OPEN Council of Governors Meeting

Schedule	Tuesday 19 November 2024, 5:30 PM — 6:30 PM GMT
Venue	Rooms 19a & b, Education Centre, WSFT, Hardwick Lane, Bury St. Edmunds. IP33 2QZ
Notes for Participants	Please advise of apologies in advance of the meeting to the FT Office.
Organiser	Ruth Williamson

Agenda

AGENDA:
OPEN Council of Governors meeting
Tuesday 19 November, 2024, 5.30pm in Rooms 19a & b, Education Centre, WSFT, Hardwick Lane, Bury St. Edmunds. IP33 2QZ

0. Agenda Open CoG meeting 19 Nov 2024 - v1.docx

GENERAL BUSINESS

5:30 PM

1. Welcome and introductions
   To welcome governors and attendees to the meeting & request mobile phones be switched to silent.
   To Note - Presented by Jude Chin

2. Apologies for absence
   To receive any apologies for the meeting

   Apologies received from:
   Governors: Carol Bull, Adam Musgrove, Evelin Hanikat
   NEDs: Michael Parsons, Roger Petter
   To Note - Presented by Jude Chin

3. Declaration of interests
   To receive any declarations of interest for items on the agenda
   To Note - Presented by Jude Chin

	4. Minutes of the previous meetings (enclosed) To note the minutes of the meetings held on 2 September 2024 For Approval - Presented by Jude Chin Item 4 Open CoG meeting 2 September 2024 minutes DRAFT.docx
	5. Matters arising action sheet (enclosed) To note updates on actions not covered elsewhere on the agenda To Note - Presented by Jude Chin Item 5 CoG Action log Annex Learning report summary.docx
5:35 PM	6. Chair's report (enclosed) To receive an update from the Chair To Note - Presented by Jude Chin Item 6 Chair's Report 19 Nov 2024.docx
5:40 PM	7. Chief executive's report (enclosed) To note a report on operational and strategic matters To Note - Presented by Ewen Cameron Item 7 CEO report 19 Nov 2024 FINAL.docx
	GOVERNOR BUSINESS (INC. STATUTORY DUTIES)
5:50 PM	8. Feedback from assurance committees (enclosed) To receive committee key issues (CKI) and observers reports from the assurance and audit committees To Note Item 8 Feedback from Board assurance committees CoG 19 Nov 2024.docx

8.1. Insight Committee

Presented by Antoinette Jackson

- Item 8.1 INSIGHT CKI report a 21 Aug FINAL AJ.docx
- Item 8.1 INSIGHT Governor observer a 21 Aug 2024 Jane Skinner.docx
- Item 8.1 INSIGHT Governor observer a 21 Aug 2024 Jayne Neal.docx
- Item 8.1 INSIGHT Governor observer a 21 Aug 2024 John-Paul Holt.docx
- Item 8.1 INSIGHT CKI report b 18 Sep 2024 FINAL AJ.docx
- Item 8.1 INSIGHT Governor observer b 18 Sept 2024 Jane Skinner.docx
- Item 8.1 INSIGHT Governor observer b 18 Sept 2024 Jayne Neal.docx
- Item 8.1 INSIGHT CKI report 16 Oct 2024 AJ.docx
- Item 8.1 INSIGHT Governor observer c 16 Oct 2024 Jane Skinner.docx
- Item 8.1 INSIGHT Governor observer c 16 Oct 2024 Jayne Neal.docx
- Item 8.1 INSIGHT Governor observer c 16 Oct 2024 John-Paul Holt.docx

8.2. Improvement Committee

Presented by Tracy Dowling

- Item 8.2 IMPROVEMENT CKI report a 21 Aug 2024 FINAL LP.docx
- Item 8.2 IMPROVEMENT Governor observer a 21 Aug 2024 Jane Skinner.docx
- Item 8.2 IMPROVEMENT Governor observer a 21 Aug 2024 Anna Conochie.docx
- Item 8.2 IMPROVEMENT CKI report b 18 Sep 2024 FINAL RP.docx
- Item 8.2 IMPROVEMENT Governor observer b 18 Sep 2024 Anna Conochie.docx
- Item 8.2 IMPROVEMENT Governor observer b 18 Sep 2024 Jane Skinner.docx
- Item 8.2 IMPROVEMENT CKI report c 16 Oct 2024 FINAL RP.docx
- Item 8.2 IMPROVEMENT Governor observer c 16 Oct 2024 Adam Musgrove.docx
- Item 8.2 IMPROVEMENT Governor observer c 16 Oct 2024 Jane Skinner.docx

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8.3. Involvement Committee

Presented by Tracy Dowling

- Item 8.3 INVOLVEMENT CKI report a 20 Aug 2024 FINAL TD.doc
- Item 8.3 INVOLVEMENT CKI report b 16 Oct 2024 FINAL TD.doc
- Item 8.3 INVOLVEMENT Governor observer a 20 Aug 2024 Sue Kingston.docx
- Item 8.3 INVOLVEMENT Governor observer a 20 Aug 2024 Val Dutton.docx
- Item 8.3 INVOLVEMENT Governor observer b 16 Oct 2024 Val Dutton.docx
- Item 8.3 INVOLVEMENT Governor observer b 16 Oct 2024 Sue Kingston.docx

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8.4. Audit Committee

Presented by Antoinette Jackson

- Item 8.4 AUDIT CKI report 1 Oct 2024 MP.docx

6:10 PM

9. Nomination Committee Report (enclosed)
To receive the report from the Nomination Committee
To Note - Presented by Jude Chin

Item 9 Nominations committee report CoG 19 Nov 2024.doc

10. Engagement Committee Report (enclosed)
To receive a report from the Engagement Committee
Presented by Sarah Hanratty

Item 10 Engagement committee report CoG 19 Nov 2024.doc

Item 10_Annex 1 Governor activities 2024 - Feedback report v2.docx

Item 10_Annex 2 FT membership and engagement strategy - DRAFT v5.docx

Item 10_Annex 3 Membership and Engagement Committee Terms of Reference 2024 v3 29 Oct 2024.doc

11. Standards Committee Report (enclosed)
To receive a report from the Standards Committee
To Note - Presented by Jude Chin

Item 11 Standards committee report CoG 19 Nov 2024.doc

Item 11_Appendix 1 Governor Code of Conduct Oct 2024.docx

Item 11_Appendix 2 Procedure for Managing Governor Conduct and Expected Standards.docx

Item 11_Appendix 3 Governors Work Programme 2025.docx

12. Staff Governor Report (enclosed)
To receive a report from the Staff Governors
To Note - Presented by Anna Clapton (nee Mills)

Item 12 Staff Governors report CoG 19 Nov 2024.doc

13. Lead Governor Report (enclosed)
To receive a report from the Lead Governor
To Note - Presented by Jane Skinner

Item 13 Lead Governor Report 19 Nov 24.docx

6:30 PM ITEMS FOR INFORMATION

14. Summary report for Board of Directors meetings (enclosed)
To receive a report from the Chair and Non-Executive Directors
To Note - Presented by Jude Chin

Item 14 Summary Report for Board of Directors meeting CoG 19 Nov 24.docx

15. Any other business
For Discussion - Presented by Jude Chin

16. Dates for meetings for 2025:
- 26 February, 2025
- 14 May, 2025
- 11 September, 2025
- 13 November, 2025
- Annual Members' Meeting - TBC

To Note - Presented by Jude Chin

17. Reflections on meeting
To consider whether the right balance has been achieved in terms of information received and questions for assurance and the Trust's values and behaviours observed
For Consideration - Presented by Jude Chin

CLOSE

SUPPORTING ANNEXES

Item 8 - IQPR full Report - August

xIQPR Board Report August 2024.pdf

AGENDA:

OPEN Council of Governors meeting

Tuesday 19 November, 2024, 5.30pm in Rooms 19a & b, Education Centre, WSFT, Hardwick Lane, Bury St. Edmunds. IP33 2QZ

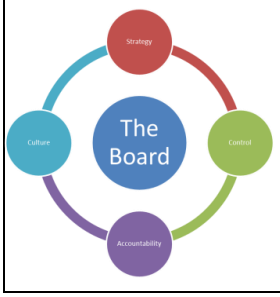
Council of Governors Meeting

There will be a meeting of the **COUNCIL OF GOVERNORS** of West Suffolk NHS Foundation Trust on **Tuesday 19 November 2024 at 5.30pm at Education Centre, rooms 19a&b, West Suffolk Hospital site, Bury St Edmunds.**

Jude Chin, Chair

Agenda

General duties/Statutory role



(a) To hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.
(b) To represent the interests of the members of the corporation as a whole and the interests of the public.

The Council's focus in holding the Board to account is on strategy, control, accountability and culture.

GENERAL BUSINESS			
17:30	**1.**	**Welcome and introductions** To welcome governors and attendees to the meeting and request mobile phones be switched to silent To note that Elspeth Lees, Partner Governor has resigned from the Council	JC
	2.	**Apologies for absence** To receive any apologies for the meeting	JC
	3.	**Declaration of interests** (enclosed) To receive any declarations of interest for items on the agenda	JC
	4.	**Minutes of the previous meeting** (enclosed) To note the minutes of the meetings held on 2 September 2024	JC
	5.	**Matters arising action sheet** (enclosed) To note updates on actions not covered elsewhere on the agenda	JC
17:35	**6.**	**Chair's report** (enclosed) To receive an update from the Chair	JC
17:40	**7.**	**Chief executive's report** (enclosed) To note a report on operational and strategic matters	EC
GOVERNOR BUSINESS (INC. STATUTORY DUTIES)			
17:50	**8.**	**Feedback from Board committees** (enclosed) To receive committee key issues (CKI) and observer reports from the assurance and audit committees:	NED chairs / Governor observers

		8.1 Insight Committee 8.2 Involvement Committee 8.3 Improvement Committee 8.4 Audit Committee	
18:10	**9.**	**Nomination Committee report** (enclosed) To receive the report from the Nomination committee	JC
	10.	**Engagement Committee report** (enclosed) To receive a report from the Engagement Committee	SH
	11.	**Standards Committee report** (enclosed) To receive a report from the Standards Committee	JC
	12.	**Staff Governors' Report** (enclosed) To receive a report from the Staff Governors	Staff Governor
	13.	**Lead Governor Report** (enclosed) To receive a report from the Lead Governor	JS
ITEMS FOR INFORMATION			
18:30	**14.**	**Summary report for Board of Directors meetings** (enclosed) To receive the report the Chair and Non-Executive Directors	JC / NEDs
	15.	**Dates for meetings for 2025** To note dates for meetings in 2025: • **26 February, 2025** • **14 May, 2025** • **11 September, 2025** • **13 November, 2025** • **Annual Members' Meeting - TBC**	JC
	16.	**Reflections on meeting** To consider whether the right balance has been achieved in terms of information received and questions for assurance and the Trust's values and behaviours observed.	JC
CLOSE			

Supporting Annexes

Agenda item	Description
8	IQPR full report – Aug

GENERAL BUSINESS

1. Welcome and introductions

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

To Note

Presented by Jude Chin

2. Apologies for absence

To receive any apologies for the meeting

Apologies received from:

Governors: Carol Bull, Adam Musgrove, Evelin Hanikat

NEDs: Michael Parsons, Roger Petter

To Note

Presented by Jude Chin

3. Declaration of interests

To receive any declarations of interest for items on the agenda

To Note

Presented by Jude Chin

4. Minutes of the previous meetings (enclosed)

To note the minutes of the meetings held on 2 September 2024

For Approval

Presented by Jude Chin

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE
COUNCIL OF GOVERNORS' MEETING - OPEN

Held on Monday 2 September 2024 at 17:30
At the Education Centre, West Suffolk Hospital site, Bury St Edmunds

Members:		
Name	**Job Title**	**Initials**
Jude Chin	Trust Chair	JC
Carol Bull	Public Governor	CB
Anna Conochie	Public Governor	AC
Val Dutton	Public Governor	VD
Sarah Hanratty	Public Governor	SH
Elizabeth Hodder	Public Governor	EH
Ben Lord	Public Governor – Deputy Lead Governor	BL
Tom Murray	Public Governor	TM
Jayne Neal	Public Governor	JN
Adrian Osborne	Public Governor	AO
Becky Poynter	Public Governor	BP
Clare Rose	Public Governor	CR
Michael Simpkin	Public Governor	MS
Jane Skinner	Public Governor – Lead Governor	JS
Gordon McKay	Public Governor	GMc
Anna Clapton (nee Mills)	Staff Governor	AC
John-Paul (J-P) Holt	Staff Governor	JPH
Louisa Honeybun	Staff Governor	LH
Andy Morris	Staff Governor	AMo
Adam Musgrove	Staff Governor	AMu
Rowena Lindberg	Partner Governor	RL
Evelin Hanikat	Partner Governor	EV
Heike Sowa	Partner Governor	HS
Elspeth Lees	Partner Governor	EL
Thomas Pulimood	Partner Governor	TP
Sue Kingston	Partner Governor	SK
In attendance:		
Ewen Cameron	CEO	EC
Jonathan Rowell	Acting Chief Finance Officer (Item 8 only)	JR
Michael Parsons	Non-executive Director	MP
Roger Petter	Non-executive Director	RP
Alison Wigg	Non-executive Director	AW
Richard Flatman	Non-executive Director	RF
Paul Zollinger-Read	Associate Non-executive Director	PZR

Richard Jones	Trust Secretary	RJ
Pooja Sharma	Deputy Trust Secretary	PS
Ruth Williamson	Foundation Trust Office Manager (Minutes)	RW

Apologies:
Anna Conochie, Public Governor
Sarah Hanratty, Public Governor
Jayne Neal, Public Governor
Clare Rose, Public Governor
Gordon McKay, Public Governor
Adam Musgrove, Staff Governor
Evelin Hanikat, Partner Governor
Elspeth Lees, Partner Governor
Antoinette Jackson, Non-executive Director
Tracy Dowling, Non-executive Director
Heather Hancock, Non-executive Director
David Weaver, Associate Non-executive Director

Members of the Public

None in attendance.

No.	Item	Action
1.	**Welcome and introductions**	
	The Chair welcomed to the meeting three of the five new non-executive directors, Alison Wigg, Richard Flatman and Paul Zollinger-Read (Associated NED), together with Jonathan Rowell, Acting Chief Finance Officer. Each provided a synopsis of their background: **Alison Wigg** – has a background in technology, working in global telecoms in the US and UK. She has experience as a non-executive director with the East of England Ambulance Service NHS Trust. **Paul Zollinger Read** – a GP for almost 25 years, during which time he became CEO of many Primary Care Trusts in the East of England. He has also held the role of global Chief Medical Officer with BUPA. During Covid he went back to working as a GP and is currently a non-executive director for a health insurer in Ireland. **Richard Flatman** – an accountant by trade, specialising in audit and risk consulting services with Deloitte. Until recently he was also the Group Chief Financial Officer at London South Bank University Group. He is currently senior independent director and Chair of the Audit and Risk Committee for South West London and St. George's Mental Health Trust. **Jonathan Rowell** – joined the Trust in July as Director of Financial Recovery and in August took on the role of Acting Chief Finance Officer. His working life has been with the NHS, his most recent substantive role having been Director of Finance for specialised commissioning in NHS England.	
2.	**Apologies for absence**	
	Apologies for absence were noted.	

3.	**Declaration of interests**	
	There were no declarations of interest made.	
4.	**Minutes of the previous meetings**	
	The minutes of the meeting held on 9 May, 2024 was approved as a true and accurate reflection.	
5.	**Matters arising on action sheet**	
	Completed actions were noted and approved. Comment received on following items: **CEO Report – 27 February, 2024 - Never Event Outcomes** – it was reported that following notification of Never Events, detail of the outcome was not being provided to governors. Noted discussions have been undertaken with the Chief Nurse, with a report now going to the Improvement Committee, providing a level of information on mechanisms in the organisation. It was suggested that this paper could be summarised for Governors in order to provide visibility. Reference was also made to the Safety Summit taking place on 16 September, which would provide an opportunity for governors to hear directly from the teams involved in this regard. It was felt that whilst it was appropriate that this was bedded in to reporting mechanisms, the outcome should be recorded and advised to governors. **Action: Trust Secretary to summarise messages from the report to the Improvement Committee and circulate to governors.** **RJ** **AOB – 9 May, 2024 - Governor visits to Virtual Ward Control Centre** – New Non-executive directors (NEDs) to be invited. **RW** **AOB – 9 May, 2024 - Governor visits to Hardwick Manor** – New NEDs to be invited. **RW**	
6.	**Chair's report**	
	The paper detailing non-executive director (NED) responsibilities was considered useful in order for the Council to understand the breadth of their responsibilities. Noted there will be an opportunity for governors to meet with NEDs at the Council of Governor meetings and public Board. Further visibility will be provided as part of governor activities observing the assurance committees. Roger Petter, in attendance at the meeting, highlighted, as part of his NED role, his position as Maternity and Neonatal Safety Champion. This involved meeting on a regular basis with the department to review all maternity and neonatal data, together with outcomes. He was also required to attend a monthly meeting with the Integrated Care Board (ICB) and undertake regular walkabouts within the hospital and community, gathering feedback from staff, relating to service user or staff safety. The document circulated for today's meeting was useful for governors to instigate conversations with NEDs and also to identify who to approach on a particular subject.	

	With regards to left shift and care in the community, in order to relieve bed pressures in the acute hospital, a question was raised as to how this was progressing within the Integrated Care System (ICS)? Noted it was the Trust's responsibility to implement and discussion would be undertaken at Board. There was a dilemma in the things that were required to be done and additional work that could be added to the list. It was advised that there was a systemwide approach to articulating the future state ideal. Some of the work that might have been undertaken this year had been curtailed due to the financial situation, but progress was required in preparation for the new hospital. This was obviously not happening as quickly as would be preferred, but work continued. Sam Tappenden, the new Director of Transformation and Strategy, was working with the Alliance on how to best look after patients, including end of life care.	
7.	**Chief Executive's report**	
	Ewen Cameron, CEO, was in attendance to present the report. **Performance** - noted Sam Tappenden, Director of Strategy and Transformation, had commenced employment, together with Jonathan Rowell, Acting Chief Finance Officer (in attendance at today's meeting). The huge drive to reduce extra contractual work was mentioned. With regards to surgical lists, some work was covered outside of the job plan; what would happen to patients if this ceased. An example was cited of trauma patients. If the payment of staff to work additional hours at the weekend was stopped and there were no additional staff available then what would happen. Concern was expressed at the danger in being too strict in this regard. It was mentioned that the Trust excelled in a number of clinical fields and would not want to compromise on this or fall below standard. The effects of this would need to be considered. It was stated that the Trust did not have any plan to remove extra contractual work. However, past payments for additional contractual overtime had not always matched what was expected. Inevitably, the Trust's efforts to control its finances would have an effect on some of the work it was hoping to carryout, but it was looking to minimise any impact on safety and quality. **Quality** - the implementation of Shared Decision Making, to ensure patients are supported by their clinicians in making decisions about the care that is right for them, has taken place. This includes mandatory training for doctors and use of the digital consent tool, Concentric. **Future** – public engagement regarding the Essex and Suffolk Elective Orthopaedic Centre, (ESEOC) has now been completed. Further work is being carried out to agree final terms and date of transfer of patients. A query was raised as to whether the preassessment work would be carried out at this Trust or ESEOC. It was noted that only the surgery would be conducted at ESEOC. Pre and post operative care would be	

	undertaken at WSFT. No transfer back to the Trust would be involved. There would be a short stay at ESEOC, who would discharge the patient, with follow up to be undertaken at WSFT.	
8.	**Finance Update**	
	Jonathan Rowell, Acting Chief Finance Officer, attended the meeting to present the report. The report provided detail of the Trust's position as at Month 4. The year-to-date position was a planned deficit of £8.1million at the end of July. However, the actual was £11.6million, £3.4million adrift from the plan. In Month 1, the Trust was £400k off plan. May and June were difficult months. Month 4 saw an improvement from the planned deficit of £1.7million, at a £2million deficit following receipt of a non-recurrent benefit of £0.5million rate rebate. The run rate average in Months 1-3 was £2.8million, with an improvement in Month 4 (July) of £0.4million. The YTD position was off plan by £3.4million. Drivers identified were a number of non-recurrent items which had hit in the first few months; not able to close an escalation ward by end of March as planned; the Cost Improvement Programme (CIP) delivery was behind schedule and increased medical spend, including sessional work above contracted hours. Nurse staffing, was cited as an example of good practice, being controlled and in budget. It was well recruited to and used limited agency staff. With an £11.6millon deficit at Month 4, it would prove challenging to reach an annual deficit of £15million at Month12. Providing a national perspective, of the 42 ICBs, very few started the year with a plan that was in balance and there have been many iterations. Whilst many were as financially challenged as WSFT, this Trust had a requirement to steward the resources allocated and therefore necessitate work to eliminate the overspend. It was advised that what happened to a system not meeting its plan was significant. An assumption could be made that with a new government would come extra funds. However, this was extremely unlikely. Whilst the pay award was welcome, there was no new money, or at least only limited provision, to cover this. The poorest performing systems had been under the national investigation and intervention regime, resulting in an inability to make any spending decisions without firstly seeking permission. Feedback from these organisations was that it was a difficult process to navigate. The Suffolk & North East Essex (SNEE) ICB was one of the few systems to submit a balanced plan. Whilst not on the national radar, locally the Trust was, as the system had a balanced plan to meet. There would be many benefits in doing so. Bonus capital and revenue would flow if	

	achieved, beneficial to both patients and the population. The £15million deficit was monies not able to be spent elsewhere in the system and therefore the external pressure was significant. The Trust needed to achieve its £16.5million CIP target and was currently tracked to deliver £10million. Recovery meetings were being held with divisions and people had engaged with these well. However, the CIP alone would not address all the issues. At July's Board Meeting, approval was given for further control measures to address external oversight, these included pay and non-pay restrictions and to review procurement contracts and high-cost interim staff requests. Due to the situation in which the Trust found itself within the system it was now in a "double lock" process. All internal decisions made on non-clinical recruitment and non-pay over £15k were now required to go to an ICB panel meeting, on a weekly basis, for approval. Question raised as to where this left the Trust. Noted the minimum requirement for the organisation was to significantly reduce the deficit on a month-by-month basis. However, this would not solve the entire issue and thought would need to be given on the 2025/2026 plan and how to make the organisation more efficient. The Director of Strategy & Transformation would assist with this. It was suggested by a governor that remaining CIP opportunities were limited. In response, it was suggested it was not possible to confirm that everything that could be done was being done at present and the organisation needed to provide that assurance to the Board and the system. Current schemes were very divisionally focused and lacking in large scale opportunities. The priority for next year was to identify a small number of key themes to drive this, for example theatre productivity. The Trust needed to demonstrate how far it could get and how to take matters forward. During Covid, CIP delivery had been paused. In the one and a half years since restarting the savings plan, the Trust had not delivered all the opportunities available. Control of the situation was required to return the Trust to a sustainable position. Clarification was requested on terms and acronyms being referred to. **Action: Glossary of finance terms and abbreviations to be provided to governors.** In terms of the impact assessment for CIPs and monies to be saved, how would this affect services provided to patients. Noted schemes had been identified, with more to come. Request made for transparency for governors in terms of potential changes to services. In order to provide assurance on an idea to deliver to bottom line, the prescribed process was for it to be entered on a CIP tracker, with detail of the idea and impact. This then went through the various gateways, in order to provide assurance that the CIP could be delivered. In terms of quality	**RW**

	impact assessment, the Chief Nurse and Medical Director assessed safety and quality on a weekly basis and whether the CIP could proceed. It was they who held corporate responsibility. Question raised as to how the message was being conveyed to operational staff, in order to provide context on why times would be tough. It was recognised that staff needed to be engaged in order to be successful. Noted communication had been undertaken through the operational management teams, who knew the pay and non-pay process. Two actions were being undertaken. On 4 September 2024, there would be an All-Staff Update, where the Acting Chief Finance Officer would discuss the financial situation. This would also be the second time when finances had been discussed at an update meeting. Noted attendance by managers was mandatory. JR was also working with the Associate Director of Communications and a number of stakeholders to produce a formal engagement communication document. This was currently in draft format. The Lead Governor (JS) referred to an email received from a member of staff expressing concern over a lack of support available to staff during this difficult time and the sense of job insecurity. Whilst governors did not participate in operational matters, JS wished to draw this to the meeting's attention and to stress that it was not solely about communication, but also support. Noted a service had shared a similar concern which was entirely understandable. The All-Staff Update would be opened up to discussion and shared in staff briefings. Acknowledged that there would naturally be some uncertainty, with much of the Trust's expenditure attributable to staff. Whilst workforce controls such as slowing recruitment were helping to save, going forward the Trust would have to examine every potential opportunity to return to a sustainable position. It was acknowledged that inevitably any potential changes could create uncertainty and be unsettling. Question raised as to whether the Trust had a real understanding of a balanced budget that was so at odds with the reality of the situation. It was requested that staff be provided with the reasoning behind any changes rather than solely a provision of figures. The meeting was advised that across the NHS, depending on the organisation, there was 15%-20% more staff working within it, than pre-Covid. Activity increases did not mirror this increase. Further, additional monies had been made available for services during Covid and the recovery period. . Permanent staffing and costs had been covered previously by non-recurrent monies that were no longer available. Concern expressed that changes required would affect staff and potentially have an impact on patients in terms of services. It was	

	acknowledged that the Trust did not have all the answers at present, but recognised staff concerns. It was queried what would happen if further savings could not be found. Noted there were efficiencies and the example of surgical theatre utilisation was cited. The organisation had many strengths. The aim was to preserve as much as possible and in order to do so, the organisation would need to be in a strong position. It was acknowledged that there was a consequence to not achieving target, with the Trust needing to do all it could to turnaround. An offer was made for the Acting Chief Finance Officer to be shown round theatres by a Staff Governor, to help identify areas that could be improved. It was highlighted that the Trust did not operate in isolation and was benchmarked against others, which had helped identify where savings could be made. Noted that when looking at the size of workforce it was not solely substantive staff, but also temporary spend. Even if the movement of pathology services was stripped out, the Trust would be at the higher end. Question raised regarding the Community Diagnostic Centre (CDC) at Newmarket. If the centre was seeing patients by Christmas for CTs etc., thus freeing up space at the Trust, had this been considered in the CIP? Further would the activity from Newmarket contribute to the Trust's CIP or be separate? Noted that the CDC was externally funded and would add to the Trust's run rate. The expectation was that it would provide the Trust with some margin this year, but at this stage the knock-on effect on the Elective Recovery Fund (ERF) was unclear. Noted the Board will make decisions on the programme of work and year end position for discussion with the ICB. Governors and staff will be kept informed.	
9.	**Feedback from Board Committees**	
9.1	The Council of Governors received an overview of the committees' key issues (CKIs) and governor observers' reports from the board assurance committees with the following highlighted: **Insight** – noted meetings held in May, June and July, 2024. July's meeting had provided minimal or partial assurance with regards to the financial position. The committee were concerned not just about the current financial year, but also next and the need to make decisions on difficult options early on. Noted Glemsford surgery's performance data had not been reported through the IQPR process. It was hoped that implementation of Data Warehouse at the end of July would provide internal control in this regard. Reasonable assurance has been provided on neurodevelopmental disorder (NDD) pathway for community paediatrics. Progress made by the division was to be commended, but the situation remained challenging.	

	In terms of 78 week waits the fact that there were people behind these statistics was highlighted. Noted these waits had a specific reason relating to a national shortage of urogynae specialists. The Trust was working hard to obtain mutual aid. Outsourcing had recently been arranged with the Nuffield in Ipswich, which was helping to reduce waits, but would not eradicate them during September. Query raised as to whether non-executive directors (NEDs) were taking this forward on behalf of the four patients, for whom this wait was likely to be debilitating. There did not appear to have been any escalation of the matter at July's meeting. It was advised that the NEDs were aware of the issue and that the Trust was working hard to find a solution, but it was not an easy one. This had been discussed amongst the NEDs as well as at Board and Insight Committee. The reason the matter had not been escalated was because the NEDs were aware of the work being done to rectify the issue. The email from a member of staff mentioned earlier in the meeting alluded to a lack of awareness by staff as to the financial situation. Mention was made of overpayment of a staff member, despite pay generating sessions being logged and approved by HealthRoster. A request was made for NED assurance that processes were picking up any such discrepancies. It was advised that an internal audit programme included work on trust processes on HR and payroll. **Action: Michael Parsons to pass on request for assurance on these processes to the auditors, for inclusion within their scope of work.** ***Insight Observer Reports*** – a comment at the May meeting by a member of the committee regarding the disconnect between executive decision making and budget setting was reported. People needed to be aligned. In July, Jonathan Rowell, Acting Chief Finance Officer, had given a comprehensive report, despite only being in post for short a number of days. In response to the disconnect between the budget process, the meeting was advised that the financial risk had been pushed back on and further work would be undertaken on the Board Assurance Framework (BAF) to address this. This would provide greater detail on actions to be taken.	**MP**
9.2	**Involvement Committee** – noted that the Workplace Strategy had been allied to the move to new hospital. Due to constraints on funding, the principle adopted for the new hospital was that there was only space for clinical work and space would have to be identified elsewhere for non-clinical staff. This might require additional space being provided off site. Noted integrated quality and performance metrics for staff turnover and sickness were currently at historically low levels. It would be important to see how this correlated to staff survey responses.	

	The need to improve how we manage the quality and accuracy of patient information on paper and the web was highlighted. This was not a simple fix, but a working group was to be formed to consider. Query raised as to whether some of this patient information could be shared electronically. Noted the Trust was required to ensure access for all and this would be one of the areas under consideration by the working group. ***Involvement Observer Report*** – a good meeting. Much discussion on the workplace strategy was noted. On this occasion, the meeting agenda was very large and ran over in to the next. In terms of patient information, national was not always relevant to individual trusts; a large piece of work, but an important one.	
9.3	**Improvement Committee** – noted the Hospital Transfusion Group had expressed concern at the delay in delivery/implementation of the closed loop blood system. Noted a new supplier was being sought. Whilst only providing partial assurance, work was in progress. Noted the level of those undertaking Basic Life Saving (BLS) training had not improved and remained at 80%. There were a number of reasons for this, including that many staff are going straight to Advanced Life Saving. Further BLS training was included as part of the junior doctor induction programme, but as they moved every six months, this had presented an issue. The Trust was working hard to ensure this training was being undertaken. In August, a deep dive was conducted on Shared Decision Making, following the roll out of the digital tool Concentric. Working is continuing to ensure engagement across all areas. In July, the deep dive related to Safe Environment (Safety in People's Homes) and the matter of lone staff working. The major risk identified was aggressive behaviour from patients, family members or even pets. June saw a deep dive on the accreditations and licences process. Noted processes were in place and licenses held by the Trust underwent a periodic review by the Clinical Effectiveness Governance Group (CEGG). Noted a presentation to the Integrated Care Board (ICB) on corridor care had been undertaken. The Trust strived to avoid this to maintain the fundamental standards of care relating to dignity and respect and person-centred care. Work was being conducted to capture data on outcomes in order to make improvements. Query raised regarding Concentric and whether it was used for Do Not Resuscitate (DNA) decisions. Noted this digital tool was not used in this regard, its purpose was to involve patients and their carers in making decisions about care. Noted the ReSPECT mechanism for discussion on a range of treatments the patient may want and are deemed appropriate had replaced the previous DNA orders. This was about care rather than resuscitation.	

9.4	**Audit Committee** – the annual report and accounts were signed off at the recent meeting and recommended to the Board for approval. The report from the external auditors had not highlighted any significant findings in relation to their value for money work and therefore issued an unqualified audit opinion. It was reported that the internal auditors had issued their opinion, noting an "adequate and effective control framework" being in place. Noted that the Counter Fraud functional standard national return had been submitted and the Trust awarded an overall rating of 'green'. At the next meeting of the Audit Committee, consideration will be given to counter fraud benchmarking information.	
10.	**Annual report and accounts, including auditor's letter**	
	Noted the accounts were signed off by the Board and submitted by the required deadline. KPMG's work on value for money included additional fieldwork in terms of financial sustainability and governance of the new hospital project. They reported satisfaction on areas of dealing with risk and that plans were in place and therefore did not qualify their opinion. Noted KPMG have indicated their intention to step down as external auditors of the Trust after this year and an alternative provider will need to be sourced.	
11.	**Nomination Committee Report**	
	It was confirmed that the NED and Chair appraisals had been completed. The Nominations Committee had received an annual report on effectiveness and review of the terms of reference, appended to today's report for approval**. The report was noted by the Council, who gave their approval to the terms of reference.**	
12.	**Engagement Committee Report**	
	The report was taken as read. Noted the meeting was undergoing a refresh and relaunch, following completion of a proposed workshop.	
13.	**Standards Committee Report**	
	The Standards Committee received detail of the governors' skills audit. This was discussed and topics identified included in the work programme for 2024/2025. Noted the committee had also discussed and recommended one amendment to the Trust's Constitution for consideration by the Council relating to the duration of tenure for a Governor. The Constitution currently makes provision for a Governor (elected or nominated) to hold office for a maximum of three terms or nine years. It was proposed to amend the Constitution so that a Governor who has reached the maximum term becomes eligible to stand for re-election after a break period of two years.	

	In considering this issue the committee sought to be flexible to accommodate individuals to serve in the role and balance this with the need to maintain a degree of independence, recognising that time in post impacts on this independence. **The Council of Governors gave approval to the proposed amendment to the Trust's Constitution and to recommended said amendment to the Board of Directors.** **The Council further noted the annual reports and gave approval to the terms of reference for the Standards Committee.**	
14.	**Staff Governors' Report**	
	Noted the meeting had agreed to staff governor members chairing the meeting in rotation. A standing item had also been added to meeting agendas to allow time for members' discussion in private.	
15.	**Lead Governor Report**	
	The report was noted and taken as read.	
16.	**Governance Report**	
	Noted the work programme had been informed by the results of the governor skills audit. Oversight of this will remain with the Standards Committee.	
17.	**Summary Report for Board of Directors Meetings**	
	The report was noted and taken as read.	
18.	**Any Other Business**	
	Frequency of Board Meetings – in view of the increased pace regarding the Trust's current financial situation, the question was raised as to whether the frequency of Board Meetings should increase to monthly from bi-monthly. Noted the Board of Directors did undertake development workshops in the months in between each meeting where there was the ability to have greater and more in-depth discussions. The assurance committees met monthly and finance was discussed at the Insight Committee. The Trust was required to provide financial plans to the ICB Finance Committee on a monthly basis and the Council could be assured that there was no shortage of discussion on the financial situation. It was queried if discussion was undertaken at one of the development workshops and therefore in private, was there a danger of the public missing out. It was advised that the workshops were in-depth discussions and any decisions would need to be ratified by the Board at a formal meeting. Noted if a matter was confidential in nature it would be discussed at a private Board meeting. It was highlighted that there was always a risk in having meetings too frequently as much of the time would be spent in preparation and follow up and therefore work would not get done.	

	New Hospital – request made for an update on a decision from the Government on whether building work would proceed. Noted the Trust had been advised that as one of the hospitals with RAAC it would not be included in the review being undertaken. However, a decision remained outstanding on capital funding. The Trust continued to be funded by the New Hospital Programme in order to undertake work necessary to move the programme at pace. ***Positives*** – it was suggested that the Trust should not forget the things it did well, alongside the work required to address the financial situation and the need to maintain these.	
19.	**Dates for meetings in 2024/2025**	
	▪ 19 November 2024 ▪ 26 February 2025 ▪ 14 May 2025 ▪ 11 September 2025 ▪ 13 November 2025	
20.	**Reflections on meeting**	
	Having just the one presentation was welcomed as it allowed time for in-depth discussion and enabled governors to carry out their statutory duties.	

5. Matters arising action sheet (enclosed) To note updates on actions not covered elsewhere on the agenda

To Note

Presented by Jude Chin

Learning report – Patient Safety and Experience (summary)

Introduction

There has been a significant shift in the approach to patient safety in recent years and most notably since the introduction of the NHS patient safety strategy. WSFT is committed to being open and candid with our patients and their families and by working together we can demystify the terminology around process and support our patients when there has been harm, or they have sought the need to tell us about their experience. Our aim is to be more proactive with communicating at an earlier stage with our patients, families and carers. The risk for us not doing this further compounds harm for all involved and as an organisation, we fail to learn and make the changes we need to promote safe and effective care.

What next:

- Monitor and review the effectiveness of the processes which are new, and those which are established.
- Establish the safety improvement group (SIG) as a forum for identifying opportunities for QI from all quality workstreams.
- Establish the mortality peer review process.

Summary of shared practices between patient safety, experience of care and the mortality team

- **Monthly complex case meeting**: To discuss new PALS concerns or formal complaints where other investigations are also being conducted. This review includes patient safety, inquests, learning from deaths (structured judgement reviews) and legal claims
- **Monthly Executive Inquest review meeting:** Arranged by the inquest team to discuss specific inquests with members of the executive team
- **Weekly Incident Triage meeting:** PALS and complaints cases are triaged and then if harm or potential harm is identified, it is presented at the weekly incident triage meeting. A member of staff (usually the lead investigator) from the relevant speciality is invited to present at the triage meeting to give their specialist view on whether the remit determines an incident investigation alongside the PALS or complaints process.
- **Emerging Incident Review (EIR):** EIR meets on a weekly basis to discuss patient safety incidents which have been categorised as severe harm or escalated as an emerging theme or cause for concern
- **Structured Judgment review Process (SJR):** Learning from deaths is a national framework and WSFT has adopted the Royal College of Physicians' Structured Judgement Review (SJR) for adult inpatients that died within the Trust

The wider patient safety team are working with the communications team to develop a suite of shared learning approaches. The first being a patient safety bulletin; used to share immediate learning for safety mitigation following patient safety incidents. These can be shared with targeted audiences, such as the medical staffing committee or the nursing and midwifery clinical council as well as through divisional governance processes. The team are also developing the quarterly thematic analysis report, previously reported to the PSQGG to include an analysis of patient safety incidents and shared learning.

6. Chair's report (enclosed)

To receive an update from the Chair

To Note

Presented by Jude Chin

WSFT Council of Governors meeting (Open)	
Report title:	Chair's report
Agenda item:	6
Date of the meeting:	19 November 2024
Sponsor/executive lead:	Jude Chin, Trust Chair
Report prepared by:	Jude Chin, Trust Chair

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 Autumn Budget

There has been a great deal of commentary on Rachel Reeves' budget, particularly as it relates to NHS funding. As always, the devil is in the detail and whilst a funding increase of £22.6 billion for day to day spending is to be welcomed, further detail is needed as to how this money will be allocated.

The government focus for the future of the NHS is:

- Hospital to Community
- Analogue to Digital
- Sickness to Prevention

Given these priorities, it may be assumed that the majority of additional funding may go into community services, which is certainly necessary if we are to achieve the 'left shift' ambition.

With the acute sector under increasing patient demand and financial pressures, it will be interesting to see how much additional cash will be allocated to this area. In addition, it should be noted that of the £22.6 billion extra funding, £12.2 billion has already been allocated to fund the 2024/25 expenditure of the NHS, leaving £10.4 billion as the additional funding for 2025/26. It is also unclear how much of the 2025/26 additional funding will be absorbed by existing deficits, pay awards and increased employers NI.

Regardless of future funding increases, this Trust will need to continue to deliver on reducing it's cost run rate to bring our overall financial position into balance as quickly as possible.

Board Development

The Board met on 25th October for a board development day, the first such day for many of the directors, both executive and non-executive. I am pleased that, for the first time in many months, we have a full strength board, which is important given the challenges that face the Trust.

The main focus on our development day was around a strategy refresh as we considered the present state of the Trust and our ambitions for the next 3-5 years. We hope to be in a position to share our refreshed strategy early in the new year.

Whilst it is important that we continue to focus on our financial challenges, it is also important that we share a vision of the future with our staff that will take us beyond the immediate future and prepare us for our move to a new hospital.

10 Year Plan Conversation

The Secretary of State for Health has made a commitment to the development of a 10 year plan for the health service. The plan, which follows on from the Darzi report, is to be developed as a joint project between the Department of Health and Social Care and NHS England and will be co-developed with the public, patients, staff and stakeholders.

A meeting of the East of England Chairs and CEOs was held on 8th November to begin the first of many conversations to feed into the 10 year plan. The particular focus of the discussions was the three priorities referred to earlier, hospital to community, analogue to digital and sickness to prevention. Members of the central team working on the 10 year plan were present to observe and take notes of the various conversations.

There was a fascinating presentation from Professor Sir Chris Whitty on the need to move resources towards the prevention of ill health and in particular for those of the most disadvantaged of our population, who not only die younger than the average but also live longer with poor health.

Suffolk and North East Essex Integrated Care System Chairs Group

The most recent meeting of the group was on 8 October, attended by the chairs or representatives from all providers of healthcare services in the SNEE ICS. We received presentations and had discussions on:

- Anchors Programme Board – a core objective of the ICS is to help the NHS support broader social and economic development within SNEE. The Anchor Programme Board has as it's initial priorities, development of an anchors dashboard, raising awareness of Anchors activity and work around initiatives on local spend and embedding social value.

