OPEN Council of Governors meeting

Schedule	Monday 2 September 2024, 5:30 PM — 7:30 PM BST
Venue	Drummond Education Centre, 19a&b, West Suffolk Hospital site, BSE
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
Monday 2 September 2024, 5.30pm at Drummond Education Centre, rooms 19a&b, West Suffolk Hospital site, BSE

0. Agenda Open CoG meeting 2 Sept 2024.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

5:40 PM

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

   Apologies received from:
   Governors: Jayne Neal, Anna Conochie, Evelin Hanikat, Sarah Hanratty, Adam Musgrove, Clare Rose
   NEDs: Antoinette Jackson, Tracy Dowling
   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 9 May 2024 For Approval - Presented by Jude Chin Item 4 Open CoG minutes 9 May 2024 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 Open Action log from 9 May 2024.docx
5:50 PM	6. Chair's report (enclosed) To receive an update from the Chair To Note - Presented by Jude Chin Item 6 Chair report to CoG 2 September 2024.docx Item 6.1 NEDs responsibilities August 2024.doc
5:55 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 CoG 2 Sept 2024.docx
6:05 PM	8. Finance Update (enclosed) To receive an update on financial position For Report - Presented by Jonathan Rowell Item 8 Finance update CoG 2 Sept 2024.docx
	GOVERNOR BUSINESS (INC. STATUTORY DUTIES)

6:35 PM 9. Feedback from assurance committees (enclosed)

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

To Note

Item 9 Feedback from Board assurance committees CoG 2 Sept 2024.docx

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9.1. Insight Committee

Presented by Michael Parsons

Item 9.1 INSIGHT CKI report a 15 May 2024 FINAL AJ.docx

Item 9.1 INSIGHT CKI report b 19 June 24 FINAL AJ.docx

Item 9.1 INSIGHT CKI report c 17 July 2024 FINAL AJ.docx

Item 9.1 INSIGHT Governor observer a 15 May 2024 - John-Paul Holt.docx

Item 9.1 INSIGHT Governor observer a 15 May 2024 Jayne N.docx

Item 9.1 INSIGHT Governor observer b 19 June 2024 Jane Skinner.docx

Item 9.1 INSIGHT Governor observer b 19 June 2024 Jayne Neal.docx

Item 9.1 INSIGHT Governor observer b 19 June 2024 Liz Hodder.docx

Item 9.1 INSIGHT Governor observer c 17 July 2024 Jayne Neal.docx

Item 9.1 INSIGHT Governor observer c 17 July 2024 John-Paul Holt.docx

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9.2. Improvement Committee
Presented by Roger Petter

- Item 9.2 IMPROVEMENT CKI report a 15 May 2024 LP.docx
- Item 9.2 IMPROVEMENT CKI report b 19 June 2024 LP.docx
- Item 9.2 IMPROVEMENT CKI report c 17 July 24 JC.docx
- Item 9.2 IMPROVEMENT Governor observer a 15 May 2024 Anna Conochie.docx
- Item 9.2 IMPROVEMENT Governor observer b 19 June 2024 Anna Conochie.docx
- Item 9.2 IMPROVEMENT Governor observer b 19 June 2024 Jane Skinner.docx

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9.3. Involvement Committee

- Item 9.3 INVOLVEMENT CKI report 19 June 2024 AJ.docx
- Item 9.3 INVOLVEMENT Governor observer a 19 June 2024 Sarah Hanratty.docx
- Item 9.3 INVOLVEMENT Governor observer a 19 June 2024 Val Dutton.docx

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9.4. Audit Committee
Presented by Michael Parsons

- Item 9.4 AUDIT CKI report MP.docx

6:55 PM 10. Annual Accounts and Report 2023/24 and Annual Auditor's Letter (enclosed)
To receive the report
Presented by Michael Parsons

- Item 10 Annual Auditors report 2023-24.docx
- Item 10_Annex 2023-24 Auditors Annual Report.pdf

7:05 PM

11. Nomination Committee Report (enclosed)
To receive the report form the Committee meeting on 8 July 2024
To Note - Presented by Jude Chin

Item 11 Nominations committee report CoG 2 Sept 2024.doc

Item 11_Annex A Nominations Committee Terms of Reference 2024.docx

Item 11_ Annex B Nominations sub committee annual report on effectiveness Jul 2024.docx

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12. Engagement Committee Report (enclosed)
To receive a report from the Engagement Committee
Presented by Sarah Hanratty and Jane Skinner

Item 12 Engagement committee report CoG 2 Sept 2024.doc

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

Item 13 Standards committee report CoG 2 Sept 2024.doc

Item 13_Appendix A Standards Committee Terms of Reference July 2024.docx

Item 13_Appendix B Standards Annual report Governor sub committees July 2024 v1.docx

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14. Staff Governor Report (enclosed)
To receive a report from the Staff Governors
To Note

Item 14 Staff Governors report CoG 2 Sept 2024.doc

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

Item 15 Lead Governor report CoG 2 Sept 2024.docx

7:20 PM	16.	Governance Report (enclosed) To receive the governance report For Discussion - Presented by Pooja Sharma Item 16 Governance report CoG 2 Sept 2024.doc Item 16_Appendix A Governors Work Programme 2024-25.docx
7:25 PM		ITEMS FOR INFORMATION
	17.	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 17 Summary Report for Board of Directors meeting CoG 2 Sept 24.docx
	18.	Any other business For Discussion - Presented by Jude Chin
	19.	Dates for meetings for 2024 • 24 September 2024 (Annual Members' Meeting) • 19 November 2024 To Note - Presented by Jude Chin
	20.	Reflections on meeting To consider whether the right balance has been achieved in terms of information received and questions for assurance and the Trust's values and behaviours observed For Consideration - Presented by Jude Chin
		CLOSE
		SUPPORTING ANNEXES
		Item 9 - IQPR full Report - June xIQPR June 2024.pdf

AGENDA:

OPEN Council of Governors meeting

Monday 2 September 2024, 5.30pm at Drummond Education Centre, rooms 19a&b, West Suffolk Hospital site, BSE

Council of Governors Meeting

There will be a meeting of the **COUNCIL OF GOVERNORS** of West Suffolk NHS Foundation Trust on **Monday 2 September 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 Welcome to new NEDs and attendees.	JC
17:40	**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 meetings** (enclosed) To note the minutes of the meetings held on 9 May 2024	JC
	5.	**Matters arising action sheet** (enclosed) To note updates on actions not covered elsewhere on the agenda	JC
17:50	**6.**	**Chair's report** (enclosed) To receive an update from the Chair	JC
17:55	**7.**	**Chief executive's report** (enclosed) To note a report on operational and strategic matters	EC
18:05	**8.**	**Finance update** (enclosed) To receive an update on financial position	JR

GOVERNOR BUSINESS (INC. STATUTORY DUTIES)			
18:35	**9.**	**Feedback from Board committees** (enclosed) To receive committee key issues (CKI) and observer reports from the assurance and audit committees: 9.1 Insight Committee 9.2 Involvement Committee 9.3 Improvement Committee 9.4 Audit Committee	NED chairs / Governor observers
18:55	**10.**	**Annual report and accounts, including auditor's letter** (enclosed) To receive the report	MP
19:05	**11.**	**Nomination Committee report** (enclosed) To receive the report from the committee meeting on 8 July,2024	JC
	12.	**Engagement Committee report** (enclosed) To receive a report from the Engagement Committee	SH/JS
	13.	**Standards Committee report** (enclosed) To receive a report from the Standards Committee	JC
	14.	**Staff Governors' Report** (enclosed) To receive a report from the Staff Governors	Staff Governor
	15.	**Lead Governor Report** (enclosed) To receive a report from the Lead Governor	JS
19:20	**16.**	**Governance report** (enclosed) To receive the governance report	PS
ITEMS FOR INFORMATION			
19:25	**17.**	**Summary report for Board of Directors meetings** (enclosed) To receive the report the Chair and Non-Executive Directors	JC / NEDs
	18.	**Any Other Business**	JC
	19.	**Dates for meetings for 2024** To note dates for meetings in 2024: • 24 September 2024 (annual members' meeting) • 19 November 2024	JC
	20.	**Reflections on meeting** To consider whether the right balance has been achieved in terms of information received and questions for assurance and the Trust's values and behaviours observed.	JC
CLOSE			

Supporting Annexes

Agenda item	Description
9	IQPR full report - June

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: Jayne Neal, Anna Conochie, Evelin Hanikat, Sarah Hanratty, Adam Musgrove, Clare Rose

NEDs: Antoinette Jackson, Tracy Dowling

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 9 May 2024

For Approval

Presented by Jude Chin

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE
COUNCIL OF GOVERNORS' MEETING - OPEN

Held on Thursday 9 May 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 Osbourne	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
Sue Kingston	Public Governor	SK
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
David Brandon	Partner Governor	DB
Elspeth Lees	Partner Governor	EL
Rowena Lindberg	Partner Governor	RL
Thomas Pulimood	Partner Governor	TP
Heike Sowa	Partner Governor	HS
In attendance:		
Gary Norgate	Programme Director, Future System Programme (Item 1-9 only)	GN
Nicola Cottington	Chief Operating Officer (Item 1-9 only)	NC
Louisa Pepper	Non-Executive Director	LP
Antoinette Jackson	Non-Executive Director	AJ
Michael Parsons	Non-Executive Director	MP
Roger Petter	Non-Executive Director	RP
Richard Jones	Trust Secretary	RJ

Pooja Sharma	Deputy Trust Secretary	PS
Apologies: Elizabeth Hodder, Public Governor Elspeth Lees, Partner Governor David Brandon, Partner Governor Thomas Pulimood, Partner Governor		
Members of the Public		
Ian Campbell		

No.	Item	Action
1.	**Welcome and introductions**	
	The Chair welcomed three new governors to the meeting Sue Kingston (Partner Governor), Gordon McKay (Public Governor) and Rowena Lindberg (Partner Governor).	
2.	**Apologies for absence**	
	Apologies for absence were noted.	
3.	**Declaration of interests**	
	There were no declarations of interests declared.	
4.	**Minutes of the previous meetings**	
	The minutes of the meeting held on 27 February 2024 were approved as a true and accurate reflection.	
5.	**Matters arising on action sheet**	
	Open item: **Minute Ref 7 – 27 February 2024: Communication with Governors regarding incidents and outcomes, including "Never Events".** Noted work on this being undertaken by the Chief Nurse. **Minute Ref 15 – 27 February 2024: Updating FSUP Posters** - Work being undertaken with the Communications Team to address. Governors noting any out-of-date posters to advise the Deputy Trust Secretary. Completed actions approved.	
6.	**Chair's report**	
	The Trust Chair (JC) provided an overview of recent developments, with the following highlights: ***Budget 2024/25*** – after an approach from the ICB, the Board has agreed, in principle, to find an additional £2.8million in savings/additional revenue to reduce the burden on other elements of the system, giving a deficit of £15.2 million for 2024/25. A detailed plan is yet to be produced, but areas identified for further exploration would deliver up to £3million. This presents a significant challenge to the Trust, who are not alone in such a situation.	

	Non-Executive Director (NED) Update – noted two NEDs have stepped down, with effect from 30th April. The recruitment process is underway, with shortlisting scheduled for end of May and interviews in June. ***Director of Strategy & Transformation*** – Sam Tappenden has been appointed. Start date to be confirmed, but anticipated by 1 July 2024.	
7.	**Chief Executive's report**	
	The Chief Operating Officer (NC) presented the report highlighting the following: ***Urgent & Emergency Care*** – 74% achieved for the four-hour standard in emergency care in March, 2024, just slightly below the target of 76%. This was an achievement on previous months, reflective of the efforts throughout the Trust. However, the challenge remains. ***Elective Recovery*** - significant reduction seen in long waits for elective care. At the end of March, 470 patients were waiting over 65 weeks and 47 over 78. This position, whilst still not acceptable, would have been better, but for industrial action taking place throughout the year. ***Cancer Performance*** – the Trust achieved 76% in patients achieving a diagnosis of cancer or an all clear within 28 days. A patient safety initiative, ***Call 4 Concern***, (C4C), has been launched; a safety net for patients and family concerned that a loved one is deteriorating and not getting the attention they need. Such a call will result in a timely response from the Critical Care Outreach Team, responding to the bedside as appropriate. ***Staff Survey*** – whilst improvement has been demonstrated, results from some areas are concerning. Results show an increase in numbers for staff stating a poor experience at work, involving bullying and harassment, sometimes on the basis of race or another protected characteristic. This is unacceptable and the Board have agreed a plan to work with staff to gain an understanding of the problem and address the issue. ***Strategic Priorities*** – financial challenges will have an impact on the way the Trust provides its services, whilst ensuring it remains as productive as possible. Noted staff experience of a department is through the line manager and team and one of the priorities will be to support and develop leaders and managers. ***Essex and Suffolk Elective Orthopaedic Centre (ESEOC)*** – noted it is proposed that 55% of WSFT elective orthopaedic work will be transferred to the centre. Engagement with staff and public is taking place.	
8.	**Operating Planning and Guidance**	
	The Chief Operating Officer (NC) presented the report and drew attention to the following:	

	Uro-Gynae - question raised regarding the issue within uro-gynae in terms of capacity constraints. These were complicated and multifactored, relating to theatre capacity and workforce issues. Waiting lists built up during Covid and assistance is required to recover. This is a specialist area and to employ people with these skills is difficult. The Trust had joined a national scheme to try and identify other providers, alongside contacting other local trusts, but have been unsuccessful in obtaining mutual aid. However, the waiting time has been reduced up to March and a planning submission has been made to reduce the number of patients over 65 weeks to zero by September 2024, including uro-gynae. In terms of managing the waiting list, the Trust is in regular contact with patients, offering a number of routes should they have a query. A link is also available to the ICS Waiting Well website, which offers support. The Trust has undertaken a Waiting Well pilot for some of its orthopaedic patients, which includes the identification of any red flag symptoms and what to do about them. All patients are advised that if they do deteriorate and depending on the issue and whether related to the existing condition to contact their GP or specialty doctor. Patients are reprioritised, as necessary. The Clinical Harm and Prioritisation Policy is used to identify any patients who may be harmed whilst on the waiting list and this is documented and investigated. It is often difficult to ascertain if the wait has been the cause and therefore not a large number are reported and some patients will deteriorate regardless of receipt of treatment. In terms of cancer and diagnostic ambitions and focus on the delivery of core access standards by March 2025, the Community Diagnostic Centre capacity will be required, together with additional activity in endoscopy to deliver the 95% target modelled. The Trust is confident of delivery. Diagnostics has previously been an area where it has been difficult to gain traction, as people waiting for a cancer diagnosis have been prioritised when there are constraints in capacity and a large backlog. Last year, the Trust received a 92% bed occupancy target from the national team. Whilst no longer a national target, the Trust aims is to keep it at that level in order to achieve flow. This is a challenge with the constrained estate. ***Urgent and Emergency Care Planning (UEC)*** - for the Emergency Department (ED), achievement of 78% against the 4-hour standard by March 2025 is a key focus of urgent and emergency care planning. This is not just an ED target, as is contributed to by the entire Trust, including community services. Significant progress was made in March, but this has been difficult to sustain and the Trust is looking to see what had been done previously in order to replicate. Managers were often in the department until 10 pm in order to drive this, with much done on goodwill. However, this cannot be sustained. The plan will be for a minors emergency care unit to come on line in July, creating a space for patients not requiring admission, enabling them to be treated in a separate space from the rest of ED. This will release capacity in the main department for assessment.	

	Question was raised as to the use of the virtual ward system to enhance the meeting of targets and production of income. Noted emergency care plans were predicated on the use of virtual ward. The difficulty lay in the fact that urgent and emergency care activity did not generate additional income; elective activity did. No matter how many patients went through ED, no further monies would be received. Numbers had increased, with 300 patients being regularly seen in one day. It was a matter of prioritisation of resources. There was funding available to support UEC. Within the alliance most of the resources had been put into the community space to help facilitate discharge and avoid admission. It was often difficult to justify this to staff in ED, who were dealing with hundreds of patients on a daily basis. However, in developing community services, patients who did not need to visit ED would not. It was suggested that with such a backlog in ED, in order to meet targets, some patients would be moved into beds allocated for elective surgery. As income was made on elective, might it be financially advantageous in the admission avoidance funding, to improve elective income? It was advised that conversations were taking place on the best use of ward space available to ensure patients were treated well and the Trust remained financially stable. **It was asked that in moving some of the orthopaedic activity to ESEOC, with the resultant effect that other elective activity would be undertaken at the Trust; what form would this take?** Noted this would be a range of non-orthopaedic surgical activities, including urology, ENT and general surgery. The exact mix was being worked through at present and consideration would need to be given to those patients requiring a bed after surgery and any support required. **Question was raised as to whether for the Elective and Waiting Well pathways, patient access was immediate, or only for those patients on the list for a certain period?** Further, did the pathway include a wellbeing check in? Noted all patients, once listed for a surgery/procedure, were able to access the website for support and kept updated on waiting times. In addition, a waiting well pilot for orthopaedic patients had been undertaken for intensive support. The Integrated Care System (ICS) waiting well offer, included access to wellbeing and psychological support. For some it is more about financial support, as unable to work whilst waiting. **Query was raised that if outsourcing, insourcing or working at weekends, were the non-executive directors (NEDs) being provided with the necessary and adequate assurance that pathways, particularly around patients, staff wellbeing and digital were robust?** The Chief Operating Officer advised that she would be happy to supply the NEDs with information. In terms of quality data checks, assurance would be in place if utilising an independent provider and good working relationships were already in place with some of these. The question was raised why are the waits on the website for gastroscopy and sigmoidoscopy longer for urgent referrals than routines?	

	(Response received from Chief Operating Officer post meeting) This is because there is independent sector capacity for endoscopy that is used, but only less complex, more routine cases are suitable for this provision. Outsourced endoscopy capacity such as this quickly reduces the total amount of routine patients waiting, we are reliant on specialist consultant lists for some urgent cases, which therefore creates a longer wait for those patients, comparatively. Opportunities to increase Nurse Endoscopist scoping competency are being explored to release consultant colorectal capacity, will help make access more equitable. This is also why Insourcing has been preferable to outsourcing. **It was asked how much missed appointments were factored in and was there a way to make up for these?** It was acknowledged that more could be done in this regard and that numbers varied from service to service. In terms of productivity, a work stream was looking at DNAs. In terms of surgery, the preassessment team was proactively contacting patients to talk in advance about how well they were prior to surgery, as some cancellations were due to patients not being well enough to have surgery. There was waste within the system currently and DNA formed part of that lost capacity. **It was queried whether the DNA rates for outpatient services were known?** Noted it varied from service to service. *(Further clarification received from Chief Operating Officer post meeting)* In April 2024, the overall DNA rate for the Trust was 4.95% against a target of 5%. There is significant variation between specialities, ranging from 2% to 8% and the outpatient transformation programme is focussed on improving utilisation in outpatients.	
9.	**Future System Update**	
	The Programme Director (GN) for the Future System Programme provided an update. Significant physical progress is being made on site, supported by the New Hospital Programme (NHP), with funding in the region of £12million to carryout out archaeological checks, provision of power to site, new access road and planting. Work continues at pace and discharges some of the planning conditions. Agreement reached on what constitutes a right-sized hospital. WSFT is the first Trust to go through a detailed review with national experts and reach an agreed size, approximately 92,000 square metres, at a cost of around £1.3billion. The costs from the NHP are only £200k adrift from those predicted by the Trust. This has been confirmed in writing. The strategic outline case is considered sufficiently robust to continue with construction of the outline business case and to focus on design.	

	The NHP case for funding has been through the Treasury and the Trust awaits allocation of budget, anticipated by the end of the month and in the region of £1billion. The Future System Team are now involved in coproducing to the 1:200 level, coordinating departments, technical specifications and interaction. This should be completed by October 2024 (RIBA Stage 2). Due to the extra scrutiny that will now follow, the Trust is reviewing the internal governance arrangements to reflect this increased level of design of its programme, working with Q5 Partners, a nationally appointed consultant, in order to agree a structure to allow executives and non-executive directors greater input and insight into decisions, as they happen. The project plan, agreed with NHP, with some contingency, should be operational by March 2031. It is hoped that this can be brought forward. The longest element will be construction. In using national templates for the business case this will condense the time required to sign off a business case. It is important to get builder and supplier engagement as soon as possible and the NHP have agreed that this can commence. There are only three potential suppliers who could build a hospital such as this and one has already expressed an interest. In terms of next steps: • Receipt of confirmation of budget, anticipated for the month end • Receipt of template and completion of outline business case, May to June • New governance structure, end of May 2024 • RIBA Stage 2, end of October 2024 • Pre-construction services agreement with potential build partner October/November 2024. **Questions**: ***With a potential change of government looming, were there any risk factors involved to the programme?*** It was acknowledged that the incoming government could seek to pause the programme and review but recognise that the RAAC risk presents a real challenge to any delays and necessitates replacement of the existing hospital by 2030. The programme also had the support of the local MP and the ministerial lead for the programme. However, the risk remained and was noted on the Risk Register. ***Did the Trust still plan to have construction access adjacent to Gypsy Lane?*** Confirmed that the current survey work is ongoing prior to construction of site to allow access to construction vehicles. It was confirmed	

	construction access adjacent to Gypsy Lane would be just prior to construction. Access will occur off the bottom of Horringer Road and not Gypsy Lane. There will be a dedicated haul route, the length of the field to the compound. It will not disrupt Gypsy Lane traffic and will have a dedicated road. The work undertaken in the field to the side of Gypsy Lane was archaeological in nature and has been completed. Gypsy Lane is of scientific interest due to bats that forage within the tree end hedge line. ***Construction work is likely to take a long time, when will it commence?*** It was understood that this would not take long as there will be tracking and not tarmac to allow the heavy goods through. This will be carried out just before site construction begins. ***Was there any desire to build the car park first, in order to provide staff parking, enabling savings from monies paid to the Rugby Club, or were resident objections stopping this?*** Noted the Trust has worked constructively with local residents and provided them with a cul-de-sac and buffer planting has begun to provide screening ready for when construction commences. Introduction of the new access road will reduce car parking capacity for the period of construction and alternatives will have to be sourced. In using the Rugby Club, and walking to site, it was recognised that there were health benefits to staff in terms of the promotion of health agenda. ***Will the Trust not have two car parks in operation whilst the new hospital is built?*** Noted the longer-term plan was to have as much on-site parking as possible and demolition of the old hospital will allow, subject to planning permissions. Any additional spaces required must be permanent and the Rugby club was not considered permanent. ***Is the Trust convinced there will be sufficient parking as mentioned earlier not just for staff, but for patients too?*** The current parking for patients is insufficient. Noted it was the local council's planning department that was specifying requirements. The Trust had a good relationship and had worked with them to arrive at the calculation. The Trust was looking to keep people fitter for longer and out of hospital. The increase in footprint was designed to allow more effective operation rather than an increase in inpatients. Much work was being carried out on demand and capacity planning and this included car parking. ***How is the Trust addressing communication on the new hospital with staff? How will NEDs be assured that all departments required will be located in the new hospital (feedback received suggests one large department has not been included)? What should governors say when asked if the new hospital will be built?*** In terms of staff engagement and not bringing all departments into the hospital, there were 13 specialties, all represented by a coproduction lead who was actively engaged in the development and design of their	

	department. Numerous workshops have been undertaken thus far. An acute hospital should be a medical environment and therefore outpatients was not to be included, due to the potential for infection, but would sit in the current Day Surgery area, still in proximity of the hospital. In terms of assurance for NEDs, the new governance structure being put in place would entail two NEDs on the Scheme Executive Programme Board (SEPB), one of which would chair, thus providing an independent challenge. In terms of what governors should be telling staff, more posters have been erected signposting the detailed plans that are available and contact points for further information. Governors can direct people to these, have bought a site, £22million allocated for development of business case, have undertaken archaeology and have an access road to connect the two sites and by end of month will have formal letter confirming budget. ***Only three potential construction companies have the wherewithal to deliver the building, one of which has thus far expressed an interest in tendering. Will there be a risk of trade availability?*** Noted there were other hospitals due to be built in the area and the NHP was working with suppliers and the supply chain to enable this. The Programme Director had visited the building company who had expressed an interest, and had built the new hospital at Dumfries and Galloway. They have established their own supply chain and invested in the mechanisation of mass production, using preformed building blocks, different to the RAAC process. Whilst remaining a risk, it was a mitigated one. The initial engagement with the supplier has shown an innovative approach to building, using modern methods of construction. This will limit the demand for local skilled labourers. ***What percentage of the 40 new hospitals are existing RAAC hospitals and where does this Trust stand in terms of how far forward, compared to these? Has the new cancer hospital, to be built at Addenbrookes, had an effect on the design plans for WSFT?*** Noted whilst there were 40 programmes, now increased to 47, not all were new hospitals; Addenbrookes was to be a cancer wing. Of the 47, 7 were RAAC. Five were largely completed hospitals, having previously been halted by the collapse of Carillion and included in the original 40, but nearly completed. Seven agile hospitals, such as the cancer wing, were relatively small and could be completed quickly. The remainder fitted in to two categories, Cohort 3s, i.e. Hillingdon, Leeds, Manchester and Harlow and announced before WSFT were a little ahead in terms of designs. Of the others, including James Paget and King's Lynn, WSFT was one of the five furthest forward, having completed its review, purchased land and obtained outline planning permission. The rest were 6-12 months behind. In terms of design, the new cancer wing was not a factor. The Dame Clare Marx Building, home of the Essex and Suffolk Elective Orthopaedic	

	Centre, had had an influence. In utilising this, it had enabled the Trust to reduce a couple of theatres worth of capacity. ***When working with local councils on parking, was it district or county?*** Noted it was both and they were members of the Programme Board. The planners the Trust were working with were from West Suffolk Council. ***Were there reserved matters on the outline application?*** Yes, there were 82 planning conditions to be discharged, the most significant of which, compensation strategy, had been discharged. The team were working through the conditions and reserved matters was scheduled for next year, possibly September.	
10.	**Feedback from Board Committees**	
	The Council of Governors received an overview of the committees' key issues (CKIs) and governor observer reports from the board assurance committees with the following highlighted: **Insight** - the committee noted the minimal level of assurance on the planned response to financial diagnostics framework. A question was raised as to what assurances were being sought to raise the level. It was noted that the initial action plan from the PA Consulting financial diagnostic review had been very process driven. Insight felt the plan needed greater strategic focus on financial recovery. It was further felt that the action plan needed to include the CIP deficit and process and capacity improvements required. An improved plan was seen at the recent Board meeting, where discussion took place on the CIP deficit and the plan will be looked again in June meeting. The time and expertise being expended on the deficit was noted and the question raised as to whether there was any further help available to simplify matters. Noted additional support had been considered at Insight and discussions are ongoing with the Integrated Care Board (ICB) level of source and expertise for the recovery. **Involvement Committee** - the report from the involvement committee was noted by the Council of Governors. **Improvement Committee** - the size of agenda for this meeting was queried and whether all items needed to be included. If so, should a longer time be allocated for discussion. It was advised that these meetings were constantly evolving and acknowledged that the format is developing to focus on 'must have' and prioritisation. However, the key issues affecting patient safety and staff, which were improvement issues, were being discussed. **Audit Committee** - The report from the Audit Committee was noted.	
11.	**Nomination Committee Report**	
	The Nominations Committee report was noted.	

	The role of governors in the NED appraisal process was reviewed at the recent committee meeting. Noted changes have been made to reflect the national approach around a new framework for the Chair's appraisal for 2023/24. The committee gave its approval to the Trust's proposed approach to NED appraisals and a report will be presented to the Council of Governors' meeting in September.	
12.	**Engagement Committee Report**	
	The Engagement Committee report was noted. **Action: JP Holt to be included on the list for members of the Engagement Committee, detailed in Appendix A (Item 17.2) of today's meeting.**	**PS**
13.	**Standards Committee Report**	
	The Standards Committee report was taken as read. Noted access options for governors wishing to use a Trust email address have been clarified.	
14.	**Lead Governor Report**	
	The lead governor report was taken as read. Noted the Experience of Care & Engagement Committee did not take place in April due to number of apologies. The May meeting did take place, with feedback to be given to the next Engagement Committee.	
15.	**Staff Governors' Report**	
	The Council of Governors noted the report.	
16.	**Quality Accounts 2023/24**	
	The Trust Secretary (RJ) presented the report and stated that production of a set of Quality Accounts is a requirement for all NHS providers. As part of the structure and content, commentary has been invited from key external parties, including the ICB, County Council and Governors. The Standards Committee has reviewed and updated the commentary to reflect 2023/24. **Subject to minor amendments, the Council of Governors approved the draft governor commentary, which will appear in the Trust Quality Accounts for 2023/24.** Governor volunteers to act as readers for the accounts to contact the FT office.	
17.	**Governance Report**	
	The Trust Secretary (RJ) presented the report and drew attention to the following: ***Register of Governors'* Interests** - request made for any changes to be notified to the Foundation Trust Office as soon as possible. ***CoG Sub-committees*** – these have been reformed to support the work of the Council. Appendix A, item 17.2, details updated membership.	

	Work Programme 2024/25 – Feedback welcomed on content. ***Non-Executive Director Resignations*** – recent resignations were noted. The Trust remains legally compliant as per its Constitution. ***Board Assurance Framework (BAF)*** – this has been evolving over the last 6 months. Update to come to next Council of Governors' Meeting.	
18.	**Summary Report for Board of Directors Meetings**	
	Report noted.	
19.	**Any Other Business**	
	Virtual ward control room - visit to be arranged for those governors interested. ***Hardwick Manor Site*** - visit to be arranged for those governors who are interested. ***Basic Life Saving Training*** - session offered to governors. Interest to be gaged and session(s) organised. ***International Nurses Day 10th May*** - a variety of events have been organised to celebrate and governors are welcome to attend. ***NED appraisals volunteers*** - governors interested in participating to contact Deputy Trust Secretary. ***Skills & audit questionnaire*** - this will be circulated to all governors for completion and will be used to inform the future work plan. ***753 bus service*** - noted this service now on offer Saturday and Sunday, early and late and includes a stop at the hospital. Copies of the timetable available from Foundation Trust Office.	**RW** **RW** **RW**
20.	**Dates for meetings in 2024**	
	▪ 2 September 2024 ▪ 24 September 2024 (Annual Members' Meeting) ▪ 19 November 2024	
21.	**Reflections on meeting**	
	• Consider alternative way of reporting matters that are for noting only to give longer for items requiring discussion • Good to have an in-person presentation • Push to talk a success in helping attendees to hear better.	

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

To Note

Presented by Jude Chin

ACTION LOG – Open Council of Governors meeting – following 9 May 2024 meeting

OPEN ACTIONS

None

CLOSED ACTIONS

Minutes Ref No.	Paper/Agenda item Ref	Meeting date	Action	Lead	Progress	Target Date	RAG	Date completed
7.	Chief executive's report	27 Feb 2024	To consider communicate with Governors regarding incidents and the outcomes, including 'never event'.	RJ	The shared learning report was received at the Improvement Committee in August. This communicated the range of processes in place to capture and learn from events occurring across the Trust. We will continue to update the Governors through these processes, including reporting at the Improvement Committee observed by Governors. [9 May 2024] This has been reviewed with the Chief Nurse who is keen to develop a learning report that includes incidents and patient engagement. It is proposed that this is communicated within the Trust as well as shared with Governors.	Sep 2024	**Complete**	
5	Engagement Committee Report	9 May 2024	JP Holt to be included on the list for members of the Engagement Committee, detailed in Appendix A (Item 17.2) of today's meeting (9.5.24).	PS	The list for membership was updated. **Action closed.**	Sep 2024	**Complete**	Sep 2024
6	Any Other business	9 May 2024	FT office team to arrange visit to Virtual Ward Control Room for governors.	RW	Sessions booked for 6th and 18th November. **Action closed.**	Sep 2024	**Complete**	Aug 2024

Minutes Ref No.	Paper/Agenda item Ref	Meeting date	Action	Lead	Progress	Target Date	RAG	Date completed
7	Any Other Business	9 May 2024	FT office team to arrange visit to Hardwick Manor site for governors	RW	Visits arranged for 12th and 19 September 2024. **Action closed.**	Sep 2024	**Complete**	Aug 2024
8	Any Other Business	9 May, 2024	FT office team to gauge governor interest to attend Basic Life Skills training and book appropriate sessions	RW	Sessions booked for 23rd July and 2nd September 2024. **Action closed.**	Sep 2024	**Complete**	July 2024
15	Any other business	27 Feb 2024	FT office team to get in touch with the comms colleagues to action the updated posters	PS	FSUP Guardian and Champions are working with the comms team to visit various departments, including community teams, to identify out of date posters and provide with the new posters. An electronic version for printing updated posters is also offered. However, a change to the QR code has again necessitated them being updated and resent. Those currently in display do have the correct phone and email contacts. A lot of work has been done by Champions and managers to locate and replace posters with the new version including the new QR code and expected to be completed by September 2024.	Sep 2024	**Complete**	Sept 2024

RAG RATING:

Key	
Completed	
On track/On trajectory - The action is expected to be completed by the due date	
Some slippage/Off trajectory - The action is behind schedule and may not be delivered	

Serious Issues/Due date passed and action not completed	

LEAD:

Name	Initials
Jude Chin	JC
Ewen Cameron	EC
Richard Jones	RJ
Jeremy Over	JMO
Ruth Williamson	RW
Pooja Sharma	PS

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:	2 September 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

NED responsibilities

Following the resignation of Krishna Yergol and Geraldine O'Sullivan, Louisa Pepper completing her second term and the appointment of five new NEDs and the return of Tracy Dowling from her secondment to the Mid and South Essex ICB, there has been a lot of work to review and allocate NED responsibilities. Conversations have now been had with all NEDs to identify preferences and also best use of relevant skills. A schedule summarising the NEDs' responsibilities is attached for information.

It should be noted that these responsibilities are not 'set in stone' and may change as NEDs carry out their roles, particularly those NEDs from a non-NHS background. The objective is to achieve a fair share of responsibilities as well as find roles that the NEDs are best able to contribute to.

NED appraisals and objective setting

NED appraisals and objective setting has been completed for the 2023-24 period. I would like to thank all governors who provided feedback and also the Nominations Committee of the Council of Governors who assisted in summarising the feedback for appraisals I carried out.

My appraisal has also been completed with objectives set around:

- Board development
- Support for the executive team
- Support for the delivery of the financial targets
- System working with the ICS and Region
- Further development of Board and Council of Governor agendas and papers.

Suffolk and North East Essex Integrated Care System Chairs Group

The SNEE ICS Chairs group meet bi-monthly and includes chairs/representatives from all the providers of healthcare services in our ICS. These include the acute trusts, community services, mental health trusts, ambulance services, voluntary services, hospice providers, local authorities and Healthwatch.

The meeting is an opportunity to share information and initiatives relevant to our system. Our most recent meeting was on 6 August where we received presentations on:

- Uncomfortable Truths – a summary of the key points emerging from a series of three one day workshops reflecting on issues within our healthcare system such as inequality of access, inequality of care and inequality of outcomes. A series of twenty-two actions have been highlighted for system partners to work on.

- System learning from winter – a paper summarising the key system learnings from winter with an objective of identifying what could be done differently, with a particular focus on the urgent and emergency care (UEC) pathway.

- 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.

- 50 compassionate leaders for the Future – a program to facilitate a chosen cohort of 50 senior staff in the ICS to explore the concept of compassionate leadership. The first event will be a 'masterclass' at the ICS Expo on 13 September.

External Meetings attended

Meetings attended include:

- NHSE – Eastern region – focus around regional and national finance, performance targets and new initiatives such as NHS Impact a program to assess the cultural readiness of organisations for delivering effective continuous improvement

- NHS Confederation Chairs Group – NHS Confederation is a membership organisation that supports and speaks for the healthcare system in England, Wales and Northern Ireland. Delivers regular briefings on conversations with government whilst facilitation discussion of common issues across healthcare providers.

Board Workshop

Since the last Council of Governors meeting, we have had one board workshop on 28 June where we had discussions around our digital strategy and operations, our children and young people special education needs (SEND) strategy and a financial update.

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

Non-executive directors' responsibilities – August 2024

	Primary responsibilities	Responsibilities as required	Lead assurance roles (Bold indicates mandated)
Jude Chin **Chair and Non-executive director** **Fixed Term:** 4 July 2022 – 3 July 2023 **Appointed:** 1 June 2023 – 31 May 2026	• Board – Public, Closed (**Chair**) • Council of Governors (**Chair**) • Audit Committee (in attendance) • Remuneration Committee (**Chair**) Specialist committees: • *Option to attend any other Board committees* • ICS Chairs meeting • NHS Confederation Chairs group • NHSE (East of England) CEO and Chairs group	• Board Workshops • External relationships • Consultant appointments • 15-steps visits • Governor meetings with NEDs • Investigations and appeals	• Integrated care system • NHS England and Improvement • West Suffolk Alliance • NED link to CEO
Tracy Dowling **Non-executive director** **Term:** 1 November 2022 – 17 November 2023 **Reappointed:** 1 August 2024 – 17 August 2026	• Board meeting – Public, Closed • Deputy Chair • Remuneration Committee • Audit Committee Specialist committees: • Involvement Committee (**Chair)** • Improvement Committee • Member Collaborative Oversight Group	• Board Workshops • Consultant appointments • 15-steps visits • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• Patient experience and public engagement • NED link to Director of Workforce, including OD

	Primary responsibilities	Responsibilities as required	Lead assurance roles (Bold indicates mandated)
Richard Flatman **Non-executive director** **Term:** 1 September 2024 – 31 August 2027	• Board meeting – Public, Closed • Remuneration Committee • Audit Committee Specialist committees: • Insight Committee • Charitable Funds Committee (**Chair**) • Member of SNEE ICB Finance Committee	• Board Workshops • Consultant appointments • 15-steps visits • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• **Health and wellbeing guardian** • NED link to CFO
Heather Hancock **Non-executive director** **Term:** 1 September 2024 – 31 August 2027	• Board meeting – Public, Closed • Remuneration Committee Specialist committees: • Involvement Committee • Insight Committee • Charitable Funds Committee	• Board Workshops • Consultant appointments • 15-steps visits • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• Equality, diversity and inclusion • NED link to Director of Strategy and Transformation
Antoinette Jackson **Non-executive director** **Term:** 1 November 2022 – 31 October 2025	• Board meeting – Public, Closed • Senior Independent Director • Remuneration Committee • Audit Committee Specialist committees: • Insight Committee (**Chair**) • Involvement Committee • Charitable Funds Committee	• Board Workshops • Consultant appointments • 15-steps visits • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• **Board freedom to speak up guardian, including whistleblowing** • NED link to Director of Integrated Adult Health and Social Care

	Primary responsibilities	Responsibilities as required	Lead assurance roles (Bold indicates mandated)
Michael Parsons **Non-executive director** **Term:** 1 May 2023 – 30 April 2026	• Board meeting – Public, Closed • Audit Committee (**Chair**) • Remuneration Committee Specialist committees: • Insight Committee • Future System Executive Programme Board (**Chair**)	• Board Workshops • Consultant appointments • 15-steps visits • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• **Security management** • NED link to Programme Director, Future Systems
Roger Petter **Non-executive director** **Term:** 1 Mar 2023 – 28 Feb 2026	• Board meeting – Public, Closed • Remuneration Committee • Audit Committee Specialist committees: • Improvement Committee (**Chair**) • Involvement Committee	• Board Workshops • Consultant appointments • 15-steps visits • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• **Maternity and neonatal safety champion** • **Doctors' disciplinary** • NED link to Medical Director
David Weaver **Associate Non-executive director** **Term:** 1 September 2024 – 31 August 2027	• Board meeting – Public, Closed • Remuneration Committee Specialist committees: • Insight Committee • Improvement Committee • Future System Executive Programme Board	• Board Workshops • Consultant appointments • 15-steps visits • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• Safeguarding adults and children • NED link to Chief Operating Officer
Alison Wigg **Non-executive director** **Term:** 1 September 2024 – 31 August 2027	• Board meeting – Public, Closed • Remuneration Committee Specialist committees: • Involvement Committee • Future System Executive Programme Board • Digital Programme Board	• Board Workshops • Consultant appointments • 15-steps visits • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• Cyber security • NED link to CIO

	Primary responsibilities	Responsibilities as required	Lead assurance roles (Bold indicates mandated)
Paul Zollinger-Read **Associate Non-executive director** **Term:** 1 September 2024 – 31 August 2027	• Board meeting – Public, Closed • Remuneration Committee Specialist committees: • Improvement Committee • Charitable Funds Committee • Doctors' Revalidation Support Group	• Board Workshops • Consultant appointments • 15-steps visits • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• Patient safety including learning from deaths • Theatre utilisation • NED Link to Chief Nurse

All NEDs will be invited to attend audit committees (including deep dive presentations) but only those specified above are members of the committee

All NEDs can attend the assurance committees but only those specified above are members of the committee

All NEDs are members of the Remuneration Committee

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:	2 September 2024
Sponsor/executive lead:	Dr Ewen Cameron, chief executive
Report prepared by:	Dr Ewen Cameron, chief executive Sam Green, communications manager Helen Davies, associate director 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

Performance

Governors will be aware, as some of you were involved in the process, that we have recruited some new Board posts - two new Board members and five new non-executive directors. They bring an incredible amount of expertise and knowledge and will help the Trust to build a positive and successful future.

