NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday 30 January 2026, 9:15 AM — 1:15 PM GMT
Venue	Northgate Room
Description	A meeting of the Board of Directors in the Public domain on Friday 30 January 2026
Organiser	Emma Whight

Agenda

9:25 AM	1.5.	Questions from Governors and the public relating to items on the agenda (verbal) To Note - Presented by Jude Chin	29
9:35 AM	1.6.	Patient story - (verbal) To Review - Presented by Daniel Spooner	30
10:00 AM	1.7.	Chief Executive's report (ATTACHED) To inform - Presented by Ewen Cameron	31
		Item 1.7 - CEO Board report - January 2026 FINAL.docx	32
10:10 AM	1.8.	BAF and Risk Report (ATTACHED) Presented by Paul Bunn	38
		Item 1.8 BAF & Risk Report - Open Board Jan 2026.docx	39
10:15 AM	2.	HIGH QUALITY CARE	48
10:15 AM	2.1.	Integrated Quality & Performance Report (IQPR) (ATTACHED) For Approval - Presented by Sam Tappenden and Daniel Spooner	49
		Item 2.1 - IQPR Cover Sheet November 25.docx	50
		Item 2.1 Board Report November 2025 v2.pptx	53
10:45 AM		COMFORT BREAK	89
10:55 AM	2.2.	Quality & Patient Safety Committee (Improvement) - Committee's Key Issues (ATTACHED) To Assure - Presented by Paul Zollinger-Read	90
		Item 2.2 - Quality & Patient Safety Committee CKIs - December 2025.docx	91

11:20 AM	2.3.	National Patient Survey Report (ATTACHED) To Assure - Presented by Daniel Spooner	95
		Item 2.3 Inpatient survey coversheet.docx	96
		Item 2.3 - Inpatient Survey 2024 - report.doc	98
	2.4.	Quality and Nurse staffing report (ATTACHED) To Assure - Presented by Daniel Spooner	102
		Item 2.4 - Nurse Midwifery staffing report November and December 2025 Final.docx	103
11:20 AM	2.5.	Maternity Services Report (ATTACHED) To Assure - Presented by Karen Newbury	120
		Item 2.5 - January 26 Perinatal Qualtiy and Safety Board report.docx	121
11:20 AM	3.	JOINED UP SERVICES	132
	3.1.	Strategic priorities update (ATTACHED) To Review - Presented by Sam Tappenden	133
		Item 3.1 - Open Board Strategy Paper January 2026.docx	134
		Item 3.1 - Appendix A - Strategy Poster.pdf	138
		Item 3.1 - Appendix A - Values Poster.pdf	139
	3.2.	West Suffolk Alliance and SNEE Integrated Care Board update (ATTACHED) Presented by Maddie Baker -Woods	140
		Item 3.2 - WSFT report final MBW12_25 and 1_26 - new template.docx	141
11:40 AM	4.	EMPOWERED TO IMPROVE	146

	4.1. People & Organisational Development Committee - Committee's Key Issues (ATTACHED) To Assure - Presented by Tracy Dowling	147
	Item 4.1 - Involvement CKIs December 2025.docx	148
	4.2. Freedom to Speak Up (FTSU) Report (ATTACHED) - Jane Sharman To Assure	154
	Item 4.2 - Board Report Cover Sheet Q3 2025.26 FINAL.docx	155
	Item 4.2 - WSFT FTSUG report Q3 2025-26 FINAL.doc	157
	4.3. Putting You First Report (ATTACHED) - Christian Jenner To Assure - Presented by Greg Bowker	166
	Item 4.3 - PYF slides for Board Jan 2026 (002).pptx	167
12:05 PM	COMFORT BREAK	172
12:15 PM	5. RESPONSIBLE WITH RESOURCES	173
1:00 PM	5.1. Finance and Performance Committee - Committee's Key Issues (ATTACHED) To Assure - Presented by Antoinette Jackson	174
	Item 5.1 - Finance and Performance Committee CKI 2025 December FINAL (002).docx	175
	Item 5.1 - Finance and Performance Committee CKI 2025 November FINAL.docx	187
	5.2. Finance Report (ATTACHED) To Review - Presented by Jonathan Rowell	197
	Item 5.2 - M9 Finance Board Report.pptx	198

	5.3. Outline of annual capital programme (VERBAL) Presented by Jonathan Rowell	215
	5.4. Charitable Funds Committee - Committee's Key Issues (ATTACHED) Presented by Richard Flatman	216
	Item 5.4 - CFC draft CKI report 2 December 2025.docx	217
	5.5. Audit Committee - Committee's Key Issues (ATTACHED) Presented by Michael Parsons	224
	Item 5.5 - AUDIT CKI report 16 Dec 2025.docx	225
	5.6. Business Planning Update (ATTACHED) Presented by Sam Tappenden	229
	Item 5.6 - MTP Paper January 2026 Open Board.docx	230
1:00 PM	6. FIT FOR TOMORROW	232
	6.1. Future system board report (ATTACHED) To Assure - Presented by Ewen Cameron	233
	Item 6.1 - wsft public board January 26 - new template.docx	234
1:05 PM	7. GOVERNANCE	238
	7.1. Governance report (ATTACHED) To inform - Presented by Paul Bunn	239
	Item 7.1 Governance Report Trust Board Jan 2026.docx	240
	7.2. Agenda items for next meeting To inform - Presented by Jude Chin	246

1:10 PM	7.3. Reflections on meeting To Assure - Presented by Jude Chin	247
	7.4. Date of next meeting - 27 March 2026 For Approval - Presented by Jude Chin	248
	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	249
	8. SUPPORTING APPENDICES To inform - Presented by Jude Chin	250
	IQPR Full Report To Note - Presented by Nicola Cottington	251

AGENDA

Presented by Jude Chin

WSFT Board of Directors – meeting in public

A meeting of the committee will take place on **Friday 30 January 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 28 November 2025	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**	Patient Story	Chief Nurse	Review	Verbal
10.00	**1.7**	CEO Report	Chief Executive	Inform	Report
10.10	**1.8**	BAF & Risk Report	Acting Trust Secretary	Inform	Report
	High quality care				
10.15	**2.1**	Integrated Quality & Performance Report (IQPR)	Director of Resources/Chief Operating Officer/Chief Nurse	Review	Report
10.45 Comfort Break – 10 mins					
10.55	**2.2**	Quality & Patient Safety committee - Committee's Key Issues	Committee Chair	Assure	Report
	2.3	National Patient Survey Report	Chief Nurse	Assure	Report
	2.4	Quality and Nurse staffing report – quality priorities and learning from deaths	Chief Nurse	Assure	Report
	2.5	Maternity Services Report	Karen Newbury/Kate Croissant/Simon Taylor	Approval	Report
	Joined up services				
11.20	**3.1**	Strategic priorities update	Chief Executive /Director of Strategy & Transformation	Inform	Report
	3.2	West Suffolk Alliance and SNEE Integrated Care Board update	West Suffolk Alliance Director	Assure	Report
	Empowered to improve				
11.40	**4.1**	People & Organisational Development Committee – Committee's Key Issues	Committee Chair	Assure	Report
	4.2	Freedom to Speak Up Guardian	FTSU Guardian	Assure	Report
	4.3	Putting you First Award	Head of Communications	Assure	Report
12.05 Comfort Break – 10 mins					
	Responsible with resources				
12.15	**5.1**	Finance & Performance Committee – Committee's Key Issues	Committee Chair	Assure	Report

	5.2	Finance Report	Chief Finance Officer	Review	Report
	5.3	Outline of annual capital programme	Chief Finance Officer	Inform	Report
	5.4	Charitable Funds Committee – Committee's Key Issues	Committee Chair	Assure	Report
	5.5	Audit Committee – Committee's Key Issues	Committee Chair	Assure	Report
	5.6	Business Planning Update	Director of Strategy & Information	Inform	Report
	Fit for tomorrow				
13.00	**6.1**	Future system board report	Chief Executive	Assure	Report
		Governance			
13.05	**7.1**	Governance report	Trust Secretary	Assure	Report
	7.2	Agenda items for next meeting	Chair	Note	Verbal
13.10	**7.3**	Reflections on meeting	Chair	Discuss	Verbal
	7.4	Date of next meeting – 27 March 2026	Chair	Note	Verbal

1. GENERAL BUSINESS

Presented by Jude Chin

1.1. Welcome and apologies for absence - Richard Jones

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 - 28 November 2025 (ATTACHED)

To Approve

Presented by Jude Chin

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE
Open Board meeting

Held on Friday 28 November 2025, 09:15 – 13:15
Northgate Meeting Room, Quince House, WSFT

Members:		
Name	**Job Title**	
Jude Chin	Trust Chair	JC
Ewen Cameron	Chief Executive Officer	EC
Nicola Cottington	Executive Chief Operating Officer	NC
Dan Spooner	Executive Chief Nurse	DS
Richard Goodwin	Executive Medical Director/Board Level Maternity and Neonatal Safety Champion	RG
Jonathan Rowell	Chief Finance Officer	JR
Sam Tappenden	Director of Strategy & Transformation	ST
Julie Hull	Chief People Officer	JH
Antoinette Jackson	Non-Executive Director/SID	AJ
Tracy Dowling	Non-Executive Director	TD
Richard Flatman	Non-Executive Director	RF
Alison Wigg	Non-Executive Director	AW
Michael Parsons	Non-Executive Director	MP
Paul Zollinger-Read	Non-Executive Director	PZR
Maddie Baker-Woods	Executive Director (Designate), Primary Care and Neighbourhood Health for Suffolk	MBW
Clement Mawoyo	Area Director, Homefirst, Safeguarding and West Suffolk	CM
In attendance:		
Ravi Ayyamuthu	ED Consultant and Deputy Medical Director	RA
Sarah Ward	Deputy Chief Nurse	SW
Matt Keeling	Deputy Chief Operating Officer	MK
Paul Bunn	Trust Solicitor	PB
Anna Hollis	Deputy head of communications	AH
Karen Newbury	Director of Midwifery (Item 6.3 only)	KN
Kate Croissant	Consultant in Obstetrics and Gynaecology	KC
Simon Taylor	ADO, Women & Children and Clinical Support Services (Item 6.3 only)	ST
Jane Sharland	Freedom to Speak Up Guardian	JS
Hayley McBride	Interim Deputy Head of Midwifery	HMcB
Jo Sanger	Trust Office Executive Assistant (minutes)	JoS
Apologies: Richard Jones, Nicola Cottington, Richard Goodwin, Sarah Judge		
Governors observing: David Slater		
Staff: - Matthew Casey - Senior Operations Manager, Community Paediatric Med (CDC); Luis Da Silva – trainee Advanced Care Practitioner; Charlotte Clarke – trainee Advanced Care Practitioner		
Members of the public: none in attendance.		

1.0 GENERAL BUSINESS		
1.1	**Welcome and apologies for absence**	**Action**
	The Trust Chair (JC) welcomed all to the meeting and apologies for absence, detailed above, were noted.	
1.2	**Declarations of interest**	
	There were no declarations of interest for items on the agenda.	
1.3	**Minutes of the previous meeting**	
	The minutes of the previous meeting on 26 September 2025, were approved as a true and accurate record of the meeting, subject to an amendment at 3.1 (IQPR report) which should read "the reopening of G5 beds".	**RW**
1.4	**Action Log and matters arising**	
	Action Ref 3159 – FTSU report Q4: Jane Sharland (JS) met with doctors to ensure they are aware of the routes for speaking up and for receiving feedback. This has been very well received. **Action Ref 3171 – System Update/Alliance report:** Refer to the Closed Board record of discussions. **Action Ref 3172 – Digital Board Report:** A new assurance committee is in place and terms of reference are in progress. Agreed this matter may be CLOSED. **Action Ref 3173 – IQPR:** Ongoing. Agreed this may be CLOSED. **Action Ref 3174 – Insight Committee Report:** Agreed this may be CLOSED. **Action Ref 3175 – Improvement Committee Report:** Agreed this may be CLOSED. **Action Ref 3177 – Maternity Services Report:** The action is being taken to the Involvement Committee; agreed this may be CLOSED. Completed actions noted.	
1.5	**Questions from Governors and the public relating to items on the agenda**	
	There were no questions raised.	
1.6	**Patient Story**	
	Dan Spooner, Chief Nurse (DS) introduced the Patient Story for this meeting which is a reality story from a pair of sisters describing	

	their experience of end-of-life communications relating to their late mother. It was noted that the value of sharing stories is now embedded in committees such as NMCC and Quality Improvement. Shared learning has been discussed, actions have been taken and a checklist made for loved ones. It was agreed that staff need to understand the requirements of being compassionate at these times. Discussions continued and it was noted that these sisters could have been seen in the mortuary space. Education of our staff relating to the actions taken at end-of-life and the next steps after death is key and the learnings will be disseminated across the hospital. Ewen Cameron, Chief Executive Officer (EC) noted that there is a potential gap where teams of staff change, and it is therefore important that these stories are heard more widely. DS gave assurance that the NMCC encourages members to share their stories and learnings with their teams and it was also noted that all stories are shared on Totara. <u>Questions</u> Antoinette Jackson, Non-Executive Director (AJ) asked why the deceased was not taken straight to the mortuary on this occasion. DS stated that usually choices are given to the relatives, and end-of-life discussions normally take place in side rooms. In this case it was noted the sisters felt they were rushed. Discussions ensued as to whether the relatives could have been called ahead of the expected death in this case and the time taken to transfer to the mortuary. **Action: DS to review guidance and protocols for EOL care and where to care for these patients.** Tracy Dowling, Non-Executive Director (TD) observed that it is the role of the ward nurse in terms of ensuring that learning is shared with teams of staff from these cases and that any changes are dealt with rapidly. The ward nurses are rotated each week and assurance was given that they do communicate their shared learnings. Paul Zollinger-Read, Non-Executive Director (PZR) asked why there are choices given for the relatives to see their deceased loved one either on a ward or in the mortuary and how improvements to this process are measured. DS stated the current processes involve good and consistent communications amongst the nurses and teams and that the nursing staff may be reluctant to offer the mortuary as an option as they feel this is not the best environment for relatives. It was agreed that the choices for the relatives must be made very clear and their options clarified with the focus of the discussions being held in the most compassionate manner.	**DS**

	JC summarised that the incidences we do well should be captured and dovetailed at the NMCC. **Action: JC will follow up with the patients – Claire and Janet – from this story.**	**JC**
1.7	**CEO Report**	
	Ewen Cameron, Chief Executive Offer (EC), presented the report which was taken as read. With regards the investment made in September 2025 to help reduce waiting lists, it was noted that we are now moving out of Tier 1 into Tier 2 which has shown improvements. The number of long waiters has reduced and therefore our return on this investment is already visible. Matt Keeling, Deputy Chief Operating Officer (MK) added that the 52 weeklong waiters are rapidly reducing. PZR offered thanks for all staff who worked amazingly through the latest industrial action. TD asked about the impact of the flu which is currently circulating. EC reported that vaccinations are still being offered and will continue to be offered through to March 2026 for all staff. MK advised that the statistics remain the same as in previous years. JC observed that the UEC performance at 93.2% is a remarkable achievement and that within the acute trusts, we featured 4th out of 134. JC asked that RA passes on sincere thanks to the teams from the Board. In terms of the performance going forward, it was noted that there are many fluctuations on circumstances affecting the figures. RA stated that during the last industrial action, the flow was smooth and there was good motivation at that time. TD noted that with sufficient learning from the data being analysed on performance rates in ED, there should be transformation opportunities to shift senior decision makers and job plans for resident doctors to be involved to achieve improvements. RA advised that considerable job planning has been carried out as shown in the report and lots of changes have taken place which have in turn seen significant improvements. It was however noted that a little goodwill has been lost due to the cost cutting exercises. In terms of considering clinical leadership going forward for the benefit of both patients and staff, it was suggested that clinical leaders should take the opportunities to shape the changes needed. JC agreed that it is a considerable challenge to create a sustainable workforce and to change the cultures across the whole organisation. Senior level clinicians making the right decisions and	

	taking ownership of ward level flow would have the greatest impact and benefits for the ED department. A question was raised by Alison Wigg, Non-Executive Director (AW) as to the completion rates of the staff survey and it was noted that this sits at 44.8% currently, which is just below the average for acute trusts.	
2.0 STRATEGY		
2.1	**Update on Business Planning**	
	Sam Tappenden Director of Strategy and Transformation (ST) referred to the report which was taken as read. The following key highlights were summarised: • The service plan is being developed to meet the set deadlines which involves several multi-disciplinary teams reviewing activity, finance and workforce plans with corporate colleagues. A triangulation session will then take place to check, challenge and re-profile the plan. • Executive decisions are being planned alongside a further check and challenge session for a planned initial submission on 17 December. Questions TD raised concerns that the national process sets out three areas for the five-year commissioning plans with integrated delivery and neighbourhood health plans prior to submission. TD continued to comment that the submission process appears to be light on narrative and heavily acute based in terms of traditional quantitative metrics, which themselves appear to be inadequate for the shift in community and growth of neighbourhood services which is required. It was noted that from the current data, there does appear to be a misalignment with time frames in terms of different elements of the plan being delivered. It is intended however that whilst the templates have yet to be received, there will be recommended sections to be included in the narrative for the final plan. With regards the Community analytics, following a recent presentation from the BI team, it is anticipated that we will see a much better sense of this data early in the New Year along with an idea of how these interface with the acute elements. ST continued with assurance that since the process began in June, there has been a cascade of activity covering quality, safety, digital and finance aspects for the whole organisation and thus we are relatively well prepared. However, we also recognise that this is a long term exercise incorporating alignment and coordination. Maddie Baker-Woods, Executive Director Primary Care and Neighbourhood Health for Suffolk (MBW) agreed with this	

	summary, stating the 10-year plans are ongoing with the aim of delivery of the intended shifts in the course of time. Julie Hull, Chief People Officer (JH) stated a letter had been received warning of implications of 2025/26 pay awards. It was noted that structural changes of the agenda for change system of pay must be aligned to minimum wages, ensuring these take account of the implications for pay structure, morale, recruitment and retention challenge for the whole workforce within the NHS. It was further agreed that the Board should be aware of the wider context when engaging in business planning processes and how we present to the government. Decisions need to be taken as to the trust supporting progressive pay arrangements and the infrastructure for payment systems. EC stated that the political cycle impacts ten-year plans due to the changeovers, and we need to be clear on what we want to include within the local commissioning plans to deliver the shift as it needs to be sustainable and long term. The process cannot be done in isolation and will involve the ICB, and a possible care management service; it was agreed that further discussions are needed in this area.	
2.2	**Enabling strategy re next steps to implement and deliver the new strategy**	
	Sam Tappenden (ST) took the paper presented as read. The paper outlines our proposed approach to embedding on strategy. Whilst it is anticipated this will take two years to thoroughly embed through the organisation, significant activity has been undertaken particularly by the Communications team in terms of launching the strategy internally via the All-Staff updates. The launch has also taken place externally at the Annual Members meeting. There are four broad stages set up for launching, spreading, embedding and sustaining the strategy going forward and each of these different phases has its own roll-out plan. It was suggested that regular updates on the progress should be provided on a quarterly basis. In terms of measuring the success of this process, without the metrics available currently, a suite of combined steps should be created to be linked with the IQPR. Discussions continued as to communication of the new processes via the staff surveys. MK suggested this is an opportunity to take the link back to the strategic objectives and ensure a clearer, more disciplined delivery throughout the organisation. It was noted that the products have been tested via various forums and that an easy read version will be created to be available on the intranet.	

	Questions Heather Hancock, Non-Executive Director (HH) raised a question as to accessibility of these assets for all colleagues generally but also in terms of incorporating within workflows. In respect of changing the culture of the organisation over the coming months, we need to consider tangible behavioural changes at the same time and ask whether the facilities are being used successfully, or at all. AJ asked whether in terms of measuring KPIs, are we aware of the differences being experienced on what we are enabling. ST explained that the outcomes and measurements of the data will be captured over a series of workshops where functional level strategies will be reviewed and clear metrics produced. HH raised a question on implementation going forward as to identifying where resources need to be placed for programmes to work on the new strategy. ST suggested that a quality improvement approach should be adopted which should encourage people to put forward ideas and support. The Chair acknowledged that works are progressing well and gave thanks to ST for this.	
2.3	**Future System Board Report**	
	EC took the report as read and highlighted that there are a number of teams who are engaged in the project of rebuilding the West Suffolk hospital. The project is currently developing its Outline Business Case through a process of "progressive assurance" with experts within NHP and this remains on track, to be submitted in August 2026. In terms of the new template for all new hospitals, the Royal Colleges are involved in the process, with concerns as to validity and importance being addressed within the ongoing planning. With regards the expectations set, an idealistic approach is being adopted with measured parameters, and most of the plans are agreed. We are aiming for our new hospital to be very modern with state-of-the-art facilities.	
2.4	**System update/Alliance report**	
	The Chair welcomed Maddie Baker-Woods (MBW) from the West Suffolk Alliance. MBW commented that since she has been in post over the past two months, she has noticed a great sense of place, purpose and partnership within our organisation. The National Neighbourhood Implementation programme is ongoing, and it was noted that West Suffolk is 1 of 43 to be selected to partake.	

	This is an opportunity for us to share what is happening within West Suffolk and to learn from other organisations. The feedback thus far is very positive from meetings held between GPs, hospital colleagues, pharmacists, team leaders and social care colleagues over discussions of the proposed forward plan. One current focus is around diabetes in terms of measurement and progress in this service. MBW has met with the team leader from Sudbury as to the needs of that community in respect of emotional health, mental wellbeing and young people's needs within the community. A further session has been held by colleagues from the Trust focussed on frailty, with a holistic approach on the prevention of falls, dementia and a forthcoming end-of-life strategy. It was noted this will be brought back in January 2026. Within the community there is also a large focus in Primary Care on enablers and the Better Care Fund, as well as digital enablers. Clement Mawoyo, (CM) commented that the digital opportunity referenced in the paper has been paused and a stock-take is underway with IT colleagues. <u>Questions</u> PZR asked a question regarding the weight loss drug GLP1 as to whether a review is being undertaken. MBW stated there is a specialist service currently for people who have been waiting on this pathway to be seen and given the support they require. There is however a much bigger piece of work ongoing to understand the system within a wider approach. In terms of frailty, PZR stated that recent University College London (UCL) visits have resulted in a considerable reduction in emergency admissions. Focus is on use of the current resources in place for these pathways. TD asked whether there is priority to develop metrics to measure the impact of the alliance work, and whether any positive differences being made from this work are captured. MBW responded that a quantitative report will be available in December 2025 looking at services specifically dedicated around community and Primary Care pathways. In the new overarching strategic plan for the new ICB, there will be far tighter outcome measures and the KPIs will be closely examined.	

	CM stated that the Better Care Fund is being closed monitored and we are looking to narrow the metrics during an agreed workshop to be held with the Alliance. MBW assured the Board that cooperation and support is very well received from colleagues within the Trust.	
2.5	**Digital Board report**	
	On behalf of Sarah Judge, Matt Keeling (MK) confirmed that the report is taken as read. The matters highlighted relate to completed works regarding the upgrades carried out for Windows 11; it was noted that there have been no significant residual issues. In terms of the digital element, the current focus is on technical legacy debt. This is about ensuring that our infrastructure which is aging or is at risk of no longer being supported can be fully risk managed with any notable risks being successfully mitigated across the organisation. This work is being linked to critical infrastructure and business continuity plans which are ongoing. The Chair asked whether the Assurance Committee for digital data has a date for their first meeting. AW confirmed that this is to be held on 29 January 2026. With regards to leadership positions currently under recruitment, a question was raised by the Chair as to whether a full cohort of team members has been formed. Matt K will revert on this. **Action: MK to verify a full leadership team is in place** Jonathan Rowell, Chief Finance Officer (JR) stated that, in terms of budget setting and business planning, this project is not likely to be a cost pressure for the Trust as it is likely to be beyond inflation. However, it is important to capture what we are expecting to fund when the time comes to replacing the legacy systems. It was noted that a plan should be put in place where issues need to be identified as well as the works which may be required. ST commented that there have been several systems which have been decommissioned due to not being used.	**MK**
2.6	**Joint Productivity Board**	
	Sam Tappenden (ST) took the paper as read. It was noted that the next meeting will take place in February 2026. EC highlighted that for delivery of significant improvements in productivity, two factors should be considered: - The specific amounts which were highlighted in the sustainability review have fundamental flaws.	

	- The collaboration providers will be looking to see increased productivity over the coming years. ST gave assurance that an update on the progress may be brought to the next meeting. The Chair suggested that Alex Royan, Director for Strategy and Healthcare Intelligence from the ICB should be invited to the January 2026 meeting.	
3.0 ASSURANCE		
3.1	**IQPR Report**	
	Matt Keeling (MK) presented the report, highlighting the following: ***Elective recovery position data*** Progress has been seen according to the data presented. ***Diagnostics*** Significant improvements which were forecast for the end of year delivery show a prediction of 74% by the end of March 2026. ***UEC*** The 4-hour performance plan was not achieved and an increase in 12-hour waits has been seen recently. However, this performance is not indicative of a new trend but more the result of a difficult month. <u>Questions</u> TD raised a query as to whether the significant shift in improvements includes within ultrasound. MK confirmed that the data does include ultrasound, and more detail will be covered within the insider CKIs. PZR asked whether any positive changes have been seen for the neurodevelopmental delays. MK reported that there are ongoing negotiations between the various parties discussing the recommissioning of this service.	
4.0 PEOPLE, CULTURE AND ORGANISATIONAL DEVELOPMENT		
4.1	**Involvement Committee Report**	
	Tracy Dowling, (TD) Non-executive Director, presented the report from the October meeting and this was taken as read. This meeting focussed on patient experience. A deep dive has been carried out on complaint responses and Charlie Firmin from the Patient Liaison Service (PALS) presented data showing improvements using AI and also benchmarking our trust with other organisations. The main highlight to be drawn from this is that our	

	current policy is not as effective for complainants as it could be, and thus further work is required to see positive progress. Discussions were held around management and leadership competence skills within the organisation which led to the staff survey and engagement scores. It was noted that improving the skills of managers and their ability to lead throughout the organisation is a key topic to be worked on going forward. The meeting saw an excellent presentation from the new Associate Director for Estates and Facilities, Neil Jackson. Neil has been working with his staff to identify areas where they may be more productive, have less sickness leave and improve their turnover rates. This engagement seems to have led to increased morale within the teams which should ultimately see future positivity. <u>Questions</u> The Chair highlighted the leadership development programme and how the impact and positive outcomes may be measured. JH responded that the management and leadership framework is to be mandated with the aim that managers will be credited via these standards to ensure they are correctly trained and compliant. In terms of imposing these standards when recruiting managers from outside the NHS, the integration of qualifications is being worked on. The importance of a performance management strategy was highlighted to ensure the balance is correct when staff leave the organisation and when recruiting new colleagues with the right management competencies. JH suggested the data on progress tracking through different development programmes may be taken to the Involvement Committee. **Action: TD review of job planning culture and senior decision making and review of data to track progress on leadership courses.**	**TD**
4.2	**Freedom to Speak Up (FTSU) report**	
	The Chair gave thanks to Jane Sharman (JS) for the updated quarterly report. JS highlighted that the National Guardians office is closing in March 2026, and a closure project board is ongoing. A marginal increase in the number of concerns raised has been seen over the last quarter, however anonymous reporting remains low which indicates an increase in confidence with confidentiality. A notable increase has been seen in staff speaking up from administrative and clerical teams with regards the ongoing reviews. The review is having a strong effect on staff and JS has given reassurance that our fields of communication via the new hub on the intranet should provide them with updated information.	

	In terms of themes, no sexual safety concerns have been raised and JS stated this may be partly due to a new channel having been created where QR codes are used effectively. The ongoing consultations are clearly causing concern, and it is important to continue with compassionate communications with those affected staff. Some concerns have been raised regarding the anti-racism charter although reassurances have been given via the Central Safety Charter where the high priority is for a proactive anti-racist organisation. Smoking on site continues to be an issue despite a slight decrease in the data shown. JS also welcomed any assistance with litter picking over the site should anyone be interested. JS highlighted that management communication training is always available for those who feel they may need further support and guidance in this area. Finally, with regards to empowering staff to speak up, many channels are being used to encourage this. The HR Information Zone on the intranet was shown to the meeting as a resource which is not well known yet, and therefore underutilised. It was agreed that this platform would be an excellent place to encourage staff to not only raise concerns, but to contribute their ideas also. TD noted the five concerns which had been raised by medical staff and commented it is good to know the existing processes are working. However, it was agreed that it would be useful to identify how many members of medical staff have voiced their concerns via the normal route, ie, their line manager, as opposed to the FTSU channels. JS agreed to begin collecting this data which would prove useful from the perspective of learning about managers who do have the relevant skills to process issues raised. **Action: JS to collate data relating to how staff concerns are raised.**	**JS**
	Putting You First	
	Julie Hull, (JH) presented the report which was taken as read. The Board noted the recent staff awards and extended congratulations and thanks to all the recipients. It was noted that all awards are recognised across the Trust and those people who go the extra mile are acknowledged.	
5.0 OPERATIONS, FINANCE AND CORPRATE RISK		
5.1	**Insight Committee Report**	
	Antoinette Jackson, Non-executive Director (AJ), presented the report which was taken as read.	

	AJ highlighted a deep dive exercise into elective recovery had taken place in September which analysed the issues without action plans and the fact that we were not achieving the planned trajectory. In October however partial assurance was given due to investments made and action plans subsequently being created. Revised forecasts have been submitted for December for which the support of the Board was given. Discussions were also held on diagnostics and improvement plans which rely on the right staff with the right skills being recruited. <u>Questions</u> AW asked whether we are on trajectory following the December forecasts. MK confirmed that we are on track in respect of the overall 18-week performance levels. MK continued stating the point on validation has been analysed further recently and there have been quarterly externally funded validation sprints where a modest amount of income for every pathway validated is received. We have engaged with an external supplier known as MBI to provide the validation service. EC noted that in respect of the RTT figures, these have seen improvements since August although not as high as anticipated. Since the elective performance is based over a 12-month period, the improvements noted are in fact quite substantial. PZR queried the wait times in respect of breast cancer. MK responded that our cancer performance over recent months has been much more stable where we have either met the national target or our own trajectory. We have moved into Tier 2 although await confirmation that we are to exit the tiering arrangements for cancer entirely, which is a level of assurance.	
5.2	**Finance Report**	
	Jonathan Rowell (JR) reported that month 7 has been positive where our underlying position was reduced. We are consistently exceeding expectations against our plan month by month. The CIP target does sharply increase for the remainder of 2025. We remain prudent however and are aware of potential CIP challenges over the months ahead along with the inevitable winter pressures. The Chair noted the progress which has been achieved with the Trust's financial position and acknowledged the efforts made across the finance team and the whole organisation. ST stated that despite the many challenges, the wider efforts made across the Trust are to be recognised and thanks given.	

	PZR queried the £2.3M outstanding regarding CIP and JR responded that with regards the run rate, this gap remains at this level for the current CIPs and the teams are fully aware of this position.	
6.0 QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT		
6.1	**Quality and Patient Safety Committee Report (was Improvement Committee)**	
	Paul Zollinger-Read, Non-executive Director (PZR), presented the report and highlighted the following main topics which arose: <u>Maternity</u> A deep dive took place for the maternity statistics and as a result the committee were assured that we are giving a good service, although there are lessons always to be learned. <u>SHMI</u> The information shows our mortality data is deteriorating essentially due to coding issues. There is a plan to address this, however there is a need to identify indicators for reassurance on our mortality position first. EC stated that there is a national shortage of coders with ongoing difficulties in recruiting for this role and this was acknowledged. PZR advised that coroners have been getting increasingly dissatisfied with the way trusts have been investigating deaths which is related to the incident investigation system called PSIRF. However, Patricia Mills reassured the committee that our Trust has a parallel tracking system giving more detail into deaths which does satisfy the coroners. With regards the Respect form, PZR explained this is a form for patients to complete detailing what they would like to do towards the end of their life. The completion rates are low, however following an education system by resident doctors working with the medical teams, the rate of completion has slightly increased. PZR summarised that the focus of this committee is for a bigger emphasis on risk, with reviews on strategic issues. CM noted concerns regarding discharge letters and stated this relates to the fact that care providers do not always receive sufficient information relating to the patient. It was felt that this is due to a theory of discharging to assess, as opposed to assessing to discharge. It was agreed that improvements are required to this process. In terms of the Respect form, MBW advised investment has been put into a new system which would support individuals with their carers and families to enable the Respect forms to be completed more fully going forward.	
6.2	**Quality and Nurse Staffing Report**	

	Dan Spooner (DS), Chief Nurse, introduced Sarah Ward, Deputy Chief Nurse (SW) to present the report. This was taken as read with the following highlighted: - Overall fall rates remain stable - For CHPPD, whilst improving, we are consistently within the lower quartile for this - We have seen successful onboarding of qualifying nursing/midwifery nursing students into employment at the end of September - The CNSST2 (Community Nursing Safer Staffing Tool) has been relaunched and the team met with the regional division. Following this, self-assessments were completed which gave good assurances overall. EC queried the noticeable fall in whole time equivalents over the period September/October. SW responded that this relates to the closure of Glastonbury Court and leavers but will investigate further. **Action: SW to review data on decline for WTE** ST raised a question for MBW relating to community nursing for non-housebound patients and potentially reducing the demand on this service. MBW will investigate further and revert. **Action: MBW to investigate demand on non-housebound patient services** AJ noted there had been significantly more incidents reported and queried whether there were any underlying issues for this. SW responded that some related to actual reporting systems, increased acuity and more dependence on mental health services. CM asked in terms of the shared services delivery model and the CNSST2, whether these consider the delivery of Virtual Ward and urgent community responses. SW confirmed that it does. From the AHP perspective, CM asked whether the analysis takes place alongside that for nursing and Acute. SW responded that developing workforce safeguards does consider the entire workforce from medical to nursing and AHPs.	**SW** **MBW**
6.3	**CQC preparedness**	
	Dan Spooner (DS) stated there is a high likelihood of future CQC visits and we are aware of increasing activity within the region. It was noted that the trust has taken proactive steps to enhance inspection readiness, including implementing a structured CQC preparedness framework and strengthening governance oversight. Continuous monitoring takes place via the PRM meetings and with a comprehensive communications strategy.	

	During the peer reviews, it has become apparent that many staff do lack confidence in preparing for a CQC inspection and our communications team are working on this with them. DS reported that from a longer-term perspective, the work for preparedness will be integrated into our care accreditation model and updates will be forthcoming through various future forums. The Chair noted that the CQC system for inspections is changing and suggested that the Board takes time during a Board Development Day to address the changes. JR commented that the CQC may select relatively simple matters such as untidiness or more minor matters. DS acknowledged this stating it is clearly for the whole trust to be prepared for an inspection.	**JC - Chair**
6.4	**Maternity services report**	
	The Chair welcomed Kate Croissant (KC), Simon Taylor (ST) and Karen Newbury (KN) to the meeting. Hayley McBride attended in place of Justyna Sconieczny who is on work experience with the regional teams until March 2026. The report was taken as read with the following matters highlighted: - A letter has been received from NHS England with regards to future expectations. Assurance was given to the Board that all actions listed are being worked on. - Culture is a focus for the whole team with Health Innovation East where coaching sessions are ongoing with the provision of support to the teams throughout. - The award ceremony has taken place to recognise members of staff who have gone above and beyond in their work. This included “Peoples Choice” which encompassed patient nominations, and we received over 100+. - From the New Year, we are going to trial our own reverse mentorship which is a national scheme. - We are coming to the end of the maternity incentive scheme time, noting we are on track and have achievements of more than 90% for each staff group. The Chair gave thanks to the team for the report which gives assurances the Board is looking for in terms of meeting standards and quality indicators. ST gave thanks for the flexibility given to the team to enable the works and improvements to be carried out. In terms of future developments, KN highlighted that our home birth service team will prepare a report for the Quality and Patient Safety committee going forward, and considerations are ongoing for the future build of the new hospital. KN continued that the CQC survey embargo is to be lifted shortly, and the findings will be shared in due course.	

	In terms of staffing, the vacancy rates are less than 2% currently which is good to report. TD asked the team about their vision for the future service of maternity and neonatal. KN responded that they are looking for midwifery to engage further with service users and to look at national levels with a view to providing the safest service. A real change in outcomes for mothers and babies has been due to the continuity of care in midwifery services and we are looking to have that continuity during the antenatal/post-natal services also. It was recognised that this is always an improving service where we are looking to ensure we are equipped to deal with all eventualities. JH gave thanks for the report and queried whether, during times of high pressure, the team feels supported by the Board and by the division in terms of the proposals for future development of the services. JH gave encouragement for the team to approach the executives for any support they feel they need and to share ideas. Kate Croissant (KC) reported that the team does feel supported by the Board, and this was acknowledged by the Chair who gave thanks for the good leadership within this team.	
7.0 GOVERNANCE		
7.1	**Charitable Funds Committee Report**	
	Richard Flatman, Non-executive Director (RF), presented the report which was taken as read. No matters were identified for escalation. RF highlighted the following: - The trust has welcomed George Chilvers as Corporate Fundraising Manager recently. - A meeting is forthcoming to finalise the 2024/25 accounts and some good ideas for increasing our fundraising activity have been shared within the team. - Further work is required in respect of due diligence and governance which will be addressed at the next meeting. - Work is continuing for the ROBOT in terms of the supplier and for a funding strategy for this expensive piece of equipment.	
7.2	**Audit Committee**	
	Michael Parsons, Non-executive Director (MP) presented the report. MP stated there has been good progress with the audit programme with recommendations being followed up. Three audits for extra contractual sessions have been held which gave partial assurance and to note that substantial assurance has been achieved for financial planning and governance.	

	In terms of tackling cyber challenges, the cyber assessment audit concluded by drawing attention to the high risks and noted that our competences gave assurance and positive reports have been received on counter-fraud issues following an annual review of the strategic risks.	
7.2	**Board Assurance Framework**	
	Paul Bunn, Trust Solicitor and Acting Trust Secretary (PB), presented the report which was taken as read. PB summarised that the report highlights the work which has been carried out by sub-committees and the Council of Governors. The BAF risks have been of focus as of late and are contained within this report. The Chair noted the output from Board Development sessions in terms of risk categories, suggesting those raised today are highlighted at the end of this meeting.	
7.3	**Governance Report**	
	Paul Bunn, Trust Solicitor and Acting Trust Secretary (PB), presented the report for information. The Board noted the contents. PB highlighted the changes relating to the 3i committees as to the new names for each and the fact that a new digital committee is to be set up for assurance purposes relating to digital data. The most significant change relates to the Patient Safety and Quality committee (was Improvement), where the patient experience element will move across from the involvement workstream. PB set out the name changes as: • Improvement – **Quality and Patient Safety** • Insight – **Finance and Performance** • Involvement – **People and Organisational Development** • Digital Board – **Digital & Data Assurance** If approved by the Board today, the terms of reference will need to be amended accordingly. TD suggested that experience of care and engagement committee should also be incorporated within the Quality and Patient Safety. The Chair agreed that this would be reviewed after the Board have agreed the initial committee's name changes. **Action: PB to arrange to liaise with the Chairs of each committee as to the topics falling within each committee agenda.**	**PB**

	JR commented that Estates must also be considered within the remit of the appropriate committee going forward. AJ requested a review of the workload of each committee in terms of the agendas to ensure there is a correct balance. ST advised that each of the new committee names align very well with the new strategy and ambitions, and this was noted. **The Board gave approval to the name changes for each of the committees**. It was acknowledged that further reviews will be required as to the topics each will be dealing with.	
8.0 OTHER ITEMS		
8.1	**Any Other Business**	
	None noted.	
8.2	**Reflections on meeting**	
	AW felt the discussions during this Board meeting today were very good and of a more relaxed nature. In terms of risks, PZR raised the workforce for the future development models which would be required to meet ongoing and new challenges. The Chair stated that the ongoing BAF iterations would be reviewed. MBW stated this meeting felt like a positive reflective, with respectfully challenging discussions incorporating the alignment of future strategy and plans. The meeting closed at 12.50 pm.	
8.3	**Date of next meeting** 30 January 2026.	

1.4. Action log and matters arising (ATTACHED)

To Review

Presented by Jude Chin

30 January Open Board Actions – Active /Closed

Closed Actions for review and approval.

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
2251	Open	28/11/2025	2.5	**Digital Board report**	To verify a full leadership team is in place. - **Jan Update completed by MK**	MK	30/01/26	Complete	22/01/2026
2253	Open	28/11/2025	4.2	**Freedom to Speak Up**	A request for the next report to review data of staff that have tried to raise concerns through their line manager as opposed to approaching via FTSU directly. - **Jan update - JS recording now and will be in the next quarterly report.**	JS	30/01/26	Complete	22/01/2026
2256	Open	28/11/2025	7.3	**Governance**	Discuss with assurance committee chairs the workstreams, agendas and subcommitee reporting lines. - **Jan update - PB confirms discussion taken place work plans amended and further dicussed in 7.2 in Gov report**	PB	30/01/26	Complete	
3176	Open	26/09/2025	6.2	**Quality and Nurse Staffing Report -** Explore communication in community nursing, referencing complaints analysis in more depth, linking to staff engagement. Feedback to come to future Board meeting.	**The deep dive into complaints management was completed at the October Involvement Committee and the Committee will continue to keep Complaints and PALS under review. There is further work in progress to review the effectiveness of communications through the Trust with recommendations to a future meeting.**	TD/JH/GB	28/11/25	Amber	
2250	Open	28/11/2025	1.6	**Patient Story**	Follow up letter to patient story contributors to reassure them action taken and to thank them for their time. **Jan update - Awaiting comms input on letter**	JC - Chair	30/01/26	Amber	
2252	Open	28/11/2025	4.1	**Involvement Committee**	To review how to change culture around job planning and senior decision making (noting a good process is in place in the Stroke Unit - are there lessons to learn and share? A review of data to track progress on leadership courses. - **Jan update - Meeting taking place to follow up with TD/JH/RG**	TD/RG/JH	30/01/26	Amber	
2249	Open	28/11/2025	1.6	**Patient Story**	Review guidance and protocols for EoL care and where to care for these patients.	DS	30/01/26	Green	
2254	Open	28/11/2025	6.2		Investigate demand on non-housebound patient services.	SW MBW	30/01/26	Green	
2255	Open	28/11/2025	6.3	**CQC preparedness**	Allocate time in February for business planning, next steps and the Board's role in that; session on what does the Board need to do to understand its role in CQC preparedness.	JC - Chair	27/03/26	Green	

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

To Note

Presented by Jude Chin

1.6. Patient story - (verbal)

To Review

Presented by Daniel Spooner

1.7. Chief Executive’s report (ATTACHED)

To inform

Presented by Ewen Cameron

West Suffolk NHS Foundation Trust Board

Report information

Report title: Chief Executive Officer's report
Agenda item: 1.7
Sponsor/Executive lead: Dr Ewen Cameron, chief executive officer
Report prepared by: Dr Ewen Cameron, chief executive; Sam Green, senior communications officer; Greg Bowker, head of communications; Anna Hollis, deputy head of communications
This report is for: ☐Approval ☒ Assurance ☐Discussion ☒Information

This report supports the following ambitions within the organisational strategy:

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

Executive summary

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

This report summarises the main headlines for December 2025 and January 2026.

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

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

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

The items reported will be actioned through the appropriate routes.

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

Governance and compliance

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

Compassionate care, healthier communities

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

Chief Executive Officer's report

1. Introduction

1.1. December and the first half of January have been incredibly busy and challenging periods. Alongside the expected increased demand for our services, we have been dealing with flu. Whilst the wave of flu was not as severe as initially feared, we did see a spike in staff absences due to sickness. Thankfully, we are now seeing a decline in flu amongst our patients and a reduction in sickness-related absences. I would like to reiterate that the best way to prevent the spread of flu and protect your health is to get your vaccination. Thanks to the hard work of our vaccination team, we passed the NHS England staff vaccination target on the 10 December. We will continue vaccinations until March.

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

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

1.4. Furthermore, we're continuing to see our financial situation improving, showing we have turned a corner. This means the tough decisions we've made over the last 12 months are making a difference and gives us a reason to be much more positive. While we still have a way to go in achieving financial sustainability, we've earned the trust and confidence of others to decide our path. Controls remain in place to ensure we don't allow the hard-earned ground to be lost, but it's thanks to all colleagues and their consistent support that we are now at this point in our journey.

2. Financial performance

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

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

3. Elective recovery

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

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

3.3. Between August and the end of December 2025, the number of patients waiting 52 weeks or more decreased by 56% from 1,746 to 761. The number of patients waiting 65 weeks or more also reduced by 54% from 72 to 33 in a single month between the end of November and the end of December. This comes following a huge push by our teams to support our patients.

3.4. We are also making good progress in reducing our 18-week waits, currently achieving a performance of 61.9%. Our focus is to bring the number of people waiting down, so we meet the target of 92% by the end of this Parliament.

4. Urgent and emergency care

4.1. Our performance against the 4-hour standard was 71.2% in December, ahead of our trajectory. We're still undertaking a number of transformation projects to improve our care pathways, with an aim of delivering more effective patient flow and admission prevention.

5. Cancer

5.1. 28-day Faster Diagnosis Standard (75% target):
September 25 –74.1%
October 25 – 74.6%
November – 73.3%

5.2. 31-day Diagnosis to Treatment (96% target):
September 25 – 100%
October 25 – 100%
November – 100%

5.3. 62-day Referral to Treatment (85% target):
September 25 – 84.9%
October 25 – 81.7%
November – 86.4%

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

6. Quality

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

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

6.3. In January 2025 we trialled delivering IV Furosemide in the homes of heart failure patients, instead of them attending one of our hospitals and needing one of our beds. Following an extensive but positive trial, this was subsequently agreed as a permanent care pathway. Community nurses have been trained to deliver this treatment, working alongside the cardiac team. As this treatment is delivered, they are monitored by our virtual ward which means if they need further medical assistance we can deliver this quickly. Approximately nine patients a day require this treatment, so having patients being able to remain in their homes gives us an additional nine beds every day for those needing inpatient care, as well as being a better experience for patients. Additionally, GPs and Trust staff can refer into this service, which

gives patients greater flexibility in how we deliver their care. This is an excellent project, which aligns perfectly with two of the 'three shifts' outlined in the 10-Year Health Plan for England: acute to community, and analogue to digital.

7. Workforce

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

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

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

7.4. Many working here will spend all, or the majority, of their careers within the NHS. Throughout the year, I am afforded the pleasure of writing to those who

have worked for the NHS for 20 years or more and I'm always amazed at the number of people who achieve this.

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

8. Future

8.1. The plans for our new hospital on Hardwick Manor in Bury St Edmunds continues to make good progress. We're finalising the design with our New Hospital Programme colleagues at NHS England, and we look forward to sharing these with you soon.

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

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

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

1.8. BAF and Risk Report (ATTACHED)

Presented by Paul Bunn

Open Board of Directors – 30 January 2026

Report information

Report title: BAF Update and Risk Report
Agenda item: 1.8
Sponsor/Executive lead: Ewen Cameron, CEO
Report prepared by: Paul Bunn, Acting Trust Secretary
Previously considered by: Standing Board Agenda item
This report is for: ☐Approval ☒ Assurance ☐Discussion ☐information

This report supports the following ambitions within the organisational strategy:

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

Executive summary

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

To provide the Board with the latest version of the Board Assurance Framework (BAF) detailing the most significant strategic risks to the organisation and the changes since this was last considered in September 2025.

The BAF remains structured around **10 strategic risks** (agreed in November 2022). The process of review is that operational and nominated executive leads review their BAF risks at a functional level. Any changes to the cause, effect and mitigations are highlighted and discussed at the Management Executive Group (MEG). Once finalised, the updated strategic risk is reported into the relevant Board assurance committee. As per accepted best practice, WSFT operates 3 levels of assurance for each strategic risk.

Q how has the BAF changed since September 2025?

