OPEN Council of Governors Meeting

Schedule	Wednesday 26 February 2025, 5:30 PM — 7:30 PM GMT
Venue	Rooms 19a & b, Education Centre, WSFT, Hardwick Lane, Bury St. Edmunds. IP33 2QZ
Notes for Participants	Please advise of apologies in advance of the meeting to the FT Office.
Organiser	Ruth Williamson

Agenda

AGENDA:
OPEN Council of Governors meeting
Wednesday 26 February, 2025, 5.30pm in Rooms 19a & b, Education Centre, WSFT, Hardwick Lane, Bury St. Edmunds. IP33 2QZ

0. Agenda Open CoG meeting 26 Feb 2025.docx

5:30 PM 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 - Tom Murray
   NEDs - 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

NHS
West Suffolk
NHS Foundation Trust

4. Minutes of the previous meeting (enclosed)
   To note the minutes of the meetings held on 19 November 2024
   For Approval - Presented by Jude Chin

   Item 4 2024 11 19 November - WSFT Public CoG minutes - Draft v1.docx

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5. Matters arising action sheet (enclosed)
   To note updates on actions not covered elsewhere on the agenda
   To Note - Presented by Jude Chin

   Item 5 CoG Action log from Open 19 November 2024.docx

5:40 PM

6. Update on Transformation Programme (presentation)
   To receive an update
   To inform

5:55 PM

7. SNEE Sustainability Review
   To receive an update on the review
   To inform

   Item 7 SNEE Sustainability review CoG 26 Feb 2025.doc

   Item 7.1 20250106 SNEE scoping discussion vFF.pdf

6:15 PM

8. Chair's report (enclosed)
   To receive an update from the Chair
   To Note - Presented by Jude Chin

   Item 8 Chair's Report 26 Feb 2025.docx

6:25 PM

9. Chief executive's report (enclosed)
   To note a report on operational and strategic matters
   To Note - Presented by Ewen Cameron

   Item 9 CEO report CoG 26 Feb 2025.docx

6:35 PM GOVERNOR BUSINESS (INC. STATUTORY DUTIES)

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10. Feedback from assurance committees (enclosed)
To receive committee key issues (CKI) and observers reports from the assurance and audit committees
To Note

Item 10 Feedback from Board assurance committees CoG 26 Feb 2025.docx

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10.1. Insight Committee
Presented by Antoinette Jackson

Item 10.1 INSIGHT CKI report 15 Jan 2025 AJ.docx
Item 10.1 INSIGHT CKI report 18 Dec 2024 AJ.docx
Item 10.1 INSIGHT CKI report 20 Nov 2024 AJ.docx
Item 10.1 INSIGHT Governor observer a 20 Nov 2024 J Neal.docx
Item 10.1 INSIGHT Governor observer a 20 Nov 2024 J Skinner.docx
Item 10.1 INSIGHT Governor observer a 20 Nov 2024 JP Holt.docx
Item 10.1 INSIGHT Governor observer b 18 Dec 2024 J Skinner.docx
Item 10.1 INSIGHT Governor observer b 18 Dec 2024 JP Holt.docx
Item 10.1 INSIGHT Governor observer b 18 Dec 2024 T Murray.pdf
Item 10.1 INSIGHT Governor observer c 15 Jan 2025 A Musgrove.docx
Item 10.1 INSIGHT Governor observer c 15 Jan 2025 J Skinner.docx

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10.2. Involvement Committee

- Item 10.2 IMPROVEMENT CKI report 15 Jan 2025 RP.docx
- Item 10.2 IMPROVEMENT CKI report 18 Dec 2024 RP.docx
- Item 10.2 IMPROVEMENT Governor observer a 20 Nov 2024 A Conochie.docx
- Item 10.2 IMPROVEMENT Governor observer a 20 Nov 2024 J Skinner.docx
- Item 10.2 IMPROVEMENT Governor observer b 18 Dec 2024 J Skinner.docx
- Item 10.2 IMPROVEMENT Governor observer b 18 Dec 2024 T Murray.pdf
- Item 10.2 IMPROVEMENT Governor observer c 15 Jan 2025 J Skinner.docx
- Item 10.2 IMPROVEMENT Governor observer c 15 Jan 2025 S Kingston.docx

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10.3. Improvement Committee

- Item 10.3 INVOLVEMENT CKI report 18 Dec 2024 TD.doc
- Item 10.3 INVOLVEMENT Governor observer a 18 Dec 2024 B Poynter.docx
- Item 10.3 INVOLVEMENT Governor observer a 18 Dec 2024 S Kingston.docx

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10.4. Audit Committee

Presented by Antoinette Jackson

- Item 10.4 AUDIT CKI report 10 Dec 2024 MP.docx

7:00 PM 11. Nomination Committee Report (enclosed)

To receive the report from the Nomination Committee

To Note - Presented by Jude Chin

- Item 11 Nominations committee report and NED Appraisal process CoG 26 Feb 2025.doc

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

Item 12 Membership & Engagement committee report CoG 26 Feb 2025.doc

Item 12_Annex 1 Governor activities 2024 - Feedback report v2.docx

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13. Standards Committee Report - No Meeting since October 2024
To Note - Presented by Jude Chin

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14. Staff Governor Report (enclosed)
To receive a report from the Staff Governors
To Note - Presented by John-Paul Holt

Item 14 Staff Governors report CoG 26 Feb 2025.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 Gov report 26 Feb 2025.docx

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16. Governance Report (enclosed)
To receive the governance report
To inform

Item 16 Governance report CoG 26 Feb 2025.doc

Item 16_Appendix A Governors Work Programme 2025.docx

Item 16_Appendix B Governors forward planner 2025-26.docx

7:20 PM ITEMS FOR INFORMATION

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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 26 Feb 2025.docx

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

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

To Note - Presented by Jude Chin

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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 10 - IQPR full Report - November 2024

xIQPR Board November 2024.pdf

AGENDA:

OPEN Council of Governors meeting

Wednesday 26 February, 2025, 5.30pm in Rooms 19a & b, Education Centre, WSFT, Hardwick Lane, Bury St. Edmunds. IP33 2QZ

Council of Governors Meeting

There will be a meeting of the **COUNCIL OF GOVERNORS** of West Suffolk NHS Foundation Trust on **Wednesday 26 February 2025 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	JC
	2.	**Apologies for absence** To receive any apologies for the meeting	JC
	3.	**Declaration of interests** (enclosed) To receive any declarations of interest for items on the agenda	JC
	4.	**Minutes of the previous meeting** (enclosed) To note the minutes of the meetings held on 19 November 2024	JC
	5.	**Matters arising action sheet** (enclosed) To note updates on actions not covered elsewhere on the agenda	JC
17:40	**6.**	**Update on transformation programme** (presentation) To receive an update	ST
17:55	**7.**	**SNEE Sustainability review** (enclosed) To receive an update on the review	ST
18:15	**8.**	**Chair's report** (enclosed) To receive an update from the Chair	JC
18:25	**9.**	**Chief executive's report** (enclosed) To note a report on operational and strategic matters	EC
GOVERNOR BUSINESS (INC. STATUTORY DUTIES)			

18:35	**10.**	**Feedback from Board committees** (enclosed) To receive committee key issues (CKI) and observer reports from the assurance and audit committees: 10.1 Insight Committee 10.2 Involvement Committee 10.3 Improvement Committee 10.4 Audit Committee	NED chairs / Governor observers
19:00	**11.**	**Nomination Committee report** (enclosed) To receive the report from the Nomination committee	JC
	12.	**Management and Engagement Committee report** (enclosed) To receive a report from the Management and Engagement Committee	SH
	13.	***Standards Committee report*** *(No meeting since Oct 2024)*	
	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
	16.	**Governance report** (enclosed) To receive the governance report	PS
ITEMS FOR INFORMATION			
19:20	**17.**	**Summary report for Board of Directors meetings** (enclosed) To receive the report the Chair and Non-Executive Directors	JC / NEDs
	18.	**Dates for meetings for 2025** To note dates for meetings in 2025: • **14 May 2025** • **11 September 2025** • **13 November 2025** • **Annual Members' Meeting - TBC**	JC
	19.	**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
10	IQPR full report - November 2024

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 - Tom Murray

NEDs - 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 meeting (enclosed)

To note the minutes of the meetings held on 19 November 2024

For Approval

Presented by Jude Chin

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE
COUNCIL OF GOVERNORS' MEETING - OPEN

Held on Tuesday 19 November 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
Anna Conochie	Public Governor	AC
Sarah Hanratty	Public Governor	SH
Elizabeth Hodder	Public Governor	EH
Ben Lord	Public Governor – Deputy Lead Governor	BL
Jayne Neal	Public Governor	JN
Adrian Osborne	Public Governor	AO
Becky Poynter	Public Governor	BP
Michael Simpkin	Public Governor	MS
Jane Skinner	Public Governor – Lead Governor	JS
Gordon McKay	Public Governor	GMc
Anna Clapton (nee Mills)	Staff Governor	AC
John-Paul (J-P) Holt	Staff Governor	JPH
Louisa Honeybun	Staff Governor	LH
Andy Morris	Staff Governor	AMo
Heike Sowa	Partner Governor	HS
Thomas Pulimood	Partner Governor	TP
Sue Kingston	Partner Governor	SK
In attendance:		
Ewen Cameron	CEO	EC
Jonathan Rowling	Interim Chief Finance Officer	JR
Antoinette Jackson	Non-executive Director	AJ
Tracy Dowling	Non-executive Director	TD
Richard Flatman	Non-executive Director	RF
Richard Jones	Trust Secretary	RJ
Pooja Sharma	Deputy Trust Secretary	PS
Ruth Williamson	Foundation Trust Office Manager (Minutes)	RW
Apologies: Carol Bull, Public Governor Val Dutton, Public Governor Tom Murray, Public Governor Clare Rose, Public Governor Adam Musgrove, Staff Governor Rowena Lindberg, Partner Governor Michael Parsons, Non-executive Director		

Roger Petter, Non-executive Director Paul Zollinger-Read, Associate Non-executive Director Heather Hancock, Non-executive Director David Weaver, Associate Non-executive Director Alison Wigg, Non-executive Director
Members of the Public
None in attendance.

No.	Item	Action
1.	**Welcome and introductions**	
	Thanks were offered to Elspeth Lees, partner governor, for her contribution to the Council following her resignation. A replacement is being sought from West Suffolk College.	
2.	**Apologies for absence**	
	Apologies for absence were noted, as detailed above.	
3.	**Declaration of interests**	
	There were no declarations of interest made.	
4.	**Minutes of the previous meetings**	
	The minutes of the meeting held on 2 September, 2024 were approved as a true and accurate reflection, subject to the following amendment: **Item 8 – Finance Update** – "… An offer was made for the Acting Chief Finance Officer to be shown round theatres by a Staff Governor, to help identify areas that could be improved **as it was felt there was a disparity between reported developments and what was happening at ground level."**	
5.	**Matters arising on action sheet**	
	Minute 5 – Governor Visits to Virtual Ward Control Centre – noted these visits had been cancelled due to operational pressures. New dates to be arranged. ***Minute Ref 7 – CEO Report – Never Events*** – whilst the process for dealing with Never Events had been made clear, governors had requested an update on those events reported. **Action: Trust Secretary to request summary of progress and learning from last year's Never Events for circulation to governors.**	**RW** **RJ**
6.	**Chair's Report**	
	Autumn Budget – it was noted that of the £22.6b additional funding provided for the NHS, £12.2b had already been allocated to fund 2024/25 expenditure. The remaining monies for 2025/26 would need to consider pay rises in the NHS (the final figure for this was unknown at this stage). Noted the increased employer NI contributions would be refunded to the NHS. It was understood that funding would be tight for next year and	

	therefore the Trust would need to continue with its Cost Improvement Programme (CIP). ***Meeting with Staff Governors*** – the Chair and Chief Executive had recently met with staff governors. Noted the Board was very aware of pressures currently being faced by staff, both operationally and financially. The Board would try to mitigate these wherever possible and were grateful to staff for their hard work.	
7.	**Chief Executive's report**	
	Ewen Cameron, CEO, was in attendance to present the report. ***Elective Recovery:*** a number of patients waiting in excess of 65-weeks remain, with challenges in two areas, dermatology and urogynae. Assistance is being sought from the Nuffield in Ipswich to help clear the backlog before the end of December, 2024. ***Emergency Department*** – a minor emergency care unit has been placed outside of the department to assist with treatment of lower acuity patients, thereby creating capacity in the department for others. ***Inpatient survey*** – congratulations were offered to staff at the hospital and in the community who helped the Trust reach 5th place nationally, acute and combined, in the annual NHS Adult Inpatient Survey for 2023. The amber scoring for **Referral to Treatment (RTT)** times was queried. Noted no further work was required to achieve the targets. As the Trust was not at zero, question raised as to level of assurance available that patients were not susceptible to harm as a result. Noted defining levels of harm was reliant upon reporting of same as they occurred. WSFT was not alone in not achieving a zero target. Question raised as to whether the Trust should take a proactive approach in this regard and seek patients out for clinical review. It was understood that some other trusts were doing this. **Action: CEO to ascertain whether review of patients on the waiting list in excess of 65 weeks was being undertaken.** Question raised as to where the 63 whole time equivalent (WTE) staff, required for the new Community Diagnostic Centre (CDC) in Newmarket, would come from. Would these be new appointments or staff moved from elsewhere? Noted these would be newly recruited, with some already employed. In view of the Trust's current financial situation how would this be funded? Noted the CDC was part of a national programme and funded through that. However, these additional staff members were included in the Trust's workforce totals, meaning a reduction in recruitment elsewhere. If funded nationally, why was this included in the Trust's workforce total? Noted the reason for this was due to the Trust's current financial deficit.	**EC**

	Was there a timeframe for cessation of national funding when the Trust would be expected to bear the costs? This was difficult to predict, but would likely continue in some form as there was a dearth in the service nationally. It was queried whether the large numbers being seen in the Emergency Department, on a daily basis, was as a result of difficulties for people in getting a GP appointment. Noted there was no evidence to suggest this. Recent primary care industrial action had not affected urgent appointments and had had minimal effect on the hospital. In terms of the Essex and Suffolk Elective Orthopaedic Centre (ESEOC) was the number of patients willing to attend at appropriate levels? It was too early to say, but the centre had started operating this week on WSFT patients. At present a greater number were being performed locally.	
8.	**Feedback from Board assurance committees**	
8.1	**Insight Committee**	
	Antoinette Jackson presented the report and highlights noted: ***Contracts & Procurement*** - concern was expressed at forward planning for contract renewals, allowing sufficient time for the Board to approve contracts. Work is being carried out on process improvement. ***Community & Wheelchair Equipment Service*** – this is a year-to-date cost pressure, some of which relates to demand, but is also due to provision of services out of area. The Trust is seeking a more equitable split of costs. An incidence was cited where a patient's relative reported to the hospital that they were advised to dispose of equipment if they could not return it to Ipswich. Whilst this was seen as a potential waste of NHS resources, it is important to note that there is a process for collecting community equipment. This process ensures efficient use of resources, although it may not apply when a local collection address is unavailable. Suggestion made that as equipment required checking and cleaning on return, it was more cost effective to buy new. It was understood that the equipment, provided by a private company, was being recycled. A governor advised that when attempting to return renal equipment to the Trust they were informed this should be taken to Cambridge, which was not possible and therefore disposed of. Noted the dialysis unit on site is run by Cambridge University Hospitals Foundation Trust and not WSFT. ***Elective Recovery & Cancer Targets*** – noted partial assurance rating. Performance has not met target for the year and question raised as to when this should be escalated. Noted the matter had been escalated to the Board at different times over the year and the Board is provided with performance data within their reports. An action plan is in place and there has been some improvement in the metrics.	

	Terms of Reference for Insight Committee – noted these had been approved at a recent meeting. Query raised as to whether the attendance of governors as observers should be included. This was agreed. **Action: Trust Secretary to include attendance of governors in ToR.** ***Staffing*** – question raised as to insights from the impact assessments following the recruitment freeze. Noted quality impact was reviewed on a monthly basis by the Management Executive Group. Noted the figures for the organisation as a whole did not necessarily translate to an impact on the smaller teams or individuals. Noted turnover rates at the Trust were low. In terms of the vacancy rate, consideration should be given to how this varied across different services and how assurance could be gained that this was on an equal footing. Question raised regarding equality impact as well as quality. Noted the Insight Committee were to have a deep dive at their next meeting to understand how to measure the quality impact in terms of performance and operational metrics. Query raised as to whether the current duration of the Insight Committee was sufficient to enable detailed discussions. It was felt the monthly meetings were in order, but further consideration of agenda content would be undertaken and kept under review.	**RJ**
8.2	**Improvement Committee**	
	The Non-Executive Director (TD) presented the report and highlights noted: Significant discussion has been undertaken on C-diff and the number of incidences in the area. The Trust has produced a detailed action plan. The ICB Chief Nurse, who attended this particular meeting, gave assurance that the Trust was doing all it could in this regard. A particular reason for the number of incidences has yet to be identified. Noted in terms of overdue NICE guidelines the team overseeing policies were also overseeing these. The Clinical Effectiveness Governance Group will maintain oversight, with the Corporate Risk Governance Group feeding in to the Involvement Committee. It was queried whether incidents of corridor care were a measure of concern. It was agreed that whilst pressures on the NHS at times meant this was the best that could be offered it was not to become the norm. Assurance was given that in the event such incidences arose everything was done to limit the length of time and work undertaken with the system to minimise any such occasions. Query raised as to whether Governance should be used to reflect on any incidences of corridor care for potential learning. Noted this was the reason the matter had been raised at the Involvement Committee who will consider the data.	

	Observer feedback: The difference between completion of trust-wide and individual audits was noted. TD will be discussing this with the new Medical Director.	
8.3	**Involvement Committee**	
	Noted concerns regarding travel and costs associated for those attending the Essex and Suffolk Elective Orthopaedic Centre, identified via Healthwatch engagement, have been passed to the ICB for response. It was reported that the committee had received an excellent presentation from Philippa Lakins, Organisational Development Lead – OD and Learning on work with veterans. ***Observer comments:*** It was a productive meeting that exceeded the scheduled time, but this was subsequently addressed.	
8.4	**Audit Committee**	
	Lack of clarity on right-off of £80k highlighted. The two invoices in question related to a service hosted by the Trust and another company that had gone into liquidation. This has been addressed at the Audit Committee.	
9.	**Nomination Committee Report**	
	The report was noted and taken as read.	
10.	**Engagement Committee Report**	
	The Council of Governors noted the report from engagement committee. **The Council agreed to recommend the draft membership and engagement strategy to the Board of Directors for approval.** **The Council of Governors unanimously agreed the new name for the committee "WSFT Council of Governors' Membership and Engagement Committee" and approved the revised terms of reference of the Committee.**	
11.	**Standards Committee Report**	
	Appendix 1 – the Council of Governors approved the Governor Code of Conduct, subject to the following amendment: Item 9.2 "Governors are also accountable to NHS England (deleting and Improvement) for their conduct. **Appendix 2 – Procedure for Managing Governor Conduct and Expected standards was approved by the Council of Governors.**	
12.	**Staff Governors' Report**	
	Noted the staff governors had met with the Chair and Chief Executive to discuss concerns. These will be circulated to non-executive directors and	

	themes identified from these discussions will be picked by the Involvement Committee. **Action: All governors to be cited on letter detailing concerns.**	**RW**
13.	**Lead Governor Report**	
	The report was noted and taken as read.	
14.	**Summary Report for Board of Directors Meetings**	
	The report was noted and taken as read.	
15.	**Dates for meetings in 2024/2025**	
	▪ 26 February 2025 ▪ 14 May 2025 ▪ 11 September 2025 ▪ 13 November 2025 ▪ Annual Members' Meeting - TBC	
16.	**Reflections on meeting**	
	• It was proposed that for future meetings all papers be considered as read, providing sufficient time for discussion and questions. **Action: Chair and Lead Governor to consider meeting format.**	**JC/JS**

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 19 November 2024 meeting

OPEN ACTIONS

Minutes Ref No.	Paper/Agenda item Ref	Meeting date	Action	Lead	Progress	Target Date	RAG	Date completed
5	AOB – Governor Visits to Virtual Ward Control Centre	02/09/2024	New Non-executive directors (NEDs) to be invited. 19/11/2024 - Visits cancelled due to operational pressures. New dates to be arranged.	RW	Invite extended. Action Closed. **Following discussion with Caroline Millard, these visits are to be rescheduled for April, 2025. Dates to be confirmed.**	20/09/2024 May 2025	**On Track**	

CLOSED ACTIONS

Minutes Ref No.	Paper/Agenda item Ref	Meeting date	Action	Lead	Progress	Target Date	RAG	Date completed
7	Chief executive's report	27/2/2024	To consider communication with Governors regarding incidents and the outcomes, including 'never event'. 2/9/2024 - summarise messages from the report to the Improvement Committee for governors. **Continued below…**	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. A summary is provided as an annex to this report.	19/11/2024	**Complete**	17/-02/2024

Minutes Ref No.	Paper/Agenda item Ref	Meeting date	Action	Lead	Progress	Target Date	RAG	Date completed
			19/11/2024 - Summary of **progress** of Never Events reported in 2023/2024 to be circulated to governors.		Two Never Events occurred in the period 2023/2024: 1. Concerned the tip of a wire introducer becoming detached and retained in a patient's blood vessel during a challenging cardiac procedure. This was an event which had not been seen before. **These items are now part of a formal count at the end of the procedure.** 2. Occurred during an outpatient procedure when a patient had a steroid medication injected into the wrong toe webspace. The site had been marked, however the mark had been washed off by the skin cleanser prior to the procedure. **Permanent markers have now been obtained.**			

Minutes Ref No.	Paper/Agenda item Ref	Meeting date	Action	Lead	Progress	Target Date	RAG	Date completed
7	CEO Report – Referral to Treatment	19/11/2024	CEO to ascertain whether review of patients on the waiting list in excess of 65 weeks was being undertaken.	EC	**The policy for assessing harm on the waiting list is for this to be assessed at each patient contact and then to be reported on RADAR when identified. There are currently very few patients over 65 weeks. Validation of the waiting list has been carried out in line with NHSE requirements. There is insufficient clinical resource to assess harm more proactively without impacting further on waiting times.**	26/02/2025	**Complete**	14/02/2025
8.1	Insight Committee – Terms of Reference	19/11/2024	Attendance of governors, as observers, at Insight Committee to be included in the Terms of Reference	RJ	**Included in Insight Committee Terms of Reference. Action closed.**	26/02/2025	**Complete**	26/02/2025
9.1	Feedback from Board Committees – Insight	09/05/2024	To pass on request for assurance on HR and payroll processes to the auditors, for inclusion within their scope of work.	MP	Internal Audit Plan 2025/6 being discussed at Audit Committee on 10 December, 2024 and will be raised then. **At Audit Committee on 10 December, auditors RSM were asked to ensure financial control audits (including HR/payroll) feature much more prominently in the 25/26 Internal Audit plan.**	10/12/2024	**Complete**	10/12/2024
12	Staff Governors' Report	19/11/2024	Letter to CEO and Chair regarding concerns to be circulated to governors.	RW	**Actioned.**	30/11/2024	**Complete**	November 2024
16	Reflections of Meeting	19/11/2024	Consideration of meeting format to allow sufficient time for discussion and questions.	JC/JS	**Agreed that at future meetings CKI reports to be taken as read, using time for discussion and questions.**		**Complete**	26/02/2025

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
Richard Jones	RJ
Michael Parsons	MP
Ruth Williamson	RW
Jude Chin	JC
Jane Skinner	JS

6. Update on Transformation Programme (presentation)

To receive an update

To inform

7. SNEE Sustainability Review

To receive an update on the review

To inform

NHS
West Suffolk
NHS Foundation Trust

WSFT Council of Governors meeting (Open)	
Report title:	SNEE Sustainability review
Agenda item:	7
Date of the meeting:	26 February 2025
Sponsor/executive lead:	Sam Tappenden, executive director of Strategy & Transformation
Report prepared by:	Sam Tappenden, executive director of Strategy & Transformation

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

SNEE ICB has commissioned a piece of work supported by McKinsey to consider how to deliver a 'future shift' of resource into primary and community services while improving the clinical and financial sustainability of the system overall addressing three main questions: (1) Which services and activities are driving acute financial sustainability challenges? (2) Which services have clinical and operational sustainability concerns? (3) What are the options for addressing the challenges?

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

The review has commenced and the scope have been shared with the Council of Governors for information.

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

The Governors will be updated at regular intervals on progress.

Action required / Recommendation:

The Council of Governors is asked to **note** the report.

Previously considered by:	Board of Directors
Risk and assurance:	Council of Governors unable to undertake its statutory duties.
Equality, diversity and inclusion:	Designed to address Inequalities.

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

McKinsey & Company

Suffolk and North East Essex system transformation

Scoping document

7 Jan 2025

NHS Suffolk and North East Essex

Problem statement worksheet: questions to consider

Basic question

- How can SNEE best secure clinically and financially sustainable services for the populations it serves? What does the path to delivering this look like, including critical enablers?

1 Context

- Challenging operational environment with key standards not met
- ESNEFT expected to meet control total;
- WSFT forecasting £23m underlying annual deficit
- ICB plan to see a future 'left shift' of activity and resources in line with national strategy
- WSFT planning a new hospital to address long-standing estate challenges – however potential concerns around clinical and financial sustainability
- Provider collaborative not yet showing progress at pace required

2 Criteria for success

- Plan to deliver clinically and financially sustainable services to the populations served by SNEE, improving quality of services as appropriate
- Consistent with the vision and principles of the SNEE system
- Building on previous work and underpinned by robust analysis / evidence base
- Stakeholder buy-in and alignment
- Delivery plan, including focus on critical enablers
- Effective leveraging of community services in 'future shift' model

3 Scope of solution space

- "Future shift" of services, resources, capacity and funding into community (through increased focus on prevention + integrated models of primary, community, social care and mental healthcare)
- Productivity improvements in all settings of care
- Increased service integration and collaboration (both vertical and horizontal)
- Consolidation savings across acute providers in key areas
- Funding flows

4 Constraints within solution space

- The funding allocation for the ICB and the two Trusts historically, currently and projected over the next ten years
- Solutions must recognise delivery capacity and capability, drawing on an evidence for track record
- Clinical risk from any extended delays in addressing West Suffolk estate challenges

5 Stakeholders

- ICB executive team
- ESNEFT and WSFT CEO/COO/CFO/clinical leaders
- Local authorities
- Other providers including primary care, voluntary sector, social care
- NHSE and other regulators
- Patients and staff

6 Key sources of insight

- Prior work on provider efficiency opportunities/benchmarking
- Prior work on clinical sustainability of key services
- SNEE Joint Forward Plan
- NHP SOC
- McKinsey benchmarking, case studies and experts
- Population segmentation model
- WS demand and capacity model
- System demand and capacity report
- Regional model of care description
- Collaboration materials

A | Key acute sustainability questions to address

Which services and activities are driving acute financial sustainability challenges?

- What is the activity per consultant WTE by specialty for ESNEFT and WSFT, how does this benchmark vs peers and how has this changed over time?
- What are the contribution margin of each service at each trust and how has this changed?
- Do any services have costs or workforce requirements allocated that are out of line with activity?
- Where are there discrepancies in cost base of service delivery between the two trusts, after adjusting for case mix?
- Where are there opportunities for further improvement in back-office and non-patient facing activities?
- What are the implications of the proposed new West Suffolk hospital on financial, operational and clinical sustainability?

Which services have clinical and operational sustainability concerns?

- Which services are likely clinically sub-scale?
- Which services have consistent staffing challenges, e.g. high staff vacancy, sickness or turnover?
- Which services have challenges delivering high quality outcomes?

What are the options for addressing the challenges?

- For which services do clinical challenges overlap with financial challenges?
- Which of these services have structural challenges, and which can be addressed through improving clinical operations within the trust?
- For which services could consolidation across sites be considered – either in terms of management or delivery?
- For which services are changes to in-hospital or wider model of care required to address challenges?

B | There is a well-established menu of evidence-based interventions to deliver a sustainable system

Not exhaustive

Reduce pressure on hospitals

Reduce unit costs across the system

1. **Care management for high-risk population cohorts**
2. **Care navigation for patients on elective waitlists**
3. **Improved primary care access**
4. **Front door triage / low acuity urgent care**
5. **Improved hospital discharge pathways and processes**
6. **Improved productivity in non-acute settings**
7. **Improvements in clinical operations** (UEC, OP, Theatres)
8. **Workforce optimisation and controls**
9. **External spend**
10. **Optimise fixed cost base** (including through service reconfiguration)
11. **Consolidation of back-office services**
12. **More efficient models of planned elective care**

Key questions

Which initiatives are to be prioritised?

What is their expected impact over next 5 years?

Who is accountable for delivery of each?

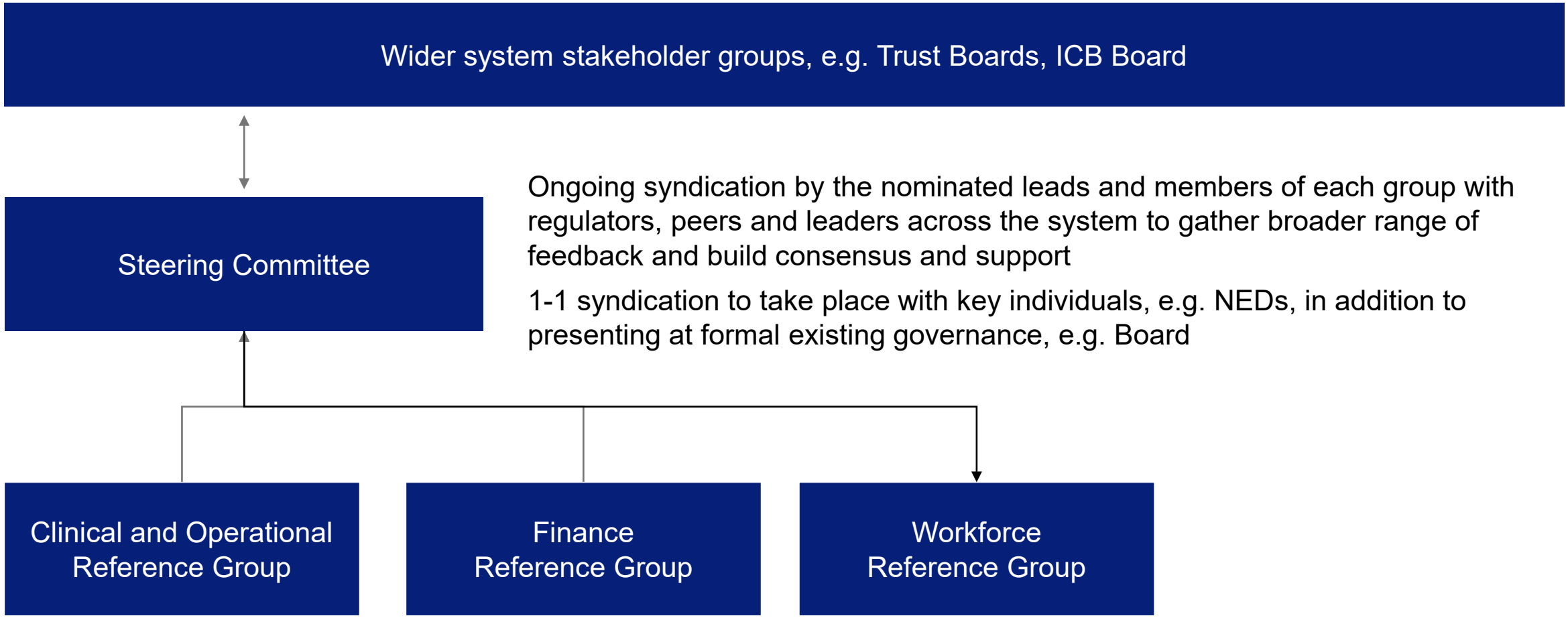
What is the role of the ICB in overseeing delivery?

What are the enablers required, e.g. governance, capabilities?

Proposed governance

	Attendees	Role in programme	Frequency
Steering Committee	Ed Garratt (Chair), Nick Hulme, Ewen Cameron, Richard Watson, Shane Gordon, Sam Tappenden, Richard Spencer, Elaine Noske, Tracy Dowling	Makes key decisions on all elements of the programme	1 x 90 min session per month
Clinical and Operational Reference Group *[Core set of attendees for initial meetings focused on acute performance; widened set of attendees TBD depending on subsequent agenda]*	Strategy and Transformation: Richard Watson, Shane Gordon, Sam Tappenden; CMOs: Andrew Kelso, Tim Leary, Richard Goodwin; COOs: Alison Stace, Nicola Cottington, Mike Meers; Community COOs: Paul Little, Clement Mawoyo CNOs: Lisa Nobes, Sue Wilkinson, Catherine Morgan; Primary Care Leads TBC, Alliance Directors: Maddie Baker-Woods, Peter Wightman, Laura Taylor-Green; ICP Susannah Howard; Ruth Bushaway	Inputs into, reviews and validates analysis of acute sustainability and development of initiatives, incl collaboration and 'future shift'	3-4 x 2h sessions plus interviews with key leads
Finance Reference Group	CFOs: Howard Martin, Adrian Marr, Jonathan Rowell and / or deputies: James Rowe, Chris Armitt, Nick MacDonald	Facilitates data sharing, reviews baseline, methodology, assumptions and outputs of financial modelling	5x 1h sessions
Workforce Reference Group	CPOs - Kate Read, Jeremy Over and Amanda Lyes	Reviews implications on workforce of proposed changes	2x1h sessions
Core day-to-day point of contact	Alex Royan, Andy Higby, Chris Armitt, Sam Tappenden	Provides key input and coordination for programme	1x per week plus ad-hoc

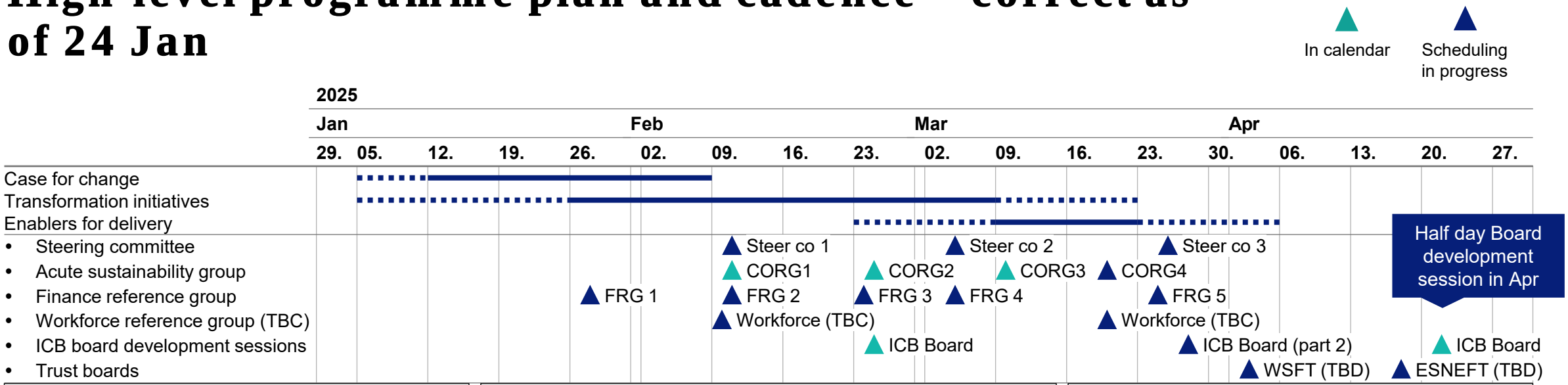
Steer Co will work through a structured set of decisions and manage comms to rest of system, supported by input from core groups



Ongoing syndication by the nominated leads and members of each group with regulators, peers and leaders across the system to gather broader range of feedback and build consensus and support

1-1 syndication to take place with key individuals, e.g. NEDs, in addition to presenting at formal existing governance, e.g. Board

High-level programme plan and cadence – correct as of 24 Jan



Steer Co 1

Review case for change outputs including:

- Acute sustainability review outputs
- Financial baseline outputs

Initial sizing and prioritization of major transformation initiatives

Steer Co 2

Review emerging sustainability plan including:

- Description and impact of initiatives
- KPIs and trajectories implied against financial plan
- Enablers required to deliver

Confirmation on enablers to work up in more depth

Steer Co 3

Review revised sustainability plan, including roadmap, impact and charters

Review blueprints for priority enablers to accelerate delivery

CORG[1] 1

Review acute sustainability analysis and case for change narrative

CORG 2

Development of key acute-focused initiatives, e.g. collaboration

CORG 3

Development of key 'future shift' initiatives, e.g. care mgmt. model

CORG 4

Task and Finish (deep dive into select topic(s) and next steps)

Finance reference group 1

Review finance baseline for ICS and trusts; agree modelling approach

Finance reference group 2

Review acute productivity metrics across two trusts

Finance reference group 3

Financial baseline projection

Finance reference group 4

Impact of initiatives on financial projection

Finance reference group 5

Financial implications of enablers, e.g. capex, workforce shifts, financial flows

Workforce reference group (TBC)

Implications of proposed service changes on workforce

(initial session to cover work context)

1. Clinical and Operational Reference Group

8. 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:	8
Date of the meeting:	26 February 2025
Sponsor/executive lead:	Jude Chin, Trust Chair
Report prepared by:	Jude Chin, Trust Chair

Purpose of the report:

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

Executive Summary

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

The Chief Executive (Ewen Cameron) has set out in his report the current status of our financial and operational position and I do not intend to repeat his messages here.