Earlier in the summer we welcomed our first executive director of strategy and transformation, Sam Tappenden. Recruiting to this role was one of our strategic objectives for 2023/24, and Sam will help us make transformative changes and improvements in a wide range of areas. Sam joins us from East and North Hertfordshire Health and Care Partnership where he was director of development. In addition, we have recently welcomed Jonathan Rowell, who takes on the position of director of financial recovery for a 12-month secondment from NHS England and is acting up into the CFO role to cover sickness. Jonathan has more than 25 years' experience in NHS finance and will be key to helping us turn around our financial position.

You will all know that we are in a significant period of financial constraint and cost savings are critically important over the next three years. Together Sam and Jonathan will be working with our teams to help recover our financial position. While this is a sizeable challenge and one being felt across the NHS, patient safety will always be our highest priority.

For those of you who were not involved in the non-executive director (NED) recruitment, we have taken on five new NEDs from a great pool of talented candidates. They are:

- **David Weaver:** David has 35 years' experience in leadership positions in the financial services sector, where he advised and financed technology and growth companies. David is currently chair of the Orbit Group, which manage more than 47,000 homes in the midlands and the east of England.
- **Alison Wigg:** Alison has non-executive director experience within the East of England Ambulance Service NHS Trust and has chaired the strategic digital investment committee for the Suffolk and North East Essex Integrated Care Board (SNEE ICB), as well as more than 30 years' experience in global telecoms. Alison is currently a Board member for Suffolk Libraries and a STEM ambassador to promote science and technology in schools.
- **Dr Paul Zollinger-Read C.B.E.:** Paul worked as a GP in Braintree for almost 25 years, during which he became the chief executive officer of various primary care trusts in the east of England. Paul was also the former director of primary care at the East of England Strategic Health Authority and Bupa's chief medical officer. Paul currently holds several non-executive positions in health organisations.
- **Heather Hancock:** Heather trained as a scientist and has risen to board-level roles at biopharma company GSK and BMI Healthcare, before becoming chief executive officer for Promatica Digital. Heather is currently chief strategist and change maker for healthcare consulting service, The Conclusion People.
- **Richard Flatman:** Previously of Deloitte and group chief finance officer for London Southbank University Group, Richard is currently a non-executive director, senior independent director and chair of the audit and risk committee at South West London and St George's Mental Health Trust. Richard is also vice chair and chair of the audit and finance committee for South Bank Academies and Multi Academy Trust.

In order to address our financial challenges, we are continuing to build a strong and dynamic cost improvement programme (CIP) that focuses not just on reducing spending, but improving efficiencies in how we work. The benefits of this will be seen not just in the overall financial position, but in the improvement of the quality of the services we provide for our patients, staff, and visitors too.

At the end of June, we finished the month with a £9.5 million deficit. This is significant as we planned to finish 2024/25 with a £15.2 million deficit, therefore, we are £3.1 million over where we

wanted to be at that point in the year. While we hit our CIP targets for the first three months, this significantly increases from £507,000 a month to more than £1.5 million a month until the end of year, which will take considerable effort to achieve.

Achieving our CIP is crucial, and we will undoubtedly have to take some difficult decisions, that being said, there are positives we can highlight. Our pharmacy teams have worked hard during 2023/24 to implement a programme of medicines optimisation, which includes using biosimilar medicines and generic medicines to reduce our spending, as well as reducing the wastage of medicines and improving our procurement practices. During 2023/24, the team identified a £1 million CIP, with the first swap to a biosimilar medicine due to provide £250,000 to £300,000 of savings every year. We spent almost £29 million on medicines alone in 2023/24, so it is important that we spend every pound wisely.

We have also been improving how efficiently we use our theatres, particularly for planned elective operating sessions. Under NHS England's Getting It Right First Time (GIRFT) programme, trusts are expected to achieve 85% capped theatre utilisation, which supports NHS England's priorities and planning guidance to secure sustainable elective recovery. Over the past five years, the Trust has improved its capped and uncapped theatre utilisation rates, and thanks to a concerted effort from our surgery teams, we are expected to achieve 83.4% in 2024/25 for capped and 92% for uncapped. This means we are much better at using our time, staff, and resources to ensure we are seeing as many patients as possible, improving productivity and reducing running costs.

Despite further industrial action, we continue to make progress in our elective recovery. At the end of July, there were:

- 532 patients waiting more than 65 weeks (this is compared to April 2023, when the cohort of patients who needed to be treated was 15,878). We are now working towards eliminating 65 week waits by the end of September
- 60 patients waiting more than 78 weeks, of which 43 were capacity related breaches.

Quality

To ensure our patients are supported by their clinicians in making decisions about their care that are right for them, the Trust recently began implementing Shared Decision Making. This is a professional duty set out by the General Medical Council (GMC), with the National Institute for Health and Care Excellence (NICE) also mandating that all NHS organisations promote this process. These conversations bring together a clinician's expertise with what the patient knows best - their personal preferences, circumstances, goals, values, and beliefs. We made a mandatory training e-learning module available to our doctors on 1 July, which will also form part of induction training for all new doctors that join the Trust. Our public health teams are in the process of rolling this out to other clinical staff cohorts later this year.

I would like to take the time to thank one of our Trust charities – Friends of West Suffolk Hospital – who have generously funded numerous projects across the Trust with a series of grants. Totalling almost £90,000, this funding was made possible through donations and legacies from the local community, as well as funds raised by volunteers in their shop at the West Suffolk Hospital. We will share news on these in due course.

Workforce

Despite the pressure that the Trust is under, our colleagues continue to be innovative, creating and implementing new initiatives to improve patient safety and the quality of the care we provide. This is perfectly demonstrated through multiple team award nominations and successes.

Our surgical nursing teams have been shortlisted under the 'Theatre and Surgical Nursing Award' category for this year's Nursing Times Awards, for the work they are doing to improve patients' recovery from hip fracture surgery by providing targeted nutritional supplementation. Our

maternity service has been shortlisted for an HSJ Award under the category of 'Safety Improvement through Technology', for their use of social media to help women and pregnant people best understand the choices they have around their birth and care, as well as promoting health advice antenatally and postnatally.

In addition, the 'Virtual Bones' initiative, which enhances the efficiency of musculoskeletal injuries management and pathway referral, won in the category of 'Improving Urgent and Emergency Care through Digital' at the HSJ Digital Awards 2024.

These are incredible achievements and testament to our staff's commitment to improving patient care. Congratulations to those who have won and best of luck to those teams shortlisted.

It is fantastic to see our Trust's thriving staff networks – the REACH, Pride, disability and parent and carer networks support colleagues and offer the opportunity to connect over shared experiences and identities. Our Pride staff network marked Pride Month in June, underlining the Trust's commitment to making this an inclusive and respectful place in which to work, or be cared for.

To support the health and wellbeing of our workforce, in June, the organisational development team launched the Trust's first 'workplace adjustments' package. This new suite of resources will help support colleagues with diverse needs. Created in collaboration with the disability staff network, it contains helpful resources designed to support the identification, implementation, and future amendments of adjustments for colleagues with health conditions.

We have also announced the implementation of a new policy to help manage unacceptable behaviour. This deals with actions by patients, relatives, visitors and the public towards staff and includes discriminatory behaviour based on race, gender, sexual orientation and other protected characteristics. Given the recent abominable rioting and disorder in some parts of the country, it is timely to be bringing this in. We spoke about these topics recently in one of our staff All Staff Updates and I stated how deplorable this kind of behaviour was and is. Everyone, no matter who they are, should feel safe to go to work and live peacefully in their community.

With this year being the 50th anniversary of the West Suffolk Hospital, we have recently revived the historical society. Originally formed in 2019 but unfortunately petered out during Covid-19, this gives our staff the opportunity to share stories about the Trust and delve into the archives to uncover the history behind this hospital, which has provided care for our communities for half a century. With the first meeting taking place on 12 August, I hope this continues as another unique part of the social fabric of the West Suffolk NHS Foundation Trust.

Future

From mid-May to 30 June, the Trust along with SNEE ICB, carried out public engagement on plans to move approximately 60% (around 1,500 operations a year) of planned elective orthopaedic services from the West Suffolk Hospital to the new, state of the art centre in Colchester. The centre, which is due to open later in 2024, will be called the Essex and Suffolk Elective Orthopaedic Centre (ESEOC), and will be housed in a new building called the Dame Clare Marx Building.

The engagement was carried out through an online survey, outreach events and mini exhibitions, where members of the public were able to ask questions and find out more about the proposal. The engagement was also promoted at local libraries, GP practices, supermarkets, and local community groups. It finished with more than 2,200 responses. The results were independently analysed by Healthwatch Suffolk and they have now published their report on their website. The responses showed that about two thirds of those waiting for orthopaedic care from us are broadly supportive of the proposals compared to 40% of the wider public. The main issues raised were around transport and travel to and from the centre as well as access and choice. At the end of July, the ICB unanimously agreed to accept the proposals to move our services and we are now working on the themes raised in the report and next steps to move these services.

To the west of our area, significant progress is being made to deliver a new Community Diagnostic Centre (CDC) at the Newmarket Community Hospital. Construction began in early 2024, and the project is now more than halfway done, with the interior spaces beginning to take shape. Due to be completed by early-November 2024, the first patients are expected to be seen before Christmas 2024.

This facility will provide a wide range of diagnostic tests, such as MRI, CT and ultrasound scans, and blood and lung function tests. Around, 100,000 tests are expected to be carried out a year, which will not only help us reduce waiting times, but importantly, improve patient outcomes, and provide the care our communities need, closer to home.

To deliver on these ambitions we need the workforce. I was delighted to see how popular the recent West Suffolk Community Training Academy was, which offers those in our local communities with no prior experience in the health or care sector the opportunity to gain these skills and experience an exciting and rewarding career in the NHS. The first cohort have completed masterclasses, are currently finishing their placements, and will be preparing for or will have gone through their guaranteed interview for a position within the Newmarket CDC, the wider Trust or within primary care. This is one of the ways in which we collaborate with our local education system and health partners to build new pathways into the NHS. I look forward to meeting the successful applicants when this new facility is up and running.

While we frequently work across the Suffolk and North East Essex Integrated Care System (SNEE ICS), particularly with our ICB partners, we have been working very closely with the East Suffolk and North Essex NHS Foundation Trust (ESNEFT) for some time. We have recently formalised this collaborative approach with the formation of the Suffolk and North East Essex Provider Collaborative at a joint Board meeting on 4 June. A key milestone, this strengthens the governance arrangements between our organisations and will ensure we use our resources as efficiently as possible, reducing replication in key areas and capitalising on economies of scale, with the ultimate goal of delivering a single system approach to healthcare.

Over the year, the focus of this will be in five areas: clinical services; elective recovery; efficiencies at scale; digital; and development. Example workstreams include producing an integrated care system clinical strategy, increasing our diagnostics workforce, reviewing our corporate services, looking for digital opportunities across the system and the formation of a collaborative project management function.

On 24 September, we will host healthcare event and Annual Members' Meeting at The Apex in Bury St Edmunds. This gives us the opportunity to give our local communities insight and access to a range of the Trust's services, other local health and care services, as well as an update on how we've done over the past year. This year, the event will focus on the West Suffolk Hospital's 50th anniversary and how we are developing and improving our diagnostic imaging. It will start at 3.30pm, featuring stalls from our teams and health and care partners, with a talk from 5.30pm to 6.35pm. Attendees will have the opportunity to ask any questions to our presenters and executive team and light refreshments will be available. All are welcome and it is free to attend. I look forward to seeing you there.

8. Finance Update (enclosed)

To receive an update on financial position

For Report

Presented by Jonathan Rowell

WSFT Council of Governors meeting (Open)	
Report title:	Finance update
Agenda item:	8
Date of the meeting:	2 September 2024
Lead:	Jonathan Rowell, Executive Director Financial Recovery
Report prepared by:	Nick Macdonald, Deputy Director of Finance

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

Financial Position July 2024 (M4).

	In-Month Budget £m	In-Month Actuals £m	In-Month Variance £m F/(A)	YTD Budget £m	YTD Actuals £m	YTD Variance £m F/(A)	Annual Budget £m	Forecast £m	Forecast Variance £m F/(A)
Impairments									
Finance Costs	**0.4**	**0.4**	**0.0**	**1.8**	**1.8**	**0.0**	**6.8**	**6.8**	**0.0**
Depreciation	**1.4**	**1.4**	**0.0**	**5.6**	**5.6**	**0.0**	**16.6**	**16.6**	**0.0**
EBITDA									
Expenditure									
Non-pay Costs	9.3	9.4	-0.1	38.2	39.2	-1.0	107.5	107.5	0.0
Pay Costs	23.3	23.6	-0.4	92.8	94.9	-2.1	272.9	272.9	0.0
Total	**32.6**	**33.0**	**-0.4**	**131.0**	**134.1**	**-3.1**	**380.4**	**380.4**	**0.0**
Income									
Other Income	3.4	3.5	0.1	13.3	12.9	-0.4	37.6	37.6	0.0
NHS Contract Income	29.2	29.3	0.1	117.0	117.1	0.0	351.1	351.1	0.0
Total	**32.7**	**32.8**	**0.1**	**130.3**	**130.0**	**-0.3**	**388.6**	**388.6**	**0.0**
EBITDA Position	**0.1**	**0.2**	**-0.3**	**0.7**	**4.2**	**-3.4**	**8.3**	**8.3**	**0.0**
Deficit/(Surplus)	**1.7**	**2.0**	**-0.3**	**8.1**	**11.6**	**-3.4**	**15.2**	**15.2**	**0.0**

- The plan is to record a deficit of £15.2m in 2024-25. This plan is contingent on:
  - Delivering CIP - £16.5m for 24-25 (4%)
  - Improving our run rate - £2.5m per month
- The reported I&E for July is an adverse variance of £0.3m to budget (£3.4m YTD)
- The July actuals (£2.0m deficit) reported an improvement against the M1-3 trend (average £3.2m deficit per month)
  - This included a non-recurring benefit of £0.5m
  - The recurring run rate improved by £0.4m in July (£2.4m vs £2.8m average M1-3)

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

Year to date position (M4)

The YTD position reports an adverse variance of £3.4m which is largely due to:

- Underachieved CIP £1.3m
- ECW above plan £1.1m
- Backdated (unbudgeted) APA claims and payments £0.6m

Cost Improvement Programme

The Trust has delivered £2.3m CIP YTD against a target of £3.5m, (£1.2m behind plan). It is important to note that the majority of the 24/25 delivery YTD is due to the full year benefit of 23/24 schemes (£548k), PDC reduction (£795k) and non-current CNST premium reduction (£270k). Other new recurring schemes for 24/25 have contributed £649k YTD.

In month CIP progress (July)

The table below provides a summary of our most up to-date risk adjusted CIP plan. We achieved our CIP target for April and May (£1.0m cumulatively) but failed to achieve our June plan by £360k and July by £921k (£551k against a plan of £1.472m).

Our CIP plan increased by £458k in July to £1.472m and will increase by a further £155k in August to £1.627m per month, remaining at that level for the rest of the year.

Since June we have identified a further £700k of schemes.

Achieving the planned £16.5m CIP remains a significant risk. The Executive Recovery Meetings scheduled week commencing 19th August will review the divisional CIP plans as part of the divisions' financial recovery plan.

Whilst around £13.4m of CIP schemes have been identified (FYE) after risk adjusting and incorporating time slippage, we would anticipate these schemes would deliver £10.6m of savings in 2425. This is currently £5.9m below our target.

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

Actions being implemented

A number of controls and processes have been put in place in line with the ten measures shared with the Board at the end of July. In terms of standing these actions up, in the very short term we are repurposing our PMO support to focus on getting these in place as soon as possible.

A financial recovery plan has been shared with the ICB. These actions suggest a target of around £700k improvement per month but this requires further work up to be confidently quantified.

Meanwhile, we have set up of a non-pay control panel (NPCP) for orders above £500 which started meeting at the beginning of August. The ICB have now introduced double lock arrangements for approval of items above £15k.

We have also scheduled financial recovery meetings with each Division week commencing 19th August – the ADO will present their divisions financial recovery plan to the CEO and CFO at this meeting.

Whilst it is clear that more actions will need to be put in place these will form part of a fuller financial recovery plan that will be shared at the September Insight meeting.

Progress will be monitored and reported through FRG, FAC and Insight.

CIP

In order to achieve our target of £16.5m for 24-25, a further £5.9m CIP needs to be delivered (notwithstanding slippage), which translates to broadly a further £8.5m needing to be identified urgently. There are currently 147 schemes in the pipeline that will contribute to closing this gap.

Cost of time slippage in M1-4 is estimated at £1.1m however, further slippage due to timeframes of implementation would further heighten the challenge, therefore it is important to identify opportunities and that all schemes are moved to gateway 3 (delivery) ASAP.

Budget Holding Division	Target £k	Identified 24/25 £k	Gateway 1 RA 60% £k	Gateway 2 RA 40% £k	Gateway 3 RA 20% £k	In delivery RA 0% £k	Plans 24/25 after RA £K	Time Slippage £k	Gap to Target £k	Pipeline PIDs
Community	1,613	1,053	229	-	277	135	640	(200)	(1,172)	30
Corporate	4,838	3,637	258	-	201	2,742	3,201	(226)	(1,864)	11
CSS	939	939	191	-	164	256	612	(137)	(464)	19
Estates & Facilities	936	720	66	-	76	460	602	(66)	(399)	9
Medicine	2,211	1,794	124	-	173	1,268	1,564	(303)	(949)	16
Surgery	2,621	1,880	65	-	164	1,513	1,742	(124)	(1,003)	22
Women & Children	542	479	34	49	5	307	394	(22)	(170)	5
To be agreed	-	105	-	-	-	105	105	-	105	35
Additional	2,800	2,800	520	-	-	2,280	2,800	-	-	-
	16,500	**13,408**	**1,487**	**49**	**1,060**	**9,065**	**11,660**	**(1,077)**	**(5,917)**	**147**

Recommendation / action required

The Council of Governors is asked to note the report.

Previously considered by:	NA
Risk and assurance:	Financial risk
Equality, diversity and inclusion:	N/A
Sustainability:	Financial sustainability
Legal and regulatory context:	NHS Act 2006, West Suffolk NHS Foundation Trust Constitution

GOVERNOR BUSINESS (INC. STATUTORY DUTIES)

9. 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:	2 September 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			
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:

15 May 2024 (observed by Jayne Neal and John-Paul Holt)

- Report from sub-committees: Financial Accountability Committee and Patient Access Governance Group
- IQPR - data for March 2024
- NDD Update
- Corporate risk governance group report
- Operational planning guidance submission
- Board assurance framework
- Escalations to and from other board assurance committees and board
- Forward Plan

19 June 2024 (observed by Jayne Neale, Jane Skinner and Liz Hodder)

- Report from sub-committees: Financial Accountability Committee and Patient Access Governance Group
- Productivity deep dive
- MRI managed service procurement
- IQPR – data for April 2024
- Escalations to and from other board assurance committees and board
- Forward Plan

17 July 2024 (observed by Jayne Neale and John-Paul Holt)

- Report from sub-committees: Financial Accountability Committee and Patient Access Governance Group
- Workforce planning
- Glemsford surgery deep dive
- Alliance UEC Group terms of reference
- BAF risk – System capacity
- IQPR - data for May 2024
- Corporate risk governance GROUP
- Outcome of committee self-evaluation process
- Escalations to and from other board assurance committees and board
- Forward Plan

IMPROVEMENT COMMITTEE:

15 May 2024 (observed by Anna Conochie 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, CQC May update and agree any areas requiring assurance review
- Glemsford CQC report
- Patient safety priorities 2024/25
- Risk Management and Governance
- Board assurance framework
- RADAR update
- Oversight on Trust financial decisions
- Escalations to and from other board assurance committees and board

19 June 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, CQC update and agree any areas requiring assurance review
- Home Office Visit - update and feedback
- Deep Dive - Accreditations / Licences process
- Quality (priorities, improvement and assurance) including patient safety priorities 2024-25, Learning from recent Inquest – challenges
- Risk management and governance
- Board assurance framework
- RADAR update
- Oversight on Trust financial decisions
- Escalations to and from other board assurance committees and board

17 July 2024 (observed by Adam Musgrove)

- Reports from governance sub-groups: Patient Quality & Safety
- Maternity incentive scheme update
- Birth trauma gap analysis
- Quality & patient safety insight: IQPR and content, PRM packs and areas requiring assurance review
- Repatriation of Anaemia patients
- Deep Dive – Safe Environment (Safety in peoples' homes)
- Risk management and governance, BAF Governance risk Review,
- Annual review of effectiveness and terms of reference
- Escalations to and from other board assurance committees and board

INVOLVEMENT COMMITTEE:

19 June 2024 (observed by Sarah Hanratty and Val Dutton)

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

First for future:

- Workplace Strategy

First for staff:

- Case study: using staff survey to drive improvement in staff experience (SaLT)
- People and Culture Plan 2024/25 – for approval
- Learning themes from employment relations cases

First for patients:

- Patient Experience annual quality report
- Update on Complaints quality improvement project

Governance:

- People and Culture Group update - January 2024 report
- Experience of Care and Engagement Committee report
- Quarterly Guardian of Safe Working report

- Board Assurance Framework domain 1: Capability

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

Assurance Grid

June 2024		ASSURANCE: Pass (P)	ASSURANCE: Hit and Miss (?)	ASSURANCE: Fail (F) – Not Met
VARIANCE	Special Cause Improvement (H / L)		**INSIGHT** Cancer 62 Days Performance **INVOLVEMENT** Staff Sickness– Rolling 12month Staff Sickness Mandatory Training	**INSIGHT** RTT 78+ Week Waits **INVOLVEMENT** Appraisal Turnover
VARIANCE	Common Cause	**INSIGHT** Urgent 2 Hour Response	Please see box to right	**INSIGHT** 12 Hour Breaches Virtual Ward Total Average Occupancy Number Respiratory Bay Average Occupancy Number Heart Failure Bay Average Occupancy Number IV Abx Bay Average Occupancy Number Frailty Bay Average Occupancy Number Incomplete 104 Day Waits
Deteriorating	Special Cause Concern (H / L)		**INSIGHT** 12 Hour Breaches as a Percentage of Attendances	

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
% Patients with No Criteria to Reside
Virtual Ward Total Average LOS per Patient
28 Day Faster Diagnosis
Community Paediatrics RTT Overall 78 Weeks Wait
Community Paediatrics RTT Overall 104 Weeks Wait
IMPROVEMENT:
C-Diff Hospital & Community
INVOLVEMENT:
Overdue Responses

INSIGHT: Glemsford GP Practice – the following KPIs are applicable to the practice:
- Urgent appointments within 48 hours
- Routine appointments within 2 weeks
- Increase the % of patients with hypertension treated to NICE guidelines to 77% by March 2024
- Increase the % of patients aged 25-84 years old with a CVD risk score of >20% on lipid lowering therapies to 60%

Currently this data is not available to the Trust, however the Information Team are working to resolve this.

*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 Ca use of Concerning Nature by area:
INSIGHT - Urgent & Emergency Care: 12 Hour Breaches, 12 Hour Breaches as a Percentage of Attendances, Virtual Ward Total Average Occupancy Number, 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
INVOLVEMENT – Well Led: Appraisal, Turnover

9.1. Insight Committee

Presented by Michael Parsons

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			**Date of meeting: 15 May 2024**		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Craig Black**		
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
PAGG/IQPR	The Committee discussed the fact that caseloads in Paediatric Speech and Language therapy remained high. Compliance with 18 weeks performance was 79.8% with 87 children waiting over 18 weeks and the longest wait at 43 weeks.	**3 Partial**	The trial for the preschool complex needs pathway is proving effective but caseloads remain high A system-wide approach is needed to respond to the levels of need and the link to the SEND inspection action plan for the area which needs to consider sufficiency of provision.	The ICB will update on plans for a programme of review at the May 2024 contract meeting, in the context of the Suffolk SEND inspection action plan. The service will also be engaging with the Joint Strategic Needs Assessment which is programmed to happen before the end of December 24 as this links to resources needed to respond to increased SEND demand. The waiting times for paediatric speech and language therapy will not reduce until the system response is agreed and resources aligned to that.	2 Escalate to ICB contract meeting

Originating Committee: Insight Committee			Date of meeting: 15 May 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Craig Black**		
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
Operational Planning Guidance 24/25	The Committee focused its discussion on the Operational Planning guidance and the trajectories the Trust has set over 24/25. The guidance contains 32 national operational targets with which the SNEE ICB needs to comply. As a provider Trust within the geography, we need to identify our own targets and trajectories across elective activity, diagnostics, cancer and urgent and emergency care.	**2 Reasonable**	Many of the targets are continuations or enhancements of those targets the Committee has been tracking during 23/24 and the Trust did not achieve all of those targets so additional activity or performance improvements will be required in 24/25. All performance expectations are planned to be met, with the exception of the absolute elective activity targets where we are not forecast to reach 108.09% of 2019/20 levels. However, this is achieved when taking into account the Value Weighted Activity (VWA) calculation. In 2023/24 we did not achieve the original 107% ambition, but did reach the threshold through VWA.	Insight Committee endorsed the proposals for onward reporting in detail to Public Board on 24 May 2024. Insight will continue to monitor progress against performance monthly. The opening of the Community Diagnostic Centre in November will contribute to performance delivery and the benefits of this need to be maximised	3 To be presented to Board on 24 May

Originating Committee: Insight Committee			Date of meeting: 15 May 2024		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Craig Black		
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
			The 65-week wait target has been extended to Sept 2024. This will require the backlog 407 patients to be cleared as well as new patients reaching that threshold. We are modelling a static position for people waiting more than 52 weeks. The key risks to delivery include ensuring the changes introduced in 23/24 are followed through in the new financial year; managing bed allocations between elective and urgent and emergency care; managing the requirement to keep whole time equivalent staffing numbers static and the demands of our financial recovery plan. Meeting these targets is crucial to patient safety as they will be a more risk of harm the longer they wait for treatment.		

Originating Committee: Insight Committee			Date of meeting: 15 May 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Craig Black**		
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
Community Paediatrics - Neurodevelopmental Disorders pathway (NDD) update	The Committee received an update on the progress had been made to deal with the system-wide backlog of referrals from the Barnardo's co-ordination service. There is not enough clinical resource to meet the demand and so the ICB committed £660k of non-recurrent funding to WSFT to support dealing with the backlog of 586 children who had not been triaged by the Barnardo's service. The focus is the first cohort of children whose cases were received by Barnardo's before September 2023	**2 Reasonable**	The service remains as a red risk Over 11% of the backlog has waited more than 65 weeks for an appointment. There remains concern about impact on the wider pathway of delays in the Norfolk and Suffolk NHS Foundation Trust. There are also concerns about the impact of demand on the resilience and well-being of the team.	The procurement to find external providers was successful and two have been identified and the triage process started ahead of schedule. It is due to conclude in November 2024. The SNEE ICB is being supportive and on-going liaison is happening at system level to ensure there is focus on the capacity of the core NDD service as well as the backlog. WSFT will also be hosting a NDD Transformation Project lead who will support the system to develop of a future service model.	Escalate to Board for information

Originating Committee: Insight Committee			Date of meeting: 15 May 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Craig Black**		
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
Board Assurance Framework (BAF)	The Committee considered the draft assessment of the Finance Risk within the BAF	**3 Partial**	There appeared to be a mismatch between some of the more optimistic scores and the lack of effective financial controls demonstrated through the budget setting process.	The Financial Accountability Committee to review the risk template and update this for reporting back to Insight Committee. Insight to undertake deep dives into the risks and mitigations on a rolling programme. Chair of the Audit Committee to and Trust Secretary to give consideration to the role of the Audit Committee to ensure the work of both committees was complementary	3 escalation to Board for information

Originating Committee: Insight Committee			Date of meeting: 15 May 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Craig Black**		
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
Finance Accountability Committee	**2024/25 budget** In response to a request from SNEE ICB the Board have agreed to an additional £2.8m savings in 24/25 to reduce the budgeted deficit to £15.2m. This requires a Cost Improvement Programme of £16.5m which is the equivalent of 4%. The new initiatives identified to bridge this gap need integrating with the updated action plan, which tackled the PA consulting report and original plan for a deficit of £18m. This will enable performance monitoring against planned trajectories.	**3 Partial**	The CIP target will be challenging and will need sustained focus. It will be imperative to move the schemes through the gateway process in a timely way and tack the timing of the cost improvements being delivered. As a scheme may have go-ahead through the gateway process but the benefits may not be realisable immediately depending on the complexity of the implementation plan. This remains a significant risk for the Trust.	Insight will review the progress against plan at each meeting. The Executive team is reviewing what additional support may be required to support the programme.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 15 May 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Craig Black**		
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
	Month 1 performance In Month 1 there was an adverse performance against plan of £370k this relates to the April costs of UEC improvement; the escalation ward being open; and backdated APA claims		These appear to be non-recurrent costs. There appears to be a mismatch between what has been budgeted and the plans for the escalation ward which concerned the committee.	The Executive team need to review how this mismatch has occurred. Work is being undertaken to ensure there are no backdated APA claims in future	

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!
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Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			**Date of meeting: 19 June 2024**		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Craig Black**		
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
Finance Accountability Committee	**24/25 Budget Month 2 report** There was a £1.3m variance against planned budget in Month 2.	**3 Partial**	It is concerning to be off plan already in the financial year. Half of this amount is non-recurrent. Inflationary pressures and backdated APA's in medical staffing are drivers of the additional costs. The escalation ward is now closed although there is concern that this might drive costs elsewhere.	Further scrutiny of the increases in Additional Programmed Activities in consultant job plans is being undertaken by the Workforce Resource Group Insight Committee will be undertaking a deep dive into bed allocation at a future meeting. The future of ward F9 will need consideration at the end of the RAAC decant programme.	Escalate to Board for information
	Financial Plan and CIP programme The committee consider the consolidated financial plan to address the deficit of £15.2m in 24/25. Good progress had been made in first two months against the CIP plan but the scale of CIP required is challenging.	**3 Partial**	The good progress made is encouraging but there is a significant amount of CIP still to be identified and the targets for delivery are more challenging in coming months. This remains a significant risk to achieving the agreed financial plan.	The Committee expressed concern about the scale of CIP project still to be identified and request intervention to increase the pace on identifying projects to enable implementation in year.	Escalate to Management Executive Team for action. Board to be advised of risk

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Referral from Improvement Committee	**Patient Safety** Improvement Committee drew the Insight Committee's attention to the need to ensure the quality pf patient care is considered alongside financial implications of the CIP programme.	**2 Reasonable**	It is important to balance quality and safety issues alongside the financial imperatives the Trust faces.	Chief Nurse and Medical director to be involved in the quality assurance process of CIP schemes.	No escalation
Deep Dive - benefit realisation of investment decisions	The committee undertook a deep dive to explore whether the benefit of investment decisions were consistently evaluated and appropriate action taken if investments were not achieving the benefits identified in their business case. The Investment Panel's terms of reference include evaluating the	**3 Partial**	The deep dive highlighted a need for clearer business cases which articulated the benefits to be achieved and how these would be assessed. Clinical input is needed in this process to ensure clinical benefits are properly assessed. Digital projects in particular need clearer benefits realisation processes and greater clarity of the costs and benefits of bespoke IT solutions.	Investment Panel to review remainder of investments to assess whether they are achieving agreed outcomes and if disinvestment may be appropriate. Improvements need to be made to business case processes and these	Escalate to the investment Panel and Digital Board. To note the Invetsment Panel will convene the next benefits

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	benefits of investments of 36 funded schemes in last two years only 18 had been reviewed to assess whether benefits had been achieved. The remaining 18 were approved as cost pressures at Management Executive Group as part of budget setting on 14th February 2024 and had therefore not yet been evaluated. The deep dive also looked at work force planning in the context of the growth in staff numbers and the need to keep whole time equivalent staff numbers the same or lower by the end of the financial year.		When financial savings are promised, relevant budgets should be reduced to reflect the benefits to be realised. There should be explicit decision making around disinvesting in initiatives that are not achieving benefits. There is a need to develop better workforce planning to keep track of staff numbers and to ensure resource is aligned to need and achieving agreed outcomes.	need to be developed for digital projects. Further discussions are need on work force planning and the Director of People and communications to be invited to the next Insight Committee	realisation session on 19th July and monthly thereafter.

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PAGG/IQPR	There is still inconsistent performance across the range of operational targets. The committee discussed in particular: **Cancer Targets** All were on trajectory in month **65 and 78 week waits** There was an increase in patients waiting over 65 weeks between March and April but the total cohort is on trajectory to be treated by the end of September 2024. The total number of 78 week waits remains static with capacity breaches in gynaecology. CT is also off trajectory	**3 Partial**	Patients are at increased risk of harm the longer they wait for treatment The committee were given detailed trajectories against which performance will be measured in subsequent meetings.	Urogynae engagement with the Nuffield in Ipswich is continuing. The Surgical division has plans to mitigate forecast deficits Further information has been requested on CT trends over the last 12 months.	Escalate to COO to review non-admitted target

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	Dermatology Due to staffing shortages the service will not be offering new patients phototherapy or Isotretinoin. **Urgent and Emergency Care (UEC)** 12 hour breaches as a percentage of attendance is consistently above 2% 4 hour performance is just under trajectory Ambulance handover performance is still problematic Further information has been requested on CT trends over the last 12 months, as it is not meeting its target.		Patients will be offered alternative treatments and may access these ones when the staffing situation has improved Patients do not have a good experience of they face significant delays and re 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 Committee asked for non-admitted performance targets to be reviewed to see if we should be more ambitious with a target of 90% not 80%.	GPs are being informed and patients will be seen as and offered alternative treatments Work continues with alliance partners to focus on the UEC recovery plan, with a new structure to be operational by the end of June. The Minor Emergency Care Unit is predicted to be delivered by the end of July/early August. We await formal feedback from the NHSE Improvement team, who visited in May 2024 to review UEC pathways. Chief Operating Officer to be asked to review non-admitted target.	

Guidance notes

The practice of scrutiny and assurance

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Board assurance committee - Committee Key Issues (CKI) report

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PAAG/IQPR	**65 and 78 week waits** There was an increase in patients waiting over 65 weeks from April to May, although the total cohort of 65 week waits to be treated before the end of September 2024 is on trajectory overall. The deficit in Plastics, ENT and General Surgery has been mitigated and the Orthopaedics gap significantly reduced. Gynaecology are over trajectory by 31 currently. There is an on-going risk to both 78 and 65 week waits within Gynaecology, which is not fully mitigated.	**3.Partial**	Patients are at risk of harm the longer they wait for treatment	Urogynaecology continues to be the area with 78 week capacity breaches. Patients have started to be transferred to Nuffield. The next step is to review the shortfall, as many patients are not suitable for transfer, and agree a plan to mitigate this gap, which includes the feasibility of weekend working. Surgery have plans to mitigate their deficit with weekend lists and no dropped lists over the summer months. There will be an ICB wide review of pre-outpatient demand with a view to reducing variance and demand.	1 No escalation

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PAGG/IQPR	**Cancer Targets** Performance against the 28-day Faster Diagnosis Standard (FDS) is not being consistently met. The standard was met in February 2024 and March 2024 above 75%, but there has been a drop to 70.8% in April due to challenges in Lower GI investigations and delays with photography and review in dermatology. 62-day performance is at 80.8%, which is above the national ambition of 70% performance by the end of March 2025	**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.	Specific actions include: Reviewing the current community pathway for dermatology with the aim of reducing demand on secondary care. Continuation of insourced dermatology activity to be presented to Management Executive Group on the 03/07/2024. Implementation of the cancer alliance priorities, with specific focus on Gynaecology HRT and Urology re-stratification, in line with national objectives by Q3.	1 Escalation to Management Executive Group

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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 Ambulance handover in 30 mins was 84.2% in May 4-hour performance was 67.71%, just under the improvement trajectory 12-hour breaches are consistently failing with common cause variation and were at 8.6%	**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.	Work continues with alliance partners to focus on the UEC recovery plan with a trajectory to achieve the 78% 4hr ED target by March '25. Weekly performance meetings will review periods of reduced performance to identify future improvements. A new rota for ED leadership team will see them based solely in ED supporting performance. There is a focused work plan for improving overnight ED performance with a series of projects beginning in July 24. Implementation date for Minor Emergency Care Unit is likely to be end August 24	1 No escalation

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Deep Dive Glemsford Surgery	The Committee requested a deep dive into Glemsford Surgery performance data as information was not being reported through the IQPR process. The internal Informatics team have access to some data but there is no internal reporting structure for the surgery. Some data is held by the ICB and this is not made available in a timely way. The surgery does have access to Radar to report patient harm. The only consistently available data is patient feedback. There were no patient complaints in the last quarter and two comments were received via PALs about access.	**4 Minimal**	The Trust is unable to measure the performance of a key service or gain assurance about the quality of services provided due to lack of any reliable and timely data. There appears to be a lack of a clear governance process to escalate and prioritise data requests. The committee discussion highlighted the struggle there had been to escalate the issue internally and there was learning to be gleaned from this experience.	The implementation of the data warehouse will go live by the end of July and will take two months to test. This should give the Trust internal control over the information but this requires further clarification. COO to clarify whether the Trust will still be reliant for the ICB for any data and, if so to escalate to the ICB the need for this to be provided in a timely way.	2Escalate to the ICB if required

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Finance Accountability Group	**Current year** The Trust was £3.1m off plan year to date by the end of month 3, with a deficit of £9.5m against a planned deficit of £6.4m. The current run rate is £2.7m above budget and the CIP programme is £400k behind. The Trust has requested cash support and this adverse variance intensifies the need for further support. The Executive Director of People joined the committee for a discussion about workforce planning. The discussion focused on how we track and influence workforce decisions	**4 Minimal**	Pay costs continue to be a significant driver of the deficit and there is an urgent need to understand what is driving medical staffing costs and the relationship with increased ERF performance. The SNEE ICB Finance Committee will be recommending the implementation of stronger double lock mechanisms for future financial decisions. Lack of cash will impact on payments to suppliers. There is a significant amount of CIP still to be identified and the targets for delivery are more challenging in coming months.	A new director of Financial Recovery has been appointed and has begun to review the underlying financial position. The Committee agreed a new set of non-pay control measures to be recommended to the Board. Further work is needed to understand the drivers of pay costs and what appropriate controls were needed, particularly in relation to medical pay costs. Exec to consider messaging around this and how we assess quality and safety impacts of decisions. Also to consider the information and data	3 Escalate to Board and to Executive

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	corporately when a lot of those decisions are currently devolved to divisions.		This remains a significant risk to achieving the agreed financial plan. The current control measures are not achieving the desired financial impact and tighter controls are needed. The committee recognised the tensions in balancing Trust's culture of devolved responsibility with the need for greater scrutiny and control of financial decisions. There also appear to be gaps in knowledge about what is happening at a granular level which need to be addressed. There is a need to have clear messaging about balancing quality and safety in services – the committee noted these are not the same thing and can be conflated.	collection required to drive future decisions.	