- ***BAF 2 Capacity*** **-** Additional assurance provided that internal audit actions on business continuity planning can be closed. Mitigations updated to reflect: use of winter plans and use of escalation areas; plans to develop a QI methodology to support strategic objectives; and, PRM in revised format from Jan 2026.
- ***BAF 3 Collaboration*** – amended to reflect: strategy developed and now delivering enabling work; work in the provider collaborative; and, refreshed the primary care interface. Some challenges remain regarding the well led audit and how to approach key stakeholders so no change to current score of 16. Aim is to reduce score to 12 by April 2026.
- ***BAF 4 Continuous Improvement*** **–** Risk reduced to 12 to reflect work across the pathway has progressed. Significant work undertaken to: strengthen systems relationships and partnership working; and focus on cultural change and QI initiatives. Acknowledged gaps remain with transformation portfolio as resources shifted to medium term planning process.

- ***BAF 5 Digital*** – This is outside risk appetite score of 9 (cautious).Currently scores 16 but mitigation action plan updated and trajectory is to reduce score to 12 in January 26 if mitigations focusing on: processes developed for managing a cyber incident published on hub; development of cyber strategy and review out of hours escalation process are delivered.
- ***BAF 6 Estates*** – Risk remains outside appetite of 12, current score is 15. New cause noted reflecting past decision to suspend maintenance on non-essential plant and equipment and the impact this has on unplanned outages. Mitigation revised to address that including: detailed assets survey underway as part of 12 month recovery programme.
- ***BAF 7 Finance*** – Finance & Ops agreed in November to reduce risk score from 16 to 12 (target score is 9) reflecting progress made in developing budgets and plans for 26/27. Business planning work also provides greater assurance around 26/27 process. Mitigation work underway on training and development programme for appropriate staff. Effect of downgrade is that risk moves to 6 monthly review cycle.
- ***BAF 8 Governance*** – Inherent score reduced from 20 to 16 to reflect reporting cycle is monthly not weekly. Existing controls updated to reflect work on amending divisional board meetings and agendas. Additional external assurance added referencing: NOF; GIRFT; and, maternity incentive scheme work. Gaps updated to reflect work needed on developing clinical effectiveness committee and work programme. Risk management updated to reflect enhance executive overview.
- ***BAF 9 Patient Engagement*** – This is within risk appetite (9 cautious). BAF amended to change emphasis away from external engagement which is picked up by BAF 3 collaboration and focus on more organisational culture eg embed policy so that engagement is considered at every stage of service redesign.

The following are due for review this month:-

- BAF 1 – Capability & Skills currently within risk appetite
- BAF 10 – Staff Wellbeing – currently outside risk appetite

Appendix 1 **maps movement for each of the BAF risks** according to the risk score for 'current' (with existing controls in place) and 'future' (with identified additional controls in place).

Appendix 2 summarises and tracks the inherent, current and future risks score. Only BAF 9 is within risk appetite currently but 7 have a plan to achieve this over the coming months. Acting Trust Secretary to work with BAF leads in future to map progress and ensure we are meeting mitigations by due date.

Workplan
The future workplan and reporting lines are contained within **Appendix 3:** 4 strategic risks are reviewed every 6 months; 6 are reviewed quarterly.

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

BAF 26/27
The current BAF was reviewed at the October 25 Board Development workshop. Due to other operational pressures work has not progressed on this as fast as we would have hoped. However, the Executive team plan to meet at end of January and discuss implementation of

the new BAF themes and next steps to revise this and an update will be provided in March 2026.

The following broad themes for future BAFs are listed below for reference:

• Cyber	• Workforce: Staff engagement; supply chain; diversity
• Estates	• Quality of care
• Finance – loss of control	• Performance
• Preparedness and resilience – single point of failure	• Transformation of care – change and preparing for the new hospital

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

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

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

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

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

1. Agree and finalise new BAF risks and align with the strategy. Then revise forward plan. This will also include review and assessment of the risk appetite for each risk (Q4-Feb 26)
2. To arrange a Board Risk Management workshop to discuss risk appetite. (Q1 2026/27)
3. A matrix will be developed to map the interdependencies between individual BAF risks after the strategy refresh. (Q1-26/27)
4. Review and refresh longer term assessment of the mitigation and risk for each of the BAF risks to achieve the agreed risk appetite (2026/27).

Action required by the board:

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

Governance and compliance

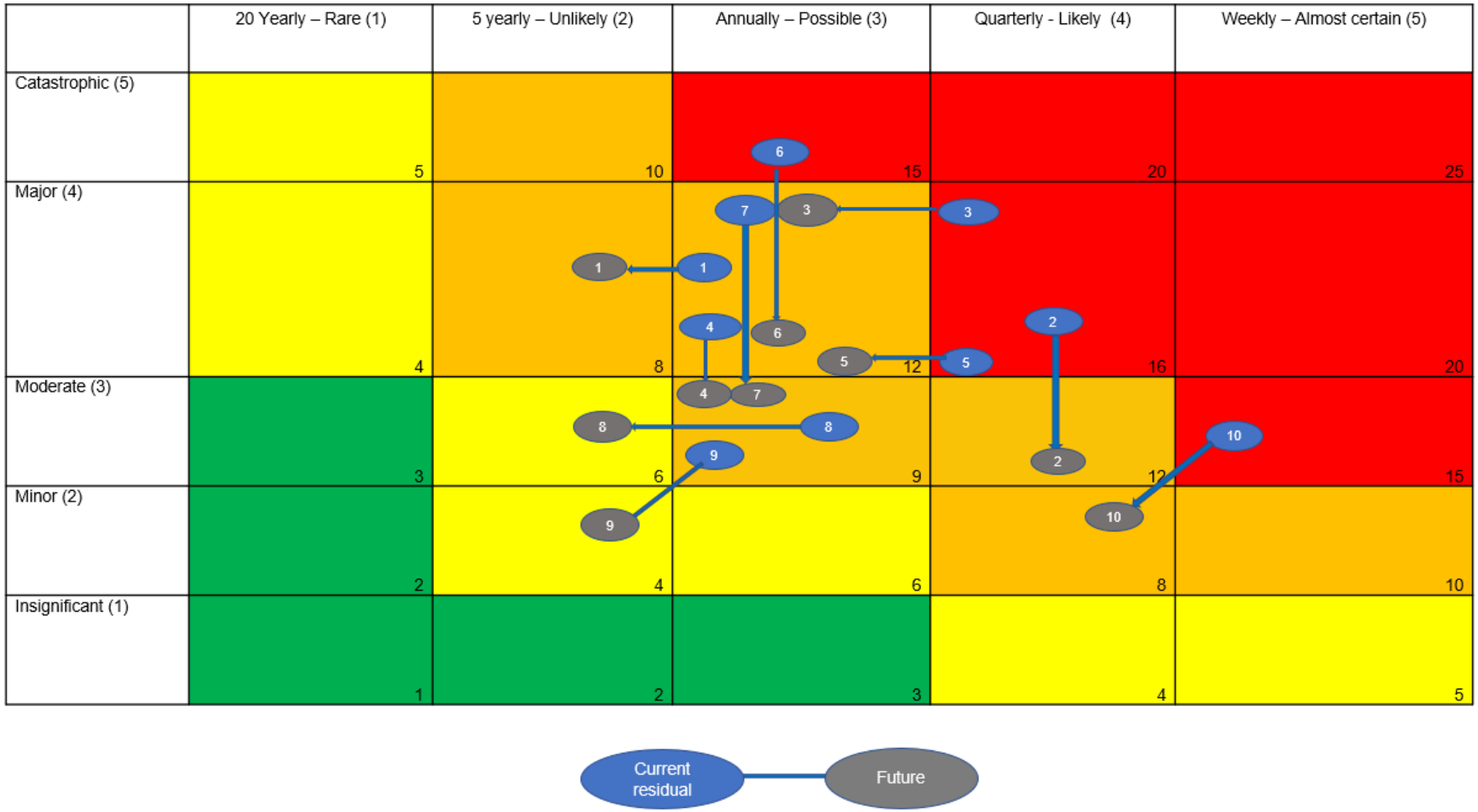
Risk and assurance: Failure to effectively manage risks to the Trust's strategic objectives. Agreed structure for Board Assurance Framework (BAF) review with oversight by the Audit Committee. Internal Audit review and testing of the BAF.

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

Sustainability: A properly managed BAF ensures WSFT will be fit for the future and able to meet the future healthcare needs of the population of West Suffolk.

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

Appendix 1: BAF Risk Movement



Compassionate care,
healthier communities

Appendix 2: Risk themes – summary table

Risk Descriptions	Exec lead	Board comm.	Appetite Level and score	Inherent risk score	Current risk score	Future risk score (target date)	Future risk within appetite?	Assur. level
BAF 1 Fail to ensure the Trust has the capability and skills to deliver the highest quality, safe and effective services that provide the best possible outcomes and experience (Inc developing our current and future staff)	CPO	PQ&S Planned for Feb 26 (MEG-Jan 26)	Cautious (9)	20	12	8 (Oct 25)	Yes	Reasonable
BAF 2 The Trust fails to ensure that the health and care system has the capacity to respond to the changing and increasing needs of our communities	COO	F&O Planned for Apr-26 (MEG-Mar 26)	Cautious (9)	20	16	12 (Mar 26)	No	Partial
BAF 3 The Trust fails to collaborate effectively with partners, causing an inability to deliver the 'Future Shift', leading to a failure to implement strategic transformation priorities, the Future Systems Programme, and/or new models of care that could improve population health outcomes, Trust sustainability, and operational performance.	DST	P&OD Planned for Apr-26 (MEG-Mar '26)	Open (12)	16	16	12 (Apr 26)	Yes	Partial
BAF 4 There is a risk that the Trust does not have the capacity, capability, or commitment to change the way it provides health and care services, which could lead to a failure to respond to changing demand pressures, unsustainable services, and/or not delivering major projects, which would worsen operational pressures, quality of care, and financial viability.	DST	PQ&S Planned for Mar '26 (MEG-Feb '26)	Open (12)	16	12	9 (Apr 26)	Yes	Partial

Compassionate care,
healthier communities

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

Compassionate care,
healthier communities

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

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

Compassionate care,
healthier communities

NHS
West Suffolk
NHS Foundation Trust

Appendix 3 – Forward Plan

	Score	Frequency	Executive lead	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	Jul-26
Management Executive Group																			
BAF 1-Capability and skills	12	six monthly	CPO (Julie Hull)				X						X						X
BAF 2-Capacity	16	quarterly	COO (Nicola Cottington)			X			X			X			X			X	
BAF 3-Collaboration	16	quarterly	DST (Sam Tappenden)			X			X			X			X			X	
BAF 4-Continous improvement and Innovation	16	quarterly	DST (Sam Tappenden)		X			X			X			X			X		
BAF 5-Digital	16	quarterly	COO (Nicola Cottington)			X			X		X			X			X		
BAF 6-Estates	15	quarterly	DoR (Jonathan Rowell)		X			X			X			X			X		
BAF 7- Finance	12	six monthly	DoR (Jonathan Rowell)	X			X			X			X			X			
BAF 8-Governance	9	six monthly	ECN (Dan Spooner)			X						X						X	
BAF 9-Patient Engagement	9	six monthly	ECN (Dan Spooner)						X						X				
BAF 10-Staff Wellbeing	15	quarterly	CPO (Julie Hull)				X			X			X			X			X
Quality and Patient Safety Committee																			
BAF 4 -Continous improvement and Innovation	16	quarterly	DST (Sam Tappenden)			X			X			X			X			X	
BAF 8 -Governance	9	six monthly	ECN (Dan Spooner)				X						X						X
Finance and Perfomance Committee																			
BAF 2-Capacity	16	quarterly	COO (Nicola Cottington)	X			X			X			X			X			X
BAF 6-Estates	15	quarterly	DoR (Jonathan Rowell)			X			X			X			X			X	
BAF 7- Finance	12	six monthly	DoR (Jonathan Rowell)		X			X			X						X		
People and Organisational Development Committee																			
BAF 1-Capability and skills	12	six monthly	CPO (Julie Hull)					X						X					
BAF 3-Collaboration	16	quarterly	DST (Sam Tappenden)	X			X			X			X			X			X
BAF 9-Patient Engagement	9	six monthly	ECN (Dan Spooner)	X						X						X			
BAF 10-Staff Wellbeing	15	quarterly	CPO (Julie Hull)					X			X			X			X		
Digital and Data Committee																			
BAF 5-Digital	16	quarterly	COO (Nicola Cottington)	X			X			X			X			X			X

Compassionate care,
healthier communities

2. HIGH QUALITY CARE

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

For Approval

Presented by Sam Tappenden and Daniel Spooner

WSFT Board of Directors (Open)	
Report title:	**Integrated Quality and Performance Report**
Agenda item:	2.1
Date of the meeting:	
Sponsor/executive lead:	Daniel Spooner, chief nurse Nicola Cottington, chief operating officer Julie Hull, interim chief people officer
Report prepared by:	Andrew Pollard, information analyst. Narrative provided by clinical and operational leads.

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

Executive summary:

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

To update and provide assurance to the Board of Directors on performance during November 2025.

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

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

1. The ability to reliably meet targets and standards (pass/fail)

2. Statistically significant improvement or worsening of performance over time.

Narrative is provided to explain what the data is demonstrating (what?), the drivers for performance, what the impact is (so what?) and the remedial actions being taken (what next?).

This month, the National Oversight Framework (NOF) overview is included in the pack. WSFT's league table position in quarter 2 has improved to 57 out of 134 acute sites. The average metric score has also improved to 2.27, from 2.51, and the Trust's unadjusted segment is 2 (adjusted for financial deficit override to 3). Please note other changes to the IQPR are in progress, to include a refreshed assurance grid summary, health inequalities, digital and productivity metrics.

The following areas of performance are highlighted below for the board's attention:

- The Trust continues to perform comparatively well on ambulance handover metrics, with 88% of handovers happening within 30 minutes.
- In November, the in-month trajectory for 4-hour performance was exceeded achieving 75.16% an 12 hour breaches also reduced below trajectory to 5 of all attendances.
- Virtual Ward occupancy continues to be below target (60% against target of 80%). The Division is adjusting capacity and flexing capacity across Virtual Ward and Early Intervention Team to make best use of resources.
- Cancer Faster Diagnosis Standard (FDS) performance continues to underperform at 74.1%, due to reduced capacity in the breast service but is forecast to improve in November and December. 62-day performance continues above target at 81.9% of patients treated within 2 months of referral.
- Diagnostic performance against the 6-week standard continued an upward trajectory to 56.7%. Recovery actions forecast improvement from current overall DM01 position to 76% by end of March 2026.
- At the end of November 2025 there were 55 patients waiting over 65 weeks for elective care with a further reduction forecast by the end of December.
- The total waiting list size remained stable and there was a slight improvement in the 18-week compliance performance at just over 62%, this was slightly behind forecast of 63%.
- There is sustained deterioration in waiting times for the paediatric team due to the level of demand and reduced capacity within the clinical team. The longest waits are within the neurodevelopmental delay (NDD) pathway. Agency support is being provided and an expansion of substantive capacity is planned.
- Activity plans for first outpatient attendances were met for the first time this year in November 2025 but with the gap in elective activity widening once again to -13.7%. Day case activity fell behind plan, having been ahead for the previous three months.

- The C-Difficile improvement programme has now moved into business as usual and will be monitored through the Improvement Committee. Monthly data remains in common cause variation. WSFT remain above trajectory due to the high numbers seen in M4.
- Percentage of reportable harm returning to under the national average for fourth consecutive month
- PPH for vaginal births and caesarean section are in common cause variation. All cases are reviewed individually for learning.
- SHMI three months of special cause concern attributed to coding back log. Recovery plan to address back log has been agreed at MEG. Not correlating with actual inpatient deaths which has been below average for past 5 data points
- We will monitor the impact the current staffing within the PALS and patient complaints team has on performance. Recruitment into the new structure has commenced. Extensions of complaints timeframes in special cause improvement
- Appraisal participation rates are below target and increased slightly in month to 86.3%.
- Mandatory training completion rates are special cause for concern dropping below target of 90% target currently at 88.6%.
- Staff retention remains stable with a turnover rate (9.9%) better than the target threshold of 10%.

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

The items reported through this report will be actioned through the appropriate routes.
A task and finish group has been set up to review the content of the IQPR to ensure the correct metrics are being measured and monitored with regard to workforce data. The outputs from this work will become

part of the IQPR. Other metrics are being reviewed in line with the new NHS National Oversight Framework (NOF) and new Trust Strategy, and to include health inequalities, digital and productivity metrics.
Action required / Recommendation:
The Board of Directors is asked to note the Integrated Quality and Performance Report for October 2025.

Previously considered by:	Board assurance committees Component metrics are considered by Patient Safety and Quality Group and Patient Access Governance Group.
Risk and assurance:	**BAF risk: Capacity (Ref: 02): The Trust fails to ensure that the health and care system has the capacity to respond to the changing and increasing needs of our communities**
Equality, diversity and inclusion:	Monitoring of waiting times by deprivation score and ethnicity are monitored at ICB level. The Trust is reviewing how to routinely include EDI metrics in a wider range of reports.
Sustainability:	Organisational sustainability
Legal and regulatory context:	NHS Act 2006, West Suffolk NHS Foundation Trust Constitution

Overall segment and domain scores

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

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

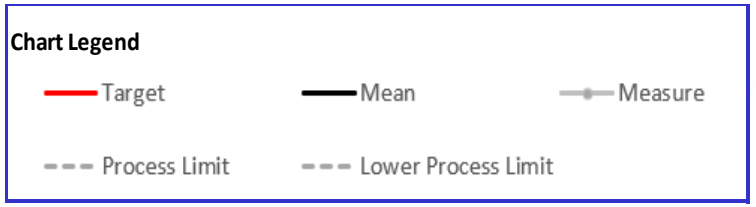
Assurance Grid

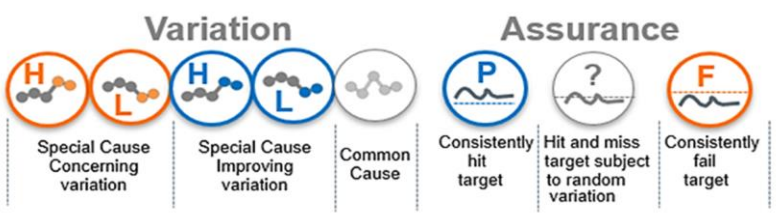
Performance in November 2025		ASSURANCE: Will we reliably meet the target based? Pass (P)	Hit and Miss (?)	Not Met: Fail (F)	No Target
VARIANCE: Variation from the mean. The colours indicate the trend- positive (blue), Negative (orange), or neither (grey)	Special Cause Improvement (H / L)	**FINANCE &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

Items for escalation based on those indicators that are failing the target, or are worsening and therefore showing Special Cause of Concerning Nature by area:
FINANCE & PERFORMANCE - Cancer: Incomplete 104 Day Waits
Elective: Diagnostic Performance - % within 6 weeks Total, RTT 65+ Week Waits
PEOPLE & ORGANISATIONAL DEVELOPMENT – Well Led: Appraisal

FINANCE & PERFORMANCE COMMITTEE METRICS

Urgent & Emergency Care summary

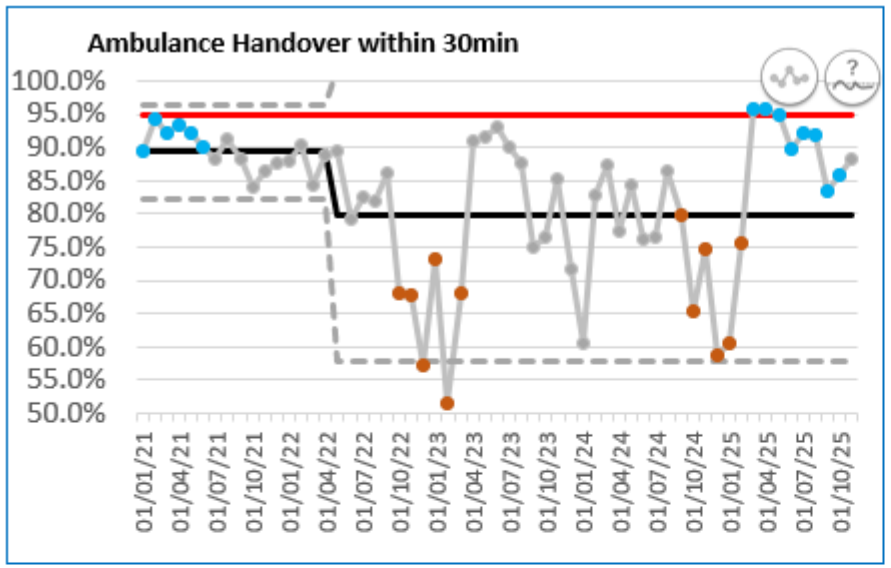


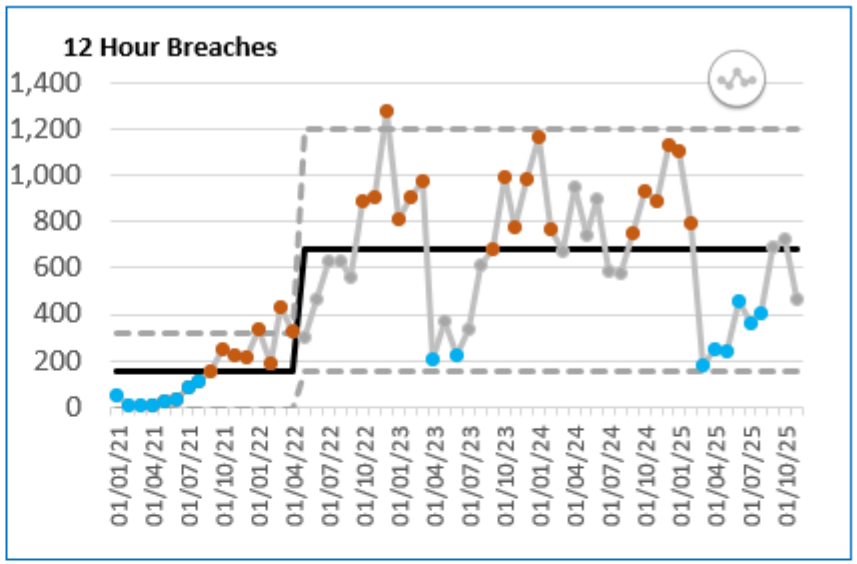


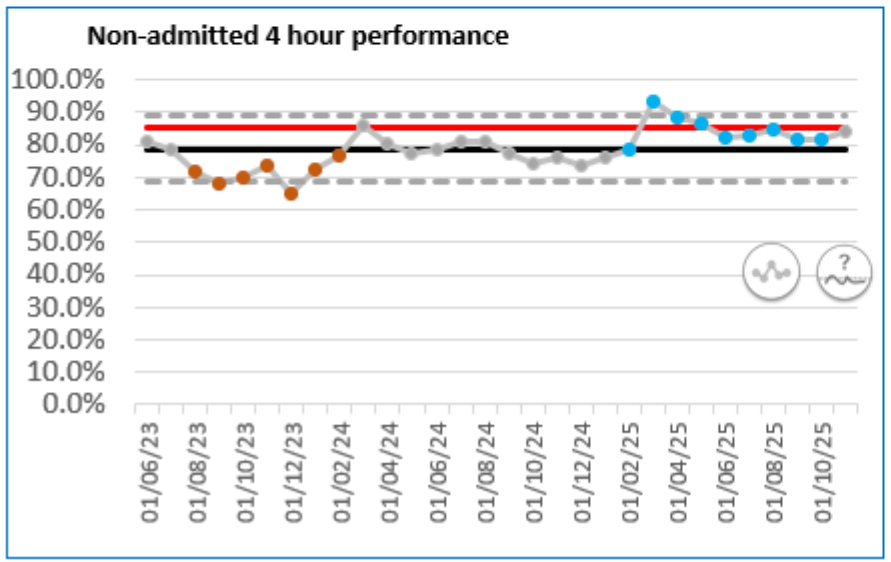
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover within 30min	Nov 25	88.1%	95.0%			79.8%	57.9%	101.7%
12 Hour Breaches	Nov 25	464				679	157	1201
Non-admitted 4 hour performance	Nov 25	84.3%	85.0%			78.7%	68.6%	88.8%
12 hour breaches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

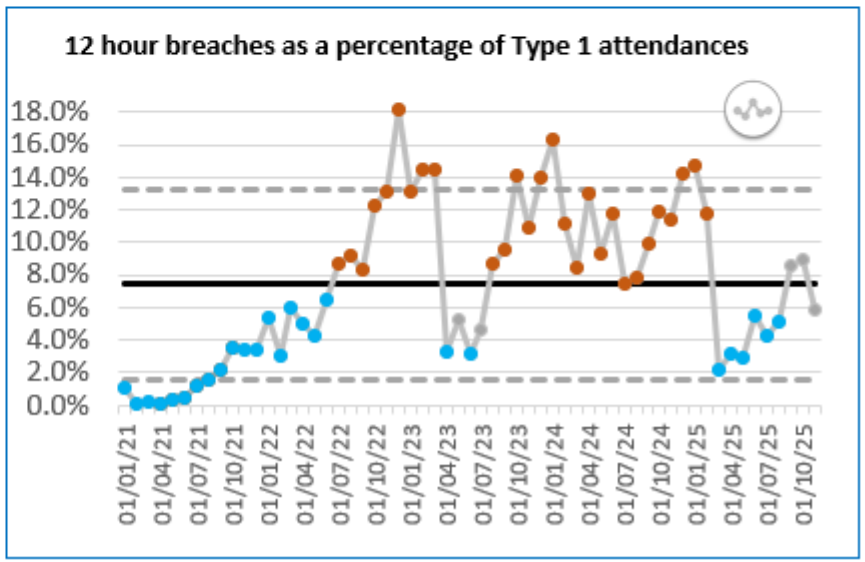
** Figures are for Glastonbury and Newmarket only, data not currently captured at Hazel Court.

Urgent & Emergency Care: ED 4 Hour Performance

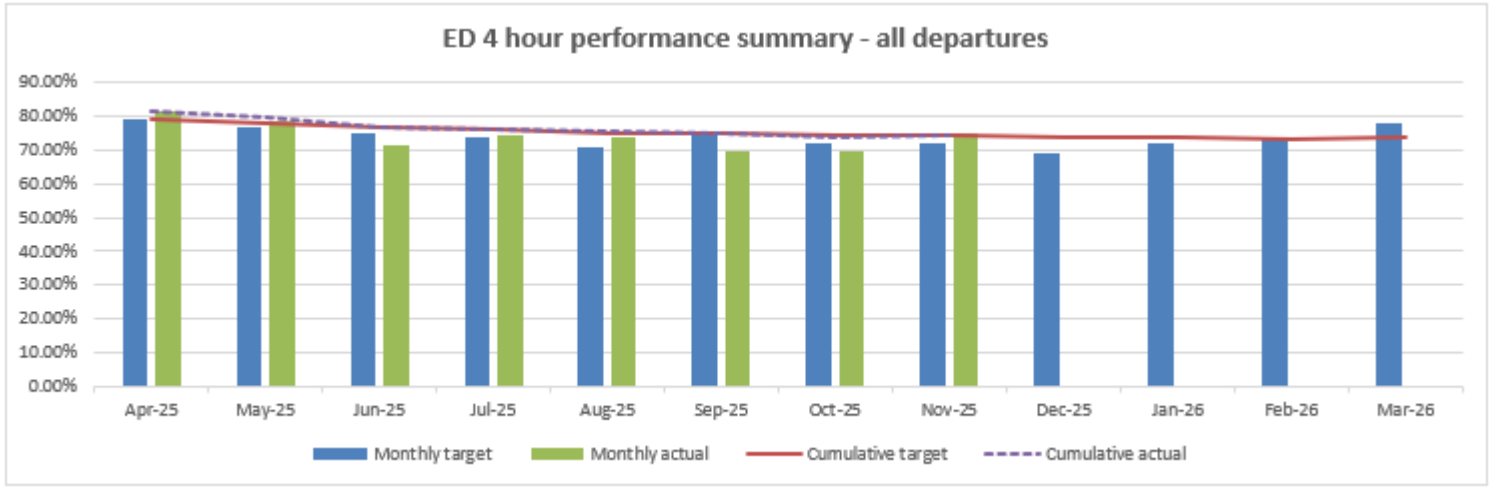


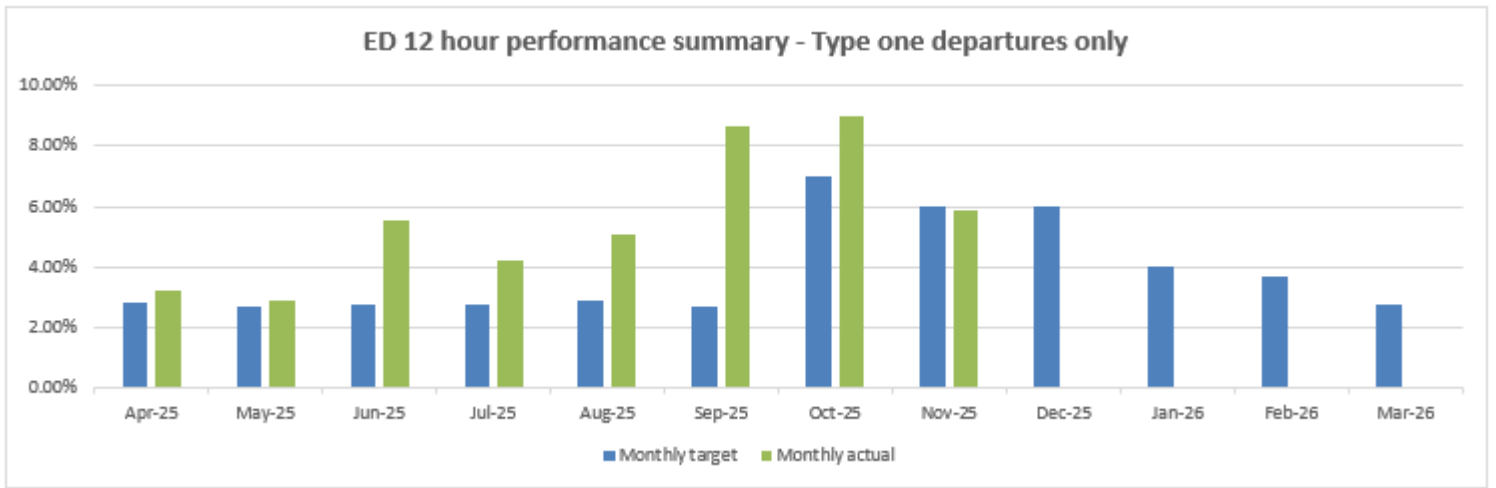






Urgent & Emergency Care: ED 4 Hour Performance





Urgent & Emergency Care

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

Community Access Glemsford Surgery

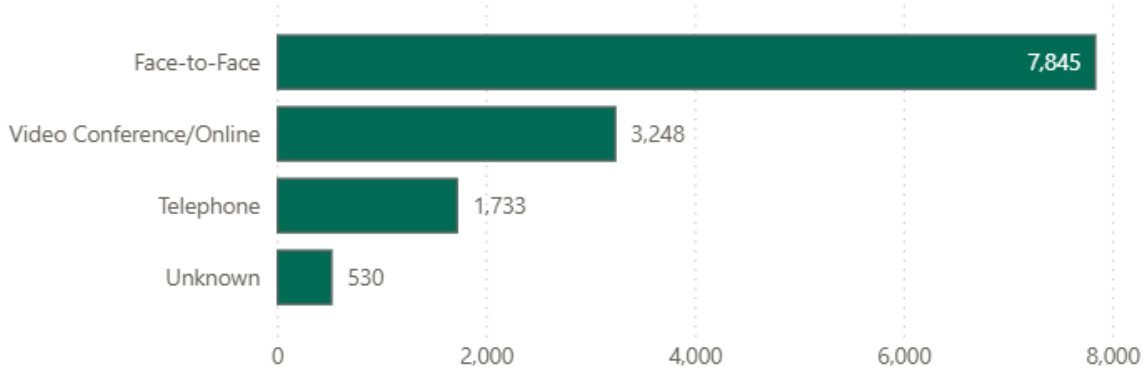
Practice Appointments

SNEE Business Intelligence

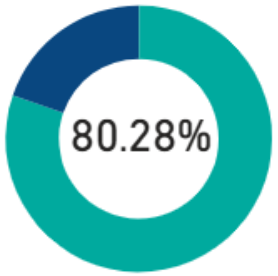
NHS Suffolk and North East Essex Integrated Care Board

Alliance	PCN	Practice	Financial Year
All	All	Glemsford	2025/26

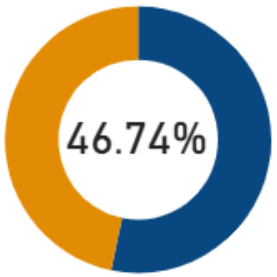
Practice appointments by contact mode



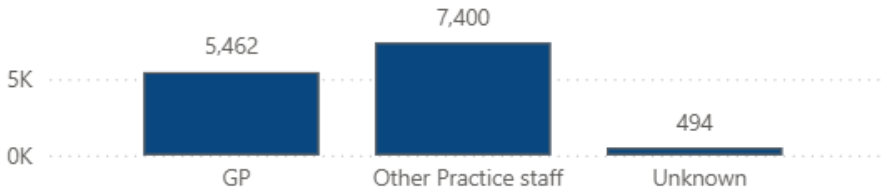
Seen within 2 weeks



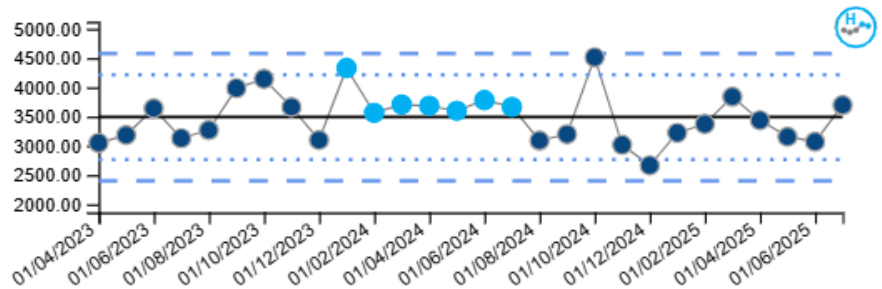
Seen within 48 hours



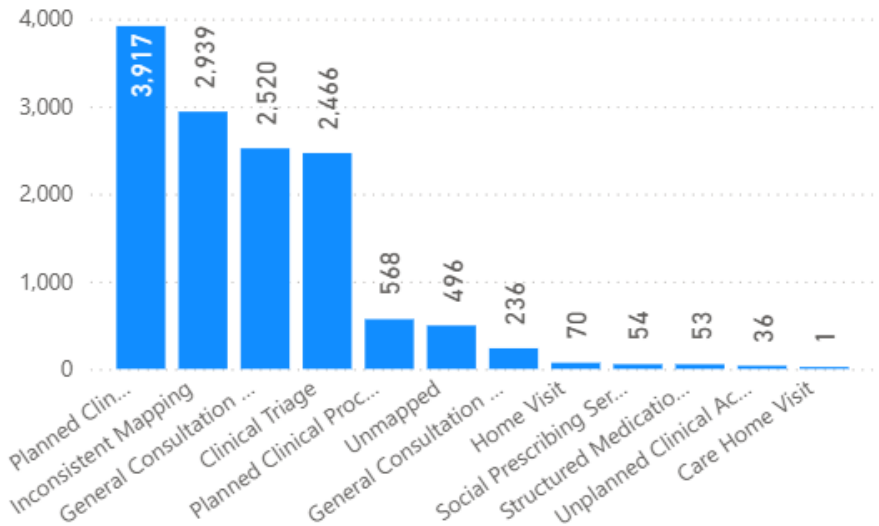
Practice appointments by health care professional type



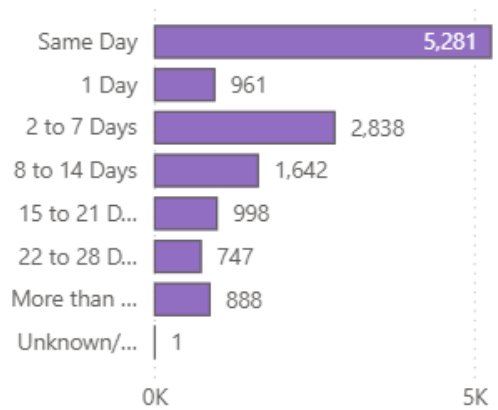
Total appointments by month



Sum of Total Appointments by National Category

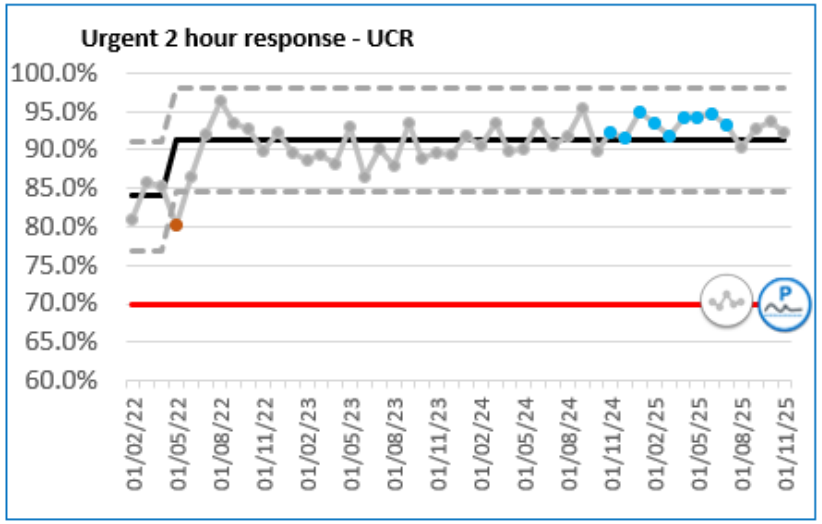


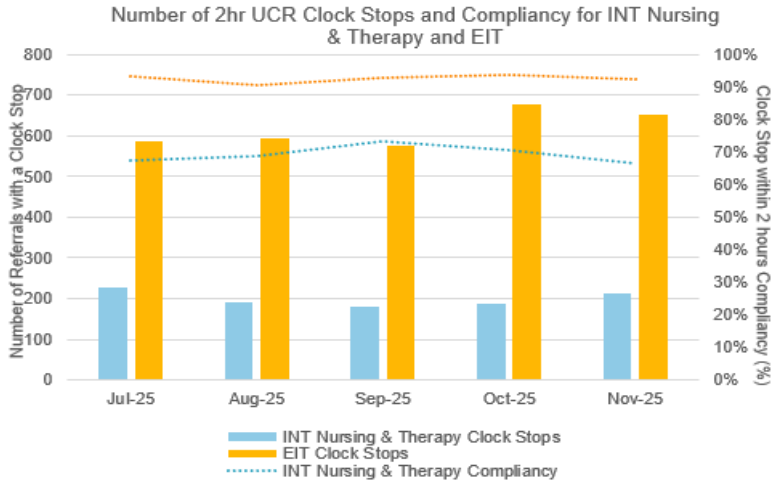
Appointments by wait time

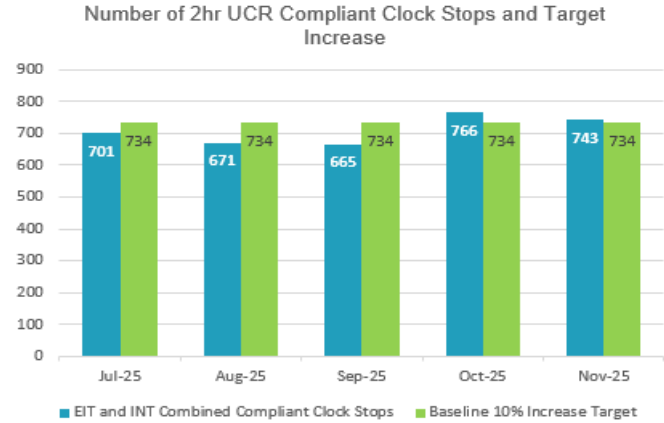


Produced by ICB

Urgent & Emergency Care: UCR







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

What

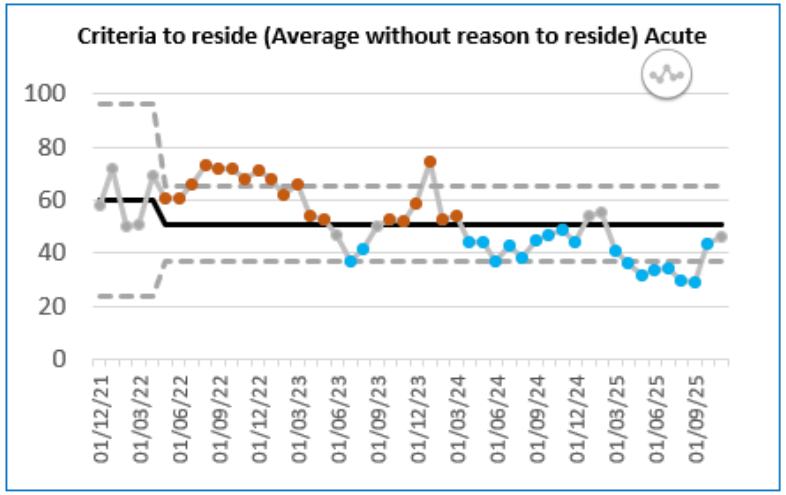
UCR 2-hour performance remains above target at 88%. Community Urgent Care Response (UCR) 2 hour response is at 67% in Integrated Neighbourhood Teams (INTs) under the 70% target. UCR requires clinical prioritisation with current workforce capacity. In October (November data unavailable) an average of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

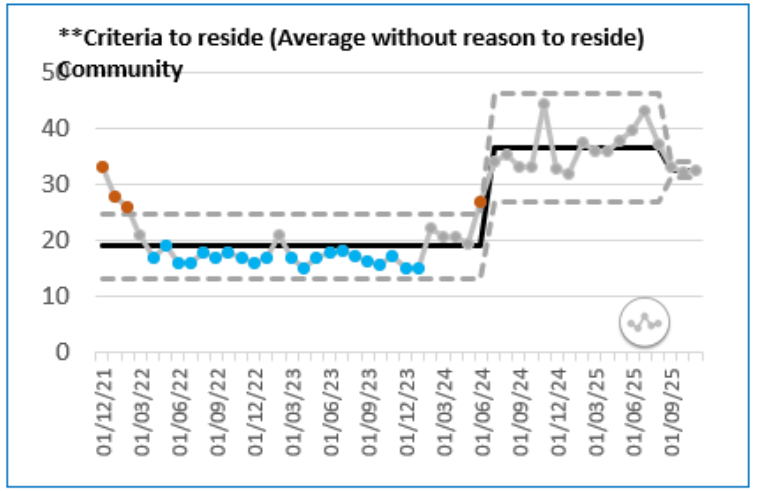
So What?

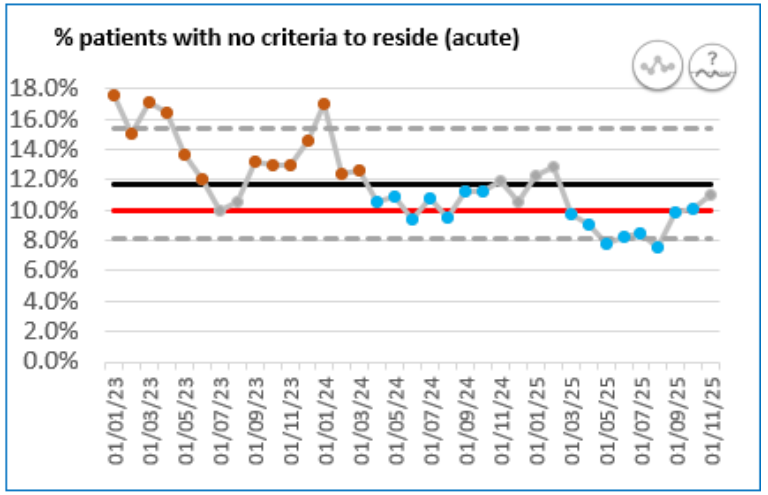
Increased cancellations of planned care presents risk to quality of patient care and increases the workload for co-ordinators and clinicians to re-organise care.

What Next?