It is clear from Ewen's report that the Trust faces numerous challenges, none of which are unique to this Trust, however, we are faced with overcoming these challenges and in a timeframe which can demonstrate real progress. Through the efforts of colleagues across the Trust, much has been achieved in the current year. The challenge only increases for 2025/26 as the NHS has to begin to turn around a financial deficit in excess of £2billion as well as delivery on waiting list and targets for urgent and emergency care.

Any organisation that has to achieve fundamental change can only do so with the support and cooperation of all of its staff. In my New Year message to staff, I began by thanking all our colleagues for their hard work, care and compassion, as evidenced in the examples in Ewen's report, and for all they do for our patients and our community.

I also made a direct appeal to them to take part in the efforts to improve our financial situation and to improve our productivity, using their unique knowledge of our services and our patients. I pointed out the importance of the Board keeping everyone informed of changes and initiatives, of being open and honest, and using all the communication routes available to us. I also wanted to make the point that everyone in the Trust has the ability to make a difference and bring about transformation. Without this active participation we will not achieve the level of change required.

Whilst we have formal routes for staff to share suggestions for improvement, for example, the "Bright Ideas" email, I want to encourage all our colleagues to feel supported to make direct contact with the executive team, particularly if they believe that their ideas are not being given a fair hearing.

With governors and NEDs, I am taking part in the NHS 15 Steps programme. On my 15 steps visits, I too often hear from people working on our wards and in our services that they are put off from raising issues because they feel they will not be listened to. This is a mindset we need to shift, but can only do so if there is genuine consideration of ideas put forward and honest feedback to those who have come forward with suggestions.

The Board takes responsibility for the position of our Trust, and is aware that we need a culture shift to begin to deal with the many, and significant, challenges we face along with the whole NHS. Changing culture is one of the most difficult things any organisation will encounter. Change starts with the Board but to achieve progress, it must engage the people who make up our workforce. The changes we need to drive will take time, enormous commitment and energy, learning from past mistakes and embracing the opportunities for our future.

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

9. 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:	CEO report
Agenda item:	9
Date of the meeting:	26 February 2025
Sponsor/executive lead:	Dr Ewen Cameron, Chief executive
Report prepared by:	Dr Ewen Cameron, Chief executive Sam Green, communications manager Anna Hollis, acting head of communications

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

Executive Summary

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

December, January and February have proved a challenging period for the Trust, due to the operational pressure our acute and community services have been under and our financial position.

I would first like to thank all colleagues across our Trust for how they have dealt with the demand for our services recently, particularly those in urgent and emergency care (UEC). Having regularly walked through our UEC service areas, I was taken aback by how busy they were, and I am sure colleagues will agree that this was unprecedented. From those working in our emergency department, the wards in our hospitals, theatres, clinical support services such as pharmacy, to our community colleagues, I am immensely proud of how they are dealing with this period and the challenges of moving our patients through our services.

We are continuing to see positive signs of progress against our financial recovery plan, cost improvement programme and the additional measures we have put in place to reduce our spend. Colleagues across all services have worked hard and diligently to help us get to this point where we are seeing improvement, and I thank them for working with us on this. While we still have some way to go, I would like to stress that it is vitally important that we return to a financially sustainable position, which is hard, but absolutely necessary.

Performance

Finance

At the end of January, our reported position in-year was a £23.3 million deficit, which is £8.9 million worse than planned.

Work continues at pace to support the Trust's financial recovery plan; we are on track to deliver beneath the revised year end deficit target at £23.9 following a £2.6 million one-off payment from the ICB. Spend remains more each month than received income, however, it is positive news that the underlying deficit continues to reduce due to a lot of hard work. It is acknowledged that it is difficult to save money like this, but we are turning a corner and moving in the right direction.

There is much work to do to reduce the deficit month on month by March 2025 (and into 2025/26), however, due to measures in place, there is confidence that it will continue to decrease.

Workforce has been a key area of focus, and it is recognised this is where colleagues will feel the impact and difficulty of these changes. Overall workforce numbers have reduced; substantive staffing is just beginning to reduce and temporary staffing numbers and spend are much reduced, however, the Trust is employing more substantive staff than at the start of 2024.

The challenge for next year remains and we are working through plans in view of the national 'Planning Guidance' for 2025/26; we continue to identify opportunities to improve our situation, working with our colleagues to meet this challenge head on.

Elective recovery

Despite the pressure we have been under in recent months, our work to reduce elective care waits continues.

We have continued to make progress in our elective recovery generally; at the end of January 2025:

- 92 patients over 65 weeks: 68 of these are capacity related.
- 10 patients over 78 weeks: this continues to reduce each month.
- The focus is now on reducing our 65 week waits.

It is also fantastic that since 11 November we are now able to provide high-quality elective care at both the new, purpose-built Essex and Suffolk Elective Orthopaedic Centre facility in Colchester as well as our main West Suffolk Hospital site. This is supporting increased activity and has had a positive impact on our overall waiting list position in orthopaedics and will ensure our orthopaedic elective patients receive the care they need more quickly, so they can get back to their lives much sooner.

Urgent and emergency care

Our performance against the 4-hour standard was 63.9% in January, up from 62.1% in December, against a trajectory of 73.0% in January 2025.

We continue to see high levels of demand for our urgent and emergency care services, including inpatient admissions. We've been dealing with the seasonal prevalence of winter illnesses such as flu, which did see a rise earlier than in previous years, and norovirus, which has resulted in wards having to temporarily close. This has impacted ambulance handover at times and meant many of our patients have been waiting longer than we would like.

Inpatient flow has also been challenging but teams have been working hard on initiatives to better support this. The number of patients who no longer meet the criteria to reside who are not discharged on the same day is much lower than the national average.

Cancer

This year, we have focused on the early detection of cancer and reducing waiting times for patients with cancer. We have been aiming to improve our performance against the faster diagnosis standard to 77% - which means our patients having cancer confirmed or ruled out within 28 days, and 70% of patients beginning their cancer treatment within 62 days. At the end of December 2024, the position is:

- 72.7% of patients had cancer ruled out or confirmed within 28 days, this is behind the national standard and our internal Trust trajectory.
- 70.8% of patients were treated within 62 days, this is above the national requirement for 2024/25.

While we still have some way to go, we are using innovative methods to ensure the patients that are most likely to have a head and neck cancer, are seen as quickly and begin their treatment as quickly as possible. Here, we pre-screen patients over the phone prior to their first in-person appointment to determine the likelihood of them having cancer, allowing us to move the most at-risk patients to the front of the queue. This means we can begin their treatment as soon as possible which increases their chances of recovery, as well as improving our performance against the 62-day target. Please look out for more information on this in our newsroom soon.

Quality

Since November 2022, the Trust has been providing hospital care in the places our patients call home, such as their houses or care homes. During peak periods of demand for our services, the virtual ward helps us prevent avoidable admissions and keep those who may be vulnerable to infection, such as those who are frail or immunosuppressed, out of hospital.

We have recently expanded our virtual ward from 42 to 50 ‘beds’. This means it increases our capacity to care for and monitor our patients by more than a whole additional ward. We also know that often our patients do not want to be in hospital, or they would like to leave sooner than may be appropriate. The virtual ward facilitates patients returning home earlier while remaining under the observation of a multi-disciplinary team remotely while also receiving in-person care from our community teams.

The Government has outlined that as part of its 10-year plan it wants to move hospital care into the community and digitise the NHS to increase efficiency. The virtual ward is therefore a shining example of this, whereby using technology to monitor our patients remotely and shifting the care patients receive from hospital into community, allows us to work more effectively.

Setting this up and steadily growing the virtual ward has been a significant task. Building trust in this new way of delivering care in our teams and with our patients has taken some time, as well as getting our UEC, ward-based and community colleagues to think of this when deciding which care pathway is most appropriate for our patients. I would like to thank the whole virtual ward team and all those involved for their work in this area over the last two years, specifically Dr Vivian Yiu, who has led this project as consultant clinical lead and recently completed a secondment to the Integrated Care Board to develop virtual wards across the local healthcare system.

To further our digitisation ambitions, in November, we upgraded our Patient Portal, opening it up to new registrations. This new version has been designed to make managing your health information easier and more convenient, as the new portal provides an enhanced experience, allowing our patients access to their information and appointment details whenever and wherever they need them.

I am glad to say that so far, more than 25,137 patients have signed up for the Patient Portal, which is a significant proportion of our local population, and surpasses the number that had registered for the previous version.

Those already using the NHS App will be able to access the new portal with their existing NHS App login details. Those not using the NHS App should register for this before registering for the Patient Portal.

Workforce

As always, I've been out and about to meet colleagues nominated for Putting you First staff awards.

Anna Troughton, our learning and development lead for leadership and management was peer-nominated by Gina Suddaby, learning and development lead for coaching and mentoring.

Gina has recently moved into the NHS from the private sector and says Anna has been a helpful and supportive colleague through her transition and specifically stepped in to cover an entire day's training when she was off sick, ensuring the students didn't miss their day of learning.

Thank you to Anna and all colleagues who support each other in their work endeavours.

Visiting teams across the Trust provides me with insight into the breadth and scope of the work our teams carry out every day. I was really pleased to visit our colleagues at Newmarket Community Hospital (NCH) recently, where I had a tour of the fantastic new Community Diagnostic Centre. It's a brilliant development of that site and supporting patients living in the west of the region with quicker and faster access to a wide range of tests, such as MRI, CT, X-ray, and ultrasound, with others such as lung function and cardiology coming on in the near future. Colleagues are delighted to be working in a new and innovative space.

I also had valuable time with many other colleagues working at Newmarket and heard first-hand about the issues they are facing and the pressures impacting their work. Our colleagues based in community locations deliver crucial work supporting patients closer to home and I do not underestimate their daily challenges.

We are one Trust, and I thank all our colleagues in all our services for everything they do.

Future

The Government recently reaffirmed its commitment to replacing West Suffolk Hospital. Our plans for a new, state-of-the-art hospital on the Hardwick Manor site in Bury St Edmunds are moving forward.

They are continuing to prioritise the replacement of RAAC hospitals, such as West Suffolk Hospital, and we welcome the confirmation of a broad budget and a timeframe for commencing construction, following completion of the New Hospital Programme review.

This is good news for our patients, staff and communities in and around west Suffolk. We are pleased our plans align with the estimates provided by the Department of Health and Social Care and, working closely with the Government's New Hospital Programme team, we will continue to ensure the project is completed in the most effective way.

In what is a major milestone at the NCH site, the Newmarket Community Diagnostic Centre (CDC) began seeing its first patients on Monday, 16 December 2024. Up to 31 January 2025, the CDC has seen more than 2,800 patients and conducted at least 3,300 tests and scans, which is an incredible feat.

With the additional diagnostics services held there this means waiting times will be reduced for patients, and a decrease in the length of time between being referred for tests, having appointments, getting results, and beginning any necessary treatment.

As I said earlier, I have visited the centre and it's a great example of a sustainable build as well. To help the Trust meet the NHS 2040 net zero targets, the CDC has been designed to use low-carbon prefabricated materials, as well as incorporating sustainable methods of construction such as neutralising the water used in concrete production with specialist equipment, reducing the building energy use through modern design and building simulation techniques, and offsetting further energy use with renewable sources. Both on the CDC and across the NCH site, more than 120 solar panels have been installed, which contribute towards a minimum of 46% on-site energy generation for the building This is also supported by heat pumps that will provide heating and cooling to the building year-round.

The Suffolk and North East Essex Integrated Care System's (SNEE ICS) strategy aims to meet the changing needs of our population by supporting our communities to remain in good health while providing swift access to high quality healthcare for all who need it. Like much of the country, our health and care system is operating under significant pressure in the face of increasing demand and a challenging financial environment. There is a need now to identify opportunities to strengthen the delivery of swift access for our population to high quality services when and where people need them.

To support this ambition, the Trust is working closely with the Suffolk and North East Essex Integrated Care Board (ICB) and the East Suffolk and North Essex NHS Foundation Trust (ESNEFT) to complete a system Sustainability Review into local NHS acute and community health services. This will help local NHS organisations, and our partners consider how to deliver a 'future shift' of resources into primary and community services while improving the clinical and financial sustainability of the system overall. This review aligns to the Government's 10-year plan expected to be published later this year, which will focus on moving from: hospital to community, analogue to digital and treatment to prevention. It is expected to last for four months and will be supported by an external partner, and leaders from across our organisations. The Trust is playing a leading role in the completion of this review to ensure we provide the best possible services for our local communities.

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

GOVERNOR BUSINESS (INC. STATUTORY DUTIES)

10. 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:	10
Date of the meeting:	26 February 2025
Sponsor/executive lead:	Non-Executive Directors / Governor observers at the Board's assurance committees
Report prepared by:	Chairs of the assurance committees Governor Observers at the assurance committees Richard Jones, Trust Secretary Pooja Sharma, Deputy Trust Secretary

Purpose of the report:

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

Executive summary:

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

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

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

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

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

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

INSIGHT COMMITTEE:

20 November 2024 (observed by Jane Skinner, Jayne Neal and John-Paul Holt)

- Report from sub-committees:
  - Financial Accountability Committee including Month 7 reporting, update following ICB extraordinary board meeting, 2025/26 emerging financial position and recommendations for reducing capital spend
  - Patient Access Governance Group including Quality Impact Assessment panel outcomes, EDI Monitoring of service delivery and waiting lists Deep Dive and patient surveillance outstanding actions
- IQPR - data for September 2024
- Escalations to and from other board assurance committees and board

18 December 2024 (observed by John-Paul Holt, Tom Murray and Jane Skinner)

- Report from sub-committees: Financial Accountability Committee and Patient Access Governance Group
- Quality Impact Assessment Panel Outcomes
- Month 8 reporting
- Financial Recovery update
- Estates & Facilities Review
- Board Assurance Framework - BAF 2 capacity (via Access) and BAF 7 financial sustainability (via FAC)
- IQPR – data for October 2024
- Corporate Risk Governance Group
- Final Submission – EPRR Core Standards
- Escalations to and from other board assurance committees and board
- Forward Plan

15 January 2025 (observed by Jane Skinner and Adam Musgrove)

- Report from sub-committees: Financial Accountability Committee and Patient Access Governance Group
- Month 9 Reporting
- Control Total Reset Proposal
- Outcome of Self Evaluation Process
- Quality Impact Assessment Panel Outcomes
- Environmental Sustainability
- Corporate Risk Governance Group
- IQPR - data for November 2024
- Board Assurance Framework - BAF 7 financial sustainability (via FAC), BAF 2 capacity (via Access) from December meeting
- Internal Audit Report
- Escalations to and from other board assurance committees and board
- Forward Plan

IMPROVEMENT COMMITTEE:

20 November 2024 (observed by Anna Conochie and Jane Skinner)

- Reports from governance sub-groups: Patient Quality & Safety, Clinical Effectiveness and Transfer of Care Group report

- Quality & patient safety insight: Quality & safety datasets, IQPR, PRM packs, and agree any areas requiring assurance review
- Quality priorities, improvement, and assurance - CQC single assessment framework - end of life and Maternity report, including post-partum haemorrhage
- Risk Management and Governance - Board assurance framework - review of governance BAF risk
- Escalations to and from other board assurance committees and board

18 December 2024 (observed by Tom Murray and Jane Skinner)

- Reports from governance sub-groups: Patient Quality & Safety, Clinical Effectiveness Governance Group report
- Quality & patient safety insight: Quality & safety datasets, IQPR, PRM packs
- Quality priorities, improvement, and assurance - Deep Dive: PSIRF and Pharmacy - drug storage in ED next to Omnicell, maternity report
- Risk Management and Governance
- Board assurance framework - review of governance BAF risk 4 Transformation
- BLS training update
- Escalations to and from other board assurance committees and board

15 January 2025 (observed by Sue Kingston and Jane Skinner)

- Reports from governance sub-groups: Patient Quality & Safety, Clinical Effectiveness Governance Group report
- Quality & patient safety insight: Quality & safety datasets, IQPR, PRM packs, C-difficile – update and agree any areas requiring assurance review
- Quality priorities, improvement, and assurance - Deep Dive – Shared Decision Making, CQC single assessment framework, Implementation of external reporting pathway update and Maternity report
- Risk Management and Governance - Terms of Reference - annual review and Update on divisional governance review
- Board assurance framework - BAF review forward plan update and BAF 8 Governance – Jan 2025
- Escalations to and from other board assurance committees and board

INVOLVEMENT COMMITTEE:

18 December 2024 (observed by Becky Poynter and Sue Kingston)

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

First for staff:

- Pulse survey data review 2021-2024
- Sexual Safety in the workplace
- Staff Wellbeing workplan

First for patients:

- Publication and maintenance of patient information leaflets
- Latest CQC patient survey results (maternity / UEC)
- Adult Inpatient establishment review 2024

Governance:

- Experience of Care and Engagement Committee report
- Collaboration BAF
- Patient Engagement BAF
- Terms of Reference – annual review

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
- Correspondence / concerns from staff governors

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)

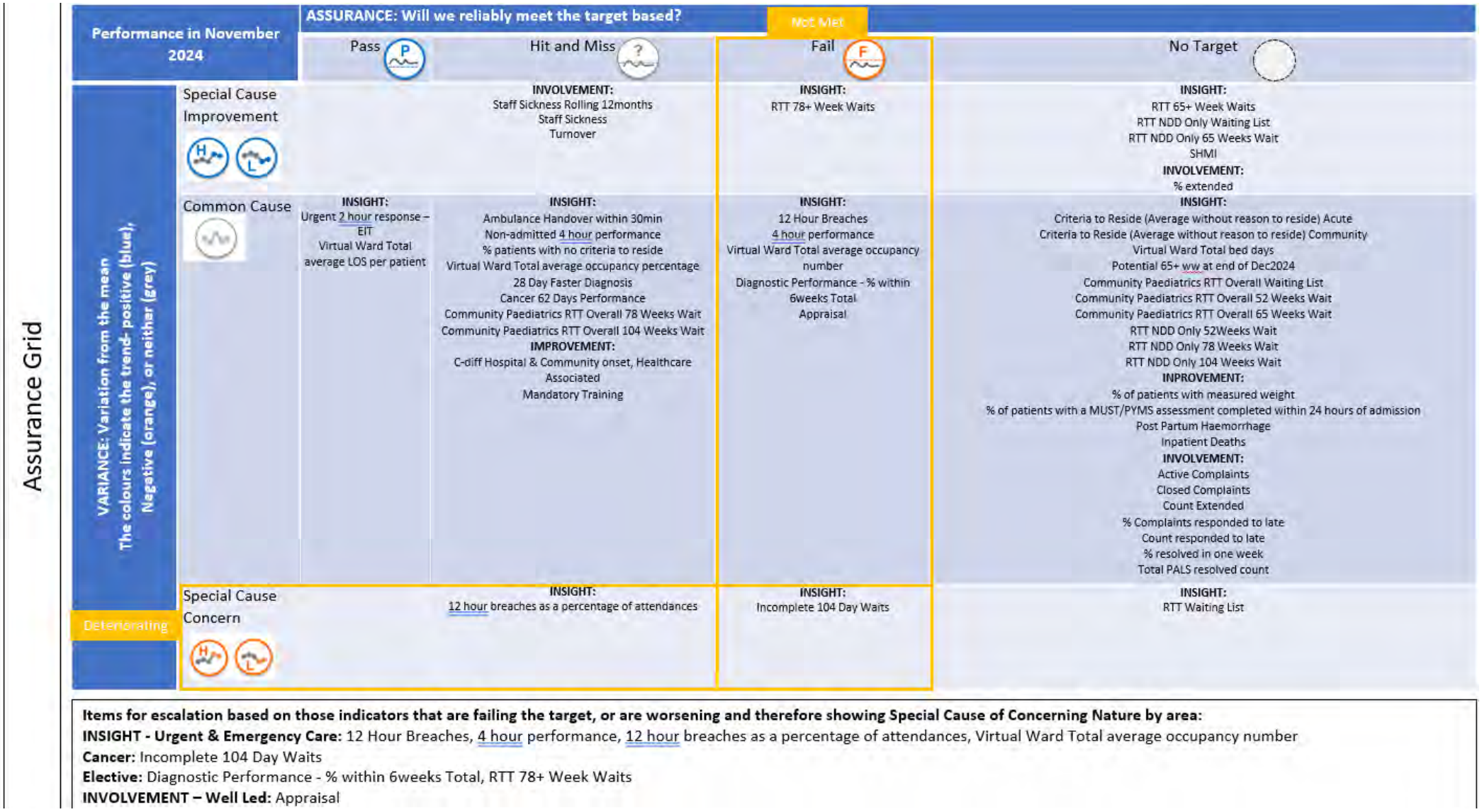
The items reported through this report will be actioned through the appropriate routes.

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



10.1. Insight Committee

Presented by Antoinette Jackson

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			Date of meeting: 15 January 2025		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
PAAG/IQPR	**Elective Recovery** The cohort of elective patients waiting 65 weeks or more is reducing, however the provisional December month end position is 109 patients over 65 weeks, and as of 8 January 2025 this stands at 118 patients, of which 90 are capacity breaches.	**3 Partial**	Elective long wait trajectories are being reforecast to deliver zero 65 week waits by the end of March 2025 at the latest. Dermatology are expected to meet this threshold by 02 March 2025, with gynaecology by 30 March 2025. The latter assumes additional theatre capacity and surgical activity of four cases per week can be delivered alongside the continuation of activity being delivered by Nuffield Health.	As a result of our elective and diagnostic performance we have been placed into 'Tier 2' nationally, with fortnightly meetings including WSFT, SNEE ICB and the NHS England East of England regional team to agree recovery actions and trajectories for the elective specialties and diagnostic modalities that are driving underperformance. Regional intervention will stay in place until the Trust reaches zero 65 week waits and stays there for a whole quarter.	3. Escalate to Board

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PAAG/IQPR	**Diagnostics** Diagnostic performance against the 6-week standard is expected to be c.80% in March 2025, against the expectation of 95% compliance. Current levels of activity do not support this ambition, and although the opening of the Newmarket CDC in late 2024 will see the modelled step change increase in imaging performance delivered, delays to the DEXA service relocation, non-obstetric ultrasound and levels of endoscopy activity will need to be addressed to regain compliance.	**3 Partial**	Longer waiting times for diagnosis and treatment have a detrimental effect on patients.	As a result of our elective and diagnostic performance we have been placed into 'Tier 2' nationally, with fortnightly meetings including WSFT, SNEE ICB and the NHS England East of England regional team to agree recovery actions and trajectories for the elective specialties and diagnostic modalities that are driving underperformance.	*3.Escalate to Board*

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PAAG/IQPR	**Urgent and Emergency Care** Ambulance handovers within 30 min and non-admitted 4-hour performance are not reliably hitting target, The overall four-hour performance trajectory was missed again in November with the same performance as October, 64.8% against a plan of 74%.	**3 Partial**	Not meeting urgent and emergency standards means some patients are waiting longer in the Emergency Department than they should be and being nursed in escalation areas which makes for a poor patient experience.	Recovery against the 4-hour UEC trajectory needs to ensure improvement initiatives are delivering expected benefits, alongside robust daily management of performance expectations. The UEC delivery plan has been revised and is being supported the fortnightly UEC Delivery Group and weekly Emergency Department leadership meetings, reporting to the monthly West Suffolk Alliance Operational Group.	3 Escalate to Board

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IQPR/PAAG	**Cancer Faster Diagnosis (FDS) Targets** Cancer Faster Diagnosis Standard performance has not consistently met the 75% target in any month of 2024/25, with a further month of consecutive decline in October, projected to continue into November though with recovery on the breast pathway being demonstrated in December.	**3 Partial**	Achieving the FDS target of 77% and a 62-day performance of 70% by March 2025 are the key objectives for cancer in 2024/25 planning. Under performance has largely been driven by activity not keeping pace with demand in the high-volume breast and skin pathways. Breast clinic activity has reduced due to radiographer shortages and fewer shifts from external bank staff The skin pathway has been impacted by increases in demand across the summer, ceasing of insourcing and sickness within the photography team for the teledermatology service provided as part of the pathway	Improving radiological support to suspected breast cancer clinics, will be a key area of focus, alongside the plan to deliver more dermatology activity for the suspected cancer pathway alongside elective long waits. It is expected that FDS performance will increase from December with one-stop breast clinics being booked within 28 days once more.	3. Escalate to Board

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Reforming elective care for patients	On 06 January 2025, NHS England and the Department of Health and Social Care published the plan "Reforming elective care for patients". This plan sets out a commitment to the constitutional standard of 92% of patients waiting less than 18 weeks by March 2029, with an interim milestone of 65% by March 2026. As of 5 January 2025, WSFT's performance is 55.95%.	**For information**	The plan includes 75 actions and recommendations to be delivered by NHS England, Integrated Care Boards, primary care and providers of elective services, across four domains: • empowering patients • reforming delivery • delivering care in the right place • aligning funding, performance oversight and delivery standards.	An action plan in response to the document will be developed alongside the national operational planning guidance when this is published. This will enable Insight Committee to assess the risk to delivery and assess overall levels of assurance.	3 Escalate to Board for information

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Finance Accountability Committee	**Month 9 and Financial Recovery** The financial recovery plan (FRP) forecasts a deficit of £28.5m. During December the Trust was able to recognise a significant improvement in Elective Recovery Fund (ERF) income which has resulted in a £1.5m improvement in the year-to-date position. The in-month position is a run rate deficit of £0.5m which includes adjustments to ERF year to date of c £1.3m. The underlying deficit in December is £1.8m. The trust is £91k better than the anticipated FRP trajectory in month, on an underlying basis	**2 Reasonable**	The Trust is optimistic that it will exceed its 'likely case' outturn position as presented in the FRP and are now forecasting a deficit of £26.5m. This revised forecast remains challenging and has some risks. However, the focus remains on ensuring that the exit monthly run rate for the year is in line with the original plan at £1.3m deficit per month. This exit rate for 24/25 is important in determining the start position for the 25/26 plan. The FRP aims to improve our recurring run rate as we plan for 25-26 and therefore all recurring savings made in 24-25 will help ensure a robust plan to improve our financial position for 25-26.	Work continues on the development of the Financial Recovery Plan for 2025/26 An update on progress will be reported to the January 2025 Board meeting.	3.Escalate to Board

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	The combined efficiency schemes were planned to deliver £10.2m YTD with actual delivery of £13.5m YTD, a favourable variance of £3.3m YTD. The cash position remains critical and the Trust has put in an application for a further £15.5m of revenue (deficit) support for quarter 4.				

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Control Total reset	Following a review conducted jointly by the ICB and Regional finance teams, SNEE ICB wrote to the chief executive with a proposal to formally re-set WSFT's 2024/25 control total to £26.5m for the year, from the original £15.3m plan. The letter also outlined a number of further mitigations or conditions to the offer which the board were asked to accept in order to reach agreement on the re-set. Because of timing issues in relation to the ICB's meetings Insight Committee was making a decision on behalf of the Board and the meeting was attended by the Chair and some other members of the Board for this item.	**2 Reasonable**	Given the improved performance in month 9 described above the Committee agreed that the Trust should accept the proposals as outlined, and agreed a draft response to be sent from the CEO to the ICB. The key components were to accept a control total of £26.5 m for 24/25 and to aim to exit 2024/25 at a run rate deficit of £1.3m per month. This was caveated by the current financial uncertainty nationally about the future of ERF funding. The Board could not commit to final targets for 25/26 until further information on operational planning guidance is available and the 25/26 budget can be considered by the Board.	The Chief Executive has written to the ICB with the Committee's decision, and they will consider the response at their next Board meeting.	3. Escalate to Board for information

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Deep Dive Environmental Sustainability	The Committee received a presentation on the work the Trust was undertaking on Environmental Sustainability. The NHS produces around 20 million tonnes of carbon a year (5.4% of the UK's total carbon emissions). There are two targets the NHS much achieve: For the emissions it can control, the NHS must reach net zero by 2040, with the ambition to reach an 80% reduction by 2028-2033 For the emissions it can only influence, the NHS must reach net zero by 2045, with an ambition to reach an 85% reduction by 2036-2039 (both from a 1990 baseline). As an NHS Trust we must support these targets, and we demonstrate our commitment to them through our Green Plan.	**1 Substantial**	The Trusts current Green Plan runs from 2021-2025. There are 9 key focus areas: Workforce and System Leadership • Sustainable Models of Care •Digital Transformation • Travel and Transport • Estates and Facilities • Medicines • Supply chain and Procurement • Food and Nutrition • Adaptation Progress has been made in many areas with the most recent example being the Community diagnostic centre in Newmarket, which saved 238 tonnes of carbon in the construction. Photo-voltaic and heat pump technologies are contributing to 45% of the building energy requirements and 100% of electricity is from renewable electricity supply.	The Green Plan will be updated during 2025. The Committee noted that there had been limited focus on this work at Board and Assurance Committees. In future the Sustainability Net Zero Steering Group (SNZSG) will be reporting into Insight twice a year. The Group is responsible for the delivery of plans designed to achieve the Net Zero target for the NHS and addressing any gaps; and acts in an advisory capacity to the wider organisation.	

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BAF Risk 7	The committee considered an updated version of BAF risk 7 which deals with financial sustainability and BAF risk 2 which relates to organisational capacity Success in managing this risk is also linked to other risks on the risk register including those relating to capability and transformation.	**3. Partial**	There is still work to be done to finalise risks scores and mitigating actions and currently both risks are higher than the Board's risk appetite.	A further report to Board is needed on the updated risk and mitigations so the Board can consider this and its associated risk appetite. There is also a need to consider how we report and consider the interdependency between risks. Some mitigating actions are being reported elsewhere, when another assurance committee owns that particular risk. This makes it harder to understand what assurance is in place. The Trust Secretary will give further thought to how we best report these interdependencies.	3. Escalate to Board

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Internal Audit Update	The Committee considered items on the Internal audit plan which were relevant to the Committee's remit. One new report has been issued on Key Financial Controls - Creditors Review. This had been given reasonable assurance.	**2. Reasonable**	The Head of Internal audit's opinion for 23-24 stated that "The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance, and internal control to ensure that it remains adequate and effective." The Internal Audit Plan provides some external assurance for the Insight Committee on those issues where internal audits have been undertaken.	The Committee noted that much progress had been made on business continuity planning, but escalated to the Audit Committee the number of outstanding actions that still existed in relation to business continuity plans.	3. Escalate to the Audit Committee

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.

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PAAG/IQPR	**Elective Recovery** The cohort of elective patients waiting 65 weeks or more is reducing. As of the week ending 6th December, Orthopaedics were 63 patients ahead of trajectory, supported by ESEOC activity. Gynaecology had an unmitigated position of 43 (reduced from 72) patients, and dermatology 34 (reduced from 62).	**3 Partial**	Even with additional activity in gynaecology and dermatology the deadline of zero patients by 22 December 2024 is at risk. The forecast is dermatology to achieve target by February 25 and gynaecology by the end of March 25.	Tier two meetings have been held with NHS East of England to discuss the mitigations plans for 65 week waits and diagnostics and a recovery plan is in place. The ICB representative present at the Insight meeting noted the good working between the Trust and the ICB on these issues. Regional intervention will stay in place until the Trust reaches zero 65 week waits and stays there for a whole quarter.	3. Escalate to Board

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PAAG/IQPR	**Diagnostics** November performance is forecast as 55.73% which is lower than October performance, All modalities except cardiology are currently underperforming. March 2025 compliance is predicted to be around 80.0% against the performance expectation of 95.0%.	**3 Partial**	Imaging modalities will see a step change increase in performance when Community Diagnostic Centre (CDC) activity commences by the end of 2024 To achieve the performance target additional activity is required in endoscopy (which will not benefit from the CDC), DEXA (which has impacted by delays to bring the service back in house following cessation of external provider provision) and non-obstetric ultrasound. These will cause costs pressures which will need to be evaluated and approved by WSFT and SNEE ICB as part of the financial double lock arrangement.	Diagnostic performance is included in regional Tier 2 meetings. There are no specific exit criteria for diagnostics, elective performance will determine the removal of intervention from region (see above).	3.Escalate to Board

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PAAG/IQPR	**Urgent and Emergency Care** Ambulance handovers within 30 min and non-admitted 4-hour performance are still not reliably hitting target. Ambulance handovers within 30 mins reduced to 65% against target of 95%. 4-hour performance dropped below the Trusts in-month trajectory of 73% to 64.7%. 12-hour waits have increased to 10.9% in October against a target of 2% and this remains an area of concern. Acute patients not meeting criteria to reside at 11.3% against target of 10%, however discharge delays remain low (average time to discharge is consistently less than 1 day).	3 Partial	Not meeting urgent and emergency standards means some patients are waiting longer in the Emergency Department than they should be and being nursed in escalation areas which makes for a poor patient experience.	The Committee considered the detailed recovery plan agreed with the West Suffolk Alliance Operational Group. The plan focuses on actions with the most significant impact to regain progress against the 4-hour trajectory. 4-hour performance is heavily correlated to both ambulance handover and 12-hour performance, indicating that actions focused on 4-hour will enable delivery of all three.	3 Escalate to Board

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	Urgent Community Response 2-hour performance increased to 95.4% and the target is consistently met, however activity has reached capacity.				