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Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 15th May 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 again, including Board Assurance Framework, NDD Update, Operational Planning Guidance Submission, Updated Action Plan to PA Consulting's Report & the Trust's response to the ICB's revised CIP target. • 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.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• No medical representation at today's meeting, though noted trust-wide email stating the Trust's Medical Director is currently away from work for an unknown length of time. An Interim Director has been appointed, though was not in attendance for today's meeting. • A NED self-nominated at the start of today's meeting, to take notes and provide reflections at the end of the meeting. The reflections were well constructed and presented, highlighting that good challenges were made throughout and how discussions reflected the Trust's FIRST Values. • Discussions were had when reviewing the minutes from the previous meeting regarding the length of the minutes & how these could be better summarised. The Chair referred to some of the recommendations from the Trust's Well-Led Review and how these could be tied into possible changes in how the minutes of each meeting are recorded. • Proposal made to invite new UEC & Elective ICB Lead to future INSIGHT meetings, as ICB attendance has been lacking recently & it was unanimously agreed by the Committee that this would be highly beneficial.

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.*
• Challenges made & assurance sort by NEDs throughout meeting on a range of different topics. • It was highlighted that there is an apparent disconnect between executive decision making & budget setting, also particularly mentioned between operational & financial teams. I would like to seek assurance that this is addressed.
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• I was delighted by the committee's response to today's NDD Update. The Chair & Exec's gave positive feedback and encouragement in response to the great work that has been done on the NDD Pathway. Representative from NDD Team was informed by the Chair that this will be escalated to Board, to ensure that everyone is aware of the great work that has been done within the team.

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 15 May 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 meeting included the regular finance and operational matters. • The Committee discussed the Board Assurance Framework (BAF) risks relevant to finance and capacity and risks around Emergency Planning and Preparedness. • There was a verbal update concerning the recent Financial Accountability Committee (FAC) work around the updated PA Consulting Action Plan and with the ICB and CIP targets • There was also an update on Neurodevelopmental Disorders (NDD) in Suffolk
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*

- The meeting began on time. The Chair welcomed everyone
- The meeting conduct was polite and respectful throughout with all attendees being given the opportunity to contribute
- Searching questions were asked by NEDs, in particular concerning finance matters and IQPR issues
- At the end of the meeting agenda a NED was asked to independently reflect on the meeting. They highlighted the open conversations around difficult subjects which attendees had closely and respectfully challenged
- At the conclusion of the meeting the Chair summarised key issues arising from their discussions and thanked everyone for their contributions. FIRST values were demonstrated throughout the meeting

Assurance

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- More work is required to improve levels of confidence and assurance around the BAF risks discussed today.
- Low level of assurance re CIP and budgets.
- Mixed levels of assurance regarding reducing waiting times due to difficulties in balancing treating more in and outpatients vv increased emergency demand. It's hoped diagnostic activity will improve when the Newmarket facilities open in November. The programme is currently on-track, timewise.

Governor observer Notes

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

- The update concerning NDD was encouraging. Still high levels of complicated caseloads but reviewing ways of working may help; i.e. not every case needs to be medically driven by a consultant or doctor so better use of nurses and psychologists where appropriate, whilst bearing in mind the wellbeing and potential knock-on effects on the community paediatric team.

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 19th June 2024
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*
• The main focus of this meeting was on the Trust's financial position generally and at month 2, and on CIPs, some confidential issues discussed. • IQPR metrics are still being developed • Discussion on MRI managed service procurement • Insight forward plan presented including proposed deep dives
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Reflection: well chaired as usual, good timing, attendees' opinions and views listened to. Challenging conversation, felt a safe place to challenge, which was respectful and fair and good eye contact
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.*
• Focus on assurance or lack of it. • Chair attends ICB finance meeting which now follows Insight and so is better aligned • Board has minimal assurance that financial recovery/risk is being controlled effectively. Subsequent to the meeting it was announced that a new externally appointed finance director (1 year secondment) to oversee financial action plan

• CIPs affecting service provision are subject to impact assessment
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• Deep Dive into benefits from investment and tracking WTE growth presented. The work force has grown over the last few years but productivity has not matched that increase. I am not sure how this productivity is measured, in addition more staff work flexibly and from home, I wondered how the productivity of those working from home is measured? • Governors will need to seek assurance on the impact of decision taken re managing the MRI service on patient waiting times for MRI scans

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 19 June 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 and relevant papers were available in advance of the meeting. • The meeting included the regular finance and operational matters, plus a productivity deep dive and a discussion on the MRI Managed Procurement Service
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• The meeting began on time. The Chair welcomed everyone • The meeting conduct was polite and respectful throughout with all attendees being given the opportunity to contribute • Searching questions were asked by NEDs and all executives • At the end of the meeting agenda a NED was asked to independently reflect on the meeting. They highlighted the open conversations around difficult subjects which attendees had closely and respectfully challenged • At the conclusion of the meeting the Chair summarised key issues arising from their discussions and thanked everyone for their contributions. FIRST values were demonstrated throughout the meeting • The finance and 'deep dive' discussions over-ran time wise which left less time for operational / IQPR matters but the Chair gave an assurance the July meeting will focus on these areas.

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 deficit continues to be of major concern and will continue, particularly as there are already some known escalation of costs for next financial year. Financial planning is focussing on identifying more CIP schemes but this is increasingly challenging as potential inflation costs and other external factors beyond the control of the Trust may influence budgeting • There has been increased theatre use recently, therefore, more patients have been treated which generates additional income. Increasing the numbers of diagnostic tests being carried out will also help, similarly.
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• The Productivity deep dive focussed on staffing matters and related costs (overlapping with earlier budgetary discussions). • The proposal to manage the MRI service in-house was discussed and agreed. This will offer a range of benefits including high quality maintenance service. This same approach has been adopted by the endoscopy service and has worked well.

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 19 June 2024
Governor observer (observed by): Elizabeth Hodder

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• This was my first Insight meeting. I found it fascinating and very illuminating. I hope my input via this form next time will be more fulsome.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• *The meeting was conducted admirably and pace maintained.*
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.*
• *None*
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• *Although this was my first meeting. I cannot put my hand on anything I could readily identify for improvement.*

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 17 July 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 and most of the papers were available in advance of the meeting. There was one late addition to the agenda. • The meeting included the regular finance and operational matters, plus discussions on workforce planning and controls to address both pay and non-pay expenditures. • The agenda included discussions around the limited amount of data available from the Glemsford surgery, (part of the West Suffolk NHS FT) mainly due to poor IT issues.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• The meeting began on time. The Chair welcomed everyone • The meeting conduct was polite and respectful throughout with all attendees being given the opportunity to contribute • Searching questions were asked by all executives and the NED in attendance • At the end of the meeting the acting Medical Director independently reflected on the meeting. They highlighted there was lots of respectful challenge from attendees and in particular the final 30 minutes of the meeting was challenging and productive around difficult subjects. • At the conclusion of the meeting the Chair summarised key issues arising from their discussions and highlighted areas for escalation. Everyone was thanked everyone for their contributions. • FIRST values were demonstrated 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.*
• The financial deficit continues to be of major concern and the meeting focussed on how some aspects of this has occurred, along with actions and processes to address overspends.
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• In addition to the Chair, only one NED was available for this meeting which was not the norm.

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 17th July 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, including Deep-Dive of Glemsford Surgery presented by the Community Clinical Lead for Quality & Safety • 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.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Interim Medical Director was in attendance for today's meeting. Was able to provide vital contributions to discussion & also self-nominated to do feedback at end of the meeting. Feedback was thorough & largely complimented by the other members of the committee. • The Trust's chair was also in attendance at today's meeting. • Aside from the Chair of the Committee, there was only one NED in attendance today. The attending NED made good challenges throughout the meeting, particularly with regard to his area of expertise, which was discussed in today's Deep-Dive, as well as, offering his support in addressing some of the issues currently being faced. • As two external non-committee members had been invited to present and join discussions in different parts/times of today's meeting, the Chair managed the timings of today's meeting well. At one stage discussions were paused on one topic by the Chair, to allow for the presentation and then restarted after the non-committee member had left following their presentation. • Several difficult and frank discussions were had throughout the meeting regarding an array of different topics. Questions were asked and challenges were made, though discussion remained respectful, allowing for one person to speak at a time & outcomes were well summarised by the chair.

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.*
• Little to none assurance could be provided regarding some topics discussed in todays Glemsford Surgery Deep-Dive. Plan in place to have an update to the Committee in a few months, where better assurance should be able to be attained. • I was disappointed by the lack of NED representation at today's meeting, when compared to attendance at previous meetings. I would like to seek assurance that upon the commencement of our newly recruited NEDs, that they are in regular attendance of all 3i Committee Meetings.
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• Despite being unwell, I was delighted to see that the Trust's Director of Financial Recovery was in attendance via MS Teams for today's meeting. Additionally, he presented a comprehensive report despite having only been in post for less than 2 weeks! His expertise was valued in multiple discussions throughout the meeting and it is already clear that he with play a crucial role in addressing the trust's current financial situation.

9.2. Improvement Committee

Presented by Roger Petter

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Improvement Committee			Date of meeting: 15th May 2024		
Chaired by: Louisa Pepper			**Lead Executive Director: Susan Wilkinson and Paul Molyneux**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
5.1	IQPR including Divisional PRM packs. Received for information	1 Substantial	IQPR and PRM reports demonstrate divisional level breakdown of key Trust metrics as well as those specific to each Division.	Work has been undertaken to develop reporting of key quality and safety information as part of the committee's assurance process whilst incorporating aspects of patient safety and quality. First month of new data sets presented for this Improvement Committee. The Committee will discuss and feedback over the next few months to ensure the revised information contributes to the level of assurance required.	1
5.1.3	CQC Single Assessment Framework – Introduced 2024. Five key questions relating to:- Safe	2 Reasonable	The Trust is identifying systems and processes e.g. Management Committees	It has been agreed – 26 quality statements covering safe, effective, caring and responsive would be reviewed. 13 completed by initial lead(s)	1

Originating Committee: Improvement Committee			Date of meeting: 15th May 2024		
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	Effective Caring Responsive Well Led Underpinned by 34 quality statements – each one containing detailed sub-topics. Assessed across 11 core areas which make up the service of our Trust.		Strategies, policies, and guidelines Training People/roles in WSFT Data/systems Local programmes of work Links to national publications, initiatives, and accreditation In addition, Audit One Well Led Review is being mapped to CQC quality statements.	13 leads identified and review in progress. Next steps: - Complete outstanding reviews Assess how to address any gaps identified. In addition, the CQC is still developing and publishing additional guidelines to aid the reviews. Some quality statements are multi-faceted and require more than one review lead. Recent CQC communication indicates WSFT should consider prioritising the following: - Children and Young People Critical Care	

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				(these are the oldest assessments) Additionally:- Safe Responsive Well Led Areas previously identified as requiring improvement. The Management Exec Group will consider how to develop assurance for these areas. CQC Quality Statement and Ockenden requirements are now under the same assurance umbrella. Update to Improvement Committee July 24.	
5.2	Glemsford Surgery – CQC Report.	2 Reasonable	Progress and improvement of key issues: -	Glemsford Management Practice Team and the Community	1

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	Progress and Improvement Plan. (Rated overall good with Safe requiring improvement)		Safe – Clinical Pharmacist position remains unfilled, but vacancy mitigated through procurement of a six-month primary care network virtual pharmacy service. Effective – access to GP appointments work on going. Working with ICB on additional digital options to increase compliance with 2-week standard. Offer to a GP to cover 8 of the outstanding 9 sessions has been made. Caring – Patient Participation Group (PPG) is not active, but PCN is considering a PCN wide PPG. Responsive – Wellness room is due for completion end of July to facilitate mental health consultations thereby freeing up clinical space. Fire compliance	Division will progress the improvement plan with support from WSFT.	

Originating Committee: Improvement Committee			Date of meeting: 15th May 2024		
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			of building to complete end of May. Well Led – Advance Nurse Practitioner appointed. Nursing student placements continue. Practice GP Trainee Assessment was successful.		
6.1	Patient Quality and Safety Group (PQASG) Updates provided from the following meetings: - Hospital Transfusion Group Thrombosis Group Deteriorating Patient group HTA/Mortuary Dementia and Frailty Mortality Oversight Group	2 Reasonable	Regular monthly report using the Trust's 1-4 assurance level scale. Areas of partial assurance: - Delay in delivery/implementation of closed loop blood system. Human Tissue Authority (HTA) Reportable Incidents – one reportable incident. Investigation on-going. Submission to HTA by 5th June 24. HTA inspection of mortuary services w/c 1st July 24.	PQSGG will continue to maintain oversight of all items reported as emerging concerns through its reporting framework. The last item concerning the Controlled Drug Licence will be escalated to Board. (In addition, PQSGG reviewed its annual activities and those of its sub-groups to determine effectiveness and compliance with its TOR. Assurance that the activity review is consistent with TOR).	1

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	End of life Group Drugs and Therapeutics		Sepsis compliance – focused work in ED. Wet signatures for prescription of controlled drugs removed during COVID 19. Review by NHS England to remove this requirement nationally – await the outcome. Controlled Drug Licence renewal is in progress. Awaiting HO visit 20th May 24.		
6.2	Clinical Effectiveness Governance Group (CEGG) Updates from the meeting: - Pathology including accreditation. NICE Guidelines Guidelines Editorial Group	1 Substantial	2 new NBP publications Publications – National Paediatric Diabetes Audit Report and National Lung Cancer Audit. Pathology – working towards ISO 15189:2022 and accreditation.	CEGG will continue to maintain oversight of all new items reported as emerging concerns through its framework.	1

Originating Committee: Improvement Committee			Date of meeting: 15th May 2024		
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	CEGG Development Plan update Departmental Licences		Projects to comply with GIRFT recorded on Life QI. Water Shed being replaced. Medical staff shortages in Microbiology. CEGG development plan – work on-going on nine actions and four development areas. CEGG are currently reviewing the organisational licence renewal process. Collation of Divisional Licence Lists on-going for review by CEGG June 24.		
6.3	Transfer of Care Group (TOCG) Update regarding: - TOR, membership and quoracy Sub-groups and info flow	2 Reasonable	Transfer of patents back to their home or other healthcare facility is complex and requires numerous systems and processes to work together to ensure care is communicated	Sub-groups report to TOCG every 3 months. Update to Improvement committee – June 2024.	2

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	Work plan. KPI dashboard		well and supported by internal systems. Partial assurance: - Completion of single point of access referral form within E-Care Discharge Waiting Area (DWA) oversight and Governance – Safety Summit completed with actions.		
7.1	Trust Quality Priorities – The Trust proposes three Trust priorities for patient safety, clinical effectiveness, and patient experience. The safety and effectiveness priorities will be monitored through Improvement Committee. Clinical Effectiveness Priority: -	1 Substantial	To ensure we are providing high quality, safe services, and the best experience for our patients, we have committed two key elements of safe and effective care to Improvement Committee.	Each priority will be supported by QI methodology and progress reported to the Improvement Committee through the 2024/25 work programme to ensure good governance.	1

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	To deliver measurable improvement in the quality and timeliness of discharge summaries to ensure appropriate communication at the point of transfer of care. Patient Safety Priority: - To reduce rates of hospital on-set healthcare associated and community on-set healthcare associated C-Difficile infection.				
8.2	RADAR New risk management system (replaced Datix). RADAR is Learning from Patient Safety Events compliant. Number of events available for use. Go Live was a success with a few issues. Next two events for roll out:- Risk Register	2 Reasonable	Datix used by the Trust for 12 years. RADAR is LFPSE compliant. PMO support for on-going roll out and RADAR team support is essential for smooth transition. PMO support finishes summer 24 is a risk. Oversight provided by RADAR Oversight Group.	Next events for May and June 24: - Risk Register – go live June 2024 Audit – launch events May 2024	1

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	Audits Other events for future implementation				

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Improvement Committee			Date of meeting: Wednesday 19th June 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:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
5.1	Patient Quality & Safety Governance Group (PQSGG) Updates from: - Safeguarding Adults Safeguarding Children & Young People Mental Health Transformation Group Duty of Candour Learning Disabilities Steering Group Human Factors Update	1 Substantial	Regular monthly report using the Trust's 1-4 assurance level scale. Areas of partial assurance: - Due to increasing referrals re POT, LADO & Sec 42 enquiries, improved governance is required to provide assurance and enquiry into these cases. Draft policy completed. Full SOP & governance process by Aug 24. The Trust was seeking clarification regarding the level of training for staff and the impact of delivering the Olive McGowan training (learning disabilities and autism) to understand how to progress compliance. National & local increase in demand for mental health beds	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

Originating Committee: Improvement Committee			Date of meeting: Wednesday 19th June 2024		
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			for formal & informal mental health patients. Impacts length of stay & patient flow. Raised with ICB & partners. Joint crisis protocol being drafted by task & finish group. Two band 7 mental health practitioners funded by the system to support this. Under 18's in mental health crisis. Peripatetic funding support discontinued by the ICB April 24. Therefore the Trust is now unable to access funding for skilled support for 1:1 observation for our complex young peopleThere has also been an assumption that an acute paediatric setting is a place of safety whilst alternative placements are sought, which can take some time.. ICB negotiations on-going. Work with West Suffolk professionals to explore care & support agencies.		

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			Crisis model under review by system. Duty of Candour – Trust compliance with 10-day delivery of written/verbal duty of candour decreased in Q4, following a decrease in Q3. It is not now a statutory obligation but should be applied as soon as is reasonably practical. DOC audit to be shared widely with Divisions. Review of data sets. Q1 work re improvement on-going. Support to the Trust from Patient Quality & Safety Team on-going.		
5.2	Clinical Effectiveness Governance Group (CEGG)	1 Substantial	Three new NBP publications. Retained swabs following invasive procedures. Nutrition	CEGG recommends no CQUINS added to ICB contract for formal monitoring. CQIN 1&12 to remain	1

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	Updates from the meeting: - CQUIN Accreditation & Licences CEGG development Plan Review of Risk Log – 4 risks		Management. Patients at Risk of Self Harm. CQUIN: - NHS England have proposed pausing the scheme for 24/25. ICB have referred the decision to organisations to decide reporting CQUIN in contract. No financial penalty or incentive either way. In 23/24, all CQUIN achieved by the Trust except:- Staff Flu Vaccinations (we performed better than many Trusts) & Pressure Ulcers in the community. CQUIN supports improvements in the quality of care. Previously CQUIN funding was granted or withheld depending on full or partial CQUIN achievement. CQUIN indicators will continue to be published as a non-mandatory list. No data will be collected by NHS England. WSFT Clinical Leads feel that	with local oversight & project support (12). CEGG will continue to maintain oversight of all new items reported as emerging concerns through its framework.	

Originating Committee: Improvement Committee			Date of meeting: Wednesday 19th June 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
			additional scrutiny via contractual reporting is unlikely to improve already good performance. CEGG Development plan is a work in progress.		
5.3	Transfer of Care Group (TOCG) Update regarding development and progress.	2 Reasonable	Transfer of patients back to their home or other healthcare facility is complex and requires numerous systems and processes to work together to ensure care is communicated well and supported by internal systems.	Engagement with key stakeholders is on-going. All sub-groups reporting every three months. Discharge summaries work on-going. Improvement is supported by a QI project.	1
6.15	Home Office Visit and Inspection of the Pharmacy re compliance	2 Reasonable	The pharmacy is licenced by the Home Office to dispense controlled drugs to St Nicholas	The visit was positive, and the Home Office undertook a comprehensive inspection. In	1

Originating Committee: Improvement Committee			Date of meeting: Wednesday 19th June 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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	in respect of pharmaceutical storage and distribution.		Hospice. Periodically the Home Office carry out inspections looking at a vast number of compliance issues concerning the storage, dispensing of drugs and the overall governance of the department.	preparation for this a review was undertaken on the storage of drugs on wards, this has led to the replacement of many drugs fridges and it is anticipated that this will lead to an improvement of and reduction in drugs being inappropriately stored and therefore disposed of.	
6.2	Deep Dive – Accreditations & Licences Process. Development of a process to provide oversight & assurance for WSFT clinical department accreditation. Aim is a process where all clinical departments undertaking accreditation: - Provide an assurance report to CEGG at an agreed frequency. Have an identified escalation route to highlight & address concerns requiring action to	2 Reasonable	Accreditations underpin quality in health and social care provision to ensure consistency in the delivery of healthcare, services to patients and commissioners. Accreditation builds confidence in standards & quality initiatives. Accredited assessment services help promote quality performance requirements – regulatory & non-regulatory and verify they are met. CQC use accreditation schemes to inform inspection activity. A Trusts participation in	Clinical support Division are piloting the process for oversight of clinical accreditation using UKAS in Pathology, ISAS in Radiology & JAG in Endoscopy. Paper to management Exec Committee setting out proposed pathways & a request for all relevant departmental accreditations in that division. Subject to pilot, all accreditations held by WSFT or those that are	1

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	enable successful award of accreditation. Record & manage risks which may have an adverse impact on achieving accreditation. Clinical Support have agreed to trail the process.		accreditation schemes is reflected in the areas of well led and Effective.	working towards will fall within this framework. Where an accreditation body listed does not form part of WSFT aspirational development, the reasons will be considered and understood. CEGG will provide regular updates on progress with this as part of its development programme updates to the Improvement Committee.	
7.2	Learning from recent inquest challenges. To ensure the inquest process at WSFT reviews patient deaths leading to an inquest we can demonstrate learning and service improvements relating to care and experience of patients, carers and staff, thereby avoiding a Preventing Future	1 Substantial	Clear pathway to review all deaths subject to an inquest with colleagues from Patient Experience, Learning from Deaths, Patient Safety and Legal Teams. This will mean: - Families will feel listened to, their questions answered and where	Adopt process. Review & evaluate process in 6/12 months to assess impact & effectiveness. Success will be measured in the low number of witnesses called to give evidence, No surprises for staff on day of inquest and continued level of PFD reports issued by the Coroner.	1

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	Death (PFD) Report from the Coroner		possible service improvements initiated and delivered. Staff can review and reflect on the care provided ahead of the inquest. Trust can triangulate learning from various sources. Trust can avoid reputational damage & loss of confidence when a PFD report is issued.		

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Improvement Committee			Date of meeting: 17th July 2024		
Chaired by: Jude Chin			**Lead Executive Director: Susan Wilkinson and Paul Molyneux**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
5.1	Patient Quality and Safety Governance Group report Updates provided from the following meetings: - **Nutrition**: There has been an overall improvement in the completion of nutrition assessments within 24hrs and the CQUIN Target for 'Eat drink and Mobilisation after surgery' was exceeded by at least 5% in all areas. Peer reviews have shown improvements in relation to both protected mealtimes and mouthcare	2 Reasonable	A focus on diet and nutrition aids recovery, avoids deconditioning and reduces length of stay	Areas for improvement include. • handwashing prior to food delivery • cleaning of tables, • continuation of training for mouthcare champions. Additional action points for wards will also now be generated from the Patient Satisfaction Survey	1
	Infection Prevention Control Committee:	3 Partial	The reduction of C-Diff is a Trust Quality priority and has resulted in the current projects around	Teams channel set up to enable better collaboration and better sharing of information across the	1

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	C-Diff levels for both inpatients and post discharge continue to trend above target. Five out of the six identified projects with a C-Diff improvement plan are established and active.		hand hygiene, audit & governance, antimicrobial stewardship and isolation.	project's teams. The QI Lead is creating an action log tool to better manage the work streams, this will be referred to at a newly established monthly program	
	Increase in prevalence of measles nationally and regionally requires robust plans to manage incidents and potential infections	2 Reasonable	Measles is one of the most transmissible diseases and impact of infection can be potentially catastrophic	Isolation facilities in paediatrics ED being reviewed.	1
	The Trust is not fully compliant with national Guidance on Carbapenems screening	3 Partial	In many cases, Carbapenems (a powerful group of antibiotics) are the last effective defence against infections caused by multi-resistant bacteria, Resistance to carbapenems has emerged and is beginning to spread	CPE policy going to IPCC for sign off in June. Will not meet full requirements of national guidance and entry on risk register to be completed. Due to not swabbing all hospital stays in last 12 months. All repatriations from UK hospitals and abroad will be	1

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				covered. Currently working with ECare team to put screening in place prior to admission as inpatient.	
	Falls: Decrease in falls reported potentially linked to switch to Radar 50 low rise beds delivered in June as part of bed replacement program	2 Reasonable		Falls with harm per 1000 beds to be added to IQPR	1
	Pressure ulcers There has been a significant decrease in the number of pressure ulcers reported since Radar has been introduced. There is a concern that technical issues surrounding Radar have been responsible for the	2 Reasonable	The decrease in reported pressure ulcers is likely to be unsustainable if caused by misreporting in Radar. Intentional rounding (IR) is required to check on patient positioning and pain.	Additional training in areas with higher levels of pressure ulcers. Relaunch and delivery of pocket mirrors to aid inspecting pressure areas when repositioning patients.	1

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	decrease in numbers.				
5.2	Maternity Incentive scheme A summary of claims for the 10 year period to 31-12-2023 was presented. Maternity claims represented 12% of Trust claims by volume but 50% by value due to the higher levels of claim in maternity cases. A report was presented on the ongoing compliance of the Trust with the NHS Resolution Maternity Incentive Scheme as regards the Trust being able to demonstrate an effective system of clinical workforce planning.	2 Reasonable	Details of claims are reviewed quarterly at both the Maternity Quality and Safety and the Maternity and Neonatal safety Champions meetings. The Trust is monitoring four elements of obstetric planning to assess compliance: Use of short term locums – only locums from existing workforce used Use of long term locums – ROCG checklist used when long term locums required Compensatory rest for Consultant Obstetricians –	Continue to monitor themes and safety issues identified and take appropriate action. Continue to monitor compliance through daily safety huddles and MDT working	1

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	The bi-annual report on Midwifery workforce for the six month period to 31-3-2024 was reviewed.		monitored regularly The presence of Consultant Obstetricians at high risk births – high levels of compliance The Trust is able to demonstrate an effective system of Midwifery workforce planning.	Ongoing monitoring of recruitment and retention as per workforce plan	
5.3	Birth Trauma gap analysis A summary of the Trust's response to recommendations from a government report on birth trauma, "Listen to mums: ending the postcode lottery on perinatal care".	2 Reasonable	The level of compliance with twelve actions from the report have been assessed (not all actions are relevant to the Trust). The Trust has fully implemented three of the actions, partially implemented six and three of the actions are not relevant to the Trust.	Continual monitoring and further action on partial implementation.	1
6.4	Repatriation of Anaemia patients The Trust received notification	2 Reasonable	The Trust will have to develop clinical guidelines for these patients (in line with what	Addenbrookes have been asked to delay the transfer of these patients until the Trust is able to	3 To monitor at Board

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	that Addenbrookes were to transfer all West Suffolk renal anaemia patients receiving Aranesp, currently managed by them, to the Trust on 1st August 2024. The Trust is able to accommodate these patients (57) but not in the timeframe suggested.		Addenbrookes is already doing). The Trust will also need to have the drugs approved by the Drugs and Therapeutics committee and will require the equivalent of one WTE to cover additional nursing, pharmacy, technician and clerical support.	put in place all the elements for their safe and effective treatment. Negotiations are taking place with Addenbrookes but no conclusions as yet. Work required to ascertain whether there are any patients currently without this service.	and escalate if necessary.
7.1	Deep dive – Safe Environment (Safety in peoples' homes) The report from the community adult services team identified 20 incidents of aggressive behaviour, security breaches and one indecent assault. The Lone Working Safety Policy requires staff to use an App based device when working at patients' homes. The device is	2 Reasonable	If the Lone Working Safety Policy is not complied with, there will be an increased risk of potential incidents.	Further work required on the communication of the importance of the use of the App.	2 to Involvement Committee

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	not always used. Concerns were raised concerning the equipment available for staff.		Assurance was given that equipment, facilities, processes and technology support for safe care is continuously monitored.	Single Assessment Framework testing will continue to be reviewed to assess the levels of assurance gained.	

**See guidance notes for more detail*

NHS West Suffolk NHS Foundation Trust

Guidance notes

The practice of scrutiny and assurance

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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?

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Feedback from assurance committees: Governor observer report

Board assurance committee: Improvement
Meeting date:15 May 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*
• It was stated by project leads that 3i regular reviews are seen as valuable to keep projects "on the front burner".
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Professional, thorough, respectful and appreciative as usual. No defensiveness…always a wish to learn. There was an awareness of using sensitive language for data driven feedback. e.g. "Discharge ***failure***"
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 was an awareness that in seeking assurances, there is a pressure between "timeliness" versus quality/quantity of feedback.
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• Someone said*…" we shouldn't strive to meet the target at the risk of missing the point".* This is always a risk in target driven services and I think it was very healthy that this was recognised as a risk in this meeting.

Feedback from assurance committees: Governor observer report

Board assurance committee: Improvement
Meeting date: 19 June 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*
• This was a smaller meeting than of previous months and much more manageable for everyone.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• As always…professional, thorough, respectful and appreciative as usual. No defensiveness…always a wish to learn. There was an awareness of using acronyms as a potential problem.
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 we are seeking assurance about topics that are inappropriately/unhelpfully worded. i.e. are we seeking to tick a box rather than always improve the outcome. How much of this is about compliance rather than improvement. If questions were framed differently, would this lead to clearer and more timely interevntions?
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• Are we assured that there isn't considerable duplication of reporting across the 3i committees…particularly Involvement and Improvement.

Feedback from assurance committees: Governor observer report

Board assurance committee: Involvement
Meeting date:19 June 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*
• Radar the new incident reporting tool continues to be rolled out, to be audited as some technical issues • In the patient safety and governance report there was level 3 assurance only around small but increasing numbers of referrals around Position of Trust (POT)/Local authority designated officer (LADO) and Section 42 enquiries (relates to the duty of the local authority to make enquiries if an adult is at risk of abuse or neglect). I have defined these terms as it wasn't clear from the report text. Policy to be written and actioned. • Discussion held around the lack of mental health beds and that such patients often wait in ED/acute care beds for long periods, which is not best care for them and impacts on patient flow. This is on the risk register. • Level 3 assurance only for care of under 18s in crisis who may remain in an acute paediatric setting for longer than ideal
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• More manageable agenda and meeting finished on time • Well chaired • Reflection: Good timing, clear direction and participation, one voice at a time, eye contact, papers summarised, challenge polite, virtual attendees integrated,
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.*

- Note Duty of Candour changing to open and honest, problems with how to measure compliance and 10 day target no longer statutory requirement
- Discussion on managing re-accreditations and renewing licences so as not to miss the due dates. Deep dive presented. Noted CQC lists 10 acute sector accreditation standards. What Next work plan in progress and updates to be given.
- Transfer of care group making progress and to report back regularly
- Governors should be concerned over the provision of appropriate place for care and availability of appropriately qualified staff for adults, and under 18s, with mental health illness, by the system (ICS).

Governor observer Notes

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

- The focus of the meeting was on providing evidence and assurance
- Abbreviations in reports should be explained/defined

9.3. Involvement Committee

Item 3.1 Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Involvement Committee			Date of meeting: 19 June 2024		
Chaired by: Antoinette Jackson			Lead Executive Director Jeremy Over / Susan 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
Workplace Strategy	The Committee received a draft Workplace Strategy which considered aspects of the future use of the Trust's Estate in the context of the new hospital programme. The Strategy sets out objectives for the future based on agile working, shared staff workhubs, corporate service integration, and shared environments. Whilst it has been developed by members of the Future System programme team, the 'operationalisation' of the strategy will become part of business as usual activity.	**2 Reasonable**	The strategy is a response to the demands of the new hospital programme which will require us to prioritise the use of administrative space in the new hospital, as well planning how we will provide quality staff working and welfare facilities. The strategy sets a future principle of non-clinical teams being based at an alternative location to the West Suffolk Hospital site which will involve significant change and opportunity for those affected.	The Committee agreed to recommend the principles of the strategy to the Board whilst noting funding needed to be identified and a proper programme management structure would need to be put in place. It was proposed the strategy would be overseen by the People and Culture committee which currently does not have finance and estate representation so this will need review.	3. Escalate to Board

Originating Committee: Involvement Committee			Date of meeting: 19 June 2024		
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Speech and language service – staff survey case study	The Committee heard a case study demonstrating how one service had worked with staff in response to the staff survey and developed an action plan in co-production with staff to address concerns.	**1 Substantial**	Liza Asti demonstrated how the Speech and Language service achieved significant improvement in staff engagement in the survey and future results improved dramatically.	The service will continue its work to engage staff and address area of underperformance. The Committee were keen that the good practice of this case study was widely shared as an example of how to engage effectively with staff in a practical way.	3 Escalate to Board
Patient Experience Annual Quality report (2023-24)	177 formal complaints had been received during the 12-month period. The Committee were pleased to see that 95% of complaints were resolved at first point of contact. 2 complaints were referred to the Parliamentary and Health service Ombudsman (PHSO). One was partially upheld and one is still being investigated. This latter complaint was also referred to the Local	**2 Reasonable**	The top six complaint themes (in descending order of prevalence) were as follows: 1. Communications 2. Patient care including nutrition/hydration 3. Clinical treatment in medical services 4. Clinical treatment in surgical services 5. Staff values & behaviours 6. Clinical treatment in obstetrics & gynaecology	Further, planned actions, particularly in response to the national surveys include: 1. Creation of further patient and service user focus groups related to survey topics 2. Additional, local survey monitoring in-year to provide more frequent insights and assurance 3. Review of the structure and resourcing to support	1.no escalation

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Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation**: 1. No escalation 2. To other assurance committee / SLT 3. Escalate to Board
	Government Ombudsman and was not upheld by them. Work is ongoing to engage with people with protected characteristics to ensure our complaints process is accessible and our services meet the diverse needs of the community we serve. 3 national surveys showed the Trust was performing as well or better than other Trusts on all questions. 599 compliments were received by the patient experience team (figure does not include compliments that that have been received by teams but not shared with the patient experience team).		In addition to case-specific responses and actions, organisational actions in response to themes include: • Focus on improved communications between ward teams and relatives • Enhancements to the approach in maternity services to support those who have suffered baby-loss beyond 13 weeks • Additional support in the emergency department at times of increased demand on the service • A number of training and policy related improvements including the sharing of unwelcome news, discharge processes, patient falls and communication skills	professional development in midwifery 4. Expansion of the contribution made by our volunteers to support those in inpatient care 5. Improvements to the environment in the waiting areas in ED	

Originating Committee: Involvement Committee			Date of meeting: 19 June 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director Jeremy Over / Susan 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
Complaints QI project	A complaints quality improvement project is underway based on a target of meeting with 50% of complainants early on in the complaint process. The first PDSA cycle will take place in July 2024.	**1 Substantial**	It is hoped that meeting people early will help provided a more personalised service and earlier resolution of issues	Involvement Committee will have quarterly updates with a fuller evaluation reports the beginning of the 25/26 financial year.	1 No Escalation
People and Culture Plan 2024/25	The executive director of workforce and communications presented a plan for 2024/25. This has been developed to address areas for action highlighted by the national staff survey and to support the Trust's strategic priorities.	**1 Substantial**	The committee approved the plan on behalf of the Trust Board.	Implementation and monitoring of the people and culture plan over the course of 2024/25, including sharing of the priorities and progress with staff.	1 No Escalation
IQPR metrics	Three of the four workforce-related metrics are better than target: turnover, sickness and mandatory training. The fourth, appraisal, is missing target by 2% (88 vs 90%).	**2 Reasonable**	The metrics provide good evidence of overall workforce stability and compliance with statutory knowledge and skills training. Appraisal participation is high but falling just short of the 90% target.	Continued focus on appraisal participation rates through division and corporate performance review discussions.	1. No Escalation

Originating Committee: Involvement Committee			Date of meeting: 19 June 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director Jeremy Over / Susan 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
Experience of Care and Engagement Committee	The committee provided feedback on their recent meeting highlighting substantial assurance on the personalised complaints processes and the engagement of community voices. A red risk was highlighted on the lack of a robust corporate system to manage the quality and accuracy of patient information in paper and on the web.	**3 Partial**	There is a risk that patient information developed by clinical teams and published by the Trust (in leaflet and electronic form) is not up to date due to the size of the library (c.1200 documents) and the associated resource requirements to maintain it.	A working group to be set up to look at the information issue. Finding a corporate solution is not straightforward give the range and breadth of patient information provided	3.Escalate to Board
Board Assurance Framework, domain 1: capability and skills	A draft of a new BAF statement for this strategic risk was presented and discussed by the committee.	**2 Reasonable**	The statement sets out the risks, assurance, gaps and controls in relation to our role as an educator of the healthcare workforce, staff recruitment and retention, and the changing demand and complexity of healthcare provision and their impact on the workforce.	Review and agreement of revised risk scores.	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: Involvement
Meeting date: 19 June 2024
Governor observer (observed by): Sarah Hanratty

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 focused on providing assurance to the Board on involvement and strategic programmes to engage with staff, patients, partners and stakeholders • A number of items of strategic importance were on the agenda for discussion and clear discussion took place around the scope and depth of engagement and involvement to develop these programmes was evident.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Everyone was welcomed to the meeting and roundtable introductions were made including Governor observers. • Everyone was reminded of the Trust FIRST values and to treat colleagues with respect. • A member volunteered to provide reflections at the end of the meeting. • Positive recognition and thanks for colleagues' input and work on the papers was celebrated, particularly the Workplace Strategy, Patient engagement, Speech and Language Therapy Staff Survey and HR colleagues who led the People and Culture Plan work. • There was clear evidence of openness and honesty when addressing challenging issues and robust evidence of healthy, constructive and polite challenge throughout the meeting. • The meeting was conducted in a spirit of honesty, openness and partnership. • Everyone present made a contribution to 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.