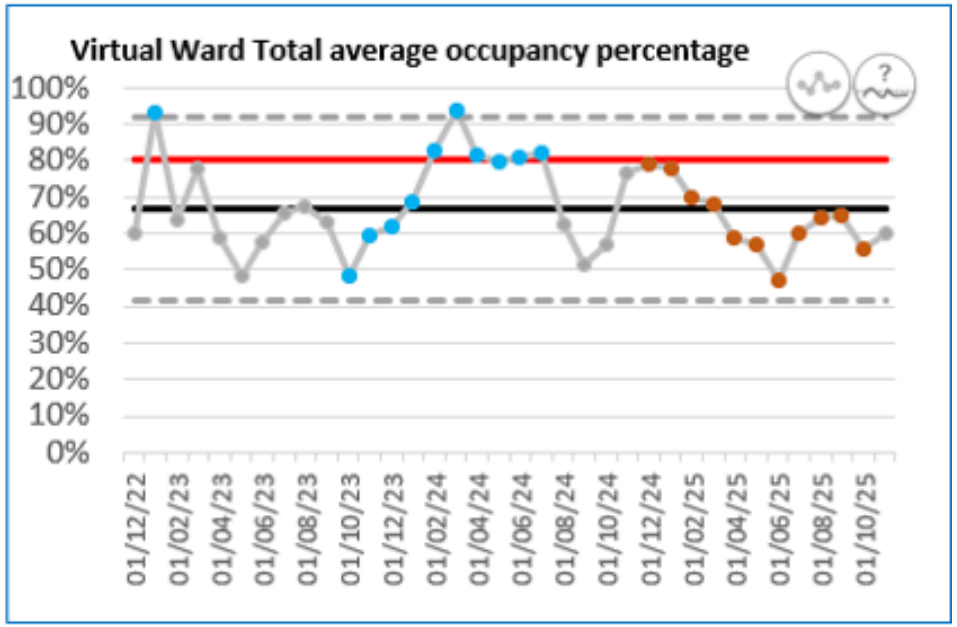
Working with INTs to take on more UCR therapy work during the daytime, to free up Early Intervention Team (EIT) therapy staff to focus on Emergency Dept/ Acute Assessment Unit to support performance. Aim to pilot from mid-January. Will need to monitor effect on other INT Referral To treatment performance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





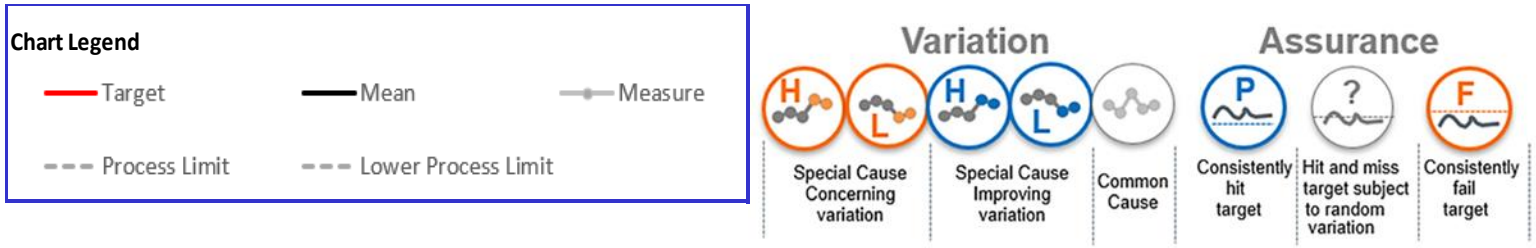


What	So What?	What Next?
The monthly average acute no criteria to reside (NCTR) has increased to 11.0% the highest this year since February. In comparison the NCTR for November 2024 was 11.9%. Transfer of Care Hub (TOCH) teams have had staffing challenges due to long and short term, planned and unplanned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



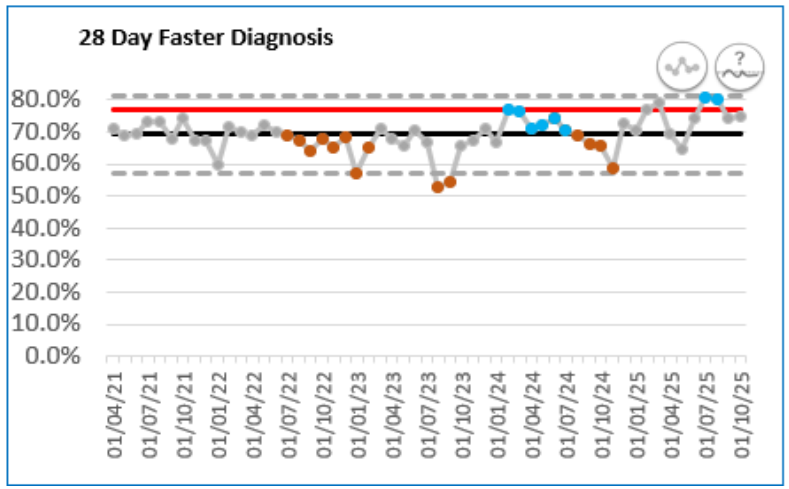
What	So What?	What Next?
Average occupancy in November was 60%, an increase from 55% the previous month. Total bed nights occupied were 954 (increase from 911). Patient flow is supported by effective length of stay which is well managed at average 8.3 in November (decrease from 8.7 the previous month).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

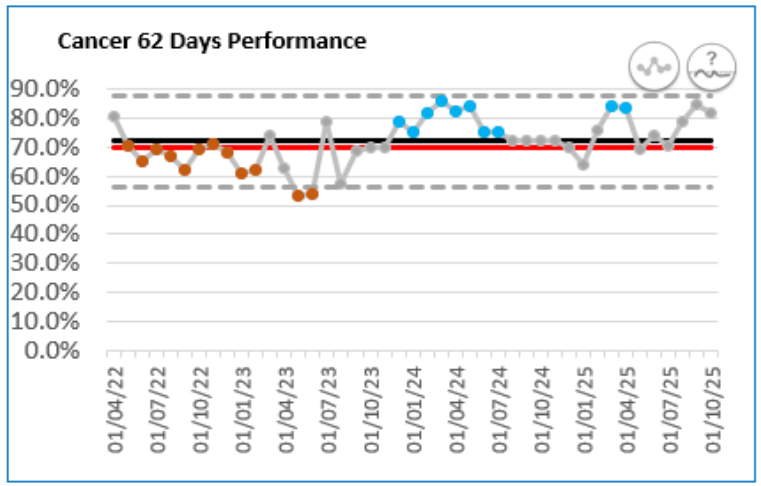
Cancer Access Summary

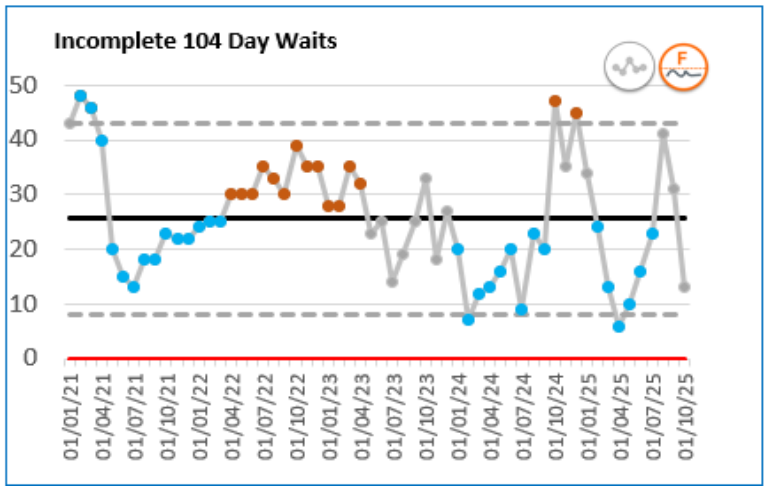


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	Oct 25	74.8%	77.0%			69.2%	57.2%	81.2%
Cancer 62 Days Performance	Oct 25	81.9%	70.0%			72.1%	56.2%	87.9%
Incomplete 104 Day Waits	Oct 25	13	0			26	8	43

Cancer Access (Month Behind)

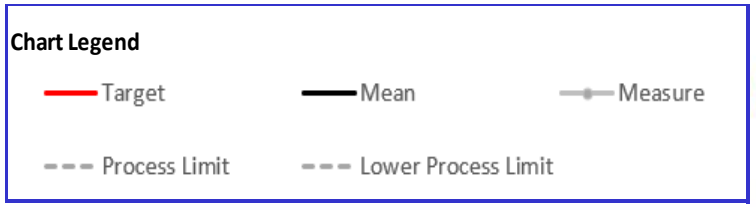


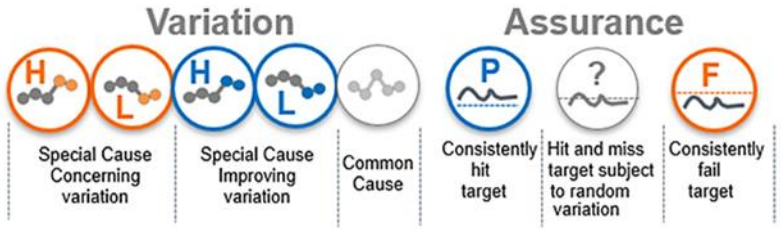




What	So What?	What Next?
28-day performance was 74.8% for October 2025. The under performance is mostly related to the Breast performance which was at 68%. This was due to vacancies and sickness within all staff groups. Performance is expected to improve in November and December but sickness is still having an impact. Performance was sustained in Gynaecology, Head and Neck, Skin, Lung and Upper GI with focus required in Lower GI and Urology. Despite these challenges the 62 day treatment performance increased to 81%, with strong performance in all tumour sites. The volume of patients over 104 days reduced significantly following the clearance of the patients in the Skin upgrade backlog.	Recovering the cancer standards is key to the operational planning guidance 25/26. The priorities for this year focus on seeing, diagnosing and treating patients in line with national guidance to improve patient outcomes and maintain standards.	External review for breast service to be completed by Cancer Alliance. Urology pathway reviews underway, faster diagnosis steering group recommenced with several key actions in place including revising the bladder pathway and a focus on reporting – new pathway due to commence in January 2026. Continue with additional cancer session in endoscopy to improve FDS performance.

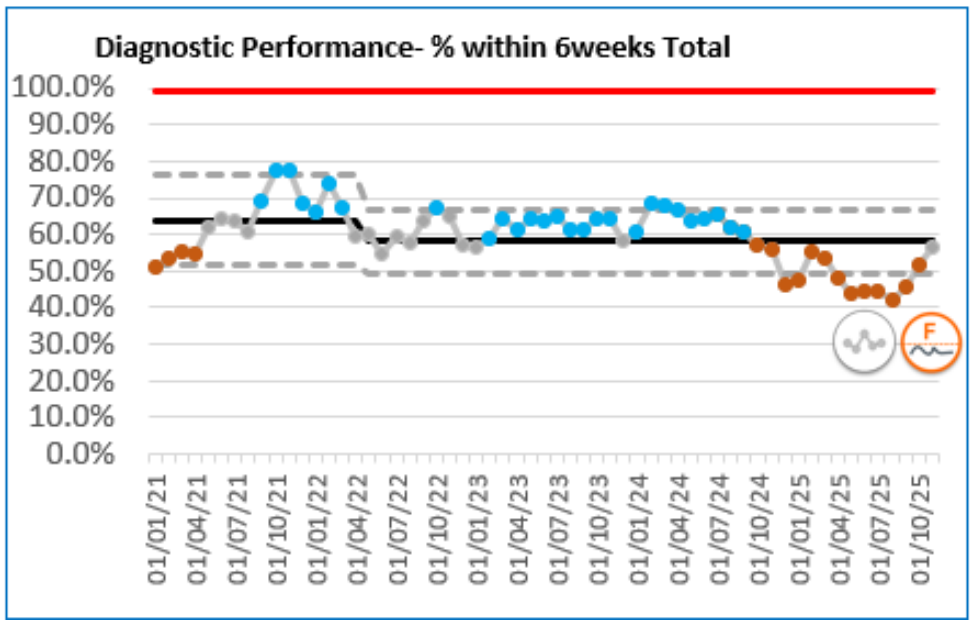
Elective Access: Summary





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

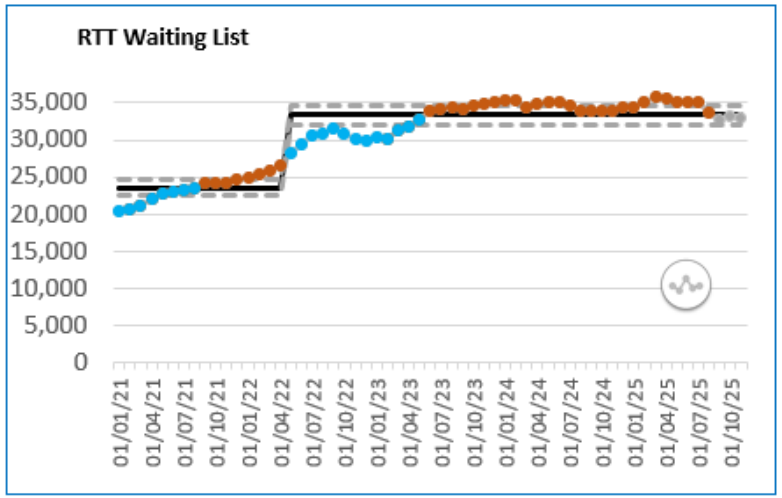
Elective Access

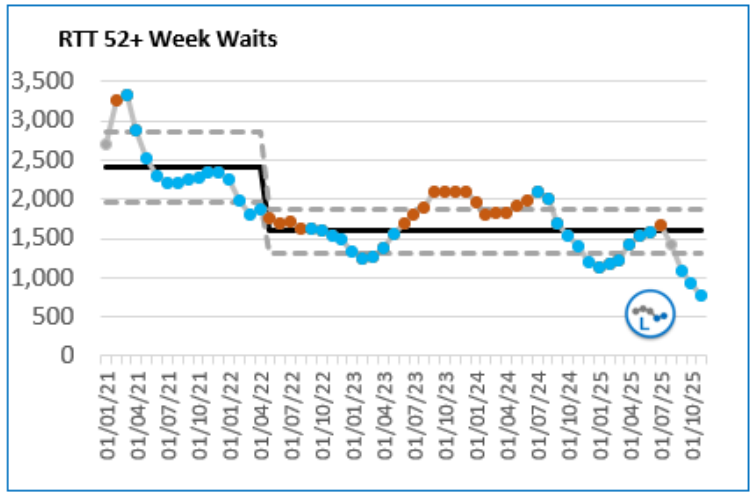


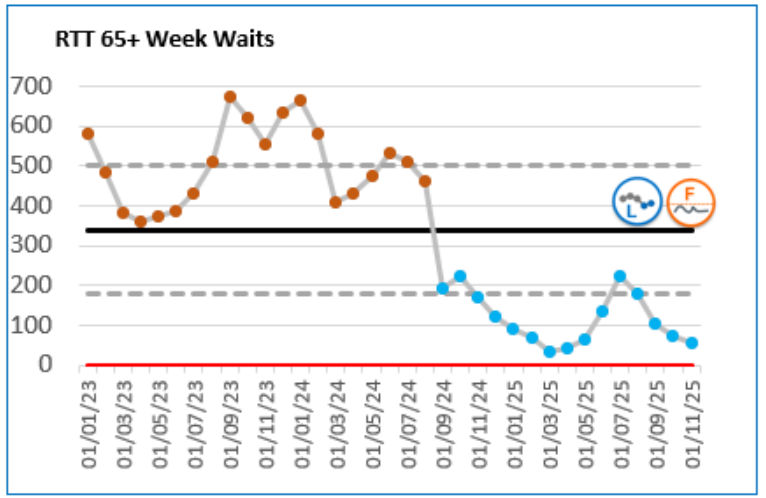
Diagnostics

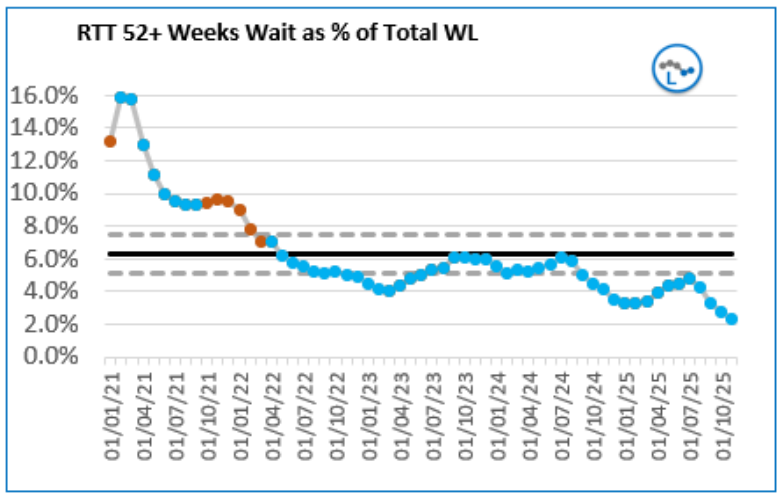
What	So What?	What Next?
MRI - Marginally under DM01 target at 98.4% in month. **CT** –compliant with DM01 target at 99.5% in month. **US** – The total waiting list size continues to reduce and DM01 has started to improve as a result of the weekend insourcing lists and additional in week capacity. Current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

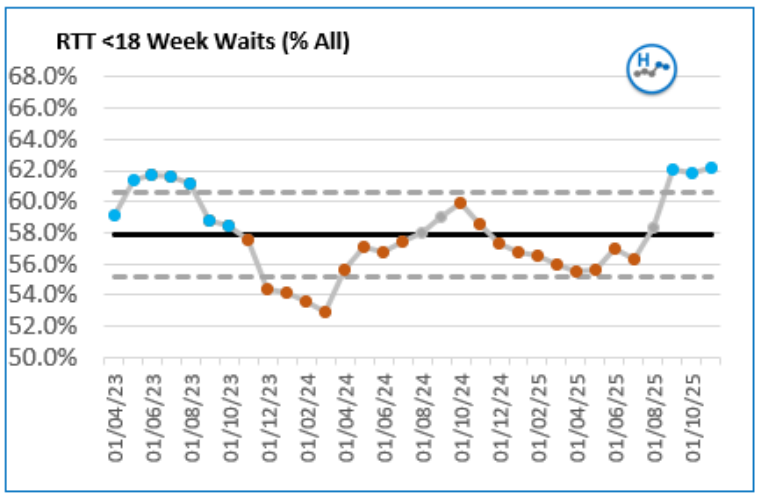
Elective Access: RTT

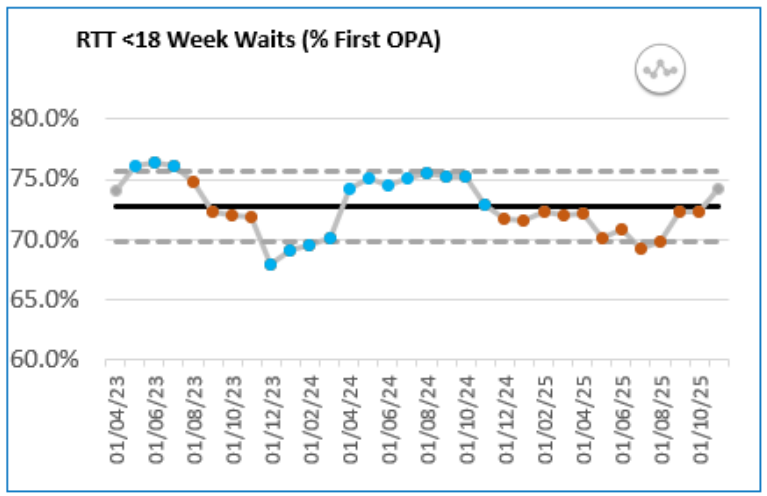




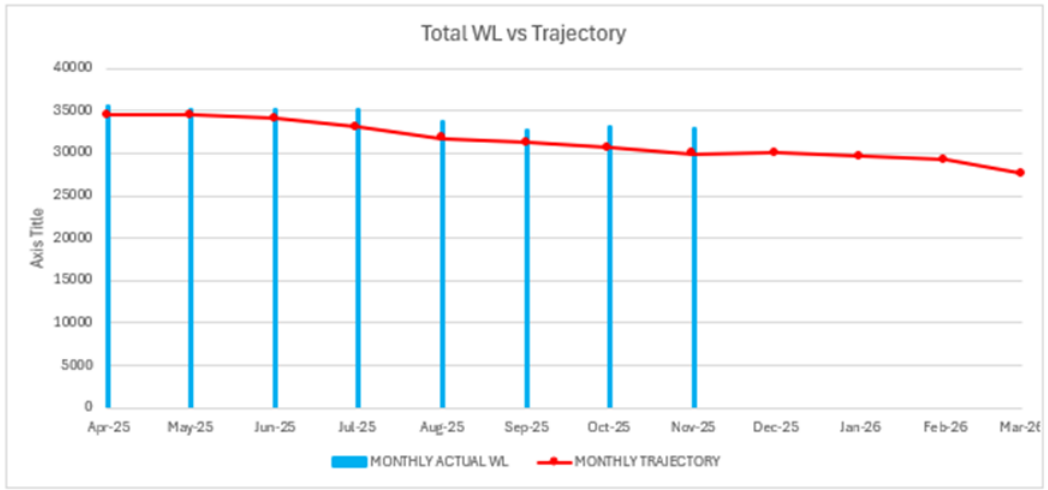


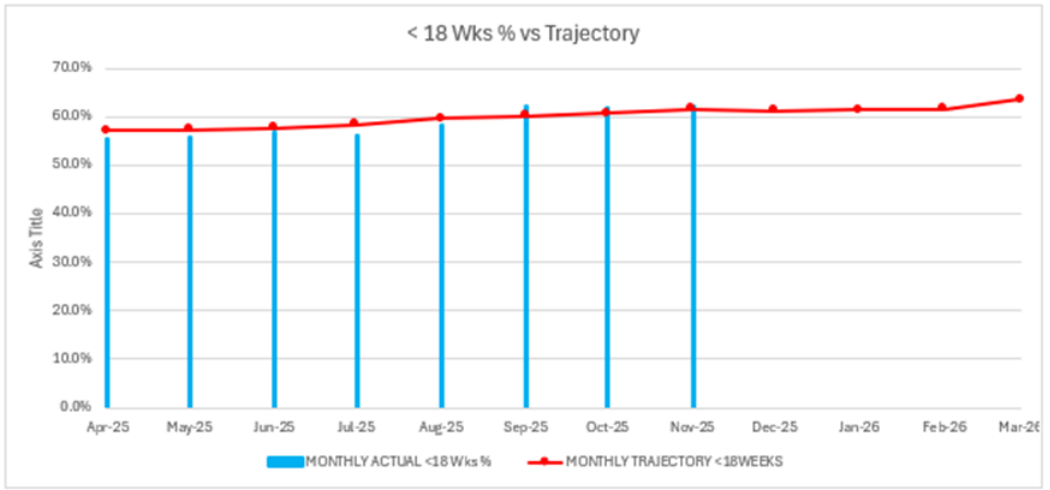


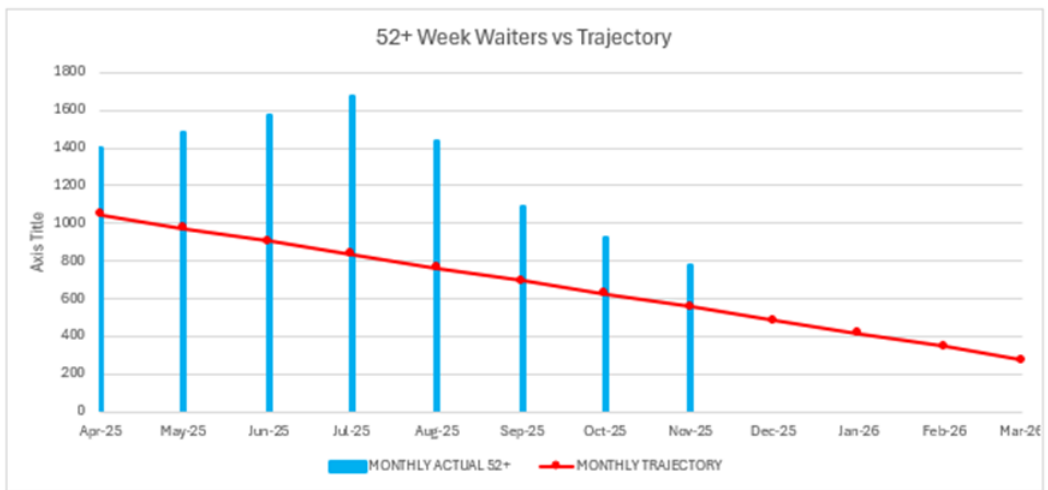


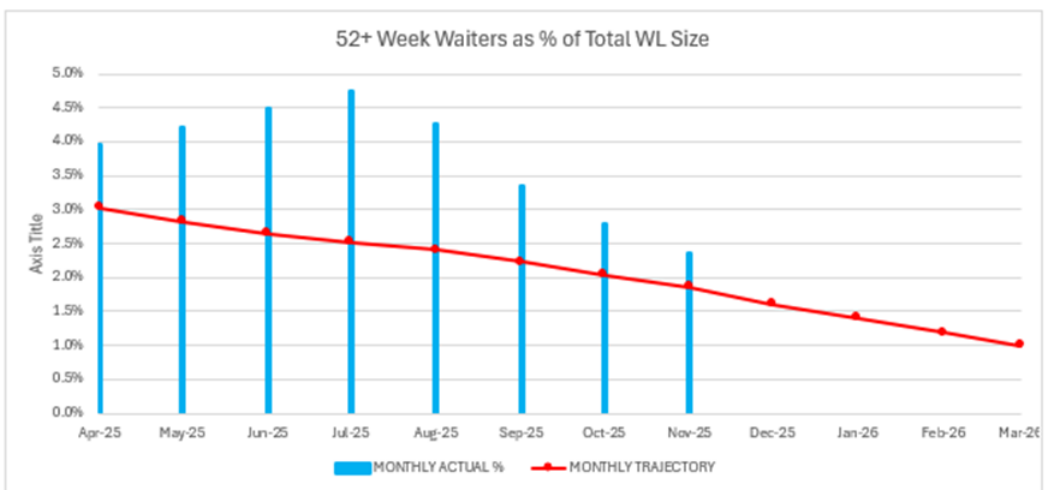


Elective Access: RTT





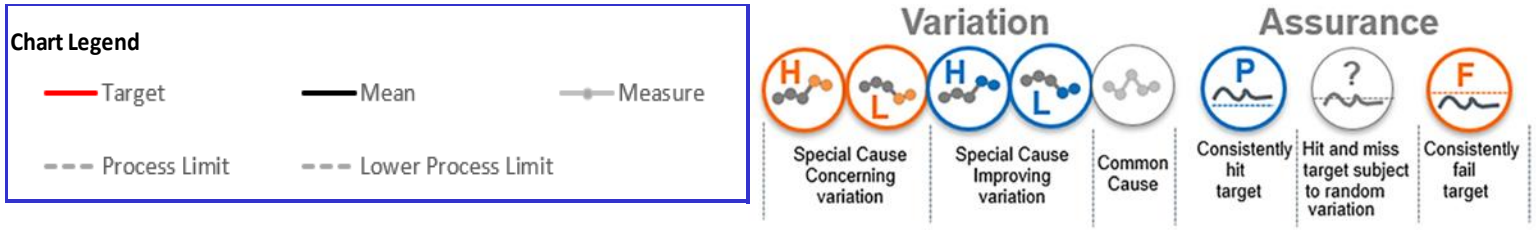




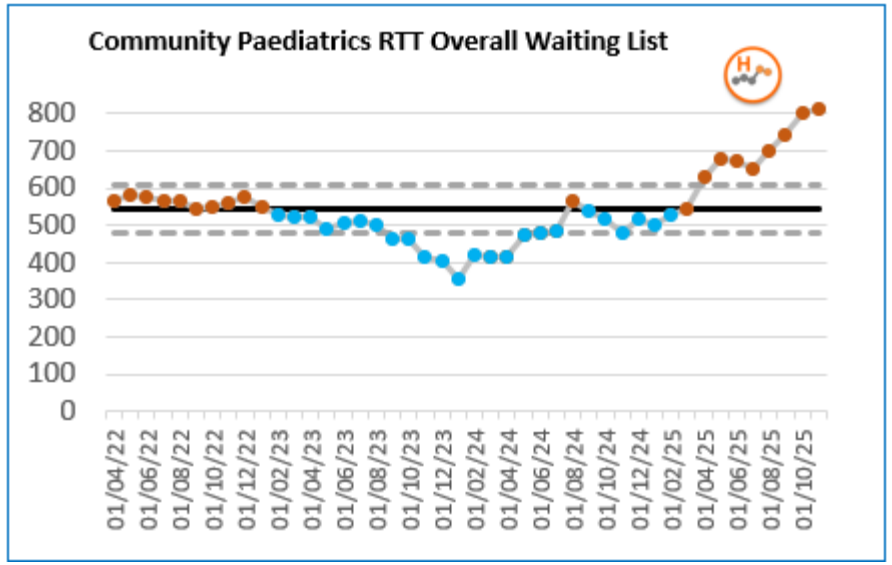
Elective Access: Activity

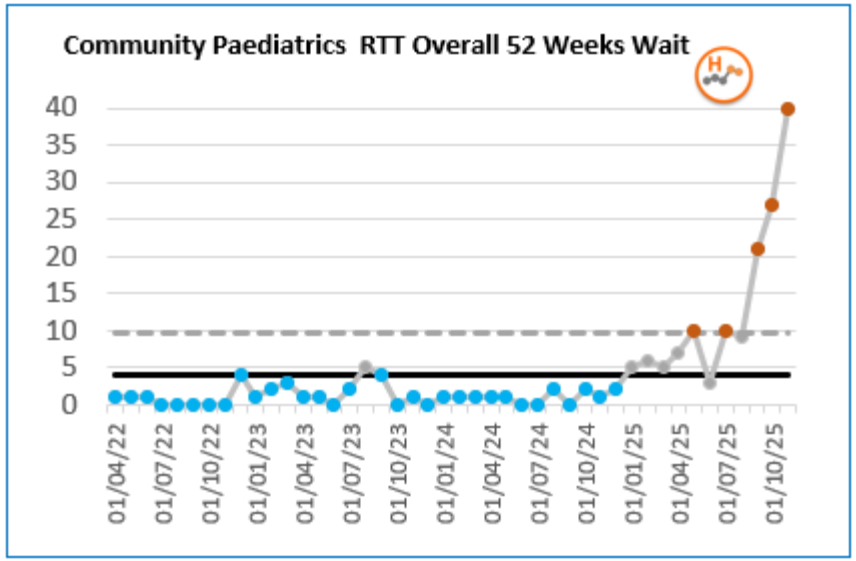
What	So What?	What Next?
End of November 2025 saw a further reduction in patients waiting over 65 weeks with 55 patients reported this month, with the ambition to continue to reduce to 0, with patient choice and clinical breaches forecast there will be a further reduction in December. The total waiting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

Elective Access: Summary



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





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

Elective Access: Activity

last refresh 15/12/2025 11:03

NHS England - 25/26 (Monthly - IQPR)

** Outpatient weekly data only includes e-care records (no Cardiology Diagnostics or Radiology)*

West Suffolk NHS
NHS Foundation Trust

All

All

Outpatient First

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

November 2025

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

Daycase

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

November 2025

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

Outpatient Follow Up

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

November 2025

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

Elective

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

November 2025

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

What

Activity plans for first outpatient attendances were met for the first time this year in November 2025 but with the gap in elective activity widening once again to -13.7%. Day case activity fell behind plan, having been ahead for the previous three months. Outpatient follow ups being behind plan and the 2024/25 position is generally seen as a positive, as this reduces the new to follow up ratio and creates more new patient capacity

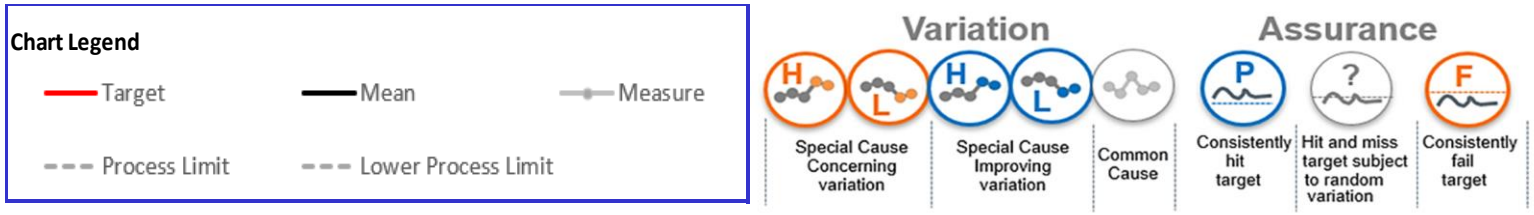
So What?

From 2025/26, ICB's and providers must agree an Indicative Activity Plan (IAP), failure of which to deliver can result in contractual penalties. Delivery of increased activity levels is also required to meet improvements in Referral to Treatment (RTT): 5% improvement in the number of patients waiting 18 weeks or less and less than 1% of people waiting 52 weeks or more.

What Next?

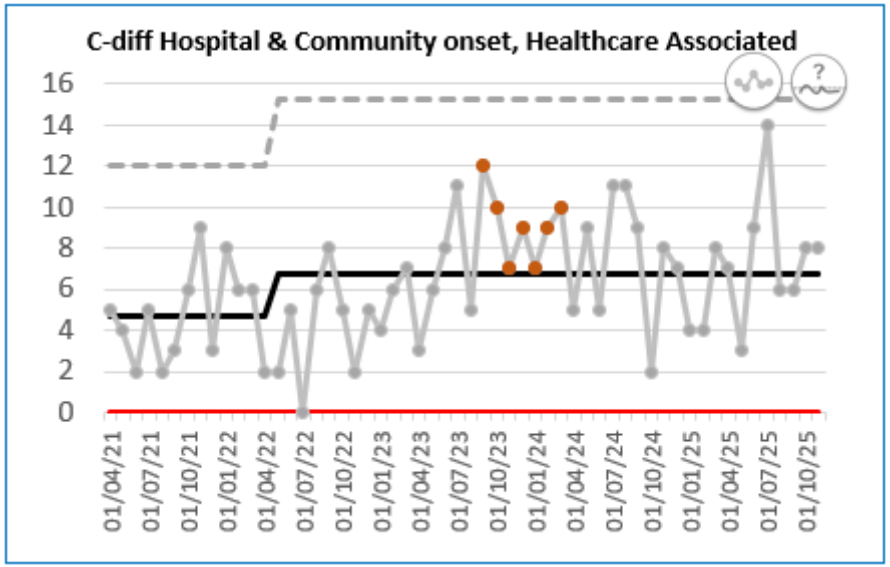
Specialty level RTT trajectories are monitored through weekly access meetings – for most specialties the activity required to deliver these will exceed the Indicative Activity Plan totals. Spending is being reviewed against the £440K allocation from Management Executive Group to identify opportunities to go further, as well as responding to national initiatives to incentivise 52 week wait reduction and additional new outpatient activity in Q4. Delivery of productivity initiatives across theatres and outpatients is supported through the Productivity Programme Board.

QUALITY & PATIENT SAFETY COMMITTEE METRICS



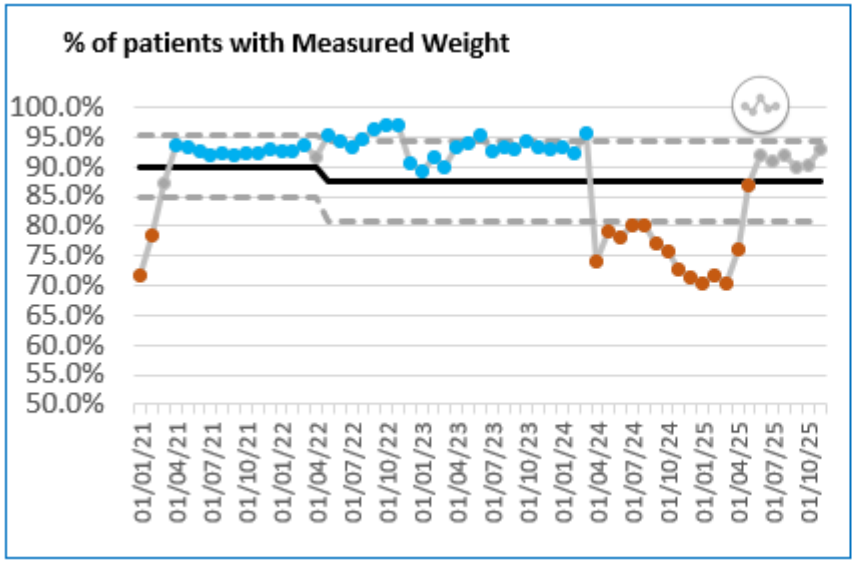
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
C-diff Hospital & Community onset, Healthcare Associated	Nov 25	8	0			7	-2	15
% of patients with Measured Weight	Nov 25	93.0%				87.5%	80.7%	94.3%
% of patients with a MUST/PYMS assessment completed within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

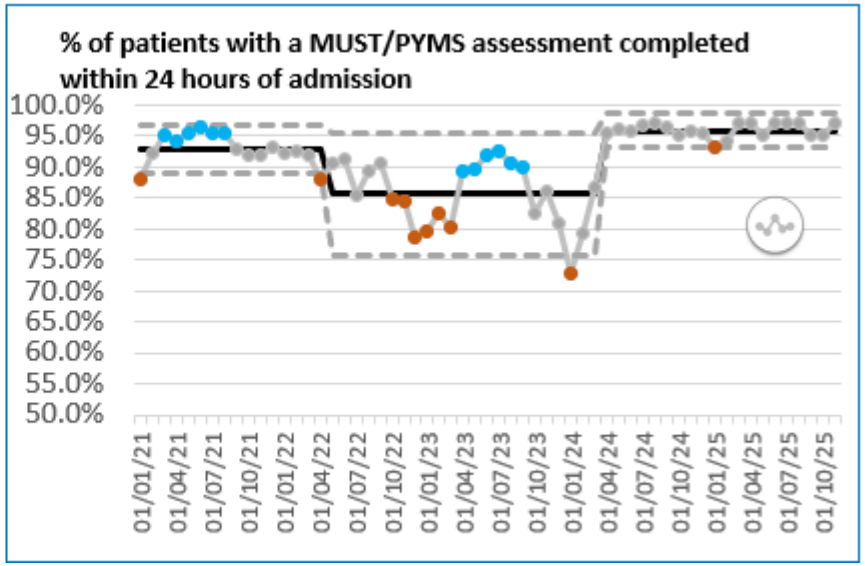
Safe



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

Safe





What

Nutritional assessment (MUST) within 24hrs – 97.0%
% of Patients with a measured weights – 93.0%

The measured weights metric is currently exhibiting common cause variation above established mean. This positive shift reflects the impact of our ability to drill down to ward-level data, which has enabled a more targeted and responsive improvement approach.

Progress and key outcomes are now routinely monitored through monthly performance meetings, ensuring that actions remain aligned with wider quality, safety. This structure supports sustained improvement and early identification of any emerging issues.

The MUST results continue to demonstrate expected natural (common-cause) variation, indicating a stable and reliable process. Performance remains consistently high, supporting the delivery of high-quality nutritional care for our patients. The strengthened collaboration between dietitians and nursing teams is contributing to this positive performance, reflected in sustained compliance and improved patient outcomes

So What?

Good nutrition is an integral component of patient care. Eating well not only provides significant physical benefits but also contributes to a patient's psychological comfort and overall experience during their admission.

Adequate nutrition strengthens the immune response and reduces vulnerability to hospital-acquired infections, supporting safer and more effective recovery. The World Health Organization has also recognised the importance of nutrition, and between 2016–2025 has promoted the broader concept of "food as medicine", emphasising the essential role diet plays in health and healing.

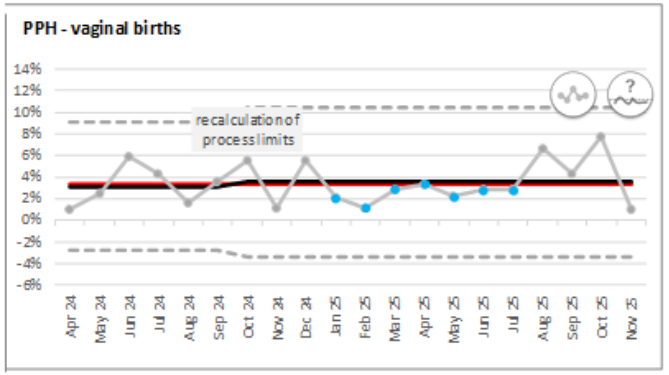
Improving nutritional care remains a key focus for all teams, and there is growing awareness that strong nutritional practice is central to achieving positive patient outcomes.

While effective MUST scoring can be completed using estimated weights, obtaining an actual measured weight remains best practice and supports more accurate assessments. Additional MUST training is available within Tōtara to ensure staff feel confident and competent in applying the tool consistently.

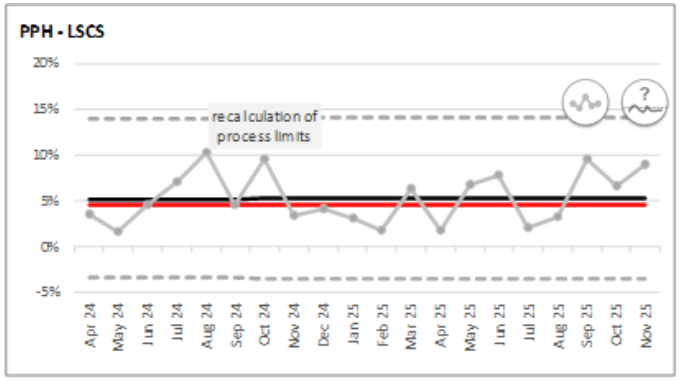
What Next?

- Liaise with Dieticians to monitor impact of any delayed assessments and shared learning from this.
- To build stronger working relationships with Dieticians on the ward, scheduled slot on the medical and surgical ward managers meeting. This relationship improvement is now impacting the data
- Weights on admission is maintaining at a high level, to be further reviewed in January
- Targeted approach continues, with wards now owning their own data and acting on this as required, this is then reviewed at monthly performance.
- Continue focus on the importance of Nutrition, reviewing protected mealtime audit data, looking at conducting peer reviews between wards, this is on hold currently due to IT issues. A fix is now being developed and hopefully should go live in the new year.
- Charitable funding now being resourced for plate guards and adaptative cutlery
- Re launch of the protected mealtimes audit and the importance of this

Safe



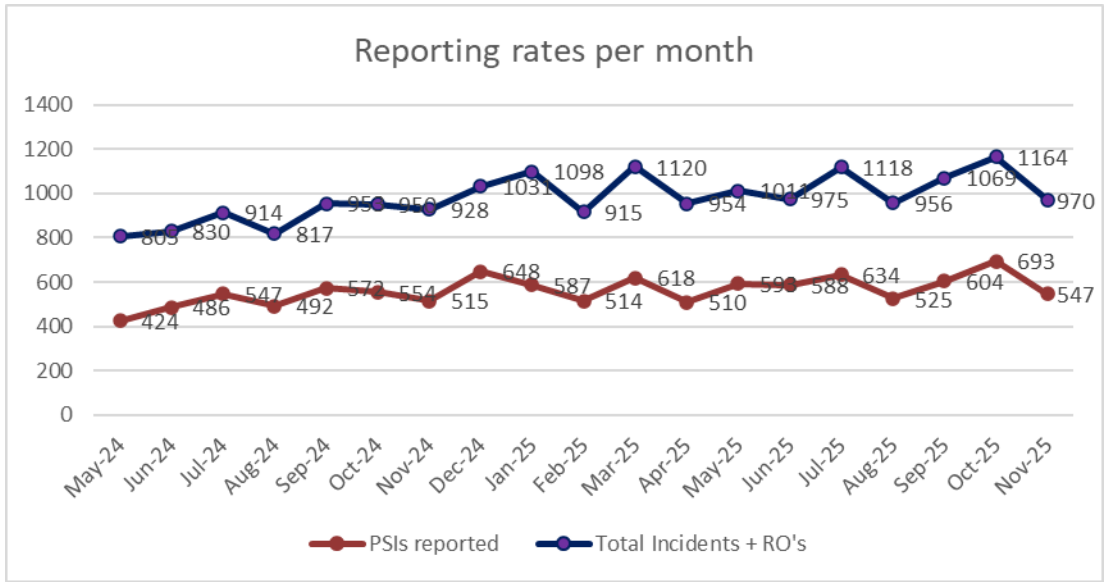
Quarter	Total vaginal births	PPH after vaginal birth	Total Quarterly rate
1 (Apr- Jun 2024)	338	10	3.00%
2 (Jul- Sept 2024)	374	11	2.90%
3 (Oct- Dec 2024)	284	11	3.90%
4 (Jan- Mar 2025)	300	6	2.00%
1 (Apr- June 2025)	347	9	2.60%
2 (Jul- Sept 2025)	331	14	4.20%

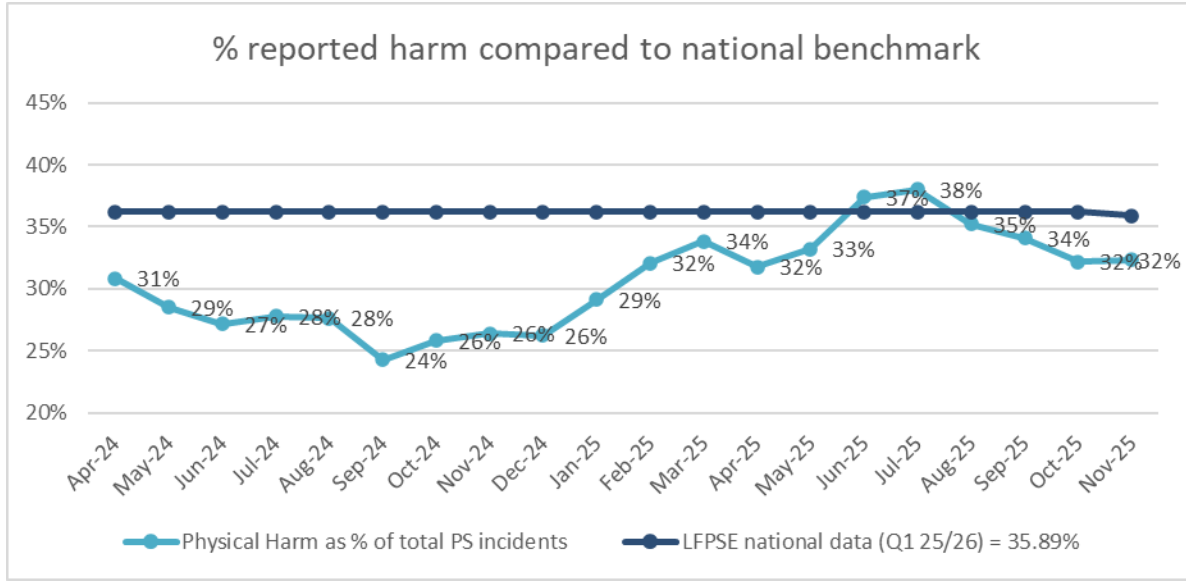


Quarter	Total C. section performed	PPH at CS	Total Quarterly rate
1 (Apr- Jun 2024)	205	9	4.40%
2 (Jul- Sept 2024)	191	12	6.30%
3 (Oct- Dec 2024)	213	11	5.20%
4 (Jan- Mar 2025)	194	6	3.10%
1 (Apr- June 2025)	182	9	4.90%
2 (Jul- Sept 2025)	198	10	5.10%

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

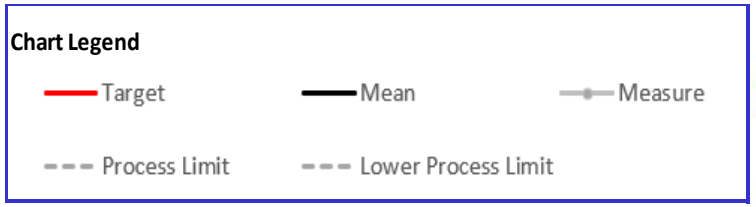
Safe

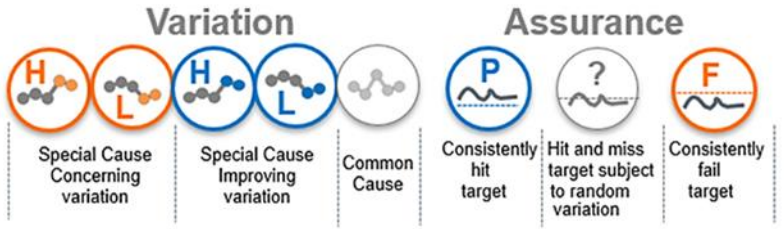




What	So What?	What Next?
In November, there was a decline in reporting rates for incidents and reportable occurrences. Incidents related to bed capacity, information governance, discharge, transfer and follow up, clinical care and treatment, as well as slips, trips and falls, all showed reductions. In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

Mortality Summary

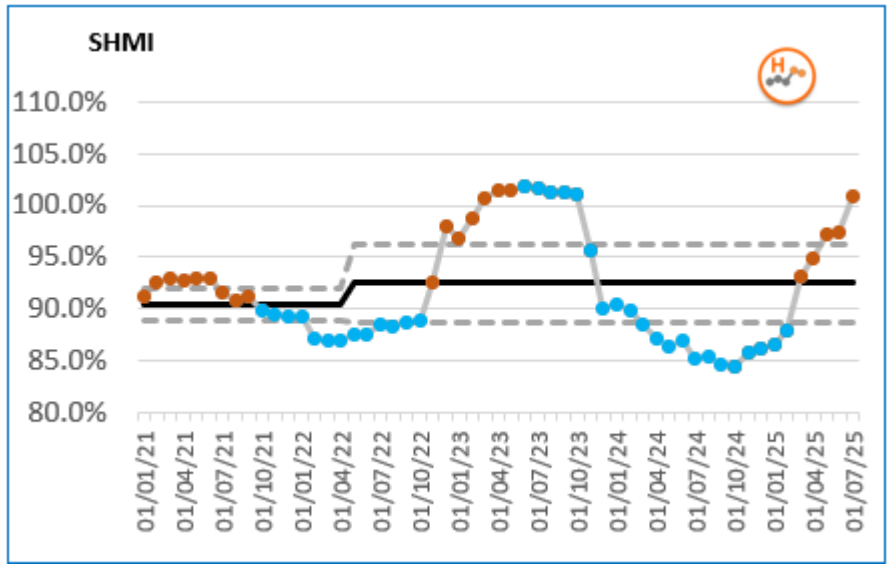


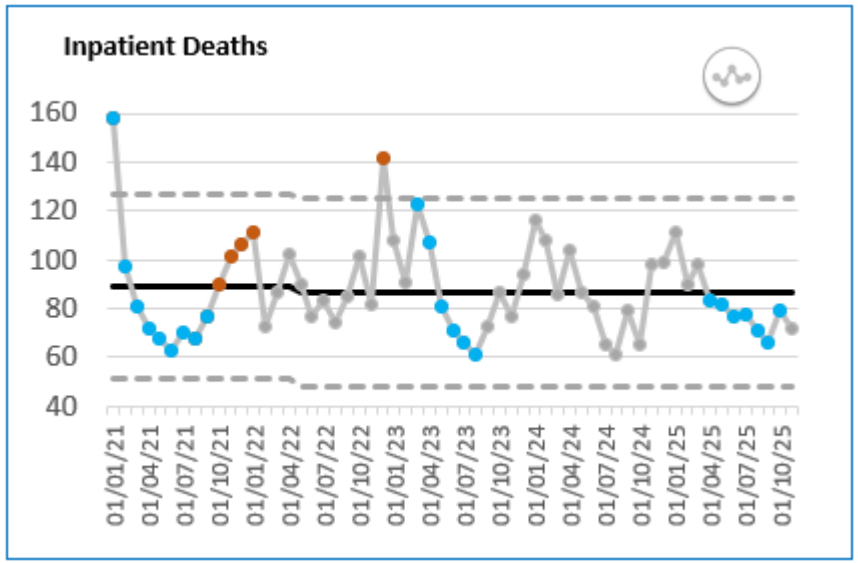


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SHMI	Jul 25	100.9%				92.6%	88.9%	96.3%
Inpatient Deaths	Nov 25	72				87	48	125