- ICS Voluntary Community Faith and Social Enterprise (VCFSE) Assembly – the VCFSE Assembly provides a platform for VCSFE partners to connect with each other on strategic ideas and learning. There are currently 130 VCFSE members. A paper was presented setting out the recent work of the Assembly.

- Future Shift – a report on progress on how our system will achieve the 'left shift' that is a key element of the ICB Joint Forward Plan. Feedback on various workshops and meetings looking at how we shift demand and capacity away from our hospitals and into the community, with a particular focus on the clinical principles for a future shift.

Remembrance Parade Bury St Edmunds

On Sunday 10th November I attended the Remembrance Parade on Angel Hill, laying a wreath on behalf of the West Suffolk NHS Foundation Trust, at the War Memorial.

Quality and Performance

Without wishing to duplicate the detail within the CEO report, it is important to recognise the financial and operational pressures that the Trust is facing. We are starting to see some improvements in the financial position but there remain challenges to delivering a sustainable financial run rate. I do not underestimate the impact of this on our staff and I thank them for their continued support and efforts in delivering these improvements.

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

To keep council of governors informed of some of the key issues taking place across the Trust.

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

-

Action Required

The Council of Governors is asked to note the report.

Risk and assurance:	NA
Equality, Diversity and Inclusion:	NA
Sustainability:	NA
Legal and regulatory context	NA

7. Chief executive's report (enclosed)

To note a report on operational and strategic matters

To Note

Presented by Ewen Cameron

WSFT Council of Governors' Meeting (Open)	
Report title:	Council of Governors' CEO report
Agenda item:	7
Date of the meeting:	19 November 2024
Sponsor/executive lead:	Dr Ewen Cameron, Chief executive officer
Report prepared by:	Dr Ewen Cameron, chief executive Sam Green, communications manager Anna Hollis, Deputy head of communications

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 summarises the recent Trust-wide activities and key issues across the Trust.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
To keep the council of governors informed about what is happening in the Trust.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
For awareness of council of governors and to inform discussion or questions to CEO.
Action Required
The Council of Governors is asked to note the report.

Risk and assurance:	NA
Equality, Diversity and Inclusion:	NA
Sustainability:	NA
Legal and regulatory context	NA

The Trust continues at pace to deal with a difficult financial position and since the last meeting of the Council of Governors, we have been taking considerable steps to get back on a sustainable financial footing. I am grateful to our staff, who are balancing patient safety with the need to identify opportunities to deliver more cost-effective services. We have had to make some tough decisions, and I do not underestimate the impact of these.

Despite this, we remain committed to improving our services for our communities and I share detail of some initiatives that support our patients below.

Performance

At the end of September, our reported position in-year was a £16m million deficit, which is £6.2 million worse than we planned to be at this point. Therefore, we continue doing much work to identify opportunities to improve this situation, working with our colleagues to meet this challenge head on.

We are starting to see small areas of improvement and a shift in the right direction to drive financial recovery so the measures we have in place, such as slowing recruitment, reducing temporary and agency staff spend and usage, theatre utilisation and medicines optimisation will remain in place for now.

Elective recovery

We have continued to make progress in our elective recovery. At the end of September, there were:

- 192 patients waiting more than 65 weeks
- 36 patients waiting more than 78 weeks, with 26 of these being capacity related.

Whilst there is more to do, we have been improving how we use our theatre space to increase the efficiency of the process and see more patients. This includes a review of our theatre templates to create all-day operating, using the same theatre team, surgeon and anaesthetics all day to provide continuity and increased efficiency, and running additional lists on the weekends. Known as ‘super Saturdays’ – they focus on a particular specialty and reduce backlogs in that area, making a positive difference to our long-waiting patients.

Alongside this, we are continuing to make progress in expanding the number of procedures we offer as a ‘day case’. This is where patients have their procedure and are discharged on the same day. Optimising our processes and care in this way leads to better outcomes for our patients while helping us save inpatient beds for those who need them most.

Urgent and emergency care

Our performance against the 4-hour standard was 64.8% against a trajectory of 73%.

Inpatient flow has been challenging – although our average length of stay (LOS) benchmarks well compared to regional/national peers we did see an increase in the number of patients with 14+ and 21+ day LOS in October. Increased admissions and lower discharges have meant patients waiting longer for admission in the emergency department than we would like. The Minor Emergency Care Unit opened in October with the aim of freeing up space within the main emergency department footprint to reduce waits and overcrowding, so that patients can be seen more quickly.

Cancer

The focus for 24/25 is to improve faster diagnosis performance to 77% having cancer confirmed or ruled out by day 28 and 70% of patients having their cancer treatment by day 62. Our August performance against this is as follows:

- 68.8% of patients achieving the faster diagnosis standard

- 72% of patients treated within 62 days.

Quality

Various initiatives are being implemented by our quality improvement team who help nurture, coach and guide numerous projects to improve the way we work day-to-day and the care we provide. Some notable projects include improving our decision-making timings with PICC lines for our paediatric patients requiring long-term antibiotics, standardising chest drain procedures across our inpatient wards and reviewing all our community housebound diabetic patients.

These three projects are delivering great results. So far, our paediatric patients are receiving their PICC line insertions within the target timespan 92% of the time compared to 67% before; incidents relating to chest drains have been reduced by more than 10% in 10 months due to the roll out of a comprehensive training package (which is being monitored to ensure the sustainability of these improvements); and, after having reviewed all our community housebound diabetic patients, we were able to safely discontinue 20 patients from this treatment, saving our district nursing teams 7,280 visits a year (equivalent to a cost saving of £323,378 a year). As part of this project, we were also able to identify those patients with very high and low glucose levels and commence insulin titration - adjusting the insulin dose to improve target blood glucose levels - to improve their health and reduce long-term complications.

Back in September the Trust held its annual Patient Safety Summit. This event highlights the work that is ongoing across the Trust around patient safety, how we learn from when things do not go as planned and how we implement the improvements identified from our investigations. Alongside a packed agenda at the Drummond Education Centre at the West Suffolk Hospital, there were also numerous stalls across the site as part of the ‘solution gallery’. It was fantastic to see our colleagues visiting the numerous stalls which promote the ways that patient safety is being enhanced in their areas, and learning about how they can bring these into their own departments.

The result of all this work means that the quality and safety of the care we provide and outcomes for patients improve, and their experience is enhanced. That is why I was delighted to learn the Trust’s results from the annual NHS Adult Inpatient Survey for 2023. The Trust was rated 8.5 out of 10 for overall experience, placing fifth highest in England for all acute and combined trusts, and second in the region behind Papworth for all trusts. The Trust also scored in the top two or top five in the region on most other criteria including admission and leaving the hospital, the hospital and ward, doctors, nurses, care and treatment, kindness, compassion, respect and dignity. The Trust also scored well on the support available when leaving hospital and the food served. This is a hard earned but well-deserved achievement. Delivering our services to this standard takes a village, and I am very proud of everyone working in all services across our Trust as every member of staff contributes directly or indirectly to achievements like these.

Workforce

Whether it’s presenting our staff ‘Putting You First’ awards to the recipients or seeing the vast number of long-service awards that are sent out to those that have achieved 20 years of service in the NHS, I love to celebrate our staff. Therefore, it was an absolute honour for myself and our executive chief nurse, Sue Wilkinson, to present one of our midwives with a special long service award. As we celebrate 50 years of our West Suffolk Hospital, one of our labour suite midwives, Diane Hele, has been working in the NHS since before the existing hospital opened in 1973. In those years she has worked in the theatre sterile supply unit at the old West Suffolk Hospital, then training as a registered nurse which she completed in 1977. From 1978, Diane trained as a midwife, completing this in 1980. Diane has worked in the NHS for 51 years, 44 of those as a midwife, which is a remarkable feat. It is truly people like Diane that make the NHS what it is, and she is a shining example of what public service in healthcare is all about.

I was also recently thrilled to learn that our preceptorship programme has been shortlisted in the Preceptorship Programme of the Year category for the Nursing Times Workforce Awards 2024. The project – 'To improve attendance of the multi-professional preceptorship programme' – aims to increase the engagement and attendance of study days by understanding what the barriers are to going to them. Making improvements in this area is very important, as preceptorship programmes are key to making sure our newly qualified nurses, midwives and other staff start their careers with the tools they need to thrive. This ultimately helps us retain these highly skilled colleagues so we can help them to continue to grow and go on to have successful and rewarding careers in the NHS.

On Friday, 13 September the Suffolk and North East Essex (SNEE) 'Can Do' Health and Care Awards 2024 took place, which celebrates the best of the health and care work that has happened in the area over the last year. Many of our teams were nominated across most of the eight categories and while none came home the ultimate winners, it was heartening to see how many runners-up were or received commendations for the work they've done. This includes the Trust's speech and language therapy team as a runner-up for the 'Healthier Lives Award' and Rachel Grimwood, our student and young volunteer coordinator, as a runner-up for the 'Young People's Champion Award'. Additionally, our virtual ward service and 'The Tablet Course' - a 'computer club' run by our speech and language therapy team and Realise Futures CIC to support those who have experienced a stroke or have aphasia/apraxia to explore how tech can support their needs - were highly commended for an 'Innovation in Health Award'. Congratulations to all those involved.

Future

On 1 August, the Trust marked an exciting milestone in our delivery of a new Community Diagnostic Centre (CDC) at the Newmarket Community Hospital. The centuries old tradition of 'topping out' commemorates the building reaching its tallest point. It has been remarkable to see the difference over the last eight months, from when we broke ground in January to now, as the building is watertight, and the inside is starting to come together rapidly. We remain in a position to finish construction in November and welcome our first patients before Christmas, which will be a wonderful moment.

Once fully open, the CDC will provide approximately 100,000 tests per year, including MRI, CT, X-ray, ultrasound, heart and lung scans as well as blood tests – all from a new, dedicated facility. This will help us deliver care closer to where our communities live and expand our diagnostic capacity to ensure we get our patients the treatments they need more quickly, which will ultimately help reduce health inequalities and improve outcomes.

It was excellent news that the Chancellor confirmed in the Autumn Budget that the project to deliver a new West Suffolk Hospital will continue at pace. As one of the seven RAAC hospitals, we await further information about the allocated capital budget and in the meantime, continue to work closely with our community, colleagues and the national New Hospital Programme team to design and build a hospital fit for the future.

We are pushing forward with transformative projects which will make sure we are ready to take advantage of all the opportunities this new facility offers. That is why we are looking at improving the way we work and how we use technology to deliver the high quality and safe care our communities need, when they need it. Virtual outpatient appointments are a way that our staff can see more patients and our patients can more easily access the care they need. Particularly those that may struggle to attend an in-person consultation due to childcare, work or transport restrictions. Our aim is to grow the number of virtual outpatient consultations that we conduct to 25%, so that we can keep up with the growing demand for our services and fully utilise the space available in the new healthcare facility.

And finally, it was fantastic to see so many of our community come down to The Apex in Bury St Edmunds for our Annual Members' Meeting, which focused on the 50th anniversary of the West

Suffolk Hospital and the past, present and future of diagnostics. I enjoyed seeing so many of our services and our health and care partners represented at the healthcare marketplace, where attendees could learn more about our use of artificial intelligence, get their blood pressure tested or experience some virtual reality technology and how we use it in our education and training.

GOVERNOR BUSINESS (INC. STATUTORY DUTIES)

8. Feedback from assurance committees (enclosed)

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

To Note

WSFT Council of Governors meeting (Open)	
Report title:	Feedback from Board assurance committees
Agenda item:	9
Date of the meeting:	19 November 2024
Sponsor/executive lead:	Non-Executive Directors / Governor observers at the Board's assurance committees
Report prepared by:	Chairs of the assurance committees Governor Observers at the assurance committees Richard Jones, Trust Secretary Pooja Sharma, Deputy Trust Secretary

Purpose of the report:

For approval	For assurance	For discussion	For information
☐	☒	☒	☒
Trust strategy ambitions	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
Please indicate Trust strategy ambitions relevant to this report.	☒	☒	☒

Executive summary:

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

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

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

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

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

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

INSIGHT COMMITTEE:

21 Aug 2024 (observed by Jane Skinner, Jayne Neal and John-Paul Holt)

- Report from sub-committees: Financial Accountability Committee including Month 4 performance and Financial Recovery Action Plan
- Update on National Cost Collection
- IQPR - data for June 2024
- Quality Impact Assessment Panel Outcomes
- Board assurance framework - revised financial risk
- Escalations to and from other board assurance committees and board
- Forward Plan

18 Sept 2024 (observed by Jayne Neale and Jane Skinner)

- Report from sub-committees: Financial Accountability Committee and Patient Access Governance Group
- Quality Impact Assessment Panel Outcomes
- Financial Recovery Plan
- Board Assurance Framework - BAF 2 capacity and BAF 7 financial sustainability (via FAC)
- IQPR – data for July 2024
- Core Standards Submission
- Terms of Reference
- Escalations to and from other board assurance committees and board
- Forward Plan

16 Oct 2024 (observed by Jane Skinner, Jayne Neale and John-Paul Holt)

- Report from sub-committees: Financial Accountability Committee and Patient Access Governance Group
- Oversight to the Financial Recovery Plan for Community Equipment Services and Wheelchair Services
- Quality Impact Assessment Panel Outcomes
- Bed Occupancy Deep Dive
- Board Assurance Framework- BAF 2 capacity
- Internal Audit Report
- Corporate Risk Governance Group
- IQPR - data for Aug 2024
- Escalations to and from other board assurance committees and board
- Forward Plan

IMPROVEMENT COMMITTEE:

21 Aug 2024 (observed by Anna Conochie, Jane Skinner and Adam Musgrove)

- Reports from governance sub-groups: Patient Quality & Safety, Clinical Effectiveness and Transfer of Care Group report
- Quality & patient safety insight: Quality & safety datasets, IQPR, PRM packs, and agree any areas requiring assurance review
- Quality priorities, improvement, and assurance - Deep Dive – Shared decision making, Corridor care – presentation to ICB and Learning report – patient safety and experience
- Risk Management and Governance
- Board assurance framework - review of governance BAF risk
- RADAR update

- Scope for Divisional Governance Review
- Escalations to and from other board assurance committees and board
- Forward plan for assurance deep dives

18 Sept 2024 (observed by Adam Musgrove, Anna Conochie and Jane Skinner)

- Reports from governance sub-groups: Patient Quality & Safety, Clinical Effectiveness and Transfer of Care Group report
- Quality & patient safety insight: Quality & safety datasets, IQPR, PRM packs, and agree any areas requiring assurance review
- Quality priorities, improvement, and assurance - Deep Dive – patient safety priorities – C. difficile and ConsultOne well led response
- Risk Management and Governance
- Board assurance framework - review of governance BAF risk
- RADAR update
- Scope for Divisional Governance Review
- Escalations to and from other board assurance committees and board
- Forward plan for assurance deep dives

16 Oct 2024 (observed by Adam Musgrove and Jane Skinner)

- Reports from governance sub-groups: Patient Quality & Safety, Clinical Effectiveness and Transfer of Care Group report
- Quality & patient safety insight: Quality & safety datasets, IQPR, PRM packs, C-difficile – update and agree any areas requiring assurance review
- Quality priorities, improvement, and assurance - Deep Dive – CQC single assessment framework – Critical Care and Maternity incidents update
- Risk Management and Governance
- Board assurance framework - BAF review forward plan update: BAF 4 Transformation – Dec 2024 and BAF 8 Governance – Jan 2025
- Assurance committees report October 2024
- Escalations to and from other board assurance committees and board

INVOLVEMENT COMMITTEE:

20 Aug 2024 (observed by Sue Kingston and Val Dutton)

- Setting the scene: Our FIRST values and committee purpose - Fairness, Inclusivity, Respect, Safety, Teamwork

First for staff; first for the future:

- Exploring the relationship between financial recovery and our organisational culture

First for patients:

- ESEOC engagement – summary of Healthwatch feedback & recommendations

Governance:

- People and Culture Group update – July 2024 report
- Experience of Care and Engagement Committee report
- Quarterly Guardian of Safe Working report
- Board Assurance Framework domain 1: Capability
- Board Assurance Framework domain 10: Staff wellbeing

- Annual self-evaluation – report

Other items for oversight and assurance:

- IQPR extract for Involvement Committee (staff & patient experience KPIs)
- Escalations to and from other board assurance committees and board

16 Oct 2024 (observed by Sue Kingston and Val Dutton)

- Setting the scene: Our FIRST values and committee purpose - Fairness, Inclusivity, Respect, Safety, Teamwork

First for staff:

- Lone worker safety in community services
- A Framework of quality assurance for responsible officers and revalidation

First for the future:

- Finance, Workforce, Culture and Engagement
- What can we learn from the impact of workforce controls introduced thus far?
- What is the approach to shifting the workforce in a level that is financially, clinically and operationally sustainable?
- Veterans paper

First for patients:

- CQC Inpatient Survey 2023 results.
- EDI thematic review
- Service user feedback and subsequent co-produced action plan
- Publication and maintenance of patient information leaflets

Governance:

- People and Culture Group update – September 2024 report
- Experience of Care and Engagement Committee report
- Update on formal complaints quality improvement project
- Patient Engagement BAF
- Collaboration BAF
- Internal audit reporting – Q3 report

Other items for oversight and assurance:

- IQPR extract for Involvement Committee (staff & patient experience KPIs)
- Escalations to and from other board assurance committees and board

AUDIT COMMITTEE

Audit Committee's key issues report presented by the Committee Chair

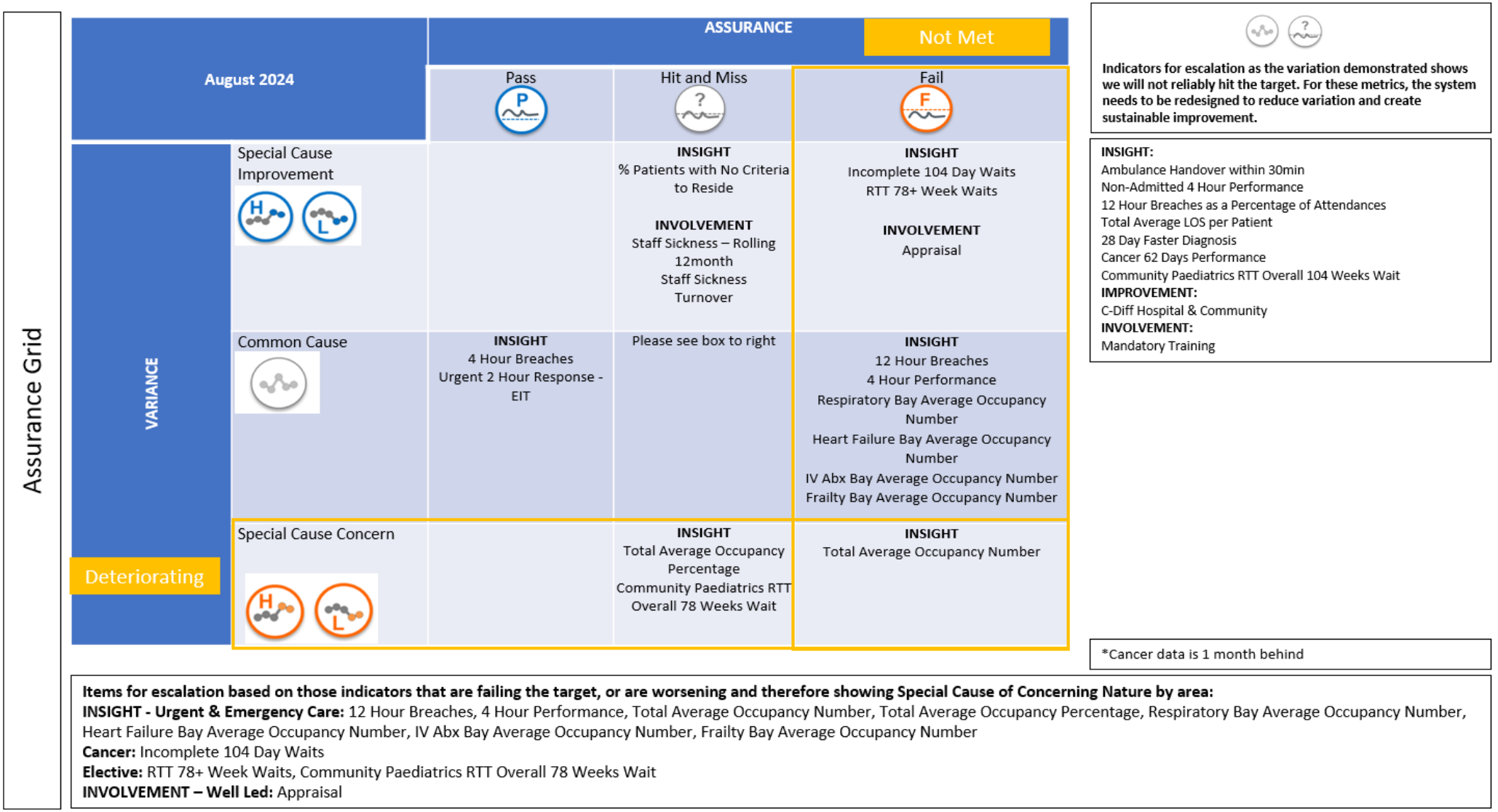
WHAT NEXT?
Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)

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

Action required / Recommendation:

The Council of Governors is asked to note the feedback from Board assurance committees.	
Previously considered by:	N/A
Risk and assurance:	Council of Governors unable to undertake its statutory duties.
Equality, diversity and inclusion:	N/A
Sustainability:	N/A
Legal and regulatory context:	West Suffolk NHS Foundation Trust Constitution Health & Social Care Act 2022 NHSE Code of Governance 2022

Annex A: IQPR – exception summary slide



8.1. Insight Committee

Presented by Antoinette Jackson

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			**Date of meeting: 21 August 2024**		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item 5.1	**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
Finance Accountability Group	**Current year** The Trust was £3.5m off plan year to date (YTD) by the end of month 4, with a deficit of £11.6m against a planned deficit of £8.1m. The CIP programme is behind plan by £1.2m YTD. Some of the progress that has been made against CIP is due to a non-recurring rates rebate of £550k. There has been a reduction in the run rate compared to June but expenditure is still £2.1m above income and to hit our target deficit of £15.2m requires and improvement in the run rate of £2.5m per month. Our cash position remains challenging although we have received £1m received	**4. Minimal**	The current measures that are in place are not delivering the pace of change needed to deliver against the Trusts financial plan and a more comprehensive financial recovery plan is required (see below)	See financial recovery item below	

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			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
	support in Month 5 from DHSC and we have been advised we will receive £4.4 m from the ICB in relation to depreciation funding which will also help our cash position.				

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	Financial Recovery Plan Good progress has been made in implementing the control measures agreed at the July Insight Committee including the implementation of a non-pay control panel and controls on Extra Contractual Work spend. The controls are also helping identify further potential CIPs although there is a need to ensure we are not double counting between the control measures and the CIP programme. The ICB has introduced a double lock mechanism which requires their approval of all relevant non-pay spend over £15k. Any such requests will have gone through the Trust's own internal processes first.	**3 Partial**	The control measures are beginning to show some results but the pace of change and financial delivery needs significant improvement given the scale of the gap. Efforts are currently very focused on the current year but there is a need for a coherent Financial Recovery plan that takes a longer-term view of the transformation needed to ensure financial sustainability into the future. This needs also needs to embrace cash recovery and workforce planning. Consideration needs to be given to the any gaps in capacity and capability in the organisation that need to be addressed to deliver the plan	A comprehensive financial recovery plan to be considered by Insight on 19 September and Board on 27 September. An extensive communications plan to be developed alongside this, to explain the future direction of travel and what this means for the Trust and its workforce.	

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PAAG/IQPR	**65 and 78 week waits** The total waiting list size remains high with no signs of reducing. At the end of June, 60 patients were waiting more than 78 weeks. 46 of these were related to capacity, with the largest volumes within Urogynaecology. There are four 78 -week patients in Urogynae without a specific plan. Fifty-six patients have now been transferred to the Nuffield to have their surgery before the end of September. On the whole we are doing better than our forecast for the 65-week cohort as at the end of June. There are however a number of surgical specialities which are slightly above	**3.Partial**	Delivering the objective of no patients waiting over 65 weeks by September 2024 is the central focus of 2024/25 planning, – as 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.	Additional activity, either in week or on Saturdays is in the planning stages with Gynaecology, with the patients not suitable for the Nuffield now being screened for weekend list suitability. Additional weekend lists are in place throughout the summer months.	1 No escalation

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	trajectory. There are plans in these services to reduce his with an increase in activity prior to the end of September.				

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PAGG/IQPR	**Cancer Targets** Performance against the 28-day Faster Diagnosis Standard (FDS) is still not being consistently met. 62-day performance is above the which is above the national ambition of 85%. Actions are focussed on the skin and lower GI pathways.	**3. Partial**	Achieving the FDS target of 77% and a 62-day performance of 70% March 2025 are the key objectives for cancer in 2024/25 planning.	Continue with FDS steering groups in Skin, Colorectal, Breast and Gynae to monitor performance and required transformational changes. Implement required changes into the Skin community pathway, improving on the community consultant review to reduce referrals. Implementation of post menopausal bleeding (PMB) pathway for people receiving HRT to be managed outside an Urgent Suspected Cancer referral by Q3. Implement risk stratification tools in Prostate to reduce unnecessary progression to MRI and/or biopsy.	1 no Escalation

Originating Committee: Insight Committee			Date of meeting: 21 August 2024		
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PAAG/IQPR	**Urgent and Emergency Care (UEC)** Ambulance Handovers within 30 min and non-admitted 4-hour performance are not reliably hitting target and 12-hour breaches are consistently missing the target too.	**3 Partial**	Patients do not have a good experience of they face significant delays and are at risk of harm. There is a lack of flow out of the ED and some patients are waiting longer than acceptable for a specialist bed. Achievement of the metrics remains challenging with contributing factors including overcrowding within the Emergency Department (ED) by patients with an increased length of stay, resulting in the need to cohort patients into escalation areas including Rapid Assessment Triage Area (RAT), which reduces the ability and capacity to offload ambulances.	The UEC recovery plan has a trajectory to achieve the 78% 4hr ED target by March '25. The following projects commenced in July '24. Pre booked next day returner slots to support minor injuries attending after 10pm Rapid Assessment for non-admitted patients with a consultant triaging to either assess and discharge them or to redirect to other services Ambulance patients who are fit enough to sit will be triaged in streaming to release ambulances. The Minor Emergency Care Unit is on track to open by end of August 24	1 No escalation

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Agenda item 5.1	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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Quality Assurance Panel Outcomes	Improvement Committee had previously raised with Insight Committee the risk of quality considerations not being considered fully in the CIP programme and other financial decision making. Insight requested a report on outcomes form recent Quality Impact Assessment (QIA) reviews. The Panel reviews and scrutinises QIAs for all CIP schemes or projects and then either approves or rejects the proposal. The report updated the committee on the schemes that had been considered over the last 4 weeks.	**1.Substantial**	The report showed that there is a robust process in place to scrutinise schemes before they are agreed. 14 schemes had been considered in the previous 4 weeks and the risks and mitigations of these had been considered. The report showed that one scheme had been rejected and further work on the business case had been requested. Some schemes had been approved, but with conditions or recommendations attached.	Insight will continue to receive reports to future meetings.	No escalation

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 21 August 2024
Governor observer (observed by): Jane Skinner

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Agenda weighted to finance issues and discussion. • Long agenda
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Well chaired • Trust values clearly written on the agenda. A volunteer was selected to reflect at the end – finance focused and 'sombre', more focus on BAF needed, assurance focus, honest conversation and engagement.
Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
• A number of controls across the Trust have been implemented as CIPs- examples: reduce use of agency and temporary staff, WTE control, employment controls new staff, senior sign off for > £500 items - non-pay control panel set up, ICB "double lock" imposed, lap top control. Further work pending within divisions. The financial benefit of these and other CIPs is not yet fully realised in the financial position. • As a Governor I feel assured that there is a concentrated focus on CIPs and finance but less assurance that the balance at year end will be achieved. The finance report and other financial papers submitted to the meeting were very detailed. Also,

Governors are aware that staff are concerned about how the financial position will affect them, their jobs and their area of practice. There was assurance that staff are being communicated with about the financial position - for example the last all staff brief.

- Assurance – a clinically led Quality Impact Assessment (QIA) Panel reviews QIAs which are an integral component of CIPs
- The IQPR for ambulance handovers, 12-hour breeches, and 4-hour performance remained the same and did not meet the required standards some assurance for improvement in the What Next action plans.
- BAF showing red levels of assurance (minimal) around the cause and effect of the finance position and the agreement of a financial strategy and trajectory
- There was minimal assurance following the last meeting as to how Glemsford surgery data is to be collected and why the issues were not escalated and addressed earlier. Data collection and surrounding governance remains an action point.

Governor observer Notes

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

- It was suggested that finance should feature in the IQPR
- The virtual ward occupancy targets were not met in June – a wider roll out plan has been agreed.
- It was emphasised that all staff have financial accountability

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 21 August 2024
Governor observer: Jayne Neal

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• The majority of the meeting focussed on finance matters, including the financial recovery plan. The IQPR report highlighted the Urgent and Emergency Care matters and waiting times, along with cancer / FDS
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• The Chair welcomed everyone and new attendees were introduced. • There was strong challenge throughout the meeting from the NEDs, in respect of the difficult financial situation. This was conducted with respect and all contributions were listened to carefully. • The Executive Chief Nurse independently reflected on the meeting and observed this was a focussed meeting, discussing serious concerns which were addressed honestly • FIRST values were demonstrated throughout
Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*

- As previously, there is only minimal assurance on the financial situation but the committee is committed to focusing its efforts on ensuring an improved outcome. This will include strong communication messages throughout the Trust, particularly to budget holders, along with supporting finance colleagues to improve their skill levels.

Governor observer Notes

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

Antionette Chaired the meeting very fairly and gave everyone in attendance an opportunity to speak. She summarised the conversations at the end of each topic and outlined the way forward for the next meeting.

Tracey Dowling (returning NED) offered useful examples and contacts from her recent experiences working in Mid and South Essex who have similar financial constraints. This was agreed to be followed through.

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 21 August 2024
Governor observer (observed by): John-Paul (J-P) Holt

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Large agenda, with many items relating to Finance. The majority of the meeting was taken up by financial matters, with less time taken on operational matters. Despite this imbalance, it was acknowledged by their entire committee that this was appropriate given the current situation of the Trust. • Relevant papers were available in advance of the meeting. • All items on the agenda were discussed thoroughly and none were deferred to the next meeting. • As per the committee's forward plan, today's agenda should have included a Deep-Dive of Environmental Sustainability, but this seems to have been an oversight & was not included in today's meeting. This is to be rescheduled by the Operational Team for another committee meeting in the near future.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Both the newly recruited Executive Directors of Financial Recovery and Strategy & Transformation were in attendance of today's meeting. They were both able to largely contribute to presentations and discussions and it was incredibly clear to see that both have already completed a lot of work, despite having only been in post for a relatively short amount of time. It was very apparent that there has been fantastic integration of both into the wider Trust's management structure and collaborative working, particularly with the Deputy Director of Resources. • There were more NEDs in attendance at today's meeting. They were all vocal in asking questions and providing challenges to all items on the agenda, particularly in their areas of individual expertise.

- Committee Chair again managed timings of today's meeting well. Despite some items on the agenda requiring extended discussions, these were managed effectively and summarised by the Chair well. Today's meeting did overrun slightly, but less so than previous meetings.

Assurance

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

- There seems to have become an overall lack of willingness for members of the committee to self-nominate themselves as an Observer to provide reflections at the end of the meeting with regard to meeting conduct and whether it aligned with the Trust's FIRST Values etc. I have noted that some committee members have self-nominated several times since the start of the year, yet others haven't at all. Would this be managed better by a rota system?

Governor observer Notes

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

- It was very apparent today that the recently returning NED had very quickly got back up to speed with things at the trust, despite her time away. They were a part of many discussions throughout the meeting and their expertise, challenges & support were widely shared and welcomed.

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			**Date of meeting: 18 September 2024**		
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PAAG/IQPR	**Urgent and Emergency Care (UEC)** Ambulance Handovers within 30 min and non-admitted 4-hour performance are not reliably hitting target although 4-hour performance was above trajectory in July. 12-hour breaches are consistently missing the target too, although they are decreasing.	**3 Partial**	Patients do not have a good experience of they face significant delays and are at risk of harm. There is a lack of flow out of the ED and some patients are waiting longer than acceptable for a specialist bed.	The UEC recovery plan has a trajectory to achieve the 78% 4hr ED target by March '25. The following projects commenced in July '24. Pre booked next day returner slots to support minor injuries attending after 10pm Rapid Assessment for non-admitted patients with a consultant triaging to either assess and discharge them or to redirect to other services Ambulance patients who are fit enough to sit will be triaged in streaming to release ambulances. The Minor Emergency Care Unit is now due to open on 14 October 2024.	1 No escalation

Originating Committee: Insight Committee			Date of meeting: 18 September 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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PAGG/IQPR	**Cancer Targets** Performance against the 28-day Faster Diagnosis Standard (FDS) is not being consistently met, however there was an increase in June 2024 to 74.5% against a target of 75%. The 62 day performance is above trajectory and above the national requirement of 70% by the end of March 2025. There is an emerging risk in relation to Breast clinics. Radiology support is reducing from September 2024 which means wait times could extend out to more than 7 weeks, without additional actions in place.	**3. Partial**	Achieving the FDS target of 77% and a 62-day performance of 70% by March 2025 are the key objectives for cancer in 2024/25 planning.	Continue with FDS steering groups in to monitor performance and required transformational changes. Review the impact of the changes made in the skin pathway. Review the future of the community pathway from March 2025. Implementation of new post - menopausal bleeding (PMB) pathway for people receiving HRT Implement risk stratification tools in Prostate to reduce unnecessary progression to MRI, biopsy or treatment regimens by Q3. Review radiological support to the Breast clinics.	1 no Escalation

Originating Committee: Insight Committee			Date of meeting: 18 September 2024		
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Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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PAAG/IQPR	**65 and 78 week waits** The 78-week wait position for the end of July was 52 patients, with the majority within the sub speciality of Urogynaecology. At the end of July, we were on trajectory for our 65-week wait cohort. But the Trust will not reach zero by the end of September and will have approximately 112 patients waiting over 65 weeks. There are a number of specialities which are slightly above trajectory including Gynaecology, Orthopaedics and Plastics. There is mitigation in place for Orthopaedics and Plastics to reduce this gap but limited options for Gynaecology. There are currently 47	**3.Partial**	Delivering the objective of no patients waiting over 65 weeks by September 2024 is the central focus of 2024/25 planning, – as 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.	Additional weekend lists are in place throughout the summer months. Continued focus on both data quality and administrative validation to ensure all patients still require their treatment.	1 No escalation

Originating Committee: Insight Committee			Date of meeting: 18 September 2024		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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	patients in total without a plan within Urogynaecology specifically. The total waiting list size remains high with no signs of reducing.				

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Finance Accountability Group	**Current year** The Trust was £5m off plan year to date (YTD) by the end of month 5, with a deficit of £14m against a planned deficit of £9m. The CIP programme is behind plan by £1.8 YTD. £3.3m has been delivered against a target of £5.1m. The run rate is still £2.4m above income and to hit the target deficit of £15.2m requires and improvement in the run rate of £2.5m per month. Our cash position remains challenging. We have received £7m support from DHSC but have not yet received more due to not meeting our workforce target. As the deficit increases the cash gap will widen.	**4. Minimal**	The additional control measures put in place are not yet delivering substantial reductions to the run rate but it is hoped the outcomes from these changes this will be more evident by October. Additional costs of the Cerner contract are showing in the run rate from July onwards.	See financial recovery item below	3 Escalate to Board

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Financial Recovery Plan	Work has continued on developing a financial recovery plan. The detailed work on this suggests that the Trust will not meet the plan for the year previously agreed with the ICB. The reasons for this are a mix of the cost base being higher than assumed and planned CIP savings not being achieved. Divisions are overspending against budget and only approximately 50% of CIP delivery is being achieved. CIP that is being achieved is addressing overspending and not necessarily reducing overall budgets.	**3 Partial**	A series of detailed actions have been identified for 24/25 which aim to achieve a run rate reduction and an improved outturn against current performance. These actions would need to be achieved in full, so this is not without risk. The actions will require difficult decisions to be made about some service areas There is an action plan for cash to minimise the additional cash requirements in year. This will be challenging for the organisation and staff will need to be supported through significant change.	The financial recovery plan will be considered by Board on 27 September and the ICB Finance Committee on 1 October. This plan focusses primarily on 24/25 and work to build on this will take place to address 25/26 and beyond. The aim for 25/26 will be to focus on a smaller number of high impact schemes. Some options for the future will require wider discussion with system partners including requesting support to deliver the actions in the plan. Additional support is being	3 Escalate to Board

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			There are gaps in capacity and capability in the organisation to manage the scale of change required.	explored on a fee contingent basis to support CIP maximisation in year. The Director of Strategy and Transformation is undertaking a restructure of the Programme Management Office and the Improvement team to better support the change required. An extensive communications plan will be implemented, to explain the future direction of travel and what this means for the Trust and its workforce. The Committee encouraged the Executive to be bold in tackling difficult issues sooner rather than later.	

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Roche Contract Extension	The Roche managed service contract ends on the 14th November 2024 and is the major supplier for Biochemistry and Blood Transfusion service. The Committee considered options for the future of the contract and the associated third-party suppliers	**2 Reasonable**	The committee noted the desirability of aligning with ESNEFT and others for a substantive procurement exercise in the future. The ICB also needs to be involved in procurement decisions at an early stage given the double lock process and there is a need to develop the process and working relationships on this.	The closed Board will consider the Committee's recommendations about the contract on 27 September. There needs to be better pre-planning on proposed extension renewals so the Board can consider the principle of extension or alternative tender processes well in advance, to allow time for a full procurement exercise where necessary. The contracts register needs developing and there is a need to align the consideration of future contracts alongside the ICB double lock process.	3 Escalate to Board

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Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Date of the Meeting: 18 September 2024
Governor observer (observed by): Jane Skinner

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Emphasis of the meeting was on finance although operational presentation was early on the agenda and full discussion allowed • Long and full agenda
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Well Chaired, every one given a chance to have their say, meeting was moved on at one point • 6 NEDS present including 2 new and Trust Chair • Good challenge from NEDS and Execs, which was respectful but not at the expense of rigor • The meeting over ran and energy levels seemed to drop towards the end • Trust values upheld
Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
• Quality of papers, evidence and presentations • Honest and transparent discussion

- Work needed, as raised in the meeting, on making sure that end dates for equipment contracts are known in time for new tenders to be made, ensuring the best solution can be found. Tender process can take 2 years.
- Minor injuries unit to be running by mid October

Governor observer Notes

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

- The financial recovery plan was presented. Much of the content and discussion (lengthy) was confidential, the next step was for this plan to be discussed at Closed Board before going to the ICB.
- I thought the Terms of Reference for the meeting should mention Governor observers and their role/purpose for being there plus assurance for meeting members that we understand that we hear confidential information which must not be disclosed
- It was felt that the BAF template could be improved

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 18 September 2024
Governor observer: Jayne Neal

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• The majority of the meeting focussed on finance matters, including the financial recovery plan. The IQPR report highlighted waiting times, along with cancer / FDS. There was discussion concerning the use of the Virtual Wards; i.e. need to focus on expansion and better use of these resources. The possible extension of existing biochemistry / blood transfusion / pathology contracts was also discussed.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• The Chair welcomed all attendees and invited the new NEDs joining the meeting for the first time to introduce themselves. • The Chief Operating Officer, Nicola Cottington, took the opportunity to explain some of the identifiers behind the KPIs for the benefit of the new attendees. • The meeting was respectful throughout but not at the expense of challenge and rigour • FIRST values were demonstrated at all times
Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*

- As previously, there is only minimal assurance on the financial situation. The committee is committed to working collaboratively across the Trust and with the ICB to improve the predicted deficit. IQPR, the FRP and the biochemistry contracts will be on the next Board agenda.

Governor observer Notes

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

This meeting was particularly well attended by NED colleagues.

Antionette Jackson Chaired the meeting very fairly and gave everyone in attendance an opportunity to speak. She summarised the conversations at the end of each topic and outlined the way forward for the next meeting and highlighted areas for escalation to Board.