- Workplace Strategy – highly commended in-depth and focused paper and recognition given to all colleagues involved in its development over a 3 year period with clear evidence of structured staff engagement to help shape the plans,
- Agenda Content and Length – there were 14 items on the agenda including large items of significant strategic importance (inc. Workplace Strategy, People and Culture Plan and Board Assurance Framework RAG ratings). The agenda was too overloaded for the time allowed and through no fault of the Chair, the meeting subsequently overran. This meant that important papers on key issues for assurance and decision did not have sufficient time for in-depth debate due to time constraints. Several people had to leave the meeting before completion as a result.
- 3I Committee Crossover – good recognition demonstrated that there are potential areas for cross over with other assurance committees and clear process around signing off an action on Involvement for taking forward by Insight.
- Board Assurance Framework – there was insufficient time to discuss the BAF items – this needs to have sufficient time and space for discussion and allocation off RAG ratings.
- Engagement – an outstanding item for the Board is the offer of a patient engagement workshop. Good recognition that this is of utmost importance and will be progressed.
- Learning and sharing good practice – good evidence of looking out to other trusts and organisation to identify areas of best practice which can be adopted by WSFT without having to reinvent wheels. Strong evidence and commendation for the patient engagement workstreams.
- Cross- departmental working: Positive commendation of the use of the staff survey to deep dive into departmental level areas and developing a programme to improve and enable to staff to feel empowered and scope for them to take ownership. Strong evidence of cross departmental working and sharing involvement approaches highlighted by Speech and Language approach and good discussion about how to share this approach across departments.

Governor observer Notes

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

- Agenda order – good practice is for items for decision or assurance be placed at the top of the agenda so they are the focus for the meeting with items “To inform” should follow.
- Agenda Timings – The size and scope of the agenda was not achievable within the time frame. Would recommend good governance practice of having a suggested timing for each item. This would enable realistic views about whether it is achievable to have all items on the agenda and whether there is sufficient time to give them the consideration they merit.

Feedback from Board Assurance Committee: Governor observer report

Board assurance committee: Involvement
Meeting date: 19 June 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 and had the chance to participate in what were often in-depth discussions of the agenda items. • The behaviour of all participants was respectful and polite. • I felt everyone was included and given time 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 a gained by some in-depth discussions and polite appropriate challenges for clarification of information provided. • There were informative presentations which everyone found interesting and were followed by questions which were answered clearly and in detail. • It was acknowledged there were some large projects and pieces of work being undertaken and implemented in the organisation, and the committee will be updated with on-going reports of the development and progression of these.

• The following agenda items were referred to next meeting: 9.3 Quarterly Guardian of Safe Working report
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 some very large, important and on-going pieces of work.

9.4. Audit Committee

Presented by Michael Parsons

Board Committee CKI Report - Audit Committee

Originating Committee: Audit Committee			Date of meeting: 20th June and 25th June 2024		
Chaired by: Michael Parsons			**Lead Executive Director: Nick Macdonald (deputy director of finance)**		
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
External Audit (KPMG)	Received KPMG's Report to those charged with Governance (ISA260) and Annual Audit Report	1 Substantial	Audit nearing completion and on track to meet the deadline. KPMG noted that there was just one unadjusted audit error, otherwise a very clean position with no other issues or amendments to the draft accounts.	KPMG did not note any significant findings in relation to their VFM work.	1
Annual Report and Accounts 2023/24	Approved the 2023/24 Annual Report and Accounts	1 Substantial	Both the Annual Report and Accounts were recommended for approval by the Trust Board.	Approved by the Trust Board on 25th June	1
Internal Audit (RSM)	Head of Internal Audit Opinion 2023/24	2 Reasonable	Head of Internal Audit opinion issued, noting an 'adequate and effective framework' being in place.	Noting that any Internal Audit Reports issued with a 'partial assurance' opinion have been highlighted in the AGS.	1

Originating Committee: Audit Committee			Date of meeting: 20th June and 25th June 2024		
Chaired by: Michael Parsons			**Lead Executive Director: Nick Macdonald (deputy director of finance)**		
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
Internal Audit (RSM)	Update on delivery of internal audit plan and implementation of recommendations	2 Reasonable	Noted that the 2023/24 audit plan was now fully complete and all reports have been issued.	Continuing good progress with 2024/25 audit plan. Positive progress with implementation outstanding audit actions, although more work to continue in this area.	Management Executive Group
LCFS (RSM)	LCFS Annual Report 2023/24	2 Reasonable	Noted that the Counter Fraud functional standard return had been submitted and the Trust was awarded an overall rating of 'green'.	The LCFS annual benchmarking report has been issued and will be presented at the next Audit Committee.	1
Losses & special payments	Summary of losses and special payments made in 2023/24	2 Reasonable	A high level report on the key areas where losses and special payments had occurred during 2023/24, noting that pharmacy stock losses (for expired	Noted that a large late payment fee was incurred by the Trust due to processes not being adhered to and the expenditure for an IT contract being incurred without a purchase order.	Audit Committee

Originating Committee: Audit Committee			Date of meeting: 20th June and 25th June 2024		
Chaired by: Michael Parsons			**Lead Executive Director: Nick Macdonald (deputy director of finance)**		
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
			and damaged drugs) was the highest area.	This particular area of focus will be picked up as part of the key controls audit performed by RSM.	
Waivers	Annual review of waivers issued in 2023/24	2 Reasonable	A total of 28 waivers were issued during 2023/24, totalling £2.3m.	This was slightly lower than the prior year.	1

Assurance level

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

10. Annual Accounts and Report 2023/24 and Annual Auditor's Letter (enclosed)

To receive the report

Presented by Michael Parsons

WSFT Council of Governors meeting (Open)

Report title:	**Annual Accounts and Annual report 2023/24** **Annual Auditor's Report 2023/24**
Agenda item:	10
Date of the meeting:	2 September 2024
Sponsor/executive lead:	Michael Parsons, non-executive director and audit committee chair
Report prepared by:	KPMG, external auditors

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

Annual Report and Accounts 2023/24

The annual accounts and report 2023/24 were approved by the Board in June. The Trust is legally required to lay the document before Parliament. This took place on 19 July 2024.

Annual Auditor's Report 2023/24

The Auditor's Annual Report provides a summary of the findings and key issues arising from our 2023-24 audit of West Suffolk NHS FT (the 'Trust'). This report has been prepared in line with the requirements set out in the Code of Audit Practice published by the National Audit Office and is required to be published by the Trust alongside the annual report and accounts.

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 is asked to receive the annual accounts and report and annual auditors' report 2023/24 in public session.

The full annual report is available via the link below and the auditors report is appended to this document:

Annual report 2023 - 24 (wsh.nhs.uk)

WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
The Board's audit committee will maintain oversight of issues and recommendations arising from the audit work.
Action Required
The Council of Governors is asked to receive the report.

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

Auditor's Annual Report 2023/24

West Suffolk NHS FT

—

June 2024

Contents

KEY CONTACTS

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This report is addressed to West Suffolk NHS FT](the Trust). We take no responsibility to any member of staff acting in their individual capacities, or to third parties.

External auditors do not act as a substitute for the audited body's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

01 Executive Summary

Executive Summary

Purpose of the Auditor's Annual Report

This Auditor's Annual Report provides a summary of the findings and key issues arising from our 2023-24 audit of West Suffolk NHS FT (the 'Trust'). This report has been prepared in line with the requirements set out in the Code of Audit Practice published by the National Audit Office and is required to be published by the Trust alongside the annual report and accounts.

Our responsibilities

The statutory responsibilities and powers of appointed auditors are set out in the Local Audit and Accountability Act 2014. In line with this we provide conclusions on the following matters:

Accounts - We provide an opinion as to whether the accounts give a true and fair view of the financial position of the Trust and of its income and expenditure during the year. We confirm whether the accounts have been prepared in line with the Group Accounting Manual prepared by the Department of Health and Social Care (DHSC).

Annual report - We assess whether the annual report is consistent with our knowledge of the Trust. We perform testing of certain figures labelled in the remuneration report.

Value for money - We assess the arrangements in place for securing economy, efficiency and effectiveness (value for money) in the Trust's use of resources and provide a summary of our findings in the commentary in this report. We are required to report if we have identified any significant weaknesses as a result of this work.

Other reporting - We may issue other reports where we determine that this is necessary in the public interest under the Local Audit and Accountability Act.

Findings

We have set out below a summary of the conclusions that we provided in respect of our responsibilities

Accounts	We issued an unqualified opinion on the Trust's accounts on 27th June 2024. This means that we believe the accounts give a true and fair view of the financial performance and position of the Trust. We have provided further details of the key risks we identified and our response on page 7.
Annual report	We did not identify any significant inconsistencies between the content of the annual report and our knowledge of the Trust. We confirmed that the Governance Statement had been prepared in line with the Department of Health and Social Care requirements.
Value for money	We are required to report if we identify any matters that indicate the Trust does not have sufficient arrangements to achieve value for money. We identified significant risks relating to the arrangements for Financial Sustainability and Governance. We have provided further detail on page 9-16.
Other reporting	We did not consider it necessary to issue any other reports in the public interest

02
Audit of the Financial Statements

Audit of the financial statements

KPMG provides an independent opinion on whether the Trust's financial statements:

- Give a true and fair view of the state of the Trust's affairs as at 31 March 2024 and of its income and expenditure for the year then ended;
- Have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2024 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2023/24; and
- Have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Audit opinion on the financial statements

We have issued an unqualified opinion on the Trust's financial statements before 28 June 2024.

The full opinion is included in the Trust's Annual Report and Accounts for 2023/24 which can be obtained from the Trust's website.

Further information on our audit of the financial statements is set out overleaf.

Audit of the financial statements

The table below summarises the key risks that we identified to our audit opinion as part of our risk assessment and how we responded to these through our audit.

Risk	Procedures undertaken	Findings
Valuation of land and buildings The carrying amount of revalued Land and buildings differ materially from the fair value.	– We critically assessed the independence, objectivity and expertise of Gerald Eve the valuers used in developing the valuation of the Trust's properties at 31 March 2024 – We inspected the instructions issued to the valuers for the valuation of land and buildings to verify they are appropriate to produce a valuation consistent with the requirements of the Group Accounting Manual; – We compared the accuracy of the data provided to the valuers for the development of the valuation to underlying information, such as floor plans, and to previous valuations, challenging management where variances were identified – We evaluated the design and implementation of controls in place for management to review the valuation and the appropriateness of assumptions used; – We challenged the appropriateness of the valuation of land and buildings; including any material movements from the previous revaluations. We challenged key assumptions within the valuation, including the use of relevant indices and assumptions of how a modern equivalent asset would be developed], as part of our judgement – We performed inquiries of the valuers in order to verify the methodology that was used in preparing the valuation and whether it was consistent with the requirements of the RICS Red Book and the GAM; – We agreed the calculations performed of the movements in value of land and buildings and verified that these have been accurately accounted for in line with the requirements of the GAM – We utilised our own valuation specialists to review the valuation report prepared by the Trust's valuers to confirm the appropriateness of the methodology utilised; and – Disclosures: We considered the adequacy of the disclosures concerning the key judgements and degree of estimation involved in arriving at the valuation.	We did not identify any material misstatements relating to this risk. However we have noted a control deficiency related to review of assumptions and inputs used by the valuers. We considered the estimate to be balanced based on the procedures performed.

Audit of the financial statements

The table below summarises the key risks that we identified to our audit opinion as part of our risk assessment and how we responded to these through our audit.

Risk	Procedures undertaken	Findings
Fraudulent expenditure recognition Auditing standards suggest for public sector entities a rebuttable assumption that there is a risk expenditure is recognised inappropriately. We recognised this risk over non payroll, non depreciation expenditure.	– We inspected a sample of invoices of expenditure and payments made, in the period after 31 March 2024, to determine whether expenditure has been recognised in the correct accounting period; – We selected a sample of year end accruals and inspected evidence of the actual amount paid after year end in order to assess whether the accruals have been accurately recorded. – We inspected journals posted as part of the year end close procedures that decrease the level of expenditure recorded in order to critically assess whether there was an appropriate basis for posting the journal and the value can be agreed to supporting evidence; – We performed a retrospective review of prior year accruals in order to assess the existence and accuracy with which accruals had been recorded at 31 March 2023 and consider the impact on our assessment of the accruals at 31 March 2024.	We did not identify any material misstatements relating to this risk. However we have noted a control deficiency related to Journal authorisation.
Management override of controls We are required by auditing standards to recognise the risk that management may use their authority to override the usual control environment.	– In line with our methodology, evaluated the design and implementation of controls over journal entries and post closing adjustments. – Assessed the appropriateness of changes compared to the prior year to the methods and underlying assumptions used to prepare accounting estimates. – Assessed the business rationale and the appropriateness of the accounting for significant transactions that are outside the Trust's normal course of business, or are otherwise unusual. – We have analysed all journals through the year and focused our testing on those with a higher risk, such as journals impacting expenditure recognition posted during the final close down.	We did not identify any material misstatements relating to this risk. However we have noted a control deficiency related to Journal authorisation.

03 Value for Money

Value for Money

Introduction

We are required to consider whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources or 'value for money'. We consider whether there are sufficient arrangements in place for the Trust for the following criteria, as defined by the National Audit Office (NAO) in their Code of Audit Practice:

- Financial sustainability: How the Trust plans and manages its resources to ensure it can continue to deliver its services.
- Governance: How the Trust ensures that it makes informed decisions and properly manages its risks.
- Improving economy, efficiency and effectiveness: How the Trust uses information about its costs and performance to improve the way it manages and delivers its services

Approach

We undertake risk assessment procedures in order to assess whether there are any risks that value for money is not being achieved. This is prepared by considering the findings from other regulators and auditors, records from the organisation and performing procedures to assess the design of key systems at the organisation that give assurance over value for money.

Where a significant risk is identified we perform further procedures in order to consider whether there are significant weaknesses in the processes in place to achieve value for money.

We are required to report a summary of the work undertaken and the conclusions reached against each of the aforementioned reporting criteria in this Auditor's Annual Report. We do this as part of our commentary on VFM arrangements over the following pages.

We also make recommendations where we identify weaknesses in arrangements or other matters that require attention from the Trust.

Summary of findings

	Financial sustainability	Governance	Improving economy, efficiency and effectiveness
Commentary page reference	12-13	14-15	16
Identified risks of significant weakness?	Yes	Yes	No
Actual significant weakness identified?	No	No	No
2022-23 Findings	Risk to significant weakness noted but did not materialise into significant weakness	Risk to significant weakness noted but did not materialise into significant weakness	No significant weakness identified
Direction of travel	⇩	⇩	⇔

Value for Money

NATIONAL CONTEXT

Financial performance

The 2023-24 financial year saw a significant increase in the level of financial pressures facing the NHS sector. This followed the end of Covid-19 related financing arrangements. The sector has faced cost pressures from a range of factors, most significantly the impacts of inflation felt during the year and the costs of industrial action.

At the end of January 2024 NHS England forecast that the NHS would record an overspend of £1.1bn against its agreed budgets. This came after additional funding had been made available earlier in the year to support with the costs of industrial action.

Operational performance

In January 2023 the Government announced five pledges for 2023, including reducing NHS waiting lists and the time people wait for procedures. Waiting lists had grown significantly during the Covid-19 pandemic as elective activity was postponed in order to prioritise the treatment of Covid patients and ensure safe working.

According to the Health Foundation the NHS waiting list had grown from 6.2 million patients at the beginning of 2022 to 7.2 million in January 2023. There had also been a significant increase in the number of patients with long waits. At the end of 2023 there remained 355,000 patients that had been waiting over a year for treatment. Income arrangements for the acute sector were revised in year to reimburse providers for elective activity based on the actual number of patients treated.

System working

The Health and Care Act 2022 formally established integrated care systems (ICSs), 42 partnerships within local geographies to promote closer working between the organisations responsible for healthcare delivery. Integrated Care Boards were formed on 1 July 2022, taking over commissioning responsibility from Clinical Commissioning Groups.

In their first full year of operation ICSs have continued to work to develop and embed governance arrangements both within the ICBs themselves and as systems.

LOCAL CONTEXT

West Suffolk NHS FT (WSFT)provides hospital and community services to a population of around 280,000 people who live in west Suffolk. They provide acute hospital services from their 430 be hospital set in parkland on the outskirts of Bury St Edmunds.

The hospital has an emergency department, obstetrics, maternity and neonatal services, a day surgery unit, eye unit and children's wards and provides the full range of secondary care services.

The income expenditure budget for the Trust for 2023-24 was to record a deficit of £2.7m which included achieving cost improvements (CIP) of 3% (£10.6m). At M5 the Trust had a deficit of £5.5m which indicated a deficit of around £10m at year end. Based on this the Trust submitted a Financial Recovery Plan with a revised forecast deficit of £6.3m for 2023-24 and this was contingent on ERF income of £5m, Delivering CIP of £5m and Improving run rate £3.4m.

At year end the Trust met its full year revised forecast of £6.3m deficit which included benefits resulting from £15m of non recurring support. The Trust also achieved Delivering CIP of £5m, Improving run rate £3.4m and ERF income of £1.7m.

The Suffolk and North East Essex ICS (the system) achieved its target revenue position in 2024/25. The system recorded an overall surplus of £0.034m, comprising surpluses at the ICB (£4.478m), Other Trusts (£1.826) offsetting a deficit of £6.270m at WSFT.

The income and expenditure budget for the Trust for 2024-25 is a deficit of £15.2m which includes Cost improvements (CIP) of 4% (£16.5m).

As at M1 the Trust reported deficit of £2.8m against planned deficit of £2.4m, giving an adverse variance of £0.4m. The Trust achieved their CIP target in full for April(£507k).

The Trust has prepared a high level plan tp breakeven by 2026-27 and this is dependent on 3.6% CIP of 12.7m in both 2025-26 and 2026-27.

There has been significant progress in reducing waiting time for patients during 2023-24 including the elimination of 104 week wait time. The 2023-24 planning guidance requirement to eliminate elective waits of 65 weeks or more has been extended by six months to be delivered by the end of September 2024. For WSFT, this will require the end of March backlog of 407 patients to be cleared, as well as patients whose waits are not yet at 65 weeks but will be by the end of September deadline. This will require additional activity within the sub-specialty of urogynaecology.

Financial Sustainability

How the Trust plans and manages its resources to ensure it can continue to deliver its services.

We have considered the following in our work:

- How the Trust ensures that it identifies all the significant financial pressures that are relevant to its short and medium-term plans and builds these into them;
- How the Trust plans to bridge its funding gaps and identifies achievable savings;
- How the Trust plans finances to support the sustainable delivery of services in accordance with strategic and statutory priorities;
- How the Trust ensures that its financial plan is consistent with other plans such as workforce, capital, investment, and other operational planning which may include working with other local public bodies as part of a wider system; and
- How the Trust identifies and manages risks to financial resilience, e.g. unplanned changes in demand, including challenge of the assumptions underlying its plans

Budget Setting process

The budget setting principles guidance brings together the financial principals used for the budget setting process. The guidance lists the principles that will steer the budget setting process. The process is divided into 3 phases – Phase 1 : Setting the recurrent baseline. Phase 2: Impact of commissioned service changes and Phase 3: Efficiency requirement.

Cost Improvement programme development policy details the governance infrastructure for the Cost Improvement Programme. This document sets out the Trust CIP framework providing a process for colleagues to follow when identifying, monitoring, and reporting CIP schemes. The Financial Recovery Group reviews the potential savings against the financial target for the CIP programme as the programme is being developed in advance of the new financial year.

Governance and assurance of the overall programme and schemes within the programme is overseen through standardised reporting to the Financial Recovery Group on a weekly basis.

Budgeted performance vs actual

The income expenditure budget for the Trust for 2023-24 was to record a deficit of £2.7m which included achieving cost improvements (CIP) of 3% (£10.6m). The Trust monitors its financial performance very closely and regular updates are provided to the board via monthly finance reports.

At the end of M5 the trust noted that there was a deficit of £5.5m against the planned deficit of £2.3m which resulted in an adverse variance of £3.2m. A straight line extrapolation of the deficit indicated a deficit of around £10m in 2023-24 that was £7.3m worse than planned.

In response to the above, the Trust submitted a Financial Recovery Plan with a forecast deficit to £6.3m for 2023-24 and this was contingent on ERF income £5m, Delivering CIP of £5m and Improving run rate £3.4m. The revised deficit of £6.3m was submitted to NHSE via the M9 submission on 23rd January 2024.

We have reviewed the minutes of Suffolk and North East Essex ICB dated 21 November 2023 where the ICB finance committee approved the revised forecast outturn with WSFT having revised deficit of £6.3m and overall ICS at breakeven.

Financial Sustainability

The Trust met its full year revised forecast of £6.3m deficit which included benefits resulting from £15m of non recurring support. The Trust also achieved Delivering CIP of £5m, Improving run rate £3.4m and ERF income of £1.7m.

Plan for 2024-25

As per April 2024 Finance report the income and expenditure budget for the Trust for 2024-25 is to record a deficit of £15.2m which includes Cost improvements (CIP) of 4% (£16.5m).

The CIP target includes £1.4m of CIP's that started in 2023-24 that will be completed in 2024-25 and also includes stretch CIP of £2.8m. £11.5m of CIP schemes have been identified and after risk adjusting it is anticipated that this would deliver £7m of savings. A further £9.5m of CIP needs to be delivered which translates to a further £13m needing to be identified. There are 160 schemes in the pipeline that should contribute to this £13m. However any slippage due to timeframes of implementations would heighten the challenge.

As at M1 the Trust reported deficit of £2.8m against planned deficit of £2.4m, giving an adverse variance of £0.4m. The Trust achieved their CIP target in full for April(£507k).

The Trust has also prepared a high level plan top breakeven by 2026-27 and this is dependent on 3.6% CIP of 12.7m in both 2025-26 and 2026-27.

Conclusion:

Based on the above we have not identified a significant weakness associated with Financial sustainability. However we note an ongoing risk in relation to the Trust's ability to identify and deliver a challenging CIP target for 2024-25.

Key financial and performance metrics:	2023-24	2022-23
Planned surplus/(deficit)	(£2.7m)	£1m
Actual (deficit)	(£6.27m)	£0.03m
Planned CIP as a % of spend		
- Recurrent	2%	1.9%
- Non-recurrent	0.9%	0.3%
Actual CIP as a % of spend		
- Recurrent	1%	1.7%
- Non-recurrent	0.7%	0.3%
Year-end cash position	£9.3m	£7.9m

Governance

How the Trust ensures that it makes informed decisions and properly manages its risks.

We have considered the following in our work:

- how the Trust monitors and assesses risk and how the body gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud;
- how the Trust approaches and carries out its annual budget setting process;
- how the Trust ensures effective processes and systems are in place to ensure budgetary control; to communicate relevant, accurate and timely management information (including non-financial information where appropriate); supports its statutory financial reporting requirements; and ensures corrective action is taken where needed, including in relation to significant partnerships;
- how the Trust ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency; and
- how the body monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements and standards in terms of management or Board members' behaviour

Risk Management

The Trust has a Strategy and Policy for Risk management. Risks are captured on the risk register as 'Operational' (risks local to an area or service), 'Corporate' (risks with a wide organisational impact) or 'Strategic' (risks to delivery of strategic objectives). Risks are rated as Red (high), Amber (medium) and Green (low) based on an assessment of the likelihood and consequence (harm) of a risk materialising. This risk rating informs the escalation requirements. Monitoring arrangements are in place to ensure that risks are appropriately reviewed and agreed action taken. The Trust flagged the risk around the year end deficit at M5 and the same was reported to the finance committee and board. In response a Financial Recovery Plan was submitted to revise the year end deficit from £2.7m to £6.7m with a lower CIP target of £8.4m(original CIP target was £10.6m)

WSFT has Fraud conduct, whistleblowing and freedom to speak-up policies to prevent and detect fraud. These policies are reviewed and updated regularly by the Trust's Information Governance team. Trust has RSM as their Local counter fraud specialist and the result of their work is reported and reviewed by the Audit committee.

Governance

Operational performance is reviewed in line with the Trust's 3 branch governance structure. Performance is monitored through monthly performance review meetings which feed in to the Senior Leadership Team and also through Patient Access Governance Group (PAGG) into Insight Committee, to Board. Metrics used to evaluate the data have national/local standards but other information is used to contextualise the data such as NHS benchmarking, Model Hospital, GIRFT and ICB data.

Decisions are approved as per the scheme of delegation. Key decisions with capital investment >£1m or gross revenue expenditure >£250k additionally need Trust Board approval. Business cases are presented to the investment panel. Financial, quality and performance information is expected to be included within the Business Case.

The Trust has anti-bribery, whistle blowing and other policies established to prevent instances of non compliance of laws and regulations. Any breaches of law and regulation are reported to TCWG on monthly basis. All the attendees at the board meeting are fully informed on the Trust's compliance with laws and regulations.

Governance

Trust has SFI's that detail the financial responsibilities and provides formal authorisation limits for awarding contracts. The procurement policy ensures transparent, fair and open competition. We have inspected the tender waiver register and noted that all waivers are approved by the appropriate approver based on the set limits.

NHSE review

A review commissioned by NHSE on behalf of the DoH, noted that the Trust fell short on both ensuring accountability and shaping culture in 2021. WSFT acted on the same and developed a detailed action plan which was approved by the Board in March 2022. During 2023-24 we noted that all the actions on the report have now been successfully completed and no actions are overdue or outstanding.

New Hospital Programme

Trust has been announced as one of the 40 hospital to receive funding for a new hospital by 2030. We have noted that the Trust has made good progress, having its Strategic outline case approved and issued in July 2023. The Trust has received its initial funding envelop for development of Outline Business Case from NHP central team and have also finalised the site for new hospital. The Trust has undergone review by NHP investment committee and have received constructive feedback. The report recognised Trust's governance framework to be fit for purpose. Trust has a dedicated team that focuses on the NHP governance and enhancement of Governance framework as the scheme progresses. Trust's proposed governance framework is based on the NHP best practice model and takes into account all the recommendations received from external reviews.

Conclusion:

As the programme steps up pace with the ambition for completion of the project by 2030 there is a risk that without robust governance arrangements the project may be subject to delays which could result in unforeseen additional expenditure. The Trust has made progress and is working on recommendations received from external reviews for a robust governance structure and there have been no concerns raised on the existing governance arrangements we can conclude that this will not lead to a significant weakness for 2023-24.

	2024	2023
Control deficiencies reported in the Annual Governance Statement	None noted	None noted
Head of Internal Audit Opinion	Adequate and effective framework for risk management with further enhancements.	Adequate and effective framework for risk management with further enhancements.
Oversight Framework segmentation	3	3
Care Quality Commission rating	Requires Improvement	Requires Improvement

Improving economy, efficiency and effectiveness

How the Trust uses information about its costs and performance to improve the way it manages and delivers its services

We have considered the following in our work:

- how financial and performance information has been used to assess performance to identify areas for improvement;
- how the Trust evaluates the services it provides to assess performance and identify areas for improvement;
- how the Trust ensures it delivers its role within significant partnerships and engages with stakeholders it has identified, in order to assess whether it is meeting its objectives; and
- where the Trust commissions or procures services, how it assesses whether it is realising the expected benefits.

Cost improvement programme identification

Cost improvement programme development policy details the governance infrastructure for the Cost improvement programme. The CIP process starts while identifying the future priorities during business planning. The Finance team will identify a minimum saving target for each division to be made through CIP. Once the annual savings have been identified each division will be required to identify where efficiencies and savings can be made.

The Financial Recovery Group reviews the potential savings against the financial target for the CIP programme as the programme is being developed in advance of the new financial year. The governance and assurance of the CIP programme is overseen by the Programme Management Office (PMO) and the financial oversight flows through the Financial Recovery Group (FRG) and Financial Accountability Committee (FAC).

The trust had a target of achieving Cost Improvement (CIP) of 3% £10.6m. At M5 a Financial recovery plan was submitted with revised deficit and lower CIP target of £8.4m. At year end the Trust achieved its revised CIP target of £8.4m split into Delivering CIP £5m and improving run rate £3.4m.

For 2024-25 the Trust has CIP target of £16.5m(4%).

Partnership working

The activities of the local ICS are reported to the Board and monitored at an organisational level via the board meeting. Update on ICS is a standing item on the open board meetings. WSFT participates and contributes to the ICS plans by representation on the ICB board and being part of integrated care partnership.

Performance of providers or sub contractors is monitored through meetings that take place on monthly basis with a log and tracker of actions. Contracts have differing performance requirements and these are normally outlined in the main contract documentation and form part of the monitoring meetings. In case of dispute, all agreements contain a dispute resolution process with stepped arrangements and named positions for responsibility of the parties.

Improving economy, efficiency and effectiveness

Trust has SFI's that detail the financial responsibilities and provides formal authorisation limits for awarding contracts. The procurement policy ensures transparent, fair and open competition. We have inspected the tender waiver register and noted that all waivers are approved by the appropriate approver based on the set limits.

WSFT monitors the performance of providers and sub contractors through the monthly monitoring meetings. We obtained the action log and agenda for M9 monitoring meeting for Cambridge university hospital. In every meeting the log of actions is reviewed in details and actions agreed. The action log provides details of all the actions, owners and status.

Conclusion:

Based on the procedures performed we have not identified a significant weakness associated with the improving economy, efficiency and effectiveness.

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11. Nomination Committee Report (enclosed)

To receive the report form the Committee meeting on 8 July 2024

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:	11
Date of the meeting:	2 September 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 8 July 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 (for noting)

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

On 26 October 2023, the Council approved the recommendation to allow Tracy Dowling (TD) to take up the interim Chief Executive position offered in Mid and South Essex ICB, allowing TD to leave the Trust and subsequently re-join as a non-executive director. The Council's nominations committee reviewed the fit and proper person process undertaken which allowed TD to be re-join as a NED on 1 August.

NEDs and Chair appraisals (for noting)

The 360° feedback reports for Jude Chin, Antoinette Jackson, Michael Parsons, Louisa Pepper and Roger Petter were reviewed and discussed. The committee agreed emergent themes from stakeholder assessments, areas of strength and identified opportunities to increase impact and effectiveness, for discussion at the individual's appraisal meetings. All appraisals have now been completed.

Nominations Committee Terms of Reference (for approval)

The draft Nominations Committee Terms of Reference were presented for review as part of the annual process. The committee noted nil changes and recommended for approval by the Council of Governors in September 2024 **(Annex A for approval)**

ACTION

- Approve the terms of reference.

Annual report on committee effectiveness (for noting)

Annual report on committee effectiveness was presented to the committee which summarised the activities of the Nominations Committee for the financial year 2023/24 setting out how it met its terms of reference and key priorities. The committee discussed the areas identified for improvement in 2024/25. The committee agreed that the areas for improvement should be added to the committee's forward plan. The Nominations Committee approved and agreed to endorse the report for presentation to the Council of Governors **(Annex B for noting)**

ACTION

- Note the annual report on committee effectiveness

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 and **approve** the terms of reference.

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

FT GOVERNORS' NOMINATIONS, APPOINTMENTS & REMUNERATION COMMITTEE
Terms of Reference

1. Purpose of the Committee

1.1 The Nominations Committee is a sub-committee of the Council of Governors.

1.2 The Council of Governors resolves to establish the Nominations, Appointments & Remuneration Committee to be known as the Nominations Committee. The Nominations Committee in its workings will be required to adhere to the Constitution of West Suffolk NHS Foundation Trust, the Terms of Authorisation and Code of Governance issued by the Independent Regulator for NHS Foundation Trusts. As a Committee of the Council of Governors the Standing Orders of the Trust shall apply to the conduct of the working of the Committee.

1.3 The Committee's primary purpose is to make recommendations to the Council of Governors on the appointment and remuneration of the Chair and Non-Executive Directors of the Trust, and on plans for their succession.

2. Level of Authority

2.1 The Nominations Committee has delegated authority from the Council of Governors to deliver its key duties and responsibilities. The committee will have authority to establish sub-groups/committees who shall remain accountable to the Nominations Committee.

2.2 The Nominations Committee has authority to establish processes and procedures which fall within the scope of the terms of reference of the committee.

2.3 The Council of Governors is responsible for appointing the Chair and other Non-Executive Directors and for determining their terms and conditions. The Nominations Committee shall act in an advisory capacity only and will make recommendations to the Council of Governors.

2.4 The Committee is authorised to seek information and advice either within the Trust or externally on any matters within its terms of reference. In doing so it should work through the offices of the Trust Secretary.

3. Duties and responsibilities

The Nominations Committee shall undertake the following making recommendations for any changes or action to the Council of Governors:

3.1 Approve job descriptions and person specifications detailing the skills, knowledge and experience required for non-executive directors, as proposed by the remuneration committee of the Board of Directors.

3.2 Approve the recruitment, selection and reappointment processes for Non-Executive Directors, elements of which are likely to include:

- Arrangements for advertising/raising of local awareness of the post(s)
- Arrangements for short listing of candidates against agreed criteria
- Arrangements for formal interviews
- Recommendation of the successful candidate(s) for approval by the Council of Governors

- Receive reports in relation to the terms and conditions of office and remuneration of current or newly appointed Chair and Non-Executive Directors and make recommendations to the Council of Governors

3.3 To make recommendations to the Council of Governor regarding the remuneration of the Chair and Non-Executive Directors

3.4 To make recommendations to the Council of Governors for the process to appraise the performance of the Chair and Non-Executive Directors

3.5 To receive reports on the process and outcome of the appraisals of the Chair and Non-Executive Directors and agree areas to be considered in Chair/NED appraisal meetings.

3.6 To formulate plans for succession for the Chair and Non-Executive Directors

3.7 To consider any matter relating to the continuation in office of the Chair and any Non-Executive Director when requested to do so by the Board or the Council of Governors

3.8 To agree an annual schedule of business of the Committee's planned activities

4. Membership

Membership of the Committee will comprise:

4.1 Members of the Committee shall be appointed by the Council of Governors and shall be made up of the following:

- Chair of the Trust (Chair)
- A minimum of four Public Governors (one of whom should be the Lead Governor)
- Up to two Staff Governors
- Up to two Partner Governors

4.2 The Council of Governors will review membership of the Committee mid-way through the term of office for the Council.

4.3 The chair of the trust will chair the committee, except where the business under discussion concerns the appointment of or terms for chair of the Trust, in which event the Committee will be chaired by the Deputy Chair/NED/Lead Governor.

4.4 Members of the Committee may be required to undertake training and development commensurate with the responsibilities outlined in these terms of reference.

4.5 If a Governor who is a member of the committee is seeking appointment as a Non-Executive Director or Chair, they will withdraw from the appointment process.

4.6 The committee will consider and agree the structure of the interview process and composition of the interview panel. This will consider the number of public and other governors as well as inclusion of the lead governor and external advisors and support from Trust staff.

4.7 The Executive Director of Workforce & Communications will provide professional advice and support to the Committee to ensure that the recruitment and appointment processes are managed in accordance with best practice and that the recommendations to the Council of Governors on terms and conditions of office are appropriate and relevant to local circumstances.

4.8 External advisers with appropriate skills may be invited to attend for all or part of any meeting, as and when appropriate.

4.9 The Chief Executive or other Directors may be invited to attend meetings depending upon issues under discussion.

4.10 The Governors may nominate a chair when both chair and lead governor are absent. Additional members may be co-opted to the committee as necessary.

4.11 Representatives from the Trust may also be in attendance at meetings, including the Trust Secretary, Deputy Trust Secretary, Foundation Trust Office Manager, and others as required.

5. Quorum

5.1 A quorum shall be four members, to include at least two Public Governors

6. Frequency of meetings

6.1 The Committee shall meet at least once a year and at such other times as the Chair of the committee shall require.

7. Sub-committees

7.1 None established.

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

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

8.2 The minutes of the Committee meetings shall be formally recorded and submitted to the next meeting of the Nominations Committee.

9. Accountability and reporting arrangements

9.1 The Nominations Committee will be accountable to the Council of Governors

9.2 The Nominations 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 the outlining areas of key discussion and any actions taken or issues for escalation.

9.3 The Chair of the committee will report on the proceedings of each meeting to the next meeting of the Council of Governors. Where necessary, this discussion will take place in a private session, i.e. not open to members or the public, when the names and details of individuals are being discussed. Where the report concerns the Chair of the Trust the report will be given by the Lead Governor.

10. Monitoring effectiveness and compliance with terms of reference

10.1 The Committee shall carry out an annual review of its effectiveness against its terms of reference. The Committee will review its own performance, relevant sections of the constitution, and terms of reference at least once a year. Any proposed changes will be submitted to the Council of Governors for approval.

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 Nominations Committee: July 2024
Date approved by the Council of Governors:
Next review date: July 2025

Nominations, Appointments & Remuneration Committee	
Report title:	Annual report from the Chair of the Nominations, Appointments & Remuneration Committee
Agenda item:	7
Date of the meeting:	8 July 2024
Sponsor/executive lead:	Jude Chin, Chair of the Nominations Committee
Report prepared by:	Richard Jones, Trust Secretary Ruth Williamson, FT Office Manager 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:	Good practice states that the Council of Governors (CoG) should review the performance of its committees annually to determine if they have been effective, and to identify whether further development work is required. To bring this to effect, the committee should conduct a self-evaluation and assessment on an annual basis and use the evaluation process to identify strengths and weaknesses, to flag areas for improvement, and to plan for further action as appropriate. This Annual Report summarises the activities of the Nominations Committee for the financial year 2023/24 setting out how it met its Terms of Reference and key priorities. Attendance at the committee was in line with the quorum set within its Terms of Reference. Having reviewed its activities and undertaken a self-assessment review (attached at **Appendix 1**) it is the view of the committee that its activities have been consistent with its Terms of Reference. Areas identified for improvement are highlighted in the report.
Action required/ recommendation:	The Nominations Committee is asked to receive and endorse the report for presentation to the Council of Governors.

	A plan to respond to the conclusions and actions (section 5) will be received at the next meeting
Previously considered by:	None
Risk and assurance:	N/A
Equality, diversity and inclusion:	N/A
Sustainability:	N/A
Legal and regulatory context:	N/A

Nominations Committee 2023-24 Annual Report

1. Background

1.1 Good Practice states that the Council of Governors should review the performance of its committees annually to determine if they have been effective, and to identify whether further development work is required.

1.2 The purpose of the committee is laid down in its Terms of Reference.

1.3 In summary the committee is responsible for making recommendations to the Council of Governors on the appointment and remuneration of the Chair and Non-Executive Directors of the Trust, and on plans for their succession.

1.4 This Annual Report summarises the activities of the Nominations Committee for the financial year 2023/24 setting out how it met its Terms of Reference and key priorities and also provides summarised feedback gathered from input from committee members to support its review of effectiveness and identification of next steps required (**Appendix 1**).