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

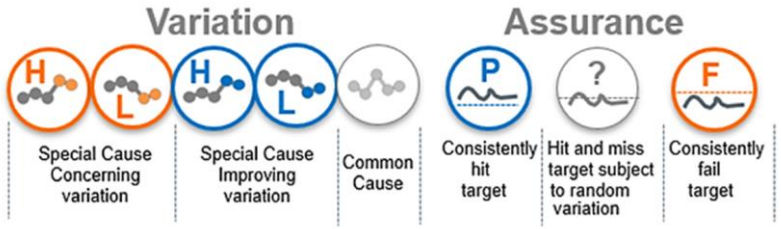
Mortality





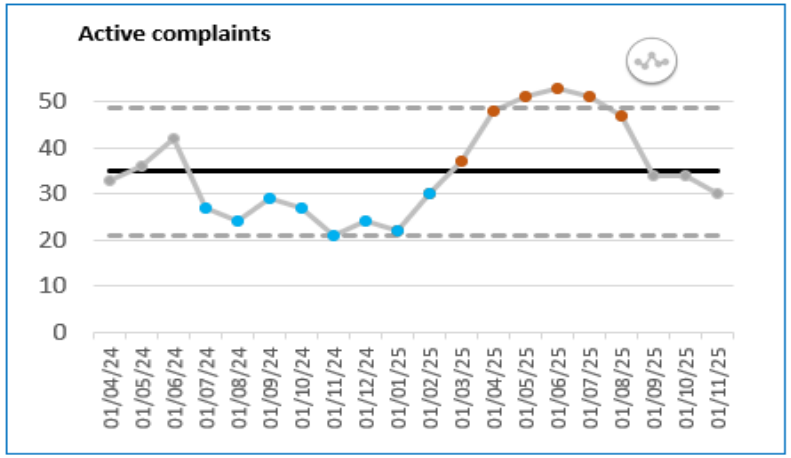
What	So What?	What Next?
This data is showing us that the West Suffolk Foundation Trust (WSFT) SHMI data has had a sudden incline starting in March 2025. SHMI is currently sitting as expected (1.0) The sudden incline appears to be down to a coding error in which there has been a period of uncoded episodes.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

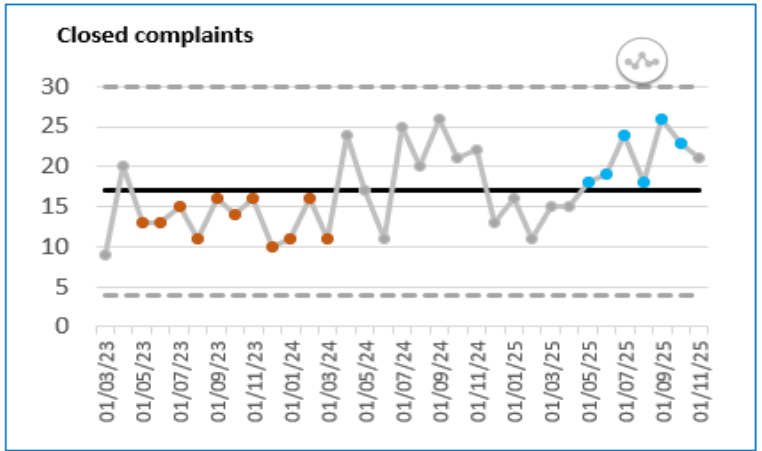
PEOPLE & ORGANISATIONAL DEVELOPMENT COMMITTEE METRICS

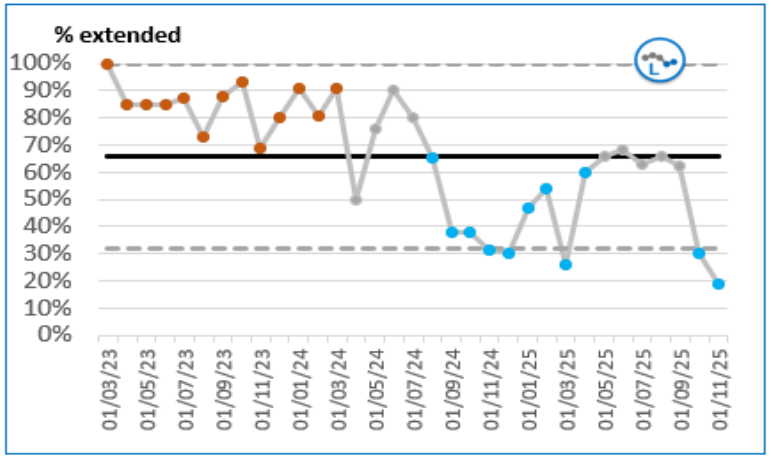


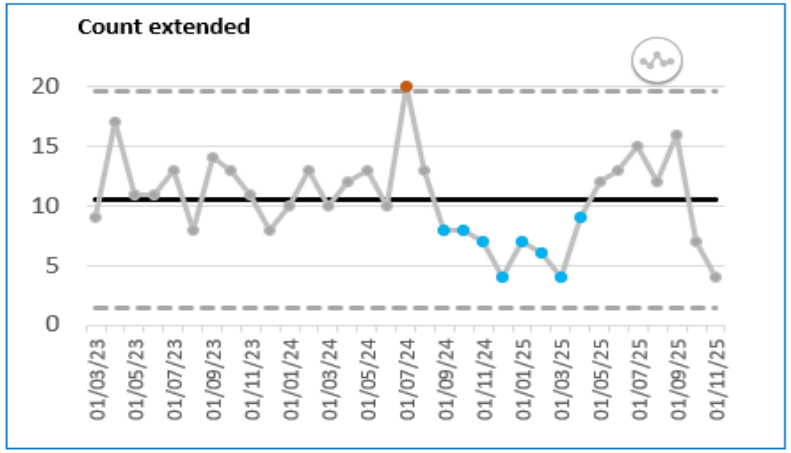
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Active complaints	Nov 25	30	-			35	21	49
Closed complaints	Nov 25	21	-			17	4	30
% extended	Nov 25	19%	-			66%	32%	99%
Count extended	Nov 25	4	-			11	1	20
% Complaints responded to late	Nov 25	5%	-			9%	-19%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

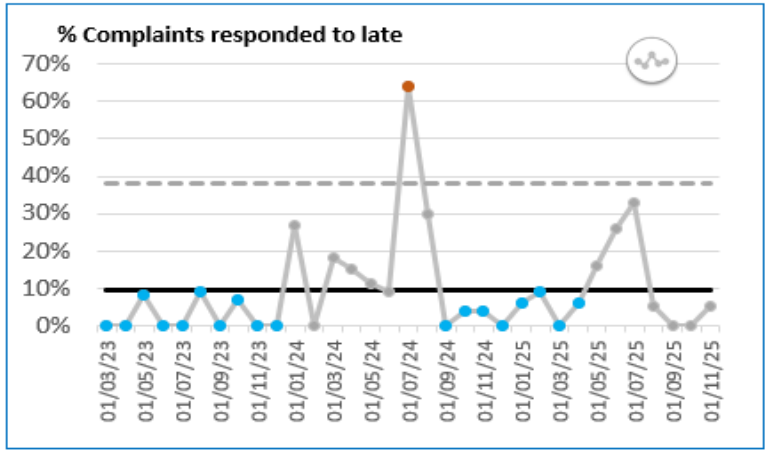
Safe

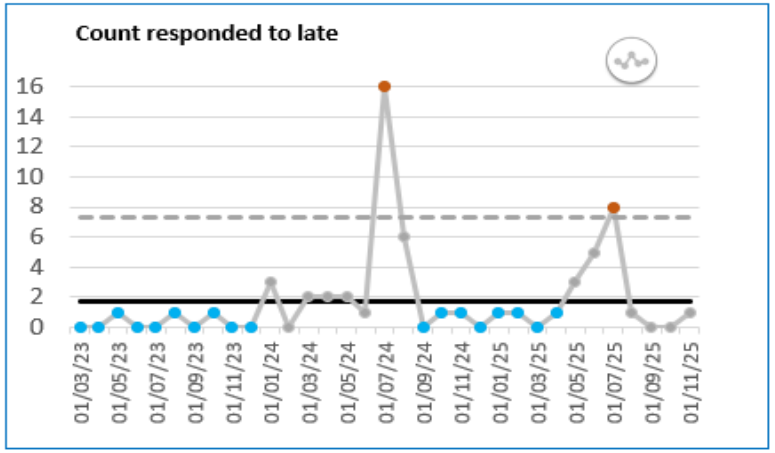

Active complaints
50
40
30
20
10
0
01/04/24
01/05/24
01/06/24
01/07/24
01/08/24
01/09/24
01/10/24
01/11/24
01/12/24
01/01/25
01/02/25
01/03/25
01/04/25
01/05/25
01/06/25
01/07/25
01/08/25
01/09/25
01/10/25
01/11/25

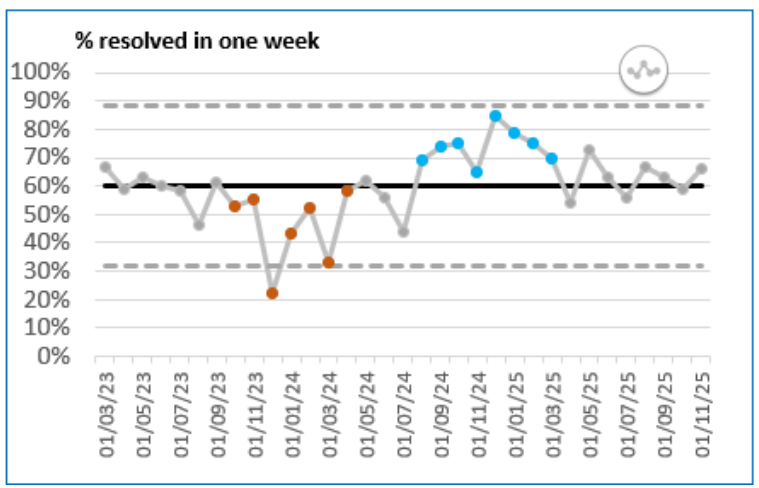

Closed complaints
30
25
20
15
10
5
0
01/03/23
01/05/23
01/07/23
01/09/23
01/11/23
01/01/24
01/03/24
01/05/24
01/07/24
01/09/24
01/11/24
01/01/25
01/03/25
01/05/25
01/07/25
01/09/25
01/11/25

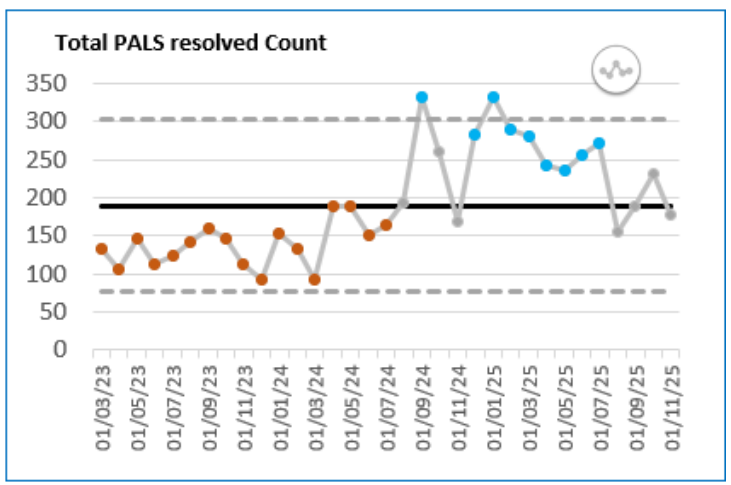

% extended
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
01/03/23
01/05/23
01/07/23
01/09/23
01/11/23
01/01/24
01/03/24
01/05/24
01/07/24
01/09/24
01/11/24
01/01/25
01/03/25
01/05/25
01/07/25
01/09/25
01/11/25


Count extended
20
15
10
5
0
01/03/23
01/05/23
01/07/23
01/09/23
01/11/23
01/01/24
01/03/24
01/05/24
01/07/24
01/09/24
01/11/24
01/01/25
01/03/25
01/05/25
01/07/25
01/09/25
01/11/25


% Complaints responded to late
70%
60%
50%
40%
30%
20%
10%
0%
01/03/23
01/05/23
01/07/23
01/09/23
01/11/23
01/01/24
01/03/24
01/05/24
01/07/24
01/09/24
01/11/24
01/01/25
01/03/25
01/05/25
01/07/25
01/09/25
01/11/25

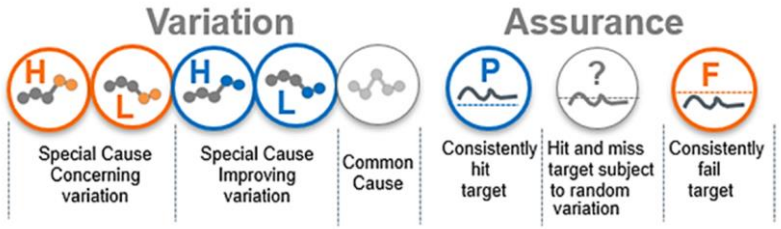

Count responded to late
16
14
12
10
8
6
4
2
0
01/03/23
01/05/23
01/07/23
01/09/23
01/11/23
01/01/24
01/03/24
01/05/24
01/07/24
01/09/24
01/11/24
01/01/25
01/03/25
01/05/25
01/07/25
01/09/25
01/11/25


% resolved in one week
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
01/03/23
01/05/23
01/07/23
01/09/23
01/11/23
01/01/24
01/03/24
01/05/24
01/07/24
01/09/24
01/11/24
01/01/25
01/03/25
01/05/25
01/07/25
01/09/25
01/11/25


Total PALS resolved Count
350
300
250
200
150
100
50
0
01/03/23
01/05/23
01/07/23
01/09/23
01/11/23
01/01/24
01/03/24
01/05/24
01/07/24
01/09/24
01/11/24
01/01/25
01/03/25
01/05/25
01/07/25
01/09/25
01/11/25

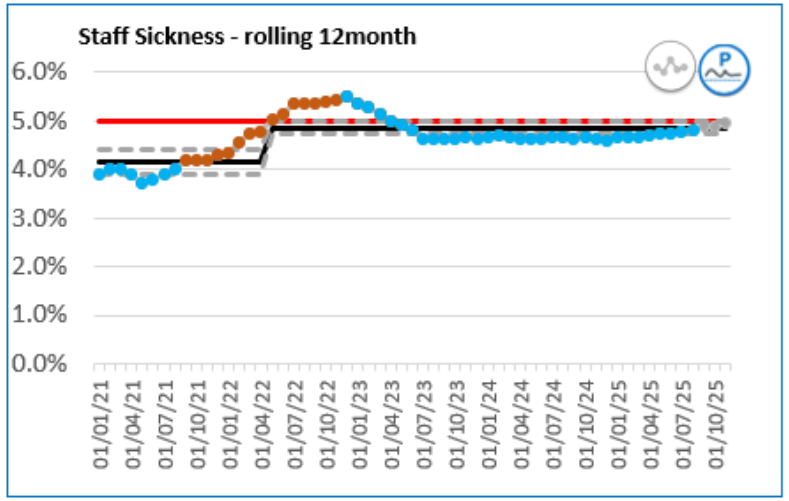
Safe

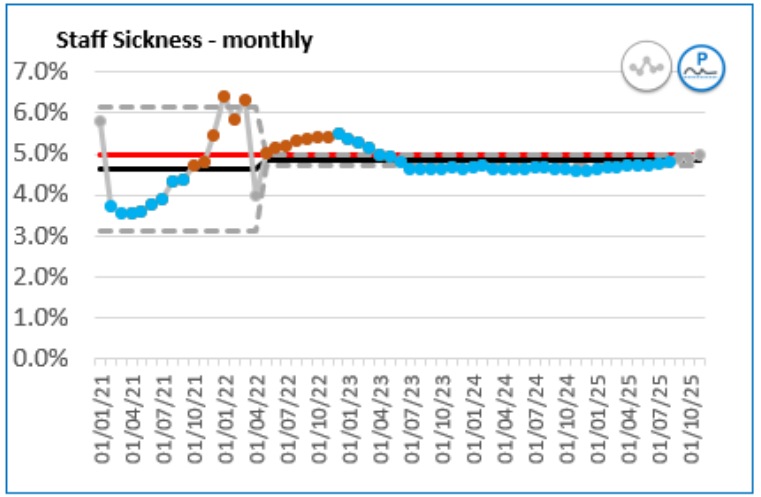
What	So What?	What Next?
Active formal complaints have reduced further with 30 open at the time of reporting whilst the number of resolved complaints reduced slightly, we were able to reduce the current open volume. This is a positive trend and is due to a reduction in new formal complaints received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

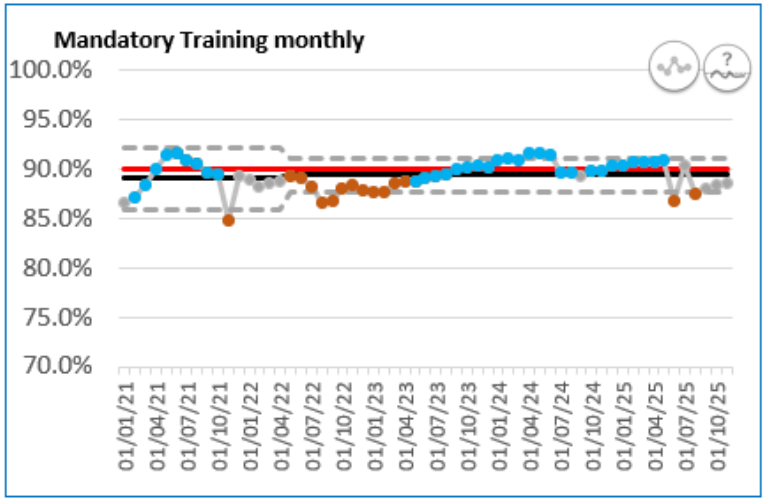


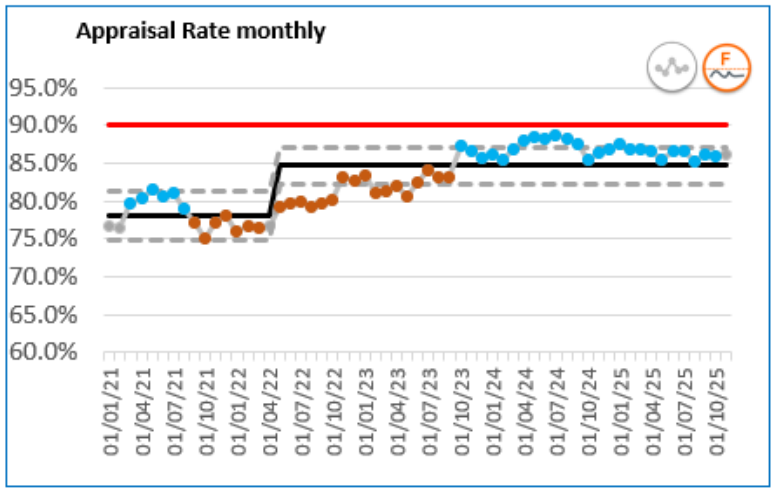
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	Nov 25	5.0%	5.0%		P	4.9%	4.7%	5.0%
Staff Sickness - monthly	Nov 25	5.0%	5.0%		P	4.9%	4.7%	5.0%
Mandatory Training monthly	Nov 25	88.6%	90.0%		?	89.4%	87.7%	91.0%
Appraisal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

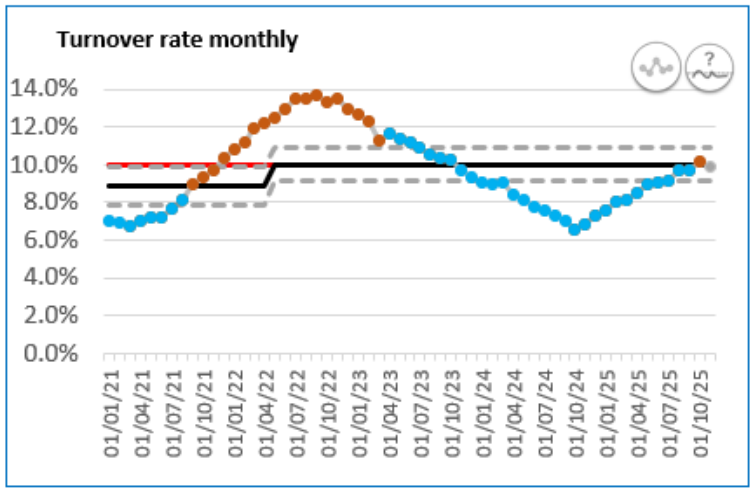
Well Led











What	So What?	What Next?
Sickness – 5% 12-month rolling performance versus 5% target. Mandatory Training – failing target this month at 88.6% versus 90% target. Appraisal – consistently failing target, 86.3% versus 90% target. Turnover – achieving target, 9.9% versus 10% target.	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.	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.

COMFORT BREAK

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

To Assure

Presented by Paul Zollinger-Read

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Quality & Patient Safety Committee (formerly known as the Improvement Committee)			Date of meeting: 17 December 2025		
Chaired by: Dr Paul Zollinger-Read			Lead Executive Director: Dan Spooner – Executive Chief Nurse / Dr Richard Goodwin – Executive Medical Director		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
6.1	Lack of confidence in addressing gaps in legal compliance and safeguarding assurance under the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), especially in community settings, uncertainty whether or not these concerns also apply to inpatient care.	3	Risk of failure to comply with safeguarding regulations	DS / SW To bring a detailed update in March 2026, including process, compliance, and audit findings	1
6.2	Concern was expressed that the Clinical Effectiveness Governance Group (CEGG) is struggling to gain traction on its core responsibilities, with many objectives still marked as 'in development' or 'requiring further progress.'	3	Risk of ineffective clinical effectiveness function	To arrange a meeting in January with key stakeholders (Dr Richard Goodwin, Dan Spooner, Nicola Cottington, Paul Bunn, Dr Paul Zollinger-Read) to agree improvements and clarify responsibilities.	1

Originating Committee: Quality & Patient Safety Committee (formerly known as the Improvement Committee)			Date of meeting: 17 December 2025		
Chaired by: Dr Paul Zollinger-Read			Lead Executive Director: Dan Spooner – Executive Chief Nurse / Dr Richard Goodwin – Executive Medical Director		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board

See guidance notes for more detail

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

2.3. National Patient Survey Report (ATTACHED)

To Assure

Presented by Daniel Spooner

Public Board	
Report title:	CQC Inpatient Survey 2024
Agenda item:	2.3
Date of the meeting:	30 January 2026
Sponsor/executive lead:	Dan Spooner, executive chief nurse
Report prepared by:	Anna Wilson, patient engagement and equalities manager

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

Executive summary:
WHAT? *Summary of issue, including evaluation of the validity the data/information*
This paper highlights the results from the recent CQC Inpatient Survey 2024, summarising key findings, a comparison of the results against other trusts as well as against those from the 2023 survey. This paper is for information following presenttaion at the most recent 'people and OD sub board' [previously known as involvment
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
It is important to acknowledge the areas where the Trust has scored well, as well as highlight the areas of improvement.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
Actions and escalations will be overseen by the Experience of Care and Engagement Committee.
Action required / Recommendation:
Note content of report and escalation (information only) within.

Previously considered by:	N/A
Risk and assurance:	Experience of Care and Engagement Committee has responsibility to oversee.
Equality, diversity and inclusion:	Equitable access to services and care is essential to meet Trust quality priorities and strategic objectives. Specific issues with equal access are highlighted within.
Sustainability:	Patient experience improvements contribute to long-term, sustainable healthcare practices.

Legal and regulatory context:	Equality Act (2010) NHS Constitution (2013) Principle 4 NHS Act (2006) Sections 242, 13Q & 14Z35

1. About this survey

- ✓ Involved 131 NHS acute trusts across England
- ✓ Responses were received from 62,444 people across the country
- ✓ National response rate was 41%
- ✓ 561 WSFT patients responded to the survey
- ✓ WSFT response rate was 47%
- ✓ Trusts sampled patients who met the eligibility criteria and were discharged from hospital during November 2024
- ✓ Fieldwork took place between January and April 2025

2. Methodology

This report provides benchmark results for West Suffolk NHS Foundation Trust, in advance of publication of the 2024 inpatient survey. It contains the scoring and 'banding' (how the Trust performed compared to other trusts that took part).

Each evaluative question is scored on a scale from 0 to 10. The scores represent the extent to which the patient's experience could be improved. A score of 0 is assigned to all responses that reflect considerable scope for improvement, whereas a score of 10 refers to the most positive patient experience possible.

Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. Where options were provided that did not have any bearing on the trust's performance in terms of patient experience, the responses are classified as "not applicable" and a score is not given. Similarly, where respondents stated they could not remember or did not know the answer to a question, a score is not given.

Interpreting our data

Scoring and benchmarking shows how the Trust scored for each evaluative question in the survey, compared with other trusts that took part; using the 'expected range' analysis technique.

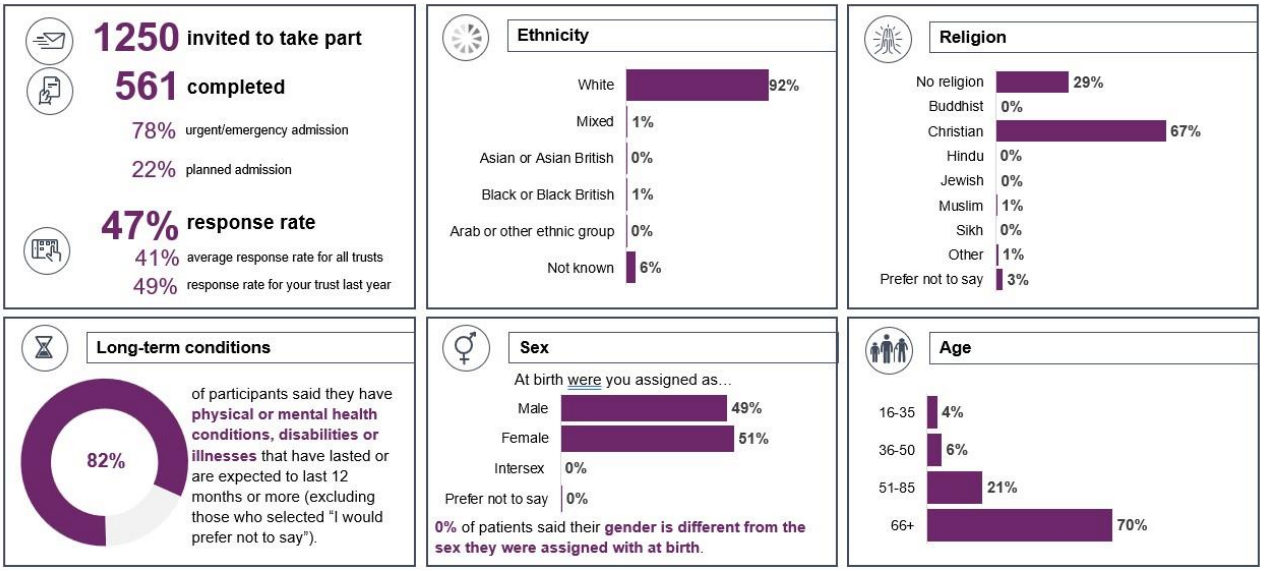
This allows us to see the range of scores achieved and compare ourselves with the other organisations that took part in the survey. Benchmarking can provide us with an indication of where we perform better than the average, and what we should aim for in areas where we may wish to improve.

Section score slides also include a comparison with other trusts in our region. It can be helpful to compare ourselves with regional trusts, so we can learn from and share learnings with trusts in the area who care for similar populations.

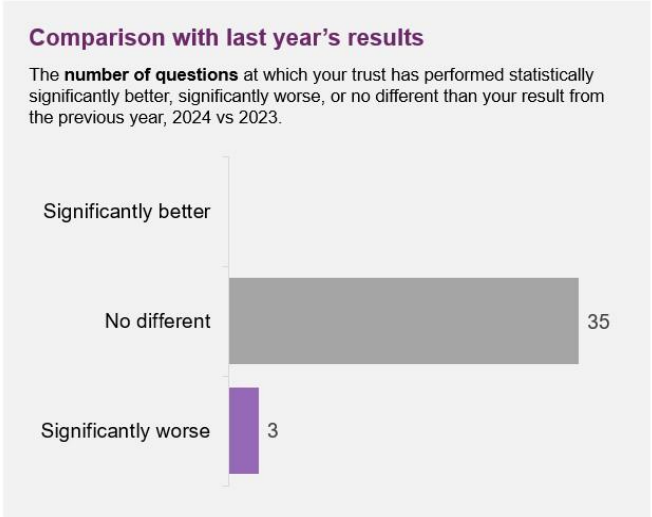
Change over time

This includes the Trust's mean score for each evaluative question across survey years, 2020, 2021, 2022, 2023 and 2024. Significance test tables, below the chart, allows us to see if the Trust has made statistically significant improvements between survey years.

3. Who took part in the survey?



4. Summary of findings



5. Comparison other trusts

Much better than most expected on 0 questions

Better than expected on 1 question

- Q47. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Somewhat better than expected on 3 questions

- Q28. Were you given enough privacy when being examined or treated?
- Q29. Do you think the hospital staff did everything they could to help control your pain?
- Q46. Overall, did you feel you were treated with kindness and compassion while you were in the hospital?

Somewhat worse than expected on 0 questions

Worse than expected on 1 question

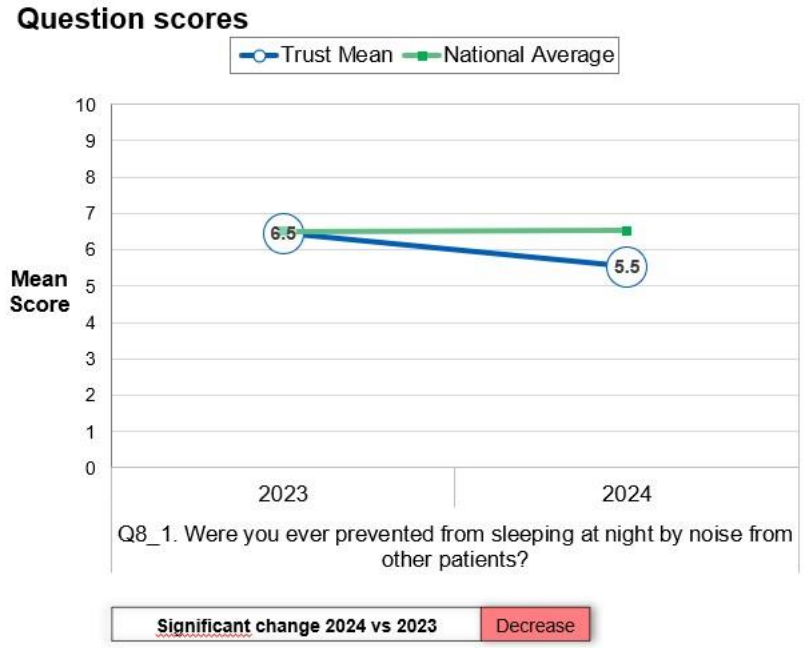
- Q8_1. Were you ever prevented from sleeping at night by any of the following? Noise from other patients

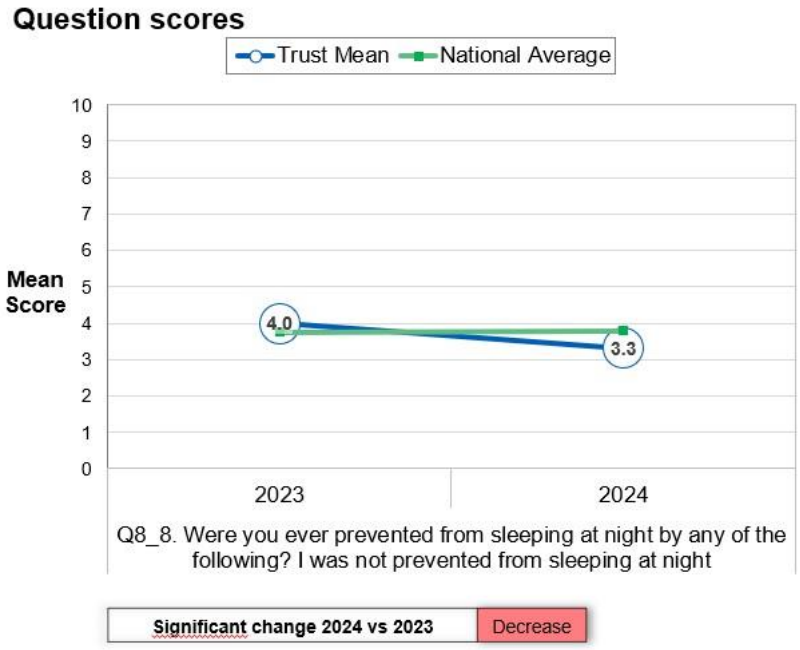
Much worse than expected on 0 questions

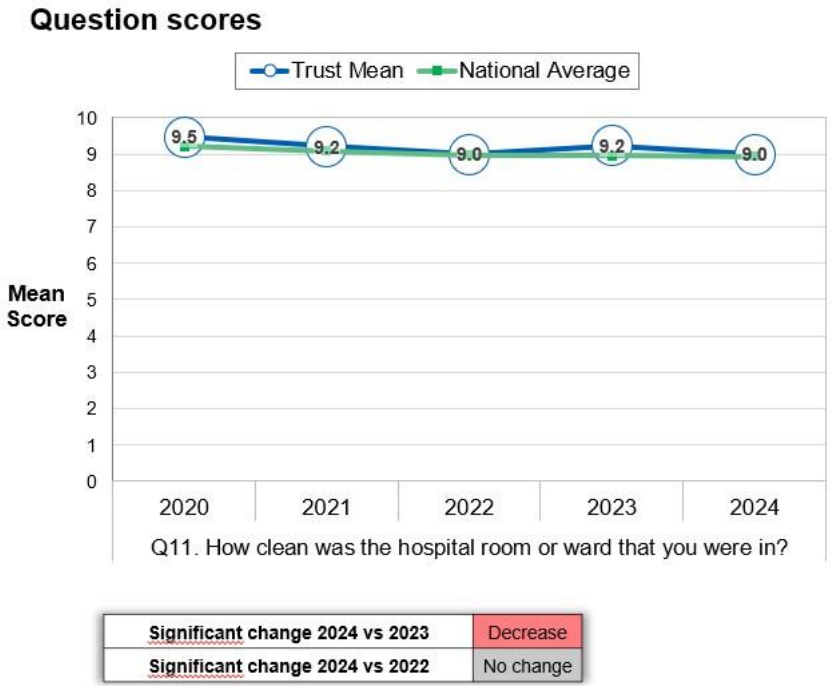
About the same as other trusts on 41 questions

6. Banding - compared to our 2023 results

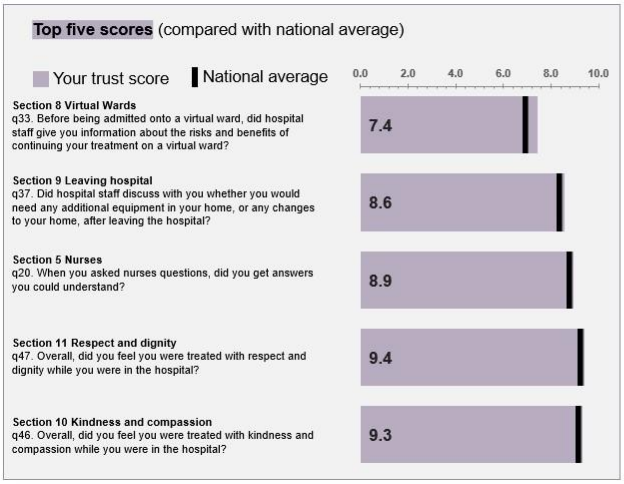
The following 3 questions saw a significant change in our results in 2023:

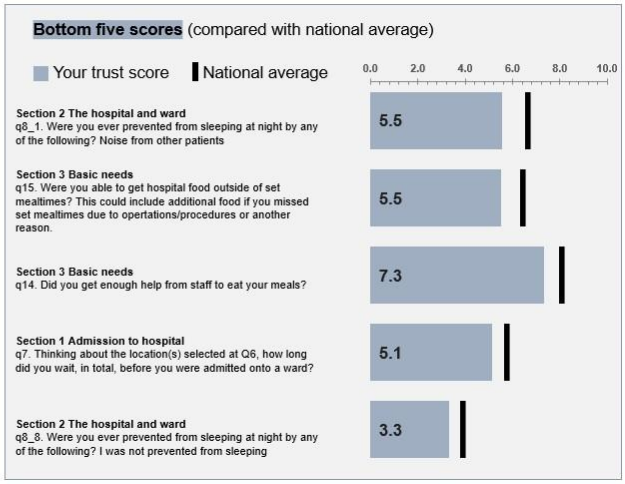






7. Best and worst performance relative to the national average





8. Where patient experience is best, and where it could improve

Where patient experience is best

- ✓ **Information about virtual wards:** Patients getting information about risks & benefits of continuing treatment on virtual wards
- ✓ **Leaving hospital:** Staff discussing with patient whether they would need any additional equipment in their home after leaving
- ✓ **Answers from nurses:** Patients getting answers to their questions from nurses in a way they can understand
- ✓ **Respect and dignity:** Patients feeling they were treated with respect and dignity while they were in hospital
- ✓ **Kindness and compassion:** Patients feeling they were treated with kindness and compassion while they were in hospital

Where patient experience could improve

- ○ **Sleeping:** Patients being prevented from sleeping at night due to noise from other patients
- ○ **Food:** Patients being able to get hospital food outside of set mealtimes
- ○ **Help from staff to eat:** Patients' getting enough help from staff to eat meals
- ○ **Waiting in the hospital:** Length of time waited (in another location) before admission to a ward
- ○ **Sleeping:** Patients not being prevented from sleeping at night

2.4. Quality and Nurse staffing report (ATTACHED)

To Assure

Presented by Daniel Spooner

Public Board	
Report title:	**Nursing and Midwifery safe staffing report:** November and December 2025
Agenda item:	
Date of the meeting:	
Sponsor/executive lead:	**Daniel Spooner: Executive Chief Nurse**
Report prepared by:	**Sarah Ward: Deputy Chief Nurse and Julie Wiggin : PA to DCN**

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

Executive Summary

WHAT?

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

The report provides an overview of safe staffing levels, fill rates, contributory factors, and key quality indicators across inpatient areas for **November and December 2025**. It complies with national quality board (NQB) recommendations to demonstrate effective deployment and utilisation of nursing and midwifery staff. It outlines planned versus actual staffing, highlights areas where staffing shortfalls occurred, and actions to mitigate where possible. The report also reviews vacancy levels, nurse-sensitive quality indicators, and recruitment activity. In addition, it sets out how nursing and midwifery workforce deployment is supporting the Trust's wider financial recovery ambitions.

SO WHAT?

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

- Staffing performance in the period shows increasing trend in sickness absence in both registered and unregistered staff, predominantly related to winter virus.
- Overall fill rates remained stable at 90% across all shifts in months 6 and 7.
- Care Hours Per Patient Day (CHPPD) were consistent but continue to sit in the lower national quartile.
- Newly registered nursing and midwifery graduates have been successfully integrated into established rotas
- Temporary nursing spend is reducing, supported by oversight from the Nursing and Midwifery Deployment Group.

WHAT NEXT?

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

Ongoing embedding and monitoring of temporary staffing spend controls and CIP delivery, with continued oversight of any associated safety risks. Sustained focus on recruiting and retaining nursing assistants to strengthen the unregistered workforce.

Completion of a further community nursing census using the Community Nursing Safer Staffing Tool (CNSST II). Delivery of the next inpatient SNCT census in January 2026, including coverage of the Emergency Department.

Action Required
For assurance regarding the daily management and mitigation of nurse and midwifery staffing and oversight of nursing and midwifery establishments. No action from board required.

Risk and assurance:	Red Risk 4724 amended to reflect surge staffing and return to BAU
Equality, Diversity and Inclusion:	Ensuring a diverse and engaged workforce improves quality patient outcomes. Safe staffing levels positively impacts engagement, retention and delivery of safe care
Sustainability:	Efficient deployment of staff and reduction in temporary staffing and improving vacancy rates contributes to financial sustainability
Legal and regulatory context	Compliance with CQC regulations for provision of safe and effective care

Nurse Staffing Report : November and December 2025.

1. Introduction

1.1 The paper outlines how WSFT managed and deployed its nursing and midwifery workforce during November and December 2025 (M8 and M9). It reviews the impact of staffing levels on key quality indicators such as falls, pressure ulcers and complaints and confirms compliance with national requirements, including CNST midwifery standards. It also highlights ongoing work to review establishments and strengthen cost-effective deployment of the nursing and midwifery workforce.

2. Background

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

3. Key indicators

3.1 **Nursing Fill Rates**

The Trust's safer staffing data has been submitted to NHS Digital for November and December 2025. Table 1. summarises the overall trust fill rate percentages for these months and for comparison, the previous four months. This is monitored at ward level as illustrated in Appendix 1a and 1b. Exception reporting for low and high fill rates is monitored through the Nursing and Midwifery Deployment Group (NMDG) and the daily rhythm of divisional staffing meetings.

	Day		Night	
Average fill rate (planned Vs actual)	Registered	Care Staff	Registered	Care staff
July 2025	91%	96%	96%	99%
August 2025	89%	92%	95%	99%
September 2025	91%	96%	96%	99%
October 2025	90%	90%	96%	100%
November 2025	90%	89%	96%	99%
December 2025	88%	87%	93%	97%

Table 1.

The overall average of 'planned versus actual' staffing fill rates show a stable position across November and December 2025 (Chart 1).

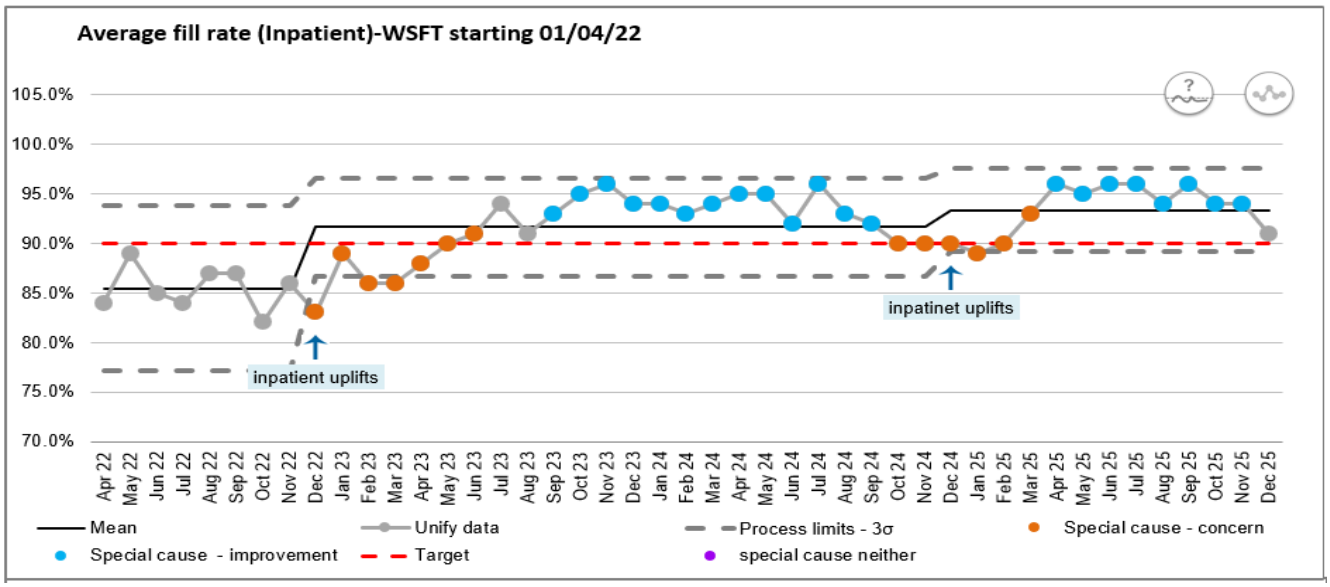


Chart 1.

3.2 **Care hours per patient day**

Model hospital data indicates that WSFT is in the lowest quartile nationally when benchmarked against other organisations with inpatients beds (Appendix 2). This suggests that WSFT provides less care hours per patient than many organisations. When opening additional beds, it is expected that CHPPD will fall. There has been some improvement in this position with a fourteen place positive position change nationally. Assumptions around high sickness, low fill rates and capacity demands would be appropriate when seeing a fall in CHPPD. November achieved CHPPD of 7.6 and December achieved 7.8.

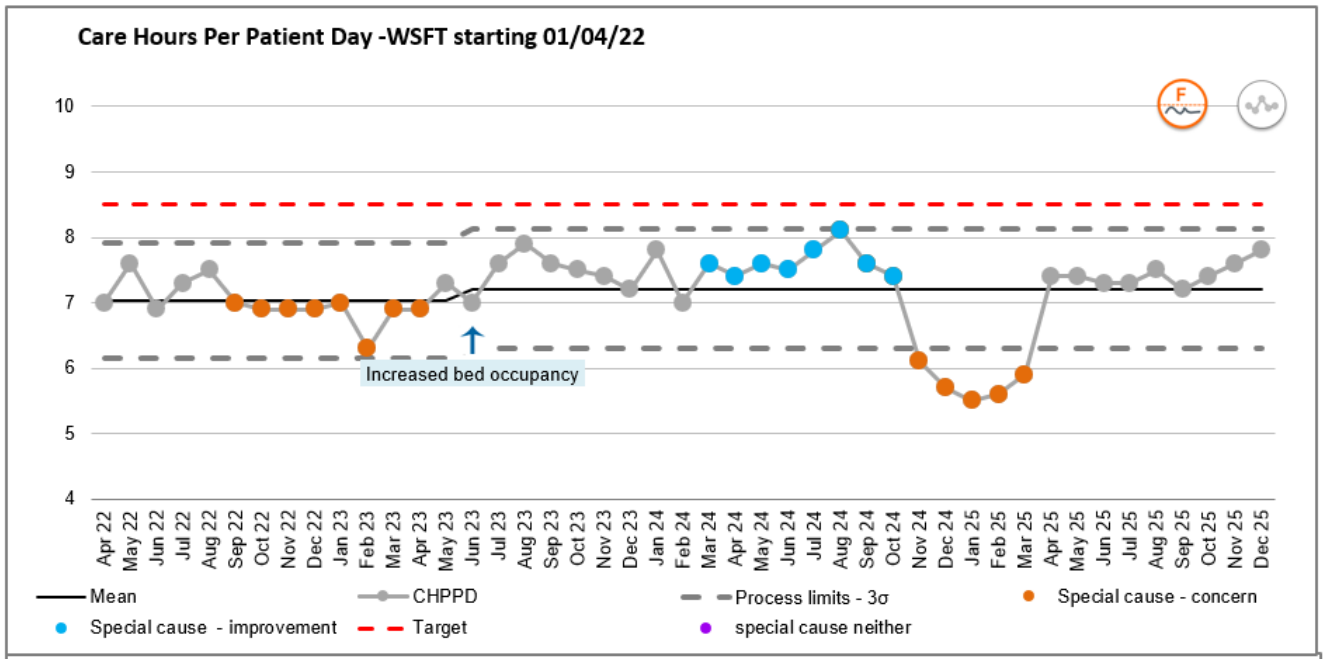


Chart 2.