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IQPR/PAAG	**Cancer Faster Diagnosis (FDS) Targets** Cancer FDS performance decreased further in October (reporting one month in arrears) – driven by breast and skin pathways not delivering sufficient activity to meet demand. Additional radiologist cover for breast clinics approved by the Management Executive Group (MEG) means appointment times are now less than 28 days.	**3 Partial**	Achieving the FDS target of 77% and a 62-day performance of 70% by March 2025 are the key objectives for cancer in 2024/25 planning.	Additional skin activity to reduce backlogs and meet demand will be planned alongside elective activity, with a system wide pathway review meeting being held in early December – focussed on teledermatology image taking and straight to surgery pathways. FDS performance is predicted to decrease further in October given the high volume and proportion of breast and skin pathways but should begin to improve in November.	3. Escalate to Board

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Finance Accountability Committee	**Month 8 -** the Trust was £2m ahead of its revised savings plan for the year, and ahead of its Financial Recovery plan (FRP) trajectory. Workforce savings are being demonstrated with the trust having 92 fewer whole time equivalent (WTE) staff in November than in April. YTD capital spend is behind plan, mainly due delayed expenditure on RAAC projects, Newmarket CDC and general estates projects. There is likely to be a underspend by year end of £1m. The Trust's cash position remains critical and the committee approved an application for a further £15.5m of revenue (deficit) support for quarter 4.	**2 Reasonable**	There is increasing confidence of the Trust achieving its 'likely case' outturn position of £28.5m, and work continues to seek to reduce the deficit further	Work continues on the development of the Financial Recovery Plan – see below. An update on progress will be reported to the January 2025 Board meeting	3.Esclate to Board

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	Financial Recovery 2025/26 Detailed recovery programmes are being developed to ensure a focus on 25/26 recovery. These are being developed across three themes: Productivity; Workforce; and Estates, Corporate and Non-Pay. Each workstream will have an identified target supported by detailed workstreams. Progress is being made on the corporate review with a phased approach in place. Areas with the largest benchmarked opportunity (IT, Finance) being targeted for implementation by April 2025. Remaining areas are targeted for October 2025.	**3. Partial**	It will be critical to the recovery that these programmes start as early as possible to ensure we see the full year effect of them.	The remaining PA commissioned support is now focusing on assisting the delivery of these workstreams, and the development of further, smaller, workstreams. Further information will be reported to the Board in January which will give greater understanding of Levels of assurance for FRP delivery.	3. Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 18 December 2024		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			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
BAF Risk 7	The committee considered an updated version of BAF risk 7 which deals with financial sustainability. Success in managing this risk is also linked to other risks on the risk register including those relating to capacity and transformation.	**3. Partial**	There is still work to be done to finalise risks scores and mitigating actions and currently the risk is higher than the Board risk appetite for this risk which is cautious.	A further report to Board is needed on the updated risk and mitigations so the Board can consider this and its associated risk appetite.	3. Escalate to Board

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Estates and Facilities Deep dive	The Committee had requested a deep dive into the benchmarking data for the Estates and Facilities service and where future quality efficiency measures should be focused. It was clear that the way data is collected nationally has some inconsistencies in reporting so some measures were less reliable than others.		The data highlighted that the Trust should review portering and domestic services, the latter is complete, and the former will be complete shortly. Interventions are in-place to support cost reduction in Linen and Laundry although the delay to the introduction of new scrubs has impacted on progress in this area.	Work will continue with ESNEFT to compare approaches and to identify opportunities for joint working. This will include a workshop to compare definitions and data collection to ensure good practice and consistency. An action plan will be developed to tackle further opportunities for efficiency and cost reduction. Chris Todd will make contact with the national team to discuss the underlying discrepancies in the data and what can be done to improve the validity of the data set for accurate benchmarking.	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.

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			Date of meeting: 20 November 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:** **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
IQPR/PAGG	**Glemsford Surgery** The Committee had previously expressed concern about the lack of data on Glemsford performance. Data is now available via the ICB, showing that 77.9% of appointments are within the headline 2-week standard 40.36% are within 48 hours.	**2 Reasonable**	There has been limited data available previously to measure performance	It will now be possible to track performance	1. no escalation

Originating Committee: Insight Committee			Date of meeting: 20 November 2024		
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PAAG/IQPR	**Urgent and Emergency Care** No indicators are on target except Urgent Community 2 hour response, and most indictors have got worse. 4-hour performance October 24 forecast 64.8% against trajectory of 73%. (compared to 67.7% in September) 12-hour waits have increased since August as a % of attendances – 9.2% against a target of 2% Ambulance handovers within 30 mins at 79.7% against target of 95%. This decreased from last month, but remains one of the top regional performers.	4 Minimal	Not meeting urgent and emergency standards means some patients are waiting longer in the Emergency Department than they should be and being nursed in escalation areas which makes for a poor patient experience. The Minor Emergency Care Unit opened on 14 October 2024 but it is too early to see the impact of this. There is variation in non-admitted performance day to day and overnight.	The West Suffolk Alliance Operational Group (UEC) agreed the WSFT UEC Delivery Group plan being revised to focus on 3-4 actions with the most significant impact to regain progress against the 4-hour trajectory. This will include looking at the underlying cause of variations in performance. The current focus for Early Intervention Team is on supporting the Emergency Department and building the team's resilience	3 Escalate to Board

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Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
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	Acute patients not meeting criteria to reside at 11.3% against target of 10%, however discharge delays remain low (average time to discharge is consistently less than 1 day). Urgent Community Response 2-hour performance increased to 95.4% and the target is consistently met, however activity has reached capacity.				

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IQPR/PAAG	**Cancer Faster Diagnosis (FDS) Targets** Cancer FDS performance decreased further in August (reporting is one month in arrears) – driven by breast and skin pathways not delivering sufficient activity to meet demand. Additional radiologist cover for breast clinics was approved however uptake of sessions has been low.	**4 Minimal**	Achieving the FDS target of 77% and a 62-day performance of 70% by March 2025 are the key objectives for cancer in 2024/25 planning.	Skin activity will be planned alongside elective activity, with a system wide pathway review meeting being held in early December – focussed on teledermatology image taking and straight to surgery pathways. FDS performance is predicted to decrease further in September and October given the high volume and proportion of breast and skin pathways.	3. Escalate to Board

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Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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	Elective The deadline to meet zero patients waiting 65 weeks at the end of September was missed by 192 patients, with largest cohorts in orthopaedics and gynaecology. 72 patients in Gynaecology and 62 in dermatology require treatment plans and this will require delivering additional activity either in-house or externally The volume of patients over 78 weeks has reduced this month. The total waiting list remains high, but has stabilised, and does not appear to be continuing to rise.	**3 Partial**	There is a lack of external assurance for these services. Delivering the objective of no patients waiting over 65 weeks by September 2024 is the central focus of 2024/25 planning, – as patients are at increased risk of harm and/or deteriorating the longer they wait. This increases demand on primary and urgent and emergency care services.	Orthopaedics are planning to meet the revised deadline of 22 December, supported by additional ESEOC activity from November. Gynaecology will expand elective inpatient activity through weekend lists, with the potential for further increase should the inpatient bed base be reconfigured as part of ESEOC backfill. Skin activity will be planned alongside elective activity, with a system wide pathway review meeting being held in early December – focussed on teledermatology image taking and straight to surgery pathways.	

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	Diagnostics September performance was 65.03%, with an October forecast of 57.05%. All services except urodynamics and cardiology are currently underperforming. Current March 2025 compliance is predicted to be around 80.0% against the performance expectation of 95.0%.	**4. Minimal**	Delayed diagnosis impacts on patient treatments. There is a lack of external assurance for these services. Following the latest review of national tiering of providers, WSFT have been placed into Tier 2 for elective and diagnostic performance. This will require fortnightly meetings with the NHSE regional team to develop and agree a targeted action plan for recovery	Imaging services will see step change increase in performance when Community Diagnostic Centre activity begins at the end of 2024. Additional activity is required in endoscopy and DEXA to regain progress against 95% target. However, this will represent a cost pressure. Endoscopy will not benefit from the CDC and DEXA (bone density scanning) is impacted by delays to bring the service back in house following cessation of external provider provision. Recovery plans will be developed with the NHSE regional team.	3. Escalate to Board

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Deep Dive **Health inequalities in Elective Access**	WSFT data has been reviewed via the SNEE ICB's 'Strategic Programmes Elective and Diagnostic Committee'. To date this has demonstrated that there is no statistically significant difference in either deprivation or ethnicity data. In more recent data, there had looked to be a difference in the ethnicity data, however further analysis of the waiting list suggested this was due to the very small numbers of patients in minority ethnic groups. There are 15% of patients on the list where ethnicity is not recorded and this needs addressing to give fuller assurance. It was noted that Equality Impact Assessments (EQIAs) should be completed as part of Trust decision making.	**2. Reasonable**	Inclusivity and fairness are core values for the Trust. By taking a comprehensive and inclusive approach, the Trust can significantly reduce health disparities and improve patient outcomes.	Ethnicity, deprivation, age and gender are already agreed metrics that the Trust needs to measure and report. These will be reported through the IQPR going forward. Involvement Committee is due to receive a report on EQIAs. Agreed to escalate to the committee Insight's concern about how the Trust monitors the effectiveness of these. Action will be taken to improve the accuracy of data to provide assurance and enable improvements to be targeted appropriately. There continues to be an ongoing focus on capturing ethnicity at the point of care.	2. Escalate to Involvement Cttee

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Finance Accountability Group	In October the Trust was £18.9m in deficit against a planned deficit of £11m. This results in an adverse variance of £7.9m YTD. The October figures include the net cost of pay awards partially offset by increased Elective Recovery Fund income. The recurring run rate in October was around £100k better than in September and would have been £250k better without the pay award issue. This reduction in run rate is largely as a result in a drop in staffing numbers (73.5 WTEs in total during October). In October, the Board agreed a financial mitigation Recovery plan, which outlined a best-case outturn	**3 Partial**	WSFT's deficit impacts on the rest of SNEE ICB system partners. Some of the financial control measures put in place as part of the FRP are beginning to show a financial impact but some of this is slower than anticipated. Considerable risk remains, and the impact of junior doctor pay awards could worsen the position in month 8. The Committee discussed the need to maintain pace in the current year to ensure the Trust entered 25/26 in a good place. The importance of the 25/26 Budget plans and the need to consider options and choices was stressed.	The Quality Improvement panel evaluates budget proposals. The Committee asked for more information about the risks and impacts of approved schemes to help assurance. The budget plans for 25/26 will be discussed at the Board in November and January.	3 Escalate to Board

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	position of £25.5m, and a likely case of £28.5m. In month 7, the trust is £0.7m better than the anticipated FRP trajectory. For ease of monitoring and reporting the efficiencies from the revised CIP and FRP programmes have been combined. The combined schemes were planned to deliver £5.6m YTD (£19.8m full year), with actual delivery of £6.6m YTD, a favourable variance of £1.0m YTD. As the Trust continues to report a deficit, the cash position continues to deteriorate. To date, the Trust has received £9m in revenue (deficit) support across quarters 1 and 2 and £2.1m in working capital revenue				

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	support in quarter 3. The Trust originally asked for £17m of revenue support for quarter 3 and to date has only received £2.1m of this request.				

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Capital Programme	The original Capital Plan for 2024/25 was £44m. £11.99m will be internally funded, with the remaining £32m being funded by Public Dividend Capital (PDC). Further PDC of £7.4m has been awarded for the New Hospital Programme since the original Capital Plan was set along with £1.1m for a CT Scanner at Newmarket Community Diagnostic Centre. Because of the Trust's financial deficit the capital programme has been reviewed and schemes worth £1.4m have been removed from the 24/25 programme and reprofiled into 25/26.	**3. Partial**	Removing a number of capital schemes in the last half of 2024/25 and putting them into 2025/26 does not cause operational risk to the Trust. The Estates and Facilities Team have prioritised statutory compliance. The Digital Team have prioritised core Infrastructure and Cyber Security However simply moving the schemes back, causes an over commitment of £5.12m as the starting point for the 25/26 programme. This is unsustainable, so all schemes will need to be rigorously reviewed as part of 25/26 capital planning.	Capital panning for 2025/26 will begin in December.	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!
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What next? Exploring what should be **done next** (or not), informing **future** tactic / strategy, agreeing follow-up and future **evidence of impact**		• Recommendations for action • What impact are we intending to have and how will we know we've achieved it? • How will we hold ourselves accountable?

Assurance level

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Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 20 November 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*
• Full agenda with regular Finance and Operational matters discussed. • There was a paper and discussion concerning Equality, Diversity and Inclusion (EDI) monitoring of service delivery. The objective is the reduction of long waiting times and increasing access to healthcare services in order to improve health and social inequalities • The Capital Programme for 2024/25 was considered; some schemes are likely to be deferred until the next financial year
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• The meeting was well attended by NEDs and Executives • There was a good level of positive, respectful challenge with contributions from all attendees • Well Chaired with AJ summing up key points at the end of each agenda item • Trust values were demonstrated throughout
Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*

- Meeting financial targets continues to be of major concern but Governors can be assured that Insight Committee members have some assurance that trends are progressing in the right direction
- There is assurance that the long waits for diagnostic services will show improvements by the end of January 2025 after the new centre at Newmarket opens in December.

Governor observer Notes

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

- The discussions at this meeting demonstrated a good balance of how the financial and operational work areas overlap and the potential consequences of different courses of action
- The Committee confirmed that rigorous controls would continue after the 1 December, when considering business cases to fill priority posts. Divisions are making appropriate decisions to move staff across their work areas to avoid detrimental impact on patients

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 20 November 2024
Governor observer (observed by): Jane Skinner

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Long and full agenda as usual, this month operational papers came first to ensure fair time apportioned over finance which always generates discussion
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Well chaired with short over run, Chair demonstrates in depth understanding of the issues discussed and asks insightful questions. • Observer for reflection at meeting end appointed • Introductions made • Reflection: In depth discussion, good level of contribution, good challenge, positive environment, some cross over between operational and assurance
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 IQPR demonstrates, in the What, So What and What Next columns, a high level of analysis, oversight, prediction and action planning with regards to the data presented. Some IQPR data relates to July and this is November – eg ambulance handover, 12 hour breaches, diagnostic standard

- At COG a question was asked re Equality, or EDI impact assessments and whether they were done for changes in services due to CIPs and other cost controls? It was admitted that this was not always thought about but should be in future. Might go to Involvement for oversight.
- Comment from the Chair again about the limitations of the current QIA report. It is not possible to understand what the change is being assessed nor the risk. I wondered what level of risk was thought acceptable to the panel and whether this was an objective or subjective measure.

Governor observer Notes

- The committee was informed of several operational causes for concern:

The Trust is failing to meet important targets in ED, cancer and the deadline to have zero elective waits by end September. Orthopaedic patients will now be able to go to Colchester so reducing that element of long waits but there is a national problem with uro-gynae, of which Governors are aware.

- Virtual ward capacity reduced, relied on temporary staff now reduced.
- Escalation to Board re Tier 2 allocation (I didn't fully understand this)
- Full financial discussion much of confidential nature

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 20th November 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 today, including Deep Dive of Equality, Diversity & Inclusivity (EDI) Monitoring of Service Delivery & Waiting-Lists • Relevant papers were available in advance of the meeting, although some of the items on the agenda, were verbal updates only without any associated papers. • All items on the agenda were discussed and none were deferred to the next meeting.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• 4 NEDs in attendance today, plus the Chair of the Committee and the Trust Chairman. • New Medical Director was in attendance today, who was able to contribute to discussion well, despite only being in post for a short time. Was able to provide clarity to the new NEDs regarding national trends and schemes, particularly regarding Endoscopy & Radiology. • Thorough Reflections of the meeting provided by one of the newly recruited NEDs, who had been asked to do by the Committee Chair at the start of the meeting. • Constant reference to the wellbeing of staff and patients in all discussions. Reference made to the impact that decisions and current pressures are having on both staff and patients. • It was clear that the NEDs had taken on the concerns raised by the Staff Governors and questioned the Executive Members of the committee regarding these.

Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
• As part of today's Deep Dive, it was mentioned that 15% of patients registered in E-Care do not have an ethnicity recorded. Hope is for better reporting of characteristics via the new Patient Portal, though can the trust be more proactive in improving this. Attaining this information from the NHS Spine (Summary Care Record?) • ICB agree that the planned £28.5 Million deficit at the end of the financial year is accurate and achievable. NEDs feel they are getting assurance regarding this too.
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• Continued desire from Chair of the Committee and NEDs for increased visibility and transparency of decisions being made throughout the trust as part of the CIP Scheme. • Following today's Deep-Dive, there will now be regular reporting of Health Inequalities in Elective Access, to this committee.

Feedback from assurance committees: Governor observer report

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

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Not such a long agenda as usual; no time to read some items pre meeting as arrived on Convene late. • Monthly finance report presented including progress against recovery plan again confidential discussion and content
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Well Chaired as usual, introductions made, NED asked to lead reflections, slight over run • Attended by Trust Chair and 3 other NEDs. Trust values adhered to. • Elizabeth Maloney Director of Operations SNEE in attendance, contributed throughout ?to be regular attendee
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 Chair once again asked committee members whether or not sufficient information was provided in the QIA panel report for them to understand the details of the scheme being discussed. No support for more detail. Only 3 schemes quality assessed this time but the detail of the schemes remain unclear to me, assurance remains only that schemes are QI assessed. • Much detailed work, insight and oversight of financial position in evidence.

- Estates and facilities review – thorough but data collection, ERIC used nationally, said to be unreliable and have flawed methodology so benchmarking and data itself not accurate and “cannot be relied” upon!
- Concerns in operational report and IQPR metrics showing several required standards have not been achieved eg diagnostic performance, ED standards. Reports demonstrate the high level of work being done to mitigate and understand issues and to improve performance.

Governor observer Notes

- I feel concern regarding impacts of controls and restructuring on workforce morale.

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 18th December 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*
• Whilst still many points to be discussed in today's meeting, Agenda felt slightly lighter recent months. • Today's meeting included a review of Estates and Facilities, presented by Chris Todd, (Associate Director of Operations, Estates and Facilities.) • Relevant papers were available in advance of the meeting, with some updates being uploaded to Convene just before the start of the meeting. • All items discussed.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Aside from the Chair of the Committee and Trust Chairman, only 2 other NEDs in attendance today. • Elizabeth Moloney from the ICB was in attendance for today's meeting and was able to contribute to discussions throughout. I feel regular attendance by Elizabeth would be of great benefit to the committee. • Satisfaction from NEDs/Wider Committee that the level of explanation/detail in the QIA Panel report is now adequate. • Good contributions/reflections from NEDs regarding re-assessment of strategy of Financial Risk of BAF. • Fantastic end of meeting reflections by one of the newly appointed NEDs, who had been selected to do so by the Committee Chair. Mention made to collaborative working between Execs, also appreciation for ICB involvement in discussions.

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.*
• I felt there was a greater sense of assurance today of the collaborative working between the Trust and ICB on improving our financial situation. ICB representative pleased with the work that is currently being done and attitudes of Board in working to improve our financial position. • It was felt that there was adequate assurance from today's review of Estates and Facilities, including the identification of areas where potential savings could be made – these have mainly been drawn from comparison of our costings to other trusts, both within SNEE & further afield. However, there is further work to be done on assessing the potential impact of these savings. • There appears to be minimal assurance from the belief that if the trust improves in 4-Hour Performance within the Emergency Department, this will automatically provide subsequent positive improvements to other UEC Metrics within the IQPR, which we are currently consistently failing to meet.
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• Month-8 reported to have a "good month" in terms of finances. Sustained belief that we will meet the forecasted deficit of £28.5 million.

NHS
West Suffolk
NHS Foundation Trust

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date:18 December 2024
Governor observer (observed by): Tom Murray

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• With over 208 papers, I would have preferred a synopsis, then go into details,
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• The meeting was well chaired, however usual problems hearing as committee has its back to us and we struggle to hear. I am afraid I will not attend these meetings again unless its an emergency, as I feel I'm missing to much.
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.*
• I was pleased to hear the financial recovery programme being explained in some detail.
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• Concerns were raised about how inflation has affected so much of the hospital budget including food, costs. • I was concerned after the meeting with government changes to national insurance and even work rules how the insight committee can investigate these outcomes fairly, in light of patients and staff.

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 15 January 2025
Governor observer (observed by): Adam Musgrove

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Nice that it wasn't solely financially focused • Timing of meeting and guests arriving was perfect
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Nice selection of questioning from a range of NEDS on the finances. • Chair asked for comparable data and not just accepted data given
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.*
• Would have liked stronger assurances about the target of 1.3m being saved. It came across more of we will tell ICB we will get to 1.3m and hopefully get away with it • Just an acceptance on the net zero presentation. Would have been nice to have questioned how their data is acquired. I'm working on a printing reduction project that will reduce the printing, reduce the paper used and will reduce the amount of paper being shredded and collected. Three different elements to go green and I have no idea how or if I should let them know. Thought someone might have asked how future projects are going to liaise with the group.
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*

- Enjoyed the time saving element of the chair nominating an observer for trust values.

Feedback from assurance committees: Governor observer report

Board assurance committee: Insight
Meeting date: 15 January 2025
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*
• The Gov' document on "Reforming Elective Care for Patients" was included in the pack, yet to be fully understood and actioned • Operational and financial reports presented, all very thorough
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Well Chaired as usual, introductions made, Exec Director volunteered to lead reflections, some voices are very quiet. Finished on time. • All Board members had been invited to this meeting where approval re a response to the ICB was required on a financial target. There was good attendance by NEDS, 6, and by Trust Chair. • Trust values adhered to, good challenge, assurance focus and engagement. Good news presentation on the Trust Green initiatives.
Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*

• Discussion on MECU and whether it has made a difference. Said to be difficult to spot the input, temporary arrangement which could be revised and utilization expanded and extended beyond trial. • The QIA report once again lacked detail and contained information incomprehensible to non NHS staff eg SAMBA

10.2. Involvement Committee

NHS West Suffolk NHS Foundation Trust

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Improvement Committee			**Date of meeting: 15 January 2025**		
Chaired by: Roger Petter			**Lead Executive Director: Susan Wilkinson, Richard Goodwin**		
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 **PQSGG**	**<u>Nutrition Steering Group</u>** Must Risk Assessment <24 hrs	3	Improvements seen, moving from special cause concern to common cause variation. This allows timely intervention / referral.	Impact of early assessment in ED being reviewed. Ongoing 'food as medicine' QI programme. Ward managers monitoring performance.	1
	Insufficient staff able to operate Cortrak machine for placement of enteral feed tubes	2	Equipment uses electromagnetic sensing so fewer Xrays and more effective placement. Issue when nutrition nurse unavailable.	Gastro registrars may be trained, but with their turnover this may not be justified. ITU staff have been trained.	
	Patients requiring parenteral nutrition cared for on designated wards (eg gastro and surgical)	2	Small audit suggests that safety & monitoring is much improved	Continued audits will be performed. ECare recording of PN should help compliance.	
5.1 **PQSGG**	**<u>Trauma Group</u>** areas requiring improvement: Level 2 trauma training for ED nurses (currently all Level 1);	3	Trauma peer review is expected summer 2025. WSFT is a designated trauma unit and part of EoE trauma network.	Trauma network aiming to increase nurse training, so training level should improve.	1

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	No trauma coordinator at WSFT; Performing and reporting of trauma CTs within 1 hour both require improvement; M&M review of all trauma deaths			May recruit trauma coordinator by summer 2025, but funding will be an issue (business case in progress). QI in place for CT scanning. M&M reviews - data requested for next PQSGG.	
5.1 **PQSGG**	**<u>Infection Prevention Cttee</u>** C diff M pox FFP3 Fit test training	 3 2 3	 Rates in common cause variation. A high consequence infectious disease (HCID) Training delivery not at adequate level.	 QI programme relaunch Nov 24-Jan 25. Collaborative project underway with ICB focussing on high incidence areas. Working group established, looking at risk assessment, pathways & PPE. PPE in stock, and outstanding training for use has been escalated. Future delivery being explored by execs, within current budget	1

Originating Committee: Improvement Committee			Date of meeting: 15 January 2025		
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5.1 PQSGG	**Falls Steering Group** Falls data improving Lighting at night may contribute to falls of frail patients	 1 2	Falls incidence and falls per 1000 bed days improving. Falls with severe harm data shows WSFT below national average. Emphasis on falls with harm rather than just numbers.	Falls lead working with Estates and will submit bid to MyWish to see if they will help fund improvements to lighting. Some work to be done re falls with frailty and functional assessments.	1
5.1 PQSGG	**Pressure Ulcer Prevention Group** New acute pressure ulcers in common cause variation. Pressure Ulcer evaluation tool (PURPOSE-T) now embedded following training. Concerns over community staffing levels in TVN team	 2 1 3	PURPOSE-T supports nurse decision making and also identifies those with previous ulcers requiring input Reduced admin support has affected clinical time available due to performing admin tasks	Continued compliance with recruitment restrictions	1
5.1 PQSGG	**Drugs & Therapeutics**				1

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	Medication incidents now at similar level to pre-RADAR	1	Initial decline with RADAR as anticipated	Monthly audit to continue	
	Naloxone safety audit completed	2	Most use appropriate (for opioid side effects or to treat overdose). 10% cases may have had avoidable harm	Findings to be shared and used in new Sedation Committee	
	Omnicell cabinets introduced in ED	1	Increased governance and safety	To monitor for quality and safety impact in ED	
5.1	**<u>Patient Safety</u>** Patient Safety and Quality quarterly report presented	1	Reporting back to pre-RADAR levels; % of incidents resulting in harm is reducing; 92% staff completed patient safety level 1 training; compliance with DoC remains in common cause variation.	Consider sharing report wider. In general, reporting is high and harms are low, which is good.	1
	Learning outcomes from the RADAR form were assessed	1	Some incidents presented a challenge when assessed with the HSSIB tool.	Audit to be repeated in Q3	

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			Evidence suggests the avoidance of blame language, indicating a positive safety culture.		
5.2 **CEGG**	**Microbiology Accreditation**	2	Microbiology has a surveillance programme in place. Challenges include: new revision of standards, current condition of containment level 3 room, staffing issues for OOH, reduction of SAMBA services, rejection of orders	Most of the challenges can be met within the department	1
5.2 **CEGG**	**NICE**	3	14 guidance documents reviewed and 4 had areas of non-compliance requiring action: Improvement projects focusing on shared decision making; updates to urinary incontinence pathways; review of jaundice guidelines; cost evaluation of phototherapy monitoring devices	NICE guidance assessments are being prioritised. Use of RADAR to streamline recording is to be assessed. Two active clinical risks were identified and the impact of these needs to be evaluated.	3

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5.2 **CEGG**	**Research & Development**	1	R&D performance report for 2023/24 provided assurance of compliance with statutory obligations.	Targeted initiatives will continue to build research capacity, and commercial research will be explored. Engagement and relationships with key partners will be strengthened. It was agreed that more oversight and visibility of R&D is needed (? a deep dive or develop R&D strategy)	1
6.1 6.2	**Integrated Quality and Performance Report (IQPR)** Including **Performance Review Meetings (PRM Packs)**	2 2 2	C diff data - November rates fell but remain in common cause variation due to the multiple factors involved. Nutritional assessments within 24 hours in common cause variation. ED pressures affect completion and screening tool continues to identify highest risk. Post-partum Haemorrhage (>1500 ml) - ongoing quality improvement. Nov data shows	Remains an organisation key priority. QIP in progress. Collaborative research with ICB focussing on high incident areas. ED short assessments will continue to be monitored and reviewed. Incidents relating to nutritional intake or support will be monitored. Work following the 'Food as Medicine" workshop is in progress.	1

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		1	normal variation (3 cases). Primary cause a combination of trauma and poor tone. Ongoing implications for mother, baby, family, staff and organisation. The number of Patient Safety Incidents (PSI) and reportable occurrences (RO) remain stable. We are reporting low harm and near-miss events, indicating safe care. SHMI data shows we currently have fewer deaths than expected for our demographic	Ongoing QI programme. Engagement with local and regional QI programmes. Best methods of supporting both parents are being evaluated. This month there has been an increase in incidents relating to nutrition and a reduction in medication incidents. Monthly reports are used to support clinical teams. This is a good indicator of safe care.	
7.1	**Deep Dive: Shared Decision Making**	2	Very helpful presentation on the process by which patient, family, doctors and nurses make shared decisions. Required by GMC, LMC, NHSE, CQC. Mandatory training in place. Roll out to ACPs, nurses and midwives due	Guidelines for CYP and adults without capacity are nearing completion. Future work on guidelines for EOLC, with anticipated benefits for patients and the Trust. Outcomes will	1

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			April 2025. Trust's guidelines for adults with capacity are in place.	need to be assessed and there are various ways of doing so	
7.2	**Implementation of External Reporting Pathway - update**	2	Incident reporting to external regulators should be timely, accurate, owned (executive and subject matter expert leads), and improvement focussed. Currently in pilot, with phase 2 about to begin.	Clear flow charts in place. Phase 2 to use RIDDOR and SNOW and further reviews + phase 3 after that. It was agreed this should be embedded and we should proceed.	1
7.3	**Single Assessment Framework - update**	3	The SAF has been implemented, but the CQC is reviewing the process through a series of stakeholder events, so the process could change. Helpful summary of what the trust has done, is currently doing, and might do in the future in order to improve our CQC rating.	Future areas could include local measures (eg self-assessment using the SAF framework, core area specific self-assessment and development of staff guidance), and also Strategic measures such as being a pilot site for the national "improving patient safety culture – a practical guide", taking part in an ICB CQC leads meeting, and application to be part of CQC national work.	3

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			We need to demonstrate the improvements made, eg to corridor care and safety issues.	It was agreed that a CQC inspection is likely this year, and Richard Sue and Rebecca will meet to plan this.	
7.4	**Maternity Report** Neonatal Workforce Planning	1	As part of the Maternity Incentive Scheme, we are required to demonstrate effective neonatal workforce planning, and we meet the criteria. Effective escalation pathway ensures any gaps are covered by the consultant paediatrician, planned rostering, or with locums or consultants acting down	Staffing levels are monitored monthly and reported 6-monthly. Neonatal clinical lead has oversight of training. Recruitment and retention of staff is a key strategy. Consultant compliance with the required neonatal training is 93% - one consultant has to complete the required amount.	1
7.4	**Maternity Report** Obstetric Workforce Planning	1	4 measures used: a) use of short-term locums; b) use of long-term locums; c) compensatory rest for consultant obstetricians; d) presence of consultant obstetrician at certain high-risk births or clinical scenarios. The Trust was not	6 monthly reports will monitor the situation, particularly use of long-term locums. Locum use is reported to Board. RADAR reports are monitored to assess consultant obstetrician attendance at high-risk	1

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			compliant with b) between 1 Feb – 31 July 2024, but systems are now in place to improve this. A repeat audit between 1July – 31 Dec showed that the Trust WAS compliant. We were compliant with a), c) and d) in the reporting period.	scenarios, and such attendance is reported to Board. An action plan has been completed to improve recruitment of locum obstetric staff – the need for locums is now reducing.	
7.4	**Maternity Report** Anaesthetic Staffing within Maternity Services	1	In Q1and Q2 of 2024-25 we were compliant with all requirements: rostered dedicated obstetric anaesthetist; elective caesarean section lists covered separately; named consultant on rota. No current vacancies for consultant obstetric anaesthetists.	The situation will continue to be monitored, particularly in relation to Ockenden recommendations.	1
8.1	**BAF – Review Forward Plan Update**	3	Overview of current risks to providing health and care services and responding to changing pressures and demands. This could impact	Ongoing progress in many areas and risk appetite discussed. Assurance and control gaps identified. Various mitigations to reduce risk, and some of these are already completed. The BAF	1

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			quality of care, operational pressures and financial viability	risk wording will be looked at so that once actions are embedded, they can move up the risk rating. Some indication of time course (long or short term) will be provided.	
8.2	**Improvement Committee Terms of Reference**	1	Minor changes to the ToR were agreed	For annual review	1
8.3	**Update on Divisional Governance Review**	2	Internal review of divisional governance to see how effective our accountability and reporting structures are. Structures in different divisions are variable and based on different models. Strong governance is vital for the Trust and for CQC.	Standardised templates (with some flexibility) will improve accountability and reporting, and the documentation of Divisional Board meetings. Process still in development, but the plan is to move to a governance framework. Completion aimed for summer 2025.	1

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

	Questions regarding quality of evidence…	Further consideration…
What? Deepening **understanding** of the evidence and ensuring its **validity**	**Validity** – the degree to which the evidence… • measures what it says it measures • comes from a reliable source with sound/proven methodology • adds to triangulated insight	• Good data without a strong narrative is unconvincing. • A strong narrative without good data is dangerous!
So what? Increasing **appreciation** of the **value** (importance and impact) – what this means for us	**Value** – the degree to which the evidence… • provides real intelligence and clarity to board understanding • provides insight that supports good quality decision making • supports effective assurance, provides strategic options and/or deeper awareness of culture	• What is most significant to explore further? • What will take us from good to great if we focus on it? • What are we curious about? • What needs sharpening that might be slipping?
What next? Exploring what should be **done next** (or not), informing **future** tactic / strategy, agreeing follow-up and future **evidence of impact**		• Recommendations for action • What impact are we intending to have 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: 18 December 2024		
Chaired by: Roger Petter			**Lead Executive Director: Susan Wilkinson, Richard Goodwin**		
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 **PQSGG**	**Human Factors**	1	Project work on implant identification in orthopaedic theatres following a Never Event. Human Factors perspective on patient safety. A good example of learning from events.	We discussed possible future input from the Human Factors team at board level and may follow up at a board development day.	1
5.1 **PQSGG**	**Mental Health** Inpatient and ED length of stay	3	Ensure patient receives care in right environment. Waits in ED reduce flow and decrease opportunities for MH therapy	Compliance with 4-hour standard is improving. Case-by-case assessment is made	1
	Eating Disorders	1	Following an increase in admissions, clear care pathways have been implemented	This has reduced emergencies and improved patient experience and is now established care	1

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	Training	2	MH mandatory training agreed via eLearning. Reduced time commitment. Ward managers attending 3-day personality disorders training to support staff	Target tbc but likely to be 90-95%. Will be monitored through ESR	1
5.1 **PQSGG**	**Learning Disability & Autism**	2 1	Oliver McGowan mandatory training delayed due to ICB concerns about delivery at WSH, and the financial implications of training and staff backfill. Resource folders now available across inpatients and community	Agreement recently reached so we can now proceed with the training Reasonable adjustments can more easily be provided. Use and feedback to be monitored	1 1
5.1 **PQSGG**	**Safeguarding Adults** Safeguarding Training	3	Safeguarding Training: Level 1 and 2 are at 93% Level 3 not currently offered	Gap analysis underway to identify staff requiring Level 3 training which will be presented to MEG to expedite implementation of Level 3. Methods to include safeguarding supervision sessions, team-	3

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	Serious safeguarding allegations and section 42 review governance group now running	1	Group provides oversight and advice on any SG issues involving WSFT staff	based learning, safeguarding champions, on-site training Shared learning of section 42 themes and outcomes	 1
5.1 **PQSGG**	**Safeguarding CYP** Procurement of cameras Transition from yearly Level 3 training to 3-yearly Improved training compliance for Level 3 training	 3 1 2	 Photos taken by clinicians are not currently admissible in court. Procurement of cameras and training are outstanding Approach agreed with clinical teams Overall compliance 93%. Improvements in ED medical staff helped by training flexibility	 Currently stalled, awaiting funding approval. Camera purchase order to be submitted to non-pay control panel Total training hours and cost remain the same, but new system will be more flexible. A&E nursing staff next target group, using flexible accessible approach.	 1 1 1
5.2 **CEGG**	**Biochemistry Accreditation**	2	4-year cycle of accreditation. Biochem has a surveillance programme in place. Challenges include: formalised testing of	Consideration of the reporting pathways for SNOW	1