1.5 Report will be provided to the Council of Governors from the committee chair.

2. Responsibilities

2.1 The Nominations Committee is responsible for:

- Approving job descriptions and person specifications detailing the skills, knowledge and experience required for non-executive directors, as proposed by the remuneration committee of the Board of Directors
- Approving the recruitment, selection and reappointment processes for Non-Executive Directors
- Receive reports in relation to the terms and conditions of office and remuneration of current or newly appointed Chair and Non-Executive Directors and make recommendations to the Council of Governors

2.2 During 2023/24 the Committee has delivered the key responsibilities as set out in the Terms of Reference (Appendix 1). Compliance with the key responsibilities was evidenced by the routine presentation and consideration of reports.

2.3 In addition to its regular reports, the Committee also undertook its responsibilities under its Terms of Reference through the following:

- Longlisting and shortlisting meetings for recruitment of the Chair
- Participation in the interview panels
- Feedback summary of NEDs' 360°
- Overseeing the implementation of revised NHSE Fit and Proper Person Test (FPPT) Framework
- Reports on the appraisals and performance of the Chair and Non-Executive Directors
- Support implementation of the new framework for conducting annual appraisals of NHS chairs
- Review of recruitment process
- Appointment of new recruitment partner
- Review of Non-Executive Director job description and person

specification
- Review of size, structure and composition of the Board

3. Reporting

3.1 The Committee reported to the CoG after each meeting during the year. Reports included a description of the agenda items discussed and key actions agreed.

4. Membership and Attendance Record

4.1 During financial year 2023/24 the Nominations Committee met five times, including the shortlisting meeting with regard to chair recruitment, with attendance recorded (for full meetings) in the table below.

- 24 April 2023
- 11 May 2023 (Chair recruitment shortlisting)
- 12 July 2023
- 19 October 2023
- 11 March 2024

4.2 The table below demonstrates that every meeting of the Committee during the year was quorate. *The quorum for any meeting shall be four members, to include at least two Public Governors.* Deputies can attend and be counted in the quorum.

Committee Membership: Attendance FY 2023-24 (total four meetings)

Jude Chin	Non-Executive Director/Chair	3/3
Louisa Pepper	Non-Executive Director/Deputy Chair	1/1
Antoinette Jackson	Non-Executive Director/SID	1/1
Liz Steele *(until Nov 2023)*	Public Governor	3/3
Clive Wilson *(until Nov 2023)*	Public Governor	2/3
Jane Skinner	Public Governor (Lead)	4
Carol Bull	Partner Governor	4
Martin Wood *(until Nov 2023)*	Staff Governor	3/3
Jayne Neal	Public Governor	4
Ben Lord	Public Governor (Deputy Lead)	4
John-Paul Holt *(from Feb 2024)*	Staff Governor	1/1
Andy Morris *(from Feb 2024)*	Staff Governor	1/1
Adrian Osborne *(from Feb 2024)*	Public Governor	1/1
Thomas Pulimood *(from Feb 2024)*	Partner Governor	1/1
Heike Sowa *(from Feb 2024)*	Partner Governor	0/1

Attendance is based on the eligibility of members to attend the total number of meeting/s i.e. meetings took place and attended by governors in their term as committee member.

5. Conclusion and actions for 2024/25

5.1 The review has identified that the Nominations Committee has delivered its responsibilities as set out in its Terms of Reference.

5.2 Attendance has been good and the Committee has been quorate for all meetings.

5.3 Areas identified through the effectiveness review for further development in 2024/25 are:

- Review recruitment processes
- Consideration to update job descriptions for Chair and NEDs in line with the NHS England Framework for conducting annual appraisals of NHS chairs and expected change to NEDs appraisals.

- Additional training for committee members on recruitment and appraisals

6. Recommendation

6.1 The Nominations Committee is asked to receive and endorse the report for presentation to the Council of Governors.

Jude Chin
Nominations Committee Chair July 2024

Appendix 1: Summary output from the Committee effectiveness review

Total Responses Received: 6

Questions	1 Strongly agree	2	3	4	5 Strongly disagree
1. The committee has carried out its required duties as stated within its Terms of Reference:	4	2			
2. The committee has adequate resources (for example, budget, people) to support its function:	3	3			
3. The meetings are held regularly, with appropriate frequency and begin/end as scheduled:	4	2			
4. The Committee receives agenda and materials in advance of the meeting to allow for appropriate review and preparation:	4	1		1	
5. Attendance at the meetings is consistent and/or repeated non-attendance is addressed:	1	3	1		
6. The minutes of the meetings are accurate and reflect the discussion, next steps and/or action items articulated by the members:	5	1			
7. Minutes are circulated in sufficient time to support the working of the committee:	4	2			
8. The membership represents the talent and skill set required to fulfil the goals and purpose of the committee:	1	4	1		

Question 5: one no response

* Areas to improve

General Comments

What was liked the most about the meetings?	What would improve the meetings?	What areas should the Committee focus on in the future?
• Well planned and run • I enjoy the recruitment process for NEDs • Good range of experience in Committee Members • Seek external advice in recruitment of NEDs • Well chaired • Papers sent out prior to each meeting • As I have not attended any yet I find this hard to reply to • Excellent minute keeping and administrative support • Meetings are scheduled at the appropriate times with papers that are concise and to the point.	• An openness to looking at candidates with different, possibly slightly unconventional backgrounds • Some choice in the dates for long listing, shortlisting and interviews of NEDs • CV / recruitment papers have been received at very short notice before long-listing meetings • Attendance could be nearer 100%	• How we recruit • Pro-active consideration to updating job descriptions for Chair and NEDS in light of change to Chair's appraisal documents already and expected change to NED's as well. • Additional training for committee members on recruitment and appraisals • I am glad that there enough members in the committee to ensure adequate representation as the number of meetings are frequent • Limited scope for the committee.

12. Engagement Committee Report (enclosed)

To receive a report from the Engagement Committee

Presented by Sarah Hanratty and Jane Skinner

WSFT Council of Governors meeting (Open)	
Report title:	Engagement Committee report
Agenda item:	12
Date of the meeting:	2 September 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 meeting (additional) held on 22 May 2024.

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

In March meeting, it was agreed that an additional or special meeting of the committee would be convened to discuss in detail the engagement priorities for 2024-25 and review the terms of reference for the committee to ensure they are aligned with the Trust's overarching strategy. Following this decision, the committee met on 22 May to further this work.

The committee's discussion focussed on how the membership engagement strategy would integrate with the Trust's strategic priorities and experience of care strategy. A key point of discussion was the need for clarity and clear definition regarding the role of the governors and engagement committee in delivering the strategy. This would ensure effective implementation of the strategy and prevent any overlap or confusion in responsibilities.

During the meeting, it was proposed that the current membership engagement strategy be revised or rewritten. An accompanying action plan should be developed to clearly outline the steps to be taken each year to implement the strategy effectively. This would ensure that the plans are actionable and measurable.

In July, the committee chair, lead governor and deputy trust secretary met with the head of patient experience and engagement to gain a better understanding of the role and remit of governors and the committee related to patient engagement.

It was concluded that as the strategy is being drafted, the committee chair, lead governor, and head of patient experience would be engaged early in the process. This approach aims to establish a

consensus on the role and purpose of the Engagement Committee. This would help avoid any ambiguity regarding the governors' roles, the purpose of the membership engagement strategy, and its alignment with Trust's broader engagement initiatives.

The committee also considered identifying best practices from other foundation trusts to inform development of the role of governors' engagement committee. This benchmarking is intended to ensure that the committee's approach is in line with the effective practices observed in other FTs.

The committee agreed to schedule a workshop to discuss the draft membership engagement strategy. A further update will be provided at the Council of Governors meeting scheduled on 19 November 2024.

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.

The ongoing work on the membership engagement strategy is crucial to aligning the committee's efforts with the Trust's strategic priorities. By refining the strategy, clarifying roles, and adopting best practices, the committee aims to enhance its effectiveness in driving meaningful engagement with members and supporting the Trust's broader goals.

Action required / Recommendation:

The Council of Governors is asked to note the report from the meeting held on 22 May 2024.

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

13. 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:	13
Date of the meeting:	2 September 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 at the Standards Committee of the Council of Governors held on 7 August 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:

- **Governor skills audit report**

  The Trust undertook an audit of skills held by Governors that are relevant to the role of Governor. It aimed to help shape and develop a Governor Development Programme for 2024/25. The governors were asked to rate themselves on a sliding scale on a number of questions, including their role as a governor.

  The Trust received a total of 20 out of 25 responses from the governors and a report was presented for discussion/consideration **Governors' skills audit responses** and agreeing on the way forward**.**

  Some themes of interest that had emerged from the skills audit are:

  - Understanding of the Trust's strategy and delivery plans
  - 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 role of the Foundation Trust Governor and practical ways to carry out the statutory roles of a governor
  - Data interpretation and how governors make use of the data.

These topics will be incorporated into the training and governor work programme 2024-25 as reflected in the governance report on today's agenda.

- **Trust Constitution review & amendments**

All Foundation Trusts are required by law to have a Constitution. The Constitution provides details of how the Foundation Trust will operate, its membership area, the size and composition of its Council of Governors and its Board of Directors and other information relating to the governance of the organisation and the conduct of meetings. The Constitution can only be changed with the approval of both the Council of Governors and the Board of Directors.

The Standards Committee of the Governors 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 Governors (elected or nominated) to hold office for a maximum of three terms or nine years. It is 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.

To allow the change a paragraph as set out below would be added to the Constitution.

> *Notwithstanding paragraph X, any individual may stand for re-election or re-appointment as a Governor provided that a period of two years has passed since the end of that individual's previous maximum term as Governor.*

Paragraph *X would vary for each Governor constituency – public, staff and partner.*

ACTION
- Recommend the amendment to the Trust's Constitution to the Board of Directors

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

The Committee noted that the FPPT's annual self-attestations were received from all Governors. Requests for next updated FPPT declarations and to re-confirm compliance will be made in March 2025 and reported to the committee in April. To ensure full compliance, HR also conducted other checks to cover disqualification and removal clauses for Governors as described in the Trust Constitution. Requests were issued for Disclosure and Barring Service (standard) checks and the responses processed with only two outstanding (one being new governor). The Committee will review progress with this at its next meeting.

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

- **Standards Committee Terms of Reference**

The Committee reviewed its terms of reference. The terms of reference are attached for approval by the Council **(Appendix A)**

ACTION

- Approve the committee terms of reference.

- **Annual report on Committee effectiveness**

The Standards Committee noted and endorsed the annual report for presentation to the Council of Governors. The Council of Governors is asked to receive the report and note areas of improvement highlighted in the report **(Appendix B)**

ACTION

- Note the annual report on Committee effectiveness.

- **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.

- **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 April to June 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.

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

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.

Enclosures:

Appendix A - Standards Committee terms of reference
Appendix B - Annual report on Committee effectiveness

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

FT Governors' Standards Committee Terms of Reference

1. Purpose of the Committee

1.1 The Standards Committee (the committee) is a sub-committee of the Council of Governors.

1.2 The purpose of the committee is to take responsibility to review issues relating to standards and governance of the Council. Part of this remit would be to review the constitution and specifically consider membership of the Council in terms of number of seats and partner organisations.

2. Level of Authority

2.1 The Standards Committee has delegated authority from the Council of Governors to deliver its key duties and responsibilities. The committee will have authority to establish sub-groups/committees reporting to it. It shall remain accountable to the Council for the work of any group reporting to it.

2.2 The committee has authority to make processes and procedures.

3. Duties and responsibilities

3.1 The Standards Committee shall undertake the following making recommendations for any changes or action to the Council of Governors:

- **Constitution:** review and development Trust Constitution, including membership area, constituencies and membership of the Council in terms of number of seats and partner organisations
- **Code of conduct:** review of code of conduct to ensure the code supports a culture of fairness, openness and learning
- **Procedure for Managing Governor Conduct and Expected Standards**: 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 sit as the panel to hear the outcome of that investigation
- **Governors elections:** plan and implement legal and effective election procedures to yield a diverse field of candidates
- **Governor induction and training:** ensure a programme is in place to support new Governors and maintain the required levels of knowledge and competence for all Governors
- **Governors' attendance:** review non-attendance at meetings and consider mitigating circumstances
- **Governance arrangements**: to consider arrangements for the working of the Council.

4. Membership

4.1 Membership of the Committee will comprise:

- Trust Chair
- Lead Governor
- Staff Governor
- Public Governor
- Appointed/Partner Governor

The Governors may nominate a chair when both chair and lead governor are absent. Additional members may be co-opted to the committee as necessary.

Representatives from the Trust may also be in attendance at meetings, including the Trust Secretary, Deputy Trust Secretary, Foundation Trust Office Manager, and others as required.

5. Quorum

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

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

6. Frequency of meetings

6.1 Meetings will normally be held no more than quarterly.

7. Sub Committees

7.1 None established.

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

8.1 The committee shall be supported by the Foundation Trust Office.

9. Accountability and reporting arrangements

9.1 The committee will be accountable to the Council of Governors.

9.2 The Standard 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 outlining the key areas of discussion and any actions taken or issues for escalation.

9.3 The minutes of the committee meetings shall be formally recorded and submitted to the next meeting of the Standard Committee.

10. Monitoring effectiveness and compliance with terms of reference

10.1 The committee shall carry out an annual 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 Standards Committee: 7 Aug 2024
Date approved by the Council of Governors:
Next review date: August 2025

WSFT Council of Governors' Standards Committee	
Report title:	Annual report from the Chair of the Standards Committee
Agenda item:	8
Date of the meeting:	7 August 2024
Sponsor/executive lead:	Jude Chin, Trust Chair / Chair of the Standards Committee
Report prepared by:	Richard Jones, Trust Secretary 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:	Good practice states that the Council of Governors (CoG) should review the performance of its committees annually to determine if they have been effective, and to identify whether further development work is required. To bring this to effect, the committee should conduct a self-evaluation and assessment on an annual basis and use the evaluation process to identify strengths and weaknesses, to flag areas for improvement, and to plan for further action as appropriate. This Annual Report summarises the activities of the Standards Committee for the financial year 2023/24 setting out how it met its Terms of Reference and key priorities. Attendance at the committee was in line with the quorum set within its Terms of Reference. Having reviewed its activities and undertaken a self-assessment review (attached at **Appendix 1**) it is the view of the committee that its activities have been consistent with its Terms of Reference. Areas identified for improvement are highlighted in section 5.2 of the report.
Action required/ recommendation:	The Standards Committee is asked to receive and endorse the report for presentation to the Council of Governors.
Previously considered by:	N/A

Risk and assurance:	N/A
Equality, diversity and inclusion:	N/A
Sustainability:	N/A
Legal and regulatory context:	N/A

Standards Committee 2023-24 Annual Report

1. Background

1.1 Good Practice states that the Council of Governors should review the performance of its committees annually to determine if they have been effective, and to identify whether further development work is required.

1.2 The purpose of the committee is laid down in its Terms of Reference.

1.3 In summary the committee is responsible for making recommendations to the Council of Governors on the to review issues relating to standards and governance of the Council. Part of this remit is also to review the constitution and specifically consider membership of the Council in terms of number of seats and partner organisations.

1.4 This Annual Report summarises the activities of the Standards Committee for the financial year 2023/24 setting out how it met its Terms of Reference and key priorities and also provides summarised feedback gathered from input from committee members to support its review of effectiveness and identification of next steps required (**Appendix 1**).

1.5 Report will be provided to the Council of Governors from the committee chair.

2. Responsibilities

2.1 The Standards Committee is responsible for:

- **Constitution:** review and development Trust Constitution, including membership area, constituencies and membership of the Council in terms of number of seats and partner organisations
- **Code of conduct:** review of code of conduct to ensure the code supports a culture of fairness, openness and learning
- **Procedure for Managing Governor Conduct and Expected Standards**: 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 sit as the panel to hear the outcome of that investigation
- **Governors elections:** plan and implement legal and effective election procedures to yield a diverse field of candidates
- **Governor induction and training:** ensure a programme is in place to support new Governors and maintain the required levels of knowledge and competence for all Governors
- **Governors' attendance:** review non-attendance at meetings and consider mitigating circumstances
- **Governance arrangements**: to consider arrangements for the working of the Council.

2.2 During 2023/24 the committee has delivered the key responsibilities as set out in the Terms of Reference (Appendix 1). Compliance with the key responsibilities was evidenced by the routine presentation and consideration of reports.

2.3 In addition to its regular reports, the committee also undertook its responsibilities under its Terms of Reference through the following:

- Policy for Engagement between Board and CoG
- Governor elections, induction and training programme
- Lead & Deputy Lead Governor election process, role spec and term of office
- Managing non-attendance at the Council of Governors meetings
- Trust Constitution - review & amendments
- Usage of governors' email addresses for Trust communication.

3. Reporting

3.1 The committee reported to the CoG after each meeting during the year. Reports included a description of the agenda items discussed and key actions agreed.

4. Membership and Attendance Record

4.1 During financial year 2023/24 the Standards Committee met two times, with attendance recorded in the table below.

- 19 April 2023
- 10 July 2023

4.2 The table below demonstrates that every meeting of the Committee during the year was quorate. The quorum for any meeting shall be three members. Deputies can attend and be counted in the quorum.

Committee membership - attendance April 2023 - March 2024 (total of two meetings)

Carol Bull	Partner Governor	1 (of 2)
Jude Chin	Non-Executive Director/Committee Chair	2
Amanda Keighley	Staff Governor	2
Adrian Osborne	Public Governor	1 (of 2)
Jane Skinner	Public Governor / Lead Governor	2

Attendance is based on the eligibility of members to attend the total number of meeting/s i.e. meetings took place and attended by governors in their term as committee member.

5. Conclusion and actions for 2024/25

5.1 The review has identified that the Standards committee has delivered its responsibilities as set out in its Terms of Reference.

5.2 Attendance has been good and the committee has been quorate for all meetings.

Areas identified through the effectiveness review for further development in 2024/25 are:

- Consider ongoing training opportunities for governors and areas of training for the governing body to make them even more productive to fulfil the role
- Consideration as to whether governors should receive any of the mandatory training other staff/volunteers receive.

6. Recommendation

6.1 The Standards Committee is asked to receive and endorse the report for presentation to the Council of Governors

6.2 Items list under 5.2 are review and incorporated into the committee's forward plan.

Jude Chin
Chair of the Standards Committee
July 2024

Appendix 1: Summary output from the committee effectiveness review

Total Responses Received: 5

Questions	1 Strongly agree	2	3	4	5 Strongly disagree
1. The committee has carried out its required duties as stated within its Terms of Reference:	2	3			
2. The committee has adequate resources (for example, budget, people) to support its function:	1	4			
3. The meetings are held regularly, with appropriate frequency and begin/end as scheduled:		5			
4. The Committee receives agenda and materials in advance of the meeting to allow for appropriate review and preparation:	2	3			
5. Attendance at the meetings is consistent and/or repeated non-attendance is addressed:		4			
6. The minutes of the meetings are accurate and reflect the discussion, next steps and/or action items articulated by the members:	2	3			
7. Minutes are circulated in sufficient time to support the working of the committee:		5			
8. The membership represents the talent and skill set required to fulfil the goals and purpose of the committee:		4			

Ques 8: one no response
Ques 5: one no response

General Comments (as received)

What was liked the most about the meetings?	What would improve the meetings?	What areas should the Committee focus on in the future?
• Having only attended 1, I have little experience to draw on but I enjoyed the open discussion, everyone's opinion was valued and actions we made moving forward. It was evident that actions had be carried out as set from previous meetings • They are well run and generally to time and discussions are kept on point • I think we have had effective discussion • The committee has tackled some difficult issues but is prepared to do so with appropriate contribution from members. • Since I have been on the Committee, there has only been one meeting. I am not really in a position to comment substantively therefore, or make any suggestions for change/improvements at this time.	• I feel it is too early for me to make much comment on this • **Attendance/Quorum:** Not sure if repeated non attendance at this meeting is addressed or in fact happens • Consideration as to whether governors should receive any of the mandatory training other staff/volunteers receive	• Ongoing governor training opportunities • Whether there is a need to review the whole standards document proactively on a regular basis rather than just be reactive? • Could induction to being a governor be standardized for everyone independent of when they join the council? • Maybe look at areas of training for the governing body to make them even more productive.

14. Staff Governor Report (enclosed)

To receive a report from the Staff Governors

To Note

WSFT Council of Governors meeting (Open)	
Report title:	Staff Governors' report
Agenda item:	13
Date of the meeting:	2 September 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 2 July 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) & Richard Jones (Trust secretary) and Ruth Williamson (Foundation Trust Office Manager).

Summary/Highlights:

Freedom to Speak Up - Executive directors' drop-in sessions

Executives continue efforts to increase visibility, including visits to Newmarket Hospital and WSFT. The July Board meeting was scheduled at Newmarket, with opportunity for Board members to visit wards and departments. There was a discussion regarding the reinstating of executive sessions in "Time Out" – these have now been reinstated and also planning how to increase visibility in the community.

Freedom to Speak Up – update on themes: The staff governors noted an overview of themes related to speaking up within the Trust. Improvements in champion levels were noted and looking to improve diversity. Reaching out to relevant staff networks to volunteer. An Equality, Diversity, and Inclusion (EDI) survey will be conducted at the end of the year to conduct a gap analysis. Efforts have been made to update outdated FTSU posters across departments, with a request for staff to notify the FTSU Guardian if any are found. An activity log has been instated to collect and collate information from champions. Other recurring themes included communication from managers, car parking, changes in payment methods for certain staff bands due to minimum wage rules, external parking issues, phased return

policies, staff relationships. Work is being undertaken to address these through leadership programmes and external relevant training.

Staff briefing sessions on Teams: Attendance in staff briefing sessions via Teams is in the range of 80-100 attendees. Efforts are being made to increase attendance, including alternating days and times and encouraging department representatives to join. Issues with governors accessing the staff briefing link were reported and are being addressed.

Flexible working requests: The introduction of a new Vacancy Application Form (VAF) panel for flexible working requests is linked to the vacancy process and is driven by the current financial situation. This topic will be addressed in the upcoming staff briefings, where questions can be raised.

Volunteer forum: The recent introduction of a volunteer forum by the deputy director of workforce has been positively received by volunteers.

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 2 July 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

15. 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:	15
Date of the meeting:	2 September, 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

I begin by thanking all Trust staff for their continued hard work. It might be summer but the pressure on services is unrelenting, as evidenced in the various operational reports and statistics available to us. Governors receive the staff newsletter, known as the Green Sheet, it contains so many positive stories of the achievements of individuals and teams. There is a lot of excellent and interesting work going on to enhance patient care. Recently, our Staff Governors have been featured in a series of articles highlighting their role to other staff. We are also invited to the Trust Team Brief, work is underway to ensure we can listen to this live, or by recording, as we can only read the brief at the moment. However, this does keep us informed.

Governors are aware of the Trust's difficult financial position, which is not unique, the whole NHS being under financial pressure. A presentation on the Trust's financial position is an agenda item for this meeting; Governors will have opportunity to meet the new director of financial recovery (a 12-month secondment from NHS England) and to ask questions for the purpose of gaining assurance. Cost Improvement Programs (CIPs) are necessary to meet the financial target at year end. We know that CIPs are likely to affect staff, usual practice and services; we have been assured that CIPs are subject to impact assessment.

Members of the Nomination Committee recently shortlisted and interviewed prospective Non-Executive Directors (NEDs). We were impressed by the number and standard of the applicants. Thanks to Jeremy Over, for his recruitment process update, a recording of this presentation is still available if any governor would like to watch it. Following interviews, appointment recommendations were made to the Council in June, by the interview panel, and subsequently approved. We therefore welcome Heather Hancock, Richard Flatman and Alison Wigg as NEDs and David Weaver and Paul Zollinger-Read as associate NEDs. The latter will operate with full NED responsibilities as non-voting Board members and will fill any future NED vacancies, which may arise. They bring a wealth and range of experience to the Board.

We are very pleased to welcome NED, Tracy Dowling, back from secondment as Interim Chief Executive, Mid and South Essex Integrated Care System. NED Louisa Pepper stood down from her role at the end

of August, having completed two terms. She fulfilled her role with enthusiasm, hard work, compassion and integrity and will be greatly missed.

Dr David Brandon stood down as Partner Governor in August, thank you David for your contribution. Dr Evelin Hanikat has been appointed in David's place, Evelin is the Deputy Medical Director at Suffolk and North East Essex Integrated Care Board.

Since the last CoG, Governors have conducted business-as-usual:
15 Steps visits, Courtyard café surveys, observing and reporting on Board assurance committee meetings, and attending informal and sub-committee meetings.

Thank you to Public Governor, Sarah Hanratty, who having volunteered to chair the Engagement Committee, is in the process of revitalising and refocusing it. The Governor Engagement Strategy, previously focused on increasing Trust membership, will be reviewed to ensure it aligns and integrates with other Trust patient engagement and experience strategies and policies. Cassia Nice, Head of Patient Experience and Engagement, is working with the committee to do this. A workshop for committee members is planned in September.

Twenty Governors responded to the recent skills audit. The results of this audit will inform the Governor development program going forward. Richard, Pooja and Ruth work hard to ensure Governors are developed to carry out their role effectively, thank you. We recently participated in a "Living the Trust Values" session, which was interactive and thought provoking.

Some of us took the opportunity to be updated in our basic life support skills. We were surprised to hear that this is not mandatory training for all Trust staff, only clinical staff. Those of us who attended left with the confidence to put skills into action should they be required. Thanks to Andy Morris for organising this.

Some of us volunteered to meet the public by manning a stall at the My WiSH annual Soap Box Challenge on August 31st. This is a major fund-raising event for the Trust; who could forget the sight of the Trust team, steering their vehicle downhill, at breakneck speed, last year! It is a fun day out.

Another important event in our calendar is the Annual Members Meeting on September 24th. The theme this year is "Fifty years of the West Suffolk Hospital". Governors will have excellent opportunity to meet members of the public. The clinical presentation this year focuses on diagnostics – history, current and the future. Annual updates are given by the Chair, Chief Executive and (very brief!) Lead Governor, followed by a Q&A session. All Governors are expected to attend or apologise, as per public CoG meeting attendance, please.

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

16. Governance Report (enclosed)

To receive the governance report

For Discussion

Presented by Pooja Sharma

WSFT Council of Governors meeting (Open)	
Report title:	Governance report
Agenda item:	16
Date of the meeting:	2 September 2024
Sponsor/executive lead:	Richard Jones, Trust Secretary & Head of Governance
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

This report summarises the main governance headlines for Aug 2024, as follows:

- Council of Governors sub-committees' membership and attendance 2024
- Governor work programme 2024/25

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

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

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

The items reported 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 set out in the body of the report.

Governance Report

1. Council of Governors sub-committees 2024

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

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

As highlighted in the standards committee report attendance at subcommittees will be reviewed to support individuals and the effective working of the committees.

2. Governor work programme 2024-25

The annual work programme aims to be reasonable in terms of time commitment and coverage. The draft programme 2024/25 is presented to the CoG for information. **(Appendix A)**

ACTION

- Note and comment on the programme.

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
5 December 2024	Session on Integrated Care Board introduction and provider collaboration	Interests of members and the public	ICB partners/Chair/Trust Secretary
4 March 2025	Experience of care and engagement session	Interests of members of public	Head of Patient Experience & Engagement
TBC	Themes of interest that have emerged from the governors' skills audit 2024 will be incorporated into the training and governor work programme 2025:	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	Trust Secretary

Timing	Themes	Rationale	Led by
	➢ Understanding of the Trust's strategy and delivery plans ➢ 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 role of the Foundation Trust Governor and practical ways to carry out the statutory roles of a governor ➢ CQC new inspection framework ➢ Data interpretation and how governors make use of the data.	events. The programme will be developed to reflect these priorities.	

ITEMS FOR INFORMATION

17. 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:	17
Date of the meeting:	2 September 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	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 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 compliments 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 – 24 May, 2024			
Patient Story – a video presentation from the High Sheriff of Suffolk was received. This talked about the positive end of life care received by his mother, whilst a patient in the Trust, with particular mention of the part played by MyWish. The importance of interplay between humanity and systems was emphasised and how these were nurtured in organisation's culture.	• To improve working experience for the staff	• Model for future care	Verbal
Future System Board Report – Update received on the new hospital programme. Noted anticipated delay in confirmation of capital budget due to General Election on 4 July, 2024 and potential risk of any new administration taking the decision to delay some capital programmes altogether. It was felt that the risk in not replacing a RAAC hospital was high and therefore a threat to the programme was not anticipated. However, a funding reduction could not be ruled out.	• Ongoing assurance/monitoring • Board to receive future updates	• Sustainable service improvements	2.1 report
West Suffolk Alliance and SNEE Integrated Care Board – The Primary Care Strategy 24/25 was presented at the Integrated Care Board in July. Work being undertaken with Community Action Suffolk to formulate a model to enable a strength-based approach on prevention, recognising the pivotal role the voluntary sector plays in this regard. The CEO of Community Action Suffolk is working with WSFT.	• Strengthened provider collaboration	• Focus on system working	2.2 report

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
People and OD Highlight Report, including FTSU Report - Final engagement work being undertaken on the **people, culture and workforce priorities.** The current financial situation has been reflected in the plan. **NHS Sexual Safety Charter** – Following the launch by NHS England of the first ever sexual safety in the workplace charter for the NHS, a question on this subject was added to the Trust's 2023 staff survey, with 4% of the workforce confirming they had been subject to unwanted attention. The Trust will gain an understanding of the issue and this has been included as a priority within the People and Culture Plan. The Trust is committed to delivering the 10 actions contained within the Charter. **FTSU** – Jane Sharland, FTSU Guardian provided an update. An increase in the number of concerns raised was seen as a positive step in staff feeling able to raise issues. Themes identified from concerns raised included major changes for staff shifts, pay and use of emails as a communication method, relationships, incivility, estates and facilities issues.	• Ongoing assurance/monitoring	• Delivery of People and Culture Priorities for 2024/25	3.1.1 report
Insight – The Board received a report of the meetings held in March and April, 2024. Noted a review of the metrics used in the Integrated Quality and Performance Report (IQPR) has been undertaken.	• Focus on improvement • Increase visibility on the benchmark performance within the system • Insight Committee to keep track of the initiatives	-	4.1 report
NHS 2024/25 Priorities and Operational Planning Guidance – the Board was presented with guidance released in March 2024, containing 32 national objectives, requiring numerical activity and/or performance trajectories to be submitted alongside a narrative description of how delivery will be achieved. The Trust's final plans were submitted on 25 April 2024 with the aim of treating more patients and reducing waiting times and resultant levels of harm.	• Ongoing assurance/monitoring	-	4.1.1 report

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Finance Report – Noted at a recent extraordinary meeting, the Board had given its approval to amend the deficit for 24/25 from an £18.9m deficit to a £15.2m deficit, predicated on a Cost Improvement Programme of £16.5m.	• Ongoing assurance/monitoring • Overseeing and delivering FRP • Visibility on divisional delivery	• Financial sustainability	4.1.2 report
Improvement Committee – Reports received from the March and April, 2024 meetings. Noted two deep dives undertaken on level Clostridioides difficile and post-partum haemorrhage. Following a request from the CQC, a response is to be sent to questions raised regarding the paediatric audiology service and quality of care.	• Ongoing assurance/monitoring • On-going improvement plan		4.2 report
Quality and Nurse Staffing Report – The Board were advised of a pause to overseas nursing recruitment due to the challenge of placing in vacancies. This was seen as indicative of positive vacancy rates and will be reviewed in Quarter 3.	• Ongoing assurance/monitoring • Overseeing quality indicators Review of the international recruitment pipeline		4.3 report
Maternity Services – Noted changes made to the approval process for the Maternity Incentive Scheme, with key safety actions required to be achieved. A change in reporting pathways means that supporting papers can be reviewed and approved at the Improvement Committee, as part of the evidence packs for submission to the Safer Nursing Care Tool (Feb 25).	• Ongoing assurance/monitoring in areas of priority		4.3.1 report
Audit Committee Report – A deep dive has been undertaken on Procurement and the Insight Committee has been tasked to look at the procurement dashboard, as part of its regular reporting. The audit plan has been agreed for the year and assurance provided by the auditors. The Board gave its approval to the Scheme of Reservation and Delegation of Powers and Standing Financial Instructions.	• Board visibility and oversight		4.4 report

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Board Assurance Framework - Ten strategic risks have been identified. In terms of financial risk the Financial Accountability Committee (FAC) has reviewed this in detail and will report to the Insight Committee.	• 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	5.1 report
Governance Report - The improvement plan to address the findings of the Well Led report, structured around the recent CQC guidance is planned to come to Board in July.	• Board oversight	-	5.2 report
Board of Director Key Issues – 26 July, 2024			
Patient Story – a video story was received on experience of the organisation from a profoundly deaf patient, whose means of communication was through British Sign Language. A major theme was the loss of independence due to barriers to communication. (Not all deaf people can read and write) and difficulties highlighted in provision of an interpreter in a timely fashion. The feedback from this patient will be incorporated in to work on Equality Diversity and Inclusion and reported to the Involvement Committee.	• To improve working experience for the staff • Annual reviews of staff for reasonable adjustments	• Model for future care	Verbal
CEO Report - Noted two new director appointments made, Sam Tappenden, Director of Strategy & Transformation and Jonathan Rowell, Director of Financial Recovery.	-	-	1.7 report
Strategic Priorities Report - Update on progress made across the year was received. The ambition to grow staffing within community has been impacted by the national imperative not to recruit.	• Ongoing assurance/monitoring	• Deliver the Trust strategy	2.1 report

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Future System Board Report – Letter confirming funding remains outstanding. However, indication received is that commitment to RAAC hospitals will be honoured. A new governance process for the Future System Programme is being set up to provide assurance.	• Ongoing assurance/monitoring • Board to receive future updates	• Sustainable service improvements	2.2 report
West Suffolk Alliance and SNEE Integrated Care Board – Work with Howard Estate continues. Outcome of engagement work on hypertension and atrial fibrillation to be used for similar work in Haverhill. The Trust is joining a system working group as part of the Decaffeination Project, looking at effects on reduction in falls and bladder heath for inpatients.	• Strengthened provider collaboration • Forward planning and the delivery of plan • Board visibility and oversight of the work	• Focus on system working	2.3 report
Collaborative Oversight Report – Noted scoping commenced in identification of opportunities for collaboration in corporate services between WSFT and ESNEFT.	• Board visibility and oversight of the work	• Focus on system working	2.4 report
Essex and Suffolk Elective Orthopaedic Centre (ESEOC) - A presentation was received from Cassia Nice, Head of Patient Safety and Engagement, WSFT and Simon Morgan, Associate Director of Communications, SNEE ICB on the engagement work undertaken. Healthwatch, as an independent body, hosted the survey and have analysed the data and the final report, with recommendations, is now in the public domain. Noted the issue of transport was identified as a key theme and discussions are being undertaken on way forward.	• Strengthened provider collaboration	• Focus on system working	2.5 report

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Involvement Committee – Case Study made to the June, 2024 meeting on the Trust Speech and Language Therapies department actioning of staff survey results. The Committee endorsed the People and Culture Plan 24/25. Updates will be reported on throughout the year. Noted there was a risk that patient information, developed by clinical teams and published by the Trust (in leaflet and electronic form), is not up to date due to the size of the library (c.1200 documents) and the associated resource requirements to maintain it. A risk assessment is being undertaken.	• Detailed analysis of CKIs	• Workforce sustainability	3.1 report
Freedom to Speak Up (FTSU) – An increase in concerns raised was noted, but seen as a positive indication that staff were comfortable to raise issues. Anonymous reporting has decreased, again seen as a positive indication of people feeling safe to speak up. Themes have been identified and are being worked through. Work is being undertaken on increasing the number of FTSU champions.	• Ongoing assurance/monitoring	-	3.1.1 report
Insight Committee – Deep dive undertaken in June, 2024 Meeting on benefits realisation of investment decisions to explore whether decisions made were consistently evaluated and appropriate action taken if not achieving the benefits identified in the business case. Further work is being undertaken, from a financial recovery perspective, on the finance risk contained within the Board Assurance Framework.	• Focus on improvement • Increase visibility on the benchmark performance within the system • Insight Committee to keep track of the initiatives	-	4.1 report

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Finance – The Trust, at Month 3, was £3.1m adverse to plan. High level reasons for this, including medical pay and contractual work off plan. As a consequence, the ICB will decide on controls to be implemented on the Trust's spending. Potential detrimental impact on organisational culture and need for clear communication noted.	• Ongoing assurance/monitoring • Overseeing and delivering financial recovery plan (FRP) • Visibility on divisional delivery	• Financial sustainability	4.1.1 report
Improvement Committee – The Trust is seeking clarification on the level of training for staff and the impact of delivering the Oliver McGowan mandatory training (learning disabilities and autism) to understand how to progress compliance. Deep dive undertaken on the accreditations and licences process. Pilot being undertaken of the process for clinical accreditation using UKAS in Pathology, ISAS in Radiology & JAG in Endoscopy. The Clinical Effectiveness Governance Group (CEGG) will provide updates to the Improvement Committee.	• Ongoing assurance/monitoring • On-going improvement plan	• ICS resources which could be tapped into	4.2 report
Quality and Nurse Staffing Report – Concern expressed at level of qualified vacancies available. Review undertaken and foreign recruitment has been paused. The level of registered nurses qualifying in 2025 is expected to reduce. Following comments received, the language used within the RADAR reporting system to be reviewed in order to reflect the culture of the Trust, as one of learning rather than blame.	• Ongoing assurance/monitoring • Overseeing quality indicators • Review of the international recruitment pipeline	-	4.3 report

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Maternity – Following the results of the SCORE cultural survey, (undertaken as part of the Perinatal Culture and Leadership Programme), a culture coach will be used to focus on learning, improvement of the safety climate and speaking up. The Be Well Bus programme, launched in April, 2024, across Suffolk and North East Essex, as a one-stop shop to offer health and wellbeing support to women antenatally and postnatally will be used as an opportunity to gather service users' feedback to help shape the Trust's future service and co-produce an action plan in response to the Healthwatch and CQC survey.	• Ongoing assurance/monitoring in areas of priority	-	4.3.1 report
Audit Committee – The audited accounts were completed and signed off. No substantive issues were raised.	• Ongoing assurance	-	4.4 report
Board Assurance Framework – Noted the Trust had considered risk appetite. Assurance committee agendas reflect strategic risks and allow for deep dives to be undertaken in areas highlighted.	• 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	5.1 report
Governance Report – Board accepted the proposal not to renew commercial insurance for personal accidents during patient transfer. Such cover is included within insurance provision provided by NHS Resolution. Noted the Board approved the updated terms of reference for the Board Remuneration and Nomination Committee. The Board agreed the annual process of reviewing effectiveness of committees to be undertaken in a single point in the year, rather than spread throughout.	• Board oversight	-	5.2 report

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Any Other Business - The Board gave its thanks to Paul Pearson, Unison Staff Representative on his retirement and Louisa Pepper, Non-Executive Director, who finishes her tenue at the end of August, 2024.	-	-	Verbal

18. Any other business

For Discussion

Presented by Jude Chin

19. Dates for meetings for 2024

- 24 September 2024 (Annual Members' Meeting)
- 19 November 2024

To Note

Presented by Jude Chin

20. Reflections on meeting

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

For Consideration

Presented by Jude Chin

CLOSE

SUPPORTING ANNEXES

Item 9 - IQPR full Report - June

Assurance Grid

June 2024		ASSURANCE: Pass (P)	ASSURANCE: Hit and Miss (?)	ASSURANCE: Fail (F) — Not Met
VARIANCE	Special Cause Improvement (H / L)		**INSIGHT** Cancer 62 Days Performance **INVOLVEMENT** Staff Sickness – Rolling 12month Staff Sickness Mandatory Training	**INSIGHT** RTT 78+ Week Waits **INVOLVEMENT** Appraisal Turnover
VARIANCE	Common Cause	**INSIGHT** Urgent 2 Hour Response	Please see box to right	**INSIGHT** 12 Hour Breaches Virtual Ward Total Average Occupancy Number Respiratory Bay Average Occupancy Number Heart Failure Bay Average Occupancy Number IV Abx Bay Average Occupancy Number Frailty Bay Average Occupancy Number Incomplete 104 Day Waits
Deteriorating	Special Cause Concern (H / L)		**INSIGHT** 12 Hour Breaches as a Percentage of Attendances	

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
% Patients with No Criteria to Reside
Virtual Ward Total Average LOS per Patient
28 Day Faster Diagnosis
Community Paediatrics RTT Overall 78 Weeks Wait
Community Paediatrics RTT Overall 104 Weeks Wait
IMPROVEMENT:
C-Diff Hospital & Community
INVOLVEMENT:
Overdue Responses

INSIGHT: Glemsford GP Practice – the following KPIs are applicable to the practice:

- Urgent appointments within 48 hours
- Routine appointments within 2 weeks
- Increase the % of patients with hypertension treated to NICE guidelines to 77% by March 2024
- Increase the % of patients aged 25-84 years old with a CVD risk score of >20% on lipid lowering therapies to 60%

Currently this data is not available to the Trust, however the Information Team are working to resolve this.