3.3 **Sickness**

For November and December, sickness absence across the RN/RM workforce remained above 5%. For unregistered staff, absence levels continued to exceed the 5% target, peaking at 8.57% in September. Although there was a reduction in October, sickness rates increased again to 8.24% in December (see Table 2 and Chart 3).

	May 25	June 25	July 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
Unregistered staff (HCSW)	6.62%	6.77%	6.45%	6.66%	8.57%	6.79%	7.21%	8.24%
Registered Nurse/Midwives	4.43%	4.57%	4.32%	4.74%	4.61%	5.28%	5.42%	5.90%
Combined Registered/Unregistered	**5.12%**	**5.26%**	**5.01%**	**5.35%**	**5.87%**	**5.75%**	**5.98%**	**6.63%**

Table 2.

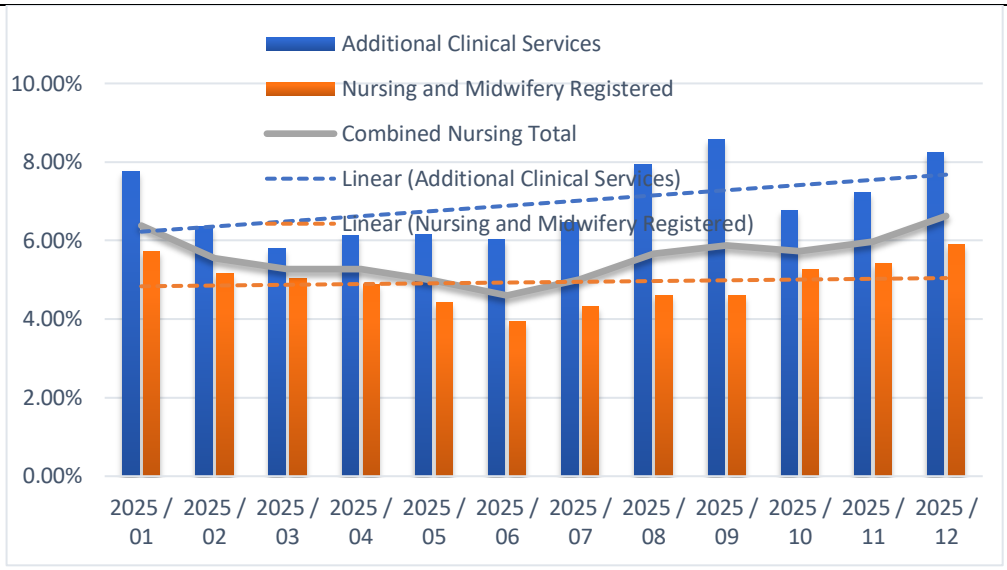


Chart 3.

3.4.1 **Recruitment and Retention**

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

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

- **Inpatient RN/RM** vacancy percentage at M9 is **7.6%** ⇩
- **Total RN/RM** vacancy rate at M9 is **5.8%** ⇩
- **Inpatient NA** vacancy rate at M9 is **10.7%** ⇩
- **Total NA** vacancy at M9 is **10.6%** ⇩

	Sum of Month 4	Sum of Month 5	Sum of Month 6	Sum of month 7	Sum of month 8	Sum of month 9	WTE vacancy at M7
RN	706.2	695.5	691.9	689.8	698.6	698	79.3
NA	385.5	376.2	370.5	361.7	361.9	365.7	51.1

Table 3. Inpatient actual substantive staff WTE

3.4.2 **New Starters**

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

	May 25	June 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25
RN/RM	13	10	7	4	20	12	13	9
NA	11	12	10	3	3	5	12	15

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

- **During November -** 13 registrants attended induction (5 RNs acute, 1 RN bank staff, 6 RNs community). 12 NAs attended induction (10 NAs acute, 1 NA for midwifery, 1 NA community)
- **During December -** 9 registrants attended induction (6 RN acute, 2 RN bank, 1RN community). 15 NAs attended induction (11 NAs acute, 1NA midwifery, 3 NAs community).

3.4.3 **Turnover**

On retrospective review of the last rolling twelve months, turnover for RNs continues positively to be under the ambition of 10%, decreasing to 8.5%. NA turnover continues to be over 10%.

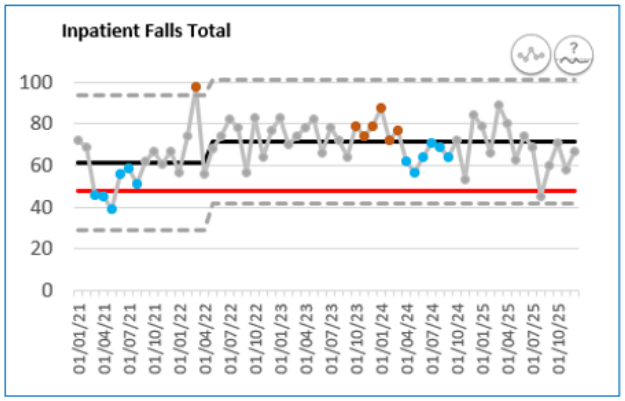
		Turnover	01/01/2025	-	31/12/2025			
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,515.50	1,332.2286	73	59.7600	130	101.2224	8.5780%	7.5980%
Additional Clinical Services	587.00	499.5096	85	75.4933	120	98.3608	20.4429%	19.6915%

Table 5. (Data from workforce information)

3.5 **Quality Indicators**

Falls and acquired pressure ulcers

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



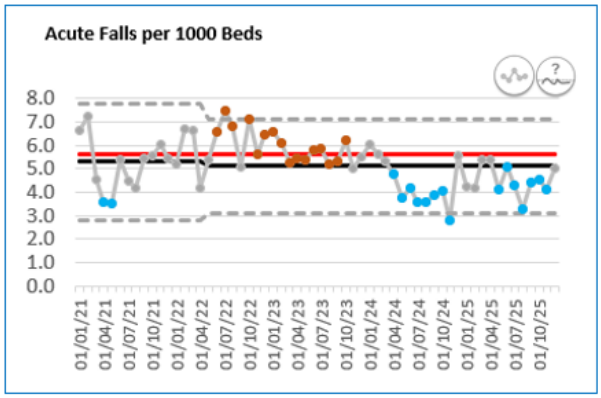
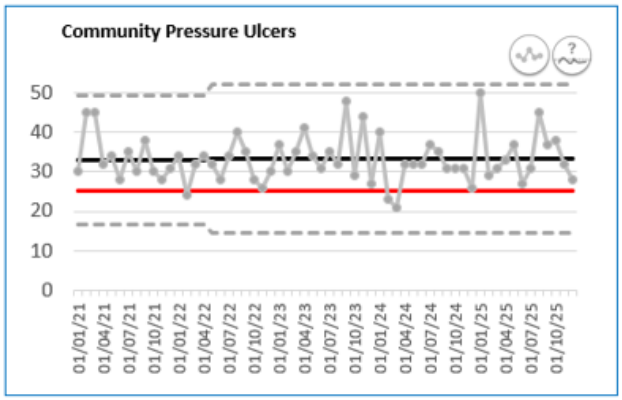


Chart 4. inpatient falls

Pressure ulcers remain in common cause variation and the spike seen in January 2025 has fallen to normal variation.



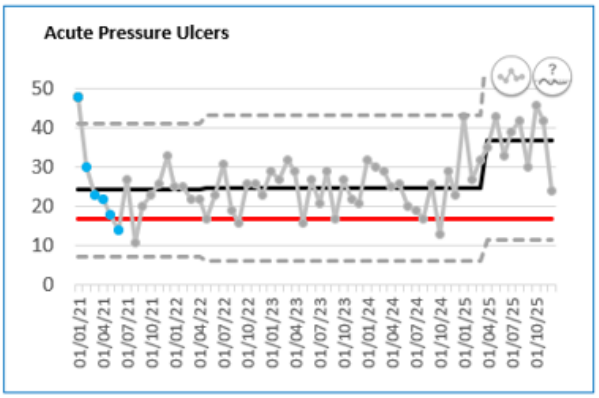


Chart 5. Pressure ulcers acquired in care

3.6 **Staffing incidents**

Following a reduction in October, November and December saw an increase. (Chart 6.below).

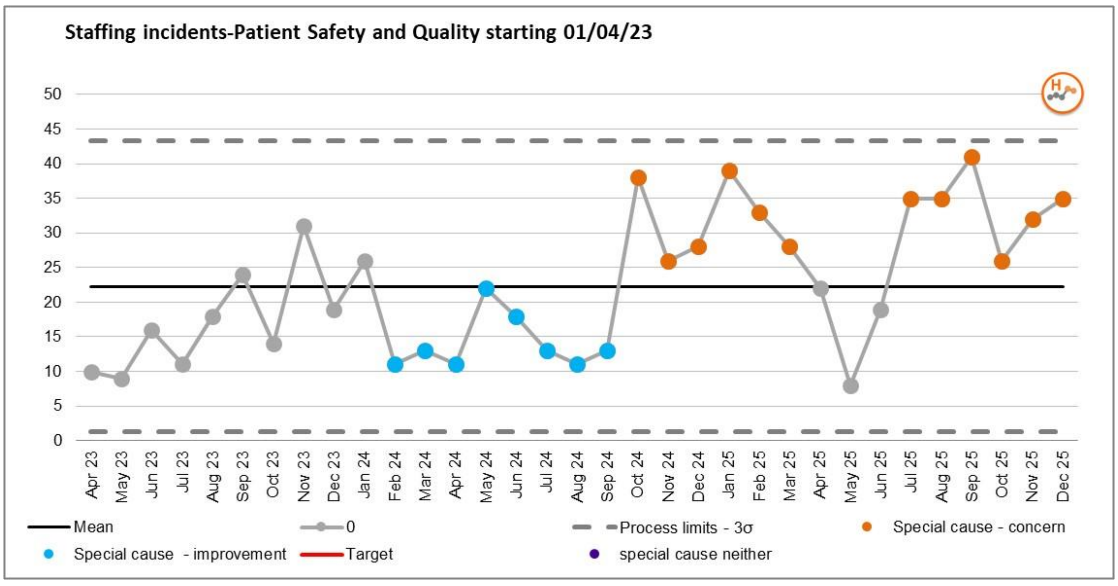


Chart 6.

Red flags as per NQB (Appendix 4) have been reported via RADAR from M9 24/25 (Chart 7). November-December 2025 saw significantly more staffing incidents reported. The most common Red Flag event reported was inpatient nurse staffing shortfall impacting on care.

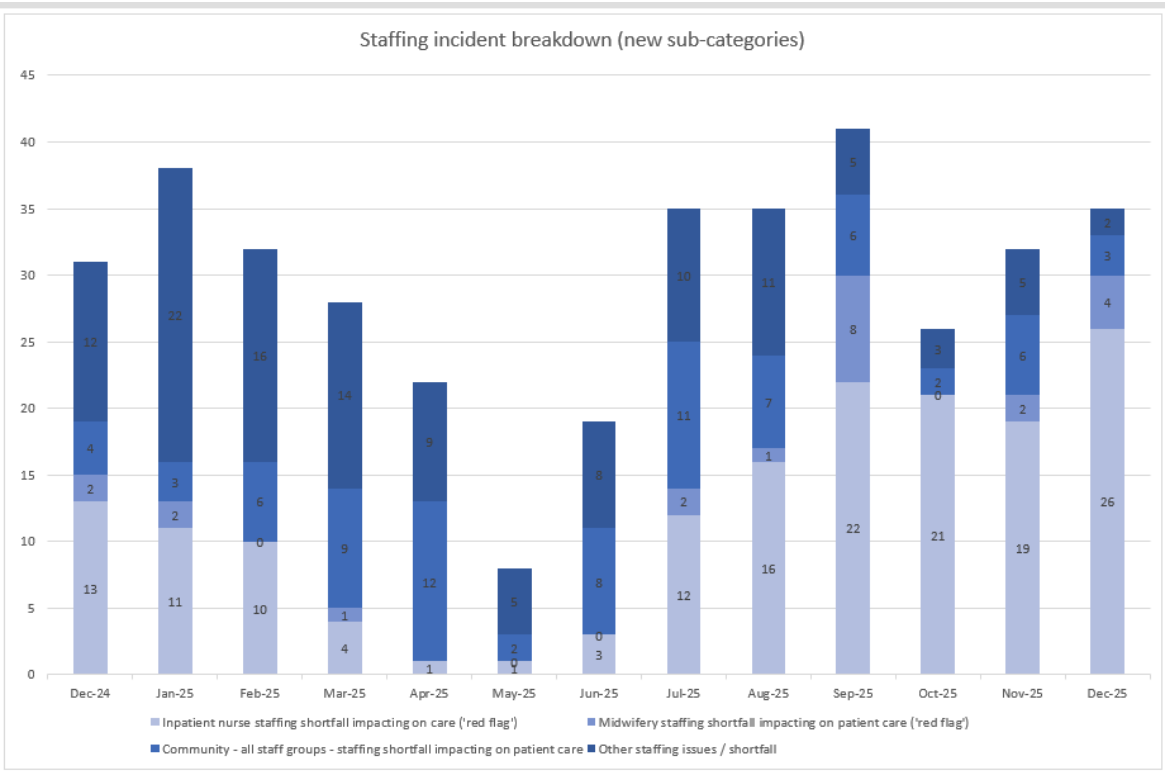


Chart 7.

3.7 **Maternity services**

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

1:1 Care in Labour

NICE's guidance on safe staffing recommends safe midwifery staffing levels for women, birthing people and their babies in their chosen setting. This recommendation is also one of the ten safety actions published as part of the Maternity Incentive Scheme. 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 November and December 2025.

Red Flag events

NICE safe midwifery staffing for maternity settings (2015), defines Red Flag events as events that are immediate indications that something is wrong, and action is required to prevent the situation deteriorating. Action includes escalation to the senior midwife in charge of the service, and the response includes allocating additional staff to the ward or unit. All Red Flag events are recorded in RADAR and addressed during the daily Maternity Safety Huddle, where they are highlighted and mitigated as necessary.

Two Red Flags were reported in November 2025, one for a delay during induction of labour process and another for an unachievable workload booked on the elective caserean theatre list. Although there were three theatre cases scheduled, one patient required significantly increased support due to complex needs including autism, which impacted the teams ability to complete the list within the planned timeframes. All four red flags in December 2025 were attributed to delays in the induction process over an 11 day period.

Midwife to Birth ratio

The latest BirthRate Plus® review was undertaken in March 2023 and illustrated that Midwife demand to Birth ratio at West Suffolk NHS Foundation Trust has reduced to 1:21. The ratios are based on the Birthrate Plus® dataset, national standards with the methodology and local factors, such as percentage uplift for annual, sickness and study leave, case mix of women birthing in hospital, provision of

outpatient/day unit services, total number of women having community care irrespective of place of birth and primarily the configuration of maternity services.

- November 2025 Midwife to birth ratio demand rose to 1:19, achieving target ratio.
- December 2025 there has been a delay with IT reports, we will report December's data in addition in the next maternity service review.

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 November and December.

	Standard	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Supernumerary Status of LS Coordinator	100%	100%	100%	100%	100%	100%	100%	100%
1-1 Care in Labour	100%	100%	100%	100%	100%	100%	100%	100%
MW: Birth Ratio	1:21	1:19	1:18	1:18.8	1:23	1:20	1:19	-
No. Red Flags reported	NA	0	2	1	8	3	2	4

Table 6.

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

Sickness & Turnover
Sickness in the division is 5.4% overall, however, there are areas of high sickness. For nursing, Rosemary Ward and INT teams this is much higher than trust target. A specific quality improvement approach to address high sickness levels in the INTs has commenced. While there are some minor rapid improvement opportunities, it is felt the sickness is related to the high workload in the teams.

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

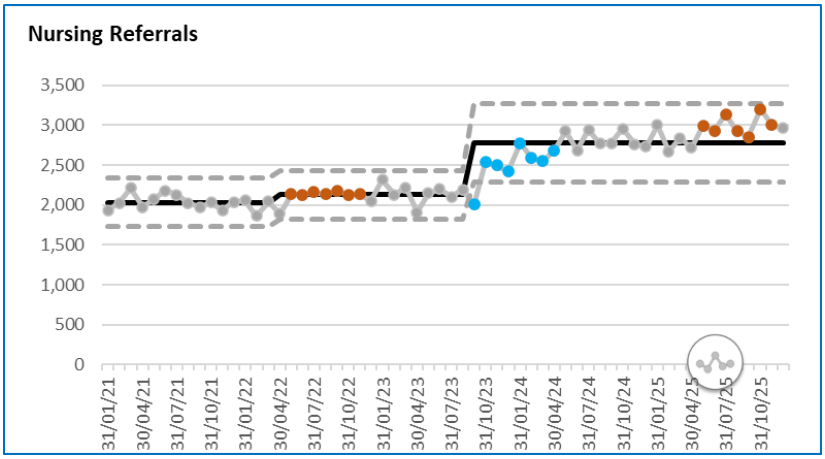


Chart 8.

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

the community equivalent of corridor care and is a “red flag” from the Queens Nursing Institute. Deferred or cancelled care is approximately 5-10% of the total care delivered. Senior matrons monitor the clinical impact which currently shows this is associated with a low level of harm.

CNSST II

The relaunched Community Nursing Safer Staffing Tool provided census data in July 2025 and will be repeated from 28th January 2026. The triangulation of CNSST data informed redeployment of staffing resource to mitigate risk. A business case is in development to be presented to investment panel in February 2026 to support the underlying deficit.

Run rates in community and integrated therapies division.

Chart 9 below shows headcount has significantly reduced (12.6%) to achieve financial stability while manging a rising demand.

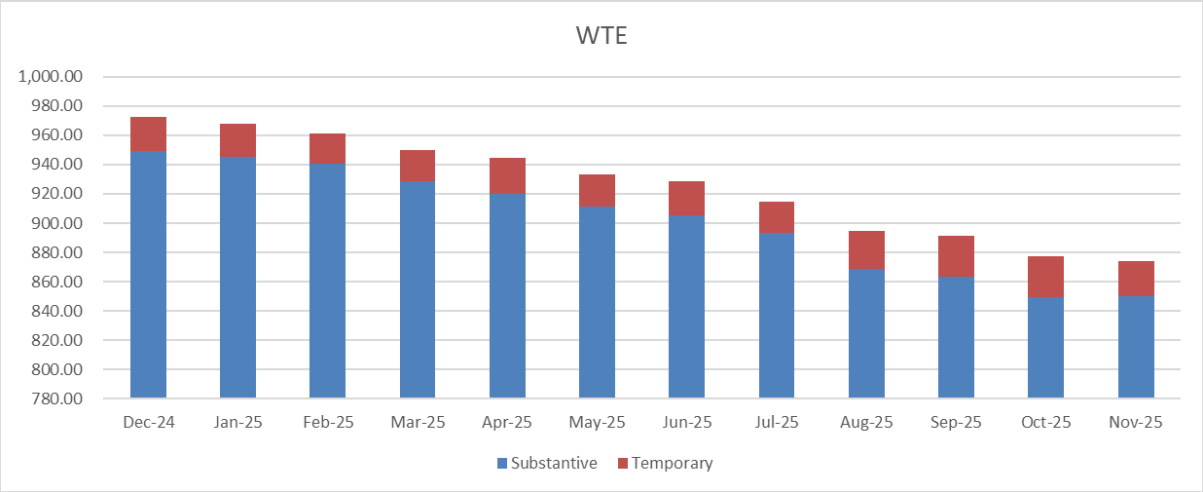


Chart 9.

Community based actions

- CNSST census Jan-Feb
- Productivity workstreams continue (maximising virtual appointment, geographical efficiency, streamline documentation, maximise skill mix).
- INT sickness project.
- QI project to improve documentation quality.
- Protocol adopted for safe deferral of care to be monitored in INTS
- Business case for community nursing to investment panel.

4. Next steps/Challenges

4.1 **Nursing resource oversight group**

The Nursing Deployment Group continue to meet monthly to review best practice methods of deploying staff and to reduce the temporary nursing spend.

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

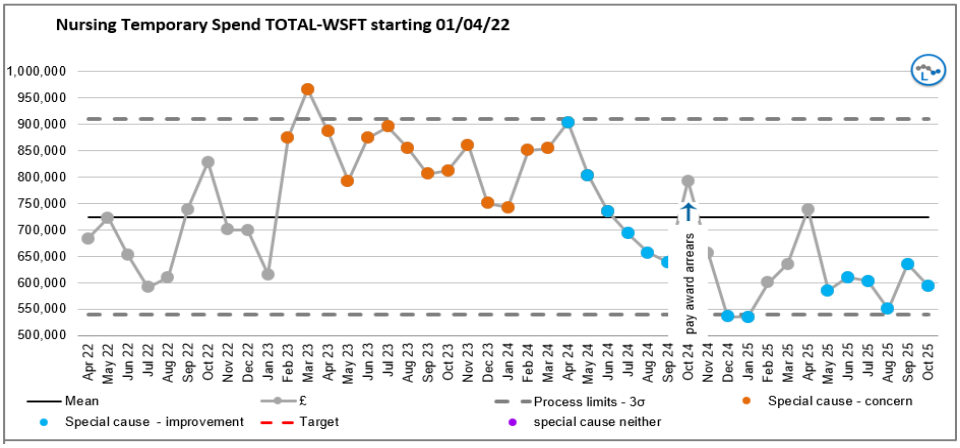


Chart 10.

4.2	**SNCT Biannual inpatient review** The winter inpatient establishment census data will be collected throughout January to include the Emergency Department. The census data will continue to inform our assurance of nurse staffing levels and inform recommendations.
4.3	**Newly registering student recruitment** We maintain our commitment to support newly registered nursing and midwifery colleagues to transition into the workforce and strong partnerships with educational institutions and system partners, in line with national commitments. A recruitment plan for the 2026 qualifying cohorts will be agreed at PQASG in January.
5.	**Conclusion**
5.1	The Trust continues to demonstrate a proactive and data-driven approach to nursing and midwifery workforce management. Recruitment of registered nurses remains positive, with vacancy rates consistently below 10%, while nursing assistant recruitment shows signs of stabilisation. The Trust's commitment to financial sustainability is evident through ongoing efforts to reduce temporary staffing spend and optimise deployment. Continued focus on quality indicators, safe staffing compliance, and strategic workforce planning is essential to maintaining high standards of patient care and supporting the Trust's recovery ambitions.
6.	**Recommendations**
	For the board to take assurance regarding the daily management of our nurse and midwifery staffing resource and oversight of nursing and midwifery establishments to ensure patient safety.

Appendix 1a. Fill rates for inpatient areas (November 2025) Data adapted from NHSE Unify submission.
RAG: Red <79%, Amber 80-89%, Green 90-100%, Purple >100

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1379	1302.916667	1724.75	1450.25	1035	1010	1380	1320	94%	84%	98%	96%	933	2.5	3.0	5.4
Acute Assessment Unit	2296	2276.333333	1987.75	1826.3333	1713.5	1720.5	1368.5	1343.8333	99%	92%	100%	98%	738	5.4	4.3	9.7
Cardiac Centre	1717.16667	1516.166667	1035	755.5	1725	1667.5	680	668.5	88%	73%	97%	98%	641	5.0	2.2	7.2
G10	1719	1444.083333	1715	1547.8333	1035	1018.75	1725	1630	84%	90%	98%	94%	953	2.6	3.3	5.9
G9	1725	1640	1380.5	1220	1380	1380	1035	1009.5	95%	88%	100%	98%	792	3.8	2.8	6.6
F12	677.25	645.25	339.5	310.75	690	674.5	311.5	277	95%	92%	98%	89%	229	5.8	2.6	8.3
F7	1591.5	1351	1711.5	1613.25	1305.5	1154.5	1725	1551	85%	94%	88%	90%	966	2.6	3.3	6.1
G1	954	754.25	345	204.5	690	689.5	345	333.5	79%	59%	100%	97%	355	4.1	1.5	5.6
G3	1698.5	1430.5	1719.5	1693.75	1035	1023.5	1380	1566.5	84%	99%	99%	114%	984	2.5	3.3	5.8
G4	1725.5	1511.5	1716.5	1573.5	1035	993.5	1380	1444.5	88%	92%	96%	105%	955	2.6	3.2	5.8
G5	1426	1402.25	1674.25	1317.5	1035	997.5	1380	1351.5	98%	79%	96%	98%	963	2.5	2.8	5.3
G8	2203.91667	1737.733333	1817.5	1564.25	1633	1542.4	1122	1030.9333	79%	86%	94%	92%	829	4.0	3.1	7.1
F8	1690	1466.166667	1704	1606.6667	1035	975.9166667	1380	1563	87%	94%	94%	113%	0	*	*	*
Critical Care	2340	2221.916667	142.5	141.25	2288.5	2115.25	0	11	95%	99%	92%	*	213	20.4	0.7	21.1
F3	1725	1524.5	1693.5	1427	1035	1044	1372.5	1356	88%	84%	101%	99%	887	2.9	3.1	6.0
F4	591.75	717.25	465.5	347.25	609.5	578	0	34.5	121%	75%	95%	*	171	7.6	2.2	10.2
F5	1374.5	1352	1379	1270	1035	998.3333333	1023.5	939	98%	92%	96%	92%	440	5.3	5.0	10.4
F6	1656	1491.083333	1636	1465.5	1035	1025.5	1334	1355.5	90%	90%	99%	102%	880	2.9	3.2	6.2
Neonatal Unit	1718.5	1504.5	306	345	1080	1015.25	576	504	88%	113%	94%	88%	280	9.0	3.0	12.0
F1	2117	1764.75	688.25	676.75	1380	1322.25	0	23	93%	98%	96%	*	231	13.4	3.0	16.4
F14	360	384	360	345	720	709	0	0	107%	96%	98%	*	118	9.3	2.9	12.2
Total	**32,685.58**	**29,438.15**	**25,541.50**	**22,701.83**	**24,530.00**	**23,655.65**	**19,518.00**	**19,312.77**	**90%**	**89%**	**96%**	**99%**	**12,558**	**4.2**	**3.3**	**7.6**

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

Appendix 1b. Fill rates for inpatient areas (December 2025) 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	1430.75	1371.25	1786.25	1427.5	1069.5	1059	1419	1303.5	96%	80%	99%	92%	983	2.5	2.8	5.3
Acute Assessment Ur	2367.25	2345.416667	2042	1855.9167	1764.5	1739.5	1403	1322.5	99%	91%	99%	94%	765	5.3	4.2	9.5
Cardiac Centre	1777.5	1526.5	1061	848.5	1782.5	1595	713	715.5	86%	80%	89%	100%	654	4.8	2.4	7.2
G10	1777.75	1468.333333	1766.25	1543.75	1069.5	986.25	1782.5	1677	83%	87%	92%	94%	911	2.7	3.5	6.2
G9	1736.5	1557	1426	1296.25	1403	1367.5	1069.5	1070.5	90%	91%	97%	100%	797	3.7	3.0	6.7
F12	713	705.5	356.5	329.5	713	628	356.5	356.5	99%	92%	88%	100%	229	5.8	3.0	8.8
F7	1552.5	1352	1777.5	1420	1345.5	1105	1782.5	1620	87%	80%	82%	91%	978	2.5	3.1	5.6
G1	1000.5	784	356	334.5	713	713	356.5	322	78%	94%	100%	90%	356	4.2	1.8	6.0
G3	1777.5	1448.5	1777.5	1556	1069.5	1035	1426	1473	81%	88%	97%	103%	973	2.6	3.1	5.7
G4	1777.5	1546.5	1782.25	1659.75	1069.5	966	1426	1518	87%	93%	90%	106%	950	2.6	3.3	6.0
G5	1565	1433.25	1764.5	1305	1069.5	957.5	1426	1421	92%	74%	90%	100%	957	2.5	2.8	5.3
G8	2302	1761.25	1921.75	1588.4167	1702	1650.466667	1150	1069.5	77%	83%	97%	93%	830	4.1	3.2	7.3
F8	1777.5	1460.5	1767	1526.5	1069.5	970.5	1426.5	1437.3333	82%	86%	91%	101%	0	*	*	0.0
Critical Care	2673.75	2339.75	165	128.5	2620	2289.416667	0	11.5	88%	78%	87%	-	214	20.4	0.7	21.1
F3	1717	1428.75	1765.75	1526.5	1069.5	1003.666667	1426	1421.5	83%	86%	94%	100%	817	3.0	3.6	6.6
F4	706.5	680.3333333	474.08333	426.58333	690	553.5	0	23	96%	90%	80%	-	182	6.8	2.5	9.2
F5	1501.66667	1429.833333	1377.3333	1274.5833	1046.5	989	1012	980	95%	93%	95%	97%	375	6.5	6.0	12.5
F6	1588.36667	1405.583333	1673	1490.5	1046.5	1033	1346	1321	88%	89%	99%	98%	815	3.0	3.4	6.4
Neonatal Unit	1686.5	1803.583333	364.5	441	1044	1122.5	660	552	107%	121%	108%	84%	253	11.6	3.9	15.5
F1	2233.5	1775.25	713	731.25	1426	1380	0	15.75	79%	103%	97%	-	251	12.6	3.0	15.5
F14	372	379	372	372	744	720	0	0	102%	100%	97%	-	105	10.5	3.5	14.0
Total	**34,034.53**	**30,002.08**	**26,489.17**	**23,082.50**	**25,527.00**	**23,863.80**	**20,181.00**	**19,631.08**	**88%**	**87%**	**93%**	**97%**	**12,395**	**4.3**	**3.4**	**7.8**

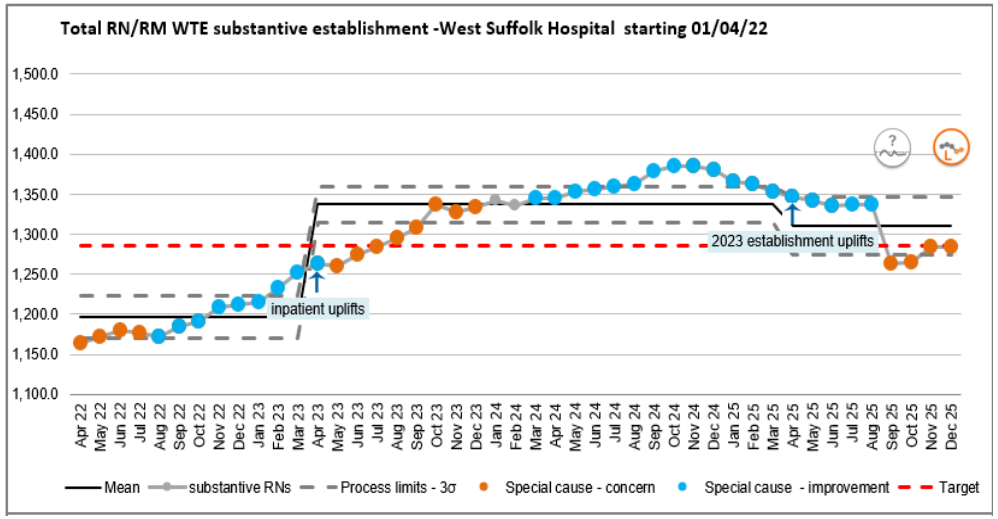
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours

Appendix 2. CHPPD Model Hospital data (accessed 15.1.26)

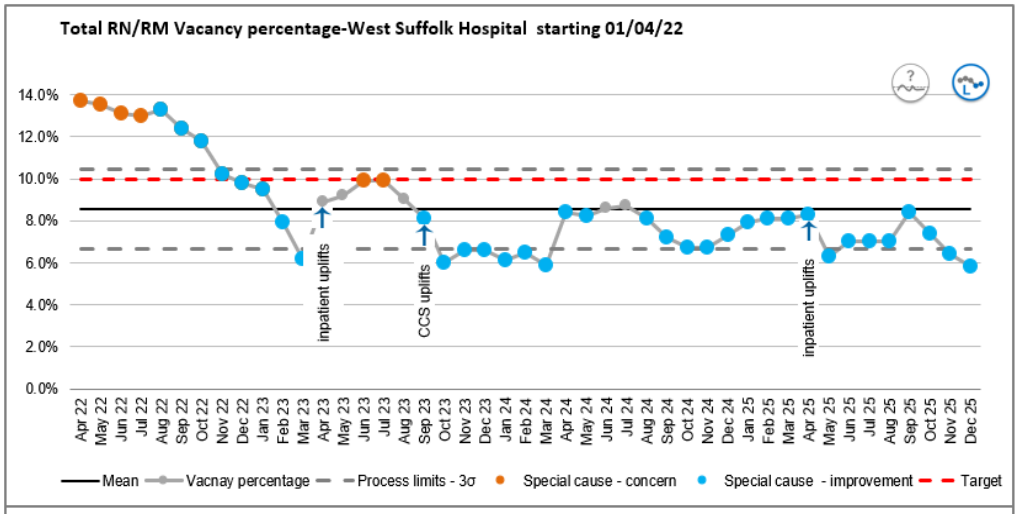
CHPPD is a measure of workforce deployment and is reportable to NHS Digital as part of the monthly returns for safe staffing (Appendix 1a/b).
CHPPD is the total number of hours worked on the roster by both Registered Nurses & Midwives and Nursing Support Staff divided by the total number of patients 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.

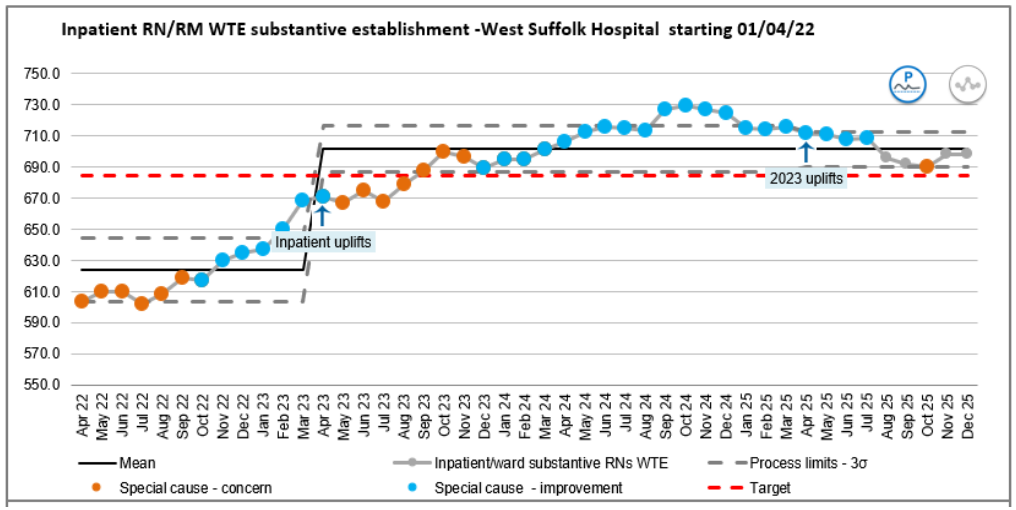
A) Trust Total RN/RM WTE



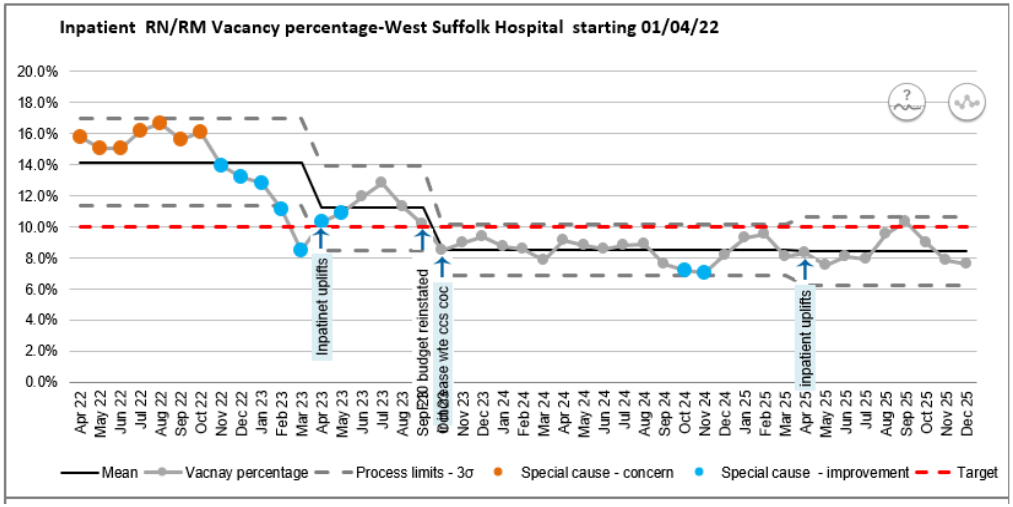
B) Trust Total RN/RM vacancy %



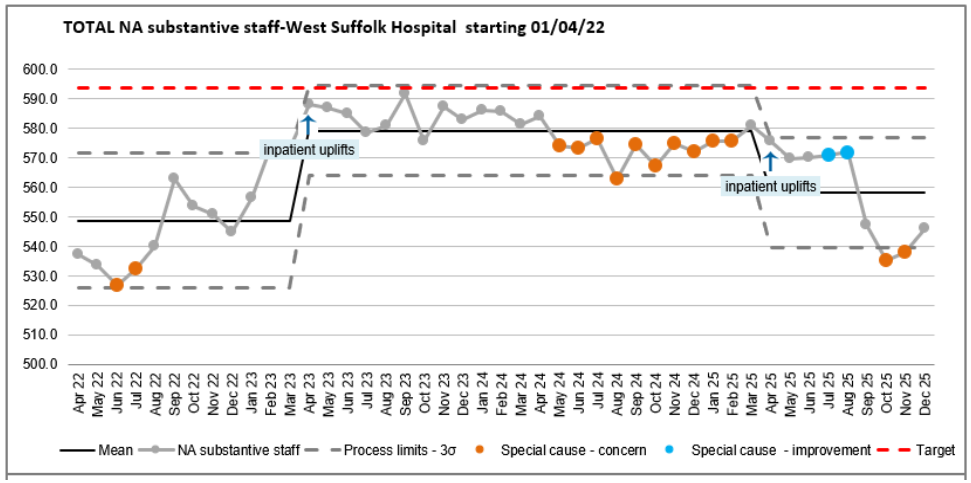
C) Inpatient RN/RM WTE



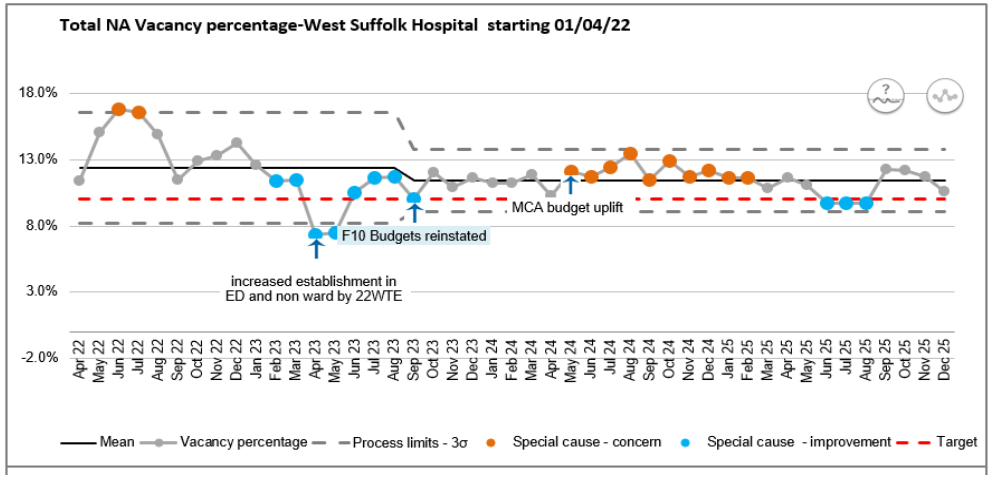
D) Inpatient RN/RM vacancy %



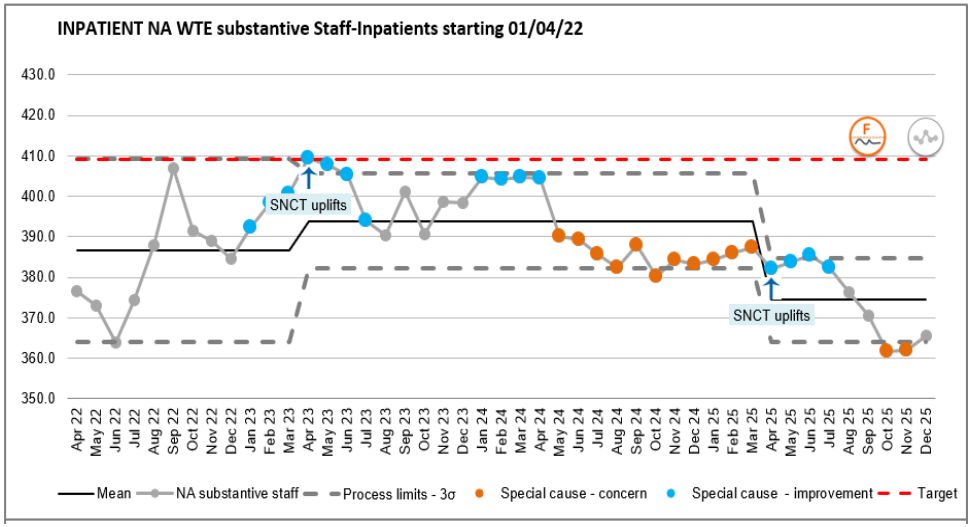
E) Total NA/unregistered WTE.



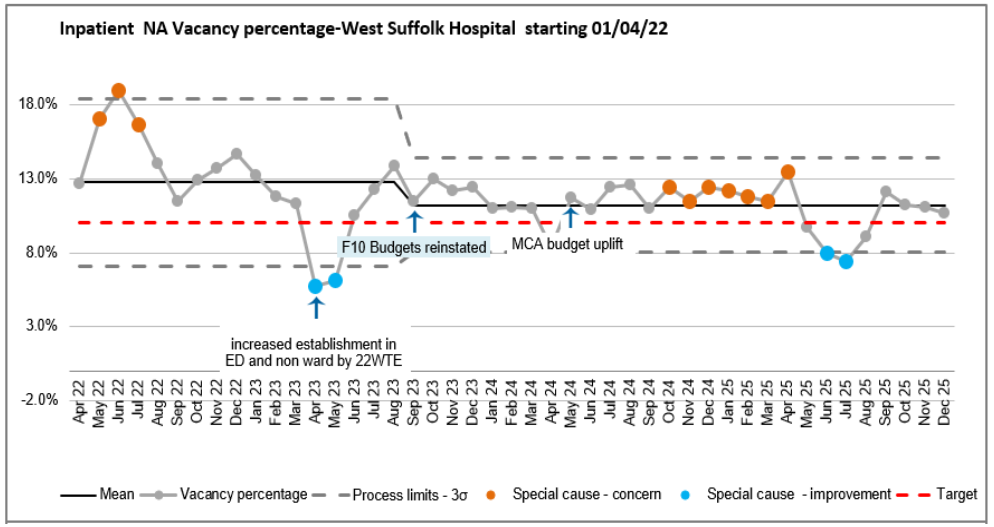
F) Total NA/Unregistered vacancy %



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.

2.5. Maternity Services Report (ATTACHED)

To Assure

Presented by Karen Newbury

Open Trust Board	
Report title:	Perinatal quality, safety, and performance report
Agenda item:	Maternity and Neonatal services
Date of the meeting:	30th January 2026
Lead:	Dan Spooner, Executive Chief Nurse Richard Goodwin Medical Director & Executive Mat/Neo Safety Champion
Report prepared by:	Karen Newbury, Director of Midwifery Hayley McBride interim Head of Midwifery

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

Executive Summary

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

This report presents a document to enable board scrutiny of Maternity and Neonatal services and receive assurance of ongoing compliance against key quality and safety indicators and provide an update on quality & safety initiatives in line with the NHS Perinatal Quality Oversight Model (June 2025).

This report contains:

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

• Closed Board reports; o (Nil this month) • Next steps
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
The report meets NHSE standard of perinatal oversight by providing the Trust board a methodical review of maternity and neonatal safety and quality.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
Action plans will be monitored, and any areas of non-completion will be escalated as appropriate. Quarterly, bi-annual and annual reports will evidence the updates. As applicable, reports will be shared with external stakeholders as required.
Recommendation / action required
For assurance and information.

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

Perinatal quality, safety, and performance report

1. Detailed sections and key issues

1.1 **Perinatal Quality Oversight Model**

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

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

In addition, to the PQOM, three significant national documents relating to perinatal care have been published; Baroness Amos' initial findings from the National Maternity and Neonatal Investigation (December 2025), the Maternal Care Bundle (January 2026), and the Postnatal Care Toolkit (January 2026). All three will require Trust Board oversight to ensure delivery during 2026/27. Quater1 2026 will focus on leadership ownership, gap analysis against national expectations, engagement with women and families, alignment of maternity and system partners, and confirmation of governance, metrics, and reporting routes, followed by phased implementation through 2026/27 and ongoing Board assurance of cultural change, equity and safety impact.

Furthermore, Baroness Amos' final report is due by the end of Spring 2026, Donna Ockenden's review of Nottingham perinatal services and the final report of the Thirlwall Inquiry are expected later in 2026, with national recommendations anticipated in relation to leadership, culture, governance and patient safety within neonatal and maternity services. As soon as these reports are published, the above process will be followed to provide Board assurance.

1.2 **Safety Champion feedback**

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

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

Richard Goodwin (Executive Director, Maternity/Neonatal Safety Champion) visited the community midwives based at Newmarket hospital on the 25th November 2025. An

	open discussion took place regarding homebirths outside of guidance, drugs available for community midwives to carry for post-partum haemorrhages at home and the lack of jobs for newly qualified midwives. Board Safety Champions meet with the perinatal leadership team and Maternity and Neonatal Voice Partnership lead for the ICB at least bi-monthly to review progress and determine whether additional Trust Board support is required. Any escalations are formally recorded in the Safety Champion Action Log and monitored through the monthly Maternity/Neonatal Safety Champion meeting. The leadership team have raised their concerns regarding the increasing mandatory training requirements for perinatal staff and how this can be accommodated without impacting clinical care. This has been raised with the regional team who awaiting clarity on expectations and timeframes for compliance with the proposed new training elements.
1.3	**Listening to Staff** The maternity and neonatal service continues to promote all staff accessing the Freedom to Speak up Guardians, Safety Champions, Professional Midwifery/Nursing Advocates, Unit Meetings and 'Safe Space'. In addition to this there are maternity and neonatal staff focus groups, which provide an opportunity to listen to staff. Any issues raised are responded to and fed back to the team. A SCORE Culture Survey was undertaken in early 2025 and was the final component of wave one of the Perinatal Culture & Leadership Programme. The aim of the programme is to nurture a positive safety culture, enabling psychologically safe working environments, and building compassionate leadership to make work a better place to be and is included in the requirements for NHS Resolutions Maternity Incentive Scheme. All staff across Women's & Children were invited to participate in the survey with a response rate of 49%. An external culture coach then met with targeted groups to gain further understanding of the survey results. This feedback has been reviewed and the following aspirations identified. 1. Develop a strong and effective communication ethos, 2. Create a strong sense of belonging for all, across the service 3. Culture is embedded and prioritised as how we do things here. The Perinatal Quadrumvirate, supported by our in-house Culture Coaches, continues to drive improvements in safety culture and deliver on our aspirations across the service in relation to the above aspirations by the following examples; With ongoing support from Health Innovation East, two 'Enabling a Coaching Culture' workshops took place in November and December 2025. These sessions were open to all staff within the perinatal service and provided practical tools to strengthen communication and embed a coaching mindset An inclusive, multidisciplinary approach is embedded across the Trust's perinatal services, with consistent engagement from all staff groups, as demonstrated through routine audits of safety huddles and high levels of compliance with mandatory training. In collaboration with the Trust's Learning and Development team, we are preparing to launch a Reverse Mentoring and Sponsorship Programme in the spring of 2026. This initiative aims to foster inclusive leadership, broaden perspectives, and support career development across the workforce

1.4

Service User feedback

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

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

Ward/Dept	November Survey Responses	November Very good and good %	% of discharged people provided feedback*	December Survey Responses	December Very good and good %	% of discharged people provided feedback*
F11	32	100	9%	37	95%	10%
Labour Suite	6	83%	18%	2	100%	6%
Birthing Unit	6	100%	43%	3	100%	21%
NNU	6	93%	-	10	94%	-
Antenatal Community	33	82%		4	100%	
Postnatal Community	8	100%		2	100%	
Antenatal Clinic	29	93%		17	71%	

*Target of ≥30%

Due to the limited volume of feedback received, the maternity and neonatal team is working in close collaboration with the Patient Engagement Team, as well as the Parent Education and Patient Experience Lead Midwife, to improve response rates.