Board assurance committee - Committee Key Issues (CKI) report

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Contracts and Procurement Panel	The Contracts and Procurement Panel was created in November 2022 in recognition of the lack of forward planning and governance around the award and extension of contracts and the number of contracts being renewed or extended at short notice. Insight Committee asked for assurance that the process for timely tendering and award of such contracts was robust. Contracts are managed on the Atamis database. Whilst improvements have been made, this database does not yet include 100% of contracts (with a	3 Partial	If procurement processes are not robust there is a risk that the Trust will not deliver value for money and the best outcomes. The fact that the Atamis database is not comprehensive means there is still a risk of issues emerging late in the day, particularly over the next 5 months before comprehensive tracking is in place. The timeframe to implement an alternative solution isn't always factored into the tendering process, so the likely lead time has now been added to the database to the database to aid proper forward planning.	There is an action plan in place to address the deficiencies in the recoding of contracts and the lead in time to the procurement process. The original Terms of Reference (ToR) of the Panel to be reviewed, to include consideration of efficacy, value for money and the specification of each contract. This also includes a review of Membership to include IT and Medical Staff representation. The opportunities to remove or renegotiate existing contracts to deliver savings at pace is also being reviewed.	3 Escalate to Board

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	particular shortfall in relation to IT contracts). There are currently 420 contracts on this database, of which around 60 will be due for renewal in the next 12 months.		Both internal and external factors can cause delays to the procurement process (such as stakeholders not engaging in the project early enough or suppliers being slow to respond.	WSFT host the Collaborative Procurement Hub (CPH) and meetings are in place to ensure the Trust is maximising the support and benefits that they can provide. The wider procurement capacity required by the Trust will be considered in the review of Corporate Services As the majority of contracts will be captured by the double lock arrangement with the ICB, a process will be agreed to discuss high-level approval in principle, before the tender process commences. This will help avoid unnecessary work on detail if approval is not forthcoming.	

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Community and Wheelchair Equipment Service	**Community Equipment** Community Equipment Services have incurred a YTD cost pressure of £328k This is a mix of rising costs and growth in demand. Demand pressures include activity to help achieve WSFT and ESNEFT's community urgent and crisis response targets; increased activity in relation to hospital discharges; the ordering of increasingly complex equipment to enable step down to community services and to help people remain in their home environment for longer; supporting choice to stay at home at the end of life; and the growth of the Virtual Ward.	**2 Reasonable**	The service is important to enable timely discharge from hospital to support seasonal plans, community urgent and crisis response targets and patient flow through escalation ward. The Trust is commissioned to deliver the service on behalf of other providers so an equitable mechanism for sharing risk and growth pressures is needed.	The service has comprehensive action plan in place to reduce the run rate of the service. Recovery of the community "block" element of overspend being negotiated with ESNEFT. Recovery of Social Care, ESNEFT (acute) and ICB costs is already in place within the contract. In the longer term, a review is needed as to how the Trust agreed to contract terms which did not share risk more effectively. Insight will receive a further update report in November.	2 Escalation to ESNEFT and ICB on contractual issues.

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	The CES is also incurring cost pressures that are linked to contractual inflation. Some cost are recovered from commissioners proportionally but not from ESNEFT for those services that are commissioned on a "block" basis. **Wheelchair Services** Increased demand for Wheelchair Equipment (aligned to performance recovery), has incurred a YTD cost pressure of £155 £143k of additional costs were avoided YTD, through refurbishment of wheelchairs.		Increased demand is driven by an increase in referrals	There is also an action plan in place for this service. This includes prioritisation of recycled equipment to contain cost increases as far as possible and work with SNEE ICB to address the financial impact of growth that has been significantly above the levels provided in growth funding for 2024/25.	

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PAAG/IQPR	**Urgent and Emergency Care (UEC)** Ambulance handovers within 30 min and non-admitted 4-hour performance are not reliably hitting target. 12-hour breaches are considerably above the target of 2% of all attendances, though they have improved further on July's position – halving the number seen in January 2024. The four-hour performance trajectory was narrowly missed in August – 69.6% against a plan of 71.0%.	3 Partial	Patients do not have a good experience if they face significant delays and are at risk of harm. There is a lack of flow out of the ED and some patients are waiting longer than acceptable for a specialist bed.	The UEC recovery plan discussed in previous Insight meetings is being implemented and has a trajectory to achieve the 78% 4hr ED target by March '25. The Minor Emergency Care Unit opened on 14 October 2024.	1 No escalation

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PAGG/IQPR	**Virtual ward** Virtual ward (VW) occupancy is showing a deterioration, having decreased over six consecutive months back to December 2023 levels. Average occupancy on the Virtual Ward reduced from 76% (July) to 66% in August largely due to constraints in nursing capacity.	3 Partial	During the month there were a small number of long stays (complex patients) resulting in an increase in bed nights occupied (increase from 755 in July to 861 in August). This is also reflected in the small increase in length of stay from the previous month. Appropriate length of stay is important to facilitate effective patient flow across Trust. Virtual Ward capacity is crucial in enabling patient flow and achieving the strategic ambition of caring for patients at or near home wherever possible.	A Pilot to assess and move patients in nursing homes direct to the Virtual Ward commenced in June. There will be evaluation and review with local partner (Stowhealth Care). A rollout plan (including potential for direct onboarding by primary care colleagues) is under development. An integrated service delivery model has been implemented in Mildenhall. VW nursing visits are now managed via Integrated Neighbourhood Team (INT) in this locality. There is a plan in place for wider rollout into other INTs.	3 Escalate to Board

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PAGG/IQPR	**Cancer Targets** Performance against the 28-day Faster Diagnosis Standard (FDS) is not being met, and performance has not consistently met the 75% target in any month of 2024/25. Continued challenges with the skin pathway, compounded by an increase in referrals over the summer has had the biggest impact on performance, with reduced performance also noted in Gynaecology and Breast.	3. Partial	Achieving the FDS target of 77% and a 62-day performance of 70% by March 2025 are the key objectives for cancer in 2024/25 planning.	Radiological support to breast clinics, which are critical to delivery of the Faster Diagnosis Standard will be reviewed by the Management Executive Group in October. With external support withdrawing from October 2024 there is significant risk to performance recovery and to delayed diagnosis.	3 Escalate to Board

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PAAG/IQPR	**65 and 78 week waits** Although the volume of actual 65 and 78 week waits has reduced this month, the number of patients in the 65 week wait cohort is now above trajectory, with both Orthopaedics and Gynaecology unable to hit a zero position by the end of September deadline. The target is now 239 patients over 65 weeks at the end of October and zero by December 2024.	**3.Partial**	Delivering the objective of no patients waiting over 65 weeks by September 2024 is the central focus of 2024/25 planning, – as 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.	Trajectories for Orthopaedics and Gynaecology are to be rebased with a revised clearance date. The benefits and sustainability of sending Gynaecology patients to the Nuffield to be reviewed and next steps to be agreed.	1 No escalation

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Deep Dive Bed Occupancy	The Committee requested this depp dive to understand the process for balancing bed allocation for UEC and Elective recovery. A comprehensive plan for UEC improvement is being delivered at system, place and provider level, across acute and community services, alongside elective activity. Day-to-day decisions on flow and capacity are managed through the Command, Control and Co-ordination (C3) plan and Tactical Patient Flow Escalation Plan. This plan includes the use of escalation capacity when there are no beds available and there is a material risk to patient safety, addressing the	2 Reasonable	Failing to plan for the winter period or planning without the lessons learned from previous years will lead to longer waits for admission to hospital and for discharge to a more appropriate care setting, a continuously overcrowded Emergency Department an increase in risks to patient safety as well as staff wellbeing. Under-delivering elective activity will result in increased risk of harm from prolonged waits, as well as risks to delivery of the financial recovery plan, which is predicated partly on Elective Recovery Fund income. The elective and non-elective bed allocations were reviewed by the Management Executive Group in	Current plans for winter include use of a winter escalation ward as in previous years. Bed modelling has been refreshed and indicates that to avoid the costs of opening a winter escalation ward, non-elective length of stay will need to reduce by an average of almost 1 day through the winter months. Decisions are also taken dynamically at tactical level and in exceptional circumstances a decision may be taken at joint strategic level to reduce elective programme activity for a period of days. Activity for long waits, clinically urgent and cancer pathway patients would always be prioritised in these circumstances.	1 no escalation

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	expectations set out in NHS England's supplementary guidance on "Principles for providing safe and good quality care in temporary escalation spaces".		August 2024 to agree their nominal size, balancing the two priorities within the physical size and resource constraints of the WSFT estate.	Although a specific length of stay reduction workstream has been established, there is insufficient evidence yet to establish whether this will achieve the saving required. All improvement initiatives, particularly those using external or specific funding, should be assessed for tangible evidence of benefits realisation, and where that evidence is insufficient should have their funding considered for reallocation to proven schemes but which can be scaled up, to cover increased costs.	

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Finance Accountability Group	**Current year** The Trust was off plan year to date (YTD) by the end of month 6, with a deficit for the year to September of £16.1m against a planned deficit of £9.8m. This resulted in an adverse variance of £6.2m YTD (compared to £5.0m at the end of August). There has been a small improvement in the monthly run rate of £300k. The CIP programme is behind plan for the year to September (£4m against a plan of £6.7m). This is £2.7m adverse variance YTD. The trust has applied for £9m of cash support but at the time of the meeting had only received £2.1m	**3 Partial**	The additional control measures put in place in the Financial Recovery Plan (FRP) are delivering small improvements to the run rate to date and further improvement is expected but this is not yet evident. At month 6, the trust is £0.6m better recurrently than anticipated in the FRP trajectory. Although considerable risk remains, in particular, winter pressures and the impact of pay awards. The latter is now projected to be significantly higher than expected, with a £3.3m unfunded potential pressure against £1.45m, anticipated in the FRP. This is a pressure across the system and is being raised nationally.	PA consulting have been appointed to assess deliverability of the Financial Recovery plan and to help identify any further measures that could be adopted. More detail on the CIP tracker to be reported to the next meeting of Insight. A report on the emerging 25/26 financial plan will be reported to the November Board meeting.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 16 October 2024		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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	In September the Board agreed a new financial mitigation recovery plan.		Agreement has been reached with ESNEFT about the financial arrangements in 24/25 for the East Suffolk Elective Orthopaedic Centre which has removed a financial risk in the current year		

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Internal audit report	**Progress against action from Internal Audit reports** The Committee noted that there were still outstanding actions from an internal audit in May 2021 into Surveillance Patient Processes. It was suggested that IT system limitations had prevented the actions being taken forward.	**3 Partial**	The agreed actions need to be reviewed to understand whether they are achievable and, if not, assess what actions can be undertaken to address the underlying concerns raised by the original audit. The format of reporting on the audit plan to the assurance committees does not give detail on the actions themselves, just the number that are outstanding which makes it harder to understand the scale of issue that is outstanding.	Further report to Insight in November 2024. Trust Secretary to review format of future Internal Audit reports to the assurance committees.	1 no escalation

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 16 October 2024
Governor observer (observed by): Jane Skinner

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Community equipment and wheelchair provision deep dive presented as demand is associated with cost pressure and lack of equipment can cause discharge delays • Focus on finance, some discussion points remain confidential
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Well attended by NEDs with 5 present • Meeting overran by 30 minutes but participation and attention remained high, long agenda • Well chaired with astute questioning but sometimes difficult to hear • Reflection: good interaction and challenge, transparent, respectful, Trust values maintained • Jumping around of agenda • The finance director was accompanied by a representative he was sponsoring as part of a NHS finance scheme for underrepresented groups, welcomed to the meeting. General introductions were made.
Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*

Governors can take assurance from the oversight shown in the discussion and papers, including:

- Assurance given that contracts for supplies, equipment etc will carry over into the new build and not just stop.
- Assurance around wheelchairs/equipment cost recovery plan which should be owned across ICS

Governor observer Notes

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

This observation was made by the Chair and having read the papers for the last 3 meetings I would have liked to question on this point if permitted:

There is assurance for Governors that CIPs are subject to quality impact assessment, however, the paper which comes to Insight, does not describe the scheme, so exactly what the scheme is being assessed is totally unclear, the outcome is stated as approved or not with no detail. If not approved what evidence is required for further assessment is described but has little meaning as the scheme is unclear. I feel this paper lacks detail and only assures that assessments are carried out.

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 16 October 2024
Governor observer: Jayne Neal

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• The agenda covered comprehensive discussions on the financial situation. Progress on the Financial Recovery Plan (FRP), was discussed, which included the budget and supply challenges on the community equipment and wheelchair services. • Patient Access Governance Group (PAGG) and IQPR covered waiting times for urgent and E/D care and the difficulties around aiming to protect elective beds, particularly with the approaching winter challenges
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• The Chair welcomed everyone and individuals introduced themselves for the benefit of new attendees • Serious and difficult subjects were discussed in an open and transparent manner • There was good, challenging and respectful interaction between all attendees, within Trust values. • At the conclusion of the meeting the Chair summarised key issues arising and thanked all participants for their contributions
Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*

- The financial pressures continue to be of great concern. The FRP gives the Committee assurance that much work is being done and must continue, but only limited assurance of the realities of a successful outcome
- More work is needed to monitor service contracts and procurement, particularly their timeframes and how to align these with partner organisations. In order to gain greater assurance, a more focused and strategic approach is required

*G***overnor observer Notes**

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

- The Chair asked the Committee to consider work areas for future 'deep dive' analysis for next year's meetings
- The Committee organiser, Emma Whight, had highlighted to the Chair the need to think about the timing of some of next year's meetings to avoid clashes and overlaps with other meetings and public holidays

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 16 October 2024
Governor observer (observed by): John-Paul (J-P) Holt

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Large agenda, with many items relating to Finance, including Oversight to the Financial Recovery Plan for Community Equipment Services and Wheelchair Services • Relevant papers were available in advance of the meeting. • All items on the agenda were discussed and none were deferred to the next meeting.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• 3 of newly appointed NEDs were in attendance for today's meetings. • One of the new NEDs was appointed by the Chair, to provide feedback/reflections at the end of the meeting. Reflections were thorough and well explained, with links made to the Trust's FIRST Values. • Today's meeting included the most questioning and challenging from the NEDs, that I have seen since starting as an Observor. New NEDs were largely involved in this and were able to provide suggestions and insights to the rest of the Committee. Whilst some challenges sparked moments of debate, these remained professional throughout, contributing to clarity, assurance and actions being gained/created where necessary. • Thorough review of all outstanding actions by the Chair. I was pleased to see that some were able to be combined and condensed into single actions, with agreement from the entire Committee, as the Action Log had got quite long. • Given the attendance of 3 of the newly appointed NEDs, there were several moments during the meeting in which deeper explanation was given by presenters, allowing for greater understanding of the current situation.

Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
• The committee meetings are now regularly overrunning, given the required large agendas and vital discussions required at every meeting. There have been moments where the Chair has had to either accelerate or end discussions, or an agreement has been made to continue discussions "offline" to allow for other matters on the agenda to be discussed. To ensure all matters are discussed thoroughly and with oversight of the entire Committee, does the Chair feel that the current arrangements are suitable? Or do changes need to be made to the size of the agenda, or length of the meetings?
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• Delighted to see that the Chair has now decided to appoint a member of the Committee at the start of each meeting to provide feedback/reflections, rather than asking for a volunteer. • The previous Sustainability Deep-Dive which had originally been an oversight for August's meeting, has been rescheduled for January. • Continued vital contributions by the Director of Financial Recovery & Director of Strategy and Transformation. • Pleased to hear it quoted during the meeting that the relationship between the Trust & ICB has improved since the start of the double-lock measures. • Several moments again today where transparency was prioritised. Also recognised by the NED appointed to provide feedback/reflections at the end of the meeting.

8.2. Improvement Committee

Presented by Tracy Dowling

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Improvement Committee			**Date of meeting: Wednesday 21st August 2024**		
Chaired by: Louisa Pepper			**Lead Executive Director: Susan Wilkinson/Ravi Ayyamuthu**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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5.1	Patient Quality & Safety Governance Group (PQSGG) Hospital Transfusion Group (HTC) Deteriorating Patient Group (DPG) Dementia Steering Group Drugs & Therapeutics Mortality Oversight Group End of Life Operational Group Mortuary & HTA Thrombosis Group	1	Regular monthly report using the Trust's 1-4 assurance level scale. Areas of partial assurance: - HTC – Closed Loop Blood Project. Project has been on-going since 2017. Closed Loop Blood delivery systems increase transfusion safety and improve compliance with regulatory requirements for traceability. Progression with the current supplier is no longer an option. Refund being secured. Further business case to be developed and presented including research of other Trusts systems and processes. HTC – The Blood Safety & Quality Regulations 2005 require	PQASG will continue to maintain oversight of all items reported as emerging concerns through its reporting framework. No actions or escalations for Improvement Committee.	1

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			100% traceability of blood components. Incomplete traceability should be an exceptional risk and risks regulatory non-compliance. Quality Improvement Project commenced to improve results. Sepsis Data – separated into individual elements of sepsis 6 bundle to track compliance. Antibiotic is positively improving despite not quite achieving 90% target. Early identification and implementation of sepsis 6 bundle will improve mortality and morbidity associated with sepsis. Paediatric Early Warning System may improve early recognition – commenced July 24. Sepsis awareness session held weekly in ED. Engagement with E OF E Sepsis Forum mirrors challenge of sepsis bundle within one hour. Two Hour monitoring to		

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			commence to provide assurance, and this will be followed up. DPG – BLS compliance training not improving. Compliance = 80% due in part to low medical compliance and 6-month rotation of junior doctors. Required so staff have the right skills & training to deliver effective care. Doctors with ILS or ALS training don't need to be signed off for BLS, so a data cleanse may improve these figures. Dementia & Frailty Steering Group – NAD? recommendations – work continues to improve outcome of national audit of dementia – SQID compliance averaging 97.5%. Further work using QI approach to improve 4AT (a rapid assessment test for delirium detection). This will		

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			improve identification of delirium. This will then help in the appropriate planning of care. Drugs & Therapeutics – CQC Engagement Call. Recognition of limitation of pharmacy provision to support LD&A. Pharmacy Team are reviewing mitigation to address gap.		
5.2	Clinical Effectiveness Governance Group (CEGG) Updates from the meeting: - QI Update MBRACE report and peer review of BAME Mothers Shared Decision Making & Consent Policies	1	Six new NBP publications. May need some further detail? For example have the documents been reviewed by relevant groups?	CEGG will continue to maintain oversight of all new items reported as emerging concerns through its framework.	1
7.1	Deep Dive – Shared Decision Making (SDM)	2	SDM is mandated by; -	The SDM Group is overseeing this work. Work is progressing for	1

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	SDM is a process whereby patients and clinicians work together to make evidenced based decisions centred on patient values & preferences. This may be a test or to go ahead with surgery. SDM ensures individuals are supported to make decisions which are right for them.		NHS Long Term Plan CQC – will be assessed NICE – for adults, for C&YP without capacity End of Life GMC Nursing & Midwifery Council The Health & Care Professions Council of Standards of Proficiency Shared decision making is a framework that will support patient and carer discussions about their care, treatment options and enable informed decision making and therefore improve patient centred care.	all NICE categories. SDM training for medical & dental staff is mandated on ESR. SDM is incorporated in Midwives mandatory training. SDM training for ACP's and other healthcare professionals cannot be assured at this time. Some departments are not fully engaging with Concentric but this is a rolling programme. The quality of SDM training in primary care and the community cannot be assured.	

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7.2	Corridor Care – where care is given in. corridors or non-bed spaces. CQC have 11 basic standards of care. Person centred care Visiting & Accompanying Dignity & Respect Consent Safety Safeguarding from abuse Food & Drink Premises & Equipment Complaints	1	Three areas used in the Trust: - Arrive by 9 QI Project – where patient is moved before 9am Mon – Fri against a patient being discharged. Discharge patient moved to a chair in a designated space or in-coming patient waits in a chair for the bed if patient being discharged is unable to sit. Clear clinical oversight & on-going QI project. ED RAT corridor – supports 3 patients when there is ambulance off load delays or departmental over-crowding. Privacy screens used & dedicated staff member to care for patients. Oversight by senior departmental member of staff.	Analyse baseline data & impacts Develop a report with Information Team Continue to gather patient feedback Monitor incidents Continue to gather staff feedback Capture patient outcomes To note – the Trust would prefer not to deliver any care in these areas, however the Trust meets the fundamental care standards.	1

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	Good Governance Staffing & Duty of Candour		AAU corridor – supports 4 patients. Trust is in OPEL 4 – Trust escalation policy. Only used between 9-5pm. AAU Matron oversight & responsibility. Upward reporting – DCN. RADAR logged. HON or DHN visit.		
7.3	Learning Report Patient Safety & Experience The Patient Safety, Patient Experience & Mortality Teams have processes to identify opportunities for learning & change, whilst maintaining oversight of good governance practices. To ensure patients, their families and carers come first.	1	The Trust has championed patient safety since the introduction of NHS Patient Safety Strategy. WSFT is committed to being open & candid with patients to demystify terminology around processes or where harm has been caused or where patients want to share their experiences. This underpins our desire to communicate with patients sooner, to learn and make changes to further develop safe & effective care.	Safety Improvement Group to continue to have oversight of this subject. Monitor & review new & established processes. Establish mortality per review process.	1

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7.4	Maternity Claims Scorecard Incidents & Complaints Scorecard claims are reviewed quarterly at the Maternity Quality & Safety & Maternity Neonatal Safety Champions meetings. Themes are analysed against other safety & quality data. Details of incidents & complaints are reviewed monthly & improvements are identified.	1	Report summarised claims from 1/4/23 – 31/12/23 alongside incident & complaint data from 1/1/24 – 31/3/24. Identifying themes & learning.	Safe practices & proactive assessment of women & babies to identify potential risk factors & anticipate complications & opportunities to escalate & offer management & treatment which may reduce the adverse effects on health & well-being of babies. Oversight to be maintained by Maternity Quality & Safety & Neonatal Safety Champions Meeting.	1
7.5	Obstetric Anaesthetic Workforce Board Report Safe staffing of maternity services is one area of safety standards & actions expected for the Maternity Incentive Scheme. Report provides evidence of compliance with safe staffing requirements for obstetric	1	The anaesthetic services prioritise covering obstetric anaesthetic bleep role & the rotas demonstrate 100% compliance for this period of audit.	Attendance at emergency obstetric MDT training days will be monitored to ensure staff initial attendance & thereafter annually. Any issues identified will be worked through to ensure a competent obstetric anaesthetist is always available. Maternity & Anaesthetic depts to	1

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	anaesthesia with the WSFT Maternity Unit. Covers 1/10/23 – 31/3/24			compile 6-month reports on compliance.	
7.6	Neonatal Medical Workforce Report Neonatal medical staffing in the WSFT Neonatal Unit is required to meet the standards set by te Association of Perinatal Medicine for all tiers of staffing. The Maternity Incentive Scheme is in its 6th year & the requirement in unchanged from year 5 & the Trust meets the BAPM standards for safe staffing in the unit.	1	The rotas were assessed against the standards from 1/10/23 – 31/3/24. There were 2 occasions where the weekday sessions on Mon/Wed or Fri were not covered. The escalation is the on-call Paediatrician will attend the Neonatal Unit. This did not result in harm or any adverse outcomes. There is forward planning for retirements & upcoming vacancy rates are proactively managed to ensure gaps are covered. 87.5% Consultant Paediatricians have attended 8 hours of training in the last year. 2 Consultants are outstanding. Oversight of	6 monthly reports on staffing levels against BAPM requirements Neonatal lead to continue oversight of training, record keeping and compliance. Recruitment & retention of staff key to service of high-quality care. Any projected vacancies minimised by forward planning. All shortages to be managed effectively. Review of NNU consultant cover undertaken daily to ensure high	1

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			training by MDT lead educator and Neonatal clinical lead.	standards are consistent throughout the week.	
7.7	Maternity Scorecard and Triangulation	1	Details of claims outlined by injury - volume and values and causes – volume and values. Complaints in Q4 = 2 Themes Q4 Unanticipated neonatal deterioration 1 hour following birth Birth choice discussions in presence of evolving risks Utilising most appropriate clinical escalation tools Themes led to learning of 4 key issues: - Senior Paediatrician to attend if significant meconium	Improvement Committee will continue to maintain assurance oversight of items reported on a quarterly basis.	1

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			Regional CFM guidance not followed re guidance for neonates requires formal implementing with appropriate governance processes Urgent emergency messaging was used instead of emergency escalation Response to cardiac arrest on post-natal ward demonstrated actions put in place delivered an exemplary response. To note learning from Q4 included in Action Plan.		
7.8	Neonatal Staffing Report Report on progress towards meeting safe staffing standards within neonatal workforce.	1	Whilst the calculator is useful when applied to Neonatal staffing, it has limitations and doesn't consider Neonatal	Regular reviews of staffing levels & skills mix to reflect the activity and acuity going forward.	1

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Chaired by: Louisa Pepper			**Lead Executive Director: Susan Wilkinson/Ravi Ayyamuthu**		
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
	Standards outlined in British Association of Perinatal Medicine. Assessed using the Neonatal Clinical Review Group nursing workforce calculator. The calculator uses local data for activity, bed occupancy & staff to measure staff numbers to safely manage service. There is currently a shortfall in Qualified in Speciality trained staff of 9.4% projected to fall to 5.8% in near future. Vacancy rate of 1.46% WTE		Transitional Care (NTC) & Neonatal Community Service (NCS). These services reduce separation of mother & baby and provide a safe alternative to routine admission and prolonged hospital stays. As not all units provide the NTC or NCS this results in an inequity of service and budgeting of neonatal services.	Allowance to be made for NTC and NCS. Band 6 QIS Neonatal Shift Leader to be supernumerary to supervise and oversee neonatal activity. Funding identified and recruitment to be commenced asap. This role identified in our previous Maternity Incentive Scheme submission and will feature in this years. Action plan to be developed Neonatal calculator to be completed annually.	
8.1	Revision process for external incident reporting New governance framework currently being piloted for the management of incidents	2	RADAR – The Trust incident reporting system captures incidents affecting patients, staff & the organisation. Designated to enable analysis of themes, trends & highlight cases requiring specific investigation. There are also requirements to	WSFT Incident Reporting process is sound & robust, however the governance arrangements for oversight & improvement focus needed structure. The framework provides that structure.	1

Originating Committee: Improvement Committee			Date of meeting: Wednesday 21st August 2024		
Chaired by: Louisa Pepper			Lead Executive Director: Susan Wilkinson/Ravi Ayyamuthu		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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	requiring external regulatory reporting. Reporting is – timely, accurate, owned and improvement focused.		report some incidents externally – some of which are underpinned by regulatory/statutory requirements. Trusts must have clear & effective governance and management & accountability arrangements. In addition, there needs to be the ability to test new & innovative ideas within a service whilst ensuring notifications are consistently submitted to external organisations as required.	Next steps Test pathway for RIDDOR reporting Liaise with Radiology to test pathway for IR(ME)R Review initial pilot Confirm other external regulatory reporting pathways for WSFT. Test pathway for full list of pathways. Feedback to Improvement Committee Dec 24	
8.2	RADAR Incident Reporting Outline of incident reporting data & how measures on new system are being developed.	2	RADAR captures incidents in 3 different formats; - Patient Safety Incidents Staff & Non-Patient Safety Incidents	Reportable Occurrences is a new pathway of reporting for staff. KPI's are being developed. Workflow dashboard being introduced delivering a one-step report for leads.	1

Originating Committee: Improvement Committee			**Date of meeting: Wednesday 21st August 2024**		
Chaired by: Louisa Pepper			**Lead Executive Director: Susan Wilkinson/Ravi Ayyamuthu**		
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			Reportable Occurrences Only Patient Safety Incidents are reported to Learning from Patient Safety Events. All 3 categories are used for local analysis & review. In addition, RADAR has a national requirement to record pressure ulcers. It is therefore not possible to do a like for like comparison of the volume of incidents, however the total number of PSI's & RO's is improving.	Implementation with a training package and ongoing monitoring of utilisation/ reporting of the system	
8.4	Review of Governance – WSFT Clinical Divisions. To ensure each WSFT clinical division operates effectively. Identify gaps & risks in governance & reporting structures & improve	2	To assess & enhance the efficiency, compliance & effectiveness of the divisional governance & structure within the Trust.	Review over next 3-5 months the divisional governance arrangements with the aim to strengthen the decision-making processes, clarify roles & responsibilities & ensure robust oversight within the divisions.	1

Originating Committee: Improvement Committee			Date of meeting: Wednesday 21st August 2024		
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	accountability, decision making & better resource allocation.			Report to Improvement in 3 months and thereafter on completion in 6 months.	

**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.
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Feedback from assurance committees: Governor observer report

Board assurance committee: Improvement
Meeting date: 21 August 2024
Governor observer (observed by): Jane Skinner

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
Long agenda as usual, my highlights: • Paper presented re issues with recording specialist reviews of patients, known as professional standards. • "Shared Decision Making" deep dive presented. This is a mandated change and refers to the process whereby clinicians and patients work together to make evidence based decisions centred on the patient's preferences and values. • Corridor Care presentation
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Last meeting for the Chair who leaves the Trust this month, her contribution to the meetings was acknowledged and thanks given • Reflection observer nominated. Reflection: Items on the agenda were not taken in order for various reasons, this resulted in some visiting presenters having to wait. This seemed time wasting for them. Those attending had clearly read the papers. The chair clarified action points with those present. People listened, good conversation. Full agenda but chair kept to time. Trust values adhered to. • Well attended by NEDS and Chair who challenged and questioned throughout the meeting.
Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*

- There are complex IT/e care issues around collecting data re compliance with professional standards, verbal assurance that the standard is met given to the meeting but little assurance around improving data collection. The review was written as requested at a previous meeting. It was suggested that the issues should be discussed further outside the meeting. The problems highlighted are ongoing and it didn't feel as though there was a resolution yet.
- SDM – "reassurance" given regarding the progress of the work in some areas, but that some departments are not fully engaged and therefore assurance not possible. The presentation clearly outlined the breadth of the work being undertaken on this project, what has been achieved and what needs to be done.
- Governors have previously been made aware that in very busy periods, as a last resort, patients in ED are cared for in corridor spaces. Assurance – in depth knowledge and oversight of the situation as demonstrated in the data and facts presented and corridor care is solution of last resort. Gaps in assurance and where there is risk – impact on quality of care, impact on wider Trust staffing, potential increase in incidents.

Governor observer Notes

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

Data collection issues:

- Professional standards
- Although BLS compliance appears down there are problems with recording compliance of clinicians, who are trained beyond BLS level, in the data.
- Technical problems with Radar are also making data appear inaccurate and possibly preventing incident reporting e.g. medicine errors. Perhaps Governors could have a presentation on Radar to improve our understanding of the incident reporting process and how it has changed.

Feedback from assurance committees: Governor observer report

Board assurance committee: Improvement
Meeting date: 21 August 2024
Governor observer (observed by): Anna Conochie

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Agenda items covered both “things that could be improved” as well as reporting on things that were “broken and needed mending”, so a wide range of issues were kept on the front burner and positively aired across a number of senior professionals/disciplines. Can we be assured that there isn’t considerable duplication across many different meetings?
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• *Conducted with impressive professionalism and respect as usual.*
Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair’s key issues report.*
• *Can we be assured that the data “collection & recording process” itself, (rather than the clinical behaviour that we are purportedly measuring,) hasn’t become the goal/industry in its own right? i.e is the tail wagging the dog?*
Governor observer Notes *Use this section to highlight any other areas for example good practice or ‘even better if’*
• *Is there a danger that what started as good practice (i.e. trying to record outcomes of responsive good practice), is now unable to do justice to recording the necessary nuances of clinical behaviour and will either fail to do justice to representing the positive changes or worse, change what we do because it doesn’t fit into an easily measurable reporting structure?*

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Improvement Committee			Date of meeting: 18 September 2024		
Chaired by: Roger Petter			**Lead Executive Director: Susan Wilkinson, Ravi Ayyamuthu**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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5.1	**Patient Quality & Safety Governance Group (PQSGG)** Updates received from: a) Claims and Litigation b) Human Factors update c) Duty of Candour d) Learning Disability e) Adult Safeguarding f) Safeguarding CYP g) Mental health Transformation	1-2, except 3 for item f) below	Regular monthly reports using the Trust's 1-4 assurance level scale. Areas of partial assurance relating to: a) the 'look back' function on Radar requires further work so that historical Datix info can be obtained, in order to meet insurance and civil claims obligations. d) eLearning for Tier 1 now live. No dates released from ICB re Tier 2 training. LD&A training will be a KLOE from regulatory bodies. e) Level 3 safeguarding training only offered to those with regular safeguarding	a) The Radar Oversight Group meets weekly to discuss this. d) Escalated to ICB regarding delay in Tier 2 training. Difficulties securing the right trainers. e) Current data suggests high compliance, but we need to ensure training is offered to all appropriate	1

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		3	interventions. Possible gap in PREVENT and WRAP (Wellness Recovery Action Plans) training offered. f) Clinical photography issues not yet resolved: current image quality may not be accepted in a court of law.	staff. Following review with Mandatory Training Steering Group, further training may be added to the templates of most staff in the Trust. f) Dan Spooner to take forwards re trying to obtain funding for a suitable camera	
5.2	**Clinical Effectiveness Governance Group (CEGG)** Reports from: Clinical Audit Public Health Cervical Screening External Quality Visit (substantial assurance)	2	Areas of partial assurance: Clinical Audit – lack of assurance that clinical audit processes are being followed to maximise the benefit and learning arising. Plenty of audits are registered but the proportion completed is below expectation.	CEGG will continue to maintain oversight of all new items reported as emerging concerns through its framework. Risk relating to clinical audit participation will be added to CEGG risk log. This will be reviewed after the new MD is in post.	

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6.1 6.2	**Integrated Quality and Performance Report (IQPR)** Including **Performance Review Meetings (PRM Packs)** Uses Making Data Count methodology to report on 1) Compliance with targets and standards 2) Statistically significant improvement or worsening of performance over time	2	C diff data now includes both hospital onset healthcare associated (HOHA) and community onset healthcare associated (COHA) cases. Incidence rates are variable and there has been no significant reduction in rates since Sept 2023. Rates have increased nationally over the last two reporting years. Nutritional assessments - QIPs are continuing to support timely nutritional assessments. There is ongoing improvement of assessments at 48 hours post admission. Post-partum Haemorrhage (>1500 ml) - ongoing quality improvement within maternity services. This is one of the commonest obstetric emergencies and worldwide is	Impact of 6 key interventions for C diff is still embedding and will unlikely improve until Q3/Q4. Nutritional assessments will continue to be monitored through Nutritional Steering Group, divisional performance review meetings, and patient safety and quality group. Completing weight and nutritional assessments in a timely manner is difficult if patients are delayed in ED and so the ED staff are introducing a short assessment to help with this. The impact of this will be monitored. PPH rates will continue to be monitored through maternity	1

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			the leading cause of maternal death. It has implications for length of stay, additional treatments and costs, as well as interactions between mother and baby.	improvement board, performance review meetings, and externally through local maternity and neonatal system strategic meetings. 5 workstreams have been identified.	
7.1	**Deep Dive:** **Patient Safety Priorities – C difficile.** Verbal update from Dan Spooner rather than the planned deep dive presentation.	2	92 point action plan in place, under 6 headings: Hand hygiene; Antimicrobial stewardship; Environment; Isolation process; Community.	Amanda Devereux will be invited back to give an update on progress.	1
7.2	**ConsultOne** **Well-Led Response**	2	The Trust commissioned ConsultOne to undertake a well led review of leadership and governance at the Trust. They highlighted the following well-led strengths: Culture; First values; Staff wellbeing; Patient /	31 recommendations were made in the context of CQC Quality statements. Of these: 27 have been assessed as within an existing plan, including a timescale for delivery,	3: submission of response to the Board agreed

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			carer engagement activities; Governance structure and processes; Local partner working and integration. They highlighted the following well-led areas of focus: Ambition drive and focus; Strategy; Wider system partnering and collaboration; Clinical leadership; Accountability; Use of information; Risk management focus and profile.	2 are deferred for future action, including a timescale to revisit as part of 2025-26 objectives, 2 are complete The committee agreed the response and submission to the Board. It also agreed an update in April 2025 to review progress against the recommendations.	

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

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Feedback from assurance committees: Governor observer report

Board assurance committee: Improvement
Meeting date: Improvement: 18 September 2024
Governor observer (observed by): Anna Conochie

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Is it possible that the scope of the agenda is too wide and covers internal audits as well as a range of local and national targets and thereby risks becoming unmanageable?
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Very well managed by new Chair. Good “reporting/clarification” however, fewer “assurances/changes to “traffic light colours” • Conducted with impressive professionalism and respect as usual.
Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair’s key issues report.*
• Is there a risk that the meeting could end up focussing on “counting more than on quality”
Governor observer Notes *Use this section to highlight any other areas for example good practice or ‘even better if’*
• Would it be “better if ”Trustwide Audits” were centrally initiated and “individual audits initiated because of a training requirement only” were dealt with in the department/profession of origin via supervision?

Feedback from assurance committees: Governor observer report

Board assurance committee: Improvement
Meeting date: 18 September 2024
Governor observer (observed by): Jane Skinner

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Not such a full agenda as usual
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• This was the first meeting chaired by the new Chair who ensured that everyone was heard and the meeting felt relaxed • Trust values were upheld, everyone was polite and respectful, good engagement • New NEDS and the ICB chief nurse were present • Although some NEDS are members of the Committee it was suggested that all NEDS could have open invitations to attend all 3i meetings as able
Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
• Discussion often concludes that an e care update/change is required but these go onto a list of work in sequence rather than in priority, it was suggested that each e care update needed to be prioritised so that the most essential were dealt with first. • *C.diff* incidence remains high. Lots of discussion re hand hygiene, use of gloves and minimal side rooms. Infection Control Team working very hard to improve compliance with preventive measures. It was felt that staff who repeatedly failed to obey hand hygiene rules and other evidence based practices, should be subject to disciplinary procedure. • It seems a lot of audits are registered and started but not finished, Audit One review noncompliant, therefore a risk

Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• Interesting that treatment for cessation of smoking included the use of e cigarettes, themselves harmful • Paper on the Consult One recommendations presented. Of the 31, 27 are within an existing plan, 2 for future action and 2 complete, This paper will be available to all Governors when it goes to the Board. • BAF presented, contains partial and red risks. I think the BAF concept needs to be presented to Governors as a development session. I found it difficult to understand.