*Cancer data is 1 month behind

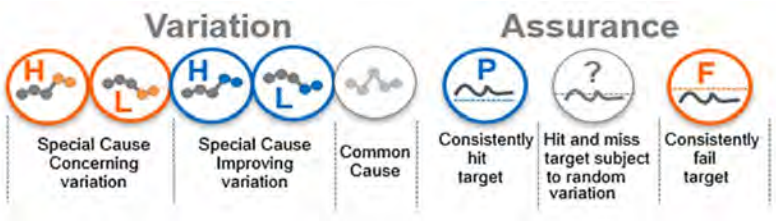
Items for escalation based on those indicators that are failing the target, or are worsening and therefore showing Special Cause of Concerning Nature by area:
INSIGHT - Urgent & Emergency Care: 12 Hour Breaches, 12 Hour Breaches as a Percentage of Attendances, Virtual Ward Total Average Occupancy Number, 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
INVOLVEMENT – Well Led: Appraisal, Turnover

Urgent & Emergency Care summary

Chart Legend

Target — Mean — Measure

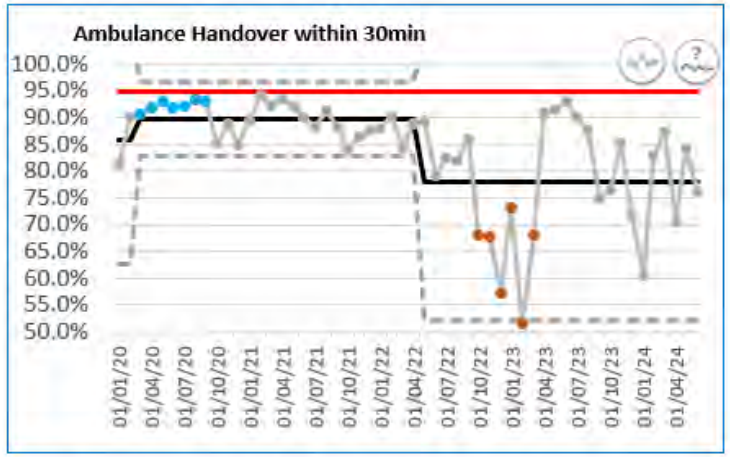
Process Limit — Lower Process Limit

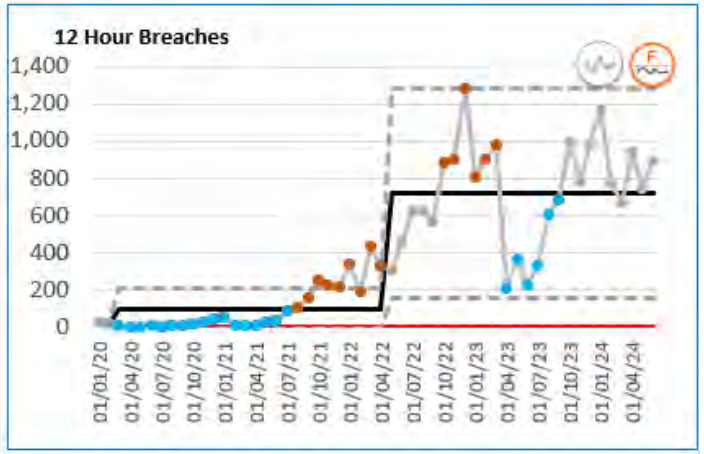


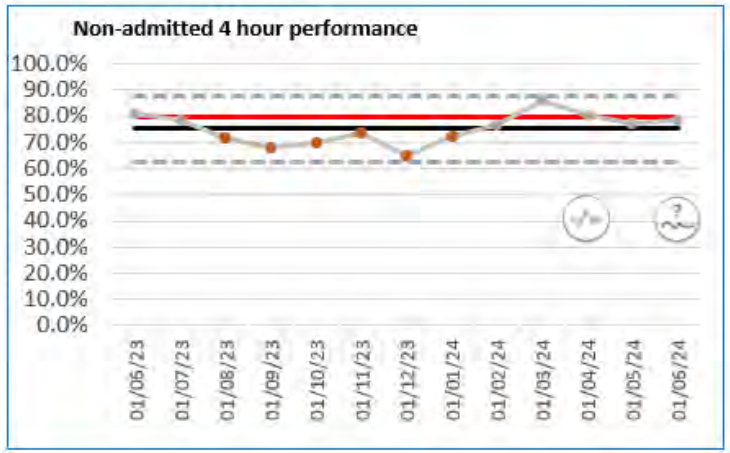
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover within 30min	Jun 24	76.3%	95.0%			78.0%	52.1%	103.9%
12 Hour Breaches	Jun 24	893	0			719	151	1287
4 hour breaches	Jun 24	2837	0					
4 hour performance	Jun 24	66.0%	78.0%					
Non-admitted 4 hour performance	Jun 24	78.3%	85.0%			75.3%	62.6%	88.0%
12 hour breaches as a percentage of attendances	Jun 24	10.7%	2.0%			5.2%	1.1%	9.2%
Urgent 2 hour response	Jun 24	93.5%	70.0%			90.3%	82.6%	98.0%
Criteria to reside (Average without reason to reside) Acute	Jun 24	37				57	43	72
**Criteria to reside (Average without reason to reside) Community	Jun 24	27				18	13	23
% patients with no criteria to reside	Jun 24	9.4%	10.0%			13.3%	9.0%	17.6%
Adult G&A Beds Open Vs Plan	Jun 24	432	463					
Virtual Beds Trajectory	Jun 24	40	40					
Total average occupancy number	Jun 24	31.3	80.0			23.2	14.7	31.7
Total average occupancy percentage	Jun 24	78%	80%			72%	43%	101%
Total bed days on VW	Jun 24	755	-			603	301	904
Total average LOS per patient	Jun 24	8.0	14.0			9.8	3.6	16.1
Respiratory Bay average occupancy number	Jun 24	2.1	8.0			2.9	-0.8	6.6
Heart Failure Bay average occupancy number	Jun 24	5.5	12.0			5.3	1.5	9.1
IV Abx Bay average occupancy number	Jun 24	1.2	6.4			2.5	-0.9	5.9
Frailty Bay average occupancy number	Jun 24	3.7	16.0			2.8	-0.7	6.3

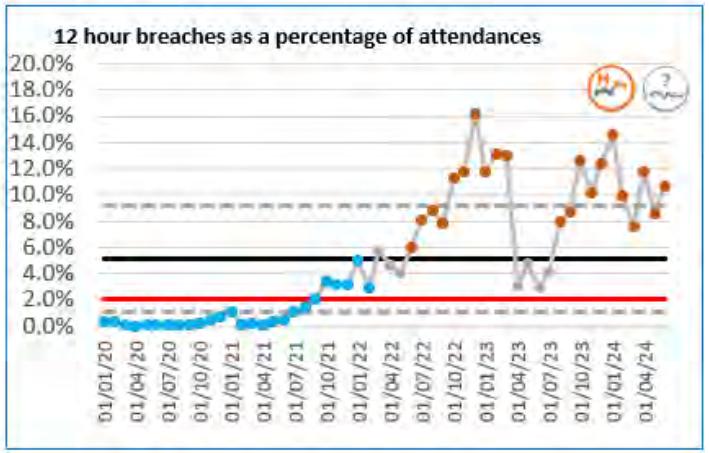
** Figures are for Glastonbury and Newmarket only, data not currently captured at Hazel Court.

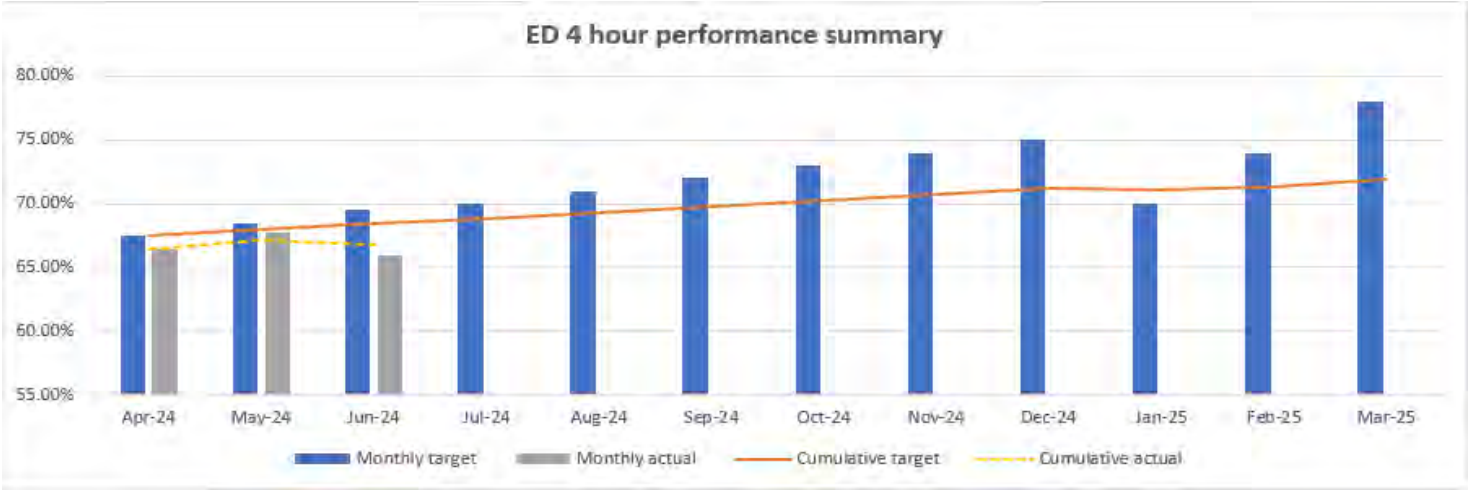
Urgent & Emergency Care: ED 4 Hour Performance







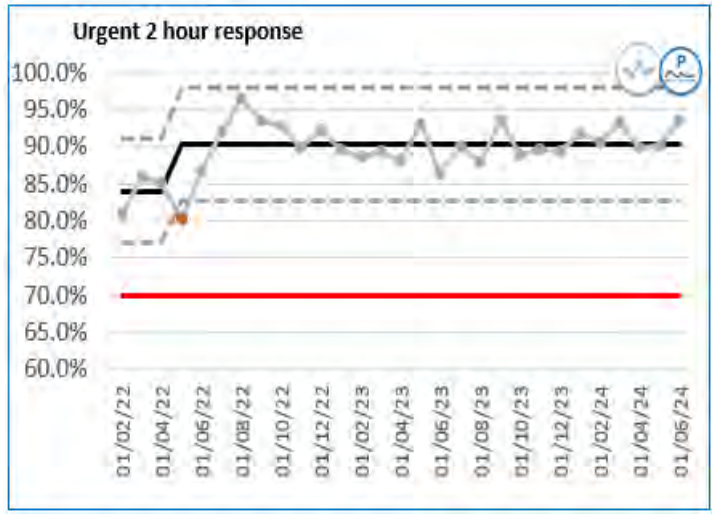


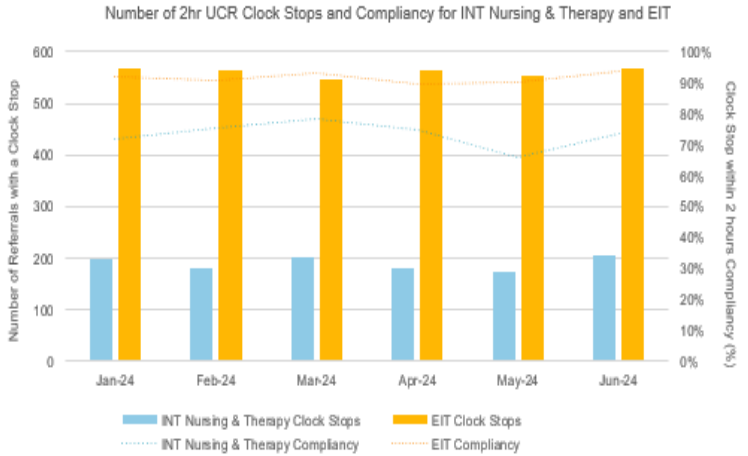


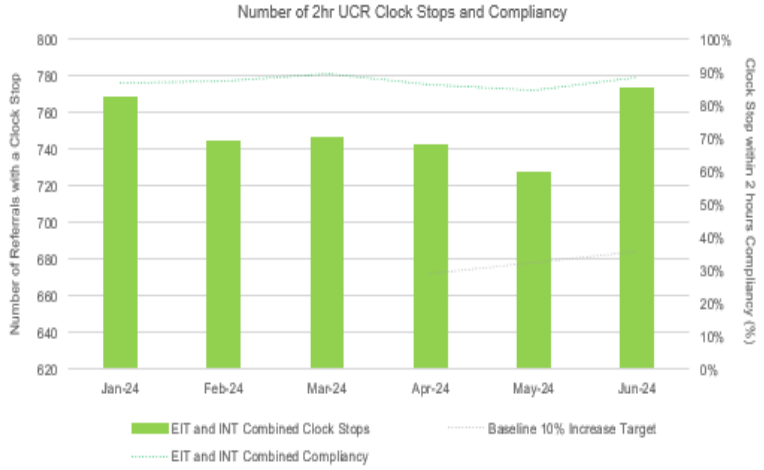
Urgent & Emergency Care

What	So What?	What Next?
Ambulance handover performance continues to show no significant change. Achievement of this metrics remains challenging with contributing factors including a number of patients within the Emergency Department (ED) with an increased length of stay, waiting for a bed, resulting in the need to cohort patients into escalation areas including Rapid Assessment Triage Area (RAT), which reduces our ability and capacity to offload ambulances. The number of 12 hour breaches in the month of June demonstrates no significant change, although there were 150 more patients waiting longer than 12 hours in the department when compared to May. We continue not to meet this metric. The number of 12 hour breaches as a percentage of attendances shows no significant change, but remains concerning. Non-admitted performance demonstrates no significant change. June's 4-hour performance was 65.98%, meaning that we did not achieve our trajectory of 69.5%.	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 ED standard will meet the national targets. Some patients are waiting longer in the ED department than they should be and being nursed in escalation areas which makes for a poor patient experience.	Revised UEC action plan developed with trajectory to achieve 78% 4hr ED target by March '25. Internal UEC delivery group with workstream leads has commenced. ED Tri to Divisional Tri weekly performance meetings with associated action plan. Robust data and clinical review for periods of reduced performance to obtain learning to improve performance. Focussed work for improving overnight ED performance including: • Template guidance for Emergency Physician In Charge (EPIC) to Emergency Registrar in Charge (ERIC) handover with clear actions for night • Focused leadership training for Registrars overnight to be included within study sessions • Support from OD team in developing leadership skills in senior team • Review of current shift patterns Implementation of projects to commence in July '24 • Pre booked next day returner ENP slots – support minor injuries attending after 10pm • Rapid Assessment for non admitted patients – consultant based at point of streaming/triage to assess & discharge or redirect to other services ie SDEC between 3-6pm • Fit to sit – ambulance patients will come through streaming and be triaged there to release the ambulances. As from July new rota for ED leadership team to be solely based in ED supporting performance. AAU also have similar rota. Planning for Minors Emergency Care Unit (MECU) continues – currently awaiting fire testing to be completed for outer walls expecting initial report 11th July. Implementation date for MECU likely end August '24 The use of agency ambulance personnel for reverse cohorting will cease towards the end of July. If required to open the escalation area, a request will be made to staffing Matron of the Day to look for alternatives across the Trust to staff this.

Urgent & Emergency Care: UCR





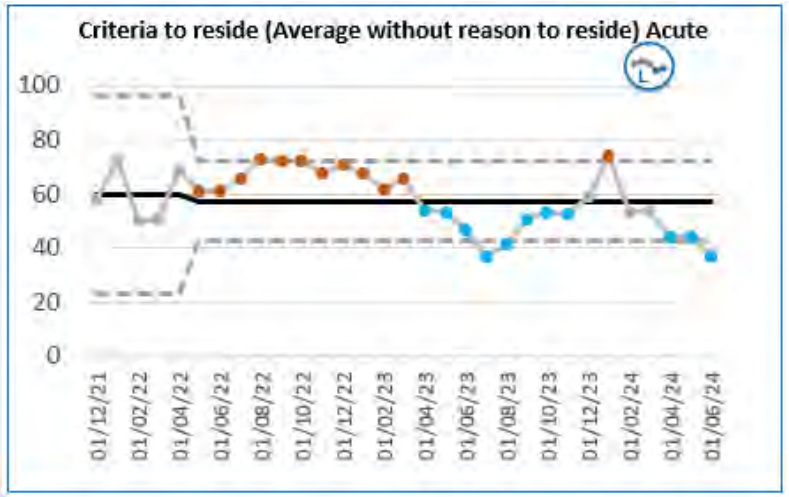


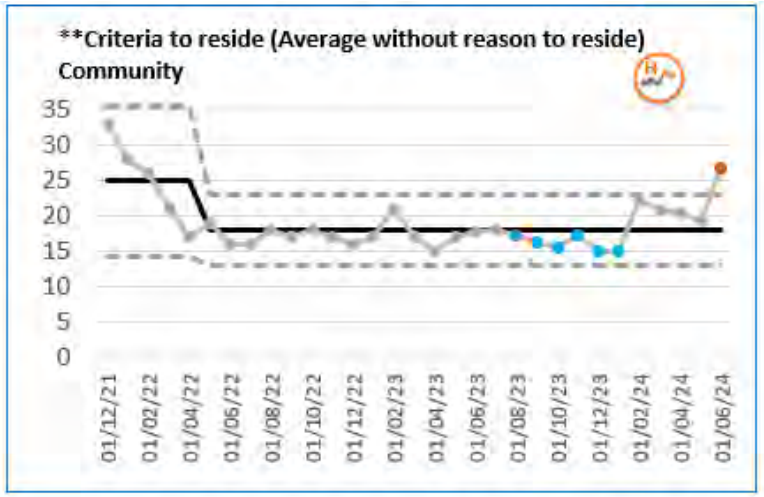
Team	Jan-24				Feb-24				Mar-24				Apr-24				May-24				Jun-24			
	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock 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	199	143	56	72%	180	136	44	76%	201	158	43	79%	179	134	45	75%	175	115	60	66%	204	150	54	74%
Total EIT	569	522	46	91.90%	564	511	53	90.60%	545	509	36	93.39%	563	506	57	89.88%	552	498	54	90.22%	569	532	37	93.50%
Combined Total	768	665	102	86.59%	744	647	97	86.96%	746	667	79	89.41%	742	640	102	86.25%	727	613	114	84.32%	773	682	91	88.23%

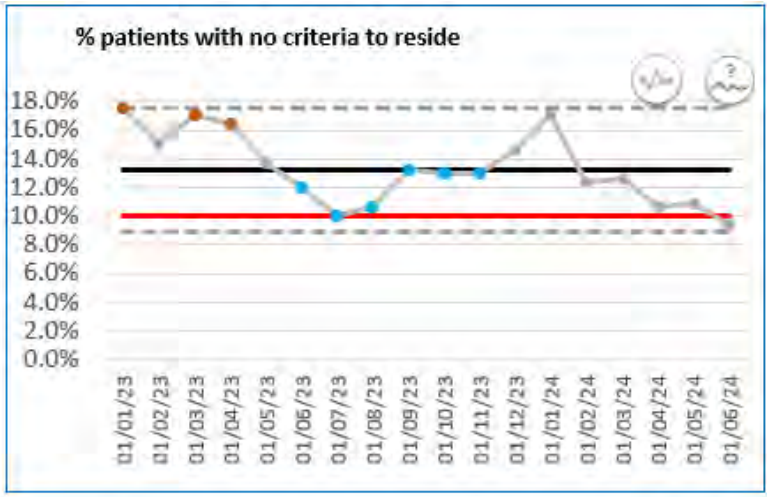
Urgent & Emergency Care: UCR

What	So What?	What Next?
The Early Intervention Team's (EIT) 2 hour performance remains consistently above the 70% target Now receiving data from eCare on EIT response to ED within 15 minutes of referral - currently at 70%.	Admission avoidance visits are being completed in a timely manner, supporting patients to remain at home when possible.	Continuing to collaborate with Integrated Neighbourhood Teams (INT's) and virtual ward (VW) to sustain performance and capacity to be more resilient. ICB aiming to launch falls pick up service in next few months to provide some additional capacity to support cleric. Slide to be prepared for next PRM report to highlight EIT activity and response to ED referrals.
2-hour INT nursing response has improved from 66% to 74%.	2-hour INT nursing response compliance although improved, remains lower than compliance achieved by EIT. This may indicate capacity is challenged; sickness remains at 5%, INT use of temporary staffing is being monitored, teams have reported higher acuity patients in teams for example the number of patients requiring multiple syringe drivers. A deep dive into 2 hour breaches has discovered that the majority of patients are seen within 2.5 hours	INT Leads and Specialist Therapists to review demand and capacity and agree reporting and escalation process for non-urgent as well as urgent demand and capacity to be captured and monitored via the INT dashboard & escalation calls - to be completed July 2024 Clinicians have been reminded to report capacity concerns / reasons for breaches that have potential for patient harm via RADAR. Reports to be reviewed for themes via Community Clinical Governance Steering group on monthly basis. Escalation calls stepped up when capacity across INTs challenged.
The trajectory to increase 2 hour compliance has fallen short over the last 3 months but has improved this month closing the gap between activity and proposed trajectory to achieve 10% increase by year end. Compliance to achieve 2 hr response remains above 70% target	Failure to achieve the proposed trajectory for increase in 2 hr response due to lower than anticipated numbers of referrals for urgent response to both EIT & INT, however 88% of referrals were seen within 2 hours. This indicates that it is the number of urgent care response requests that would need to increase to achieve target.	As the gap in activity to target has closed this month, to review 2 hr response referral numbers next month to understand if trend of referrals continues to increase. If referrals continue to fall below proposed target trajectory a wider system investigation will be required to understand if there is appropriate urgent care to be directed to the Integrated Neighbourhood Team (INT/EIT) .

Urgent & Emergency Care: Criteria to reside







What

The number of patients in the acute without criteria to reside continues to reduce following a gradual rise in August 2023 and Jan 2024.
The reduction in patients without criteria to reside in the acute is mirrored by the % of patients with no criteria to reside reducing below the 10% target- the lowest % of patients with no criteria to reside since July 2023.

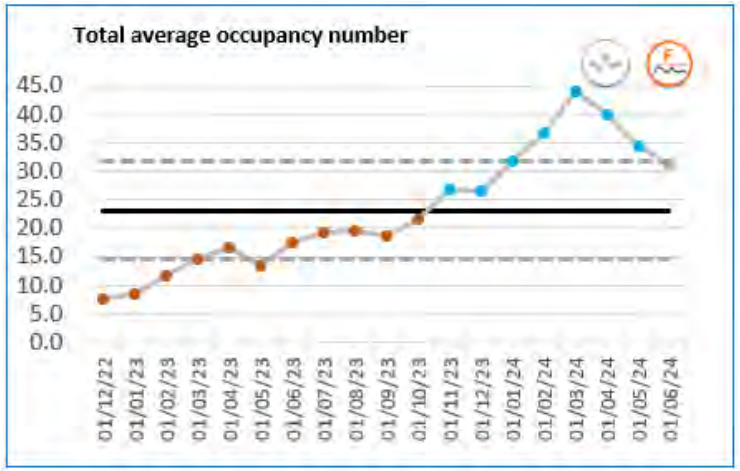
The numbers of patients in community beds without criteria to reside increased in February and has remained high, June's figure the highest reported since Feb 2022. This directly correlates with a project aimed at diverting patients from Pathway 2 (P2) to P1, resulting in empty Community Assessment Bed's (CAB) which have been utilised by transferring 'non-traditional' CAB patients into these to support flow.
This change in CAB usage does not appear to have directly impacted overall LOS. Our flow throughout the CABs has improved, and has continued to improve since we have been utilising the CABs in this way with 'non traditional' CAB patients transfer.

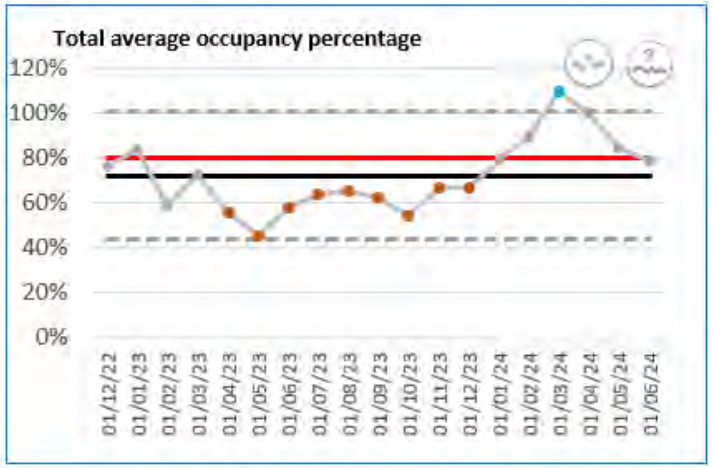
So What?

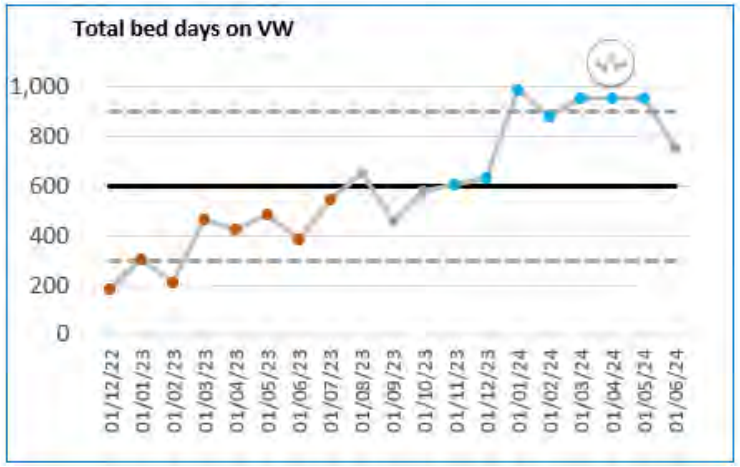
Patients remaining in hospital longer without criteria to reside directly impacts on bed capacity and patient flow within the Trust.
Increase numbers of vacancies within CAB bases gives flexibility to support patient flow, which is evident with our lower acute criteria to reside figures for June. However this has led to a change within the cohort of patients in CAB, which has subsequently increased numbers of patients in CABs with no criteria to reside. This is expected to continue as we continue to encourage the use of P1 discharge routes and getting patients back to their own environments.

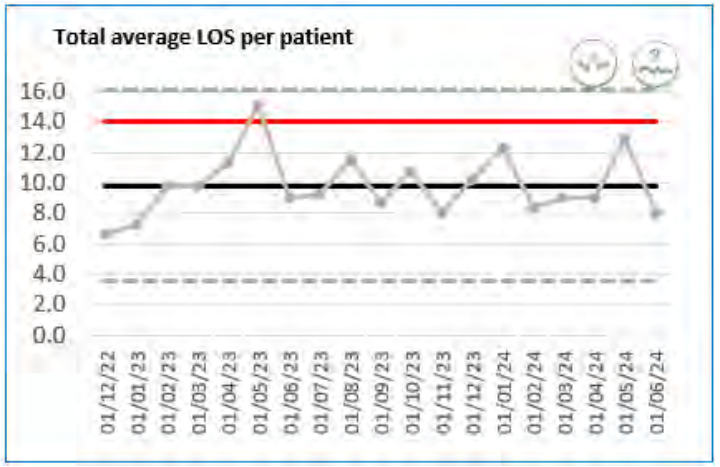
What Next?

The project briefs for 5 priority workstreams have been agreed by Divisional Programme Board in July. Project leads to provide monthly SMART updates to the board re progress and impact – next meeting date set in August. Workstreams were detailed in Aprils PRM slides
1.
In addition:
•CAB Matron will continue to have close oversight of 'non traditional' patient cohort at CAB.
•New NHSE Reasons for Delayed Discharge (RfDD) codes have officially changed for reporting on Discharge Sitrep and on eCare. The introduction of these codes should enable an easier way to highlight RfDD, identify any areas of escalation and support more transparency for those patients remaining within the Trust. We are still in a transition period whilst all staff familiarise themselves with the new codes.
•A singular Transfer of Care HUB (TOCH) referral has been requested, with the aim to make referring into the TOCH for supported P1-3 discharges easier for referrers, reducing delays and confusion in referrals. A confirmed date has not yet been agreed, and this will require training and comms.
•A 3rd Stepping Home flat has been sourced and is currently being finalised alongside set up. We are still awaiting a confirmed date, but the hope is this will be able to be admitted into with the next month.
•Discussions surrounding strengthening our Overflow West P1 process (Overflow Responsive Pathway) continues, with exploring options to make this process more time and resource effective in the future.

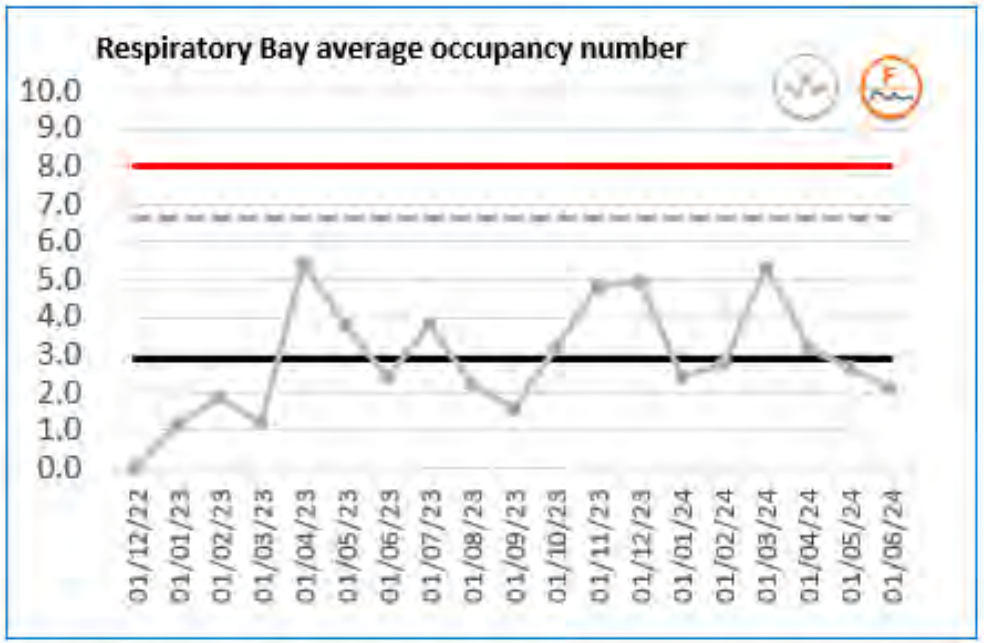








What	So What?	What Next?
Average number of patients cared for on Virtual Ward decreased from 34.5 (May) to 31.3 (June), partly due to managed reduction in average Length of stay (LOS) from 13 to 8 days (achieved by implementing learning from recent audit). Average utilisation rate was 78% against target of 80%.	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 on 11 June 2024 as planned. Test & learn in Mildenhall & Brandon locality underway to develop integrated service delivery model. Wider rollout plan agreed.


Respiratory Bay average occupancy number
10.0
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
01/12/22
01/01/23
01/02/23
01/03/23
01/04/23
01/05/23
01/06/23
01/07/23
01/08/23
01/09/23
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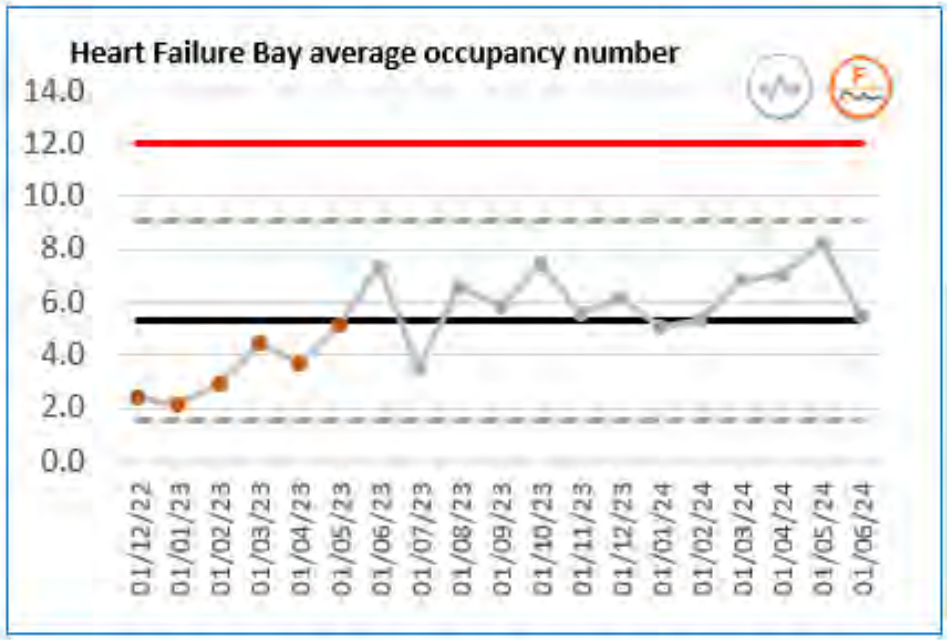
Heart Failure Bay average occupancy number
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
01/12/22
01/01/23
01/02/23
01/03/23
01/04/23
01/05/23
01/06/23
01/07/23
01/08/23
01/09/23
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01/04/24
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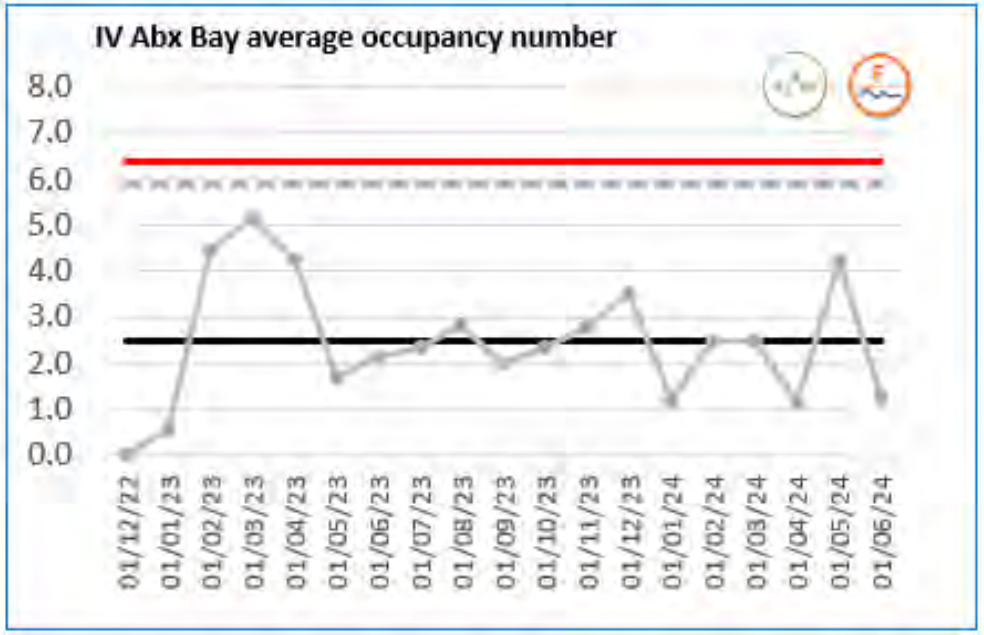
01/06/24