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			Business Continuity Plan; more emphasis on recording of risk to patient care; no fulltime on site clinical lead. Concerns over the Trust's oversight of ext reporting of 'significant non-conformities of work" (SNOW)		
5.2 CEGG	**Quality Improvement**	1	Updates on current QI projects; priorities such as transfer of care and C diff; training uptake;	Further development of QI support	1
5.2 CEGG	**Public Health** Prevention, Health Inequalities and Personalised Care strategy	2	Of 18 actions in the PHIPC strategy, 4 are complete, 8 green, 4 amber and 2 red. Overall this is good progress given our financial constraints	Current actions continue to end March 2025. New plan to be developed for 2025-27, and will be presented to CEGG in Feb 2025	1
5.2 CEGG	**Public Health** Population Health Management (PHM)	2	Identifying patient groups that would benefit from evidence-based interventions. Primary care datasets are not available to PHM.	Dataset issue escalated to ICB and hoped this will be resolved by New Year	1

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			Population Health tool has been removed from Oracle Cerner (cost saving)	PHM tool risk mitigated by ICS linked dataset and local risk stratification	
5.2 **CEGG**	**CEGG Development Plan**	2	Main area for development is a CEGG dashboard with measures for all subject areas		1
6.1 6.2	**Integrated Quality and Performance Report (IQPR)** Including **Performance Review Meetings (PRM Packs)**	2 2	C diff data - October rates lowest for 18 months, but remain in common cause variation. Nutritional assessments within 24 hours in common cause variation. Slight decline in last 3 months in line with ED pressures. ED screening tool in place to identify highest risk, though this is not a full assessment.	Remains an organisation key priority. QIP in progress and will run till at least April 2025. Enhanced cleaning of ED in progress. Work underway with Norfolk ICB to provide more information on Thetford patients. Nutritional assessments will continue to be monitored through Nutritional Steering Group. Updated reporting process will relate data to the ward area rather than the admitting area.	3

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		3 1	Post-partum Haemorrhage (>1500 ml) - ongoing quality improvement. Oct data shows special cause concern (11 cases). Most were white British women and primary cause a combination of trauma and poor tone. Ongoing implications for mother, baby, family, staff and organisation. The number of Patient Safety Incidents (PSI) and reportable occurrences (RO) remain stable and there is an ongoing gradual reduction in harm as a % of total incidents, indicating safe care. SHMI data shows we currently have fewer deaths than expected for our demographic	PPH rates will continue to be monitored through the usual channels. Ongoing QI project, 5 workstreams identified. Feedback from service users has highlighted the need for support for both partners following PPH, and the methods for doing so are being evaluated. This month there has been an increase in incidents relating to medication and equipment, nutrition hydration and feeding tubes, IT, and staffing level difficulties. This is a good indicator of safe care.	
7.1	**Deep Dive: <u>Patient Safety Incident Response Framework</u>**	2	Comprehensive overview particularly relating to learning from incidents, improved	Transition to Radar is complete and we are compliant with LFPSE. Our current Patient	1

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			governance and oversight and a better experience for those affected. The Emerging Incident Review process addresses proportionate response, Duty of Candour and staff support. We have completed transition to Learning From Patient Safety Events (LFPSE).	Safety Incident Response Plan (PSIRP) will be reviewed Jan-March 2025. The Plan is now specifically used to focus efforts. Ongoing work with FTSU and with People and Culture Committee so staff feel supported to raise concerns. Strengthen links with Patient Safety Specialists. Continue to work on our Safety Culture, eg by piloting safety walkabouts.	
7.2	**Omnicell Automated Dispensing Cabinets**	1	Automated drug dispensing cabinets have been installed: Phase 1 Central Pharmacy Controlled Drugs; Phase 2 Emergency Drug Cupboard; Phase 3 Emergency Department. These are fully secure (access via fingerprint bioID) and have automatic inventory and reordering.	Training for use of the cabinets is ongoing and ED has attained close to 100% completion for nursing staff. CD policies have been updated. It is expected that savings in staff time and costs will result and these will be monitored.	1

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7.3	**Maternity Report** **Midwifery Workforce Planning**	1	As part of the Maternity Incentive Scheme, we are required to demonstrate effective midwifery workforce planning, and we meet the criteria. Vacancies for Band 6 midwives are hard to fill but we successfully recruit Band 5, and from abroad. Vacancy rate overall is 5.3% (up from 3.4% in April). We have a low staff turnover & there are fewer staffing 'red flags' than in April	There are numerous projects aimed at recruiting, developing and retaining staff. Any recurring red flags that relate to staffing will be reviewed so that mitigations can be put in place.	1
7.3	**Maternity Report** **Maternity Claims Scorecard, Incident and Complaint Data**	2	Data required for compliance with the Maternity Incentive Scheme. Over the last 10 years, claims totalled £31.5 million with an average claim approx £1 million. Obstetric reportable events include anal sphincter injuries,	Proactive monitoring is required to mitigate risks and improve outcomes. Moving to digital recording of fetal heart monitoring ensures that traces can be accessed indefinitely. Current risks of a digital trace being stored on the	1

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			PPH, Term admissions to neonatal unit. Escalation during emergencies and communication are key themes. There is an emphasis on learning from events.	wrong patient's notes but with training and education, audits show compliance is increasing. Paper printouts remain until full compliance is met.	
8.1	**BAF – Review Forward Plan Update**	3	Overview of current risks to providing health and care services and responding to changing pressures and demands. This could impact quality of care, operational pressures and financial viability	Ongoing progress in many areas and risk appetite discussed. Assurance and control gaps identified. Various mitigations to reduce risk, and some of these are already completed. The BAF risk wording will be looked at so that once actions are embedded, they can move up the risk rating. Some indication of time course (long or short term) will be provided.	3

*See guidance notes for more detail

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

Feedback from assurance committees: Governor observer report

Board assurance committee: Improvement
Meeting date: 20/11/24
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*
• Matters discussed openly and thoroughly but few changes to RAG ratings or sign-offs
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• *Conduct professional as always.*
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.*
• *Are we assured that we don't run the risk of prioritising "easy wins" for compliance over "clinical relevance and accuracy"?* • *Are we assured that we are clear about WSFT's obligations vis a vis the Dementia Pathway?* • *Are we assured that Harm Review Processes vis a vis waiting times, are as systematic as they need to be and that people know where this is reported.*
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*

- *Would some time be better spent making representation to National/ICB "target setters" to explain why their targets are sometimes worded in a way which is "clinically inappropriate or inefficient"? e.g. Transfer of Care letters "in-patient versus out-patient"*
- *Should representation be made to National/Regional/Local bodies to the effect that Foundation Trusts are reaching a tipping point whereat theywill be spending so much time reporting that they won't have time to "do".*

Feedback from assurance committees: Governor observer report

Board assurance committee: Improvement
Meeting date: 20 November 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*
Full agenda, including: EOL and CQC single assessment framework presentation. Transfer of care presentation PPH review with really in-depth analysis
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• The usual NED Chair of this meeting, Dr Roger Petter, was on leave therefore it was chaired by a newly appointed NED, David Weaver. • It was well chaired with many insightful challenges by the Chair and others. However, a reflection on the meeting was not held at the end of the meeting, and no reminders from any committee members! • An action log was compiled as the meeting progressed. • Committee members adhered to the Trust principles of behaviour, everyone had a say, people were welcomed, challenge was robust especially on quality issues.
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.*

- Two examples of committee members taking issues, highlighted in a meeting, away making a difference and reporting back positive changes:

Previously we had heard that there were numerous e care actions/changes/updates waiting for attention of the digital team. These went back a long time and were not sorted in order of priority. A new process for managing and prioritising these requests was being devised and will come back to the Committee next year.

At the last meeting it was disclosed that due to pressure to admit to cubicles in ED there was little time to clean between patients posing an infection control risk, as decontamination was sometimes not carried out. The committee was assured that a new process of cleaning between patients is now in place.

- "Transfer of care" report and presentation demonstrated better understanding of the problem but little assurance of improvement in numbers of discharge summaries completed and sent. No clinical guideline.
- A challenge was made that some data in the IQPR lags, eg August data and it is now November. This has been challenged previously.
- Barriers to the best EOL care identified and include: poor out of hours cover, recruitment pause, ward environment, staff poor knowledge of family carers. Previously Governors have head that the dying patient is not always recognised.

Governor observer Notes

Changes have taken place to the sepsis six protocol, the one hour time recommendation has changed to two hours for antibiotic administration, e care data will reflect this next year.

The new MECU is funded for 6 month trial, it is helping patient flow in minors but not with the 4 hour target

Feedback from assurance committees: Governor observer report

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

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
Agenda included two “deep dive” reports: PSIRF and Omnicell drug storage in ED
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Well Chaired, introductions, everyone had a say, good pace. Volunteer for reflection also collated actions which are agreed at the end. • Trust values evident, listening and eye contact • Quite robust challenge re quality issues and safe guarding training
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.*
• For a long while and at various meetings I have heard that a room for relatives to use in the mortuary dept needs to be provided. This seems to have been delayed yet again, assurance was given that it will be reprioritised by estates in April. • Discharge summaries said to be ongoing, still! Possibility of automation mentioned • The Nurse Director provided verbal assurances as to the processes in place in order to deliver the best care possible to patients with mental health problems, given that they are in a general place of care rather than in a mental health facility. Good working relationship with mental health team. Complaints are more around ED stage of care.

- Omnicell – automated, safer, well received, cost saving in long run, automatic top up and reconciliation.
- PSIRF – Patient safety incident response framework – lots of assurance as to the thorough processes involved in investigation, learning , changing culture, support, duty of candour but (and there was a point made by a committee member) there was no mention of the process to be followed in the case of professional competency failings or accidents which require external referral. Registered practitioners are accountable for their practice to professional body, law and employer, I would have expected the process for managing this to be outlined in the deep dive. In my opinion what, how and why are vital but in some cases there is a who.

Notes

(For those of us who observe the assurance committees it is really difficult to pick out what we think is relevant to put in our reports).

NHSI is looking at all aspects of MT. Who has to do what, how often etc.

Doctors and BLS training discussed. Anyone doing ILS or ALS are BLS competent but consultants are falling behind. Discussion as to why and way forward. As I understand it BLS updates are annual but ALS is three yearly therefore for the 2nd and 3rd years following ALS training BLS in ALS trained individuals is not up to date.

NHS
West Suffolk
NHS Foundation Trust

Feedback from assurance committees: Governor observer report

Board assurance committee: Improvement
Meeting date:18 December 2024
Governor observer (observed by): Tom Murray

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• With over 500 papers, I would have preferred tp hear a synopsis, then go into details,
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• *Well chaired* , as usual, with enough time allotted to each item, some overly long answers.
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 overall process seemed robust, but overly complex, problems is that where we sit with air-conditioning ducts above us, people speaking so quietly I frankly struggled to hear. I am in future not putting my name forward for these meetings.
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• Concerned about the impact on future tacking of the financial recovery plan, I felt it lacked a certain clarity.

Feedback from assurance committees: Governor observer report

Board assurance committee: Improvement
Meeting date: 15 January 2025
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*
Usual high standard of reports. Presentation on external reporting pathway. In detail maternity reports
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Well Chaired, introductions, everyone had a say, good pace. Volunteer for reflection also collated actions which are agreed at the end. 10 minute over run. • Trust values evident, listening and eye contact and constructive challenge • Good attendance by NEDs and Trust Chair. 2 Governors observing
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.*
• Much discussion and challenge around findings of trauma group re zero level 2 nurse training, no trauma coordinator in place, timely reporting of trauma CT scan – ED peer review due in summer. Robust questioning on do we need to worry, benchmarking against others (?) has there been improvement since last review. This discussion was a good example of challenging the information in a report, assessing risk and seeking assurance on patient safety.

- Radar reporting of incidents said to be up to Datix levels which is a good thing
- Interesting discussion about the adoption of shared decision making, ie clinicians and patients share the treatment decision making process, it was thought that this model could be utilised in more areas of the Trust such as ED.

Notes

After the last Improvement committee meeting I commented on the lack of information re external reporting of incidents in the PSIRF report. The report presented on external reporting pathways at this meeting covered RIDDOR but not clinical incidents, which require external reporting.

Feedback from assurance committees: Governor observer report

Board assurance committee: Improvement
Meeting date: 15th Jan 2025
Governor observer (observed by): Sue Kingston

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Large agenda including, • Action Log opened for January • IQPR Report • PQSGG Report • Maternity Report Update • CEGG Key issues Report
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• Meeting started on time, was held in Northgate meeting room. Teams also available. • The Chair welcomed everybody and asked for introductions for the benefit of any new members • The meeting was well attended by NED's • The Chair was thorough and respectful in the handling of the meeting. • A NED volunteered to reflect on the meeting. • I felt trust values were maintained throughout

Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
• Once again, due to a large agenda and the importance of finishing the meeting on time, it moved at quite a pace • Many challenges in this meeting the most I have seen at any of my observations, which led to longer discussions on some matters. However, it was important that the challengers were addressed, and the assurances provided. • There were good presentations giving a good analysis of the subject being discussed, which gave assurances to the committee. The Chair remained in good control and sought clarification whenever necessary, even if this prolonged the subject being discussed.
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• The reflections of the meeting by the appointed NED were excellent. They missed nothing and raised many questions. It's very good to see that the chair appoints a volunteer for reflections at the beginning of the meeting, rather than asking for it at the end and waiting for a reluctant volunteer, as a result its more focused and a positive benefit to the whole committee. • Its good to see transparency being prioritised and that was apparent in this meeting.

10.3. Improvement Committee

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Involvement Committee			Date of meeting: December 18th 2024		
Chaired by: Tracy Dowling – Non-executive Director			**Lead Executive Directors: Jeremy Over and Sue Wilkinson**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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5.1	Feedback from Governors regarding line management, performance management and appraisal	2. Reasonable	• The Committee was asked to consider the feedback as it underwent the business of the meeting	• Director of Workforce to discuss any outstanding concerns with staff governors at their regular informal forum	1. No escalation
6.1	People and Culture Group	3. Partial	• The November meeting was cancelled due to poor attendance, with urgent items from this meeting escalated to this committee.	• Director of Workforce to attend the Senior Operational Forum to discuss way forward with ADOs	1. No escalation
6.2	Experience of Care and Engagement Committee	2. Reasonable	• Feedback received from VOICE network and experience of care committee • Issue raised from Insight Committee regarding oversight of EIAs and QIAs	• Deputy Director of Workforce, OD and Learning in process of reviewing EIA process and will consider how we align review of QIA and EIA	1. No escalation but for follow up at next meeting
7.1	**First for Staff** Pulse staff survey results 2021-2024	2. Reasonable	• WSFT has consistently achieved better results than peer trusts and good response rates	• Continue to undertake Pulse survey and review with annual survey – especially and ward / department level	1. No escalation

Originating Committee: Involvement Committee			Date of meeting: December 18th 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
			• Current measures regarding financial recovery are impacting on scores and a reduction in staff scores is anticipated from the annual staff survey	• Consider how communication and engagement of staff with recovery programme can be enhanced	
7.2	Sexual Safety in the Workplace	2. Reasonable	• The extent of reporting issues of unwanted sexual behaviours nationally and at WSFT was shared • The NHS ENGLAND Charter for Sexual Safety in Healthcare was presented • The areas of development in the action plan were shared	• Progress with developing and implementing the action plan to be presented to the April meeting of the Involvement Committee	1. No escalation
7.3	Staff Wellbeing Workplan	2. Reasonable	• The priorities in the current plan were approved	• Agreed to review progress and to review areas of priority again in a further 6 months.	1. No escalation
9.1	**First for Patients** Publication and maintenance of Patient Information leaflets	2. Reasonable	• The agreed process for development and maintenance of patient information leaflets was presented	• Suggestion to link to quality indicator work for assurance.	1. No escalation

Originating Committee: Involvement Committee			Date of meeting: December 18th 2024		
Chaired by: Tracy Dowling – Non-executive Director			Lead Executive Directors: Jeremy Over and Sue Wilkinson		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
	Latest CQC survey results a) UEC b) Maternity Services	2. Reasonable	• For UEC - WSFT scored amongst the highest in the region in most areas. • For maternity again scores were for the most part better than average.	• Areas of improvement are being worked through including communicating with patients when there are long waits • There is an improvement plan in place even for areas where we have scored highly; the only area of concern is delays on the day of discharge.	1. No escalation
9.3	Adult in-patient establishment review	1. Substantial	• The biannual review has been completed for 17 ward areas. There are no areas of concerns regarding staffing levels being low, with 2 areas reviewing whether their staffing is high	• Continue to undertake biannual review of adult inpatient establishments in line with national guidance • Align required resource levels with 25-6 budget setting	1. No escalation
10.1	IQPR extract for Involvement Committee	2. Reasonable	• Good sustained performance on workforce metrics and patient experience indicators in spite of operational challenges	• Continue to focus improvement on appraisal participation rates which are just below target levels	1. No escalation

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

Feedback from assurance committees: Governor observer report

Board assurance committee: Involvement
Meeting date: 18 December 2024
Governor observer (observed by): Becky Poynter

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• The agenda covered items inline with the remit of the committee focusing on the “First” values.
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• The chair opened the meeting with a reminder of the Trust values and purpose of the committee. As always, members conducted themselves in a respectful and professional manner.
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.*
• CoG should be assured that concerns recently shared by staff governors were reported to this meeting in an appropriate manner and time given to discussion around these issues
Governor observer Notes *Use this section to highlight any other areas for example good practice or ‘even better if’*
• It was interesting to hear of the collaboration between the insight/involvement committee and to note that the term of reference for each of the 3is committees have been standardised. • NEDs were well prepared for the meeting and offered a level of appropriate challenge to the Executive.

- The agendas for these meeting are very full and although the meeting was well chaired there is a lot to get through in the time allocated.

Feedback from assurance committees: Governor observer report

Board assurance committee: Involvement
Meeting date:18 December 2024
Governor observer (observed by): Sue Kingston

Agenda: scope and coverage *Any issues to highlight in terms of the matters considered in the meeting and the discussion that took place*
• Large Agenda, papers available in advance of the meeting. Highlights including: - • Pulse Survey data review • Sexual Safety in the NHS update • Wellbeing Workplan Update • CQC Patient Survey Results/Maternity and UEC
Meeting conduct *Any issues to highlight in terms of how the meeting was conducted or behaviours*
• The meeting started on time and was held in Northgate Meeting Room. Teams were also available, • The Chair was welcoming, and introductions were made round the table for the benefit of any new members. • The meeting was respectful and polite. It felt very inclusive. • The Chair ensured that attendees were given the opportunity to speak and contribute. This included challenges and questions. • Reflections were taken both from members and from observers. • All agenda items were covered and the meeting closed on time! • Trust values were maintained throughout the meeting.

Assurance *Use this section to highlight any issues you would like to bring to the CoGs attention. Please note that the focus of this should be on processes and effectiveness, rather than content of the meeting. The content is reported via the Chair's key issues report.*
• Many topics covered today, and assurance provided by NED challenges on some topics and indeed the chair setting dates for further meetings and clarification in arears where she felt action was necessary. • It was also positive to hear that concerns recently raised by staff governors have been received by the committee and are being delt with appropriately. • Encouraging to see the Wellbeing Workplan being executed however, some deadlines have come and gone due to challenging circumstances. One of those being financial. Now it is difficult to see what the new deadlines are as most are yet to be confirmed. This was challenged by a NED and further assurance will be sought at the next meeting.
Governor observer Notes *Use this section to highlight any other areas for example good practice or 'even better if'*
• The presentations at the meeting today seemed better timed and were perhaps shorter, but still concise and delivered the required information resulting in all agenda items being covered, and nothing felt rushed.

10.4. Audit Committee

Presented by Antoinette Jackson

NHS West Suffolk NHS Foundation Trust

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Audit Committee			Date of meeting: 10 December 2024		
Chaired by: Michael Parsons			Lead Executive Director: Jonathan Rowell		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT 3. Escalate to Board
Progress report on Internal Audit plan 2024/25 (RSM)	Update on delivery of internal audit plan and implementation of recommendations.	Reasonable	The Committee considered two final reports that had been issued, both with positive opinions: Data Security & Protection Toolkit and DBS Checklist. The Committee agreed to vary the audit plan to defer (to later in the year) the divisional governance structure audit, and to bring forward the consultant job planning process audit. The Committee also reviewed progress with implementation of recommendations.	Welcomed ongoing reduction in outstanding audit actions, although requires continuing focus by management to address the overdue actions.	2 -> Management Executive

Originating Committee: Audit Committee			Date of meeting: 10 December 2024		
Chaired by: Michael Parsons			Lead Executive Director: Jonathan Rowell		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT 3. Escalate to Board
5.4	Preparations for new public procurement regulations	Substantial	Considered a report on WSFT's readiness for the introduction of the new public procurement regulations in February 2025. Stressed importance of strengthening contract management and improved forward planning.	Noted delay in Government issuing all the necessary templates and launching the digital platform. An early audit would be welcomed to review arrangements after the first few tenders under the new regs.	Chief Opersintg Officer to follow up on IT contracts.
6	Progress report on Internal Audit (IA) and Counter Fraud activity (CF) undertaken by RSM	Reasonable	The Committee considered recent audit reports and approved minor changes to the 24/25 audit plan and agreed a revised protocol (which sets out expectations and timelines for responding to IA). Stressed importance of engaging and agreeing scopes for audits well in advance. Discussed the coverage of financial controls (including	Noted concern that many audits were now delayed to the back end of the financial year and the importance of keeping to timelines to ensure the majority of the audit plan was completed.	Exec requested to respond promptly to remaining audits planned for the year – and to continue progress on clearing recommendations from previous audits.

Originating Committee: Audit Committee			Date of meeting: 10 December 2024		
Chaired by: Michael Parsons			Lead Executive Director: Jonathan Rowell		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT 3. Escalate to Board
			financial strategy, budgeting, workforce controls, and contract management) in recent audit plans. Given WSFT's financial position, agreed that these areas were a priority focus for the 25/26 audit plan. Discussed activity during Fraud Awareness month. Considered revisions for the Anti-Fraud Policy but asked for content on cyber fraud to be reviewed before approval at a future meeting.		Chief Operating Officer to review cyber fraud content with RSM.
7	External Audit	Substantial	External audit plan approved.		No escalation
8	Charitable Funds Annual Report & Accounts (ARA)	Substantial	CF ARA approved.		No escalation.

Originating Committee: Audit Committee			Date of meeting: 10 December 2024		
Chaired by: Michael Parsons			Lead Executive Director: Jonathan Rowell		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT 3. Escalate to Board
AOB	Contractual arrangements for Internal Audit / Counter Fraud and External Audit	Substantial	Noted CoG had approved award of external audit contract to EY and a contract was being drawn up. Noted Director of Finance was reviewing the required number of internal audit days, before finalising the extension of the IA contract.	Update to next meeting.	No escalation

See guidance notes for more detail

NHS West Suffolk NHS Foundation Trust

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.

11. Nomination Committee Report (enclosed)

To receive the report from the Nomination Committee

To Note

Presented by Jude Chin

WSFT Council of Governors meeting (Open)	
Report title:	Nominations Committee report
Agenda item:	11
Date of the meeting:	26 February 2025
Sponsor/executive lead:	Jude Chin, Trust Chair
Report prepared by:	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 14 January 2025.

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

The Committee's agenda focussed on the following areas:

- **NEDs Terms of Office** - The terms of office for the NEDs were reviewed and noted.
- **NEDs and Chair appraisal process (for approval)**

  In 2024, the Council noted the new NHSE framework for conducting annual appraisals of NHS chairs and as approved by the Council new framework for the Chair's appraisal was adopted. Similar to Chair's appraisal process in 2024 and in line with the NHS England Framework for conducting annual appraisals of NHS chairs, the chair appraisal 2025 to be carried out. A new board member appraisal framework was expected to launch in autumn 2024 which was delayed, however, now in the final stages for approval and awaiting a confirmation for publication.

  The Trust will continue with the existing appraisal process for NEDs and ensure the self-assessment and discussion relating to the competencies in the Leadership Competency Framework for board members is incorporated into annual appraisals. The Committee approved the revised NED appraisal form template that was reviewed to reflect LCF domains and agreed to use this form internally for all the NED appraisals in 2025, including Chair. This change was considered to ensure that internal feedback is structured around the LCF, maintaining consistency with the NHSE framework and guidance.

  As part of this appraisal framework, the Committee agreed revising the appraisal timeline for 2024-

25 to meet the requirement of submission of Chair's appraisal to senior appointments and assessment team SAAT by 30 June 2025.

The Committee also reached a consensus to include the five new NEDs in the process as they will have been in post for six months at the point that feedback is completed recognising it is likely that there will be some areas where feedback is still developing for these individuals. This applied to Alison Wigg, David Weaver, Heather Hancock, Paul Zollinger-Read and Richard Flatman.

The appraisal process includes board, governor and for the chair external observers. The process is described in more detail in **Annex A** but the key components include:

- Circulate forms to appraisers (w/c 3 March)
- Senior independent director to meet with non-executive directors to collectively appraise the chair's performance (Mid to late April)
- Nominations Committee meeting to discuss results of observer questionnaires and identify themes/concerns (early May)
- NED appraisal by Chair and Chair appraisal by Lead Governor and Senior independent Director (late May-mid June)
- Submission of Chair's appraisal to Regional Director (w/c 23 June)
- Report on process to CoG (September)

ACTION

- Approve the proposed approach to NED appraisal and seek nominations from Governors to act as observers (appraisers) using the appraisal questionnaires
- Note the timescale for the appraisal process

- **NED composition and skills of Board**

The Committee reviewed the size, structure and composition of the present Board. At present, WSFT Board is constituted of eight non-executive directors (including Chair), two associate NEDs (with non-voting rights) and seven executive directors. Any changes or developments around Board composition in the near future will be dealt via appropriate route and Trust processes.

We are undertaking an in-house board skills audit and a skills matrix template was circulated to the existing non-executive directors with initial inputs from CVs. NEDs were asked to confirm/complete the matrix template to map competencies, experience, and expertise. This included areas such as non-executive/chair experience, finance, audit & control, clinical management/operational service expertise, organisational development, governance & legal.

The outcome of the review will be used to identify any areas which may benefit from additional expertise or skills as well as consideration of Board's diversity. Any gaps will be used to focus the engagement activities by the recruitment partner for any future appointments.

The summary of this skills audit will be presented to the next Nomination Committee meeting.

- **Nomination Committee forward planner 2025** - The Committee noted the forward plan.

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 take actions as recommended in the report.	
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

Annex A

Chair and NED appraisal process 2025

1. NEDs' appraisal process

In accordance with the Code of Governance 2022 Section C: there should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. ***For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair.***

Proposal - Chair and Non-Executive Director appraisal process

(a) The proposed observer groups and numbers for Chair and NED appraisal are described in tables 1a and 1b respectively.

Table 1a - Chair - Observers

Stakeholder group	Feedback from
Non-Executive Directors	All NEDs **- Nine**
Chair	Self-appraisal
Executive Directors	All EDs including Chief Executive **- Seven**
Governors	Lead Governor plus **four** Governors **- Five**
External Stakeholders	To be nominated by Chair **- Four**
Regional Director	**One**

Table 1b - NEDs - Observers

Stakeholder group	Feedback from
Non-Executive Directors	All NEDs, including Chair **- Ten**
Executive Directors	All EDs including Chief Executive **- Seven**
Governors	Governors **- Five**

(b) A group of at least five Governors who have volunteered to take part in this process will be allocated as observers (appraisers) for the Chair and each of the NEDs.

(c) Feedback from the Chair's and NEDs' observer (appraiser) questionnaires will be aggregated and reported at a meeting of the Nominations Committee. This will be used to identify areas for focus in the appraisal meetings for each individual. The purpose of this will be to identify themes and issues to be considered at the appraisal meetings.

(d) Appraisal for the Chair will be undertaken by the Lead Governor and Senior Independent Director.

(e) Appraisals of the NEDs will be undertaken by the Chair.

(f) An overall summary of the Chair's and NEDs' appraisal process will be reported to the Council of Governors meeting following completion.

The Committee is also asked to note the revised appraisal documentation. This has been developed to include feedback from the previous nominations committee meetings:

- **Appendix 1: NED appraisal form 2025 Blank**
- **Appendix 2: NED appraisal reporting template blank**
- **Appendix 3: FPPT self-attestation form (for NEDs and Chair)**

Table 2: Proposed Chair and NED appraisal schedule 2025

Task	Action	Date
Volunteers to undertake appraisals to be identified at CoG meeting on 26 February 2025	**Deputy Trust Secretary**	Wednesday 26 Feb 2025
Circulate forms to appraisers and appraisees for completion and return to FT Office	**FT Office**	w/c 3 Mar 2025
Completed forms to be returned to FT Office	**FT Office**	Friday 28 Mar 2025
Forms to be analysed and summarised	**FT Office**	Mid April 2025
Senior independent director to meet with non-executive directors to appraise the chair's performance	**FT Office**	Mid to late April 2025 (prior to Nominations Committee meeting)
Nominations Committee meeting to discuss results of observer questionnaires and approve the identified themes/concerns	**Nominations Committee**	7 May 2025
Lead Governor and SID to undertake Chair's appraisal	**Lead Governor / SID / Chair**	Mid May 2025
Chair to undertake NEDs' appraisals	**Chair / NEDs**	Mid May to mid Jun 2025
Submission of Chair's appraisal to RD	**Deputy Trust Secretary**	w/c 23 June 2025
Report to CoG meeting	**Chair**	11 September 2025

12. Membership and Engagement Committee Report (enclosed)

To receive a report from the Membership and Engagement Committee

Presented by Sarah Hanratty

WSFT Council of Governors meeting (Open)	
Report title:	Membership and Engagement Committee report
Agenda item:	12
Date of the meeting:	26 February 2025
Sponsor/executive lead:	Sarah Hanratty, Public Governor (Chair of Membership & 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 Membership and Engagement Committee meeting on 21 January 2025.

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

Summary/Highlights

In the meeting on 21 January, the Committee focussed on the following key areas:

- The Committee noted an update on **Patient Engagement and VOICE** with an overview of patient experience and engagement activities and a number of projects VOICE have been involved in, including the smoking cessation project, advising on designs for the Community Diagnostic Centre and planned contribution to other future social value projects such as reasonable adjustments and accessible information, public involvement in service or policy changes and digital inpatient menus.

- The Committee received a report on **Governor activities** from November 2024 onwards and discussed the emerging themes from the feedback received from the observers. The activities identified a significant number of positives across these areas including our staff, environments and the focus on patients and care. The Governor activities coversheet is included for oversight for the CoG **(Annex 1**) and includes two 15-steps visits, one area observation and one environmental walkabout.

  Key themes from activity analysis were confirmed and will be considered through the Trust's Experience of Care and Engagement committee:

  - Environment – Decoration and cleanliness, lack of storage space, accessibility

- Awareness and information – use of templates, understanding for reporting incidents

The Committee has also agreed that emerging themes and trends that are identified through the visits are compiled and circulated more broadly to all Governors, so they can use these as a basis for their ward visits/observations and other activities.

- **Membership and Engagement Strategy Development Plan** was shared with the Committee and views were sought on the phased approach for future actions, spread across three phases. The Committee agreed with Phase I focussing on actions in the next six months Jan-Jun 2025, Phase II - actions planned for July-Dec 2025 and Phase III - actions undertaken from Jan-Dec 2026. This will be a live document to be reviewed, developed and monitored by the Committee.

  An interim annual review of the strategy will be undertaken by the Membership and Engagement Committee with periodical reviews of the development plan. The Committee will also review progress against the objectives of this strategy reporting back on progress at the Council of Governors through an update from the Committee chair.

  The Committee encourages all Governors to sign up for activities and events to support delivery of the Membership and engagement strategy and development plan.

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

- The Committee noted the **forward plan 2025.**

The Committee would also like to draw to the attention of the Council of Governors that there are now two vacancies on the Committee following the resignation of Elspeth Lees (partner governor) and John-Paul Holt (staff governor). The Committee makes a recommendation to invite governor colleagues to join the Committee and support in order to take forward the membership and engagement programme.

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 21 January 2025
- to invite members of the Council to join the Membership & Engagement Committee following recent vacancies on the Committee
- encourage all Governors to sign up for activities in the Membership and Engagement Strategy Development Plan.

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

regulatory context:	NHSE Code of Governance 2022

Council of Governors' Membership and Engagement Committee	
Report title:	Governor activities 2024/25 - Feedback report
Agenda item:	5
Date of the meeting:	21 January 2025
Sponsor/executive lead:	Richard Jones, Trust Secretary
Report prepared by:	Ruth Williamson, Foundation Trust 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:

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

This paper summarises the Governor activities from November 2024 and the emerging themes from the feedback received from the observers.

15 steps visits led by Deputy Chief Nurse (Annex A)

- 30 October 2024: Radiology, X-Ray & Endoscopy by Jane Skinner, (Public Governor), J-P Holt, Staff Governor and Roger Petter, (non-executive director).
- 27 November 2024: Outpatients & Fracture Clinic/F3 by Anna Conochie, (Public Governor), Jayne Mills, (Public Governor), Anna Clapton, (Staff Governor) and Jude Chin, (Chair).

Area observations led by patient experience and engagement team (Annex B)

- 5 November 2024: Diabetic Centre by J-P Holt, (Staff Governor)

Environmental reviews led by Estates and Facilitates (Annex C)

- 11 December 2024: Cardiac Unit by Jane Skinner (Public Governor)

Courtyard Café led by FT office team

- No sessions to report up to December, 2024.

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

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

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

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

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

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

Some themes from visiting teams are identified below:

15 steps:

- Availability of porters – resulting in delay of transport to radiology for procedure.
- Understanding of use of RADAR to report incidents
- Lack of storage space
- Decoration

Area observations:

- Decoration and cleanliness
- Access for wheelchair users

Environmental reviews:

- Patient awareness of where to attend for appointment.
- Notices/Instructions – use of correct Trust templates and replacement of out-of-date documents

Action required / Recommendation:

The Membership and Engagement Committee is asked to:

- note the report and emerging themes
- consider how these can be further tested in future governors activities –provide a short briefing of themes for governor undertaking visits / activities
- consider any locations of particular focus for future visits / activities

Previously considered by:	NA
Risk and assurance:	Council of Governors is unable to undertake its statutory duties.

Equality, diversity and inclusion:	NA
Sustainability:	NA
Legal and regulatory context:	West Suffolk NHS Foundation Trust Constitution Health & Social Care Act 2022

13. Standards Committee Report - No Meeting since October 2024

To Note

Presented by Jude Chin

14. Staff Governor Report (enclosed)

To receive a report from the Staff Governors

To Note

Presented by John-Paul Holt

WSFT Council of Governors meeting (Open)	
Report title:	Staff Governors' report
Agenda item:	14
Date of the meeting:	26 February 2025
Sponsor/executive lead:	Staff Governors
Report prepared by:	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			
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 9 January 2025. 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, John-Paul Holt, Andy Morris, Adam Musgrove, Louisa Honeybun, Jeremy Over (executive director of workforce & communications), Ruth Williamson (FT Office Manager) and Pooja Sharma (Deputy Trust secretary).