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Improvement Committee			Date of meeting: 16 October 2024		
Chaired by: Roger Petter			**Lead Executive Director: Susan Wilkinson, Ravi Ayyamuthu**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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5.1	**Patient Quality & Safety Governance Group (PQSGG)** Updates received from: <u>Infection Prevention and Control (IPC) Committee</u> C Diff rates variable and unpredictable. Emerging ribotype 955 is more serious, more transmissible and more difficult to clean from the environment. UKHSA recommends fogging as part of cleaning regime. FFP3 Fit Testing compliance poor. Concern given the need for measles and Mpox preparation	3	Ceiling target from ICB is 91 which equates to <8 cases per month. Following a review of the literature a decision model relating to the use of HPV fogging for cleaning post C-Diff infection, it was agreed to cease routine fogging and focus on robust deep cleaning. The Trust currently has no fogging equipment fit for purpose, so for now the current deep-clean will continue.	Project manager identified, will receive support from DCN to continue to progress the improvement programme Housekeeping Lead will appraise options, to be presented to IPCC. Similar challenges across the system so DCN will discuss SNEE collaborative training.	1

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5.1	**PSQGG** <u>Nutrition Steering Group</u> Slight decline in MUST assessments within 24-48 hours, though overall improvement over 6/12. Increased number of incidents relating to parenteral nutrition (eg rate / route / regime / management of line)	2	Good nutrition affects physical and mental health as well as recovery from illness and surgery.	Food Is Medicine workshop in October Parenteral nutrition has been limited to specific wards where training will be mandatory. Training sessions planned.	1
5.1	**PSQGG** <u>Falls Steering Group</u> Falls are in common cause variation. Falls per 1000 bed days are improving. Most falls are low or no harm.	2	Falls potentially harm patients and affect recovery and length of stay. Ensure patients are risk assessed and mitigation is in place to reduce harm.	Bed rails risk assessments are now in place. Trolley assessments to be adapted for care of patients in ED and DSU on trolleys. Competency development for support staff to measure standing	1

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				and lying bp for patients at risk of falls. Engagement in Falls Steering Group improved. Falls with severe harm data set requested	
5.1	**PSQGG** <u>Pressure Ulcer Prevention Group</u> Reduction in pressure ulcers seen in acute services (ongoing since Feb 2024). Incidence in community is in common cause variation.	2	Some reduction could reflect changes to RADAR reporting, but ongoing decline since Feb 24. Increased training has been offered, and a reporting deep dive is being undertaken to provide additional assurance.	TVN team is developing a QIP to develop consistency in pressure ulcer documentation.	1
5.1	**PSQGG** <u>Patient Safety Group</u> Reduced reporting could result from improvements <u>or</u> the	2	Improvement trends in reporting could reflect a drop in reporting,	Follow up and monitoring will occur with PSQGG and DCN and	1

Originating Committee: Improvement Committee			Date of meeting: 16 October 2024		
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			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
	change in reporting to RADAR. Groups with a decrease in reporting will be targeted for analysis.		rather than a drop in incidents/ reportable occurrences.	through the RADAR implementation group.	
	A patient safety summit was held in Sept 2024 "Getting it right for patients and staff: place, service and pathway"	1	We need a clear strategy for patient safety.	This theme will guide a formal improvement programme: the Head of Patient Safety will collaborate with the Director of Strategy and Transformation.	
5.1	**PSQGG** <u>Diabetes Information Flow</u> Workforce challenges around service provision Work has started with the QI team to monitor improvements in diabetes care. There is no	2	Increased demands on outpatient, inpatient and community services due to increased nos with DM and at high risk of developing DM. Clear KPIs will evidence improvements. Insulin treatment	Recruitment has improved and new staff start in November. Transition to E-roster for the clinical team has been successful and this will also help support service improvement. To report in December. HON to review mandatory training.	1

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	current suite of mandatory training for insulin administration.		is a common theme in treatment incidents.		
	Trust currently has no insulin self-administration policy. Pharmacy capacity to lead on this has been an issue	3	Risk to food-insulin gap, and also not in line with patient centred care and patient autonomy.	DCN to discuss at next D&T meeting.	2 – DS to discuss at next D&T meeting
5.2	**Clinical Effectiveness Governance Group (CEGG)** Reports from: <u>NICE compliance</u> A new monthly meeting to review publications issued, compliance with baseline assessment and guideline compliance. Between April 2020 and June 2024, 161 publication updates, of which 49 still outstanding for review.	3	. Meetings will help to escalate as needed, address compliance issues, mitigate risks, implement required actions	Longer term, RADAR is being considered to help manage this.	1

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5.2	**CEGG** <u>Guidelines Editorial Group (GEG)</u> This group reviews guidelines and policies prior to publication on the trust intranet. Since Oct 2023 it has reviewed 60 guidelines: 47 approved and published; 8 needed minor amendments; 5 required major amendments.	3	Two main concerns: 1 – variation in review undertaken. Most members of the group have reviewed <5 guidelines, whilst one member has reviewed 51. Concerns if this member stops. 2 – Reforming GEG has been positive but there are still 41 guidelines >6/12 out of date. The information governance team has limited influence to get authors to update their guidelines.	In the future, GEG will report to the Information Governance steering group rather than CEGG. Medical staff will be awarded a certificate / CPD point for reviews with the aim of improving involvement.	1
5.2	**CEGG** <u>Anaesthesia Clinical Services Accreditation (ACSA)</u> First report as part of CEGG's aim to strengthen oversight of	3	ACSA scheme is voluntary, but it provides QI through peer review of performance, and is supported by CQC. Multiple benefits of subscription include	Many of the standards yet to be rated depend on audit data. Progress and areas of challenge will be reported by CEGG,	1

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	accreditation trust-wide. Ambition is to achieve accredited status by 2025. 148 out of 151 standards must be met. 53.3% are currently met and a further 21.7% in progress.		structured support, engagement in QI and service development, access to a network of accredited departments and an ACSA online portal, and comparison with local regional and national standards.	including how the challenge has been escalated.	
5.2	**CEGG** Clinical Audit Poster Competition First prize awarded to a team from G3 for "Inpatient mental capacity assessment and documentation"	2	A national campaign to promote the benefit of clinical audit and QI. There was limited uptake of the competition, reflected in the low uptake in clinical audit reported last month.		1
6.1 6.2	**Integrated Quality and Performance Report (IQPR)** Including **Performance Review Meetings (PRM Packs)**	2	C diff data shows rates are in common cause variation; there has been no significant reduction in rates since Sept 2023. Rates have increased nationally over the last two reporting years. WSH set threshold is 91 and our	C diff is an organisational key priority. QIP will run for at least 6/12 once measures are agreed. Regular oversight meetings planned. Environment and cleaning plans in place. DCN to	1

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	Three key areas for the Trust are C diff rates, nutritional assessments and PPH.		incidence rates are tracking close to this already and only in 2nd quarter. <u>Nutritional assessments</u> – percentage of patients with measured weight is consistently >95%. Nutritional assessments within 48 hours now moving into common cause variation. This will improve experience and outcomes for our patients. <u>Post-partum Haemorrhage</u> (>1500 ml) - ongoing quality improvement within maternity services. This is one of the commonest obstetric emergencies and worldwide is the leading cause of maternal death. It has implications for length of stay, additional treatments and costs, as well as interactions between mother and	review subgroup membership to improve KPI monitoring. Plans in place to capture the timeliness of assessments when patients are admitted to a ward. This will improve the accuracy and compliance of this metric. No start date yet set and this has been escalated. Focus on UEC performance and monitor impact of the short ED assessment. PPH rates will continue to be monitored, and a QI 3rd cycle has been launched. Ongoing engagement with LMNS and Regional QI projects. 5 workstreams have been identified.	2

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			baby. Overall, PPH incidence is in common cause variation but with an increase since June 2024. Massive Obstetric Haemorrhage (MOH) is in line with regional rates.		
6.1, 6.2	**IQPR** and **PRM** Patient Safety Incidents (PSI) and Reportable Occurrences (RO)	1	Numbers remain stable, but overall, less than numbers reported on Datix. This is scrutinised at Radar Oversight Group (ROG). We are reporting low harm and near miss events which is a good indicator of safe care.	A 6-month analysis is being prepared for discussion at ROG to help understand current reporting trends and ensure data is triangulated to reflect our safety climate.	1
6.1, 6.2	**IQPR** and **PRM** Mortality Data	1	SHMI data shows that the variation from the previous coding error is resolving. The Trust has a below expected SHMI for our patient mix.	Data will continue to be monitored	1

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			Inpatient deaths are within expected common variation. This gives good assurance of our care outcomes.		
6.4	**C difficile Update** We are the third lowest performing Trust nationally and the lowest regionally. No significant reduction in rates over the last year.	3	This is a key priority, due to the risk to patients, staff and visitors, the morbidity associated with infection, and the costs to the NHS. Threshold of cases 2024-25 has been set at 91, as at end Sept we had reported 50. Numerous factors could be driving the rates, including no empty decant ward (RAAC), limited side room availability, cessation of fogging, cessation of probiotics use etc.	QIP started in March with 6 sub-groups. These include: Antimicrobial stewardship, Environment and cleaning, Governance and audit, Hand hygiene, Isolation, additional workstreams for update Feb 2025. Progress has been slower than planned, but it is anticipated this will improve with the identification of a project manager and oversight group chair	1
7.1	**Deep Dive:** **CQC single assessment framework – Critical Care**	2	. Last inspection was "good" overall, but "Requires Improvement" in the Responsive	.	1

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	Critical Care is one of the CQC 12 Core Areas. Last inspected 2016 so a likely CQC target. Rated "Good" overall at that time		KLOE. Concerns around sideroom visibility, utilising PACU for extended periods of time and single sex accommodation breaches. Areas of challenge include staffing restructure & staffing levels, including dedicated pharmacist on risk register; patient flow leading to delayed discharges; ongoing work around delayed admission to CCU	CYP is another Core Area which was last inspected in 2016, and a deep dive into this is planned.	
7.2	**Maternity Incidents Update** Summary of Maternity claims scorecard from 01/04/13 to 31/06/24, and Incident and Complaint data 01/04/24 to 31/06/24. Themes and learning arising	2	In the last 10 years maternity claims for the Trust are about £31.15 million, with the average claim approx 1 million. No new claims in the reporting period. Themes from Incidents Q1 24/25: Term admissions to NNU; Obstetric anal sphincter injury;	All actions identified should be progressed and if any changes to practice are instigated, these should be audited within 6/12 to ensure new practices are embedded.	

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			PPH; Newborn screening incidents. Themes from complaints Q1: 1 complaint regarding care on postnatal ward with delayed identification of urinary retention. 10 responses received through PALS, but none proceeded to a formal complaint. Themes from mortalities: extreme preterm labour; birth before the threshold of viability; term stillbirth.	No actions relating to the deaths in this reporting period. Care is taken to ensure learning occurs from outcomes. .	

**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.
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Feedback from assurance committees: Governor observer report

Board assurance committee: Improvement
Meeting date: 16 October 2024
Governor observer (observed by): Adam Musgrove

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Really interesting discussion regarding C.Diff. Amanda was very informative and delivered a great topic.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Seemed to be a joyous atmosphere • Concerned about the pressures ED are under with no ability to clean beds. Good to hear that Nicola and Sue will review this. Hope this becomes an offer of help and not an offer to review and then implement
Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
• Really would like assurance that consultants are not going to continue to do as they wish regarding hygiene on the wards.
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• Meeting well chaired (again) by Roger • NED's not afraid to seek assurances on various points and challenge the execs. Tracy is tenacious with her questioning and her knowledge is second to none. A real asset to the board.

Feedback from assurance committees: Governor observer report

Board assurance committee: Improvement
Meeting date: October 24th
Governor observer (observed by): J Skinner

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Interesting discussion around back up of numerous system requests (180) for changes/updates to e care, some 4 years old, not currently prioritised. Paper to come back to Improvement re plan to triage these. • Still some Radar issues and question of possible under reporting as staff get used to a new system • ICN presented latest *c diff* information and action plan. • Result of covert hand washing audit presented – interesting discussion on non compliance by some staff. Medical Director is going to take this forward. • Very difficult to deep clean ED as so busy, no time to clean bays between patients, lots of discussion on this subject. • Number of clinical guidelines are out of date, as presented from CEGG report and is a risk
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Chair has taken a new approach to compiling a meeting action log, a committee member volunteers to keep the log as the meeting progresses, this helps with minute writing. Worked well last meeting. • Well Chaired good NED attendance • Introductions made at the start and “guest” speakers welcomed. Suggestion that members could have their names on display so that attendees knew who they were. • Reflection: Trust values adhered to, good challenge, order of meeting jumped a round due to timing of guest speakers’ attendance.

Assurance

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

- Transparency and concern over several issues where the processes involved could be improved – time to clean ED bays, enhanced ED clean, adherence to hand washing/bare below elbows policy, *c diff* numbers, e care back up – oversight apparent and plans in place to improve processes. Hand hygiene aim for zero tolerance and focused campaign.

Governor observer Notes

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

- Closed action log details many issues listed as actions and now dealt with, this provides some measure of what has been achieved in terms of improvement.

- Individual reports presented to the meeting contain a rag rated mixture of good practice and concerns. It is disappointing that poor practice, such as non- compliance with hand hygiene, inappropriate wearing of gloves and not being bare below the elbows when working clinically, remain a problem so many years after relevant research emerged.

8.3. Involvement Committee

Presented by Tracy Dowling

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Involvement Committee			Date of meeting: 20th August 2024		
Chaired by: Tracy Dowling - Non-Executive Director			**Lead Executive Directors: Jeremy Over and Sue Wilkinson**		
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6.1	First for Staff Presentation and discussion exploring the relationship between financial recovery and the organisational culture – led by Jeremy Over, Sam Tappenden and Helen Davies	3. Partial	• Concerns identified by staff worried about what the changes may mean for them and their work • Concerns regarding need for honest formal communications about the scale of the financial challenge and approach to addressing this • Want transparency of decision making • Some staff understandably feel under pressure to deliver • Has changed the job of ward managers to be accountable for the ward budgets. • Clear that current culture does need to evolve to ensure financial accountability is considered alongside clinical and	• Ensure regular Pulse staff surveys • Clarify and develop organisational messaging on 'red lines' • Develop clear communications on what staff can expect regarding job security • Support development of triumvirate structures so leadership responsibility is shared in divisions • Develop business planning processes for medium term and in line with finance plan horizons • Be clear that next 6 months will be about grip and control • Start to work through what the target – culture needs to be for an organisation that can deliver expected quality, safety and performance standards within funding allocations • Consider the training and development needed to implement	1. Keep on Involvement Committee agenda 2. Escalation to executive management team to progress the actions 3. Escalate to Board regarding approaches to financial recovery and organisational development

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			performance accountability at all levels of the organisation • Clear that maintaining and developing a 'Just Culture' – and continuing to live the Trust values as these accountabilities are strengthened is vital	the actions and organisational development needed for financial recovery	
7.1	First for Patients Presentation from Cassia Nice – Summary of feedback from Healthwatch engagement with the public and patients regarding the transfer of some elective orthopaedic care to the ESEOC	2. Reasonable	• 54% responders were members of the public; 37% were patients on the orthopaedic waiting list at WSFT; 5% identified as family or carers of people on the waiting list • Mixed responses – 48% positive; 35% negative • Main concerns about transport – especially those living furthest from Colchester • People pleased to have shorter wait times	• Discussions regarding the engagement results to take place with the ICB and to include responsibility for leading the response to the engagement • WSFT still in discussion about the consequences of moving some orthopaedic activity and agreed that addressing the issues from the engagement needs to be part of these discussions about the practical impacts on patients • Clear that patients would still have the choice to elect to have their surgery at WSFT	2. To executive management team

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			• Concerns about clarity of information • Concerns for vulnerable people and accessibility		
8.1	Update from People and Culture Leadership Group	1. Substantial	Developing work re. values based leadership and management standards.	Bi-monthly reports from PCLG.	1.
8.2	Experience of Care and Engagement Report	2. Reasonable	Report from the work of the latest committee meeting.	Particular request to provide future updates to Involvement Committee re. the focus on Women's Health in the emergency pathway / department	1.
8.3	Quarterly Report – Guardian of Safe Working Hours (GSWH)	1. Substantial	No immediate safety concerns reported in this quarter.	Continued quarterly reporting in line with national terms and conditions	1.
8.4 & 8.5	Board Assurance Framework – risk report	2. Reasonable	Reflection and discussion on latest drafts of BAF statements in relation to capacity and skills, and staff wellbeing.	Regular reviews of BAF frameworks to reflect strategic risks and mitigation	1.
8.6	Committee Annual Evaluation Report	1. Substantial	Completion of annual evaluation with good engagement from members.	Areas for development identified: • Continued focus to preserve and protect cultural progress while managing financial pressures • Ensuring reviews and decisions align with Trust strategies, priorities,	1.

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				values and financial parameters • Strengthening focus on patient engagement, including themes from feedback such as complaints and PALS • Develop focus on enhancing workforce productivity • Review processes in place to ensure public involvement in all service changes or redesigns as part of business-as-usual operations • Strengthen focus on the board assurance framework (BAF) risk allocated to the committee and ensuring this informs the focus assurance.	
9.1	Workforce KPs	2. Reasonable	• It was highlighted that 3 of the four KPI's are continuing to track above target. • Corporate areas need continued focus on appraisals. • Retention partner recruited,	Ongoing monitoring of workforce KPIs, in particular appraisal and mandatory training in light of the risk of these being deprioritised due to financial pressures.	1.

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			funded for 12 months from the ICB, working alongside ESNEFT • Training compliance has improved, achieving target for 10 consecutive months.		

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Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Involvement Committee			Date of meeting: 16th October 2024		
Chaired by: Tracy Dowling - Non-executive Director			**Lead Executive Directors: Jeremy Over and Sue Wilkinson**		
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	**First for Staff** Presentation and discussion exploring arrangements for lone worker safety in the community	2. Reasonable	• Active work with community teams seeking to improve routine use of love worker devices • Technology part of policy arrangements to keep staff safe – also includes risk assessments; visiting in pairs	• Further work with teams including community midwives to ensure alarms are embedded into routine use. • Include identifying staff who never use the devices to explore why • Need to understand how devices are funded – follow up By Chief Operating Officer	1. No escalation
6.2	**First for Staff** A framework of quality assurance for responsible officers and revalidation	1. Substantial	• Clear framework and evidence of continuous improvement (Peer review visit from Milton Keynes NHS Foundation Trust)	• Some input to enhance the submission data from Jermey Over; and support from Nicola Cottington to revise the section on reporting to the Board • Submission approved by the Committee	1. No escalation Submission approved on behalf of the Board
7.1	**First for the Future** Finance, workforce, culture and engagement. Review of draft presentation for staff communications	2. Reasonable	• Constructive discussion building on the presentation. Multiple elements of feedback given to refine the presentation	• Executive directors and Head of Communications to revise and test with a small group of staff I advance of trust wide staff briefing and team engagement sessions / Town Hall type events	1. No escalation; however Board members should all have sight of

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			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
	regarding the financial recovery planning and the impact on staff and the organisation			• Involvement Committee reaffirmed the need for two-way communication mechanisms; and for some urgency as lack of communications causes paralysis and fear among staff.	the presentation and key messages
7.2	Veteran's Aware Accreditation Plan	2. Reasonable	• Excellent presentation from Philippa Lakins, Organisation Development Lead on work she has led to secure accreditation as a 'Veteran's Aware' NHS provider	• Action Plan in progress to secure accreditation by end October 2024; with progress expected by October 2025 to maintain accreditation	1. No escalation but return to Involvement Committee for further assurance of progress in June 2025
8.1	**First for Patients** CQC Inpatient Annual Survey Results	1. Substantial	• The Trust was 2nd highest rated in the region (Royal Papworth rated 1st) and 5th highest in England for acute and community combined trusts. • The committee was assured that the drive to continue to improve is strong	• Further work in progress to support ○ Patients getting a good night's sleep ○ Virtual ward information ○ Doctors including patients in conversations about them	1. No escalation

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			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
8.2	ED&I Thematic Review (Maternity Services)	1. Substantial	• Karen Newbury (Director of Midwifery) and Daniela Turner (ED&I Lead Midwife) presented a confidential report detailing learning from a thematic review exploring causation and complications for women from Black, Asian and minority ethnic groups at West Suffolk Foundation Trust	• The Committee was assured by the detail, sensitivity and learning implemented by the West Suffolk midwifery service; in partnership with third sector organisations in West Suffolk. • As a result of the thematic review changes to clinical practice and enhanced community support for Black, Asian and minority ethnic women has been established	1. No escalation
8.3	Maternity service user feedback and subsequent co-produced action plan	1. Substantial	• Jacki Brown, (Parent Education and Patient Experience Lead Midwife) presented results of the CQC 2023 and Healthwatch Suffolk 2024 Maternity Care Surveys. • The responses were positive with a continuous quality improvement approach taken to responding to service user's themes	• The Committee was assured that actions have been taken with respect to: 1. Involvement of partners / carers in maternity care and delivery – as much as they wish 2. Pain relief during labour and birth 3. Parenting classes 4. Birth partner/ significant other staying overnight 5. Staffing to ensure staff can take breaks	1. No escalation

Originating Committee: Involvement Committee			Date of meeting: 16th October 2024		
Chaired by: Tracy Dowling - Non-executive Director			Lead Executive Directors: Jeremy Over and Sue Wilkinson		
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
8.4	Publication and maintenance of patient information leaflets	3. Partial	• A solution to the issue of producing and maintaining leaflet content has been identified		1. No escalation
9.1	Update from People and Culture Leadership Group	1. Substantial	• Report assures progress with recruitment, staff development and workforce planning	• Bi-monthly reports from PCLG.	1. No escalation
9.2	Experience of Care and Engagement Report	2. Reasonable	• Report from the work of the latest committee meeting.	• Clear actions in progress regarding overseas visitors; end of life communications; communications regarding medications and availability of religious texts for patients.	1.No escalation
9.3	Update on formal complaints quality improvement project	1. Substantial	• Mid point report received. QI project to continue to year end.	• Continued quarterly reporting in line with national terms and conditions	1.No escalation
9.4	Board Assurance Framework – Patient Engagement	3. Partial	• Risk relating to the Head of Patient Engagement leaving the Trust in December are defined; risks regarding patient and public engagement requirements identified.	• Update to next meeting on measures to mitigate factors causing immediate risk increases.	1.No escalation

Originating Committee: Involvement Committee			Date of meeting: 16th October 2024		
Chaired by: Tracy Dowling - Non-executive Director			Lead Executive Directors: Jeremy Over and Sue Wilkinson		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
9.5	Board Assurance Framework - Collaboration	Carried Forward to next meeting	• The recently appointed Director of Strategy and Transformation is in the process of rewriting the risks and actions for this BAF; including redefining the risk. Assurance is therefore minimal as a lot of work is needed to understand and address this risk.	• Director of Strategy and Transformation to continue work with colleagues to progress this area of risk. • Agreed to put the proposed BAF – Collaboration as an early item on the next meeting agenda to thoroughly review this and support the work Sam Tappenden is doing.	1. No escalation
9.6	Internal Audit Reporting Q3 Report	1. Substantial	• Report received from Richard Jones demonstrating level of assurance for audits this committee has oversight responsibility for.	• Actions in progress as planned.	1. No escalation
10.0	IQPR extract for Involvement Committee including Workforce KPIs	2. Reasonable	• It was highlighted that 2 of the four workforce KPI's are continuing to track above target. • New patient experience report included	• Ongoing monitoring of workforce KPIs, in particular appraisal and mandatory training.	1.No escalation

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

Feedback from assurance committees: Governor observer report

Board assurance committee: Involvement
Meeting date: 20 August 2024
Governor observer (observed by): Sue Kingston

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
The agenda was full and inclusive, and items were in line with providing assurance to the board. FIRST values were verbally discussed, as was the purpose of the committee, and the need to be mindful in delivery.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
The meeting was held face to face, in the Northgate Meeting Room. Teams were also available on the day, but nobody joined that way on this occasion. It was a full meeting with a large agenda. The Chair was thorough, and everybody was included and given the time and space to speak. The behaviour of all participants was respectful and polite During the reflection of the meeting, participants concluded that the meeting was respectful, and their views were listened to.
Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
Assurance was gained by in depth discussions and challenges when clarification was needed.

When presentations were made, any questions asked after were answered in detail and with re-assurance. It was acknowledged that some projects needed further clarification and work being undertaken and implemented within the trust also needed further clarity. The committee was given assurance that on going reports and progression would be forthcoming.
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• During reflection, as an observer we were also asked to comment on how things were for us, could we hear the meeting etc and anything that would make our job of observing any easier and more productive. I was able to thank the committee for the offer of asking us to sit at the table with them at the start of the meeting which we politely declined. On reflection though, it made me realise that it is very difficult to hear when people are talking and because of positioning, some members have their backs to you. Also, sitting at a table would be an advantage because you could then have a laptop to follow the agenda and have a better understanding of who is talking. However, this is something perhaps to discuss with the governors as to whether this would be appropriate?

Feedback from assurance committees: Governor observer report

Board assurance committee: Involvement
Meeting date: 20 August 2024
Governor observer (observed by): Val Dutton

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• The agenda items were in line with providing assurance to the Board on delivery of quality and safety which is inclusive and engaging of our staff, patients and stakeholders.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• It was a full meeting with a large agenda, but everyone was included in the discussions and had the chance to participate and speak openly on agenda items. • Behaviour of all participants was respectful and polite
Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
• The new chair of the committee was very efficient and ensured the meeting was conducted in a productive manner. • Assurance was gained by in-depth and open discussions, with any challenges requesting clarification or further information made in a respectful manner. • There were some in-depth discussions on current challenges facing the organisation, which were conducted in an effective honest and open manner.
Governor observer Notes

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

Feedback from assurance committees: Governor observer report

Board assurance committee: Involvement
Meeting date: 16 October 2024
Governor observer (observed by): Val Dutton

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• The agenda items were in line with providing assurance to the Board on delivery of quality and safety which is inclusive and engaging of our staff, patients and stakeholders
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• It was a full meeting with a large agenda, and the chairperson ensured everyone was included and had the opportunity to Participate and this ensured open and honest discussions were held. • The behaviour of all participants was respectful and polite. • I observed everyone was included and given the chance to speak.
Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
• Assurance was gained by some in-depth discussions and polite challenges for clarification of information provided. • There were very interesting presentations given and the presenters were able to answer questions regarding the information they were providing.
Governor observer Notes

Use this section to highlight any other areas for example good practice or 'even better if'
• The meeting was very informative and covered a wide range of relevant and important issues. • The large agenda made it difficult to keep to the meeting times but still allow the necessary discussions to take place. The chairperson ensures a very good meeting is held and agenda items are covered.

Feedback from assurance committees: Governor observer report

Board assurance committee: Involvement
Meeting date: 16 October 2024
Governor observer (observed by): Sue Kingston

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Agenda and papers available in advance of the meeting. Large agenda, including: • Lone Worker Safety • CQC Inpatient survey • EDI Thematic Review • CQC Maternity Services & HWS Survey results • Veterans Aware Accreditation Plan
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Meeting started on time and was face to face held in the Northgate Meeting Room. Teams was also available. • The Chair welcomed everybody, and introductions were made round the table. • The meeting was polite and respectful. Attendees were all given the opportunity to speak and contribute. • I felt everyone was included and the Chair was thorough and respectful in the handling of the meeting. • A new NED was asked to reflect on the meeting as it was their first on this committee. They highlighted the conversations that had taken place and those in particular that had been respectively challenged by other attendees. • As observers, the Chair also asked for our reflections on the meeting.

- Deep dive discussions resulted in the meeting overrunning which left less time for the BAF Risk Report and other items on the agenda.
- Trust values maintained throughout the meeting.

Assurance

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

- Insufficient time to discuss BAF Risk report
- Formal Complaints Quality Improvement Project, significant rise in complaints since last update. Monitoring continuing until the end of the financial year
- Workforce KPI's insufficient time for discussion.
- Informative presentations provided insight and a deep dive analysis on their subject matter, resulting in assurances and clarification to the committee.
- The Chair acknowledged that due to the very large agenda, not enough time was dedicated to some important areas. These would be prioritised at the next meeting.

Governor observer Notes

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

- Agenda order to ensure items that were not fully discussed in this meeting take priority next time.
- Presentations made to the committee perhaps should have a time limit to ensure there is the capacity to accommodate them within the agenda
- As an observer, being invited by the Chair to sit at the table with the committee, enhanced my experience of observing and felt very inclusive.

8.4. Audit Committee

Presented by Antoinette Jackson

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Audit Committee			Date of meeting: 1st October 2024		
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 / SLT 3. Escalate to Board
Progress report on Internal Audit plan 2024/25 (RSM)	Update on delivery of internal audit plan and implementation of recommendations.	Reasonable	The Committee considered two final reports that had been issued, both with positive opinions: Data Security & Protection Toolkit and DBS Checklist. The Committee agreed to vary the audit plan to defer (to later in the year) the divisional governance structure audit, and to bring forward the consultant job planning process audit. The Committee also reviewed progress with implementation of recommendations.	Welcomed ongoing reduction in outstanding audit actions, although requires continuing focus by management to address the overdue actions.	2 -> Management Executive

Originating Committee: Audit Committee			Date of meeting: 1st October 2024		
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 / SLT 3. Escalate to Board
Progress report on Counter Fraud activity (RSM)	Discussion on CF activities, including results from national benchmarking reports.	Substantial	The Committee considered a review of declarations of interest and gifts and hospitality and noted very strong comparative performance in the national fraud benchmarking report on declaration of interests. The relatively low level of fraud referrals at WSFT compared to national benchmarking was discussed. RSM reported that there had been an increase in referrals this year and they were confident staff were aware of the routes to report. In relation to the national fraud best practice report, RSM reassured the Committee that they received strong support for counter fraud activity at WSFT.	NHS Counter Fraud Authority are running a national exercise on procurement around due diligence and contract management.	1. No escalation

Originating Committee: Audit Committee			Date of meeting: 1st October 2024		
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 / SLT 3. Escalate to Board
Single Tender Waivers	Consideration of single tender waivers in 2023/24 and national benchmarking comparisons.	Substantial	Use of waivers at WSFT continues to decline (in number and value) and performs well in relation to national benchmarking.		1. No escalation
Supply Chain Risk	Considered the annual report on risk in WSFT's supply chain.	Reasonable	The Committee welcomed the comprehensive report, and the approach set out for high-risk suppliers. Systematic weakness in financial strength of pharma companies was an issue recognised nationally, with little WSFT could do. The rating for one local supplier would be considered further by Executive Director Finance.		2 -> ED Finance

Originating Committee: Audit Committee			Date of meeting: 1st October 2024		
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 / SLT 3. Escalate to Board
Debt write-offs	Consideration of two high-value debt write-offs.	Reasonable	The Committee authorised the write-off of two invoices, amounting to £80k – this would impact the financial system as no bad debt provision had been made for these invoices. Finance would be reviewing processes as both invoices had been managed outside Finance systems / overview.		2 -> ED Finance / COO
Contractual arrangements for Internal Audit / Counter Fraud and External Audit	Considered the performance of current contractors and discussed options for extension / retendering. RSM would be willing to extend their Internal Audit / Counter Fraud contract; however KPMG have declined to continue as External Auditor.	Reasonable	Concern was expressed about the challenge in securing interest in the external audit commission as the big forms (who have the necessary expertise) find consultancy work more profitable than audit work.	Finance to develop proposals. Appointment of new External Auditor is matter for Council of Govenrors.	Proposals for both contracts to be taken through appropriate governance.

**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.

9. Nomination Committee Report (enclosed)

To receive the report from the Nomination Committee

To Note

Presented by Jude Chin

NHS
West Suffolk
NHS Foundation Trust

WSFT Council of Governors meeting (Open)	
Report title:	Nominations Committee report
Agenda item:	9
Date of the meeting:	19 November 2024
Sponsor/executive lead:	Jude Chin, Trust Chair
Report prepared by:	Richard Jones, Trust Secretary & Head of Governance Pooja Sharma, Deputy Trust Secretary

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 summarises discussions that took place at the Nominations Committee meeting on 10 October 2024.

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

The Committee's agenda focussed on the following areas:

- **NEDs Terms of Office** - The terms of office for the NEDs were reviewed and noted.
- **Nomination Committee forward planner 2025** - The Committee noted the forward plan and recommendations from annual report on committee effectiveness will be actioned through the Committee's forward plan.
- **NED remuneration** - a recommendation to be considered by the Council in closed session.

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.

Action required / Recommendation:

The Council of Governors is asked to **note** the report from the Nominations Committee held on 10 October and 11 November 2024.

Previously considered by:	Council of Governors' Nominations Committee

Risk and assurance:	Council of Governors unable to undertake its statutory duties.
Equality, diversity and inclusion:	Ensure inclusion and fair recruitment and staff management processes
Sustainability:	N/A
Legal and regulatory context:	West Suffolk NHS Foundation Trust Constitution Health & Social Care Act 2022 NHSE Code of Governance 2022

10. Engagement Committee Report (enclosed)

To receive a report from the Engagement Committee

Presented by Sarah Hanratty

WSFT Council of Governors meeting (Open)	
Report title:	Engagement Committee report
Agenda item:	10
Date of the meeting:	19 November 2024
Sponsor/executive lead:	Sarah Hanratty, Public Governor (Chair of Engagement Committee)
Report prepared by:	Sarah Hanratty, Public Governor Pooja Sharma, Deputy Trust Secretary Ruth Williamson, Foundation Trust Office Manager

Purpose of the report:

For approval	For assurance	For discussion	For information
☐	☒	☒	☐
Trust strategy ambitions	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
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 summarises the discussions that took place at the Engagement Committee workshop held on 7 October and meeting on 29 October 2024.

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

Summary/Highlights

On 7 October, the Committee workshop was convened to discuss and feedback on draft membership and engagement strategy, feedback on development/action plan, agree on name of the Committee and discuss and agree revised draft terms of reference. The drafts were shared with the Committee ahead of the workshop. On 7 October, the Committee members provided inputs/feedback and views were collated in the final drafts presented to the Engagement Committee on 29 October for endorsing to the Council of Governors for consideration and approval.

In the meeting on 29 October, the Committee focussed on the following key areas:

- The Committee noted an update on **Patient Engagement and VOICE** including overview of data from patient experience feedback, formal complaints, actions and learning from complaints, PALS and complaints improvement QI project.

- The Committee received a report on **Governor activities** from March 2024 and discussed the emerging themes from the feedback received from the observers. The activities identified a significant number of positives across these areas including our staff, environments and the focus on patients and care. It was agreed that issues flagged should be escalated through the relevant Trust process rather than the Council of Governors. The Committee also agreed that the Governor activities coversheet to be included for oversight in papers for the CoG meeting in November **(Annex 1**) and includes six 15-steps visits, one area observation; two environmental

walkabout and three courtyard café visits (WSH and NMH).

Key themes from activity analysis were confirmed and will be considered through the Trust's experience of care and engagement committee:

- Environment – maintenance, noise and clutter
- Information – leaflets (availability/language), templates and electronic availability

- The Committee received feedback from governor observers of **VOICE** and members attending the **Experience of Care & Engagement Committee.**

- The Committee received **report from workshop** held on 7 October to highlight the following:

  - Views of the Committee were collated and the final **draft membership and engagement strategy** is presented to the Council of Governors for endorsing to the Board for approval. **(Annex 2 for approval).**

  - The feedback on the draft strategy was also used to translate the objectives and aims into a **development plan**. This will be a live document to be reviewed, developed and monitored by the Committee to focus on next steps to deliver the strategy

  - Revised **terms of reference** were discussed and the Committee agreed to recommend to the Council for approval. **(Annex 3 for approval)**

  - The Committee also discussed and considered new name for the Committee and agreed to propose to the Council to rename as "**Council of Governors' Membership and Engagement Committee**".

ACTION

The Council of Governors is asked to note the report and:

- Recommend the **draft membership and engagement strategy** to the Board of Directors for approval
- Approve the new name "WSFT Council of Governors' Membership and Engagement Committee"
- Approve the revised **terms of reference** of the Committee.

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.

Action required / Recommendation:

The Council of Governors is asked to note the report and take actions as recommended in the report.

Previously considered by:	Council of Governors' Engagement Committee
Risk and assurance:	Council of Governors unable to undertake its statutory duties.
Equality, diversity and	N/A

inclusion:	
Sustainability:	N/A
Legal and regulatory context:	West Suffolk NHS Foundation Trust Constitution Health & Social Care Act 2022 NHSE Code of Governance 2022

WSFT COUNCIL OF GOVERNORS' ENGAGEMENT COMMITTEE	
Report title:	Governor activities 2023/24 - Feedback report
Agenda item:	6
Date of the meeting:	29 October, 2024
Sponsor/executive lead:	Richard Jones, Trust Secretary
Report prepared by:	Ruth Williamson, Foundation Trust Office Manager

Purpose of the report:

For approval	For assurance	For discussion	For information
☐	☐	☒	☒
Trust strategy ambitions	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
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 summarises the Governor activities from March 2024 and the emerging themes from the feedback received from the observers.

15 steps visits (Annex A)

- 27 March 2024: Pharmacy and Eye Treatment Centre/Day Surgery Unit by Michael Simpkin (public governor) and Antoinette Jackson (non-executive director)
- 24 April 2024: Physio/Physio Outpatients and F5/Surgical Same Day Emergency Care (SDEC) by Sarah Hanratty (public governor), Andy Morris (staff governor) and Roger Petter (non-executive director)
- 29 May 2024: F12 and Discharge Waiting Area by Jayne Neal (public governor),and Jane Skinner, (public governor).
- 26 June 2024: Neo-Natal Unit (NNU) and Pathology and Labs by Becky Poynter (public governor), Carol Bull (public governor) and Jude Chin, (Chair).
- 31 July, 2024: Theatres and Macmillan Cancer Support (G1) by Anna Conochie (public governor), Liz Hodder (public governor) and Antoinette Jackson (non-executive director)
- 28 August 2024: Emergency Department and Acute Assessment Unit (AAU) by Rowena Lindberg (partner governor), Jane Skinner, (public governor), Sue Kingston, (partner governor) and Roger Petter, (non-executive director).

Area observations (Annex B)

- 6 August 2024: Radiology by Becky Poynter, (public governor)

Environmental reviews with Estates and Facilitates (Annex C)

- 20 March 2024: Pathology by Adam Musgrove, (staff governor)
- 15 May 2024: Day Surgery Unit/Eye Treatment Centre by Carol Bull (public governor)

Courtyard Café (Annex D)

- 4 April 2024, WSFT by Anna Conochie (public governor) and Val Dutton (public governor)
- 4 June, 2024, Newmarket by Val Dutton (public governor) and Carol Bull (public governor)
- 1 October, Newmarket by Val Dutton (public governor) and Clare Rose (public governor)

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

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

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

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

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

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

Some themes from visiting teams are identified below:

15 steps:

- Physical environment - maintenance
- Volunteers - clarity of role of Volunteers working in departments.
- Staff Identification – name badges, the meaning of different uniforms and poster explaining same.

Area observations:

- Physical environment – noise level and temperature
- Leaflets – availability in different languages

Environmental reviews:

- Physical environment – maintenance and trip hazards
- Notices/Instructions – use of correct Trust templates

Courtyard Café: • Parking – accessibility, availability and cost • Difficulty accessing leaflets on line
Action required / Recommendation:
The Engagement Committee is asked to: - note the report and emerging themes - consider how these can be further tested in future governors activities – suggested that we provide a short briefing of themes for governor undertaking visits / activities - consider any locations of particular focus for future visits / activities - summarise the issues considered and themes in the committee report to the Council of Governors

Previously considered by:	NA
Risk and assurance:	Council of Governors is unable to undertake its statutory duties.
Equality, diversity and inclusion:	NA
Sustainability:	NA
Legal and regulatory context:	West Suffolk NHS Foundation Trust Constitution Health & Social Care Act 2022

West Suffolk NHS Foundation Trust Council of Governors' membership and engagement strategy

An engagement strategy for the interests of the Foundation Trust's members and the public

Table of content

1.	**Introduction** As a Foundation Trust (FT), West Suffolk NHS Foundation Trust is accountable to the local community, the patients it cares for and the people it employs through its membership. A 'member' is defined as any person registered as a member of the Trust and authorised to vote in elections to select Governors. Being a 'member' of an NHS FT provides the general public and staff with the opportunity to participate and get involved with their local hospital. Those living in communities that are served by the Trust can become members with the membership community being made up of public (including patients/carers) and staff members. From these members, Governors are elected to the Council of Governors to represent members' interests. We recognise the need to commit resources, both in time and effort, to developing our membership and engaging with the members and the public and the strategy sets out the actions that we will take in support of this. The Council of Governors' Membership and Engagement Committee will undertake a key role in leading and managing the implementation of this strategy and its future development. The Committee will monitor the progress against this strategy and other related actions, and report to the Council of Governors as appropriate. The steps and actions underpinning the delivery of this strategy will be led by Foundation Trust Office which includes Trust Secretary, Deputy Trust Secretary and Foundation Trust Office Manager. The FT Office will engage others to develop an annual programme of activities and events to support the progress of this strategy. It is important to understand the scope of this membership engagement, which focusses on engaging with the FT members - existing members and potential new members. This enables Governors to canvass the opinion of these groups (such as patients, staff and the public) on the Trust's objectives, priorities and strategy. This compares with the Trust's wider experience of care and engagement strategy which focuses on how the Trust meets its statutory requirements surrounding involving patients and our local people and communities who receive, or may receive, care from WSFT in the future. This includes wider stakeholder engagement to ensure people are involved in decisions about service change, development and improvements to patient experience, led by employees of the Trust. While related, they serve different purposes within the organisation. Understanding this difference, will help to effectively tailor this strategy to meet the needs of FT members.
2.	**Defining our membership** The membership of WSFT is split into public and staff constituencies. **The Public Constituency**: The Trust has a single Public Constituency. The area of the Public Constituency is made up of all local government electoral areas/wards of Suffolk, Norfolk, Cambridgeshire and Essex. **The Staff Constituency**: The Staff Constituency will comprise a single class. The Trust maintains a membership database for public members and staff details are taken from the Electronic Staff Record. Staff are members unless they choose to opt out.