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

It is important to highlight that the Chair of the Maternity and Neonatal Voices Partnership (MNVP) stepped down at the beginning of 2024. Since then, the MNVP has been without a Chair and has faced challenges due to insufficient membership, limiting its ability to operate effectively. The publication of updated MNVP guidance in November 2023 enabled our Local Maternity and Neonatal System (LMNS) to evaluate and establish a more sustainable approach. As a result, a new LMNS MNVP Lead was appointed and began their role in October 2024, with responsibility for re-establishing the WSFT MNVP, which is still in its infancy.

The 2025 Maternity service user CQC Survey results demonstrate a sustained and positive improvement in patient experience across the maternity care, reflecting the impact of actions taken following the 2024 survey. Overall performance was positive, with all domains rated ‘About the same as other trusts’ or higher, no areas scored worse than expected. This outcome indicates a consistently positive patient experience across antenatal, intrapartum and postnatal care. A notable area of improvement relates to birthing partner access, where the department recorded one of its most significant increases in positive responses. This improvement aligns with targeted engagement work on Ward F11, including the introduction of 24 hour visiting, enabling

birthing partners to remain throughout the inpatient stay. An action plan has been co-produced with our MNVP lead to address areas where further enhancement is required, including feeding support contact, particularly during nights and weekends and reducing delays in discharge, ensuring timely transitions from hospital to home. A full review will be shared with the Quality and Patient Safety Committee in due course.

Compliments, PALS enquiries and Complaints;

Measure	November 2025	December 2025	Trend / Narrative Summary
Compliments	1 compliment received, relating to labour care	1 compliment received, relating to labour care	This represents a reduction compared to the previous reporting period (September–October 2025), during which a total of four compliments were received.
PALS Enquiries	4 enquiries received: • 3 relating to patient care • 1 relating to staff behaviour	1 enquiry received: relating to miscommunication and perceived unprofessional behaviour	The overall number of PALS enquiries remains unchanged compared to the previous reporting period
Formal Complaints	1 complaint received, concerning patient care during an emergency situation	2 complaints received, primarily focused on patient care and concerns about not being listened to	Overall reduction compared to the previous reporting period, despite a slight increase in December. Themes align with listening, communication and patient experience.

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

1.5 **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.

	November 25	December 25
No. of MNSI referrals	1*	0
No. of Patient safety incidents	81	103

*This referral has now been rejected by MNSI due to family disengagement

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

The maternity service is represented at the Local Maternity and Neonatal System (LMNS) monthly safety forum, where incidents, reports and learning are shared across all three maternity units.

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 groups in maternity related to the core competency framework

Nov 2025	Saving Babies Lives E-Learning Module	GAP/GROW	Maternity Emergencies / OMET	Skills and Drills	CO Monitor	Safeguarding	Neonatal Life Support Yearly	Fetal Heart Surveillance	Newborn Feeding update 3 yearly	SDM
Midwives	61.6%	90.2%	98%	98%	97.5%	99.3%	98%	96%	82%	92.1%
MCA/MSW	N/A	N/A	100%	100%	92.4%	100%	100%	N/A	88%	N/A
Consultant Obstetrician	35.3%	88.3%	93.75%	93.75%	89%	99%	N/A	93%	N/A	100%
Obstetric Registrar	50%	90%	90%	90%	100%	89%	N/A	90%	N/A	100%
SHO/Core trainees	89%	89%	100%	100%	100%	92%	N/A	N/A	N/A	100%
Sonographer	N/A	89.5%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Consultant Anaesthetist (obs)	N/A	N/A	94.5%	94.5%	N/A	N/A	N/A	N/A	N/A	N/A
Obstetric Anaesthetists	N/A	N/A	100%	100%	N/A	N/A	N/A	N/A	N/A	N/A
Neonatal Consultants	N/A	N/A	N/A	No Data	N/A	90%	92.86	N/A	55%	78 %
Neonatal Nurses	N/A	N/A	N/A	No Data	N/A	100 %	100%	N/A	77%	100 %
Neonatal Doctors	N/A	N/A	N/A	No Data	N/A	100%	100 %	N/A	50 %	No data
ANNP/PA	N/A	N/A	N/A	No Data	N/A	100%	100%	N/A	50 %	No data

End of month data December 2025	Saving Babies Lives E-Learning Module	GAP/GROW	Maternity Emergencies / OMET	Skills and Drills	CO Monitor	Safeguarding	Neonatal Life Support Yearly	4 Yearly NLS update	Fetal Heart Surveillance	Newborn Feeding update 3 yearly	SDM
Midwives	79%	91.2%	99.3%	99.3%	98%	98.1%	99.3%	N/A	93%	85%	95.1%
MCA/MSW	N/A	N/A	93.1%	93.1%	90.7%	98%	93.1%	N/A	N/A	88%	N/A
Consultant Obstetrician	56.2%	100%	80%	80%	100%	95%	N/A	N/A	100%	N/A	100%
Obstetric Registrar	44.4%	88.9%	90%	90%	100%	91%	N/A	N/A	90%	N/A	100%
SHO/Core trainees	25%	37.5%	66.6%	66.6%	100%	88%	N/A	N/A	N/A	N/A	62.5%
Sonographer	N/A	94.5%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Consultant Anaesthetist (obs)	N/A	N/A	83.4%	83.4%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Obstetric Anaesthetists	N/A	N/A	100%	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Neonatal Consultants	N/A	N/A	N/A	No Data	N/A	90%	91.67%	91.67%	N/A	71%	94%
Neonatal Nurses	N/A	N/A	N/A	93%	N/A	100%	100%	100%	N/A	95%	100%
Neonatal Doctors	N/A	N/A	N/A	No Data	N/A	100%	100%	100%	N/A	76%	No data
PA	N/A	N/A	N/A	No Data	N/A	100%	100%	100%	N/A	100%	No data

RAG	Standard	Actions
	Above 90%	Maintain
	80-90%	Identify non-attendance and rebook; monitor until >90% for 3 months
	Below 80%	Urgent review and rebook; monitor monthly until >90% or direct management if <90%
	Not applicable to that staff group	Review criteria for training as part of annual review
	New training for that staff group	Review compliance trajectory after 3 months

To note; new SHO/core trainees started with the organisation on the 7/12/25. Historically the organisation had aligned full compliance with the Maternity Incentive Scheme end date, hence full compliance in November. It has now been recognised that there needs to be consistent compliance throughout the year, which the service is working towards.

In response to the introduction of the Perinatal Core Competency Framework version 2, additional training sessions were initiated at the start of 2024. While compliance in these areas was on the rise, it remained challenging to release all staff groups for training. A comprehensive review of the current training requirements has taken place

	to identify more effective training delivery methods, unfortunately in addtion to this, further mandatory trainng has been introduced to meet National and local standards. With exception of the midwifery and nursing workforce the remaining staff groups are excepitonally small teams and therefore non-compliance relates to one or two staff members. Compliance is monitoried closely by the leadership team and whereby individual staff members training expires, they are scheduled for the next availble training. Data collection regarding compliance is another challenging area due to internal, external and self-directed learning for some topics, measures have been implemented to address this issue; however, for certain training components, compliance is dependent on individuals providing evidence of their training.
1.7	**NHS Resolution (NHSR) Maternity Incentive Scheme (MIS) Year 7 progress** Now in its seventh year of operation, NHS Resolution's Maternity (Perinatal) Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025. The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). Year 7 of the scheme was launched in April 2025 for the reporting period 1st December 2024 - 30th November 2025. The nature of the ten safety actions remains largely unchanged from previous years covering ongoing reporting and monitoring of mortality and morbidity, compliance with national frameworks, standards of care, reporting criteria and timeframes, education and training, workforce standards, involving service users in the safety and improvement work and quality and sharing of learning. Whilst there are still areas where the maternity and neonatal services can continue to develop and improve, maintenance and monitoring of standards is a key part of everyday working within the maternity and neonatal units. The chart below reflects our full compliance with Year 7 safety actions and a report detailing the evidence supporting this was presented to and approved by the Quality and Patient Safety committee on the 21st January 2026. This evidence has also been shared and verified by the Local Maternity and Neonatal System on behalf of the Integrated Care Board.

Overview of progress on MIS year 7 safety action requirements

*Mandated Safety Action Requirements:

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

Key:

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

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

Next steps: The MIS year 7 declaration form has been signed by the WSFT Chief Executive Officer and shared with the Integrated Care Board Accountable Officer for countersignature before formal submission to NHS Resolution by the deadline of 12 noon on 3 March 2026.

2. Reports

2.1 **Reports approved by the Trust Board sub-committees**

The NHS Resolution Maternity Incentive Scheme (MIS) introduced a change in the processes and pathways for Trust committee and Board oversight in 2024. This has afforded the Trust the opportunity to optimise the reporting structures and assurance processes to ensure that each report has appropriate oversight and approval during this time.

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

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

No reports were due to be presented to any of the sub-committees held in November 2025.

Reports presented and approved at the Involvement Committee held on the **17th December 2025**:

- **Midwifery biannual workforce report** (April- September 2025)
- **Neonatal medical workforce report** (April- September 2025)
- **Obstetric workforce report** (February- July 2025)

	• **Obstetric anaesthetist workforce report** (April- September 2025) Reports presented and approved at the Quality and Patient Safety Committee held on; The **17th December 2025**: • **Maternity Claims scorecard Q2 25/26** • **Exploring stereotypes and Pain Management disparities in Maternity Care** The **21st January 2026**: • **Homebirth service review** • **Maternity Incentive Scheme – Year 7 declaration of full compliance**.
3.	**Reports for CLOSED Board** There are no reports due for Closed board.
4.	**Next steps**
4.1	Reports will be shared with the external stakeholders as required. Action plans will be monitored and updated accordingly.

Annex A

Perinatal Quality Oversight Model Data Measures

Metric	Frequency to be shared with board	Where evidence will be presented
1.Findings of review of all perinatal deaths using the real time data monitoring tool	Quarterly	Closed board- Perinatal Mortality Report, Early Notification Scheme and Maternity and Neonatal Safety Investigation reports.
2. Findings of review of all cases eligible for referral to MNSI	Quarterly	Closed board- Maternity and Neonatal Safety Investigation reports.
Report on: 2a. The number of patient safety incidents logged and what actions are being taken	Quarterly	Quality and Patient Safety committee (previously known as the Improvement board) – Triangulation of legal claims, complaints and incidents
2b. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training (%)	Bi-monthly	Open board- Perinatal Quality, Safety and Performance paper
2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	Bi-annual	Involvement board – separate midwifery and obstetric workforce papers.
3.Service User Voice Feedback - Themes	Bi-monthly	Open board- Perinatal Quality, Safety and Performance paper
4.Staff feedback from frontline champion and walk-abouts – themes	Bi-monthly	Open board- Perinatal Quality, Safety and Performance paper
5.MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	As applicable	Closed board- Perinatal Mortality Report, Early Notification Scheme and Maternity and Neonatal Safety Investigation reports.
6.Coroner Reg 28 made directly to Trust	As applicable	Closed board- Perinatal Mortality Report, Early Notification Scheme and Maternity and Neonatal Safety Investigation reports.
7.Progress in achievement of CNST 10 Safety actions	Bi-monthly	Open board- Perinatal Quality, Safety and Performance paper

8.Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	Annual	Open board- Perinatal Quality, Safety and Performance paper
9.Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours (Reported annually)	Annual	Open board- Perinatal Quality, Safety and Performance paper

3. JOINED UP SERVICES

3.1. Strategic priorities update (ATTACHED)

To Review

Presented by Sam Tappenden

Open Board

Report information

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

This report supports the following ambitions:

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

Executive summary

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

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

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

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

What next? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
The purpose of this paper is to update the Board on the activities undertaken to embed the strategy across the Trust, the process underway to develop our 'enabling' strategies, and work underway to refresh our Board Assurance Framework (BAF).

Action required by the board:

- Provide any feedback regarding the approach taken
- Help embed the strategy throughout the organisation

Compassionate care, healthier communities

Governance and compliance

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

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

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

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

Update on embedding the Trust's corporate strategy

1. Purpose

2.1. The purpose of this paper is to update the Board on the activities undertaken to embed the strategy across the Trust, the process underway to develop our 'enabling' strategies, and work underway to refresh our Board Assurance Framework (BAF).

2. Progress embedding the strategy

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

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

2.3. Significant work is well underway to embed the strategy with internal and external stakeholders, aligned with our phased approach:

Phase 1: launch

- **Roadmap stage:** 'recover'
- **Timescales:** October 2025 – February 2026
- **Focus:** awareness of internal and external stakeholders
- **Key activities:**
  - Strategy uploaded to intranet, website, and briefing emails
  - Development of all digital and physical assets
  - Presenting overviews at key meetings (e.g. Senior Leadership Team, divisional boards, staff networks, VOICE, Council of Governors, patient engagement events, and stakeholder briefings)
  - Start distribution of materials to all acute and community services.

Phase 2: spread

- **Roadmap stage:** 'renew'

- **Timescales:** February 2026 – June 2026
- **Focus:** integration into strategic processes
- **Key activities:**
    - Digital briefing and briefing packs for teams to cascade
    - Launch the complete strategic framework (i.e. enabling strategies)
    - Embed in planning, decision-making, and governance (e.g. committees, procurement processes, contracts etc.)

Phase 3: embed

- **Roadmap stage:** 'renew'
- **Timescales:** July 2026 – December 2026
- **Focus:** behavioural and cultural adoption
- **Key activities:**
    - Incorporate into organisational BAU processes:
        - Appraisals, objective setting, leadership programmes
        - Complementary launch of values and behaviours framework
        - Continuous Quality Improvement approach
        - Operational governance (e.g. divisional boards).

Phase 4: sustain

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

2.4. Most of the activities in phase one have been completed (e.g. briefing at ASU, SLT, and AMM, physical assets have been developed, and materials are being distributed across the Trust).

2.5. Please see **Appendix A** for the materials which are in the process of being distributed across Trust acute and community services.

2.6. Strategy-specific questions have also been added to the Trust's quarterly staff 'pulse' survey, including:

- I am aware of our strategy 2025-2028 - compassionate care healthier communities
- I am aware of the five ambitions that sit within our Trust strategy
- I am aware of how my role/team contributes to the delivery of our Trust strategy

2.7. These three questions will help the Board to assess our colleagues' awareness of the strategy, its ambitions, and how well 'connected' colleagues' feel their roles are to it.

2.8. The intention is to include these questions twice a year, which we will monitor on an on-going basis.

2.9. Furthermore, the strategy section on the Trust's external website has received 1,023 views, while the strategy section within the Trust's intranet has received 632 views, the majority of which were recorded immediate following the launch in October.

3. Enabling strategy development

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

3.2. Development workshops are being held with the responsible corporate leads, some strategies are well-developed (e.g. digital), and others are at a relatively early stage (e.g. partnerships).

3.3. The integrated clinical and quality strategy will require a slightly different approach to the other strategies, given its relative breadth, significant previous engagement, and its criticality to the FSP.

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

3.5. We are anticipating that the full suite of strategies will be completed in April, and those strategies, combined with our medium-term planning process, will enable completion of our strategic planning framework.

4. Board Assurance Framework

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

4.2. The BAF will be refreshed in alignment with the Trust's strategies, plans, and Board development session feedback, for April.

4.3. This will ensure that for start of the new financial year, the Trust's full suite of strategic planning documents will be completed.

5. Summary and next steps

5.1. Considerable work is underway to embed our new strategy, develop our 'enabling' strategies, and align efforts behind our priorities.

5.2. Further work includes completion of the phased embedding of our corporate strategy, completion of our enabling strategies, and refresh of the BAF.

West Suffolk
NHS Foundation Trust

Our strategy 2025-2028

Our strategy sets five connected ambitions and is powered by our FIRST values

- Fairness
- Inclusivity
- Respect
- Safety
- Teamwork

High quality care

People in our communities are healthier and more independent

Priorities

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

Joined-up services

Patients experience services that are centred around their needs

Priorities

- Provide more care closer to home through transformed hospital and community services
- Create new models of preventative care with our partners
- Work closely with our partners to create the conditions for success.

Empowered to improve

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

Priorities

- Nurture a safe, high performing and inclusive culture
- Proactively support colleagues' health, wellbeing and development
- Strengthen leadership to foster autonomy, accountability and ensure staff feel valued.

Responsible with resources

Achieve the best possible value for money for taxpayers

Priorities

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

Fit for tomorrow

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

Priorities

- Accelerate the adoption of technology to enhance our services
- Improved access to data to enhance decision-making
- Modernise the way we work to free up time for colleagues.

Scan the QR code to read the strategy in full

Compassionate care, healthier communities

West Suffolk
NHS Foundation Trust

Our values

Fairness

We value fairness and treat each other appropriately and justly.

Inclusivity

We are inclusive, appreciating the diversity and unique contribution everyone brings to the organisation.

Respect

We respect and are kind to one another and to patients. We seek to understand each other's perspectives so that we all feel able to express ourselves.

Safety

We put safety first for patients and staff. We seek to learn when things go wrong and create a culture of learning and improvement.

Teamwork

We work and communicate as a team. We support one another, collaborate and drive quality improvements across the Trust and wider local healthcare system.

Compassionate care,
healthier communities

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

Presented by Maddie Baker -Woods

West Suffolk NHS Foundation Trust Board

Report information

Report title: West Suffolk Alliance Health and Wellbeing Committee
Agenda item: 3.2
Sponsor/Executive lead: Maddie Baker-Woods, Alliance Executive Director
Report prepared by: C King / M Shorter
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 attached paper provides a summary of the key items of business for West Suffolk Alliance for the Committee meetings held 9 December 2025 and 13 January 2026

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

Board members are asked to note progress identified and risks associated with the changes to the ICB.

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

Actions are managed through the Alliance Committee process.

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

Governance and compliance

Risk and assurance: Risks due to the imminent changes to the ICB function and structure.
Equality, diversity and inclusion: Health Inequalities is reported to the HIPPC

Committee in the ICB. Clear links to reducing health inequalities are contained in all programmes.

Sustainability: Sustainability Impact Assessments are in place for all newly commissioned services and transformation workstreams – governance held in the ICB.

Legal and regulatory context: Governance held within the ICB. This report is for information to the Trust.

West Suffolk Alliance Health and Wellbeing Committee

1. Introduction

1.1. West Suffolk Alliance Update including Committee meetings held 9 December 2025 and 13 January 2026

2. WSA Delivery Plan mid-year review

2.1. The mid-year review of the WSA delivery plan demonstrated good progress across the majority of workstreams against planned activity. Highlights included:

- Successfully applying to the National Neighbourhood Health Implementation Programme (NNHIP) with a focus on supporting people with Diabetes; the co-design and implementation of a WS winter plan including additional respiratory clinics in primary care; the expansion of Home First reablement leading to a decrease in individuals requiring long-term care as well as supporting the acute discharge profile; the launch of an integrated weight management and obesity service; an integrated specialist Palliative and End of Life Care services resulting in 99% of people supported by the service achieving their preferred place of care and death; Primary Care/Secondary Care interface meetings. 100% compliance against national mandate to have online consultation tools in primary care, has been achieved.
- **Challenges:** These included: digital integration/interoperability between health and social care teams within INTs; onboarding on to Joy, which had been slower than anticipated; significant changes to the ICB because of cost reduction programme.
- **Focus 26/27**: Workforce development, digital enablement, health equity and patient-centred care.

3. Be Well

3.1. **Achievements:** Launch of the child obesity program which aims to reduce obesity below national target by 2028; 508 people accessing smoking cessation service, with 32% quitting; NHS dental activity increasing.

3.2. **Initiatives:** Active Lakenheath; 4,500+ referrals to the exercise referral pathway, 48% continuing participation.
3.3. **Challenges:** declining rates of referrals to smoking cessation service ensuring adequate communication re Sport England work; on-going impact of the ICB restructure and work prioritisation.

4. Strategic Programmes and Long-Term Conditions, Cancer & Specialised Commissioning

4.1. Programme focused on tobacco dependency, weight management, diabetes, respiratory care, stroke, neuro-rehab, CVD, renal and cancer pathways. Overarching objective is to ensure quality in pathways and align services with neighbourhood model.
4.2. From April 2026 there will be a transition as programme aligns across newly formed ICB geography, including review of governance, ways of working and ICB role.
4.3. Committee discussed the need for Place based engagement in development of the strategic programmes to enable high quality local delivery within Neighbourhoods.

5. IUC Strategic Plan

5.1. The aim of the strategy is to define future urgent care model for Norfolk and Suffolk, ensuring the system is able to respond to national targets and rising demand.
5.2. Four strategic themes: accessibility, clinical excellence, agile and responsive and efficiency.
5.3. Next steps: finalise service specification; conclude provider engagement; options appraisal for procurement; begin procurement in early 2026 with contract to be awarded early 2027.

6. Virtual ward

6.1. **Capacity & Performance:** 53 beds; step-up pilot success; occupancy at 65% (target 80%).
6.2. **Integration & Care:** New community pathways (antibiotics, CRP testing); expand diagnostics.
6.3. **Next Steps:** Boost community admissions; align investment; roll out IV therapy/testing.

7. Dementia update

7.1. West Suffolk currently below national target for dementia diagnosis rate, with the lowest rate of diagnosis in SNEE and have long waits for dementia assessment services, provided by NSFT.
7.2. MATS waitlist reduced to 669 down 93 from 762 in September 2025. However, current assessment rate insufficient to prevent future growth of waiting list.
7.3. Recovery actions: more clinics including exploration of overbooking clinics, daily triage, process improvements, and a dementia pilot.
7.4. Rising dementia cases highlight need for ongoing service efficiency.

8. Suffolk Mental Health Collaborative ASK – Summary & Action Points

8.1. Proposes expanding MHST to all Suffolk schools for inclusive support.
8.2. Calls for tailored help for special schools, SEND, and vulnerable groups.
8.3. Emphasises integrated, collaborative delivery with local partners.

9. WSFT Strategy 25-28 Compassionate Care/healthier communities

9.1. Articulates a vision for healthier communities through compassionate, high-quality, coordinated care.
9.2. Focuses on five strategic ambitions, grounded in core values of fairness, inclusivity, respect, safety, and teamwork.
9.3. Emphasises partnership, digital innovation, and resource management to improve outcomes and ensure resilience.

10. Population health and commission strategy

10.1. Five-year strategy to improve healthy life expectancy for all, reducing health inequalities, and improving access to consistently high-quality services.
10.2. Ambitions: sickness to prevention, care closer to home, analogy to digital, and social and economic development Immediate priority: improve NHS operational performance to national standards or better, operate within our allocated budget, improve productivity and deliver value for money, maintain or improve the quality of care delivered, implement an effective local NHS operating model for strategic commissioning.

11. Future shift

11.1. The ICB has shared its intention with providers to utilise two sources of funding for future shift investments in line with national guidance. Total potential funding of £26.8m in 26/27 increasing to £60.3m in 27/28.

11.2. All withdrawn monies need to be reinvested to fund initiatives specifically identified to reduce pressure on acute services and to support the 10-year plan ambition of moving hospital activity to community. If investment plans don't deliver, the ICB carries the risk of UEC overperformance

11.3. **Key focus areas for WS:** Care management Service, Suffolk End-of-Life care pathway, urgent community response, enhanced primary/community services, integrated diabetes care, and community monitoring of Long-term conditions (formerly the third space).

12. BCF Annual Plan preparation

12.1. **Strategic Focus:** Align local priorities with national BCF goals—shifting from sickness to prevention and promoting independent living.

12.2. **Collaboration & Data:** Joint planning, annual reviews, and better data sharing to guide funding and performance.

12.3. **Re-profiling the BCF portfolio:** aim of exercise is not to de-commission schemes, but to align portfolio to national BCF criteria with ongoing evaluation and coordination. Schemes historically funded by BCF, where the decision is to move out of BCF will need alternative funding source or decommission plan.

13. Review of discharge pathway for cohort with a housing need

13.1. **Review & Recommendation:** West Suffolk Alliance assessed four models to improve hospital discharge for patients with housing needs.

13.2. **Next Steps:** partner engagement prior to submission of business case to secure funding.

14. Next steps

14.1. Focus on forward strategy and plan for 25/26.

14.2. At pace progression of the national neighbourhood implementation of work.

14.3. Focus resilience and capacity of primary and community services across the winter period.

15. Conclusion

15.1. WSA continues as a strong integrated partnership with well attended Committee meetings and focus on the delivery of its plan.

4. EMPOWERED TO IMPROVE

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

To Assure

Presented by Tracy Dowling

NHS
West Suffolk
NHS Foundation Trust

COMMITTEE/SUBGROUPS REPORT

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

Originating Committee: Involvement Committee			Reporting to: Trust Board Meeting		
Chaired by: Tracy Dowling Non-executive Director			Date of meeting: 17th December 2025		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To MEG / other assurance committee **3.** To Board
7.3	Sexual Safety in the Workplace	2. Reasonable	Progress update since least reported April 25. Full communications plan implemented; development sessions being delivered; 67% actions achieved and 33% in progress	Self assessment against the Charter due Spring 2026. Workplan being updated to prioritise outstanding actions	1. No escalation
7.4	Update on Nursing Profiles Project	3 Partial	Significant Project to evaluate all nursing and midwifery posts against the new national job profiles – with refreshed and aligned job descriptions.	Project team established; detailed project plan in development with anticipated timescales of January – September 2026. Risks relate to impact on staff and finances if current roles undertaken do not reflect the bandings in the new profiles	1. No escalation
7.5	Annual Nurse Staffing Review	1. Substantial	Assurance received that adult inpatient establishments meet the Developing Workforce Standards (2018) and CQC regulatory compliance	Bi-annual review to be a regular item to this Committee. Arrangements in place for Emergency Department and Theatres staffing to be aligned / included in future reports.	1. No escalation
7.6	Bi-annual workforce reviews for the Maternity Incentive Scheme: • Midwifery • Obstetric	1. Substantial	Detailed reports received in relation Maternity Incentive Scheme Workforce. Compliance noted in all four areas.	Actions detailed to keep under review; particular focus on staff being able to attend multi-disciplinary training. Future neonatal standards for medical	2. Escalate to MEG consideration of future standards for neonatal medical workforce levels.

Originating Committee: Involvement Committee			Reporting to: Trust Board Meeting		
Chaired by: Tracy Dowling Non-executive Director			Date of meeting: 17th December 2025		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To MEG / other assurance committee **3.** To Board
	• Neonatal Medical Workforce • Anaesthetic staffing to maternity services			workforce are not met and will be considered as part of 2026-6 business planning	
7.7	Addressing staff engagement at WSFT	2. Reasonable	Update received on progress with gaining insight and progressing actions identified from the staff survey in 2024.	Continue implementation of 'Each Person'; review findings from 2025 staff survey; Managers training and support materials for launch early 2026	1. No escalation
8.0 8.1	**First for the Future** Trust workforce strategy and business plan	2.Reasonable	Julie Hull set out plans progressing development of the People, Culture and OD strategy aligned to the Trust strategy and 10 Yr Health Plan.	Progress developing the 2026-7 business plan for delivery of Year 1 of the People, Culture and OD Strategy is also in progress. Sign off of both documents expected March 2026	1. No escalation
8.2	Review of feeder groups and governance arrangements	2. Reasonable	Approval was given to streamline the four workforce groups that report to the People and Culture Committee to two.	Workforce Planning and Development Group to be established; Workforce wellbeing and Inclusion Group to be established. Review of the People	1. No escalation

Originating Committee: Involvement Committee			Reporting to: Trust Board Meeting		
Chaired by: Tracy Dowling Non-executive Director			Date of meeting: 17th December 2025		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To MEG / other assurance committee **3.** To Board
				and Culture Committee to be undertaken	
9.0 9.1	**First for Patients** Patient story – Martha's rule	1. Substantial	Julie Head presented an overview of the arrangements in place to implement Martha's rule with patient stories and data to illustrate how well this has been established	Continue to review data and patient / carer experience. Continue to share our learning to support other organisations with their implementation.	1. No escalation
9.2	Experience of care and engagement committee report	2. Reasonable	Report received shows good breadth of work to consider the experience of our patients to improve services. Reduced staffing levels as we reorganise to 'live within our means' has led to change in how activities are undertaken	Impact of staff changes and processes regarding PALS and complaints handling will remain under review.	1. No escalation
9.3	Inpatient CQC results and action plan	2. Reasonable	Report received regarding work undertaken in response to 2024 CQC inpatient survey results. Areas being addressed include noise at night; access to food outside of mealtimes and access to help with eating	Actions and escalations to be overseen by the Experience of Care and Engagement Committee	1. No escalation

Originating Committee: Involvement Committee			Reporting to: Trust Board Meeting		
Chaired by: Tracy Dowling Non-executive Director			Date of meeting: 17th December 2025		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To MEG / other assurance committee **3.** To Board
10	**Governance** Audit One Well led response update	3. Partial	Following a detailed review MEG now received monthly updates on actions with assurance that progress is being made.	Continue to be reviewed by MEG with 15 outstanding actions	1. No escalation
10.2	Staff Wellbeing BAF	3. Partial	The updated BAF was agreed with actions noted.	Continue to prioritise staff wellbeing as part of work to improve staff engagement at WSFT	1. No escalation
11.0	**Items for Information** **IQPR extract** **Professional standards framework for quality assurance and information**		Items for information received for information		

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

4.2. Freedom to Speak Up (FTSU) Report (ATTACHED) - Jane Sharman

To Assure

WSFT Board of Directors (Open)	
Report title:	**Freedom to Speak Up Quarter 3 2025-26**
Agenda item:	
Date of the meeting:	30th January 2026
Sponsor/executive lead:	Julie Hull, Chief People Officer
Report prepared by:	Jane Sharland, Freedom to Speak Up Guardian

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

Executive Summary
WHAT? *Summary of issue, including evaluation of the validity the data/information*
The attached report summarises the data regarding concerns raised to the Freedom to Speak Up Guardian in Quarter 2 2025-2026, with comparison to previous quarters, and highlights themes identified from concerns raised. The report contains: 1. Data sent to NGO 2. Anonymous reporting – percentages and themes 3. Who is speaking up – by professional group 4. Themes identified, and learning and actions 5. Feedback on the FTSU experience 6. Actions to promote a speaking up culture within the organisation.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
The report ensures Board oversight of numbers and themes of concerns being raised via the FTSU service. It also assures the Board of ongoing work to promote and support a speaking up culture across the organisation, and compliance with NGO principles.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
Actions in response to the themes are included in section 4.
Action Required
The Trust Board is invited to note the themes identified and actions that have been taken.

Risk and assurance:	This work aims to support staff to speak up about any concerns in a psychologically safe way, and for those concerns to heard by the Board and acted on appropriately

Equality, Diversity and Inclusion:	All work towards promoting freedom to speak up aims to be fully inclusive.
Sustainability:	N/A
Legal and regulatory context	The current NHS England standard contract (5.10) requires all Trusts to appoint a Freedom to Speak Up Guardian and comply with the requirements of the National Guardian's Office.

Freedom to Speak Up: Guardian's Report Q3. 2025-26 October, November, December 2025 2025

News from the National Guardians Office (NGO)

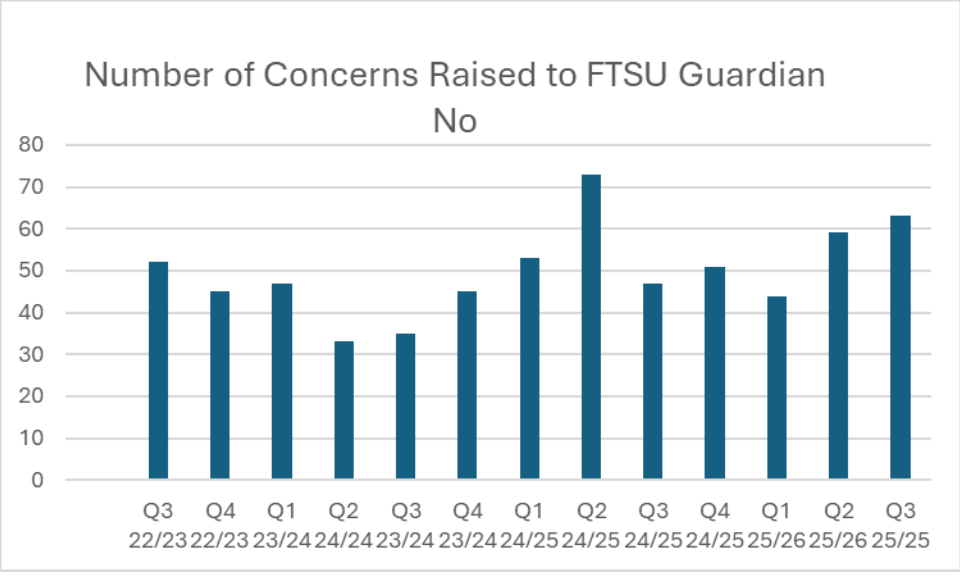
Data for Quarter 3 has been submitted to the NGO portal as usual. This will continue for Quarter 4. There has been a recent update from the closure project board that the NGO will now continue until end June 2026 to allow time for engagement with Guardians, NHS leaders and other broader stakeholders around the transition of functions. Following the retirement of Jayne Chidgey-Clark, the role of National Guardian is not being replaced at this time. Beth Carter, National Lead for guardian support will act as interim Director for the NGO during the transition period.

Speak Up Week, 13th – 17th October

During Speak Up Week (SUW) the importance of speaking up was highlighted in the All Staff Update and recruitment of FTSU champions was supported with a 'meet the champions' article in the green sheet. On the Wednesday there was a stall in Time Out to raise awareness of ways of speaking up and focusing on this year's theme, which was #follow up - i.e. action taken when people speak up.

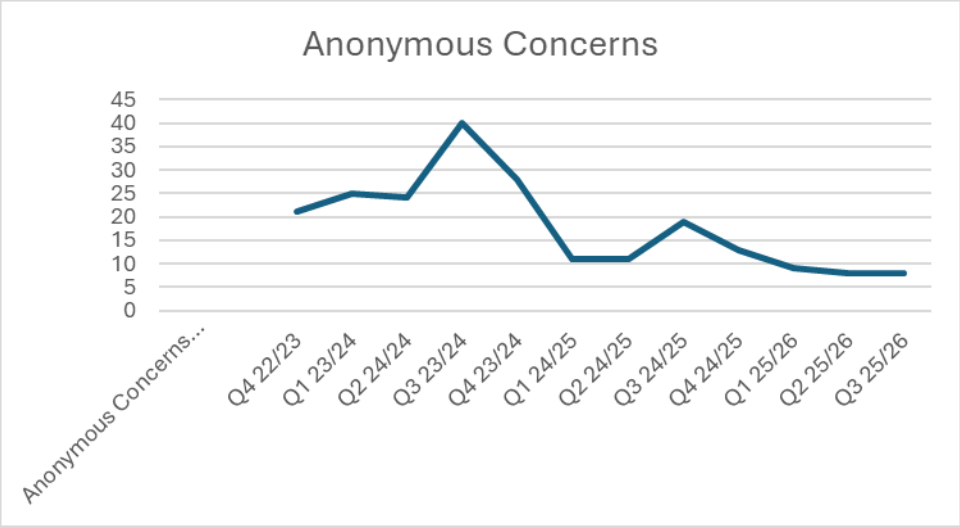
1. Data Sent to National Guardian's Office – Number of concerns

The number of concerns raised with the Guardian in Quarter 3 was 64. This is an increase in the average for the last 3 years (49).



2. Anonymous Reporting

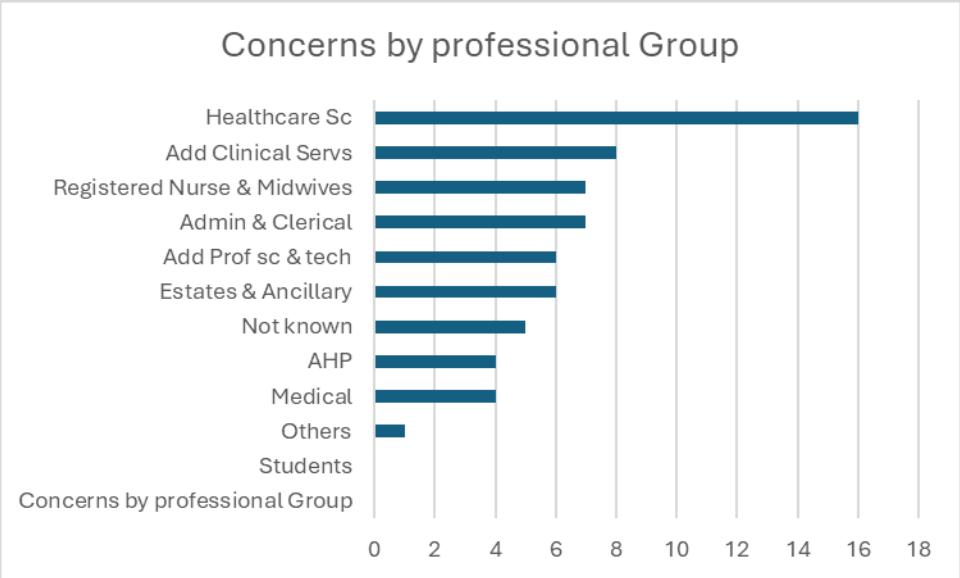
Whilst it is important to have an option for anonymous reporting, there are challenges in investigating anonymous cases due to limited information and the difficulty in providing feedback or support for those raising the concern.
Anonymous reporting option is available via the Raising Concerns page of the Trust Intranet, or by letter to the Guardian at the Education Centre. In Quarter 3, there were 5 anonymous reports, all via the reporting form, which is 8%, showing a relatively low level of anonymous reporting. The national figure is 11%. The percentage of anonymous concerns is an indicator for how confident staff feel to speak up, so it is positive to see the continuing declining trend for anonymous reporting.

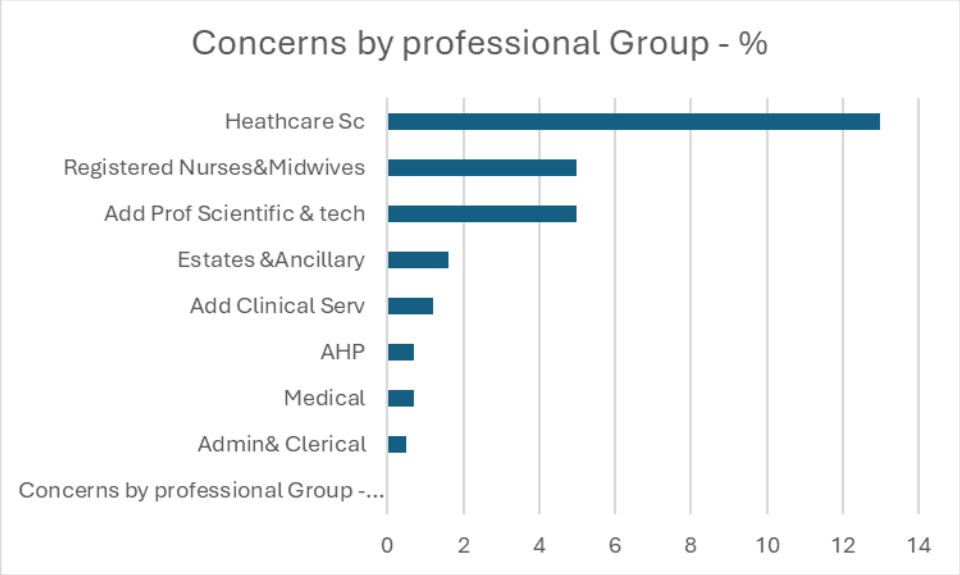


Anonymous reporting themes

These anonymous reports are taken seriously, and each one was investigated as far as possible. The subject of the 5 anonymous reports were: incivility by senior staff member, GDPR, HR processes when arranging formal meetings, redundancy process, apprenticeship approval.
The Guardian, working with the Trust's Speak Up champions, continues to tackle barriers to speaking up (see Principles of FTSU below) and to assure staff that detriment to those who do speak up will not be tolerated in the Trust.

3. Who is speaking up?

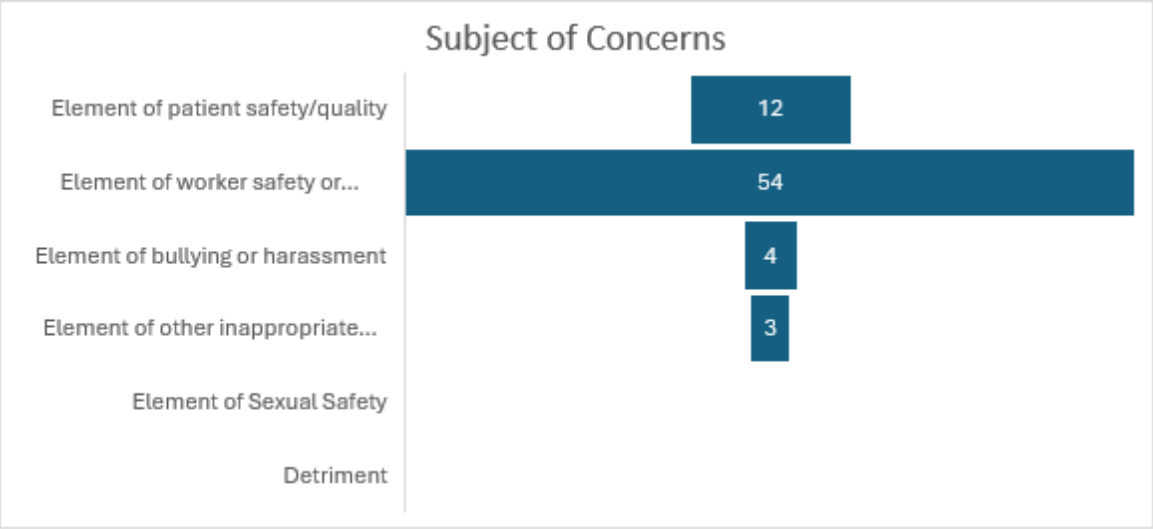




This quarter, the highest number of concerns were raised by healthcare scientists, but these were all related to the same concern. – this is explained further in the Themes section of this report. Beyond this, Registered nurses and midwives and HCSWs were the next highest reporters.

4. What were people speaking up about?

Most cases involve an element of staff safety or wellbeing. Patient safety concerns comprised 19 percent of concerns raised, which mirrors the national figure. These concerns involved infection prevention and control, patient access to services, staffing levels, cover arrangements for a particular consultant, escalation pathway for clinical concerns. Each of these cases has been investigated and addressed individually. The Trust has a patient safety team and robust systems in place where most patient safety concerns are reported.



5. Themes from Q3. 2025/26, with learning and actions

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

Sexual safety Concerns

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

Theme: Relationships between colleagues: Incivility and inappropriate language between staff members, particularly senior to junior staff has been reported.

Learning and action: The importance of maintaining a professional and calm attitude and tone of voice, and supportive language, even when under pressure. Each incidence has been directly addressed, there has been learning and improvement. Apologies have been issued, which have been well received.

Theme: Recruitment, re-deployment and fixed term contracts: A number of staff within one department (Pathology) raised their concerns individually regarding the re-deployment of a colleague into a post for which interviews had been arranged.

Learning and action: Trust policy, Agenda for Change Terms and Conditions and ACAS guidance on re-deployment was followed.

Communication to all recruiting managers to ensure they are aware of the rules around fixed term contracts and the implications of reckonable service going forward. Communication to those raising the concern explaining that the Trust had acted wholly appropriately within ACAS guidance and employment law.

Theme: Abuse from patients, lack of bystander support: There have been some concerns raised regarding the lack of action by some staff when they have witnessed their colleagues being the subject of verbal and racial abuse.

Learning and Action: The Trust has a zero-tolerance policy with regard to abuse of its staff. Work has been done over the last year, by the Learning and Development Team, the FTSU Guardian, the OD Manager, for Equality, Diversity and Inclusion, and the OD Manager – Health and Wellbeing, to develop a structured Active Bystander framework to ensure training is delivered consistently. Bystander training is being incorporated into the Conflict Resolution. This training is being delivered to groups and teams throughout the Trust, including being incorporated into mandatory conflict resolution training. Targeted training has been delivered in specific areas where this concern was raised.

Theme: Bullying: The percentage of concerns where an element of bullying is mentioned has declined from 8% last quarter to 6%. This is a relatively low level (the NGO reports an average of 18%) but no cases of bullying are acceptable, and we understand from previous staff survey results that cases often go unreported.

Learning and Action: Each case reported has been investigated and addressed, and those speaking up about it have been offered support.

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

Staff feeling able to speak up about bullying is an important step to address it. The work being done around active bystander training (see above) is also an important part of supporting a psychologically safe workspace where bullying will not be tolerated.

Theme: Reduction in service: A concern was raised regarding a perceived gap in the support for discharge of patients with delirium following the loss of the Delerium Discharge Nurse.

Learning and Action: This post is no longer funded by the ICB, so the Trust are no longer commissioned to offer this service. The chief nurse provided the following information: A presentation to the Execs was given by the discharge team who reviewed activity and impact and found that the numbers of patients that benefitted from this service was very small, so the decision was made not to absorb this funding as the cost didn't outweigh the benefits. This was supported by the discharge team.

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

Staff feeling able to speak up about bullying is an important step to address it. The work being done around active bystander training (see above) is also an important part of supporting a psychologically safe workspace where bullying will not be tolerated.

6. Feedback on the Freedom to Speak Up Process

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

The figures below show a summary of evaluations received in Q3.

- Only two responses were received to the FTSU feedback survey for Quarter 3. Both respondents said they would speak up again.
- Free text comments and other feedback received verbally and via email was generally positive. Feedback taken from the form and email responses include:

Thank you again—I truly appreciate your support and feel heard

Good communication throughout.

Many thanks for your help over recent weeks and for meeting with our managers. Our manager is adamant that things will change.

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

Principle 1: Value Speaking Up:

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

What's going well:

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

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

What's going well:

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

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

What's going well:

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

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

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

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

What's going well:

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

Next steps:

- Senior Leaders to complete 'Follow Up' training.

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

What's going well:

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

Next steps:

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

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

What's going well:

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

Principle 7: Barriers to speaking up are identified and tackled

What's going well:

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

Next Steps:

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

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

What's going well:

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

Next Steps:.

- **FTSU policy requires update planned for February 2026– this to be undertaken by FTSU guardian and HRBP for policy, and brought to policy governance group**
- **Completion of NGO's Reflection and Planning Tool by FTSU Guardian, NED and senior leaders for May Board.**

4.3. Putting You First Report (ATTACHED) - Christian Jenner

To Assure

Presented by Greg Bowker

West Suffolk
NHS Foundation Trust

Putting You First awards

November 2025 – January 2026 winners

Board of Directors: 30 January 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 sent to the chief people officer during the first or second week of every other month.

The nominees are reviewed by members of the executive group and winners selected (usually 2-4 winners per process). The citations are included in the following Trust Board report.

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

Compassionate care,
healthier communities

Emma Scrivener, POCT coordinator

Nominated by Elaine Attree, Admin Assistant

West Suffolk NHS Foundation Trust

Our manager Emma in general is always an excellent trainer and team leader, as well as great mentor to us all. She is very supportive to our team and her door is always open, despite her heavy workload, and she goes above and beyond to assist anyone.

In May I was diagnosed with Ovarian Cancer and had a major operation (I had nursed my mother with this same cancer and found it very difficult). Emma has been very supportive and caring throughout this difficult period of time.