IV Abx Bay average occupancy number
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
01/12/22
01/01/23
01/02/23
01/03/23
01/04/23
01/05/23
01/06/23
01/07/23
01/08/23
01/09/23
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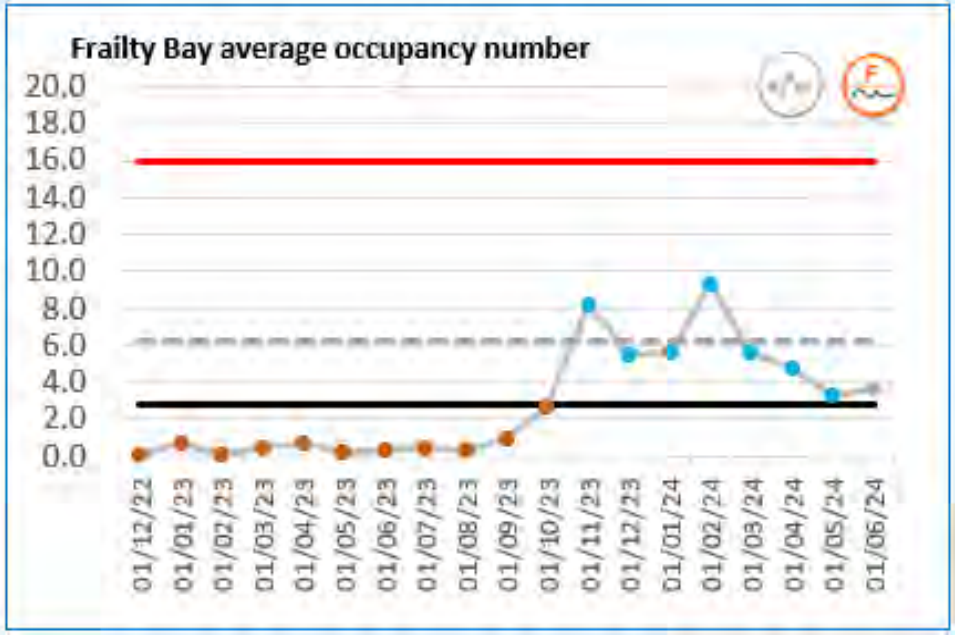
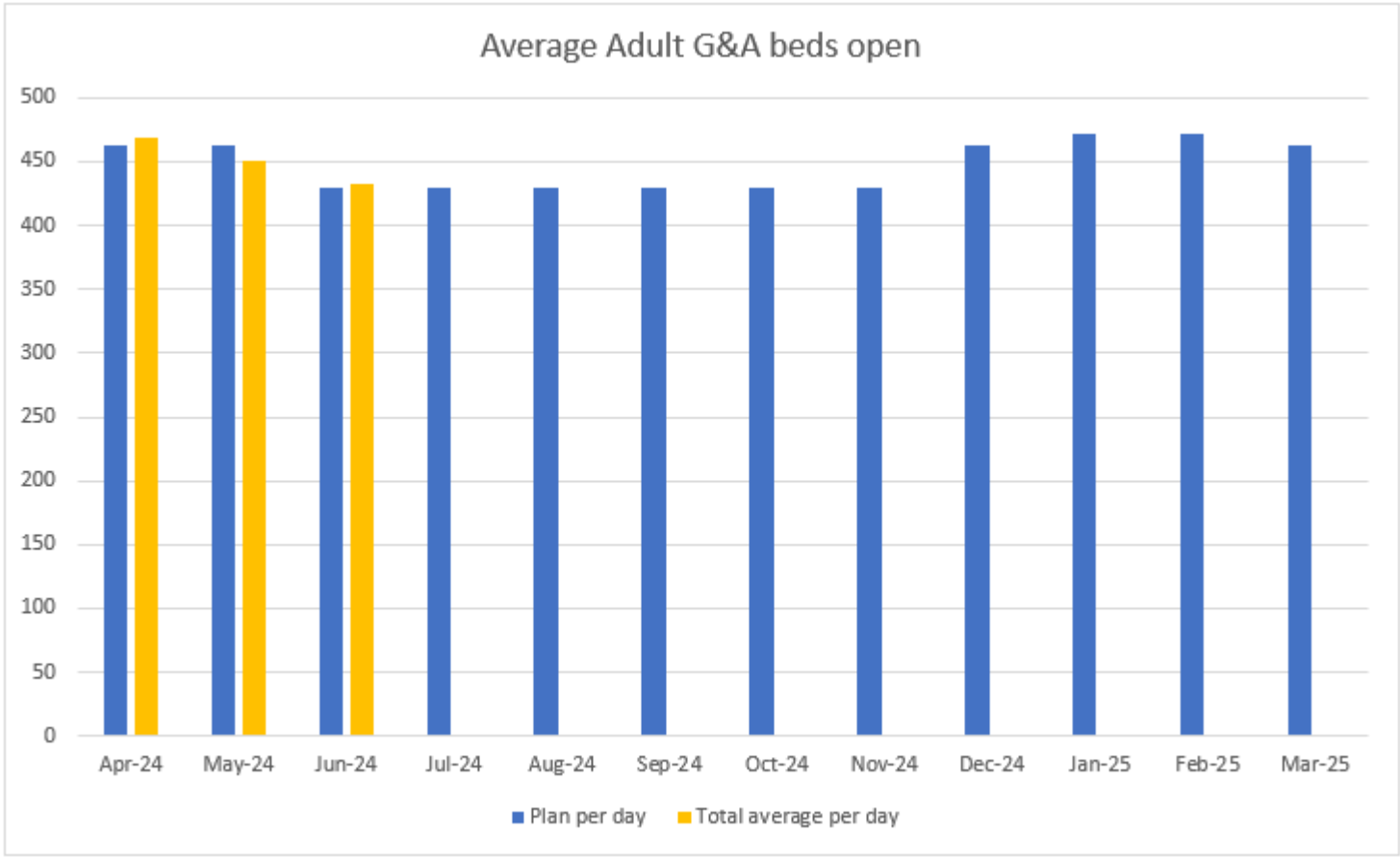
01/04/24
01/05/24
01/06/24


Frailty Bay average occupancy number
20.0
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
01/12/22
01/01/23
01/02/23
01/03/23
01/04/23
01/05/23
01/06/23
01/07/23
01/08/23
01/09/23
01/10/23
01/11/23
01/12/23
01/01/24
01/02/24
01/03/24
01/04/24
01/05/24
01/06/24

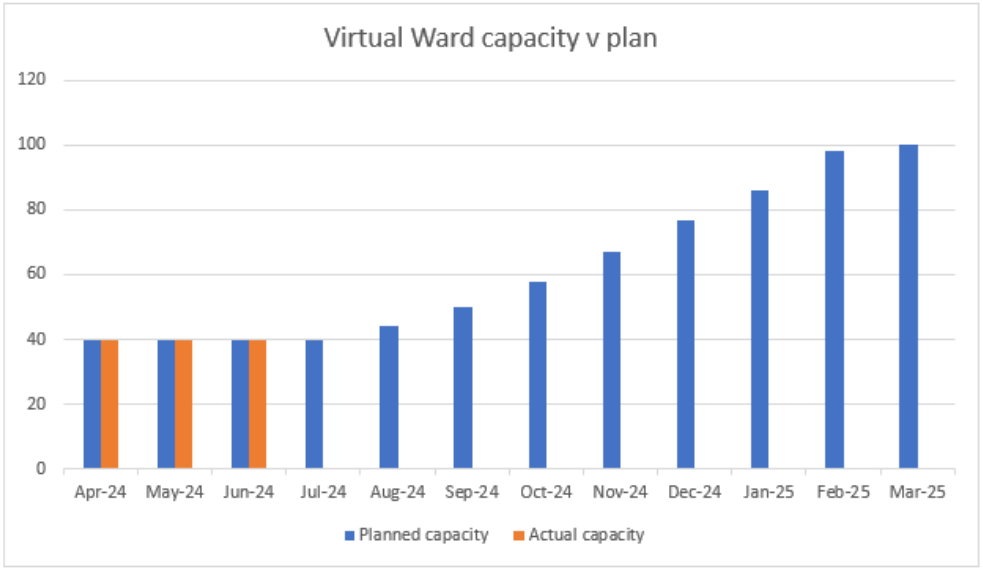
Urgent & Emergency Care (TRUST – Virtual Ward)

What	So What?	What Next?
Occupancy on respiratory, heart failure, Intra Venous antibiotics (IV Abx) and frailty pathways were under monthly targets for June: Respiratory – achieved 2.1 against target of 5.0 Heart failure – achieved 5.5 against target of 7.0 Intra- venous antibiotics (IV Abx)– achieved 1.2 against target of 4.0 Frailty – achieved 3.7 against target of 6.0 Occupancy on the Acute Kidney Injury (AKI) pathway increased in June, achieving average occupancy of 6.6 against target of 5.0. Occupancy on General Medicine increased in June although the pathway did not achieve target (average occupancy of 9.7 against target of 11.0).	Targets are in place to ensure that the capacity created on the Virtual Ward is fully utilised, maximising capacity for acuity unwell patients and enabling patients to be cared for at or near home.	Overall service capacity: •Trajectory on target to increase from 40 to 44 by end August 2024. Respiratory: •Expand to accept any respiratory patient (except acute asthma) by end July 2024 •Implement agreed changes in specialist staffing from 2 x B6 nurses to 1 x Respiratory ACP in post to support enhanced pathway by end October 2024. • Heart failure: •Increase step up referrals via Community HF team by 50% by end September 2024. •Expand to accept patients requiring subcutaneous furosemide by end October 2024. IV ABx: •Expand to include orals as well as IVs by end August 2024. •Expand to accept patients requiring multidose treatments (currently limited to BD) by end November 2024. • Frailty: •Agree plan to expand direct referrals from nursing homes across West Suffolk by end December 2024. •VW funded Advanced Clinical Practitioner (ACP) in place in frailty team from July. • AKI: •Expand to accept any renal patient by end August 2024. •Agree and recruit specialist practitioner by end October 2024. Diabetes: •Agree and implement pathway by end September 2024. • Paediatrics: •Launch pathway by end September 2024. Specialist nurses recruited. • Surgery: •Discussions ongoing re significant pathway challenges. Meeting with lead consultants scheduled.

Urgent & Emergency Care: Beds

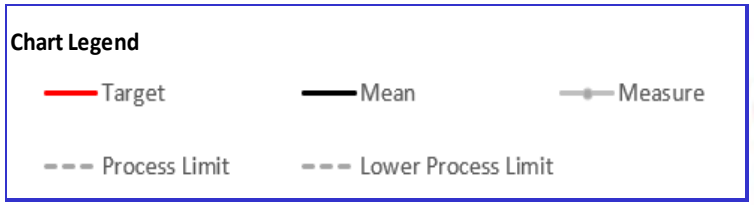


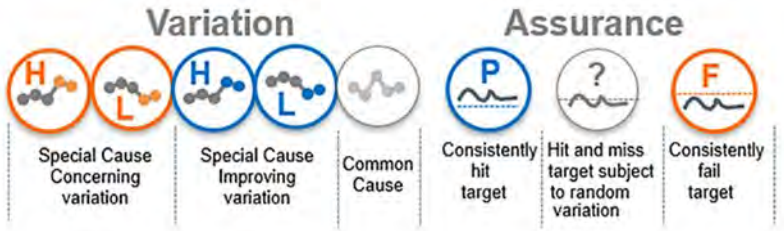
What	So What?	What Next?
Our actual average number of core beds open has decrease in line with plan, following the full closure of F9 as the winter escalation ward. Although patient flow in June has been challenging, the criteria for using medical SDEC as unfunded escalation have been more robustly used in line with the Tactical Patient Flow Escalation Plan, which has contributed to a reduction in average escalation beds open.	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 will be 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. Options for the future configuration of WSFT's General & Acute bed base will be presented to Management Executive Group in July, pending the relocation of some orthopaedic elective activity to ESEOC.



What	So What?	What Next?
Capacity is currently meeting the planned capacity.	As the virtual ward builds on its successes' and grows as an established way of working the target is for capacity to increase as set by national targets.	Capacity is relates to specific pathways as above.

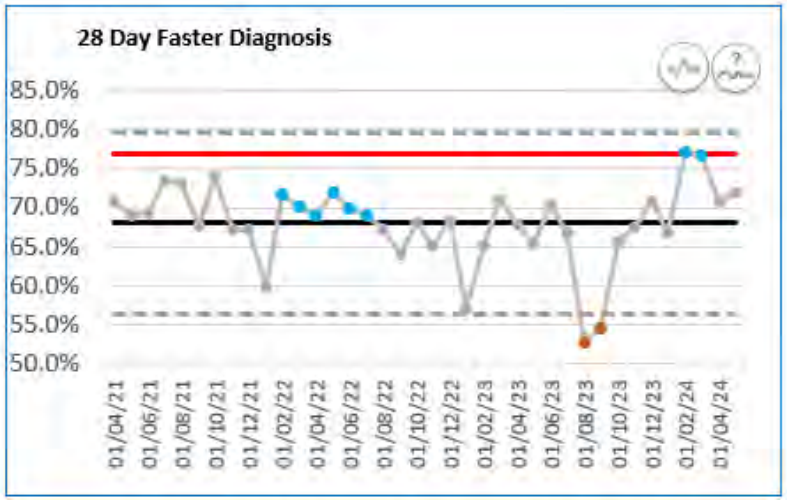
Cancer Access Summary

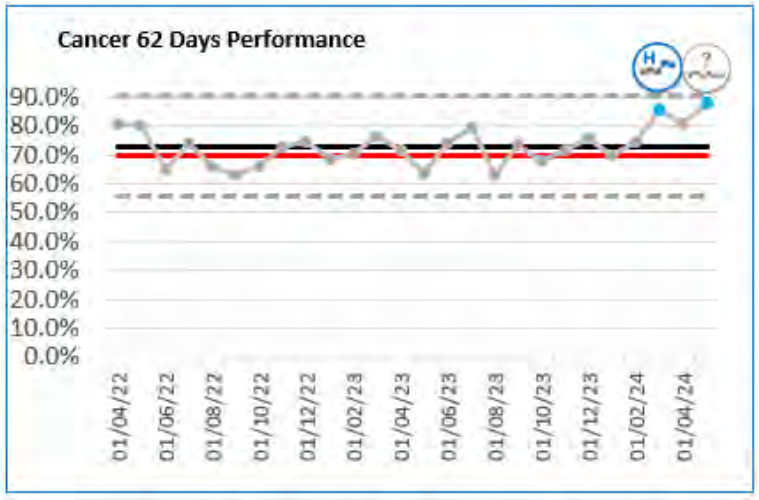


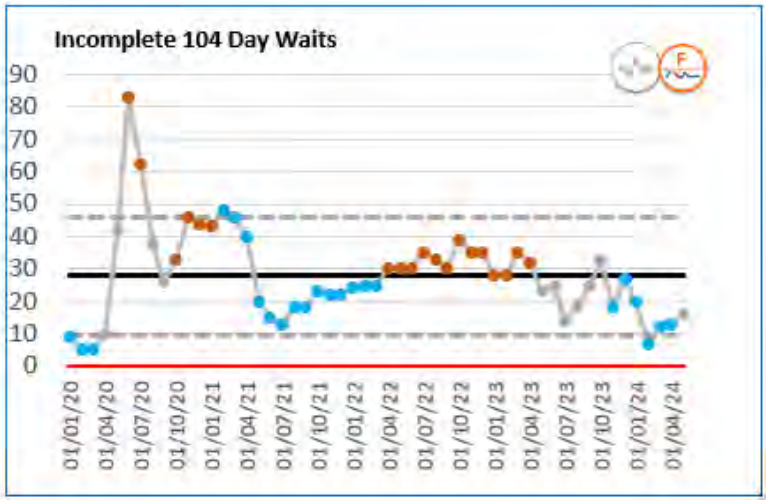


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	May 24	71.9%	77.0%			68.0%	56.3%	79.7%
Cancer 62 Days Performance	May 24	88.1%	70.0%	H		73.0%	55.6%	90.4%
Incomplete 104 Day Waits	May 24	16	0		F	28	10	46

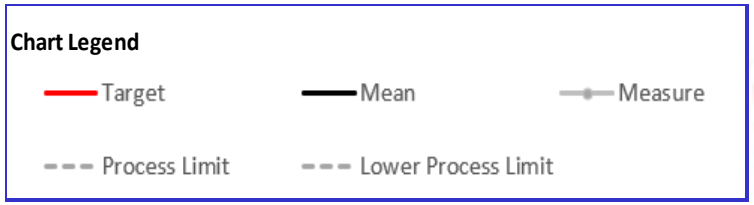
Cancer Access (Month Behind)

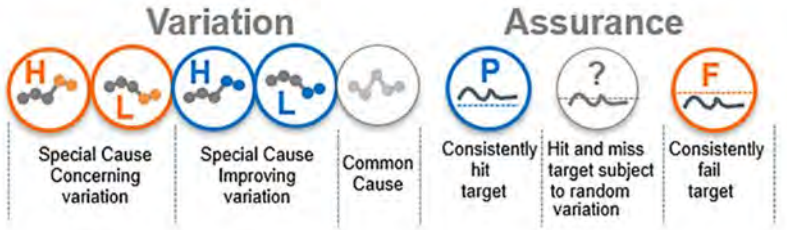






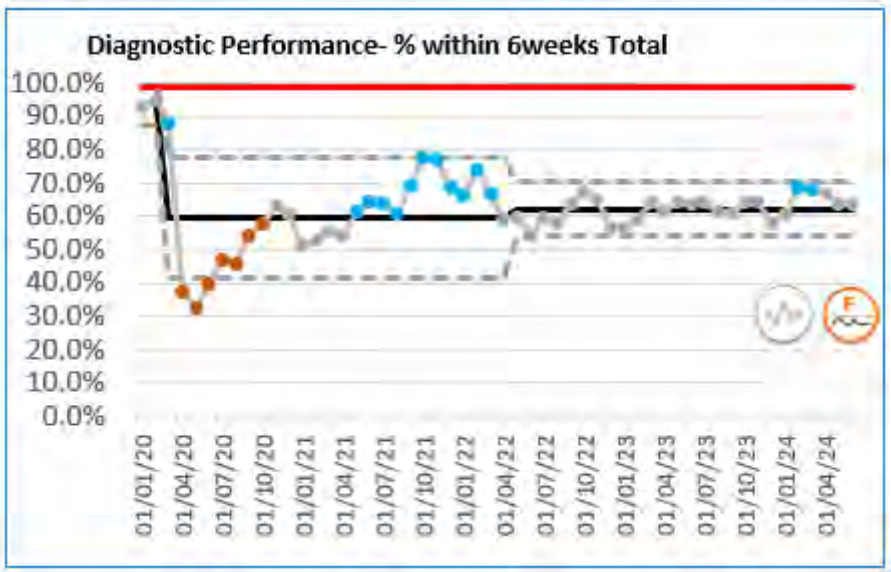
What	So What?	What Next?
Performance against the 28-day Faster Diagnosis Standard (FDS) is not being consistently met, however the standard was met in February 2024 and March 2024 above 75%, there has been a slight increase to 71.9% in May. The 62 day performance is above the national standard of 85% and 25/26 adjusted standard of 70%.	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. Implement required changes into the Skin community pathway, such as reducing to 1 lesion and 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 progression to biopsy and/or progression to treatment regimens by Q3.





KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Diagnostic Performance- % within 6weeks Total	Jun 24	64.0%	99.0%			62.3%	54.0%	70.6%
RTT Waiting List	Jun 24	35205				32679	31301	34058
RTT 65+ Week Waits	Jun 24	532				505	325	684
RTT 78+ Week Waits	Jun 24	60	0			167	93	240
Potential 65+ ww at end of Sept 2024	Jun 24	1852	0					
Community Paediatrics RTT Overall Waiting List	Jun 24	481	-			501	451	551
Community Paediatrics RTT Overall 52 Weeks Wait	Jun 24	0	-			1	-2	4
Community Paediatrics RTT Overall 65 Weeks Wait	Jun 24	2	-			0	0	0
Community Paediatrics RTT Overall 78 Weeks Wait	Jun 24	0	0			0	0	0
Community Paediatrics RTT Overall 104 Weeks Wait	Jun 24	0	0			0	0	0
RTT NDD Only Waiting List	Jun 24	75	-			85	63	106
RTT NDD Only 52 Weeks Wait	Jun 24	0	-			0	0	0
RTT NDD Only 65 Weeks Wait	Jun 24	1	-			1	1	1
RTT NDD Only 78 Weeks Wait	Jun 24	0	-			0	-2	3
RTT NDD Only 104 Weeks Wait	Jun 24	0	-			0	0	0

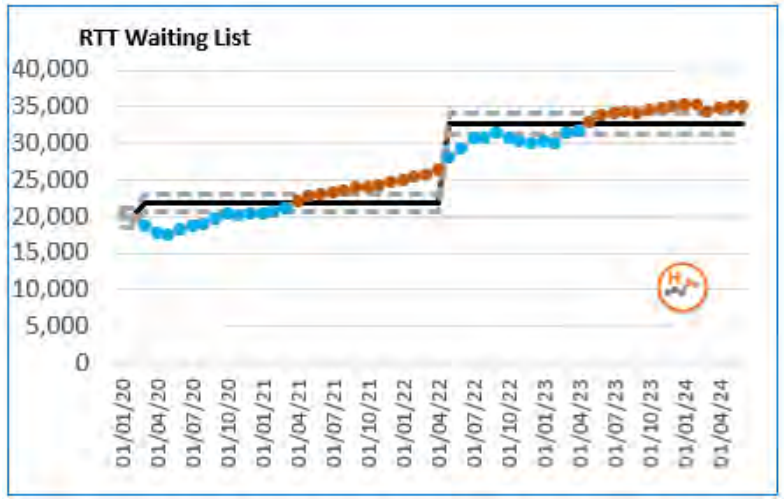
Elective Access

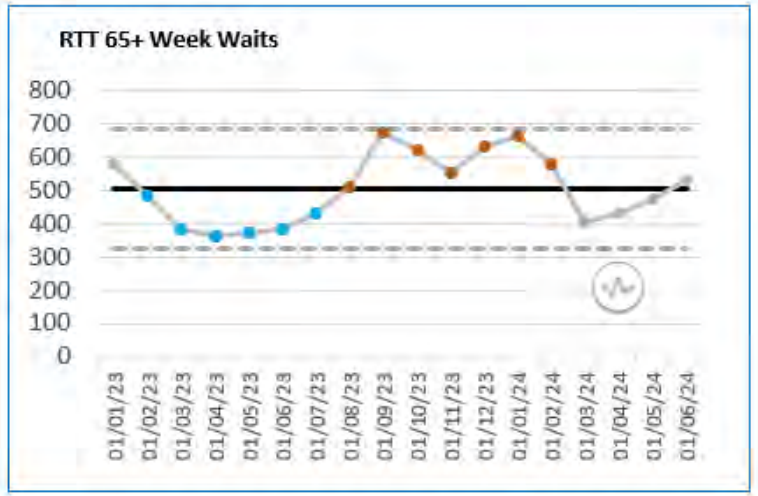


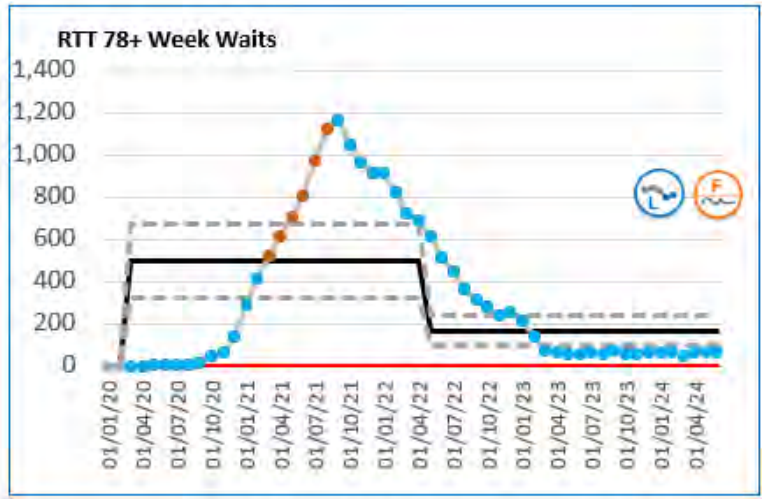
Diagnostics

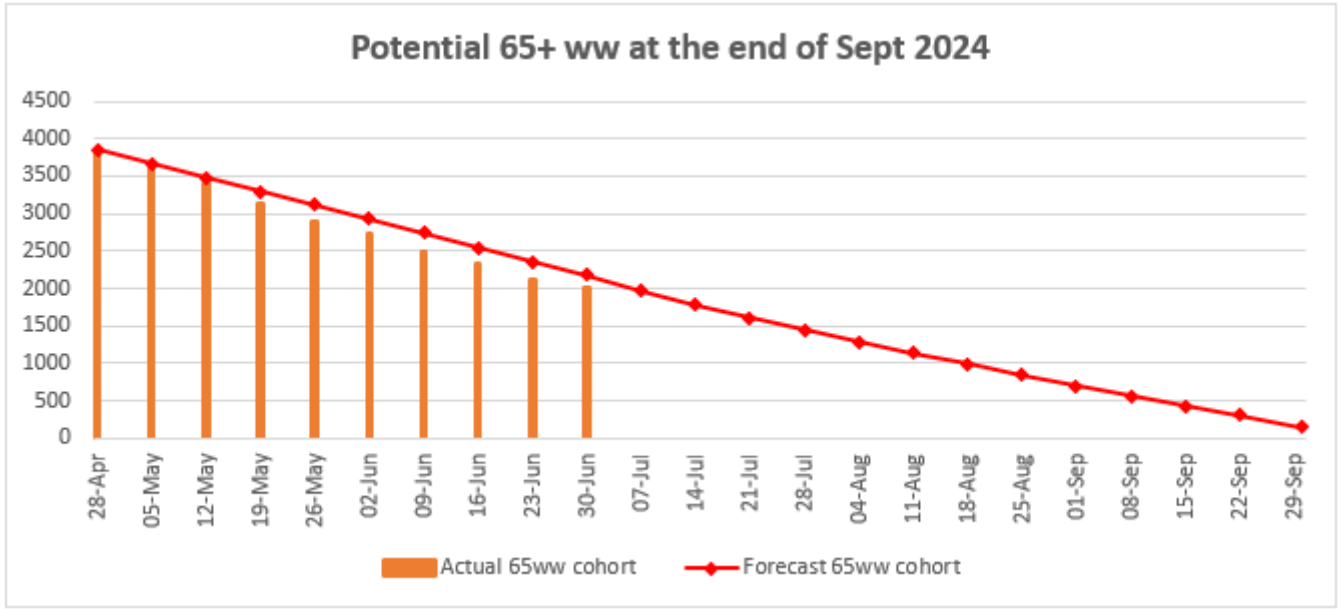
What	So What?	What Next?
Audiology (39.8%)- a 2.4% improvement on last month, overall decline in performance is driven by staff sickness within the team and in particular, a lack of PTL validation. ENT secretaries have received training to support validation and this is now happening, weekly position (28/07) at 79.75%. Recognition that compliance is impossible within current footprint, the team exploring the creation of an additional soundproofed booth at Newmarket. **Urodynamics (83.3%)-**performance deteriorated in month driven by industrial action and reduction in capacity. However, upward trend developing. Two candidates interested in fixed term consultant posts which will support compliance. Cystoscopy continues to be prioritised due to impact on cancer pathways. **Cystoscopy (82.6%)-**performance deteriorated in month driven by industrial action and reduction in capacity. However, overall upward trend developing. Two candidates interested in fixed term consultant posts which will support compliance. In week position at 28/07, 85.82%	Where possible patients receive a diagnostic test within 6 weeks, generally the capacity within the service meets the needs of the majority of patients. We are prioritising the right patients and developing solutions that will ensure more people are seen within 6 weeks.	• Estates review of Newmarket site and quotation • ENT secretaries supporting validation on a rostered basis • Refresh of previous DM01 trajectory, deadline 12/08 • Greater ASM focus on performance • Interviews for consultant posts- August 2024 • Refresh of previous DM01 trajectory, deadline 12/08 • Urology away day (26/07), development of more nurse led clinics, “do what only you can do”.
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. We are currently performing better score than previously predicted despite the replacement of the scanner and the use of a less productive mobile scanner. There has been an additional small uplift in activity due to staff undertaking a number of 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.	Longer waiting times for diagnosis and treatment have a detrimental effect on patients. Delay in achieving DM01 compliance standards.	• Interviews for consultant posts- August 2024 • Refresh of previous DM01 trajectory, deadline 12/08 • Release of consultants to enable consistent cystoscopy provision **MRI** – Mitigations including the delivery of the CDC will see MRI reaching DM01 compliance in February 2025
CT –Currently not meeting DM01 compliance target due to impacts of the replacement programme.. Our current DM01 position is 16% lower than previously anticipated. This due to an increase in inpatient and UEC demand displacing DM01 activity and impacting capacity for the longer waiting patients. First 6 months of 2023 compared to first 6 months of 2024 shows a 12.8% increase in total activity. Average inpatient demand for the first 6 months of 2023 is 585.5, compared to 632 for the first 6 months for 2024, an increase of 8%. Average emergency department demand for the first 6 months of 2023 is 823 per month compared to 1011 for the first 6 months of 2024, an increase of 23%. A utilisation review has identified an opportunity for an additional 5 patients per week. This will be reflected in July’s activity.		**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 –A step increase in the recovery trajectory can be observed but has plateaued and remains statistically insignificant. Increased inpatient and UEC demand is compounded by recruitment challenges within the team. Performance remains vulnerable until recruitment improves.		**US** –Staffing issues unresolved, and CDC capacity will not be realised until recruitment picture improves. Management team reviewing recruitment options aligned to CDC.
Endoscopy – Priority has been given to patients on a cancer pathway requiring a rebalancing of capacity to support. Performance impacted by IA. 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. This has led to a compound effect and a plateauing of DM01 performance. However, consistent reductions in the numbers of patients waiting over 13 weeks and 6 weeks can be demonstrated and are slightly above trajectory currently to meet the March 2025 ambition of 95%. Additional activity delivery will be required to meet this target.		**Endoscopy** - Anticipated compliance with the DM01 target ambition of 95% by March 2025. Actions focussed on increasing NE opportunities and review of core job planned capacity for medical and surgical consultant endoscopists. Alongside further work on reducing DNA’s and increased productivity. Assessment being undertaken to understand how ERF might support increased insourced capacity and income generation. Work under way to remove constraints on the flexi banding pathway, the Endoscopy User Group is meeting to explore the potential to increase points per list, further opportunities for increased general surgical support to endoscopy are being agreed with the surgical division.

Elective Access: RTT





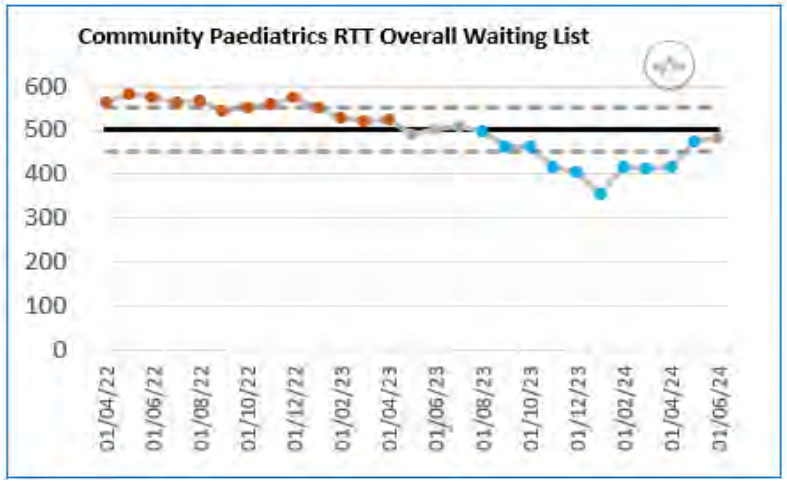


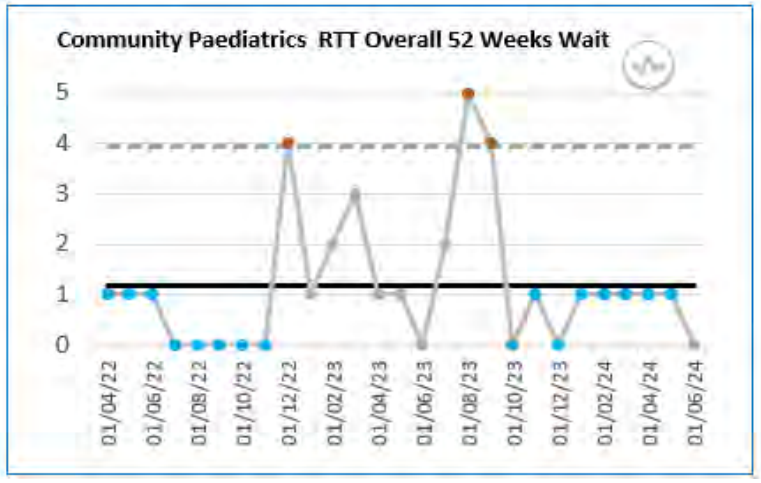


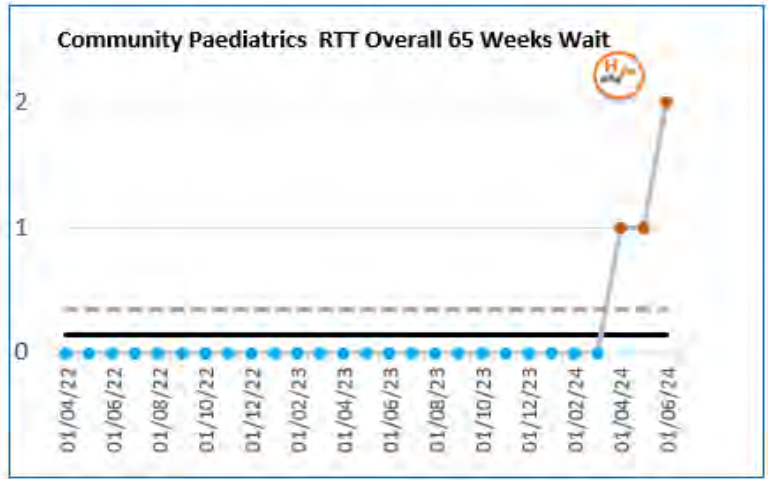
Elective Access: RTT

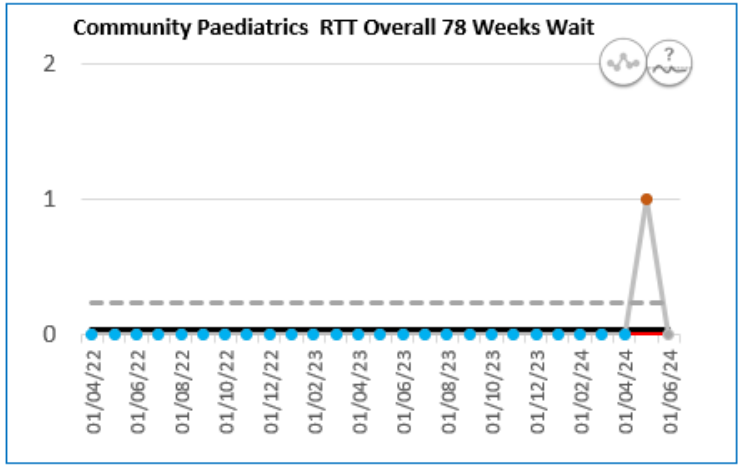
What	So What?	What Next?
The 78 week wait position for the end of June was 60 patients, 46 of these were related to capacity with the largest volumes within Urogynaecology. 56 patients have now been transferred to the Nuffield to have their surgery before the end of September and there are currently 4 patients in the 78ww without a plan within Urogynae specifically. On the whole we are below 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 trajectory however there are however clear plans in these services to clear with an increase in activity prior to the end of September. There are currently 40 patients in total without a plan within Urogynaecology specifically. The total waiting list size remains high with no signs of reducing.	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.	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.

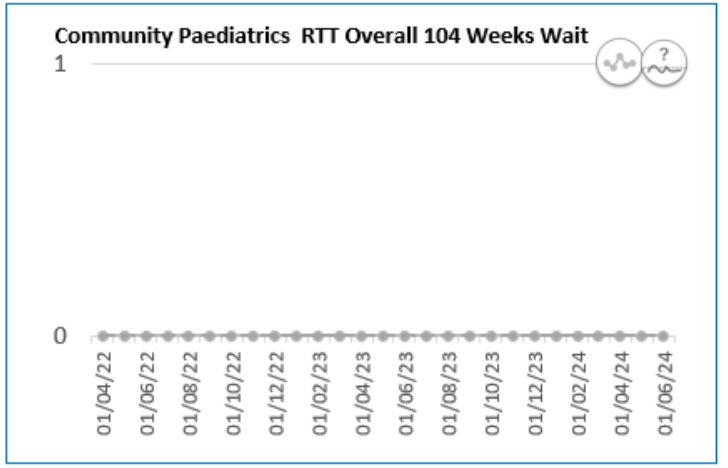
Elective Access (Community Paediatrics)











What	So What?	What Next?
The impact of receiving the backlog of neurodevelopmental (NDD) assessments for autism in school age children has increased waiting times within the service. The longest waiters are being managed by outsourcing assessments within the ICB funded recovery plan. Some long waiters over 65weeks have been taken into the paediatricians caseload due to risks identified at the triage stage by the external provider. In addition to the NDD pressure, the paediatric team are seeing increasing complexity with preschool pathway and in rising caseloads.	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 the Care Coordination Centre Children continue to be prioritised according to clinical need.	Due to a high acceptance rate for school age autism assessments there is insufficient funding to clear the backlog of longest waiting children. ICB have agreed in principle to the additional funding needed (Circa 250k) and this will be agreed via contract meeting. Structured discussion with ICB to review paediatric capacity pressures and internal actions will be taken forward. It has been agreed that a quality impact paper will be completed and will be shared with ICB children's quality team.