	On 31 March 2024 there were 6,552 public members and 5,461 staff members, giving a total of 12,013 members.
3.	**Purpose of the Strategy** For the Trust to meet its responsibilities to stakeholders, including patients, staff, the community and system partners, the board of directors should ensure effective engagement with them, and encourage collaborative working at all levels with system partners. The purpose of this strategy is to outline our vision and methods to: - Develop our membership and ensure it is representative - Communicate with members and the public - Engage with members and the public to understand and facilitate feedback from members of the public to the Trust Membership and engagement strategy objectives are detailed in section 5.
4.	**Key Drivers for member, patient and public engagement** The Council has two main duties in legislation[1] (Health and Social Care Act 2012), included at paragraph 16 of the Trust Constitution, and as most recently described in the Code of Governance for NHS provider trusts 2022: *NHS foundation trusts are public benefit corporations and their boards of directors have a framework of local accountability through members and a council of governors. The NHS foundation trust council of governors is responsible for holding the non-executive directors individually and collectively to account. In turn, NHS foundation trust governors are accountable to the members who elect them and must represent their interests and the interests of the public. (Code of Governance)* *In fulfilling the Code's requirements of good governance, it states: Satisfactory engagement between the board of directors, the council of governors and members of foundation trusts, and patients, service users and the public is crucial to the effectiveness of trusts' corporate governance approach.* Section C, 5.15 (NHS foundation trusts only) *Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.* Health and Social Care Act 2012 empowers patients and gives a new focus to public health; it extends the duty of governors to represent the interests of the public as well as membership. NHS England's Your statutory duties and Addendum to Your statutory duties: A reference guide for NHS foundation trust governors, published October 2022 reiterates this expanding role.
5.	**Role of Council of Governors**

[1] https://www.legislation.gov.uk/ukpga/2012/7/part/4/enacted

	Members' views and opinions are heard through the Council of Governors. This strategy enables and supports the Council of Governors to carry out one of their statutory duties to fulfil their role - *representing the interests of the members of the NHS foundation trust and the public* which can be achieved through engagement. Governors are responsible for engaging with the local community and the public to promote the benefits of becoming a member of the Trust. They act as representatives of the members and the public, ensuring that their views and concerns are considered by the Trust's board of directors. Governors help raise awareness about the Trust and encourage people to join as members through various outreach activities. This can include attending community events, speaking to local groups, and utilising the Trust's communication channels to support developing a diverse and representative membership that reflects the demographics of the local community.
6.	**Oversight of membership engagement** (role of Board, Council of Governors and the Committee) The Board of Directors has an overall responsibility for the membership of the Trust. The Council of Governors is responsible for reviewing the Trust's membership and membership engagement. The Council of Governors will contribute to and support the delivery of strategy with support from the FT office. The Membership and Engagement Committee works to deliver the responsibilities of the strategy for the Council of Governors; reporting plans and findings to the Council.
7.	**Objectives of the strategy** The Trust is committed to being a successful membership organisation and strengthening its links with the local community. To achieve this vision, our strategy sets out three overarching objectives. These objectives form the framework by which we hold ourselves to account. The objectives recognise and build on the Trust's FIRST values, frameworks and processes which the Trust has in place to grow, engage and involve its membership.
	Objective 1: **Develop our membership** *We aim to:* - *Build and maintain an active membership* - *Ensure our membership is representative of the community we serve.*
	Objective 2: **Communicate with our membership and the public** *We aim to:* - *Sustain, review and improve communication with our members and the public to keep them informed through engaging communications that reflect their interests* - *Promote the work of the Trust's Governors, as representatives of our members and the public.*
	Objective 3: **Engage with members and the public to understand their interests**

	We aim to: - *Sustain, review and improve engagement activities with our members and the public* - *Ensure effective mechanisms are in place to capture feedback from members, patients and public* - *Use feedback mechanisms to enable Governors to canvass the opinion of members and the public on the Trust's forward plan, including its objectives, priorities and strategy.*
8.	**Existing activities to deliver objectives** Positive engagement with our members is extremely important. The Membership and Engagement Committee of the Council of Governors have considered how we can most effectively engage with our membership. Member recruitment and engagement are often most effective when undertaken together. Therefore, direct recruitment plans will also in effect provide effective engagement activities. Methods of engagement and communication used at present: • Area observations • 15 steps ward visits • Environmental reviews • Observing VOICE meetings • Membership on Experience of Care and Membership and Engagement Committee • Courtyard café events • Medicine for members • Annual members meeting • Trust members' newsletter • Other community events • Print and digital campaigns • Invitations to key events run by the Trust or partner organisations • Staff governors to communicate to staff via the "Green Sheet". Future vision of engagement plans with our members will also include: • Greater use of Trust's electronic communication with members • Identification of underrepresented groups to recognise areas for better engagement. • staff governors to explore new ways of engaging with staff and to raise the profile of staff governors e.g. holding staff member engagement sessions • working with partner organisations to establish best practice in membership engagement e.g. NHS Providers and other NHS FTs. **Recruitment plan** We aim to recruit new members to maintain our number of engaged public members. As part of the recruitment plan, experience has shown that engaging with the public is a very effective way of recruiting new members and gaining their views on services we provide at the West Suffolk Hospital, Newmarket Hospital and in the community. Methods of recruitment used at present include: • attending public meetings and events including festivals, stands in sports & healthy living events and recruitment fairs • on-line recruitment through the Trust's website • in-house e.g. Courtyard Café

	• public education events e.g. “medicine for members”. *Media coverage at present:* • Trust website and intranet • membership newsletter, Trust leaflets and messages • social media • emails to both staff and public members.
9.	**Membership and engagement development plan** A development plan to set out the steps we will take each year to implement the strategy will be developed and overseen by the Membership and Engagement committee so that it is clear how we will put our plans into action.
10.	**Evaluating impact and monitoring success** The progress on delivery of the membership and engagement strategy will be monitored on behalf of the Board of Directors by the Membership and Engagement Committee of the Council of Governors. The Membership and Engagement Committee will undertake the detailed monitoring of implementation evaluating success and impact and will report regularly to the Council of Governors. The FT Office and Membership and Engagement Committee will undertake a key role in leading and managing the implementation of this strategy and its future development. **Measures of success** The success of the strategy will be measured by the following criteria: • Membership diversity and inclusion of underrepresented groups • Membership numbers • Member attendance at annual members’ meeting • Number of events where governors or WSFT have a presence • Quality and quantity of feedback and responses to surveys and engagement with members/patients/public • ‘You said, we did’ examples **Continuous Learning** To ensure that both members and the Trust get the best out of membership, members will be able to provide feedback at any stage, for our learning and improvement into all membership initiatives. **Email**: foundationtrust@wsh.nhs.uk **Telephone:** 01284 713224 The Trust will also actively seek to learn lessons through: - Membership survey - Governor survey - Feedback forms at events - Membership database reports (e.g. meeting/event attendance, membership growth, membership demographics)

11.	**Governance of the strategy** The Membership and Engagement Committee will undertake the detailed monitoring and review progress against the objectives of this strategy reporting back on progress at the Council of Governors through an update from the committee chair. The Council will endorse the strategy and recommend to the Board for approval. This will be reviewed on a regular basis. An interim annual review of the strategy will be undertaken by the Membership and Engagement Committee with periodical reviews of the development plan by the Membership and Engagement Committee. The committee will also review progress against the objectives of this strategy quarterly reporting back on progress at the Council of Governors through an update from the committee chair.
12.	**Resources to support delivery of the strategy** The FT Office and Membership and Engagement Committee will undertake a key role in leading and managing the implementation of this strategy and its future development. The delivery of the strategy will be supported by various stakeholders including the Council of Governors, Executive Team, Foundation Trust Office, Communication team and Patient Experience and Engagement Team.

Approved by:
Council of Governors' Membership and Engagement Committee: 29 October 2024
Council of Governors:
Trust Board:

Annex 1 Becoming a member

Public membership

Any person aged 16 or over who lives within the membership area is eligible to be a public member. Public members are recruited on an opt-in basis.

Membership is completely free and gives everyone the chance to keep up to date with our news and to have a say about our work.

Contact the Foundation Trust membership office:

- Email: foundationtrust@wsh.nhs.uk
- Telephone: 01284 713224
- Online link here or https://secure.membra.co.uk/join/westsuffolk
- Request form from the membership office or from the hospital's main reception

Staff membership

All WSFT staff who are employed by the Trust under a contract of employment which has no fixed term; has a fixed term of at least 12 months; or have been continuously employed by the Trust under a contract of employment for at least 12 months are eligible to become staff members unless they choose to opt out.

Staff who exercise functions for the purposes of the Trust, without a contract of employment, continuously for a period of at least 12 months are also eligible to become staff members unless they choose to opt out. This does not include individuals who exercise functions for the purposes of the Trust on a voluntary basis.

Contact procedures for members:

Contact details for the Foundation Trust office are detailed above as well on the website.

WSFT Council of Governors' Membership and Engagement Committee Terms of Reference

1. Purpose of the Committee

The Membership and Engagement Committee (the Committee) is constituted as a sub-committee of the Council of Governors (the "CoG") of West Suffolk NHS Foundation Trust (the "Trust"). The constitution and terms of reference of the Committee are subject to amendment by the CoG, to which it remains accountable.

The Committee shall embody the principles of the NHS Constitution and the Trust's FIRST values, at all times. The purpose of the Committee is to support Governors in fulfilling their statutory duty to represent the interests of the members of the foundation trust and the public.

1.1 Build and maintain an active membership.

1.2 Ensure our membership is representative of the community we serve.

1.3 Sustain, review and improve communication with our members and the public to keep them informed through engaging communications that reflect their interests.

1.4 Promote the work of the Trust's Governors, as representatives of our members and the public.

1.5 Sustain, review and improve engagement activities with our members and the public.

1.6 Ensure effective mechanisms are in place to capture feedback from members, patients and public.

1.7 Use feedback mechanisms to enable Governors to canvass the opinion of members and the public on the Trust's forward plan, including its objectives, priorities and strategy.

2. Level of Authority

2.1 The Membership and Engagement Committee is accountable to the Council of Governors to deliver its key duties and responsibilities. The Committee will have an authority to establish working groups reporting to it. They shall remain accountable to the Engagement Committee for the work of any group reporting to it.

2.2 The Committee has authority to make processes and procedures which fall within its terms of reference.

3. Duties and responsibilities

3.1 The Membership and Engagement Committee shall undertake the following, making recommendations for any changes or action to the Council of Governors:

- To develop membership and engagement strategy
- The Committee will undertake a key role in leading and managing the implementation of this strategy and its future development.

- to deliver the responsibilities of the strategy for the Council of Governors i.e. reporting plans and findings to the Council
- to monitor on behalf of the Council of Governors and report progress on implementation, evaluating success and impact
- Any other relevant matter as may arise from time to time.

4. Membership

4.1 The Membership and Engagement Committee will have a membership of at least 6 governors, including the lead governor and a staff governor.

4.2 The Committee will elect one of its members as Chair.

4.3 Additional members may be co-opted to the Committee as necessary.

4.4 Representatives from the Trust may also be in attendance at meetings, including the Trust Secretary, representative from communications team, foundation trust office manager, representative from patient experience and engagement or future systems programme teams, head of fundraising and others as required.

5. Quorum

5.1 The number of members required for a quorum shall be three governors.

5.2 Deputies appointed by the governors from the council of governors will be counted for the purposes of the quorum.

5.3 Virtual attendance will count towards the quorum.

6. Frequency of meetings

6.1 Meetings will normally be held no more than quarterly. Additional meetings or workshops may be held as required.

7. Sub Committees

7.1 The Committee shall have the ability to establish working groups as an when required, with ultimate discretion to disband such groups, in accordance with this provision.

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

8.1 The Committee shall be supported by the Foundation Trust Office.
8.2 The minutes of the Committee meetings shall be formally recorded and submitted to the next meeting of the Membership and Engagement Committee.
8.3 Minutes will be prepared after each meeting of the Committee and once confirmed by the chair of the committee, to be circulated to members of the Committee and others as necessary, in sufficient time to support the working of the Committee.

9. Accountability and reporting arrangements

9.1 The Membership and Engagement Committee will be accountable to the Council of Governors.

9.2 The Committee will report to meetings of the Council of Governors on its activities. The Committee Chair shall provide a report to the Council of Governors after each meeting to outline areas of key discussion and any actions taken or issues for escalation.

10. Monitoring effectiveness and compliance with terms of reference

10.1 The Committee shall carry out a two-yearly review of its effectiveness against its terms of reference.

11. Ratification of terms of reference and review arrangements

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

Date approved by the Membership and Engagement Committee: 29 October 2024
Date approved by the Council of Governors:
Next review date:

11. Standards Committee Report (enclosed)

To receive a report from the Standards Committee

To Note

Presented by Jude Chin

WSFT Council of Governors meeting (Open)	
Report title:	Standards Committee report
Agenda item:	11
Date of the meeting:	19 November 2024
Sponsor/executive lead:	Jude Chin, Trust Chair
Report prepared by:	Richard Jones, Trust Secretary & Head of Governance Pooja Sharma, Deputy Trust Secretary

Purpose of the report:

For approval	For assurance	For discussion	For information
☒	☒	☒	☐
Trust strategy ambitions	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
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 summarises discussions at the Standards Committee of the Council of Governors held on 17 October 2024.

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

Summary

The Committee focussed on the following key areas:

- **Code of conduct and managing governor conduct and standards**

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

ACTION

- Note and approve the Code of conduct and managing governor conduct and standards

- **Trust Constitution**

The Standards Committee met on 7 August 2024 and recommended one amendment to the Trust's Constitution for consideration by the Council relating to the duration of tenure for a Governor (Constitution clause 12. Council of Governors – tenure) - *any individual may stand for re-election or re-appointment as a Governor provided that a period of at least two years has passed since the end of that individual's previous maximum term as Governor.*

The Council of Governors discussed in their meeting on 2 September and recommended the

amendment to the Board of Directors for approval.

The Board in their meeting on 27 September considered the proposed amendment, and a query was raised regarding plans to maintain a balance between retaining expertise and bringing in fresh perspectives and encouraging diversity on the Council of Governors. A suggestion was also made to explore opportunities within the West Suffolk Alliance and tap into some ongoing work with the community leaders around identifying health inequalities as that might allow the Trust to acquire members for a range.

Recognising that this was not a time critical decision as the next governor elections are due in 2026, the Board asked for clarification be provided in terms of how the Trust reaches and engages with the underrepresented groups and links within the Alliance.

It was agreed that an outline is prepared detailing the engagement activities which will be undertaken as part of the next Governor elections and this is shared with the Board. This will build on the comprehensive range of activities undertaken previously but will also be informed by discussions with the West Suffolk Alliance and other relevant partners.

ACTION
- Note update

- **Fit and Proper Persons Test and Disclosure and Barring Service checks**

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

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

- **Governor attendance at Council meetings**

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

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

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

Attendance at Governors' sub-committees was also considered by the committee, and it was agreed that each committee should maintain oversight of attendance to support individuals to attend meetings and maintain the effective working of the sub-committees. The Standards Committee will maintain oversight of this issue and concerns regarding non-attendance highlighted.

The Committee reviewed the treatment of the Annual Members' Meeting in terms of counting towards attendance. It was understood that a number of other trusts did not treat this as a Council of Governors' meeting, as was the case here. It was felt that the Trust should do more to communicate that governors should attend wherever possible or send their apologies. This recognised the event as a great opportunity for engagement with members. However, it was agreed that the meeting format

should not be altered to make more formal and thereby risk disengagement of the audience.

ACTION

- Note the update.

- **Cases/concerns regarding compliance with the code of conduct**

The Trust operates a just culture for managing staff conduct and it is therefore appropriate for the Council of Governors to adopt a similar approach when dealing with any allegations of conduct breaches relating to Governors.

Part of Standards Committee's remit is to review alleged breaches of the Code by Governors and advise on the procedure for managing the governor's conduct and expected standards.

In case of any breaches in Governors' conduct, the Standards Committee is asked to note the matters of alleged breach of code of conduct and approve a recommendation to the Council of Governors in terms of next course of action. No cases of breach were reported between July to September 2024.

ACTION

- Note that there have been no concerns or cases raised relating to breach of code of conduct by the Governors that trigger review or escalation to the Committee for the period.

- **Proposal to review structure and schedule for council of governors' committee's effectiveness**

For some time, there was a structure in place so that Board and governors' sub-committees self-assess and evaluate their effectiveness annually.

As per the feedback received on board committees, the timing of these assessments has been varied and will be more streamlined to undertake this work across all Board committees in a single period. While this will mean that individuals who are members of multiple committees will receive multiple self-assessment questionnaires to complete, this will be undertaken in a structured way to allow time for these assessments.

It was proposed that the same approach for the governors' sub-committees effectiveness review, and that consideration be given to undertaking reviews on a two-yearly basis, with a more concise template and provision of a future schedule.

- **May** - circulation of review templates to the committee members and regular attendees
- **June** - collate responses and analyse to draft annual effectiveness review reports
- **July/August** - presentation of reports at relevant committee
- **September** - report to the Council highlighting areas of focus and improvement actions.

Request was made that new governors be given time to assimilate prior to being asked to review. Therefore, it was agreed that the first year after election be avoided in the cycle.

ACTION

- Note the revised schedule for council of governors' committees' effectiveness review

- **Council of Governors Work Programme 2025**

The Committee noted the forward workplan that was developed to ensure timely consideration of relevant issues.

The work programme will be maintained as a live document to reflect new issues.

ACTION

- Note the Governors Work Programme 2025 **(Appendix 3)**

- **Recommendations from committee's annual effectiveness review 2024**

An update on progress with the recommendations from the committee's annual effectiveness review will be included on the agenda of the next meeting.

ACTION

- Note the update.

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.

Action required / Recommendation:

The Council of Governors is asked to **note** the report and **actions** as specified above, including approval of Appendix 1 and 2.

Enclosures:
Appendix 1 - Code of Conduct
Appendix 2 - Procedure for Managing Governor Conduct and Expected Standard
Appendix 3 – Governors' Work Programme 2025

Previously considered by:	Council of Governors' Standards Committee
Risk and assurance:	Council of Governors unable to undertake its statutory duties.
Equality, diversity and inclusion:	N/A
Sustainability:	N/A
Legal and regulatory context:	West Suffolk NHS Foundation Trust Constitution Health & Social Care Act 2022 NHSE Code of Governance 2022

Appendix 1

ANNEX 6 - CODE OF CONDUCT FOR GOVERNORS

1. Introduction

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

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

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

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

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

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

1.6.1 at face to face meetings

1.6.2 at online or telephone meetings

1.6.3 in written communication

1.6.4 in verbal communication

1.6.5 in non-verbal communication

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

2. Qualifications for office

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

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

Appendix 1

3. General Principles

3.1 Governors should at all times:

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

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

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

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

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

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

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

4. Confidentiality

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

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

5. Trust Policies

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

5.1.1 Internet and Intranet Policy

5.1.2 Respect for Others Policy

5.1.3 Equal opportunities and developing an inclusive culture

5.1.4 Freedom to Speak up

5.1.5 Data Protection Policy

5.1.6 Management of Violence and Aggression Policy

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

Appendix 1

6. Conflict of interests

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

6.1.1 shall not vote on any such matters.

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

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

7. Conduct in meetings

7.1 Governors should at all times:

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

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

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

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

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

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

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

8. Personal conduct

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

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

8.1.1 acknowledge that the Trust is an apolitical organisation.

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

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

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

8.1.5 accept responsibility for their actions.

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

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

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

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

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

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

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

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

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

9 Accountability

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

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

10. Induction and development

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

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

11. Visits to Trust Premises

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

12. Non-compliance with the Code of Conduct

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

Procedure for Managing Governor Conduct and Expected Standards

Introduction

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

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

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

Standards Committee

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

Membership of the committee shall comprise the following:

Trust Chair
Lead Governor
One public governor
One staff governor
One partner governor

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

Arrangements relating to Staff Governors

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

Referrals to the Standards Committee

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

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

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

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

Informal Stage

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

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

Formal Procedure

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

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

Investigation

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

- Alleged breach of the code
- Grounds giving rise to the allegation and the provisions of the code which are alleged to have been breached
- The terms of reference and timeframe for the investigation

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

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

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

- The findings of the investigation in relation to the alleged breach
- Whether there is a case to answer and any recommendations as to any further investigation or steps which should be undertaken by the committee

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

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

Panel Hearing

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

The notice must include the following:

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

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

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

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

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

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

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

The chair shall ensure that the investigated governor receives:

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

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

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

Appeal

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

Non-Executive Director

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

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

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

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

- The process for the appeal hearing

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

Support for the Governor

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

Sanctions

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

- Issuing a written warning as to future conduct. This shall remain on the governor's record for the remainder of their term of office
- Requiring the investigated governor to provide written undertakings as to future conduct
- Withholding the payment of expenses, if the breach related to the wrongful claiming of expenses
- Removal from office as a governor and removal as a member of the Trust

Dismissal

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

Governors' Work Programme 2024-25

Timing	Themes	Rationale	Led by
30 January 2024	• Governance and the role of governors • Effective questioning and challenge • Member and public engagement • NHS structure	Interests of members and the public	NHS Providers
29 April 2024	Briefing on Virtual Wards	Interests of members and the public.	As agreed/VW consultant lead Dr Vivian Yiu
13 June 2024	Essex & Suffolk Elective Orthopaedic Centre (ESEOC) Engagement	Interests of members and the public.	Associate Director of Communications/COO/Head of Patient Experience & Engagement
13 August 2024	Living the Trust values	Interests of members and the public	Chief Executive, Director of Workforce, FTSU Guardians
23 October 2024	Session on Future Systems Programme	Holding the NEDs to account for the performance of the Board	Chief Executive / others as agreed
13 November 2024	WSFT & ESNEFT Governors' Collaboration Meeting		Trust Chairs Stephanie Rose, Programme Director Suffolk and North Essex Provider Collaborative=
5 December 2024	Session on "Making Data Count"	Interests of members and the public	Karen Hayllar, NHS England
4 March 2025	Session on Integrated Care Board introduction and provider collaboration	Interests of members and the public	ICB partners/Chair/Trust Secretary

Timing	Themes	Rationale	Led by
TBC – March/April '25	Understanding of the Trust's strategy and delivery plans	Item from annual skills audit – we are liaising with Sam Tappenden to schedule engagement with the governors as part of the review of the Trust's strategy and priorities	Director of Strategy and Transformation
TBC – March/April '25	The role of the Foundation Trust Governor and practical ways to carry out the statutory roles of a governor	Item from annual skills audit – considering options for local delivery to support working of the Council	Trust Secretary
TBC – April/June '25	CQC inspection framework	Forward plan topic.	Sue Wilkinson
TBC	Themes of interest that have emerged from the governors' skills audit 2024 will be incorporated into the training and governor work programme 2025: ➢ Building relationships with the Board of Directors, including non-executive directors ➢ Assessing performance of board and individuals, including understanding more about how governors hold non-executive directors to account. The following items are included in the programme as specific items: ➢ Understanding of the Trust's strategy and delivery plans ➢ The role of the Foundation Trust Governor and practical ways to carry out the statutory roles of a governor	These were reviewed in the Standards Committee in August and will be delivered through a range of ad hoc sessions as well as governor training events. The programme will be developed to reflect these priorities.	Trust Secretary

Timing	Themes	Rationale	Led by
	➢ CQC new inspection framework ➢ Data interpretation and how governors make use of the data – scheduled on 5 December 2024		

12. Staff Governor Report (enclosed)

To receive a report from the Staff Governors

To Note

Presented by Anna Clapton (nee Mills)

WSFT Council of Governors meeting (Open)	
Report title:	Staff Governors' report
Agenda item:	12
Date of the meeting:	19 November 2024
Sponsor/executive lead:	Staff Governors
Report prepared by:	Richard Jones, Trust Secretary & Head of Governance Pooja Sharma, Deputy Trust Secretary Ruth Williamson, Foundation Trust Office

Purpose of the report:

For approval ☐	For assurance ☐	For discussion ☒	For information ☒
Trust strategy ambitions	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
Please indicate Trust strategy ambitions relevant to this report.	☒	☒	☒

Executive summary:

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

The Staff Governors met on 1 October 2024. The report summarises discussions that took place.

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

The meeting was attended by the staff governors Anna Clapton (nee Mills), John-Paul (J-P) Holt, Andy Morris, Adam Musgrove, Louisa Honeybun, Jeremy Over (director of workforce & communications), Jane Sharland (Freedom to speak up Guardian) and Pooja Sharma (Deputy Trust secretary).

Summary/Highlights:

Freedom to Speak Up – update on themes: The staff governors noted an overview of themes related to speaking up within the Trust from the last quarter which included preceptorship pressures, role of nursing associates, investigations (HR and conduct), community, colleague relationships, environmental issues from night shift, staff wellbeing service. Recruitment of FTSU Champions continues, with improvements noted in champion levels. Clarification was sought as to whether governors should also be FTSU champions and it was clarified that a discussion took place at the national FTSU Guardian forum where it was felt preferable to keep the roles separate, as matters could become complicated as to which role was being performed.

It was highlighted that there were approximately 300 volunteers working in the Trust and the question raised as to whether they were made aware of the role of the FTSU Guardian and the ability to speak up, should they so wish to. The FTSU Guardian confirmed that volunteers are very much part of the organisation and work to raise awareness is being taken forward.

Staff Governor Engagement – raising the governor profile: Update on suggestions made for staff governor engagement activities was noted. Some of the proposed engagement activities included staff governor stand in Time Out, staff governor profiles in the Green Sheet, proposal for governors to make pledges, approaching staff networks and attendance at off-site hubs.

Staff Governor response to Trust actions involving staff: The staff governors reiterated that it would be helpful if they are made aware of any actions taken by the Trust that impacts staff and be given advance warning and reasoning behind such decisions in order to be able to facilitate discussions with the staff.

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.

Action required / Recommendation:

The Council of Governors is asked to note the report from the meeting held on 1 October 2024.

Previously considered by:	Staff Governors
Risk and assurance:	Council of Governors unable to undertake its statutory duties.
Equality, diversity and inclusion:	N/A
Sustainability:	N/A
Legal and regulatory context:	West Suffolk NHS Foundation Trust Constitution Health & Social Care Act 2022 NHSE Code of Governance 2022

13. Lead Governor Report (enclosed)

To receive a report from the Lead Governor

To Note

Presented by Jane Skinner

WSFT Council of Governors' Meeting (Open)	
Report title:	Lead Governor Report
Agenda item:	13
Date of the meeting:	19 November 2024
Sponsor/executive lead:	Jane Skinner, lead governor
Report prepared by:	Jane Skinner, lead governor

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

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

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

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

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

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

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

Governors will continue to carry out activities and to develop engagement strategies which are in line with the achievement of their Statutory duties and responsibilities.
Action Required
The Council of Governors is asked to note the report.

Risk and assurance:	N/A
Equality, Diversity and Inclusion:	N/A
Sustainability:	N/A
Legal and regulatory context	NHS Act 2006 Social Care Act 2012 WSHFT Constitution WSHFT Governors Code of Conduct

Lead Governor Report	
1.	**Introduction**
1.1	This report will highlight some of the Governor activities carried out during the last quarter.
1.2	The Executive Director of Finance outlined the Trust's financial position to us at the last CoG. The financial recovery plan will be presented at this CoG meeting. A very helpful and comprehensive glossary of financial terms is now available to us on Convene.
1.3	These are uncertain times for Trust staff, given the Trust's financial position and cost saving controls already in place, with more to come. These are impacting on staff in the workplace. Governors have been made aware of the concerns of some individual staff and staff groups. These concerns, as expressed to Staff Governors, and by email to me, have been passed on to the Chair. A meeting has been arranged with the CEO, Trust Chair and Staff Governors to discuss further.
1.4	As representatives of members and the public Governors are worried about the impact of cost savings on staff including staff morale, patients and services. We must continue to seek assurance that the equality and clinical impact of savings are fully assessed, communicated and understood.
2.	**CoG Sub-Committees**
2.1	**Engagement Committee** I would like to thank the Chair, Sarah Hanratty, Committee members and Trust staff Richard, Pooja and Ruth, for their work in updating and rewriting the Membership and Engagement Strategy. Further information will be available in the Committee Chair's Report, an agenda item to this CoG. Since March, Governors and NEDs have visited 14 Trust departments on "15 Steps" visits. Governors have participated in Courtyard and Newmarket café visits, during which conversations are had with visitors and satisfaction/experience surveys completed. We have carried out environmental reviews with estates staff and participated in area observations. These activities support continuous improvement and are a valuable source of qualitative information. Members of the Committee observe the Trust VOICE group and attend The Trust Experience of Care and Engagement Committee. Feedback is given to the whole Committee. A thematic report will be available to the CoG. The Committee is keen that any staff and patient concerns and estates recommendations are followed through and not forgotten about. The Deputy Director of Nursing has been really helpful in providing the Committee feedback on changes made as a result of our feedback. Our visits always highlight many excellent practices, which are also fed back to staff. Governors are very grateful to staff for allowing us to visit their departments and for their time, transparency and openness.
2.2	**Nominations and Remuneration Committee** The NEDs terms of office were noted: no recruitment requirements in the near future. The annual remuneration options for the Chair and NEDs were reviewed. The Committee's recommended option will be presented at the closed CoG.
2.3	**Standards Committee** A change to the Trust Constitution, giving Governors an option to return as Governors after a 2-year break, having already completed 9 years in office, was recommended to the COG, and ratified in September. (Currently Governors can complete 3 terms or 9 years in office with no return allowed) This amendment was not approved by the Board on 27 September. The Standards Committee agreed that this recommendation would be resubmitted to the next Board meeting together with the requested information. Concern was expressed that some Governors, having volunteered to be CoG sub-committee members, were not attending meetings. Consideration was given to addressing this with the few individuals concerned to find out why and if appropriate replace them on the committee.
3.	**Annual Members Meeting (AMM) September 24** This is always an excellent occasion for Governors to meet the members they represent, it was a well-attended meeting by members, staff and Governors with information stalls and presentations. I was interested to hear, from Regional Lead Governors at our last meeting, that some Trusts are still holding their AMMs via Teams and that attendance is much less than at our meeting.

4.	**Board Assurance Meetings** Governors continue to observe monthly assurance meetings, their reports are submitted as agenda items to this CoG. We also have opportunity to question the Chairs of these meetings during the presentations of their KPIs to the CoG, which I encourage Governors to do. Governors are reminded that the approved Closed Board minutes and Assurance Committees approved minutes are available to read on Convene. Also, a reminder that Governors are able to observe Board meetings and take opportunity to ask questions as an agenda item. Questions seeking assurance can also be submitted to the Trust office via the dedicated email.
5.	**Governor Updates and Development** Thanks to Gary Norgate for Teams presentation and update on the new hospital program. Governors also enjoyed a site visit via the new access road recently.
6.	**Changes to the CoG** Partner Governor Elspeth Lees has resigned from the Council, we wish her well for the future. Her replacement has not yet been appointed. We welcome new Partner Governor Dr Evelin Hanikat to the Council. Evelin is a GP in Brandon and Deputy Medical Director SNEE ICB.
7.	**Conclusion** I would like to thank all the Governors for their commitment to the role. On behalf of the Governors I would like to conclude by thanking staff across the Trust for their hard work. We are always impressed by the staff we meet on our Trust visits and can see from the Staff Brief and Green Sheet the many good ideas and achievements of our staff.

ITEMS FOR INFORMATION

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

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

To Note

Presented by Jude Chin

WSFT Council of Governors Meeting (Open)	
Report title:	Summary Report for Board of Directors meetings
Agenda item:	14
Date of the meeting:	19 November 2024
Sponsor/executive lead:	Jude Chin, Trust Chair
Report prepared by:	Richard Jones, Trust Secretary & Head of Governance Pooja Sharma, Deputy Trust Secretary Ruth Williamson, Foundation Trust Office 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 report is from the Board of Directors to the Council of Governors and recognises the statutory duties of the Governors to:

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

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

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

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

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

The Council of Governors to review this report in order to:

- consider any elements relating to the **performance of the board** arising from this report which they wish to raise with the non-executive directors,

• consider any **areas of priority** identified in this report for future engagement with members and the public.
Action required / Recommendation:
The Council of Governors is asked to note and review the summary report.

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

Board of Director Key Issues

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Board of Director Key Issues – 27 September 2024			
Patient Story – a pre-recorded story was heard from the wife of a patient who had passed away at the Trust in November, 2020. Diagnosed in 2018 with inoperable cancer, an emergency admission took place in November, 2020, due to infection. There was a delay in recognising the husband was in the last days of life, and was heavily sedated at the time the family arrived, resulting in an inability for them to say a meaningful goodbye. Changes have been made to end of life care from the learning of this story with the introduction of Call4Concern, enabling patients and their families to raise concerns with a peripatetic team. RESPECT also provides an opportunity for open and honest discussions with patients and families to ensure their wishes are respected.	• To improve end of life care for patients and their families.	• Model for future care	Verbal
Strategic Priorities Report – the Trust has signed up to the NHS Smoke Free Pledge. Working out of the Emergency Department, with assistance from Suffolk County Council and the Trust's Tobacco Dependence Team, people will be encouraged to give up smoking.	• Ongoing assurance/monitoring	• Deliver the Trust strategy	2.1
Future System Board Report – confirmation received that RAAC hospitals will not be included in the new hospital programme review.	• Ongoing assurance/monitoring • Board to receive future updates	• Sustainable service improvements	2.2
SNEE ICB Joint Forward Plan Update – Alexander Royan, Deputy Director for Strategic Analytics, SNEE ICB attended the meeting to provide an update. Feedback provided by the Board will be taken into consideration for the strategy refresh, alongside the request for integration of public health grants received by local councils.	• Strengthened provider collaboration	• Focus on system working	2.3

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
West Suffolk Alliance and SNEE Integrated Care Board: ***Bus Routes*** - from Mildenhall, Sudbury and Haverhill have been amended to include direct access to the hospital, rather than having to change buses in the town. ***Dental Commissioning*** – four practices (two in Haverhill and one in Sudbury and Mildenhall) on a sessional basis, will undertake treatment for those most in need, i.e. cancer patients and those calling 111. ***Health Equity*** – approval granted for the West Suffolk Equity Plan, which aims to improve health outcomes for target populations showing adverse variation for specific health indicators. Actions will include Bury St. Edmunds, Mildenhall, Haverhill, Sudbury and Mildenhall.	• Strengthened provider collaboration	• Focus on system working	2.4
Digital Board Report – the Trust scored the second highest of 14 acute trusts in the Digital Maturity Assessment. Data from this was used to inform part of the Darzi report an independent investigation of the NHS in England.	• Ongoing assurance/monitoring		2.5
IQPR Report – incident rates of c-difficile have been variable and reasons multi-faceted. The Trust has gained assurance from the Chief Nurse of the ICB that it is doing all it can to minimise. The Trust is trialling a minor emergency care unit from the middle of October in order to stream patients with minor injuries to a different space.	•		3.1
Finance Report – the Board has approved an application for revenue support in the sum of £17million.	• Ongoing assurance/monitoring	• Financial sustainability	3.2

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Involvement Committee – the Board received a report of the meeting held in August, 2024. Areas of key concern for the local population regarding the transfer of some elected orthopaedic care to Essex and Suffolk Elective Orthopaedic Centre (ESEOC) was discussed, i.e. travel in winter, use of public transport and cost of same. Noted further work is being carried out with the ICB to address these.	• Detailed analysis of CKIs	• Workforce sustainability	4.1
Insight Committee – the Board received a report of the meetings held in August and September, 2024. Sixty-five week waits discussed and impact of industrial action and a contamination incident noted. The Trust is working on agreement of an end-date for these waits.	• Focus on improvement	-	5.1
Improvement Committee – the Board received a report of the meetings held in August and September, 2024. Basic Life Support (BLS) training compliance issue discussed. Noted those staff undertaking the higher level of training did not require the basic and this data will be cleansed.	• Ongoing assurance/monitoring	-	6.1
Response to Well Led Report – the report has been through the Improvement Committee and received its support. An update on progress will be received by Improvement in April, 2025 and in turn the Board.	•		6.2
Quality and Nurse Staffing Report – fill and turnover rates for nursing assistants noted. The Care Certificate Programme is helping and includes regular visits to ensure staff are being supported.	• Ongoing assurance/monitoring • Overseeing quality indicators		6.3
Maternity Services – Promotion of Health, Opportunity, Equality, Benevolence and Empowerment (PHOEBE), a charity offering specialist advice, information, casework, advocacy and support and counselling services to black and ethnic minority women and children, based in Ipswich, have agreed to support the Trust in the delivery of antenatal education to this cohort.	• Ongoing assurance/monitoring in areas of priority		6.4

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Charitable Funds Committee Report – Role of Chair has passed to Richard Flatman, non-executive director. Chief Nurse and Medical Director have been invited to join the membership to provide a clinical perspective. Approval granted by the committee to proceed with a fundraising appeal to purchase a robot for the trust, subject to provision of assurance on the underwriting risk to the organisation by the Management Executive Group to the Board.	• Board visibility and oversight		7.1
Board Assurance Framework - regular reporting on the Board Assurance Framework (BAF) is being undertaken at the Management Executive Group (MEG), alongside visibility at the assurance committees.	• To update the BAF based on agreed strategic objectives • Alignment of the risks to the assurance committees with the Board to receive findings of assurance reviews that are undertaken	• Risk oversight • Risk appetite	7.2
Governance Report - Board approval sought to amend Trust Constitution, as recommended by the Council of Governors (CoG) so that a Governor who has reached the maximum term becomes eligible to stand for re-election after a break period of at least two years. Clarity was sought on plans to engage different groups to the role.	• Board oversight	-	7.3

15. Any other business

For Discussion

Presented by Jude Chin

16. Dates for meetings for 2025:

- 26 February, 2025
- 14 May, 2025
- 11 September, 2025
- 13 November, 2025
- Annual Members' Meeting - TBC

To Note

Presented by Jude Chin

17. Reflections on meeting

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

For Consideration

Presented by Jude Chin

CLOSE

SUPPORTING ANNEXES

Item 8 - IQPR full Report - August

Assurance Grid

August 2024		ASSURANCE		Not Met
		Pass	Hit and Miss	Fail
VARIANCE	Special Cause Improvement		**INSIGHT** % Patients with No Criteria to Reside **INVOLVEMENT** Staff Sickness – Rolling 12month Staff Sickness Turnover	**INSIGHT** Incomplete 104 Day Waits RTT 78+ Week Waits **INVOLVEMENT** Appraisal
	Common Cause	**INSIGHT** 4 Hour Breaches Urgent 2 Hour Response - EIT	Please see box to right	**INSIGHT** 12 Hour Breaches 4 Hour Performance Respiratory Bay Average Occupancy Number Heart Failure Bay Average Occupancy Number IV Abx Bay Average Occupancy Number Frailty Bay Average Occupancy Number
Deteriorating	Special Cause Concern		**INSIGHT** Total Average Occupancy Percentage Community Paediatrics RTT Overall 78 Weeks Wait	**INSIGHT** Total Average Occupancy Number

Indicators for escalation as the variation demonstrated shows we will not reliably hit the target. For these metrics, the system needs to be redesigned to reduce variation and create sustainable improvement.