I could not have asked for more help or a listening ear when needed. She has adjusted my working role whilst I was in phased return and, now I'm back full time, she keeps a close eye on my workload and wellbeing.

I would like to nominate Emma as my hero for always going above and beyond her role, and always putting the needs of the team and the wards we support first.

Anyone would be very lucky to have Emma as their manager. I consider her to be a Leader of true value.

Compassionate care, healthier communities

Catherine Morley, highly specialist physio children's community physiotherapy

Nominated by Christine Hawley, service lead paeds physio (recently retired)

Cat has been a longstanding member of the team. She leads the orthopaedic service for children with complex disabilities.

Alongside managing a community caseload, she has set up a new spinal pathway & monitoring for children with Cerebral Palsy linked to the national database. This requires ongoing training, roll out to the wider team, plus liaison and radiological review with consultants.

I highlight Cat's compassionate care for young people. For the last 4 years, she has supported a family to explore every means to enable a young person regain their independence following their life changing spinal cord injury. This involved 1;1 support, hydrotherapy in local swimming pools and every opportunity to access disability sport, charitable networks and holidays to widen horizons.

The family have repeatedly expressed their gratitude to Cat: "Thank you for the continuous support which has not only been technical, but also a motivational boost for X to keep making progressed on the route of Independence. X is increasingly confident, calm and more focused on her schooling tasks. This is so comforting".

Received recently: "Just wanted to say a huge thank you for your detailed email, for the understanding, encouragement, and support you've given. We truly can't thank you enough. We've been so grateful for everything you've done for us. you've gone way above and beyond what we could've hoped for—and we really appreciate you reaching out to her college to speak up for her. We know you've been working nonstop to find more in-depth NHS resources."

Compassionate care, healthier communities

Teresa Caruth, Eye treatment centre dept manager

Nominated by Kirsty Charlick, HAS

Teresa is a fantastic manager to our team at the Eye Treatment Centre. She always puts her staff and patients first, and goes above and beyond to support us all.

I personally feel extremely lucky to have her as a manager as she has helped me through some tough times when I needed her but has also supported and encouraged me in my job role. She celebrates all our achievements big or small.

Teresa is the head of the ETC family and we truly are a family who work well together and support each other, and this could not be done without the tremendous efforts of our amazing manager.

Not only does she have the thankless task of organising rotas for the weeks ahead, she always has an ear to listen whenever any of us need it and I speak for the whole team by saying how much we appreciate her.

I want to nominate her for this award as there is no one more deserving than her and this is just a small thank you for all she does.

Compassionate care,
healthier communities

COMFORT BREAK

5. RESPONSIBLE WITH RESOURCES

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

To Assure

Presented by Antoinette Jackson

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			Date of meeting: 17 December 2025		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	***WHAT NEXT?*** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	***Escalation:*** *1. No escalation* *2. To other assurance committee /MEG* ***3.** Escalate to Board*
PAGG/IQPR	**NHS Oversight Framework** The Q2 2025/26 update of the NHS Oversight Framework was released on 28 November 2025. Although WSFT remains in overall segment 3, the unadjusted segment improved from 3 to 2, with improvements seen in scores across all domains except effectiveness and experience of care (the lower the score in each domain, the better the ranking).	**2 Reasonable**	The Trust cannot move out of segment 3 because of its financial deficit position but the Board can take assurance from the improvements seen across many domains.	The Framework will be updated quarterly.	3 To Board for information

Originating Committee: Insight Committee			Date of meeting: 17 December 2025		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	***WHAT NEXT?*** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	***Escalation:*** *1. No escalation* *2. To other assurance committee /MEG* ***3.** Escalate to Board*
PAGG/IQPR	**Urgent and Emergency Care** In urgent and emergency care October 4-hour performance was similar to September at 69.5%, missing the in-month trajectory of 72%. 12-hour waits increased again, from 8.62% in September to 9.00%, above plan but still below the comparable 2024 position**.**	**3 Partial**	Not meeting urgent and emergency standards means some patients are waiting longer in the Emergency Department than they should be.	Recovering delivery of the 4-hour performance trajectory will be the key focus for urgent and emergency care in November, with 72% needing to be achieved. Provisional November data indicates the trajectory for that month was exceeded by 4%. 12-hour waits will also need to meet a resubmitted trajectory of 6% in November and December. WSFT will be required to submit performance trajectories for 2026/27 to 2028/29 in response to the publication of the Medium-Term Planning framework.	3. Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 17 December 2025		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	***WHAT NEXT?*** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	***Escalation:*** *1. No escalation* *2. To other assurance committee /MEG* ***3.** Escalate to Board*
PAGG/IQPR	**Cancer Targets** 28-day Faster Diagnosis Standard performance decreased to 74.1% in September (from 80.4% in August). In comparison 62-day performance increased to 84.9% in September (from 78.6% in August) Overall improvements to Cancer performance have resulted in the Trust being moved out of Tiering completely.	**2 Reasonable**	Due to the challenges in breast there is a continued risk to the faster diagnosis standard and 62-day performance. Whilst challenges remain the Board can take assurance from the Trust's removal from the Tiering process for Cancer performance	The Trust has committed to achieving the 62-day standard (75%) and Faster Diagnosis Standard (FDS) (80%) for 2025/26. Gynaecology, skin and lower gastrointestinal (LGI) are the areas of focus for transformation. WSFT will be required to submit performance trajectories for 2026/27 to 2028/29 in response to the publication of the Medium-Term Planning framework.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 17 December 2025		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	***WHAT NEXT?*** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	***Escalation:*** *1. No escalation* *2. To other assurance committee /MEG* ***3.*** *Escalate to Board*
PAGG/IQPR	**Elective Recovery** The total waiting list and RTT 18-week compliance were comparatively stable from September to October, giving high confidence in meeting the March 2026 target for both. As at the end of October 2025 there were 72 patients over 65 weeks, a further reduction from 102 in September, this volume is expected to continue to reduce over the coming weeks with a national expectation of 0 from the 21st December. The volume of 52 week waits reduced further in October to 2.8% of the total waiting list (target 1% by March 2026), in line with the revised trajectory.	**2 Reasonable**	There is a risk of patient harm if patients are not treated in a timely way. Significant efforts in this area are beginning to show sustained improvement. Our regional ranking on long waits has improved from 92nd to 52nd. Regional data shows WSFT is one of only four Trusts ahead of its RTT 18-week plan; has a lower than average 65-week cohort; and has the third smallest 52 week wait cohort. WSFT has increased capped theatre utilisation but needs to catch up on waiting list validation. Given the Trust's improved performance we have been moved from Tier 1 into Tier 2 in the national support system.	Trajectories for elective access standards were resubmitted as part of the NHS mid-year review process. While these allowed for a "reset" against current delivery, a concerted effort is required to regain progress against original plans in Q4.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 17 December 2025		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	***WHAT NEXT?*** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	***Escalation:*** *1. No escalation* *2. To other assurance committee /MEG* ***3.** Escalate to Board*
Diagnostics	September DM01 performance increased further, from 45.54% to 51.5%. Additional ultrasound activity commences in October, which will see further recovery in subsequent months and an improved forecast year performance at 76% by March 2026.	**3 Partial**	Longer waiting times for diagnosis and treatment have a detrimental effect on patients, as well as delay in achieving the diagnostic 6-week DM01 compliance standards.	Given the national recruitment challenges, a SNEE ICB diagnostic strategy is currently being developed. DEXA are working through the back log as planned with increased activity 5 days a week Ultrasound plans to clear the majority of the back log by the end of the financial year. This will mean less use of temporary staffing and insourcing going forward, using a pipeline of the Trust's own trainees. The proposed solution for endoscopy is CDC expansion, if the business case for this is approved. Longer term there may be technological advances, offering further solutions for some services.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 17 December 2025		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	***WHAT NEXT?*** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	***Escalation:*** *1. No escalation* *2. To other assurance committee /MEG* ***3.** Escalate to Board*
Finance Accountability Committee	**Month 8 Reporting** At month eight the Trust is reporting a £1.0m year to date(YTD) underspend against the plan. There is a YTD deficit of £16.3m, compared to the planned deficit of £17.3m. We continue to forecast meeting our planned deficit of £20.7m for 25/26. The CIP plan is currently on plan at £17.7m YTD. CIP targets in the second part of the year remain challenging. Year to date capital spend at month 8 is £10.3m. This is behind the phased plan, bit it is anticipated that the plan for 2025/26 will be achieved, subject to final PDC funding agreements being in place. The Trust has been successful in its application for £14m of cash support in quarter 3 and has applied for a further £6m of cash support in quarter 4, which is in line with our plan.	**2 Reasonable**	It is positive to see the monthly run rate reducing ahead of plan as this will help the position going into 2025/26. The CIP programme monthly targets ramp-up significantly through the rest of the year and remains a risk.	Delivery of the CIP programme needs continued focus – see below	3.Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 17 December 2025		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	***WHAT NEXT?*** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	***Escalation:*** *1. No escalation* *2. To other assurance committee /MEG* ***3.** Escalate to Board*
Cost Improvement Programme (CIP) delivery	At Month 8, the Trust has delivered £17.7m of CIP against a budgeted plan of £17.7m. It has identified £28.9m/£28.1m of unweighted/weighted CIP opportunities respectively against a full year target of £32.8m. This compares to £29.4m/£27.0m of unweighted/weighted CIP opportunities respectively, reported at last month's Insight. A gap of £3.8m/£4.7m remains when considering the unweighted/weighted CIP position respectively.	**3 Partial**	There are several high value schemes progressing through the change control process, which will lead to a fluctuation in some figures and not all will achieve their original targets. Those with significant risk of delivery continue to be corporate services and clinical productivity. The CIP programme only captures formal schemes not all financial changes. There will be other fortuitous savings which will help bridge the 2025/26 deficit. The Quality Impact Assessment panel continues to take a critical look at proposed schemes and not all are approved if there are risks to patient safety.	The Business Planning process will help identify ideas for 2026/27, as well as exploring the full year effect of 2025/26 schemes. See report on CIP Plans for 2026/27 below	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 17 December 2025		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	***WHAT NEXT?*** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	***Escalation:*** *1. No escalation* *2. To other assurance committee /MEG* ***3.** Escalate to Board*
PA Consulting Deep Dive	The Trust commissioned PA consulting to support CIP delivery for 25/26. Given the scale of the CIP challenge facing the Trust at the time and the level of grip and pace required, the Board agreed that substantial temporary resources would be required to assure Board of delivery. The purpose of the deep dive was to review the effectiveness of the contract with PA Consulting in delivering the outcomes required and to establish what learning had been built into the Trust's future approach to managing CIP.	**1 Substantial**	The management of the contract was broadly successful, given the value of schemes delivered with PA support, the flexibility of the arrangement, and the incentivisation of work on priority areas. The outcomes delivered varied by work stream and by necessity evolved through the contract period. Significant learning has been captured which is directly feeding-in to planning for the 26/27 CIP programme.	Learning from the contract has fed into the plans for 26/27CIP delivery (see below) The Trust will continue to develop internal skills and capacity and address identified gaps in capability Regular updates will be provided to the Finance and Performance Committee on the 26/27 CIP approach.	3 Escalate to Board for information

Originating Committee: Insight Committee			Date of meeting: 17 December 2025		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	***WHAT NEXT?*** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	***Escalation:*** *1. No escalation* *2. To other assurance committee /MEG* ***3.** Escalate to Board*
CIP Planning 2026/27	The Committee considered a paper setting out the proposed approach to CIP delivery in 26/27. The report outlined the proposed programme management arrangements to deliver a sustainable approach to CIP delivery which will deliver of the Trust's full 26/27 CIP target by March 2027. The programme will also seek to deliver the effective management of risks to service quality and maximise alignment between organisational priorities; and support the shift to a more empowered culture. The Trust's approach to CIP has improved significantly in the last two years, but opportunities remain to enhance the approach.	**2 Reasonable**	While the Trust's approach has matured, there are opportunities to empower staff further, ensure decisions are data driven, and to clarify strategy. Given the considerable cost reductions made in 25/26, the strategy to delivering CIP will now shift more to enhancing productivity. The proposed approach has been informed by the learning from previous years. This gave the committee assurance that the Trust would start 2026/27 on a good footing, not withstanding the fact that there will be challenging targets to deliver.	The Trust will identify the key opportunities for 26/27 through analysis of key information sources (e.g. NHS benchmarking), early engagement workshops with colleagues, and sharing best practice Targets will be developed in December as part of the Medium-Term Planning Process. This will be supported by an action plan and roadmap which will highlight the clear interdependencies with related activities. It will also set out the key implementation milestones.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 17 December 2025		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
Agenda item	**WHAT?** Summary of issue, including evaluation of the validity the data*	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	***WHAT NEXT?*** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	***Escalation:*** *1. No escalation* *2. To other assurance committee /MEG* ***3.*** *Escalate to Board*
Emergency Preparedness, Resilience and Response (EPPR)	NHS England (NHSE) requires the Trust to participate in the annual Emergency Preparedness, Resilience and Response (EPRR) assurance process, which is undertaken by a self-assessment against a set of national core standards. This is how NHSE obtains assurance that NHS funded organisations are sufficiently capable to respond to business as usual, business continuity, critical and major incidents. In 2024, WSFT was assessed as 'Partially Compliant' having reached 80.65% against the standards, with 12 core standards where the Trust were not fully compliant. An action plan against all areas of non-compliance was delivered, with a particular focus on core standards relating to decontamination capability, mass casualty incident plans and business continuity management.	**1.Substantial**	The approach taken in the action planning process involved a significant change in approach and simplification of key processes with the needs of the end user in mind. (For example, Business continuity plans were reduced from 166 documents to 20). It is a good case study in stepping back from how things have always been done and reimagining how they could be done differently. As a result of the work undertaken through the action plan the Trust could demonstrate improvement to 'Substantially Compliant' in 60 out of 62 standards (96.78%). This was accepted and confirmed by Suffolk & North East Essex Integrated Care Board (SNEE ICB) who undertook an assurance visit.	There are action plans in place to achieve fully compliance on the outstanding two standards.	3. Escalate to Board

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

Board assurance committee - Committee Key Issues (CKI) report

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

PAGG/IQPR	**Urgent and Emergency Care** September 4-hour performance decreased to 69.7%, not meeting the in-month trajectory of 75%. 12-hour waits as a percentage of attendances increased from 4.7% in August to 8.62% in September, not meeting plan but below the comparable 2024 position**.**	**3 Partial**	Not meeting urgent and emergency standards means some patients are waiting longer in the Emergency Department than they should be.	Recovering delivery of the 4-hour performance trajectory will be the key focus for urgent and emergency care in November, with 72% needing to be achieved. 12-hour waits will also need to meet a resubmitted trajectory of 7% in October and 6% in November and December. WSFT will be required to submit performance trajectories for 2026/27 to 2028/29 in response to the publication of the Medium-Term Planning framework.	3. Escalate to Board

PAGG/IQPR	**Cancer Targets** 28-day Faster Diagnosis Standard performance remained stable at 80.4% in August. 62 day performance increased to 78.6% in August from 70% in July.	***3 Partial***	Due to the challenges in breast there is a continued risk to the faster diagnosis standard and 62-day performance.	The Trust has committed to achieving the 62-day standard (75%) and Faster Diagnosis Standard (FDS) (80%) for 2025/26. Gynaecology, skin and lower gastrointestinal (LGI) are the areas of focus for transformation. WSFT will be required to submit performance trajectories for 2026/27 to 2028/29 in response to the publication of the Medium-Term Planning framework.	3 Escalate to Board

PAGG/IQPR	**Elective Recovery** The total waiting list was 32,635 at the end of September, down from 33,671 at the end of August. Overall RTT compliance increased from 58.39% to 62.1% due to additional activity and validation in September. As at the end of September there were 102 patients over 65 weeks, a further reduction from August, this volume is expected to continue to reduce over the coming months with a national expectation of zero from the 21st December. The volume of 52 week waits also reduced in September to 3.3% of the total waiting list (target 1% by March 2026) but we remain off plan.	**3 Partial**	There is a risk of patient harm if patients are not treated in a timely way. As a result of the Trust's variance to plan, we were placed into 'Tier 1' for elective care, alongside diagnostics. This requires fortnightly meetings with national and regional NHS England teams. Gynaecology remains a particular area of risk and a high reliance on ultrasound is impacting their ability to recover.	The Management Executive Group (MEG) has approved an additional £424k for elective recovery and the investment will be profiled to provide the best value for money through targeting specialities which can provide high volume, accelerated recovery whilst also reducing long waits in all specialities. Trajectories for elective access standards were resubmitted as part of the NHS mid-year review process. While these allowed for a "reset" against current delivery, a concerted effort to recover is required to regain progress against original plans in Q4.	3 Escalate to Board

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

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

Finance Accountability Committee	**Month 7 Reporting** At month seven the Trust was reporting a £1.2m year to date (YTD) underspend against the plan, with a YTD deficit of £15.3m, compared to the planned deficit of £16.5m. We continue to forecast meeting our planned deficit of £20.7m for 25/26 The CIP plan is currently on plan at £14.1m YTD. However, challenging CIP targets in the second part of the year remain. YTD capital spend at month 7 is £7.8m. This is behind the phased plan, but it is anticipated that the plan for 2025/26 will be achieved, subject to final PDC funding agreements being in place.	**3 Partial**	It is positive to see the monthly run rate reducing ahead of plan as this will help the position going into 2025/26. The CIP programme monthly targets ramp-up significantly through the rest of the year and remain a risk. Cash is being rigorously monitored to ensure that the Trust remains on plan and does not fall below the £1.1m limit that must be maintained The Trust applied for £10m in cash support for November, but has only been awarded £5.7m.	Discussions are being held with NHSE to ensure that the full level of cash support is received in December. Delivery of the CIP programme needs continued focus – see below	3.Escalate to Board for information

Cost Improvement Programme (CIP) delivery	At month 7 the Trust had identified £29.4m/£27m of unweighted/weighted CIP opportunities respectively against a full year target of £32.8m. This compares to £29.3m/£26.1m of unweighted/weighted CIP opportunities reported the previous month. A gap of £3.4m/£5.8m remains against the 25/26 CIP target when considering unweighted/weighted CIP positions respectively The overall gap in the portfolio has reduced, with 90% of the CIP target identified (82% weighted).	**3 Partial**	There are several high value schemes progressing through the change control process, which will lead to a fluctuation in some figures and not all will achieve their original targets. Those with significant risk of delivery continue to be corporate services and clinical productivity. The CIP programme only captures formal schemes not all financial changes. There will be other fortuitous savings which will help bridge the 2025/26 deficit. The Quality Impact Assessment panel continues to take a critical look at proposed schemes and not all are approved if there are risks to patient safety.	The Business Planning process will help tease out ideas for 2026/27, as well as exploring the full year effect of 2025/26 schemes.	3 Escalate to Board

Guidance notes

The practice of scrutiny and assurance

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

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

Assurance level

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

5.2. Finance Report (ATTACHED)

To Review

Presented by Jonathan Rowell

WSFT Monthly Finance Report

2025-26 – December 2025 (M9)
for Public Board
30th January 2026

Putting you first

Executive Summary as at December 2025

West Suffolk NHS Foundation Trust

Summary

The Trust has agreed a £20.7m deficit budget for the year, and at month nine is reporting a £0.8m year to date underspend against the plan. The reported Income and Expenditure (I&E) for month nine shows a YTD deficit of £16.5m, compared to the planned deficit of £17.3m. The M9 position includes recognition of income that was previously deferred, and this has driven an in month deficit of only £203k.

Forecast and underlying position

The Trust is forecasting to achieve its planned deficit for the year. However, the underlying position is important in planning for 2026/27, and in December the underlying deficit has remained at £1.54m.

Workforce

The Trust are reporting a decrease in WTEs in December 2025 (4,783.5 WTEs) compared to December 2024 (4,952.0 WTEs), a reduction of 168.5 WTEs with reductions in Nursing (40.1 WTEs), AHPs (33.3 WTEs) and A&C staff (112.5 WTEs) with an increase in Medical Staff of 28.4 WTEs. WTEs are 251.5 below the annual workforce plan as of month nine and we continue to spend zero on Agency Nursing. Since April 2024, we have reduced our staffing levels by 337.0 WTEs (6.6%).

Efficiencies

The CIP schemes were aimed at delivering £32.8m for the year. The year-to-date target was £21.4m, and this has been delivered. Delivery of CIP increases in the second part of the year and is £3.7m in December. Work to de-risk future CIP continues, with vacancy and non-pay controls remaining in place.

Cash

The cash balance as at 31 December 2025 was £15.2m compared to a plan of £1.1m. Cash is higher than plan due to the timing of a creditors payment run. The balance also includes cash that is earmarked specifically for spend on capital projects. Cash is being rigorously monitored to ensure that the Trust remains on plan and does not fall below the £1.1m limit that must be maintained and is enforced by NHS England. The Trust has been successful in its application for £14m of cash support in quarter 3. We have applied for a further £6m of cash support in quarter 4, which is in line with our plan.

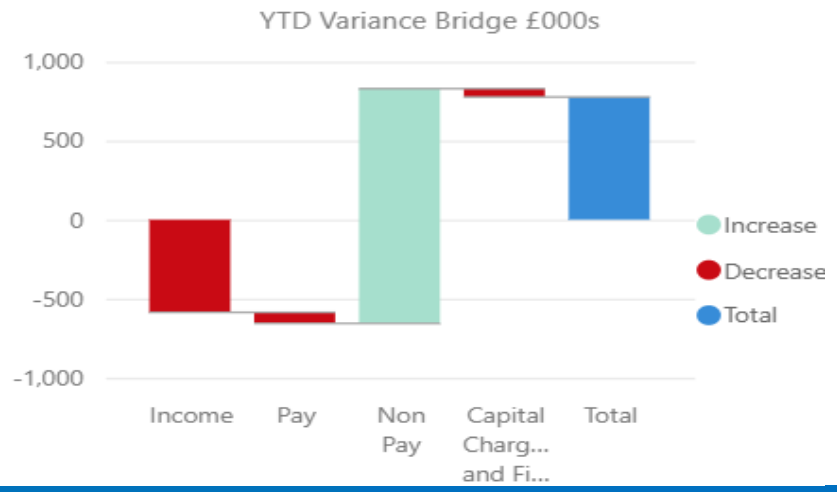
Capital

The Capital Plan for 2025/26 was agreed at £25.6m. An additional £1m of CDEL and £7.2m of PDC was awarded to the Trust in the first quarter. Further adjustments to PDC has resulted in a Capital Plan for 2025/26 of £31.4m. £11.5m of this is internally funded, with the remaining £19.9m being funded by Public Dividend Capital (PDC). Year to date capital spend at month 9 is £13.3m. This is behind the phased plan, but after a detailed review of forecast spend we anticipate that the plan for 2025/26 will be achieved, subject to final PDC funding agreements being in place. There is a risk that some schemes funded by PDC will not be delivered due to the delay in receiving the funding from NHS England and DHSC. PDC funding will be returned where schemes are not delivered.

M9 position

	In-Month Budget £m	In-Month Actuals £m	In-Month Variance £m F/(A)	YTD Budget £m	YTD Actuals £m	YTD Variance £m F/(A)	Annual Budget £m	Forecast £m	Forecast Variance £m F/(A)
EBITDA									
Income									
NHS Contract Income	32.2	34.3	2.1	288.7	287.7	-1.1	385.3	385.3	0.0
Other Income	3.3	3.1	-0.2	29.9	30.4	0.5	39.9	39.9	0.0
Total	**35.5**	**37.5**	**1.9**	**318.6**	**318.0**	**-0.6**	**425.2**	**425.2**	**0.0**
Expenditure									
Pay Costs	25.0	24.8	0.2	231.3	224.7	6.6	309.4	309.4	0.0
Non-pay Costs	8.7	10.9	-2.2	87.4	92.6	-5.2	113.5	113.5	0.0
Total	**33.6**	**35.7**	**-2.0**	**318.7**	**317.3**	**1.4**	**422.9**	**422.9**	**0.0**
EBITDA Position	**1.9**	**1.8**	**-0.1**	**0.1**	**0.7**	**0.8**	**2.3**	**2.3**	**0.0**
Depreciation	**1.5**	**1.4**	**0.0**	**13.4**	**13.2**	**0.2**	**17.8**	**17.8**	**0.0**
Finance Costs	**0.4**	**0.4**	**0.1**	**3.8**	**3.9**	**-0.1**	**5.2**	**5.2**	**0.0**
Impairments	**0.0**	**0.2**	**-0.2**	**0.0**	**0.2**	**-0.2**	**0.0**	**0.0**	**0.0**
Deficit/(Surplus)	**0.0**	**0.2**	**-0.2**	**17.3**	**16.5**	**0.8**	**20.7**	**20.7**	**0.0**

Deficit YTD £	**16.5M**	
Variance against plan YTD £	**0.8M**	**Favourable**
Movement in month against plan £	**-0.2M**	**Adverse**
EBITDA Postion YTD £	**0.7M**	**Favourable**
EBITDA margin YTD	**0%**	**Favourable**
Cash at bank	**£15.2M**	



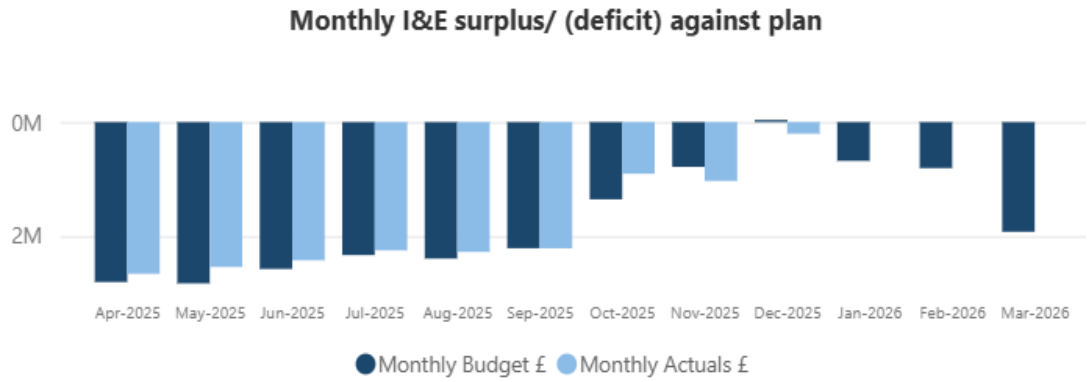
Income and Expenditure Summary – December 2025

NHS West Suffolk NHS Foundation Trust

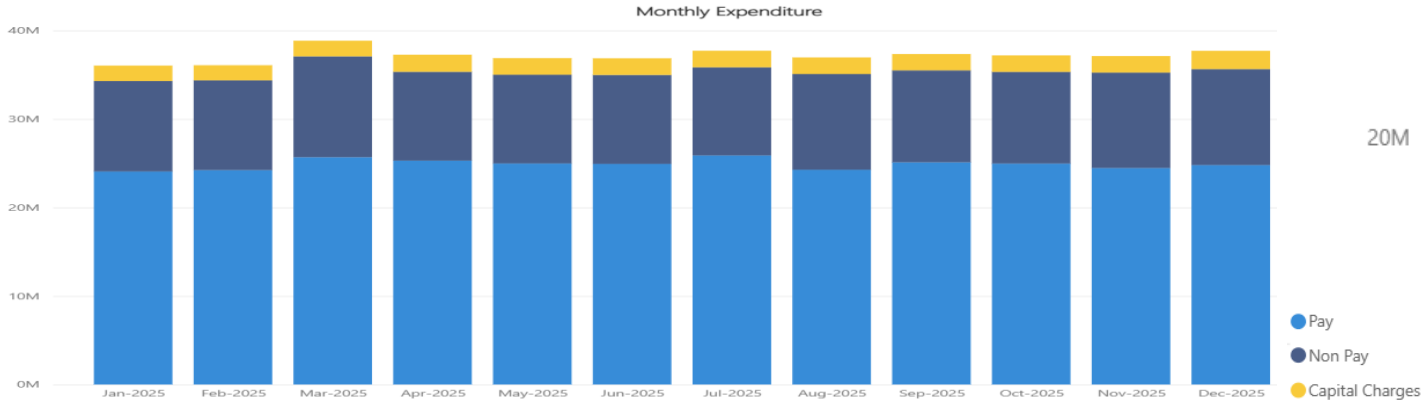
An adverse variance of £210k was reported in December, being £776k favourable YTD.

Board Report Item	Original Plan/ Target £000s	Actual/ Forecast £000s	Variance to Plan £000s F/(A)	
In month surplus/ (deficit)	7	-203	-210	↓
YTD surplus/ (deficit)	-17,286	-16,510	776	↑
Clinical Income YTD	288,743	287,673	-1,070	→
Non-Clinical Income YTD	29,867	30,350	484	↑
Pay YTD	231,325	224,713	6,613	↑
Non-Pay YTD	87,368	92,565	-5,197	↓
EBITDA YTD	-83	745	829	↑
EBITDA %	0.0	0.2	0.2	

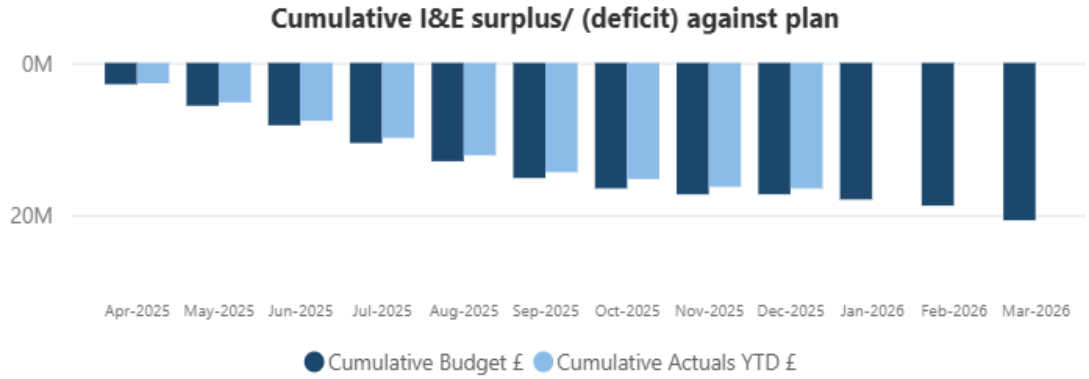
Adverse variance > 1% ↓
Adverse variance within 1% →
On plan or favourable variance ↑



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



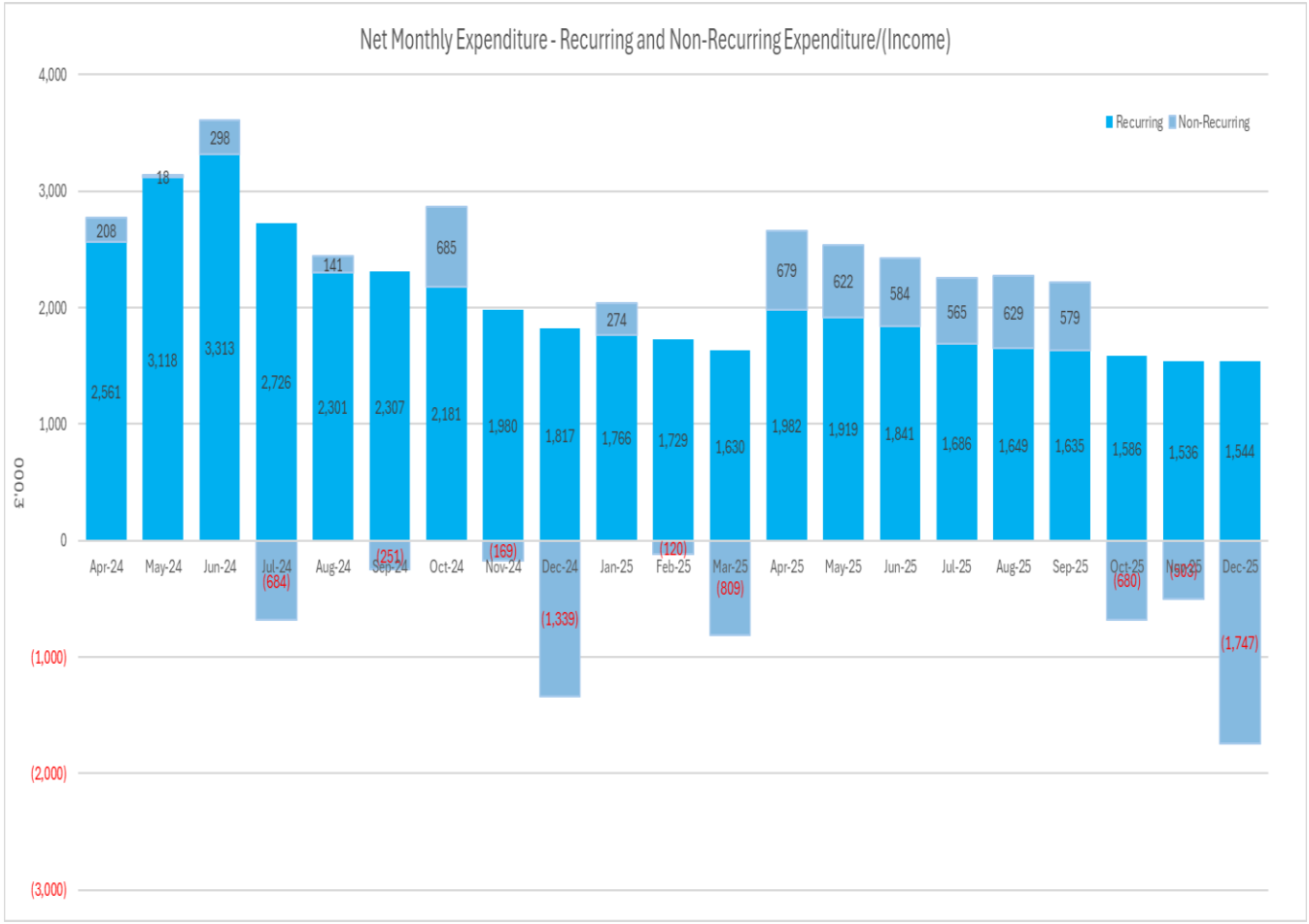
Excludes impairments and centrally funded pension contributions



M9 recurring position

There has been a steady decrease in our recurring monthly costs since June 2024 (other than the pay awards that came into effect in April 2025), but this has levelled off over the last 3 months.

	Apr-25 £'000	May-25 £'000	Jun-25 £'000	Jul-25 £'000	Aug-25 £'000	Sep-25 £'000	Oct-25 £'000	Nov-25 £'000	Dec-25 £'000
Net Expenditure	**2,661**	**2,541**	**2,425**	**2,251**	**2,278**	**2,214**	**906**	**1,033**	**(203)**
Recurring	**1,982**	**1,919**	**1,841**	**1,686**	**1,649**	**1,635**	**1,586**	**1,536**	**1,544**
Non-Recurring									
Income adjustment	200	250	416	336	0		0	(172)	(2,582)
HEE income							(670)	0	0
Private patient income				(37)	(200)		0	(180)	0
Staff recharges			(136)				0	0	0
Pay arrears	49	350		(22)	(423)	148	0	110	(38)
Industrial Action					154		0	182	173
Consumables	178	(178)					0	0	0
Glemsford									580
Rent arrears	53					4	0	0	0
Ecare accrual					300		0	0	0
Utilities			(51)			78	0	0	50
External Support	300	300	330	330	330	201	0	0	0
VAT refund reversed					439		0	0	0
Other	(101)	(100)	25	(42)	29	148	(10)	6	(4)
Non-Recurring	**679**	**622**	**584**	**565**	**629**	**579**	**(680)**	**(503)**	**(1,747)**

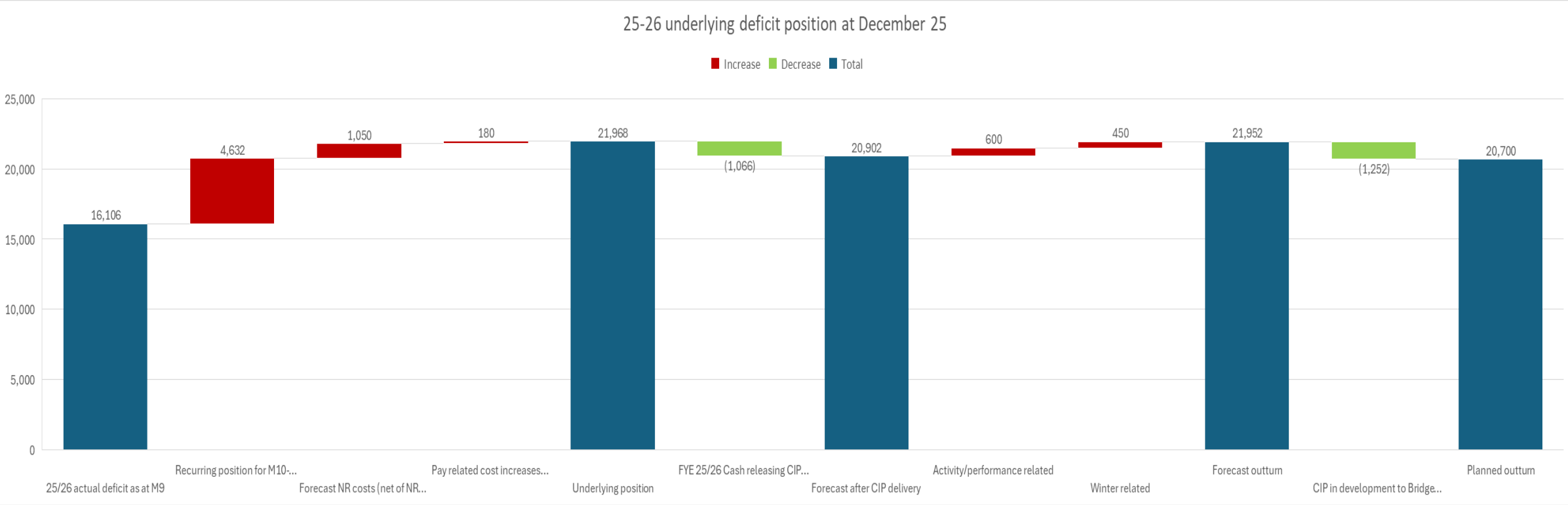


25/26 Underlying Position and Forecast

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

As at M9 the forecast continues to be to deliver the plan as below, assuming that the recurring position is currently broadly £1.54m deficit per month, and that CIP delivery increases over the second part of the year, as well as seasonal and activity related costs varying throughout the year. Redundancy costs and any associated CIP are included in this forecast.

However, this forecast is contingent on delivering around £1.3m of CIP that has been identified but not yet in delivery, a reduction of £0.8m since month 8. Should the activity at the CDC increase without any significant increase in costs this gap will be covered by CDC related income.

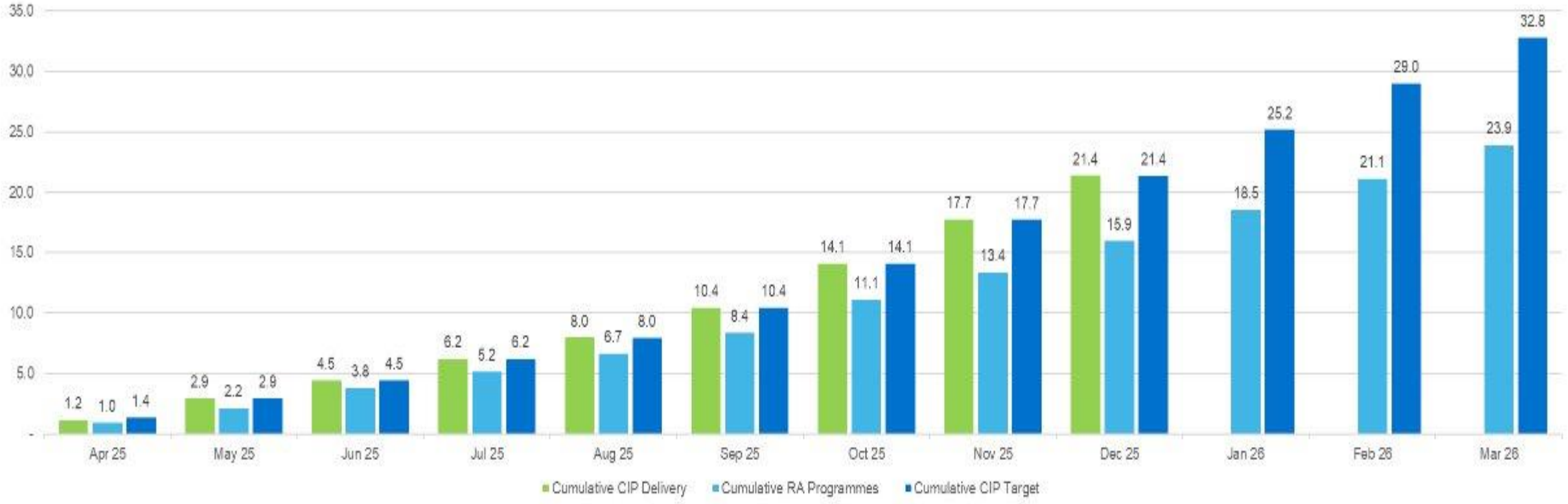


25/26 CIP Progress

The FY25/26 CIP target is £32.8m. Delivery of this ramps up through the year, see graph below. (H1: 32% H2: 68%)

As at M9, the Trust has delivered £21.4m of CIPs, against a budgeted plan of £21.4m, resulting in delivery to plan YTD.

All reported numbers are now recorded on the CIP Tracker.



Divisional Financial Performance

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

Division	In-Month Budget £000s	In-Month Actuals £000s	In-Month Variance £000s	YTD Budget £000s	YTD Actuals £000s	YTD Variance £000s
Medical Services	**7,885**	**8,660**	**-775**	**71,344**	**73,998**	**-2,654**
Income	-422	-509	86	-3,822	-4,393	571
Pay	6,179	6,438	-258	55,597	57,836	-2,239
Non Pay	2,081	2,685	-604	19,149	20,140	-991
Capital Charges	47	46	1	421	415	6
Surgical Services	**5,894**	**5,895**	**-1**	**54,453**	**54,237**	**216**
Income	-393	-462	69	-3,459	-3,770	311
Pay	4,884	4,979	-95	44,413	45,073	-660
Non Pay	1,375	1,360	15	13,246	12,718	528
Capital Charges	28	18	10	253	216	37
Women and Children Services	**2,191**	**2,373**	**-182**	**19,860**	**20,423**	**-563**
Income	-244	-237	-7	-2,193	-2,634	441
Pay	2,251	2,461	-209	20,580	21,727	-1,147
Non Pay	181	149	32	1,456	1,324	131
Capital Charges	2	0	2	17	6	12
Clinical Support	**3,587**	**3,984**	**-397**	**33,558**	**36,830**	**-3,273**
Income	-893	-690	-202	-7,033	-4,796	-2,237
Pay	3,097	3,121	-25	28,243	27,518	725
Non Pay	1,380	1,550	-170	12,322	14,083	-1,760
Capital Charges	3	3	0	26	26	0
Community Services	**5,136**	**5,358**	**-222**	**47,053**	**46,573**	**480**
Income	-582	-555	-26	-5,037	-5,073	35
Pay	4,071	3,867	204	37,008	36,125	883
Non Pay	1,586	1,997	-411	14,534	15,041	-506
Capital Charges	61	50	11	548	481	68
Facilities	**1,817**	**1,792**	**25**	**16,098**	**15,463**	**635**
Income	-441	-371	-70	-3,915	-3,536	-379
Pay	1,277	1,178	99	11,165	10,638	527
Non Pay	980	985	-4	8,846	8,360	486
Capital Charges	0	0	0	2	1	1
Contract Income & Corporate	**-26,517**	**-27,858**	**1,341**	**-225,080**	**-231,014**	**5,934**
Income	-32,638	-34,685	2,046	-293,802	-294,367	565
Pay	2,908	2,757	151	27,637	25,796	1,840
Non Pay	1,163	2,115	-952	18,630	21,592	-2,963
Reserves	298	0	298	6,683	0	6,683
Capital Charges	1,752	1,955	-202	15,772	15,964	-191
Deficit/(Surplus)	**-7**	**203**	**-210**	**17,286**	**16,510**	**776**

Pay Costs by Staff Type

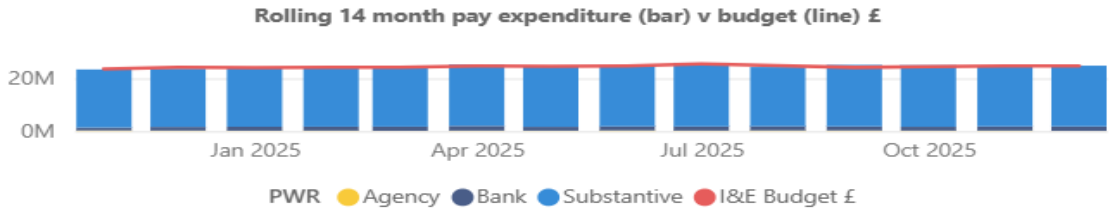
Pay costs in December includes costs relating to junior doctors strike action (£173k) and redundancy costs (£36k).