Summary/Highlights:

Freedom to Speak Up – update on themes: The staff governors noted an overview of themes related to speaking up within the Trust which included impact of financial constraints on the staffing levels in clinical and non-clinical groups, results from champions' diversity survey, noting steps have been taken to improve the Trust's understanding of diversity within the FTSU champion cohort and those speaking up. Further work to be undertaken in terms of ethnic minority representation.

Staff Governor Engagement – raising the governor profile: Update on suggestions made for staff governor engagement activities was noted. Some of the proposed engagement activities included staff governor approaching staff networks. It was felt timely to have the FT membership and engagement strategy in place, together with associated development action plan. One of the aims is to develop targeted campaigns to raise the profile of the staff governors and encourage more staff to stand as staff governors for elections in 2026. This strategy would aid staff governors in detailing the approach to the staff network chairs.

Financial Position – React, Recover, Renew Strategy: The staff governors noted the Trust's React, Recover, Renew approach, a roadmap to secure the future sustainability of the organisation. The staff governors had met with the Chair and CEO to apprise them of staff inputs regarding the approach. It was noted that feedback from colleagues received so far has helped to address challenges and shape

the future. The Trust is committed to being transparent, inclusive and using insights to shape solutions.
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 9 January 2025.

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:	26 February 2025
Sponsor/executive lead:	Jane Skinner, Lead Governor
Report prepared by:	Jane Skinner, Lead Governor

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

Executive Summary

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

Brief summary of Governors' main meetings, activities and concerns over the last quarter.

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

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

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

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

WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
Governors will continue to carry out activities and to develop engagement strategies which are in line with the achievement of their statutory duties and responsibilities.
Action Required
The Council of Governors is asked to note the report.

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

Lead Governor Report

1.	**Introduction**
	This report will highlight some of the Governor activities carried out during the last quarter and meetings attended. Concerns will also be outlined.
2.	**COG Sub-Committees**
2.1	**Membership and Engagement and Committee** The Chair of this committee has submitted a full report to this CoG meeting. Governors are now not only participating in activities such as the 15 Steps and providing feedback to Trust staff, but a mechanism to follow up on "what happened next" is now in place. The committee has a clear strategy and forward plan on how their vision and objectives will be implemented leading up to election year. The committee is short of two members, so please do put your name forward to join.
2.2	**Nominations and Remuneration Committee** The last meeting was held in January when the main business was to discuss and approve the Chair and NED appraisal process. Governors were provided with appraisal training on 16th January during which the role of Governors was explored and opportunities to make observations of NED performance identified. Governor volunteers will be sought to participate in the appraisal process by providing feedback to the appraisees.
2.3	**Staff Governor Group** The rotational Chair will present his full report to this CoG meeting. The group is attended by the Lead Governor and supported by the Executive Director of Workforce and Communication and Freedom to Speak Up Guardian. It is apparent that these are difficult times for Trust staff in terms of the effects of financial constraints and controls, staff sickness and workload.
3.	**Board Assurance committee meetings** Governors continue to observe monthly assurance meetings, their reports are submitted as agenda items to this CoG. We also have opportunity to question the Chairs of these meetings during the presentations of their KPIs to the CoG, which I encourage Governors to do. Those of us observing these meetings plan to review what and how feedback is provided to CoG; currently numerous reports are generated – up to 9 for one day.

	Governors are reminded that the approved Closed Board minutes and Assurance Committees' approved minutes are available to read on Convene. Governors are reminded that they can attend Trust public Board meetings during which they may ask questions arising from the papers presented.
4.	**Governor Updates and Development** Thanks to Sam Tappenden for involving Governors, at this early stage, in the development of a refreshed Trust Strategy. Very positive feedback was given by those of us who attended. Thank you to Ruth, who has had the unenviable task of compiling our activity and meeting program for the next year. There are still some gaps to fill; some Governors have volunteered for several activities. If any Governor feels they have missed the opportunity to participate in an activity please let Ruth know, as you might be able to replace someone else, or be otherwise added to the list.
6.	**Concerns** These are difficult times for NHS organisations across the UK. We have been kept well informed about the financial situation of the Trust and the recovery plan so far. The Trust's expected deficit had consequences for other partners in the ICS as the ICB must break even this year. We have been informed that a SNEE commissioned Sustainability Review is in progress. I have been in communication with the ESNEFT Lead Governor and Professor Will Pope, ICB Chair. He is supportive of Governors receiving ongoing information about this review and suggested a joint Governor meeting, sometime in March, to discuss the findings at that point. I understand more information will be provided to us at this CoG meeting as part of Sam's presentation. I am sure we will have opportunity to ask questions of Sam. We can see from Board papers that operationally things are difficult. The ED has been exceptionally busy and quality standards, such as for the 4 hour wait, have not been met. In addition 'flu has caused higher than expected staff sickness and patient admissions and currently Norovirus is being managed as well. For a fuller picture, please see the IQPR report. This may generate some questions for assurance by Governors at CoG.
7.	**Changes to CoG** Very sadly John Paul Holt has resigned from the Council due to his increased workload in other areas of responsibility. He has been a committed Governor and will be missed by us all. Good luck J-P and thank you. Welcome to new Partner Governor Lisa Parish who represents the West Suffolk College.
8.	**Conclusion** On behalf of the Governors, I would like to conclude by thanking staff across the acute Trust and community for their hard work during this really difficult period.

16. Governance Report (enclosed)

To receive the governance report

To inform

WSFT Council of Governors meeting (Open)	
Report title:	Governance report
Agenda item:	16
Date of the meeting:	26 February 2025
Sponsor/executive lead:	Richard Jones, Trust Secretary & Head of Governance
Report prepared by:	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 February 2025, as follows:

- Fit and Proper Persons Test and Register of Interest
- Readers for Quality Accounts and Annual Report
- Governor commentary for the Quality Accounts
- Council of Governors sub-committees 2025
- Governor work programme and forward planner 2025

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.

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

Governance Report

1. Fit and Proper Persons Test and Register of interests and Gift & Hospitality

The NHSE Code of Governance (2022) for NHS provider trusts, section C 4.1 states that directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence.

In November 2023, the Council of Governors agreed the implementation of Fit and Proper Persons Test (FPPT) a regulatory requirement of the Code of Governance 2022. The FPPT for governors was introduced as an annual self-attestation process and standardised template was adopted in line with the new FPPT framework.

At each Council of Governors (CoG) meeting declarations are also received for items to be considered as part of the agenda. The FPPT declarations and declaration of interests of governors was received from the governors as part of their induction documentation.

The Register of Governors' Interests should be formally reviewed and updated on an annual basis. For accuracy and completeness of our register of interests, we will be sending out the declaration of interest forms to all the governors to capture any relevant interests or relationships. Updates from governors will be requested in March and the updated register of interests will be presented to the Council of Governors at the May meeting.

As part of this annual process, we will contact the Governors for filling in FPPT and DoIs/G&H forms and return to the FT office.

ACTION

- The 'Fit and Proper Person Test' annual self-attestation and declaration of interests and G&H forms to be circulated to the Council of Governors in March 2025.

2. Readers for Quality accounts and annual report

The Trust's timetable for final submissions of annual report and accounts 2024-25 is the end of June. This impacts on the preparation of the quality accounts as the information for these documents does overlap.

a) Readers for the Annual Report (including aspects for the Quality Accounts)

It is proposed that up to four Governors are identified as readers for the draft Annual Report and associated Quality Accounts. This will be to ensure that the report, while complying with the requirements of national guidance, remains accessible for the public in terms of language.

Readers will receive the draft Annual Report and Quality Accounts for comment in late April/early May. The document is likely to be approximately 125 pages in length and it would be expected that comments will be received within two weeks to allow the submission of the final report to the Board.

ACTION

- Identify up to four Governors as readers for the draft annual report (including quality accounts).

3. Governor commentary for the Quality Accounts

The Council of Governors provides commentary for inclusion in the annual Quality Accounts. The Standards Committee will review and draft this commentary with the lead governor. The updated draft commentary will be presented to the CoG in May for discussion and approval for inclusion in the Quality Accounts.

ACTION

- Note approach to drafting Governors' commentary for inclusion in the quality accounts.

4. Council of Governors sub-committees 2025

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

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

The Standards Committee oversees the attendance at subcommittees to support individuals and the effective working of the committees. The Committee maintains oversight of this issue and concerns regarding non-attendance highlighted for any sub-committee. The next Standards Committee meeting is to discuss the membership and attendance of the Council of Governors' committees.

5. Governor work programme 2025 and forward planner 2025-26

The annual programme tries to be reasonable in terms of time commitment and coverage. The draft programme 2025 is presented to the CoG for approval **(Appendix A)**

We have also attached the draft forward planner 2025-26 for the CoGs meetings for discussion **(Appendix B).** The forward planner is a live document that will be frequently reviewed and is not an exhaustive list of items.

ACTION

- Note and comment on the Governors' work programme and forward planner.

Governors' Work Programme 2025

Timing	Themes	Rationale	Led by
16 January 2025	Non-executive appraisals training	Interests of members and the public	Organisational Development and Learning Team
5 February 2025	Trust's strategy refresh	Interests of members and the public Interactive engagement with the governors as part of the review of the Trust's strategy and priorities	Director of Strategy and Transformation
4 March 2025	Session on Integrated Care Board introduction and provider collaboration	Interests of members and the public	ICB partners/Chair/Trust Secretary
3 April 2025	CQC single assessment framework	Interests of members and the public	Chief Nurse
TBC – June or Aug 2025	Finance workshop or Effective questioning and holding the NEDs to account for the performance of the Board	Interests of members and the public Holding the NEDs to account for the performance of the Board	NHS Providers
TBC - June or Aug 2025	Session on Future Systems Programme	Holding the NEDs to account for the performance of the Board	Chief Executive / Programme Director / others as agreed
TBC – Oct or Dec 2025	The role of the Foundation Trust Governor and practical ways to carry out the statutory roles of a governor	Item from annual skills audit – considering options for delivery to support working of the Council	Trust Secretary
	Themes of interest that have emerged from the governors' skills audit 2024 will be incorporated into the training and governor work programme 2025:	These will be reviewed in the Standards Committee in April and will be delivered through ad hoc sessions as well as governor training events. The	Trust Secretary

Timing	Themes	Rationale	Led by
	➢ Building relationships with the Board of Directors, including non-executive directors ➢ Assessing performance of board and individuals, including understanding more about how governors hold non-executive directors to account. The following items are included in the programme as specific items: ➢ ~~Understanding of the Trust's strategy and delivery plans~~ delivered on 5 February 2025 ➢ ~~The role of the Foundation Trust Governor and practical ways to carry out the statutory roles of a governor~~ – on forward planner above ➢ ~~CQC new inspection framework~~ on forward planner above ➢ ~~Data interpretation and how governors make use of the data~~ – delivered on 5 December 2024	programme will be developed to reflect these priorities.	

West Suffolk NHS Foundation Trust

WSFT COUNCIL OF GOVERNORS' FORWARD PLANNER 2025-26

		May	Sept	Nov	Feb	
Date		**14/05/25**	**11/09/25**	**13/11/25**	**TBC/02/26**	
Venue		WSH site	WSH site	WSH site	WSH site	
Papers circulation (min 5 working days before the meeting)		07/05/25	04/09/25	06/11/25	TBC/02/26	
Item	**Lead**					**Notes**
Standing Items						
Minutes	Chair	Y	Y	Y	Y	For approval
Chair's report	Chair	Y	Y	Y	Y	For information
Chief executive's report	CEO	Y	Y	Y	Y	For information
Feedback on assurance committees	3i Chairs/Governor observers	Y	Y	Y	Y	For information
Lead Governor Report	Lead Governor	Y	Y	Y	Y	For information
Summary report for Board of Directors meetings	Chair/NEDs/TS	Y	Y	Y	Y	For information
Reflections on meeting	Chair	Y	Y	Y	Y	For noting
Recurring Items						
Report from Governors' Nomination & Remuneration Committee to include recruitments of NEDs and appraisals	Committee Chair	Y	Y	Y	Y	For information
Membership & Engagement Committee report	Committee Chair	Y	Y	Y	Y	For information
Standards Committee report	Committee Chair	Y	Y	Y	Y	For information
Staff Governors' Report	Staff Governor	Y	Y	Y	Y	For information
Future System update	CEO			Y		For information
Review of Governors' sub-committees - membership and composition	TS	Y				For discussion/approval
Annual Items						
Strategic planning and priorities	CEO	Y				For discussion
Membership and Engagement Strategy (bi-annual)	TS					For approval
Forward Plan including briefing & development sessions	TS			Y	Y	For discussion/approval
Quality Accounts – commentary from Governors	TS/CN	Y			Y	For information/approval
Annual report and accounts, including Independent Auditor's report	AC chair/TS/Auditors		Y			For information
Fit and Proper Persons Test	TS	Y				For information
Other / As Required						
Changes to the Constitution	TS					For approval
Audit and effectiveness as recommended by the Standards Committee	TS					
Any items requested by Executives/Governors	TS					

Notes:										

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:	26 February 2025
Sponsor/executive lead:	Jude Chin, Trust Chair
Report prepared by:	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 complements the reports received from the Board's assurance committees earlier on the agenda.

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

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

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

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

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

Board of Director Key Issues

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Board of Director Key Issues – 29 November, 2024			
Patient Story – The Board received a presentation regarding the impact and health benefits to patients attending the Therapeutic Gardening Group based in Sudbury, funded by donations. Potential to adapt this group to include exercises in the garden space with the added benefit of group contact.	• To provide benefits of group participation alongside traditional occupational therapy.	• Model for future care	Verbal
CEO Report – WSFT ranked 5th nationally for acute and combined Trusts and 9th for Urgent and Emergency Car. Chancellor has stated intentions for the new hospital to be built as soon as possible.	• Ongoing assurance/monitoring	• Deliver the Trust strategy	1.7
West Suffolk Alliance and SNEE Integrated Care Board: ***Essex and Suffolk Elective Orthopaedic Centre (ESEOC) Transport*** – noted decision to rely on existing transport provision. A hardship fund and supported patient transport available for those meeting the criteria. Patients and families will be advised of the voluntary sector transport option.	• Strengthened provider collaboration	• Focus on system working	2.1
Digital Board Report – use of Artificial Intelligence (AI) discussed and inclusion within cyber security. Capacity constraints within Virtual Ward noted due to cessation of use of agency staff. These constraints have now been mitigated by the neighbourhood team.	• Ongoing assurance/monitoring		2.4
IQPR Report – plans in place to reduce waiting times for 65-week elective surgery waits for Dermatology and Gynaecology. C.difficile antimicrobial stewardship continues.	• Ongoing assurance/monitoring		3.1

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Finance Report – Month 7 saw an improvement in the ERF performance. Work continues on workforce efficiencies and tracking of savings. Trust has requested £8m additional cash support. Trust is also looking at apportionment of costs for wheelchair services across trusts.	• Ongoing assurance/monitoring	• Financial sustainability	3.2
Guardian of Safe Working Annual Report – Board advised of residents' concerns regarding staffing pressures as a result of cost improvement measures. Director of Workforce to take forward.	• Ongoing assurance/monitoring	• Workforce sustainability	4.2
Freedom to Speak Up – Executive support to be provided to the FTSU Guardian by the Chief Nurse.	• Ongoing assurance/monitoring	-	4.2
Improvement Committee – Assurance on surgical achievement of some metrics is being sought.	• Ongoing assurance/monitoring	-	6.1
Quality and Nurse Staffing Report – support being offered to spread workload from staff movement requirements, including to UEC from inpatient areas. Reduction in falls noted, with G10 promoting "bay watch – stay in bay" .	• Ongoing assurance/monitoring • Overseeing quality indicators	-	6.2
Maternity Services – NHSE and ICB assurance visits rearranged to end of January at their request. Noted 49% participation in staff survey undertaken as part of Perinatal Leadership Programme. Action plan to be produced for each aspiration.	• Ongoing assurance/monitoring in areas of priority	-	6.3
Audit Committee – consideration being given to extension of internal auditor contract.	• Board visibility and oversight	-	7.1
Governance Report – External auditors ratified by Council of Governors. Board approval granted to change in constitution to allow existing governors to re-stand. Approval given to the updated Membership and Engagement Strategy. This will go to the Council for approval.	• Board oversight	-	7.3

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Board of Director Key Issues – 31 January 2025			
Patient Story – The Board heard a recording from a patient's wife regarding her and her husband's experience of end-of-life treatment for her husband whilst a patient of the hospital. Learning to be shared with staff.	• To improve end of life care for patients and their families.	• Model for future care	Verbal
CEO Report – WSFT and ESNEFT will be completing a sustainability review commissioned by the ICB in order to deliver a "future shift" of resources in to primary and community services, whilst improving clinical and financial sustainability of the system overall.	• Ongoing assurance/monitoring	• Deliver the Trust strategy	1.7
Future System Report - WSFT new hospital to be in the first wave of projects with build anticipated to commence in 2027/8. New leads appointed, Dr. Philip Vaughn Clinical, Michelle Warwick, Workforce and Sara Spearpoint, NHP Project.	• Ongoing assurance/monitoring	•	2.1
Anchor Programme Update Report – The Health and Care Act 2022 lays the foundations to improve population health outcomes by joining up NHS, social care and public health services at a local level. It strengthens duties on NHS organisations to consider the impact of their decisions on health inequalities. Impact report received.	• Ongoing assurance/monitoring	•	2.2

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
West Suffolk Alliance and SNEE Integrated Care Board ***Suffolk Enhanced Bus Partnership*** - High utilisation of new bus routes introduced in 2024/5 to include stops at WSFT Main hospital site. 2025/6 funding announced and ideas requested from Alliance members. ***Evaluation of Physical Activity Pilot – Abbeycroft Leisure*** – outcomes positive. Physical Strategy Group to determine the way forward, including potential partner financial contributions and commissioning requirements.	• Strengthened provider collaboration	• Focus on system working	2.3
IQPR Report – Lack of significant improvement in ambulance handovers, linked to UEC performance challenges. UEC delivery plan is monitored at all levels and currently being rationalised in line with national winter objectives. Significant improvement in total volume of patients over 65 weeks, but risk in Dermatology and Gynaecology in meeting the revised target deadline remains.	• Ongoing assurance/monitoring		3.1
Finance Report – The revised forecast (£26.5m deficit) remains challenging and has some risks. However, the focus remains on ensuring that the exit monthly run rate for the year is in line with the original plan. This exit rate for 24/25 is important in determining the start position for the 25/26 plan.	• Ongoing assurance/monitoring	• Financial sustainability	3.2
Quality and Nurse Staffing Report – High sickness levels in Q3 and this period have impacted on staffing challenges. An increase in cold/flu symptoms is noted as the reason for absence.	• Ongoing assurance/monitoring • Overseeing quality indicators		4.2
Maternity Services – Compliance with Maternity Incentive Scheme Year 6 Safety Actions discussed. The Board is assured that all possible steps have been undertaken to provide safe care and services within the Maternity and Neonatal care settings.	• Ongoing assurance/monitoring in areas of priority		4.3

Summary of Key Issues	Board Action/Intervention	Future Implications for the Trust, Board and Council	Board doc. ref
Freedom to Speak Up Report – Speak Up Month in October, included a promotion in Time Out and Green Sheet. Noted largest group raising concerns was within nursing and midwifery, which was anticipated due to being the largest proportion of staff.	• Ongoing assurance/monitoring		6.1
Audit Committee – delay of some audits to back end of financial year. Requests made for prompt completion and progression of previous actions.	• Ongoing assurance/monitoring		7.1

18. Any other business

For Discussion

Presented by Jude Chin

19. Dates for meetings for 2025:

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

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 10 - IQPR full Report - November 2024

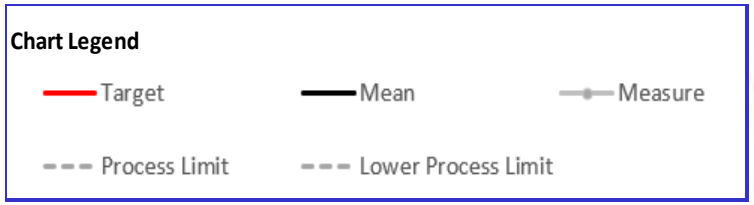
Assurance Grid

Performance in November 2024		ASSURANCE: Will we reliably meet the target based?		Not Met	
		Pass	Hit and Miss	Fail	No Target
VARIANCE: Variation from the mean The colours indicate the trend- positive (blue), Negative (orange), or neither (grey)	Special Cause Improvement		**INVOLVEMENT:** Staff Sickness Rolling 12months Staff Sickness Turnover	**INSIGHT:** RTT 78+ Week Waits	**INSIGHT:** RTT 65+ Week Waits RTT NDD Only Waiting List RTT NDD Only 65 Weeks Wait SHMI **INVOLVEMENT:** % extended
	Common Cause	**INSIGHT:** Urgent 2 hour response – EIT Virtual Ward Total average LOS per patient	**INSIGHT:** Ambulance Handover within 30min Non-admitted 4 hour performance % patients with no criteria to reside Virtual Ward Total average occupancy percentage 28 Day Faster Diagnosis Cancer 62 Days Performance Community Paediatrics RTT Overall 78 Weeks Wait Community Paediatrics RTT Overall 104 Weeks Wait **IMPROVEMENT:** C-diff Hospital & Community onset, Healthcare Associated Mandatory Training	**INSIGHT:** 12 Hour Breaches 4 hour performance Virtual Ward Total average occupancy number Diagnostic Performance - % within 6weeks Total Appraisal	**INSIGHT:** Criteria to Reside (Average without reason to reside) Acute Criteria to Reside (Average without reason to reside) Community Virtual Ward Total bed days Potential 65+ ww at end of Dec2024 Community Paediatrics RTT Overall Waiting List Community Paediatrics RTT Overall 52 Weeks Wait Community Paediatrics RTT Overall 65 Weeks Wait RTT NDD Only 52Weeks Wait RTT NDD Only 78 Weeks Wait RTT NDD Only 104 Weeks Wait **INPROVEMENT:** % of patients with measured weight % of patients with a MUST/PYMS assessment completed within 24 hours of admission Post Partum Haemorrhage Inpatient Deaths **INVOLVEMENT:** Active Complaints Closed Complaints Count Extended % Complaints responded to late Count responded to late % resolved in one week Total PALS resolved count
Deteriorating	Special Cause Concern		**INSIGHT:** 12 hour breaches as a percentage of attendances	**INSIGHT:** Incomplete 104 Day Waits	**INSIGHT:** RTT Waiting List

Items for escalation based on those indicators that are failing the target, or are worsening and therefore showing Special Cause of Concerning Nature by area:
INSIGHT - Urgent & Emergency Care: 12 Hour Breaches, 4 hour performance, 12 hour breaches as a percentage of attendances, Virtual Ward Total average occupancy number
Cancer: Incomplete 104 Day Waits
Elective: Diagnostic Performance - % within 6weeks Total, RTT 78+ Week Waits
INVOLVEMENT – Well Led: Appraisal

INSIGHT COMMITTEE METRICS

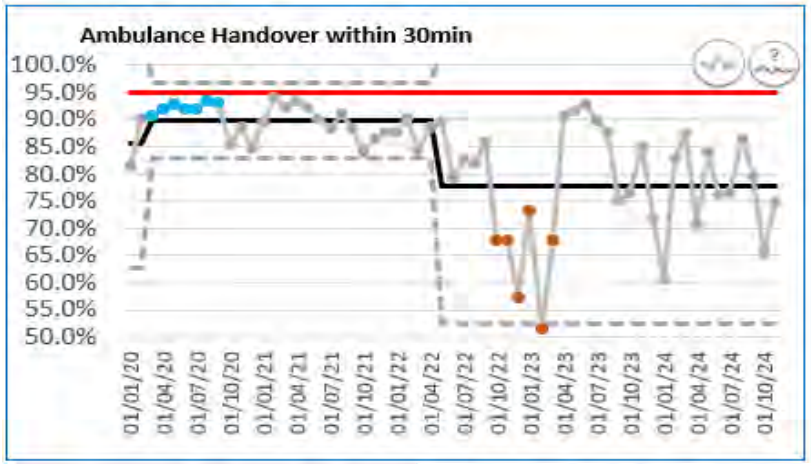
Urgent & Emergency Care summary

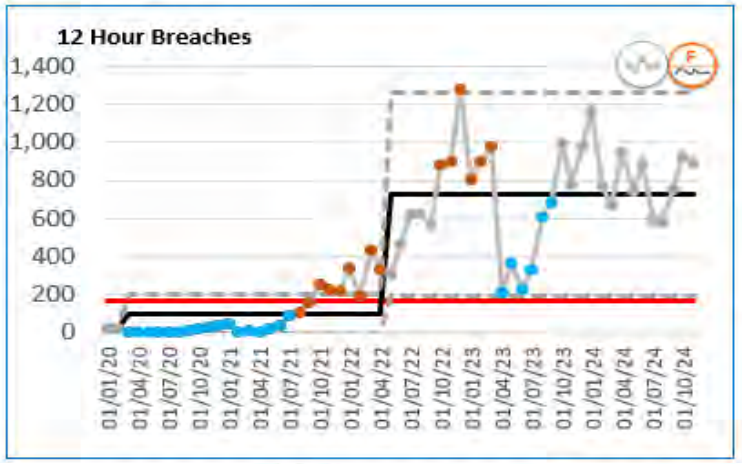


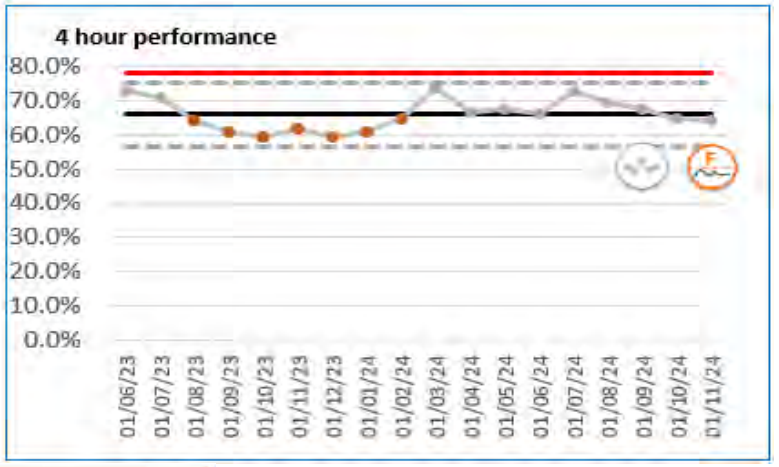
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover within 30min	Nov 24	74.6%	95.0%			77.8%	52.6%	103.0%
12 Hour Breaches	Nov 24	888	165			724	188	1259
4 hour performance	Nov 24	64.3%	78.0%			66.1%	56.8%	75.3%
Non-admitted 4 hour performance	Nov 24	75.8%	85.0%			76.0%	65.2%	86.8%
12 hour breaches as a percentage of attendances	Nov 24	10.6%	2.0%			5.5%	1.4%	9.6%
Urgent 2 hour response - EIT	Nov 24	92.3%	70.0%			90.6%	82.8%	98.3%
Criteria to reside (Average without reason to reside) Acute	Nov 24	49	-			55	41	70
**Criteria to reside (Average without reason to reside) Community	Nov 24	44	-			36	26	46
% patients with no criteria to reside (acute)	Nov 24	11.9%	10.0%			12.8%	8.8%	16.7%
Virtual Beds Trajectory	Nov 24	40	40					
Virtual Ward Total average occupancy number	Nov 24	27.5	47.2			22.4	14.5	30.3
Virtual Ward Total average occupancy percentage	Nov 24	69%	80%			67%	42%	92%
Virtual Ward Total bed days	Nov 24	883				665	325	1006
Virtual Ward Total average LOS per patient	Nov 24	7.5	14.0			9.1	5.0	13.2

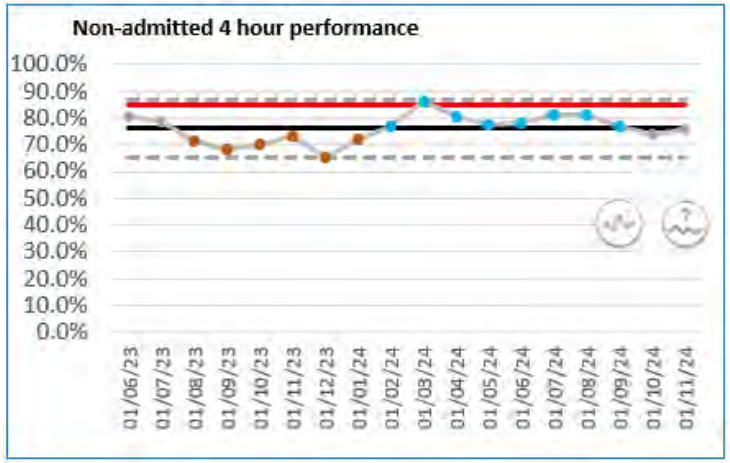
** Figures are for Glastonbury and Newmarket only, data not currently captured at Hazel Court.

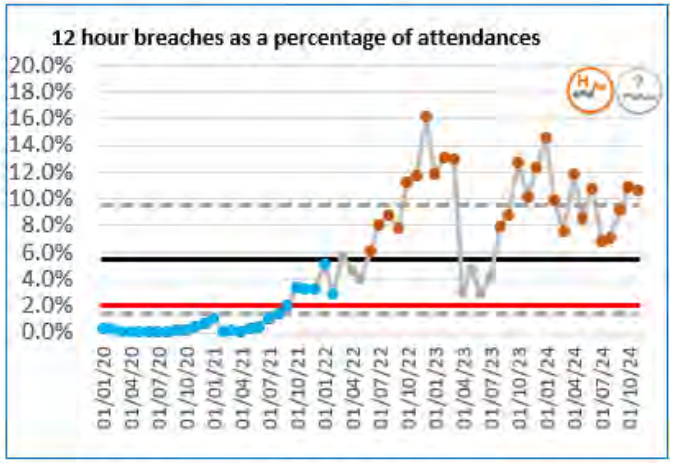
Urgent & Emergency Care: ED 4 Hour Performance

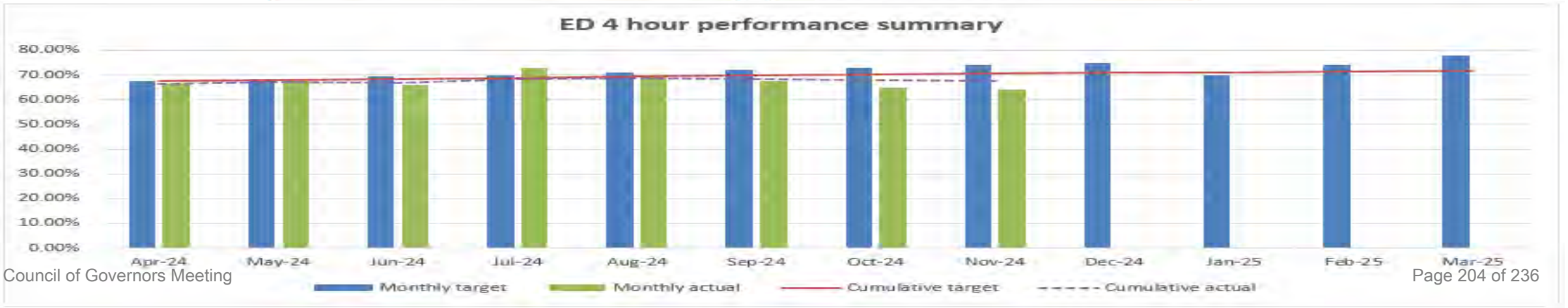












Urgent & Emergency Care

What	So What?	What Next?
No significant change in performance is demonstrated in the 30 minute ambulance handover metric and this remains a challenge. Factors contributing to this include the high number of patients in the Emergency Department with an increased length of stay, waiting for a bed, which results in the need to cohort patients into escalation areas including the Rapid Assessment Triage Area, which then reduces ability and capacity to offload ambulances. The number of 12 hour length of stay breaches in the month of November demonstrate no significant change. There were 888 breaches which was 41 less than when compared to October. We continue not to meet this metric. The number of 12 hour breaches as a percentage of attendances shows no significant change, but remains high and a cause for concern. Non-admitted performance demonstrates no significant change and was 75.9% for the month of November. The Emergency Department 4 hour performance dropped below our in-month trajectory of 74% to 64.3 %.	Meeting the Urgent and Emergency Care (UEC) performance metrics is key to ensuring that our patients receive timely, safe care. Achieving the ambulance handover metrics and the 78% 4 hour Emergency Department standard will meet the national targets. Keeping to the trajectory will mean we are on track to achieve 78% by March for the 4 hour standard. Some patients are waiting longer in the Emergency Department than they should be and being nursed in escalation areas, making for a poorer patient experience.	An internal Urgent and Emergency Care delivery group with workstream leads is in operation. Working through a revised/condensed Urgent and Emergency Care action plan in order to achieve 78% 4hr Emergency Department target by March '25. Weekly triumvirate performance meetings between the Emergency Department and Medical Division Senior Leaders/Executives continues. **Plans/Projects in December '24** • Focused bite sized leadership training for Registrars to improve overnight leading of the team has begun. • Consultation process has begun with Resident doctors regarding amendments to their rota to match the activity profile of the emergency department. New rota going live on 27th January. • The Minor Emergency Care Unit (MECU) is functioning well, next plans for this are a two week trial of extending the hours until midnight, commencing in January and continuing to review and learn from missed opportunities. • Pre booked next day returner Emergency Nurse Practitioner slots to support minor injuries attending after 10pm continues. • Ambulance handover action plan in place – actions currently being worked through. • Release to Respond commenced 28th November. Working collaboratively with the East of England Ambulance Trust to agree a solution for patients waiting longer than 45 minutes in an ambulance • Continuing to embed the new pathways for Ear, Nose and Throat and Orthopaedic expected patients to be accommodated in surgical same day emergency care. • The continuation of the rota for the Emergency Department leadership team to be solely based in department supporting performance. The Acute Admissions Unit also have a similar rota. • Taskforce for Emergency Department Admission Avoidance working in the department for the week commencing December 16th '24.