INSIGHT:
Ambulance Handover within 30min
Non-Admitted 4 Hour Performance
12 Hour Breaches as a Percentage of Attendances
Total Average LOS per Patient
28 Day Faster Diagnosis
Cancer 62 Days Performance
Community Paediatrics RTT Overall 104 Weeks Wait
IMPROVEMENT:
C-Diff Hospital & Community
INVOLVEMENT:
Mandatory Training

*Cancer data is 1 month behind

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:
INSIGHT - Urgent & Emergency Care: 12 Hour Breaches, 4 Hour Performance, Total Average Occupancy Number, Total Average Occupancy Percentage, Respiratory Bay Average Occupancy Number, Heart Failure Bay Average Occupancy Number, IV Abx Bay Average Occupancy Number, Frailty Bay Average Occupancy Number
Cancer: Incomplete 104 Day Waits
Elective: RTT 78+ Week Waits, Community Paediatrics RTT Overall 78 Weeks Wait
INVOLVEMENT – Well Led: Appraisal

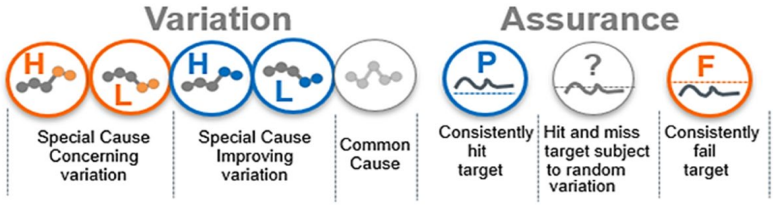
INSIGHT COMMITTEE METRICS

Urgent & Emergency Care summary

Chart Legend

Target — Mean — Measure

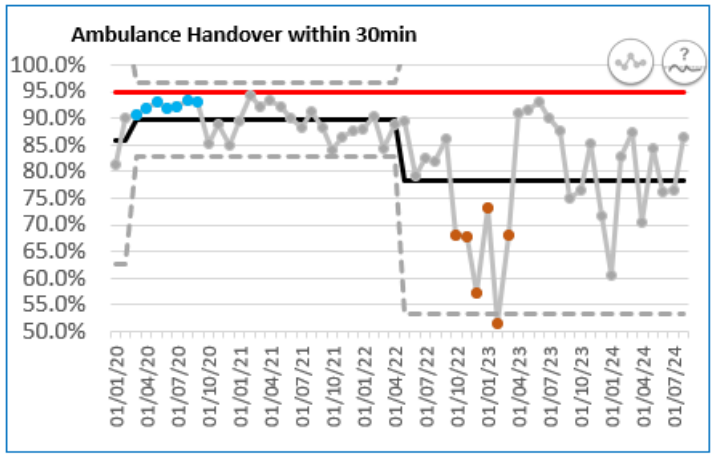
Process Limit — Lower Process Limit

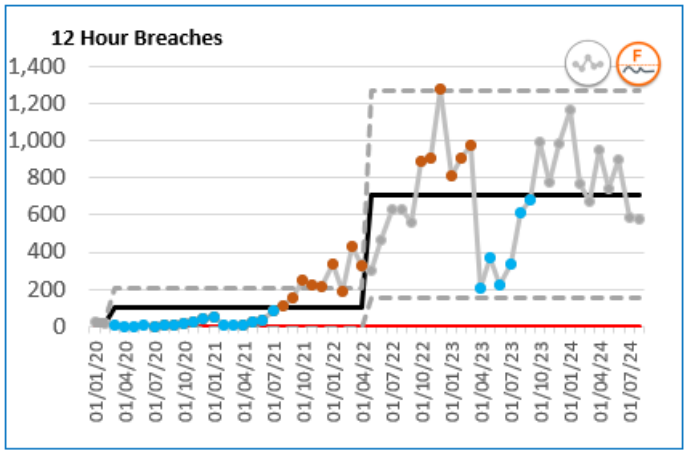


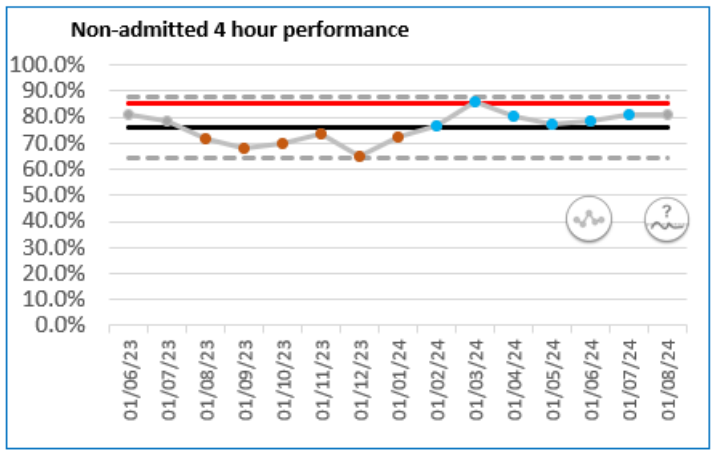
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover within 30min	Aug 24	86.5%	95.0%			78.3%	53.3%	103.3%
12 Hour Breaches	Aug 24	581	0			709	153	1266
4 hour breaches	Aug 24	2476	0			2720	2001	3439
4 hour performance	Aug 24	69.6%	78.0%			66.2%	55.9%	76.4%
Non-admitted 4 hour performance	Aug 24	81.0%	85.0%			76.1%	64.6%	87.6%
12 hour breaches as a percentage of attendances	Aug 24	7.1%	2.0%			5.2%	1.1%	9.4%
Urgent 2 hour response - EIT	Aug 24	91.7%	70.0%			90.4%	82.9%	97.9%
Criteria to reside (Average without reason to reside) Acute	Aug 24	38				56	41	71
**Criteria to reside (Average without reason to reside) Community	Aug 24	35				19	14	25
% patients with no criteria to reside	Aug 24	9.5%	10.0%			13.0%	8.7%	17.2%
Virtual Beds Trajectory	Aug 24	40	40					
Total average occupancy number	Aug 24	26.3	80.0			23.7	15.4	32.0
Total average occupancy percentage	Aug 24	66%	80%			72%	44%	99%
Total bed days on VW	Aug 24	861	-			639	295	983
Total average LOS per patient	Aug 24	8.5	14.0			9.8	4.0	15.5
Respiratory Bay average occupancy number	Aug 24	1.4	8.0			2.8	-0.8	6.5
Heart Failure Bay average occupancy number	Aug 24	4.1	12.0			5.3	1.4	9.3
IV Abx Bay average occupancy number	Aug 24	1.9	6.4			2.4	-0.8	5.6
Frailty Bay average occupancy number	Aug 24	4.3	16.0			2.9	-0.5	6.2

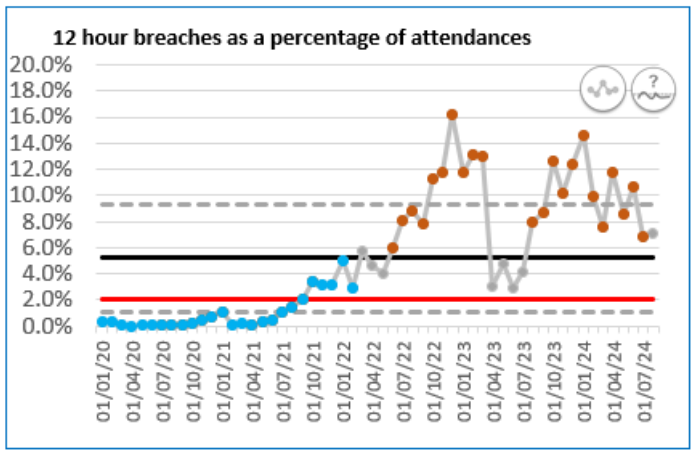
** Figures are for Glastonbury and Newmarket only, data not currently captured at Hazel Court.

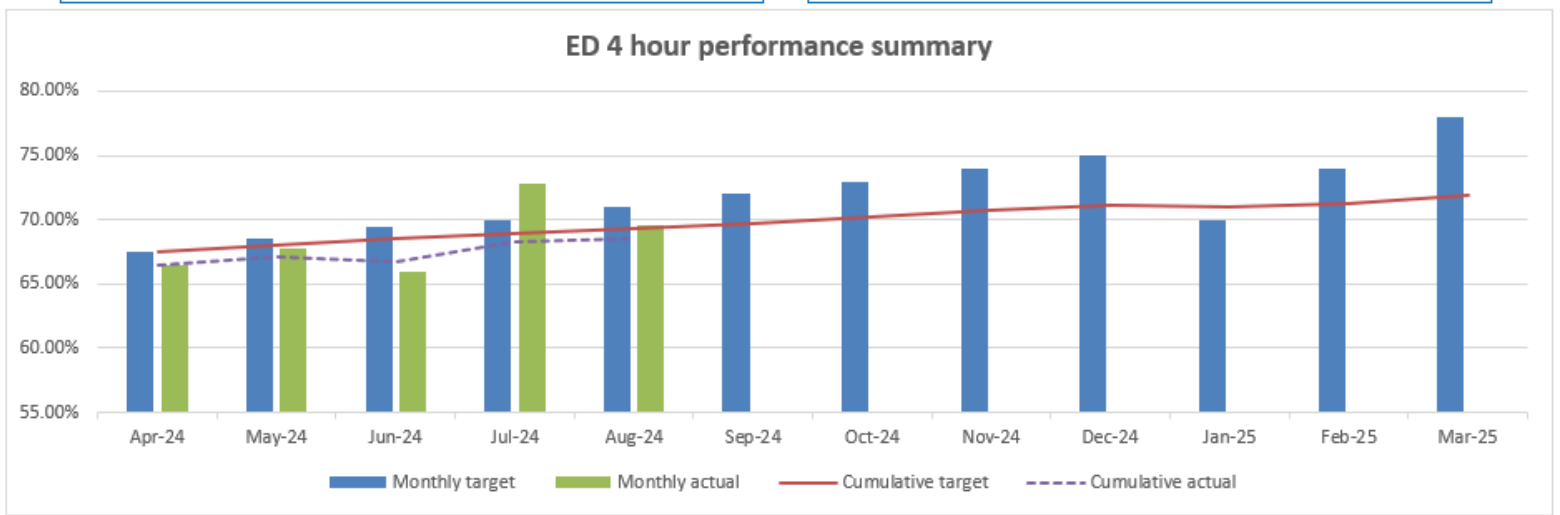
Urgent & Emergency Care: ED 4 Hour Performance











Urgent & Emergency Care

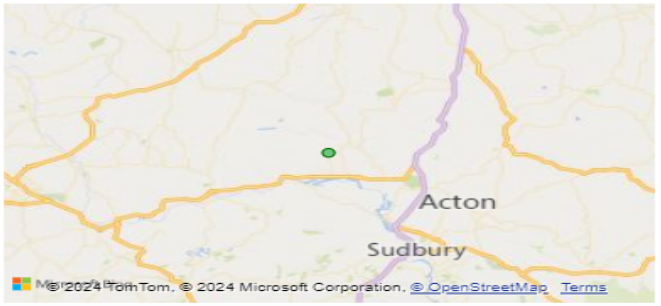
What	So What?	What Next?
30 minute Ambulance handover performance shows no significant change and continues to remain a challenge. The factors contributing to this include the number of patients in the Emergency Department with an increased length of stay waiting for a bed, resulting in the need to cohort patients into escalation areas including the Rapid Assessment Triage Area, which then reduces our ability and capacity to offload ambulances. The number of 12 hour length of stay breaches in the month of August demonstrates no significant change, with 581 patients breaching. We continue not to meet this metric. The number of 12 hour breaches as a percentage of attendances shows no significant change, remaining a concern. Non-admitted performance demonstrates no significant change and was 80.95% for the month of August. The Emergency Department 4 hour performance dropped below our in-month trajectory of 71% to 69.6 %.	Meeting the Urgent and Emergency Care (UEC) performance metrics is key to ensuring 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. Reaching the trajectory will keep us on track to achieve 78% by March for the 4 hour standard. Some patients are waiting longer in the Emergency Department than they should be and being nursed in escalation areas, making for a poorer patient experience.	Revised Urgent and Emergency Care action plan developed with a trajectory to achieve 78% 4hr Emergency Department target by March '25. An internal Urgent and Emergency Care delivery group with workstream leads is in operation. Weekly triumvirate performance meetings between the Emergency Department and Medical Division Senior Leaders with an associated action plan. Robust data and clinical review for periods of reduced performance to obtain learning to improve performance. Focussed work for improving overnight Emergency Department performance including: • Template guidance for Emergency Physician in Charge handover with clear actions for night • Focused leadership training for Registrars overnight to be included within study sessions • Support from the Organisational Development team in developing the leadership skills of the senior medical team within the Emergency Department. • Profiling of doctor's shift patterns in relation to activity within the department, using the Emergency Care Improvement Support Team (ECIST) Safecare tool. **Projects in August/September '24** • Pre booked next day returner Emergency Nurse Practitioner slots to support minor injuries attending after 10pm commenced 24th August - pilot continues.. • 3-6pm Front Door Rapid Assessment for non admitted patients – consultant/registrar based at point of streaming/triage to assess & discharge or redirect to other services i.e. Same Day Emergency Care. Successful pilot completed. Continuing as business as usual with an increase in hours 1-6pm and planned for future 1pm to midnight. The continuation of the rota for the Emergency Department leadership team to be solely based in department supporting performance. The Acute Admissions Unit also have a similar rota. Enhanced support for last 10 days of September including twilights and weekends, The Minor Emergency Care Unit (MECU) is being delivered on 29th September with a go live date planned for the 14th October.

Community Access Glemsford Surgery

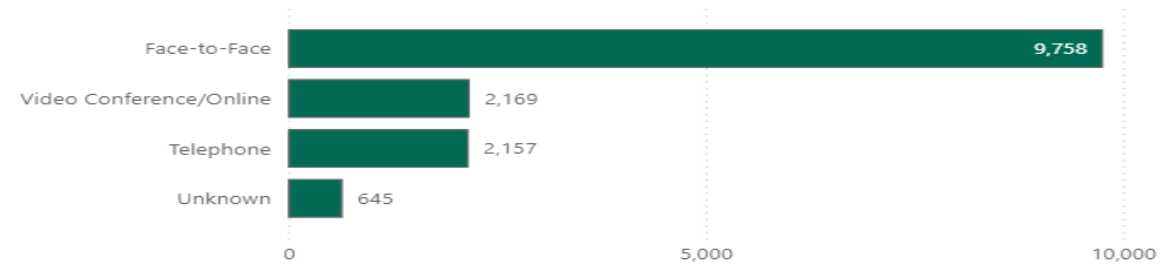
Practice Appointments

Refreshed on 11/09/2024, Data coverage up to 01/07/2024

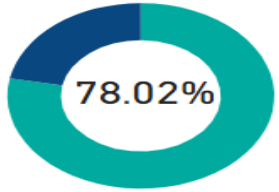
Alliance: All | PCN: All | Practice: Glemsford



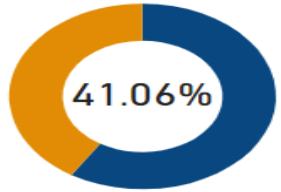
Practice appointments by contact mode



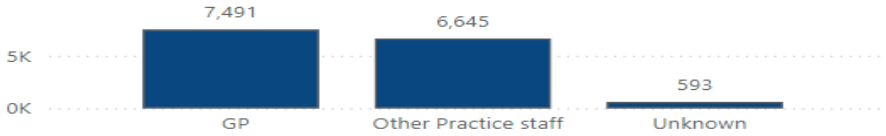
Seen within 2 weeks



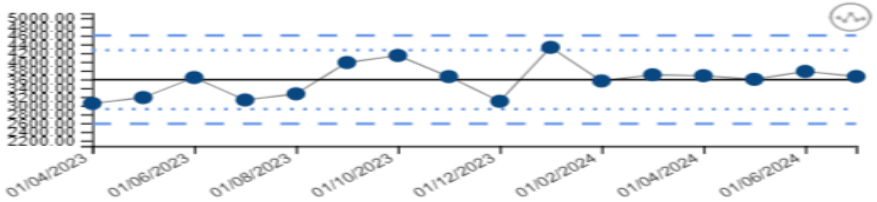
Seen within 48 hours



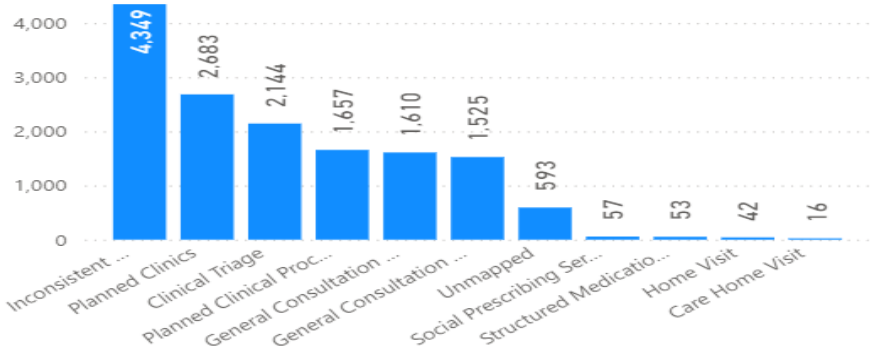
Practice appointments by health care professional type



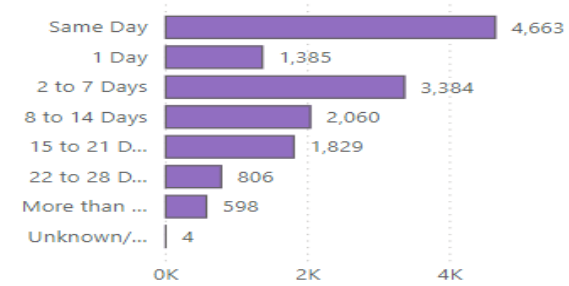
Total appointments by month



Sum of Total Appointments by National Category



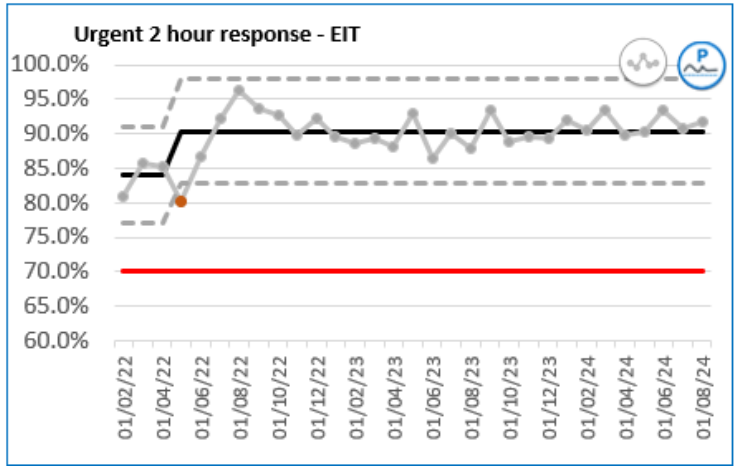
Appointments by wait time

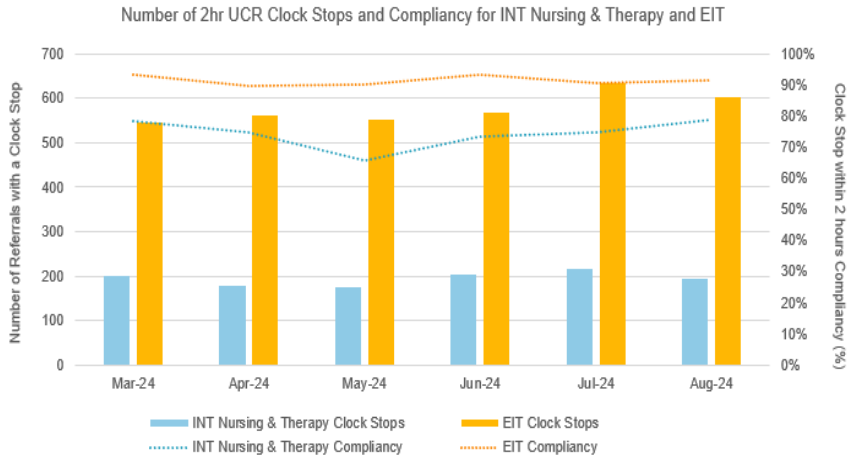


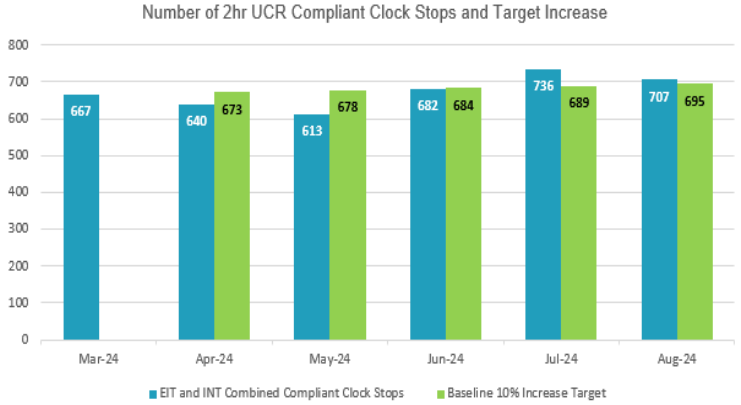
Produced by ICB

What	So What?	What Next?
78% of patients requiring unplanned practice appointments are being seen within 2 weeks, this falls short of the 85% target. The majority of patients are seen within 7 days. The % of patients seen within 2 weeks at Glemsford Surgery has improved since it was last reported March 2024 but has not achieved the target of 85%.	Timely access to primary care is crucial for detecting ill health and improving treatment outcomes.	Doctors' new rosters commenced 1st August 2024. GP vacancy reduced but remains a risk to access delay. Recruitment unsuccessful. Access impact assessment identified opportunity to move to a digital enabled on the day appointment system – this is being procured by the Primary Care Netwok and will provide a triage system. The AI triage system, evaluated well by another local surgery, releases clinical time through safe redirection of minor illness attendance. Introduction planned for November 2024.

Urgent & Emergency Care: UCR







Team	Mar-24				Apr-24				May-24				Jun-24				Jul-24				Aug-24			
	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	201	158	43	79%	179	134	45	75%	175	115	60	66%	204	150	54	74%	217	162	55	75%	194	153	41	79%
Total EIT*	545	509	36	93.39%	563	506	57	89.88%	552	498	54	90.22%	569	532	37	93.50%	633	574	59	90.68%	604	554	50	91.72%
Combined Total	746	667	79	89.41%	742	640	102	86.25%	727	613	114	84.32%	773	682	91	88.23%	850	736	114	86.59%	798	707	91	88.60%

*Using CSDS figures

What

Community 2-hour response remains above 70% compliance target. No significant change to performance.

Emergency Department (ED) data has been amended so now focuses on Early Intervention Team (EIT) capacity and performance. Target of 80% has been set and just below this target.

So What?

Continue to meet national target and also increase in referrals as per alliance plan.

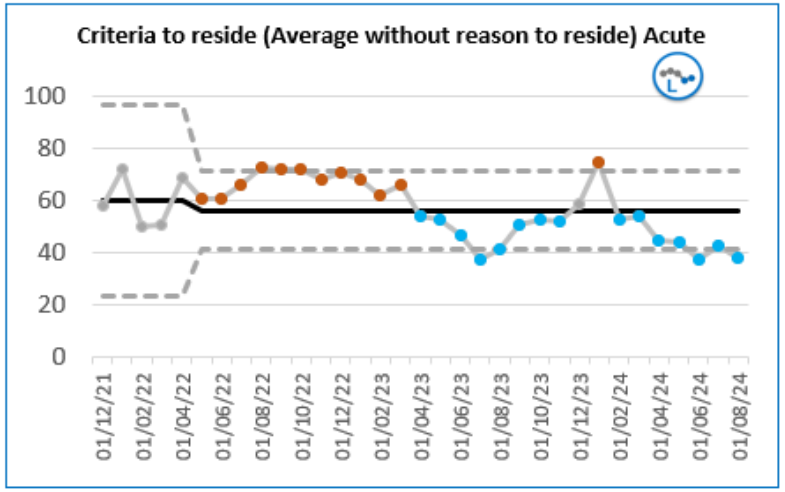
What Next?

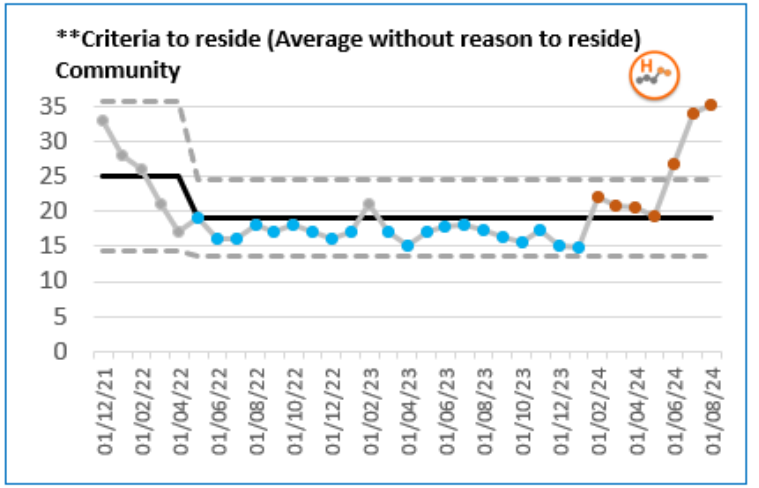
Liaised with IT and information team regarding AAU 4-hour response data. They are aiming to get this added to eCare in early October and EIT will then start to report on this target.

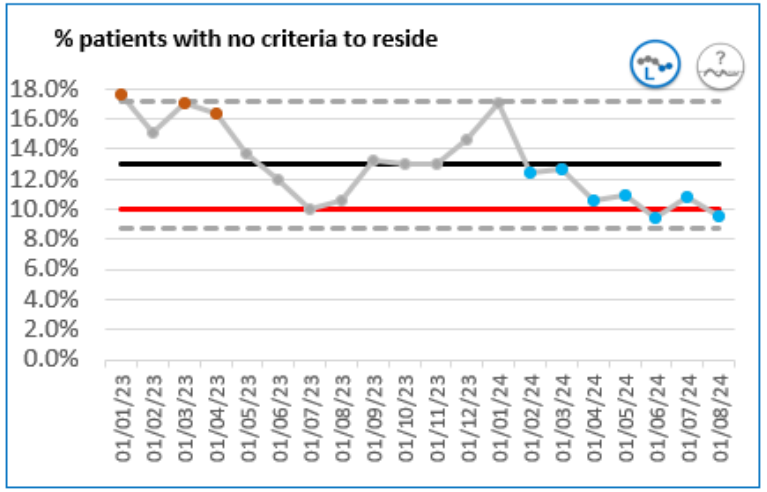
Pilot move for EIT "community therapy and daytime nursing service" to West Suffolk House to commence 1st October for 6 weeks. Will need to track effect on performance for community and ED.

Will monitor community referrals that are "decision not to treat" due to capacity. These are cleric referrals, as the team are prioritising community referrals via the Care Co-ordination Centre (CCC) and acute/ ED work.

Urgent & Emergency Care: Criteria to reside

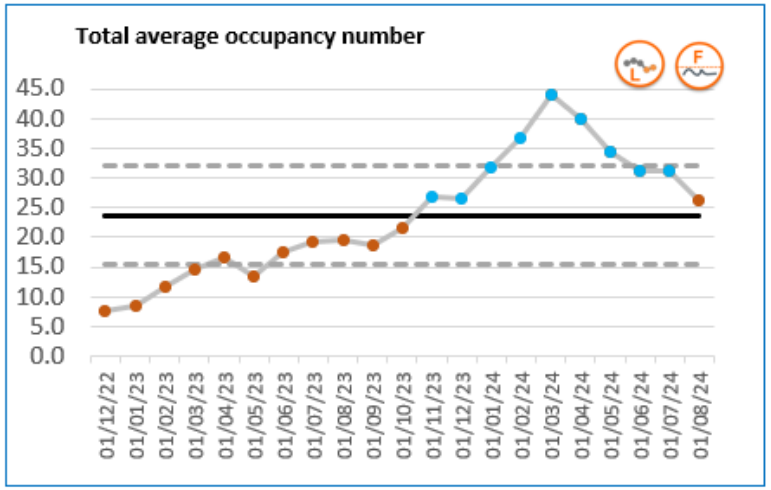


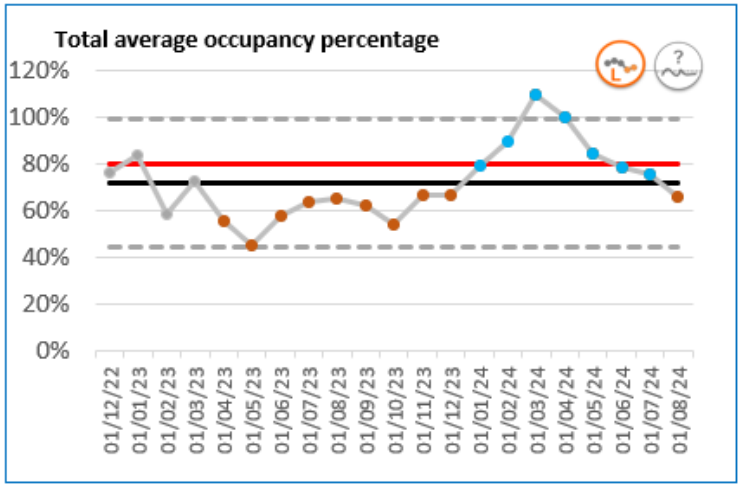


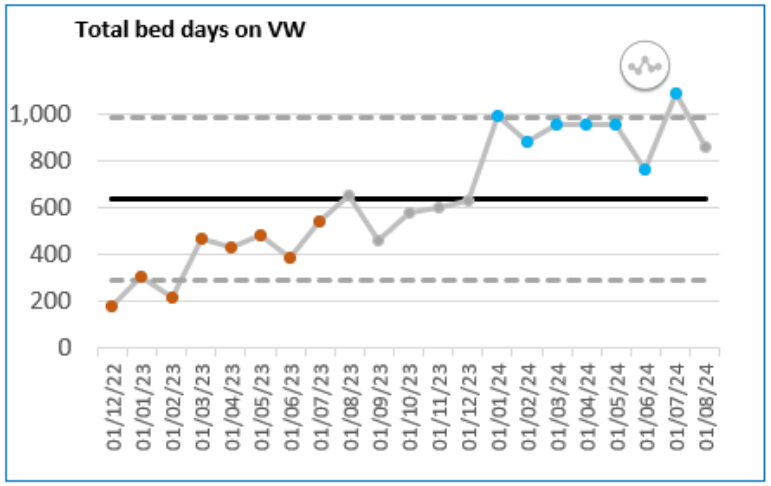


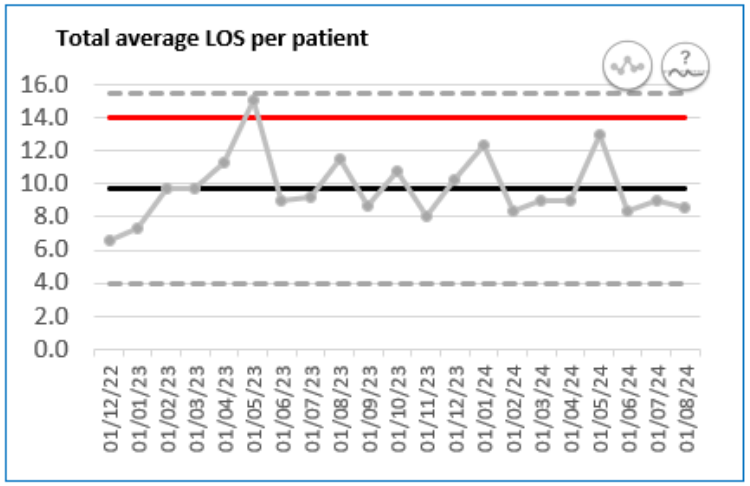
What	So What?	What Next?
August saw a decrease in the average number of patients in the acute setting without reason to reside. This is directly reflected in the % figure which is down to 9% from 11% in July. Throughout August we have continued to see availability in pathway 2 community assessment beds which has enabled the Transfer of Care Hub to transfer a cohort of "non-traditional" patients from the acute setting without reason to reside who are waiting for care or require further assessment or interventions prior to discharge. This however has had a negative impact on the numbers of patients in the community beds without criteria to reside. Please note the community assessment beds from August include patients at Hazel Court Community Assessment Beds (CAB) and the interim Discharge to Assess (D2A) beds funded via the hospital discharge fund.	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.	5 workstreams aiming to reduce the numbers of patients without criteria to reside and improve flow and discharge delays in both acute and community settings – reporting into the Programme Board for Community Adult Services on a monthly basis. Additional work to develop a Standard Operating Procedure for patients moving to CAB alongside acceptance criteria for both CAB and interim beds is being undertaken. A singular Transfer of Care Hub (TOCH) referral is being launched on the 30th September 2024, the aim is to make referring into the TOCH for supported P1-3 discharges easier for referrers, reducing delays and confusion in referrals. A third Stepping Home flat is now fully functioning providing additional capacity for patients waiting for house clearance, deep cleaning or other housing issues before returning home or to their onward discharge destination.

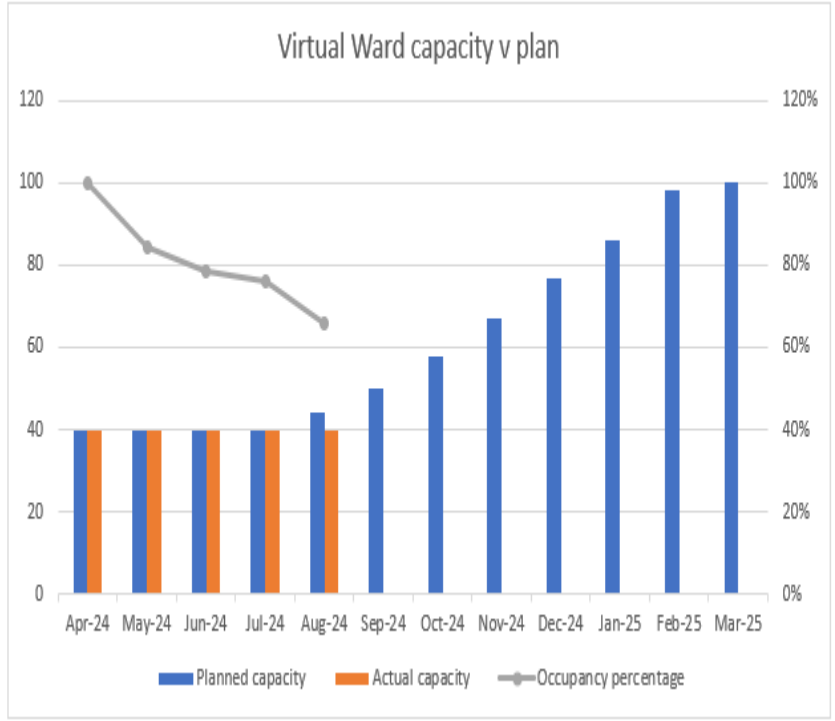
Urgent & Emergency Care (TRUST – Virtual Ward)





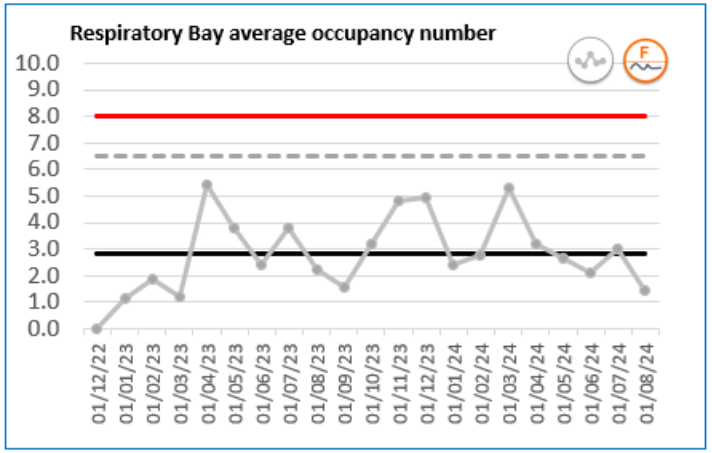


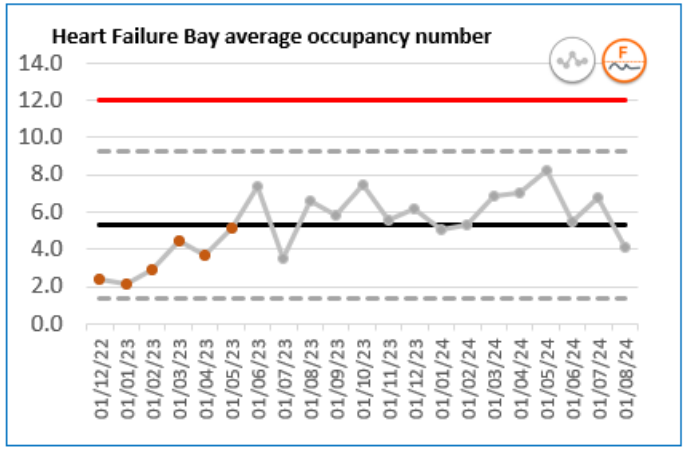


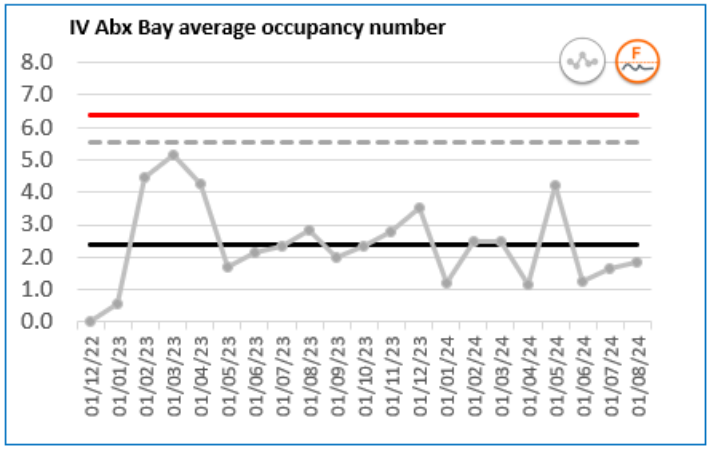


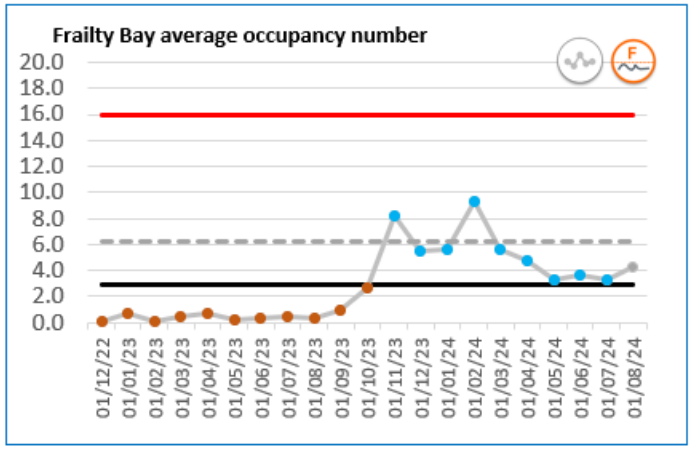
What	So What?	What Next?
Average occupancy on the Virtual Ward (VW) reduced from 76% (July) to 66% in August largely due to constraints in nursing capacity. During the month there were a small number of long stays (complex patients) resulting in an increase in bed nights occupied (increase from 755 in July to 861 in August). This is also reflected in the small increase in Length of Stay from the previous month. Pilot of paediatric pathway went live on 16 September 2024.	Virtual Ward capacity is crucial in ensuring adequate capacity to enable patient flow in West Suffolk and strategic ambition of caring for patients at or near home wherever possible. Appropriate length of stay is important to facilitate effective patient flow across Trust.	Pilot to assess and onboard patients in nursing homes direct to VW commenced in June. Evaluation and review with local partner (Stowhealth Care) on 8 October. Rollout plan (including potential for direct onboarding by primary care colleagues) under development. Integrated service delivery model implemented in Mildenhall therefore VW nursing visits are now managed via Integrated Neighbourhood Team (INT) in this locality. Wider rollout plan into other INTs in place via Shared Service Delivery project.

Urgent & Emergency Care (TRUST – Virtual Ward)



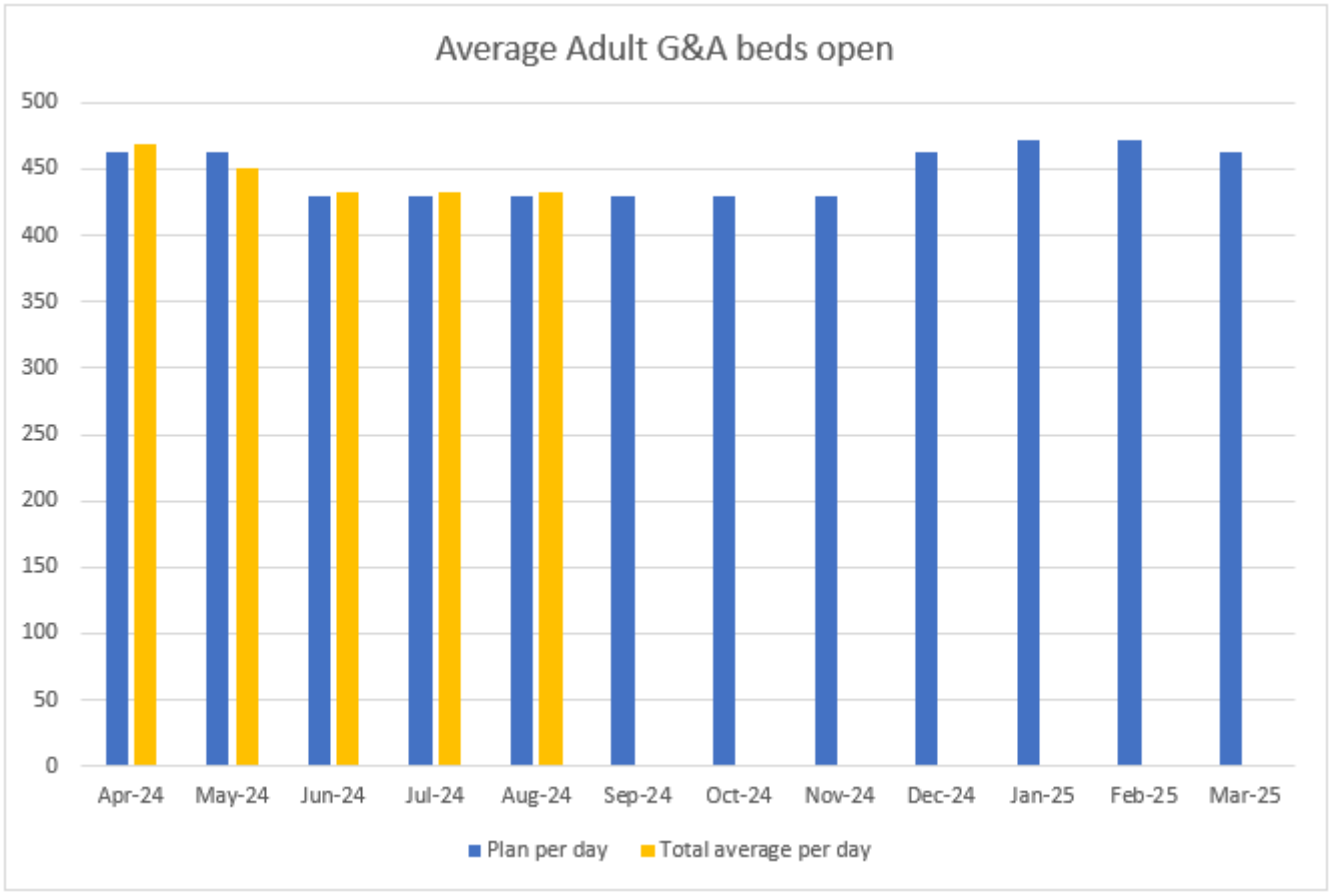






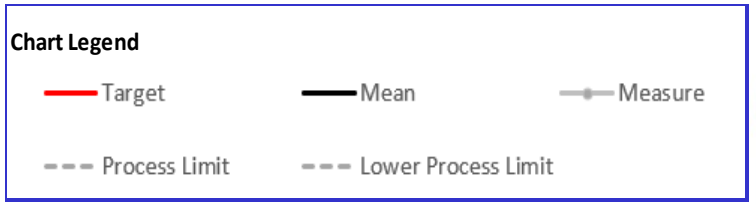
What	So What?	What Next?
Average pathway occupancy during August: Respiratory: average occupancy 1.4 patients (decrease from July) Heart failure: average occupancy 4.1 patients (decrease from July) Intra Venous (IV) Antibiotics: average occupancy 1.9 patients (decrease from July) Frailty: average occupancy 4.3 patients (increase from July)	Virtual Ward capacity is crucial in ensuring adequate capacity to enable patient flow in West Suffolk and strategic ambition of caring for patients at or near home wherever possible.	Agency nursing has been ceased with no further investment for new posts due to Trust financial constraints. This has Impacted the capacity to do nursing visits. Post November, there will be no further expansion of Virtual Ward capacity and therefore focus will be exclusively on occupancy (especially step-ups) and the delivery of a sustainable operating model. Options for the development of virtual care will be presented to Management Executive Group during October with recommendations.