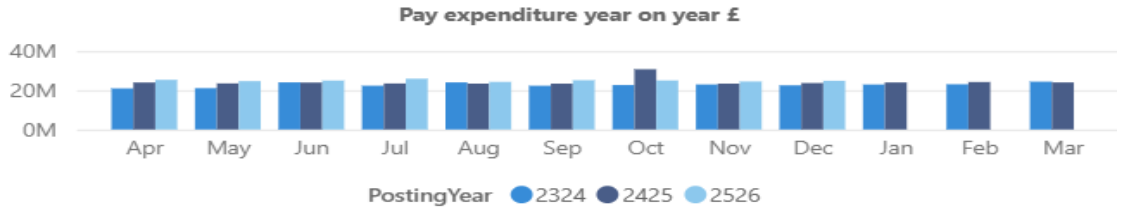
		Prior Month Actuals £000	In-Month Actuals £000s	In-Month Budget £000s	In-Month Variance £000s	YTD Actuals £000s	YTD Budget £000s	YTD Variance £000s
Substantive	Medical Staff	6,244	6,013	6,493	480	54,315	58,612	4,296
	Nursing	8,366	8,386	8,819	433	75,321	80,020	4,699
	Sci & Professional	1,192	1,174	1,272	98	10,603	11,412	808
	A&C	2,937	3,410	3,769	360	31,811	34,064	2,253
	AHP	2,418	2,455	2,826	371	22,122	24,773	2,652
	Prof & Tech	261	264	264	0	2,258	2,365	106
	Support Staff	864	876	929	53	7,873	8,271	398
	Other	429	464	601	137	4,751	7,424	2,673
	Unallocated central funding	0	0	-593	-593	0	-388	-388
	Total	22,711	23,042	24,380	1,338	209,055	226,553	17,498
Additional Medical Sessions	Medical Staff	286	315	202	-113	2,532	1,564	-968
	Total	286	315	202	-113	2,532	1,564	-968
Bank & Locum Staff	Medical Staff	428	500	192	-308	3,743	1,526	-2,217
	Nursing	578	599	29	-570	5,308	249	-5,058
	Sci & Professional	16	11	2	-9	157	20	-137
	A&C	62	56	9	-47	416	60	-356
	AHP	11	13	1	-12	111	9	-102
	Prof & Tech	2	2	1	-1	7	7	0
	Support Staff	170	164	142	-22	1,564	1,269	-295
	Total	1,266	1,344	375	-969	11,306	3,140	-8,166
Agency	Medical Staff	107	5	0	-5	946	0	-946
	Nursing	0	0	0	0	23	0	-23
	Sci & Professional	1	0	0	0	10	0	-10
	A&C	12	12	0	-12	58	0	-58
	Prof & Tech	17	14	0	-14	179	0	-179
	Support Staff	0	0	-2E-5	-2E-5	-8	0	8
	Total	136	31	-5E-5	-31	1,209	0	-1,209
Overtime	Nursing	25	27	1	-26	213	8	-205
	Sci & Professional	7	5	0	-5	62	0	-62
	A&C	9	13	7	-6	69	60	-9
	AHP	14	13	0	-13	162	0	-162
	Prof & Tech	11	11	0	-11	105	0	-105
	Total	66	68	8	-60	611	69	-543
Total		24,465	24,800	24,966	165	224,713	231,325	6,613

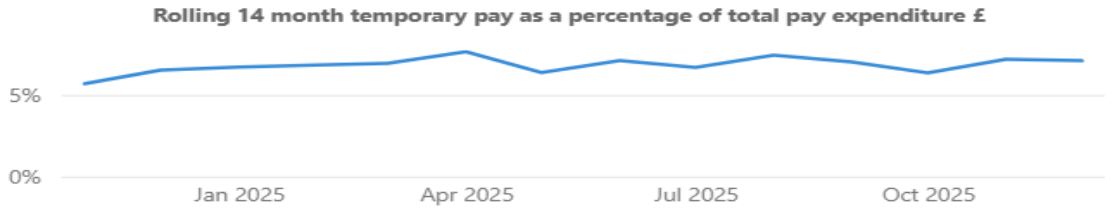
Pay Costs (by Staff Group)

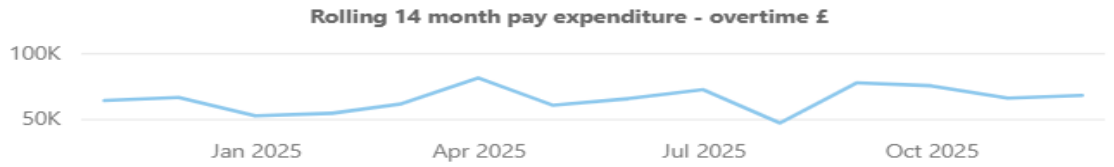
		Prior Month Actuals £000	In-Month Actuals £000s	In-Month Budget £000s	In-Month Variance £000s	YTD Actuals £000s	YTD Budget £000s	YTD Variance £000s
Medical Staff	Substantive	6,244	6,013	6,493	480	54,315	58,612	4,296
	Additional Medical Sessions	286	315	202	-113	2,532	1,564	-968
	Bank & Locum Staff	428	500	192	-308	3,743	1,526	-2,217
	Agency	107	5	0	-5	946	0	-946
	Total	7,065	6,834	6,887	54	61,536	61,701	165
Nursing	Substantive	8,366	8,386	8,819	433	75,321	80,020	4,699
	Bank & Locum Staff	578	599	29	-570	5,308	249	-5,058
	Agency	0	0	0	0	23	0	-23
	Overtime	25	27	1	-26	213	8	-205
	Total	8,969	9,011	8,849	-162	80,865	80,278	-587
Sci & Professional	Substantive	1,192	1,174	1,272	98	10,603	11,412	808
	Bank & Locum Staff	16	11	2	-9	157	20	-137
	Agency	1	0	0	0	10	0	-10
	Overtime	7	5	0	-5	62	0	-62
	Total	1,215	1,190	1,275	85	10,832	11,431	599
A&C	Substantive	2,937	3,410	3,769	360	31,811	34,064	2,253
	Bank & Locum Staff	62	56	9	-47	416	60	-356
	Agency	12	12	0	-12	58	0	-58
	Overtime	9	13	7	-6	69	60	-9
	Total	3,020	3,491	3,785	294	32,355	34,184	1,830
AHP	Substantive	2,418	2,455	2,826	371	22,122	24,773	2,652
	Bank & Locum Staff	11	13	1	-12	111	9	-102
	Overtime	14	13	0	-13	162	0	-162
	Total	2,443	2,480	2,827	347	22,394	24,783	2,388
Prof & Tech	Substantive	261	264	264	0	2,258	2,365	106
	Bank & Locum Staff	2	2	1	-1	7	7	0
	Agency	17	14	0	-14	179	0	-179
	Overtime	11	11	0	-11	105	0	-105
	Total	290	291	265	-26	2,549	2,372	-178
Support Staff	Substantive	864	876	929	53	7,873	8,271	398
	Bank & Locum Staff	170	164	142	-22	1,564	1,269	-295
	Agency	0	0	-2E-5	-2E-5	-8	0	8
	Total	1,034	1,040	1,071	30	9,429	9,540	111
Other	Substantive	429	464	601	137	4,751	7,424	2,673
	Total	429	464	601	137	4,751	7,424	2,673
Unallocated central funding	Substantive	0	0	-593	-593	0	-388	-388
	Total	0	0	-593	-593	0	-388	-388
Total		24,465	24,800	24,966	165	224,713	231,325	6,613

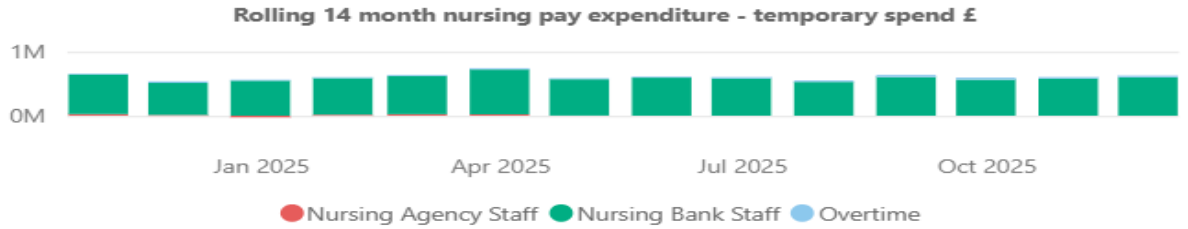
Pay Costs (trends)

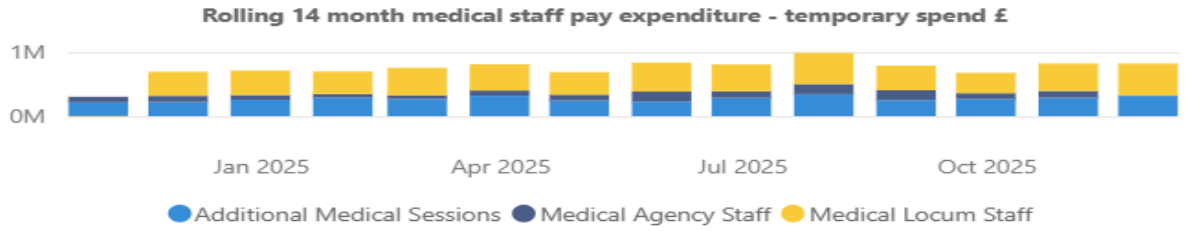


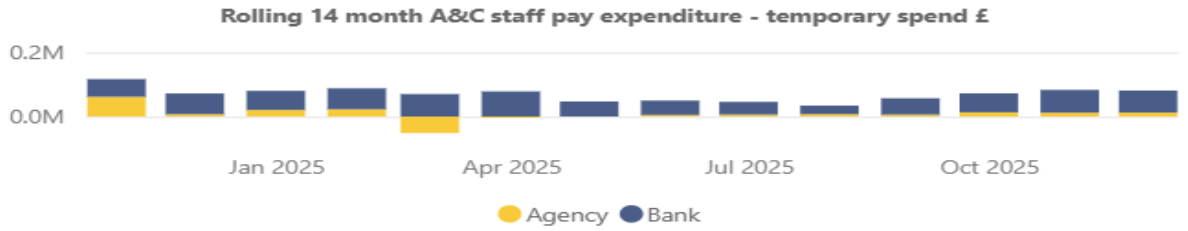












Workforce – WTEs by Staff Type

Substantive staff have decreased by 2.3 WTEs in month, with an increase in Nursing (7.2 WTEs) and a decrease in A&C staff (6.1 WTEs). Temporary staffing has decreased by 17.6 WTEs, mainly due to extra contracted sessions decreasing by the equivalent of 7.2 WTEs since November included extra sessions relating to the junior doctors strike. There was also a decrease in Medical Agency (5.8 WTEs) and A&C Agency (2.4 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	1,893.3	1,952.0	1,900.5	2,056.3	155.8	1,900.5	2,072.1	171.6
	A&C	859.2	966.4	853.1	988.3	135.2	894.6	995.3	100.8
	AHP	529.9	559.1	530.2	597.5	67.3	539.5	600.0	60.6
	Medical Staff	612.4	587.0	608.5	646.4	37.9	596.5	647.0	50.5
	Sci & Professional	277.6	272.2	274.5	296.7	22.2	274.7	294.0	19.2
	Support Staff	282.2	285.1	285.1	302.0	16.9	281.3	296.5	15.1
	Other	54.5	66.3	54.4	70.9	16.5	53.1	67.3	14.2
	Unallocated central funding	0.0	0.0	0.0	2.7	2.7	0.0	-6.2	-6.2
	Prof & Tech	52.5	49.0	53.0	55.0	2.0	50.1	54.9	4.8
	Total	4,561.5	4,737.1	4,559.2	5,015.8	456.5	4,590.4	5,020.9	430.5
Additional Medical Sessions	Medical Staff	14.6	9.2	7.4	2.9	-4.5	9.2	3.9	-5.3
	Total	14.6	9.2	7.4	2.9	-4.5	9.2	3.9	-5.3
Agency	Sci & Professional	0.3	1.3	0.0	0.0	0.0	0.3	0.0	-0.3
	Support Staff	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Nursing	0.0	3.9	0.1	0.0	-0.1	0.6	0.0	-0.6
	Prof & Tech	2.1	3.3	2.0	0.0	-2.0	2.6	0.2	-2.4
	A&C	4.4	0.0	2.0	0.0	-2.0	1.3	0.0	-1.3
	Medical Staff	8.1	1.7	2.3	0.0	-2.3	4.9	0.0	-4.9
	Total	14.9	10.2	6.4	0.0	-6.4	9.6	0.2	-9.4
Overtime	A&C	0.7	2.4	0.8	0.8	1.1E-16	1.3	0.8	-0.5
	Sci & Professional	1.0	1.1	0.8	0.0	-0.8	1.0	0.0	-1.0
	AHP	2.6	2.0	2.3	0.0	-2.3	3.5	0.0	-3.5
	Prof & Tech	3.0	2.9	2.8	0.0	-2.8	3.1	0.0	-3.1
	Nursing	5.8	5.3	6.0	0.3	-5.8	5.6	0.4	-5.2
	Total	13.0	13.6	12.7	1.1	-11.6	14.6	1.2	-13.4
Bank & Locum Staff	Other		0.6						
	Prof & Tech	0.4	0.3	0.5	0.3	-0.2	0.2	0.3	0.0
	AHP	1.8	3.1	2.2	0.0	-2.2	2.2	0.1	-2.1
	Sci & Professional	4.7	6.8	3.4	0.3	-3.1	5.2	0.8	-4.4
	Support Staff	14.2	13.8	11.6	1.0	-10.6	15.6	1.1	-14.5
	A&C	18.7	15.6	15.9	2.8	-13.0	14.0	2.8	-11.2
	Medical Staff	30.1	25.7	33.7	8.8	-24.9	30.5	8.9	-21.7
	Nursing	129.6	116.3	130.7	2.2	-128.4	132.2	1.7	-130.5
	Total	199.4	182.0	197.9	15.3	-182.5	200.0	15.6	-184.4
Total		4,803.4	4,952.0	4,783.5	5,035.1	251.5	4,823.7	5,041.8	218.0

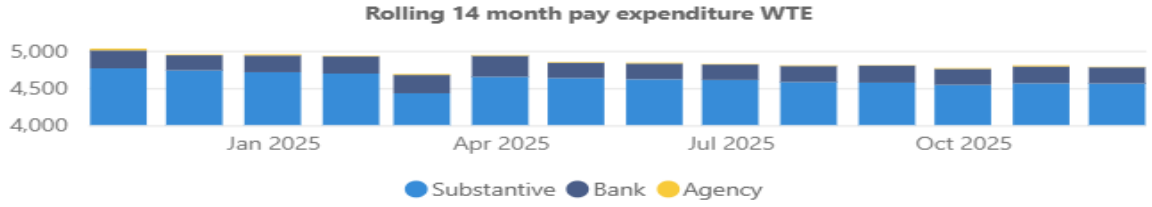
Workforce - WTE (by Staff Group)

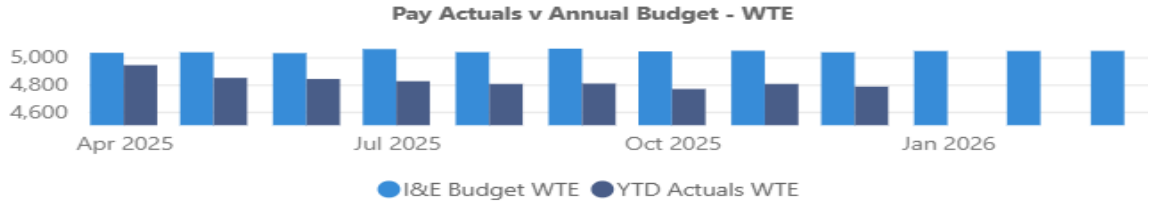
In December 2025 we are reporting a reduction of 19.9 WTEs compared with November 2025, and a reduction of 168.5 WTEs when comparing with December 2024 (3.4%).There has been a reduction of 337.0 WTEs since April 2024 (5,120.5 WTEs) (6.6%).
Medical Staff have increased by 28.4 WTEs over the past year (although this includes increases relating to the junior doctors industrial action, equivalent to around 12 WTEs).The favourable variance against establishment is 251.5 WTEs in December 2025.

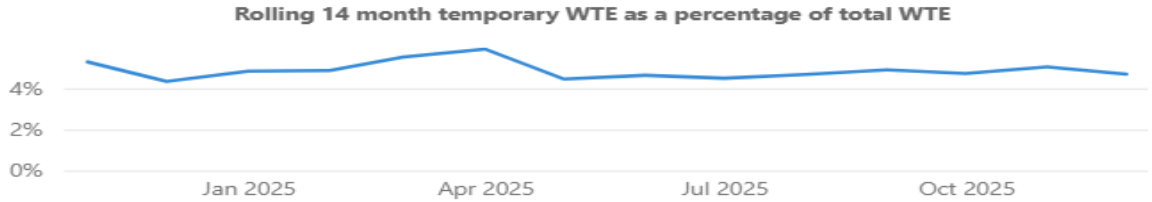
		Prior Month Actuals WTE	Prior Yr Same Period Actuals WTE	In-Month Actuals WTE	In-Month Budget WTE	In-Month Variance WTE	YTD Actuals Average WTE	YTD Budget Average WTE	YTD Variance Average WTE
Medical Staff	Substantive	612.4	587.0	608.5	646.4	37.9	596.5	647.0	50.5
	Additional Medical Sessions	14.6	9.2	7.4	2.9	-4.5	9.2	3.9	-5.3
	Bank & Locum Staff	30.1	25.7	33.7	8.8	-24.9	30.5	8.9	-21.7
	Agency	8.1	1.7	2.3	0.0	-2.3	4.9	0.0	-4.9
	Total	665.2	623.5	651.9	658.1	6.1	641.2	659.7	18.6
Nursing	Substantive	1,893.3	1,952.0	1,900.5	2,056.3	155.8	1,900.5	2,072.1	171.6
	Bank & Locum Staff	129.6	116.3	130.7	2.2	-128.4	132.2	1.7	-130.5
	Agency	0.0	3.9	0.1	0.0	-0.1	0.6	0.0	-0.6
	Overtime	5.8	5.3	6.0	0.3	-5.8	5.6	0.4	-5.2
	Total	2,028.7	2,077.4	2,037.3	2,058.8	21.5	2,038.9	2,074.1	35.2
Sci & Professional	Substantive	277.6	272.2	274.5	296.7	22.2	274.7	294.0	19.2
	Bank & Locum Staff	4.7	6.8	3.4	0.3	-3.1	5.2	0.8	-4.4
	Agency	0.3	1.3	0.0	0.0	0.0	0.3	0.0	-0.3
	Overtime	1.0	1.1	0.8	0.0	-0.8	1.0	0.0	-1.0
	Total	283.6	281.4	278.7	297.0	18.3	281.2	294.8	13.5
A&C	Substantive	859.2	966.4	853.1	988.3	135.2	894.6	995.3	100.8
	Bank & Locum Staff	18.7	15.6	15.9	2.8	-13.0	14.0	2.8	-11.2
	Agency	4.4	0.0	2.0	0.0	-2.0	1.3	0.0	-1.3
	Overtime	0.7	2.4	0.8	0.8	1.1E-16	1.3	0.8	-0.5
	Total	882.9	984.3	871.8	991.9	120.2	911.1	999.0	87.9
AHP	Substantive	529.9	559.1	530.2	597.5	67.3	539.5	600.0	60.6
	Bank & Locum Staff	1.8	3.1	2.2	0.0	-2.2	2.2	0.1	-2.1
	Overtime	2.6	2.0	2.3	0.0	-2.3	3.5	0.0	-3.5
	Total	534.4	564.2	534.7	597.5	62.8	545.2	600.1	55.0
Prof & Tech	Substantive	52.5	49.0	53.0	55.0	2.0	50.1	54.9	4.8
	Bank & Locum Staff	0.4	0.3	0.5	0.3	-0.2	0.2	0.3	0.0
	Agency	2.1	3.3	2.0	0.0	-2.0	2.6	0.2	-2.4
	Overtime	3.0	2.9	2.8	0.0	-2.8	3.1	0.0	-3.1
	Total	57.9	55.4	58.1	55.2	-2.9	56.1	55.4	-0.7
Support Staff	Substantive	282.2	285.1	285.1	302.0	16.9	281.3	296.5	15.1
	Bank & Locum Staff	14.2	13.8	11.6	1.0	-10.6	15.6	1.1	-14.5
	Agency	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total	296.3	298.8	296.7	303.0	6.3	297.0	297.6	0.6
Other	Substantive	54.5	66.3	54.4	70.9	16.5	53.1	67.3	14.2
	Total	54.5	66.3	54.4	70.9	16.5	53.1	67.3	14.2
Other	Bank & Locum Staff		0.6						
	Total		0.6						
Unallocated central funding	Substantive	0.0	0.0	0.0	2.7	2.7	0.0	-6.2	-6.2
	Total	0.0	0.0	0.0	2.7	2.7	0.0	-6.2	-6.2
Total		4,803.4	4,952.0	4,783.5	5,035.1	251.5	4,823.7	5,041.8	218.0

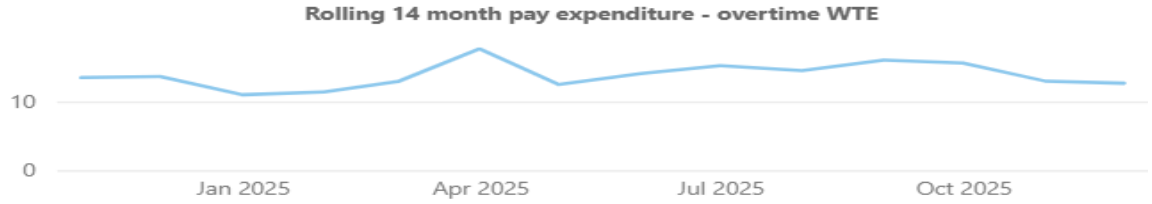
Workforce - WTE (trends)

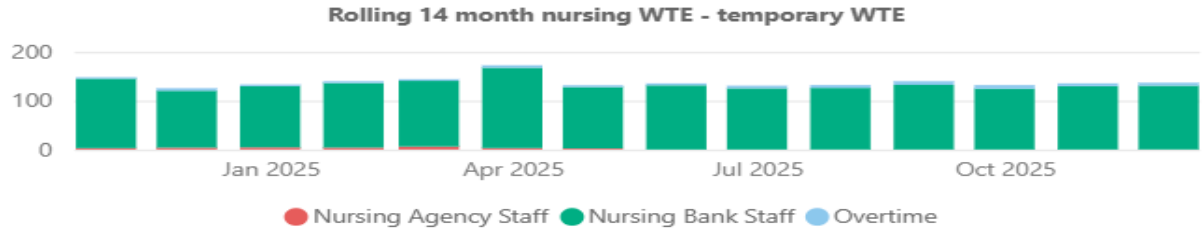
West Suffolk NHS Foundation Trust

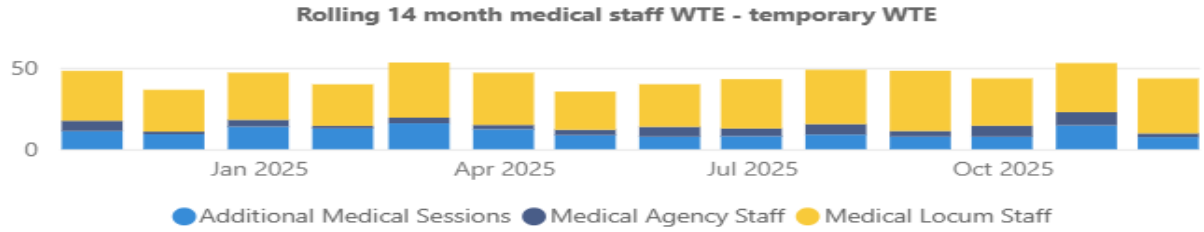


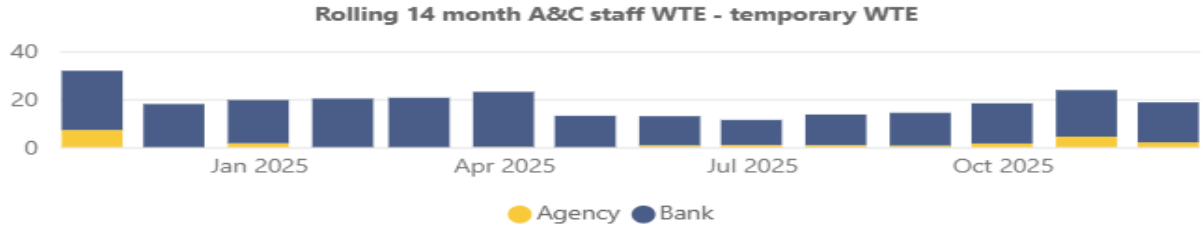












Statement of Financial Position – 31 December 2025

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2025	Plan 31 March 2026	Plan YTD 31 December 2025	Actual at 31 December 2025	Variance YTD 31 December 2025
	£000	£000	£000	£000	£000
Intangible assets	54,005	44,573	46,199	48,911	2,712
Property, plant and equipment	146,062	200,307	190,126	152,564	(37,562)
Right of use assets	9,807	7,544	8,036	8,492	456
Trade and other receivables	7,162	7,158	7,158	7,162	4
Total non-current assets	**217,036**	**259,582**	**251,520**	**217,129**	**(34,391)**
Inventories	5,128	5,000	5,000	5,941	941
Trade and other receivables	18,989	21,668	21,668	21,939	271
Non-current assets for sale	490	490	490	490	0
Cash and cash equivalents	12,659	1,107	1,107	15,243	14,136
Total current assets	**37,266**	**28,265**	**28,265**	**43,613**	**15,348**
Trade and other payables	(41,296)	(28,250)	(28,841)	(43,805)	(14,964)
Borrowing repayable within 1 year	(4,510)	(4,627)	(4,627)	(4,578)	49
Current Provisions	(2,524)	(70)	(70)	(1,259)	(1,189)
Other liabilities	(938)	(2,685)	(2,685)	(5,639)	(2,954)
Total current liabilities	**(49,268)**	**(35,632)**	**(36,223)**	**(55,281)**	**(19,058)**
Total assets less current liabilities	**205,034**	**252,215**	**243,562**	**205,461**	**(38,100)**
Borrowings	(39,716)	(34,656)	(36,393)	(37,086)	(693)
Provisions	(385)	(400)	(400)	(418)	(18)
Total non-current liabilities	**(40,101)**	**(35,056)**	**(36,793)**	**(37,504)**	**(711)**
Total assets employed	**164,933**	**217,159**	**206,769**	**167,957**	**(38,812)**
Financed by					
Public dividend capital	326,166	390,273	378,287	345,695	(32,592)
Revaluation reserve	12,319	11,941	11,941	12,319	378
Income and expenditure reserve	(173,551)	(185,055)	(183,459)	(190,057)	(6,598)
Total taxpayers' and others' equity	**164,934**	**217,159**	**206,769**	**167,957**	**(38,812)**

The table shows the year-to-date Statement of Financial Position as at 31 December 2025.

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

Cash is higher than plan due to the timing of a creditors payment run. The balance shown also includes cash that is earmarked for capital spend. Cash is being rigorously monitored to ensure that the Trust remains on plan and does not fall below the £1.1m limit that must be maintained and is enforced by NHS England. The Trust has been successful in its application for cash support in quarter 3, receiving £14m. An application has been submitted for a further £6m of cash support in quarter 4, which is in line with our plan.

Trade and other payables appears to have increased significantly against plan, however the increase since the 2024/25 month 12 outturn position is much smaller at £2.5m.

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

Better Payment Practice Code (BPPC) – Month 9

West Suffolk NHS Foundation Trust

December 2025		
Better Payment Practice Code	**Total bills paid YTD Performance Number**	**Total £ paid YTD Performance £'000**
Non NHS		
Total bills paid in the year	25,233	119,449
Total bills paid within target	18,435	102,863
Percentage of bills paid within target	***73%***	***86%***
NHS		
Total bills paid in the year	1,195	16,458
Total bills paid within target	515	9,954
Percentage of bills paid within target	***43%***	***60%***
Total		
Total bills paid in the year	26,428	135,907
Total bills paid within target	18,950	112,817
Percentage of bills paid within target	**72%**	**83%**
Previous month performance	**73%**	**83%**

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

The performance is measured over the year and the table shows the Trust's performance at month 9. The performance has remained stable, however we are starting to see this performance decline as our cash balance decreases.

Capital progress report - Month 9

Capital Spend - 31st December 2025	Year to Date - Month 9			Full Year		
	YTD Forecast	YTD Actual	Variance to Forecast	Full year Forecast	*Funding Split*	
Capital Scheme					*Internal*	*PDC Available*
	£000's	**£000's**		£000's	***£000's***	***£000's***
****New Hospital Programme**	5,371	**5,403**	- 32	11,012		***11,012***
RAAC	682	**701**	- 19	1,340		***1,340***
Estates	3,282	**2,077**	1,205	6,913	***5,575***	
Digital/IT	2,376	**2,538**	- 162	3,138	***3,138***	
***Medical Equipment**	325	**563**	- 237	619	***550***	***69***
Radiology	488	**844**	- 356	877	***1,215***	
Newmarket Endoscopy	1,098	**585**	514	2,133		***2,133***
Net zero	164	**158**	6	509		***509***
UEC (ED)	-	**-**	-	-	***1,000***	
UEC RtCS	200	**-**	200	3,634		***3,634***
Diagnostics RtCS	324	**-**	324	572		***572***
Elective RtCS	69	**274**	- 204	523		***523***
CDC Pathway	-	**117**	- 117	117		***131***
Total Capital Schemes	14,380	**13,258**	1,238	31,387	***11,478***	***19,923***
Capital Schemes excluding NHP	9,009	**7,855**	1,154	20,375	***11,478***	***8,911***
Overspent vs Plan					***31,401***	
Underspent vs Plan						

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

The Capital Plan for 2025/26 was agreed at £25.6m. In month 2 an additional £1m of CDEL was awarded to the Trust, and in month 3 additional PDC was awarded of £7.2m taking the Capital Plan to £33.8m. Further adjustments to PDC has occurred resulting in the Capital Plan now being £31.4m. £11.5m of this is internally funded, with the remaining £19.9m being funded by Public Dividend Capital (PDC).

Year to date capital spend at month 9 is £13.3m. This is behind the phased plan.

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

For some of the other Urgent and Emergency Care (UEC) schemes, the Trust is still waiting for confirmation of funding from DHSC for £3.3m, which includes a project at Newmarket Hospital for the frailty hub, the Minor Emergency Care Unit (MECU) at West Suffolk, along with some other equipment. Due to the timing of the funding not yet being approved there is a risk that these schemes will not be delivered by 31 March 2026. If these schemes are not delivered by the 31 March, the funding will be required to be returned.

5.3. Outline of annual capital programme (VERBAL)

Presented by Jonathan Rowell

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

Presented by Richard Flatman

Charitable Funds Committee Key Issues (CKI) report

Originating Committee: Charitable Funds Committee			Date of meeting: 2 December 2025		
Chaired by: Richard Flatman			**Lead Executive Director: Julie Hull**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / MEG 3. Escalate to Board
1.1	***Welcome and apologies*** Committee noted that Heather Hancock had stood down from Charitable funds following her appointment to the new Digital and data assurance Committee.	Substantial	Chair thanked Heather for her contributions to Charitable funds. Committee continues to have appropriate non-executive membership.		No escalation
1.4	***Matters arising*** Committee received an update on the planned Free Wills scheme whereby for an annual cost of £2k to the Charitable funds, supporters, staff and general members of the public could have their will written or amended for free (worth up to £150)	Reasonable	Approval was granted at the September meeting contingent on completing several actions, including due diligence on Octopus and assessing if the scheme could cover lasting powers of attorney. Those matters are complete, and it was agreed to proceed on a trial basis to monitor progress.	Consideration as to the process for launch/ communication which needs to be done with sensitivity.	No escalation

2	***Fundraising report*** Committee received a fundraising report summarising progress and priorities for the next few months	Reasonable	The team highlighted the key activities and the focus for the next 3 months. Significant progress has been made regarding the resolution of several longstanding property disposals associated with historical legacies.	Priorities include a range of ongoing fundraising activity and management of various legacies.	No escalation
3.1	***Year and report and accounts*** Committee received the MyWish annual accounts and the Annual Report together with the ISA260 Audit findings report from Lovewell Blake and the draft letter of representation.	Substantial	All major audit risks flagged during planning were adequately addressed, with no material misstatements found, resulting in the auditors issuing an unmodified opinion on the audit report. A couple of control recommendations had been made – both of which had been accepted and neither of which were considered significant. All representations in the letter of rep were standard. All matters were referred to audit committee and recommended for approval. Committee thanked the auditors and the Finance team for a smooth audit process in 2025.	All matters were subsequently approved at Audit Committee on 16 December 2025.	No escalation

3.2	***Charitable Funds policy and Procedure*** Committee again reviewed an updated policies and procedure document for the Charitable Funds	Reasonable	Committee welcomed the considerable work that had been done since the September meeting to simplify the numerous forms included therein. Financial authority approval levels were reviewed and agreed. No changes needed. It was confirmed that only business cases over £25k require committee approval. Subject to some minor final amendments the policy document was approved.	A final version will come to the next committee meeting for information only.	No escalation
3.3	***Robot*** The committee received a verbal update on negotiations with the robot supplier.	Partial	Committee was encouraged by the discussions and agreed that the rationale for purchase / use of robot was clear. It was agreed that a short update paper was required (also to go via trust governance processes) with a clear recommendation taking account of cost / warranty / financials etc, and with a key issue being the timing of purchase commitment. It was agreed that this should go via MEG to Board for	Consideration by the Board at its extraordinary meeting on 16 December. Launch of a fundraising campaign early in 2026.	No escalation

			approval given the capital purchase sum required.		
4	***Business cases >£5k*** 3 business cases were noted	Substantial	All 3 had been approved at the appropriate level and none of which required Committee approval.	It was agreed that in future such updates will be included in the finance report for information.	No escalation
5	***Policy completeness*** The committee received a list of current MyWish policies, along with a summary of other policies that are typically expected to be in place.	Partial	Policies required for compliance with law/ Charities commission	Additional policies to be drafted (working in close consultation with the Trust governance team and aligning with Trust policy as required/ wherever possible) and brought to a future meeting for approval.	No escalation at this stage
6	***Financial performance*** Regular finance report received.	Reasonable	Finances remain in line with expectations.	Ongoing financial review.	No escalation
6.2	***Investment Report*** November investment report received.	Reasonable	Noted the fund value in November of £1.6m. We had a previous deep dive on investment performance at the June meeting.	Review of position at next meeting.	No escalation

6.3 & 6.4	***Funds closed and fund balances*** Update on fund balances and any funds closed.	Substantial	No funds closed. Noted fund balances.		No escalation

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

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

Presented by Michael Parsons

Board assurance committee - Committee Key Issues (CKI) report

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

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

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

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.

5.6. Business Planning Update (ATTACHED)

Presented by Sam Tappenden

Open Board

Report information

Report title: update on the Medium-Term Planning process and submission
Agenda item:
Executive lead: Sam Tappenden, Executive Director of Strategy and Transformation
Report prepared by: Sam Tappenden
Previously considered by: Closed Board
This report is for: ☐Approval ☒ Assurance ☐Discussion ☒information

This report supports the following ambitions:

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

Executive summary

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

The Trust is finalising its final MTP submission for 12th February. The purpose of this report is to update Board on progress and outline next steps.

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

It is crucial that the Trust delivers an achievable, credible, and compliant submission.

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

Make further adjustments and deliver the final submission for the 12th February.

Action required by the board:

- None required.

Governance and compliance

Risk and assurance: Failure to design and develop a structured, repeatable business planning process could result in misalignment of national and local delivery trajectories.

Equality, diversity and inclusion: Developing plans that are robust and triangulated improves patient outcomes and reduces health inequalities.

Sustainability: Developing a standardised approach with tools will contribute to a structured, repeatable business planning process for the Trust.

Legal and regulatory context: NHS Contract

NHS 2025/26 priorities and operational planning guidance
NHSE Planning Framework for the NHS in England

Update ahead of MTP submission on 12th February

1. Process

1.1. The Medium-Term Planning (MTP) process is well underway, with a structured approach aligning divisional plans to national requirements and an integrated delivery plan.

1.2. A multi-disciplinary steering group is overseeing development, triangulation (activity, finance, workforce, quality), and corporate alignment.

1.3. The Trust has received feedback from NHSE regarding the first submission which is being reviewed.

2. Progress

2.1. All four divisions' service developments and cost pressures have been reviewed by a subset of the Management Executive Group (MEG).

2.2. Clear criteria were used to assess the developments including whether the developments: (1) are quality 'must dos'; (2) enable performance requirements; (3) represent run rate costs that need baselining and (4) provide potential to generate a financial benefit in-year.

2.3. An extended Investment Panel will be held on 6th February to bring together those cases that need evaluation, as well as an additional Capital Strategy Group, to ensure capital requests are reviewed.

2.4. Feedback from NHSE regarding our first submission was received on the 14th of January, and this is being reviewed by our teams.

3. Next steps

3.1. Complete service developments, numerical plans, and other documents:

- Complete modelling on divisional service developments and reflect agreed developments in numerical planning.
- Review and incorporate feedback from the first submission from NHSE where appropriate.
- Receive feedback regarding the ICB regarding the Trust's medium-term plans.
- Complete the narrative submission, and refresh Board Assurance Statements.

3.2. Submit the final MTP to NHSE:

- Final tweaks between 30th January and 12th February, with a further 'exceptional' Board on 11th February for MTP approval.
- Full submission noon 12th February 2026.

6. FIT FOR TOMORROW

6.1. Future system board report (ATTACHED)

To Assure

Presented by Ewen Cameron

West Suffolk NHS Foundation Trust Board

Report information

Report title: Future System Board Report
Agenda item: 6.1
Sponsor/Executive lead: Dr Ewen Cameron, chief executive officer
Report prepared by: Gary Norgate, programme director
This report is for: ☐Approval ☒ Assurance ☒Discussion ☒information

This report supports the following ambitions within the organisational strategy:

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

Executive summary

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

The project to replace the current West Suffolk Hospital is formally a **Scheme** within the national New Hospitals **Programme** (NHP). The following report provides an overview of progress being made towards our goal to build a sustainable new hospital for West Suffolk.

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

As previously reported, the project to build a new West Suffolk Hospital is within the first wave of schemes to be built with an expected commencement date in 2027/28 and a capital budget of between £1 and £1.5bn. A more precise capital figure, within this range and based on a new build space of 97k sqm has been confirmed in writing but remains commercially sensitive[1].

Since our last meeting the following progress has been made:

- **RIBA2 Design** continues to be communicated and discussed across WSFT clinical teams and across the national NHP Programme. Although 95% of the design has been agreed, there are a small number of issues to resolve.
- **Outline Business Case (OBC) production** – the team remains on track to complete and submit a full and compliant OBC by August 2026. Content has been substantially "progressively assured" by NHP and NHSE. The

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

outstanding element will be the comprehensive investment review which is dependent upon the completion of RIBA3 designs. Once complete, the case will be presented to the Executive Programme Board, Trust Board, ICB and NHSE before formal submission. In recent weeks, the strategic case has been completed, a draft "comprehensive investment appraisal" has been completed and management and commercial cases are now being consolidated.

- **Planning Permission** – The timely completion of RIBA3 designs will enable us to trigger the reserved matters[2] planning process that will ensure we protect our outline planning permission and secure full planning (process must be triggered on or before May 2026).
- **Power Provision –** following agreement by Trust Board, the case for the provision of the power infrastructure required by the new hospital was agreed by New Hospital Programme (NHP) investment committee and is progressing.
- **Operational Affordability –** A working group to solve the issue created by the capital charges[3] associated with building a new hospital has been established by NHSE and aims to recommend a solution in time for the submission of our OBC.

Scheme Status

The project is currently developing its Outline Business Case through a process of "progressive assurance"[4] with experts from NHP and remains on track to submit in August 2026 (with the date being driven by the completion of our RIBA3 design stage).

That said, failure to find a solution that will allow us to achieve compliance with H2.0 whilst remaining within the allocated capital budget will mean that the scheme cannot continue past its current design stage.

Remedies are being sought with NHP leadership and progress will be reported regularly to the West Suffolk Board.

The communication of the West Suffolk design has been positive with c.95% of layouts accepted (there have been requests to understand the demand modelling process, but these have been largely satisfied).

This outcome represents excellent progress and is an indication of how well our teams are engaged and the quality of the design.

Commercial Progress

[2] Reserved Matters deals with detailed aspects of the development, like appearance, landscaping, scale and layout. This follows on from, and builds upon our outline planning consent.
[3] Capital Charges refer to the cost of the "loan" provided by the Government for the building of the new hospital.
[4] Progressive assurance aims to present subject matter experts with chapters of the business case in advance of submission. The process should mean that the eventual case is largely "pre-approved".

The process through which construction partners will be selected was completed at the end of December.

The next step will be meetings with prospective partners and expressions of interest for the West Suffolk project.

Operational Affordability

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

However, there are signs of a national solution:

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

No additional information to report.

Communications and Engagement

We continue to share 1:200 plans with both staff and external stakeholders.

Work now commences on the "pre-planning application" engagement process – ensuring we can evidence public engagement in the design of our hospital and the submission of our reserved matters planning application.

Finance

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

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

- Continue to work with NHP on final design and capital budget realisation
- Commence RIBA 3 design – October 25 to August 26
- Formal Full Planning Application submitted – 3 May 26
- OBC Submission – 28 August 2026

The outcome of the first bullet could significantly change the scheme programme plan.

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

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.

7. GOVERNANCE

7.1. Governance report (ATTACHED)

To inform

Presented by Paul Bunn

Open Board of Directors – 30 January 2026

Report information

Report title: Governance report – General Update: December-January 2026
Agenda item: 7.2
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? *Summary of issue, including evaluation of the validity the data/information*

This paper provides the Trust Board with an update on governance arrangements for the period December 2025 – January 2026 as well as referencing future work.

The Board is asked to consider if there is any appetite to change the frequency of public Board meetings – section 1.1 refers to this discussion topic.

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

In summary:-

- No urgent decisions have been made between board meetings.
- The reorganisation of the assurance committees has proceeded smoothly.
    - The patient experience portfolio has moved to Quality and Patient Safety and People and OD is now looking at developing a workplan that includes reviewing the Trust transformation projects.
    - Trust Office is now liaising with sub-committee chairs that feed into the assurance committees to ensure those committee are effective and that reporting lines remain correct.

- The Trust's seal has been used once in relation to executing a Deed of Surender for Glemsford Surgery.
- Board Development, dates for 2026 have been compiled and significant school holiday dates avoided where possible. A schedule of topics and draft forward plan is within Appendix 1 for noting/discussion.
- By way of assurance and to demonstrate effective decision-making:
    - MEG has met regularly and discussed a wide portfolio of work.
    - SLT has met twice to undertake command and control training and discuss CIP launch.
    - The Council of Governors continues to fulfil its statutory obligations, with no issues to escalate. It next meets on 5 March 2026 where it is hoped we will be able to appoint to the UEA NED vacancy.
- Work to clean and update the risk register continues and is monitored through the Quality and Patient Safety committee. There are currently 9 red risks all with Executive oversight.
- The Board future workplan and reporting matrix is being revised to align with the new strategy.

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

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

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

1. Continue work with subcommittee chairs that feed into the assurance committees to ensure reporting lines and committees remain effective – to report to each assurance committee
2. Work with Communications team to develop subcommittee reporting templates that as far as possible comply with accessible information standards – to be approved these through MEG.
3. Continue to liaise with Divisions to ensure all amber and green risks are scored and reviewed regularly and top risks reported through the PRM process.
4. Finalise the revised BAF to align with new strategy – MEG and Trust Board
5. Continue to liaise with Council of Governors over its future and discuss possible options for the future once formulated – Trust Board/COG
6. Work with Strategy and Transformation team to ensure any new partnerships and ways of working have governance embedded and appropriate accountability.
7. Refresh the Board reporting Matrix (last reviewed Jan 2024) to align with the new strategy and enable future agenda setting.

Action required by the board:

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

1. Is there any appetite to move the frequency of the reporting cycle for the Public Board
2. The Board development workshop schedule – appendix 1.

Governance and compliance

Risk and assurance: BAF 8 Governance; Failure to effectively manage risks to the Trust's strategic objectives.
Equality, diversity and inclusion: Decisions should ensure inclusivity for individuals or groups with protected characteristics
Sustainability: Decisions should not add environmental impact, oversight of workforce should help succession planning
Legal and regulatory context: NHS Act 2006, Health and Social Care Act 2013, NHS Code of Governance, WSFT Constitution

Governance report – General Update: December - January 2026

1. Organisational Structure

1.1 The Trust has successfully renamed its assurance committees as follows:

- Insight – Finance and Operations
- Involvement – People and Organisational Development
- Improvement – Quality and Patient Safety
- Digital Board – Digital and Data

The Digital and Data Committee terms of reference will follow at the March Board for approval after discussion at MEG and its inaugural meeting on 29 January 2026.

These changes have seen the work programme for Patient Experience transfer across to Quality and Patient Safety from People and Organisational Development. Whilst the strategy updates have been agreed to remain at Board level oversight, People and Organisational Development is now exploring how it can receive oversight reports on the Trust's transformation into this committee and the workplan will be updated in due course.

Work is now underway to liaise with subcommittee chairs that feed into the assurance committees to ensure reporting lines are clear and committees effective. This will involve liaising with key stakeholders to look at assurance report templates for future reporting.

1.2 Future Board Meetings

React, Recover, Renew is a roadmap that was introduced in December 2024 to guide the Trust through a period of challenge and transformation. WSFT has now moved beyond the initial *React* phase and is entering the *Recover* phase, which focuses on opportunities to transform how we work and deliver care. Therefore, as the Board matures and moves to a more business as usual approach to the portfolio of work, the Board is asked to consider if there is any appetite for moving away from the current bimonthly reporting cycle of the Open Board? Some neighbouring Trusts report publicly on a quarterly basis. Although, a quick benchmarking search confirms the overwhelming majority continue to report on a bimonthly basis.

The advantages of reducing the number of open boards, but potentially keeping closed boards at the current frequency, is that it would enable additional time on board development in the sessions that it frees up. The negative impact is that the does potentially reduce the transparency of the Board and efforts would need to be made to ensure that the public still feel there is sufficient oversight and scrutiny.

The frequency of open Board meetings is not explicitly defined in legislation. However, piecing together other guidance from NHS England[1] it suggests boards should review the strategy every 6 months. NHS Resolution's Maternity Incentive Scheme requires board level reporting at least quarterly and there is also mandatory quarterly reporting on certain learning from deaths data. Initial searches have not found requirements for more frequent reporting than on a quarterly basis.

WSFT's constitution is not explicit in the number of Board meetings that are needed per annum or the frequency. Annex 8 para 3.1.1 (page 97) says:-

"Meetings of the Board shall be held at regular intervals at such times and places as the Board may determine."

It is therefore in the gift of the Board to resolve to change the frequency of its open meetings. If there is any appetite to consider changing this, further work can be undertaken, with appropriate benchmarking and an impact analysis, informing proposals in a future paper submitted to the March Board for further consideration.

2. Senior Leadership Team report

The Senior Leadership Team (SLT) has met twice since the last report:

- *December 2025* – focused on practical exercise and strategic commanders training involving practicing real world scenarios and breakout groups to discuss approaches and scenarios.
- *January 2026* – in person CIP launch meeting for 2026/27.

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

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 escalation of emerging themes. A snapshot of the non-commercially sensitive matters reviewed include: the business planning process, business case for use of a surgical robot, fit testing proposals, use of copilot AI licences, progress on the management actions from the internal audit and enabling strategy to support the new corporate strategy.

4. Council of Governors report

3.1 The Council of Governors (COG) is scheduled to meet again on 5 March 2026.

The COG Nominations committee met on 14 January 2026 and discussed the appointment process for the CUH NED vacancy. Interviews have been arranged for prospective candidates

[1] NHS England » The insightful provider board – supporting guidance dated December 2024

in preparation of submitting nominations to the full COG in March 2026. NED appraisal process was reviewed and a second term of Office for Michael Parsons was agreed for approval to COG in March 2026.

Standards committee is due to meet on 27 January 2026 and will look at: minor amends to governor code of conduct; be assured that fit and proper person tests check are in place and current; review governor attendance and governor development programme; as well as the workplan for the year ahead.

Future of COG

With Governor elections due later in the year, governors remain anxious to seek clarity around the government proposal in the NHS 10 year plan to abolish council of governors and to ascertain what the future holds. Acting Trust Secretary has attended a number of national briefings on the future, but no decisions have yet been reached, guidance is expected in the spring.

5. Board development

The February Board Development session has been moved to 13 March 2026. The working draft Board Development plan is at Appendix 1 for noting and further discussion.

6. Risk

Please see separate report for an update on the Board Assurance Framework (BAF).

With regards to review of corporate and clinical risks. This was the subject of a deep dive at the audit committee and progress is reviewed by the Quality and Patient Safety Committee. There are now 9 red operational risks - 8 clinical and 1 corporate. Work is underway to review amber and green risks with the Divisions to ensure they are part of an appropriate review cycle at Divisional level and that mitigations are captured.

The Executive team will meet on 26.1.26 to review all red risks, provide check, challenge and oversight to ensure all safety concerns are correctly captured and that risks are scored consistently on the risk register.

7. Urgent decisions by the Board

No urgent decisions have been requested. However, extraordinary meetings have been required to be scheduled to factor in Board approval of the business planning process and accommodate national timelines.

8. Use of Trust Seal

The Trust seal has been used on one occasion – on 1 December 2025 it was used to execute a Deed of surrender relating to premises at Glemsford Surgery.

9. Agenda Items for the Next Meeting

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

Appendix 1

Forward Plan		***Team & Knowledge development***	***Specialist Subject Focus***
Feb - (moved to 13.3. 26)		- How do you define what is a high performing board? - Is that something we want to aspire to? - Given where we are, what is the gap, change and stepping stones to achieve that.	CQC Prep (Well Led)
April -17.4.26			- Quality Improvement – how do we lead on this - Risk Appetite
June – 26.6.26			
Aug – 28.6.26			
Oct – 16.10.26			
Shortlist of topics to pick from:			- EDI focus - SEND - Partnership and System Leadership

7.2. Agenda items for next meeting

To inform

Presented by Jude Chin

7.3. Reflections on meeting

To Assure

Presented by Jude Chin

7.4. Date of next meeting - 27 March 2026

For Approval

Presented by Jude Chin

RESOLUTION

The Trust Board is invited to adopt the following resolution:

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

8. SUPPORTING APPENDICES

To inform

Presented by Jude Chin

IQPR Full Report

To Note

Presented by Nicola Cottington