Community Access Glemsford Surgery

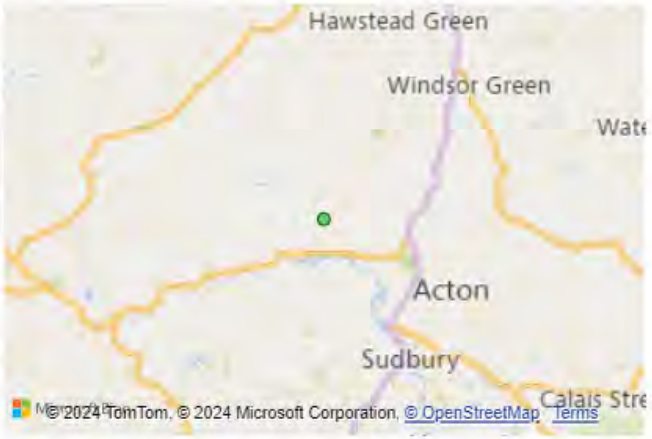
Practice Appointments

SNEE Business Intelligence

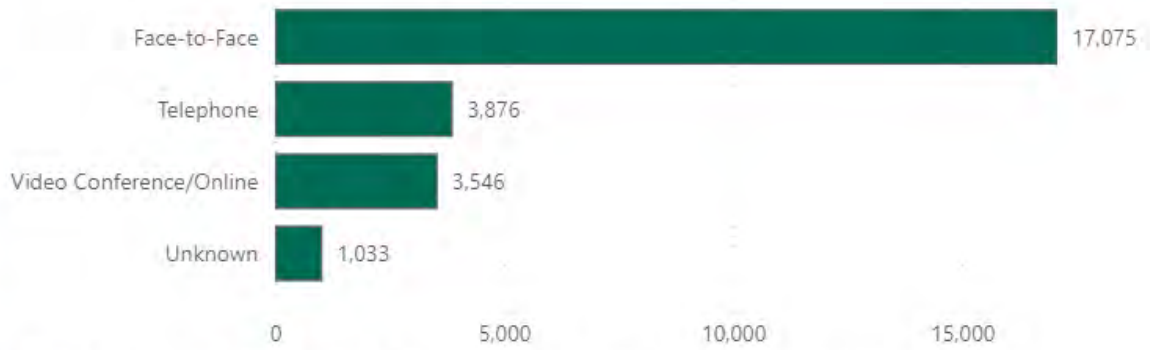
Refreshed on 17/12/2024, Data coverage up to 01/10/2024

NHS Suffolk and North East Essex Integrated Care Board

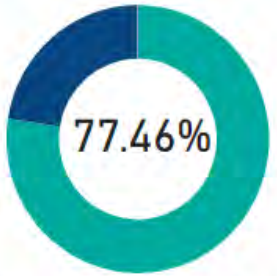
Alliance: All | PCN: All | Practice: Glemsford



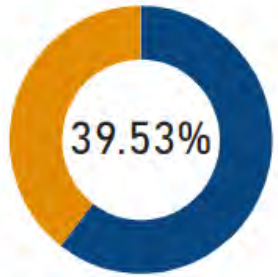
Practice appointments by contact mode



Seen within 2 weeks

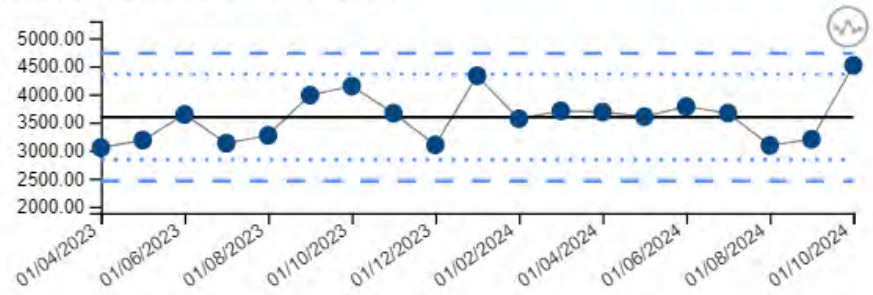


Seen within 48 hours

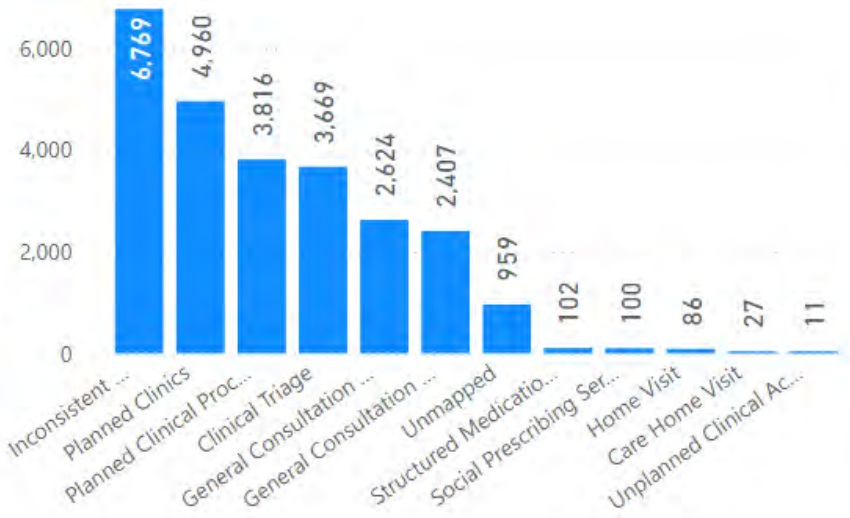


Practice appointments by health care professional type

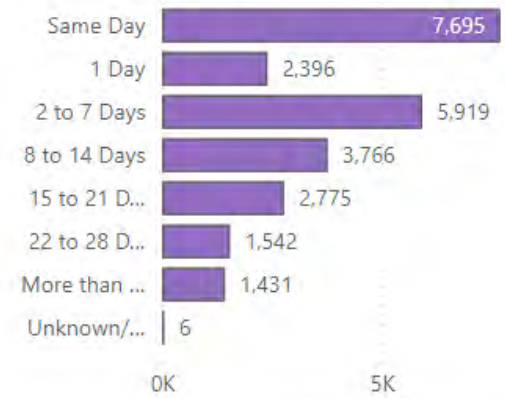
Total appointments by month

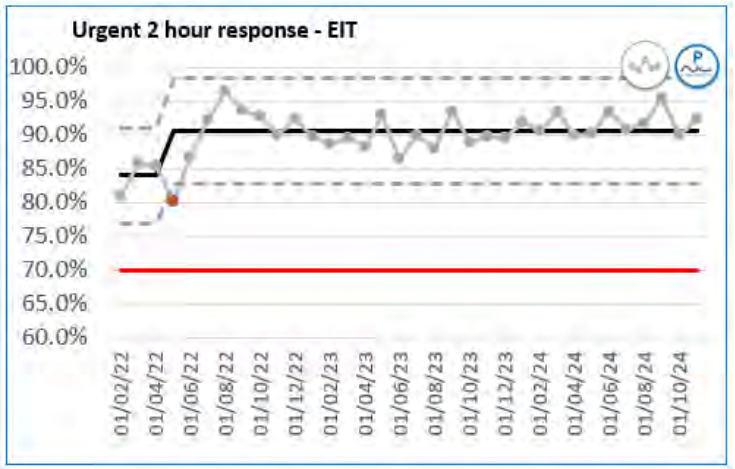


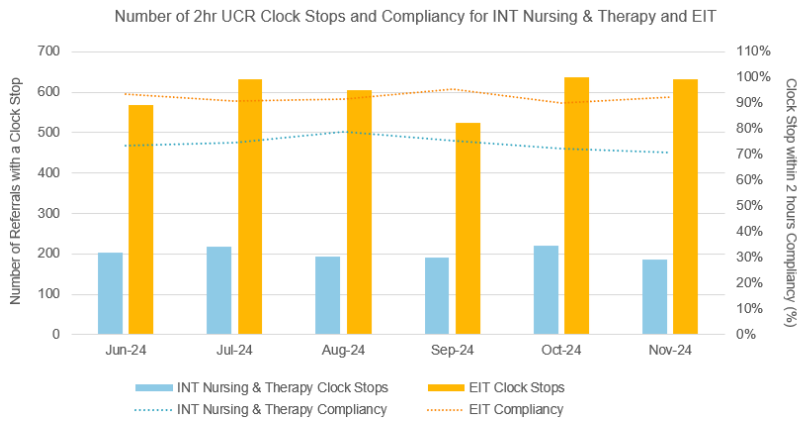
Sum of Total Appointments by National Category

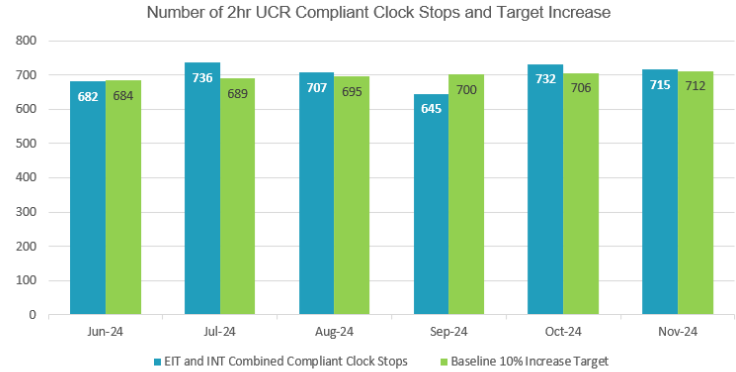


Appointments by wait time





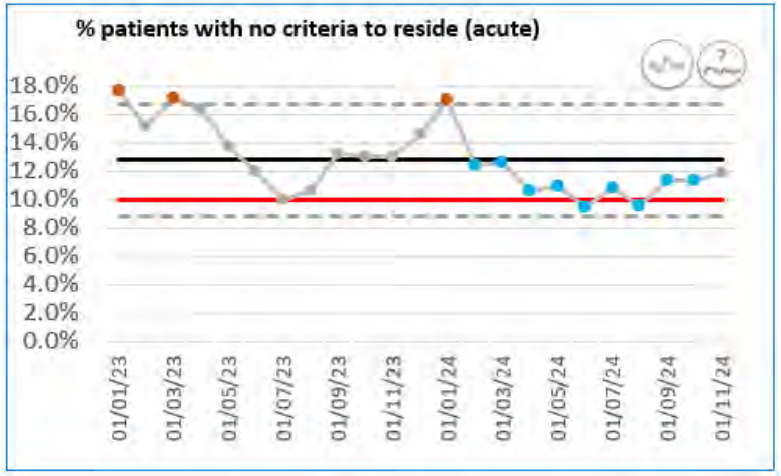


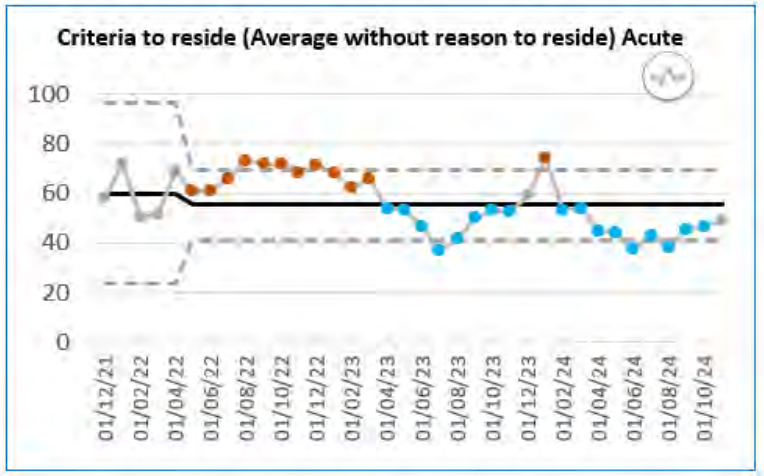


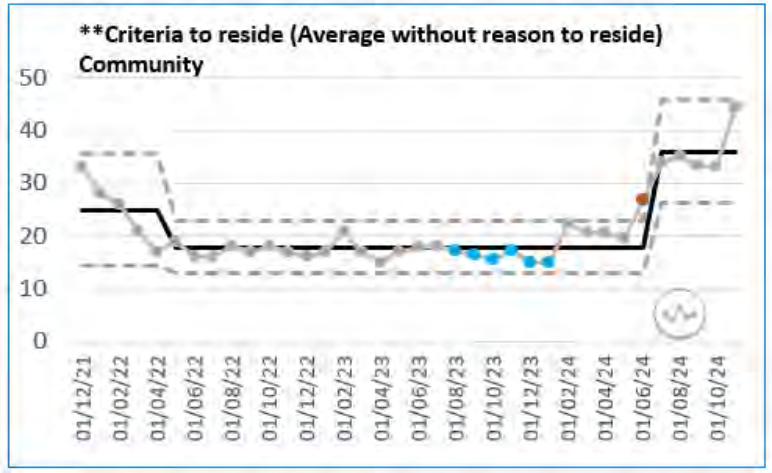
Team	Jun-24				Jul-24				Aug-24				Sep-24				Oct-24				Nov-24			
	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock 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	204	150	54	74%	217	162	55	75%	194	153	41	79%	191	144	47	75%	220	159	61	72%	186	132	54	71%
Total EIT*	569	532	37	93.50%	633	574	59	90.68%	604	554	50	91.72%	525	501	24	95.43%	637	573	64	89.95%	632	583	49	92.25%
Combined Total	773	682	91	88.23%	850	736	114	86.59%	798	707	91	88.60%	716	645	71	90.08%	857	732	125	85.41%	818	715	103	87.41%

Urgent & Emergency Care: UCR

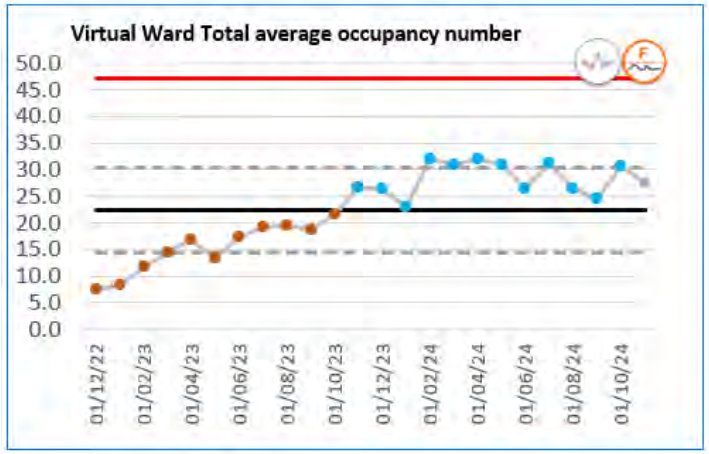
What	So What?	What Next?
2 hours Urgent Care Response in Integrated Neighbourhood Team (INT) and Early Intervention Team (EIT) maintained and in line with target for 10% increase. Compliance for 18 weeks is stable as a combined data set across services. Comparing November 2023 to November 2024, in addition to the increase in activity, there is a shift from 75% of activity being 2 hour and 2 day in the INTs to 85% of activity being responsive. To manage more urgent demand the INTs are cancelling or deferring more care.	Important to meet patient needs in a timely way.	EIT have 1 vacancy being filled in January. EIT are being considered in the task force which are supporting the emergency department. The outcomes of the taskforce will be shared as soon as possible, to date it is 5 days of data. Cancelled visits are monitored and harms are monitored via incident reporting. An audit of therapy triage will be shared in January 2025. Nursing are trialling ringfencing capacity for urgent care and outcomes will be presented to programme board in January 25. To work with informatics to commence WSFT Community OPEL framework in line with new national reporting in January 2025.

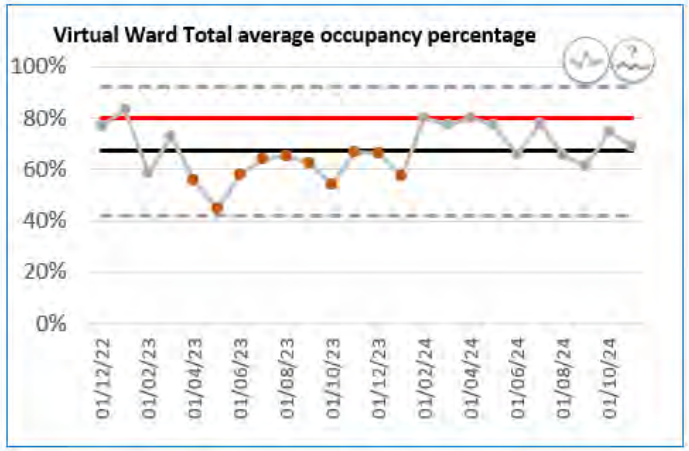


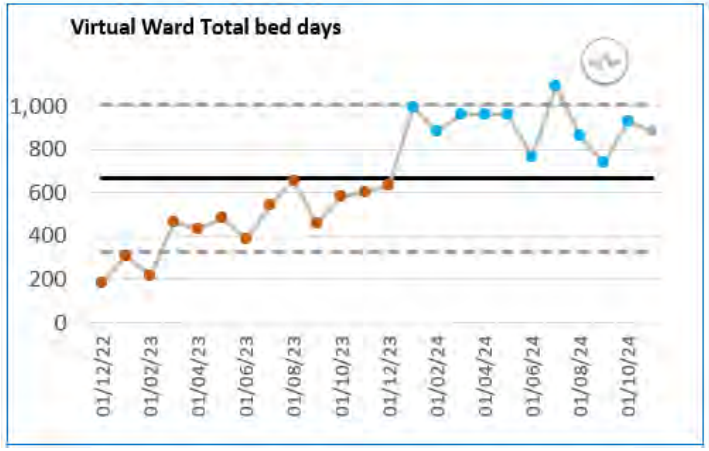


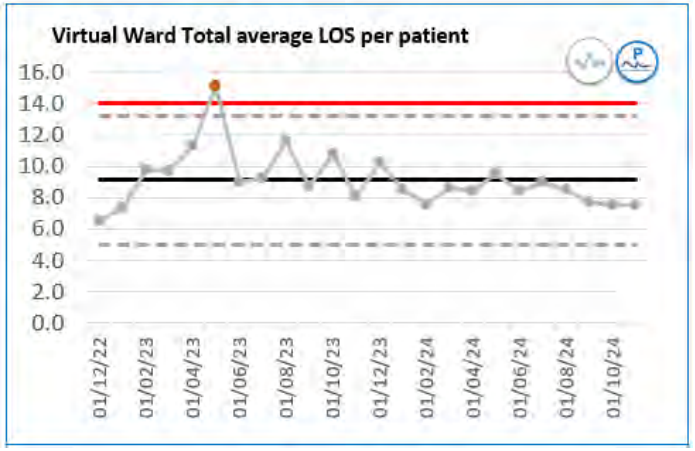


What	So What?	What Next?
The percentage of patients without criteria to reside in the acute is at 11.9% this month. The community figures have risen this month to an average of 44, from 33 the previous two months. The Discharge to Assess Interim beds (included in the Community data set since July) had a number of patients with an extended length of stay without criteria to reside whilst long term placements were sourced – this coupled with the continued use of community beds for non-traditional cohorts of patients have contributed to an increase in the numbers of patients without criteria to reside.	Patients remaining in hospital longer without criteria to reside directly impacts on bed capacity and patient flow within the Trust. Longer length of stay leads to greater deconditioning and loss of independence.	Informatics team are preparing a draft daily data set to identify patients with no criteria to reside for greater than 24hours. This will enable improved monitoring of delays and identification of actions and escalations during the daily Transfer of Care Hub (ToCH) review meeting. This will be available by the end of December. Further support from the informatics team to identify timescales patients remain within certain Reason for Delayed Discharge codes has been requested to inform areas for focused work to reduce the overall percentage of patients with no criteria to reside.



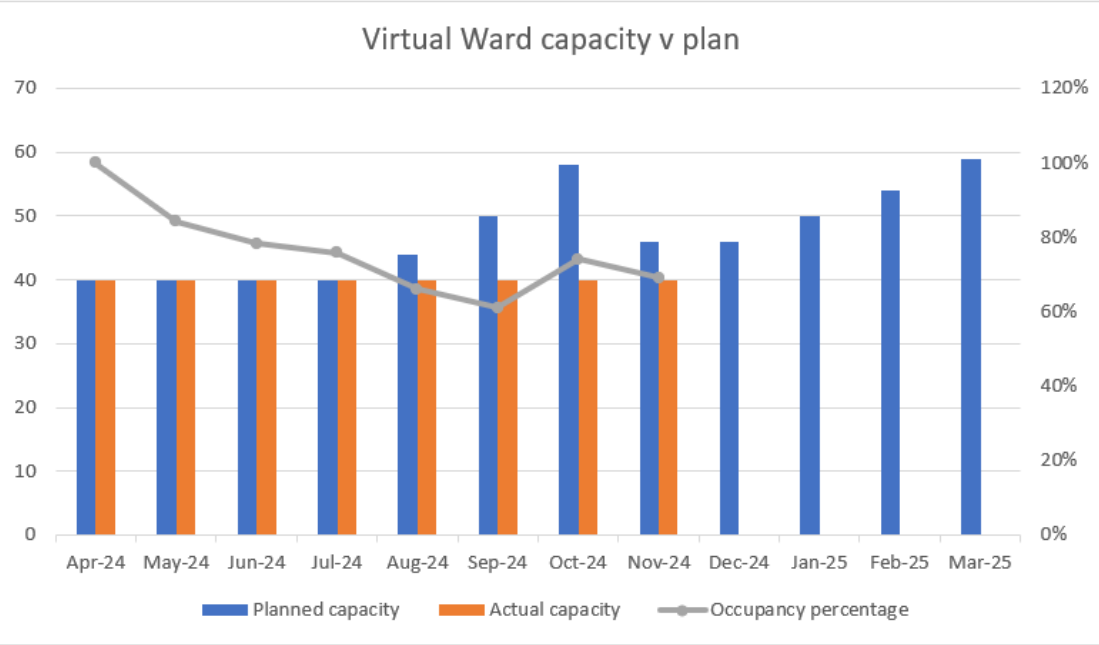






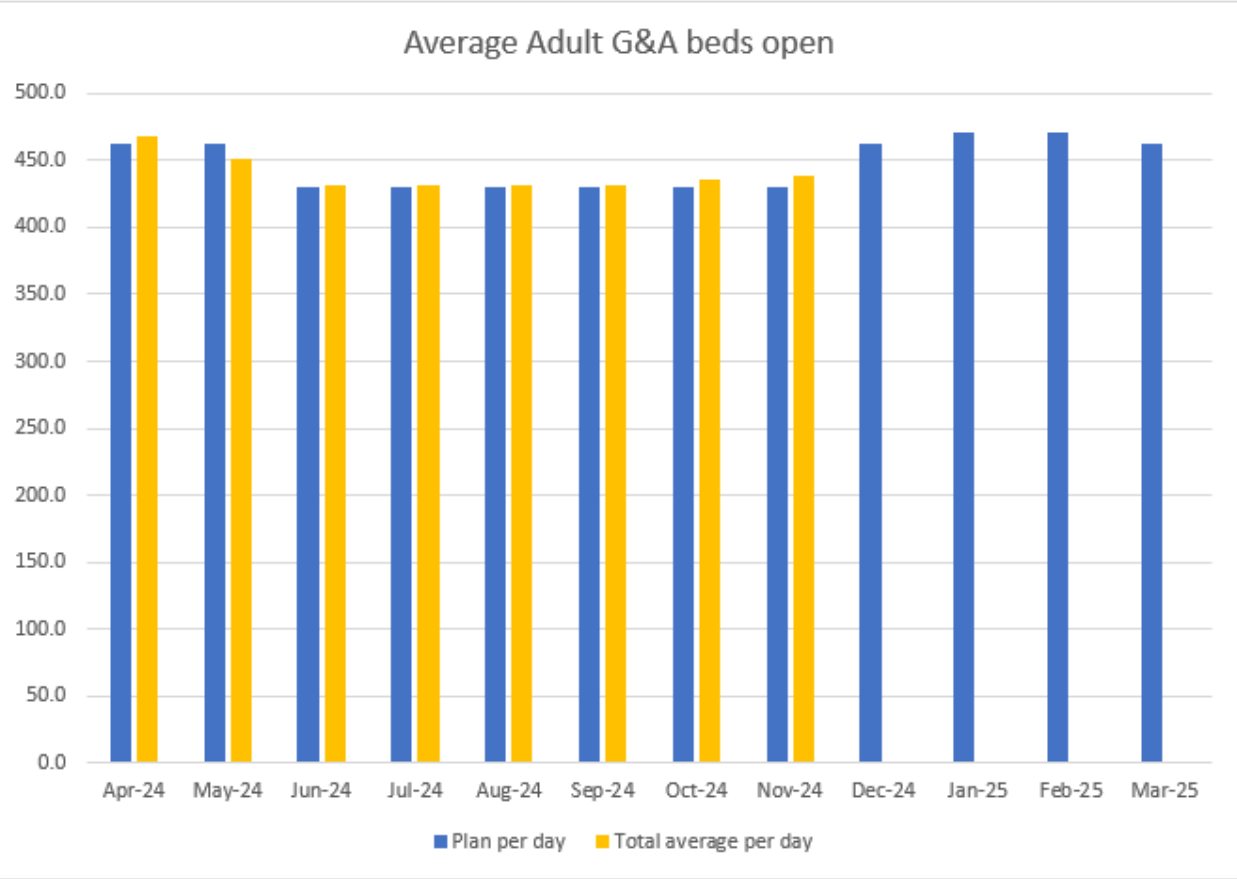
What	So What?	What Next?
Small decrease in overall occupancy on the Virtual Ward (VW) from 74% (October) to 69% (November) and associated reduction in bed days occupied from 931 (October) to 883 (November). Average length of stay has remained stable at 7.5 (7.7 in September and 7.5 in October) following an enhanced focus on reducing LOS across all pathways earlier in the year.	Virtual Ward capacity is crucial in ensuring adequate capacity to enable patient flow across the Trust and strategic ambition of caring for patients at or near wherever possible. Appropriate length of stay is important to facilitate effective patient flow and ensure that value for money is achieved in relation to the investment in virtual care.	As part of Shared Service Delivery programme, home nursing visits have now been migrated from VW core team into INT teams in Mildenhall, Newmarket and Sudbury. On target to migrate into Haverhill INT on 30 December thereby releasing further efficiencies. Initial discussions commenced with Dr Hanikat on 12 December re primary care pilot for direct onboarding from primary care to virtual care.

Urgent & Emergency Care (TRUST – Virtual Ward)



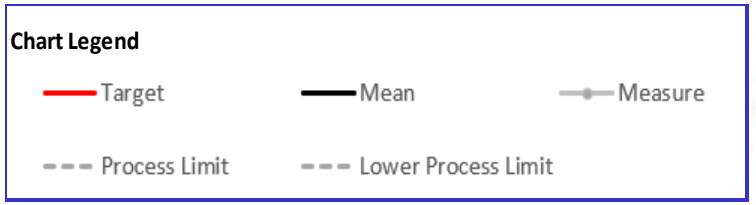
What	So What?	What Next?
This report reflects the revised trajectory 13 Nov 2024 ie increasing capacity to 59 (including paediatrics) by March 2025. ED Taskforce (w/c 16 December) concluded that virtual ward BAU processes are effective in identifying and onboarding appropriate patients from the Emergency Department at West Suffolk Hospital. Workstreams to continue to increase volume of stepdown patients from acute wards is ongoing. Action plan to increase stepup patients is under development (completion due January 2025); there are dependencies on delivery of integrated staffing model under Shared Service Delivery programme.	By the end of December 2024 migration of home nursing visits to virtual patients will have been completed in 4 out of 6 teams. This change releases efficiencies, thereby creating capacity to help achieve target.	Work underway to implement recommendations agreed by MEG on 13 November 2024 including (I) development of virtual ward service to maximise care of surgical patients (ii) recruitment of joint VW consultant/community geriatrician (iii) expansion of capacity to 59 beds (including paeds) by March 2025. Issue: significant difficulties in service provision ongoing due to disparity in acute and community footprint. Recommendation that these are aligned.

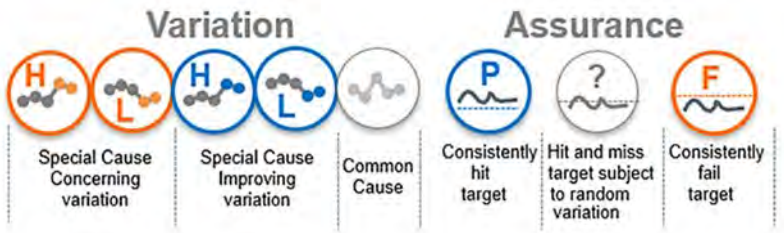
Urgent & Emergency Care: Beds



What	So What?	What Next?
Our actual average number of core beds open remains in line with plan. Use of escalation beds has increased by an average of 1.5 in November, given increased unmet demand, as flow at times has proven challenging with multiple patients awaiting beds in the Emergency Department, increased attendances and a static conversion rate to admission.	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 SDEC as an escalation area is monitored through the daily capacity meetings in conjunction with the Medicine divisional leadership team to ensure it is in line with the Tactical Patient Flow Escalation Plan. Given current numbers of patients waiting >12 hours and for admission in the Emergency Department, it is likely that the planned increase in bed capacity through use of a winter escalation ward will be required in January and February 2025. A taskforce led by Community and Integrated Therapies is reviewing all emergency decisions to admit to identify and deploy alternatives to admission, with learning transferred to business as usual processes.

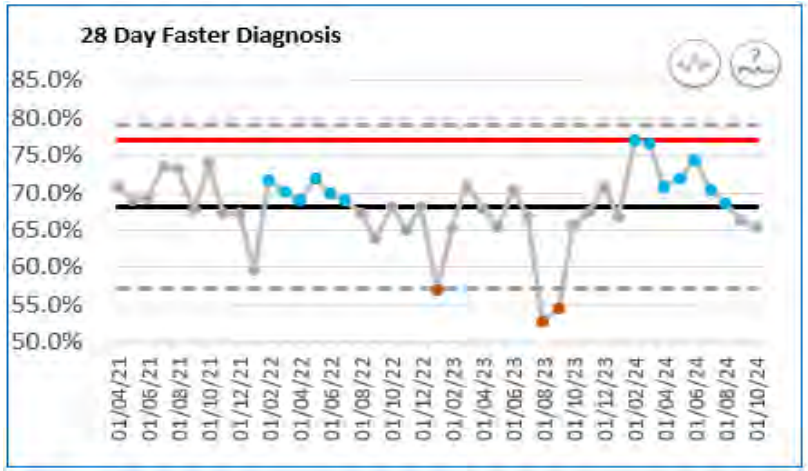
Cancer Access Summary

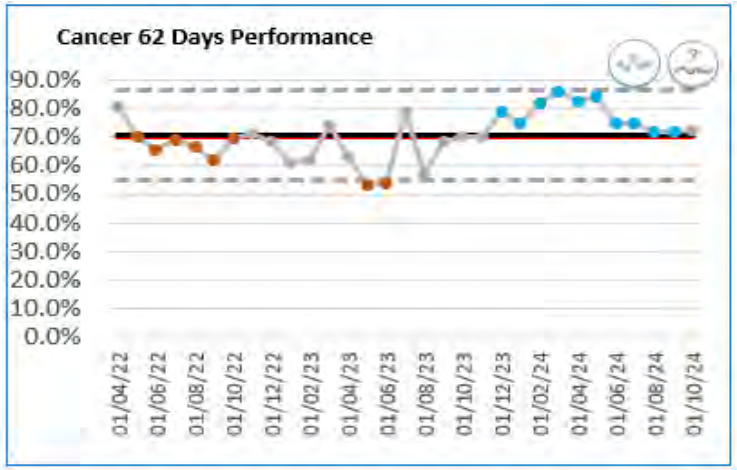


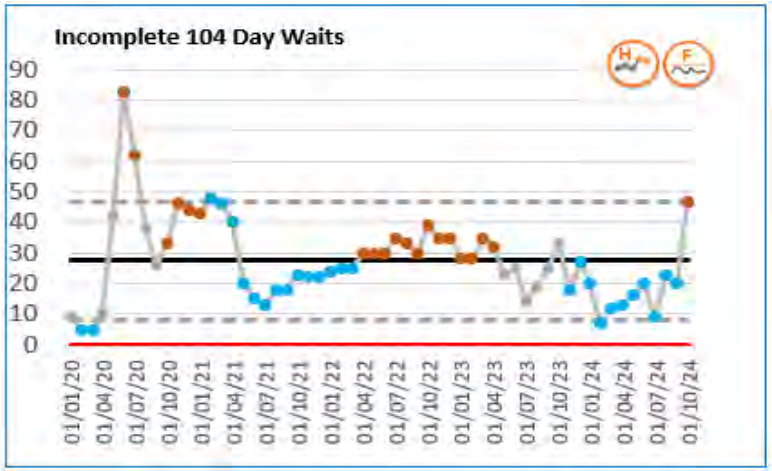


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	Oct 24	65.4%	77.0%			68.1%	57.1%	79.1%
Cancer 62 Days Performance	Oct 24	72.4%	70.0%			70.7%	54.7%	86.6%
Incomplete 104 Day Waits	Oct 24	47	0			28	8	47

Cancer Access (Month Behind)

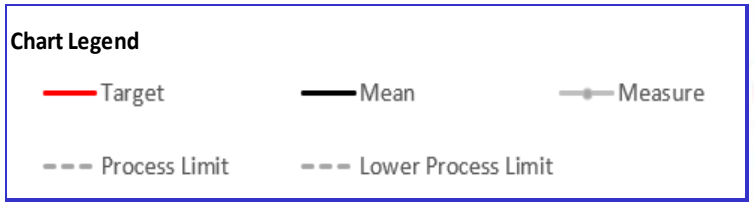


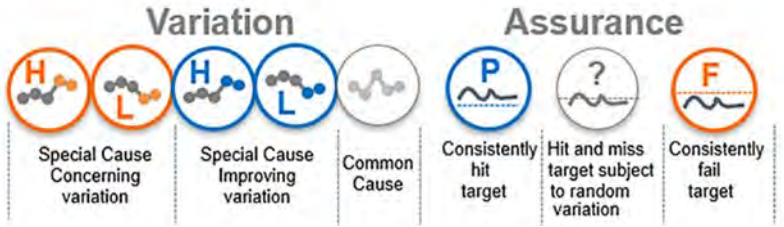




What	So What?	What Next?
Performance continues to drop for the overall FDS performance. The biggest driver for the underperformance in Skin at 42% and breast at 76%. Skin has significant challenges with November performance forecast to worsen. The wait time for photography in October remained high, which limits the opportunity to achieve the faster diagnosis standard. Breast performance is impacted by the lack of radiological cover and will see a further drop in November before improving from December onwards. Improvements in compliance are noted in Head and Neck, Gynaecology, Lower and Upper GI and Urology through into November. 62 Day performance is currently above the national requirement of 70% by the end of March 2025, with October performance improving to 73%, Breast are still maintaining high performance at 94%, with improvements noted in Gynaecology and Head and Neck performance at 100% for the second month running. Skin is the main driver for the performance reduction at 28%, significantly lower than previous months.	Recovering the cancer standards is key to the operational planning guidance 24/25 The priorities for this year focus on seeing, diagnosing and treating patients in line with national guidance to improve patient outcomes and maintain standards.	Additional photography capacity coming online in November through bank and additional Saturday sessions. Review of community tele dermatology model, with revised model to be proposed from April 2025. Multiple actions in place following Skin cancer meeting 03/12, including review of other skin analytic sites, workforce modelling and re-allocation of capacity. Additional substantive radiographer paper approved at trust level, to be presented to ICB in January. Continue with FDS steering groups in Skin, Colorectal, Breast and Gynae to monitor performance and required transformational changes as guided by the BPTP audits. For Lower GI, allocation of surgical cases is a focus with an agreement now in place to review 62-day breach dates when allocating cases in MDT. For Skin, performance is set to worsen in November to the challenges at the front end of the pathway. Additional weekend sessions to support the reduction in waiting times are in place for both Dermatology and Plastics.