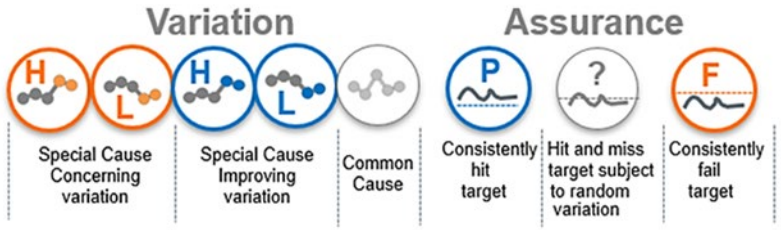
Urgent & Emergency Care: Beds



What	So What?	What Next?
Our actual average number of core beds open has decreased in line with plan, following the full closure of F9 as the winter escalation ward. We have been able to maintain the reduction in the number of unfunded escalation beds open in August through following the Tactical Patient Flow Escalation Plan more robustly, though flow at times has proven challenging with multiple patients awaiting beds in the Emergency Department.	Maintaining core beds open as per plan is a key requirement of the NHS 2024/25 operational priorities and planning guidance. Delivering the plan maximises patient flow and reduces extended waits for admission from the Emergency department, contributing to reduced 12-hour waits and improved 4-hour performance. However, using escalation beds impacts on the ability of those areas being used to fulfil their primary purpose and uses unbudgeted staffing resources.	Use of Medical Same Day Emergency Care (SDEC) as an escalation area is monitored through the daily capacity meetings in conjunction with the Medicine divisional leadership team to ensure it is in line with the Tactical Patient Flow Escalation Plan. Given current numbers of patients waiting >12 hours and for admission in the Emergency Department, it is likely that the planned increase in bed capacity through use of a winter escalation ward will be required.

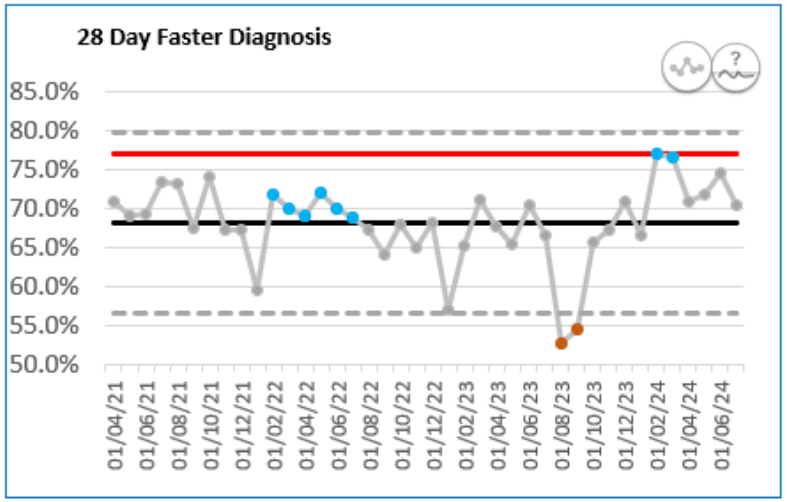
Cancer Access Summary

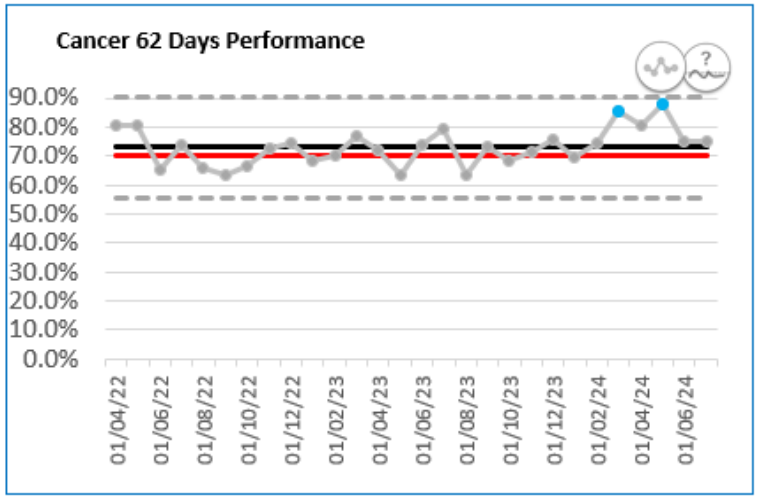


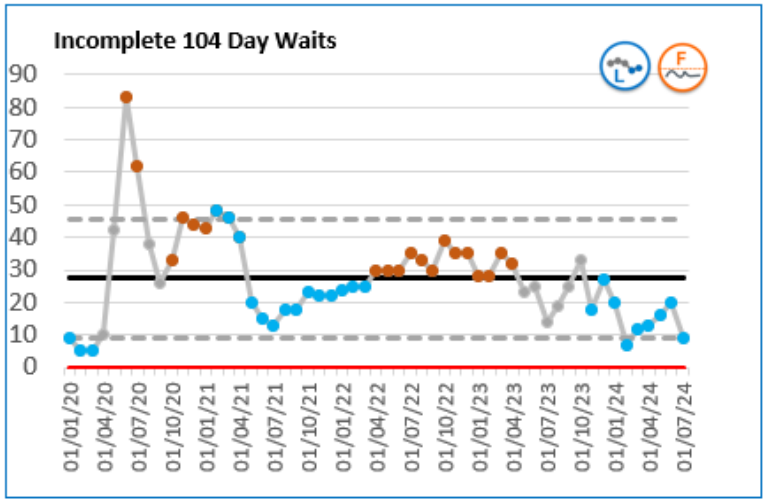


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	Jul 24	70.4%	77.0%			68.2%	56.7%	79.7%
Cancer 62 Days Performance	Jul 24	75.0%	70.0%			73.1%	55.6%	90.6%
Incomplete 104 Day Waits	Jul 24	9	0	L	F	27	9	46

Cancer Access (Month Behind)

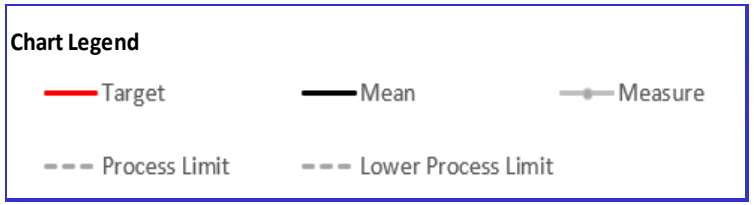


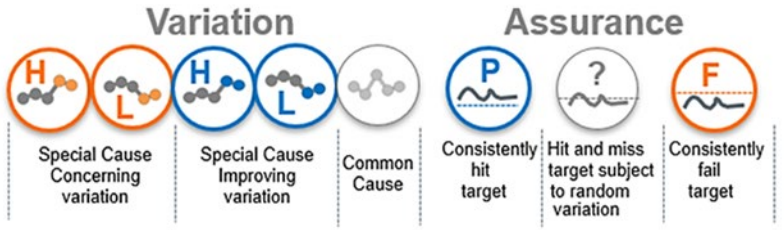




What	So What?	What Next?
Performance against the 28-day Faster Diagnosis Standard (FDS) is not being consistently met, with performance dropping to 70% in July, which is below the trajectory of 75%. Continued challenges with the skin pathway, compounded by an increase in referrals over the summer has the biggest impact on performance, with reduced performance also noted in Gynaecology and Breast. The 62 day performance is above trajectory and above the national requirement of 70% by the end of March 2025.	Achieving the FDS target of 77% and a 62-day performance of 70% March 2025 are the key objectives for cancer in 2024/25 planning.	Continue with FDS steering groups in Skin, Colorectal, Breast and Gynae to monitor performance and required transformational changes as guided by the BPTP audits. Review the impact of the changes made in the skin pathway, such as reducing to one lesion and removing second review of benign lesions via AI. Work commencing on the future of the community pathway from March 2025. Implementation of post menopausal bleeding (PMB) pathway for people receiving HRT to be managed outside an Urgent Suspected Cancer referral by Q3. Monitor the impact of the implementation of risk stratification tools in Prostate to reduce unnecessary progression to MRI and/or progression to biopsy and/or progression to treatment regimens. Review radiological support to the Breast clinics, with external support withdrawing from October 2024 there is significant risk to delivery.

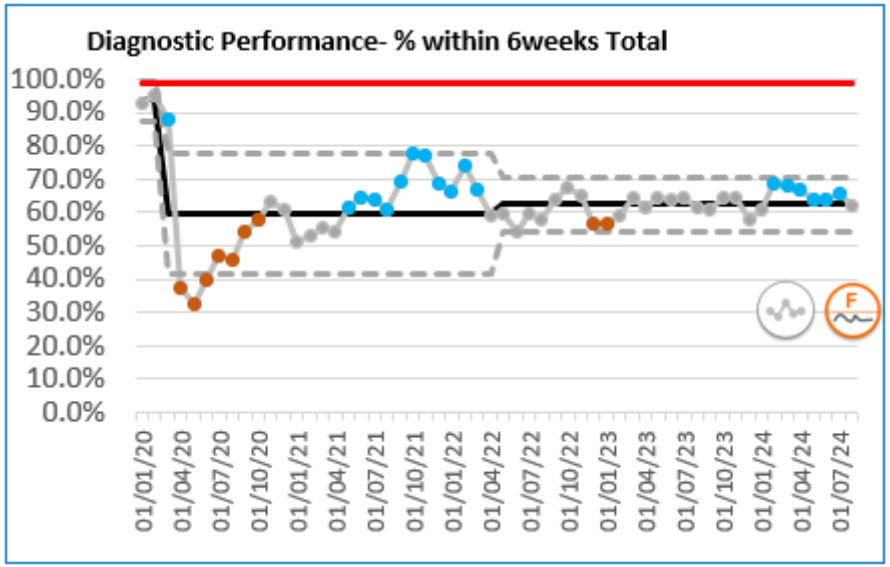
Elective Access: Summary





KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
RTT Waiting List	Aug 24	33887				32795	31389	34201
RTT 65+ Week Waits	Aug 24	463				503	333	673
RTT 78+ Week Waits	Aug 24	53	0			159	90	227
Potential 65+ ww at end of Sept 2024	Aug 24	741	0					
Community Paediatrics RTT Overall Waiting List	Aug 24	565	-			503	448	557
Community Paediatrics RTT Overall 52 Weeks Wait	Aug 24	2	-			1	-2	4
Community Paediatrics RTT Overall 65 Weeks Wait	Aug 24	0	-			0	0	1
Community Paediatrics RTT Overall 78 Weeks Wait	Aug 24	1	0			0	0	0
Community Paediatrics RTT Overall 104 Weeks Wait	Aug 24	0	0			0	0	0
RTT NDD Only Waiting List	Aug 24	74	-			78	51	105
RTT NDD Only 52 Weeks Wait	Aug 24	0	-			0	0	0
RTT NDD Only 65 Weeks Wait	Aug 24	0	-			1	0	1
RTT NDD Only 78 Weeks Wait	Aug 24	0	-			0	-1	2
RTT NDD Only 104 Weeks Wait	Aug 24	0	-			0	0	0

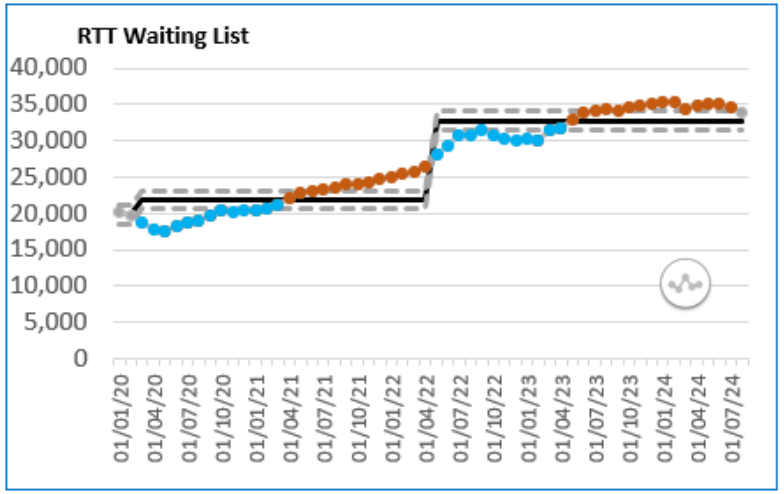
Elective Access

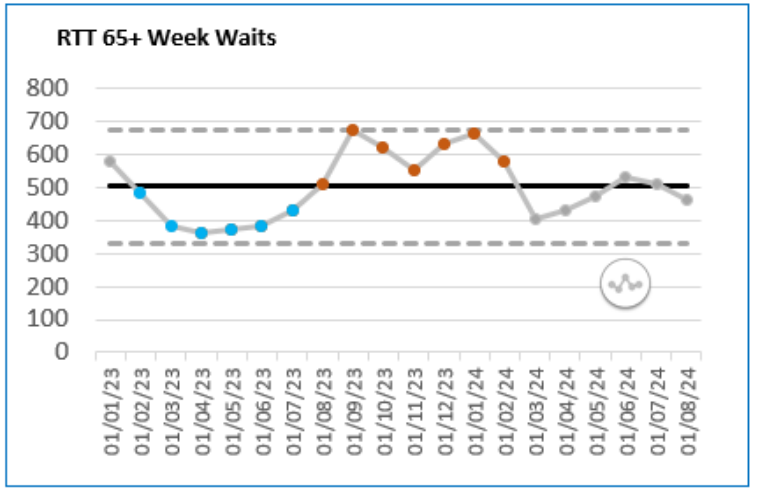


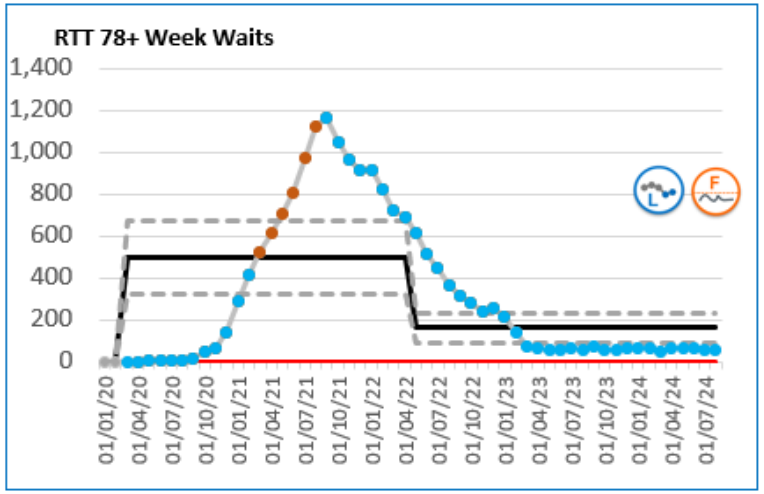
Diagnostics

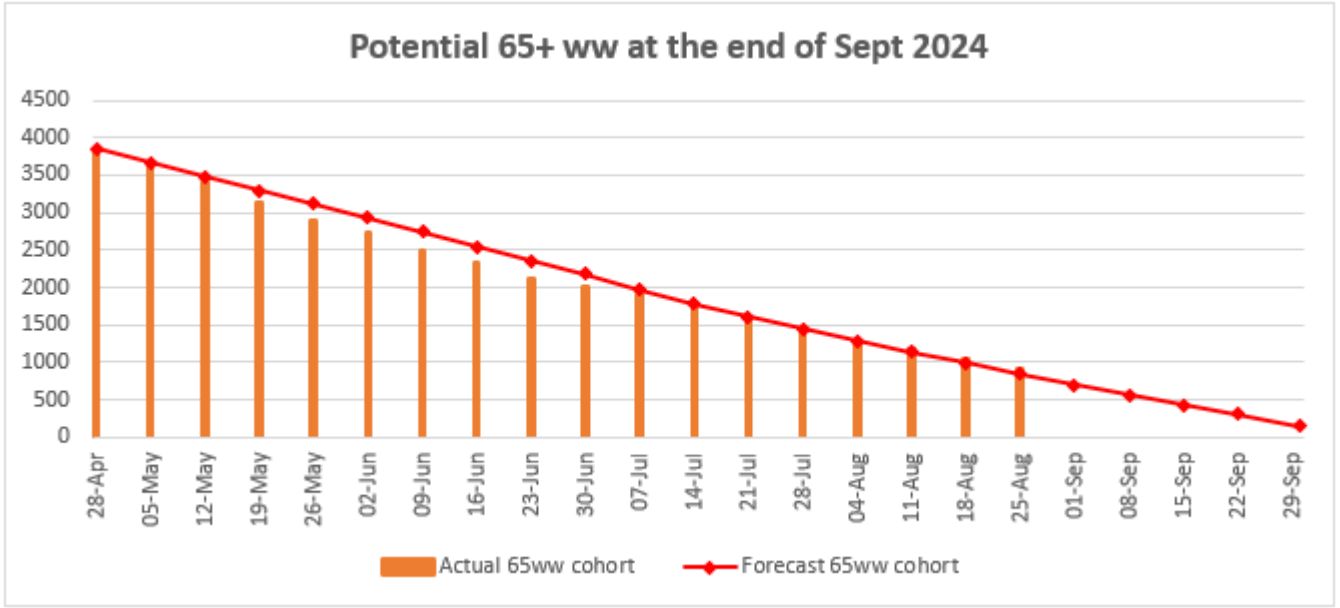
What	So What?	What Next?
MRI – Common cause consistently failing target. Running at full capacity across the seven days but current capacity insufficient. MRI 2 replacement programme commenced 27/11/2023 is now completed but has a legacy impact on performance. There has been an additional small uplift in activity due to staff undertaking additional hours. This is not a sustainable capacity increase and there are staff welfare issues associated. MRI capacity will continue to deteriorate until the commencement of scanning at the CDC due to demand continuing to exceed capacity. CT – Currently not meeting DM01 compliance target due to impacts of the replacement programme. Our current DM01 position is lower than previously anticipated. This is due to an increase in inpatients and UEC demand displacing DM01 activity and impacting capacity for the longer waiting patients. A utilisation review has identified an opportunity for an additional 5 patients per week. US – A step increase in the recovery trajectory can be observed but plateaued and has deteriorated in month. Increased inpatient and UEC demand is compounded by recruitment challenges within the team. Performance remains vulnerable until recruitment improves. DEXA – We will not be able to go live with out DEXA service in November 2024 due to estates delays relative to ventilation and fire protection works. Anticipated go live now March 2025. Approval to be sought for extension of temporary mobile cover to bridge to new opening date. Endoscopy – Priority has been given to patients on a cancer pathway requiring a rebalancing of capacity to support. Cohort of low complexity, low risk patients suitable for outsourcing and nurse endoscopists (NE) has been exhausted with limited scope for flexing of the criteria with outsourced provider. However, consistent improvements have been demonstrated to date. Impact of financial recovery will likely delay DM01 target compliance to August 2025. Overall diagnostic performance may be impacted by financial recovery measures and workforce controls. Audiology saw a 6.7% reduction due to LT sickness in addition to AL within the ENT secretarial team The DM01 trajectory has been refreshed, compliance expected in March 2025 as previously indicated. Urodynamics and cystoscopy have also seen a reduction in performance (8.9%/3.7%), driven by an increased need for TP biopsies in additional to AL. The urology trajectories indicating compliance in January 2025.	Longer waiting times for diagnosis and treatment have a detrimental effect on patients. Delay in achieving DM01 compliance standards. We continue to prioritise diagnostic activity for those most clinically urgent, using the space and staffing resource we have available as flexibly as possible. We continue to seek ways to improve the care we provide, enabling improved performance.	MRI – Mitigations including the delivery of CDC will see MRI reaching DM01 compliance in February 2025. CT – Impact from CT replacement programme is now expected to recover. With an expected return to DM01 compliance by Q4 of 24/25 supported by CDC capacity. US – Staffing issues remain unresolved, and CDC capacity will not be realised until recruitment picture improves. Management team continue to review recruitment options aligned to CDC and cognisant of the workforce controls in place around financial recovery. DEXA – Once open the new service will increase DEXA capacity from 3 days per month to 3 days per week once staff are training and service is up and running fully. This will allow quick recovery of DEXA DM01 compliance. Endoscopy – Anticipated compliance with the DM01 target ambition of 95% by August 2025. Financial recovery measures may impact additional hours worked to deliver performance improvements against the DM01 standard across multiple modalities. Further work is required to deliver core services on a substantive staffing model rather than historic temporary staffing arrangements especially around core OOH acute service provision. Development of long-term workforce plan for urology and further exploration of provider collaboration- away day 26th July Consultant recruitment 9th September 2024 Ongoing ENT secretary validation of audiology waiting list Introduction of further risk stratified pathways to reduce demand/triage. Liaison with CUH regarding opportunities for joint working, there being an established relationship

Elective Access: RTT





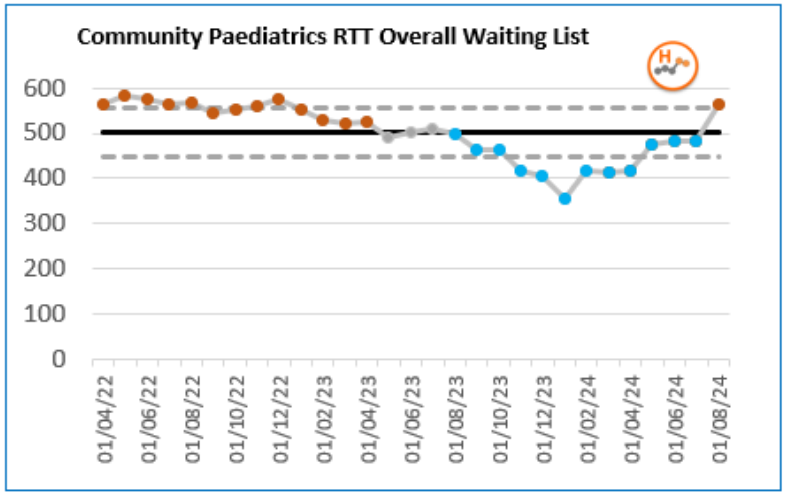


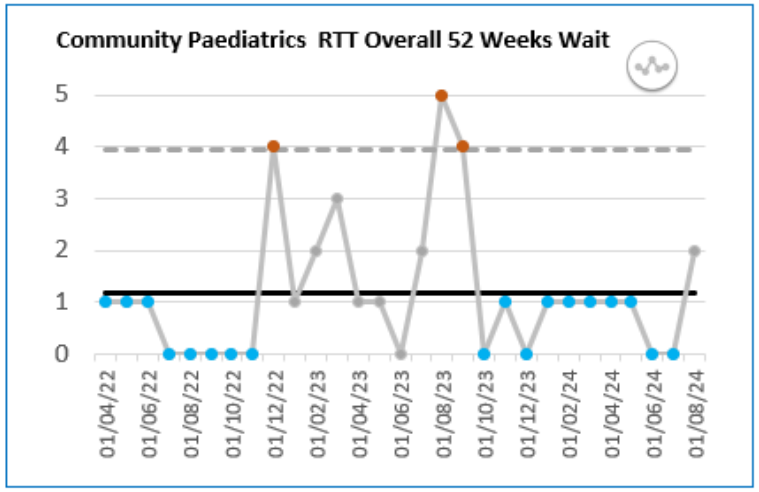


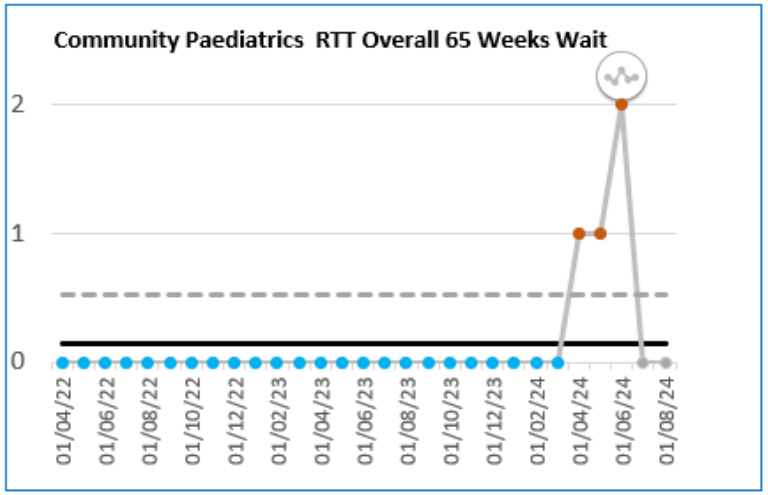
Elective Access: RTT

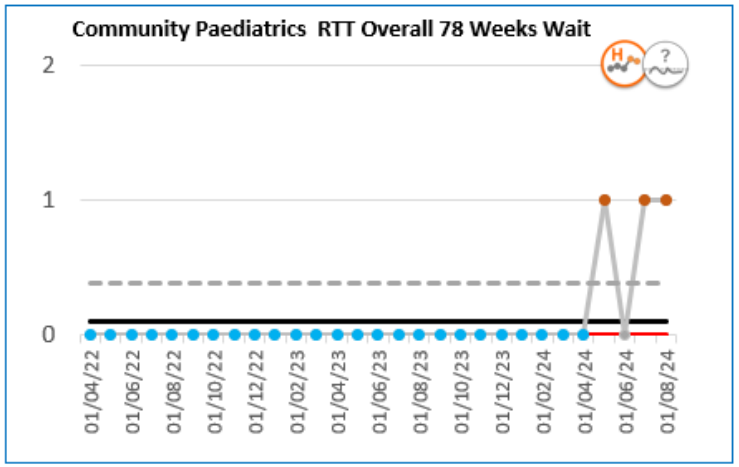
What	So What?	What Next?
The volume of actual 65 week waits has reduced this month. The total volume of patients in the 65 week wait cohort is now above trajectory, with both Orthopaedics and Gynaecology unable to hit a 0 position. It is anticipated that there will be around 70 capacity breaches in Gynaecology a the end of September 2024 and 42 in Orthopaedics, with smaller numbers across other treatment functions. The ability to clear 65 week waits remains at risk, and it is not possible to forecast a 0 position for the end of October, however there will be a significant reduction in the number of 78 week wait patients. The total waiting list size remains high.	Delivering the objective of no patients waiting over 65 weeks by September 2024 is the central focus of 2024/25 planning, delivering an improved set of outcomes and experience for our patients – as 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.	Benefits and sustainability of sending Gynaecology patients to the Nuffield to be reviewed and next steps to be agreed from October onwards. Nuffield are yet to confirm how much capacity they would be able to offer us from October onwards to allow modelling to be undertaken. In addition additional Saturdays for urogynae have been requested in the day surgery unit, however staffing these is challenged. The trajectories for both Orthopaedics and Gynaecology will be rebased, with ESEOC activity supporting the clearance of long waits later in the year.

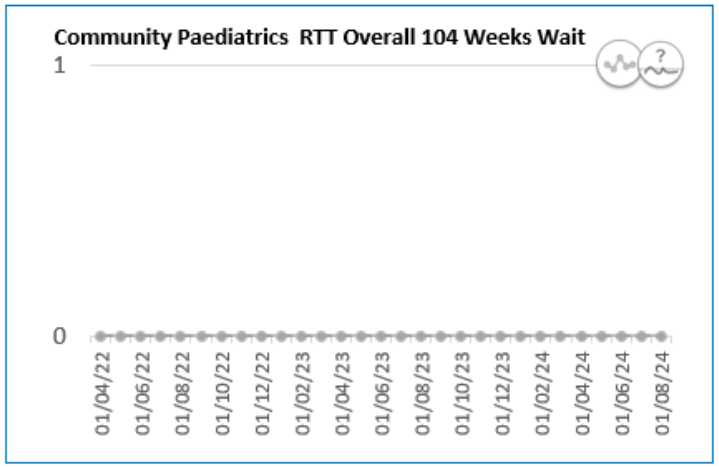
Elective Access (Community Paediatrics)











What	So What?	What Next?
The impact of receiving and managing the backlog of neurodevelopmental (NDD) assessments for autism in school age children (not shown here) has impacted on capacity as some children have transferred to community caseload due to complexity. Increased new referral numbers for the pathway in July. The longest waiters are being managed by outsourcing assessments within the ICB funded recovery plan. In addition to the NDD pressure, the pediatric team continue to see increasing complexity with preschool pathway and in raising caseload.	Children continue to wait longer for school age autism assessments due to high demand. Signposting to support services is undertaken as appropriate. Referral enquiries relating to waiting times are sent into a dedicated email inbox via Care Coordination Centre but this is challenging to manage responses. Children continue to be prioritised according to clinical need. Insufficient clinical capacity to triage volume of referrals received in usual timescale.	Due to high acceptance rate for school autism assessments there has been further funding granted by the ICB to clear the longest waiters. Structured discussion with ICB to review paediatric capacity pressures in the context of the new NDD pathway proposals has been requested. Options to manage demand and capacity being explored formally.

NHS England - 24/25 (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	23/24	ERF	24/25	Var %
Apr	9,544	10,332	10,278	(0.5%)
May	9,660	10,457	10,314	(1.4%)
Jun	9,090	9,840	9,851	0.1%
Jul	10,165	11,004	10,645	(3.3%)
Aug	8,967	9,707	9,226	(5.0%)
Sep	9,544	10,332		
Oct	10,453	11,316		
Nov	9,891	10,707		
Dec	8,744	9,465		
Jan	10,345	11,199		
Feb	9,205	9,965		
Mar	9,365	10,138		
Total (YTD)	47,426	51,341	50,314	(2.0%)

August 2024

23/24	8,967
ERF	9,707
24/25	9,226
Var	(481)
Var %	(5.0%)

Daycase

Mon	23/24	ERF	24/25	Var %
Apr	2,191	2,373	2,435	2.6%
May	2,245	2,431	2,569	5.7%
Jun	2,084	2,257	2,265	0.4%
Jul	2,364	2,560	2,614	2.1%
Aug	2,109	2,284	2,326	1.8%
Sep	2,245	2,431		
Oct	2,459	2,663		
Nov	2,408	2,608		
Dec	2,056	2,227		
Jan	2,420	2,621		
Feb	2,219	2,404		
Mar	2,241	2,428		
Total (YTD)	10,992	11,905	12,209	2.5%

August 2024

23/24	2,109
ERF	2,284
24/25	2,326
Var	42
Var %	1.8%

Outpatient Follow Up

Mon	23/24	ERF	24/25	Var %
Apr	25,352	27,046	27,924	3.2%
May	25,659	27,373	28,140	2.8%
Jun	24,145	25,758	26,476	2.8%
Jul	27,000	28,804	28,063	(2.6%)
Aug	23,819	25,410	25,070	(1.3%)
Sep	25,352	27,046		
Oct	27,767	29,621		
Nov	26,272	28,027		
Dec	23,225	24,776		
Jan	27,479	29,315		
Feb	24,451	26,085		
Mar	24,875	26,537		
Total (YTD)	125,974	134,390	135,673	1.0%

August 2024

23/24	23,819
ERF	25,410
24/25	25,070
Var	(340)
Var %	(1.3%)

Elective

Mon	23/24	ERF	24/25	Var %
Apr	256	277	270	(2.5%)
May	267	289	293	1.5%
Jun	247	267	232	(13.1%)
Jul	280	303	274	(9.6%)
Aug	256	277	277	0.0%
Sep	256	277		
Oct	284	307		
Nov	268	290		
Dec	249	269		
Jan	234	253		
Feb	244	264		
Mar	244	264		
Total (YTD)	1,306	1,413	1,346	0.0%

August 2024

23/24	256
ERF	277
24/25	277
Var	0
Var %	0.0%

Outpatient attendances that are a first attendance or with a procedure

All

All

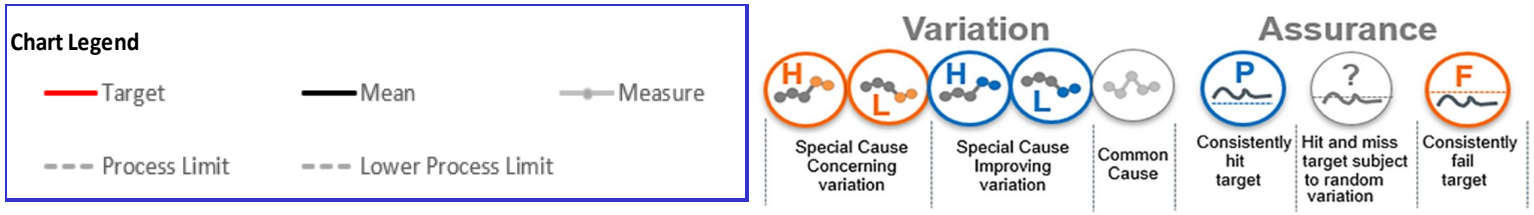
Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
23/24	37.4%	36.4%	36.6%	37.7%	37.9%	37.8%	35.9%	35.0%	36.3%	36.2%	37.1%	37.7%	36.8%
24/25	37.2%	36.2%	36.4%	37.8%									36.9%

Target	46.0%
Month	37.8%
YTD	36.9%

Elective Access: Activity

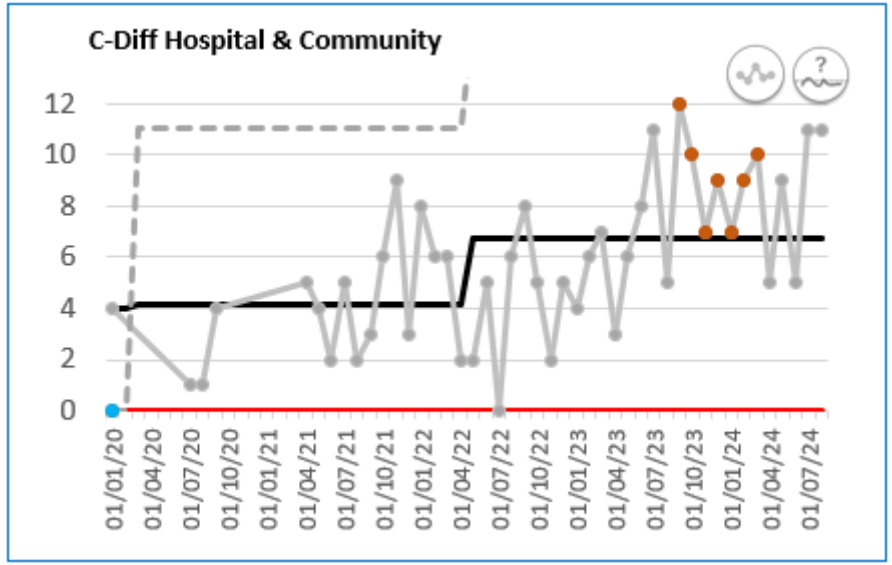
What	So What?	What Next?
Day cases are meeting the required threshold to deliver the system level activity target of 108.09% of 2019/20 activity levels, and elective activity has recovered in August to 0.4% ahead. Outpatient follow ups have dropped below 2019/20 levels in July and August, having been over between April and June. These do not attract ERF unless they include a procedure. Outpatient first attendances (that do attract ERF), have decreased further to 5% behind plan in August. Outpatient attendances that are a first attendance or with a procedure show no significant change from the 2023/24 average, though have increased in August from July's percentage.	Although achievement is measured in terms of value and at a system level, increasing absolute activity is required to achieve Elective Recovery Fund income and deliver on the objective to eliminate waits of >65 weeks by September 2024. Although there is no specific requirement to deliver a reduction in outpatient follow ups this year, doing so will support delivery of the other modalities on which the Elective Recovery Fund threshold is based and will support the new ambition of 46.2% of outpatients to either be first attendances or with procedures.	**W&C:** Ensuring sufficient beds available to deliver increased uro-gynae activity, with a continued focus of general paediatrics Patient Initiated Follow Up (PIFU) and assessing impact of winter staffing requirements on outpatient activity. **Medicine:** • Division to review outpatient ERF opportunities (new outpatient activity). • Further Faster outpatient checklist being reviewed within specialties to ensure baseline is standardised. • Dermatology enacting focussed recovery plan for cancer/elective waits which will increase activity. • Respiratory activity now above ERF threshold following new consultant recruitment. • Trial of 12 point endoscopy lists in September to increase activity. • **Surgery:** • Reinforcement and monitoring of Patient Initiated Follow Up. • Increased delivery of HVLC lists. • Continuation of weekend lists. • All lists booked to 90% - 100%. • Specialty level ERF tracker and identification of shortfall. • Delivery of ERF plan.

