FUNDS COMMITTEE

Terms of Reference

1. Purpose of the Committee

1.1. The Trust Board hereby resolves to establish a committee to be known as the Charitable Funds Committee (the Committee), to make and monitor arrangements for the control and management of the Trust's Charitable Funds in accordance with any statutory or other legal requirements or best practice required by the Charity Commission and Fundraising Regulator.

1.2. The Committee has no executive powers other than those specifically delegated in these terms of reference.

2. Level of Authority

2.1. The Charitable Funds Committee will act on behalf of the Trust in satisfying the duties and responsibilities of the Corporate Trustee (The Board of Directors) in managing the charitable and other funds held on Trust. The powers of the Trustees are set out in the Trust Deed.

2.2. The Committee is authorised by the Corporate Trustee to initiate 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 Corporate Trustee to obtain legal and other expert professional advice and to secure the attendance of experts and external representatives or persons with relevant experience/expertise if it considers it necessary.

2.3. The Committee has authority to make decisions and must act in accordance and in compliance with the Trust Standing Orders, Standing Financial Instructions and Scheme of Delegation.

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

3. Duties and responsibilities

The Charitable Funds Committee is authorised to ensure that the Charity's fundraising strategies and underpinning policies, leadership and behaviours are aligned with those of the Trust, with the aim of ensuring that the Board is discharging its responsibilities as corporate trustee of the funds held on trust. It must ensure that there is an effective governance, risk management and internal control systems in place to ensure that duty is undertaken properly and prudently and to ensure compliance with the Trustee Act 2000, the Charities Act 2011 and 2016 and any other regulations or standards issued by the Charity Commission and Fundraising Regulator.

3.1. The key responsibilities of the Committee shall be:

The Committee oversees the management, investment and disbursement of the charitable funds held on Trust, specifically:

Governance

- Review and approve all policies and procedures pertaining to the management of charitable funds
- To determine the strategy for Charitable Funds in line with the Trust's objectives, subject to the approval of the Trust Board.
- The Committee as part of the strategy, will consider the approach to fundraising, the investment of funds, the approach to expenditure and the approval of procedures associated with the use of Charitable Funds.
- To continuously review how the Charity could operate more efficiently
- To ensure the information held by the Charity Commission is kept up to date and reviewed by the Committee on a regular basis
- Adhere to the principles and responsibilities of trusteeship as defined by the Charity Commission.
- Consider any internal or external audit reports of charitable funds, (including the adequacy of any management response) in liaison with the Audit Committee.

Investment

- Consider any changes in investment strategy and policy, making recommendations to the Board of Directors.
- Review performance of current investments in respect of both income and capital appreciation.

Fundraising

- Establish and oversee the implementation of a fundraising strategy. Review the fundraising methods used and ensure that they are acceptable in terms of a health / public body context.
- To monitor the fundraising performance
- To ensure that there are procedures in place to co-ordinate the fundraising activities of the Trust
- To consider whether the Trust should undertake major fundraising appeals and establish the appropriate framework to ensure that any appeal is properly managed.

Expenditure

- To agree the expenditure strategy and policies of the Funds within the framework of the Governing Document which defines the purposes for which the charity has been established.
- To monitor compliance with the strategy and policies and ensure that the wishes of the donors are met.
- To consider and as appropriate approve Charitable Fund bids in accordance with the relevant procedures.

Reporting

- To determine the format of the performance information it requires in managing the Charitable Fund in the most effective manner. This will include information on fundraising, expenditure and investment.

Audit and Accounts

- To oversee submission of the Charity Annual Report and Accounts prior to submission to the Audit Committee and Trust Board ensure these are submitted in the appropriate form and within the required legislative timetable
- To receive and consider any Internal and External Audit Reports on Charitable Funds and monitor any action being taken to address matters of concern raised.
- To consider any other return required by the Charity Commission or other statutory body.
- To ensure that sound financial control is exercised, assets are safeguarded from fraud, that all income due to the Charity is received and that no breaches of relevant legal and other regulations occur.

Other

- To develop formal links with outside voluntary organisations, such as the League of Friends, to ensure a co-ordinated approach.
- To maintain a strong link to the Trust's Investment Panel and the Capital Strategy Group through the presence of the Chief Operating Officer and Director of Resources.

Powers and duties of Fundholders

- The Fundholder for an individual fund will be a senior staff member as delegated by the Charitable Funds Committee.
- All Fundholders must be employees of West Suffolk NHS Foundation Trust.
- Individual Fundholders hold a delegated responsibility from the Trustees for the individual funds under their stewardship.
- The income and property of the fund must be applied in furtherance of the purpose of the Charity and for no other purpose.
- The Fundholder has a delegated responsibility to ensure that the donor's wishes are complied with.
- The Fundholder has a responsibility in complying with the Standing Orders, Standing Financial Instructions and Scheme of Delegation of West Suffolk NHS Foundation Trust.
- The Fundholder must comply with the authorisation levels as set out in the Charitable Funds policy.

4. Membership

4.1. Membership of the Committee will comprise:

At least two non-executive directors, one of whom will chair the meeting.

Executive Leads:

- Chief Finance Officer
- Chief Operating Officer
- Chief People Officer
- Chief Nurse

- Medical Director

Others in attendance would be:

- Head of Fundraising
- Assistant Director of Finance
- Charitable Fund Accountant
- Trust Office Executive Assistant (for minuting purposes)
- Patient/carer representative
- Staff representative

Other Members

The chair, other non-executive directors and chief executive have an open invitation to attend meetings of the Committee.

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, the Head of Internal Audit or a representative of the Trust's External Auditors 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 any three members, one of whom must be a non-executive director and one must be an 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 quorum.

6. Frequency of meetings

6.1. The Committee shall operate as follows:

- The Committee will meet at least on a quarterly basis.
- The Committee chair may convene an ad-hoc meeting if there is urgent business to transact.
- Papers will be sent out by the Trust Office at least 5 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 does not have a subcommittee.

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

8.1. The Committee shall be supported by Trust office.

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. 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 Charitable Funds Committee: 26 March 2026
Date approved by the Board of Directors:
Next review date: July 2027

Sources of further information supporting the committee in the exercise of its responsibilities

The following guidance is available from the Charity Commission:

• NHS Charities Guidance
• Board Members' role in managing funds held by their NHS body
• Consultation on draft guidance on NHS charities: Glossary
• Guidance for corporate Trustees and trustee bodies on managing NHS charitable Funds
• NHS charities and independence indicators and evidence
• Trusts and trusteeship under NHS acts 1946-2006
• Consultation on draft guidance on NHS charities: power to compromise
• Consultation on draft guidance on NHS charities: www.gov.uk/government/publications/nhs-charities- guidance

The following guidance is available from the Fundraising Regulator

- Code of Fundraising Practice

https://www.fundraisingregulator.org.uk/code-offundraising-practice/code-of-fundraising-practice