Elective Access: Summary

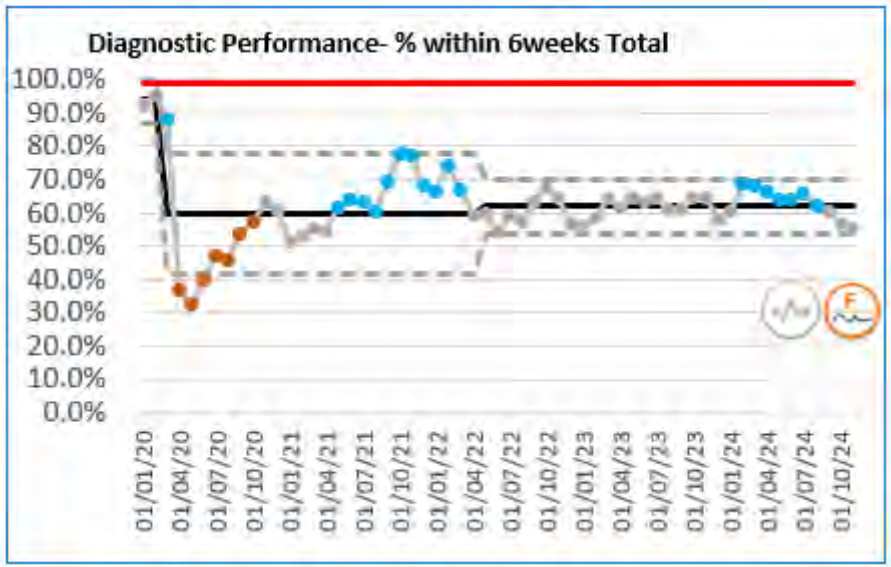




KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Diagnostic Performance- % within 6weeks Total	Nov 24	55.7%	99.0%			62.0%	54.0%	69.9%
RTT Waiting List	Nov 24	33805				32900	31608	34192
RTT 65+ Week Waits	Nov 24	172				463	274	652
RTT 78+ Week Waits	Nov 24	15	0			145	80	211
Potential 65+ ww at end of Dec 2024	Nov 24	402				1019	-743	2782

Community Paediatrics RTT Overall Waiting List	Nov 24	482	-			504	447	560
Community Paediatrics RTT Overall 52 Weeks Wait	Nov 24	1	-			1	-2	4
Community Paediatrics RTT Overall 65 Weeks Wait	Nov 24	0	-			0	0	0
Community Paediatrics RTT Overall 78 Weeks Wait	Nov 24	0	0			0	0	0
Community Paediatrics RTT Overall 104 Weeks Wait	Nov 24	0	0			0	0	0
RTT NDD Only Waiting List	Nov 24	29	-			68	35	102
RTT NDD Only 52 Weeks Wait	Nov 24	1	-			0	-1	2
RTT NDD Only 65 Weeks Wait	Nov 24	0	-			0	0	1
RTT NDD Only 78 Weeks Wait	Nov 24	0	-			0	-1	1
RTT NDD Only 104 Weeks Wait	Nov 24	0	-			0	0	0

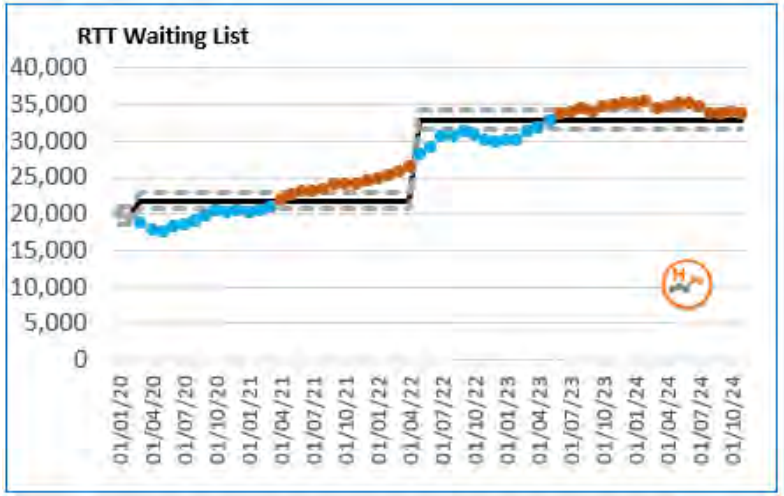
Elective Access

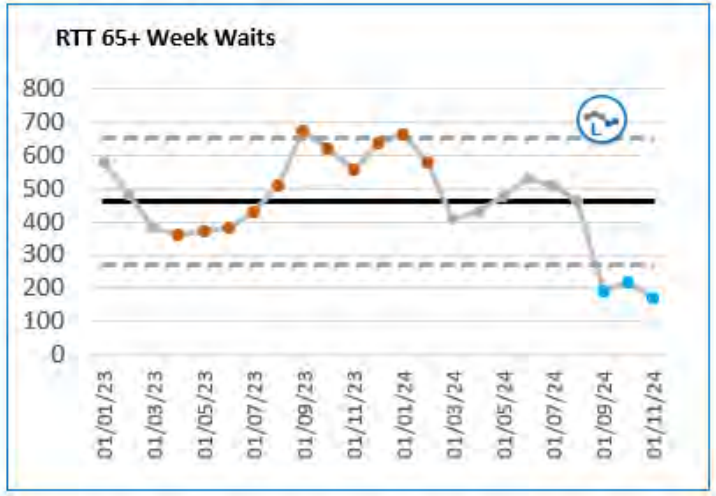


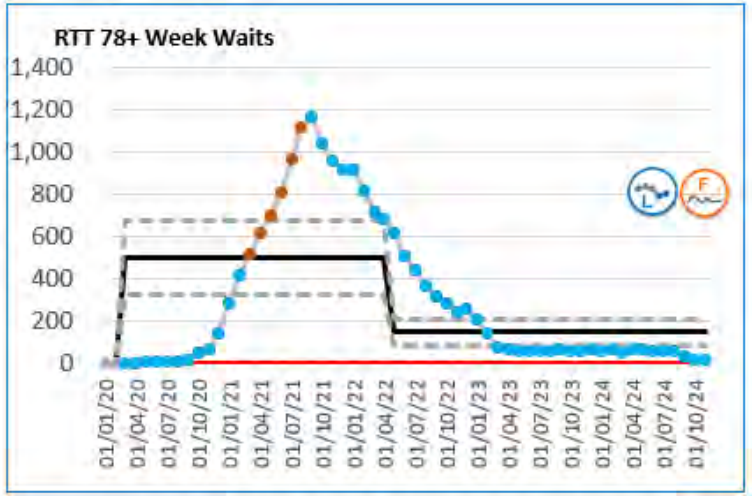
Diagnostics

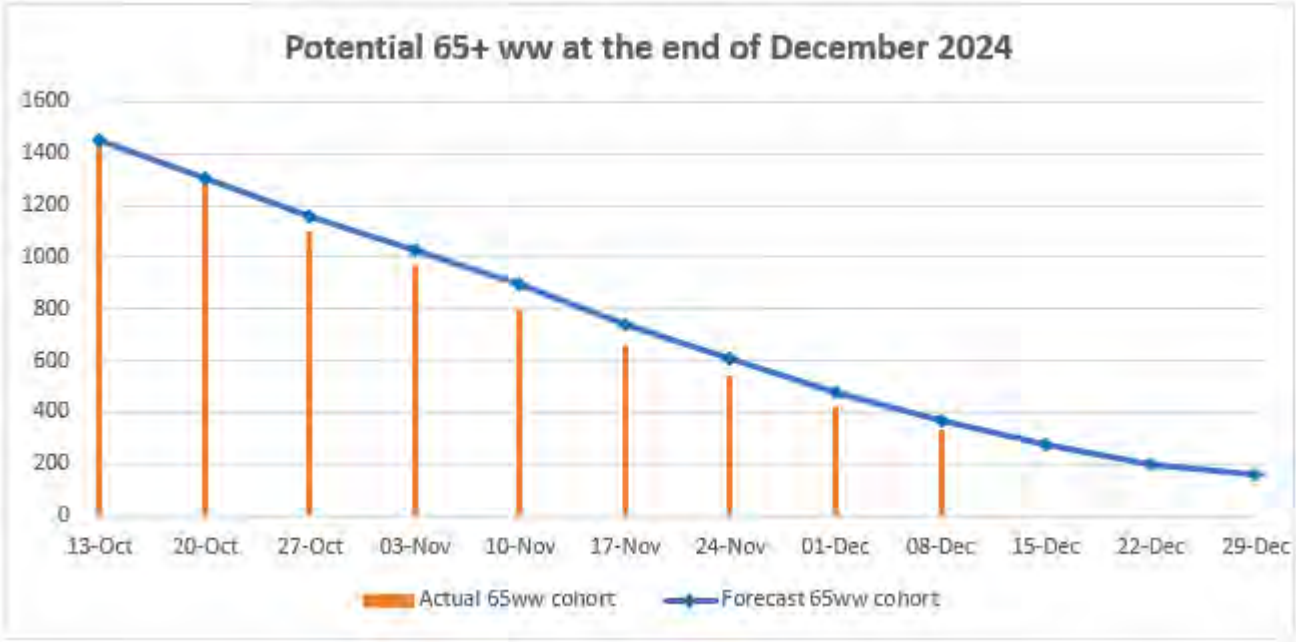
What	So What?	What Next?
MRI – Common cause consistently failing target. Running at full capacity across the seven days but current capacity insufficient. MRI 2 replacement has a legacy impact on performance the reduction in voluntary additional hours has seen an effect on capacity and DM01. MRI capacity will continue to deteriorate until the commencement of scanning at the CDC due to demand continuing to exceed capacity. CDC MRI capacity planned to go-live 06/01/2025, later than the other modalities which go-live on 16/12/2024. The MRI delay is due to an error in the programme by the supplier (GE) requires a further two weeks. However, work is being undertaken to bring this date forward. **CT** – Currently not meeting DM01 compliance target due to impacts of the replacement programme but now recovering well although not yet statistically significant. The reduction in voluntary additional hours has seen an effect on capacity and DM01. **US** – With varying factors DM01 attainment prediction is difficult to describe. Temporary staffing controls are compounded by recruitment challenges within the team. Agency support has been enabled for vascular US due to clinical risk, but MSK US is without support. And the wait time for USGI is risk of 65ww breaches in the T&O pathway. Performance remains vulnerable until recruitment improves, including capacity at the CDC. No forecast recovery without further intervention with a picture of deterioration to around 7% by April 2027. **DEXA** – We will not be able to go live with our DEXA service in November 2024 due to estates delays relative to ventilation and fire protection works. Anticipated go live now end of March 2025. Approval given for extension of temporary mobile cover to bridge to new opening date. Forecast recovery extends beyond February 2027 with existing planned capacity. **Endoscopy** – Priority has been given to patients on a cancer pathway requiring a rebalancing of capacity to support, Cohort of low complexity, low risk patients suitable for outsourcing and nurse endoscopists (NE) has been exhausted with limited scope for flexing of the criteria with outsourced provider. This has led to a compound effect and a plateauing of DM01 performance. Impact of financial recovery is being seen on DM01 target compliance. Colonoscopy and Gastroscopy trajectories have reversed with the reduction in weekend and additional lists. Flexisigmiodoscopy is predicted to improve once NE's commence haemorrhoidal banding. No forecast recovery within the next 12 months without intervention. **Breast Imaging** – Staffing issues have and will continue to impact the delivery of the screening service and overall cancer performance. To mitigate the risk to the service the department was employing two full time agency mammographers to help support the running of the screening and symptomatic services. However, due to financial restraints across the Trust this has now been reduced to one mammographer. The faster diagnosis performance is already dropping to 77% in August (against a trajectory of 94%) and this will continue to drop over the coming months. Breast is a high volume area, and it will therefore not be possible to hit the national standard of 77% faster diagnosis compliance or the 70% 62day standard by March 2025, which will increase national scrutiny and may result in tiering.	Longer waiting times for diagnosis and treatment have a detrimental effect on patients. Delay in achieving DM01 compliance standards	**MRI** – Mitigation including the delivery of the CDC will see MRI reaching DM01 compliance in April 2025. **CT** – the delivery of the CDC will see CT reaching DM01 compliance by March 2025. **US** – Staffing issues remain unresolved, and CDC capacity will not be realised until recruitment picture improves. Management team continue to review recruitment options aligned to CDC and cognisant of the workforce controls in place around financial recovery. Further review of temporary staffing options will take place to mitigate the long waits and 65ww risk. **DEXA** – Once open the new service will increase DEXA capacity from 3 days per month to 3 days per week once staff are trained and the service is up and running fully **Endoscopy** – Currently an unmitigated flat line trajectory of around 60% DM01 performance can be described. This assumes no further uptake in additional work. Options are available to enhance recovery of performance but require financial support. **Breast Imaging** – Investment panel and MEG have approved the request for recruitment of a permanent Consultant Breast Radiographer. This will now go to ICB Double Lock Panel at the next available date in early January for approval. Short term, requests for bank/agency to fill gaps and ensure service provisions is being sought via the TSCP. Financial recovery measures are having an impact additional hours worked to deliver performance improvements against the MD01 standard across multiple modalities. Further work is required to deliver core services on a substantive staffing model rather than historic temporary staffing arrangements especially around core OOH acute service provision. A DM01 recovery paper was presented to MEG on 11/12/2024, and the NHSE/ICB tier 2 meeting on the 16/12/24 with costed options for a consideration to support recovery of diagnostic waiting times. Temporary staffing support has been approved as an interim measure and will be managed via the Temporary Staffing Control Panel (TSCP) and the ICB Double Lock Panel

Elective Access: RTT





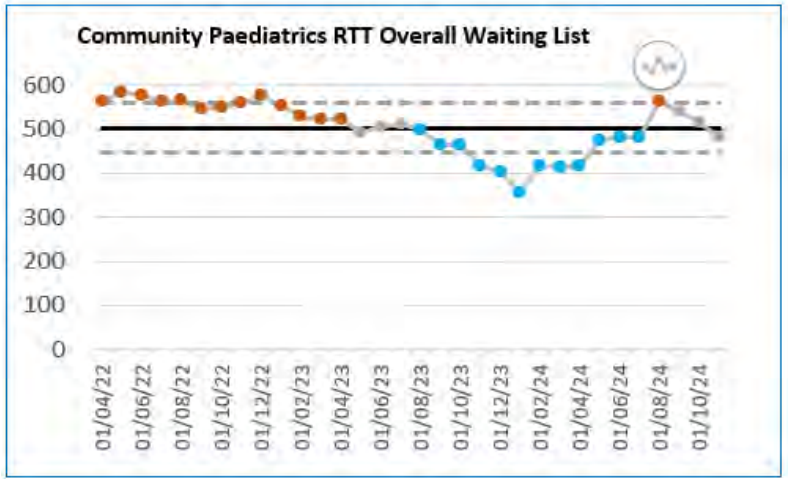


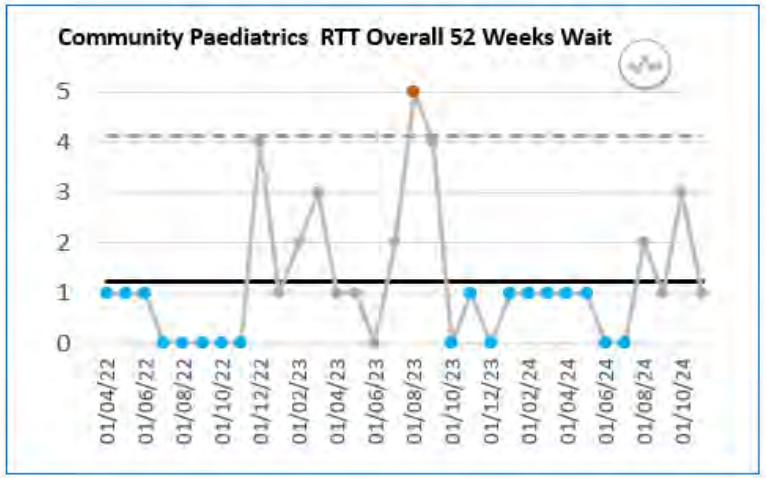


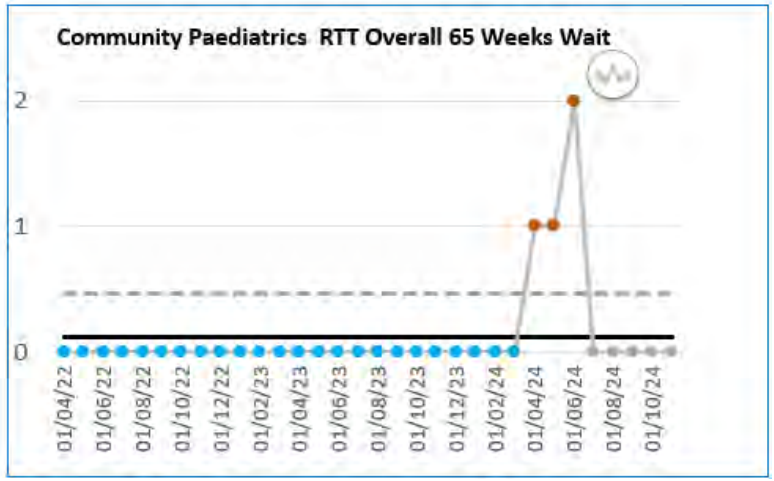
Elective Access: RTT

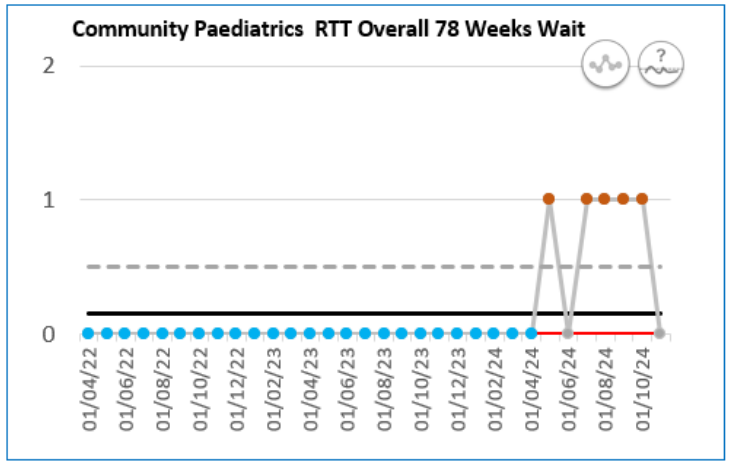
What	So What?	What Next?
The 78 week wait position for the end of November was 15 patients. A continued reduction of 78 week waits is now forecast with committed to reach 0 by the end of January 2025. The number of patients in both the actual 65ww and 65ww cohort are continuing to decrease, whilst it will not be possible to reach 0 by the end of December, progress continues to be made with the current forecast of 109 patients.	Delivering the objective of no patients waiting over 65 weeks by December 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.	Continue to send patients to Nuffield health for Gynaecology. Review ability to increase Gynaecology theatre capacity in Q4 to reduce the backlog and reach a sustained position. Additional sessions to continue for Dermatology in January and February, with current forecast to clear 65ww by the end of February. Further discussion with Berts health on gynaecology transformation and referral reduction scheduled for 13/01/2025. Implement new pathway for skin cancer patients from April 2025 ICB/WSFT integration meeting set for January 2025 for Dermatology.

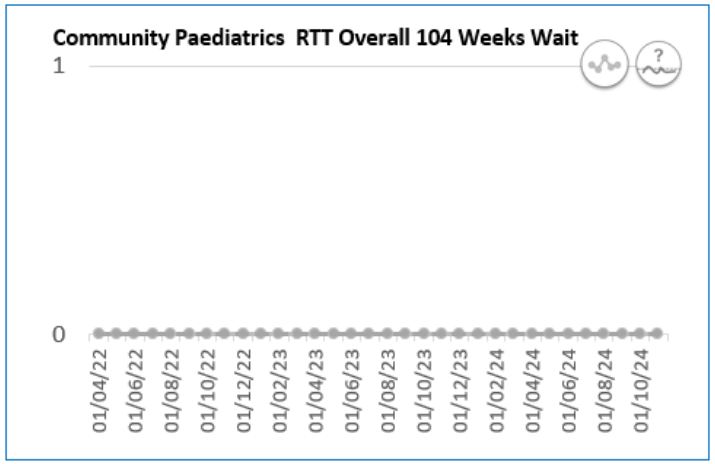
Elective Access (Community Paediatrics)











What	So What?	What Next?
The paediatric medical team has a longest wait of 51wks.	Children continue to wait longer for initial assessment within the medical team due to overall service demand and challenges with service capacity.	Mitigating actions are having minimal impact on improving capacity due to high clinical caseload.

Elective Recovery Fund (ERF) threshold achievement

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	9,545	10,333	10,285	(0.5%)
May	9,660	10,458	10,315	(1.4%)
Jun	9,090	9,841	9,879	0.4%
Jul	10,165	11,004	10,669	(3.0%)
Aug	8,967	9,708	9,262	(4.6%)
Sep	9,545	10,333	9,861	(4.6%)
Oct	10,454	11,317	10,663	(5.8%)
Nov	9,891	10,708	10,115	(5.5%)
Dec	8,744	9,466		
Jan	10,345	11,200		
Feb	9,206	9,966		
Mar	9,365	10,138		
Total (YTD)	77,316	83,699	81,049	(3.2%)

November 2024

23/24	9,891
ERF	10,708
24/25	10,115
Var	(593)
Var %	(5.5%)

Daycase

Mon	23/24	ERF	24/25	Var %
Apr	2,191	2,373	2,434	2.6%
May	2,245	2,431	2,568	5.6%
Jun	2,084	2,257	2,264	0.3%
Jul	2,364	2,560	2,613	2.1%
Aug	2,109	2,284	2,331	2.0%
Sep	2,245	2,431	2,424	(0.3%)
Oct	2,459	2,663	2,515	(5.6%)
Nov	2,408	2,608	2,512	(3.7%)
Dec	2,056	2,227		
Jan	2,420	2,621		
Feb	2,219	2,404		
Mar	2,241	2,428		
Total (YTD)	18,103	19,608	19,661	0.3%

November 2024

23/24	2,408
ERF	2,608
24/25	2,512
Var	(96)
Var %	(3.7%)

Outpatient Follow Up

Mon	23/24	ERF	24/25	Var %
Apr	25,353	27,046	27,943	3.3%
May	25,659	27,373	28,151	2.8%
Jun	24,145	25,758	26,717	3.7%
Jul	27,001	28,804	28,290	(1.8%)
Aug	23,819	25,411	25,445	0.1%
Sep	25,353	27,046	26,353	(2.6%)
Oct	27,767	29,622	27,712	(6.4%)
Nov	26,273	28,028	25,035	(10.7%)
Dec	23,225	24,777		
Jan	27,480	29,316		
Feb	24,452	26,086		
Mar	24,876	26,537		
Total (YTD)	205,37(	219,090	215,646	(1.6%)

November 2024

23/24	26,273
ERF	28,028
24/25	25,035
Var	(2,993)
Var %	(10.7%)

Elective

Mon	23/24	ERF	24/25	Var %
Apr	256	277	271	(2.1%)
May	267	289	294	1.9%
Jun	247	267	233	(12.8%)
Jul	280	303	274	(9.6%)
Aug	256	277	277	0.0%
Sep	256	277	286	3.3%
Oct	284	307	337	9.9%
Nov	268	290	287	(1.1%)
Dec	249	269		
Jan	234	253		
Feb	244	264		
Mar	244	264		
Total (YTD)	2,114	2,286	2,259	(1.1%)

November 2024

23/24	268
ERF	290
24/25	287
Var	(3)
Var %	(1.1%)

Outpatient attendances that are a first attendance or with a procedure (one month in arrears – target 46.0%)

All

All

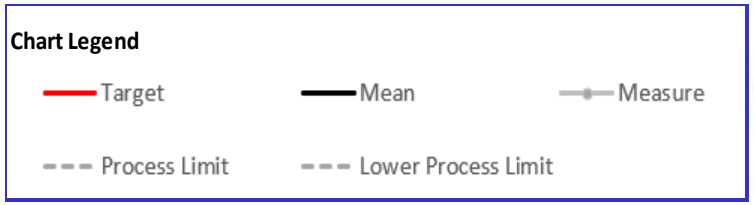
Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
23/24	38.2%	37.2%	37.0%	38.2%	38.5%	38.5%	36.6%	35.7%	37.4%	36.6%	38.2%	38.6%	37.5%
24/25	39.7%	38.8%	39.2%	40.1%	41.8%	39.1%	39.0%						39.6%

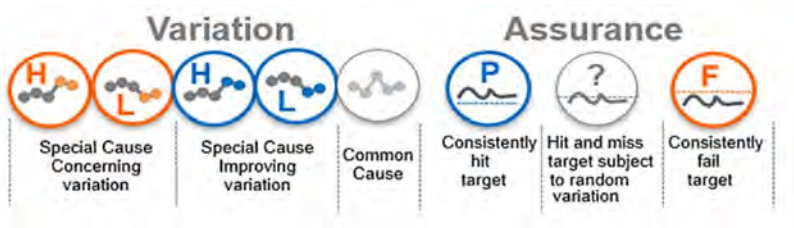
Target	46.0%
Month	40.1%
YTD	39.6%

Elective Access: Activity

What	So What?	What Next?
Day cases year to date are just meeting the required threshold to deliver the system level activity target of 108.09% of 2019/20 activity levels, with the November monthly position recovering slightly to -3.8%. Elective activity has decreased to -1.1% in month, reversing the trend of August to October and leaving the year to date gap at 1.1% behind. Elective procedures will attract the highest ERF income, however day case rates are an important productivity metric on which we are monitored externally and can deliver the high volumes of activity required to reduce waiting times in line with operational performance expectations. Day case rates were challenged in October due to staff absence in theatres, with elective activity prioritised. Outpatient follow ups continued to decrease below 2019/20 levels in October, having been over between April and June. These do not attract ERF unless they include a procedure. New outpatients continue to track behind the ERF threshold. Although not attracting the same levels of income as elective or day case procedures, this represents the biggest opportunity for the medical division and is also important for reducing overall waiting times, in line with operational planning expectations. Outpatient attendances that are a first attendance or with a procedure show no significant change from the 2023/24 average, September representing the lowest figure in year.	Although achievement is measured in terms of value and at a system level, increasing absolute activity is required to achieve Elective Recovery Fund income as part of our Financial Recovery Plan and deliver on the objective to eliminate waits of >65 weeks by 22 December 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.	**Surgery:** • Reinforcement and monitoring of Patient Initiated Follow Up (PIFU) • Increased delivery of High Volume Low Complexity lists • Continuation of weekend lists • All lists booked to 90 -100% • Specialty level Elective Recovery Fund (ERF) tracker and identification of shortfall, assuring delivery of ERF plan • Delivery of ERF plan **Women's & Children's:** • Gynaecology: over performing in elective and day case. Further expansion of elective inpatient activity through weekend lists, potential for further increase should inpatient bed base be reconfigured as part of ESEOC backfill. • Paediatrics: Continued focus on general paediatrics PIFU and assessing impact of winter staffing requirements on outpatient activity. **Medicine:** • Further additional clinics to be booked where ERF income will be realised. • 'Further Faster' continues a specialty level focus on areas of non-compliance. • Dermatology additional activity proposal approved at Management Executive Group. • Gastroenterology 3 month adjustment to clinic templates, converting 2 follow up to 1 new appointment.

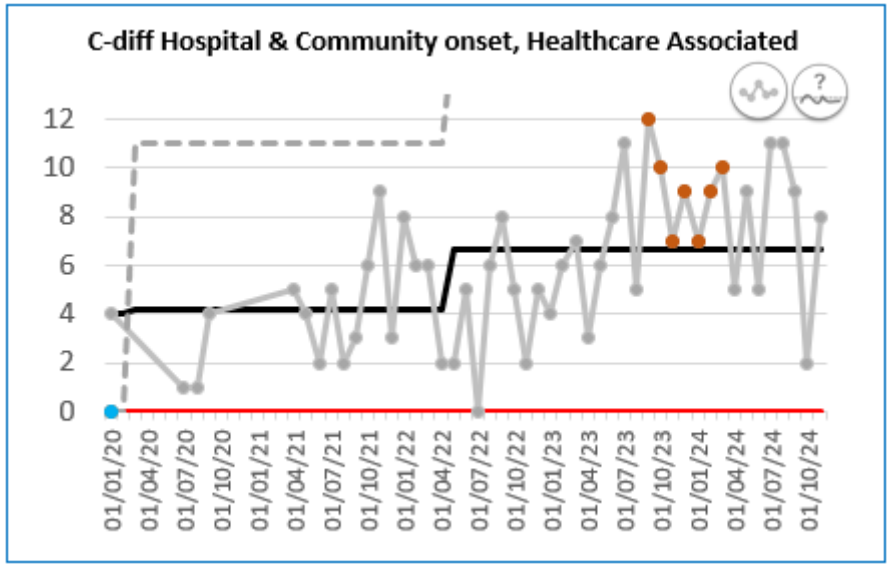
IMPROVEMENT COMMITTEE METRICS





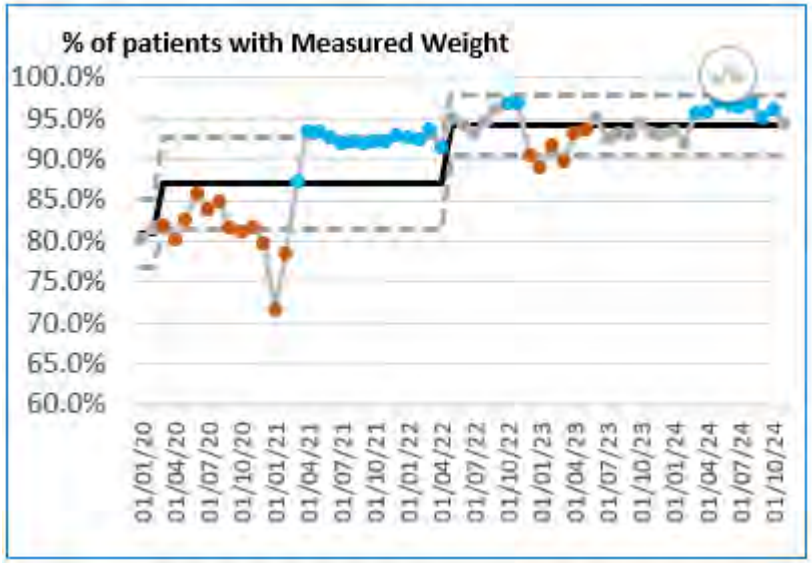
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
C-diff Hospital & Community onset, Healthcare Associated	Nov 24	8	0			7	-2	16
% of patients with Measured Weight	Nov 24	94.5%				94.2%	90.5%	97.9%
% of patients with a MUST/PYMS assessment completed within 24 hours of admission	Nov 24	86.8%				86.1%	77.3%	94.8%
Post Partum Haemorrhage	Nov 24	3				7	0	15

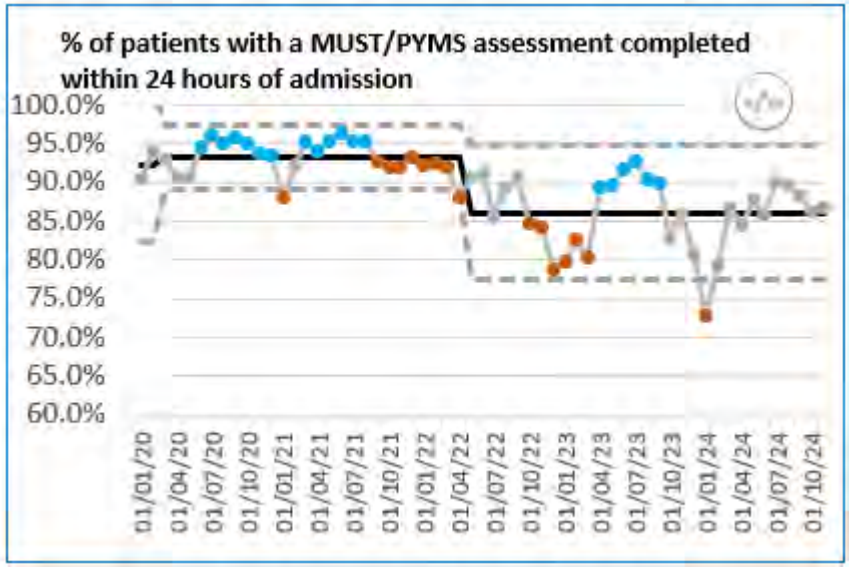
Safe



What	So What?	What Next?
The data set combines HOHA & COHA cases which provides the organisations measure for national/regional data and better demonstrates the impact on our patient group. Whilst there was a reduction in *Clostridioides difficile* infection cases last month the data is still showing random variation and suggesting that rates are not predictable or currently no in control This is due to the multifaceted issues surrounding *Clostridioides difficile* infection and we do not expect to see a significant change in performance for some time following the commencement of the quality improvement programme. 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. They can pose a serious risk to patients, staff and visitors, can increase length of stay due to illness or prevent discharges particularly to care home settings. *Clostridioides difficile infection* may cause significant morbidity to those infected and incur significant costs for the NHS. In addition, a new strain of *Clostridioides difficile* has been identified which has been linked with extensive outbreak scenarios within the UK. Infection prevention and control is a key priority for all NHS providers. The NHS Standard Contract 2024/25: Minimising *Clostridioides difficile* is now published with a WSH threshold of 91 cases 2024-25.	Reduction in C-diff rates as been identified as an organisational key priority, with escalations via patient quality & safety group and attendance at the improvement committee March & October 2024. The Quality Improvement Programme is ongoing QI update: • QI programme re-launch – Nov 24 -Jan 2025 following additional project management and clinical support from education team • Oversight meetings planned for January 2025 to ensure quality improvement workstreams have robust oversight and progression • Review of isolation signage and Trust roll out – Jan – Feb 2025 • Review and imbed RADAR actions when a *Clostridioides difficile* infection case is identified – Jan 2025 • Collaborative research project with ICB IPC colleagues –research project underway focusing on high incident area Dec 24 – April 2025. Hopefully will yield additional learning around opportunities for intervention and improvement.