IMPROVEMENT COMMITTEE METRICS



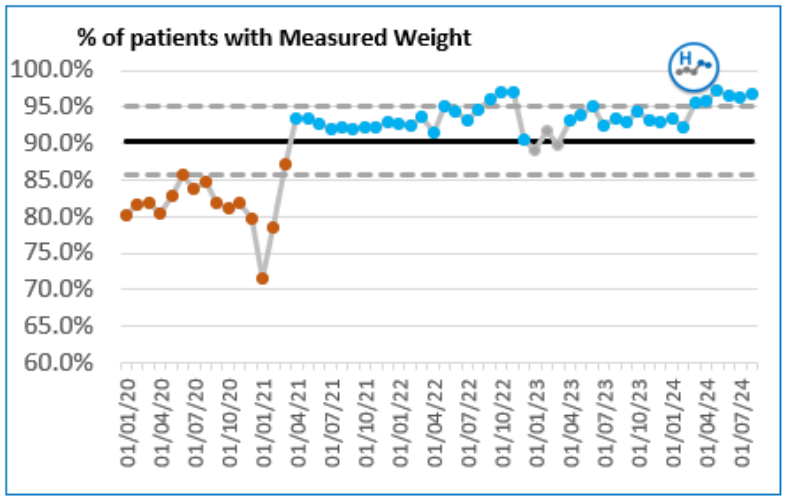
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
C-Diff Hospital & Community	Aug 24	11	0			7	-2	15
% of patients with Measured Weight	Aug 24	96.8%				90.4%	85.7%	95.0%
% of patients with a MUST/PYMS assessment completed within 24 hours of admission	Aug 24	89.6%				89.6%	82.7%	96.4%
% of patients with a MUST/PYMS assessment completed within 48 hours of admission	Aug 24	95.2%				93.2%	89.1%	97.3%
Post Partum Haemorrhage	Aug 24	8				8	-2	17

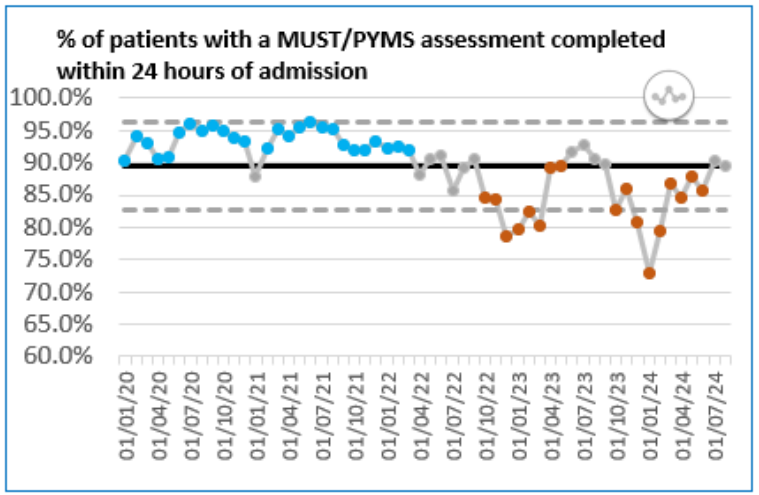
Safe

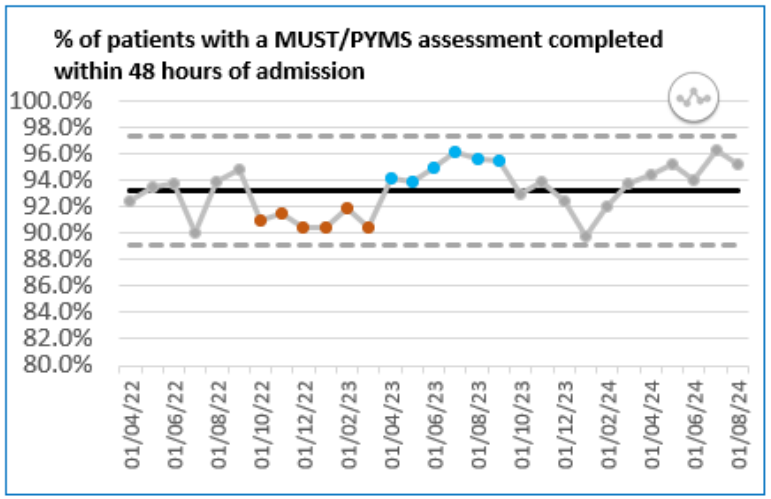


What	So What?	What Next?
There has been no significant reduction in rates since September 2023 due to the multifaceted issues surrounding *Clostridioides difficile* infection. Rates of C-diff are in common cause variation indicating no predictable or sustained achievement of performance The threshold set combines HOHA & COHA cases which provides the organisations measure for national/regional data and better demonstrates the impact on our patient group. It is recognised Nationally that the rates of *Clostridioides difficile* have increased significantly over the last two reporting years. The NHS Standard Contract 2024/25: Minimising Clostridioides difficile is now published with a WSH threshold of 91 (increased from 49 2023-24). Incident rates tracking close to this at M5	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. HCAIs pose a serious risk to patients, staff and visitors. They can incur significant costs for the NHS and may cause significant morbidity to those infected. As a result, infection prevention and control is a key priority for all NHS providers.	The situation is complex and has been identified as an organisational key priority, with escalations via patient quality & safety group and the improvement committee. The Quality Improvement Programme will run for at least 12 months once the measures are agreed. There are six subgroups which all have leads identified and are active. Some actions: • QI oversight meeting – Project Manager & oversight chair to be identified – October 2024. • Regular oversight meetings to be planned – October 2024 • Environment & cleaning – Enhance clean of ED in phases, discussed with Matron who will discuss logistics with domestic staff – target sluices, commonly touched areas, de-clutter where possible of counter tops for ease of cleaning. • AMS – Hard stop to go live 7th October 2024. • Project manager confirmed (September '24) to support pace and progression of improvement plan • Deputy chief nurse to review sub group membership to improve KPI monitoring

Safe



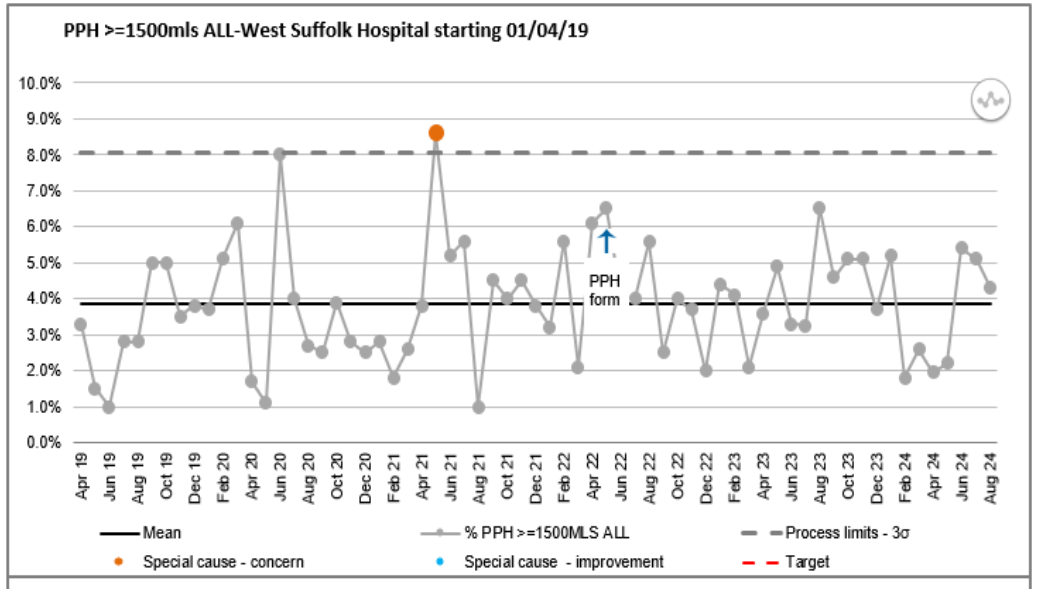


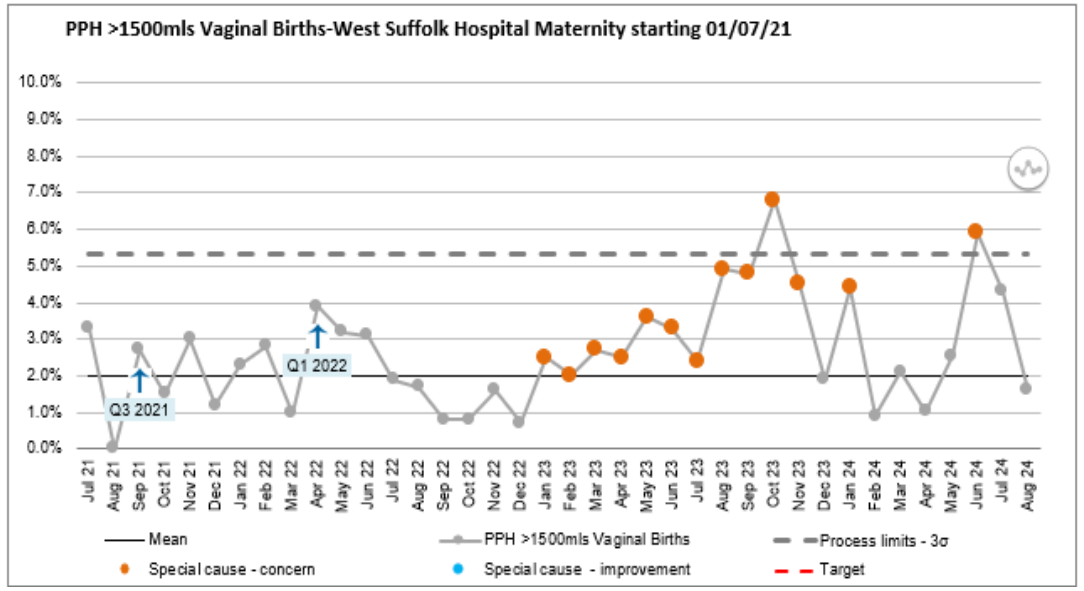


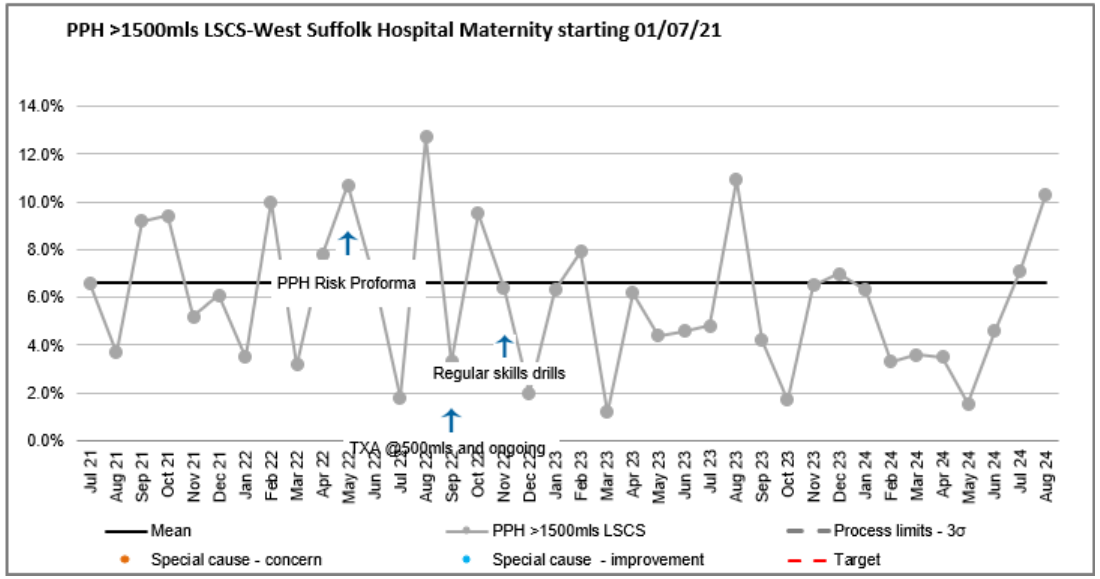
What	So What?	What Next?
% measured weights during inpatient stay: Consistent achievement of weights above 95%. % risk assessments: Moving out of cause for concern into common cause variation for past two months. Driven in part by improvements in flow within UEC pathway	Nutrition and hydration is a fundamental element of care and continues to be an area of focus and improvement for all the teams in the Trust. There is improved awareness that this will underpin a positive experience and outcome for the patients in our care. There are plans in place to renew the reporting process to capture the timeliness of assessments when patients are admitted to a ward. This will provide teams with the opportunity to improve the compliance and accuracy of this important metric. There are recurrent delays in receiving this data set due to issues with the data warehouse implementation. Confirmation of a start date for this remains outstanding and has been escalated.	• Engage and focus on activities to improve the UEC performance and continue to monitor these improvements against the nutrition assessment data. • Monitor introduction of short assessment in ED and observe the impact on this – October 2024 • Information team to change reporting metrics to ensure each ward area is being accurately monitored for compliance – To seek assurance and gain a start date pending • Continue to share the data with teams monthly to provide awareness to the teams where areas of improvement need to be made or highlight improvements made • Monitor for incidents or complaints raised regarding nutritional intake or support at department level to gain assurance. • 'Food is medicine' MDT workshop to be delivered in September 2024

Post-partum haemorrhages (PPH) above 1500mls

Safe







Safe

What	So What?	What Next?
The data illustrates that overall, the PPH incidence are in common cause variation. From February 2024 to May 2024, the incident rate declined and dropped below the target of 3%. However, the data from June 2024 onwards shows an increase in incidents for both Lower Section Caesarean Sections (LSCS) and Vaginal Births, resulting in an overall rate of 4.3 %. The NMPA (National Maternity and Perinatal Audit)targets based on 2022 data are not being consistently met.	Severe bleeding after childbirth - postpartum haemorrhage (PPH) - is the leading cause of maternal mortality world-wide. Each year, about 14 million women experience PPH resulting in about 70,000 maternal deaths globally (WHO 2023) PPH is one of the most common obstetric emergencies and requires clinical skills, with prompt recognition of the severity of a haemorrhage and emphasise communication and teamwork in the management of these cases. Following a PPH there is the potential increase of length of stay and additional treatment and financial implications for the organisation and family. Family bonding time is affected as well as subsequent related issues for example; postnatal depression, establishing breast feeding etc.	Quality Improvement 3rd cycle launched 5 workstreams identified; Anaemia, Training, Risk, Equipment/Estates and Medication (in progress) Continue engagement with Local Maternity and Neonatal System and Regional QI projects regarding PPH Site visits to maternity units with acceptable range of PPH (Q3 2024) Undertake ‘so what’ review, in relation to PPH The Regional team to remove the NMPA targets and monitor regional trends.

Safe

Regional year to date data- July 2024

NHS England East of England

Maternity Data - East of England Collection

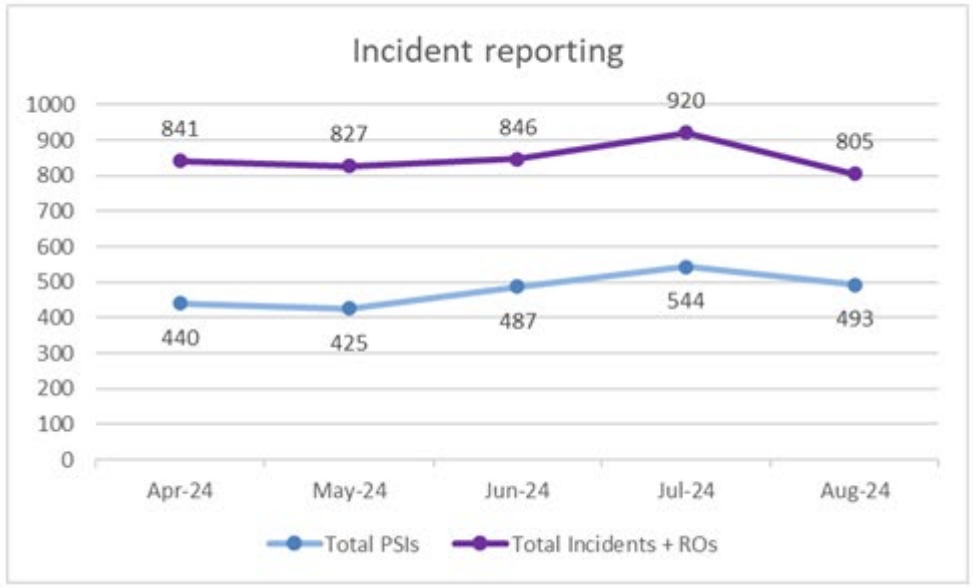
Site: Regional Year to date view (April - July 2024)

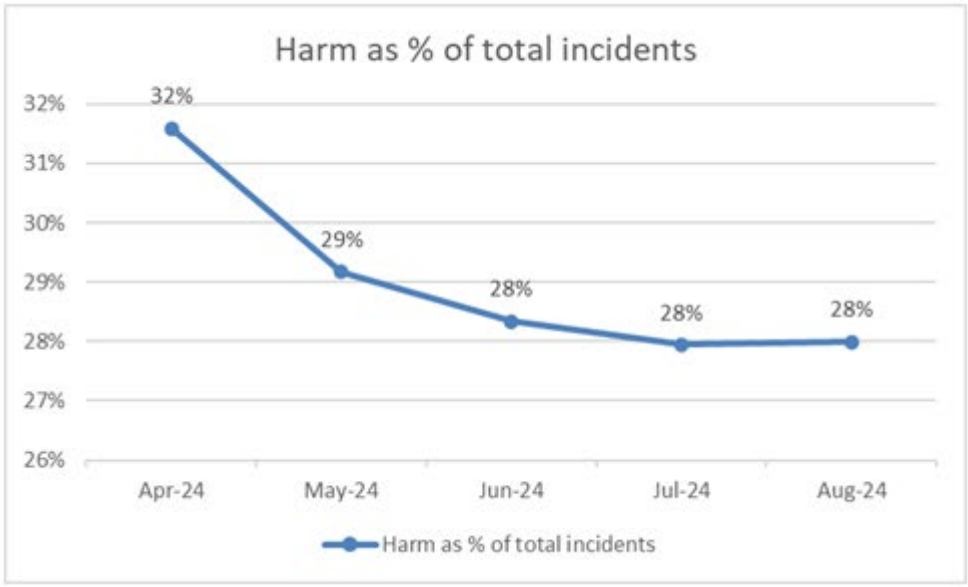
Metrics in grey are automatically calculated

	Metric	Metric ID	Description	Target	SNEE West Suffolk	Regional year to date
	MOH ≥ 1500mls	MH001	All single, term, vaginal births		433	**11688**
		MH002	Single, term, vaginal births - with Massive Obstetric Haemorrhage		15	**392**
		MH003	% Vaginal Birth - Massive Obstetric Haemorrhage		3%	**3.4%**
		MH004	All single, term caesarean births		228	**7731**
		MH005	Single, term caesarean births -with Massive Obstetric Haemorrhage		9	**268**
		MH006	% Caesarean birth - Massive Obstetric Haemorrhage		4%	**3.5%**

What	So What?	What Next?
For additional assurance and benchmarking the above data is submitted to the regional team from individual maternity units. The NMPA targets have been removed by the Regional team. Massive Obstetric Haemorrhage (MOH) rates at the WSFT are in line with regional average (financial year to date).	This demonstrates how WSFT compares with regional peers	Continue engagement with Local Maternity and Neonatal System and Regional QI projects regarding PPH Continue to monitor SPC to be generated once a 12 months of data is available.

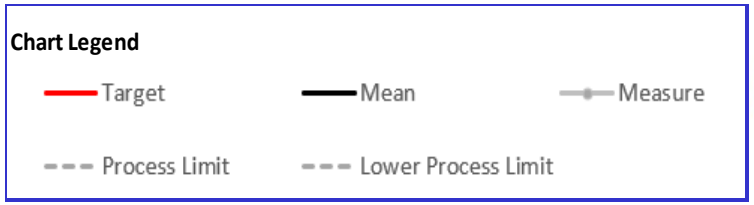
Safe

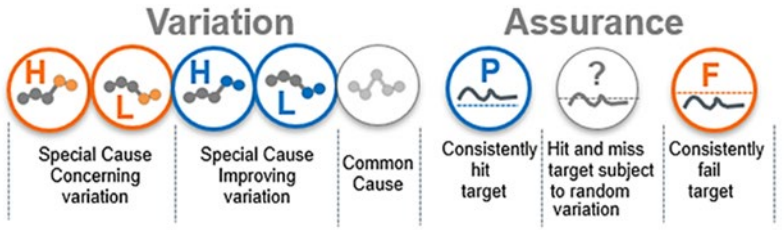




What	So What?	What Next?
The number of reported patient safety incidents (PSI) and reportable occurrences (RO) continue to be stable but overall reduced when compared with reporting on Datix. This is scrutinised at the Radar Oversight Group (ROG). Harm as a % percentage of total reported PSI is a measure of safety and demonstrates we are reporting low harm and near miss events as well as incidents which are attributed to harm. The low percentage is a good indicator of safe care.	An in-depth six month analysis report is being prepared for discussion at ROG and for inclusion in the patient safety report for the PSQGG (due this month). The report will provide a like for like comparison of reporting figures for areas and subject (where available). The report will highlight areas where reporting is markedly down and where areas have embraced and are reporting more incidents and ROs via Radar. Through this analysis can encourage more reporting with the goal to reduce the percentage of harm indicator.	The report will allow the patient safety team to work closely with those areas to understand what the enablers and barriers are for our current reporting trends. We will also engage with subject matter leads to ensure triangulation of data to ensure this is representative of our current safety climate. The patient safety team have refreshed the quarterly thematic analysis report which is shared at PQASG to ensure it analyses the data to allow for learning outcomes to be shared widely with the clinical divisions and the specialists leads. This will report will be combined include quarterly incident data for analysis. Metrics for measuring safety into improvement are being developed with the QI team and will be reviewed at the new safety improvement group, due to launch in October 2024 following the patient safety summit which was held in September.

Mortality Summary

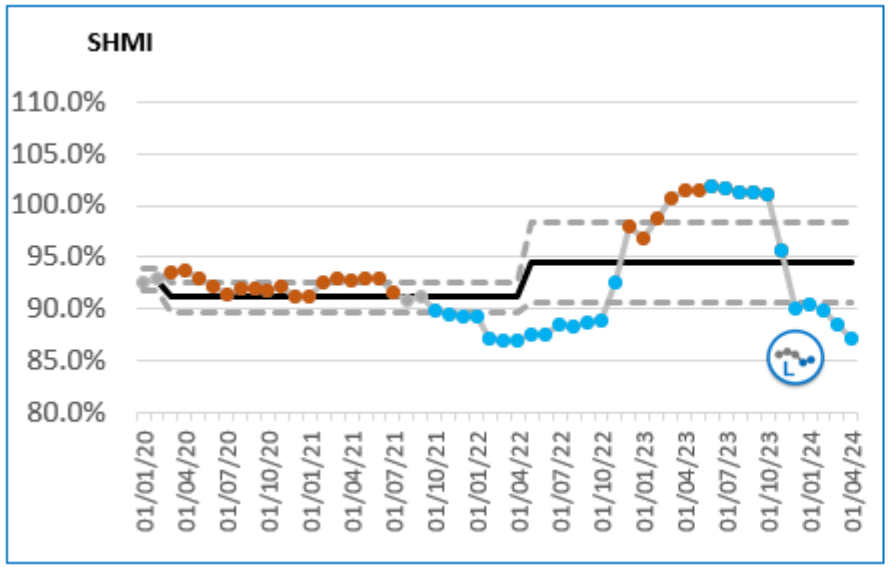


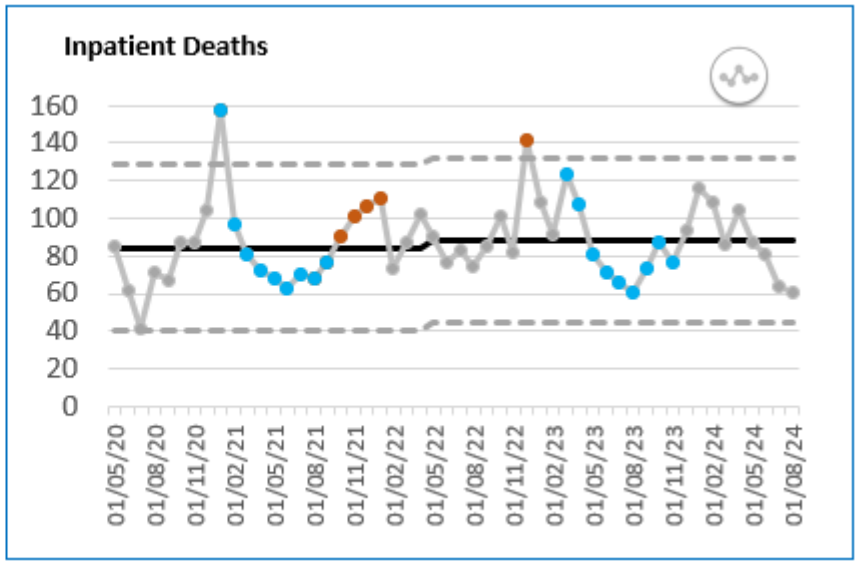


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SHMI	Apr 24	87.1%				94.5%	90.7%	98.3%
Inpatient Deaths	Aug 24	61				89	45	132

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

Mortality





What	So What?	What Next?
The data is showing us that the SHMI data for WSH is on a low special cause improving variation. This is showing that the variation from the coding error is now falling back to where it would have likely been. Inpatient deaths is within expected common variation and within range fair range of the mean. The flag alert on the WSH data narrative has now been removed from the SHMI database because we are back to normal variation.	This is important as it shows the Trust has a below expected SHMI for our patient mix. This is reassuring that the care we are providing is good, and in comparison with other providers we have more patients who survive to discharge in a particular diagnostic groups.	Our Trust will continue to monitor variation and investigate any change that is not expected common cause variation.

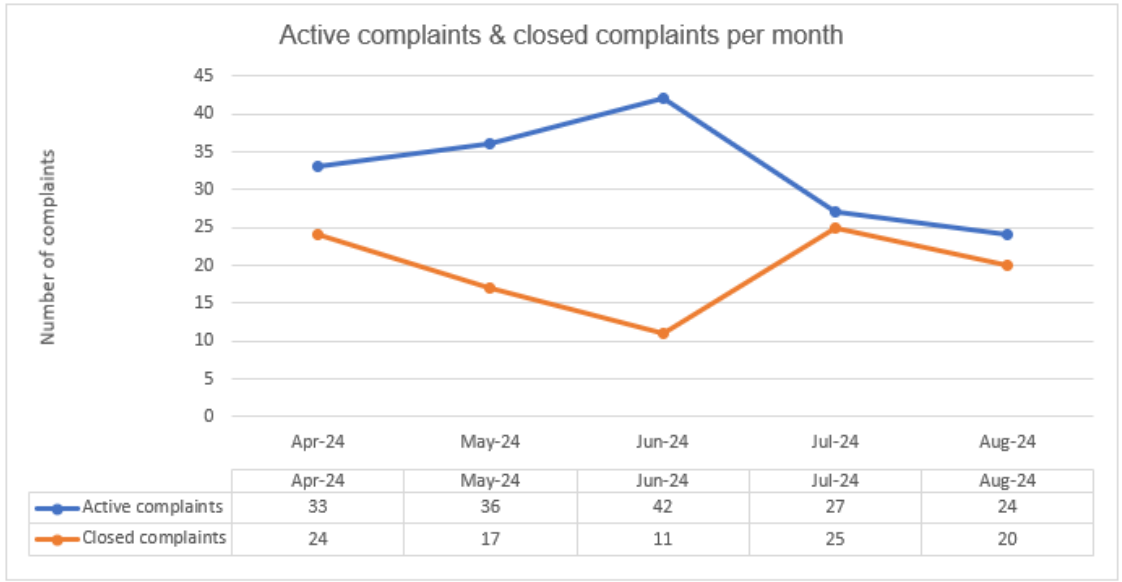
INVOLVEMENT COMMITTEE METRICS

Safe

	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Active complaints	33	36	42	27	24
Closed complaints	24	17	11	25	20

	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Count responded to	24	17	11	25	20
% extended	50%	76%	90%	80%	65%
Count extended	12	13	10	20	13
% Complaints responded to late	15%	11%	9%	64%	30%
Count responded to late	2	2	1	16	6

	Apr-24	May-24	Jun-24	Jul-24	Aug-24
% resolved in one week	58%	62%	56%	44%	69%
Total PALS resolved Count	188	188	150	165	193



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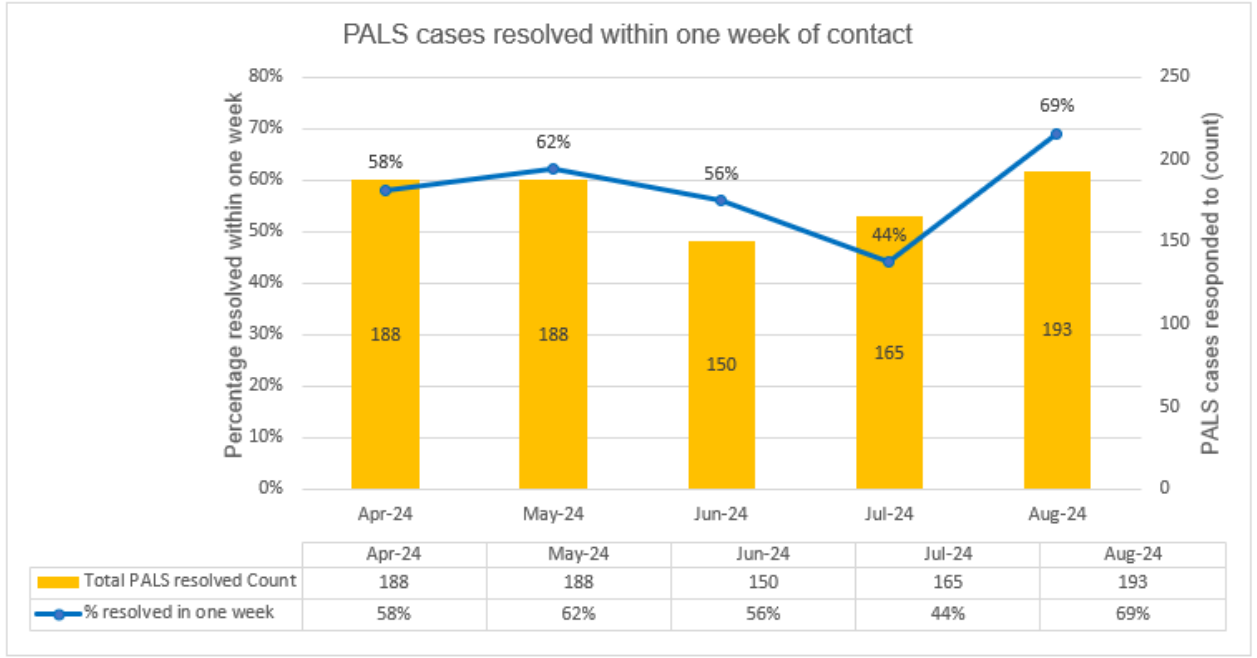

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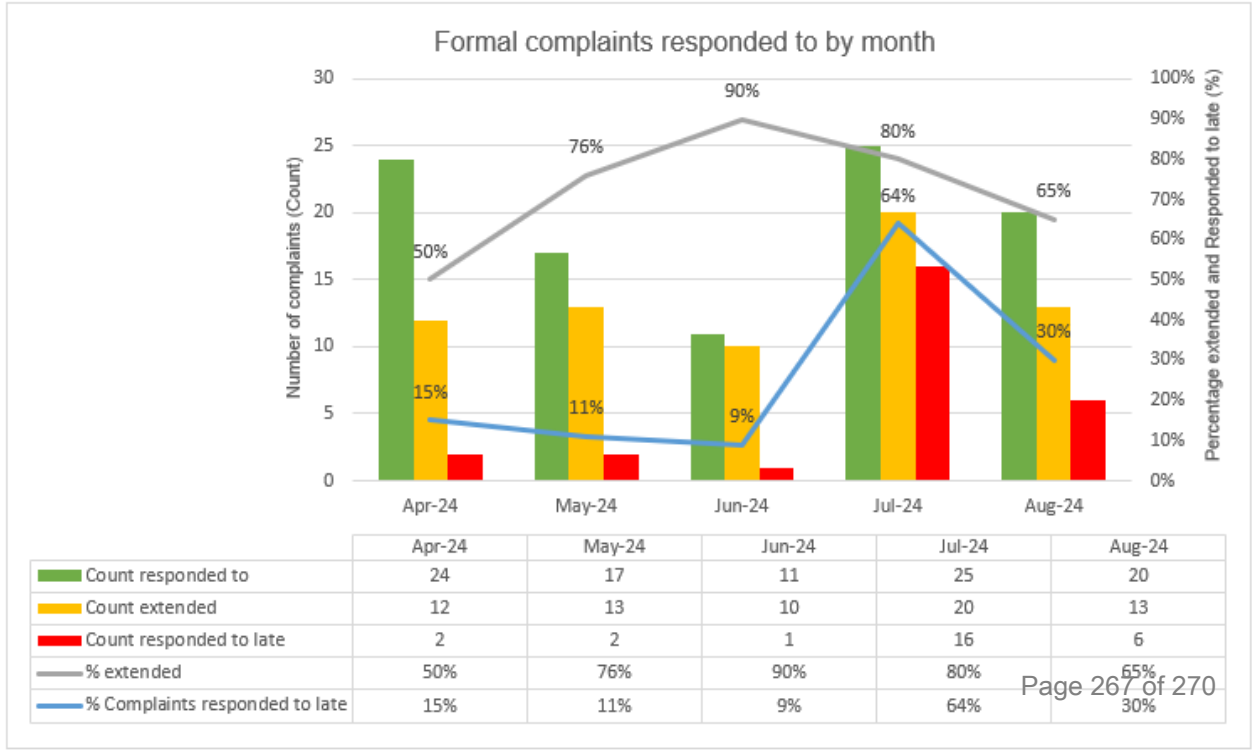

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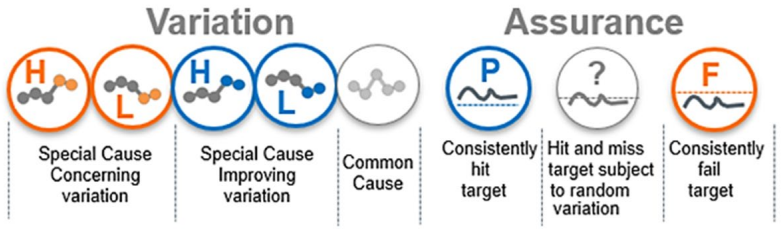
Count extended	12	13	10	20	13
Count responded to late	2	2	1	16	6
% extended	50%	76%	90%	80%	65%
% Complaints responded to late	15%	11%	9%	64%	30%

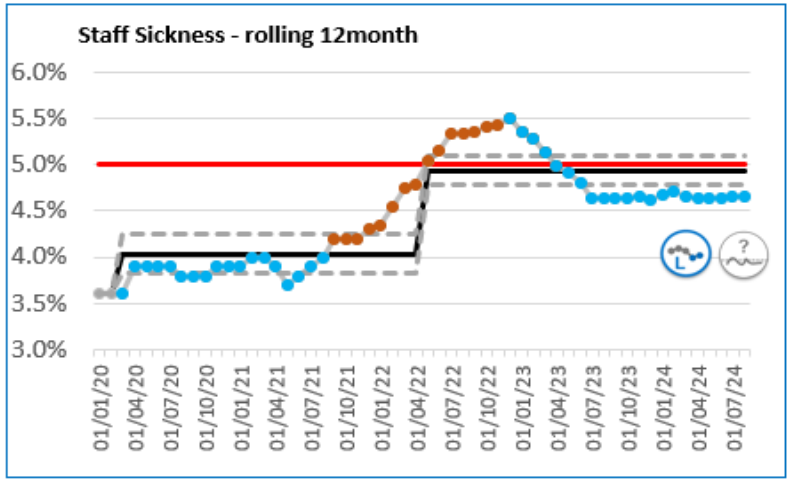
Safe

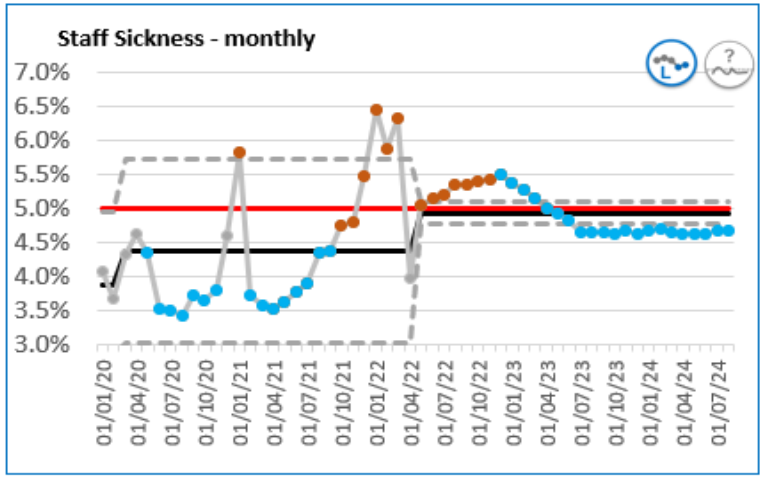
What	So What?	What Next?
193 PALS cases resolved within August with 69% closed within one week. This is the highest amount of cases resolved within one week for this financial year and nearing our target of 75%. When analysing the data, the average time for resolution is 10 days. The team historically had not been logging all activity due to the time taken to record on RADAR and so improvements have been made to a shorter version of the PALS form to ensure activity is logged accurately. At the time of reporting we had 24 open complaints for the Trust in total, across all divisions. In August the complaints team resolved 25 complaints which helped reduce this figure. Of the 25 complaints that were responded to, 6 were classified as late. 2 of these complaints we were waiting for SJR's to be completed and the further 4 late complaints were due to complainants being dissatisfied with the length of time for a response. This was due to waiting for clinical staff responses. Of the 20 that were responded to, 65% were extended, which is greater than we would expect, however these extensions are in line with our policy and national regulations, whereby complaints can be extended with the agreement of the complainant. Whilst the volume of complaints extended are below expected standards, this doesn't appear to impact the complainant satisfaction levels as the current first-time resolution rate remains high at 92%. We will continue to monitor the overall picture with aims to improve all metrics alongside our investigating colleagues and sign off at the Trust Office.	The PALS team have introduced new working methods to ensure time is taken to accurately record PALS activity which doesn't require full investigation. The team are constantly providing support, advice, information and guidance to patients and their loved ones on a daily basis which doesn't always require investigation, however can take a considerable amount of time. The complaints team continue to implement and adapt the new strategy of obtaining staff responses in a more timely manner, whereby we remind staff that the due date for their response is coming up rather than only informing them once overdue. This is working well and we are receiving staff investigations at an earlier stage.	The PALS team are continuing to work towards reaching their goal of a minimum of 75% resolved within 1 week by the end of December 2024. August's data reflects that they are on course to achieve this. Further amendments to the PALS RADAR form are being considered for more streamlined recording. The second PDSA cycle of the QI test and learn project has been completed within the complaints team for increased early resolution meetings, as opposed to written responses. There were no successful meetings for a number of varied reasons (Complaint was inappropriate for a meeting, lack of staff engagement or had already been through a previous learning pathway). For the third PDSA cycle, we will issue Trust wide comms about the project and also issue information on the medical directors bulletin with an aim to increase engagement. This will be issued before October 2024 and before the 3rd PDSA cycle starts. To support divisional oversight, we have adapted our sign off process to ensure divisional leads and service managers etc. have input into the draft responses prior to going for exec sign off. This appears to be working well with good engagement at this stage of the process. Regarding extensions, we will continue to monitor this data closely and are reviewing our own working methods, in particular how we prioritise cases where we have received all staff responses and can begin drafting reports. The performance of this is influenced by investigating colleagues and sign-off for which we will monitor and make improvements to our process as sustainable long-term solutions become apparent.

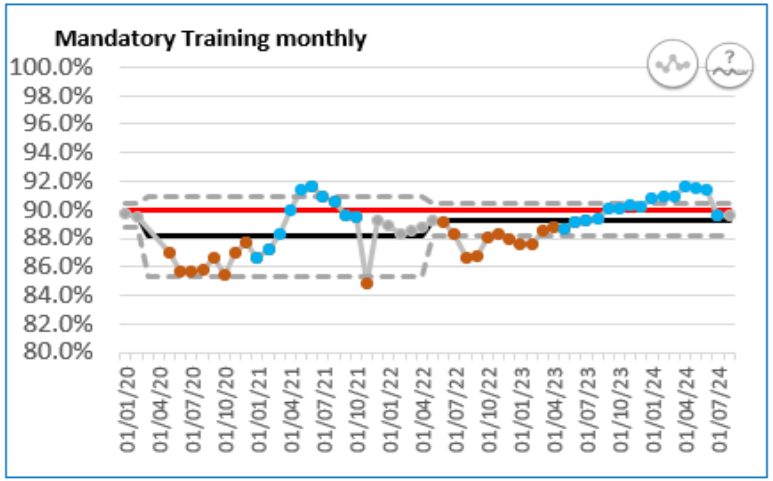


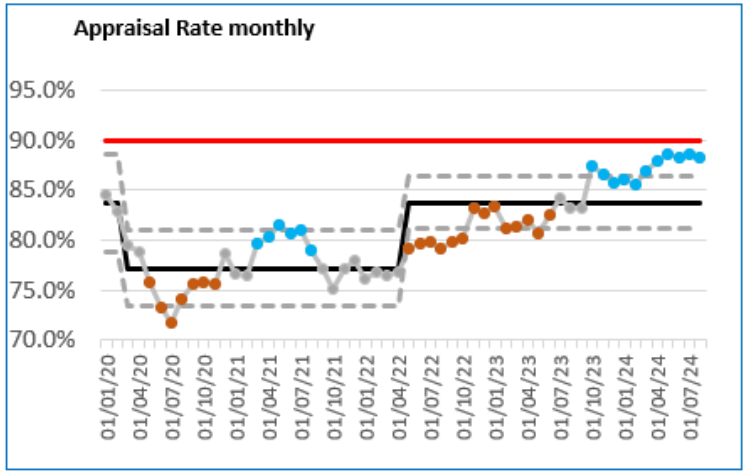
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	Aug 24	4.7%	5.0%	L	?	4.9%	4.8%	5.1%
Staff Sickness - monthly	Aug 24	4.7%	5.0%	L	?	4.9%	4.8%	5.1%
Mandatory Training monthly	Aug 24	89.7%	90.0%		?	89.3%	88.1%	90.5%
Appraisal Rate monthly	Aug 24	88.2%	90.0%	H	F	83.8%	81.1%	86.4%
Turnover rate monthly	Aug 24	7.3%	10.0%	L	?	10.8%	10.0%	11.7%

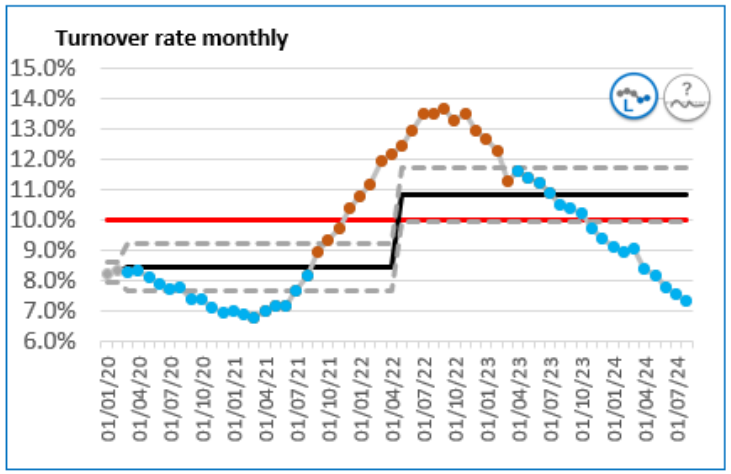
Well Led











What	So What?	What Next?
Three out of four of our key performance indicators continue to record an improving variation with mandatory training marginally below target. Sickness – achieving target at 4.7% versus 5% target. Mandatory training – slightly below target at 89.7%. Appraisal – consistently failing target, 88.2% versus 90% target. Turnover – achieving target, sustained improvement since November 2022.	These workforce key performance indicators directly impact on staff morale, 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.	Maintain improvements in staff attendance and continue to monitor at department level. Recover the target 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.