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	10,182	10,277	0.9%
May	9,660	10,305	10,271	(0.3%)
Jun	9,090	9,697	9,817	1.2%
Jul	10,165	10,844		
Aug	8,967	9,566		
Sep	9,544	10,182		
Oct	10,453	11,152		
Nov	9,891	10,551		
Dec	8,744	9,328		
Jan	10,345	11,036		
Feb	9,205	9,820		
Mar	9,365	9,990		
Total (YTD)	**28,294**	**30,184**	**30,365**	**0.6%**

June 2024

23/24	9,090
ERF	9,697
24/25	9,817
Var	120
Var %	1.2%

Daycase

Mon	23/24	ERF	24/25	Var %
Apr	2,191	2,342	2,432	3.8%
May	2,245	2,400	2,565	6.9%
Jun	2,084	2,228	2,264	1.6%
Jul	2,364	2,527		
Aug	2,109	2,255		
Sep	2,245	2,400		
Oct	2,459	2,629		
Nov	2,408	2,574		
Dec	2,056	2,199		
Jan	2,420	2,587		
Feb	2,219	2,373		
Mar	2,241	2,397		
Total (YTD)	**6,519**	**6,970**	**7,261**	**4.2%**

June 2024

23/24	2,084
ERF	2,228
24/25	2,264
Var	36
Var %	1.6%

Outpatient Follow Up

Mon	23/24	ERF	24/25	Var %
Apr	25,352	27,046	27,908	3.2%
May	25,659	27,373	27,952	2.1%
Jun	24,145	25,758	25,348	(1.6%)
Jul	27,000	28,804		
Aug	23,819	25,410		
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)	**75,156**	**80,176**	**81,208**	**1.3%**

June 2024

23/24	24,145
ERF	25,758
24/25	25,348
Var	(410)
Var %	(1.6%)

Elective

Mon	23/24	ERF	24/25	Var %
Apr	256	273	270	(1.2%)
May	267	285	291	2.1%
Jun	247	264	232	(12.0%)
Jul	280	299		
Aug	256	273		
Sep	256	273		
Oct	284	303		
Nov	268	287		
Dec	249	265		
Jan	234	250		
Feb	244	260		
Mar	244	260		
Total (YTD)	**770**	**822**	**793**	**(12.0%)**

June 2024

23/24	247
ERF	264
24/25	232
Var	(32)
Var %	(12.0%)

Outpatient attendances that are a first attendance or with a procedure

All

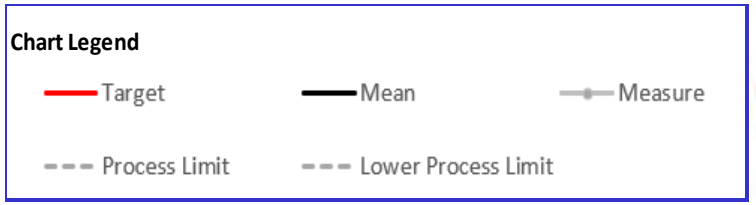
All

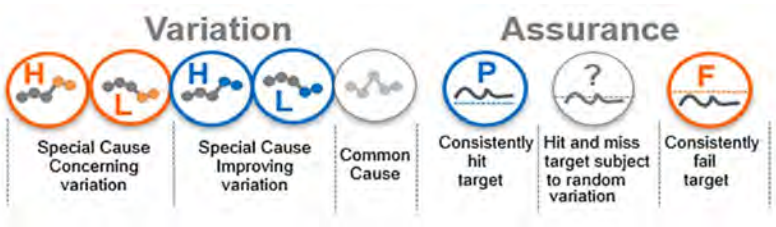
Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
23/24	37.4%	36.4%	36.6%	37.7%	37.9%	37.8%	35.9%	35.0%	36.3%	36.2%	37.1%	37.7%	**36.8%**
24/25	37.2%	35.9%											**36.5%**

Target	46.0%
Month	37.2%
YTD	36.5%

Elective Access: Activity

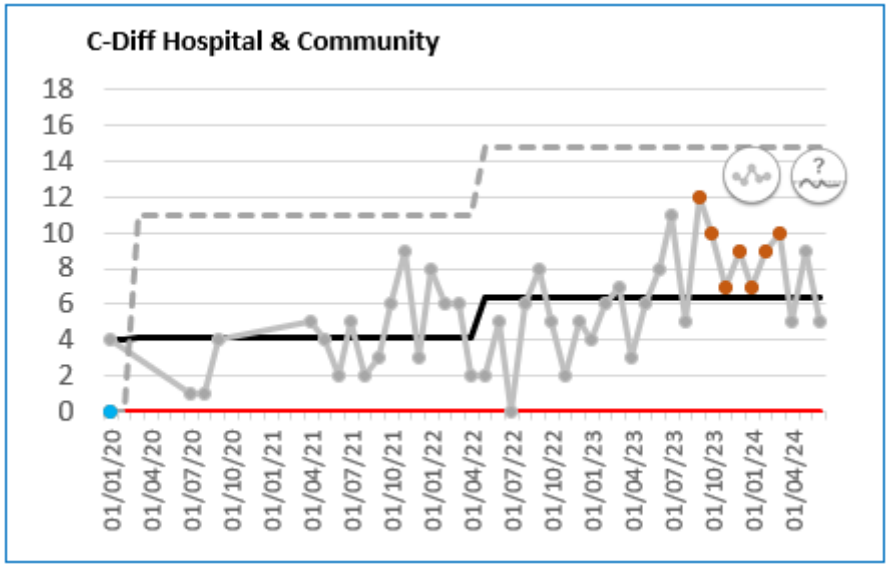
What	So What?	What Next?
Day cases and outpatient first attendances are meeting the required threshold to deliver the system level activity target of 108.09% of 2019/20 activity levels, however elective activity has dropped from 2.1% over to 12.0% under in June. Outpatient follow ups have dropped below 2019/20 levels in June, having been over in April and May. These do not attract ERF therefore a 2024/25 total below the 'target' is required to demonstrate improvement. Outpatient attendances that are a first attendance or with a procedure show no significant change from the 2023/24 average. **W&C:** June activity behind plan by 3 electives and 5 day cases, 6.82% behind plan in new outpatients. Outpatient capacity constrained by available nursing support with small elective bed base limiting additional activity, compounded by industrial action and theatre contamination in June. Outsourcing of uro-gynae procedures will increase activity and will be reflected in July's data. **Medicine:** New patient activity was an improvement (1.2%) on May but remains behind target. The division lost some activity due to the Junior doctors strike (directly and indirectly) so the likelihood is that the division would have been much closer to the 108% without IA. Willingness of consultants to do extra sessions and some services having reduced referrals (Cardiology and Rheumatology) are the primary drivers. Day case numbers remain significantly above the ERF target. **Surgery:** Reduction in elective activity driven by staff sickness, plus activity lost to industrial action and 107 procedures lost from contamination of the sterile storeroom. Outpatient first attendances are slightly adrift of target – breast and plastics due to consultant absence.	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:** Financial support to gynae outpatient nursing business case required to maximise clinic usage, alternatives being explored including video clinics and Newmarket. Ward reconfiguration paper to be presented in Management Executive Group in July with potential to increase elective capacity if supported.. Proposal to close lists that cannot be staffed has not impacted urogynae 65- week but effects being experienced in other gynae subspecialties with the closure of day surgery unit lists. This is resulting in rapid access day case procedures being undertaken in main theatres. **Medicine:** • Clinic template further analysis completed with some opportunities in specialities to be reviewed with consultant job plans. Service Managers and Clinical Leads to provide feedback by end of July. • Exploring clinic utilisation – awaiting data from outpatient transformation manager. • Two additional job planned clinics in respiratory to commenced in late June focusing on New patients utilising resource of new consultant. • Further additional clinics to be booked in Gastro and Diabetes with long waiting lists. This is over the summer period to ensure activity remains high. **Surgery:** • Reinforcement and monitoring of Patient Initiated Follow Up. • Focus of efficiency project has commenced, plastics and ophthalmology, with positive impact seen. • Conversion of 2 follow up to new, or additional new appointment added to each clinic from August. • HVLC lists to be cohorted and booked to 100%. • 21 weekend lists booked until end October. • Formalisation of anaesthetic obstetric clinics delivering outpatient first attendances.





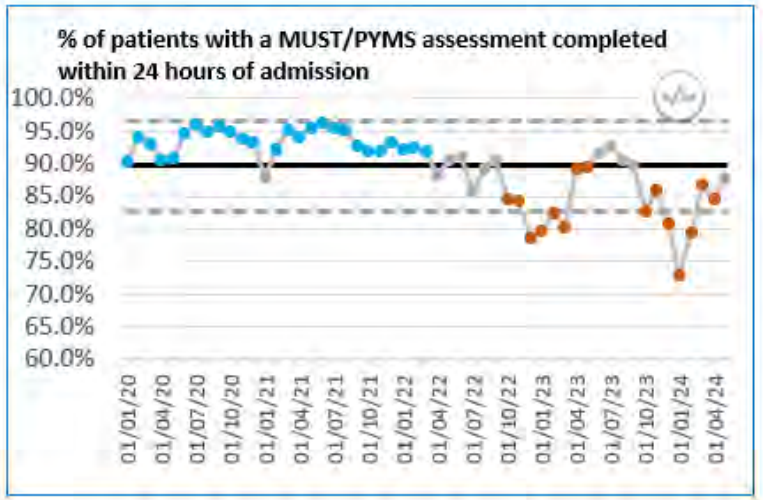
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
C-Diff Hospital & Community	Jun 24	5	0			6	-2	15
Patient Safety Incidents Reported	Jun 24	487	-			809	616	1002
Patient Safety Incidents Resulting in Harm	Jun 24	136	-			170	117	224
% of patients with Measured Weight	Jun 24	96.6%	-			90.1%	85.3%	94.9%
% of patients with a MUST/PYMS assessment completed within 24 hours of admission	Jun 24	85.7%	-			89.6%	82.7%	96.4%
% of patients with a MUST/PYMS assessment completed within 48 hours of admission	Jun 24	94.0%	-			93.1%	89.0%	97.1%
Total number of incidents and Reportable Occurrences (RO) reported on RADAR	Jun 24	846	-			846		
Patient Saftey Incidents (PSIs) reports	Jun 24	487	-			487		
PSIs with harm as a percentage of total PSIs	Jun 24	28%	-			28%		

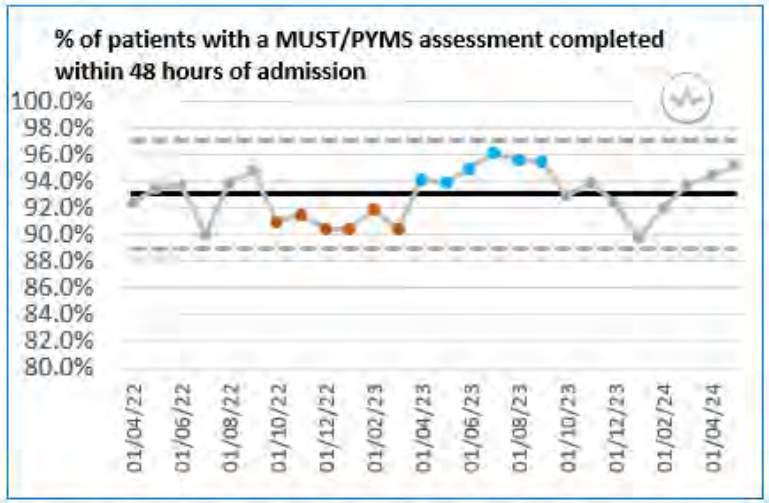
Safe



What	So What?	What Next?
Incident rates of C-difficle across the acute and community were below expected average in the month of June. The trend has moved out of cause for concern to common cause variation following two months under expected average (April and June) there is no sustained improvement yet. It is recognised Nationally that the rates of *Clostridioides difficile* have increased significantly over the last two reporting years.	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 current year 2024-25 thresholds/ceiling target is pending publication.	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: • Hand hygiene – point prevalence survey/audit carried mid – May, creation of short presentation/lecture cast in progress to be shared with all staff members, cascaded from managers. PPS to be repeated – August 2024 with escalations if required. • Environment & cleaning - Cleaning poster to be created to support ward and housekeeping staff –August 2024 • Audit & Governance – review of policies and guidelines. IPC Audit programme proposal presented to IPCC July 2024, audit tools to be reviewed in line with Tendable to Radar switch. – October 2024 • CDI retrospective analysis report is currently under analysis, report being written – August 24 • Lead appointed for 'other work streams' which includes the initiation and regular review of the CDI case load for IPN's and to explore using ICNet to support this – August 2024

Safe





What

Patient receiving actual weights during their inpatient stay is consistently within an improvement trend and high confidence to maintain performance

In June, 96.6% of inpatients had a measured weight recorded, with 64.7% being achieved in the first 24hrs and 78.8% at 48 hours. On review of the data, the wards who receive patients directly from the Emergency Department have much greater compliance with the metrics.

Completion of nutrition assessments (MUST/PYMS) has seen a consistent decline often mirroring capacity challenges in Accident and Emergency (A&E) dept and subsequent delays in admission from the [as the count starts once decision to admit has been made within the A&E]. June data has moved out of cause for concern to common cause variation.

So What?

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.

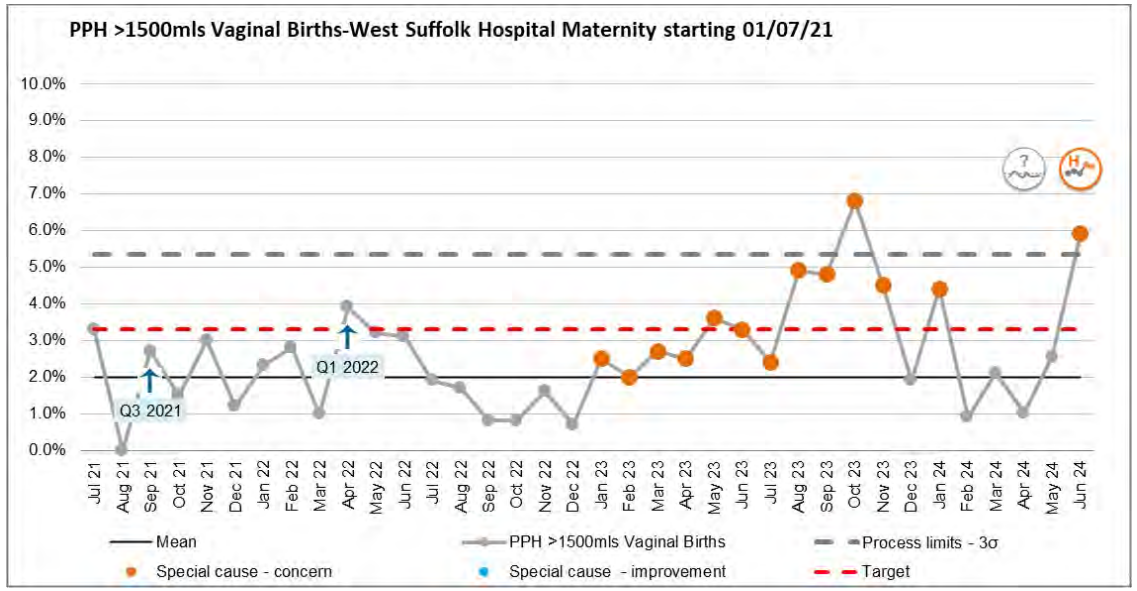
There are plans in place to renew the reporting process to capture the timeliness of assessments when patients are admitted to a ward. This will provide teams with the opportunity to improve the compliance and accuracy of this important metric. There are recurrent delays in receiving this data set due to issues with the data warehouse implementation. Confirmation of a start date for this remains outstanding and has been escalated.

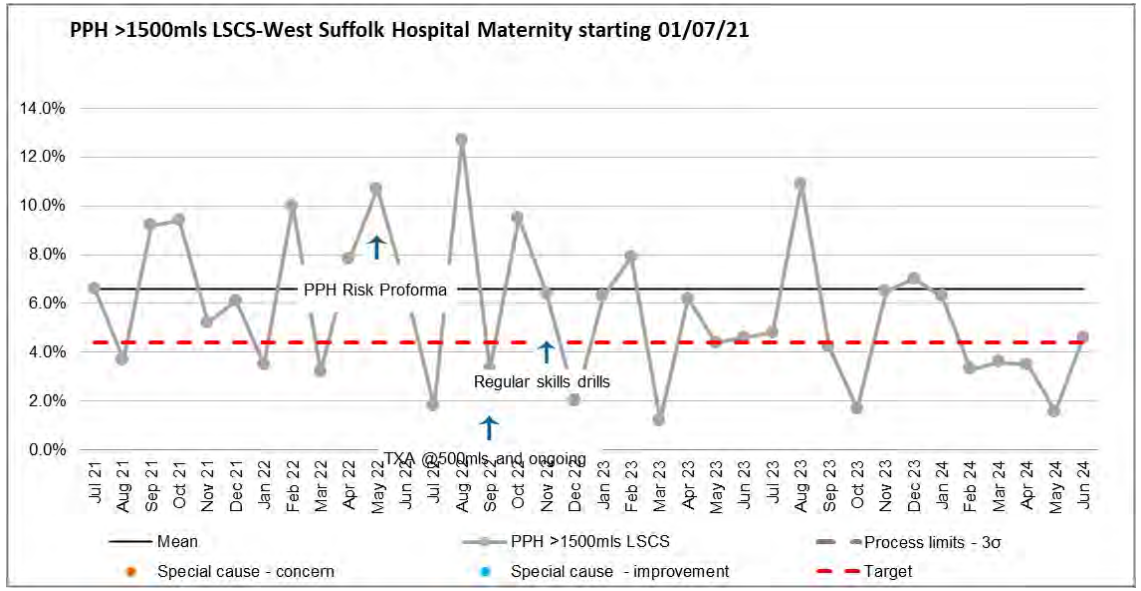
To ensure the safety of patients waiting in the emergency department, a shorter assessment is being introduced, though this will not replace the full nutritional risk assessment.

What Next?

- Introduction of short nutritional assessment in ED and observe the impact on this – October 2024
- Review of data at performance meetings and Governance reviews monthly to inform performance in each ward / department to identify areas of focus and improvement
- 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 for this – Escalated May 24
- 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.
- Mouthcare audit/peer review compliance moved to BAU and highlighting improvements result since launch in April 2024

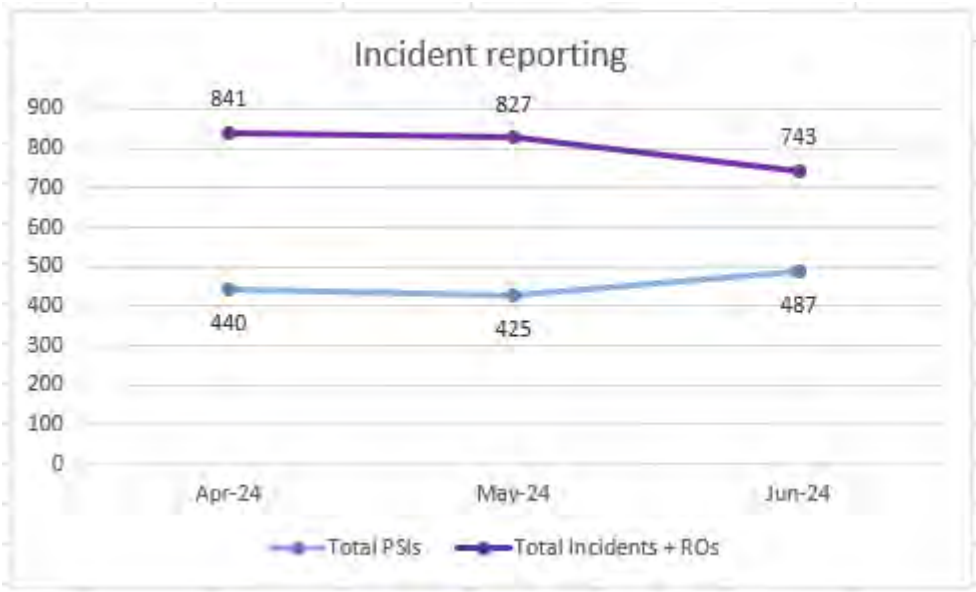
Safe

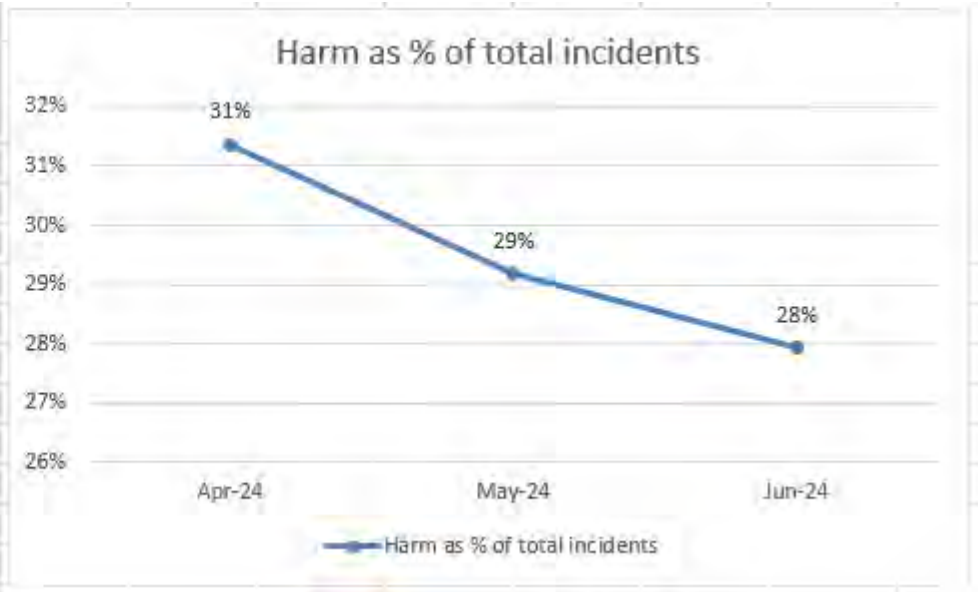




What	So What?	What Next?
Post-partum Haemorrhages (PPH) (>1500 mls) for Lower Section Caesarean Sections (LSCS) and Vaginal Births.	Severe bleeding after childbirth - postpartum haemorrhage (PPH) - is the leading cause of maternal mortality world-wide. Each year, about 14 million women experience PPH 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 affect 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 Promote Multidisciplinary representation at QI workshops Site visits to maternity units with acceptable range of PPH and areas of good practice identified and implemented. Undertake 'so what' review, in relation to PPH

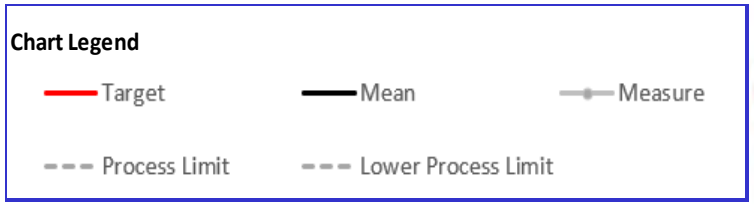
Safe

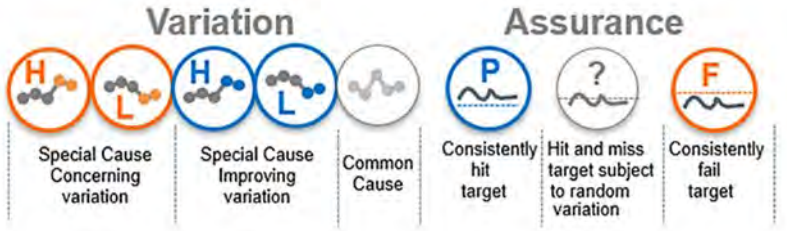




What	So What?	What Next?
<u>New indicators 1 + 2: Total incidents + ROs / Total PSIs reported</u> This provides a measure of system usage. We are aiming for a high number which shows a good reporting safety culture. It is recognised that currently the overall rate of reporting on Radar is currently lower than on Datix which is attributed to the use of a new risk management system in the Trust. As with any new system it was anticipated that there might be a fall in overall reporting at go live and a package of training and comms support was put into place to ensure staff were able to use the new system. There have been some unforeseen IT system connectivity issues which have impacted upon the ability to report and this may have also contributed to the fall in reporting. <u>New indicator 2: Harm as a % of total PSIs reported</u> This provides a measure of safety (low is good). A healthy reporting culture will report near miss / no harm incidents regularly to enable system learning. This measure is provided at a regional level to our ICB. This is a measure of all patient harm (not just serious harm). There is insufficient data to make any meaningful conclusions at this time but all measures will be kept under close scrutiny as part of the reporting to PQASG.	Incident data from April 2024 (now reported on Radar) is not comparable with that previously included in the IQPR (from Datix) and direct comparison should not be made between the two systems. There is no longer a requirement nationally to record deep tissue injury and moisture damage (within the wider pressure ulcer categories). In addition, incidents are now reported across two 'event types' : Incidents and Reportable occurrences (ROs). For this reason, the SPC harts cannot be produced until there are sufficient data periods to use the 'making data count' methodology.	The patient safety team are working closely with colleagues to ensure the timely and accurate reporting of PSI and RO, providing guidance and support. A training package was developed to assist colleagues to report and investigate incidents on the Radar system and the Radar team are assisting colleagues by aiding and triaging requests which are submitted to the general enquiries mailbox. In addition to the online package of training there will be visits to clinical and department areas in a 'floor walking' style for at the elbow support. The IT team have been working with Radar to trouble-shoot the IT system connectivity issue which has been communicated to all staff via the system alerts dashboard. This is overseen by the Radar Oversight Group (ROG). The patient safety team are reviewing the quarterly thematic analysis report which is shared at Patient Safety and Quality Governance Group to ensure it analyses the data to allow for learning outcomes to be shared widely with the clinical divisions and the specialists leads. Metrics for measuring safety into improvement are being developed with the QI team and will also be reported in the future.

Mortality Summary

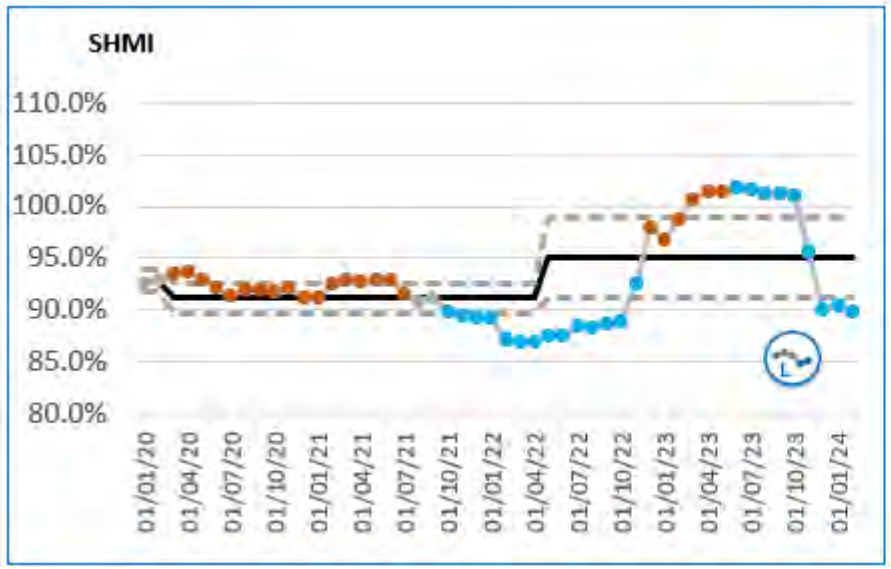


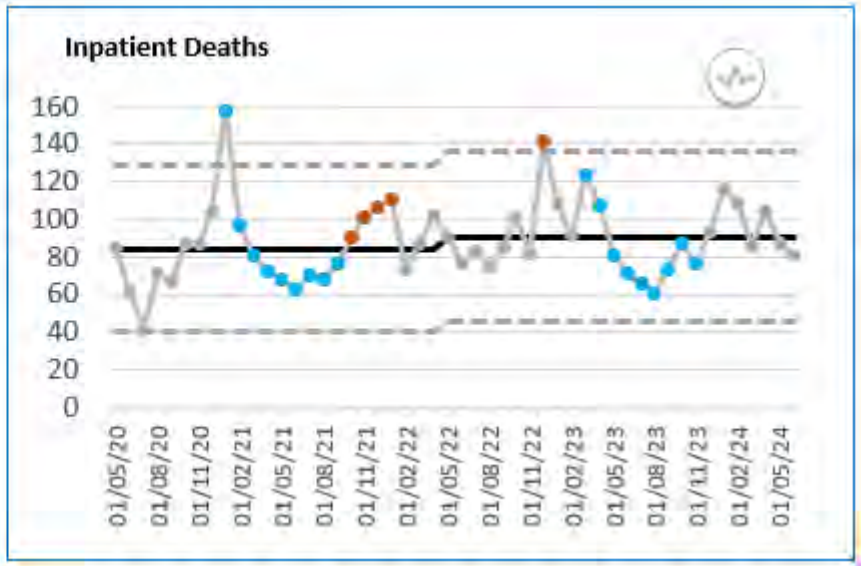


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SHMI	Feb 24	89.8%	-			95.1%	91.3%	98.9%
Inpatient Deaths	Jun 24	81	-			91	45	136

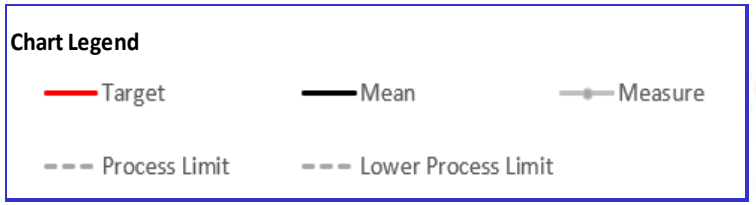
These will be updated once the SHMI data has been published and the Deaths have been agreed

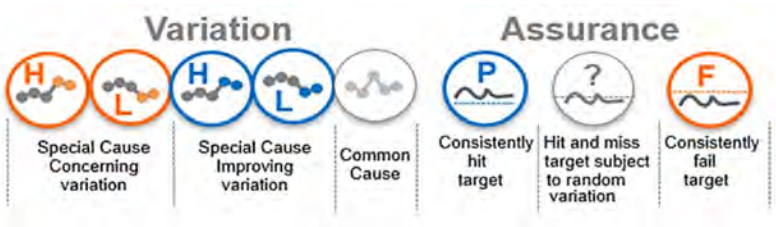
Mortality





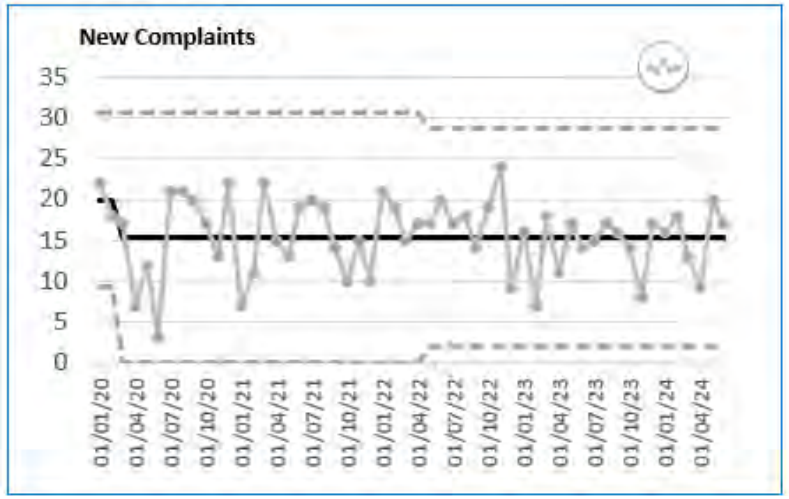
What	So What?	What Next?
The SHMI is returning towards the figure we would expect. This is because the months of Nov/Dec 2022 which were submitted uncoded at the time are no longer included in the "12 months up to .." total Mortality Oversight Group (MOG) looks at deaths by cause, age, location and speciality so there can be rapid identification of anomalies	Now the coding issue has been resolved the SHMI is returning to where we would expect it to be. Our inpatient deaths figure is in line with what we would expect to see both in terms of numbers, locations and age	Our SHMI returned to the figure it was prior to the anomalous period with Nov/Dec 2022 uncoded data however this will be kept under observation on a monthly basis by the mortality oversight group. Now the data is all coded, the diagnosis groups can be monitored for changes below the trust-wide total figure. MOG reports to Patient Quality and Safety Governance group, which we continue to include SHMI data, therefore we are proposing that this can be removed from IPQR going forwards.

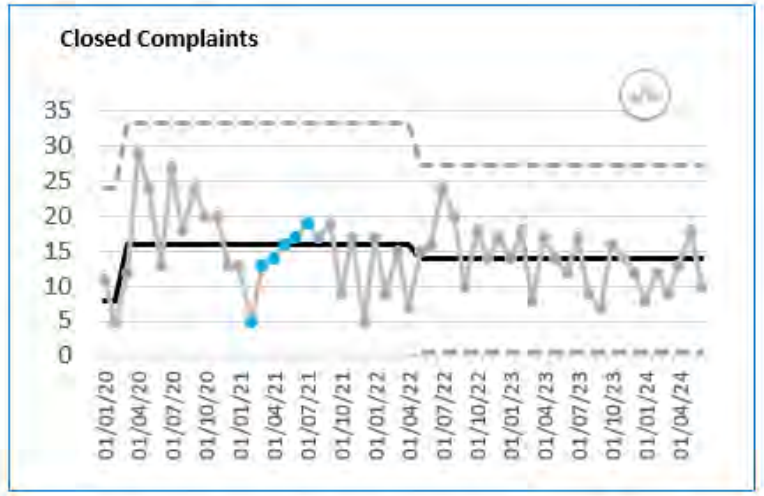


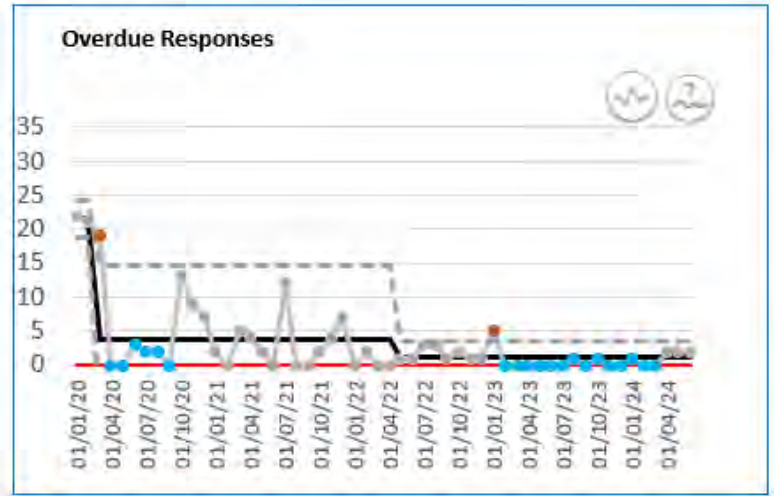


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
New Complaints	Jun 24	17				15	2	29
Closed Complaints	Jun 24	10				14	1	27
Overdue Responses	Jun 24	2	0			1	-1	3

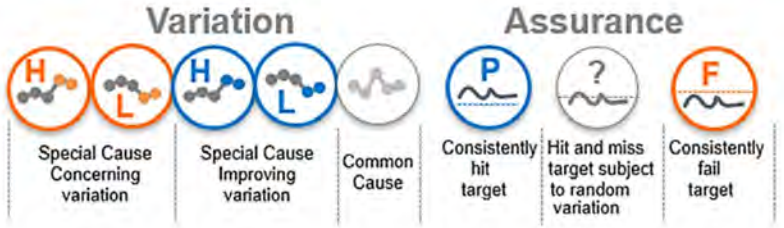
Safe





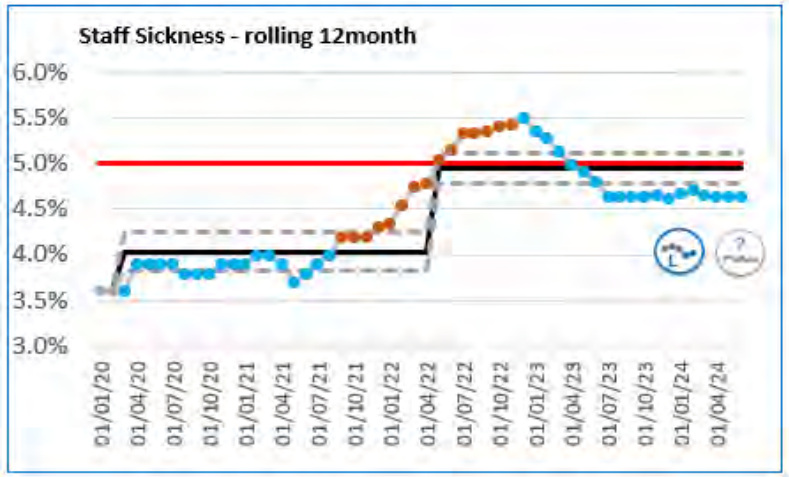


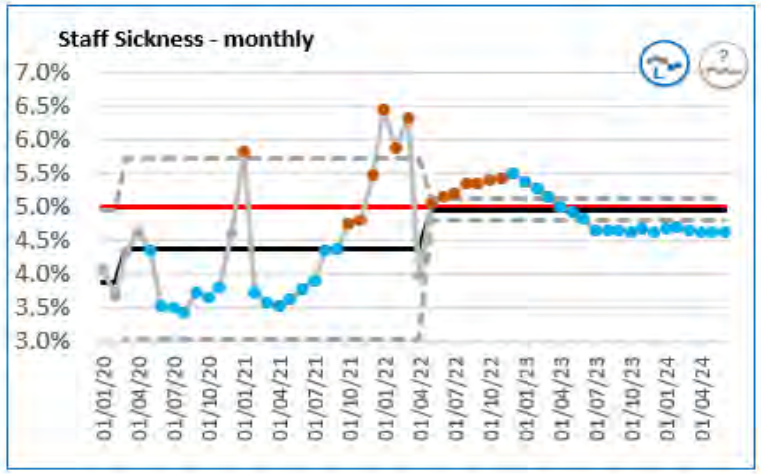
What	So What?	What Next?
June saw a slight reduction in new complaints received from 18 to 17 which is still average for what we would normally see at this time of year. 10 formal complaints were resolved with 2 complaints resolved out of time due to amendments required within the review process. The total new complaints remain stable and within the controlled limits over the past year. Overdue responses remain low, and the IQPR will focus on new data lines to ensure transparency around extended timeframes for response. It is routine practice, and within NHS complaints regulations, that timeframes can be extended with the agreement of the complainant, but we are keen to ensure the scale of this is clear.	Over 2024-25 we are testing new working strategies with staff to obtain their comments in a timelier manner which is working well, resulting in prompter investigation conclusions. We also ensure a robust review process is in place to maintain quality and consistency with our responses and will continue to work with teams to develop their skills and, in turn, the quality of investigations. IQPR data will reflect overdue responses in greater clarity to consider extended timeframes.	We will closely monitor any emerging themes related to potential impact service changes may have on experience of care over the next three years. It is anticipated that service changes may increase the total number of new complaints as changes to provision occurs across the organisation. We are continuing to work with clinical staff to provide timely responses to complaints. Throughout 2024-25 we are conducting a quality improvement test to aid prompter, truer resolution, and fewer extensions/overdue investigations. This should also see a greater number of closed complaints and higher satisfaction with the process. By March 2025, we will have resolution meetings with 50% of complaints received. Results of this project will be reported to Involvement Committee on a quarterly basis.

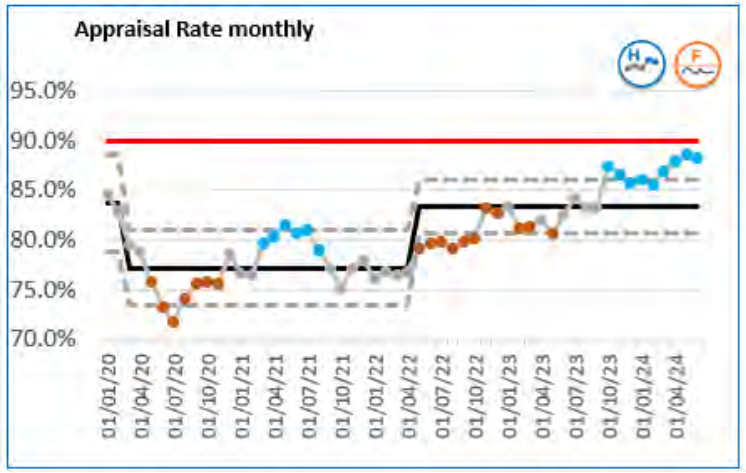


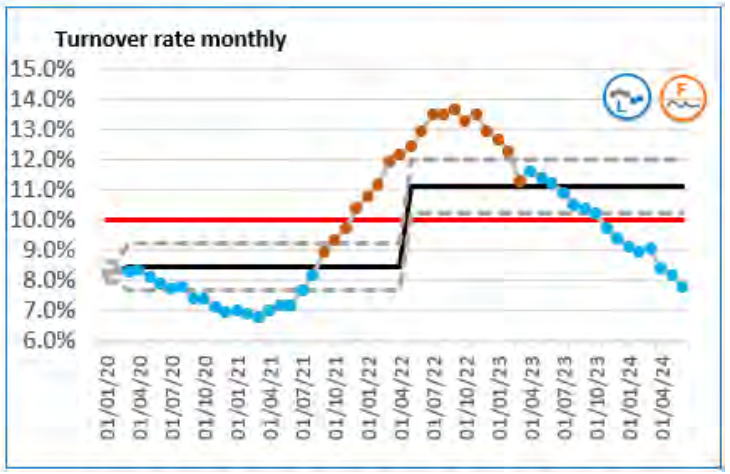
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	Jun 24	4.6%	5.0%	L	?	5.0%	4.8%	5.1%
Staff Sickness - monthly	Jun 24	4.6%	5.0%	L	?	4.9%	4.8%	5.1%
Mandatory Training monthly	Jun 24	91.4%	90.0%	H	?	89.3%	88.2%	90.4%
Appraisal Rate monthly	Jun 24	88.3%	90.0%	H	F	83.4%	80.7%	86.2%
Turnover rate monthly	Jun 24	7.8%	10.0%	L	F	11.1%	10.2%	12.0%

Well Led









What	So What?	What Next?
All key performance indicators continue to record an improving variation. **Sickness** – Achieving target, sustained improvement since December 2022 **Mandatory training** – achieving target for tenth consecutive month **Appraisal** – consistently failing target, -0.2% on previous month **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. Sustain 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.