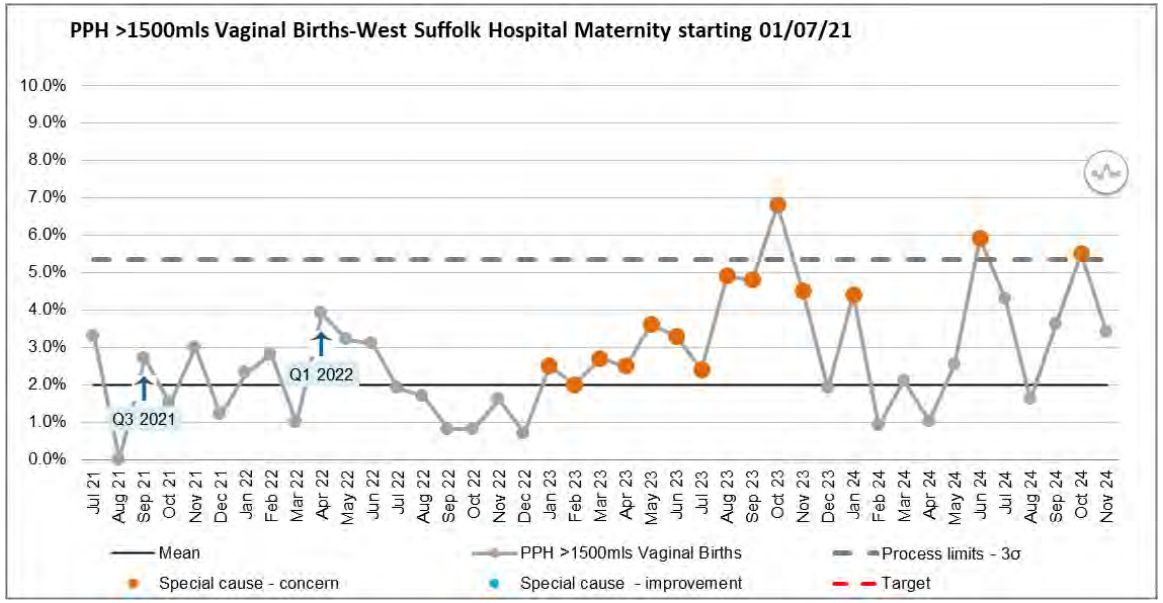
Safe

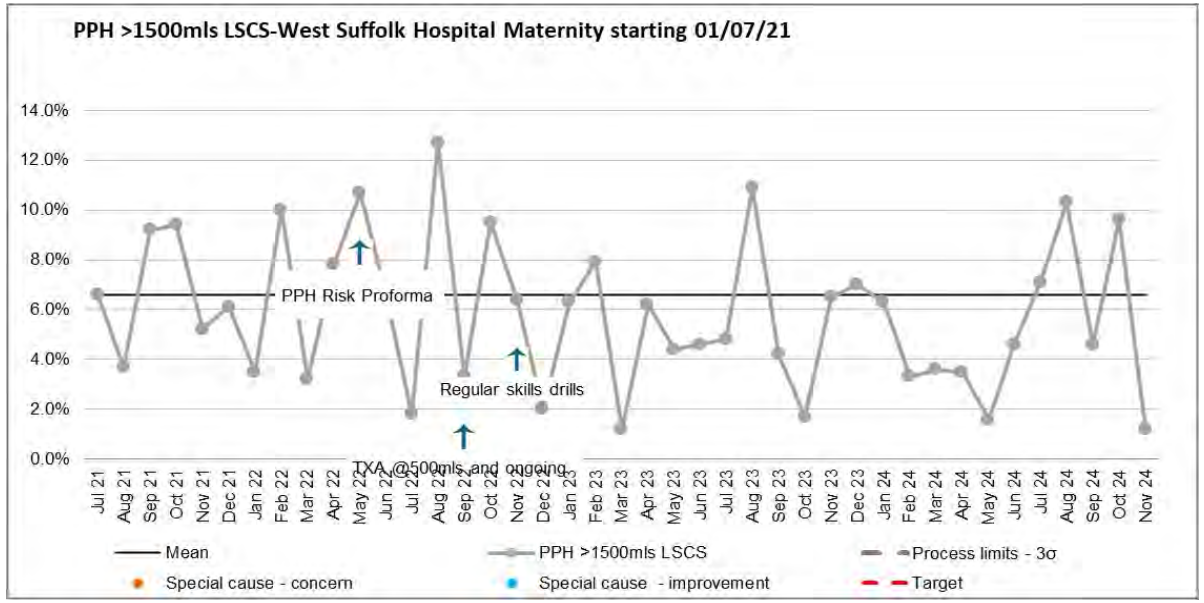




What	So What?	What Next?
Compliance with nutrition assessments being completed within 24 hrs of admission remains unchanged in month despite a change in how the information is being reported. This continues to correlate with Urgent and Emergency care pressures, which delay the completion of these assessments due to increased LOS in the ED With the changes in reporting, individual wards can monitor their performance more effectively, however, overall the data is still being pulled from the point the decision the patient is being admitted, so delays on arriving to the ward will still affect this. The Emergency Department have commenced a screening assessment tool to identify those most at risk in the initial period. This is not captured in this data set, but adds additional assurance of early recognition of risk. Most patients have a weight recorded during their admission, but the teams continue to focus on ensuring this is measured within the first 24hrs.	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. The reporting process to capture the timeliness of assessments when patients are admitted to a ward has been updated and will provide teams with the opportunity to improve the compliance and accuracy of this important metric as they will receive reliable information regarding their own area, as opposed to the admitting area.	• Engage and focus on activities to improve the UEC performance and continue to monitor these improvements against the nutrition assessment data. • Monitor introduction of short assessment in ED and observe the impact on this • Review of data in December following changes to reporting - **Completed** • Monitor for incidents or complaints raised regarding nutritional intake or support at department level to gain assurance. • To commence improvement work streams following the 'Food as medicine' workshop – **In progress** • Monitor weight on admission and every 7 days compliance via safety reports and Radar assurance audit.

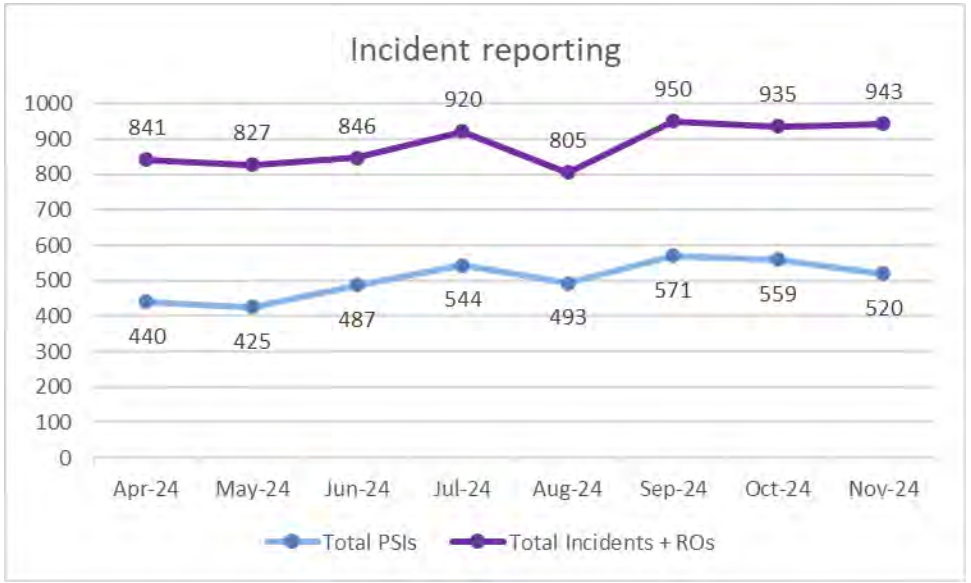
Safe

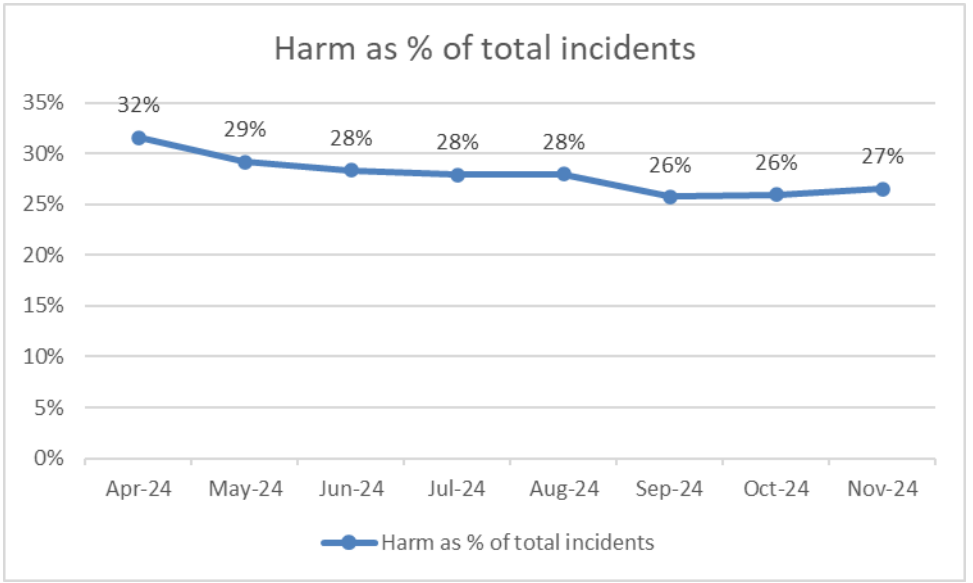




What	So What?	What Next?
This month data of Post-partum Haemorrhages (PPH) exceeding 1500 mls for Vaginal/ LSCS Births indicates normal variation. A comprehensive review of all cases was conducted in line with the internal governance procedures. In November 2024, there were three reported cases of PPH over 1500 mls, with one occurring after a vaginal birth and two following Lower segment Caesarean Section (LSCS). The primary cause of PPH identified during the review was a combination of tone and trauma. As noted in the Birth Trauma report from May 2024, individuals giving birth and their support partners often find PPH to be a traumatic experience, and actions for improvement have been identified through a "so what" review process. Previous targets were set by The NMPA (National Maternity and Perinatal Audit)using 2022 data. Due to significant changes in practice (increased induction of labour and elective caesarean births) these targets have been removed as they are no longer relatable to the service.	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. 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) Following a PPH there is an increased risk of psychological impact, exacerbation of mental health issues as well as affecting family bonding time, which can have irreversible consequences. Exposure of psychological trauma to patients and our staff.	Quality Improvement 3rd cycle launched 5 workstreams identified; Anaemia, Training, Risk, Equipment/Estates and Medication Engagement with local, LMNS (Local Maternity & Neonatal System) and regional QI programmes has shown some improvements these are not constantly sustained. Ongoing work continues to deep dive into the reasons for our PPH >1.5L. A review of the "So what" initiative was undertaken in relation to PPH and subsequently presented to the WSFT Improvement Committee and the LMNS Safety Forum in November 2024. The feedback from service users highlighted the need for enhanced support for both parents following PPH, and the methods for implementing these improvements are currently under evaluation. With the removal of nationally set targets, to monitor performance in line with maternity units across the region.

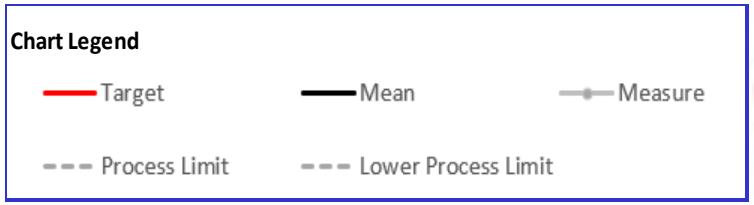
Safe

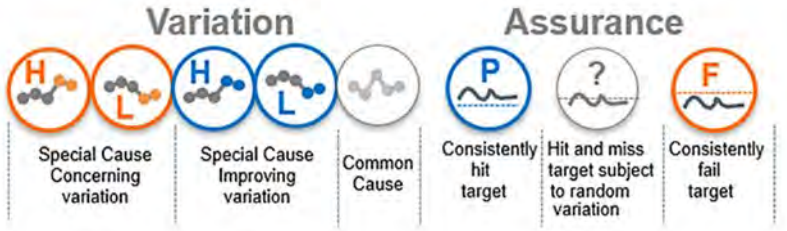




What	So What?	What Next?
The number of reported patient safety incidents (PSI) and reportable occurrences (RO) remains consistent, together with harm as a percentage of total incidents. Harm as a % percentage of total reported PSI is a measure of safety and demonstrates we are reporting low harm and near miss events as well as incidents which are attributed to harm. The low percentage is a good indicator of safe care. An analysis of patient safety incidents is undertaken on a monthly basis. This month we have seen a rise in nutrition incidents and a reduction in medication incidents.	Measuring patient safety incidents is an important element of safety insight but should not used in silo. The patient safety team will report the quarterly patient safety report to the December Patient Safety and Quality Governance Group (PSQGG). This will help us measure safety and culture in more depth and allow us opportunity to analysis interaction with the Radar system. Monthly analysis is prepared for the Radar Oversight Group (ROG) to scrutinise interaction with our risk management system and aid improvement.	Aim to reduce the percentage of harm as a total number of reported incidents by encouraging reporting of incidents. We will use the monthly report to highlight areas of low reporting trends and support reporting of near miss, low harm by supporting clinical teams at the elbow. We have seen success in some areas with this method, such as theatres. Safety actions are recorded on Radar and areas for improvement are captured on LifeQI. Measurement of safety actions forms part of the new patient safety report and part of the divisional governance project which is underway to ensure accurate capture and action. Use the quarterly patient safety report to triangulate prioritisation of safety improvement with our Human Factors lead and our QI team in monthly triage meeting.

Mortality Summary

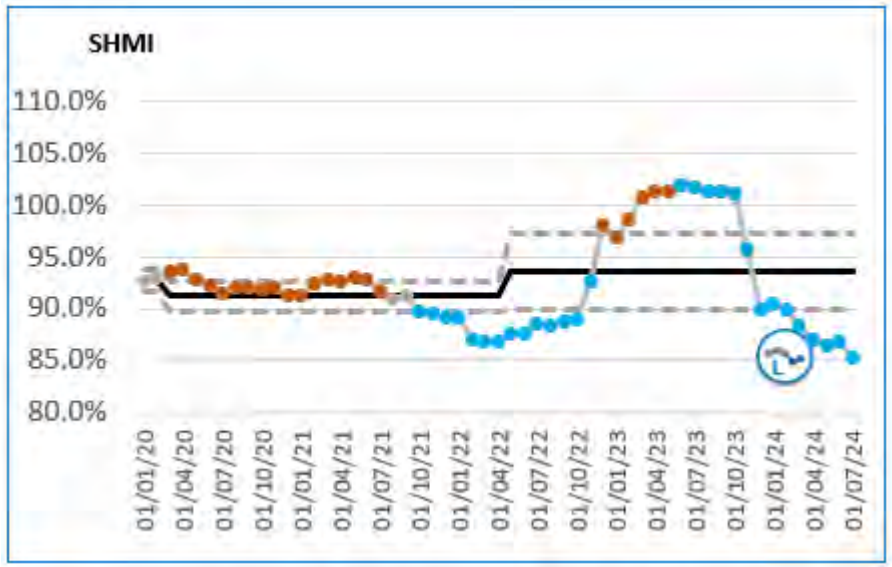


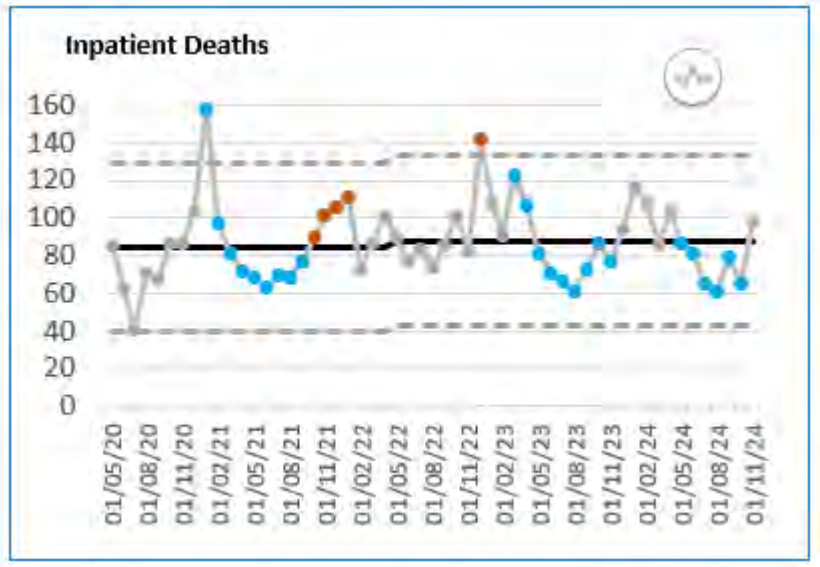


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SHMI	Jul 24	85.2%				93.6%	89.9%	97.2%
Inpatient Deaths	Nov 24	98				88	43	133

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

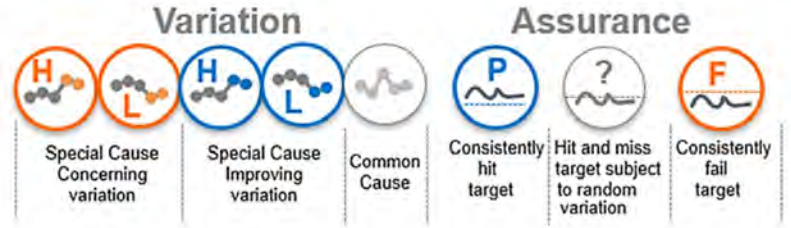
Mortality





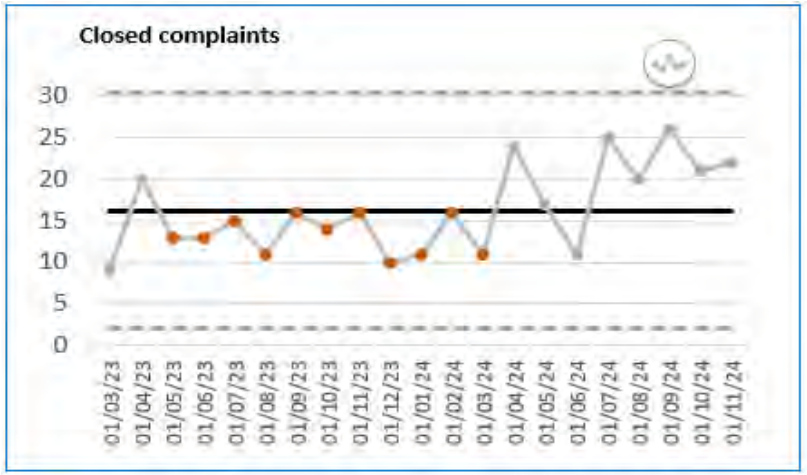
What	So What?	What Next?
On analysis of our current SHMI data we can see that we continue to have slightly lower than expected deaths, given our patient demographics and disease coding.	This data demonstrates that we are performing well as an organisation. More patients are surviving to discharge than expected. This is reassuring that in comparison to some other Trusts that our organisational is performing well.	We continue to monitor our SHMI data monthly and benchmark our Trust against comparable data from other organisations.

INVOLVEMENT COMMITTEE METRICS



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Active complaints	Nov 24	21	-			30	15	45
Closed complaints	Nov 24	22	-			16	2	30
% extended	Nov 24	31%	-			75%	41%	109%
Count extended	Nov 24	7	-			11	2	21
% Complaints responded to late	Nov 24	4%	-			10%	-24%	43%
Count responded to late	Nov 24	1	-			2	-4	8
% resolved in one week	Nov 24	65%	-			56%	26%	86%
Total PALS resolved Count	Nov 24	169	-			157	49	265

Safe


Closed complaints
30
25
20
15
10
5
0
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
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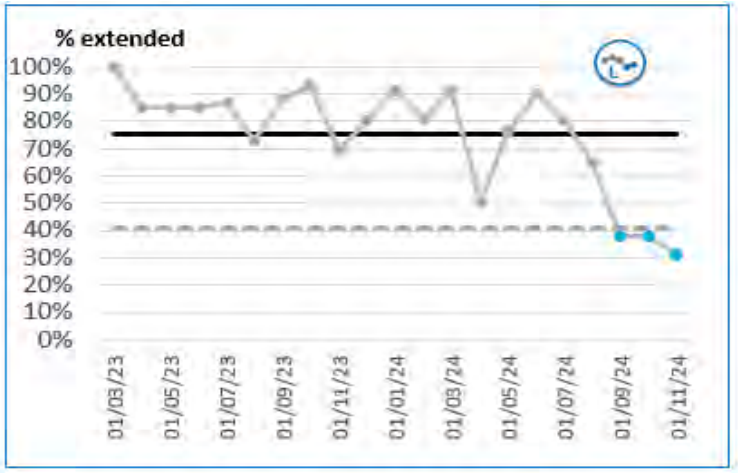
01/06/24
01/07/24
01/08/24
01/09/24
01/10/24
01/11/24


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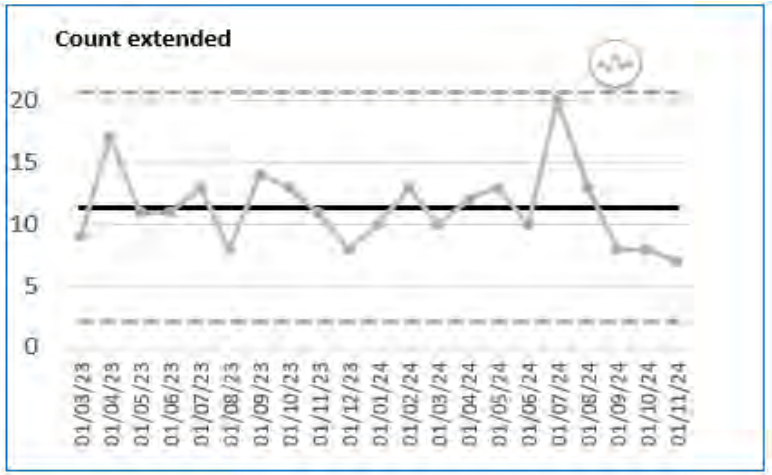
01/05/24
01/07/24
01/09/24
01/11/24


Count extended
20
15
10
5
0
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
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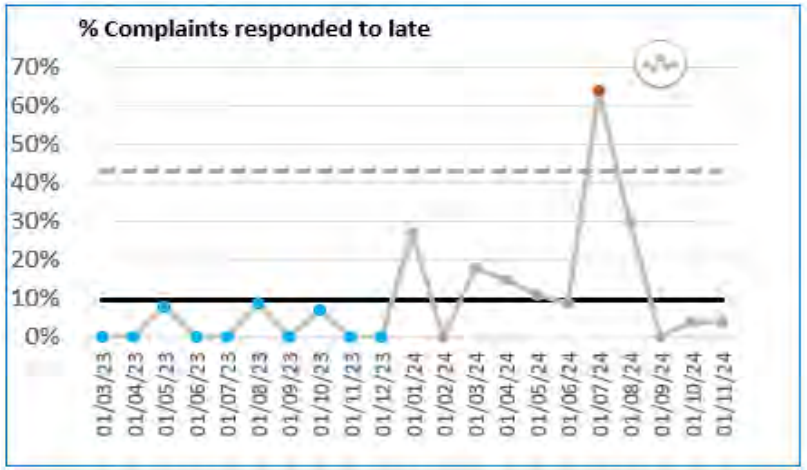
01/11/24


% Complaints responded to late
70%
60%
50%
40%
30%
20%
10%
0%
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
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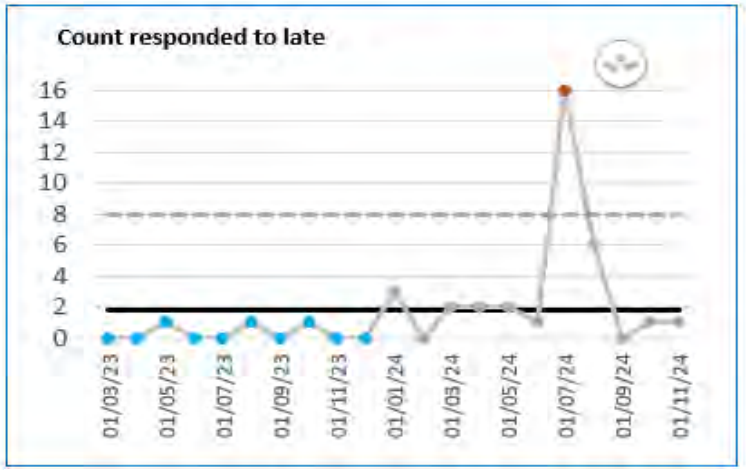
Count responded to late
16
14
12
10
8
6
4
2
0
01/03/23
01/05/23
01/07/23
01/09/23
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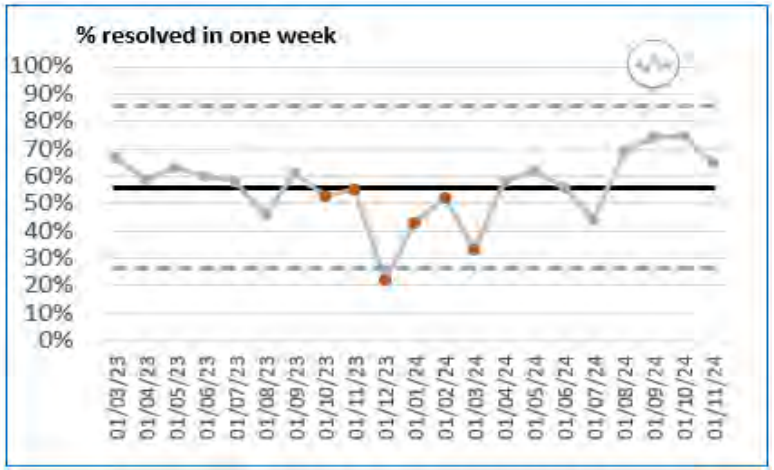
01/01/24
01/03/24
01/05/24
01/07/24
01/09/24
01/11/24


% resolved in one week
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
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
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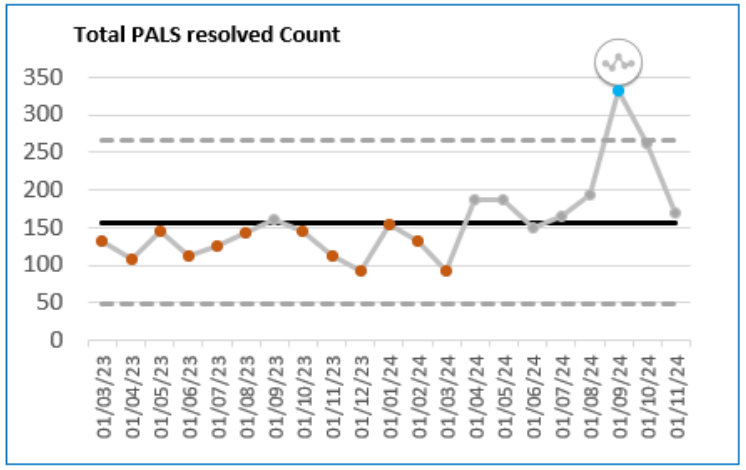
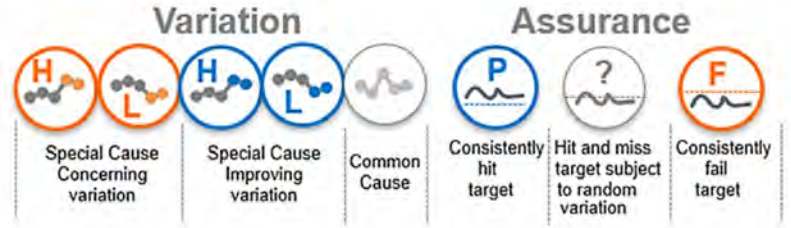
01/11/24


Total PALS resolved Count
350
300
250
200
150
100
50
0
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
01/07/24
01/08/24
01/09/24
01/10/24
01/11/24

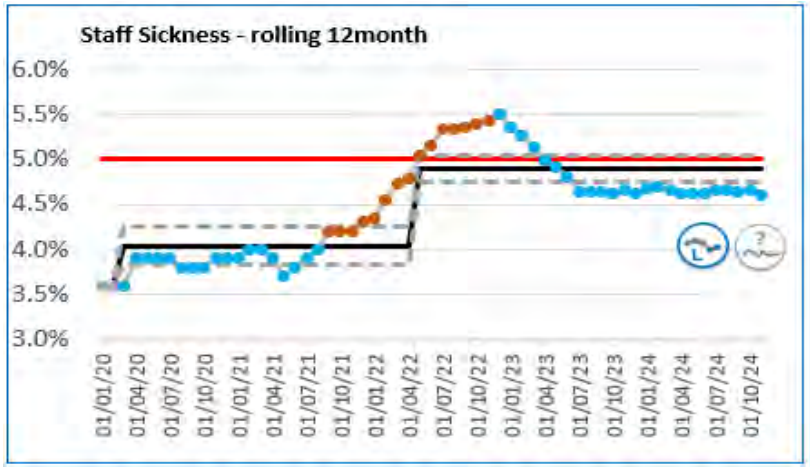
Safe

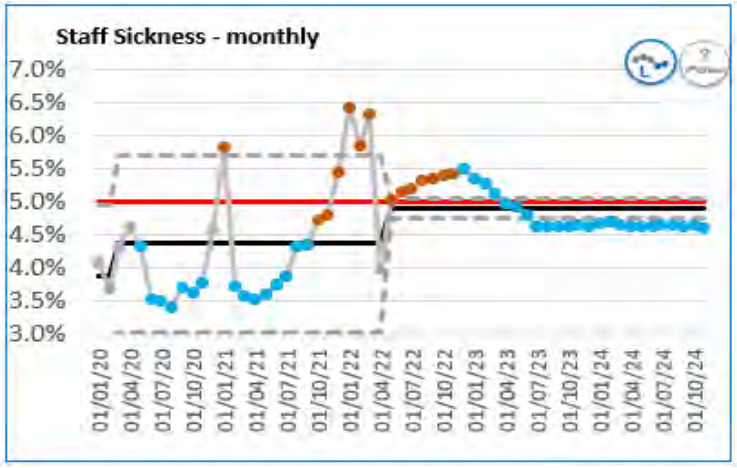
What	So What?	What Next?
22 formal complaints were responded to in November. A significant improvement of 31% of these were extended from it's original timeframe from a previous average of 75%. Out of the 22 complaints responded to, 1 was classified as late which was due to the investigation taking longer than initially expected due to the complexity involved. This remains within the controlled limits. Closed complaints remain consistent and volume of complaints extended are on a downward trend, which is a reflection that the working methods to obtain staff responses are working. This in turn has had a positive effect on the total open complaints, which has reduced to 21 which is an all-time low. 169 PALS cases resolved within November with 65% closed within one week. However both data set remains within the controlled limits.	The complaints team continue to implement the new staff response strategy to obtain statements of reflection in a timelier manner. This is working well which is reflected in the complaints closed performance and reduction in complaints extended, whereby we are receiving staff investigations at an earlier stage. The reduction of PALS cases resolved is a reflection of the staff shortages we are experiencing and through a period of uncertainty with 2 members of the patient experience team leaving the Trust. The PALS team continue to review and adapt how feedback is recorded for thematic analysis. The team are constantly providing support, advice, information and guidance to patients and their loved ones on a daily basis which doesn't always require investigation. We are working on how we track this activity for performance and productivity measures.	The target remains for the PALS team to reach a minimum of 75% of cases resolved within one week. Direct line management and support is being given to PALS to ensure this metric reaches the target and is maintained. Total PALS resolved cases is expected to increase in the new year from November however given the reduction in staff, this is not predicted to reach previous highs. A weekly internal report is now being provided to the PALS team to track performance more closely and to ensure KPIs are on track. We are reviewing resource within the wider patient experience and engagement team to help with any delays and backlogs within PALS. We expect after the festive period, from February, that we will have more stability within the team and a clearer picture on the new average for each of the PALS KPIs. The complaints team will continue to monitor extensions and are prioritising complaints where we have received all staff responses and can begin drafting reports. The performance of this is influenced by investigating colleagues and sign-off for which we will monitor and make improvements to our process as sustainable long-term solutions become apparent. The complaints service is on track with expected service levels however our target is to reduce volume of extended complaints to 20% as a maximum by June 2025.

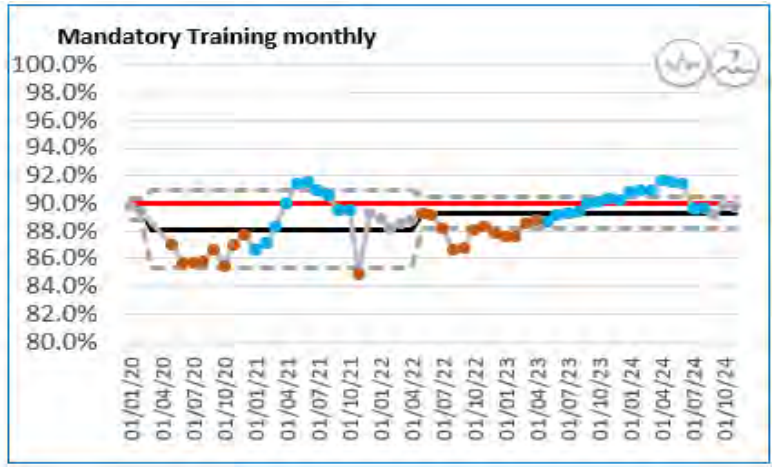


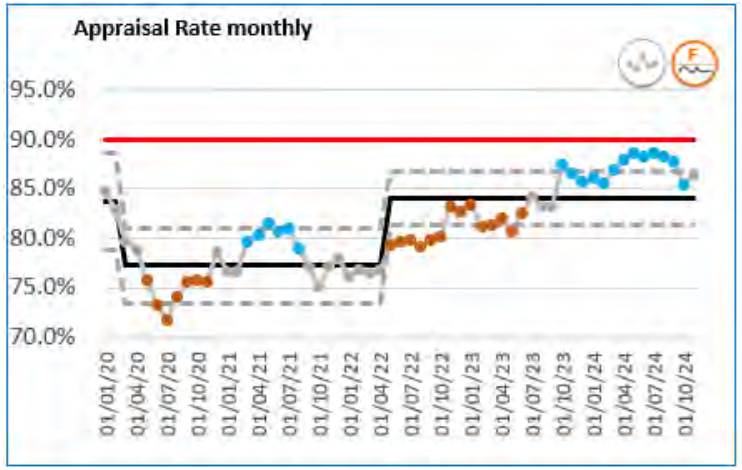
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	Nov 24	4.6%	5.0%			4.9%	4.8%	5.0%
Staff Sickness - monthly	Nov 24	4.6%	5.0%			4.9%	4.8%	5.0%
Mandatory Training monthly	Nov 24	89.7%	90.0%			89.3%	88.2%	90.5%
Appraisal Rate monthly	Nov 24	86.4%	90.0%			84.0%	81.3%	86.7%
Turnover rate monthly	Nov 24	6.8%	10.0%			10.5%	9.6%	11.3%

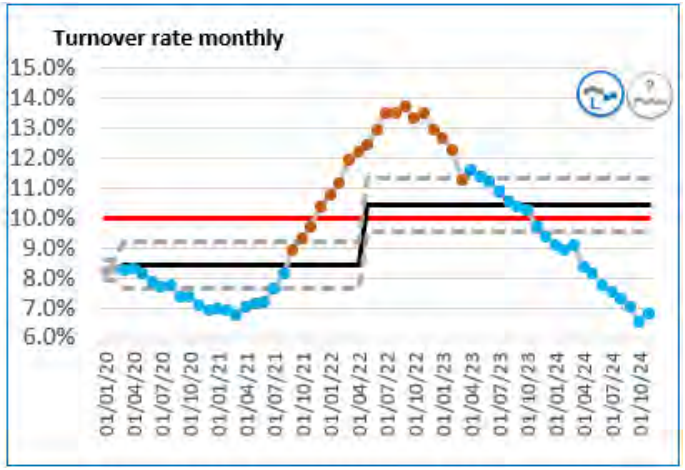
Well Led











What	So What?	What Next?
Two out of four of our key performance indicators continue to record an improving variation with mandatory training marginally below target. Sickness – achieving target at 4.6% versus 5% target. Mandatory training – slightly below target at 89.7%. Appraisal – consistently failing target, 86.4% versus 90% target. Turnover – achieving target, sustained improvement since November 2022.	These workforce key performance indicators directly impact on staff morale, staff retention, and therefore, patient care and safety. Additionally, improvements in these workforce key performance indicators will strengthen our ability to be the employer of choice for our community and the recognition as a great place to work.	Maintain improvements in staff attendance and continue to monitor at department level. Recover the target compliance of mandatory training ensuring areas and staff groups are identified where further focus and support may be required. Continued analysis of appraisal data to support and challenge areas in need of action and improvement. Maintain focus on the delivery of our people and culture plan and priorities.